Harrogate and District
NHS Foundation Trust

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
ANNUAL REPORT AND ACCOUNTS 2016/2017

You matter most

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ANNUAL REPORT AND ACCOUNTS 2016/2017

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Contents

1. CHAIRMAN'S STATEMENT 6

2. CHIEF EXECUTIVE'S INTRODUCTION 8

3. PERFORMANCE REPORT 10

3.1. Overview of Performance 10

3.2. Performance Analysis 12

4. ACCOUNTABILITY REPORT 22

4.1. Director's Report 22

4.2. Remuneration Report 33

4.3. Staff Report 39

4.4. NHS Foundation Trust Code of Governance 53

4.5. NHS Improvement's Single Oversight Framework 81

4.6. Statement of Accounting Officer's Responsibilities 82

4.7. Annual Governance Statement 83

5. Harrogate and District NHS Foundation Trust Quality Account 2016 – 2017 ....

6. Annual Accounts 2016/17 ....

1. CHAIRMAN'S STATEMENT

I am delighted to present Harrogate and District NHS Foundation Trust's (the Trust) Annual Report for 2016/17 which records another successful year for the Trust. It also charts the ongoing transformation of our acute and community services aligned to our core vision of delivering Excellence Every Time and underpinned by our values of 'passionate, respectful and responsible'.

This will be the last time I write this introduction to the Annual Report after nearly nine years as Chairman. Therefore this year I am reflecting back not only on the performance of the Trust in 2016/17, but also setting this in the context of our journey as a Trust since 2008. Looking back, our income in 2008/2009 was £112 million and we had 2,350 members of staff, delivering acute hospital based services from Harrogate District Hospital and Ripon Community Hospital. This year we had an income of £217.7m delivered by 4,432 staff working in a variety of acute and community services: south to north from our Minor Injuries Unit in Selby to our School Nurses in Stanley, west to east from our Dental team in Skipton to podiatrists in Scarborough. This journey over the last nine years demonstrates the Trust's ability to transform and change to meet both the ever changing needs of the communities we serve and the challenges of a complex and evolving health system.

As you will see from this year's report, the Trust has maintained and built upon its reputation for the delivery of high quality care and has continued to advance and extend its remit, providing additional services in the acute setting with outpatient clinics at Alwoodley Medical Centre and Wharfedale Hospital and in the community with a strong presence in the provision of Children's Services across North Yorkshire, Middlesbrough, Darlington and County Durham. The Trust met all its key performance requirements and delivered an important, albeit small, underlying financial surplus which was achieved despite many challenges for the health economy locally, regionally and nationally. In July we received the results from our Care Quality Commission inspection that had taken place earlier in the year. We were pleased to receive a 'Good' rating overall and delighted that the *Caring* domain was rated as 'Outstanding'. My thanks go out to all our staff and volunteers whose dedication, professionalism and passion for their individual service enables the Trust to receive national affirmation of the quality of the care provided.

In addition, partnership work was a strong feature of the year. As you will read in this report we progressed, with our local partners in a Vanguard project, the development of a New Care Model for community care services. As part of a national initiative we became a member of the West Yorkshire and Harrogate Sustainability and Transformation Planning (STP) area; this is a great opportunity for us to work positively and proactively in collaboration with our partners across the area in both health and local authorities to develop and strengthen services for the public.

I would like to thank the Executive Team, led by Dr Ros Tolcher, and all the staff who have actively engaged in many of the individual and innovative projects that we are progressing with our partners in the STP and with other Trusts in the region. Our ability to learn and share with others, to embrace new ways of working and to continuously seek to improve will sustain and nourish the services we offer individually as a Trust and collaboratively with our partners.

I would also like to thank my Non-Executive Director colleagues, and in particular Professor Sue Proctor, who left us on 31 March 2017 after four years of exceptional service to the Trust.

The commitment and involvement of our Council of Governors, representing the interests of members and the public as a whole, is outstanding; they support us in sustaining our unwavering focus on delivering high quality, compassionate care. I would like to thank them

all for their individual and joint contribution over the year. Most importantly, I would like to thank those who have stepped down from the Council of Governors: Michael Armitage, John Ennis, Joanna Parker and Joyce Purkis. I would also like to note the strong contribution of Pamela Allen, Deputy Chairman/Lead Governor, to many aspects of the Trust's governance responsibilities.

The involvement of an active and energetic membership is central to the governance of a Foundation Trust and we appreciate and encourage participation in a multiple of ways. We now have over 18,000 members who have attended a wide range of meetings, participated in governor elections and received regular communication and updates from us. In addition we had another highly successful Open Event and nearly 100 people attended our interactive Annual Members Meeting, and many members have come to our ever popular Medicine for Members events.

It has been my pleasure and my honour to chair the Trust over the last nine years and I am truly indebted to the professionalism, support, guidance and commitment of my fellow Board Directors, the Council of Governors and all the staff and volunteers across the Trust who have so warmly and freely shared their experiences, ideas and views with me over the years. The delivery of high quality care is founded on the skill, professionalism and dedication of staff and I am assured constantly that our staff go the extra mile. Over the last few months it has been a delight to be involved in awarding the 'Making a Difference Awards' to staff who have been singled out by patients and their colleagues as individuals who demonstrate our core values and enable us to strive for our vision of Excellence Every Time.

As I look ahead, I do not doubt that the next few years will be both very exciting and very challenging; I am confident that I leave the Trust in a very strong position with excellent leadership and phenomenal staff who will strive continuously and passionately to deliver transformational high quality services for all the people who access our acute and community care provision across our extended region.

Mrs Sandra Dodson
Chairman, Harrogate and District NHS Foundation Trust
24 May 2017

2. CHIEF EXECUTIVE'S INTRODUCTION

As the Accounting Officer of Harrogate and District NHS Foundation Trust I am delighted to introduce you to our Annual Report for the year ended 31 March 2017. The report highlights the excellent care provided by colleagues across the organisation and demonstrates our commitment to showing our patients and service users that despite the many challenges facing the NHS and partner organisations we have remained true to our values and You Matter Most philosophy.

This year we have continued to plan and deliver services based on our vision for Excellence Every Time. The organisation is committed to driving up care quality, to working with partners so that patients experience integrated care and to ensuring that our services are resilient and sustainable. This report reflects the progress we have made on each of these objectives – the challenges along the way and the optimism and confidence we have for the years ahead.

We were proud to win the contracts to provide Children's Services in County Durham, Darlington and Middlesbrough, leading to the very welcome transfer of 458 colleagues in to the Trust on 1 April 2016. These services, in addition to those we already provide to North Yorkshire County Council, established the Trust as the biggest provider of 0-19 Children's Services nationally. Coinciding with the commencement of this new contract and reflecting the growing importance of Children's Services for the Trust, we re-structured our Clinical Directorates so that from 1 April we established a Directorate of Children's, Community and County-wide services. Alongside the Directorates of Planned and Surgical Care and Long Term Conditions and Urgent Care, we now have three Directorates structured to ensure patients experience seamless care designed around their needs. Providing services commissioned by Local Authorities as well as NHS Clinical Commissioning Groups brings a diversity of services and opportunities enabling even closer working with communities.

In July 2016 we received the welcome confirmation that the Trust had been rated as 'Good' following a comprehensive Care Quality Commission (CQC) inspection in February 2016. Caring was rated as Outstanding – a well-deserved reflection of the awesome commitment of staff across the Trust. Four core services were also rated outstanding, and the great majority of other individual elements were rated as good or outstanding. The CQC also reported on some areas which have more work to do before attaining good or outstanding ratings and work continues to ensure that the improvements required are embedded and that patients will truly benefit from these actions.

We are proud of our strong reputation for care quality and throughout the year we have strived to sustain performance across the essential areas of performance: care quality, operation performance and financial performance. During 2016/17 we were one of the few Trusts which consistently performed well in of these three areas. In each quarter of the year, patients have benefited from timely access to essential services and the Trust has consistently met or exceeded the NHS Constitution standards for referral to treatment times and cancer services. Attainment of the national Four Hour Wait target for Accident and Emergency departments (95% of people to be seen, treated and admitted or discharged within four hours) is often taken as a proxy measure for the overall resilience of an organisation because it depends on the inter-play of so many parts of the acute hospital. Increasingly it is also seen as a barometer of health and social care efficiency across the wider system. It is therefore particularly pleasing to end the year knowing that overall 95.1% of people attending our Emergency Department were seen, treated and admitted or discharged within this four-hour window. Colleagues across our community and acute services are to be congratulated on this outstanding achievement.

2016/17 has been another year in which the Trust has continued to work with local system partners in driving forward our New Care Models programme for community services. The

Trust is part of the West Yorkshire and Harrogate STP area and this has created new opportunities for the Trust to collaborate with other providers in this STP footprint as a means of bringing greater resilience to local clinical services and overall improvements in efficiency. This programme of work will continue in to 2017/18 with key areas of work affecting stroke services, vascular services and standardisation of clinical practice to name just a few areas. The Trust has a strong history of delivering high quality care through clinical alliances and we see this approach as an important element of achieving our strategic ambition for clinically and financially sustainable services in the longer term.

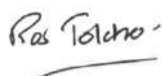
I am clear that the most powerful determinant of care quality is the collective knowledge, skills and behaviours of the people providing care and those supporting and leading them. Promoting a culture of openness, transparency and learning is a fundamental part of my commitment to delivering Excellence Every Time. Our annual staff survey results for 2016 offer an insight in to how well we are doing and how engaged colleagues across the organisation are feeling. I was delighted with this year's results which deliver the top score for overall engagement across the whole of Yorkshire and the Humber. This is something every employee can feel proud of and something I hope we will improve even further as we work together in the year ahead. We were delighted to be featured in the 2016 Parliamentary Review which paid tribute to the focus on quality and staff engagement and described the Trust as "a shining example of what good looks like".

2016 saw the launch of our innovative Quality Charter, designed to support continuous improvement through clinical leadership. A key element of this is describing our ambition for quality and creating the conditions for outstanding care in every part of the Trust. To date, 26 colleagues have become bronze level Quality of Care Champions.

I would like to pay tribute to the people who make our ambition for excellent healthcare a reality for people using our services day in day out. Emergency Department attendances were up by nearly 1,000 on the previous year and emergency admissions grew by nearly 5%. Despite this, we were still able to exceed the 95% 4 hour wait target. This extraordinary achievement is a credit to the whole site including clinical support and community services working together. We achieved all of the NHS Constitution standards for waiting times and cancer pathways and over the full 12 months.

The year also saw 1,900 women giving birth with us, 28,100 people receiving day case surgery, 3,600 people admitted for elective care, thousands of people cared for by our new 0-19 services, and so much more. Achieving consistently high quality care, meeting constitutional standards and managing resources efficiently for another year is an exceptional team effort. My thanks go out to staff in all of our community and hospital services in whatever capacity they contribute. Thanks are also due to our Non-Executive Directors and Governors who have helped, supported and challenged constructively throughout the year.

And finally, a very special thank you to our Trust Chairman Mrs Sandra Dodson for whom this will be her last Annual Report. Sandra has been an outstanding Chairman for the last nine years. The continued success of this organisation, its reputation and the values we work to are a reflection of her leadership, passion and dedication to achieving the best for the people we provide care to. We all wish her well and will strive to sustain the high standards she has set for the Trust in her time as its Chairman.



Ros Tolcher
Chief Executive, Harrogate and District NHS Foundation Trust
24 May 2017

3. PERFORMANCE REPORT

3.1. Overview of Performance

A Brief History of Harrogate and District NHS Foundation Trust and its Statutory Background

Harrogate and District NHS Foundation Trust (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 provides services to north and west Leeds representing a catchment population of approximately 1.2m. Since April 2011, the Trust has provided a wide range of community-based services covering the Harrogate and District locality and some services covering the whole of North Yorkshire. In April 2016, the Trust was awarded three contracts to provide 0-19 Children's Services in the County Durham, Darlington and Middlesbrough localities, making the Trust the largest provider of Children's Services in the country.

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 three further theatres. The Sir Robert Ogden Macmillan Centre (SROMC) provides assessment and treatment, for the diagnosis and treatment of patients with cancer. 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 provides Maternity Services with an Antenatal Unit, central Delivery Suite, Special Care Baby Unit (SCBU) and Post Natal ward, 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 Minor Injuries Unit, and offers a range of outpatient services to the communities of Ripon and the surrounding area. The Trust 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 Hospital NHS Foundation Trust (YTHFT) include Breast and Cervical Screening, Dermatology, Ear Nose and Throat (ENT), Neurophysiology, Non-Surgical Oncology, Ophthalmology, Oral and Maxillofacial Surgery, Orthodontics, Renal Medicine, Rheumatology, Urology, Vascular Services and a Satellite Renal Unit. The renal unit is managed by YTHFT, but provided at a facility on the Harrogate District Hospital site.

In addition, the Trust has a number of established clinical links with the Leeds Teaching Hospitals NHS 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.

Further outpatient outreach clinics are held at Wetherby Primary Care Centre and Yeadon Health Centre for the specialities of Dermatology, Gastroenterology, General Surgery, Gynaecology, Maternity, Neurology, Paediatrics, Respiratory, Rheumatology, Urology, and Vascular clinics. Endoscopy and Gastroenterology services are provided at Wharfedale General Hospital.

In May 2016, an additional outreach clinic facility was established at Alwoodley Medical Centre which includes the specialties of Audiology, ENT, General Surgery, Gynaecology, Orthopaedics, Rheumatology and Urology clinics. There is also a dedicated Radiology service providing plain film x-ray and ultrasound services to support the above mentioned clinics, as well as providing GP Direct Access for the surrounding practices.

Patient Choice is an important part of the NHS Constitution and patients from surrounding areas regularly choose Harrogate for their care. The Trust will continue working in partnership with Clinical Commissioning Groups to expand secondary care services and meet this demand.

The Trust provides the following community based services:

- Children and Family Services;
- School Nurses Vaccination and Immunisation Services;
- Community Podiatry Services;
- District and Community Nursing;
- Health Visitors;
- GP Out of Hours Services;
- Infection Prevention and Control/Tuberculosis Liaison Services;
- Minor Injury Units;
- Older People and Vulnerable Adults Services;
- Safeguarding Children Services;
- Salaried Dental Services; and
- Specialist Community Services.

The Community Equipment and Wheelchair service were provided by the Trust between 1 April 2016 and 30 November 2016.

The overall catchment population for these services can be as great as 1.2m people.

Going Concern Statement

After making enquiries, the Board has a reasonable expectation that 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 Trust's Strategy

The strategic aims of the organisation continue to be to:

- Drive up quality and continue to deliver high quality care;
- Work with partners to deliver integrated care; and
- Increase services provided to ensure clinical and financial sustainability.

Our overarching vision is to deliver Excellence Every Time. This will be achieved by continuing to work with our partners, through alliances and networks, and expanding our catchment population into North Leeds, across North Yorkshire and in relation to our Children's Services into the North East of England in County Durham, Darlington and Middlesbrough. We have a strong history of alliance based working, with well-established clinical alliances with YTHFT and LTHT already in place. We are also a member of the West Yorkshire Association of Acute Trusts (WYAAT) and are formalising our governance arrangements to enable greater collaboration in the future. A strong focus on organisational culture and the philosophy of 'You Matter Most' is the bedrock of that ambition.

As a part of the West Yorkshire and Harrogate STP, we are actively engaged with the leadership from the West Yorkshire and Harrogate Health and Care organisations to deliver a range of transformational plans to improve the care to the populations we serve. To support the achievement of our strategy, we will strive to deliver our annual goals, which are to:-

- Place patients/people who use our services at the centre of decision making;
- Support and engage with staff;
- Use resources carefully; and
- Plan for the future.

These complement the Trust's key Quality Priorities which are set out in the Quality Account contained within this Annual Report at Section 5.

3.2. Performance Analysis

Regulatory Ratings

The Trust's regulatory performance against Monitor's Risk Assessment Framework from April to September was Green in all categories in line with risk ratings contained in the Operational Plan and the Trust has met its infection control targets. From October regulatory performance changed in line with NHS Improvement's (NHSI) Single Oversight Framework and for Quarter three and Quarter four, the Trust achieved a financial rating of one (best) and met all four key performance indicators for the year.

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. The table in Section 4.5 indicates the Trust's regulatory ratings for 2016/17.

Performance Summary of 2016/17

The Trust achieved all applicable Cancer Waiting Times standards for each Quarter of 2016/17, with the exception of the 62 day screening standard where the Trust was below the 90% standard in Quarter 4.

Overall Trust performance against the A&E (Emergency Department) 4-hour waiting time standard was above 95% for three of the four Quarters during 2016/17. However, sustained delivery of this standard remained challenging over the winter period. The development and implementation of plans to enable the Trust to move back to a positive performance position continued throughout the year, including improved staffing deployment and requirements, co-location of the GP Out of Hours Service, and an improvement in the departmental physical clinical capacity.

There were eight ambulance handover delays of over 60 minutes reported in 2016/17 and one hundred and four handover delays of over 30 minutes. Seven of the eight handover delays of over 60 minutes occurred in the winter period of the year when the department was under exceptional pressure. Emergency Department attendances were 2.2% higher than for the same period last year.

Activity levels at the Trust have increased during 2016/17. Elective (waiting list) admissions were 1.6% higher in 2016/17 when compared to 2015/16 and Outpatient attendances also increased by 3.3%. Non-elective admissions increased by 4.8% and the number of avoidable admissions (as per the national Commissioning for Quality and Innovation definition) decreased by 2% over the same period.

During 2016/17 there was a 6% increase in face to face contacts recorded by the adult community nursing teams.

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 below the 80% standard in 2016/17 with 78.4% of patients meeting the standard. Delivery of the Transient Ischaemic Attack (TIA) standard was at 85% against the 60% national standard. The Trust achieved the 18 week Referral to Treatment (RTT) standard throughout the year.

The Trust reported 29 cases of hospital acquired *Clostridium difficile* in 2016/17. Root Cause Analysis (RCA) results indicated that 24 of these cases were not due to lapses in care, and therefore, these would be discounted from the Trust's trajectory for 2016/17. No cases of hospital acquired MRSA (Methicillin-resistant Staphylococcus Aureus) were reported in 2016/17. The following table demonstrates the Trust's performance against the key indicators for each quarter in 2016/17:

Indicator description	Target	Q1	Q2	Q3	Q4	2016/17
Referral to Treatment Times admitted pathways (% within 18 weeks)	>=92%	96.1%	95.2%	94.2%	94.1%	94.9%
A&E: Total time spent in A&E is less than 4 hours	>=95%	95.4%	95.6%	93.8%	95.4%	95.1%
Cancer - Maximum waiting time of 14 days from urgent GP referral to date first seen for all urgent suspect cancer referrals (%)*	>=93%	95.6%	96.4%	97.9%	97.9%	97.0%
Cancer - maximum waiting time of 14 days for symptomatic breast patients (cancer not initially suspected)*	>=93%	96.2%	97.8%	98.0%	96.6%	97.1%
Cancer - 31 day wait for second or subsequent treatment: Surgery*	>=94%	100.0%	95.0%	94.9%	100.0%	97.6%
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	>=98%	100.0%	100.0%	100.0%	100.0%	100.0%
Cancer - 31 day wait for second or subsequent treatment: Radiotherapy*	>=94%	NA	NA	NA	NA	N/A
Cancer - Maximum waiting time of 31 days from diagnosis to treatment for all cancers (%)	>=96%	99.6%	99.2%	98.3%	100.0%	99.2%
Cancer - 62 day wait for first treatment from urgent GP referral to treatment: all cancers	>=85%	89.6%	86.7%	92.6%	89.4%	89.6%

Indicator description	Target	Q1	Q2	Q3	Q4	2016/17
Cancer - 62 day wait for first treatment from consultant screening service referral: all cancers*	>=90%	90.9%	94.7%	95.2%	73.2%	85.4%
Clostridium difficile – cases due to a lapse in care (cumulative)	<= 12 cases in year	3	5	5	6	6
Community services data completeness - RTT information	>=50%	72.5%	82.0%	82.0%	82.1%	79.7%
Community services data completeness - Referral information	>=50%	68.2%	73.3%	73.8%	75.8%	72.8%
Community services data completeness - Treatment activity information	>=50%	81.0%	87.6%	91.3%	91.0%	87.7%

Performance 2016/17 and 2017/18

The Trust completed 2016/17 with a Financial Use of Resource Rating of one and a Green Governance rating, in line with NHSI's Single Oversight Framework, which is detailed in section 4.5. In the coming year, the Trust aims to achieve a surplus of £5.9m and to meet all the required performance targets as laid out in the framework. The surplus relates to the achievement of an underlying surplus of £2.1m, supported by Sustainability and Transformation funding.

The Trust will seek to achieve a minimum rating of two for Financial Use of Resources and maintain a rating of Green for Governance in 2017/18 and has detailed in its Operational Plan to NHSI, 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.

Significant Developments for 2017/18

In line with the Trust's Operational Plan for 2017/18 to 2018/19, the significant developments over the next two years can be summarised as follows:-

Urgent and Emergency Care

The Trust is part of the West Yorkshire Urgent and Emergency Care Network; this network is one of the eight national Urgent Care Vanguards and is focussed on delivery of the eight principles of Integrated Urgent Care. As part of the work, the Trust is engaged in a region wide Radiology Collaborative, which is leading procurement and developing transformational opportunities for the services. The Network has been designated an Acceleration Zone, with the focus on system wide delivery of the urgent care standards and supporting the rapid roll

out of Discharge along with enhanced streaming to primary and ambulatory care. This has supported the Trusts Capital plan to provide additional Emergency Department capacity which is now in place.

Stroke Care

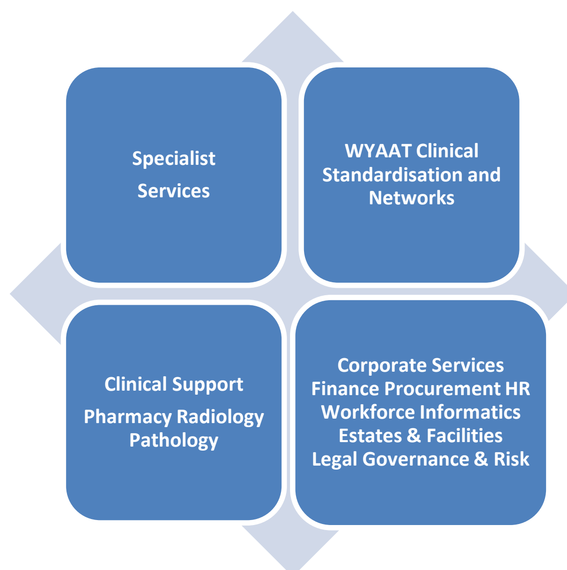
The Trust currently has a hyper acute stroke unit within Oakdale Ward. Discussions are ongoing through the Stroke Care Network to review services across acute Trusts to examine the pathway to ensure patients receive the most appropriate care in the right place at the right time. These discussions include YTHFT, as the future model is likely to require collaboration with this acute provider. This may mean stroke patients being treated in York for the first 72 hours where we can ensure sustainable hyper acute care will be provided. Patients will then return to the Trust for the remainder of their hospital stay.
Acute Hospital Collaboration

The Trust has a strong history of alliance based working, with well-established clinical alliances with YTHFT and LTHT already in place. We are also a member of WYAAT and are in the process of formalising our governance arrangements to enable greater collaboration. A high level programme structure linked to the West Yorkshire and Harrogate STP and the provision of a WYAAT Committee in Common has been agreed.

- **Developing 'Centres of Excellence'** approach to higher acuity specialties e.g. hyper-acute stroke, neurology, cancer, vascular, ear, nose and throat, maxillo facial, eliminating avoidable cost of duplication and driving standardisation;
- **Developing West Yorkshire and Harrogate standardised operating procedures and pathways** across services, building on current best practice and using Getting it Right First Time (GIRFT) to drive out variations in quality as well as operational efficiency and facilitating safer free movement of bank staff across providers;
- **Collaborating to develop clinical networks and creating alliances** as a vehicle (e.g. hyper acute stroke, cancer etc.) which will protect local access for patients whilst consolidating skills (and therefore resilience) and reducing operational cost of duplicated facilities. Using the principles of GIRFT, outcome variation data and the WYAAT work on sustainable services will assist in identifying the case for change for specific services;
- **Developing workforce planning at scale** to secure the pipeline of fit for purpose staff and improved productivity, managing workforce risk at system level and supporting free movement of bank and agency staff under single shared bank arrangements with the aim of reducing spend on agency staff and reduce the administration costs of the flexible workforce; and
- **Delivering economies of scale in back office and support functions** e.g. procurement, pathology services, Estates and Facilities Management and other infrastructure e.g. IT. The default position being consolidation.

The WYAAT Programme Approach

The structure of the programme will reflect these priorities as shown in the work stream in the diagram overleaf:



Work will continue in 2017/18 to take forward the key initiatives identified.

Quality

The Trust is fully committed to high quality care. The Quality Account, included within this Annual Report at Section 5, details progress made on the quality priorities identified in 2016/17 and the agreed quality priorities for the coming year. These priorities have been agreed with staff and stakeholders and have clear and measurable targets, with performance against these monitored regularly through the Trust's Quality Committee.

There is a governance and reporting framework in place to ensure that the Trust continues to deliver its operational plans and targets, which include other quality initiatives and indicators. Further detail about this is reported in the Annual Governance Statement in Section 4.7 of this report.

Operating and Financial Review of the Trust

The income and expenditure position for the Trust for 2016/17 was a surplus of £3,688k.

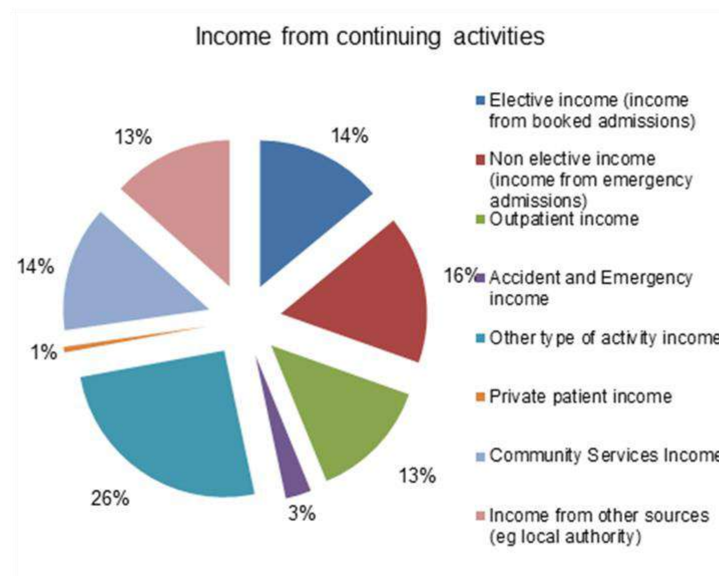
The table below provides a high level comparison of the income and expenditure account for 2016/17.

	2015/16 actual £000s	**2016/17 actual £000s**
Income	188,692	213,951
Expenditure	(188,315)	(213,713)
Net Surplus	377	238
Sustainability and Transformation Funding*	0	3,450
Reported surplus for financial year	377	3,688

*Sustainability and Transformation funding was given to Trusts from NHSI for achievement of control totals. £1.15m was available to the Trust each Quarter.

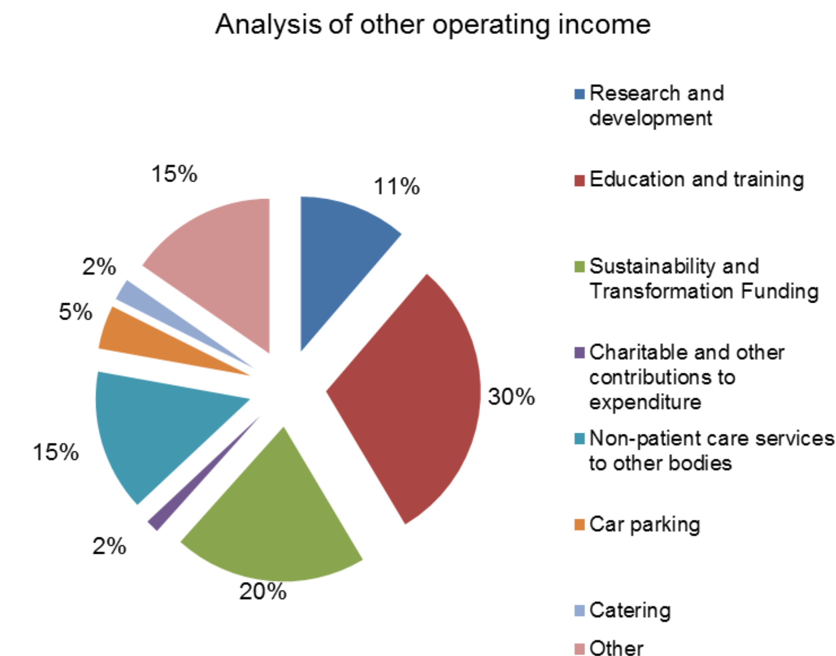
Income Generated from Continuing Activities

Total income from continuing activities for the year 2016/17 was £200,310k. This represented 92.1% of total income for the year. An analysis of this income is show overleaf:



Other Operating Income

Other operating income totalled £17,075k during 2016/17. This represented 7.9% of total income for the year and an analysis of this income is shown below:



Cash

The Trust has a cash balance of £4,555k at the close of the financial year.

NHSI Use of Resource Metric

The Trust received a Use of Resource Rating of 1 at the end of 2016/17. Financial Risk is assessed on a scale of 1 (low risk) to 4 (high risk).

Financial Outlook 2017/18

The Trust recognises the financial challenges both within the NHS and across the public sector as a whole. The Trust also recognises the opportunity to provide further resilience through the Sustainability and Transformation (S&T) funding offer, and through working with our local and regional partners within our STP footprint and beyond.

The Board is absolutely committed to delivering our agreed control total in both 2017/18 and 2018/19 and to making the necessary efficiency savings to enable the Trust to continue to develop based on a robust financial position.

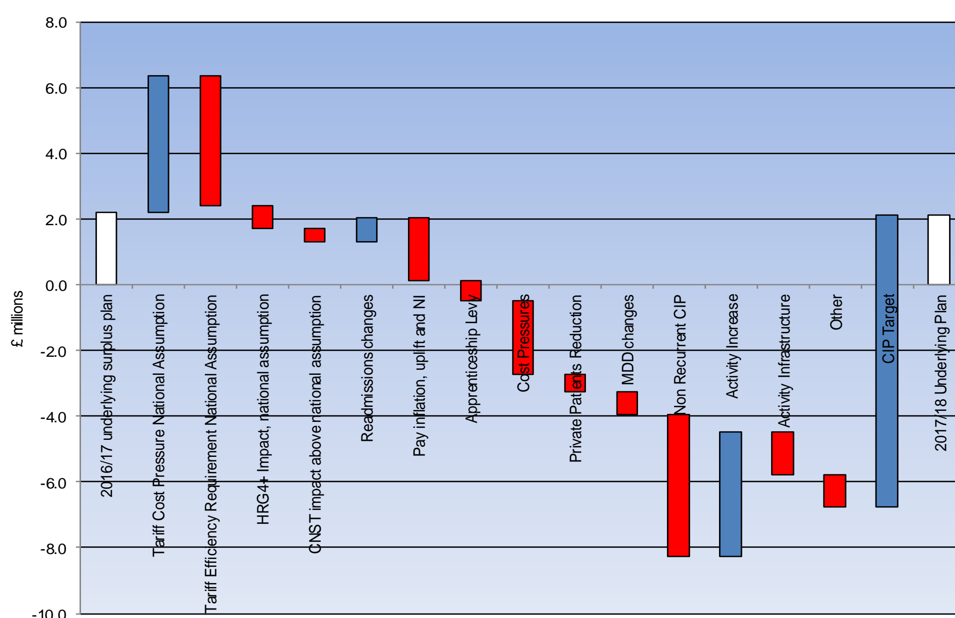
By accepting the offer of the S&T Funding, the Trust is committed to delivering a surplus of £5.9m in 2017/18 and 2018/19. This is an underlying surplus of £2.1m pre impairments and transfers, supported by the general element of S&T Fund of £3.8m. The assumptions within the plan are outlined below.

The following table describes the financial risks within the 2017/18 plan.

Planning Assumptions

	£'m
2016/17 underlying surplus plan	2.2
Tariff Cost Pressure National Assumption	4.2
Tariff Efficiency Requirement National Assumpti	-4.0
HRG4+ Impact, national assumption	-0.7
CNST impact above national assumption	-0.4
Readmissions changes	0.8
Pay inflation, uplift and NI	-1.9
Apprenticeship Levy	-0.6
Cost Pressures	-2.2
Private Patients Reduction	-0.6
MDD changes	-0.7
Non Recurrent CIP	-4.3
Activity Increase	3.8
Activity Infrastructure	-1.3
Other	-1.0
CIP Target	**8.9**
2017/18 Underlying Plan	2.132

CIP Percentage	4.15%
Recurrent Percentage	2.14%
Non Recurrent Percentage	2.01%



Issue	Financial Risk (£m)	Comments/Mitigations
Harrogate and Rural (HaRD) Contract	11.4	Strategy in relation to switching activity. STP priority in respect of elective centres and repatriation of work from private sector
Cost improvement plan (CIP) Delivery	2.3	Continued development of programme pre 1.4.17
Vanguard Programme	1.7	National funding decision. System wide commitment. Contract discussion to ensure neutrality

Capital Investment Activity

During 2016/17, the Trust invested £4.623m as part of the Trust's capital programme. The breakdown of the investment is show in the table overleaf:

Scheme	£'000
Carbon Energy Fund	1,080
Other	3,543
Total	**4,623**

Land Interests

During the financial year ending 31 March 2017, the Trust's land and buildings were re-valued by the Valuation Office Agency (Royal Institute of Chartered Surveyors qualified) 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 a valuation of the Trust's land and buildings of £87,656,864, which has been incorporated into the accounts.

Investments

The Trust 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

The Trust will drive forward the delivery of efficiency with the Clinical Transformation Board (CTB) and implementation of the Business Development Strategy supporting Directorates to deliver CIPs. This support is advancing, recognising the need to meet an increasingly challenging transformational programme.

The Transformation Programme which has developed over recent years is maturing, building on initial schemes and driving forward the implementation of challenging changes. The programme is also utilising internal benchmarking, model hospital data and other external benchmarks to scan the horizon for new opportunities. The financial risk related to achievement of these schemes is slightly higher than those linked to business as usual, reflecting the complex nature of many of the required changes.

The Business Development Strategy has continued its success and aims to continue to support the sustainability of the Trust, both financially and clinically.

The Quality Impact Assessment process relating to the efficiency programme continues to play a key role in ensuring quality, safety, and access is not compromised by efficiencies. This process has been further refined to include the impact on equality as part of these changes.

The Trust CIP target is £8.9m for 2017/18. It is recognised that the 4% target represents a challenging target, particularly when compared to the national efficiency target of 2%. The additional value is a result of non-recurrent CIPs from previous years. Although this is challenging the Trust has historically met these challenges. Processes are in place to give assurance and confidence that this target will be achieved.

Strategic Risks

The Trust records strategic risks to the organisation in the Board Assurance Framework (BAF), which is reviewed by the Board monthly in outline and quarterly in detail. The Board undertakes a 'deep dive' on each strategic risk at its development days to ensure appropriate oversight and understanding of the internal and external environment, and its impact on the Trust.

The risks on the corporate risk register for 2016/17 and going forward relate to the:

- Risk to the quality of service delivery in Medicine due to gaps in rotas following the Deanery allocation process;
- Risk to service delivery due to the lack of experienced registered nurses due to national labour market shortage;
- Risk to financial sustainability from failure to deliver the Clinical Transformation Programme at pace and scale;
- Risk to urgent care system due to a lack of capacity in the out of hospital services;
- Risk of financial deficit and impact on service delivery due to failure to deliver the Trust Annual Plan by having excess expenditure or a shortfall in income;
- Risk of patient harm as a result of being lost to follow-up;
- Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down;
- Risk to patient safety due to a lack of provision of acute oncology services;
- Risk of temporary reduced or loss of activity as a result of disruption to services due to the major refurbishment to the Sterile Services Department; and
- Risk to reputation due to non-compliance with DNACPR policy caused by failure of some clinicians to implement policy.

The BAF is reviewed by the Board of Directors, Audit Committee and the Trust's Corporate Risk Review Group to ensure appropriate triangulation of issues across the organisation. The committees carry out deep dives into individual areas of responsibility to ensure that the strategic risks are mitigated as far as possible, and that gaps in assurance and control are identified.

Further Details of the Trust's Strategic Plans

A range of actions are planned over the next few years to deliver the Trusts strategy. These are contained within the Trust's Operational Plan for 2017/18 and 2018/19 which can be found on the Trust website (www.hdft.nhs.uk).

The issues in relation to environmental matters, social, community and human rights can be found in the Accountability Report.

Approval by the Directors of the Performance Report

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

Signed

Dr Ros Tolcher
Chief Executive
24 May 2017

4. ACCOUNTABILITY REPORT

4.1. Director's Report

The Directors of the Trust during the year 2016/17 were:

Mrs Sandra Dodson	Chairman (Non-Executive Director)
Professor Sue Proctor*	Non-Executive Director and Vice Chairman
Mr Ian Ward	Non-Executive Director and Senior Independent Director
Mrs Maureen Taylor	Non-Executive Director and Chairman of Finance Committee
Mr Chris Thompson	Non-Executive Director and Chairman of Audit Committee
Mrs Lesley Webster	Non-Executive Director and Chairman of Quality Committee
Mr Neil McLean	Non-Executive Director
Dr Ros Tolcher	Chief Executive
Mr Jonathan Coulter	Finance Director and Deputy Chief Executive
Dr David Scullion	Medical Director
Mrs Jill Foster	Chief Nurse
Mr Robert Harrison	Chief Operating Officer
Mr Phillip Marshall	Director of Workforce and Organisational Development

*Professor Sue Proctor left the Trust on 31 March 2017

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. The Council of Governors' register is taken to the Council of Governor meetings on a quarterly basis. Both registers are available on the Trust website (www.hdft.nhs.uk) and on request from the Foundation Trust Office.

Accounting Policies

The Trust prepares its financial statements under direction from NHSI, in exercising the statutory functions conferred on Monitor, in accordance with the Department of Health Group Accounting Manual 2016/17, 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.

Better Payment Code of Practice

The Better Payment Code of Practice requires the Trust to aim to pay all valid non-NHS invoices within 30 days of receipt, or the due date, whichever is the later.

Year to 31 March 2016	Numbers	Year to 31 March 2017
46,667	No of invoices Paid to Date	53,867
8,559	No of invoices Paid in 30 Days	9,447
18%	% of invoices Paid in 30 Days	18%

Year to 31 March 2016	Values	Year to 31 March 2017
61,549	£K Value of invoices Paid to Date	76,491
23,960	£K Value of invoices Paid in 30 Days	39,404
39%	% of invoices Paid in 30 Days	52%

The Board 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.

Countering Fraud and Corruption

The Trust's counter fraud arrangements are in compliance with the Secretary of State's Directions on countering fraud and 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'. A Local Counter Fraud Annual Plan is produced and approved by the Trust's Audit Committee and identifies the actions to be undertaken to create an anti-fraud culture to deter, prevent, detect and, where not prevented, investigate suspicions of fraud.

Cost Allocation

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

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. The Trust 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 2017, the value of the funds held on trust amounted to £2,093,000, which is an increase of £329,000 from 2015/16, while the value of income received in the full 12 months amounted to £779,000 (£460,000 in 2015/16). The value of resources expended amounted to £701,000 (£819,000 in 2015/16). There was a gain on valuation of investments of £251,000 (£106,000 loss in 2015/16).

The investment portfolio is managed on discretion by Brewin Dolphin based in Leeds. Brewin Dolphin has powers to make changes to the investments without firstly obtaining agreement from the Trust's 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 2017 stood at £1,906,000 (£1,750,000 as at March 2016).

The Charitable Fund Annual Report and Accounts for the year ended 31 March 2017 is published separately and is available from the Trust on request.

Statement as to Disclosure to Auditors and Accounts Prepared under Direction from NHSI

So far as the Directors are aware, there is no relevant audit information of which the Auditors are unaware, and the Directors have taken all of the 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 Auditors are aware of that information. The Trust's accounts have been prepared under direction from NHSI, in exercising the statutory functions conferred on Monitor, in accordance with the Department of Health Group Accounting Manual.

Statement of Accounting Policies

Accounting policies for pensions and other retirement benefits are set out in notes 5.3 and 5.4 to the accounts. Details of senior employees' remuneration can be found in the remuneration report in Section 4.2.

Charitable and Political Donations

During 2016/17 no charitable or political donations were made by the Trust.

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 2016/17.

Enhanced Quality Governance Reporting

The Board of Directors continues to improve its approach to quality governance which is the combination of structures and processes to ensure the delivery of high quality care. This included improving reporting processes and triangulating performance outcomes across the organisation, taking action on sub-standard performance and driving continuous improvement, ensuring delivery of best-practice, and identifying and managing risks to quality of care.

The Board constituted the Quality Committee to have delegated authority for driving and monitoring the work to deliver quality of care, by focusing on the leadership, management, measurement, and monitoring of quality improvement. Quality improvement priorities and work plans are developed with identified leads, targets and metrics, and the progress with each is monitored regularly by the committee. The priorities reflect the three elements of quality; patient safety, effective care and patient experience. Other quality indicators and work is lead, reported and monitored within the quality governance structure of the Trust. The Quality Committee and the governance structure promote the embedding of quality throughout the Trust.

Detail of quality performance is described in the Quality Account (Section 5), and further detail of quality governance is included in the Annual Governance Statement (Section 4.7).

The publication of Monitor's Well-led framework for governance reviews (April 2015) provided a framework based on Monitor's quality governance framework, for Trusts to gain assurance that they are well led. The framework is comprised of a self-assessment against a body of 'good practice' outcomes and evidence that can be used to assess governance processes, and evaluate the organisation's performance, internal control and BAF. The Trust commissioned Deloitte to undertake an independent review of our self-assessment with a view to identifying areas of improvement to ensure the Trust continues to have a strong platform on which to set strategy, lead the organisation, and be truly accountable to stakeholders in the future.

The outcome of the assessment in December 2015 was extremely positive and highlighted many areas of good practice in the Trust. An action plan was developed to address recommendations to enhance the Trust's strong quality governance processes even further. This was completed in October 2016, except for an action to undertake a further independent Board effectiveness review over the next twelve months to assess the impact of the Board's refreshed governance structures as they become further embedded.

The Trust will be reviewing the new Care Quality Commission well-led framework which aims to be a single structure through which leadership, management and governance can be assessed and reviewed, to ensure the delivery of sustainable, high quality, patient-centred care across local health and care economies, support learning and innovation, and promote an open and fair culture.

NHS Foundation Trust Code of Governance

The Trust complies with the provisions of the 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 Section 4.4 of the report. Information relating to quality governance systems and process is detailed throughout this Annual Report, but in particular, in the Annual Governance Statement and Quality Account.

Care Quality Commission (CQC) Reports

The CQC, the independent regulator of all health and adult social care services in England, carried out an inspection of the Trust between 2 and 5 February 2016. The CQC register, monitor, and inspect services to make sure Trusts provide safe, effective, compassionate, high-quality care. Patients and families who had used the Trust's acute and/or community services were invited to meet the CQC inspectors as an opportunity to discuss their experiences.

The report of this inspection was published on 27 July 2016 and there was much to be proud of. The Trust was rated as good overall, with services overall rated as outstanding for caring. Some individual services were rated as outstanding including community dental services, community health services for adults, services within critical care, and outpatients and diagnostic services. Several areas of outstanding practice were noted and subsequently highlighted in the publication by the CQC: The state of care in NHS acute hospitals 2014 – 2016 (March 2016). The inspection report noted that there was a strong governance framework, which ensured that responsibilities were clear and that quality, performance and risks were understood and managed.

There were some specific areas where the Trust was required to make improvements and an action plan was developed to ensure these were progressed effectively, with evidence to support the improvements made and on-going assurance of improvement. Key areas for service improvement were to ensure:

- The environment on the paediatric ward is appropriate to allow the needs of children and young people with mental health needs to be fully taken into account;
- Accurate nursing records are kept in line with professional standards particularly in urgent and emergency services;
- Medical records are stored securely;
- Good infection prevention and control practices are adhered to;
- An effective infection prevention and control audit programme for the environment and hand hygiene in adult community services and Selby MIU is in operation;
- All medicines are stored safely and disposed of when out of date;
- There are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice at all times;
- All staff have completed mandatory training, role specific training and had an annual appraisal;
- Guidelines and protocols are up to date and there is an effective system in place to review these in a timely manner;
- Medical devices are subject to servicing in line with recommended guidelines; and
- The facilities in and access to the mortuary is improved.

Progress is being reported to the CQC regularly and actions defined to meet the improvement requirements have now largely been completed.

<u>Children who are Looked After and Safeguarding (CLAS) Reviews</u>

We have had three CLAS reviews by the CQC during 2016/17:

- October 2016 - Durham 0-19 service;
- December 2016 – City of York (Looked after Children only); and
- February 2017 – North Yorkshire (Acute and Community Services).

The reviews are conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups. The review explores the effectiveness of health services for Looked After Children and the effectiveness of safeguarding arrangements within health for all children. The focus is on the experiences of Looked After Children, and children and their families who receive safeguarding services.

The CQC Children's Services Inspection teams look at:

- The role of healthcare providers and commissioners;
- The role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews; and
- The contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.

They also check whether healthcare organisations are working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2015.

Where they find areas for improvement in services provided by NHS but commissioned by the Local Authority, they will bring these issues to the attention of the local public health team in a separate letter.

We are awaiting the reports from these reviews.

The Board can confirm that there are no material inconsistencies between: the Annual Governance Statement; Annual and Quarterly Board statements as required by the Risk Assessment Framework; the Corporate Governance Statement submitted with the Annual Plan; the Quality Account; this Annual Report; and, any reports from the Care Quality Commission.

Development of Services Involving Other Local Services/Agencies and Involvement in Local Initiatives

The Trust has been a major partner in the PAC Vanguard working with colleagues at North Yorkshire County Council (NYCC), Harrogate Borough Council (HBC) Tees, Esk and Wear Valley (TEWV) NHS Foundation Trust, HaRD Clinical Commissioning Group (CCG) and Yorkshire Health Network (YHN) the local GP Federation, to implement integrated community teams within the district. As part of the Vanguard work four locality Community Care Teams have been established to provide joined up care to the populations within these areas. We are currently entering the final year of the Vanguard funding and are testing out a new way of integrating teams across social, primary care, mental and adult health services. This involves the establishment of a multi-agency team that will focus on a group of high risk individuals identified by GP practices to see if we can provide them with support to reduce attendances and admissions to hospital. We will be evaluating this during 2017/18 and if it is effective consider how we can roll this out across the district.

Stakeholder Involvement

- New Macmillan Lead Nurse for Cancer and End of Life

Noreen Hawkshaw was appointed to Lead Nurse for Cancer and End of Life and commenced in post in October 2016. Noreen has a wealth of experience as a Nurse Specialist within Upper Gastrointestinal (GI) and Hepatobiliary cancers in Leeds. Noreen is also an Executive Nurse /AHP member of Association of Upper GI Surgeons. She has worked with Specialist Commissioners to advise regarding the appropriate configuration of pancreatic services across Yorkshire. Since appointment in Harrogate she is a member of the West Yorkshire and Harrogate Cancer Alliance Patient Experience Group

- Living With and Beyond Cancer Project

The overall aim of this project is to develop and implement new cancer follow-up pathways and a ‘Recovery Package’ in line with the National ‘Living With and Beyond Cancer Programme’ recommendations. This is to ensure that future services can fulfil the unmet need identified by the National Programme, whilst continuing to meet the increasing demand on resources resulting from the rising incidence of cancer and increased survival rates.

In May 2014 a steering group was convened with a broad range of stakeholders including patient representatives from the Harrogate Cancer Action Partnership, Macmillan Involvement Coordinator, HaRD CCG, and GP Cancer Lead.

In 2016 we appointed two fixed term posts funded by Macmillan to deliver health and wellbeing programmes. These commenced initially for Breast and Colorectal. These are group sessions whereby patients who have completed treatment and triaged through MDT as low or medium risk of cancer recurrence attend the group to learn more about their disease, strategies for recovery and self-care.

This reduces the need for formalised attendance at consultant led clinics, whilst also enhancing the patient experience and ability to recover, resume previous or new opportunities for healthy lifestyles and equip with the skills in recognising appropriate early signs of cancer recurrence and how to re- access services again in a timely way. This will be formally re-evaluated in late 2017 to determine how we progress further to other sites.

The use of an electronic holistic needs assessment tool piloted in 2015 is now being rolled out. This method of assessing patient need is intended to enhance the use and consistency of assessments and will enable the resulting care plan to be shared electronically with both primary and secondary care colleagues.

- Cancer Locality Board

The Cancer Locality Board's purpose is to ensure there is locality-wide and cross-organisational influence and agreement for the cancer agenda and cancer pathways. Representation includes the Chairman and patient representative from Harrogate Centres for Voluntary Service (CVS) as well as GP, CCG, Cancer Alliance, Cancer Research UK (CRUK) colleagues. The group ensures local needs are articulated and met appropriately for cancer patients and their carers.

- Quality Surveillance Program (Formerly Cancer peer Review)

The new Quality Surveillance Program was introduced in 2016. This is a surveillance program for all specialised commissioned services and cancer. New indicators were introduced which consolidated a number of previous Cancer peer Review measures. In 2016 we were requested to 'self-declare' against the newly published indicators. Our self-declaration has been assessed at regional level and triangulated with other national data i.e. outcomes, incidents, risks and National Patient Experience Survey. This triangulation informs the level of assessment required for 2017/18. All cancer sites have been assessed as only requiring a self-declaration for 2017.

Other developments within cancer services are reported within the Quality Account.

<u>Surveys and Patient and Service User Feedback</u>

When national patient survey reports are published the Trust assigns a lead person to review the report. The Trust performance is reported to the Quality Committee, and progress with any action plans developed to address recommendations is monitored to ensure actions to deliver improvements are implemented.

Local patient and service user feedback is valued and shared with staff. Positive feedback encourages staff engagement in ongoing provision of high quality care, and negative feedback is used to encourage learning and improvement. A quarterly patient experience report triangulates all patient and service user feedback including from the Patient Experience Team, the Friends and Family Test, and from social media, and is presented to the Learning from Patient Experience Steering Group and the Quality Committee.

Further detail about specific patient surveys and other patient and service user feedback is contained within the Quality Account, which is included at Section 5.

<u>Partnerships and Alliances/Relationship Management</u>

The Trust has a strong history of alliance based working with well-established clinical alliances with YTHFT and LTHT already in place.

Over the last 12 months we have engaged with YTHFT to explore opportunities for greater collaboration. Discussions have also continued with LTHT with a number of new initiatives introduced, including providing Endoscopy sessions at Wharfedale General Hospital in Otley. Work will continue between both organisations to scope options for further collaborations across a range of specialties, including paediatric medicine and maternity services.

We are also a member of WYAAT and have been formalising our governance arrangements to enable greater collaboration. A high level programme structure linked to the West Yorkshire and Harrogate STP and WYAAT Committee in Common has been agreed. This will be rolled out in 2017/18.

Work has also continued through our relationship management model to ensure that the Trust is fully engaged with its key stakeholders keeping them fully up to date on work that is ongoing in the Trust and to explore further opportunities for partnerships and alliance based working.

Significant Activities in the Field of Research and Development

Information on research and development within the Trust is contained within the Quality Account, which is included at Section 5.

New Services and Developments

New service initiatives in 2016/17 included a review of the staffing within the Estates department, which involved a restructure of the department to deliver improvements in quality and response times. A new structure was successfully implemented in March 2017.

In addition, the Facilities Department also provided additional domestic support to the community hospital in Ripon.

Business Development

The organisation has been actively taking forward the implementation of the Business Development Strategy. We have been successful in 2016/17 in taking forward a number of key initiatives including:

- Successfully mobilised the 0 – 19 Children's Services in County Durham, Darlington and Middlesbrough to enable smooth transition with 'business as usual';
- Successfully won the tender to deliver Podiatry Services for Vale of York, Ryedale and Scarborough CCGs and progressing with the mobilisation of the Service to commence on 1 May 2017; and
- Providing Vaccination and Immunisation Services in York, North Yorkshire, Teesside County Durham and Darlington.

In addition to securing additional income through bidding for services, the Trust has also commenced the delivery of a range of Outreach Clinics in a new GP facility in Alwoodley, North Leeds.

Work will continue to roll out the next phase of our Business Development Strategy. This will include consolidation and expansion of Children's Services, continue to increase services for Leeds and the implementation of the Private Patient and Communications and Marketing Strategies, which will form part of our work programme in the coming months.

Improvements in Patient/Carer Information

At the start of 2016/17, the Trust launched a completely new website, delivering an improved user experience, clearer information and a much more modern look and feel which better reflects the Trust's vision and values.

The redevelopment of the website included extensive engagement with users including patients, visitors, and staff, who helped the development team to fully understand the needs of site visitors.

On the site's home page, a greater, clearer focus has been given to the key information that people want the most – how to find us, contact details, car parking, and visiting hours. There is also a large area for promoting the Trust's latest news.

The website also features a completely new consultants area which features a short biography and photograph of all the consultants working at the Trust. Elsewhere, all services pages have been reviewed, reordered, and in many cases, completely refreshed.

In line with all NHS trusts, the Trust was legally obliged to start implementing the Accessible Information Standard. The Standard tells organisations how they should make sure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate. The Trust has continued its work with a local not-for-profit company, Straight Talkers, who agreed to support the Trust to engage with patients to understand their needs and put in place systems for capturing and appropriately recording patient preferences. Ways of capturing patient requirements are being built in to a new patient records system, currently in development.

The Trust has continued to develop its social media presence, opening up new channels of dialogue with patients, members of the public, and other stakeholders. The Trust's main corporate Facebook and Twitter accounts have shown strong growth in follower numbers/likes over the year, as well as overall levels of engagement. These channels have been particularly useful for sharing information at times when urgent communication is required, such as when the Trust has faced winter pressures.

Over the year, significant support and guidance has been provided to teams across the Trust who wish to have their own service page. There are now approximately 20 Trust social media accounts in place now, with more due to come online. This process has been supported by the development of a Trust-wide Social Media Policy and a clear process for the approval of accounts based around need and objectives.

Patient information leaflets continue to be developed with the assistance of volunteer lay readers who evaluate the content and presentation. This enhances the readability of the leaflet which in turn helps ensure patients are better informed regarding appointments, procedures, treatment and self-care. There continues to be internal processes to ensure high standards are maintained with regular review of leaflets.

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 and in community locations. Patient Experience Volunteers (PEV) work to publicise the Making Experiences Count Policy and the process by which the public can share feedback regarding the Trust's services. They are based at the front of Harrogate District hospital in the Main Reception during normal working hours.

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 complainant, 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 between the complainant and Trust from the outset and must be proportionate to the issue raised.

Where a complaint is graded as 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 checks 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.

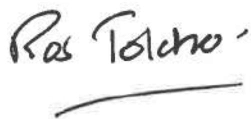
There is no time limit for giving feedback to the Trust for those issues which fall outside the Complaints Regulations. All feedback will be received and acted upon wherever possible to ensure learning and improvement for the organisation. Where the issue is coded as a complaint, the regulations set 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 Learning from Patient Experience Group (LPEG) and the Quality Committee on a quarterly basis and in turn to the Board of Directors.

Approval by the Directors of the Accountability Report

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

Signed



Dr Ros Tolcher
Chief Executive
24 May 2017

4.2. Remuneration Report

The Remuneration Committee for Executive Directors meets as and when required and comprises:

Date of Meeting	21 April 2016	27 June 2016	26 Sept 2016	24 Oct 2016
Sandra Dodson Chairman	✓	✓	✓	✓
Professor Sue Proctor Non-Executive Director and Vice-Chairman *	✓	X	✓	✓
Ian Ward Non-Executive Director and Senior Independent Director	✓	X	X	✓
Lesley Webster Non-Executive Director	✓	✓	✓	✓
Chris Thompson Non-Executive Director	✓	✓	X	✓
Maureen Taylor Non-Executive Director	✓	✓	✓	X
Neil McLean Non-Executive Director	✓	✓	✓	✓

*Professor Sue Proctor left the Trust on 31 March 2017.

Dr Ros Tolcher, Chief Executive and Mr Phillip Marshall, Director of Workforce and Organisational Development attend meetings of the Committee in an advisory capacity. The Remuneration Committee is a sub-committee of the Board of Directors and the key outcomes from this Committee are shared with the full Board of Directors.

The details of remuneration of individual Directors are included within this report. The basic salaries of Directors in 2016/17 were uplifted by 1% for inflation/cost of living purposes, consistent with the Very Senior Manager Pay Framework in the NHS. In addition, remuneration for Directors was benchmarked against other organisations and adjustments made as the committee felt appropriate.

There are no bonuses paid or special provisions regarding early termination of employment for Executive Directors. Either party can waive the rights to notice or accept payment in lieu of notice. Trust policy works within the principles contained in HM Treasury Guidance on how to manage public funds in respect of ‘special payments’ and the Code of Governance for NHS Foundation Trusts.

The Trust’s Remuneration Committee has agreed Terms of Reference which includes specific aims and objectives. These terms are published on the Trust’s Intranet site for all staff to access.

The role of the Remuneration Committee is to make such recommendations to the Board of Directors on remuneration, allowances and terms of service as 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.

The Committee provides advice to the Board of Directors on pay policy and other contractual matters for the Chief Executive and all Executive Directors. Comparative sources of guidance used by the Remuneration Committee for the determination of Directors' remuneration have been the NHS Providers Remuneration Survey and the CAPITA NHS Foundation Trust Board Remuneration Report. 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. External benchmarking information is used wherever possible so that decisions on remuneration are objective, fair, and proportionate.

The Committee monitors and evaluates the performance and development of the Chief Executive and all Executive Directors and advises on and oversees appropriate contractual arrangements for the Chief Executive and all Executive Directors. This includes the proper calculation and scrutiny of termination payments, as appropriate in the light of available guidance, all aspects of salary (including any performance-related element) and the provisions for other benefits, including pensions and cars.

All other senior managers (and all non-medical staff below Director level) are remunerated at Agenda for Change pay rates and 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 members of the performance of the Chief Executive and each Director.

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. The Chief Executive and the Directors 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 Directors are offered permanent and full-time contracts of employment. The Chief Executive and all Directors are entitled ordinarily to six months' notice to terminate their employment.

There was an increase in the net remuneration paid to the Chief Executive from the start of the financial year.

As a result of changes in pension regulations around the Lifetime Allowance, the Trust's Remuneration Committee followed HM Treasury guidance and agreed a new policy. For individuals employed by the Trust who are reaching or exceeding their pension Lifetime Allowance, the Trust now offers a Pensions Restructuring Payment. This payment is typically equal to the employer's contribution to the NHS Pension Scheme, paid net of employer's National Insurance contribution. This is a financially neutral model for the Trust.

The Chief Executive's application for a pension restructuring payment was approved by the Trust's Remuneration Committee. In addition, the Committee agreed that an uplift in the basic remuneration of the Chief Executive should be awarded, after reviewing benchmarking information and performance.

Under the requirement to disclose where one or more senior managers are paid more than £142,500, Harrogate and District NHS Foundation Trust can confirm that the salary of Dr Tolcher, Chief Executive, is the only officer of the Trust to exceed this value. The remuneration Committee assessed the salary of the Chief Executive in light of the Trust's performance and circumstances and is satisfied that this salary paid is fair and appropriate.

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

Name and Title	2016/17						2015/16					
	Salary	Taxable benefits	Total Salary and taxable benefits in year	Pension related benefits	Total	Ratio of Total Salary to Median for All Staff (1)	Salary	Taxable benefits	Total Salary and taxable benefits in year	Pension related benefits	Total	Ratio of Total Salary to Median for All Staff (1)
	(bands of £5,000) £'000s	Rounded to the nearest £	(bands of £5,000) £'000s	(bands of £2,500) £'000s	(bands of £5,000) £'000s		(bands of £5,000) £'000s	Rounded to the nearest £100	(bands of £5,000) £'000s	(bands of £2,500) £'000s	(bands of £5,000) £'000s	
Dr R Tolcher - Chief Executive (2)	210-215	-	210-215	-	210-215	6.67	160-165	1000	160-165	15-17.5	175-180	5.97
Mr. J Coulter - Deputy Chief Executive	135-140	-	135-140	125-127.5	265-270	5.04	120-125	-	120-125	17.5-20	140-145	4.63
Dr D Scullion - Medical Director (3)	180-185	5669	190-195	57.5-60	245-250	6.45	190-195	-	190-195	72.5-75	220-225	7.39
Mrs. J Foster - Chief Nurse	105-110	-	105-110	87.5-90	195-200	3.91	95-100	-	95-100	0	95-100	3.73
Mr. R Harrison - Chief Operating Officer	120-125	-	120-125	67.5-70	190-195	4.48	110-115	-	110-115	37.5-40	150-155	4.19
Mr. P Marshall - Director of Workforce and Organisational Development	110-115	2837	110-115	75-77.5	185-190	4.11	105-110	200	105-110	15-17.5	120-125	4.01
Mrs. S Dodson - Chairman	45-50	-	45-50	-	45-50	-	45-50	-	45-50	-	45-50	-
Prof. S Proctor - Senior Independent Director of the Board of Directors (4)	15-20	-	15-20	-	15-20	-	15-20	-	15-20	-	15-20	-
Mrs. M Taylor - Non-Executive Director	10-15	-	10-15	-	10-15	-	10-15	-	10-15	-	10-15	-
Mr. I Ward - Non-Executive Director	15-20	-	15-20	-	15-20	-	15-20	-	15-20	-	15-20	-
Mrs. L Webster - Non-Executive Director	10-15	-	10-15	-	10-15	-	10-15	-	10-15	-	10-15	-
Mr. N McLean - Non-Executive Director (5)	10-15	-	10-15	-	10-15	-	10-15	-	10-15	-	10-15	-
Mr. C Thompson - Non-Executive Director/ Audit Committee Chairman	15-20	-	15-20	-	15-20	-	15-20	-	15-20	-	15-20	-

(1) The median salary for all staff in 2016/17 was £27,631. The median salary for all staff in 2015/16 was £26,041. The median calculation is the annualised full time remuneration of all staff in the Trust as at 31 March 2017 (excluding agency staff), excluding the highest paid Director. The ratio is based on the total salary and benefits in year.

(2) For individuals employed by the Trust who are reaching or exceeding their pension Lifetime Allowance, the Trust now offers a Pensions Restructuring Payment. This payment is typically equal to the employer's contribution to the NHS Pension Scheme, paid net of employer's National Insurance contribution. This is a financially neutral model for the Trust.

The Chief Executive's application for a pension restructuring payment was approved by the Trust's Remuneration Committee. This payment is outlined under other remuneration.

(3) The Medical Director remuneration includes payment to Dr Scullion for both this role and his clinical post as Consultant Radiologist. The Medical Director proportion of his salary equates to 25% of the salary outlined above.

(4) Prof. S Proctor ceased as Non-Executive Director on 31 March 2017.

(5) Mr. N McLean commenced as Non-Executive Director on 1 May 2015.

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

The nature of taxable benefit figures relate to taxable expenses and lease car arrangements.

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.

	Number in post on 31 March 2017	Number claiming expenses	Total value claimed (rounded to £00)	Number in post on 31 March 2016	Number claiming expenses	Total value claimed (rounded to £00)
Board of Directors	13	10	7,300	13	6	4,900
Council of Governors	22	2	500	22	8	500

Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2017 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2017 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Real Change in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension to nearest £100
Dr Rosamond Tolcher - Chief Executive	£Nil	£Nil	£Nil	£Nil	£Nil	£Nil	£Nil	£Nil
Mr. Jonathan Coulter - Deputy Chief Executive	5-7.5	10-12.5	40-45	110-115	571	683	112	£Nil
Dr David Scullion - Medical Director	2.5-5	10-12.5	65-70	195-200	1,260	1,371	111	£Nil
Mrs. Jill Foster - Chief Nurse	2.5-5	12.5-15	40-45	130-135	707	810	104	£Nil
Mr. Robert Harrison - Chief Operating Officer	2.5-5	5-7.5	20-25	55-60	226	270	44	£Nil
Mr. Phillip Marshall - Director of Workforce and Organisational Development	2.5-5	5-7.5	40-45	115-120	603	676	73	£Nil

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

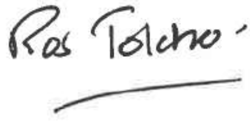
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made 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.

Approval

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

Signed

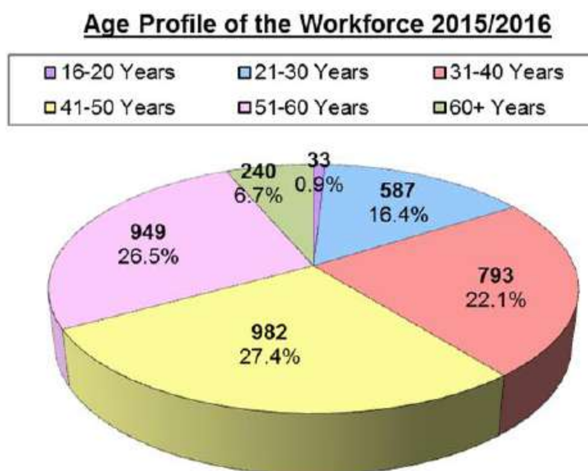


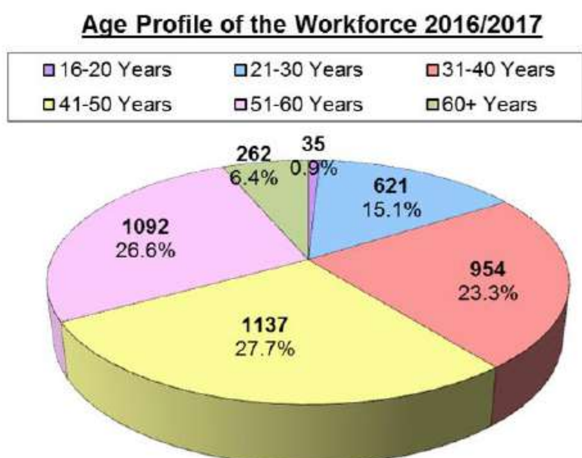
Dr Ros Tolcher
Chief Executive
24 May 2017

4.3. Staff Report

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 2015/16 and 2016/17. All figures are taken for the end of the financial year.

Analysis of the Age Profile of the Workforce as at 31 March 2017





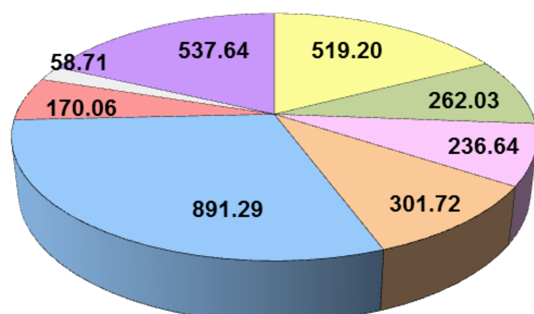
The table below gives a breakdown of the number of employees, by age, as at 31 March 2017.

