Council Of Governors 18 February 2017

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Harrogate and District NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS' MEETING

A meeting of the Harrogate and District NHS Foundation Trust Council of Governors will take place on Saturday, 18 February 2017 in The Hatcher Room (next to Constance Green Hall), St Aidan's Church of England High School, Oatlands Drive, Harrogate, HG2 8JR

Start: 10.45am Finish: 1.00pm
(Private discussion for Governors and the Board will commence at 10.15am)

		AGENDA		
Time	**Item No.**	**Item**	**Lead**	**Paper No.**
10.45	**1.0**	**Welcome and apologies for absence** *Welcome to the public and setting the context of the meeting*	Mrs S Dodson, Chairman	-
10.45	**2.0** **2.1** **2.2**	**Minutes of the meeting held on 2 November 2016** **Minutes of the Extra-ordinary Council of Governors' meeting held on 30 November 2016** **Minutes of the Annual Members' Meeting held on 13 September 2016** *To review and approve the minutes*	Mrs S Dodson, Chairman	2.0 2.1 2.2
10.50	**3.0**	**Matters Arising and Review Action Log** *To provide updates on progress of actions*	Mrs S Dodson, Chairman	3.0
10.55	**4.0**	**Declarations of Interest** *To declare any interests relevant to the agenda and to receive any changes to the register of interests*	Mrs S Dodson, Chairman	4.0
10.55	**5.0**	**Chairman's verbal update on key issues including:** • **Election Results** *To receive the verbal update for consideration*	Mrs S Dodson, Chairman	-
11.05	**6.0** **6.1** **6.2** **6.3** **6.4**	**Governor Sub-Committee Reports** *To receive the reports for comment* **Volunteering and Education Group** **Membership, Development and Communications Group** **Patient and Public Involvement:** • **Quality of Care Teams - Individual Governor feedback on attendance at Quality of Care Teams** • **Update from Chief Nurse on review of Quality of Care Teams process** **Patient Safety Visits Annual Report**	Mrs S Dodson, Chairman Mrs Jane Hedley, Public Governor Ms P Allen, Deputy Chair of the Council of Governors/ Public Governor Governors Mrs J Foster, Chief Nurse Mrs J Foster, Chief Nurse	 6.1 6.2 - - 6.4

	6.5	**Update on Quality Account Process**	Mrs J Foster, Chief Nurse	-
11.30	**7.0**	**Report from the Nominations Committee** *To receive the report for comment and approve:* *- Minutes of the meeting held 27 January 2017* *- Re-appointment of Mr Chris Thompson, Non-Executive Director*	Mrs S Dodson, Chairman	7.0
	7.1	**Update from the Nominations Committee on the Chairman's Recruitment Process** *To receive the verbal update on progress*	Ms Pamela Allen, Deputy Chair of Governors/Public Governor	-
11.40	**8.0**	**Presentation – Youth Forum – listening to young people's experiences and ideas for healthcare improvement**	Mrs Emily Reid, Education Liaison, Work Experience and Membership Officer / Mr R Chillery, Operational Director, Children's and County Wide Community Care	-
11.50 am - 12.00 noon – Break				
12.00	**9.0**	**Chief Executive's Strategic and Operational Update, including Integrated Board Report** *To receive the update and report for comment*	Dr R Tolcher, Chief Executive	9.0
12.15	**10.0**	**Question and Answer Session for members of the public and Governors** *To receive and respond to questions from the floor relating to the agenda*	Mrs S Dodson, Chairman	-
12.45	**11.0**	**Non-Executive Directors' Feedback:** ***Update on involvement in the Annual Plan for 2017/18 and two-year Operational Plan*** *To receive and respond to questions from the floor*	Non-Executive Directors	-
12.55	**12.0**	**Any other relevant business not included on the agenda** *By permission of the Chairman*	Mrs S Dodson, Chairman	-
13.00	**13.0**	**Close of meeting**	Mrs S Dodson, Chairman	-

Date and time of next meeting –
Wednesday, 3 May 2017 at 5.15 pm (public meeting commences at 5.45 pm)

Harrogate and District NHS
NHS Foundation Trust

Council of Governors

Minutes of the public Council of Governors' meeting held on 2 November 2016 at 17:45 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
Mr Michael Armitage, Public Governor
Cllr. Bernard Bateman, Stakeholder Governor
Dr Sally Blackburn, Public Governor
Mrs Angie Colvin, Corporate Affairs and Membership Manager
Mr Jonathan Coulter, Director of Finance/Deputy Chief Executive
Ms Clare Cressey, Staff Governor
Mrs Liz Dean, Public Governor
Mr Tony Doveston, Public Governor
Mrs Emma Edgar, Staff Governor
Mrs Jill Foster, Chief Nurse
Mrs Joanne Harrison, Deputy Director of Workforce and Organisational Development
Mr Rob Harrison, Chief Operating Officer
Mrs Jane Hedley, Public Governor
Miss Debbie Henderson, Company Secretary
Mrs Pat Jones, Public Governor
Mrs Sally Margerison, Staff Governor
Mr Neil McLean, Non-Executive Director
Mrs Zoe Metcalfe, Public Governor
Prof. Sue Proctor, Non-Executive Director
Dr Daniel Scott, Staff Governor
Dr David Scullion, Medical Director
Mrs Maureen Taylor, Non-Executive Director
Mr Chris Thompson, Non-Executive Director
Dr Ros Tolcher, Chief Executive
Mr Ian Ward, Non-Executive Director
Mrs Lesley Webster, Non-Executive Director

In attendance:

11 members of the public
Mr David Griffin, Non-Executive Director observer (Delegate of The Insight Programme)

1. Welcome to the public and setting context of the meeting, including apologies for absence and introductions

Apologies were received from Mrs Yvonne Campbell, Staff Governor, Mrs Cath Clelland, Public Governor, Dr Sarah Crawshaw, Stakeholder Governor, Mrs Beth Finch, Stakeholder Governor, Mr Phillip Marshall, Director of Workforce and Organisational Development, Mr Peter Pearson, Public Governor, Mrs Joyce Purkis, Public Governor, and Dr Jim Woods, Stakeholder Governor

Mrs Dodson offered a warm welcome to the members of the public and was delighted to introduce Mrs Harrison who would be presenting the Global Health Exchange Programme under item 7 on the agenda. Mrs Dodson also introduced Mr Griffin who had been allocated a placement at the Trust for a period of six months as part of 'The Insight Programme' to learn about the role of Non-Executive Directors.

Mrs Dodson was expecting Mrs Edgar to arrive late to the meeting due to a prior commitment in Leeds. She welcomed questions for item 9 on the agenda and asked for these to be submitted during the break.

2. Minutes of the last meeting, 3 August 2016

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

3. Matters arising and review of actions schedule

Mrs Foster provided an update regarding the progress of Nutritional Assistants; item 3 on the outstanding action schedule. She confirmed that the Nutritional Assistant role would be reviewed by the new Nutrition and Dietetic Lead, commencing in post shortly, and a further update would be provided at the next meeting.

Mrs Dodson confirmed that the remaining actions on the outstanding schedule at Paper 3.0 were ongoing.

ACTION:

- **Mrs Foster to provide update regarding the progress of Nutritional Assistants at the next meeting in February 2017.**

4. Declaration of interests

There were no 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 was delighted to see so many members of the public at the meeting. She hoped they would find the meeting interesting and informative and encouraged questions for Governors or any member of the Board in attendance.

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 Clinical Health Care Support Apprenticeship Scheme outlined in her report.

Mrs Harrison was pleased to comment on the renewed emphasis on apprenticeships as a key factor in the development of the future workforce. The scheme would have significant benefits for the Trust by creating a well-trained workforce and providing wider access to employment and career opportunities within the NHS.

There were no questions for Mrs Hedley.

Mrs Dodson reiterated the longer term benefits for our future nursing workforce and the opportunities for staff to realise their personal and professional potential.

6.2 Membership Development and Communications

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

Ms Allen highlighted the Annual Members' Meeting which was held at the Cedar Court Hotel in Harrogate on 13 September. She was delighted with the number of people in attendance and there had been lots of positive feedback received. There was also some areas which could be improved and this would be tailored into the planning arrangements for next year.

Ms Allen reported a busy autumn in terms of membership including the popular Medicine for Members' event, the newly formed Youth Forum, and the ongoing Elections.

Mrs Dodson commented on the importance of listening to feedback from people attending events and meetings. On reflection, and regarding the request for more time designated to questions, Mrs Dodson hoped the

agenda would enable more time for questions and debate at the meeting this evening.

There were no questions for Ms Allen.

6.3 Patient and Public Involvement

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

In Mrs Purkis's absence, Mrs Dean highlighted the quarterly Quality Reports submitted to the Group.

Mrs Dean and Mrs Lennon, Chair of the Patient Voice Group, had reviewed the content of the Quality Reports and requested more benchmarking data and learning outcomes. Further discussion would take place with Mrs Foster to review the content and style of the reports going forward. Mrs Dean acknowledged the amount of information provided and was mindful that the reports were also used for other purposes.

In addition, Mrs Dean was also delighted to highlight the ongoing nurse recruitment campaign and was pleased that 26 newly qualified nurses had commenced work at the Trust this autumn as well as four further nurses from Spain. There was a positive effort to retain these nurses by providing a comprehensive induction programme and mentoring schemes, and exit interviews were being actively encouraged for experienced nurses leaving the organisation.

There were no questions for Mrs Dean.

7. Presentation – Global Health Exchange Programme

Mrs Dodson welcomed Mrs Annie McClusky, Matron, who joined Mrs Harrison in presenting the Global Health Exchange Programme.

Mrs Harrison started the presentation by confirming the increase in Registered Nurse vacancies across the UK and she described the challenges for workforce planning as this gap continued.

Yorkshire and the Humber Local Education and Training Board, of which Mr Marshall Director of Workforce and Organisational Development was a member, established the Global Health Exchange Programme, an innovative solution to this gap through funding by departments including Health Education England and NHS England. Mrs Harrison was delighted to report that Mr Marshall and Mrs McClusky had been invited to travel to India with representatives from Health Education England to establish the 'Earn, Learn and Return' initiative with the Apollo Group, a major provider of healthcare in India.

Mrs Harrison talked more about the Apollo Group who were aligned to the Trust's principles and values. Their mission was to bring healthcare of international

standards within the reach of every individual and a commitment to the achievement and maintenance of excellence in education, research and health care for the benefit of humanity.

Describing the pilot initiative, Mrs Harrison stated that Registered Nurses would undertake an International English Language Test System as well as Nursing and Midwifery Council training – part 1 in India and part 2 in the UK. Health Education England would fund a Practice Learning Facilitator to support staff as they moved through the three year placement in the UK. The aim would be to recruit significant numbers of Registered Nurses across the UK with Harrogate and District NHS Foundation Trust filling 20 posts. During the three years in the UK they would work in a number of areas and receive a formal leadership qualification funded by Health Education England and then return to leadership posts in India to further develop their health economy. There would be plans to expand the programme with opportunities for other staff groups in the future, including Emergency Department doctors and theatre staff.

Next steps would be interviews and conditional offers of employment and the Trust would be hosting a visit from senior executives from the Apollo Group later that month. It was anticipated that staff would commence in post at the end of March 2017 and a further update would be provided to Governors at the next meeting in February 2017.

Finally, Mrs Harrison acknowledged Mr Marshall's involvement and influence in the programme and stated how proud the Trust was to be leading on this initiative.

Mrs Dodson opened up questions from the floor.

Mrs Margerison asked if the programme would be opened up to community nurses. Mrs McClusky confirmed that the programme was aimed at hospital based nurses at this stage, but opportunities would be developed over the next three years.

Mrs Dean asked if there would be further nurses recruited to the programme when the initial nurses returned to India. Mrs Harrison stated that the programme would be evaluated along with national vacancies and training at that stage.

Ms Allen asked for more detail regarding staff induction. Mrs McClusky confirmed each individual's CV and personal specification had been screened and most of the nurses had been qualified for at least two years and they were working clinically at the current time.

Dr Scott asked if the nurses could apply for permanent jobs. Mrs Harrison explained that it was not their intention to stay in the UK; the initiative would support the nurses to return to India to develop the Indian health economy.

A member of the public in attendance at the meeting commented on promoting nursing jobs to the local community and Mrs Foster confirmed the Trust had a positive interface with the education establishment and work was underway to provide local jobs for local people through the Trust's Clinical Workforce Strategy.

There were no further questions for Mrs Harrison or Mrs McClusky and Mrs Dodson thanked them for such an informative presentation.

ACTION:
- **Update on the Global Health Exchange Programme.**

8. Chief Executive's Strategic and Operational Update including Integrated Board Report

Dr Tolcher presented the following headlines:

Current Performance

Dr Tolcher referred to the Integrated Board Report which had been circulated prior to the meeting and was also available on the Trust's website*. This report provided a snapshot of Key Performance Indicators (KPI's) and how these were rated. She was pleased to report that the Trust continued to perform well on the A&E 4-hour standard and, at the time of the meeting, it was the best performing Emergency Department in the country.

Dr Tolcher 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 described actions the Trust was taking to make improvements. Quality had four red rated KPI's including: safety thermometer, the number of incidents, the number of Serious Incidents Requiring Investigation (SIRIs), and staff mandatory training rates. Dr Tolcher offered reassurance that the main reason for the decrease in performance was due to an increase in the number of pressure ulcers that patients already had. The harm free percentage for September was 94.6%, a decrease from 97.3% in the previous month, but above the latest national average of 94.2%.

Moving on to finance and efficiency with four red-rated KPI's in delayed transfers of care, cash balance, cost improvement programme achievement and capital spend, Dr Tolcher confirmed that the Trust was slightly ahead of plan and noted that, as a result, the Trust would receive the second quarter of Sustainability and Transformation funding. She expressed the importance of these funds to be able to invest in equipment and service improvement.

The Operational Performance summary demonstrated two red-rating KPI's in Cancer 31 day wait for second or subsequent treatment and recruitment to National Institute for Health Research (NIHR) adopted research studies.

West Yorkshire & Harrogate Sustainability and Transformation Plan (STP)

Dr Tolcher provided a brief overview of the West Yorkshire and Harrogate STP; delivered by local health and care organisations working together across the region to support changes needed to improve services for its population. The Trust would be part of the West Yorkshire STP footprint.

She summarised the funding gaps for both West Yorkshire and the Trust in order to achieve sustainability by 2020/21 and compared the 'do nothing' approach to the 'do something' initiative to drive efficiencies. The figures shown on the presentation slide

were already out of date in view of the current position and in addition to the funding gap there was also the health outcomes and care quality for patients to consider.

The nine West Yorkshire STP work streams identified were:

- Cancer
- Mental health
- Prevention at scale
- Specialised commissioning
- Stroke
- Urgent and emergency care
- Primary and community care
- Standardisation of commissioning policies
- Acute collaboration.

Dr Tolcher explained that the first six work streams were clinically focussed and the remaining three had been introduced more recently to help close the gaps:

- Primary and community care – the focus on GP and community services to prevent patients coming in to hospital.

- Standardisation of commissioning policies – accessing care across the region. Harrogate and Rural District Clinical Commissioning Group had embarked on a healthy optimisation programme for planned care focussing on support for patients to give up smoking and to reach a healthy Body Mass Index (BMI).

- Acute collaboration – focus on significant developments between six acute Trusts; working together to deliver the best possible outcomes.

Dr Tolcher talked about the changing landscape of commissioning for West Yorkshire STP and other considerations of strategic importance.

Finally, Dr Tolcher finished her presentation by summarising the next six months. The focus would be to continue keeping 'business as usual', safe and sound with a capable and motivated workforce; to continue to deliver the Trust's plans and to position ourselves well for 2017/18. The Trust would continue to face the challenges of reduced national funding and the ongoing media interest but would focus on working collaboratively with other organisations, engaging with people who use the Trust's services, and retaining our workforce to provide high quality of care.

Mrs Margerison commented on the Community Care Teams being rolled out as part of the new integrated Vanguard teams. She acknowledged the challenges of integration and asked if social care was still on board with this vision.

Dr Tolcher agreed there was still more work to do but provided assurance that the six partners involved, including North Yorkshire County Council and Harrogate Borough Council, remained committed to the programme.

In response to a comment made by a member of the public regarding Harrogate being part of West Yorkshire STP's footprint, Dr Tolcher explained the Trust did not have a choice but that the NHS and local councils had come together in 44 areas covering the whole of England, like a 'jigsaw', built around the needs of the local

population. Dr Tolcher added that, as a provider of children's services in County Durham, Darlington and Middlesbrough, our reach was wider than the West Yorkshire STP.

Mrs Edgar asked if the Trust would lose some acute services as part of the STP. Dr Tolcher confirmed that, as far as conversations had gone up to date, there was no indication of this. There would be some changes, particularly around stroke services, however this was the direction of travel prior to STP's.

Mrs Margerison raised how Non-Executive Directors and Governors had been engaged with plans for collaboration. Dr Tolcher confirmed that Non-Executive Directors had been fully engaged and Governors briefed through the Council of Governors' meetings. She also added that work had progressed to establish a more formal governance arrangement between the six acute Trusts in order to achieve the level of ambition described by the STP. All Trusts had considered the options for collaboration and supported in principle the creation of a Committee in Common. Company Secretaries would be meeting the following week to talk about this further.

Mrs Dodson clarified that not all Trusts had Foundation Trust status and therefore not all Trusts had Governors. She expressed the importance for good governance and noted the need for ongoing Governor briefings and further training as well as networking with fellow Governors across the STP footprint.

Dr Scullion referred to negative media and Dr Tolcher was pleased to inform Governors that the West Yorkshire and Harrogate STP would be published the following week. This would set out the vision, ambitions and priorities for the future of health and social care in the region and was the result of many months of discussions across the STP partnership. Information would be available in different formats including easy read and video.

Mr McLean noted that the STP would be a vehicle to deliver better care however he commented that some aspects of the draft plans for better health and social care in West Yorkshire might impact on the Trust.

Mrs Dodson clarified that each area had its own plan and Dr Tolcher explained further how STPs were a national direction with a place based approach; West Yorkshire and Harrogate STP had one of the largest footprints but each area would be allowed local plans in their area.

Mr Ward referred to the £2.3 million sustainability and transformation funding and Mr Coulter explained this in more detail. He explained that the Trust would receive a total of £4.6 million sustainability and transformation funding (up to £1.15 million per quarter is available) if the Trust delivered the £2.2 million financial plan and there was a strong focus on this in order to invest in service development and improvement.

Mrs Webster clarified how the Trust could use the additional funding next year towards the capital programme.

In response to a request from a member of the public asking for further information about how the Trust was addressing the red-rated quality key performance indicators, Dr Tolcher explained that the percentages were based on a monthly snapshot. In relation to the Safety thermometer indicator, there was no nationally defined target; a score of 95% or above was considered best practice and the Trust

Red Amber Green (RAG)-rated anything below 95% as 'red'. The Trust's score for the most recent month was 94.6%. The Trust was working hard on the number of incidents and number of serious incidents requiring investigation; the Board would be analysing the data further and, whilst the report showed these as red, the Trust's percentages were better than benchmarking comparators. With regards to delayed transfers of care, Dr Tolcher confirmed this was an ongoing challenge for the Trust. There were patients currently in hospital who were fit for discharge but due to a variety of reasons, for example social care assessments and family decisions, delayed transfers of care remained above the maximum threshold. The Discharge Steering Group had been tasked to look into this further and this rating promoted the collaborative work ongoing with our partners. With regard to the cost improvement programme achievement, Dr Tolcher stated this was marginally below plan and comprehensive recovery plans were underway.

Mr Harrison commented on the Operational Performance red-rated key performance indicator for Cancer 31 day wait for second or subsequent treatment highlighted in Dr Tolcher's presentation. He confirmed that in September there were two beaches of the 31 day standard however performance for Quarter 2 overall was above the standard. He stated that, as patient numbers in this indicator were low, if one patient breached the standard it would result in a red-rating.

Mrs Edgar asked if the reason for the patient breaching the 31 day standard was due to staff capacity. Mr Harrison provided reassurance that the Cancer Steering Group had reviewed this in detail and, on this occasion, it was due to patient choice, as was their right, but this was still recorded as a breach under the standards criteria.

Finally, Dr Tolcher commented on recruitment to National Institute for Health Research and expressed that this was an important element to attract and retain clinicians and was good for our patients. She confirmed we were a little behind, but this was not a particular concern at this level.

Mrs Dodson thanked Dr Tolcher for an informative update and was pleased with the level of questioning from the floor. She acknowledged how hard the Executive Team was working to ensure 'business as usual' whilst progressing through a significant period of change.

There were no further questions for Dr Tolcher and Mrs Dodson called for a refreshment break.

9. 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.

Mrs Liz Dean, Public Governor, had submitted the following question:

"The question is related to Harrogate Council's Urban Housing Plan which is out for consultation shortly. The plan is to build around 11,500 houses by 2025 around the district. Is the Trust involved with planning and what assurances can the Trust give us that they will be able to cope and not compromise quality of service to patients?"

