HARROGATE AND DISTRICT NHS FOUNDATION TRUST

ANNUAL REPORT AND ACCOUNTS 2014 / 2015

Harrogate and District NHS
NHS Foundation Trust

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

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CHAIRMAN'S STATEMENT

The year 2014/15 was one of exciting changes and challenges for us as a Trust, set against a national context which was often demanding and difficult. At the heart of the whole year was our continued commitment to the delivery of the highest possible effective and appropriate quality of care. Therefore I am delighted that, despite the many and varied demands, the Trust delivered a strong performance both in terms of the quality of the care provided and performance against national standards.

Our ability to be able to deliver appropriate, efficient high quality care was, and continues to be, dependent on our partnerships across the whole heath community, including partnerships with the public, an appetite for transformation and innovation, dedicated and committed staff underpinned by robust governance.

Strong governance from 'Board to floor' is undoubtedly essential for the delivery of high quality care. I am indebted to the Council of Governors which adds significant challenge to our governance structure. Our Governors give their time generously and freely and I would like to thank them all for their support and commitment over the year. I would like to thank those who have stepped down from the Council of Governors: Paul Hyde, Stuart Martin and Sara Spencer.

One of the key changes and challenges to our governance structure during the year was the retirement and departure of members of the Board of Directors and the arrival of new Directors. I would like to record my deepest thanks to John Ridings, Vice Chair, who was a Non-executive Director for nine years, to Sue Symington newly elected Vice Chair, who was appointed Chair of York Teaching Hospital Trust from 1 April 2015, to Angela Monaghan, Chief Nurse who retired after long service in the NHS and 12 years on our Board and last and not least to Richard Ord, who retired after 30 years at HDFT and 5 years at the helm as CEO.

A strength of the NHS is its belief in the need and its ability to regularly refresh our leadership capacity and so I was delighted to welcome new high calibre members to the Board of Directors: Mrs Maureen Taylor, Non-Executive Director, who brings a wealth of experience and expertise from the public sector, Jill Foster, Chief Nurse, highly experienced in both acute and community care, and Dr Ros Tolcher, Chief Executive, who joined us from her role as Chief Executive, Solent NHS Trust. I know the new team relish the opportunity of moving the Trust forward into a new era of health and social care.

Working in partnership with our colleagues in the health and social care sector was, and continues to be, central to our strategic vision and we saw much progress on collaborative working in the year. Partnership with our local community is really important to us as a Foundation Trust. We now have more than 17,500 members whose opinions and contributions we value. An important part of this engagement are the public events held throughout the year. This year we had another highly successful Open Event, with over 50 teams, from both the acute and community services, participating and a very popular and stimulating Annual Members Meeting. As a part of our partnership with Macmillan, the Sir Robert Ogden Macmillan Centre was officially opened last autumn by Lady Halifax, President of Macmillan and Christine Talbot, from Calendar TV, and we were delighted that Sir Robert and Lady Ogden were with us for this landmark event for a Centre of nationally-recognised high quality.

The engagement of staff to deliver transformational and innovative ways of working was core to coping with the challenges and demands of the year. I am pleased to report that we had 13 Rapid Process Improvement Workshops, a process which enables staff to reflect on and redesign services. In addition, we determined a new way of delivering our energy through the Carbon Energy Fund project. This is a really exciting innovation that will both deliver efficiency and also improve the patient

environment. Our ability to cope with future demands and challenges will be predicated on our pursuit of new ways of working and this sets an exciting agenda for the next year.

As a busy acute and community Trust our staff had contact during the year with over 500,000 patients in the hospital setting and over 400,000 in the community. The compassion, professionalism and hard work of our 3,300 staff, in all their many and diverse disciplines, and the dedication of our 500 volunteers delivered the care we are so proud of which is outlined in this report. I would like to thank them all for their sustained commitment over the last year.

During the year we embarked on a project involving staff and patients on a new values and behaviours framework and through this work have identified three core values – respectful, responsible and above all passionate. I am confident with these underpinning values we, in collaboration with our partners, will passionately develop and deliver efficient and compassionate services for you, our population.

Mrs Sandra Dodson

Chairman

STRATEGIC REPORT

Chief Executive's Introduction

I am proud to present my first Annual Report as Chief Executive of Harrogate and District NHS Foundation Trust. Over the last twelve months the Trust has continued to deliver care of the highest quality, despite an exceptionally challenging period of change and financial restraint for the NHS. We provide hospital-based care from Harrogate District Hospital and Ripon Community Hospital and a variety of community services across North Yorkshire. We are pleased to provide care not just for the people of Harrogate but also for an increasing number of people from Leeds and the wider area.

Our aim is to ensure that people who rely upon our services experience safe, effective and compassionate care with the best possible outcomes. Feedback from people using our services consistently places HDFT amongst the best nationally. During 2014/15 our hard working and highly committed staff ensured that we met all of the national targets for access to care including the Emergency Department 4 hour waiting target, cancer access targets and referral to treatment targets. We place a high emphasis on ensuring that we have a clean and safe environment for care and for the first year ever there were no cases of MRSA in our care. The number of cases of *Clostridium difficile* was also the lowest recorded, at nine cases for the whole 12 months. Harrogate and District NHS Foundation Trust is a research active organisation and the Trust has maintained its position as a high recruiter to clinical trials. Being research active benefits patients by improving access to new and innovative treatment options and helping to attract forward looking and enquiring staff.

Reflecting a challenging national picture, the demand for health care has continued to grow over the last 12 months. The winter months, which are always a busy time for the Trust, were particularly challenging. Attendances at the Emergency Department overall increased by 1.5% and the increasing complexity of cases meant that the proportion of people requiring admission from the Department rose to 21.4%, the highest level we have seen. A key objective of the Trust is to work with partners and deliver integrated care where this is beneficial for patients. It is testimony to the hard work of community and hospital staff and GP colleagues that, despite rising demand for care, there was a overall fall of 0.7% in the number of emergency admissions. Although small, this reduction is contrary to the national picture where an 4% increase in emergency admissions was recorded for 2014/15. The Trust has delivered almost 10% more elective activity over the year and our community nursing services recorded a 12% increase in activity.

Responding to high levels of demand, stringent performance targets and the need to ensure the highest quality of care requires exceptional financial stewardship. This is particularly so when the national payment mechanisms do not always reflect the real cost of care. Our commitment to ensuring safe and responsive services meant that we could not deliver our financial plan in full in 2014/15, ending the year instead with a small operating surplus for reinvestment in services.

In the autumn we undertook an audit of bed use across all sites. This important clinically-led review, undertaken jointly with local authority and commissioning partners, allowed us to learn more about the needs of people being admitted to hospital and the factors which affect their length of stay in hospital and decisions to admit. The findings of the audit helped us to improve services in the hospital and are a crucial part of our shared plans for delivering new models of care in 2015/16 and beyond. The Trust remains committed to its overall strategic objectives of driving up quality, working with partners to deliver integrated care and ensuring long-term sustainability. Achieving support for our plans for service transformation as national Vanguard site with our local system partners will enable us to go further and faster with this ambition.

This Annual Report describes the HDFT strategy for the next 5 years, the major issues we are responding to and our priorities for quality improvement and service development. It should be read alongside our annual Quality Report. These remarkable achievements would not be possible without

the commitment of our workforce, to whom I extend my personal thanks. I am humbled by their continued focus and dedication to our patients and to the future of the Trust. I should also pay tribute to my predecessor, Mr Richard Ord, who retired as Trust CEO in August 2014. He left a true legacy of excellence. This year also saw the retirement of our Chief Nurse, Mr Angela Monaghan, to whom I extend my thanks for 36 years' service.

The forward view for the NHS is challenging but presents real opportunities for a new era of care - an era in which the traditional boundaries between parts of the health and social care system will be dissolved and an era in which HDFT will develop new models of care which deliver the highest quality while continuing to deliver excellent outcome for people using our services.

Dr Ros Tolcher

Chief Executive

A Brief History of the Foundation Trust and its Statutory Background

Harrogate and District NHS Foundation Trust (HDFT or the Trust) was founded under the Health and Social Care (Community Health and Standards) Act 2003 and authorised as an NHS Foundation Trust from 1 January 2005. The Trust is the principal provider of hospital services to the population of Harrogate and surrounding district, and also provides some services to north and west this represents a catchment population of approximately 900,000. In addition, on 1 April 2011, the Trust took responsibility for a wide range of community-based services covering the Harrogate and District locality and some services covering the whole of North Yorkshire, as part of the Transforming Community Services programme.

Harrogate District Hospital has an Emergency Department, extensive outpatient facilities, Intensive Therapy Unit and High Dependency Unit, Coronary Care Unit, plus five main theatres and a Day Surgery Unit with further theatres. The new Sir Robert Ogden Macmillan Centre (SROMC), opened in March 2014, provides assessment and treatment, principally 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 has a central delivery ward and Maternity services, together with an Early Pregnancy Assessment Unit.

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

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

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

The range of hospital services that are provided in partnership with York Teaching Hospitals NHS Foundation Trust (YHFT) include Breast and Cervical Screening, Dermatology, Ear Nose and Throat (ENT), Neurophysiology, Non-Surgical Oncology, Ophthalmology, Oral and Maxillofacial Surgery, Orthodontics, Renal Medicine, Rheumatology, Urology, Vascular Services, Genito-Urinary Medicine (GUM)/Sexual Health Services and a Satellite Renal Unit. The latter two services are managed by YHFT, but provided at facilities on the Harrogate District Hospital (HDH) site.

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

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

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

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

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

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

The Foundation Trust's Strategy

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

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

2. Work with our partners to develop and implement the joint service strategy across the health communities we serve.

3. Develop more integrated community based services, enabling people who use our services to be treated closer to home, or at home.

4. Continue to expand our secondary care services into Leeds and the wider catchment area.

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

1. Further embed a culture of delivering the highest standards of care and compassion, particularly within all patient facing teams and nursing.

2. Develop clear plans to ensure that people are only admitted to hospital when it is the right care setting for them. Once admitted, they have a defined, well communicated care plan which includes plans for a safe and timely discharge.

3. Progress a sustainable Consultant delivered model of secondary care for all our patients that provides consistently high quality and equitable care, on a seven day per week basis.

4. Ensure consistent attainment of all national performance standards, including the continuing reduction in the Trust's mortality rate.

5. Expand the provision of outreach services by HDFT into the Leeds locality, including outpatients, diagnostics, Maternity services and follow up care, and explore further opportunities.

6. Simplify and co-ordinate the pathways of care for people with Long Term Conditions.

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

Current and Expected Future Performance

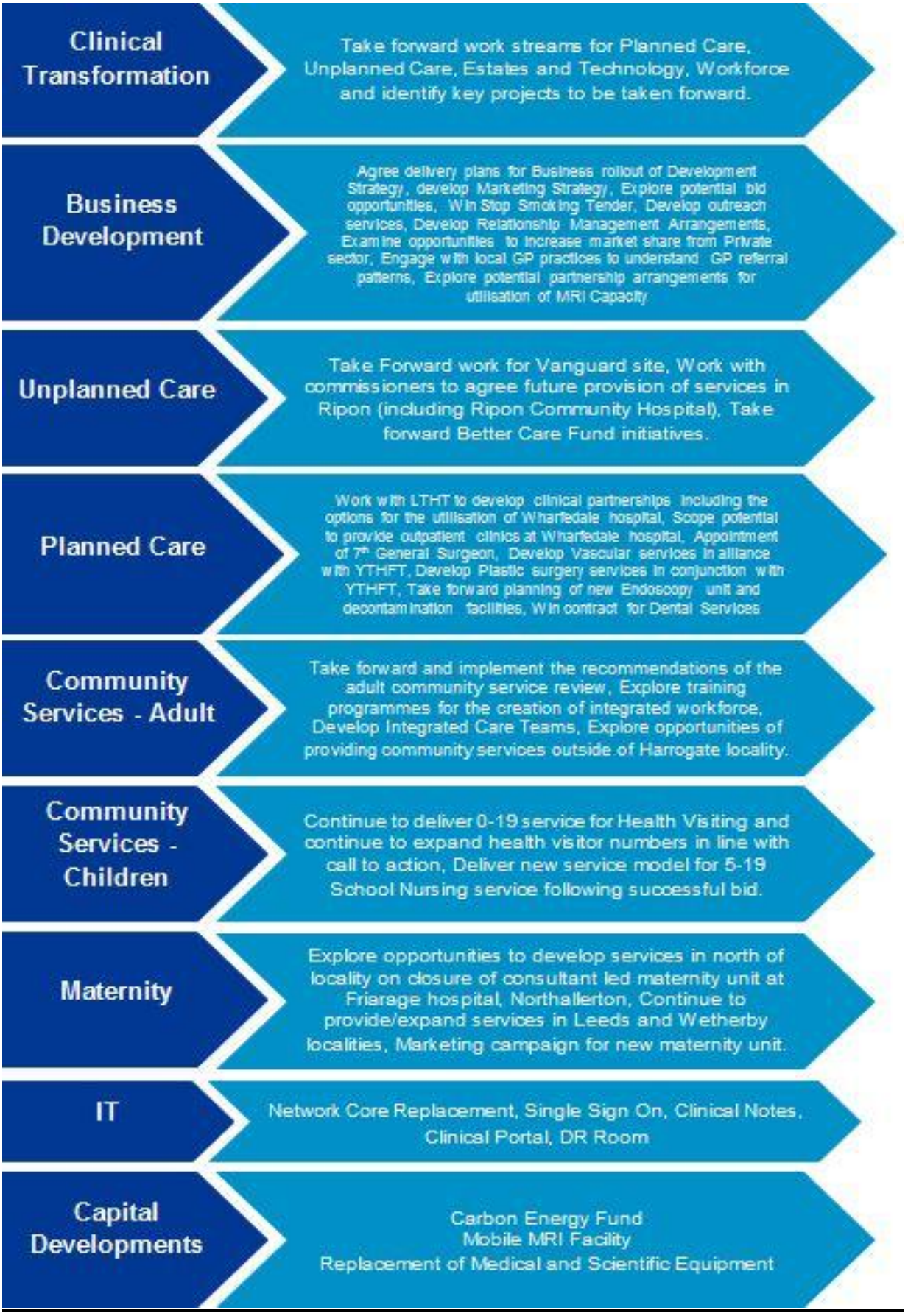
Overall Performance 2014/15 and 2015/16

The Trust completed 2014/15 with a Continuity of Services rating of three and a green Governance rating, in line with Monitor's Risk Assessment Framework. In the coming year, the Trust aims to achieve a surplus of £1.8m and will meet all the required performance targets as laid out in the Risk Assessment Framework.

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

Significant Developments in 2015/16

In line with the Trust's five year Strategic Plan and the Operational Plan for 2015/16, the significant developments for the coming year are detailed in the diagram below. In addition, the Trust will continue to work with partners to identify areas where it can continue to work collaboratively to develop new models of care delivery and implement transformational schemes, which will enhance the quality of, and improve efficiency in, the services it delivers. A key initiative that will be taken forward in 2015/16 is implementing new care models with local partners as a nationally supported Vanguard site. This will deliver a comprehensive, integrated care model, providing access to prevention advice and information for individuals in crisis/acute situations, seven days a week, 24 hours a day, without defaulting to the Emergency Department. Work will continue over the next 12 months to implement this model with a view to having the key elements in place by April 2016.


Clinical Transformation
Take forward work streams for Planned Care, Unplanned Care, Estates and Technology, Workforce and identify key projects to be taken forward.
Business Development
Agree delivery plans for Business rollout of Development Strategy, develop Marketing Strategy, Explore potential bid opportunities, Win Stop Smoking Tender, Develop outreach services, Develop Relationship Management Arrangements, Examine opportunities to increase market share from Private sector, Engage with local GP practices to understand GP referral patterns, Explore potential partnership arrangements for utilisation of MRI Capacity
Unplanned Care
Take Forward work for Vanguard site, Work with commissioners to agree future provision of services in Ripon (including Ripon Community Hospital), Take forward Better Care Fund initiatives.
Planned Care
Work with LTHT to develop clinical partnerships including the options for the utilisation of Wharfedale hospital, Scope potential to provide outpatient clinics at Wharfedale hospital, Appointment of 7th General Surgeon, Develop Vascular services in alliance with YTHFT, Develop Plastic surgery services in conjunction with YTHFT, Take forward planning of new Endoscopy unit and decontamination facilities, Win contract for Dental Services
Community Services - Adult
Take forward and implement the recommendations of the adult community service review, Explore training programmes for the creation of integrated workforce, Develop Integrated Care Teams, Explore opportunities of providing community services outside of Harrogate locality.
Community Services - Children
Continue to deliver 0-19 service for Health Visiting and continue to expand health visitor numbers in line with call to action, Deliver new service model for 5-19 School Nursing service following successful bid.
Maternity
Explore opportunities to develop services in north of locality on closure of consultant led maternity unit at Friarage hospital, Northallerton, Continue to provide/expand services in Leeds and Wetherby localities, Marketing campaign for new maternity unit.
IT
Network Core Replacement, Single Sign On, Clinical Notes, Clinical Portal, DR Room
Capital Developments
Carbon Energy Fund
Mobile MRI Facility
Replacement of Medical and Scientific Equipment

Quality

The Trust is fully committed to high quality care. The Quality Report, included within this Annual Report, details progress made on the Quality Priorities identified in 2014//15 and the agreed Quality Priorities for the coming year. These are clear measurable priorities that have been agreed with staff and stakeholders. The Trust will monitor performance against them through its Quality Committee.

The latest CQC Intelligence report (December 2014) reported the Trust as having four "at risk" measures. This means that HDFT had a risk score of five, placing it in band 5 (where 1 is highest risk and 6 is lowest risk).

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

Operating and Financial Review of the Foundation Trust

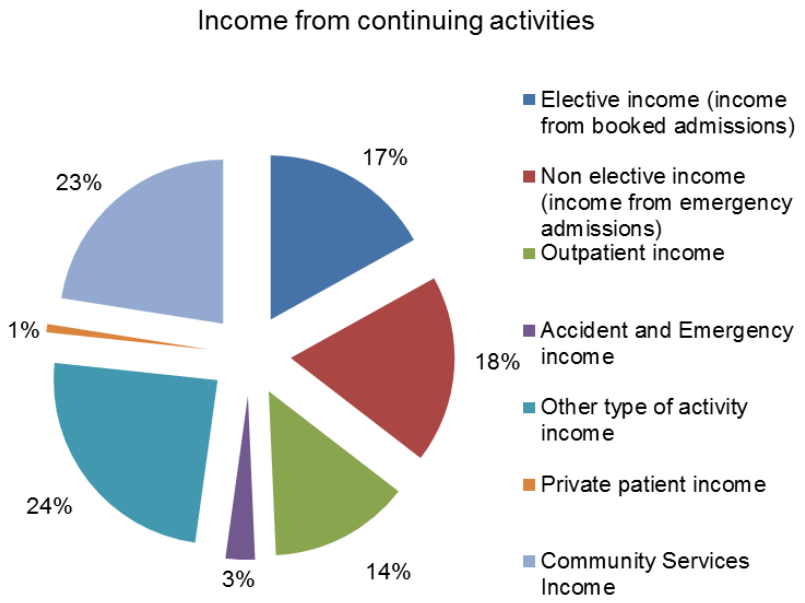
The income and expenditure position for the Trust for 2014/15 was a surplus before technical items of £10,000.

The table below provides a high level comparison of the income and expenditure account for 2014/15:

	2014/15 actual £000s	2013/14 actual £000s
Income	186,119	182,260
Expenditure	(186,109)	(181,992)
Surplus before exceptional items	10	268
Income from Macmillan for capital expenditure	-	5,048
Impairments on fixed assets	(587)	(4,645)
Reported (deficit)/surplus for financial year	(577)	671

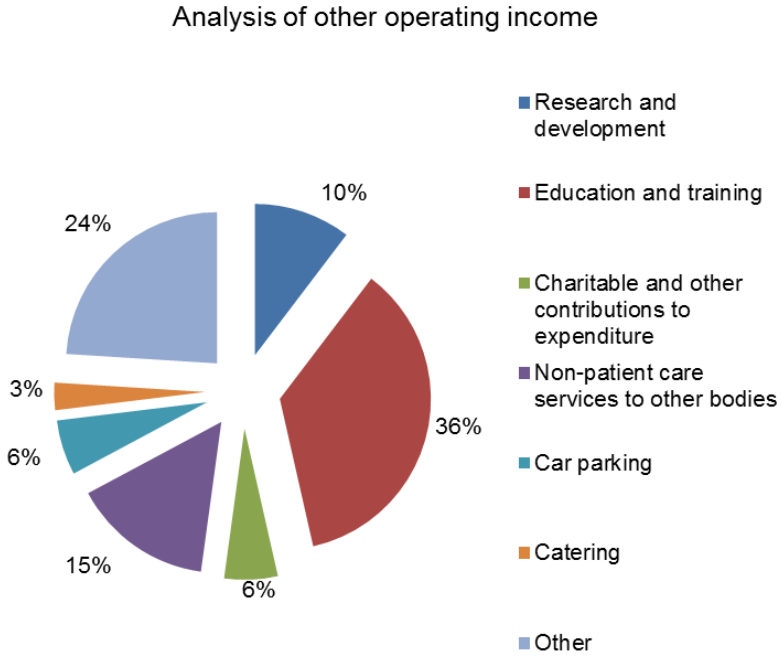
Income generated from continuing activities

Total income from continuing activities for the year 2014/15 was £174.8m. This represented 94% of total income for the year. An analysis of this income is shown below:



Other operating income

Other operating income totalled £11.98m during 2014/15. This represented 6.4% of total income for the year and an analysis of this income is shown below:



Cash

The Trust had a cash balance of £4.90m at the close of the financial year, which was marginally below the original plan of £4.95m.

Monitor risk rating

The Trust achieved a Continuity of Services risk rating of 3 at the end of 2014/15. Financial risk is assessed on a scale of 1 (high risk) to 4 (low risk).

2015/16 financial outlook

There continue to be a number of financial risks in the Trust's Business Plan for 2015/16; however, in line with the 5 year plan a financial risk rating of 4 is expected in 2015/16. Budgets and activity plans have been agreed which, if fully delivered, will generate a recurrent surplus of £1.8m.

At the time of writing this report the Trust remains in discussions with its main commissioner (Harrogate and Rural District CCG) on a contract value for 2015/16. The Trust remains confident that a contract level and associated income will be agreed in line with its annual planning assumptions.

There are a number of financial risks for 2015/16 that will require monitoring, review and potential mitigating management action. These are detailed as follows:

Key financial risk	Mitigation
Activity is below plan causing a shortfall in income.	Plan for 2015/16 is prudent with growth agreed with Commissioners.
Activity is above plan causing expenditure and capacity pressures	Capacity plans in detail allow for additional activity to be undertaken. A premium rate reserve is available for extra elective activity which would be paid at tariff. For non-elective activity, the new MRET rules mitigate some of the financial risk, as does our work integrating pathways across the hospital and community elements of our organisation. Resilience funding of £700k assumed, no further funding planned for so any additional resource would mitigate any pressures.
Efficiency programme not delivered in full	The efficiency target has been set £1.4m in excess of that required to deliver our surplus plan. This is funding to boost our capital programme or service developments but will only be released if efficiency delivered. Approach to funding developments / capital is to review each quarter and release if funding available. More rigorous and structured approach to efficiency delivered through clinical transformation with Programme Management Office support, enhanced clinical leadership and buy in
Medical staffing costs exceed budget	Contingency is in place to provide resilience against increasing costs in this area. A neutral vendor contract is also in place to manage locum costs.
Shortfall in income / overspending causing cashflow difficulties	In addition to mitigations above, capital funding only available if financial performance allows. Agreement with CCG in relation to a more favourable cash profile within the proposed contract. Use of Independent Trust Financing Facility for business development capital investment. Continued focus to optimise debtors as delivered in final quarter of 2014/15.

Capital investment activity

During 2014/15, HDFT invested £4.7m as part of the Trust's capital programme. The breakdown of the investment is shown in the table below:

Scheme	**£'000**
MRI Scanner	1,461
Radiology IT renewal and upgrade	282
Electronic Prescribing	575
Real Time Patient Observation System	567
Other (including equipment replacement, IT replacement, environmental improvements)	1,795
TOTAL	**4,700**

Land interests

During the financial year ending 31 March 2015, the Trust's land and buildings were revalued by the Valuation Office Agency (VOA) which is an Executive Agency of HM Revenue and Customs (HMRC). This valuation, in line with the Trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in an increase in value of the Trust's land and buildings of £2,698,000, which has been incorporated in the accounts.

Accounting policies

The Trust prepares the financial statements under direction from Monitor in accordance with NHS Foundation Trust Annual Reporting Manual 2014/15 which is agreed with HM Treasury. The accounting policies follow International Financial Reporting Standards (IFRS) to the extent they are meaningful and appropriate to NHS Foundation Trusts.

Investments

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

Details of activities designed to improve value for money

The Trust has changed the approach to the delivery of efficiency. A clinical transformation programme underpinned by a more robust Project Management Office (PMO) has been introduced during the final quarter of 2014/15. This approach has increased the rigour and improved the Quality Impact Assessment process relating to the efficiency programme. These changes have been assessed by our Internal Audit service and significant assurance has been received in relation to the new arrangements.

The Trust Cost Improvement Programme (CIP) target is £8.8m. It is recognised that at 4.7% this will provide a significant challenge in 2015/16 and beyond. Prior to the enhanced tariff option directorates were working to targets developed on the basis the efficiency requirement was £10.2m. Internally it has been agreed to continue to monitor against this higher target.

The clinical transformation and business development work streams which have been set up in the Trust aim to support the process of delivering further efficiency and improvements in care. Their impact is necessarily longer term and will support further efficiency achievement in future years.

Better Payment Code of Practice

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

Summary of Position 2014/15

Year to 31 March 2014	Numbers	Year to 31 March 2015
51,122	No of Bills Paid to Date	49,048
11,186	No of Bills Paid in 30 Days	6,860
22%	% of Bills Paid in 30 Days	14%

Year to 31 March 2014	Values	Year to 31 March 2015
58,788	£K Value of Bills Paid to Date	54,434
19,510	£K Value of Bills Paid in 30 Days	15,884
33%	% of Bills Paid in 30 Days	29%

The Board of Directors recognises that compliance with this code is compromised by the levels of clinical activity provided above contract where payments from the commissioners, working to national payment timescales, do not coincide with the timing of extra costs. As such, the organisation's cash management strategy is acknowledged to have a detrimental impact on this performance measure.

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. An annual counter fraud plan identifying the actions to be undertaken to create an anti-fraud culture, deter, prevent, detect and, where not prevented, investigate suspicions of fraud is produced and approved by the Trust's Audit Committee.

Going Concern

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

Cost Allocation

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

Charitable funds

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

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

As at 31 March 2015, the value of the funds held on trust amounted to £2,229,000, which is a decrease of £102,000 from 2013/14, while the value of income received in the full 12 months amounted to £600,000 (£992,000 in 2013/14). The value of resources expended amounted to £845,000 (£640,000 in 2013/14).

The investment portfolio is managed on a discretionary basis by Brewin Dolphin, based in Leeds. Brewin Dolphin does have powers to make changes to the investments without firstly obtaining agreement from the HDFT 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 2015 stood at £2,003,000 (£1,860,000 as at 31 March 2014). The investment portfolio increased during the year by £143,000.

The Charitable Fund Annual Report and Accounts for the year ended 31 March 2015 is published separately and is available from the Trust on request.

Statement as to Disclosure to Auditors and accounts prepared under direction from Monitor

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 a direction issued by Monitor under the National Health Service Act (2006).

Statement of accounting policies

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

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

Charitable and Political Donations

During 2014/15 no political or charitable donations were made by the Trust.

Strategic Risks

The Trust records strategic risks to the organisation in the Board Assurance Framework (BAF), which is reviewed monthly in outline and quarterly in detail.

There were 12 strategic risks to the organisation as at 31 March 2015, as follows:

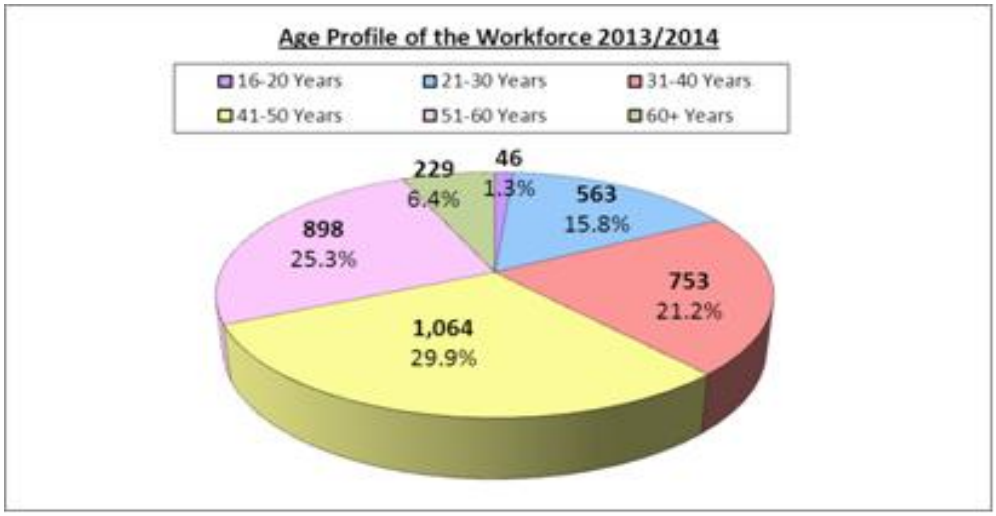
Reference	Description
BAF#1	Lack of Medical, Nursing and Clinical staff
BAF#2	High level of frailty in local population
BAF#3	Failure to learn from feedback and Incidents
BAF#4	Lack of integrated IT structure
BAF#5	Service Sustainability
BAF#6	Understanding the market
BAF#7	Lack of robust approach to new business
BAF#8	Visibility and reputation
BAF#9	Risk of failing to defend current business
BAF#10	Failure to deliver the Operational Plan
BAF#11	Loss of Monitor Licence to operate
BAF#12	External funding constraints

Information on the Trust's Employees

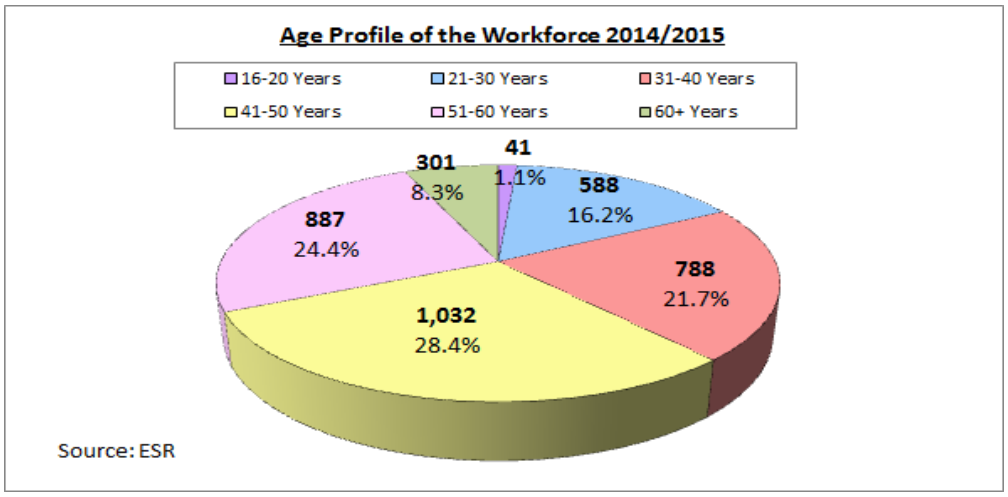
All of the data profiles of the Trust's staff in the charts below have been collated from the Trust's Electronic Staff Record (ESR) system and provides a comparison between 2013/14 and 2014/15. Percentages have been rounded to one decimal point and may not therefore total 100%. All figures are taken for the end of the financial year.

Organisational Profiles

Age Profile 2013/2014

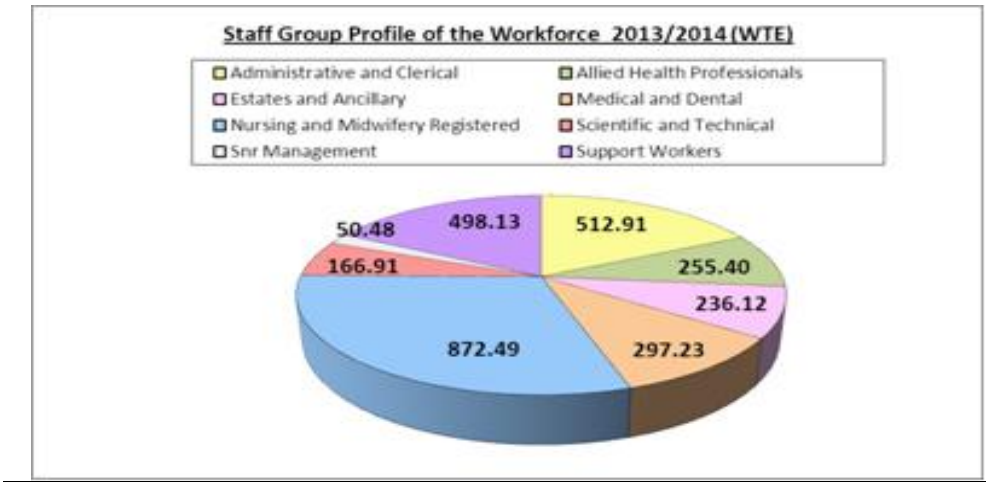


Age Profile 2014/2015

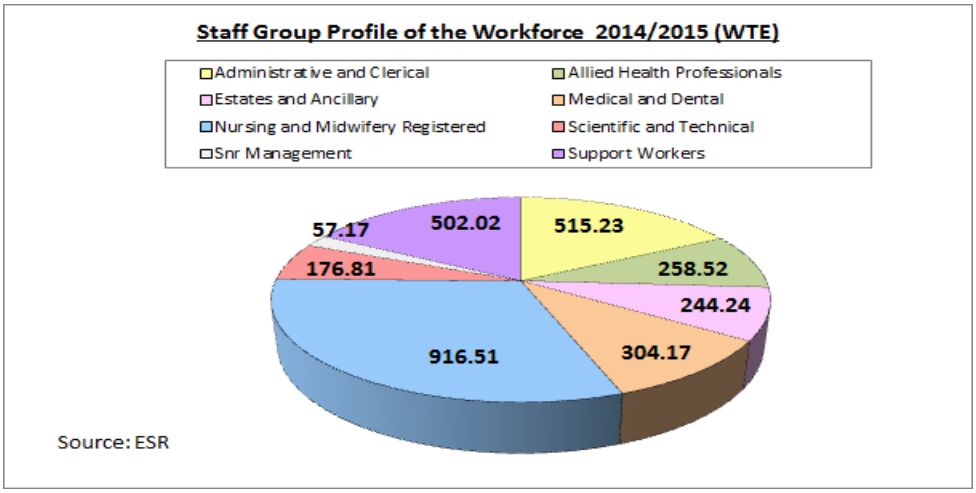


	2013/2014		2014/2015	
Age Band	**Headcount**	**% of Workforce**	**Headcount**	**% of Workforce**
16-20 Years	46	1.3%	41	1.1%
21-30 Years	563	15.8%	588	16.2%
31-40 Years	753	21.2%	788	21.7%
41-50 Years	1,064	29.9%	1,032	28.4%
51-60 Years	898	25.3%	887	24.4%
60+ Years	229	6.4%	301	8.3%
TOTAL	**3,553**		**3,637**	

Staff Group Profile 2013/2014



Staff Group Profile 2014/2015



	2013/2014		2014/2015	
Staff Group	**WTE**	**Headcount**	**WTE**	**Headcount**
Administrative and Clerical	512.91	643	515.23	636
Allied Health Professionals	255.40	322	258.52	325
Estates and Ancillary	236.12	278	244.24	292
Medical and Dental	297.23	400	304.17	395
Nursing and Midwifery Registered	872.49	1,054	916.51	1,102
Scientific and Technical	166.91	187	176.81	201
Snr Management	50.48	52	57.17	60
Support Workers	498.13	617	502.02	626
TOTAL	**2,889.65**	**3,553**	**2,974.67**	**3,637**

Senior Staff Changes during 2014/15

Appointments

Mr.	Efstathios	Altanis	Consultant - Obs & Gynae
Mr.	Richard	Atkinson	IT Project Leader
Dr	Shimona	Basu	Consultant - Paediatrics
Mrs.	Louise	Binns	Specialist Nurse - Skin Cancer
Miss	Dawn	Bowness	Advanced Podiatrist
Mrs.	Claire	Burton	Specialist Screening Practitioner
Dr	Emma	Dugdale	Consultant - Oncology
Dr	Daniel	Fascia	Consultant - Radiology
Mrs.	Jill	Foster	Chief Nurse
Mr.	Jonathan	Gill	Consultant - Urology
Dr	Sarah	Glover	Clinical Scientist - Blood Sciences
Dr	Lauren	Heath	Consultant - Medical Microbiology
Dr	Richard	Hobson	Consultant - Medical Microbiology
Miss	Lesley	Hudson	Sister/Charge Nurse - Mentor
Dr	Hayley	Kemp	Consultant - Anaesthetics
Mrs.	Sara	Keogh	Head of Midwifery
Mrs.	Sandra	King	Specialist Radiographer (Reporting Sonographer)
Miss	Mahsa	Kouhestani	Clinical Pharmacist - Haematology and Oncology
Dr	Karen	Lee-Donaldson	Clinical Psychologist
Dr	Anna	Linden	Consultant - Paediatrics
Mr.	Jordan	McKie	Deputy Director - Finance
Dr	Ewan	McNeill	Clinical Psychologist – Child Development Centre
Mr.	Murad	Moosa	Consultant - Ophthalmology
Dr	Heather	Mortimer	Consultant - Respiratory Medicine
Mrs.	Alison	Pritchard	Highly Specialist Applied Psychologist
Dr	Anna	Sampson	Clinical Psychologist - Autism Service
Mrs.	Maureen	Taylor	Non-Executive Director

Miss	Kathy	Thwaites	Clinical Psychologist
Dr	Rosamond	Tolcher	Chief Executive
Mrs.	Rebecca	Ventress	Senior Pharmacist - Aseptics Oncology and Haematology
Mrs.	Rachael	Wilcox	Specialist Occupational Therapist
Ms.	Rebecca	Wixey	Clinical Effectiveness and NICE Manager

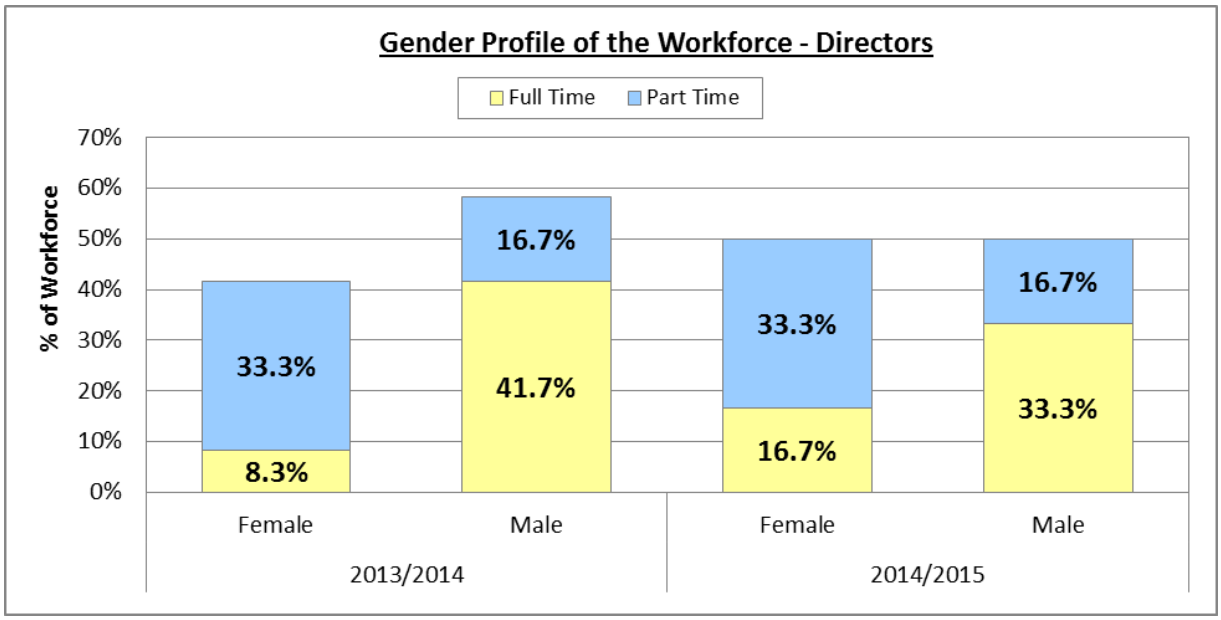
Departures

Mr.	David	Allwood	Pharmacy Clinical Services Manager
Dr	Kay	Baxter	Consultant - Dermatology
Mrs	Hannah	Beba	Clinical Pharmacist
Mrs.	Sandra	Broadbent	Senior Manager Wheelchair Services
Mrs.	Emma	Burns	Advanced Speech and Language Therapist
Mrs.	Susan	Chase	Advanced Biomedical Scientist - Haematology
Miss	Edel	Cosgrave	Consultant - Ophthalmology
Mrs.	Janet	Doemling	Advanced Occupational Therapist
Mrs.	Jenny	Ehrhardt	Deputy Director - Finance
Dr	Anthony	Fennerty	Consultant - Respiratory Medicine*
Mr.	Gary	Flavell	IT Project Leader
Mrs.	Elizabeth	Fletcher	Community Matron - Mentor
Miss	Hannah	Fletcher	Clinical Pharmacist Haematology and Oncology
Mrs.	Jane	Gauntley	Team Leader – Mentor
Mrs.	Alison	Gough	Midwife
Mrs.	Ruth	Grasty	Finance Manager
Mrs.	Pauline	Holloway	Principal Radiographer
Mr.	Robert	Howie	Estates Officer (Engineering Design)
Mrs.	Margaret	Jennings	Specialist Nurse
Dr	Berenice	Lopez	Consultant - Chemical Pathology
Mrs.	Sarah	Martin	Sister/Charge Nurse - Mentor
Mrs.	Angela	Monaghan	Chief Nurse
Dr	Neil (Doug)	Munro	Consultant - Paediatrics
Mrs.	Shannon	Nickson	Clinical Pharmacist
Mr.	Abdurrahman	Nuhu	Systems Development and Reporting Manager
Mr.	Richard	Ord	Chief Executive
Mr	Jonathan	Parkin	Operational Director
Mrs.	Emily	Rickus	Specialist Radiographer (Reporting Sonographer)
Mr.	John	Ridings	Non-Executive Director/Audit Committee Chairman
Ms.	Moraig	Rollo	Professional Lead Nutrition & Dietetics
Dr	Anna	Sampson	Clinical Psychologist - Autism Service
Ms.	Helen	Scoullar	Child Protection Advisor
Mrs.	Ruby	Spruce	Community Matron
Miss	Barbara	Stearn	Clinical Effectiveness Manager*
Mrs.	Louise	Stevenson	Older People's Champion
Ms.	Susan	Symington	Non-Executive Director, Vice-Chair
Dr	Nigel	Weightman	Consultant - Medical Microbiology
Mrs.	Claire	Wilkinson	Speech & Language Therapist
Mr.	Ronald	Wilkinson	Urgent Care Practitioner / Paramedic

* Denotes left their main employment and returned to a different contract

Gender Profile

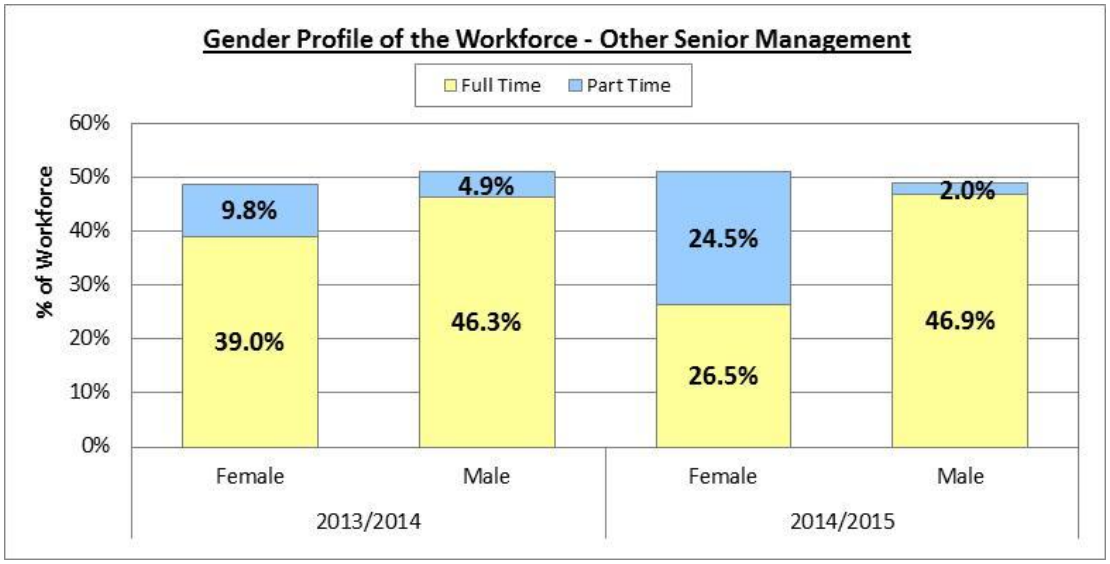
Directors



The table below gives a breakdown of the number of Directors, including Non-Executive Directors, by gender, as at 31 March 2015.