	2015/2016		2016/2017	
Age Band	**Headcount**	**% of Workforce**	**Headcount**	**% of Workforce**
16-20 Years	33	0.9%	35	0.9%
21-30 Years	587	16.4%	621	15.1%
31-40 Years	793	22.1%	954	23.3%
41-50 Years	982	27.4%	1,137	27.7%
51-60 Years	949	26.5%	1,092	26.6%
60+ Years	240	6.7%	262	6.4%
TOTAL	**3,584**		**4,101**	

An Analysis of Average Staff Numbers

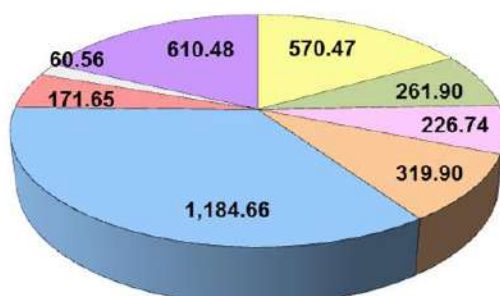
Staff Group Profile of the Workforce 2015/2016 (WTE)

Administrative and Clerical
Allied Health Professionals
Estates and Ancillary
Medical and Dental
Nursing and Midwifery Registered
Scientific and Technical
Senior Management
Support Workers



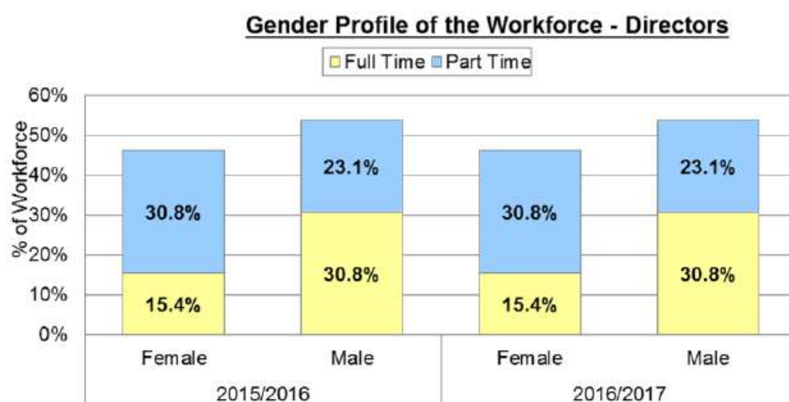
Staff Group Profile of the Workforce 2016/2017 (WTE)

Administrative and Clerical
Allied Health Professionals
Estates and Ancillary
Medical and Dental
Nursing and Midwifery Registered
Scientific and Technical
Senior Management
Support Workers



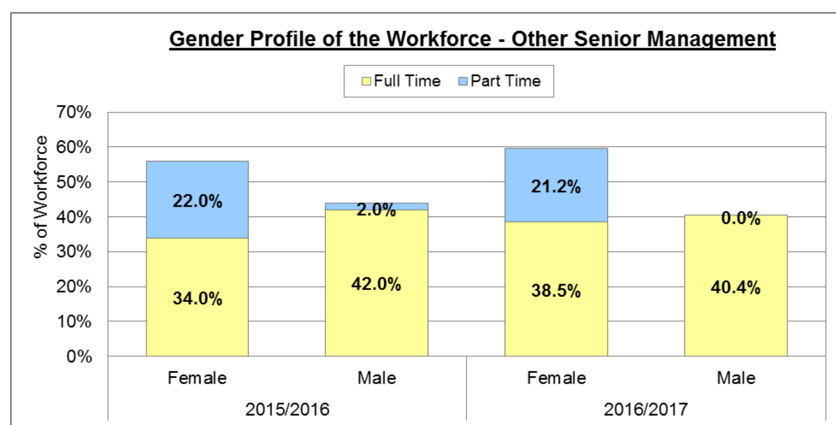
Staff Group	2015/2016		2016/2017	
	Whole Time Equivalent (WTE)	Headcount	WTE	Headcount
Administrative and Clerical	519.20	626	570.47	685
Allied Health Professionals	262.03	324	261.90	321
Estates and Ancillary	236.64	285	226.74	272
Medical and Dental	301.72	368	319.90	400
Nursing and Midwifery Registered	891.29	1,069	1,184.66	1,411
Scientific and Technical	170.06	192	171.65	191
Senior Management	58.71	61	60.56	63
Support Workers	537.64	659	610.48	758
TOTAL	**2,977.29**	**3,584**	**3,406.36**	**4,101**

Analysis of the Male and Female Directors, Other Senior Managers and Employees as at 31 March 2017



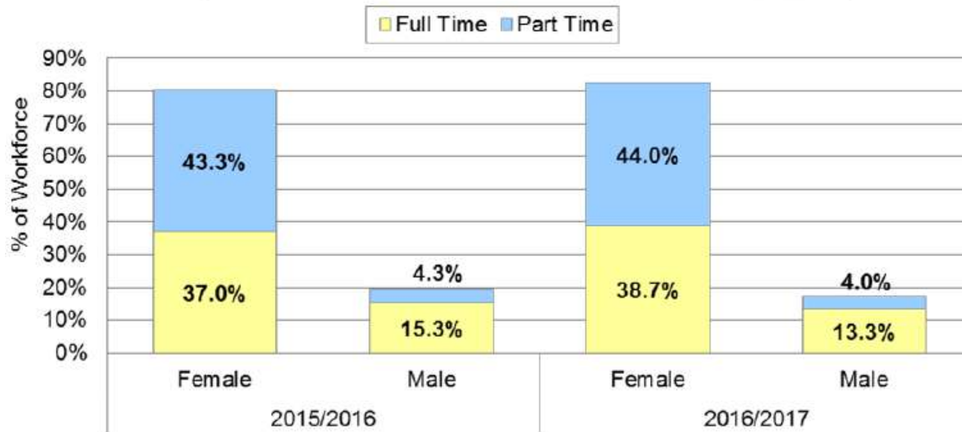
The table below gives a breakdown of the number of Directors, including Non-Executive Directors, by gender, as at 31 March 2017.

Directors		2015/2016	2016/2017
Gender	Category		
Female	Full Time	2	2
	Part Time	4	4
Male	Full Time	4	4
	Part Time	3	3
TOTAL		13	13



The table below gives a breakdown of the number of other senior management, by gender, as at 31 March 2017.

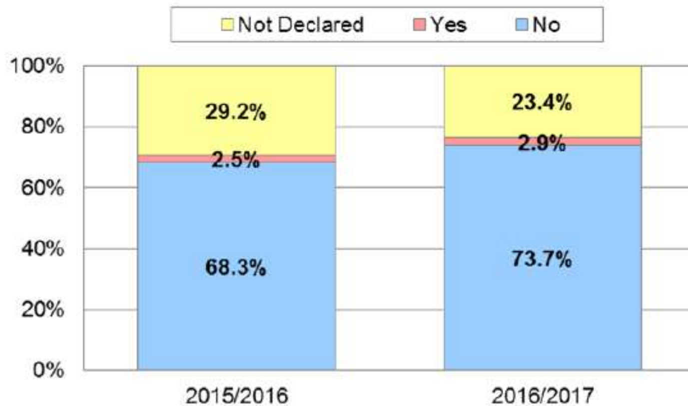
Other Senior Management	Category	2015/16	2016/17
		Headcount	Headcount
Female	Full Time	17	20
	Part Time	11	11
Male	Full Time	21	21
	Part Time	1	0
TOTAL		50	52



The table below gives a breakdown of the number of other employees, by gender, as at 31 March 2017.

Gender Other Employees	Category	2015/2016 Headcount	2016/2017 Headcount
Female	**Full Time**	1304	1561
	Part Time	1526	1775
Male	**Full Time**	540	538
	Part Time	151	162
TOTAL		**3,521**	**4,036**

Analysis of the Disability Profile of the Workforce as at 31 March 2017



The table below gives a breakdown of the number of employees registered as having a disability as at 31 March 2017.

Disabled	2015/2016 Headcount	2016/2017 Headcount
No	2,449	3,022
Yes	88	119
Not Declared	1,047	960
TOTAL	**3,584**	**4,101**

Sickness Absence Data

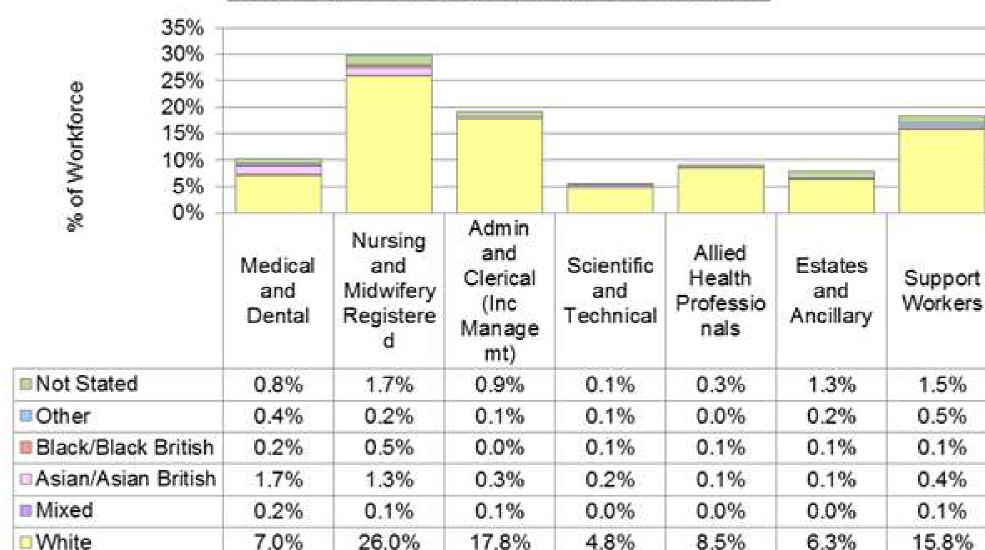
The table below shows the Trust's sickness absence data for each quarter during the 2016/17 financial year.

DIRECTORATE	16/17 Q1 % Abs Rate (FTE)	16/17 Q2 % Abs Rate (FTE)	16/17 Q3 % Abs Rate (FTE)	16/17 Q4 % Abs Rate (FTE)	Cumulative % Abs Rate
Children's and County Wide Community Care	4.65%	4.31%	4.77%	3.93%	4.41%
Corporate Services	3.69%	3.06%	3.06%	3.73%	3.38%
Long Term and Unscheduled Care	4.00%	3.51%	3.94%	4.33%	3.94%
Planned and Surgical Care	3.95%	4.08%	4.59%	5.04%	4.42%
TRUSTWIDE TOTAL	**4.09%**	**3.79%**	**4.17%**	**4.30%**	**4.08%**

Key
16/17 Q1 – April 2016 to June 2016
16/17 Q2 – July 2016 to September 2016
16/17 Q3– October 2016 to December 2016
16/17 Q4 – January 2017 to March 2017

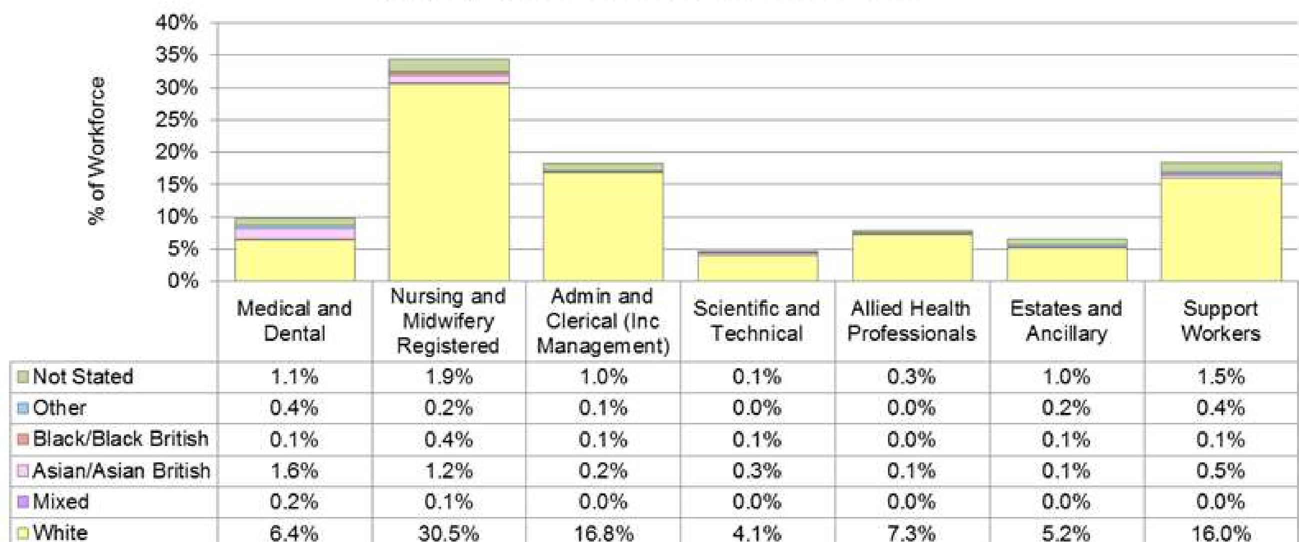
Equality and Diversity and Human Rights

The Trust continues to meet its requirements with regard to the Equality Duty and the Equality Act 2010. This year, evidence in support of the Trust's compliance included publishing the Trust's second Annual Workforce Race Equality Standard (WRES) report in October 2016, followed by the Equality Delivery System (EDS2) assessment in January 2017. Both of these reports are available to download via the equality and diversity pages of the Trust website. To improve governance arrangements, the stakeholder and workforce equality groups are now in place attended by officers of the Trust, service users, stakeholders, and interested volunteers from the workforce. Actions identified from the Workforce Race Equality Standard are being taken forward and implemented by the Workforce Equality Group.



	Medical and Dental	Nursing and Midwifery Registered	Admin and Clerical (Inc Managemt)	Scientific and Technical	Allied Health Professionals	Estates and Ancillary	Support Workers
Not Stated	0.8%	1.7%	0.9%	0.1%	0.3%	1.3%	1.5%
Other	0.4%	0.2%	0.1%	0.1%	0.0%	0.2%	0.5%
Black/Black British	0.2%	0.5%	0.0%	0.1%	0.1%	0.1%	0.1%
Asian/Asian British	1.7%	1.3%	0.3%	0.2%	0.1%	0.1%	0.4%
Mixed	0.2%	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%
White	7.0%	26.0%	17.8%	4.8%	8.5%	6.3%	15.8%

HEADCOUNT	Medical and Dental	Nursing and Midwifery Registered	Admin and Clerical (Inc. Management)	Scientific and Technical	AHP	Estates and Ancillary	Support Workers	TOTAL
Not Stated	29	61	34	4	12	45	53	**238**
Other	14	8	3	3	0	6	17	**51**
Black/Black British	6	18	1	4	2	3	3	**37**
Asian/Asian British	60	47	10	8	4	3	15	**147**
Mixed	8	4	2	0	1	1	3	**19**
White	251	931	637	173	305	227	568	**3,092**
TOTAL	**368**	**1,069**	**687**	**192**	**324**	**285**	**659**	**3,584**



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
Not Stated	45	78	42	5	14	43	60	**287**
Other	16	10	3	2	0	8	16	**55**
Black/Black British	5	18	4	4	1	3	5	**40**
Asian/Asian British	64	48	7	12	6	3	20	**160**
Mixed	8	5	2	1	0	1	1	**18**
White	262	1,252	690	167	300	214	656	**3,541**
TOTAL	**400**	**1,411**	**748**	**191**	**321**	**272**	**758**	**4,101**

Starters and Leavers During 2016/2017

	Headcount	FTE
Starters	1036	875.49
Starters of which TUPE	459	372.22
Leavers*	484	379.63
Leavers of which TUPE	45	35.37

*Exclusions applied to leavers:

- Retire and Returns
- Locum Medical and Dental staff
- Bank Staff
- Junior Doctors
- Fixed-Term Contractors
- Secondary Assignments

Human Resource (HR) Policies and Staff Information

The Trust has a suite of policies and procedures in relation to the workforce in order to support staff in their roles. Some of the key policies are detailed as follows:

The Single Equality Scheme and Strategy for 2014-2017 brings together the Trust's approach to equality, across all the protected interest groups, and respecting the basic human rights. It sets out proposals to strengthen and deepen the equality and diversity agenda and build on the previous Equality Schemes and action plans. It incorporates information on the Trust's approach to equal opportunities for staff in relation to recruitment, training and promotion and therefore replaces the need for a dedicated Equal Opportunities Policy. However, the Recruitment, Selection and Pre-Employment Checks Policy contains full information on the processes for recruitment and the Training Policy contains information on access to training for staff.

Modern Slavery is addressed under the umbrella of safeguarding at the Trust. All safeguarding training has been updated to include Modern Slavery and it is included in the Adult Safeguarding Policy. All staff are required to undertake safeguarding training to ensure they understand how to raise a concern.

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.

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 continues to strive for continuous improvement and continues to give priority to engaging with staff, setting high standards, learning from 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, the Trust acknowledges that staff should have confidence that their input is valued and that the Trust is responsive to their views in the decisions it takes, building on that positive relationship.

The Trust has a number of mechanisms through which it communicates information to its employees. These include a weekly all user e-mail, monthly Team Brief, departmental meetings, *ad hoc* briefings, Twitter accounts, personal letters, and pay slip messages and attachments. The Trust continues to offer the 'Ask a Director' facility which enables staff to

ask questions of the senior team (anonymously if desired) 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 managers are asked to make all staff aware of information communicated by electronic means.

The weekly all user e-mail, the intranet and Team Brief are all used as a means of conveying official information, as appropriate, which is of benefit to staff in a social, personal and developmental way. Examples include reporting on staff achievements, benefits and services available, activities and events taking place, health related information and offers. There are separate pages on the intranet for staff health, benefits and wellbeing offering an extensive range of discounts and contacts as well as sources for support, development and training.

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 HR 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, terms and conditions. The Local Negotiating Committee is the forum for medical and dental staff.

All Trust policies are available on the intranet for staff information, including the extensive range of HR policies, many of which are about services available directly in support of staff. Examples include: Special Leave Policy, Employment Break Policy, Flexible Working Policy, Managing Attendance and Promoting Health and Wellbeing Policy, Speaking Out Policy and Shared Parental Leave Policy.

Quality Charter

The Trust recognises that valuing and celebrating the achievements of the workforce is essential to enable the future growth and development of the organisation and the individuals who are part of it. This is also now recognised through the introduction of the Quality Charter. The approach is to drive continuous quality improvement through staff engagement and the Charter was launched in January 2016.

The charter has been built on four 'joining' elements:

1. Setting our **ambition** for Quality and Safety;
2. Promoting staff **engagement**;
3. Providing **assurance** on care quality; and
4. Supporting a positive **culture.**

Each of the schemes within the Quality Charter has been brought together under a distinct sub-brand, which echoes key design elements of our corporate values brand. This helps to reinforce the connection between the two. The Charter sub-brands are shown overleaf:

QUALITY CHARTER

"Recognising and Rewarding Excellent Quality of Care"

The Chairman & Chief Executive's recognition scheme that celebrates the everyday individual successes that you, our colleagues achieve.

Continued targeted campaigns relating to Quality Improvement.

The scheme that recognises and rewards you, our colleagues who undertake training and deliver quality improvements.

The Chairman & Chief Executive's recognition scheme that celebrates the successes that you, our hospital and community teams achieve.

Our annual event to showcase individual and team endeavours which promote care of the highest quality.

Health and Safety, and Occupational Health

The Occupational Health Department provides a first class service to maintain a high standard of health within the workforce of the Trust, to ensure that it is fit for purpose and protected against workplace hazards.

The work of the Occupational Health Department includes:

- pre-work health assessment and communicable disease screening to support recruitment of new employees ensuring they are fit and able to work in a healthcare environment, presenting no risk of infection to their patients or colleagues;
- provision of work-related immunisations for employees to protect from infection risk;
- supporting managers and employees to maintain satisfactory attendance, work performance and facilitate return to work of staff on long term sickness absence;
- promoting health, safety and wellbeing; and
- provision of staff counselling services (see wellbeing service report below).

Representatives of the Occupational Health Department are included in the 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: Health and Safety, Asbestos Management, Infection Prevention and Control and Workforce and Organisational Development.

A high level of collaborative working with other regional NHS occupational health services ensures that Trust staff working in the 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 Flu Steering Group continues to develop initiatives to enhance delivery of seasonal influenza vaccination to front line staff. Collaboration with the Trust Moving and Handling Co-ordinator ensures a co-ordinated approach to musculo-skeletal/ergonomic assessment, advice and training requirements. Joint working with the Trust Health and Wellbeing lead

and Human Resources colleagues has resulted in the delivery of a staff health and wellbeing promotional event and implementation of a pilot staff wellness programme (provided by Sheffield Hallam University) offering a free health, lifestyle and fitness assessment with the option for follow-up to monitor progress with lifestyle changes and health improvements. Joint working with Recruitment Team colleagues has resulted in improved tracking and timeliness of pre-employment health clearance for candidates.

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. We are 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, a national network of NHS occupational health providers, enabling benchmarking against other providers and involvement in both national and regional initiatives for development of the specialism and collaborative working.

The Staff Counselling Service is a confidential service accessible by employee self-referral which provides support to NHS employees in the Trust. It can support employees through periods of change and uncertainty assisting them to deal with issues in either work or personal life.

The service 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. In addition to focussed short term work, comprehensive assessment sessions assist staff with more complex, severe or enduring issues to access long term services.

The 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 are required to be BACP members and work to the Ethical Framework for Good Practice in Counselling and Psychotherapy.

In line with the Trust's Health and Wellbeing Strategy for addressing workplace mental health, the service has been instrumental in the implementation of new initiatives within this year. Schwartz Rounds have been introduced to provide an opportunity for both clinical and non-clinical workers to share experiences of healthcare work and explore the emotional impact within a safe and supportive environment. A team of Mental Health Champions have been trained in mental health first aid and will be provided with on-going development to enable them to support their colleagues and work teams. In addition, Mentally Healthy Workplace training sessions have been made available to all staff to help raise awareness and provide skills to create a more mentally healthy workplace.

'Mindful Employer'

The Trust has signed up to the Mindful Employer Charter, which provides businesses and organisations with easier access to information and support for staff who experience stress, anxiety, depression or other mental health conditions. Whilst it is not an accreditation, award or a set of quality standards, it is about working towards the principles of the Charter – signing up is a step along a journey and the Trust will continue to improve the resilience of staff by taking full advantage of the resources which are made available.

National Staff Survey 2016

The Trust undertook the staff survey between September and December 2016. The Trust provided staff with either online surveys or paper copies. Staff were encouraged to complete the survey through promotion of the survey being live to enable as many staff as possible to take part in the process.

Overall the results of the 2016 staff survey were extremely positive, demonstrating that Trust staff take pride in the care they deliver, and recommend the Trust as a place to work and receive treatment.

The Trust had the third highest response rate to the survey in the country, in the category of Combined Acute and Community Trusts.

The Staff Engagement score of 3.92 (on a scale of 1 being poorly engaged and 5 being highly engaged), is ranked above average, which is the highest rank possible in the category of Combined Acute and Community Trusts. The Trust was rated the highest for overall staff engagement in all Trusts within the Yorkshire and Humber region.

From the staff survey benchmarking analysis out of the 32 key findings, the Trust's ratings against other combined Acute and Community Trusts were ranked as follows:

- 22 were above (better than) average;
- 8 were average; and
- 2 were below (worse than) average.

The response rate is as follows:

Overall Response rate	2015		2016	
	Trust	National Average	Trust	National Average
	59%	41%	54%	42%

The top five ranking scores and bottom five ranking scores are detailed in the tables below:

Top 5 ranking scores	2016		2015	
	Trust	National Average	Trust	National Average
Quality of non-mandatory training, learning or development	4.01	4.04	4.15*	4.07
Staff confidence and security in reporting unsafe clinical practice	3.74	3.65	3.84*	3.68
Staff believing that the organisation provides equal opportunities for career progression or promotion	92%	87%	92%	87%
Staff satisfied with the opportunities for flexible working patterns	59%	50%	57%	51%
Staff experiencing discrimination at work in the last 12 months (the lower the score the better)	10%	10%	7%	10%

Bottom 5 ranking scores	2015		2016	
	Trust	National Average	Trust	National Average
Staff reporting errors, near misses, or incidents witnessed in the last month	92%	90%	89%	91%
Staff/colleagues reporting most recent experience of violence.	68%	52%	57%	67%
Staff experiencing physical violence from staff in the last 12 months.	1%	2%	2%	2%
Staff feeling unwell due to work related stress in the last 12 months.	33%	36%	36%	36%
Staff working extra hours	72%	72%	71%	71%

There are two areas which have improved significantly since the 2015 Staff Survey, they are:

- Quality of non-mandatory training, learning or development; and
- Percentage of staff agreeing that their role makes a difference to patients/ service users.

The Trust scored below average in two out of the 32 key findings:

- Percentage of staff reporting errors, near misses or incidents witnessed in the last month; and
- Percentage of staff/colleagues reporting most recent experience of violence.

Summary Details of Any Local Surveys and Results

The Trust takes part in the quarterly NHS Staff Friends and Family Test, which asks staff *"How likely are you to recommend the Trust to friends and family as a place to work?"* During 2016/17 the Trust surveyed all staff in each quarter. As with the NHS Staff Survey, the Trust utilises both online and paper surveys to ensure accessibility for all staff.

How likely are you to recommend the Trust to friends and family as a place to work?	Extremely likely/ Likely
Quarter 1 (June 2016)	70%
Quarter 2 (September 2016)	69%
Quarter 3 (December 2016)	Survey not required – National Staff Survey
Quarter 4 (March 2017)	(currently taking place – results available early May)

Staff Survey - Future Priorities and Targets

The Trust is working with key stakeholders to develop a Trust wide action plan focusing on the key areas for improvement. Each Directorate will use its own results to develop local action plans. By communicating this information clearly, staff can be assured that the Trust has understood their feedback and subsequent action will be taken.

The results of the 2016/17 National Staff Survey and quarterly NHS Staff Friends and Family Test will be utilised to monitor progress in overall staff engagement and against the key areas above.

Investors in People

The Trust was awarded Bronze accreditation against the Investors in People (IiP) Standard in March 2017, demonstrating its commitment to high performance through good people management. IiP defines what it takes to lead, support and manage people effectively to achieve sustainable results. It enables organisations to benchmark against the best in the business on an international scale.

The Trust has held IiP accreditation for six years. Accreditation is 'for life' subject to reviews at least every three years and the Trust was required to undergo a second review by 31 March 2017.

Bronze accreditation represents a significant amount of development work by the Trust since its original achievement of the standard level of IiP accreditation. It is recognition of a significant change in the standard of our leadership and management practices and another step on the Trust's journey to reach the highest standard of IiP accreditation that is possible.

Celebrating Success Awards

Following eight extremely successful events since 2008, the Trust continues to promote the Celebrating Success Awards which aim to celebrate good practice and innovation across the Trust and share new ways of working. The Awards are an opportunity to celebrate the success of innovative approaches to working and be appropriately rewarded for the effort involved. There is significant evidence across the Trust of existing good practice to be acknowledged, celebrated and shared with colleagues. Celebrating Success seeks to recognise this outstanding work. The six categories of Awards are:

- The Chairman's Award for the most outstanding application;
- The Mark Kennedy Award for Enhancing Patient Experience;
- The Anne Lawson Award for Outstanding Contribution to High Quality Care;
- The Governors' Award for Outstanding Partnership Working;
- The Chris Skeels Award for Living the Trust Values; and
- Making a Difference Awards; The Governor's Award for Outstanding Contribution from a Team and the Richard Ord Award for Outstanding Contribution from an Individual

In 2016 the Trust held its first Summer Fair for staff and their families incorporating the Celebrating Success awards. The Summer Fair was created following feedback from staff that they would like an event that was more accessible and family orientated. The event, which was generously sponsored by external partners, was judged to be a great success and will be repeated.

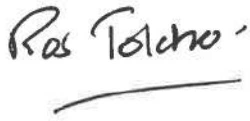
Off-payroll Arrangements

The decision to appoint Board members or senior officials with significant financial responsibility through an off-payroll arrangement would be made, if required, at a very senior level and only for exceptional operational reasons. The Trust can confirm that there were no off-payroll engagements of Board members and/or senior officials with significant financial responsibility during 2016/17.

Approval by the Directors of the Performance Report

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

Signed



Dr Ros Tolcher
Chief Executive
24 May 2017

4.4. NHS Foundation Trust Code of Governance

The Board of Directors and Council of Governors

The Board of Directors (the Board) and Council of Governors (the Council) 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 meets formally with the Council 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 and Council 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, information sessions, directorate inspections and patient safety visits. Examples include membership of Governor working groups and consultations about the development of the Trust's Operational Plan and Quality Account. Informal meetings are also held with the Council three times a year. The Chairman attends these meetings to support the Council and to ensure the Board have an opportunity to obtain the views of the Council and their members in the planning of services for the local community.

Informal meetings between the Non-Executive Directors and the Council 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.

The Board of Directors

The Board of Directors is collectively responsible for exercising all of the powers of the Trust; however, it has the option to delegate these powers to senior management and other committees. The Board meets in public 11 times per 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 allocation of resources to support the achievement of organisational objectives, ensure clinical services are safe, of a high quality, patient focused and effective.

The Board ensures high standards of clinical and corporate governance and, along with the Council of Governors, engages members and stakeholders to ensure effective dialogue with the communities it serves.

The Board is accountable to stakeholders for the achievement of sustainable performance and the creation of stakeholder value through development and delivery of the Trust's long term vision, mission, and strategy. The Board ensures that adequate systems and processes are maintained to deliver the Trust's Annual Plan, deliver safe, high quality healthcare, measure and monitor the Trust's effectiveness and efficiency as well as seeking continuous improvement and innovation.

The Board delegates some of its powers to a committee of Directors or to an Executive Director and these matters are set out in the Trust's scheme of delegation which is available from the Foundation Trust Office on request. The Terms of Reference for the Board of Directors and its sub-committees are available on the Trust's website (www.hdft.nhs.uk).

Balance, Completeness and Appropriateness of the Board of Directors

The balance, completeness and appropriateness of the Board of Directors is reviewed as required and the Trust is confident that it has a balanced and appropriately skilled Board of Directors to enable it to discharge its duties effectively.

Decision making and operational management of the Trust is led by the Executive Directors, reporting to the Chief Executive as Accounting 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 deemed to be 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

- ***Dr Ros Tolcher, Chief Executive (Executive Director) appointed 4 August 2014***

Dr Tolcher trained as a doctor at Southampton University Medical School, qualifying with honours in 1985. She was appointed as the Trust's Chief Executive in 2014 having previously been CEO at a large community and mental health Trust in the South of England.

Dr Tolcher's initial clinical training included a GP vocational training scheme. She later switched focus to specialise in community reproductive health. In 1994 Dr Tolcher became a Consultant and Clinical Director of sexual health services. She went on to work as a Primary Care Trust (PCT) Medical Director and later the Managing Director of PCT provider services. In this role, she successfully led a merger of two PCT provider arms and set up a new standalone Community and Mental Health NHS Trust as part of the national Transforming Community Services programme.

Throughout her career, Dr Tolcher has maintained an unwavering focus on patient experience and the quality of care provided. She brings to the role extensive experience of working across acute, community, and primary care and has been at the forefront of developing new models of integrated health and social care.

- ***Mr Jonathan Coulter, Finance Director and Deputy Chief Executive (Executive Director) – appointed 20 March 2006***

Mr Coulter 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, he has also obtained a post graduate qualification in Health and Social Care Management.

Mr Coulter became Finance Director for North Bradford Primary Care Trust (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, Mr Coulter was appointed as Finance Director at the Trust in March 2006.

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

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

Dr Scullion 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 divides his week 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. Dr Scullion is aided in this role by both clinical and managerial colleagues.

- ***Mrs Jill Foster, Chief Nurse (Executive Director) – appointed 1 July 2014***

Mrs Foster was appointed as the Trust's Chief Nurse in 2014 having previously held positions as Director of Nursing in London and Deputy Chief Nurse at a large university hospital in Bristol. She qualified as a Registered Nurse in 1987 at Barnsley District General Hospital and specialised in critical care, coronary care, and acute medicine. She has held various clinical positions at ward level and as Matron.

Mrs Foster has a strong track record in professional nursing and operational management and is passionate about delivering high quality fundamental nursing and midwifery care. She is the Executive Lead for Nursing, Midwifery and Allied Health Professionals, Clinical Governance (with the Medical Director), Infection Prevention and Control, Adult and Children's Safeguarding, and Patient Experience, End of Life Care, Children's Services, Executive Champion for Maternity Services and Baby Friendly Initiative.

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

Throughout Mr Harrison's career, he has demonstrated a record of leading the sustainable delivery of services to meet or exceed national standards. Having originally trained as a Research Biochemist, Mr Harrison 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. Mr Harrison 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 the Trust's clinical services, 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. In addition, Mr Harrison is the Chief Operating Officer lead for Urgent and Emergency Care and Stroke on behalf of the WYAAT.

- ***Mr Phillip Marshall, Director of Workforce and Organisational Development (Executive Director) – appointed 2 October 2006***

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

Mr Marshall 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. Mr Marshall is a certified practitioner for Neuro-Linguistic Programming and Myers-Briggs Type Indicator (MBTI).

The Director of Workforce and Organisational Development is responsible for providing strategic and operational human resource leadership; with Lead Board Director responsibility for associated areas including Innovation and Improvement, Organisational Development, Medical Education, Military Health, and Health and Wellbeing. He is a Board member of the Local Education and Training Board, Health Education England (HEE) for the North region and a Board member of the West Yorkshire and Harrogate Local Workforce Action Board.

Non-Executive Directors

Non-Executive Director appointments are for a term of three years. Non-Executive Directors 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 in line with the requirements of the NHS Foundation Trust Code of Governance. 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.

The table overleaf sets out the names, appointment dates and tenure of the Chairman, Vice Chairman, Senior Independent Director, and Non-Executive Directors of the Trust.

Name and Designation	Appointment	End of first Term	End of second Term	End of third Term
Mrs S Dodson	1 October 2008	30 September 2011	30 September 2014	30 September 2017
Mr I Ward	1 October 2012	30 September 2015	30 September 2018	N/A
Professor S Proctor*	1 August 2013	31 July 2016	31 July 2019	N/A
Mrs L Webster	1 January 2014	31 December 2016	1 January 2019	N/A
Mr C Thompson	1 March 2014	28 February 2017	29 February 2020	N/A
Mrs M Taylor	1 November 2014	31 October 2017	N/A	N/A
Mr N McLean	1 May 2015	30 April 2018	N/A	N/A

* Professor S Proctor left the Trust on 31 March 2017.

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

Mrs Dodson has been a Harrogate and District resident for nearly 25 years and was a Non-Executive Director of the Trust between 1996 and 2006. Mrs Dodson returned to the Trust in 2008 to take on the role of Chairman, and to further the Trust's vision of providing high quality care to the people of Harrogate and Rural District.

In addition to her role as Chairman, Mrs Dodson has been a Trustee of Yorkshire Cancer Research since March 2014 and sits on the Consultative Committee of Harrogate College.

She 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. Mrs Dodson is currently Chairman of the Members of the Red Kite Multi Academy Trust, having previously been a Governor and later Chairman of Governors at Harrogate Grammar School between 2000 and 2010.

In addition to her other charitable roles, Mrs Dodson 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.

There have been no changes in the Chairman's significant commitments during 2016/17.

Mrs Dodson was reappointed as Chairman and Non-Executive Director on 3 August 2016 and is will cease be Chairman on 30 September 2017 at the end of her third and final term.

- ***Mr Ian Ward, Non-Executive Director – appointed 1 October 2012; appointed Senior Independent Director 25 February 2015***

Mr Ward has spent over 40 years in financial services including his role as Chief Executive of Leeds Building Society (LBS) for 16 years until his retirement from that position in August 2011. In a Non-Executive capacity, Mr Ward is now a Director of Newcastle Building Society, a member of its Group Risk Committee, and a Director of its Information Technology subsidiary. He is also Vice-Chairman and Senior Independent Director of the Charter Court Financial Services Group of Companies which includes Charter Savings Bank, where he

also chairs the Risk Committee and sits on the Audit and Remunerations/Nominations Committees

Mr Ward was a Director and Vice-President of Leeds, York and North Yorkshire Chamber of Commerce and Chairman of its Property Forum. He was also 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). He moved to Knaresborough in 1996, shortly after taking up his Chief Executive position at LBS. He is particularly interested in how the Trust's strategy will evolve to ensure its continued success and delivery of high quality care.

- ***Professor Sue Proctor, Non-Executive Director – appointed 1 September 2013; appointed Vice Chairman 4 February 2015***

Professor Proctor has over 30 years' experience in health care organisations as a nurse, midwife, researcher and leader. Until 2010, she was Director of Patient Care and Partnerships at NHS Yorkshire and Humber. From 2013-2014 she chaired the major investigation at Leeds Teaching Hospitals Trust into matters relating to Jimmy Savile, and then led the NHS Savile Legacy Unit which oversaw a further 16 such investigations.

Professor Proctor runs a management consultancy business working with health, charity and faith based organisations. She is also Chairman of the Strategic Safeguarding Group for the Diocese of York, a lay Canon at Ripon Cathedral and a lay member of the Royal College of Veterinary Surgeons' Nursing Council.

Within the Trust, Professor Proctor is a member of the Audit Committee, Quality Committee Remuneration/Nominations Committees. She is also the nominated lead Non-Executive for research and development.

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

*Professor Sue Proctor left the Trust on 31 March 2017

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

For over 30 years Mrs Webster 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.

Prior to joining the Trust, Mrs Webster held Senior Executive and Board level posts, where she was influential in leading strategic business development and directing sales, marketing, customer care, and engineering functions.

Being an ex-nurse has influenced Mrs Webster 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 patient 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.

Mrs Webster took early retirement in 2012 and since this time has been a Volunteer Enterprise Mentor for PRIME (Prince's Trust Charity for people setting up in business when over 50) and continues to provide mentoring on a volunteer basis.

Mrs Webster is in her second term as a Non-Executive Director and is Chairman of the Quality Committee and nominated Non-Executive lead on learning from deaths.

In addition she is also a member of the Finance Committee and Remuneration/Nomination Committees.

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

Mr Thompson 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 ten 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.

He is currently Deputy Treasurer of the University of York and sits on the University Council. Inside the Trust, he is Chairman of the Audit Committee and a member of the Remuneration and Nomination Committees.

- ***Mrs Maureen Taylor, Non-Executive Director – appointed 1 November 2014***

Mrs Taylor is a chartered accountant and until 31 March 2015 was the Chief Officer for Financial Management at Leeds City Council. She has spent over 31 years in Financial Services at Leeds City Council, qualifying as an accountant in 1987. She has extensive experience, working in a wide range of financial disciplines more recently leading the Council's capital programme and treasury management functions and overseeing aspects of the revenue budget.

As part of her council role Mrs Taylor held three directorship positions being public sector Director of Community Ventures Leeds Limited, Director at Norfolk Property Services (Leeds) Limited, and Alternate Director for the Leeds Local Education Partnership.

Mrs Taylor is a Vice-Chairman of Governors and Resources Committee member at a local Church of England Primary School.

Mrs Taylor is Chairman of the Finance Committee and is a member of the Audit Committee and Remuneration/Nominations Committees.

- ***Mr Neil McLean, Non-Executive Director – appointed 1 May 2015***

Mr McLean joined the Board in May 2015. For most of his professional life he was a lawyer specialising in major property development and regeneration work and capital and portfolio transactions throughout England and Wales for many nationally known clients. He was Managing Partner in Leeds and a Board member of DLA Piper UK, one of the largest law firms in the world.

Mr McLean has also chaired the Board of Leeds City College, the Leeds City Region Local Enterprise Partnership and the White Rose Academies Trust. He currently chairs Northern Consortium UK Ltd and the Ahead Partnership Ltd.

He was awarded the CBE in the Queen's Birthday Honours List 2014 for services to skills and business in West Yorkshire.

Mr McLean is a member of the Remuneration, Quality and Nomination Committees, and provides support on educational initiatives to the Governor Working Group for Volunteering and Education sub-committee of the Council of Governors.

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 Chairman/Lead Governor 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; and
- An annual review of the effectiveness of each sub-committee.

In November 2015, the Board of Directors commissioned an independent review against Monitor's 'Well-led framework for governance'. This provided the Board of Directors with assurance that systems and process were in place to ensure that the Board and Senior Leadership Team had good oversight of quality of care, operations and finances. The Board recognises the importance of good governance in delivery of the Trust's vision to provide excellence every time, and although a positive response was received following the independent review, the Board has undertaken a number of actions during 2016/17 to improve even further the governance systems in the Trust. The Trust is awaiting guidance from NHSI and the CQC on how to take this work forward following a joint consultation by these two organisations on "Consultation on use of resources and well-led assessments" which closed on 14 February 2017.

The information below details the Executive and Non-Executive Director attendance at Board of Directors meetings in 2016/17. The Board of Directors met 11 times in 2016/17. No Board meeting was held in August 2016.

Individual attendance	Board of Director meeting dates 2016/17										
	27/04/16	25/05/16	29/06/16	27/07/16	28/09/16	26/10/16	30/11/16	21/12/16	25/01/17	22/02/17	29/03/17
Mrs S Dodson	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mr I Ward	Y	Y	Y	Y	Y	Y	Y	Apologies provided	Y	Y	Y
Professor S Proctor	Y	Y	Y	Y	Y	Y	Y	Y	Apologies provided	Y	Y
Mrs L Webster	Y	Y	Y	Y	Y	Y	Y	Apologies provided	Y	Y	Y
Mr C Thompson	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mrs M Taylor	Y	Y	Y	Apologies provided	Y	Y	Y	Y	Y	Y	Y
Mr N McLean	Y	Y	Y	Y	Y	Y	Y	Y	Apologies provided	Y	Y
Dr R Tolcher	Y	Apologies provided	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mr J Coulter	Y	Y	Y	Apologies provided	Y	Y	Y	Y	Y	Y	Y
Dr D Scullion	Y	Y	Y	Y	Y	Apologies provided	Y	Y	Y	Apologies provided	Y
Mrs J Foster	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mr R Harrison	Y	Y	Y	Apologies provided	Y	Y	Y	Y	Y	Apologies provided	Y
Mr P Marshall	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Statement of Compliance with the NHS Foundation Trust Code of Governance

Harrogate and District NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

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

A full review of compliance with the Code is submitted to the Audit Committee on an annual basis to support endorsement with this statement. A copy of the full report to the Audit Committee is available on request from the Foundation Trust Office. The Trust carried out a detailed self-assessment against the requirements of the NHS Foundation Trust Code of Governance and submitted the assessment to the Trust's Audit Committee for approval to support this statement that the Trust continues to comply with the principles of the Code, with the following exception:

Code Provision	Explanation for non-compliance
B.1.1. The Board of Directors should identify in the Annual Report each Non-Executive Director it considers to be independent. The Board should determine whether the Director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement. The Board of Directors should state its reasons if it determines that a Director is independent despite the existence of relationships or circumstances which may appear relevant to its determination, including if the Director has, or has had within the last three years, a material business relationship with the Trust either directly, or as a partner, shareholder, director or senior employee of a Board of Directors that has such a relationship with the Trust; or has served on the Board of the Trust for more than six years from the date of their first appointment.	The Chairman was a Non-Executive Director of the Trust in the preceding five years prior to becoming Chairman. There was a two year gap between completing her term as Non-Executive Director and her post as Chairman. The Chairman is subject to an annual rigorous review via an established appraisal process undertaken by the Deputy Chairman of the Council of Governors led by the Senior Independent Director. The Chairman's current term of office ends on the 30 September 2017 when she will stand down from the Board.

NHS Foundation Trusts are required to provide a specific set of disclosures in relation to the provisions within schedule A of the NHS Code of Governance. Harrogate and District NHS Foundation Trust is compliant with these as outlined in the table below:

Provision	Reference
A.1.1	Included in the Annual Report – section 4.4
A.1.2	Included in the Annual Report – section 4.4
A.5.3	Included in the Annual Report – section 4.4
B.1.1	Included in the Annual Report (and see table above)
B.1.4	Included in the Annual Report – section 4.4
B.2.10	Included in the Annual Report – section 4.3
B.3.1	Included in the Annual Report – section 4.4
B.5.6	Included in the Annual Report – section 4.4
B.6.1	Included in the Annual Report – section 4.4

Provision	Reference
B.6.2	Included in the Annual Report – section 4.4
C.1.1	Included in the Annual Report – section 4.4
C.2.1	Included in the Annual Report – section 4.7
C.2.2	Included in the Annual Report – section 4.7
C.3.5	Not applicable – would be included in the Annual Report if required
C.3.9	Included in the Annual Report – section 4.4
D.1.3	Not applicable – would be included in the Remuneration Report if required
E.1.4	Included in the Annual Report – section 4.4
E.1.5	Included in the Annual Report – section 4.4
E.1.6	Included in the Annual Report – section 4.4

Audit Committee

The Audit Committee met formally on six occasions during 2016/17. An additional extraordinary meeting was held in July* to discuss limited assurance internal audit reports. Audit Committee members attendance is set out in the table below. In addition, all Audit Committee members attended an informal meeting in late April 2016 to undertake a detailed review of the draft accounts (relating to the 2015/16 financial year). Members of the Committee also attended relevant Audit Committee training events during the course of the year.

Audit Committee Member's Attendance:

	5 May	19 May	*5 Jul	8 Sept	8 Dec	27 Jan	9 Mar
Mr Chris Thompson	Y	Y	Y	Y	Y	Y	Y
Professor Sue Proctor	Y	Y	Apologies provided	Y	Y	Y	Y
Mr Ian Ward	Y	Apologies provided	Y	Y	Apologies provided	Y	Y
Mrs Maureen Taylor	Y	Y	Y	Y	Y	Y	Y

The Audit Committee had a membership of four Non-Executive Directors and during the 2016/17 financial year this comprised of:

- Mr Chris Thompson (Chairman)
- Professor Sue Proctor
- Mr Ian Ward
- Mrs Maureen Taylor

The Committee is supported, at all of its meetings by:

- The Deputy Chief Executive/Finance Director
- The Deputy Director of Finance
- The Head of Financial Accounts
- Deputy Director of Governance
- Company Secretary
- Internal Audit (Head of Internal Audit and Internal Audit Manager)
- External Audit (Director and Senior Manager)

Other representatives (e.g. Chief Nurse, Local Counter Fraud Specialist and Local Security Management Specialist) attend the Audit Committee as and when required.
The attendance details of all attendees at Audit Committee Meetings during 2016/17 are set out in the table below:

	5 May	19 May	8 Sept	8 Dec	27 Jan	9 Mar
HDFT						
Mr Jonathan Coulter	Y	Y	Y	Y	Y	Y
Mr Thomas Morrison	Y	Y	Y	N	Y	Y
Mr Jordan McKie	N	Y	N	Y	Y	Y
Miss Debbie Henderson (1)	Y	Y	Y	N		
Dr Sylvia Wood	Y	Y	Y	Y	Y	Y
Mr Stuart Kelly	Y					
Dr Ros Tolcher		Y				
Internal Audit & Counter Fraud						
Ms Helen Kemp-Taylor	Y	N	Y	Y	N	Y
Mr Tom Watson	Y	Y	Y	Y	Y	Y
Mr Steve Moss		Y		N		Y
External Audit						
Mrs Clare Partridge (2)	N					
Mr Andrew Smith (3)	Y	Y	N	Y		
Mr Rashpal Khangura (4)					Y	N
Mr James Boyle (5)		Y	N	N	N	N
Mr Thilina De Zoysa			Y		Y	Y

(1) Miss Debbie Henderson left the Trust at the end of December 2016.
(2) Mrs Clare Partridge no longer oversaw the Delivery of External Audit services from May 2016.
(3) Mr Andrew Smith became the Trust's External Audit Director from May and then left KPMG at the end of December 2016.
(4) Mr Rashpal Khangura took over from Mr Smith as the Trust's External Audit Director
(5) Mr James Boyle became the Trust's External Audit manager from May 2016.

The Committee received secretarial and administrative support from Miss Kirstie Anderson who is employed by the Trust's internal audit providers but has no managerial responsibility for the Trust's Internal Audit Plan.

Audit Committee members meet in private prior to the start of each Committee meeting. Separate, private sessions are held with Internal Audit and External Audit prior to Audit Committee meetings as required, and no less than once a year.

There is a documented Audit Committee timetable which schedules the key tasks to be undertaken by the Committee over the course of a year and which is reviewed at each meeting.

Detailed minutes are taken of all Audit Committee meetings and are reported to the Board of Directors.

Action lists are prepared after each meeting and details of cleared actions and those carried forward are presented at the following meeting.

Duties of the Audit Committee

Following a review of the Audit Committee's Terms of Reference in January 2017, the key duties of the Audit Committee are categorised as follows:

- Governance, Risk Management and Internal Control
    - Review of the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives, primarily through the assurances provided by internal and external audit and other assurance functions.
- Financial Management and Reporting
    - Review of the Foundation Trust's Financial Statements and Annual Report, including the Annual Governance Statement, before submission to the Board of Directors.
    - Review of the Charitable Trust's Financial Statements and Annual Report before submission to the Board of Directors acting in its role as Corporate Trustee.
    - Ensuring that systems for financial reporting are subject to review to ensure completeness and accuracy of information and compliance with relevant legislation and requirements.
    - Review of the Trust's Treasury Management Policy, Standing Financial Instructions and systems in place to ensure robust financial management.
- Internal Audit and Counter Fraud Service
    - Ensuring an effective internal audit and counter-fraud service that meets mandatory standards and provides appropriate, independent assurance to management and the Audit Committee.
    - Review of the conclusion and key findings and recommendations from all Internal Audit reports and review of regular reports from the Local Counter Fraud Specialist.

    - Monitoring of the implementation of Internal Audit and Counter Fraud recommendations.

- Local Security and Management Services (LSMS)

    - Ensuring an effective LSMS service that meets mandatory standards and provides appropriate assurance to management and the Audit Committee.
    - Review the Annual Report and Plan for the following year.

- External Audit

    - Ensuring that the organisation benefits from an effective external audit service.
    - Review of the work and findings of external audit and monitoring the implementation of any action plans arising.

- Clinical and Other Assurance Functions

    - Review of the work of the Quality Committee within the organisation, whose work provides relevant assurance over clinical practice and processes.
    - Review of the findings of other significant assurance functions, both internal and external to the organisation, and consideration of the implications for the governance of the organisation.

Work Undertaken During 2016/17

The Committee has organised its work under five headings "Financial Management and Reporting", "Governance", "Clinical Assurance", "Internal Audit and Counter Fraud" and "External Audit".

Financial Management and Reporting

The 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 2016/17 were the implications of the Carter Review and the report following the Costing Assurance review of reference costing.

The Committee oversees and monitors the production of the Trust's financial statements. During the 2016/17 financial year, this included:

- An informal but detailed review of the draft accounts prior to submission to NHSI and External Audit on 21 April 2016;
- A formal Committee meeting to discuss the draft accounts and External Audit's findings on 5 May 2016; and
- A formal Committee meeting on 19 May 2016 to review the final accounts and Annual Report for 2015/16 (including the Quality Account) prior to submission to the Board of Directors and NHSI.

[Note: similar meetings have occurred during April and May 2017 relating to the 2016/17 financial statements, Annual Report and Quality Account].

In March 2017 the Committee formally reviewed and approved the Trust's accounting policies (to be used in relation to the 2016/17 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 2016/17 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 2015/16 were reviewed by the Committee on 19 May 2016 prior to submission to the Corporate Trustee.

The Audit Committee also reviewed and approved:

- Single Tender Actions;
- The Trust's Losses and Special Payments register in May 2016;
- The Annual Procurement Savings Report in September 2016;
- Revisions to the Trust's Treasury Management Policy in September 2016; and
- The recommendation to the Trust Board of the use of the going concern principle as the basis for the preparation of the 2015/16 accounts in May 2016.

The review of Post Project Evaluations (arising from capital schemes and service initiatives) is a standing item on the Audit Committee's agenda during the year.

Governance, Risk Management and Internal Control

The Audit Committee receives the minutes of the Corporate Risk Review Group. These minutes provide detail of the changes to the Corporate Risk Register and new risks considered. In addition the Audit Committee receives the minutes of the Quality Committee, which is a formal sub-committee of the Board of Directors.

The BAF, Corporate Risk Register and mechanisms for reporting strategic risks to the Board are reviewed on a periodic basis alongside the review of the Corporate Risk Review Group minutes.

Additionally the Staff Registers of Interests and Gifts and Hospitality were reported to the Audit Committee on 19 May 2016.

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 2016/17:

- Assessment of Audit Committee Effectiveness in December 2016, the findings of which were presented to the Board of Directors;
- Review and approval of Audit Committee Terms of Reference in January 2017 which were presented to the Board of Directors for approval; and
- Ongoing review and revision of the Audit Committee's timetable.

Clinical Assurance

The revised Quality and Governance structure means that the Audit Committee receives assurance on the effectiveness of clinical processes through the meeting minutes and Annual Report of the Quality Committee.

Internal Audit and Counter Fraud Service

Internal Audit and Counter Fraud Services are provided by Audit Yorkshire (previously North Yorkshire Audit Services). The Chairman of the Audit Committee sits on the Audit Yorkshire Board which oversees Audit Yorkshire at a strategic level. The Board met on four occasions during 2016/17.

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 2016.

The Audit Committee approved the planning methodology to be used by Internal Audit to create the Internal Audit Plan for 2016/17, and gave formal approval of the Internal Audit Operational Plan in March 2016.

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. This has been an area of focus by the Committee during the year and Trust management have worked hard to ensure that the process for responding to internal audit recommendations has been improved.

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

The effectiveness of Internal Audit was reviewed by Trust staff and the Audit Committee in January 2017, 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 2016/17 financial year the Trust tendered the contract for provision of External Audit Services. Following a competitive tendering process, KPMG were re-appointed as the Trust's External Auditors for a further three year term. The Audit Committee reviewed External Audit's Annual Governance Report and Management Letter in relation to the 2015/16 financial statements.

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 2016/17 financial statements and the related audit fee in January 2017.

The effectiveness of External Audit was reviewed by Trust staff and the Audit Committee in May 2016, resulting in a satisfactory evaluation which was reported to the Council of Governors.

Specific Significant Issues Discussed by the Audit Committee during 2016/17

The committee included a number of significant accounting issues and treatments in its consideration of the Trust's financial statements for the year ended 31 March 2017. During the year the committee critically addressed the issues around the appropriateness of the Accounting Policies that have been adopted and was satisfied that the policies were reasonable and appropriate. As part of the full year reporting process, the External Auditors, KPMG, consider the key areas of accounting judgement and disclosure. For each of these areas, the committee critically review and assess the policies and judgements that have been applied, the consistency of policy application from year to year and the appropriateness of the relevant disclosures made, together with the compliance with applicable accounting standards.

The key areas of accounting judgement and disclosure that have been considered by the External Auditors, and how each was assessed by the committee, is set out below:

- NHS Income Recognition and NHS Receivables

The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners. These contracts make up 95% of the Trust's income from activities. In order to satisfy itself as to the validity of the income, the committee has confirmed that the Agreement of Balances exercise has been undertaken on a diligent and comprehensive basis. The committee has also confirmed that effective income cut-off procedures were applied around the year end.

The committee has been able to place reliance upon work undertaken by the External Auditors as part of the work that they undertook to enable them to develop their Audit Opinion.

A number of Internal Audits were undertaken during the year around the core financial records and processes, in particular concerning the operation of the General Ledger, and the outcomes from that work have also provided the committee with reassurance as to the income figures for the year that have been included within the financial statements.

- Valuation of Land and Buildings

The valuation of land and buildings that is incorporated in the financial statements represents an estimate of market value at the date of the Trust's balance sheet. It has been determined using the outcome from a full valuation exercise that was carried out for the Trust by the District Valuer's office, which forms part of Her Majesty's Valuation Office Agency. The valuation recognises the differing treatment that has to be adopted for assets of a specialised and non-specialised nature, full details of which are included within the Trust's Accounting Policies.

As noted above, the committee has been able to place reliance upon work undertaken by the External Auditors as part of the work that they undertook to enable them to develop their Audit Opinion.

The committee has also been able to satisfy itself as to the basis on which the external valuation was undertaken and has confirmed that it was undertaken on a basis consistent with the terms of the Accounting Policy referred to above. In addition the committee has

relied upon work carried out by Internal Audit during a number of pieces of work that have provided reassurance on the way in which asset costs and valuations have been reflected within the Trust's underlying books and records.

The following additional significant issues have been discussed by the Audit Committee during 2016/17:

- Ongoing compliance issues with IV Cannula Care and nursing staff rostering;
- Issues in relation to the timely discharge of patients; and
- The timeliness of response by management to internal audit draft reports and the implementation of outstanding internal audit recommendations.

Conclusion

The Audit Committee considers that it has conducted itself in accordance with its Terms of Reference and work plan during 2016/17.

The Audit Committee considers that this Annual Report is consistent with the draft Annual Governance Statement and the Head of Internal Audit Opinion.

Council of Governors

The Council of Governors (the Council) represent the interests of the Foundation Trust members and the general public. They have an important role to play in acting as the eyes and ears of the membership, keeping a watchful eye over how the Trust is managed and being assured about the way services are being delivered.

The Council does not undertake the operational management of the Trust; rather they act as a vital link between members, patients, the public and the Board of Directors, so they have an ambassadorial role in representing and promoting the Trust. The Council's primary statutory duty is to hold the Non-Executive Directors individually and collectively to account for the performance of the Board, and represent the interests of the members of the Trust as a whole and the interests of the public. The Council is responsible for regularly feeding back information about the Trust's vision, strategy, and performance to their constituencies and the stakeholder organisations that appointed them.

Governors are elected by staff (Staff Governors) and the membership (Public Governors), or nominated by partner organisations, for example, North Yorkshire County Council (Stakeholder Governors). The Council of Governors consists of 18 elected and six nominated Governors.

The Council of Governors has specific statutory responsibilities to:

- Hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors;
- Represent the interests of the members of the Trust as a whole and the interests of the public;
- Appoint, or remove the Chairman and the other Non-Executive Directors;
- Decide the remuneration of the Chairman and Non-Executive Directors;
- Approve the appointment (by the Non-Executive Directors) of the Chief Executive;
- Appoint, reappoint or remove the Trust's external auditor;
- Consider the Trust's Annual accounts, auditor's report and Annual Report;
- Bring their perspective in determining the strategic direction of the Trust;
- Be involved in the Trust's forward planning processes;

- Approve any merger, acquisition, separation or dissolution application and the entering into of any significant transactions;
- 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
- Approve any amendments to the Trust's Constitution.

The following table highlights the composition of the Council of Governors and includes each Governor's term of office and attendance at the quarterly public Council of Governor meetings held during the year 1 April 2016 to 31 March 2017.

Constituency	Name	Term of Office	May 2016	Aug 2016	Nov 2016	*Nov 2016	Feb 2017
Harrogate and surrounding villages – publicly elected	Mr Tony Doveston	Jan 2016 – Dec 2018	Y	Y	Y	Y	Y
	Mrs Pat Jones	Jan 2011 – Dec 2013 Jan 2014 – Dec 2016 Jan 2017 – Dec 2019	Y	Y	Y	N	Y
	Dr Sally Blackburn	Aug 2011 – Jul 2014 Aug 2014 – Jul 2017	N	Y	Y	Y	Y
	Ms Pamela Allen, Deputy Chairman of Governors/ Lead Governor from Jan 2016	Jan 2014 – Dec 2016 Jan 2017 – Dec 2019	Y	Y	Y	Y	Y
	Mrs Liz Dean	Dec 2014 – Dec 2015 (remainder of term following resignation of Sara Spencer) Jan 2016 – Dec 2018	Y	Y	Y	N	N
Knaresborough and East District – publicly elected	Mrs Zoe Metcalfe	Jan 2016 – Dec 2018	N	N	Y	Y	Y
	Mrs Joyce Purkis	Jan 2014 – Dec 2016	Y	Y	N	Y	N/A
	Mrs Ann Hill	Jan 2017 – Dec 2019	N/A	N/A	N/A	N/A	Y
Rest of North Yorkshire and York – publicly elected	Mrs Cath Clelland	Jan 2015 – Dec 2017	N	N	N	N	Y
Ripon and West District – publicly elected	Mr Peter Pearson	Aug 2014 – Jul 2017	N	Y	N	Y	Y
	Miss Sue Eddleston	Jan 2017 – Dec 2019	N/A	N/A	N/A	N/A	Y

Constituency	Name	Term of Office	May 2016	Aug 2016	Nov 2016	*Nov 2016	Feb 2017
Wetherby and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley Wards – publicly elected	Mrs Jane Hedley	Jul 2011 – Jun 2014 Jul 2014 – Jun 2017	Y	N	Y	Y	Y
	Mr Michael Armitage	Jan 2014 – Dec 2016	N	N	Y	Y	N/A
	Mr Steve Treece	Jan 2017 – Dec 2019	N/A	N/A	N/A	N/A	Y
**Rest of England	Vacant Seat						

Staff Constituency	Name	Term of Office	May 2016	Aug 2016	Nov 2016	*Nov 2016	Feb 2017
Medical Practitioners Staff Class – staff elected	Dr Daniel Scott	Jan 2013 – Dec 2015 Jan 2016 – Dec 2018	Y	Y	Y	Y	Y
Non-Clinical Staff class – staff elected	Mrs Yvonne Campbell	Jan 2016 – Dec 2018	Y	Y	N	N	Y
Nursing and Midwifery Staff class – staff elected	Mrs Emma Edgar	Jan 2011 – Dec 2013 Jan 2014 – Dec 2016 Jan 2017 – Dec 2019	Y	Y	Y	N	N
	Mrs Sally Margerison	Jan 2014 – Dec 2016 Jan 2017 – Dec 2019	Y	Y	Y	Y***	N
Other Clinical Staff class – staff elected	Ms Clare Cressey	Jan 2016 – Dec 2018	Y	Y	Y	N	Y

* Extra Council of Governor meeting 30 November 2016 to discuss the recommendation of the Nominations Committee
** A 'Rest of England' constituency was approved in February 2016. Despite elections, this seat remains vacant
*** Vote cast by telephone

Nominating Organisation	Name	Term of Office	May 2016	Aug 2016	Nov 2016	*Nov 2016	Feb 2017
North Yorkshire County Council	Councillor Bernard Bateman	Nominated from Jan 2014 – Dec 2016 Second Term from Jan 2017 – Dec 2019	Y	Y	Y	Y	Y
Harrogate Borough Council	Councillor John Ennis	Nominated from Jun 2011 – May 2014 Second term from Jun 2014 – May 2017 Stood down May 2016	Y	N/A	N/A	N/A	N/A

Nominating Organisation	Name	Term of Office	May 2016	Aug 2016	Nov 2016	*Nov 2016	Feb 2017
	Councillor Ivor Fox	Nominated from Jul 2016 – May 2017 (remainder of term following resignation of John Ennis Stood down Oct 2016	N/A	N	N/A	N/A	N/A
	Councillor Phil Ireland	Nominated from Nov 2016 – May 2017 (remainder of term following resignation of Ivor Fox)	N/A	N/A	N/A	N	Y
University of Leeds	Dr Sarah Crawshaw	Nominated from Jan 2014 – Dec 2016 Second Term from Jan 2017 – Dec 2019	N	N	N	N	N
Harrogate Division YOR Local Medical Committee	Dr Jim Woods	Nominated from Jun 2011 – May 2014 Second Term from Jun 2014 – May 2017	N	Y	N	N	N
Voluntary Sector	Mrs Beth Finch	Feb 2016 – Jun 2016 (remainder of term following resignation of Jane Farquharson) Second term from Jul 2016 – June 2019	Y	N	N	N	N
Patient Experience	Mrs Joanna Parker	Nominated from Feb 2015 – Jan 2018 Stood down Sept 2016	Y	Y	N/A	N/A	N/A

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, 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 table on the following page highlights the attendance of each Executive Director and Non-Executive Director at the quarterly public Council of Governor meetings held during the year April 2016 to March 2017.

Board member individual attendance	Position	Council of Governor meeting dates 2016/17			
		May 2016	Aug 2016	Nov 2016	Feb 2017
Mrs Sandra Dodson	Chairman	Y	Y	Y	Y
Professor Sue Proctor	Non-Executive Director/ Vice Chairman (from 4.2.15)	Y	Y	Y	Y
Mr Ian Ward	Non-Executive Director/Senior Independent Director (from 25.2.15)	N	Y	Y	N
Mr Chris Thompson	Non-Executive Director	Y	Y	Y	Y
Mrs Lesley Webster	Non-Executive Director	Y	Y	Y	Y
Mrs Maureen Taylor	Non-Executive Director	Y	N	Y	Y
Mr Neil McLean	Non-Executive Director	N	Y	Y	Y
Dr Ros Tolcher	Chief Executive	Y	Y	Y	Y
Mr Jonathan Coulter	Deputy Chief Executive / Finance Director	Y	N	Y	N
Dr David Scullion	Medical Director	Y	Y	Y	N
Mrs Jill Foster	Chief Nurse	Y	Y	Y	Y
Mr Robert Harrison	Chief Operating Officer	Y	N	Y	N
Mr Phillip Marshall	Director of Workforce and Organisational Development	Y	N	N	Y

- Council of Governors' Nominations Committee

The Nominations Committee is a formally constituted sub-committee of the Council of Governors and has responsibility for overseeing the recruitment and selection processes to secure the appointments of Non-Executive Directors (including the Chairman). The Committee takes into consideration the knowledge, skills and experience on the Board of Directors and is responsible for making recommendations to the Council of Governors on the appointment and reappointment of Non-Executive Directors (including the Chairman) of the Trust. The Committee is comprised of members of the Council of Governors and is chaired by the Chairman of the Trust or the Senior Independent Director, where the Chairman has a conflict of interest, for example when the Committee is considering the Chairman's re-appointment. The Nominations Committee is supported by the Chief Executive, Director of Workforce and Organisational Development, Company Secretary and Corporate Affairs and Membership Manager, in an advisory capacity.

The Nominations Committee met on four occasions during 2016/17 as follows:

- 25 July 2016 to review the re-appointment of Professor Sue Proctor, Non-Executive Director, to a second term of office and review the annual re-appointment of Mrs Sandra Dodson, Chairman. The meeting was chaired by Mrs Dodson and Mr Ian Ward, Senior Independent Director, for the item relating to Mrs Dodson's re-appointment.

- 21 November 2016 to review the re-appointment of Mrs Lesley Webster, Non-Executive Director, to a second term of office. The meeting was chaired by Mrs Dodson.

- 27 January 2017 to review the re-appointment of Mr Chris Thompson, Non-Executive Director, to a second term of office and to progress the recruitment process for a new Chairman.

- 15 February 2017 to further progress the recruitment process for a new Chairman.

Recommendations of the Nominations Committee have been presented to, and subsequently approved by, the Council of Governors following every meeting.

<u>Council of Governors Remuneration Committee</u>

The Remuneration Committee is a formally constituted sub-committee of the Council of Governors and is responsible for setting the remuneration of the Chairman and other Non-Executive Directors. The Committee is chaired by the Deputy Chairman of Governors and conducts an annual review of, and makes a recommendation to the Council of Governors in relation to, the remuneration of the Non-Executive Directors and Chairman of the Trust. The Remuneration Committee is supported by the Chief Executive, the Director of Finance, the Director of Workforce and Organisational Development, the Company Secretary and Corporate Affairs and Membership Manager, in an advisory capacity.

The Remuneration Committee met once during 2016/17 and held a detailed discussion regarding the role of the Non-Executive Directors, salary details, guidance received and current financial challenges. The recommendation submitted to, and subsequently approved by the Council of Governors, was to apply a cost of living uplift to the Non-Executive Directors and Chairman of the Trust, consistent with Very Senior Managers in Clinical Commissioning Groups and Area Teams from 1 April 2016 and set the remuneration for:

- Non-Executive Director with no additional responsibilities;
- Non-Executive Director with responsibility for chairmanship of the Quality Committee and Finance Committee;
- Non-Executive Director with statutory responsibility as Chairman of the Audit Committee, Senior Independent Director and Vice Chairman; and
- Chairman.

<u>Membership Development and Engagement</u>

- Our Membership

The Trust is accountable to the local population that it serves through the Council of Governors and encourages local ownership of health services through its membership. On 31 March 2017 the Trust had 18,225 members; people who have chosen to become a member, who are interested in the NHS and want the opportunity to get more involved in their local health services. Members can become involved in a variety of different ways; by receiving updates and newsletters, attending open days, meetings and events, volunteering, and being consulted on with plans for future developments, to name a few.

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

- Eligibility to be a Member

As of 1 March 2016, public membership by constituency applies to residents aged 16 or over across the whole of England. As the Trust is providing services further afield, and patients have the right to choose where to receive treatment, we hope to continue encouraging a membership which reflects the wider population.

Public constituencies are:

- Harrogate and surrounding villages;
- Ripon and west district;
- Knaresborough and east district;
- The electoral wards of Wetherby and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley wards;
- Rest of North Yorkshire and York; and
- Rest of England.

The Rest of England constituency will represent those people who access Trust services but do not live in the Trust's previous catchment area (as displayed on the map below):

The Trust has no patient constituency.

Staff membership applies to any employee of the Trust holding a permanent contract of employment or a fixed term contract of at least 12 months, unless they opt out.

The Staff Constituency includes the following Staff Classes:

- Medical Practitioners
- Non-Clinical

- Nursing and Midwifery
- Other Clinical

*Membership by constituency and volume

Through the work of the Governor Working Group for Membership Development and Communications, a sub-committee of the Council of Governors responsible for the delivery of the Membership Development Strategy, we continue to develop a representative and vibrant membership, offering innovative and active engagement across the organisation.

Throughout 2016/17 we have continued to actively engage with, and recruit, members between the ages of 16 and 21 years through our unique Education Liaison Programme, Work Experience Scheme and with our young volunteers. In December 2016 we set up a new Youth Forum (members between the ages of 13 and 19); providing young people with the chance to discuss relevant issues, engage with decision makers and contribute to improving the lives of young people within their communities.

