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## COUNCIL OF GOVERNORS' MEETING

A meeting of the Harrogate and District NHS Foundation Trust Council of Governors will take place on Wednesday, 3 May 2017 in The Cover Room, The Pavilions of Harrogate, Great Yorkshire Showground, Harrogate, HG2 8NZ

**Start: 5.45pm      Finish: 8.00pm**  
**(Private discussion for Governors and the Board will commence at 5.15pm)**

AGENDA				
Time	Item No.	Item	Lead	Paper No.
5.45	1.0	<b>Welcome and apologies for absence</b> <i>Welcome to the public and setting the context of the meeting</i>	Mrs Sandra Dodson, Chairman	-
5.45	2.0	<b>Minutes of the meeting held on 18 February 2017</b> <i>To review and approve the minutes</i>	Mrs Sandra Dodson, Chairman	2.0
5.50	3.0	<b>Matters arising and review of action log</b> <i>To provide updates on progress of actions</i>	Mrs Sandra Dodson, Chairman	3.0
5.55	4.0	<b>Declarations of interest</b> <i>To declare any interests relevant to the agenda and to receive any changes to the register of interests</i>	Mrs Sandra Dodson, Chairman	4.0
5.55	5.0	<b>Chairman's verbal update on key issues including:</b> <ul style="list-style-type: none"> <li><b>Update on Governors' terms of office</b></li> </ul> <i>To receive the verbal update for consideration</i>	Mrs Sandra Dodson, Chairman	5.1
6.05	6.0	<b>Governor Sub-Committee Reports</b> <i>To receive the reports for comment</i>	Mrs Sandra Dodson, Chairman	
	6.1	<b>Governor Working Group - Volunteering and Education</b>	Mrs Jane Hedley, Public Governor	6.1
	6.2	<b>Governor Working Group - Membership Development and Communications</b>	Ms Pamela Allen, Deputy Chair of the Council of Governors/ Public Governor	6.2
	6.3	<b>Patient and Public Involvement – Learning from Patient Experience Group</b>	Mrs Liz Dean, Public Governor	6.3
6.15	7.0	<b>Update on Quality of Care Teams</b>	Mrs Jill Foster, Chief Nurse	7.0
	7.1	<b>Quality Priorities for 2017/18</b> <i>To receive the reports for comment</i>	Mrs Jill Foster, Chief Nurse	7.1

6.25	8.0	<b>Report from the Nominations Committee</b> <i>To receive the report for comment and approval:</i> <ul style="list-style-type: none"> <li>• Minutes of the meeting held 12 April 2017</li> <li>• Update on the appointment schedule for Non-Executive Director</li> <li>• Appointment of Vice Chairman</li> </ul>	Mrs Sandra Dodson, Chairman	8.0
	8.1	<b>Update from the Nominations Committee on the Chairman's recruitment process</b> <i>To receive the verbal update on progress</i>	Ms Pamela Allen, Deputy Chair of Governors/Public Governor	-
6.35	9.0	<b>Presentation – Apprenticeship Scheme</b>	Mrs Shirley Silvester, Head of Learning and Organisational Development and Mrs Sharon Wilkes, Clinical Workforce Transformation Lead	-
<b>6.50 - 7.00 pm – Break</b>				
7.00	10.0	<b>Chief Executive's Strategic and Operational Update, including Integrated Board Report and Operational Plan 2017/18</b> <i>To receive the update and report for comment</i>	Dr Ros Tolcher, Chief Executive	10.0
7.20	11.0	<b>Question and Answer Session for members of the public and Governors</b> <i>To receive and respond to questions from the floor relating to the agenda</i>	Mrs Sandra Dodson, Chairman	-
7.45	12.0	<b>Assurance on challenges for 2017/18 and reflection on performance 2016/17</b> <i>To receive and respond to questions from the floor</i>	Non-Executive Directors	-
7.55	13.0	<b>Any other relevant business not included on the agenda</b> <i>By permission of the Chairman</i>	Mrs Sandra Dodson, Chairman	-
8.00	14.0	<b>Close of meeting</b>	Mrs Sandra Dodson, Chairman	-

**Date and time of next meeting –**

**Wednesday, 2 August 2017 at 5.45 pm (private meeting commences at 5.15 pm) to be held at St. Aidan's Church of England High School, Harrogate**

### **Council of Governors**

Minutes of the public Council of Governors' meeting held on 18 February 2017 at 10:45 hrs  
at St Aidan's Church of England High School, Oatlands Drive, Harrogate, HG2 8JR

**Present:**

- Mrs Sandra Dodson, Chairman
- Ms Pamela Allen, Public Governor/Deputy Chair of Council of Governors
- Cllr. Bernard Bateman, Stakeholder Governor
- Dr Sally Blackburn, Public Governor
- Mrs Yvonne Campbell, Staff Governor
- Mrs Cath Clelland, Public Governor
- Mrs Angie Colvin, Corporate Affairs and Membership Manager
- Ms Clare Cressey, Staff Governor
- Mr Tony Doveston, Public Governor
- Miss Sue Eddleston, Public Governor
- Mrs Jill Foster, Chief Nurse
- Mrs Jane Hedley, Public Governor
- Mrs Ann Hill, Public Governor
- Cllr. Phil Ireland, Stakeholder Governor
- Mrs Pat Jones, Public Governor
- Mr Phillip Marshall, Director of Workforce and Organisational Development
- Mr Neil McLean, Non-Executive Director
- Mrs Zoe Metcalfe, Public Governor
- Mr Peter Pearson, Public Governor
- Prof. Sue Proctor, Non-Executive Director
- Dr Daniel Scott, Staff Governor
- Mrs Maureen Taylor, Non-Executive Director
- Mr Chris Thompson, Non-Executive Director
- Dr Ros Tolcher, Chief Executive
- Mr Steve Treece, Public Governor
- Mrs Lesley Webster, Non-Executive Director

**In attendance:**

- 11 members of the public
- Mrs Emily Reid, Education Liaison, Work Experience and Membership Officer
- Mr Richard Chillery, Operational Director, Children's and County Wide Community Care Directorate

## **1. Welcome and apologies for absence**

Apologies were received from Mr Jonathan Coulter, Director of Finance/Deputy Chief Executive, Dr Sarah Crawshaw, Stakeholder Governor, Mrs Liz Dean, Public Governor, Mrs Emma Edgar, Staff Governor, Mrs Beth Finch, Stakeholder Governor, Mr Rob Harrison, Chief Operating Officer, Mrs Sally Margerison, Staff Governor, Dr David Scullion, Medical Director, Mr Ian Ward, Non-Executive Director, and Dr Jim Woods, Stakeholder Governor.

Mrs Dodson was delighted to see so many members of the public at the meeting and offered them a warm welcome. She hoped they would find the meeting interesting and informative and welcomed questions for Governors or any member of the Board in attendance. She asked that any questions for item 10 on the agenda to be submitted during the break.

Mrs Dodson was also delighted to introduce Mrs Reid and Mr Chillery, who would be talking about the Youth Forum under item 8 on the agenda and she welcomed the new Governors who had commenced their term of office on 1 January: Miss Eddleston, Mrs Hill, Cllr. Ireland and Mr Treece.

## **2. Minutes of the last meeting, 2 November 2016**

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

### **2.1 Minutes of the Extra-ordinary Council of Governors' meeting, 30 November 2016**

The minutes of the Extra-ordinary Council of Governors' meeting held on 30 November 2016 were agreed as a true and accurate record.

### **2.2 Minutes of the Annual Members' Meeting (AMM) held on 13 September 2016**

Mrs Dodson asked for the minutes of the last AMM to be noted and any comments to be forwarded to Mrs Colvin. The minutes would then be ratified at the next AMM in September.

## **3. Matters arising and review of action schedule**

Mrs Foster provided an update regarding the progress of Nutritional Assistants; item 1 on the outstanding action schedule. She confirmed there were eight well-established Nutritional Assistants based on the wards and they were making a valuable contribution in supporting patients with their nutrition.

Mrs Hedley had a keen interest in the role of the Nutritional Assistants as she attended the Nutrition Group meetings as a member of the Patient Voice Group. Mrs Foster confirmed that the Nutritional Assistants provided nutritional support at breakfast and lunch times Monday to Friday; evenings and weekends were covered by Care Support Workers and registered nurses.

Mr Marshall provided an update regarding the Global Health Exchange Programme; item 2 on the outstanding action schedule. He was delighted to report that a small team of representatives from the Apollo Group and Health Education England, who



were running the Indian element of the Global Health Exchange initiative, had visited the Trust on 22 November 2016 and had the opportunity to meet Trust staff and have a guided tour of Harrogate Hospital.

Interviews had taken place for the first cohort of nurses and 24 had been given conditional offers of employment. Mr Marshall confirmed that ten nurses had taken their first set of exams, including English language, that day in Hyderabad, India and the results would be known the following week. For those who were successful, the next steps would be to apply for a visa and then travel to England to complete further training at Northampton University. Mr Marshall would be pleased to provide a further update at the next meeting.

Cllr Bateman enquired whether the nurses would stay in the UK. Mr Marshall confirmed that the programme was based on an 'earn, learn and return' initiative and the aim was for the staff to return to India.

Following a question submitted at the last meeting covered under items 3, 4 and 5 on the outstanding action schedule, confirmation had been received that seating was now available in the Strayside entrance on Harrogate District Hospital and other areas were also being reviewed. There was a telephone near the emergency maternity entrance of the hospital and a laminated notice with key contact numbers was now displayed. Mrs Dodson confirmed she had spoken with Mrs Tomlinson, Volunteer Services Manager, and agreed that the 'Meet and Greet' Volunteers based at the main entrance to the hospital would be very happy to help anyone who entered at the maternity entrance and rang for assistance.

Miss Eddleston welcomed the positive response and commented that further seating would also be appreciated.

Mrs Dodson confirmed that she had thanked Dr Leigh for her presentation at the Medicine for Members' Event in October 2016 and this was the final action on the schedule.

**ACTION:**

- **Mr Marshall to provide a further update on the Global Health Exchange Programme at the next meeting in May.**
- **An update on the review of seating arrangements in Harrogate District Hospital.**

#### **4. Declaration of interests**

In response to Mrs Dodson's request for any declarations of interest, Mr Treece confirmed that he was an employee of NHS Digital and this was recorded on Paper 4.0.

There were no other declarations of interests from Governors.

Mrs Dodson reminded Governors that they would be asked to sign a Declaration of Interest form on an annual basis and that 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 introduced the newly elected Public Governors: Miss Eddleston, Mrs Hill and Mr Treece, and also Cllr. Ireland, the newly appointed Stakeholder Governor representing Harrogate Borough Council to their first meeting. She explained that Stakeholder Governors were not elected as local representatives but nominated by their respective organisations and then appointed by the Trust to foster stakeholder engagement and to seek views on service development and specialist advice, to name a few.

As well as Harrogate Borough Council, the Council of Governors included Stakeholder Governors representing North Yorkshire County Council, Leeds University, the Voluntary Sector, Patient Experience, and Harrogate and Rural District Local Medical Committee.

Mrs Dodson wished to formally thank Mr Michael Armitage, Public Governor for Wetherby and Harewood, who had finished his term of office at the end of December 2016 for his contribution on the Council for the last three years.

On behalf of the Trust, Mrs Dodson was delighted to congratulate Mrs Clelland who had been awarded an MBE in the 2016 Queen's Birthday Honours for her services to the community in West Yorkshire. Mrs Clelland had received her prestigious award from Prince Charles.

Finally, Mrs Dodson also congratulated Professor Proctor on her appointment as Chair of Leeds and York Partnership NHS Foundation Trust; a provider of NHS mental health and learning disability services across Leeds and specialist services across Yorkshire and the Humber. Professor Proctor would take up her new role from 1 April. Mrs Dodson commented that the Trust was disappointed to lose such a valued Non-Executive Director and Vice Chair on the Board but was delighted for Leeds and York Partnership Trust and both Trusts would continue to work in partnership. Mrs Dodson thanked Professor Proctor and wished her all the very best for the future.

## **6. Governor Sub-Committee Reports**

Mrs Dodson moved on to clarify the role of the two formal sub committees and the Patient and Public Involvement, Learning from Patient Experience Group. She said how important it was for the general public to hear about the work of these sub-committees 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 Hedley, had been circulated prior to the meeting and was taken as read.

Mrs Hedley highlighted the new volunteers from Ripon Grammar School who had commenced volunteering in Trinity Ward at Ripon Community Hospital, outlined in her report.

There were no questions for Mrs Hedley.

Mrs Dodson was pleased to hear about the volunteers who were actively engaging with the patients in Ripon and expressed how important this was for patients who were often required to stay in hospital for longer periods of time.

## 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 membership recruitment and engagement outlined in her report. She thanked Miss Kirsty Burt, Corporate Administrative Assistant and Mrs Colvin for their focus on engaging with new members in the age group 22 – 45 and with people residing in rural communities.

Ms Allen commented that members of the sub-committee would welcome the opportunity to meet and talk to different groups to promote membership and the role of the Governor.

There were no questions for Ms Allen.

## 6.3 Patient and Public Involvement

Mrs Dodson took a question from a member of the public at this stage in the meeting. The member of public needed to leave before item 10 on the agenda. The question submitted was as follows:

**“What are the changing facilities at the hospital for adult disabled visitors/patients as the disabled toilets are not suitable.” In addition, a member of the public commented about access issues to the hydrotherapy pool.**

Mrs Dodson thanked the member of the public for her question and said that it was an important question to raise which highlighted general accessibility for everyone. She confirmed that the Trust's Equality and Diversity Stakeholder Group had Governor representation and such issues were discussed in that forum.

In relation to the issues around access to the hydrotherapy pool, Mrs Foster agreed to follow this up outside of the meeting with the Operational Director for Planned and Surgical Care. With regard to a 'Changing Places' facility in Harrogate Hospital, Mrs Foster was pleased to report a space had been identified near Herriot's Restaurant on the first floor and this was currently in the planning phase. In the meantime, if anyone visiting the hospital required such a facility they could ask at the front reception desk and the Site Co-ordinator or Matrons would be able to identify somewhere appropriate on a ward.

Mrs Dodson explained that any actions as a result of questions submitted, or indeed from any discussions throughout the meeting, would be recorded on the action schedule and raised at the following meeting for a further response. This would provide assurance for members of the public that actions were being dealt with.

Following the comment about access to the hydrotherapy pool, another member of the public asked about the cost of a hoist. Mrs Dodson agreed that the finer detail of the individual's issue would be dealt with outside of the meeting.

### **6.3.1 Quality of Care Teams – individual Governor feedback on attendance at Quality of Care Teams**

Mrs Dodson explained that Quality of Care Teams formed part of the Trust's governance structure and the aim of these multidisciplinary teams was to ensure that quality and safety was discussed as a matter of priority at local level. She acknowledged that some Quality of Care Team meetings were more effective than others and welcomed feedback from Governors who were assigned to a Team.

Mrs Jones confirmed that she was involved with the Quality of Care Team for the Special Care Baby Unit and Woodlands children's ward. She thoroughly enjoyed being part of their team which met once per month and provided positive feedback regarding both the team and the format of the meetings. Mrs Jones highlighted the opportunity to spend time talking to patient's families about their experience with children in hospital.

Mrs Dodson was pleased to hear such positive feedback and commented how this demonstrated a well-managed Quality of Care Team.

Mr Doveston confirmed he had joined the Sir Robert Ogden Macmillan Centre Quality of Care Team which was attended by hard-working and dedicated staff, including doctors. This experience provided him with a good insight into team working and team morale. He gave examples of what was discussed in a typical meeting including items on the risk register, service development, new drugs, audit trials, and feedback from patient experience; both positive and negative issues. He was pleased to say he felt very welcome at the meetings and the discussions were genuine and honest.

Mrs Dodson acknowledged that there could be positive and negative issues highlighted at such meetings and it was important to have a culture of openness and honesty.

Mr Pearson was pleased to confirm he had joined the Pathology Quality of Care Team which met once a month to review a wide range of pathology related aspects. He gave some examples of the papers the team looked at in detail and acknowledged that external pressures, including freedom of information requests and inspections, could have an impact on a variety of priorities.

Mrs Dodson thanked Mr Pearson for his detailed feedback and clarified that the Governors' role on these teams was to gain an understanding of the quality and risk issues being discussed. This involvement demonstrated how much Governors were engaged

across the organisation and the insight they could gain from being a member of these teams.

Ms Allen stated that she was pleased to hear from fellow Governors about the success of the Quality of Care Teams they were involved with. Unfortunately, she had not had a similar experience and the team she was assigned to did not function as effectively which meant she was not currently involved.

Dr Blackburn provided an overview of her involvement with the Joint Health Visitor and School Nursing Harrogate and Rural Quality of Care Team, which met monthly. They focussed on children's services provided in the community and Dr Blackburn thoroughly enjoyed attending meetings.

Mrs Dodson stated that it was important to recognise that not all Quality of Care Teams followed the successful role model however the initiative was a fundamental aspect of governance and consistency across the teams was needed.

Mrs Dodson confirmed that Quality of Care Teams were held both in the hospital and across the community and acknowledged the challenges faced by community staff to come together for such a meeting once a month. Mrs Dodson set the challenge to teams in the hospital to be able to do the same.

### **6.3.2 Update from the Chief Nurse on review of Quality of Care Teams process**

Mrs Foster thanked all the Governors for their comments and their valuable time in attending Quality of Care Team meetings. She was aware that not all of the teams were functioning as well and acknowledged that further progress was required. She stated that Directorates reported back to her on a six monthly basis, including Quality of Care Team actions, and agreed to provide a further update at the next Council of Governors meeting in May.

#### **ACTION:**

- **Mrs Foster to provide a further update on the progress of Quality of Care Teams at the Council of Governors' meeting in May.**

### **6.4 Patient Safety Visits Annual Report**

Mrs Dodson explained that patient safety visits were a way of ensuring that:

- Executives and Non-Executives were informed first hand, regarding the safety concerns of frontline staff.
- Senior leaders demonstrated visible commitment by listening to and supporting staff when issues of safety were raised.
- The safety of patients was seen as the priority of the organisation.

One Governor was invited to join the visiting team on each planned patient safety visit.

The purpose of patient safety visits was to:

- Encourage staff to raise any concerns in a forum which was supportive.
- Build good communication and relationships with staff.
- Enable senior leaders to promote a positive safety culture among all staff, such as the value of incident reporting in order to learn and improve the delivery of safe care.
- Obtain and act on information that identifies risk and areas for improvement.
- Promote the use of local solutions whenever possible.

Mrs Foster referred to her annual report which had been circulated prior to the meeting and taken as read. She confirmed that patient safety visits were an important mechanism to meet with staff on the frontline and discuss any concerns. Meetings were organised in advance and the meeting would take place with any staff available, and on duty, that day.

There were no questions for Mrs Foster.

#### **6.5 Update on the Quality Account Process**

Mrs Foster outlined the purpose of the Quality Account, an integral part of the Annual Report and Account, which reflected on the highest priorities of the Trust for the forthcoming year and reported on progress made in the past year.

Mrs Foster highlighted the importance of stakeholder engagement in producing the Quality Account and to determine the quality priorities for the coming year. This would involve engaging with a variety of stakeholders, including Governors, to ensure representation of the local community. The final report would be submitted for publication at the end of May.

Mrs Dodson added that the Quality Account would continue to be monitored through the Quality Committee.

### **7. Report from the Nominations Committee**

Mr Thompson left the room at this stage in the meeting.

Mrs Dodson confirmed the responsibility of the Council of Governors to appoint and reappoint the Chairman and Non-Executive Directors. Paper 7.0 had been circulated prior to the meeting, including the recommendations of the Nominations Committee to the Council of Governors, and this was taken as read.

The Nominations Committee had met on 27 January to discuss the reappointment of Mr Thompson to a second term of office as Non-Executive Director from 1 March 2017 to 29 February 2020.

Mrs Dodson referred to the minutes of the meeting held on 27 January and these were approved.



Moving on to the recommendation for the reappointment of Mr Thompson, Mrs Dodson had recommended to the Nominations Committee that Mr Thompson be reappointed to a second term, subject to the approval of the Council of Governors. Ms Allen fully endorsed the recommendation commending Mr Thompson's competency, enthusiasm and commitment to his role as Non-Executive Director and Chair of the Audit Committee.

There were no questions for the Nominations Committee and the Council of Governors was in unanimous agreement and approved the recommendation.

Mr Thompson returned to the room at this stage of the meeting and Mrs Dodson was pleased to congratulate him and report that the recommendation had unanimously been approved.

#### **7.1 Update from the Nominations Committee on the Chairman's Recruitment Process**

Ms Allen provided an update on the progress made regarding the recruitment process to appoint a new Chair. Following a tender exercise to select an Executive search organisation, presentations and interviews were held on 27 January and the panel were unanimous in recommending that Gatenby Sanderson should be appointed to facilitate the recruitment process. The Nomination Committee met with Mr Robin Staveley and Ms Emma Pickup from Gatenby Sanderson on 15 February to discuss the process in further detail including the timeline, job description, person specification and agree members of the interview panel. It was agreed that the following Governors would be on the interview panel: Ms Allen, Ms Cressey, Mrs Metcalfe and Mr Doveston. Dr Scott and Mr Treece would be on the focus groups. Ms Allen confirmed the closing date for applications would be 3 April and interviews would take place on 22 May, allowing candidates to meet with key members of Trust staff. The Council of Governors would be asked to ratify the appointment of the new Chair at an Extra-ordinary Council of Governors meeting on 16 June.\*

A member of the public enquired as to why Mrs Dodson could not continue as Chair to which Ms Allen confirmed, in accordance with the Trust's constitution, Mrs Dodson would be coming to the end of her third and final term of office on 30 September.

#### **8. Presentation – Youth Forum – listening to young people's experiences and ideas for healthcare improvement**

Mrs Dodson welcomed Mrs Reid and Mr Chillery to present about the new Youth Forum.

Mrs Reid thanked Mrs Dodson for the opportunity to present at the meeting and she provided an overview of the new Youth Forum to date. The Youth Forum was set up as a sub-group of the Governor Working Group for Membership Development and Communications for young people between the ages of 13 – 19. A variety of ways to promote the forum to young people included notices at events, posters in the hospital and in schools, invitations to young volunteers and work experience students, and networking with other local group contacts. The first meeting took place on 8 December 2016 and members agreed to meet every six weeks.

Current members were from a range of schools and some had long-term health conditions and had experienced some of the Trust's services. Mrs Reid was delighted to present some of the ways in which the Trust would be working alongside the Youth Forum to listen to their views, and actively involve them in projects across the organisation. Some of the suggestions to date included new methods of communication, innovative fundraising ideas, mystery shopper, and the exciting opportunity to work with the Children's and County Wide Community Care Directorate to develop a new Children's Strategy.

Mrs Reid displayed a photograph of some of the current members of the Youth Forum stating that each person brought their own unique blend of interests and the views of their peers. Mrs Reid and Mrs Colvin, with support from Governors and colleagues across the Trust, would support the Youth Forum to develop their own brand and enable their voices to be heard. Through networking with their peers, the Youth Forum would strengthen the Trust's relationship with schools and have opportunities to link up with other Youth Forums in the area. Two members had already volunteered to attend the North Yorkshire Youth Executive meeting; an excellent opportunity to take local health priorities to a county wide forum.

Mr Chillery talked about the expansion of children's services across North Yorkshire and more recently across Darlington, County Durham and Middlesbrough which he managed as Operational Director of the Children's and County Wide Community Care Directorate. He commented on the importance of listening to young people as well as receiving feedback through a variety of mechanisms. He acknowledged that this may bring its challenges but hoped that it would inspire the Trust to drive forward high quality children's services. Mr Chillery highlighted the objective to develop the Trust's strategy for young people and he looked forward to engaging with such a valuable resource within the Youth Forum and taking a steer from the community the Trust served.

Mrs Dodson opened up questions from the floor.

Mrs Webster noted that the forum was predominantly made up of girls. Mrs Reid confirmed there were boys in the group, albeit not as many, and one boy who was present when the photograph was taken chose not to be in the photograph. Mrs Reid confirmed recruitment would continue to be promoted to all and the challenge was put back to the forum to encourage more boys to join.

Cllr Bateman offered his support to the group. Mrs Reid thanked him and noted for a future opportunity.

Mr Chillery confirmed the forum was still new and the Corporate team was keen to allow them the time to develop as a group and feel confident in making decisions as to what was on their agenda.

Professor Proctor thanked Mrs Reid and Mr Chillery for an inspiring presentation. She asked: if young people raised issues around services not provided by the Trust, for example mental health, how these views would be communicated to other providers. Mr Chillery confirmed that mental health was already an emerging theme however through a variety of networks this should not be seen as a barrier to stifle communications.



Mrs Lennon, Chair of the Patient Voice Group, who had attended the meeting as a member of the public, expressed her delight towards the Youth Forum and asked how responsive providers could be towards any ideas they may put forward. Mr Chillery thanked Mrs Lennon for her question and confirmed that already the group were being involved in quick turnaround projects, so they would be able to see the results of their valuable input. In terms of the strategy, Mr Chillery explained this would be a longer term project and his aim would be to take this forward with the Youth Forum step by step and create opportunities to network with local schools.

There were no further questions for Mrs Reid and Mr Chillery and Mrs Dodson thanked them for such an informative presentation.

## **9. Chief Executive's Strategic and Operational Update, including Integrated Board Report**

Dr Tolcher presented the following headlines:

### Winter pressures and current performance

Dr Tolcher highlighted the considerable operational pressures experienced over the Christmas and New Year period, both in the hospital and across community services. The demand reached an all-time high for the organisation with emergency department attendances up by 12% compared to last year and emergency admissions up by 10%. She recognised that staff across the organisation had worked incredibly hard and commented that the Trust's performance was a tribute to their dedication and commitment in maintaining services and providing high quality care to our patients.

Dr Tolcher presented detailed charts of operational performance during surges in demand, including non-elective (emergency) bed days (adults, per 100,000), Emergency Department 4 hour standard, delayed transfers of care, and referral to treatment incomplete pathways, taken from the Integrated Board Report, available on the Trust's website.\*\* These charts demonstrated how the Trust was performing in the Emergency Department against national data and, despite not achieving its usual performance, the Trust had been recognised by NHS Improvement as one of the best performing Emergency Departments in England.

Dr Tolcher provided further information regarding the referral to treatment data; a national standard on how quickly patients were seen and treated. She explained the importance of reporting on quality and how long patients would expect to wait as people could choose where to receive treatment. Despite having some clinical specialities which exceeded the 18 week standard, namely orthopaedics and general surgery, the Trust performed well averaging around 94%.

Dr Tolcher moved on to a snapshot of Key Performance Indicators (KPIs) recorded in December 2016 and explained how these were rated. She explained some of the detailed information which related to the red-rated areas in the report taken from the Quality, Finance and Efficiency, and Operational Performance Indicators and provided reassurance on the actions being taken. Quality had three red-rated KPIs including: total number of falls, falls causing harm, and total number of incidents. Dr Tolcher offered reassurance that, although the overall aim was to have no falls, there had been a considerable reduction of fractures due to falls with five to date compared with 12 last year. Overall the number of falls was also less compared with last year.

Finance and efficiency had five red-rated KPIs in standardised readmissions, non-elective bed days, delayed transfers of care, surplus/deficit variance to plan, and cash balance. In relation to the Trust's financial position, Dr Tolcher stated that the Trust remained ahead of the financial plan in Q3, however there were significant risks to delivery at year end.

The Operational Performance summary demonstrated two red-rated KPIs in NHS Improvement single oversight framework and A&E 4 hour standard, which had dipped in the last quarter resulting in a red rating.

Dr Tolcher was pleased to report that the vast majority of performance indicators remained green, including all cancer pathways, referral to treatment, safety thermometer, infection control, and complaints and incidents, all despite the winter pressures.

#### Strategic landscape: Sustainability and Transformation Plans and New Care Models

Moving on to the strategic landscape Dr Tolcher provided a brief update on the West Yorkshire and Harrogate Sustainability and Transformation Plan (STP); delivered by local health care organisations working together across the region to support changes needed to improve services for its population. The Trust was part of the West Yorkshire STP footprint working collaboratively with five other acute hospitals having agreed a Committee in Common to make network decisions.

In addition, Dr Tolcher confirmed the local New Care Model (Vanguard) was in its last year of a three-year funding programme and formal evaluation would be shared at a later date.

#### Risks and Issues

Dr Tolcher went on to talk about the risks affecting the organisation at the current time, both internally and externally. She highlighted some of the top scoring strategic risks for the Trust which related to:

- The ability to deliver integrated models of care.
- Medical and nurse staffing levels.
- System level financial risks.
- Lack of a single care record.

The two top scoring operational risks in the organisation were:

- Ability to meet the Emergency Department 4 hour wait target.
- Income shortfall due to activity below plan.

In addition, Dr Tolcher talked about additional issues affecting the organisation including workforce supply issues, pressures on critical infrastructure (e.g. too much activity and not enough theatre capacity), finance, and future health and care architecture (the amount of time being engaged in all the different programmes).

Finally, Dr Tolcher finished her presentation by highlighting some of the initial findings from the National Staff Survey 2016; a mandatory report consisting of 21 questions based on quality of care and what each organisation was like to work for.

The final results were expected imminently, but Dr Tolcher was pleased to report initial positive findings: a 5% increase in the number of staff feeling confident to raise concerns. Dr Tolcher stated that this increase was remarkable given that the Trust already scored higher than average. A slightly more disappointing finding was a 3% decrease in the number of staff recommending the Trust as a place to work – 66% compared to 69% last year, however it was still reassuring that this figure was above the national average of 57% and Dr Tolcher looked forward to receiving detailed analysis of the figures shortly.

Mrs Dodson thanked Dr Tolcher for her update and opened up questions from the floor.

Dr Scott asked how the finance shortfall was impacting on the STP.

Dr Tolcher confirmed there was a complete freeze on capital spending in the NHS at the current time; the Trust had some developments on hold however, it was too early to provide any additional information at this stage.

A member of the public asked for clarification on bed management and Dr Tolcher confirmed this remained a challenge with difficulties moving patients back home or on to other care providers.

Mr Doveston asked, at this early stage with the STP, did the Trust see areas of vulnerability for Harrogate and had there been any reduction in services.

Dr Tolcher stated that a key objective for the Trust was to ensure clinical and financial sustainability. The aim in working with other acute trusts was to offer better value and better outcomes for patients. The NHS Five Year Forward View focussed on three gaps: closing the care and quality gap, closing the health and wellbeing gap, and closing the funding and efficiency gap. Dr Tolcher confirmed that health professionals across West Yorkshire and Harrogate were already engaging with local people regarding stroke services across the area and how these could be improved further whilst making the most of latest technology, staff skills and maximising the best outcome following a stroke. This engagement work was being supported by Healthwatch and would initially take six weeks. She explained that it was important for people to understand that stroke services would not disappear in Harrogate but if patients were transferred to a specialist unit quickly, this could provide the best outcome for that patient.

Mrs Hill asked if this would mean patients being moved to another area for stroke services. Dr Tolcher confirmed there was local tension regarding access to local services. The number of people having a stroke was expected to increase in the future and evidence showed the care people received in the first few hours could make a difference to how well they recovered. This included receiving specialist treatment in sustainable and resilient hyper acute stroke units which could mean that patients may be taken a longer distance to receive such treatment. Ongoing rehabilitation should however be provided at locations closer to where people live. Consultation would follow the initial engagement and the Trust would continue to provide an acute stroke service in the short-term.

Miss Eddleston commented that, on a recent visit to the Emergency Department, and despite it being very busy, she was pleased that every member of staff acted in a caring and professional manner and the department appeared calm. She confirmed

she would be writing to Mrs Foster and Dr Tolcher to praise the staff involved and she acknowledged the importance in recognising staff working in difficult conditions. She did however express concern for patients coming into the department on their own and asked how they could be supported to go home.

Dr Tolcher thanked Miss Eddleston for her valuable feedback and confirmed the Emergency Department team would be very pleased to receive her thanks. She expressed that the team wouldn't want anyone to be alone for any length of time whilst in the department, but this could happen at busy times. When well enough to leave the department and go home, people often relied on family and friends, as transport was not available to everyone. Staff would not knowingly let people go home alone and frightened late at night and they would support anyone, as much as they could, if this was the case.

Dr Scott commented on Dr Tolcher's slide regarding the initial findings from the National Staff Survey and wondered if Staff Governors could assist in the future with specific findings. Dr Tolcher confirmed the vast majority of staff had recommended the Trust as a place to work however, as the Trust provided services across a wide area staff may not choose to receive treatment here if they lived further afield. Mr Marshall and his team would be looking into the final results in greater detail.

There were no further questions in relation to Dr Tolcher's presentation.

#### **10. Question and Answer session for members of the public and Governors**

Mrs Dodson moved to the tabled questions submitted prior to the meeting and during the break.

**Ms Cressey, Staff Governor, had submitted the following comment:**

**"I would like to be assured that the Trust is being paid for treatment for overseas visitors and this is not impacting on the financial balance."**

Dr Tolcher confirmed the Trust had a policy under development and the Trust did recover costs wherever possible.

**Mrs Edgar, Staff Governor, had submitted the following comment which Mrs Dodson read out in her absence:**

**"I would like an update on how the community care teams are developing and if we think some of the increase in unscheduled admissions might be attributed to the changes in community care and particularly the loss of the community matron role."**

Mrs Foster confirmed there hadn't been an increase in non-elective admissions but a significant increase in the number of referrals to the Community Specialist Nurses. The Directorates were looking into this in further detail and would be keeping admissions under review in order to take action early if avoidable admissions occurred.

Dr Tolcher referred to her presentation and added that there had been an upward spike relating to winter pressures, but prior to this, numbers had gone down.

**Mrs Margerison, Staff Governor, had submitted the following question which Mrs Dodson read out in her absence:**

**“Can the Board assure us that there is a strategy in place for managing patients with long-term conditions within the New Care Model? I would also like to seek assurance that End of Life Care management in the community is being addressed as a priority in view of the Care Quality Commission report last year.”**

In response, Mrs Foster confirmed the Trust was not commissioned to provide end of life care in the community. The Trust are commissioned to provide Specialist Palliative Care Nurses in the community who provide advice, care and treatment for patients with specialist palliation needs. The End of Life Working Group is working closely with external stakeholders to improve EOLC across Harrogate and the wider district.

**Dr Scott, Staff Governor, had submitted the following comment:**

**“I would suggest Governors seek assurance regarding the major investment in a Trust wide IT system”**

Mrs Dodson asked Mr Thompson to address this item.

Mr Thompson confirmed this was a hugely complicated area and the Board accepted that a good Information Technology system was critical as the Trust moved forward. The Board had considered and approved the IT Strategy recently which focussed on a robust IT infrastructure including both hardware and software. Mr Thompson referred to Dr Tolcher’s presentation earlier and expressed the importance of an electronic patient record to save duplication of data and multiple log-ons. He confirmed that Non-Executive Directors had met in May 2016 to understand the electronic patient record in finer detail and the risks associated with a large transitional programme. Non-Executive Directors were assured that the Board was managing associated risks effectively through Board meetings, Committee meetings and audit, and they had confidence moving forward.

He added that, following recent media regarding cyber security, KPMG had recently presented to the Board and he was reassured that the IT team were confident.

Mr Treece, Public Governor, had submitted a similar question prior to the meeting and was satisfied that Mr Thompson’s response had addressed this.

**Miss Eddleston, Public Governor, had submitted the following question:**

**“There seems to be fewer podiatry clinic appointments in Ripon yet patients are unaware as to the reason this should be so. Special concern for diabetics attending, normally every three months, yet being seen every six months or longer. One elderly lady had reported not being seen for over 12 months for her foot care.”**

Dr Tolcher stated that it was important to emphasise there was no ‘normal’ podiatry follow up for people with diabetes, each person had individual requirements and these could vary from weekly to annually dependent on the foot condition. She was pleased to reassure Governors that the number of Podiatry clinics had not reduced,

compared to last year, with ten clinical sessions per week at Ripon using the one room to full capacity. The service however, was seeking additional space.

**A member of the public asked for an update on the situation with the Royal Voluntary Service (RVS) café on the ground floor in Harrogate District Hospital.**

Dr Tolcher confirmed the seven-year lease for the RVS coffee shop at Harrogate District Hospital would come to an end on 30 June this year. Options had been explored to build on the existing high quality service for all the patients and public who visit the hospital including, enhancing the range and quality of food and drinks provided as well as extending the opening times to include weekends. There would be a complete refurbishment of the coffee shop area which was expected to re-open in the autumn. This would be a Trust-run service with volunteers supporting paid members of staff.

Dr Tolcher confirmed the RVS volunteers were part of the Trust's valued volunteer community and hoped they would continue to be associated with us.

There were no other questions and Mrs Dodson moved to the next item on the agenda.

**11. Non-Executive Directors' Feedback: Update on involvement in the Annual Plan for 2017/18 and two year Operational Plan**

Mrs Taylor, Chair of the Finance Committee, confirmed it was the role of the Committee to spend time looking at the finer detail of the plan. They had looked at all assumptions, levels of activity income, growth in services and population, and income and contractual arrangements with Clinical Commissioning Groups. The Committee understood system risks and investment challenges in capital infrastructure as Dr Tolcher had summarised in her presentation. She commented on how the plan reflected the STP landscape and how the Committee kept a close eye on the highest risks on the Risk Register. She was confident that any issues would be picked up and the Committee fully supported the two year Operational Plan.

There were no questions for Mrs Taylor.

**12. Any other business**

There were no further items of business and therefore Mrs Dodson closed the meeting. She thanked everyone for attending and confirmed the next meeting would take place on Wednesday, 3 May at 5.45pm at a venue to be confirmed.

\* Post meeting note – change of date for the meeting to ratify the appointment of the new Chair.