Mr Coulter confirmed his colleague, Mrs Gillett, Deputy Director of Planning, was aware of the Council's plan and he acknowledged that it would have a larger impact on primary care. Increases in population were discussed as part of the Trust's annual planning cycle and any influx in population would be considered in the Clinical Commissioning Group's funding allocation. He reiterated that the Trust's key strategic objective was always to deliver high quality care.

Mr Harrison added that the Trust had grown its footprint into North Leeds and he saw the increase in population as positive for the Trust.

Mrs Emma Edgar, Staff Governor, had submitted the following question:

"In light of the Clinical Commissioning Group's policy decision to limit elective surgery to non-smokers with a BMI of less than 30, are the Non-Executive Directors confident that the risks to patients and to the organisation have been properly considered?"

Mrs Webster acknowledged this was a difficult subject however she recognised the Clinical Commissioning Group's financial challenge and the need to take proactive action, focussing on preventative care and people being responsible for their own health and wellbeing. She also commented that GPs would continue to provide patients with advice and best possible outcomes for surgery depending on their individual circumstances.

Professor Proctor endorsed Mrs Webster's comments and recognised both national and local financial challenges. She expressed the importance for Non-Executive Directors to gain assurance from the Executive Team and through dialogue with staff and the general public on learning and outcomes.

In her role as Cardiology Specialist Nurse, Mrs Edgar commented that she had seen first-hand the difficulties faced by some of her patients as a result of this decision.

Dr Scullion provided a medical perspective on what was a contentious subject. He confirmed there was medical evidence that patients in good health recover better after an operation and have fewer complications. He clarified that this was not a blanket ban and emphasised the criteria set by Harrogate and Rural District Clinical Commissioning Group to help patients to stop smoking or reduce their weight before being referred for routine (non-urgent) surgery.

Mr Coulter also commented on the exclusions for the six month health optimisation period and stated that patients meeting the criteria would still be provided with lifestyle advice from their GP.

Ms Pamela Allen, Public Governor, had submitted the following question:

"The Royal College of Midwives have initiated a 'Caring for You' Charter of which HDFT has agreed to participate in. Said charter is to help midwives manage stress, heavy workloads, burnout and other negative aspects of the job. Is the Trust aware of any similar charters being propose for other nursing groups such as critical care and paediatrics and how does this charter apply to nurse generalists?"

Mrs Foster was not aware of any other proposed charters and confirmed that the Trust's Head of Midwifery was reviewing the 'Caring for You' Charter. The Trust offered a range of health and wellbeing initiatives to staff including a Staff Wellness Programme and a good response had been received in a recent staff stress audit. The Trust had appointed a Bereavement Midwife who would be able to support staff as well as service users. The stress audit would be reviewed again in six months' time.

Mrs Harrison echoed Mrs Foster's comments about the Trust's commitment to the health and wellbeing of staff including managing stress and there were a number of initiatives around focussed interventions. Mrs Harrison was proud to announce the Trust had signed the Mindful Employer Charter and was committed to upholding the values and principles associated with it.

Miss Sue Eddleston, Trust Member, had submitted the following question (in her absence, Mrs Dodson read out the question):

"In the past two years there have been occasions whereby I have had to attend Harrogate District Hospital for various appointments. Some appointments I have arrived at the hospital by Patient Transport, however, there have been many occasions when I have used public transport and got off the bus on Knaresborough Road. There is a long walk from the road down to enter the hospital via the back entrance, near the maternity unit. On entering the hospital at this point there are no seats for anyone to sit down before they make their way to the main entrance and all the outpatient departments. All along the main corridor there are no seats, apart from one bench near to the Cardiology department. For myself I found his to be both challenging and very tiring, due to initially having severe osteoarthritis in both knees and then recovering from both knee replacements. I felt my journey to the orthopaedic department was never ending and would have welcomed to have been able to sit down initially when I arrived in the hospital and then subsequently along the main corridor. I also note there are very few seats outside the main entrance of the hospital. I welcome the views from Harrogate Hospital why there is a lack of seating. I am also a patient at the Friarage Hospital in Northallerton and James Cook at Middlesbrough, both hospitals have numerous seating areas outside the hospital as well as numerous couches situated all along the corridors so that the patient with mobility difficulties or an elderly person are able to rest as they make their way to their appointment.

Also I just wonder whether there would also be added benefit if there was a phone at the back entrance so that a patient could alert the front desk that someone at the rear entrance was in need of assistance and possibly benefit from there being a wheelchair available to get them along the corridor."

Mr Harrison thanked Miss Eddleston for her detailed question which was very helpful. He would task the Deputy Director of Estates to review the seating arrangements and find suitable places for seating to be made available. He confirmed there was a phone near the emergency maternity entrance but no sign to indicate this; he would follow up this action.

Mrs Dodson confirmed volunteers would be happy to help patients with mobility difficulties and she would talk to Mrs Tomlinson, Volunteer Services Manager about this.

Mrs Dodson confirmed this was a good example of 'You said, we did' and thanked the member for submitting such a valuable question.

Miss Victoria Pawlak did not submit a question, but wished to thank Dr Rebecca Leigh for the outstanding Medicine for Members presentation to members in October.

Mrs Dodson thanked Miss Pawlak for her kind words and would convey them to Dr Leigh.

ACTION:

- **Deputy Director of Estates to review the seating arrangements and find suitable places for seating to be made available.**
- **Arrange for a sign near the telephone near the emergency maternity entrance.**
- **Mrs Dodson would talk to Mrs Tomlinson, Volunteer Services Manager about volunteers helping patients with mobility difficulties entering the hospital near the emergency maternity entrance.**
- **Mrs Dodson to pass on thanks to Dr Leigh.**

10. Non-Executive Directors' Feedback: Overview of Sustainability and Transformation Plans and 2-year Contract Discussions

Mr McLean described the STP as a vehicle to looking at doing things differently, making improvements and focussing on cost efficiencies. He confirmed there had been many discussions at Board; he acknowledged that the population put their trust in the services that we provided and he expressed the importance of protecting the delivery of high quality care. Noting the NHS was massively underfunded, Mr McLean echoed earlier comments from Mrs Edgar in relation to demand on the system. He appreciated the need to work collaboratively and recognised the complications and difficult decisions for the Clinical Commissioning Group.

Following on from Dr Tolcher's presentation, Mrs Taylor confirmed that the level of detail was still awaited regarding the nine work streams. She acknowledged the proposed improvements for care and efficiencies, but stated that HDFT was a high performing Trust and its key responsibility was to continue to serve the people of Harrogate and rural district.

Mr McLean welcomed the Trust doing more of what we were good at if the capacity and resources were available.

Mr Thompson acknowledged that there were some areas the Trust could improve on and there was a clear potential to save money in areas such as procurement. He felt that the challenge going forward would be in relation to governance and the STP strategy.

Mrs Webster commented that the Trust already had collaborations with York Teaching Hospital NHS Foundation Trust and Leeds Teaching Hospitals NHS Trust and working together we would use our expertise and continue building a sustainable organisation.

Dr Tolcher summarised some of the comments made throughout the meeting about the Trust being a high performing organisation with a motivated workforce, good systems and processes, a culture of learning, and key objectives. She expressed clearly that the success of an organisation was based on its workforce and she was proud of the willingness of staff in a changing environment. Standing still was not an option and the West Yorkshire and Harrogate STP provided a solution to work in collaboration for the benefit of the local population.

Mr Ward commented on collaborative arrangements outside of the West Yorkshire footprint and Dr Scullion noted the possible risk of other acute trusts in the patch.

Dr Tolcher confirmed each Trust held responsibility for its own control total and the Trust would set its own contractual income.

There were no further questions or comments and Mrs Dodson thanked the Non-Executive Directors for their feedback.

11. Any other business

Governor Elections

Mrs Colvin confirmed that the deadline for UK Engage to be in receipt of Governor Election nominations was 5pm on Monday 7 November. Ballot packs would be issued to members on Tuesday 22 November and the close of Poll was 5pm on Thursday 15 December.

Elections would be held for the following number of Governors in the following constituencies and classes:

Public – Harrogate and surrounding villages – 2 seats
Public – Knaresborough and east district – 1 seat
Public – Ripon and west district – 1 seat
Public – The Rest of England – 1 seat
Public – Wetherby and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley wards – 1 seat
Staff – Nursing and Midwifery – 2 seats

Evaluation forms

Mrs Colvin asked everyone to complete an evaluation sheet after the meeting and return them to her.

Acknowledgements and thanks

Mrs Dodson confirmed that Mrs Purkis, Public Governor for Knaresborough and east district would be standing down at the end of her term of office on 31 December. Mrs Purkis was unable to attend the meeting today, but Mrs Dodson wished to formally thank her for her contribution, enthusiasm, and commitment to her Governor role over the last three years.

Mrs Dodson also thanked Mrs Joanna Parker, Stakeholder Governor for Patient Experience who had resigned in September. Mrs Parker had secured a staff post at the Trust and was therefore unable to continue her role as a Stakeholder Governor.

Finally, Mrs Dodson confirmed this would be Miss Henderson's last meeting as she had secured a Company Secretary post at South Tyneside NHS Foundation Trust. Mrs Dodson thanked Miss Henderson for her support and, on behalf of the Board and the Council of Governors, wished her well for the future.

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 a Saturday morning in February, to be confirmed.

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

Harrogate and District NHS
NHS Foundation Trust

Council of Governors

Minutes of the Extra-ordinary Council of Governors' meeting held on 30 November 2016 at 16:30 hrs
at The Pavilions of Harrogate, Great Yorkshire Showground, Harrogate, HG2 8NZ

Present:

Mrs Sandra Dodson, Chairman
Ms Pamela Allen, Public Governor/Deputy Chair of Council of Governors (Chair)
Mr Michael Armitage, Public Governor
Cllr. Bernard Bateman, Stakeholder Governor
Dr Sally Blackburn, Public Governor
Mrs Angie Colvin, Corporate Affairs and Membership Manager
Mr Tony Doveston, Public Governor
Mrs Jane Hedley, Public Governor
Miss Debbie Henderson, Company Secretary
Mrs Sally Margerison, Staff Governor (via phone)
Mrs Zoe Metcalfe, Public Governor
Mr Peter Pearson, Public Governor
Mrs Joyce Purkis, Public Governor
Dr Daniel Scott, Staff Governor
Dr Ros Tolcher, Chief Executive
Mr Ian Ward, Non-Executive Director

1. Apologies

Apologies were received from Mrs Yvonne Campbell, Staff Governor, Mrs Cath Clelland, Public Governor, Ms Clare Cressey, Staff Governor, Mrs Liz Dean, Public Governor, Mrs Emma Edgar, Staff Governor, Cllr Phil Ireland, Stakeholder Governor, Mrs Pat Jones, Public Governor, and Dr Jim Woods, Stakeholder Governor.

2. Report from the Nominations Committee

Ms Allen referred to the minutes of the Nominations Committee held on 21 November and these were approved.

Ms Allen summarised the discussion and recommendation of the Nominations Committee to reappoint Mrs Lesley Webster to a second term of office as Non-Executive Director from 1 January 2017 until 31 December 2019.

The Council of Governors were in unanimous agreement and approved the recommendation.

3. Proposed Timeline for the Appointment of Chairman of the Trust

Ms Allen summarised the report which had been circulated prior to the meeting and taken as read.

The Council of Governors was asked:

- to note the timeline for the Chairman's appointment process for Harrogate and District NHS Foundation Trust;
- to put forward expressions of interest to take part in the recruitment process; and,
- to approve the proposal to appoint a recruitment firm to support the Nominations Committee in the appointment process for Chairman of the Trust, in line with the options appraisal detailed in the appendix and the implementation of a tendering exercise.

Before moving to the recommendation, Ms Allen asked if there were any questions and referred to the options detailed in the appendix for the Council of Governors to consider.

Governors discussed the decision to appoint a recruitment firm in detail taking into account related costs and relevant experience. They agreed on the importance of a competitive, robust and transparent process to find the right Chairman for the Trust.

In view of the proposed timeline, Miss Henderson asked for expressions of interest from Governors to take part in the appointment process and stated that involvement in the whole process would be required. She assured Governors that they would be supported throughout and that she would be happy to answer any queries or concerns.

In his role as Senior Independent Director, Mr Ward confirmed he would be supporting the Governors as Chair of the Nominations Committee, as stated in the Terms of Reference, and would report the proceedings of the meetings to the Council of Governors.

The Council of Governors approved the proposal to appoint a recruitment firm to support the Nominations Committee in the appointment process for Chairman and the implementation of a tendering exercise.

4. Any other business

There was no other business and the meeting was closed.

Harrogate and District NHS
NHS Foundation Trust

ANNUAL MEMBERS' MEETING – 2015/16

The Harrogate and District NHS Foundation Trust Annual Members' Meeting held on Tuesday 13 September 2016 at 6:00 pm at the Cedar Court Hotel, Park Parade, Harrogate, HG1 5AH

Present

Governors	
Pamela Allen, Public Governor / Deputy Chair of the Council of Governors	Clare Cressey, Staff Governor
Sally Blackburn, Public Governor	Emma Edgar, Staff Governor
Liz Dean, Public Governor	Dr Daniel Scott, Staff Governor
Tony Doveston, Public Governor	Cllr Bernard Bateman, Stakeholder Governor
Zoe Metcalfe, Public Governor	
Peter Pearson, Public Governor	Cllr Ivor Fox, Stakeholder Governor
Yvonne Campbell, Staff Governor	Joanne Parker, Stakeholder Governor

In attendance	
Sandra Dodson, Chairman	Neil McLean, Non-Executive Director
Dr Ros Tolcher, Chief Executive	Prof Sue Proctor, Non-Executive Director
Jonathan Coulter, Deputy Chief Executive / Finance Director	Chris Thompson, Non-Executive Director
Jill Foster, Chief Nurse	Lesley Webster, Non-Executive Director
Robert Harrison, Chief Operating Officer	Maureen Taylor, Non-Executive Director
Phillip Marshall, Director of Workforce & Organisational Development	Debbie Henderson, Company Secretary
Dr David Scullion, Medical Director	Angie Colvin, Corporate Affairs and Membership Manager

Members in attendance:
Gerald Andrews, Nigel Ayre, Barry Blake, Phillipa Bogle, Erica Cadbury, David Calvert, Linda Calvert, Richard Chillery, Amy Clarke, Cllr Jim Clarke, Kathy Clark, Adele Coulthard, Maggie Cowman, Joanne Crewe, Simon Crossfield, Ertugrul Dalkiran, Cath Doman, Peter Edward Doyle, John Dudley, Richard Eastoe, Dr John Edwards, Matthew Evans, William Forshaw,

Andrew Forsyth, Sue Foster, Joyce Griffith, Adrienne Guthrie, Dave Hall, Joanne Harrison, Alison Hurley, Deborah Jacobs, Sara Keogh, Carmen Lawn, Michael Lawn, Barbara Lyon, Christine Clayton, Rosemary Herbert, Jean Hopper, Victoria Pawlak, Judy Lennon, Rosemary Marsh, John Marshall, Herbert Masterson, Lorraine McDonald, Neil Munro, Jeremy Odle, Lynn Parsons, Anna Pearson, Angelo Phillips, Mrs M Pinder, Lynda Provins, Carol Rand, Emily Reid, John Reid, Joseph Reynolds, Elizabeth Ritchie, Sue Roberts, Lesley Simpson, Paul Simpson, Ann Valerie Smith, David Smith, Elizabeth Margaret Smith, Dr Chunda Sri-Chandana, Ruth Stockdale, Sue Symington, Ian Watling, Dr Chris Watson, Karen Weaver, Richard Webb, Andy Wilkinson, Dr Bruce Willoughby, Rev Dr Mervyn Willshaw and Steve Wright.

1. Welcome and Apologies for absence

The Chairman, Mrs Dodson, welcomed all attendees including Governors, staff, volunteers and partner organisations. She said that the Annual Members' Meeting was always an important opportunity to review what had happened during the year, but noted that the Trust would also be taking the opportunity to 'continue the journey' with members and to look at the future direction of the Trust and the health care system as a whole. Dr Tolcher, Chief Executive, Mr Coulter, Deputy Chief Executive/Finance Director and Ms Allen, Deputy Chair of Governors/Public Governor, would be supporting the meeting.

Mrs Dodson was also pleased to welcome panel members Dr Willoughby, Governing Body Member, Harrogate and Rural District Clinical Commissioning Group (HaRD CCG), and Mr Webb, Corporate Director, Health and Adult Services, North Yorkshire County Council to the meeting.

Apologies for absence had been received from: Andrew Alldred (Clinical Director), Michael Armitage (Public Governor), Cath Clelland (Public Governor), Tony Collins (St. Michael's Hospice), Sarah Crawshaw (Stakeholder Governor), Bridget Fletcher (Airedale NHS Foundation Trust), Dr Claire Hall (Deputy Medical Director), Dr Andy Harris (NHS Leeds South and East CCG), Jane Hedley (Public Governor), Helen Hirst (Vale of York CCG), Alison Hudson (Care Quality Commission), Cllr Andrew Jones MP (Harrogate Borough Council), Cllr Pat Jones (Public Governor), Suzanne Joyner (Darlington Borough Council), Karen Knapton (Care Quality Commission), Philip Lewer (Leeds South and East CCG), Sally Margerison (Staff Governor), Colin Martin (Tees, Esk and Wear Valley NHS Foundation Trust), Jordan McKie (Deputy Finance Director), Sir Robert Ogden, Carole Payne (Durham County Council), David Plews (Deputy Director of Partnerships and Innovation), Janet Probert (Hambleton Richmond and Whitby CCG), Joyce Purkis (Public Governor), Keith Ramsay (Vale of York CCG), Hazel Rhodes (member), Wallace Sampson (Harrogate Borough Council), Dr Matt Shepherd (Consultant in Emergency Medicine / Clinical Lead), Dr Sarah Sherliker (Consultant), Dr Gordon Sinclair (Leeds West CCG), Cllr Julian Smith MP (North Yorkshire County Council), Dr Claire Taylor (Respiratory Consultant), Julie Walton

(Care Quality Commission) Roger Watkins (member) and Dr Jim Woods (Stakeholder Governor).

2. Chairman's welcome, introduction and overview – Mrs Dodson, Chairman.

Mrs Dodson extended a warm welcome to the meeting and noted that Mrs Angie Colvin would be taking photographs throughout the evening to be used as part of promotional material and on the website in future. Any members in attendance who did not wish their photograph to be used were asked to inform Mrs Colvin.

Mrs Dodson reflected on the highlights of the year and noted key successes and landmarks. 2015/16 had been a particularly successful year and the Trust had continued to progress towards achieving its vision to deliver 'excellence every time' underpinned by the Trust's core values of 'responsibility, respectful and passionate'.

Mrs Dodson noted that the Trust values were reflected in the outcome of the Care Quality Commission (CQC) inspection undertaken in February 2016, which had resulted in a 'Good' rating for the Trust overall and a rating of 'Outstanding' for the caring domain, demonstrating the dedication and commitment of staff trust wide in continuing to embrace the values, vision and culture of the Trust. Mrs Dodson referred to the Trust's mission to provide 'excellence every time' and emphasised the commitment of the Trust to strive for 'Outstanding' overall and address the gaps identified in the CQC report, particularly relating to the areas rated as 'requiring improvement' in the safety domain. Dr Tolcher would provide further detail on the report later in the meeting.

Mrs Dodson referred to the significant work during 2015/16 to expand the Trust's footprint into Leeds, Whitby, Scarborough, County Durham, Darlington, Middlesbrough, Yeadon and Wharfdale and took an opportunity to thank the commitment and dedication of the executive team, led by Dr Tolcher, who continued to ensure the local population have local services, a dedicated workforce, and a strong future, in extremely challenging fiscal times. Mrs Dodson also acknowledged the achievement of meeting performance targets, and continually raising the bar on quality, while preparing for an uncertain future.

Mrs Dodson took the opportunity to acknowledge the commitment of the Council of Governors who continued to play a vital role in the governance structure of the Trust. The Governors played an important role in ensuring the Trust delivered its strategic objectives by holding the Chairman and Non-Executive Directors to account for the performance of the Board.

Mrs Dodson thanked the Governors, led by Ms Allen, and acknowledged the contribution of Rev Dr Willshaw for undertaking the role prior to Ms Allen. Mrs Dodson acknowledged the significant work of the Governors in representing the views of their members and to ensure the Board continued to deliver services in the best interests of the local population.

Attendees were reminded of the forthcoming elections to the Council of Governors and were asked to contact Mrs Colvin for further information.

Finally, Mrs Dodson stated that the evening would provide an opportunity to look at one of the key strands of work which would help the Trust deliver high quality services, locally, within a continually challenging financial envelope. Mrs Dodson said that although progress towards fully embedding New Models of Care (NMC) would be challenging, the hard work and dedication of Trust staff, and commitment and leadership of the executive team, would provide the foundations of success. Attendees were thereby asked to join the Trust in its journey to improve, give feedback, and talk about how the system could continue to provide high quality services to local people.