Whilst it is important to the Trust to continue to recruit a wide and diverse membership in a representative and inclusive manner, the Membership Development Strategy continues to drive the focus on quality membership engagement activity.

The public membership profile		**Rep. of public**	
Harrogate	6,820	82,599	8.3%
Ripon and west district	2,064	37,571	5.5%
Knaresborough and east district	2,449	37,699	6.5%
Wetherby and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley wards	2,232	102,771	2.2%
Rest of North Yorkshire and York	360	638,559	0.06%
Rest of England	385	52.1m*	
TOTAL	**14,310**	***899,199****	***1.6%****

*https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/populationandhouseholdestimatesfortheunitedkingdom/2011-03-21

*** Figures based on Trust catchment area not including Rest of England.*

The staff membership profile		**Rep. of total staff**	
Medical Practitioners*	269	492	*54.7%*
Non-Clinical	943	1,004	*93.9%*
Nursing and Midwifery	1,385	1,478	*93.7%*
Other Clinical	1,309	1,395	*93.8%*
TOTAL	**3,906**	**4,369**	***89.4%***

**It is important to note that this constituency contains a number of both medical and dental practitioners whom are on short term contracts and are therefore ineligible for staff membership.*

The volume of members has increased; this is due to ongoing active recruitment, the transfer of people who were on our database as 'Affiliates' but became members following

the introduction of the Rest of England constituency, and the increase in staff providing Trust services in County Durham, Darlington and Middlesbrough.

On 31 March 2017, the Trust had 81 'Affiliates'; 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 are not counted within our membership numbers.

Staff membership is via an opt-out scheme and 89.4 % 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.

Both the Board of Directors and Council of Governors agree that an active and engaged membership will continue to enhance the development of the Trust's strategic objectives to:

- Drive up quality and continue to deliver high quality care;
- Work with partners to deliver integrated care; and
- Increase services provided to ensure clinical and financial sustainability.

During the forthcoming year, the Trust will continue to actively recruit members across the catchment area; in particular, from the rest of North Yorkshire and York where our membership representation is at its lowest and from the Rest of England constituency, focussing particularly on areas where the Trust is providing services in County Durham, Darlington and Middlesbrough and in North and West Leeds. The plans will be overseen by the Governor Working Group for Membership Development and Communications and will form part of the Membership Development Strategy. Membership recruitment plans include, promoting membership to local employers and schools, attendance at community events, distributing membership leaflets to GP practices and local community premises such as libraries and voluntary organisations, and social media platforms. The focus will also be to promote membership and active inclusion to people from protected and disadvantaged groups.

- Gender and ethnicity

The public membership is made up of 50.4% females and 49.5% males, with 0.1% unknown. The number of female members has increased the greatest, demonstrating a similar balance to the male/female population in England (*50.8% females and 49.2% males, Office for National Statistics, Census 2011).*

Gender	Number of Members	*Eligible membership	Percentage
Male	7,078	*440,383	*1.6%
Female	7,218	*458,816	*1.6%
Not specified	14		
Total	**14,310**	***899,199**	***1.6%**

** Figures based on Trust catchment area not including Rest of England.*

Ethnic Origin of the Public Membership

Ethnicity	Number of Members	*Eligible membership
White	2,664	*863,226
Mixed	19	*9,110
Asian or Asian British	62	*19,196
Black or Black British	24	*4,599
Unknown	11,541	*3,068
Total	**14,310**	***899,199**

** Figures based on Trust catchment area not including Rest of England.*

The ethnicity of all new members is captured from the membership application form. It would be challenging to update the ethnicity of the majority of members who joined prior to the development of this data capture.

- How we develop our Membership

The Membership Development Strategy continues to be reviewed on an annual basis with detailed work plans to drive forward targeted recruitment in under-represented areas and innovative high quality membership engagement activity in line with the Trust's strategic objectives. The Governor Working Group for Membership Development and Communications continues to report to the Council of Governors at each quarterly public meeting.

Our annual target membership figure for 2017/18 remains at 18,000 members. This decision is based on the focus to provide quality membership engagement activity as well as ongoing data cleansing and natural loss.

Recruitment, 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;
- 'Chairman's Letter' or alternative communication, i.e. a postcard;
- Notification of meetings and events on the Trust's website;
- Social media platforms;
- Media;
- 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 staff communications, 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 schemes continue to be highly successful and are an extremely effective vehicle to enable the Trust to recruit young people and provide high quality membership engagement. These projects are overseen by the Governor Working Group for Volunteering 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@hdft.nhs.uk

4.5. NHS Improvement's Single Oversight Framework

NHSI's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

The Trust is recognised as being in segment two as at 31 March 2017. This segmentation information is the Trust's position as at 31 March 2017. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and Use of Resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

The table below outlines the Trust's performance in 2016/17.

Area	Metric	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	Capital service capacity	1	1
	Liquidity	1	1
Financial efficiency	I&E margin	1	1
Financial controls	Distance from financial plan	2	3
	Agency spend	1	1
Overall scoring		**1**	**1**

4.6. 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 NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their 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 Officer Memorandum issued by NHSI.

NHSI, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Harrogate and District NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. 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 Department of Health Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, 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 Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- Ensure that the use of public finds complies with the relevant legislation, delegated authorities and guidance; 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 her 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 the NHS Foundation Trust Accounting Officer Memorandum.

Signed

Dr Ros Tolcher
Chief Executive
24 May 2017

4.7. Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Harrogate and District NHS Foundation Trust (the Trust), to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Accounting Officer, supported by Board members, I have responsibility for the integration of governance systems. I have delegated executive lead to the Chief Nurse and Medical Director for the implementation of integrated governance and risk management.

The Board of Directors recognises that risk management is an integral part of good management practice and to be most effective should be part of the Trust's culture. The Board is, therefore, committed to ensuring that risk management forms an integral part of its philosophy, practices and business plans rather than viewed or practised as a separate programme and that responsibility for its implementation is accepted at all levels of the organisation.

The Board acknowledges that the provision of appropriate training is central to the achievement of this aim. Staff are appropriately trained and supported in incident reporting, carrying out risk assessments, mitigating risk and maintaining risk registers. Directors and Departmental Managers ensure that all staff, including those promoted or acting up, Board Directors, Contractors, locum, agency or bank staff, undergo corporate and specific local induction training appropriate to their area including risk management, incident reporting and hazard recognition training. An ongoing training programme has been developed based on a training needs analysis of staff. The programme includes formal training for:

- Staff in dealing with specific everyday risks, e.g. basic risk management information including an overview of patient safety, incident reporting and investigation, complaints investigation and development of measures to improve

patient experience, fire safety, information governance, health and safety, moving and handling, infection control, and security; and

- Specific staff involved in the maintenance of risk registers at directorate and department level, investigation and root cause analysis, the investigation of serious incidents (SIs) and risk assessment for health and safety.

The Trusts Human Resources department monitors all mandatory and essential training and reports directly to the Board of Directors. Completion of training is included in staff performance monitoring, appraisals and revalidation. This process has been strengthened by linking pay progression to the completion of essential and mandatory training.

Employees, contractors and agency staff are required to report all incidents and concerns and this is closely monitored. The Trust supports an “open” culture, meaning that we are open with service users, carers and staff when things go wrong. A significant emphasis is placed upon ensuring that we comply with the requirements of the statutory duty of candour that came into force on 27 November 2014. This follows the introduction of a number of new standards that NHS boards need to comply with including not only duty of candour, but also the fit and proper person’s test and improving openness and transparency. The Board receives regular updates to ensure compliance in these areas.

Guidance on reporting incidents on Datix, grading of incidents, risk assessment, risk registers, undertaking root cause analysis and statement writing, is available for staff on the Trust intranet.

The Trust also supports a “learning” culture, and we share and embed learning from incidents following an objective investigation or review. In addition, the Trust seeks to identify and share good practice within the organisation. This happens at Board and directorate level through various mechanisms including feedback from patient safety visits and Director inspections and an annual “Celebrating Success Awards” event. National guidelines and standards that relate to good practice are shared and there are processes in place to ensure action plans to implement recommendations are developed and monitored to completion.

Quality and equality impact assessments have been strengthened during 2016/17 to improve the assurance that the Board and its committees receive in terms of impact from cost improvement programmes, risks and how these will be managed. Further work is needed to integrate this effectively into other service developments.

The risk and control framework

The key objectives regarding risk and control are to achieve:

- Compliance with external regulatory and other standards for quality, governance and risk including Care Quality Commission fundamental standards and regulations;
- A culture of effective risk management at all levels of the organisation;
- Delivery of the Trust’s strategic aims and objectives; and
- A robust framework to ensure all controls and mitigation of risks are in place and operating, and can provide assurance to the Board of Directors on all areas of governance being:
    - Corporate governance
    - Quality governance

- Clinical governance
- Financial governance
- Risk management
- Information governance including data security
- Research governance
- Clinical effectiveness and audit
- Performance governance

The Trust has a system of integrated governance described in the Risk Management Policy.

Risk identification and assessment is the process that enables the Trust to understand the range of risks faced, the level of ability to control those risks, their likelihood of occurrence and their potential impacts. Risk assessment is a continuous process with risks assessed at ward, team and department level in line with risk assessment guidance. This is carried out proactively as part of the health and safety processes as well as reactively when risks are identified from incidents, complaints, local reviews, patient feedback etc.

Risks are scored based on the likelihood of the risk materialising (score 1-5) multiplied by the impact or consequence of that risk (score 1-5). The risk scoring matrix evaluates the level of risk as low (1-5), medium (6-10) or high (12-25), and therefore the priority for action, and must be used for all risk scoring within the Trust in order to ensure a consistent and standardised approach. This allows the organisation to gain an appreciation of the magnitude of each risk, set targets for improvement based on its risk appetite, and track progress against an agreed, timed action plan. The Board of Directors decides what level of risk is reported to them. The threshold is a risk score of 12.

Risks are recorded in the health and safety control books and in risk registers. A risk register is a specific tool for recording and managing risk in a standard format to allow comparison and aggregation. Taking each risk in turn, the risk register records the controls (the things we do to mitigate that risk) already in place, the original risk score and the current risk score based on those controls. Gaps in controls can then be identified and actions agreed to close these gaps. Targets based on an acceptable level of risk can be agreed, and progress towards achieving the target risk score can be tracked. Assurances (the evidence that controls are effective) are also recorded.

The identification and management of risk as communicated in risk registers aids decision-making and resource prioritisation. It produces proper information by which the Trust can reassure the public, patients and stakeholders that it is effective and efficient and delivering the objectives of the organisation.

Risk assessment and management is addressed using risk registers at four levels across the Trust:

1. Departmental

Risk assessments are carried out routinely as part of the health and safety process as well as from incidents, complaints, local reviews, patient feedback and information contained in relevant quality, safety, workforce and financial dashboards. The departmental risk registers will reflect these risk assessments, including all residual medium and high risks from the health and safety control books.

It is the responsibility of directorate leads for governance to review and where appropriate, challenge scores applied to risks on departmental registers at least quarterly. All risks that are scored 9 or above on departmental risk registers are escalated to directorate risk registers.

2. Directorate

The directorate risk registers and corporate functions risk registers are key management tools which are scrutinised monthly within management meetings to ensure effective oversight of risk management. Clinical Directors, Operational Directors, Corporate Directors and Deputy Directors are responsible for the risk registers.

The directorate risk register will reflect departmental risk registers where relevant by including risks that are scored 9 or above or form a trend across more than one departmental register. At this level risk assessment is performed alongside objective setting and business planning.

All risks that are scored 12 or more will be discussed at the Corporate Risk Review Group, together with any other risks that the risk register owner is concerned about.

3. Corporate

The corporate risk register is a live document, reviewed and updated as circumstances change, new risks arise and established risks are treated. Risks are escalated up to the corporate risk register, or back down to clinical directorate or corporate functions risk registers, based on the agreed threshold of 12 for designating corporate risk.

It therefore identifies key organisational risks. The corporate risk register is reviewed at the Corporate Risk Review Group every month, with a focus on progress of actions to achieve the target risk score for existing risks. Risks from clinical directorate and corporate functions risk registers are discussed and will be included on the corporate risk register if the agreed risk score is 12 or more.

The Senior Management Team, chaired by the Chief Executive Officer, reviews the updated corporate risk register and a report from the Corporate Risk Review Group every month. The Audit Committee also receives an update from the Corporate Risk Review Group at each meeting and the Board of Directors receive an update each month, and a more detailed report together with the complete corporate risk register on a quarterly basis.

4. Board Assurance Framework

The Board Assurance Framework (BAF) is an essential tool which brings together the key strategic objectives, the requirements of licensing and regulatory bodies and provides detail and assurance on the systems of control which underpin delivery of the strategic objectives. It offers visible assurance on the board’s overall governance responsibilities.

The BAF brings together all of the essential elements for achieving the Trusts goals and ambitions, and of maintaining regulatory compliance and compliance with the Foundation Trust Licence. It systematically evaluates the risks to achieving these. It asks:

- What are the things we have agreed as strategic priorities?
- What are the essential prerequisites to confidently maintaining regulatory compliance?
- What are the essential prerequisites for compliance with the terms of our Foundation Trust Licence?
- What are the risks to these prerequisites?

Taking each risk in turn, the BAF records the controls and the assurances already in place. Gaps in controls and assurances can then be identified and actions agreed to close the gaps. By focusing on gaps in controls and assurances, the Board can be confident that all necessary steps are being taken to assure delivery of the trusts overall objectives and obligations as above, and that resources can be allocated in the right place. The BAF is a live document which is reviewed by Executive Directors on a monthly basis.

Some gaps in controls or assurances will also feature on the corporate risk register as they present a current risk which requires mitigation.

The risks on the corporate risk register for 2016/17 and going forward relate to the:

- Risk to the quality of service delivery in Medicine due to gaps in rotas following the Deanery allocation process;
- Risk to service delivery due to the lack of experienced registered nurses due to national labour market shortage;
- Risk to financial sustainability from failure to deliver the Clinical Transformation Programme at pace and scale;
- Risk to urgent care system due to a lack of capacity in the out of hospital services;
- Risk of financial deficit and impact on service delivery due to failure to deliver the Trust annual plan by having excess expenditure or a shortfall in income;
- Risk of patient harm as a result of being lost to follow-up;
- Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down;
- Risk to patient safety due to a lack of provision of acute oncology services;
- Risk of temporary reduced or loss of activity as a result of disruption to services due to the major refurbishment to the Sterile Services department;
- Risk to reputation due to non-compliance with DNACPR policy caused by failure of some clinicians to implement policy.

During 2016/17 the strategic risks identified on the BAF included risk of:

- Lack of medical, nursing and clinical staff;
- High levels of frailty in local population;
- Failure to learn from feedback and incidents;
- Insufficient focus on quality in the Trust;
- Failure to deliver integrated models of care;
- Lack of interoperable systems across New Models of Care partners to enable access by all concerned to a single shared record;
- Misalignment of Commissioner/partner strategic plans;
- Service sustainability;
- Failure to deliver the Operational Plan;
- Loss of Monitor Provider Licence;

- External funding constraints;
- Lack of fit for purpose critical infrastructure; and
- Insufficient senior leadership capacity.

In 2016/17 the Board of Directors ensured that detailed controls were in place to mitigate risks and support assurance. The Board of Directors will ensure going forward that detailed controls will continue to be in place to support assurance and mitigate risks. All risks, mitigation and progress against actions are monitored formally at Directorate, Corporate and Board level every month.

The quality of performance information is the responsibility of the Senior Information Risk Owner (SIRO) who chairs the Data and Information Governance Steering Group and advises the Board of Directors on the effectiveness of information risk management across the organisation. In addition, the quality of performance information is tested by both Internal and External Audit within their planned programmes of work.

The Trust has put in place due processes to ensure information governance and data security in accordance with national recommendations led by the Senior Information Risk Owner at Board level. The Information Governance Toolkit return is formally approved by the Board of Directors prior to submission.

The Trust has an Integrated Board Report (IBR) which triangulates key information metrics covering quality, workforce, finance and efficiency and operational performance, presenting trends over time to enable identification of improvements and deteriorations. The report currently includes 65 RAG (red, amber, green) rated indicators of which 26 relate to quality, 18 to finance and efficiency and 21 to operational performance.

In addition there is a quality dashboard which has additional quality indicators at Trust level and at ward level.

The IBR is available to each Board meeting and meetings of the Council of Governors, and this and the quality dashboard are reviewed by the Quality Committee and are available to each of the steering groups responsible for leading work to ensure compliance with CQC standards.

In addition there are regular director inspections and patient safety visits which provide assurance on quality and compliance with CQC standards.

Internal Audit most recently assessed compliance with Monitor’s Licence conditions in November 2014 and with CQC fitness to register in March 2017 and gave significant assurance for both. The Audit Committee reviews the evidence for compliance with CQC registration requirements annually.

Principal risks to compliance with Monitor’s Licence Section 6 – NHS Foundation Trust Condition 4 (FT governance) relate to:

- Effectiveness of governance structures;
- Responsibilities of Directors and subcommittees;
- Reporting lines and accountabilities between the Board, subcommittees and Executive team;
- Submission of timely and accurate information to assess risks to compliance with Trusts licence;
- Degree and rigour of oversight the Board has over trust performance.

There are no significant risks that have been identified to compliance with the NHS Foundation Trust Licence Condition 4 (FT governance). The Trust ensures compliance with the requirements of Monitors Provider Licence in it's entirety via annual and in-year submission as required by NHS Improvement's Single Oversight Framework. These submissions include detailed information on financial performance, plans and forecasts, and third party information, in order to assess the risk to continuity of services and governance.

This Annual Governance Statement also provides an outline of the structures and mechanisms that the Trust has in place to maintain a sound system of governance and internal control to meet the requirement of the Licence Condition 4, Section 6. It takes assurance from these structures as well as feedback from Internal and External Audit and other internal and external stakeholders regarding the robustness of these governance structures. These same mechanisms are used by the Board to ensure the validity of the annual Corporate Governance Statement.

In order to mitigate the risks to compliance with Monitor's Licence Condition 4, the Trust has in place a well defined governance framework with clear accountability and reporting to ensure integrated governance, to deliver the Trusts objectives and to provide assurance to the Board of Directors.

In 2015 staff from across the organisation participated in a rapid process improvement review of quality governance structures and processes. The outcome was a well-defined framework of committees and groups with clear accountability and reporting to ensure integrated governance, to deliver the Trusts objectives and to provide assurance to the Board of Directors. Quality of patient care is at the heart of this framework.

Executive Directors, Non-Executive Directors, Governors, lay members and other stakeholders are key participators in many of the Trust's committees.

During 2015, the Trust commissioned an independent review of governance against Monitor's Well-led framework for governance reviews. The review noted a number of areas of strength and good practice including:

- A Board which is composed of high calibre individuals from a broad spectrum of backgrounds which were observed to bring insightful challenge and debate to all aspects of the Trust's business;
- Clear processes for holding people to account for delivery which are widely considered by the workforce to be effective in practice;
- Robust succession planning which is in place several tiers below executive level; and
- The fostering of a positive culture within the Trust, with good engagement from the wider workforce in the success and sustainability of the organisation.

There were no material areas of concern in relation to the Board and the governance arrangements in place at the Trust. There were some areas identified for further progress and improvement:

- More explicit tracking and monitoring of progress against strategic objectives and milestones at Board, committee and Directorate Board meetings;
- Restating the roles of the Board committees to ensure that they have sufficient time to cover the accountabilities set out in their terms of reference, and that the

expectations of assurance reporting into them from directorates are both clarified and standardised; and
- An acknowledged need to increase the opportunities for engagement with staff working in community services.

Work has been undertaken to address each of these recommendations.

The Trust was inspected by the Care Quality Commission (CQC) as part of its routine programme of inspections in February 2016. The Trust and Harrogate District Hospital were given a rating of “good” overall. Harrogate District Hospital, Community Services and the Trust were rated as “outstanding” for the caring domain, and four individual services were rated as “outstanding”. Improvements identified by the CQC formed the basis of a trust-wide action plan which is almost complete.

The Board of Directors is responsible for exercising all of the powers of the Trust; however, it has the option to delegate these powers to senior management and other committees. The Board:
- sets the strategic direction for the Trust;
- allocates resources;
- monitors performance against organisational objectives;
- ensures that clinical services are safe, of a high quality, patient-focused and effective;
- ensures high standards of clinical and corporate governance; and
- along with the Council of Governors, engages members and stakeholders to ensure effective dialogue with the communities it serves.

The Board is also responsible for ensuring that the Trust exercises its functions effectively, efficiently and economically and that compliance with the Trust’s Licence; and Constitution are maintained.

During 2016/17 there have been five formally constituted committees of the Board; the Audit Committee, the Quality Committee, the Nomination Committee, the Remuneration Committee and the Finance Committee.

The Audit Committee

Four Non-Executive Directors comprise the Audit Committee, and one of these is the Chair. The Deputy Chief Executive/Finance Director and Deputy Director of Governance have a standing invitation to meetings and the Chief Executive attends one meeting per year, when considering the Annual Report and Accounts and Annual Governance Statement. Other Executive Directors attend meetings when the Committee is discussing areas of risk or operations that are the responsibility of those individual Directors.

The key responsibilities of the Audit Committee are to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities (both clinical and non-clinical), that supports the achievement of the organisation’s objectives. The Committee ensures that there is an effective Internal Audit function that meets mandatory NHS Internal Audit Standards. Internal Audit’s primary role is to provide an opinion and assurances on the adequacy and effectiveness of the systems of internal control and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. The Committee also reviews the work and findings of the External Auditors

appointed by the Council of Governors and considers the implications and management's responses to their work. The Audit Committee receives reports from Internal and External Audit, the Quality Committee and the Corporate Risk Review Group which enable it to provide independent assurance on governance and controls to the Board. This also enables triangulation of key issues to enhance the Board and Committee's oversight and assurance role. The annual audit plans for Internal Audit are approved by the Audit Committee and are prioritised to focus on areas of risk and concern.

The Quality Committee

The Quality Committee is the primary mechanism by which the Board gains assurance regarding the safety and quality of services. It is chaired by a Non-Executive Director, and two other Non-Executive Directors are members including one who is a member of the Audit Committee. There is senior representation from the clinical directorates and corporate functions including the Chief Nurse, Director of Workforce and Organisational Development, Chief Operating Officer, Clinical Directors, Deputy Medical Director, Deputy Director of Governance and Head of Risk Management. On behalf of the Board, it seeks assurance on the systems and processes in place to deliver high quality care and provides scrutiny of the outcomes of these systems and processes in relation to quality. It also provides direction regarding the delivery of the Trusts quality improvement priorities and strategic objectives in respect of quality, and provides oversight and seeks assurance on regulatory compliance. The annual clinical audit plans are approved and monitored by the Quality Committee. Governor representatives sit on the Quality Committee as observers.

The Finance Committee

The key responsibilities of the Finance Committee are to ensure appropriate oversight of strategic financial planning by scrutinising the development of the Trust's financial and commercial strategy; the assumptions and methodology used in developing the strategy; recommending to the Board the 5 year financial plan and 2 year operational financial plan; and ensuring appropriate due diligence is undertaken in relation to any significant transactions. The Committee also provides assurance to the Board on in-year financial performance, including budget setting and progress against cost improvement plans. The Committee is comprised of three Non-Executive Directors, one of whom is the Chair. The Deputy Chief Executive/Finance Director, Chief Operating Officer and Deputy Finance Director also attend each meeting, and other Trust representatives may be requested to attend to discuss particular items. Governor representatives sit on the Finance Committee as observers.

The Remuneration Committee

The key responsibilities of the Remuneration Committee is to make recommendations to the Board on the remuneration, allowances and terms of service for the Executive Directors, to ensure that they are fairly rewarded for their individual contribution to the organisation, having proper regard to the organisations circumstances and performance, as well as the national position of the NHS as a whole. The Committee is comprised of the Trust's Chairman and all other Non-Executive Directors. The Chief Executive and Director of Workforce and Organisational Development attend in an advisory capacity.

The Nomination Committee

The key responsibilities of the Nomination Committee is to review and approve job descriptions and person specifications for each Executive Director, including consideration of the knowledge, skills and experience required for each post, taking into account the needs of the Board as a whole. The Committee approves the process and arrangements for the recruitment, selection and appointment of the Executive Directors. The Committee is comprised of the Chairman and all other Non-Executive Directors for the purposes of the appointment of the Chief Executive. For the purposes of the appointment of other Executive Directors, the Chief Executive will also be invited to attend meetings in an advisory capacity.

The Senior Management Team

The Senior Management Team meeting is the principal forum for ensuring and assuring the delivery of the Trust's business, including annual operating and financial plans. It exists to ensure that the Trust's strategic and operational objectives are met. The group maintains oversight of operational performance and management of risk in a systematic and planned way. The group is the most senior executive decision making forum and receives reports and recommendations from sub-groups and via the Chief Executive, reports to the Board of Directors.

The Senior Management Team is supported by the clinical directorates and a number of subgroups, with a collective responsibility to drive and co-ordinate the Trust's objectives. The key subgroups are the Learning from Patient Experience Steering Group, Improving Patient Safety Steering Group, Improving Fundamental Care Steering Group, Supporting Vulnerable People Steering Group, Providing a Safe Environment Steering Group, Workforce and Organisational Development Steering Group, Operational Delivery Group and Corporate Risk Review Group. There is appropriate representation on these groups from the clinical directorates and corporate functions and they are chaired by Executive Directors, with the exception of the Corporate Risk Review Group which is chaired by the Deputy Director of Governance.

The clinical directorates and the subgroups of the Senior Management Team ensure delivery of the Trust's objectives through a broad framework of groups that manage and deliver work, for example: the Mortality Review Group; Information Technology Steering Group; End of Life Care Steering Group; Infection Prevention and Control Steering Group. Information Governance is managed by the Data and Information Governance Steering Group. The Complaints and Risk Management Group (CORM) comprising senior staff meets weekly to monitor and ensure active risk management is in place. Concerns identified from incidents, claims, complaints and risk assessments are investigated to ensure that lessons are learnt.

Each Directorate Board oversees quality and governance within the directorate, ensures appropriate representation on groups within the governance framework and reports to the Senior Management Team. The directorates work within an accountability framework which ensures that the systems of control are in place and adhered to. The Executive Director Team regularly review the work of the directorates against the accountability framework.

There is a weekly meeting of the Executive Director Team where operational matters are discussed in detail and actioned.

Quality of Care Teams exist at ward, team and department level to champion, monitor and promote quality care and report to the Directorate Quality and Governance Groups. Interested public governors have formed alliances with some of the teams.

There are regular meetings with Commissioners at the Contract Management Board and other meetings, and with NHS England and Public Health Commissioners to review performance and quality.

The Trust has conducted a self-assessment against the conditions set out in its Provider Licence with Monitor and was deemed to be fully compliant. In addition it has also carried out self-assessments against the updated NHS Foundation Trust Code of Governance, as part of the Annual Reporting Framework. This process has ensured that there is clarity relating to robust governance structures, responsibilities, reporting lines and accountabilities and the provision of timely and accurate performance information to the Board.

The robust risk and control framework described enables the Trust to declare assurance against the validity of its Corporate Governance Statement, which will be submitted to NHS Improvement in June 2017 in line with the requirements of the Single Oversight Framework.

The Trust actively engages with patients, service users and stakeholders and has an effective structure for public stakeholder involvement, predominantly through the Council of Governors and its sub-committees. Consultations with Commissioners on the wider aspects of risk are undertaken through the monthly contract management meetings.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Trust produces an annual Operating Plan that is underpinned by detailed plans produced by the directorates. The Plan details how the Trust will utilise its resources throughout the year, identifies the principal risks to the delivery of the Plan and the mitigation and is supported by detailed financial forecasting. Each directorate is required to deliver cost improvement plans in order to ensure economy, efficiency and effectiveness of the use of resources. The cost improvement plans are scrutinised and

approved by the Medical Director and Chief Nurse via the process of quality impact assessments to ensure the quality of services is maintained.

The capital programme and the prioritisation of revenue resources to form the annual Operating Plan are informed by the Trust objectives, quality improvement priorities and identified risks.

During 2016/17 the Trust continued to implement a carbon efficiency scheme to deliver reductions in carbon emissions and to deliver significant energy efficiency.

The annual Operating Plan is produced in consultation with the Council of Governors and approved by the Board of Directors.

Directorates work within the terms of an accountability framework and meet regularly with Executive Directors to ensure compliance. There is a monthly report to the Board relating to performance and finance against plans and targets. The BAF serves as a monitoring document to ensure that appropriate action is being taken against the principal risks of failing to deliver the business plan.

There is monthly reporting to NHS Improvement relating to performance and finance against plans and targets, and reference costs are submitted annually. The Trust reviews information and feedback from regulators and external agencies e.g. Care Quality Commission, National Staff Survey, National Patient Surveys, to benchmark performance against other organisations and to improve economy, efficiency and effectiveness.

Information governance

Any potential information governance incidents are reported internally and reviewed by the Data and Information Governance Steering Group. The Trust has reported two Level 2 incidents to the ICO during 2016/17. Both incidents relate to staff inappropriately accessing patient information. The first incident has been looked into by the ICO and they confirmed that offence was committed against the Trust and that they were satisfied that appropriate measures were taken and closed the incident. The second incident is still under investigation by the Trust and once this investigation has been completed the ICO will look into it.

Annual Quality Report

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. NHS Improvement *(in exercise of the powers conferred on Monitor)* has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The content of the Quality Account has been prepared within the established governance structures and framework and in accordance with the Annual Reporting Manual and other guidance from NHS Improvement. Leadership comes from the Board of Directors with clearly devolved responsibility and accountability for individual quality improvement priorities.

Quality improvement priorities and associated quality metrics are established each year based on consultation with stakeholders, and reflect the priorities of the organisation. They are approved by the Senior Management Team and the Board of Directors. A framework for reporting data and progress against local targets to the Quality Committee is in place. This has enabled a regular and routine review of the progress with quality improvement throughout the year.

The Chief Nurse is responsible for the preparation of the Quality Account and for ensuring that this document presents a balanced view of quality within the Trust. The Quality Account is prepared with contributions from all responsible and accountable leads and drafted by the Deputy Director of Governance. The Quality Committee is responsible for approving the report prior to submission with the Annual Report and Accounts to the Audit Committee and then the Board of Directors. The NHS Foundation Trust's External Auditors KPMG carry out a limited review of the arrangements around the data quality and information included in the Quality Account and assess whether a balanced view of quality is presented based on other information.

Internal Audit provides further assurance regarding the systems in place to ensure that the Quality Account is compliant with national guidance and that adequate data quality controls are in place to ensure that performance data is accurate and complete. Internal Audit has found that robust processes are in place to collect, validate and monitor performance data in relation to both the A&E four hour wait and the 14 day cancer wait targets. Data included in the Quality Account for both targets was consistent with data reported internally and externally by NHS England. An opinion of high assurance has been given for the Quality Account 2016/17.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, Clinical Audit and the Executive Managers and Clinical Leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors, the Audit Committee, the Quality Committee, the Complaints and Risk Management Group (CORM) and Corporate Risk Review Group, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I have also reviewed the systems for writing and validating the Quality Account and for the involvement of stakeholders therein.

The Board of Directors has concluded that the systems of internal control are effective, and evidenced by:

- NHS Improvement’s use of resources risk rating for the Trust is currently 1 (risk ranges from 1, the least serious risk, to 4, the highest risk);
- The governance risk rating, issued by NHS Improvement is green;
- CQC rating for the Trust following comprehensive inspection in 2016 is “good”;
- The BAF and the Corporate Risk Register;

- Presentation of the Annual Governance Statement to the Audit Committee by the Accountable Officer;
- The Audit Committee Annual Report, which includes Internal Audit and assurance relating to Corporate Risk Review Group;
- The Quality Committee Annual Report;
- Annual report from Senior Management Team and subgroups and directorates;
- Internal and Clinical Audit Plan, prioritised on areas of risk and concern;
- Clinical Audit Annual Report;
- Internal Audit periodic reports and follow up of Internal Audit recommendations;
- Internal Audit Annual Report and Head of Internal Audit opinion;
- ISA260 Audit Highlights Memorandum (External Audit Report);
- Independent review of governance against the Well-led Framework by Deloitte (December 2015).

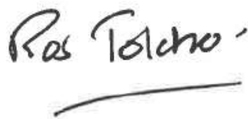
I am assured adequate and well-designed systems are in place, but there remain some control weaknesses in the operational compliance with these systems, evidenced by Internal Audit and the Head of Internal Audit opinion in relation to intravenous cannula care and staff rostering. In addition, following control weaknesses previously identified in relation to safety netting in ophthalmology (ensuring that all patients are appropriately followed up), a new expanded and broader audit focusing on additional services has highlighted some further gaps in control. The associated risk has been recognised on the corporate risk register and controls are being established.

This is an area of constant vigilance for myself as Accounting Officer and the Board of Directors, and progress will be monitored and subject to further audit during 2017/18.

Conclusion

In summary I am assured that the NHS Foundation Trust has a robust system of internal control in place, which is designed to manage the key organisational objectives and minimise the NHS Foundation Trust's exposure to risk. The Board of Directors is committed to continuous improvement and enhancement of the system of internal control.

Signed



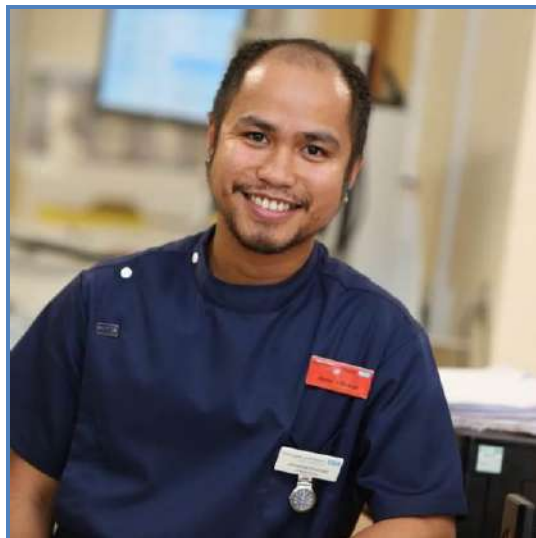
Dr Ros Tolcher
Chief Executive
24 May 2017

5. HARROGATE AND DISTRICT NHS FOUNDATION TRUST QUALITY ACCOUNT 2016 – 2017

Harrogate and District NHS Foundation Trust

Harrogate and District NHS Foundation Trust's

Quality Account 2016/17



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Contents

1. STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE 3
2. PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE 4
   - 2.1 Priorities for improvement 2017/18 4
   - 2.2 Progress against quality priorities identified in 2015/16 Quality Account 5
     - 2.2.1 Reduce morbidity and mortality related to sepsis 5
     - 2.2.2 Improve the care of people with learning disabilities 7
     - 2.2.3 Provide high quality stroke care demonstrated by improvement in national indicators 12
     - 2.2.4 Improve the management of inpatients on insulin 14
   - 2.3 Statements of assurance from the Board 18
   - 2.4 Reporting against core indicators 32
3. REVIEW OF OTHER QUALITY PERFORMANCE 44
   - 3.1 Patient Safety 44
     - 3.1.1 Medicines Safety 44
     - 3.1.2 Falls 52
     - 3.1.3 Pressure ulcers 57
   - 3.2 Patient Experience 61
     - 3.2.1 Pain management 61
     - 3.2.2 Maternity 66
     - 3.2.3 Healthy Child Programme 70
   - 3.3 Effective Care 73
     - 3.3.1 End of Life Care 73
     - 3.3.2 Dementia care 76
     - 3.3.3 Discharge 79
   - 3.4 Performance against indicators in the Single Oversight Framework 84
   - 3.5 Other Quality Information 85
     - 3.5.1 National Inpatient Survey 2016 85
     - 3.5.2 National Staff Survey 2016 and Staff Friends and Family Test 86
     - 3.5.3 Complaints and compliments 88
     - 3.5.4 The Patient Voice Group 91
     - 3.5.5 Clinical Transformation Programme 92
     - 3.5.6 Rapid process improvement activity 94
     - 3.5.7 Quality Charter 95
     - 3.5.8 Volunteers 100
     - 3.5.9 Speech and Language Therapy 101
     - 3.5.10 Cancer Services 103
     - 3.5.11 Duty of candour 109
     - 3.5.12 Safety improvement 110
4. ANNEX ONE: STATEMENTS FROM STAKEHOLDERS 113
5. ANNEX TWO: STATEMENT OF DIRECTORS' RESPONSIBILITIES 117
6. ANNEX THREE: NATIONAL CLINICAL AUDITS 2016/17 119
7. ANNEX FOUR: GLOSSARY 125

1. STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

The overriding goal of HDFT is to achieve 'Excellence Every Time' for our patients and service users. As Chief Executive of the Trust I aim to create the conditions for outstanding care to be the norm wherever and whenever people need us. The single most powerful determinant of the quality of care people receive is the collective knowledge, skills and behaviours of the people who provide that care. Our approach to driving continuous improvements in care quality is based on this belief and a commitment to supporting, developing and empowering our workforce at every level.

Our 2016/17 Quality Account, which should be read alongside our Annual Report, describes the outcome of work we have done to improve care quality over the last twelve months, and our priorities for 2017/18. In a picture of rising demand and ever more challenging financial constraints remaining true to our Trust Values of being respectful, responsible and passionate has been an important part of our success. Within this document, as well as information on our 2015/16 priority areas, you will find more information about our 2016 Care Quality Commission (CQC) inspection, the National Staff Survey 2016 and a number of national patient surveys, all of which reflect our unwavering focus on the quality of care.

The CQC rated the Trust overall as 'Good' and 'Outstanding' in the 'caring' domain. Four core services were rated as outstanding, seven were rated as good and three core services required improvement in order to achieve good or outstanding ratings. Work undertaken since the inspection has addressed all of the areas highlighted as requiring improvement. CQC inspections examine five domains of quality by considering whether services are safe, effective, caring, responsive and well led. From a patient perspective it is only when all five of these elements are good that truly outstanding care can flourish. The Trust's very positive result in national staff and patient surveys is welcome affirmation that we are continuing to drive up care quality across our services.

Last year's quality improvement priorities helped to direct the work of our clinical directorates and played an important part in a comprehensive approach to quality improvement. This year will be no different. We have selected quality priorities for 2017/18 which encompass patient experience, safety and clinical effectiveness. Providing care to children and young people is an important part of our portfolio of services and we have purposefully chosen to improve the voice of the child in the Trust, alongside our other objectives of learning from feedback to ensure that our 'You Matter Most' philosophy is as real for children and young people as it is for adults.

This quality account is written for patients and the public, for our Members and Governors, for our local partners and for our staff. Whoever you are, I hope that you feel inspired by what you read and proud of the part you play.

The high quality care we provide is only possible because of the dedication and commitment of people within the Trust and our partners with whom we work. I would like to thank all who contributed to this report and who will be striving over the year ahead, to make our ambition a reality.

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

Dr Ros Tolcher (Chief Executive)

2. PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE

2.1 Priorities for improvement 2017/18

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

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

1. Improve learning from incidents, complaints and good practice

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

2. Improve the patient experience of discharge processes

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

3. Reduce the morbidity and mortality related to sepsis

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

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

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

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

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

2.2 Progress against quality priorities identified in 2015/16 Quality Account

In the 2015/16 Quality Account we identified the following quality improvement priorities to:

- Reduce morbidity and mortality related to sepsis;
- Improve the care of people with learning disabilities;
- Provide high quality stroke care demonstrated by improvement in national indicators;
- Improve the management of inpatients on insulin.

This section describes the work that has been undertaken since then, the results achieved, and further work that is planned.

2.2.1 Reduce morbidity and mortality related to sepsis

The UK Sepsis Trust describes sepsis as a life threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis leads to shock, multiple organ failure and death especially if not recognised early and treated promptly. Sepsis can be caused by a huge variety of different bugs, with most cases being caused by common bacteria which we all come into contact with every day without making us ill. Sometimes though, the body responds abnormally to these infections and causes sepsis.

Unfortunately sepsis is a lot more common than most people realise. It is estimated to cause over 44,000 deaths per year in the UK which is more than breast, prostate and bowel cancer combined.

<u>What were we aiming to achieve?</u>

We were aiming to improve the timely care of patients with sepsis in the Trust – both those who present as an emergency and also patients who develop sepsis whilst under our care. About 20% of cases nationally occur in patients who are already in hospital. In particular we were looking to improve screening for patients with possible sepsis, shortening the time it takes for us to give antibiotics to these patients and ultimately looking to see more patients survive sepsis. This work has been included in the national Commissioning for Quality and Innovation (CQUIN) scheme for 2016/17.

<u>What have we done?</u>

- To improve screening:

Initially we embedded a paper screening tool into all acute admission documents, to enable prompt screening of all new patients. More recently we have introduced a computerised assessment tool using Patientrack, our system for recording vital signs and observations. This indicates if a sepsis screen is required whenever a set of nursing observations is taken. If possible sepsis is identified, a doctor is called to assess and start treatment.

- To improve quicker administration of antibiotics:

Medical staff in the Emergency Department (ED) have now been trained in intravenous antibiotic preparation and administration, a task that had previously been performed only by nursing staff. The antibiotic guidelines for sepsis have been streamlined meaning that a single antibiotic is appropriate for the vast majority of patients. In conjunction with the Yorkshire Ambulance Service (YAS), the ED is now notified of the imminent arrival of any patient who paramedics have diagnosed with sepsis. Changes in procedure for patients who arrive in ED by other modes of transport ensure that they are seen more promptly.

- To improve survival (in addition to the above):

An internationally agreed yet simple treatment plan is in every set of medical notes. Cases of severe sepsis (often referred to as “red flag” sepsis) are escalated to our Critical Care Outreach Sisters who advise on treatment and assist with admission to the Intensive Care or High Dependency Units if required. Teaching sessions have been undertaken across the Trust to ensure staff engagement. All patients who are prescribed antibiotics for sepsis have this reviewed within 72 hours by a senior doctor.

What are the results?

We have undertaken audits of patient records every month as part of the CQUIN scheme.

Sepsis screening	Q2 (July-Sept 2016)	Q3 (Oct-Dec 2016)	Q4 (Jan-March 2017)
ED patients requiring sepsis screening who received it	88% (43/49)	94% (61/65)	94% (153/162)
Inpatients requiring sepsis screening who received it	80% (4/5)	67% (10/15)	41% (65/159)

Table 1: Sepsis CQUIN screening performance

The bigger inpatient sample size in Q4 reflects a much better method of identifying patients who need a sepsis screen and it is clear that we have screened a much higher number of patients. Patientrack enables the identification of patients triggering a sepsis screen at any point during their inpatient stay. However it is extremely disappointing that only 41% of inpatients sampled had documented evidence of screening in Q4. It is likely that earlier results were positively impacted by the small numbers effect.

Timely antibiotic administration	Q2 (July-Sept 2016)	Q3 (Oct-Dec 2016)	Q4 (Jan-March 2017)
ED patients with red flag sepsis receiving IV antibiotics within 60 or 90 minutes as appropriate*	50% (6/12)	48% (12/25)	38% (11/29)
Inpatients with red flag sepsis receiving IV antibiotics within 60 or 90 minutes as appropriate*	78% (7/9)	92% (11/12)	89% (8/9)
Median time for IV antibiotics to be given if above 60 minutes	2 hours 20 minutes	1 hour 25 minutes	1 hour 21 minutes

Table 2: Sepsis CQUIN treatment performance

*Patients who do not appear septic on admission but then develop it have a 90 minute target; patients with sepsis on arrival to hospital have a 60 minute target. These are national targets.

Senior doctor review of antibiotics within 72 hours	Q2 (July-Sept 2016)	Q3 (Oct-Dec 2016)	Q4 (Jan-March 2017)
ED patients receiving antibiotic review within 72 hours	100% (14/14)	100% (24/24)	100% (28/28)
Inpatients receiving antibiotic review within 72 hours	100% (9/9)	100% (12/12)	100% (9/9)

Table 3: Sepsis CQUIN antibiotic review performance

Regarding patient survival following sepsis, unfortunately there is still no nationally agreed way to record deaths from sepsis. This is because it has traditionally been included in data from a wide range of conditions, for example urinary infections and pneumonia. Data from death certification

does not differentiate between patients with these conditions who did not have sepsis, and those who did. The one area of the hospital which does collect this data is the Critical Care Unit which includes both Intensive Care and High Dependency Units, as part of the national Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC) continual audit. Our most recent report is from April-December 2016. This has demonstrated that:

- 34.8% of our Critical Care patients had sepsis, compared to a national average of 33.9% from similar units. This suggests that an appropriate number of cases are being escalated to Critical Care, so our ICNARC sample is representative.
- Of those patients with sepsis who are admitted to Critical Care, 76.3% of our patients leave hospital alive, compared to 72.1% nationally.

Summary

The survival data shown in the ICNARC report is very reassuring and is probably the most important metric. However the data from the sepsis audits is disappointing and demonstrates the need for further improvement.

Regarding screening, the new computerised system should enable us to approach 100% of all new and current inpatients being appropriately screened. Unfortunately, its introduction has shown problems which have been replicated at other hospitals using the same software. A recent meeting has instituted a number of local changes to improve compliance, including automatic notification of a senior ward nurse if a sepsis screen is needed, together with real-time display of patients who may be septic.

The challenge to ensure more rapid antibiotic administration will remain a focus for the next year. The audit data does not single out one particular reason for delayed antibiotics, so a program for multiple “marginal gains” will be introduced focused initially in the ED.

2.2.2 Improve the care of people with learning disabilities

It is estimated that 1,198,000 people in England have a learning disability (British Institute of Learning Disabilities 2011). Learning disabilities are varied conditions, but are defined by three core criteria:

- Lower intellectual ability, usually defined as an intelligence quotient (IQ) of less than 70;
- Significant impairment of social or adaptive functioning;
- Onset in childhood.

It includes adults with autism who also have learning disabilities, but does not include people who have a specific “learning difficulty” such as dyslexia or dyscalculia.

People with a learning disability face many health inequalities, often resulting in worse health than the general population. On average people with a learning disability die 16 years earlier than the general population (Department of Health, 2013).

What were we aiming to achieve?

The Trust recognised that the input from a specialist nurse with a learning disability nursing registration would enhance the provision of care of people with learning disabilities. We successfully recruited a Learning Disability Liaison Nurse (LDLN) who commenced in post in June 2016.

We wanted to increase the identification of people with learning disabilities by using, with their consent, flags on electronic patient systems. This will enable staff to identify people who may need additional support and to use that information to deliver high quality, personalised care. Our aim was to increase the number of people identified in this way by 50% by April 2017.

We wanted the LDLN to be aware of every patient in our care identified as having a learning disability, and to ensure that reasonable adjustments are made to meet the patient's individual needs. We planned to audit this by the end of the financial year and expected the number of documented adjustments made to increase by at least 100% as the provision and recording of these improve.

In December 2015 we carried out a survey to gauge staff confidence in and awareness of caring for people with a learning disability. Another survey was to be undertaken early in 2017 to assess the impact of training and awareness raising that would be provided by the LDLN.

We wanted to strengthen compliance with the Accessible Information Standard through further development of the library of easy read resources available on the Trust intranet.

We aimed to enable people with a learning disability to participate in the NHS Friends and Family Test (FFT) by ensuring people flagged as having a learning disability that are discharged following an inpatient admission are sent an easy read FFT survey to complete and return. It was agreed that the target response rate would be 40% as this was the highest previous national target for inpatients.

What have we done?

The LDLN reviewed existing flagging request forms and developed an easy read form for use in the community. This was shared with social care, specialist community learning disability services, care providers and local self-advocacy forums. The flagging of people with learning disabilities was also promoted internally through various internal communications and awareness raising opportunities.

The LDLN was made aware of all inpatients, flagged as having a learning disability through the existing notification system. The LDLN engaged with HDFT teams to raise awareness of his role and support available in the provision of reasonable adjustments.

A patient-held health passport has been developed and printed. This is used as a communication tool to enable staff to provide appropriate care and reasonable adjustments based on individual needs.

Figure 1: VIP Health Passport

A reasonable adjustments checklist was reviewed and piloted in the Emergency Department prior to approval by the Health Records Committee in January 2017. This checklist also forms part of an enhanced admission proforma for patients with learning disabilities which is currently being piloted on three inpatient wards.

Currently learning disability training is not mandatory or essential, although it does form part of the care certificate for all care support workers and therapy assistants. This e-learning package has been completed by 238 staff in the last three years. A training needs analysis has recently been completed and proposes learning disabilities awareness e-learning becomes essential training for

all clinical staff and a higher level face-to-face training is provided for identified staff groups. Bespoke training has been requested by and delivered to staff in the Emergency Department, Trinity ward and to nutritional assistants, and is planned for dieticians and the staff in Outpatients and Endoscopy. A teaching session for senior doctors and nurses with the theme of "Mental capacity and people with learning disabilities" has also been provided by the LDLN and the Consultant in Special Care Dentistry.

A range of easy read leaflets have been collated from various sources including bespoke HDFT leaflets. An easy read FFT has been developed and is now sent out weekly to all flagged patients following discharge from an inpatient stay.

What are the results?

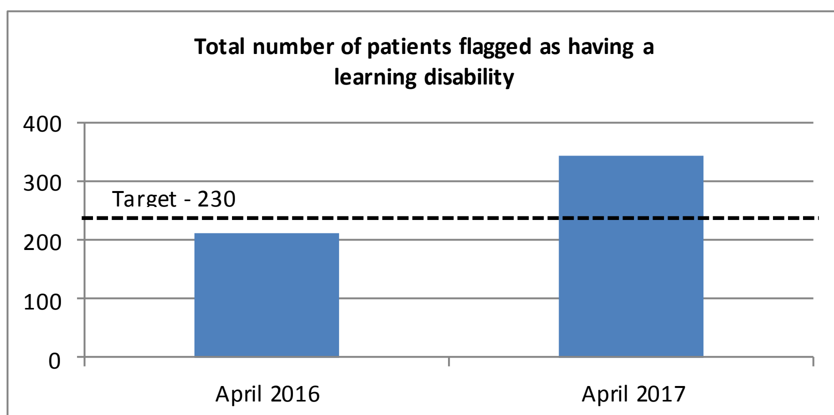

Figure 2: Total number of patients flagged as having learning disabilities April 2016 and April 2017

Prior to April 2016 there were 213 patient records flagged to indicate that the patient had a learning disability. We had hoped to increase this by at least 50%. This has been achieved with a further 130 learning disability flags added in 2016/17.

In response to patient feedback an additional flag has been implemented, alerting staff that a child's parent has a learning disability.

An audit of reasonable adjustments was undertaken in 2015/16, identifying a total of 34 documented reasonable adjustments. We aimed for a 100% increase in documented reasonable adjustments with a target of 68. An audit of the reasonable adjustments checklist pilot in ED and the enhanced admission proforma pilot on three inpatient wards was undertaken, and this alone demonstrated that the target was achieved with a total of 241 documented adjustments. This data does not include other adjustments made throughout the Trust or those coordinated by the LDLN.

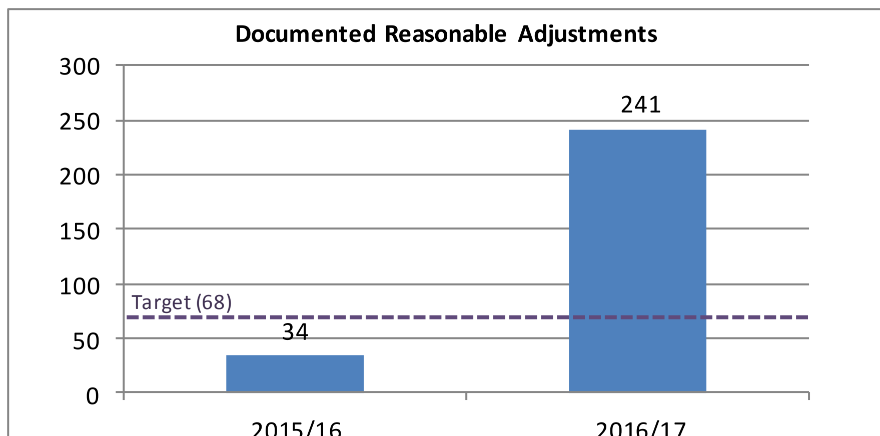

Figure 3: Documented reasonable adjustments by audit 2015/16 and 2016/17

A reasonable adjustments audit is planned for August 2018 following the Trust-wide roll-out of the reasonable adjustments checklist.

The reasonable adjustments provided have included familiarisation visits, coordinating complex admission plans, support with discharge and facilitating pony therapy for an inpatient.

Patient and carer feedback has demonstrated the impact that these adjustments can have on patients and those that care for them. One parent commented that they:

' ……particularly appreciate the planning that went into accommodating [patient]'s special needs. On the day, we really felt that we had VIP treatment'.

Photo 1: Mr P the therapy pony!

The three question staff awareness survey was repeated in early 2017 with an additional question relating to awareness of the Trust LDLN. Our aim was that this would demonstrate an increase in staff knowledge from the 2015/16 data.

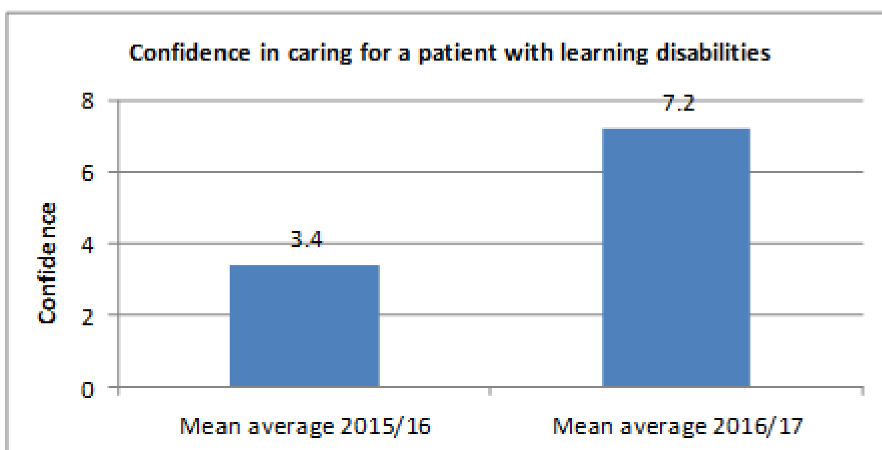

Figure 4: Staff confidence in caring for a patient with learning disabilities 2015/16 and 2016/17

Staff confidence in caring for a patient with learning disabilities was scored by respondents on a scale from 1-10 (with 10 being very confident). The survey identified that the mean average staff confidence score had increased from 3.4 to 7.2.

The proportion of staff surveyed that reported to have received learning disabilities training increased from 34.5% in 2015/16 to 51.4% in 2016/17.

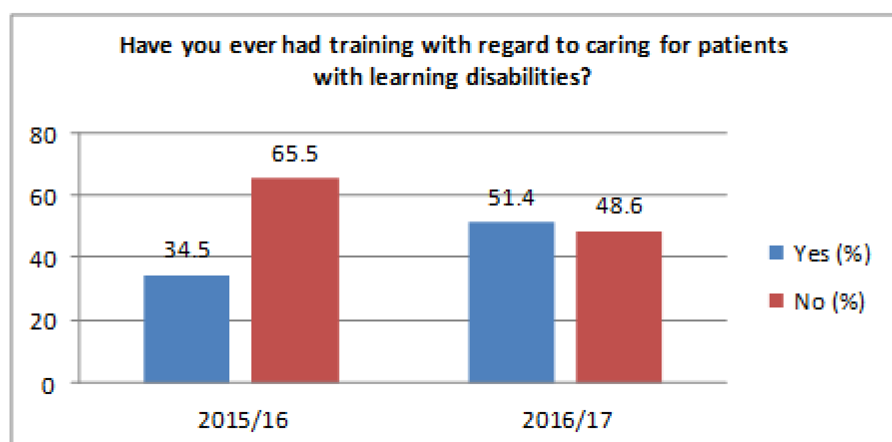

Figure 5: Staff training for caring for a patient with learning disabilities 2015/16 and 2016/17

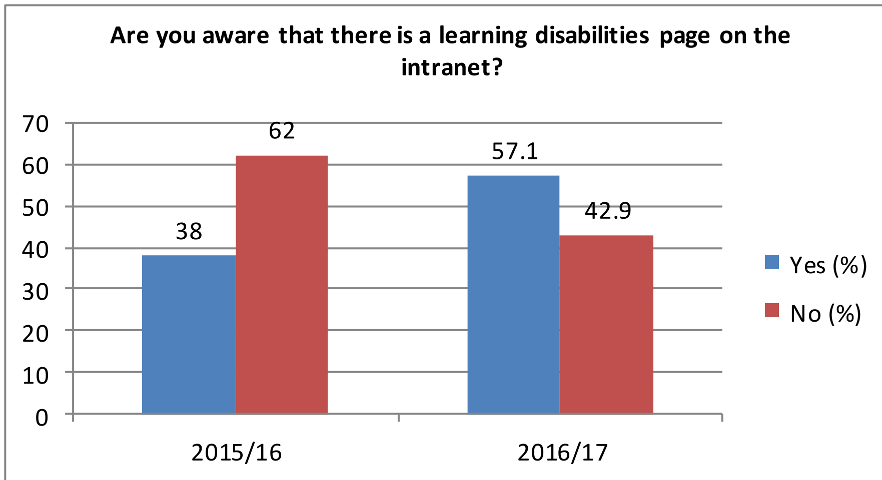

Figure 6: Staff awareness of learning disabilities intranet page 2015/16 and 2016/17

Awareness of the learning disabilities resource page on the staff intranet also increased from 38% in 2015/16 to 57.1% in 2016/17.

Of the people surveyed 76.4% were aware that there is a LDLN in the hospital.

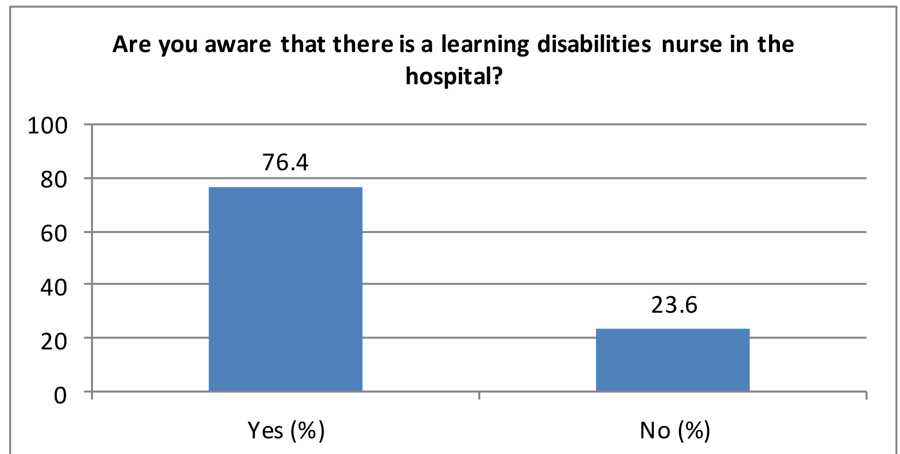

Figure 7: Staff awareness of the LDLN 2016/17

A total of 60 FFTs were sent to patients with learning disabilities following an inpatient stay. The agreed target return rate for the FFT was 40%. This was achieved with a return rate of 62.5%. Some examples of comments from returned FFTs include:

Figure 8: Patients with learning disabilities FFT comments

Summary

There has been significant progress in improving the care of patients with learning disabilities and this should continue with further development of the learning disability service. An increase in staff awareness and confidence has been evidenced through a staff survey and this will be supported by providing further opportunities for staff training and development. The numbers of documented reasonable adjustments has increased and the FFT and direct feedback received has demonstrated that this has had a positive effect on patient experience. The promotion of health passports and an increasing number of patients flagged as having learning disabilities will enable the Trust to continue to develop the provision of reasonably adjusted services to this group of patients.

Further work is required on developing the staff intranet resource and to support the implementation of learning disability documentation.

Future projects include maternity and day surgery pathways for people with learning disabilities, a learning disability page on the HDFT website and the development of a link worker scheme.

2.2.3 Provide high quality stroke care demonstrated by improvement in national indicators

Good stroke care reduces mortality and disability and there has been a national and local campaign to improve performance in particular measures of care following both acute stroke and transient ischaemic attack (TIA or threatened stroke).

The HDFT stroke service contributes data for all acute stroke admissions to the Sentinel Stroke National Audit Programme (SSNAP) to allow quarterly reporting of performance, which is subsequently released into the public domain. Based upon this data Trusts are allocated a category from 'A-E' and HDFT was placed as a category 'C' based on our scores last year. A summary of the scores across the last three years can be found in the table below.

Domain	Jul to Sept 2013	Oct to Dec 2013	Jan to Mar 2014	Apr to Jun 2014	Jul to Sept 2014	Oct to Dec 2014	Jan to Mar 2015	Apr to Jun 2015	Jul to Sept 2015	Oct to Dec 2015	Jan to Mar 2016	Apr to Jul 2016	Aug to Nov 2016
SSNAP level	D	C	D	D	C	D	C	D	D	C	D	C	D
SSNAP score	52.2	62	52.7	58.9	63.9	59.8	60.8	56.7	45.6	64.0	54.2	61.8	57
Case ascertainment band	A	A	C	A	A	A	A	A	A	A	A	A	A
Audit compliance band	C	A	A	B	C	B	B	C	B	A	B	B	B
Combined Total Key Indicator level	D	C	C	C	B	C	C	C	D	C	D	C	C
Combined Total Key Indicator score	58	62	62	62.0	71	63	64	63	48	64.0	57	65	60
1) Scanning	C	D	C	C	D	D	E	E	D	D	D	D	D
2) Stroke unit	C	B	B	C	B	C	B	C	D	B	C	B	C
3) Thrombolysis	C	D	D	D	C	C	E	D	D	D	D	E	D
4) Specialist Assessments	C	B	B	C	B	C	B	C	C	C	C	B	D
5) Occupational therapy	C	B	C	A	A	B	A	A	C	B	B	A	B
6) Physiotherapy	E	C	C	B	B	B	B	B	D	B	D	B	B
7) Speech and Language therapy	C	D	E	E	C	D	D	C	E	C	D	D	C
8) MDT working	B	C	B	C	C	B	B	C	D	C	C	B	C
9) Standards by discharge	C	B	B	B	B	B	B	B	B	B	B	B	B
10) Discharge processes	D	C	C	C	C	C	C	C	C	C	C	C	C

Table 4: SSNAP scores July 2013 – November 2016

What were we aiming to achieve?

In line with the Trust's commitment to high quality, clinically effective care, the Quality Committee requested an improvement plan for 2016/17 that stretched the ambition of the stroke services. It was agreed that stage one of the improvement programme would focus on bringing the identified indicators to a level comparable with the national average. The aim of stage two would be to bring all domain performances up to a category 'B'.

What have we done?

The following actions have been undertaken in the last year to improve stroke care:

- In August 2016 a task and finish group was established with terms of reference and monthly meetings scheduled to progress improvement actions. The group is comprised of clinical staff from a wide range of professions and services including the Stroke Unit, Emergency Department (ED) and Radiology.
- Two half-day workshops were held in November 2016 to improve the number of patients with stroke transferred from the ED to Radiology for a computed tomography (CT) scan within an hour of arrival in hospital as part of the existing stroke pathway. Improvement actions implemented following on from the workshops include:
    - The ED triage nurse to request the CT scan prior to the arrival of the stroke nurse in ED as part of a revised pathway to CT scan from ED;
    - A new standard operating procedure (SOP) for YAS pre-alert information;
    - Junior doctor and nurse training in the new SOP and revised pathway;
    - Care support worker or registered nurse assigned as dedicated support for stroke response per shift;
    - ED to phone CT staff as an alert for scans.
- Re-iteration of documentation processes to all therapy staff regarding hours of therapy undertaken.

What are the results?

The task and finish group have concentrated on the areas in the table below. It is clear that some improvement has been made in the areas identified, with indicators 6.3 (hours of physiotherapy) and 7.3 (hours of speech and language therapy) above national average. Areas 1.1 (scanning with an hour), 1.2 (scanning with 12 hours), 3.3 (thrombolysed within an hour), and 9.2 (continence plans) have also shown improvement. There has been no improvement against 10.2, early supported discharge.

Indicator number	Indicator	Previous performance (Apr-July 2016)	Current performance (Aug-Nov 2016)	National average
1.1	Percentage of patients scanned within one hour of clock start (arrival at hospital)	25%	28.1% (36% Dec 16)	48%
1.2	Percentage of patients scanned within 12 hours of clock start	77%	82%	93%
3.3	Percentage of patients who were thrombolysed within one hour of clock start	0%	16.7%	58%
6.3	Median percentage of days as an inpatient on which physiotherapy is received	58%	74.6%	70%
7.3	Median percentage of days as an inpatient on which speech and language therapy is received	31%	59.7%	45%
9.2	Percentage of applicable patients who have a continence plan drawn up within three weeks of clock start	76%	87.5%	90%
10.2	Percentage of patients treated by a stroke skilled Early Supported Discharge team	0%	1.7%	34%

Table 5: Performance metrics for stroke

Summary

The task and finish group have focused upon the early part of the pathway since August 2016 and will continue to work on the areas in Table 5 with aim of meeting the national average, and the aspiration to achieve SSNAP category ‘B’.

A key area of improvement in the next phase of work will be timely access to specialist assessment, particularly speech and language therapy and supporting patient care in the community upon discharge from hospital.

2.2.4 Improve the management of inpatients on insulin

Over the last two years at HDFT we recognised an increase in the number, type and severity of reported insulin related incidents and errors in both acute and community settings.

Insulin prescribing and administration safety was identified in 2014/15 as a safety concern by Diabetes UK, the Association of Clinical Diabetologists and endorsed by National Clinical Directors. All Trusts were written to and insulin use and safety continues to be a focus of the National Diabetes Inpatient Audit (NADIA).

The safe use of insulin is also affected by the range and complexity of new insulin types and devices, which whilst a major step forward, have also been highlighted by UK and European Medicines Regulatory Authorities (MHRA and EMEA) as a potential risk of medication error.

What have we done?

We instigated a “safe use of insulin group” (SING), comprising diabetes nurse specialists (adult and paediatric), consultants, community matron and pharmacists to develop a programme of work to improve the safe use of insulin at HDFT. This group has monitored insulin incidents and errors reported on Datix (incident reporting system) across HDFT and classified numbers, types, locations of error and levels of harm.

This has allowed a targeted work programme focused on:

- Improving the reporting and investigation of incidents including feedback to clinical teams;
- Analysis of five years of reported insulin error data to target interventions;
- Utilising and improving ePMA (electronic prescribing and medicines administration system) to help minimise prescribing errors;
- Developing a dashboard identifying all inpatients prescribed insulin to allow early intervention by the diabetes team and pharmacy staff;
- Developing a self-administration programme for patients using insulin;
- Developing a training needs analysis and implementing an essential skills training programme on the safe use of insulin for all relevant doctors, nurses, care support workers, pharmacists and pharmacy technicians;
- Utilising the Unipoc dashboard (highlighting patients with abnormal blood glucose levels) to proactively monitor blood glucose levels and target interventions as appropriate;
- Continuing to participate in NADIA and report its findings.

The quality improvement programme specifically aimed to:

- Continue a high level of reporting of insulin errors and incidents in acute and community settings;
- Investigate all errors, classify with a level of harm and provide feedback and learning to clinical teams;
- Reduce to zero the number of serious incidents requiring investigation (SIRIs) involving insulin;
- Reduce the number and proportion of moderate and severe harm insulin errors below the 2015/16 level;
- Increase the proportion of no and low harm reported insulin errors above the 2015/16 level;
- Embed the dashboard of patients prescribed insulin into clinical practice and use to target early interventions;
- Implement the essential skills training packages on safe use of insulin across all acute (adult and paediatric) and community settings;
- Embed the dashboard of patients with abnormal blood glucose levels (Unipoc) into clinical practice and use to pro-actively identify patients needing review;
- Reduce the number of patients on insulin experiencing at least one insulin error below 34.4% as found in NADIA 2015.

What are the results?

We used 2015/16 data as our baseline position and agreed the metrics described below.

An important component of the safety programme during 2016/17 was to maintain or improve on the level of reporting but affect the proportion of harm levels i.e. increase the ratio of no and low / higher harm reports. This would demonstrate a good reporting culture. In 2016/17 we have seen a similar number of reported errors at 40 demonstrating a good reporting culture. Insulin errors accounted for 10% of the total medicine related errors. We have seen a rise in the number of errors reported in the acute setting to 35 and a significant fall in the community setting errors, reduced from 13 to five.