\*\* [www.hdft.nhs.uk](http://www.hdft.nhs.uk)



## **HDFT Council of Governor Meeting Actions Schedule – May 2017**

### **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	3 August 2016	Calendar of meetings - 2017	Mrs Angie Colvin, Corporate Affairs		Complete
2	29 July 2015	Update on progress of Nutritional Assistants	Mrs Jill Foster, Chief Nurse		Update provided 18 May 2016 Update provided 2 November 2016 Update provided 18 February 2017 - Complete
3	2 November 2016	Signage for telephone near emergency maternity entrance to Harrogate District Hospital	Mr Rob Harrison, Chief Operating Officer		Update provided 18 February 2017 - Complete
4	2 November 2016	Volunteers assisting patients with mobility difficulties entering the hospital near emergency maternity entrance	Mrs Sandra Dodson, Chairman		Update provided 18 February 2017 - Complete
5	2 November 2016	Thanks to Dr Leigh for presentation at Medicine for Members' Event	Mrs Sandra Dodson, Chairman		Update provided 18 February 2017 - Complete

### **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	2 November 2016	Update on the Global Health Exchange Programme	Mr Phillip Marshall, Director of Workforce and Organisational Development	Further update due 3 May 2017	Update provided 18 February 2017
2	2 November 2016	Seating arrangements to be made available	Mr Rob Harrison, Chief Operating Officer	Further update due 3 May 2017	Update provided 18 February 2017
3	18 February 2017	Update on review of Quality of Care Teams	Mrs Jill Foster, Chief Nurse	Further update due 3 May 2017	



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

1 (updated May 2017)

Name	Governor Status	Interests Declared	
<b>Mrs Cath Clelland MBE</b>	Public elected	<b>Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).</b>	Owner/Director - Canny Consultants Ltd Owner/Director – City Kipping Ltd (dormant) Non-Executive - York St John University, York
<b>Dr Sarah Crawshaw</b>	Stakeholder	<b>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</b>	National Institute for Health Research Clinical Research Network (NIHR CRN)
<b>Ms Clare Cressey</b>	Staff elected		NONE
<b>Mrs Liz Dean</b>	Public elected		NONE
<b>Mr Tony Doveston</b>	Public elected	<b>A position of Authority in a charity or voluntary organisation in the field of health and social care</b>	Volunteer for Yorkshire Air Ambulance
<b>Miss Sue Eddleston</b>	Public elected		NONE
<b>Mrs Emma Edgar</b>	Staff elected		NONE
<b>Mrs Beth Finch</b>	Stakeholder	<b>A position of Authority in a charity or voluntary organisation in the field of health and social care</b>  <b>Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services</b>	Operational Senior Service Manager, British Red Cross Independent living (Yorkshire Area)  Operational Senior Service Manager, British Red Cross Independent Living (Yorkshire Area)
<b>Mrs Jane Hedley</b>	Public elected		NONE
<b>Mrs Ann Hill</b>	Public elected	<b>Other</b>	Chair of Harrogate District over Fifties Forum (HDOFF) Harrogate representative on North Yorkshire Forum for Older People (NYFOP)

2 (updated May 2017)

Name	Governor Status	Interests Declared	
<b>Cllr Phil Ireland</b>	Stakeholder	<b>Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies)</b>  <b>A position of Authority in a charity or voluntary organisation in the field of health and social care</b>  <b>Position of authority in a local council or Local Authority</b>  <b>Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services</b>	Ingenium Lighting Ltd  Trustee – Relate Yorkshire  Member – Harrogate Borough Council, Knaresborough King James Ward  Relate Yorkshire
<b>Mrs Pat Jones</b>	Public elected	<b>Position of authority in a local council or Local Authority</b>  <b>Position of authority in a charity or voluntary organisation in health and social care</b>	Conservative Councillor representing Stray Ward  Trustee at Harrogate CVS Governor at Harrogate Ladies College
<b>Mrs Sally Margerison</b>	Staff elected		NONE
<b>Mrs Zoe Metcalfe</b>	Staff elected	<b>Position of authority in a local council or Local Authority</b>  <b>Position of authority in a charity or voluntary organisation in health and social care</b>	Conservative Harrogate Borough Councillor  Trustee at Hollytree Foundation Charity

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3 (updated May 2017)

Name	Governor Status	Interests Declared	
Mr Peter Pearson	Public elected	<b>Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies)</b>  <b>Position of authority in a local council or Local Authority</b>	Director – Severn Valley Railway (Holdings) PLC  Conservative Councillor representing Spa Ward, Ripon City Council.
Dr Daniel Scott	Staff elected		NONE
Mr Steve Treece	Public elected	<b>Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services</b>	Employee of NHS Digital
Dr Jim Woods	Stakeholder	<b>Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies)</b>  <b>Ownership, part-ownership or directorship of private companies, business or consultancies likely or possibly seeking to do business with the NHS</b>  <b>Other</b>	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

4 (updated May 2017)

## Report to the Council of Governors' Meeting

3 May 2017

**Report Title:** Update on Governors' Terms of Office

**Report From:** Mrs Sandra Dodson, Chairman

**Report Purpose:** For information

### 1. Background

Following a review of Governors' terms of office, and those with tenures expiring mid-year, Mrs Dodson and Ms Allen met with Dr Blackburn, Mrs Hedley and Mr Pearson individually to discuss extending their term of office until 31 December 2017. This would create both cost and resource efficiencies and bring the election process back in line with annual Council of Governor elections rather than the need to hold two elections this year.

In accordance with the Trust's Constitution, section 11.6.1, elected Governors:

- shall normally hold office for a period of three years;
- subject to the next sub-paragraph, are eligible for re-election after the end of that period;
- may not hold office for more than nine years in total or three terms of office.

None of the Governors named above will have served more than two terms, or six years in office, and it is therefore in our remit to extend their term of office until 31 December 2017.

### 2. Governors' Terms of Office

The Council of Governors are asked to note the following amendments to the terms of office for:

Dr Sally Blackburn, Public Governor for Harrogate and surrounding villages, second term of office 1 August 2014 to 31 December 2017.

Mrs Jane Hedley, Public Governor for Wetherby and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley wards, second term of office 1 July 2014 to 31 December 2017.

Mr Peter Pearson, Public Governor for Ripon and west district, first term of office 1 August 2014 to 31 December 2017.

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**Report to the Trust Council of Governors: 3 May 2017**

<b>Title</b>	<b>Paper 6.1 Governor Working Group – Volunteering and Education</b>
<b>Author(s)</b>	<b>Mrs Jane Hedley, Public Governor</b>
<b>Report Purpose</b>	<b>For information</b>

**This report summarises the items discussed at the last meeting of the Governor Working Group for Volunteering and Education, held on 4 April 2017.**

**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 large number of students who have applied to shadow a doctor and the large number of consultants who have offered work experience ensuring the success of the project.**

## Volunteering

We have 571 active volunteers; of these 428 are over 25 years of age and 143 under 25 years of age. Our volunteers contribute approximately 2,000 hours per month to the Trust.

New volunteers have been placed in the following areas:

- Admin volunteer for Endoscopy.
- Admin volunteer for the General Surgeons team.
- Admin volunteer for the Child Development Centre in Northallerton.
- Volunteer for the weekly Hip Replacement Education Classes.
- The Sir Robert Ogden Macmillan Centre has a new Admin volunteer and also a new Clinical Unit volunteer. The new Volunteer Art Therapist started her weekly sessions for patients in February.
- Two new Chaplaincy volunteers have joined the Chaplaincy Team; both are 6<sup>th</sup> form students, which is a first for this service.
- Ripon Community Hospital: A new Therapy Dog is due to shortly start visiting Trinity Ward every Friday.

Fifty Tea Time Preparation volunteers are helping in seven wards between 4-5 pm and 12 of them are trained Meal Time Volunteers so they stay from 5-6 pm to help with the evening meal service.

## Work Experience

The Work Experience team have received 55 applications from students to shadow a doctor. A strong team of consultants have offered work experience and the students will be matched according to their specific interest.

No more applications will be accepted this year as these have to be processed and delivered before the end of August.

## Education Liaison

Several staff attended the first Careers Fair, at Harrogate College. They promoted various careers in the Trust and found that many students had not considered the Trust as a possible employer.

Mock interviews with six students interested in a career in healthcare were undertaken at Outwood Academy. Feedback from Ripon states that their tour of the hospital enabled them to improve pass grades to merits and distinctions, as they could refer to the good practice they had observed.

Belmont Grosvenor School have chosen to support the hospital as their charity of the year, and are raising money to buy games and toys for Woodlands ward.



**Report to the Trust Council of Governors: 3 May 2017**

<b>Title</b>	<b>Paper 6.2 Governor Working Group – Membership Development and Communications</b>
<b>Author(s)</b>	<b>Ms Pamela Allen, Public Governor</b>
<b>Report Purpose</b>	<b>For information</b>

**This report summarises the items discussed at the last meeting of the Governor Working Group for Membership Development and Communications, held on 3 April 2017.**

**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 next Medicine for Members' presentation.**

## Youth Forum Update

Members of the Youth Forum are now actively providing valuable feedback and engaging in the work of the Trust as well as linking in with their peers across North Yorkshire.

Activities to date include:

- Providing feedback on e-safety posters;
- Attending North Yorkshire Youth Executive;
- 'Secret Shoppers';
- Starting to work with the Children's and County Wide Community Care Directorate on a Children and Young People's Strategy; and,
- Two members will be involved in the presentation audience for the recruitment of a new Chair for the Trust.

The Youth Forum are also starting to think about their own brand and name.

Governors are delighted with this initiative and look forward to listening to the views of this group. Further details can be found on the Trust website at:

<https://www.hdft.nhs.uk/about/education-liaison/youth-forum/>

## Membership Recruitment and Engagement

Through the work of this group, we continue to develop a representative and vibrant membership, offering innovative and active engagement across the organisation. A focus on promoting membership through a variety of different initiatives has increased our monthly membership figures from approximately 15 to 45 new members each month.

A few of the benefits of being a member include:

- A membership card offering a discount in Herriot's Restaurant on the first floor at Harrogate District Hospital and there will be a new loyalty scheme when the hospital Café re-opens on the ground floor in the autumn.
- A discount card which can be used across the country to obtain great offers and discounts at local and national retailers.
- Invitations to attend meetings and events and to take part in consultations and surveys, ensuring that your voice is heard.
- The right to vote and stand to be a Governor in Elections;

For further details, visit the website at:

<https://www.hdft.nhs.uk/about/membership/benefits/>

### Medicine for Members' Event

The next Medicine for Members' event takes place on:

**Thursday, 18 May at 6 – 7.15 pm and again on,  
Thursday, 25 May at 2 – 3.15 pm.**

Diabetes Nurses will be talking about recent work that has been undertaken in the hospital to sustain and promote safe insulin management. They will also be sharing information about the transition service – a service which helps young people aged 16-25 and their families to live with diabetes, how we support older people with diabetes at home or in the residential/nursing home care setting and how we are working closely with GPs and Practice Nurses to help with their knowledge and understanding of diabetes.

The presentations will take place in the **Lecture Theatre, Strayside Education Centre, 3<sup>rd</sup> Floor, Harrogate District Hospital** and there will be tea, coffee and biscuits available in the Enterprise Room 30 minutes before each presentation.

For further details including how to book a place, please visit the website or contact the Foundation Trust Office on 01423 554489:

<https://www.hdft.nhs.uk/about/membership/calendar/>

### Annual Members' Meeting 2017

The next Annual Members' Meeting will take place on:

**Thursday, 21 September at 6 – 8 pm with registration and refreshments from 5.30 pm.**

The agenda is yet to be confirmed, but the meeting will take place at The Pavilions of Harrogate, Great Yorkshire Showground, Harrogate, HG2 8NZ.

### Governor Elections

A decision has been made to incorporate mid-year and end of year elections in 2017. Dr Sally Blackburn, Mrs Jane Hedley and Mr Peter Pearson will therefore extend their term of office until the end of year.

The election process will commence in the autumn and further details will be provided at the next meeting in July and will also be available on the website at:

<https://www.hdft.nhs.uk/about/council-of-governors/governor-elections/>

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**Report to the Trust Council of Governors: 3 May 2017**

<b>Title</b>	<b>Paper 6.3 Patient and Public Involvement - Learning from Patient Experience</b>
<b>Author(s)</b>	<b>Liz Dean, Public Governor</b>
<b>Report Purpose</b>	<b>For information</b>

**This report summarises the items discussed at the last meeting of the Learning from Patient Experience Group, held on 12 April 2017.**

**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.**

## Chief Nurse Report

The Deputy Chief Nurse presented a summary of the report which was circulated in advance of the meeting and taken as read. Key points were highlighted:

### Unannounced Directors' Inspections 2016-2017

The rolling programme of unannounced Directors Inspections is designed to provide assurance on care standards with particular regard to infection prevention and control.

Ten wards were rated green in 2016 with a further six being rated either red or amber one of which is no longer the responsibility of the Trust. Further inspections are planned and will continue until a green status is achieved. The Chief Nurse explained that there are other activities also going on to address the issues identified.

### Complaints

The number of complaints received in February was the highest of the year to date. Following the increase in and intensity of activity and pressure on services in December, January and February there was no surprise expressed at the increase in the number of complaints. It was noted that 15 of the 26 complaints related to the Emergency Department and the Wards. A short discussion took place as to the potential reasons for the increase. It was concluded that there were probably a number of reasons.

We were given assurance that the Directorates are currently in the process of responding to the complaints. The Patient Learning Experience Group will receive feedback in due course.

The Improving Patient Safety Group noted that there has been a spike in concerns being raised and incidents regarding the DNACPR status of patients and the use of the forms. This has been discussed in a number of forums. As a result new risks have been added to the Corporate Risk Register until the mitigating actions are embedded.

### Nurse Recruitment

Nurse recruitment continued to be a key topic for discussion and lots of good work was being done to recruit and keep those with offers of employment 'warm' and engaged in an attempt to ensure that those with offers start employment with the Trust.

1. A recruitment evening was held on 21<sup>st</sup> March 2017:
  - a. 6 conditional offers of employment were made to student nurses qualifying in September and
  - b. 5 Registered Nurses.
2. A total of 40 conditional offers of employment have now been made to student nurses qualifying in September.
3. A successful 'on-boarding' event took place on 29<sup>th</sup> March 2017 with 25 students attending.

Nurse revalidation: since 1 April 2016 50 nurses have been supported through the revalidation process without difficulty.

#### Children's Services Inspections

CLAS (Combined Looked After and Safeguarding) Children Inspection in North Yorkshire took place during February 2017 which involved the HDFT Specialist Looked After Children Team, 0 – 19 Children's Service, Midwifery, Acute Paediatrics and the Emergency Department.

Verbal feedback has been given which raised some areas for improvement but no major concerns. The written feedback is expected in April.

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**Report to the Trust Council of Governors: 3 May 2017**

<b>Title</b>	<b>Paper 7.0 Quality of Care Team Meetings Assurance Framework</b>
<b>Author(s)</b>	<b>Jill Foster, Chief Nurse</b>
<b>Report Purpose</b>	<b>For information and to provide assurance on the regularity and effectiveness of the Quality of Care Teams</b>

This report is to provide information and assurance on the regularity and effectiveness of the Quality of Care Teams across the Trust.

The Quality of Care Team meetings underpin the quality governance framework of the Trust to promote quality of care. This report provides assurance regarding the governance framework which provides oversight of the effectiveness of the Quality of Care Teams.

## **Quality of Care Team Meetings**

The Quality of Care Team meetings are frontline service meetings developed as part of the methodology that underpins the quality governance framework of the Trust to promote quality of care. The services the Trust provides are varied, therefore it was agreed to provide direction for the standards expected of local multi-disciplinary arrangements for promoting quality of care, whilst each Directorate should determine the formatting and frequency of meetings and which services should hold Quality of Care Team Meetings.

The content of the meetings needs to provide assurance that the teams are meeting the standards expected which are:

- To promote quality improvement and a culture of 'being open', learning and safety;
- Support for local initiatives relevant to Trust and Directorate quality improvement priorities;
- Review key performance indicators for quality and what these are eg quality dashboard, Infection Prevention and Control audits, complaints, Friends and Family Test, incidents etc;
- To progress and embed actions related to complaints, incidents, audits, SIRIs, patient safety visits etc;
- To engage actively in audits;
- To ensure completion of risk assessments and the departmental risk register and progress actions to mitigate risk;
- To celebrate successes and innovation; and
- To share information about quality and the meetings with all relevant staff.

For information, the expected standards are published on the internet and are in Appendix One.

Each Quality of Care Team is responsible for implementing and monitoring actions at a local level and embedding lessons learned at departmental level. They are also responsible for timely completion and submission of departmental risk registers and for any risks unable to be managed at department level, to be incorporated into the Directorate Risk Register. Teams are encouraged to discuss SALUS issues if any arise. The meetings are also expected to discuss and respond to learning from the outcome of complaints. Discussion about audits and initiatives to improve the patient experience are discussed within the Quality of Care team meetings and learning is brought to the Directorates Quality and Governance meetings.

The Directorates are required to provide six monthly reports to the Learning from Patient Experience meetings.

## **Quality in Care Team Reports from the Directorates**

The Directorates were asked to review and provide assurance regarding the number and effectiveness of their Quality of Care Team meetings against the criteria set out below.

## CCWCC Quality of Care Meetings

Service	Governor Link	Multi-Disciplinary	Minutes shared with the Team	Do they meet the QoC standard
Safeguarding Children (including Looked after Children)	No	No	Yes	Yes
Community Dentistry	No	Yes	Yes	Yes
Co Durham 0-19	No	No	Yes	Yes
Middlesbrough 0-19	No	No	Yes	Yes
Darlington's 0-19	No	No	Yes	Yes
North Yorkshire 0-19	No	No	Yes	Yes
CHIS	No	No	Yes	Yes
5-19 Vaccination & Immunisation Steering Group (Durham & Darlington)	No	No	Yes	Yes
5-19 Vaccination & Immunisation Steering Group (Durham & Darlington)	No	No	Yes	Yes
Podiatry	No	No	Yes	Yes
Living with Pain & Chronic Fatigue	No	Yes	Yes	Yes
Specialist Children's Therapy Services (Harrogate and Hambleton & Richmondshire)	No	Yes	Yes	Yes
Speech & Language Therapy Adult LD	No	No	Yes	Yes
Paediatrics	Yes	Yes	Yes	Yes

## Planned & Surgical Care Quality of Care Teams

Service	QoC Team	How often they meet	Minutes Provided	Appropriate MDT attendance	Governor Link	Review incidents	Review risk register	Review complaints
Anaesthetics (incl Pain Team)	Yes	Monthly	No	Yes	No	Going Forward	Going Forward	Going Forward
Critical Care	Yes	Monthly	No	Yes	No	Going Forward	Going Forward	Going Forward
Gastro	Yes	Monthly	Yes	Yes	No	No	No	No
General Surgery	Yes	Bi-Monthly		Going Forward	No	Yes	N/A	Yes
Outpatients	Yes		Yes	Yes	No	Yes	No	Yes
Orthopaedics	Yes	B-Monthly	Yes	Ltd medical attendance	No	Yes	No	Yes
Maternity	Yes (MRMG)	Bi-monthly	Yes	Yes	No	Yes	Yes	Yes
Gynaecology	Yes Gynae PAP	Bi-monthly	Yes	Yes	No	Yes	N/A	Yes
Rheumatology	Yes	Bi-monthly	Yes	Yes	No		No	
Dermatology	Yes	Monthly	Yes	Yes	No	No	No	No
Ophthalmology	Yes	Monthly	No	Yes	No	Yes	No	Yes
Urology	<b>Feedback not obtained</b>							
Endoscopy	<b>Feedback not obtained</b>							
Theatres	<b>Feedback not obtained</b>							
Cardiorespiratory & Heart Centre	Sits with LTUC Cardiology							

## Long Term and Unscheduled Care

Team	Meets at least bi-monthly?	Appropriate MDT attendance?	TOR in place	Governor Link?	Agenda	Produces minutes?	Shared with team?	Minutes received by Quality Lead	Meet Quality Standards
Community Adult In AROS	Monthly	Yes	No	No	Yes	Yes	Yes	Yes	No
ED	Bi-monthly	Yes	Yes	No*	Yes	Yes	Yes	Yes	Yes
IPC	Bi-monthly	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Pathology	Bi-monthly	Yes	Yes	Yes	Yes	Yes	Yes	Some	Yes
Pharmacy	Bi-monthly	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Radiology	Monthly	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Ripon – Trinity	Monthly	Yes	No	No	No	Yes	Yes	No	No
Ripon MIU	Bi-monthly	Yes	No	No	Yes	Yes	Yes	Yes	No
Selby MIU	Bi-monthly	Yes	No	No	Yes	Yes	Yes	Yes	Yes
SROMC	Bi-monthly	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Bylands / Jervaulx	Monthly	-	-	-	-	-	-	No	No
CATT ward / Clinic & AMU	Bi-monthly	Yes	No	No	Yes	Yes	Yes	Yes	Yes
Granby (Respiratory)	Monthly	-	-	-	-	-	-	No	No
Oakdale (Stroke)	Monthly	-	-	-	-	-	-	No	No
Lascelles	Monthly	Yes	No	No	Yes	Yes	Yes	Yes	Yes
Haematology	Bi-monthly	Yes	No	No	Yes	Yes	Yes	Yes	Yes
GP OOH - Catterick & Northallerton	Bi-monthly	Yes	No	No	Yes	Yes	Yes	Yes	No
GP OOH - Harrogate	Bi-monthly	-	-	-	-	-	-	No	No

\*Awaiting allocation of replacement governor

## Action Plan

ID No	Issue / Finding / Theme	Action(s)	Operational Lead	Responsible Lead	Target Date	Evidence of Completion	Date of Completion
1	Not all groups are having regular Quality of Care Meetings	Quality of Care team meeting requirements to be re-issued	S Morrison	T Campbell	30/04/2017	email	
2	Not all groups meet the required quality standard	Standards and draft Terms of Reference to be re-issued to leads	S Morrison	T Campbell	30/04/2017	email	
		Directorate representation at groups (HoN / QAL / Matrons/ General Manager)	S Morrison	T Campbell	31/05/2017	Meeting minutes	
3	There is not a clear escalation path to the Clinical Safety & Governance Group	Minutes and summary including escalation for inclusion in the CS&G agenda	S Morrison	T Campbell	31/05/2017	CS&G meeting minutes	
4	Lack of Governor representation	Discuss with Corporate Affairs and Membership Manager	S Morrison	T Campbell	30/04/2017	Meeting notes / email	

## Conclusion

Not all areas where Directorates have decided Quality of Care Team Meetings are required, are having meetings that meet the standards required for Quality of Care meetings. It is important that we are assured of the effectiveness and the regularity of the meetings, therefore the Directorates have been asked to provide assurance through action plans how they will ensure their Quality of Care Team Meetings meet regularly and are effective.

### **Standards expected of local multidisciplinary arrangements for promoting quality of care**

#### **Accountability**

The Directorate's Governance Group / Board is required to approve the local arrangements for multi-disciplinary promotion of high quality care if Quality of Care Teams are not in place.

#### **Standards**

The arrangements must ensure that the local multi-disciplinary team receives regular and up to date information in a way that enables awareness of quality performance and engagement with quality improvement.

The arrangements must provide assurance of:

- An expectation that the multidisciplinary team will promote quality improvement and:
  - a culture of 'being open'
  - a culture of learning
  - a culture of safety
- Support for local initiatives relevant to Trust and directorate quality improvement priorities;
- How key performance indicators for quality will be reviewed, monitored and shared within the team. These include:
  - Quality dashboard
  - Infection prevention and control and other audits
  - Complaints
  - Friends and Family Test (FFT) results
  - Patient survey results
  - Trend reports regarding incidents and complaints.
- How progress with local action plans related to complaints, incidents, audits, SRI's, patient safety visits etc is monitored to ensure progress with agreed actions and embedding in service delivery;
- How ideas for audit are identified and shared with the directorate senior management team for inclusion in the annual audit plan
- How completion of risk assessments is assured
- How the departmental risk register is maintained and reviewed to ensure progress with actions to mitigate risk
- Celebrating successes and innovation
- Information and action notes for sharing

If Quality of Care teams are in place to meet these standards, the generic terms of reference should be used.

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**Report to the Trust Council of Governors: 3 May 2017**

<b>Title</b>	<b>Paper 7.1 Quality Improvement Priorities</b>
<b>Author(s)</b>	<b>Dr Sylvia Wood, Deputy Director of Governance</b>
<b>Report Purpose</b>	<b>For information</b>

This report summarises the quality improvement priorities agreed for 2017/18 following review of quality performance, and discussion with staff, governors and external stakeholders.

The detail of each priority to include specific work streams, targets, and metrics will be reported to Quality Committee in June 2017, and progress during the year will be monitored there and then reported in the 2017/18 Quality Account.

# Quality Improvement Priorities 2017/18

We have consulted with our external stakeholders and within the Trust about the priorities for quality improvement during 2017/18. We have considered the extended range of community services across Darlington, County Durham and Middlesbrough from 1 April 2016, and across North Yorkshire.

The final indicators reflect national and local priorities for improvement, current performance and objectives and have been approved by the Board of Directors. We will set targets for achievement and will monitor progress regularly at the Quality Committee. We aim to:

## **1. Improve learning from incidents, complaints and good practice**

We are planning to focus on working with staff to promote the reporting of incidents, near misses and concerns, identify the factors that contribute to these and maximise the learning to prevent recurrence. We will focus on high quality mortality reviews and subsequent learning and action. In addition we will identify learning from examples of great practice in order to spread excellence.

## **2. Improve the patient experience of discharge processes**

We are intending to focus on proactive and safe discharge, ensuring that patients are cared for in the most appropriate environment and reducing the impact on patients of staying in hospital longer than clinically required. This will include a focus on timely discharge to the most appropriate place of care at end of life.

## **3. Reduce the morbidity and mortality related to sepsis**

This has been a quality priority during 2016/17 and whilst performance is improving we are still not achieving our target performance. We are therefore intending to continue to focus on monitoring progress and ensuring we achieve the highest standards of care.

## **4. Provide high quality stroke care demonstrated by improvement in national indicators**

Again, this has been a quality priority during 2016/17 and whilst performance is improving we are still not achieving our target performance. We are therefore intending to continue to focus on monitoring progress and ensuring we achieve the highest standards of care.

## **5. Strengthen the voice of children, young people and families by seeking patient reported experience and using this in the development of a number of services**

We are aiming to co-produce a children's and young people's strategy for HDFT and are intending to promote the inclusion of the voice of children, young people and families in relation to accessibility to children's services. We are scoping out creative approaches with children and families to engage their views in a patient centred manner and have an emerging Youth Forum which we want to promote further.

Overleaf we have started to define the ambition for each priority and indicated who will be leading each.

Quality improvement priority	Ambition	Lead
Improve learning from incidents, complaints and good practice	<ul style="list-style-type: none"> <li>To promote the reporting of incidents, near misses and concerns</li> <li>To identify the factors that contribute to errors and how to prevent recurrence</li> <li>To establish high quality mortality reviews and identify learning</li> <li>To identify examples of great practice</li> <li>To identify and implement methods of sharing learning and excellence</li> </ul>	Improving Patient Safety Steering Group
Improve the patient experience of discharge processes	<ul style="list-style-type: none"> <li>To promote proactive and safe discharge</li> <li>To ensure patients are cared for in the most appropriate environment , reducing the impact on patients of staying in hospital longer than clinically required</li> <li>To ensure timely discharge to the most appropriate place of care at end of life.</li> </ul>	Mike Forster
Reduce the morbidity and mortality related to sepsis	<ul style="list-style-type: none"> <li>To develop an understanding of sepsis and the impact of timely treatment, allowing the achievement of the national CQUIN targets for sepsis screening and antibiotic treatment</li> <li>To introduce a program for multiple “marginal gains” focused initially in the ED</li> </ul>	Dave Earl / Matt Shepherd
Provide high quality stroke care demonstrated by improvement in national indicators	<ul style="list-style-type: none"> <li>To bring the identified stroke indicators to a level comparable with the national average in the Sentinel Stroke National Audit Programme (SSNAP)</li> <li>To bring all domain performance up to a category ‘B’.</li> <li>To ensure timely access to specialist assessment, particularly speech and language therapy and supporting patient care in the community upon discharge from hospital.</li> </ul>	Jodie Roberts
Strengthen the voice of children, young people and families by seeking patient reported experience and using this in the development of a number of services	<ul style="list-style-type: none"> <li>To co-produce a children’s and young people’s strategy for HDFT</li> <li>To promote the inclusion of the voice of children, young people and families in relation to accessibility to children’s services, engaging their views in a patient centred manner</li> <li>To further promote the emerging Youth Forum</li> </ul>	Richard Chillery

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## **Report to the Council of Governors' by the Nomination Committee**

**3 May 2017**

<b>Report Title:</b>	<b>Recruitment of a new Non-Executive Director and appointment of a new Vice Chair</b>
<b>Report from:</b>	<b>Mrs Sandra Dodson, Chairman</b>
<b>Report purpose:</b>	<b>To discuss and ratify the minutes of the Nominations Committee meeting of 12 April 2017 and approve the appointment of a new Vice Chair</b>
<b>Action required:</b>	<b>For decision and approval</b>

### **1. Background and context**

The Nominations Committee met on 12 April to discuss the recruitment of a new Non-Executive Director and the appointment of a new Vice Chair of the Board of Directors.

The minutes of the Nominations Committee are attached at Appendix A.

### **2. Recruitment process for a Non-Executive Director and appointment of Vice Chair**

In accordance with the Trust Constitution and NHS Foundation Trust Code of Governance, the Council of Governors is responsible for the appointment and reappointment of Non-Executive Directors. For the purposes of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Council of Governors will also appoint a Non-Executive Director to be Vice Chair for a period, not exceeding the remainder of their term as a Non-Executive Director of the Trust.

A Nominations Committee makes a recommendation to the full Council for discussion and approval.

The Nominations Committee discussed the current Non-Executive Director vacancy, which arose as the result of the appointment of Professor Sue Proctor as Chair of Leeds and York Partnership NHS Foundation Trust. This also created a vacancy for the post of Vice Chair.

The Nominations Committee considered the person specification, role description, advertisement and timetable for the appointment of the Non-Executive Director. These were agreed and are attached, along with the minutes, at Appendix A. The Committee also undertook

a detailed discussion on the utilisation of the most appropriate and effective ways to advertise the post to ensure the best field of applications.

The Nominations Committee considered Mrs Dodson's recommendation for the post of Vice Chair and agreed that Mr Chris Thompson should be nominated.

### **3. Recommendation of the Nominations Committee to the Council of Governors**

The Nominations Committee ask the Council of Governors to **APPROVE**:

- The minutes of the Nominations Committee held on 12 April 2017.
- The recommendation to appoint Mr Chris Thompson as Vice Chair of the Board of Directors for the remainder of his second term of office, until 29 February 2020.

**Mrs Sandra Dodson**  
**Chairman**

**FOR AND ON BEHALF OF THE COUNCIL OF GOVERNORS' NOMINATION COMMITTEE**

**Minutes of the Nominations Committee  
held on Wednesday, 12 April 2017  
in the Boardroom Trust HQ, 3<sup>rd</sup> Floor, Harrogate District Hospital**

Present

Members: Mrs Sandra Dodson (Chairman)  
Ms Pamela Allen, Deputy Chair of Council of Governors  
Ms Clare Cressey, Staff Governor  
Mrs Liz Dean, Public Governor  
Mr Tony Doveston, Public Governor  
Miss Sue Eddleston, Public Governor  
Mr Peter Pearson, Public Governor

Ex Officio: Mr Andrew Forsyth, Compliance and Revalidation Manager  
(Minutes)  
Mrs Joanne Harrison, Deputy Director of Workforce and  
Organisational Development  
Dr Ros Tolcher, Chief Executive

**1. Apologies for absence**

Apologies were received from Mr Phillip Marshall, Director of Workforce and Organisational Development and Mrs Colvin, Corporate Affairs and Membership Manager. Mrs Dodson explained that because Ms Pamela Allen was involved in the recruitment process for the new Chair of the Trust, she had been 'stood down' from this Nominations Committee process, in order to make best use of her time.

Mrs Dodson highlighted that the meeting would consider two distinct elements – the appointment of a new Vice Chair for the Board of Directors, following the resignation of Professor Sue Proctor, and the recruitment process for a new Non-Executive Director to replace her.

**2. Appointment of a new Non-Executive Director – appointments process**

Mrs Dodson began by emphasising that Professor Proctor had brought a clinical back ground to her tenure – she had not only been a Chief Nurse but had also been involved in direct clinical experience outside the NHS. Both CQC and the Well Led Review process indicated that having a Non-Executive Director with a clinical background was highly recommended. This would also narrow the net to a manageable field of candidates, rather than the 35 – 40 who might otherwise apply.

Moving to the person specification, skill set and experience, a draft of which had been provided with the papers, Dr Tolcher suggested that a similar approach to that being taken with the recruitment of the new Chair should be taken ie not having Essential and Desirable requirements but describing the ideal requirements without segregating them under these two headings. Mrs Dean felt that the two headings were helpful and in her experience were still widely used. There was a wide-ranging discussion during which it was agreed that the pool would be narrowed by the requirement for clinical experience but that using the headings was helpful to candidates, although did open the Trust to future challenge should a candidate with the essential criteria not be shortlisted at least.

Mrs Dodson said that whilst balancing the experience of the Non-Executive Directors on the Board it was as much a question of the culture as well as the absolute skills and competences. Ms Cressey said that in her recent training the need for a Board skills audit had featured and she endorsed the view that a clinical background was lacking with the departure of Professor Proctor. Mrs Dodson considered that an expertise around governance was needed and it was agreed that this should be both clinical and corporate, although Dr Tolcher considered that experience of clinical governance was more important –experience of operating at a senior enough level should bring with it understanding of corporate governance.

Mrs Metcalfe felt that the list of criteria was comprehensive and asked what would be missed most without Professor Proctor. Mrs Dodson replied that it was depth of knowledge and experience of NHS working, clinical governance and a mindset around safeguarding – Professor Proctor had always asked questions with *gravitas* and experience. Dr Tolcher added that she understood what made the workforce tick. Mrs Harrison cautioned against trying to define ‘another Professor Proctor’ through the criteria. Mrs Dodson wanted to see evidence of personal commitment to the values of the Trust whilst others emphasised what was meant by a team player whilst maintaining independence. Networking skills were felt to be important as was being supportive of fellow Board members and others. Whilst opening up the criteria could encourage applicants who were less suitable it was generally agreed that a good candidate might not necessarily meet all the criteria but could make a good Non-Executive Director.

Discussion of the draft advertisement included more careful expression of the time commitment and a question about the words ‘commercial and political’ being included. Mrs Dodson confirmed that the new Non-Executive Director would not have any additional responsibilities.

The text of the job description, person specification and advertisement were amended and approved. Final versions are attached at Annex to these Minutes.



Mrs Dodson explained that the draft timeline which had been included with the papers for the meeting was designed to allow the Chair (designate) to participate in the selection process in an *ex-officio* capacity, and she had been concerned that leaving the recruitment to the autumn, when the new Chair was in post, would have been too long a period without a full complement of Non-Executive Directors. The timeline was agreed.

There was discussion about where to advertise the post, especially in view of the requirement for candidates with clinical experience. A mailshot to members of the Trust, e-mail to all doctors and GPs in the Trust, use of Facebook and Twitter and the Trust's intranet and website were all agreed as appropriate methods. Advertorial with the Harrogate Advertiser, perhaps linked with the press release on the National Staff Survey, might also be effective. Mrs Harrison undertook to discuss this with Mr Widdowfield. Use of media which reached into Leeds, Durham, Darlington and Middlesbrough was also agreed as being worthwhile. Mrs Dean asked why a recruitment consultancy was not being used, as for recruitment of the Chair, and Mrs Dodson said that this was not considered to be cost effective as there were always plenty of candidates for Non-Executive Director vacancies. She also noted that advertising in faith-based media should be considered. Further discussion would take place outside the meeting, taking into account cost effectiveness of the various media being considered.

### **3. Appointment of Vice Chairman**

Mrs Dodson confirmed that the appointment of the Vice Chairman of the Board was the constitutional responsibility of the Council of Governors. The role required an experienced Non-Executive Director and of the five current Non-Executive Directors she considered that there were two candidates. She had discussed the nomination with one of these candidates who, for various reasons, could not go forward.

Mr Chris Thompson is a measured, thoughtful and supportive Non-Executive Director, in Mrs Dodson's view, who networked well and was a good chairman of the Audit Committee. He would provide strong support to the new Chair.

Mr Doveston said that Mr Thompson was rounded, well liked and worked well with the Governors, and he considered that Mr Thompson would provide good continuity for the new Chair, whilst Mr Pearson said that Mr Thompson was knowledgeable and he concurred with the views expressed Mrs Dean and Miss Eddleston agreed.

Ms Cressey asked about the position of Mr Ward and in reply Mrs Dodson said that his strength was as the Senior Independent Director. Following a question from Mrs Harrison, Mrs Dodson confirmed that the

Vice Chair role was compatible with Mr Thompson continuing to chair the Audit Committee; there was a precedent within the Trust.

Mrs Dodson said that Mr Thompson has indicated that he would be delighted to accept the nomination as Vice Chair.

The Nominations Committee **agreed** to **recommend** to the Council of Governors the nomination of Mr Chris Thompson as Vice Chair of the Board of Directors.

#### **4. Any other business**

There was no other business and Mrs Dodson declared the meeting closed.

DRAFT



## Harrogate and District NHS Foundation Trust

### High Performing Foundation Trust seeks to appoint a Non-Executive Director

This is an exceptional opportunity for an exceptional individual.