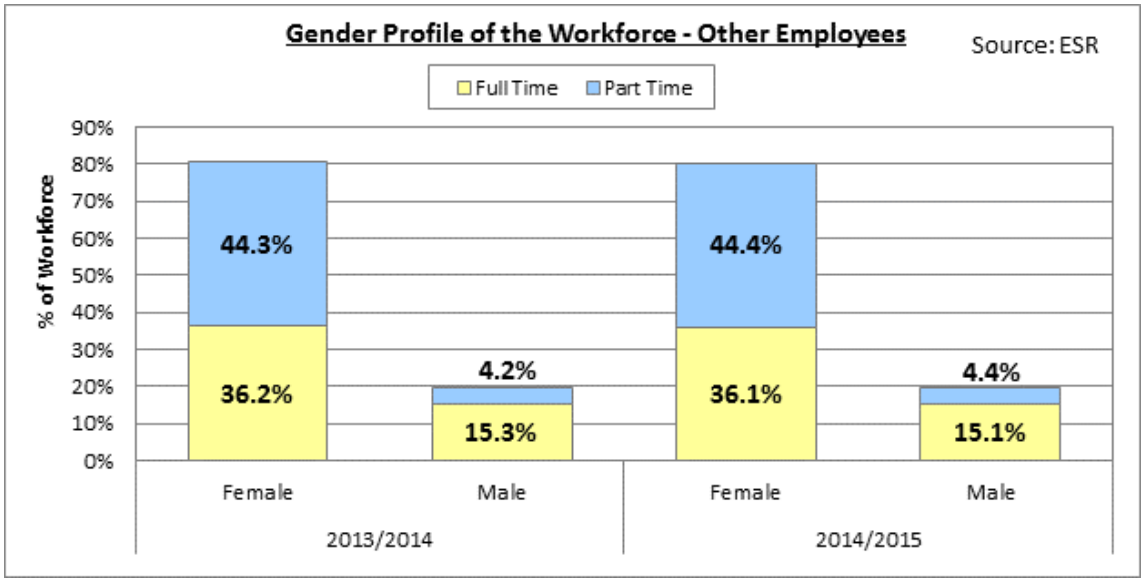
		2013/2014	2014/2015
Gender	**Category**	**Headcount**	**Headcount**
Female	**Full Time**	1	2
	Part Time	4	4
Male	**Full Time**	5	4
	Part Time	2	2
TOTAL		**12**	**12**

Other Senior Management



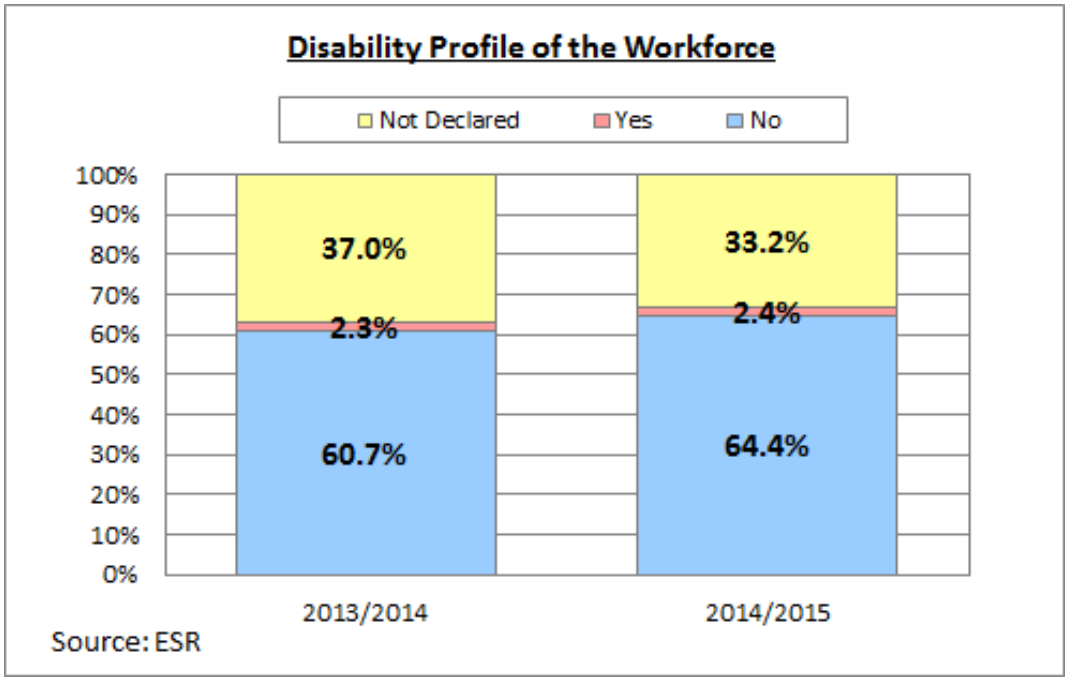
		2013/2014	2014/2015
Gender	**Category**	**Headcount**	**Headcount**
Female	**Full Time**	16	13
	Part Time	4	12
Male	**Full Time**	19	23
	Part Time	2	1
TOTAL		**41**	**49**

Other Employees



		2013/2014	2014/2015
Gender	**Category**	**Headcount**	**Headcount**
Female	**Full Time**	1,268	1,290
	Part Time	1,550	1,586
Male	**Full Time**	535	540
	Part Time	147	159
TOTAL		**3,500**	**3,575**

Disability Profile



	2013/2014	2014/2015
Disabled	**Headcount**	**Headcount**
No	2,156	2,343
Yes	81	87
Not Declared	1,316	1,207
TOTAL	**3,553**	**3,637**

Equality and Diversity and Human Rights

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

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

The Trust aims to ensure that its services are accessible, appropriate and sensitive to the needs of the whole community and that we prevent discrimination, by promoting policies and services which are based on fairness, openness and inclusiveness, by treating everyone with dignity and respect and by increased staff awareness through equality and diversity training. Levels of staff awareness training in equality and diversity are high in all directorates and renewed every three years.

The Trust publishes on its website www.hdft.nhs.uk employment monitoring statistics and approved equality impact assessments. We have also published evidence of the many areas of our good equality and diversity practice to demonstrate our compliance with the public sector duty identified in the Equality Act 2010. The Trust has updated its Single Equality Scheme and Strategy for 2014-2017 and has an annual associated Work Plan which is also available on the website. The ethnicity profile of the workforce is more diverse than the local community which at the 2011 census was 91.3% white British.

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

Harrogate and District NHS Foundation Trust is fully committed to meeting its legal duties in the area of equality and diversity. As equality legislation has developed over the years the Trust has had various policy and procedure documents in place. The Trust no longer maintains a dedicated Equal Opportunities Policy or individual documents covering race, gender and disability equality as all these areas are incorporated into this Single Equality Scheme document and strategy. Diversity covers a much wider framework than just the equal opportunities legal requirements and is now coupled with equality.

The Single Equality Scheme and Strategy for 2014-2017 brings together the Trust's approach to equality, across all the protected interest groups, and to respecting the basic human rights and 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.

The Trust recognises that different people have different needs. Equality for the Trust means:

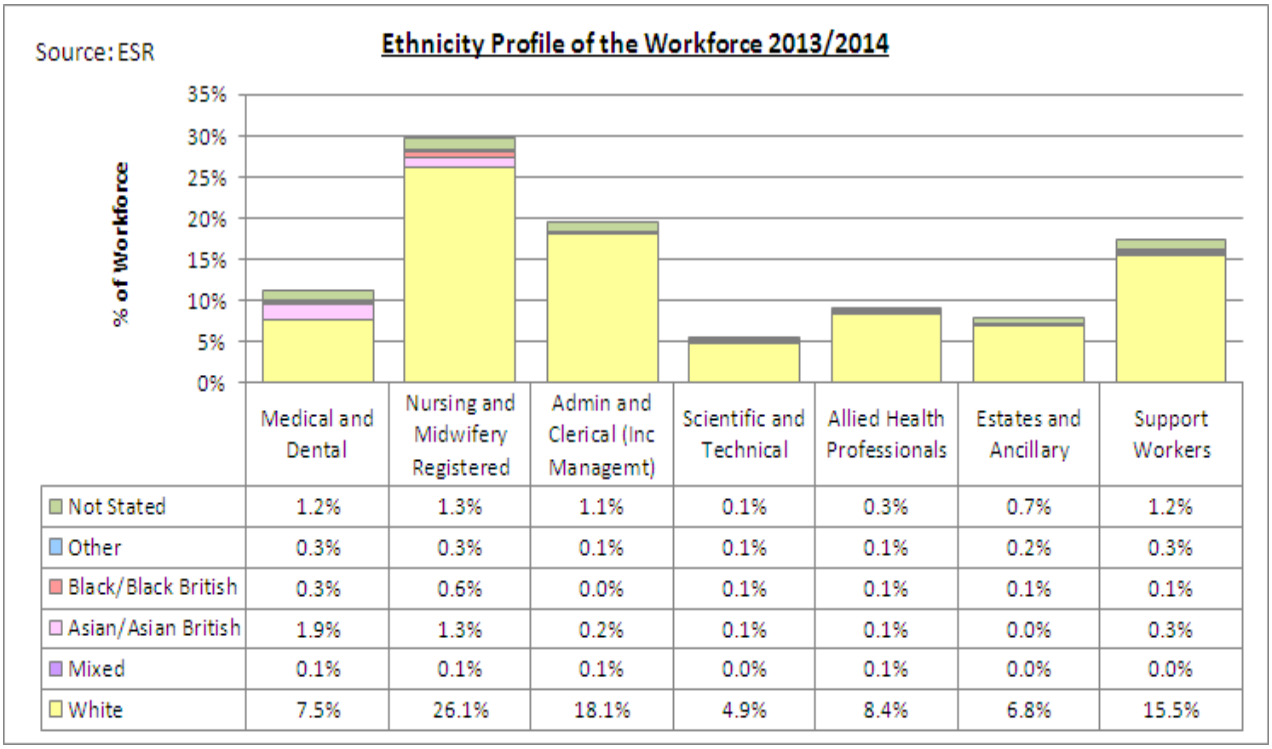
- Opportunities for employment, promotion, training and development are open to all on an equal basis. Appendix 1 of the Single Equality Scheme is specifically about employing people with a disability, which includes the legal obligation to make reasonable adjustments where an individual with a disability would be at a substantial disadvantage in comparison with persons who do not have a disability;
- Access to services are sensitive to individual needs and requirements irrespective of colour, disability, ethnic origin, age, gender, illness (such as long term conditions), marital status, nationality, race, religion and belief, sexual orientation and social background;
- All future service developments consider the needs of all groups within the community;
- Patients, staff, volunteers and all other service users and providers are treated with dignity and respect.

Ward and department based dignity/dementia champions promote in their areas the dignity and rights of service users with dementia symptoms.

The Trust will continue to promote equality via the implementation of the nationally agreed Equality Delivery System and Workforce Race Equality Standard.

Ethnicity Profile 2013/14

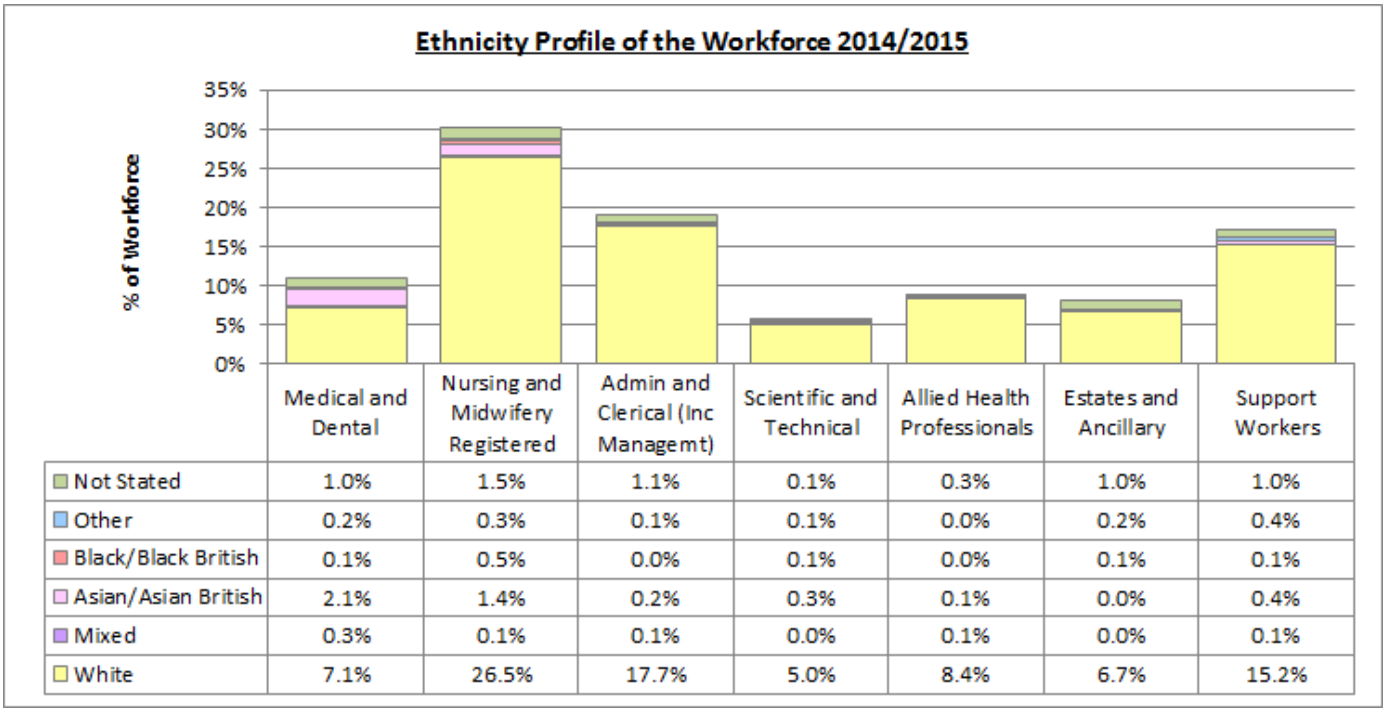
Source: ESR



	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	1.2%	1.3%	1.1%	0.1%	0.3%	0.7%	1.2%
Other	0.3%	0.3%	0.1%	0.1%	0.1%	0.2%	0.3%
Black/Black British	0.3%	0.6%	0.0%	0.1%	0.1%	0.1%	0.1%
Asian/Asian British	1.9%	1.3%	0.2%	0.1%	0.1%	0.0%	0.3%
Mixed	0.1%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%
White	7.5%	26.1%	18.1%	4.9%	8.4%	6.8%	15.5%

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

Ethnicity Profile 2014/15



Headcount	Medical and Dental	Nursing and Midwifery Registered	Admin and Clerical inc Management	Scientific and Technical	Allied Health Professionals	Estates and Ancillary	Support Workers	TOTAL
White	259	963	642	182	304	244	554	**3,148**
Mixed	10	4	3	1	2	1	3	**24**
Asian/Asian British	78	51	8	10	5	1	14	**167**
Black/Black British	3	18	0	4	1	2	4	**32**
Other	9	10	3	2	1	6	13	**44**
Not Stated	36	56	40	2	12	38	38	**222**
TOTAL	**395**	**1,102**	**696**	**201**	**325**	**292**	**626**	**3,637**

Environmental Sustainability

The Trust is committed to achieving a more sustainable future through conserving the natural environment and its resources. This includes meeting national targets to reduce our carbon footprint, an increased focus on using renewable energies, investing in sustainable technologies and reducing waste.

The Trust's Sustainability Strategy and Plan have been reviewed and updated to take account of an update to the 2009 NHS Carbon Reduction Strategy for England 'Saving Carbon, Improving Health and the Trust's Carbon Management Plan. Additionally, the Trust's assessment score of "excellent" under the Good Corporate Citizenship Assessment Model was maintained in 2014/15.

The Trust's Carbon Management Plan sets out its strategy and action plan for reducing carbon emissions over the next 6 years. It identifies the tangible and intangible benefits of carbon management and describes the governance arrangements to keep the programme on track. An ambitious carbon reduction target has been set to reduce the Trust's carbon emissions by 30%, from a 2011/12 baseline by 2020. To achieve this, carbon reduction projects have been identified in the following areas:

- Invest to save energy reduction projects
- Efficient energy generation projects (Combined Heat and Power (CHP))
- Waste management projects

In order to deliver the targeted reduction in carbon emissions and energy costs, the Estates Department has been working with the Carbon & Energy Fund, a not for profit organisation which is part of NHS Shared Business Service. In March 2015 the Board of Directors of the Trust approved a £6.9m capital project which will invest in the replacement of primary mechanical and electrical engineering infrastructure with modern energy efficient equipment and support the Trust's energy reduction programme. The project will be delivered in 2015/16.

The Trust has continued to seek to engage staff in the sustainability agenda through a range of staff communications. These have included:

- Notices on the Trust's daily e-bulletin for staff, highlighting how much money and carbon can be saved through simple steps like turning off lights and computers;

- The Estates team presenting to a number of the Trust's monthly Team Brief sessions, explaining some of the initiatives that they have undertaken e.g. recycling food waste and the Trust's application to the Carbon and Energy Fund;

- Providing the Trust's Sustainability Environment Champions with posters to display in their workplaces: for example, Trust staff have already demonstrated an appetite for reducing the carbon footprint by their positive reception to the auto-switch off of idle computers.

The Supplies and Procurement Department continues to promote the sustainability agenda with the Trust's key procurement partners NHS Supply Chain and the North of England Commercial Procurement Collaborative (NOECPC). A recent project in which the Trust has indirectly benefited from, involves a project that NHS Supply Chain undertook with its supplier for many of the Trust's sharps bins. A rationalisation of packaging and delivery formats has benefitted all parties e.g. changing to a bulk pallet packaging & delivery format into the NHS Supply chain distribution centre significantly reduced the amount of packaging by 46.5 tonnes per year and enabled more goods to be delivered as a result, thus reducing the equivalent of 18 deliveries per annum. These savings in turn have a benefit to the Trust in terms of the amount of waste that needs to be disposed of.

The Trust's Sustainability Group continued to drive forward developments directly or monitor through other established groups on subjects such as:

- The ongoing review of the premises and locations from which the Trust provides services;
- Paperless reporting;
- The Trust's travel plan;
- Energy/carbon reduction initiatives;
- Automatic "switch off" of non-clinical computers that are sitting idle after a period of time.

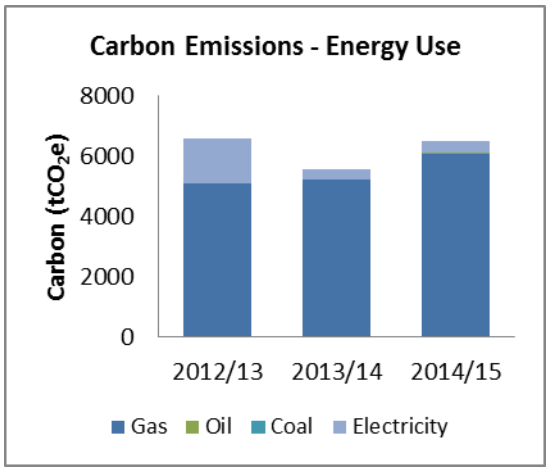
<u>Energy</u>

Energy consumption for 2014/15 is 9.7% greater than for 2013/14 and this can be attributed to the capital projects which have become fully operational during the year. In order to minimise the financial effect of the energy consumption increase the utilisation of the Trust's CHP engine has reduced the Trust's spend to £1,412,710 in 2014/15 which is a 3% reduction on 2013/14.

The Trust's energy-related carbon emissions have increased as a result of the increased gas consumption of the CHP engine and whilst this has reduced the consumption of imported grid electricity, it does not reduce the associated carbon emissions as the grid electricity used is 100% renewable.

Resource		2012/13	2013/14	2014/15
Gas	Use (kWh)	27610693	28351407	32969298
	tCO_2e	5081.5	5217.8	6067.7
Oil	Use (kWh)	50800	21280	241310
	tCO_2e	13.8	5.8	65.6
Coal	Use (kWh)	0	0	0
	tCO_2e	0	0	0
Electricity	Use (kWh)	4,317,894	5,634,776	4,111,348
	tCO_2e	1474.9	355.6	356
Total Energy CO_2e		6570.2	5579.2	6488.8
Total Energy Spend		£ 1,331,979.00	£ 1,453,863.00	£ 1,412,710.63

kWh = Kilowatt hours
tCO_2e = tonnes of carbon dioxide emitted



Waste Management

The Trust has continued to work closely with its waste management partners over the course of the year and has partnered with a new organisation to recycle its food waste which is now used to generate off site electricity, with the by-product being used as fertiliser.

Waste		2012/13	2013/14	2014/15
Recycling	(tonnes)	277	252.57	234.241
	tCO_2e	5.8	5.3	4.9
Re-use	(tonnes)	0	0	0
	tCO_2e	0	0	0
Compost	(tonnes)	0	0	11.16
	tCO_2e	0	0	0.066
WEEE*	(tonnes)	7.3	0.8	1.69
	tCO_2e	0.15	0.018	0.035

High Temp recovery	(tonnes)	0	0	0
	tCO_2e	0	0	0
High Temp disposal	(tonnes)	136	137.1	130.5
	tCO_2e	2.8	2.8791	2.7405
Non-burn disposal	(tonnes)	210	208.4	223.2
	tCO_2e	4.41	4.3764	4.6872
Landfill	(tonnes)	134	132.83	160.711
	tCO_2e	32.7	32.4	39.2
Total Waste (tonnes)		764.3	731.7	761.5
% Recycled or Re-used		36.2	34.51	30.7
Total Waste tCO_2e		45.9	45.0	51.7

* WEEE = Waste Electrical and Electronic Equipment

Further Details of the Trust's Strategic Plans

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

Approval by the Directors of the Strategic Report

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

Signed

Dr Ros Tolcher
Chief Executive 27 May 2015

DIRECTORS' REPORT

Directors of the Trust

The Directors of the Trust during the year 2014/15 were:

Mrs Sandra Dodson	Chairman (Non-Executive Director)
Mr John Ridings	Non-Executive Director (Vice Chair and Senior Independent Director until 30 April 2014, Chair of Audit Committee until 30 July 2014)
Ms Sue Symington	Non-Executive Director (Vice Chair and Senior Independent Director to 31 January 2015)
Mr Ian Ward	Non-Executive Director (Senior Independent Director from 25 February 2015)
Professor Sue Proctor	Non-Executive Director (Vice Chair from 4 February 2015)
Mrs Maureen Taylor	Non-Executive Director (from 3 November 2014)
Mr Chris Thompson	Non-Executive Director (Chair of Audit Committee from 31 July 2014)
Mrs Lesley Webster	Non-Executive Director (Chair of Finance Committee)
Mr Richard Ord	Chief Executive (until 3 August 2014)
Dr Ros Tolcher	Chief Executive (from 4 August 2014)
Mr Jonathan Coulter	Finance Director and Deputy Chief Executive
Dr David Scullion	Medical Director
Mrs Angela Monaghan	Chief Nurse (to 30 June 2014)
Mrs Jill Foster	Chief Nurse (from 1 July 2014)
Mr Robert Harrison	Chief Operating Officer
Mr Phillip Marshall	Director of Workforce and Organisational Development

Company Directorships held by Directors or Governors

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

Charitable and Political Donations

During 2013/14 and 2014/15 no political or charitable donations were made by the Trust.

Cost Allocation Disclosure

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

Financial Instruments Disclosure

The Trust takes a very prudent approach to risk and neither buys or sells financial instruments. Details can be found in Note 23 of the Annual Accounts.

Enhanced Quality Governance Reporting

The Quality and Governance Group drives and monitors 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. The quality improvement priorities reflect the three elements of quality; patient safety, effective care and good patient experience. The Quality and Governance Group promotes the embedding of quality throughout the NHS Foundation Trust with engagement of all staff groups, and oversees the production of the Quality Report.

Detail of quality performance is described in the Quality Report, and further detail of quality governance is included in the Annual Governance Statement.

Early in 2015, a full review of quality governance was undertaken by staff from across the organisation. Monitor's Quality Governance Framework was a key reference document and resource for this work, and the first stage of the outcome of this work is being implemented from 1 April 2015. This is focused on a new governance framework of committees and groups, with supporting processes to ensure management and delivery of work, driving and coordinating objectives and robust assurance. A plan that detailed the transition arrangements was approved by the Board of Directors on 25 March 2015. Further work has started to undertake a self-assessment against Monitor's Well-led framework for governance reviews.

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 this Annual 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 Report.

The Trust's Assurance Structure

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

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

Care Quality Commission (CQC) Reports

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

There have not been any reviews of the NHS Foundation Trust or reports from the Care Quality Commission during 2014/15. The action plan relating to the last inspection by the CQC in November 2013 was completed and closed in November 2014.

National Adult Inpatient Survey

The National Adult Inpatient Survey 2014 was published by the Care Quality Commission on 21 May.

Overall HDFT performed very well, scoring "significantly better than average" for 7 out of 59 questions (compared to 6 out of 60 last year), including 4 questions from the "leaving hospital" section. For the fourth consecutive year, HDFT had no questions rated "significantly worse than average". 461 patients treated at HDFT responded in the survey this year, a local response rate of 56%, which is the same as last year.

A more detailed review of the outcomes of the Survey is contained in the Quality Report, which is included later in this Annual Report.

Significant Activities in the Field of Research and Development

Information on research and development within the Trust is contained within the Quality Report, which is included later in this Annual Report.

Improving Patient Care

The Trust strives at all times to improve patient care for all users of our services. Detailed information in relation to what the Trust has done during 2014/15 and what it plans to do in 2015/16 is contained within the Quality Report, which is included later in the Annual Report.

Complaints Handling

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

The Trust promotes pro-active, on the spot resolution of problems at a local level, thus reducing the need for patients/carers to raise issues in a more formal way. It is recognised that lessons must be

captured from this type of feedback locally to promote sharing of learning and good practice. Quality of Care Teams, which are department based teams of frontline staff, are encouraged to facilitate the resolution of issues in their own areas and promote learning.

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

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

For those cases graded as a complaint, an Investigating Officer is appointed by the Directorate with the most involvement and a formal written acknowledgement is sent from the Chief Executive. An individual resolution plan will be developed with the 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 yellow, amber or red the most serious levels of concern, or where there are serious risk management implications, the Patient Experience Officer will refer to the Head of Risk Management to ensure appropriate action is taken in relation to any ongoing patient care or incident investigation. For serious complaints, a root cause analysis of the case will be carried out by the Investigating Officer.

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

If the person is not a patient, but is raising issues on behalf of a patient, the PET 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 Quality Experience Group (QEG) on a quarterly basis and in turn to the Board of Directors. Complaint trend reports are also sent to Directorates for dissemination and feedback of actions taken in response to identified themes.

Statement as to Disclosure to Auditors

For each individual who is a Director of the Trust as of 27 May 2015, there is no relevant audit information of which the NHS Foundation Trust's auditors are unaware.

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

Company Directorships and Other Significant Interests held by Directors and Governors

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

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

REMUNERATION REPORT – EXECUTIVE AND NON-EXECUTIVE DIRECTORS

Executive Directors

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

Mrs Sandra Dodson, Chairman and Committee Chairman
Professor Sue Proctor, Non-Executive Director
Mr John Ridings, Non-Executive Director (until 30 June 2014)
Ms Sue Symington, Non-Executive Director (until 31 January 2015)
Mr Chris Thompson, Non-Executive Director (from 1 March 2014)
Mr Ian Ward, Non-Executive Director
Mrs Lesley Webster, Non-Executive Director (from 1 January 2014)
Mrs Maureen Taylor, Non-Executive Director (from 3 November 2014)

Mr Richard Ord, Chief Executive (until 3 August 2014) - *ex-officio*
Dr Ros Tolcher, Chief Executive (from 4 August 2014) – *ex-officio*
Mr Phillip Marshall, Director of Workforce and Organisational Development - *ex-officio*

The committee last met on 24 March 2014. The attendance was as follows::

Mrs S Dodson	✓
Professor S Proctor	x
Mr J Ridings	✓
Ms S Symington	✓
Mr C Thompson	x
Mr I Ward	✓
Mrs L Webster	✓
Mr R Ord	✓
Mr P Marshall	✓

The Remuneration Committee has not met during 2014/15.

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

The details of remuneration of individual Directors are included within this report.
There was no uplift to basic salaries of Directors in 2014/15 for inflation/cost of living purposes.

No performance related pay scheme (e.g. pay progression or bonuses) is currently in operation within the Trust for Executive or Non-Executive Directors and there are no special provisions regarding early termination of employment.

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;

- To monitor and evaluate the performance and development of the Chief Executive and all Executive Directors;
- To advise on and oversee appropriate contractual arrangements for the Chief Executive and all Executive Directors including:

    - The proper calculation and scrutiny of termination payments in the light of appropriate guidance as is appropriate;
    - All aspects of salary (including any performance-related elements/bonuses);
    - The provisions for other benefits, including pensions and cars.

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

Comparative sources of guidance used by the Remuneration Committee for the determination of Directors' pay are:

- Foundation Trust Network (FTN) Remuneration Survey 2012;

- CAPITA NHS Foundation Trust Board Remuneration Report 2012.

The FTN Remuneration Survey was the only real-time information source used, as it was based on a survey conducted in October 2013. The CAPITA report used data collated from Foundation Trusts' Annual Reports and Accounts for the previous financial year. The Trust does not currently consult with staff on the level of remuneration for senior managers.

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

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

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

As well as performance in the role and consideration of the organisation being managed, the salaries paid to individual post holders will also reflect a range of personal factors including skills and experience. Directors and the Chief Executive receive an annually agreed salary. Unless otherwise agreed by the Trust's Remuneration Committee, and in order to recruit and retain high performing individuals, all Directors are offered permanent and full-time contracts of employment.

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

All Directors are employed on a permanent basis. The Chief Executive and all Directors are entitled to six months' notice ordinarily to terminate their employment.

The Trust does not currently have in place a policy on the use of off-payroll arrangements; this is in the course of development.

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

There are no special provisions regarding the early termination of contracts of employment for the Chief Executive, Directors and Senior Managers.

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

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Name and Title	2014/15						2013/14					
	Salary	Other remuneration	Taxable benefits	Total	Pension related benefits	Ratio of Total remuneration to Median for All Staff (1)	Salary	Other remuneration	Taxable benefits	Total	Pension related benefits	Ratio of Total remuneration to Median for All Staff (1)
	(bands of £5,000) £'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	(bands of £5,000) £'000s	Rounded to the nearest £100	(bands of £5,000) £'000s	(bands of £2,500) £'000s	
Mr R Ord - Chief Executive (2) (3)	25-30	-	-	25-30	-	3.11	75-80	-	-	75-80	-	2.95
Dr R Tolcher - Chief Executive (4)	105-110	-	1,000	105-110	92.5-95	6.00	-	-	-	-	-	-
Mr. J Coulter - Deputy Chief Executive	120-125	-	-	120-125	2.5-5.0	4.63	120-125	-	-	120-125	57.5-60	4.79
Dr D Scullion - Medical Director	40-45	140-145	-	185-190	0-2.5	1.56	35-40	100-105	-	135-140	12.5-15	1.39
Mrs. A Monaghan - Chief Nurse (5)	25-30	-	500	25-30	-	4.02	100-105	-	1,600	100-105	75-77.5	4.11
Mrs. J Foster - Chief Nurse (6)	75-80	-	-	75-80	(20)-(22.5)	3.74	-	-	-	-	-	-
Mr. R Harrison - Chief Operating Officer	105-110	-	-	105-110	30-32.5	4.01	100-105	-	-	100-105	25-27.5	3.88
Mr. P Marshall - Director of Workforce & Organisational Development	105-110	-	1,800	105-110	45-47.5	4.01	100-105	-	1,800	100-105	12.5-15	3.99
Mrs. J Probert - Director of Partnerships & Innovations (7)	-	-	-	-	-	-	40-45	-	-	40-45	2.5-5	1.62
Miss A Lawson - Director of Governance (8)	-	-	-	-	-	-	5-10	-	-	5-10	-	-
Mrs. S Dodson - Chairman	45-50	-	-	45-50	-	-	45-50	-	-	45-50	-	-
Mr. J Ridings - Non-Executive Director (9)	-	-	-	-	-	-	15-20	-	-	15-20	-	-
Mrs S Nattress - Non-Executive Director (10)	-	-	-	-	-	-	10-15	-	-	10-15	-	-
Prof. S Proctor - Senior Independent Director of the Board of Directors (11)	15-20	-	-	15-20	-	-	5-10	-	-	5-10	-	-
Ms. S Symington - Non-Executive Director, Vice-Chair (12)	10-15	-	-	10-15	-	-	10-15	-	-	10-15	-	-
Mrs. M Taylor - Non-Executive Director (13)	5-10	-	-	5-10	-	-	0-5	-	-	0-5	-	-
Mr. I Ward - Non-Executive Director	10-15	-	-	10-15	-	-	10-15	-	-	10-15	-	-
Mrs. L Webster - Non-Executive Director (14)	10-15	-	-	10-15	-	-	-	-	-	-	-	-
Mr. C Thompson - Non-Executive Director/ Audit Committee Chairman (15)	15-20	-	-	15-20	-	-	0-5	-	-	0-5	-	-
Mr. R Wivell - Non-Executive Director (16)	-	-	-	-	-	-	5-10	-	-	5-10	-	-

(1) The median salary for all staff in 2014/15 was £26,822. The median salary for all staff in 2013/14 was £25,783. The median calculation is the annualised full time remuneration of all staff in the Trust as at 31 March 2015 (excluding agency staff), excluding the highest paid Director.
(2) Mr R Ord ceased to be the Chief Executive on 3 August 2014. The 2014/15 median salary multiple has been calculated based only on the part-year.
(3) With respect to the remuneration of the Chief Executive, the Remuneration Committee agreed that Mr Ord would retire on 5 April 2012 and return to work. Following his retirement and prior to 3 August 2014 when Mr Ord ceased the role, the Committee agreed that when he returned to work he would receive a salary which, when combined with his retirement pension, would equate to his total salary earnings prior to his retirement.
(4) Dr R Tolcher commenced as Chief Executive of the Trust on 4 August 2014. The 2014/15 median salary multiple has been calculated based only on the part-year.
(5) Mrs A Monaghan ceased as Chief Nurse on 30 June 2014. The 2014/15 median salary multiple has been calculated based only on the part-year.
(6) Mrs J Foster commenced as Chief Nurse on 30 June 2014. The 2014/15 median salary multiple has been calculated based only on the part-year.
(7) Mrs J Probert ceased to be Director of Partnerships and Innovation on 31 August 2013.
(8) Miss A Lawson ceased to be Director of Governance on 30 April 2013.
(9) Mr J Ridings ceased as Non-Executive Director 31 July 2014. He was paid a salary in the £0-£5k bracket.
(10) Mrs S Nattress ceased as Non-Executive Director on 6 February 2014.
(11) Prof S Proctor commenced as Non-Executive Director on 1 August 2013.
(12) Ms S Symington ceased as Non-Executive Director 28 February 2015.
(13) Mrs. M Taylor commenced as Non-Executive Director on 3 November 2014.
(14) Mrs L Webster commenced as Non-Executive Director on 1 January 2014.
(15) Mr C Thompson commenced as Non-Executive Director on 1 March 2014.
(16) Mr R Wivell ceased as Non-Executive Director on 31 July 2013.

The Trust does not pay any performance related bonuses or payments.
The nature of the other remuneration figure relates to the payment for clinical activities with the Trust.
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 31st March 2015	Number claiming expenses	Total value claimed (Rounded to £00)	Number in post on 31st March 2014	Number claiming expenses	Total value claimed (Rounded to £00)
Board of Directors	16	10	17,000	13	7	2,200
Council of Governors	23	6	548	22	6	900

Pension benefits

Name and title	Real increase in pension and related lump sum at age 60 (bands of £2,500) £000	Total accrued pension and related lump sum at age 60 at 31 March 2015 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Real Change in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension to nearest £100
Mr R Ord - Chief Executive	£Nil	£Nil	£Nil	£Nil	£Nil	£Nil
Dr Rosamond Tolcher - Chief Executive	10.0-12.5	205-210	865	1,007	119	£Nil
Mr. Jonathan Coulter - Deputy Chief Executive	2.5-5	135-140	504	546	28	£Nil
Dr David Scullion - Medical Director	5-7.5	225-230	1,068	1,154	57	£Nil
Mrs. Monaghan Angela - Chief Nurse	£Nil	£Nil	£Nil	£Nil	£Nil	£Nil
Mrs. Jill Foster - Chief Nurse	0-2.5	150-155	658	685	7	£Nil
Mr. Robert Harrison - Chief Operating Officer	7.5-10	65-70	168	201	28	£Nil
Mr. Phillip Marshall - Director of Workforce and Organisational Development	10-12.5	145-150	513	583	56	£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.

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 **27 May 2015**

NHS FOUNDATION TRUST CODE OF GOVERNANCE

The Board of Directors and Council of Governors

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

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

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

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

The Board of Directors

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

The Board is responsible for:

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

Balance, completeness and appropriateness of the Board of Directors.

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

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

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

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

Executive Directors

Chief Executive – Mr Richard Ord (Executive Director) appointed 11 January 2010: retired 3 August 2014

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

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

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

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

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

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

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

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

Ros's initial clinical career was grounded in GP training prior to switching focus to specialise in community reproductive health. In 1994 Ros became a Consultant and Clinical Director of sexual

health services. She went on to work as a Primary Care Trust Medical Director and later the Managing Director of PCT provider services. In this role, she successfully led a merger of two CCG provider arms and set up a new standalone Community and Mental NHS Trust as part of the national Transforming Community Services programme.

Throughout her career, Ros 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.

Finance Director and Deputy Chief Executive (from 11 January 2010) – Mr Jonathan Coulter (Executive Director) – appointed 20 March 2006

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

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

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

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

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

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

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

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

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

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

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

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

Jill was appointed as HDFT's new 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.

Jill has a strong track record in professional nursing and operational management and is passionate about delivering high quality fundamental nursing and midwifery care.

Jill 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.

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

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

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

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

The Chief Operating Officer is responsible for the day to day operational management of 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.

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

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

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

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

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

Non-Executive Directors

Non-Executive Director Appointments

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

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

Sandra has been a Harrogate and District resident for around 21 years and was a Non-Executive Director of the Trust between 1996 and 2006. Sandra returned to the Trust in 2008 to take on the role of Chairman, and to further the Trust's vision of providing high quality and appropriate care to the people of Harrogate and District. In addition to her role as Chairman, Sandra maintains her own business consultancy and training business delivering strategic support and organisational change to the professional sector.

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

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

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

There have been no changes in the Chairman's significant other interests during 2014/15.

Mrs Dodson was reappointed as Chairman and Non-Executive Director on 30 July 2014 and is subject to annual reappointment until her retirement date of 30 September 2017.

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

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

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

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

Non-Executive Director – Ms Sue Symington – appointed 12 May 2008; appointed Vice-Chairman 1 May 2014 – resigned 31 January 2015

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

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

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

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

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

Sue provides organisational development consultancy to a number of local businesses, is a Non-Executive Director of The Beverley Building Society, Non-Executive Chair of the Pollards Hill Community Committee and Vice Chair of The Independent Advisory Panel at The Army Foundation College in Harrogate. She runs her own successful business near Knaresborough. In 2014 Sue was selected as the' 'New Director of the Year' by the Chartered Institute of Directors.

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

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

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

Ian was a Director and Vice-President of Leeds, York and North Yorkshire Chamber of Commerce and Chairman of its Property Forum. 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).

Ian moved to Knaresborough in 1996, shortly after taking up his CEO 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. He is a member of the Audit and Remuneration Committees.

Non-Executive Director - Professor Sue Proctor – appointed 1 September 2013; Senior Independent Director 1 May 2014 relinquished 3 February 2015; appointed Vice Chairman 4 February 2015

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

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

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

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

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

Sue chaired the Leeds Hospital NHS Trust Inquiry into Jimmy Savile.

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

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

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

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

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

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

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

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

Lesley is chair of the Finance Committee and a member of the Remuneration Committee.

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

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

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

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

Chris is chair of the Audit Committee and a member of the Remuneration Committee.

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

Maureen is a Chartered Accountant and until 31 March 2015 was the Chief Officer for Finance 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 Maureen 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.

Maureen left her full time post in the Spring of 2015 and is looking forward to contributing, in her new role at Harrogate, to the continued success of the Trust.

Maureen is also an Independent Board Member at British Showjumping and a member of the Audit Committee and is a Governor and Resources Committee member at a local Church of England Primary School.

Maureen is a member of the Finance Committee.

<u>Performance evaluation of the Board of Directors</u>

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

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

There has not been a formal external evaluation of the Board of Directors during 2014/15.

The information below details the Executive and Non-Executive Director attendance at Board of Directors meetings in 2014/15

The Board of Directors met 11 times in 2014/15. No Board meeting was held in December 2014.

Attendance by Directors at full Board meetings is detailed in the following table:

Name	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014 (4 Sep)	Sep 2014	Oct 2014	Nov 2014	Jan 2015	Feb 2015	Mar 2015
S Dodson	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
J Ridings	Y	Y	Y								
S Symington	Y	Y	Y	Y	Y	Y	Y	Y	Y		
I Ward	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
S Proctor	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
L Webster	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
C Thompson	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
M Taylor								Y	Y	Y	Y
R Ord	Y	Y	N	Y							
R Tolcher				Y	Y	Y	Y	Y	Y	Y	Y
J Coulter	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
A Monaghan	Y	Y	N								
J Foster				Y	Y	Y	Y	Y	Y	Y	Y
D Scullion	Y	Y	N	Y	Y	N	Y	Y	Y	Y	Y
R Harrison	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
P Marshall	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y

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

The Nominations Committee met twice during 2014/15.

At the meeting on 16 July 2014 the Committee discussed the recruitment process for a Non-Executive Director to replace Mr Ridings, who was retiring from the Board, and the reappointment of Mrs Dodson for a third term, subject to annual reappointment.

The following members were present:

Mrs Sandra Dodson, Chairman (Chair – recruitment process)
Mrs Sue Symington, Vice Chairman (Chair – reappointment of Chairman)
Mr Michael Armitage, Public Governor
Dr Sally Blackburn, Public Governor
Mrs Carol Cheesebrough, Staff Governor
Mrs Emma Edgar, Staff Governor
Mrs Jane Hedley, Public Governor
Mrs Sally Margerison, Staff Governor
Dr Daniel Scott, Staff Governor
Rev. Dr Willshaw, Public Governor and Deputy Chair of Governors
Mrs Fiona Wilson, Staff Governor

Ex Officio: Mrs Angie Colvin, Corporate Affairs and Membership Manager
Mr Jonathan Coulter, Director of Finance and Deputy Chief Executive
Miss Polly McMeekin, Deputy Director of Workforce and Organisational Development

The Committee agreed to recommend to the Council of Governors' meeting on 30 July 2014 that Mrs Dodson be reappointed for a third term of three years, subject to annual reappointment. The Committee endorsed the proposed process for the appointment of a Non-Executive Director to replace Mr Ridings.

The Nominations Committee met on 26 January 2015 to discuss the process for the recruitment of a Non-Executive Director and the appointment of a Vice Chairman of the Board of Directors.

The following members were present:

Mrs Sandra Dodson, Chairman
Ms Pamela Allen, Public Governor
Mr Michael Armitage, Public Governor
Mrs Liz Dean, Public Governor
Mrs Emma Edgar, Staff Governor
Mrs Jane Hedley, Public Governor
Mrs Sally Margerison, Staff Governor
Mr Peter Pearson, Public Governor
Mrs Joyce Purkis, Public Governor
Dr Daniel Scott, Staff Governor
Mrs Fiona Wilson, Staff Governor

Ex Officio: Mrs Angie Colvin, Corporate Affairs and Membership Manager
Mr Andrew Forsyth, Interim Head of Corporate Affairs

Miss Polly McMeekin, Deputy Director of Workforce and Organisational Development
Mr Jonathan Coulter, Director of Finance and Deputy Chief Executive

The Committee agreed the process for the recruitment of a Non-Executive Director, to replace Ms Sue Symington, who had resigned to take up a post elsewhere. The Committee also agreed to recommend to the Council of Governors' meeting on 4 February 2015 that Professor Sue Proctor be appointed as Vice Chairman of the Board of Directors, to replace Ms Symington.

The Council of Governors' subsequently approved the appointment of Professor Proctor.

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.

The Trust complies, either to the letter or in effect, with the Code of Governance.

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

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

The Trust's Assurance Structure

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

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

- Compliance with external regulatory and other standards for quality, governance and risk including Monitor, the Care Quality Commission Standards, and NHS Litigation Authority Risk Management Standards;
- A culture of effective risk management at all levels of the organisation;
- A robust assurance and risk framework to confirm all controls and mitigation of risks are in place and operating;
- The integration of quality, governance and risk within the Trust's strategic aims and objectives;
- Integrated governance encompassing financial, clinical, quality, corporate, information, performance and research governance systems.

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

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

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

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

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

The Quality and Governance Group drives and monitors 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. The quality improvement priorities reflect the three elements of quality; patient safety, effective care and good patient experience. The Quality and Governance Group promotes the embedding of quality throughout the NHS Foundation Trust with engagement of all staff groups, and oversees the production of the Quality Report.

Detail of quality performance is described in the Quality Report, and further detail of quality governance is included in the Annual Governance Statement.

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

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

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

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

The Board Assurance Framework was revised during the year and now gives the Board visibility of those strategic risks which might impact on the Trust's strategic objectives and quality priorities. It is reviewed monthly by the Executive Directors who own the risks.

A detailed review was undertaken against Monitor's Quality Governance Framework in October 2013. Early in 2015, a full review of quality governance was undertaken by staff from across the organisation. Monitor's Quality Governance Framework was a key reference document and resource for this work, and the first stage of the outcome of this work is being implemented from 1 April 2015. This is focused on a new governance framework of committees and groups, with supporting processes to ensure management and delivery of work, driving and coordinating objectives and robust assurance. A plan that detailed the transition arrangements was approved by the Board of Directors on 25 March 2015. Further work has started to undertake a self-assessment against Monitor's: Well-led framework for governance reviews: guidance for NHS foundation trusts (updated April 2015), which has now replaced the quality governance framework.

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

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

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

Council of Governors

The Council of Governors represent the interests of the Foundation Trust members and the general public; they have an important role 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 of Governors 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 and have an ambassadorial role in representing and promoting the Trust. They have a statutory responsibility to ensure that the Non-Executive Directors are reviewing, questioning and challenging the Executive Directors to make sure the Trust is running effectively and smoothly as a business.

Governors regularly feedback and seek the views of members about the Trust, its vision and its performance.

Governors are elected by staff (Staff Governors) and the membership (Public Governors), or nominated by partner organisations such as, for example, North Yorkshire County Council (Stakeholder Governors). The Council of Governors consists of 17 elected and 6 nominated Stakeholder Governors.