The most important component of these reports is the associated levels of harm. In 2015/16 we saw 34 errors (83%) classified as no or low harm and seven errors (17%) classified as moderate or severe harm, including two severe harms with one progressing onto a full SIRI investigation. In 2016/17 we saw a significant change in this ratio with 37 errors (92%) classified as no or low harm and three errors (8%) classified as moderate. There were no severe insulin related errors during 2016/17. This demonstrates a really significant improvement in the safe use of insulin at HDFT.

	2015/16	2016/17
Total number of reported insulin errors in acute and community settings	41	40
Acute hospital reported insulin errors	28	35
Community services reported insulin errors	13	5
% Insulin errors as a proportion of all reported medicine incidents and errors	9%	10%
% errors investigated	100%	100%
Number and % of reported no or low insulin harms	34 (83%)	37 (92%)
Number and % of reported moderate insulin harms	5 (12%)	3 (8%)
Number and % of reported severe insulin harms	2 (5%)	0
Number of insulin related SIRIs	1	0
Number of Datix reported insulin incidents triggered by use of the dashboard to allow early intervention	6	18 Note [1, 2]

Table 6: Comparison of insulin reported errors at HDFT (2015/16 and 2016/17)

***Note*[1]*:** ePMA Dashboard reviewed 100% Mon – Fri now fully embedded into practice. Pharmacist review at weekends where possible.* ***Note*[2]**: *Identified as innovative practice by CQC.*

We developed an insulin dashboard utilising ePMA during late 2015/16. This report identifies all patients prescribed insulin on a daily basis, allowing early intervention from the diabetes specialist nurses and/or pharmacists. Early intervention has prevented any insulin related issue to go on to cause harm to a patient. We believe this has added significantly to our safe use of insulin programme, led to an increase in early reporting and contributed to the change in harm ratio increasing the proportion of no or low harm errors.

National Adult Diabetes Inpatient Audit (NADIA)

HDFT contributes annually to the National Adult Diabetes Inpatient Audit. This is a snapshot audit and took place on one day in September 2016. We have compared our results with the 2015 audit and the data described below substantiates the improvements we have made with the safe use of insulin. We have seen improvements across the medicines related domains and are either better or similar to the England average.

The data does however demonstrate that we have further improvements to make.

	HDFT 2015	HDFT 2016	England average 2016	England quartile*	
				2015	2016
Medication error (all diabetes related medication errors - includes oral hypoglycaemic agents)	53%	33.3%	37.8%	4	2
Prescription error (insulin not prescribed, wrong name / dose, wrong time etc.)	40.6%	16.7%	21.1%	4	2
Medication management error (dose not adjusted, inappropriate omission etc.)	34.4%	25%	24.1%	4	3
Insulin error (insulin prescription or management error)	34.4%	25%	22.7%	4	3

Table 7: Comparison of errors identified from NADIA 2015 and 2016

** The quartile column represents how each value compares to the England distribution for the audit year; Quartile 1 means that the result is in the lowest 25%, whereas quartile 4 means the result is in the highest 25%. Quartile 1 is the best performance in relation to errors i.e. fewer errors.*

Use of the Unipoc system for monitoring of abnormal blood glucose levels

The Unipoc system and dashboard allows the diabetes team to monitor abnormal patient blood glucose levels to allow early intervention and to adjust treatment as required. The system was implemented during late 2015/16. In combination with the insulin prescription dashboard this proactive monitoring of blood glucose has contributed to the improvements in the safe use of insulin at HDFT. The criteria for review has been refined so the dashboard has become more specific in allowing the diabetes specialist nurses to review patients who require specialist input and treatment modification.

Essential skills training programme

During the late summer of 2016/17 we introduced a safe use of insulin essential skills training programme for all staff handling insulin. The programme has commenced and progress is being made. This will form part of the Trust monitoring process for 2017/18.

Staff groups	Training required	Compliance
Acute Trust nurses	Medicines Management Training	73%
Community nurses	Community Nurses Medicines Management Training	52%
Pharmacists and pharmacy technicians	Bespoke Training session	100%

Table 8: Medicines Management training compliance 2016/17

We are also providing healthcare support workers, doctors in training and consultants with bespoke training sessions.

Summary

During 2016/17 we have made significant improvements in the safe use of insulin and have met our quality improvement goals. We have:

- Maintained a high level of reporting of insulin errors and incidents in acute and community settings;
- Investigated 100% errors and classified each with a level of harm;
- Reduced to zero the number of SIRIs involving insulin;
- Reduced the number and proportion of moderate and severe harm insulin errors below the 2015/16 level;
- Increased the proportion of no and low harm insulin errors above the 2015/16 level;
- Embedded the dashboard of patients prescribed insulin into clinical practice and used to target early interventions;
- Embedded the dashboard of patients with abnormal blood glucose levels (Unipoc) into clinical practice and used to pro-actively identify patients needing review;
- Reduced the proportion of patients on insulin experiencing at least one insulin error below 34.4% as found in NADIA 2015;
- Implemented the essential skills training packages on safe use of insulin across all acute (adult and paediatric) and community settings.

This work will continue to be progressed and monitored.

2.3 Statements of assurance from the Board

1. Provision of relevant health services and income

During 2016/17 HDFT provided and/or sub-contracted 61 relevant health services.

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

The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by HDFT for 2016/17.

2. National & Local Audits

National Audits

During 2016/17, 33 national clinical audits and six national confidential enquiries and clinical outcome review programmes covered relevant health services that HDFT provides. The national clinical audits comprised 44 individual audits or work streams.

During that period HDFT participated in 31 of the 32 national clinical audits which actually ran during the year (97%) and six national confidential enquiries (100%) of the national clinical audits and national confidential enquiries which it was eligible to participate in.

To provide further context, there were 32 mandatory audit programmes on the National Clinical Audit and Patient Outcome Programme (NCAPOP), 23 of which were relevant to HDFT. One of these did not end up running, so in total the trust participated in all 22 (100%) of the programmes in which it was eligible to do so and which collected data during 2016/17.

There were also 19 non-NCAPOP audits, seven of which were not relevant to HDFT. The Trust participated in 11 of the 12 which were relevant (92%).

The national clinical audits and national confidential enquiries that HDFT was eligible to participate in during 2016/17 are as follows:

National audits:

1. Acute coronary syndrome or Acute myocardial infarction (MINAP)
2. Adult Asthma
3. Asthma (paediatric and adult) care in emergency departments (CEM)
4. Bowel cancer (NBOCAP)
5. Cardiac Rhythm Management
6. Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC)
7. Diabetes (Paediatric) (NPDA)
8. Elective Surgery (National PROMs Programme)
9. Falls & Fragility Fractures Audit Programme (FFFAP)
10. Inflammatory Bowel Disease (IBD) Programme
11. Learning Disability Mortality Review Programme (LeDeR)
12. Major Trauma Audit (Trauma Audit & Research Network - TARN)
13. Maternal, New-born & Infant Clinical Outcome Review Programme (MBRRACE-UK)
14. National Audit of Dementia

15. National Cardiac Arrest Audit (NCAA)
16. National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
17. National Comparative Audit of Blood Transfusion – Audit of Patient Blood Management in Scheduled Surgery
18. National Diabetes Audit (Adults)
19. National Emergency Laparotomy Audit (NELA)
20. National Heart Failure Audit
21. National Joint Registry (NJR)
22. National Lung Cancer Audit (NLCA)
23. National Ophthalmology Audit
24. National Prostate Cancer Audit
25. Neonatal Intensive and Special Care (NNAP)
26. Nephrectomy Audit
27. Oesophago-gastric Cancer (NAOGC)
28. Paediatric Pneumonia
29. Percutaneous Nephrolithotomy (PCNL)
30. Rheumatoid and Early Inflammatory Arthritis *(Did not run during 2016/17)*
31. Sentinel Stroke National Audit Programme (SSNAP)
32. Severe Sepsis and Septic Shock – care in emergency departments (CEM)
33. Stress Urinary Incontinence Audit

Clinical Outcome Review Programmes:

Medical & Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome & Death (NCEPOD):

1. Mental Health
2. Acute Pancreatitis
3. Acute Non Invasive Ventilation
4. Chronic Neurodisability

Child health clinical outcome review programme:

5. Young people's mental health
6. Cancer in Children, Teens and Young Adults

The national clinical audits and national confidential enquiries that HDFT participated in during 2016/17 are as follows:

National audits:

1. Acute coronary syndrome or Acute myocardial infarction (MINAP)
2. Adult Asthma
3. Asthma (paediatric and adult) care in emergency departments (CEM)
4. Bowel cancer (NBOCAP)
5. Cardiac Rhythm Management
6. Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC)
7. Diabetes (Paediatric) (NPDA)
8. Elective Surgery (National PROMs Programme)
9. Falls & Fragility Fractures Audit Programme (FFFAP)

10. Inflammatory Bowel Disease (IBD) Programme
11. Learning Disability Mortality Review Programme (LeDeR)
12. Major Trauma Audit (Trauma Audit & Research Network - TARN)
13. Maternal, New-born & Infant Clinical Outcome Review Programme (MBRRACE-UK)
14. National Audit of Dementia
15. National Cardiac Arrest Audit (NCAA)
16. National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
17. National Comparative Audit of Blood Transfusion – Audit of Patient Blood Management in Scheduled Surgery
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28. Paediatric Pneumonia
29. Sentinel Stroke National Audit Programme (SSNAP)
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Medical & Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome & Death (NCEPOD):

1. Mental Health
2. Acute Pancreatitis
3. Acute Non Invasive Ventilation
4. Chronic Neurodisability

Child health clinical outcome review programme:

5. Young people's mental health
6. Cancer in Children, Teens and Young Adults

The national clinical audits and national confidential enquiries that HDFT participated in, and for which data collection was completed during 2016/17 are listed at 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 reports of five of the national clinical audits and one of the NCEPOD reports were reviewed during 2016/17, and HDFT intends to take the following actions to improve the quality of healthcare provided.

National Cardiac Arrest Audit (NCAA)

In 2014 the National Cardiac Arrest Audit highlighted a higher than average number of patients over 85 years being resuscitated at HDFT compared to other hospitals in the UK. This was also at a time when survival to hospital discharge was 3.7%, lower than the national average of 18%, indicating that perhaps there was a correlation and some of these resuscitations may have been inappropriate.

At the same time the Resuscitation Committee reviewed the case notes of all patients that had cardiac arrests on general wards. Again a theme of inappropriate resuscitation was identified and it was noted that multiple opportunities were missed in both primary and secondary care to discuss resuscitation decisions.

The findings were escalated to the Improving Patient Safety Steering Group (IPSSG) and an action plan put in place to raise awareness of how to discuss and record “do not attempt cardio-pulmonary resuscitation” (DNACPR) decisions correctly. In addition a programme of nurse-led DNACPR decision making courses was developed as one of several strategies to reduce inappropriate attempts at resuscitation. Local audit following this intervention indicates that nurse completed forms are comparable and slightly better than doctor completed DNACPR forms.

Whilst the latest NCAA reports demonstrate a much improved position, showing more favourable outcomes for patients in cardiac arrest that are above the national average, work continues to build on and maintain the improvements made in the last two years. Local re-audit shows that full and accurate completion of the DNACPR form remains a concern, but reassuringly the communication of decisions with patients (and their families if relevant) has improved significantly over the last few years.

It was agreed at the March 2017 IPSSG that the NCAA action plan would be closed and the remaining issue in relation to DNACPR processes monitored through the separate DNACPR action plan.

National Comparative Audit of Blood Transfusion: Audit of red cells and platelet transfusion in adult haematology patients

This national comparative audit was undertaken to determine the transfusion practice of red cells and platelets to patients with haematological malignancies. The audit numbers were very small (23 patients with 25 transfusion episodes) which causes difficulties when interpreting the results. The Hospital Transfusion Committee reviewed the findings and in those areas where we did not meet the national standard it was felt that the majority of issues were clinically justified as each deviation from the guidelines was executed according to the individual patient requirements. However, this rationale was not always documented in the medical records and this has been highlighted to the clinical staff involved.

In addition, some reports and action plans from older national clinical audits and confidential enquiries were reviewed by HDFT in 2016/17 due to delays in national reporting timescales and the fact that some action plans remained open. Examples of the following actions for improvement have been taken:

College of Emergency Medicine (CEM) Audits

The three CEM audits completed in 2015/16 were all reviewed by the lead Consultant in Emergency Medicine and action plans put in place to address any areas of deficiency.

- Procedural sedation: A new integrated proforma has been introduced as well as new monitors to measure end tidal carbon dioxide (the concentration of carbon dioxide at the end of an exhaled breath). The local re-audit in March 2017 shows an improved 95% compliance with all standards.
- Vital signs in children: The electronic Patientrack system for recording vital signs and observations has now been implemented for children and there is a clear escalation procedure in place. A local re-audit is currently underway.
- Venous thromboembolism (VTE) risk assessment:

Criteria	National upper quartile performance	HDFT performance in CEM audit	HDFT local re-audit May 2016	HDFT local re-audit Sept 2016
Standard 1: VTE risk assessment completed	100%	50%	78%	**93%**
Standard 2: Patient information leaflet given (documented)	17%	17%	n/a	**63%**

Table 9: VTE risk assessment and provision of patient information in ED

Further recommendations include awaiting the Web-V electronic platform to move to a paperless form when a leg cast is needed, automating the risk assessment and patient information leaflet. There will also be continued education at medical inductions and nurse practitioner teachings and spot re-audits every six months to ensure this improved performance is maintained within the ED.

UK Parkinson's Audit 2015

The National Parkinson's Audit involved submission of data from HDFT's Neurology, Physiotherapy, Speech & Language Therapy and Occupational Therapy departments. The audit was made up of data obtained from case note review and a patient reported experience measure (PREM) questionnaire. Four separate individual service reports were received and reviewed by the relevant teams. The results benchmarked against the national data were excellent, with some areas for improvement identified.

Since the audit, a new and improved case history form has been developed by the Speech & Language Therapy team to ensure accurate recording of whether patients are in an 'on' or 'off' state during assessment. Group work screening is now routinely implemented within 12 weeks and the group work programme has been maintained; an anxiety management group ran in November - December 2016 and a fatigue management group is currently running. A new part-time rehabilitation practitioner post has been created to support Neurology out-patient occupational therapy (OT) and physiotherapy (PT) in clinical and administrative tasks including assisting with the OT/PT group work programme. Neurology OT/PT discharge letters are now being done using the Trust's electronic system, ICE, which means that discharge reports are managed more efficiently and should ensure that an improved percentage of the team's interventions are reported to referrers and other key people. It is hoped these improvements will be reflected in the next national audit which is scheduled for later in 2017.

National Clinical Audit of Biological Therapies: UK Inflammatory Bowel Disease (IBD) Audit

The gastroenterology team has been proactive in developing the service. Since the IBD specialist nurse commenced her role in January 2016 the team have been able to roll out a number of improvements. They have been promoting the new service through attendance at general practice meetings, a stall in the hospital reception area, communications on Facebook and Twitter, and in the Harrogate Advertiser. A review of the above report was completed and the key national findings and recommendations alongside progress at HDFT are detailed in the table below.

National recommendations	Progress at HDFT
Clinicians should use infliximab biosimilars as the first line anti-TNFα for appropriate patients with active IBD.	Since this data collection all patients have now been switched to biosimilars.
Clinicians should completely screen all patients prior to treatment with biological therapies. Adult patients must have a chest X-ray and screening for TB (Gamma interferon or a Mantoux screen), as well as hepatitis B, hepatitis C and HIV. Paediatric patients must have a chest X-ray and screening for hepatitis B and TB (Gamma interferon or a Mantoux).	In this audit, only 63% of patients had received adequate pre-treatment screening. Since the IBD specialist nurse has been in post, all patients are now referred and the IBD nurse conducts this screening.
Clinicians should document follow-up in all patients within three months and at one year following initial treatment with biologics. A disease activity index should also be recorded in all patients at baseline, three months and one year as a minimum. These steps will ensure that only appropriately responding patients continue to have treatment.	In this audit at three months only 38% of patients had documented follow up and none had the documented disease activity index. Multidisciplinary team (MDT) meetings have been established since November 2016. The most high risk patients have been reviewed first and a rolling programme established to ensure all patients are reviewed by the team. The IBD specialist nurse now has a database of all patients on biologics to facilitate this.
Steroid use in all patients should be kept to a minimum. Infliximab has a steroid sparing effect and steroids should be stopped at the first opportunity.	This is normal practice at the Trust and national guidance is followed.
Clinicians should audit all patients on biological therapies to ensure their safe and appropriate use. Data can also be provided to studies such as the Personalised Anti-TNF Therapy in Crohn's disease study (PANTS) for research. The UK IBD Registry can be used as a mechanism to keep a register of this information, comparing local to national outcomes and supporting audit and quality improvement.	Regular audit has not yet been established but the development of the monthly MDT and move to the IBD registry will support this going forward. A concern and risk for the team is the capacity to support the increased workload associated with collecting the information and inputting into the registry, as well as funding for the annual subscription cost from May 2017. We have undertaken a local patient satisfaction survey to attempt to capture as many patients as possible. The Trust is not involved in PANTS but discussion is underway with the research & development team regarding potential participation in a European research study.
Clinicians should share findings and recommendations of this report at relevant multidisciplinary team, clinical governance and audit meetings, with the aim of developing a local action plan for implementing improvement.	The findings will be discussed at the directorate governance group and new MDT meeting to ensure ongoing monitoring of the action plan.

Table 10: Progress against recommendations from the UK IBD Audit

Local Audits

During 2016/17 a joint audit programme between clinical effectiveness and internal audit was in place as per previous years, which focused on the high priority areas for the Trust in order to provide assurance through the governance structure. This ensured that there was no duplication of work and therefore utilised resources more efficiently. Joint audit planning has been undertaken again in preparation for 2017/18.

175 projects (excluding national audits) were registered with the Clinical Effectiveness Department during 2016/17. This includes projects aimed at improving quality by using service evaluation and

patient experience surveys. Some of these were for completion during the financial year and some had extended timescales which will remain open into 2017/18.

The results of local audits are presented at the relevant directorate or specialty audit or governance meetings where the results, recommendations and an action plan are discussed. Audits are defined as complete when a 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, where appropriate.

The reports of 51 local projects (clinical audits, service evaluations and patient surveys) were reviewed by relevant audit or governance groups at HDFT during 2016/17 and HDFT intends to take the following actions to improve the quality of healthcare provided.

Soft Diet Audit

Individuals may need to eat a texture modified diet because they are generally unwell or have oro-pharyngeal dysphagia (difficulty chewing and swallowing food). An individual who has oro-pharyngeal dysphagia may be at risk of choking and/or aspiration of food into the lungs. This audit and evaluation was designed to ensure that all current soft options meals are compliant with the soft options criteria in line with the International Dysphagia Diet Standardisation Initiative (IDDSI) framework, as well as to identify whether there are any additional 'normal' diet meals which would be suitable for patients on a soft options diet.

Unfortunately, the audit found that only 49% of the meals currently labelled 'S' on the menu are compliant with the soft options texture checklist, indicating that many of the foods we are currently providing to patients requiring this diet are not suitable for their needs. Immediate discussions have taken place between the Speech & Language Therapists and the Catering Manager to agree actions to be taken to bring the soft options foods on offer at the Trust in line with the IDDSI framework.

Smoking Cessation in Pregnancy

An audit on smoking cessation in pregnancy was undertaken which showed that smoking status was generally well recorded with 98% of ladies having smoking status recorded at booking. However, carbon monoxide (CO) testing was generally not performed with only 10% of women having a CO level checked at booking. Some booklets had a documented reason for CO testing not being performed and usually this was due to a broken machine. Given the criteria for referral, only 58% of women who should have been offered a referral were. However there were also two women who received a referral despite not meeting these criteria, suggesting that more education may be needed so that antenatal staff are aware of those who need a smoking cessation referral. As a result of this audit the following recommendations were made:

1. The department needs to invest in reliable CO machines;
2. Increased education for midwives about smoking cessation and referral criteria;
3. Staff information leaflet about smoking cessation in pregnancy, relevant investigations and referral criteria.

Information Sharing Patient Survey

An information sharing survey was undertaken during 2016 to satisfy requirements of the Information Governance Toolkit in relation to NICE Clinical Guideline 138 and Quality Standard 15. The table below shows results compared to those from the previous survey in 2015. It should be noted that the 2016 survey included community patients, who were not included in the original 2015 survey.

Question	Overall level of performance (2015)	Overall level of performance (2016)
Are you aware of the different uses of your information?	78% (163/208)	57% (128/226)
Are you aware of your choices with regard to sharing your information?	77% (158/206)	54% (120/223)
Were you asked about your preferences regarding the healthcare staff sharing information with your partner, family members and/or carer?	50% (102/205)	50% (106/213)
If yes, do you feel those preferences were respected?	95% (97/102)	99% (98/99)

Table 11: Information sharing patient survey results

In general terms inpatients appear to be best informed and happiest with the management of their information. An inpatient stay allows more time for staff to have discussions with the patient regarding information governance. The results show that there are many patients who do not have an awareness of the uses of their personal information and a number who are not aware of their choices with regard to sharing of personal information. It is possible that the inclusion of the information sheet "Your Personal Information" with the questionnaire this year highlighted to respondents exactly what happens to their personal information and made many realise that their level of awareness was previously low.

In a community setting it is particularly difficult for staff to spend much time on discussing uses of information with patients, so as a result of this survey it was suggested that a small information card could be produced, signposting patients to further information contained on the HDFT website.

An outpatient transformation project is also underway, and the provision of high quality information on electronic screens within the outpatient waiting areas is a key component of this work stream.

Dermatology Patient Survey (Ripon)

22 people completed the survey in May 2016. Results were excellent and in terms of overall experience of the care provided by the Dermatology Department, 100% of respondents answered "I was completely satisfied with the service from the Dermatology Department". The only suggestion for improvement was: *"somebody to welcome / better signage - so quiet we thought [we were] in wrong place!"*

Women's Unit Pain Survey

Outpatient hysteroscopy is a diagnostic test carried out at the Women's Unit using endoscopic equipment to visualise the uterine cavity. It is largely well tolerated, safe and has high success rates, but as with any invasive procedure it can be associated with pain and anxiety. In February 2015, a survey was conducted on pain encountered with this procedure. The main finding was that women who took the recommended pain relief had lower pain scores. It was recommended that patients have written information instructing them to take non-steroidal anti-inflammatory (NSAID) based analgesia prior to their procedure. Opiate based analgesia is not recommended. The purpose of the current project was to see if this recommendation had been fulfilled.

Patients attending the Women's Unit in August 2016 for an outpatient hysteroscopy were given surveys to complete based on their perception of pain around their procedure and how well this pain was managed. A total of 50 questionnaires were completed. The main findings were:

- 100% of patients who took the survey said that they fully understood what to expect from the procedure. No patients took opiate analgesia;
- Fewer women took analgesia prior to their procedure in this round compared to 2015;

- Local anaesthetic was found to make no difference to perceived pain scores;
- Pain scores for patients who took analgesia were lower than those who did not.

Based on these results an action plan has been developed with the following recommendations:

- Review use of local anaesthetic as there was no impact on pain score;
- Thorough history and examination in gynaecology outpatients prior to referral to the Women's Unit;
- Increase awareness of patient information and ensure provision of information leaflet;
- Ensure patients are reminded to take appropriate pain relief prior to their procedure.

Enhanced Recovery Programme (ERP)

This project was conducted in three stages:

1. Pre-audit service evaluation questionnaire to address which aspects of ERP are currently practiced and desired for orthopaedic patients at HDFT;
2. Agreement of data collection tool;
3. Pilot data collection tool with 20 orthopaedic patients.

The project identified a lack of national guidelines or local pathway for an orthopaedic enhanced recovery programme making clinical audit in this area problematic. No specific local pathway or specific documentation for enhanced recovery for orthopaedic patients resulted in difficult, time consuming data collection. In addition to highlighting a lack of documentation, the study identified key areas for focus when developing the orthopaedic ERP pathway. The results were presented to the ERP working group and also fed into the Internal Audit Advisory Review: Control Improvement Audit on Enhanced Recovery. Since the audit key performance indicators have been developed alongside dedicated paperwork which will allow better ongoing monitoring by the working group. A clinical audit is planned for later in 2017.

3. Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by HDFT in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 2885.

HDFT is committed to the promotion of evidence informed practice with the aim of continuous improvement to quality and patient outcomes and as of March 2017, the number of studies open and recruiting at HDFT was 84. 133 clinicians covering 28 clinical areas offer patients the opportunity to be part of research studies; they are supported by 43 National Institute for Health Research (NIHR) funded delivery staff.

Given the proven positive outcomes for organisations and patients as a result of their involvement in research, HDFT is fully committed to ensure every patient has opportunity to be involved in research and the Trust continues to embed a culture such that the offer of trial participation is considered part of standard care.

Training and education

Core research competencies continue to be identified for all staff and adapted to align with specialist areas. A process is in place to ensure 'Good Clinical Practice' training is up to date for all staff involved in research. Over the last year the Trust has implemented induction packages for research posts which involve new members of staff spending time in each clinical area, the

Research and Development (R&D) office and in support departments. Student practitioner placements are encouraged and facilitated by student mentors. All new consultants meet the Associate Medical Director for Research as part of their induction.

Matching research to national prerogatives and working with partners to ensure high quality studies are conducted

The research teams are continuing to examine studies aligned to and with a focus on the Vanguard initiative, developing new care models and greater integration of primary and acute services and systems. Preliminary work has also been undertaken to understand where research can positively influence the Sustainability and Transformation Plans being implemented within West Yorkshire and Harrogate. With HDFT's increased provision of the 0-19 service the department has keenly explored increasing research activity with local partners such as North Yorkshire County Council. Research sees community based studies as a strong area for growth in activity as well as closer working with Care Home providers within our region.

The research team has worked closely with Clinical Commissioning Groups and GP Federations to ensure patients have the opportunity to take part in research. Pharmaceutical companies in collaboration with clinical teams around the country, including those at HDFT, are exploring several new potential therapies through large clinical trials. Potential opportunities to deliver studies involving biosimilar medications are being explored and the economic benefits to health care systems considered. The team at Harrogate has demonstrated an ability to work with GPs to identify suitable participants in a systematic way using information from GP databases. A community research nurse based at HDFT is liaising with GP clusters to ensure GP practices are 'research ready' and supported with expertise to deliver studies in primary care and to ensure close collaboration across the primary / secondary care interface.

We continue to work with academic partners to explore focused development of our workforce and to ensure we attract high quality studies to the Trust. Current partners include Bradford Institute for Health Research and University of York (reproductive health and healthcare delivery); Centre of Evidence-based Dermatology; Centre of Immunology and Infection; Clinical Trials Units in York, Leeds and Sheffield as well as the Yorkshire and Humber Collaboration for Leadership in Applied Health Research and Care (CLAHRC) and School of Health and Related Research (SCHaRR). NIHR supported studies have been conducted within the Trust over the last year as a result of these collaborative working arrangements thus enabling our patients to have access to high quality research. In addition the fieldwork for studies has produced useful information to inform the Trust quality agenda.

The Trust is an active member of the Yorkshire and Humber Academic Health Science Network (YHAHSN) which brings together organisations in Yorkshire and Humber which have an interest in increasing the health and wealth of the region and its population as well as dissemination of evidence based practice. Research plays a role with innovation and in collaboration with the HDFT Partnership and Innovation team, connects with Medipex – the Yorkshire and Humber Innovation specialists. The area has a history of organisational collaboration including academic (White Rose Consortium), Leeds University, Bradford Teaching Hospitals, Local Education and Training Boards (LETB), Collaboration for Leadership in Applied Health Research and Care (CLAHRC), Hull and York Medical School and Clinical Trial Units based within the region.

HDFT has a long history of engagement with commercial research organisations such as pharmaceutical and more recently Med Tech companies and as a result has been selected to recruit into multi-centre international commercial studies over the last year as a result of key opinion leaders and reputation for being able to deliver to time and to target.

Research governance and performance

R&D Unit staff conduct pragmatic research governance via a suite of usable standard operating procedures (SOP) for research which reflect the national process of study approval via the Health Research Authority (HRA). Research delivery is overseen monthly by a multidisciplinary R&D Group, chaired by the Trust's Medical Director. SOPs have been amended and are continually developed in line with HRA reviews. Study performance is monitored and managed locally within the Trust; additionally performance against the higher level objectives is managed with the Yorkshire and Humber Clinical Research Network at a regional and national level. Research metrics are escalated to Trust Board within the report from the Chief Operating Officer. Patient experiences and feedback are reported via the Medical Director's report and a bi-annual presentation from the Associate Medical Director for Research.

Monitoring, measuring service quality and sharing the impact of research

HDFT has two Patient Research Ambassadors bringing a patient perspective to delivery of research in the organisation. The Patient Research Ambassadors are involved in project feasibility assessment, quality assurance via the participant survey, performance via team meetings and raising awareness about research opportunities. The annual survey assesses the quality of service delivery as perceived by research participants. Findings are shared and acted upon. The intention is that this will feed into a national survey of research participants in future. HDFT research staff seek out findings of projects conducted at HDFT and ensure these are shared with individual participants but also ensure that the findings are available to all the population HDFT serves and clinical teams and the impact of research within the organisation is recognised. These and opportunities for involvement are publicised via a HDFT Research Facebook account.

4. Use of the Commissioning for Quality and Innovation Framework

A proportion of HDFT income in 2016/17 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 2016/17 and for the following 12 month period are available electronically at: https://www.hdft.nhs.uk/about/trust/statutory-info/

The quality improvement and innovation goals for 2016/17 were agreed with Harrogate and Rural District (HaRD) Clinical Commissioning Group (CCG) and were a variation of the national scheme to support local transformation.

The monetary total for the amount of income in 2016/17 conditional upon achieving quality improvement and innovation goals was £3,147,000. The monetary total for the associated payment in 2015/16 was £2,863,000.

5. Registration with the Care Quality Commission

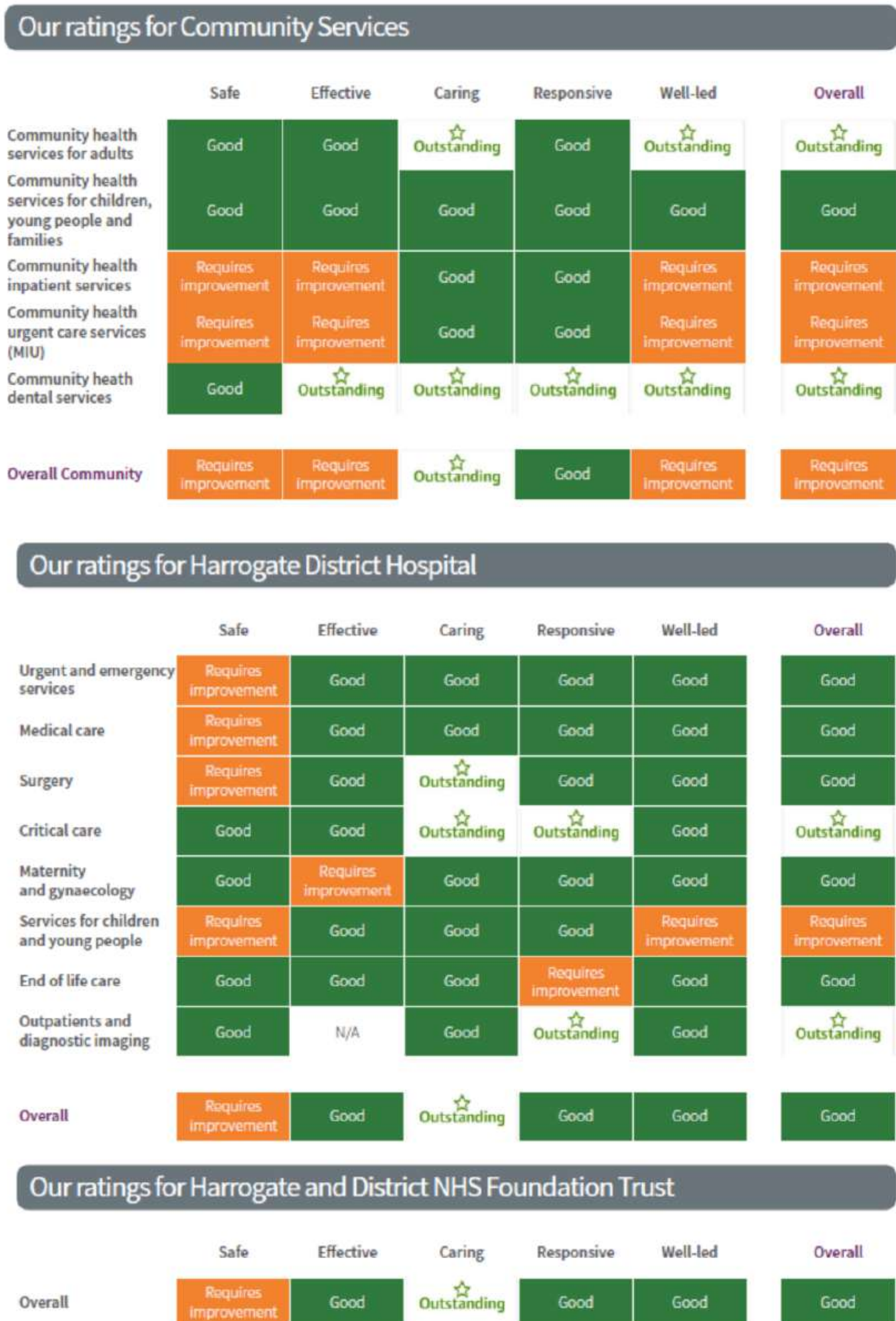
HDFT is required to register with the Care Quality Commission and its current registration status is unconditional. HDFT has no conditions on registration.

HDFT had the following sites registered during 2016/17:

- Harrogate District Hospital
- Lascelles Unit
- Ripon Community Hospital

The Care Quality Commission has not taken enforcement action against Harrogate and District NHS Foundation Trust during 2016/17. HDFT has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

HDFT had a planned inspection by the Care Quality Commission (CQC) during 2016 and had a rating of “good” overall for Harrogate District Hospital and the Trust. Harrogate District Hospital, Community Services and the Trust were rated as “outstanding” for the caring domain, and four services were rated as “outstanding”.



Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Outstanding	Good	Outstanding	Outstanding
Community health services for children, young people and families	Good	Good	Good	Good	Good	Good
Community health inpatient services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Community health urgent care services (MIU)	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Community heath dental services	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Overall Community	Requires improvement	Requires improvement	Outstanding	Good	Requires improvement	Requires improvement

Our ratings for Harrogate District Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Outstanding	Good	Good	Good
Critical care	Good	Good	Outstanding	Outstanding	Good	Outstanding
Maternity and gynaecology	Good	Requires improvement	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Requires improvement	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Outstanding	Good	Outstanding
Overall	Requires improvement	Good	Outstanding	Good	Good	Good

Our ratings for Harrogate and District NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Good	Outstanding	Good	Good	Good

Figure 9: Overview of CQC ratings

There were some specific areas where the Trust was required to make improvements and an action plan was developed to ensure these were progressed effectively, with evidence to support the improvements made and on-going assurance of improvement. Key areas for service improvement were to ensure:

- The environment on the paediatric ward is appropriate to allow the needs of children and young people with mental health needs to be fully taken into account;
- Accurate nursing records are kept in line with professional standards particularly in urgent and emergency services;
- Medical records are stored securely;
- Good infection prevention and control practices are adhered to;
- An effective infection prevention and control audit programme for the environment and hand hygiene in services for community adults and Selby Minor Injuries Unit (MIU) is in operation;
- All medicines are stored safely and disposed of when out of date;
- There are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice at all times;
- All staff have completed mandatory training, role specific training and had an annual appraisal;
- Guidelines and protocols are up to date and there is an effective system in place to review these in a timely manner;
- Medical devices are subject to servicing in line with recommended guidelines;
- The facilities in and access to the mortuary is improved.

The action plan is almost complete.

6. Information on the Quality of Data

HDFT submitted records during 2016/17 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:
  - 99.9% for admitted patient care
  - 99.9% for outpatient care
  - 98.7% for accident and emergency care

- Which included the patient's valid General Practitioner Registration Code was:
  - 100% for admitted patient care
  - 100% for outpatient care
  - 100% for accident and emergency care

7. Information Governance

HDFT's Information Governance Assessment Report overall score for 2016/17 was 84% and was graded green/satisfactory with all standards at level two or above (there are three levels with level three being the highest).

8. Payment by Results

HDFT was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.

The Trust however commissioned an external clinical coding audit to meet Information Governance requirements during 2016/17. The audit was carried out in March 2017 by nationally registered clinical coding auditors from D & A Clinical Coding Consultancy Limited. An audit sample of 200 episodes was reviewed, 50 episodes from each of the following specialties, General Surgery, Obstetrics, Elderly Medicine and Cardiology were randomly selected from across the whole range of activity for the period July – September 2016. The results showed an overall error rate for coding errors affecting the healthcare resource group (HRG) of 4% compared to the latest published national average error rate of around 7%. 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 procedure coding error rate	2.5%
Secondary procedure coding error rate	0.5%
Primary diagnose coding error rate	6.5%
Secondary diagnose coding error rate	3.5%

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 Trust will continue to annually review its Clinical Coding Audit and Training programmes to ensure both are sufficient to identify and reduce coding errors;
- 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 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 tables 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 (HSCIC).

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 1.000 – a Trust score significantly above 1.000 indicates higher than expected death rates, whereas a score significantly below 1.000 indicates lower than expected death rates.

	Data period	
	Jul 15 to Jun 16	Oct 15 to Sep 16
HDFT value	0.963	0.925
HDFT banding	2 (as expected)	2 (as expected)
National average	1.000	1.000
Highest value for any acute Trust	1.171	1.164
Lowest value for any acute Trust	0.694	0.690

Table 12: Summary Hospital Level Mortality Index

Note - highest and lowest trust scores include all providers with data published by NHS Digital. Data source: http://www.hscic.gov.uk/SHMI

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 by the Medical Director.

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

- Actively using the Healthcare Evaluation Data (HED) 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;
- Being a Northern pilot site for the regional structured case note review template. This methodology is currently being rolled out nationally across England and Scotland. It is an excepted methodology for case note review and in line with recommendations in the recent guidance: *National Guidance on Learning from Deaths* (National Quality Board March 2017). The Trust will use the guidance to develop a process for national mortality reporting and shared learning. In addition to specialty specific case note reviews, focused reviews of situation specific deaths will also be undertaken (such as maternal deaths, death in childhood, deaths from sepsis, elective surgical deaths and deaths of patients with learning disabilities);
- Using this methodology to undertake a recent in-depth case note review of stroke mortality in response to a CQC mortality outlier alert. In addition to highlighting good practice, areas for learning have been identified.

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.

	Data period	
	Jul 15 to Jun 16	**Oct 15 to Sep 16**
HDFT value	22.6	23.0
National average	29.2	29.7
Highest value for any acute Trust	54.8	56.3
Lowest value for any acute Trust	0.6	0.4

Table 13: Percentage of patient deaths with palliative care coded at either diagnosis or specialty level

Note - highest and lowest trust scores include all providers with data published by NHS Digital. Data source: http://www.hscic.gov.uk/SHMI

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 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:

- Embedding the use of SystmOne (a shared electronic clinical record) in the Specialist Palliative Care Team. This ensures clinical activity is accurately recorded and clinical records are shared by the majority of community services including GPs and District Nursing Teams;
- Recording preferred and actual place of death (and reasons why this may not have been achieved) for all patients who die on the caseload of the Specialist Palliative Care Team. All these deaths are discussed as part of the Specialist Palliative Care Team weekly multidisciplinary team meeting. Any incidents or learning from this is escalated and disseminated via the HDFT End of Life Care Steering Group;
- Developing a Trust wide work programme for end of life care as part of the HDFT End of Life Care Steering Group;
- Seeking ongoing feedback using a validated questionnaire from all bereaved relatives of patients who die in hospital;
- Auditing the pilot Care Plan for the Last Days of Life in use in the hospital with a plan to develop based on audit results.

Further information about our work in relation to end of life care is given in section 3.3.

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 do not perform

significant numbers of varicose vein operations and so the HDFT data for this procedure has been excluded from the results. A high health gain score is good.

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

	Data period	
	2014/15 (final)	**2015/16 (provisional)**
HDFT value	0.068	0.068
National average	0.088	0.088
Highest value for any acute Trust	0.146	0.146
Lowest value for any acute Trust	0.021	0.021

Table 14: PROMS – Groin hernia surgery

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

	Data period	
	2014/15 (final)	**2015/16 (provisional)**
HDFT value	Data suppressed due to small numbers	Data suppressed due to small numbers
National average	0.094	0.095
Highest value for any acute Trust	0.154	0.149
Lowest value for any acute Trust	-0.009	0.018

Table 15: PROMS – Varicose vein surgery

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

	Data period	
	2014/15 (final)	**2015/16 (provisional)**
HDFT value	0.423	0.442
National average	0.436	0.438
Highest value for any acute Trust	0.487	0.492
Lowest value for any acute Trust	0.331	0.320

Table 16: PROMS – Hip replacement surgery

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

	Data period	
	2014/15 (final)	**2015/16 (provisional)**
HDFT value	0.302	0.323
National average	0.315	0.320
Highest value for any acute Trust	0.385	0.374
Lowest value for any acute Trust	0.204	0.198

Table 17: PROMS - Knee replacement surgery

***Note** - highest and lowest trust scores exclude independent sector providers. Data looks at primary hip and knee procedures only. 2016/17 (Apr to Sep) provisional data published Feb-17 but not included in above as results too provisional Data source: http://www.hscic.gov.uk/proms*

HDFT's latest published health gain scores for hip replacements and knee replacements are above the national average. The score for groin hernias is slightly below the national average.

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

- We have 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;
- An analysis of the data shows that HDFT has a pre-operative score above the England average in all cases, which might indicate that patients who rate their pre-op health highly have a reduced chance of a health gain. Patient perception is a useful but subjective measure of performance;
- 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;
- Continuing to investigate any areas of below average health gain scores by sharing the patient-level data extract with the relevant department, with the aim of contacting patients with worsened scores and establishing in more detail the key issues affecting their health state.

Emergency readmissions to hospital within 28 days

***Note** – the data for this section has not been published by HSCIC since December 2013. The data below and comments were from 2013/14 but are required to be included.*

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 and 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.

Age 0-15	Data period		
	2009/10	2010/11	2011/12
HDFT value	10.95	10.55	9.64
National average	10.01	10.01	10.01
Highest value for any acute Trust	56.38	23.33	47.58
Lowest value for any acute Trust	0	0	0

Table 18: Emergency readmission to hospital within 28 days (age 0-15)

Age 16+	Data period		
	2009/10	2010/11	2011/12
HDFT value	9.19	10.02	9.96
National average	11.18	11.43	11.45
Highest value for any acute Trust	15.26	17.1	17.15
Lowest value for any acute Trust	0	0	0

Table 19: Emergency readmission to hospital within 28 days (age 16+)

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 SUS dataset; this is a national system and data quality indicators linked to this system indicate an excellent compliance rate.

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

- Using an evaluation tool that enables us 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.

We have included below our internal data for readmissions to provide more recent information. The data shows the total number of emergency readmissions within 30 days and then the number after applying the national payment by results exclusions. The aim of the payment by results exclusions is to remove readmissions that were likely to have been unavoidable. Both figures are then expressed as a percentage of all emergency admissions.

Emergency readmissions within 30 days

	2013/14	2014/15	2015/16	2016/17
Total number of emergency readmissions within 30 days	3235	3593	3895	4183
As a percentage of all emergency admissions	18.3%	18.1%	18.9%	19.38%
Number of emergency readmissions within 30 days (payment by results exclusions applied)	2155	2482	2696	2739
As a percentage of all emergency admissions	12.2%	12.5%	13.1%	12.69%

Table 20: Emergency readmissions within 30 days

Data source:
http://harrogatedata/Reports/Pages/Report.aspx?ItemPath=%2fFinance%2fEmergency+Readmissions

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

- The data presented is taken from the Trust's main patient administration system, iCS;
- The data is sourced from the admitted patient care spells data set. The data quality of this data is routinely assessed and published nationally by NHS Digital. HDFT's latest data quality results are presented in section 2.3 (item 6);
- The excluded readmissions are based on national definitions. These are identified by clinically coded data and the Trust consistently performs better than average in external clinical coding audits, as detailed in section 2.3 (item 8) of this report.

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

- Emergency readmissions information is routinely presented to the Trust Board each month;
- Overall, our readmission rates have been increasing slightly over the last few years. However we continue to carry out a number of clinical audits to understand this further;
- A review of local and national data relating to 30 day readmissions was undertaken during 2016/17 in order to understand how HDFT compares to a benchmark group of similar trusts and local trusts. This analysis focused on both the standardised readmission ratio and also the crude 30 day readmission rate. HDFT performs worse than comparators for the standardised readmission ratio. However for crude readmission rates, HDFT performs

better than average when compared to local trusts and about average when compared to the benchmark group of similar trusts. For the standardised readmission ratio, HDFT is above expected levels for 5 specialties - Paediatrics, Well Babies, Clinical Haematology, Medical Oncology and Cardiology (the latter being only just above expected levels). The Trust is in the process of carrying out a clinical case note review of a sample of paediatric and well babies readmissions;
- The Trust is currently undertaking a joint audit with HaRD CCG of readmissions during a seven day period in October 2016. A team consisting of clinicians and managers from both organisations are reviewing all non-elective readmissions to HDFT during the audit period to determine the proportion which were clinically avoidable. Following the detailed audit with commissioners, the results will be brought to Trust Board as part of the reporting against this key measure.

3. Ensuring that people have a positive experience of care

Inpatient survey – responsiveness to inpatients' personal needs

This measure is the average weighted score of five questions from the national inpatient survey relating to responsiveness to inpatients' personal needs presented out of 100, with a high score indicating good performance. Year on year HDFT has seen improved results with 2015 seeing the highest value of the Trust's performance yet.

	Data period		
	2013	2014	2015
HDFT value	71.8	72.6	73.3
National average	68.7	68.9	69.6
Highest value for any acute Trust	84.2	86.1	86.2
Lowest value for any acute Trust	54.4	59.1	58.9

Table 21: Inpatient survey results 2013, 2014, 2015

Data source: HSCIC indicator portal, NHS Outcomes Framework
https://indicators.hscic.gov.uk/webview/

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 priority for the Trust for the last three years. We have 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 communication, nutrition, prevention of falls and pressure ulcers and infection prevention and control;
- These standards are monitored through a governance system which includes daily safety assurance checks by matrons, extended senior nurse presence in the evenings and at weekends, unannounced director led inspections, patient safety visits and local quality of care teams;
- 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:

- Continuing to focus on the five questions from the national inpatient survey where the trust would like to improve on the care offered to patients. Further information about this is given in section 3.5.

National Staff Survey – Standard of Care Provided

Staff who would recommend the trust to their family or friends as a place to be treated
Question 12d

Proportion of staff who responded "strongly agree" or "agree".	Data period		
	2014	2015	2016
HDFT value	72	78	80
National average	65	68	69
Highest value for any acute Trust	89	93	91
Lowest value for any acute Trust	38	46	48

Table 22: National staff survey results

Note *- this is now Q21d in the 2015 and 2016 survey and is worded: If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.*
Confirmed as comparable question to previous Q12d
Benchmark data for 2016 includes both "acute trusts" and "combined acute and community trusts"
Data source: http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2016/

The data shows 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 one, 'Staff recommendation of the Trust as a place to work and/or receive treatment' in the National Staff Survey for 2016. The Trust achieved a ranking of 6th out of 39 when compared with all acute and community trusts for this key finding.

The full report can be found at http://www.nhsstaffsurveys.com/ and there is further detail in section 3.5 of this report.

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

- The Trust has continued to focus on our values which hold patient care at the heart of everything we do;
- The Trust has developed a Quality Charter which is built on the goals of; setting our ambition for quality and safety, promoting staff engagement, providing assurance on care quality and supporting a positive culture. This allows staff to help suggest and deliver improvements to the services we provide as well as sharing best practice;
- The Trust ran a pilot staff wellbeing programme providing health assessments for staff alongside motivational interviewing to support staff to identify and take action to improve their own health and wellbeing;
- The Trust has run a number of Schwartz Rounds which allows staff to share their experiences of providing healthcare. (https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/);
- A continuation of our proactive recruitment strategy including embracing social media with targeted recruitment for specific work areas or staff groups, and recruitment days for nurses.

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

- Appointing a Freedom to Speak Up Champion to enable staff to feel confident in raising concerns;

- Regularly reporting on safer staffing levels within the Trust;
- Reviewing incidents reported through risk management processes to ensure that these are investigated and appropriate action is taken;
- Providing training to all staff regarding escalation of risks;
- Communicating on how to report incidents;
- Working on sharing outcomes of investigations with learning between directorates;
- Including a message on payslips about the Being Open Policy.

Friends and Family Test – Patient

The NHS Friends and Family Test (FFT) is a feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. People are also given an opportunity to leave a comment about their response.

Response rate

	Jan-17		Feb-17	
	Inpatient wards	A&E	Inpatient wards	A&E
HDFT value	21.1%	4.5%	22.2%	3.7%
National average	23.6%	12.3%	24.3%	12.7%
Highest value for any acute Trust	95.5%	44.4%	100.0%	45.5%
Lowest value for any acute Trust	3.8%	0.5%	4.0%	0.7%

Table 23: Patient FFT response rate

Percentage who would recommend

	Jan-17		Feb-17	
	Inpatient wards	A&E	Inpatient wards	A&E
HDFT value	93.5%	96.5%	95.0%	90.0%
National average	95.7%	86.7%	96.0%	87.0%
Highest value for any acute Trust	100.0%	100.0%	100.0%	100.0%
Lowest value for any acute Trust	79.5%	45.5%	76.0%	48.0%

Table 24: Patient FFT percentage who would recommend

Notes: *England figures exclude independent providers*
NHS England now publish FFT data for additional services to inpatients and A&E (Accident and Emergency). Data source: https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/

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

- We promote the completion of a questionnaire by inpatients at discharge and the responses are collated by our volunteers;
- We use an automated telephone service to contact patients who have attended ED, the Day Surgery Unit, outpatient clinics and community services. During 2016/17 we had feedback from over 6,200 inpatients, 24,600 outpatients, more than 1,900 patients who attended the ED and more than 5,500 rehabilitation and therapy patients.

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

- Sharing the results of the FFT widely each week with staff in each area to reflect on their service, celebrating good feedback and implementing improvement whenever possible;

- Seeking to address negative comments for example improving the paediatric experience within the outpatient setting, and improving the signage to the toilets in the ED;
- Exploring other ways of seeking patient FFT feedback that will promote a higher response rate and reliable data that we can use effectively with other patient feedback to improve services and delivery of care.

4. Treating and caring for people in a safe environment and protecting them from avoidable harm

Venous thromboembolism (VTE) risk assessment

The National Institute for Clinical Excellence (NICE) recommends that all patients in hospital should be assessed for their risk of developing VTE (blood clots). This measure shows the percentage of eligible inpatients who were risk assessed. A high percentage score is good.

	Data period		
	Q1 2016/17	Q2 2016/17	Q3 2016/17
HDFT value	96.7	95.9	96.0
National average	95.7	95.5	95.6
Highest value for any acute Trust	100.0	100.0	100.0
Lowest value for any acute Trust	80.6	72.1	76.5

Table 25: Percentage of eligible admitted patients risk assessed for VTE

Data Source: http://www.england.nhs.uk/statistics/statistical-work-areas/vte/

HDFT's published scores are consistently above the national average.

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 Trust's main patient administrative 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:

- Continuing to identify wards with poorer performance and examining whether there are issues with completion of the risk assessment or inputting of information onto iCS;
- Explore the option of electronic VTE risk assessment with the roll out of Web V clinical portal across the Trust.

Clostridium difficile rates

The table shows the number of cases of *C. difficile* infection (CDI) per 100,000 bed days reported from hospital inpatients aged two years or over.

	Data period		
	2013/14	2014/15	2015/16
HDFT value	14	9	33.8
National average	14.7	15.0	14.9
Highest value for any acute Trust	37.1	62.2	66.0
Lowest value for any acute Trust	0	0	0

Table 26: Number of cases (rate) of CDI per 100,000 bed days

Data source: https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data (Table 8b is used)

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

- The number of Trust-apportioned *C. difficile* apparently increased dramatically in 2015/2016 compared with previous years. We felt that this was most likely to have represented an under-ascertainment in previous years, although it was difficult to gauge the extent of this over a genuine increase in numbers;
- In August 2015 HDFT changed its stool sampling policy to lower the threshold of "looseness" for sending stool samples for *C. difficile* investigation;
- In August 2015 the laboratory changed its testing policy to test all stools that were submitted as "loose" (i.e. including Bristol Stool Types 5 and 6) rather than only testing stools that were liquid on receipt;
- Following these changes the number of stool samples received and tested for *C. difficile* increased by 32.6% and 59.4% respectively compared with the corresponding months in 2014/2015;
- There was no suggestion or evidence of a community-wide outbreak of CDI and minimal evidence of in-hospital transmission.

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

- Reviewing the prescribing of antimicrobials, particularly of the "4 C" antibiotics, namely the cephalosporins, clindamycin, the quinolones and co-amoxiclav. Overall, the use of antimicrobials at HDFT is below the regional and national average. In September 2016, we introduced an alternative antimicrobial prescribing strategy with the specific aim of reducing the consumption of co-amoxiclav within the acute Trust;
- Holding an antimicrobial awareness day in November 2016, with 75 members of staff signing up as an antibiotic stewardship guardian, a substantial increase from the previous year. Publication of national data in early 2017 strongly point to a reduction in the use of certain antibiotics, particularly the quinolones, as being the most effective driver in the reduction of *C. difficile* infection (CDI) nationally over the last ten years. Unfortunately with frequent interruptions to the national supply chain of piperacillin/ tazobactam (*Tazocin*) and aztreonam in early 2017 we may have to re-introduce the cephalosporins and quinolones for treatment of some infections;
- Reviewing our cleaning and decontamination strategy as the evidence for the role of the environment in the transmission of healthcare associated infection (HCAI) including CDI is now overwhelming. We have:
    - Reappraised the role of the ward hygienists and clarified what they do;
    - Reviewed our provision of hydrogen peroxide vapour (HPV) and decided to renew our aging Bioquell HPV machines with two new ones from Hygiene Solutions who also agreed to give us a year's free loan of an ultraviolet C (UVC) machine;
    - Delivered an enhanced cleaning programme to Trinity ward and Lascelles, particularly concerning cleaning of commodes.
- Reviewing training to enable ward staff to attend. The Director of Infection Prevention and Control and infection control nurses met with ward managers to look at specific issues

pertaining to their ward area and team. Having been told that it was getting increasingly difficult to release staff for mandatory training or to attend link nurse meetings, we developed an in-house infection prevention “Masterclass” series aimed at senior nurses. This was run as a series of five whole day training days which covered a variety of infection prevention and control (IPC) related topics, including *C. difficile* and the role of the environment in the transmission of HCAI, including *C. difficile*. It was easier for nurses to be released for a whole day rather than for part of a shift, and gave us the opportunity to cover topics in more depth than we would otherwise have been able to do. The study days proved popular, and we received excellent feedback, and plan more for the coming year;

- Developing a simplified loose stool decision tool and clarified when to send a stool sample after the administration of laxatives;
- Redesigning our patient hand hygiene posters;
- Reintroducing a staff IPC newsletter with the aim of increasing staff engagement with infection prevention and control.

In 2016/2017, the number of Trust apportioned CDI cases has decreased; much of this decrease has been seen in the last six months of 2016/2017 when the percentage of Trust-apportioned cases fell from 77% in March - September 2016, to 41% in October 2016 - March 2017. There were three cases in quarter four (January to March 2017), compared with 14 in the corresponding quarter of 2016. As we put in a variety of measures it is as yet unclear whether this represents a lasting decrease, nor which of the interventions outlined above have had the greatest effect. The testing strategy introduced in 2015 did not change.

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 1,000 bed days. 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 of reported incidents that resulted in severe harm or death. A low score is good.
- The rate of reported incidents per 1,000 bed days that resulted in severe harm or death. A low score is good.

HDFT’s latest published scores are below.

	Oct 15 - Mar 16			Apr 16 - Sep 16		
	Rate of incidents reported (per 1,000 bed days)	Incidents that resulted in severe harm or death		Rate of incidents reported (per 1,000 bed days)	Incidents that resulted in severe harm or death	
		Number	Rate (per 1,000 bed days)		Number	Rate (per 1,000 bed days)
HDFT value	39.86	3	0.058	43.85	7*	0.141
National position (all acute trusts)	38.58	2642	0.156	39.89	2516	0.149
Highest value for any acute Trust	75.91	94	0.973	71.81	98	0.595
Lowest value for any acute Trust	14.77	0	0.000	21.15	1	0.008

Table 27: Patient safety incidents reported to the NRLS

Data source: https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports

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

- The data relating to patient safety incidents is reported by front line staff;
- 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;
- *The Trust held data differs from that published by the NRLS. According to local data on Datix, during April – September 2016 we reported to NRLS five incidents resulting in severe harm (and no deaths), which gave rise to a rate (per 1,000 bed days) of 0.101. Two cases were downgraded from severe following investigation to moderate harm but were not resubmitted to the NRLS which accounts for the additional two cases in the HDFT value for incidents that resulted in severe harm or death in April - September 2016. Provisional data checks failed to pick up this anomaly prior to publication;
- Of the five severe harm incidents reported, all were robustly investigated in line with the Trust's policy and processes and actions to address the findings have been put in place.

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

- Continuing to promote patient safety as a key objective across the organisation and implementing a number of mechanisms to ensure compliance with, and delivery of national frameworks;
- Ensuring there is a continued 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;
- Identifying a quality improvement priority for the forthcoming year to focus on the learning from incidents and complaints.

3. REVIEW OF OTHER QUALITY PERFORMANCE

This section provides an overview of the quality of care offered by HDFT based on performance in 2016/17 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
- Patient experience
- Effective care

3.1 Patient Safety

3.1.1 Medicines Safety

Medicines play an integral role in the management of disease. They are pivotal to achieving good patient outcomes but there is room for improvement in the way patients take their medicines. 30-50% of patients do not take their medicines as intended by the prescriber. 30% of patients state they do not receive appropriate information about their medicines. 8-10% of hospital admissions are associated with a medicine related event. The NHS wastes £300-£400 million per annum on unused medicines, 50% of which is deemed avoidable, and around 200,000 medicines incidents are reported to the NHS England Patient Safety Division through the NRLS. The greater the number of medicines a patient takes the greater their risk of suffering an adverse event. 98% of patients admitted to hospital take one or more medicines, with 95% taking four or more.

Consequently HDFT has been working over the last few years to use medicines more safely and effectively, especially as we administer over two million medicines doses per annum and dispense around 150,000 medicine packs (items) per year.

What were we aiming to achieve?

Our aim regarding medicines safety in 2016/17 was to consolidate improvements made in 2015/16 and seek to further improve patient safety by reducing errors in prescribing, dispensing and administration of medicines and also to improve the information given to patients about their medicines. Specifically we intended to:

- Extend the functionality of the electronic Prescribing and Medicines Administration (ePMA) system into ED and to commence the planning to implement in Outpatients, and the prescribing of complex infusions;
- Embed into practice the ePMA dashboard to target interventions to patients on high risk medicines;
- Continue the focus on safe, prescribing, dispensing and administration of medicines to include:
    - A reduction in the number of incorrectly prescribed medicines;
    - A reduction in the number of medicines not prescribed that should be;
    - A reduction in the number of medicines not administered as intended by the prescriber;
    - A reduction in the number of medicines not administered at the time intended by the prescriber;
    - A reduction in the number of dispensing errors leaving the Pharmacy department;
    - An increase in the number of patients receiving relevant information about their medicines.

What have we done?

We have embarked on a wide ranging programme to use medicines safely and effectively by:

- Developing and agreeing a Board approved Hospital Pharmacy Transformation plan;
- Consolidating the Royal Pharmaceutical Society Medicines Optimisation Principles into clinical practice;
- Completing the roll out of the ePMA system further across the organisation;
- Embedding dashboards using ePMA to target patients on high risk medicines (warfarin, insulin, antimicrobials);
- Establishing a range of metrics to measure safe use of medicines;
- Consolidating our medicines reconciliation processes and rates. Medicines reconciliation is the process of obtaining an up to date and accurate medication list that has been compared to the most recently available information and has documented any discrepancies, changes deletions and additions;
- Continuing to adapt and deliver medicines management training for nursing staff;
- Continuing to review, report and learn from incidents relating to medicines use;
- Proactively seeking to inform patients about their medicines.

Whilst this is not an exhaustive list of the programme it does summarise some of the fundamental elements. The metrics agreed included:

- The number of incident reports classified as prescribing, dispensing or administration errors with a defined denominator to allow comparison;
- Missed doses of medicines;
- Medicines reconciliation rates;
- National inpatient survey data;
- Training compliance rates.

The targets are to continue to demonstrate improvement against baseline regarding the number of errors and missed doses, and to increase the information given to patients. Regarding dispensing errors, regional and national benchmarking data identify HDFT as already achieving low numbers of errors per items dispensed, and therefore maintaining the current low level of errors continues to be the target for this metric.

What are the results?

We have made significant progress over the year with our medicines safety programme.

1. Board approved Hospital Pharmacy Transformation Plan

In line with NHS England and NHS Improvement requirements, the HDFT Board of Directors agreed and approved the HDFT Hospital Pharmacy Transformation Plan (HPTP) which was submitted to NHS Improvement in February 2017. The key elements of the plan are focused around:

- Increasing the number of pharmacist prescribers;
- Improving medicines stock holding, e-trading and supply chain opportunities;
- Further roll out of e-prescribing (complex infusions and outpatients);
- Building on the already high performing front line core clinical service provision (for pharmacists and non-pharmacist staff) supporting medicines optimisation for our patients;
- Continuing and further developing collaboration of key pharmacy infrastructure services in order to maximise productivity and efficiency.

The overall programme of work is summarised below:

Figure 10: Hospital Pharmacy Transformation Board work programme

<u>Roll out of ePMA</u>

The roll out of ePMA to all wards has now been completed. We saw the final roll out to ED in May 2016. We are one of only a handful of trusts in the UK to have full ePMA use in all clinical areas.

Planning for the complex infusions module has commenced. This software update has been in development and has only recently been implemented at Guys and St Thomas's NHS Foundation Trust as the early adopter. This will now be a key focus for HDFT in 2017. Planning for outpatient prescribing will follow in 2018/19.

ePMA has made a significant improvement in the safe use of medicines across the Trust.

2. <u>Safer prescribing for inpatients</u>

We have analysed the impact of ePMA on safe prescribing since implementation in 2011/12. The data below demonstrates the progress that has been made in this regard. There has been a substantial year on year reduction in prescribing errors from 2011/12 to 2014/15 with a slight rise in 2015/16 accounted for by an increase in insulin prescribing errors. We have seen a reduction on the 2015/16 position during 2016/17.

Year	Number of adjusted prescribing errors per 100,000 prescribed doses reported via Datix
2011/12 (Pre ePMA)	3.43
2012/13	3.25
2013/14	3.19
2014/15	2.12
2015/16	3.34
2016/17	3.12

Table 28: Number of adjusted prescribing errors per 100,000 prescribed doses

In addition we have seen a positive move in the levels of harm associated with prescribing errors with a significant increase in the proportion of no or low harm errors and a reduction in the moderate harm errors. We had no severe harm errors in 2016/17.

Year	Levels of harm (%)		
	No / low harm	Moderate harm	Severe harm
2012/13	87%	13%	0%
2013/14	89%	11%	0%
2014/15	85%	15%	0%
2015/16	88%	11%	1%
2016/17	93%	7%	0%

Table 29: Levels of harm associated with prescribing errors

3. Safer administration of medicines

We have analysed the impact of ePMA on the safe administration of medicines since implementation in 2011/12. The data below demonstrates the progress that has been made.

Year	Number of adjusted administration errors per 100,000 administered doses reported via Datix
2011/12 (Pre ePMA)	8.34
2012/13	3.44
2013/14	3.56
2014/15	5.34
2015/16	6.24
2016/17	3.80

Table 30: Number of adjusted administration errors per 100,000 administered doses

We have seen a substantial reduction in the number of medicines administration errors since the introduction of ePMA. Of note is the slight increase in 2014/15 and 2015/16 (although this was still less than the pre ePMA baseline). We refreshed our training for nurses and focused on increased support. In 2016/17 we have seen a significant reduction in administration errors to the lowest level since 2013/14 and this remains a 50% reduction compared with the pre ePMA position in 2011/12.

In addition we have seen a positive move in the levels of harm associated with administration errors with a significant increase in the proportion of no or low harm errors and a reduction in the moderate harm errors. We had no severe harm errors in 2016/17.

Year	Levels of harm (%)		
	No / low harm	Moderate harm	Severe harm
2012/13	85%	15%	0%
2013/14	91%	7%	2%
2014/15	88%	8%	4%
2015/16	88%	11%	1%
2016/17	94%	6%	0%

Table 31: Levels of harm associated with administration of medicine errors

4. Reducing missed doses and improving the timeliness of medicines administration

Over the last five years we have seen a steady reduction in the percentage of medicine administrations delayed to patients, meaning more patients are getting their medicines in a timely manner. We have also seen a very substantial reduction in the percentage of missed doses, with 2016/17 delivering the lowest percentage of missed doses since the implementation of ePMA.

Year	% Delayed doses	% Missed doses
2012/13	2.6	2.99
2013/14	2.9	3.17
2014/15	2.6	2.13
2015/16	2.0	0.96
2016/17	2.0	0.83

Table 32:Medicines administration – delayed and missed doses

5. Reduction in “potential” prescribing errors through pharmacist activity and implementation of ePMA

Potential prescribing errors are “those errors that are near misses that did not result in a wrong dose/medicine etc. given to a patient”. These errors are identified by a ward clinical pharmacist before any level of harm is caused. We undertake an annual intervention audit to demonstrate the activity that pharmacists undertake.

At HDFT our pharmacists perform over 20,000 interventions per annum ensuring the safe prescribing and administration of medicines. Since the introduction of ePMA we have also seen a reduction in the number of potential major and life threatening interventions made by pharmacists.

Year	Total no. of pharmacist interventions	Total no. of potential harm interventions	Total no. of unclassified interventions	Total no of actual harm interventions	Levels of potential harm			
					Minor	Moderate	Major	Severe or life threatening
2011 - 2012	254	206	30	14	127	0	68	11
2015 - 2016	250	250	0	0	133	84	31	2
2016 - 2017	190	190	0	0	81	100	17	0

Table 33: Pharmacist intervention audit results

6. Development of an ePMA dashboard to target patients on high risk medicines

The ePMA system captures all medicines prescribed and administered to our patients. Interrogation of the system has facilitated the development of a live dashboard that identifies patients on high risk medicines in order to allow early intervention and help to avoid errors and harm arising from the use of these medicines.

It is well documented nationally through the NRLS that a small number of medicines are more likely to cause harm to patients. Using this data we have developed a live dashboard for a number of patient groups:

- Patients prescribed insulin;
- Patients prescribed warfarin;
- Patients prescribed antibiotics;
- Patients with an unknown allergy status.

We also are able to identify any patient awaiting medicine reconciliation or level two clinical review. The consequence of these reports means we are now able to identify and prioritise clinical intervention to ensure optimal prescribing and avoidance of harm. There are several case examples of this.

7. Maintaining low numbers of dispensing errors

Our dispensing errors (14/100,000) continue to be well below the regional average (18/100,000) and some of the lowest across the Yorkshire and Humber region. HDFT data for 2016/17 has fallen compared to previous years from a rate of 16/100,000 dispensed items to 14/100,000 dispensed items. Only three trusts (range 9-11/100,000 dispensed items) demonstrate a lower rate.

Our error rates in aseptic services (preparation of intravenous medicines including chemotherapy) are also extremely low and one of the two lowest trusts in the region. This has also further reduced from 5/100,000 dispensed items in 2014/15 to 3.85/100,000 dispensed items in 2016/17.

Trust	Inpatient dispensing error rate / 100,000 dispensed items	Aseptic dispensing error rate / 100,000 dispensed items
HDFT	14	3.85
Yorkshire and Humber average	18	10
Yorkshire and Humber range	9-30	3-30
National average	20	Unknown

Table 34: Dispensing errors compared to local and national averages

8. Learning from medicines errors

In 2014/15 we built a database of all medicines errors reported on Datix, our incident reporting system. This now covers six years from 2011/12. This allows us to identify common themes and errors, map trends and analyse progress. All reported errors are investigated and actions put into practice to learn from such events. All errors are discussed at the monthly Medication Safety Review Group. We have focused on three areas so far. These include:

a. Progress on the management of missed doses

The graph below demonstrates the progress being made with reducing missed doses. We have seen a consistent year on year reduction in the percentage of missed doses and the proportion of delayed doses, meaning patients are receiving medicines in a more timely manner.