Harrogate and District NHS Foundation Trust is a high-performing organisation rated as 'Good' overall and 'Outstanding' for care by the Care Quality Commission. With a vision to provide Excellence Every Time, HDFT places an unwavering focus on care quality and living up to our values of being Respectful, Responsible and Passionate. The Trust's catchment area stretches across Harrogate, the rest of North Yorkshire, North Leeds and into County Durham, Darlington and Middlesbrough.

### Join our vigorous and forward-thinking Board of Directors

We are seeking a Non-Executive Director with Board-level or equivalent expertise in an expanding and complex enterprise. We would particularly welcome applications from those with experience of working as a clinical practitioner at a senior level in the NHS, in a field which would complement that of our existing Board of Directors.

Your experience should include a demonstrable track record of success and an understanding of, and commitment to, values of accountability, probity, openness and equality of opportunity. You will be a strategic thinker and experienced in leading and delivering complex organisational change. You will have excellent communication and listening skills, as well as being commercially and politically astute. An understanding of the role of Non-Executive Directors is essential, as is an ability to analyse complex information and an appreciation of the emerging context for the NHS.

This is an exciting role in a vibrant environment, providing the opportunity to be at the forefront of new thinking in today's NHS. The time commitment is on average five days per month and the post will attract remuneration at the rate of c£13,000 per annum.

**If you would like to learn more about this exciting opportunity, or to request an application pack, please contact Lynn Parsons, Executive Assistant to the Chairman on 01423 554423, or via email at [lynn.parsons@hdft.nhs.uk](mailto:lynn.parsons@hdft.nhs.uk)**

Candidates must be, or be eligible to become, a Member of the NHS Foundation Trust.  
**For further details of this vacancy, visit our website at [www.hdft.nhs.uk](http://www.hdft.nhs.uk)**

Closing date for applications:	Noon on Monday 22 May 2017
Shortlisting:	Week commencing 12 June 2017
Interviews:	Week commencing 26 June 2017

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## **HARROGATE AND DISTRICT NHS FOUNDATION TRUST NON-EXECUTIVE DIRECTOR – IDEAL PERSONAL CRITERIA**

<b>Knowledge and Experience</b>	<ul style="list-style-type: none"> <li>• Senior (Board level or equivalent) experience in an expanding and complex enterprise</li> <li>• Demonstrable strategic experience</li> <li>• Track record of success</li> <li>• Understanding of, and commitment to, public service values of accountability, probity, openness and equality of opportunity</li> <li>• Experience of interfacing with multiple partners at a strategic level</li> <li>• Experience of working as a clinical practitioner in the NHS</li> </ul>
<b>Skills and Abilities</b>	<ul style="list-style-type: none"> <li>• Understands the independent role of Non-Executive Directors</li> <li>• Strong influencing skills</li> <li>• Excellent communication and listening skills</li> <li>• Ability to analyse complex information, with an understanding of performance and financial reporting and monitoring</li> <li>• Experience of leading and delivering complex organisational change</li> <li>• Commercially and politically astute</li> </ul>
<b>Personal Qualities</b>	<ul style="list-style-type: none"> <li>• Ability to think strategically, understand complex issues and make decisions pragmatically</li> <li>• Prepared to take difficult decisions and challenge constructively</li> <li>• Integrity and high ethical standards</li> <li>• A strong personal commitment to the values of the Trust and the NHS</li> <li>• Independent and impartial approach</li> <li>• Sound judgement and an enquiring mind</li> </ul>
<b>Other specific requirements</b>	<ul style="list-style-type: none"> <li>• Must be a Member of HDFT and reside within its constituencies</li> <li>• Understanding of the unique responsibilities of NHS FT Boards</li> <li>• Understanding of public, patient and stakeholder expectations of the NHS</li> <li>• Understanding of the emerging strategic context for the NHS</li> <li>• A desire to work closely with Health and Social Care and other partners</li> <li>• Flexibility to adapt to varied roles</li> </ul>

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## **ROLE DESCRIPTION - NON-EXECUTIVE DIRECTOR**

This role reports to the Chair and Council of Governors

### **Purpose of the role**

As part of the unitary Board of Directors, Non-Executive Directors are ultimately and collectively responsible for all aspects of the performance of the Trust and play a crucial role in bringing an independent perspective to the boardroom 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, as laid out in the Nolan principles, and to foster good relations in the boardroom. They should apply similar standards of care and skill in their role as a Non-Executive Director of a Foundation Trust as they would in similar roles elsewhere.

Non-Executive Directors, including the Chair, have a duty to facilitate the Council of Governors in holding the Non-Executive board members to account for the performance of the Board of Directors.

Non-Executive Directors are expected to participate fully as members of committees of the Board of Directors to which they are appointed and to take the role of committee Chair when so appointed.

Non-Executive Directors will meet regularly with the Chair in the absence of Executive Directors to discuss issues of interest or concern in addition to the annual meetings to deal with appraisal of and objective setting for the Executive Directors.

Non-Executive Directors will meet at least once a year with the Senior Independent Director in the absence of the Chair to participate in the Chair's appraisal and the setting of objectives for the Chair. In exceptional circumstances they may be asked to meet with the Senior Independent Director to attempt to resolve issues concerning the Chair's performance or to take action in that respect.

Non-Executive Directors must comply with the requirements of the Fit and Proper persons Test.

### **Non-Executive Directors have a responsibility to:**

- Act as a member of the unitary board at all times, taking decisions both in Board of Directors and formal sub-committees in accordance with appropriate principles of cabinet responsibility;
- Support the Chair, Chief Executive and Executive Directors in promoting the Foundation Trust's values;

- Support a positive culture throughout the Foundation Trust and adopt behaviours in the boardroom and elsewhere that exemplify the corporate culture;
- Challenge the proposed decisions of the Board constructively and appropriately;
- Develop and deliver the vision and strategic plan;
- Develop and deliver the Trust's corporate risk strategy; and,
- Help develop proposals on values and standards.

**Non-Executive Directors have a duty to:**

- Conform with the code of conduct for Directors and to act in the best interest of the Trust at all times;
- 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;
- Commission and use external advice as necessary; 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 (acting in the appropriate committees) for:**

- Determining appropriate levels of remuneration of Executive Directors;
- Participating in the appraisal of Executive Directors, their fellow Non-Executive Directors and the Chair;
- Appointing the Chief Executive (with the approval of the Council of Governors);
- Appointing other Executive Directors along with the Chief Executive;
- Where necessary, removing Executive Directors;
- Succession planning for key executive posts;
- Relations with the Council of Governors;
- Chairing of grievance and appeal panels;
- Acting as lay member on appointment panels for consultants and deputy Directors; and
- Participating in Directors' inspections and Patient Safety Visits.

**Final April 2017**



**Non-Executive Directors should:**

- Attend meetings of the Council of Governors with sufficient frequency to ensure that they understand the views of Governors on the key strategic and performance issues facing the Foundation Trust;
- Take into account the views of Governors and other members to gain a different perspective on the Foundation Trust and its performance;
- Have on-going dialogue with the Council of Governors on the progress made in delivering the Foundation Trust's strategic objectives, the high level financial and operational performance of the Foundation Trust; and,
- Receive feedback from the Council of Governors regarding performance and ensure that the Board of Directors is aware of this feedback.

**Terms of office of Non-Executive Directors**

The Trust's Constitution states that:

The Chairman and the Non-Executive Directors are to be appointed for a period of office in accordance with the terms and conditions of office decided by the Council of Governors at a general meeting. Non-Executive Directors will serve a three year period and will not normally exceed a maximum of three terms of office except in exceptional circumstances.

Any terms beyond two terms (six years) should be subject to annual endorsement of the continued appointment by the Council of Governors.

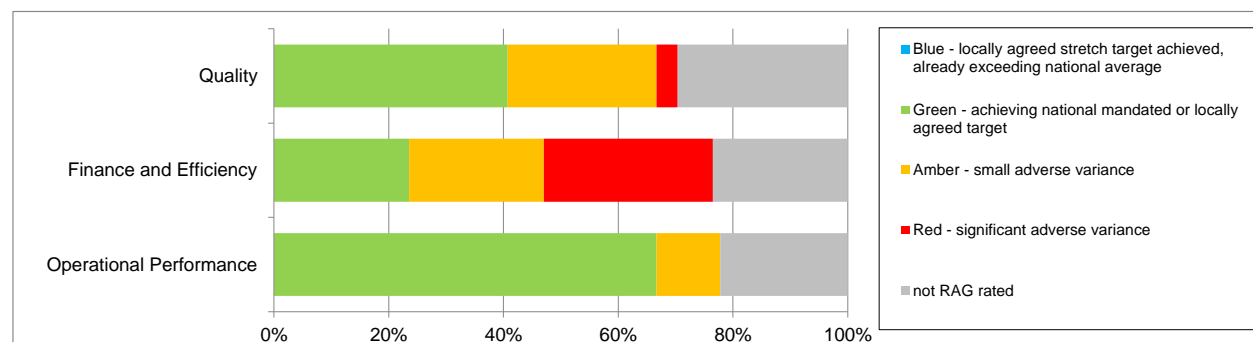
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## Integrated board report - March 2017

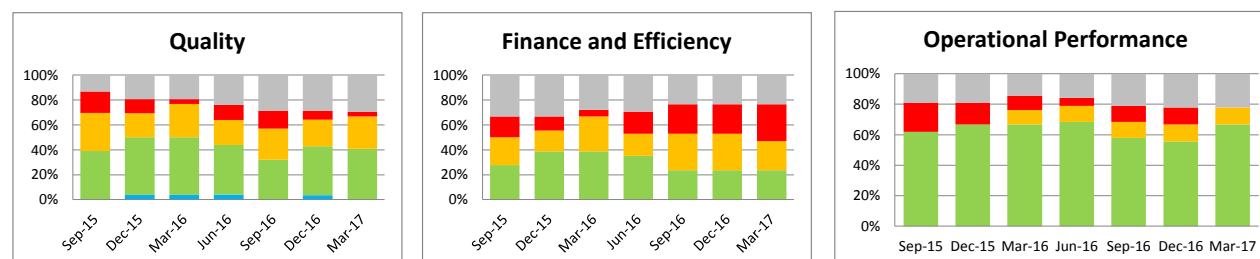
### Key points this month

1. In March, HDFT achieved all 4 key operational performance metrics in the NHS Improvement Single Oversight Framework and reported a rating of 1 (where 1 is best) for the Use of Resource Metric.
2. A significant improvement in the Trust's performance against the A&E 4-hour standard was seen in March, with Trust level performance at 97.2%. HDFT has therefore delivered the 4-hour standard for the 2016/17 year overall with annual performance of 95.1%.
3. The cash balance position continues to be a concern for the Trust with a number of actions in place to improve the outstanding debtors position.
4. Agency spend increased in March to 3.7% of pay spend. Although the value is below the agency ceiling for the Trust, this ceiling reduces in 2017/18 and the current run rate would potentially result in exceeding the new value.
5. Further work is needed to understand the Trust's current incident reporting ratio of high/low risks incidents as latest published data places us in the bottom 25% of Trusts nationally. Despite this, the number of inpatients falls fell by 14% in 2016/17 and the number of reported SIRIs was also much lower than last year.
6. The number of complaints received by the Trust remained above average in March with 25 received during the month. These relate to a number of different services across the Trust and are partly reflective of the significant operational pressures that the Trust was under during the month.
7. Delayed transfers of care remain high and increased to 6.6% when the snapshot was taken in March, remaining above the maximum threshold of 3.5% set out in the contract.

### Summary of indicators - current month




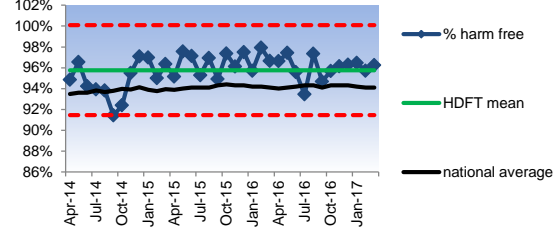

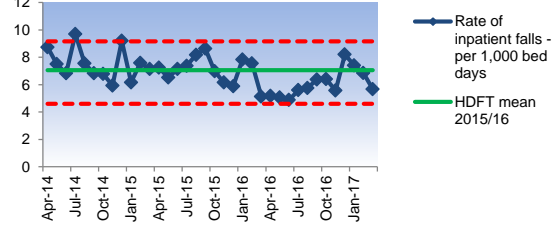

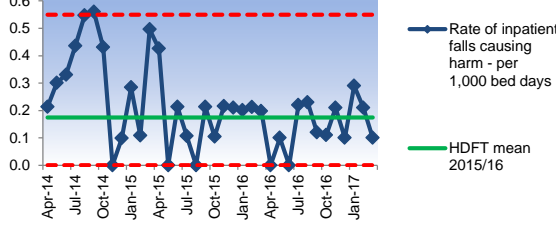

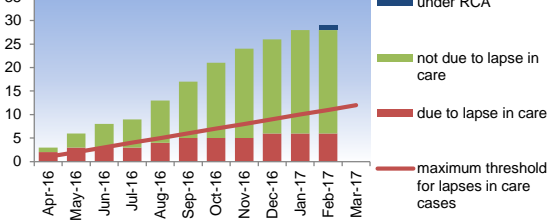
### Summary of indicators - recent trends




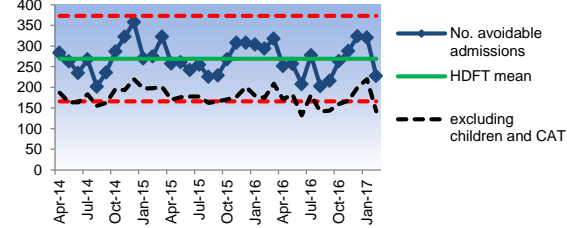

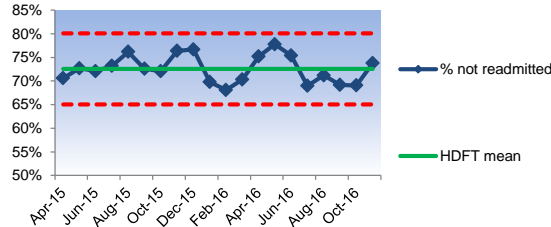

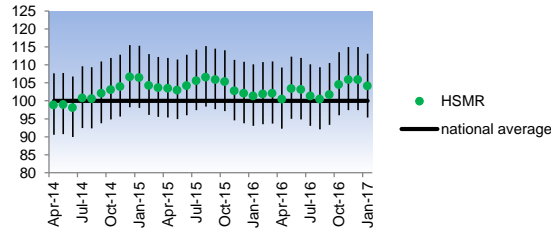

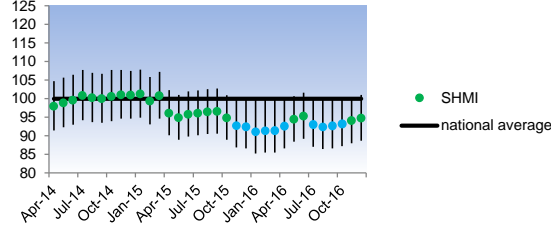
## Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<div>✓</div> <b>Pressure ulcers - hospital acquired</b>	<p>The chart shows the cumulative number of category 3 or category 4 hospital acquired pressure ulcers in 2016/17. The Trust has set a local trajectory for 2016/17 of zero avoidable hospital acquired category 3 or category 4 pressure ulcers. The data includes hospital teams only.</p>		<p>There were 5 hospital acquired category 3 pressure ulcers and 1 unstageable pressure ulcer reported in March. In 2016/17, 33 hospital acquired category 3 or unstageable pressure ulcers have been reported. Of these, 16 were deemed to be avoidable, 9 unavoidable and 8 cases are still under root cause analysis (RCA).</p> <p>There have been no hospital acquired category 4 pressure ulcers reported in 2016/17.</p>
	<p>The chart includes category 2, 3 and 4 and unstageable hospital acquired pressure ulcers. A maximum trajectory for 2016/17 of 155 cases of category 2-4 hospital acquired pressure ulcers has been agreed via the Quality Committee. The data includes hospital teams only.</p>		<p>The number of hospital acquired category 2-4 (or unstageable) pressure ulcers increased in March with 23 cases reported, compared to 17 in February.</p> <p>There have now been 205 cases reported in 2016/17. This compares to 155 in 2015/16.</p>
<div>✓</div> <div>⚠</div> <b>Pressure ulcers - community acquired</b>	<p>The chart shows the cumulative number of category 3 or category 4 community acquired pressure ulcers in 2016/17. This metric includes all pressure ulcers identified by community teams including pressure ulcers already present at the first point of contact.</p>		<p>There were 6 community acquired category 3 (or unstageable) pressure ulcers reported in March. In the year to date, 78 community acquired category 3 or 4 or unstageable pressure ulcers have been reported (including 3 category 4 cases). Of these, 36 were deemed to be avoidable, 29 unavoidable and 13 cases are still under root cause analysis (RCA).</p>
	<p>This additional chart has been added this month showing the trend in category 2, 3 and 4 community acquired pressure ulcers. A maximum trajectory for the number of category 2-4 community acquired pressure ulcers was agreed at the Quality Committee and is based on a 20% reduction against the number of cases reported in 2015/16. The data includes community teams only.</p>		<p>The number of community acquired category 2-4 (or unstageable) pressure ulcers reported in March was 25 cases, compared to 21 last month.</p> <p>In 2016/17, 263 cases have been reported, compared to 167 in 2015/16. The observed increase in reported cases may be partly due to improvements in incident reporting during the period.</p>


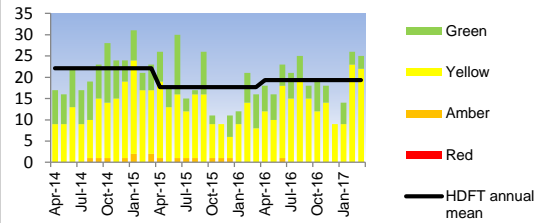

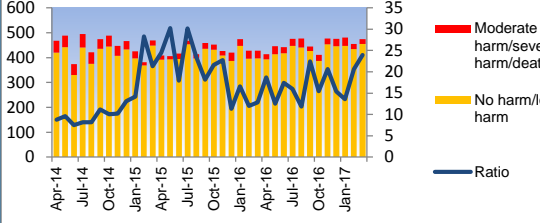

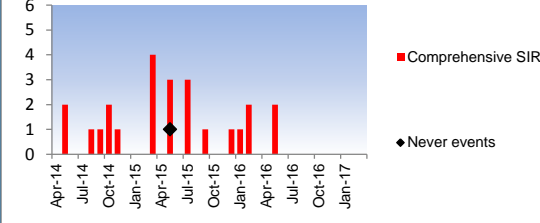

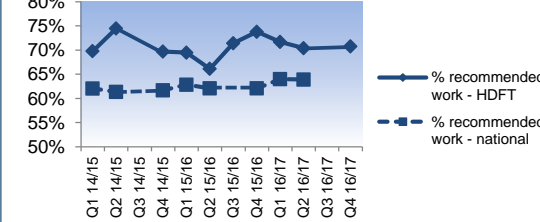
## Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Safety Thermometer - harm free care</b> 	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 96.3%, an increase on last month and remaining above the latest national average.
<b>Falls</b> 	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 5.8 per 1,000 bed days in March, a decrease on last month. In 2016/17, 697 inpatient falls have been reported (including those not causing harm). This is a 14% reduction on the number of inpatient falls reported on 2015/16.
<b>Falls causing harm</b> 	The number of inpatient falls causing significant harm, expressed as a rate per 1,000 bed days. The data includes falls causing moderate harm, severe harm or death. A low rate is good.		<p>There was 1 inpatient fall causing moderate harm in March, compared to 2 last month. The rate per 1,000 bed days is now below the HDFT average for 2015/16.</p> <p>There have been 16 inpatient falls causing moderate or severe harm in 2016/17, 15 of which resulted in a fracture. This compares to 20 in 2015/16.</p>
<b>Infection control</b> 	The chart shows the cumulative number of hospital apportioned C. difficile cases during 2016/17. HDFT's C. difficile trajectory for 2016/17 is 12 cases, no change on last year's trajectory. Cases where a lapse in care has been deemed to have occurred would count towards the Monitor risk assessment framework. Hospital apportioned MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2016/17. The last reported case of hospital acquired MRSA at HDFT was in Oct-12.		<p>There was no cases of hospital apportioned C. difficile reported in March, making the year to date total 29 cases. 28 cases have now have root cause analysis (RCA) completed and discussed and agreed with HARD CCG. Of these, 6 have been determined to be due to a lapse in care and 22 were determined to not be due to a lapse in care.</p> <p>No cases of hospital apportioned MRSA were reported in 2016/17.</p>


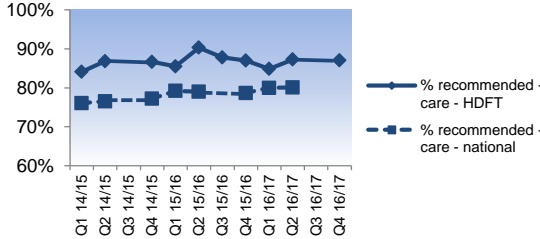

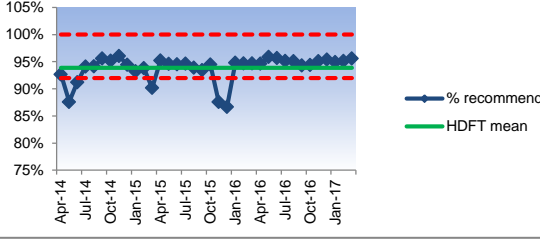

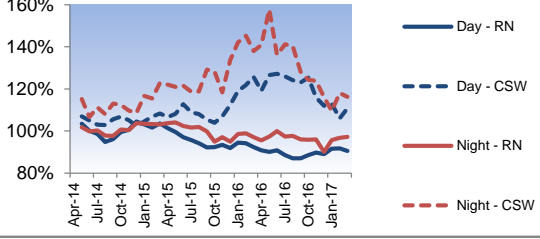

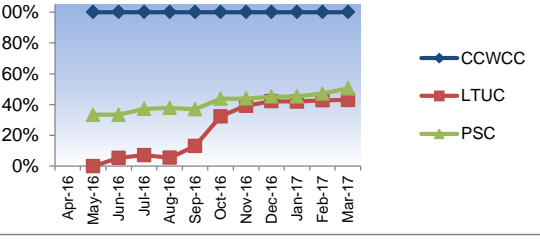
## Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Avoidable admissions</b> 	<p>The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.</p>		<p>There were 228 avoidable admissions in February, a significant decrease on recent months.</p> <p>Adult admissions (excluding CAT attendances) also fell this month.</p>
<b>Reducing hospital admissions in older people</b> 	<p>The chart shows the proportion of older people aged 65+ who were still at home 91 days after discharge from rehabilitation or reablement services. A high figure is good.</p> <p><i>This indicator is in development.</i></p>		<p><i>This indicator has not been updated this month.</i></p> <p>For patients discharged from rehabilitation or reablement services in November, 74% were still in their own home at the end of February, an improvement on the previous month.</p> <p>From next month onwards, this metric will report on patients discharged from any service within the new Integrated Care Teams. This will provide a more robust metric involving a larger group of patients but it will not be possible to present historical trend data.</p>
<b>Mortality - HSMR</b> 	<p>The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.</p>		<p>HDFT's HSMR decreased to 104.11 for the rolling 12 months ending January 2017 and remains within expected levels. At specialty level, two specialties (Geriatric Medicine and Stroke Medicine) have a standardised mortality rate above expected levels.</p> <p>The Trust is in the process of reviewing recently published national guidance about the requirement for Trusts to start publishing information on learning from deaths during 2017/18. This work will be led by the Medical Director, in conjunction with the existing mortality review process.</p>
<b>Mortality - SHMI</b> 	<p>The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good.</p>		<p>HDFT's SHMI increased to 94.72, compared to 94.03 last month, remaining within expected levels. At specialty level, two specialties (Geriatric Medicine and Gastroenterology) have a standardised mortality rate above expected levels.</p>

## Quality - March 2017


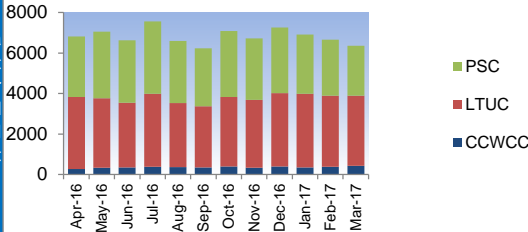

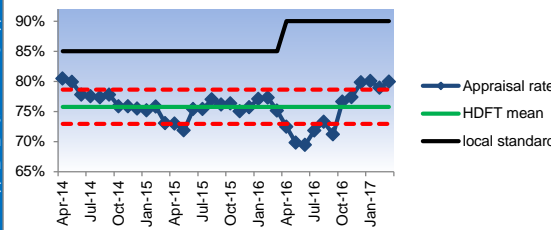


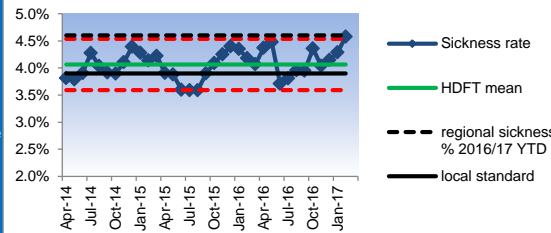
Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Complaints</b> 	<p>The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents.</p> <p>The data includes complaints relating to both hospital and community services.</p>		<p>25 complaints were received in March, compared to 26 last month, remaining above the 2015/16 average. This remains above the 2015/16 average. As with last month, the complaints received in March relate to a number of different services across the Trust and are partly reflective of the significant operational pressures that the Trust was under during the month.</p> <p>There were no complaints classified as amber or red in March.</p>
<b>Incidents - all</b> 	<p>The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services.</p> <p>A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture</p>		<p>The latest published national data (for the period Apr - Sep 16) shows that Acute Trusts reported an average ratio of 37 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's local reporting ratio for the same period was 18 which places the Trust in the bottom 25% nationally. The focus going forward is to improve our incident reporting rate particularly encouraging staff to report no harm/ near miss incidents. Options to improve the Datix system to simplify the incident reporting process are being explored.</p>
<b>Incidents - SIRIs and never events</b> 	<p>The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services.</p> <p>We have changed this indicator to only include comprehensive SIRIs, as concise SIRIs are reported within the pressure ulcer and falls indicators above.</p>		<p>There were no comprehensive SIRIs and no never events reported in March.</p>
<b>Friends &amp; Family Test (FFT) - Staff - % recommend as a place to work</b> 	<p>The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in.</p> <p>The chart shows the percentage of staff that would recommend the Trust as a place to work. A high percentage is good. The Trust's aim is to feature in the top 20% of Trusts nationally which would typically mean that 71% of staff would recommend the Trust as a place to work.</p>		<p>In Quarter 4, 70.8% of HDFT staff surveyed would recommend HDFT as a place to work, a slight increase on Quarter 2 (when the survey was last carried out) and remaining above the most recently published national average of 64%. The response rate at HDFT for Quarter 4 was 15%, compared to the most recently published national average of 12%.</p>

## Quality - March 2017


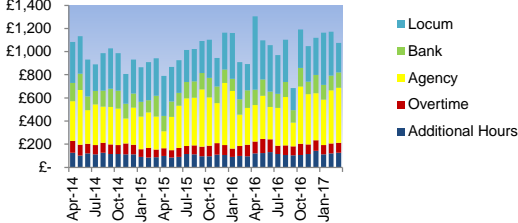

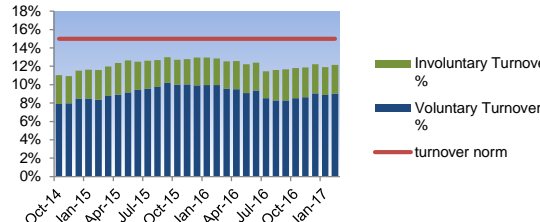

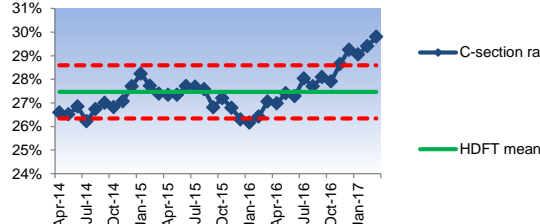

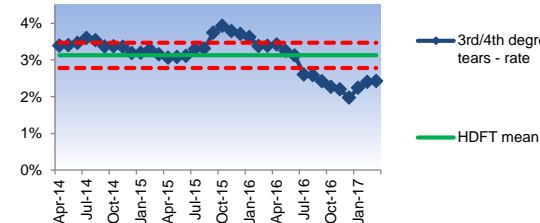
Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Friends &amp; Family Test (FFT) - Staff - % recommend as a place to receive care</b> 	<p>The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in.</p> <p>The chart shows the percentage of staff that would recommend the Trust as a place to receive care. A high percentage is good. The Trust's aim is to feature in the top 20% of Trusts nationally which would typically mean that 88% of staff would recommend the Trust as a place to work.</p>		<p>In Quarter 4, 87.0% of HDFT staff surveyed would recommend HDFT as a place to receive care. This is a slight decrease on Q2 (when the survey was last carried out) but remains above the most recently published national average of 80%. The response rate at HDFT for Quarter 4 was 15%, compared to the most recently published national average of 12%.</p>
<b>Friends &amp; Family Test (FFT) - Patients</b> 	<p>The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.</p>		<p>95.6% of patients surveyed in March would recommend our services, remaining in line with recent months and above the latest published national average.</p> <p>Around 5,600 patients responded to the survey this month, which equates to an average of 179 responses per day, an increase on last month.</p>
<b>Safer staffing levels</b> 	<p>Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is published on the Trust website.</p>		<p>Overall staffing compared to planned was at 99.5% in March. Registered nurse staffing levels remain similar to last month at 93% overall. Care Support Worker staffing remains high compared to plan - this is reflective of the increased need for 1-1 care and the number of newly qualified nurses working before they have received full registration.</p>
<b>Electronic rostering timeliness</b> 	<p>The chart shows the proportion of rosters that were published on time on Rosterpro (at least 4 weeks before the roster start date). It includes data for 20 specific clinical areas (mostly inpatient wards) involved in the pilot phase. Data presented is for a rolling 12 months period and is split by Clinical Directorate. A high percentage is good.</p>		<p>Overall, 52% of rosters were published on time during the period May 2016 to March 2017. All three Clinical Directorates are showing improvements in recent months.</p> <p>Publishing electronic rosters in a timely manner improves staff morale, increases bank fill rates and reduces bank/agency costs.</p>




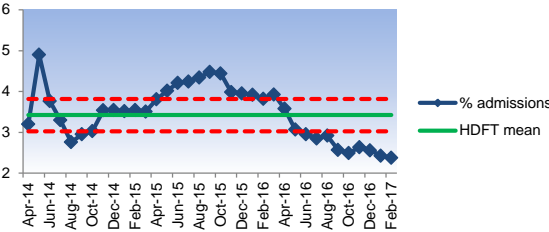
## Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation																		
<div>Electronic rostering hours owed</div> <div></div>	<p>This metric shows the sum of unused hours for staff as a running balance from the Trust's predefined audit start date. To allow for some flexibility in assigning hours over rosters (ie. for Night workers), an alert will be triggered when staff owe 15 hours or more. Data is split by Clinical Directorate for 20 specific clinical areas (mostly inpatient wards) involved in the pilot phase. A low number is good.</p>		<p>The data has been rebased and now shows the cumulative position from March 2015 onwards (previously March 2016). As can be seen on the chart, the number of owed hours has consistently reduced over the last 3 months. this is a positive downward trend demonstrating that wards are getting these balances under control.</p> <p>Properly managed balances increase available clinical hours, improves staff morale and management decision making.</p>																		
<div>Staff appraisal rates</div> <div></div>	<p>The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good.</p> <p>The figures from May 2016 onwards exclude employees currently on maternity leave, career break or suspension and staff who TUPE transferred into the organisation from Darlington, Durham and Middlesbrough from 1st April 2016.</p>		<p>The appraisal rate for the 12 months to end March is 79%.</p> <p>The new appraisal period commences from 1st April and runs until 30th September. The expectation is that all appraisals will be completed during this timeframe for 2017/18. There are a number of briefings scheduled for managers and staff during April with more to be scheduled in May. Guidance on conducting team appraisals has been up-loaded onto the Appraisal toolkit and incorporated into Pathway to Management training.</p>																		
<div>Mandatory training rates</div> <div></div>	<p>The table shows the most recent training rates for all mandatory elements for substantive staff.</p>	<table><tr><th>Competence Name</th><th>% Completed</th></tr><tr><td>Equality, Diversity and Human Rights - Level 1</td><td>90</td></tr><tr><td>Fire Safety Awareness</td><td>79</td></tr><tr><td>Infection Prevention &amp; Control (Including Hand Hygiene) 1</td><td>100</td></tr><tr><td>Infection Prevention &amp; Control (Including Hand Hygiene) 2</td><td>85</td></tr><tr><td>Information Governance: Introduction</td><td>91</td></tr><tr><td>Information Governance: The Beginners Guide</td><td>96</td></tr><tr><td>Prevent Basic Awareness (December 2015)</td><td>99</td></tr><tr><td>Safeguarding Children &amp; Young People Level 1 - Introduction</td><td>95</td></tr></table>	Competence Name	% Completed	Equality, Diversity and Human Rights - Level 1	90	Fire Safety Awareness	79	Infection Prevention & Control (Including Hand Hygiene) 1	100	Infection Prevention & Control (Including Hand Hygiene) 2	85	Information Governance: Introduction	91	Information Governance: The Beginners Guide	96	Prevent Basic Awareness (December 2015)	99	Safeguarding Children & Young People Level 1 - Introduction	95	<p>The data shown is for the end of March and includes the staff who were TUPE transferred into the organisation on the 1st April 2016. The overall training rate for mandatory elements for substantive staff is 90%.</p> <p>The new follow up procedure is now in place for Directorates to use and we hope to see a positive impact on compliance going forward.</p>
Competence Name	% Completed																				
Equality, Diversity and Human Rights - Level 1	90																				
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Safeguarding Children & Young People Level 1 - Introduction	95																				
<div>Sickness rates</div> <div></div>	<p>Staff sickness rate - includes short and long term sickness.</p> <p>The Trust has set a threshold of 3.9%. A low percentage is good.</p>		<p>The staff sickness rate rose to 4.58% in February. However the Trust remains below the regional average of 4.8% for the month and just below the year to date regional (and national) average of 4.6%. HDFT's sickness for the year to date is 4.1%.</p> <p>Our new attendance lead Vicki Godfrey joined the Trust in April. She is currently in the process of reviewing all long-term sickness cases and updating action plans appropriately. In line with developing some further workforce metrics, she will establish our baseline for the average length of long term sickness which will then be reviewed quarterly. The sickness rate and reasons for this were discussed at SMT this month. Directorates were requested to ensure there was an absolute focus on the completion of return to work interviews and to continually monitor sickness levels and progress matters through the policy when it is appropriate to do so.</p>																		


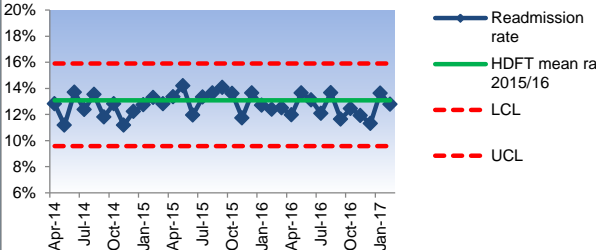

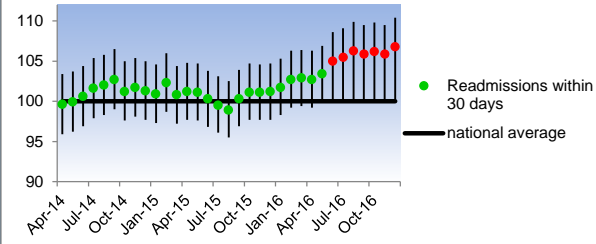

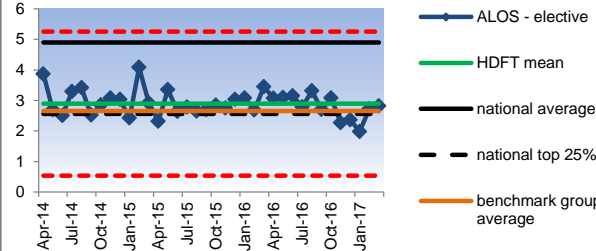

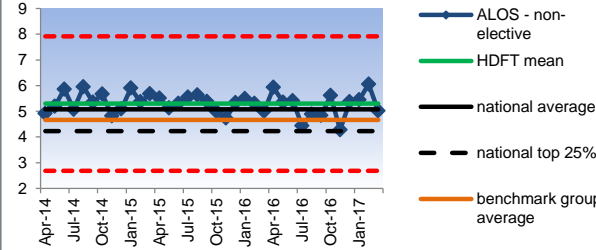
## Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Temporary staffing expenditure - medical/nursing /other</b> 	<p>The chart shows staff expenditure per month, split into contracted staff, overtime and additional hours and temporary staff. Lower figures are preferable.</p> <p><i>The traffic light criteria applied to this indicator is currently under review.</i></p>		<p>The Trust has established an advisory group to address actions designed to reduce, and if possible eliminate, spend and reliance on engagement of temporary staff, especially through agencies. Meetings are held fortnightly and review all agency bookings, and especially those above wage and/or rate cap. The instruction not to engage temporary staff with substantive NHS contracts through agencies, issued by NHSI at the end of February, was rescinded the day before implementation, although agreement had been reached across WYAAT to enforce it. Separately the business case for the development of an internal bank for temporary medical staff will be considered at ODG on 25 April. Once established, this has the potential to reduce significantly expenditure on this group and is a first step towards a collaborative bank across WYAAT.</p>
<b>Staff turnover rate</b> 	<p>The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust.</p> <p>Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.</p>		<p>Turnover was at 12.2% in March. Analysis is taking place in relation to identifying key areas with high level of labour turnover. Once identified a process for completing exit/save interviews within those areas will be drafted and sent to ODG and Directors for approval. This will provide data, identifying themes on experience of working at the Trust and reasons for leaving which will in turn inform our retention strategy.</p>
<b>Maternity - Caesarean section rate</b> 	<p>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.</p> <p>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.</p>		<p>HDFT's C-section rate for the 12 months ending March was 29.8% of deliveries, an increase on last month and remaining higher than average.</p> <p>The major contributing factor to the recent upward trend appears to be a significant increase in elective caesarean sections during 2016/17, with the emergency caesarean section rate remaining static and within expected parameters.</p>
<b>Maternity - Rate of third and fourth degree tears</b> 	<p>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.</p> <p>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.</p>		<p>The rate of third or fourth degree tears was 2.4% of deliveries in the 12 month period ending March, remaining well below previous months. This may reflect the significant amount of quality improvement work aimed at reducing the incidence of third degree tears.</p>