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

- to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors;
- to be representative of the interests of the members of the Trust as a whole and the interests of the public;
- to appoint or remove the Chairman and the other Non-Executive Directors;
- to approve the appointment (by the Non-Executive Directors) of the Chief Executive;
- to appoint or remove the Trust's external auditor;
- to decide the remuneration of the Chairman and Non-Executive Directors;
- to consider the Trust's Annual Accounts, Auditor's Report and Annual Report;
- to bring their perspective in determining the strategic direction of the Trust;
- to be involved in the Trust's forward planning processes;
- to approve any merger, acquisition, separation or dissolution application and the entering into of any significant transactions;
- to approve any proposals to increase by 5% or more of the Trust's proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England;
- to organise an Annual Members Meeting;
- To approve appropriate 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 April 2014 to March 2015.

Constituency	Name	Term of office	Apr 2014	Jul 2014	Oct 2014	Feb 2015
Harrogate and surrounding villages – publicly elected	Rev Dr. Mervyn Willshaw, Deputy Chair of Governors/Lead Governor	January 2010 to December 2012 January 2013 to December 2015	Y	Y	Y	N
	Mrs Pat Jones	January 2011 to December 2013 January 2014 to December 2016	Y	Y	Y	Y
	Dr Sally Blackburn	August 2011 to July 2014 August 2014 to July 2017	N	Y	Y	Y
	Miss Sara Spencer	January 2013 to December 2015 (Stood down October 2014)	Y	N	N/A	N/A
	Ms Pamela Allen	January 2014 to December 2016	Y	Y	Y	Y
	Mrs Liz Dean	December 2014 to December 2015 (remainder of term following resignation of Sara Spencer)	N/A	N/A	N/A	Y
Knaresborough and East District – publicly elected	Mrs Jane Hare	January 2013 to December 2015	Y	N	Y	Y
	Mrs Joyce Purkis	January 2014 to December 2016	Y	Y	Y	Y
Rest of North Yorkshire and York – publicly elected	Mr Paul Hyde	July 2011 to June 2014	Y	NA	N/A	N/A
	Mrs Cath Clelland	January 2015 to December 2017	N/A	N/A	N/A	Y

Constituency	Name	Term of office	Apr 2014	Jul 2014	Oct 2014	Feb 2015
Ripon and West District – publicly elected	Mr Stuart Martin	July 2011 to June 2014	N	N/A	N/A	N/A
	Mr Andy Robertson	July 2013 to June 2016	N	Y	Y	Y
	Mr Peter Pearson	August 2014 to July 2017	N/A	N/A	Y	Y
Wetherby and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley Wards – publicly elected	Mrs Jane Hedley	July 2011 – June 2014 July 2014 – June 2017	Y	Y	Y	Y
	Mr Michael Armitage	January 2014 to December 2016	Y	Y	N	Y

Staff Constituency	Name	Term of office	Apr 2014	Jul 2014	Oct 2014	Feb 2015
Medical Practitioners Staff Class – staff elected	Dr Daniel Scott	January 2013 to December 2015	Y	Y	Y	Y
Non-Clinical Staff Class – staff elected	Mrs Carol Cheesebrough	January 2013 to December 2015	Y	Y	Y	Y
Nursing and Midwifery Staff Class – staff elected	Mrs Emma Edgar	January 2011 to December 2013 January 2014 to December 2016	Y	Y	Y	Y
	Mrs Sally Margerison	January 2014 to December 2016	Y	N	Y	Y
Other Clinical Staff Class – staff elected	Mrs Fiona Wilson	January 2007 to December 2009 January 2010 to December 2012 January 2013 to December 2015	Y	Y	Y	Y

Nominating Organisation	Name	Term of office	Apr 2014	Jul 2014	Oct 2014	Feb 2015
North Yorkshire County Council	Cllr. Bernard Bateman	Nominated from January 2014	Y	N	Y	Y
Harrogate Borough Council	Cllr John Ennis	Nominated from June 2011	Y	Y	Y	N
University of Leeds	Dr Sarah Crawshaw	Nominated from January 2014	N	Y	Y	N
Harrogate Division YOR Local Medical Committee	Dr Jim Woods	Nominated from June 2011	N	Y	Y	N
Voluntary sector	Ms Jane Farquharson*	Nominated from July 2013	N	N	N	N
Patient Experience	Mrs Joanna Parker	Nominated from February 2015	N/A	N/A	N/A	Y

** unable to attend the Council of Governor meetings during this time due to illness.*

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

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

The following table highlights the attendance of each Executive Director and Non-Executive Director at the quarterly public Council of Governor meetings held during the year April 2014 to March 2015.

Name	Position	Apr 2014	Jul 2014	Oct 2014	Feb 2015
Mrs Sandra Dodson	Chairman	Y	Y	Y	Y
Mr Richard Ord	Chief Executive (retired from post 3 Aug 2014)	N	Y	N/A	N/A
Dr Ros Tolcher	Chief Executive (commenced in post 4 Aug 2014)	N/A	N/A	Y	Y
Mr Jonathan Coulter	Deputy Chief Executive / Finance Director	Y	N	Y	Y
Dr David Scullion	Medical Director	Y	Y	Y	Y
Mrs Angela Monaghan	Chief Nurse (retired from post 30 Jun 2014)	Y	N/A	N/A	N/A
Mrs Jill Foster	Chief Nurse (commenced in post 1 Jul 2014)	N/A	Y	Y	Y
Mr Robert Harrison	Chief Operating Officer	Y	Y	N	Y
Mr Phillip Marshall	Director of Workforce and Organisational Development	N	Y	Y	Y
Name	**Position**	**Apr 2014**	**Jul 2014**	**Oct 2014**	**Feb 2015**
Mr John Ridings	Non-Executive Director/Vice Chair (retired from post end July 2014)	Y	N/A	N/A	N/A
Mrs Sue Symington	Non-Executive Director/Vice Chair (from 1 May 2014) (resigned from post 31 Jan 2015)	Y	Y	Y	N/A
Prof. Sue Proctor	Non-Executive Director/ Vice Chair (from 4 Feb.2015)	Y	Y	Y	N
Mr Ian Ward	Non-Executive Director/Senior Independent Director (from 25 Feb 2015)	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 (commenced in post 1 Nov 2014)	N/A	N/A	N/A	Y

MEMBERSHIP

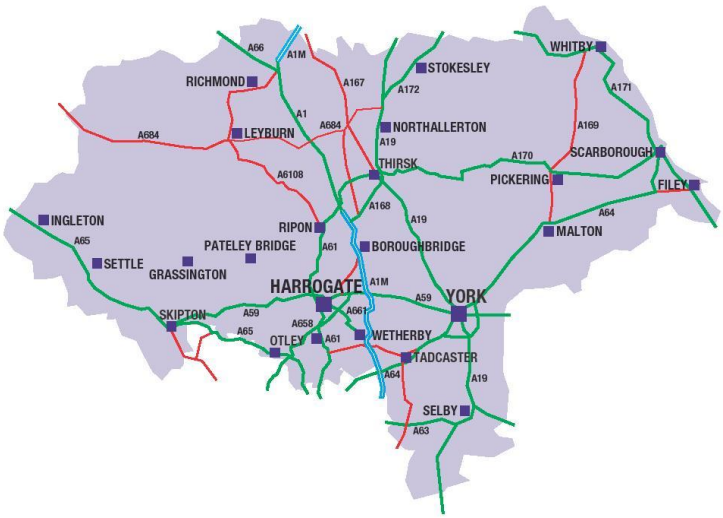
Our Membership

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 2015 the Trust had 17,736 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

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



Anyone living in the defined catchment area aged 16 or over, or who is an employee of the Trust holding a permanent contract of employment or a fixed term contract of at least 12 months, is entitled to become a member and hold voting rights.

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.

The Staff Constituency includes the following Staff Classes:

- Medical Practitioners;
- Nursing and Midwifery;
- Other Clinical;
- Non-Clinical

The Trust has no patient constituency.

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, the Trust continues to develop a representative and vibrant membership, offering innovative and active engagement across the organisation.

Throughout 2014/15 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.

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 has detailed action plans in place to drive the focus on quality membership engagement activity.

The public membership profile	Members	Population	% Members
Harrogate	6853	82599	8.3%
Ripon and west district	2066	37571	5.5%
Knaresborough and east district	2468	37699	6.5%
Harewood and Wetherby including Otley and Yeadon, Adel and Wharfedale and Alwoodley wards	2309	102771	2.2%
Rest of North Yorkshire and York	331	638559	0.05%
TOTAL	**14027**	**899199**	**1.56%**

The staff membership profile	Members	Total staff	% Members
Medical Practitioners*	437	534	81.8%
Nursing and Midwifery	1527	1546	98.8%
Other Clinical	720	744	96.8%
Non-Clinical	1025	1042	98.4%
TOTAL	**3709**	**3866**	**95.9%**

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

The volume of members has increased across all the public constituencies during 2014/15 and the membership for the rest of North Yorkshire and York continues to grow, increasing by 8.5% compared with 7% last year.

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 aims to:

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

Staff membership is via an opt-out scheme and 95.9% of staff are currently members. The membership database is updated on a quarterly basis from the electronic staff record taking into account, new starters, leavers, and individual detailed records.

During the forthcoming year, the Trust will continue to actively recruit members across the catchment area and, in particular, from the rest of North Yorkshire and York where our membership representation is at its lowest and in North and West Leeds where expanding services is a Trust objective. The plans to do so will be overseen by the Governor Working Group for Membership Development and Communications and will form part of the Membership Development Strategy. Membership recruitment plans include encouraging staff leavers to join as public members, promoting membership to local employers, attendance at community events, the use of leaflet stands in GP practices and local community premises such as libraries and voluntary organisations, social media platforms and one-to-one recruitment by Governors and staff.

Gender and ethnicity

The public membership is made up of 49.1% females and 50.8% males, with 0.1% unknown. The figures this year continues to demonstrate the shift towards a more equal balance between males and females than in previous years.

Gender	Number of Members	Eligible membership	Percentage
Male	7129	440383	1.6%
Female	6884	458816	1.5%
Not specified	14		
Total	**14027**	**899199**	**1.56%**

Ethnic origin of the public membership

Ethnicity	Number of Members	Eligible membership
White	2336	863226
Mixed	13	9110
Asian or Asian British	46	19196
Black or Black British	17	4599
Unknown	11615	3068
Total	**14027**	**899199**

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

Affiliates

In addition to the voting membership, we have 'affiliates', totalling 455, a slight increase from 430 in 2013/14. Affiliates are those people who have an interest in the Trust but do not qualify to be a member, either due to their age (i.e. they are below 16 years of age) or because they live outside of the Trust's catchment area. Affiliates are not counted within our membership numbers. On reaching 16 years of age, an affiliate becomes a member and receives the benefits of full membership including voting rights.

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 high quality membership engagement activity in line with the Trust's strategic aims. 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 is set as part of the Annual Planning process and remains at 17,500 members by the end of 2015/16. Active recruitment will be required to maintain the membership following data cleansing and natural losses however, the focus remains on providing effective and informative communication and high quality membership engagement.

Communication and membership activities are delivered in the following ways:

- a welcome pack including a welcome letter from the members' elected Governor(s), a membership card, a questionnaire and a discount card to use with local and national companies;
- 'Foundation News' membership magazine (approximately every eight months)*;*
- 'Chairman's Letter' or alternative communication, i.e. a postcard (approximately every eight months;
- members' area on the website including notification of meetings and events;
- local media articles and notifications;
- invitations to membership events, for example 'Medicine for Members' lectures;
- invitations to community events in partnership with stakeholders;
- public Council of Governor meetings;
- Governor public sessions, for example speaking at local committees and groups;
- Annual Members' Meeting;
- annual Trust open event;
- elections to the Council of Governors;
- members' notice board;

- access to Trust strategic documents, including the Annual Report and Accounts, Quality Report and Operational 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;
- 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 engagement for them, with a number joining as affiliates. 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

Work of the Audit Committee

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

Financial Management & 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 2014/15 were the move to invest solely with the Government Banking Service and evidencing significant issues considered in respect of financial statements.

The Committee oversees and monitors the production of the Trust’s financial statements. During the 2014/15 financial year, this included:

- an informal but detailed review of the draft accounts prior to submission to Monitor and External Audit on 22 April 2014,
- a formal Committee meeting to discuss the draft accounts and External Audit’s findings on 9 May 2014,
- A formal Committee meeting on 22 May 2014 to approve the final accounts and Annual Report for 2013/14 (including the Quality Report) prior to submission to the Board of Directors and Monitor.

[Note: similar meetings have occurred during April and May 2015 relating to the 2014/15 financial statements, Annual Report and Quality Report]

In January 2015 the Committee formally reviewed and approved the Trust’s accounting policies (to be used in relation to the 2014/15 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 2014/15 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 2013/14 were approved by the Committee on 22 May 2014 prior to submission to the Corporate Trustee.

The Audit Committee also reviewed and approved:

- Single Tender Actions,
- the Trust’s Losses & Special Payments register in May 2014,
- the Annual Procurement Savings Report in September 2014,
- revisions to the Trust’s Treasury Management Policy in September 2014, and
- The recommendation to the Trust Board of the use of the going concern principle as the basis for the preparation of the 2013/14 accounts in May 2014.

The review of Post Project Evaluations (arising from capital schemes) is a standing item on the Audit Committee’s agenda during the year. The lack of timely completion of Post Project Evaluations and submission of these to the Audit Committee has continued to be a source of some frustration during 2014/15, however a Post Project Evaluation Group has now been set up to monitor progress and there is evidence that this is improving the timeliness of Post Project Evaluation submissions.

Governance, Risk Management & Internal Control

The Audit Committee receives the minutes of the Standards Group and Corporate Risk Review Group. In addition the Audit Committee receives the minutes of the Quality and Governance Group, which is formally accountable to the Senior Management Team and the Board of Directors. This will change from the 1 April 2015 as a result of the review undertaken by the Trust of its Quality and Governance Structure.

During 2014/15 the Audit Committee reviewed and approved the Quality Governance and Risk Strategy in September 2014, prior to submission to the Board of Directors. The Trust has since changed the format of its Board Assurance Framework, Corporate Risk Register and mechanisms for reporting strategic risks to the Board, which were implemented towards the end of the financial year and the new documents first reported to the Board in March 2015.

Additionally the Staff Registers of Interests and Gifts and Hospitality were reported to the Audit Committee in 22 May 2014.

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 2014/15:

- Assessment of Audit Committee Effectiveness in December 2014, the findings of which were presented to the Board of Directors. The assessment confirmed that the Committee was generally operating in an effective way and fulfilling its key objectives, although a number of areas for improvement were identified and these have been addressed;
- Review and approval of Audit Committee Terms of Reference in January 2015 which were presented to the Board of Directors for approval.
- Ongoing review and revision of the Audit Committee's timetable.

Clinical Assurance

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

The Audit Committee additionally received the annual report from the Standards group on 9 May 2014. The Clinical Effectiveness and Audit Group is a sub-committee of and reports directly to the Standards Group. The Audit Committee reviewed and approved the Standards Policy in December 2014.

A joint Audit Plan covering the work of both Internal Audit and Clinical Audit and including some audits undertaken jointly by the two departments was again produced for 2014/15. The implementation of all aspects of this plan was reviewed by the Audit Committee at each of its meetings and the effectiveness of Internal Audit and Clinical Audit joint working was considered during 2014/15 by the Committee.

The Audit Committee has received assurance in relation to the effectiveness of Clinical Audit through the Annual Clinical Audit Report and the Annual Standards Group Report. As is noted above, these arrangements may be subject to some change following the review of quality and governance arrangements.

Internal Audit & Counter Fraud Service

Internal Audit and Counter Fraud Services are provided by North Yorkshire NHS Audit Services (NYAS). The Chair of the Audit Committee and the Finance Director sit on the Alliance Board which oversees NYAS at a strategic level. The Board met on four occasions during 2014/15.

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 2014.

The Audit Committee approved the planning methodology to be used by Internal Audit and Clinical Audit to create a joint Audit Plan for 2014/15, and gave formal approval of the Internal Audit Operational Plan in March 2014.

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 are working hard to ensure that the process for responding to internal audit recommendations is improved.

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

The effectiveness of Internal Audit was reviewed by HDFT staff and the Audit Committee in January 2015, 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 2014/15 financial year, the Audit Committee reviewed External Audit's Annual Governance Report and Management Letter in relation to the 2013/14 financial statements.

A policy is in place which governs the amount of non-audit work that the external auditors are allowed to undertake for the Trust. This policy was reviewed and confirmed during the 2014/15 financial year. No non-audit external audit work was undertaken during the 2014/15 financial year, although some additional audit work has been undertaken during 2015/16 to review the accounting treatment of a new contract for a Managed Laboratory Service. The fee for this additional audit work was £3,950. No non-core external audit work was undertaken during the 2014/15 financial year, although some work has been undertaken during 2015/16 to provide guidance on the accounting treatment to be adopted in respect of certain financial arrangements in place at the 31 March 2015.

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 2014/15 financial statements and the related audit fee in January 2015.

The effectiveness of External Audit was reviewed by HDFT staff and the Audit Committee in September 2014, resulting in a satisfactory evaluation which was reported to the Council Governors. A further review was undertaken in April 2015 which also resulted in a satisfactory evaluation.

Specific Significant Issues discussed by the Audit Committee during 2014/15

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 2015. 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 KPMG and how each was assessed by the Committee is set out below:

a. NHS Income Recognition

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 Trusts income from activities. In order to satisfy itself as to the validity of the income, the Committee has confirmed that the Agreement of Balances ("AoB") 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, KPMG, 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.

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.

b. 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 outcomes from a “desk-top” 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 recognizes the differing treatment that has to be adopted for assets of a specialised and non-specialised nature, full details of which are included at item 1.6 within the Trust’s Accounting Policies.

As noted above, the Committee has been able to place reliance upon work undertaken by the external auditors, KPMG, 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 Committee oversees and monitors the production of the Trust’s financial statements.

The following additional significant issues have been discussed by the Audit Committee during 2014/15:

- Pre-employment checks, particularly for agency workers
- Security arrangements of the Theatre Stores
- Ongoing compliance issues with IV Cannula Care
- Budget holder compliance with SFI’s for expenditure
- Changes in respect of the Board Assurance Framework and Corporate Risk Register
- Implications of Quality and Governance Review

Audit Committee Members’ Attendance

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

	9 May	22 May	9 Sept	9 Dec	30 Jan	10 Mar
Mr Chris Thompson	Y	Y	Y	Y	Y	Y
Prof Sue Proctor	Y	N	Y	Y	Y	Y
Mr Ian Ward	Y	Y	Y	Y	Y	Y
Mr John Ridings	Y	Y				

Attendance Details of Attendees at the Audit Committee

	9 May	22 May	9 Sep	9 Dec	30 Jan	10 Mar
HDFT						
Mr Jonathan Coulter	Y	Y	Y	Y	Y	Y
Mr Thomas Morrison	Y	Y	Y	Y	Y	Y
Mr Jordan McKie (1)			N	Y	Y	Y
Mrs Harriet Dow	N	Y				
Mr Andrew Forsyth (1)			Y	Y	Y	Y
Dr Sylvia Wood	Y	N	Y	Y	Y	Y
Dr Claire Hall	Y	N	Y	Y	Y	Y
Mr Stuart Kelly	Y					
Mrs Angela Monaghan	Y					
Miss Barbara Stearn	Y			Y		
Internal Audit & Counter Fraud						
Ms Helen Kemp-Taylor	Y	Y	Y	Y	N	Y
Mr Tom Watson	Y	Y	Y	Y	Y	Y
Mr Steve Moss	N	Y		Y		
External Audit						
Mrs Clare Partridge	Y	Y	Y	N	Y	N
Mr Andrew Smith	N	Y	Y	Y	Y	Y

(1) Mr Andrew Forsyth and Mr Jordan Mckie attended Audit Committee meetings from September 2014.

QUALITY REPORT 2014-15

Contents

1. STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

The overriding focus of Harrogate and District Foundation Trust (HDFT) is to provide care for people who use our services which is safe, effective, responsive and compassionate.

Staff working in the Trust are passionate about the quality of our services, and the feedback we receive from service users consistently places us amongst the best both locally and nationally. This Quality Account is written for a wide audience but principally for the people who rely upon us to provide the care they need, whether this is at Harrogate District Hospital, Ripon Community Hospital or via one of our many community services across North Yorkshire. It describes the progress we have made on our quality commitments since last year and our plans for 2015/16. It describes what we will do to deliver on our commitment to continuously drive up the quality of care we provide, and to place people who use our services at the centre of our decision making.

Despite rising demand and unprecedented financial challenges during 2014/15 the Trust maintained its very high level of performance across a broad range of externally reported quality indicators. These are summarised below and more details are contained both within this Quality Account report and in our monthly Board reports.

Hospital acquired MRSA (meticillin-resistant Staph. aureus)	No cases
Hospital acquired *Clostridium difficile* infections*	9 cases
Referral to treatment targets	Achieved
Cancer waiting time targets	Achieved
A&E 4 hour standard	Achieved
National maternity patient survey 2013	Top 3 maternity units
National cancer patient survey 2014	3rd nationally
National inpatient survey 2013	14th out of 142 acute trusts
National Emergency Department survey 2014	13th out of 142 acute trusts
National staff survey – overall staff engagement	Top 20% acute trusts
Patient Friends and Family Test (FFT) – response targets	Achieved
Staff FFT: staff recommending the Trust as place to work	74%
Staff FFT: staff recommending the Trust as place to receive care	87%
Safety thermometer harm free care	Above 95% for 6 months
Mortality indicators (HSMR and SHMI**)	Within expected levels
Stroke performance standards	Achieved

** Maximum permitted cases for this Trust 15*
*** HSMR is Hospital Standardised Mortality Ratio, SHMI is Summary Hospital Mortality Index*

During 2014/15 alongside our many quality initiatives we undertook to place a particular focus on four specific areas for quality improvement. These were chosen as priorities following engagement of staff and service users. In each case we set the bar high, aiming to deliver the very best outcomes.

Our first Quality Account improvement priority was to reduce the numbers of health care acquired pressure ulcers. Pressure ulcers cause pain and distress and can lead to longer stays in hospital. They are particularly common in frail and older people and with the right level of care and expertise they are usually avoidable. This report explains how we have tackled this issue and the steady improvement we have made over the year. There were no grade 4 hospital acquired pressure ulcers (the most serious grade) during 2014/15.

Our second Quality Account improvement priority was to reduce possible harm to patients in our care by having an increased focus on fluid management, pain control and preventing falls. A wide range of actions including staff training, surveys of patient experience and new

care arrangements have taken place over the year. Feedback from our service users tells us that we are now getting pain management right 95-100% of the time. We have also seen a significant reduction in the rate and number of falls across the organisation as a result of improved awareness and falls prevention work. Despite this encouraging trend the number of people falling and sustaining a fracture while in hospital is concerning and will remain the focus of very determined efforts to prevent avoidable harm in the year ahead.

A further Quality Account improvement priority in 2014/15 was to improve our responsiveness to patient's clinical needs including the escalation of concerns and handover between clinicians. We chose this area because safe care requires early intervention when someone's condition deteriorates and excellent communication between clinical teams providing care. As part of our approach to this improvement priority we introduced Patientrack, an active safety and communication system which enables the capture of clinical information in real-time at the point of care. This has helped us to improve the detection of clinical concerns and the recording and handover of information.

Our fourth Quality Account priority relates to our Public Health responsibilities and focused on smoking, misuse of alcohol and obesity. We provide a number of services which specifically support this agenda and we recognise that with a large workforce we have the opportunity to make every contact count. Helping people choose healthy lifestyles reduces the burden of avoidable illness and improves the outcome of other healthcare interventions such as surgery. Public health improvement is a long term process but the many brief interventions over the year have helped many individuals to improve their own health and wellbeing.

HDFT is also actively engaged in a broad range of research activity which offers additional benefits to patients by enabling access to specialist expertise and innovative treatment options. The Trust is widely recognised for the quality of its research and is one of only 3 trusts in the region to have exceeded recruitment targets during 2014/15.

Many of the initiatives from 2014/15 described in this Quality Account will continue in to 2015/16 and beyond. As well as these we have selected some new priorities for 2015/16 choosing this year to have a particular focus on 'human factors' in health care. We selected these priorities in consultation with staff, governors and wider stakeholders. I am particularly proud that we have set an ambition to become a centre of excellence for caring for older people. There is a renewed focus on partnership working across Harrogate and Rural District and our ambition of excellence for older people also supports a local ambition to make Harrogate a dementia friendly town.

Our 2015/16 Quality Account priorities have been agreed by our Board of Directors and will be monitored throughout the year.

The NHS is going through an unprecedented period of change, with new models of care and the difficult task of balancing growing demand against falling resources. During 2015/16 as we work ever more closely with our partners across the health and social care system the Trust will retain an unwavering focus on quality and supporting our excellent workforce in their commitment to safe, effective and compassionate care. I am proud and humbled by the work of staff across the organisation and wish to record my personal thanks to them.

I hope you will enjoy reading our Quality Account.

Dr Ros Tolcher
Chief Executive **27 May 2015**

2. PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE

2.1. Priorities for improvement 2015/16

In seeking to identify its quality priorities for 2015/16, the Trust involved staff, Governors and other stakeholders, including:

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

Clearly work will continue to be focused on improving the fundamental standards of care and the areas of work previously prioritised and reported within this document. However, the Trust has identified three key priorities for quality improvement in 2015/16. These have been informed by the discussions and suggestions from the stakeholders identified above, as well as reviews of data and reports relating to the quality of care delivered during 2014/15. The priorities have been approved by the Board of Directors. The responsibility for ensuring detailed work is developed and progressed to support the delivery of improvements in relation to these areas will be embedded in our new quality governance structures and processes. There will be identified leads, together with robust accountability for ensuring engagement with staff and effective monitoring of progress.

1. Creating the conditions for safety by improving communication.

Poor communication is an underlying root cause of many patient safety incidents and complaints. The focus of the work will include:

- Prioritising time to talk to patients and relatives;
- Empowering staff to have confidence when holding difficult discussions;
- "Hello, my name is …" campaign to encourage staff to introduce themselves, to build relationships and trust;
- Our safety improvement plan developed for the national "Sign up to Safety" campaign which is focused on using awareness of human factors in patient care, to improve communication, team working and leadership.

2. Improving patients' experience of using our services.

This will focus particularly on arrangements for admission, discharge and delivery of community services, and will include:

- Patient flow, as evidence suggests that enhancing patient flow also increases patient safety and is essential to ensuring that patients receive the right care, in the right place, at the right time, all of the time
- Pathways of care
- Effective discharge processes and avoiding readmission/avoidable transfers
- Outpatient management.

3. Becoming a centre of excellence for the care of the frail elderly.

We have just started on the journey towards creating a centre of excellence on Jervaulx and Byland Wards, for the inpatient care of older people with frailty, and we aspire to provide excellent care to the increasing number of complex elderly patients on every ward.

Older people living with frailty are at risk of dramatic deterioration in their physical and mental wellbeing after an apparently small event which challenges their health (e.g. infection, new medication, fall, constipation or urine retention).

2.2. Progress against quality priorities identified in 2013/14 Quality Account

2.2.1. Reducing health care acquired pressure ulcers

Introduction

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, 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 1 (least severe) to category 4 (most severe). They are more likely to occur in people who are ill, have a neurological condition, poor mobility, impaired nutrition, poor posture or a deformity.

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 part of our quality improvement priorities since 2012/13 but we wanted to have a clear, specific and effective focus on this during 2014/15. Reduction of inpatient newly acquired preventable pressure ulcers has also been a national indicator under the Commissioning for Quality and Innovation (CQUIN) scheme for 2014/15.

What were we aiming to achieve?

Our aims have been to:

1. Reduce the incidence of category 2, 3 and 4 pressure ulcers acquired by people whilst in HDFT care;
2. Promote best practice in prevention and management of pressure ulcers;
3. Understand if a pressure ulcer was avoidable or unavoidable and to learn from investigations into the root cause of pressure ulcers;
4. Increase the number of staff accessing pressure ulcer management training.

What have we done?

Since June 2014 all category 3 and 4 pressure ulcers have been reported as serious incidents requiring investigation (SIRI) and training has been delivered to senior ward and community registered nurses to enable them to effectively investigate these incidents and undertake root cause analysis (RCA). The recurrent themes from these are:

Hospital:

- Poor documentation of consistent skin inspection;
- Poor documentation of consistent position changes;
- Timeliness of air replacement mattress requesting;
- Inaccurate categorisation of pressure ulcers;

- Inaccurate risk assessment score and repeat risk assessment on transfer between wards;
- Reassessment of pressure ulcer risk not done to the expected Trust standard;
- Inconsistent photographing of pressure ulcers.

Community:

- Poor documentation and care planning;
- Inconsistent photographing of pressure ulcers;
- Delay in obtaining pressure relieving equipment once requested;
- Inaccurate categorisation of pressure ulcer;
- Errors with scheduling of visits and allocation of correct staff to undertake the visit;
- Incomplete wound assessment chart.

These identified themes have been the basis of work undertaken during the year.

The most significant change has been the introduction of SSKIN (skin, surface, keep moving, incontinence, and nutrition) bundles from November 2014 across all adult inpatient wards, for patients assessed as being at risk of pressure ulcer development. SSKIN bundles encourage a focus on the simple steps that prevent pressure ulcers. In addition a pressure ulcer skin inspection sticker was developed to assist registered nursing staff in the documentation of skin inspection, and changes were made to the nursing documentation to emphasise the need to repeat pressure ulcer risk assessment on transfer between wards. The implementation of the SSKIN bundles coincided with a mobile pressure ulcer educational event across inpatient wards for the international “STOP – Pressure Ulcer Day” on 20 November 2014.

An information leaflet was developed to ensure patients and carers have clear information about the prevention and management of pressure ulcers. A poster was produced and supplied to all clinical areas to help staff identify, categorise and treat appropriately pressure ulcers and other similar skin lesions.

Pressure ulcers affecting heels were a particular concern, and work has been undertaken between nursing and podiatry staff. Specific heel pressure relief equipment was trialled and then purchased, and a poster clarifying the equipment available in the equipment store to ward staff was produced. All patients with heels identified as being at risk of pressure damage, and any foot ulcerations can now be referred to Podiatry for an assessment, and the provision of heel casts, to protect the skin over patients’ heels if appropriate.

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 in July 2014. Instant cameras were purchased to enable community nurses to photograph pressure ulcers, which assists in monitoring care and progress. The wound care formulary was updated for the community areas in 2014.

Training of staff has been a priority during the year, with 186 registered nurses, 36 care support workers and five occupational therapists or physiotherapists accessing the SSKIN bundle training between October 2014 and March 2015.

Further training on skin care and pressure ulcer prevention, recognition and management has been delivered by the Tissue Viability Nurses on the 2 day Trust mandatory training course for care support workers. An eLearning package for pressure ulcers was identified and since January 2015 has become essential annual training for all general and paediatric registered nurses and 3 yearly training for midwives.

It is really important that staff see reporting pressure ulcers as part of improving care, and we have continued to encourage staff to report category 2, 3 and 4 pressure ulcers by incident reporting and also using the NHS Safety Thermometer which is undertaken on all wards and by all community teams on one day each month.

Pressure ulcer prevalence and incidence data, training data and progress with the introduction of these measures has been monitored by the Pressure Ulcer Steering Group, with reports on progress being received throughout the year by the Quality and Governance Group and the Board of Directors via the Chief Nurse report. Recurrent themes from RCA have been reviewed by the Pressure Ulcer Steering Group. Action plans have been developed to address the issues and the learning shared across the organisation.

From June 2014 to 9 March 2015, 48 category 3 and 4 pressure ulcers have been reported as SIRIs.

What are the results?

NHS Safety Thermometer data for HDFT

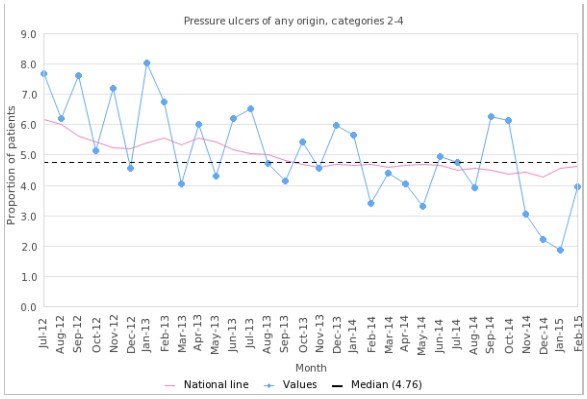


Figure 1. All pressure ulcers

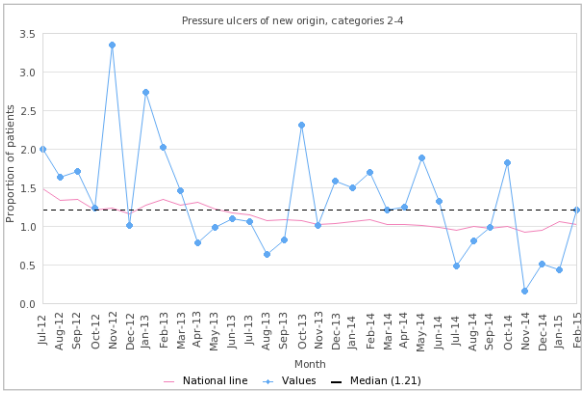


Figure 2. New pressure ulcers

The two graphs above show the results of the NHS Safety Thermometer data since July 2012 until February 2015, 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

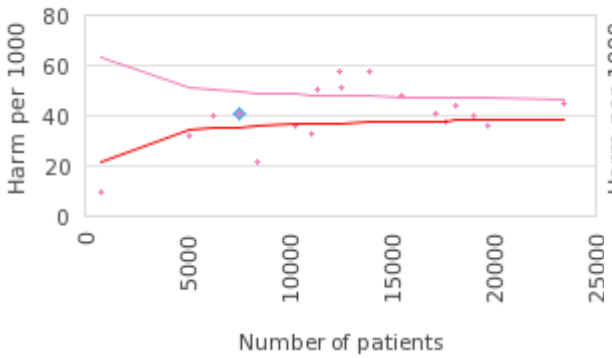


Figure 3. Prevalence or all pressure ulcers
♦ represents HDFT

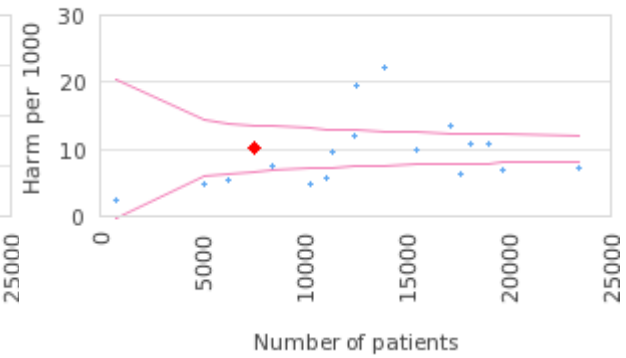


Figure 4. Incidence or new pressure ulcers

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 17 other integrated trusts, which are trusts that provide both acute and community services. Being within the "funnel" means that HDFT is within the expected range. Please note that in previous years HDFT was compared with acute trusts rather than integrated trusts.

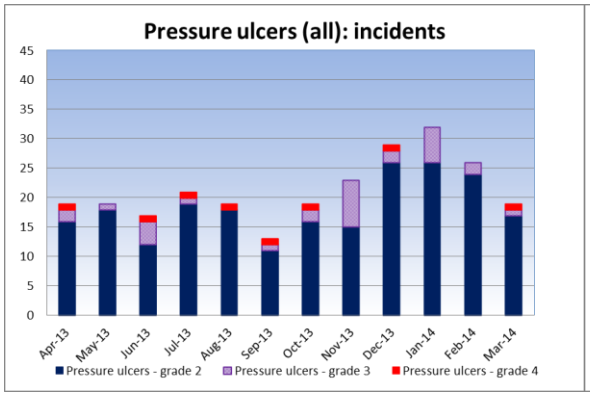


Figure 5. All pressure ulcers reported 2013/14

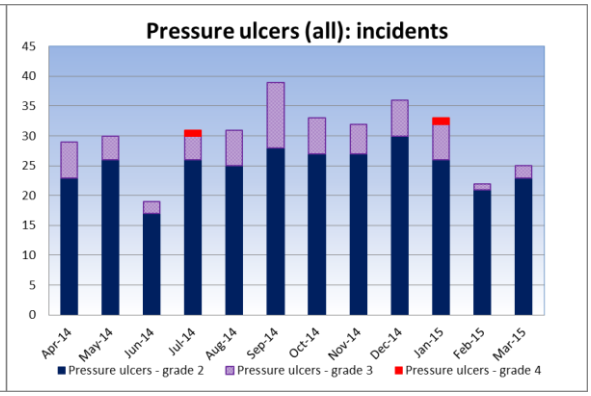


Figure 6. All pressure ulcers reported 2014/15

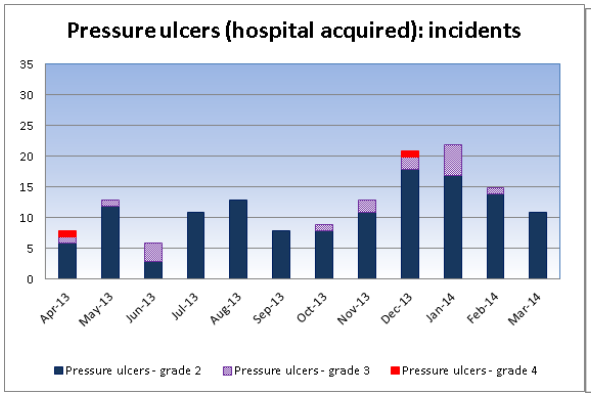


Figure 7. Hospital acquired 2013/14

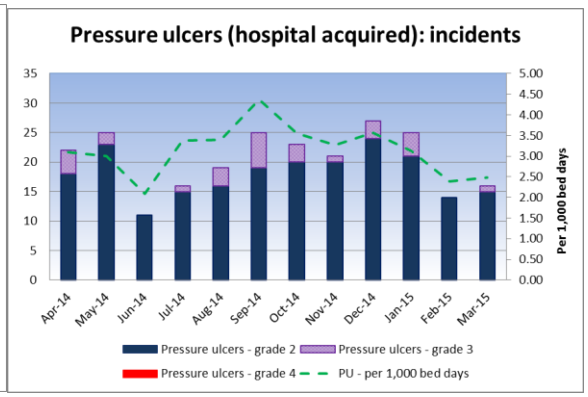


Figure 8. Hospital acquired 2014/15

Figures 5 and 6 show an increase in all pressure ulcers reported in 2014/15 compared to 2013/14, and figures 7 and 8 show an increase in hospital acquired category 2 and 3 pressure ulcers. We feel this could represent the active encouragement for staff to report *all* pressure ulcers, category 2, 3 and 4. There have been no category 4 hospital acquired pressure ulcers in 2014/15.

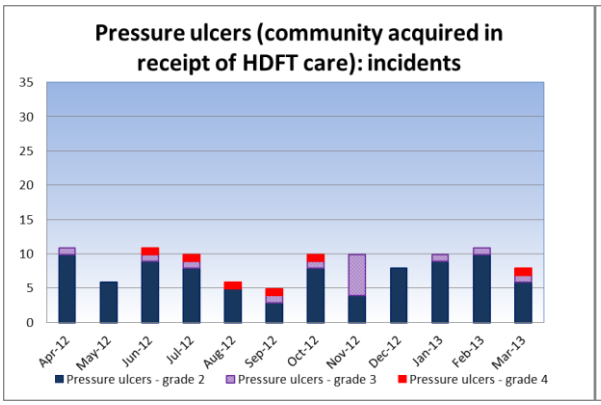


Figure 9. Community acquired 2013/14

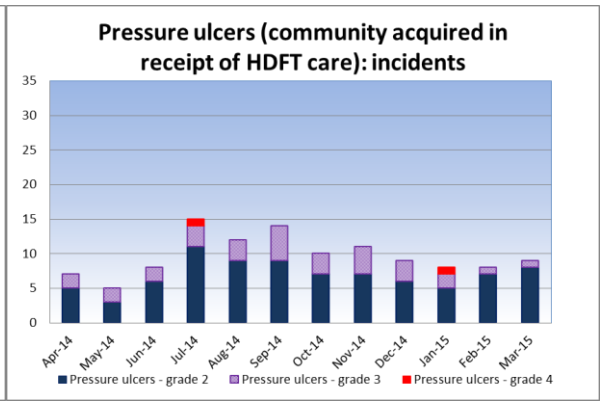


Figure 10. Community acquired 2014/15

Figures 9 and 10 demonstrate that category 2 community acquired pressure ulcers for patients in receipt of community nursing care remain similar in 2013/14 and 2014/15, with an increase in category 3 pressure ulcers. Category 4 pressure ulcers have decreased from six in 2013/14 to two in 2014/15.

Summary and next steps

There has been a significant amount of work undertaken during 2014/15 with the aim of reducing avoidable HDFT acquired pressure ulcers. However the numbers of preventable hospital and community acquired pressure ulcers (community being those patients in receipt of HDFT community nursing care) remain a cause for concern.

Ongoing training and monitoring of pressure ulcer prevention strategies is required to see progress on actions implemented this year realised in 2015/16. The Trust supports a "zero tolerance" approach to avoidable pressure ulcer development in people who are receiving nursing care, and this will be supported by our training principles and investigation processes.

2.2.2. Reducing harm to patients

This priority was to reduce harm caused to patients by an increased focus of work to improve fluid management and pain control, and to prevent falls.

1. Fluid Management

Introduction

Intravenous (IV) fluids are one of the most common "drugs" used in hospital medicine. Traditionally however they have not been thought of as such, with prescriptions often being written by junior team members with little experience in their use. Studies have identified that managing fluid balance is an area of weakness and risk to patient safety. Whilst it is relatively easy to diagnose a patient who has been given insufficient fluid, signs of too much fluid are vague. This has meant that doctors have commonly erred on the side of caution and given more fluid than is actually necessary. There is increasing evidence that this may significantly worsen outcomes.

NICE guideline CG174 (published December 2013) offers evidence-based advice on IV fluid therapy for adults in hospital. It introduced significant changes to IV fluid management in adults, and the standard prescription regimens used. The guidance points out that the standards of recording and monitoring IV fluid and electrolyte therapy are often poor. Current undergraduate education and most textbooks incorporating this topic are now outdated. The full introduction of this guideline therefore represents a significant challenge in order to change long established prescribing habits.

What were we aiming to achieve?

We wanted to introduce more focused, evidence based fluid prescribing for adults, in line with the NICE guideline. This involves fluid prescriptions being "tailor-made" for each patient on at least a daily basis, including frequent reviews and reassessments.

What have we done?

Although there have been some obvious changes over the last year such as the withdrawal of certain fluid types from the Trust where evidence for their benefit was lacking, the main

thrust of this campaign is education. Our new Foundation Year (FY) 1 doctors received in-house training soon after their arrival in the Trust. Clinicians within the Trust have developed an e-learning module and all fluid prescribers will soon be using this for annual training and assessment.

What are the results?

It is not possible to accurately collect outcome data in this area. We already collect incident reports when there have been major errors in fluid use, but these are rare and sporadic in nature. Potentially, good fluid management may be a contributor to lower mortality rates and shorter lengths of stay.

Summary and next steps

Improving training for fluid prescribers is an important area which has historically been overlooked by the medical and nursing bodies internationally. There is now increased interest and research in this area and it is likely that new evidence as to how to provide optimal care will emerge in the next few years. By establishing a recurrent model of training, we are well positioned to implement such changes as they become indicated.

During 2015/16 we will implement an electronic fluid management module of Patientrack, an electronic patient observation system, which will facilitate accurate recording of fluid input and output, to enable effective monitoring of fluid balance and hydration needs. The aim will be to ensure that:

1. All patients are assessed for their fluid needs
2. A plan is made to ensure optimum hydration
3. Fluid intake is managed continuously
4. Hydration is reviewed for early detection of deterioration
5. Education is provided for all involved
6. There is effective communication to underpin the principles of successful fluid management.

It will then be possible to monitor compliance with standards of care in relation to fluid management.

2. Pain Management

Introduction

As individuals we will all experience pain at some point in our lives, from minor injuries or trauma, to giving birth, complex surgeries, and as part of growing old. Assessing and managing our patients' pain through such experiences should not only be a humanitarian act but also a privilege and priority for all health care providers.

The report from the Care Quality Commission inspection in November 2013 and the National Cancer Patient Survey 2013 highlighted inadequacies with pain control within the Trust. Clinical audits showed that the recording of pain scores in surgical patients was sub-optimal and only a slight improvement occurred after feedback of the initial results to the ward areas. An audit of medical patients showed similar results.

What were we aiming to achieve?

The overall aim of the priority was to improve the consistency of assessing the pain of our patients. This is simply ensuring that we ask patients whether they have pain and how severe that is, but it is generally felt that effective assessment can lead to a higher quality of pain control and management.

We aimed to improve the quality of patient experience by improving staff awareness and knowledge of pain management, and to be able to demonstrate this by improving our audit results.

What have we done?

There are a variety of assessment tools available for health care workers to assess pain. For several years we have used a numerical rating scale of 0 – 10. Patients are asked: 'If 0 is no pain and 10 is the worst pain imaginable please give a number that best represents your pain'. This is a simple tool, relying on a verbal response and adaptable to different situations, such as in the Emergency Department, Theatre Recovery etc. These numbers or 'scores' can then be cross referenced to the 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 11).

