HARROGATE AND DISTRICT NHS FOUNDATION TRUST
ANNUAL REPORT AND ACCOUNTS 2015 / 2016

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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1. CHAIRMAN'S STATEMENT

I am pleased to present Harrogate & District Foundation Trust's Annual Report for 2015/16; the year was one of both transformation and the core delivery of high quality care across our acute and community services. Combining an agenda of transformation with a clear focus on 'Excellence Every Time' is never easy, therefore I am proud that the Trust delivered a strong performance both in terms of the quality of the care provided and performance against national standards whilst pursuing a number of exciting and innovative changes to the way we deliver services.

Central to this ambition to transform the way we do things, the Trust was successful in being nominated as a national Vanguard site, and this has enabled us to progress our transformational agenda working in partnership with our colleagues across health and local government. This innovative project involves the development of New Models of Care for our service users.

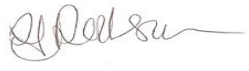
The continual focus on the achievement of high quality, underpinned by a culture of transparency, openness and innovation, is led with vigour by the Executive team; I would like to recognise their contribution under the leadership of Dr Ros Tolcher in achieving nationally acclaimed performance in 2015/16, including excellent results in both national patient and staff surveys. Our Board of Directors has seen only one change during the year with the arrival of Mr Neil McLean, Non-executive Director. Neil's expertise and experience, both as a commercial lawyer and in partnership working across the public sector, have enriched the skills of the Board.

Strong governance within a Foundation Trust is dependent on the commitment and contribution of the Council of Governors. Our Governors are energetic and committed in fulfilling their primary function of representing the interests of members and the public as a whole and I would like to thank them all for their support and energy over the year. Most importantly I would like to thank those who have stepped down from the Council of Governors: Carol Cheesebrough, Jane Farquharson, Jane Hare, Andy Robertson and also Mervyn Willshaw, who so ably supported both me, and his fellow Governors, as Deputy Chair of Council of Governors, and Fiona Wilson who served a full 3 terms, 9 years, as a Staff Governor. The Trust is indebted to their individual and combined contribution.

The contribution and views of members is an important element of the Foundation Trust model that we value and foster. We now have approximately 17,500 members who we seek to involve in a myriad of ways in the development and delivery of our services. This year we had another highly successful Open Event and held an interactive Annual Members Meeting which involved many members of the public, and our partners from both the health sector and local authority.

Delivering high performance is dependent on our staff, and I commend them all for their passion for quality, professionalism and hard work, in all their specialities and diverse roles. As a busy acute and community Trust, during the year our staff had over 500,000 patient contacts in the hospital setting and over 400,000 in the community. Our staff have been supported by a dedicated group of 500 volunteers. I would like to thank them all for their commitment and hard work over the last year.

As I look ahead, I do not doubt that next year will be another very challenging one; however, the Trust has strong foundations in place and remains focused on being an exceptional provider of services for our patients and service users.



Mrs Sandra Dodson
Chairman
25 May 2016

2. CHIEF EXECUTIVE'S INTRODUCTION

As Chief Executive Officer of Harrogate and District NHS Foundation Trust (HDFT) I am accountable for ensuring that our services are safe, effective, caring, responsive and well led. This Annual Report describes the work we have done over the last twelve months to ensure that this commitment is a reality for people using our services and that we have managed public funds responsibly.

Our vison is to deliver Excellence Every Time so that patients accessing our services - whether they are community or hospital based – can be confident that their needs will be met with care and compassion and in a timely manner. We deliver on this commitment by striving to be an exceptional provider. What this means in practice is that colleagues across the organisation are capable and motivated and that we have a culture which promotes learning, openness and transparency.

The national fiscal challenges mean that collaboration and partnership between health and social care is more crucial than ever. Early in 2015 the Trust was successful in bidding with local system partners to become a National Vanguard site. A significant part of our work over the last twelve months has been about using this partnership to co-design New Care Models which will allow all of us to deliver safe and patient centred care together. Reducing the reliance on hospital bed based care, and increasing prevention, personalisation and independence are core elements of our shared vision. The performance of the Trust overall has been underpinned by this ambition.

In HDFT we believe that careful management of financial resources is just as important as our unwavering focus on the quality of care we provide. This Annual Report provides more detail about the challenges we have faced, our operational and financial performance, and some of the national drivers impacting on the Trust as we plan for the year ahead.

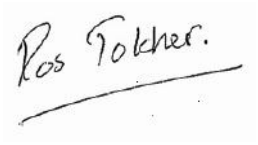
The Annual Report is complemented by our Annual Quality Account which offers a deeper insight in to our approach to quality and the progress we have made during 2015/16. We are particularly proud of our growing patient safety culture and the evidence of improvements in the fundamentals of care.

The Trust has once again performed extremely well across the full range of NHS Constitution standards which means that people choosing to have their care at Harrogate District Hospital have benefited from high quality, responsive, accessible services. The Trust met all of the key waiting times for cancer services and all of the referral to treatment waiting times. Our emergency department saw 1.5% more patients in the last 12 months and achieved full compliance with the 4 hour waiting time target in eight of the twelve months. Overall, 95.4% of people attending the emergency department and Ripon Minor Injuries Unit were seen and treated, admitted or discharged within the 4 hour target time.

In summary 2015/16 has been a pivotal year for the Trust. In the face of the relentless stretch to sustain quality and meet rising demand and expectation, the Trust has delivered on all of its key NHS Constitution commitments. Our services have been rated as amongst the best nationally by the people who use them and our staff survey places the Trust the top in three nationally when compared to peers.

I would like to extend my thanks to our Non-Executive Directors who work tirelessly to promote the values and ambitions of the Trust and provide support and positive challenge to the executive team. I would also like to thank our Governors and members for their contributions to our success.

Most of all, I applaud and thank colleagues across the Trust who contribute to delivering the very best possible care day in and day out. Whether they are in hospital or community services, direct patient care or a support role, it is their collective knowledge, skills and behaviours which enable truly outstanding care.



Dr Ros Tolcher
Chief Executive Officer
May 2016

3. PERFORMANCE REPORT

3.1. Overview of Performance

A brief history of Harrogate and District NHS Foundation Trust and its statutory background

Harrogate and District NHS Foundation Trust (the Trust) was founded under the Health and Social Care (Community Health and Standards) Act 2003 and authorised as an NHS Foundation Trust from 1 January 2005. The Trust is the principal provider of hospital services to the population of Harrogate and surrounding district, and also provides services to north and west Leeds representing a catchment population of approximately 900,000. Since April 2011, the Trust has provided a wide range of community-based services covering the Harrogate and District locality and some services covering the whole of North Yorkshire.

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 Sir Robert Ogden Macmillan Centre (SROMC) 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 Minor Injuries Unit, and offers a range of outpatient services to the communities of Ripon and the surrounding area. The Trust also acts as the first contact for access to more specialist services through alliance based working with neighbouring hospitals. These extended services are provided by visiting consultants, or alternatively, by the patient travelling to hospitals in York or Leeds.

The range of hospital services that are provided in partnership with York Teaching Hospital NHS Foundation Trust (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) and a Satellite Renal Unit. The latter two services are managed by YHFT, but provided at facilities on the Harrogate District Hospital site.

In addition, the Trust has a number of established clinical links with the Leeds Teaching Hospitals NHS Trust. 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 provided at Wharfedale Hospital. The Trust will start to provide outreach services at a new medical practice in Alwoodley, Leeds early in 2016/17. These will include services for Rheumatology, Gynaecology, General Surgery, Orthopaedics and Endocrinology.

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

- Children and Family Services;
- Community Equipment and Wheelchairs Stores;
- Community Podiatry Services;
- 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 the Selby War Memorial Hospital;
- Older People and Vulnerable Adults Services;
- Safeguarding Children Services;
- Salaried Dental Services; and
- Specialist Community Services.

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

Going concern statement

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

The Trust's strategy

During 2015/16, the Board of Directors (the Board) reviewed the strategy and engaged with staff across the Trust in respect of our values and our mission. The strategic aims of the organisation continue to be to:

- drive up quality and continue to deliver high quality care;
- work with partners to deliver integrated care; and
- increase services provided to ensure clinical and financial sustainability.

Our overarching vision is to deliver 'Excellence Every Time'. This will be achieved by continuing to work with our partners, through alliances and networks, developing more integrated services closer to home and expanding our catchment population into Leeds and North Yorkshire. A strong focus on organisational culture and the philosophy of 'You Matter Most' is the bedrock of that ambition. The Trust will continue to pursue the opportunities of vertical integration, and also use its existing clinical networks as the starting point for horizontal integration, where this makes sense.

Our strategy is therefore clearly in line with National Sustainability and Transformation Plans and the commissioning intentions of our main commissioners. It has been developed through discussion and collaboration with each organisation. The Trust is now actively engaged with local commissioning groups to implement the strategy, with a view to introducing different models of care across the health community. To support the achievement of our strategy, the Trust has agreed its goals, following consultation with staff and stakeholders. These are:

- to place patients/people who use our services at the centre of decision making;
- to support and engage with staff;
- to use resources carefully;
- to plan for the future; and
- use information to drive resilience, model future demand and manage risk proactively.

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

3.2. PERFORMANCE ANALYSIS

Regulatory ratings

The Trust's regulatory performance during the year has remained Green in all categories, in line with risk ratings contained in the Operational Plan and the Trust has met its infection control targets. 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 Monitor (NHS Improvement with effect from 1 April 2016) Risk Assessment Framework uses a wide range of metrics and data sources to assess the Trust's governance rating, including information from the Care Quality Commission (CQC) and other third party reports. The Trust reported a Green governance rating for each quarter of 2015/16.

Performance summary of 2015/16

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 2015/16.

Overall Trust performance against the A&E (Emergency Department) 4-hour waiting time standard was above 95% for eight out of 12 months during 2015/16. However, sustained delivery of this standard remained challenging and Quarter 4 was the first time that the Trust had been below the 95% standard for the quarter overall. The development and implementation of plans to enable the Trust to move back to a positive performance position continue, including reviewing staffing deployment and requirements, co-location with the GP Out of Hours Service, and a review of departmental physical clinical capacity.