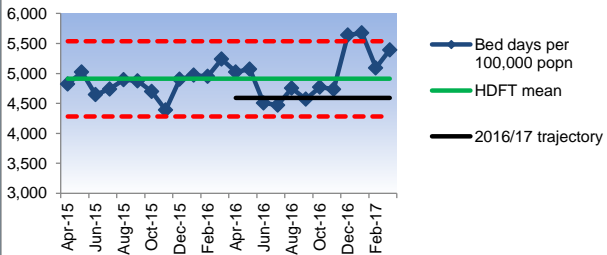

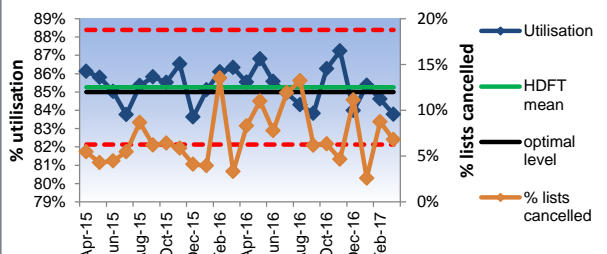

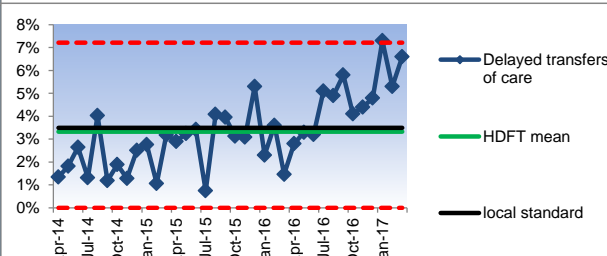

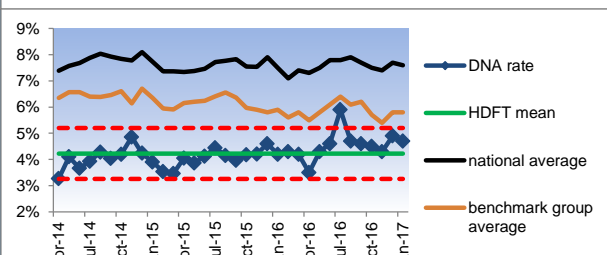
## Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Maternity - Unexpected term admissions to SCBU</b>  	<p>This indicator is a reflection of the intrapartum care provided. For example, an increase in the number of term admissions to special care might reflect issues with understanding of fetal heart rate monitoring in labour.</p> <p>The charts shows a 12 month rolling average position.</p>	 <p>The chart displays the percentage of term babies (those born at greater than 37 weeks gestation) who were admitted to the Special Care Baby Unit (SCBU) over time. The blue line represents the monthly percentage of admissions, and the green line represents the 12-month rolling average (HDFT mean). The data shows a general downward trend from a peak of nearly 5% in mid-2014 to a low of around 2.1% in early 2017.</p>	<p>The chart shows the percentage of term babies (those born at greater than 37 weeks gestation) who were admitted to the Special Care Baby Unit (SCBU). The chart has been amended this month as it was identified that the data being displayed was the number of admissions to SCBU, not the percentage of births as was being described. This has been corrected this month to show the percentage.</p> <p>2.1% of term babies were admitted to SCBU in the 12 months ending March, continuing the downward trend seen in recent months.</p>


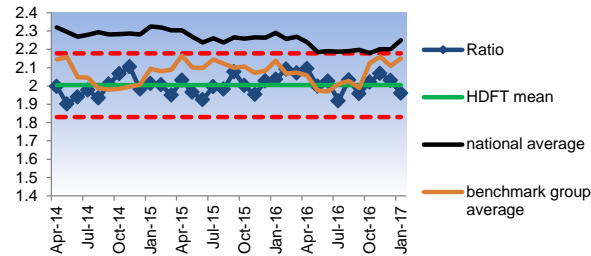

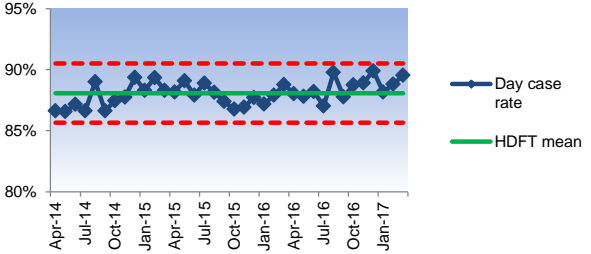

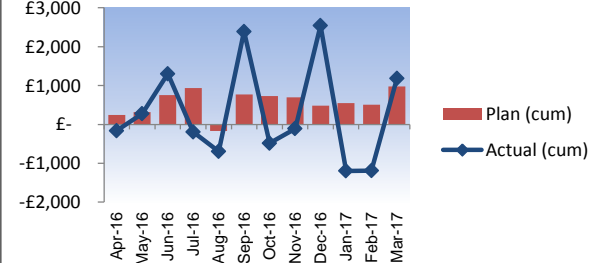

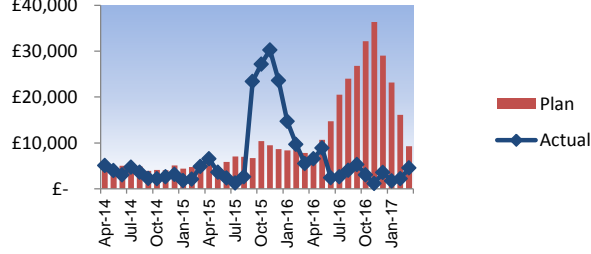
## Finance and Efficiency - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Readmissions</b> 	<p>% of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance. This data is reported a month behind so that any recent readmissions are captured in the data.</p>		<p>The number of readmissions decreased in February, when expressed as a percentage of all emergency admissions, and is now below the average rate for 2015/16.</p> <p>HDFT and HARD CCG are now concluding a joint clinical audit of readmissions to determine the proportion which were avoidable.</p>
<b>Readmissions - standardised</b> 	<p>This indicator looks at the standardised readmission rate within 30 days. The data is standardised against various criteria including age, sex, diagnosis, comorbidities etc. The standardisation enables a more like for like comparison with other organisations. The national average is set at 100. A low rate is good - rates below 100 indicate a lower than expected readmission rate and rates above 100 indicate higher than expected readmission rate.</p>		<p>HDFT's standardised readmission rate increased to 106.8 in the most recently available data on HED, remaining above the national average and above expected levels.</p> <p>At specialty level, the same 5 specialties have a standardised emergency readmission rates above expected levels (Cardiology, Clinical Haematology, Paediatrics, Medical Oncology and Well Babies). A clinical audit of a sample of paediatric and well babies readmissions is being carried out by CCCC Directorate.</p>
<b>Length of stay - elective</b> 	<p>Average length of stay in days for elective (waiting list) patients. The data excludes day case patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.</p>		<p>The average elective length of stay for March was 2.8 days, an increase on the previous month and just above benchmark group average.</p>
<b>Length of stay - non-elective</b> 	<p>Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.</p>		<p>The average non-elective length of stay for March was 5.0 days, a significant decrease on last month and now below the national average. However, HDFT's length of stay remains above the benchmark group average.</p>



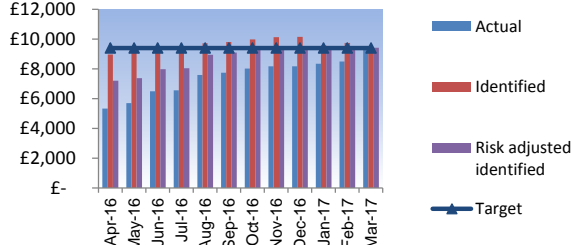

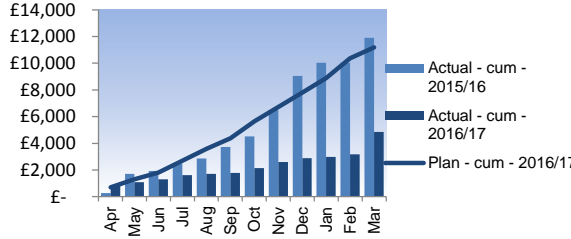

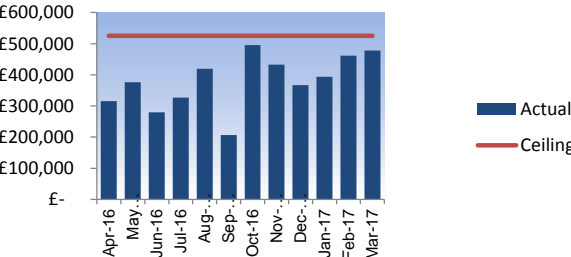
## Finance and Efficiency - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Non-elective bed days</b> 	<p>The charts shows the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per 100,000 population. The chart only includes the local HARD CCG area. The 2016/17 trajectory is based on allowing for demographic growth and reducing by the non-elective reductions identified in the Value Proposition. A lower figure is preferable.</p>		<p>Non-elective bed days for patients aged 18+ increased in March and is above the level reported in March last year. However when expressed per day, this is a reduction on last month.</p>
<b>Theatre utilisation</b> 	<p>The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of this.</p> <p>A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.</p>		<p>Theatre utilisation decreased to 83.8% in March. However the number of cancelled sessions also decreased to 6.8%.</p>
<b>Delayed transfers of care</b> 	<p>The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable.</p> <p>A snapshot position is taken at midnight on the last Thursday of each month. The maximum threshold shown on the chart (3.5%) has been agreed with the CCG.</p>		<p>Delayed transfers of care increased to 6.6% when the snapshot was taken in March, remaining above the maximum threshold of 3.5% set out in the contract. Data shared by NHS Improvement suggests that nationally delayed transfers of care have been at around 5% in 2017 to date.</p> <p>Further work to understand the reasons for this continued increase is being carried out by the Discharge Steering Group.</p>
<b>Outpatient DNA rate</b> 	<p>Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance.</p> <p>A low percentage is good. Patient DNAs will usually result in an unused clinic slot.</p>		<p>HDFT's DNA rate decreased to 4.7% in January and remains below that of both the benchmarked group of trusts and the national average.</p>


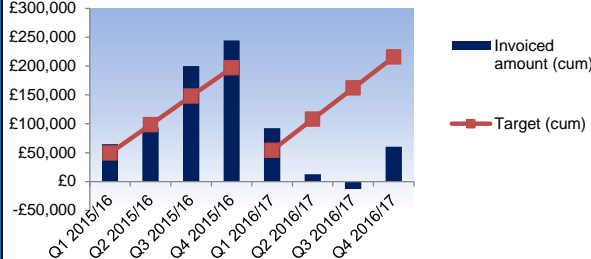
## Finance and Efficiency - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Outpatient new to follow up ratio</b> 	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.		Reducing the number of follow ups is a major part of HARD CCG's financial recovery plan. HDFT's new to follow up ratio decreased in January and remains below both the national average and the benchmark group average.
<b>Day case rate</b> 	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 case rate increased to 89.5% in March and remains above the HDFT average.
<b>Surplus / deficit and variance to plan</b> 	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 a surplus of £3,688k for 2016/17. This position included £3,450k of sustainability and transformation funding, resulting in an underlying surplus of £238k. This position was £2m behind the control total set by NHS Improvement.
<b>Cash balance</b> 	Monthly cash balance (£'000s)		Cash continues to be a concern for the Trust. The cash balance at the end of March was reported at £4.55m, with a number of actions in place to improve the outstanding debtors position. The increase in March is a result of these actions, as well as prepayment of a contract.

## Finance and Efficiency - March 2017



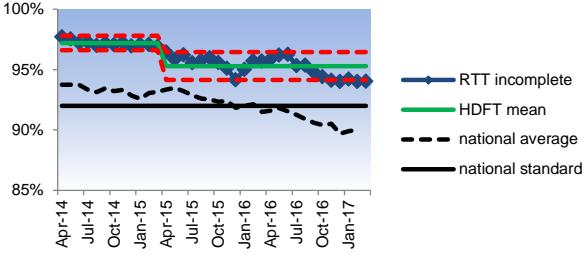

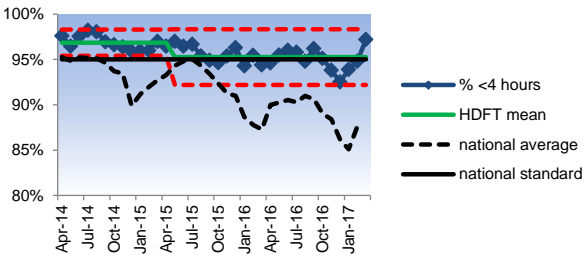

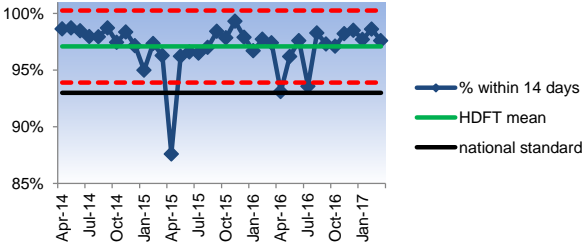
Indicator name / data quality assessment	Description	Trend chart	Interpretation																					
NHS Improvement Single Oversight Framework - Use of Resource Metric 	From 1st October 2016, NHS Improvement introduced the Single Oversight Framework. As part of this this, Use of Resource Metric was introduced to replace the previous Financial Sustainability Risk Rating. This is the product of five elements which are rated between 1 (best) to 4.	<table><thead><tr><th>Element</th><th>Plan</th><th>Actual</th></tr></thead><tbody><tr><td>Capital Service Cover</td><td>1</td><td>1</td></tr><tr><td>Liquidity</td><td>1</td><td>1</td></tr><tr><td>I&amp;E Margin</td><td>1</td><td>1</td></tr><tr><td>I&amp;E Variance From Plan</td><td></td><td>3</td></tr><tr><td>Agency</td><td>1</td><td>1</td></tr><tr><td>Financial Sustainability Risk Rating</td><td>1</td><td>1</td></tr></tbody></table>	Element	Plan	Actual	Capital Service Cover	1	1	Liquidity	1	1	I&E Margin	1	1	I&E Variance From Plan		3	Agency	1	1	Financial Sustainability Risk Rating	1	1	The Trust reported a rating of 1 in March, in line with plan.
Element	Plan	Actual																						
Capital Service Cover	1	1																						
Liquidity	1	1																						
I&E Margin	1	1																						
I&E Variance From Plan		3																						
Agency	1	1																						
Financial Sustainability Risk Rating	1	1																						
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.		Despite the adverse position above, performance against the efficiency programme has remained positive with directorates actioning schemes for the full target set for 2016/17. This contains a number of non recurrent benefits, adding risk to the 2017/18 programme.																					
Capital spend 	Cumulative Capital Expenditure by month (£'000s)		Cumulative capital expenditure remains behind plan.																					
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.		At 3.7% of pay spend, agency expenditure was high in March. At £477k for the month (October was the only higher month) this is a concern for the Trust. Although the value is below the agency ceiling for the Trust, this ceiling reduces in 2017/18 and the current run rate would potentially result in exceeding the new value.																					

## Finance and Efficiency - March 2017


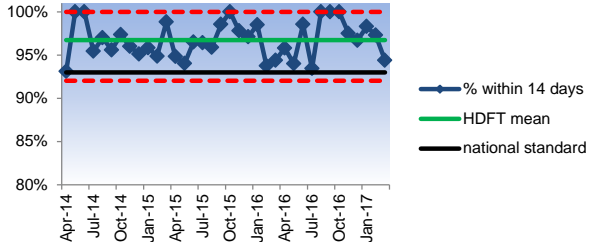

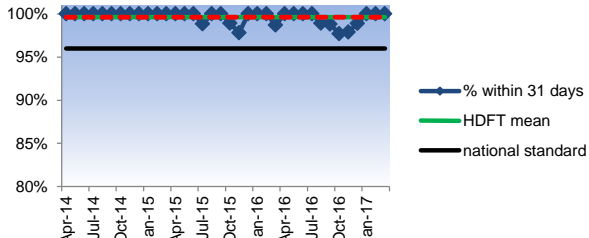

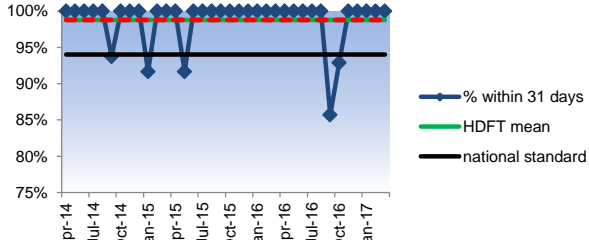

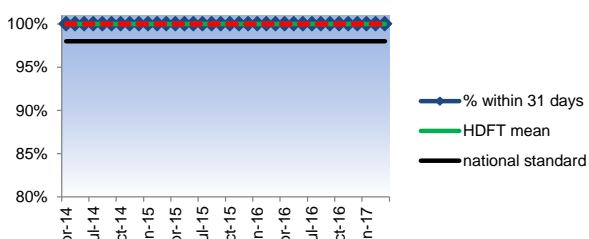
Indicator name / data quality assessment	Description	Trend chart	Interpretation																										
<div>Research - Invoiced research activity</div> <div></div>	Aspects of research studies are paid for by the study sponsor or funder.	<div></div> <table><caption>Estimated data from Trend Chart</caption><thead><tr><th>Quarter</th><th>Invoiced amount (cum) (£)</th><th>Target (cum) (£)</th></tr></thead><tbody><tr><td>Q1 2015/16</td><td>~50,000</td><td>~60,000</td></tr><tr><td>Q2 2015/16</td><td>~100,000</td><td>~110,000</td></tr><tr><td>Q3 2015/16</td><td>~150,000</td><td>~160,000</td></tr><tr><td>Q4 2015/16</td><td>~200,000</td><td>~210,000</td></tr><tr><td>Q1 2016/17</td><td>~250,000</td><td>~260,000</td></tr><tr><td>Q2 2016/17</td><td>~100,000</td><td>~110,000</td></tr><tr><td>Q3 2016/17</td><td>~50,000</td><td>~160,000</td></tr><tr><td>Q4 2016/17</td><td>~223,000</td><td>~223,000</td></tr></tbody></table> <div>As set out in the Research &amp; 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.</div>	Quarter	Invoiced amount (cum) (£)	Target (cum) (£)	Q1 2015/16	~50,000	~60,000	Q2 2015/16	~100,000	~110,000	Q3 2015/16	~150,000	~160,000	Q4 2015/16	~200,000	~210,000	Q1 2016/17	~250,000	~260,000	Q2 2016/17	~100,000	~110,000	Q3 2016/17	~50,000	~160,000	Q4 2016/17	~223,000	~223,000
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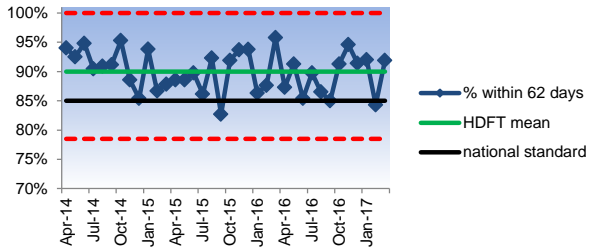

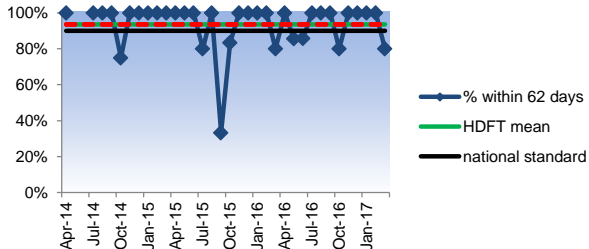

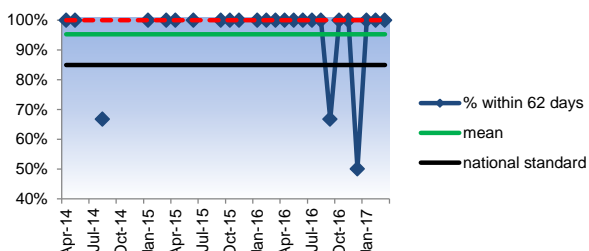

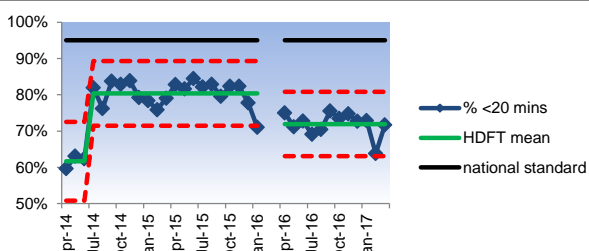
## Operational Performance - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation																																								
<b>NHS Improvement Single Oversight Framework</b> 	<p>From October 2016, NHS Improvement will 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 "operational performance metrics" section.</p>	<table border="1"> <thead> <tr> <th>Standard</th><th>Oct-16</th><th>Nov-16</th><th>Dec-16</th></tr> </thead> <tbody> <tr> <td>RTT incomplete pathways</td><td>94.4%</td><td>94.1%</td><td>94.0%</td></tr> <tr> <td>A&amp;E 4-hour standard</td><td>95.1%</td><td>93.8%</td><td>92.5%</td></tr> <tr> <td>Cancer - 62 days</td><td>91.3%</td><td>94.6%</td><td>91.4%</td></tr> <tr> <td>Diagnostic waits</td><td>99.9%</td><td>99.8%</td><td>99.9%</td></tr> </tbody> </table> <table border="1"> <thead> <tr> <th>Standard</th><th>Jan-17</th><th>Feb-17</th><th>Mar-17</th></tr> </thead> <tbody> <tr> <td>RTT incomplete pathways</td><td>94.2%</td><td>94.0%</td><td>94.0%</td></tr> <tr> <td>A&amp;E 4-hour standard</td><td>93.9%</td><td>94.8%</td><td>97.2%</td></tr> <tr> <td>Cancer - 62 days</td><td>92.0%</td><td>84.3%</td><td>92.1%</td></tr> <tr> <td>Diagnostic waits</td><td>99.9%</td><td>99.8%</td><td>99.8%</td></tr> </tbody> </table>	Standard	Oct-16	Nov-16	Dec-16	RTT incomplete pathways	94.4%	94.1%	94.0%	A&E 4-hour standard	95.1%	93.8%	92.5%	Cancer - 62 days	91.3%	94.6%	91.4%	Diagnostic waits	99.9%	99.8%	99.9%	Standard	Jan-17	Feb-17	Mar-17	RTT incomplete pathways	94.2%	94.0%	94.0%	A&E 4-hour standard	93.9%	94.8%	97.2%	Cancer - 62 days	92.0%	84.3%	92.1%	Diagnostic waits	99.9%	99.8%	99.8%	<p>In March, HDFT was above the required level for all 4 key operational performance metrics.</p>
Standard	Oct-16	Nov-16	Dec-16																																								
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<b>RTT Incomplete pathways performance</b> 	<p>Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks. A high percentage is good.</p>		<p>94.0% of patients were waiting 18 weeks or less at the end of March, above the required national standard of 92% and no change on last month's performance.</p> <p>At specialty level, Trauma &amp; Orthopaedics and General Surgery remain below the 92% standard.</p>																																								
<b>A&amp;E 4 hour standard</b> 	<p>Percentage of patients spending less than 4 hours in Accident &amp; Emergency (A&amp;E). The operational standard is 95%. The data includes all A&amp;E Departments, including Minor Injury Units (MIUs). A high percentage is good. Historical data for HDFT included both Ripon and Selby MIUs. In agreement with local CCGs, York NHSFT are reporting the activity for Selby MIU from 1st May 2015.</p>		<p>HDFT's Trust level performance for March was 97.2%, above the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Harrogate ED in March was 96.6%.</p> <p>HDFT has therefore delivered the 4-hour standard for the 2016/17 year overall with annual performance of 95.1%.</p>																																								
<b>Cancer - 14 days maximum wait from urgent GP referral for suspected cancer referrals</b> 	<p>Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.</p>		<p>Delivery at expected levels.</p>																																								


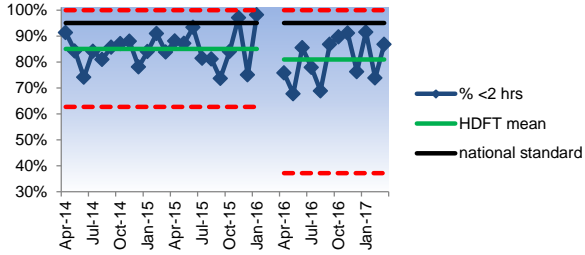

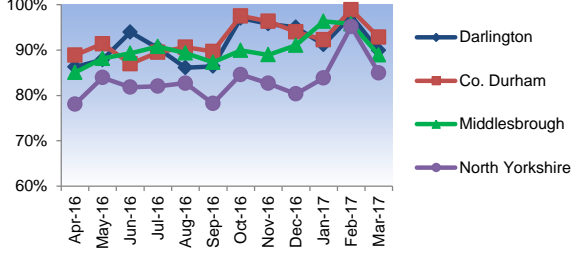

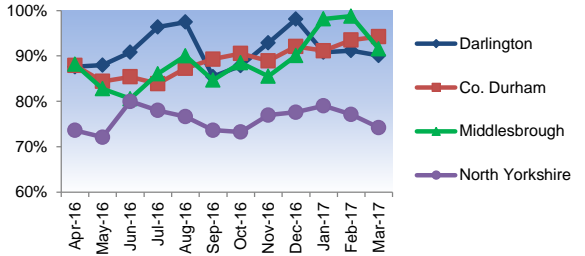

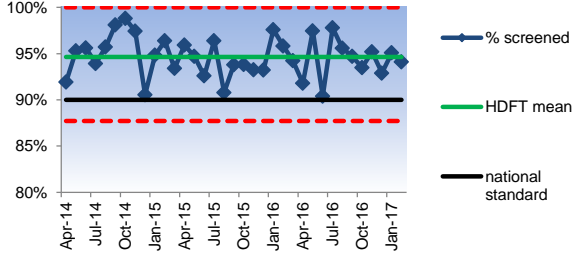
## Operational Performance - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Cancer - 14 days maximum wait from GP referral for symptomatic breast patients</b> 	Percentage of GP referrals for breast symptomatic patients seen within 14 days. The operational standard is 93%. A high percentage is good.		Delivery at expected levels.
<b>Cancer - 31 days maximum wait from diagnosis to treatment for all cancers</b> 	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.
<b>Cancer - 31 day wait for second or subsequent treatment: Surgery</b> 	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.
<b>Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug</b> 	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.


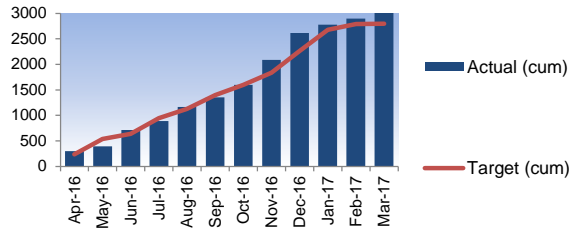

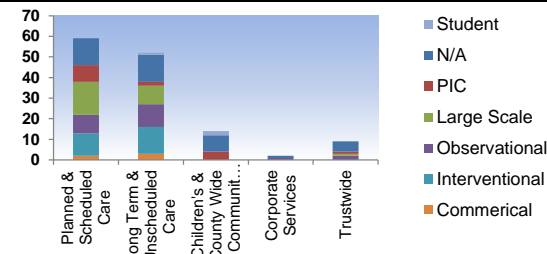
## Operational Performance - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Cancer - 62 day wait for first treatment from urgent GP referral to treatment</b> 	Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good.		Provisional performance for March is above the required 85% standard at 91.9% with 5 accountable breaches. Of the 11 tumour sites, 2 had performance below 85% in March - colorectal and upper gastrointestinal.
<b>Cancer - 62 day wait for first treatment from consultant screening service referral</b> 	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.		Performance was below 90% in March. However with only 5 accountable pathways in the month, this is below the de minimis level for reporting performance. Performance for Quarter 4 overall is above the standard at 94.4%.
<b>Cancer - 62 day wait for first treatment from consultant upgrade</b> 	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.
<b>GP OOH - NQR 9</b> 	NQR 9 (National Quality Requirement 9) looks at the % of GP OOH telephone clinical assessments for urgent cases that are carried out within 20 minutes of call prioritisation. A high percentage is good.		<p>Performance remains below the required 95% for this metric but improved to 72% in March.</p> <p>Work continues with the Information Team to implement new, meaningful performance metrics and assure the quality of the data and reports from the Adastra system. The service is also undertaking a GP performance review which will provide further assurance as to the quality of the service provision.</p>










## Operational Performance - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>GP OOH - NQR 12</b> 	<p>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.</p> <p>The data presented excludes Selby and York as these do not form part of the HFT OOH service from April 2015. A high percentage is good.</p>		<p>Performance remains below the required 95% for this metric but improved to 87% in March.</p> <p>Work continues with the Information Team to implement new, meaningful performance metrics and assure the quality of the data and reports from the Adastra system. The service is also undertaking a GP performance review which will provide further assurance as to the quality of the service provision.</p>
<b>Children's Services - 10-14 day new birth visit</b> 	<p>The percentage of babies who had a new birth visit by the Health Visiting team within 14 days of birth. A high percentage is good.</p> <p>Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level.</p>		<p>In March, the provisional, unvalidated performance position is that 89% of babies were recorded on Systmone as having had a new birth visit within 14 days of birth. It is anticipated that once the data is fully validated that we will report an improved, more accurate performance position for March. This will be reflected in next month's report.</p> <p>As can be seen on the chart, the improved validation process recently implemented has had a significant impact on the February performance position which now better reflects the actual performance of the services.</p>
<b>Children's Services - 2.5 year review</b> 	<p>The percentage of children who had a 2.5 year review. A high percentage is good.</p> <p>Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level.</p>		<p>In March, the provisional performance position is that 86% of children were recorded on Systmone as having had a 2.5 year review.</p> <p>It is anticipated that once the data is fully validated that we will report an improved, more accurate performance position. This will be reflected in next month's report.</p>
<b>Dementia screening</b> 	<p>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.</p>		<p>Delivery at expected levels.</p>

## Operational Performance - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Recruitment to NIHR adopted research studies</b> 	The Trust has a recruitment target of 2,800 for 2016/17 for studies on the NIHR portfolio. This equates to 234 per month. Over recruitment is encouraged.		Provisional data indicates that recruitment to research studies during 2016/17 was 12% above plan.
<b>Directorate research activity</b> 	The number of studies within each of the directorates - included in the graph is Trustwide where the study spans directorates. The Trust has no specific target set for research activity within each directorate. It is envisaged that each clinical directorate would have a balanced portfolio.		The directorate research teams are subject to studies that are available to open. The 'type of study', Commercial, Interventional, Observational, Large scale, Patient Identification Centre (PIC) or N/A influence the activity based funding received by HDFT. Each category is weighted dependant on input of staff involvement. N/A studies are those studies which are not on the NIHR portfolio. They include commercial, interventional, observational, large scale, PIC, local and student projects. They do not influence the recruitment target.

## Data Quality - Exception Report




Report section	Indicator	Data quality rating	Further information
Quality	Pressure ulcers - community acquired - grades 2, 3 or 4	Amber 	The observed increase in reported cases over the last two years may be partly due to improvements in incident reporting during the period.
Operational Performance	GP Out of Hours - National Quality Requirement 9	Amber 	Following patient pathway changes in late 2015, reports from the Adastral system no longer calculate the correct start time for these patients and as a result, the performance reported for NQR9 was incorrect. Significant work from has been carried out by information staff at HDFT and we are now able to report performance again for this metric again, based on calculations from raw data extracts from the Adastral system. The new calculations have been shared with HARD CCG.
Operational Performance	GP Out of Hours - National Quality Requirement 12	Amber 	
Quality	Reducing readmissions in older people	Amber 	This indicator is under development. We have recently amended the calculation of this indicator so that it correctly handles patients who had multiple admissions and multiple contacts with community services.
Finance and efficiency	Theatre utilisation	Amber 	The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of cancelled sessions.
Operational Performance	Children's Services - 10-14 day new birth visit	Amber 	Caution should be exercised as further work is required to understand the completeness and quality of this data.
Operational Performance	Children's Services - 2.5 year review	Amber 	Caution should be exercised as further work is required to understand the completeness and quality of this data.
Quality	Electronic rostering timeliness	Amber 	Caution should be exercised as further work is required to understand the completeness and quality of this data.
Quality	Electronic rostering hours owed	Amber 	Caution should be exercised as further work is required to understand the completeness and quality of this data.