3. Confirmation of Minutes of the Annual Members' Meeting 2014/15

The minutes of the 2014/15 Annual Members' Meeting, held on 3 September 2015, had been presented as draft to the Council of Governors' meeting on 18 May 2016. Mrs Edgar, Staff Governor proposed their acceptance as a true record and Mrs Dean, Public Governor seconded the proposal. There were no objections.

Mrs Dodson reported that the Nominations Committee had met once during the year. Ms Allen would provide a further update on the business of the Nomination Committee later in the meeting.

Mrs Dodson also confirmed that there had been no changes to the Trust's Constitution affecting the role and remit of Governors.

Mrs Dodson then introduced the Deputy Chair of the Council of Governors, Ms Allen, to provide the Council of Governors' overview of the year.

4. Council of Governors' Overview of the Year – Ms Allen, Deputy Chair of Governors

Ms Allen welcomed everyone to the meeting and began by providing an overview of the role of the Council of Governors, which was not to undertake the operational management of the Trust; but to provide a vital link to the wider community, work with the Board of Directors, and collectively hold them to account via the Chairman and Non-Executive Directors for their performance.

Ms Allen briefed attendees on the composition of the Council of Governors and made particular reference to the introduction of a 'Rest of England' position on the Council in response to the Trust's continued growth into the wider communities such as Leeds, County Durham, Darlington and Middlesbrough.

Ms Allen took an opportunity to congratulate newly elected and re-elected Governors Mrs Dean, Mr Doveston, Mrs Metcalfe, Dr Scott, Ms Cressey, and Mrs Campbell following the elections held in December 2015.

In terms of accountability, Ms Allen reaffirmed the responsibility of the Council of Governors to represent the interests of the membership and ensure these views were taken into account within the governance and decision making structure of the Trust. Ms Allen acknowledged the strong, effective and respectful relationship between the Board of Directors, Council of Governors, and members of staff, and emphasised the importance of building and maintaining relationships to ensure the three primary roles of the Council could be fulfilled: seeking assurance; statutory responsibilities; and membership engagement.

Ms Allen provided examples of activity undertaken by the Council of Governors during the year which included: attendance at various statutory and general meetings; Board to Board meetings to work with Directors on key issues; participation in Patient Safety Visits and Quality of Care Teams; attendance at the Patient Voice and Learning from Patient Experience Groups; ensuring the delivery of the membership engagement strategy; supporting the Trust's volunteer service, education liaison and work experience programmes; and contribution to the development of strategic and operational planning.

Examples of how the Council of Governors engaged with their membership and local communities included distribution of the Trust's Foundation News magazine and Chairman's newsletter to all members, invitations to attend Medicine for Members Events, Council of Governor meetings and the Annual Members' Meeting; and Staff Governor meetings with the Chairman and Chief Executive.

The Nomination Committee, a formally constituted sub-committee of the Council of Governors has responsibility for the appointment, re-appointment and removal of the Chairman and Non-Executive Directors (NEDs). Ms Allen confirmed that the Committee met once during the year to recommend the re-appointment of Mrs Dodson for a final year as Chairman, and Professor Proctor for a second term of office. Both recommendations were approved by the Council of Governors.

As part of the Council's responsibility for Chairman and NED appointments, the Council played a significant role in undertaking the annual appraisal process for the Chairman and NEDs. This process supports the Council's responsibility for seeking assurance and provided an opportunity for personal and professional growth for both the NEDs and the Council of Governors.

In terms of looking forward to 2016/17, Ms Allen provided a summary of the work plan and vision for the Council of Governors which included: the establishment of a Youth Forum, to engage with younger members in the community; strengthening the membership engagement strategy; complete the process to appoint an External Auditor; complete the

process to appoint a new Chairman to succeed Mrs Dodson when she stepped down from the role at the end of September 2017.

On behalf of the Council of Governors, Ms Allen took the opportunity to acknowledge and thank the contribution made by the Board of Directors, Dr Tolcher and Mrs Dodson who had continued to truly support and endorse the vision, mission, and values of the Trust.

Finally, Ms Allen noted her gratitude for the support provided to the Council of Governors to enable them to fulfil their role. She acknowledged that although the role required commitment and dedication above and beyond the statutory requirements, the personal benefit of being a Governor had been invaluable in understanding one of the key institutions of the UK.

Mrs Dodson thanked Ms Allen for her presentation and introduced a film, available to watch on 'You Tube' at https://www.youtube.com/watch?v=7HxCtp7Z2Lo outlining the benefits of NHS Foundation Trust membership and being a Governor.

5. 'What matters to you…..continuing the journey' – Dr Tolcher, Chief Executive

Mrs Dodson introduced Dr Tolcher to present the highlights from 2015/16 and a preview of the year ahead.

Dr Tolcher thanked everyone for taking the time to attend the meeting. She reminded attendees of the 2014/15 Annual Members' Meeting at which the importance of listening to the people who rely on the Trust's services was acknowledged, along with the importance of working closely with colleagues from Primary Care, Local Authorities and Commissioners. As a result, the Trust and its partners had taken the journey forward over the last 12 months in the development of New Care Models.

Dr Tolcher referred to another successful year for the Trust in the context of an incredibly challenging picture nationally, and noted that the Annual Members' Meeting would reflect these challenges by welcoming colleagues from the Local Authorities and Commissioners to respond to questions and engage in discussion regarding the developments in New Care Models.

Dr Tolcher reminded attendees that Harrogate and District NHS Foundation Trust (HDFT) was not only a District General Hospital, but also provided community services across County Durham, Darlington and Middlesbrough and North Yorkshire, and noted that HDFT was one of the largest providers of universal Children's Services nationally.

Dr Tolcher referred to the highly publicised state of NHS finances over the last 12 months, and suggestions about the prudency or otherwise of NHS spending. As Accountable Officer, she referred to her responsibility for ensuring that the care provided by the Trust remained

safe, effective, responsive, caring and well-led. In terms of finances and use of resources, Dr Tolcher provided comparative information of the Trust's cost profile, and confirmed that overall, the Trust delivered good value for money and costs per service were typically at, or below, the average. Dr Tolcher emphasised the importance of this in terms of being able to deliver more care from the funds available.

Dr Tolcher reminded everyone of the Trust's vision to 'deliver excellence every time' and the three top level objectives which the Trust committed to achieve over the longer term to: deliver consistently high quality services; work with partners to implement New Care Models; and manage finances prudently and win new business.

In terms of performance during 2015/16, the Trust performed well across all of the NHS constitution national standards in year with 95.6% of patients being seen and treated within 4 hours in the Emergency Department. This Trust also saw a reduction in mortality rates and achieved performance of 97% linked to the safety thermometer to deliver harm free care, as well as a reduction in hospital acquired pressure ulcers and falls causing harm.

Dr Tolcher provided assurance with regard to the continued achievement of the Trust's top strategic priority to drive up quality by sharing a summary of the outcome of the CQC inspection undertaken in February 2016. The inspection focused on five key domains: safe; effective; caring; responsive; and well-led. Dr Tolcher confirmed that the Trust received an overall rating of 'Good' and four areas received 'Outstanding' ratings: community health services for adults; community health dental services; outpatients and diagnostic imaging; and critical care. The Trust also received an 'Outstanding' rating for the caring domain overall.

Dr Tolcher noted that the Trust received a 'Requires Improvement' rating for the safety domain overall, and reassured attendees that although this did not reflect unsafe practice, the issues highlighted for improvement were known to the Trust, and steps had been taken to address the issues highlighted in the report.

In terms of comparison, Dr Tolcher stated that only 30% of NHS Trusts and NHS Foundation Trusts in the country had received a 'Good' or 'Outstanding' rating.

Dr Tolcher referred to other successes reported during the year including: the visit by His Royal Highness Prince Charles and Camilla, Duchess of Cornwall to the Sir Robert Ogden MacMillan Centre; the purchase of a mobile MRI scanner to enable diagnostic testing to be more accessible; the Food for Life Bronze Award from the Soil Association for using locally sourced ingredients resulting in reduced costs and healthier options for patients, the public and staff; and the new mural and refurbishment undertaken at the Child Development Centre in Northallerton.

Finally, Dr Tolcher reminded attendees of the Annual Members' Meeting theme for 2014/15 and the feedback given on 'what matters most' and the Trust's plans to transform health care to enable care to be delivered closer to home and support people in their homes. The aim of the work was to remove the reliance on hospital beds and to ensure more people stay healthier and independent for longer, with choice and control over their lives whilst reducing costs across the system to ensure sustainable care in the future.

Rather than presenting a detailed update via PowerPoint, Dr Tolcher introduced a film of patients and staff telling their stories and experiences of receiving treatment, or delivering care, under the New Care Model to integrate and improve care, piloted in Knaresborough, Boroughbridge and Green Hammerton

Panel Discussion

Mrs Dodson thanked Dr Tolcher for her detailed presentation and for the emotive and moving film. Mrs Dodson acknowledged how powerful it had been to listen to the patients and staff, and moved to an opportunity for attendees to engage further by considering via interactive table discussions the following two questions:

- How confident are you that care can be delivered safely and successfully closer to home?
- Do you believe that encouraging and supporting people to take control of their health and wellbeing is an important element of our New Care Model?

Following the interactive table discussion, Mrs Dodson introduced the Question and Answer Panel comprising of Mrs Dodson, Dr Tolcher, Dr Willoughby and Mr Webb.

A member asked how much the New Care Model cost and how many people had benefited from its introduction over the last 12 months

Dr Tolcher provided an overview of the New Care Model, also known as the 'Vanguard Programme' whose membership comprised of HDFT, Local Authorities and other healthcare providers, including GPs, and commissioners. National funding had been available to pump prime the concept initially, with funding being invested in new posts, leadership development, organisational development, and information technology. The initial funding allowed the team to test if the new model would work. There was a circa £3.5m extra non-recurrent funding for the New Care Model this year,, as well as the existing contract of £11.5m for all community services. Dr Tolcher confirmed that the non-recurrent funding from 2015/16 would not be available in 2017/18.

Dr Willoughby referred to the multi-disciplinary approach to care under the new model, referenced in the patient and staff film shown earlier in the meeting. Multi-disciplinary meetings took place on a weekly basis to discuss the care and treatment of between 10 and

30 patients per week. The current case load of the Community Care Teams was approximately 600 patients.

A member asked how funding would be provided to sustain the New Care Model in the future.

Mr Webb acknowledged the significant challenge faced by the partners to secure funding to continue to develop the service over the longer term. He emphasised the importance of a pilot approach to enable areas of priority to be identified, and introduce change, and associated funding requirements in a step by step way.

A member referred to the film, and asked if consideration had been given to the levels of social isolation prevalent in the country at the moment.

Dr Willoughby agreed that it was important that the New Care Model's work didn't only involve multi-disciplinary teams linked to Primary Care, but also recognised other agencies, such as Social Care which supported programmes linked to health prevention and social isolation. It was also important to recognise the funding requirements needed to support these programmes i.e., supporting communities to help people overcome isolation and loneliness, and making steps to connect people in their communities. It was also acknowledged that loneliness was in the eye of the beholder and was very different for everyone. The NHS investment in social prescribing would be fundamental to support people to regain their confidence.

Mrs Edgar asked members of the Panel 'what keeps you awake at night about the programme'.

Dr Willoughby suggested that time pressures to deliver the programme and NHS financial pressures were his concern, and the ability to balance these pressures with ensuring successful delivery in the longer term.

Dr Tolcher stated that truly excellent healthcare could only be delivered through a truly excellent workforce, and her concern would be sustainability of the current workforce who provided excellent care by going above and beyond for the services every day. She emphasised the importance of doing everything possible to protect and support the workforce.

Mr Webb also noted the challenges in the UK relating to a need for a sustainable care market including residential and nursing homes.

Mrs Dodson thanked the Panel members for their time, and the attendees for their insightful questions. Mrs Dodson also acknowledged the time pressures of meetings and confirmed

that members of the Panel would be available at the end of the meeting should anyone have any further questions.

6. Harrogate and District NHS Foundation Trust Annual Report and Accounts 2015/16 – Mr Coulter, Deputy Chief Executive and Finance Director

Mr Coulter thanked everyone for attending the meeting and noted that copies of the Annual Report and Accounts for 2015/16 had been made available to all members attending, and were also available on the Trust's website at https://www.hdft.nhs.uk/about/trust/statutory-info/.

Mr Coulter provided an overview of the Trust's financial performance during 2015/16 and reminded attendees of the Board's responsibility to manage Trust resources effectively. Mr Coulter confirmed that the Trust achieved a break-even position at 31 March 2016, despite the Trust's plan to achieve a modest operating surplus. The Trust had a cash balance of £5.5m at 31 March 2016, £2.2m behind plan, and achieved a Financial Sustainability Risk Rating of 3 at the end of 2015/16. Financial risk is assessed on a scale of 1 (high risk) to 4 (low risk).

Mr Coulter confirmed that the Trust invested £11.9m during 2015/16 as part of the Trust's capital programme, and referred to the significant schemes including the carbon energy scheme, mobile MRI scanner and schemes involving equipment replacement, IT replacement and environmental improvements.

Mr Coulter confirmed KPMG's, the Trust's External Auditor's, unqualified opinion on the Trust's accounts, detailed in their independent opinion to the Council of Governors which confirmed that the financial statements gave a true and fair view of the state of the Trust's affairs as at 31 March 2016, and they had been satisfied that the Annual Report was consistent with the detailed financial accounts.

With regard to Charitable Funds, Mr Coulter confirmed that the Board of Directors also act as Corporate Trustees for the Trust' charity, Harrogate Hospital and Community Charity. The Charity had a total value of £1.76m thanks to the generous donations received from the local community. Mr Coulter confirmed that KPMG had audited the charity accounts which had received a clean opinion.

One of the requirements of the Trust's Annual Report was the inclusion of a Quality Account, which was a report on the quality of services provided by the Trust and an overview of progress toward achieving the quality priorities set by the Board and the Trust's stakeholders at the beginning of each year. Mr Coulter encouraged everyone to read the Quality Account which also included actions to be undertaken to improve services further. The Trust's External Auditors were also required to provide external assurance on the production of the

Quality Account and confirmed a clean (limited assurance) opinion on the content of the Trust's Quality Account.

In terms of final thoughts, Mr Coulter reiterated that due to the significant fiscal challenges within the NHS, the Trust continued to be mindful of avoiding complacency, despite the 2015/16 performance demonstrating efficiency and value for money. Mr Coulter encouraged everyone to continue to support and value the NHS both nationally and locally, and ensure a consistent focus on sustainability and affiliation between the public, members of staff and the NHS as a whole.

A member referred to historical financial challenges in the public sector and the tendency for training needs and routine maintenance to be overlooked. At a recent meeting, a discussion took place on lack of funding available relating to maintenance services i.e., replacement chairs etc., and the member requested assurance regarding the allocation of financial support in regard to maintenance issues.

Mr Coulter confirmed that the use of Charitable Funds was for the benefit of the Trust, therefore the spending of donations, unless donated for a particular service, could be determined by the Corporate Trustees. In terms of assurance regarding the use of Charitable Funds for routine maintenance, Mr Coulter confirmed that the Carbon Energy Fund Scheme delivered savings of approximately £150k which were re-invested in estates staffing. With regard to chairs, a rolling programme of chair replacement was in place. In summary, Mr Coulter acknowledged that although financial prudence was required, the Trust recognised the importance of, and the need to invest in, routine maintenance.

Councillor Ivor Fox asked if the £9m loan was fixed and if so, for how long.

Mr Coulter confirmed that the £9m was one of four loans which varied in terms of lifetime, but provided assurance that prior to the approval of any business case to enter into a loan agreement; the Board would require assurance in terms of the benefits, including the lifetime of the loan.

A member asked do Junior Doctors get paid when undertaking industrial action.

Mrs Dodson confirmed that Junior Doctors do not get paid when undertaking industrial action.

Dr Tolcher took an opportunity to feedback following the interactive discussions and consideration of the two questions referred to earlier in the meeting. In response to the question *'do you believe that encouraging and supporting people to take control of their health and wellbeing is an important element of our New Care Model?'*, Dr Tolcher fed back a resounding 'yes'. Additional comments included: the importance of taking responsibility for a holistic approach; ensuring the information would be accessible; and ensuring every contact counts to educate people around prevention and self-care.

With regard to the question *'how confident are you that care can be delivered safely and successfully closer to home?'*, Dr Tolcher fed back a range of responses particularly relating to: a need to provide assurance on the safety of the new model; longevity of arrangements; financial challenges to sustaining the model; accessibility for people living outside of the Harrogate area; ensuring the right skills, competencies and supervision are in place to deliver care in the right way; ensuring the right number of beds; and ensuring the right equipment would be in place.

Dr Tolcher thanked members for their lively and enthusiastic participation and engagement. She particularly thanked everyone for giving up their time to attend and providing valuable feedback, which would be incorporated into future planning for New Care Models.

7. Listening to your feedback – 'the journey continues…..'

Mrs Dodson thanked the Governors, members of the public, volunteers, commissioning colleagues and Local Authority colleagues and members of the Board for attending and engaging on all issues, particularly the discussion on New Care Models, and the dedication to driving care forward in the fiscally challenged world.

Mrs Dodson closed the meeting at 8.05pm.

Harrogate and District NHS
NHS Foundation Trust

HDFT Council of Governor Meeting Actions Schedule – February 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	18 May 2016	Circulate salary benchmarking information provided to Remuneration Committee to all Governors for information	Mr Jonathan Coulter, Deputy Chief Executive/Director of Finance		Complete
2	3 August 2016	Calendar of meetings - 2017	Mrs Angie Colvin, Corporate Affairs		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	29 July 2015	Update on progress of Nutritional Assistants	Mrs Jill Foster, Chief Nurse	Further update required 18 February 2017	Update provided 18 May 2016 Update provided 2 November 2016
2	2 November 2016	Update on the Global Health Exchange Programme	Mr Phillip Marshall, Director of Workforce and Organisational Development	Update due 18 February 2017	
3	2 November 2016	Seating arrangements to be made available	Mr Rob Harrison, Chief Operating Officer	Update due 18 February 2017	
4	2 November 2016	Signage for telephone near emergency maternity entrance to Harrogate District Hospital	Mr Rob Harrison, Chief Operating Officer	Update due 18 February 2017	
5	2 November 2016	Volunteers assisting patients with mobility difficulties entering the hospital near emergency maternity entrance	Mrs Sandra Dodson, Chairman	Update due 18 February 2017	
6	2 November 2016	Thanks to Dr Leigh for presentation at Medicine for Members' Event	Mrs Sandra Dodson, Chairman	Update due 18 February 2017	

Harrogate and District NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS
DECLARATION OF INTERESTS

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

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

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

Name	Governor Status	Interests Declared	
Mrs Cath Clelland MBE	Public elected	**Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).**	Canny Consultants Ltd, Director and part owner York St John University Board of Governors
Dr Sarah Crawshaw	Stakeholder	**Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks**	National Institute for Health Research Clinical Research Network (NIHR CRN)
Ms Clare Cressey	Staff elected		NONE
Mrs Liz Dean	Public elected		NONE
Mr Tony Doveston	Public elected	**A position of Authority in a charity or voluntary organisation in the field of health and social care**	Volunteer for Yorkshire Air Ambulance
Miss Sue Eddleston	Public elected		NONE
Mrs Emma Edgar	Staff elected		NONE
Mrs Beth Finch	Stakeholder	**A position of Authority in a charity or voluntary organisation in the field of health and social care** **Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services**	Operational Senior Service Manager, British Red Cross Independent living (Yorkshire Area) Operational Senior Service Manager, British Red Cross Independent Living (Yorkshire Area)
Mrs Jane Hedley	Public elected		NONE
Mrs Ann Hill	Public elected	**Other**	Chair of Harrogate District over Fifties Forum (HDOFF) Harrogate representative on North Yorkshire Forum for Older People (NYFOP)

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

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

Report to the Trust Council of Governors: 18 February 2017

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

This report summarises the items discussed at the last meeting of the Governor Working Group for Volunteering and Education, held on 17 January 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 six volunteers at Ripon from the Grammar School who are volunteering in Trinity Ward, Ripon Community Hospital. They are reading, painting, knitting and playing the piano.

Volunteering

We have 511 active volunteers; of these 335 are over 25 years of age and 92 under 25 years of age. Volunteers carried out a travel survey which gave a snapshot of travel arrangements for staff, patients and visitors on 26 October 2016. On average, our volunteers contribute 2,000 hours per month to the Trust.

Eight new mealtime volunteers have been trained; 73 volunteers have had induction; of these 70 were 6th form students who commenced their roles on the wards in January.

New Volunteer Opportunities: mealtime volunteers have started in Lascelles Unit; also new volunteers are working on Pannal ward, the Discharge Lounge, the eye clinic, and the ante-natal clinic.