There were two ambulance handover delays of over 60 minutes reported in 2015/16 and 101 handover delays of over 30 minutes. The two handover delays of over 60 minutes occurred on the same day which was an exceptionally busy day for the Emergency Department. Emergency Department attendances were 1.4% higher than for the same period last year.

Activity levels at the Trust have increased during 2015/16. Elective (waiting list) admissions were 2.8% higher in 2015/16 when compared to 2014/15. Outpatient attendances also increased by 2.8%. Non-elective admissions increased by 4.0% however the number of avoidable admissions (as per the national Commissioning for Quality and Innovation definition) decreased by 3.4% over the same period.

During 2015/16, there was a 13.6% increase in face to face contacts recorded by the community nursing teams. This increase may be partly due to improved data capture, but is also reflective of increased activity within these services.

Provisional data suggests that the stroke performance standard (the percentage of stroke patients who spend over 90% of their stay on the stroke unit) was delivered in 2015/16 with 84.3% of patients meeting the standard. Delivery of the Transient Ischaemic Attack (TIA) standard was at 78.1% against the 60% national standard. The Trust achieved the 18 week standard throughout the year.

The Trust reported 34 cases of hospital acquired Clostridium Difficile in 2015/16. Root Cause Analysis (RCA) results indicated that 23 of these cases were not due to lapses in care, and therefore, these would be discounted from the Trust's trajectory for 2015/16. Three cases are still under RCA consideration. No cases of hospital acquired MRSA (Methicillin-resistant Staphylococcus aureus) were reported in 2015/16. The following table demonstrates the Trust's performance against the indicators in Monitor's Compliance and Risk Assessment Frameworks for each quarter in 2015/16:

Indicator description	Target	Q1	Q2	Q3	Q4	2015/16
Referral to Treatment Times admitted pathways (% within 18 weeks)	>=92%	96.2%	95.7%	95.0%	95.6%	95.6%
A&E: Total time spent in A&E	>=95%	96.6%	95.7%	95.4%	94.7%	95.9%
Cancer - Maximum waiting time or 14 days from urgent GP referral to date first seen for all urgent suspect cancer referrals (%)*	>=93%	93.7%	97.5%	98.4%	97.3%	96.7%
Cancer - maximum waiting time of 14-days for symptomatic breast patients (cancer not initially suspected)*	>=93%	95.3%	96.9%	98.2%	95.5%	96.6%
Cancer - 31 day wait for second or subsequent treatment: Surgery*	>=94%	100.0%	100.0%	100.0%	100.0%	100.0%
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug*	>=98%	100.0%	100.0%	100.0%	100.0%	100.0%
Cancer - 31 day wait for second or subsequent treatment: Radiotherapy*	>=94%	NA	NA	NA	NA	N/A
Cancer - Maximum waiting time of 31 days from diagnosis to treatment for all cancers (%)	>=96%	100.0%	99.6%	99.0%	99.6%	99.6%
Cancer - 62 day wait for first treatment from urgent GP ref to treatment: all cancers	>=85%	88.9%	87.7%	93.4%	89.2%	89.9%
Cancer - 62 day wait for first treatment from consultant screening service referral: all cancers*	>=90%	100.0%	50.0%	95.8%	93.1%	88.9%
C-Difficile – cases due to a lapse in care (cumulative)	<= 12 cases in year	0	4	4	8 (tbc)	8 (tbc)
Community services data completeness - RTT information	>=50%	79.6%	80.6%	80.4%	79.9%	80.1%
Community services data completeness - Referral information	>=50%	71.3%	72.7%	73.0%	68.2%	71.3%
Community services data completeness - Treatment activity information	>=50%	81.4%	81.6%	81.4%	80.8%	81.4%

** Note: The target does not apply to Trusts with five or fewer cases in a quarter – the number of cases reported by the Trust during Q1 and Q2 was below this level.*

Risk Assessment Framework	Regulatory Ratings comparison							
	2014/2015				2015/16			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Financial Sustainability Risk Rating	3	3	3	3	4	3	3	3
Governance Rating	Green	Green	Green	Green	Green	Green	Green	Green

Performance 2015/16 and 2016/17

The Trust completed 2015/16 with a Financial Sustainability Risk Rating of 3 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 £6.9m and will meet all the required performance targets as laid out in the framework. The increase in surplus relates to the achievement of an underlying surplus of £2.2m, supported by Sustainability and Transformation funding.

The Trust will seek to achieve a minimum rating of 3 for Financial Sustainability 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 for 2016/17

In line with the Trust's Operational Plan for 2016/17, the significant developments for the coming year are detailed in the diagram on the following page.

In addition, the Trust will continue to work with partners to identify areas where it can continue to work collaboratively to develop new care models 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 2016/17 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 2017.

Quality

The Trust is fully committed to high quality care. The Quality Report, included within this Annual Report at Section 5, details progress made on the Quality Priorities identified in 2015/16 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 achievement of these through its Quality Committee, as well as on-going performance against the priorities from 2015/16.

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


Clinical Transformation
• Take forward work streams for Planned Care, Unplanned Care, Estates and Information Technology, and Workforce identifying key projects to be taken forward
Business Development
•Continue to roll out the Business Development Strategy, exploring further bid oppertunities for services
•Engage with local GPs to improve services
•Develop alliance based working with neighbouring provider organisations
Unplanned Care
• Take forward new care models with the implementation of Harrogate Vanguard
• Work with commissioners to agree the future provision of services in Ripon (Including Ripon Hospital)
Planned Care
• Take forward the implementation of 7-day working across the Trust
• Roll out plans for outreach services in Alwoodley, Leeds
• Take foward the Endoscopy unit and Decontamination projects
• Work to develop clinical partnerships
Community Services
•Continue to develop 0-19 Healthy Child Programme for Children's Services across North Yorkshire, County Durham, Darlington, and Middlesbrough
•Explore bid oppertunities for services
•Continue to review/rationalise community Estate
IT
•Continue on the path to operating 'paper-free at the point of care'
•Continue to develop and fully integrate our electronic patient record (EPR)
•Continue to review and improve the community IT infrastructure
•Work with local commissioners, providers, and social care partners to develop the Local Digital Roadmap
Capital Developments
• Develop capital ctrategy for Harrogate District Hospital Site
• Replace medical and scientific equipment
• Continue to progress work on the Decontamination Services and Endoscopy Unit projects

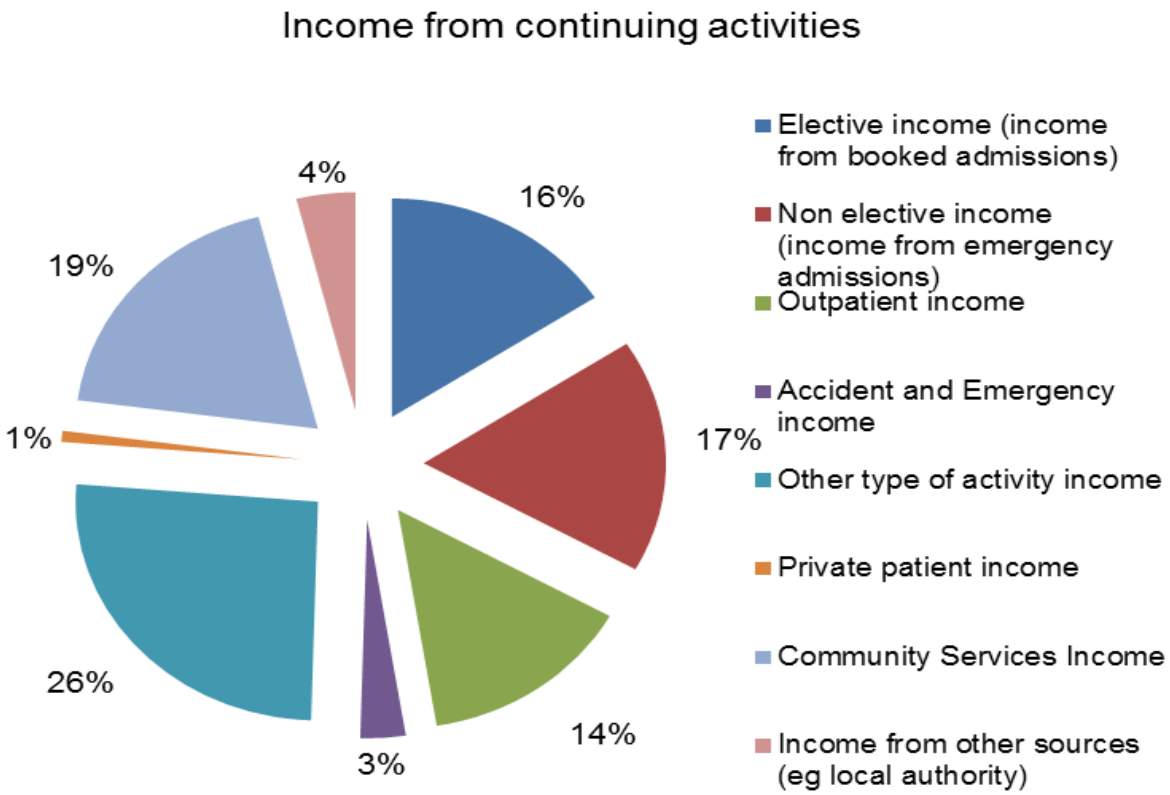
Operating and financial review of the Trust

The income and expenditure position for the Trust for 2015/16 was a surplus before technical items of £27,000. The table below provides a high level comparison of the income and expenditure account for 2015/16:

	2014/15 actual £000s	2015/16 actual £000s
Income	186,119	187,781
Expenditure	(186,109)	(187,754)
Surplus before technical items	10	27
Reversal of Impairment	-	350
Impairments on fixed assets	(587)	-
Reported (deficit)/surplus for financial year	(577)	377

