

HARROGATE AND DISTRICT NHS FOUNDATION TRUST  
**ANNUAL REPORT AND ACCOUNTS 2013 / 2014**



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**Presented to Parliament pursuant to Schedule 7 paragraph 25 (4)(a) of the National Health  
Service Act 2006**



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## **CHAIRMAN'S STATEMENT**

The year 2013/14 reflects another period of significant success and achievement for the Trust despite a challenging 12 months for the health sector as a whole. It saw fundamental changes in the structure of the NHS, combined with continued national financial pressures and the publication of the second Francis Report into the failings at Mid Staffordshire NHS Foundation Trust.

The Francis Report, rightly, put the spotlight firmly on the quality of the services provided across the whole of the NHS; we, at Harrogate and District NHS Foundation Trust, pride ourselves on the quality of the services we offer which this year have been endorsed by external scrutiny. This included the successful re-assessment of our Maternity services at level 2 of the Clinical Negligence Scheme for Trusts (CNST), through the very positive National Inpatient and Staff Surveys and lastly and most importantly by the strong feedback and positive report from the Care Quality Commission following their inspection of our acute services in the autumn of 2013. In addition, we achieved all aspects of our key performance targets ending the year with a small surplus and reporting a green Governance rating to Monitor, our regulator.

A vital part of our governance is our Council of Governors and I would like to thank all Governors who have given so freely of their time to assist the Board of Directors in developing and delivering our vision and providing assurance to the Foundation Trust Members and the wider public regarding the effectiveness and efficiency of the Trust. In particular, I would like to recognise those Governors who retired last December after nine years of invaluable service, commitment and contribution: Mrs Pat Hewitson, Councillor Margaret-Ann de Courcey Bailey and Mr Andy Wilkinson were pioneer Governors back in 2005 and they did much to advance the role of Foundation Trust governorship.

We also in the year saw a number of changes to the Board of Directors and I would like to record my thanks to Robert Wivell, Vice Chair and Non-Executive Director, Sarah Nattress, Non-Executive Director, Anne Lawson, Director of Governance and Janet Probert, Director of Partnerships and Innovation, all of whom left us. Angela Monaghan, Chief Nurse, will also be retiring in June 2014 and we are delighted that Mrs Jill Foster has been appointed in her place. During the year we welcomed to the Board of Directors, Professor Sue Proctor, Mrs Lesley Webster and Mr Chris Thompson as Non-Executive Directors, all of whom bring a wealth of experience and expertise in both the public and private sectors.

We continue to build on our vision to improve quality of care, work with our partners, play an active role in the community and expand our services to more people in a wider area. To enable us to achieve this we need to embrace new ways of doing things as we must do more within financial constraints to meet the expectations of the public we serve. An example of this is the move to provide more services on a seven day a week basis, which is being rolled out across additional areas of the Trust. Combined with this we will listen to and take on board your feedback on how we can do better; the introduction of the Family and Friends Test will afford us a new way of gathering vital patient and carer feedback. At times we do not get everything right and this we recognise; we are indebted to the work of the Patient Voice Group, which assists us through an independent and constructive methodology to assess our services and harness vital feedback so that we can constantly improve.

As a NHS Foundation Trust, it is important that we work with our local community to ensure that our services reflect their needs and expectations. We now have more than 14,000 public and over 3,000 staff Members who take an interest in the work that we do and the services we provide. We value and welcome the opinions and contributions they bring to our work and our Members are key to influencing service. We have held a number of public events such as our biggest ever Open Event with over 50 teams, from both acute and community services participating and highly successful 'Medicine for Members' lectures which are a crucial part of our public engagement. We always welcome new Members to the Trust. If you would like to join, please contact the Foundation Trust Office on 01423 554489, email [nhsfoundationtrust@hdfnhs.uk](mailto:nhsfoundationtrust@hdfnhs.uk) or visit [www.hdfnhs.uk](http://www.hdfnhs.uk)

We are delighted to announce that the Sir Robert Ogden Macmillan Centre, a state of the art facility, opened in March. This centre provides a ground breaking environment in which we can offer a whole range of clinical and holistic services to cancer patients and their carers and we are indebted to Sir Robert and to Macmillan Cancer Support for their help in making this happen. In addition, we opened a new day case theatre, a new stroke unit and have developed a new model of community stroke care through telehealth which was cited as innovative good practice by the Care Quality Commission.

However, none of our success or our confidence in our ability to meet the challenges ahead would be possible without the continued dedication, hard work and passion of our 3,500 staff and our 500 volunteers. Our duty of care to them was evident in our retaining our Investors in People status and now we strive to attain the bronze award to demonstrate our ongoing commitment to our invaluable staff. I am grateful to each and every one of them and I am proud to be able to work alongside them all as part of a strong, compassionate and successful team.

My final words must be to thank Mr Richard Ord, Chief Executive, who retires this summer after five years at the helm and nearly 30 years of service at our Trust, and we look forward to welcoming Dr Ros Tolcher, who is currently Chief Executive of Solent NHS Trust and has been appointed as Richard's successor. We are all indebted to Richard who has led this Trust with total commitment to and passion for the quality of service provided to patients and those who access our services. Under Richard's leadership the Trust has gone from strength to strength and he leaves the Trust in an excellent state of health, with a clear vision and strength of purpose. I personally would like to thank Richard for his exemplary leadership and commitment.

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

## **STRATEGIC REPORT**

### **Chief Executive's Introduction**

The last year has been an exciting and challenging one. The Trust has been extremely busy delivering services both within its hospitals in Harrogate and Ripon and across the communities of North Yorkshire and Leeds that we serve.

We were inspected by the Care Quality Commission (CQC) in November 2013. We were one of the first Trusts in the country to be inspected under the new regime. The inspection looked at services provided at Harrogate District Hospital and found them to be safe, effective, caring, responsive and well-led. There were no actions that the hospital was required to take to improve and in two areas, the use of telehealth in stroke care and the use of volunteers, the Trust was found to be an example of good practice.

There were four areas where it was suggested that the hospital could improve and the Trust is progressing work to address each of these:

- Review staffing levels in wards, particularly those caring for older people;
- Improve pain control in some areas;
- Improve do not attempt cardiopulmonary resuscitation (DNACPR) recording at end of life;
- Review thresholds for reporting serious incidents.

Whilst this is an excellent endorsement of the services we offer, I am keen to emphasise that we are not complacent, and we know that we do not get it right all the time. We work extremely hard to continually improve the services that we deliver and we always welcome your feedback to help us to provide the best possible care to people who use our services.

The Trust continues to focus on its strategic vision, namely to:

1. Drive forward improvements in the quality of services to improve patient safety, outcomes and experience for people who use our services.
2. Work with our partners to develop and implement the joint service strategy across the health communities we serve.
3. Develop more integrated community based services, enabling people who use our services to be treated closer to home, or at home.
4. Continue to expand our secondary care services into Leeds and maximise income.

Alongside our vision, we have agreed the following priorities, linked to improving the quality of care we offer:

- Reducing pressure ulcers
- Improving fluid management
- Improving pain control
- Preventing falls
- Improving handover of information between professionals
- Supporting people to make healthy lifestyle choices
- Improving discharge, especially on the day of discharge
- Improving end of life care
- Improving dementia care

- Making the best use of patient feedback.

These priorities allow us to have a specific focus on areas where we want to further improve, though they represent only a part of our commitment to high quality care.

I am delighted that the Sir Robert Ogden Macmillan Centre has opened this year, offering state of the art facilities for cancer patients and their carers. The Centre offers enhanced services, especially in wellbeing and welfare, enabling a more holistic approach to cancer care. The building of the Sir Robert Ogden Macmillan Centre was possible thanks to the generosity of Sir Robert himself and Macmillan Cancer Support and I would once again thank them on behalf of the Trust and all those who will benefit.

The Trust has also been doing a significant amount of work to enhance and expand services offered closer to people's homes. This has included new services at Yeadon Health Centre and increasing the number of Community Midwives and Health Visitors. Also, at Harrogate District Hospital, we have also employed additional nursing staff, working towards offering the most responsive care possible to our patients.

I would like to take this opportunity to thank all staff and our volunteers for their continued hard work and dedication in providing high quality services and care. As I leave the Trust in the summer of 2014, I know that the coming year will be equally exciting and challenging and everyone within the Trust is continually aiming to deliver high quality care to ensure safe, positive experiences across all of the services we provide, for all people who use our services. I wish the Trust and everyone involved with its work all the best for the future.

**Richard G Ord**  
**Chief Executive**

### **A Brief History of the Foundation Trust and its Statutory Background**

Harrogate and District NHS Foundation Trust (HDFT or the Trust) was founded under the Health and Social Care (Community Health and Standards) Act 2003 and authorised as an NHS Foundation Trust from 1 January 2005. The Trust is the principal provider of hospital services to the population of Harrogate and surrounding district and also to north Leeds. This represents a catchment population of approximately 200,000. In addition, on 1 April 2011, the Trust took on responsibility for a wide range of community based services covering the Harrogate and District locality and some services covering the whole of North Yorkshire, as part of the Transforming Community Services programme.

Harrogate District Hospital has an Emergency Department, extensive outpatient facilities, Intensive Therapy Unit and High Dependency Unit, Coronary Care Unit, plus five main theatres and a Day Surgery Unit with further theatres. The Macmillan Dales Unit has provided assessment and treatment, principally for the diagnosis and treatment of patients with cancer until these services moved into the new Sir Robert Ogden Macmillan Centre in March 2014. Dedicated purpose built facilities are also provided on site for Cardiology, Endoscopy, Pathology, Pharmacy, Radiology and Therapy Services, as well as a Child Development Centre, Stroke Unit and Women's Unit. The Trust also has a central delivery ward and Maternity services, together with an Early Pregnancy Assessment Unit.

The Lascelles Neurological Rehabilitation Unit provides care for inpatients with a range of neurological conditions and brain injuries.

Ripon Community Hospital has an inpatient ward and offers a range of outpatient services to the communities of Ripon and the surrounding area.

HDFT also acts as the first contact for access to more specialist services through alliance based working with neighbouring hospitals. These extended services are provided by visiting Consultants, or alternatively, by the patient travelling to hospitals in York or Leeds.

The range of hospital services that are provided in partnership with York Teaching Hospitals NHS Foundation Trust (YHFT) include Breast and Cervical Screening, Dermatology, Ear Nose and Throat (ENT), Genito-Urinary Medicine (GUM)/Sexual Health Services\*, Neurophysiology, Non-Surgical Oncology, Ophthalmology, Oral and Maxillofacial Surgery, Orthodontics, Renal Medicine, Rheumatology, Urology, Vascular Services and Satellite Renal Unit\*.

(\*Services managed by YHFT, but provided in facilities on the Harrogate District Hospital (HDH) site.)

In addition, HDFT has a number of established clinical links with Leeds Teaching Hospitals Trust (LTHT). These include Coronary Heart Disease, Neurology, Plastic Surgery, Specialist Paediatrics and access to specialist Cancer Services.

Links have also been strengthened with commissioners in Leeds, providing further services in Orthopaedics and General Surgery and an outpatient clinic for ENT services at Chapeltown Health Centre and an outreach outpatient clinic for Orthopaedic services at the Street Lane GP practice in Leeds. Further outpatient outreach clinics are held at Wetherby Primary Care Centre and Yeadon Health Centre for the specialities of Dermatology, General Surgery, Gynaecology, Maternity, Paediatrics, Neurology, Respiratory, Gastroenterology, Urology, Vascular and Rheumatology clinics.

With the advent of Patient Choice, the Trust recognises the opportunities to expand services to offer health care to a wider population. The Trust will continue working in partnership with Clinical Commissioning Groups to expand secondary care services where possible into Leeds.

In terms of community based services, the Trust provides services including:

- Children and Family Services;
- Community Equipment and Wheelchairs Stores;
- Community Podiatry Services;
- Contraception and Sexual Health (CASH);
- District and Community Nursing;
- Health Visitors;
- GP Out of Hours services;
- Infection Prevention and Control/Tuberculosis Liaison Services;
- Minor Injury Units at Ripon Community Hospital and New Selby War Memorial Hospital;
- Older People and Vulnerable Adults services;
- Safeguarding Children Services;
- Salaried Dental Services;
- Smoking Cessation Services, and;
- Specialist Community Services.

The overall catchment population for these services can be as great as 800,000.

### **The Foundation Trust's Strategy**

The Trust continues to focus on its strategic vision, namely:

1. Drive forward improvements in the quality of services to improve patient safety, outcomes and experience for people who use our services.

2. Work with our partners to develop and implement the joint service strategy across the health communities we serve.
3. Develop more integrated community based services, enabling people who use our services to be treated closer to home, or at home.
4. Continue to expand our secondary care services into Leeds.

To support these, the Trust has agreed its Objectives, following consultation with staff. These are:

1. Further embed a culture of delivering the highest standards of care and compassion, particularly within all patient facing teams and nursing.
2. Develop clear plans to ensure that people are only admitted to hospital when it is the right care setting for them. Once admitted, they have a defined, well communicated care plan which includes plans for a safe and timely discharge.
3. Progress a sustainable Consultant delivered model of secondary care for all our patients that provides consistently high quality and equitable care, on a seven day per week basis.
4. Ensure consistent attainment of all national performance standards, including the continuing reduction in the Trust's mortality rate.
5. Expand the provision of outreach services by HDFT into the Leeds locality, including outpatients, diagnostics, Maternity services and follow up care, and explore further opportunities.
6. To simplify and co-ordinate the pathways of care for people with Long Term Conditions.

These complement the Trust's key Quality Priorities which are set out in the Quality Report contained within this Annual Report.

## **Current and Expected Future Performance**

### Overall Performance 2013/14 and 2014/15

The Trust completed 2013/14 with a Continuity of Services rating of four and a green Governance rating, in line with Monitor's Risk Assessment Framework. In the coming year, the Trust aims to achieve a surplus of £1.7m and will meet all the required performance targets as laid out in the Risk Assessment Framework.

It will maintain these ratings of four for Continuity of Services and green for Governance in the current year and has detailed, in its Operational Plan to Monitor, the ways in which this will be achieved. The five year Strategic Plan also details the longer term organisational strategy, as well as the strategic opportunities and risks for the Trust.

### Quality

The Trust is fully committed to high quality care, as confirmed by the CQC inspection that took place in November 2013. The Quality Report, included within this Annual Report, details progress made on the Quality Priorities identified in 2013/14 and the agreed Quality Priorities for the coming year. These are clear measurable priorities that have been agreed with staff and stakeholders. The Trust will monitor performance against them through its Quality and Governance Group.

The latest CQC Intelligence report rated the Trust as having a risk score of zero, one of only six acute Trusts in the country with the lowest (best) possible score, and only one of two non-specialist organisations.

There is a clear governance and reporting framework in place to ensure that the Trust is delivering its operational plans and targets. Further detail about this is reported in the Annual Governance Statement and later in the Annual Report.

**Operating and Financial Review of the Foundation Trust**

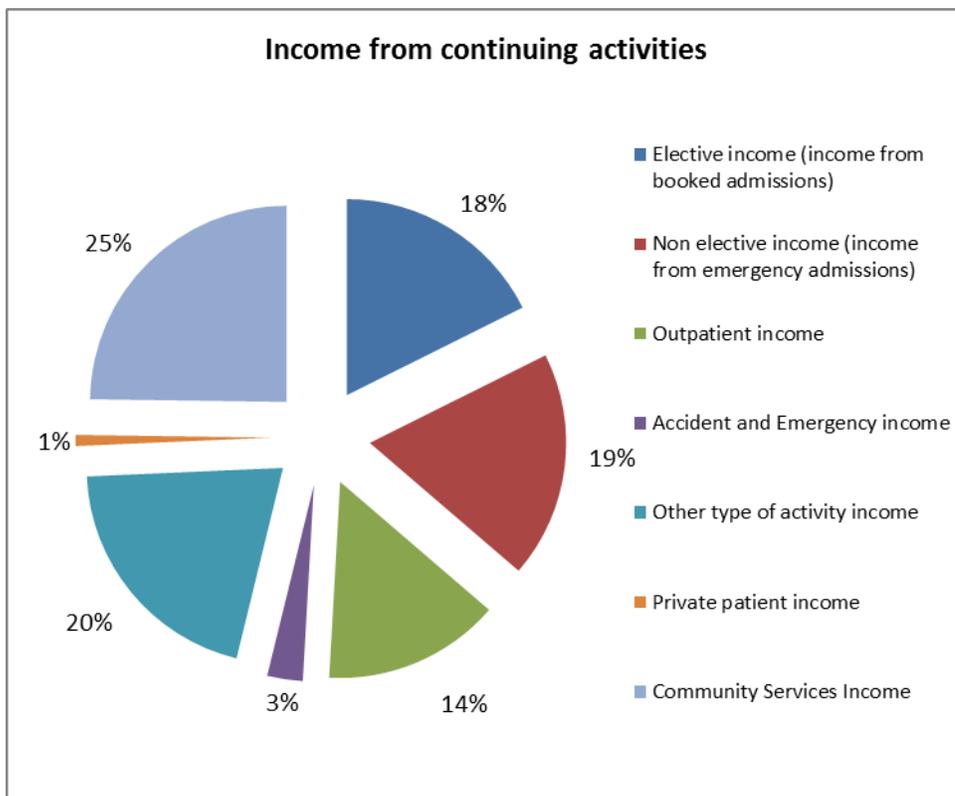
The income and expenditure position for the Trust for 2013/14 was a surplus of £671,000. Before exceptional items, the surplus was £268,000.

The table below provides a high level summary of the income and expenditure account for 2013/14.

	2013/14 actual £000s
Income	182,260
Expenditure	(181,992)
Surplus before exceptional items	268
Donations from Sir Robert Ogden and Macmillan Cancer Support for capital expenditure	5,048
Impairments of fixed assets	(4,645)
Reported (deficit)/surplus for financial year	671

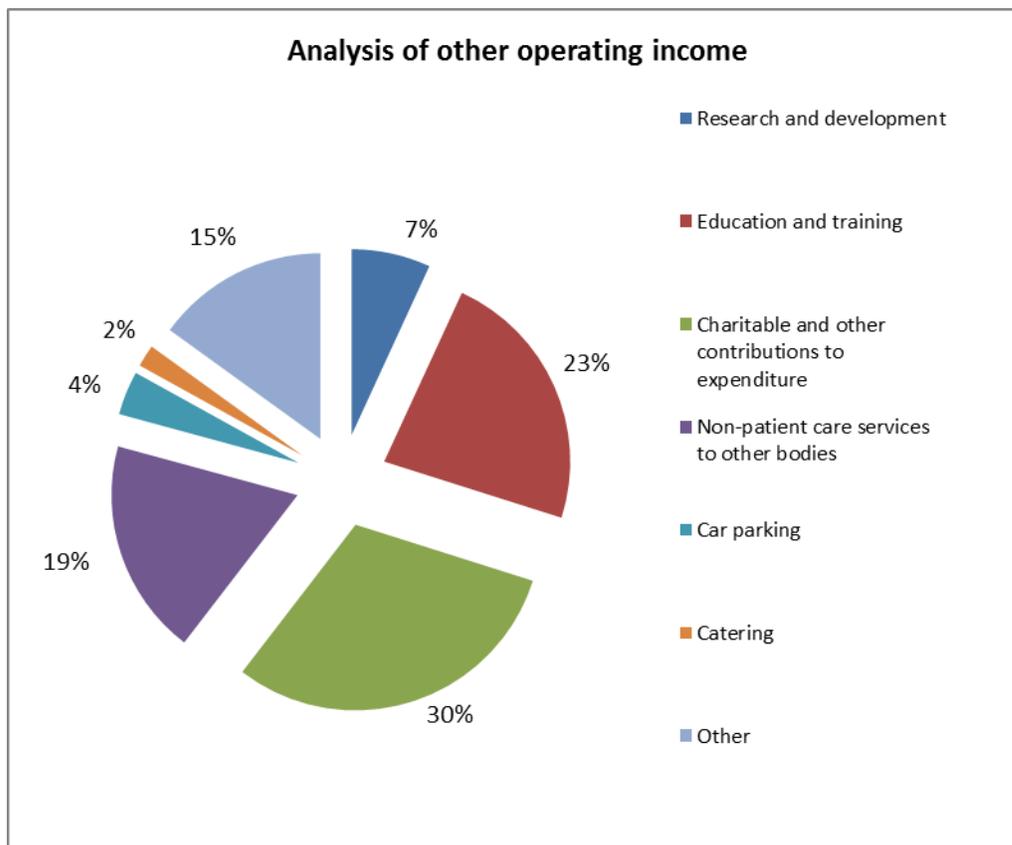
**Income generated from continuing activities**

Total income from continuing activities for the year 2013/14 was £169.9m. This represented 93% of total income for the year. An analysis of this income is shown below:



#### Other operating income

Other operating income totalled £17.3m during 2013/14. This represented 7% of total income for the year and an analysis of this income is shown below:



### Cash

The Trust had a cash balance of £5.2m at the close of the financial year, which was marginally above the original plan of £5.1m.

The Trust had a working capital facility during 2013/14 of £13.5m. This was not accessed and following review by the Board of Directors this facility has not been renewed for 2014/15.

During 2013/14, the Trust agreed a loan from the Foundation Trust Financing Facility of £1.5m for investment in a replacement MRI scanner.

### Monitor risk rating

The Trust achieved a Continuity of Services risk rating of 4 at the end of 2013/14. Financial risk is assessed on this scale from 1 (high risk) to 4 (low risk).

### 2014/15 financial outlook

The Trust's Business Plan for 2014/15 includes a financial plan that delivers a Continuity of Services rating of 4. Budgets and activity plans have been agreed which, if fully delivered, will generate a recurrent surplus of £1.7m. This includes the requirement to deliver a Cost Improvement Programme in excess of £11m.

At 28 May 2014, the Trust remains in discussions with its main commissioner (Harrogate and Rural District (HaRD) Clinical Commissioning Group (CCG)) on a contract value for 2014/15. The Trust remains confident that a satisfactory contract level will be agreed and that income will be received in line with its annual planning assumptions.

There are a number of financial risks for 2014/15 that will require monitoring, review and potential mitigating management action. These are detailed as follows:

Nature of Risk	Mitigating /control actions
<p><b>Acute and Community services contract</b></p> <p>Achievement of income from HaRD CCG for the acute services and community services contract</p>	<p>In the event that the Trust cannot agree a contract in line with the planning assumptions included in the plan, contingency plans are in place which include utilising the planning contingency and Trust surplus to address the deficit. Finally the Trust could defer implementing some of the service and capital expenditure priorities included in the plan for 2014/15 and manage the infrastructure costs on a non-recurrent basis.</p>
<p><b>CCG seeking to reduce emergency activity but without investment in community</b></p> <p>The CCG has indicated an intention to reduce the levels of emergency activity seen within the Trust. This would require additional investment in the community services, which may not be forthcoming.</p>	<p>The Trust has good relationships with the local CCG, and will maintain a dialogue to try to ensure plans are robust and deliverable.</p>
<p><b>Monitor Risk Assessment Framework (RAF)</b></p> <p>The Monitor RAF places greater emphasis on liquidity than the existing Financial Risk Rating. Cashflow and the management of debtors and creditors will become more important. If the Trust drops below a level 4, Monitor will require monthly monitoring of performance.</p>	<p>The capital expenditure programme could be delayed to some extent. Non-essential non-pay expenditure would have to be reduced and some service developments could be deferred.</p>
<p><b>Cashflow</b></p> <p>Non-payment by commissioners for activity delivered or lack of expenditure control internally causing cash shortages</p>	<p>Capital expenditure programme could be delayed. Planning contingency available. Strong cash controls internally.</p>
<p><b>Expenditure control</b></p> <p>Ability to deliver the agreed levels of Cost Improvement Programme (CIP)</p>	<p>The Trust has a track record of delivering CIP and overall expenditure control has generally proved successful in previous years. A piece of work is currently being undertaken to emphasise and embed expenditure controls on pay. The management structures and accountability framework internally will ensure that cost control has sufficient emphasis. The financial plan includes uncommitted reserves as contingency together with a small amount for developments which will not be released unless expenditure is controlled.</p>
<p><b>Reduction in quality of services</b></p>	<p>Specific investment is included in the plan for improvements in quality. The plan recognises that there is a lead time for</p>

<p>In the move to improve efficiency, the quality of services in the hospital and the community is compromised. This would result in a reduction in our ratings, poor reputation, non-compliance with national standards etc. This in turn would result in a reduction in activity as patients choose not to come to HDFT for their treatment.</p>	<p>improving the quality of services and gaining efficiencies that come as result. Any changes are phased in the plan and the financial gains included at the appropriate stage. The performance and quality standards of the Trust will continue to be monitored rigorously through the Performance Group to ensure high standards are maintained and enhanced where possible.</p> <p>The efficiency programme is signed off at Directorate level by Clinical Directors and clinicians have been involved in development of efficiency plans from the early stages.</p>
<p><b>Activity growth</b></p> <p>The Trust's ability to continue to increase activity to enable growth year on year with our commissioners, particularly Leeds CCGs.</p>	<p>The percentage growth is based on historic trends and demographic assumptions, together with a step change delivered through the move to provide services locally to Leeds West patients in Yeadon. It is likely, as in previous years, that the Leeds CCGs would take up any additional capacity available in the event of a reduction in demand from HaRD CCG.</p> <p>Whilst activity is likely to grow, HaRD CCG have indicated further and more restrictive thresholds will be needed due to the funding being constrained in future years. The Trust is engaged with HaRD CCG in discussing clinical thresholds and has worked together in the past successfully to ensure activity is appropriate and clinically beneficial.</p>
<p><b>Insufficient Capacity</b></p> <p>The Trust does not have sufficient staffing resources or physical accommodation to be able to deliver the required levels of activity either in the hospital or the community</p>	<p>Look to recruit staff wherever possible or link with other organisations e.g. through alliances. In relation to the physical estate, additional theatre capacity was available from June 2013, and further discussions with partners are exploring the potential availability of suitable premises outside of the hospital site. Work is ongoing to improve utilisation of the community estate.</p>

#### Capital investment activity

During 2013/14, HDFT invested £3.5m as part of the Trust's capital programme. The breakdown of the investment is shown in the table below:

<b>Scheme</b>	<b>£'000</b>
Sir Robert Ogden Macmillan Centre & Single Deck Car Park	1,154
Maxillofacial, Orthodontics and Day Surgery Unit	853
Replacement MRI scanner enabling works	150
Care Closer to Home Ward Improvements	145
Endoscopes	716

Other (including equipment replacement, IT replacement, environmental improvements)	474
<b>TOTAL</b>	<b>3,492</b>

In addition, donations of £3 million each were received to complete the Sir Robert Ogden Macmillan Centre from Sir Robert Ogden and Macmillan Cancer Support.

### Land interests

During the financial year ending 31 March 2014, the Trust's land and buildings were revalued by the Valuation Office Agency (VOA) which is an Executive Agency of HM Revenue and Customs (HMRC). This valuation, in line with the Trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in an increase in value of the Trust's land and buildings of £4,624,000, which has been incorporated in the accounts.

### Accounting policies

The Trust prepares the financial statements under direction from Monitor in accordance with NHS Foundation Trust Annual Reporting Manual 2013/14 which is agreed with HM Treasury. The accounting policies follow International Financial Reporting Standards (IFRS) to the extent they are meaningful and appropriate to NHS Foundation Trusts.

### Investments

HDFT made no investments through joint ventures or subsidiary companies and no other financial investments were made and no financial assistance was given or received by the Trust.

### Details of activities designed to improve value for money

A formal cost improvement programme (CIP) was approved for 2013/14, which set targets and action plans aimed at improving efficiency. The CIP was monitored monthly and achieved £10.0m against its target savings of £11m. Examples of higher value schemes are:

- Delivering additional activity at lower cost than the associated additional income;
- Savings on the Trust's 'insurance' premium due to improvements in quality and governance;
- Savings through no longer using the private sector to deliver activity.

### Charitable funds

The Board of Directors acts as corporate Trustee for all funds held on trust and is registered with the Charity Commission as a single charity.

HDFT continues to receive donations from a wide variety of benefactors, for which it is extremely grateful, and continues to utilise these funds for the benefit of both patients and staff.

As at 31 March 2014, the value of the funds held on trust amounted to £2,331,000, which is an increase of £457,000 from 2012/13, while income received in the full 12 months amounted to £992,000 (£391,000 in 2012/13). The value of resources expended amounted to £640,000 (£432,000 in 2012/13).

The investment portfolio is managed on a discretionary basis by Brewin Dolphin, based in Leeds. Brewin Dolphin does have powers to make changes to the investments without firstly obtaining agreement from the investment panel, however any such changes are subject to an ethical investment policy (e.g. shares

of tobacco manufacturers cannot be held). The portfolio is reviewed quarterly by the Investment Panel, ensuring compliance with the ethical investment policy.

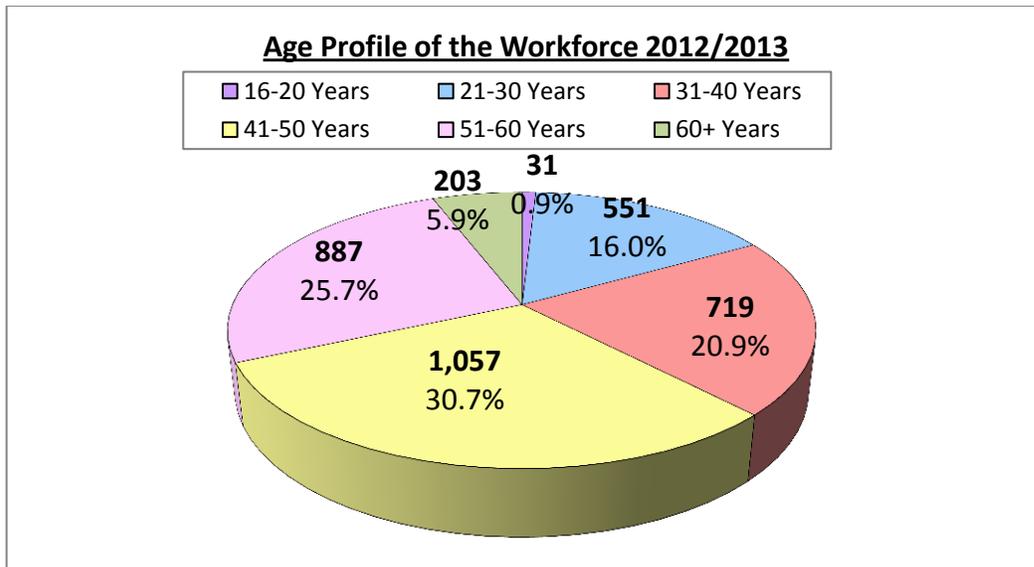
The investment portfolio at 31 March 2014 stood at £1,860,000 (£1,765,000 as at 31 March 2013). The investment portfolio increased during the year by £95,000.

The Charitable Fund Annual Report and Accounts for the year ended 31 March 2014 is published separately and is available from the Trust on request.

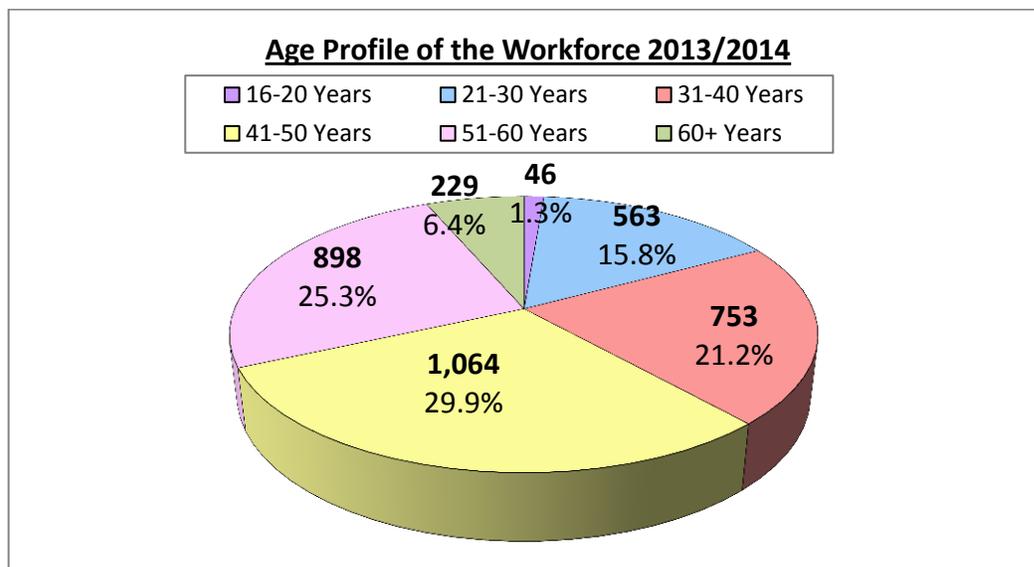
### **Information on the Trust's Employees**

All of the data profiles of the Trust's staff in the charts below have been collated from the Trust's Electronic Staff Record (ESR) system and provides a comparison between 2012/13 and 2013/14. Percentages have been rounded to one decimal point and may not therefore total 100%. All figures are taken for the end of the financial year.

#### **Age Profile 2012/2013**



## Age Profile 2013/2014

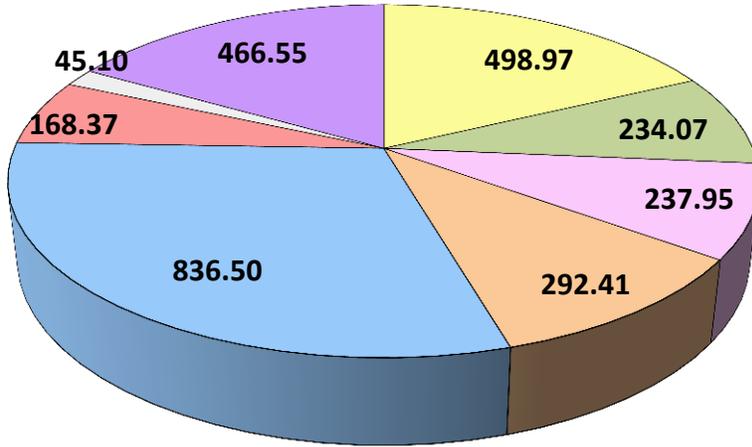


Age Band	2012/2013		2013/2014	
	Headcount	% of Workforce	Headcount	% of Workforce
16-20 Years	31	0.9%	46	1.3%
21-30 Years	551	16.0%	563	15.8%
31-40 Years	719	20.9%	753	21.2%
41-50 Years	1,057	30.7%	1,064	29.9%
51-60 Years	887	25.7%	898	25.3%
60+ Years	203	5.9%	229	6.4%
<b>TOTAL</b>	<b>3,448</b>	<b>100.1*</b>	<b>3,553</b>	<b>99.9*</b>

## Staff Group Profile 2012/2013

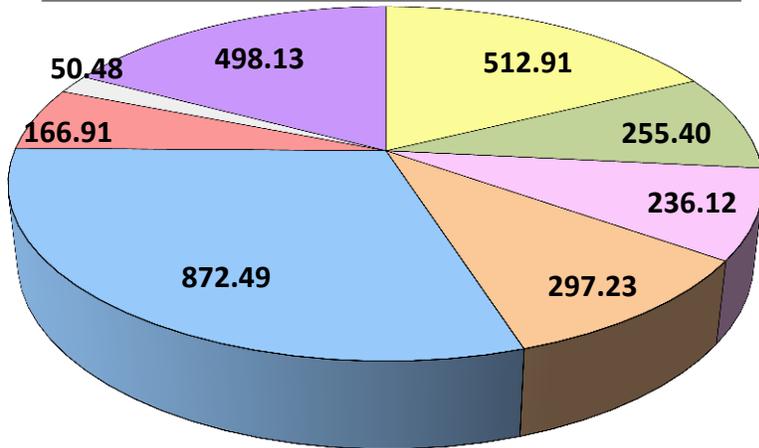
The charts below show the number of Trust employees working in each staff group in 2012/13 and 2013/14.

**Staff Group Profile of the Workforce 2012/2013 (WTE)**



**Staff Group Profile 2013/2014**

**Staff Group Profile of the Workforce 2013/2014 (WTE)**



Staff Group	2012/2013		2013/2014	
	Whole Time Equivalent	Headcount	Whole Time Equivalent	Headcount
Administrative and Clerical	498.97	623	512.91	643
Allied Health Professionals	234.07	295	255.40	322
Estates and Ancillary	237.95	284	236.12	278
Medical and Dental	292.41	396	297.23	400
Nursing and Midwifery Registered	836.50	1,024	872.49	1,054
Scientific and Technical	168.37	186	166.91	187
Snr Management	45.10	47	50.48	52
Support Workers	466.55	593	498.13	617
<b>TOTAL</b>	<b>2,779.92</b>	<b>3,448</b>	<b>2889.67</b>	<b>3,553</b>

### Senior Staff Changes during 2013/14

#### Appointments

Mr	David	Barker	Local Security Manager Specialist
Ms	Fiona	Clarke	General Manager - Integrated Care
Mrs	Lorraine	Cooper	Service Improvement Facilitator
Dr	Madhuri	Dasarathi	Consultant - Paediatrics
Mr	William	Davenport	Estates Manager - Performance and Contracts
Mr	Gary	Flavell	IT Project Leader
Ms	Hannah	Fletcher	Pharmacist
Mrs	Jacqueline	Goldthorpe	Specialist Radiographer
Mrs	Sarah	Grant	Health and Wellbeing Area Manager
Mrs	Ruth	Grasty	Finance Manager
Dr	Natalia	Gunaratna	Consultant - Acute Elderly Care
Mr	Jonathan	Hammond	General Manager - Elective Care
Mr	Robin	Hansford	Logistics Manager
Miss	Jennifer	Harris	Head of Fundraising and Development
Ms	Clare	Hedges	General Manager, Acute and Cancer Care
Mrs	Laura	Henry	Team Leader – Smoking Cessation Service
Mrs	Michelle	Ingham	Quality Improvement Manager - Integrated Care
Mr	Jolyon	Ingle	Systems Development and Reporting Manager
Mrs	Mrunmayee	John	Therapy Team Leader - Physio
Dr	Sharon	McKenna	Clinical Psychologist
Mrs	Lorna	McLean	Clinical Lead – Trinity Ward, Ripon Community Hospital
Mrs	Beverley	McManus	Senior Urgent Care Practitioner
Mrs	Ann	Morrison	Urgent Care Practitioner
Mr	Abdurrahman	Nuhu	Systems Development and Reporting Manager
Ms	Ruth	Orchard	Pharmacist
Miss	Michelle	Page	Improvement Facilitator
Mrs	Debbie	Pearson	Specialist Occupational Therapist
Mr	David	Plews	Deputy Director Partnership and Innovations
Mrs	Odile	Poole	Midwife
Prof.	Susan	Proctor	Non-Executive Director
Dr	Lauren	Ralston	Consultant - Acute Elderly Care

Dr	Matthew	Shepherd	Consultant – Emergency Department
Miss	Esther	Sliva	Emergency Department Manager
Mrs	Louise	Stevenson	Older People's Champion
Mr	Chris	Thompson	Non-Executive Director
Dr	Robert	Tuffin	Consultant - Anaesthetics
Dr	Alison	Walker	Consultant – Emergency Department
Mr	Matthew	Walker	Urgent Care Service and Development Manager
Mrs	Lesley	Webster	Non-Executive Director
Mr	Darren	Wilkinson	Urgent Care Practitioner / Paramedic
Mr	Ronald	Wilkinson	Urgent Care Practitioner

### Departures

Mrs	Jacqueline	Adams	Child Protection Advisor
Mrs	Debbie	Artis	Advanced Physiotherapist
Ms	Sarah	Ashworth	Sister/Charge Nurse
Mrs	Fiona	Bell	Deputy Director Partnership and Innovations
Mrs	Charlotte	Boyes	Sister/Charge Nurse
Dr	Christopher	Bulmer	Senior Nurse
Mrs	Elaine	Carlyle	Health Visitor
Mrs	Becky	Case	General Manager - Integrated Care
Mrs	Catherine	Chandler	Sister
Ms	Susan	Clarke	Child Protection Advisor
Ms	Fiona	Davidson	Cancer Manager
Mrs	Elizabeth	Davis	Senior Urgent Care Practitioner
Miss	Katherine	Duke	Human Resources Manager
Mrs	Angela	Edmunds	Productive Ward Project Manager
Miss	Rachel	Gallacher	Specialist Radiographer (Reporting Sonographer)
Mrs	Brigid	Gough	Child Protection Adviser
Dr	Zeenie	Girn	Consultant - Obstetrics & Gynaecology
Mrs	Kaye	Grannon	Specialist and Adult Services Manager
Mrs	Lesley	Hawkin	Deputy Healthcare Manager
Mrs	Elaine	Hawley	Healthcare Manager
Mrs	Rita	Hill	Senior Manager, Specialist Children's Team
Mr	Phillip	Husband	Advanced Biomedical Scientist - Microbiology
Mrs	Josephine	Johnson	Matron - Universal Children's Services
Mr	Nicholas	Kirby	Systems Development and Reporting Manager
Miss	Anne	Lawson	Director of Governance
Mrs	Jacqueline	McMahon	Associate General Manager, Integrated Care
Mrs	Ashley	Milburn	Matron
Mrs	Sarah	Nattress	Non-Executive Director/ Audit Committee Chairman
Mrs	Fiona	O'Connor	Team Leader Specialist Nursing
Mrs	Lynda	Parkinson	Podiatry Manager
Ms	Chinny	Patnaik	Senior Pharmacist
Dr	Pui	Poon	Consultant - Anaesthetics
Mr	Neil	Porter	Urgent Care Practitioner
Mrs	Janet	Probert	Director of Partnerships and Innovation
Mrs	Sara	Redfearn	Health Care Manager, HMP Northallerton
Mr	Steve	Redfern	Operational Director, Elective Care
Miss	Claire	Robinson	Ultrasonographer
Mrs	Gillian	Sands	Sister/Charge Nurse
Mr	John	Silverwood	Head - Paymaster Services
Mrs	Margaret	Simpson	Infection Prevention and Control Nurse

Mrs Tracy	Thirlwell	Midwife
Mr Simon	Valente	Podiatrist
Mrs Marie	Walker	Specialist Nurse - Skin Cancer
Mr Darren	Wilkinson	Emergency Care Practitioner
Mr Robert	Wivell	Non-Executive Director/ Vice-Chairman

**Deaths in Service**

Mr David	Borrick	Driver Technician
Mr Alan	Briscoe	Cleaning Operative
Mr Andrew	Collier	Head of Community Infection Prevention and Control
Mrs Tracy	Crowther	Ward Clerk
Mrs Tina	Flannigan	Pharmacy Homecare & Administration Officer
Mrs Mary	Gough	Health Care Support Worker
Mrs Emma	O'Shea	Bank Nurse

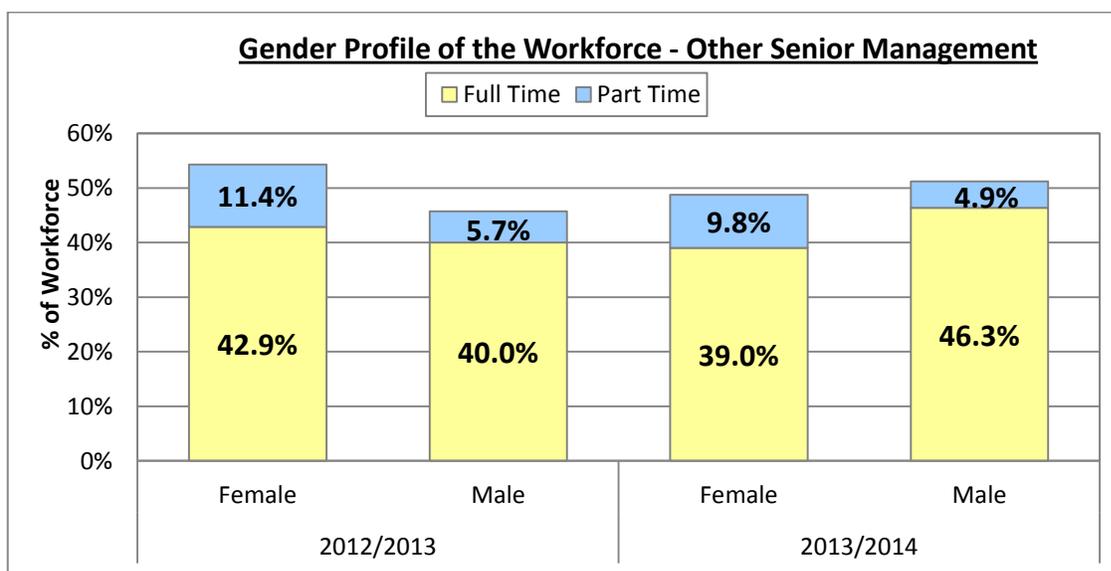
**Gender Profile**

**Directors**

The table below gives a breakdown of the number of Directors, including Non-Executive Directors, by gender.