Six 6th form students from Ripon Grammar School are registered volunteers and have started volunteering on Trinity Ward, Ripon Community Hospital.

The Annual Celebration of Volunteering took place on 16 December 2016, when the theme was "Volunteering Saves Lives". Two speakers told of life-saving episodes and the audience were encouraged to sign the Donor register.

At the staff Christmas Oscars, Volunteer of the year was won by Gillian Crowther who helps in the Orthopaedic clinic.

Work Experience

The Work Experience team have received 19 medical, 18 clinical and six non-clinical requests. Risk assessments are now carried out by the team and a booklet has been produced for all students with information such as advice on what to wear for work, a quiz, and a map of the hospital.

In seeking feedback, the team received a 'Case Study' from a work experience student from Nidderdale High School and Community College and this was presented at the meeting.

Education Liaison

Fifty students attended the 'Preparing for Medical School' talk. Twenty-five students attended the mock interviews, and 20 students attended the Nursing mock interviews. These were all rated very useful in the feedback. Many staff took part and we are grateful to them for their helpful input to these events.

A 'Living Library' session was held for 48 students at Harrogate Grammar School with several staff, resulting in intentions to pursue medical careers and work experience applications.

A group from Boroughbridge High School visited Woodlands Ward, Sterile Services and the Chapel.

A magnificent new stand has been obtained for use at careers fairs to promote careers, education and work experience opportunities, membership, and to signpost to the Trust's website and social media.

Harrogate and District NHS
NHS Foundation Trust

Report to the Council of Governors, 18 February 2017	**Paper No: 6.4**
Title	Patient Safety Visit Annual Report
Sponsoring Director	Jill Foster, Chief Nurse
Author(s)	Michael England, Governance & Emergency Planning Officer and Dr Sylvia Wood, Deputy Director of Governance
Report Purpose	To provide information and assurance regarding the Patient Safety Visit programme

Patient Safety Visits: Annual Report January 2016 – December 2016

Background

Patient Safety Visits were introduced at Harrogate and District NHS Foundation Trust (HDFT) in 2009. Since then 146 patient safety visits have taken place to wards and departments across the Trust. This includes all inpatient wards, 23 community areas, and 29 departments.

This report summarises the patient safety visits undertaken since the last annual report to Board of Directors in January 2016. It provides examples of issues raised and resolved since previous visits and includes detail from the patient safety visit database of issues identified as high priority to provide assurance of action taken. It contains the reviewed and updated standard operating procedure for patient safety visits for ratification.

It should be noted that in November 2016 the Board asked for a review of the format and value of patient safety visits.

1. Patient Safety Visits 2016

At the beginning of 2016, the Clinical Directorates and Corporate Services were asked to identify services to prioritise for a visit.

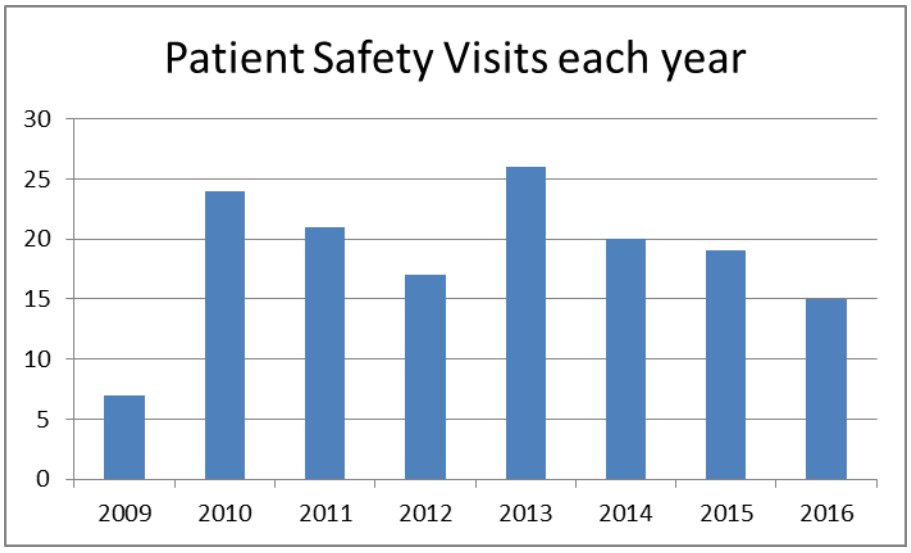
At the same time potential dates for visits were identified in Executive and Non-Executive Director's diaries. As always, more dates were identified in diaries than we expected to need in order to have some spare options as some dates are not convenient for the areas to visit. The Governance Officer contacts the lead for each service and attempts to match an available date for a visit, with days and times that are convenient for the service.

Since January 2016, when patient safety visits were last reported to the Board of Directors, there have been visits to 15 services; five of these have been new visits and ten re-visits. The log of all visits undertaken is at Appendix 1.

It is worth noting that as a result of preparation for the Care Quality Commission (CQC) inspection there were lots of senior management led visits to wards and departments, and no patient safety visits were arranged between January and March 2016.

During the visit when staff raise operational issues as a concern, they are encouraged to use existing departmental and directorate structures and processes. Where issues cannot be easily remedied, such as those that may require large capital expenditure it is important that these are progressed via other established structures and processes e.g. business planning and risk registers. There are a small number of concerns raised that are appropriate to follow up as a matter of some urgency outside these established methods. These are identified at the time by the Executive lead for the visit and recorded on the patient safety visit action log as high priority.

During 2016, reports have been received at Senior Management Team and key findings from patient safety visits have been highlighted and discussed.



Year	Number of Visits
2009	7
2010	24
2011	21
2012	17
2013	26
2014	20
2015	19
2016	15

The services that have been visited for the first time during the period are:

- The Equipment Library
- Scarborough Wheelchair Service
- Orthopaedic Outpatients
- Sewing Room
- Stanley Education Centre

The services that have had a re-visit during the period are:

- Clinical Assessment, Triage and Treatment (CATT)
- Kingswood Dental Practice
- Wensleydale Ward
- Maternity Services
- Lascelles Rehabilitation Unit
- Intensive Therapy Unit/High Dependency Unit (ITU/HDU)
- Radiology
- Ripon Community Hospital
- Woodlands Ward
- Jervaulx/Byland Ward

Visits that were not arranged or undertaken

The following services were identified as locations for a patient safety visit, but a visit was either not arranged or not undertaken in the period:

Farndale Ward

Due to last minute staff absences on the ward (including Ward Manager and Sister) a patient safety visit was cancelled at short notice on 6 May. This was discussed at the time with the Matron responsible for the area and ITU/HDU was identified as an alternative location for the patient safety visit. A visit to Farndale Ward will be rearranged in 2017.

Acute Medical Unit (AMU)

The day before the arranged patient safety visit to AMU on 8 November it became clear that the Ward Manager would be absent and the ward team were not aware of the planned visit. Staffing levels meant this could not proceed and an alternative location could not be offered. However the Matron suggested that a patient safety visit to CATT would be more beneficial and a visit was arranged and undertaken on 6th December.

Antenatal Clinic

A visit has been arranged for 6 January 2017.

GP Out Of Hours (OOH)
There continue to be issues with arranging a suitable visiting time out of hours.

Community Children's Services
Service managers suggested patient safety visits to the new Community Children's Services in Middlesbrough, Darlington and County Durham once they had been incorporated into the Trust. A visit took place to the County Durham Community Children's Service at Stanley Education Centre on 25 October 2016 and visits to the remaining services will be arranged in due course.

Concern had been raised by the Non-Executive Directors and Governors about patient safety visits being cancelled at short notice; it can be seen below that this is not a consistent issue.

	2015	2016
Potential dates identified	29	23
Dates not utilised and therefore removed from diaries	6	7
Patient safety visits arranged and confirmed	23	16
Number of arranged visits cancelled	4	1
Number of visits undertaken	19	15

2. Patient Safety Visiting Team

An Executive Director usually leads a patient safety visit with the Deputy Director of Governance and a Non-Executive Director. Members of the Council of Governors are also invited to take part in patient safety visits.

Non-Executive Director		Executive director		Governors	
Sandra Dodson	2	Ros Tolcher	2	Claire Cressey	2
Ian Ward	3	David Scullion	2	Beth Finch	2
Sue Proctor	2	Jonathan Coulter	5	Bernard Bateman	1
Lesley Webster	2	Jill Foster	3	Joyce Purkis	1
Chris Thompson	2	Phillip Marshall	2	Jane Hedley	1
Maureen Taylor	2	Rob Harrison	1	Daniel Scott	1
Neil Mclean	2				
Total	15		15		8

3. Information for the visiting team

Prior to a number of visits in 2016 the Governance Officer produced a summary sheet for the visiting team to provide an overview of patient safety information including staffing levels, staff turnover, recent incidents and complaints, any serious incidents requring investigation (SIRIs), and patient experience feedback. It was hoped that these summaries would promote focused lines of enquiry and discussions during the visit. However this involved a considerable amount of time to produce and was often not used. It was felt to add limited value to the outcome of of the patient safety visit and was therefore discontinued.

4. The value of patient safety visits

Patient safety visits have a unique purpose and value in encouraging a positive safety culture. They encourage staff to raise any concerns in a forum which is supportive, building good communication and establishing local solutions to minimise risk whenever possible.

Sometimes when wards and services are very busy, staff are only able to participate for a short time, but in general the informal feedback that we receive from staff who attend patient safety visits is that they value the opportunity to meet senior leaders and raise concerns with them.

The most useful visits are those where staff are clear about the purpose of the visit and have had an opportunity to think about issues they might want to highlight. It is disappointing that despite the effort that goes into the arrangements, staff are sometimes unprepared and not expecting the visit when we contact them to confirm in the days before the visit.

5. Sample of issues raised at patient safety visits

A small sample of issues recorded from patient safety visits during 2016 has been included to illustrate some of the findings.

5.1. Good practice

Team Working

A number of areas reported good team working. These include Radiology, Lascelles, Scarborough Wheelchair and Podiatry Services, Linen/Sewing Room and Wensleydale Ward. Anecdotally, in a number of areas experiencing high operational pressures, nursing staff said that it was working with their colleagues that meant they continued to turn up to work.

Patient Focused Innovation Projects

These include SITUP (Supporting Intensive Treatment Unit Patients) clinics for patients discharged from ITU; Wanderguard devices trialled on Lascelles; Reminiscence Sessions on Jervaulx and Byland for elderly patients; Acclimatisation Programme for patients visiting Kingswood Dental Service.

5.2. Themes and ongoing issues

Staffing

A number of areas reported issues relating to staffing pressures including: national shortage of radiographers for Magnetic Resonance Imaging (MRI); low morale amongst teams such as ITU who are often redeployed to cover staffing gaps in other areas; pressures on the nurse-in-charge responsible for junior nursing staff and having to fill nursing gaps themselves in order to deliver safe care to patients; concerns regarding nurse to patient ratios on night shifts particularly due to an increase in acuity of patients in Byland Ward; transferring patients in ‘bulk’ rather than staggering the flow during de/escalation puts teams under unnecessary pressure; the impact of an increased turnover of staff is felt in other supporting services such as the Linen/Sewing Room; difficulties in releasing staff in order that they can undertake mandatory and essential skills training; student nurses and new starters who are supposed to be super-numerary are often relied on as part of the ward establishment; teams feeling that they are struggling to deliver fundamental aspects of care due to staff shortages.

Environment and equipment issues
A number of areas continued to report issues associated with equipment maintenance and within an unsuitable environment. Issues were reported in Lascelles, Ripon Community Hospital, Orthopaedic Outpatients, Jervaulx & Byland Ward, Woodlands Ward and CATT ward. Issues include: delays in maintenance and repair from time of reporting; shortage of equipment; unsuitable and ageing environments; under-utilised space that is no longer fit for purpose. It is hoped that following the reconfiguration of the estates workforce during 2016/17 that this will address a number of these recurrent issues.

Patientrack
There were some recurrent themes regarding Patientrack including the reliability and timely repair of equipment, connectivity issues and usability. A number of areas including Jervaulx and Wensleydale wards had specifically reported difficulties using the fluid balance module, opting to use paper based charts instead. However it was also recognised that Patientrack had made the recording of routine observations easier.

5.3. Issues noted as resolved since previous visit

Medical Cover at Lascelles
The team reported that since the development of a proper protocol for medical cover, the issues relating to getting an appropriate on call medical response to acute requests for review of a patient had been resolved.

Fluid and food thickening on Jervaulx/Byland
Following a patient safety alert relating to the risk associated with thickening powder both wards had undertaken risk assessments and had addressed the risk using different approaches.

Volunteers
Jervaulx ward had gained volunteers to assist with patient feeding at lunch time. To encourage young volunteers to continue supporting the ward for a longer period the clinicians were providing incentives such as being offered the opportunity to observe care of the elderly ward rounds.

Maternity Unit
Carpet replaced with flooring during refurbishment. Staff reported more monitoring equipment available now and cardiotocography (CTG) monitors were appropriately labelled. Admin support was much improved with a full time ward clerk. The team were being proactive about replacing staff with eight recently recruited midwives at the time of the visit.

5.4. High priority issues

Following a patient safety visit there is usually a quick debrief between members of the visiting team in order to identify any high priority actions. Over the past year, whilst there have been a number of actions that have been followed up promptly, there have been a limited number of actions considered “high priority”.

Mental Health facilities on Woodlands Ward
Whilst work was underway to create a “ligature free” side room, Dr Tolcher felt that it would be appropriate for a full mental health review of the ward based on the foreseeable needs of young people admitted. Following feedback from the directorate and department it is understood that this action has been incorporated into the CQC action plan which is being overseen by the Operational Director for Children’s & County Wide Community Care.

6. Future Planning

The Standard Operating Procedure has been reviewed and updated and approved at Senior Management Team on 18 January 2017. Essentially we are proposing that the process continues without significant changes.

The Clinical Directorates have been asked to identify four - five sites/wards/departments each for visits in 2017 with a particular focus on those services that might not have been visited before or they feel might benefit from a visit. Corporate services have also been asked to consider any areas that may benefit from a patient safety visit. Visits may also be requested during the year and this will be accommodated if possible.

We will continue to ask ward and service managers to communicate effectively within the local team in order that staff are aware of a planned patient safety visit and its purpose, and can participate.

The Board of Directors at their meeting on 25 January 2017 gave their commitment to the continued focus on Patient Safety Visits.

7. Summary

Patient safety visits continue to provide valuable opportunities to:

a. Increase the awareness of safety issues among all staff.
b. Make safety a priority for senior leaders by spending dedicated time promoting a safety culture.
c. Educate staff about patient safety concepts such as incident reporting.
d. Obtain and act on information that identifies areas for improvement.
e. Build communication and relationships with frontline staff to work together to deliver safe care.

Appendix 1: Patient safety visits undertaken by location and date

Site	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5
Jervaulx	11/01/2010	12/08/2011	11/09/2013	11/03/2015	13/07/2016
Byland	16/11/2009	08/06/2011	23/10/2013	11/03/2015	13/07/2016
Woodlands/Special Care Baby Unit (SCBU)	11/03/2010	29/11/2011	08/11/2013	08/04/2015	27/09/2016
Ripon Community Hospital	30/06/2011	21/03/2013	28/08/2013	09/05/2014	14/06/2016
Endoscopy	18/11/2010	05/03/2013	24/10/2013	23/04/2015	
Emergency Department (ED)	25/10/2010	17/11/2011	30/10/2013	13/08/2015	
Main Theatre	07/05/2010	03/07/2012	12/09/2013	03/09/2015	
Fountains/Bolton/AMU/Clinical Assessment Team (CAT)	15/04/2010	02/11/2011	04/10/2013	09/09/2015	
Littondale	03/11/2009	02/06/2011	16/10/2013	07/10/2015	
Nidderdale	01/02/2010	13/10/2011	10/10/2013	01/12/2015	
Radiology	20/05/2010	25/07/2011	12/03/2014	13/04/2016	
Critical care (ITU/HDU)	12/11/2009	27/06/2011	11/06/2014	06/05/2016	
Lascelles	01/03/2009	07/07/2011	11/10/2013	12/05/2016	
Maternity (Pannal)	09/03/2010	01/05/2012	03/10/2013	02/08/2016	
Wensleydale	08/02/2010	05/07/2011	14/08/2013	25/11/2016	
Oakdale	05/03/2010	04/10/2012	21/08/2013		
Granby	07/12/2009	21/11/2011	18/09/2013		
Harlow	25/01/2010	11/05/2012	11/02/2014		
Outpatients	06/08/2010	22/11/2012	26/09/2014		
Pharmacy	09/12/2010	25/10/2012	19/11/2014		
Pre-operative Assessment and Admissions Unit (PAAU)	24/09/2010	10/08/2012	31/03/2015		
Therapy Services	14/06/2010	13/07/2012	05/05/2015		
Day Theatre	03/06/2010	01/08/2011	25/09/2015		
Phlebotomy	28/09/2009	12/03/2013	13/11/2015		
Haematology/Transfusion	23/08/2010	06/10/2011			
Clinical Sterile Services Department (CSSD)	30/09/2010	31/10/2011			
Swaledale	21/12/2009	14/11/2011			
Hotel Services	16/12/2010	14/09/2012			
Elmwood	19/07/2010	14/11/2012			
Biochemistry	29/11/2010	21/01/2013			
Heart Centre	20/10/2011	23/01/2013			
Pathology	10/12/2010	30/01/2013			
Critical Care Outreach	07/12/2010	13/02/2013			
Site Co-ordinators	28/11/2011	07/03/2013			
Selby Minor Injuries Unit (MIU)	02/08/2012	05/09/2013			
Scarborough Podiatry	04/09/2012	01/04/2015			
Ripon Rapid Response Team (RRT)	31/07/2012	05/11/2015			
Kingswood Dental Surgery	14/05/2014	27/09/2016			
Askham Grange	08/12/2011				
Northallerton Prison	12/12/2011				
Monkgate Dentistry	03/05/2012				

Speech and Language Therapy (SALT) – Northallerton	07/08/2012				
Iles lane Virtual Ward Team (VWT)	06/09/2012				
Knaresborough Health Visiting	09/11/2012				
Boroughbridge Virtual Ward Team (VWT)	29/01/2013				
Farndale	23/08/2013				
HDH Catering Services	06/03/2014				
Hornbeam – Harrogate Community Nursing Team	03/04/2014				
Ripon Community Nursing Team	29/04/2014				
Selby/York GPOOH	29/05/2014				
Selby Health Visiting (HV) Team	10/07/2014				
Scarborough – Children's Services and Sexual Health	25/07/2014				
Blood Sciences Lab	13/08/2014				
Sir Robert Ogden Macmillan Centre (SROMC)	11/09/2014				
Portering Services	05/11/2014				
General Office	28/11/2014				
Selby/York Podiatry	03/12/2014				
Easingwold – Specialist Children's Service	18/12/2014				
York Wheelchair Services	30/04/2015				
Domestic Services	07/05/2015				
Ophthalmology	09/06/2015				
Medical Day Unit	24/11/2015				
Skipton Podiatry	17/12/2015				
The Equipment Library	08/06/2016				
Scarborough Wheelchair Service	28/06/2016				
Orthopaedic Outpatient's	01/07/2016				
Sewing Room	27/09/2016				
Stanley Education Centre	25/10/2016				
AMU	08/11/2016				
CATT	06/12/2016				
Key	Visits undertaken since last report to Board (Jan 2016)				
	Visits arranged but cancelled				
	Visits not arranged				

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Harrogate and District NHS
NHS Foundation Trust

Report to the Council of Governors' Meeting

18 February 2017

Report Title:	**Report from Council of Governors' Nominations Committee**
Report From:	**Council of Governors' Nomination Committee**
Report Purpose:	**To consider and approve the recommendations contained within the report**

1. Background

The Nominations Committee met on 27 January 2017 to discuss the reappointment of Mr Chris Thompson to a second term of office.

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 the Chairman and Non-Executive Directors. A Nominations Committee makes a recommendation to the full Council for discussion and approval.

The following reports are attached as follows:

Appendix 1 Minutes of the meeting, 27 January 2017.

Appendix 2 Recommendation to re-appoint Mr Chris Thompson to a second term of office as Non-Executive Director from 1 March 2017 – 29 February 2020.

2. Recommendation of the Nominations Committee to the Council of Governors

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

- The recommendation to re-appoint Mr Chris Thompson for a second term, from 1 March 2017.
- The minutes of the meeting held 27 January 2017.