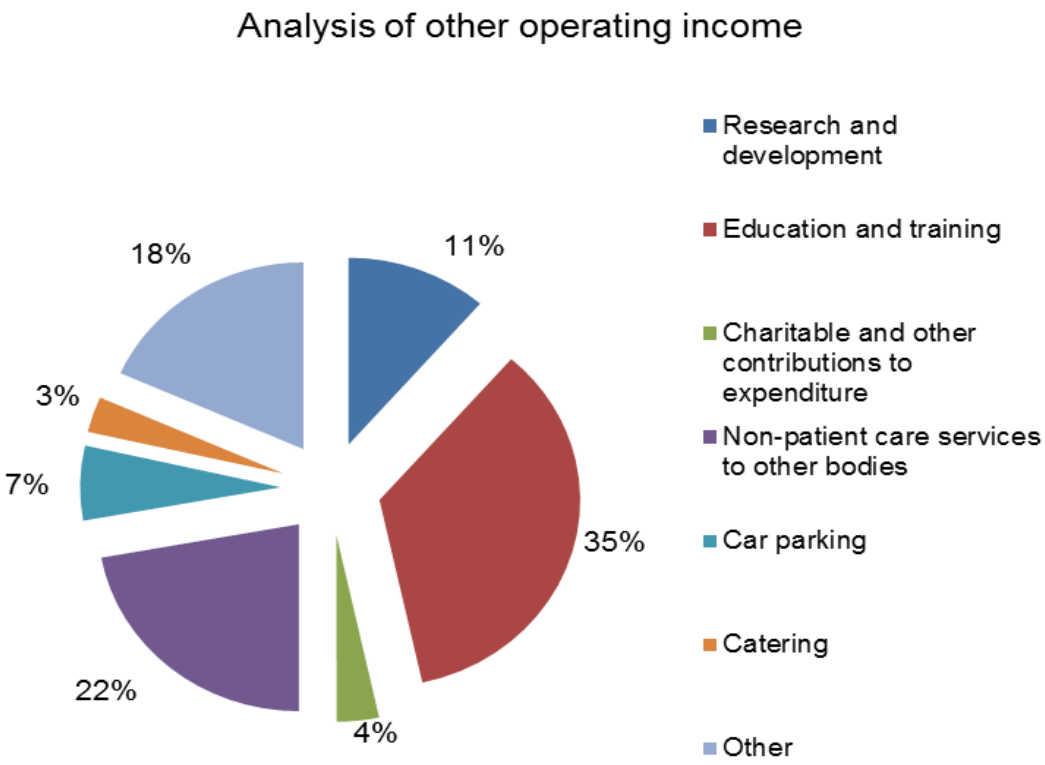
Income generated from continuing activities

Total income from continuing activities for the year 2015/16 was £177.1m. This represented 94% of total income for the year. An analysis of this income is shown below:



Other operating income

Other operating income totalled £11.8m during 2015/16. This represented 6.3% of total income for the year and an analysis of this income is shown below:



Cash

The Trust had a cash balance of £5.5m at the close of the financial year; £2.2m behind plan.

Monitor risk rating

The Trust achieved a Financial Sustainability Risk Rating of 3 at the end of 2015/16. Financial risk is assessed on a scale of 1 (high risk) to 4 (low risk).

Financial outlook 2016/17

The Trust recognises the financial challenges both within the NHS and across the public sector as a whole. The following financial year will continue to present a challenging productivity and efficiency requirement for the NHS, given the increasing demand for healthcare. However, the Trust recognises the opportunity in 2016/17 to provide further resilience following the Spending Review and sustainability and transformation funding offer, supporting both the local health economy and national provider sector.

Our financial plan acknowledges the financial pressures within the NHS and the actions we will need to take in 2016/17. The Board is absolutely committed to delivering its agreed control total in 2016/17 and to making the necessary efficiency savings to enable the Trust to continue to develop based on a robust financial position.

The following sections describe the assumptions within the plan, the actions in relation to income, expenditure and cash that we are taking, and the financial risks and mitigations going forward.

Key financial risk	**Mitigation**
Activity is below plan causing a shortfall in income.	Plan for 2016/17 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.
Efficiency programme not delivered in full	The efficiency target has been set at a level to include service developments, however, these are being held until the plan is being achieved. 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. The benefit of the agency cap rules has not been included in the plan, however, it is anticipated this will have a impact in this area.
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 2015/16.
Impact of not receiving sustainability and transformation funding	The sustainability and transformation funding is based on three criteria: 1. Achieving the financial control total 2. Achieving improvement trajectories on key metrics 3. Progress on transformation We are awaiting confirmation around the detail of these conditions, however, mitigations are covered in a number of points already outlined.

Capital investment activity

During 2015/16, the Trust invested £11.914m as part of the Trust's capital programme. The breakdown of the investment is shown in the table below:

Scheme	**£'000**
2nd MRI Scanner – Mobile Van	1,390
Carbon Energy Fund	6,841
Other (including equipment replacement, IT replacement, environmental improvements)	3,683
TOTAL	**11,914**

Land interests

During the financial year ending 31 March 2016, the Trust's land and buildings were revalued by the Valuation Office Agency (Royal Institute of Chartered Surveyors qualified) which is an Executive Agency of HM Revenue and Customs (HMRC). This valuation, in line with the Trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in an increase in value of the Trust's land and buildings of £2,892,000, which has been incorporated in the accounts.

Investments

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

Details of activities designed to improve value for money

The Trust will continue the 2015/16 approach to delivering efficiency with directorates supported to deliver Cost Improvement Programmes (CIPs) by the Clinical Transformation Board (CTB) and Business Development Strategy. This additional support is in recognition of the need to meet an increasingly challenging transformational programme.

The CTB is moving forward a number of long-term savings plans which require a significant transformational process. Part of this work related to benchmarking services to understand opportunities. There is a close parallel with the potential efficiencies identified by the work undertaken as part of Lord Carter of Coles productivity review. The Trust is actively engaging in this work using the outlined opportunities to drive further efficiencies.

With regard to business development, the Trust has a well-developed bid/no bid process in place when deciding whether to tender for new contracts. Any business development opportunity is assessed against an agreed set of criteria to determine its attractiveness and likelihood of success. Only when this exercise has been completed is a decision taken as to whether it is in line with our strategy and will contribute to our efficiency.

To date the Business Development Strategy has had distinct success with increases in both non-NHS clinical income and further development of clinical services in North Leeds.

The Quality Impact Assessment process relating to the efficiency programme continues to play a key role in ensuring quality, safety, and access is not compromised by efficiencies. This process has been assessed by our Internal Audit service and significant assurance opinion has been received in relation to the arrangements.

The Trust CIP target for 2016/17 is £8.2m (3.9%). It is recognised that the 3.9% target is challenging, particularly when compared to the national efficiency target of 2%. An additional 1.3% represents the impact of non-recurrent CIPs from previous years. The Trust has processes in place to give assurance and confidence that this will be achieved.

Strategic Risks

The Trust records strategic risks to the organisation in the Board Assurance Framework, which is reviewed by the Board monthly in outline and quarterly in detail. The Board undertakes a 'deep dive' on each strategic risk at its development days to ensure appropriate oversight and understanding of the internal and external environment, and its impact on the Trust. There were 15 strategic risks to the organisation as at 31 March 2016, as follows:

- risk of a lack of medical, nursing and clinical staff;
- risk of a high level of frailty in local population;
- risk of a failure to learn from feedback and incidents;
- risk of insufficient focus on quality in the Trust;
- risk to delivery of integrated models of care;
- risk of a lack of interoperable systems across New Models of Care partners to enable access by all concerned to a single shared medical record;
- risk of misalignment of commissioner/partner strategic plans;
- risk of service sustainability;
- risk of a lack of understanding of the market;
- risk of a lack of robust approach to new business;
- risk of a lack of visibility and impact on reputation;
- risk to current business;
- risk of failure to deliver the Operational Plan;
- risk of loss of Monitor Provider Licence; and
- risk of the impact of external funding constraints.

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

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 for 2016/17 and Strategic Plan for 2014 - 2019, 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.

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

Approval by the Directors of the Performance Report

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

Signed

Mr Jonathan Coulter
Acting Chief Executive
25 May 2016

4. ACCOUNTABILITY REPORT

4.1. Directors' Report

The Directors of the Trust during the year 2015/16 were:

Mrs Sandra Dodson	Chairman (Non-Executive Director)
Professor Sue Proctor	Non-Executive Director and Vice Chair
Mr Ian Ward	Non-Executive Director and Senior Independent Director
Mrs Maureen Taylor	Non-Executive Director and Chair of Finance Committee
Mr Chris Thompson	Non-Executive Director and Chair of Audit Committee
Mrs Lesley Webster	Non-Executive Director and Chair of Quality Committee
Mr Neil McLean	Non-Executive Director (from 1 May 2015)
Dr Ros Tolcher	Chief Executive
Mr Jonathan Coulter	Finance Director and Deputy Chief Executive
Dr David Scullion	Medical Director
Mrs Jill Foster	Chief Nurse
Mr Robert Harrison	Chief Operating Officer
Mr Phillip Marshall	Director of Workforce and Organisational Development

Company Directorships held by Directors or Governors

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

Accounting policies

The Trust prepares the financial statements under direction from Monitor in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16 which is agreed with HM Treasury. The accounting policies follow International Financial Reporting Standards (IFRS) to the extent they are meaningful and appropriate to NHS Foundation Trusts.

Better Payment Code of Practice

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

Year to 31 March 2015	Numbers	Year to 31 March 2016
49,048	No of Bills Paid to Date	46,667
6,860	No of Bills Paid in 30 Days	8,559
14%	% of Bills Paid in 30 Days	18%

Year to 31 March 2015	Values	Year to 31 March 2016
54,434	£K Value of Bills Paid to Date	61,549
15,884	£K Value of Bills Paid in 30 Days	23,960
29%	% of Bills Paid in 30 Days	39%

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

Countering fraud and corruption

The Trust's counter fraud arrangements are in compliance with the Secretary of State's Directions on countering fraud and the NHS Standards for providers: fraud, bribery and corruption. These arrangements are underpinned by the appointment of accredited Local Counter Fraud Specialists and the introduction of a Trust-wide 'Countering Fraud and Corruption Policy'. A Local Counter Fraud Annual Plan is produced and approved by the Trust's Audit Committee and identifies the actions to be undertaken to create an anti-fraud culture, deter, prevent, detect and, where not prevented, investigate suspicions of fraud.

Cost allocation

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

Charitable funds

The Board of Directors acts as Corporate Trustee for all funds held on trust and is registered with the Charity Commission as a single charity. The Trust continues to receive donations from a wide variety of benefactors, for which it is extremely grateful, and continues to utilise these funds for the benefit of both patients and staff.