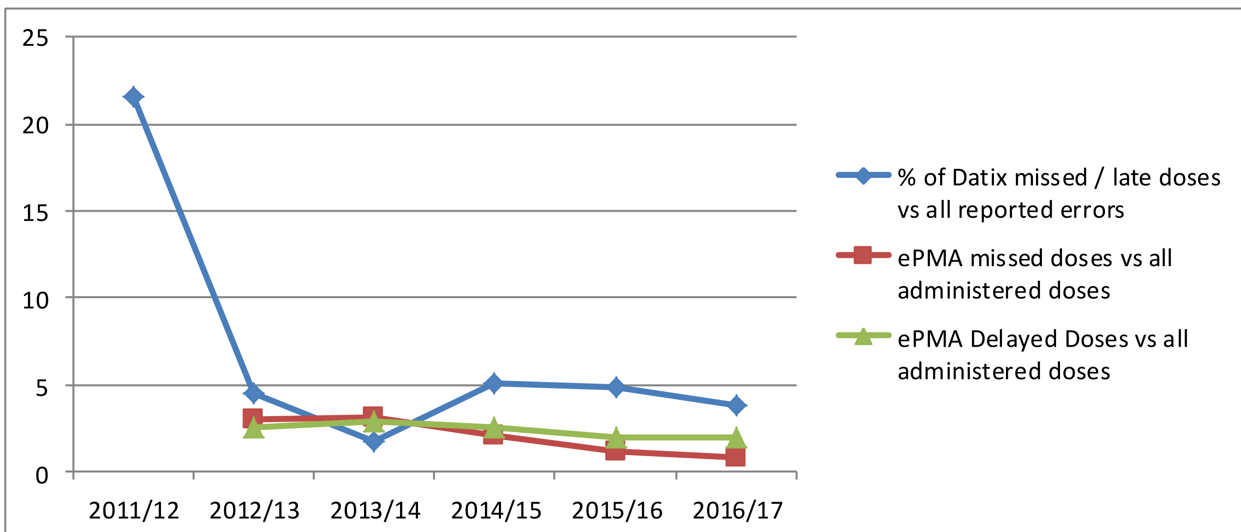


Figure 11: % missed and late doses from Datix reports and ePMA (2011/12 – 2016/17)

b. Patient identity errors

Patient identify errors are defined as “patient A is mistakenly given patient B’s medicines”. An analysis of the database has highlighted a reduction post ePMA, though there was a small rise in 2014/15. Further work has reduced this level again in 2016/17. The level remains significantly below the pre ePMA level.

Year	Number (and % of all medicine errors) of patient identity errors reported via Datix
2011/12 (Pre ePMA)	15 (6.1%)
2012/13	4 (1.12%)
2013/14	4 (1%)
2014/15	8 (1.95%)
2015/16	8 (1.78%)
2016/17	5 (1.45%)

Table 35: Patient identity errors

c. Safe use of insulin

Analysis of the error database during 2015/16 highlighted an increase in the number and type of insulin related errors (see figure 12). This prompted a specific task and finish group to be convened and a quality improvement programme to be initiated. This group implemented a whole range of actions including the development of an insulin safety dashboard and the addition of safe use of insulin competency to the essential skills training programme.

A detailed analysis of this quality improvement programme is provided in section 2.1.2. However we have seen significant improvement in the safe use of insulin at HDFT. The total number of incidents or errors has fallen slightly. The % of insulin reported errors has slightly increased, demonstrating good reporting culture and there has been a significant reduction in the number of community incidents (from 13 to five). Whilst we continue to see a rise in the number of hospital reported errors, this relates to the proactive use of the insulin dashboard. Using this tool, the diabetes team and pharmacists are able to intervene early.

The rise in the number of hospital reported errors, has also seen a corresponding and significant increase in the proportion of no or low harm errors (83% in 2015/16 to 92% in 2016/17), a fall in the number of moderate harm errors (12% in 2015/16 to 8% in 2016/17), and a fall in severe harm errors (2% in 2015/16 to zero in 2016/17). These are substantial improvements on previous years.

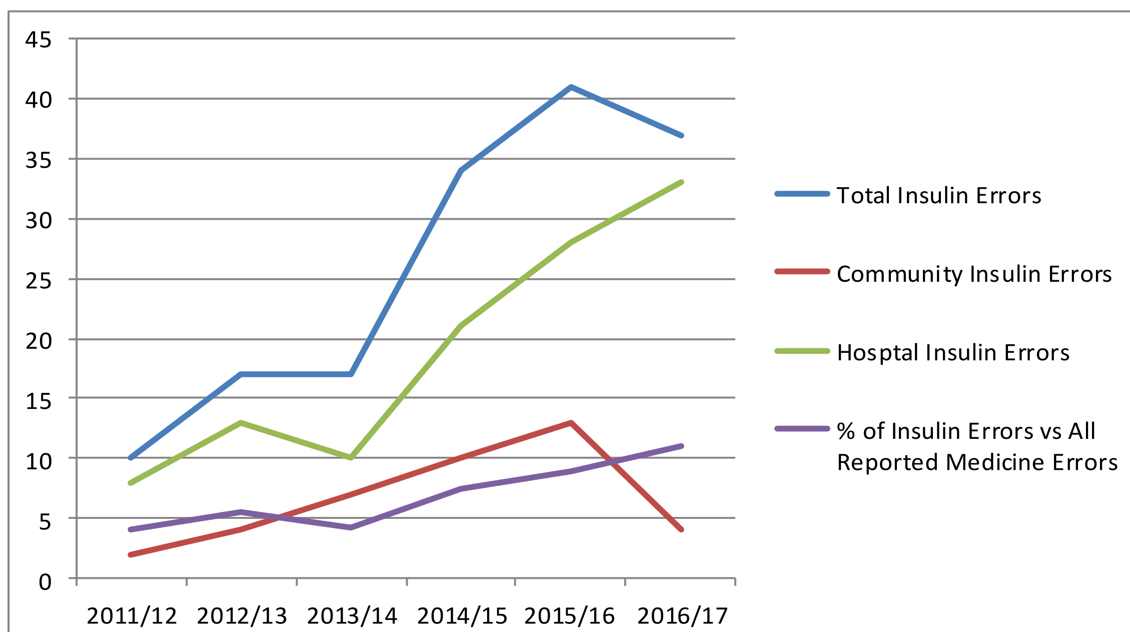


Figure 12: Insulin errors 2011/12 - 2016/17

9. Medicines reconciliation

Medicines reconciliation is the process by which the accuracy and completeness of a patients medicines history is checked and verified when a patient is admitted to hospital. NICE guidance recommends all patients have a medicines reconciliation undertaken within 24 hours of admission by a competent practitioner. Evidence demonstrates an improvement in morbidity and mortality when this occurs. Audit data below demonstrates our improvement over the last four years. The national benchmark is around 70%.

	2013/14	2014/15	2015/16	2016/17
% of patients receiving a medicines reconciliation within 24 hours of admission	75%	80%	90%	90%

Table 36: Patients receiving medicines reconciliation within 24 hours of admission

10. Medicines management training for doctors, nurses and pharmacists

Medicines management training for clinical staff has been in place for four years and continues to be updated to reflect changes to the management of medicines in the Trust, receiving positive feedback from staff on improving their understanding of medicines use.

Compliance rates with training have improved or remained stable year on year. We have seen a fall in compliance with community nursing medicines management training during 2016/17 and this will be addressed in 2017/18.

Training competency	Renewal	Percentage compliance 1.3.2016	Percentage compliance 1.3.2017
ePMA	Once only	94%	96%
Antibiotic stewardship	2 yearly	87%	88%
Medicines management for community nursing	3 yearly	70%	60%
Medicines management for hospital based nurses	3 yearly	73%	78%
Safe prescribing toolkit	Once only	85%	85%
Safe fluid prescribing toolkit (introduced December 2015)	Once only	N/a	85%

Table 37: Medicines management training compliance

11. Patient engagement and providing information to patients

National Inpatient Survey	% of patients						Better than national / Picker average
	2012	2013	2014	2015	2016	National / Picker average	
Question 1: Not fully told purpose of medicines	22	17	18	22	20	25	**Yes**
Question 2: Not fully told side effects of medicines	58	57	59	57	55	61	**Yes**
Question 3: Not told how to take medication clearly	21	19	19	25	20	24	**Yes**
Question 4: Not given completely clear written/printed information about medicines	22	23	22	26	21	28	**Yes**

Table 38: Medicines information provision - national inpatient survey results

Information provision to patients and the perception of patients receiving relevant information about their medicines has improved (see the results of three out of the four national inpatient survey questions) over the last four years and we are consistently above the national average.

Summary

The medicines safety programme has made a substantial step forward in terms of safety improvements in 2016/17 and continues to build on previous quality improvements relating to medicines optimisation and safety. During 2016/17 we have seen reductions in:

- Prescribing errors;
- Administration errors;
- Dispensing errors (inpatient and aseptic services);
- Missed doses;
- Patient identity errors;
- Insulin errors.

We have seen improvements in the ratio of no and low harm prescribing and administration errors, and a reduction in moderate harm incidents. We have had no serious harm incidents relating to the use of medicines during 2016/17.

We have maintained good levels of training compliance though the year and have seen improvements in the provision of information to patients.

This has been facilitated through the roll out of ePMA, development of live medicines dashboards, improved medicines reconciliation rates, pharmacy activity at ward level, reviewing and acting on trends in medicines administration, dispensing and prescribing errors and medicines management teaching and training.

Whilst significant improvements are being demonstrated, we will continue to work to optimise the use of medicines at HDFT.

3.1.2 Falls

Falls and fall-related injuries are a common and serious problem for older people, particularly those who have underlying pathologies or conditions. Falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged 75 and older in the UK.

People aged 65 and older have the highest risk of falling. Around 30 to 35 per cent of adults who are over 65 and living at home will experience at least one fall a year (approximately 37,000 to 40,000 people in North Yorkshire). This rises to 50% of adults over 80 who are either at home or in residential care.

Most falls do not result in serious injury, but annually approximately 5% of older people living in the community who fall experience a fracture or need hospitalisation. The Royal College of Physicians

> "The last figures available from PHE (*Public Health England*) show that across North Yorkshire the number of people aged 65 and over who were injured due to falls (hospital admissions) are lower than both the England and regional average and it is similar picture for fractured hips (95% of which are the result of a fall). However we need to do more to reduce the number of falls and fractures in our older population which leads to pain and distress as well as increasing costs to health and social care."

Figure 13: Extract from North Yorkshire County Council letter dated 03/03/17

(2011) report “Falling standards, broken promises” highlights that falls and fractures in people aged 65 and over account for over four million hospital bed days each year in England alone.

Falls in hospitals are the most common patient safety incidents reported in hospital trusts in England. The National Patient Safety Agency (2011) report “Essential care after an inpatient fall” states that each year around 282,000 patient falls are reported to the NHS England's Patient Safety division from hospitals and mental health units. A significant minority of these falls result in death or in severe or moderate injury.

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year. Therefore falling has an impact on quality of life, health and healthcare costs (NICE Quality Standard 86).

What were we aiming to achieve?

The Falls Prevention Co-ordinator and Falls Strategy Steering Group have three main objectives in relation to preventing falls among inpatients and supporting older people in the community:

- Reduce the rate of harmful falls occurring in hospital;
- Improve compliance with falls prevention intervention;
- Increase the number of staff completing falls prevention training.

Harrogate has a multi-agency Falls Strategy Group which is led by the HDFT Falls Prevention Co-ordinator and has representatives from the Trust (acute and community), YAS, the voluntary sector, Patient Voice, HaRD CCG and the Healthy Ageing Co-ordinator for North Yorkshire. The group looks at both community and acute hospital aspects of falls prevention and management.

At Harrogate District Hospital there is a weekly Falls Clinic which provides assessment by a multi-disciplinary team comprising an elderly care consultant, occupational therapist, physiotherapist and podiatrist, for complex patients referred by GPs, ED or the Community Care Teams (CCTs).

In the Harrogate area multi-factorial falls assessments are carried out by four area CCTs. The teams carry out appropriate interventions and/or signpost or refer patients to other interventions via a team hub called the “single point of access.”

Unfortunately there is a lack of appropriate exercise groups in the area for people who are at risk of falls, and a lack of capacity within the CCTs which can result in long delays in the assessment of people at risk of falls. In addition there is no commissioned service to identify and provide interventions for people who may have osteoporosis and are at risk of fragility fractures.

What have we done?

- The part time role of Falls Prevention Co-ordinator was made into permanent post in January 2016. The role is largely educational in falls prevention, assessment and risk factor reduction and includes chairing the Falls Strategy Group;
- Working with the Yorkshire and Humber Academic Health Science Network (AHSN) Improvement Academy, Harrogate District Hospital has introduced fall safety huddles and fall sensors on wards where there are relatively high numbers of falls. This is reducing the number of inpatient falls;
- Continued support has been provided to develop and increase the capacity of the community MDT Falls Prevention Clinic in 2017/18 with a newly qualified advanced practitioner specialising in care of the elderly working alongside the Consultant for Elderly Care;

- Funding has been confirmed to provide specialised training to two physiotherapists who will be able to develop a “train the trainer” programme across the Trust including the community. This will enable the Trust to provide strength and stability exercise programmes for older people in rehabilitation;
- An Internal Audit was undertaken for falls prevention in October 2016. Several areas of good practice were highlighted and a range of recommendations were also made. These included the ongoing review and updating of policies, training materials, risk assessment and documentation, and post fall management. A plan to address the majority of these recommendations was already in place and was scheduled to be completed in April 2017. Several of the recommendations will also be incorporated into the Falls Strategy action plan for 2017/18;
- A new e-learning package called “Care Fall” has been introduced and is aimed at doctors and medical staff and concentrates on post fall management of patients;
- Following learning opportunities relating to findings from root cause analyses, new documentation has been developed to enhance the recording of information relating to inpatient falls;
- A training package: ‘Taking and recording lying and standing blood pressure’ has been updated with the Clinical Educator in line with NICE guidance;
- A proposal was presented to the innovation team in January 2017 to consider a new model of integrated training that could improve access and quality to a range of training for clinical and medical staff.

What are the results?

Reduction in harmful falls

There has been a 32% reduction in the total number of inpatient number of falls over the last four years and the rate of inpatient falls per 1000 bed days. There has also been a significant decrease in moderate or severe harm or death per 1000 bed days.

	2013/14	2014/15	2015/16	2016/17
Inpatient falls - all	1024	859	809	697
Inpatient falls - all - per 1,000 bed days	8.95	7.49	7.04	6.10
Inpatient falls - moderate harm, severe harm or death	25	36	20	15
Inpatient falls - moderate/severe/death - per 1,000 bed days	0.22	0.31	0.17	0.13
Inpatient falls - resulting in fracture	16	17	16*	14

Table 39: Number of patient falls over the past 4 years

**Please note: The number of inpatient falls resulting in fracture in 2015/16 has previously been reported as 13. An additional three fractures were originally reported as harmful falls (no fracture) and the data source was not updated until a fracture was confirmed at a later reporting date.*

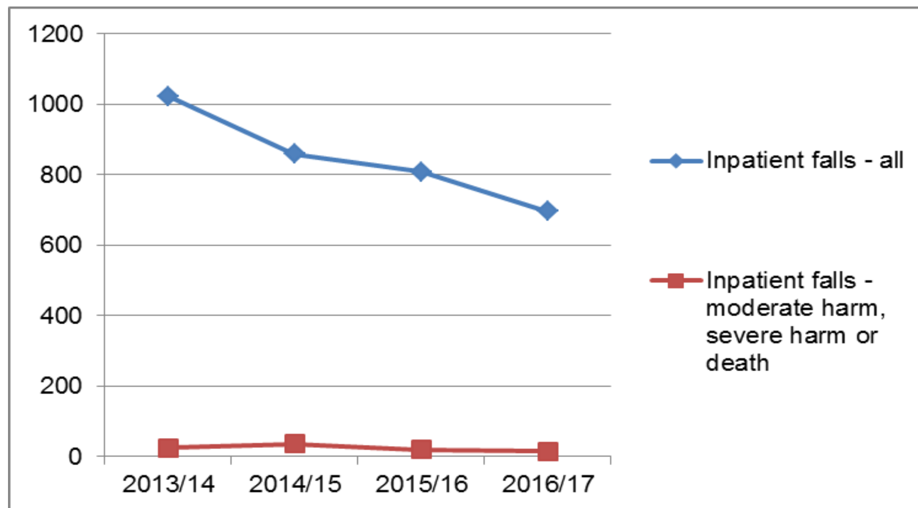


Figure 14: Number of inpatient falls and harm 2013/14 – 2016/17

<u>Introduction of falls safety huddles to reduce inpatient falls</u>

Four wards are involved in the falls safety huddle and each team are consistently increasing the number of days between inpatient falls. This is confirmed by each ward being able to report a statistical reduction in the number of falls they have had during 2016/17. The best results of consecutive fall free days include: Trinity - 70 days; Jervaulx - 62 days; Farndale - 41 days; Byland - 30 days. The chart below illustrates the significant reduction in falls from baseline following introduction of the falls safety huddle on Farndale ward.

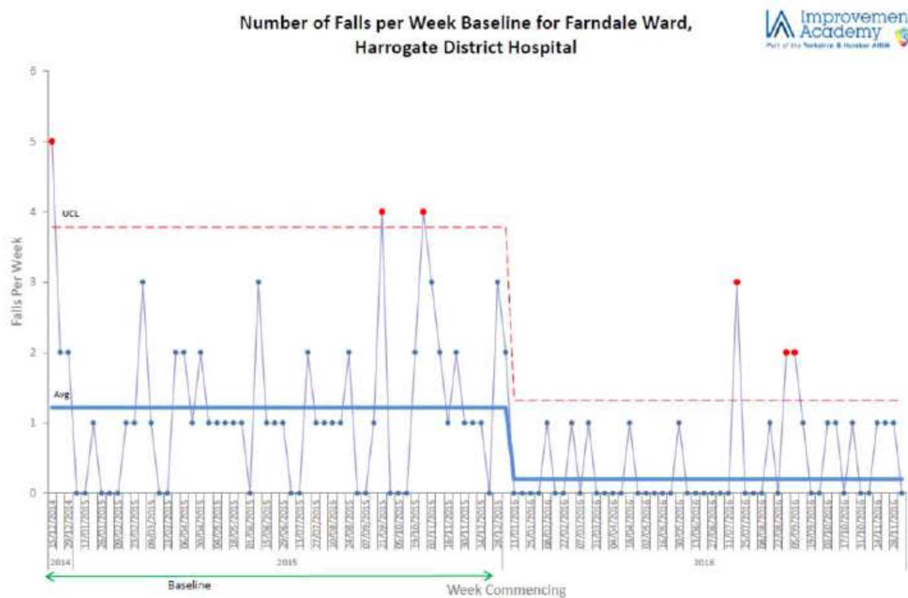


Figure 15: Number of falls per week on Farndale ward

<u>Staff falls prevention training</u>

Falls prevention training is an essential training requirement for various groups of clinical staff. A recent push on training has ensured that 92% of community staff is now trained. Staff training levels remains fairly constant with 80-85 % of staff being up to date with their falls prevention training every month in 2016/17. All existing training packages are being updated to reflect new data, recent policies changes, NICE clinical guidelines and quality standards.

Directorate		February 2017	March 2017
Children's and County Wide Community Care	% compliant	**92%**	**88%**
	Total staff	119	120
Corporate Services	% compliant	**63%**	**100%**
	Total staff	8	2
Long Term & Unscheduled Care	% compliant	**77%**	**79%**
	Total staff	595	596
Planned & Surgical Care	% compliant	**81%**	**81%**
	Total staff	266	270

Table 40: Staff falls prevention training compliance

As a result of some of this work staff have received various awards:

- Byland ward was highly commended for the Chairman and Chief Executive's Team of the Month Award in January 2017.
- Trinity ward was the Team of the Month Award winners for December 2016.
- Jervaulx ward were the winners of the Governors' Award for Outstanding Contribution from a Team - "Working together, making a difference"
- Winner of the Richard Ord Award for outstanding contribution from an individual - Sheena Murthick, Ward manager Byland ward.

Photo 2: Team of the Month Award to Trinity ward December 2016

Summary

Overall the total number falls and harmful falls has reduced over the last two years. Staff training percentages have also remained consistent. The development of an integrated training model could drive up the quality and percentage of staff trained.

An internal audit highlighted that there is a constant need to update policies, documentation and training materials to ensure that they are in line with national guidelines and quality standards. The Trust will participate in the next National Audit of Inpatient Falls in May 2017 and Trinity ward at Ripon Hospital will be included for first time as the audit intends to collect data from rehabilitation and community settings. The current shift towards healthy aging strategies being delivered in community is starting to impact on the remit of the falls prevention strategy objectives and this may need to be reflected in future priorities.

3.1.3 Pressure ulcers

Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair the blood supply. They cause pain and distress, can mean longer stays in hospital and cost the NHS a significant amount of money. They are graded by severity according to a classification by the European Pressure Ulcer Advisory Panel (EPUAP) from category one (least severe) to category four (most severe). They are more likely to occur in people who are ill, have a neurological condition, poor mobility, impaired nutrition and poor posture.

Pressure ulcers are usually preventable with good assessment of individual risk and effective application of preventative measures such as use of effective equipment to reduce pressure, regular position change, good nutrition and hydration and good skin care.

The prevention of avoidable pressure ulcers has been a specific part of our quality improvement work at HDFT since 2012/13 and there has been a significant amount of work undertaken at the Trust with the aim of reducing avoidable HDFT acquired pressure ulcers. For the year 2015/16 we reported a reduction in hospital acquired pressure ulcers.

What were we aiming to achieve?

The Trust has a Pressure Ulcer Group that meets on monthly basis. The objectives of this group are to drive continual improvement of pressure ulcer prevention with the overall aim of no avoidable pressure ulcers acquired by patients receiving either HDFT hospital or community district nursing care. Pressure ulcers are defined as unavoidable if all reasonable care and treatment has been provided to prevent or minimise damage to skin through pressure.

Our aims have been to:

- Reduce the incidence of category two, three and four pressure ulcers acquired by people whilst in HDFT care;
- Promote best practice in prevention and management of pressure ulcers;
- Understand if a pressure ulcer was avoidable or unavoidable and to learn from investigations into the root cause of pressure ulcers. All category three and four pressure ulcers are reported as SIRIs;
- Continue with our programme of pressure ulcer management, training and education for staff;
- Continue to support a “zero tolerance” approach to avoidable pressure ulcer development in people who are receiving nursing care, which will be supported by our pressure ulcer prevention strategies including training and investigation processes.

What have we done?

Key successes to date have surrounded three broad areas, these being;

1. Education and training

Training for staff has been a priority and since January 2015 an e-learning package for pressure ulcers has become essential annual training for all general and paediatric registered nurses, and three yearly training for midwives. Training on skin care and pressure ulcer prevention, recognition and management is also delivered by the Tissue Viability Nurses during the essential two day ‘fundamentals of care’ training course attended by our unregistered nursing staff.

Training has also been delivered to senior ward and community registered nurses to enable them to effectively investigate pressure ulcer incidents, undertake root cause analysis and generate an action plan with recommendations.

The Trust has actively participated in the national 'STOP - Pressure Ulcer Days' with mobile educational events and equipment demonstrations. In addition the NHS England 'React to Red' training package is in the process of being rolled out across residential homes through support of a Clinical Educator for nursing homes.

A new information leaflet has been produced for patients, carers, families, residential and home care services, explaining shared care in relation to pressure ulcer prevention and management.

2. Documentation and risk assessment

In 2014 we introduced SSKIN (skin, surface, keep moving, incontinence, and nutrition) bundles across all adult inpatient wards, for patients assessed as being at risk of pressure ulcer development. This was supported with a SSKIN bundle educational package and educational posters for clinical staff to aid the identification and categorisation of pressure ulcers. Changes were made to the nursing documentation to emphasise the need to repeat pressure ulcer risk assessment on transfer between wards. In response to themes from our root cause analyses regarding documentation the SSKIN bundle chart has now been replaced by a new skin inspection and repositioning record in December 2016.

We have implemented a new pressure ulcer risk assessment tool and associated documentation for use in our community areas, with plans to extend this to our adult inpatient areas in 2017/18. Work to develop a full pressure ulcer risk assessment tool for use in paediatrics is progressing.

3. Equipment

Following an audit of inpatient bedside chairs we have established a rolling programme for the purchase of chairs that have inbuilt pressure relieving cushions. The hospital has an equipment library which houses specialised pressure relieving mattresses and other pressure relieving equipment and this can be accessed 24 hours a day.

Work has also focused on patients being cared for in the community, with new pressure relieving equipment being available from the community equipment stores, and the implementation of a more efficient electronic equipment tracking system from July 2014. Equipment "drop-in" training days were commenced in 2016 for community nursing staff.

All categories of pressure ulcer are reported via the incident reporting system and through the NHS Safety Thermometer point prevalence data which is collected on all wards and by all community teams on one day each month.

What are the results?

The reduction in hospital acquired pressure ulcers achieved in 2015/16 has not continued in 2016/17 and the number of reported pressure ulcers has plateaued. Community acquired pressure ulcers (community being those patients in receipt of HDFT community nursing care) also remain a challenge.

The data is displayed on the Trust's dashboards shared through reports to our senior management teams. Our inpatient wards display data on their quality and safety boards.

All pressure ulcer data reported through the HDFT incident reporting system

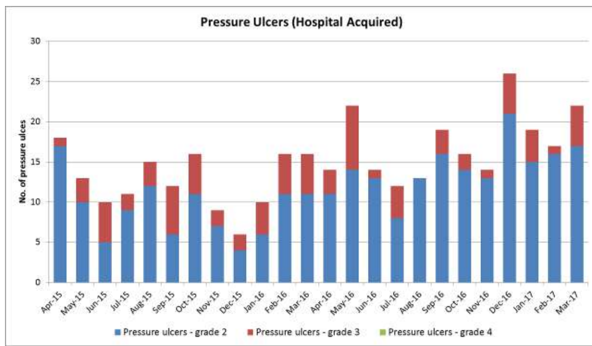


Figure 16: Hospital acquired April 2015 to March 2017

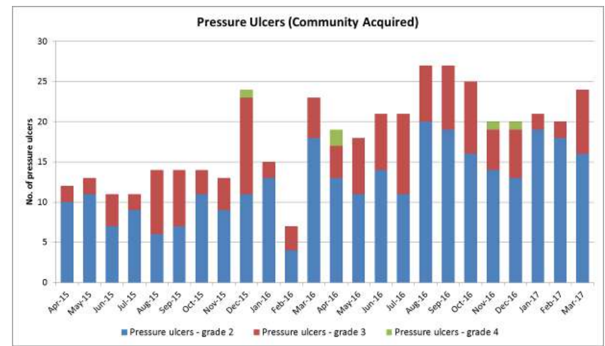


Figure17: Community acquired April 2015 to March 2017

Figure 16 and 17 demonstrate the plateau in the reduction of hospital acquired pressure ulcers and the challenges with regards to community acquired pressure ulcers. In part we believe this plateau for the hospital acquired pressure ulcers and the increase in community acquired pressure ulcers is due to better and earlier identification and reporting and continued education around the recognition and categorisation of pressure ulcers. We have also have observed a 5% activity increase in non-elective admissions during 2016/17.

NHS Safety Thermometer data for HDFT

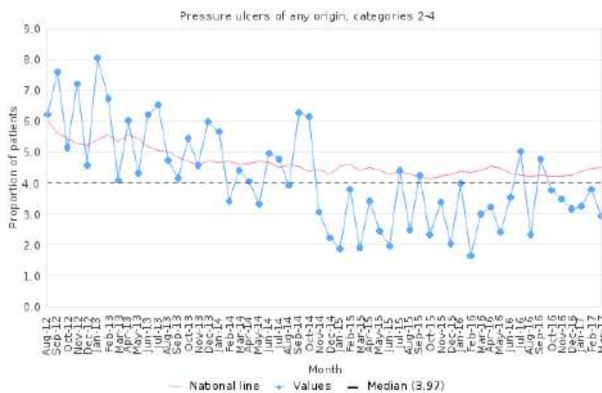


Figure 18: All pressure ulcers

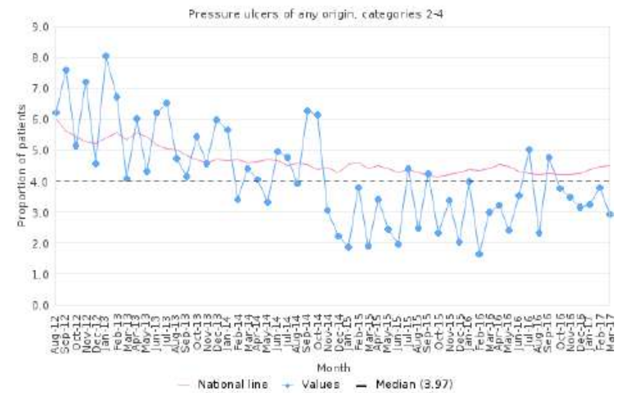


Figure 19: New pressure ulcers

The two graphs above show the results of the NHS Safety Thermometer data from July 2012 to February 2017 for all pressure ulcers identified and for new pressure ulcers. There has been a steady reduction over this period, but the reduction since November 2014 appears to be particularly significant.

NHS Safety Thermometer funnel plots

The funnel plots compare the Trust's performance over a 12 month rolling period of harm caused by pressure ulcers per 1000 patients surveyed, against other integrated trusts, which are trusts that provide both acute and community services. Funnel plot charts get their name by the lines running across the chart creating a funnel. These are called 'upper' and 'lower control limits'. Each dot represents an organisation. Organisations inside the funnel lines are regarded as average or statistically indistinguishable. Organisations outside of these lines are called outliers, which can be either positive or negative. In this case lower is positive and therefore HDFT has low harm compared to other trusts providing acute and community services.

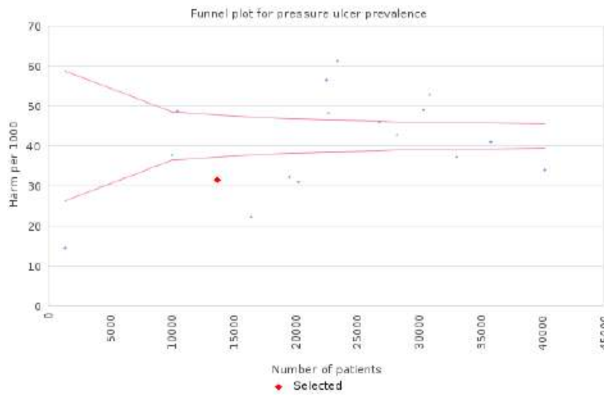


Figure 20: Prevalence or all pressure ulcers

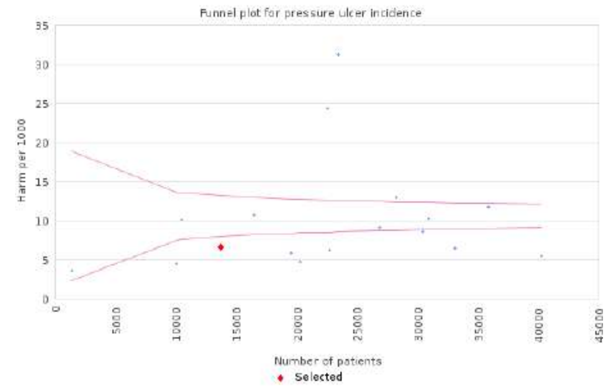


Figure 21: Incidence or new pressure ulcers

♦ represents HDFT
Data source: https://www.safetythermometer.nhs.uk/

Summary

There has continued to be a significant amount of work undertaken during 2016/17. Although the reduction in pressure ulcers has plateaued we have introduced some new initiatives such as the revised skin inspection and repositioning chart on our inpatient wards and the new community risk assessment document that we will further embed in 2017/18. Community acquired pressure ulcers remain a challenge and will continue to be an area of focus.

The Trust aims to eliminate avoidable pressure ulcer development in people who are receiving nursing care, and will continue to develop pressure ulcer prevention strategies including training and investigation processes. Some key things to be progressed in 2017/18 include:

- Further strengthening of training and education with a pressure ulcer masterclass for senior nurses and plans to enhance our existing e-learning pressure ulcer training package for registered and unregistered nurses;
- Continued support of the “React to Red” training package;
- Additional practice educator posts will be appointed for our inpatient ward areas to further support learning in the clinical environment.

Progress will be monitored by the directorate teams and the Pressure Ulcer Group.

3.2 Patient Experience

3.2.1 Pain management

Poor assessment and management of pain has been well documented with Apfelbaum (2003) stating that 80% of patients experience pain after surgery, with up to 20% experiencing severe pain. However pain does not just affect surgical patients, with one third to one half of the UK population suffering from chronic pain (Fayaz, 2015). Therefore the assessment and management of our patients' pain should be a priority for all health care providers.

What were we aiming to achieve?

Our initial aim was to highlight to staff the importance of assessing patients' pain and managing it accordingly. This is simply ensuring that we ask patients whether they have pain and how severe it is. It is generally felt that effective assessment can lead to a higher quality of pain control and management.

By increasing the staffs' knowledge of pain assessment using validated tools, we aim to empower them to manage patients' pain, ensuring access to pain relief and thus improving the quality of patient experience and reducing suffering. We aimed to continue to monitor the quality of the patients' experience and identify any potential areas of concern using the additional questions about pain added to the inpatient FFT.

As part of our commitment to improving quality we have been developing further enhanced recovery after surgery programmes. Enhanced recovery is an evidence-based approach that helps people recover more quickly after having major surgery. Enhanced recovery is sometimes referred to as rapid or accelerated recovery. It aims to ensure that patients:

- are as healthy as possible before receiving treatment;
- receive the best possible care during their operation;
- receive the best possible care while recovering.

What have we done?

We have introduced the numerical rating scale of 0-10 as a mandatory field on Patientrack, our electronic tool for recording vital signs and observations, ensuring patients are asked about their levels of pain at least twice daily. Patients are asked: 'If 0 is no pain and 10 is the worst pain imaginable please give a number that best represents your pain'. These numbers or 'scores' can then be cross referenced to the World Health Organization (WHO) analgesic ladder for guidance about appropriate analgesic medication. For example, for a pain score of 4 – 6 we may administer a mild opioid such as codeine (see figure 22).

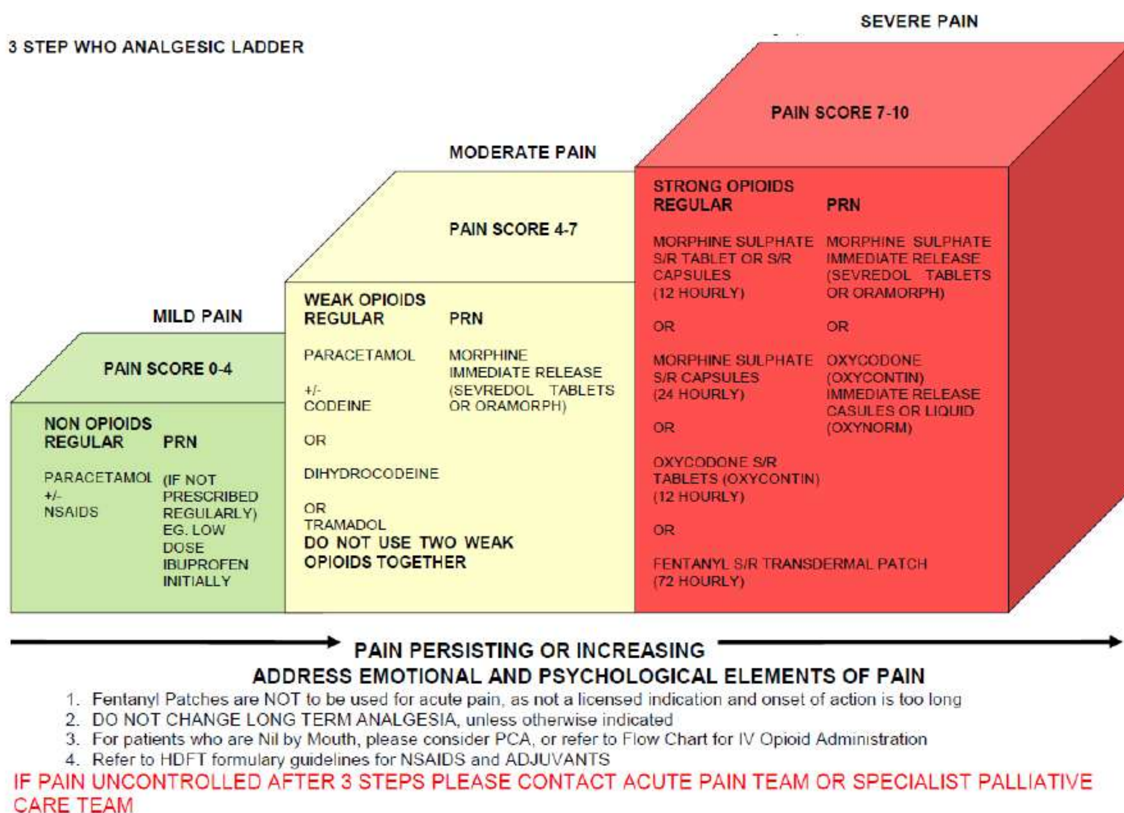
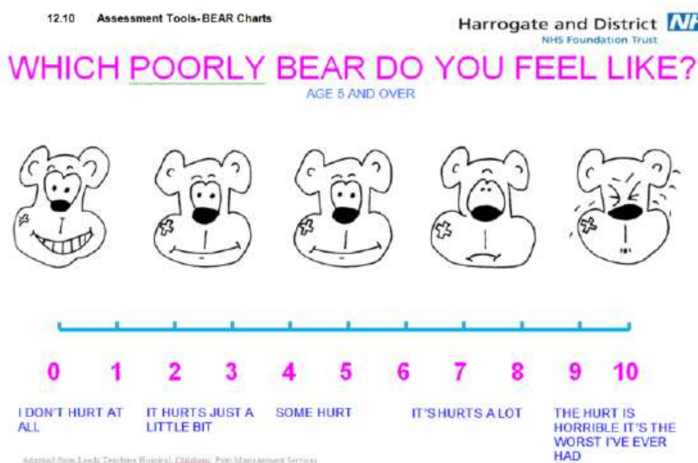


Figure 22: WHO analgesic ladder

For patients unable to communicate due to age, dementia or learning difficulties, we introduced the ‘PAINAD’ tool. This assessment tool relies on non-verbal expressions of pain such as facial expression, body posture and vocalisation, and also creates a pain score of 0-10.

Following a review of the Paediatric Pain Policy this year, further assessment tools were introduced to the Trust that were age specific. These included a series of faces or a ruler that the child can point to or the Infant Pain Assessment chart used for nonverbal children. The charts have been implemented on Woodlands ward, and in recovery areas and ED.



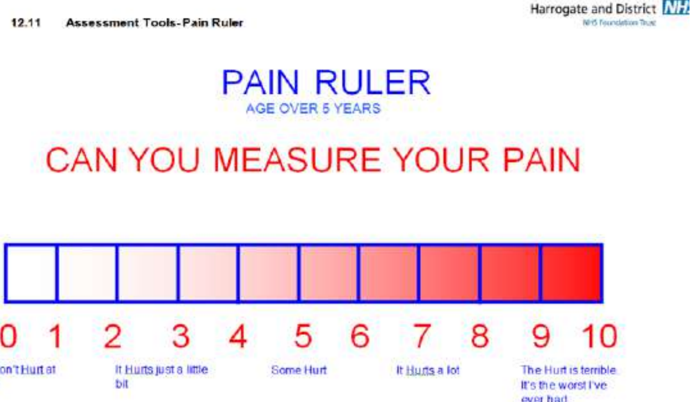


Figure 23 and 24: Pain assessment tools

INFANT PAIN ASSESSMENT CHART

AGE 0 to 5 YEARS

Laughing	Distract easily	Able to distract for short periods only	Difficult to distract	Unable to distract
Smiling / Contented Gurgling / Chatting	Articulating pain	Withdrawn Miserable	Miserable / Moaning Crying	Screaming Aggressive
Actively playing	Grimaces on movement	Touching painful area	Sensitive to handling Guarding	Grimacing persistently
Contented sleep	Restless sleep	Uncomfortable	Irritable	Abnormally still Exhausted sleep
Normal observations	Normal observations	A potential for altered observations	Probable altered observations	Abnormal observations Physical signs
0-2 (No pain)	3-4 (Mild pain)	5-6 (Moderate pain)	7-8 (Severe pain)	9-10 (Excruciating)

Adapted from Leeds Teaching Hospital Children's Pain Management Services

Figure 25: Infant and children pain assessment charts

As well as all resources being available on the Trust intranet, we remain committed to the education of nursing and medical staff, with ongoing training of surgical nurses and junior doctors. Teaching of fascia iliaca blocks to junior doctors has continued, resulting in more patients receiving a block following a fractured hip, reducing pain and alleviating stress.

Regarding the development of further enhanced recovery after surgery programmes, a multi-disciplinary working group for orthopaedics has reviewed current practice, undertaken an audit, and developed nursing documentation and a patient information leaflet.

<u>What are the results?</u>

<u>Enhanced recovery in elective orthopaedics</u>

The enhanced recovery clinical audit in elective orthopaedics highlighted several areas where care could be improved. The ethos of the enhanced recovery programs is to admit, where possible, on the day of surgery, allowing the patient to be comfortable at home for as long as possible. However the audit showed that 60% of patients were admitted on the evening before surgery. We will therefore aim to look at ways to reduce the amount of time spent in hospital prior to surgery.

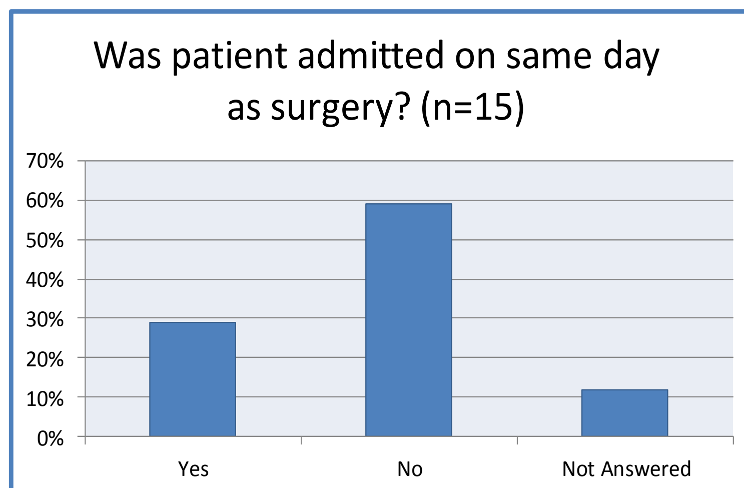


Figure 26: Day of Admission

Latest evidence demonstrates that patients should be without fluids for two hours and solids for four - six hours prior to surgery. The audit identified that patients were being starved for longer periods prior to theatre (see figure 27). Communication between theatres and the ward staff has therefore been improved to ensure shorter fasting times.

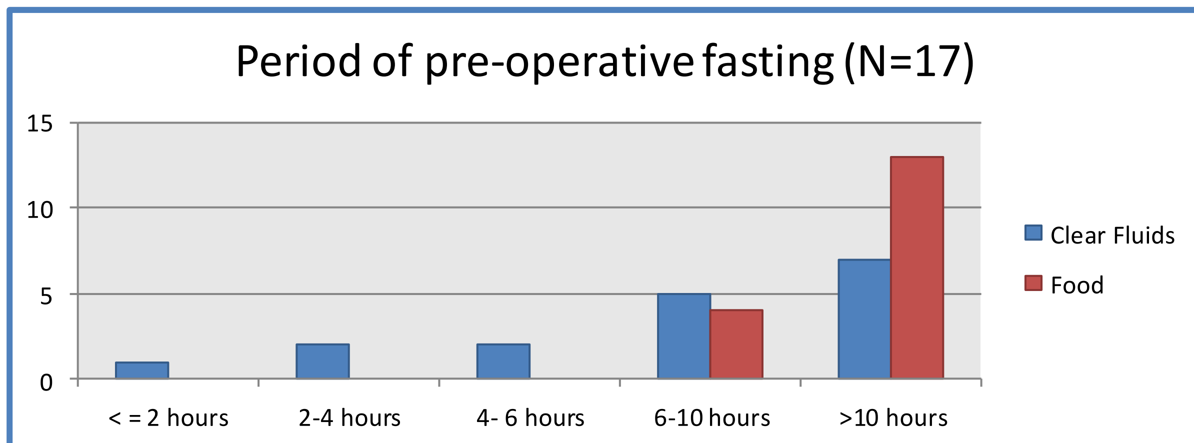


Figure 27: Fasting times

Following hip or knee replacement, pain scores peak 24 hours post-op as expected, with the majority of analgesia also being required within that period.

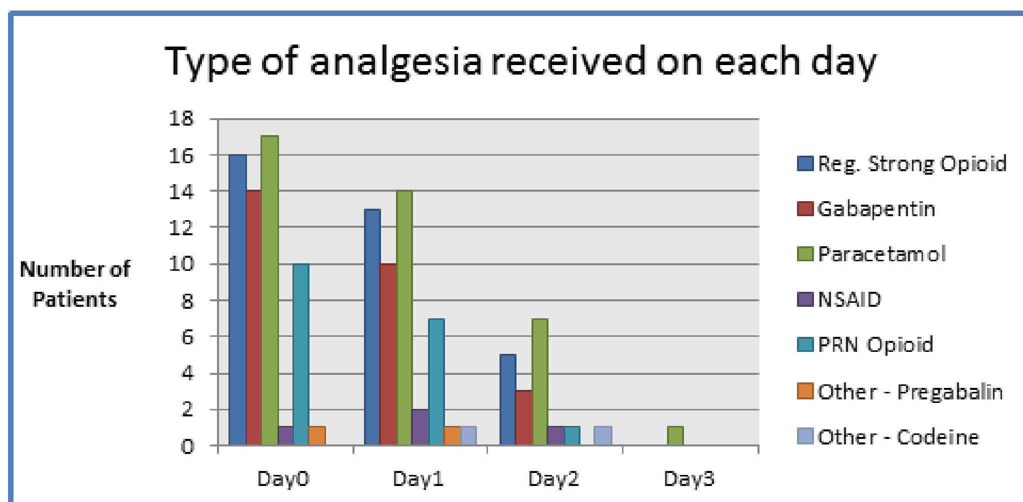


Figure 28: Type of analgesia used post-operatively for hip and knee replacements

<u>Fascia iliaca blocks for hip fractures</u>

Fascia iliaca nerve blocks are a technique advocated by NICE guidelines and the Association of Anaesthetists of Great Britain and Ireland (AAGBI) for post-operative pain relief for procedures and injuries involving the hip, anterior thigh and knee. Following the introduction of teaching for doctors on performing fascia iliaca blocks for hip fractures, we have nearly doubled the number of blocks performed with an increase in out-of-hours service provision (see Figure 29). Blocks performed by doctors were equally as effective as those performed previously by the specialist nurses.

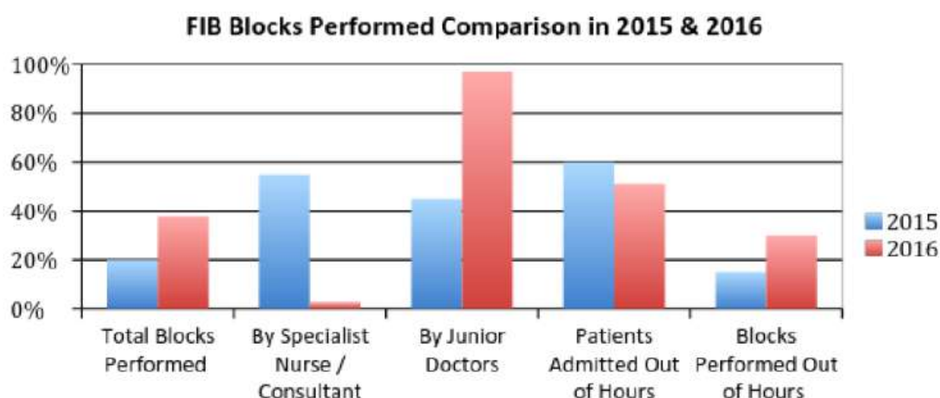


Figure 29: Fascia iliaca blocks (FIB) performed 2015 – 2016

Friends and Family Test (FFT) pain questions

Since November 2014 we have incorporated questions about pain into our inpatient FFT. We have monitored and shared the results and comments from patients with ward staff in order to promote learning and reflection. Patient comments from January 2017 include:

Ward	Comments relating to pain questions
AMU – Acute Medical Unit	When experienced it was dealt with immediately.
CATT ward	This aspect of my care was comprehensively covered.
Farndale ward	Admitted with pain - left without. Cannot ask for anything better.
Granby ward	The nurse has to wait for another nurse to oversee the strong painkiller which sometimes takes time.
Granby ward	Very good.
Nidderdale ward	Pain management offered was excellent.
Nidderdale ward	The staff did all they could to keep my pain at ease throughout my stay here. Thank you.
Nidderdale ward	Very quick in giving pain relief
Nidderdale ward	When certain pain relief was given and ineffective, the staff discussed and then administered the most appropriate relief as and when required.
Wensleydale ward	I knew I could ask for pain relief anytime.
Wensleydale ward	Very helpful especially by introducing me to the pain nurse - very reassuring.

Table 41: FFT pain question patient feedback

Summary and next steps

In order to further enhance and develop the Acute Pain Service, it was determined that investment was required and a business case to expand the service was submitted to the Trust Board in 2014. Whilst supported in principal, this has yet to come to fruition due to more pressing priorities for the Trust. Therefore we are exploring inventive ways of maximising the current resources within the pain team to ensure the balance between clinical and educational responsibilities is deliverable.

3.2.2 Maternity

Last year we completed the refurbishment of the Maternity Department and launched the Harrogate Maternity Mums and Midwives Facebook page. During 2016/17 we have continued to work hard to maintain safe and high quality midwifery care which is assessed by the Local Supervising Authority audit. We continue to use the results of national maternity patient satisfaction surveys and the maternity friends and family test to improve services.

What have we done and what are the results?

Maternity Services Survey 2015

The Maternity Department took part in a national survey of women's experiences of maternity services in 2015. This survey is part of a series of national patient surveys by the CQC for all NHS acute trusts with maternity services in England. The purpose of the survey is to understand what maternity patients think of healthcare services provided. This includes the whole patient journey from the first booking to the acute hospital setting and discharge from the community midwife to the health visitor.

Women were eligible for the survey if they had a live birth during February 2015, were aged 16 years or older, gave birth in a hospital, birth centre, maternity unit, or who had a home birth. The response rate at HDFT was 51%.

The report was published in January 2016 and the Maternity Department developed an action plan and has made significant progress in the last 12 months on the following:

- **Labour and delivery - confidence and trust in staff**
  We have introduced a recognised communication tool called SBAR (situation, background, assessment and recommendation) for use at all handovers between midwives for women in labour. An SBAR sticker prompts midwives to ensure all appropriate information is handed over. This has also been introduced for the medical review of high risk women on Delivery Suite. This handover occurs in front of the woman and her partner so that they are involved in plans of care.

- **Advice, support and encouragement with breast feeding**
  A one day training programme has been implemented and all staff have attended. We have also implemented a feeding assessment on the postnatal ward which is completed prior to discharge home; this provides valuable information on agreed plans of care for the community midwives.

There is a further national maternity review planned in 2017 which HDFT will be taking part in. All women who deliver in February and March (up to 250 women) will be sent a survey to complete in May. Results will be available towards the end of this year.

Maternity Friends and Family Test (FFT)

The FFT in maternity services enables women to provide feedback:

- At the 36 week antenatal appointment (GP surgery, Children's Centre, home or hospital);
- After delivery;
- On discharge from hospital;
- On discharge from the community midwife.

The results of the maternity FFT are given below. HDFT achieved a higher proportion of women recommending each element of the service than the national average.

Service		Q1	Q2	Q3	Q4	Full Year	National data 16/17
Q1: Antenatal	% recommend	98.9%	97.7%	97.7%	97.8%	98.0%	96.3%
	% would not recommend	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%
	% response rate	16.2%	17.5%	17.2%	19.3%	17.5%	
	No. responses	89	87	88	89	353	
Q2: Labour	% recommend	96.6%	98.9%	94.3%	98.3%	97.0%	97.1%
	% would not recommend	0.5%	0.6%	0.6%	0.0%	0.4%	1.0%
	% response rate	40.6%	39.9%	35.5%	39.7%	38.9%	23.1%
	No. responses	204	174	174	176	728	
Q3: Postnatal	% recommend	97.6%	99.4%	97.7%	95.4%	97.5%	93.9%
	% would not recommend	0.0%	0.6%	1.8%	0.6%	0.7%	2.1%
	% response rate	41.8%	40.1%	34.9%	39.3%	39.0%	
	No. responses	210	175	171	174	730	
Q4: Community Postnatal	% recommend	98.1%	98.5%	100.0%	100.0%	99.1%	98.0%
	% would not recommend	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%
	% response rate	14.0%	14.5%	8.8%	11.7%	12.1%	
	No. responses	52	67	43	52	214	

Table 42: Maternity FFT results 2016/17

The response rate and scores are monitored closely by senior midwifery managers and displayed in the maternity unit for staff and women to see. Both positive and negative feedback is used to encourage and improve care when individual staff are named.

Our response rates are nearly always above 20% and scores are very high for delivery, postnatal care in hospital and at home by the community midwife. We have had disappointingly low response rates from the antenatal appointments despite attempts to improve this. We are considering other methods of seeking feedback in the future in the hope that we can improve the response rate.

<u>Maternity Facebook page</u>

This continues to be very well received and we receive large numbers of positive feedback from the women who use the maternity services in Harrogate.

<u>Local Supervising Authority audit report</u>

Supervisors of Midwives (SOM) are appointed by the Local Supervising Authority (LSA) and the LSA function sits within NHS England. The main responsibility of the LSA is to protect the public by monitoring the quality of midwifery practice through the mechanism of statutory supervision for midwives. Audits of statutory supervision are completed by the LSA Midwifery Officer (MO) and a small group of external assessors for all maternity units and supervisory teams on an annual basis. The aim of the LSA audit is:

- To review the evidence demonstrating that the standards for supervision in midwifery are being met;
- To ensure that there are relevant systems and processes in place for the safety of mothers and babies;
- To review the impact of supervision of midwives on midwifery practice;
- To ensure that midwifery practice is evidence based and responsive to the needs of women.

The LSA audit is carried out annually and at the end of the process the LSAMO provides an audit report with recommendations for the local supervisory team to complete before the next audit. The LSA audit at Harrogate took place on 8 September 2016 and an action plan has been implemented for the local supervisory team to complete. All recommendations from the previous audit in 2015 had been completed. The audit in 2016 showed that:

- The supervisory team at HDFT have demonstrated effective delivery of their action plan following the 2014/15 LSA audit visit. There are clear links between statutory supervision and the clinical governance processes of the Trust.
- The SOM team and Trust have met all the required standards measured by the Local Supervising Authority on behalf of the Nursing and Midwifery Council (NMC).
- For midwives the support from the Supervisory team was appreciated by the midwifery staff and all the midwives spoken to have a good understanding of revalidation and an awareness of the changes to statutory supervision.
- The SOM team are working widely with women and their families to ensure safe, quality care is available to women choosing care outside of local guidance. It was recognised that the SOM team are active in promoting normality through working with women in promoting water birth and reducing third degree tears.
- There is positive engagement with executive board members and high level support and acknowledgement for the work and functioning of the supervisory team which was confirmed by the Head of Midwifery who met with the LSAMO at the audit visit. The Head of Midwifery also has an effective and key link with the Trust Board and feels assured of ongoing support for both women and midwives in and around the future model for a non-statutory form of supervision.
- The team have been provided with the required resources to be highly effective in their role. The contact SOM is very proactive within the team regularly sharing the activities and workload widely. This has significantly improved the quality of the evidence submission and it was very apparent how collaborative and inter supportive the team are.

A small action plan developed after receipt of the report is now almost complete.

The future of supervision

In January 2015 the NMC took a decision to ask for a change in its legislation in order to remove the additional tier of regulation applying to midwives. The NMC have accepted the two principles that:

- Midwifery supervision and regulation should be separated;
- The NMC should be in direct control of the regulatory function.

The decision for this change followed a review of midwifery supervision by the Kings Fund following the investigation into the serious failings in maternity care at Morecombe Bay, where failings in midwifery supervision were identified as contributing factors. The decision was made to remove supervision from statute from 31 March 2017.

A new model called advocating for education and quality improvement (AEQUIP) has been in pilot form with the introduction of Professional Midwifery Advocates (PMAs) to replace the role of SOMs as part of this model. This employer led model includes a continuous improvement process that builds personal and professional resilience, enhances quality of care for women and their babies, and supports preparedness for appraisal and professional revalidation.

Until this new model is introduced we will have an interim period between one model ceasing and another one starting. The existing SOMs will now be called Midwifery Advocates who will continue to have a caseload each to advise on professional development, encourage discussion and reflection on clinical cases and to attend in this role at governance meetings. We will be involved in coaching all midwives to support informed choice for women by having ad hoc sessions on current and previous cases.

Collaborative working

Perinatal mental health is high on the maternity services agenda and as a consequence of this we have improved links between maternity services and the Improving Access to Psychological Therapies service which commenced in February 2016. The service had two primary objectives:

- To ensure all women presenting with mild or moderate mental health issues have access to evidence based psychological therapies;
- To build relationships between midwives, medical staff and mental health staff to ensure seamless joint working.

There is a high intensity therapist based in antenatal clinic once a week to see women referred to this service. We have seen a high success rate for women referred to the service and positive feedback from these women.

We were shortlisted for an award with the Royal College of Midwives for evidence of partnership working. We hope to extend this collaborative service by providing bespoke antenatal and postnatal courses and to target more vulnerable groups of women and include their partners.

Sign up to Safety

The Maternity Department were successful in getting monies from the NHS Litigation Authority for our safety improvement plan prepared for the Sign Up to Safety campaign. Sign up to Safety is a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible.

The department wanted to achieve a measurable improvement in the quality of patient focused care in relation to human factors that contribute to a positive safety culture, embedding reporting and learning from incidents and near misses, leadership, communication, escalation and team working. In addition we wanted to focus on implementing the NICE guidance (2014) on cardiotocography (CTG) interpretation, and our current daily multi-disciplinary case review discussion.

We seconded a Band 7 safety midwife to work one day a week and during the last 12 months she has:

- Improved staff skill and confidence in CTG interpretation using NICE guidance;
- Introduced the SBAR communication tool to improve handover of information;
- Improved communication skills by implementing human factors training for all staff;
- Implemented a post-partum haemorrhage (PPH) risk assessment tool to reduce the numbers of women having a PPH in hospital. We are one of the first maternity units in England to implement such a tool.

We have had to review the CTG interpretation after recent changes made by NICE. The SBAR handover sticker is well established with the midwifery staff and we have received very positive feedback from the human factors training sessions.

Summary and next steps

The Maternity Department has developed some quality objectives for 2017/18.

1. Reduction of the elective Caesarean section rate: We are undertaking an audit to understand more about the reasons for women choosing elective Caesarean sections and will review our birth choice clinic that promotes normal birth and supports women in shared decision making.

2. Reduction in the postpartum haemorrhage (PPH) rate: We are in the process of completing an audit on the PPH risk assessment tool and are hopeful that this will reduce the number of women having a PPH.
3. Reduction in 3rd/4th degree perineal tears: This is on-going work with education about the prevention of 3rd/4th degree perineal tears for both midwives and medical staff.
4. Reducing term admissions to Special Care Baby Unit (SCBU): Although all incidents are currently reviewed, we will be reinstating the neonatal/obstetric meetings to provide a forum for discussion about clinical cases and pathways between midwives, obstetrician and paediatric staff.
5. Improving handover of information between midwifery staff: We will continue to promote and monitor effective and accurate handover of information using SBAR.
6. Extending further the links between maternity services and the Improving Access to Psychological Therapies service: We plan to increase the amount of time the high intensity therapist has in the antenatal clinic to provide bespoke antenatal and postnatal group courses and to target more vulnerable groups of women and partners.

3.2.3 Healthy Child Programme

In April 2016 Darlington, County Durham and Middlesbrough 0-19 contracts transferred to HDFT from the incumbent providers. The Trust has worked with commissioners to ensure that we deliver the Healthy Child Programme in a way that ensures equality of access, taking in to consideration:

- The geographical spread and diverse population of the areas and the very different needs of each locality;
- The requirements of the service specifications for each area;
- Proactive communication and engagement to ensure that families, children and young people have the ability and desire to proactively engage with the 0-19 services including those who experience physical, language and/or cultural barriers;
- The need to expand availability of the service throughout the year and in terms of daily access, including expanded hours and weekend working when this meets the needs of communities.

<u>What have we done and what are the results?</u>

Over the last 12 months we have strengthened the training of the 0-19 workforce to ensure they remain skilled, competent practitioners who deliver an evidence based service to the population. This has included the Institute of Health Visiting training on perinatal mental health, infant mental health, infant feeding, diet and nutrition, and training on infant attachment and baby brain development through Solihull and Braselton training.

We have co-located many of the 0-19 workforce with Local Authority colleagues to ensure we maximise resources to meet the needs of families.

We work closely with our commissioners to agree monitoring arrangements for each of the performance indicators for the Healthy Child Programme with an agreed dashboard based on the specification. We have quarterly contracts meetings in each area to discuss our performance from a quantitative, qualitative and continual improvement perspective. In County Durham a robust monthly performance management process has been developed including a consistent data validation process, a regular record keeping audit and the submission of case studies and patient stories. Performance management also includes an element of patient experience, ensuring that the patient voice is heard.

Improving Patient Experience

- Staff in County Durham took part in the Young People Takeover Challenge. Young people joined our teams to look at some key priorities and look at solutions together. These same young people have now joined us on interview panels for the recruitment of staff in the 0-19 service.
- County Durham has achieved Young Carers Charter accreditation. The key question regarding young carers is included in all our family health needs assessments and support promoted through the 0-19 teams for this group of children and young people.
- The directorate is developing a Patient Experience Tool which is being piloted in County Durham and will roll out across the directorate. The tool includes the use of comments cards, a questionnaire via a telephone contact and the FFT.

Exploring Innovative Practice

- The Growing Healthy Brand was developed in consultation with children, young people and families. The brand has been promoted through the "Growing Healthy Bus" in County Durham. The bus has been visiting schools, colleges and community venues since September 2016 and has been successful in reaching out to thousands of young people with health promotion messages and promoting the role of the school nurse. The Growing Healthy Bus will continue to visit sites across the county until the end of the summer term.
- We have worked with our colleagues in the Trust's communications team to develop the use of social media with our teams having their own Facebook pages and Twitter accounts. The Growing Healthy Bus now has 200 followers and this format is used to promote health messages and to engage with our service users as we never have before. The teams have also developed a text messaging service, not only to engage clients with health promotion messages but to reduce the number of ineffective visits.
- Implementation of agile working solution. All 0-19 practitioners have access to mobile working solutions which will create further efficiency in our teams.

Developing Clinical Practice

- In County Durham we have worked with Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust to employ five Emotional Resilience Nurses. These nurses work alongside the school nursing team to address emotional health issues with students in secondary schools. The teams have been responsible for the delivery of phase one of Youth Awareness in Mental Health training to year nine students. This will be presented at the Biennial School Nurses International Conference in San Francisco in July 2017.
- We have worked with colleagues from Public Health England to develop a leadership training course specifically for 0-19 staff. This leadership training is being delivered to 50 health visitors who will roll out the training to colleagues. This programme aims to develop leadership skills in our teams, supporting staff to take on leadership roles in the community.
- Implementation of universal school health profiling to identify local need and ensure effective targeting of school nurse resources. The school health profile identifies the specific health needs of the school. The school nurse ensures that the needs are met by coordinating the response.
- Development of the vulnerable parent pathway. A multi-agency approach to support the most vulnerable families identified in the antenatal period.
- Launch of multi-agency screening team. The multi-agency team are screening referrals to the health and social care children's services to ensure that referrals are signposted to the correct agency. This initiative was the winner of the Local Government Chronicle Awards Partnership of the Year Award 2017.
- Implementation of the home environment checklist to identify the early signs of neglect, provide an opportunity to action plan with the family.

- Managing healthy weight through the Family Initiative Supporting Children's Health (FISCH) programme in County Durham. This programme tackles childhood and family obesity following identification through the national child measurement programme. School nurses and health trainers provide support both in schools and in the home. School nurses in North Yorkshire and Middlesbrough are being trained in the Henry programme which is an evidenced based programme in tackling childhood obesity.

Unicef Baby Friendly Accreditation across all areas

We are striving to achieve full Unicef accreditation across all areas. Currently, we have different levels of accreditation and are supporting each other to share good practice and experience in order to achieve and maintain full accreditation.

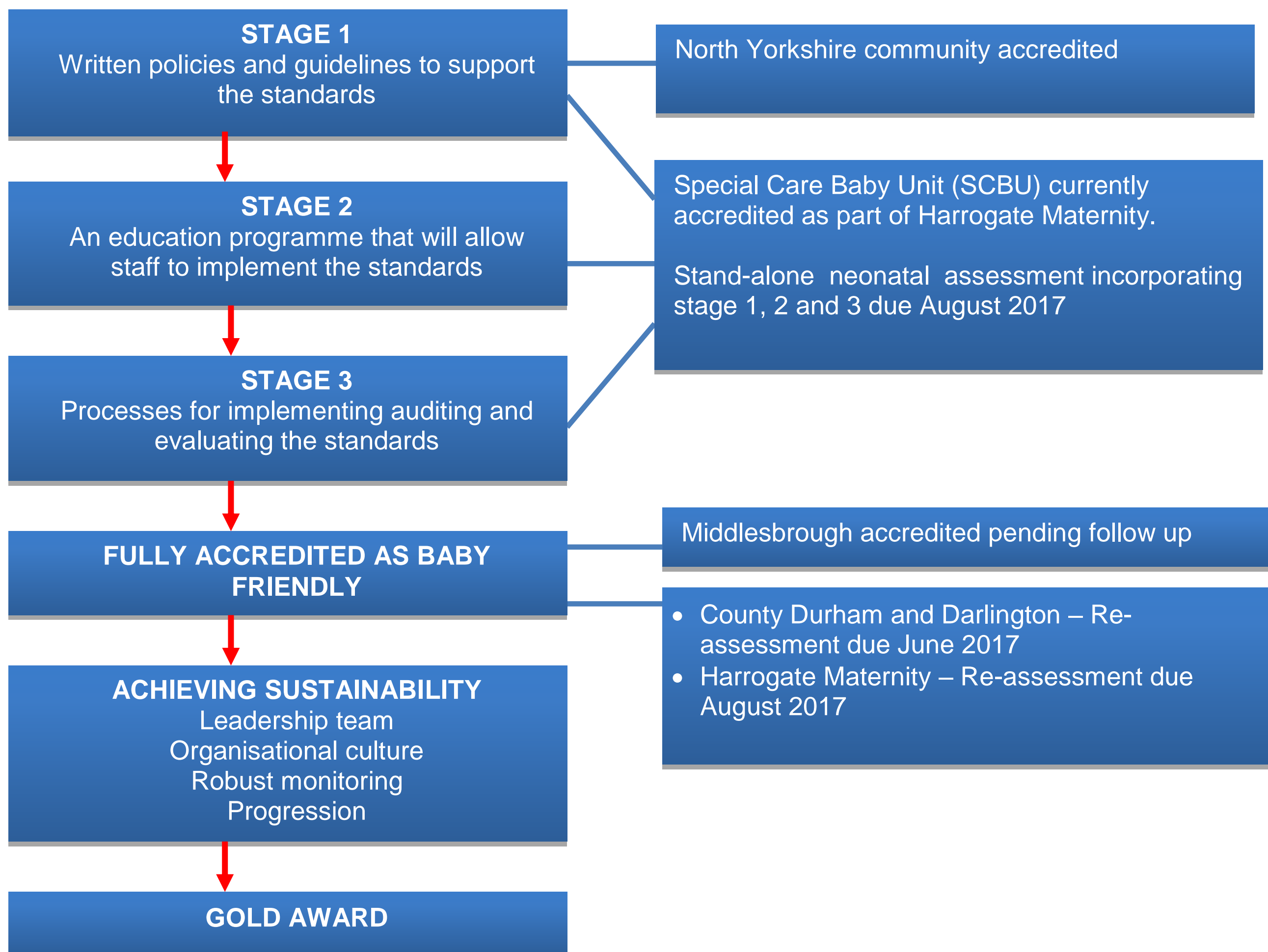


Figure 30: Unicef Baby Friendly Accreditation progress

Summary

From April 2016 we significantly increased our provision of Community Children's Service to include County Durham, Darlington and Middlesbrough. This is in addition to the services we have historically managed in North Yorkshire. The expansion of services has enabled us to use best practice and develop innovation across a large geographical area.