Indicator traffic light criteria

Section	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Quality	Pressure ulcers - hospital acquired	No. category 3 and category 4 avoidable hospital acquired pressure ulcers	tbc	tbc
Quality	Pressure ulcers - community acquired	No. category 3 and category 4 community acquired pressure ulcers	tbc	tbc
Quality	Safety thermometer - harm free care	% harm free	Blue if latest month $\geq 97\%$ , Green if $\geq 95\%$ 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	Falls	IP falls per 1,000 bed days	Blue if YTD position is a reduction of $\geq 50\%$ of HDFT average for 2015/16, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2015/16, Amber if YTD position is a reduction of up to 20% of HDFT average for 2015/16, Red if YTD position is on or above HDFT average for 2015/16.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	Falls causing harm	IP falls causing moderate harm, severe harm or death, per 1,000 bed days	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year.	NHS England, NHS Improvement and contractual requirement
Quality	Infection control	No. hospital acquired C.diff cases	tbc	tbc
Quality	Avoidable admissions	The number of avoidable emergency admissions to HDFT as per the national definition.	tbc	tbc
Quality	Reducing hospital admissions in older people	The proportion of older people 65+ who were still at home 91 days after discharge from rehabilitation or reablement services.	tbc	tbc
Quality	Mortality - HSMR	Hospital Standardised Mortality Ratio (HSMR)	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	Comparison with national average performance.
Quality	Mortality - SHMI	Summary Hospital Mortality Index (SHMI)	Blue if no. complaints in latest month is below LCL, Green if below HDFT average for 2015/16, Amber if on or above HDFT average for 2015/16, Red if above UCL. In addition, Red if a new red rated complaint received in latest month.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	Complaints	No. complaints, split by criteria	Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%	Comparison of HDFT performance against most recently published national average ratio of low to high incidents.
Quality	Incidents - all	Incidents split by grade (hosp and community)	Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month.	
Quality	Incidents - comprehensive SIRIs and never events	The number of comprehensive SIRIs and the number of never events reported in the year to date. The indicator includes hospital and community data	Blue if latest month score places HDFT in the top 10% of acute trusts nationally and/or the % staff recommending the Trust is above 95%, Green if in top 25% of acute trusts nationally, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Quality	Friends & Family Test (FFT) - Staff	% staff who would recommend HDFT as a place to work	Green if latest month $\geq$ latest published national average, Red if $<$ latest published national average.	Comparison with national average performance.
Quality	Friends & Family Test (FFT) - Staff	% staff who would recommend HDFT as a place to receive care	Green if latest month overall staffing $\geq 100\%$ , amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
Quality	Friends & Family Test (FFT) - Patients	% recommend, % not recommend - combined score for all services currently doing patient FFT	Annual rolling total - 90% green, Amber between 70% and 90%, red $< 70\%$ .	Locally agreed target level based on historic local and NHS performance
Quality	Safer staffing levels	RN and CSW - day and night overall fill rates at trust level	Blue if latest month $\geq 95\%$ , 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 appraisal rate	Latest position on no. staff who had an appraisal within the last 12 months	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	Mandatory training rate	Latest position on the % staff trained for each mandatory training requirement	tbc	tbc
Quality	Staff sickness rate	Staff sickness rate	tbc	tbc
Quality	Temporary staffing expenditure - medical/nursing/other	Expenditure per month on staff types.	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	Staff turnover	Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts.	Green if $< 25\%$ of deliveries, amber if between 25% and 30%, red if above 30%.	tbc
Quality	Maternity - Caesarean section rate	Caesarean section rate as a % of all deliveries	Green if $< 3\%$ of deliveries, amber if between 3% and 6%, red if above 6%.	tbc
Quality	Maternity - Rate of third and fourth degree tears	No. third or fourth degree tears as a % of all deliveries	tbc	tbc
Quality	Maternity - Unexpected term admissions to SCBU	Admissions to SCBU for babies born at 37 weeks gestation or over.	Blue if latest month rate $<$ LCL, Green if latest month rate $<$ HDFT average for 2015/16, Amber if latest month rate $>$ HDFT average for 2015/16 but below UCL, red if latest month rate $>$ UCL.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Finance and efficiency	Readmissions	No. emergency readmissions (following elective or non-elective admission) within 30 days.	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	Readmissions - standardised	Standardised emergency readmission rate within 30 days from HED	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Finance and efficiency	Length of stay - elective	Average LOS for elective patients		
Finance and efficiency	Length of stay - non-elective	Average LOS for non-elective patients		

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

#### Data quality assessment

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



## COUNCIL OF GOVERNORS' MEETING

A meeting of the Harrogate and District NHS Foundation Trust Council of Governors will take place on Wednesday, 3 May 2017 in The Cover Room, The Pavilions of Harrogate, Great Yorkshire Showground, Harrogate, HG2 8NZ

**Start: 5.45pm      Finish: 8.00pm**

***(Private discussion for Governors and the Board will commence at 5.15pm)***

AGENDA				
Time	Item No.	Item	Lead	Paper No.
5.45	1.0	<b>Welcome and apologies for absence</b> <i>Welcome to the public and setting the context of the meeting</i>	Mrs Sandra Dodson, Chairman	-
5.45	2.0	<b>Minutes of the meeting held on 18 February 2017</b> <i>To review and approve the minutes</i>	Mrs Sandra Dodson, Chairman	2.0
5.50	3.0	<b>Matters arising and review of action log</b> <i>To provide updates on progress of actions</i>	Mrs Sandra Dodson, Chairman	3.0
5.55	4.0	<b>Declarations of interest</b> <i>To declare any interests relevant to the agenda and to receive any changes to the register of interests</i>	Mrs Sandra Dodson, Chairman	4.0
5.55	5.0	<b>Chairman's verbal update on key issues including:</b> <ul style="list-style-type: none"> <li><b>Update on Governors' terms of office</b></li> </ul> <i>To receive the verbal update for consideration</i>	Mrs Sandra Dodson, Chairman	5.1
6.05	6.0	<b>Governor Sub-Committee Reports</b> <i>To receive the reports for comment</i>	Mrs Sandra Dodson, Chairman	
	6.1	<b>Governor Working Group - Volunteering and Education</b>	Mrs Jane Hedley, Public Governor	6.1
	6.2	<b>Governor Working Group - Membership Development and Communications</b>	Ms Pamela Allen, Deputy Chair of the Council of Governors/ Public Governor	6.2
	6.3	<b>Patient and Public Involvement – Learning from Patient Experience Group</b>	Mrs Liz Dean, Public Governor	6.3
6.15	7.0	<b>Update on Quality of Care Teams</b>	Mrs Jill Foster, Chief Nurse	7.0
	7.1	<b>Quality Priorities for 2017/18</b> <i>To receive the reports for comment</i>	Mrs Jill Foster, Chief Nurse	7.1

6.25	8.0	<b>Report from the Nominations Committee</b> <i>To receive the report for comment and approval:</i> <ul style="list-style-type: none"> <li>• Minutes of the meeting held 12 April 2017</li> <li>• Update on the appointment schedule for Non-Executive Director</li> <li>• Appointment of Vice Chairman</li> </ul>	Mrs Sandra Dodson, Chairman	8.0
	8.1	<b>Update from the Nominations Committee on the Chairman's recruitment process</b> <i>To receive the verbal update on progress</i>	Ms Pamela Allen, Deputy Chair of Governors/Public Governor	-
6.35	9.0	<b>Presentation – Apprenticeship Scheme</b>	Mrs Shirley Silvester, Head of Learning and Organisational Development and Mrs Sharon Wilkes, Clinical Workforce Transformation Lead	-
<b>6.50 - 7.00 pm – Break</b>				
7.00	10.0	<b>Chief Executive's Strategic and Operational Update, including Integrated Board Report and Operational Plan 2017/18</b> <i>To receive the update and report for comment</i>	Dr Ros Tolcher, Chief Executive	10.0
7.20	11.0	<b>Question and Answer Session for members of the public and Governors</b> <i>To receive and respond to questions from the floor relating to the agenda</i>	Mrs Sandra Dodson, Chairman	-
7.45	12.0	<b>Assurance on challenges for 2017/18 and reflection on performance 2016/17</b> <i>To receive and respond to questions from the floor</i>	Non-Executive Directors	-
7.55	13.0	<b>Any other relevant business not included on the agenda</b> <i>By permission of the Chairman</i>	Mrs Sandra Dodson, Chairman	-
8.00	14.0	<b>Close of meeting</b>	Mrs Sandra Dodson, Chairman	-

**Date and time of next meeting –**

**Wednesday, 2 August 2017 at 5.45 pm (private meeting commences at 5.15 pm) to be held at St. Aidan's Church of England High School, Harrogate**

### **Council of Governors**

Minutes of the public Council of Governors' meeting held on 18 February 2017 at 10:45 hrs  
at St Aidan's Church of England High School, Oatlands Drive, Harrogate, HG2 8JR

**Present:**

- Mrs Sandra Dodson, Chairman
- Ms Pamela Allen, Public Governor/Deputy Chair of Council of Governors
- Cllr. Bernard Bateman, Stakeholder Governor
- Dr Sally Blackburn, Public Governor
- Mrs Yvonne Campbell, Staff Governor
- Mrs Cath Clelland, Public Governor
- Mrs Angie Colvin, Corporate Affairs and Membership Manager
- Ms Clare Cressey, Staff Governor
- Mr Tony Doveston, Public Governor
- Miss Sue Eddleston, Public Governor
- Mrs Jill Foster, Chief Nurse
- Mrs Jane Hedley, Public Governor
- Mrs Ann Hill, Public Governor
- Cllr. Phil Ireland, Stakeholder Governor
- Mrs Pat Jones, Public Governor
- Mr Phillip Marshall, Director of Workforce and Organisational Development
- Mr Neil McLean, Non-Executive Director
- Mrs Zoe Metcalfe, Public Governor
- Mr Peter Pearson, Public Governor
- Prof. Sue Proctor, Non-Executive Director
- Dr Daniel Scott, Staff Governor
- Mrs Maureen Taylor, Non-Executive Director
- Mr Chris Thompson, Non-Executive Director
- Dr Ros Tolcher, Chief Executive
- Mr Steve Treece, Public Governor
- Mrs Lesley Webster, Non-Executive Director

**In attendance:**

- 11 members of the public
- Mrs Emily Reid, Education Liaison, Work Experience and Membership Officer
- Mr Richard Chillery, Operational Director, Children's and County Wide Community Care Directorate

## **1. Welcome and apologies for absence**

Apologies were received from Mr Jonathan Coulter, Director of Finance/Deputy Chief Executive, Dr Sarah Crawshaw, Stakeholder Governor, Mrs Liz Dean, Public Governor, Mrs Emma Edgar, Staff Governor, Mrs Beth Finch, Stakeholder Governor, Mr Rob Harrison, Chief Operating Officer, Mrs Sally Margerison, Staff Governor, Dr David Scullion, Medical Director, Mr Ian Ward, Non-Executive Director, and Dr Jim Woods, Stakeholder Governor.

Mrs Dodson was delighted to see so many members of the public at the meeting and offered them a warm welcome. She hoped they would find the meeting interesting and informative and welcomed questions for Governors or any member of the Board in attendance. She asked that any questions for item 10 on the agenda to be submitted during the break.

Mrs Dodson was also delighted to introduce Mrs Reid and Mr Chillery, who would be talking about the Youth Forum under item 8 on the agenda and she welcomed the new Governors who had commenced their term of office on 1 January: Miss Eddleston, Mrs Hill, Cllr. Ireland and Mr Treece.

## **2. Minutes of the last meeting, 2 November 2016**

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

### **2.1 Minutes of the Extra-ordinary Council of Governors' meeting, 30 November 2016**

The minutes of the Extra-ordinary Council of Governors' meeting held on 30 November 2016 were agreed as a true and accurate record.

### **2.2 Minutes of the Annual Members' Meeting (AMM) held on 13 September 2016**

Mrs Dodson asked for the minutes of the last AMM to be noted and any comments to be forwarded to Mrs Colvin. The minutes would then be ratified at the next AMM in September.

## **3. Matters arising and review of action schedule**

Mrs Foster provided an update regarding the progress of Nutritional Assistants; item 1 on the outstanding action schedule. She confirmed there were eight well-established Nutritional Assistants based on the wards and they were making a valuable contribution in supporting patients with their nutrition.

Mrs Hedley had a keen interest in the role of the Nutritional Assistants as she attended the Nutrition Group meetings as a member of the Patient Voice Group. Mrs Foster confirmed that the Nutritional Assistants provided nutritional support at breakfast and lunch times Monday to Friday; evenings and weekends were covered by Care Support Workers and registered nurses.

Mr Marshall provided an update regarding the Global Health Exchange Programme; item 2 on the outstanding action schedule. He was delighted to report that a small team of representatives from the Apollo Group and Health Education England, who

were running the Indian element of the Global Health Exchange initiative, had visited the Trust on 22 November 2016 and had the opportunity to meet Trust staff and have a guided tour of Harrogate Hospital.

Interviews had taken place for the first cohort of nurses and 24 had been given conditional offers of employment. Mr Marshall confirmed that ten nurses had taken their first set of exams, including English language, that day in Hyderabad, India and the results would be known the following week. For those who were successful, the next steps would be to apply for a visa and then travel to England to complete further training at Northampton University. Mr Marshall would be pleased to provide a further update at the next meeting.

Cllr Bateman enquired whether the nurses would stay in the UK. Mr Marshall confirmed that the programme was based on an 'earn, learn and return' initiative and the aim was for the staff to return to India.

Following a question submitted at the last meeting covered under items 3, 4 and 5 on the outstanding action schedule, confirmation had been received that seating was now available in the Strayside entrance on Harrogate District Hospital and other areas were also being reviewed. There was a telephone near the emergency maternity entrance of the hospital and a laminated notice with key contact numbers was now displayed. Mrs Dodson confirmed she had spoken with Mrs Tomlinson, Volunteer Services Manager, and agreed that the 'Meet and Greet' Volunteers based at the main entrance to the hospital would be very happy to help anyone who entered at the maternity entrance and rang for assistance.

Miss Eddleston welcomed the positive response and commented that further seating would also be appreciated.

Mrs Dodson confirmed that she had thanked Dr Leigh for her presentation at the Medicine for Members' Event in October 2016 and this was the final action on the schedule.

**ACTION:**

- **Mr Marshall to provide a further update on the Global Health Exchange Programme at the next meeting in May.**
- **An update on the review of seating arrangements in Harrogate District Hospital.**

#### **4. Declaration of interests**

In response to Mrs Dodson's request for any declarations of interest, Mr Treece confirmed that he was an employee of NHS Digital and this was recorded on Paper 4.0.

There were no other declarations of interests from Governors.

Mrs Dodson reminded Governors that they would be asked to sign a Declaration of Interest form on an annual basis and that 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 introduced the newly elected Public Governors: Miss Eddleston, Mrs Hill and Mr Treece, and also Cllr. Ireland, the newly appointed Stakeholder Governor representing Harrogate Borough Council to their first meeting. She explained that Stakeholder Governors were not elected as local representatives but nominated by their respective organisations and then appointed by the Trust to foster stakeholder engagement and to seek views on service development and specialist advice, to name a few.

As well as Harrogate Borough Council, the Council of Governors included Stakeholder Governors representing North Yorkshire County Council, Leeds University, the Voluntary Sector, Patient Experience, and Harrogate and Rural District Local Medical Committee.

Mrs Dodson wished to formally thank Mr Michael Armitage, Public Governor for Wetherby and Harewood, who had finished his term of office at the end of December 2016 for his contribution on the Council for the last three years.

On behalf of the Trust, Mrs Dodson was delighted to congratulate Mrs Clelland who had been awarded an MBE in the 2016 Queen's Birthday Honours for her services to the community in West Yorkshire. Mrs Clelland had received her prestigious award from Prince Charles.

Finally, Mrs Dodson also congratulated Professor Proctor on her appointment as Chair of Leeds and York Partnership NHS Foundation Trust; a provider of NHS mental health and learning disability services across Leeds and specialist services across Yorkshire and the Humber. Professor Proctor would take up her new role from 1 April. Mrs Dodson commented that the Trust was disappointed to lose such a valued Non-Executive Director and Vice Chair on the Board but was delighted for Leeds and York Partnership Trust and both Trusts would continue to work in partnership. Mrs Dodson thanked Professor Proctor and wished her all the very best for the future.

## **6. Governor Sub-Committee Reports**

Mrs Dodson moved on to clarify the role of the two formal sub committees and the Patient and Public Involvement, Learning from Patient Experience Group. She said how important it was for the general public to hear about the work of these sub-committees 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 Hedley, had been circulated prior to the meeting and was taken as read.

Mrs Hedley highlighted the new volunteers from Ripon Grammar School who had commenced volunteering in Trinity Ward at Ripon Community Hospital, outlined in her report.

There were no questions for Mrs Hedley.



Mrs Dodson was pleased to hear about the volunteers who were actively engaging with the patients in Ripon and expressed how important this was for patients who were often required to stay in hospital for longer periods of time.

## 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 membership recruitment and engagement outlined in her report. She thanked Miss Kirsty Burt, Corporate Administrative Assistant and Mrs Colvin for their focus on engaging with new members in the age group 22 – 45 and with people residing in rural communities.

Ms Allen commented that members of the sub-committee would welcome the opportunity to meet and talk to different groups to promote membership and the role of the Governor.

There were no questions for Ms Allen.

## 6.3 Patient and Public Involvement

Mrs Dodson took a question from a member of the public at this stage in the meeting. The member of public needed to leave before item 10 on the agenda. The question submitted was as follows:

**“What are the changing facilities at the hospital for adult disabled visitors/patients as the disabled toilets are not suitable.” In addition, a member of the public commented about access issues to the hydrotherapy pool.**

Mrs Dodson thanked the member of the public for her question and said that it was an important question to raise which highlighted general accessibility for everyone. She confirmed that the Trust's Equality and Diversity Stakeholder Group had Governor representation and such issues were discussed in that forum.

In relation to the issues around access to the hydrotherapy pool, Mrs Foster agreed to follow this up outside of the meeting with the Operational Director for Planned and Surgical Care. With regard to a 'Changing Places' facility in Harrogate Hospital, Mrs Foster was pleased to report a space had been identified near Herriot's Restaurant on the first floor and this was currently in the planning phase. In the meantime, if anyone visiting the hospital required such a facility they could ask at the front reception desk and the Site Co-ordinator or Matrons would be able to identify somewhere appropriate on a ward.

Mrs Dodson explained that any actions as a result of questions submitted, or indeed from any discussions throughout the meeting, would be recorded on the action schedule and raised at the following meeting for a further response. This would provide assurance for members of the public that actions were being dealt with.

Following the comment about access to the hydrotherapy pool, another member of the public asked about the cost of a hoist. Mrs Dodson agreed that the finer detail of the individual's issue would be dealt with outside of the meeting.

### **6.3.1 Quality of Care Teams – individual Governor feedback on attendance at Quality of Care Teams**

Mrs Dodson explained that Quality of Care Teams formed part of the Trust's governance structure and the aim of these multidisciplinary teams was to ensure that quality and safety was discussed as a matter of priority at local level. She acknowledged that some Quality of Care Team meetings were more effective than others and welcomed feedback from Governors who were assigned to a Team.

Mrs Jones confirmed that she was involved with the Quality of Care Team for the Special Care Baby Unit and Woodlands children's ward. She thoroughly enjoyed being part of their team which met once per month and provided positive feedback regarding both the team and the format of the meetings. Mrs Jones highlighted the opportunity to spend time talking to patient's families about their experience with children in hospital.

Mrs Dodson was pleased to hear such positive feedback and commented how this demonstrated a well-managed Quality of Care Team.

Mr Doveston confirmed he had joined the Sir Robert Ogden Macmillan Centre Quality of Care Team which was attended by hard-working and dedicated staff, including doctors. This experience provided him with a good insight into team working and team morale. He gave examples of what was discussed in a typical meeting including items on the risk register, service development, new drugs, audit trials, and feedback from patient experience; both positive and negative issues. He was pleased to say he felt very welcome at the meetings and the discussions were genuine and honest.

Mrs Dodson acknowledged that there could be positive and negative issues highlighted at such meetings and it was important to have a culture of openness and honesty.

Mr Pearson was pleased to confirm he had joined the Pathology Quality of Care Team which met once a month to review a wide range of pathology related aspects. He gave some examples of the papers the team looked at in detail and acknowledged that external pressures, including freedom of information requests and inspections, could have an impact on a variety of priorities.

Mrs Dodson thanked Mr Pearson for his detailed feedback and clarified that the Governors' role on these teams was to gain an understanding of the quality and risk issues being discussed. This involvement demonstrated how much Governors were engaged



across the organisation and the insight they could gain from being a member of these teams.

Ms Allen stated that she was pleased to hear from fellow Governors about the success of the Quality of Care Teams they were involved with. Unfortunately, she had not had a similar experience and the team she was assigned to did not function as effectively which meant she was not currently involved.

Dr Blackburn provided an overview of her involvement with the Joint Health Visitor and School Nursing Harrogate and Rural Quality of Care Team, which met monthly. They focussed on children's services provided in the community and Dr Blackburn thoroughly enjoyed attending meetings.

Mrs Dodson stated that it was important to recognise that not all Quality of Care Teams followed the successful role model however the initiative was a fundamental aspect of governance and consistency across the teams was needed.

Mrs Dodson confirmed that Quality of Care Teams were held both in the hospital and across the community and acknowledged the challenges faced by community staff to come together for such a meeting once a month. Mrs Dodson set the challenge to teams in the hospital to be able to do the same.

#### **6.3.2 Update from the Chief Nurse on review of Quality of Care Teams process**

Mrs Foster thanked all the Governors for their comments and their valuable time in attending Quality of Care Team meetings. She was aware that not all of the teams were functioning as well and acknowledged that further progress was required. She stated that Directorates reported back to her on a six monthly basis, including Quality of Care Team actions, and agreed to provide a further update at the next Council of Governors meeting in May.

##### **ACTION:**

- **Mrs Foster to provide a further update on the progress of Quality of Care Teams at the Council of Governors' meeting in May.**

#### **6.4 Patient Safety Visits Annual Report**

Mrs Dodson explained that patient safety visits were a way of ensuring that:

- Executives and Non-Executives were informed first hand, regarding the safety concerns of frontline staff.
- Senior leaders demonstrated visible commitment by listening to and supporting staff when issues of safety were raised.
- The safety of patients was seen as the priority of the organisation.

One Governor was invited to join the visiting team on each planned patient safety visit.

The purpose of patient safety visits was to:

- Encourage staff to raise any concerns in a forum which was supportive.
- Build good communication and relationships with staff.
- Enable senior leaders to promote a positive safety culture among all staff, such as the value of incident reporting in order to learn and improve the delivery of safe care.
- Obtain and act on information that identifies risk and areas for improvement.
- Promote the use of local solutions whenever possible.

Mrs Foster referred to her annual report which had been circulated prior to the meeting and taken as read. She confirmed that patient safety visits were an important mechanism to meet with staff on the frontline and discuss any concerns. Meetings were organised in advance and the meeting would take place with any staff available, and on duty, that day.

There were no questions for Mrs Foster.

#### **6.5 Update on the Quality Account Process**

Mrs Foster outlined the purpose of the Quality Account, an integral part of the Annual Report and Account, which reflected on the highest priorities of the Trust for the forthcoming year and reported on progress made in the past year.

Mrs Foster highlighted the importance of stakeholder engagement in producing the Quality Account and to determine the quality priorities for the coming year. This would involve engaging with a variety of stakeholders, including Governors, to ensure representation of the local community. The final report would be submitted for publication at the end of May.

Mrs Dodson added that the Quality Account would continue to be monitored through the Quality Committee.

### **7. Report from the Nominations Committee**

Mr Thompson left the room at this stage in the meeting.

Mrs Dodson confirmed the responsibility of the Council of Governors to appoint and reappoint the Chairman and Non-Executive Directors. Paper 7.0 had been circulated prior to the meeting, including the recommendations of the Nominations Committee to the Council of Governors, and this was taken as read.

The Nominations Committee had met on 27 January to discuss the reappointment of Mr Thompson to a second term of office as Non-Executive Director from 1 March 2017 to 29 February 2020.

Mrs Dodson referred to the minutes of the meeting held on 27 January and these were approved.

Moving on to the recommendation for the reappointment of Mr Thompson, Mrs Dodson had recommended to the Nominations Committee that Mr Thompson be reappointed to a second term, subject to the approval of the Council of Governors. Ms Allen fully endorsed the recommendation commending Mr Thompson's competency, enthusiasm and commitment to his role as Non-Executive Director and Chair of the Audit Committee.

There were no questions for the Nominations Committee and the Council of Governors was in unanimous agreement and approved the recommendation.

Mr Thompson returned to the room at this stage of the meeting and Mrs Dodson was pleased to congratulate him and report that the recommendation had unanimously been approved.

#### **7.1 Update from the Nominations Committee on the Chairman's Recruitment Process**

Ms Allen provided an update on the progress made regarding the recruitment process to appoint a new Chair. Following a tender exercise to select an Executive search organisation, presentations and interviews were held on 27 January and the panel were unanimous in recommending that Gatenby Sanderson should be appointed to facilitate the recruitment process. The Nomination Committee met with Mr Robin Staveley and Ms Emma Pickup from Gatenby Sanderson on 15 February to discuss the process in further detail including the timeline, job description, person specification and agree members of the interview panel. It was agreed that the following Governors would be on the interview panel: Ms Allen, Ms Cressey, Mrs Metcalfe and Mr Doveston. Dr Scott and Mr Treece would be on the focus groups. Ms Allen confirmed the closing date for applications would be 3 April and interviews would take place on 22 May, allowing candidates to meet with key members of Trust staff. The Council of Governors would be asked to ratify the appointment of the new Chair at an Extra-ordinary Council of Governors meeting on 16 June.\*

A member of the public enquired as to why Mrs Dodson could not continue as Chair to which Ms Allen confirmed, in accordance with the Trust's constitution, Mrs Dodson would be coming to the end of her third and final term of office on 30 September.

#### **8. Presentation – Youth Forum – listening to young people's experiences and ideas for healthcare improvement**

Mrs Dodson welcomed Mrs Reid and Mr Chillery to present about the new Youth Forum.

Mrs Reid thanked Mrs Dodson for the opportunity to present at the meeting and she provided an overview of the new Youth Forum to date. The Youth Forum was set up as a sub-group of the Governor Working Group for Membership Development and Communications for young people between the ages of 13 – 19. A variety of ways to promote the forum to young people included notices at events, posters in the hospital and in schools, invitations to young volunteers and work experience students, and networking with other local group contacts. The first meeting took place on 8 December 2016 and members agreed to meet every six weeks.

Current members were from a range of schools and some had long-term health conditions and had experienced some of the Trust's services. Mrs Reid was delighted to present some of the ways in which the Trust would be working alongside the Youth Forum to listen to their views, and actively involve them in projects across the organisation. Some of the suggestions to date included new methods of communication, innovative fundraising ideas, mystery shopper, and the exciting opportunity to work with the Children's and County Wide Community Care Directorate to develop a new Children's Strategy.

Mrs Reid displayed a photograph of some of the current members of the Youth Forum stating that each person brought their own unique blend of interests and the views of their peers. Mrs Reid and Mrs Colvin, with support from Governors and colleagues across the Trust, would support the Youth Forum to develop their own brand and enable their voices to be heard. Through networking with their peers, the Youth Forum would strengthen the Trust's relationship with schools and have opportunities to link up with other Youth Forums in the area. Two members had already volunteered to attend the North Yorkshire Youth Executive meeting; an excellent opportunity to take local health priorities to a county wide forum.

Mr Chillery talked about the expansion of children's services across North Yorkshire and more recently across Darlington, County Durham and Middlesbrough which he managed as Operational Director of the Children's and County Wide Community Care Directorate. He commented on the importance of listening to young people as well as receiving feedback through a variety of mechanisms. He acknowledged that this may bring its challenges but hoped that it would inspire the Trust to drive forward high quality children's services. Mr Chillery highlighted the objective to develop the Trust's strategy for young people and he looked forward to engaging with such a valuable resource within the Youth Forum and taking a steer from the community the Trust served.

Mrs Dodson opened up questions from the floor.

Mrs Webster noted that the forum was predominantly made up of girls. Mrs Reid confirmed there were boys in the group, albeit not as many, and one boy who was present when the photograph was taken chose not to be in the photograph. Mrs Reid confirmed recruitment would continue to be promoted to all and the challenge was put back to the forum to encourage more boys to join.

Cllr Bateman offered his support to the group. Mrs Reid thanked him and noted for a future opportunity.

Mr Chillery confirmed the forum was still new and the Corporate team was keen to allow them the time to develop as a group and feel confident in making decisions as to what was on their agenda.

Professor Proctor thanked Mrs Reid and Mr Chillery for an inspiring presentation. She asked: if young people raised issues around services not provided by the Trust, for example mental health, how these views would be communicated to other providers. Mr Chillery confirmed that mental health was already an emerging theme however through a variety of networks this should not be seen as a barrier to stifle communications.

Mrs Lennon, Chair of the Patient Voice Group, who had attended the meeting as a member of the public, expressed her delight towards the Youth Forum and asked how responsive providers could be towards any ideas they may put forward. Mr Chillery thanked Mrs Lennon for her question and confirmed that already the group were being involved in quick turnaround projects, so they would be able to see the results of their valuable input. In terms of the strategy, Mr Chillery explained this would be a longer term project and his aim would be to take this forward with the Youth Forum step by step and create opportunities to network with local schools.

There were no further questions for Mrs Reid and Mr Chillery and Mrs Dodson thanked them for such an informative presentation.

## **9. Chief Executive's Strategic and Operational Update, including Integrated Board Report**

Dr Tolcher presented the following headlines:

### Winter pressures and current performance

Dr Tolcher highlighted the considerable operational pressures experienced over the Christmas and New Year period, both in the hospital and across community services. The demand reached an all-time high for the organisation with emergency department attendances up by 12% compared to last year and emergency admissions up by 10%. She recognised that staff across the organisation had worked incredibly hard and commented that the Trust's performance was a tribute to their dedication and commitment in maintaining services and providing high quality care to our patients.

Dr Tolcher presented detailed charts of operational performance during surges in demand, including non-elective (emergency) bed days (adults, per 100,000), Emergency Department 4 hour standard, delayed transfers of care, and referral to treatment incomplete pathways, taken from the Integrated Board Report, available on the Trust's website.\*\* These charts demonstrated how the Trust was performing in the Emergency Department against national data and, despite not achieving its usual performance, the Trust had been recognised by NHS Improvement as one of the best performing Emergency Departments in England.

Dr Tolcher provided further information regarding the referral to treatment data; a national standard on how quickly patients were seen and treated. She explained the importance of reporting on quality and how long patients would expect to wait as people could choose where to receive treatment. Despite having some clinical specialities which exceeded the 18 week standard, namely orthopaedics and general surgery, the Trust performed well averaging around 94%.

Dr Tolcher moved on to a snapshot of Key Performance Indicators (KPIs) recorded in December 2016 and explained how these were rated. She explained some of the detailed information which related to the red-rated areas in the report taken from the Quality, Finance and Efficiency, and Operational Performance Indicators and provided reassurance on the actions being taken. Quality had three red-rated KPIs including: total number of falls, falls causing harm, and total number of incidents. Dr Tolcher offered reassurance that, although the overall aim was to have no falls, there had been a considerable reduction of fractures due to falls with five to date compared with 12 last year. Overall the number of falls was also less compared with last year.

Finance and efficiency had five red-rated KPIs in standardised readmissions, non-elective bed days, delayed transfers of care, surplus/deficit variance to plan, and cash balance. In relation to the Trust's financial position, Dr Tolcher stated that the Trust remained ahead of the financial plan in Q3, however there were significant risks to delivery at year end.

The Operational Performance summary demonstrated two red-rated KPIs in NHS Improvement single oversight framework and A&E 4 hour standard, which had dipped in the last quarter resulting in a red rating.

Dr Tolcher was pleased to report that the vast majority of performance indicators remained green, including all cancer pathways, referral to treatment, safety thermometer, infection control, and complaints and incidents, all despite the winter pressures.

### Strategic landscape: Sustainability and Transformation Plans and New Care Models

Moving on to the strategic landscape Dr Tolcher provided a brief update on the West Yorkshire and Harrogate Sustainability and Transformation Plan (STP); delivered by local health care organisations working together across the region to support changes needed to improve services for its population. The Trust was part of the West Yorkshire STP footprint working collaboratively with five other acute hospitals having agreed a Committee in Common to make network decisions.

In addition, Dr Tolcher confirmed the local New Care Model (Vanguard) was in its last year of a three-year funding programme and formal evaluation would be shared at a later date.

### Risks and Issues

Dr Tolcher went on to talk about the risks affecting the organisation at the current time, both internally and externally. She highlighted some of the top scoring strategic risks for the Trust which related to:

- The ability to deliver integrated models of care.
- Medical and nurse staffing levels.
- System level financial risks.
- Lack of a single care record.

The two top scoring operational risks in the organisation were:

- Ability to meet the Emergency Department 4 hour wait target.
- Income shortfall due to activity below plan.

In addition, Dr Tolcher talked about additional issues affecting the organisation including workforce supply issues, pressures on critical infrastructure (e.g. too much activity and not enough theatre capacity), finance, and future health and care architecture (the amount of time being engaged in all the different programmes).

Finally, Dr Tolcher finished her presentation by highlighting some of the initial findings from the National Staff Survey 2016; a mandatory report consisting of 21 questions based on quality of care and what each organisation was like to work for.



The final results were expected imminently, but Dr Tolcher was pleased to report initial positive findings: a 5% increase in the number of staff feeling confident to raise concerns. Dr Tolcher stated that this increase was remarkable given that the Trust already scored higher than average. A slightly more disappointing finding was a 3% decrease in the number of staff recommending the Trust as a place to work – 66% compared to 69% last year, however it was still reassuring that this figure was above the national average of 57% and Dr Tolcher looked forward to receiving detailed analysis of the figures shortly.

Mrs Dodson thanked Dr Tolcher for her update and opened up questions from the floor.

Dr Scott asked how the finance shortfall was impacting on the STP.

Dr Tolcher confirmed there was a complete freeze on capital spending in the NHS at the current time; the Trust had some developments on hold however, it was too early to provide any additional information at this stage.

A member of the public asked for clarification on bed management and Dr Tolcher confirmed this remained a challenge with difficulties moving patients back home or on to other care providers.

Mr Doveston asked, at this early stage with the STP, did the Trust see areas of vulnerability for Harrogate and had there been any reduction in services.

Dr Tolcher stated that a key objective for the Trust was to ensure clinical and financial sustainability. The aim in working with other acute trusts was to offer better value and better outcomes for patients. The NHS Five Year Forward View focussed on three gaps: closing the care and quality gap, closing the health and wellbeing gap, and closing the funding and efficiency gap. Dr Tolcher confirmed that health professionals across West Yorkshire and Harrogate were already engaging with local people regarding stroke services across the area and how these could be improved further whilst making the most of latest technology, staff skills and maximising the best outcome following a stroke. This engagement work was being supported by Healthwatch and would initially take six weeks. She explained that it was important for people to understand that stroke services would not disappear in Harrogate but if patients were transferred to a specialist unit quickly, this could provide the best outcome for that patient.

Mrs Hill asked if this would mean patients being moved to another area for stroke services. Dr Tolcher confirmed there was local tension regarding access to local services. The number of people having a stroke was expected to increase in the future and evidence showed the care people received in the first few hours could make a difference to how well they recovered. This included receiving specialist treatment in sustainable and resilient hyper acute stroke units which could mean that patients may be taken a longer distance to receive such treatment. Ongoing rehabilitation should however be provided at locations closer to where people live. Consultation would follow the initial engagement and the Trust would continue to provide an acute stroke service in the short-term.

Miss Eddleston commented that, on a recent visit to the Emergency Department, and despite it being very busy, she was pleased that every member of staff acted in a caring and professional manner and the department appeared calm. She confirmed

she would be writing to Mrs Foster and Dr Tolcher to praise the staff involved and she acknowledged the importance in recognising staff working in difficult conditions. She did however express concern for patients coming into the department on their own and asked how they could be supported to go home.

Dr Tolcher thanked Miss Eddleston for her valuable feedback and confirmed the Emergency Department team would be very pleased to receive her thanks. She expressed that the team wouldn't want anyone to be alone for any length of time whilst in the department, but this could happen at busy times. When well enough to leave the department and go home, people often relied on family and friends, as transport was not available to everyone. Staff would not knowingly let people go home alone and frightened late at night and they would support anyone, as much as they could, if this was the case.

Dr Scott commented on Dr Tolcher's slide regarding the initial findings from the National Staff Survey and wondered if Staff Governors could assist in the future with specific findings. Dr Tolcher confirmed the vast majority of staff had recommended the Trust as a place to work however, as the Trust provided services across a wide area staff may not choose to receive treatment here if they lived further afield. Mr Marshall and his team would be looking into the final results in greater detail.

There were no further questions in relation to Dr Tolcher's presentation.

#### **10. Question and Answer session for members of the public and Governors**

Mrs Dodson moved to the tabled questions submitted prior to the meeting and during the break.

**Ms Cressey, Staff Governor, had submitted the following comment:**

**"I would like to be assured that the Trust is being paid for treatment for overseas visitors and this is not impacting on the financial balance."**

Dr Tolcher confirmed the Trust had a policy under development and the Trust did recover costs wherever possible.

**Mrs Edgar, Staff Governor, had submitted the following comment which Mrs Dodson read out in her absence:**

**"I would like an update on how the community care teams are developing and if we think some of the increase in unscheduled admissions might be attributed to the changes in community care and particularly the loss of the community matron role."**

Mrs Foster confirmed there hadn't been an increase in non-elective admissions but a significant increase in the number of referrals to the Community Specialist Nurses. The Directorates were looking into this in further detail and would be keeping admissions under review in order to take action early if avoidable admissions occurred.

Dr Tolcher referred to her presentation and added that there had been an upward spike relating to winter pressures, but prior to this, numbers had gone down.



**Mrs Margerison, Staff Governor, had submitted the following question which Mrs Dodson read out in her absence:**

**“Can the Board assure us that there is a strategy in place for managing patients with long-term conditions within the New Care Model? I would also like to seek assurance that End of Life Care management in the community is being addressed as a priority in view of the Care Quality Commission report last year.”**

In response, Mrs Foster confirmed the Trust was not commissioned to provide end of life care in the community. The Trust are commissioned to provide Specialist Palliative Care Nurses in the community who provide advice, care and treatment for patients with specialist palliation needs. The End of Life Working Group is working closely with external stakeholders to improve EOLC across Harrogate and the wider district.

**Dr Scott, Staff Governor, had submitted the following comment:**

**“I would suggest Governors seek assurance regarding the major investment in a Trust wide IT system”**

Mrs Dodson asked Mr Thompson to address this item.

Mr Thompson confirmed this was a hugely complicated area and the Board accepted that a good Information Technology system was critical as the Trust moved forward. The Board had considered and approved the IT Strategy recently which focussed on a robust IT infrastructure including both hardware and software. Mr Thompson referred to Dr Tolcher’s presentation earlier and expressed the importance of an electronic patient record to save duplication of data and multiple log-ons. He confirmed that Non-Executive Directors had met in May 2016 to understand the electronic patient record in finer detail and the risks associated with a large transitional programme. Non-Executive Directors were assured that the Board was managing associated risks effectively through Board meetings, Committee meetings and audit, and they had confidence moving forward.

He added that, following recent media regarding cyber security, KPMG had recently presented to the Board and he was reassured that the IT team were confident.

Mr Treece, Public Governor, had submitted a similar question prior to the meeting and was satisfied that Mr Thompson’s response had addressed this.

**Miss Eddleston, Public Governor, had submitted the following question:**

**“There seems to be fewer podiatry clinic appointments in Ripon yet patients are unaware as to the reason this should be so. Special concern for diabetics attending, normally every three months, yet being seen every six months or longer. One elderly lady had reported not being seen for over 12 months for her foot care.”**

Dr Tolcher stated that it was important to emphasise there was no ‘normal’ podiatry follow up for people with diabetes, each person had individual requirements and these could vary from weekly to annually dependent on the foot condition. She was pleased to reassure Governors that the number of Podiatry clinics had not reduced,

compared to last year, with ten clinical sessions per week at Ripon using the one room to full capacity. The service however, was seeking additional space.

**A member of the public asked for an update on the situation with the Royal Voluntary Service (RVS) café on the ground floor in Harrogate District Hospital.**

Dr Tolcher confirmed the seven-year lease for the RVS coffee shop at Harrogate District Hospital would come to an end on 30 June this year. Options had been explored to build on the existing high quality service for all the patients and public who visit the hospital including, enhancing the range and quality of food and drinks provided as well as extending the opening times to include weekends. There would be a complete refurbishment of the coffee shop area which was expected to re-open in the autumn. This would be a Trust-run service with volunteers supporting paid members of staff.

Dr Tolcher confirmed the RVS volunteers were part of the Trust's valued volunteer community and hoped they would continue to be associated with us.

There were no other questions and Mrs Dodson moved to the next item on the agenda.

**11. Non-Executive Directors' Feedback: Update on involvement in the Annual Plan for 2017/18 and two year Operational Plan**

Mrs Taylor, Chair of the Finance Committee, confirmed it was the role of the Committee to spend time looking at the finer detail of the plan. They had looked at all assumptions, levels of activity income, growth in services and population, and income and contractual arrangements with Clinical Commissioning Groups. The Committee understood system risks and investment challenges in capital infrastructure as Dr Tolcher had summarised in her presentation. She commented on how the plan reflected the STP landscape and how the Committee kept a close eye on the highest risks on the Risk Register. She was confident that any issues would be picked up and the Committee fully supported the two year Operational Plan.

There were no questions for Mrs Taylor.

**12. Any other business**

There were no further items of business and therefore Mrs Dodson closed the meeting. She thanked everyone for attending and confirmed the next meeting would take place on Wednesday, 3 May at 5.45pm at a venue to be confirmed.