As at 31 March 2016, the value of the funds held on trust amounted to £1,764,000 which is a decrease of £465,000 from 2014/15, while the value of income received in the full 12 months amounted to £460,000 (£600,000 in 2014/15). The value of resources expended amounted to £819,000 (£845,000 in 2014/15). There was a loss on valuation of investments of £106,000 (£143,000 gain in 2014/15).

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 Trust's investment panel; however any such changes are subject to an Ethical Investment Policy (e.g. shares of tobacco manufacturers cannot be held). The portfolio is reviewed quarterly by the Investment Panel, ensuring compliance with the Ethical Investment Policy.

The investment portfolio at 31 March 2016 stood at £1,750,000 (£2,003,000 as at 31 March 2015).

The Charitable Fund Annual Report and Accounts for the year ended 31 March 2016 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 in Section 4.3.

Charitable and political donations

During 2015/16 no charitable or political donations were made by the Trust.

Income Disclosures required by Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012)

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than the Trust's income from the provision of goods and services for any other purposes. The Trust confirms that it has met this requirement during 2015/16.

Enhanced quality governance reporting

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

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

The publication of Monitor's Well Led Framework for Governance provided a framework for Trusts to gain assurance that they are well led. This means that the leadership, management and governance of the organisation assures the delivery of high quality care for patients, supports learning and innovation, and promotes an open and fair culture. The framework is comprised of a self-assessment against a body of 'good practice' outcomes and evidence that can be used to assess governance processes. The Trust therefore commissioned Deloitte to undertake an independent review of the self-assessment with a view to identifying areas of improvement to ensure the Trust continues to have a strong platform on which to set strategy, lead the organisation, and be truly accountable to stakeholders in the future.

The outcome of the assessment was extremely positive and highlighted many areas of good practice in the Trust. An action plan was developed to address recommendations to enhance the Trust's strong quality governance processes even further, and this will be subject to continual review by the Board.

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

NHS Foundation Trust Code of Governance

The Trust complies with the provisions of the updated NHS Foundation Trust Code of Governance and has embedded its principles into the integrated governance of the organisation. Further details are given later in Section 4.4 of the report. Information relating to quality governance systems and process is detailed throughout this Annual Report, but in particular, in the Annual Governance Statement and Quality Report.

Care Quality Commission (CQC) reports

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

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

Development of services involving other local services/agencies and involvement in local initiatives

Health and social care partners in Harrogate and Rural District recognise that a sustainable local health and care economy is dependent on transforming the way that services are delivered for local people. We also believe that local people should expect to be able to access services that are joined up and support them to remain healthy, well, and independent. We are working with partners to dissolve the boundaries between services, so that no-one (public or professional) experiences gaps between services and can get the right support and advice at the right time. This requires a new model of care.

We have already made significant progress on this journey to develop new models of care, along with our five key partners: Harrogate Borough Council; Harrogate and Rural District Clinical Commissioning Group; North Yorkshire County Council (Health and Adult Services); Tees, Esk and Wear Valleys NHS Foundation Trust; and Yorkshire Health Network.

In addition, we work closely with Harrogate and Ripon Centres for Voluntary Service (CVS) and are developing opportunities with the Yorkshire Ambulance Service, the Fire and Rescue Service, and North Yorkshire Police.

Value propositions have been developed to show how collaboration can help us to realise our aims of ensuring that more people stay healthier and independent for longer, have choice and control over their lives and care, and that costs are reduced across the system. Work has progressed under four main activities:

- Embedding prevention and early intervention, and to empower the community

We are aligning prevention activity across all of the partners to achieve a greater impact on primary prevention. Our partnership with the borough and county councils and voluntary and community sector strengthens our ability to emphasise a preventative, community asset-based approach. The core purpose of our Local Integrated Teams is better planned and proactive care to pre-empt need and avoid unplanned care.

- Integrate and expand community health, mental health, and social care teams

We are putting in place four Locality Integrated Teams reflecting local communities. All community health and care services will operate as one service. The teams in Knaresborough, Green Hammerton and Boroughbridge are now operational. The Calderdale Framework approach used assesses the skills required to meet local needs and will enable us to develop the workforce to suit, including role-blurring and skill-sharing as well as new types of worker.

- Expand the rapid response in the community

Our new care model is supporting GP practices to change their skill mix to free-up GP time to support the integrated teams and respond rapidly to acute need in the community. Ten extra community beds to support “step-up” and “step-down” care have been opened. A District-wide Response and Overnight service provides a rapid response to de-escalate and stabilise patients who are acutely unwell and support carers with a night-sitting service.

- Develop systems and infrastructure to enable delivery of the new care model

We recognise that our systems and infrastructure are major enablers and that their current states can act as blocks to transformation. Shared IT records, estate and business intelligence are the cornerstones. We are also developing our approach to commissioning the new care model and the delivery entity which will achieve system sustainability and better outcomes for patients.

Involvement in other local initiatives has included:

- engaging with new public and voluntary and community sector partners in County Durham, Darlington, and Middlesbrough to prepare for the effective delivery of 0-19 Children’s Services from April 2016;
- participating in System Leadership Local Vision work in Harrogate to deliver “Let’s Talk About Dementia” engaging face-to-face with people with dementia and their families, friends, and carers; and,
- participating in “My Neighbourhood” Group, managing community development work in key wards in the borough of Harrogate to support the health and wellbeing of local people.

To support the Trust's approach to engagement and consultation with local groups and organisations, Dr Ros Tolcher attends the following meetings and forums:

- Public Services Leadership Board – the Board's vision states: "Together we will lead and support the design and delivery of quality services that are efficient, innovative, and reflect the specific needs and priorities of our local communities; ensuring better outcomes and improving the lives of local people".
- North Yorkshire Delivery Board – the delivery arm of the North Yorkshire Health and Wellbeing Board.
- Harrogate Health Transformation Board – drives the local approach to new care models.
- West Yorkshire Association of Acute Trusts (WYAAT) – a collaboration of West Yorkshire acute hospitals established to provide a collaborative leadership forum between Trusts to underpin the design, delivery, and operational effectiveness of acute services across West Yorkshire.
- Informal consultation opportunities – with local authority Chief Executives and General Practitioners, including visits with the Chief Operating Officer to 16 GP practices during May- November 2015.

The Trust embraces the value of true engagement with stakeholders, patients, members and the local community and examples of engagement activity during the year has included:

- mutual work shadowing arrangements between some GPs and hospital consultants;
- Harrogate and Rural District Vanguard "Open Space" Stakeholder Event. The event encouraged stakeholders to set the agenda for the discussion in relation to a shared question about creating a new model of care for Harrogate;
- engaging with City of York Council's Overview and Scrutiny Committee about Healthwatch York's report into wheelchair services;
- evidence given to Harrogate Borough Council's Social Isolation Task and Finish Group, provided an update on HDFT's perception of social isolation in the borough of Harrogate and what we are doing to support those who live with it; and
- consultation with people with dementia and their families, friends and carers at a "Let's Talk About Dementia" café event. The event was delivered in collaboration with leaders from across the health and social care system and supported by Harrogate Public Services Leadership Board. The event received very positive feedback and secured a number of improvements for people with dementia and their families, friends, and carers. This has led to further planning for a similar event in Knaresborough.

Stakeholder involvement

- Harrogate Cancer Action Partnership Group (HCAP)

The HCAP group has been established for over ten years and is a forum for representatives from varied organisations in the locality who contribute to service delivery in cancer and representatives from patients/carers who have been affected by cancer. Membership by patients/carers has normally been as a representative from each of the cancer support groups in the locality. The main focus of the group has been to:

- provide support opportunities for adult cancer patients, survivors and carers to meet with cancer commissioners and providers to examine how local cancer services can be improved in order to deliver improved health outcomes;
- enable patient representatives, with appropriate support, to fully participate in the multi-agency Harrogate Cancer Locality Board, working to improve local cancer services;
- act as a critical friend to Cancer Services, including contributing to the peer review of services; and
- provide support to the cancer self-help groups in the Harrogate District to help them become more sustainable.

As such, the group and representatives from the group have been co-opted to assist in reviewing and developing plans for continued service improvement. The group is hosted by Harrogate and Ripon CVS who also act as chair. The Chair is a key point of contact to help source individuals who wish to be involved in any aspect of user involvement. The group has played a key role in the development plans for the Sir Robert Ogden MacMillan Centre (SROMC).

Moving forward with additional funding from Macmillan the group aims to outreach to our service users outside of the traditional Harrogate population to determine the needs of patients/service users in our wider locality.

- Living With & Beyond Cancer Project

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

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

As part of the project a Patient and Public Involvement Strategy has been produced which defines the objective to listen, learn, and respond to service users wherever possible, in order to co-design a pathway of follow-up care and support that will best meet patient need within the resources available. A brief implementation plan outlines the various ways in which this will be achieved.

This was produced with input from the patient representatives and the Macmillan Involvement Coordinator, with a clear indication that service user involvement does not mean patients being passive recipients of services and information, but rather being truly involved on a parity of esteem basis, co-creating new services.

Stakeholders have also been involved in producing an options paper for the delivery of group health and wellbeing programmes, intended to replace traditional out-patient follow-up visits. Further views will continue to be gathered from attendees to the programmes, which are to be piloted later this year with the content and structure revised accordingly.

The use of an electronic holistic needs assessment tool is also to be piloted shortly in partnership with Macmillan. This method of assessing patient need is intended to enhance the use and consistency of assessments and will enable the resulting care plan to be shared electronically with both primary and secondary care colleagues. The aggregated data will also be of value in assessing future service needs and will provide evidence for peer review.

- Cancer Locality Board

The Cancer Locality Board's purpose is to ensure there is locality-wide and cross-organisational influence and agreement for the cancer agenda and cancer pathways. Representation includes the Chair and patient representative from HCAP as well as GP and CCG colleagues. The group ensures local needs are articulated and met appropriately for cancer patients and their carers.

- Cancer Peer Review

The national Cancer Peer Review programme exists to ensure services meet a set of standards for a given tumour site which demonstrate compliance with local and national guidance for quality and improving outcomes. The Trust undertakes internal verification in addition to the external visits from the national team. Our internal verification visits are treated as a formal process and commissioners, and patient representatives/service users are invited to form part of the panel. We are encouraging more service users to come and observe the process with a view to taking part in the future so we can increase our pool of users and ensure this valuable input continues.