		2012/2013	2013/2014
Gender	Category	Headcount	Headcount
Female	Full Time	2	1
	Part Time	4	4
Male	Full Time	5	5
	Part Time	2	3
<b>TOTAL</b>		<b>13</b>	<b>13</b>

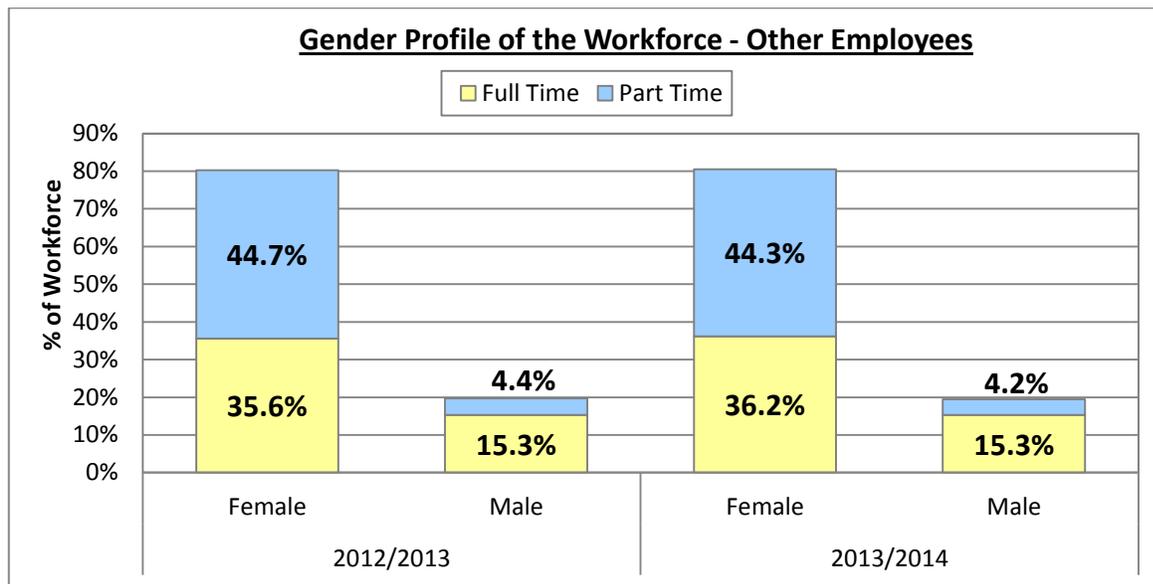
**Other Senior Management**



		2012/2013	2013/2014
Gender	Category	Headcount	Headcount
Female	Full Time	15	16
	Part Time	4	4
Male	Full Time	14	19
	Part Time	2	2
<b>TOTAL</b>		<b>35</b>	<b>41</b>

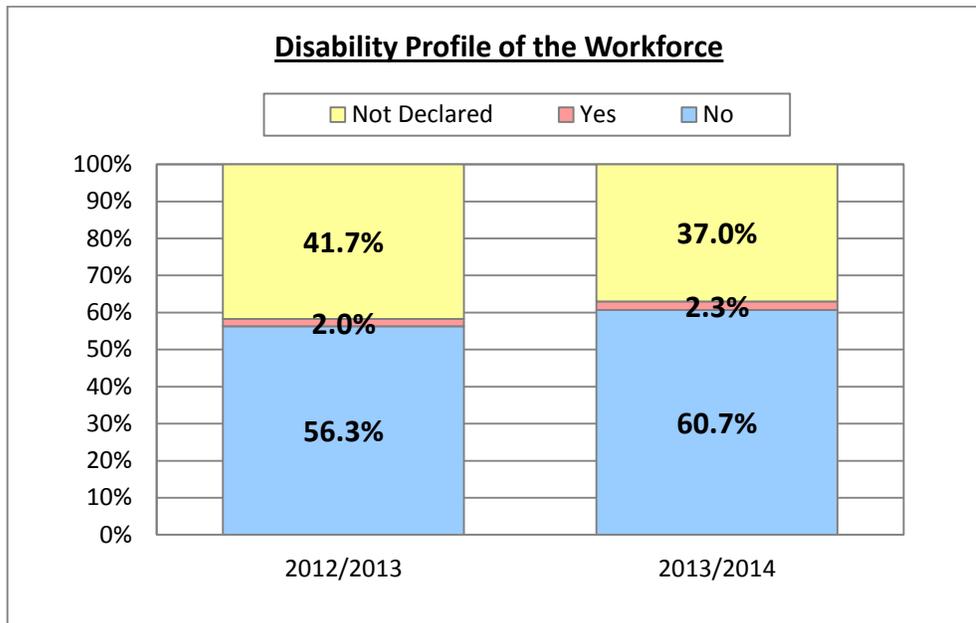
## Other Employees

As illustrated in the tables below, the Trust has increased its headcount over the past year. The majority of this increase is attributable to the appointment of additional nursing staff.



		2012/2013	2013/2014
Gender	Category	Headcount	Headcount
Female	Full Time	1,210	1,268
	Part Time	1,521	1,551
Male	Full Time	520	535
	Part Time	150	147
<b>TOTAL</b>		<b>3,401</b>	<b>3,501</b>

## Disability Profile



	2012/2013	2013/2014
<b>Disabled</b>	<b>Headcount</b>	<b>Headcount</b>
No	1,941	2,156
Yes	68	81
Not Declared	1,439	1,316
<b>TOTAL</b>	<b>3,448</b>	<b>3,553</b>

## Equality and Diversity and Human Rights

The Trust aims to ensure that services are accessible, appropriate and sensitive to the needs of the whole community and that it has a workforce representative at all levels of the population it serves.

The Trust is working hard to deliver services to its patients and staff, which reflect equality and diversity in all areas and respect of human rights, in accordance with the requirements of the Equality Act 2010. The Harrogate and District NHS Foundation Trust Equality Group has a pivotal role in reviewing services, representing interests, responding to concerns and raising standards. Membership is wide ranging and is drawn from interest groups within the community and from professional staff, whose work remit includes elements of equality and diversity. Meetings are held quarterly and ad hoc sub groups work on specific matters. The group has a role in ensuring the Trust has appropriate systems in place to:

- Recruit, develop and retain a workforce that is able to deliver high quality services and is reflective of the community served by HDFT;
- Deliver services that are accessible, responsive, and appropriate to the needs of the different interest groups and individuals;
- Become an 'Employer of Choice';
- Make a difference to the health of all groups within the communities the Trust serves.

The Equality Group covers all areas of the Trust and aims to ensure that there is consistent good practice through all services. The Trust aims to prevent discrimination, by promoting policies and services which are based on fairness, openness and inclusiveness, by treating everyone with dignity and respect and by

increased staff awareness through equality and diversity training. Levels of staff training in equality and diversity remain at high levels in all Directorates and there is an ongoing requirement for the training to be renewed every three years.

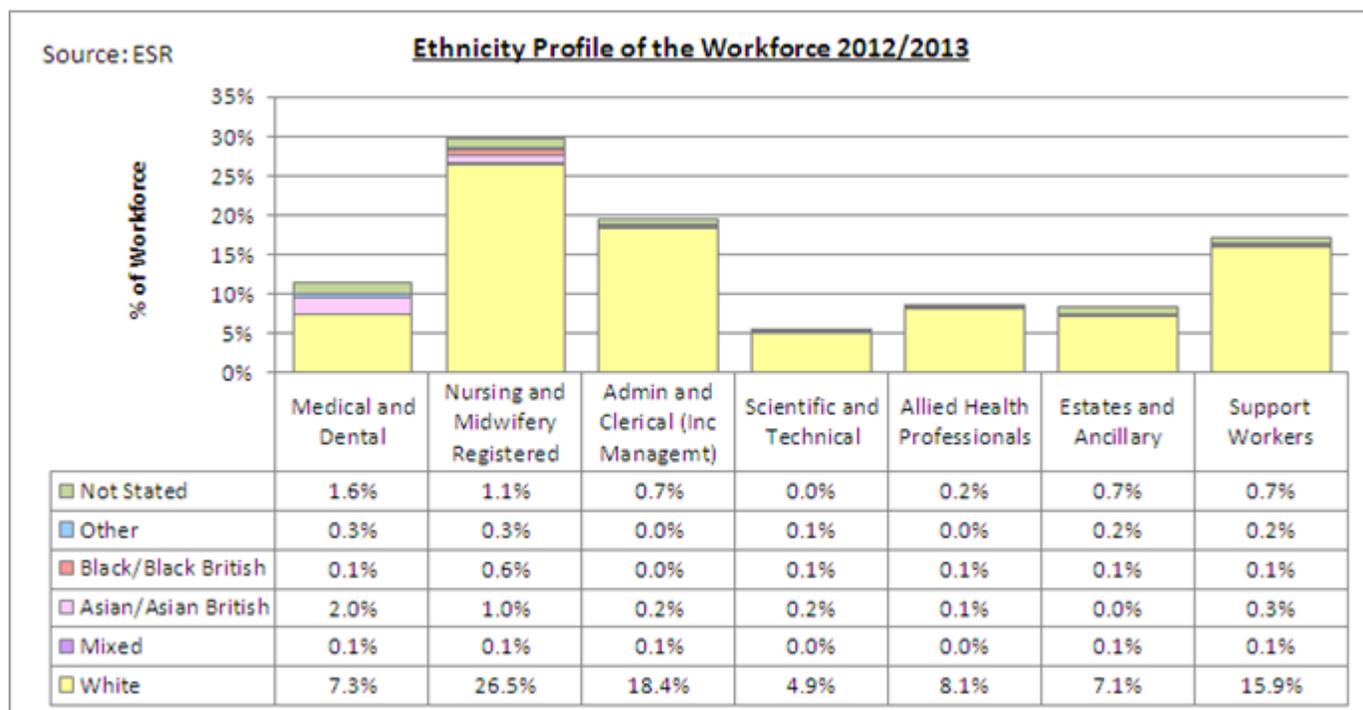
The Trust publishes employment monitoring statistics on its website ([www.hdft.nhs.uk](http://www.hdft.nhs.uk)) along with approved equality impact assessments. It has also published a report to evidence the many areas of good equality and diversity practice to demonstrate that it is meeting the public service duties identified in the Equality Act 2010. The Trust's Single Equality Scheme and Action Plan are available on the Trust's website. The ethnicity profile of the workforce is more diverse than the surrounding community which at the 2011 census was 91.3% white British.

Trust policy in respect of disabled applicants who clearly indicate that they wish to be considered for a post under the 'Positive about Disability Scheme' is that they will be shortlisted and invited for interview where they meet the requirements for the post. The Trust supports existing staff who become disabled with workplace adaptations and training. All staff have access to the local workforce development programme and the training courses provided through the programme. Staff are able to discuss their training needs with their line manager during their appraisal or at other times as arranged locally.

The Trust's Older Person's Champion co-ordinates a team of ward and department based dignity/dementia champions, who promote the dignity and rights of service users in their area with dementia symptoms.

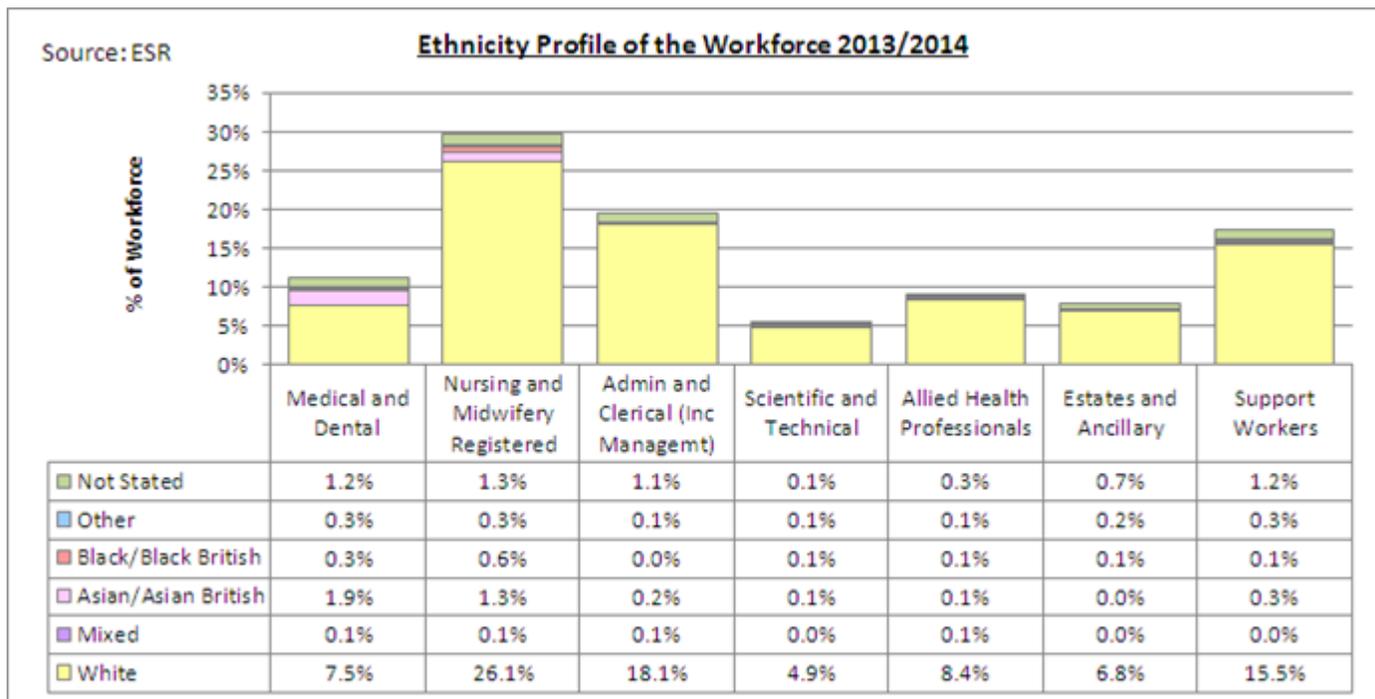
### Ethnicity Profile 2012/13 and 2013/14

The tables below detail the ethnicity profile of the Trust in 2012/13 and 2013/14.



HEADCOUNT	Medical and Dental	Nursing and Midwifery Registered	Admin and Clerical (Inc Management)	Scientific and Technical	Allied Health Professionals	Estates and Ancillary	Support Workers	TOTAL
White	253	912	634	170	279	245	547	3,040
Mixed	4	4	3	1	1	2	2	17
Asian/Asian British	68	36	7	8	3	1	9	132
Black/Black British	5	22	1	4	3	3	4	42
Other	12	12	1	2	1	8	7	43
Not Stated	54	38	24	1	8	25	24	174
<b>TOTAL</b>	<b>396</b>	<b>1,024</b>	<b>670</b>	<b>186</b>	<b>295</b>	<b>284</b>	<b>593</b>	<b>3,448</b>

## Ethnicity Profile 2013/14



HEADCOUNT	Medical and Dental	Nursing and Midwifery Registered	Admin and Clerical (Inc Mangmt)	Scientific and Technical	Allied Health Professionals	Estates and Ancillary	Support Workers	TOTAL
White	268	927	642	174	298	242	550	3,101
Mixed	5	4	3	0	2	1	1	16
Asian/Asian British	67	45	6	5	5	1	11	140
Black/Black British	9	20	1	3	3	2	4	42
Other	9	12	3	3	2	8	10	47
Not Stated	42	46	40	2	12	24	41	207
<b>TOTAL</b>	<b>400</b>	<b>1,054</b>	<b>695</b>	<b>187</b>	<b>322</b>	<b>278</b>	<b>617</b>	<b>3,553</b>

## Environmental Matters

The Trust is committed to reducing the impact on the environment from its activities wherever possible whilst at the same time improving the quality of care to its patients and service users and their carers.

Additionally, the Trust recognises that sustainability has an economic significance that will increase in coming years. The economic position now and over the coming years will mean a greater need to focus on waste reduction, efficiency and productivity. Promoting sustainability in the Trust's everyday work and through its commissioning will make a significant contribution to productivity and value for money.

Being conscious of its role and responsibilities as a good corporate citizen in the local community, the Trust has always strived to work with and encourage local suppliers wherever possible. Initiatives include:

- The majority of catering supplies are sourced from the Yorkshire Region.
- The Estates Department works with local companies where the skills and services which the department need are available. This includes engineering firms, grounds maintenance and risk management organisations. Having local companies available supports the objectives of investment in the local business environment and helps the overall management of the Trust's carbon footprint.

In October 2012, the Trust signed up to the Good Corporate Citizenship Assessment Model and achieved an initial rating of "getting there". A further assessment against the model was undertaken in January 2014. This assessment demonstrated that significant progress is being made, with a revised rating of "excellent" being achieved under the new Assessment model.

To help drive sustainability throughout the organisation, the Trust has developed a sustainability strategy and management plan to help the organisation achieve a standard of sustainable development that will have positive impacts on health, expenditure, efficiency and equity in the wider environment.

The management plan has helped drive a number of initiatives over the past 12 months. These have included:

- Reducing vehicle CO<sub>2</sub> emissions through the setting of a maximum emissions cap of 130 (g/km) CO<sub>2</sub> for lease vehicles and any vehicles that are available through the Trust's Salary Sacrifice Scheme.
- The Trust working with one of its key partners, NHS Supply Chain, to identify the amount of carbon used in relation to the Trust's procurement activities. This work identified that the amount of carbon saved in 2013/2014 amounted to 46.4 tonnes through making use of the consolidated NHS Supply Chain service as opposed to purchasing direct from suppliers.

The Trust is working in partnership with the Carbon Trust to identify energy consumption across the Harrogate District Hospital site to identify opportunities for reducing the Trust's use of gas and electricity. In parallel with this review, a site wide condition survey has also been undertaken to establish the level of backlog maintenance that the Trust currently bears. The collation of these two elements of work has identified opportunities for reducing energy consumption and replacing life expired engineering systems in the medium to long term.

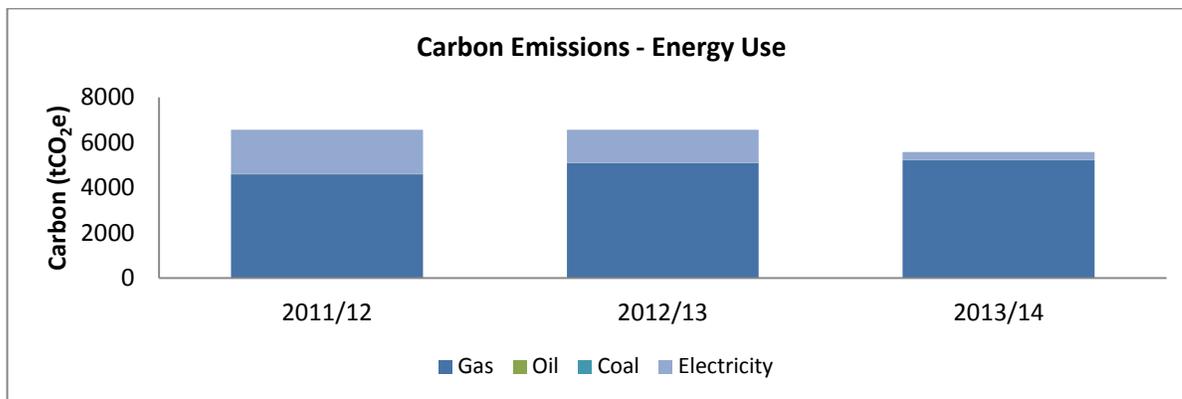
## Energy

The Trust has spent £1,453,863 on energy in 2013/14, which is a 9.2% increase on energy spend from 2012/13, reflecting a 6.3% increase in consumption. This increase can be attributed to the capital projects which have been completed or in construction in the year, in particular the new Day Surgery theatre and the Sir Robert Ogden Macmillan Centre.

Resource	2011/12	2012/13	2013/14
Gas			
Use (kWh)	24,990,667	27,610,693	28,351,407
tCO2e	4599.2	5081.4	5217.7
Oil			
Use (kWh)	31,802	50,800	21,280
tCO2e	8.64251152	13.805408	5.7830528
Electricity			
Use (kWh)	4,389,673	4,317,894	5,634,776
tCO2e	1955.5	1474.8	355.5
Total Energy CO2e	6563.4	6570.1	5579.1
Total energy use (kWh)	29,412,142	31,979,387	34,007,464
Total Energy Spend	£1,076,904.00	£1,331,979.00	£1,453,863*

\*data estimated at time of submission  
tCO2e – tonnes of carbon dioxide emitted  
kWh – kilowatt hours

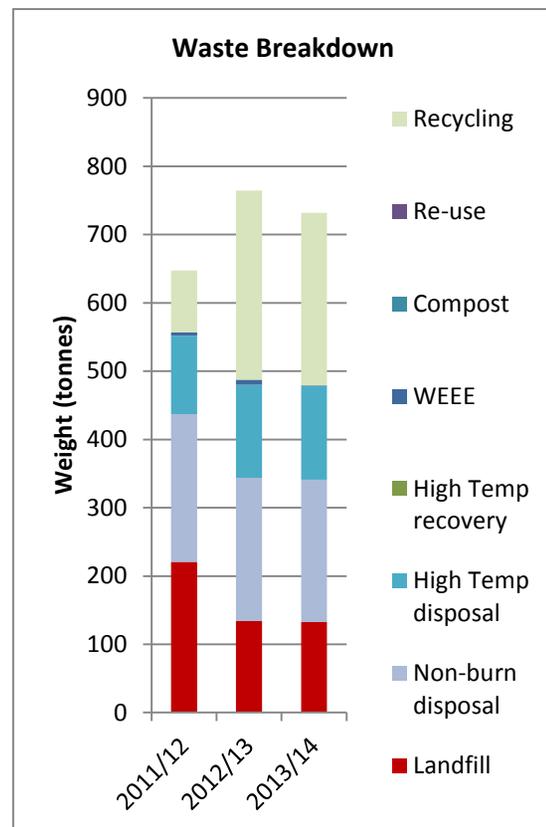
Despite the increase in energy consumption, the Trust's overall energy related carbon footprint has reduced due to a combination of increased utilisation of its combined heat and power unit together with its imported grid electricity being rated as 100% renewable.



## Waste Management

The Trust has continued to work closely with its waste management partners over the course of the year to continue its reduction in the carbon footprint of its various waste streams. There has been a significant decrease in Waste Electrical and Electronic Equipment (WEEE) as a result of an initiative to recycle computer equipment and generate an income stream as opposed to a cost to the organisation of disposal.

Waste		2011/12	2012/13	2013/14
Recycling	(tonnes)	90.6	277	252.57
	tCO <sub>2</sub> e	1.9026	5.817	5.30397
Re-use	(tonnes)	0	0	0
	tCO <sub>2</sub> e	0	0	0
Compost	(tonnes)	0	0	0
	tCO <sub>2</sub> e	0	0	0
WEEE	(tonnes)	4.85	7.304	0.86
	tCO <sub>2</sub> e	0.10185	0.153384	0.01806
High Temp recovery	(tonnes)	0	0	0
	tCO <sub>2</sub> e	0	0	0
High Temp disposal	(tonnes)	115	136	137.1
	tCO <sub>2</sub> e	12.19	14.416	14.5326
Non-burn disposal	(tonnes)	216	210	208.4
	tCO <sub>2</sub> e	178.632	173.67	172.3468
Landfill	(tonnes)	221	134	132.83
	tCO <sub>2</sub> e	64.09	38.86	38.5207
Total Waste (tonnes)		647.45	764.304	731.76
% Recycled or Re-used		13.9	36.2	34.5
Total Waste tCO <sub>2</sub> e		256.91645	232.916384	230.72213



## **Going Concern**

After making enquiries, the Board of Directors has a reasonable expectation that the Harrogate and District NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the accounts.

The NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and the Office of Public Sector Information guidance.

## **Statement of Accounting Policies**

Accounting policies for pensions and other retirement benefits are set out in notes 1 and 5 to the accounts.

Details of senior employees' remuneration can be found in the remuneration report on page 41.

## **Direction from Monitor**

The Annual Accounts of Harrogate and District NHS Foundation Trust for 2013/14 have been prepared under a Direction issued by Monitor under the National Health Service Act 2006.

## **Further details of the Trust's Strategic Plans**

The deliver the Trust's Strategy, a range of actions are planned over the next few years. These are contained within the Trust's Operational Plan and Strategic Plan, both of which can be found on the Trust's website ([www.hdft.nhs.uk](http://www.hdft.nhs.uk)). These discuss the Trust's strengths, weaknesses, opportunities and threats, alongside the strategic risks of the Trust.

## **Approval by the Directors of the Strategic Report**

This Strategic Report has been approved by the Board of Directors of Harrogate and District NHS Foundation Trust.

Signed

**Richard G Ord**  
Chief Executive

**28 May 2014**

## **DIRECTORS' REPORT**

### **Directors of the Trust**

The Directors of the Trust throughout the year 2013/14 were:

Mrs Sandra Dodson	Chairman (Non-Executive Director)
Mr Robert Wivell	Vice Chair and Senior Independent Director (Non-Executive Director – until 31 July 2013)
Mr John Ridings	Vice Chair and Senior Independent Director – from 1 August 2013 (Non-Executive Director and Chair of Audit Committee*)
Ms Sue Symington	Non-Executive Director
Mrs Sarah Nattress	Non-Executive Director and Chair of Audit Committee* (until 6 February 2014)
Mr Ian Ward	Non-Executive Director
Professor Sue Proctor	Non-Executive Director (from 1 September 2013)
Mrs Lesley Webster	Non-Executive Director (from 1 January 2014)
Mr Chris Thompson	Non-Executive Director (from 1 March 2014)
Mr Richard Ord	Chief Executive
Mr Jonathan Coulter	Finance Director and Deputy Chief Executive
Dr David Scullion	Medical Director
Mrs Angela Monaghan	Chief Nurse
Mr Robert Harrison	Director of Performance and Delivery
Mr Phillip Marshall	Director of Workforce and Organisational Development (Voting Director from 1 January 2014)
Miss Anne Lawson	Director of Governance (Non-Voting – until 30 April 2013)
Mrs Janet Probert	Director of Partnerships and Innovation (Non-Voting – until 31 August 2013)

\*Mr John Ridings stood down as Chair of the Audit Committee on 30 November 2013 for Mrs Sarah Nattress to take over from Mr Ridings, who had retired as a Non-Executive Director in April 2014. Following Mrs Nattress departure from the Board on 6 February 2014, Mr Ridings agreed to extend his term and also resume the position as Chair of the Audit Committee following approval from the Council of Governors.

### **Company Directorships held by Directors or Governors**

There are no company directorships or other significant interests held by Directors or Governors that are considered to conflict with their responsibilities. Registers of Interests for all members of the Board of Directors and the Council of Governors are held within the Trust and continually updated. The Board of Directors' register is taken on a monthly basis to the public Board of Directors meetings and is available on the Trust website ([www.hdft.nhs.uk](http://www.hdft.nhs.uk)). Both registers are available on request from the Foundation Trust Office.

### **Charitable and Political Donations**

During 2012/13 and 2013/14 no political or charitable donations were made by the Trust.

### **Cost Allocation Disclosure**

The NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and the Office of Public Sector Information guidance.

## **Financial Instruments Disclosure**

The Trust takes a very prudent approach to risk and neither buys or sells financial instruments. Details can be found in note 25 of the Annual Accounts.

## **NHS Foundation Trust Code of Governance**

The Trust complies with the provisions of the newly updated NHS Foundation Trust Code of Governance and has embedded its principles into the integrated governance of the organisation. Further details are given later in this Annual Report.

Information relating to quality governance systems and process is detailed throughout the annual report, but in particular in the Annual Governance Statement and Quality Report.

The Trust has regard to Monitor's Quality Governance Framework and carried out a detailed self-assessment as part of its review of governance arrangements in 2013/14.

## **The Trust's assurance structure**

The Trust can confirm that there are no material inconsistencies between the Annual Governance Statement, the annual and quarterly Board statements required by the Risk Assessment Framework, the Corporate Governance Statement, the Quality Report, Annual Report and reports arising from Care Quality Commission planned and responsive reviews of the NHS Foundation Trust and any consequent action plans.

Further details of the Trust's arrangements to govern service quality are provided on page 56 of this Annual Report and in the Quality Report and Annual Governance Statement.

## **Care Quality Commission (CQC) Reports**

In November 2013, the Trust was inspected in the first wave of the new model of Care Quality Commission inspections of acute hospitals. The inspection report was based on a combination of inspection results, information from the CQC "intelligent monitoring" and information from patients, staff, the public and other organisations.

The overall summary was that Harrogate District Hospital provides care that is safe, effective, caring, responsive and well-led. The hospital was clean and it had systems in place for infection control. There were no actions that the hospital was required to take to improve. There were four areas where it was suggested that the hospital could improve:

- Review staffing levels in wards, particularly those caring for older people;
- Improve pain control in some areas;
- Improve do not attempt cardiopulmonary resuscitation (DNACPR) recording at end of life;
- Review thresholds for reporting serious incidents.

The Trust is progressing work to address each of these areas with a detailed action plan developed and submitted to the CQC. The Trust is regularly reviewing and monitoring the action plan to ensure the plan is delivered.

## **National Adult Inpatient Survey**

The National Adult Inpatient Survey 2012 was published by The Care Quality Commission (CQC) on 16 April 2013.

Overall HDFT performed well, scoring “significantly better than average” for two out of 64 questions. It remains a significant achievement that HDFT had no questions rated “significantly worse than average”. 473 patients treated at HDFT responded in the survey this year (a local response rate of 57%), similar to last year.

The following question is ranked “significantly better” in both 2012 and 2011:

Q3 - While you were in the A&E Department, how much information about your condition or treatment was given to you?

The following question is ranked “significantly better” in 2012 and “about the same” in 2011:

Q47 - Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain in a way you could understand?

The following four questions were ranked “about the same” in 2012 and “significantly better” in 2011:

Q21 - How would you rate the hospital food?

Q29 - Did nurses talk in front of you as if you weren't there?

Q48 - After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?

Q59 - Did a member of staff tell you about any danger signals you should watch for after you went home?

## **Significant Activities in the Field of Research and Development**

Information on research and development within the Trust is contained within the Quality Report elsewhere in this Annual Report.

## **Improving Patient Care**

The Trust has continued to successfully deliver high quality services in both the hospital and across the communities that it serves.

In addition to the CQC inspection outlined earlier in this Report, the Trust was also visited by the NHS Litigation Authority regarding Maternity services where its rating under the CNST was upgraded from level 1 to level 2.

Whilst these are excellent endorsements of the services the Trust offers, it is not complacent. It will continually work to improve the services that it delivers and always welcomes feedback to help it to provide the best possible care to users of its services.

During 2013/14, a number of developments were taken forward to ensure the Trust continued to deliver high quality care for its patients. These included:

- **Increased numbers ward nursing staff**

The organisation has strengthened the number of nurses on the wards to ensure the continued provision of high quality care to its patients.

- **Enhanced stroke services**

A number of developments have been taken forward both in the hospital and community to continue to strengthen and improve the quality of stroke services by developing a more community based service. Following a successful visit by the Yorkshire & Humber Stroke Services Accreditation panel, stroke services received full accreditation. The panel commented that there was “clear leadership across the pathway” and that we have developed an “integrated system that clearly works”.

- **Additional Consultant posts**

New consultant appointments were made in the Emergency Department, Anaesthetics, Elderly Care and Paediatrics.

- **Provision of additional Health Visitors in the community**

The Trust successfully recruited additional Health Visitors in its community services in line with the national “A Call to Action” strategy.

- **Increased outreach outpatient clinics in Leeds**

The Trust has successfully commenced a number of outreach outpatient services at the Yeadon Health Centre, which is catering for west Leeds patients, in a number of services including General Surgery, Orthopaedics, Gynaecology and Urology. The Trust has also established Community Midwifery services in the Health Centre at Yeadon, which means that women who choose to have their babies at Harrogate also have a seamless antenatal service provided by the Trust.

- **New Day Surgery Theatre**

The Trust completed the build of a new day surgery theatre to meet the increasing demand on Trust elective services and to maintain a high quality of care for its patients.

- **Sir Robert Ogden Macmillan Centre**

The new Sir Robert Ogden Macmillan Centre was completed and opened in March 2014. This is a state of the art cancer centre and the Trust would once again like to thank Sir Robert Ogden and Macmillan Cancer Support for their generous donations which have enabled the building of this facility.

During 2014/15, work will continue on the “Healthy Ripon” project to look at both short term and long term solutions for the local health community. The Trust remains committed to the future of healthcare services in Ripon and will continue to work with a broad range of partners, stakeholders and the wider community. This project aims to ensure that the current hospital facility remains fit for purpose in the short term, whilst also considering ways in which health and social care services can be delivered in the most effective way to meet the needs of the people of Ripon and the rural surrounding areas.

The Trust is working jointly with York Teaching Hospitals NHS Foundation Trust, which is the provider of the current renal service on the Harrogate site, to provide a new Self-Care Renal unit in 2014/15. This new initiative will allow patients more choice in how they manage their dialysis care.

- **Endoscopy JAG Accreditation**

The Trust’s endoscopy unit was assessed against the Joint Advisory Group for GI Endoscopy (JAG) accreditation criteria.

JAG assessed the unit on the following:

- Endoscopy unit environment;
- Decontamination facilities;
- Global Rating Scale – a series of 282 indicators across 4 domains; clinical effectiveness, patient experience, workforce and Endoscopist training;

- Clinical audit programme.

Following significant work by the Endoscopy team, the Trust was delighted that it was successful in gaining full accreditation.

### **Complaints Handling**

The Trust's aim is to "get it right first time, every time". The Trust recognises that managing patient feedback well can both improve services and enhance the public perception of the Trust.

The Trust promotes pro-active, on the spot resolution of problems at a local level, thus reducing the need for patients/carers to raise issues in a more formal way. It is recognised that lessons must be captured from this type of feedback locally to promote sharing of learning and good practice. Quality of Care Teams, which are department based teams of frontline staff, are encouraged to facilitate the resolution of issues in their own areas and promote learning.

In order to publicise the service, leaflets and posters are available in all departments across the Trust. A Patient Experience Contact Point is located in the main reception area of Harrogate District Hospital and staffed by Patient Experience Volunteers (PEV) during normal office hours. PEVs work to publicise the Making Experiences Count Policy and the process by which the public can share feedback regarding the Trust services.

The Patient Experience Team (PET) is made up of Patient Experience Officers who receive and make an assessment of all new feedback within three working days. To assist this assessment the issue is graded to identify the severity of the concern being raised and the level of investigation that is necessary as well as the internal and external reporting requirements.

For those cases graded as a complaint, an Investigating Officer is appointed by the Directorate with the most involvement and a formal written acknowledgement is sent from the Chief Executive. An individual resolution plan will be developed with the contact, via the Investigating Officer, which identifies the nature of the issue and how this will be dealt with.

Local resolution may, for example, be achieved by means of a written investigation, a meeting with staff or a telephone call. The resolution plan is agreed by the contact and Trust from the outset and must be proportionate to the issue raised.

Where a complaint is graded as yellow, amber or red the most serious levels of concern, or where there are serious risk management implications, the Patient Experience Officer will refer to the Head of Risk Management to ensure appropriate action is taken in relation to any ongoing patient care or incident investigation. For serious complaints, a root cause analysis of the case will be carried out by the Investigating Officer.

Failure by the Trust to satisfy the complainant entitles the complainant to request a further investigation by the Health Service Ombudsman. This request must be made within 12 months of the initial concern, unless there are extenuating circumstances.

If the person is not a patient, but is raising issues on behalf of a patient, the PET check that the patient knows about this and has given consent. In exceptional cases, where the complaint is graded yellow, amber or red, the Trust will determine what investigation can proceed without consent and what, if anything is disclosed.

There is no time limit for giving feedback to the Trust for those issues which fall outside the Complaints Regulations. All feedback will be received and acted upon wherever possible to ensure

learning and improvement for the organisation. Where the issue is coded as a complaint, the regulations set a time limit of 12 months from the event or awareness of the event, for making the complaint. The Trust, however, adopts a flexible attitude to complaints about incidents occurring outside this timescale.

Action plans are considered by the Directorates for each complaint which is raised. Action plans are required for all issues that have been upheld following investigation and quality assurance by the Directorate. Complaint trends and action plans, including those developed in response to Health Service Ombudsman reviews are reported to the Quality Experience Group (QEG) on a quarterly basis and in turn to the Board of Directors. Complaint trend reports are also sent to Directorates for dissemination and feedback of actions taken in response to identified themes.

### **Statement as to Disclosure to Auditors**

For each individual who is a Director of the Trust as of 28 May 2014, there is no relevant audit information of which the NHS Foundation Trust's auditors are unaware.

The Directors have taken all steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information.

### **Company Directorships and Other Significant Interests held by Directors and Governors**

Directorships and other significant interests held by Directors and Governors are detailed in the Board of Directors and Council of Governors sections, contained within the NHS Foundation Trust Code of Governance chapter of this Annual Report.

In addition, the Trust maintains a publicly available Register of Interests of the Board of Directors and Council of Governors, which can be obtained from the Foundation Trust Office.

## **REMUNERATION REPORT**

### **Remuneration of the Chairman and Non-Executive Directors**

The Remuneration Committee for the Chairman and Non-Executive Directors met twice during 2013/14.

The first meeting took place on 11 March 2013 to make a forward recommendation to the Council of Governors in relation to the remuneration for the Non-Executive Directors, including the Chair, for the 2013/14 financial year.

The members of the Remuneration Committee were:

Rev. Dr Willshaw, Public Governor and Deputy Chair of the Council of Governors (Chair)  
Dr Blackburn, Public Governor  
Mrs Colvin, Corporate Affairs and Membership Manager (Ex Officio)  
Mr Coulter, Deputy Chief Executive and Finance Director (Ex Officio)  
Mrs Dow, Head of Corporate Affairs (Ex Officio)  
Mrs Edgar, Staff Governor  
Mr Ellings, Public Governor  
Mrs Hare, Public Governor  
Mr Marshall, Director of Workforce and Organisational Development (Ex Officio)  
Mr Ord, Chief Executive (Ex Officio)  
Mr Wilkinson, Public Governor

The recommendation of the Remuneration Committee was to propose a 1% pay uplift for inflation for the Chairman and Non-Executive Directors with effect from 1 April 2013.

The recommendation was approved by the Council of Governors at its meeting on 17 April 2013

The next meeting of the Remuneration Committee took place on 29 July 2013. This was a specific meeting to consider the following two items:

- 1) The transfer of Mr Ridings onto the salary for Vice-Chair of the Board of Directors and Senior Independent Director from 1 August 2013 when he took over the role from Mr Wivell; and
- 2) The uplift of Mrs Nattress' salary by £3,183 to £15,921 to take effect from 1 December 2013 when she took on the role of Chair of Audit Committee.

The members of the Remuneration Committee were:

Reverend Dr Willshaw – Public Governor and Deputy Chair of Council of Governors (Chair)  
Dr Blackburn – Public Governor  
Cllr De Courcey Bayley – Stakeholder Governor  
Mrs Dow, Deputy Director of Corporate Affairs (Ex Officio)  
Mrs Ehrhardt, Deputy Director of Finance (Ex Officio)  
Mrs Hewitson – Public Governor  
Mr Marshall, Director of Workforce and Organisational Development (Ex Officio)  
Dr Scott – Staff Governor

The two items considered by the Remuneration Committee were recommended for approval.

The recommendations were approved by the Council of Governors at its meeting on 29 July 2013.

## Remuneration of the Executive Directors

The Remuneration Committee for Executive and non-voting Directors meets as and when required and includes:

Mrs Dodson, Chairman and Committee Chairman

Mrs Nattress, Non-Executive Director (*left the Trust on 6 February 2014*)

Prof. Proctor, Non-Executive Director (*joined the Trust on 1 September 2013*)

Mr Ridings, Non-Executive Director

Ms Symington, Non-Executive Director

Mr Thompson, Non-Executive Director (*joined the Trust on 1 March 2014*)

Mr Ward, Non-Executive Director

Mrs Webster, Non-Executive Director (*joined the Trust on 1 January 2014*)

Mr Wivell, Non-Executive Director (*left the Trust on 31 July 2013*)

Mr Ord, Chief Executive (ex-officio)

Mr Marshall, Director of Workforce and Organisational Development (ex-officio)

The committee met five times during 2013/14:

	25/3/2013	17/09/2013	20/09/2013	26/02/2014	24/03/2014
Mrs S Dodson	✓	✓	✓	✓	✓
Mrs S Nattress	✓	✓	✓		
Professor S Proctor		✓	x	✓	x
Mr J Ridings	✓	✓	✓	✓	✓
Mrs S Symington	✓	✓	✓	✓	✓
Mr C Thompson					x
Mr I Ward	✓	✓	✓	✓	✓
Mrs L Webster				✓	✓
Mr R Wivell	x				
Mr R Ord	✓	✓	✓	✓	✓
Mr P Marshall	✓	✓	x	x	✓

The Remuneration Committee is a sub-committee of the Trust Board and the key outcomes from this Committee are shared with the full Board of Directors.

The details of remuneration of individual Directors are included elsewhere within this report.

The role of the Remuneration Committee is:

- To make such recommendations to the Board of Directors on remuneration, allowances and terms of service to ensure that Directors are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national agreements where appropriate;
- To monitor and evaluate the performance and development of the Chief Executive and all Executive Directors;
- To advise on and oversee appropriate contractual arrangements for the Chief Executive and all Executive Directors including:
  - The proper calculation and scrutiny of termination payments in the light of appropriate guidance as is appropriate;
  - All aspects of salary (including any performance-related elements/bonuses);
  - Provisions for other benefits, including pensions and cars;

- To advise the Board of Directors on pay policy and other contractual matters for the Chief Executive and all Executive Directors.

The Executive Directors received a 1% uplift to their remuneration in 2013/14. No performance related pay scheme (e.g. pay progression or bonuses) is currently in operation within the Trust for Executive or Non-Executive Directors and there are no special provisions regarding early termination of employment. Comparative sources of guidance for the determination of Director's pay are:

- Foundation Trust Network (FTN) Remuneration Survey 2012
- CAPITA NHS Foundation Trust Board Remuneration Report 2012.

All other senior managers (and indeed, all non-medical staff below Director level) are subject to Agenda for Change pay rates, terms and conditions of service, which are determined nationally.

All Directors are subject to an annual appraisal. They are assessed against previously agreed objectives and a report is prepared for the Remuneration Committee to inform the Committee of the performance of each Director and the Chief Executive.

Pay data and other sources of information generally show a close relationship between salary and the size of the organisation in the NHS. It is important to consider the size of the organisation being managed and the nature and complexity of the management task.

As well as performance in the role and consideration of the organisation being managed, the salaries paid to individual post holders will also reflect a range of personal factors including skills and experience.

Directors and the Chief Executive receive an annually agreed salary.

Unless otherwise agreed by the Trust's Remuneration Committee, and in order to recruit and retain high performing individuals, all Executive Directors are offered permanent and full-time contracts of employment. The Chief Executive and all Directors are entitled to six months' notice ordinarily to terminate their employment.

Any decisions regarding uplifts of basic salaries for inflation purposes are only taken when consideration of the approach taken with all other employees has been made.

The Trust's Remuneration Committee has agreed Terms of Reference in place that include specific aims and objectives. These terms are published on the Trust's Intranet site for all staff to access.

**Board of Directors remuneration and other benefits are detailed in the table below.**

Name and Title	2013/14						2012/13					
	Salary	Other remuneration	Taxable Benefits	Total	Pension-related benefits	Ratio of Total Remuneration to Median for All Staff (1)	Salary	Other remuneration	Taxable Benefits	Total	Pension-related benefits	Ratio of Total Remuneration to Median for All Staff (1)
	(bands of £5,000) £000	(bands of £5,000) £000	Rounded to the nearest £100	(bands of £5,000) £000	(bands of £2,500) £000		(bands of £5,000) £000	(bands of £5,000) £000	Rounded to the nearest £100	(bands of £5,000) £000	(bands of £2,500) £000	
Mr R Ord - Chief Executive (2)	75-80			75-80		2.95	65 - 70			65-70		2.63
Mr J Coulter - Deputy Chief Executive and Finance Director	120-125			120-125	72.5-75	4.79	115 - 120			115-120	0-2.5	4.66
Dr C Gray - Medical Director (3)							30 - 35	45 - 50		75-80	N/A	3.27
Dr D Scullion - Medical Director (4)	35-40	100-105		135-140	25-27.5	1.39	15 - 20	45-50		65-70	N/A	0.79
Mrs A Monaghan - Chief Nurse	100-105		1,600	100-105	87.5-90	4.11	95 - 100		1,200	95-100	40-42.5	3.95
Mr R Harrison – Chief Operating Officer	100-105			100-105	37.5-40	3.88	90-95			90-95	22.5-25	3.79
Mr P Marshall - HR Director	100-105		1,800	100-105	25-30	3.99	95-100		1,30	95-100	12.5-15	3.95
Mrs J Probert - Director of Partnerships and Innovations (5)	40-45			40-45	2.55	1.62	95-100			95-100	(5-7.5)	3.95
Miss A Lawson - Director of Governance (6)	5-10			5-10			50-55			50-55	N/A	2.05
Mrs S J Dodson – Chairman	45-50			45-50			45-50			45-50		
Mr J Ridings - Non-Executive Director	15-20			15-20			15-20			15-20		
Mrs S Nattress - Non-Executive Director (7)	10-15			10-15			15-20			15-20		
Ms S Symington - Non-Executive Director	10-15			10-15			10-15			10-15		
Mr I Ward - Non-Executive Director (8)	10-15			10-15			5-10			5-10		
Prof S Proctor – Non- Executive Director (9)	5-10			5-10								
Mr C Thompson - Non-Executive Director (10)	0-5			0-5								
Mrs L Webster – Non-Executive Director (11)	0-5			0-5								
Mr R Wivell - Non-Executive Director (12)	5-10			5-10			15-20			15-20		
Mr P Stevenson - Non-Executive Director (13)							5-10			5-10		

- (1) The median salary for all staff in 2013/14 was £25,783. The median salary for all staff in 2012/13 was £25,075. The median calculation is the annualised full time remuneration of all staff in the Trust as at 31 March 2014 (excluding agency staff), excluding the highest paid Director.
- (2) With respect to the remuneration of the Chief Executive, the Remuneration Committee agreed that Mr Ord would retire on 5 April 2012 and return to work. Following his retirement, the Committee agreed that when he returned to work, he would receive a salary which, when combined with his retirement pension, would equate to his total salary earnings prior to his retirement
- (3) Dr C Gray ceased to be the Medical Director on 31 August 2012. The 2012/13 median salary multiple has been calculated based only on the part-year.
- (4) Dr D Scullion commenced as Medical Director on 1 September 2012. The median salary multiple has been calculated based only on the part-year.

- (5) Mrs J Probert ceased to be Director of Partnerships and Innovation on 31 August 2013. Her pension value reduced in 2012/13.
- (6) Miss A Lawson ceased to be Director of Governance on 30 April 2013.
- (7) Mrs S Nattress ceased as Non-Executive Director on 6 February 2014.
- (8) Mr I Ward commenced as Non-Executive Director on 1 October 2012.
- (9) Prof S Proctor commenced as Non-Executive Director on 1 August 2013.
- (10) Mr C Thompson commenced as Non-Executive Director on 1 March 2014.
- (11) Mrs L Webster commenced as Non-Executive Director on 1 January 2014.
- (12) Mr R Wivell ceased as Non-Executive Director on 31 July 2013.
- (13) Mr P Stevenson ceased as Non-Executive Director on 30 September 2012.

The Trust does not pay any performance related bonuses or payments.

The nature of the other remuneration and taxable benefit figures relates to the payment for clinical activities with the Trust and the provision of a lease car, respectively.

Members of the Board of Directors and of the Council of Governors are entitled to claim expenses incurred in relation to their duties. The table below gives further information on the expenses claimed.

	2013/14			2012/13		
	Number in post on 31 <sup>st</sup> March 2014	Number claiming expenses	Total value claimed (Rounded to £00)	Number in post on 31 <sup>st</sup> March 2013	Number claiming expenses	Total value claimed (Rounded to £00)
Board of Directors	13	7	£2,200	14	8	£3,100
Council of Governors	22	6	£900	19	3	£300

## Pension benefits

Name and title	Real increase in pension and related lump sum at age 60  (bands of £2,500) £000	Total accrued pension and related lump sum at age 60 at 31 March 2014  (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2013  £000	Cash Equivalent Transfer Value at 31 March 2014  £000	Real Change in Cash Equivalent Transfer Value  £000	Employer's contribution to stakeholder pension  To nearest £100
Mr R Ord - Chief Executive (1)	£Nil	£Nil	£Nil	£Nil	£Nil	£Nil
Mr J Coulter - Deputy Chief Executive and Finance Director	12.5-15	125-130	431	504	64	£Nil
Mr R Harrison - Director of Performance and Delivery	5-7.5	55-60	141	168	24	£Nil
Mrs J Probert – Director of Partnerships and Innovation (2)	2.5-5	170-175	731	788	40	£Nil
Mrs A Monaghan - Chief Nurse	15-17.5	165-170	712	827	99	£Nil
Mr P Marshall – Director of Workforce and Organisational Development	2.5-5	130-135	471	513	32	£Nil
Dr D Scullion – Medical Director	17.5-20	215-220	926	1,068	122	£Nil
Miss A Lawson - Director of Governance	The information relating to Miss A Lawson, Director of Governance, supplied by the Pensions Agency is considered by the Trust not to be factually accurate and is therefore not included.					