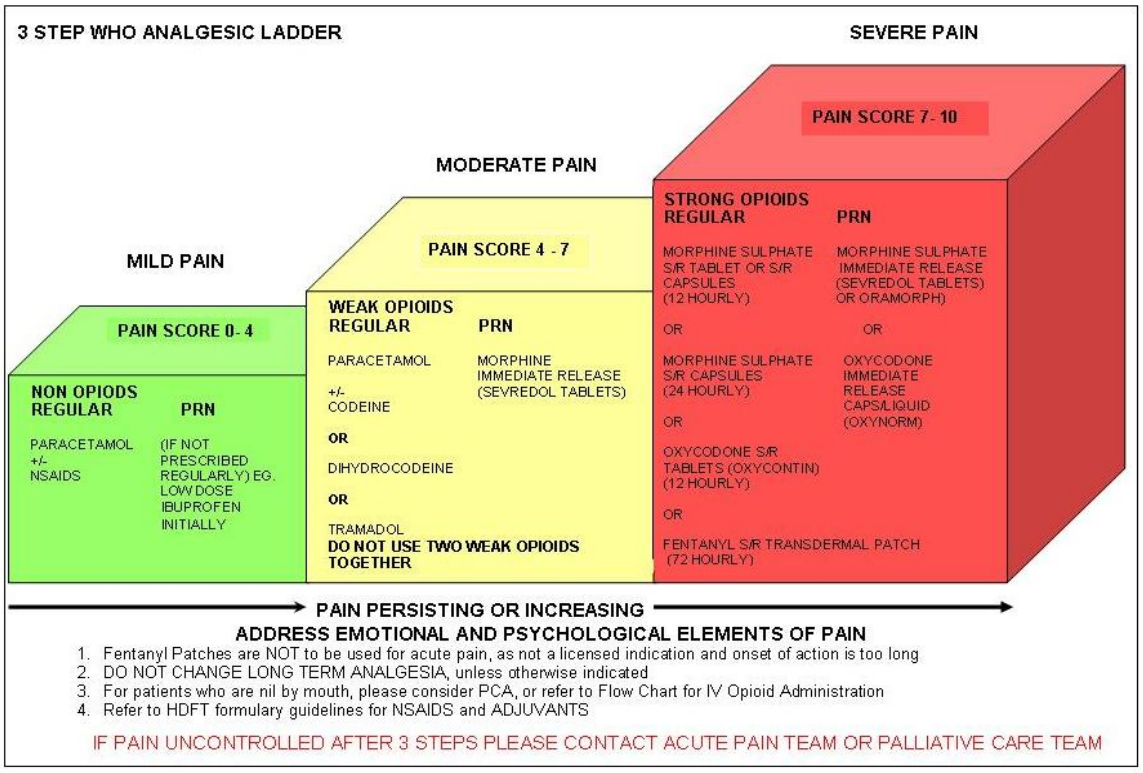


Figure 11. WHO Analgesic Ladder

There may be difficulties in assessing pain when patients are unable to speak or understand the scale of 0 – 10. This may be due to extremes of age, or existing conditions such as dementia or learning difficulties.

An assessment tool for patients with dementia and communication or learning difficulties has therefore been introduced during the past year. Referred to as the 'PAINAD tool' (see figure 12), this assessment tool relies on non-verbal expressions of pain such as facial expression, body posture and vocalisation. This assessment process also results in a pain score between 0 and 10. There is a reminder to involve other members of the multi-disciplinary

team, e.g. physiotherapists, and family and care givers as they have other insights into the patient's experience of and reaction to pain.

Pain Assessment in Advanced Dementia (PAINAD) Scale/ Communication Difficulties

		0	1	2
1.	Breathing independent of vocalisation	Normal	Occasional laboured breathing. Short period of hyperventilation.	Noisy laboured breathing. Long period of hyperventilation. Cheyne-Stokes respirations.
2.	Negative Vocalisation	None	Occasional moan or groan. Low-level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.
3.	Facial Expression	Smiling or Inexpressive	Sad. Frightened. Frown.	Facial grimacing.
4.	Body Language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.
5.	Consolability	No need to Console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.
	Document Comments by family members/ care givers in nursing notes			
	Liaise with physiotherapy re Pain on movement			
	SCALE: 0 = NO PAIN 1 – 3 = MILD PAIN 4 – 7 = MODERATE PAIN 8 – 10 = SEVERE PAIN			

Score each of the 5 categories either 0, 1, or 2. Add all 5 scores together to achieve pain score of 0 to 10

A higher score indicates more severe pain (0 = 'no pain', 10 = 'severe pain')

Pain Score to be documented on NEWS observation as per HDFT guidelines.

Chart for REFERENCE only – do not place in Medical/Nursing notes

Figure 12. PAINAD assessment tool

Pain scores should be measured alongside the routine nursing observation such as blood pressure, pulse, temperature and respiration rate, as high pain levels can sometimes have a direct effect on these vital signs. The score should be documented with other nursing observations, however this was frequently omitted. We were aware that the layout of the previous paper observation chart used within the Trust contributed to staff omitting to document pain assessments.

We have during 2014/15 introduced an electronic patient observation system, Patientrack, which requires that a pain score is included in every set of observations recorded.

Training on pain assessment and management has continued to be delivered by the Acute Pain Service and nursing staff and students have been encouraged to spend time with the Acute Pain Sister and participate in regular pain rounds. A nurse representative from every department, including Ripon Hospital has been able to attend meetings of the Pain Management Link Nurse Group, which are led by the Acute Pain Nurse and Palliative Care Nurse Specialist. There are 3 – 4 meetings per year and topics such as pain assessment in dementia, the history of opioids and case studies are discussed.

A wide range of sources have been developed and made available to provide support and advice to the health care professionals. These include:

- Comprehensive pain management guidelines which include protocols for post-operative analgesia, neuropathic pain and pain in complex patients;
- Flow charts for the administration of analgesia;
- Posters on methods of post-operative pain management;
- Protocols on the electronic medication chart, ePMA.

Since October 2014, the Friends and Family Test for inpatients has been amended to include questions about pain; whether pain was assessed, and whether analgesia was given within an appropriate time frame. This has enabled regular monitoring of patient experience on all inpatient wards.

What are the results?

Criteria	Expected performance	AUDIT 2013	AUDIT 2014			
		Surgical	January		May	
			Surgical	Medical	Surgical	Medical
Pain scores recorded on admission to ward	100%	47%	46.4%	13%	73%	48%
Pain scores recorded on return to ward following surgery and recorded with 1st set of observations	100%	53%	61%	N/A	58%	N/A
Pain scores recorded with all observations	100%	3%	41%	22%	65%	46%
Pain score of 7 or above is reassessed within 30 minutes	100%	0%	50% (numbers small)	0%	50% on admission 100% post-op	8%

Table 1. Clinical Audit Results 2013/14

Table 1 shows some improvement in audit results during 2014 but further improvement was required, and the use of an electronic patient observation system was expected to enable this to happen.

Following the introduction of Patientrack, the audit was repeated in March 2015 and preliminary results are shown in Table 2. 100% of all medical and surgical patients are now being asked for a pain score with every set of nursing observations. Numbers for reassessment of high scores within 30 minutes remain low but future developments in Patientrack should lead to further improvement.

Criteria	Expected performance	AUDIT MARCH 2015		
		Surgical Post-op N=29	Surgical Pre-op N=13	Medical N=40
Pain scores recorded on admission to ward	100%	100%	100%	100%
Pain score of 7 or above on admission is reassessed within 30 minutes	100%	N=8 0%	N=2 0%	N=3 0%
Any pain score of 7 or above during the next 72 hours is reassessed within 30 minutes	100%	N/A	N=2 0%	N=8 12%
Pain scores recorded with 1st set of observations on return to ward following surgery	100%	100%	N/A	N/A
Pain score of 7 or above post-op is reassessed within 30 minutes	100%	N=18 11%	N/A	N/A
Pain scores recorded with all observations	100%	N/A - Patientrack now requires that a pain score is included in every set of observations recorded.		

Table 2. Clinical Audit Results 2015. N = number of patients. N/A = not applicable

January	Question 1		Question 2		Question 3		Question 4	
Ward	Yes	% Responded Yes	Yes	% Responded Yes	Yes	% Responded Yes	Yes	% Responded Yes
Medical	142	97.9%	99	99.0%	91	95.8%	85	93.4%
Surgical	76	93.8%	75	98.7%	70	92.1%	68	93.2%
Harlow	12	100.0%	11	91.7%	11	91.7%	11	91.7%

February	Question 1		Question 2		Question 3		Question 4	
Ward	Yes	% Responded Yes	Yes	% Responded Yes	Yes	% Responded Yes	Yes	% Responded Yes
Medical	182	97.8%	105	96.3%	94	95.9%	86	90.5%
Surgical	76	95.0%	76	98.7%	73	96.1%	69	94.5%
Harlow	5	100.0%	5	100.0%	5	100.0%	5	100.0%

Table 3. Friends and Family Test Results January and February 2015. Harlow Ward has both medical and surgical patients.

Table 3 indicates the results from the pain questions asked at the time of the Friends and Family Test, and clearly indicate a high percentage of positive responses. Where negative comments have been given, these have highlighted where further work is needed. The questions are:

Q1. Do our staff ask you about pain regularly?
Q2. If you have pain, are you offered pain relief?
Q3. If you were offered pain relief, did the staff give that in a reasonable time?
Q4. If you had pain relief, was it effective?

Summary and next steps

Throughout the last year we have managed to raise the profile and awareness of pain assessment and management. With the implementation of Patientrack we are confident that we can achieve 100% compliance with pain assessment. Work will continue to ensure methods for pain assessment, re-assessment and management are embedded across all specialities. We are planning to audit the use of the PAINAD tool in the summer of 2015.

In order to enhance the Acute Pain Service, it has been established that investment is required and a business case to expand the service has been submitted to the Trust Board.

3. Preventing Falls

Introduction

Falls are an important public health problem which can be devastating for an individual. They can cause distress, pain, injury, loss of confidence, loss of independence and mortality. There are many different risk factors for falls and as people age their risk of falling increases. People aged 65 and older have the highest risk of falling, with 50% of people older than 80 falling at least once a year.

Hospital patients suffer falls, and this may be related to surgery that affects mobility or memory, as well as sedation, pain relief, anaesthetic or other medication, which increases the risk of falling. Delirium increases the risk of falling and is particularly likely to affect patients on medical wards, and patients with dementia are more vulnerable to falls. Preventing patients from falling is a challenge because patients' safety has to be balanced against their right to make their own decisions about the risks they are prepared to take, and their dignity and privacy.

What were we aiming to achieve?

In seeking to prevent falls amongst inpatients of Harrogate District Hospital our three key aims were:

a. To reduce the rate of harmful falls occurring in hospital;
b. To improve compliance with falls prevention interventions;
c. To increase the number of staff who are up to date with their falls prevention training.

What have we done?

Our work has focused on several key areas: training staff in falls prevention, understanding what has happened when a patient has a fall in hospital and undertaking service improvement projects to act on the risk factors for falls.

- Falls prevention training

Clinical staff including doctors, nurses and care support workers receive training in falls prevention at least every three years. Most are trained at induction when they first join the Trust and then again at regular intervals. The training covers the principles of falls prevention for example the risk factors which can contribute to someone having a fall and the preventative measures we can take as healthcare professionals. Training is also provided on the processes we use in hospital for assessing a patient's risk of falling and planning care to minimise this risk.

- Understanding what happened when a patient has a fall in hospital

When a patient falls in hospital, staff complete an incident report which identifies what has happened. An investigation then takes place which aims to identify any issues that may have contributed to the patient falling and to take immediate corrective action.

When a patient suffers a fracture as a result of a fall, a root cause analysis is undertaken. The root cause analysis is completed by the manager for the affected area and is then discussed in a formal meeting with the patient's consultant of care, the manager, the matron and the falls prevention coordinator. This process aims to identify the lessons to minimise the risk of patients falling in future.

- Comprehensive medication review for all patients admitted to our elderly care wards

We undertook a pilot project where all patients on elderly care wards received a review of their medication from the ward pharmacist, specifically aiming to reduce their risk of falls. We are now seeking to expand this approach to our other adult wards.

- Learning from elsewhere

We reviewed the success of a falls prevention project at Leeds Teaching Hospitals, where by implementing daily staff huddles, which are short team meetings, falls have reduced by up to 50% on some wards. Following this our lead consultant for falls prevention is to work with the Yorkshire and Humber Improvement Academy to implement a similar approach in Harrogate.

What are the results?

a. Rate of harmful falls occurring in hospital

	2012/13	2013/14	2014/15
All reported HDFT inpatient falls	952	967	962
Falls rate (per 1000 OBD*)	9.25	9.09	8.42
Harmful falls	307	246	236
Fractures	16	12	16
Harm rate (per 1000 OBD*)	2.98	2.31	2.06

Table 4. Rate of harmful falls occurring in hospital (occupied bed days)*

Overall the rate of harmful falls occurring in Harrogate District Hospital this year has reduced, but it is a concern that 16 patients have had a fall resulting in a fracture.

b. To improve compliance with falls prevention interventions

We carry out an annual audit to review the falls assessments and preventative care plans documented for inpatients.

All inpatients should have a risk assessment (RA) completed for falls risk and use of bedrails within six hours of admission. If patients are identified as being at risk of falls, the falls prevention care guidance must be followed and documented within the nursing fundamental care plan.

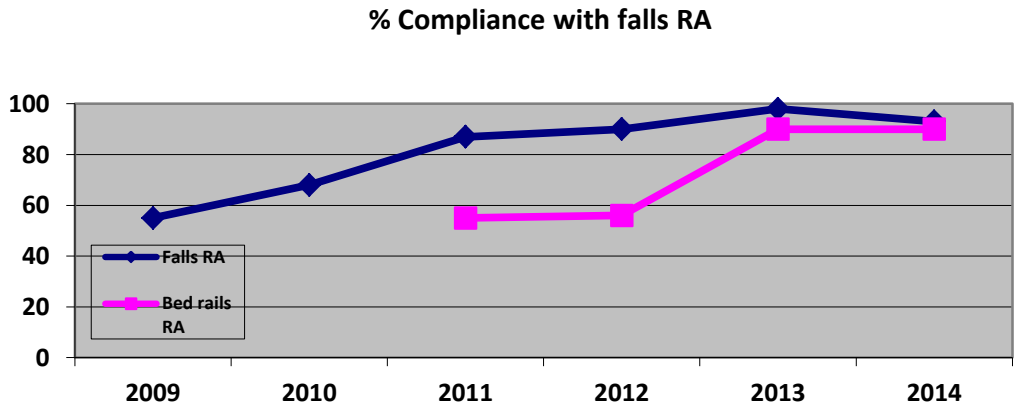


Figure 13. Compliance with falls and bed rails risk assessment (RA)

The graph above demonstrates a small decrease in compliance with 93% of patient records having a completed falls risk assessment in 2014 in comparison with 98% in 2013. Bed-rails risk assessment compliance remains at 90%.

The 2014 audit identified 52% of patients at risk of falls, and of these 18% had fully completed care plans and a further 19% had some of the actions on the care plan completed. This is a significant improvement compared to the 2013 audit in which only 1% of patients had fully complete care plans. The audited care plans indicated that:

- 12% of at risk patients had a falls medication review on admission;
- 18% of at risk patients had a postural blood pressure check;

- 15% of at risk patients were given falls prevention information;
- 18% of at risk patients had appropriate footwear;
- 15% of at risk patients had appropriate mobility assessment / aids;
- 23% of at risk patients had completed urinalysis & toileting plans;
- 20% of at risk patients had appropriate frequency of patient contact rounds.

Clearly further progress is required.

c. To increase the number of staff who are up to date with their falls prevention training

The percentage of permanent staff that are up to date with their falls prevention training has increased steadily over several years, see figure 14 below. In February 2015 a total of 954 permanent staff and 49 bank or locum staff were up to date with their falls prevention training.

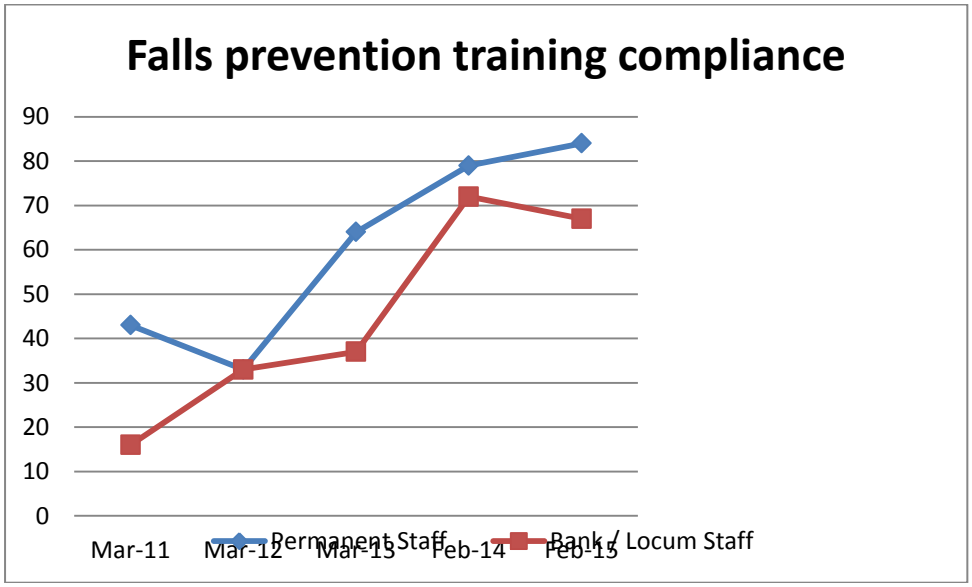


Figure 14. Falls prevention training compliance

Summary

In summary we continue to try and reduce the number of patients who fall whilst in hospital. This year we have seen a reduction in our falls rate and rate of harm from falls however we have still seen a high number of fractures from falls. We will continue to focus on falls prevention as a patient safety priority and are taking forward a number of initiatives.

2.2.3. Improved responsiveness to patient need

Introduction

This quality priority aimed to improve the responsiveness to patient need by focusing work on the effective escalation of concerns and handover of information between teams, in order to provide good continuity of care.

Effective healthcare requires the timely identification of patients' medical needs, with effective communication between members of the healthcare team, particularly when care is handed over from one team to another, and rapid escalation of concerns when these arise.

The fundamentals of safe and effective handover can be encompassed in the following five standards:

1. WHO should be involved?
2. WHEN should handover take place?
3. WHERE should it take place?
4. HOW should it happen?
5. WHAT needs to be handed over?

What were we aiming to achieve?

The Trust aimed to enhance communication and safety, particularly around responses to deteriorating patients by purchasing and implementing an electronic system to enable:

- Recording of observations;
- Automatic escalation and faster communication of concerns and patient deterioration;
- Paperless assessments;
- A combined nursing, medical and allied health professionals handover tool.

At the same time we wanted to establish clear standards for handover, which would ensure that current processes for handover by different specialities could be assessed against these, and also that the planned electronic tool would be developed to meet these standards.

What have we done?

April 2014 saw the start of a procurement process leading to the purchase of Patientrack. Patientrack is an active safety and communication system which enables the capture of clinical data in real-time at the point of care. It enables nursing staff to capture patient observations at the bedside using touchscreen devices, small enough to fit into uniform pockets, but large enough to clearly see and make use of the vital patient information. When observations are entered the system calculates an Early Warning Score and indicates the escalation procedure when required.

The project team were able to go-live with the first ward by August 2014 and Patientrack is now implemented on all of the adult inpatient wards in Harrogate District Hospital (excluding maternity). During this initial roll-out Patientrack has been calculating the early warning score from the observations entered and then reminding nursing staff who the escalation policy says they needed to contact.

Improvements have been made to the escalation policy, to utilise some of the additional functionality an electronic system can provide to improve safety and response to a deteriorating patient, and the system of bleep management.

Standards for handover that detail the expectations of the Trust in relation to handover have been developed, approved and shared across the organisation.

What are the results?

Patientrack has enabled the following:

- Early warning scores are now calculated correctly 100% of the time;
- Increase in the percentage of observations taken on time;

- Full set of observations always recorded;
- Pain scores recorded with every set of observations;
- Information sharing is improved;
- Visual display of whole ward/hospital identifying most unwell patients.

Photo 1: Staff using Patientrack on a mobile device

An audit was undertaken jointly by Internal Audit and Clinical Effectiveness and Audit in April 2014 and identified various concerns including the senior clinical leadership of some handovers, and variable documentation of handover attendance and content. Surgical handover processes were audited in more detail by junior doctors and as a result on call consultant general surgeons now undertake evening ward round reviews of acute admissions, and general surgical middle grade doctor attendance at morning and evening handover is now mandatory.

A recent follow up audit by Internal Audit has shown significant assurance with progress made against all the recommendations from the previous audit.

Summary and next steps

There has been a very successful roll-out of stage one of this project to all adult inpatient wards at Harrogate District Hospital. The next stages are:

- Automatic escalation and bleeping in-line with the Trust escalation policy;
- Implementation in Emergency Department, Lascelles and Trinity Rehabilitation Wards, Paediatrics, Maternity and Sir Robert Ogden Macmillan Centre;
- Assessments including fluid balance;
- Handover.

The automatic sending of messages to bleeps held by clinical staff, will mean that nurses will no longer have to leave the bedside of a deteriorating patient to bleep someone by telephone. The bleep messages sent out by Patientrack will be to the appropriate clinician and will include more detail than a traditional bleep. It will show for example ‘patient in ward x has a high early warning score and needs attention now’. If the situation is not improved quickly, then the alert will be escalated to a more senior clinician.

The progression to an effective electronic handover tool that contains all of the patient observation data will ensure constantly updated handover information accessible to all relevant staff, whilst ensuring an accurate audit trail. Medical and nursing staff will be able to share and contribute to the same core set of key information which avoids duplication and ensures improved accuracy.

2.2.4. Improved public health

Introduction

This quality priority was focused on improving public health by providing information and education to patients to increase the opportunities for people to self-care and make healthy lifestyle choices, particularly relating to reduction of smoking prevalence, misuse of alcohol and obesity.

As an organisation we have a number of services that specifically support this agenda, however, we recognised that many colleagues were unaware of these services.

What were we aiming to achieve?

We were aiming to ensure all of the specific services that provide public health messages were publicised within the organisation and that all other services began to undertake very brief advice around three main areas of public health – smoking, misuse of alcohol and obesity.

What have we done?

We have developed a booklet that provides details of each service that directly supports public health along with contact details. We have also directly undertaken specific work for the three areas of public health identified as a focus for 2014/15:

Reducing smoking prevalence

- Our smoke free policy has been updated and ratified and a communications plan has been developed;
- We continue to deliver a comprehensive specialist stop smoking service;
- We are working with commissioners to support them in developing a future model for service delivery;
- In-patient support for smokers – we have developed a protocol for smoking cessation on in-patient medical wards and identified additional capacity by the specialist service to support implementation of the protocol;
- Training and education - Very Brief Advice training was delivered to 121 health- and social-care workers in quarter 2 2014/15 (47 in City of York, 74 in North Yorkshire), including secondary care (vascular imaging in York, for example), primary care (such as GP trainees in York), mental health (Richmondshire and Harrogate) and midwifery staff (Scarborough and York);
- “Stop before Your Op” campaign was launched by Harrogate & District CCG in October 2014. This has unfortunately resulted in only 2 referrals to the specialist service and so we are reviewing other ways to support this initiative in the next year.

Obesity in children

- Healthy education is provided to pupils in one of the secondary schools in Harrogate in a relaxed and interactive way over lunchtimes, delivering nutrition related aspects of the curriculum, working with catering to ensure food served in school is consistent with healthy eating and with school food standards and food labelling regulations, supporting pupils and parents with food related concerns, supporting pupils with food allergies to safely eat school meals, and supporting other schools in transforming catering services to benefit learning and academic performance of pupils.
- Breastfeeding is known to reduce the chances of children becoming obese in their early years. Our health visiting service is currently applying for breastfeeding accreditation with the UNICEF UK Baby Friendly Initiative, which will ensure that all Trust health visiting staff are able to provide up to date infant feeding information and advice which will enable parents to make informed decisions about how they would like to feed their babies.
- We have undertaken a pilot project of proactive telephone calls following up the national child measurement programme to support parents in understanding the results and providing information for referral on to community weight management programmes.
- A new children's community weight management service has been procured by North Yorkshire County Council and a referral pathway has been developed in order that Trust staff can refer children and young people aged 5-19 into this service. In addition young people who have been identified by the paediatricians are referred to a residential weight management service.

Misuse of alcohol

It is estimated that more than 24% of people aged 16-65 consume alcohol in a way that is potentially harmful, with 4% of the population in England being alcohol dependent, (NICE guidelines 2010).

Brief interventions have been evidenced to be useful in reducing alcohol consumption in people with hazardous and harmful drinking. There are a number of brief interventions ranging from asking about alcohol consumption, simple advice regarding consumption and alcohol education, (NICE guidelines 2011). The type of intervention conducted is based on the alcohol consumption and the Alcohol Use Disorders Identification Test (AUDIT) score as set out in the table below:

Alcohol use	AUDIT score	Intervention
Low use	0-7	Alcohol education
Excess Alcohol	8-15	Simple advice
Harmful	16-19	Simple advice and brief counselling
Dependence	20-40	Referral to specialist service

Table 5: Brief interventions

We have focused efforts for screening and brief advice interventions within the Clinical Assessment Team (CAT) and the gastroenterology outpatient department. We have audited compliance with screening and delivery of brief intervention.

<u>Clinical Assessment Team</u>

Opportunistic alcohol screening has been well implemented by CAT with 81% of patients attending being screened and 100% of those who required brief intervention being offered one.

Gastroenterology Outpatient Department

Alcohol screening has been implemented in gastroenterology with 75% of all new outpatients being screened. 87% of patients who required a brief intervention were offered one. Of the 33 patients who were not screened for alcohol intake:

- 10 patients had been referred by another consultant within HDFT for specific advice;
- 2 patients were being followed up post endoscopy;
- 1 patient was 98 and therefore screening was deemed inappropriate;
- 20 had no obvious reason why screening was not undertaken.

What are the results?

Public health improvement is a long term process and therefore it is unrealistic to see significant change within one year of implementation of a focus on this area. However the awareness of all of these public health issues has been raised within all areas of our organisation and staff feel that they have more information available at their disposal in terms of referral to relevant services, support from specialist teams and an understanding of what very brief advice is and how it can be given to people they work with.

Summary

We have raised awareness of all the different services that provide public health advice and support, and we have provided a network of public health services who are working together and linking service aims together.

There has been agreement within the service areas that a focus on smoking would continue to be beneficial and we will continue to focus on the smoke free agenda within HDFT with support of the specialist smoking team. There will be a continued focus on reducing alcohol consumption in the CAT and gastroenterology particularly. Children's services will maintain their focus on health and wellbeing agenda as they move their service to focus on the public health agenda for all children and young people.

2.3. Statements of assurance from the Board

3. Provision of relevant health services and income

During 2014/15 HDFT provided and/or sub-contracted 60 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 2014/15 represents 100% of the total income generated from the provision of relevant health services by HDFT for 2014/15.

4. National & Local Audits

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

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

National Audits

During 2014/15, 33 national clinical audits and 4 national confidential enquiries covered relevant health services that HDFT provides.

During that period HDFT participated in 88% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

To provide further context, there were 29 mandatory audits on the National Clinical Audit and Patient Outcome Programme (NCAPOP), 21 of which were relevant to HDFT. Of these, the trust participated in 100%.

There were also 17 audits which were run by other organisations, 14 of which were relevant to HDFT. The Trust participated in 10 of those which were relevant (71%).

The national clinical audits and national confidential enquiries that HDFT was eligible to participate in during 2014/15 are as follows:

National audits:

1. Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
2. Adult Community Acquired Pneumonia
3. Bowel Cancer (NBOCAP)
4. Cardiac Rhythm Management
5. Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC)
6. Diabetes (Adult) - National Diabetes Foot care Audit
7. Diabetes (Paediatric)
8. Elective Surgery National PROMS Programme
9. Epilepsy 12 (Childhood Epilepsy)
10. Falls and Fragility Fractures Audit Programme (FFFAP)
11. Fitting Child (care in Emergency Department)
12. Inflammatory Bowel Disease Programme
13. Lung Cancer (NLCA)
14. Major Trauma: The Trauma Audit & Research Network (TARN)
15. Maternal, New-born and Infant Clinical Outcome review Programme (MBRRACE-UK)
16. Mental Health (care in Emergency Department)
17. National Audit of Dementia
18. National Audit of Intermediate Care
19. National Cardiac Arrest Audit (NCAA)
20. National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
21. National Comparative Audit of Blood Transfusion Programme
22. National Emergency Laparotomy Audit (NELA)
23. National Heart Failure Audit
24. National Joint Registry (NJR)
25. Prostate Cancer

26. Neonatal Intensive and Special Care (NNAP)
27. Non-invasive Ventilation – adults
28. Oesophago-gastric Cancer (NAOGC)
29. Older People (care in Emergency Department)
30. Pleural Procedure
31. Pulmonary Hypertension
32. Rheumatoid and Early Inflammatory Arthritis
33. Sentinel Stroke National Audit Programme (SSNAP)

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

1. Lower Limb Amputation: Working Together
2. Gastrointestinal Haemorrhage Study
3. Sepsis Study
4. Acute Pancreatitis Study

The national clinical audits and national confidential enquiries that HDFT participated in during 2014/15 are as follows:

National audits:

1. Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
2. Bowel Cancer (NBOCAP)
3. Cardiac Rhythm Management
4. Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC)
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Medical & Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome & Death (NCEPOD):

1. Lower Limb Amputation: Working Together
2. Gastrointestinal Haemorrhage Study
3. Sepsis Study
4. Acute Pancreatitis Study

The national clinical audits and national confidential enquiries that Harrogate and District NHS Foundation Trust participated in, and for which data collection was completed during 2014/15 are listed at Annex 3, 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 three of the national clinical audits and one of the NCEPOD reports were reviewed, and HDFT intends to take the following actions to improve the quality of healthcare provided.

Lower Limb Amputation: Working Together

The report was published by NCEPOD in November 2014 and was received at Standards Group in December 2014. As the vascular service is provided by an alliance with York Teaching Hospital NHS Foundation Trust, it is understood that an assessment of compliance is currently being undertaken by the Lead Clinician for Vascular Surgery at York to include all Trusts involved in the network. It is anticipated that any relevant recommendations particularly around multi-disciplinary team clinics and improving patient pathways will then be circulated as appropriate.

National Audit of Inflammatory Bowel Disease (IBD) Service Provision

A number of actions had already been undertaken based on the results from the previous audit. In addition, an IBD checklist is being developed to be implemented by nursing staff, and an upper gastrointestinal checklist to be developed by the Core Trainee. A further local audit will be undertaken as part of the Junior Doctor programme.

National Chronic Obstructive Pulmonary Disease (COPD) Audit

In the national audit, 81% of hospitals managed NIV on the respiratory ward. The provision of NIV needs to be carefully examined to ensure that it is always provided on wards with optimal staffing. HDFT does not have a medical/respiratory High Dependency Unit so patients requiring level 2 care for non-invasive ventilation (NIV) are managed on wards that can provide the correct ratio of staff to patients, and staff trained in its usage.

The availability of services for patients with COPD at HDFT is excellent, with access to daily input from a respiratory consultant and nurse specialist (Monday to Friday). However we will consider whether 7 day access to nurse specialists would be beneficial in assisting with timely discharges.

Whilst HDFT provide hospital delivered pulmonary rehabilitation, there is a lengthy waiting time between referral and commencement, and the Trust is considering how to develop this service. At present there is no dedicated sessional consultant time in integrated COPD care,

although the nurses spend a lot of time in the community with community clinics and educational sessions. The team are looking to improve this service with a second respiratory consultant in place.

In addition, 32 national clinical audits from the 2012/13 and 2013/14 programmes applicable to Harrogate and District NHS Foundation Trust were reviewed by HDFT in 2014/15. The clinical teams review these reports and undertake a gap analysis prior to reporting actions to be taken and progress with actions to the Standards Group. Examples of the following actions for improvement have been identified:

Anaesthetics in Hip Fracture Sprint Audit

Local guidelines for hip fracture are to be developed alongside further education for staff in the Anaesthetic Department. Further discussions are taking place regarding consultant cover for trauma lists to ensure that patients are anaesthetised by a consultant or specialist with similar clinical experience.

Parkinson's Audit

The majority of actions on this action plan have been completed but additional actions reviewed during the year are:

- The provision of a Trust Healthy Bones leaflet for patients and discussion with the Falls Prevention Coordinator to ensure an assessment of osteoporosis and falls in patients with Parkinson's Disease.
- A consultant neurologist is undertaking a palliative care education programme and will be auditing the care of patients with Parkinson's Disease as part of this. A further local audit has been planned for 2015/16, and the Trust has also registered for the National Parkinson's Audit 2015.

National Cardiac Arrest Audit

Harrogate District Hospital data showed survival to discharge statistics following cardiac arrest that are lower than the majority of participating Trusts. Statistics may include the resuscitation of patients for whom it is futile, denying patients a natural and peaceful death and adversely affecting outcome statistics. This is seen as likely and triangulates with cardiac arrest case note reviews and 'do not attempt cardiopulmonary resuscitation' (DNACPR) audits. Considerable work has gone into ensuring discussion with patients and relatives in relation to DNACPR decisions, but early identification of patients for whom resuscitation would be futile is clearly important.

Work by the Resuscitation Training Officer to improve the situation is ongoing and discussions are being held regarding advanced care planning and DNACPRs.

Consideration was given to the Trust cardiac arrest prevention strategy and agreed this remains good. The escalation of patients in a timely manner was shown as satisfactory in an internal audit report. Resuscitation skill delivery was also reviewed and training is delivered by competent workforce with high compliance rates.

Feverish Illness in Children (College of Emergency Medicine)

A number of actions have been identified from the results as follows:

- A rolling monthly audit is planned covering observations undertaken on febrile children at initial assessment.
- The development of new Emergency Department (ED) documentation is ongoing with pilots running intermittently. The new documentation will include a tick box to indicate that discharge advice has been given. In the context of this patient group a discharge advice leaflet already exists.
- Further education is needed within medical and nursing teaching streams regarding the criteria, warning signs and recommended actions. This has highlighted a capacity issue with regards to the provision of ongoing training to nursing staff in this area.

There is ongoing regular teaching to ED junior doctors and they are made aware of the guidelines through the induction process.

National Diabetes Inpatient Audit

A foot assessment form has been developed which incorporates the inpatient foot pathway. Guidelines and referral form have been produced for primary care to assist in referring patients appropriately. There will also be a triage system by lead podiatrists so that patients are referred appropriately to a multi-disciplinary team foot clinic for high risk podiatry and seen within 24-48 hours. The foot assessment form now requires trialling for inpatients on two wards with training for nursing staff, care support workers and junior doctors; if successful it will be rolled out across the Trust. There is also a need to trial the referral form with GPs.

In relation to medication errors, hypoglycaemia and diabetes control, more training has been set up for nurses to access. Diabetes Link Nurse meetings have commenced and training arranged for Foundation Year 1 and 2 doctors on a rolling basis. Training for pharmacists and pharmacy technicians has been completed. A local audit of insulin prescriptions has been carried out, and an 'insulin round' and insulin timing checklists have been implemented in each relevant area. Work is also ongoing to update the self-administration of medicines policy to include insulin, and an insulin checklist has been developed for ward staff to complete.

Epilepsy in England

A pathway for referral from the Emergency Department (ED) to neurology services has been developed. An information sheet for patients has also been developed and is awaiting approval. An education session with Middle Grade medical staff in ED has taken place and a ‘First Fit’ database has been developed with cases from 1 January 2015 being included. A further local audit has also been undertaken.

MBRRACE-UK

MBBRACE-UK published ‘Saving Lives, Improving Mothers’ Care’ which reported on maternal deaths and morbidity for the triennium 2009-2012, in December 2014. For the first time the report also includes women affected with severe morbidity as well as maternal deaths, recognising that significant lessons for future care can be learned from these cases. This report is currently being reviewed by the Head of Midwifery and a senior consultant obstetrician, and any recommendations will be considered and implemented as appropriate, following benchmarking against current practice at HDFT. We have a nominated senior midwife within the HDFT Maternity Services who is the contact for MBRRACE-UK.

The Head of Midwifery and a consultant obstetrician are participating in the numerous Yorkshire and the Humber Strategic Clinical Network project work streams, which includes stillbirths and which extended to include perinatal mental health in February 2015. We also have representation on the national project, ‘Every Baby Counts’, and are considering being a pilot site for the National Stillbirth Care Bundle, due to commence in early 2015.

Elective & Emergency Surgery in the Elderly: An Age Old Problem (2010)

This NCEPOD report highlights the process of care of elderly patients who died within 30 days of emergency or elective surgery. The report takes a critical look at areas where the care of patients might have been improved, from lack of input from Medicine for the Care of

Older People to the level of pain relief provided. Remediable factors have also been identified in the clinical and the organisational care of these patients.

A gap analysis was initially undertaken in October 2011 and was reported to the Board of Directors in the Annual Report on the progress against the recommendations of the National Confidential Enquiries. An update was given to the Board of Directors in September 2012 and September 2014 on the progress of the action plan.

Following last year's Annual Report, progress with this action plan continues to be slow with the remaining actions reflecting cross-directorate issues.

Tracheostomy Care: On the right trach? (2014)

This NCEPOD report highlights the process of care for patients who undergo a tracheostomy or a laryngectomy. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have also been identified in the clinical and the organisational care of these patients.

This report was published in June 2014 and received at Standards Group in July 2014. A lead was appointed and a gap analysis was undertaken and progressed by the Critical Care Delivery Group. A review of progress was received by Standards Group in January and May 2015. Whilst there will be ongoing monitoring of attendance at training, all actions have now been completed.

Alcohol Related Liver Disease Study: Measuring the units (2013)

It was agreed that the remaining actions from the NHS Atlas Variation in Healthcare for People with Liver Disease action plan should be amalgamated with the recommendations from this NCEPOD report and progressed as a composite action plan.

Subarachnoid Haemorrhage: Managing the flow (2013)

This NCEPOD report highlights the process of care for patients who are admitted with aneurysmal subarachnoid haemorrhage, looking both at patients that underwent an interventional procedure and those managed conservatively. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have also been identified in the clinical and the organisational care of these patients.

In September 2014 it was noted that further progress of this action plan was dependent upon a coordinated regional response which was being led by Leeds General Infirmary. In January 2015 Standards Group were informed that the Yorkshire Regional Subarachnoid Haemorrhage Network had been established. It is anticipated that further updates on progress are to come from these discussions.

Local Audits

141 projects (excluding national audits) were registered with the Clinical Effectiveness Department during 2014/15. This includes projects aimed at improving quality by using service evaluation and patient experience surveys.

The results of local audits are presented at the directorate or specialty audit or governance meetings where the results, 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. During 2014/15, 28 re-audits were undertaken (included in the overall total above).

During 2014/15 a joint audit programme with Clinical Effectiveness and Audit, and Internal Audit functions was in place, which focused on the high priority areas for the Trust in order to provide assurance to the Audit Committee that the systems and processes in place lead to improved outcomes for patients. 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 2015/16.

The reports of 62 local clinical audits were reviewed by relevant audit and governance groups at HDFT during 2014/15. HDFT also continued to review completed audits which had been registered and commenced during 2013/14. HDFT intends to take the following actions to improve the quality of healthcare provided.

Pathology and Radiology Reporting (joint Internal Audit and Clinical Audit)

Systems are in place to ensure that all requests for diagnostic investigations are registered, reviewed and prioritised on receipt, and to report the results of investigations undertaken to the requesting practitioners.

In recent years, the Trust has been moving towards a paper-light reporting process for both pathology and radiology investigations. Consequently, most requests are now received from and reported back to requesting practitioners using the requesting and reporting system (ICE). Reports also continue to be returned to requesting practitioners in paper format. The ICE system also provides system users with the facility to view the diagnostic status of each patient and the status of each diagnostic request.

The review found that there is scope to further improve the operation of the system, by ensuring in particular that all critical results are promptly reported, and that practitioners promptly review and record their response in relation to reports received.

The principal recommendations were:

- Radiologists should be reminded to ensure that the reason to refuse or cancel an investigation request, and a record of this refusal or cancellation being communicated to the referrer should be recorded on the Radiology Information System in accordance with the Radiology procedure.
- Action is taken to ensure all investigations are undertaken and reported promptly to the referring practitioners.
- The Pathology procedure is amended to specify any areas where critical results do not require reporting within the one hour standard. Action is taken to ensure that all critical Pathology results are phoned through to the relevant clinician within the one hour standard, where relevant, and that the Trust record keeping standards are adhered to when documenting this communication.
- Radiology highlighted reports in relation to critical and urgent results are separately identified from non-urgent results, so that the communication of these results can be specifically monitored.
- Departments are reminded that paper reports received from Pathology and Radiology departments are signed and dated by the clinician on receipt and are promptly filed in patient paper notes files.
- Practitioners are reminded of their responsibility for reviewing all investigation results

that are reported, and action in relation to examinations should be recorded in patients' medical notes in accordance with procedure.

Obstetrics and Gynaecology (OG) Drug Allergy Audit

The objectives of the audit were to review ePMA (electronic prescribing system) to ensure that all OG hospital inpatients have a documented allergy status, and ensure that all OG inpatients have the correct colour wristband. The audit showed generally very good compliance (see table 6) and results have been discussed within the specialty to ensure that further improvements can be made.

Criteria	Expected level of performance	Actual level of performance
All hospital inpatients have a documented allergy status on ePMA	100%	99.5%
All inpatients with an allergy have a red wristband	100%	92.3%
No medicines are dispensed or administered without a documented allergy status	100%	Unknown
No medicines are dispensed or administered to which a patient has a recorded allergy	100%	98.5%
If allergy status is not recorded on ePMA, it should be documented in the notes	100%	100%

Table 6: Obstetrics and Gynaecology drug allergy audit results

Initial assessment and Management of Urinary Incontinence in Women

The standards for the initial assessment and management of women with urinary incontinence were audited.

Criteria	Expected level of performance	Actual level of performance
Urine dip performed for all women with symptoms of urinary incontinence (UI) and/or overactive bladder (OAB)	100%	60%
Mid-stream urine sample sent if urine dip positive for leucocytes/nitrites or if patient symptomatic of urinary tract infection	100%	92%
Bladder diary for at least 3 days in all women with UI/OAB	100%	48%
Weight loss advice given if BMI >30	100%	62%
Fluid management advice given in all women with UI/OAB	100%	56%
Caffeine reduction advised in all women with OAB	100%	100%
Bladder training for at least 6 weeks as first line treatment for urge or mixed UI	100%	100%
Supervised pelvic floor exercises for at least 3 months for stress or mixed UI	100%	100%

Table 7: initial assessment and management of women with urinary incontinence audit results

The results demonstrate some excellent care and advice in relation to some criteria, and other areas for further improvement.

Audit of the WHO Safe Surgery Checklist Sign out Section

The World Health Organisation (WHO) Safe Surgery Checklist identifies three phases of an operation, each corresponding to a specific period in the normal flow of work: Before the induction of anaesthesia (“sign in”), before the incision of the skin (“time out”) and before the

patient leaves the operating room ("sign out"). In each phase, it must be confirmed that the surgery team has completed the listed tasks before it proceeds with the next stage of the operation.

This audit of the sign out section of the WHO checklist demonstrated that this was not being used consistently, and in this sample it was only signed in 32% of cases. The prescription of thromboprophylaxis, treatment to prevent venous thrombosis in the post-operative period, was also assessed as the form includes a prompt for the clinical team to consider this.

Criteria	Expected level of performance	Actual level of performance
The sign out section of the WHO checklist is complete (identified by signature)	100%	32%
The sign out section has the practitioner's name printed	100%	31%
If thromboprophylaxis is required it is prescribed on ePMA (i.e. defined as ticked on WHO checklist)	100%	58%
If thromboprophylaxis is prescribed it has been started post-operatively	100%	93% 7% omissions acceptable

Table 8: WHO Safe Surgery Checklist sign out section audit results

The results of this audit were disappointing and have prompted the Trust to address the underlying causes and to ensure a further review of the WHO Safe Surgery Checklist process by Internal Audit during 2015/16.

A Re-audit of Antibiotic Prophylaxis

A re-audit of antibiotic prophylaxis (treatment given to prevent infection) in obstetrics and gynaecology was undertaken. Overall there was an improvement in the antibiotic prescribing according to HDFT antimicrobial standards and better use of ePMA than in the previous audit.

Criteria	Expected level of performance	Actual level of performance
All women who undergo a caesarean section should receive antibiotic prophylaxis prior to skin incision	100%	100% received antibiotics.75% had evidence of antibiotic given at correct time
All women who undergo a termination of pregnancy/ERPC should receive antibiotic prophylaxis prior to procedure	100%	57% received antibiotics.86% had evidence of antibiotic given at correct time
All women who undergo a 'major' gynaecological procedure should have antibiotic prophylaxis at induction of anaesthesia	100%	96% received antibiotics.83% had evidence of antibiotic given at correct time
All women who undergo a 'minor' gynaecological procedure should NOT routinely receive antibiotic prophylaxis prior to surgery	100%	78% had antibiotics withheld
All prophylactic antibiotics should be prescribed on ePMA	100%	68% had antibiotics prescribed on ePMA

Table 9: Antibiotic Prophylaxis re-audit results

Recommendations from the audit were a further revision to the antimicrobial guideline to provide clarification of examples of major and minor procedures which may assist with staff awareness of when to prescribe prophylactic antibiotics.

A Re-Audit of Temporary Tracheostomy Practice

A temporary tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to provide an alternative breathing route until other medical issues are resolved. The original 2011 local audit into temporary tracheostomy practice identified a lack of awareness of our new Trust policy and a lack of thorough documentation of insertion procedures. Only 75% of procedures had some form of documentation; percutaneous procedures done at the bedside in the Intensive Care Unit (ICU) were often not recorded fully, though for surgical procedures done in theatre, operative notes were recorded.

In this re-audit it is apparent that documentation of tracheostomy insertion is much improved and now 100% of procedures are documented in patient notes, which is extremely encouraging. ICU nursing staff are making full use of the care pathway and it is used universally by critical care clinicians for percutaneous procedures.

Further actions have also been identified to ensure that tracheostomies performed on critically ill patients, regardless of whether they are surgical or percutaneous, have a tracheostomy care pathway. The care pathway encourages full documentation of the procedure and safe care of a patient with a tracheostomy from insertion to removal. Where a surgical tracheostomy is performed it should be the responsibility of the consultant of the week in charge of ICU to initiate the care pathway.

Simulation training has also been suggested to help staff to familiarise themselves with the emergency algorithms and appreciate the value of individual components of the policy. Amendments to the ICU observation charts have also been recommended.

Intravenous Cannula Management

Many patients admitted to hospital will have an intravenous access device inserted at some stage during their hospital stay. An intravenous device bypasses the natural defence functions of the skin and may allow the entry of micro-organisms at the time of insertion or later, causing infection either at the site of entry, in the blood or at remote sites. The incidence of infections related to intravenous therapy is reduced by appropriate care both at the time of insertion and during subsequent care of the site and infusion device. There is an up to date policy for the insertion and on-going care of intravenous cannulae available to all staff. A cannula should be prescribed on ePMA, and the cannula site observed regularly. The visual infusion phlebitis (VIP) score should be recorded on ePMA or the patient's notes.