- Ongoing evaluation/development of Sir Robert Ogden MacMillan Centre

Following the opening of the SROMC, views from service users have continued to be sought regularly to both evaluate the effectiveness/quality of the new facilities and to consider further areas which need improving/developing. This has taken the form of:

- a monthly Matron walkabout and talking to each patient receiving treatment;
- a real-time patient feedback survey for each patient attending the service. This is a quick paper survey provided to each patient. Monthly results are discussed by the centre's Quality of Care Team and displayed on TV screens. These will now be incorporated into the Directorate Quality report for Board;
- the Patient Voice Group has undertaken a review with actions under consideration; and
- an ongoing satisfaction survey of the newly developed Welfare and Benefits service. This is a telephone survey undertaken independently by one of our volunteers.

<u>Surveys and patient and service user feedback</u>

- National Adult Inpatient Survey

The survey had a response rate of 52% compared to a national average of 45%, and 87% participants rated care at the Trust as 7+ out of 10. Picker highlighted the following positive outcomes:

- 87% of patients rated their care as 7+ out of 10;
- 85% felt they were treated with respect and dignity;
- 83% always had confidence and trust in doctors;
- 98% felt their room or ward was very/fairly clean;
- 98% felt the toilets and bathrooms were very/fairly clean; and
- 91% felt there was always enough privacy when being examined or treated.

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

- National Cancer Patient Experience Survey

The Trust takes part in the annual National Cancer Patient Experience survey. We have consistently achieved excellent results in the survey; twice being first in the country before returning to third position in 2014. Results for the 2015 survey had not been released at the time of writing this report. The outcomes of the survey are shared with each multi-disciplinary team (MDT), with key actions for each MDT incorporated within their annual work plan. The work plan and outcomes are incorporated within the annual submission/assurance process for Peer Review. Each Survey is also shared fully with HCAP who independently consider where they believe areas for improvement should be focussed.

Partnerships and alliances/relationship management

As part of the Business Development Strategy, the Trust has introduced new relationship management arrangements to ensure that the organisation is fully engaged with its key stakeholders. A key account approach has been introduced with representatives from within the Trust identified to liaise with partners to keep them informed of the work being undertaken in the organisation and to explore further opportunities for partnerships and alliance based working.

Our alliances with York Teaching Hospital NHS Foundation Trust continue, with regular discussions between senior representatives from both organisations regarding opportunities for collaborative working. Over the last 12 months, these have included the developments in Plastic Surgery and Vascular services. The Trust is also actively engaged with the Leeds Teaching Hospitals NHS Trust to explore opportunities for greater engagement in developing services across the patch. Early initiatives include providing Endoscopy services at Wharfedale Hospital and the provision of Paediatric Trauma and Orthopaedic Surgery at the Trust by a visiting Leeds Consultant.

The Trust is also a member of the West Yorkshire Associations of Acute Trusts, and will be working closely with other provider organisations across West Yorkshire in the coming year, to explore areas where opportunities for collaboration can be identified and developed.

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 at Section 5.

New services and developments

- Consultant appointments

Consultant appointments were made across a number of specialities including the recruitment of two General Surgeons, two Consultant Rheumatologists, a Consultant Haematologist, a Palliative Medicine Consultant, and recruitment of a new Plastic, Reconstructive and Cosmetic Surgeon (in Partnership with York Teaching Hospital NHS Foundation Trust), all of which have enabled the organisation to continue to deliver high quality standards of care.

- Nurse staffing

The Trust successfully recruited Specialist Nurses to ensure the delivery of the highest quality care. In addition, a Harrogate District Hospital nurse had been appointed as Diabetes UK Local Clinical Champion, the only nurse among 20 other healthcare professionals.

Business development

The organisation has developed and approved the Business Development Strategy over this past year. The strategy is being rolled out and has resulted in some key successes, including the implementation of the Children's Influenza Immunisation Service in North Yorkshire and City of York. In addition, the Trust has won various tenders, including the 0-19 Children's Service across County Durham, Darlington and Middlesbrough, and the Occupational Health Service for Harrogate Borough Council Staff, all due to go live in April 2016.

Following the award of 0-19 community children's services from County Durham, Darlington and Middlesbrough, the Trust embarked on a joint consultation process under the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) with the outgoing employers South Tees NHS Foundation Trust and County Durham and Darlington NHS Foundation Trust. The Trust consulted with all staff as part of the TUPE process, led by the outgoing employers, with the involvement of the Trust managers and trade union representatives to ensure staff were supported in understanding the new 0-19 service model and ensuring a seamless transition to the employment of Harrogate and District NHS Foundation. A total of 470 staff will transfer on 1 April.

The Trust has been provided with an exciting opportunity to offer services to a new GP Practice based in North Leeds. Having been approached by the GP Practice, work is currently underway to introduce new services from 3 May 2016.

Improvements in patient/carer information

The Trust has launched a completely new website, promising a better user experience, clearer information, and a much more modern look and feel which better reflects the Trust's vision and values. The website launched in April 2016.

Recognising its website was dated and in need of refreshing, during 2015/16, the Trust undertook a project to completely develop the site. The project saw extensive engagement with users including patients, visitors, and staff, who helped the development team really understand the needs of site visitors.

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

The website also features a completely new Consultants area which features a short biography and photo of all the consultants working at the Trust. Again, user feedback suggested that this would be a very useful feature for helping people to choose to access care here. Elsewhere, all services pages have been reviewed, reordered, and in many cases, completely refreshed.

Like all NHS trusts, the Trust was legally obliged to start implementing the Accessible Information Standard during 2015/16. The Standard tells organisations how they should make sure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate. The Trust began work with a local not-for-profit company, Straight Talkers, who agreed to support the Trust to engage with patients to understand their needs and put in place systems for capturing and appropriately recording patient preferences. Work also began to improve existing patient communication mechanisms to meet the criteria set out in the Standard.

In addition the Trust outsourced the printing and distribution of outpatient appointment letters to an external company called Synertec. This has provided the opportunity to redesign our appointment

letters so that appointment information is clearer on the front of the letter with additional patient information on the reverse. Functionality of the new product will allow for letters to be tailored to the needs of individual patients such as large print and easy read leaflets.

The Trust has also developed its social media presence to open up new channels of dialogue with patients, members of the public, and other stakeholders. This focused primarily on developing the main Twitter account (@HarrogateNHSFT) and launching a brand new Trust-wide Facebook page. Both pages grew in popularity throughout the year. In addition, support was given to individual teams who wanted a social media page of their own to communicate with a specific group of patients or carers.

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

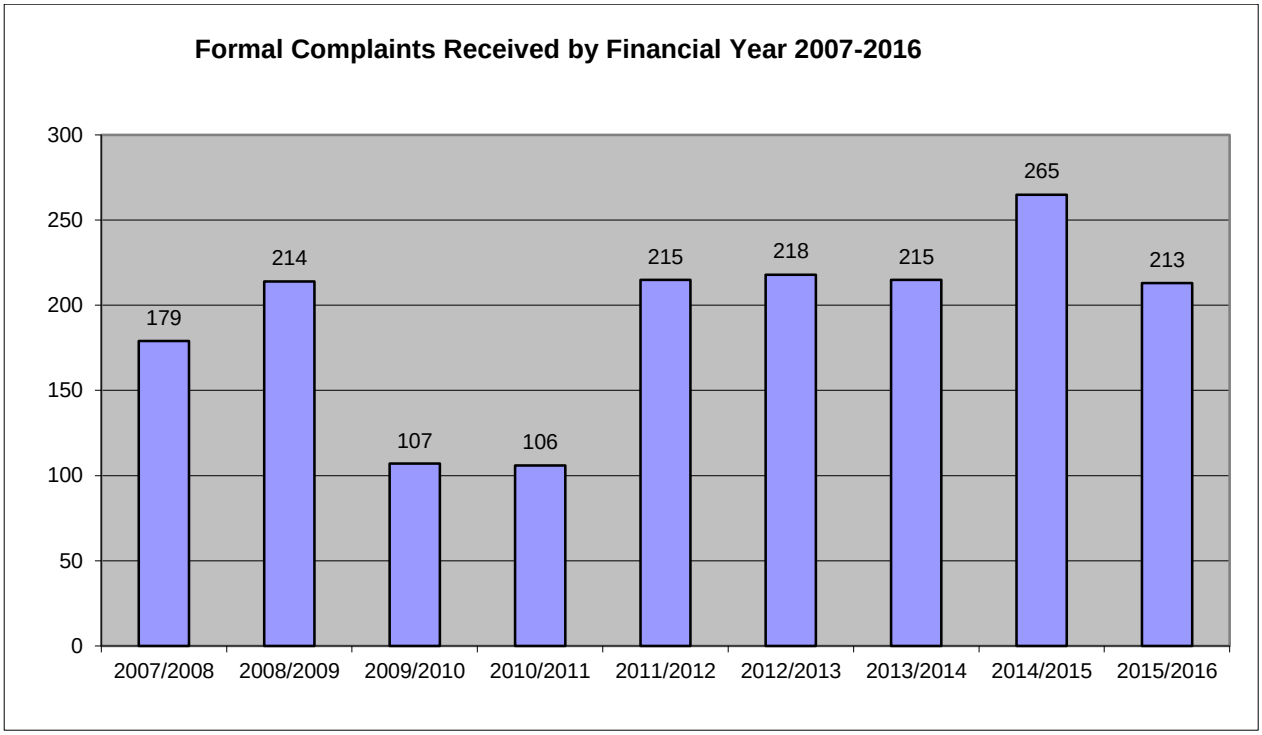
Complaints handling

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 taken 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.

The Trust welcomes patient feedback; both positive and 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 (PET) 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 18 complaints per month (2015/16) is relatively small at one per 7,000 patient contacts and is less than the average of 22 complaints per month for 2014/15.



Patient feedback data since 2007

The data from April 2007 to March 2011 refers only to acute hospital services. 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 2015/16 is presented below by grade and quarter in which it was received, compared to 2014/15.