- (1) With respect to the remuneration of the Chief Executive, the Remuneration Committee agreed that Mr Ord would retire on 5 April 2012 and return to work. Following his retirement, the Committee agreed that when he returned to work, he would receive a salary, which when combined with his retirement pension, would equate to his total salary earnings prior to his retirement. As Mr R Ord is over the Pension Scheme retirement age, the Pension Scheme prevents any cash transfer taking place and therefore the Cash Equivalent Transfer Value is nil.
- (2) As Mrs J Probert left the Trust on 31 August 2013, the figures shown relate to 31 August 2013, rather than 31 March 2014 and the increases shown relate only to the period during which she was employed at HDFT.

As Non-Executive Directors do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive Directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme, or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real change in CETV - This reflects the change in CETV effectively funded by the employer. It takes account of the change in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

As Chief Executive, I confirm that the information in this Remuneration Report is accurate to the best of my knowledge.

Signed

**Richard G Ord**  
**Chief Executive**

**28 May 2014**

## **NHS FOUNDATION TRUST CODE OF GOVERNANCE**

### **The Board of Directors and Council of Governors**

The Trust Board of Directors and Council of Governors work closely together in the best interests of the Trust. Detailed below is a summary of the key roles and responsibilities of both the Board of Directors and the Council of Governors.

The Board of Directors meets formally with the Council of Governors on a six monthly basis to seek and consider the views of the Governors in agreeing, for example, strategic aims, potential changes in service provision and public perception matters. These meetings are also used as an opportunity to update and inform the Board of Directors and Council of Governors of particular examples of good practice. The joint Chairman of both the Board of Directors and the Council of Governors proactively ensures synergy between the Board and Council through regular meetings and written communications.

The Directors (both Executive and Non-Executive) meet regularly with Governors during their day to day working through meetings, briefings, consultations and information sessions. Examples include membership of Governor working groups and consultations about the Annual Plan and Quality Account. Informal meetings are also held with the Council of Governors three times a year. Appropriate Executive Directors attend these meetings, dependent upon the subject matter and focus of the meetings.

Informal meetings between the Non-Executive Directors and the Council of Governors have been introduced to further extend the Governors' knowledge of the role of the Non-Executive Directors in response to the Health and Social Care Act 2012 and the Governors' statutory responsibility to hold the Non-Executive Directors to account. These meetings take place on a quarterly basis.

### **The Board of Directors**

The Board of Directors is collectively responsible for the exercise of powers and the performance of the Trust and meets formally in public a minimum of 10 times a year. Its role is to provide active leadership within a framework of prudent and effective controls which enable risk to be assessed and managed.

The Board is responsible for:

- The strategic direction of the Trust;
- The provision of high quality and safe healthcare services, healthcare delivery, education, training and research;
- The overall performance of the Trust in relation to standards set by the Department of Health, Monitor, the Care Quality Commission and other relevant bodies;
- Ensuring the Trust exercises its functions effectively, efficiently and economically;
- Effective governance measures;
- Compliance with the Trust's Licence;
- Compliance with the Trust's Constitution.

### **Balance, completeness and appropriateness of the Board of Directors.**

The balance, completeness and appropriateness of the Board of Directors is reviewed as required and at least annually to ensure its effectiveness. This is done formally as part of the annual planning process. A review in 2013/14 identified the requirement for an additional Non-Executive Director to be recruited, taking the total to seven. In addition, at this time, the Director of Workforce and

Organisational Development became a voting Director to ensure balance on the Board of Directors. The Trust is confident that it has a balanced and appropriately skilled Board of Directors to enable it to discharge its duties effectively.

The operational management of the Trust is led by the Executive Directors, reporting to the Chief Executive as Accountable Officer. The Standing Orders of the Board detail the decisions reserved for the Board and are available on request.

All of the Non-Executive Directors of the Trust are independent. The information below describes the skills, expertise and experience of each Board member and demonstrates the independence of the Non-Executive Directors.

### Executive Directors

#### **Chief Executive – Mr Richard Ord (Executive Director) appointed on 11 January 2010; retiring 3 August 2014**

Prior to being appointed as Chief Executive, Richard was Deputy Chief Executive for four years. In addition to the Deputy Chief Executive role, Richard had responsibilities as Director of Planning and Performance. Richard has had an extensive career in health service management, specialising in the field of strategic, business and capital planning.

Richard had significant experience of leading and managing Community Services when they were part of Harrogate Healthcare Trust, prior to their transfer to the Primary Care Trust.

Richard has also taken the lead role in taking forward the performance agenda for the organisation. He has played a key role in delivering the challenging objective of reducing waiting times and improving standards of care within the Trust, and has made a significant contribution to the organisation in helping to achieve high standards in Care Quality Commission reports, including the excellent 2011 and 2013 inspections of Harrogate District Hospital.

Since taking up his role as Chief Executive, Richard has taken responsibility for overseeing successful restructures of the organisation to ensure that it is fit for purpose. This included leading the successful transfer and integration of community-based services into Harrogate and District NHS Foundation in 2011.

The Chief Executive is responsible for all aspects of the work of the NHS Foundation Trust. Key elements of this role include:

- Implementation of Trust Board strategy and policies;
- Management of resources and performance management of objectives;
- Leadership across HDFT;
- Accountable Officer to Parliament for ensuring that the Trust operates consistently with national policy and public service values;
- Personal responsibility for service quality and the effective operation of clinical governance.

#### **Finance Director – Mr Jonathan Coulter (Executive Director) – appointed 20 March 2006. Appointed Deputy Chief Executive on 11 January 2010**

Jonathan is a member of the Chartered Institute of Public Finance and Accountancy (CIPFA) having qualified as an accountant in 1993. Since qualifying, he has taken on a number of roles in the NHS, working in various hospital trusts, where his work included the merger of Pontefract and Pinderfields Hospitals. During this time, Jonathan also obtained a post graduate qualification in Health and Social Care Management.

Jonathan became Finance Director for North Bradford PCT in 2000, gaining valuable experience of leadership and management of community-based services.

Following a successful period in North Bradford, during which time he undertook additional responsibility in the role of Finance Director for Airedale PCT, Jonathan was appointed as Finance Director at Harrogate and District NHS Foundation Trust in March 2006.

Since arriving at Harrogate, Jonathan has contributed significantly to the success of the organisation over the past eight years, both within his role as Finance Director, and recently as Deputy Chief Executive.

**Medical Director – Dr David Scullion (Executive Director) – appointed 1 September 2012**

David trained in Medicine at St Mary's Hospital in London, qualifying in 1985. An initial career in General Medicine was followed by Radiology training in both London and North America. He was appointed Consultant Radiologist in Harrogate in 1997, and has been Clinical Lead for Radiology, Deputy Medical Director and, since September 2012, Medical Director. He tries to divide his week equally between Medical Director commitments and a clinical Radiology workload.

The role of the Medical Director is many and varied but includes providing clinical advice to the Board of Directors, leading on clinical standards including the formation and implementation of policy, providing clinical leadership and acting as a bridge between the medical workforce and the Board and dealing with disciplinary matters involving doctors. The Medical Director is aided in this role by both clinical and managerial colleagues.

**Chief Nurse – Mrs Angela Monaghan (Executive Director) – appointed 2 October 2000; retiring 30 June 2014**

Angela qualified as a Registered Nurse in 1981 and has extensive clinical and managerial experience within acute and community services. She has had specialist community nursing training and worked as a District Nurse within a large rural practice in West Yorkshire for a number of years.

Angela is a graduate of the NHS General Management Training Scheme and holds an MA in Management and Leadership Studies.

As Chief Nurse, Angela provides clinical and professional leadership to the Trust's nurses and midwives and is accountable for the maintenance of professional standards. During her time at HDFT, she has played a key role in the development of the Foundation Trust and the introduction of new services and quality improvements. She has a major role in leading the quality agenda for the Trust and this work includes strong partnership working with Governors and other public representatives to ensure delivery of the highest standards and that an open and responsive culture to patient feedback is always promoted.

**Chief Operating Officer – Mr Robert Harrison (Executive Director) – appointed 4 July 2010**

Throughout Robert's career, he has demonstrated a record of leading the sustainable delivery of national targets and standards. Having originally trained as a Research Biochemist, Robert joined the NHS General Management Training Scheme in 2002. Following Graduation from the scheme, and attainment of a post graduate qualification in Health Services Management, he held a number of operational management posts in Medicine, Anaesthetics and Surgery within a large teaching hospital.

During his operational management career he has led on a number of service developments and reorganisations, including improving emergency surgical care across two hospital sites, the implementation of a regional Upper Gastrointestinal Cancer Unit, the establishment of an interventional bronchoscopy service and the expansion of Special Care Dentistry services across Central Lancashire.

In 2008, he was successful in gaining a place on the North West Leadership Academy's Aspiring Directors Programme. This focused on developing greater self-awareness and understanding the role of a Board member. Robert now uses these skills by offering mentoring to junior managers and by supporting the Management Training Scheme locally and, on occasions, through the King's Fund as part of their education component.

The Chief Operating Officer is responsible for the day to day operational management of Harrogate District Hospital, the achievement of national, regional and Trust performance targets and translating Trust strategy, business and policy development into operational reality. Duties also include responsibility for IT, Information, Estates and Facilities.

**Director of Workforce and Organisational Development – Mr Phillip Marshall (Executive Director) – appointed 2 October 2006; appointed as a voting Director from 1 January 2014**

Phillip joined Harrogate and District NHS Foundation Trust as a Director in October 2006 and has worked in the NHS in Yorkshire since 1987. Phillip is a Chartered Fellow of the Institute of Personnel and Development and holds a Master of Science degree in Human Resource Management.

Phillip has broad NHS human resource and general management experience and has worked in mental health, primary and secondary care NHS organisations. He has significant organisational change and employee relations experience having held a key role in managing three major organisational structure changes during his time at Harrogate as well as extensive experience of managing other service changes including the transfer of staff between organisations.

He is committed to working in partnership with trade union colleagues to deliver staff engagement and change and the promotion of, and adherence to, organisation values. He has led the Trust to be recognised as a top 100 healthcare employer as well as accreditation as an Investors in People organisation during which time the Trust has continually maintained its position as being in the Top 20% of Trusts in the country for overall levels of staff engagement.

The Director of Workforce and Organisational Development is responsible for providing the Trust with strategic and operational human resource leadership. Phillip has the Lead Board Director responsibility for associated areas including Medical Education, Health and Well Being and Military Health. Phillip is the Chair of the North Yorkshire and Humber Partnership Council of the Yorkshire and Humber Local Education and Training Board.

Non-Executive Directors

**Non-Executive Director Appointments**

Non-Executive Director appointments are for a term of three years. Non-Executives can be re-appointed for up to three terms of office (i.e. a maximum of nine years) with any final term of three years subject to annual reappointment. The Council of Governors carries the responsibility of terminating the contract for a Non-Executive Director where this is believed to be appropriate, in accordance with the Trust Constitution and Foundation Trust Code of Governance.

**Chairman – Mrs Sandra Dodson (Non-Executive Director) – appointed 1 October 2008**

Sandra has been a Harrogate and District resident for around 20 years and was a Non-Executive Director of the Trust between 1996 and 2006. Sandra returned to the Trust in 2008 to take on the role of Chairman, and to further the Trust's vision of providing high quality and appropriate care to the people of Harrogate and District. In addition to her role as Chairman, Sandra maintains her own business consultancy and training business delivering strategic support and organisational change to the professional sector.

Sandra worked for 16 years in a senior role for Marks and Spencer and was highly involved in the initiation and implementation of significant changes to both working practices and processes.

Sandra was a Governor and then Chair of Governors at Harrogate Grammar School for ten years and worked closely with the Senior Leadership Team in driving the change agenda and transforming structures and roles within the school.

Sandra is a Trustee of the Masiphumelele Trust, the UK arm of a South African charity raising funds for education and business support for the Masiphumelele township, and also became a Trustee of Yorkshire Cancer Research in March 2014.

There have been no changes in the Chairman's significant other interests during 2013/14.

**Vice-Chairman, Non-Executive Director and Senior Independent Director – Mr Robert Wivell – appointed 1 August 2005, final term of office ended 31 July 2013**

Robert is a Chartered Accountant who became the Chief Executive of a number of engineering companies following a period as a management consultant with PA. He then became the Non-Executive Chairman or Independent Director of a variety of businesses. He is a member of York Diocesan Board of Finance, where he oversees the Diocese's buildings and land.

Robert's expertise is in the areas of strategy and the management of change. Within HDFT, he was interested in how the Trust is to develop in the years ahead and what services it should offer, particularly in the area of integrated care. He sat on the Charitable Funds Investment Panel, the Service Transformation Committee and the Research Committee.

Over the course of his career, Robert has had considerable experience of identifying strategic threats and opportunities, evaluating and developing cases for acquisition and diversification, negotiating acquisitions and disposals, developing plans for post-acquisition policy, carrying out programmes of significant change and building effective teams.

**Non-Executive Director, Vice-Chairman and Senior Independent Director from 1 August 2013 and Chair of the Audit Committee – Mr John Ridings - appointed 28 April 2005; final term of office ending 30 June 2014**

John is a chartered accountant who spent his career with KPMG, one of the leading firms in audit, accountancy and business finance in the UK. He was a partner in KPMG for nearly 25 years and was senior partner of the Leeds office, retiring in 2002. He is Non-Executive Director of a number of private companies, including N G Bailey Group Limited and Bentley Holdings Limited. He also acts as an independent Trustee. John is a Trustee of Hollybank Trust, which provides education, development and life long care for children and adults who have complex disabilities. He is a former Chairman of the University of Bradford Audit Committee and a former Governor of Bradford Grammar School.

In addition to John's role as Chairman of the Audit Committee at HDFT, he is a member of the Remuneration Committee, the Hospital Infection Control Committee and the Healthcare Associated Infections Steering Group.

John is a Board member of North Yorkshire NHS Audit Services (NYAS). NYAS provides internal audit services to HDFT and other NHS Providers and Commissioners.

**Non-Executive Director – Ms Sue Symington – appointed 12 May 2008; appointed Vice-Chairman from 1 May 2014**

Sue joined the HDFT Board in May 2008, with extensive experience of working in leadership roles across public, private and third sector organisations.

Sue has consolidated her NED role at HDFT, by studying with the Institute of Directors, and qualifying as a Chartered Director in April 2013.

A Chartered Fellow of the CIPD, Sue has a strong background in organisational development, the leadership of change, HR, learning and development and the delivery of effective governance.

Sue is an experienced facilitator of team processes and has more than 20 years' experience in leadership development.

As chair of the Quality of Experience Group and End of Life Care Group, Sue's particular interest is in the quality of experience of our service users.

Sue provides organisational development consultancy to a number of local businesses, is a Non-Executive Director of The Beverley Building Society, Non-Executive Chair of the Pollards Hill Community Committee and Vice Chair of The Independent Advisory Panel at The Army Foundation College in Harrogate. She runs her own successful business near Knaresborough.

**Non-Executive Director and Chair of the Audit Committee from 1 December 2013 to 6 February 2014 – Mrs Sarah Nattress – appointed 1 June 2009, stepped down 6 February 2014.**

Sarah is local to Harrogate and has a wealth of experience in management and oversight roles in both the public and private sector. A Chartered Accountant, she worked for PricewaterhouseCoopers LLP for nine years where she was a Director within their Government and Public Sector team and led their public sector internal audit services for the North. Prior to this, Sarah worked for GE Capital, having initially trained with KPMG. Sarah's public sector clients included the Department for Trade and Industry, the Department for Education, an Ambulance Service Trust, a Regional Health Authority and an NHS Special Authority.

Sarah is experienced in corporate governance, risk management and regulatory compliance issues, as well as assisting public sector clients with organisational change, outsourcing of services and partnership working.

As well as participating on the Board of Directors at the Trust, Sarah also formally represented the Board on the Audit Committee, drawing on her experience of the public sector regularity compliance and corporate governance frameworks. She also has a special interest in equality and diversity and championing key elements of the patient experience. Sarah was the Non-Executive lead on the Board for *Being Open*.

**Non-Executive Director - Mr Ian Ward – appointed 1 October 2012.**

Ian has spent over 40 years in financial services including being Chief Executive of Leeds Building Society (LBS) for 16 years until his retirement from that role in August 2011. LBS is based in Leeds but operates throughout the UK. It is a successful mutual business that is owned by its 700,000 members.

In a Non-Executive capacity, Ian is now a director of Newcastle Building Society, a member of its Group Risk Committee and a director of its Information Technology subsidiary. He also undertakes consultancy work for some other businesses.

Ian was a Director and Vice-President of Leeds, York and North Yorkshire Chamber of Commerce and Chairman of its Property Forum. Also, he was a member of the National Council of the Building Societies Association (BSA) and a former Chairman of the Northern Association. Additionally, he was a director and Chairman of the Audit Committee of Leeds Training and Enterprise Council (TEC).

Ian moved to Knaresborough in 1996, shortly after taking up his CEO position at LBS. He intends to continue living in this area and is very interested in HDFT and how its strategy will evolve to ensure its continued success and delivery of high quality care. He is a member of the Audit Committee.

**Non-Executive Director - Professor Sue Proctor – appointed 1 September 2013; Senior Independent Director from 1 May 2014**

Sue has over 26 years' experience in health care organisations as a nurse, midwife, researcher and manager. Until 2010, she was Director of Patient Care and Partnerships at NHS Yorkshire and Humber.

In the last three years, she moved into a different role, and was Diocesan Secretary for the Church of England Diocese of Ripon and Leeds. As part of this role she led the administration, finance, property and strategic planning for the Diocese.

Currently, Sue runs a management consultancy business working with health, charity and faith based organisations. She is a member of the University of Leeds Council, Chair of the LEAF Multi Academy Trust in East Leeds, and a lay Canon at Ripon Cathedral. She has is also a lay member of the Royal College of Veterinary Surgeons' Nursing Council.

Within the Trust, Sue is a member of the Audit Committee, Remuneration Committee, and Quality and Governance Committee. She is also the nominated lead Non Executive for research and development.

Sue has an MSc in Nursing and a PhD in Health Services Research. In 2009 she was awarded a Visiting Professorship by Leeds Metropolitan University. Her expertise is in corporate and clinical governance, strategic planning and delivery, and her passion is in improving services for patients and carers by working in partnership with them

**Non-Executive Director – Mrs Lesley A Webster – appointed 1 January 2014**

For over 30 years Lesley has had a professional involvement with the NHS in the UK.

Starting as a Registered Nurse, she later moved into the Medical Supply Industry in 1987.

Working for a range of both International and UK based Medical Companies has meant that she has had much interaction with the NHS and through this has become knowledgeable in NHS issues relating to wound, continence and stoma care and latterly worked with the leading infection control business Vernacare Ltd. In addition, she has developed a strong network of relationships with Clinical, Procurement and Senior Management contacts across the UK.

For the last 16 years, Lesley has held Senior Executive and Board level posts, where she has been influential in leading strategic business development and directing sales, marketing, customer care and engineering functions.

Being an ex-nurse has influenced Lesley in various ways: it has been important to her to always research carefully to ensure that products and services she has been involved with worked well and have been genuinely beneficial to patients' outcomes. Furthermore, it has given her an informed view and influenced her approach in dealing with new product development which she has been actively involved with from concept to launch.

Her key achievement in product development has been her invention from concept to launch of a new infection prevention product, which won the Queen's Award for Innovation, which she was honoured to personally receive from Her Majesty the Queen in July 2011.

Lesley took early retirement in 2012 and since this time has become a Volunteer Enterprise Mentor for PRIME (Prince's Trust Charity for people setting up in business when over 50).

**Non-Executive Director – Mr Chris Thompson – appointed 1 March 2014**

Chris is a chartered accountant who was Chief Financial Officer at the University of Nottingham for the period from 2007 until 2013. His career has largely been spent in the retail and food manufacturing sectors.

He qualified as a chartered accountant with KPMG, and worked with the firm for 10 years at their Newcastle Upon Tyne and London offices. He went on to work in senior financial positions in a number of retailers, including Asda Stores and Woolworths before joining the Co-operative movement where he worked for eight years. During this time, he was responsible for the management of a number of large businesses in the funerals, pharmacy, retail, distribution and manufacturing sectors.

Chris is a Trustee, Director and Chair of the Audit Committee of Community Integrated Care, a health and social care provider based in the North West which operates services throughout the United Kingdom. He is also a Director of a multi-academy trust based in the East Midlands where he also chairs the Finance Committee.

In attendance to the Board during 2013/14

**Director of Governance – Miss Anne Lawson (Executive Director) – appointed 4 September 2002. Retired 30 April 2013**

Anne qualified in Medicine in 1974, and was appointed a Consultant General Surgeon and Urologist at Harrogate in 1991. From 2002 until her retirement, she was Governance lead for the Trust, which includes leading on all aspects of Integrated Governance.

After Anne retired from clinical practice, she was Director of Governance.

Anne's areas of responsibility included quality of care, (she was the safety lead), risk management systems, registers and training and associated documentation; assurance framework, Annual Governance Statement, assurance registers, policy management, research governance, performance governance, returns to the CQC and work regarding compliance with the NHSLA Risk Management Standards. She was also a visiting fellow at the Business School of Loughborough University.

**Director of Partnerships and Innovation – Mrs Janet Probert (Executive Director) – joined the Trust on 1 April 2011, as part of the transfer of community services. Left on 31 August 2013**

Janet joined the Trust on 1 April 2011, transferring into HDFT from North Yorkshire and York Community and Mental Health Services where she was Managing Director from October 2006.

Prior to joining HDFT, Janet worked in the Public Health department in Bolton, Lancashire, where she undertook an MBA; as Locality Manager in the Ribble Valley, and then as Clinical Director for Medical and Elderly Services in South Durham Hospitals NHS Trust. Janet joined Craven Harrogate and Rural District PCT in 2002 as Director of Nursing and Service Modernisation. She was also Nurse Advisor to the Board in Hambleton and Richmondshire PCT and Acting Director of Nursing in Selby and York PCT.

Within HDFT, Janet led on the development of effective partnerships looking at how the Trust can improve the services and outcomes for the people who use its wide range of services. Examples include stroke services, dementia and processes to ensure a safe timely discharge. In addition, Janet led on the development of a culture of innovation across the Trust to support continuous improvement.

Engaging people who use the Trust's services to inform models of delivery is an essential component of innovative delivery. Janet and her team regularly held events to enable the local population, partners and people who use the services to inform priorities and approaches to service delivery.

Janet was awarded the Florence Nightingale Scholarship for outstanding Nurse leadership and has used the scholarship to explore models of health integration and innovation within the world's highest performing organisations.

### Performance evaluation of the Board of Directors

Evaluation of the Board of Directors is delivered formally via a number of channels, which can include:

- Appraisal of Executive Director performance by the Chief Executive and Chairman on an annual basis;
- Appraisal of Non-Executive Director performance by the Chairman and Deputy Chair of the Council of Governors on an annual basis;
- Appraisal of the Chairman by the Council of Governors, led by the Senior Independent Director and Deputy Chair of the Council of Governors, after seeking views and comments of the full Council of Governors, as well as other Board colleagues;
- Appraisal of the Chief Executive by the Chairman;
- An annual Board development programme including Board development exercise led by an external assessor.

In September 2013, the Board undertook a process to self-assess its effectiveness. The Board held a development session, led by an external facilitator, to which representatives from all Clinical Directorates were invited to give feedback on specific elements of Board performance, including the 'tone from the top' and how the Board sets the strategic context. An action plan arising from the day was presented to the Board of Directors. The outcomes of the session demonstrated an open, well-balanced and visible Board of Directors.

There has not been a formal external evaluation of the Board of Directors during 2013/14.

The information below details the Executive and Non-Executive Director attendance at Board of Directors meetings in 2013/14.

The Board of Directors met 12 times in 2013/14. One of these meetings was to discuss and approve the Annual Report and Accounts and was held on 28 May 2013. No Board meeting was held in December 2013.

Attendance by Directors is detailed in the following table:

Name	April 2013	May 2013	28 May 2013	June 2013	July 2013	August 2013	September 2013	October 2013	November 2013	January 2014	February 2014	March 2014
S Dodson	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
R Wivell	Y	Y	Y	Y	Y							
J Ridings	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
S Nattress	Y	Y	N	Y	N	Y	N	Y	Y	Y		
S Symington	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
I Ward	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
S Proctor							Y	Y	Y	Y	Y	Y
L Webster										Y	Y	Y
C Thompson												N
R Ord	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
J Coulter	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
A Monaghan	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y
D Scullion	Y	Y	N	Y	Y	Y	N	Y	Y	Y	Y	Y
R Harrison	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
P Marshall	N	Y	N	Y	Y	Y	Y	N	Y	Y	Y	Y
A Lawson	Y											
J Probert	Y	Y	Y	Y	Y	N						

## Succession Planning for the Board of Directors

In preparation for two Executive Directors retiring in 2014/15, the Trust has had in place for some time a robust succession plan for the Board. Mrs Angela Monaghan, Chief Nurse and Mr Richard Ord, Chief Executive, retire in June and August 2014 respectively. This plan also details arrangements for Non-Executive Directors, Deputy Directors and Clinical Directors.

The succession plan was approved by the Board of Directors and also received by the Council of Governors. Mr Ord's and Mrs Monaghan's successors were recruited in January and February 2014 respectively. The succession plan is updated as appropriate.

## **Nominations Committee for the appointment and reappointment of Non-Executive Directors, including the Chair**

The Nominations Committee met twice during 2013/14.

The first meeting took place on 2 October 2013 and discussed the appointment of two new Non-Executive Directors. It agreed the person specification, job description and job advert for the two posts.

The members of the Nominations committee were:

Mrs Dodson, Chairman (Chair)  
Mrs Colvin, Corporate Affairs and Membership Manager (Ex Officio)  
Mrs Dow, Deputy Director of Corporate Affairs (Ex Officio)  
Mrs Edgar, Staff Governor  
Mrs Hewitson – Public Governor  
Miss McMeekin, Deputy Director of Human Resources (Ex Officio)  
Mr Ord, Chief Executive (Ex Officio)  
Dr Scott – Staff Governor  
Rev. Dr Willshaw - Public Governor and Deputy Chair of Council of Governors

The interviews for the Non-Executive Directors took place on 11 December 2013. The Nominations Committee subsequently made a recommendation to the Council of Governors to appoint Mrs Lesley Webster and Mr Chris Thompson to the Board of Directors. The recommendation was approved by the Council of Governors at its meeting on 12 December 2013.

The second meeting of the Nominations Committee took place on 10 March 2014 and discussed the following two items:

- 1) The reappointment of Mrs Sue Symington to a third term, subject to annual reappointment; and
- 2) The process for the appointment of a new Non-Executive Director.

The members of the Nominations Committee were:

Mr Ridings (Chair)  
Mr Armitage, Public Governor  
Dr Blackburn, Public Governor  
Mrs Cheesebrough, Staff Governor  
Mrs Edgar, Staff Governor  
Mrs Hedley, Public Governor  
Mrs Purkis, Public Governor  
Mr Robertson, Public Governor

Dr Scott, Staff Governor  
Rev. Dr Willshaw, Public Governor  
Mrs Wilson, Staff Governor  
Mrs Colvin, Corporate Affairs and Membership Manager (Ex Officio)  
Mrs Dow, Deputy Director of Corporate Affairs (Ex Officio)  
Miss McMeekin, Deputy Director of Workforce and Organisational Development (Ex Officio)  
Mr Ord, Chief Executive (Ex Officio)

The recommendation of the Nominations Committee, for approval by the Council of Governors at its 30 April 2014 meeting, was to reappoint Ms Symington to a third term, subject to annual reappointment.

The interviews for the Non-Executive Director post take place in June 2014.

### **NHS Foundation Trust Code of Governance**

The Trust complies with the provisions of the newly updated NHS Foundation Trust Code of Governance and has embedded its principles into the integrated governance of the organisation.

The Trust complies, either to the letter or in effect, with the Code of Governance. A detailed assessment against each code description has been carried out and was presented to the Board of Directors in March 2014, with an action plan for any areas requiring development. The Board confirmed that the Trust was compliant with all requirements of the code once the action plan was completed.

Information relating to quality governance systems and process is detailed throughout the annual report, but in particular in the Annual Governance Statement and Quality Report.

The Trust has regard to Monitor's Quality Governance Framework and carried out a detailed self-assessment as part of its review of governance arrangements in 2013/14.

### **The Trust's assurance structure**

The Trust's governance structure and assurance mechanisms enable the Board of Directors to review all elements of quality, patient experience, patient safety and effectiveness of care. Data, performance metrics, audit results, survey results and inspection reports indicate whether services are being provided to the appropriate standards set nationally and by the Trust. If deficiencies are identified, improvement plans and additional monitoring is introduced. The key Trust governance structures and systems are described below.

An internal review of the Trust governance arrangements was undertaken during 2013/14 and the Quality, Governance and Risk Management Strategy was approved in October 2013, clearly defining the responsibilities of individual Directors.

The Trust has a system of integrated governance. This includes corporate, clinical and financial governance, risk management, information governance - including data security, research governance, clinical effectiveness and audit and performance governance. This system is described in the Quality, Governance and Risk Strategy. The key objectives of this strategy are to provide the framework for achieving:

- Compliance with external regulatory and other standards for quality, governance and risk including Monitor, the Care Quality Commission Standards, and NHS Litigation Authority Risk Management Standards;

- A culture of effective risk management at all levels of the organisation;
- A robust assurance and risk framework to confirm all controls and mitigation of risks are in place and operating;
- The integration of quality, governance and risk within the Trust's strategic aims and objectives;
- Integrated governance encompassing financial, clinical, quality, corporate, information, performance and research governance systems.

The Chief Nurse and Medical Director have provided leadership at Board of Director level for implementation of integrated governance and risk management since the retirement of the Director of Governance in April 2013.

The Board of Directors places a strong emphasis on effective communication "Ward to Board" and this is reflected in the management and governance structures of the Trust;

At the heart of the structures are the three Clinical Directorates, which provide the majority of the Trust's services. The Clinical Directors attend the Board of Director meetings each month and provide strong link between the Board and front line multi-disciplinary staff;

A Quality and Governance Group for each Clinical Directorate is in place and the content of these meetings reflects both local specialty matters and cross cutting Trust clinical and non-clinical priorities;

Quality of Care Teams are in place across the organisation and report to the Directorate Quality and Governance Groups. The focus of these teams is on continual service improvement;

The Quality and Governance Group has strong representation from both senior staff within the Directorates and at corporate level, including a Non-Executive Director, and whilst this group does not report formally to the Board there is a direct line of accountability to the Senior Management Team of the Trust;

An important element within the governance structure now and previously is the separation of operational and scrutiny functions. The operational elements are described above. The scrutiny or assurance elements include the Audit Committee, which is a formally constituted sub-committee of the Board of Directors. This committee provides independent assurance on governance and controls including internal and external audit;

The Audit Committee is supported by the Standards Group. This group is responsible for ensuring that recommendations from external reports, audits, visits and regulators including the Care Quality Commission are met and that data from the Trust to outside agencies is quality assured. The Standards Group also provides assurance to the directors and Audit Committee from clinical audit. It is accountable to the Director Team, but minutes are received at the Audit Committee;

The Corporate Risk Review process is well established within the organisation. Departmental and Directorate risk registers are reviewed to enable the Board of Directors to be advised on the principal risks and the plans in place to reduce or mitigate the risks.

The Assurance Framework is produced annually within the Trust and reviewed regularly. The document draws together progress on the Trust's strategic objectives and quality priorities, the Care Quality Commission's outcomes and the principal corporate and strategic risks.

The Trust can confirm that there are no material inconsistencies between the Annual Governance Statement, the annual and quarterly board statements required by the Risk Assessment Framework, the Corporate Governance Statement, the Audit Committee Annual Report, the Quality Report, Annual

Report and reports arising from Care Quality Commission planned and responsive reviews of the NHS Foundation Trust and any consequent action plans.

The Board has conducted a review of the Trust's systems of internal control and has concluded that they are fit for purpose.

The Directors are responsible for preparing the Trust's Annual Report and Accounts and consider that, taken as a whole, they are fair, balanced and understandable and provide the necessary information for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

### **Council of Governors**

The Council of Governors is representative of the views and interests of the Foundation Trust Members and the general public. It has an important role in acting as the eyes and ears of the membership with regards to the quality of service the Trust provides.

The Council of Governors does not undertake the operational management of the Trust; rather they provide a vital link to the wider community, challenge the Board of Directors and, collectively hold them to account for the performance of the Trust.

Governors regularly feedback information about the Trust, its vision and its performance to the constituencies and stakeholder organisations that either elected or nominated them.

Governors are elected by staff (Staff Governors) and the membership (Public Governors), or nominated by partner organisations such as North Yorkshire County Council (Stakeholder Governors). The Council of Governors consists of 17 elected and six nominated Governors.

The Council of Governors has a statutory duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, including an assurance that the Trust works within the terms of its Licence.

The Council of Governors has specific statutory responsibilities. These are:

- to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors;
- to be representative of the interests of the Members of the Trust as a whole and the interests of the public;
- to appoint or remove the Chairman and the other Non-Executive Directors;
- to approve the appointment (by the Non-Executive Directors) of the Chief Executive;
- to appoint or remove the Trust's external auditor;
- to decide the remuneration of the Chairman and Non-Executive Directors;
- to consider the Trust's Annual Accounts, Auditor's Report and Annual Report;
- to bring their perspective in determining the strategic direction of the Trust;
- to be involved in the Trust's forward planning processes;
- to approve any merger, acquisition, separation or dissolution application and the entering into of any significant transactions;
- to approve any proposals to increase by 5% or more of the Trust's proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England; and,
- to approve any amendments to the Trust's Constitution to be ratified by the Trust's Members.

The following table highlights the composition of the Council of Governors and includes each Governor's term of office and attendance at the quarterly Council of Governor meetings held during the year April 2013 to March 2014.

Constituency	Name	Term of office	April 2013	July 2013	September 2013*	October 2013	December 2013**	January 2014	February 2014***
Harrogate and surrounding villages – publicly elected	Mr Andy Wilkinson	January 2005 to December 2007							
		January 2008 to December 2010	Y	Y	Y	Y	Y		
		January 2011 to December 2013							
	Rev Dr. Mervyn Willshaw, Deputy Chair of Governors/Lead Governor	January 2010 to December 2012	Y	Y	Y	Y	Y	Y	Y
		January 2013 to December 2015							
	Mrs Pat Jones	January 2011 to December 2013	N	Y	N	Y	N	Y	Y
		January 2014 to December 2016							
Dr Sally Blackburn	August 2011 to July 2014	Y	Y	Y	Y	Y	N	Y	
Miss Sara Spencer	January 2013 to December 2015	Y	Y	Y	Y	Y	Y	Y	
Ms Pamela Allen	January 2014 to December 2016							Y	Y

Constituency	Name	Term of office	April 2013	July 2013	September 2013*	October 2013	December 2013**	January 2014	February 2014***
Knaresborough and East District – publicly elected	Mrs Pat Hewitson	January 2005 to December 2007							
		January 2008 to December 2010	Y	Y	Y	Y	Y		
		January 2011 to December 2013							
	Mrs Jane Hare	January 2013 to December 2015	Y	Y	Y	Y	N	Y	Y
	Mrs Joyce Purkis	January 2014 to December 2016						Y	N
Rest of North Yorkshire and York – publicly elected	Mr Paul Hyde	July 2011 to June 2014	Y	N	N	Y	Y	Y	N
Ripon and West District – publicly elected	Mr Stuart Martin	July 2011 to June 2014	N	N	N	Y	N	Y	Y
	Mr Andy Robertson	July 2013 to June 2016	N/A	Y	Y	Y	Y	Y	N

<b>Constituency</b>	<b>Name</b>	<b>Term of office</b>	<b>April 2013</b>	<b>July 2013</b>	<b>September 2013*</b>	<b>October 2013</b>	<b>December 2013**</b>	<b>January 2014</b>	<b>February 2014***</b>
Wetherby and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley Wards – publicly elected	Mr Bryan Ellings	January 2008 to December 2010 January 2011 to December 2013	Y	N	Y	Y	Y		
	Mrs Jane Hedley	July 2011 – June 2014	Y	Y	Y	Y	Y	Y	Y
	Mr Michael Armitage	January 2014 to December 2016						Y	Y

<b>Staff Constituency</b>	<b>Name</b>	<b>Term of office</b>	<b>April 2013</b>	<b>July 2013</b>	<b>September 2013*</b>	<b>October 2013</b>	<b>December 2013**</b>	<b>January 2014</b>	<b>February 2014***</b>
Medical Practitioners Staff Class – staff elected	Dr Daniel Scott	January 2013 to December 2015	Y	Y	Y	Y	Y	Y	Y
Non-Clinical Staff Class – staff elected	Mrs Carol Cheesebrough	January 2013 to December 2015	N	N	N	N	N	Y	N

Staff Constituency	Name	Term of office	April 2013	July 2013	September 2013*	October 2013	December 2013**	January 2014	February 2014***
Nursing and Midwifery Staff Class – staff elected	Mrs Emma Edgar	January 2011 to December 2013 January 2014 to December 2016	Y	N	Y	Y	N	Y	N
	Mrs Stephanie Rees	May 2013 to April 2016 (stood down September 2013)		Y	N				
	Mrs Sally Margerison	January 2014 to December 2016						Y	Y
Other Clinical Staff Class – staff elected	Mrs Fiona Wilson	January 2007 to December 2009 January 2010 to December 2012 January 2013 to December 2015	Y	N	Y	Y	Y	Y	Y

<b>Nominating Organisation</b>	<b>Name</b>	<b>Term of office</b>	<b>April 2013</b>	<b>July 2013</b>	<b>September 2013*</b>	<b>October 2013</b>	<b>December 2013**</b>	<b>January 2014</b>	<b>February 2014***</b>
North Yorkshire County Council	Mrs Margaret-Ann de Courcey Bayley	Nominated from January 2005 (end of term of office December 2013)	Y	Y	Y	Y	N		
	Cllr. Bernard Bateman	Nominated from January 2014						Y	Y
Harrogate Borough Council	Mr John Ennis	Nominated from June 2011	N	N	N	Y	Y	N	Y
University of Leeds	Dr Joan Maclean	Nominated from January 2009 (stood down July 2013)	N	Y	N				
	Dr Sarah Crawshaw	Nominated from January 2014						N	N
Harrogate and Rural District Local Medical Committee	Dr Jim Woods	Nominated from June 2011	Y	Y	N	Y	Y	Y	N
Voluntary sector	Ms Jane Farquharson	Nominated from July 2013		Y	N	N	N	Y	N

- \* An additional meeting was held in September 2013 to approve changes made to the Constitution, namely the addition of another Non-Executive Director to the Board, and the change to make the Director of Workforce and Organisational Development a voting member of the Board of Directors from 1 January 2014.
- \*\* An additional meeting was held in December 2013 to approve the recommendation of the Nominations Committee to appoint two new Non-Executive Directors.
- \*\*\* An additional meeting was held in February 2014 to approve changes to bring forward a Non-Executive Director appointment date and to approve the extension of a Non-Executive Director's tenure.

A Register of Interests for all members of the Council of Governors is held by the Foundation Trust Office and is continually updated. This is available on request from the Foundation Trust Office.

Council of Governor meetings are attended by the Chairman of the Trust, the Chief Executive, Deputy Chief Executive/Finance Director, Chief Nurse, Medical Director, the Chief Operating Officer and the Director of Workforce and Organisational Development. In addition, there is regular attendance by Non-Executive Directors.

The following table highlights Chairman's and Executive Directors' attendance at the quarterly Council of Governor meetings held during the year April 2013 to March 2014 to advise on operational matters.

<b>Name</b>	<b>Position</b>	<b>April 2013</b>	<b>July 2013</b>	<b>October 2013</b>	<b>January 2014</b>
Mrs Sandra Dodson	Chairman	Y	Y	Y	Y
Mr Richard Ord	Chief Executive	Y	N	Y	Y
Mr Jonathan Coulter	Deputy Chief Executive / Finance Director	Y	N	Y	N
Dr David Scullion	Medical Director	N	N	N	Y
Mrs Angela Monaghan	Chief Nurse	Y	Y	Y	Y
Mr Robert Harrison	Chief Operating Officer	Y	N	N	Y
Miss Anne Lawson	Director of Governance	Y			
Mrs Janet Probert	Director of Partnerships and Innovation	Y	Y		
Mr Phillip Marshall	Director of Workforce and Organisational Development	N	Y	Y	Y

### Governors' communication with Members and the public

The Council of Governors is widely consulted on the Annual Plan for the Trust, including setting the strategic objectives. A Governor working group to look at the Business Plan, including objectives, priorities and strategy is set up every year and meets monthly throughout the planning process. Governors on the group are encouraged to canvass the opinions of their electing Members and feedback any matters that are communicated to them throughout the year that are relevant to the annual plan and strategic objectives.

Verbal updates are given to the full Council of Governors by members of the working group.

The Deputy Director of Planning, Deputy Director of Finance and Deputy Director of Corporate Affairs sit on the group and report to the Executive Directors. Governors' views are communicated to the full Council of Governors and the Chief Executive and Executive Directors.

### Governors' power to require one or more Directors to attend a Governors' meeting

The Council of Governors has not exercised its power to require one or more Directors to attend a Governors' meeting for the purpose of obtaining information about the Foundation Trust's performance of its functions or the Directors' performance of their duties.

There is consistent attendance at the Trust's Council of Governor meetings by Executive and Non-Executive Directors, enabling both Governors and Members to network and ask questions of the Board.

Director attendance at Council of Governor meetings is detailed earlier in the Annual Report.

## **Membership**

### The Trust's Membership

The Trust is accountable to the local population that it serves and encourages local ownership of health services through its membership. On 31 March 2014 the Trust had 17,493 Members; people who have chosen to become a Member and are interested in the NHS and want the opportunity to get more involved in their local health services. Members can become involved in numerous ways, from receiving updates and newsletters to being consulted with on plans for future development; attending open days and events, volunteering for the Trust and much more.

The Foundation Trust Office manages an in-house membership database containing Members' areas of interest, and as services are developed or reviewed, Members can be contacted to participate via consultations, surveys and discussion groups.

### Eligibility to be a Member

Public membership by constituency applies to residents in the Trust's defined catchment area indicated on the following map:



The public membership profile		Representation of public	
Harrogate and surrounding villages	6,768	82,599	8.2%
Ripon and west district	2,036	37,571	5.4%
Knaresborough and east district	2,434	37,699	6.5%
Harewood and Wetherby including Otley and Yeadon, Adel and Wharfedale and Alwoodley wards	2,302	102,771	2.2%
Rest of North Yorkshire and York	305	638,559	0.05%
<b>TOTAL</b>	<b>13,845</b>	<b>899199</b>	<b>1.54%</b>

The staff membership profile		Representation of total staff	
Medical Practitioners*	402	511	78.7%
Nursing and Midwifery	1,507	1,522	99%
Other Clinical	672	689	97.5%
Non-Clinical	1,067	1,083	98.5%
<b>TOTAL</b>	<b>3,648</b>	<b>3,805</b>	<b>95.9%</b>

\*It is important to note that this constituency contains a number of staff on short term contracts who are ineligible for staff membership.

The volume of Members has increased across all the public constituencies during 2013/14, except for Harewood and Wetherby (including Otley and Yeadon, Adel and Wharfedale and Alwoodley wards) which has remained static. There has been a 7% increase on last year's membership for the rest of North Yorkshire and York. Both the Board of Directors and Council of Governors continue to believe that an engaged membership is beneficial to the Trust as opposed to increased volume, particularly in the public constituencies.

Staff membership is via an opt-out scheme. 95.9% of staff are currently members. The membership database is updated on a quarterly basis from the electronic staff record taking into account new starters, leavers, and individual detailed records. With effect from 1 April 2013, following data analysis, consultation with staff and approval by the Council of Governors on 30 January 2013, the Community Services Staff Class was disbanded. Staff from the Community Services Staff Class were transferred into their representative group which increased the Staff Governor representation in the Nursing and Midwifery Staff Class to two Governors.

During the forthcoming year, the Trust will continue to actively recruit Members across the catchment area, and in particular from the rest of North Yorkshire and York where membership representation is at its lowest and in North and West Leeds where service developments are high on the agenda. The plans to do so will be overseen by the Governor Working Group for Membership Development and Communications and will form part of the Membership Development Strategy.

#### Gender and ethnicity

The public membership is made up of 48.6% females and 51.3% males, with 0.1% unknown. The figures this year continue to demonstrate the shift towards a more equal balance between males and females than in previous years.

Gender	Number of Members	Eligible membership	Percentage
Male	7,104	440,383	1.61%
Female	6,727	458,816	1.47%
Not specified	14		
<b>Total</b>	<b>13,845</b>	<b>899,199</b>	<b>1.54%</b>

#### Ethnic origin of the public membership

Ethnicity	Number of Members	Eligible membership
White	2,050	863,226
Mixed	10	9,110
Asian or Asian British	39	19,196
Black or Black British	17	4,599
Unknown	11,729	3,068
<b>Total</b>	<b>13,845</b>	<b>899,199</b>

The ethnicity of all new Members is captured from the membership leaflet and the online form.

#### Affiliates

In addition to the voting membership, the Trust has 'affiliates', totalling 430, a slight decrease from 455 in 2012/13. Affiliates are those people who have an interest in the Trust but do not qualify to be a Member, either due to their age (i.e. they are below 16 years of age) or because they live outside of the Trust's catchment area. Affiliates can receive mailings, but do not have voting rights. Affiliates are not counted within the membership numbers.

#### How we develop our Membership

The Membership Development Strategy has been reviewed in 2013/14 with detailed work plans to drive forward targeted recruitment in under-represented areas and high quality membership engagement activity, in line with the Trust's strategic aims. The Governor Working Group for Membership Development and Communications has continued to report to the Council of Governors at each quarterly public meeting.

The annual target membership figure is set as part of the Annual Planning process and remains at 17,500 members by the end of 2014/15.

Providing effective and informative communication and high quality membership engagement for the membership is the Trust's priority. Communication and membership activities are delivered in the following ways:

- A welcome pack, including a welcome letter from the Members' elected Governor(s), a membership card, a questionnaire and a discount card to use with local and national companies;
- 'Foundation News' membership magazine (approximately every eight months);
- 'Chairman's Letter' or alternative communication, i.e. a postcard (approximately every eight months);
- Members' area on the website, including notification of meetings and events;
- Local media articles and notifications;

- Invitations to membership events, for example ‘Medicine for Members’ lectures;
- Invitations to community events in partnership with stakeholders;
- Public Council of Governor meetings;
- Governor public sessions, for example speaking at local committees and groups;
- Annual Members’ Meeting;
- Annual Trust Open Event;
- Elections to the Council of Governors;
- Members’ notice board;
- Access to Trust strategic documents, including the Annual Report and Accounts, Quality Account and Annual Plan;
- Internal communications for Staff Members, for example, staff induction and Team Brief (a monthly briefing session for staff focusing on key topics, including developments in services, the Trust’s performance against its targets and finance);
- Leaflets and posters in community premises and in GP practices; and,
- Invitations to be involved with consultations, to take part in surveys and to be involved on focus groups.