\* Post meeting note – change of date for the meeting to ratify the appointment of the new Chair.

\*\* [www.hdft.nhs.uk](http://www.hdft.nhs.uk)

## **HDFT Council of Governor Meeting Actions Schedule – May 2017**

### **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	3 August 2016	Calendar of meetings - 2017	Mrs Angie Colvin, Corporate Affairs		Complete
2	29 July 2015	Update on progress of Nutritional Assistants	Mrs Jill Foster, Chief Nurse		Update provided 18 May 2016 Update provided 2 November 2016 Update provided 18 February 2017 - Complete
3	2 November 2016	Signage for telephone near emergency maternity entrance to Harrogate District Hospital	Mr Rob Harrison, Chief Operating Officer		Update provided 18 February 2017 - Complete
4	2 November 2016	Volunteers assisting patients with mobility difficulties entering the hospital near emergency maternity entrance	Mrs Sandra Dodson, Chairman		Update provided 18 February 2017 - Complete
5	2 November 2016	Thanks to Dr Leigh for presentation at Medicine for Members' Event	Mrs Sandra Dodson, Chairman		Update provided 18 February 2017 - Complete

### **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	2 November 2016	Update on the Global Health Exchange Programme	Mr Phillip Marshall, Director of Workforce and Organisational Development	Further update due 3 May 2017	Update provided 18 February 2017
2	2 November 2016	Seating arrangements to be made available	Mr Rob Harrison, Chief Operating Officer	Further update due 3 May 2017	Update provided 18 February 2017
3	18 February 2017	Update on review of Quality of Care Teams	Mrs Jill Foster, Chief Nurse	Further update due 3 May 2017	

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

1 (updated May 2017)

Name	Governor Status	Interests Declared	
<b>Mrs Cath Clelland MBE</b>	Public elected	<b>Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).</b>	Owner/Director - Canny Consultants Ltd Owner/Director – City Kipping Ltd (dormant) Non-Executive - York St John University, York
<b>Dr Sarah Crawshaw</b>	Stakeholder	<b>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</b>	National Institute for Health Research Clinical Research Network (NIHR CRN)
<b>Ms Clare Cressey</b>	Staff elected		NONE
<b>Mrs Liz Dean</b>	Public elected		NONE
<b>Mr Tony Doveston</b>	Public elected	<b>A position of Authority in a charity or voluntary organisation in the field of health and social care</b>	Volunteer for Yorkshire Air Ambulance
<b>Miss Sue Eddleston</b>	Public elected		NONE
<b>Mrs Emma Edgar</b>	Staff elected		NONE
<b>Mrs Beth Finch</b>	Stakeholder	<b>A position of Authority in a charity or voluntary organisation in the field of health and social care</b>  <b>Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services</b>	Operational Senior Service Manager, British Red Cross Independent living (Yorkshire Area)  Operational Senior Service Manager, British Red Cross Independent Living (Yorkshire Area)
<b>Mrs Jane Hedley</b>	Public elected		NONE
<b>Mrs Ann Hill</b>	Public elected	<b>Other</b>	Chair of Harrogate District over Fifties Forum (HDOFF) Harrogate representative on North Yorkshire Forum for Older People (NYFOP)

2 (updated May 2017)

Name	Governor Status	Interests Declared	
<b>Cllr Phil Ireland</b>	Stakeholder	<b>Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies)</b>  <b>A position of Authority in a charity or voluntary organisation in the field of health and social care</b>  <b>Position of authority in a local council or Local Authority</b>  <b>Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services</b>	Ingenium Lighting Ltd  Trustee – Relate Yorkshire  Member – Harrogate Borough Council, Knaresborough King James Ward  Relate Yorkshire
<b>Mrs Pat Jones</b>	Public elected	<b>Position of authority in a local council or Local Authority</b>  <b>Position of authority in a charity or voluntary organisation in health and social care</b>	Conservative Councillor representing Stray Ward  Trustee at Harrogate CVS Governor at Harrogate Ladies College
<b>Mrs Sally Margerison</b>	Staff elected		NONE
<b>Mrs Zoe Metcalfe</b>	Staff elected	<b>Position of authority in a local council or Local Authority</b>  <b>Position of authority in a charity or voluntary organisation in health and social care</b>	Conservative Harrogate Borough Councillor  Trustee at Hollytree Foundation Charity

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3 (updated May 2017)

Name	Governor Status	Interests Declared	
Mr Peter Pearson	Public elected	<b>Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies)</b>  <b>Position of authority in a local council or Local Authority</b>	Director – Severn Valley Railway (Holdings) PLC  Conservative Councillor representing Spa Ward, Ripon City Council.
Dr Daniel Scott	Staff elected		NONE
Mr Steve Treece	Public elected	<b>Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services</b>	Employee of NHS Digital
Dr Jim Woods	Stakeholder	<b>Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies)</b>  <b>Ownership, part-ownership or directorship of private companies, business or consultancies likely or possibly seeking to do business with the NHS</b>  <b>Other</b>	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

4 (updated May 2017)



## **Report to the Council of Governors' Meeting**

**3 May 2017**

**Report Title: Update on Governors' Terms of Office**

**Report From: Mrs Sandra Dodson, Chairman**

**Report Purpose: For information**

### **1. Background**

Following a review of Governors' terms of office, and those with tenures expiring mid-year, Mrs Dodson and Ms Allen met with Dr Blackburn, Mrs Hedley and Mr Pearson individually to discuss extending their term of office until 31 December 2017. This would create both cost and resource efficiencies and bring the election process back in line with annual Council of Governor elections rather than the need to hold two elections this year.

In accordance with the Trust's Constitution, section 11.6.1, elected Governors:

- shall normally hold office for a period of three years;
- subject to the next sub-paragraph, are eligible for re-election after the end of that period;
- may not hold office for more than nine years in total or three terms of office.

None of the Governors named above will have served more than two terms, or six years in office, and it is therefore in our remit to extend their term of office until 31 December 2017.

### **2. Governors' Terms of Office**

The Council of Governors are asked to note the following amendments to the terms of office for:

Dr Sally Blackburn, Public Governor for Harrogate and surrounding villages, second term of office 1 August 2014 to 31 December 2017.

Mrs Jane Hedley, Public Governor for Wetherby and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley wards, second term of office 1 July 2014 to 31 December 2017.

Mr Peter Pearson, Public Governor for Ripon and west district, first term of office 1 August 2014 to 31 December 2017.

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**Report to the Trust Council of Governors: 3 May 2017**

<b>Title</b>	<b>Paper 6.1 Governor Working Group – Volunteering and Education</b>
<b>Author(s)</b>	<b>Mrs Jane Hedley, Public Governor</b>
<b>Report Purpose</b>	<b>For information</b>

**This report summarises the items discussed at the last meeting of the Governor Working Group for Volunteering and Education, held on 4 April 2017.**

**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 large number of students who have applied to shadow a doctor and the large number of consultants who have offered work experience ensuring the success of the project.**

## Volunteering

We have 571 active volunteers; of these 428 are over 25 years of age and 143 under 25 years of age. Our volunteers contribute approximately 2,000 hours per month to the Trust.

New volunteers have been placed in the following areas:

- Admin volunteer for Endoscopy.
- Admin volunteer for the General Surgeons team.
- Admin volunteer for the Child Development Centre in Northallerton.
- Volunteer for the weekly Hip Replacement Education Classes.
- The Sir Robert Ogden Macmillan Centre has a new Admin volunteer and also a new Clinical Unit volunteer. The new Volunteer Art Therapist started her weekly sessions for patients in February.
- Two new Chaplaincy volunteers have joined the Chaplaincy Team; both are 6<sup>th</sup> form students, which is a first for this service.
- Ripon Community Hospital: A new Therapy Dog is due to shortly start visiting Trinity Ward every Friday.

Fifty Tea Time Preparation volunteers are helping in seven wards between 4-5 pm and 12 of them are trained Meal Time Volunteers so they stay from 5-6 pm to help with the evening meal service.

## Work Experience

The Work Experience team have received 55 applications from students to shadow a doctor. A strong team of consultants have offered work experience and the students will be matched according to their specific interest.

No more applications will be accepted this year as these have to be processed and delivered before the end of August.

## Education Liaison

Several staff attended the first Careers Fair, at Harrogate College. They promoted various careers in the Trust and found that many students had not considered the Trust as a possible employer.

Mock interviews with six students interested in a career in healthcare were undertaken at Outwood Academy. Feedback from Ripon states that their tour of the hospital enabled them to improve pass grades to merits and distinctions, as they could refer to the good practice they had observed.

Belmont Grosvenor School have chosen to support the hospital as their charity of the year, and are raising money to buy games and toys for Woodlands ward.

**Report to the Trust Council of Governors: 3 May 2017**

<b>Title</b>	<b>Paper 6.2 Governor Working Group – Membership Development and Communications</b>
<b>Author(s)</b>	<b>Ms Pamela Allen, Public Governor</b>
<b>Report Purpose</b>	<b>For information</b>

**This report summarises the items discussed at the last meeting of the Governor Working Group for Membership Development and Communications, held on 3 April 2017.**

**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 next Medicine for Members' presentation.**

## Youth Forum Update

Members of the Youth Forum are now actively providing valuable feedback and engaging in the work of the Trust as well as linking in with their peers across North Yorkshire.

Activities to date include:

- Providing feedback on e-safety posters;
- Attending North Yorkshire Youth Executive;
- 'Secret Shoppers';
- Starting to work with the Children's and County Wide Community Care Directorate on a Children and Young People's Strategy; and,
- Two members will be involved in the presentation audience for the recruitment of a new Chair for the Trust.

The Youth Forum are also starting to think about their own brand and name.

Governors are delighted with this initiative and look forward to listening to the views of this group. Further details can be found on the Trust website at:

<https://www.hdft.nhs.uk/about/education-liaison/youth-forum/>

## Membership Recruitment and Engagement

Through the work of this group, we continue to develop a representative and vibrant membership, offering innovative and active engagement across the organisation. A focus on promoting membership through a variety of different initiatives has increased our monthly membership figures from approximately 15 to 45 new members each month.

A few of the benefits of being a member include:

- A membership card offering a discount in Herriot's Restaurant on the first floor at Harrogate District Hospital and there will be a new loyalty scheme when the hospital Café re-opens on the ground floor in the autumn.
- A discount card which can be used across the country to obtain great offers and discounts at local and national retailers.
- Invitations to attend meetings and events and to take part in consultations and surveys, ensuring that your voice is heard.
- The right to vote and stand to be a Governor in Elections;

For further details, visit the website at:

<https://www.hdft.nhs.uk/about/membership/benefits/>

### Medicine for Members' Event

The next Medicine for Members' event takes place on:

**Thursday, 18 May at 6 – 7.15 pm and again on,  
Thursday, 25 May at 2 – 3.15 pm.**

Diabetes Nurses will be talking about recent work that has been undertaken in the hospital to sustain and promote safe insulin management. They will also be sharing information about the transition service – a service which helps young people aged 16-25 and their families to live with diabetes, how we support older people with diabetes at home or in the residential/nursing home care setting and how we are working closely with GPs and Practice Nurses to help with their knowledge and understanding of diabetes.

The presentations will take place in the **Lecture Theatre, Strayside Education Centre, 3<sup>rd</sup> Floor, Harrogate District Hospital** and there will be tea, coffee and biscuits available in the Enterprise Room 30 minutes before each presentation.

For further details including how to book a place, please visit the website or contact the Foundation Trust Office on 01423 554489:

<https://www.hdft.nhs.uk/about/membership/calendar/>

### Annual Members' Meeting 2017

The next Annual Members' Meeting will take place on:

**Thursday, 21 September at 6 – 8 pm with registration and refreshments from 5.30 pm.**

The agenda is yet to be confirmed, but the meeting will take place at The Pavilions of Harrogate, Great Yorkshire Showground, Harrogate, HG2 8NZ.

### Governor Elections

A decision has been made to incorporate mid-year and end of year elections in 2017. Dr Sally Blackburn, Mrs Jane Hedley and Mr Peter Pearson will therefore extend their term of office until the end of year.

The election process will commence in the autumn and further details will be provided at the next meeting in July and will also be available on the website at:

<https://www.hdft.nhs.uk/about/council-of-governors/governor-elections/>

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**Report to the Trust Council of Governors: 3 May 2017**

<b>Title</b>	<b>Paper 6.3 Patient and Public Involvement - Learning from Patient Experience</b>
<b>Author(s)</b>	<b>Liz Dean, Public Governor</b>
<b>Report Purpose</b>	<b>For information</b>

**This report summarises the items discussed at the last meeting of the Learning from Patient Experience Group, held on 12 April 2017.**

**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.**

## **Chief Nurse Report**

The Deputy Chief Nurse presented a summary of the report which was circulated in advance of the meeting and taken as read. Key points were highlighted:

### Unannounced Directors' Inspections 2016-2017

The rolling programme of unannounced Directors Inspections is designed to provide assurance on care standards with particular regard to infection prevention and control.

Ten wards were rated green in 2016 with a further six being rated either red or amber one of which is no longer the responsibility of the Trust. Further inspections are planned and will continue until a green status is achieved. The Chief Nurse explained that there are other activities also going on to address the issues identified.

### Complaints

The number of complaints received in February was the highest of the year to date. Following the increase in and intensity of activity and pressure on services in December, January and February there was no surprise expressed at the increase in the number of complaints. It was noted that 15 of the 26 complaints related to the Emergency Department and the Wards. A short discussion took place as to the potential reasons for the increase. It was concluded that there were probably a number of reasons.

We were given assurance that the Directorates are currently in the process of responding to the complaints. The Patient Learning Experience Group will receive feedback in due course.

The Improving Patient Safety Group noted that there has been a spike in concerns being raised and incidents regarding the DNACPR status of patients and the use of the forms. This has been discussed in a number of forums. As a result new risks have been added to the Corporate Risk Register until the mitigating actions are embedded.

### Nurse Recruitment

Nurse recruitment continued to be a key topic for discussion and lots of good work was being done to recruit and keep those with offers of employment 'warm' and engaged in an attempt to ensure that those with offers start employment with the Trust.

1. A recruitment evening was held on 21<sup>st</sup> March 2017:
  - a. 6 conditional offers of employment were made to student nurses qualifying in September and
  - b. 5 Registered Nurses.
2. A total of 40 conditional offers of employment have now been made to student nurses qualifying in September.
3. A successful 'on-boarding' event took place on 29<sup>th</sup> March 2017 with 25 students attending.

Nurse revalidation: since 1 April 2016 50 nurses have been supported through the revalidation process without difficulty.

#### Children's Services Inspections

CLAS (Combined Looked After and Safeguarding) Children Inspection in North Yorkshire took place during February 2017 which involved the HDFT Specialist Looked After Children Team, 0 – 19 Children's Service, Midwifery, Acute Paediatrics and the Emergency Department.

Verbal feedback has been given which raised some areas for improvement but no major concerns. The written feedback is expected in April.

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**Report to the Trust Council of Governors: 3 May 2017**

<b>Title</b>	<b>Paper 7.0 Quality of Care Team Meetings Assurance Framework</b>
<b>Author(s)</b>	<b>Jill Foster, Chief Nurse</b>
<b>Report Purpose</b>	<b>For information and to provide assurance on the regularity and effectiveness of the Quality of Care Teams</b>

This report is to provide information and assurance on the regularity and effectiveness of the Quality of Care Teams across the Trust.

The Quality of Care Team meetings underpin the quality governance framework of the Trust to promote quality of care. This report provides assurance regarding the governance framework which provides oversight of the effectiveness of the Quality of Care Teams.

## **Quality of Care Team Meetings**

The Quality of Care Team meetings are frontline service meetings developed as part of the methodology that underpins the quality governance framework of the Trust to promote quality of care. The services the Trust provides are varied, therefore it was agreed to provide direction for the standards expected of local multi-disciplinary arrangements for promoting quality of care, whilst each Directorate should determine the formatting and frequency of meetings and which services should hold Quality of Care Team Meetings.

The content of the meetings needs to provide assurance that the teams are meeting the standards expected which are:

- To promote quality improvement and a culture of 'being open', learning and safety;
- Support for local initiatives relevant to Trust and Directorate quality improvement priorities;
- Review key performance indicators for quality and what these are eg quality dashboard, Infection Prevention and Control audits, complaints, Friends and Family Test, incidents etc;
- To progress and embed actions related to complaints, incidents, audits, SIRIs, patient safety visits etc;
- To engage actively in audits;
- To ensure completion of risk assessments and the departmental risk register and progress actions to mitigate risk;
- To celebrate successes and innovation; and
- To share information about quality and the meetings with all relevant staff.

For information, the expected standards are published on the internet and are in Appendix One.

Each Quality of Care Team is responsible for implementing and monitoring actions at a local level and embedding lessons learned at departmental level. They are also responsible for timely completion and submission of departmental risk registers and for any risks unable to be managed at department level, to be incorporated into the Directorate Risk Register. Teams are encouraged to discuss SALUS issues if any arise. The meetings are also expected to discuss and respond to learning from the outcome of complaints. Discussion about audits and initiatives to improve the patient experience are discussed within the Quality of Care team meetings and learning is brought to the Directorates Quality and Governance meetings.

The Directorates are required to provide six monthly reports to the Learning from Patient Experience meetings.

## **Quality in Care Team Reports from the Directorates**

The Directorates were asked to review and provide assurance regarding the number and effectiveness of their Quality of Care Team meetings against the criteria set out below.

## CCWCC Quality of Care Meetings

Service	Governor Link	Multi-Disciplinary	Minutes shared with the Team	Do they meet the QoC standard
Safeguarding Children (including Looked after Children)	No	No	Yes	Yes
Community Dentistry	No	Yes	Yes	Yes
Co Durham 0-19	No	No	Yes	Yes
Middlesbrough 0-19	No	No	Yes	Yes
Darlington's 0-19	No	No	Yes	Yes
North Yorkshire 0-19	No	No	Yes	Yes
CHIS	No	No	Yes	Yes
5-19 Vaccination & Immunisation Steering Group (Durham & Darlington)	No	No	Yes	Yes
5-19 Vaccination & Immunisation Steering Group (Durham & Darlington)	No	No	Yes	Yes
Podiatry	No	No	Yes	Yes
Living with Pain & Chronic Fatigue	No	Yes	Yes	Yes
Specialist Children's Therapy Services (Harrogate and Hambleton & Richmondshire)	No	Yes	Yes	Yes
Speech & Language Therapy Adult LD	No	No	Yes	Yes
Paediatrics	Yes	Yes	Yes	Yes

## Planned & Surgical Care Quality of Care Teams

Service	QoC Team	How often they meet	Minutes Provided	Appropriate MDT attendance	Governor Link	Review incidents	Review risk register	Review complaints
Anaesthetics (incl Pain Team)	Yes	Monthly	No	Yes	No	Going Forward	Going Forward	Going Forward
Critical Care	Yes	Monthly	No	Yes	No	Going Forward	Going Forward	Going Forward
Gastro	Yes	Monthly	Yes	Yes	No	No	No	No
General Surgery	Yes	Bi-Monthly		Going Forward	No	Yes	N/A	Yes
Outpatients	Yes		Yes	Yes	No	Yes	No	Yes
Orthopaedics	Yes	B-Monthly	Yes	Ltd medical attendance	No	Yes	No	Yes
Maternity	Yes (MRMG)	Bi-monthly	Yes	Yes	No	Yes	Yes	Yes
Gynaecology	Yes Gynae PAP	Bi-monthly	Yes	Yes	No	Yes	N/A	Yes
Rheumatology	Yes	Bi-monthly	Yes	Yes	No		No	
Dermatology	Yes	Monthly	Yes	Yes	No	No	No	No
Ophthalmology	Yes	Monthly	No	Yes	No	Yes	No	Yes
Urology	<b>Feedback not obtained</b>							
Endoscopy	<b>Feedback not obtained</b>							
Theatres	<b>Feedback not obtained</b>							
Cardiorespiratory & Heart Centre	Sits with LTUC Cardiology							



## Long Term and Unscheduled Care

Team	Meets at least bi-monthly?	Appropriate MDT attendance?	TOR in place	Governor Link?	Agenda	Produces minutes?	Shared with team?	Minutes received by Quality Lead	Meet Quality Standards
Community Adult In AROS	Monthly	Yes	No	No	Yes	Yes	Yes	Yes	No
ED	Bi-monthly	Yes	Yes	No*	Yes	Yes	Yes	Yes	Yes
IPC	Bi-monthly	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Pathology	Bi-monthly	Yes	Yes	Yes	Yes	Yes	Yes	Some	Yes
Pharmacy	Bi-monthly	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Radiology	Monthly	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Ripon – Trinity	Monthly	Yes	No	No	No	Yes	Yes	No	No
Ripon MIU	Bi-monthly	Yes	No	No	Yes	Yes	Yes	Yes	No
Selby MIU	Bi-monthly	Yes	No	No	Yes	Yes	Yes	Yes	Yes
SROMC	Bi-monthly	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Bylands / Jervaulx	Monthly	-	-	-	-	-	-	No	No
CATT ward / Clinic & AMU	Bi-monthly	Yes	No	No	Yes	Yes	Yes	Yes	Yes
Granby (Respiratory)	Monthly	-	-	-	-	-	-	No	No
Oakdale (Stroke)	Monthly	-	-	-	-	-	-	No	No
Lascelles	Monthly	Yes	No	No	Yes	Yes	Yes	Yes	Yes
Haematology	Bi-monthly	Yes	No	No	Yes	Yes	Yes	Yes	Yes
GP OOH - Catterick & Northallerton	Bi-monthly	Yes	No	No	Yes	Yes	Yes	Yes	No
GP OOH - Harrogate	Bi-monthly	-	-	-	-	-	-	No	No

\*Awaiting allocation of replacement governor

## Action Plan

ID No	Issue / Finding / Theme	Action(s)	Operational Lead	Responsible Lead	Target Date	Evidence of Completion	Date of Completion
1	Not all groups are having regular Quality of Care Meetings	Quality of Care team meeting requirements to be re-issued	S Morrison	T Campbell	30/04/2017	email	
2	Not all groups meet the required quality standard	Standards and draft Terms of Reference to be re-issued to leads	S Morrison	T Campbell	30/04/2017	email	
		Directorate representation at groups (HoN / QAL / Matrons/ General Manager)	S Morrison	T Campbell	31/05/2017	Meeting minutes	
3	There is not a clear escalation path to the Clinical Safety & Governance Group	Minutes and summary including escalation for inclusion in the CS&G agenda	S Morrison	T Campbell	31/05/2017	CS&G meeting minutes	
4	Lack of Governor representation	Discuss with Corporate Affairs and Membership Manager	S Morrison	T Campbell	30/04/2017	Meeting notes / email	

## Conclusion

Not all areas where Directorates have decided Quality of Care Team Meetings are required, are having meetings that meet the standards required for Quality of Care meetings. It is important that we are assured of the effectiveness and the regularity of the meetings, therefore the Directorates have been asked to provide assurance through action plans how they will ensure their Quality of Care Team Meetings meet regularly and are effective.

### **Standards expected of local multidisciplinary arrangements for promoting quality of care**

#### **Accountability**

The Directorate's Governance Group / Board is required to approve the local arrangements for multi-disciplinary promotion of high quality care if Quality of Care Teams are not in place.

#### **Standards**

The arrangements must ensure that the local multi-disciplinary team receives regular and up to date information in a way that enables awareness of quality performance and engagement with quality improvement.

The arrangements must provide assurance of:

- An expectation that the multidisciplinary team will promote quality improvement and:
  - a culture of 'being open'
  - a culture of learning
  - a culture of safety
- Support for local initiatives relevant to Trust and directorate quality improvement priorities;
- How key performance indicators for quality will be reviewed, monitored and shared within the team. These include:
  - Quality dashboard
  - Infection prevention and control and other audits
  - Complaints
  - Friends and Family Test (FFT) results
  - Patient survey results
  - Trend reports regarding incidents and complaints.
- How progress with local action plans related to complaints, incidents, audits, SRI's, patient safety visits etc is monitored to ensure progress with agreed actions and embedding in service delivery;
- How ideas for audit are identified and shared with the directorate senior management team for inclusion in the annual audit plan
- How completion of risk assessments is assured
- How the departmental risk register is maintained and reviewed to ensure progress with actions to mitigate risk
- Celebrating successes and innovation
- Information and action notes for sharing

If Quality of Care teams are in place to meet these standards, the generic terms of reference should be used.

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**Report to the Trust Council of Governors: 3 May 2017**

<b>Title</b>	<b>Paper 7.1 Quality Improvement Priorities</b>
<b>Author(s)</b>	<b>Dr Sylvia Wood, Deputy Director of Governance</b>
<b>Report Purpose</b>	<b>For information</b>

This report summarises the quality improvement priorities agreed for 2017/18 following review of quality performance, and discussion with staff, governors and external stakeholders.

The detail of each priority to include specific work streams, targets, and metrics will be reported to Quality Committee in June 2017, and progress during the year will be monitored there and then reported in the 2017/18 Quality Account.

# Quality Improvement Priorities 2017/18

We have consulted with our external stakeholders and within the Trust about the priorities for quality improvement during 2017/18. We have considered the extended range of community services across Darlington, County Durham and Middlesbrough from 1 April 2016, and across North Yorkshire.

The final indicators reflect national and local priorities for improvement, current performance and objectives and have been approved by the Board of Directors. We will set targets for achievement and will monitor progress regularly at the Quality Committee. We aim to:

## **1. Improve learning from incidents, complaints and good practice**

We are planning to focus on working with staff to promote the reporting of incidents, near misses and concerns, identify the factors that contribute to these and maximise the learning to prevent recurrence. We will focus on high quality mortality reviews and subsequent learning and action. In addition we will identify learning from examples of great practice in order to spread excellence.

## **2. Improve the patient experience of discharge processes**

We are intending to focus on proactive and safe discharge, ensuring that patients are cared for in the most appropriate environment and reducing the impact on patients of staying in hospital longer than clinically required. This will include a focus on timely discharge to the most appropriate place of care at end of life.

## **3. Reduce the morbidity and mortality related to sepsis**

This has been a quality priority during 2016/17 and whilst performance is improving we are still not achieving our target performance. We are therefore intending to continue to focus on monitoring progress and ensuring we achieve the highest standards of care.

## **4. Provide high quality stroke care demonstrated by improvement in national indicators**

Again, this has been a quality priority during 2016/17 and whilst performance is improving we are still not achieving our target performance. We are therefore intending to continue to focus on monitoring progress and ensuring we achieve the highest standards of care.

## **5. Strengthen the voice of children, young people and families by seeking patient reported experience and using this in the development of a number of services**

We are aiming to co-produce a children's and young people's strategy for HDFT and are intending to promote the inclusion of the voice of children, young people and families in relation to accessibility to children's services. We are scoping out creative approaches with children and families to engage their views in a patient centred manner and have an emerging Youth Forum which we want to promote further.

Overleaf we have started to define the ambition for each priority and indicated who will be leading each.

Quality improvement priority	Ambition	Lead
Improve learning from incidents, complaints and good practice	<ul style="list-style-type: none"> <li>To promote the reporting of incidents, near misses and concerns</li> <li>To identify the factors that contribute to errors and how to prevent recurrence</li> <li>To establish high quality mortality reviews and identify learning</li> <li>To identify examples of great practice</li> <li>To identify and implement methods of sharing learning and excellence</li> </ul>	Improving Patient Safety Steering Group
Improve the patient experience of discharge processes	<ul style="list-style-type: none"> <li>To promote proactive and safe discharge</li> <li>To ensure patients are cared for in the most appropriate environment , reducing the impact on patients of staying in hospital longer than clinically required</li> <li>To ensure timely discharge to the most appropriate place of care at end of life.</li> </ul>	Mike Forster
Reduce the morbidity and mortality related to sepsis	<ul style="list-style-type: none"> <li>To develop an understanding of sepsis and the impact of timely treatment, allowing the achievement of the national CQUIN targets for sepsis screening and antibiotic treatment</li> <li>To introduce a program for multiple “marginal gains” focused initially in the ED</li> </ul>	Dave Earl / Matt Shepherd
Provide high quality stroke care demonstrated by improvement in national indicators	<ul style="list-style-type: none"> <li>To bring the identified stroke indicators to a level comparable with the national average in the Sentinel Stroke National Audit Programme (SSNAP)</li> <li>To bring all domain performance up to a category ‘B’.</li> <li>To ensure timely access to specialist assessment, particularly speech and language therapy and supporting patient care in the community upon discharge from hospital.</li> </ul>	Jodie Roberts
Strengthen the voice of children, young people and families by seeking patient reported experience and using this in the development of a number of services	<ul style="list-style-type: none"> <li>To co-produce a children’s and young people’s strategy for HDFT</li> <li>To promote the inclusion of the voice of children, young people and families in relation to accessibility to children’s services, engaging their views in a patient centred manner</li> <li>To further promote the emerging Youth Forum</li> </ul>	Richard Chillery

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## **Report to the Council of Governors' by the Nomination Committee**

**3 May 2017**

<b>Report Title:</b>	<b>Recruitment of a new Non-Executive Director and appointment of a new Vice Chair</b>
<b>Report from:</b>	<b>Mrs Sandra Dodson, Chairman</b>
<b>Report purpose:</b>	<b>To discuss and ratify the minutes of the Nominations Committee meeting of 12 April 2017 and approve the appointment of a new Vice Chair</b>
<b>Action required:</b>	<b>For decision and approval</b>

### **1. Background and context**

The Nominations Committee met on 12 April to discuss the recruitment of a new Non-Executive Director and the appointment of a new Vice Chair of the Board of Directors.

The minutes of the Nominations Committee are attached at Appendix A.

### **2. Recruitment process for a Non-Executive Director and appointment of Vice Chair**

In accordance with the Trust Constitution and NHS Foundation Trust Code of Governance, the Council of Governors is responsible for the appointment and reappointment of Non-Executive Directors. For the purposes of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Council of Governors will also appoint a Non-Executive Director to be Vice Chair for a period, not exceeding the remainder of their term as a Non-Executive Director of the Trust.

A Nominations Committee makes a recommendation to the full Council for discussion and approval.

The Nominations Committee discussed the current Non-Executive Director vacancy, which arose as the result of the appointment of Professor Sue Proctor as Chair of Leeds and York Partnership NHS Foundation Trust. This also created a vacancy for the post of Vice Chair.

The Nominations Committee considered the person specification, role description, advertisement and timetable for the appointment of the Non-Executive Director. These were agreed and are attached, along with the minutes, at Appendix A. The Committee also undertook

a detailed discussion on the utilisation of the most appropriate and effective ways to advertise the post to ensure the best field of applications.

The Nominations Committee considered Mrs Dodson's recommendation for the post of Vice Chair and agreed that Mr Chris Thompson should be nominated.

### **3. Recommendation of the Nominations Committee to the Council of Governors**

The Nominations Committee ask the Council of Governors to **APPROVE**:

- The minutes of the Nominations Committee held on 12 April 2017.
- The recommendation to appoint Mr Chris Thompson as Vice Chair of the Board of Directors for the remainder of his second term of office, until 29 February 2020.

**Mrs Sandra Dodson**  
**Chairman**

**FOR AND ON BEHALF OF THE COUNCIL OF GOVERNORS' NOMINATION COMMITTEE**

**Minutes of the Nominations Committee  
held on Wednesday, 12 April 2017  
in the Boardroom Trust HQ, 3<sup>rd</sup> Floor, Harrogate District Hospital**

**Present**

**Members:** Mrs Sandra Dodson (Chairman)  
Ms Pamela Allen, Deputy Chair of Council of Governors  
Ms Clare Cressey, Staff Governor  
Mrs Liz Dean, Public Governor  
Mr Tony Doveston, Public Governor  
Miss Sue Eddleston, Public Governor  
Mr Peter Pearson, Public Governor

**Ex Officio:**

Mr Andrew Forsyth, Compliance and Revalidation Manager  
(Minutes)  
Mrs Joanne Harrison, Deputy Director of Workforce and  
Organisational Development  
Dr Ros Tolcher, Chief Executive

**1. Apologies for absence**

Apologies were received from Mr Phillip Marshall, Director of Workforce and Organisational Development and Mrs Colvin, Corporate Affairs and Membership Manager. Mrs Dodson explained that because Ms Pamela Allen was involved in the recruitment process for the new Chair of the Trust, she had been 'stood down' from this Nominations Committee process, in order to make best use of her time.

Mrs Dodson highlighted that the meeting would consider two distinct elements – the appointment of a new Vice Chair for the Board of Directors, following the resignation of Professor Sue Proctor, and the recruitment process for a new Non-Executive Director to replace her.

**2. Appointment of a new Non-Executive Director – appointments process**

Mrs Dodson began by emphasising that Professor Proctor had brought a clinical back ground to her tenure – she had not only been a Chief Nurse but had also been involved in direct clinical experience outside the NHS. Both CQC and the Well Led Review process indicated that having a Non-Executive Director with a clinical background was highly recommended. This would also narrow the net to a manageable field of candidates, rather than the 35 – 40 who might otherwise apply.

Moving to the person specification, skill set and experience, a draft of which had been provided with the papers, Dr Tolcher suggested that a similar approach to that being taken with the recruitment of the new Chair should be taken ie not having Essential and Desirable requirements but describing the ideal requirements without segregating them under these two headings. Mrs Dean felt that the two headings were helpful and in her experience were still widely used. There was a wide-ranging discussion during which it was agreed that the pool would be narrowed by the requirement for clinical experience but that using the headings was helpful to candidates, although did open the Trust to future challenge should a candidate with the essential criteria not be shortlisted at least.

Mrs Dodson said that whilst balancing the experience of the Non-Executive Directors on the Board it was as much a question of the culture as well as the absolute skills and competences. Ms Cressey said that in her recent training the need for a Board skills audit had featured and she endorsed the view that a clinical background was lacking with the departure of Professor Proctor. Mrs Dodson considered that an expertise around governance was needed and it was agreed that this should be both clinical and corporate, although Dr Tolcher considered that experience of clinical governance was more important –experience of operating at a senior enough level should bring with it understanding of corporate governance.

Mrs Metcalfe felt that the list of criteria was comprehensive and asked what would be missed most without Professor Proctor. Mrs Dodson replied that it was depth of knowledge and experience of NHS working, clinical governance and a mindset around safeguarding – Professor Proctor had always asked questions with *gravitas* and experience. Dr Tolcher added that she understood what made the workforce tick. Mrs Harrison cautioned against trying to define ‘another Professor Proctor’ through the criteria. Mrs Dodson wanted to see evidence of personal commitment to the values of the Trust whilst others emphasised what was meant by a team player whilst maintaining independence. Networking skills were felt to be important as was being supportive of fellow Board members and others. Whilst opening up the criteria could encourage applicants who were less suitable it was generally agreed that a good candidate might not necessarily meet all the criteria but could make a good Non-Executive Director.

Discussion of the draft advertisement included more careful expression of the time commitment and a question about the words ‘commercial and political’ being included. Mrs Dodson confirmed that the new Non-Executive Director would not have any additional responsibilities.

The text of the job description, person specification and advertisement were amended and approved. Final versions are attached at Annex to these Minutes.

Mrs Dodson explained that the draft timeline which had been included with the papers for the meeting was designed to allow the Chair (designate) to participate in the selection process in an *ex-officio* capacity, and she had been concerned that leaving the recruitment to the autumn, when the new Chair was in post, would have been too long a period without a full complement of Non-Executive Directors. The timeline was agreed.

There was discussion about where to advertise the post, especially in view of the requirement for candidates with clinical experience. A mailshot to members of the Trust, e-mail to all doctors and GPs in the Trust, use of Facebook and Twitter and the Trust's intranet and website were all agreed as appropriate methods. Advertorial with the Harrogate Advertiser, perhaps linked with the press release on the National Staff Survey, might also be effective. Mrs Harrison undertook to discuss this with Mr Widdowfield. Use of media which reached into Leeds, Durham, Darlington and Middlesbrough was also agreed as being worthwhile. Mrs Dean asked why a recruitment consultancy was not being used, as for recruitment of the Chair, and Mrs Dodson said that this was not considered to be cost effective as there were always plenty of candidates for Non-Executive Director vacancies. She also noted that advertising in faith-based media should be considered. Further discussion would take place outside the meeting, taking into account cost effectiveness of the various media being considered.

### **3. Appointment of Vice Chairman**

Mrs Dodson confirmed that the appointment of the Vice Chairman of the Board was the constitutional responsibility of the Council of Governors. The role required an experienced Non-Executive Director and of the five current Non-Executive Directors she considered that there were two candidates. She had discussed the nomination with one of these candidates who, for various reasons, could not go forward.

Mr Chris Thompson is a measured, thoughtful and supportive Non-Executive Director, in Mrs Dodson's view, who networked well and was a good chairman of the Audit Committee. He would provide strong support to the new Chair.

Mr Doveston said that Mr Thompson was rounded, well liked and worked well with the Governors, and he considered that Mr Thompson would provide good continuity for the new Chair, whilst Mr Pearson said that Mr Thompson was knowledgeable and he concurred with the views expressed Mrs Dean and Miss Eddleston agreed.

Ms Cressey asked about the position of Mr Ward and in reply Mrs Dodson said that his strength was as the Senior Independent Director. Following a question from Mrs Harrison, Mrs Dodson confirmed that the

Vice Chair role was compatible with Mr Thompson continuing to chair the Audit Committee; there was a precedent within the Trust.

Mrs Dodson said that Mr Thompson has indicated that he would be delighted to accept the nomination as Vice Chair.

The Nominations Committee **agreed** to **recommend** to the Council of Governors the nomination of Mr Chris Thompson as Vice Chair of the Board of Directors.

#### **4. Any other business**

There was no other business and Mrs Dodson declared the meeting closed.