In 2017-18 our dedicated staff will continue to provide services that focus on the needs of children and young people making use of technology and using feedback from service users and partner agencies to develop a culture of continuous improvement in the services we provide.

3.3 Effective Care

3.3.1 End of Life Care

How we care for the dying is an indicator of how we care for all sick and vulnerable people. We are committed to developing excellence within the care of frail elderly patients, and end of life care is a key element of such an ambition.

We aim to ensure that events preceding and following the death of a patient are managed sensitively, efficiently and with the knowledge and understanding of the relatives and carers. Patients, relatives and carers have the right to receive a high standard of care, advice and support from well informed staff. Local objectives clearly highlight the need to care for people in a timely way and have their care co-ordinated and delivered in accordance with their wishes through a personalised care plan to:

- Enhance dignity, choice and equality;
- Increase likelihood that death will occur in the patient's preferred place of care;
- Palliate symptoms;
- Improve communication between patient, families and professionals.

We also recognise the importance of gathering and acting upon feedback from patients and relatives in order to ensure we are delivering a holistic and patient-focused service, and to identify any areas for improvement as we constantly strive to provide excellent care.

What were we aiming to achieve?

Our aim during 2016/17 has been to:

- Develop a well-led end of life care service;
- Ensure choice in end of life care and identify the causes of patients not dying in their preferred place;
- Harness feedback from patients and family experience using a bereavement survey;
- Improve our Mortuary viewing room facilities.

What have we done?

Developing a well-led end of life care service

Our Specialist Palliative Care Team (SPCT) historically has been provided by our local hospice, Saint Michael's, within a partnership arrangement and with joint funding between HDFT and Saint Michael's. In 2016 we elected to transfer the team fully over to HDFT whilst continuing to maintain close partnership working. Following transfer of the service we developed a work plan to take forward end of life care practice within HDFT for the hospital and community services we provide.

Our five year work plan for 2017 – 2022 has been developed and informed from a range of sources. These include:

- A detailed gap analysis undertaken jointly across our locality of *Ambitions for Palliative and End of Life Care: The national framework for local action 2015 – 2020*;
- Outcomes from our internal bereavement survey;
- Patient and family complaints and feedback;
- National Care of the Dying in Acute Hospitals Audit results;
- Outcomes from the CQC inspection in February 2016.

In order to take forward our ambitious work plan we have undertaken a staffing review of our SPCT to ensure appropriate roles are developed. Additional roles are currently being recruited to and will enable progress on the work plan in 2017/18.

Choice in end of life care

In order to accurately report upon the reasons why patients did not achieve their preferred place of death we have needed to develop mechanisms of recording the discussions had with a patient and ensuring that subsequent outcomes are also recorded. This has been implemented within the SPCT by using SystmOne as a shared patient record and is now systematically being rolled out across all community teams.

Bereavement survey

Through national surveys patients have the opportunity to 'have their say' regarding the quality of care they have received. However for patients who are dying there is no such opportunity. Therefore following pilots undertaken in previous years we have implemented a continuous survey of bereaved relatives. An information sheet is given to all bereaved relatives who collect a death certificate from the Trust's General Office, informing them of the survey and that we may write to them in approximately eight weeks' time to ask them to complete a questionnaire. This timeframe is chosen to allow relatives time to grieve. An opportunity is now included for any relatives to be contacted by our Patient Experience Team to discuss any concerns that they may have had regarding the care of their relative.

Improving our Mortuary viewing room facilities

There were misconceptions amongst hospital teams that viewings could not be made outside of normal working hours. This has now been clarified and widely communicated throughout the Trust. Our aim is to ensure we provide a flexible service at a time of great emotional difficulty for relatives. This has been enhanced by full redecoration of the viewing room.

What are the results?

A well-led end of life care service

Working cohesively with our locality colleagues we have identified key areas of priority that we will take forward jointly. This has led to agreement in taking forward a project to deliver an electronic palliative care co-ordination system (EPaCCs). This is a significant piece of work that will enable us to share people's care preferences and important details about their care at the end of life across traditional healthcare boundaries. This will lead to more people having their wishes appropriately communicated, respected and delivered upon where practically possible.

Having transferred the SPCT to HDFT and ensured clarity of leadership aligned to Trust priorities with a clearly defined work plan, we now feel confident that we are able to demonstrate strength in leadership and assure ourselves regarding a well-led end of life care service.

Choice in end of life care

There has been continued improvement in the use of SystmOne to record the preferred place of death and actual place of death within our SPCT. We have now started to roll this out systematically across all our community teams.

	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
Number with preferred place of death recorded (or not applicable)	35	56	64	94
% with preferred place of death recorded (or not applicable)	44.9%	69.1%	97.0%	95.9%
Of those, number who died in preferred place - yes	20.0%	64.3%	62.5%	62.8%
Of those, number who died in preferred place - no	0.0%	8.9%	7.8%	12.8%

Table 42: Preferred place of death and outcome

<u>Bereavement survey</u>

The bereavement survey has enabled us to identify themes for practice development and training which have been incorporated within our work plan. Importantly this has enabled relatives who have not wanted to make a complaint, to have the opportunity to share with us areas which they felt could have been improved. It has also provided the opportunity for us to clarify any misconceptions regarding care or decision making. We have achieved a consistent 37% response rate to surveys sent out. We are in no doubt that providing this opportunity can also have a positive impact upon the grieving process.

Figure 31: Bereavement survey comments

Improving our Mortuary viewing room facilities

Our viewing room has been fully redecorated with new flooring, wall decoration, soft decorations and gentle lighting.

Photo 3: Mortuary viewing room facilities

Summary

We have made significant progress in developing our foundations for moving forward. In the coming year we will complete and introduce our end of life strategy. We will continue to focus on supporting staff to provide person centred high quality care at end of life across the organisation, developing metrics that can be monitored, providing transparency and assurance.

3.3.2 Dementia care

Dementia is a progressive disease for which there is no known cure. The aim of the National Dementia Strategy is that all people with dementia and their carers should live well with dementia. At HDFT we aspire to becoming a dementia friendly hospital; this involves considering the environment we care for patients in, how we educate our staff to care for patients and the assessing the quality of the care we deliver to patients living with dementia.

What have we done?

The environment

In 2016 all the toilet door frames within the hospital's ward areas were painted red, to demarcate them clearly to patients and promoted independence and continence.

Work was previously completed on the Frailty Unit (Jervaulx and Byland wards) to improve the patient environment, with coloured door and window frames for each bay. These are in the process of being re-painted with stronger, clearer colours to facilitate orientation within the wards. The day rooms on both wards have murals and comfortable seating and patients who require distraction are invited to use the day room with one to one support provided.

Byland ward now has a "bus shelter" seating area in an alcove on the ward corridor. This is an idea adapted from Bradford Hospital ward 28, where attention has been given to improving the surroundings and allowing reminiscence and reflection on local life. The ward has also instituted a breakfast club, where patients who are more mobile can be encouraged to maintain independent by preparing their own breakfast of hot drinks, cereal and toast.

Several wards have instituted a falls huddle, whereby patients who are at risk of falls are identified at the beginning of each working day and steps taken to reduce the risk of falls put in place. This is as a result of collaboration with the NHS Improvement Academy, and has helped to reduce the number of falls, including falls in patients who have dementia and delirium.

Education and training - innovative teaching methods

TEWV NHS Foundation Trust secured a small amount of funding from the Royal College of Psychiatrists to support micro-teaching on our wards. They decided to pilot this on Byland ward early in 2017. A medical student completing an extended student-led research or evaluation project carried out a scoping exercise to identify the learning needs of staff on Byland ward, such that teaching could be tailored to their needs.

Five teaching sessions were delivered in total, covering dementia, delirium, depression, mental capacity and the Mental Health Act. These teaching sessions were multi-professional and participants included nursing staff, student nurses, medical staff, medical students and pharmacy staff. They were scheduled at a convenient time within the working day and each lasted 10 minutes. Feedback was collected by the specialty trainee in Old Age Psychiatry and this was found to be a very positive experience for staff.

We hope that this type of teaching, whereby staff are able to receive teaching without leaving their ward area can be rolled out further across the Trust. It is often difficult for staff to block out long periods of time to attend teaching but providing teaching that is short, focused and takes place within their work area, makes it more achievable. It is hoped that a similar exercise could be carried out where micro-teaching on general medical subjects is delivered to staff on the mental health wards.

Mandatory training

Compliance with mandatory dementia training for substantive staff, excluding those on long term sick, maternity leave and career breaks is:

- Dementia awareness: 85%
- Dementia tier one: 76%

Unfortunately we have not been able to continue with tier two face to face training previously provided by TEWV due to the departure of a key member of staff, but HDFT Consultants in Elderly Medicine and TEWV Old Age Psychiatrists are working together to address this.

Our Consultants in Elderly Medicine continue to teach dementia and delirium management to doctors in training as part of their teaching programmes, and have run a successful simulation session on the management of delirium for medical trainees in Elderly Medicine.

Increasing awareness in the wider community

HDFT staff attended the *Let's Do Something About Dementia* event in Knaresborough on July 14 2016. This developed from the work and ideas of the Systems Leadership Group covering all partner organisations in the locality involved in improving the lives of those living with dementia. We provided information about HDFT's role in caring for patients with dementia during a hospital stay.

We also presented two "Medicine for Members" events about the care of people living with dementia in May 2016. Feedback was very positive and suggestions were made for future presentations on post-hospital dementia care, how to prevent dementia, and options available after a dementia diagnosis.

Activities

A successful chair based exercise class was run as a taster session on Byland ward by the provider of a social enterprise, Dancing for Wellbeing in Harrogate and surrounding areas. This work is rooted in the belief that patients can lose independence during hospital admission partly

due to loss of muscle mass and strength. It takes inspiration from some research carried out at the University of Winchester on using the arts to enliven a hospital stay. See Using the arts to uplift people in hospitals for more information.

Themed tea parties continue to take place on Byland ward and are enjoyed by all. Farndale ward has knitting supplies for patients who are interested and who are looking for purposeful activity.

Volunteers

Farndale, Byland and Jervaulx wards have meal time volunteers to assist frail patients complete their menu choice slips as well as to assist them at meal times.

Caring for Carers

HDFT has registered to be part of John's Campaign. Useful material has been provided by the campaign and a statement placed on the Observer website.

> "We welcome relatives and carers of people with dementia visiting at any time in order to provide reassurance and familiarity to our patients. We support carers who wish to become involved in activities with their loved one, such as helping at mealtimes and providing diversional activities if this is something that they wish to do".

What are the results?

Photo 4: Dancing for Wellbeing Byland ward December 2016

Photo 5: Breakfast Club Byland ward

Photo 6: Tea party and music on Byland ward

We have continued to meet the targets for screening for dementia and ongoing referral for further assessment of cognitive impairments.

Summary

Unfortunately we have not progressed some anticipated achievements this year for a variety of reasons. For example, with the departure of a key member of staff in August 2016, we have been unable to deliver the more in-depth dementia training for staff requiring this. And although we re-launched the Butterfly Scheme in the autumn of 2015 we have not really seen improvements in its use across the Trust. We will be looking at how this can be re-invigorated.

However there are several strands of work that have been successful this year, particularly around innovative ways of delivering training. These have involved small numbers of staff and we want to look at how face to face training for other staff with a frontline role can be made more accessible.

During the coming year we hope to increase our participation in John's Campaign and to provide carers with support, and information about caring for those with dementia and the support available to themselves. Staff training to improve understanding of carers' needs, will be included in future tier two training. Some helpful resources are available and have been circulated through the John's Campaign team.

We are hoping that with a re-examination of the Dementia Working Group's membership and scope, that we can progress our ambitions in relation to dementia care in the coming year.

3.3.3 Discharge

As part of the Unscheduled Care Clinical Transformation Programme, a project to improve the efficiency and patient experience of the discharge process was launched in November 2016.

This discharge project along with the unplanned inpatient project is taking forward a series of initiatives which, when implemented together, aim to optimise the safe and efficient discharge of patients who are medically fit for transfer and no longer require an acute hospital bed. This will improve the quality of care and ensure that the right beds are free for the right patient at the right time.

The programme of work is as follows:

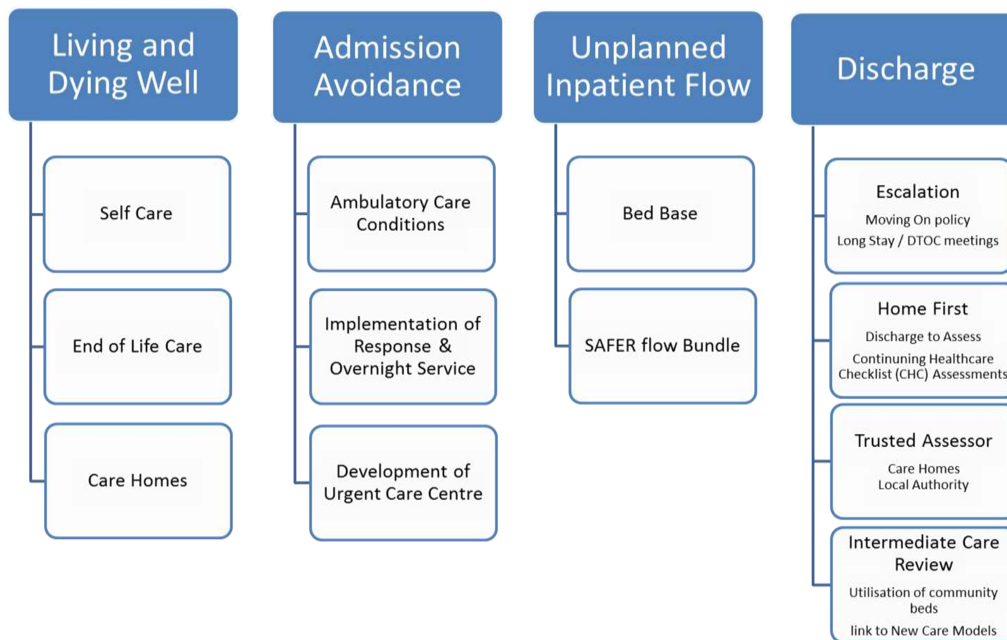


Figure 32: Unscheduled Care Clinical Transformation work streams

Quality and safety rational

There is a growing body of evidence describing the detrimental effects of remaining in hospital longer than is clinically necessary. The consequences of a patient who is ready for discharge remaining in a hospital bed include:

10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80

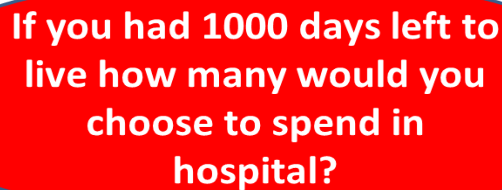
Gill et al (2004). studied the association between bed rest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity.

- Exposure to an unnecessary risk of hospital acquired infection[1];
- Physical decline and loss of mobility / muscle use[2];
- Frustration and distress to the patient and relatives due to uncertainty during any wait for a preferred choice of ongoing care setting to become available;
- Increased patient dependence, as the hospital environment is not designed to meet the needs of people who are medically fit for discharge[3];
- Patients requiring acute and elective inpatient care being unable to access services due to beds being occupied by patients who are medically fit for discharge.

[1] Hassan, M. et al, 2010. *Hospital length of stay and probability of acquiring infection.* International Journal of Pharmaceutical and Healthcare Marketing. 4(4):324-338.
[2] Kortebein, P. et al (2008). *Functional impact of 10 days of bed rest in healthy older adults.* J Gerontol A Biol Sci Med Sci. 63(10):1076-81.
[3] Monk, A. et al. 2006. *towards a practical framework for managing the risks of selecting technology to support independent living.* Applied Ergonomics, Vol.37(5).

What we are aiming to achieve?

By working together with partners from other sectors of the Harrogate Health and Social Care system, the project has been identifying areas that cause delay, or poor patient experience, along the patient journey to hospital discharge. A number of work streams have now been set up with the aim of:



- Improving the content and timeliness of the discharge information provided to patients and their families either prior to or immediately following admission;
- Ensuring that discharge is managed sensitively and consistently throughout the discharge planning process, starting at admission;
- Improving patient safety and reducing any negative effects of being in hospital for longer than is clinically necessary;
- Ensuring that beds are used appropriately and efficiently.

The agreed measures of success include:

- Reduction in the number and duration of delays to patient discharge or transfer to a more appropriate ongoing care or rehabilitation setting;
- Reduction in the number of long lengths of stay in hospital beds (starting with 50 days plus and then working down to 20 days plus and finally seven days plus);
- Ensuring 33% of all discharges from hospital to leave their hospital bed by midday;
- Ensuring that 33% of all discharge from hospital go through the discharge lounge;
- Ensuring 95% of patients have an agreed planned date of discharge.

The following targets are part of the 2017/18 discharge CQUIN and will need to be adopted as key measure of success:

- Increase the proportion of non-elective patients discharged to their usual place of residence within seven days by 2.5% from the Q3 and Q4 2016/17 baseline;
- Locally agree collection of patient outcome measures for patients discharge to care homes through discharge to assess. Discharge to assess is about funding and supporting people to leave hospital when safe and appropriate to do so, and continuing their care and assessment out of hospital. They can then be assessed for their longer-term needs in the right place.

What we have done?

We have established a Discharge Steering Group consisting of representatives including: commissioners, local authority representatives, voluntary sector and patient representation, as well as clinical and managerial staff from the hospital. The group aim is working with partners to deliver coordinated care across the health and social care sector. Group leads were appointed and have delivered the following since November 2017:

Escalation

- Development and launch of 'Moving On' process based on national best practice guidance;
- Introduction of a weekly cross system long length of stay meeting which reviews all patients in hospital for more than 20 days with a view to putting plans in place to support their discharge.

Home First

- Agreement of processes to enable a 'home first' approach to be taken for certain assessments including:
    - Enabling continuing healthcare needs assessments to be undertaken outside of the hospital setting;
    - Development of a discharge to assess approach, which would enable physiotherapy and occupational therapy assessments to be carried out in a patients' home, in familiar surroundings and after a suitable recuperation period.

Trusted Assessor

- Development of trusted assessor agreements, which would enable the appointment of a trained assessor to ensure that swift assessment and decisions are made on behalf of care homes as to the suitability of a home placement to a patient's needs.

Intermediate Care Beds

- Development of a clinical referral criteria for Trinity ward in Ripon, and understanding of the needs of those patients not meeting these criteria but currently moving, or waiting to move to this unit due to a lack of a more appropriate alternative service. To explore alternative or more appropriate options for these patients and work with commissioners to put these in place.

Unplanned Patient Flow

- We ran an 'Every Hour Matters Week' across the whole local system from the 6 – 10 March 2017. The purpose of the week was to raise awareness of the impact of unnecessary stays in hospital and have a dedicated week of working as a system to improve flow through our acute hospital beds.
- Implementation of the Emergency Care Improvement Programme (ECIP) SAFER patient flow bundle on our medical wards. Establishment of a SAFER report at a ward level that will allow us to monitor impact of the bundle.

What are the results?

Discharge and Moving On Policy

A new 'Moving On' process, including an information pack, has been produced, based upon and adhering to the principles of a nationally recommended template. This was launched at Team Brief and promoted as part of the Every Hour Matters Week.

This process has now been included in an updated Moving On and Discharge Policy. Once ratified this document, along with all supporting patient information will be uploaded to the Trust intranet for use by staff. Its use and effectiveness will be audited as part of an annual audit programme.

Plans are also underway to include discharge planning as part of staff induction and mandatory training programmes.

Home First Approach

Progress on this area of work is dependent on several aspects of health and social care services coordinating their approach and adopting new ways of working.

From April 2017 there is a national requirement for commissioners to report on how many continuing health care assessments are undertaken outside of the hospital setting. As the majority of continuing healthcare assessments are still currently undertaken in hospital, there is now a drive to agree a new process for this. The nominated Discharge Group Lead for this work attends a West Yorkshire and Harrogate wide forum, and is working with North Yorkshire County Council (NYCC) to agree a pathway to support this assessment happening outside hospital.

Trusted Assessor Agreement

The nominated Discharge Group lead for this work will be attending a meeting between NHS England, NYCC and local care home representatives in April 2017 to agree the adoption of a trusted assessor role. Once agreement has been reached it is intended to pilot this approach for a 12 month period to assess its impact.

As part of the West Yorkshire Accelerator Zone (WYAZ) the A&E Delivery Board has submitted a funding request to support this pilot in 2017/18.

Review of Community Beds

Data is being monitored against the current criteria for community beds which are utilised for rehabilitation and intermediate care. Alternative models are being discussed with partner organisations to see if a more efficient use of these beds could be developed.

Every Hour Matters

The outcome of the Every Hour Matters Week is currently being written up and the learning from the event will be added to the Unplanned Care Transformation.

Summary

The success of the discharge project is reliant on all the partner organisations across the health and social care sector working together to agree and implement new models of working. It will also require a change in culture around discharge within the Trust and wider system that does not view hospital beds as a place of safety for those patients no longer requiring hospital treatment.

Whilst work to improve the policies, processes and patient information internal to HDFT is progressing, it is too soon to see the real impact on the number and duration of delays to discharge.

This work programme commenced in November 2016 and will be a quality priority for 2017/18.

3.4 Performance against indicators in the Single Oversight Framework

The following table demonstrates HDFT's performance against the national standards included in the Operational Performance Metrics section of NHS Improvement's Single Oversight Framework for each quarter in 2016/17.

Standard	Q1	Q2	Q3	Q4
RTT incomplete pathways	96.1%	95.1%	94.2%	94.1%
A&E 4-hour standard	95.4%	95.6%	93.8%	95.4%
Cancer - 62 days	89.6%	86.6%	92.5%	89.4%
Diagnostic waiting times	99.9%	99.9%	99.9%	99.8%

Table 43: Performance against indicators in the Single Oversight Framework

Key performance to note:

- The Trust achieved all four national standards included in the Operational Performance Metrics section of NHS Improvement's Single Oversight Framework in Q4.
- Overall Trust performance against the A&E (Emergency Department) 4-hour waiting time standard was above 95% for three of the four quarters during 2016/17. However, sustained delivery of this standard remained challenging over the winter period. The development and implementation of plans to enable the Trust to move back to a positive performance position continued throughout the year, including improved staffing deployment and requirements, co-location with the GP Out of Hours Service, and an improvement in the departmental physical clinical capacity.
- The Trust achieved the 18 week standard throughout the year. Recent audit has identified some minor errors in respect of the 18 week indicator. Whilst the effect of these errors has understated the Trust's performance, the findings nevertheless indicate deficiencies in the validity of data underpinning the reported performance for this indicator, and an action plan is in place to rectify this.
- There were eight ambulance handover delays of over 60 minutes reported in 2016/17 and 104 handover delays of over 30 minutes. Seven of the eight handover delays of over 60 minutes occurred in the winter period of the year when the department was under exceptional pressure. Emergency Department attendances were 2.2% higher than for the same period last year.
- Activity levels at the Trust have increased during 2016/17. Elective (waiting list) admissions were 1.6% higher in 2016/17 when compared to 2015/16 and Outpatient attendances also increased by 3.3%. Non-elective admissions increased by 4.8% and the number of avoidable admissions (as per the national Commissioning for Quality and Innovation definition) decreased by 2% over the same period.
- During 2016/17, there was a 6% increase in face to face contacts recorded by the adult community nursing teams; this is reflective of increased activity within these services.
- 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 below the 80% standard in 2016/17 with 78.4% of patients meeting the standard. Delivery of the transient ischaemic attack (TIA) standard was at 85% against the 60% national standard.
- The Trust reported 29 cases of hospital acquired *C. difficile* in 2016/17. Root cause analysis (RCA) results indicated that 23 of these cases were not due to lapses in care, and therefore, these would be discounted from the Trust's trajectory for 2016/17. One case is still under RCA consideration. No cases of hospital acquired MRSA (Methicillin-resistant Staphylococcus aureus) were reported in 2016/17.

3.5 Other Quality Information

HDFT has identified additional elements of service quality to highlight in this Quality Account.

3.5.1 National Inpatient Survey 2016

The results of the National Inpatient Survey 2016 for Trusts whose data is analysed by Picker were published in January 2017. The complete national results from the CQC are expected in May or June 2017

We had a response from 608 patients giving a response rate of 51.2% compared to an average response rate of 41%.

Compared to the 83 other Picker trusts, we were significantly better than average on 31 questions (up from 18 last year) and significantly worse than average on three questions. The three areas causing concern are:

- Hospital: patients using bath or shower area who shared it with opposite sex;
- Nurses: did not always know which nurse was in charge of care;
- Overall: not asked to give views on quality of care (this was also the question where we performed worse than average last year).

Compared to the 2015 survey, we performed significantly WORSE on one question - Planned admission: should have been admitted sooner. However our performance on this question is rated as the same as average for other Picker trusts.

We performed significantly BETTER than last year on five questions as follows:

- Hospital: food was fair or poor;
- Hospital: not offered a choice of food;
- Nurses: talked in front of patients as if they weren't there;
- Surgery: anaesthetist / other member of staff did not fully explain how would put to sleep or control pain;
- Discharge: staff did not discuss need for additional equipment or home adaptation.

Figure 33: Word cloud based on comments from patients who completed the HDFT 2016 National Inpatient Survey

Detailed analysis of the results identifies areas which are both in need of improvement and are most important to patients and provides a different way of looking at the results to see where improvement work could have the biggest impact on overall experience. This suggests that we should be focusing our resource on addressing the following indicators:

- Poor information about condition (Q37)
- Not enough privacy when examined (Q41)
- Slow response to call button (Q44)
- Could not find staff member to discuss concerns (Q38)
- Surgery risks and benefits not explained (Q46)

3.5.2 National Staff Survey 2016 and Staff Friends and Family Test

National Staff Survey 2016

The anonymous national survey was carried out among a sample of Trust staff between September and November 2016. 1,250 surveys were distributed to members of staff and 655 were completed. HDFT had the third highest response rate in the country for our benchmark category at 54%.The average return rate in the Combined Acute and Community Trusts category was 42%.

Results are presented in 32 key areas known as 'key findings' as well as a measure of overall staff engagement. The Trust scores above average (which is the highest rank possible in the category of Combined Acute and Community Trusts) in 22 out of 32 areas.

The figure below shows how the Trust compares with other Combined Acute and Community Trusts on an overall indicator of staff engagement. Possible scores range from one to five, with one indicating that staff are poorly engaged (with their work, their team and their trust) and five indicating that staff are highly engaged. The Trusts overall Staff Engagement score of 3.92 is ranked above average, and is rated the highest for overall staff engagement in all Trusts within the Yorkshire and Humber Region.

Staff Engagement

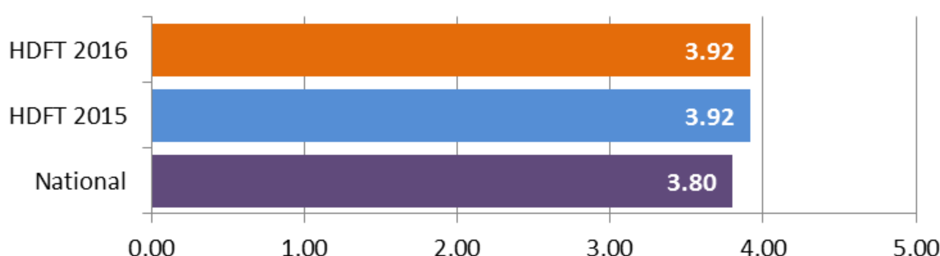


Figure 34: Staff engagement score for the National Staff Survey 2016

The top five scores for HDFT were as follows:

- Quality of non-mandatory training, learning or development (National average 4.07, HDFT 4.15);
- Staff agreeing that their role makes a difference to patients / service users (2015 90%, 2016 93%);
- Staff believing that the organisation provides equal opportunities for career progression or promotion (National average 87%, HDFT 92%);

- Staff satisfied with the opportunities for flexible working patterns (National average 51%, HDFT 57%);
- Staff confidence and security in reporting unsafe clinical practice (National average 3.68, HDFT 3.84).

Five areas for improvement were identified from last year's survey. All five of these areas have shown improvement in this year's survey.

Area for improvement	2015	2016
Staff satisfaction with the quality of work and care they are able to deliver	3.92	4.00
Quality of non-mandatory training, learning or development	4.01	4.15
Percentage of staff agreeing that their role makes a difference to patients / service users (*high result is good*)	90%	93%
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (*low result is good*)	17%	13%
Percentage of staff experiencing discrimination at work in the last 12 months (*low result is good*)	10%	7%

Table 44: Performance against previous areas for improvement

HDFT scored below average in two out of the 32 key findings:

- Percentage of staff reporting errors, near misses or incidents witnessed in the last month (National average 91%, HDFT 89%);
- Percentage of staff / colleagues reporting most recent experience of violence (National average 67%, HDFT 57%).

Three other areas were highlighted as areas for improvement in the report. These three areas are scored as average when compared with other Combined Acute and Community Trusts:

- Percentage of staff experiencing physical violence from staff in last 12 months;
- Percentage of staff feeling unwell due to work related stress in the last 12 months;
- Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months.

Regarding the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (National Staff Survey KF26) was at 22% versus 21% in 2015 however the Trust was still below the national average of 23%. The percentage believing that Trust provides equal opportunities for career progression or promotion (National Staff Survey KF21) was at 92% which was the same as last year and the national average is 87%. The full report can be found at http://www.nhsstaffsurveys.com/

Staff Friends and Family Test (FFT)

The staff FFT is a feedback tool for staff, predominately to support and influence local improvement work. It allows us to take a 'temperature check' on how staff are feeling and is a complementary engagement activity to the annual NHS Staff Survey. The staff FFT include the following two questions:

1. How likely are you to recommend the Trust to friends and family if they needed care or treatment?
2. How likely are you to recommend the Trust to friends and family as a place to work?

The staff FFT for quarter two 2016/17 was operated from 12 August 2016 to 9 September 2016 with 3,763 staff being invited to participate. There were 608 respondents which is the equivalent to a 15% response rate in comparison to a national average of 12%.

The results showed that 87.3% of staff would recommend the Trust to friends and family for the standard of care provided in comparison to a national average of 80%. 70.4% recommended the Trust as a place to work in comparison to a national average of 64%.

The survey provides the opportunity for staff to provide additional comments and the results are reviewed each quarter by the directorates to ensure continuous service development. The key reasons for the responses were due to the impact of perceived staff shortages and increased workloads, whilst the main reasons given for staff not recommending care or treatment at our Trust to family and friends were that their family and friends do not live in the area, and that recommendation would depend on the type of care or service needed as other hospitals specialise in certain treatments.

The Trust asked directorates to focus on three overarching issues and develop action plans around the following areas: Staff experiencing physical violence and discrimination, staff satisfaction with the quality of work and patient care they are able to deliver and the quality of non-mandatory training, learning or development.

By concentrating on these three areas a greater focus has been given to them and a consistent message to be shared. By communicating this information clearly staff have been assured that the Trust has understood their feedback and subsequent action is being taken.

The actions that the Trust has taken have been aligned to the actions for the staff survey.

3.5.3 Complaints and compliments

The Trust welcomes patient feedback including positive as well as negative experiences. Front line staff are encouraged and empowered to respond to patient feedback, receive compliments and resolve minor problems informally as quickly as possible. The Trust has a Making Experiences Count process and policy to resolve all concerns and complaints locally (within the Trust).

The Patient Experience Team (PET) facilitate the resolution of issues and this could include offering the opportunity of meeting with clinical staff, speaking with service managers or meeting the Medical Director and/or the Chief Nurse to discuss issues in more detail to help to address concerns and provide information and explanations. In all cases the feedback is reviewed to identify opportunities for improving patient care.

The Trust has an estimated 1.8 million patient contacts per annum, which equates to around 4,900 per day. Whilst every individual complaint is very important, especially to the complainant, the average rate of around 19 complaints per month in 2016/17 is relatively small and is similar to the average in 2015/16 (18 per month) but less than the average of 22 complaints per month for 2014/15.

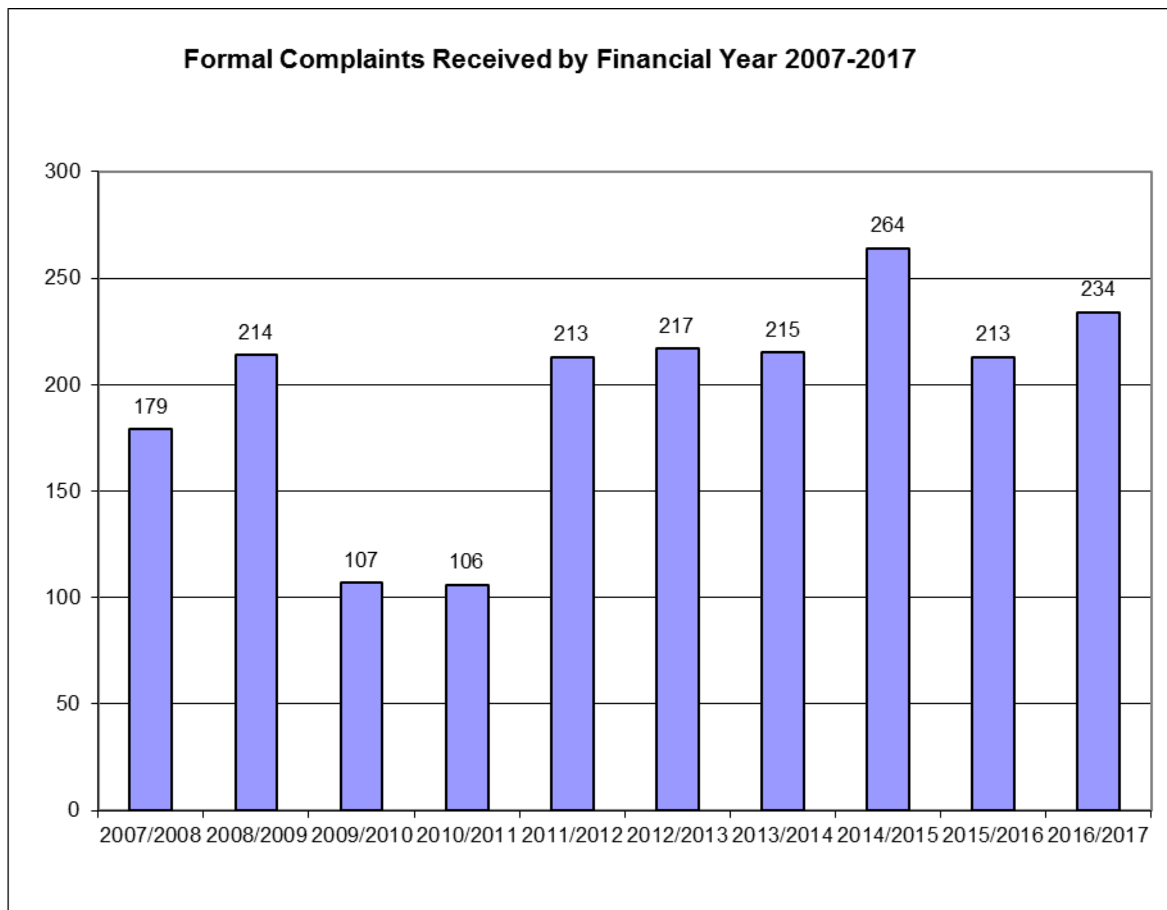


Figure 35: Local patient feedback data since 2007

Note: The data has been refreshed for previous years and the figures are different in 2011/12, 2012/13 and 2014/15 than previously reported.

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 uses a grading matrix for complaints raised, 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 2016/17 is presented below by grade and quarter in which it was received, compared to 2015/16.

Complaints	2015/16	2016/17				
	Total	Q1	Q2	Q3	Q4	Total
Complaint Green	66	18	15	11	11	55
Complaint Yellow	140	39	50	35	54	178
Complaint Amber	7	1	0	0	0	1
Complaint Red	0	0	0	0	0	0
Total	**213**	**58**	**65**	**46**	**65**	**234**

Table 45: Complaints data 2015/16 and 2016/17

The number of complaints received is more than the previous year and the number of cases indicating poor experience in several areas which are graded as moderate (yellow) or high (amber) is also higher than last year. Quarters 2 and 4 received the most numbers of complaints. The Trust is working to refocus efforts on resolving as many issues and concerns at the front line informally and as soon as possible to prevent the escalation into a formal complaint.

The resolution of informal "PALS" (Patient Advice and Liaison Service) type contacts includes concerns, information requests and comments. In total in 2016/17, 936 were received by the Patient Experience Team (PET) compared to 676 in 2014/15. Of these 936, 555 were concerns, 198 were requests for information and 183 were comments. The increase in cases dealt with informally demonstrates the ambition of all staff to address concerns before they escalate into more serious issues and the successfully signposting and publicity of the work of the PET to the general public.

The top five themes for complaints and concerns can be seen in the graph below. The main themes have consistently included issues around poor communication and attitude.

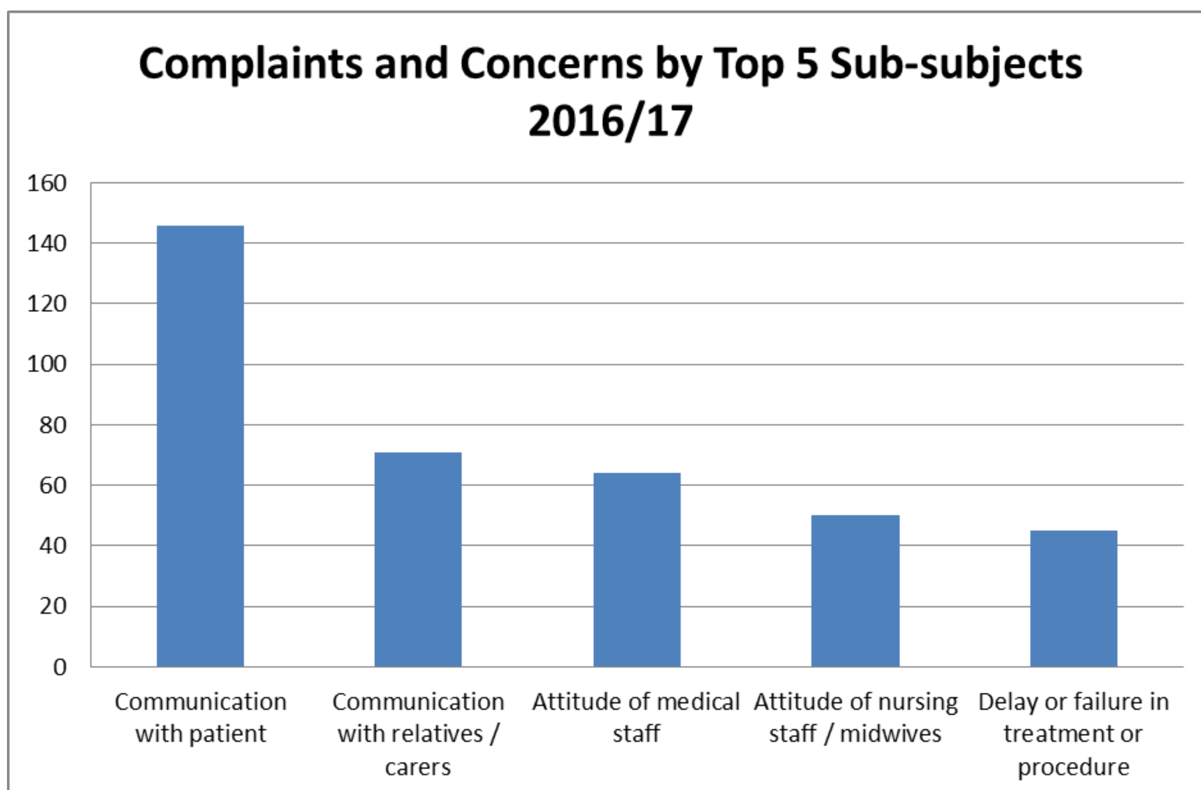


Figure 36: Local patient feedback data showing the main themes in complaints and concerns

The Trust investigates all complaints and concerns and provides appropriate feedback to the contact, after consent is established if the feedback is to a third party.

A lead investigator is expected to make early contact with the complainant to agree the issues being investigated, the method of resolution and timeframe for reply based upon the Trust's grading matrix. The investigation focuses on what happened, what should have happened and where appropriate, what the actions will be to prevent it from happening again. The investigation is then quality assured by the operational director or clinical lead for the area to determine whether the investigation and response is robust and whether the issues complained about have been upheld. It should be noted that not all complaints or concerns received are upheld.

Response timeframes for complaints are guided by the severity of the case and are agreed at the outset. The Trust introduced a complaints performance metric in 2016/17 which includes monitoring of complaints responses against a target of 95% within deadline set and monitoring of completion of action plans. The Trust met the defined timescale for reply in 35% of cases in 2016/17 and sought extensions where the deadline could not be reached. This is a drop from 52% in 2015/16.

The Trust is keen to improve this performance next year and this is being monitored closely on a quarterly basis.

Action plans are developed to improve patient care as a result of feedback and these are monitored regularly. Learning from patient feedback is at the heart of our Making Experiences Count Policy, and clinical directorates share themes and learning from these via their governance groups and front line quality of care teams. In 2017/18 a new quality improvement priority is being introduced around learning from complaints and incidents. This will focus attention on ensuring changes are made and embedded to improve services and prevent the same issues arising again.

Five cases were referred to the Health Service Ombudsman in 2016/17, which is the same as 2015/16. Of the five cases referred this current financial year:

- Three cases are currently under investigation;
- One has been investigated and found to be not upheld;
- In one case after an initial review of the case the Ombudsman decided not to proceed to investigation as considered the Trust's investigation and response to be robust.

In 2015/16 the Ombudsman investigated four cases and out of these three were found to be not upheld and one partially upheld. In one case the Ombudsman decided not to investigate following the initial review of the file.

Cloverleaf Advocacy Services (Independent Health Complaints Advocacy Service) is an organisation that provides support (known as advocacy services) to help people across the North of England to speak up and express their views, and help services to listen to and learn from people who use their services. During 2016/17 representatives from Cloverleaf Advocacy Services met with colleagues from the Trust including the Patient Experience Team to review frameworks for communication and to promote the model of advocacy services. The Trust continues to promote the advocacy services that are available for supporting complaints and patient feedback.

Compliments are received at ward and team level, by the Patient Experience Team and reported in the local media.

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Compliments received by the Patient Experience Team	354	354	291	330	315	340	325

Table 46: Local data showing compliments received by the Patient Experience Team

3.5.4 The Patient Voice Group

The Patient Voice Group (PVG) is an independent group of volunteers who work in partnership with the Trust. Our purpose is to listen to patients and relatives experiences of using HDFT services and communicate these in a meaningful way to managers, so that the quality of patient care continues to improve.

The workload of the PVG is based on the domains set by the CQC around safety, the patient experience, dignity and respect, communications and the flow of the patient journey through the different services including plans to go home. This provides opportunities to share excellent practice and also learn where improvements could be made. We do not want to appear a threat to hard working staff but to work with them. We do this by talking to patients and relatives at the most appropriate time, on the wards, at home or by telephone.

2016 has been a busy year visiting;

- Eight wards;
- Six Community Nurse Teams;
- Ophthalmology clinics in the hospital and a GP surgery;
- Three Cardiology clinics;
- Two Diabetes clinics and an education session.

We have also been following up our report on the Children's and Young People's Project.

It has become increasingly difficult to talk to patients in hospital as they are very poorly and vulnerable and we continue to investigate different ways of collating honest feedback.

The PVG findings (patients' and relatives comments and our observations) are presented at the Learning from Patient Experience Group to promote discussion among managers and staff. Responses from HDFT have included;

- Managers have thanked the PVG for the positive findings e.g. patient care and staff kindness;
- Actions have been put in place to improve the patient experience e.g. Volunteers to provide activities for patients;
- Reminders that sometimes what is thought to be embedded e.g. staff introductions and explanations to patients need addressing.

The majority of patients and relatives are very appreciative of the excellent care received and kindness shown by staff. The negative comments received are about staff being very busy and not having time to talk; patients are not aware or involved in their treatment plans; discharges are often delayed; appointments are not flexible and problems with car parking.

It is a continuous challenge to find the most appropriate time to talk to patients. The PVG will be 'befriending' areas to collate more information over time during 2017. The PVG need to raise their awareness within the Trust.

Improvements need to be made to ensure PVG papers are responded to, therefore contributing to the improvement of the patient experience through the Learning from Patient Experience Group.

3.5.5 Clinical Transformation Programme

The aim of the Clinical Transformation Programme is to: "Achieve best care for the people who receive care and treatment from Harrogate and District NHS Foundation Trust, whilst at the same time realise financial savings with improved systems and controls". The objectives are to:

- Work with our Health and Social Care partners so that people receive the right care, at the right time from the right service;
- Utilise the latest technologies to provide efficient, effective and safe patient care;
- Adopt best practices to ensure that people only stay in hospital for as long as they need to;
- Provide our staff with the skills, tools and resources to provide the very best in patient centred care;
- Ensure that the patient is at the heart of any transformational change programme.

What were we aiming to achieve?

As reported in the 2015/16 Quality Account, the Clinical Transformation Programme has four workstreams which encompass a number of projects. The Programme has successfully achieved its ambition of generating £1m in cost improvements for 2016/17. For the period 2017/18 the Programme seeks to realise £3m in cost improvements; this would take HDFT another step forward in achieving its overall target of £25m in cost improvements by 2020.

What have we done?

In addition to cost improvements, the Programme has achieved the following:

- In accordance with the national A&E Improvement Plan, the GP out-of-hours service has been co-located with Harrogate District Hospital's ED, and the ED clinical space has been expanded by 50%. This ensures that patients are appropriately triaged, and where possible, avoid admission into hospital.
- The outsourcing of printing and posting of patient letters has been implemented across a number of areas. As well as financial savings, this has improved the quality of information contained within the letter, and for those patients in the eye clinic, larger fonts are used. This project is being rolled out across the rest of the organisation, and there is scope to identify patients with individual requirements to receive the letters in an agreed format.
- The Health and Wellbeing Project has seen a reduction in sickness absence from 4.28% at the beginning of the financial year to 3.80% July 2016. In addition, spend on NHS Professionals nursing staff to cover sickness absence in the first six months of 2016/17 had reduced by 11% compared to the same period in 2015/16.
- The successful delivery of the Leadership and Management Development project has progressed to the development of a Clinical Workforce Strategy. This will place the Trust in a strong position to respond to growing workforce gaps, reduce the proportion of spend on temporary staffing, and meet the changing needs of local patients.
- Following a review of overtime and additional hours worked by staff in clinical areas, the Workforce Redesign and Reward project identified that hours were owed by staff as a result of incorrect rostering. Work is ongoing with wards and department managers to arrange for these hours to be worked or paid back to the Trust.

Summary

Building upon the success of 2016/17, a number of the existing projects within the Clinical Transformation Programme have evolved into projects with broader scopes and some are new transformational projects for 2017/18. Each workstream has access to dedicated Programme and Project Management support, provided by the Programme Management Office. The investment by HDFT into a dedicated resource for these schemes reflects the organisations ambition, to implement real and sustainable change that is responsive to the future challenges and opportunities that face the NHS.

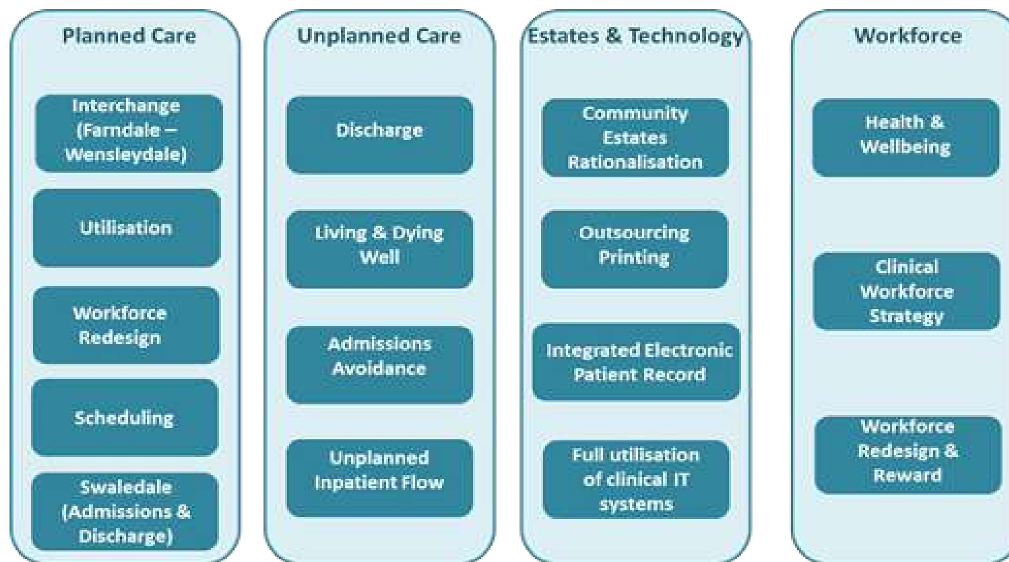


Figure 37: Clinical Transformation Programme work streams

3.5.6 Rapid process improvement activity

More than 80% of our improvement activity is now focused on supporting the delivery of the Clinical Transformation Programme described above. Remaining capacity is deployed reactively to tackle any emerging issues and risks. Examples of improvement activities are below:

Reducing Risk of Missed Appointments in Maternity Services

In November 2016, three improvement workshops were delivered to tackle an emerging risk in Maternity Services to mothers and their unborn children, of women missing appointments on their antenatal care pathway. Work continues on patching together a short-term IT solution that works across various existing systems in place at Harrogate Hospital, GP surgeries and other clinic venues. A campaign to raise awareness of the importance of attending every appointment has started, the pathway personalised and simplified and the self-referral process has been made more accessible. The project sponsor and Clinical Director has publicly stated her confidence that the actions planned will mitigate the risk described.

At the 90 day report in mid-March, encouraging progress was seen in a number of areas:

- Self-referral form drafted;
- Awareness-raising poster and social media campaign implemented;
- GPs engaged in discussion about planned change;
- Improvements to the way midwives can book appointments in place;
- Appointment tracking tool drafted;
- Key information standardised.

But difficulties in putting in place an IT solution for booking appointments and tracking women's progress through the antenatal pathway are causing some delay. This is due to the challenge of finding a solution that works as well for GP practices as it does for pregnant women, midwives and consultants. Troubleshooting activity was planned for April 2017 before further review with the project sponsor.

Prostate Cancer Pathway

The purpose of the Prostate Cancer Pathway improvement workshop was to reduce the lead times for the prostate cancer pathway. The workshop achieved some excellent outcomes:

- The target was to see if the time it takes for referral to regional centre could be reduced to an average of 35 days, and in fact the target was exceeded and the pathway reduced to average of 27 days;
- Overall, 95% of referrals were made in 38 days, against a baseline of 90%;
- 75% of referrals to HDFT were seen within seven days against a baseline of 42.6%;
- 100% of patients received timely and relevant information about the pathway of treatment that they were on.

Photo 7: "How can we remove another two hours from this prostate cancer pathway?"

These performance improvements would not have been possible without strong and positive engagement between Urology and Radiology colleagues to make significant changes to the way that prostate patients are managed in relation to the scan(s) that these patients need.

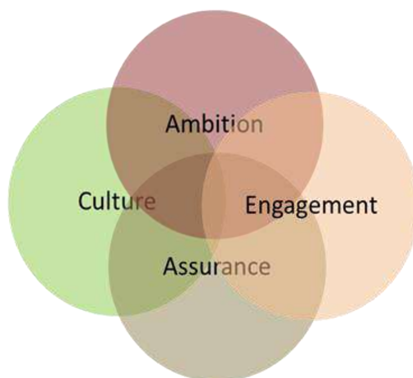
This project was delivered in June 2016 and in common with all our rapid improvement workshops, will be followed up 365 days later to ensure that improvement gains remain secure.

3.5.7 Quality Charter

The HDFT Quality Charter has been developed as part of our commitment to:

- Reward and recognise our colleagues who carry out improvement activities;
- Celebrate the everyday successes that our colleagues achieve.

The charter has been built on four 'joining' elements and we have set specific actions for each of the elements:



1. Setting our **ambition** for quality and safety
2. Promoting staff **engagement**
3. Providing **assurance** on care quality
4. Supporting a positive **culture**

The purpose of the charter is to build on the longstanding and excellent reputation we already have for the quality of care we provide. Several schemes are being progressed to facilitate the delivery of the charter, across the above four domains. These include:

- Colleague recognition schemes
  - Chairman and Chief Executive's Making a Difference Awards and Team of the Month Award.
  - Quality of Care Champions.

- Corporate approach
  - Annual Quality Conference.
  - Continued targeted campaigns relating to quality improvement e.g. falls, pressure ulcers and pain management.

Each of these schemes has been brought together under a distinct sub-brand, which echoes key design elements of the corporate values brand. This helps to reinforce the connection between the two in colleagues' perception of our Quality Charter schemes.

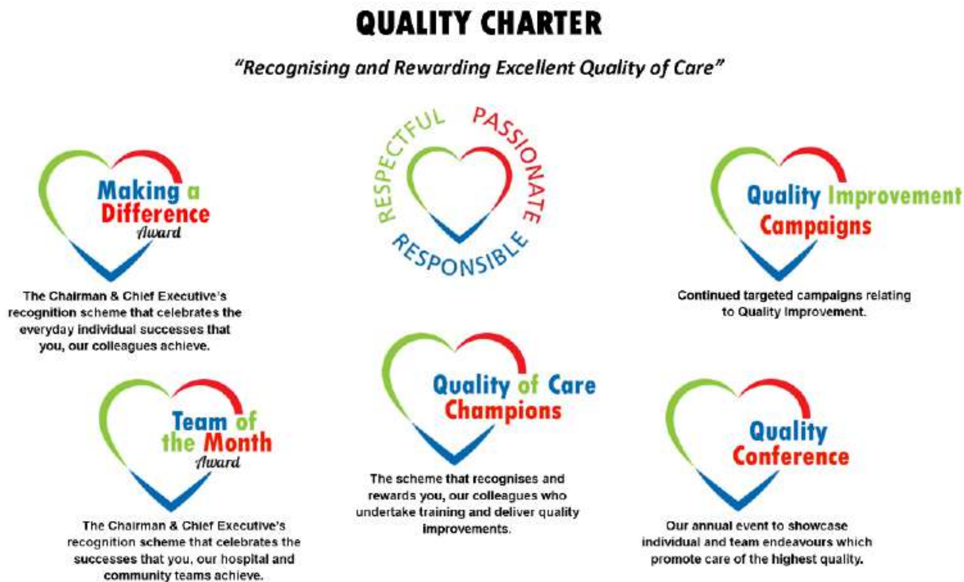


Figure 38: HDFT Quality Charter sub-brand

What have we done?

1. Making a Difference / Team of the Month Award

The Making a Difference Award was launched in July 2016 and the Team of the Month Award in August 2016.

Making a Difference Award is a recognition scheme that celebrates the everyday successes that our colleagues achieve. The awards are open to all colleagues across HDFT, who have worked or taken action in a way which goes above and beyond their usual role, and embodies:

- The Trust values:
  Respectful, Passionate, Responsible;
- Going the extra mile;
- Making a difference.

There are no categories and no limits on the number of awards. Colleagues can be nominated via their peers, leaders, directorates, patients, family and friends as well as external partners. The award includes an individual token of thanks for each successful recipient as well as a certificate and branded glass coaster. The nomination process is really simple and there is no formal application form since any supportive communication or note will suffice.

Team of the Month awards are for teams of two or more staff and are judged against the same criteria as above. The only difference being that these awards are competitive as only one team can win each month.

Dedicated intranet and internet pages have been set up for both award schemes with photos of the recipients with their awards. Details of why they were nominated are published on the internet page.

Twitter is being used to promote the scheme and celebrate our colleagues' achievements.

Figure 39: Making a Difference award promoted on HDFT Twitter account

2. <u>Quality of Care Champions</u>

This scheme was formally launched in November 2016 and will help to further improve quality of care for patients who use our services, supporting personal and professional development. Anyone can participate in this scheme, regardless of job role and place of work.

There are four levels of Quality of Care Champion. At each level there will be two components: training and action:

- Bronze (Preparing) – Accreditation as a Quality of Care Champion at Bronze level requires completion of a short online course and the proposal of an improvement project (delivered within the candidate's own team).
- Silver (Delivery) – Accreditation as a Quality of Care Champion at Silver level requires completion of a day-long face-to-face training session and delivery and completion of an improvement project.
- Gold (Teaching) – Accreditation as a Quality of Care Champion at Gold level requires completion of a two day-long face-to-face training course, and candidates will also personally support at least one project successfully with evidence of impact and/or shared learning.
- Platinum (Excellence) – Accreditation as a Quality of Care Champion at Platinum Level requires completion of the Lean Improvement Workshop Leader Training Programme based on the North East Transformation System (NETS). Trainee workshop leaders receive five days of initial training. This is followed by an assessment of candidates' suitability to progress to the practical part of the learning where candidates lead two rapid process improvement workshops (on behalf of the Trust) whilst being coached by a trained workshop leader.

Each level is meant to follow on from the next, although evidence of equivalent training and action may be considered where colleagues are already at a higher level than Bronze.

The scheme incentivises personal and professional development; therefore colleagues who may not wish to progress onto the next level should be committed to delivering improvements on a regular basis at the level that they are already performing at in order to gain accreditation.

Quality of Care Champions receive a complementary pin badge colour coordinated to their level of achievement.

Figure 40: Quality of Care Champions pin badges

Again, a dedicated intranet page was set up for this scheme with details and acknowledgement of our accredited champions. Twitter is being used to promote the scheme and celebrate our colleagues' achievements.

3. Quality Conference

The Trust's first multi-disciplinary Quality Conference is aimed at our own workforce and is open to colleagues across all job roles. The objective is to share knowledge, experience and skills; provide learning in relation to quality improvement, clinical audit, service evaluation and research; and to provide opportunities for the adoption of good practice. A multi-disciplinary advisory group has been set up to advise on and deliver the conference, which will be held on 14 June 2017.

We have set a target of engaging with around 150 staff, including via web-conferencing at confirmed satellite venues in Northallerton, Ferryhill (County Durham) and Scarborough.

A communications plan has been developed and will continue to be rolled out until the delivery of the conference. This includes updates in the Staff Bulletin and Team Brief. Twitter is also being used to promote the conference.

4. Quality Improvement Campaigns

The Quality Charter contains a clear ambition to deliver further targeted campaigns relating to quality improvement (e.g. falls, pressure ulcers and pain management).

The first campaign will be "Hammer Down Haemolysis". It will seek to change the behaviour of all staff who take blood from patients, with the aim of reducing the number of haemolysed samples that the laboratory processes. A draft campaign plan is in place, supportive key delivery partners have been identified, and a task and finish group established.

What are the results?

Since the launch of each element of the Quality Charter there have been:

- 70 nominations received for the Making a Difference Award;
- 35 nominations received for the Team of the Month Award;
- A total of 105 nominations against an overall target of 72, by 31 March 2017.

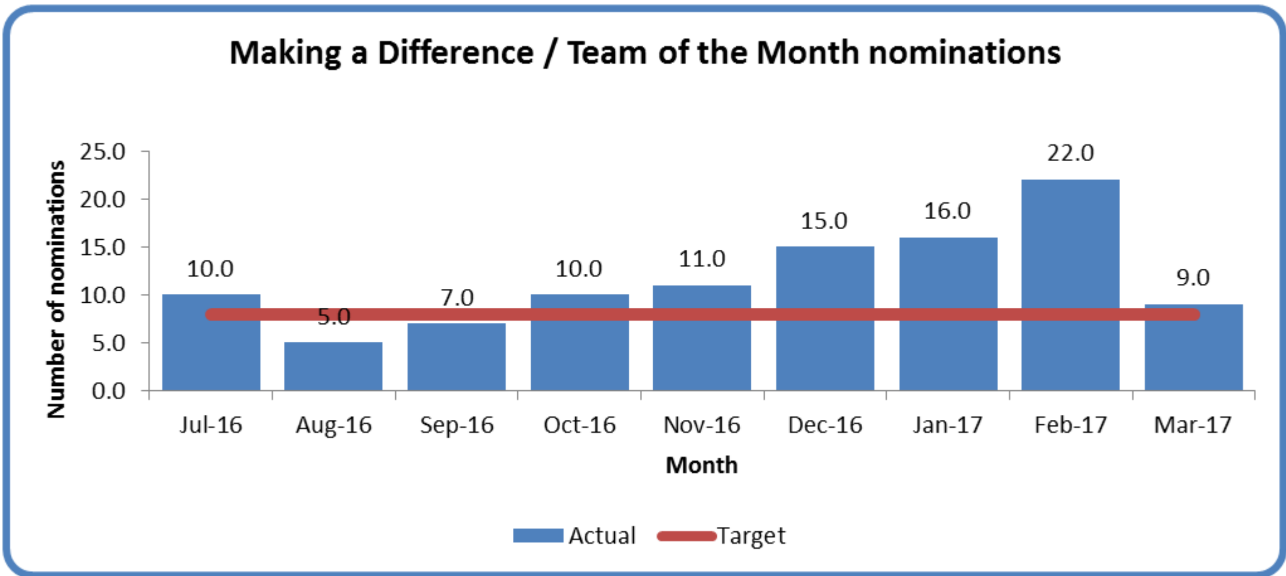


Figure 41: Making a Difference and Team of the Month nominations

The number of Quality of Care Champions accredited at Bronze level since formal launch in November 2016 is 26, against a target of 45 by 31 March 2017. There are a number of colleagues who are working towards the Silver, Gold and Platinum levels of the scheme.

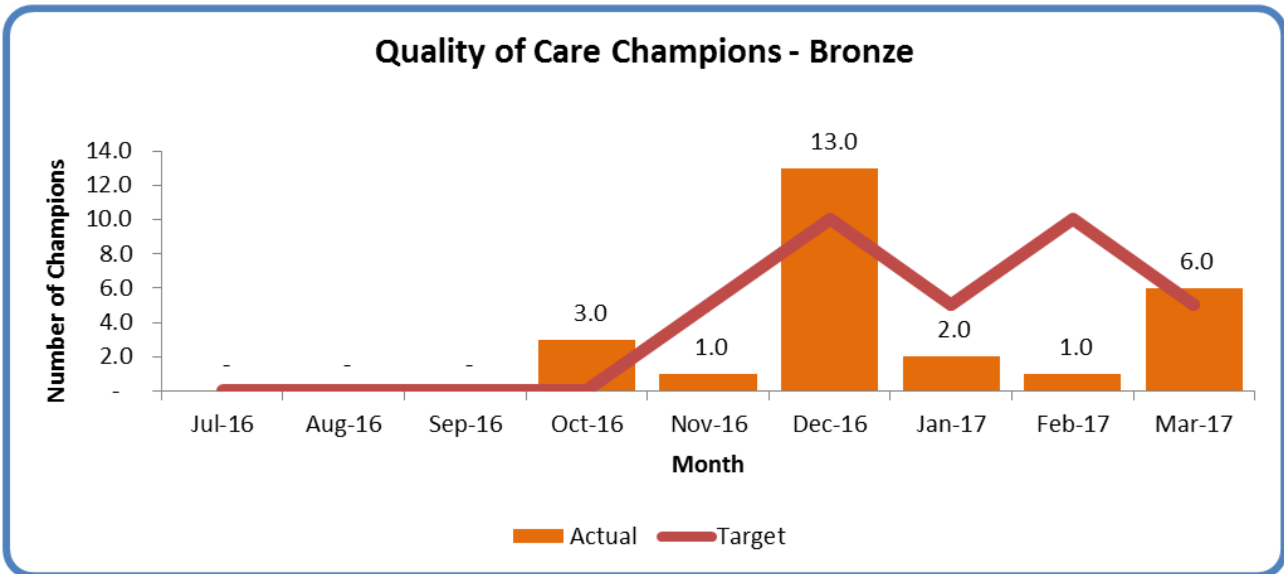


Figure 42: Overall accredited Quality of Care Champions at Bronze level

Since 1st July 2016, followers of the @HDFT_Innovation account have increased by 71% to 364.

Summary

After a strong start, further rollout of the Quality Charter will require sustained staff engagement and continued investment in the approach. In terms of securing cultural change, we know that the Quality of Care Champion scheme is pivotal. A greater focus on promoting this in order to increase the number of champions will be needed next year. This will be possible as the Making a Difference and Team of the Month schemes begin to gather a momentum of their own.

3.5.8 Volunteers

Volunteers continue to play an active and very valuable part in the delivery of patient services throughout the Trust. We currently have over 560 volunteers from all walks of life who give of their time to contribute to the patient experience, on average giving over 2,000 hours per month. Our youngest volunteer is 16 years of age and our oldest is in his 90s, all bringing their own incredible sets of skills, enthusiasm and life experiences.

Volunteers are based at Harrogate District Hospital, Ripon Community Hospital and also at various community sites in Northallerton and Scarborough. In April of 2016 with the acquisition of Community Children's Services we welcomed 75 breast feeding support volunteers from the Durham, Darlington and Middlesbrough areas. All mums themselves, along with trained staff, they help support and encourage new mums with breast feeding issues.

Volunteers help in so many ways including:

- Meal time volunteers assisting patients with their lunch and evening meals;
- Meeting and greeting in reception and outpatient clinics;
- Tea time preparation volunteers who help prepare patients for their evening meals by ensuring their hands and tables are clean;
- Gardening volunteers;
- Complementary therapy volunteers;
- Volunteer art therapist;
- Meeting and greeting, administration, information and clinical unit volunteers all for the Sir Robert Ogden Macmillan Centre;
- Chaplaincy volunteers;
- Volunteer drivers for patients living in Nidderdale;
- Hospital Radio;
- Administration volunteers in various departments;
- Maternity volunteers;
- Volunteers helping to conduct audits and surveys throughout the Trust;
- Assisting at the annual Open Event and at Medicine for Members lectures.

Photo 8: Just some of our volunteers!

Our visiting Therapy Dogs continue to provide many smiles to both patients and staff and are always a very welcome sight on the wards.

New roles have been developed at Ripon Community Hospital, and we currently have six sixth form volunteers who go in each afternoon to provide activities and musical entertainment for patients. A craft volunteer also visits once a week. A volunteer is also assisting in a reception style role for the Minor Injuries Unit a couple of evenings per week.

Once again, volunteers were thanked officially for all their support at the annual "Celebration of Volunteering" in December 2016. Afternoon tea, guest speakers and musical entertainment was on offer, and long service awards were presented.

3.5.9 Speech and Language Therapy

We have agreed a contract until 2020 to continue and expand this service in partnership with North Yorkshire County Council (NYCC) with an additional focus on working with young people with social, emotional and mental health needs and care leavers.

This three year project, funded by NYCC since November 2013, is a radical approach to working with young people with multiple vulnerabilities aged from 11-25 years old. The speech and language therapists (SLT) are employed by HDFT. The first year of the project focused on setting up a service for young people who are involved in the Youth Justice Service. The second year expanded to include those young people who were attending specialist educational provision in two schools in Harrogate and at Brompton Hall School, Scarborough. The team were also tasked to start training for the staff in the Pupil Referral Services and to give more intensive input to four Pupil Referral Services.

The second year also involved an extension to the contract to provide services to the No Wrong Door (NWD) project adding further staff to the Youth Communication Team. These 'Communication Support Workers' are co-located in the East and West NWD hubs in North Yorkshire but also work closely as part of the whole North Yorkshire Youth Communication Team. This model has ensured consistency of approach and avoided duplication when young people are involved with the Youth Justice Service and the NWD project.

The aim of the Youth Communication Team is that young people with speech, language and communication needs (SLCN) will be identified earlier, in order to increase their ability to be involved in decision making about their lives and be able to become involved in education and work and thus preventing them from becoming disengaged and involved in offending behaviour.

Youth Justice Service

Of the 320 young people in the Youth Justice Service screened over three years from December 2013 to December 2016, 149 have been identified as having SLCN. 91% of this cohort was not previously identified as having SLCN.