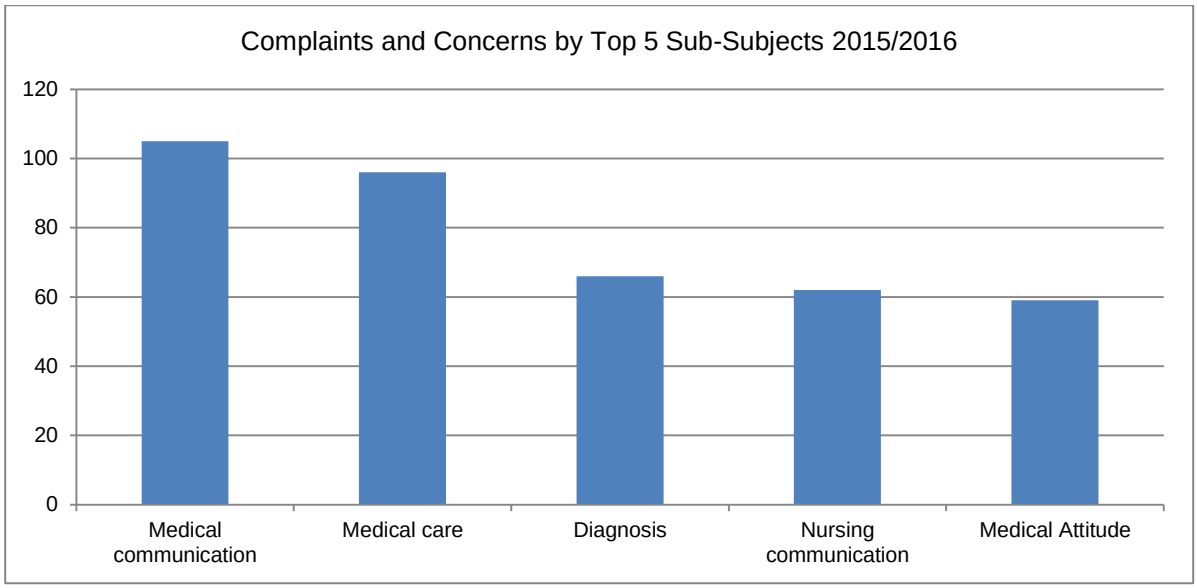
Complaints Total	**2015/16**					**2014/15**
	Q1	**Q2**	**Q3**	**Q4**	**Total**	**Total**
	74	**58**	**32**	**49**	**213**	**265**
Complaint Green	26	14	8	18	66	94
Complaint Yellow	46	42	21	31	140	163
Complaint Amber	2	2	3	0	7	8
Complaint Red	0	0	0	0	0	0

Patient feedback data showing complaints by quarter during 2015/16 and grade

The number of complaints received is less than the previous year and the number of cases indicating poor experience in several areas which are graded as moderate (Yellow) or high (Amber), is lower than last year. Quarters 1 and 2 received the most numbers of complaints. The Trust experienced high levels of patient activity during this period as did many hospitals across the NHS. The Trust also refocused efforts to resolving as many issues and concerns at front line informally as soon as possible to prevent the escalation into a formal complaint.

The resolution of informal “PALS” (Patient Advice and Liaison Service) type contacts includes concerns, information requests, and comments. In total in 2015/16, 676 contacts were received by the Patient Experience Team (PET) compared to 902 in 2014/15. Of these 676, 373 were concerns, 156 were requests for information, and 147 were comments. The data demonstrates a reduction in the number of cases presented to the PET and an indication that front line staff are responding to and handling patient feedback swiftly in the wards and departments.

The top five themes for complaints and concerns can be seen in the graph below. The main themes have consistently included issues around aspects of medical care, diagnosis, medical and nursing communication.



Patient feedback data showing the main themes in complaints and concerns

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 54% of cases in 2015/16 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. A complaints performance metric has been introduced for 2016/17 and will include monitoring of complaints responses against a target of 95% within deadline set and monitoring of completion of action plans.

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.

Five cases were referred to the Health Service Ombudsman in the period (nine in 2014/15). Of the five cases referred during 2015/16:

- one has been investigated by the Ombudsman and partially upheld. An apology and action plan to address the findings has been completed;
- two have been investigated by the Ombudsman and not upheld; and
- two are under review by the Ombudsman.

Cloverleaf Advocacy Services 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. The table below shows those received by the Patient Experience Team.

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Compliments received by the Patient Experience Team	233	354	354	291	330	315	340

Local data showing compliments received by the Patient Experience Team

Sustainability report

The Trust's Carbon Management Plan continued to gain momentum in 2015/16. The Trust signed a Carbon Energy Fund (CEF) guaranteed savings contract in March 2015 which will save £15.6m in energy costs over the next 25 years. Key activities undertaken throughout the year as part of the CEF include:

- conversion of lighting systems (external and internal) to high efficiency/low energy LED (light emitting diodes) light fittings;
- installation of new electrical cables around the perimeter of the Harrogate District Hospital site;
- installation of new boilers;
- new standby electrical generators serving the Strayside Wing installed and commissioned; and
- new chilled air infrastructure.

Additionally other non-CEF sustainability initiatives included:

- installing software to enable Trust computers to be turned off when not in use;
- provision of additional cycle storage facilities on the Harrogate District Hospital site;
- introduction of paperless reporting within Pathology and Radiology – this initiative saved not only a substantial volume of paper, but also a significant amount of staff time in transporting paper reports around the Trust; and
- increased use in mobile technology devices has reduced the need to print papers for meetings. The outcome of these changes, and increased staff awareness are considered to be key drivers in achieving a reduction across the Trust in the amount of paper ordered over the past financial year with Trust Headquarters achieving a fall of 15%.

- Meal Production

The Catering Service was awarded the Soil Association Food for Life Bronze Catering Mark in February 2016. The Catering Mark is an independently audited framework for hospitals to take steps to improve the food they serve to patients, staff and visitors. Achieving this endorsement is an exceptional achievement in the healthcare sector and a demonstration of the Trust's dedication to serving fresh, ethical sustainable food that meets nutritional guidelines. As a result of being awarded the Catering Mark, the catering service has increased the volume of locally sourced food from the Yorkshire region across all meals served.

- Procurement

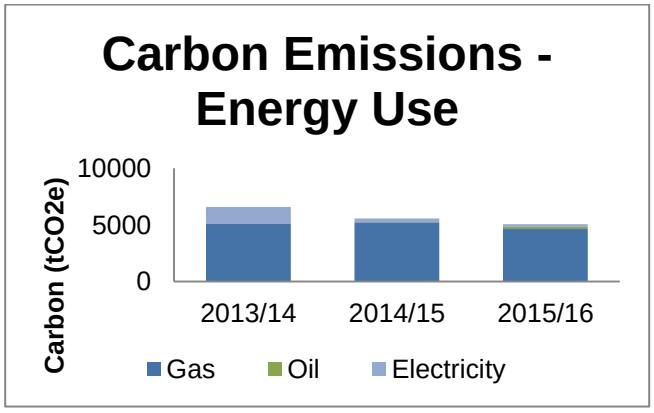
The Trust continues to make use of national contracts and receive a range of sustainability benefits from NHS Supply Chain (NHSSC). NHSCC provides the Trust with many of its essential supplies in addition to organising contracts for a range of key medical and non-medical goods ranging from chairs to CT scanners. For example over the past 12 months, NHSSC has worked with a leading medical supplier to implement supply chain efficiencies that have resulted in an 18% trailer fill improvement on deliveries from their European Distribution Centre. On a smaller scale, the Trust also benefitted in terms of both environmental and economic sustainability through NHSCC rationalising desk top stationery items from 8000 lines to fewer than 300. The Trust's information services/medical records have recently commenced a new contract with a provider of desk top mailing services which have sustainability benefits. A range of patient letters is now being sent electronically to the provider to distribute rather than being printed and mailed locally.

- Energy

Energy consumption for 2015/16 is 6.8% less than for 2014/15 and this can be attributed primarily to a reduction in gas consumption driven by the reduced operation of the CHP; this was due to the unit being off line for periods during the Carbon and Energy Fund Infrastructure Project.

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

Resource		**2013/14**	**2014/15**	**2015/16**
Gas	Use (kWh)	27610693	28351407	25190571
	tCO_2e	5081.47194	5217.792944	4636.072687
Oil	Use (kWh)	50800	21280	701400
	tCO_2e	13.805408	5.7830528	190.612464
Coal	Use (kWh)	0	0	0
	tCO_2e	0	0	0
Electricity	Use (kWh)	4,317,894	5,634,776	5,805,697
	tCO_2e	1474.881374	355.5705535	239
Total Energy CO_2e		**6570.158722**	**5579.146551**	**5065.703436**
Total Energy Spend		**£ 1,331,979.00**	**£ 1,453,863.00**	**£ 1,282,923.00**



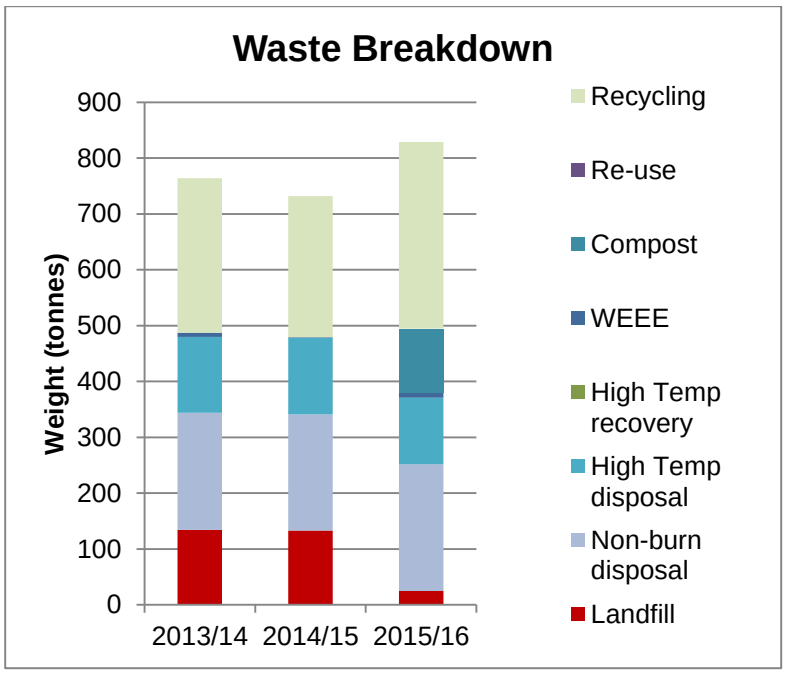
- Waste Management

The Trust has continued to work closely with its waste management partners over the course of the year and the partnership made in 2014/15 with an organisation to recycle food waste to generate off site electricity. This has really come to fruition this year providing carbon emissions saving this year of 52.99tCO_2e.