Appendix 1

Harrogate and District NHS
NHS Foundation Trust

Minutes of the Nominations Committee held on Friday, 27 January 2017 in the Boardroom Trust HQ, 3rd Floor, Harrogate District Hospital

Present Members:
Mrs Sandra Dodson, Chairman (via telephone)
Ms Pamela Allen, Public Governor/Deputy Chair of Governors
Cllr Bernard Bateman, Stakeholder Governor
Ms Clare Cressey, Staff Governor
Mr Tony Doveston, Public Governor
Miss Sue Eddleston, Public Governor
Mrs Emma Edgar, Staff Governor
Mrs Pat Jones, Public Governor
Mrs Sally Margerison, Staff Governor
Mrs Zoe Metcalfe, Public Governor
Mr Peter Pearson, Public Governor
Dr Daniel Scott, Staff Governor
Mr Ian Ward, Non-Executive Director/Senior Independent Director

Ex Officio:
Mrs Colvin, Corporate Affairs and Membership Manager
Mr Andrew Forsyth, Compliance and Revalidation Manager
Mr Phillip Marshall, Director of Workforce and Organisational Development
Dr Ros Tolcher, Chief Executive

1. Apologies for absence

Apologies were received from Mrs Liz Dean, Public Governor and Mr Steve Treece, Public Governor; both Governors wished to be on the Nominations Committee but had prior commitments and were unable to attend the meeting today.

Mr Ward welcomed everyone to the meeting and introduced Miss Eddleston, newly elected Public Governor to the Nominations Committee.

Mrs Dodson joined the meeting on the telephone and took over as chair at this stage in the meeting.

2. Minutes of the previous meeting held on 21 November 2016

The minutes of the previous meeting had been circulated for information; these had already been approved at the Extra-ordinary Council of Governor meeting on 30 November 2016.

3. To propose the re-appointment of Mr Christopher Thompson to a second term of office

Mrs Dodson referred to her paper which had been circulated prior to the meeting and taken as read.

Mr Thompson had expressed his wish to continue to a second term of office and Mrs Dodson confirmed it was the role of the Nominations Committee to propose the recommendation to the Council of Governors to reappoint Mr Thompson as Non-Executive Director for a further term of office from 1 March 2017 until 29 February 2020.

Mrs Dodson commented on Mr Thompson's competency in his role as Non-Executive Director. She highlighted Mr Thompson's personal attributes and contribution to the Board including his role as Chair of the Audit Committee.

Ms Allen confirmed she and Mrs Dodson had met with Mr Thompson on 10 June 2016 to conduct an annual review and to set his objectives for the coming year. She fully endorsed Mrs Dodson's comments commending Mr Thompson's competency, enthusiasm, and commitment to his role.

Mrs Dodson therefore recommended to the Nominations Committee that Mr Thompson be reappointed for a second term, subject to the approval of the Council of Governors on 18 February 2017.

The Nominations Committee was unanimously in favour of Mrs Dodson's recommendation.

Mrs Dodson left the meeting after this item on the agenda and Mr Ward took over as Chair supported by Ms Allen.

4. To consider the draft Job Description and Person Specification for the Chairman

Mr Ward confirmed the draft Job Description and Person Specification had been updated to reflect the current strategic direction of the Trust and relationships with other senior members in the health and social care system.

Mr Marshall added that the draft Job Description and Person Specification had been brought up to date in line with NHS Providers Code of Good Governance best practice template. He stated that Mrs Dodson had added additional comments regarding the West Yorkshire & Harrogate STP at section 'Responsibilities', item 8. He confirmed that general advice from the Executive search organisations had been incorporated, including about job descriptions and, in particular, the importance of the essential criteria listed on the person specification.

The draft Job Description and Person Specification was discussed and agreed, subject to some minor grammatical and typographical changes.

5. To consider a recommendation for the appointment of the executive search organisation

Mr Ward invited Mr Forsyth to summarise the process to date. Following the decision of the Council of Governors on 30 November, a tendering exercise had been held to select an Executive search organisation. Seven organisations had been invited to tender and six submitted proposals. Following consideration against an agreed set of criteria, four of these were shortlisted and invited to make presentations to an interview panel drawn from the Nominations Committee. One of these four had subsequently dropped out.

An interview panel of Governors, supported by Mr Marshall and Mr Forsyth had met on the morning of the meeting to consider presentations from the three remaining Executive search organisations. The panel consisted of Ms Allen, Mr Doveston, Mrs Metcalfe and Dr Scott; Mr Ward had been unable to take part due to commitments with the Audit Committee, but provided advice and guidance to the panel. The panel was unanimous in recommending that Gatenby Sanderson should be engaged as the Executive search organisation to facilitate the recruitment process. The panel had also been impressed with the presentation from the NHS Leadership Academy but had considered that, at this point, they were insufficiently experienced in recruiting to the role of Chairman.

Ms Allen informed the Nominations Committee that Gatenby Sanderson stood out from the other companies by their approach to work with the Nominations Committee to find the right Chairman for the Trust. She also highlighted their proposal to talk to different specialities across the organisation and take into account their views.

Mr Doveston endorsed Ms Allen's comments and commented that Gatenby Sanderson demonstrated a very clear understanding of this Trust.

Mrs Metcalfe had nothing further to add and was pleased to reinforce her fellow Governors' comments.

Dr Scott echoed the endorsement of his fellow Governors and commented on the process for advertising the position.

Ms Allen confirmed the advice was to advertise online rather than in print media.

Dr Tolcher also asked if Gatenby Sanderson were able to provide evidence of recruitment in our catchment area and Mr Marshall confirmed they had been assigned to Non-Executive Director roles in our region and a Chairman in the northern area. Dr Tolcher added that if Governors were not confident, and felt additional investment was required through advertisements, then it would bring recruiting an executive search organisation into question.

The Committee discussed the scoring method in detail. The Committee were assured that all Governors involved had the same preferred outcome.

In response to Cllr Bateman, Mr Marshall confirmed that it was common practice for Foundation Trusts to use the support from a recruitment firm for high level

management positions. Mr Forsyth added that the Council of Governors had considered the due process and approved the recruitment at the extra-ordinary Council of Governors' meeting on 30 November 2016.

There were no further questions or comments and the Nominations Committee agreed unanimously to the appointment of Gatenby Sanderson as the executive search organisation in the appointment of a new Chairman.

6. To agree a date to meet with the appointed executive search organisation

The Nominations Committee agreed to meet with Gatenby Sanderson on Wednesday 15 February at 4pm.

7. Any other business

Mr Ward thanked Mr Forsyth for the support he had given to the Nominations Committee and for arranging the presentations. The timeline would be reviewed again at the meeting on 15 February and agreed with Gatenby Sanderson.

Mrs Colvin referred to an email circulated to Governors regarding training by NHS Providers GovernWell Programme on 'The Governor role in Non-Executive appointments' to be held in London on 9 March. Expressions of interest were being taken for two Governors to attend. Mrs Colvin would follow this up outside of the meeting.

There was no other business and Mr Ward declared the meeting closed.

Appendix 2

Harrogate and District NHS
NHS Foundation Trust

Report to the Council of Governors' by the Nomination Committee

18 February 2017

Report Title:	**Recommendation for the reappointment of Mr Chris Thompson, Non-Executive Director**
Report from:	**Mrs Sandra Dodson, Chairman and Ms Pamela Allen, Deputy Chair of the Council of Governors**
Report purpose:	**To recommend the reappointment of Mr Chris Thompson to a second term of office**
Action required:	**For decision and approval**

Background and context

The Nomination Committee met on Friday, 27 January 2017 to discuss and consider the re-appointment of Mr Chris Thompson, Non-Executive Director, following the completion of his first term of office.

Mrs Sandra Dodson, Chairman and Ms Pamela Allen, Deputy Chair of Council of Governors met with Mr Thompson on 10 June 2016 to conduct an annual review and to set Mr Thompson's objectives for the coming year.

In summary, it was noted that Mr Thompson demonstrated a high level of competence to contribute effectively to the Board of Directors, in helping the Trust to achieve its long term strategy and maintain a high level of governance. As Chair of the Trust's Audit Committee, Mr Thompson also demonstrated a very high level of professional expertise combined with strong leadership of the committee. Mr Thompson maintains a clear focus on the delivery and outcomes of our activity in the Community and at Board and in committee work always seeks assurance in a positive and constructive manner whilst maintaining strong grip.

Recommendation

There was unanimous support from members of the Nomination Committee to endorse the recommendation to approve the re-appointment of Mr Thompson for a second term of office.

Mr Thompson's first term of office commenced on 1 March 2014 and the Council of Governors are therefore asked to approve the recommendation to reappoint Mr Thompson as Non-Executive Director for a second term of office from 1 March 2017 until 29 February 2020.

Mrs Sandra Dodson
Chairman

Ms Pamela Allen
Deputy Chair of the Council of Governors

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

Integrated board report - December 2016

Key points this month

1. In December, HDFT was above the required level for 3 of the 4 key operational performance metrics in the NHS Improvement Single Oversight Framework (with the A&E 4-hour standard being below the required level at 92.5%) and also reported a rating of 1 (where 1 is best) for the "Use of Resource Metric".

2. The Trust reported a cash position of £3,589k at the end of December. This remains significantly behind the reprofiled plan.

3. Performance against the A&E 4 hour standard deteriorated further in December. Despite this, HDFT remains one of the best performing Trusts in the country in relation to this standard.

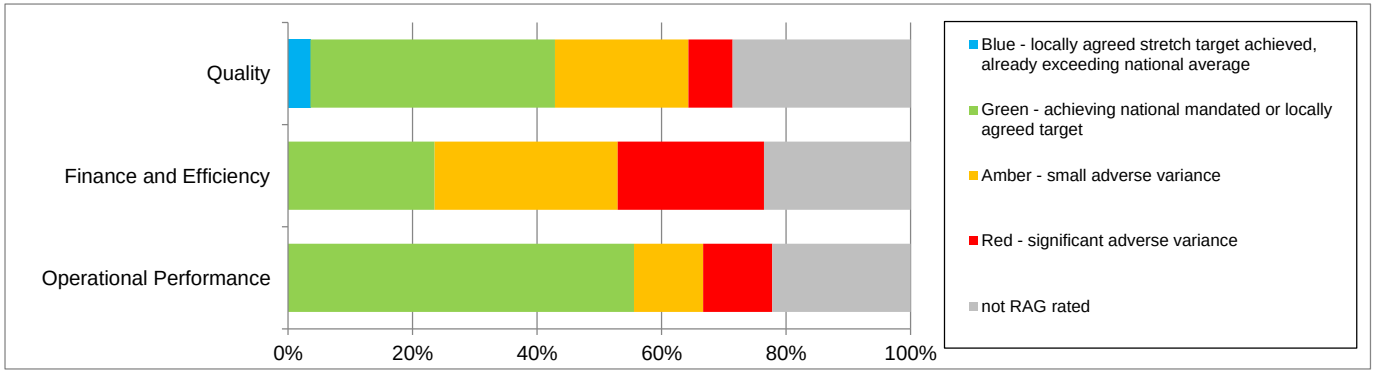
4. Non-elective bed days increased significantly in December, reflective of the serious winter pressures experienced by the Trust during this period. Delayed transfers of care also remain high and were at 4.8% when the snapshot was taken.

5. Elective theatre utilisation reduced in December. The number of lists cancelled increased due to operational pressures, including a lack of beds and staffing issues.

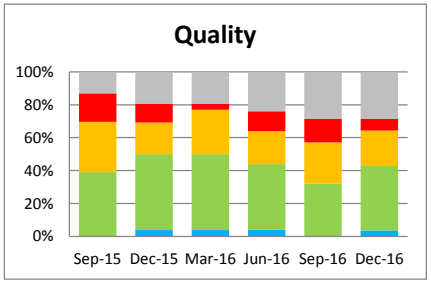
6. Inpatient falls increased during December. However there were no falls that resulted in moderate or severe harm.

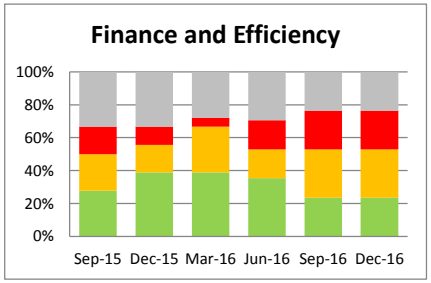
7. Staff appraisal rates increased to 79.8% in December - the highest level reported since 2014.

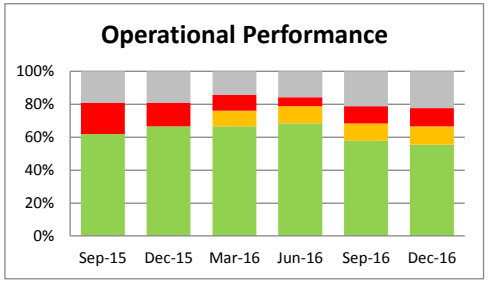
Summary of indicators - current month



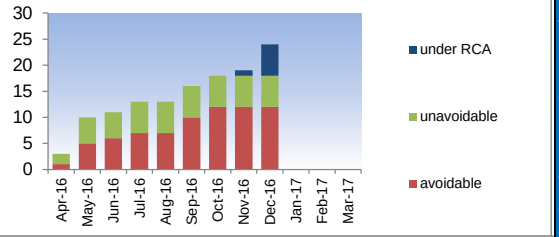
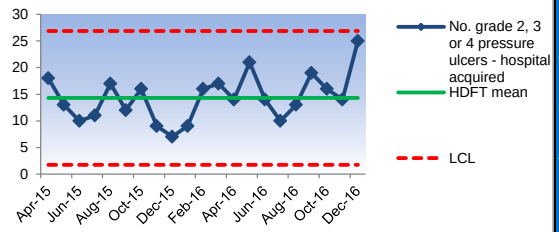
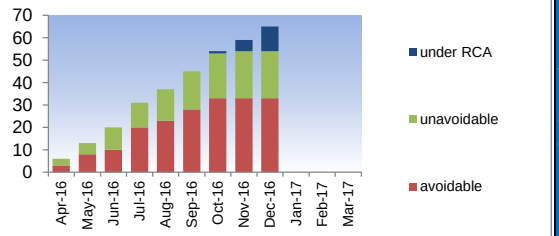
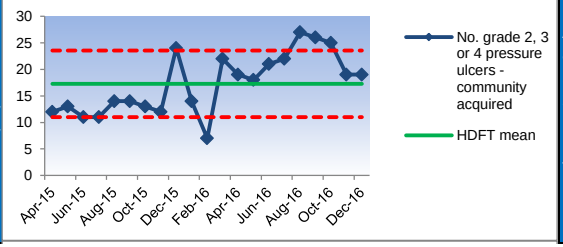
Summary of indicators - recent trends



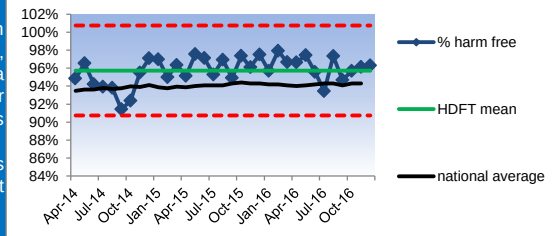
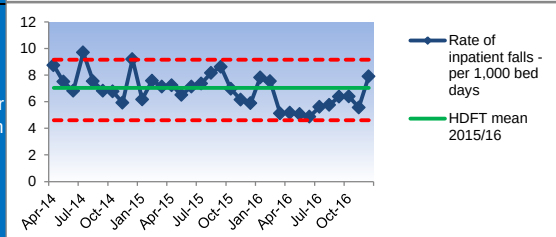
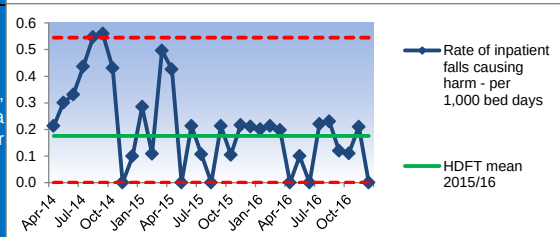
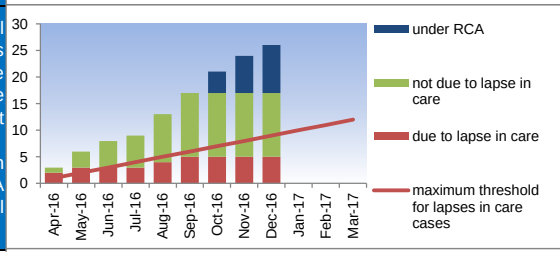




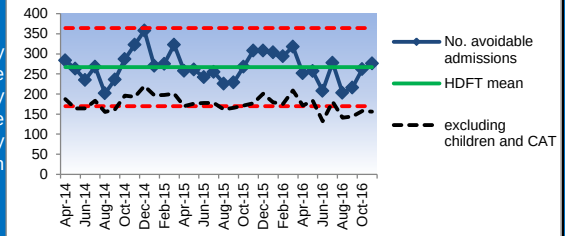
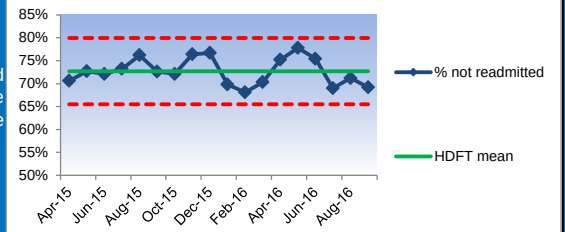
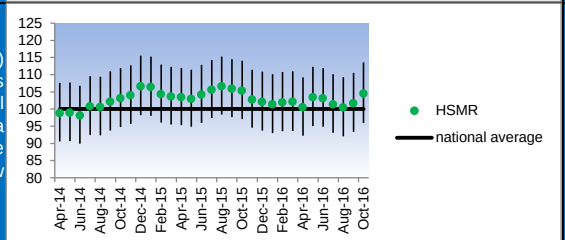
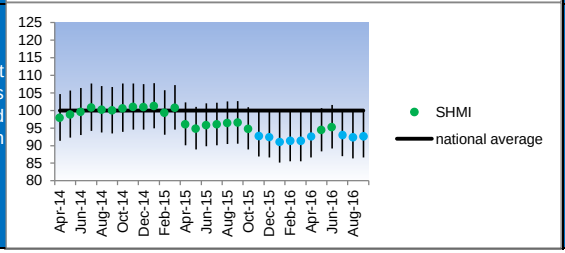
Quality - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
✓ **Pressure ulcers - hospital acquired**	The chart shows the cumulative number of category 3 or category 4 hospital acquired pressure ulcers in 2016/17. The data includes hospital teams only.		There were 5 hospital acquired category 3 or 4 pressure ulcers reported in December. In the year to date, 24 hospital acquired category 3 pressure ulcers have been reported. Of these, 12 were deemed to be avoidable, 6 unavoidable and 6 cases are still under root cause analysis (RCA). There have been no hospital acquired category 4 pressure ulcers reported in the year to date. The Trust has set a local trajectory for 2016/17 of zero avoidable hospital acquired category 3 or category 4 pressure ulcers.
✓	The chart includes category 2, 3 and 4 hospital acquired pressure ulcers. The data includes hospital teams only.		The number of hospital acquired category 2-4 pressure ulcers increased in December. There have now been 146 cases reported in 2016/17 to date. This compares to 113 in the same period last year. A maximum trajectory for 2016/17 of 155 cases of category 2-4 hospital acquired pressure ulcers has been agreed via the Quality Committee.
✓ **Pressure ulcers - community acquired**	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.		There were 6 community acquired category 3 pressure ulcers reported in December. In the year to date, 65 community acquired category 3 or category 4 pressure ulcers have been reported (including 2 category 4 cases). Of these 65 cases, 33 were deemed to be avoidable, 21 unavoidable and 11 cases are still under root cause analysis (RCA).
▲	This additional chart has been added this month showing the trend in category 2, 3 and 4 community acquired pressure ulcers. The data includes community teams only.		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. In 2016/17 to date, 196 cases have been reported, compared to 113 in the same period in 2015/16. The observed increase in reported cases may be partly due to improvements in incident reporting during the period.