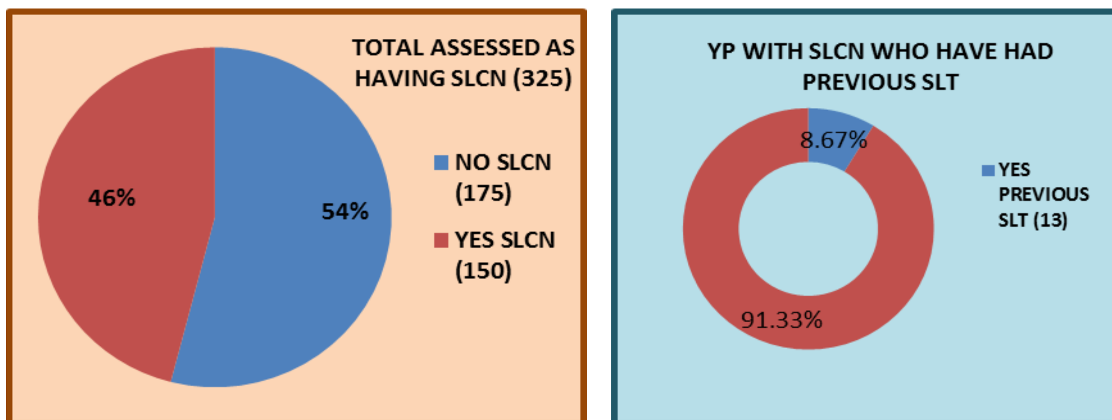


Figure 43 & 44: Young people in the Youth Justice Service with SLCN

Assessments have identified poor comprehension, difficulties managing conversation, memory and processing difficulties. These can all have a huge impact on the young person's ability to be involved in relationships, education and work. Once SLCN have been identified, some examples of interventions are as follows:

- Strategies for the young person to improve their understanding, memory and vocabulary;
- Support regarding autism spectrum condition;
- Advice given to parents, schools and other provision;
- Identification and referral on to other services such as to services regarding brain injury, learning disability etc.;
- Contribution to reports e.g. pre-sentence report;
- Provision of advice regarding vocabulary used and visual cues to support understanding e.g. sexual harm prohibition order; reworded police acceptable behaviour contract.

Specialist Educational Provision and Pupil Referral Services

For the two specialist schools for children with social, emotional and mental health (SEMH) needs and the selected Pupil Referral Services, the team followed this procedure:

- Screening for speech, language and communication needs;
- Communication reports completed for each student and referral on to others if relevant;
- Speech, language communication framework completed by staff;
- Whole school staff training on general communication strategies;
- Communication champions training for selected staff;
- Advice on classroom and corridor communication friendly environments and resources.

66%-88% of the young people screened in the two schools were identified as having SLCN.
The overall percentage of young people identified with SLCN ranged from 25% in one PRS to 50%-70% in the other three Pupil Referral Services.

No Wrong Door

The No Wrong Door (NWD) service is an innovative model providing care to young people who are in care or on the edge of care. The model enables young people to access the right services at the right time and ultimately aims to support achievement, reduce high risk behaviour and to ensure that young people in crisis receive well organised and appropriate support. The service covers all of North Yorkshire and is split into two hubs (East and West of the county). Within NWD there are two communication support workers (CSWs) who are qualified speech and language therapists. They are co-located in the East and West NWD hubs in North Yorkshire providing an embedded service to the young people in residential care and an outreach service to the other young people known to NWD. CSWs within the NWD model have actively steered away from the more formal title of speech and language therapists to a less formal and more user-friendly one.

The benefits of working in a hub-based multi-disciplinary team have been multi-faceted and include:

- Easy access for young people to CSW and vice versa;
- No discharges for ‘failing to attend’;
- No need for formal appointments;
- On-site sharing of up-to-date and relevant information regarding young people;
- Building meaningful relationships with young people in a home environment; and
- Easy on-going referrals to other services on-site (e.g. Life coaches).

The role of the CSW is to assess all young people known to NWD and identify those who may have speech language and communication needs. Of these young people the proportion with identified SLCNs is 55%. This was found to increase further if the young people were looked after, with 67% having an SLCN. If an SLCN is identified the CSW will provide:

- Advice to staff, schools, family etc. regarding needs and on maximising communication;
- Direct therapy where appropriate;
- On-going referral to other services as required, such as autism referrals;
- Communication strategies for both the key worker talking to the young person and for the young person to talk to others;
- An environment that is supportive to the communication needs of the young person;
- Training to develop skills in the workforce in identifying and meeting the communication needs of the young person.

The CSWs have been training staff to be more aware about how communication difficulties may present and strategies to use to promote effective communication with young people. CSWs also contribute to case discussion meetings which review the progress of young people referred to the NWD outreach services. Also in attendance at these meetings are the clinical psychologist, police liaison officer, NWD outreach deputy manager and the young person's NWD key worker. Communication issues are discussed in these meetings and communication advice is given to the key workers for use in their outreach sessions. Formal training sessions have continued in team meetings and clinical case discussions take place with the hub workers.

A communication checklist that staff can use with the young people has been developed to be used as a tool to identify communication difficulties and then make onward referrals to speech and language therapy.

3.5.10 Cancer Services

The quality of our cancer services continues to be a significant priority for the Trust. Each year we build upon previous years' achievements. Since the opening of our Sir Robert Ogden Macmillan Centre (SROMC) in March 2014 we have continued to focus upon redesign and improvement of our services. In 2015 we published our Cancer Strategy for 2015-20 which was developed with colleagues across all specialities and with our commissioners. It reflects the Cancer Task Force publication Achieving World-Class Cancer Outcomes: A Strategy for England 2015-20, and describes how we plan to develop our cancer services locally in line with national direction.

Photo 9: The Sir Robert Ogden Macmillan Centre

What were we aiming to achieve?

The key priority areas for cancer services in 2016/17 were to:

- Review our clinical pathways to reduce timescales for diagnosis and treatment;
- Enhance consultant oncologist and nursing provision;
- Implement the 'recovery package';
- Continue to grow our Health and Wellbeing service.

What have we done?

Review of clinical pathways

In summer 2016 we utilised service improvement methodology to completely redesign our clinical pathway for investigation of patients referred with suspected prostate cancer. The revised pathway came into effect in July 2016. The revised pathway now ensures patients have an MRI scan days before their prostate biopsy which enables a more targeted biopsy and reducing the number of patients who require a repeat biopsy.

The overall benefits have been:

- Reduction in the time from referral to diagnosis;
- Reduction in the time from referral to treatment;
- Reduction the number of repeat biopsies required;
- Removal of unnecessary multi-disciplinary team (MDT) discussions per patient;
- Reduction in the number of patient attendances between investigations.

Enhance consultant oncologist and nursing provision

As numbers of diagnosed cancers continue to grow and options for treatment and lines of subsequent treatments continue to expand so does the need for more oncologist and nurse time. We have appointed an additional nurse specialist within Haematology and following the successful bid to Macmillan Cancer Support in 2015 we have appointed an additional nurse specialist post in the Urology service.

Our care coordinators in Gastrointestinal and Haematology have continued to develop and provide many aspects of frontline support and information to patients. This has freed up specialist nursing time for more complex patient needs and increased the number of patients who can be supported.

A key priority is the need to recruit an additional oncologist. This has proved challenging and despite three attempts at recruitment there have not been any suitable candidates. This is a challenge nationally with fewer than 50% vacant consultant posts recruited to. We are working with our alliance colleagues in York and Leeds to review our approach to consultant roles and how we can maximise the opportunities to recruit. In addition we will be reviewing our oncology workforce to consider how other roles can ensure most effective use of specialised services.

The impact has been that we have been unable to take forward our aspirations to treat more patients locally who currently go to Leeds i.e. patients having chemotherapy for ovarian cancer.

Implementation of the recovery package

The recovery package is a key recommendation within the National Cancer Strategy with a national commitment that every person should have access to elements of the recovery package by 2020. It has four main interventions: Holistic needs assessment and care planning; Treatment summary; Cancer care review; and Health and wellbeing events. All except the cancer care review are

conducted within secondary care services. The cancer care review is conducted within primary care by either the patient's GP or practice nurse.

1. Holistic needs assessments

Holistic needs assessments have taken place within cancer for many years. However the introduction of electronic holistic needs assessment (eHNA) has increased the focus upon ensuring patient centred care plans are developed. This involves the use of a computerised tablet whereby the patient completes a questionnaire which identifies their main concerns. The clinical nurse specialist then uses this information to develop a care plan to meet the identified needs. Our gastrointestinal nursing team was the first to implement this and it is now firmly embedded in their practice.

The picture below is a screenshot from the eHNA system. This screen provides a summary of the assessments undertaken and the number of reported problems identified by patients. This level of information also helps us to understand the types of problems experienced by patients as a whole and how we can plan to address at service level in addition to the individual patient approach.

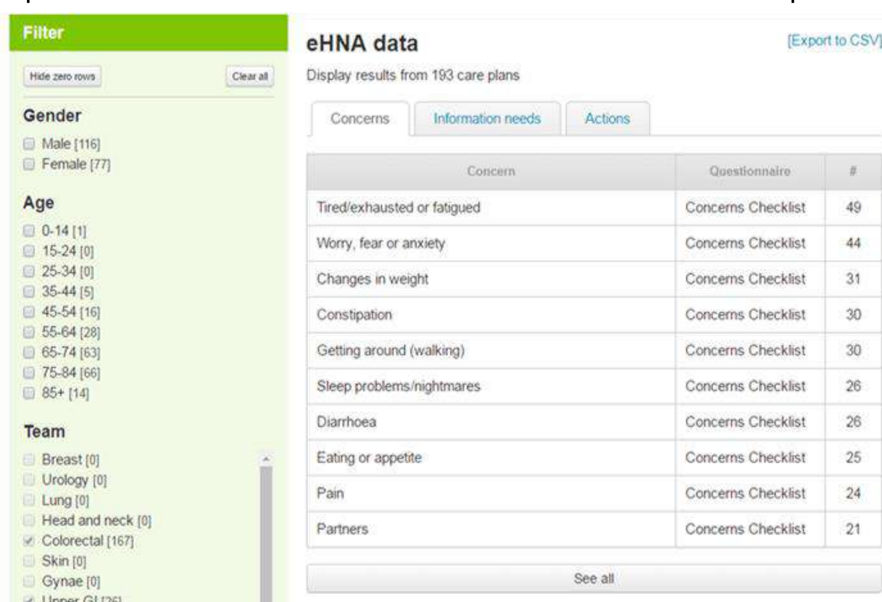


Figure 45: Screenshot from the eHNA system

The new model is now being rolled out to other sites and will continue to be a priority in 2017/18.

2. Treatment summary

Following completion of treatment the importance of ensuring patients understand any lasting consequences or side effects of treatment, warning signs of potential recurrence, how to access timely advice and support and understanding the plan for their continued follow up is important.

3. Health and wellbeing events

Following a successful bid to Macmillan we appointed an experience cancer specialist nurse and administrative support to develop health and wellbeing events within the SROMC.

These are group events for patients who have completed treatment and may be discharged earlier from traditional cancer follow up. Patients are risk stratified in MDT meetings as to whether they are suitable for low risk follow up and therefore attend a health and wellbeing event and only return to hospital thereafter for pre-identified imaging and blood tests.

The health and wellbeing event focuses on any lasting impact of their cancer treatment, promoting self-management and new healthy lifestyles, with a view to both maximising their recovery from cancer and reducing risks of other lifestyle associated health problems. These have been successful in breast and colorectal cancers and are now being explored for roll out in other sites.

Implementing these aspects of the recovery package has had the additional benefit of being able to safely and confidently implement risk stratification into our follow up practice within breast and colorectal cancer. We have redefined our follow up pathways to streamline and ensure evidence based reasoning behind interventions. This has resulted in reduced numbers of formal outpatient attendances and therefore releasing capacity for new patients being referred with suspected cancer.

Sir Robert Ogden Macmillan Centre Health and Wellbeing Service

There are approximately 500 newly diagnosed cancer patients referred to the SROMC chemotherapy unit each year. Patients have access to the range of services described below.

A library of cancer information books suitable for children was created in the final quarter of 2016. Ten of the 21 books in stock have been lent for use during that time.

The Trust website has been redesigned this year and the SROMC now has its own page. All the patient information leaflets and information about health and wellbeing services are now available at https://www.hdft.nhs.uk/services/cancer-services/sromc/. SROMC information and support services are also accessible via the website for Macmillan Cancer Support at www.macmillan.org. Information is also available via the SROMC Facebook page, which is also linked to the HDFT and Macmillan Cancer Support Twitter and Facebook pages.
https://www.facebook.com/SROMCHarrogate/

The Macmillan Welfare and Benefits Service

The Macmillan Welfare Benefit Adviser continues to operate a high quality flexible and easily accessible service, and has maintained the provision of invaluable support for patients and carers affected by a cancer diagnosis living within the Harrogate and rural district community.

Service Activity	Activity in 2015	Activity in 2016	Increase in activity
Numbers of new referrals	**404**	**415**	**2.7%**
Total claimed in annualised benefits	**£1,517,588.00**	**£1,404,215.00**	**- 7%**
Total in backdated benefit arrears claimed	**£67,024.00**	**£214,319.00**	**219%**
Total of Macmillan grants claimed	**£13,400.00**	**£16,630.00**	**24%**
Other charitable grants	**£3,336.00**	**£4,250.00**	**27%**

Table 47: The Macmillan Welfare and Benefits Service

It should be noted that only the numbers of new referrals are captured above. Many of the referrals received from the previous two years still remain part of an active caseload and require regular intervention from the Macmillan Welfare and Benefits Adviser.

The Complementary Therapy Service

The Complementary Therapy Service underwent a short period of further expansion during 2016, with the introduction of two additional volunteer complementary therapy posts to provide informal

shorter treatments for patients attending the chemotherapy unit for cancer treatment and supportive infusions.

Demand has continued to rise again this year for this very popular and effective service. Fundraising to sustain the service has also grown through the efforts of staff within the unit. Two events held specifically in aid of the complementary therapy charitable fund, raised a total of £18,000.00 towards the annual £30,000.00 cost required to run the service at the current level.

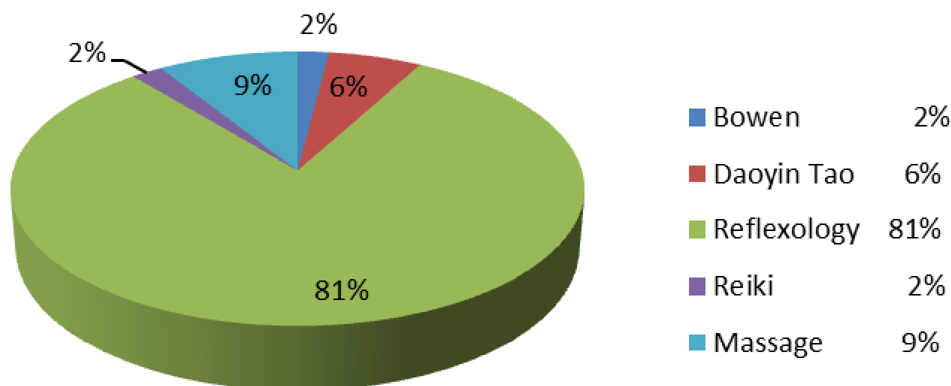


Figure 46: Breakdown of the type of complementary therapy treatments given

Reflexology continues to be the most common treatment given. The reason for this is most likely due to the benefit this treatment has on a wide range of physical symptoms and side effects experienced by patients undergoing cancer treatments. Reflexology is often combined with guided visualisation, used to reduce anxiety. This self-management practice is particularly useful for those patients undergoing stressful procedures or scans etc.

The cancer specialties of Haematology and Women's Cancer make up the most common cancer types being treated in the chemotherapy unit and so continue to generate the most referrals to the complementary therapy service.

Hair Loss Services

Wig Fitting Service	2014	2015	2016
Number of patients attended	**50**	**98**	**108**

Table 48: Patients attending the wig fitting service

Volunteer Hairdresser

Patients who have been affected by hair loss caused by their cancer treatment continue to be referred and signposted to the SROMC volunteer hairdresser consultation service. Due to pressures on room capacity within the SROMC it has become necessary to direct patients to a consultation off site, at the salon. The consultation remains a free service and patient feedback continues to reflect a high quality service.

Boots 'Feel More Like You' Beauty Therapy Sessions

The partnership between the SROMC and Boots in Harrogate has continued to grow and strengthen. The programme of beauty therapy sessions has remained a popular and beneficial service for women receiving cancer treatments. It offers professional beauty advice on skincare, make-up, eye make-up and nail care.

In February ‘Enjoy Healthy Living’ joined the programme and provided an additional monthly session until May 2016. Demand for the sessions has remained consistent and continues to receive excellent user feedback through the formal evaluations undertaken after each session. Activity in 2016:

- 9 sessions held;
- 91 referrals to attend;
- 51 attendances in total for the courses run;
- 30 user evaluations completed.

The Oesophageal Patient Association (OPA) Support Group

This group has continued to meet once a month within the SROMC throughout 2016. Initially started as a pilot by the OPA to provide local support to patients and carers affected by cancer of the oesophagus, the group has gone from strength to strength. It is particularly useful to patients in the Harrogate area by providing a local drop in facility which is accessible before or after their clinic appointment.

TLC (Talking and Listening Club)

TLC is a patient led support group commenced in 2016 by two patients who were receiving treatment in the unit. Having attended some of the other support sessions that were available in the centre, they felt there was a gap for patients to meet, talk and share experiences whatever their cancer type. The group meets once a month in the patient’s group room in the SROMC and is supported by the Macmillan Patient Information and Health and Wellbeing Manager and the Macmillan Health and Wellbeing Programme Manager. User feedback is collected for evaluation and to identify topics of interest that will require a guest speaker.

Art Therapy

A volunteer art therapist has been recruited to a new art therapy service which commenced early 2017. This service is directly linked to the clinical psychology service.

Art therapy is proven to be effective in helping patients and carers affected by a cancer diagnosis. It provides them with an alternative approach to work through emotional issues using a range of creative art techniques.

What are the results?

We seek assurance regarding the quality of our services from a range of sources. These include:

- Cancer waiting times performance i.e. ensuring our patients are seen and treated within a timely way and within the national standards;
- Compliance levels with the National Cancer Quality Surveillance Program;
- Patient reported experience through the National Cancer Patient Experience Survey, the National Chemotherapy Survey and local surveys.

We have consistently achieved our cancer waiting times targets this year for all quarters and have a high level of compliance against our quality surveillance programme indicators.

We await the results of the 2016 National Cancer Patient Survey. This surveyed patients who had treatment in 2016, with results anticipated in summer or autumn 2017.

The following comments are from our internal feedback sources from the SROMC.

The Macmillan Welfare and Benefits Service

"Had no idea I was entitled to anything and as I become less mobile the money will be so welcome for help with transport".

"Delighted with all the help I received – cannot thank you enough".

"Could not speak too highly of the service received from Phil. I feel a big debt of gratitude".

The Complementary Therapy Service

"Helped me to relax - shoulder tension and back ache gone. I haven't had a panic attack since starting the reflexology. It is as if I had forgotten how to relax - being tense all the time. That has now completely gone. I feel normal again".

''Treatments have helped me with pain and emotional issues".

"Made a fantastic contribution to my ability to face my illness and outcomes in a positive way".

"Reflexology has been like a life line to me. It has been so beneficial to me. I am sleeping and relaxing more. I have also been able to walk a lot more as well".

"The treatment has had an amazing impact. The ability to improve symptoms, side effects and mental wellbeing is second to none and a very important part of my overall treatment. I can't speak highly enough of the overall impact. Amazing positive outcome on both a physical and mental level".

"Bone pain is the best controlled it has been for a long time. He is not on analgesia at the present."

Our Volunteers

"The volunteers in the waiting room were very friendly and welcoming. The Centre feels and comforting and caring"

"Joy the hairdresser provides an amazing service, thank you for arranging me to see her; she's made such a difference to my confidence"

Boots N0'7 Feel More Like You

"A really helpful first experience"

"Beauticians were extremely helpful and sensitive to the individual's situation. Thanks very much"

"Really enjoyed the whole experience. Fantastic that this service is available"

Summary

There have been many achievements in continuing to develop high quality cancer services and we will continue to prioritise high quality care and services particularly in the areas described above.

3.5.11 Duty of candour

A statutory duty of candour was introduced by the CQC in March 2015 with detailed guidance for providers on how to meet the regulations. The aim of the duty of candour is to ensure that providers are open and transparent with people who use services in relation to care and treatment. There are specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful

information and an apology. The Trust promotes a culture that encourages candour, openness and honesty at all levels, and a culture of safety that supports organisational and personal learning.

An audit on the duty of candour was conducted jointly between Internal Audit and Clinical Effectiveness, and this offered an opinion of significant assurance. The audit found that the Trust's policy and procedures are in line with national duty of candour guidance, and testing found that the duty had been applied in 98% of incidents where it should have been triggered. On retrospective review, it was found that the duty of candour was undertaken in the one outstanding case but had not been completed at the time of the audit. Documentation in the patient notes and on Datix was found to be mixed. Where it was possible to establish the date that the duty of candour conversation took place, this occurred within the ten day standard in 57% of the cases.

Improvements have been made to the Trust's policy and templates for staff to ensure both patients and staff are adequately supported. Weekly monitoring of outstanding cases has been implemented and quarterly assurance monitoring continues to ensure that all relevant cases have the duty applied.

Following the audit and assurance offered, it was determined that there would be no further audit on duty of candour and that compliance will continue to be monitored on a quarterly basis and reported to the Improving Patient Safety Steering Group via the patient safety report.
For the year 2016/2017 the level of compliance with the duty of candour was as follows:

	Q1	Q2	Q3	Q4
Total number of incidents triggering duty of candour	43	54	43	50
Number with duty of candour applied	42	54	43	50

Table 49: Compliance with duty of candour requirements 2016/17

This table illustrates ongoing compliance with the duty of candour across the organisation. In quarter one the duty was only partially applied in one incident, as a 'being open' conversation took place but an explanatory letter was not subsequently forwarded. Further improvement will come with continued training on the duty of candour and the relevant statutory requirements, and with more timely feedback from directorates where queries regarding severity are raised, with particular emphasis on infection control incidents.

Minor changes have been made to the Being Open and Duty of Candour Policy and duty of candour letter templates to strengthen the importance of the role of patient/family liaison officer in terms of ensuring patients and/or their families are actively involved in investigations and kept apprised.

3.5.12 Safety improvement

The Trust was awarded funding from the NHS Litigation Authority to support our safety improvement plan which was developed as part of the national Sign Up to Safety campaign. Sign up to Safety is a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible.

The funding was to be prioritised for the Maternity Department where we were aiming to achieve a measurable improvement in the quality of patient focused care in relation to human factors that contribute to a positive safety culture i.e. embedding reporting and learning from incidents and near misses, leadership, communication, escalation, and team working.

We have reported on some of the work on human factors in Maternity in section 3.2.

We are now planning to share the learning from this work more widely across the organisation and in particular to use the expertise developed within the organisation in relation to human factors training to improve communication and team working.

What are human factors?

> *"Human factors encompass all those factors that can influence people and their behaviour. In a work context, human factors are the environmental, organisational and job factors and individual characteristics which influence behaviour at work".*
> *Patient Safety First (2010)*

Healthcare professionals are human beings, and like all human beings are fallible. In our personal and working lives we all make mistakes in the things we do, or forget to do, but the impact of these is often non-existent, minor or merely creates inconvenience. However, in healthcare there is always the underlying chance that the consequences could be catastrophic. It is this awareness that often prevents such incidents as we purposefully heighten our attention and vigilance when we encounter situations or tasks we perceive to be risky.

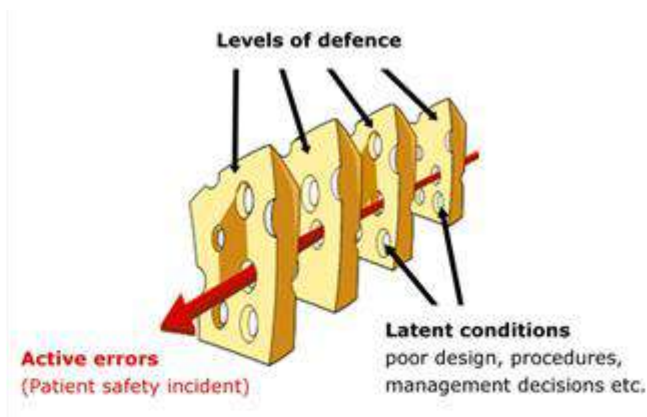


Figure 47: The Swiss Cheese Model of organisational accidents (Reason 1990)

We know from an analysis of serious incidents that human factors contribute to all serious incidents and errors.

Data from the Staff Survey 2016 (section 3.5.2) shows that HDFT scored below average for staff reporting errors, near misses or incidents witnessed in the last month (national average 91%; HDFT 89%). We want to ensure staff see near misses, incidents, errors and complaints as opportunities to learn and improve patient safety.

The appointment of our Freedom to Speak Up Guardian will support this work. Freedom to Speak Up Guardians have a key role in helping to raise the profile of raising concerns in their organisation and provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled.

The results of the 2016 staff survey shows strong results in relation to key finding 31: staff confidence and security in reporting unsafe clinical practice. HDFT received the third highest score in this key finding when compared to similar trusts.

Figure 48: HDFT 2016 staff survey results: reporting on incidents

We are planning to focus on working with staff to promote the reporting of incidents, near misses and concerns, identify the factors that contribute to these and maximise the learning to prevent recurrence. We will focus on high quality mortality reviews and subsequent learning and action. In addition we will identify learning from examples of great practice in order to spread excellence. This work has been selected as a quality improvement priority for 2017/18.

4. 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:

HARROGATE AND RURAL DISTRICT CLINICAL COMMISSIONING GROUP

Thank you for sending us a copy of the latest draft of the Quality Account for Harrogate and District Foundation Trust for 2016-17 and providing me with an opportunity to feedback comments on behalf of Harrogate and Rural District CCG.

This report has been shared with some key individuals within the CCGs and comments have been collated into my response.

The report is comprehensive and provides a significant amount of assurance that improving quality is indeed at the heart of your organisation. The introduction of 'Quality Champions' through the Quality Charter demonstrates further the innovative approaches being used by the Trust to create the climate of continuous quality improvement.

The Quality Account as a whole seems to describe the significant amount of improvement work in the children and hospital based services with some limited information about adult services provided in the community.

I would like to focus our response on some key areas of the report but equally recognise the vast amount of work being carried out within the Trust to ensure and improve the quality of services.

The CQC rating of 'Good' for the whole Trust is an excellent achievement however in areas where improvements have been recommended we would like to see some additional assurance that actions have been taken to make measurable and sustainable progress to improve.

We were invited and attended your Quality Account stakeholder engagement event where we had the opportunity to comment on the proposed priorities for 2017-18. Carrying over the two chosen priorities from 2016-17 are completely appropriate and we agree there is still a significant amount of work that needs to be achieved to improve the outcomes and experience of our patients. We welcome the opportunity to work with you to help achieve these priorities and look forward to receiving your updates of these on a regular basis through our shared quality meetings.

We are pleased to see once again that improving the discharge experience has been chosen as a quality priority for the Trust. We recognise this as being a shared local priority and we remain committed to work with you to understand and address our local system wide issues.

We are also reassured that there will be a focus on ensuring a voice truly representative of 'the child' will be included in any service redesign or strategy. It would be helpful to understand how this will be measured to demonstrate improvements in quality and the experience of children, their families or carers.

We recognise the reasons for not continuing with the other priorities from last year but would wish to see momentum for improvement continuing.

The number of local and national audits being carried out in the Trust is commendable and it would to helpful to see more information with a focus on the measurable improvement as a result of the audit recommendations and actions.

The Quality Account provides a very thorough and reassuring account of all the work underway and we have welcomed the opportunity to review the account and note the hard work that goes into continuing to provide high quality services.

Joanne Crewe, Director of Quality and Governance / Executive Nurse
NHS Harrogate and Rural District Clinical Commissioning Group
3 May 2017

NORTH YORKSHIRE COUNTY COUNCIL SCRUTINY OF HEALTH COMMITTEE

The North Yorkshire Scrutiny of Health Committee has worked with the Harrogate and District NHS Foundation Trust over the past 12 months through formal committee meetings and ongoing liaison to maintain an open dialogue about the delivery of hospital based health services in the area. This has included discussions on proposed service changes, contributions to in-depth scrutiny of End of Life Care in the county and early engagement in consultations.

The committee recognises the challenges faced by hospitals serving the population of North Yorkshire as they look to change the way in which key services are delivered, in response to rising demand, workforce shortages and financial pressures. In these circumstances, early and ongoing engagement is more important than ever.

The Scrutiny of Health Committee remains committed to a system-wide view of services that helps to ensure that decisions on the planning and delivery of health care are not made in isolation and that the key role that a broad base of community services have to play is not overlooked.

County Councillor Jim Clark
North Yorkshire Scrutiny of Health Committee
27 April 2017

COUNCIL OF GOVERNORS

The Council of Governors is pleased to have the opportunity to comment on this detailed and comprehensive Quality Account.

The year just concluded has been one of that the Trust can be justifiably proud. The Care Quality Commission rating of ‘Good’ for the whole trust following their inspection was particularly pleasing, especially with four individual services being rated as ‘Outstanding’. This highlights that the Trust continues to provide high quality care to patients.

Governors, as in previous years, have been extensively consulted on the Trust’s Operational Plan, have contributed to the development of the quality priorities for the coming year, and have reviewed the Quality Account. Individual Governors sit on and triangulate information from the Learning from Patient Experience and Patient Voice Groups, departmental Quality of Care Teams, and Patient Safety visits, all of which enable them to personally experience the challenges of maintaining quality of care in different areas of the Trust’s services.

Governors have in-depth formal meetings with the Board of Directors twice a year and with Non-Executive Directors three times a year. Both Executive and Non-Executive members of the Board of Directors regularly attend Council of Governors' meetings, In addition, Governors regularly attend as observers at Board of Directors' meetings and committee meetings, in particular the Quality Committee which has delegated responsibility and oversight of the Trust's progress towards achieving the quality priorities.

The Council of Governors supports and fully endorses the 2016/17 Quality Account and the priorities selected for particular focus during 2017/18.

Pamela Allen
Deputy Chair of Governors/Lead Governor
on behalf of the Council of Governors
04 May 2017

HARROGATE BOROUGH COUNCIL

Harrogate Borough Council welcomes the opportunity to comment on the HDFT's Annual Quality Report for 2016/17.

The report reflects the ongoing continuous improvement journey that the Trust is on and its commitment to provide both excellent care and improved outcomes for all of the people who need to use its services. Whilst the document highlights improvements in clinical practice and patients' outcome what stands out is the care and commitment of the staff who work for the Trust to make every contact count. To provide excellent care not just clinically but to ensure that everyone feels valued, respected and listened to. Of note are the national staff survey results that show that 87.3% of staff who work for HDFT would recommend the trust to family and friends for its standard of care and 93% agreeing that their role makes a difference to patients/service users. This is also clearly evidenced by the CQC inspection that occurred during 2016, which rated Harrogate District Hospital and the Trust as 'good' overall, but found that the Hospital, Community Services and the Trust were 'outstanding' for the caring domain.

Wallace Sampson, Chief Executive
Harrogate Borough Council
2 May 2017

LEEDS NORTH CLINICAL COMMISSIONING GROUP

Thank you for providing the opportunity to feedback on the Quality Account for Harrogate and District Foundation Trust for 2016-17.

This report has been shared with key individuals across the three Leeds CCGs and this response is on behalf of all three CCGs.

The report is very detailed and encompassing and reflects the large body of work being carried out within the trust to ensure and improve the Quality of services. This response will focus on key parts of this report.

The priorities for 2017-18 are appropriate and focused on patient safety and improving outcomes for patients. Two of the priorities are carried over from last year (reducing morbidity and mortality in

relation to sepsis and providing high quality stroke care) which should build on the progress made last year and address the areas where not as much progress was made as hoped. The priority to improve the patient experience of discharge is welcomed and we look forward to seeing how you address this issue which attracts much attention currently.

The two priorities from last year which are not being continued (Improving the care of people with learning disabilities and improving the management of inpatients on insulin) we assume now become business as usual, as both initiatives achieved so much.

The CQC rating of ‘Good’ for the whole trust is to be commended, especially with four individual services being rated as ‘Outstanding’. However, the community services were rated as ‘Requires Improvement’ and we would have liked to see some reassurance in the report regarding the actions being taken to address this.

The report contains very thorough descriptions of other quality indicators which have been chosen for reporting in conjunction with the Board of Directors and other stakeholders. They demonstrate a commitment to the three domains of quality (safe, effective and a good experience) within the Trust. The work around medicines and the roll out of the electronic Prescribing and Medicines Administration system is impressive and the desire to continue to improve this is to be congratulated. We were also particularly impressed with the work around pain management. The completion and introduction of the end of life strategy is obviously an initiative we look forward to being reported on through the year. The desire to instil quality and improvement and reward those who make a difference is also noted through the “Quality of Care Champions” initiative.

In conclusion we welcome the opportunity to review the account and note the hard work that has gone into providing a high quality service, evidenced by the CQC report. There is obviously scope for improvement in community services and the quality account as a whole is probably leaning more to the hospital based services rather than the community, but it does provide a very thorough and reassuring account of all the work underway.

Dr Manjit Purewal, Medical Director
Leeds North Clinical Commissioning Group
3 May 2017

5. ANNEX TWO: STATEMENT OF DIRECTORS' RESPONSIBILITIES

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement 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 NHS 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 2016/17 and supporting guidance;
- 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 2016 to April 2017
    - Papers relating to quality reported to the Board over the period April 2016 to April 2017
    - Feedback from the commissioners dated 3 May 2017
    - Feedback from Governors dated 4 May 2017
    - Feedback from Healthwatch North Yorkshire was requested 19 April but no comment was received
    - Feedback from North Yorkshire County Council Scrutiny of Health Committee dated 27 April 2017
    - The Trust's draft complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 10 May 2017
    - The 2015 national inpatient survey dated 8 June 2016
    - The 2016 national staff survey dated 7 March 2017
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2017
    - CQC inspection report dated 27 July 2016
- 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 NHS improvements annual reporting manual and supporting 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 on 24 May 2017

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Mrs Sandra Dodson
Chairman

....

Dr Ros Tolcher
Chief Executive

6. ANNEX THREE: NATIONAL CLINICAL AUDITS 2016/17

	Name of Audit/Clinical Outcome Review Programme	**Part of NCAPOP?**	**Number of patients for which data submitted 2016/17**	**Data submitted as a percentage of the number of registered cases required for that audit**
1	Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	224	100%
2	Adult Asthma	No	7	100%
3	Asthma (paediatric and adult) care in emergency departments (CEM)	No	51	100%
4	Bowel cancer (NBOCAP) *This relates to data submitted for 2015/16. The Trust has not yet submitted any patient data for 2016/17 as the deadline for this is November after the end of the financial year, therefore reporting will always be one year in arrears.*	Yes	145	117% (based on expected total of 124)
5	Cardiac Rhythm Management	Yes	228 new devices 2240 follow-ups	100%
6	Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC) *Figures for April to December 2016*	No	362	100%
7	Child health clinical outcome review programme			
	(i) Young People's mental health	Yes	1	Please note this study is still open and figures have not been finalised
	(ii) Cancer in children, teens and young adults	Yes	0	Please note this study is still open and figures have not been finalised
8	Diabetes (Paediatric) (NPDA) *This figure is for the latest round of the audit which relates to patients seen from 1 April 2015 to 31 March 2016.*	Yes	74	100%
9	Elective surgery National PROMS programme (2015/16)	No	1,205 (pre-op) 940 (post-op)	114.1% 78.9%

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2016/17	Data submitted as a percentage of the number of registered cases required for that audit
	Elective surgery National PROMS programme (April - September 2016)	No	476 (pre-op) 94 (post-op)	103.7% 47.5%
10	Falls & Fragility Fractures Audit Programme (FFFAP)			
	(i) Falls	Yes	No data collection during 2016/17 financial year	No data collection during 2016/17 financial year
	(ii) National Hip Fracture Database	Yes	256	Not known
11	Inflammatory Bowel Disease (IBD) programme *New patients 01/03/2016 to 28/02/2017*	Yes	26	Not stated
12	Learning Disability Mortality Review Programme (LeDeR)[4]	Yes	1	100%
13	Major Trauma: The Trauma Audit & Research Network (TARN) *Information is for calendar year 2016*	No	171	Awaiting 2016 HES data
14	Maternal, New-born and Infant Clinical Outcome review Programme (MBRRACE-UK)	Yes	5 Stillbirths 2 late miscarriages (above 22/40 gestation) 3 early neonatal deaths No termination of pregnancy (above 22/40 gestation) 2 Maternal deaths	100%
15	Medical & Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome & Death (NCEPOD)			
	(i) Mental Health	Yes	5	100%
	(ii) Acute Pancreatitis	Yes	5	100%
	(iii) Acute Non Invasive Ventilation	Yes	1	25%
	(iv) Chronic Neurodisability	Yes	1	Please note this study is still open

[4] Please note that there has been a staged introduction of the LeDeR programme across England, with Yorkshire & Humber only starting to report deaths from January 2017.

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2016/17	Data submitted as a percentage of the number of registered cases required for that audit
				and figures have not been finalised
16	National Audit of Dementia	Yes	50 (+5 reliability)	100%
17	National Cardiac Arrest Audit (NCAA) *Figures are for April to December 2016 (Q4 data not yet available)*	No	35	100%
18	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme			
	(i) Pulmonary rehabilitation	Yes	21	100%
	(ii) Secondary Care *Please note this is a continuous audit which commenced on 1 February 2017. Data is being collected retrospectively following clinical coding.*	Yes	0 (please see note)	Audit is continuous from 1 February 2017
19	National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery	No	9	100%
20	National Diabetes Audit (Adults)			
	National Footcare Audit *Relates to records submitted between 14 July 2014 and 8 April 2016.*	Yes	201	100%
	National Inpatient Audit (NADIA)	Yes	34	100%
	National Pregnancy in Diabetes Audit	Yes	1	100%
	Secondary Care Audit *Audit period 1 January 2015 to 31 March 2016*	Yes	720	Not stated
21	National Emergency Laparotomy Audit (NELA) *Data refers to year 3 of the audit (01/12/2015 to 30/11/2016)*	Yes	70	100%

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2016/17	Data submitted as a percentage of the number of registered cases required for that audit
22	National Heart Failure Audit	Yes	210	100%
23	National Joint Registry (NJR) *Awaiting final verification from NJR*	Yes	928	Awaiting HES data
24	National Lung Cancer Audit (NLCA) Data for calendar year 2016	Yes	138	Not stated
25	National Ophthalmology Audit	Yes	1461	100%
26	National Prostate Cancer Audit *Financial year data up to end of January 2017 (31 January 2017) – cases from February onwards still to be validated and registered.*	Yes	142	*Not stated - case ascertainment is not currently measured for prostate patients at the moment but will be in future. The cancer registry have run their own analysis on our data and have confirmed that our figures are as expected.*
27	Neonatal intensive and special care (NNAP)	Yes	Number of completed episodes of care included – 146 Number of distinct babies included - 135	Not stated
28	Nephrectomy audit	No	13	100%
29	Oesophago-gastric cancer (NAOGC) *This relates to data submitted for 2015/16. The Trust has not yet submitted any patient data for 2016/17 as the deadline for this is November after the end of the financial year, therefore reporting will always be one year in arrears.*	Yes	51	130% (based on expected total of 39)
30	Paediatric Pneumonia	No	45	100%

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2016/17	Data submitted as a percentage of the number of registered cases required for that audit
31	Percutaneous Nephrolithotomy (PCNL) [5]	No	0	N/A
32	Rheumatoid and early inflammatory arthritis	Yes	No data collection during 2016/17 financial year	No data collection during 2016/17 financial year
33	Sentinel Stroke National Audit Programme (SSNAP)	Yes	313%	100%
34	Severe Sepsis and Septic Shock – care in emergency departments (CEM)	No	71	>100%
35	Stress Urinary Incontinence Audit	No	9	100%

For information, the Trust also participated in the following audits:

Data submitted to National Audits not included in NHS England's Quality Accounts List	Number of patients for which data submitted 2016/17	Data submitted as a percentage of the number of registered cases required for that audit
Consultant Sign-off (College of Emergency Medicine)	247	>100%
National Smoking Cessation Audit	177 records including 20 smokers	100%
National Comparative Audit of Blood Transfusion - Red cell & Platelet Transfusion in Haematology	24	100%
National Maternity and Perinatal Audit 214/15 deliveries	1896 deliveries including 1872 unique births.	100%
National Maternity and Perinatal Audit 2015/16 deliveries	1950 deliveries including 1921 unique births	100%

The following nine NCAPOP audits were not relevant to HDFT due to the Trust not providing the service:

[5] Please note that only one procedure was undertaken during 2016/17 and the procedure is no longer conducted at HDFT.

- Adult Cardiac Surgery
- Chronic Kidney Disease in primary care
- Congenital Heart Disease (CHD)
- Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions
- Head and Neck Cancer Audit
- Mental Health Clinical Outcome Review Programme/National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH) (all work streams)
- National Vascular Registry
- Paediatric Intensive Care Audit Network (PICANet)
- Specialist Rehabilitation for patients with complex needs

Furthermore, the Fracture Liaison Service Database (FLSD) element of the Falls & Fragility Fractures Audit Programme (FFFAP) is not relevant to the Trust as we do not have a dedicated Fracture Liaison Service.

The following seven non-NCAPOP audits were not relevant to HDFT due to the Trust not providing the service:

- Endocrine & Thyroid National Audit
- National Audit of Pulmonary Hypertension
- National Neurosurgery Audit Programme
- Prescribing Observatory for Mental Health (POMH-UK) (all work streams)
- Radical Prostatectomy Audit
- Renal replacement therapy (Renal Registry)
- UK Cystic Fibrosis Registry

Please note that the Rheumatoid and Early Inflammatory Arthritis audit and the National Audit of Inpatient Falls which were included in the NHS England Quality Accounts List 2016/17 did not run and therefore we are unable to report on participation.

7. ANNEX FOUR: GLOSSARY

AMU	Acute Medical Unit
CAHMS	Child and Adolescent Mental Health Services
CAT	Clinical Assessment Team
CATT	Clinical Assessment, Triage & Treatment
CCG	Clinical Commissioning Group
CEM	Royal College of Emergency Medicine
CFRRT	Community Fast Response and Rehabilitation Team
CNS	Clinical Nurse Specialist
CQC	Care Quality Commission
CTG	Cardiotocography
CQUIN	Commissioning for Quality and Innovation
Dashboard	Data visualisation tool that displays the current status of metrics and key performance indicators
Datix	Incident reporting system
DNACPR	Do not attempt cardiopulmonary resuscitation
ED	Emergency Department
eHNA	Electronic holistic needs assessment
ePMA	Electronic prescribing and medicines administration system
FFT	Friends and Family Test
HaRD	Harrogate and Rural District
HDFT	Harrogate and District NHS Foundation Trust
HQIP	Healthcare Quality Improvement Partnership
ICE	Requesting and reporting software
ITU	Intensive Therapy Unit
LD	Learning disabilities
LSA	Local Supervising Authority
LSAMO	Local Supervising Authority Midwifery Officer
MDT	Multidisciplinary team
NCDAH	National Care of the Dying Audit of Hospitals
NCAPOP	National Clinical Audit and Patient Outcome Programme
NCEPOD	National Confidential Enquiry into Patient Outcome & Death
NICE	The National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NMC	Nursing and Midwifery Council
NRLS	National Reporting and Learning System
NWD	No Wrong Door
Patientrack	Electronic system for recording vital signs and observations
PVG	Patient Voice Group
RTT	Referral to treatment
SBAR	Communication tool: situation, background, assessment and recommendation
SIRI	Serious incident requiring investigation
SLCN	Speech, language and communication needs
SOM	Supervisors of Midwives
SROMC	Sir Robert Ogden Macmillan Centre
SSNAP	Sentinel Stroke National Audit Programme
SUS	Secondary Uses Service
VIP	Vulnerable inpatient
WHO	World Health Organisation
YAS	Yorkshire Ambulance Service

Harrogate and District NHS
NHS Foundation Trust

If you require this document in an alternative language or format (such as Braille, audiotape or large print), please contact our Patient Experience Team: thepatientexperienceteam@hdft.nhs.uk or 01423 555499.

Electronic copies of this Quality Account can be obtained from our website (www.hdft.nhs.uk). If you have any feedback or suggestions on how we could improve our Quality Account, please do let us know by emailing bulletin@hdft.nhs.uk.

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Harrogate and District NHS
NHS Foundation Trust

Harrogate and District NHS Foundation Trust Consolidated Financial Statements 31 March 2017.

Contents

	Page
Foreword to the accounts	1
Statement of the Chief Executive's Responsibilities as Accounting Officer	2
Independent Auditor's Report	3-7
Annual Governance Statement	8-18
Consolidated Statement of Comprehensive Income	19
Consolidated Statement of Financial Position	20
Consolidated Statement of Changes in Taxpayers' Equity	21
Consolidated Statement of Cash Flows	22
Foundation Trust Statement of Comprehensive Income	23
Foundation Trust Statement of Financial Position	24
Foundation Trust Statement of Changes in Taxpayers' Equity	25
Foundation Trust Statement of Cash Flows	26
Notes to the Consolidated and Foundation Trust Financial Statements	27-58

FOREWORD TO THE ACCOUNTS

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

The accounts for the year ended 31 March 2017 are set out on the following pages and comprise the Consolidated Statement of Comprehensive Income, the Consolidated Statement of Financial Position, the Consolidated Statement of Changes in Tax Payers' Equity, the Consolidated Statement of Cash Flows and the Notes to the Consolidated Accounts.

The accounts have been prepared by the Harrogate and District NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7, to the National Health Service Act 2006 in the form in which NHS Improvement, in exercise of the powers conferred on Monitor, the Independent Regulator of NHS Foundation Trusts, has, with the approval of HM Treasury, directed.

Signed: .... Dr Ros Tolcher - Chief Executive

Date: 24 May 2017.

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 their 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 NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the National Health Service Act 2006, has given Accounts Directions which require Harrogate and District NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. 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 Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, 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 and the Department of Health Group Accounting 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 guidance; 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 them 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 the NHS Foundation Trust Accounting Officers' Memorandum.

Signed: .... Dr Ros Tolcher - Chief Executive

Date: 24 May 2017.

Independent auditor's report

to the Council of Governors of Harrogate and District NHS Foundation Trust only

Opinions and conclusions arising from our audit

1. Our opinion on the financial statements is unmodified

We have audited the financial statements of Harrogate and District NHS Foundation Trust for the year ended 31 March 2017 set out on pages 1 to 60. In our opinion:

- the financial statements give a true and fair view of the state of the Group and Trust's affairs as at 31 March 2017 and of the Group and Trust's income and expenditure for the year then ended; and
- the Group and Trust's financial statements have been properly prepared in accordance with the Department of Health's Group Accounting Manual 2016/17.

Overview		
Materiality: Group financial statements as a whole	£4.005m (2015/16:£3.7m) 1.8% (2015/16: 2%) of total revenue	
Risks of material misstatement		**vs 2015/16**
Recurring risks	Valuation of Land and Buildings	◀▶
	New: Valuation of NHS Income and Receivables	▲

2. Our assessment of risks of material misstatement

In arriving at our audit opinion above on the financial statements, the risks of material misstatement that had the greatest effect on our audit, in decreasing order of audit significance, were as follows:

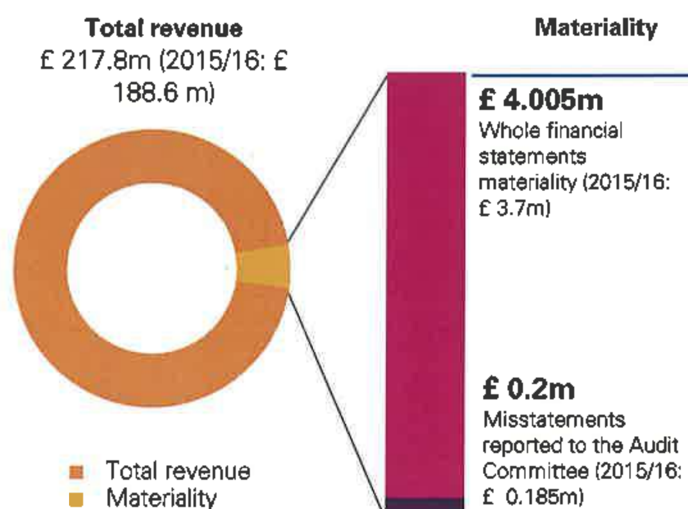
	The risk	Our response
Valuation of Land and Buildings (£87.6 million; 2016: £85.7 million) *Refer to the Audit Committee Report), Note 1.6 (accounting policy) and Note 9.1 (financial disclosures).*	**Valuation of Land and Buildings** Land and buildings are initially recognised at cost. Non-specialised property assets in operational use are subsequently recognised at current value in existing use (EUV). Specialised assets (such as hospitals) where a market value is not readily ascertainable, are subsequently recognised at the depreciated replacement cost (DRC) of a modern equivalent asset value (MEAV) that has the same service potential as the existing property. Trusts are responsible for ensuring their land and buildings are fairly valued. Guidance from GAM has suggested that Trusts typically achieve this by performing an annual review for impairment, a periodic desk top valuation (usually every three years) and a full valuation (usually in five yearly intervals). The asset valuation and impairment review processes are both use estimates and assumptions and therefore present a significant risk to the audit. There is significant judgement involved in determining the appropriate basis (EUV or DRC) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation. In 2015/16, the value of land and buildings in the financial statements was £85.7m. This consisted land value of £3.4m and building valuation of £82.3m. The valuation of these land and buildings were based on desk top valuation for the last 4 years. In line with GAM, the Trust has undertaken a full valuation of its land and buildings during 2016/17. The Trust communicated with Her Majesty's Valuation Office (HMVO) regarding scope and timing of this valuation, which was completed by 31 March 2017.	Our procedures included: — **Critical Assessment of the external valuer:** We assessed the competence, capability, objectivity and independence of the Trust's external valuer to carry out the valuation objectively and competently; — **Testing of information provided to the external valuer:** We agreed the information provided to the valuer by the Trust to underlying records of the NHS Estate held by the Trust to assess whether all land and buildings had been valued; — **Critical Assessment of assumptions:** We critically assessed the valuation method and the reasonableness of the assumptions used by the valuer to arrive at the final valuations; — **Consideration of the consistency of the valuation approach with the GAM:** We inspected the valuation report, terms of engagement of, and the instructions issued to the valuer to confirm consistency with the requirements of the GAM; — **Agreement of the external valuer's report to the financial statements:** We agreed the valuer's report to the financial statements to assess whether valuation movements are applied correctly both in total and at an individual asset level; — **Additions and disposals testing:** We tested material additions and disposals during the year to supporting documentation including invoices; — **Assessment of accounting entries:** We assessed whether the impairments and revaluations had been correctly accounted for in line with applicable accounting standards and the GAM; and — **Assessment of disclosures:** We assessed the adequacy of the disclosures about the key judgements and degree of estimation involved in arriving at the valuation and the related sensitivities

	The risk	Our response
Valuation of NHS Income and Receivables (NHS Income £180.5 million; 2016: £176 million) (NHS Receivables: £13.5 million; 2016: £11.7m) *Refer to the Audit Committee Report), Note 1.3 (accounting policy) and Note 3.1 and 12.1 (financial disclosures).*	**Valuation of NHS Income and Receivables and Fraudulent Revenue Recognition** We have added this as a new risk in 2016/17 due to an increased risk of misstatement relating to the estimation of income from Sustainability and Transformation Funding (STF) in Quarter 4 of 2016/17. This is in addition to existing risks relating to the estimation of under or over-activity against NHS contracts and estimates of income due for delivering quality measures (CQUIN). Contract income is agreed with commissioners and NHS England based on expected activity levels, but billing is based on actual activity. Over or under- performance against contracted levels of activity is agreed with the relevant commissioner at the end of the year based on submitted activity from the SLAM system. CQUIN income is based on the delivery of quality targets. The Trust receives STF based on the delivery of Key Performance Indicators (KPIs) – with 70% of the STF based on achievement of the financial control total agreed with NHS Improvements (NHSI) and 30% based on achievement of operational trajectories for key performance indicators agreed with NHSI. The Trust accrues the expected level of STF income in Quarter 4 based on its estimated performance against each of the targets. All NHS organisations take part in an agreement of balances (AoB) exercise (income, expenditure, payables and receivables) at the end of the year, which is facilitated by NHSI. A mismatch report is produced by NHSI showing where balances are not agreed between parties. It is expected that where there are variances they will be resolved between the two parties prior to finalising their accounts. There is a risk that the Trust may seek to maximise its income receivable in order to deliver its control total. As such, there is an increased risk that the AoB exercise will identify mismatches between NHS income/receivables recognised by the Trust and NHS expenditure/creditors recognised by commissioners, and that these mismatches will not be resolved by the date we sign our opinion.	Our procedures included: — **Assessment of the results of the AoB exercise:** We inspected the information provided by the Trust as part of the 2016/17 AoB exercise to agree that it is consistent with the information in the accounts covering both NHS income and NHS receivables; — **Corroboration of Sustainability and Transformation Funding:** we agreed the receipt of STF monies, including the basis for agreement of Quarter 4 funding based on relevant financial and performance measures, and confirmed the treatment is in line with guidance from the NHS Improvement; — **Investigation of mismatches:** We identified any mismatches (both income and receivables) with Commissioners and obtained explanations for the mismatches; — **Corroboration of the Trust's estimates:** We agreed any disputed NHS income or receivables to documentation which supported the Trust's estimates, including contract documentation and evidence of the achievement of required activity levels or performance measures; — **Review of adjustments:** We assessed whether any adjustments to balances agreed with other NHS organisations had been appropriately reflected in the accounts; — **Corroboration of accrued and/or deferred income balances:** We agreed any accrued or deferred income balances to supporting documentation to confirm they had been recorded appropriately; and — **Assessment of disclosures:** We assessed the adequacy of the disclosures about NHS income and receivables alongside the associated notes to the financial statements

3. Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements was set at £4.005 million (2015/16: £3.7 million), determined with reference to a benchmark of income from operations (of which it represents approximatelyy 1.8%). We consider income from operations to be more stable than a surplus-related benchmark. We report to the Audit Committee any corrected and uncorrected identified misstatements exceedingg £0.2m (2015/16: £0.185 million), in addition to other identified misstatements that warrant reporting on qualitative grounds.

The Group has two reporting components and both of them were subject to audits for group reporting purposes performed by the Group audit team at one location in Harrogate. These audits covered 100% of group income, surplus for the year and total assets. The audits performed for group reporting purposes were all performed to materiality levels set individually for each component and ranged from £4 million to £70,000 (2015/16: £3.7 million to £70,000)



4. Our opinion on other matters prescribed by the Code of Audit Practice is unmodified

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2016/17; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

5. We have nothing to report in respect of the matters on which we are required to report by exception

We are required to report to you if, based on the knowledge we acquired during our audit, we have identified information in the Annual Report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the Annual Report and financial statements taken as a whole is fair, balanced and understandable; or
- the Audit Committee's commentary in the Annual Report does not appropriately address matters communicated by us to the Audit Committee.

Under the Code of Audit Practice we are required to report to you if, in our opinion:

- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.
- the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

In addition we are required to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in respect of the above responsibilities.

6. We have completed our audit

We certify that we have completed the audit of the accounts of Harrogate and District NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Scope and responsibilities

As described more fully in the Statement of Accounting Officer's Responsibilities, the accounting officer is responsible for the preparation of financial statements that give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors. A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General, as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body, for our audit work, for this report or for the opinions we have formed.

Rashpal Khangura for and on behalf of KPMG LLP
Chartered Accountants and Statutory Auditor
1, Sovereign Square, Sovereign Street, Leeds, LS1 4DA

26 May 2017

Annual Governance Statement 2016/17

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Harrogate and District NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Harrogate and District NHS Foundation Trust (the Trust) for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Accounting Officer, supported by Board members, I have responsibility for the integrated governance systems. I have delegated executive lead to the Chief Nurse and Medical Director for the implementation of integrated governance and risk management.

The Board of Directors recognises that risk management is an integral part of good management practice and to be most effective should be part of the Trust's culture. The Board is, therefore, committed to ensuring that risk management forms an integral part of its philosophy, practices and business plans rather than viewed or practised as a separate programme and that responsibility for its implementation is accepted at all levels of the organisation.

The Board acknowledges that the provision of appropriate training is central to the achievement of this aim. Staff are appropriately trained and supported in incident reporting, carrying out risk assessments, mitigating risk and maintaining risk registers. Directors and Departmental Managers ensure that all staff, including those promoted or acting up, Board Directors, Contractors, locum, agency or bank staff, undergo corporate and specific local induction training appropriate to their area including risk management, incident reporting and hazard recognition training. An ongoing training programme has been developed based on a training needs analysis of staff. The programme includes formal training for:

- Staff in dealing with specific everyday risks, e.g. basic risk management information including an overview of patient safety, incident reporting and investigation, complaints investigation and development of measures to improve patient experience, fire safety, information governance, health and safety, moving and handling, infection control, and security; and
- Specific staff involved in the maintenance of risk registers at directorate and department level, investigation and root cause analysis, the investigation of serious incidents (SIs) and risk assessment for health and safety.

The Trusts Human Resources Department monitors all mandatory and essential training and reports directly to the Board of Directors. Completion of training is included in staff performance monitoring, appraisals and revalidation. This process has been strengthened by linking pay progression to the completion of essential and mandatory training.

Employees, contractors and agency staff are required to report all incidents and concerns and this is closely monitored. The Trust supports an "open" culture, meaning that we are open with service users, carers and staff when things go wrong. A significant emphasis is placed upon ensuring that we comply with the requirements of the statutory duty of candour that came into force on 27 November 2014. This follows the introduction of a number of new standards that NHS boards need to comply with including not only duty of candour, but also the fit and proper person's test and improving openness and transparency. The Board receives regular updates to ensure compliance in these areas.

Guidance on reporting incidents on Datix, grading of incidents, risk assessment, risk registers, undertaking root cause analysis and statement writing, is available for staff on the Trust intranet.

The Trust also supports a "learning" culture, and we share and embed learning from incidents following an objective investigation or review. In addition, the Trust seeks to identify and share good practice within the organisation. This happens at Board and directorate level through various mechanisms including feedback from patient safety visits and Director inspections and an annual "Celebrating Success Awards" event. National guidelines and standards that relate to good practice are shared and there are processes in place to ensure action plans to implement recommendations are developed and monitored to completion.

Quality and equality impact assessments have been strengthened during 2016/17 to improve the assurance that the Board and its committees receive in terms of impact from cost improvement programmes, risks and how these will be managed. Further work is needed to integrate this effectively into other service developments.

The risk and control framework

The key objectives regarding risk and control are to achieve:

- Compliance with external regulatory and other standards for quality, governance and risk including Care Quality Commission fundamental standards and regulations;
- A culture of effective risk management at all levels of the organisation;
- Delivery of the Trust's strategic aims and objectives; and
- A robust framework to ensure all controls and mitigation of risks are in place and operating, and can provide assurance to the Board of Directors on all areas of governance being:
    - Corporate governance.
    - Quality governance.
    - Clinical governance.
    - Financial governance.
    - Risk management.
    - Information governance including data security.
    - Research governance.
    - Clinical effectiveness and audit.
    - Performance governance.

The Trust has a system of integrated governance described in the Risk Management Policy.

Risk identification and assessment is the process that enables the Trust to understand the range of risks faced, the level of ability to control those risks, their likelihood of occurrence and their potential impacts. Risk assessment is a continuous process with risks assessed at ward, team and department level in line with risk assessment guidance. This is carried out proactively as part of the health and safety processes as well as reactively when risks are identified from incidents, complaints, local reviews, patient feedback etc.

Risks are scored based on the likelihood of the risk materialising (score 1-5) multiplied by the impact or consequence of that risk (score 1-5). The risk scoring matrix evaluates the level of risk as low (1-5), medium (6-10) or high (12-25), and therefore the priority for action, and must be used for all risk scoring within the Trust in order to ensure a consistent and standardised approach. This allows the organisation to gain an appreciation of the magnitude of each risk, set targets for improvement based on its risk appetite, and track progress against an agreed, timed action plan. The Board of Directors decides what level of risk is reported to them. The threshold is a risk score of 12.

Risks are recorded in the health and safety control books and in risk registers. A risk register is a specific tool for recording and managing risk in a standard format to allow comparison and aggregation. Taking each risk in turn, the risk register records the controls (the things we do to mitigate that risk) already in place, the original risk score and the current risk score based on those controls. Gaps in controls can then be identified and actions agreed to close these gaps. Targets based on an acceptable level of risk can be agreed, and progress towards achieving the target risk score can be tracked. Assurances (the evidence that controls are effective) are also recorded.

The identification and management of risk as communicated in risk registers aids decision-making and resource prioritisation. It produces proper information by which the Trust can reassure the public, patients and stakeholders that it is effective and efficient and delivering the objectives of the organisation.

Risk assessment and management is addressed using risk registers at four levels across the Trust:

1. Departmental

Risk assessments are carried out routinely as part of the health and safety process as well as from incidents, complaints, local reviews, patient feedback and information contained in relevant quality, safety, workforce and financial dashboards. The departmental risk registers will reflect these risk assessments, including all residual medium and high risks from the health and safety control books.

It is the responsibility of directorate leads for governance to review and where appropriate, challenge scores applied to risks on departmental registers at least quarterly. All risks that are scored 9 or above on departmental risk registers are escalated to directorate risk registers.

2. Directorate

The directorate risk registers and corporate functions risk registers are key management tools which are scrutinised monthly within management meetings to ensure effective oversight of risk management. Clinical Directors, Operational Directors, Corporate Directors and Deputy Directors are responsible for the risk registers.

The directorate risk register will reflect departmental risk registers where relevant by including risks that are scored 9 or above or form a trend across more than one departmental register. At this level risk assessment is performed alongside objective setting and business planning.

All risks that are scored 12 or more will be discussed at the Corporate Risk Review Group, together with any other risks that the risk register owner is concerned about.

3. Corporate

The corporate risk register is a live document, reviewed and updated as circumstances change, new risks arise and established risks are treated. Risks are escalated up to the corporate risk register, or back down to clinical directorate or corporate functions risk registers, based on the agreed threshold of 12 for designating corporate risk.

It therefore identifies key organisational risks. The corporate risk register is reviewed at the Corporate Risk Review Group every month, with a focus on progress of actions to achieve the target risk score for existing risks. Risks from clinical directorate and corporate functions risk registers are discussed and will be included on the corporate risk register if the agreed risk score is 12 or more.

The Senior Management Team, chaired by the Chief Executive Officer, reviews the updated corporate risk register and a report from the Corporate Risk Review Group every month. The Audit Committee also receives an update from the Corporate Risk Review Group at each meeting and the Board of Directors receive an update each month, and a more detailed report together with the complete corporate risk register on a quarterly basis.

4. Board Assurance Framework

The Board Assurance Framework (BAF) is an essential tool which brings together the key strategic objectives, the requirements of licensing and regulatory bodies and provides detail and assurance on the systems of control which underpin delivery of the strategic objectives. It offers visible assurance on the board's overall governance responsibilities.

The BAF brings together all of the essential elements for achieving the Trusts goals and ambitions, and of maintaining regulatory compliance and compliance with the Foundation Trust Licence. It systematically evaluates the risks to achieving these. It asks:

- What are the things we have agreed as strategic priorities?
- What are the essential prerequisites to confidently maintaining regulatory compliance?
- What are the essential prerequisites for compliance with the terms of our Foundation Trust Licence?
- What are the risks to these prerequisites?

Taking each risk in turn, the BAF records the controls and the assurances already in place. Gaps in controls and assurances can then be identified and actions agreed to close the gaps. By focusing on gaps in controls and assurances, the Board can be confident that all necessary steps are being taken to assure delivery of the trusts overall objectives and obligations as above, and that resources can be allocated in the right place. The BAF is a live document which is reviewed by Executive Directors on a monthly basis.

Some gaps in controls or assurances will also feature on the corporate risk register as they present a current risk which requires mitigation.

The highest scoring risks on the corporate risk register for 2016/17 and going forward relate to the:

- Risk to the quality of service delivery in Medicine due to gaps in rotas following the Deanery allocation process;
- Risk to service delivery due to the lack of experienced registered nurses due to national labour market shortage;
- Risk to financial sustainability from failure to deliver the Clinical Transformation Programme at pace and scale;
- Risk to urgent care system due to a lack of capacity in the out of hospital services;
- Risk of financial deficit and impact on service delivery due to failure to deliver the Trust annual plan by having excess expenditure or a shortfall in income;
- Risk of patient harm as a result of being lost to follow-up;
- Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down;
- Risk to patient safety due to a lack of provision of acute oncology services;
- Risk of temporary reduced or loss of activity as a result of disruption to services due to the major refurbishment to the Sterile Services department;
- Risk to reputation due to non-compliance with DNACPR policy caused by failure of some clinicians to implement policy.

During 2016/17 the strategic risks identified on the Board Assurance Framework included risk of:

- Lack of medical, nursing and clinical staff;
- High levels of frailty in local population;
- Failure to learn from feedback and incidents;
- Insufficient focus on quality in the Trust;
- Failure to deliver integrated models of care;
- Lack of interoperable systems across New Models of Care partners to enable access by all concerned to a single shared record;
- Misalignment of Commissioner/partner strategic plans;
- Service sustainability;
- Failure to deliver the Operational Plan;
- Loss of Monitor Provider Licence;
- External funding constraints;
- Lack of fit for purpose critical infrastructure; and
- Insufficient senior leadership capacity.

In 2016/17 the Board of Directors ensured that detailed controls were in place to mitigate risks and support assurance. The Board of Directors will ensure going forward that detailed controls will continue to be in place to support assurance and mitigate risks. All risks, mitigation and progress against actions are monitored formally at Directorate, Corporate and Board level every month.

The quality of performance information is the responsibility of the Senior Information Risk Owner (SIRO) who chairs the Data and Information Governance Steering Group and advises the Board of Directors on the effectiveness of information risk management across the organisation. In addition, the quality of performance information is tested by both Internal and External Audit within their planned programmes of work.

The Trust has put in place due processes to ensure information governance and data security in accordance with national recommendations led by the Senior Information Risk Owner at Board level. The Information Governance Toolkit return is formally approved by the Board of Directors prior to submission.

The Trust has an Integrated Board Report (IBR) which triangulates key information metrics covering quality, workforce, finance and efficiency and operational performance, presenting trends over time to enable identification of improvements and deteriorations. The report currently includes 65 RAG (red, amber, green) rated indicators of which 26 relate to quality, 18 to finance and efficiency and 21 to operational performance.

In addition there is a quality dashboard which has additional quality indicators at Trust level and at ward level.

The IBR is available to each Board meeting and meetings of the Council of Governors, and this and the quality dashboard are reviewed by the Quality Committee and are available to each of the steering groups responsible for leading work to ensure compliance with CQC standards.

In addition there are regular director inspections and patient safety visits which provide assurance on quality and compliance with CQC standards.

Internal Audit most recently assessed compliance with Monitor's Licence conditions in November 2014 and with CQC fitness to register in March 2017 and gave significant assurance for both. The Audit Committee reviews the evidence for compliance with CQC registration requirements annually.

Principal risks to compliance with Monitor's Licence Section 6 – NHS Foundation Trust Condition 4 (FT governance) relate to:

- Effectiveness of governance structures;
- Responsibilities of Directors and subcommittees;
- Reporting lines and accountabilities between the Board, subcommittees and Executive team;
- Submission of timely and accurate information to assess risks to compliance with Trusts licence;
- Degree and rigour of oversight the Board has over trust performance.

There are no significant risks that have been identified to compliance with the NHS Foundation Trust Licence Condition 4 (FT governance). The Trust ensures compliance with the requirements of Monitors Provider Licence in it's entirety via annual and in-year submission as required by NHS Improvement's Single Oversight Framework. These submissions include detailed information on financial performance, plans and forecasts, and third party information, in order to assess the risk to continuity of services and governance.

This Annual Governance Statement also provides an outline of the structures and mechanisms that the Trust has in place to maintain a sound system of governance and internal control to meet the requirement of the Licence Condition 4, Section 6. It takes assurance from these structures as well as feedback from Internal and External Audit and other internal and external stakeholders regarding the robustness of these governance structures. These same mechanisms are used by the Board to ensure the validity of the annual Corporate Governance Statement.

In order to mitigate the risks to compliance with Monitor's Licence Condition 4, the Trust has in place a well defined governance framework with clear accountability and reporting to ensure integrated governance, to deliver the Trusts objectives and to provide assurance to the Board of Directors.

In 2015 staff from across the organisation participated in a rapid process improvement review of quality governance structures and processes. The outcome was a well-defined framework of committees and groups with clear accountability and reporting to ensure integrated governance, to deliver the Trusts objectives and to provide assurance to the Board of Directors. Quality of patient care is at the heart of this framework.

Executive Directors, Non-Executive Directors, Governors, lay members and other stakeholders are key participators in many of the Trust's committees.