The contract for non-clinical waste was renewed in 2015/16 and the Trust appointed a new contractor to provide this service. This saw a significant reduction in the amount of waste sent to landfill. *Due to the change in waste service provider the data available for the first and second quarter 2015/16 is incomplete.*

As part of the Carbon and Energy Fund Project, the existing equipment that has been removed has been sent for metal recycling through our own metal waste service provider generating 24.744 tonnes of waste and generating an income for the Trust.

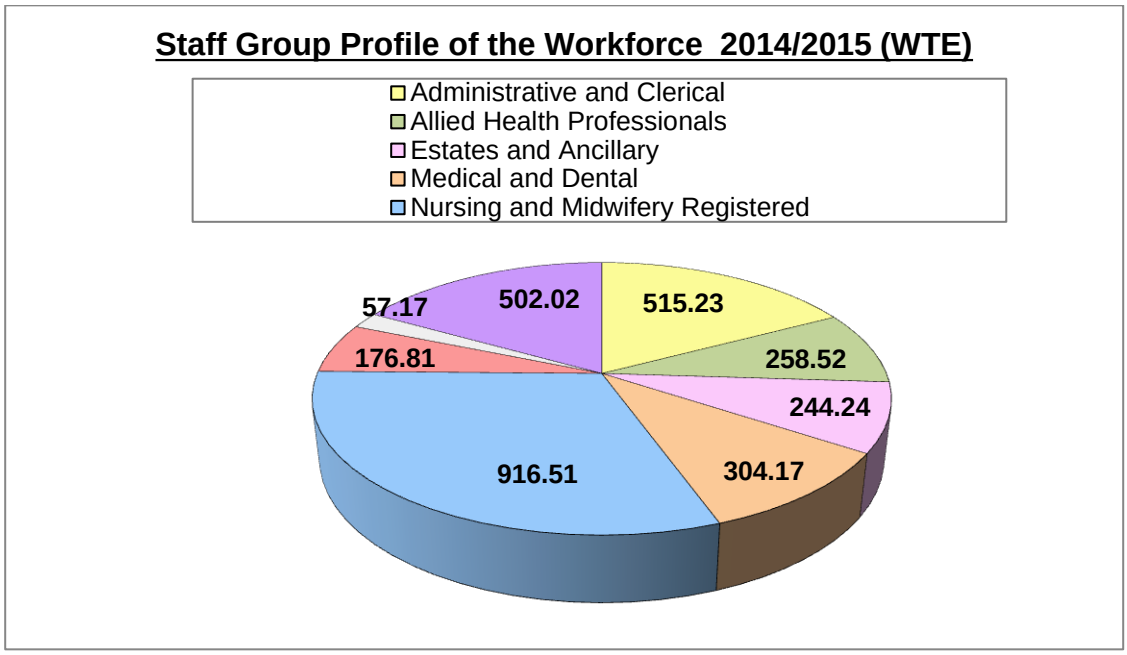
Waste		**2013/14**	**2014/15**	**2015/16**
Recycling	(tonnes)	277	252.57	334
	tCO_2e	5.817	5.30397	7.014
Re-use	(tonnes)	0	0	0
	tCO_2e	0	0	0
Compost	(tonnes)	0	0	115
	tCO_2e	0	0	0.69
WEEE	(tonnes)	7.304	0.86	9.12
	tCO_2e	0.153384	0.01806	0.19152
High Temp recovery	(tonnes)	0	0	0
	tCO_2e	0	0	0
High Temp disposal	(tonnes)	136	137.1	119
	tCO_2e	2.856	2.8791	2.499
Non-burn disposal	(tonnes)	210	208.4	227
	tCO_2e	4.41	4.3764	4.767
Landfill	(tonnes)	134	132.83	24.7
	tCO_2e	32.75197941	32.46601064	6.037118593
Total Waste (tonnes)		**764.304**	**731.76**	**828.82**
% Recycled or Re-used		**36.24212355**	**34.51541489**	**0.008462634**
Total Waste tCO_2e		**45.98836341**	**45.04354064**	**21.19863859**

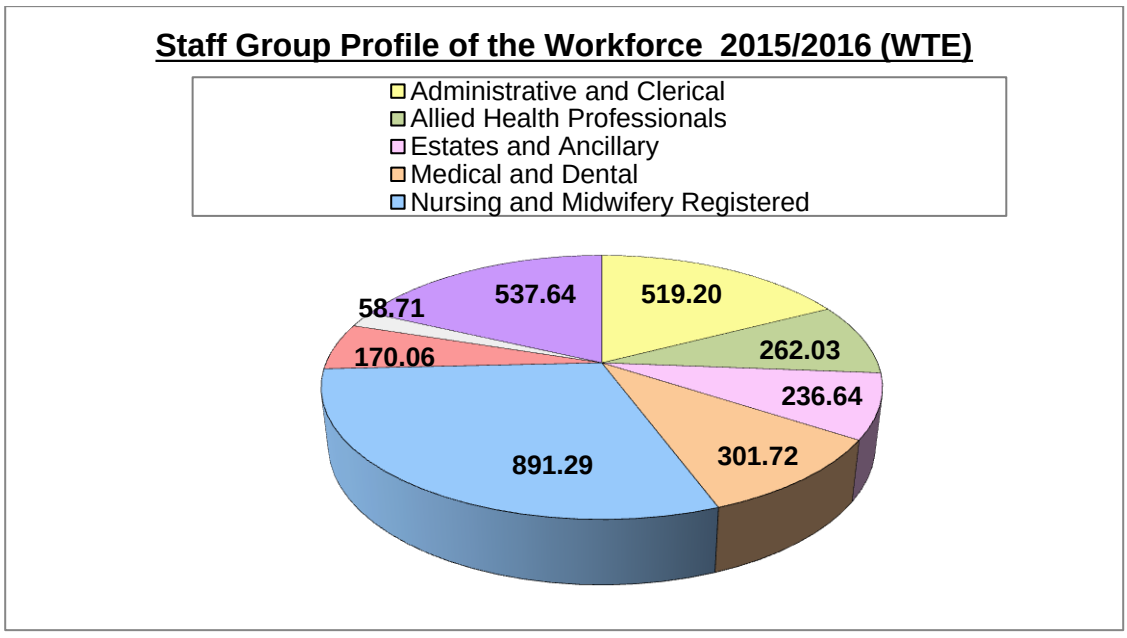

Waste Breakdown
Weight (tonnes)
900
800
700
600
500
400
300
200
100
0
2013/14
2014/15
2015/16
Recycling
Re-use
Compost
WEEE
High Temp recovery
High Temp disposal
Non-burn disposal
Landfill

4.2. STAFF REPORT

All of the data profiles of the Trust's staff in the charts below have been collated from the Trust's Electronic Staff Record (ESR) system and provides a comparison between 2014/15 and 2015/16. All figures are taken for the end of the financial year.