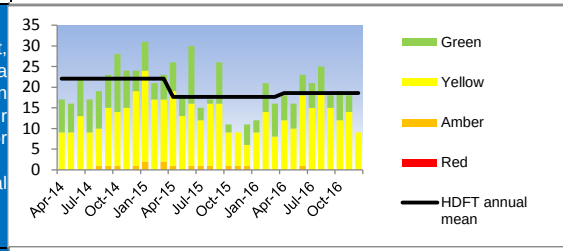
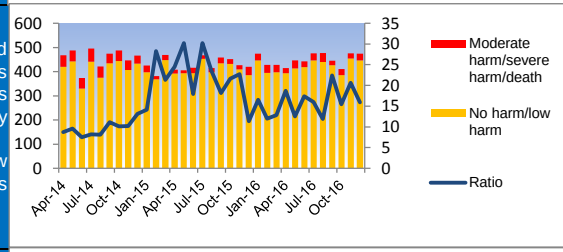
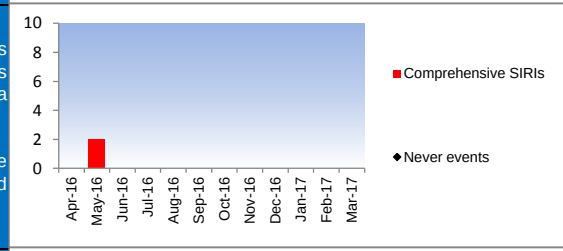
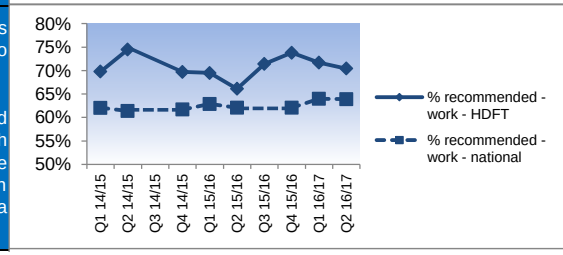
Quality - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Safety thermometer - harm free care ✓	Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.		The harm free percentage for December was 96.2%, an increase on last month and remaining above the latest national average.
Falls ✓	The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good.		The rate of inpatient falls was 7.9 per 1,000 bed days in December, an increase on last month and above the HDFT 2015/16 average rate.
Falls causing harm ✓	The number of inpatient falls causing significant harm, expressed as a rate per 1,000 bed days. The data includes falls causing moderate harm, severe harm or death. A low rate is good.		There were no inpatient falls causing moderate harm, severe harm or death in December, a decrease on the previous month and below the average HDFT rate for 2015/16. There have been 9 inpatient falls causing moderate or severe harm in 2016/17 to date, all of which resulted in a fracture. This compares to 14 moderate or severe harm falls in the same period last year.
Infection control ✓	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 acquired 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.		There were 2 cases of hospital apportioned C. difficile reported in December, bringing the year to date total to 26 cases. 17 cases have now have root cause analysis (RCA) completed and discussed and agreed with HARD CCG. Of the 17 cases discussed and agreed, 5 have been determined to be due to a lapse in care and 12 were determined to not be due to a lapse in care. The remaining cases are due to be reviewed with HARD CCG on 17th January. No cases of hospital acquired MRSA have been reported in 2016/17 to date.

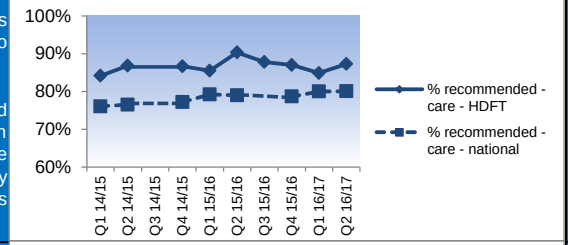
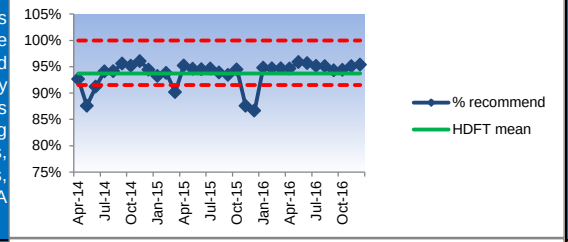
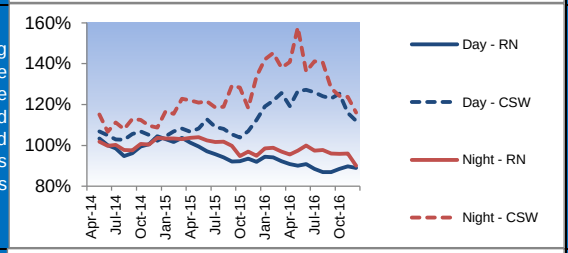
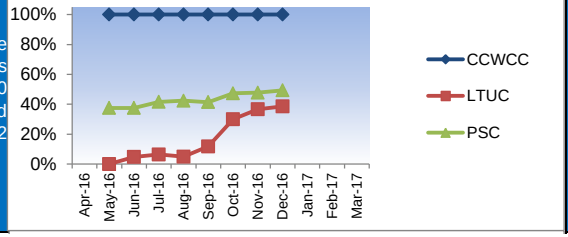
Quality - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Avoidable admissions 	The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.		There were 276 avoidable admissions in November, an increase on the previous month. There is some seasonality in this metric so an increase during the winter months is expected. The figure is slightly lower than the level in the same period last year. Despite the increase seen in the overall numbers, the adult admissions (excluding CAT attendances) have remained fairly static in recent months.
Reducing hospital admissions in older people 	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. *This indicator is in development.*		For patients discharged from rehabilitation or reablement services in September, 69% were still in their own home at the end of December, a decrease on the previous month. A case note audit of a sample of patients is being carried out to understand any themes and actions required and the results will be reported by Long Term and Unscheduled Care Directorate.
Mortality - HSMR 	The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.		HDFT's HSMR increased to 104.51 in October but remains within expected levels. At specialty level, 1 specialty (Geriatric medicine) has a standardised mortality rate above expected levels. Following a recent notification letter from CQC regarding raised mortality in patients with acute cerebrovascluar disease (stroke) at HDFT, a clinical case note review of a sample of stroke patients is being led by the Medical Director.
Mortality - SHMI 	The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good.		HDFT's SHMI increased to 92.67, compared to 92.36 last month. However this remains below the national average and below expected levels. At specialty level, 2 specialties (Geriatric Meidicine and Gastroenterology) have a standardised mortality rate above expected levels.

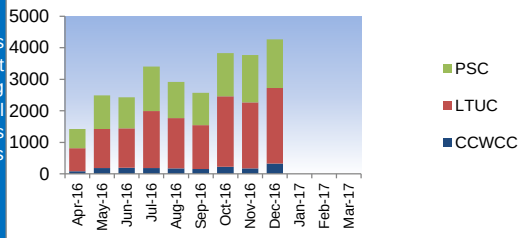
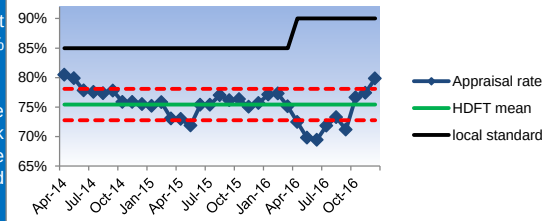
Quality - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Complaints ✓	The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents. The data includes complaints relating to both hospital and community services.		9 complaints were received in December compared to 18 last month, with none classified as amber or red. This is below the 2015/16 average.
Incidents - all ✓	The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services. A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture		The latest published national data (for the period Sep 15 to Mar 16) shows that Acute Trusts reported an average ratio of 34 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. Work is progressing to review the datix sytem to simplify the incident reporting process.
Incidents - SIRIs and never events ✓	The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services. We have changed this indicator to only include comprehensive SIRIs, as concise SIRIs are reported within the presure ulcer and falls indicators above.		There were no comprehensive SIRIs and no never events reported in December.
Friends & Family Test (FFT) - Staff - % recommend as a place to work ✓	The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in. The chart shows the percentage of staff that would recommend the Trust as a place to work. A high percentage is good. The 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.		*There is no update of this data this month.* In Quarter 2, 70.4% of HDFT staff surveyed would recommend HDFT as a place to work, this remains above the most recently published national average of 64%. The Staff Friends and Family Test will next be carried out at HDFT during Quarter 4.

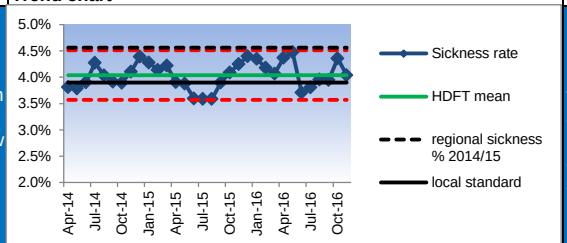
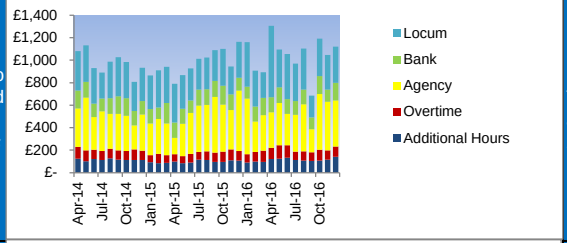
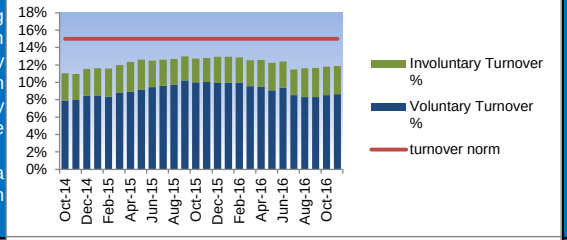
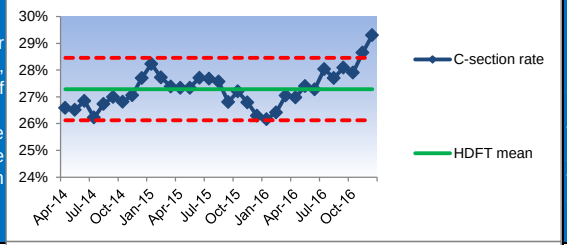
Quality - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Friends & Family Test (FFT) - Staff - % recommend as a place to receive care ✓	The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in. The chart shows the percentage of staff that would recommend the Trust as a place to 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. .		*There is no update of this data this month.* In Quarter 2, 87.3% of HDFT staff surveyed would recommend HDFT as a place to receive care. This is an increase on Q1 and above the most recently published national average of 80%. The Staff Friends and Family Test will next be carried out at HDFT during Quarter 4.
Friends & Family Test (FFT) - Patients ✓	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.		95.4% of patients surveyed in December would recommend our services, remaining in line with recent months and above the latest published national average.
Safer staffing levels ✓	Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is published on the Trust website.		Overall staffing compared to planned was at 102% in December. However, registered nurse staffing levels have reduced since last month. 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. A significant focus is being placed on Registerd Nurse recruitment and as a result, the Trust welcomed 24 newly qualified and 11 experienced Registered Nurses during September and October.
Electronic rostering timeliness ▲	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.		Overall, 49% of rosters were published on time during the period May to December 2016. The presentation of this data has been amended to show rosters based on roster start date, instead of roster end date, to provide more up to date information. All three Clinical Directorates are now showing improvements in recent when the data is presented this way. Publishing electronic rosters in a timely manner improves staff morale, increases bank fill rates and reduces bank/agency costs.

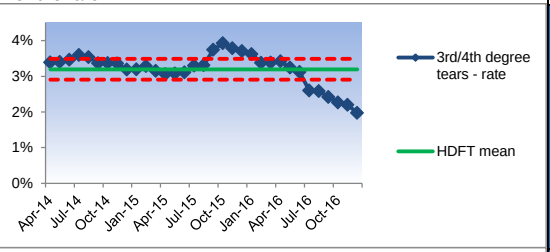
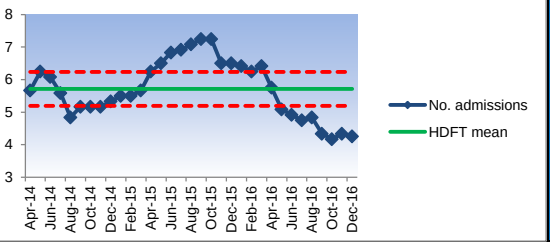
Quality - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Electronic rostering hours owed 	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 30 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.		The chart shows the cumulative position. The number of unused hours increased significantly in the last few months, partly as a result of the merging of Byland and Jervaulx wards and subsequent un-merging. Properly managed balances increase available clinical hours, improves staff morale and management decision making.
Staff appraisal rates 	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. 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.		The appraisal rate for the 12 months to end December is 79.8%, a further increase on last month. A deadline of 31st December was set to achieve 90% appraisal completion. With the exception of the Childrens and County Wide Community Care Directorate, the Trust is not achieving this target of 90%. A discussion has been taken to SMT this month to consider additional actions.
Mandatory training rates 	The table shows the most recent training rates for all mandatory elements for substantive staff. The table excludes staff who TUPE transferred into the organisation on 1st April 2016. A high percentage is good.	**Competence Name** / **% Completed** Equality, Diversity and Human Rights - Level 1: 93 Fire Safety Awareness: 82 Infection Prevention & Control 1: 99 Infection Prevention & Control 2: 86 Information Governance: Introduction: 87 Information Governance: The Beginners Guide: 77 Prevent Basic Awareness (December 2015): 99 Safeguarding Children & Young People Level 1 - Introduction: 95	The data shown is for the end of December and excludes the staff who were TUPE transferred into the organisation on the 1st April 2016. The overall training rate for mandatory elements for substantive staff in this group is 91%. 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.
Mandatory training rates 	The table shows the most recent training rates for all mandatory elements for substantive staff. The table only includes staff who TUPE transferred into the organisation on 1st April 2016. A high percentage is good.	**Competence Name** / **% Completed** Equality, Diversity and Human Rights - Level 1: 70 Fire Safety Awareness: 84 Infection Prevention & Control 1: 100 Infection Prevention & Control 2: 55 Information Governance: Introduction: 53 Information Governance: The Beginners Guide: - Prevent Basic Awareness (December 2015): 75 Safeguarding Children & Young People Level 1 - Introduction: 97	The data shown is for the end of December and shows the statistics for the TUPE staff that transferred into the organisation on the 1st April 2016 from Middlesbrough, Durham and Darlington. The overall training rate for mandatory elements for substantive staff in this group is 74%. This is an increase of 5% since last month. The TUPE staff compliance figures will be reported separately until January 2017 at which point we plan to amalgamate the figures into one table of data. This allows the newly transferred staff time to establish systems and processes to access their mandatory training, complete data validation and increase their overall compliance to the level we have achieved across the Trust prior to their transfer.

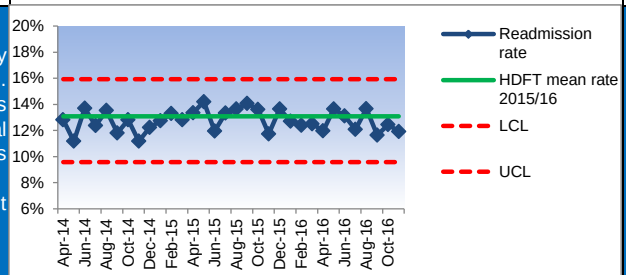
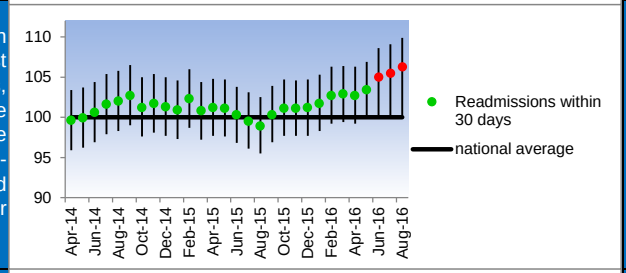
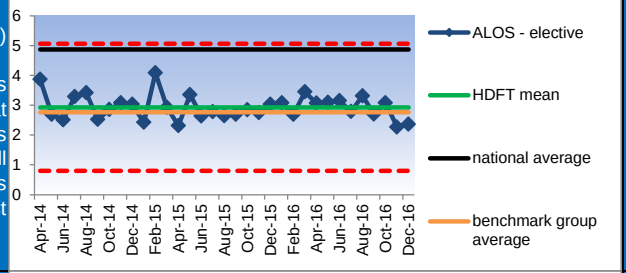
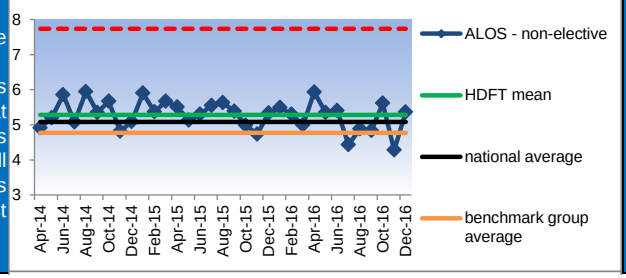
Quality - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Sickness rates ✓	Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%. A low percentage is good.		Sickness absence across the Trust showed a decrease during November to 4.0%. The Health & Wellbeing Group is relaunching its intranet site and promoting a number of activities aimed at raising awareness of both physical and emotional wellbeing. These include a survey of physical activity already undertaken by staff, and a Health and Wellbeing 'drop-in' session in Herriot's in January.
Temporary staffing expenditure - medical/nursing /other ✓	The chart shows staff expenditure per month, split into contracted staff, overtime and additional hours and temporary staff. Lower figures are preferable. *The traffic light criteria applied to this indicator is currently under review.*		The proportion of spend on temporary staff during November was 6.9%, an increase on last month but below the average level (7.6%) during 2015/16.
Staff turnover rate ✓	The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.		Labour turnover remains static across the organisation.
Maternity - Caesarean section rate ✓	The caesarean section rate is determined by a number of factors including ability to provide 1-1 care in labour, previous birth experience and confidence and ability of the staff providing care in labour. The rate of caesarean section can fluctuate significantly from month to month - as a result we have amended the presentation of this indicator this month to show a 12 month rolling average position.		HDFT's C-section rate for the 12 months ending December 2016 was 29.3% of deliveries, an increase on last month and remaining higher than average. 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.

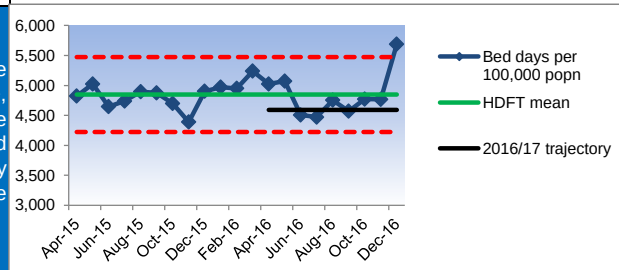
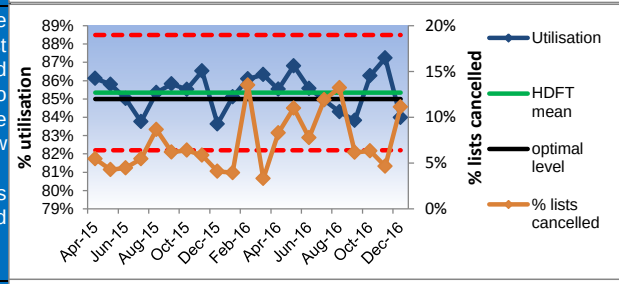
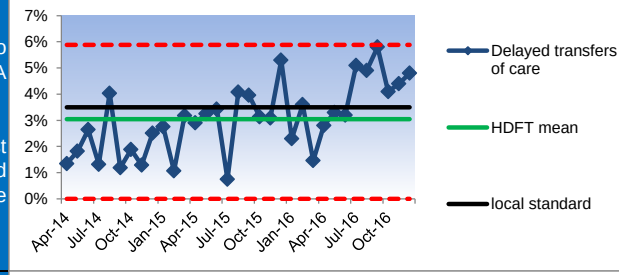
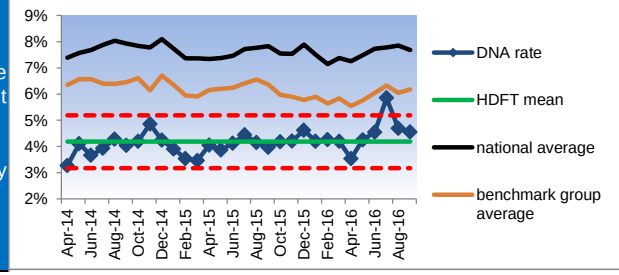
Quality - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Maternity - Rate of third and fourth degree tears ✓	Third and fourth degree tears are a source of short term and long term morbidity. A previous third degree tear can increase the likelihood of a woman choosing a caesarean section in a subsequent pregnancy. Recent intelligence suggested that HDFT were an outlier for third degree tears with operative vaginal delivery. Quality improvement work is being undertaken to understand and improve this position and its inclusion on this dashboard will allow the Trust Board to have sight of the results of this.		The rate of third or fourth degree tears was 2.0% of deliveries in the 12 month period ending December 2016, remaining well below previous months. The rolling 12 months rate is at its lowest point since the dashboard was created. This may reflect the significant amount of quality improvement work aimed at reducing the incidence of third degree tears.
Maternity - Unexpected term admissions to SCBU ✓	This indicator is a reflection of the intrapartum care provided. For example, an increase in the number of term admissions to special care might reflect issues with understanding of fetal heart rate monitoring in labour. We have amended the presentation of this indicator this month to show a 12 month rolling average position.		The chart shows the percentage of babies born at greater than 37 weeks gestation who were admitted to the Special Care Baby Unit (SCBU). The maternity team carry out a full review of all term admissions to SCBU. 4% of term babies were admitted to SCBU in December. This is line with the average over the last 12 months.