Internal Audit carried out a re-audit of the documentation of intravenous cannula insertion and on-going care during 2014. The previous audit in 2013 had resulted in an opinion of significant assurance for the majority of wards tested, but limited assurance for Pannal, Wensleydale and Woodlands Wards. The latest audit reported in January 2015 and provided significant assurance for the majority of wards tested, with limited assurance for Woodlands and Farndale Wards in relation to documentation of intravenous cannula insertion and on-going care, and Byland Ward in relation to on-going care.

In response to this audit, the matrons have looked at processes to monitor the ongoing compliance with intravenous cannula prescribing. Actions being taken are to:

- Ensure all registered nursing staff are trained to prescribe cannulae on the ePMA system and to produce an aide memoir to remind staff how to do this;
- Ensure each Band 6 or 7 nurse audit the prescribing of cannulae in their area at least weekly, and remind staff if they fail to prescribe a cannula;

- Improve the assessment and recording of VIP scores;
- Ensure that any cannulae no longer required are removed as soon as practically possible.

A further spot check audit by matrons is being developed.

Staff Rostering

An audit of staff rostering was undertaken by Internal Audit in 2014 to assess whether there are effective systems in place to ensure the accurate, efficient and safe allocation of nursing staff to shifts.

The RosterPro electronic rostering system enables managers to set up staff rosters electronically in line with Trust policy, and will record staff attendance. The system integrates with Electronic Staff Records, which is the Trusts integrated payroll and human resources system. The audit revealed a number of weaknesses in the design and operation of controls to efficiently and accurately roster staff on RosterPro. The effectiveness of the rostering tool is limited due to a number of system and user issues, for example:

- Overstaffing of rosters;
- Allocation of management time that exceeds the agreed allowance;
- Ineffective redeployment of staff between wards to cover clinical needs and lack of controls on overtime rates paid;
- Inaccurate time owing balances and annual leave entitlements.

These findings are being addressed as a matter of some urgency.

5. Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by HDFT in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 4,918.

Research and Development: Quality assurance

HDFT is committed to the promotion of evidence informed practice with the aim of continuous improvement to quality and patient outcomes. The Trust has a strong track record of ensuring the very best care is delivered by participating in research and adopting the evidence produced from high quality research studies. Over the last four years the organisation has been recognised nationally in the Guardian league tables as one of the top three small trusts recruiting into research studies. Over the last year as a partner organisation of the Yorkshire Humber Clinical Research Network (YH CRN), HDFT has embraced the many research opportunities provided by the Department of Health and has exceeded the target of 2750 set by YH CRN by recruiting 4,832 patients into National Institute for Health Research (NIHR) portfolio non-commercial and commercial studies. The Trust acknowledges the intrinsic link between patient focused service development and the need to further knowledge though research activity. A culture of research activity has been fostered in many specialist areas and the aim is to integrate this into all services with provision of support and training required to engage staff in research and service improvement initiatives. There is absolute commitment to ensure every patient has opportunity to be involved in research and the Trust continues to drive a culture such that the offer of trial participation is considered part of standard care.

As of March 2015 the number of studies open and recruiting at HDFT was 78. Currently 19 clinical areas offer patients the opportunity to take part in research. New areas include Emergency Care and Ophthalmology. Clinicians at HDFT are encouraged to be research active with around 120 involved in recruiting to studies. They are supported by 54 NIHR funded or part funded research delivery staff. Clinical areas where patients and staff have the opportunity to take part in research at HDFT include:

> Cardiology, Children's Services, Critical Care, Dementia Care, Dermatology, Diabetes, Emergency Care, Infection & Immunology, General Surgery, Gynaecology, Midwifery, Neurology, Oncology, Ophthalmology, Orthopaedic services, Rheumatology, Stroke and Wound care.

Training and education; keeping up to date

Key to the delivery of safe and high quality research is a robust and flexible infrastructure that comprises dedicated, appropriately trained research delivery staff, an efficient and effective research governance team, engaged clinical support departments and enthusiastic, motivated clinicians. 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. This provides a varied experience base for new staff and ensures that the team is responsive to the needs of the service. Access to targeted training is available to ensure appropriate development of research skills through mentored experience, internal and external training. Core competencies have been and continue to be identified for all staff and these are 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. Staff involved in research attend a monthly research and performance meeting.

Research Governance

The Trust conducts its own research governance through a dedicated R&D Unit managed by an Associate Medical Director for Research. Staff conduct pragmatic research governance via a suite of usable Standard Operating Procedures for research. These facilitate research activity and ensure appropriate safety measures for patients, staff and the organisation. The R&D Unit also provides assurances for the quality of research output and use of financial resources. R&D activity is overseen by a multi-disciplinary R&D Group, chaired by the Trust Medical Director.

Performance reports and measuring service quality

Performance of the research delivery staff and the R&D Unit is monitored and managed locally within the Trust, however performance against the high level objectives set out in the partner organisation contract with the YH CRN are managed by the Clinical Research Network at a regional and national level.

Over the last year recruitment to cancer studies has been monitored through the CQUIN scheme with an improvement target identified in discussion with NHS England and commissioners.

HDFT research delivery staff conduct an annual survey to assess the quality of service delivery as perceived by research participants. Findings are shared at the R&D Group and research meetings and acted upon. The intention is this will feed into a national survey of research participants in the future.

Research metrics have been shared with Trust Board within the Board report from the Chief Operating Officer. These are due for review and updating. The Associate Medical Director for Research provides an annual presentation to the Trust Board (last update March 2015).

Matching research to national prerogatives to ensure quality:

Integrated care pathways & management of long term conditions

The national and local agenda is to promote more community based healthcare with particular emphasis on the facilitation of patient self-management for long term conditions. Harrogate and Rural District CCG is one of the new NHS England model of care vanguard sites with well-developed plans to join up GP, hospital and community based services. The Trust has started to examine research projects that are exploring integrated care pathways and will provide intelligence and expertise for the Trust as well as delivering best practice evidence. NIHR funds health and social care research recognising that these service delivery platforms are inextricably linked. HDFT appreciate the benefits to be achieved if the services work co-operatively.

The research team has worked closely with Clinical Commissioning Groups and GP Federations to ensure patients have the opportunity to take part in diabetes research. This aligns with the relocation of the diabetes service into clinics based in GP practices. Pharmaceutical companies in collaboration with clinical teams around the country, including those at HDFT, are exploring several new potential therapies through large clinical trials. The diabetes research team at Harrogate has demonstrated an ability to work with GPs to identify suitable participants in a systematic way using information from the GP database. This model will be extended to other therapeutic areas and will facilitate collaborative relationships across primary and secondary care boundaries.

End of life care

HDFT have integrated services with St. Michael's Hospice and a palliative care team based both at the Trust and the Hospice. The Trust research team are actively examining how research can become an integral palliative care service to enhance service integration.

Dementia care and mental health research

Dementia as a specialty falls within mental health, a service provided in the Harrogate area by Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust. However, at any one time 25-30% of patients within the acute adult beds will have dementia or an acute confusion and some will have acute or chronic mental health problems. In addition much of the interventional dementia research facilitated by Harrogate and District's Mental Health services provider TEWV is undertaken in a specialist research centre in Newcastle. In practice this means that many patients with dementia in North Yorkshire have limited access to research. The research team is working with the current dementia champion to increase the number of patients having access to observational studies. In addition we will, working with research colleagues at TEWV, explore pathways for patients with dementia to access treatment research in specialist centres. Collaborations like these help to establish partnerships between trusts. Research staff are also recruiting patients who are willing to sign up to the national programme Join Dementia Research. This is an online platform for interaction between people with dementia who want to take part in research and researchers who would like to recruit patients to studies. As part of the drive to increase dementia research in the area, several research staff have signed up to become dementia champions www.dementiafriends.org.uk, part of the national drive to ensure patients with dementia and their carers receive the support they need when accessing NHS care.

The MARQUE study is collecting evidence from residents, their families and carers about how a nursing home culture and staff responses to residents with dementia affects the quality of life of those residents. HDFT research staff are collecting evidence for the study

from a local nursing home, developing links to facilitate the delivery of further research activity.

Mental health research has been identified as a national priority. We will continue to work with TEWV to facilitate research opportunities for our local population.

Monitoring and sharing the impact of research

HDFT actively monitors and shares the impact of research both in terms of research results (shared with participants and patients as well as clinical teams) and through the opportunities it brings to re-examine care pathways and operating systems. An example of research activity improving care pathways comes from a recent diabetic study. A diabetes research nurse had a dual clinical and research role and co-ran a diabetic foot ulcer clinic with a medical colleague. It was agreed to recruit patients into a study as feasibility suggested that there would be enough patients treated at HDFT who would fit the inclusion/exclusion criteria. It became clear that patients were not being referred to the foot ulcer clinic from another service as they should have been. The referral guidelines were re-written and patients are now being referred (and treated) appropriately.

A public facing HDFT research community on the cloud based NIHR platform has been implemented with a link from the Trust website. HDFT research staff will seek out findings of projects and ensure these are shared with individual participants but that the findings are also available to all the population HDFT serves and clinical teams.

Working with partners to ensure high quality studies are conducted within the organisation.

We have used our links 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 & University of York (reproductive health and healthcare delivery); Centre of Evidence-based Dermatology; Centre of Immunology and Infection; Clinical Trials Units in York, Leeds & Sheffield. 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.

The Trust is an active member of the Academic Health Science Network which brings together organisations in Yorkshire and Humber which have an interest in the health and wealth of the region. 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) and Hull and York Medical School.

HDFT have a long history of engagement with commercial research organisations such as pharmaceutical companies and have 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.

6. Use of the Commissioning for Quality and Innovation Framework

A proportion of HDFT income in 2014/15 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 2014/15 and for the following 12 month period are available electronically at:
http://www.hdft.nhs.uk/about-us/commissioning-for-quality-and-innovation-cqin/

The monetary total for the amount of income in 2014/15 conditional upon achieving quality improvement and innovation goals was £2,625,000. The monetary total for the associated payment in 2013/14 was £2,984,000.

7. 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 2014/15:

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

However during 2014/15 HMP Askham Grange and HMP Northallerton were removed from the registration.

The Care Quality Commission has not taken enforcement action against Harrogate and District NHS Foundation Trust during 2014/15.

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

8. Information on the Quality of Data

HDFT submitted records during 2014/15 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:
- 99.8% for admitted patient care
- 99.8% for outpatient care
- 97.9% for accident and emergency care

- Which included the patient's valid General Practitioner Registration Code was:
- 99.9% for admitted patient care
- 99.9% for outpatient care
- 99.8% for accident and emergency care.

9. Information Governance

HDFT’s Information Governance Assessment Report overall score for 2014/15 was 85% and was graded satisfactory/green. The Trust reported 112 out of 132 standards at level two or above (there are three levels with level three being the highest), compared to 111 out of 132 in 2013/14.

10. Payment by Results

HDFT was subject to a Payment by Results clinical coding audit in 2014/15 by the Audit Commission. The audit results are still awaited.

The Trust also commissioned an external clinical coding audit to meet Information Governance requirements during 2014/15. The audit was carried out in February 2015 by nationally registered clinical coding auditors from D & A Clinical Coding Consultancy Limited. An audit sample of 200 episodes was reviewed, 50 randomly selected episodes from General Surgery, Respiratory Medicine, Ophthalmology and Maxillofacial Surgery, from across the whole range of activity for the period July – September 2014. The results showed an overall error rate (coding errors affecting the Healthcare Resource Group (HRG)) of just 1% 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 procedures 1.95%
Secondary procedures 1.31%
Primary diagnoses 2%
Secondary diagnoses 5.43%
An overall combined diagnostic and procedural error rate 2.67% (1.67% of the error rate did not affect the HRG as described above).

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

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

2.4 Reporting against core indicators

Set out in the 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	
	Apr 13 to Mar 14	**Jul 13 to Jun 14**
HDFT value	0.975	0.992
HDFT banding	2 (as expected)	2 (as expected)
National average	1.000	1.000
Highest value for any acute Trust	1.197	1.198
Lowest value for any acute Trust	0.539	0.541
Note - highest and lowest trust scores include all providers with data published by HSCIC		

Table 10: Summary Hospital Level Mortality Index (SHMI)

HDFT's latest published score of 0.992 is within the expected range.

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

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

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

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

Palliative care coding

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

	Data period	
	Apr 13 to Mar 14	**Jul 13 to Jun 14**
HDFT value	19.8	21.8
National average	23.6	24.6
Highest value for any acute Trust	48.5	49.0
Lowest value for any acute Trust	0.0	0.0
Note - highest and lowest trust scores include all providers with data published by HSCIC		

Table 11: Percentage of patient deaths with palliative care coded at either diagnosis or specialty level

HDFT's latest published score of 19.8% is below the national average.

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

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

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

- Investing in specialist palliative care provision by increasing the hours and resource available to provide the service to patients in hospital;
- Undertaking training and ward based support by the Specialist Palliative Care Team to medical specialist teams working with people at the end of their life;
- Developing the care plan for the last days of life implemented in June 2014;
- Delivering a senior clinician development programme throughout the year;
- Holding an end of life conference on 2 October 2014 which was positively evaluated by attendees.

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 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		
	2011/12 (final)	**2012/13 (final)**	**2013/14 (provisional)**
HDFT value	0.083	0.089	0.073
National average	0.087	0.085	0.085
Highest value for any acute Trust	0.143	0.120	0.132
Lowest value for any acute Trust	0.030	0.021	0.039

Table 12: PROMs – Groin hernia surgery

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

	Data period		
	2011/12 (final)	**2012/13 (final)**	**2013/14 (provisional)**
HDFT value	Data suppressed due to small numbers	Data suppressed due to small numbers	Data suppressed due to small numbers
National average	0.095	0.093	0.093
Highest value for any acute Trust	0.167	0.176	0.150
Lowest value for any acute Trust	0.049	0.015	0.023

Table 13: PROMs – Varicose vein surgery

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

	Data period		
	2011/12 (final)	**2012/13 (final)**	**2013/14 (provisional)**
HDFT value	0.426	0.425	0.411
National average	0.416	0.438	0.436
Highest value for any acute Trust	0.470	0.538	0.483
Lowest value for any acute Trust	0.318	0.319	0.342

Table 14: PROMs – Hip replacement surgery

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

	Data period		
	2011/12 (final)	**2012/13 (final)**	**2013/14 (provisional)**
HDFT value	0.336	0.330	0.325
National average	0.302	0.318	0.323
Highest value for any acute Trust	0.371	0.376	0.400
Lowest value for any acute Trust	0.181	0.209	0.215

Table 15: PROMs – Knee replacement surgery

Note - highest and lowest Trust scores exclude independent sector providers. 2012/13 and 2013/14 data looks at primary hip and knee procedures only.

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

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

- 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;
- The Trust considers the scores indicate it is not an outlier from the national position.

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

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

Emergency readmissions to hospital within 28 days

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 & 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 16: Emergency readmissions 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 17: Emergency readmissions 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 Secondary Uses Service dataset; this is a national system and data quality indicators linked to this system indicate an excellent compliance rate.

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

- Using an evaluation tool that enables 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.

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. The scores are an average weighted score of five questions relating to responsiveness to inpatients' personal needs, presented out of 100 with a high score indicating good performance.

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

Table 18: Inpatient survey – responsiveness to inpatients' personal needs

Note: Data for historical years was rebased by the HSCIC in this year's publication and so will not match the data reported in last year's Quality Account.

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

- Driving improvement for the delivery of high quality fundamental care has been a major quality improvement priority for the Trust for the last three years. 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 nutrition and communication.
- These standards are monitored through a governance system which includes matrons' audits and meetings, unannounced Director led inspections, Patient Safety Visits, local Quality of Care Teams and the Trust's Standards Group;
- A well-established system of seeking objective feedback via external bodies and groups including the Trust's Patient Voice Group, Governors and Lay Representatives.

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

- The implementation and review of a detailed action plan relating to both the most recent 2013/14 survey and 2012/13 survey will continue through the Trust's Standards Group with accountability for the delivery of the plan sitting with the Trust's Clinical Directorates;
- The use of patient feedback through the full implementation of the national Friends and Family Test will enable further improvements to be made;
- The introduction of quality initiatives for cascading information on performance improvements and areas for focus, delayed discharge, infection control will be implemented through a group leading work to develop inpatient quality and performance notice boards.

National Staff Survey – Standard of Care Provided

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

	Data period		
	2012	**2013**	**2014**
HDFT value	73	77	72
National average	63	65	65
Highest value for any acute Trust	86	94	89
Lowest value for any acute Trust	35	40	38

Table 19: National staff survey

This question forms part of Key Finding 24, 'Staff recommendation of the Trust as a place to work and/or receive treatment' in the National Staff Survey for 2014. The Trust achieved a ranking of above (better than average) when compared with all acute Trusts for this Key Finding.

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

- Significant engagement from staff has been sought to develop the Trust's values and behaviours framework which was ratified at the Board of Directors in February 2015 and this will form part of the recruitment, management and retention of staff. The values hold the patient care at the heart of everything we do;
- Reaccreditation of Investors in People; areas of continuous improvement were identified and the link between training and development and patient outcomes and safety are clearly demonstrated by staff who were interviewed;
- The Innovation and Improvement strategy was launched in July 2014 and subsequently staff have been actively involved in scoping and implementing improvement projects many of which are based on ideas from the floor;
- All levels of staff were actively involved in the successful appointment of both the Chief Executive and Chief Nurse in early 2014;
- The introduction of Health and Wellbeing days to promote and raise awareness of individual health care within the staff;
- A proactive recruitment strategy including international recruitment, streamlining of processes and review of notice periods have enabled the recruitment and retention of staff;
- Training provided to all staff regarding escalation of risks. This includes communication on how to report incidents, sharing outcomes of investigations with learning between Directorates and the Being Open Policy;
- Overall, the Trust has received positive results in the national in-patient and other patient related surveys.

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

- Identifying areas of continuous improvement and demonstrating the link between training and development and patient outcomes and safety. Often these have been based on ideas from the staff and given them the opportunity and power to change their work. Being able to do this develops staff confidence in our services;

- The continued roll-out of the Rapid Improvement Programmes where service improvement and innovation projects take ideas from members of the workforce and then apply lean methodology to improve services for staff and patients and heighten confidence;
- The continued focus on the health and wellbeing of the workforce, ensuring we lead by example and continuing to put the health of our workforce at the centre of the strategy;
- Implementation of the leadership development programmes for consultants and matrons / senior ward staff.

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 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 2014/15	**Q2 2014/15**	**Q3 2014/15**
HDFT value	97.7	98.1	98.4
National average	96.2	96.2	96.0
Highest value for any acute Trust	100.0	100.0	100.0
Lowest value for any acute Trust	87.2	86.4	81.2

Data source: http://www.england.nhs.uk/statistics/statistical-work-areas/vte/

Table 20: Percentage of eligible admitted patients risk assessed for venous thromboembolism (VTE)

HDFT's published scores have been above the national average for the whole year to date.

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

- There is a well-established protocol for VTE risk assessment on admission;
- Data is recorded onto the Information and Clinical System (ICS) and collected via reliable IT systems;
- Education on VTE risk assessment is part of the Trust's essential training so staff understand the importance of it.

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

- Identifying wards with poorer performance and examining whether there are issues with completion of the risk assessment or inputting of information onto ICS;
- Continued scrutiny of results at Director level via the Trust's Performance Group.

Clostridium difficile 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.[1]

	Data period		
	2011/12	**2012/13**	**2013/14**
HDFT *C. difficile* cases	10	21	14
HDFT *C. difficile* rate (cases per 100,000 bed days)	10.3	20.8	13.7
National average	22.2	17.3	14.7
Highest value for any acute Trust	58.2	30.8	37.1
Lowest value for any acute Trust	0	0	0

Table 21: Number of cases (rate) of C. difficile infection (CDI) per 100,000 bed days reported from hospital inpatients aged two years or over.

At the time of writing Public Health England (PHE) has not published its official data from 2014/15 but HDFT reported only 9 cases.

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

- HDFT hospital policy is to obtain a stool sample at the first possible opportunity from all patients with diarrhoea.[2]
- The Trust has a robust four-stage diagnostic testing protocol for *C. difficile* (GDH, PCR, toxin EIA and cytotoxin assay). Local data validation has demonstrated that the testing algorithm in use at HDFT is more sensitive than the standard two-stage test recommended by DH to the extent that one out of every five cases detected using the HDFT protocol would be missed using the EIA-based DH protocol.[3]
- All confirmed CDI cases are scrutinised through the Trust's internal reporting mechanisms and subjected to root cause analysis (RCA), with input from primary care if appropriate, and reported to Public Health England (PHE), Monitor and commissioning organisations.

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

- Changing the primary disinfectant used in clinical areas from a chlorine-releasing agent to chlorine dioxide, which is known to be more effective against *C. difficile* spores (this action has been completed).[4]

[1] Data source:
<https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/336953/Clostridium_difficile_annual_and_quarterly_trusts_and_ccgs.xls>

[2] HDFT IPC Policy Section 009: *Clostridium difficile*.

[3] Implementation of nationally mandated microbiological testing protocol for *C. difficile* infection underestimates the true burden of disease (ECCMID, Barcelona, 2014); Updated Guidance on the Diagnosis and Reporting of Clostridium difficile (DH 2012)
.<https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215135/dh_133016.pdf>

[4] Speight S, May A, Macken R *et al*. Evaluation of the sporicidal activity of different chemical disinfectants used in hospitals against *Clostridium difficile*. J Hosp Infect (2011): 79; 18-22.

- Auditing the Trust's two-hour source isolation standard for patients who develop diarrhoea to minimise the risk of cross-infection from early CDI.
- Enhancing the RCA process to improve timeliness and increase participation by clinical staff.
- Promoting patient hand hygiene by introducing of "secret shopper" patient hand hygiene audits.
- Negotiating with the local CCGs in an attempt to secure funding for a community-based specialist *C. difficile* nurse to improve the co-ordination of *C. difficile* management between the hospital and the community.

Patient safety incidents

The data looks at three measures related to patient safety incidents reported to the National Reporting and Learning System (NRLS):

- The rate of incidents reported per 100 admissions. A low rate is good; however incident reporting rates may vary between trusts and this will impact on the ability to draw a fair comparison between organisations;
- The number and percentage of reported incidents that resulted in severe harm to a patient. A low score is good;
- The number and percentage of reported incidents that resulted in the death of a patient. A low score is good.

	Oct 13 - Mar 14			Apr 14 - Sep 14		
	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	13.65	3	not available	28.84	2	0.004
National position (all acute trusts)	34.18	3078	not available	36.51	2958	0.019
Highest value for any acute Trust	82.87	103	not available	94.84	97	0.122
Lowest value for any acute Trust	5.76	0	not available	0.24	0	0.000

Table 22: Patient safety incidents

Note – from the latest publication (April 2015) NRLS have changed the way they report the data. Previously they presented the data as a rate per 100 admissions but have now changed to a rate per 1,000 bed days. They have not recalculated the rate for incidents that resulted in severe harm or death so the incident rate data for this measure is not available for the period Oct 13 – Mar 14.

HDFT's latest published scores are below the national average for all measures.

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

- The data is collated by front line staff in relation to patient safety incidents;
- There is a robust policy and process within the Trust to ensure that all incidents are identified, managed, reported and investigated in accordance with national guidance;

- The Trust ensures that there are appropriate measures in place to prevent recurrence and also promotes organisational learning.

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

- Promoting patient safety as a key objective across the organisation and implementing a number of mechanisms to ensure compliance with, and delivery of national frameworks;
- There is a continual focus on quality at an organisational, Directorate and front line level through a variety of structures, for example Quality of Care Teams, Quality Governance Groups at Corporate and Directorate level, Patient Safety Visits, Quarterly Monitoring Reports, Case Conferences and Learning Events;
- Key themes and lessons learnt from incidents include inadequate handover of information, poor communication and escalation to more senior doctors. A number of work streams have been implemented to address this including more robust handover, electronic tracking of patient observations to improve real time identification of potential warning signs and immediate escalation and proposed training in human behaviours methodology;
- Trust staff provide information to HM Coroner, who on occasion may provide some recommendations. In one case this year the Coroner recommended the Trust take action to improve the risk assessment of potential thrombosis in patients who have non-weight bearing plaster casts for lower limb fractures. This process has been fully implemented;
- The Trust is part of the NHS Litigation Authority (LA) Scheme, which manages a risk pool for all NHS organisations in England, spreading the cost of claims over time. The NHSLA is supporting Sign up to Safety, a new campaign launched by the Secretary of State for Health that aims to listen to patients and staff, learn from when things go wrong and act to make care safer. Sign up to Safety's three year objective is to reduce avoidable harm by 50% and save 6,000 lives. We reviewed our claims, identified common themes and produced a safety improvement plan to reduce the associated harm. The Trust was successful in a bid for funding from the NHSLA to improve the patient safety culture and effective team working within our Maternity service.

3. OTHER INFORMATION

3.1. Review of quality performance

This section provides an overview of the quality of care offered by HDFT based on performance in 2014/15 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

We have included some of the same indicators that were included in the 2013/14 Quality Account in order to report ongoing work and progress. Some of the indicators previously

reported in this section in 2013/14 have been part of the key priorities for 2014/15 and are reported in part 2 of this report. We have also introduced a few new indicators.

3.1.1. Patient Safety

1. Medicines Safety

Introduction

Medicines play an integral role in the management of disease. They are pivotal to achieving good patient outcomes but there is significant 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 160,000 medicines incidents are reported to the NHS England Patient Safety Division through the National Reporting and Learning Scheme. 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 2 million medicines doses per annum and dispense around 150,000 medicine packs (items) per year.

This work is supported by a multi professional, multi-agency national Medicines Optimisation work programme.

What were we aiming to achieve?

The aim of our medicines safety priority was to 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.

The specific objectives were to:

- reduce the number of incorrectly prescribed medicines;
- reduce the number of medicines not prescribed that should be;
- reduce the number of medicines not administered as intended by the prescriber;
- reduce the number of medicines not administered at the time intended by the prescriber;
- reduce the number of dispensing errors leaving the pharmacy department;
- increase 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:

- Adopting the Royal Pharmaceutical Society Medicines Optimisation Principles;
- Working with NHS England to secure monies through the Safer Hospital Safer Ward Technology fund to accelerate the roll out of the electronic Prescribing and Medicines Administration (ePMA) system further across the organisation;

- Rolling out ward based pharmacy teams to improve the access and timely supply to medicines for our patients;
- Implementing the integrated use of the Summary Care Record to enhance 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;
- Developing a range of metrics to measure success.

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;
- Missed doses of medicines;
- Time taken for clinical alerts relating to incorrectly prescribed medicines to be actioned;
- National inpatient survey data followed by an internal snapshot of inpatients;
- Regional clinical pharmacy activity benchmarking data.

The targets were to reduce against baseline the number of errors and missed doses, and the time to action alerts, 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 was the target for this metric.

What are the results?

We have made significant progress over the year with our medicines safety programme.

Roll out of ePMA

The roll out of ePMA has continued to include all inpatient wards, Lascelles and, most recently, Trinity ward at Ripon Community Hospital, and the Sir Robert Ogden Macmillan Centre. Other areas now using the system include Radiology and the Heart Centre with plans for the Emergency Department and Outpatient Department to use the system in the future. ePMA has made a significant improvement in the safe use of medicines across the Trust.

The interface with the discharge letter created in ICE, our requesting and reporting software system has been tested and should be in use by May 2015. A version with parenteral fluid administration functionality is now expected in late 2015/16.

Ward Based Teams

Ward-based pharmacy teams are now in place on Bolton and Fountains, Littondale and Nidderdale, Byland and Jervaulx, Wensleydale, Harlow and Farndale Wards. The remaining areas should all be included by the end of the summer 2015. The average dispensing

turnaround time for a “to take out (TTO)” medicine is 18 minutes with the majority of TTOs (over 70%) being fulfilled at ward level (i.e. not having to leave the ward to go to pharmacy).

Summary Care Record Implementation

All relevant staff now have full access to patient summary care records, which has moved our medicines reconciliation rates within 24 hours to 80%.

Medicines Management Training for Nurses

Medicines management training for nurses has been in place for 3 years and continues to be updated to reflect changes to the management of medicines in the Trust, receiving positive feedback from nurses on improving their understanding of medicines use.

Metrics from Patient Safety Dashboard

Results from the data collected demonstrate improvement against a number of the metrics. Information provision to patients and the perception of patients receiving relevant information about their medicines has improved (see the results of 3 out of the 4 national inpatient survey questions). Further improvement in the explanation given to patients about the purpose of their medication and how to take it, has recently been reported in the 2014 national inpatient survey and a short summary of the key results is included in section 3.3.1.

National Inpatient Survey	% of patients		Improvement
	2012	2013	
Question 1: Not fully told purpose of medicines	22	17	Yes
Question 2: Not fully told side effects of medicines	58	57	Yes
Question 3: Not told how to take medication clearly	21	19	Yes
Question 4: Not given completely clear written/printed information about medicines	22	23	No

Table 1: National inpatient survey results of medicines questions

This has been achieved by increasing the time that pharmacists spend explaining medicines information to patients, as demonstrated below by the results of a local audit.

	2012/13		2013/14	
Information given to patients	**Number of patients**	**Number per hour of pharmacist activity**	**Number of patients**	**Number per hour of pharmacist activity**
7 day period	261	0.91	342	2.1

Table 2: Local audit results showing the increased time pharmacists spend explaining medicines to patients

There has been an improvement in the number and rate of prescribing errors, as illustrated in the table below. Administration errors have increased slightly compared to last year. There has been a particular spike in reported administration errors since October 2014. Following review, this appears to be related to increase reporting of insulin errors, and an increase in reported infusion related errors. The monthly average prior to this was 5.2, significantly lower than the average for 2013/14. Further work is being undertaken to address these issues.

Incident reports	2013/14		2014/15		Improvement
	Number	Average	Number	Average	

		/month		/month (Apr-Jan)	
Prescribing errors	55	4.6	42	4.2	Yes
Prescribing error rate*	1.21		1.01		
Administration errors	88	7.3	89	8.9	No
Administration error rate*	1.94		2.15		
Missed Doses	**Number**	**Average /ward/day**	**Number**	**Average /ward/day**	**Improvement**
Direct audit (5 day period)	74	0.74	33	1.3	Uncertain

Table 3: Local data of prescribing and administration errors and missed doses of medicines
**Rate = errors per 1000 finished consultant episodes*

It has not yet been possible to extract data from ePMA to measure either the number of missed doses of medicines recorded on the system or the time to action clinical alerts. A dashboard for ePMA reporting is currently being developed and will deliver the required data in the future.

The data collected for missed doses has been undertaken manually and an increase compared to 2013/14 may reflect a change in data collection methodology. A further manual data collection will be undertaken for missed doses and clinical alert reviews.

Our dispensing errors continue to be well below the regional average and some of the lowest across the Yorkshire and Humber region. HDFT data is 16/100,000 dispensed items (range 8/100,000 dispensed items to 45/100,000 items) with only two trusts showing lower rates.

Summary

This work has built on last year's quality improvements relating to medicines optimisation. This has been facilitated through roll out of ePMA, access to the patient summary care record, pharmacy activity at ward level, reviewing and acting on trends in medicines administration, dispensing and prescribing errors and medicines management teaching and training.

Whilst we have seen tangible improvements in the way we safely use medicines, there are further quality priorities that will be taken into the following year. These are developed under a set of medicines optimisation principles:

- Providing high quality and timely information to patients relating to their medicines;
- A focus on the safe prescribing, dispensing and administration of medicines;
- Optimisation of medicines supply for our patients;
- Learning and sharing best practice and supporting our workforce to optimise medicines use;
- Ensuring value for money in the purchase and use of medicines.

Specifically we intend to:

- Extend functionality of the ePMA system into prescribing complex infusions and to implement for outpatients in 2016/17;
- Develop and implement the ePMA dashboard to target interventions to patients on high risk medicines;
- Complete of the roll out of ward based teams;
- Increase the recycling of medicines to minimise waste;

- Continue the focus on safe, prescribing, dispensing and administration of medicines.

An appropriate set of metrics is currently under development.

2. Nurse Staffing Information

Introduction

At HDFT the links between appropriate nurse staffing levels and safe, high quality care is well understood. It is a long established practice within the Trust to pro-actively plan and review nurse staffing levels on a daily basis.

Since May 2014 all hospitals have been required to publish monthly information about the number of nursing and midwifery staff working on each ward. This initiative is part of the NHS response to the Francis Report, the inquiry into Mid Staffordshire NHS Foundation Trust, which called for greater openness and transparency in the health service.

The "Hard Truths" guidance issued to Trusts by NHS England and the Care Quality Commission regarding publishing staffing data (March 2014) set out specific requirements regarding the transparency of nurse staffing information. Several recommendations were to be implemented in the first phase which focused on all inpatient areas; including acute, community (we read this to mean community hospitals), mental health, maternity and learning disability units.

The commitments were to publish staffing data from June 2014 in the following ways:

- Information about the actual numbers of nurses, midwives and care staff deployed for each shift compared with what had been planned to be displayed at ward level;
- A report containing details of planned and actual staffing on a shift by-shift basis at ward level to be presented to the Board of Directors every month;
- The report to be published on the Trust's website, and on the NHS Choices website;
- A report describing the staffing capacity and capability, following an establishment review, using evidence based tools where possible to be presented to the Board of Directors every six months.

What were we aiming to achieve?

The aim of this priority was to improve the transparency of information in relation to actual and planned nursing and midwifery staffing levels and specifically to:

- Closely monitor actual versus planned staffing levels on a daily basis and escalate and respond to concerns;
- Scrutinise monthly data by ward and identify any areas of specific concern.

What have we done?

A multi-disciplinary task and finish group was convened to oversee the implementation of the first wave of the "Hard Truth's" guidance with regard to the publishing and reporting of staffing data by the end of June 2014, and good progress has been made:

- Actual versus planed staffing is now displayed in all in patient ward areas and updated on a shift by shift basis;

- Data on actual staffing levels is gathered by Ward Sisters and Charge Nurses onto an online data collection system. Information on the number of registered nurses and midwives, and care support staff working on each shift is recorded, along with commentary to explain any variations;
- A report is produced on a monthly basis which includes a breakdown of the figures by ward comparing actual versus planned registered nurses/midwives and care staff for daytime and night time shifts;
- Data is submitted to NHS England and displayed on the NHS Choices website and the Trust website;
- A nursing workforce update report for the adult inpatient wards was presented to the Board of Directors in May and November 2014.

What are the results?

The table below summarises the average HDFT fill rate since May 2014. The fill rate is calculated by comparing planned staffing hours and actual staffing achieved.

Month	Day		Night	
	Average fill rate - registered nurses/midwives	**Average fill rate - care staff**	**Average fill rate - registered nurses/midwives**	**Average fill rate - care staff**
Apr-14	Not available - data collection started in May-14			
May-14	103%	107%	102%	115%
Jun-14	100%	105%	100%	107%
Jul-14	99%	103%	100%	111%
Aug-14	95%	103%	98%	108%
Sept -14	96%	106%	98%	113%
Oct -14	99%	107%	101%	112%
Nov-14	101%	105%	100%	110%
Dec -14	104%	102%	104%	109%
Jan -15	103%	104%	103%	117%
Feb 15	102%	107%	103%	115%

Table 4: Local data for the fill rate for registered nursing staff and care support workers 2014/15

Summary

Whilst the initial aims of this priority have been achieved, some further actions are required:

- Ward staffing boards need to continue to be updated on a shift by shift basis, and this will be monitored through matrons' daily ward rounds;
- We would like to be able to extract data directly from the Trust's payroll and rostering system, Rosterpro;

- The 6 monthly nursing workforce report is to be expanded to include maternity and paediatric inpatient areas;
- Existing data needs to continue to be utilised, together with acuity dependency studies, key quality and performance indicators, professional judgement and relevant national guidance to inform future decisions regarding nurse staffing. Patient acuity refers to the patient's medical condition, with a higher acuity indicating a more serious medical condition or likelihood of deterioration. Patient dependency reflects other factors such as their condition, mobility and mental capacity.

3. Sepsis Management

Introduction

Sepsis is one of the biggest causes of death in hospital patients. In its severe form, up to 40% of patients do not survive. We know that with optimal management, this can be reduced to around 25%.

What were we aiming to achieve?

To achieve this reduction in death rates, it is essential that early diagnosis and prompt aggressive management are carried out. By setting systems in place to aid this, we are aiming to achieve the reduction in mortality as described above.

What have we done?

A major part of this work has been to educate doctors and nurses. Sepsis itself is not a diagnosis, but a marker of the severity of other common conditions such as pneumonia, urine infections, skin infections and appendicitis. We have run education events to ensure that staff know when a patient with one of these conditions is developing severe sepsis. The Critical Care Outreach Team have been particularly helpful in recognising and treating severe sepsis early, and educating ward staff as to its importance.

For a number of years, we have had a care pathway which guides teams through the early management of such patients and ensures that the correct treatment is given in a timely fashion. This use of an evidenced based "septic bundle" has now been extended from the adult inpatient wards and the Emergency Department to paediatric and maternity areas.

What are the results?

For all patients admitted to the Intensive Care Unit with severe sepsis, 78.6% survived, which is a better survival rate than achieved by many international centres.

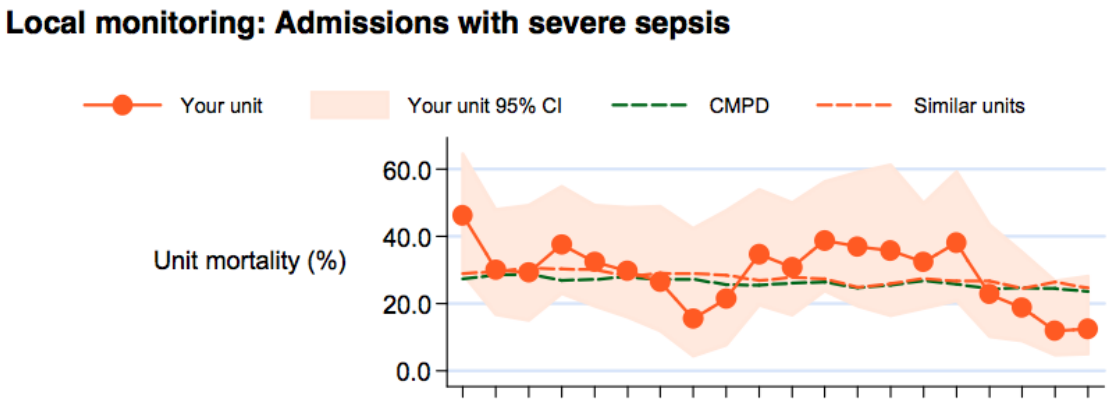


Figure 1: Graph showing the mortality of intensive care patients who have been diagnosed with severe sepsis from the latest ICNARC report (Jan-June2014). The time frame for the graph runs from 2009 to 2014.

Summary

We continue to make good progress in this field. However there are still areas to improve in the forthcoming years. The increasing use of electronic systems will enable earlier and more accurate diagnosis, which should improve our outcomes even further.

3.1.2. Patient Experience

1. High Quality and Safe Discharge

Introduction

Discharge has been a priority identified in the Trust's last four Quality Accounts but continues to be an important area for quality improvement. During 2014/15 the Discharge Improvement Steering Group has reflected on previous work and set about delivering a more patient-focused set of aims.

Discharging patients to the correct location in an efficient and safe manner is a critical part of providing high quality care. Ensuring robust processes to meet this need is particularly important given the increasing number of complex discharges, and also to enable people at end of life to be discharged much more quickly to their chosen destination.

What were we aiming to achieve?

The Discharge Improvement Steering Group's action plan focused on a number of areas, including:

a. Wider engagement with stakeholders;
b. Improving the effectiveness of electronic discharge letters;
c. Removing delays on the day of discharge, including improving patient transport arrangements;
d. Accelerating the development of a Frailty Unit.

What have we done?

a. Wider engagement with stakeholders

An event in June 2014 brought HDFT staff together with stakeholders to examine, discuss and improve our plans for improving discharge. It was also a chance for partners to hear directly from clinical staff about the challenges faced by clinicians with regard to safe and timely discharge. With support from patients and carers, GPs, Clinical Commissioning Group colleagues, local authority Social Services providers, care home providers and voluntary and community sector colleagues, our plans for improving discharge this year have been shaped by our stakeholders.

The main outcome of the event was the way in which it focused the priorities of the Improving Discharge Steering Group for the remainder of 2014/15. It also identified the potential role of the voluntary and community sector in supporting the return of confused patients (including people with dementia) to their normal place of residence. This issue has been taken forward by the Care of Confused Patients (including people with dementia) Group, particularly in relation to the development of activity volunteers in pilot wards.

b. Electronic Discharge Letters

Electronic discharge letters have been in place for all inpatient wards for some time and facilitate more effective communication with the patient's GP by ensuring legibility, and promoting consistent content. Whilst they are generally well-received by GPs, it was clear that further improvements would be helpful.

Consequently, this year we have merged all additional discharge letters or forms used into the ICE discharge letter. These combined medical, nursing and therapy templates have been used, very successfully, for all adult inpatient discharge letters since January 2015. We now have one clear and comprehensive letter, rather than multiple forms. Informal feedback from GPs has been positive.

In addition to the clinical information previously completed, the templates now contain:

- All elements previously in the handwritten nursing discharge letter. This includes details of the patient's ongoing needs, follow up and care;
- A section at the start of the letter to highlight important information or to indicate that the letter has been updated since originally sent, and has an addendum which should be read;
- A section to indicate whether the patient had an ITU or HDU stay during their admission;
- Two information sections to be completed for patients at end of life;
- Detailed sections relating to a patient's functional ability on discharge;
- Two sections to be used for Heart Failure patients to clarify the management plan;
- A section for alcohol, smoking and/or other substance use.

All of these sections are non-mandatory, and if they are not required then they do not appear on the completed letter.

The improvements have established a more coherent view of nursing, medical, therapy and end of life discharge information. Results have included a more consistent electronic approach and clearer instructions to GPs with anticipated improvements in patient safety.

c. Removing delays on the day of discharge

Earlier in 2014, there was a renewed focus on removing delays which occur on the day of discharge.

Since then, work has targeted discharge planning and the visual management of discharge on the elderly care wards. Therapy leads have been identified to lead the task synchronisation work, and staff on Bolton Ward have been working on improving the process surrounding medications that patients take home with them. There has been a review of the location of the Discharge Lounge, and further work to improve the use of this facility.

A rapid process improvement workshop on patient transport has been undertaken, which facilitated the development of a patient leaflet about the discharge process to be provided when a person is nearing medical fitness for discharge. Participants also designed a visual prompt of the discharge date which will be placed on a person's bed. A discharge checklist which serves as a prompt for ward nursing staff has been produced and a prioritisation sheet for the writing of take-out (TTO) medication prescriptions for doctors. This initial project focused on two inpatient ward areas and although it is too early to have clear evidence of the results of these changes, to date positive feedback has been received about some of the initiatives and the plan is to further extend their use to other adult in patient ward areas as applicable.

d. Accelerating the development of a Frailty Unit.

The development of a Frailty Unit on Jervaulx and Byland Wards has included a focus on encouraging social interaction and independence, and to enable the activities of daily living and to prepare for discharge. This is further reported in the section on dementia.

Summary

There has been significant progress with electronic discharge letters in the last year and we are consistently discharging over 90% patients with an electronic discharge summary. This results in an improvement in the readability of the discharge information that the patient receives, as well as an improvement in the content and timeliness of discharge information for GPs.

We continue to make changes to discharge processes to improve our patients' experience of discharge. This is resulting in some success but the work is by no means complete. Discharge will be a significant part of all of the quality priorities for 2015/16.

2. Friends & Family Test

Introduction

The Friends and Family Test (FFT) for patients was implemented across the NHS during 2013. The FFT aims to ask a simple question of patients using services which, when combined with follow up questions, provides a standardised mechanism to identify both good and bad performance and can be used to drive improvements in quality of care.

What were we aiming to achieve?

The Trust implemented the FFT in April 2013 for inpatients and the Emergency Department, and in October 2013 for Maternity Services and we reported on this in our 2013/14 Quality Account.

The aim of the work during 2014/15 was to extend implementation of the FFT to other services according the national timetable, and to ensure that the Trust is making best use of the feedback from the Friends and Family Test (FFT) and other systems of patient/client feedback. We wanted to ensure that:

- Patient feedback is encouraged;
- The FFT score is monitored;
- Results are used effectively to make improvements as a result of staff understanding of patient experience;
- There is effective and timely action in response to negative feedback;
- There is a process for reviewing FFT trends with other patient and client feedback.

What have we done?

During 2014//15 we have extended the FFT to patients who use our Outpatient Department, Day Surgery Unit, and many of our community services. We have used a telephone messaging service with a defined script which enables patients and clients to register their response and leave a verbal comment if they wish to describe their experience.

We continue to use a combination of paper questionnaires collected by our volunteers and telephone follow up after discharge, for inpatients and patients using our Maternity Services. The token system previously used in the Emergency Department is being phased out and replaced with the telephone messaging service.

The latest results and the FFT dashboard are circulated to managers, directorate governance leads, and operational directors on a weekly basis. The results are reported to the Board of Directors every month.

Directorate governance leads are expected to review FFT results and comments, identify any themes that need addressing and ensure action is taken to address these themes and any specific concerns. Each directorate now provides a quarterly update to the Quality of Experience Group in order that FFT results can be triangulated with other patient feedback reported by the Patient Experience Team, and in order to provide assurance that feedback has been used effectively.

What are the results?

Hospital based services

The table below summarises HDFT's latest results for the hospital based services that form part of the current national reporting requirements.

Hospital Service	Percentage of patients who would recommend / would not recommend the service to friends and family			
	February 2015		March 2015	
	HDFT	National average	HDFT	National average
Inpatients	96% / 1%	95% / 2%	94% / 2%	95% / 2%
Emergency Department	90% / 2%	88% / 6%	83% / 4%	87% / 6%
Maternity - Antenatal	98% / 0%	95% / 1%	98% / 0%	95% / 0%
Maternity - Birth	100% / 0%	97% / 1%	99% / 1%	97% / 1%
Maternity - Postnatal ward	99% / 0%	93% / 2%	98% / 2%	93% / 2%
Maternity - Postnatal community	100% / 0%	98% / 1%	100% / 0%	98% / 1%

Table 5: FFT data for hospital based services comparing HDFT and national average

HDFT achieved all required response rate targets for FFT for 2014/15.

The results for ward attenders, day case attenders and outpatients for Q4 2014/15 are shown in the table below. Trusts are required to start to submit FFT data for these services to NHS England from April 2015.