The Education Liaison Programme, Work Experience Programme and Young Volunteer Scheme continue to be highly successful and are an extremely effective vehicle to enable the Trust to recruit young people and provide high quality engagement with young members. These projects are overseen by the Governor Working Group for Volunteering, Workforce and Education.

### The Foundation Trust Office

The Foundation Trust office continues to be a central point of contact for all members and the public to make contact with the Trust, the Council of Governors and Board of Directors. The Foundation Trust Office is open during office hours, Monday to Friday on 01423 554489 or by email to [nhsfoundationtrust@hdfnhs.uk](mailto:nhsfoundationtrust@hdfnhs.uk)

The Foundation Trust Office sits within the Corporate Directorate, which is overseen by the Executive Directors, and reports to the Chief Executive. This, alongside attendance at Council of Governors’ meeting, the public Minutes of these meetings and the reports of the Governor working groups, enables the Directors to monitor how representative the Trust’s membership is and the level and effectiveness of membership engagement. The Directors consider that the Trust’s membership is representative and that membership engagement is regular and effective.

### **Work of the Audit Committee**

The Audit Committee currently organises its work under five headings “Financial Management & Reporting”, “Governance, Risk Management and Internal Control”, “Clinical Assurance”, “Internal Audit and Counter Fraud” and “External Audit”.

#### Financial Management and Reporting

The Audit Committee regularly receives updates and reports from the Finance Director on the Trust’s financial position and any issues arising. Items discussed in particular during 2013/14 were the proposed consolidation of Charitable Fund accounts and the transfer of North Yorkshire & York Primary Care Trust legacy balances.

The Committee oversees and monitors the production of the Trust’s financial statements. During the 2013/14 financial year, this included:

- An informal but detailed review of the draft accounts prior to submission to Monitor and External Audit on 19 April 2013,
- A formal Committee meeting to discuss the draft accounts and External Audit's findings to date on 10 May 2013,
- A formal Committee meeting on 23 May 2013 to approve the final accounts and Annual Report for 2012/13 (including the Quality Account) prior to submission to the Board of Directors and Monitor.

Similar meetings have occurred during April and May 2014 relating to the 2013/14 financial statements, Annual Report and Quality Account. The following significant financial issues were discussed:

- Income estimate for Q4;
- Valuation of land and buildings;
- Transfer of Primary Care Trust assets and legacy balances.

In January 2014, the Audit Committee formally reviewed and approved the Trust's accounting policies (to be used in relation to the 2013/14 financial statements), considering consistency over time and compliance with the Foundation Trust Financial Reporting Manual. At the same meeting, the Audit Committee also considered the plan and timetable for the production of the Trust's 2013/14 financial statements and Annual Report.

The Committee also oversees and monitors the production of the Charitable Trust's financial statements. The final Charitable Funds accounts and Annual Report for 2012/13 were approved by the Committee on 23 May 2013 prior to submission to the Corporate Trustee.

The Audit Committee also reviewed and approved:

- Single Tender Actions,
- The Trust's Losses & Special Payments register in May 2013,
- The Annual Procurement Savings Report in September 2013,
- Revisions to the Trust's Treasury Management Policy in December 2013, and
- The recommendation to the Trust Board of the use of the going concern principle as the basis for the preparation of the 2012/13 accounts in May 2013.

The review of Post Project Evaluations (arising from capital schemes) is a standing item on the Audit Committee's agenda during the year. The lack of timely completion of Post Project Evaluations and submission of these to the Audit Committee has continued to be source of frustration during 2013/14, however a Post Project Evaluation Group has now been set up to monitor progress and it is hoped that completion rates will improve going forward.

#### Governance, Risk Management and Internal Control

The Audit Committee receives the minutes of the Standards Group and Corporate Risk Review Group. In addition the Audit Committee receives the minutes of the Quality and Governance Group, which is formally accountable to the Senior Management Team and the Board of Directors.

During 2013/14, the Audit Committee reviewed and approved the following documents prior to submission to the Board of Directors:

- Risk Management Strategy in September 2013;
- Maternity Risk Management Strategy in March 2013;
- Standing Orders in March 2013;
- Whistle Blowing Policy in September 2013; and

- Assurance Framework action plan in September 2013.

Additionally, the Staff Registers of Interests and Gifts and Hospitality were reported to the Audit Committee in May 2013.

The Annual Governance Statement and the Head of Internal Audit Opinion were reviewed by the Audit Committee prior to submission to the Board. The Chief Executive (or another designated Executive Director) attends the Audit Committee annually in May to discuss assurance around the Annual Governance Statement.

In relation to the governance of the Audit Committee itself, the Committee undertook the following tasks during 2013/14:

- Assessment of Audit Committee Effectiveness in December 2013, the findings of which were presented to the Board of Directors;
- Review and approval of Audit Committee Terms of Reference in January 2014 which were presented to the Board of Directors for approval;
- Ongoing review and revision of the Audit Committee's timetable.

### Clinical Assurance

Copies of the minutes of the Standards Group, the Corporate Risk Review Group and the Quality and Governance Group are formally reported to the Audit Committee on an ongoing basis.

The Audit Committee additionally receives a six-monthly report and action plan from the Standards Group. The Clinical Effectiveness and Audit Group is a sub-committee of and reports directly to the Standards Group. The Audit Committee reviewed and approved the Standards Policy in September 2013.

A joint Audit Plan covering the work of both Internal Audit and Clinical Audit and including some audits undertaken jointly by the two departments was again produced for 2013/14. The implementation of all aspects of this plan was reviewed by the Audit Committee at each of its meetings and the effectiveness of Internal Audit and Clinical Audit joint working was considered during 2013/14 by the Committee.

The Audit Committee receives assurance in relation to the effectiveness of Clinical Audit through the Annual Clinical Audit Report and six-monthly Standards Group Reports.

### Internal Audit and Counter Fraud Service

Internal Audit and Counter Fraud Services are provided by North Yorkshire NHS Audit Services (NYAS). The Chair of the Audit Committee and the Finance Director sit on the Alliance Board which oversees NYAS at a strategic level. The Board met on three occasions during 2013/14.

An Internal Audit Charter formally defines the purpose, authority and responsibility of Internal Audit activity. This document was updated, reviewed and approved by the Audit Committee in September 2013.

The Audit Committee approved the planning methodology to be used by Internal Audit and Clinical Audit to create a joint Audit Plan for 2013/14, and gave formal approval of the Internal Audit Operational Plan in March 2013.

The conclusions (including the assurance level and the corporate importance and corporate risk ratings) as well as all findings and recommendations of finalised Internal Audit reports are shared with the Audit Committee. The Committee can, and does, challenge Internal Audit on assurances provided, and requests additional information, clarification or follow-up work if considered necessary. All Internal Audit reports are discussed individually with the Audit Committee.

A system whereby all Internal Audit recommendations are followed-up on a quarterly basis is in place. Progress towards the implementation of agreed recommendations is reported (including full details of all outstanding recommendations) to the Director Team and the Audit Committee on a quarterly basis.

HDFT's counter fraud arrangements comply with the Secretary of State's Directions on countering fraud and the requirements specified in the NHS counter fraud and corruption policy. These arrangements are underpinned by the appointment of an accredited local counter fraud specialist and the introduction of a Trust-wide countering fraud and corruption policy.

The Counter Fraud Plan was reviewed and approved by the Audit Committee and the Local Counter-Fraud Specialist (LCFS) presented bi-annual reports detailing progress towards achievement of the plan, as well as summaries of investigations undertaken.

The effectiveness of Internal Audit was reviewed by HDFT staff and the Audit Committee in January 2014, resulting in a satisfactory evaluation. The action plan arising from the review is monitored via the Internal Audit Periodic Report to the Audit Committee.

#### External Audit

External Audit services are provided by KPMG.

During the 2013/14 financial year, the Audit Committee reviewed External Audit's Annual Governance Report and Management Letter in relation to the 2012/13 financial statements. *Note: similar review meetings have occurred during May 2014 in relation to the 2013/14 Financial Statements.* No non-core external audit work was undertaken during the 2013/14 financial year.

External Audit regularly updates the Committee on progress against their agreed plan, on any issues arising from their work and on any issues or publications of general interest to Audit Committee members.

The Audit Committee reviewed and approved the External Audit Plan in relation to the 2013/14 financial statements and the related audit fee in December 2013.

The effectiveness of External Audit was reviewed by HDFT staff and the Audit Committee in December 2013, resulting in a satisfactory evaluation.

#### Specific Significant Issues discussed by the Audit Committee during 2013/14

The following additional significant issues have been discussed by the Audit Committee during 2013/14:

- Risk assessment of fire safety;
- Outstanding assurances from the Yorkshire Ambulance Service relating to the maintenance of GP out of hours vehicles and equipment;
- Discharge from hospital;

- The implementation of “TACCORDD” (Thromboprophylaxis, Antibiotics, Cannula, Catheter, Oxygen, Respiration, Dementia and Discharge);
- DNACPR (Do Not Attempt Cardiopulmonary Resuscitation);
- Compliance with nursing and midwifery statutory standards for Quality Assurance of Practice Placement;
- Medical Handover;
- Consultant Job Planning.

The membership of the Audit Committee and attendance at meetings is shown in the tables below:

	10 May 2013	23 May 2013	10 Sep 2013	3 Dec 2013	31 Jan 2014	11 Mar 2014
Mr John Ridings (1)	Y	Y	Y			Y
Mrs Sarah Nattress (1)	Y	Y	Y	Y	Y	
Prof Sue Proctor (2)				Y	N	Y
Mr Ian Ward	Y	Y	Y	Y	Y	N
Mr Chris Thompson (3)						Y

- (1) Mr John Ridings, as part of succession planning, retired as Chair and a member of the Audit Committee, on 30 November 2013. Mrs Sarah Nattress was appointed Chair of the Committee on 1 December 2013 and resigned on 6 February 2014. Mr Ridings re-joined the Audit Committee and was reappointed Chair on 1 March 2014
- (2) Professor Sue Proctor was appointed a member of the Audit Committee on 1 November 2013.
- (3) Mr Chris Thompson was appointed a member of the Audit Committee on 1 March 2014.

#### Audit Committee Attendees

	10 May 2013	23 May 2013	10 Sep 2013	3 Dec 2014	31 Jan 2014	11 Mar 2014
<b>HDFT</b>						
Mr Jonathan Coulter	Y	Y	Y	Y	Y	Y
Mr Thomas Morrison	Y	Y	Y	Y	Y	N
Mrs Jenny Ehrhardt	N	N	Y	Y	Y	Y
Mrs Harriet Dow (4)			Y	Y	N	Y
Dr Sylvia Wood	Y		Y	Y	Y	Y
Dr Claire Hall	Y		N	Y	Y	Y
<b>Internal Audit</b>						
Ms Helen Kemp-Taylor	Y	N	N	Y	Y	Y
Mr Tom Watson	Y	Y	Y	Y	Y	Y
<b>External Audit</b>						
Mr Trevor Rees (5)	N	Y	Y			
Mrs Clare Partridge (6)			Y	Y	Y	N
Mr Andrew Smith	Y	N	N	Y	Y	Y

- (4) Mrs Harriet Dow attended the meetings from September 2013.
- (5) Mr Trevor Rees retired as KPMG partner lead for the Trust in September 2013.
- (6) Mrs Clare Partridge became the KPMG client lead Director for the Trust in September 2013.

	10 May 2013	23 May 2013	10 Sep 2013	3 Dec 2014	31 Jan 2014	11 Mar 2014
<b>Fraud</b>						
Mr Steve Moss (7)	Y			Y		Y

(7) Mr Steve Moss attends for Counter Fraud items at appropriate meetings.

## **QUALITY REPORT**

### **STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE**

The purpose of this report is to provide information to the public on the quality of the Trust's services, to demonstrate progress and improvements from last year and to inform the public of the Trust's priorities for next year. Where further work is needed on previous priorities, the document details further work agreed to make the required progress. The quality priorities have been agreed through consultation with staff, Governors and other stakeholders, including patient and public representatives.

Harrogate and District NHS Foundation Trust ('HDFT' or 'the Trust') is a high-performing Trust, achieving well against all national indicators. High quality of care for every patient, every time, is the first objective of the Trust and we are committed to continuous improvement.

I, as the Chief Executive, am accountable for all that happens within HDFT and am also the sponsor for ensuring quality of care. The Executive Director lead for quality is the Chief Nurse, Mrs Angela Monaghan. Our Board of Directors and Council of Governors are fully committed to ensuring that the Trust's top priority is the delivery of high quality care.

The Trust's governance structure was reviewed in October 2013, following a previous review in 2011. This structure is clear and fit for purpose and ensures that appropriate reporting and scrutiny takes place in relation to quality matters.

The Quality and Governance Group played a key role in monitoring the quality priorities and initiatives that were identified in the last Quality Account and will continue to monitor and drive a strong programme of quality improvement initiatives for 2014/15. The work plan includes the identified priorities for next year as well as continuing the work of the priorities from last year. A Non-Executive Director is a member of this group in order to provide additional assurance to the Board of Directors of the effectiveness of the group.

The Board of Directors meets in public on a monthly basis and receives performance and benchmarking reports, which include measures of quality. The Chief Nurse's report includes a quality and safety dashboard that details a large number of areas that are measured in relation to the quality of care. This dashboard has been further developed over the past year to include ward level data.

Harrogate District Hospital was inspected by the Care Quality Commission (CQC) in November 2013. This was as part of wave one of the CQC's remodelled inspection regime. There were 18 hospitals identified as part of the first wave; six low risk, six medium risk and six high risk. Harrogate District Hospital was one of the six low risk hospitals inspected. I am pleased to say that the outcome of the inspection was a positive one, identifying that the hospital delivers services that are safe, effective, caring, responsive and well led. We were delighted with this report and the outcome was testament to the dedicated hard working staff of the Trust. Further detail is provided in part three of this document, and the full report can be accessed from the Trust's website at:

<http://www.hdft.nhs.uk/about-us/news/cqc-report/>

We reported in last year's Quality Account that the Trust had responded to the Final Report on the Inquiry into Mid Staffordshire NHS Foundation Trust (Francis Report II) and had carried out a gap analysis against the recommendations in the report. A progress update was carried out on this report in late 2013. In addition, a self assessment was undertaken against the report produced by Sir Bruce Keogh: *Review into the quality of care and treatment provided by 14 hospital trusts in England*. Both of these assessments were shared publically through a Board of Directors meeting and with our Council of Governors.

I am pleased to report that, within HDFT, there has been investment in front line ward nursing in each of the last three years. This will continue throughout 2014/15 with further investment in nursing and medical staff on the medical elderly care wards.

HDFT promotes a culture of openness in reporting incidents, claims and complaints, investigating them and learning from mistakes. The Trust has, however, identified over the past year that it could be more responsive to patients who complain to it about the care they received. In order to achieve this, a major review was undertaken of the complaints process during 2012/13. The result of the review was a significant change to the process that devolved complaints investigations into the Trust's Directorates. A case handler is now assigned to each complaint, and contact is made with complainants within three days of the Trust receiving the complaint. The aim of the change is to make the Trust more responsive to complainants, and it is closely reviewing the new process to ensure it is delivering a significantly improved service.

The Trust works hard to communicate efficiently and effectively with people who use its services and with staff. Over the last year we have continued the 'Listening Events' led by Directors, at which staff can share good practice and raise any concerns and the Trust has introduced learning events where staff can learn from mistakes that have led to any serious untoward incidents. These are extremely important listening events that will continue to be developed.

Quality of Care Teams at ward or department level across community and hospital settings provide the forum for ensuring the local delivery of quality care. They are multi-disciplinary and meet regularly. Some of the teams have a linked Public Governor. The organisation aims to ensure the values and ethos of the Trust are understood by all staff, and work continues to develop and strengthen the work of the Quality of Care Teams. This ensures local actions are taken in response to feedback and identified risks and to ensure consistent reporting.

The Trust continues with its successful programme of patient safety visits and revisits to hospital departments, wards and community based settings. In addition, to drive forward the quality agenda, the Board of Directors undertake Directors' inspections on a monthly basis. These visits are unannounced and are led by an Executive and Non-Executive Director. The outcomes of the visits are reported to the Board of Directors on a monthly basis in the Chief Nurse's report. Further detail about these visits and inspections can be found in part two of this document.

In the Quality Account last year, the Trust stated that it had increased its incident reporting rates, and I am pleased to confirm that it has maintained this and continues to match the average reporting rate for NHS Trusts.

In 2013/14, the Trust reported eight serious untoward incidents on the NHS Strategic Electronic Reporting System (STEIS) and also informed the local commissioner, Harrogate and Rural District Clinical Commissioning Group (HaRD CCG) of these. Of the eight incidents, one was categorised as a Never Event relating to a wrong prosthesis, three related to delayed diagnosis, two related to a delay in treatment, one related to safeguarding and one related to maternity screening.

Each of these incidents has been thoroughly investigated. Investigation teams include Non-Executive Directors and external professional advice as appropriate. The findings from all investigations are scrutinised by the Board of Directors and are used across the organisation to ensure that learning from these events takes place and that the possibility of recurrence of similar events is minimised. In turn, these incidents have been externally scrutinised by the Clinical Commissioning Group and the Commissioning Support Unit (CSU). We sincerely regret all adverse incidents at the Trust. Over the past year, there have been two significant coroner's inquests relating to incidents that occurred during

2012. These identified failings in the Trust's delivery of care. Considerable work has been done in response to these incidents and detailed action plans have been completed.

The Trust is appreciative of the patient and public feedback it receives and uses this proactively to drive improvements in care. HDFT is fortunate to have strong public engagement through the Trust's Members, the Governors and the lay representatives who serve on Trust Committees. The Trust's Patient Voice Group is a pro-active and highly respected group that carries out visits to departments in the hospital and community. Its excellent work was highlighted by the CQC at its recent inspection as an example of good practice.

This will be my final opening statement to a Quality Account, as I retire in August 2014. I believe that HDFT delivers high quality care to the people that use its services, facilitated by committed, excellent staff. I have been extremely proud to work for this organisation for the past 30 years and wish it well moving forward.

I would also like to thank our Chief Nurse, Mrs Angela Monaghan, for her commitment to the organisation, as she retires in June 2014.

To the best of my knowledge the information presented in this document is accurate.

Signed

**Richard G Ord (Chief Executive)**

**Date**

## **PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE**

### **Priorities for Improvement 2014/15**

In seeking to identify its quality priorities for 2014/15, the Trust involved staff, Governors and other stakeholders, including:

- Harrogate and Rural District Clinical Commissioning Group;
- Healthwatch;
- North Yorkshire County Council Scrutiny of Health Committee;
- The Trust's Patient Voice Group.

The Trust has identified four key priorities for quality improvement in 2014/15. These have been informed by the discussions and suggestions from the stakeholders identified above, as well as reviews of data and reports relating to the quality of care delivered during 2013/14. It has also considered any recommendations from the small number of serious incidents that have occurred and these have contributed significantly to the choice of quality improvement priorities. The priorities have been approved by the Board of Directors and will include:

1. Reducing morbidity by reducing the numbers of health care acquired pressure ulcers;
2. Reducing harm to patients by increased focus on fluid management, pain control and preventing falls;
3. Improved responsiveness to patient need including escalation of concerns and handover/ good continuity of care;
4. Improved public health, particularly reduction of smoking prevalence, misuse of alcohol and obesity.

There will be a continued focus on quality improvement in other areas including:

5. End of life care and high quality communications to patient and family;
6. Care of patients with dementia across the health community;
7. Hospital discharge and especially delays on the day of discharge;
8. Transparency of information regarding nursing levels, both actual and planned.

The Trust's Quality and Governance Group is responsible for ensuring that the detailed work to support delivery of improvements in relation to these areas is defined. There will be identified leads, together with a communication and reporting plan, to ensure engagement with staff and effective monitoring of progress.

### **Progress against quality priorities identified in 2012/13 Quality Account**

#### High quality and safe discharge

Discharge has been a quality priority identified in the Trust's last three Quality Accounts and continues to be an important area for quality improvement. There is now a refocused Discharge Improvement Steering Group and, whilst there are still delays on the day of discharge, targeted work is progressing. The steering group has developed a more patient-focused set of aims which are:

"Harrogate and District Foundation Trust will ensure that it has plans in place for hospital patients to be transferred back to the care of their GP when it is clinically appropriate. Patients will be able to say:

- I and/or my carers have been involved in planning my discharge;

- I have the correct medication;
- Information sent to me and to others about me is accurate and has been properly communicated to the right people at the right time with my consent;
- Any ongoing support I need is in place;
- I did not stay in hospital longer than I needed to.”

In summary, HDFT will protect “the health, welfare and safety of service users in circumstances where responsibility for the care and treatment of service users is shared with, or transferred to, others by means of... the discharge and transfer of service users.” (guidelines set by the Care Quality Commission in compliance with Regulation 24, Outcome 6, of The Health and Social Care Act 2008, (Regulated Activities) Regulations 2009”).

The quality improvement priority identified last year focuses on:

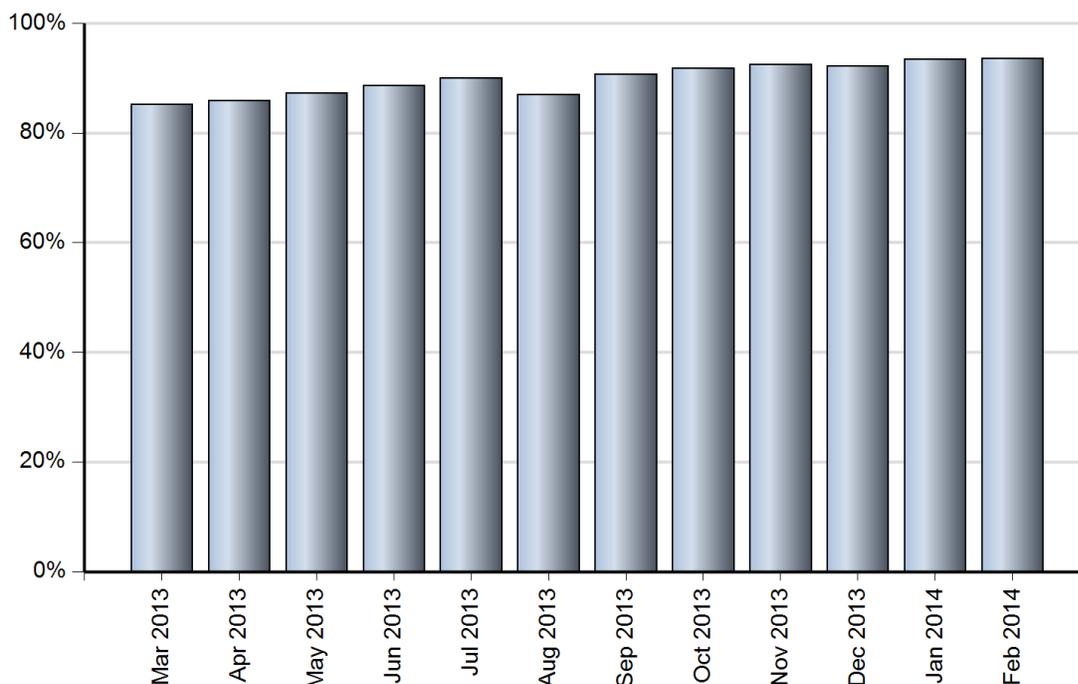
- Attainment of key performance indicators in relation to discharge planning e.g. patients discharged with electronic discharge summary;
- Effective patient flow through hospital wards and departments;
- Improved communication systems across health and social care including:
  - Improvements to discharge letters;
  - Improving safety and efficiency by reviewing patients readmitted following discharge.
- Facilitate appropriate discharge and improve patients’ independence and self-care through the provision of a high quality community equipment service;
- Improving the patient experience of discharge.

### **Electronic discharge summaries**

Electronic discharge summaries enable legibility, consistent content, and facilitate earlier and more effective communication with the patient and their GP. The Trust has implemented electronic discharge summaries using software called Integrated Clinical Environment (ICE) in areas which have previously used paper discharge letters.

There has been a gradual rise in numbers of patients discharged with an ICE electronic discharge summary from those areas where this is appropriate. A number of areas are excluded from the electronic discharge figures because they have their own systems in place already. Trinity Ward at Ripon Community Hospital is scheduled to introduce electronic discharge letters and electronic prescribing in July 2014.

## **Patients discharged with electronic discharge summary**



Work has been undertaken to improve written discharge information by standardising the Trust's discharge letters. The new letter templates are being implemented and this will improve communication regarding medication changes and further actions for the GP.

### **Patient flow and patient experience**

Achieving a safe and timely discharge can be a complex activity. Successful discharge planning should involve many staff and agencies. Both premature and delayed discharge may increase the risk of harm to patients. Progress has been made in relation to both simple and complex discharge. Simple discharge relates to patients who are usually discharged to their home and are independent and complex discharge relates to patients who have health or social needs on discharge; patients with complex discharge needs may or may not return to their own home.

An improvement workshop focused on continuing care has delivered a number of improvements relating to discharge that have clear benefits to patients:

- The Discharge Planning Team is now more visible and accessible, working from ward bases rather than a remote office site;
- Patients requiring continuing health care are now assessed according to a standard process that enables faster and more accurate electronic information sharing between agencies and a better patient/carer understanding of the process;
- Faster and more convenient arrangements are in place to plan meetings that avoid families and staff travelling long distances to poorly attended meetings;
- Stronger communication arrangements with named social services colleagues are now in place.

A further improvement workshop has delivered more timely and better quality communication with the families and carers of people with dementia. It has provided a renewed focus on "fit, ready and safe"

discharge criteria, and introduced new daily nurse-led ward rounds to speed up discharge where appropriate.

A third improvement workshop focused on the rapid discharge for patients at the end of life, to enable all eligible patients who want this to be discharged home in 48 hours, a reduction from an average of 149 hours (before the workshop) to 39 hours as measured in September 2013. Collaborative working now provides an integrated, quality service for end of life care that respects the wishes of the patients and their families and honours patient choice to die in their preferred location whenever possible.

### **Community equipment**

Community equipment provision was identified as a quality priority in order to provide an equitable and responsive community loan equipment service across North Yorkshire to support an individual's requirements to stay safely at home, enable timely discharge from hospital or improve independence and self-care.

Extensive work has been undertaken within the Trust to redesign the North Yorkshire-wide community equipment service resulting in many positive developments. In order to monitor the effectiveness of the service, the Trust required a more robust and consistent process for data collection, reporting on its performance and monitoring quality improvements.

The online equipment ordering system was piloted in February 2014. The fully electronic ordering system will address issues around accessing equipment and provide a more robust system for reporting performance. The new service, which is to be launched by July 2014, will also provide a much quicker turnaround following a request for equipment, with a large proportion of patients benefiting.

The chart below indicates the data for orders for equipment delivered within 7 days, adjusted for those orders where a justifiable reason has been given for delaying delivery, for example to coordinate with a home visit, patient away etc.

Stores	2012-13		2013-14			
	Q3	Q4	Q1	Q2	Q3	Q4
Colburn	95%	96%	97%	97%	95%	96%
Knaresborough	89%	91%	86%	90%	96%	93%
Scarborough	78%	50%	85%	87%	91%	93%
York	90%	81%	85%	93%	92%	93%
Overall Service	90%	79%	87%	92%	93%	94%

### **Next steps**

Information from complaints and other anecdotal sources show that the greatest patient dissatisfaction with discharge arrangements arises from delays occurring from the point that patients are told that they can go home today to the point when everything is actually in place to enable them to leave the hospital.

The next phase of work will focus on:

- Doing more to tackle delays that occur on the day of discharge;
- Improving weekend discharge arrangements.

## Use of technology to drive safe and effective care

### **Access to mobile technology**

The aim of this work was to improve the quality and effectiveness of care delivered to patients in their homes or other community settings by:

- Enabling community staff to access to relevant clinical records;
- Improving accuracy in recording interactions with patients;
- Improving information sharing with other professionals involved in the patient's care;
- Reducing travelling time and costs to enable increased levels of senior review, and improve the effectiveness of the care delivered.

The initial roll out of mobile technology in September 2013 using an electronic "brief case" solution for nursing teams was unsuccessful as it significantly increased the workload for the teams and reduced the time available to them to visit patients.

However, the Trust has been working with the manufacturer of "SystmOne", the electronic medical records system used by the majority of local GPs and all of HDFT's community staff, and is one of the pilot sites for a new piece of software that enables "SystmOne" to be used on mobile devices.

Following a successful trial by one of the Adult Community Nursing teams between December 2013 and January 2014, the Trust is now in the process of implementation to all of the Adult Community Nursing Team and the Universal Children's Service. It hopes to secure funding over the next year for additional mobile devices to allow it to continue to roll out this technology to all of the services that it provides in the community.

### **Telehealth pilot**

Telehealth refers to the use of technology to monitor particular physiological measures that help patients to monitor their health, for example blood pressure, and highlight to the medical team any concerns at an earlier stage. In trials around the country it has been shown to reduce the number of visits to GPs and hospital. Technology and its use in health care is continually developing and is being applied in many different ways. Teleconsultation refers to the use of technology to provide consultations for patients with doctors remotely. This technology is already in use at Harrogate District Hospital and is used to provide expert support for the Trust's stroke services outside core working hours.

The use of telehealth monitoring in secondary care was untested, but had been used successfully by the Trust's Community Nursing teams for a number of years to support patients with long term conditions to manage their own care at home. In November 2012, the Trust started a pilot project to test the use of telehealth monitoring within secondary care. Harrogate and Rural District Clinical Commissioning Group provided funding for this project.

The project was designed to identify patients attending the Clinical Assessment Team (CAT), or inpatient wards with one of six medical conditions, who might benefit from the use of the telehealth monitoring equipment. The medical conditions included in the pilot were:

- Pulmonary embolism (blood clot in the lungs);
- Atrial fibrillation (a specific irregular heart beat);
- Hypertension (high blood pressure);
- Headaches;

- Pneumonia;
- Urinary tract infection.

The patients included in the pilot were identified to use telehealth monitoring as a means of providing supportive early discharge or to prevent an admission. As well as monitoring the effectiveness of the approach, the patients' experiences were gathered via a survey.

The evidence from the patient survey has strongly indicated that the majority of patients found telehealth monitoring extremely beneficial and that it improved patient confidence post discharge. There were a small number of cases where the use of the equipment was not appropriate.

There is clear evidence from the project that a number of potential hospital admissions were prevented and occupied bed days were saved. There was a reduction in length of stay and follow up attendances. During the 12 month study period:

- 19 admissions were prevented leading to a saving of 29 occupied bed days;
- Five inpatients had their length of stay reduced leading to a saving of six occupied bed days;
- 45 follow up visits to CAT were prevented.

Whilst this was a small project, it has shown benefits from using telehealth monitoring in secondary care for this cohort of patients. Over this coming year, the Trust will continue to develop the use of this technology.

### **Safe prescribing and administration of medicines**

The aim of this work was to continue to optimise the way medicines are used at HDFT, especially using technology, to ensure safe and effective treatment of patients. MedChart Electronic Prescribing and Medicines Administration (ePMA) system, the ICE electronic discharge system and access to the Summary Care Record are used to facilitate this aim.

The specific objectives of this work were to:

- Reduce the number of prescriptions that do not follow Trust policy and guidance for accurate completion. The ePMA system ensures the legibility of medicines prescribed. Reported drug prescribing incidents caused by ambiguous or illegible prescriptions have reduced from 15 in 2012/13 to two in 2013/14. Pharmacists intervention reports are undertaken annually and detail interventions that have been required to clarify or amend prescribing to comply with Trust policy. These confirm improvement as there were 21 interventions in 2012/13 and only five in 2013/14. Clarification of brand or generic names account for the majority of these prescriptions, with handwritten outpatient prescriptions being the remainder that have led to incident reports.
- Increase the number of antibiotic prescriptions that include the indication for antibiotic use and the duration of therapy. There is a prompt on the ePMA system that encourages the recording of the indication and intended initial duration of antibiotic prescriptions and this has improved compliance. Data from the baseline Harrogate Antibiotic Prudent Prescribing and Intervention (HAPPI) audit, showed the indication for antibiotic use and the duration of therapy was documented in 53% of cases in July 2011. The most recent audit data for January 2014 showed improvement with the indication documented in 73% of prescriptions and the duration documented in 78%. Another resource introduced in June 2013 is a RAPID Live Antimicrobial Prescribing Report available on the Trust intranet homepage, which allows prescribers to review all patients currently prescribed antibiotics. This aims to further encourage compliance with antibiotic prescribing standards and it is currently being accessed approximately 150 times per month by prescribers.

- Reduce the number of prescriptions that include a drug to which the patient has a documented allergy. There were five reported incidents in 2012/13 of prescriptions that included a drug to which the patient had a documented allergy, and this has reduced in 2013/14 to three.
- Reduce the number of patients administered a drug to which they have a documented allergy. There were three reported drug incidents in 2012/13 and one incident in 2013/14.
- Reduce the number of incidents of patients being administered a medicine that was not as intended by the prescriber. There were 77 relevant reported drug incidents in 2012/13, and this has reduced in 2013/14 to 56. This reflects a reduction from an average of 6.4 per month last year to 4.7 in 2013/14.
- Use the Summary Care Record and other means to increase the proportion of patients who have a detailed medication history review within 24 hours of admission. Baseline audit data from Pharmacy audits for 2012 was 75%. 2013/14 audits show improvement with 80% of patients having a level two medication history review within 24 hours of admission. Further improvement is anticipated as access to Summary Care Records is used more often, particularly at weekends.

This work has built on last year's quality improvements and all metrics have demonstrated improvement in annual audit or monitoring report data.

### **Technology to support patient handover**

Work has been undertaken during the year to improve the quality, effectiveness and consistency of handover of care of patients on wards and to keep an electronic record of the information that was handed over.

#### Ward handovers

A trial of a standardised multidisciplinary handover template was commenced in September 2013 on three of the hospital wards. The completed handover document on each of these wards is now saved on a ward handover specific area of a central IT server twice a day to ensure that a formal record is kept. The documents are saved using a standardised naming convention to enable retrieval of information shared at handover, and they are saved in PDF format to prevent retrospective alteration.

This system of saving electronic copies is now being introduced to the rest of the wards.

#### Medical handovers

The Elective Care Directorate has been working with their medical teams to trial an internally developed electronic handover system. The system is accessible through any computer on the hospital site via an electronic link and requires a username and password. The system enables the team to select the relevant ward and patient number, then it automatically populates patient's name, consultant details and specialty with data from the Trust's patient administration system.

Once the patient has been selected, the team is able to add a diagnosis and/or procedure for the patient, issues, tasks and/or further patient details. On completion, the team save these details and store them for access later by the next team on duty. This enables more effective sharing of information about tasks to be done and patients requiring review. Further information about the patient can be added to the record. The system has offered each team a safe and robust way of reviewing patients at handover, especially at weekends.

To support the teams and to enable an audit trail of the clinical record, all amendments are recorded within a database and can be retrieved at any time before or after the patient is discharged.

## **Next steps**

The Trust is in the process of purchasing and implementing an electronic system for observations, escalation and handover. This system will incorporate a combined medical and nursing handover and utilise multiple handheld devices. The system will enable the capture of clinical data in real-time at the point of care. The progression to mobile handover will ensure a constantly updated handover document accessible to all who need the information, whilst ensuring an accurate audit trail. Medical and nursing staff will be able to share information, avoiding duplication and ensuring that everyone is using the same core set of key information.

## **Improving fundamental care**

In the 2012/13 account, the Trust stated that it would continue to focus on the delivery of the highest standards of fundamental care to all patients in relation to nutrition and hydration, pressure ulcers, communication, privacy, dignity and compassion, and environmental cleanliness. In addition, it would be:

- Working to reduce the prevalence of pressure ulcers reported using the NHS Safety Thermometer;
- Responding to the recommendations of the Francis Report II, including:
  - Responding to early warning indicators, in order to anticipate challenges to high quality care provision;
  - Continuation of Director inspections and safety visits;
  - Acting on Friends and Family Test results, including qualitative analysis and reports;
  - Improving care and compassion, through recruitment, training and ensuring an appropriate culture in clinical areas at all times by all staff;
  - Changes to complaints management and using patient feedback more proactively;
  - Using clinical audit to drive higher levels of care delivery, and documentation of fundamental care, with particular emphasis on nutrition.

## **Nutrition and hydration**

### **Patient assessment on admission**

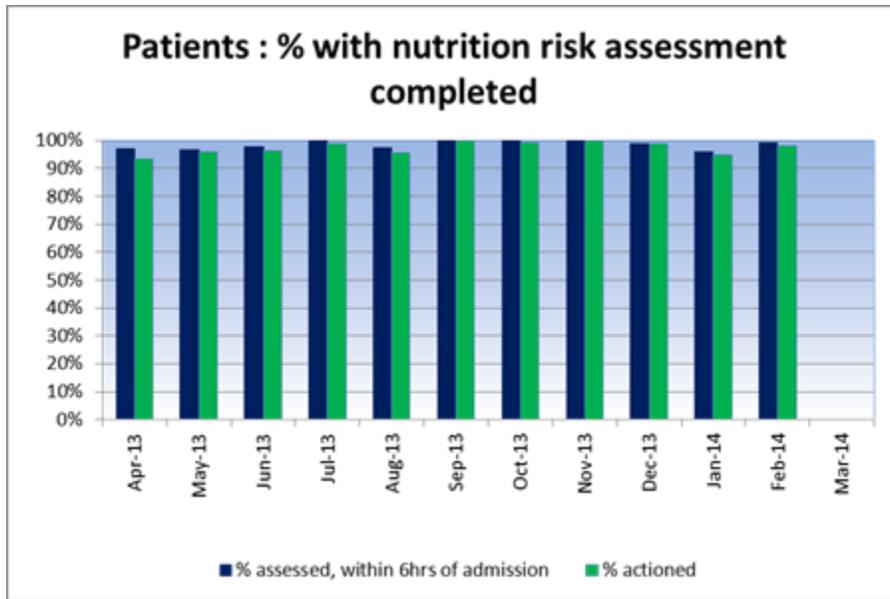
Matrons continue to monitor the recording, in the nursing documentation, of a patient's weight and nutritional risk assessment on admission to the adult inpatient wards, as part of their monthly checklist.

The data demonstrates that there are still challenges to ensuring that patients have a weight recorded on admission or a reason why this has not been possible, documented. Compliance is shown below from a sample of patients reviewed monthly:

	Patients with weight recorded on admission or reason for not weighing documented: % (proportion of sample size)
February 2012	71% (41/58)
February 2013	85% (51/60)
February 2014	69% (45/65)

A review of the adult inpatient nursing documentation highlighted duplication of places to document weight on admission and this has now been amended.

Completion of the nutritional risk assessment and taking appropriate action based on identified risk continues to show good performance.



Previous audits have shown differences between nurse and Dietitian nutritional risk assessment scoring, and further work in the form of modification of the assessment tool and teaching aids have sought to strengthen this. In addition, targeted education and training is planned for Registered Nurses, initially focusing on two pilot wards. These initiatives will be evaluated by an audit in June 2014.

Nutrition and hydration awareness week.

A nutritional focus week took place from 16 - 20 September 2013 and this involved a series of activities to raise awareness amongst staff, patients and visitors of the systems the Trust has in place to ensure good nutritional care for all patients.

Activities were planned throughout the week, with the main focus during afternoon visiting:

- The Trust’s ward based Nutrition Assistants manned stands outside the wards to highlight their unique role and the systems utilised at ward level to identify nutritionally at risk patients and to develop a nutritional care plan. Information was provided on protected mealtimes, the ‘red tray system’, nutrition risk screening, mealtime volunteers, high calorie snacks and oral nutritional supplements.
- The Nutrition and Dietetic department manned a display in the hospital foyer on the prevalence of under nutrition, its treatment and the role of the Dietitian.
- A training ‘road show’ toured the wards to provide training on enteral feeding for nursing staff.
- The Catering Department produced a ‘photo story board’ detailing the many steps involved in the production and delivery of patient meals, which was displayed in Herriot’s Restaurant throughout the week.
- A chef, a Matron and a member of the Patient Voice Group toured the wards one afternoon to speak to patients and relatives. The aim was to highlight that HDFT food is produced on the premises and to gain feedback on the food from patients.
- The Speech and Language Therapy department offered the opportunity for staff and visitors in Herriot’s Restaurant to try the altered consistency meals and thickened fluids often recommended for patients with dysphagia (difficulty swallowing).

- The availability of food 24 hours a day period was promoted. A patient information leaflet promotes the availability of food outside of the standard mealtimes.
- Nutrition related “facts of the day” were sent out to staff with the Daily Bulletin email.

The event received coverage in the local press.

### Hydration and fluid balance

An audit of fluid balance charts was undertaken in August 2013 across the adult inpatient wards, excluding the Intensive Care Unit. This demonstrated that further work was required, including changes to the fluid balance chart and the production of guidelines for fluid management based on best practice. The audit was presented to senior nurses at a “What’s New” event in January 2014. This piece of work has been led by the Critical Care Outreach Team, and the Patient Safety Group will monitor progress on actions identified. The Trust recognises that further work is required in this area and consequently, this is included within the quality improvement priorities for 2014/15.

### Pressure ulcers

In the 2012/13 account, the Trust stated that it would continue to focus on the delivery of the highest standards of fundamental care to all patients in relation to pressure ulcers, and that it would be working to reduce the prevalence of pressure ulcers reported using the NHS Safety Thermometer. This is a tool for measuring, monitoring and analysing patient harms and 'harm free' care.

The Trust now has two Tissue Viability Specialist Nurses to provide an integrated service across community and acute care settings. Patient contact rounds, regular reviews of patients by nurses every two hours on inpatient wards, have been implemented and are monitored through the adult inpatient Matrons’ monthly ward checks. The pressure ulcer guidelines were revised and re-launched in 2013. In addition, the Trust has invested in more pressure relieving equipment, including the purchase of some new inpatient bedside chairs that have inbuilt pressure relieving cushions.

A trial of gel heel support cushions has been completed and the Trust is progressing purchase of these for inpatient wards. In March 2014, the Trust has started a trial of a new pressure relieving heel lift boot on two adult inpatient wards.

The Trust has continued to provide education and training programmes around prevention of pressure ulcers for Registered and Unregistered Nurses (also known as Care Support Workers). An education event for Registered Nurses, focusing on the assessment, prevention, grading and treatment of pressure ulcers, commenced in September 2013 with a series of workshops. Ward Sisters and Senior Nurses received a pressure ulcer update from the Tissue Viability Nurses at the “What’s New” event in January 2014. Specific pressure ulcer root cause analysis training and discussion for Ward Managers, Team Leaders and Matrons will commence in April 2014.

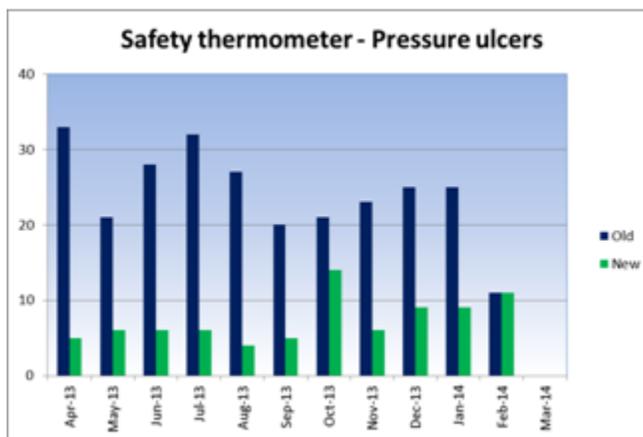
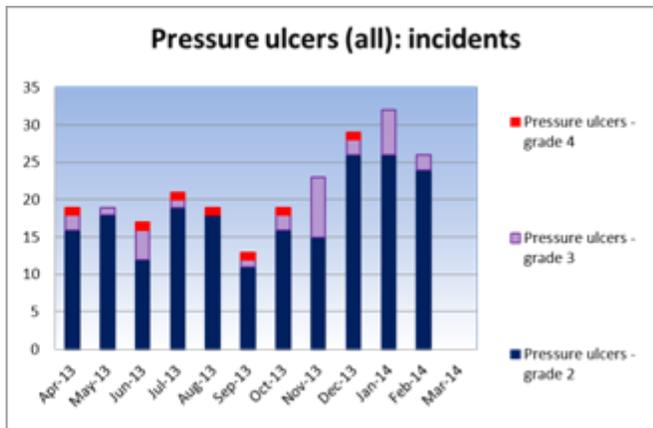
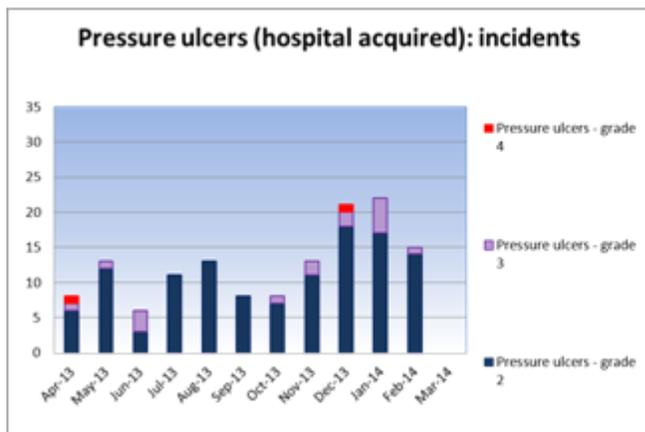
Previously, staff have reported any grade three or four pressure ulcers as clinical incidents, but from April 2013, staff have also been required to report grade two pressure ulcers that have developed whilst a patient has been receiving HDFT hospital or community care. The data is included on the Quality and Safety Dashboard which is produced each month and reviewed within the Trust, including by the Board of Directors.

The data from the NHS Safety Thermometer in relation to pressure ulcers is reviewed and the results for HDFT compared with the national results. The Pressure Ulcer Steering Group reviews the pressure ulcer incidence data to identify areas to target for further work. Currently root cause analysis (RCA) is undertaken for all grade three and above pressure ulcers and learning identified. Learning from the successful infection control methodology, it is proposed that a post RCA review meeting is

undertaken, which will allow a more detailed review of each case. From June 2014, grade three and four pressure ulcers that are HDFT acquired will be reported as serious untoward incidents. This was a recommendation from the CQC following its inspection in November 2013.

As seen on the charts below, since December 2013 there has been an increase in grade two pressure ulcers reported on the Quality and Safety Dashboard. This could be representative of further active encouragement to report grade two pressure ulcers.