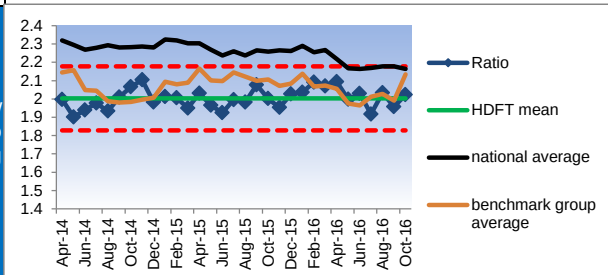
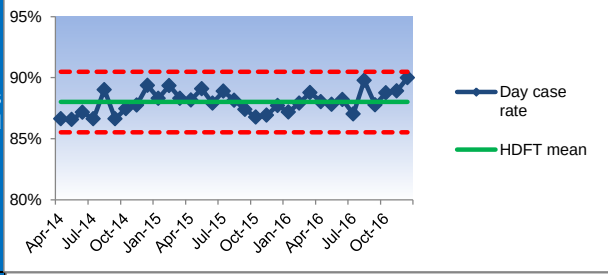
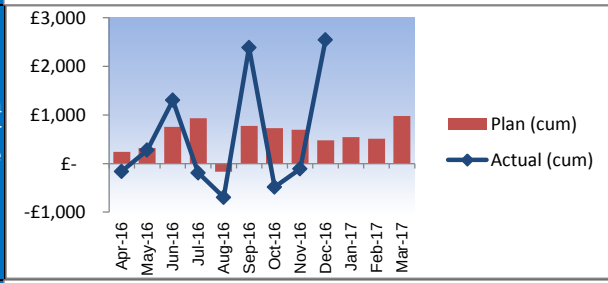
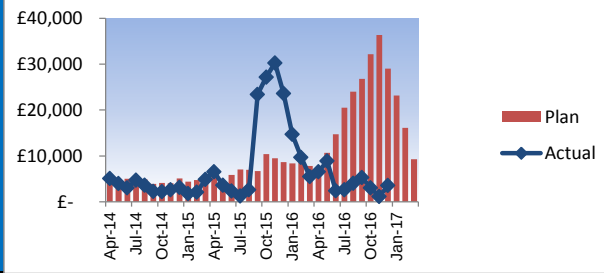
Finance and Efficiency - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Readmissions	% of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance. This data is reported a month behind so that any recent readmissions are captured in the data.		The number of readmissions decreased in October, when expressed as a percentage of all emergency admissions and remains below the average rate for 2015/16. HDFT and HARD CCG are undertaking an audit of readmissions in Quarter 3 to determine the proportion of readmissions which were avoidable.
Readmissions - standardised	This indicator looks at the standardised readmission rate within 30 days. The data is standardised against various criteria including age, sex, diagnosis, comorbidites etc. The standardisation enables a more like for like comparison with other organisations. The national average is set at 100. A low rate is good - rates below 100 indicate a lower than expected readmission rate and rates above 100 indicate higher than expected readmission rate.		*There is no update of this data this month as the data has not been updated yet within HED.* HDFT's standardised readmission rate has increased again this month - for the rolling 12 month period ending August 2016, the rate was 106.3, above the national average and above expected levels. At specialty level, Clinical Haematology, Paediatrics, Medical Oncology and Well Babies all have standardised emergency readmission rates above expected.
Length of stay - elective	Average length of stay in days for elective (waiting list) patients. The data excludes day case patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.		The average elective length of stay for December was 2.4 days, an increase on the previous month but remaining below the benchmark group average. A focus on sustainably reducing this through the Planned Care Transformation programme is underway, which includes reducing the number of patients admitted the day before surgery.
Length of stay - non-elective	Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.		The average non-elective length of stay for December was 5.4 days, an increase on the previous month and now above both the benchmark group and national average. This increase in length of stay will be partly due to an increase in the number of delayed transfers of care seen in recent weeks.

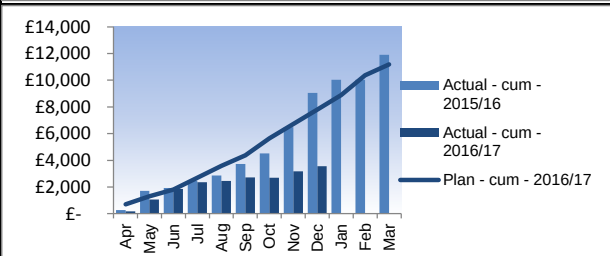
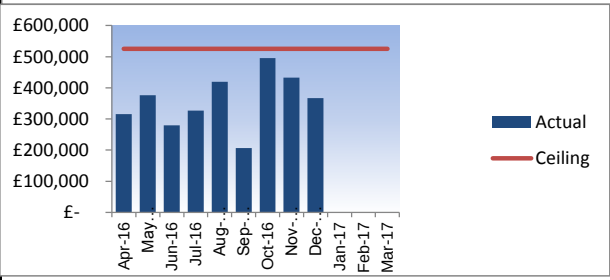
Finance and Efficiency - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Non-elective bed days ✓	The charts shows the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per 100,000 population. The chart only includes the local HARD CCG area. 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.		Non-elective bed days for patients aged 18+ increased significantly in December. There is seasonality with this metric and an increase is expected during winter months. However this is higher than the level reported in December last year. This rise is reflective of the serious winter pressures experienced by the Trust during this period - there was an 11% increase in HARD CCG adult emergency admissions compared to December last year, combined with an increase in both the average length of stay and the number of delayed transfers of care.
Theatre utilisation △	The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of this. A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.		Theatre utilisation decreased to 84.0% in December. The number of cancelled sessions was11.1%, an increase on last month. Theatre cancellations increased in response to a number of challenges including ward staffing gaps, theatre staff sickness and a lack of beds including ITU. Overall December was a very challenging month operationally with daily risk assessments on the ability to continue with elective theatre lists.
Delayed transfers of care ✓	The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable. A snapshot position is taken at midnight on the last Thursday of each month. The maximum threshold shown on the chart (3.5%) has been agreed with the CCG.		Delayed transfers of care remains high and were at 4.8% when the snapshot was taken in December, above the maximum threshold of 3.5% set out in the contract. Further work to understand the reasons for this continued increase is being carried out by the Discharge Steering Group.
Outpatient DNA rate ✓	Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance. A low percentage is good. Patient DNAs will usually result in an unused clinic slot.		HDFT's DNA rate decreased to 4.4% in August. This remains below that of both the benchmarked group of Trusts and the national average.

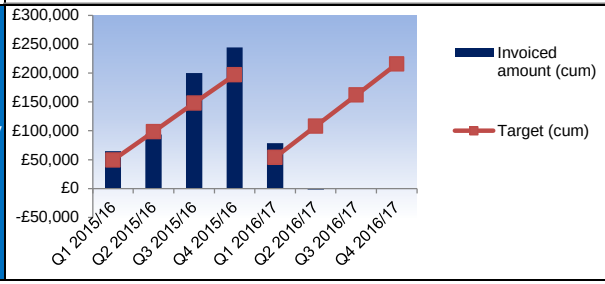
Finance and Efficiency - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Outpatient new to follow up ratio ✓	The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place.		Reducing the number of follow ups is a major part of HARD CCG's financial recovery plan. HDFT's new to follow up ratio increased in December but is still below both the national average and the benchmark group average.
Day case rate ✓	The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight. A higher day case rate is preferable.		The day case rate increased to 90.0% in December, the highest level reported for some time.
Surplus / deficit and variance to plan ✓	Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month.		The Trust reported a surplus of £4,882k for the year to the end of December, £44k ahead of plan. This position is above the control total set for the Trust and therefore includes the full S&T funding available to the Trust. There are a number of risks in this position, as outlined further in the finance report.
Cash balance ✓	Monthly cash balance (£'000s)		The Trust reported a cash position of £3,589k at the end of December. This remains significantly behind the reprofiled plan. This is a significant area of focus for the finance team at present.

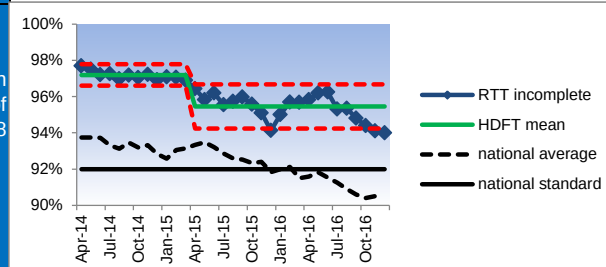
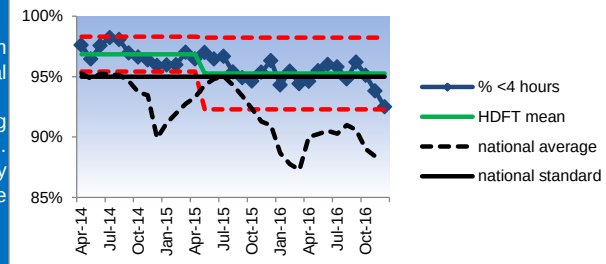
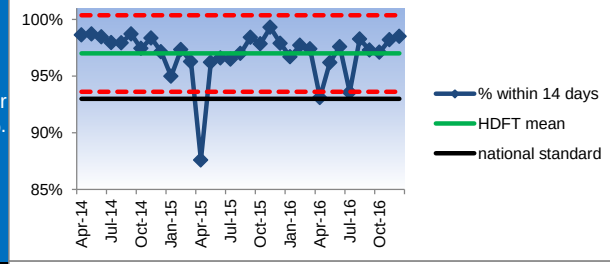
Finance and Efficiency - December 2016

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.	**Element** / **Plan** / **Actual** Capital Service Cover: 1 / 1 Liquidity: 1 / 1 I&E Margin: 1 / 1 I&E Variance From Plan: / 1 Agency: 1 / 1 **Financial Sustainability Risk Rating: 1 / 1**	The Trust reported a 1 for December.
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.		87% of CIP schemes have been actioned to date. Plans are in place for 108% of the efficiency requirement, the risk adjusted total reducing to 100%.
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.		Despite being below the agency ceiling, agency expenditure remains high at 2.9%.

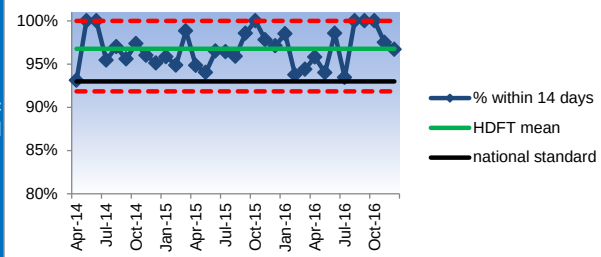
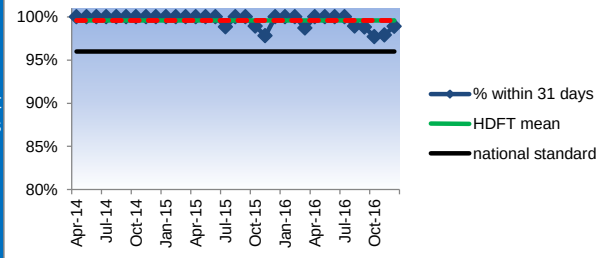
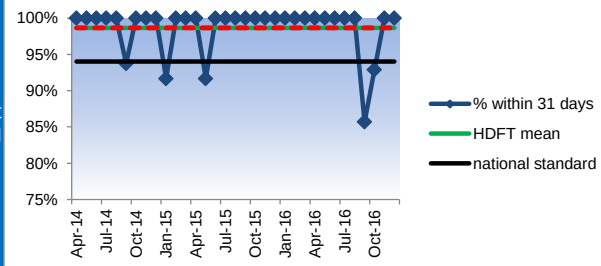
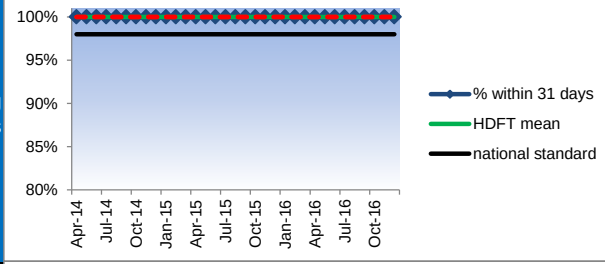
Finance and Efficiency - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Research - Invoiced research activity 	Aspects of research studies are paid for by the study sponsor or funder.		As set out in the Research & Development strategy, the Trust intends to maintain its current income from commercial research activity and NIHR income to support research staff to 2019. Each study is unique. Last year the Trust invoiced for a total of £223k.

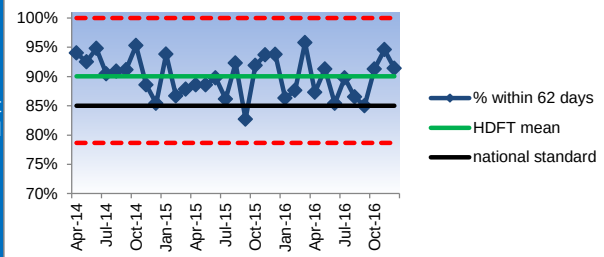
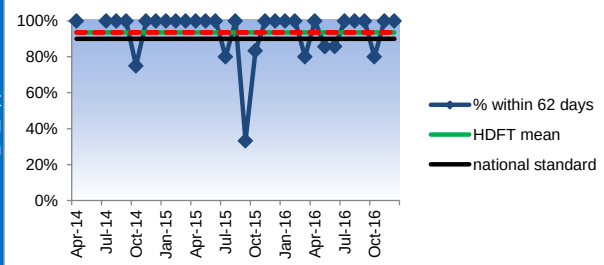
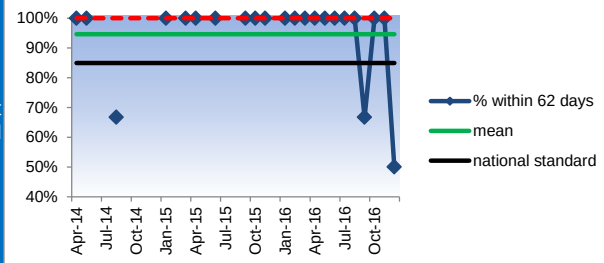
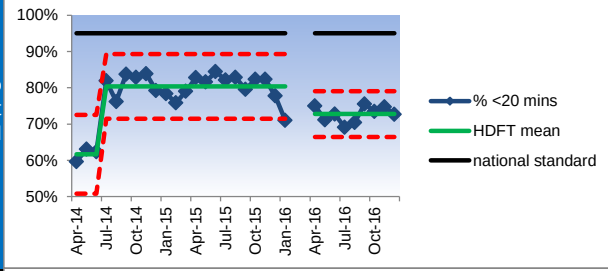
Operational Performance - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
NHS Improvement Single Oversight Framework ✓	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.	**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 A&E 4-hour standard Cancer - 62 days Diagnostic waits	In December, HDFT was above the required level for 3 of the 4 key operational performance metrics. Performance against the A&E 4-hour standard was below the required 95% as detailed below.
RTT Incomplete pathways performance ✓	Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks. A high percentage is good.		94.0% of patients were waiting 18 weeks or less at the end of December, above the required national standard of 92% but continuing the trend in deteriorating performance seen over recent months. At specialty level, Trauma & Orthopaedics and General Surgery were below the 92% standard again in December.
A&E 4 hour standard ✓	Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%. The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good. Historical data for HDFT included both Ripon and Selby MIUs. In agreement with local CCGs, York NHSFT are reporting the activity for Selby MIU from 1st May 2015.		HDFT's Trust level performance for December 2016 was 92.5%, a decrease on last month and remaining below the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Harrogate ED in December was 91.1%. This is the lowest performance reported by the Trust for some time. Despite this, HDFT remains one of the best performing Trusts in the country in relation to this standard.
Cancer - 14 days maximum wait from urgent GP referral for suspected cancer referrals ✓	Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.		Delivery at expected levels.

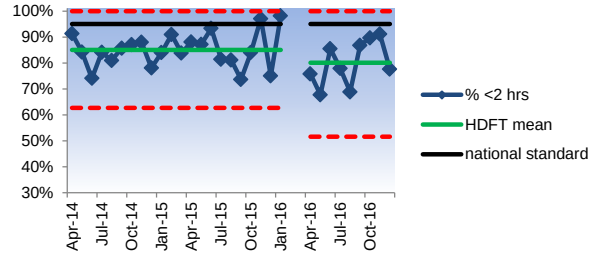
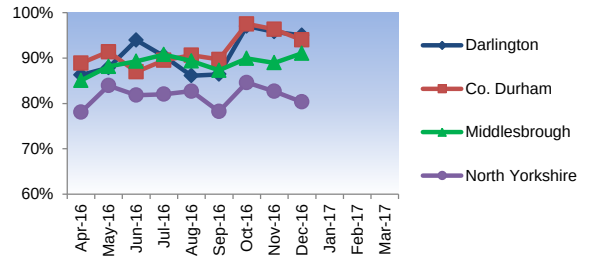
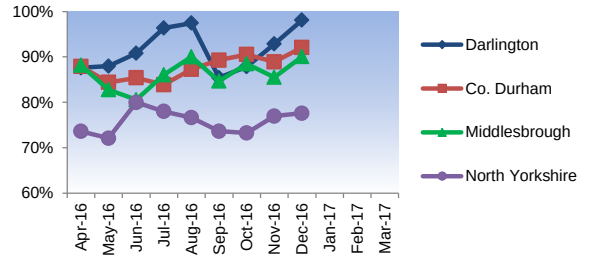
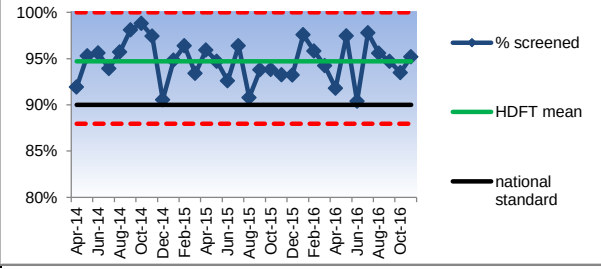
Operational Performance - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Cancer - 14 days maximum wait from GP referral for symptomatic breast patients ✓	Percentage of GP referrals for breast symptomatic patients seen within 14 days. The operational standard is 93%. A high percentage is good.		Delivery at expected levels.
Cancer - 31 days maximum wait from diagnosis to treatment for all cancers ✓	Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%. A high percentage is good.		Delivery at expected levels.
Cancer - 31 day wait for second or subsequent treatment: Surgery ✓	Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good.		Delivery at expected levels.
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug ✓	Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%. A high percentage is good.		Delivery at expected levels.

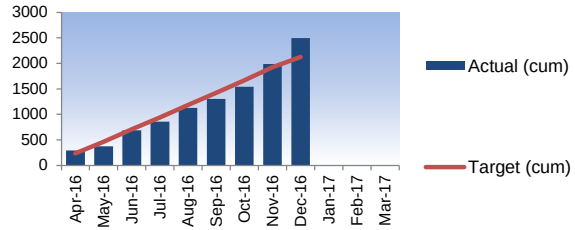
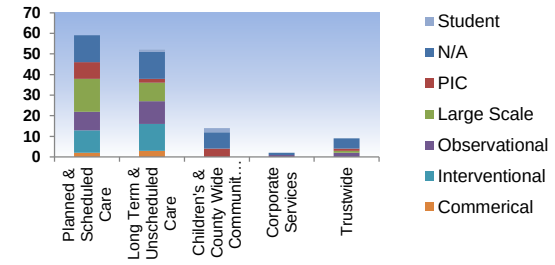
Operational Performance - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Cancer - 62 day wait for first treatment from urgent GP referral to treatment ✓	Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good.		Trust total delivery at expected levels. Of the 11 cancer sites treated at HDFT, 4 had performance below 85% in December - colorectal (1 breach), sarcoma (0.5 breach), upper gastrointestinal (0.5 breach) and urological (2 breaches). There were 2 patients who waited over 104 days for treatment in December - the main reasons for the delay was clinical complexity and patient initiated delay.
Cancer - 62 day wait for first treatment from consultant screening service referral ✓	Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%. A high percentage is good.		Delivery at expected levels.
Cancer - 62 day wait for first treatment from consultant upgrade ✓	Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%. A high percentage is good.		During December, 1 patient breached the 62 day standard. This means that for Quarter 3 there have been 4 treatments and 1 breach giving a Quarter 3 performance of 75%. However this will not be reportable as it is below the de mininis level of 5 pathways per quarter.
GP OOH - NQR 9 ▲	NQR 9 (National Quality Requirement 9) looks at the % of GP OOH telephone clinical assessments for urgent cases that are carried out within 20 minutes of call prioritisation. A high percentage is good.		Performance remains below the required 95% for this metric and was at 73% in December. 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.

Operational Performance - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
GP OOH - NQR 12	NQR 12 (National Quality Requirement 12) looks at the % of GP OOH face to face consultations (home visits) started for urgent cases within 2 hours. The data presented excludes Selby and York as these do not form part of the HFT OOH service from April 2015. A high percentage is good.		Performance remains below the required 95% for this metric at 80% in December. 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.
Children's Services - 10-14 day new birth visit	The percentage of babies who had a new birth visit by the Health Visiting team within 14 days of birth. A high percentage is good. Data shown is for 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.		In December, 88% of babies were recorded on Systmone as having had a new birth visit within 14 days of birth. Darlington and Co. Durham teams have been working with the Information team during Quarter 3 to fully validate their data resulting in an improved, more accurate performance position for their localities.
Children's Services - 2.5 year review	The percentage of children who had a 2.5 year review. A high percentage is good. Data shown is for 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.		In December, 86% of children were recorded on Systmone as having had a 2.5 year review. Darlington and Co. Durham teams have been working with the Information team during Quarter 3 to fully validate their data resulting in an improved, more accurate performance position for their localities.
CQUIN - dementia screening	The proportion of emergency admissions aged 75 or over who are screened for dementia within 72 hours of admission (Step 1). Of those screened positive, the proportion who went on to have an assessment and onward referral as required (Step 2 and 3). The operational standard is 90% for all 3 steps. A high percentage is good.		Delivery at expected levels.