	Ward attenders	Day cases	Outpatients	Total
Number of responses	80	931	6956	7967
Response rate	11%	27%	22%	22%
% recommend	98%	96%	95%	95%
% not recommend	1%	1%	1%	1%

Table 6: FFT results for HDFT ward attenders, day cases and outpatients Q4 2014/15

Community Services

From January 2015 the FFT has been expanded to include patients seen in the community by our inpatient services on Trinity Ward at Ripon Community Hospital, nursing services, rehabilitation & therapy services, and specialist services.

During March 2015, the combined community FFT response rate for HDFT services currently participating in FFT was 7.4%. The results for each area are as follows:

Community Service	Percentage of patients who would recommend / would not recommend the service to friends and family			
	February 2015		March 2015	
	HDFT	National average	HDFT	National average
Inpatients	100% / 0%	97% / 1%	100% / 0%	95% / 1%
Nursing	100% / 0%	94% / 1%	100% / 0%	94% / 1%
Rehabilitation and therapy	93% / 2%	95% / 1%	94% / 2%	95% / 2%
Specialist	No data	96% / 1%	86% / 14%	97% / 1%
Children and Family		94% / 1%	82% / 10%	95% / 1%
Community Healthcare Other		96% / 2%	93% / 2%	96% / 2%

Table 7: FFT data for community services comparing HDFT and national average

Further work will be done during 2015/16 to continue to expand FFT across our community services.

Examples of changes made as a result of FFT feedback:

- "The most significant change made as a result of the friends and family results feedback was that it strengthened the case for redecoration of 4 podiatry clinic rooms, waiting room and entrances to Springhill House, Scarborough (funded and work completed by Scarborough Hospital). This has greatly improved the patient experience and has been commented on regularly about how clean and fresh these rooms now look". Podiatry Team Lead - Scarborough, Whitby and Ryedale.

- "Patients were unclear about the staff role and responsibilities. We have ensured everyone has name badges, developed a photo board with staff names and roles, and put up an individual white board in each bay detailing the name and designation of the nursing staff caring for patients." Ward manager Granby Ward.

- "Patients commented that noise levels were quite high. We checked all doors on the ward and reported to the Estates Department doors which were banging loudly, and reminded staff about the importance of a quiet environment even on a busy ward." Ward manager Granby Ward.

- "We analysed the friends and family feedback and made a staff awards board. Many of the comments from the patients or their carers/relatives included staff names that patients felt had gone above and beyond their expected duties in caring for patients. We wanted to provide a display that included the names of staff and why they had done so well in being named in the feedback. This could be seen by all visitors, patients and other staff members on the ward." Ward manager Farndale Ward.

Summary

The Trust has successfully implemented the FFT as required to date. The response rate and scores for inpatients have been very positive during the year, although the response rate fell considerably during the winter months. The results for the Emergency Department have generally been positive but the response rate does not compare very favourably against

national results. Telephone contacts have been implemented during January 2015 and are expected to improve this. Maternity services have achieved very positive scores compared to the national benchmark.
The first data for outpatients, ward attenders and day surgery attenders is now available with over 3,900 patients providing an FFT response during Q3 with an overall response rate of 30.9%. It is significant that the response rate for ward attenders was much lower at 18.1%, and only 85.7% of patients would recommend the service to friends and family. We are putting processes in place to improve the service for ward attending patients.

Quantitative and qualitative data is considered within the directorates, to identify and ensure appropriate actions are taken and this is reported to the Quality of Experience Group quarterly to triangulate with other patient experience feedback.

However there is more work to be done. The use of patient feedback should be strengthened during 2015/16 with a new group leading the work across the organisation to ensure learning from patient experience.

3. Food for Staff & Patients

Introduction

Malnutrition is a significant problem in UK hospitals. Good nutritional support is an essential part of care.

- Disease related malnutrition cost the NHS £13 billion in 2007
- 25 – 34% patients are malnourished on admission to hospital
- Appropriate nutritional support can reduce length of hospital stay by 2 days and reduce readmissions by 28%.

The majority of hospitalised patients need more calories and protein each day when ill than they need when they are fit and well, despite the fact that they may be lying in bed all day. For example, a healthy 10 stone lady requires approximately 1650 calories and 67g protein per day. However, if she was then admitted to hospital for abdominal surgery and became septic post operatively, her requirements would be increased to 2100 calories and 80g protein per day. This increase in her requirements is equivalent to her needing to eat an extra full meal and snack per day – very difficult to achieve when she is likely to feel nauseous and have a poor appetite. Patients with a poor appetite should be encouraged to take more nourishing fluids, as they will also provide calories and protein.

What were we aiming to achieve?

The Trust wanted to continue to prioritise food for patients and aimed to achieve a Bronze Award Catering Mark with the Food for Life Soil Association that provides an independent endorsement that the food we provide is fresh, trustworthy and traceable and free from harmful additives and trans fats. In addition we aimed to continue to improve our food service to patients, staff and visitors.

What have we done?

At Harrogate District Hospital we prepare, cook and serve 503,700 meals per year to patients, staff and visitors, using locally sourced food. Patients can choose from eight different menus including: main patient menu, Halal, Kosher, Gluten free and textured food for patients with swallowing difficulties. Food is also transported to Ripon Community Hospital and Lascelles at lunchtime with the same patient choices available.

There is 24 hour patient access to food, with snacks and microwave meals available for patients who miss a meal. In addition, all wards at Harrogate District Hospital receive a homemade cake every day, produced on site in the hospital kitchen. The cake is served as a high calorie between meal snack, allowing patients to have 'afternoon tea' or a supper snack.

The Catering Department supported the National Nutritional and Hydration Week with an information stand in the main entrance to the Hospital, an HDFT meal production photo storyboard that included promotion of patient catering services and 24 hour food availability. The Chef also attended an afternoon tea party on Byland Ward where feedback from patients was excellent.

We have completed a management plan which works towards achieving the Bronze Award Catering Mark. We have completed an analysis of our patient and staff menus, with the Soil Association, providing copies of our standard recipes that show we are currently above the 75% requirement of food produced on site that meets the requirements for the Bronze Award.

What are the results?

We gather patient comments from a comments form on our menus that are returned to the department daily, and feedback from patients regarding food at HDFT is consistently excellent. For example for February 2015, at least 89% of patients who returned questionnaires (n=28) reported that they received the food they ordered, that it was hot, and that they had enough choice. The following are examples of patient feedback:

> "The catering is excellent thank you".

> "There is plenty of soft meals to choice from, also food cooked to high standard".

Following the submission of our management plan we will soon receive an assessment from an external verifier to confirm we have met all the standards for the Bronze Catering Mark. This will include a site visit and certification.

Summary

HDFT is proud of the quality of the food it provides to patients, staff and visitors, and is expecting to be able to demonstrate this soon with the Bronze Award Catering Mark.

3.1.3. Effective Care

1. End of Life Care

Introduction

The provision of compassionate care is critical for patients at the end of life. We have only one chance to get this right for an individual, and ensuring that their family and carers are supported is key to our success. Our patients may wish to be cared for in hospital, in their own home or in a variety of community settings, and we must work with our partner agencies to ensure the care they receive is of the highest quality wherever it is delivered.

What were we aiming to achieve?

Our aim is always to provide the best possible end of life care for our patients. This will be focused on the needs and wishes of the patient and we will work with them, their family and other agencies to provide this care wherever the patient choses to be at the end of their life. We strive to continually improve our service model and provide access to specialist support, through an empowered highly skilled team passionate about excellent end of life care.

We are ultimately looking to ensure that our patients who have reached the end of their life are supported to have a 'good death'. This can mean different things to different people, which makes it difficult to provide a single indicator of achievement.

End of life care has been a quality priority for the Trust for a number of years, and we have made significant improvements, empowering our clinical teams through training and specialist support. Our focus has been improving the understanding of the things that people need during the last few days of life; as we continue to strive for improvement we will expand our focus to the last year of life.

What have we done?

We have built on our successes from previous years and our partnership with Saint Michael's Hospice continues to positively influence the care that we provide. Excellent end of life care is often reliant on a combination of clinical skill and expertise to ensure that all of the patient's physical needs are met and communication skills are used to ensure that the patient's wishes are understood and acted upon, and each stage of the process is explained clearly. Our focus has consequently been on education and training across the Trust.

Senior Clinician Development Programme - Rethinking Priorities

This year five of our consultants have joined some GPs to undertake the Rethinking Priorities Programme. The 18 month programme supported by Health Education Yorkshire and the Humber is aimed at encouraging consultants and GPs to engage with end of life care issues, improve communication skills, undertake learning about end of life care, identify improvements within their own practice, share and spread learning to colleagues within their departments and generate service improvements.

District Nursing Development

Our Community Nursing Service is recognised in the area for the excellent end of life care that they deliver. To further develop the skills of this team we have delivered an extensive training programme for them, focusing on both the clinical skills required and the more holistic elements of delivering care and supporting patients their families and carers. This programme has been very well received by the teams. In addition the Specialist Palliative Care Teams are meeting regularly with community nurses at GP practices and where appropriate, are completing joint visits to patient's homes.

End of Life Conference

Extremely successful End of Life Conferences were held in September 2014 and February 2015, enabling professionals from across the health economy to come together to share ideas and learning. 79% of the 40 people who attended the first event evaluated it as excellent and the other 21% evaluated it as very good. A further series of conferences have been planned.

Care Plan for the Last Days of Life

In July 2014 the Liverpool Care Pathway was withdrawn nationally following significant negative press. As excellent end of life care is multi-faceted the Trust felt that it was important that we provided guidance to all of our clinicians to support them in delivering care at the end of life. In partnership with Saint Michael's Hospice and led by one of our palliative care consultants, a care plan for the last days of life has been developed, enabling a flexible patient centred approach to end of life care. General feedback from clinicians has been positive, and a formal evaluation will take place in the spring of 2015.

What are the results?

Providing a definitive quantitative measure of our provision of end of life care is difficult, and we continue to work on ways in which to define a 'good death' and monitor our progress in achieving this.

We regularly participate in the National Care of the Dying Audit and in the most recent survey reported in May 2014, the Trust performed well, with 8 of the 10 clinical key performance indicators better than the national average. In a relatives bereavement survey all of the respondents felt that they had been adequately supported in the last 2 days of the patient's life, and all would recommend the Trust to friends and family.

Such results are very encouraging, however we are not complacent and there are still lots of opportunities to improve the experience of our patients and their families at the end of their life.

Summary

We have continued to build on the progress that we have made in recent years, however we can always improve the critical part of the care we deliver and we intend to. During 2015/16 we will be launching our revised End of Life Strategy, providing us with a framework to develop our skills further. Shifting our focus to include supporting the needs of patients during their last year of life as well as the last days of life offers new opportunities to improve. We will continue to consider the question 'how do we measure a good death' and will participate in national surveys and benchmarking to understand if the things that have been introduced are effective.

2. Dementia Care

The Trust's strategic approach to the care of confused patients, including people with dementia, has continued to develop.

The Care of Confused Patients Steering Group meets bi-monthly and has access to subject experts for specialist issues. The aim of the steering group is to provide leadership and direction for the care of people with acute confusion, including dementia and delirium, and their families and/or carers to ensure they have a positive experience of high-quality, personalised care. This aim has been developed from a recognition that good quality care will be very similar for confused patients, regardless of their specific diagnosis.

A review of the existing dementia action plan has been undertaken and an approach proposed to simplify the planning process by maintaining a single corporate action plan with fewer priorities.

As well as delivering work to address local concerns and support national standards in this area, the group will also help the Trust to engage with the public to help educate people about the role HDFT has in treating confused patients who may be anxious and whose behaviour may be unpredictable.

A dementia care pathway has been developed and is currently being reviewed by the Area Prescribing Committee in view of the information contained detailing medications used in dementia and delirium. The care pathway will be launched in the near future and will be available on the Trust's intranet.

With the departure of the Trust's Older Persons' Champion in December 2014, some of the group's actions around the appointment of Dementia Champions on each ward and embedding the use of the Butterfly Scheme has lost some focus. However, there are several experienced staff on the Frailty Unit who are interested in taking up the role of Dementia Champions and rolling out best practice to all wards. Byland Ward, one of the wards on the Frailty Unit, is trialling having a prompt for the use of the All About Me form and the Butterfly Scheme at the multi-disciplinary team meetings.

Close working with the TEWV has continued to be of great value with access to the liaison service for hospital inpatients, as well as supporting educational and learning opportunities for HDFT staff.

National CQUIN for dementia

Elements of the identification and management of people with dementia are defined by national CQUIN (commissioning for quality and innovation) indicators.

a) Find, assess, investigate and refer

The table below shows performance during 2014/15. All domains show performance above the target of 90%. Encouragingly, the figures show that everyone who is found to have dementia and is eligible for a full diagnostic assessment and subsequent specialist referral receives this assessment and referral.

Performance Indicator Description	Q1	Q2	Q3	Q4
Dementia screening - % eligible patients screened within 72 hours of admission (find relevant patients)	94%	96%	95%	95%
Dementia screening - % eligible patients having a full diagnostic assessment for dementia (assess and investigate)	100%	100%	100%	100%
Dementia screening - % eligible patients referred on for specialist assessment (refer)	100%	100%	100%	100%

Table 8: Local data for the national CQUIN for dementia 2014/15

b) Clinical leadership and training for staff

We have an established and experienced Consultant in Elderly Medicine providing clinical leadership for older people and dementia. The clinical lead is an active participant in the Leeds-based Acute Dementia Care Champions Network, and has built contact with colleagues at Sheffield Teaching Hospitals NHS Foundation Trust to examine the advantages of "train the trainer" packages for clinicians, and has participated in the University of York's neurology research network.

An initial training plan for dementia identified types and frequency of training that was suitable for different clinical and non-clinical staff and aimed to train around 200 people over the year, focusing on those who are likely to come into close contact with people with dementia. However this target was far exceeded when the Trust agreed to increase its requirements for dementia training. A policy change was made to mandate dementia awareness training for 1,727 staff in the year from December 2014 and tier one training for 1,836 staff in the same twelve month period. Substantial progress against the increased targets has been made:

- 721 members of staff have completed one hour, face-to-face dementia awareness training, which has been well-received with some colleagues expressing an interest in formally becoming "Dementia Friends" (42% of annual target after only three months);
- 1,181 members of staff have completed tier one e-learning (64% of annual target after three months);
- 37 members of staff have completed Butterfly Scheme training;
- Learning outcomes for tier two dementia training have not yet been agreed with Health Education Yorkshire and Humber but what is provisionally rated as tier two training (one day long) has been delivered to 155 members of staff;
- 12 junior doctors have been trained in dementia and delirium
- 60 third year medical students from the University of Leeds have had one hour dementia training during the period September 2014 to May 2015 during their Classroom to Clinic placement at HDFT.

c) Supporting carers of people with dementia

The Trust has been undertaking interviews of carers of people with dementia in order to understand their needs. Using interviews as opposed to asking relatives to complete a questionnaire provides more in depth and qualitative information and allows issues that are important to families to be highlighted and explored further. It also provides the opportunity to refer families to the ward manager or matron to follow up on any issues raised.

The interviews have identified areas for improvement and confirm the findings of some of the previous local and national audits. In particular, areas for improvement are:

- To improve communication with patients and carers about the Butterfly Scheme;
- To display the butterfly above the bed in order that all staff approach and communicate appropriately;
- To improve the signposting of patients and carers to organisations which can support people living with dementia;
- To improve the understanding of personal routines and preferences through the use of the All About Me form.

Alongside these areas for improvement, relatives and carers also made repeated positive comments about the quality of ward care the person with dementia received:

- 'The surgeons and doctors were superb. My husband was quickly taken to theatre for his operation. Care support workers were fabulous. But the nursing was very task focused … The nurses always seemed to be writing or inputting in the computer.'
- 'The ward was very good, can you please pass on my thanks.'

- ‘Really kind nurses and sisters who deserve a pat on the back.’
- ‘Very good help, excellent, can’t complain.’

There is an overall action plan monitored by the Care of Confused Patients Steering Group and the actions required from these results will be agreed, recorded and monitored through this group.

d) The further development of a Frailty Unit at Harrogate District Hospital

Short improvement interventions were held during February 2015 to build upon and continue to provide a therapeutic environment in the Frailty Unit, which comprises Jervaulx and Byland Wards. Actions were delivered to meet three objectives.

1. Ensuring a calm and secure environment
The aim was to reduce patients’ agitation and distress and to promote safety with a reduction in falls. Work has started on decluttering the visual environment to improve patient orientation. Noticeboards and signs have been rationalised and the Estates Department will be completing minor improvements, including the provision of suitable new artworks.

2. Ensuring access to and engagement with meaningful activities
Work has focused on encouraging social interaction and independence, and to enable the activities of daily living. Regular group exercise activities have been introduced for those patients well enough to join in, with leisure and craft activities now being offered to patients – including interaction with friendly dogs. Activity volunteers have also been introduced onto Byland Ward. Following dementia awareness training, the volunteers chat and read with patients, use memory and reminiscence aids, and play board games. More music is now being sung and played on the Frailty Unit.

Photo 1 and 2: Community Nursing Matron Lynn Boyd and patient with patient-friendly dogs!

3. Improving mealtimes to promote social interaction and good nutrition

Promotion of social interaction has involved piloting shared meal times with carers/relatives to help patients get back into the routines of daily living in readiness for discharge. This has

included a Valentine's Day Tea, which proved very popular. Patients are now being brought together to eat their meals with others where possible and a renewed effort has been made to help patients prepare for meal times with hand-washing and toilet visits as required. New equipment has also helped to improve an environment which supports patients to eat and drink more easily.

Early results indicate the provision of a safer environment which is more dementia-friendly, the further development of a rehabilitative culture in Jervaulx and Byland Wards and positive feedback from patients, relatives and carers.

Next steps

Challenges for the year ahead include sustaining momentum on ambitious dementia training targets, and tackling persistent difficult issues around:

- improving the personalisation of care for patients with dementia;
- increasing the appropriate use of the Butterfly Scheme;
- improving the way that patients and carers/ relatives of people with dementia are signposted to support services.

3. Stroke Care

Introduction

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).

What were we aiming to achieve?

By participating fully in national audits and local accreditation processes we wished to demonstrate good compliance with all stroke performance measures and have a fully accredited stroke service which compares favorably with other providers.

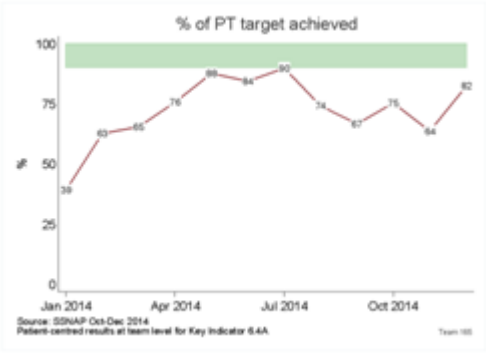
What have we done?

We have contributed data for all our stroke admissions to the Sentinel Stroke National Audit Programme (SSNAP) to allow quarterly reporting of performance, which is subsequently released into the public domain. We have participated in the Yorkshire and Humber Stroke Accreditation Process and the ongoing Peer Review for Stroke Services by the Yorkshire and Humber Strategic Clinical Network. For TIA performance we report monthly to the Clinical Commissioning Group on the management of high risk patients within 24 hours of presentation. Within the Trust this work is overseen by the Stroke Steering Group, chaired by an Executive Lead for Stroke and attended by clinicians, Yorkshire Ambulance Service, commissioners, voluntary agencies and patient representatives.

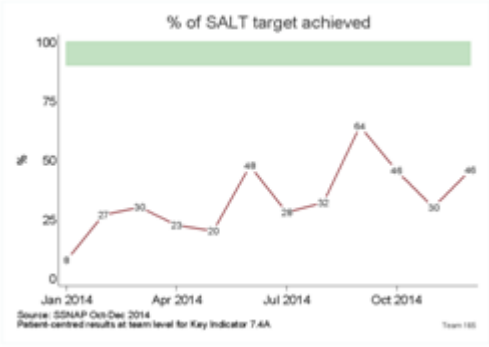
What are the results?

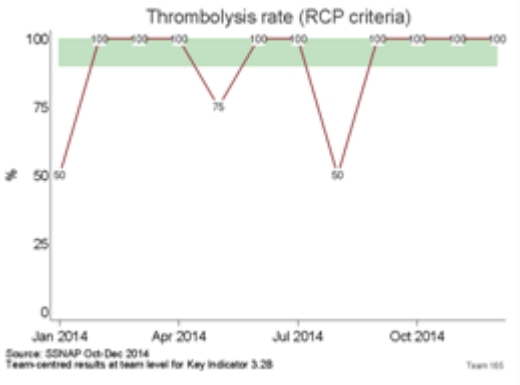
SSNAP results are presented in 10 domains covering 44 indicators looking at all aspects of stroke patients' care in hospital including arrival and diagnosis treatment and rehabilitation. Each participating Trust is given an overall SSNAP score (a banding from A to E, where A is best). Over 2014 there have been improvements in the proportions of patients achieving the

targets for physiotherapy, occupational therapy and speech and language therapy, as well as the proportion of patients treated with clot-busting drugs (see figures 2,3,4 and 5).



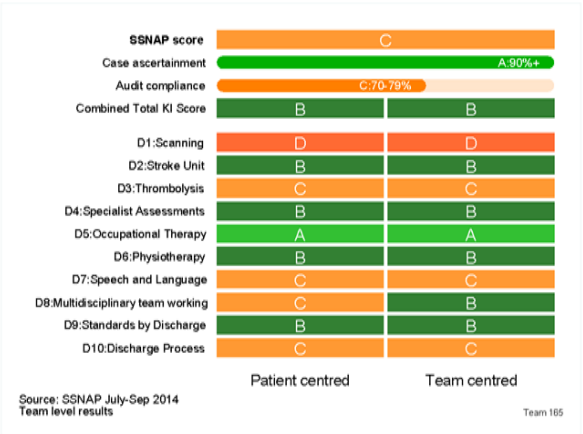
Figures 2 and 3: Percentage of physiotherapy (PT) and occupational therapy (OT) targets achieved at HDFT January–December 2014





Figures 4 and 5: Percentage of speech and language therapy (SALT) target achieved and thrombolysis rate at HDFT January–December 2014

Our overall Trust grade has fluctuated between C and D.



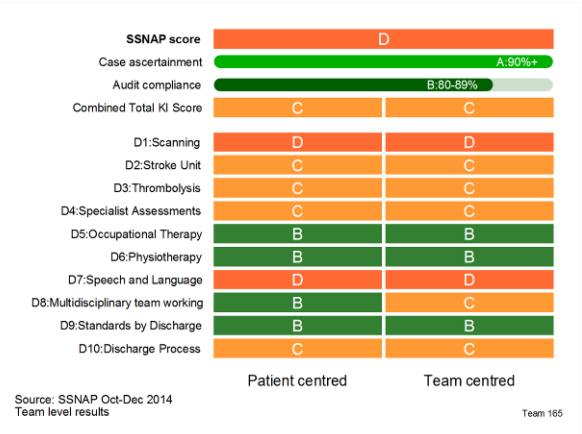


Figure 6 and 7: SSNAP scores for Q2 and Q3 2014/15

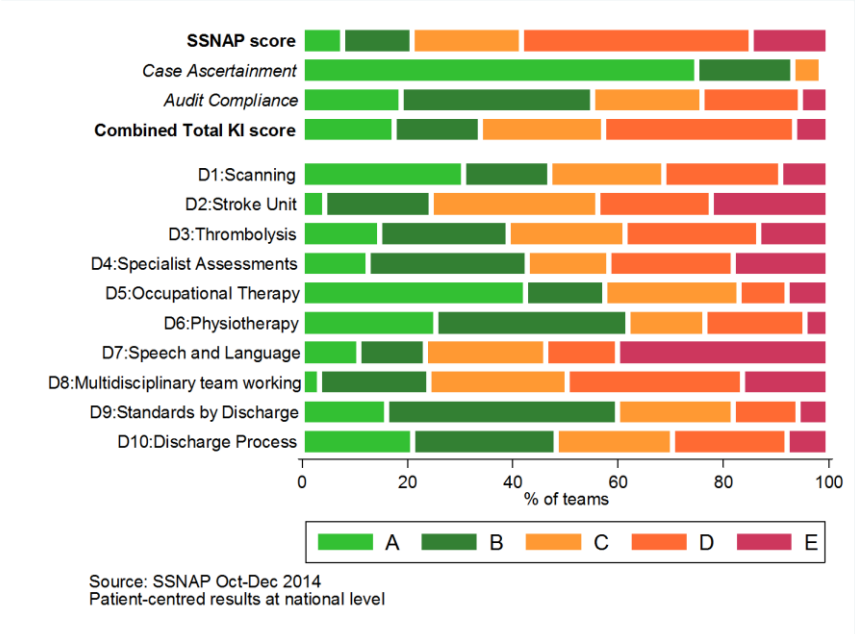


Figure 8: National distribution of SSNAP scores October – December 2014

No report is available at the time of writing regarding our last submission to the Peer Review process but we continue to have a stroke service accredited by the Yorkshire & Humber Stroke Services Accreditation panel. Indicators for high risk TIA performance have consistently been at the desired level for 2014 and into 2015 with more than 60% of referrals investigated and treated within 24 hours of first contact with health services.

Summary

We aimed to participate fully with all national and regional stroke performance monitoring and have achieved a high level patient data entry for SSNAP in 2014. This has allowed us to reflect on good quality performance data to look for areas of improvement in how we manage our patients after acute stroke. SSNAP is a continuous audit and it has taken time to embed it within our routines but it will continue to provide important information on the quality of our stroke care.

3.2. Performance against key national in the framework

The following table demonstrates HDFT's performance against the indicators in Monitor's Compliance and Risk Assessment Frameworks for each quarter in 2014/15.

Indicator description	Target	Q1	Q2	Q3	Q4
Referral to treatment (RTT) admitted pathways (% within 18 weeks)	>=90%	94.6%	94.2%	93.8%	93.7%
RTT non-admitted pathways (% within 18 weeks)	>=95%	97.2%	97.0%	97.1%	97.2%
RTT incomplete pathways (% within 18 weeks)	>=92%	97.5%	97.1%	97.1%	97.0%
A&E: Total time spent in A&E	>=95%	97.2%	97.8%	96.3%	96.3%
Cancer - Maximum waiting time or 14 days from urgent GP ref to date first seen for all urgent suspect cancer referrals (%)	>=93%	98.6%	98.2%	97.6%	96.3%
Cancer - maximum waiting time of 14 days for symptomatic breast patients (cancer not initially suspected)	>=93%	97.4%	96.0%	96.1%	96.6%
Cancer - 31 day wait for second or subsequent treatment: Surgery	>=94%	100.0%	97.4%	100.0%	96.3%
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	>=98%	100.0%	100.0%	100.0%	100.0%
Cancer - 31 day wait for second or subsequent treatment: Radiotherapy	>=94%	NA	NA	NA	NA
Cancer - Maximum waiting time of 31 days from diagnosis to treatment for all cancers (%)	>=96%	100.0%	100.0%	100.0%	100.0%
Cancer - 62 day wait for first treatment from urgent GP ref to treatment: all cancers	>=85%	93.8%	90.9%	89.8%	89.5%
Cancer - 62 day wait for first treatment from consultant screening service referral: all cancers	>=90%	100.0%	100.0%	88.9%	100.0%
C-difficile	<=15 cases in year	3	3	2	1
Community services data completeness - RTT information	>=50%	79.9%	80.2%	80.9%	80.6%
Community services data completeness - Referral information	>=50%	71.0%	71.8%	71.2%	71.0%
Community services data completeness - Treatment activity information	>=50%	85.6%	83.4%	82.2%	81.7%

Table 9: HDFT performance against indicators in Monitor Compliance and Risk Assessment Frameworks 2014/15

HDFT has now demonstrated compliance with requirements regarding access to healthcare for patients with learning disabilities. This means that HDFT's Risk Assessment Framework Governance rating for 2014/15 was Green.

Provisional data indicates that the Trust achieved all seven applicable cancer waiting times standards for Quarter 4, meaning that the Trust achieved all cancer waiting times standards for each quarter of 2014/15.

Performance at Harrogate Emergency Department (ED) was above the 95% in standard in March 2015, with 96.3% of patients spending less than 4 hours in the department but below the standard (94.9%) for Quarter 4 overall. However the combined performance for the Trust (including the two Minor Injury Units) was above the expected standard for each quarter of 2014/15.

There have been no ambulance handover delays of more than 60 minutes in 2014/15. There were 78 ambulance handover delays of more than 30 minutes at Harrogate ED in 2014/15

which compares to 116 for the previous financial year. ED attendances are 1.5% higher than for the same period last year. The Trust reviews all delays in ambulance handover and the reasons for these which generally relate to space and extreme peaks of activity. We liaise with the ambulance service to ensure delays are minimised.

Activity levels at HDFT for outpatients and elective admissions have increased in 2014/15 compared to the previous year. Elective admissions were 9.5% higher than in 2013/14, and of these, there was a 20.1% increase in activity from Leeds. The relatively small increase in follow-up appointments (2.4%) indicates an improvement in follow-up ratios in view of a 4.7% increase in new appointments.

In 2014/15 there has been a 12% increase in community nursing activity for the period October to March when compared to the same period last year.

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 achieved for March and for Quarter 4. Delivery of the TIA standard for the month of March was at 69.2% against the 60% national standard. Both standards were delivered for each quarter of 2014/15.

HDFT achieved all 18 week standards throughout 2014/15.

No cases of hospital acquired MRSA were reported in 2014/15. There were nine cases of hospital acquired C-difficile reported during 2014/15 meaning that the Trust has achieved its annual trajectory of remaining below 15 cases. NHS England have now published the C-difficile trajectories for 2015/16; HDFT's annual trajectory for 2015/16 is 12 cases.

3.3. Other quality information

HDFT has identified additional elements of service quality to highlight in this Quality Account.

3.3.1. National Inpatient Survey 2014

The National Adult Inpatient Survey 2014 for each trust was published by the Care Quality Commission on 21st May 2015. Once the full dataset is available, we will be able to compare our performance against other trusts.

Overall HDFT performed very well, scoring "significantly better than average" for 7 out of 59 questions (compared to 6 out of 60 last year), including 4 questions from the "leaving hospital" section.

For the fourth consecutive year, HDFT had no questions rated "significantly worse than average". 461 patients treated at HDFT responded in the survey this year, a local response rate of 56% which is the same as last year.

The table below provides a summary of HDFT's scores in each section of the survey, comparing this year's scores with last year. The following 7 questions are ranked "significantly better than average" in 2014:

- Q6 - How do you feel about the length of time you were on the waiting list before your admission to hospital?
- Q9 - From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?
- Q21 - How would you rate the hospital food?

- Q55 - Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?
- Q56 - Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?
- Q58 - Were you told how to take your medication in a way you could understand?
- Q63 - Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Questions 9, 56, 58 and 63 were not ranked "significantly better than average" in 2013 so have shown an improvement since last year.

Section	Number of questions in 2014	HDFT score compared to the national average in 2014			Number of questions in 2013	HDFT score compared to the national average in 2013		
		Significantly worse	About the same	Significantly better		Significantly worse	About the same	Significantly better
Emergency Department/ A&E	2	0	2	0	2	0	2	0
Waiting list and planned admissions	3	0	2	1	3	0	1	2
Waiting to get to a bed on a ward	1	0	0	1	1	0	1	0
The hospital and ward	11	0	10	1	11	0	9	2
Doctors	3	0	3	0	3	0	3	0
Nurses	4	0	4	0	4	0	4	0
Care and treatment	10	0	10	0	9	0	9	0
Operations and procedures	6	0	6	0	6	0	5	1
Leaving hospital	15	0	11	4	17	0	16	1
Overall	4	0	4	0	4	0	4	0
Total	**59**	**0**	**52**	**7**	**60**	**0**	**54**	**6**

Figure 9: Comparison of results of National Inpatient Survey 2014 and 2013

3.3.2. National Staff Survey 2014

Every autumn the Trust participates in the NHS annual staff survey. The results are published nationally and can be obtained from the national NHS staff survey web site.

In 2013 HDFT was in the best 20% of acute trusts in the country for 13 key findings which represented 46% of the total key findings. In 2014 HDFT achieved 10 key findings in the best 20% of acute trusts, which represented 34%. There were no key findings that fell into the bottom 20% of acute trusts for the Trust this year compared to one last year.

The following six key findings have placed the Trust in the 'best 20%' for the past two consecutive years:

- Staff suffering work-related stress in last 12 months (low score);
- Staff witnessing potentially harmful errors, near misses or incidents in last 12 months (low score);

- Staff experiencing physical violence from patients, relatives or the public (low score)
- Staff motivation at work.
- Staff believing the Trust provides equal opportunities for career progression or promotion;
- Staff experiencing discrimination at work in last 12 months (low score);

Overall Staff Engagement

For comparative purposes the table below demonstrates the Trust performance in relation to overall staff engagement. Overall staff engagement comprises three key findings: staff members' perceived ability to contribute to improvements at work; their willingness to recommend the Trust as a place to work or receive treatment and the extent to which they feel motivated and engaged with their work.

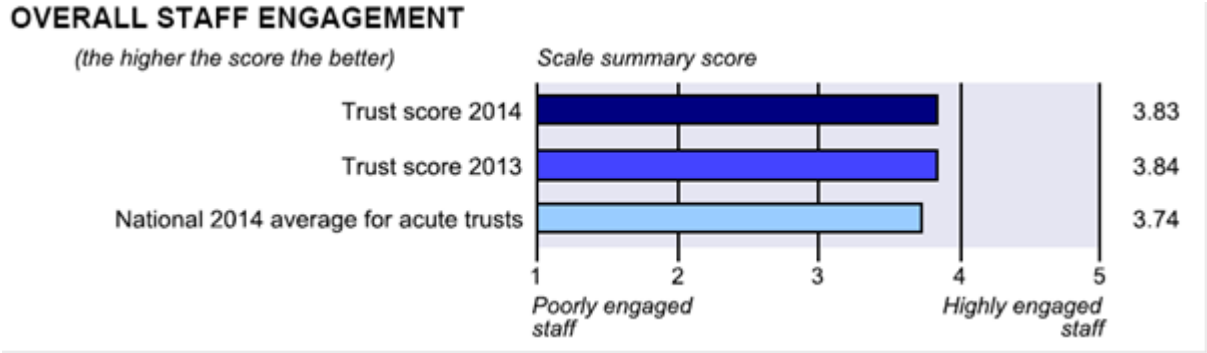


Figure 10: Staff engagement score from national staff survey 2013 and 2014 for HDFT

The Trust consistently maintains its place in the top 20% nationally for acute Trusts for 'overall staff engagement'.

2014 saw the introduction of the NHS Staff Friends and Family Test. Every quarter, every member of staff was invited to take part and answer the question: *How likely are you to recommend the Trust to friends and family as a place to work?*

The last quarter of 2014/15 showed 74% of staff would recommend the Trust as a place to work. This was an increase compared to the first quarter of the financial year which showed 70% of staff would recommend the Trust as a place to work. 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 and are a key engagement tool.

Whilst these are excellent results; we strive for continuous improvement and continue to give priority to engaging with staff, setting high standards, learning from the staff experience and strengthening partnership working. Ensuring active staff involvement in the management and direction of services at all levels is achieved through valuing staff, listening and responding to their views and monitoring quality workforce indicators. Equally, staff need to see that their input is valued and that the Trust is responsive to their views in the decisions it takes, building on that positive relationship.

3.3.3. Complaints and compliments

The Trust welcomes patient feedback including positive as well as negative experiences. Front line staff are 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 by local resolution (within the Trust).

The Patient Experience Team facilitate the resolution of issues and this could include offering the opportunity of meeting with clinical staff, 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 1.5 million patient contacts per annum, which equates to around 2,700 per day. Whilst every individual complaint is very important, especially to the complainant, the average rate of around 23 complaints per month is relatively small at one per 2,500 to 3,000 patient contacts.

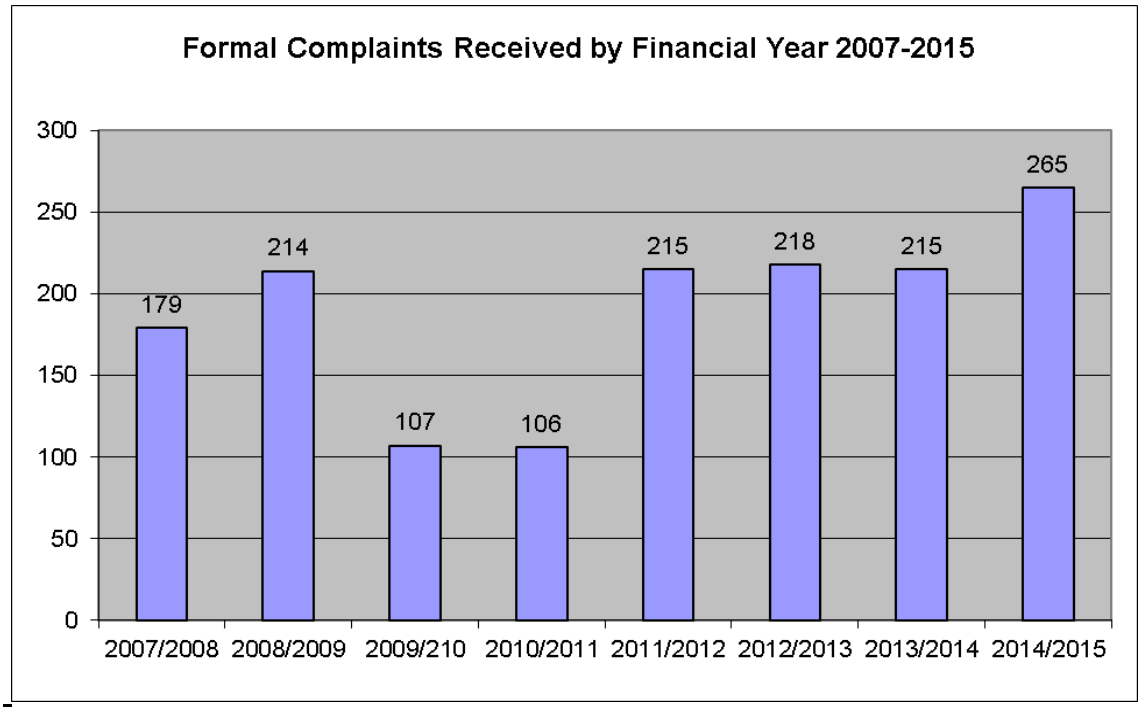


Figure 11: Local patient feedback data since 2007

The data from April 2007 to March 2011 refers only to acute hospital services and from April 2011, the data represents both acute and community services following the integration of community services into the Trust. The Trust increased in size associated with the delivery of a significant number of new services.

The Trust introduced a detailed grading matrix for negative feedback during 2011, which is based on severity of concerns and timescales for response. This includes four levels of formal complaint (green, yellow, amber and red). The breakdown of complaints received in 2014/15 is presented below by grade and quarter in which it was received, compared to 2013/14.

Complaints Total	2014/15					2013/14
	Q1	Q2	Q3	Q4	Total	Total
	55	59	76	75	265	215
Complaint Green	24	25	28	17	94	129
Complaint Yellow	31	32	46	54	163	82
Complaint Amber	0	2	2	4	8	4
Complaint Red	0	0	0	0	0	0

Table 10: Local patient feedback data showing complaints by quarter during 2014/15 and grade

The number of complaints received is greater than the previous year and the number of cases graded as moderate (yellow) or high (amber) is significantly higher than last year indicating poor experience in several areas. Quarters 3 and 4 received the most numbers of complaints. The Trust experienced high levels of patient activity during this period as did many hospitals across the NHS.

In addition, the Trust handles informal "PALS" (Patient Advice and Liaison Service) type contacts, which includes concerns, information requests and comments. In total in 2014/15, 902 were received compared to 745 in 2013/14. Of these 902, 409 were concerns, 145 were requests for information and 348 were comments. The data demonstrates an increase in the number of cases received in each of these categories of patient feedback.

The top 5 themes for complaints and concerns can be seen in the graph below. The main themes have consistently included issues around aspects of medical care, diagnosis, medical and nursing communication. Delay or problems experienced in receiving an outpatient appointment has featured in a large proportion of concerns received at an informal level.

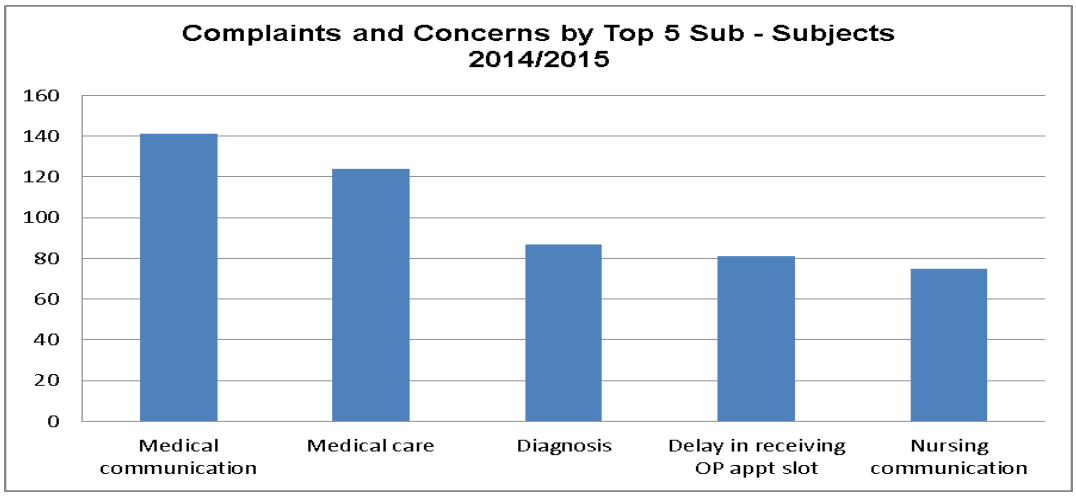


Figure 12: Local patient feedback data showing the main themes in complaints and concerns

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 revised complaint handling and investigation process was implemented in 2013/14 whereby a lead investigator is appointed who has not been involved in the provision of care. The 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 methodology is the same for all complaints. It 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 met the defined timescale for reply in 45% of cases and sought extensions where the deadline could not be reached. The Trust is keen to improve this performance and establish a robust mechanism for capturing response rate against agreed deadline.

Action plans are developed to improve patient care as a result of feedback and these are monitored regularly. In response to concerns relating to communication, the Trust provides a communications and customer care training programme, "Every Patient, Every Time". 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.

Nine cases were referred to the Health Service Ombudsman in the period, which was the same number as in 2013/14. Of the nine cases referred this current financial year:

- 1 has been investigated by the Ombudsman and partially upheld. An apology and action plan to address the findings has been completed.
- 3 have been investigated by the Ombudsman and not upheld.
- 1 case has been referred back to the Trust for local resolution.
- 4 are under review by the Ombudsman.

In 2013/14 the Ombudsman upheld or partially upheld three cases, and in one of these cases the Trust could have provided more details on the progress of actions taken to improve patient care in light of the complaint. This has been addressed through the revised process for complaints handling within the organisation.

Cloverleaf Advocacy Services 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 the year representatives from Cloverleaf Advocacy Services met with colleagues from the Trust including the Patient Experience Team to develop 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. Table 11 shows those received by the Patient Experience Team.

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Compliments received by the Patient Experience Team	233	354	354	291	330	315

Table 11: Local data showing compliments received by the Patient Experience Team

In addition, 182 records of thanks were reported via the local media in 2014/15 compared with 289 in 2013/14.

3.3.4. The Patient Voice Group

The Patient Voice Group (PVG) is an independent group of volunteers, which looks at the quality of the patient care at the Trust, with a view to both endorsing good practice and suggesting ways of enhancing the services. It performs the role of "critical friend". It responds to issues raised by the public and by PVG members, and also undertakes visits to a service at the request of the Trust. The PVG focuses on issues, not individual complaints, which are dealt with by the Trust's Patient Experience Team (PET). Information about the work of the PVG and its written reports, together with the Trust's responses to its recommendations, can be found on the Trust website to ensure full transparency.

The PVG comprises 14 lay members and one HDFT Governor, all of whom give a considerable amount of time voluntarily. The PVG reports to the Chief Nurse, and its reports and work programme are presented to the Quality of Experience Group (QEG). The PVG meets monthly, except for January and August, to work through the set work programme.

More recently the PVG has undertaken new commitments, including visits to community services. When making visits, members look at quality issues including patient care, communications, privacy and dignity and safety for patients. The PVG written report format is guided by the Care Quality Commission's new domains for assessing the quality of patient care: effective, caring, responsive to patients needs, being safe and being well-led.

1. PVG monitoring of the care of inpatients in 2014

During this year, the PVG members focused their work on the inpatient wards and undertook to visit and monitor developments and good practice in all the HDFT hospital wards as a priority. This involved two members of the group researching the ward to be visited, talking to the ward manager, staff and especially the patients, and having a look around the ward area. Views were additionally sought from patients by telephone once they were back at home, as this was felt to give patients the opportunity to provide more reflective and valuable feedback for the Trust.

Following this, the members compiled a detailed report which included some recommendations and suggestions. The PVG ward reports were then sent to the Operational Director of the relevant Directorate, the appropriate ward manager, the Chief Nurse and the Chairman of the Trust. Responses to the report and the recommendations were sought and received from the Trust using a template set up by the PVG for each report.

2. PVG involvement in other Trust matters

During 2014, the Trust asked PVG members to be involved in the Protected Mealtime survey, Out-Patients information, the Sir Robert Ogden Macmillan Centre telephone survey and the Chronic Pain Relief Clinic patient satisfaction telephone survey. Several workshops organised by the Trust had PVG representation, including the rapid improvement workshops for signage in the front foyer, outpatient appointments/reception, the CQC consultation and the dementia collaborative, and meeting with matrons, and the development of the end of life leaflet.

The PVG provided posters for the Trust Open Event. A PVG member has attended the monthly internal PEAT inspections which inspected wards and hospital environments, and which is now replaced by the new annual PLACE inspections; PVG members have been trained for this new inspection regime.

In line with HDFT's priority for enhancing the care of the elderly and the confused patient, the PVG focused in 2014 on ensuring that care for older people and those with confusion is continually improving. A large project is to be developed during 2015-16 and preparatory-work for the PVG has included meetings with relevant Trust staff. This anticipates the development of a PVG project to ensure that the voices of elderly and confused patients are heard when strategies and action plans to enhance their care are drawn up.