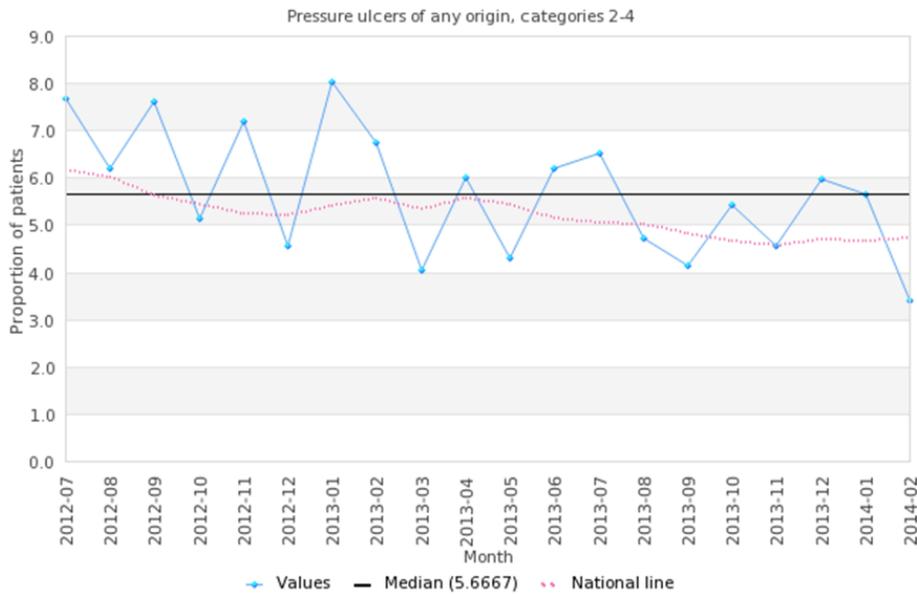
Between July-September 2013 there were no hospital acquired grade three or four pressure ulcers reported, however since October 2013 there has been an increase. A large proportion of these have been located on patient heels.



Source: HDFT Quality and Safety Dashboard February 2014

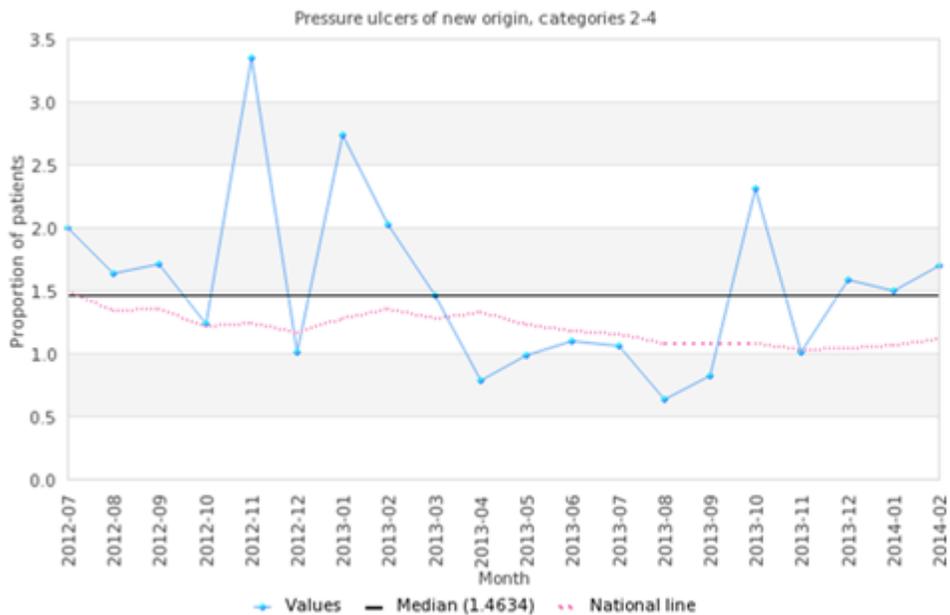
Regarding pressure ulcers reported via the NHS safety thermometer methodology, there has been a downward trend nationally for all and new pressure ulcers, but HDFT has an incidence of new pressure ulcers which is slightly higher than the national line, as described below.

The chart below shows data for old and new pressure ulcers for the reporting period March 2013 - Feb 2014.



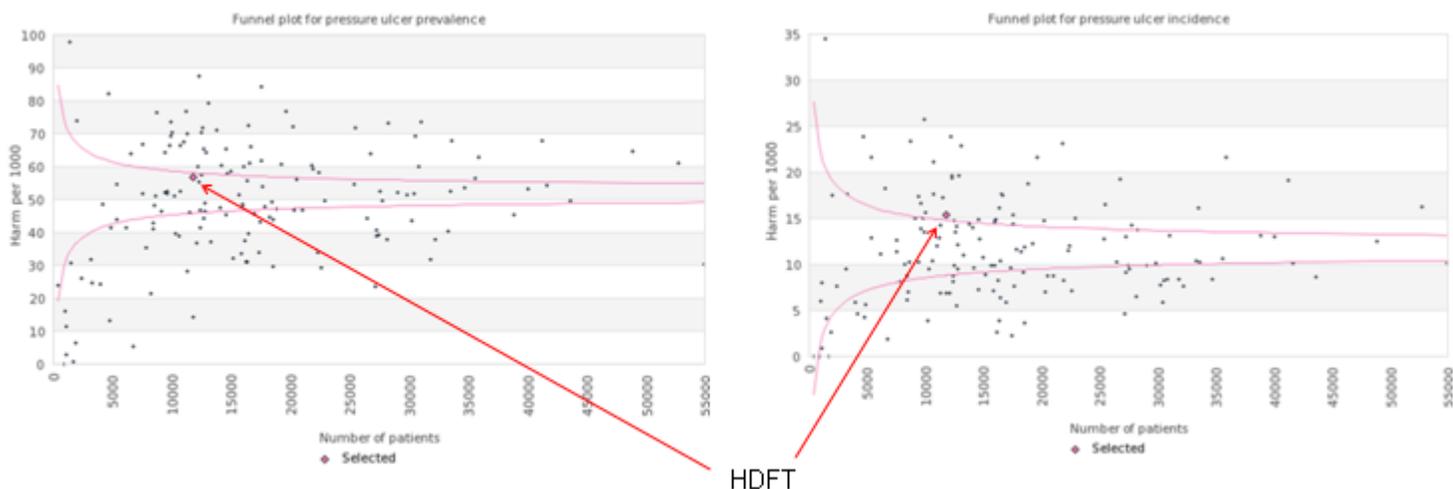
Data from [NHS Safety Thermometer funnel plots](#): March 2014

The chart below shows data for new pressure ulcers for the reporting period March 2013 - Feb 2014.



Data from [NHS Safety Thermometer funnel plots](#): March 2014

The data below shows that pressure ulcer prevalence for new and old pressure ulcers is within the expected range. However, for new pressure ulcers the incidence funnel plot shows HDFT to be slightly worse than average. This is for the period March 2013 - Feb 2014.



The Trust has identified pressure ulcers as a specific priority for quality improvement in 2014/15. Whilst it is worth noting that the Trust is seeing increasing patient frailty and increasing numbers of very elderly patients with co-morbidities (more than one condition), further work will focus on targeting the areas of greatest incidence of pressure ulcers to achieve reduction. The Trust will more explicitly adopt a “zero tolerance” approach to pressure ulcer development for those patients in receipt of HDFT nursing care and its training programmes and investigation processes support this principle.

### **Communication**

Data relating to complaints and concerns about communication and attitude of staff continue to be monitored. The tables show complaints by sub-subject and date consent received.

	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4	Total
Total Concerns and Complaints	113	155	150	161	579
Total Relating to Communication and Attitude	75	78	80	93	326
Admin Attitude	1	6	7	5	19
Medical Attitude	16	14	14	12	56
Nursing Attitude	11	13	12	18	54
Other Attitude	3	1	1	3	8
Allied Health Professional Attitude	1	1	1	2	5
Admin Communication	1	0	4	3	8
Medical Communication	22	28	28	24	102
Nursing Communication	15	12	11	14	52
Other Communication	3	0	2	10	15
Allied Health Professional Communication	2	3	0	2	7

**Table: Complaints and concerns received 2012/13**

	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4	Total
Total Number of Cases Raised as Concerns or Complaints	161	162	147	153	623
Total Number of Issues Raised Relating to Communication and Attitude	95	98	91	80	364
Admin Attitude	4	8	3	8	23
Medical Attitude	16	19	18	14	67
Nursing Attitude	15	16	11	13	55
Other Attitude	2	3	2	1	8
Allied Health Professional Attitude	2	2	1	1	6
Admin Communication	5	10	9	8	32
Medical Communication	28	21	29	18	96
Nursing Communication	20	14	11	11	56
Other Communication	0	2	4	3	9
Allied Health Professional Communication	3	3	3	3	12

Table Complaints and concerns received 2013/14.

Disappointingly, the numbers of complaints citing poor attitude and communications by clinical staff has increased this year in comparison with the previous year. More positively however, there has been a marked increase in the number of such complaints which have been upheld by the Trust, which demonstrates a more open approach to acknowledging poor communications and attitudes between staff, patients and families. In addition, the new complaint process implemented during the year, allows for earlier personal contact by an experienced member of staff with the complainant. The Trust also takes the opportunity for members of the senior management team, including the Chief Executive, Chief Nurse and Medical Director, to meet with patients and relatives where this would be helpful, as part of this process. Positive feedback has been given by both staff and complainants about the helpfulness of this approach. Finally, the scrutiny given to such complaints by the Quality of Experience Group has increased, to allow more in depth review of issues raised and therefore, to generate more local actions within Directorates, including specific feedback to individual members of staff cited in the complaints.

### **Privacy, dignity and compassion**

The Trust aims to improve care and compassion through recruitment, training and ensuring an appropriate culture in clinical areas at all times by all staff.

The '15 step challenge' is an initiative that encourages patients and staff to work together to identify improvements which may enhance the patient experience. This is being implemented with reinforcement of positive meeting and greeting by all members of staff, patient contact rounds and "Every Patient Every Time" training.

Patient contact rounds have been implemented across the wards and an initial evaluation of the project implementation was positive. It did, however, demonstrate areas that could be improved upon, relating mainly to compliance with the two hour review standard and further work is being undertaken to improve compliance with this. Patient contact round monitoring has been included in the Matrons' monthly checks since February 2014. This will focus on compliance with the two hour standard and increased observation for patients at risk of falls. An audit of the contact rounds will be undertaken in April 2014.

The Trust engaged the Royal College of Nursing to provide three workshops on dignity and respect for Registered Nurses and Care Support Workers, to enable attendees to share learning and take forward

actions related to dignity in their own areas. The initial workshops were delivered between September and November 2013 and follow up workshops will commence in June 2014 to review, monitor and share good practice.

Nursing staff now ask each inpatient on admission what their preference is regarding showers and baths and the nursing documentation has been modified to enable this to be recorded. In February 2014, monitoring of a sample of patients across nine adult inpatient wards showed that 60% patients (27/45) had their preference for this aspect of personal care documented on admission. Progress with improving this indicator will be monitored by the Matrons through their monthly ward checks.

**Environmental cleanliness**

April 2013 saw the introduction of Patient-Led Assessments of the Care Environment (PLACE). The PLACE programme applies to all providers of NHS-funded care in the NHS. Participation is voluntary, but the Care Quality Commission have indicated that if PLACE information is not available, providers will need to offer an alternative form of evidence around the areas to which the PLACE programme applies. The Trust participated in the programme.

HDFT has always had patient representatives on assessment teams. However, to ensure nationally that the patient voice is heard, a key change from the former Patient Environment Action Team (PEAT) process is that the assessment is now patient led, with an increased number of 'patient assessors'. These are individuals who represent users of healthcare services. All assessing teams must now include at least two patient assessors, who must also comprise at least 50% of the overall team. The Trust met this requirement by using volunteers from Health Watch, the Patient Voice Group and Trust Governors. External verifiers from York Teaching Hospitals NHS Foundation Trust were present at all assessments, which were undertaken over the period 18 April to 14 June 2013.

The assessment process focused on the environment in which care is provided with particular emphasis on cleanliness, general condition, appearance and maintenance, privacy and dignity and the provision of food and drinks. It did not cover clinical care provision nor how well staff were doing their job. All assessments were undertaken to a standard assessment format issued by the NHS Commissioning Board.

Results of the first PLACE assessment programme have been published by the Health and Social Care Information Centre along with national comparative data for other hospitals. The table below shows the scores achieved for Harrogate District Hospital (HDH), Ripon Community Hospital (RCH) & the Lascelles Unit. Higher scores are better.

Location	CLEANLINESS		FOOD		PRIVACY, DIGNITY AND WELLBEING		CONDITION, APPEARANCE AND MAINTENANCE	
	Trust Score	National Score	Trust Score	National Score	Trust Score	National Score	Trust Score	National Score
<b>Lascelles</b>	99.52	96.74	94.09	84.98	91.3	88.87	88.39	88.75
<b>HDH</b>	98.26	95.74	90.83	84.98	85.08	88.87	94.65	88.75
<b>RCH</b>	96.43	95.74	94.88	84.98	82.70	88.87	84.48	88.75

Regarding privacy, dignity and related patient wellbeing, the reasons for lower scores relate, in part, to the physical environment and the impact of this on ensuring ideal conditions for privacy, for example, the physical layout and the possibility for discussions to be overheard. Action plans for each location were issued to Directorate leads to progress for their areas of responsibility. Unfortunately, some of

these elements will continue to score low in future assessments until such times as the physical layout of areas can be altered.

Regarding the condition, appearance and maintenance assessments, no allowance is made for the age of the premises. Ripon Hospital is owned by NHS Property Services Ltd and the Trust is in ongoing consultation regarding the fabric of the building.

It is pleasing to note the Trust's high standards in relation to cleanliness and food across all locations, and the condition, appearance and maintenance at Harrogate District Hospital. The PLACE inspection will be repeated annually and it is anticipated that some of the assessment questions will be amended as the assessment process is evolving.

### **Early warning indicators to anticipate challenges to high quality care provision**

The Francis Report II, published February 2013, contained the findings of the public inquiry into Mid Staffordshire NHS Foundation Trust. The report clarified the importance of organisations seeking accurate information about their performance in as near real time as possible, taking advantage of all safety related information. The Trust uses a variety of mechanisms to monitor and anticipate challenges to high quality care provision. These include:

- Monitoring information in order to actively manage the pressures on services which can have a direct impact on the quality of patient care delivered. This includes staffing levels, activity such as call volume to the GP out of hours service, delayed transfers of care and discharges, admission of patients with a stroke to the Stroke Unit and acute bed occupancy. There are daily meetings to review the information relating to inpatient activity and plan appropriate management. During the autumn of 2013, the bed occupancy was sustained at a higher level than ideal and, as a direct result, an escalation ward was prepared, staffed and opened for a three month period to provide additional capacity.
- Entering patient feedback from the Friends and Family Test onto a database which is available to staff to review in real time, and which enables specific concerns to be actioned rapidly and themes and trends to be identified.
- Staff reporting incidents onto an online tool, which enables real time review of actual incidents being reported. The Complaints and Risk Management Group, chaired by the Medical Director, meets weekly and reviews incidents and complaints to identify and action any significant concerns, themes, trends or clusters.
- Updating the Quality and Safety Dashboard each month with information detailed to ward and department level, and then reporting to and discussing it at every Board of Directors meeting. The dashboard enables triangulation of information from different sources, including:
  - Matrons monthly audits on their wards;
  - Incident reports from staff, including reporting rate, top incidents types, and specific detail of areas of particular concern e.g. pressure ulcers, falls, medication incidents;
  - Results of the Friends and Family Test;
  - Results of audits and checks of hygiene standards;
  - Complaints received.
- Utilising the Healthcare Evaluation Data (HED) tool to monitor and compare data on a variety of measures, which then enables focused further investigation. For example, HDFT identified a period of increased mortality for stroke patients in November 2013 using this tool. With the small number of patients involved, this could simply be chance, but a clinical review was commissioned and the Deputy Medical Director reviewed the case notes of nine patients. The review found no serious concerns and one minor issue around intravenous fluid management, which was followed up. The review also found many examples of good practice, particularly

around the quality of clinical note taking, frequent senior clinical involvement and involvement of families in making best interest decisions.

- The Performance Report, which is reported to and discussed at every Board of Directors meeting, and includes information about service activity and performance against targets, mortality, and the Care Quality Commission's Quality & Risk Profiles, which were then replaced by "Intelligent Monitoring Reports" in Autumn 2013. See part three of this report for further information. Some of this information is based on data which, by necessity, relates to patient care in previous months. However, the most up to date information available is included.
- Planned visits and inspections to gain feedback from staff and patients. See further detail below. Patient Safety visits are specifically undertaken to seek any concerns of staff relating to patient safety. Director inspections are unannounced opportunities to check wards and departments against various standards, and include seeking the views of staff and patients.
- Audits of service delivery undertaken to review specific issues and provide information about quality of care. An audit of the time to assess admitted patients was undertaken during 2013, which revealed delays affecting the quality of care provision. As a direct result, the availability of junior medical staff in the evenings was increased.

### **Director inspections**

Unannounced Director inspections of all inpatient ward areas continue to be prioritised. A total of 29 inspections have been carried out during 2013/14. The area being inspected is assessed using set criteria related to standards that include cleanliness of areas and equipment, areas being free of clutter, correct management of IV cannulas, ward leadership, medication safety and staff and patient feedback. There are strict scoring criteria that result in a risk rating of red, amber or green.

Of the 29 areas inspected, the initial results were that 17 were found to be risk rated green, one amber and 11 red. Those found to be red are all revisited and reassessed within two weeks to ensure remedial actions have been taken. In all cases, subsequent inspections resulted in a lower risk rating, with most scoring green.

### **Patient Safety Visits**

An annual programme of safety visits and revisits to hospital departments, wards and community based settings is developed with the Directorates. Since September 2009, 99 visits have been carried out, with 20 visits between April 2013 and March 2014.

All staff are encouraged to participate and to identify any patient safety concerns that they might have. Any significant issues raised are immediately actioned if necessary and all the findings reported to the relevant Directorate and the Executive Director Team. Resolution or appropriate management of risk is achieved in the majority of cases. Examples of good practice arising from the visits include good and effective teamwork, learning from regional and national events and implementation of local protocols to encourage good practice, implementation of patient contact rounds and staff reporting improved patient care as a result. Examples of improvements reported following patient safety visits include moving and handling training introduced as part of the Care Support Workers induction, increase in Consultant cover on medical and elderly wards over the weekend, improvements to the hardware for electronic prescribing on wards, and customised local moving and handling training now available to ward staff.

The patient safety visiting team usually includes a Director and a Non-Executive Director, together with members of the Patient Safety Group. During 2013, Public and Staff Governors have participated

in some of the patient safety visits. The Trust is currently reviewing the process to ensure appropriate follow up of issues raised, to enable effective assurance to the Council of Governors.

### **Summary and further work**

The Trust has made good progress in some areas, for example, the implementation of patient contact rounds has been achieved across all in patient wards, and has had a successful nutritional focus week. Patient safety visits are giving valuable feedback about local safety issues and concerns.

There are some areas that require further work, especially in relation to pressure ulcer prevention, and staff attitudes and communication. It is envisaged that the role of the Patient Safety Group within the governance framework of the Trust will be strengthened to enable stronger monitoring of key quality priorities such as falls reduction, pressure ulcer incidence and further embedding of a strong patient safety culture across the Trust.

Much of this work will be further developed in the coming year, but pressure ulcers have been specifically identified for further quality improvement across the Trust in 2014/15.

### **Statements of Assurance from the Board**

#### 1. Provision of relevant health services and income

During 2013/14, HDFT provided and/or sub-contracted 60 relevant health services.

HDFT has reviewed all the data available to it on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 represents 100 per cent of the total income generated from the provision of relevant health services by HDFT for 2013/14.

#### 2. National and local audits

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Put more simply, clinical audit is all about measuring the quality of care and services against agreed standards and making improvements where necessary (NICE, 2011).

This means that clinical audit identifies the gaps in current practice and identifies areas for improvement. One of the most important aspects of the audit cycle is to re-audit to ensure that clinical care has improved.

### **National audits**

During 2013/14, 33 national clinical audits and four national confidential enquiry covered NHS services that HDFT provides. 19 audits are from the National Clinical Audit and Patient Outcome Programme and 14 are run by other organisations. During that period, HDFT participated in 91% of the national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that HDFT was eligible to participate in, and did participate in during 2013/14, are shown in the list at Annex Three. The national clinical audits and national confidential enquiries that HDFT participated in, and for which data collection was completed during 2013/14 are also listed in Annex Three, alongside the number of cases submitted to

each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The clinical teams review reports published following national clinical audits and national confidential enquiries and undertake a gap analysis prior to reporting action plans to the Trust's Standards Group. The reports of 22 national clinical audits were reviewed by HDFT in 2013/14 and intends to take the following actions to improve the quality of healthcare provided.

#### Adult Critical Care

As a result of the Intensive Care National Audit and Research Centre (ICNARC) report, there are many interventions being undertaken to increase awareness of, and improve management of, sepsis within the wards. This will include training for medical staff, which will be included as part of a package of essential training, based on NICE guidance on fluid management.

#### Emergency Medicine: Consultant sign off

An action plan has been developed as a result of the audit. Junior doctors are being informed at induction and teaching sessions of the importance of senior review prior to patient discharge. In order to allow junior staff to have patients reviewed by senior medical staff and/or Consultants, the job plans of Consultants and their hours have been reviewed. A review of the functionality of relevant information systems within HDFT is being undertaken in order to capture data on consultant "sign off".

#### Emergency Medicine: Severe sepsis and septic shock

Improvement in timeliness of physiological observations is expected, by including the requirements in a training programme for nursing staff, and the management of sepsis is to be included in the regular staff training programme for junior doctors. Individual case reviews will be undertaken to ensure appropriate administration of fluid management and antibiotic use.

#### Emergency Medicine: Fractured neck of femur

To improve the management of patients' pain, there is a focus on routine assessment of pain and the administration of appropriate analgesia, including intravenous paracetamol. Monthly audits of pain management are to be undertaken over the next six months and the results reported back to the Emergency Department senior management.

#### Emergency Medicine: Renal colic

This audit demonstrated a need for a review of the current pathway for urological patients by the clinical teams within the Emergency Department and the Urology Department. Following the pathway review, a re-audit will be undertaken.

#### Epilepsy management in the Emergency Department

Areas identified for improvement are the documentation of neurological assessments and observations on admission to the Emergency Department, and the documentation of a discussion regarding driving and alcohol intake. These areas are to be addressed through teaching within the department and reminders to all staff that assessments should be completed. The introduction of the NICE pathway for epilepsy is to be included in the Emergency Department's clinical guidance folder on the Trust intranet for staff to access.

## Parkinson's disease

The Trust participated in all elements of the National Parkinson's audit, which included patient management, Physiotherapy, Occupational Therapy, and Speech and Language Therapy. The multi-disciplinary team have highlighted several areas for improvement:

- The inclusion of leaflets on falls and bone health in the information pack given to patients;
- The development of a pathway with the Specialist Palliative Care Team for patients in the palliative stage of Parkinson's disease;
- Improve the timeliness of referral to Physiotherapy.

## Bowel Cancer

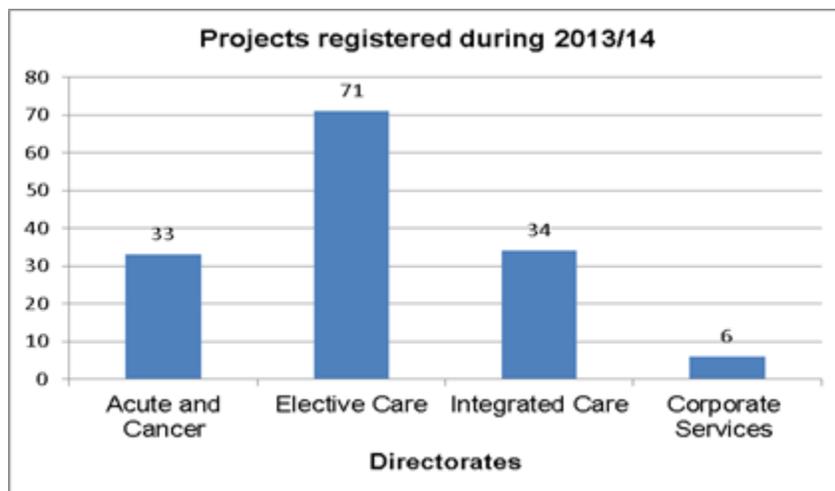
The results from the audit are used to benchmark practice and are used as part of the Cancer Peer review. The following areas all demonstrated good practice:

- Patients discussed at multi-disciplinary team meetings;
- Patients seen by Clinical Nurse Specialist;
- CT scans reported;
- MRI scans reported.

## Local audits

154 projects (excluding national audits) were registered with the Clinical Effectiveness Department during 2013/14. This includes 29 projects aimed at improving quality by using service evaluation and patient experience surveys.

The results of local audits are presented at the Directorate or specialty audit or governance meetings, where the results and recommendations are discussed. Audits are defined as complete when a summary report identifying recommendations and actions for improvement is produced. In order to close the "audit loop" and complete the audit cycle, re-audits should be completed as evidence that improvements have been made. During 2013/14, 31 re-audits were undertaken.



The chart above shows clinical audit, service evaluation and patient surveys registered during 2013/14 by Directorate.

The reports of 76 local clinical audits were reviewed by the Trust in 2013/14 and HDFT intends to take the following actions to improve the quality of healthcare provided.

Management of diarrhoea in children under 5 years of age

In 2009, NICE published guidance on the assessment, diagnosis and management of gastroenteritis in children less than five years of age, in order to promote best practice and continuity of care. Over the past three years, departmental audits were undertaken at a local level to determine the compliance of Harrogate District Hospital’s Paediatric ward in treating children with gastroenteritis. The assessment of signs of dehydration, rehydration regime, discharge information and documentation were consistently reported as poor. The re-audit has shown some improvement:

- Better assessment and documentation of signs and symptoms of dehydration;
- Better fluid management ,both intravenously, and using oral rehydration solution;
- Improved requesting of Microbiology samples.

Further actions have been implemented to improve documentation, by redesigning the clinical assessment document to include signs and symptoms identified as “red flags” for dehydration by NICE. A parent information leaflet has been developed and piloted with families.

Accuracy of completion of venous thromboembolism risk assessment

This audit followed on from an audit report in September 2012 on the accuracy of risk assessment forms for venous thromboembolism (VTE). The suggestions from that audit included completing the audit cycle, increasing the sample size to incorporate patients from other specialties and identifying whether the inaccuracies in the completion of the form affected the management of the patient.

In the re-audit, 90% of patients had a completed VTE risk assessment form in their notes, and although some patient risk factors were found to be omitted on the form, this did not affect the management of the patients and the use of appropriate thromboprophylaxis. The table below shows the results of the audit.

<b>Criteria</b>	<b>Expected performance</b>	<b>Actual performance</b>
All patients have a completed VTE risk assessment form.	100%	90%
All clinical risk factors for thrombosis are recorded on the risk assessment form	100%	45%
All risk factors for bleeding are recorded on the risk assessment form	100%	94%
All patients are appropriately managed according to risk factors	100%	94%

The following actions have been implemented:

- All health professionals undertaking VTE risk assessment have been reminded of the importance of completing the form accurately;
- The risk assessment form has been amended to include a box to indicate that the patient has no thrombotic or bleeding risk factors;
- An emergency admissions proforma has been introduced for Gynaecology, which contains the VTE risk assessment form, acting as a prompt that risk assessment should be undertaken;

- All health professionals are reminded of the importance of checking the VTE risk assessment on the ward round following admission.

Regular audit of risk assessments and appropriate use of thromboprophylaxis are undertaken across the Trust and reviewed by the Thrombosis Committee.

#### Heavy menstrual bleeding

In 2010, the Gynaecologists reviewed practice of the management of heavy menstrual bleeding as part of their local clinical audit programme, as opposed to participating in the national audit. The decision not to take part in the original national audit was because the Trust could not be confident that appropriate clinical audit standards would apply when initial details were supplied. The Trust's Standards Group approved the decision not to partake in the audit. In 2013/14, practice was reviewed again. Although some improvements were identified, there remain some areas where more focus is required. The table below indicates the initial audit results and the re-audit.

<b>Criteria</b>	<b>2010 Audit</b>	<b>2013 Audit</b>
Clinical history documented	100%	100%
Physical examination	92%	79%
Full blood count	58%	34%
Ultrasound performed when indicated	48%	94%
Biopsy taken when appropriate	100%	100%
Surgical treatment offered appropriately	88%	89%

#### Assessment of patient pain

The purpose of this audit was to observe the frequency of pain assessment undertaken by nursing staff and to highlight areas for improvement. The Acute Pain Team have been aware that the assessment of pain and subsequent record of pain scores required improvement. Without assessment of a patient's experience of pain, their management may not be appropriate.

The initial audit focussed on the surgical wards and reviewed patients that had undergone surgery and were at least 48 hours post-operation. The results of the audit identified that pain scores were not routinely recorded in conjunction with other physiological observations, for example, temperature and heart rate. In addition, where patients reported a high level of pain, it was not re-assessed in a timely manner. Results of the audit were fed back to the teams and a re-audit of surgical wards was undertaken after three months, which showed some improvement. Results of the surgical audit and re-audit are shown below.

<b>Criteria</b>	<b>Expected performance</b>	<b>Surgical audit 1</b>	<b>Surgical audit 2</b>
Pain scores are recorded on admission to ward	100%	47%	46.4%
Pain scores are recorded on return to ward following surgery and recorded with first set of observations	100%	53%	61%
Pain scores recorded with all observations	100%	3%	41%
Pain identified as a score of 7 or above is reassessed within 30 minutes (NB. small numbers in the audit samples)	100%	0%	50%

Following circulation of the audit results to the nursing teams, the Acute Pain Team, supported by the Matron for the area, are delivering short training sessions on the wards. A pain assessment policy has been developed with an appropriate information cascade to all relevant staff. A pain assessment tool for patients with cognitive impairment has also been introduced.

Pain management has been identified as an area for the Trust to focus on for quality improvement in 2014/15. A bi-annual audit will take place across the Trust and include a review of the assessment and management of patients' pain.

The four audits listed below were led by Junior Doctors and were accepted for poster presentations at the regional Yorkshire Clinical Effectiveness and Audit Conference.

#### Antibiotic prophylaxis for urological procedures at Harrogate District Hospital

The Microbiology Department has produced clear guidelines on the use of prophylactic antibiotics for patients undergoing urological surgery. The aim of this audit was to determine if these guidelines were being adhered to. The audit consisted of patients that had undergone transurethral resection of the prostate (TURP), resection of bladder tumours (TURBT) and cystoscopy.

The results showed that 80-87% of patients undergoing TURP and TURBT received appropriate antibiotic prophylaxis. However, the timeliness of the administration did not comply with the guidelines. Recommendations and actions from the audit were as follows:

- The current guidelines were updated to reflect that gentamicin dosing is to be done according to ideal body weight, and cystoscopy with ureteroscopy should always receive antibiotic prophylaxis, even when the urine is sterile;
- The timeliness of antibiotic administration is to be resolved through discussion with the Surgeons and Anaesthetists;
- A handbook including local guidelines and flowcharts will be provided to the junior staff. The outgoing junior doctor provided peer-to-peer induction to educate the incoming junior staff.

#### Management of patients with an acute upper gastrointestinal bleed

The initial audit of the presentation, initial management, Endoscopy findings and post-endoscopy management of patients presenting with acute upper gastrointestinal bleeding (AUGIB), consisted of 30 patients. Practice was assessed against NICE guidance.

The risk assessment of patients using a specific (Rockall) scoring tool had improved from a previous audit, but did not demonstrate good practice, and there were other areas of concern. Recommendations following discussion with gastroenterologists and surgeons were:

- A daily designated appointment space to be implemented in Endoscopy for AUGIB;
- A named Endoscopist to be available for AUGIB in normal working hours;
- Clarification of out-of-hours cover to be established;
- Pre-endoscopic Rockall score to be added to the Endoscopy request card;
- Post-endoscopy Rockall score to be added to Endoscopy reports;
- Education of doctors on indications for proton pump inhibitor medication.

Some of the above recommendations were initiated prior to a re-audit of 11 patients.

Criteria	Expected performance	Audit 1	Re-audit
Risk assessment score recorded on admission (Rockall)	100%	61%	92%
Proton pump inhibitor given pre-endoscopy	Not recommended	79%	67%
Risk assessment score recorded post endoscopy (Rockall)	100%	5%	17%
Endoscopy performed within 24 hours	100%	45%	27%

A review of the timeliness of Endoscopy has been repeated following the introduction of an operational policy within the Endoscopy Unit and practice will be reviewed as part of the Scope for Improvement project.

### Tilt table audit 2013

Syncope is defined as transient loss of consciousness, due to a transient global hypo-perfusion, characterised by rapid onset, short duration and spontaneous complete recovery.

It accounts for 1% of all Emergency Department referrals and out of these, 40% of patients are admitted to hospital. In the absence of a gold standard test to diagnose some types of syncope, it becomes extremely important that guidelines are followed appropriately. This in turn ensures that patients get the best level of care and that the organisation makes the best use of resources.

The audit sample consisted of 100 patients that were investigated using the tilt table test. This is a diagnostic procedure that creates changes in posture from lying to standing and can be used to assess syncope.

Criteria	Standard	Result
All patients should have the indication documented for having the tilt table procedure.	100%	97%
Only patients with a valid indication should have the tilt table procedure undertaken.	100%	75%
All patients should have a lying and standing blood pressure reading taken.	100%	80%
All patients should have an ECG as part of basic investigations.	100%	95%

Following the audit and presentation of results the recommendations and actions are listed below:

- Production of a proforma to be available on the medical wards and the Outpatient Department to decide if investigations and the tilt table procedure is appropriate;
- Proforma and guidelines to be available on the intranet for diagnosing and managing syncope;
- Re-audit once the proforma has been in place for one year;
- Electrocardiogram (ECG) and lying and standing blood pressure to be recorded for all patients prior to attending clinic appointments.

### Management of patients with unstable angina

The rationale for conducting this audit is to ensure that the Trust is compliant with NICE guidelines for unstable angina (a type of recurring chest pain) and NSTEMI (non-ST-segment-elevation myocardial infarction, a type of heart attack). These are disorders in which patients have widely varying risks. Risk

is an important driver of clinical management decisions, and accurate yet simple methods of risk assessment are important for patient care.

A sample of 52 patients was reviewed, and the recording of comorbidities (other illnesses), the appropriate use of physiological, haematological and biochemical tests was recorded. The main finding, which required a change to practice, was the assessment and documentation of a risk score (GRACE score), which is used to determine the need for angiography. This has been discussed in the clinical teams and a prompt for the risk to be assessed when the patient is admitted is to be implemented.

### 3. Participation in Clinical Research

Research remains a high priority for the Trust as there is increasing evidence that active participation in research improves patient outcomes.

The number of patients receiving relevant health services, provided or sub-contracted by HDFT in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee, was 7,965.

A large proportion of this recruitment, 6,424 patients, can be attributed to a Harrogate based, internationally recruiting, observational study affiliated to the James Lind Alliance Priority Setting Partnership (JLA PSP).

The Trust achieved the regional research target set in 2013/14. The continuing expansion of research into different clinical areas reflects investment in infrastructure, excellent collaboration between the Trust and the North East Yorkshire and Northern Lincolnshire Comprehensive Research Network (NEYNL CLRN) and a clear commitment by the Trust to support and participate in research.

Recruitment compares very favourably against the national average for small acute Trusts and has more than doubled over the past year. In addition, Harrogate was recognised nationally as undertaking the highest number of studies within a small NHS Acute Trust in 2012/13. Recruitment locally has contributed to NEYNL CLRN achieving hatched green and green national ratings for recruitment to time and target for life sciences research.

The number of National Institute for Health Research (NIHR) research studies open as one of the treatment options for Trust patients is currently 69. Of these, 39% are randomised controlled trials, 12% are sponsored and/or funded by life science partners. The Trust Research Department has the goal of ensuring taking part in research is a choice for as many patients treated within the Trust as possible. With this goal in mind, there is on-going work to track the treatment pathways of HDFT patients being treated in other centres to ensure that they also have access to research.

During 2013/14, the number of dedicated staff participating in clinical research approved by a research ethics committee at HDFT increased from 40 to 92. The research conducted at HDFT now embraces 19 different clinical specialties. The Trust, in collaboration with NEYNL CLRN, has continued to support training and education of clinical teams in 2013/14. Maintenance of a responsive workforce, with a mix of specialist and generic research staff, enables the team to manage fluctuating workloads and reduces delays in study start up.

The Trust achieved the required 30 day target for study submission to NHS Permissions to be granted.

The Trust Research and Development (R&D) Group, chaired by the Medical Director, ensures research strategy and developments are embedded in Trust governance structures and provides assurance regarding quality and safety.

The Research and Development Team provide a comprehensive support system for research teams and regularly monitor studies and report back to the R&D Group to ensure quality of study delivery. This year has seen the introduction of EDGE, a research management system which supports and improves the quality of research delivery in the NHS.

Raising awareness of research activity is vital for increasing participation in research. Research staff have worked with patient and public involvement representatives on a number of projects with this goal. This has been achieved through promotional materials on electronic screens in patient waiting areas, handing out information about research on International Clinical Trials Day, including the “OK to ask” campaign, ensuring that staff know how to refer on queries about research and displaying details of clinical research teams and on-going studies on a notice board located in main reception at Harrogate District Hospital and in the appropriate clinical area. In addition, a number of patient/public groups have been involved in consultations with local academic researchers: for example, a group of mothers of children with eczema contributed to the redesign of outcome measures for a project looking at the effectiveness of an educational intervention for eczema management. Two Trust Members have agreed to act as ambassadors for research within the Trust and the wider public.

The Dermatology Research team have led a successful James Lind Alliance Priority Setting Partnership for acne. A mixed group of clinicians and patients identified their top ten research questions after 6,400 submissions to the international survey.

A number of NIHR studies which recruited patients at HDFT have reported in the last year. An example is the venUS IV clinical trial, for which patients were recruited from primary and secondary care. The study compared four-layer bandage systems with two layer stocking systems in the treatment of venous leg ulcers. The results showed that there was no significant difference in healing times, but potential huge cost savings for the NHS. The overall cost of stockings is less than the bandage systems. Using stockings meant less nursing time to do dressings. Once the ulcer was healed and all patients were given stockings as a preventative measure, those who had the stockings from the beginning kept using them and so the ulcer was less likely to come back in this group. The study concluded “increased use of hosiery as a treatment is likely to result in substantial savings for the NHS and improved quality of life for people with venous leg ulcers.”

Trust staff remain abreast of the latest treatment possibilities and active participation in research has been shown to improve patient outcomes. Increasingly clinical staff involvement in research prompts changes to everyday practice. As an example, the use of income from research in Pathology has enabled several staff to attend project management training. As part of their training, they conduct various internal projects improving Pathology services. Internally, there has been less paper use and wastage, better stores management, reduction in waste and improved samples handling and processing.

Participation in clinical research demonstrates HDFT’s commitment to improving the quality of the care it offers, testing and offering the latest medical treatments and techniques and to making a contribution to wider health improvement.

#### 4. Use of the Commissioning for Quality and Innovation Framework

A proportion of HDFT income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between HDFT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the

Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2013/14 and for the following 12 month period are available electronically at: <http://www.hdft.nhs.uk/about-us/commissioning-for-quality-and-innovation-cqin/>

The monetary total for the amount of income in 2013/14 conditional upon achieving quality improvement and innovation goals was £2,984,000.

#### 5. Registration with the Care Quality Commission

HDFT is required to register with the Care Quality Commission and its current registration status is unconditional. HDFT has no conditions on registration.

HDFT had the following sites registered during 2013/14:

- Harrogate District Hospital;
- Lascelles Unit;
- Ripon Community Hospital;
- HMP Askham Grange;
- HMP Northallerton.

The Care Quality Commission has not taken enforcement action against Harrogate and District NHS Foundation Trust during 2013/14.

HDFT has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

#### 6. Information on the Quality of Data

HDFT submitted records during 2013/14 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data which included the:

Patient's valid NHS number was:

- 99.5% for admitted patient care;
- 99.7% for outpatient care;
- 96.0% for accident and emergency care.

Patient's valid General Practitioner Registration Code was:

- 99.8% for admitted patient care;
- 99.8% for outpatient care;
- 99.7% for accident and emergency care.

#### 7. Information Governance

HDFT's Information Governance Assessment Report overall score for 2013/14 was 84% and was graded satisfactory/green. The Trust reported 111 out of 132 standards at level two or above (there are three levels with level three being the highest), compared to 104 out of 132 in 2012/13.

## 8. Payment by results

HDFT was not subject to a Payment by Results clinical coding audit in 2013/14 by the Audit Commission. However, the Trust commissioned an external clinical coding audit to meet Information Governance requirements. The audit was carried out in January 2014 by nationally registered clinical coding auditors from D & A Clinical Coding Consultancy Limited. An audit sample of 200 episodes was reviewed, 75 randomly selected Elderly Care episodes, 75 randomly selected Urology episodes and 50 randomly selected Gynaecology episodes, from across the whole range of activity for the period July – September 2013. The results showed an overall error rate (coding errors affecting the Healthcare Resource Group (HRG)) of just 3%, compared to the latest published national average error rate of around 9%. This result should not be extrapolated further than the actual sample audited. The error rates reported for diagnoses and treatment coding (clinical coding) in the audit sample were:

- Primary procedures 4.5%;
- Secondary procedures 7%;
- Primary diagnoses 5.5%;
- Secondary diagnoses 5.1%;
- An overall combined diagnostic and procedural error rate 5.5% (2.5% of the error rate did not affect the HRG as described above).

HDFT will be taking the following actions to improve data quality:

- The Trust will continue its comprehensive training programme to enable all Clinical Coding staff to achieve the national Clinical Coding Accreditation qualification;
- The Clinical Coding team will continue to meet with individual Consultants to review and explain the clinical coding process and discuss specific operations;
- The Trust will continue to routinely review and analyse all Secondary Usage Services (SUS) processes for the commissioning data set submissions, including reviewing the quality and completeness of the data items submitted.

### **2.4 Reporting against core indicators**

Set out in the table below are the quality indicators that Trusts are required to report in their Quality Accounts this year. The data given in this section, unless otherwise stated, has been taken from the data made available to the Trust by the Health and Social Care Information Centre (H+SCIC).

#### 1. Preventing people from dying prematurely and enhancing quality of life for people with long-term conditions

##### Summary Hospital Mortality Index (SHMI)

This measure looks at deaths in hospital or within 30 days of discharge and is standardised to allow for variations in the patient mix in different hospitals. The Health & Social Care Information Centre publish a value for each Trust every quarter. The national score is set at 1.0000: a Trust score significantly above 1.0000 indicates higher than expected death rates, whereas a score significantly below 1.0000 indicates lower than expected death rates.

## **SHMI (Summary Hospital Level Mortality Indicator)**

	Data period	
	Jul 12 to Jun 13	Oct 12 to Sep 13
<b>HDFT value</b>	0.9848	0.9478
<b>HDFT banding</b>	2 (as expected)	2 (as expected)
<b>National average</b>	1.0000	1.0000
<b>Highest value for any acute Trust</b>	1.1563	1.1859
<b>Lowest value for any acute Trust</b>	0.6259	0.6301

Note - highest and lowest trust scores include all providers with data published by H +SCIC

HDFT's latest published score of 0.9478 is within the expected range.

HDFT considers that this data is as described for the following reasons:

- Independent clinical coding audits are carried out on an annual basis by accredited clinical coding auditors to provide assurance of the accuracy of coded data;
- The SHMI data is reviewed and signed off on a quarterly basis by the Medical Director.

HDFT has taken the following actions to improve this rate, and so the quality of its services, by:

- Actively using an evaluation tool that enables the Trust to clinically review and analyse mortality data in detail on an on-going basis. This has been rolled out across the organisation.
- The Trust is participating in an Academic Health Service Network (AHSN) project and regional mortality review group, evaluating methods of clinical review with a view to sharing learning.

### Palliative care coding

The data shows the percentage of patient deaths in hospital with specialist palliative care coded at either diagnosis or specialty level. This denotes that the patient had clinical input from a specialist palliative care team before their death. In some mortality measures, this is taken into account in the standardisation, making the assumption that a patient who has had specialist palliative care input should not be classified as an unexpected death. A proportion of people who die in hospital will receive specialist palliative care input, but the recording of this varies widely between hospitals.

### **Palliative care coding - % patient deaths with palliative care coded at either diagnosis or specialty level**

	Data period	
	Jul 12 to Jun 13	Oct 12 to Sep 13
<b>HDFT value</b>	14.8	15.6
<b>National average</b>	20.3	20.9
<b>Highest value for any acute Trust</b>	44.1	44.9
<b>Lowest value for any acute Trust</b>	0.0	0.0

Note - highest and lowest trust scores include all providers with data published by IC

HDFT's latest published score of 15.6% is below the national average.

HDFT considers that this data is as described for the following reasons:

- Independent clinical coding audits are carried out on an annual basis by accredited clinical coding auditors to provide assurance of the accuracy of coded data;
- The palliative care coding data is reviewed and signed off on a quarterly basis by the Medical Director.

HDFT has taken the following actions to improve this rate, and so the quality of its services, by:

- Investing in specialist palliative care provision by increasing the hours and resource available to provide the service to patients in hospital.

## 2. Helping people to recover from episodes of ill health or following injury

### PROMs – Patient Reported Outcome Measures

PROMs calculate the health gain after elective surgical treatment using pre- and post-operative patient surveys. Four common elective surgical procedures are included in the survey: groin hernias, hip replacements, knee replacements and varicose vein operations.

HDFT does not perform significant numbers of varicose vein operations and so this procedure has been excluded from the results. A high health gain score is good.

### **PROMs - Patient Reported Outcome Measures**

#### **Groin hernia surgery - adjusted average health gains (EQ-5D index)**

	Data period		
	2011/12 (final)	2012/13 (provisional)	Apr-13 to Sep-13 (provisional)
<b>HDFT value</b>	0.083	0.088	0.076
<b>National average</b>	0.087	0.085	0.086
<b>Highest value for any acute Trust</b>	0.143	0.119	0.138
<b>Lowest value for any acute Trust</b>	0.030	0.021	0.019

#### **Varicose vein surgery - adjusted average health gains (EQ-5D index)**

	Data period		
	2011/12 (final)	2012/13 (provisional)	Apr-13 to Sep-13 (provisional)
<b>HDFT value</b>	Data suppressed due to small numbers	Data suppressed due to small numbers	Data suppressed due to small numbers
<b>National average</b>	0.095	0.093	0.102
<b>Highest value for any acute Trust</b>	0.167	0.023	0.094
<b>Lowest value for any acute Trust</b>	0.049	0.175	0.058

### Hip replacement surgery - adjusted average health gains (EQ-5D index)

	Data period		
	2011/12 (final)	2012/13 (provisional)	Apr-13 to Sep-13 (provisional)
<b>HDFT value</b>	0.426	0.427	0.397
<b>National average</b>	0.416	0.438	0.447
<b>Highest value for any acute Trust</b>	0.470	0.538	0.492
<b>Lowest value for any acute Trust</b>	0.318	0.319	0.373

### Knee replacement surgery - adjusted average health gains (EQ-5D index)

	Data period		
	2011/12 (final)	2012/13 (provisional)	Apr-13 to Sep-13 (provisional)
<b>HDFT value</b>	0.336	0.327	0.355
<b>National average</b>	0.302	0.319	0.339
<b>Highest value for any acute Trust</b>	0.371	0.376	0.429
<b>Lowest value for any acute Trust</b>	0.181	0.195	0.264

Note - highest and lowest Trust scores exclude independent sector providers and PCT providers

2012/13 and 2013/14 data looks at primary hip and knee procedures only

HDFT's latest published health gain scores for groin hernias, hip replacements and knee replacements were below national average for groin hernia surgery and hip replacement surgery, and above national average for knee replacement surgery.