Operational Performance - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Recruitment to NIHR adopted research studies ✓	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.		The year to date position on recruitment to research studies is now 17% above plan, an improvement on the position reported in previous months.
Directorate research activity ✓	The number of studies within each of the directorates - included in the graph is Trustwide where the study spans directorates. The Trust has no specific target set for research activity within each directorate. It is envisaged that each clinical directorate would have a balanced portfolio.		The directorate research teams are subject to studies that are available to open. The 'type of study', Commercial, Interventional, Observational, Large scale, Patient Identification Centre (PIC) or N/A influence the activity based funding received by HDFT. Each category is weighted dependant on input of staff involvement. N/A studies are those studies which are not on the NIHR portfolio. They include commercial, interventional, observational, large scale, PIC, local and student projects. They do not influence the recruitment target.

Data Quality - Exception Report

Report section	Indicator	Data quality rating	Further information
Quality	Pressure ulcers - community acquired - grades 2, 3 or 4	**Amber** 	The observed increase in reported cases over the last two years may be partly due to improvements in incident reporting during the period.
Quality	Mandatory training rates - Darlington, Durham & Middlesbrough staff	**Amber** 	This indicator includes training data for TUPE staff that transferred into the organisation on 1st April 2016 from Middlesbrough, Durham and Darlington. There are some concerns about the quality and completeness of this information.
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 >=97%, Green if >=95% but <97%, red if latest month <95%	National best practice guidance suggests that 95% is the standard that Trusts should achieve. In addition, HDFT have set a local stretch target of 97%.
Quality	**Falls**	IP falls per 1,000 bed days	Blue if YTD position is a reduction of >=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, sever harm or death, per 1,000 bed days		
Quality	**Infection control**	No. hospital acquired C.diff cases	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year.	NHS England, NHS Improvement and contractual requirement
Quality	**Avoidable admissions**	The number of avoidable emergency admissions to HDFT as per the national definition.	tbc	tbc
Quality	**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)		
Quality	**Complaints**	No. complaints, split by criteria	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	**Incidents - all**	Incidents split by grade (hosp and community)	Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%	Comparison of HDFT performance against most recently published national average ratio of low to high incidents.
Quality	**Incidents - complrehensive SIRIs and never events**	The number of comprehensive SIRIs and the number of never events reported in the year to date. The indicator includes hospital and community data.	Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month.	
Quality	**Friends & Family Test (FFT) - Staff**	% staff who would recommend HDFT as a place to work	Blue if latest month score places HDFT in the top 10% of acute trusts nationally and/or the % staff recommending the Trust is above 95%, Green if in top 25% of acute trusts nationally, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Quality	**Friends & Family Test (FFT) - Staff**	% staff who would recommend HDFT as a place to receive care		
Quality	**Friends & Family Test (FFT) - Patients**	% recommend, % not recommend - combined score for all services currently doing patient FFT	Green if latest month >= latest published national average, Red if < latest published national average.	Comparison with national average performance.
Quality	**Safer staffing levels**	RN and CSW - day and night overall fill rates at trust level	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
Quality	**Staff appraisal rate**	Latest position on no. staff who had an appraisal within the last 12 months	Annual rolling total - 90% green. Amber between 70% and 90%, red<70%.	Locally agreed target level based on historic local and NHS performance
Quality	**Mandatory training rate**	Latest position on the % staff trained for each mandatory training requirement	Blue if latest month >=95%; Green if latest month 75%-95% overall, amber if between 50% and 75%, red if below 50%.	Locally agreed target level - no national comparative information available until February 2016
Quality	**Staff sickness rate**	Staff sickness rate	Green if <3.9% , amber if between 3.9% and regional average, Red if > regional average.	HDFT Employment Policy requirement. Rates compared at a regional level also
Quality	**Temporary staffing expenditure - medical/nursing/other**	Expenditure per month on staff types.	tbc	tbc
Quality	**Staff turnover**	Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts.	Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%.	Based on evidence from Times Top 100 Employers
Quality	**Maternity - Caesarean section rate**	Caesarean section rate as a % of all deliveries	Green if <25% of deliveries, amber if between 25% and 30%, red if above 30%.	tbc
Quality	**Maternity - Rate of third and fourth degree tears**	No. third or fourth degree tears as a % of all deliveries	Green if <3% of deliveries, amber if between 3% and 6%, red if above 6%.	tbc
Quality	**Maternity - Unexpected term admissions to SCBU**	Admissions to SCBU for babies born at 37 weeks gestation or over.	tbc	tbc
Finance and efficiency	**Readmissions**	No. emergency readmissions (following elective or non-elective admission) within 30 days.	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 - standardised**	Standardised emergency readmission rate within 30 days from HED	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	Comparison with national average performance.
Finance and efficiency	**Length of stay - elective**	Average LOS for elective patients	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
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		
Finance and efficiency	Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s)	Green if on plan, amber <1% behind plan, red >1% behind plan	Locally agreed targets.
Finance and efficiency	Cash balance	Monthly cash balance (£'000s)	Green if on plan, amber <10% behind plan, red >10% behind plan	Locally agreed targets.
Finance and efficiency	NHS Improvement Financial Performance Assessment	An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan.	Green if rating =4 or 3 and in line with our planned rating, amber if rating = 3, 2 or 1 and not in line with our planned rating.	as defined by NHS Improvement
Finance and efficiency	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

Harrogate and District NHS
NHS Foundation Trust

Council of Governors' meeting
CEO update

18 February 2017

You matter most

INVESTORS IN PEOPLE

Harrogate and District NHS
NHS Foundation Trust

Overview

- Winter pressures and HDFT current Performance
- Strategic landscape: Sustainability and Transformation Plans, New Care Models
- Risks and Issues!

"Winter" pressures

Harrogate and District NHS
NHS Foundation Trust

- Extreme pressure is the result of **higher demand** and flow issues relating to **delayed discharges**

- Demand over the Christmas/New Year period reached an **all time high**
  - Emergency Department attendances up by 12%
  - Emergency admissions up by 10%

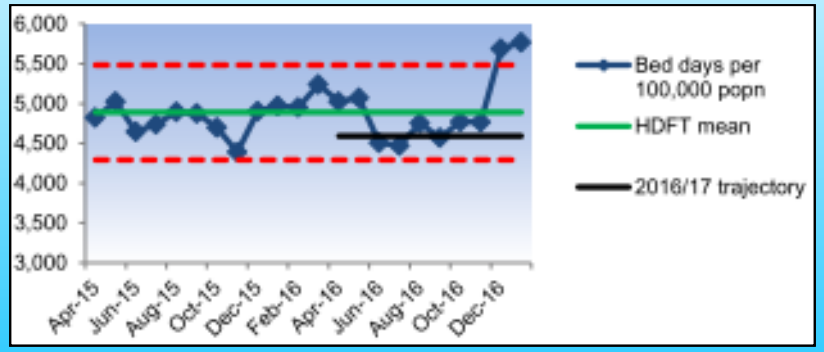
- Patient flow further compromised by **'exit block'**
  - Delayed Transfers Of Care (DTOC's) highest ever level at 7.3% of beds
  - Length of stay for emergency admissions and non-elective bed days extended

You matter most

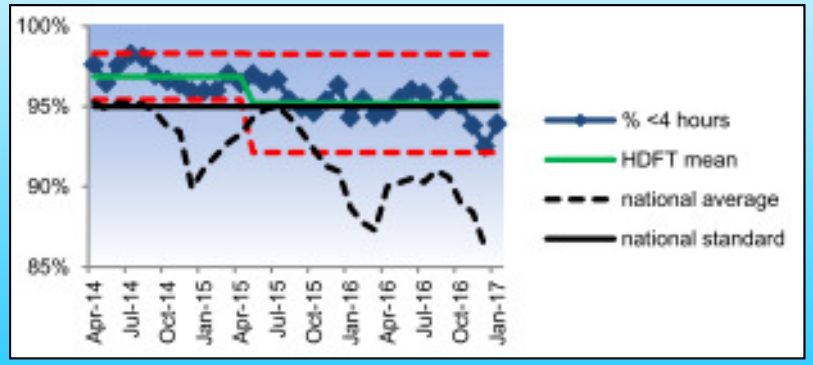
Operational performance during surges in demand

Harrogate and District NHS
NHS Foundation Trust

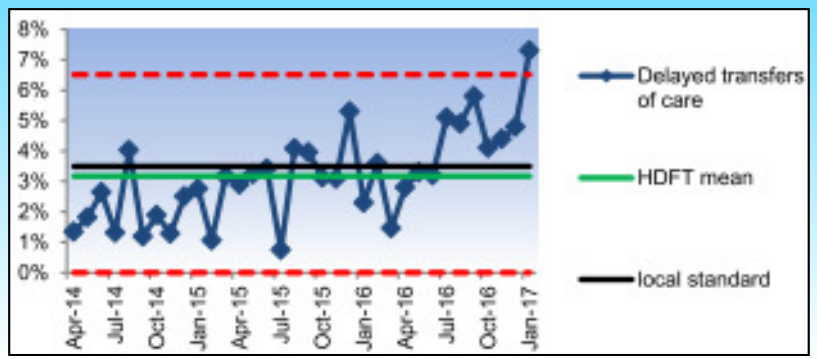
Non-elective (emergency) beds days, adults, per 100,000



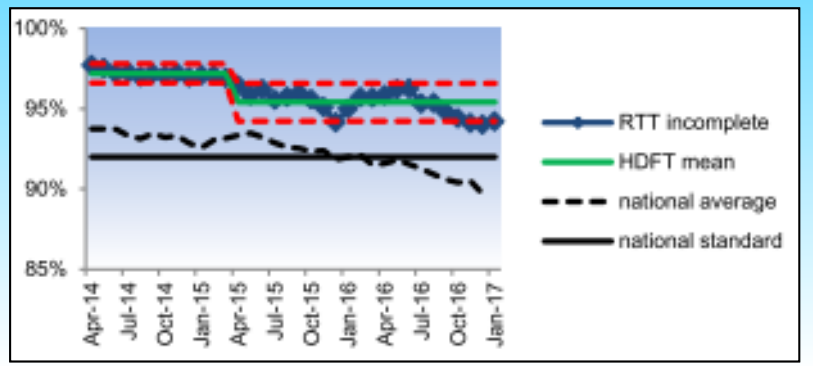
Emergency Department 4 hour standard



Delayed transfers of care



Referral to Treatment (RTT) incomplete pathways



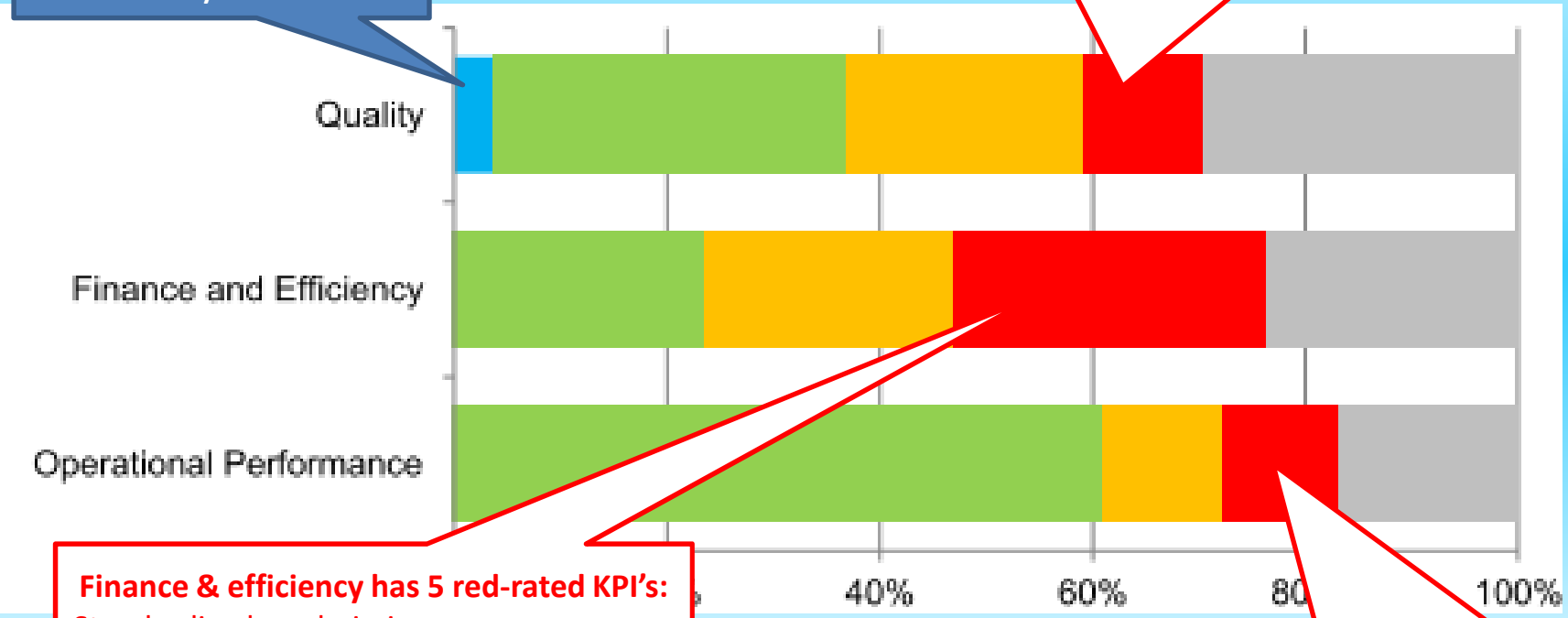
Current Performance (December 2016)

Harrogate and District NHS
NHS Foundation Trust

Locally agreed stretch target for mortality achieved

Quality has 3 red-rated Key Performance Indicator's (KPI's):

- Total number of Falls
- Falls causing harm
- Total number of incidents



Finance & efficiency has 5 red-rated KPI's:
Standardised readmissions
Non-elective bed days
Delayed transfers of care
Surplus/deficit variance to plan
Cash balance*

Operational Performance has 2 red-rated KPI's:
NHS Improvement single oversight framework
A&E 4 hour standard

* Actual cash position is in line with the revised plan agreed with NHS Improvement

Current Performance (December 2016)

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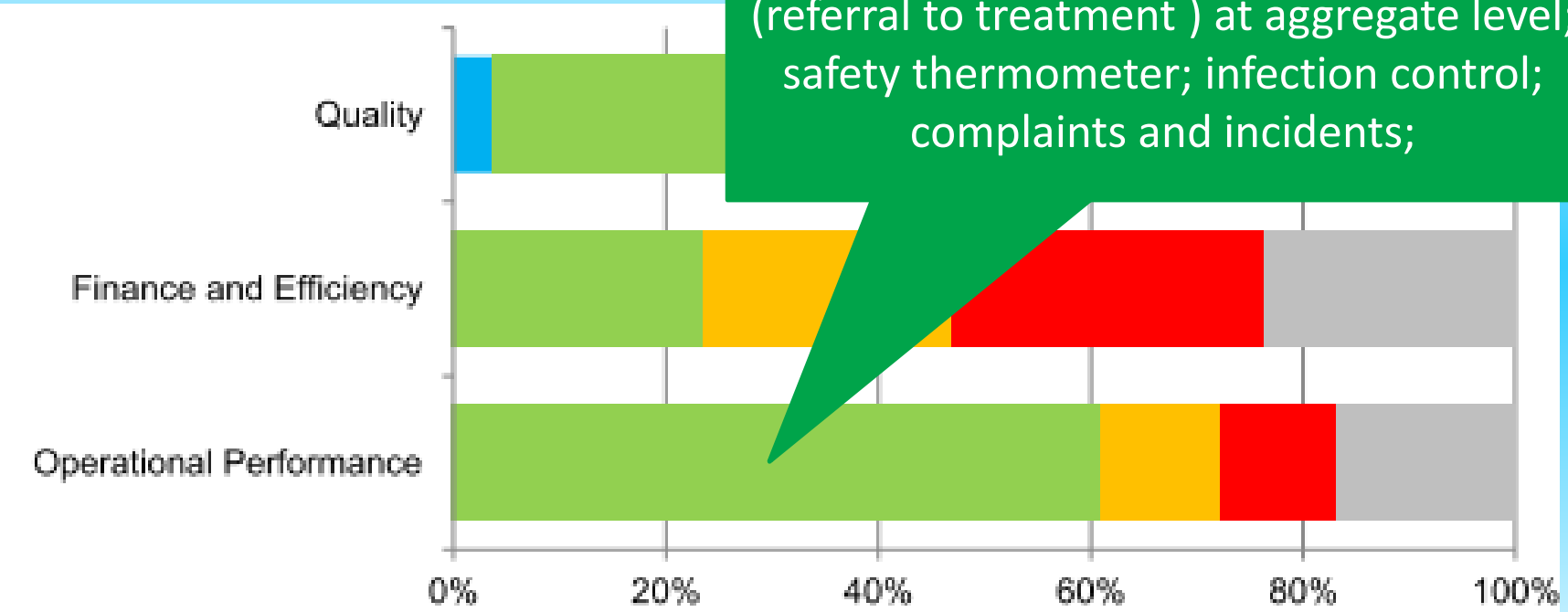
Despite winter pressures
The great majority of indicators are green, including all cancer pathways and RTT (referral to treatment) at aggregate level; safety thermometer; infection control; complaints and incidents;



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Sustainability and transformation plans

WEST YORKSHIRE & HARROGATE STP

You matter most

Harrogate and District NHS
NHS Foundation Trust

Strategic landscape

- The West Yorks and Harrogate Sustainability and Transformation Plan (STP) is moving forward
  - Commissioner landscape evolving
  - Acute Trust providers have agreed a Committee in Common
  - Specific collaborative projects being progressed
- The local New Care Model (Vanguard) is fully mobilised
  - National funding for final year confirmed but work to do to balance local investment
  - Some gaps in workforce
  - Arrangements made for formal evaluation

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RISKS AND ISSUES

You matter most

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NHS Foundation Trust

Risks

The top scoring strategic risks for the Trust relate to:

1. Ability to deliver integrated models of care
2. Medical and nurse staffing levels
3. System level financial risks
4. Lack of a Single Care Record

The top scoring operational risks in the organisation are:

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

And some tricky issues!

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Workforce supply issues

Long term planning to close the system level affordability gap

Pressure on critical infrastructure

Future health and care architecture

You matter most

And finally….

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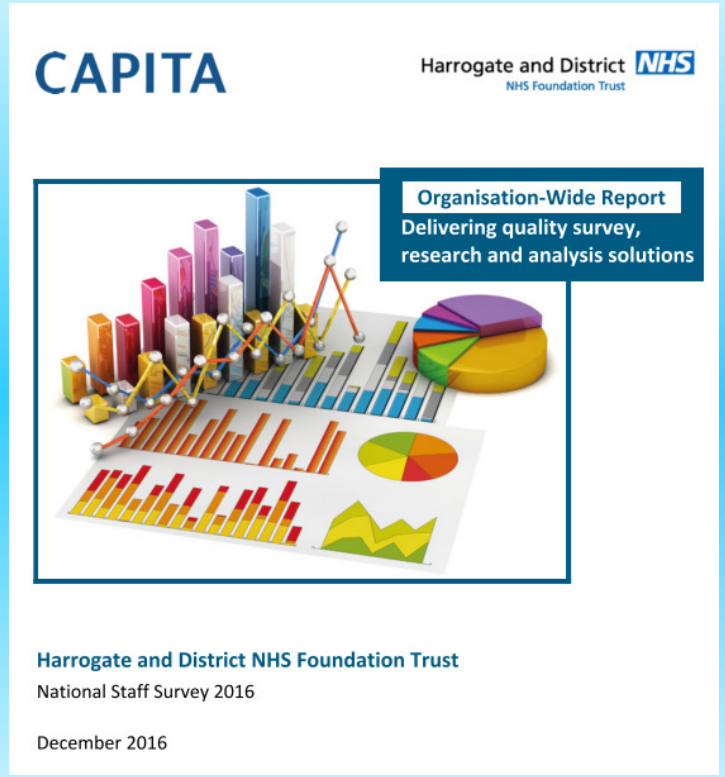

- ✓ Staff engagement score increased for 3rd consecutive year
- ✓ +5% staff feeling confident raising concerns
- ✓ +5% staff stating people are treated fairly when they do
- ✓ +2% recommend as a place to receive care

- ➢ -3% recommending HDFT as a place to work (66% this year, vs 69% in 2015. Benchmark in 2015 was 58%)

You matter most