3. Key achievements for the quality of patient care in 2014

In addition to the implementation of a number of the PVG ward recommendations in its reports, there were two significant developments in 2014 resulting from PVG recommendations:

- Improved facilities for the Orthotics service for patients as the result of persistent PVG reports commenting on the need for more space for patients;
- The Phlebotomy service now offers a service at the local Sainsbury's store, thus reducing the long queues in Phlebotomy within the hospital.

During 2014, members have endeavoured to speak to more patients at home via telephone calls and home visits to ensure patients provide honest and reflective views of services they received from HDFT services. It is generally felt that the experience of patients accessing HDFT services is very good. Those who did have concerns have usually provided positive and helpful comments which were recorded in the reports. The work of the PVG overall endorses the Trust's emphasis on providing well-led and compassionate care of patients and on listening to the needs of its service users.

4. Future work programme for 2015

The PVG will focus on listening to patients' and relatives' stories about their care. We will be listening to what went well and why, and when it did not go so well and why. The PVG will continue to write clear reports which will provide meaningful information to the Trust managers to inform how patients would like services to continue to improve.

We will work more closely with the three clinical directorates to suggest projects over the year. These will emphasise communication issues, attitudes of staff and how much patients feel involved in their care. The projects will include a variety of ways to talk with patients and relatives, whilst always having some contextual information regarding the ward or service attended. We will try to follow patients' journeys through their care from referral to discharge. The PVG is committed to working with the Trust in developing new ways of communicating with patients to ensure that a wide range of views from as many patients and relatives, where appropriate and possible, is achieved and reported on.

3.3.5. Innovation work

Rapid process improvement work has been running throughout the year. A milestone was reached when the Trust agreed its first Innovation and Improvement Strategy in July 2014.

The Strategy acknowledges that, "all of us, whatever our job, have a role to play in leading change." It sets out what the Trust will do to create a culture of continuous improvement and states that, "in the future the Trust wants more people to have a story to tell about how they have been able to deliver some of their own improvement ideas in their area of work. More NHS leaders will know that they need to act on the whole system and will… have the tools and techniques they need to work effectively across organisational boundaries."

Over the year rapid improvement work has been progressed in

- Occupational Health
- Ultrasound
- Risk Management
- Dermatology
- Therapies
- Maternity Services
- Quality Governance
- Complaints and Incidents
- Ophthalmology
- Frailty Unit
- Chronic Pain team

Spotlight on three areas of improvement:

1. Occupational Health Workshop

The Partnership and Innovation Team supported a three day improvement workshop with the Occupational Health Team in April 2014. The agreed aims of the workshop were to improve the process for self-referrals, introduce visual controls to improve the management of customers through the system, and to streamline the storage of records within the department. The team has made a number of improvements, including the:

- Development of a self-referral form to improve the triage and allocation of referrals;
- Pilot of protected time to triage referrals and process core work;
- Introduction of an electronic system to manage enquiries received by email;
- Use of a standardised process for dealing with telephone enquiries;
- Removal of unnecessary stock, equipment and stationery.

Through exploration of how the team was working, an improvement plan has been agreed which was implemented through May and June 2014. A key objective was the reduction of clinical records stored on site which will enable the creation of a second clinic room within the department.

2. Medical Records Library Team Project

The Medical Records Library Team's key aim was to reduce the overall time taken to file case notes to ensure that other essential work can be completed. The team achieved this aim by:

- Increasing the amount of case notes filed from trollies;
- Having the protected time in the office when processing the delivery from the Archive;
- Having the welcome board, intranet page and offering a training package;
- Changing the date on the white coding sticker to the discharge date.

The improvements have meant that the team has been able to get on with other jobs in the Library such as being able to remove case notes which are no longer in use. This has made a significant improvement to the overcrowding of case notes on the shelves. This has been beneficial to the Medical Records Library Team when filing but has also been beneficial to other members of the Trust who pull case notes.

The team is still pursuing other improvements within the Medical Records Library and starting to look at changes at the Archive Library using the improvement skills they learned.

The whole team has been involved in the improvement project and each member has made significant input at all stages of the process.

A key result of phase one of the work was that improving file flow allowed most of the day's files to be filed by 2pm rather than 5pm, freeing up the team to do other work and helping to minimise backlogs and improve safety in the library.

Photo 3: No more unwieldy files like this waiting for filing in the Medical Record Library following the project!

3. Improving the Glaucoma Patient Pathway in Ophthalmology

The purpose of this work was to improve the experience of patients visiting Glaucoma clinics, improve patient and information flow, improve compliance with NICE guidelines and to identify any potential for increased capacity through removal of non-value added process steps. Patients, doctors, nurses, optometrists, care support workers and others worked together to achieve this by:

- Redesigning the lay-out and content of clinic rooms, using lean workplace environment improvement techniques;
- Remapping the patient pathway, removing waits;
- Introducing virtual clinics.

Photo 4: Information flow mapping in ophthalmology

A key output of these improvements has been finalisation of plans for the introduction of a virtual clinic for lower risk glaucoma patients and the re-modelling of staffing arrangements needed to allow that to happen safely and efficiently.

Summary

A higher volume of rapid process improvement activity than ever before has taken place this year, as part of the Trust's commitment to progress further on its lean journey. A new cohort of workshop leaders will be trained in 2015/16. The cohort comprises colleagues from across the organisation and is part of the Trust's efforts to sustain the improvement gains it is making by training more leaders across the organisation to facilitate rapid improvements.

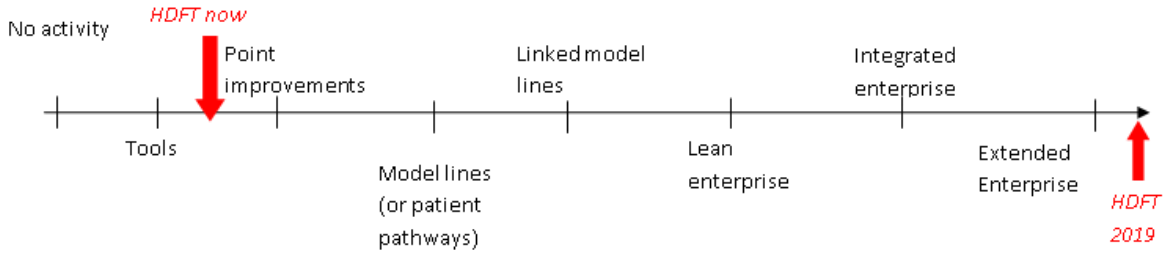


Figure 13: Summary of HDFT's lean journey

3.3.6. Volunteers

The Trust has nearly 600 volunteers ranging in age from 16 to 87. On average they provide 2000 hours each month of valuable assistance to staff and to enhance the overall patient experience. Our young volunteering programme attracts over 100 students from local sixth forms and colleges each year.

Our use of volunteers has been identified as a model of good practice by both the CQC and Healthwatch visits.

Our very successful meal time volunteering programme has been adopted by other Trusts and we continue to train on average 60 volunteers each year to assist patients with their meals at both lunch and evening meal services.

Photo 5: Young volunteer assisting with meals

New volunteering initiatives for 2014 included weekly craft volunteers at Ripon Community Hospital, Oakdale and Lascelles Wards. These have proved to be very popular for the patients. Activity volunteers were introduced onto Byland Ward in December as a pilot

scheme. Following dementia awareness training, the volunteers chat and read with patients, use memory and reminiscence aids, and play board games. Again, this has proved to be a great success and it is planned to extend this service onto other wards. Volunteers have also assisted in new roles in the Pathology Laboratories and Sir Robert Ogden Macmillan Centre, with developing "Easy Read" patient information and as Patient Research Ambassadors.
"Pets as Therapy" dogs have been introduced onto the wards for weekly visits at both Harrogate District Hospital and Ripon Community Hospital.

Volunteers continue to assist with many events in the Trust including taking part in and conducting surveys, assisting with Medicine for Members events, the annual Open Event, careers talks and fundraising, including the annual Big Picnic. Volunteers also helped during the Tour De France weekend.

The annual Celebration of Volunteering was held in December to thank our volunteers for all their hard work and dedication. The guest speaker was Gary Verity, Chief Executive of Welcome to Yorkshire.

3.3.7. Health Visitors and Healthy Child Programme

Health Visiting Service - Quality service delivery

The HDFT health visiting service is directly aligned with new NHS England National Health Visiting Core Service Specification. This ensures provision of an evidence based quality framework for the delivery of 0-5 years' early intervention and prevention public health services. HDFT has significant evidence to show improvement in quality of service delivery over the last 12 months with month on month improvements in key performance indicators. The service has recently implemented the offer of a universal antenatal contact for women after 28 weeks of pregnancy.

All HDFT health visiting teams have received validated training through York University and the Institute of Health Visiting in order to meet the requirements of the Core Service Specification. This includes;

- Perinatal Mental Health Training;
- Motivational Interviewing;
- Restorative Clinical supervision;
- Solihull Parenting Approach.

Supported by senior managers in the service a new Infant Feeding Lead secondment post is in place. The post holder will lead HDFT in achieving joint Baby Friendly Initiative accreditation for the Health Visiting Service together with NYCC Children's Centres. This is an evidence based approach which is proven to improve breastfeeding rates. An implementation visit by UNICEF has already taken place.

A patient experience survey which incorporated the Friends and Family Test (FFT) question received very positive feedback. Parents and carers are very happy with the care received from the Health Visiting Team. Parents were keen to emphasise their positive experiences. The results showed very clearly that the majority of health visitors are extremely caring in their approach and demonstrated excellent communication skills and the large majority felt their views decisions and choices were respected.

Regarding the FFT question, the majority of respondents 67% (36) said they were *very likely* to recommend the service to family and friends and 20% (11) rated *likely*. 6% (3)

respondents had no opinion on this and 4% (2) stated that they were *unlikely* to recommend the service to friends or family. Two people did not respond to the question.

Partnership working with other agencies is a key priority and quality measures are in place to safeguard children and ensure this approach is robust e.g. Children's Centre/Health Visiting Partnership Agreement is in place across North Yorkshire and notification of all new births are sent to Children's Centres by the health visitor as part of new birth visit processes.

Healthy Child Programme for 5 – 19 year olds throughout North Yorkshire

The Healthy Child Programme (HCP) aims to prevent illness and promote good health for all children, young people and families across North Yorkshire. We have a strong record of delivering our key performance indicators and related performance standards, ensuring a high quality standard and delivery of care. This is achieved through the excellent performance management and quality of care processes that are well embedded within the organisation.

We ensure that we deliver the HCP across North Yorkshire in a way that ensures equality of access, taking in to consideration:

- The geographical spread of the county;
- The diverse population and range of needs;
- Proactive communication and engagement to ensure that families, children and young people have the ability and desire to proactively engage with the HCP service, 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.

We work closely with our commissioners to agree monitoring arrangements for each of the performance indicators for the HCP by developing an agreed dashboard based on the specification. We have a quarterly review meeting to discuss our performance from a quantitative, qualitative and continual improvement perspective. A service action plan has been produced which demonstrates our activity and any areas for development and improvement.

The 5-19 Healthy Child Team has extensive experience of delivering vaccinations and immunisations to the 5-19 year old population, according to national guidelines. We have an excellent track record of delivering the required uptake targets, which is consistently above 90%. This has been supported by effective risk management processes, storage and cold chain procedures and regular monitoring and reporting.

The Healthy Child Team have been successfully coordinating and delivering the National Child Measurement Programme (NCMP) since this was established in 2005. The programme involves measuring the weight and height of Reception and Year 6 children in 260 state maintained and academy Primary Schools across North Yorkshire. In the last 12 months we have measured 4,444 (89%) reception children and 4,164 (87%) Year 6 children across North Yorkshire. This is above the national average of 84%.

We ensure the delivery of the service is fully integrated between all professionals supporting children and young people, having well established relationships with schools and GPs. Our local knowledge, effective systems and culture for learning and improvement mean we have

a strong track record of delivering the key performance indicators and Healthy Child outcomes for the service since 2005.

3.3.8. Speech and Language Therapy

Introduction

Young people who engage in criminal activity typically have a history characterised by poor school achievement, learning difficulties and truancy although the population is known to be diverse. Evidence emerging over the last decade indicates that young people who have offended are likely to be at significant risk for previously unrecognised language impairment.

66 - 90% of juvenile offenders have below average speech, language and communication skills on standardised tests. Difficulties affect the young person's abilities to communicate on a day-to-day basis, prevent them from verbally mediated interventions such as education and offending behaviour work and contribute to re-offending.

Speech and language therapy (SLT) targeted at improving the language skills of individuals can significantly reduce the numbers who re-offend. It is also important that specific disabilities and special educational needs, including difficulties with speech, language and communication are recognised in order to comply with the Disability Discrimination Act, 2005.

What were we aiming to achieve?

The planned outcomes outlined in the project plan were:

- To identify young people who may have speech, language and communication needs (SLCN) and facilitate the development of their speech, language and communication skills. When young people are identified with SLCN, input may be direct speech and language therapy working with all involved services. Where direct speech and language therapy is not required, advice and support is given to the appropriate staff and family.
- To ensure the environment is supportive to the communication needs of the young people by evaluating and collaborating on materials and methods.
- To develop skills in the workforce in identifying and meeting communication needs of the young people.

What have we done?

A new service called the North Yorkshire Youth Communication Team started on 27th November 2013. This three year project funded by NYCC is a radical, new approach to working with young people aged from 11 - 25 years old with multiple vulnerabilities. NYCC has commissioned the provision of speech and language therapy by HDFT since December 2013. The project has four speech and language therapists co-located in the Youth Justice Service (YJS) who assess and support all young people known to the YJS. The project is extending in the second year to those young people who are looked after in residential care, are on the edge of care or who are attending specialist educational provision.

What are the results?

The key outcomes were to:

a. Maximise the chances of successful communication with young people

A speech and language framework questionnaire was completed by staff in YJS, residential care and family intensive teams. Results were analysed and training tailor made for staff needs and delivered to YJS staff and key partners. The training aimed to ensure staff can minimise confrontation by setting realistic targets and appropriate communication level of intervention. Some quotes from staff following training:

> "The course made me reflect on how I work with clients and overcoming barriers to communication difficulties." YJS Caseworker.
>
> "Just to let you know getting positive feedback from staff who attended the course. Everyone is eagerly looking forward to the next one!" Manager, Children's Home.

b. Promote wider awareness of the SLCN of young people

A communication strategy and plan was developed and information and training was delivered to referral panel members, Residential Children's Home managers, magistrates and volunteers in Scarborough and Selby. Articles have been published and presentations given to various meetings and groups. A quote from a magistrate following training:

> 'At the beginning of the morning, I couldn't see the point of a speech therapist presenting to us. Now I think it is an essential part of our training and will be asking why we haven't had it before!'

c. Identify young people with SLCN

The assessment sessions have varied from 20 minutes to 80 minutes, and the number of assessments for a young person ranged from one to six sessions. 52% of young people were identified with SLCN (December 2013 - November 2014). 96% of these were not previously identified as having SLCN.

d. Treat those young people with SLCN

Young people have had SLT sessions around their identified SLCN to improve their ability to engage appropriately with the YJS. Ten young people have had therapy sessions, and 29 specific SLT reports have been written. Young people have been supported whilst attending panel meetings. Questionnaires, contracts and guidance information have been made accessible for young people so they can understand and remember the information. Examples of these are the unpaid work contract, an accessible timetable for young people available on a shared drive with photos to add for local places and accessible session and reparation feedback forms. Speech and language therapy materials are on loan for use of YJS staff.

e. Provide information for other services so there is acknowledgement of young people's communication difficulties in court settings and an ability to influence sentencing.

SLT assessment reports and recommendations for young people with SLCN have resulted in positive comments from staff within the YJS.

Summary

This next year we want to:

- Continue to develop a team to meet the desired outcomes of the present and future projects;
- Embed and ensure utilisation of skills learnt in training for YJS;
- Contribute to restorative practice and pre-sentence reports;
- Promote communication training for magistrates and police;
- Develop accessible information and projects so they are sustainable with the involvement of young people;
- Contribute to training for the Pupil Referral Services and Specialist Schools;
- Expand SLCN screening and treatment to Pupil Referral Services and Specialist Schools;
- Explore use of screening for secondary schools;
- Support transition of information into probation.

3.3.9. Maternity Services

Photo 6: Colleagues in Maternity Services

1. Maternity Patient Satisfaction Survey 2013

The 2013 survey of women's experiences of maternity services involved 137 NHS acute trusts in England. This survey is part of a series of national patient surveys by the Care Quality Commission for all NHS Acute trusts with Maternity Services in England. There is another survey planned for April/May 2015. The purpose of the survey is to understand what Maternity patients think of healthcare services provided. This includes the whole patient journey from booking to discharge to the health visitor, community midwifery services and the acute hospital setting.

Responses nationally were received from more than 23,000 service users, a response rate of 46%. Women were eligible for the survey if they had a live birth during February 2013,

were aged 16 years or older, gave birth in a hospital, birth centre, maternity unit, or who had a home birth.
Responses were received from 163 patients at Harrogate and District NHS Foundation Trust with a higher than average response rate of 62%. HDFT maternity services were in the top 3 best performing units with clear improvements from the previous survey in 2010.

Patients response for each question in the survey is converted into scores, where the best possible score is 10/10. Each trust received a rating of better, about the same or worse on how it performs for each question, compared with most other trusts.

Results for HDFT	**Score /10**	**Rating**
Labour and birth	9.2	Better
For being able to move around and choose the most comfortable position during labour	8.9	Better
For not being left alone by midwives or doctors at a time when it worried them	8.6	Better
For raising a concern and having it been taken seriously	9.0	Better
For feeling they were spoken to in a way they could understand during labour and birth	9.8	Better
For being involved enough in decisions about their care during labour and birth	9.1	Better
For being treated with respect and dignity	9.4	Better
For having confidence and trust in the staff caring for them during labour and birth	9.2	Better
Care in hospital after the birth	8.4	Better

Table 12: Maternity patient survey 2013 results for HDFT

After the results were received in 2013 we developed an action plan which the Maternity Department has been completing prior to the next survey taking place. There were three areas identified for improvement:

Review of customer care training for all staff
We have changed the Trust customer care training, "Every patient, Every Time" to be more specific to maternity and some of the information and results from the 2013 patient survey have been incorporated in the training for staff to see.

Inconsistent and conflicting advice with breast feeding
The department has invested in a further one day training for all staff in breast feeding to ensure that all advice given to new mothers is up to date and consistent and in line with the new Baby Friendly UNICEF standards.

Information available for pregnant women
We have had discussions with Baby TV to improve slides with all information for pregnant women to be displayed in the antenatal clinic. This is in the process of being agreed.

2. Friends and Family Test (Maternity)

The Friends and Family Test commenced nationally in maternity services on 1 October 2013. Women are asked to complete a short questionnaire at various stages of their care pathway, so that we can understand what has worked well and where necessary, make improvements. Women are given the opportunity to 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 details of the FFT and the results, including for maternity are given in the report of Friends and Family Test in section 3.1.2 in this document.
Locally the results are collected on a monthly basis, monitored by senior midwifery managers and displayed in the maternity unit for staff and women to see. Feedback from narrative comments is provided as often individual members of staff are named as having provided really good care to women. Any negative comments we receive are reviewed and actioned wherever possible.

Our response rates are nearly always above 20% and scores are very high showing that women are pleased with the level of care they receive in pregnancy, labour and post delivery. We are always really pleased that we receive so many narrative comments, that our response rate and scores are always good and we continue to aim to improve this even further.

3. Local Supervising Authority audit report

Introduction

Supervisors of Midwives 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. The Nursing and Midwifery Council (NMC) sets the rules and standards for the function of the Local Supervising Authorities (LSAs) and the supervision of midwives. The Local Supervising Authority Midwifery Officer (LSAMO) is professionally accountable to the Nursing and Midwifery Council. The function of the LSAMO is to ensure that statutory supervision of midwives is in place to ensure that safe and high quality midwifery care is provided to women. Audits of statutory supervision are completed by the LSA Midwifery Officer 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 in November 2014 and an action plan has been implemented for the local supervisory team to complete prior to the next audit. All recommendations from the previous audit in 2013 had been completed.

The audit in 2014 showed that:

- The local Supervisor of Midwives (SOM) continues to have a high profile within the Trust and are clearly identified to the public and the staff by wearing a pink badge;
- All midwives have a named SOM and caseloads for each SOM are within the maximum of 15 midwives for most SOM;
- There is evidence of succession planning by the local supervisory team by sending midwives on the Preparation for Supervision courses at Leeds and Sheffield Universities;
- There is good evidence of partnership working between SOM and women with a user event having taken place in June 2014, arranged and led by the supervisory team.

Local Supervisors have an action plan for the next year which includes:

- Introduction of the SOM of the week which started in January. Roles and responsibilities need to be agreed to ensure consistency;
- The SOM would be clearly identifiable at maternity meetings, separate from the substantive role;
- Dedicated time to be allocated to fulfill the role particularly for clinical midwives - this is now being allocated within the roster;
- Improved communication strategy with service users;
- Sustainable succession plan for attendance at the supervisor course;
- Training needs analysis for the supervisory team to identify training needs of the supervisory team;
- Ensure regular and consistent communication with women on a regular basis;
- Raising the profile of supervision in all settings - hospital and community.

Summary

It was a very successful audit in November 2014 and the LSA action plan will be monitored through the Maternity Risk Management Group. We have already addressed some of the actions in the action plan for 2014.

4. Maternity refurbishment

Introduction

The Maternity Department at Harrogate District Hospital was successful in gaining monies from the Department of Health to make improvements to the birth environment, to improve the privacy and dignity of women on Delivery Suite.

The planned work will be completed in three phases to reduce the potential disruption for the women and their partners as well as for the staff. Senior midwifery managers have been working closely with the Planning and the Estates Departments to ensure the project is well organised and disruption is at a minimum.

What were we aiming to achieve?

The main aim of the project is to improve the privacy and dignity for the women who use our services. We want to create a calm, relaxed atmosphere that will reduce the anxiety and stress that women and their partners may feel when they come into hospital.

What have we done?

- Replacement and redecoration of the birthing pool and room to create a calm and relaxing atmosphere and promotion of normality in childbirth. This will reduce stress and anxiety and improve the patient experience;
- Creation of ensuite facilities for all the delivery rooms;
- The development of a Maternity Assessment Centre (MAC) that will ensure the appropriate triage of women, reduce the number of unnecessary admissions to hospital and ensure continuity of care and information provided to women in the early stages of labour. By reducing unnecessary admissions to Delivery Suite, women in established labour will have 1:1 care by midwives and this will improve the patient experience and the outcome;
- Redecoration and replacement of the carpets throughout the maternity unit, including the entrance to the department creating a welcoming environment.

Summary

The work commenced in March 2015 and is estimated to last approximately 14 weeks. All women who are due to have their babies during this time have been informed by letter of the refurbishment and updates on progress will be provided via the Trust website.

Staff updates have been provided prior to the work commencing by providing information on the three phases of the project and photographs of the finished products on the notice boards within the department. Once the work is completed we plan to "launch" the project in early summer.

3.3.10. Cancer Services

Introduction

Quality of our cancer services has always been a significant priority for the Trust. Each year we build upon previous years' achievements. The new Sir Robert Ogden Macmillan Centre in March 2014 provided greater opportunity to focus upon redesign and improvement of our services.

Photo 7: The Sir Robert Ogden Macmillan Centre

What were we aiming to achieve?

The key priority areas for cancer developments in 2014/15 were:

- Development of our Acute Oncology Service
- Ensuring robust Cancer of Unknown Primary (CUP) service is developed
- Providing better Cancer Services Locally
- Development of Survivorship Pathways
- Wellbeing Services
- Better Psychological Care

What have we done?

a) Development of our Acute Oncology Service

A robust service is required in order to ensure a safe infrastructure for the recognition and management of patients presenting with complications of either their cancer or their treatment. We have developed a robust senior nursing infrastructure, and undertaken significant training throughout key areas of the Trust where patients may present. A significant further development has been to appoint a Consultant to lead Acute Oncology, which now enables a consultant review of a patient within 24 hours of admission. The additional benefit of this role has shown to be improved working with the Clinical Assessment Team, our physicians and elderly care services.

b) Ensuring development of a robust Cancer of Unknown Primary (CUP) service

Cancer of unknown primary is a term when it has not yet been possible to identify the primary site of a cancer. Whilst cancer peer review measures have been long established for all cancer sites, measures for CUP were only published in 2013. Over the last 2 years we used these measures and guidance to transform our service, and have increased our compliance with the National Peer Review measures for CUP from 4% in 2013 to 65% in 2014. The pathway is now more streamlined with increased support to patients and families at all stages.

The Acute Oncology Consultant now takes the lead for this patient group and has developed pathways and good working relationships with all MDT's, including the development of a weekly MDT specifically for CUP. This includes a Radiologist, Histopathologist and a dedicated Nurse Specialist. The Nurse Specialist is a new appointment initially funded for 2 years by Macmillan Cancer Support. The aim of this role is to ensure patients and their families have clearly navigated, timely investigations and consultations and are fully supported through uncertain diagnostic times and throughout treatment. Establishment of a CUP team enables patients to have more rapid personalised decision making, avoidance of unnecessary investigations and earlier access to appropriate diagnostics and potential treatment or transfer into palliative / end of life care.

c) Providing better Cancer Services locally

The Sir Robert Ogden Macmillan Centre provides the physical space to treat more patients. We are working with Leeds Teaching Hospitals Trust and our commissioners to repatriate selected groups of patients for chemotherapy where the treatment would be safe to deliver locally, improving the quality of care for patients and avoiding unnecessary travel. Whilst we have not yet implemented repatriation, we have undertaken significant work to understand and plan the required work and have developed an initial business case to take this forward in 2015/16.

d) Development of Survivorship Pathways

The aim of the Sir Robert Ogden Macmillan Centre was to provide a physical location for increased supportive care approaches and to enable us to focus upon the needs of patients as they complete treatment. Such approaches are often referred to as 'survivorship'. We were successful in our bid to the Yorkshire Cancer Network to appoint a Service Improvement Facilitator to take the lead upon a project group to take forward a survivorship strategy. This group has met frequently with representation from clinicians, service users, commissioners, allied health professionals and the voluntary sector. We have developed new follow up pathways for both breast and colorectal termed 'risk stratified follow up' and educational and personal recovery packages. We have a pilot programme ready to commence to test out our new pathways; however progress is stalled awaiting resolution of a national funding issue which is being taken forward by NHS England.

In addition we have been successful in a bid from Macmillan to introduce e-HNA (electronic holistic needs assessment). 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. An additional benefit is that it will capture 'data' regarding needs of patients and help us plan future capacity i.e. identify how many patients have nutritional concerns or concerns regarding resuming exercise etc. This project will be implemented in 2015/16.

e) Wellbeing Services

As part of the development of the Sir Robert Ogden Macmillan Centre, we appointed an Information and Wellbeing Manager and a Welfare and Benefits Advisor, with two years funding from Macmillan.

Photo 8: Our Information and Wellbeing Manager and Welfare and Benefits Advisor

Macmillan Welfare and Benefits Service

Our Macmillan Welfare and Benefits service has enabled more patients to have support by:

- Providing a full welfare and benefit assessment;
- Completing benefit and grant applications;
- Undertaking benefit appeals to the Department of Work and Pensions (DWP);
- Providing low level debt advice and signposts on to relevant agencies;
- Giving social care advice;
- Being awarded 'Alternative Office Status' by the DWP;
- Providing guest advice and support at cancer support groups.

Number of referrals received (1/11/13 –31/12/14)	394. This is approximately 50% of the total number of patients diagnosed with cancer each year
Total claimed in annualised benefits	£1,427,255.80
Total in backdated benefit arrears claimed	£60,055.00
Total of Macmillan grants claimed	£9,000.00
Total of cleared utility arrears and debt	£15,000.00

Table 13: Key outcomes for our Welfare and Benefits Service

Information and Wellbeing Manager

Our Information and Wellbeing Manager has enabled the development of:

- A Cancer Information Support Service (CISS) resource centre, which is fully stocked and providing cancer resources and support for patients, carers and staff on all aspects of a cancer diagnosis;
- Web site access and links;
- Cancer information email enquiry portal;
- Direct telephone enquiry line with voicemail cover;
- Volunteers providing information support;
- Active membership of the Regional Information Managers Forum;
- Co-ordination of the provision of cancer information and awareness across the Trust and partnership sites;

- Quarterly newsletter with internal and external circulation;
- Information Link nurse within the chemotherapy unit;
- Achievement of the majority of Macmillan Quality standards for Information Services at and above the expected level;
- Recording of enquiry data to inform local and national CISS service delivery.

Wellbeing Services

A complementary therapy service offers five different evidence based treatments over 22.5 hours per week. This service is funded, following a significant donation, for at least the next 3 years. The data shows:

- Number of treatments given = 375 (average of 5.5 per day)
- Number of people treated = 93
- Number of patients treated = 88
- Number of carers treated = 5

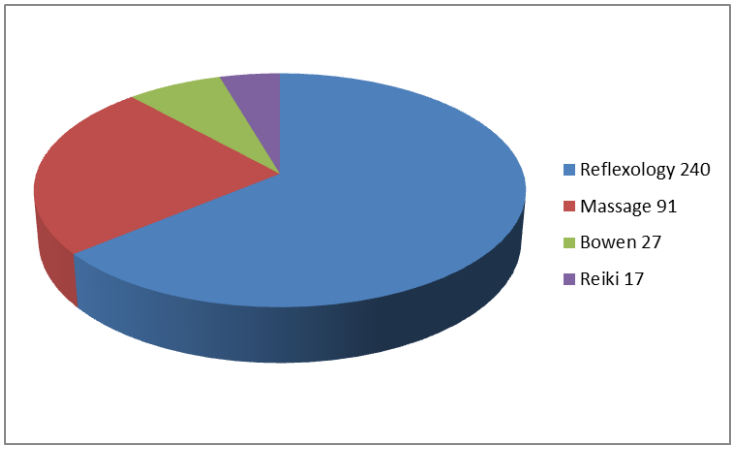


Figure 14: Types and proportion of complementary therapies given

The reasons for referral include:

- Stress
- Pain
- Lethargy
- Insomnia
- Anxiety
- Low Mood
- Hot Flushes
- Peripheral Neuropathy
- Relaxation
- Panic Attacks
- Mobility
- Swelling
- Watery Eyes
- Needle Phobias
- Exhaustion

The treatment outcomes following complementary therapy service using the 'Measure your concerns and wellbeing' (MYCAW) tool:

Patients reported concern 1 improved by 58.4%
Patients reported concern 2 improved by 57.4%
Patients reported their wellbeing improved by 57.7%

There is a hair loss service incorporating, scalp cooling, wig fitting, fashionable headwear and organic hairdresser consultations for when hair grows back. 'Feel More Like You' beauty, skin, make-up and nail sessions for ladies undergoing chemotherapy, are provided in partnership with Boots No'7 Harrogate. A Macmillan Dietician offers clinics and advice, and there is access to 'Supporting You During your Chemotherapy', a weekly rolling programme of supportive sessions. There are monthly Oesophageal Patient Association support drop in sessions and Clinical Psychology Therapy for patients/carers affected by cancer.

f) Better Psychological Care

Continuing to improve access to psychology services for patients is crucial alongside their physical treatment and whilst providing for their wider holistic needs. There is a stepped approach to describing psychological care which is often referred to as level 1, level 2, level 3, level 4. Our Clinical Nurse Specialists (CNS) for all common cancer sites are skilled to deliver level 2 psychological support. Above this it becomes the remit of Counsellors at level 3 and Psychologist / Psychiatry at level 4.

There is national evidence that approximately 10% of all patients diagnosed with cancer will require input from psychology, and this figure increases to 15% when a patient is diagnosed with advanced / palliative disease.

Whilst the Cancer Clinical Psychology service has grown considerably, provision remains under capacity, partly due to the raised expectation and profiling of the service and increased training and support to our nurses to undertake effective holistic needs assessment. This will therefore continue as a priority to develop a robust infrastructure in 2015/16.

The service is now located within the Sir Robert Ogden Macmillan Centre, rather than in the main hospital building. This has enabled an improved environment for patients and integration of the service with the cancer clinical teams.

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 Peer Review Measures;
- Patient reported experience through both the National Cancer Patient Experience Survey and local surveys.

We have consistently achieved our cancer waiting times targets, have a high level of compliance against our peer review measures and are currently third nationally in the Cancer Patient Experience Survey.

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.

Photo 9: Staff in the Sir Robert Ogden Macmillan Centre

3.3.11. PTNS Service for faecal incontinence

Introduction

Percutaneous tibial nerve stimulation (PTNS) is treatment for patients who suffer from faecal incontinence. 53 million people in Europe were estimated as being affected by faecal incontinence last year (Bladder and Bowel Foundation 2014) but the numbers are not accurate due to its embarrassing nature. People suffer in silence and suffer for many years. Not only does it affect people's quality of life, but it also has a huge psychological impact.
Faecal incontinence affects young up to the elderly, but the incidence is higher in the elderly and women following childbirth especially following third and fourth degree tears. Management has improved over the last ten years but more needs to be done (NICE 2007).

PTNS is not a first line treatment but can be given in conjunction with other treatments, and can prevent the need for more invasive options. Results can be life changing.

What were we aiming to achieve?

The aim of starting the service was to:

- Improve patients' faecal incontinence symptoms;
- Prevent patients from requiring more invasive options;
- Deliver a high standard of patient focused care;
- Promote the service to healthcare professionals and the wider public;
- Maintain staff competencies;
- Ensure staff development.

What have we done?

The service has been developed following staff development and training, with a new patient clinic and booster clinics and an associated 12 week patient pathway. The service has been supported

with a patient leaflet, and details on the Trust website. General practitioners were provided with letters and flyers explaining that the service was established and how to refer.

We have a dedicated person to deliver the treatment as a practitioner. Patients suffering with faecal incontinence are given the time, support and advice they need on the day that they attend, and afterwards if necessary. The treatment is provided in the main outpatients department. A needle is inserted in the ankle along side the tibial nerve and attached to a stimulator. The stimulation treatment is given for 30 minutes, once a week for 12 weeks. If this treatment works for patients, then boosters can be given at intervals ranging from 3 to 6 months.

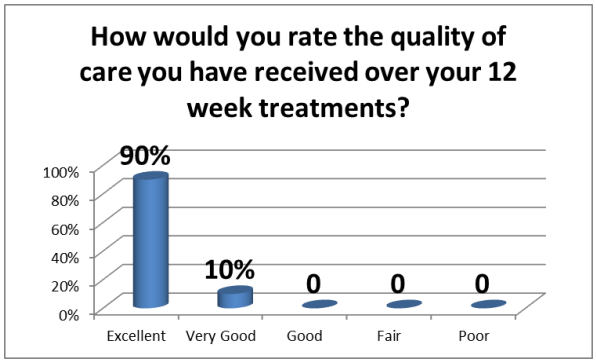
Showcases for the hospital and general public have been undertaken. Experience has been shared at Association of Continence conferences, and the service received accreditation as a centre of excellence and good practice in October 2014 from Uroplasty, the company that provides equipment and training.

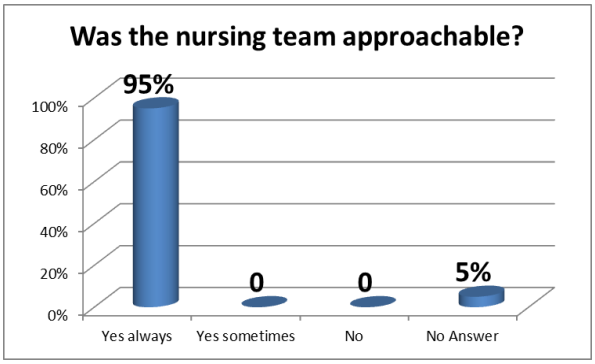
The service was delighted to win a bowel care award through PROMOCON - (Promoting Continence and product awareness - an integral service of Disabled Living UK) in February 2015.

The team have undertaken a patient survey and an audit of 40 patients in 2015.

What are the results?

The patient survey and audit are aiming to establish whether PTNS is improving patients' symptoms and measure improvements. The patient survey is a continual review of responses once patients have completed 12 weeks of treatment and results below are from the first 40 patients:





Figures 15 and 16: Results of patient survey of PTNS, quality of care and approachability of nursing team

Summary

The service has been established with staff development, the production of accurate documentation, patient information, and the promotion of the service to the public and healthcare professionals. The team will continue to reflect, review and improve the PTNS service through audit, patient survey reviews and evidence based research.

3.3.12. Community Equipment Service

Extensive work has been undertaken within the Trust to redesign the North Yorkshire-wide community equipment service resulting in many positive developments including collaborative engagement with all stakeholders.

In order to monitor the effectiveness of the community equipment service we required a more robust and consistent process for data collection, reporting on our performance and monitoring quality improvements. A fully electronic ordering system was required to address issues around accessing equipment and provide a more robust system for reporting performance. It would also

provide a much quicker turnaround following a request for equipment with a large proportion of patients benefiting.

An automated system was piloted in February 2014, and launched in July 2014. The service was then able to report in detail against new specification delivery speeds of standard (within 7 days), priority (next day) and urgent (within six hours).

Store	2012-13		2013-14				2014-15			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Colburn	95%	96%	97%	97%	95%	96%	96%	91%	92%	96%
Knaresborough	89%	91%	86%	90%	96%	93%	96%	82%	93%	97%
Scarborough	78%	50%	85%	87%	91%	93%	92%	97%	95%	98%
York	90%	81%	85%	93%	92%	93%	93%	95%	95%	96%
Service overall	90%	79%	87%	92%	93%	94%	94%	92%	94%	97%

Table 14: Percentage of requests for equipment meeting the delivery standards

Since Q3, 100% of priority and urgent orders have been achieved within timescales, and by Q4, further progress has been demonstrated by the performance statistics for the overall service which have exceeded the 95% target each month this quarter and for each store for the quarter overall. The service is beginning to realise the promise of improvements in service delivery with the stable 97% performance for each month.

ANNEX ONE: STATEMENTS FROM STAKEHOLDERS

In accordance with the NHS Quality Accounts Regulations, Harrogate and District NHS Foundation Trust sent a copy of the draft Quality Account to its lead Clinical Commissioning Group, Harrogate and Rural District, Healthwatch North Yorkshire, North Yorkshire County Council Scrutiny of Health Committee, the Council of Governors and the Health and Wellbeing Board for comment prior to publication and received the following statements:

NHS HARROGATE AND RURAL DISTRICT CLINICAL COMMISSIONING GROUP QUALITY ACCOUNT STATEMENT 2014/15

We welcome the QA and compliment the Trust on what is a comprehensive account of quality for the last year. Having seen an earlier draft, there were two issues that the CCG suggested would improve the Report - action being taken to address delays in ambulance handover at A&E and the improvement and re-modelling of community equipment services – and we are pleased to see that these have now been included.

HEALTHWATCH NORTH YORKSHIRE QUALITY ACCOUNT STATEMENT 2014/15

Healthwatch North Yorkshire would like to acknowledge the contents of Harrogate and District NHS Foundation Trust's Quality Account, especially the Trusts commitment to improving the quality of service, which will ultimately improve the experience of patients that use the array of services it provides. We intend to work constructively with the Trust to support its implementation of an improved service, and will also support in communicating any progress to members of the public. And in light of the Trust gaining new "Vanguard" status, it is hoped that this would further add momentum to the improved quality of services provided, putting patients at the heart of their care, thereby helping to deliver truly person centred care.

NORTH YORKSHIRE COUNTY COUNCIL SCRUTINY OF HEALTH COMMITTEE QUALITY ACCOUNT STATEMENT 2014/15

Thank you for inviting the North Yorkshire Scrutiny of Health Committee to contribute to the Harrogate and District NHS Foundation Trust's Quality Account (QA) for 2014/15. Please accept this letter as the comments from the Committee on the current draft version.

On the basis of our long standing involvement with the Trust I am confident that the QA is representative and comprehensive in terms of the services provided. Against this background we support the Trust's priorities for improvement in 2015/16:

- Creating the conditions for safety by improving communication;
- Improving patients' experience of using our services;
- Becoming a centre of excellence for the care of the frail elderly.

The priorities have clearly been informed by a on-going engagement process with patients and the public which has been supplemented by specific events/workshops including all stakeholders.

We note the achievement during 2014/15.

I recall that in its QA for 2012/13 the Trust was planning to improve its complaints process in 2013/14. Disappointingly formal complaints have increased significantly in 2014/15. It is therefore encouraging to hear that the work which the Trust is doing to address this situation includes working proactively with the NHS Complaints Advocacy Service (which the County Council commissions) with a view to improving how information could flow more effectively between the two organisations.

Councillor Jim Clark - Chairman

COUNCIL OF GOVERNORS QUALITY ACCOUNT STATEMENT 2014

The Council of Governors is pleased that the Trust continues to provide high quality care, as evidenced by this comprehensive Quality Account.

Governors have been extensively consulted on the Trust's strategic operational plan and the quality priorities for the organisation, and have reviewed the Quality Account. They continue to be involved directly in the Quality of Experience and Patient Voice Groups, departmental Quality of Care teams, PLACE inspection teams and Patient Safety visits, all of which enable them to see at first hand the challenges of maintaining quality at a high level on an enduring basis.

In addition, Governors have regular meetings with Non-Executive Directors and attend, in an observer role, Board of Directors meetings, as well as having in-depth discussions with Executive Directors, both formally at Council of Governor meetings and more informally. The Council of Governors supports and endorses the Quality Account and the priorities selected for particular focus over the coming year.

HEALTH AND WELLBEING BOARD QUALITY ACCOUNT STATEMENT 2014/15

No comment had been received from the Chair of the Health and Wellbeing Board at the date of approval by the Board of Directors.

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.

Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15;
- 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 2014 to March 2015
    - Papers relating to Quality reported to the Board over the period April 2014 to March 2015
    - Feedback from the commissioners dated 7 May 2015
    - Feedback from Governors dated 7 May 2015
    - Feedback from Healthwatch North Yorkshire dated 8 May 2015
    - Feedback from North Yorkshire County Council Scrutiny of Health Committee dated 1 May 2015
    - The Trust's draft complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2015
    - The 2014 national patient survey dated 21 May 2015
    - The 2014 national staff survey dated 24 February 2015
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated April 2015
    - CQC Intelligent Monitoring report dated May 2015

- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board on 27 May 2015

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Mrs Sandra Dodson
Chairman

.....

Dr Ros Tolcher
Chief Executive

ANNEX THREE: NATIONAL CLINICAL AUDITS 2014/15

	Name of Audit/Clinical Outcome Review Programme	Source	Number of patients for which data submitted 2014/15	Data submitted as a percentage of the number of registered cases required for that audit
1	Acute coronary syndrome or Acute myocardial infarction (MINAP)	NCAPOP	300	100%
2	Adult Community Acquired Pneumonia	Other	Did not participate	Did not participate
3	Bowel cancer (NBOCAP)[5]	NCAPOP	118	100%
4	Cardiac Rhythm Management	NCAPOP	1912 (number of checks)	100%
5	Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC)		207	100%[6]
6	Diabetes (Adult) National Diabetes Foot care Audit[7]	NCAPOP	6	Not stated
7	Diabetes (Paediatric)[8]	NCAPOP	65	Not stated
8	Elective surgery National PROMS programme (2013/14)		1,114 (pre-op) 809 (post-op)	97.7% 73.3%
	Elective surgery National PROMS programme (April - September 2014)		603 (pre-op) 89 (post-op)	>100% 31.7%
9	Epilepsy 12 (Childhood Epilepsy)	NCAPOP	11	91%
10	Falls & Fragility Fractures Audit Programme (FFFAP)	NCAPOP		
	(i) Falls[9]		24	100% of patients meeting sample criteria
	(ii) Fracture Liaison Service database		Not relevant	Not relevant
	(iii) National Hip Fracture Database		259	Not stated
11	Fitting Child (care in ED)	College of Emergency Medicine (CEM)	30	100%
12	Inflammatory Bowel Disease Programme	NCAPOP	The last data collection took place between Jan 2013 and March 2014, and was reported in last year's Quality Account, with reports published during 2014.	
13	Lung cancer (NLCA)	NCAPOP	106	100%
14	Major Trauma: The Trauma Audit &	TARN	104	Awaiting 2014 HES

[5] This relates to data submitted for 2013/14. The Trust has not yet submitted any patient data for 2014/15 as the deadline for this is November after the end of the financial year, therefore reporting will always be one year in arrears.

[6] This relates to January - June 2014

[7] Continuous data collection with annual submission; first deadline of 31st July 2015.

[8] This relates to 2013/14 as the audit for 2014/15 opens in April 2015 with a deadline of June.

[9] Please note this data relates to the Pilot audit in 2014. Data collection for the 2015 audit does not commence until May 2015

	Name of Audit/Clinical Outcome Review Programme	Source	Number of patients for which data submitted 2014/15	Data submitted as a percentage of the number of registered cases required for that audit
	Research Network (TARN)[10]			data
15	Maternal, New-born and Infant Clinical Outcome review Programme (MBRRACE-UK)	NCAPOP	0	TBC
16	Medical & Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome & Death (NCEPOD)	NCAPOP		
	(i) Lower Limb Amputation: Working Together	NCAPOP	1 Organisational Questionnaire only	N/A
	(ii) Gastrointestinal Haemorrhage Study	NCAPOP	4[11]	100%
	(iii) Sepsis Study	NCAPOP	5	100%
	(iv) Acute Pancreatitis Study	NCAPOP	Only Patient Identifiers submitted	Ongoing
17	Mental Health (care in ED)	College of Emergency Medicine (CEM)	30	100%
18	National Audit of Dementia[12]	NCAPOP	Audit for 2015 not yet commenced	Audit for 2015 not yet commenced
19	National Audit of Intermediate Care		Organisational questionnaire submitted	N/A
20	National Cardiac Arrest Audit (NCAA)[13]		44	100%
21	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	NCAPOP	66	100%
22	National Comparative Audit of Blood Transfusion programme			
	(i) 2015 Audit of Patient Blood Management in Scheduled Surgery		Data collection due to start 1 April 2015	Data collection due to start 1 April 2015
	(ii) 2015 Audit of the use of blood in Lower GI bleeding		Did not participate	Did not participate
23	National Emergency Laparotomy Audit	NCAPOP	75	98.7%

[10] Number of trauma patients

Submitted and approved 81

Submitted awaiting approval 13

Data collected awaiting submission 10

[11] Six sets of patient data requested- 2 excluded prior to submission. 2 excluded following submission

[12] The latest round of the National Dementia Audit took place in 2012 and was reported in the trust's 2012/13 Quality Account. The 2015 audit has not yet commenced.