HDFT considers that this data is as described for the following reasons:

- It has participated in the PROMs scheme since inception, routinely analysing and reviewing the results;
- HDFT is not a vascular surgery centre and this is reflected in the data suppression for varicose vein surgery due to small numbers;
- The data is formed from pre- and post-operative patient surveys and therefore reflects their perception of the improvement in their health following surgery;
- The Trust considers the scores indicate it is not an outlier from the national position.

HDFT intends to take the following actions to improve this score, and therefore the quality of its services, by:

- Continuing to actively participate in the scheme, reviewing and analysing the results to ensure a clear understanding of the data to inform future programmes of work.

### Emergency readmissions to hospital within 28 days

This data looks at the percentage of patients who are readmitted to hospital as an emergency within 28 days of being discharged. The data is standardised by the Health & Social Care Information Centre to enable a fair comparison between organisations and is presented in age groups: ages 0-15 and ages 16 and over. A low percentage score is good.

## Emergency readmissions to hospital within 28 days

### Age 0-15

	Data period		
	2009/10	2010/11	2011/12
<b>HDFT value</b>	10.95	10.55	9.64
<b>National average</b>	10.01	10.01	10.01
<b>Highest value for any acute Trust</b>	56.38	23.33	47.58
<b>Lowest value for any acute Trust</b>	0	0	0

### Age 16+

	Data period		
	2009/10	2010/11	2011/12
<b>HDFT value</b>	9.19	10.02	9.96
<b>National average</b>	11.18	11.43	11.45
<b>Highest value for any acute Trust</b>	15.26	17.1	17.15
<b>Lowest value for any acute Trust</b>	0	0	0

2011/12 data published Dec-13

2012/13 data due Dec-14

Note - the data for 2009/10 and 2010/11 has been re-standardised by HSCIC and so will not correlate with the data in last year's Quality Account

HDFT's latest published values for ages 0-15 and 16 and over are below the national average.

HDFT considers that this data is as described for the following reasons:

- The source data used is taken from the Secondary Uses Service dataset; this is a national system and data quality indicators linked to this system indicate an excellent compliance rate.

HDFT has taken the following actions to improve this rate and so the quality of its services, by:

- Using an evaluation tool that enables the Trust to review and analyse a range of clinical and outcome indicators including emergency readmissions in detail on an on-going basis. This enables local clinical teams to identify and review ways in which services can be improved to reduce re-admissions wherever possible.

### 3. Ensuring that people have a positive experience of care

#### Inpatient survey

This measure is the average weighted score of five questions from the national inpatient survey relating to responsiveness to inpatients' personal needs. The scores are presented out of 100 with a high score indicating good performance.

## Inpatient survey - responsiveness to inpatients' personal needs

Average weighted score of 5 questions relating to responsiveness to inpatients' personal needs (Score out of 100).

	Data period		
	2011	2012	2013
<b>HDFT value</b>	72.3	71.8	71.8
<b>National average</b>	67.4	68.1	68.7
<b>Highest value for any acute Trust</b>	85.0	84.4	84.2
<b>Lowest value for any acute Trust</b>	56.5	57.4	54.4

*Composite score for 2013 awaited from H+SCIC*

HDFT considers that this data is as described for the following reasons:

- Driving improvement for the delivery of high quality fundamental care has been a major quality improvement priority for the Trust for the last three years. It has had wide engagement from hospital based nursing staff, who have led the implementation and monitoring of rigorous standards of fundamental care, for example, in the areas of nutrition and communication.
- These standards are monitored through a governance system which includes Matrons' audits and meetings, unannounced Director led inspections, Patient Safety Visits, local Quality of Care Teams and the Trust's Standards Group.
- A well-established system of seeking objective feedback, via external bodies and groups including the Trust's Patient Voice Group, Governors and Lay Representatives.

HDFT intends to take the following actions to improve this score and so the quality of its services, by:

- The implementation and review of a detailed action plan relating to both the most recent 2013/14 survey and 2012/13 survey will continue through the Trust's Standards Group with accountability for the delivery of the plan sitting with the Trust's Clinical Directorates;
- The use of patient feedback through the full implementation of the national Friends and Family Test from April 2013 will enable further improvements to be made;

The introduction of quality initiatives for cascading information on performance improvements and areas for focus. Delayed discharge and infection control will be implemented through a group leading work to develop inpatient quality and performance notice boards.

## National Staff Survey – Standard of Care Provided

The data shown in the table below looks at the proportion of staff completing the NHS Staff Survey who responded "strongly agree" or "agree" to the question "if a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation", compared to the total number of staff that responded to the question. The scores are presented out of 100 with a high score indicating good performance.

This question forms part of Key Finding 24, "Staff recommendation of the Trust as a place to work and/or receive treatment" in the National Staff Survey for 2013. The Trust achieved a ranking of the highest (best) 20% when compared with all acute Trusts for this Key Finding.

	Data period		
	2011	2012	2013
<b>HDFT value</b>	76	73	77
<b>National average</b>	60	63	65
<b>Highest value for any acute Trust</b>	89	86	94
<b>Lowest value for any acute Trust</b>	33	35	40

HDFT considers that this data is as described for the following reasons:

- The Trust was the subject of a Care Quality Commission Inspection using their new inspection model to look at acute services. Overall, it found that Harrogate District Hospital provided care that was safe, effective, caring, responsive and well-led. The hospital was clean and it had systems in place for infection control.
- The Trust has gained accreditation in the key service areas of Stroke and Endoscopy, as well as receiving Investors in People accreditation which all endorse the service it delivers, increasing staff confidence in their own departments and the Trust generally.
- The Trust's ethos places patients and staff and the delivery of the highest standards of care at the centre of its work, demonstrated through the Trust's vision and objectives and embedded in the Trust's values and behaviours. These run throughout the Annual and Business Plan as well as the Quality objectives.
- The Trust has increased the two way channels of communication between its senior managers and patients and staff. There are more Director Walkabouts; staff have regular access to senior managers both throughout acute and community settings. There are regular Team Briefs, Listening Events, Patient Safety Visits, Director Inspections where patients are specifically spoken to about their experience of the Trust and an Ask the Directors email facility, all which focus on a culture of sharing and learning with an emphasis on improving patient safety, incident reporting and promoting a culture of openness.
- Overall, the Trust has received positive results in the national in-patient and other patient related surveys.

HDFT has taken the following actions to improve this score, and so the quality of its services by:

- Reaccreditation of Investors in People, identifying areas of continuous improvement and demonstrating the link between training and development and patient outcomes and safety. This develops staff confidence in the Trust's services.
- Rapid Improvement Programmes where service improvement and innovation projects take ideas from members of the workforce and then apply lean methodology to improve services for staff and patients and heighten confidence.
- Encouraging all Governors to have a greater role within the Trust through attendance at various patient safety/experience related events.
- Visits by Directors to a number of locations across North Yorkshire where the Trust provides services, with the aim to specifically listen to staff.
- Participated in a Dementia Collaborative with other local service providers to improve services for people with dementia.
- Provided more services closer to people's homes to improve access for patients and people that use our services.

4. Treating and caring for people in a safe environment and protecting them from avoidable harm

VTE (venous thromboembolism) risk assessment

The National Institute for Clinical Excellence (NICE) recommends that all patients in hospital should be assessed for risk of developing VTE (blood clots). This measure shows the percentage of eligible inpatients who were risk assessed. A high percentage score is good.

**VTE risk assessment - % eligible admitted patients risk assessed for VTE**

	Data period		
	Q1 2013/14	Q2 2013/14	Q3 2013/14
<b>HDFT value</b>	96.5	97.4	97.8
<b>National average</b>	95.4	95.7	95.8
<b>Highest value for any acute Trust</b>	100.0	100.0	100.0
<b>Lowest value for any acute Trust</b>	78.8	81.7	77.7

<http://www.england.nhs.uk/statistics/statistical-work-areas/vte/>

HDFT's published scores have been above the national average for the whole year.

HDFT considers that this data is as described for the following reasons:

- There is a well-established protocol for VTE risk assessment on admission;
- Data is recorded onto the Information and Clinical System (ICS) and collected via reliable IT systems;
- Education on VTE risk assessment is part of the Trust's essential training so staff understand the importance of it.

HDFT intends to take the following actions to improve this and so the quality of its services, by:

- Identifying wards with poorer performance and examining whether there are issues with completion of the risk assessment or inputting of information onto ICS;
- Continued scrutiny of results at Director level via the Trust's Performance Group.

Clostridium difficile (C.diff) rates

The data shows the rate per 100,000 bed days of cases of C.diff infection (CDI) reported amongst patients in hospital who are aged two years or over. A low rate is good.

**C.diff - rate per 100,000 bed days of cases of C.diff infection reported within the trust amongst patients aged 2 or over**

	Data period		
	2010/11	2011/12	2012/13
<b>HDFT value</b>	14.6	10.3	20.8
<b>National average</b>	29.7	22.2	17.3
<b>Highest value for any acute Trust</b>	71.2	58.2	30.8
<b>Lowest value for any acute Trust</b>	0	0	0

**Data source:**

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/ClostridiumDifficile/EpidemiologicalData/>

Note - the data for 2010/11 and 2011/12 has been re-calculated by Health Protection Agency and so will not correlate with the data in last year's Quality Account

HDFT's latest published score is above the national average.

HDFT considers that this data is as described for the following reasons:

- The Trust has an extremely robust diagnostic testing protocol which uses four stages to identify cases. Data is to be presented at an international scientific meeting later in 2014 to show that this approach identifies 30% more cases than would be diagnosed if the Trust were to follow Public Health England nationally mandated protocol which proscribes a two-stage process.
- All cases of CDI and most cases of *C. difficile* colonisation are subject to genetic fingerprinting using ribotyping and, if indicated, more detailed genetic analysis.
- All confirmed cases are closely scrutinised through the Trust's internal reporting mechanisms and subject to root cause analysis including, as appropriate, input from primary care and then reported to Public Health England, Monitor and commissioning organisations.
- The Trust's commitment to preventing *C. diff* through the key strategies of high levels of environmental cleanliness, high standards of staff and patient hand hygiene, an effective antibiotic stewardship programme and education and awareness for staff and to the public remains unchanged. A comprehensive *C.difficile* strategy has been strengthened by, for example, extension of the working hours of the Deep Clean Team, the purchase of mobile handwash stations and introduction of PCR-based testing (polymerase chain reaction).

HDFT intends to take the following actions to improve this rate, and so the quality of its services, by:

- Future scrutiny of potential cases by the internal *C. difficile* Case Attribution Panel to ensure that cases reported by the Trust satisfy, in full, the national criteria for the diagnosis of *C. difficile* infection.
- Ensuring the prompt isolation of any patient with unexplained loose stools within specific Trust standards.

- Further developing the Trust's antibiotic stewardship programme through further exploitation of the capabilities of the electronic prescribing system.

### Patient safety incidents

The data looks at three measures related to patient safety incidents reported to the National Reporting and Learning System (NRLS):

- The rate of incidents reported per 100 admissions. A low rate is good; however, incident reporting rates may vary between trusts and this will impact on the ability to draw a fair comparison between organisations.
- The number and percentage of reported incidents that resulted in severe harm to a patient/s. A low score is good.
- The number and percentage of reported incidents that resulted in the death of a patient/s. A low score is good.

<u>Patient safety incidents</u>						
	Apr 12 - Sep 12			Oct 12 - Mar 13		
	Rate of incidents reported (per 100 admissions)	Incidents that resulted in severe harm or death		Rate of incidents reported (per 100 admissions)	Incidents that resulted in severe harm or death	
		Number	Rate (per 100 admissions)		Number	Rate (per 100 admissions)
<b>HDFT value</b>	6.42	4*	0.20	7.28	3	0.20
<b>National position (all acute trusts)</b>	7.01	3390	0.72	7.76	3239	0.68
<b>Highest value for any acute Trust</b>	24.88	98	3.60	30.95	114	4.75
<b>Lowest value for any acute Trust</b>	1.37	0	0.00	1.68	0	0.00
* Please note this figure is inaccurate and should be 5. This case has been reported through NRLS but central data not updated to reflect.						
Data source:						
<a href="http://www.nrls.npsa.nhs.uk/resources/">http://www.nrls.npsa.nhs.uk/resources/</a>						

HDFT's latest published scores are below the national average for all three measures.

HDFT considers that this data is as described for the following reasons:

- The data is collated by front line staff in relation to patient safety incidents;
- There is a robust policy and process within the Trust to ensure that all incidents are identified, managed, reported and investigated in accordance with national guidance;
- The Trust ensures that there are appropriate measures in place to prevent recurrence and also promotes organisational learning.

HDFT has taken the following actions to improve this score and so the quality of its services, by:

- Promoting patient safety as a key objective across the organisation and implementing a number of mechanisms to ensure compliance with, and delivery of, national frameworks;
- There is a continual focus on quality at an organisational, Directorate and front line level through a variety of structures, for example, Quality of Care Teams, Quality Governance Groups at Corporate and Directorate level, Patient Safety Visits, Quarterly Monitoring Reports, Case Conferences and Learning Events.

In addition, the Trust can report an updated position up to September 2013. Incidents reported by degree of harm in this period were: two graded as severe, and one that resulted in death. All three

have been investigated as serious untoward incidents, and actions to address the findings put in place.

Please note that the time period described here is different to that in part one of this Quality Account.

## **OTHER INFORMATION**

### **Review of Quality Performance**

This section provides an overview of the quality of care offered by HDFT, based on performance in 2013/14 against indicators selected by the Board of Directors in consultation with stakeholders, including three priorities for the three elements of quality covering each of:

- Patient safety;
- Clinical effectiveness;
- Patient experience.

The Trust has included some of the same indicators that were included in the 2012/13 Quality Account, in order to report ongoing work and progress. Some of the indicators previously reported in this section in 2012/13 have been part of the key priorities for 2013/14 and are reported in part 2. The Trust has also introduced a few new indicators.

#### Patient Safety

##### 1. Care of the deteriorating patient

It is essential that the severity of a patient's condition is identified early, and that there is a timely and competent clinical response to their needs. This would include review by more senior staff if required.

In January 2013, the new National Early Warning Score (NEWS) was rolled out across the Trust. One of the main aims of this project was to ensure a uniform approach across the whole of the NHS in England, so that healthcare professionals in a variety of settings would use the same assessment and scoring system for their patients, ensuring better communication and a common language amongst teams. In addition to the NEWS score, a standardised nursing observation chart was developed so that staff moving between different trusts are familiar with this essential documentation.

Although the NEWS system is standardised across England, the responses to the scores obtained are decided locally to fit the resources available. Therefore, as NEWS was rolled out across the Trust, each clinical area designed their own appropriate response levels. For example, a patient with a certain score in Harrogate District Hospital may require a review by a doctor within 15 minutes, whereas a similar patient in a community setting would require a "999" ambulance call.

Prior to its introduction, a significant educational program was put in place to ensure that all staff were aware of the significant change in practice. Six months after its introduction, a scoping exercise was performed to explore any problems which had emerged since its launch. As a result of this exercise, a few minor modifications of the chart were made to improve the ease of use.

In January 2014, an in-depth audit of the escalation pathways for adults, Paediatrics and Maternity was undertaken by Internal Audit, who gave an opinion of significant assurance. It was noted that significant improvement had been achieved regarding improved compliance with the documentation of patient escalation since the introduction of the new policy, although further work is still required.

The results show:

<b>Audits of escalation of deteriorating patients</b>	<b>July 2011</b>	<b>April 2014</b>
Episodes with an Early Warning Score of 3 or 4, or NEWS of 3 or above had observations repeated in line with policy	24% (26/107)	41% (21/51)
Observations and NEWS score recorded accurately	No data available	84% (43/51)
Escalation documented	24% (30/123)	61% (31/51)
Episodes reviewed by medical staff	72% (89/123)	98% (50/51)
Timeliness of review	29% (26/89) within 30 minutes	74% (23/31) within 1 hour

Data source: HDFT

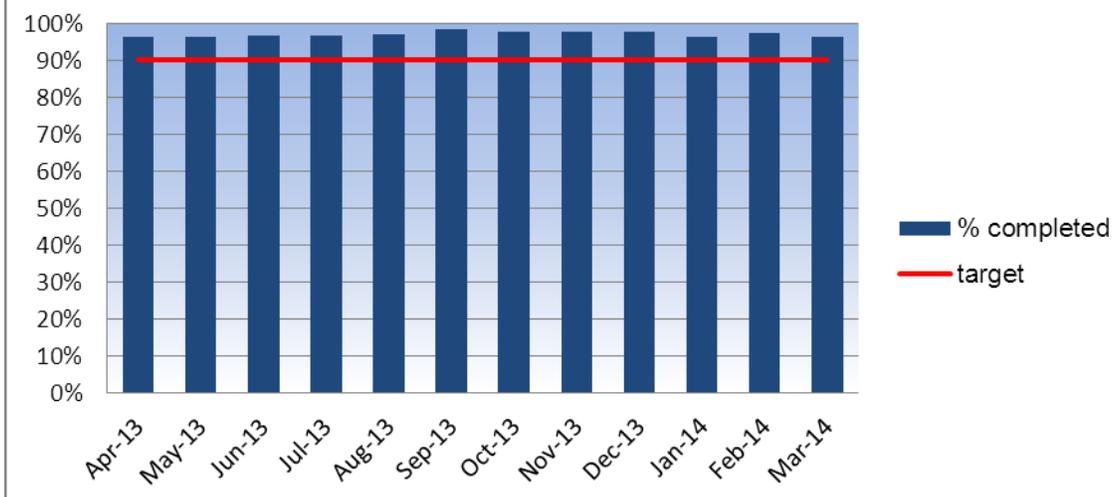
Whilst this demonstrates a significant improvement from the last audit (especially confirmation that 98% of triggers were reviewed by a doctor), there is still room for improvement, in particular relating to the timeliness of both review and repeated observations and the documentation of all escalations performed.

To ensure improvement, we are currently planning to move away from paper recording of patient observations to an electronic system which will automatically trigger an appropriate response. This should represent another significant advance in ensuring that prompt and effective care is delivered to all our patients.

## 2. Venous thromboembolism (VTE) risk assessment and root cause analysis

VTE includes deep vein thrombosis (DVT) and pulmonary embolism (PE), types of blood clots that are important causes of morbidity and mortality in hospitalised patients. The Trust's aim this year has been to maintain compliance with the target of at least 95% of all adult admissions having a risk assessment, and to introduce a process to review and undertake a root cause analysis of possible cases of hospital associated thrombosis (HAT).

## Inpatients: % with VTE risk assessment completed



Data source: HDFT

HAT is defined as any new episode of VTE diagnosed during hospitalisation or within 90 days of discharge, or following a surgical procedure.

Undertaking root cause analysis (RCA) of every case of HAT is a major challenge, which requires data capture, engaging with stakeholders to undertake a structured analysis of why the thromboembolic event happened and then feeding lessons learned back into the Trust quality management framework.

The Trust introduced such a process in 2013 and the results are below:

<b>Results of VTE RCA 2013/14</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>
Total number. of VTE cases diagnosed	41	47	49	68
Number. of potential HAT identified	14	13	20	24
Number of RCA completed on potential HAT	13	13	15	22
Number confirmed as HAT	9	7	12	16
% HAT with RCA undertaken	93%	100%	75%	92%
<b>Root causes identified</b>				
Inadequate thromboprophylaxis	1	2	0	0
Thromboprophylaxis failure	6	3	11	12
Contraindication to all thromboprophylaxis	0	1	0	0
Contraindication to chemical thromboprophylaxis	0	1	0	2
Line associated	0	0	0	0
Unexpected	2	0	1	1
HAT cases potentially preventable	1	2	0	1
% HAT cases potentially preventable	11.1%	28.6%	0.0%	6.3%

Data source: HDFT

The root cause definitions are taken from the National VTE Registry:

- Inadequate thromboprophylaxis: patient with high risk of VTE and any unexplained omission in chemical thromboprophylaxis e.g. missed doses, wrong dose, delay in starting thromboprophylaxis, failure to prescribe thromboprophylaxis, inadequate duration of thromboprophylaxis.
- Thromboprophylaxis failure: patient with high risk of VTE who was prescribed and administered chemical thromboprophylaxis as indicated.
- Contraindication to all thromboprophylaxis: patient with both VTE and bleeding risk, who also have contraindications to mechanical thromboprophylaxis e.g. stroke patients.
- Contraindication to chemical thromboprophylaxis: patient with both VTE and bleeding risks (without contraindication to mechanical thromboprophylaxis) e.g. thrombocytopenia (low platelets).
- Line-associated: DVT associated with any central indwelling catheter irrespective of VTE or bleeding risk.
- Unexpected: patient with low risk of VTE

The learning identified from this process has been shared with clinical staff and includes:

- Reminding staff that risk assessment must be completed accurately on all relevant cases.
- Ensuring timely prescription of thromboprophylaxis following risk assessment for patients at risk. This is a multidisciplinary responsibility and should be checked on ward rounds.
- Reviewing orthopaedic thromboprophylaxis guidelines.
- Reviewing evidence for weight-based dosing for dalteparin thromboprophylaxis.
- Feeding back to the Anaesthetic Clinical Lead regarding completion of the WHO surgical checklist.
- Reviewing case-notes of possible failure to follow bridging guidelines and follow up accordingly.

### 3. Falls prevention

In 2012/13, the Trust reported an improvement in the availability, delivery and uptake of falls prevention training, and a significant improvement in risk assessment and documentation. However, the impact of this on preventing falls was not as successful as hoped. Falls prevention has, therefore, continued to be a safety priority during the past year that is being monitored carefully.

Unfortunately, the Trust has more reported falls in 2013/14 than last year. It is difficult to ascertain if this is due to more falls, better reporting or elements of both.

However, when looking at falls causing harm, the numbers are more positive.

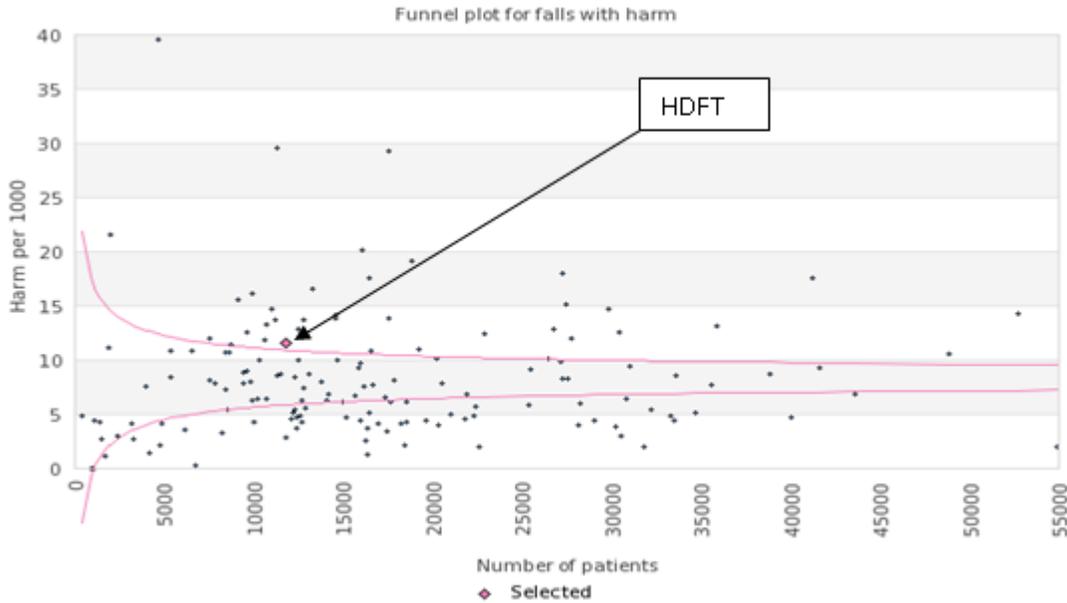
	2011/12 (Apr – Feb)	2012/13 (Apr – Feb)	2013/14 (Apr – Feb)
All Reported (inpatient) Falls	783	891	904
Harmful Falls	273	280	234
Fractures	13	16	12

Data source: HDFT local incident reports

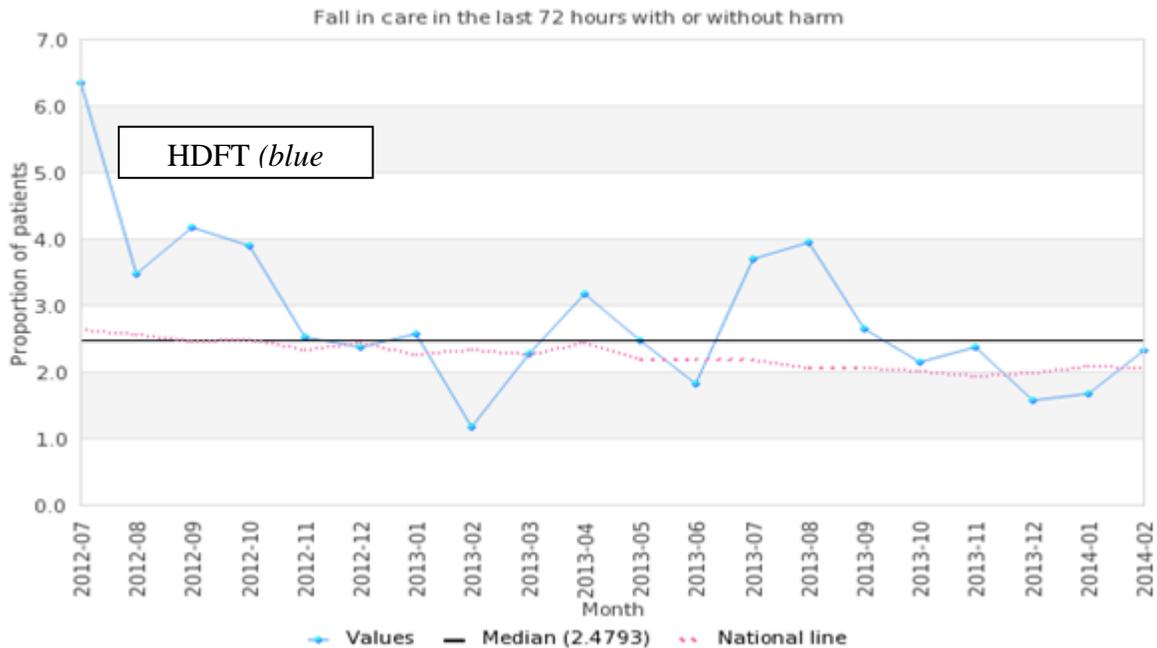
When this is converted to demonstrate the rate of falls per 1,000 occupied bed days (OBD) it reflects the same picture of higher reported falls with less harmful outcomes:

	2012/13 (Apr – Feb)	2013/14 (Apr – Feb)
Falls Rate (per 1000 OBD)	9.49	10.22
Harm Rate (per 1000 OBD)	2.98	2.64

The NHS Safety Thermometer data, which is a snapshot of falls over a period of time each month, shows the organisation as slightly outside the expected level of harmful falls as at the end of February.



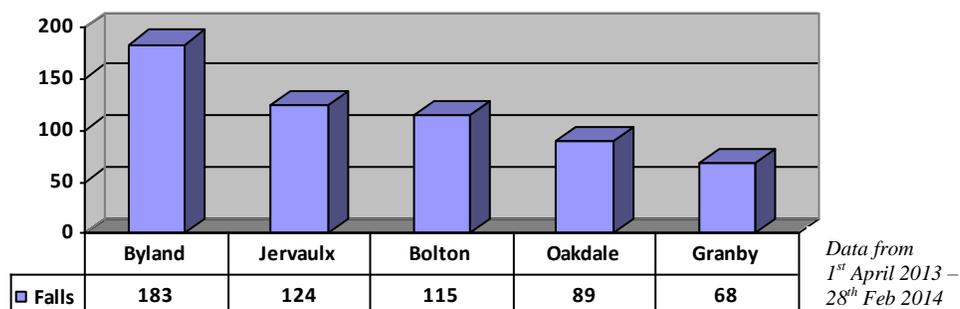
Data Source: NHS Safety Thermometer



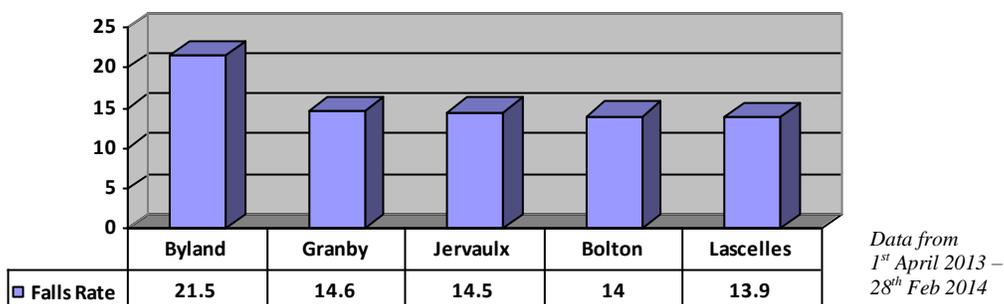
Data Source: NHS Safety Thermometer

It is important to note that the NHS Safety Thermometer data only represents the previous 72 hours of care on the audit day each month and is not representative of actual numbers of falls and harm. It also includes data from community teams and therefore is not exclusively relating to inpatients.

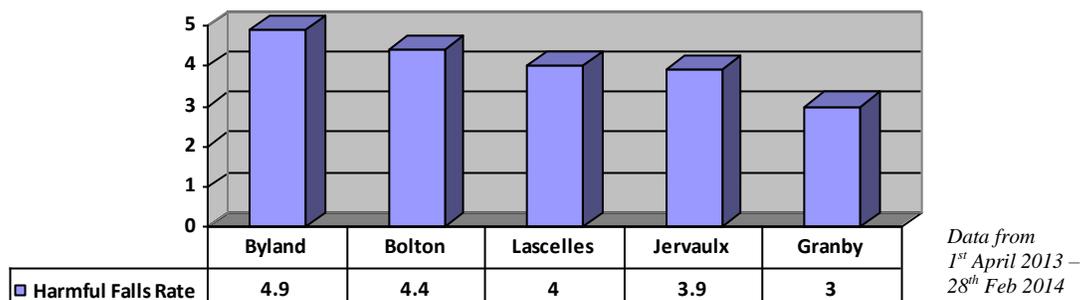
Monitoring the breakdown of falls numbers and rates by location is an ongoing process and the following areas have been identified as the five areas with highest levels of falls during 2013/14:



However, when the number of falls is calculated against the number of occupied bed days to obtain a falls rate (number of falls per 1,000 OBD) the order changes slightly:



When the number of falls resulting in harm is calculated against the number of occupied bed days to obtain a harmful falls rate (number of falls causing harm per 1,000 OBD) there is another change:

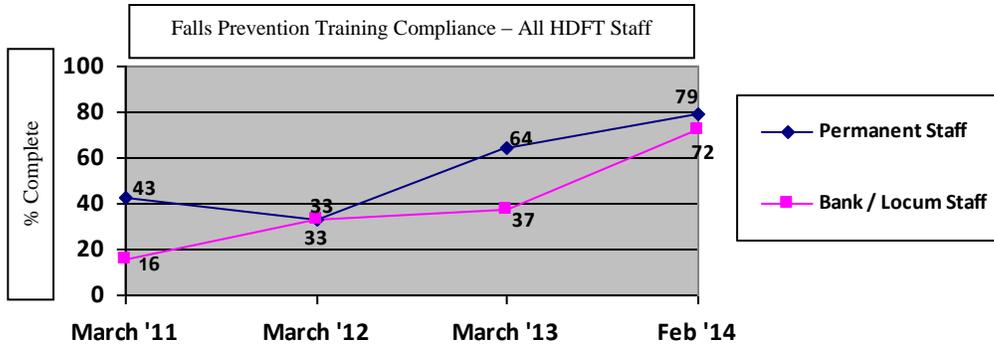


Data Source: HDFT

The ward areas that appear with the worst numbers for falls, rate and harm would be expected, as all are wards with the highest population of patients with multiple risk factors for falls, for example elderly and frail patients.

Two other priorities identified by the Trust are to improve falls prevention training compliance and documentation compliance.

Training compliance is steadily improving overall with the Trust overall now at 79% compliance for substantive staff.



Data Source: HDFT

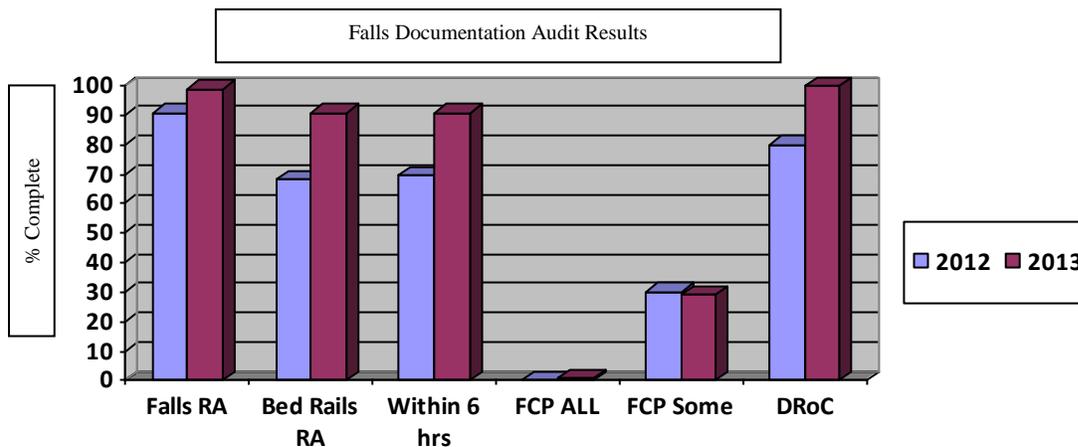
Training is now available via e-learning, face to face sessions, quarterly drop in sessions, or can be directly arranged with the Falls Co-ordinator. Community based sessions are also provided and can be delivered jointly with clinical handling training where required. Falls prevention is now also included in the Care Support Worker induction training.

Documentation compliance is also improving in parts. The annual falls documentation audit in November 2013 demonstrated the following improvements from the previous audit:

Audit area	Total Compliance	Improvement
Falls Risk Assessment	98.7%	8% increase
Bed Rails Risk Assessment	90.8%	22% increase
Risk Assessment complete within 6 hours of admission	90.6%	21% increase

Data Source: HDFT

There has also been an improvement in the daily record of care (DRoC). However, the documentation of care planning continues to be poor, despite changes being made to the fundamental care plan (FCP).



Data Source: HDFT

This clearly demonstrates that although there have been improvements in compliance of documentation completion relating to risk assessment and an appropriate daily record of care, there remains a significant issue with the documentation of planning care for falls prevention.

This has already been highlighted with Matrons and Ward Sisters and a radical change to the falls section of the fundamental care plan has been approved by the Trust's Documentation Group.

Recent and ongoing activities and developments include:

- Harrogate District Hospital is a pilot site for the national Royal College of Physicians Falls and Fragility Fracture Audit Programme Inpatient Falls Audit. The audit was completed in February 2014, and results demonstrate areas already acknowledged as requiring significant improvement, including medication reviews, postural blood pressure monitoring and care planning.
- Movement alarms for all inpatient ward areas are to be purchased in April 2014, following a successful pilot in 2013.
- A pilot scheme to review medication has commenced on Jervaulx and Byland Wards and has included a baseline audit of medication review completion. The audit has demonstrated low levels of medication reviews conducted and/or documented. Ways to improve referral to the Pharmacist for review are currently being discussed.
- Integrated working with voluntary organisations within the Trust has begun to provide exercise and stability classes for the high risk patient group. An initial trial in Ripon has been successful but there are some issues to resolve with transport and ensuring the facility is used to capacity. A location is now being sought for an additional class in the Harrogate area and then patients will be recruited into the scheme.
- The community falls assessment tool has been redesigned and a pilot of the new document commenced.
- Changes to documentation have been made to reflect NICE guidance on risk assessment and to reflect the issues established from previous audits.
- Improvements have been made to reflect the reclassification of falls resulting in fracture to a serious untoward incident from June 2014, including updating the root cause analysis template and the provision of training.
- A business case is in development for a falls prevention programme based on the national FallSafe project with support from the Royal College of Physicians Clinical Effectiveness and Evaluation Unit. This is a large quality improvement project and requires commitment and financial support from the Trust. The project plan is being drawn up and some initial streams of work have commenced:
  - Audit work to review any potential under reporting of falls for establishing a baseline;
  - Work to enable the immediate provision of walking aids;
  - Documentation review to reflect the FallSafe care bundles;
  - New data analysis to assist ward areas to focus on significant themes, including the most common time and location of falls.

### Future work

Further work is already being progressed to further improve the assessment of risk in relation to slips, trip and falls and to improve the information available to investigate incidents of falls more thoroughly. The falls pathway is to be redesigned and a multidisciplinary falls prevention passport developed. Falls prevention training is to be introduced into induction training for clinical staff, and collaborative training is planned with care homes to improve falls prevention and reduce hospital admissions. In addition, a new service is being developed in conjunction with Yorkshire Ambulance Service to reduce hospital admissions.

## Clinical Effectiveness

### 1. Stroke care

The care of patients who have had a stroke has been a priority for the Trust for some time. The stroke data reported in 2012/13 showed a marked improvement and the Trust aimed to remain at or above the national average for the relevant indicators. In addition, the Community Stroke Team was introduced in 2012 and a review was planned to enable progress to be evaluated and further improvements to be prioritised.

In the 2012/13 Quality Account, the Trust reported that the Stroke Improvement National Audit Programme (SINAP) data was not to continue in the future, and further information would be recorded in the Sentinel Stroke National Audit Programme (SSNAP), a larger data collection covering not just the first 72 hours of care for stroke patients, but the full care pathway. This was initially looking at the acute hospital phase, but it will subsequently be expanded to also include information on the post discharge period.

The Trust has fully participated in collecting and submitting the data for SSNAP. The third pilot SSNAP report was issued to participating Trusts in January 2014, prior to wider publication of the national results. The pilot report looks at data for the period July to September 2013.

Results are presented in 10 domains covering 45 key indicators and looking at all aspects of stroke patients' care in hospital, including arrival and diagnosis, treatment and rehabilitation.

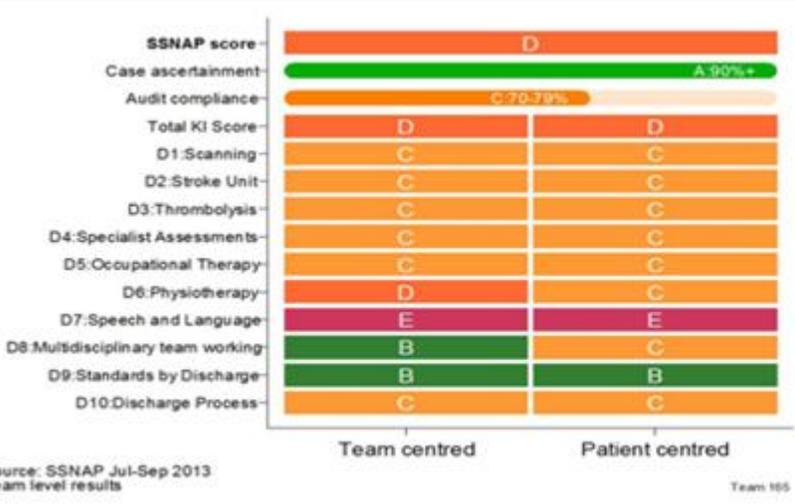
Each participating Trust is given an overall SSNAP score (a banding from A to E). HDFT has been assigned an overall rating of D this quarter, compared to E last quarter. As can be seen in the chart below, only 15% of participating Trusts scored a rating of A to C. Out of 178 trusts who submitted data this quarter, none scored in the highest band of A, eight scored B, 19 scored C, 74 scored D and 77 scored E. All trusts in the Yorkshire & Humber region scored either D or E.

100% of eligible patients were thrombolysed during the period and the number of patients scanned within one hour continues to improve (from 41% for the previous two quarters) and was 45% for the most recently published SSNAP data, which related to July – September 2013, compared to a national average of 41%.

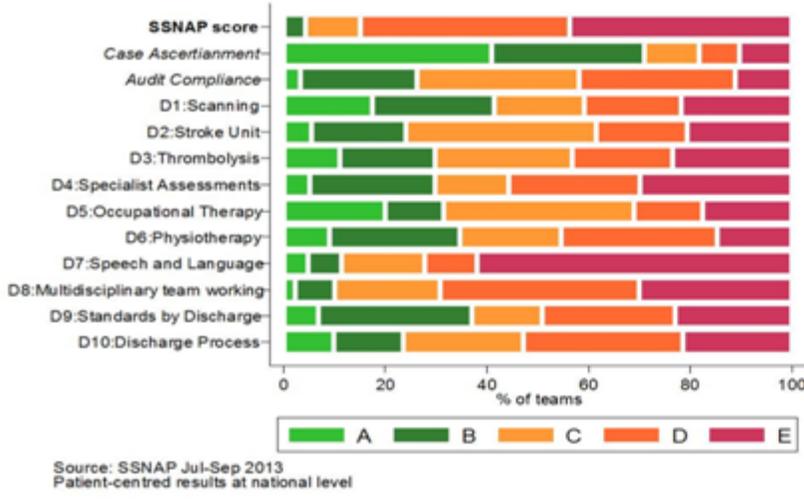
The Trust continues to perform better than average on the number of patients spending more than 90% of their time on an appropriate stroke ward. The Trust also scores significantly better than average for the “discharge processes” indicator section.

However, despite significant improvements in thrombolysis rates, the Trust still performed worse than average on the number of patients thrombolysed within one hour. It is anticipated that the introduction, from September 2013, of the Stroke Specialist Nurse attending the Emergency Department for every stroke patient will contribute to improving this position going forwards.

HDFT performs particularly well on the two domains (D9 and D10) related to discharge. The lowest scoring domain for HDFT is D7 – Speech and Language, which relates to Speech and Language Therapy input during the inpatient stay. In response to this, the Speech and Language Therapy (SALT) input into stroke care will be reviewed over the next three months and on an ongoing basis as part of the Stroke Peer Review process, with a view to improving care for patients and performance against the SALT related metrics in the SSNAP dataset. This is also the worst scoring domain nationally with 62% of teams scoring the lowest rating of E.



Scores for HDFT



National distribution of scores

The Stroke Steering Group has agreed on key indicators to focus on in their work programme, based on the SSNAP indicators where HDFT performed worse than the national average. These include time to thrombolysis, time to scan and improving multi-disciplinary team involvement and approach to Early Supported Discharge. Improvement will be monitored via the Stroke Steering Group and performance on the key indicators will also form part of the performance framework reported to the Trust's Board on a monthly basis in 2014/15.

## 2. End of life care

### End of life care provision

Over the last year, the Trust has made a number of changes to improve the care provided to patients in hospital at the end of their life. Working in partnership with Saint Michael's Hospice it has invested in the specialist Palliative Care Consultants team to increase their availability to provide support within the hospital. It has also expanded the role of the End of Life Care Facilitator. This is a dedicated Specialist Nurse role, designed to provide support for the ward clinical teams, patients and their families, as they make choices about how they are cared for at the end of their lives.

In addition to supporting patients, the End of Life Care Facilitator is also available on the wards to assist nursing, medical and caring staff with advice and guidance around having difficult conversations, supporting decision making, symptom control, supporting staff advocacy and ensuring

accurate documentation is completed. They are part of the Saint Michael's Hospice Team and can help to signpost patients, carers and staff to seek expert specialist advice from other clinicians.

These changes were introduced in Autumn 2013 and are already producing positive results for patient care. Wards are working closely with the End of Life Facilitator and valuing the input and support that they receive. The increased presence on the wards is also providing the Trust's End of Life Steering Group with valuable qualitative information about opportunities for further improvement. Whilst progress has been good, there are still some improvements to be made which the Steering Group is addressing.

The Trust continues to develop its systems and processes to support effective end of life care across all of the services it provides. This year, it has updated its End of Life Care Pathway for patients cared for by the Community Nursing Team and completed a comprehensive training programme to support the use of the pathway. The Community Nursing teams are often involving in supporting patients in their own homes at the end of their life and the introduction of this improved pathway will further strengthen the quality of care this team provides.

The Trust is continually looking for ways to improve the care it provides and learn more about areas its patients and their carers believe it can improve. This year, it completed its first bereavement survey and is extremely appreciative of the valuable information received from families who had lost a loved one, but were willing to give feedback on their experiences. Overall, the families told the Trust that the care and support provided at the end of their relatives life was good. However, they did highlight some areas where they believed that the care could be improved. These areas included communication about services available to the families, communications about what to expect of the dying process and providing a consistent approach to symptom control. The Trust has developed an information sheet summarising the services available to families and believes that the additional training and support it has invested into ward teams will start to address the other issues.

The Trust has also participated in the Royal College of Physicians National Care of the Dying Survey, which is due to report in April 2014. This involved an organisational audit of staffing and facilities, a case note audit to review decision making and quality of care provided, and a bereavement survey. The Trust expects that this will provide it with valuable benchmarking information about the services it provides and help to identify further areas to develop and improve. Following a review of the results of this survey, the Trust will then plan its next bereavement survey to help to understand if the changes that have been introduced over the past year have made the positive impact it believes that they have.

The work on this quality priority will continue in 2014/15. The Trust has already planned training programmes for its medical teams, is developing the Advance Care Plan and looking at how it can effectively use national frameworks to support patients and staff. Both HDFT and St Michael's Hospice have recently made further investments into the Specialist Palliative Care team and the Trust will be working closely with all its partner agencies over the coming year to continue to improve the care that it provides to patients at the end of their life.

#### Promoting good resuscitation decision making

Cardio pulmonary resuscitation (CPR) could be attempted on any individual in whom cardiac or respiratory function ceases. Such events are inevitable as part of dying and thus, theoretically, CPR could be used on every person prior to death. It is therefore essential to identify patients for whom CPR is inappropriate, or who have requested that CPR is not attempted at the end of their life, in order to ensure dignity, quality of care and patient choice. This involves sensitive and skilled communication with patients and their families. The decision making is documented on a "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) form. The regional DNACPR form was implemented in 2011, supported by a local DNACPR policy.

Initially completion of this form was poor, and a considerable amount of education and support has been invested in ensuring adherence to the policy. The results below demonstrate that considerable headway has been made in improving standards, yet there is still some progress to be made to ensure the Trust provides the best quality care in respect of resuscitation decision making to all patients.