During 2015, the Trust commissioned an independent review of governance against Monitor's Well-led framework for governance reviews. The review noted a number of areas of strength and good practice including:

- A Board which is composed of high calibre individuals from a broad spectrum of backgrounds which were observed to bring insightful challenge and debate to all aspects of the Trust's business;
- Clear processes for holding people to account for delivery which are widely considered by the workforce to be effective in practice;
- Robust succession planning which is in place several tiers below executive level; and

- The fostering of a positive culture within the Trust, with good engagement from the wider workforce in the success and sustainability of the organisation.

There were no material areas of concern in relation to the Board and the governance arrangements in place at the Trust. There were some areas identified for further progress and improvement:

- More explicit tracking and monitoring of progress against strategic objectives and milestones at Board, committee and Directorate Board meetings;
- Restating the roles of the Board committees to ensure that they have sufficient time to cover the accountabilities set out in their terms of reference, and that the expectations of assurance reporting into them from directorates are both clarified and standardised; and
- An acknowledged need to increase the opportunities for engagement with staff working in community services.

Work has been undertaken to address each of these recommendations.

The Trust was inspected by the Care Quality Commission (CQC) as part of its routine programme of inspections in February 2016. The Trust and Harrogate District Hospital were given a rating of "good" overall. Harrogate District Hospital, Community Services and the Trust were rated as "outstanding" for the caring domain, and four individual services were rated as "outstanding". Improvements identified by the CQC formed the basis of a trust-wide action plan which is almost complete.

The Board of Directors is responsible for exercising all of the powers of the Trust; however, it has the option to delegate these powers to senior management and other committees. The Board:

- sets the strategic direction for the Trust;
- allocates resources;
- monitors performance against organisational objectives;
- ensures that clinical services are safe, of a high quality, patient-focused and effective;
- ensures high standards of clinical and corporate governance; and
- along with the Council of Governors, engages members and stakeholders to ensure effective dialogue with the communities it serves.

The Board is also responsible for ensuring that the Trust exercises its functions effectively, efficiently and economically and that compliance with the Trust's Licence; and Constitution are maintained.

During 2016/17 there have been five formally constituted committees of the Board; the Audit Committee, the Quality Committee, the Nomination Committee, the Remuneration Committee and the Finance Committee.

The Audit Committee

Four Non-Executive Directors comprise the Audit Committee, and one of these is the Chair. The Deputy Chief Executive/Finance Director and Deputy Director of Governance have a standing invitation to meetings and the Chief Executive attends one meeting per year, when considering the Annual Report and Accounts and Annual Governance Statement. Other Executive Directors attend meetings when the Committee is discussing areas of risk or operations that are the responsibility of those individual Directors.

The key responsibilities of the Audit Committee are to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. The Committee ensures that there is an effective Internal Audit function that meets mandatory NHS Internal Audit Standards. Internal Audit's primary role is to provide an opinion and assurances on the adequacy and effectiveness of the systems of internal control and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. The Committee also reviews the work and findings of the External Auditors appointed by the Council of Governors and considers the implications and management's responses to their work. The Audit Committee receives reports from Internal and External Audit, the Quality Committee and the Corporate Risk Review Group which enable it to provide independent assurance on governance and controls to the Board. This also enables triangulation of key issues to enhance the Board and Committee's oversight and assurance role. The annual audit plans for Internal Audit are approved by the Audit Committee and are prioritised to focus on areas of risk and concern.

The Quality Committee

The Quality Committee is the primary mechanism by which the Board gains assurance regarding the safety and quality of services. It is chaired by a Non-Executive Director, and two other Non-Executive Directors are members including one who is a member of the Audit Committee. There is senior representation from the clinical directorates and corporate functions including the Chief Nurse, Director of Workforce and Organisational Development, Chief Operating Officer, Clinical Directors, Deputy Medical Director, Deputy Director of Governance and Head of Risk Management. On behalf of the Board, it seeks assurance on the systems and processes in place to deliver high quality care and provides scrutiny of the outcomes of these systems and processes in relation to quality. It also provides direction regarding the delivery of the Trusts quality improvement priorities and strategic objectives in respect of quality, and provides oversight and seeks assurance on regulatory compliance. The annual clinical audit plans are approved and monitored by the Quality Committee. Governor representatives sit on the Quality Committee as observers.

The Finance Committee

The key responsibilities of the Finance Committee are to ensure appropriate oversight of strategic financial planning by scrutinising the development of the Trust's financial and commercial strategy; the assumptions and methodology used in developing the strategy; recommending to the Board the 5 year financial plan and 2 year operational financial plan; and ensuring appropriate due diligence is undertaken in relation to any significant transactions. The Committee also provides assurance to the Board on in-year financial performance, including budget setting and progress against cost improvement plans. The Committee is comprised of three Non-Executive Directors, one of whom is the Chair. The Deputy Chief Executive/Finance Director, Chief Operating Officer and Deputy Finance Director also attend each meeting, and other Trust representatives may be requested to attend to discuss particular items. Governor representatives sit on the Finance Committee as observers.

The Remuneration Committee

The key responsibilities of the Remuneration Committee is to make recommendations to the Board on the remuneration, allowances and terms of service for the Executive Directors, to ensure that they are fairly rewarded for their individual contribution to the organisation, having proper regard to the organisations circumstances and performance, as well as the national position of the NHS as a whole. The Committee is comprised of the Trust's Chairman and all other Non-Executive Directors. The Chief Executive and Director of Workforce and Organisational Development attend in an advisory capacity.

The Nomination Committee

The key responsibilities of the Nomination Committee is to review and approve job descriptions and person specifications for each Executive Director, including consideration of the knowledge, skills and experience required for each post, taking into account the needs of the Board as a whole. The Committee approves the process and arrangements for the recruitment, selection and appointment of the Executive Directors. The Committee is comprised of the Chairman and all other Non-Executive Directors for the purposes of the appointment of the Chief Executive. For the purposes of the appointment of other Executive Directors, the Chief Executive will also be invited to attend meetings in an advisory capacity.

The Senior Management Team

The Senior Management Team meeting is the principal forum for ensuring and assuring the delivery of the Trust's business, including annual operating and financial plans. It exists to ensure that the Trust's strategic and operational objectives are met. The group maintains oversight of operational performance and management of risk in a systematic and planned way. The group is the most senior executive decision making forum and receives reports and recommendations from sub-groups and via the Chief Executive, reports to the Board of Directors.

The Senior Management Team is supported by the clinical directorates and a number of subgroups, with a collective responsibility to drive and co-ordinate the Trust's objectives. The key subgroups are the Learning from Patient Experience Steering Group, Improving Patient Safety Steering Group, Improving Fundamental Care Steering Group, Supporting Vulnerable People Steering Group, Providing a Safe Environment Steering Group, Workforce and Organisational Development Steering Group, Operational Delivery Group and Corporate Risk Review Group. There is appropriate representation on these groups from the clinical directorates and corporate functions and they are chaired by Executive Directors, with the exception of the Corporate Risk Review Group which is chaired by the Deputy Director of Governance.

The clinical directorates and the subgroups of the Senior Management Team ensure delivery of the Trust's objectives through a broad framework of groups that manage and deliver work, for example: the Mortality Review Group; Information Technology Steering Group; End of Life Care Steering Group; Infection Prevention and Control Steering Group. Information Governance is managed by the Data and Information Governance Steering Group. The Complaints and Risk Management Group (CORM) comprising senior staff meets weekly to monitor and ensure active risk management is in place. Concerns identified from incidents, claims, complaints and risk assessments are investigated to ensure that lessons are learnt.

Each Directorate Board oversees quality and governance within the directorate, ensures appropriate representation on groups within the governance framework and reports to the Senior Management Team. The directorates work within an accountability framework which ensures that the systems of control are in place and adhered to. The Executive Director Team regularly review the work of the directorates against the accountability framework.

There is a weekly meeting of the Executive Director Team where operational matters are discussed in detail and actioned.

Quality of Care Teams exist at ward, team and department level to champion, monitor and promote quality care and report to the Directorate Quality and Governance Groups. Interested public governors have formed alliances with some of the teams.

There are regular meetings with Commissioners at the Contract Management Board and other meetings, and with NHS England and Public Health Commissioners to review performance and quality.

The Trust has conducted a self-assessment against the conditions set out in its Provider Licence with Monitor and was deemed to be fully compliant. In addition it has also carried out self-assessments against the updated NHS Foundation Trust Code of Governance, as part of the Annual Reporting Framework. This process has ensured that there is clarity relating to robust governance structures, responsibilities, reporting lines and accountabilities and the provision of timely and accurate performance information to the Board.

The robust risk and control framework described enables the Trust to declare assurance against the validity of its Corporate Governance Statement, which will be submitted to NHS Improvement in June 2017 in line with the requirements of the Single Oversight Framework.

The Trust actively engages with patients, service users and stakeholders and has an effective structure for public stakeholder involvement, predominantly through the Council of Governors and its sub-committees. Consultations with Commissioners on the wider aspects of risk are undertaken through the monthly contract management meetings.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Trust produces an annual Operating Plan that is underpinned by detailed plans produced by the directorates. The Plan details how the Trust will utilise its resources throughout the year, identifies the principal risks to the delivery of the Plan and the mitigation and is supported by detailed financial forecasting. Each directorate is required to deliver cost improvement plans in order to ensure economy, efficiency and effectiveness of the use of resources. The cost improvement plans are scrutinised and approved by the Medical Director and Chief Nurse via the process of quality impact assessments to ensure the quality of services is maintained.

The capital programme and the prioritisation of revenue resources to form the annual Operating Plan are informed by the Trust objectives, quality improvement priorities and identified risks.

During 2016/17 the Trust continued to implement a carbon efficiency scheme to deliver reductions in carbon emissions and to deliver significant energy efficiency.

The annual Operating Plan is produced in consultation with the Council of Governors and approved by the Board of Directors.

Directorates work within the terms of an accountability framework and meet regularly with Executive Directors to ensure compliance. There is a monthly report to the Board relating to performance and finance against plans and targets. The Board Assurance Framework serves as a monitoring document to ensure that appropriate action is being taken against the principal risks of failing to deliver the business plan.

There is monthly reporting to NHS Improvement relating to performance and finance against plans and targets, and reference costs are submitted annually. The Trust reviews information and feedback from regulators and external agencies e.g. Care Quality Commission, National Staff Survey, National Patient Surveys, to benchmark performance against other organisations and to improve economy, efficiency and effectiveness.

Information governance

Any potential information governance incidents are reported internally and reviewed by the Data and Information Governance Steering Group. The Trust has reported two Level 2 incidents to the ICO during 2016/17. Both incidents relate to staff inappropriately accessing patient information. The first incident has been looked into by the ICO and they confirmed that offence was committed against the Trust and that they were satisfied that appropriate measures were taken and closed the incident. The second incident is still under investigation by the Trust and once this investigation has been completed the ICO will look into it.

Annual Quality Report

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. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual.*

The content of the Quality Account has been prepared within the established governance structures and framework and in accordance with the Annual Reporting Manual and other guidance from NHS Improvement. Leadership comes from the Board of Directors with clearly devolved responsibility and accountability for individual quality improvement priorities.

Quality improvement priorities and associated quality metrics are established each year based on consultation with stakeholders, and reflect the priorities of the organisation. They are approved by the Senior Management Team and the Board of Directors. A framework for reporting data and progress against local targets to the Quality Committee is in place. This has enabled a regular and routine review of the progress with quality improvement throughout the year.

The Chief Nurse is responsible for the preparation of the Quality Account and for ensuring that this document presents a balanced view of quality within the Trust. The Quality Account is prepared with contributions from all responsible and accountable leads and drafted by the Deputy Director of Governance. The Quality Committee is responsible for approving the report prior to submission with the Annual Report and Accounts to the Audit Committee and then the Board of Directors. The NHS Foundation Trust's External Auditors KPMG carry out a limited review of the arrangements around the data quality and information included in the Quality Account and assess whether a balanced view of quality is presented based on other information.

Internal Audit provides further assurance regarding the systems in place to ensure that the Quality Account is compliant with national guidance and that adequate data quality controls are in place to ensure that performance data is accurate and complete. Internal Audit has found that robust processes are in place to collect, validate and monitor performance data in relation to both the A&E four hour wait and the 14 day cancer wait targets. Data included in the Quality Account for both targets was consistent with data reported internally and externally by NHS England. An opinion of high assurance has been given for the Quality Account 2016/17.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, Clinical Audit and the Executive Managers and Clinical Leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors, the Audit Committee, the Quality Committee, the Complaints and Risk Management Group (CORM) and Corporate Risk Review Group, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I have also reviewed the systems for writing and validating the Quality Account and for the involvement of stakeholders therein.

The Board of Directors has concluded that the systems of internal control are effective, and evidenced by:

- NHS Improvement's use of resources risk rating for the Trust is currently 1. (risk ranges from 1, the least serious risk, to 4, the highest risk);
- The governance risk rating, issued by NHS Improvement is green;
- CQC rating for the Trust following comprehensive inspection in 2016 is "good";
- The Board Assurance Framework and the Corporate Risk Register;
- Presentation of the Annual Governance Statement to the Audit Committee by the Accountable Officer;
- The Audit Committee Annual Report, which includes Internal Audit and assurance relating to Corporate Risk Review Group;
- The Quality Committee Annual Report;
- Annual report from Senior Management Team and subgroups and directorates;
- Internal and Clinical Audit Plan, prioritised on areas of risk and concern;
- Clinical Audit Annual Report;
- Internal Audit periodic reports and follow up of Internal Audit recommendations;
- Internal Audit Annual Report and Head of Internal Audit opinion;
- ISA260 Audit Highlights Memorandum (External Audit Report);
- Independent review of governance against the Well-led Framework by Deloitte (December 2015).

I am assured adequate and well-designed systems are in place, but there remain some control weaknesses in the operational compliance with these systems, evidenced by Internal Audit and the Head of Internal Audit opinion in relation to intravenous cannula care and staff rostering. In addition, following control weaknesses previously identified in relation to safety netting in ophthalmology (ensuring that all patients are appropriately followed up), a new expanded and broader audit focusing on additional services has highlighted some further gaps in control. The associated risk has been recognised on the corporate risk register and controls are being established.

This is an area of constant vigilance for myself as Accounting Officer and the Board of Directors, and progress will be monitored and subject to further audit during 2017/18.

Conclusion

In summary I am assured that the NHS Foundation Trust has a robust system of internal control in place, which is designed to manage the key organisational objectives and minimise the NHS Foundation Trust's exposure to risk. The Board of Directors is committed to continuous improvement and enhancement of the system of internal control.

Signed: .... Dr Ros Tolcher - Chief Executive
Date: 24 May 2017.

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2017

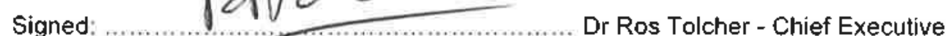
	Note	Group 2016/17 Total £000	Group 2015/16 Total £000
Operating income from continuing operations	3	**217,782**	188,563
Operating expenses of continuing operations	4	**(211,094)**	(185,922)
OPERATING SURPLUS		**6,688**	2,641
FINANCE COSTS			
Finance income	6.1	65	104
Finance expense - financial liabilities	7	(233)	(118)
Finance expense - unwinding of discount on provisions	15.2	(8)	(10)
Public Dividend Capital - dividends payable		(2,746)	(2,260)
NET FINANCE COSTS		(2,922)	(2,284)
Losses on disposal of assets		-	(339)
Movement in fair value of investments	10	**251**	(106)
SURPLUS/(DEFICIT) FOR THE YEAR		4,017	(88)
Other comprehensive income			
Revaluations	9.1 & 9.2	**1,968**	2,892
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		5,985	2,804

The notes on pages 27 to 58 form part of these financial statements.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
as at 31 March 2017

	Note	Group 31 March 2017 £000	Group 31 March 2016 £000
Non-current assets			
Intangible assets	8	**402**	443
Property, plant and equipment	9	**100,440**	98,091
Other Investments	10	**1,906**	1,750
Trade and other receivables	12.1	**294**	316
Total non-current assets		**103,042**	100,600
Current assets			
Inventories	11.1	**2,427**	2,621
Trade and other receivables	12.1	**18,932**	15,119
Cash and cash equivalents	13	**4,688**	5,568
Total current assets		**26,047**	23,308
Current liabilities			
Trade and other payables	14	**(16,495)**	(16,703)
Borrowings	17	**(999)**	(999)
Provisions	15.1	**(131)**	(101)
Other liabilities	16	**(2,142)**	(2,707)
Total current liabilities		**(19,767)**	(20,510)
Total assets less current liabilities		**109,322**	103,398
Non-current liabilities			
Borrowings	17	**(10,776)**	(11,776)
Provisions	15.1	**(238)**	(289)
Total non-current liabilities		**(11,014)**	(12,065)
Total assets employed		**98,308**	91,333
Financed by taxpayers' equity:			
Public Dividend Capital		**79,668**	78,678
Revaluation reserve		**16,801**	14,833
Income and expenditure reserve		**(254)**	(3,942)
HDFT charitable fund reserves	24	**2,093**	1,764
Total taxpayers' equity (see page 21)		**98,308**	91,333

The notes on pages 27 to 58 form part of these financial statements.

Signed:  Dr Ros Tolcher - Chief Executive

Date: 24 May 2017.

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2017

	HDFT charitable fund reserve	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Group Total
	£000	£000	£000	£000	£000
Balance as at 1 April 2016	1,764	78,678	14,833	(3,942)	91,333
Surplus for the financial year (Page 19)	662	-	-	3,355	4,017
Revaluations (Note 9.1)	-	-	1,968	-	1,968
Public Dividend Capital received	-	990	-	-	990
Other reserve movements - charitable funds consolidation adjustment	(333)	-	-	333	-
Balance at 31 March 2017	2,093	79,668	16,801	(254)	98,308

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2016

	HDFT charitable fund reserve	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Group Total
	£000	£000	£000	£000	£000
Balance as at 1 April 2015	2,229	78,680	11,922	(4,302)	88,529
(Deficit) for the financial year (Page 19)	20	-	-	(108)	(88)
Transfers between reserves	-	(2)	19	(17)	-
Revaluations (Note 9.2)	-	-	2,892	-	2,892
Other reserve movements - charitable funds consolidation adjustment	(485)	-	-	485	-
Balance at 31 March 2016	1,764	78,678	14,333	(3,942)	91,333

The notes on pages 27 to 58 form part of these financial statements.

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2017

	Note	Group 2016/17 £000	Group 2015/16 £000
Cash flows from operating activities			
Operating surplus from continuing operations		**6,688**	2,641
		6,688	2,641
Non-cash income and expense			
Depreciation and amortisation	4.1	**4,657**	4,572
Reversals of impairments	9.1	**(159)**	(350)
Increase in trade and other receivables		**(3,663)**	(4,463)
(Increase)/Decrease in inventories	11.1	**194**	(47)
Increase/(Decrease) in trade and other payables		**(79)**	1,685
Increase/(Decrease) in other liabilities	16	**(565)**	2,018
Decrease in provisions		**(29)**	(93)
HDFT Charitable Funds - net adjustments for working capital		**(149)**	39
NET CASH GENERATED FROM OPERATIONS		**6,895**	6,002
Cash flows from investing activities			
Interest received		**17**	46
Purchase of Intangible assets	8	**(94)**	(204)
Purchase of Property, Plant and Equipment		**(4,828)**	(11,709)
HDFT Charitable funds - net cash flows from investing activities		**144**	205
Net cash used in investing activities		**(4,761)**	(11,662)
Cash flows from financing activities			
Public dividend capital received		**990**	-
Loans received from the Department of Health	17	**-**	8,965
Loans repaid to the Department of Health		**(999)**	(545)
Interest paid		**(234)**	(73)
PDC dividend paid		**(2,771)**	(2,265)
Net cash generated/(used) in financing activities		**(3,014)**	6,082
Net increase/(decrease) in cash and cash equivalents	13	**(880)**	422
Cash and cash equivalents at 1 April 2016	13	**5,568**	5,146
Cash and cash equivalents at 31 March 2017	13	**4,688**	5,568

The notes on pages 27 to 58 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2017

	Note	Foundation Trust 2016/17 Total £000	Foundation Trust 2015/16 Total £000
Operating income from continuing operations	3	**217,385**	188,646
Operating expenses of continuing operations	4	**(210,726)**	(185,588)
OPERATING SURPLUS		**6,659**	3,058
FINANCE COSTS			
Finance income	6	**16**	46
Finance expense - financial liabilities	7	**(233)**	(118)
Finance expense - unwinding of discount on provisions	15.2	**(8)**	(10)
Public Dividend Capital - dividends payable		**(2,746)**	(2,260)
NET FINANCE COSTS		**(2,971)**	(2,342)
Losses on disposal of assets		-	(339)
SURPLUS FOR THE YEAR		3,688	377
Other comprehensive income			
Revaluations	9.1 & 9.2	1,968	2,892
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		5,656	3,269

The notes on pages 27 to 58 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF FINANCIAL POSITION
as at 31 March 2017

	Note	Foundation Trust 31 March 2017 £000	31 March 2016 £000
Non-current assets			
Intangible assets	8	**402**	443
Property, plant and equipment	9	**100,440**	98,091
Trade and other receivables	12.1	**294**	316
Total non-current assets		**101,136**	98,850
Current assets			
Inventories	11.1	**2,427**	2,621
Trade and other receivables	12.1	**18,803**	15,000
Cash and cash equivalents	13	**4,555**	5,527
Total current assets		**25,785**	23,148
Current liabilities			
Trade and other payables	14	**(16,420)**	(16,557)
Borrowings	17	**(999)**	(999)
Provisions	15.1	**(131)**	(101)
Other liabilities	16	**(2,142)**	(2,707)
Total current liabilities		**(19,692)**	(20,364)
Total assets less current liabilities		**107,229**	101,634
Non-current liabilities			
Borrowings	17	**(10,776)**	(11,776)
Provisions	15.1	**(238)**	(289)
Total non-current liabilities		**(11,014)**	(12,065)
Total assets employed		**96,215**	89,569
Financed by taxpayers' equity:			
Public Dividend Capital		**79,668**	78,678
Revaluation reserve		**16,801**	14,833
Income and expenditure reserve		**(254)**	(3,942)
Total taxpayers' equity (see page 25)		**96,215**	89,569

The notes on pages 27 to 58 form part of these financial statements.

Signed: .... Dr Ros Tolcher - Chief Executive

Date: 24 May 2017.

FOUNDATION TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2017

	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Foundation Trust Total
	£000	£000	£000	£000
Balance as at 1 April 2016	78,678	14,833	(3,942)	89,569
Surplus for the financial year (see page 23)	-	-	3,688	3,688
Revaluations (Note 9.1)	-	1,968	-	1,968
Public Dividend Capital received	990	-	-	990
Balance at 31 March 2017	79,668	16,801	(254)	96,215

FOUNDATION TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2016

	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Foundation Trust Total
	£000	£000	£000	£000
Balance as at 1 April 2015	78,680	11,922	(4,302)	86,300
Surplus for the financial year (see page 23)	-	-	377	377
Transfers between reserves	(2)	19	(17)	-
Revaluations (Note 9.2)	-	2,892	-	2,892
Balance at 31 March 2016	78,678	14,833	(3,942)	89,569

The notes on pages 27 to 58 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2017

	Note	Foundation Trust 2016/17 £000	2015/16 £000
Cash flows from operating activities			
Operating surplus from continuing operations		**6,659**	3,058
		6,659	3,058
Non-cash income and expense			
Depreciation and amortisation	4.1	**4,657**	4,572
Reversals of impairments	9.1	**(159)**	(350)
Increase in trade and other receivables		**(3,824)**	(4,371)
(Increase)/Decrease in inventories	11.1	**194**	(47)
Increase in trade and other payables		**14**	1,627
Increase/(Decrease) in other liabilities	16	**(565)**	2,018
Decrease in provisions		**(29)**	(93)
NET CASH GENERATED FROM OPERATIONS		**6,947**	6,414
Cash flows from investing activities			
Interest received		**17**	46
Purchase of Intangible assets	8	**(94)**	(204)
Purchase of Property, Plant and Equipment		**(4,828)**	(11,709)
Net cash used in investing activities		**(4,905)**	(11,867)
Cash flows from financing activities			
Public dividend capital received		**990**	-
Loans received from the Department of Health	17	**-**	8,965
Loans repaid to the Department of Health		**(999)**	(545)
Interest paid		**(234)**	(73)
PDC dividend paid		**(2,771)**	(2,265)
Net cash generated/(used) in financing activities		**(3,014)**	6,082
Net increase/(decrease) in cash and cash equivalents	13	**(972)**	629
Cash and cash equivalents at 1 April 2016	13	**5,527**	4,898
Cash and cash equivalents at 31 March 2017	13	**4,555**	5,527

The notes on pages 27 to 58 form part of these financial statements.

1 GROUP ACCOUNTING POLICIES AND OTHER INFORMATION

NHS Improvement (NHSI), in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHSI has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accouning Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to the NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property and investments.

International Accounting Standard (IAS) 1 requires management to assess, as part of the accounts preparation process, the NHS foundation trust's ability to continue as a going concern. In accordance with the DH GAM the financial statements have been prepared on a going concern basis as the trust's management does not intend to apply to the Secretary of State for the dissolution of the NHS foundation trust, nor have management been informed by the relevant national body of the intention of dissolution.

1.2 Consolidation

The NHS foundation trust is the corporate trustee to the Harrogate and District NHS Foundation Trust Charitable Fund (registered charity number 1050008). The NHS foundation trust has assessed its relationship with the charitable fund and determined it to be a subsidiary because the NHS foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable funds statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the NHS foundation trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the NHS foundation trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.4 Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.4 Expenditure on employee benefits (continued)

Pension costs - NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust (consistent with all participating members of the scheme) to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the Scheme, except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the NHS foundation trust commits itself to the retirement, regardless of the method of payment.

Pension costs - National Employment Savings Trust (NEST) Pension Scheme

The Pensions Act 2008 requirements created a duty for the NHS foundation trust to provide a pension scheme for employees who are ineligible to join the NHS Pension Scheme. The NHS foundation trust selected NEST as it's partner to meet this duty. The scheme operated by NEST on the NHS foundation trust's behalf is a defined contribution scheme, employers contributions are charged to operating expenses as and when they become due.

1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the NHS foundation trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- individually has a cost of at least £5,000; or
- collectively has a cost of at least £5,000 and individually has a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Capitalised set up costs and grouped assets are reviewed annually and if fully depreciated are removed from the Fixed Asset Register and the Accounts.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

1.6 Property, plant and equipment (continued)

Valuation

Land and buildings used for the NHS foundation trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the statement of financial position date. Fair values are determined as follows:

Land and specialised buildings – depreciated replacement cost
Non specialised buildings – existing use value

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. All valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS). The NHS foundation trust had a desktop valuation of its land buildings carried out as at 31 March 2016 based on an alternative site in-line with HM Treasury's approach. The NHS foundation trust's management having taken advice from professionally qualified valuers, determined that a full valuation should be carried out as at 31 March 2017 ensuring that land and buildings are held at fair value. The full valuation will also be based on an alternative site in-line with with HM Treasury's approach, this revised valuation has been incorporated in the financial statements.

An item of property, plant and equipment which is surplus with no plan to bring back into use is valued at fair value under IFRS 13.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Costs include professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by International Accounting Standard (IAS) 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as a proxy for fair value.

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income. Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of "Other Comprehensive Income".

In accordance with the DoH GAM, impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment. Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.6 Property, plant and equipment (continued)

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Plant and equipment assets are depreciated on a straight line basis over the following asset life ranges:

	Years
Plant and machinery	5-15
Transport equipment	10
Information technology	5-10
Furniture and fittings	5-10
Buildings and Dwellings (Assessed by a RICS qualified valuer when a valuation takes place)	1-90

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;

- the sale must be highly probable i.e.

    - management is committed to a plan to sell the asset;
    - an active programme has begun to find a buyer and complete the sale;
    - the asset is being actively marketed at a reasonable price;
    - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.7 Intangible assets

Intangible assets are capitalised when they have a cost of at least £5,000. Intangible assets acquired separately are initially recognised at fair value. The NHS foundation trust does not recognise any internally generated assets and associated expenditure is charged to the statement of comprehensive income in the period in which it is incurred. Expenditure on research activities is recognised as an expense in the period in which it is incurred.

1.7 Intangible assets (continued)

Following initial recognition, intangible assets are carried at amortised historic cost as this is not considered to be materially different from fair value. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13. The NHS foundation trust's intangible fixed assets are wholly software licences which are purchased and are deemed to have a finite life determined by the licence agreement. The NHS foundation trust does not hold a revaluation reserve for intangible assets.

1.8 Leases

Finance Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating Leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight line basis over the term of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.9 Inventories

Pharmacy inventories are valued at weighted average historical cost. Other inventories are valued at the lower of cost and net realisable value using the first in, first out method.

1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.11 Provisions

The NHS foundation trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted a discount rate of 2.9% in real terms.

1.12 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to operating expenses. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed in note 15.

1.13 Non-clinical risk pooling

The NHS foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS foundation trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in the financial statements, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.15 Value Added Tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable the amounts are stated net of VAT.

1.16 Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange profits and losses are taken to the Statement of Comprehensive Income. At the Statement of Financial Position date, monetary items denominated in foreign currencies are retranslated at the rates prevailing.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. Details of third party assets are given in note 20 to the accounts.

1.18 Public Dividend Capital (PDC) and PDC dividend

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of International Accounting Standard (IAS) 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets, cash held with the Government Banking Service (GBS), excluding cash balances held in GBS accounts that relate to a short term working capital facility and any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average net assets as set out in the "pre-audit" version of the annual accounts. The dividend so calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.19 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the Statement of Comprehensive Income on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.20 Corporation Tax

The NHS foundation trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this but the trust is potentially within the scope of corporation tax in respect of activities where income is received from a non public sector source.

However the NHS foundation trust has determined that it has no corporation tax liability, as all activities are either ancillary to healthcare or below the de minimus level of profit at which tax is payable.

1.21 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the NHS foundation trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described in note 1.8 above.

Purchase or sales are recognised and derecognised, as applicable, using the trade date.

All other financial assets and financial liabilities are recognised when the NHS foundation trust becomes party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the NHS foundation trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as loans and receivables.

Financial liabilities are classified as other financial liabilities.

1.21 Financial instruments and financial liabilities (continued)

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The NHS foundation trust's loans and receivables comprise: cash and cash equivalents, NHS receivables and other receivables.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income. Loans from the Department of Health are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

Impairment of financial assets

At the Statement of Financial Position date, the NHS foundation trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the assets carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly or through the use of a bad debt provision. Bad debt provisions are used when there is some uncertainty that the debt will be paid. Bad debts are written off directly only when there is certainty that the debt will not be paid.

1.22 Critical accounting estimates and judgements

The preparation of financial statements under IFRS requires the trust to make estimates and assumptions that affect the application of policies and reported amounts. Estimates and judgements are continually evaluated and are based on historical experience and other factors that are considered to be relevant.

Revisions to accounting estimates are recognised in the period that the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

1.22 Critical accounting estimates and judgements (continued)

Although the NHS foundation trust makes estimates within these financial statements such as incomplete patient spells, accrued income, annual leave accrual and provisions e.g. early retirements, the amounts involved would not cause a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

In relation to incomplete patient spells the NHS foundation trust makes an assessment of activity for work in progress at 31 March, based on bed occupancy at midnight. The methodology used is to assess the value of income due, to be accounted for in the period between admission and month end, based on an average daily price at speciality/point of delivery, this is calculated and used as the basis of the accrual.

In relation to estimations for uncoded NHS income at the financial yearend, the NHS foundation trust runs a forecast for income relating to March based on the average income received by specialty and point of delivery, all uncoded activity is then priced using an average. This methodology is used throughout the year and has proven to be robust with only very minor variances showing once the activity is coded and then costed.

In addition, a revaluation of the NHS foundation trust's land and buildings was undertaken at a prospective date of 31 March 2017 (see 1.6). The NHS foundation trust relies on the professional services of the Valuation Office for the accuracy of such valuations.

1.23 Non current investments

Investments are stated at market value as at the statement of financial position date. The statement of comprehensive income includes the net gains and losses arising on revaluation and disposals throughout the year.

1.24 Accounting standards and amendments that have been issued but have not yet been adopted

The following table presents a list of recently issued accounting standards and amendments which have not yet been adopted within HM Treasury's Financial Reporting Manual (FReM), and are therefore not applicable to Department of Health group accounts in 2016/17.

Change published	
IFRS 9 Financial Instruments	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 14 Regulatory Deferral Accounts	Not yet EU endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to Department of Health group bodies.
IFRS 15 Revenue from contracts with customers	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 16 Leases	Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2 Operating segments

2.1 Group operating segments

The NHS foundation trust's management has reviewed IFRS 8 (Operating Segments) and has determined that the consolidated financial statements consist of two segments "Healthcare" and "Charity".

	Group		Group	
	Healthcare	**Charity**	Healthcare	Charity
	2016/17	**2016/17**	2015/16	2015/16
	£000	**£000**	£000	£000
Operating Surplus/(Deficit)	**6,659**	**29**	3,058	(417)
Net Finance (Costs)/Income	**(2,971)**	**49**	(2,342)	58
Losses on disposal of assets	**-**	**-**	(339)	-
Movement in fair value of investments	**-**	**251**	-	(106)
SURPLUS/(DEFICIT) FOR THE YEAR	**3,688**	**329**	377	(465)
Non-current assets	**101,136**	**1,906**	98,850	1,750
Current assets	**25,785**	**262**	23,148	160
Current liabilities	**(19,692)**	**(75)**	(20,364)	(146)
Non-current liabilities	**(11,014)**	**-**	(12,065)	-
TOTAL ASSETS EMPLOYED	**96,215**	**2,093**	89,569	1,764
Financed by taxpayers' equity:				
Public Dividend Capital	**79,668**	**-**	78,678	-
Revaluation reserve	**16,801**	**-**	14,833	-
Income and expenditure reserve	**(254)**	**-**	(3,942)	-
HDFT Charitable fund reserves	**-**	**2,093**	-	1,764
TOTAL TAXPAYERS' EQUITY	**96,215**	**2,093**	89,569	1,764

3 Operating Income from continuing operations

3.1 Analysis of operating income	**Foundation Trust & Group**	
	2016/17	2015/16
	£000	£000
Income from activities by classification:		
Elective income	**28,076**	27,986
Non elective income	**32,859**	30,582
Outpatient income	**26,813**	25,442
Accident and Emergency income	**5,708**	5,335
Other NHS clinical income	**50,964**	45,739
Community services income from CCGs and NHS England	**27,871**	33,601
Community services income from other sources (e.g. local authorities)	**26,776**	6,969
Private patient income	**1,243**	1,446
Total income from activities	**200,310**	177,100

	Foundation Trust & Group	
	2016/17	2015/16
	£000	£000
Income from activities by source:		
NHS Foundation Trusts	**546**	506
NHS Trusts	**99**	4
CCGs and NHS England	**170,588**	166,990
Local Authorities (see below**)	**26,776**	6,969
Department of Health	**9**	-
NHS Other	**80**	142
Non NHS: Private Patients	**1,243**	1,446
Non-NHS: Overseas patients (chargeable to patient)	**77**	55
NHS injury scheme (see below*)	**541**	548
Non NHS: Other	**351**	440
Total income from activities	**200,310**	177,100

	Group	
	2016/17	2015/16
	£000	£000
Group other operating income:		
Research and development	**1,929**	1,347
Education and training	**5,147**	4,155
Non-patient care services to other bodies	**2,431**	2,618
Sustainability and Transformation Fund income	**3,450**	-
Rental revenue from operating leases (see note 3.4)	**184**	185
Staff recharges (secondments)	**645**	435
HDFT Charitable Funds: Incoming Resources excluding investment income	**730**	402
Other (see note 3.2)	**2,956**	2,321
Group total other operating income	**17,472**	11,463
Group total operating income	**217,782**	188,563

* NHS injury scheme income is subject to a provision for doubtful debts of 22.94% (2016: 21.99%) to reflect expected rates of

** The NHS foundation trust successfully tendered for 3 contracts to provide a range of children's services across Middlesbrough, Durham and Darlington, the contracts for providing these additional services commenced on 1 April 2016 and they have a collective annual value of £18m. The income is reflected above and the associated operating expenditure and employee numbers are included within notes 4 and 5.

3.1 Analysis of operating income (continued)

	Foundation Trust	
	2016/17	2015/16
	£000	£000
Total income from activities	**200,310**	177,100
Foundation Trust other operating income:		
Research and development	**1,929**	1,347
Education and training	**5,147**	4,155
Received from NHS charities: Receipt of grants/donations for capital acquisitions	**236**	412
Non-patient care services to other bodies	**2,528**	2,691
Sustainability and Transformation Fund income	**3,450**	-
Rental revenue from operating leases (see note 3.4)	**184**	185
Staff recharges (secondments)	**645**	435
Other (see note 3.2)	**2,956**	2,321
Foundation Trust total other operating income	**17,075**	11,546
Foundation Trust total operating income	**217,385**	188,646

3.2 Analysis of Other Operating Income: Other

	Foundation Trust & Group	
	2016/17	2015/16
	£000	£000
Car Parking	**777**	762
Estates recharges	**8**	10
Pharmacy Sales	**11**	12
Staff accommodation rentals	**124**	119
Clinical Tests	**435**	399
Catering	**384**	364
Property Rentals	**5**	30
Other income*	**1,212**	625
	2,956	2,321

NHS Improvement requires the NHS foundation trust to provide an analysis of other operating income using the categories above (see note 3.1).

*Other "Other" income includes for example Finance Staff Development levies (hosted service for the region), Mortuary fee income and income from the Trust's Staff Lottery.

3.3 Analysis of income from activities by Commissioner Requested Services (CRS) and Non-Commissioner Requested Services (Non-CRS).

	Foundation Trust & Group	
	2016/17	2015/16
	£000	£000
Commissioner Requested Services	**106,153**	100,391
Non-Commissioner Requested Services	**94,157**	76,709
Total	**200,310**	177,100

3.4 Operating lease income and future annual lease receipts

	Foundation Trust & Group	
	2016/17	2015/16
	£000	£000
Operating lease income	**184**	185
	184	185
Future minimum lease receipts due on buildings expiring		
- not later than one year;	**161**	158
- later than one year and not later than five years;	**387**	219
- later than five years.	**612**	20
	1,160	397

3.5 - Overseas visitors (relating to patients charged directly by the foundation trust)

Income recognised in year relating to overseas visitors was £77k (2016 £55k), cash payments received in year (relating to invoices raised in current and previous years) was £36k (2015 £54k) and amounts written off in year (relating to invoices raised in current and previous years) was £4k (2016 £0k).

4. Operating Expenses from continuing operations

4.1 Group operating expenses comprise:	**Group**	
	2016/17	2015/16
	£000	£000
Services from NHS Foundation Trusts	**789**	736
Services from NHS Trusts	**797**	809
Services from CCGs and NHS England	**63**	326
Services from other NHS bodies	**6**	5
Purchase of healthcare from non NHS Bodies	**19**	14
Employee Costs - Executive directors	**918**	875
Non-executive directors	**152**	141
Employee Costs - Staff	**150,944**	127,501
Drug costs (see note 11.2)	**14,061**	13,829
Supplies and services - clinical	**17,598**	17,789
Supplies and services - general	**2,684**	2,478
Establishment	**1,780**	1,358
Research and development	**24**	-
Transport	**885**	807
Premises - business rates payable to local authorities	**851**	926
Premises - other	**6,843**	5,919
Increase in provision for irrecoverable debts	**143**	978
Rentals under operating leases	**2,708**	2,030
Depreciation on property, plant and equipment (see note 9.1)	**4,522**	4,466
Amortisation on intangible assets (see note 8)	**135**	106
Impairments of property, plant and equipment	**(159)**	(350)
Audit services- statutory audit	**65**	79
Other auditor remuneration (external auditor only)	**-**	6
NHS Litigation Authority contribution - Clinical Negligence	**2,997**	2,562
Legal fees	**111**	90
Consultancy costs	**430**	518
Internal audit costs	**166**	166
Training, courses and conferences	**739**	766
Patients' travel	**16**	16
Redundancy	**31**	45
Early retirements	**7**	(15)
Hospitality	**-**	7
Insurance	**266**	212
Other services, eg external payroll	**18**	-
Losses, ex gratia and special payments (see note 19)	**75**	34
Other	**42**	359
HDFT Charitable funds: Other resources expended	**368**	334
Group total operating expenses	211,094	185,922

4. Operating Expenses from continuing operations (Continued)

4.2 Foundation Trust operating expenses comprise:

	Foundation Trust	
	2016/17	2015/16
	£000	£000
Services from NHS Foundation Trusts	**789**	736
Services from NHS Trusts	**797**	809
Services from CCGs and NHS England	**63**	326
Services from other NHS bodies	**6**	5
Purchase of healthcare from non NHS Bodies	**19**	14
Employee Costs - Executive directors	**918**	875
Non-executive directors	**152**	141
Employee Costs - Staff	**150,944**	127,501
Drug costs (see note 11.2)	**14,061**	13,829
Supplies and services - clinical	**17,598**	17,789
Supplies and services - general	**2,684**	2,478
Establishment	**1,780**	1,358
Research and development	**24**	-
Transport	**885**	807
Premises - business rates payable to local authorities	**851**	926
Premises - other	**6,843**	5,919
Increase in provision for irrecoverable debts	**143**	978
Rentals under operating leases	**2,708**	2,030
Depreciation on property, plant and equipment (see note 9.1)	**4,522**	4,466
Amortisation on intangible assets (see note 8)	**135**	106
Net impairments of property, plant and equipment	**(159)**	(350)
Audit services- statutory audit	**65**	79
Other auditor remuneration (external auditor only)	**-**	6
NHS Litigation Authority contribution - Clinical Negligence	**2,997**	2,562
Legal fees	**111**	90
Consultancy costs	**430**	518
Internal audit costs	**166**	166
Training, courses and conferences	**739**	766
Patients' travel	**16**	16
Redundancy	**31**	45
Early retirements	**7**	(15)
Hospitality	**-**	7
Insurance	**266**	212
Other services, eg external payroll	**18**	-
Losses, ex gratia and special payments (see note 19)	**75**	34
Other	**42**	359
Foundation Trust total operating expenses	**210,726**	185,588

4.3 Current year operating lease expenditure and future annual lease payments

	Foundation Trust & Group			
	2016/17	Buildings	Plant & Machinery	Other
	£000	£000	£000	£000
Minimum lease payments	**2,708**	**1,493**	**179**	**1,036**
	2,708	**1,493**	**179**	**1,036**
Future minimum lease payments due expiring;				
Within 1 year	**1,860**	**1,493**	**152**	**215**
Between 1 and 5 years	**337**	**-**	**183**	**154**
	2,197	**1,493**	**335**	**369**

4.4 Prior year operating lease expenditure and future annual lease payments

	Foundation Trust & Group			
	2015/16	Buildings	Plant & Machinery	Other
	£000	£000	£000	£000
Minimum lease payments	2,030	1,090	304	636
	2,030	1,090	304	636
Future minimum lease payments due expiring:				
Within 1 year	1,352	1,090	189	73
Between 1 and 5 years	256	-	192	64
	1,608	1,090	381	137

4.5 Limitation on external auditor's liability

	Foundation Trust & Group	
	2016/17	2015/16
	£000	£000
Limitation on external auditor's liability	**1,000**	1,000
	1,000	1,000

5. Employee costs and numbers

5.1 Employee costs

	Foundation Trust & Group			Foundation Trust & Group		
		Permanently			Permanently	
	2016/17	**Employed**	**Other**	2015/16	Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**122,458**	**120,135**	**2,323**	104,418	102,699	1,719
Social Security costs	**10,680**	**10,680**	-	7,247	7,247	-
Employer contributions to NHS Pensions Agency	**14,313**	**14,313**	-	12,355	12,355	-
Termination benefits	**38**	**38**	-	30	30	-
Agency/contract staff	**4,594**	-	**4,594**	4,508	-	4,508
Total employee expenses	**152,083**	**145,166**	**6,917**	128,558	122,331	6,227
Less costs capitalised as part of assets	**(183)**	**(183)**	-	(152)	(152)	-
Total employee costs excluding capitalised costs	**151,900**	**144,983**	**6,917**	128,406	122,179	6,227

5.2 Average number of employees (WTE basis)

	Foundation Trust & Group			Foundation Trust & Group		
		Permanently			Permanently	
	2016/17	**Employed**	**Other**	2015/16	Employed	Other
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**337**	**315**	**22**	316	297	19
Ambulance staff	**2**	**2**	-	2	2	-
Administration and estates	**618**	**615**	**3**	556	553	3
Healthcare assistants and other support staff	**379**	**379**	-	359	359	-
Nursing, midwifery and health visiting staff	**1,472**	**1,472**	-	1,155	1,155	-
Nursing, midwifery and health visiting learners	**22**	**22**	-	12	12	-
Scientific, therapeutic and technical staff	**460**	**460**	-	448	448	-
Healthcare science staff	**95**	**95**	-	94	94	-
Bank and agency staff	**68**	-	**68**	66	-	66
Other	**3**	**3**	-	2	2	-
Total	**3,456**	**3,363**	**93**	3,010	2,922	88
Less capitalised employees	**(6)**	**(6)**	-	(3)	(3)	-
Total excluding capitalised WTE	**3,450**	**3,357**	**93**	3,007	2,919	88

WTE = Whole time equivalents

5.3 Pension costs

Past and present employees are covered by the provisions of the two NHS Pensions Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the Financial Reporting Manual (FReM) requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

5.3 Pensions costs (continued)

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend the contribution rates payable by employees and employers. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this "employer cost cap" assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

5.4 Retirements due to ill-health

During the year ended 31 March 2017 there were 8 (2016: 3) early retirements from the NHS foundation trust agreed on the grounds of ill-health. The estimated additional pension liability of the ill-health retirement is £625,000 (2016: £211,000). The cost of ill-health retirements are borne by the NHS Business Services Authority Pensions Division.

5.5 Staff exit costs

NHS Improvement requires NHS foundation trusts to disclose summary information regarding redundancy and mutually agreed resignation scheme (MARS) staff costs agreed in the financial year.

	Foundation Trust & Group		Foundation Trust & Group	
Exit cost band	**2016/17 Number of compulsory redundancies**	**2016/17 Number of MARS departures agreed**	2015/16 Number of compulsory redundancies	2015/16 Number of MARS departures agreed
<£10,000	-	-	-	-
£10,001 - £25,000	-	-	1	-
£25,001 - £50,000	-	**1**	1	-
£50,001 - £100,000	-	-	-	-
£100,001 - £150,000	-	-	-	-
£150,001 - £200,000	-	-	-	-
>£200,000	-	-	-	-
Total number of exits by type	-	**1**	2	-
Total resource cost	**£0**	**£31,000**	£45,000	£0

5.6 Analysis of termination benefits

	Foundation Trust & Group		Foundation Trust & Group	
	2016/17 Number	**2016/17 £000**	2015/16 Number	2015/16 £000
No of Cases	1	-	2	-
Cost of Cases	-	31	-	45
	1	31	2	45

6. Finance revenue

6.1 Group finance revenue received during the year is as follows:

Finance revenue received during the year is as follows:	Group	
	2016/17	2015/16
	£000	£000
Interest income:		
Interest on bank accounts	**16**	46
HDFT Charitable funds: investment income	**49**	58
	65	104

6.2 Foundation Trust finance revenue received during the year is as follows:

Finance revenue received during the year is as follows:	Foundation Trust	
	2016/17	2015/16
	£000	£000
Interest income:		
Interest on bank accounts	**16**	46
	16	46

7. Finance expenses

Finance expenses incurred during the year are as follows:	Foundation Trust & Group	
	2016/17	2015/16
	£000	£000
Interest expense:		
Capital Loans from the Department of Health (formerly ITFF see note 17)	**233**	118
	233	118

8. Current year intangible fixed assets

	Foundation Trust & Group	
	Software Licences	Total
	£000	£000
Gross cost at 1 April 2016	681	**681**
Additions - purchased	94	**94**
Disposals	(15)	**(15)**
Gross cost at 31 March 2017	**760**	**760**
Amortisation at 1 April 2016	238	**238**
Provided during the year	135	**135**
Disposals	(15)	**(15)**
Amortisation at 31 March 2017	**358**	**358**
Net book value		
- Purchased at 31 March 2017	402	**402**
- Total at 31 March 2017	**402**	**402**

8.1 Prior year intangible fixed assets

	Foundation Trust & Group	
	Software Licences	Total
	£000	£000
Gross cost at 1 April 2015	477	477
Additions - purchased	204	204
Gross cost at 31 March 2016	**681**	**681**
Amortisation at 1 April 2015	132	132
Provided during the year	106	106
Amortisation at 31 March 2016	**238**	**238**
Net book value		
- Purchased at 31 March 2016	443	443
- Total at 31 March 2016	**443**	**443**

9. Property, plant and equipment

9.1 Current year property, plant and equipment comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Foundation Trust & Group Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	3,400	80,511	1,762	256	17,242	128	8,894	951	**113,144**
Additions - purchased	-	1,891	-	632	1,150	27	984	60	**4,744**
Reversal of impairments credited to operating expenditure	-	159	-	-	-	-	-	-	**159**
Reclassifications	-	60	-	(75)	15	-	-	-	-
Transfer to revaluation reserve	(200)	53	21	-	-	-	-	-	**(126)**
Disposals	-	-	-	-	(364)	(20)	(1,265)	(205)	**(1,854)**
Cost or valuation At 31 March 2017	**3,200**	**82,674**	**1,783**	**813**	**18,043**	**135**	**8,613**	**806**	**116,067**
Depreciation at 1 April 2016	-	-	-	-	9,085	75	5,310	583	**15,053**
Provided during the year	-	2,006	88	-	1,390	14	947	77	**4,522**
Transfer to revaluation reserve	-	(2,006)	(88)	-	-	-	-	-	**(2,094)**
Disposals	-	-	-	-	(364)	(20)	(1,265)	(205)	**(1,854)**
Depreciation at 31 March 2017	-	-	-	-	**10,111**	**69**	**4,992**	**455**	**15,627**
Net book value									
- Purchased at 31 March 2017	3,200	78,131	1,783	813	6,926	66	3,586	337	**94,842**
- Donated at 31 March 2017	-	4,543	-	-	1,006	-	35	14	**5,598**
Net book value at 31 March 2017	**3,200**	**82,674**	**1,783**	**813**	**7,932**	**66**	**3,621**	**351**	**100,440**

At 31 March 2017, of the Net Book Value £3,200,000 related to land valued at open market value and £82,674,000 related to buildings valued at open market value and £1,783,000 related to dwellings valued at open market value. The land and buildings (including dwellings) of the trust were revalued by the Valuation Office Agency which is a government agency of Her Majesty's Revenue and Customs (RICS qualified) as at 31 March 2017. This valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a increase in value of £1,968,000.

9. Property, plant and equipment (continued)

9.2 Prior year property, plant and equipment comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Foundation Trust & Group Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2015	3,400	71,901	1,652	92	15,109	128	9,313	983	102,578
Additions - purchased	-	8,047	-	192	2,504	-	1,301	22	12,066
Reversal of impairments credited to operating expenses	-	350	-	-	-	-	-	-	350
Reclassifications	-	16	-	(28)	10	-	2	-	-
Revaluations	-	550	110	-	-	-	-	-	660
Disposals	-	(353)	-	-	(381)	-	(1,722)	(54)	(2,510)
Cost or valuation At 31 March 2016	**3,400**	**80,511**	**1,762**	**256**	**17,242**	**128**	**8,894**	**951**	**113,144**
Depreciation at 1 April 2015	-	-	-	-	8,206	62	6,187	535	14,990
Provided during the year	-	2,175	81	-	1,250	13	845	102	4,466
Transfer to revaluation reserve	-	(2,151)	(81)	-	-	-	-	-	(2,232)
Disposals	-	(24)	-	-	(371)	-	(1,722)	(54)	(2,171)
Depreciation at 31 March 2016	**-**	**-**	**-**	**-**	**9,085**	**75**	**5,310**	**583**	**15,053**
Net book value									
- Purchased at 31 March 2016	3,400	76,055	1,762	256	7,132	53	3,573	365	92,596
- Donated at 31 March 2016	-	4,456	-	-	1,025	-	11	3	5,495
Net book value at 31 March 2016	**3,400**	**80,511**	**1,762**	**256**	**8,157**	**53**	**3,584**	**368**	**98,091**

At 31 March 2016, of the Net Book Value £3,400,000 related to land valued at open market value and £80,511,000 related to buildings valued at open market value and £1,762,000 related to dwellings valued at open market value. The land and buildings (including dwellings) of the trust were revalued by the Valuation Office Agency which is a government agency of Her Majesty's Revenue and Customs (RICS qualified) as at 31 March 2016. This valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a increase in value of £2,892,000.

10. Investments

	Group	
	2016/17	2015/16
	£000	£000
Carrying value at 1 April 2016	**1,750**	2,003
Acquisitions in year - other	**256**	320
Movement in fair value of investments	**251**	(106)
Disposals	**(351)**	(467)
Carrying value at 31 March 2017	**1,906**	1,750

Investments held are wholly attributable to the Harrogate and District NHS Foundation Trust Charitable Fund (registered charity number 1050008), for further information please see the charity's Annual Accounts and Report.

11. Inventories

11.1 Analysis of inventories

	Foundation Trust & Group	
	2016/17	2015/16
	£000	£000
Drugs	**739**	827
Consumables	**1,688**	1,794
Total	**2,427**	2,621

11.2 Inventories recognised in expenses

	Foundation Trust & Group	
	2016/17	2015/16
	£000	£000
Drug Inventories recognised as an expense in the year	**14,061**	13,829
Total	**14,061**	13,829

12. Trade and other receivables

12.1 Trade and other receivables are made up of:

	Group	
	2016/17	2015/16
Current	**£000**	£000
NHS receivables	**13,491**	11,699
Other receivables with related parties	**1,160**	609
PDC Dividend receivable (Department of Health)	**53**	28
Provision for the impairment of receivables (see note 12.2)	**(532)**	(984)
Interest receivable	**1**	2
Prepayments	**1,849**	1,313
VAT receivables	**386**	324
Other receivables	**2,524**	2,128
Total	**18,932**	15,119

	Foundation Trust	
	2016/17	2015/16
Current	**£000**	£000
NHS receivables	**13,491**	11,699
Other receivables with related parties	**1,160**	609
PDC Dividend receivable (Department of Health)	**53**	28
Provision for the impairment of receivables (see note 12.2)	**(532)**	(984)
Interest receivable	**1**	2
Prepayments	**1,849**	1,313
VAT receivables	**386**	324
Other receivables	**2,395**	2,009
Total	**18,803**	15,000

	Foundation Trust & Group	
	2016/17	2015/16
	£000	£000
Non-Current		
Other receivables	**381**	405
Provision for the impairment of receivables (see note 12.2)	**(87)**	(89)
Total	**294**	316

The majority of the NHS foundation trust's trade is with Commissioners for NHS patient care services which are funded by the Government to buy NHS patient care services therefore no credit scoring for them is considered necessary.

12.2 Movements in the provision for impairments of receivables	Foundation Trust & Group	
	2016/17	2015/16
	£000	£000
Balance at 1 April 2016	**1,073**	274
Increase in provision	**143**	978
Amounts utilised	**(597)**	(179)
Balance at 31 March 2017	**619**	1,073

NHS Injury Benefit Scheme income is subject to a provision for impairment of 22.94% (2016: 21.99%) to reflect expected rates of collection. Other debts are assessed by management considering age of debt and the probability of collection.

12. Trade and other receivables (continued)

12.3 Ageing of the provision for impaired receivables

	Foundation Trust & Group	
	2016/17	2015/16
	£000	£000
0-30 Days	**9**	46
30-60 Days	**5**	9
60-90 Days	**19**	17
90-180 Days	**23**	44
Over 180 Days	**563**	957
	619	1,073

12.4 Ageing of non-impaired receivables

	Group		Foundation Trust	
	2016/17	2015/16	**2016/17**	2015/16
	£000	£000	**£000**	£000
0-30 Days	**12,642**	8,278	**12,525**	8,265
30-60 Days	**529**	872	**529**	872
60-90 Days	**454**	705	**454**	705
90-180 Days	**715**	687	**715**	687
Over 180 Days	**2,597**	3,226	**2,597**	3,226
	16,937	13,768	**16,820**	13,755

13. Cash and cash equivalents

	Group		Foundation Trust	
	2016/17	2015/16	**2016/17**	2015/16
	£000	£000	**£000**	£000
Balance at 1 April 2016	**5,568**	5,146	**5,527**	4,898
Net change in year	**(880)**	422	**(972)**	629
Balance at 31 March 2017	**4,688**	5,568	**4,555**	5,527
Made up of:				
Cash with Government Banking Service	**4,667**	5,544	**4,543**	5,517
Cash at commercial banks and in hand	**12**	10	**12**	10
Other current investments	**9**	14	**-**	-
Cash and cash equivalents	**4,688**	5,568	**4,555**	5,527

14. Trade and other payables

	Group		Foundation Trust	
	2016/17	2015/16	**2016/17**	2015/16
Current	**£000**	£000	**£000**	£000
Receipts in advance	**20**	8	**20**	8
NHS payables	**4,821**	3,634	**4,821**	3,634
Amounts due to other related parties	**2,011**	1,726	**2,011**	1,726
Other trade payables - capital	**1,537**	1,621	**1,537**	1,621
Social Security costs	**1,631**	1,119	**1,631**	1,119
Other tax payable	**1,358**	1,146	**1,358**	1,146
Other payables	**4,360**	4,364	**4,285**	4,218
Accruals	**757**	3,085	**757**	3,085
Total	**16,495**	16,703	**16,420**	16,557

15. Provisions

15.1 Provisions current and non current

	Foundation Trust & Group Current		Foundation Trust & Group Non current	
	2016/17	2015/16	**2016/17**	2015/16
	£000	£000	**£000**	£000
Pensions relating to the early retirement of staff pre 1995	**45**	45	**143**	179
Legal claims	**66**	37	**-**	-
*Other	**20**	19	**95**	110
	131	101	**238**	289

*Other provisions total £115,000 (2016: £129,000) referring to the NHS Injury Benefit Scheme.

15.2 Provisions by category

	Pensions relating to the early retirement of staff pre 1995	Legal claims	*Other	**Foundation Trust & Group Total**
	£000	£000	£000	**£000**
At 1 April 2016	224	37	129	**390**
Arising during the year	4	76	2	**82**
Utilised during the year	(45)	(15)	(19)	**(79)**
No longer required	-	(32)	-	**(32)**
Unwinding of discount	5	-	3	**8**
At 31 March 2017	**188**	**66**	**115**	**369**

*Other provisions total £115,000 (2016: £129,000) referring to the NHS Injury Benefit Scheme.

15.3 Expected timing of cashflows by category:

	Pensions relating to the early retirement of staff pre 1995	Legal claims	*Other	**Foundation Trust & Group Total**
	£000	£000	£000	**£000**
Within one year	45	66	20	**131**
Between one and five years	114	-	66	**180**
After five years	29	-	29	**58**
	188	66	115	**369**

£55,401,560 is included in the provisions of the NHS Litigation Authority at 31 March 2017 in respect of clinical negligence liabilities of the NHS foundation trust (31 March 2016 - £46,133,704). Please see note 1.12.

16. Other liabilities

	Foundation Trust & Group	
	2016/17	2015/16
Current	**£000**	£000
Deferred income	**2,142**	2,707
Total	**2,142**	2,707

17. Borrowings

	Foundation Trust & Group	
	2016/17	2015/16
Current	**£000**	£000
Capital loans from Department of Health (formerly ITFF)*	**999**	999
Total	**999**	999
Non-Current		
Capital loans from Department of Health (formerly ITFF)*	**10,776**	11,776
Total	**10,776**	11,776

*During 2012/13, the Trust signed a 10 year loan agreement for £3.4m from the Independent Trust Financing Facility (ITFF) to fund the provision of additional theatre capacity, the loan was drawn down in full during the financial year. During 2013/14, the Trust signed an additional 10 year loan for £1.5m from the ITFF to fund the replacement of an MRI Scanner. The loan was drawn down in full during the financial year. During 2014/15 the NHS foundation trust did not undertake any additional borrowing. During 2015/16 the Trust signed a 25 year loan agreement from the Department of Health for £7.5m to fund a Carbon Efficiency capital scheme and a 10 year loan agreement from the Department of Health for £1.5m to fund the purchase of a Mobile MRI Scanner, both of these loans were drawn down in full during the financial year. The NHS foundation trust did not undertake any additional borrowing during 2016/17.

The interest rates on the NHS foundation trust's loans are:-

Additional theatre capacity loan £3.4m is fixed at 0.93% per annum (10 year term).
Replacement MRI loan £1.5m is fixed at 1.75% per annum (10 year term).
Carbon efficiency capital scheme loan £7.5m is fixed at 2.5% per annum (25 year term).
Mobile MRI Scanner loan £1.5m is fixed at 0.90% per annum (10 year term).

Interest accrued is paid every six months see finance expense note 7.

There have been no defaults or breaches in relation to the Department of Health (formerly ITFF) loans.

18. Finance lease obligations

The NHS foundation trust does not have any finance leases obligations either as a lessee or lessor.

19. Losses and special payments

	Foundation Trust & Group			
	2016/17 Total number of cases	**2016/17 Total value of cases**	2015/16 Total number of cases	2015/16 Total value of cases
		£000		£000
Losses:				
Other loss of cash	**-**	**-**	5	1
Bad debts private patients	**60**	**7**	17	2
Bad debts overseas visitors	**8**	**4**	3	-
Bad debts other	**363**	**27**	181	4
Damage to buildings, property stores losses	**-**	**-**	30	21
Total losses	**431**	**38**	236	28
Special payments:				
Compensation under legal obligation	**3**	**32**	2	3
Ex gratia payment loss of personal effects	**10**	**5**	9	2
Ex gratia payment other	**-**	**-**	5	1
Total special payments	**13**	**37**	16	6
Total losses and special payments	**444**	**75**	252	34

20. Third Party Assets

The NHS foundation trust held £428 cash at bank and in hand at 31 March 2017 which related to monies held by the NHS foundation trust on behalf of patients (31 March 2016: £891).

21. Contractual Capital Commitments

Commitments under capital expenditure contracts at 31 March 2017 were £2,546,000 (31 March 2016: £1,633,000).

22. Related Party Transactions

22.1 Transactions with key management personnel

IAS 24 requires disclosure of transactions with key management personnel during the year. Key management personnel is defined in IAS 24 as "those persons having authority and responsibility for planning, directing and controlling the activities of the entity, directly or indirectly, including any director (whether executive or otherwise) of that entity". The Trust has deemed that its key management personnel are the board members (voting and non-voting directors and non-executive directors) of the NHS foundation trust.

However the DH GAM states the requirement in IAS 24 to disclose the compensation paid to management, expenses allowances and similar items paid in the ordinary course of an entity's operations will be satisfied with the disclosures in the Remuneration Report. There were no transactions with board members or parties related to them other than those from the ordinary course the NHS foundation trust's operations.

22.2 Transactions with other related parties

Harrogate and District NHS Foundation Trust is a public benefit corporation authorised by NHS Improvement. NHS Improvement has determined that all bodies within the scope of "Whole Government Accounts" are related parties, as ultimately they are under common control.

	Foundation Trust & Group			
	2016/17		2015/16	
	Income	**Expenditure**	Income	Expenditure
	£000	**£000**	£000	£000
Department of Health	**29**	**3**	13	2,260
*Other NHS Bodies	**183,343**	**10,400**	175,521	8,972
*Other WGA Bodies	**26,948**	**26,333**	7,147	20,365
	210,320	**36,736**	182,681	31,597
	Receivables	**Payables**	Receivables	Payables
	£000	**£000**	£000	£000
Department of Health	**75**	**-**	29	-
*Other NHS Bodies	**13,464**	**4,797**	11,665	3,605
*Other WGA Bodies	**1,551**	**6,890**	966	4,020
	15,090	**11,687**	12,660	7,625

* The Other NHS and Other WGA bodies with which the NHS foundation trust considers material transactions have taken place are included in note 22.3.

22. Related Party Transactions (continued)

22.3 Material transactions with other NHS bodies and Other WGA bodies

	Foundation Trust & Group			
	2016/17		2015/16	
	Income	**Expenditure**	Income	Expenditure
	£000	**£000**	£000	£000
Tees, Esk And Wear Valleys NHS Foundation Trust	**956**	**123**	949	33
York Hospitals NHS Foundation Trust	**1,029**	**2,891**	1,036	2,475
NHS Airedale, Wharfdale And Craven CCG	**1,991**	**-**	1,538	-
NHS Hambleton, Richmondshire And Whitby CCG	**5,347**	**1**	5,892	-
NHS Harrogate And Rural District CCG	**109,019**	**235**	105,375	576
NHS Leeds North CCG	**21,106**	**-**	19,600	-
NHS Leeds South And East CCG	**903**	**137**	1,176	-
NHS Leeds West CCG	**3,648**	**-**	3,676	-
NHS Scarborough And Ryedale CCG	**2,019**	**-**	2,417	-
NHS Vale Of York CCG	**6,197**	**-**	6,638	-
NHS England	**20,074**	**(70)**	18,193	80
Health Education England	**5,154**	**1**	4,362	-
NHS Litigation Authority	**-**	**3,116**	-	2,674
Department of Health (PDC dividend only)	**-**	**2,746**	-	2,260
North Yorkshire County Council	**8,683**	**78**	5,954	71
HMRC	**-**	**10,680**	-	7,247
NHS Property Services	**28**	**1,491**	104	1,083
NHS Pension Scheme	**-**	**14,313**	-	12,355

	Foundation Trust & Group			
	Receivables	**Payables**	Receivables	Payables
	£000	**£000**	£000	£000
Tees, Esk And Wear Valleys NHS Foundation Trust	**26**	**27**	19	12
York Hospitals NHS Foundation Trust	**494**	**933**	1,112	999
NHS Airedale, Wharfdale And Craven CCG	**202**	**-**	87	-
NHS Hambleton, Richmondshire And Whitby CCG	**665**	**140**	1,348	-
NHS Harrogate And Rural District CCG	**7,488**	**181**	5,146	255
NHS Leeds North CCG	**49**	**-**	69	-
NHS Leeds South And East CCG	**-**	**302**	71	-
NHS Leeds West CCG	**158**	**-**	172	-
NHS Scarborough And Ryedale CCG	**865**	**-**	441	-
NHS Vale Of York CCG	**930**	**18**	727	-
NHS England	**844**	**53**	1,580	82
Health Education England	**293**	**1**	36	-
NHS Litigation Authority	**-**	**10**	-	-
Department of Health (PDC dividend only)	**53**	**-**	28	-
North Yorkshire County Council	**716**	**1,867**	605	-
HMRC	**-**	**2,989**	324	2,265
NHS Property Services	**28**	**2,143**	84	1,429
NHS Pension Scheme	**-**	**2,011**	-	1,726

In addition, the NHS foundation trust has had a number of transactions with other Government Departments and other central and local Government bodies.

23. Financial instruments.

	Group		Foundation Trust	
	2016/17	2015/16	**2016/17**	2015/16
	£000	£000	**£000**	£000
Financial assets				
Loans and receivables (including cash and cash equivalents)	**20,875**	18,695	**20,742**	18,654

The NHS foundation trust's financial assets all fall under the category 'loans and receivables'.

	Group		Foundation Trust	
	2016/17	2015/16	**2016/17**	2015/16
Financial liabilities				
Other financial liabilities	**23,250**	25,479	**23,250**	25,479

The NHS foundation trust's financial liabilities all fall under the category 'other financial liabilities'.

Management consider that the carrying amounts of financial assets and financial liabilities recorded at amortised cost in the financial statements approximate to their fair value.

The majority of the NHS foundation trust's income is from NHS Commissioners of patient care services which are funded by the Government to purchase NHS patient care therefore NHS foundation trusts are not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies. The NHS foundation trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS foundation trust in undertaking its activities.

24. Charitable funds reserve.

Unrestricted income funds comprise those funds which the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include designated funds, where the donor has made known their non binding wishes or where the Corporate Trustee, at its discretion, has created a fund for a specific purpose.

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by the donor.

The charity has one permanent endowment fund. The income of the Elsie Sykes Endowment Fund can be used for medical equipment or medical research (excluding transplant or vivisection work).

	Group	
	2016/17	2015/16
	£000	£000
Unrestricted income funds	**496**	391
Restricted funds	**41**	22
Endowment fund	**1,556**	1,351
	2,093	1,764

25. Ultimate parent.

As an entity operating in the National Health Service in England, the ultimate parent holding is considered as the Department of Health.