DRAFT



## Harrogate and District NHS Foundation Trust

### High Performing Foundation Trust seeks to appoint a Non-Executive Director

This is an exceptional opportunity for an exceptional individual.

Harrogate and District NHS Foundation Trust is a high-performing organisation rated as 'Good' overall and 'Outstanding' for care by the Care Quality Commission. With a vision to provide Excellence Every Time, HDFT places an unwavering focus on care quality and living up to our values of being Respectful, Responsible and Passionate. The Trust's catchment area stretches across Harrogate, the rest of North Yorkshire, North Leeds and into County Durham, Darlington and Middlesbrough.

### Join our vigorous and forward-thinking Board of Directors

We are seeking a Non-Executive Director with Board-level or equivalent expertise in an expanding and complex enterprise. We would particularly welcome applications from those with experience of working as a clinical practitioner at a senior level in the NHS, in a field which would complement that of our existing Board of Directors.

Your experience should include a demonstrable track record of success and an understanding of, and commitment to, values of accountability, probity, openness and equality of opportunity. You will be a strategic thinker and experienced in leading and delivering complex organisational change. You will have excellent communication and listening skills, as well as being commercially and politically astute. An understanding of the role of Non-Executive Directors is essential, as is an ability to analyse complex information and an appreciation of the emerging context for the NHS.

This is an exciting role in a vibrant environment, providing the opportunity to be at the forefront of new thinking in today's NHS. The time commitment is on average five days per month and the post will attract remuneration at the rate of c£13,000 per annum.

**If you would like to learn more about this exciting opportunity, or to request an application pack, please contact Lynn Parsons, Executive Assistant to the Chairman on 01423 554423, or via email at [lynn.parsons@hdft.nhs.uk](mailto:lynn.parsons@hdft.nhs.uk)**

Candidates must be, or be eligible to become, a Member of the NHS Foundation Trust.  
**For further details of this vacancy, visit our website at [www.hdft.nhs.uk](http://www.hdft.nhs.uk)**

Closing date for applications:	Noon on Monday 22 May 2017
Shortlisting:	Week commencing 12 June 2017
Interviews:	Week commencing 26 June 2017

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## **HARROGATE AND DISTRICT NHS FOUNDATION TRUST NON-EXECUTIVE DIRECTOR – IDEAL PERSONAL CRITERIA**

<b>Knowledge and Experience</b>	<ul style="list-style-type: none"> <li>• Senior (Board level or equivalent) experience in an expanding and complex enterprise</li> <li>• Demonstrable strategic experience</li> <li>• Track record of success</li> <li>• Understanding of, and commitment to, public service values of accountability, probity, openness and equality of opportunity</li> <li>• Experience of interfacing with multiple partners at a strategic level</li> <li>• Experience of working as a clinical practitioner in the NHS</li> </ul>
<b>Skills and Abilities</b>	<ul style="list-style-type: none"> <li>• Understands the independent role of Non-Executive Directors</li> <li>• Strong influencing skills</li> <li>• Excellent communication and listening skills</li> <li>• Ability to analyse complex information, with an understanding of performance and financial reporting and monitoring</li> <li>• Experience of leading and delivering complex organisational change</li> <li>• Commercially and politically astute</li> </ul>
<b>Personal Qualities</b>	<ul style="list-style-type: none"> <li>• Ability to think strategically, understand complex issues and make decisions pragmatically</li> <li>• Prepared to take difficult decisions and challenge constructively</li> <li>• Integrity and high ethical standards</li> <li>• A strong personal commitment to the values of the Trust and the NHS</li> <li>• Independent and impartial approach</li> <li>• Sound judgement and an enquiring mind</li> </ul>
<b>Other specific requirements</b>	<ul style="list-style-type: none"> <li>• Must be a Member of HDFT and reside within its constituencies</li> <li>• Understanding of the unique responsibilities of NHS FT Boards</li> <li>• Understanding of public, patient and stakeholder expectations of the NHS</li> <li>• Understanding of the emerging strategic context for the NHS</li> <li>• A desire to work closely with Health and Social Care and other partners</li> <li>• Flexibility to adapt to varied roles</li> </ul>

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## **ROLE DESCRIPTION - NON-EXECUTIVE DIRECTOR**

This role reports to the Chair and Council of Governors

### **Purpose of the role**

As part of the unitary Board of Directors, Non-Executive Directors are ultimately and collectively responsible for all aspects of the performance of the Trust and play a crucial role in bringing an independent perspective to the boardroom 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, as laid out in the Nolan principles, and to foster good relations in the boardroom. They should apply similar standards of care and skill in their role as a Non-Executive Director of a Foundation Trust as they would in similar roles elsewhere.

Non-Executive Directors, including the Chair, have a duty to facilitate the Council of Governors in holding the Non-Executive board members to account for the performance of the Board of Directors.

Non-Executive Directors are expected to participate fully as members of committees of the Board of Directors to which they are appointed and to take the role of committee Chair when so appointed.

Non-Executive Directors will meet regularly with the Chair in the absence of Executive Directors to discuss issues of interest or concern in addition to the annual meetings to deal with appraisal of and objective setting for the Executive Directors.

Non-Executive Directors will meet at least once a year with the Senior Independent Director in the absence of the Chair to participate in the Chair's appraisal and the setting of objectives for the Chair. In exceptional circumstances they may be asked to meet with the Senior Independent Director to attempt to resolve issues concerning the Chair's performance or to take action in that respect.

Non-Executive Directors must comply with the requirements of the Fit and Proper persons Test.

### **Non-Executive Directors have a responsibility to:**

- Act as a member of the unitary board at all times, taking decisions both in Board of Directors and formal sub-committees in accordance with appropriate principles of cabinet responsibility;
- Support the Chair, Chief Executive and Executive Directors in promoting the Foundation Trust's values;

**Final April 2017**

- Support a positive culture throughout the Foundation Trust and adopt behaviours in the boardroom and elsewhere that exemplify the corporate culture;
- Challenge the proposed decisions of the Board constructively and appropriately;
- Develop and deliver the vision and strategic plan;
- Develop and deliver the Trust's corporate risk strategy; and,
- Help develop proposals on values and standards.

**Non-Executive Directors have a duty to:**

- Conform with the code of conduct for Directors and to act in the best interest of the Trust at all times;
- 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;
- Commission and use external advice as necessary; 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 (acting in the appropriate committees) for:**

- Determining appropriate levels of remuneration of Executive Directors;
- Participating in the appraisal of Executive Directors, their fellow Non-Executive Directors and the Chair;
- Appointing the Chief Executive (with the approval of the Council of Governors);
- Appointing other Executive Directors along with the Chief Executive;
- Where necessary, removing Executive Directors;
- Succession planning for key executive posts;
- Relations with the Council of Governors;
- Chairing of grievance and appeal panels;
- Acting as lay member on appointment panels for consultants and deputy Directors; and
- Participating in Directors' inspections and Patient Safety Visits.

**Final April 2017**

**Non-Executive Directors should:**

- Attend meetings of the Council of Governors with sufficient frequency to ensure that they understand the views of Governors on the key strategic and performance issues facing the Foundation Trust;
- Take into account the views of Governors and other members to gain a different perspective on the Foundation Trust and its performance;
- Have on-going dialogue with the Council of Governors on the progress made in delivering the Foundation Trust's strategic objectives, the high level financial and operational performance of the Foundation Trust; and,
- Receive feedback from the Council of Governors regarding performance and ensure that the Board of Directors is aware of this feedback.

**Terms of office of Non-Executive Directors**

The Trust's Constitution states that:

The Chairman and the Non-Executive Directors are to be appointed for a period of office in accordance with the terms and conditions of office decided by the Council of Governors at a general meeting. Non-Executive Directors will serve a three year period and will not normally exceed a maximum of three terms of office except in exceptional circumstances.

Any terms beyond two terms (six years) should be subject to annual endorsement of the continued appointment by the Council of Governors.

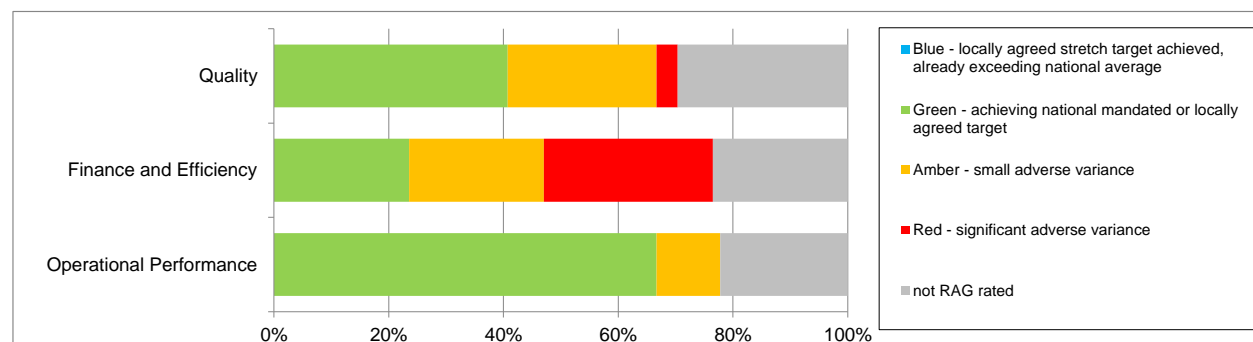
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## Integrated board report - March 2017

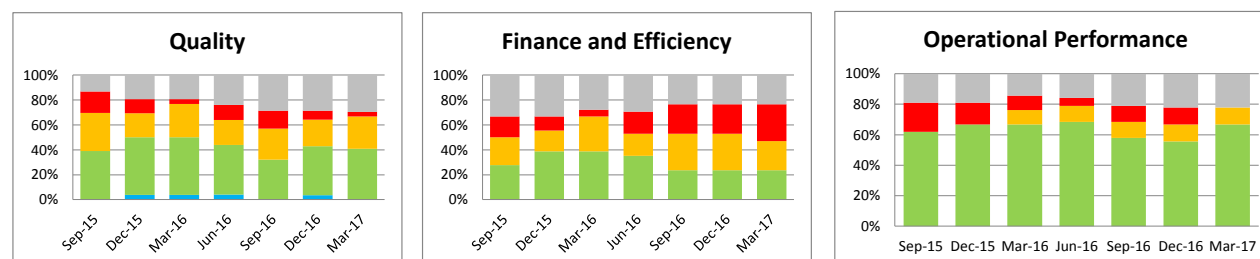
### Key points this month

1. In March, HDFT achieved all 4 key operational performance metrics in the NHS Improvement Single Oversight Framework and reported a rating of 1 (where 1 is best) for the Use of Resource Metric.
2. A significant improvement in the Trust's performance against the A&E 4-hour standard was seen in March, with Trust level performance at 97.2%. HDFT has therefore delivered the 4-hour standard for the 2016/17 year overall with annual performance of 95.1%.
3. The cash balance position continues to be a concern for the Trust with a number of actions in place to improve the outstanding debtors position.
4. Agency spend increased in March to 3.7% of pay spend. Although the value is below the agency ceiling for the Trust, this ceiling reduces in 2017/18 and the current run rate would potentially result in exceeding the new value.
5. Further work is needed to understand the Trust's current incident reporting ratio of high/low risks incidents as latest published data places us in the bottom 25% of Trusts nationally. Despite this, the number of inpatients falls fell by 14% in 2016/17 and the number of reported SIRIs was also much lower than last year.
6. The number of complaints received by the Trust remained above average in March with 25 received during the month. These relate to a number of different services across the Trust and are partly reflective of the significant operational pressures that the Trust was under during the month.
7. Delayed transfers of care remain high and increased to 6.6% when the snapshot was taken in March, remaining above the maximum threshold of 3.5% set out in the contract.

### Summary of indicators - current month



### Summary of indicators - recent trends


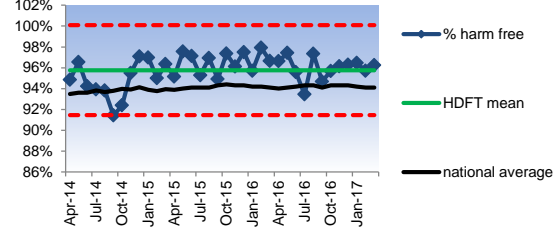

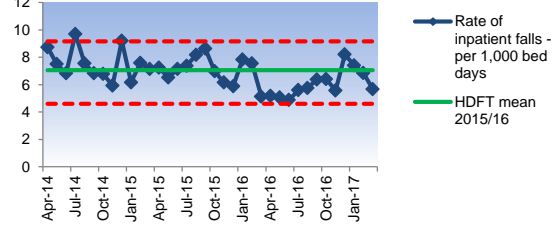

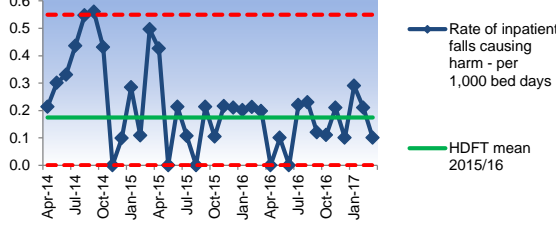

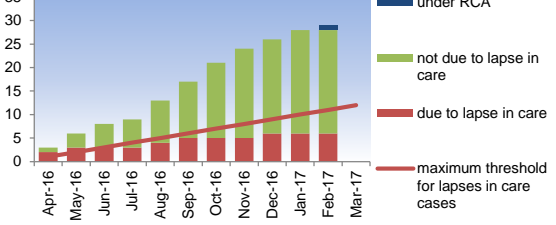


## Quality - March 2017


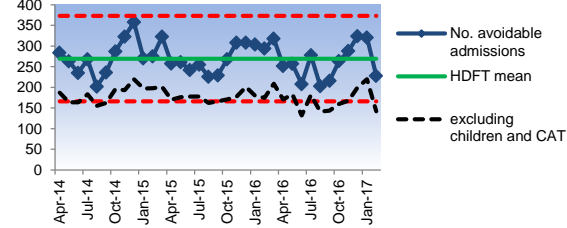

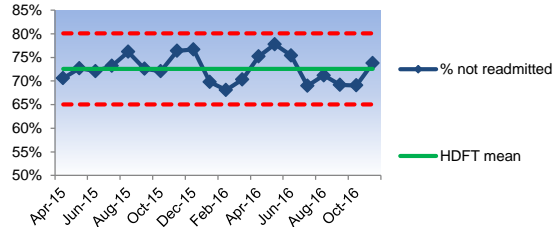

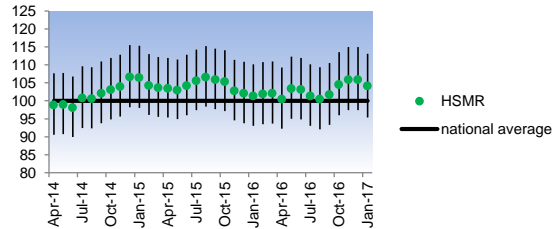

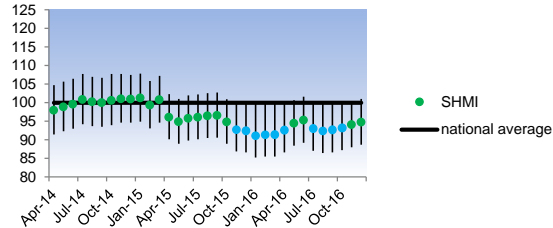
Indicator name / data quality assessment	Description	Trend chart	Interpretation
<div>✓</div> <b>Pressure ulcers - hospital acquired</b>	<p>The chart shows the cumulative number of category 3 or category 4 hospital acquired pressure ulcers in 2016/17. The Trust has set a local trajectory for 2016/17 of zero avoidable hospital acquired category 3 or category 4 pressure ulcers. The data includes hospital teams only.</p>		<p>There were 5 hospital acquired category 3 pressure ulcers and 1 unstageable pressure ulcer reported in March. In 2016/17, 33 hospital acquired category 3 or unstageable pressure ulcers have been reported. Of these, 16 were deemed to be avoidable, 9 unavoidable and 8 cases are still under root cause analysis (RCA).</p> <p>There have been no hospital acquired category 4 pressure ulcers reported in 2016/17.</p>
	<p>The chart includes category 2, 3 and 4 and unstageable hospital acquired pressure ulcers. A maximum trajectory for 2016/17 of 155 cases of category 2-4 hospital acquired pressure ulcers has been agreed via the Quality Committee. The data includes hospital teams only.</p>		<p>The number of hospital acquired category 2-4 (or unstageable) pressure ulcers increased in March with 23 cases reported, compared to 17 in February.</p> <p>There have now been 205 cases reported in 2016/17. This compares to 155 in 2015/16.</p>
<div>✓</div> <b>Pressure ulcers - community acquired</b>	<p>The chart shows the cumulative number of category 3 or category 4 community acquired pressure ulcers in 2016/17. This metric includes all pressure ulcers identified by community teams including pressure ulcers already present at the first point of contact.</p>		<p>There were 6 community acquired category 3 (or unstageable) pressure ulcers reported in March. In the year to date, 78 community acquired category 3 or 4 or unstageable pressure ulcers have been reported (including 3 category 4 cases). Of these, 36 were deemed to be avoidable, 29 unavoidable and 13 cases are still under root cause analysis (RCA).</p>
	<p>This additional chart has been added this month showing the trend in category 2, 3 and 4 community acquired pressure ulcers. A maximum trajectory for the number of category 2-4 community acquired pressure ulcers was agreed at the Quality Committee and is based on a 20% reduction against the number of cases reported in 2015/16. The data includes community teams only.</p>		<p>The number of community acquired category 2-4 (or unstageable) pressure ulcers reported in March was 25 cases, compared to 21 last month.</p> <p>In 2016/17, 263 cases have been reported, compared to 167 in 2015/16. The observed increase in reported cases may be partly due to improvements in incident reporting during the period.</p>




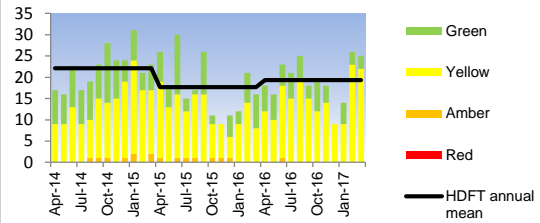

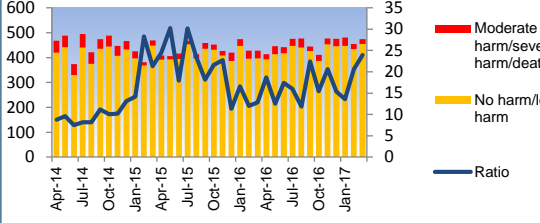

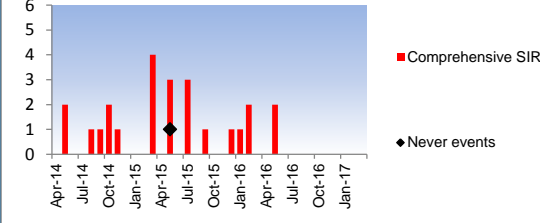

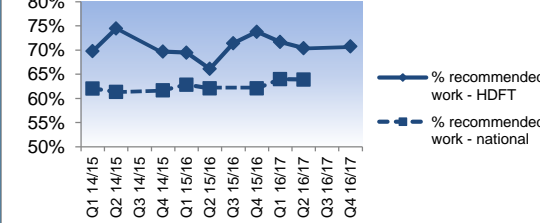
## Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Safety Thermometer - harm free care</b> 	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 96.3%, an increase on last month and remaining above the latest national average.
<b>Falls</b> 	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 5.8 per 1,000 bed days in March, a decrease on last month. In 2016/17, 697 inpatient falls have been reported (including those not causing harm). This is a 14% reduction on the number of inpatient falls reported on 2015/16.
<b>Falls causing harm</b> 	The number of inpatient falls causing significant harm, expressed as a rate per 1,000 bed days. The data includes falls causing moderate harm, severe harm or death. A low rate is good.		<p>There was 1 inpatient fall causing moderate harm in March, compared to 2 last month. The rate per 1,000 bed days is now below the HDFT average for 2015/16.</p> <p>There have been 16 inpatient falls causing moderate or severe harm in 2016/17, 15 of which resulted in a fracture. This compares to 20 in 2015/16.</p>
<b>Infection control</b> 	The chart shows the cumulative number of hospital apportioned C. difficile cases during 2016/17. HDFT's C. difficile trajectory for 2016/17 is 12 cases, no change on last year's trajectory. Cases where a lapse in care has been deemed to have occurred would count towards the Monitor risk assessment framework. Hospital apportioned MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2016/17. The last reported case of hospital acquired MRSA at HDFT was in Oct-12.		<p>There was no cases of hospital apportioned C. difficile reported in March, making the year to date total 29 cases. 28 cases have now have root cause analysis (RCA) completed and discussed and agreed with HARD CCG. Of these, 6 have been determined to be due to a lapse in care and 22 were determined to not be due to a lapse in care.</p> <p>No cases of hospital apportioned MRSA were reported in 2016/17.</p>


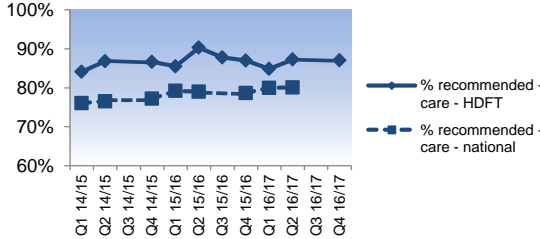

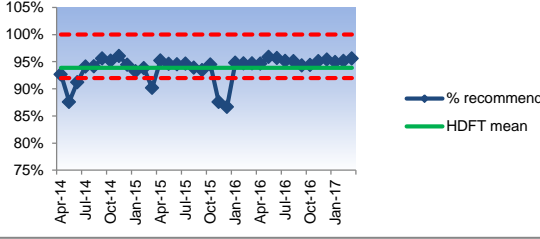

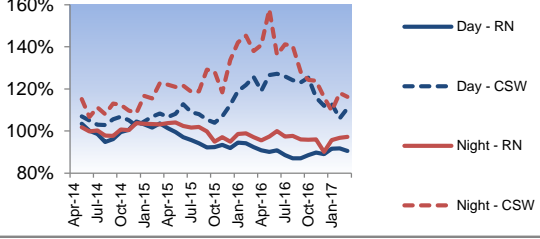

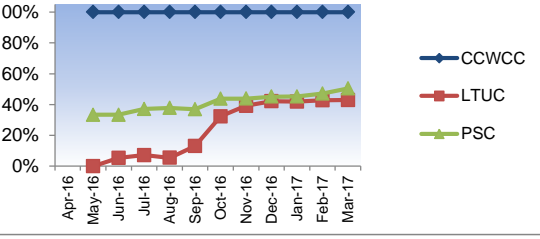
## Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Avoidable admissions</b> 	<p>The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.</p>		<p>There were 228 avoidable admissions in February, a significant decrease on recent months.</p> <p>Adult admissions (excluding CAT attendances) also fell this month.</p>
<b>Reducing hospital admissions in older people</b> 	<p>The chart shows the proportion of older people aged 65+ who were still at home 91 days after discharge from rehabilitation or reablement services. A high figure is good.</p> <p><i>This indicator is in development.</i></p>		<p><i>This indicator has not been updated this month.</i></p> <p>For patients discharged from rehabilitation or reablement services in November, 74% were still in their own home at the end of February, an improvement on the previous month.</p> <p>From next month onwards, this metric will report on patients discharged from any service within the new Integrated Care Teams. This will provide a more robust metric involving a larger group of patients but it will not be possible to present historical trend data.</p>
<b>Mortality - HSMR</b> 	<p>The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.</p>		<p>HDFT's HSMR decreased to 104.11 for the rolling 12 months ending January 2017 and remains within expected levels. At specialty level, two specialties (Geriatric Medicine and Stroke Medicine) have a standardised mortality rate above expected levels.</p> <p>The Trust is in the process of reviewing recently published national guidance about the requirement for Trusts to start publishing information on learning from deaths during 2017/18. This work will be led by the Medical Director, in conjunction with the existing mortality review process.</p>
<b>Mortality - SHMI</b> 	<p>The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good.</p>		<p>HDFT's SHMI increased to 94.72, compared to 94.03 last month, remaining within expected levels. At specialty level, two specialties (Geriatric Medicine and Gastroenterology) have a standardised mortality rate above expected levels.</p>


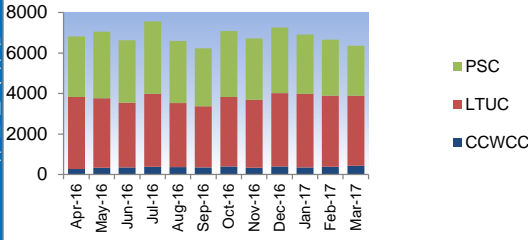

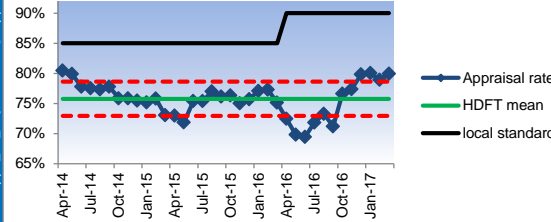


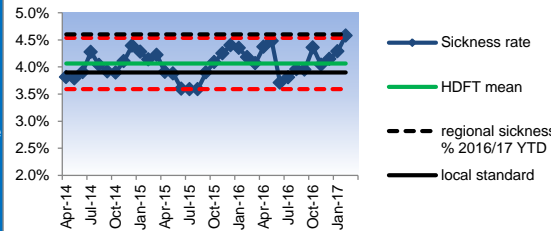
## Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Complaints</b> 	<p>The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents.</p> <p>The data includes complaints relating to both hospital and community services.</p>		<p>25 complaints were received in March, compared to 26 last month, remaining above the 2015/16 average. This remains above the 2015/16 average. As with last month, the complaints received in March relate to a number of different services across the Trust and are partly reflective of the significant operational pressures that the Trust was under during the month.</p> <p>There were no complaints classified as amber or red in March.</p>
<b>Incidents - all</b> 	<p>The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services.</p> <p>A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture</p>		<p>The latest published national data (for the period Apr - Sep 16) shows that Acute Trusts reported an average ratio of 37 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's local reporting ratio for the same period was 18 which places the Trust in the bottom 25% nationally. The focus going forward is to improve our incident reporting rate particularly encouraging staff to report no harm/ near miss incidents. Options to improve the Datix system to simplify the incident reporting process are being explored.</p>
<b>Incidents - SIRIs and never events</b> 	<p>The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services.</p> <p>We have changed this indicator to only include comprehensive SIRIs, as concise SIRIs are reported within the pressure ulcer and falls indicators above.</p>		<p>There were no comprehensive SIRIs and no never events reported in March.</p>
<b>Friends &amp; Family Test (FFT) - Staff - % recommend as a place to work</b> 	<p>The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in.</p> <p>The chart shows the percentage of staff that would recommend the Trust as a place to work. A high percentage is good. The Trust's aim is to feature in the top 20% of Trusts nationally which would typically mean that 71% of staff would recommend the Trust as a place to work.</p>		<p>In Quarter 4, 70.8% of HDFT staff surveyed would recommend HDFT as a place to work, a slight increase on Quarter 2 (when the survey was last carried out) and remaining above the most recently published national average of 64%. The response rate at HDFT for Quarter 4 was 15%, compared to the most recently published national average of 12%.</p>


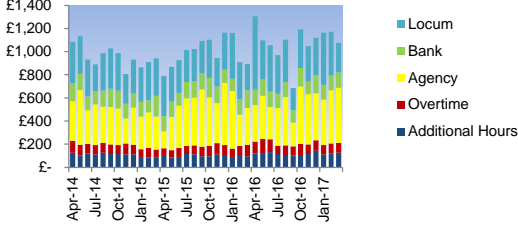

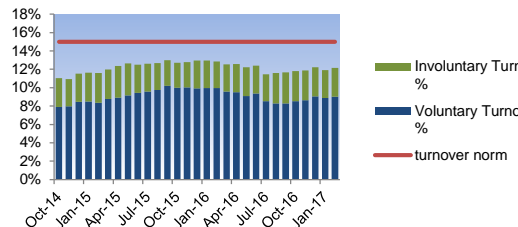

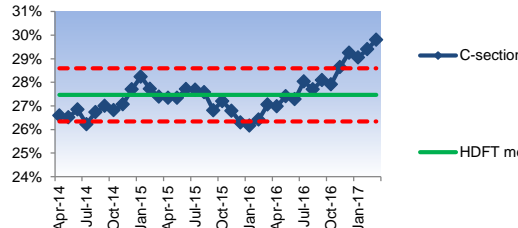

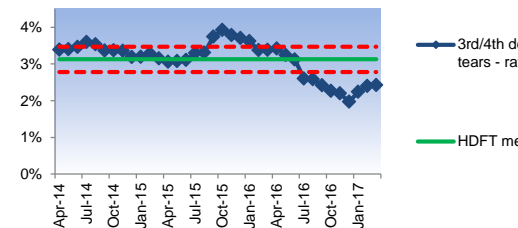
## Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Friends &amp; Family Test (FFT) - Staff - % recommend as a place to receive care</b> 	<p>The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in.</p> <p>The chart shows the percentage of staff that would recommend the Trust as a place to receive care. A high percentage is good. The Trust's aim is to feature in the top 20% of Trusts nationally which would typically mean that 88% of staff would recommend the Trust as a place to work.</p>		<p>In Quarter 4, 87.0% of HDFT staff surveyed would recommend HDFT as a place to receive care. This is a slight decrease on Q2 (when the survey was last carried out) but remains above the most recently published national average of 80%. The response rate at HDFT for Quarter 4 was 15%, compared to the most recently published national average of 12%.</p>
<b>Friends &amp; Family Test (FFT) - Patients</b> 	<p>The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.</p>		<p>95.6% of patients surveyed in March would recommend our services, remaining in line with recent months and above the latest published national average.</p> <p>Around 5,600 patients responded to the survey this month, which equates to an average of 179 responses per day, an increase on last month.</p>
<b>Safer staffing levels</b> 	<p>Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is published on the Trust website.</p>		<p>Overall staffing compared to planned was at 99.5% in March. Registered nurse staffing levels remain similar to last month at 93% overall. Care Support Worker staffing remains high compared to plan - this is reflective of the increased need for 1-1 care and the number of newly qualified nurses working before they have received full registration.</p>
<b>Electronic rostering timeliness</b> 	<p>The chart shows the proportion of rosters that were published on time on Rosterpro (at least 4 weeks before the roster start date). It includes data for 20 specific clinical areas (mostly inpatient wards) involved in the pilot phase. Data presented is for a rolling 12 months period and is split by Clinical Directorate. A high percentage is good.</p>		<p>Overall, 52% of rosters were published on time during the period May 2016 to March 2017. All three Clinical Directorates are showing improvements in recent months.</p> <p>Publishing electronic rosters in a timely manner improves staff morale, increases bank fill rates and reduces bank/agency costs.</p>


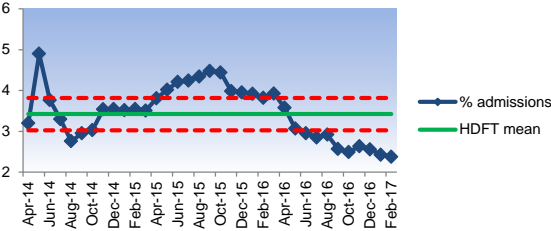
## Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation																		
<div>Electronic rostering hours owed</div> <div></div>	<p>This metric shows the sum of unused hours for staff as a running balance from the Trust's predefined audit start date. To allow for some flexibility in assigning hours over rosters (ie. for Night workers), an alert will be triggered when staff owe 15 hours or more. Data is split by Clinical Directorate for 20 specific clinical areas (mostly inpatient wards) involved in the pilot phase. A low number is good.</p>		<p>The data has been rebased and now shows the cumulative position from March 2015 onwards (previously March 2016). As can be seen on the chart, the number of owed hours has consistently reduced over the last 3 months. this is a positive downward trend demonstrating that wards are getting these balances under control.</p> <p>Properly managed balances increase available clinical hours, improves staff morale and management decision making.</p>																		
<div>Staff appraisal rates</div> <div></div>	<p>The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good.</p> <p>The figures from May 2016 onwards exclude employees currently on maternity leave, career break or suspension and staff who TUPE transferred into the organisation from Darlington, Durham and Middlesbrough from 1st April 2016.</p>		<p>The appraisal rate for the 12 months to end March is 79%.</p> <p>The new appraisal period commences from 1st April and runs until 30th September. The expectation is that all appraisals will be completed during this timeframe for 2017/18. There are a number of briefings scheduled for managers and staff during April with more to be scheduled in May. Guidance on conducting team appraisals has been up-loaded onto the Appraisal toolkit and incorporated into Pathway to Management training.</p>																		
<div>Mandatory training rates</div> <div></div>	<p>The table shows the most recent training rates for all mandatory elements for substantive staff.</p>	<table><thead><tr><th>Competence Name</th><th>% Completed</th></tr></thead><tbody><tr><td>Equality, Diversity and Human Rights - Level 1</td><td>90</td></tr><tr><td>Fire Safety Awareness</td><td>79</td></tr><tr><td>Infection Prevention &amp; Control (Including Hand Hygiene) 1</td><td>100</td></tr><tr><td>Infection Prevention &amp; Control (Including Hand Hygiene) 2</td><td>85</td></tr><tr><td>Information Governance: Introduction</td><td>91</td></tr><tr><td>Information Governance: The Beginners Guide</td><td>96</td></tr><tr><td>Prevent Basic Awareness (December 2015)</td><td>99</td></tr><tr><td>Safeguarding Children &amp; Young People Level 1 - Introduction</td><td>95</td></tr></tbody></table>	Competence Name	% Completed	Equality, Diversity and Human Rights - Level 1	90	Fire Safety Awareness	79	Infection Prevention & Control (Including Hand Hygiene) 1	100	Infection Prevention & Control (Including Hand Hygiene) 2	85	Information Governance: Introduction	91	Information Governance: The Beginners Guide	96	Prevent Basic Awareness (December 2015)	99	Safeguarding Children & Young People Level 1 - Introduction	95	<p>The data shown is for the end of March and includes the staff who were TUPE transferred into the organisation on the 1st April 2016. The overall training rate for mandatory elements for substantive staff is 90%.</p> <p>The new follow up procedure is now in place for Directorates to use and we hope to see a positive impact on compliance going forward.</p>
Competence Name	% Completed																				
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<div>Sickness rates</div> <div></div>	<p>Staff sickness rate - includes short and long term sickness.</p> <p>The Trust has set a threshold of 3.9%. A low percentage is good.</p>		<p>The staff sickness rate rose to 4.58% in February. However the Trust remains below the regional average of 4.8% for the month and just below the year to date regional (and national) average of 4.6%. HDFT's sickness for the year to date is 4.1%.</p> <p>Our new attendance lead Vicki Godfrey joined the Trust in April. She is currently in the process of reviewing all long-term sickness cases and updating action plans appropriately. In line with developing some further workforce metrics, she will establish our baseline for the average length of long term sickness which will then be reviewed quarterly. The sickness rate and reasons for this were discussed at SMT this month. Directorates were requested to ensure there was an absolute focus on the completion of return to work interviews and to continually monitor sickness levels and progress matters through the policy when it is appropriate to do so.</p>																		

## Quality - March 2017


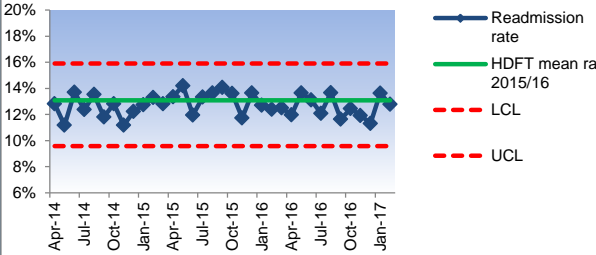

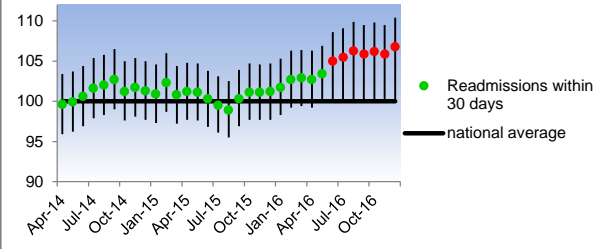

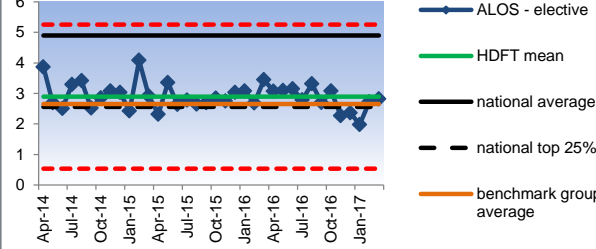

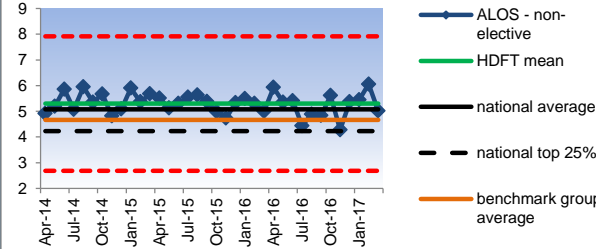
Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Temporary staffing expenditure - medical/nursing /other</b> 	<p>The chart shows staff expenditure per month, split into contracted staff, overtime and additional hours and temporary staff. Lower figures are preferable.</p> <p><i>The traffic light criteria applied to this indicator is currently under review.</i></p>		<p>The Trust has established an advisory group to address actions designed to reduce, and if possible eliminate, spend and reliance on engagement of temporary staff, especially through agencies. Meetings are held fortnightly and review all agency bookings, and especially those above wage and/or rate cap. The instruction not to engage temporary staff with substantive NHS contracts through agencies, issued by NHSI at the end of February, was rescinded the day before implementation, although agreement had been reached across WYAAT to enforce it. Separately the business case for the development of an internal bank for temporary medical staff will be considered at ODG on 25 April. Once established, this has the potential to reduce significantly expenditure on this group and is a first step towards a collaborative bank across WYAAT.</p>
<b>Staff turnover rate</b> 	<p>The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust.</p> <p>Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.</p>		<p>Turnover was at 12.2% in March. Analysis is taking place in relation to identifying key areas with high level of labour turnover. Once identified a process for completing exit/save interviews within those areas will be drafted and sent to ODG and Directors for approval. This will provide data, identifying themes on experience of working at the Trust and reasons for leaving which will in turn inform our retention strategy.</p>
<b>Maternity - Caesarean section rate</b> 	<p>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.</p> <p>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.</p>		<p>HDFT's C-section rate for the 12 months ending March was 29.8% of deliveries, an increase on last month and remaining higher than average.</p> <p>The major contributing factor to the recent upward trend appears to be a significant increase in elective caesarean sections during 2016/17, with the emergency caesarean section rate remaining static and within expected parameters.</p>
<b>Maternity - Rate of third and fourth degree tears</b> 	<p>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.</p> <p>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.</p>		<p>The rate of third or fourth degree tears was 2.4% of deliveries in the 12 month period ending March, remaining well below previous months. This may reflect the significant amount of quality improvement work aimed at reducing the incidence of third degree tears.</p>

## Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Maternity - Unexpected term admissions to SCBU</b> 	<p>This indicator is a reflection of the intrapartum care provided. For example, an increase in the number of term admissions to special care might reflect issues with understanding of fetal heart rate monitoring in labour.</p> <p>The charts shows a 12 month rolling average position.</p>	 <p>The chart displays the percentage of term babies (those born at greater than 37 weeks gestation) who were admitted to the Special Care Baby Unit (SCBU) over time. The blue line represents the monthly percentage of admissions, and the green line represents the 12-month rolling average (HDFT mean). The data shows a general downward trend from a peak of nearly 5% in mid-2014 to a low of around 2.1% in early 2017.</p>	<p>The chart shows the percentage of term babies (those born at greater than 37 weeks gestation) who were admitted to the Special Care Baby Unit (SCBU). The chart has been amended this month as it was identified that the data being displayed was the number of admissions to SCBU, not the percentage of births as was being described. This has been corrected this month to show the percentage.</p> <p>2.1% of term babies were admitted to SCBU in the 12 months ending March, continuing the downward trend seen in recent months.</p>


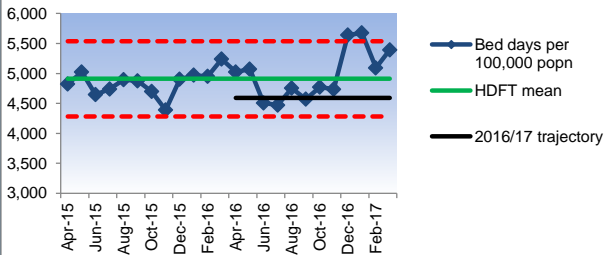

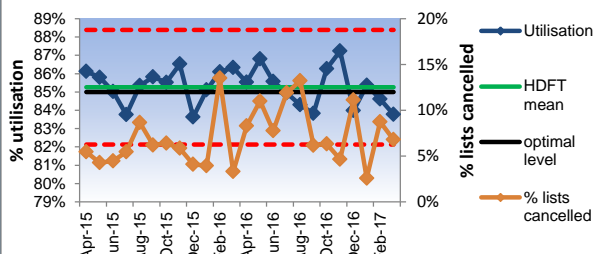

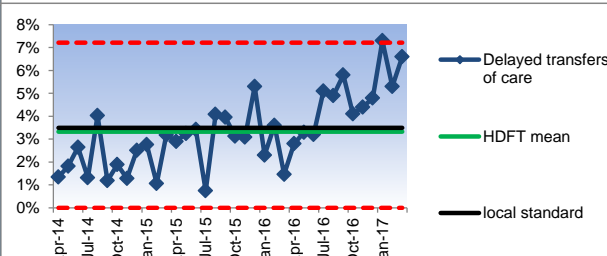

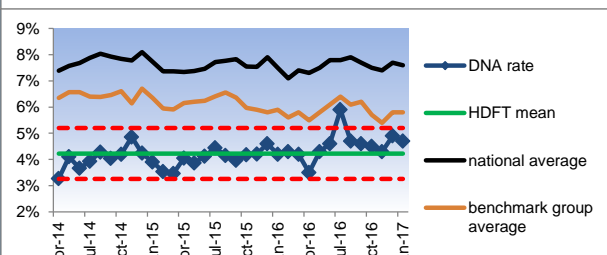


## Finance and Efficiency - March 2017


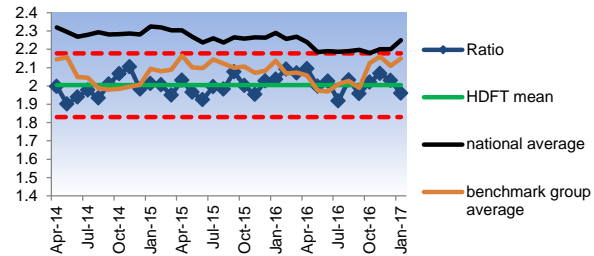

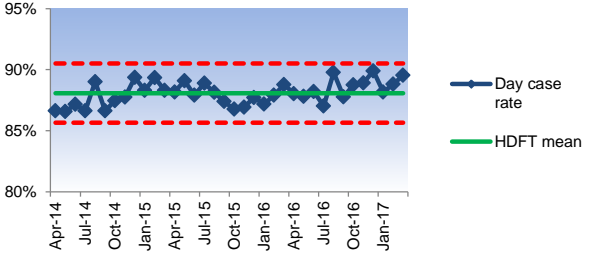

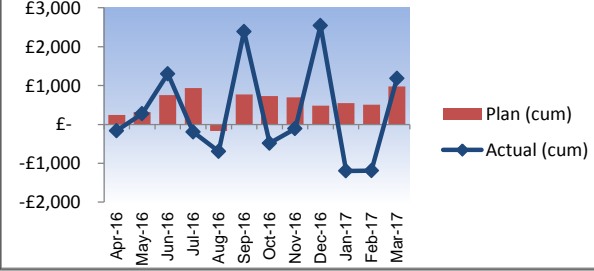

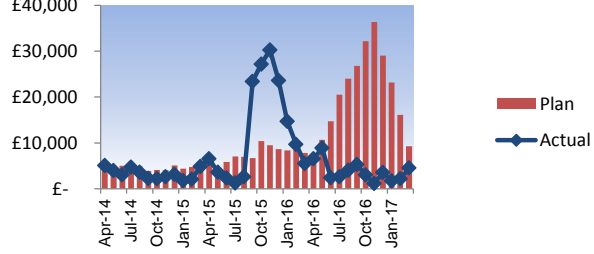
Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Readmissions</b> 	<p>% of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance. This data is reported a month behind so that any recent readmissions are captured in the data.</p>		<p>The number of readmissions decreased in February, when expressed as a percentage of all emergency admissions, and is now below the average rate for 2015/16.</p> <p>HDFT and HARD CCG are now concluding a joint clinical audit of readmissions to determine the proportion which were avoidable.</p>
<b>Readmissions - standardised</b> 	<p>This indicator looks at the standardised readmission rate within 30 days. The data is standardised against various criteria including age, sex, diagnosis, comorbidities etc. The standardisation enables a more like for like comparison with other organisations. The national average is set at 100. A low rate is good - rates below 100 indicate a lower than expected readmission rate and rates above 100 indicate higher than expected readmission rate.</p>		<p>HDFT's standardised readmission rate increased to 106.8 in the most recently available data on HED, remaining above the national average and above expected levels.</p> <p>At specialty level, the same 5 specialties have a standardised emergency readmission rates above expected levels (Cardiology, Clinical Haematology, Paediatrics, Medical Oncology and Well Babies). A clinical audit of a sample of paediatric and well babies readmissions is being carried out by CCCC Directorate.</p>
<b>Length of stay - elective</b> 	<p>Average length of stay in days for elective (waiting list) patients. The data excludes day case patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.</p>		<p>The average elective length of stay for March was 2.8 days, an increase on the previous month and just above benchmark group average.</p>
<b>Length of stay - non-elective</b> 	<p>Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.</p>		<p>The average non-elective length of stay for March was 5.0 days, a significant decrease on last month and now below the national average. However, HDFT's length of stay remains above the benchmark group average.</p>





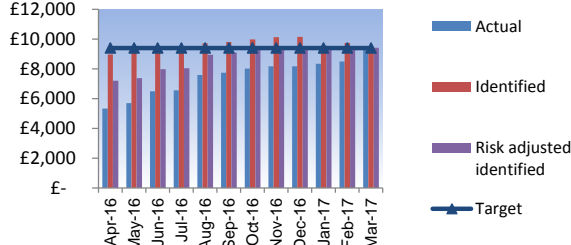

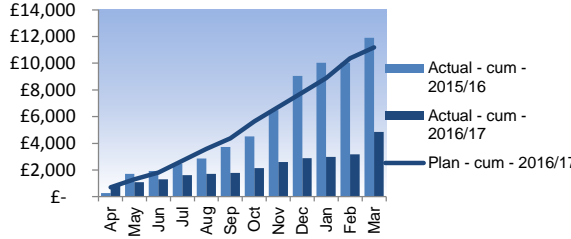

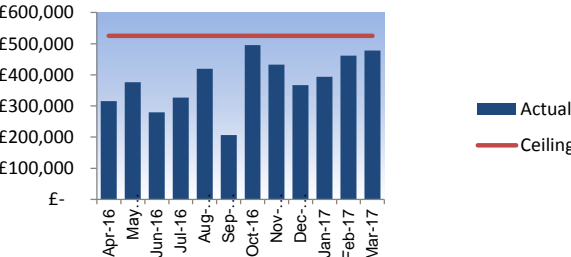
## Finance and Efficiency - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Non-elective bed days</b> 	<p>The charts shows the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per 100,000 population. The chart only includes the local HARD CCG area. The 2016/17 trajectory is based on allowing for demographic growth and reducing by the non-elective reductions identified in the Value Proposition. A lower figure is preferable.</p>		<p>Non-elective bed days for patients aged 18+ increased in March and is above the level reported in March last year. However when expressed per day, this is a reduction on last month.</p>
<b>Theatre utilisation</b> 	<p>The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of this.</p> <p>A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.</p>		<p>Theatre utilisation decreased to 83.8% in March. However the number of cancelled sessions also decreased to 6.8%.</p>
<b>Delayed transfers of care</b> 	<p>The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable.</p> <p>A snapshot position is taken at midnight on the last Thursday of each month. The maximum threshold shown on the chart (3.5%) has been agreed with the CCG.</p>		<p>Delayed transfers of care increased to 6.6% when the snapshot was taken in March, remaining above the maximum threshold of 3.5% set out in the contract. Data shared by NHS Improvement suggests that nationally delayed transfers of care have been at around 5% in 2017 to date.</p> <p>Further work to understand the reasons for this continued increase is being carried out by the Discharge Steering Group.</p>
<b>Outpatient DNA rate</b> 	<p>Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance.</p> <p>A low percentage is good. Patient DNAs will usually result in an unused clinic slot.</p>		<p>HDFT's DNA rate decreased to 4.7% in January and remains below that of both the benchmarked group of trusts and the national average.</p>


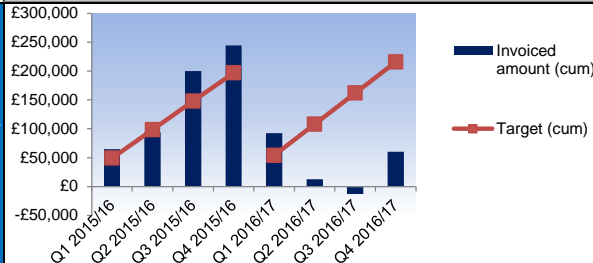
## Finance and Efficiency - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Outpatient new to follow up ratio</b> 	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.		Reducing the number of follow ups is a major part of HARD CCG's financial recovery plan. HDFT's new to follow up ratio decreased in January and remains below both the national average and the benchmark group average.
<b>Day case rate</b> 	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 case rate increased to 89.5% in March and remains above the HDFT average.
<b>Surplus / deficit and variance to plan</b> 	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 a surplus of £3,688k for 2016/17. This position included £3,450k of sustainability and transformation funding, resulting in an underlying surplus of £238k. This position was £2m behind the control total set by NHS Improvement.
<b>Cash balance</b> 	Monthly cash balance (£'000s)		Cash continues to be a concern for the Trust. The cash balance at the end of March was reported at £4.55m, with a number of actions in place to improve the outstanding debtors position. The increase in March is a result of these actions, as well as prepayment of a contract.



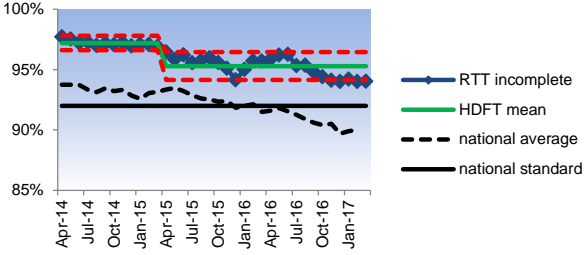

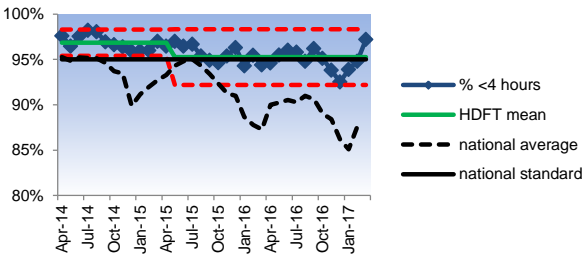

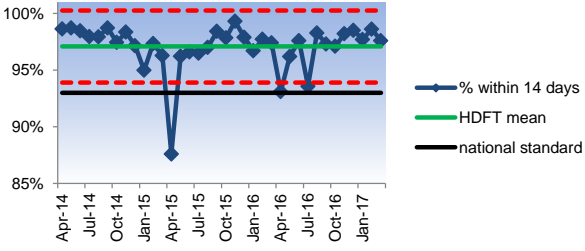
## Finance and Efficiency - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation																					
NHS Improvement Single Oversight Framework - Use of Resource Metric 	From 1st October 2016, NHS Improvement introduced the Single Oversight Framework. As part of this this, Use of Resource Metric was introduced to replace the previous Financial Sustainability Risk Rating. This is the product of five elements which are rated between 1 (best) to 4.	<table><thead><tr><th>Element</th><th>Plan</th><th>Actual</th></tr></thead><tbody><tr><td>Capital Service Cover</td><td>1</td><td>1</td></tr><tr><td>Liquidity</td><td>1</td><td>1</td></tr><tr><td>I&amp;E Margin</td><td>1</td><td>1</td></tr><tr><td>I&amp;E Variance From Plan</td><td></td><td>3</td></tr><tr><td>Agency</td><td>1</td><td>1</td></tr><tr><td>Financial Sustainability Risk Rating</td><td>1</td><td>1</td></tr></tbody></table>	Element	Plan	Actual	Capital Service Cover	1	1	Liquidity	1	1	I&E Margin	1	1	I&E Variance From Plan		3	Agency	1	1	Financial Sustainability Risk Rating	1	1	The Trust reported a rating of 1 in March, in line with plan.
Element	Plan	Actual																						
Capital Service Cover	1	1																						
Liquidity	1	1																						
I&E Margin	1	1																						
I&E Variance From Plan		3																						
Agency	1	1																						
Financial Sustainability Risk Rating	1	1																						
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.		Despite the adverse position above, performance against the efficiency programme has remained positive with directorates actioning schemes for the full target set for 2016/17. This contains a number of non recurrent benefits, adding risk to the 2017/18 programme.																					
Capital spend 	Cumulative Capital Expenditure by month (£'000s)		Cumulative capital expenditure remains behind plan.																					
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.		At 3.7% of pay spend, agency expenditure was high in March. At £477k for the month (October was the only higher month) this is a concern for the Trust. Although the value is below the agency ceiling for the Trust, this ceiling reduces in 2017/18 and the current run rate would potentially result in exceeding the new value.																					


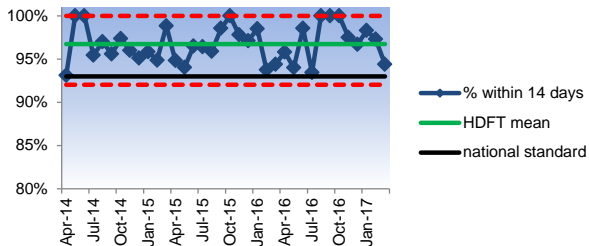

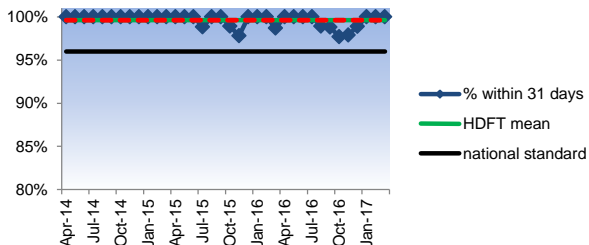

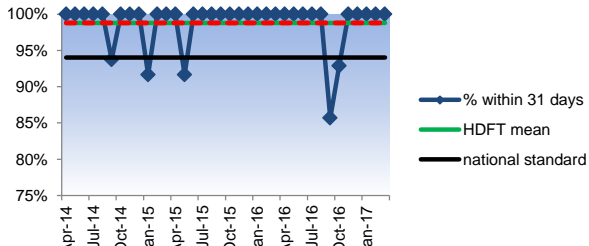

## Finance and Efficiency - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation																											
<div>Research - Invoiced research activity</div> <div></div>	Aspects of research studies are paid for by the study sponsor or funder.	<div><table><caption>Estimated data from Trend Chart</caption><thead><tr><th>Quarter</th><th>Invoiced amount (cum) (£)</th><th>Target (cum) (£)</th></tr></thead><tbody><tr><td>Q1 2015/16</td><td>~50,000</td><td>~60,000</td></tr><tr><td>Q2 2015/16</td><td>~100,000</td><td>~110,000</td></tr><tr><td>Q3 2015/16</td><td>~150,000</td><td>~160,000</td></tr><tr><td>Q4 2015/16</td><td>~200,000</td><td>~210,000</td></tr><tr><td>Q1 2016/17</td><td>~250,000</td><td>~260,000</td></tr><tr><td>Q2 2016/17</td><td>~100,000</td><td>~110,000</td></tr><tr><td>Q3 2016/17</td><td>~50,000</td><td>~160,000</td></tr><tr><td>Q4 2016/17</td><td>~223,000</td><td>~223,000</td></tr></tbody></table></div>	Quarter	Invoiced amount (cum) (£)	Target (cum) (£)	Q1 2015/16	~50,000	~60,000	Q2 2015/16	~100,000	~110,000	Q3 2015/16	~150,000	~160,000	Q4 2015/16	~200,000	~210,000	Q1 2016/17	~250,000	~260,000	Q2 2016/17	~100,000	~110,000	Q3 2016/17	~50,000	~160,000	Q4 2016/17	~223,000	~223,000	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.
Quarter	Invoiced amount (cum) (£)	Target (cum) (£)																												
Q1 2015/16	~50,000	~60,000																												
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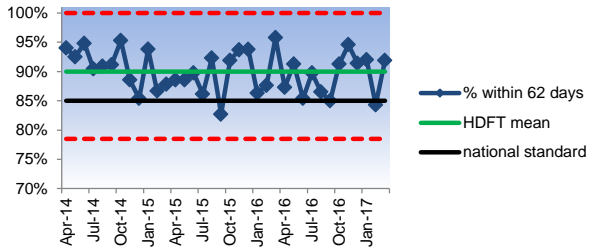

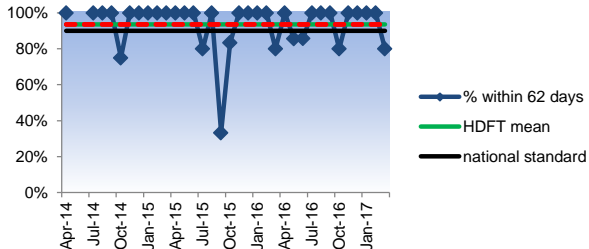

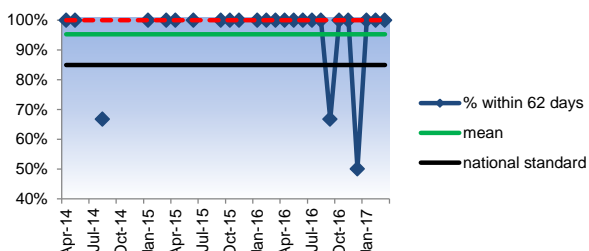

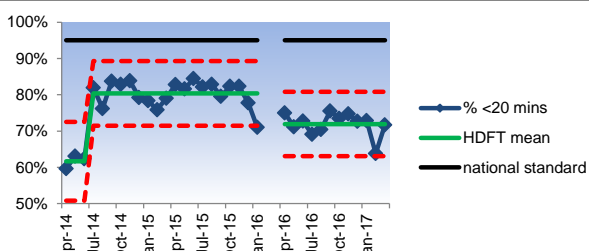
## Operational Performance - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation																																								
<b>NHS Improvement Single Oversight Framework</b> 	<p>From October 2016, NHS Improvement will 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 "operational performance metrics" section.</p>	<table border="1"> <thead> <tr> <th>Standard</th><th>Oct-16</th><th>Nov-16</th><th>Dec-16</th></tr> </thead> <tbody> <tr> <td>RTT incomplete pathways</td><td>94.4%</td><td>94.1%</td><td>94.0%</td></tr> <tr> <td>A&amp;E 4-hour standard</td><td>95.1%</td><td>93.8%</td><td>92.5%</td></tr> <tr> <td>Cancer - 62 days</td><td>91.3%</td><td>94.6%</td><td>91.4%</td></tr> <tr> <td>Diagnostic waits</td><td>99.9%</td><td>99.8%</td><td>99.9%</td></tr> </tbody> </table> <table border="1"> <thead> <tr> <th>Standard</th><th>Jan-17</th><th>Feb-17</th><th>Mar-17</th></tr> </thead> <tbody> <tr> <td>RTT incomplete pathways</td><td>94.2%</td><td>94.0%</td><td>94.0%</td></tr> <tr> <td>A&amp;E 4-hour standard</td><td>93.9%</td><td>94.8%</td><td>97.2%</td></tr> <tr> <td>Cancer - 62 days</td><td>92.0%</td><td>84.3%</td><td>92.1%</td></tr> <tr> <td>Diagnostic waits</td><td>99.9%</td><td>99.8%</td><td>99.8%</td></tr> </tbody> </table>	Standard	Oct-16	Nov-16	Dec-16	RTT incomplete pathways	94.4%	94.1%	94.0%	A&E 4-hour standard	95.1%	93.8%	92.5%	Cancer - 62 days	91.3%	94.6%	91.4%	Diagnostic waits	99.9%	99.8%	99.9%	Standard	Jan-17	Feb-17	Mar-17	RTT incomplete pathways	94.2%	94.0%	94.0%	A&E 4-hour standard	93.9%	94.8%	97.2%	Cancer - 62 days	92.0%	84.3%	92.1%	Diagnostic waits	99.9%	99.8%	99.8%	<p>In March, HDFT was above the required level for all 4 key operational performance metrics.</p>
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Diagnostic waits	99.9%	99.8%	99.8%																																								
<b>RTT Incomplete pathways performance</b> 	<p>Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks. A high percentage is good.</p>		<p>94.0% of patients were waiting 18 weeks or less at the end of March, above the required national standard of 92% and no change on last month's performance.</p> <p>At specialty level, Trauma &amp; Orthopaedics and General Surgery remain below the 92% standard.</p>																																								
<b>A&amp;E 4 hour standard</b> 	<p>Percentage of patients spending less than 4 hours in Accident &amp; Emergency (A&amp;E). The operational standard is 95%. The data includes all A&amp;E Departments, including Minor Injury Units (MIUs). A high percentage is good. Historical data for HDFT included both Ripon and Selby MIUs. In agreement with local CCGs, York NHSFT are reporting the activity for Selby MIU from 1st May 2015.</p>		<p>HDFT's Trust level performance for March was 97.2%, above the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Harrogate ED in March was 96.6%.</p> <p>HDFT has therefore delivered the 4-hour standard for the 2016/17 year overall with annual performance of 95.1%.</p>																																								
<b>Cancer - 14 days maximum wait from urgent GP referral for suspected cancer referrals</b> 	<p>Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.</p>		<p>Delivery at expected levels.</p>																																								


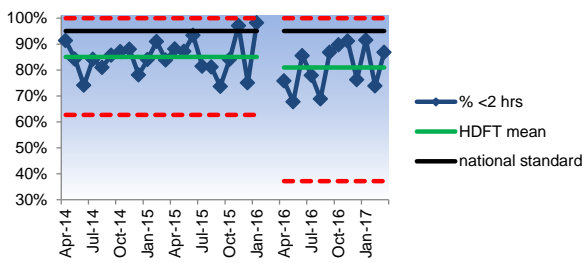

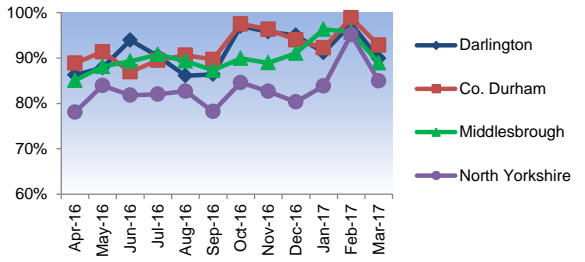

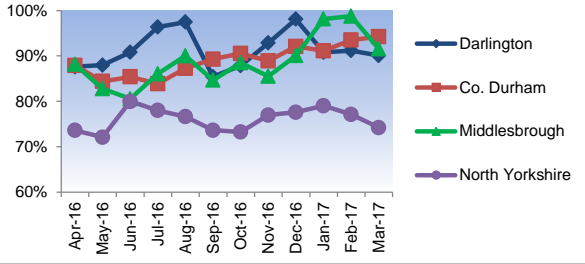

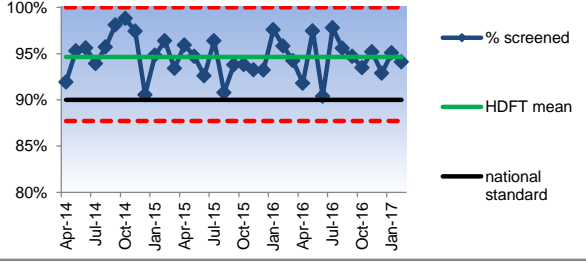
## Operational Performance - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Cancer - 14 days maximum wait from GP referral for symptomatic breast patients</b> 	Percentage of GP referrals for breast symptomatic patients seen within 14 days. The operational standard is 93%. A high percentage is good.		Delivery at expected levels.
<b>Cancer - 31 days maximum wait from diagnosis to treatment for all cancers</b> 	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.
<b>Cancer - 31 day wait for second or subsequent treatment: Surgery</b> 	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.
<b>Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug</b> 	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 2017


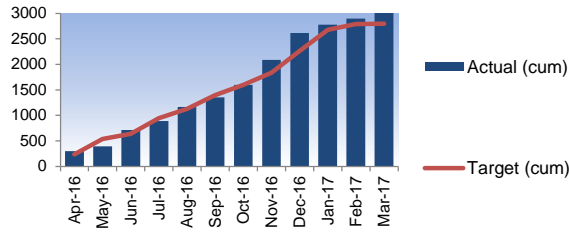

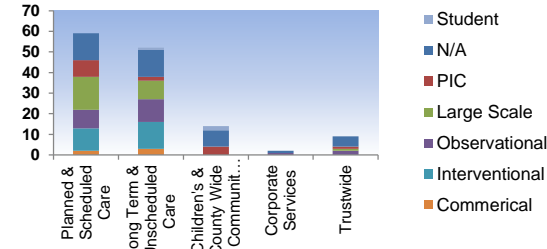
Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Cancer - 62 day wait for first treatment from urgent GP referral to treatment</b> 	Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good.		Provisional performance for March is above the required 85% standard at 91.9% with 5 accountable breaches. Of the 11 tumour sites, 2 had performance below 85% in March - colorectal and upper gastrointestinal.
<b>Cancer - 62 day wait for first treatment from consultant screening service referral</b> 	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.		Performance was below 90% in March. However with only 5 accountable pathways in the month, this is below the de minimis level for reporting performance. Performance for Quarter 4 overall is above the standard at 94.4%.
<b>Cancer - 62 day wait for first treatment from consultant upgrade</b> 	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.
<b>GP OOH - NQR 9</b> 	NQR 9 (National Quality Requirement 9) looks at the % of GP OOH telephone clinical assessments for urgent cases that are carried out within 20 minutes of call prioritisation. A high percentage is good.		<p>Performance remains below the required 95% for this metric but improved to 72% in March.</p> <p>Work continues with the Information Team to implement new, meaningful performance metrics and assure the quality of the data and reports from the Adastra system. The service is also undertaking a GP performance review which will provide further assurance as to the quality of the service provision.</p>

## Operational Performance - March 2017










Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>GP OOH - NQR 12</b> 	<p>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.</p> <p>The data presented excludes Selby and York as these do not form part of the HFT OOH service from April 2015. A high percentage is good.</p>		<p>Performance remains below the required 95% for this metric but improved to 87% in March.</p> <p>Work continues with the Information Team to implement new, meaningful performance metrics and assure the quality of the data and reports from the Adastra system. The service is also undertaking a GP performance review which will provide further assurance as to the quality of the service provision.</p>
<b>Children's Services - 10-14 day new birth visit</b> 	<p>The percentage of babies who had a new birth visit by the Health Visiting team within 14 days of birth. A high percentage is good.</p> <p>Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level.</p>		<p>In March, the provisional, unvalidated performance position is that 89% of babies were recorded on Systmone as having had a new birth visit within 14 days of birth. It is anticipated that once the data is fully validated that we will report an improved, more accurate performance position for March. This will be reflected in next month's report.</p> <p>As can be seen on the chart, the improved validation process recently implemented has had a significant impact on the February performance position which now better reflects the actual performance of the services.</p>
<b>Children's Services - 2.5 year review</b> 	<p>The percentage of children who had a 2.5 year review. A high percentage is good.</p> <p>Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level.</p>		<p>In March, the provisional performance position is that 86% of children were recorded on Systmone as having had a 2.5 year review.</p> <p>It is anticipated that once the data is fully validated that we will report an improved, more accurate performance position. This will be reflected in next month's report.</p>
<b>Dementia screening</b> 	<p>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.</p>		<p>Delivery at expected levels.</p>



## Operational Performance - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Recruitment to NIHR adopted research studies</b> 	The Trust has a recruitment target of 2,800 for 2016/17 for studies on the NIHR portfolio. This equates to 234 per month. Over recruitment is encouraged.	 <p>Actual (cum)</p> <p>Target (cum)</p>	Provisional data indicates that recruitment to research studies during 2016/17 was 12% above plan.
<b>Directorate research activity</b> 	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.	 <p>Student</p> <p>N/A</p> <p>PIC</p> <p>Large Scale</p> <p>Observational</p> <p>Interventional</p> <p>Commerical</p>	The directorate research teams are subject to studies that are available to open. The 'type of study', Commercial, Interventional, Observational, Large scale, Patient Identification Centre (PIC) or N/A influence the activity based funding received by HDFT. Each category is weighted dependant on input of staff involvement. N/A studies are those studies which are not on the NIHR portfolio. They include commercial, interventional, observational, large scale, PIC, local and student projects. They do not influence the recruitment target.

## Data Quality - Exception Report




Report section	Indicator	Data quality rating	Further information
Quality	Pressure ulcers - community acquired - grades 2, 3 or 4	Amber 	The observed increase in reported cases over the last two years may be partly due to improvements in incident reporting during the period.
Operational Performance	GP Out of Hours - National Quality Requirement 9	Amber 	Following patient pathway changes in late 2015, reports from the Adastra system no longer calculate the correct start time for these patients and as a result, the performance reported for NQR9 was incorrect. Significant work from has been carried out by information staff at HDFT and we are now able to report performance again for this metric again, based on calculations from raw data extracts from the Adastra system. The new calculations have been shared with HARD CCG.
Operational Performance	GP Out of Hours - National Quality Requirement 12	Amber 	
Quality	Reducing readmissions in older people	Amber 	This indicator is under development. We have recently amended the calculation of this indicator so that it correctly handles patients who had multiple admissions and multiple contacts with community services.
Finance and efficiency	Theatre utilisation	Amber 	The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of cancelled sessions.
Operational Performance	Children's Services - 10-14 day new birth visit	Amber 	Caution should be exercised as further work is required to understand the completeness and quality of this data.
Operational Performance	Children's Services - 2.5 year review	Amber 	Caution should be exercised as further work is required to understand the completeness and quality of this data.
Quality	Electronic rostering timeliness	Amber 	Caution should be exercised as further work is required to understand the completeness and quality of this data.
Quality	Electronic rostering hours owed	Amber 	Caution should be exercised as further work is required to understand the completeness and quality of this data.

## Indicator traffic light criteria

Section	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Quality	Pressure ulcers - hospital acquired	No. category 3 and category 4 avoidable hospital acquired pressure ulcers	tbc	tbc
Quality	Pressure ulcers - community acquired	No. category 3 and category 4 community acquired pressure ulcers	tbc	tbc
Quality	Safety thermometer - harm free care	% harm free	Blue if latest month $\geq 97\%$ , Green if $\geq 95\%$ 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	Falls	IP falls per 1,000 bed days	Blue if YTD position is a reduction of $\geq 50\%$ of HDFT average for 2015/16, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2015/16, Amber if YTD position is a reduction of up to 20% of HDFT average for 2015/16, Red if YTD position is on or above HDFT average for 2015/16.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	Falls causing harm	IP falls causing moderate harm, severe harm or death, per 1,000 bed days	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year.	NHS England, NHS Improvement and contractual requirement
Quality	Infection control	No. hospital acquired C.diff cases	tbc	tbc
Quality	Avoidable admissions	The number of avoidable emergency admissions to HDFT as per the national definition.	tbc	tbc
Quality	Reducing hospital admissions in older people	The proportion of older people 65+ who were still at home 91 days after discharge from rehabilitation or reablement services.	tbc	tbc
Quality	Mortality - HSMR	Hospital Standardised Mortality Ratio (HSMR)	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	Comparison with national average performance.
Quality	Mortality - SHMI	Summary Hospital Mortality Index (SHMI)	Blue if no. complaints in latest month is below LCL, Green if below HDFT average for 2015/16, Amber if on or above HDFT average for 2015/16, Red if above UCL. In addition, Red if a new red rated complaint received in latest month.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	Complaints	No. complaints, split by criteria	Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%	Comparison of HDFT performance against most recently published national average ratio of low to high incidents.
Quality	Incidents - all	Incidents split by grade (hosp and community)	Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month.	
Quality	Incidents - comprehensive SIRIs and never events	The number of comprehensive SIRIs and the number of never events reported in the year to date. The indicator includes hospital and community data	Blue if latest month score places HDFT in the top 10% of acute trusts nationally and/or the % staff recommending the Trust is above 95%, Green if in top 25% of acute trusts nationally, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Quality	Friends & Family Test (FFT) - Staff	% staff who would recommend HDFT as a place to work	Green if latest month $\geq$ latest published national average, Red if $<$ latest published national average.	Comparison with national average performance.
Quality	Friends & Family Test (FFT) - Staff	% staff who would recommend HDFT as a place to receive care	Green if latest month overall staffing $\geq 100\%$ , amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
Quality	Friends & Family Test (FFT) - Patients	% recommend, % not recommend - combined score for all services currently doing patient FFT	Annual rolling total - 90% green, Amber between 70% and 90%, red $< 70\%$ .	Locally agreed target level based on historic local and NHS performance
Quality	Safer staffing levels	RN and CSW - day and night overall fill rates at trust level	Blue if latest month $\geq 95\%$ ; 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 appraisal rate	Latest position on no. staff who had an appraisal within the last 12 months	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	Mandatory training rate	Latest position on the % staff trained for each mandatory training requirement	tbc	tbc
Quality	Staff sickness rate	Staff sickness rate	tbc	tbc
Quality	Temporary staffing expenditure - medical/nursing/other	Expenditure per month on staff types.	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	Staff turnover	Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts.	Green if $< 25\%$ of deliveries, amber if between 25% and 30%, red if above 30%.	tbc
Quality	Maternity - Caesarean section rate	Caesarean section rate as a % of all deliveries	Green if $< 3\%$ of deliveries, amber if between 3% and 6%, red if above 6%.	tbc
Quality	Maternity - Rate of third and fourth degree tears	No. third or fourth degree tears as a % of all deliveries	tbc	tbc
Quality	Maternity - Unexpected term admissions to SCBU	Admissions to SCBU for babies born at 37 weeks gestation or over.	Blue if latest month rate $<$ LCL, Green if latest month rate $<$ HDFT average for 2015/16, Amber if latest month rate $>$ HDFT average for 2015/16 but below UCL, red if latest month rate $>$ UCL.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Finance and efficiency	Readmissions	No. emergency readmissions (following elective or non-elective admission) within 30 days.	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	Readmissions - standardised	Standardised emergency readmission rate within 30 days from HED	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Finance and efficiency	Length of stay - elective	Average LOS for elective patients		
Finance and efficiency	Length of stay - non-elective	Average LOS for non-elective patients		

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

#### Data quality assessment

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