The data below presents the results of quarterly audits undertaken on all adult wards on the Harrogate District Hospital site, Lascelles Unit and Ripon Community Hospital on a single day in the month specified, to determine if patient case notes contained a DNACPR form. Each form is reviewed against specified standards. All forms are reviewed three weeks later following the first stage of the audit to record any changes made to the form. The audit is conducted quarterly and yields a sample size of between 37-56 forms.

	Objectives	Standards	2014 (March)	2013 (Dec)	2013 (Sep)	2013 (July)	2013 (March)
1.	DNACPR orders are filed correctly at the front of the notes.	100%	<b>96%</b>	96%	100%	90%	100%
2.	DNACPR orders completed by a Non-Consultant grade should be endorsed by a Consultant within 24 hours	100%	<b>61%</b>	68%	64%	43%	47%
3.	DNACPR orders contained adequate patients demographics identified as three unique identifiers	100%	<b>100%</b>	100%	100%	98%	100%
4.	DNACPR order contains relatives details in full.	100%	<b>77%</b>	71%	38%	43%	35%
5.	All DNACPR forms must have at least one of the boxes ticked in Section one (Reason for DNACPR).	100%	<b>100%</b>	100%	100%	100%	100%
6	Indication on the DNACPR form that this has been discussed with patient/ and/or relevant others.	100%	<b>72%</b>	90%	56%	77%	52%
7.	Documentation in the notes regarding DNACPR order	100%	<b>Not audited</b>	86%	90%	86%	62%
8.	Review section on DNACPR form must be completed	100%	<b>60%</b>	77%	33%	25%	10%
9.	Discharged patients had the DNACPR form correctly sent home.	100%	<b>73%</b>	90%	93%	81%	81%
10	Section must be complete. (Print, Sign, Designation, Date, Organisation)	100%	<b>79%</b>	83%	50%	75%	56%
11	The form must be completed in full. * Includes review section (new addition to audit)	100%	<b>37%</b>	48%	18%	12%	* 0%

Data Source: HDFT

The areas currently being focussed upon are:

- Ensuring forms are endorsed by a Consultant within 24 hours;
- Ensuring communication regarding the DNACPR process is shared with the patient and/or their relatives;
- Ensuring review dates are recorded;
- Ensuring appropriate discharge processes.

An action plan detailing a number of initiatives to improve standards has been produced. These actions include:

- Notification to the Consultant in charge of the patient's care if any gaps in DNACPR form completion are identified at audit, with a request for the case to be reviewed and a rationale provided for incomplete form completion. This notification is copied to the Medical Director.
- Widespread publication of audit results and education at nursing and medical forums.
- Ensuring time allocation on junior doctors induction to discuss DNACPR.
- Placing of folders on all wards that contain helpful information on how to complete DNACPR forms and a frequently asked questions sheet.
- Addition of DNACPR as a topic on all Resuscitation Council (UK) Immediate Life Support courses (Intermediate level).

It is hoped that, with these actions, the standards relating to DNACPR decision making will continue to rise, giving patients and their families confidence that this is a transparent process that will play an important part in facilitating a peaceful and natural death.

### 3. Endoscopy – Histopathology Specimen Pathway

The Trust has a developing programme of rapid process improvement workshops which can potentially cover any aspect of the Trust's services. A recent workshop relating to the processing of tissue samples from the Endoscopy Unit has taken place. This workshop was held on 10-14 March 2014. The purpose of this workshop was to:

- Improve the flow of samples from Endoscopy through to the Histopathology Department;
- Reduce duplication between manual and IT-based reporting systems;
- Reduce the other repetition in the work processes.

Before the workshop, samples from Endoscopy were sent in batches at the end of clinics. This meant that there were issues with the timeliness of transportation of samples, and some samples missed overnight processing in the laboratory causing 24 hour delays. 16% of samples contained errors.

The laboratory had lean processes already in place, but there were lots of ideas from colleagues during the workshop on how to improve further.

An efficient process was sought to ensure samples got to Histopathology in smaller batches (four to five patients) throughout the day, for same day processing, and therefore earlier availability of results. A trial of a webcam at the front desk was put in place. The webcam was placed above the collection tray and once small batches of samples were ready, a "ready to go" sign was placed over them. Porters regularly checked the webcam and arranged collection when the sign was in place. The webcam alert for rapid transportation of samples cut delays by 60%.

In Endoscopy, multiple checks have been replaced with one effective check; this has not only saved time but reduced the error rate to 0%.

Future rapid process improvement work will be delivered according to priorities agreed in the Trust's first Improvement Strategy, due for authorisation early in 2014/15.

## Patient Experience

### 1. Outpatient waiting times

An improvement event was held on the 11-13 December 2013. Members of the team were tasked with looking at improving outpatient flow throughout the hospital. The aims were to:

- Improve the quality of contact with patients before their outpatient appointments;
- Improve the patient experience in the department by improving the quality of information for patients using visual controls and reducing waiting times at the main outpatient reception desks;
- Improve follow-up of patients after the appointment.

Before the event, it was observed that patients would often queue at the wrong reception desk before being directed to the right place where they would have to join another queue. The signage in the main reception was cluttered and confusing, leading to some patients becoming lost in the hospital. This negative experience was the result of unclear signage and instructions. The appointment letters to patients were found to be complicated with too much information. Vital clinic information was often missed by patients, resulting in them not preparing correctly for their appointment.



Since the event, key departments along the main corridor have been given colour coded boxes outside their entrances. This enables staff to give clear instructions to patients to enable them to easily locate departments. Volunteers at the front of the hospital are now wearing red polo tops that make them more visible to patients.

Around 40 signs have been removed from the reception area and this has opened up the space. Direction enquiries were monitored by General Office staff and volunteers before and after the signs were removed. The reduction in signage did not increase the level of enquiries from patients and visitors, but did improve patient speed through departments. It has been identified that all departments in the main corridor would benefit from this system, so work is on-going to colour code a number of other areas. New maps to support the colour coding system are being planned. Clearer, more concise appointment letters with essential self-preparation and self-care information at the top of the letter have been introduced. Smaller appointment cards are also to be introduced.

The information packs being sent to patients attending outpatient clinics have been streamlined:

- MRSA infection information sheets will no longer be sent and patients with MRSA will be communicated with directly;
- The blue patient information leaflet will no longer be included, as it was felt the majority of the information is not relevant;
- Large coloured maps of the hospital site will no longer be included with the outpatient letter.

Specific work undertaken in one Urology clinic has led to an average reduction of 90 minutes waiting time for each patient seen in the clinic. The reduction in waiting time has freed up one clinical room session per week and one member of the nursing staff per week.

Next Steps

To take the learning from the event and the improvements made within the Urology clinic, and look for opportunities in other clinics to improve patient flow and patient experience.

2. Dementia care

The Trust’s strategic approach to the care of confused patients, including people with dementia, has been recently reviewed and revised.

The Dementia Steering Group has been replaced by a smaller steering group that meets monthly and a wider reference group that will meet around four times per year. The steering group is now called the Care of Confused Patients and Dementia Steering Group. The aim of the Steering Group is to provide leadership and direction for the care of people with acute confusion, including dementia and delirium, and their families and/or carers, to ensure they have a positive experience of high-quality, personalised care. This aim has been developed from a recognition that good quality care will be very similar for confused patients, regardless of their specific diagnosis.

A review of the existing dementia action plan has been undertaken and an approach proposed to simplify the planning process by maintaining a single corporate action plan with fewer priorities.

As well as delivering work to address local concerns and support national standards in this area, the group will also help the Trust to engage with the public to help educate people about the role HDFT has in treating confused patients who may be anxious and whose behaviour may be unpredictable.

**National CQUIN for dementia**

Elements of the identification and management of people with dementia are defined by national CQUIN (commissioning for quality and innovation) indicators.

**a) Find, assess, investigate and refer**

The table below shows performance during 2013/4. All domains show performance above the target of 90%. Encouragingly, the figures show that everyone who is found to have dementia and is eligible for a full diagnostic assessment and subsequent specialist referral, receives this assessment and referral.

<b>Performance Indicator Description</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>
Dementia screening - % eligible patients screened within 72 hours of admission (FIND)	93.5%	92.2%	93.1%
Dementia screening - % eligible patients having a full diagnostic assessment for dementia (ASSESS/INVESTIGATE)	100%	100%	100%
Dementia screening - % eligible patients referred on for specialist assessment (REFER)	100%	100%	100%

Data Source: HDFT

## **b) Clinical leadership and training for staff**

The Trust has an established and experienced Consultant in Elderly Medicine providing clinical leadership for older people and dementia. An initial training plan for dementia identified types and frequency of training that is suitable for different clinical and non-clinical staff. The aims of the Trust's approach to training were:

- To employ an Older Persons' Champion to work with the Clinical Lead for Older People to co-ordinate and deliver training;
- To assess opportunities for participation in regional training;
- To promote the use of the Butterfly Scheme, which aims to improve the safety and well-being of people with dementia (or any kind of memory problems) during their hospital stay, with a focus on engagement with nursing colleagues;
- To promote an e-learning module and invest time in the development of an improved package that better meets the identified training needs of the workforce;
- To revise and re-launch an up-to-date day-long training course about the care of patients with dementia and confused behaviour;
- To encourage and support participation in rapid process improvement workshops.

Training of staff regarding caring for patients with dementia during 2013/14 has included:

- 107 people during the year received training relating to the use of the dementia Butterfly Scheme;
- 11 people during the year completed the dementia e-learning package to raise their awareness of issues surrounding dementia;
- 12 people during the year participated in a day-long course about the care of patients with dementia and confused behaviour. The course covered legal issues, safeguarding, the effects of dementia and how the condition affects the patient and others, as well as a range of case studies covering hospital absconding, nutrition, hydration and other key factors;
- The Older Persons' Champion has worked with the Mental Health Liaison Nurse to make a number of personalised advice/informal training interventions which have provided bespoke learning opportunities;
- Staff from Byland and Jervaulx Wards have been trained in the delivery of rapid process improvements through their participation in the Harrogate Dementia Collaborative.

Intelligence and insight gained from the Older Persons' Champion's work with colleagues in acute settings has led to the preparation of a more detailed training plan for 2014/15.

## **c) Supporting carers of people with dementia**

Interviews of carers of people with dementia have been carried out during the year. It has been a significant challenge for those undertaking the interviews to access carers or relatives at the right time when they are visiting the hospital.

The majority of relatives to some degree felt involved in the planning of care for their family member while they were in hospital, and were asked about personal routines and preferences.

Over 70% were asked to help complete the "All About Me" form, which assists staff in delivering patient centred care. However, there was limited knowledge or awareness of it being fully utilised and one family had to ask for the form.

A leaflet about the Butterfly Scheme is available on the wards, but only 14% of relatives were given any written information about the scheme.

One of the carers reported that whilst they were not offered the Butterfly Scheme, the symbol was automatically put at the bedside and the carer was reassured about the patient's care in hospital because of the Butterfly Scheme. Although planned dates for discharge were not consistently given for all patients, carers felt that they were up-to-date with current thinking when plans for discharge were progressing. Overall, interviewees did feel supported on the wards.

The methodology used to seek feedback from carers of patients with dementia needs to change and a mixed approach is being considered with face-to-face interviews, supplemented by asking carers for feedback by questionnaire, using paper forms or telephone follow-up following discharge. The possibility of involving experienced volunteers in this audit work, in order to generate more responses and, therefore, more meaningful results is also being explored.

The comments received include:

- *"Care delivered on the ward was wonderful";*
- *"Lack of therapy input";*
- *"Lack of continuity in communication as sees a different member of staff every time she visits";*
- *"Staff approaching patients did so in a way as to put the patient at ease, and placing items within reach or within sight".*

The audits have provided a lot of rich and detailed feedback, which will be used to focus future improvement work. In particular, areas for improvement are:

- to ensure that relatives and carers feel involved in their relative's plan of care and are kept informed of progress and changes;
- to ensure relatives and carers are encouraged and supported to share their expert knowledge of the patient with the ward staff so that delivery of care is patient centred and individualised to need.

Rapid process improvement work relating to the discharge of a patient with dementia and complex needs from hospital has already begun to address some of the identified issues.

#### **d) Participation in rapid process improvement work**

HDFT is a founding member of the Dementia Collaborative within Harrogate. The collaborative was established with the aim of improving service quality and experience for people living with dementia by:

- Establishing user-focused services able to meet the needs of an ageing population;
- Facilitating large-scale, cross-organisational change;
- Removing wasted time and adding value;
- Developing a sustainable platform for improvement.

As planned, HDFT has participated in and/or advised on ten rapid process improvement workshops benefiting people with dementia since July 2012:

1. Byland Ward: patient flow and experience;
2. Referral to mental health community services;
3. Movement of patients with dementia through the Emergency Department;

4. Standard assessments across health and social care community teams;
5. Reducing avoidable attendance at the Emergency Department from care homes;
6. Primary care dementia screening;
7. Domiciliary care referral;
8. Mental health hospital liaison;
9. The discharge of patients with dementia and complex needs from hospital;
10. Respite and support for carers of people with dementia.

Many and varied outputs have included:

- Development of a multi-agency community assessment to reduce duplication between community, mental health and social care assessments;
- Development of a minor injury process, designed to improve the flow of patients through the Emergency Department, with results showing the new approach shortens the visit by 47%;
- Development of a standard approach to managing residents' personal files in care homes (being implemented in five care homes in the Harrogate area) and improving communication and raising alerts. The expectation is to reduce the number of residents with dementia who visit the Emergency Department;
- Introduction of continuous flow to the process of managing referrals in mental health services for older people;
- Daily nurse ward rounds on some wards at visiting times to support patients and carers, combined with clearer and more visible patient and carer information;
- Jervaulx Ward has improved its multi-disciplinary team meetings to re-focus on "fit, ready and safe" discharge criteria to hasten discharge and reduce likelihood of readmission, which will bring particular benefits to patients with dementia.
- Improved patient experience, and carers and relatives who feel better informed;
- Hospital admissions avoided and shorter stays for people who are admitted.

The Harrogate Dementia Collaborative ends in its current format at the end of March 2014. The Collaborative Project Board is currently examining options for future delivery.

### Next Steps

The rationalisation and prioritisation of the dementia action plan will mean that HDFT will concentrate on making progress against fewer priorities next year, with particular emphasis on embedding the Butterfly scheme, developing the work of the Dementia Collaborative into a second phase, educating members of the public about the needs and rights of people with dementia, to help tackle the stigma surrounding the condition.

### 3. Patient feedback and Friends and Family Test

The Friends and Family Test (FFT) was implemented across the NHS during 2013. The FFT aims to ask a simple question which, when combined with follow up questions, provides a standardised mechanism to identify both good and bad performance and can be used to drive improvements in quality of care. This Trust implemented the FFT for inpatient wards and the Emergency Department in April 2013, building on an existing patient questionnaire that had been in use across its inpatient wards for some years.

A baseline combined response rate of 15% was expected by NHS England at the end of Q1, increasing to 20% by the end of Q4 2013/14, as part of the national CQUIN. In October 2013, the Maternity FFT was also fully implemented, which asked patients their views on the Maternity services at the following stages:

1. Antenatal care – to be surveyed at the 36 week antenatal appointment;
2. Birth – to be surveyed at discharge from the ward/birth unit/following a home birth;
3. Care on the postnatal ward – to be surveyed at discharge from the ward/birth unit/following a home birth;
4. Postnatal community care – to be surveyed at discharge from the care of the Community Midwifery team to the care of the Health Visitor/GP (usually at 10 days postnatal).

The FFT asks a standardised question: “How likely are you to recommend our ward/A&E (Emergency Department) department/maternity service to friends and family if they needed similar care or treatment?” The possible answers are: extremely likely; likely; neither likely nor unlikely; unlikely; extremely unlikely; don’t know.

There are currently three methodologies the Trust is using to meet the target response rate for FFT feedback: paper feedback forms, a token system used in the Emergency Department and telephone interviews to patients at home within 48 hours of discharge.

A net promoter score is used to enable consistent comparison across the NHS. It is calculated as follows:

Proportion of respondents who would be extremely likely to recommend (response category: “extremely likely”)	minus	Proportion of respondents who would not recommend (response categories: “neither likely nor unlikely”, “unlikely” and “extremely likely”)
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FFT results from the Emergency Department, inpatient wards and Maternity are included on the Quality and Safety Dashboard and these, and comments received, are shared widely throughout the organisation. The results are reviewed regularly by the Trust’s Performance Management Group. Individual areas are expected to use the results and comments to drive improvements, and the wards provide “you said – we did” updates on their noticeboards to highlight comments received and what actions are being taken.

Results

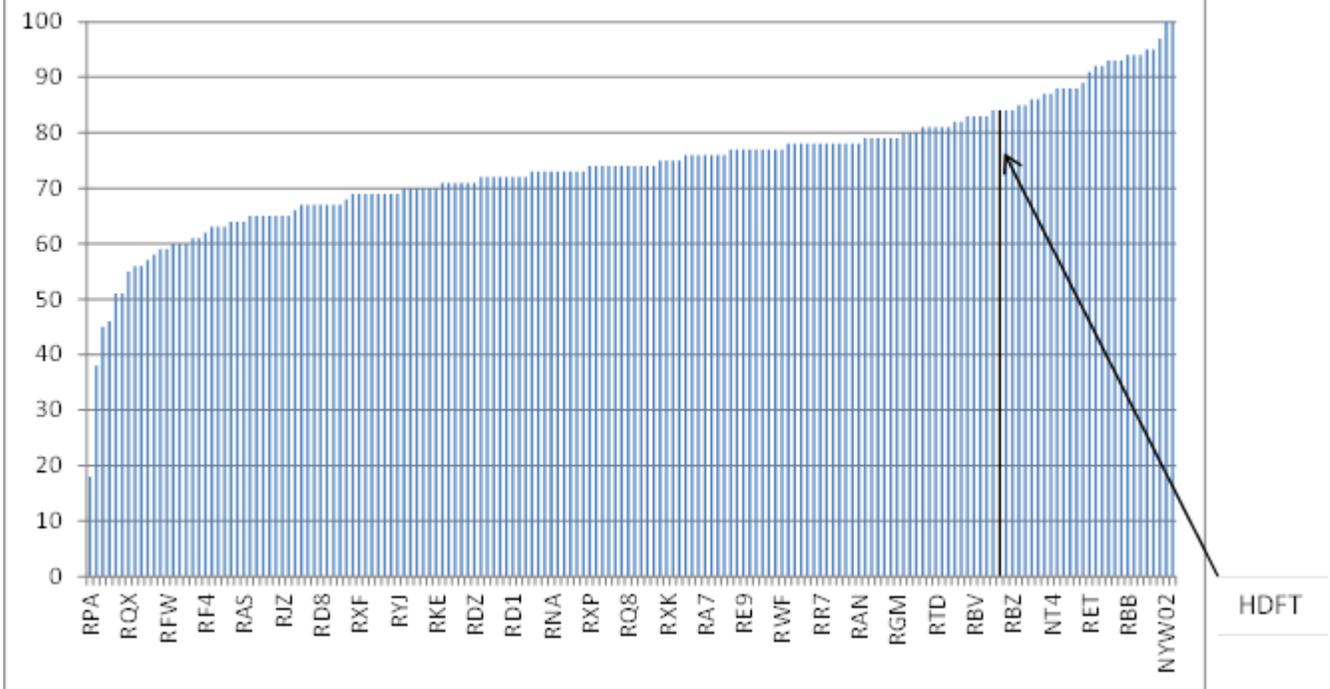
The table below shows the results for each quarter during 2013/14 for inpatient wards, A&E, combined inpatient wards and A&E, and the overall results for Maternity as well as antenatal care, birth, care on postnatal ward and postnatal community provision.

<b>Family and Friends Test Summary 2013/14</b>		<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>
<b>Inpatient Wards</b>	FFT Score	73	68	73	80
	Response Rate %	21.89%	36.23%	34.78%	36.25%
	No of Responses	705	1227	1156	1211
<b>A&amp;E</b>	FFT Score	69	56	59	60
	Response Rate %	15.32%	20.72%	16.85%	22.51%
	No of Responses	1078	1548	1140	1505
<b>Combined Wards and A&amp;E</b>	FFT Score	71	61	73	69
	Response Rate %	17.39%	25.55%	34.78%	27.09%
	No of Responses	1783	2775	2296	2716

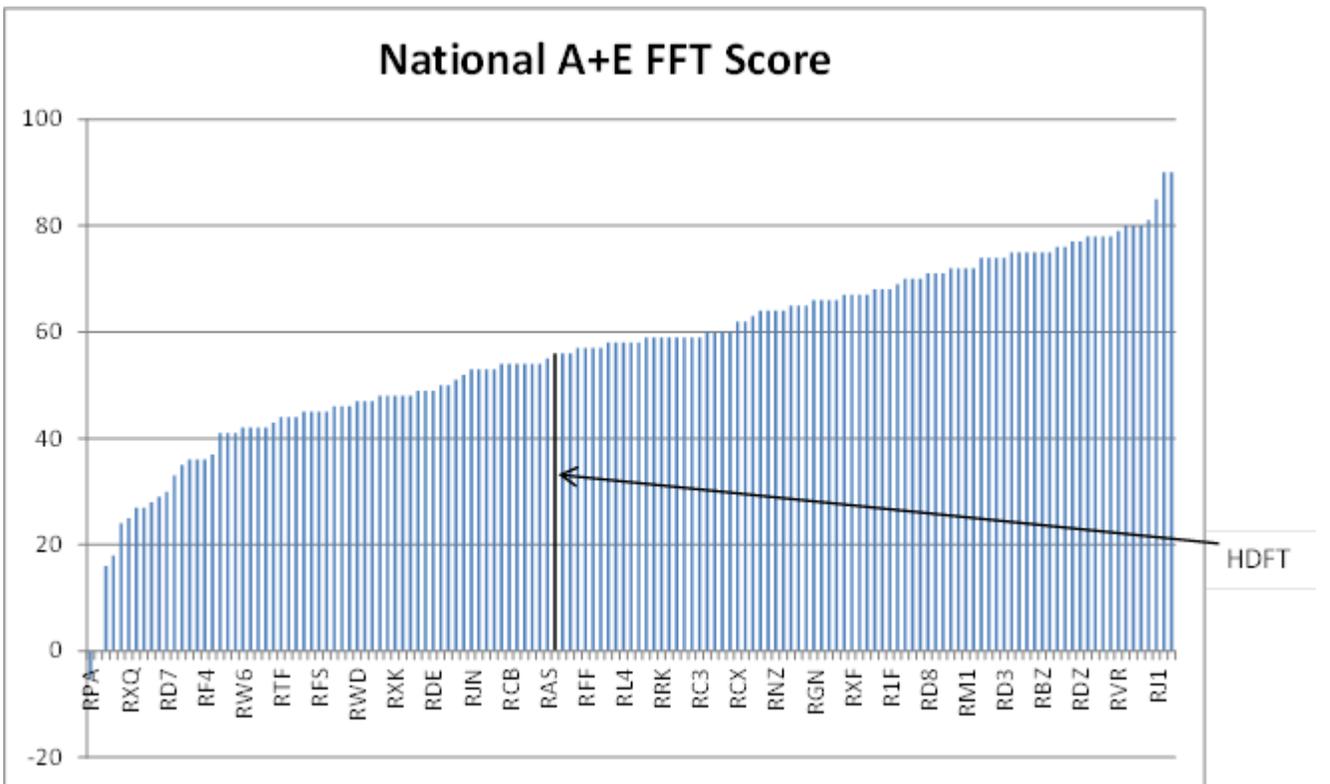
<b>Maternity (overall)</b>	FFT Score			85	88
	Response Rate %			16.90%	21.90%
	No of Responses			312	381
<b>Antenatal care</b>	FFT Score			73	78
	Response Rate %			17.50%	24.00%
	No of Responses			97	119
<b>Birth</b>	FFT Score			94	94
	Response Rate %			20.80%	20.50%
	No of Responses			101	95
<b>Care on postnatal ward</b>	FFT Score			91	88
	Response Rate %			15.60%	21.30%
	No of Responses			76	99
<b>Postnatal community provision</b>	FFT Score			79	94
	Response Rate %			12.00%	21.40%
	No of Responses			38	68

The following graphs show the FFT score for eligible NHS Trusts for inpatient s and A&E in February 2014 (latest data) and the position of HDFT. The codes along the bottom axis are organisational codes for each trust providing acute services .

### National Inpatient FFT Score



### National A+E FFT Score



Data source: NHS England

<b>Friends &amp; Family Test - Patient</b>						
<b>Response rate</b>						
	Jan-14			Feb-14		
Month	Inpatient wards	A&E	Combined	Inpatient wards	A&E	Combined
HDFT value	30.3%	13.4%	19.3%	39.2%	29.6%	32.8%
National average	31.0%	17.4%	22.0%	34.0%	18.6%	23.8%
Highest value for any acute Trust	76.3%	52.4%	71.0%	78.9%	66.1%	73.1%
Lowest value for any acute Trust	10.9%	1.7%	6.1%	16.2%	1.5%	7.8%
<b>FFT score</b>						
	Jan-14			Feb-14		
Month	Inpatient wards	A&E	Combined	Inpatient wards	A&E	Combined
HDFT value	79	61	71	84	56	67
National average	72	57	64	72	55	63
Highest value for any acute Trust	97	92	97	94	90	94
Lowest value for any acute Trust	27	0	10	18	-5	4
England figures exclude independent providers						
Note - data updates are published monthly.						
Mar-14 data due to be published end May-14						
<a href="http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/">http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/</a>						

In 2014/15, there is a target response rate for inpatients of 30% and ED of 20% by Q4. In addition, the FFT is to be extended to other services, which will require the implementation of different methodologies within HDFT. The Quality of Experience Group is to start reviewing all feedback from the FFT to identify any trends and opportunities for additional learning and improvement.

### Performance against key national priorities including indicators and performance thresholds in the framework

The following table demonstrates HDFT's performance against the indicators in Monitor's Compliance and Risk Assessment Frameworks for each quarter in 2013/14.

Indicator description	Target	Q1	Q2	Q3	Q4 (provisional)
RTT admitted pathways (% within 18 weeks)	>=90%	93.6%	95.2%	94.8%	93.8%
RTT non-admitted pathways (% within 18 weeks)	>=95%	97.8%	98.0%	97.8%	97.4%
RTT incomplete pathways (% within 18 weeks)	>=92%	97.0%	97.6%	97.8%	97.1%
A&E: Total time spent in A&E	>=95%	97.9%	97.5%	96.8%	96.8%
Cancer - Maximum waiting time or 14 days from urgent GP ref to date first seen for all urgent suspect cancer referrals (%)*	>=93%	98.9%	99.2%	99.4%	99.5%
Cancer - maximum waiting time of 14-days for symptomatic breast patients (cancer not initially suspected)*	>=93%	97.0%	98.6%	96.8%	97.1%
Cancer - 31 day wait for second or subsequent treatment: Surgery*	>=94%	100.0%	96.6%	100.0%	100.0%
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug*	>=98%	100.0%	100.0%	100.0%	100.0%
Cancer - 31 day wait for second or subsequent treatment: Radiotherapy*	>=94%	NA	NA	NA	NA
Cancer - Maximum waiting time of 31 days from diagnosis to treatment for all cancers (%)*	>=96%	100.0%	99.6%	100.0%	100.0%
Cancer - 62 day wait for first treatment from urgent GP ref to treatment: all cancers*	>=85%	93.4%	91.2%	91.0%	91.6%
Cancer - 62 day wait for first treatment from consultant screening service referral: all cancers*	>=90%	92.9%	92.6%	91.2%	94.4%
C-Difficile	<= 11 cases in year	3	2	6	3 (*)
Community services data completeness - RTT information	>=50%	79.8%	80.7%	82.3%	81.9%
Community services data completeness - Referral information	>=50%	70.0%	70.8%	73.7%	70.8%
Community services data completeness - Treatment activity information	>=50%	78.5%	82.1%	85.5%	84.2%

## Performance summary of 2013/14

- Provisional data indicates that the Trust has achieved all 18 week and Cancer waiting times standards in March with performance at 100% for six of the eight applicable cancer standards. The Trust has therefore achieved all 18 week and cancer waiting times standards for all quarters of 2013/14.
- One case of hospital acquired C-Difficile were reported in March which means the total for 2013/14 is 14 cases of C-Difficile against an annual trajectory of 11. One of these cases is subject to an appeal which has been flagged with NHS England.
- No cases of hospital acquired MRSA were reported in March which means the year-to-date total remains at one reported case.
- The Trust reported two mixed sex accommodation breaches in 2013/14. These occurred in February during a period of significant bed pressures within the medical specialties.
- The Trust's four hour performance was above the 95% standard in March. Throughout 2013/14, 97.3% of patients spent less than four hours in the Trust's Emergency Department (ED)/ Minor Injury Units(MIUs). Performance at Harrogate ED was above the 95% standard for 9 out of 12 months during 2013/14.
- The number of Health Visitors in post at end March was 96.2wte, which is below the end year target level of 96.5wte, but above the 2012/13 outturn. 2wte staff are due to start in April and further posts are currently out for recruitment.
- The Trust continues to consistently achieve all three dementia screening performance indicators. All eligible patients have received a full diagnostic assessment and onward referral for specialist advice / follow-up in 2013/14 and throughout the year, 93% of eligible patients have been screened within 72 hours of admission.
- The TIA standard (urgent referrals to be seen and treated within 24 hours) was above the 60% national standard in 11 out of 12 months during 2013/14. This is a significant improvement on the performance in 2012/13, but the Trust will continue to strive to improve the performance further. Provisional data suggests that the stroke performance standard (the percentage of stroke patients who spend over 90% of their stay on the stroke unit) was at 86.8% at year end and has been above the national standard of 80% throughout 2013/14.
- HDFT's Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Mortality Index (SHMI) for the most recently available 12 months both remain within expected levels.

## **Other quality information**

HDFT has identified additional elements of service quality to highlight in this Quality Account.

### Quality inspections and accreditation

In 2013, HDFT was identified in the first wave of inspections announced by the Care Quality Commission using its new inspection regime. The Trust was identified as a low risk organisation prior to the inspection.

The inspection took place within Harrogate District Hospital only, not within the community services, and consisted of a two day announced inspection and an unannounced inspection ten days later that took place at night.

There were 32 inspectors involved in the process and it was a detailed inspection which included many staff members, Governors and a public consultation.

The outcome of the inspection was positive, and the resulting report identified that the hospital was safe, effective, caring, responsive and well led. There were some areas for improvement identified. The conclusion of the inspection report stated:

“Harrogate District Hospital is the main acute hospital managed by Harrogate and District NHS Foundation Trust. It has 396 beds, a 24-hour A&E, maternity and children’s departments, and a range of other services. It serves the population of Harrogate, parts of North Yorkshire, York and North and West Leeds. The trust employs more than 3,500 staff and has a budget of £175 million.

Overall, Harrogate District Hospital provided care that was safe, effective, caring, responsive and well-led. The hospital was clean and it had systems in place for infection control.

However, there were some areas, in terms of being safe, effective and responsive, that the trust could improve. Staffing levels in some areas, particularly in the care of older people, meant that although staff were keeping patients safe and meeting their needs, they were not at times able to do so promptly. Pain control on some surgical wards was not always effective. Some patients we talked to did not feel that their pain was effectively controlled. The completion of ‘do not attempt cardio pulmonary resuscitation’ (DNACPR) records in end of life care was not consistent. The trust’s thresholds for reporting serious incidents were not comparable with most trusts.

There were some areas of good practice. These included the way in which the trust valued and used volunteers, and the use of telemedicine in patient care”.

In response to the report, the Trust has implemented actions to address the areas for improvement and is regularly reporting on progress against the actions to the Care Quality Commission.

The Trust was successful in achieving Level 2 of the NHS Litigation Authority (NHSLA) Risk Management Standards for Maternity Services in September 2013 with a score of 48/50 standards. This is a significant achievement.

#### Key staff survey results 2013 and comparison with 2012

Every autumn, the Trust participates in the NHS annual staff survey. The results are published nationally and can be obtained from the national NHS staff survey web site.

In 2012, HDFT was in the best 20% of Acute Trusts in the country for 11 key findings. This represented 39.3% of the total key findings. In 2013, HDFT improved upon this record achieving 13 key findings in the best 20% of Acute Trusts, which represented 46% of the total key findings.

The Trust had one key finding that fell into the bottom 20% of Acute Trusts. This related to staff receiving job relevant training, learning or development in the last 12 months and equated to 3.6% of the staff survey’s key findings.

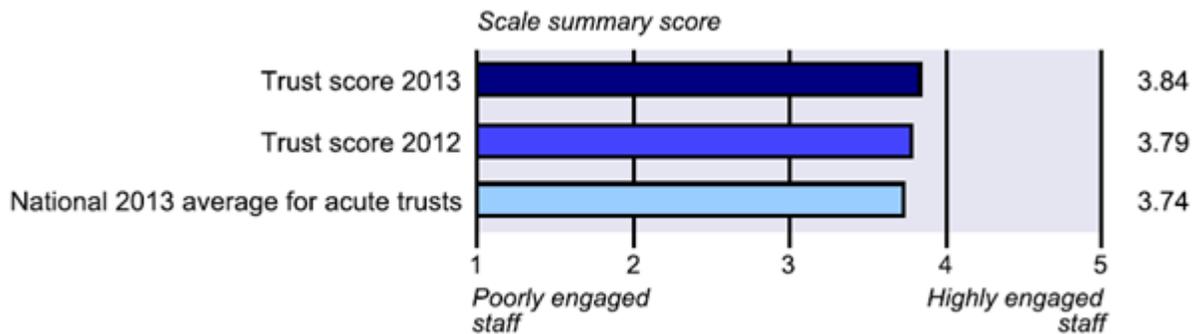
The following 9 key findings have placed the Trust in the ‘best 20%’ for the past two consecutive years:

- Staff suffering work-related stress in last 12 months (low score);
- Staff witnessing potentially harmful errors, near misses or incidents in last 12 months (low score);

- Staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (low score);
- Staff experiencing harassment, bullying or abuse from staff in last 12 months (low score);
- Staff believing the Trust provides equal opportunities for career progression or promotion;
- Staff experiencing discrimination at work in last 12 months (low score);
- Staff job satisfaction;
- Staff recommendation of the Trust as a place to work or receive treatment;
- Staff motivation at work.

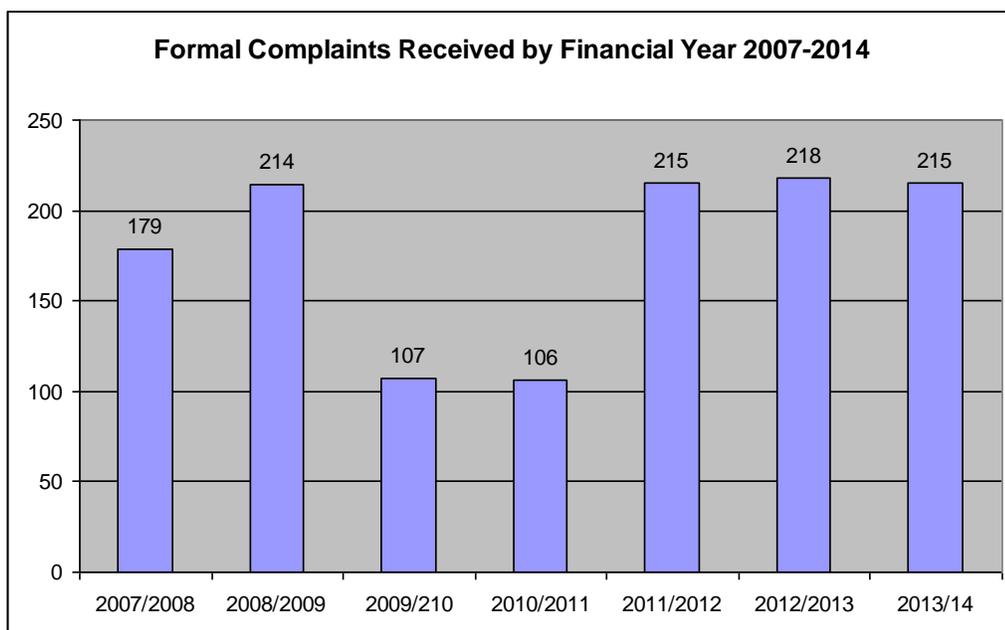
Overall Staff Engagement

For comparative purposes, the table below demonstrates the Trust performance in relation to overall staff engagement. Overall staff engagement comprises three key findings: staff members’ perceived ability to contribute to improvements at work; their willingness to recommend the Trust as a place to work or receive treatment, and the extent to which they feel motivated and engaged with their work.



Formal and informal complaints and compliments

Results- Formal Complaints and Informal “PALS” Type Contacts



Data source is local patient feedback data

The data from April 2007 to March 2011 refers only to acute hospital services and from April 2011, the data represents both acute and community services following the integration of community services into the Trust. The Trust increased in size associated with the delivery of a significant number of new services.

The Trust introduced a detailed grading matrix for negative feedback during 2011, which is based on severity of concerns and timescales for response. This includes four levels of formal complaint (green, yellow, amber and red). The breakdown of complaints received in 2013/14 is presented below by grade and quarter in which it was received.

	2013/14					2012/13
	Q1	Q2	Q3	Q4	Total	Total
<b>Complaints Total</b>	<b>57</b>	<b>47</b>	<b>54</b>	<b>57</b>	<b>215</b>	218
Complaint Green	40	29	23	37	129	127
Complaint Yellow	17	17	29	19	82	83
Complaint Amber	0	1	2	1	4	8
Complaint Red	0	0	0	0	0	0

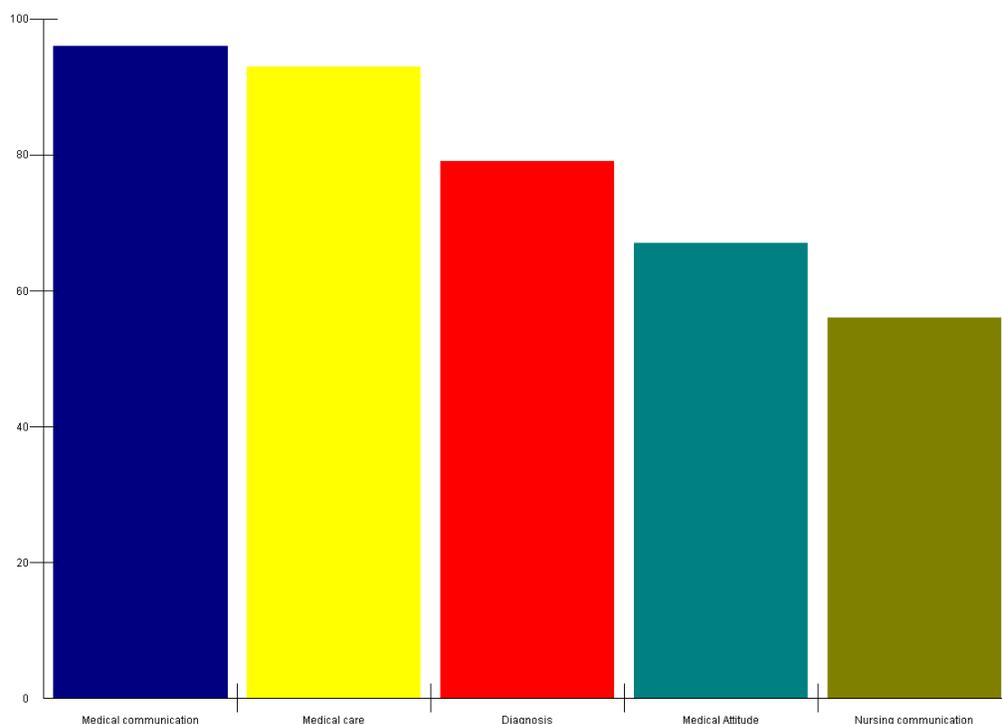
Data source is local patient feedback data

The number of complaints received is similar to the previous year and the number of cases graded as low level (green) and moderate (yellow) are similar. The number of high level (amber) cases has reduced in comparison to last year. The numbers of cases received has been consistent across three quarters but there was a reduction in complaints in Quarter 2. During Quarter 2 slightly more contacts were made informally.

In addition, the Trust handles informal "PALS" (Patient Advice and Liaison Service) type contacts, which includes concerns, information requests and comments. In total in 2013/14, 745 were received compared to 762 in last year's report for 2012/13. Of these 745, 408 were concerns, 106 were requests for information and 231 were comments. Although less in overall number this year compared with 2012/13, the data demonstrates a fall in the number of comments compared with 2012/13 and an increase in the number of concerns.

The top five themes for complaints and concerns can be seen in the graph below. The main themes have consistently included issues around aspects of medical care, including diagnosis, medical and nursing communication and attitude of medical staff. Nursing care was highlighted as a theme in the top five for 2012/13 and although it does not feature in the top five issues for 2103/14, nursing communication is now in the top five.

Complaints and Concerns by Top 5 Sub-Subject 2013/2014



It should be noted that not all complaints / concerns received are upheld. Action plans are developed to improve patient care as a result of feedback and these are monitored regularly. In response to the communication concerns, the Trust provides a communications and customer care training programme, “Every Patient, Every Time”, described elsewhere in this report.

Nine cases were referred to the Health Service Ombudsman in the period (compared to seven last year). Out of the nine cases:

- Two have been closed with no further investigation or action
- Four have been investigated of which three have been found to be upheld and actions requested, one was not upheld
- one is currently being investigated
- two are awaiting consideration for investigation

Of the three that were found to be upheld, in two cases compensation has been paid to the complainant following the Ombudsman’s recommendation, and in one case the Trust has written to the complainant with an update on the actions taken as a result of their complaint.

Results- Compliments

	2009/10	2010/11	2011/12	2012/13	2013/14
Compliments received by the Patient Experience Team, excluding to the media	233	354	354	291	330*

Data source is local patient feedback data. This data excludes all records of thanks received directly at ward and team level.

\* for 2013/14 289 records of thanks were reported via the local media compared to 331 in 2012/13.

### Care Quality Commission (CQC) Intelligent Monitoring Reports

As part of the CQC's new operating model, the Quality & Risk Profiles (QRPs) were replaced by "Intelligent Monitoring Reports" in Autumn 2013. CQC initially published a report for each trust in October, followed by an update in March 2014.

The reports include around 150 indicators and are used by CQC as part of the new inspection process to raise questions about the quality of care at acute trusts and were chosen by CQC to reflect the five key questions that they will ask of all services: are they safe, effective, caring, responsive and well led? For each indicator, Trusts are assessed as "no evidence of risk", "at risk" or "elevated risk". In addition, each Trust is given a banding from 1-6, where 1 indicates highest risk and 6 indicates lowest risk.

For the latest publication in March 2014, HDFT has no indicators assessed as either "elevated risk" or "at risk", out of 93 applicable indicators. This makes HDFT one of only six trusts nationally (two acute and four specialist trusts) with a zero risk score.

This is an improvement on HDFT's score in first reports published in October 2013 when HDFT had one indicator assessed as "elevated risk" and one indicator assessed as "risk" and the remaining applicable indicators assessed as "no evidence of risk".

### The Patient Voice Group (PVG)

The PVG comprises 14 lay members and one HDFT Governor, all of whom give a considerable amount of time voluntarily. The PVG looks at the quality of the patient care at the Trust with a view to both endorsing good practice and suggesting ways of enhancing the services. It performs the role of "critical friend". It responds to issues raised by the public and by PVG members, and will also undertake visits to a service at the request of the Trust. The PVG reports to the Chief Nurse as Patient and Public Involvement lead, and its reports and work programme are presented to the Quality of Experience Group (QEG). The group meets monthly, except for January and August, to work through the set work programme.

The PVG is *an independent group of volunteers*, which focuses on issues, not individual complaints, which are dealt with by the Trust's Patient Experience Team (PET). Information about the work of the PVG and its written reports, together with the Trust's responses to its recommendations, can be found on the Trust website for all to read.

The group has more recently also undertaken new developments including *visits to community services*. When making visits, members look at quality issues including patient care, communications, privacy and dignity and safety for patients. The PVG written report format is guided by the Care Quality Commission's new domains for assessing the quality of patient care: effective care, responsive to patients needs, being safe, being well-led.

#### 1. PVG monitoring of the care of inpatients in 2013

During this year, the PVG members focussed their work on the inpatient wards and undertook to visit and monitor developments and good practice in all the HDFT hospital wards as a priority. This involved two members of the group researching the ward to be visited, talking to the ward manager,

staff and especially the patients and having a ward look around. Following this, the members compiled a detailed report which included some recommendations and suggestions.

More recently, views from patients by telephone once they are at home have been sought as this is felt to give patients the opportunity to provide more reflective feedback for the Trust. The PVG ward reports were then sent to the Operational Director of the relevant Directorate, the appropriate Ward Manager, the Chief Nurse and the Chairman of the Trust. Responses to the report and the recommendations were sought and received from the Trust using a template set up by the group for each report.

## 2. PVG involvement in other Trust matters

During 2013, the Trust asked PVG members to be involved in: the Protected Mealtime survey; the Diabetics audit; the Discharge telephone survey, and the Chronic Pain Relief Clinic patient satisfaction telephone survey. Several workshops organised by the Trust had PVG representation including: end of life; outpatient appointments/reception; CQC Consultation; dementia collaborative and meeting with Matrons, and the development of the end of life leaflet.

The group provided posters for the Trust Open Event. Training for the new annual PLACE inspections also took place, and a PVG member attends the monthly internal PEAT, now called PLACE, which inspects wards and hospital environments.

In line with HDFT's priority for enhancing the care of the elderly and the confused patient, the PVG focused in 2013 on ensuring that care for older people and those with confusion is continually improving. A large project is to be developed during 2014 and pre - work for the PVG has included meetings with relevant Trust staff. This is in preparation for developing a PVG project to ensure that the voices of elderly and confused patients are heard when strategies and action plans are drawn up to enhance their care.

## 3. Key achievements for the quality of patient care in 2013

In addition to the implementation of a number of the PVG ward recommendations in their reports, there were two significant developments in 2013 resulting from PVG recommendations:

- An improvement in the quality of the Orthotics service for patients as the result of persistent PVG reports commenting on the need for more space for patients;
- The Phlebotomy service is looking at providing additional external space for patients, thus reducing the long queues in Phlebotomy within the hospital.

During 2013, members have endeavoured to speak to more patients at home via telephone calls and home visits to ensure patients provide honest and reflective views of services they received from HDFT services. It is generally felt that the experience of patients accessing HDFT services is very good. Those who did have concerns usually provided positive and helpful comments which were recorded in the reports. The work of the PVG overall endorses the Trust's emphasis on providing well-led and compassionate care of patients and on listening to the needs of its customers.

## 4. Future work programme, 2014

The PVG will continue to monitor areas already looked at in 2013, such as discharge, protected mealtimes, bed management, communication, care of the elderly. Several ward reports are due to be followed up to see whether the recommendations made in the reports have been implemented, e.g. reports on Children's ward, Byland, Oakdale, Farndale, Littondale, etc. The group will also be looking at some of the Community Services, including a follow up to their Community Nursing Report in 2012,

and will make a contribution of the patient perspective to the CCG/HDFT Review of Community Services.