[13] Figures for April to December 2014. Quarter 4 data not yet available.

	Name of Audit/Clinical Outcome Review Programme	Source	Number of patients for which data submitted 2014/15	Data submitted as a percentage of the number of registered cases required for that audit
	(NELA)[14]			
24	National Heart Failure Audit	NCAPOP	169	100%
25	National Joint Registry (NJR)	NCAPOP	960	111.5%
26	Prostate Cancer[15]	NCAPOP	94	100%
27	Neonatal intensive and special care (NNAP)	NCAPOP	97	Ongoing
28	Non-invasive ventilation – adults		Did not participate	Did not participate
29	Oesophago-gastric cancer (NAOGC)[16]	NCAPOP	42	100%
30	Older people (care in ED)	College of Emergency Medicine (CEM)	50	300%
31	Pleural procedure	Other	Did not participate	Did not participate
32	Pulmonary Hypertension		Did not participate	Did not participate
33	Rheumatoid and early inflammatory arthritis	NCAPOP	22	Not identified due to coding
34	Sentinel Stroke National Audit Programme (SSNAP)	NCAPOP	342	>90%

[14] Data refers to year 1 of the audit (01/12/2013 to 30/11/2014).

[15] Data correct as at 31 December 2014 – cases from January onwards still to be validated and registered

[16] This relates to data submitted for 2013/14. The Trust has not yet submitted any patient data for 2014/15 as the deadline for this is November after the end of the financial year, therefore reporting will always be one year in arrears.

For information, the Trust also participated in the following audits:

Data submitted to National Audits not required to be reported on	Number of patients for which data submitted 2014/15	Data submitted as a percentage of the number of registered cases required for that audit
Diabetes in Pregnancy	6	Not stated

The following 8 NCAPOP audits were not relevant to HDFT due to the trust not providing the service:

- Chronic Kidney Disease in primary care;
- Congenital Heart Disease (Paediatric Cardiac Surgery);
- Coronary Angioplasty/National Audit of PCI;
- Head & Neck Oncology;
- National Adult Cardiac Surgery Audit;
- National Confidential Inquiry into Suicide and Homicide for People with Mental Illness;
- National Vascular Registry;
- Paediatric Intensive Care Audit Network.

The following 3 non-NCAPOP audits were not relevant to HDFT due to the trust not providing the service:

- British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing;
- Prescribing Observatory for Mental Health (POMH): Prescribing for substance misuse – alcohol detoxification;
- Renal Replacement Therapy (Renal Registry).

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF HARROGATE AND DISTRICT NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Harrogate and District NHS Foundation Trust to perform an independent assurance engagement in respect of Harrogate and District NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following two national priority indicators:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
- Emergency readmissions within 28 days of discharge

We refer to these two national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2014/15 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- board minutes for the period April 2014 to March 2015;
- papers relating to quality reported to the board over the period April 2014 to March 2015;
- feedback from Commissioners, dated 7 May 2015;
- feedback from governors, dated 7 May 2015;
- feedback from local Healthwatch organisations, dated 8 May 2015;
- feedback from Overview and Scrutiny Committee dated 1 May 2015;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX, dated May 2015;
- the national patient survey 2014
- the national staff survey 2014

- Care Quality Commission Intelligent Monitoring Report, dated December 2014; and
- the Head of Internal Audit's annual opinion over the trust's control environment, dated April 2015.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Harrogate and District NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Harrogate and District NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- testing key management controls
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Harrogate and District NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

Chartered Accountants

Leeds

27 May 2015

National Staff Survey

The Trust received another excellent set of results from the 2014 national staff survey. It was placed in the top 20% of Trusts of a similar type for 10 key findings out of a total of 29 key findings. These top performing areas were:

- The percentage of staff feeling they are able to contribute towards improvements at work;
- Staff motivation at work;
- The percentage of staff having equality and diversity training in the last 12 months;
- The percentage of staff believing the Trust provides equal opportunities for career progression or promotion;
- The percentage of staff reporting errors, near misses or incidents;
- The (low) percentage of staff experiencing discrimination at work in the last 12 months;
- The (low) percentage of staff feeling pressured in the last 3 months to attend work when feeling unwell;
- The (low) percentage of staff suffering work related stress in the last 12 months;
- The (low) percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month;
- The (low) percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

A key area of significant improvement was in the percentage of staff appraised in the last 12 months. In 2013, 82% of staff had an appraisal and in 2014, this had increased to 87%.

	2014	2013	Trust Improvement/Deterioration
Response Rate	56%	59%	Maintained best 20% position

No information is available for the national average acute trust response rate.

The five strongest performing areas were:	2014		2013		Trust Improvement/ Deterioration
	Trust	Nat Av	Trust	Nat Av	
Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	92%	87%	94%	88%	No significant change
Percentage of staff reporting errors, near misses or incidents witnessed in the last month.	94%	90%	89%	90%	No significant change
Percentage of staff suffering work related stress in last 12 months (the lower the score the better)	32%	37%	34%	37%	No significant change
Percentage of staff experiencing discrimination at work in last 12 months (the lower the score the better).	8%	11%	8%	11%	No significant change
Percentage of staff experiencing physical violence from staff in the last 12 months (the lower the score the better).	3%	3%	2%	2%	No significant change

The three weakest performing areas were:	2014		2013		Trust Improvement/ Deterioration
	Trust	Nat	Trust	Nat	

		Av		Av	
Fairness and effectiveness of incident reporting procedures.	3.49%	3.54%	3.54%	3.51%	No significant change
Percentage of staff working extra hours.	72%	71%	69%	70%	No significant change.
Percentage of staff receiving job relevant training, learning, or development in the last 12 months. (the higher the score the better)	81%	81%	78%	81%	No significant change

None of the weakest performing areas fell within the lowest 20% of Trusts. In comparison with other Trusts our weakest performing areas were very close to or were the same as the national average performance when compared with all Trusts and confirms that our standard across the range of key factors was again very high.

The actual percentage of staff receiving job-relevant training, learning or development has increased each year with 79% in 2012 and 78% in 2013. The 2014 score was the same as the national average of 81% although our internally reported percentage was 86%. The Trust has worked to ensure an extensive job relevant training programme is provided. Mandatory training completion is now linked to pay progression for staff which assists with compliance and the Trust continues to focus on providing relevant training for staff.

The percentage of staff working extra hours has increased slightly by 3% since 2013. This follows a decrease in 2013 compared to 2012 when 71% staff worked extra hours showing that the Trust has maintained a level of consistency. The Trust is concerned that this is perceived as a weak area and will continue to work on reviewing and increasing staffing levels. Longer notice periods have been introduced for key staff groups to ensure rosters are covered during the recruitment process. Health and wellbeing activities have been introduced for staff with a key drive on staff managing their own health and wellbeing including personal resilience.

The percentage of staff experiencing physical violence from staff has not appeared in the low performing areas for the Trust before and is a concern. This was the same as the national average for similar Trusts with no significant change to previous years' results. There have been no reported cases within the Trust of such acts; however, work will continue to encourage an open reporting culture.

The Trust will work at improving these areas and other areas where there are implied weaknesses. The Trust has communicated the results of the staff survey to staff through the team briefing process and daily notices; the reports are also included on the staff intranet.

Celebrating Success

The staff achievement awards and Autumn Ball was held on 21 November 2014. The event celebrated staff achievements with six awards, the winners of which received training bursaries. The awards are for good practice and innovation within the Trust and have the joint aims of giving recognition to individuals for their exemplary work and also to share with others the new and different ways of working. Long service awards were presented to staff who have achieved 25, 35 and 40 years NHS service.

The 2014 awards categories and winners were:

The Mark Kennedy Award for excellence in enabling care closer to home.

- Linda Milburn, Dr John Smith and the CAT team.

The Anne Lawson Award for outstanding contribution to high quality care

- Tricia Feber and Tracy Malton

The Governors' Award for outstanding contribution from a team

- Tour De France Planning Group

The Richard Ord Award for outstanding contribution from an individual

- Alan Fisher

Outstanding Partnership Working

- Cardiac rehabilitation specialist nurse team

Chairman's Award for Making a Difference

- Specialist Children's Services, Hambleton & Richmond.

Regulatory ratings

The Trust's regulatory performance during the year has remained green in all categories, in line with risk ratings contained in the Annual Plan. No formal regulatory action has been taken or is planned.
The Trust continues to have robust measures in place to monitor performance and quickly address areas of concern. The Trust has met its infection control targets.

Monitor's Risk Assessment Framework uses a wide range of metrics and data sources to assess the Trust's governance rating, including information from CQC and other third party reports. The Trust reported a green governance rating for each quarter of 2014/15.

Performance summary of 2014/15

HDFT has now demonstrated compliance with requirements regarding access to healthcare for patients with learning disabilities. This means that HDFT's Risk Assessment Framework Governance rating for 2014/15 was Green.

Provisional data indicates that the Trust achieved all 7 applicable Cancer Waiting Times standards for Quarter 4, meaning that the Trust achieved all cancer waiting times standards for each quarter of 2014/15.

Performance at Harrogate ED was above the 95% in standard in March, with 96.3% of patients spending less than 4 hours in the department but below the standard (94.9%) for Quarter 4 overall. However the combined performance for the Trust (including the two Minor Injury Units) was above the expected standard for each quarter of 2014/15.

There have been no ambulance handover delays of more than 60 minutes in 2014/15. There were 78 ambulance handover delays of more than 30 minutes at Harrogate ED in 2014/15 which compares to 116 for the previous financial year. ED attendances are 1.5% higher than for the same period last year.

Activity levels at HDFT for outpatients and elective admissions have increased in 2014/15 compared to last year. Elective admissions were 9.5% higher than in 2013/14, and of these, there was a 20.1% increase in activity from Leeds. The relatively small increase in follow-up appointments (2.4%) indicates an improvement in follow-up ratios in view of a 4.7% increase in new appointments.

In 2014/15 there has been a 12% increase in District Nursing activity for the period October to March when compared to the same period last year.

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 achieved for March and for Quarter 4. Delivery of the TIA standard for the month of March was at 69.2% against the 60% national standard. Both standards were delivered for each quarter of 2014/15.

HDFT achieved all 18 week standards throughout 2014/15.

No cases of hospital acquired MRSA were reported in 2014/15. There were 9 hospital-acquired C-Difficile reported during 2014/15 meaning that the Trust has achieved its annual trajectory of remaining below 15 cases. NHS England has now published the C-Difficile trajectories for 2015/16 – HDFT's annual trajectory for 2015/16 is 12 cases.

The following table demonstrates HDFT's performance against the indicators in Monitor's Compliance and Risk Assessment Frameworks for each quarter in 2014/15:

Indicator description	Target	Q1	Q2	Q3	Q4
RTT admitted pathways (% within 18 weeks)	>=90%	94.6%	94.2%	93.8%	93.7%
RTT non-admitted pathways (% within 18 weeks)	>=95%	97.2%	97.0%	97.1%	97.2%
RTT incomplete pathways (% within 18 weeks)	>=92%	97.5%	97.1%	97.1%	97.0%
A&E: Total time spent in A&E	>=95%	97.2%	97.8%	96.3%	96.3%
Cancer - Maximum waiting time or 14 days from urgent GP ref to date first seen for all urgent suspect cancer referrals (%)*	>=93%	98.6%	98.2%	97.6%	96.3%
Cancer - maximum waiting time of 14-days for symptomatic breast patients (cancer not initially suspected)*	>=93%	97.4%	96.0%	96.1%	96.6%
Cancer - 31 day wait for second or subsequent treatment: Surgery*	>=94%	100.0 %	97.4%	100.0 %	96.3%
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug*	>=98%	100.0 %	100.0 %	100.0 %	100.0 %
Cancer - 31 day wait for second or subsequent treatment: Radiotherapy*	>=94%	NA	NA	NA	NA
Cancer - Maximum waiting time of 31 days from diagnosis to treatment for all cancers (%)*	>=96%	100.0 %	100.0 %	100.0 %	100.0 %
Cancer - 62 day wait for first treatment from urgent GP ref to treatment: all cancers*	>=85%	93.8%	90.9%	89.8%	89.5%
Cancer - 62 day wait for first treatment from consultant screening service referral: all cancers*	>=90%	100.0 %	100.0 %	88.9%	100.0 %
C-Difficile	<= 11 cases in year	3	3	2	1
Community services data completeness - RTT information	>=50%	79.9%	80.2%	80.9%	80.6%
Community services data completeness - Referral information	>=50%	71.0%	71.8%	71.2%	71.0%
Community services data completeness - Treatment activity information	>=50%	85.6%	83.4%	82.2%	81.7%

Regulatory Ratings

	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14	Q1 2014/15	Q2 2014/15	Q3 2014/15	Q4 2014/15
Under the Compliance Framework								
Financial Risk Rating	3	3						
Governance Risk Rating	Green	Green						
Under the Risk Assessment Framework								
Continuity of service rating			4	4	3	3	3	3
Governance rating			Green	Green	Green	Green	Green	Green

INCOME DISCLOSURES REQUIRED BY SECTION 43(2A) OF THE NHS ACT 2006 (AS AMENDED BY THE HEALTH AND SOCIAL CARE ACT 2012)

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than the Trust's income from the provision of goods and services for any other purposes.

The Trust confirms that it has met this requirement during 2014/15.

OTHER DISCLOSURES IN THE PUBLIC INTEREST

Staffing information

Putting patients first and raising staff engagement continue to be central to Trust management. The Trust was delighted to maintain its placing in the top 20% of Trusts of a similar type nationally for staff engagement in the 2014 National Staff Survey. The component questions which contribute to measuring staff engagement are the ability of staff to contribute towards improvements at work, staff recommendation of the Trust as a place to work or receive treatment and staff motivation at work. Scoring well in these areas is testament to the hard work and dedication from all staff employed by the Trust.

2014 saw the introduction of the NHS Staff Friends and Family Test. Every quarter, every member of staff was invited to take part and answer the question:

How likely are you to recommend the Trust to friends and family as a place to work?
The last quarter's results showed 74% of staff would recommend the Trust as a place to work. This was an increase compared to the first quarter which showed 70% of staff would recommend the Trust as a place to work. 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 and viewed as a key engagement tool.

The Trust will continue to give priority to engaging with staff, setting high standards, learning from the staff experience and strengthening partnership working. Ensuring active staff involvement in the management and direction of services at all levels is achieved through, valuing staff, listening and responding to their views and monitoring quality workforce indicators. Equally, staff need to see that their input is valued and that the Trust is responsive to their views in the decisions it takes, building on that positive relationship.

The Trust has a number of mechanisms through which it communicates information to its employees. These include through a daily, all user, e-mail, team brief, departmental meetings, ad hoc briefings, twitter accounts, personal letter, 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 with the questions and answers being published on the intranet. The method(s) used will be the most appropriate for the particular information to be conveyed but one or more methods will be used for all matters of importance. The Trust also runs a staff intranet providing information regarding the latest changes and developments as well as routine information. The Trust understands that not all clinical and support staff use electronic communication methods and always ensures that managers are asked to make all staff aware of information communicated by electronic means.

The Trust works to engage with staff and obtain their feedback on matters being communicated. This occurs through the Team Brief process and through the regular meetings of the Partnership Forum and Local Negotiating Committee where trade unions and professional association representatives meet with senior managers to discuss issues affecting staff and local conditions of service. There are two sub groups of the Partnership Forum, the Policy Advisory

Group and the Pay, Terms and Conditions Group. The Policy Advisory Group agrees and updates Human Resources policies in line with current employment law and ensures they have broad agreement within the organisation. The Pay, Terms and Conditions Group negotiates on local issues affecting staff pay and conditions. The Local Negotiating Committee is the forum for medical and dental staff and the British Medical Association and British Dental Association trade union representatives to be involved in the decision making process at all stages which affects their working lives, contractual arrangements and the delivery of health care. It provides the means for joint problem solving in relation to issues affecting the well-being of medical and dental employees and contributes to the efficient management of the Trust.

The daily 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, new starters and leavers, 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.

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

Feedback from staff through official sources e.g. the Friends and Family Test, Team Brief, staff survey and 'Ask the Directors' as well as other anecdotal feedback is that the Trust is a good place to work, does consult with its staff and that communications are good. Departments will survey staff on specific issues where feedback is needed and focus groups will also be convened as required. Other means of obtaining staff information will be through open email requests.

Staff Sickness Levels 2014/15

DIRECTORATE	13/14 Q4 % Abs Rate (FTE)	14/15 Q1 % Abs Rate (FTE)	14/15 Q2 % Abs Rate (FTE)	14/15 Q3 % Abs Rate (FTE)	Cumulative % Abs Rate
Acute and Cancer Care	3.11%	3.13%	3.80%	3.51%	**3.39%**
Corporate Services	3.91%	4.79%	3.94%	3.74%	**4.09%**
Elective Care	4.29%	4.96%	4.35%	4.38%	**4.50%**
Integrated Care	3.32%	2.59%	4.08%	4.49%	**3.63%**
TOTAL	**3.69%**	**3.83%**	**4.08%**	**4.13%**	**3.94%**

Key

FTE = Full Time Equivalent
13/14 Q4 – January 2014 to March 2014
14/15 Q1 – April 2014 to June 2014
14/15 Q2 – July 2014 to September 2014
14/15 Q3 – October 2014 to December 2014

Occupational Health

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

The work of the Occupational Health Department covers:

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

Occupational Health staff 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: Clinical and Non Clinical Risk Management; Health and Safety; Infection Control; and Human Resources meetings.

A high level of collaborative working with other regional NHS occupational health services ensures that Trust staff working in 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 & 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 two health and wellbeing days and development of initiatives to address mental health issues in the workplace.

Work has continued on a major project to review work-related immunisation records against the most recent Department of Health standards for healthcare workers, and to update those who commenced in post prior to the implementation of the current standards. Alongside this project, processes to improve the timeliness of checking and updating any new staff as and when required have been introduced. This will improve patient and staff safety by further reducing the risk of communicable disease transmission between staff and patients, and avoid potential exclusion of non-immune staff contacts from work that leads to lost working time.

The department continues to hold contracts for the provision of Occupational Health services to other NHS and non-NHS organisations in the local community, supporting the working population and their employers and generating income for the Trust. 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 (previously NHS Plus), and has continued to work towards accreditation by the Safe Effective Quality Occupational Health Service (SEQOHS) scheme.

Health and Safety

The Trust has a legal duty to provide a safe environment in its buildings and grounds, free of danger or harm to its patients, staff, contractors and visitors. Health and safety standards at the Trust are managed, monitored and maintained through a number of specific actions which are outlined below:-

- a rolling programme of mandatory training for staff covering: Induction Training, Clinical Handling, Display Screen Equipment and Object Handling, Breakaway Techniques, Fire response training;

- reporting of all incidents and accidents via an Incident Reporting system which is monitored by the Risk Management Department ensuring review of risk and any appropriate follow up action is instigated;
- use of fully maintained departmental SALUS health and safety record books which are maintained by a named person in each department and regularly assessed;
- quarterly meetings of a Health and Safety Committee, drawn from workplace managers and staff health and safety representatives;
- the work of the Local Security Management Specialists (acute and community);
- departmental management and monitoring of correct practices.

Wellbeing Service

The wellbeing service is a fully independent confidential service which provides staff counselling, psychotherapy and coaching support to NHS employees in the Foundation 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 also contributes to arrangements for monthly supervision for staff whose work may be particularly emotionally demanding such as in cancer services; support for staff who have encountered incidents of physical or verbal aggression in the course of their work and cases of PTSD (post-traumatic stress disorder); and supporting departments going through organisational change. The service can facilitate sessions and tailor solutions to specific needs.

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. It also provides evidence of compliance in stress audits and inspections by the Health and Safety Executive. In addition to focussed short term work, comprehensive assessment sessions assist staff with more complex, severe or enduring issues to access long term services.

There is an ongoing gradual increase in the usage of the service and work has been undertaken to identify service development needs to be taken forward during the next year.

The wellbeing service is registered with the British Association for Counselling and Psychotherapy (BACP) and is a member of the Association for Counselling at Work. Counsellors working in the service are required to be BACP members and work to the Ethical Framework for Good Practice in Counselling and Psychotherapy.

A new Wellbeing Manager is to be recruited following retirement of the current post-holder in April 2015, therefore the role and remit of wellbeing services will be subject to future review as changes in service delivery and staffing occur.

Education, Learning & Development

<u>Values and Behaviours</u>

The Trust has spent time over the last 12 months consulting with patients, Trust members and staff to determine the values that represent the Trust's values. This consultation has resulted in the selection of the Values of Respectful, Responsible and Passionate. A behavioural framework which underpins these values has also been developed; this framework is the basis for the values based interviewing for candidates wishing to join the Trust. It will also form the basis for values led appraisal and it clearly defines the behaviours that the Trust expects to see demonstrated by our staff. It reminds everyone that at the heart of everything we do as a Trust is the patient experience. The following 12 months will see the roll out and wider communication of the values and the associated recruitment and retention tools that are based on these.

Workforce Transformation

The Trust has actively participated in a regional project to develop new roles/skills mix in the form of Advanced Clinical Practitioners. These roles are being developed to bridge the gap emerging as fewer doctors in training enter the NHS and national shortages of middle grade doctors are arising. The Trust has innovated within the Yorkshire & Humber region around the development of an education programme, which has both academic and work placement components for the safe and effective development of these roles.

Seven trainee Advanced Clinical Practitioners were recruited at HDFT and have commenced their training during the period covered by this Annual Report, with further recruitment planned for the forthcoming financial year, together with other projects reviewing the development of further new types of roles.

Corporate and Clinical Induction Programmes

To support new employees joining the Trust a Corporate Induction Programme is held twice monthly on the first and third Mondays and Tuesdays and coincides with new starter employment commencement dates. Induction time is treated as protected time for the new employee. The programme is delivered by a blend of face to face and eLearning, together with local workplace information.

Clinical induction programmes are held three times per year and timed to coincide with the doctors in training rotations.

Training Programme

Our compliance with the requirement for our workforce to undertake statutory, mandatory and essential skills training which is deemed necessary to enable them to perform their roles in a safe and effective way continues to increase and is now at 86% compliance.

Beyond the statutory, mandatory and essential skills training, employees are able to access a significant programme of internal training modules to support their development. These are either face to face training or eLearning, which is now embedded as a tool for the delivery of knowledge based learning throughout the Trust. The Trust offers Qualifications Credit Framework qualifications through our own in-house centre and have extended the range of these to include Health & Social Levels 2 and 3, and the following all at Level 3 - Clinical Healthcare Support, Healthcare Support Services, Allied Health Profession Support, Perioperative Support, Assessor Award and the Internal Verifier Award.

Employees also attend external training programmes as appropriate and a strong relationship with Health Education Yorkshire & the Humber (HEY&H) enables the Trust to access educational funding to further support the continued professional development of our workforce.

We are developing a training and assessment process to ensure that the Trust fully complies with the recommendations made in the Cavendish Report regarding the training and competence requirements for Health Support Workers and, in addition to this, a project to review roles and skills requirements at Bands 1-4 is scheduled to start early in the next financial year.

Clinical Skills and Simulation Training

The Trust Clinical Skills and Simulation facility continues to develop safer practice amongst multi professional staff groups. The facility was audited by HEYH and is evidenced as being used to its' full extent, with Clinical Skills training being delivered for almost 100% of time available. Due to these results, our Clinical Skills Training facility is deemed by HEYH to be one of the most used and successful centres in the region due to innovation of the clinical skills team. In 2015 funding was received from HEYH for the purchase of a paediatric high-fidelity simulation mannequin. This

will enable multispecialty and multi professional simulation training in paediatric emergencies for Emergency Department, Anaesthetics and Paediatric teams.

The team is utilising technology more to support education methodology, by video streaming and recording simulation scenarios for playback and evaluation purposes. HDFT is one of the few Trusts in the region which use simulation for the fundamentals of care training.

Apprenticeships

As the largest employer in Harrogate, the Trust is committed to providing opportunities for people to gain experience and qualifications whilst earning at the same time.

As well as working with schools to help pupils understand and experience career pathways available within the NHS, the Trust continues to offer apprenticeships and during the period covered by the annual report we employed 17 apprentices in areas such as Business Administration, Health & Social Care with Decontamination and Pharmacy Service Skills.The apprenticeship programmes, which run over 12 to 24 months, have enabled inexperienced individuals to receive formal training and on the job learning and development that will equip them with a qualification and skills that are transferrable into employment by the Trust or to other employers.

During the forthcoming financial year we are reviewing our Apprenticeship Strategy and plan to include apprenticeships into Health Support Workers.

Doctors in Training and Student Placements

The Trust actively participates in supporting the education and training of the healthcare professionals of the future. It works in partnership with our local Deanery and have approximately 120 Doctors in Training working with us. The Trust provides structured education, training and on-going support and work based experience to these individuals.

The Trust also works alongside local Universities and hosts nursing, midwifery and allied health professional students on practice placements. We are committed to the provision of high quality placements for the students to enable them to become fully equipped and competent healthcare workers. Students undertake work based education and learning, supported by an experienced mentor.

Organisational Development Associates

The Senior Management Team continues to support organisational development projects, which can introduce innovative changes, improve service provision and bring with them the possibility of economies and cost savings. The Organisational Development Associates Group will continue to facilitate the delivery of the Organisational Development strategy and lead in identifying projects suitable for development.

The Trust is represented on the Accelerate Leadership programme, Emerging Leaders Network, and Team and Systems Coaching. Internal leadership programmes have been widely attended on courses such as Flexible Thinking – How to do things Differently, Productive Leader and Productive Ward training, Lean Methodology and a whole range of other programmes are on offer in the Workforce Development programme manual.

All of the above programmes have rated extremely well. They are all a crucial element of succession planning arrangements for all leadership positions within the Trust. A Leadership Forum has been developed to bring together leaders from across the Trust to focus on the leadership challenges associated with delivering our plan.

Transformation Project Group

A Transformation Project Group has been established to oversee the delivery of major changes projects. There are four designated themes of Planned Care, Unplanned Care, Estates and Technology and Workforce, each overseen by a Director. Within each theme there are several work streams/project groups established with wide representation from our workforce to respond to the identified challenges.

Sir Robert Ogden Macmillan Centre (SROMC)

The SROMC was officially opened during 2014/15 and provides high quality cancer care in a modern, patient-friendly facility. Following the opening of the SROMC, views have been sought regularly from service users, to both evaluate the effectiveness and quality of the new facilities and to consider further areas which need improvement or development.

This has taken the form of:

- Monthly matron walkabouts and talking to each patient receiving treatment;
- A real-time patient feedback survey for each patient attending the service (started in November 2014). This is a quick paper survey provided to each patient. Monthly results are discussed at the unit's Quality of Care Team meetings and displayed on internal TV screens. These are being incorporated into the Directorate Quality report to the Board of Directors;
- A review by the Trust's Patient Voice Group – the report is being considered for actions;
- An ongoing satisfaction survey of the newly-developed Welfare and Benefits service. This is a telephone survey undertake independently by one of the Trust volunteers.

National Cancer Patient Experience Survey

The Trust takes a full part in the annual National Cancer Patient Experience Survey. It has achieved consistently excellently results in the survey, having previously (twice) been first in the country and, following the impact of inpatient configurations, in third position in 2014. The outcomes of the survey are shared with the Multi-Disciplinary Team (MDT), with key actions for each MDT incorporated into its annual workplan. This workplan and outcomes are incorporated within the annual submission/assurance process for Peer Review.

Each survey is also shared fully with the Harrogate Cancer Action Partnership (HCAP) group, which independently considers where it believes work on areas for improvement should be focused. A dedicated meeting with HCAP was held in October 2014 to consider the latest results and *verbatim* comments made by patients.

Local MDT Surveys

Each MDT also undertakes local surveys and, along with the outcomes of the National Cancer patient survey, considers whether a more in depth approach using either focus groups or further surveys is required to address any issue which are identified.

This work is supported by the national cancer peer review programme which exists to ensure services meet the required standards for cancer care in relation to quality and outcomes.

Serious Incidents involving data loss or confidentiality breaches

The Trust had no Serious Untoward Incidents regarding data loss or confidentiality breaches during 2014/15.

Environmental Sustainability Reporting

Information on the Trust's impact on the environment and measures being taken to mitigate this are contained within the Strategic Report section above.

STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF THE HARROGATE AND DISTRICT NHS FOUNDATION TRUST

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including her responsibility for the propriety and regularity of public finances for which she is answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officers' Memorandum issued by Monitor.

Under the National Health Service Act 2006, Monitor has directed Harrogate and District NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Harrogate and District NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and 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 Monitor's NHS Foundation Trust Accounting Officers' Memorandum.

Signed

Dr Ros Tolcher
Chief Executive **27 May 2015**

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 2015. In our opinion:

- the financial statements give a true and fair view of the state of the Group's and the Trust's affairs as at 31 March 2015 and of the Group's and the Trust's income and expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

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 were as follows:

Valuation of land and buildings - £76.9 million

Refer to page 73 (Audit Committee Report), page 16 (accounting policy) and pages 13 -18 (financial disclosures).

The risk: Land and building valuation is an estimate**,** arrived using various assumptions and judgements. Land and buildings are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost of a modern equivalent asset value (MEAV) that has the same service potential as the existing property. There is significant judgement involved in determining the appropriate basis (EUV or MEAV) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation, including the condition of the assets. In particular the MEAV basis requires an assumption as to whether the replacement asset would be situated on the existing site or, if more appropriate, on an alternative site, with a potentially significant effect on the valuation.

For 2014/15 an interim "desk-top" revaluation of all of the land and buildings, which did not involve the physical inspection of the assets, was undertaken by an external valuer from Her Majesty's Valuation Office Agency There is thus a risk that the valuation may not reflect the current use or condition of the assets.

Our response*:* In this area our audit procedures included:

- Assessing the competence, capability, objectivity and independence of the Trust's external valuer;
- Reviewing the valuation report, terms of engagement of, and the instructions issued to, the valuer to confirm consistency with the requirements of the NHS Foundation Trust Annual Reporting Manual (FT ARM);
- Critically assessing the reasonableness of the valuation indices applied by the valuer by benchmarking them against those used across the healthcare sector;
- Reconciling the valuer's report to the financial statements to ensure that valuation movements had been applied correctly both in total and at an individual asset level;

- Critically assessing whether the impairments and revaluations have been correctly accounted for in line with applicable accounting standards and the FT ARM; and
- Assessing the adequacy of the disclosures about the key judgments and degree of estimation involved in arriving at the valuation and the related sensitivities.

NHS Income Recognition - £174.8 million

Refer to page 73 (Audit Committee Report), page 16 (accounting policy) and pages 13 - 18 (financial disclosures).

The risk: The main source of income for the Group is the provision of healthcare services to the public under contracts with NHS commissioners, which make up 95% of income from activities. The Group participates in the national Agreement of Balances (AoB) exercise for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department of Health's resource accounts. The AoB exercise identifies mismatches between receivable and payable balances recognised by the Group and its commissioners, which will be resolved after the date of approval of these financial statements. Mis-matches can occur for a number of reasons such as:

- the Group and commissioners record different accruals for completed periods of healthcare which have not yet been invoiced or agreed in the first place;
- income relating to a partially completed period of healthcare is apportioned across the financial years and the commissioners and the Group make different apportionment assumptions;
- accruals for out-of-area treatments not covered by direct contracts with commissioners, but authorised by, for example, GPs on behalf of commissioners, are not recognised by commissioners; or
- there is a lack of agreement over proposed contract penalties for sub-standard performance.

We do not consider NHS income to be at high risk of significant misstatement, or to be subject to a significant level of judgement. However, due to its materiality in the context of the financial statements as a whole NHS income is considered to be one of the areas which had the greatest effect on our overall audit strategy and allocation of resources in planning and completing our audit.

Our response*:* In this area, our audit procedures included:

- Using the results of the AoB exercise to match the Trusts' NHS income with counterparty expenditure. We investigated differences by reconciling the initial contract value with the counterparty to the final income reported in the financial statements, determining the reasons for any differences and critically assessing the validity of recognising reconciling income items in the Trust's financial statements.
- for estimated accruals relating to completed periods of healthcare, comparing a sample of accruals to the invoice raised in the new financial year and checking evidence of payment;
- Checking the validity of accruals for partially completed spells by reconciling to counterparty balances and for a sample of balances checking evidence of payment or acceptance after the year end;
- For a sample of invoices raised immediately before and after the balance sheet date checking that income had been recognised in the correct financial period.

3 Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements was set at £4 million, determined with reference to a benchmark of income from operations (of which it represents 2.1%). 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 exceeding £200,000, in addition to other identified misstatements that warrant reporting on qualitative grounds.

The Group has two reporting components, Harrogate and District NHS Foundation Trust and Harrogate and District NHS Foundation Trust Charitable Fund, and both were subject to an audit 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 component audits performed for group reporting purposes were performed to materiality levels ranging from £4 million to £50,000.

4 Our opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts 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 2014/15; and
- the information given in the Strategic Report and the Directors' 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

Under ISAs (UK and Ireland) we are required to report to you if, based on the knowledge we acquired during our audit, we have identified other 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 accounts taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Group's performance, business model and strategy; or
- the Report of the Audit Committee, which describes the work of the Audit Committee, does not appropriately address matters communicated by us to the audit committee.

Under the Audit Code for NHS Foundation Trusts 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 2014/15, is misleading or is not consistent with our knowledge of the Group 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

We have nothing to report in respect of the above responsibilities.

Certificate of audit completion

We certify that we have completed the audit of the accounts of Harrogate and District NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Respective responsibilities of the accounting officer and auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page [x] the accounting officer is responsible for the preparation of financial statements which 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.

Scope of an audit of financial statements performed in accordance with ISAs (UK and Ireland)

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 purpose of our audit work and to whom we owe our responsibilities

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.

Clare Partridge
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
1 The Embankment
Leeds
LS1 4DW
27 May 2015

Annual Governance Statement 2014/15

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 for the year ended 31 March 2015 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 Quality, Governance and Risk Management Strategy was published in October 2013, and clearly defines the responsibilities of individual Directors specifically and generally. The strategy applies to all employees and requires an active lead from managers at all levels to ensure risk management is a fundamental part of the total approach to quality, corporate and clinical governance, performance management and assurance.

To ensure the successful implementation and maintenance of the NHS Foundation Trust's approach to risk management, staff are appropriately trained 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;

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

The NHS Foundation Trust's Human Resources Department monitors all mandatory and essential training and reports directly to the Board of Directors. This process has been strengthened by linking pay progression to the completion of essential and mandatory training.

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.

Employees, contractors and agency staff are required to report all incidents and concerns and this is closely monitored. The NHS Foundation 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.

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" event. National guidelines and standards that relate to good practice are identified and shared by the Trust Standards Group to ensure implementation plans are developed and monitored.

The risk and control framework

The NHS Foundation Trust has a system of integrated governance as described in the Quality, Governance and Risk Strategy. The key objectives of this strategy are to provide the framework for achieving:

- Compliance with external regulatory and other standards for quality, governance and risk including Care Quality Commission fundamental standards and regulations.
- A culture of effective risk management at all levels of the organisation.
- A robust assurance and risk framework to confirm all controls and mitigation of risks are in place and operating.
- The integration of quality, governance and risk within the Trust's strategic aims and objectives.
- Integrated governance encompassing financial, clinical, quality, corporate, information, performance and research governance systems.

There is 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. Non-Executive Directors, Governors, lay members and other stakeholders are key participators in many of the Trust's committees, and the quality of patient care is at the heart of this framework.

During 2014/15 there have been four formally constituted sub-committees of the Board; the Audit Committee, the Nomination Committee, the Remuneration Committee and the Finance Committee. The Quality and Governance Group, although not a formally constituted committee, reports to the Senior Management Team and via the Chief Executive, to the Board of Directors. It is chaired by the Chief Nurse and has representation from a Non-Executive Director, the clinical directorates and corporate functions, and receives minutes from the directorate quality and governance groups. This ensures that good governance is owned and delivered at directorate level as well as having corporate oversight.

The Mortality Review Group, Performance Management Group, IT Steering Group, Strategic Implementation Group and Corporate Risk Review Group report to the Senior Management Team.

The Quality of Experience Group, Clinical Risk Management Group, Non-clinical Risk Management Group, Patient Safety Group, End of Life Care Steering Group, Healthcare Associated Infection Steering Group, Harrogate Equality Group, Data and Information Governance Steering Group, Medical Education Strategy Group, Research and Development Group, Discharge Steering Group and Care of Confused Patients Steering Group report to the Quality and Governance Group.

Each directorate has a quality and governance group that reports to the Directorate Board and the Quality and Governance Group. Each directorate is represented on the Quality and Governance Group, the Clinical Risk Management Group and the Non-Clinical Risk Management Group.

The Complaints and Risk Management Group (CORM) comprising senior staff meets weekly to monitor and ensure active risk management, and reports directly to the Chief Executive. Concerns identified from incidents, claims, complaints and risk assessments are investigated to ensure that lessons are learnt.

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

The Quality and Governance Group drives and monitors 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. The quality improvement priorities reflect the three elements of quality; patient safety, effective care and good patient experience. The Quality and Governance Group promotes the embedding of quality throughout the NHS Foundation Trust with engagement of all staff groups, and oversees the production of the Quality Account.

The Quality and Governance Group works closely with the Audit Committee to assure the Board of Directors by ensuring robust arrangements for effective governance and risk management, and thus integrated governance is embedded in the organisation and practiced at all levels.

The Audit Committee receives reports from clinical, internal and external audit which enable it to provide independent assurance on governance and controls to the Board. Three Non-Executive Directors comprise the Audit Committee, and one of these is the Chair. The Deputy Director of Governance, a Deputy Medical Director, and others attend the committee. The integration of clinical audit and internal audit assurance is delivered through the Audit Committee, thus ensuring true integrated governance and assurance to the Board. The audit plan for clinical and internal audit is approved by the Audit Committee and is prioritised to focus on areas of risk and concern.

Internal Audit's primary role as a service to management and the Board of Directors is to provide an opinion and assurances on the adequacy and effectiveness of the systems of internal control.

Information governance is managed by the Data and Information Governance Steering Group. The NHS Foundation 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 received by the Board of Directors prior to submission. The Standards Group is responsible for ensuring that recommendations from external reports, audits, visits, inspections and regulators including Care Quality Commission (CQC) are met and for quality assuring returns from the NHS Foundation Trust to outside agencies. Both these groups are accountable to the Executive Director team and also report to the Audit Committee.

There are regular meetings with commissioners at the Contract Management Board to review performance and quality.

These committees and groups provide assurance to the Board of Directors on all areas of governance being:

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

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 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 identification and management of risk as communicated in risk registers aids decision-making and resource prioritisation. Risk registers hold operational risks in a standard format to allow comparison and aggregation. Risk assessment and management is addressed at three levels across the NHS Foundation Trust:

1. **Departmental**

Risks are assessed at ward, team and department level by the Quality of Care Teams or other relevant groups in line with guidance. Identified risks are recorded and monitored in departmental risk registers. The risk registers at this level reflect risk assessments carried out routinely as part of the health and safety process, as well as risks identified from other sources including incidents, complaints, local reviews and patient feedback.

Local Quality of Care Teams exist at ward, team and department level to champion quality care, to monitor it, and to promote it. Interested public governors have formed alliances with some of the teams. The Quality of Care Teams report to the directorate quality and governance groups, which report to the Quality and Governance Group.

2. **Directorate**

At directorate level, risk assessment is performed in line with objective setting. Risk registers are maintained at this level and risk is monitored by the Directorate Boards and designated sub-committees, with minutes of the Directorate Boards being received by the Senior Management Team. Risks are escalated as necessary from the departmental risk registers.

The Directorates work within an accountability framework which ensures that the systems of control are in place and adhered to. The Quality, Finance and Performance review meetings and the Executive Director Team regularly review the work of the directorates against the accountability framework.

3. Corporate

At corporate level, risks are identified against the organisation's objectives, and as a result of trust-wide assessment. Risks are escalated as necessary from the directorate and corporate functions registers. The risks are prioritised and form the basis of the corporate risk register. The Corporate Risk Review Group meets monthly and is responsible for reviewing the key risks identified, challenging risk scores where appropriate and monitoring progress with mitigating actions. The principal corporate risks are approved by the Senior Management Team every month. An update is reported each month to the Board of Directors, and the complete corporate risk register is reviewed quarterly.

This process reflects the Trust's appetite for risk.

The highest scoring risks on the corporate risk register for 2014/15 and going forward relate to:

- Patient harm due to failure to identify and manage mental health and mental capacity needs
- Harm to ward attending patients due to high numbers and failure to provide assessment in a timely manner and with sufficient observation of Gynaecology, General Surgery and Urology patients.
- Harm to ophthalmology patients and risk to reputation due to the high number of follow up patients
- Risk to business objectives relating to transformation programme for urgent and emergency care due to non-delivery of an integrated IT system across acute, community and social care, including a patient facing portal, through a lack of funding and internal expertise
- Risk to service delivery due to a reduction in trainee numbers allocated to the Trust by Health Education Yorkshire and the Humber due to the national reduction in trainee numbers

A Board Assurance Framework is regularly updated to assure the Board of Directors of the effectiveness of the system of control and the ways in which the organisation is addressing its future risks systematically. The Board Assurance Framework maps to the NHS Foundation Trust's identified objectives, and the mandated requirements for maintaining regulatory and FT licence compliance, and identifies the principal strategic risks. It includes the key controls against the risks, assurances in controls, as well as gaps in controls and assurance, target risk score and progress with actions required to address gaps and to achieve the target score. It is reviewed by the Board of Directors quarterly.

During 2014/15 the future risks identified on the Board Assurance Framework included:

- Lack of medical, nursing and clinical staff and the risk that quality of care is compromised if the Trust is unable to employ sufficient clinical staff to meet the demand for safe staffing and seven day working.
- High level of frailty in the local population with the risk that frail older people suffer a harm due to falls, pressure ulcers and other risks associated with frailty.
- Failure to learn from feedback and incidents.
- Lack of integrated IT infrastructure and the risk that clinical records are not accessible or that data to manage services and monitor contracts is incomplete.
- Service sustainability if the Trust fails to retain core business due to re-tendering of services.
- Understanding the market sufficiently to make informed commercial decisions.
- Lack of robust approach to new business with a risk that the Trust fails to undertake due diligence and agrees contracts which are loss-making.
- Visibility and reputation with the risk that the Trust has low recognition outside the current and traditional markets or fails to maintain a reputation as a high-achieving Trust.

- Risk to current business if the Trust fails to properly manage current business and fails to defend a market challenge due to a lack of foresight.
- Failure to deliver the Operational Plan with a risk of financial failure due to overspending, fall in income, lack of CIP delivery, poor controls or any combination of the above.
- Loss of Monitor licence to operate due to financial failure or a failure of governance.
- External funding constraints with a risk that the income received under national pricing models and contracts is insufficient to provide safe care and a continuity of services rating of 3 or more and under the current business model.

In 2014/15 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 monitored at directorate and Trust level every month.

The Trust has conducted a self-assessment against the conditions of its Licence conditions with Monitor and was fully compliant. In addition it has also carried out self-assessments against the Monitor Quality and Governance Framework and the updated NHS Foundation Trust Code of Governance. 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 of Directors.

A detailed review of quality governance and the governance framework was undertaken in January and February 2015, involving staff from across the organisation. The key outcomes from this piece of work have been a redesign of the committee structure with changes that include a new formally constituted committee of the Board for quality assurance, and new steering groups that will drive and coordinate delivery of the Trusts objectives. There are supporting processes to ensure purposeful meetings within the governance framework, and resources to engage staff in quality governance. These changes are to be implemented from 1 April 2015.

During 2014/15 the Trust reviewed and updated its CQC registration documentation and a new statement of purpose was submitted. A process for services to self-assess against CQC inspection requirements has been introduced, and the requirements of the new CQC fundamental standards are embedded in the terms of reference of the new steering groups in the governance framework. The Internal Audit plan includes assessment and audit of compliance with Monitor's licence conditions and CQC fitness to register. The Audit Committee reviews the evidence for compliance with CQC registration requirements annually.

A review against Monitor's: Well-led framework for governance reviews: guidance for NHS foundation trusts (updated April 2015) is in progress prior to an external review of governance during 2015/16.

There are no significant risks that have been identified to compliance with the NHS Foundation Trust condition 4 (FT governance).

The robust risk and control framework described will enable the Trust to declare assurance against the validity of its Corporate Governance Statement.

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 business 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 to ensure the quality of services is maintained.

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

The annual business plan is produced in consultation with the Council of Governors and approved by the Board of Directors. From 2014, a short term two year business plan has been developed, together with a five year strategic business plan.

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 of Directors 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 quarterly reporting to Monitor 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. Intelligent Monitoring Reports from the 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 not had any serious reportable information governance incidents including data loss or confidentiality breaches in 2014/5.

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. 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 Monitor. 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. A framework for reporting data and progress against local targets to the Quality and Governance Group is in place. This has enabled a regular and routine review of the quality metrics 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. The data quality and report are reviewed by the Quality and Governance Group. This Group is responsible for approving the report prior to submission with the annual 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.

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, including the quality and accuracy of elective waiting time data. The data reported for incomplete 18 week pathways has not been in line with national definitions since these were recently amended. A review of the impact of this revealed a negligible impact on the accuracy of the data, and processes have been amended from 1 April 2015. An opinion of significant assurance has been given for the Quality Account 2014/15.

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 and Governance Group, the Complaints and Risk Management Group (CORM), Standards Group 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:

- Monitor, the regulator of NHS Foundation Trusts continuity of services rating (COSR) for the Trust is currently 3.
- The governance risk rating, issued by Monitor, is green.
- CQC intelligent monitoring reports show a current risk score of six.
- CQC registration with no conditions.
- The Board Assurance Framework.
- Presentation of the Annual Governance Statement to the Audit Committee by the Accountable Officer
- The Audit Committee Annual Report, which includes internal audit and clinical assurance relating to clinical audit, reporting from Quality and Governance Group, Standards Group and Corporate Risk Review Group.
- The Corporate Risk Register.
- 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.
- Improving Working Lives status.
- ISA260 Audit Highlights Memorandum (External Audit Report).

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, staff rostering and requesting medical locums.

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 2015/16.

Conclusion

In summary I am assured that the NHS Foundation Trust has a sound 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 **27 May 2015**