The PVG is committed to working with the Trust in developing new ways of communicating with patients to ensure that a wide range of views from as many patients and relatives, where appropriate and possible, is achieved and reported on.

**Rosemary Marsh**  
**PVG Chair – April 2014**

Innovation work

As well as improvement work carried out as part of the Harrogate Dementia Collaborative and separately to improve outpatient flow, further rapid process improvement work has been carried out in antenatal care.

Antenatal Care Workshop

This improvement workshop was held on 10-14 March 2014, for members of the team to seek improvements in the delivery of care to patients through an evaluation of the current booking of patients and clinic model. Before the workshop there was an identified need for improvements in the quality of the service to improve safety, outcomes and people's personal experiences of the services. There was too much waiting time in antenatal care, some people were making too many visits to the service and there was no standard room layout in the clinics. The aims were to:

- Reduce the overall lead time by reducing waits;
- Increase the number of patients attending antenatal care who can attend a one stop service to avoid multiple visits;
- Develop standard work for staff;
- Standardise the layout of rooms;
- Improve patient confidentiality.

Following implementation of identified changes, there has been a significant reduction in the time patients spend at the clinic. Patients are now in the clinic for under an hour compared to 1 hour 41 minutes before the improvement work started. There have been some changes to the clinic timings, enabling the Sonographer to start earlier, which both improves patient flow and minimises delays for clinicians. There has also been an improvement in clinical appointment letters to make them easier for patients to understand. This is part of a corporate approach to improving outpatient letters.

De-cluttering has improved waiting areas and clinic layouts. A standard layout for the clinic rooms has been implemented, with everything removed that is not required. The store room has been de-cluttered and labelled making it easier to find equipment. Tighter stock control has saved £2,500 in stationery costs.



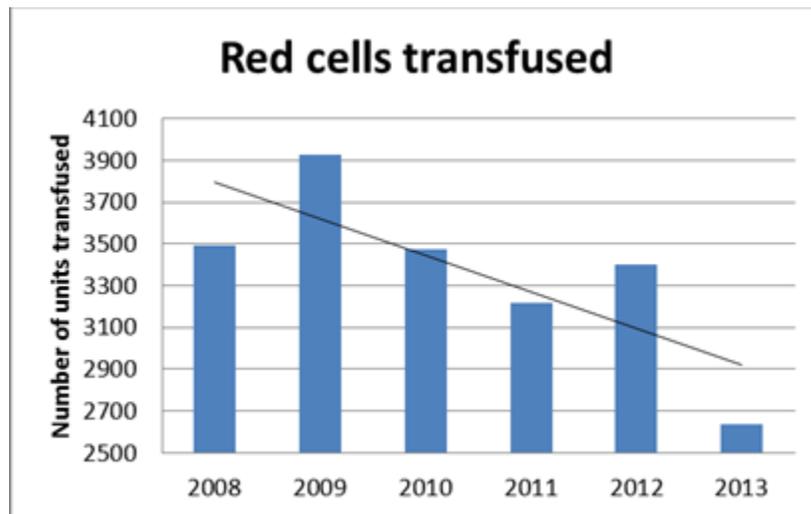
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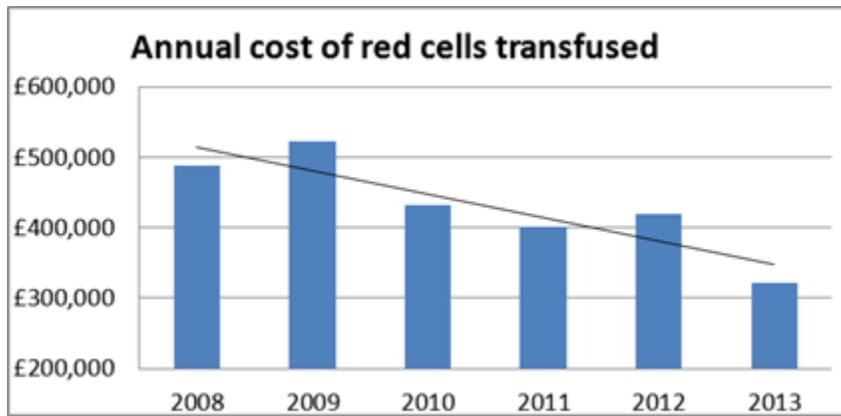
After

Review of annual red cell (blood transfusion) use 2008 – 2013

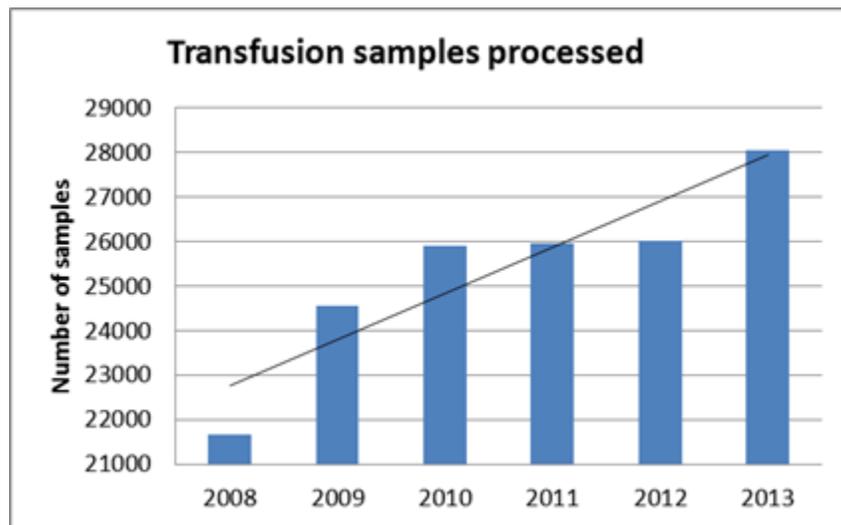
There has been a steady reduction of red cell use over the past six years (see chart below). This has been achieved by a number of strategies implemented in line with the Department of Health (DH) publications 'Better Blood Transfusion' in 2002, 2007 and 2009. Together with national guidelines produced by the British Committee for Standards in Haematology (BSCH) and Serious Hazards of Transfusion (SHOT), changes have enabled the reduction of blood transfused by implementing blood conservation strategies at a local level using accurate and informative data and guidelines to influence practice.



There have been considerable cost savings for the Trust (see chart below). This has led to a cumulative cost saving of £166,231 over the past six years, with a cost reduction of over £97,000 in the year 2013, compared with 2012.



These reductions in blood use have occurred despite the growth in activity in the transfusion department with a consistent increase in samples processed over the same period (see below). The increase in samples relates partially to increased activity in the Trust, but mostly because national guidelines now require two samples to be on the laboratory database before non-emergency blood products can be issued.



This achievement is only possible through the hard work and assistance of all staff involved in the transfusion process. This includes the Hospital Transfusion Team, the transfusion department staff and all the clinical staff either involved in making the decision to transfuse or administering the transfusion appropriately and safely.

## **ANNEX ONE: STATEMENTS FROM STAKEHOLDERS**

In accordance with the NHS Quality Accounts Regulations, Harrogate and District NHS Foundation Trust sent a copy of the draft Quality Account to its lead Clinical Commissioning Group, Harrogate and Rural District, Healthwatch North Yorkshire, North Yorkshire County Council Scrutiny of Health Committee, the Council of Governors and the Health and Wellbeing Board for comment prior to publication and received the following statements:

### NHS HARROGATE AND RURAL DISTRICT CLINICAL COMMISSIONING GROUP QUALITY ACCOUNT STATEMENT 2014

NHS Harrogate and Rural District Clinical Commissioning Group welcome the Quality Account and is pleased to note the progress detailed by HDFT in most areas. We look forward to continue to monitor progress with HDFT through the regular contract monitoring meetings.

### HEALTHWATCH NORTH YORKSHIRE QUALITY ACCOUNT STATEMENT 2014

Quality Account supplied for comment but no comment received.

### NORTH YORKSHIRE COUNTY COUNCIL SCRUTINY OF HEALTH COMMITTEE QUALITY ACCOUNT STATEMENT 2014

#### **Quality Account 2013/14**

Thank you for engaging with the North Yorkshire Scrutiny of Health Committee (SoHC) on the development of the Harrogate and District NHS Foundation Trust's Quality Account (QA) for 2013/14 and for giving the Committee an opportunity to comment on its final content.

Please accept this letter as the comments from the Committee.

The way in which the Trust has engaged with the Committee on the QA demonstrates that the Trust has entered into the spirit of QAs and welcomes Elected Members' contribution towards improving quality in terms patient safety, clinical effectiveness and patient experience.

With regard to the specific priorities for improvements in 2014/15, it is reassuring that fundamental care (including reducing the incidence of health care acquired pressure ulcers, fluid management, pain support, ward cleanliness and reducing falls) continue to feature strongly in the QA. Hospital discharge continues to be a focus for quality improvement. These aspects of care are those which patients and carers would regard as being key elements of patient experience.

We note the commitment to improve "transparency of information regarding nursing levels both actual and planned". We anticipate this will inform decisions regarding the deployment of nursing resources so that the priorities referred to in the previous paragraph will be taken forward. Indeed, without sufficient nursing resources these priorities will not be delivered and the need to review staffing levels in wards, particularly those caring for older people, was highlighted by the Care Quality Commission (CQC) in its Inspection of November 2013.

Promoting smoking cessation and tackling misuse of alcohol and obesity demonstrates that the Trust recognises its wider public health role and to support wellbeing by working with communities and partners across healthcare. The Healthy Ripon initiative is another example of how the Trust is working with partners.

We support the Trust's commitment towards greater use of technology - for instance to support people in their own homes and to improve prescribing and administration of medicines.

We also support work that will be taken forward in Section 2.4, Performance Against Core Indicators. We feel this work will address the remaining aspects of quality - patient safety and clinical effectiveness. We feel, therefore, that the Quality Account is comprehensive.

This QA is being published little more than 4 months after the CQC Inspection was published. Summing up we feel the QA builds on the conclusions in the Inspection that the Trust is providing services which are safe, effective and consistently to a good standard. It confirms the Trust is addressing the Inspection's areas of concern.

Yours sincerely  
County Councillor Jim Clark  
Chairman – North Yorkshire County Council Scrutiny of Health Committee

**9 May 2014**

#### COUNCIL OF GOVERNORS QUALITY ACCOUNT STATEMENT 2014

The Council of Governors members are exposed to a wide variety of quality issues on a regular basis across the Trust and are involved in many aspects of Trust life. This is through membership of a number of working groups including the Quality of Experience Group and Patient Voice Group, involvement in PLACE inspections and the "buddying" of Public Governors to ward and department Quality of Care Teams. Governors have also over the last year been a part of the Trust's programme of Patient Safety Visits. Governors also have a direct input into how the Trust is managed and the qualities of leadership under-taken by senior managers within the organisation. This is achieved through the check and challenge style of approach taken at Council of Governors meetings, regular meetings with Non- Executive Directors and attendance (not participation) at Board of Director meetings. We have been extensively consulted on the Trust's strategic operational plan and the quality priorities for the organisation, and have reviewed the Quality Account. The Council of Governors supports and endorses the Quality Account and the priorities selected for further focus over the coming year.

#### HEALTH AND WELLBEING BOARD QUALITY ACCOUNT STATEMENT 2013/14

Quality Account supplied for comment, but no comment received.

## ANNEX TWO: STATEMENT OF DIRECTORS' RESPONSIBILITIES

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2013 to April 2014
  - Papers relating to Quality reported to the Board over the period April 2013 to April 2014
  - Feedback from the commissioners dated 16/05/2014
  - Feedback from governors dated 19/05/2014
  - Feedback from local Healthwatch organisations: not received
  - Feedback from Health and Wellbeing Board: not received
  - Feedback from North Yorkshire County Council Scrutiny of Health Committee dated 09/05/2014
  - The trust's draft complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 15/05/2014
  - The 2013 national patient survey 08/04/2014
  - The 2013 national staff survey 25/02/2014
  - The Head of Internal Audit's annual opinion over the trust's control environment dated April 2014
  - CQC Intelligent Monitoring Reports dated xx/xx/xx
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

.....Date.....Chairman

.....Date.....Chief Executive

### ANNEX THREE: NATIONAL CLINICAL AUDITS 2013/14

This table contains a list of the national clinical audits that HDFT was eligible to participate in during 2013/14.

National Clinical Audit and Patient Outcome Programme (NCAPOP)	Number of patients data submitted for 2013-14	Data submitted as a percentage of the number of registered cases required for that audit
<b>National Confidential Enquiry into Patient Outcome and Death (NCEPOD)</b>		
Medical and surgical clinical outcome review. Subarachnoid Haemorrhage (Managing the Flow) NCEPOD	1 organisational questionnaire only	None required
Tracheostomy Care	2	100%
Alcohol Related Liver Disease	2	66%
Lower limb amputation	1 organisational questionnaire	Audit remains open
<b>Trauma and Orthopaedics</b>		
National Joint Registry (NJR)	954	89%
Hip fracture database (NHFD)	277	100%
<b>Cancer Services</b>		
Bowel cancer (NBOCAP)	69	100%
Lung cancer (NLCA)	119	100%
Oesophago-gastric cancer (NAOGC)	41	100%
<b>Respiratory</b>		
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme*	24	Data collection ongoing data collection started in February 2014
<b>Cardiology</b>		
Acute coronary syndrome or Acute myocardial infarction (MINAP)	311	100%
National Heart Failure Audit	218	100%
Cardiac Rhythm Management	600	100%
<b>Long term Conditions</b>		
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)*	26	100%
Inflammatory bowel disease (IBD) and Biological Therapies	22	96%
Rheumatoid and early inflammatory arthritis	10	8

<b>National Audit Clinical Outcome Review Programme (NCAPOP)</b>	<b>Number of patients Data submitted for 2013-14</b>	<b>Data submitted as a percentage of the number of registered cases required for that audit</b>
<b>Paediatrics</b>		
Diabetes (Paediatric) (NPDA)	94	100%
Epilepsy 12 audit (Childhood Epilepsy)	9	Study still open
Neonatal intensive and special care (NNAP)	177	100%
Maternal, New-born and Infant Clinical Outcome review Programme	8	100%
Child health clinical outcome review programme (CHR-UK)	1	100%
<b>Acute medicine</b>		
Sentinel Stroke National Audit Programme (SSNAP)	299	100%
<b>General Surgery</b>		
National emergency laparotomy audit (NELA)	9	Data collection ongoing started in December 2013

<b>Data submitted to National Audit not part of NCAPOP</b>	<b>Number of patients Data submitted for 2013-14</b>	<b>Data submitted as a percentage of the number of registered cases required for that audit</b>
<b>Audits not part of National Clinical Audit Outcome Programme</b>		
Case Mix Intensive Care National Audit Research Centre	390	100%
National Cardiac Arrest (Part of ICNARC)	HDFT did not participate in 2013/14	Joined and Started data collection 01/04/2014
<b>Emergency Medicine</b>		
National Audit of Seizures in Hospitals (NASH)	31	100%
Severe sepsis & septic shock	50	100%
Paracetamol overdose (care provided in emergency departments)	50	100%
Moderate or severe asthma in children (care provided in emergency)	50	100%

Data submitted to National Audit not part of NCAPOP	Number of patients Data submitted for 2013-14	Data submitted as a percentage of the number of registered cases required for that audit
departments)		
<b>Trauma</b>		
Severe trauma (Trauma Audit & Research Network, TARN)	60	42%
Anaesthetic Sprint Audit (Anaesthetics in Hip fracture patients)	58	89%
<b>Transfusion</b>		
National Comparative Audit of Blood Transfusion programme:		
• Consent for transfusion	24	100%
	23	100%
• Appropriate use of red cells	27	100%
• Anti-D		
<b>Elderly Medicine</b>		
Falls and Fragility Fractures Audit Programme (FFFAP)	24	96% Pilot audit of In-patient at risk of falls
<b>Paediatrics</b>		
Paediatric Bronchiectasis	HDFT did not participate in 2013/14	
Paediatric asthma	25	100%
<b>Surgery</b>		
Elective surgery (National PROMs Programme)	447 (Pre-op)	82.6% Pre-op
	224 (post-op)	42.9 Post-op
<b>Respiratory</b>		
Emergency use of oxygen	HDFT did not participate in 2013/14	

For information, the Trust also participated in the following three audits.

Data submitted to National Audit not part of NCAPOP	Number of patients Data submitted for 2013-14	Data submitted as a percentage of the number of registered cases required for that audit
Care of dying in hospital (NCDAH)	52	>100%
Prostate Cancer	Organisational audit submitted	Clinical data collection commencing April 2014
Diabetes in pregnancy	1	14%

## STAFF SURVEY

The Trust received another excellent set of results from the 2013 national staff survey.

The Trust was placed in the top 20% of Trusts of a similar type for 13 key factors out of a total of 28 key factors, which represents a two key factor improvement over the 2012 results.

These top performing areas were:

- Effective team working;
- Percentage of staff receiving health and safety training in last 12 months;
- Percentage of staff suffering work-related stress in last 12 months;
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month;
- Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months;
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months;
- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months ;
- Staff job satisfaction;
- Staff recommendation of the trust as a place to work or receive treatment;
- Staff motivation at work;
- Percentage of staff having equality and diversity training in last 12 months;
- Percentage of staff believing the trust provides equal opportunities for career progression or promotion;
- Percentage of staff experiencing discrimination at work in last 12 months.

	2013	2012	Trust Improvement/ Deterioration
Response Rate	59%	60%	Maintained best 20% position

No information is available for the national average acute Trust response rate.

The four strongest performing areas were:	2013		2012		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Percentage of staff having equality and diversity training in last 12 months	80%	60%	68%	55%	Significant improvement
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (the lower the score the better)	10%	15%	15%	15%	Significant improvement
Percentage of staff believing the trust provides equal opportunities for career progression or promotion	94%	88%	93%	88%	No significant change

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (the lower the score the better)	23%	29%	26%	28%	Improvement
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The four weakest performing areas were:	2013		2012		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Percentage of staff receiving job-relevant training, learning or development in last 12 months	78%	81%	79%	81%	No significant change
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	89%	90%	90%	90%	No significant change
Percentage of staff appraised in last 12 months	82%	84%	82%	84%	No change
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	78%	79%	77%	78%	No significant change

The survey results showed that the percentage of staff receiving health and safety training and equality and diversity training in last 12 months had significantly improved in both areas and was in the best 20% of Trusts.

In comparison with other Trusts, our weakest performing areas were very close to the national average performance when compared with all Trusts and confirms that our standard across the range of key factors was very high.

Our weakest key factor was the percentage of staff receiving job-relevant training, learning or development in last 12 months. This fell within the lowest 20% of Trusts, but was only three percentage points below the average, which indicates that the percentage range for all Trusts must have been within a close range. The actual percentage figures for the Trust for staff receiving job-relevant training, learning or development has remained consistent since 2009. The Trust has been working hard to provide an extensive job relevant training programme and to increase levels of mandatory and essential skills training.

The percentage of staff reporting errors, near misses or incidents witnessed in the last month fell by one percentage point from 2012 and is not regarded as a significant change.

The percentage of staff appraised in the last 12 months was 82%, which was identical to the figure in 2012. A new system for recording and reporting appraisals has been in place for over a year to simplify the associated processes.

The percentage of staff feeling satisfied with the quality of work and patient care they were able to deliver increased slightly having been at 77% in both 2011 and 2012, again showing that the Trust has maintained a level of consistency.

The Trust has a number of mechanisms through which it communicates information to its employees. These include through monthly newsletter, daily all user e-mail, team brief, departmental meetings, ad

hoc briefings and personal letter. The Trust has also commenced 'Ask a Director' which enables staff to ask questions of the senior team with the questions and answers being published on the intranet. The method(s) used will be the most appropriate for the particular information to be conveyed but one or more methods will be used for all matters of importance. The Trust also runs a staff intranet providing information regarding the latest changes and developments as well as routine information. The Trust understands that not all clinical and support staff use electronic communication methods and always ensures that managers are asked to make all staff aware of information communicated by electronic means.

The Trust works to engage with staff and obtain their feedback on matters being communicated. This occurs through the Team Brief process and through the regular meetings of the Partnership Forum and Local Negotiating Committee where trade unions and professional association representatives meet with senior managers to discuss issues affecting staff and local conditions of service.

The key priorities for the coming year are to improve communication and feedback mechanisms with community based staff and develop new communications tools.

The Trust has already begun a series of community Team Brief events and these will be rolled out more widely. These will be monitored for attendance and take up.

The Trust has also undertaken an extensive piece of work to examine the potential for using social media to communicate with both staff and the public. It is expected that this will begin during 2014/15, with performance indicators in place for the level of responses received to Trust messages and how many people follow Trust social media feeds.

The Trust will continue to work at improving areas where there are implied weaknesses.

The Trust has communicated the results of the staff survey to staff through the Team Brief process and the information is also included on the staff intranet.

## **REGULATORY RATINGS**

The Trust's regulatory performance during the year has remained green in all categories, in line with risk ratings contained in the Annual Plan. No formal regulatory action has been taken or is planned.

The Trust continues to have robust measures in place to monitor performance and quickly address areas of concern. An example of this during 2013/14 has been holding urgent meetings of key staff to examine any incidences of increased infections and to take action including reminding all staff of the importance of good hand hygiene and utilising Hand Hygiene Volunteers to help ensure compliance with hand washing. As a consequence, the Trust has met its infection control targets.

Monitor's Risk Assessment Framework replaced the Compliance Framework from October 2013. The new framework assesses the Foundation Trust's continuing compliance with the licence and focuses on financial sustainability and governance requirements. The Risk Assessment Framework uses a wider range of metrics and data sources to assess the Trust's governance rating, including information from CQC and other third party reports. The Access and Outcomes indicators within the Risk Assessment Framework are the same as those used within the Compliance Framework. The MRSA indicator was dropped from the compliance framework 2013/14 in the final version that was published in August 2013. The Trust reported a green governance rating for each quarter of 2013/14 – Q1 and Q2 under the Compliance Framework and Q3 and Q4 under the Risk Assessment Framework.

## Monitor Risk Assessment Framework Performance Indicators

Indicator description	Target	Q1	Q2	Q3	Q4 (provisional)
RTT admitted pathways (% within 18 weeks)	>=90%	93.6%	95.2%	94.8%	93.8%
RTT non-admitted pathways (% within 18 weeks)	>=95%	97.8%	98.0%	97.8%	97.4%
RTT incomplete pathways (% within 18 weeks)	>=92%	97.0%	97.6%	97.8%	97.1%
A&E: Total time spent in A&E	>=95%	97.9%	97.5%	96.8%	96.8%
Cancer - Maximum waiting time or 14 days from urgent GP ref to date first seen for all urgent suspect cancer referrals (%)	>=93%	98.9%	99.2%	99.4%	99.5%
Cancer - maximum waiting time of 14-days for symptomatic breast patients (cancer not initially suspected)	>=93%	97.0%	98.6%	96.8%	97.1%
Cancer - 31 day wait for second or subsequent treatment: Surgery	>=94%	100.0%	96.6%	100.0%	100.0%
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	>=98%	100.0%	100.0%	100.0%	100.0%
Cancer - 31 day wait for second or subsequent treatment: Radiotherapy	>=94%	NA	NA	NA	NA
Cancer - Maximum waiting time of 31 days from diagnosis to treatment for all cancers (%)	>=96%	100.0%	99.6%	100.0%	100.0%
Cancer - 62 day wait for first treatment from urgent GP ref to treatment: all cancers	>=85%	93.4%	91.2%	91.0%	91.6%
Cancer - 62 day wait for first treatment from consultant screening service referral: all cancers	>=90%	92.9%	92.6%	91.2%	94.4%
C-Difficile	<= 11 cases in year	3	2	6	3 (*)
Community services data completeness - RTT information	>=50%	79.8%	80.7%	82.3%	81.9%
Community services data completeness - Referral information	>=50%	70.0%	70.8%	73.7%	70.8%
Community services data completeness - Treatment activity information	>=50%	78.5%	82.1%	85.5%	84.2%

\* - Monitor reviewed the Trust's C-difficile compliance and confirmed that the Trust remained compliant for this indicator.

Regulatory Ratings

	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14
<i>Under the Compliance Framework</i>								
Financial Risk Rating	3	3	3	3	3	3		
Governance Risk Rating	Amber-green	Green	Green	Green	Green	Green		
<i>Under the Risk Assessment Framework</i>								
Continuity of service rating							4	4
Governance rating							Green	Green

**INCOME DISCLOSURES REQUIRED BY SECTION 43(2A) OF THE NHS ACT 2006 (AS AMENDED BY THE HEALTH AND SOCIAL CARE ACT 2012)**

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than the Trust's income from the provision of goods and services for any other purposes.

The Trust confirms that it has met this requirement during 2013/14.

## **OTHER DISCLOSURES IN THE PUBLIC INTEREST**

### **Staff Engagement**

Putting patients first and raising staff engagement continue to be central to Trust management.

The Trust was delighted it maintained its placing in the top 20% of Trusts of a similar type nationally for staff engagement in the 2013 National Staff Survey with an increased score. The component questions which contribute to measuring staff engagement are the ability of staff to contribute towards improvements at work, staff recommendation of the Trust as a place to work or receive treatment and staff motivation at work. Scoring well in these areas is testament of the hard work and dedication from all staff employed by the Trust.

We will continue to give priority to engaging with staff, setting high standards, learning from the staff experience and strengthening partnership working. Ensuring active staff involvement in the management and direction of services at all levels is achieved through valuing staff, listening and responding to their views and monitoring quality workforce indicators. Equally, staff need to see that their input is valued and that the Trust is responsive to their views in the decisions it takes, building on that positive relationship. Going forward the new NHS Staff Friends and Family Test introduced in April 2014 will further support service improvement.

The Trust has a number of mechanisms through which it communicates information to its employees. These include through a staff newsletter, all user e-mails, including a weekday notices bulletin, a monthly Team Brief which always includes information on the Trust's finances and performance, departmental meetings, ad hoc briefings and personal letter. The Trust has also commenced 'Ask a Director' which enables staff to ask questions of the senior team with the questions and answers being published on the intranet. The method(s) used will be the most appropriate for the particular information to be conveyed, but one or more methods will be used for all matters of importance. The Trust also runs a staff intranet providing information regarding the latest changes and developments as well as routine information. The Trust understands that not all clinical and support staff use electronic communication methods and always ensures that managers are asked to make all staff aware of information communicated by electronic means.

The Trust works to engage with staff and obtain their feedback on matters being communicated. This occurs through the Team Brief process and through the regular meetings of the Partnership Forum and Local Negotiating Committee, where trade unions and professional association representatives meet with senior managers to discuss issues affecting staff and local conditions of service. There are two sub groups of the Partnership Forum: the Policy Advisory Group and the Pay, Terms and Conditions Group.

The Policy Advisory Group agrees and updates Human Resources policies in line with current employment law and ensures they have broad agreement within the organisation.

The Pay, Terms and Conditions Group negotiates on local issues affecting staff pay and conditions.

The Local Negotiating Committee is the forum for medical and dental staff and the British Medical Association and British Dental Association trade union representatives to be involved in the decision making process on contractual arrangements and the delivery of health care. It provides the means for joint problem solving in relation to issues affecting the well-being of medical and dental employees and contributes to the efficient management of the Trust.

## **Disabled Employees and Applicants**

Trust policy in respect of disabled applicants who clearly indicate that they wish to be considered for a post under the 'Positive about Disability Scheme' is that they will be shortlisted and invited for interview where they meet the requirements for the post. The Trust supports existing staff who become disabled with workplace adaptations and training.

All staff, including disabled colleagues, have access to the local workforce development programme and the training courses provided through the programme. Staff are able to discuss their training needs with their line manager during their appraisal or at other times as arranged locally.

## **Occupational Health**

The Occupational Health Department ensures a high standard of health within the workforce is maintained as well as protected against workplace hazards.

The work of the Occupational Health Department covers:

- Pre-placement health assessment and communicable disease screening to support recruitment of new employees ensuring they are both fit to work in a healthcare environment and present no risk of infection to their patients;
- Provision of work-related immunisations to protect from infection risk;
- Supporting managers and employees to maintain satisfactory attendance and work performance and facilitate return to work of staff on long term sickness absence;
- Promoting health, safety and wellbeing;
- Provision of staff counselling and coaching services (see Wellbeing Service report below).

Occupational Health staff have membership of various working groups, which manage services and introduce improvements, ensuring a staff health perspective is considered and contributing to staff health, safety and wellbeing in order to enhance delivery of safe, effective and compassionate patient care. These groups include: Clinical and Non-Clinical Risk Management, Health and Safety, Infection Control, and Human Resources meetings.

A high level of collaborative working with other regional NHS Occupational Health services ensures that Trust staff working in various locations throughout the county are able to access services locally when required, and ensures access to advice from a Consultant in Occupational Medicine when required. In addition, multidisciplinary collaboration via the Trust's Flu Steering Group continued to develop initiatives to enhance delivery of seasonal influenza vaccination to staff and collaboration with the Trust's Moving & Handling Co-ordinator ensures a co-ordinated approach to musculo-skeletal/ergonomic assessment, advice and training requirements.

During 2013, a major project was commenced to review the work-related immunisation records of all current staff against the most recent Department of Health standards for healthcare workers, and to update those who commenced in post prior to the implementation of the current standards. This project will improve patient and staff safety by further reducing the risk of communicable disease transmission between staff and patients and avoid potential exclusion of non-immune staff contacts from work, which leads to lost working time.

The department continues to hold contracts for the provision of Occupational Health services to other NHS and non-NHS organisations in the local community, supporting the working population and their employers and generating income for the Trust. It is proud to have maintained successful relationships with significant local employers in both the private and public sectors.

The department maintained membership of the NHS Health at Work Network (previously NHS Plus), and has continued to work towards accreditation by the Safe Effective Quality Occupational Health Service (SEQOHS) scheme.

### **Health and Safety**

The Trust has a legal duty to provide a safe environment in its buildings and grounds free of danger and harm to its patients, staff, contractors and visitors. Health and Safety standards at the Trust are managed, monitored and maintained through a number of specific actions:

- A rolling programme of mandatory training for staff covering: Induction Training, Clinical Handling, Display Screen Equipment, Object Handling, Breakaway Techniques, Fire Response training;
- Reporting of all incidents and accidents via an Incident Reporting system, which is monitored by the Risk Management Department, ensuring review of risk and any appropriate follow up action is instigated;
- Use of fully maintained departmental SALUS health and safety record books which are maintained by a named person in each department and regularly assessed;
- Quarterly meetings of a Health and Safety Committee, drawn from workplace managers and staff health and safety representatives;
- The work of the Local Security Management Specialist;
- Departmental management and monitoring of correct practices.

The Risk Management Department now report on staff slips, trips and falls looking at location, type of injury sustained and number of occurrences.

### **Staff Sickness levels 2013/14**

DIRECTORATE	13 Q1	13 Q2	13 Q3	14 Q4	Cumulative % Absence Rate
	% Absence Rate (WTE)				
Acute and Cancer Care	2.74%	2.61%	3.74%	3.11%	3.05%
Corporate Services	3.76%	2.68%	3.03%	4.02%	3.37%
Elective Care	3.62%	3.09%	3.51%	4.37%	3.64%
Integrated Care	3.52%	3.39%	4.03%	3.36%	3.58%
<b>TOTAL</b>	<b>3.44%</b>	<b>3.02%</b>	<b>3.63%</b>	<b>3.75%</b>	<b>3.46%</b>

In the last year, a dedicated Senior Human Resources Advisor has been appointed who supports managers and staff with the implementation of the Managing Attendance and Promoting Health and Wellbeing Policy, monitoring and auditing the application of the policy and attending meetings where required for the management of attendance. The introduction of case management conferences with Occupational Health, provision of localised training for managers and dedicated support have seen the sickness percentage levels reduced from the previous year.

### **Wellbeing Service**

The Wellbeing Service is a fully independent, confidential service, which provides staff counselling, psychotherapy and coaching support to employees of the Trust. It can support employees through periods of change and uncertainty, assisting them to deal with issues they are facing in the workplace, or returning to work from periods of sickness.

The service has, in the last year, arranged monthly supervision in cancer services management for staff and managers.

It has assisted in responding to staff who have encountered incidents of physical or verbal aggression in the course of their work and cases of post-traumatic stress disorder (PTSD), and assisting in departments going through organisational change. The service can facilitate sessions and tailor solutions to specific needs.

It is pro-active in enabling people to deal with change and make appropriate decisions in managing their own lives. It offers help to alleviate stress, and can assist in life and career coaching for staff. It also provides evidence of compliance in stress audits and inspections by the Health and Safety Executive. In addition to focussed short term work, comprehensive assessment sessions assist staff with more complex, severe or enduring issues to access long term services.

There is an ongoing gradual increase in the use of the service with the widening of the range of services on offer especially the coaching work, which is a new dimension for staff who are able to work in partnership and in a focussed way related to their life and career choices.

The Wellbeing Service is registered with the British Association for Counselling and Psychotherapy (BACP) and is a member of the Association for Counselling at Work. Counsellors working in the Service, either in an employed capacity or as volunteers, are BACP members and work to the Ethical Framework for Good Practice in Counselling and Psychotherapy.

The role and remit of Wellbeing Services will be subject to future review as changes in service delivery and staffing occur.

### Education, Learning & Development

The Trust has Investors in People accreditation and aims to provide education, learning and development opportunities across all staff groups to ensure that the Trust has the right staff in the right place at the right time with the right skills.

### Corporate and Clinical Induction Programmes

To support new employees joining the Trust, a Corporate Induction Programme is held twice monthly on the first and third Mondays and Tuesdays of the month and coincides with new starter employment commencement dates. Induction time is treated as protected time for the new employee. The programme is delivered by a blend of face to face and eLearning, together with local workplace information.

Clinical induction programmes are held three times per year and timed to coincide with the commencement of doctors' training rotations.

### Training Programme

Significant effort has been made across the organisation to ensure that the workforce have undertaken the required statutory, mandatory and essential skills training which is deemed necessary to enable them to perform their roles in a safe and effective way.

Beyond the statutory, mandatory and essential skills training, employees are able to access a significant programme of internal training programmes to support their development. These are either face to face training or eLearning, which is now embedded as a tool for the delivery of knowledge

based learning throughout the Trust. The Trust utilises the NHS National Learning Management System, which is free to NHS Trusts, and enables the workforce to access high quality learning material, developed by professional bodies, such as the Royal College of Paediatrics & Child Health and the Royal College of Physicians. The Trust offers Qualifications Credit Framework qualifications through its own in-house centre and has extended the range to these to include Health & Social Care NVQ Levels 2 and 3, and the following all at NVQ Level 3: Clinical Healthcare Support, Healthcare Support Services, Allied Health Profession Support, Perioperative Support, Assessor Award and the Internal Verifier Award.

Employees also attend external training programmes, as appropriate.

#### Partnership with Health Education Yorkshire & the Humber (HEYH)

The Trust works in close partnership with HEYH and is able to access educational funding from them to further support the development of the workforce. The Trust accesses funding which is specifically ring-fenced for staff that work at Bands 1 to 4 in roles such as Porterage, Clinical Support Workers and Domestic staff and this funding allows additional training and educational opportunities to be made available.

#### Leadership and Management Development

To supplement the internal leadership and management development activity, the Trust has also made good use of the national NHS Leadership Academy, which offers a range of Leadership & Management Development programmes, from introduction to leadership level, to a top leaders programme. The Trust has encouraged and enabled a number of employees to participate in these national programmes.

#### Clinical Skills and Simulation Training

The Trust was awarded funding in 2012 to develop the Clinical Skills & Simulation facility and this has gone from strength to strength. The facility is being used to its full extent. The Clinical Skills Training Centre is deemed by HEYH to be one of the most used and successful centres in the region. Funding enabled the purchase of a high fidelity simulation mannequin which has allowed the development of innovative and effective training to be delivered to clinical staff. HDFT is one of the few Trusts in the region that uses simulation for fundamentals of care training.

#### Apprenticeships

As the largest employer in the Harrogate district, the Trust is committed to providing opportunities for people to gain experience and qualifications, whilst earning at the same time.

The Trust offers apprenticeships and has employed 14 apprentices during 2013/14. Examples of apprenticeships undertaken include Health & Social Care with Decontamination, Business Administration, National BTEC in Pharmaceutical Services and Clinical Skills & Simulation. The apprenticeship programmes, which run over 12 to 24 months, have introduced inexperienced individuals to work areas where they receive formal training and on the job learning and development that will equip them with a qualification and skills that are transferrable into employment by the Trust or other employers.

#### Doctors in Training and Student Placements

The Trust actively participates in supporting the education and training of the healthcare professionals of the future. It works in partnership with the local Deanery and has approximately 80 Doctors in

Training. It provides structured education, training and on-going support and work based experience to these individuals.

The Trust also works alongside local universities and hosts nursing, midwifery, scientific and allied health professional students on practice placements. The Trust is committed to the provision of high quality placements for the students to enable them to become fully equipped and competent healthcare workers. Students undertake work based education and learning.

### Values Based Recruitment

The Trust is currently developing its recruitment processes to ensure that when an individual applies for role with the Trust, part of the recruitment process undertakes to assess the personal values that the individual holds. These being aligned with the Trust's values is as important as them having the required technical knowledge and skills for their role.

### Senior Medical Staff Job Plans

Work is underway to improve the job planning process for senior medical staff, both to ensure that every doctor complies with the requirement to have a current job plan i.e. to have agreed plan which is reviewed at least every 12 months, and that there are accurate and comprehensive records and a process for prompting review. An internal audit has been undertaken on the arrangements that have been put in place and the work that has been done. Directorates hold the responsibility for agreement of the job plan with advice on the format and content being provided by the Medical Staffing team. The Revalidation Project Manager has responsibility for maintaining records of job plans and prompting reviews where necessary. Proof of a current job plan will be part of the mandatory supporting information required as part of a doctor's appraisal.

### Organisational Development (OD) Associates

The Senior Management Team continues to support organisational development projects, which can introduce innovative changes, improve service provision and bring with them the possibility of economies and cost savings. The Organisational Development Associates Group will continue to facilitate the delivery of the OD strategy and lead in identifying projects suitable for development.

The Trust is represented on the Accelerate Leadership programme, Emerging Leaders Network, and Team and Systems Coaching. Internal leadership programmes have been widely attended on courses such as Flexible Thinking – How to do things Differently, Productive Leader and Productive Ward training, Lean Methodology and a whole range of other programmes on offer in the Workforce Development programme manual.

All of the above programmes have rated extremely well. They are all a crucial element of succession planning arrangements for all leadership positions within the Trust.

### Embracing Technology to improve Human Resources services

The HR operational team has been increasingly using new technology to improve services. A number of bespoke toolkits have been developed on the intranet with attached resources. The toolkits include key documents relating to specific topics, e.g. forms and policies with the addition of other useful items including flowcharts, frequently asked questions, crib sheets to run meetings, spreadsheet calculator documents and key pointer documents for managers, which had not previously been used. The toolkits are user friendly using a series of logos, sub sections and icons to signpost managers through the process.

Data collection in relation to certain processes, such as return to work interviews and appraisals, has been improved through automated sending of electronic forms, which allows managers to report completion. Webinars have also been used for delivering HR related training. This allows access for community based staff without the need for travel.

### Celebrating Success

The staff achievement awards and summer ball were held on 19 July 2013. The event celebrates staff achievements with five awards, the winners of which receive training bursaries. The awards were for good practice and innovation within the Trust and had the joint aims of giving recognition to individuals for their exemplary work and also to share with others the new and different ways of working. Long service awards were presented to staff who have achieved 25, 35 and 40 years NHS service.

The 2013 awards categories and winners were:

#### **The Mark Kennedy Award for involving the people who use our services in implementing change and improving the quality of care**

- Helen Williams – Long term conditions pathway

#### **The Anne Lawson Award for improving patient safety**

- Dr Jo McCreanor and Dr Claire Taylor – TACORD: A project to embed quality and safety actions into every ward round

#### **The Governors' Award for outstanding contribution from a team**

- Melanie Davies – Sterile Services Department

#### **The Richard Ord Award for outstanding contribution from an individual**

- Elaine Carlyle, Health Visiting and School Nursing Team

#### **The Chairman's Award for the most outstanding application of the year**

- Andrew Jackson and Les Phipps - Pathology Service Improvement Team

### Seven Day Working

The Trust, through a Task and Finish group, has been considering and developing proposals to move to seven day working where job roles and staff groups would positively impact on patient care if that service was provided seven days a week. The Trust has progressed significantly in recent years with more services being routinely run over seven days, including Endoscopy, Radiology and the provision of additional weekend consultant physician ward rounds. This excellent work was recognised with a Highly Commended Award from Dr Foster Intelligence in January 2014 for making significant improvements in weekend performance between 2011/12 and 2012/13. The Trust is one of just 12 in the country to be highly commended and the award recognises improved care in the repair of broken hips at a weekend.

## Consultations with Staff, Local Groups and Organisations

The Trust engages with its stakeholders in relation to many aspects of the services it provides. Over the past year it has liaised with a wide range of stakeholders on a number of issues. These stakeholders have included the Trust's Council of Governors, The Trust's Patient Voice Group, Harrogate Borough Council and North Yorkshire County Council, including the Scrutiny of Health Committee.

The majority of interaction with stakeholders is through regular communications at scheduled meetings. The opportunity is always taken to update partners on issues of relevance and importance.

In relation to direct consultation, one specific issue has been taken to stakeholders for consultation in 2013/14:

- The priorities for inclusion in the Trust's Quality Account for 2014/15;

In addition, the Trust has continued to engage with staff, local people and stakeholders on the future shape of health and wellbeing services in and around Ripon, as part of the Healthy Ripon project. This is a collaborative partnership between health, social care, local authorities and others.

In 2014/15, the Trust will be working with Harrogate and Rural District Clinical Commissioning Group to carry out a review of community based health services in the Harrogate district. This will involve consultation with patients, staff and other key stakeholders.

## Valuing volunteers

The volunteering programme continued to flourish in 2013/14 and was recognized as an example of good practice by the Care Quality Commission in its inspection report. Volunteers have taken up opportunities in the Emergency Department, the Women's Unit, Medical Records, on wards, in the Ophthalmic clinic, with Hospital Radio and volunteers continue to play a key role in the 'Patient Experience Volunteer' service that is based at the front entrance of Harrogate District Hospital, as part of the Patient Experience Team.

In recognition of the Trust's volunteers' achievements, the annual Volunteers Tea Party, held in December 2013, acknowledged the dedication of the many voluntary groups and individuals that work to support the Trust and also praised the volunteers for their work during the past year.

Awards were presented in recognition of 10, 15, 20 and 25 years' service. The volunteers are presented with a pin badge featuring the number of years they have served as a volunteer.

The minimum age to be a volunteer is 16 years and volunteers come from all walks of life; the Trust's oldest volunteer is over 90. Dependent on the time each volunteer has to offer, they are recruited to work in a specific area and help out anything from once a week to once a month. Anyone interested in volunteer work at the hospital should contact Fiona Tomlinson, Volunteer Co-ordinator, on 01423 553014.

The Harrogate Hospital and Community Friends and the RVS also make a valuable contribution to the smooth running of the Trust. Their dedication and enthusiasm in assisting patients and visitors and generally helping to make the Trust as welcoming and friendly as possible is greatly valued by all.

HDFT's volunteers are a familiar sight and the Trust's close partnerships with other voluntary organisations like the Harrogate Hospital and Community Friends, Friends of Ripon Hospital, Harrogate Hospital Radio and the RVS are incredibly important to the Trust.

## Education Liaison Programme

As a Foundation Trust, it is important that HDFT engages with and supports its community, schools and young people.

During 2013/14, the Trust continued to develop its Education Liaison initiative and is now working with all mainstream secondary schools, colleges and special schools, and also with some primary schools. In excess of 5,000 students have been engaged with the programme since May 2007. The main focus of the programme is to:

- Work in partnership with schools to support careers advice on the range of opportunities within the NHS;
- Offer equitable work experience placements to students from all schools across the catchment area of the Trust;
- Work with teachers, students and health professionals to develop innovative solutions to interactive working and education, across the full complement of health service professions.

This programme has been exceptionally successful and has now been recognised nationally as a model of good practice with the Trust giving presentations about its engagement with young people at two national events this year.

Achievements and demonstration of impact include:

- Contributing to the personal and professional development of hospital staff, through consulting and involving them with schools' sessions, talks and events;
- A significant contribution by and attendance from young people attending the Trust's Annual Open Event;
- Careers talks – generic NHS careers talks, aimed to highlight the vast range of careers available throughout the NHS;
- Tours and activity days;
- Various classroom interventions to contribute to specific delivery of Health and Social Care and Applied Science Curricula.

The Education Liaison programme has significantly strengthened the Trust's links with its wider community. As the programmes grow, new and innovative ideas are developed.

## Counter-fraud policies and procedures

The Foundation Trust's counter fraud arrangements are in compliance with the NHS Standards for providers: fraud, bribery and corruption. These arrangements are underpinned by the appointment of accredited local counter fraud specialists and the introduction of a Trust-wide countering fraud and corruption policy. An annual counter fraud plan identifying the actions to be undertaken to create an anti-fraud culture, deter, prevent, detect and, where not prevented, investigate suspicions of fraud is produced and approved by the Trust's Audit Committee.

## Better Payment Code of Practice

The Better Payment Practice Code requires the Trust to aim to pay all valid non-NHS invoices within 30 days of receipt or the due date whichever is the latter.

## Summary of Year 2013-14

Year to 31 March 2014	Numbers	Year to 31 March 2013
51,122	No of Bills Paid to Date	46,815
11,186	No of Bills Paid in 30 Days	20,634
22%	% of Bills Paid in 30 Days	44%

Year to 31 March 2014	Values	Year to 31 March 2013
58,788	£K Value of Bills Paid to Date	46,042
19,510	£K Value of Bills Paid in 30 Days	23,776
33%	% of Bills Paid in 30 Days	52%

The Board of Directors recognises that compliance with this code is compromised by the levels of clinical activity provided above contract where payments from the commissioners, working to national payment timescales, do not coincide with the timing of extra costs. As such, the organisation's cash management strategy is acknowledged to have a detrimental impact on this performance measure.

### **Serious Incidents involving data loss or confidentiality breaches**

The Trust had no Serious Untoward Incidents regarding data loss or confidentiality breaches during 2013/14.

### **Sustainability Reporting**

Information on the Trust's impact on the environment and measures being taken to mitigate this are contained within the Strategic Report.

## **STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES**

### **STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF THE HARROGATE AND DISTRICT NHS FOUNDATION TRUST**

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS foundation trust. The relevant responsibilities of the Accounting Officer, including his responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officers' Memorandum issued by Monitor.

Under the National Health Service Act 2006, Monitor has directed Harrogate and District NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Harrogate and District NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officers' Memorandum.

Signed

**Richard G Ord**  
**Chief Executive**

**28 May 2014**