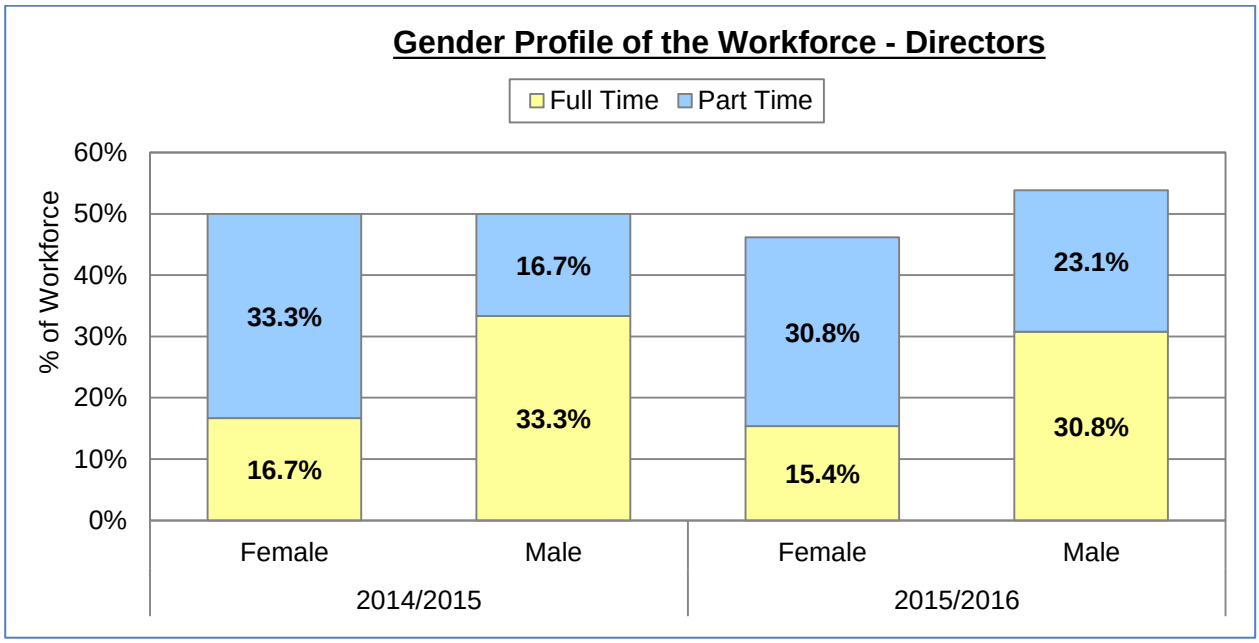
An analysis of average staff numbers





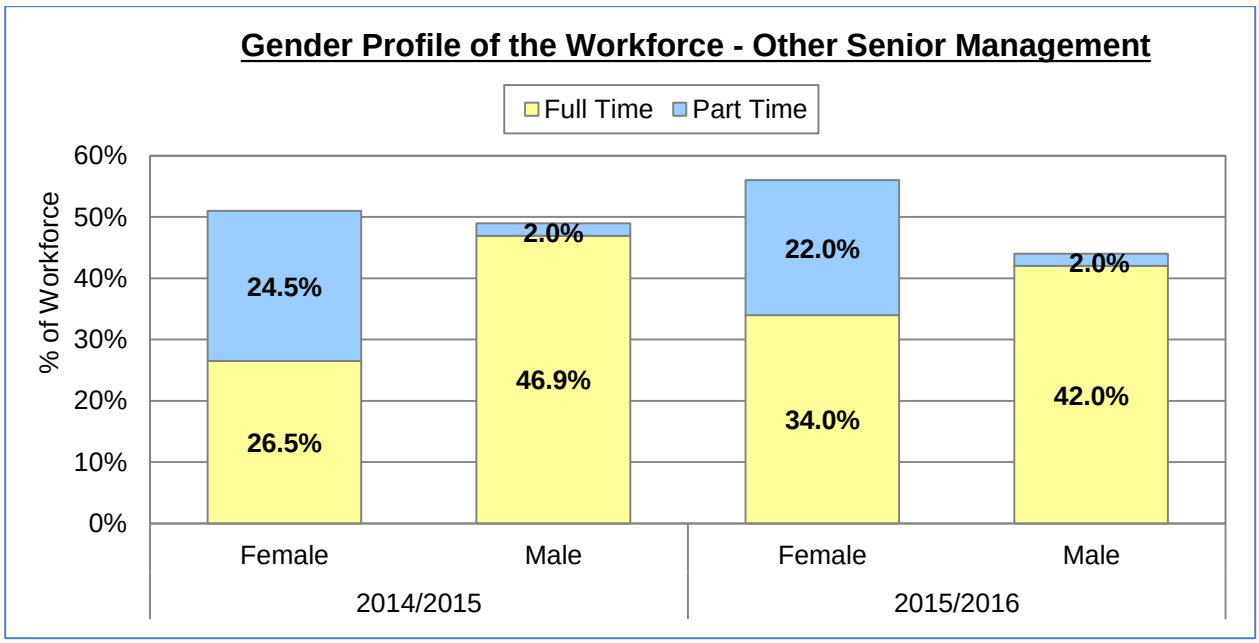
Staff Group	2014/2015		2015/2016	
	WTE	Headcount	WTE	Headcount
Administrative and Clerical	515.23	636	519.20	626
Allied Health Professionals	258.52	325	262.03	324
Estates and Ancillary	244.24	292	236.64	285
Medical and Dental	304.17	395	301.72	368
Nursing and Midwifery Registered	916.51	1,102	891.29	1,069
Scientific and Technical	176.81	201	170.06	192
Senior Management	57.17	60	58.71	61
Support Workers	502.02	626	537.64	659
TOTAL	**2,974.67**	**3,637**	**2,977.29**	**3,584**

Analysis of the male and female Directors, other senior managers and employees as at 31 March 2016



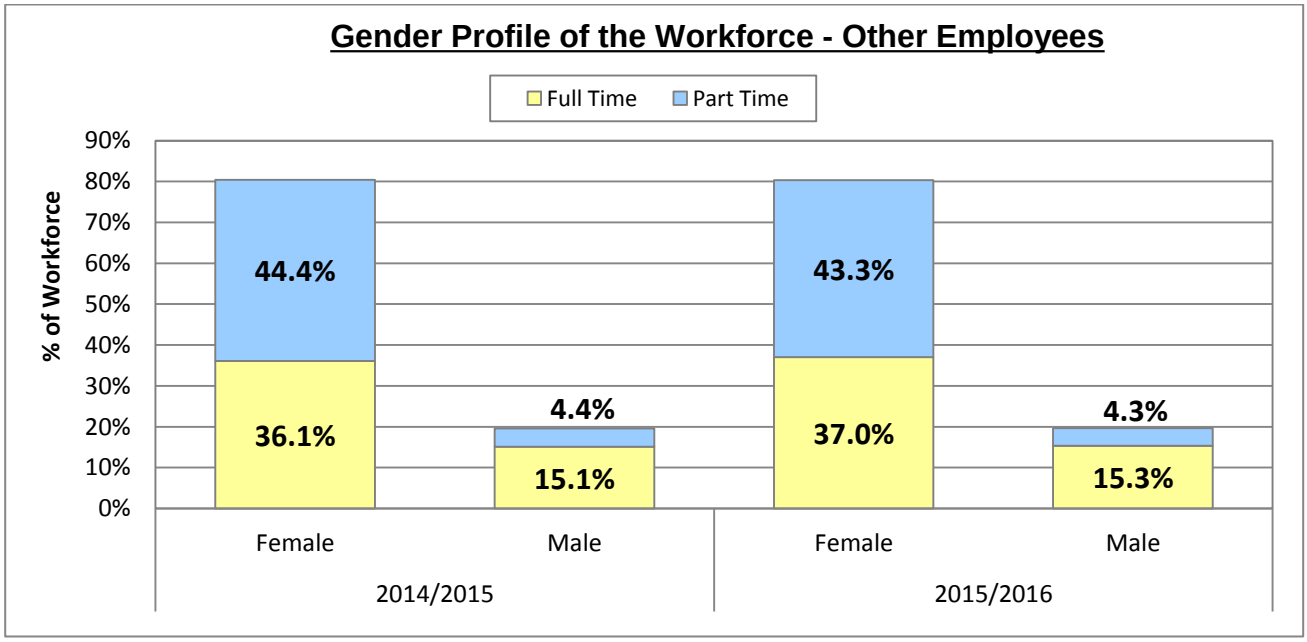
The table below gives a breakdown of the number of Directors, including Non-Executive Directors, by gender, as at 31 March 2016

Gender – Directors (Executive and Non-Executive Directors)		2014/2015	2015/2016
	Category		
Female	**Full Time**	2	2
	Part Time	4	4
Male	**Full Time**	4	4
	Part Time	2	3
TOTAL		**12**	**13**



The table below gives a breakdown of the number of other senior management, by gender, as at 31 March 2016

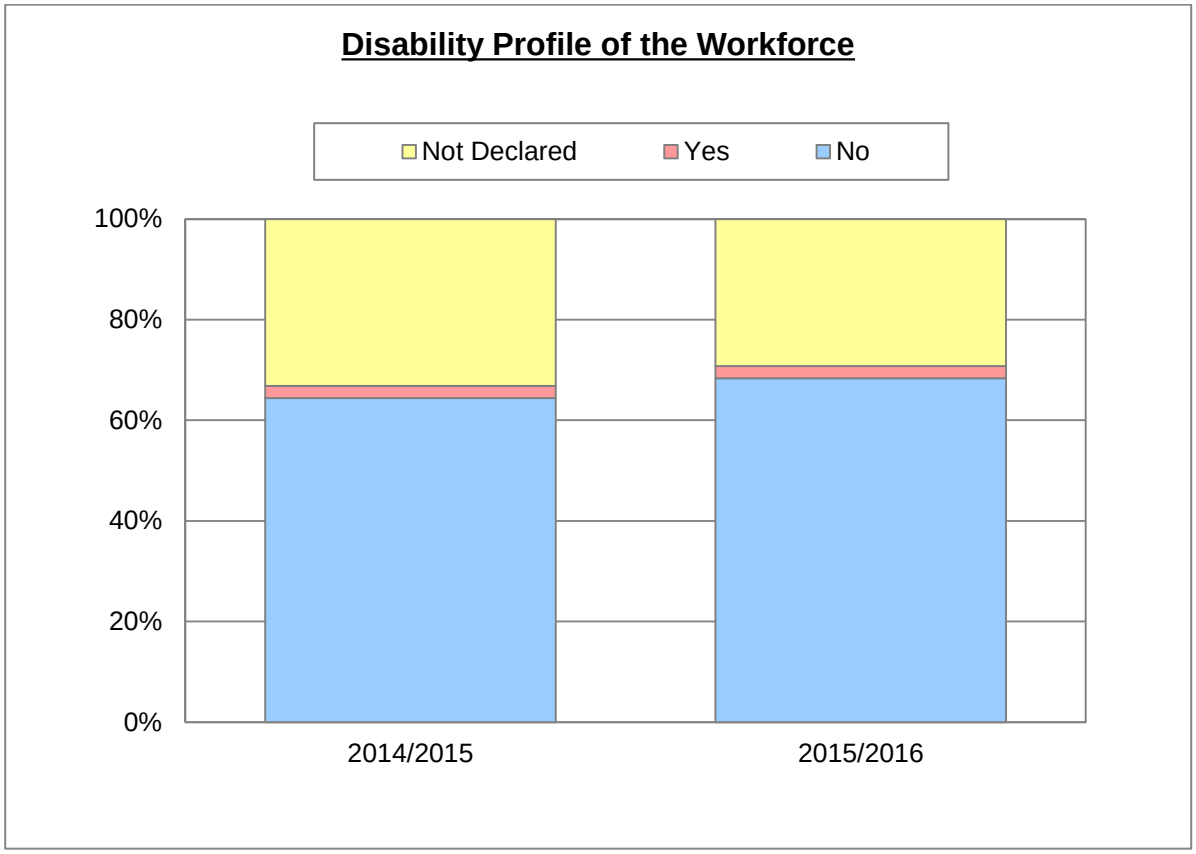
Gender – other senior managers	Category	2014/2015	2015/2016
		Headcount	Headcount
Female	Full Time	13	17
	Part Time	12	11
Male	Full Time	23	21
	Part Time	1	1
TOTAL		49	50



The table below gives a breakdown of the number of other employees, by gender, as at 31 March 2016

Gender – other employees	Category	2014/2015	2015/2016
		Headcount	Headcount
Female	Full Time	1290	1304
	Part Time	1586	1526
Male	Full Time	540	540
	Part Time	159	151
TOTAL		3,575	3,521

Analysis of the disability profile of the workforce as at 31 March 2016



The table below gives a breakdown of the number of employees registered as having a disability as at 31 March 2016

Disabled	2014/2015		2015/2016	
	Headcount	Percentage	Headcount	Percentage
No	2,343	64.4%	2,449	68.3%
Yes	87	2.4%	88	2.5%
Not Declared	1,207	33.2%	1,047	29.2%
TOTAL	3,637	100%	3,584	100%

Sickness absence data

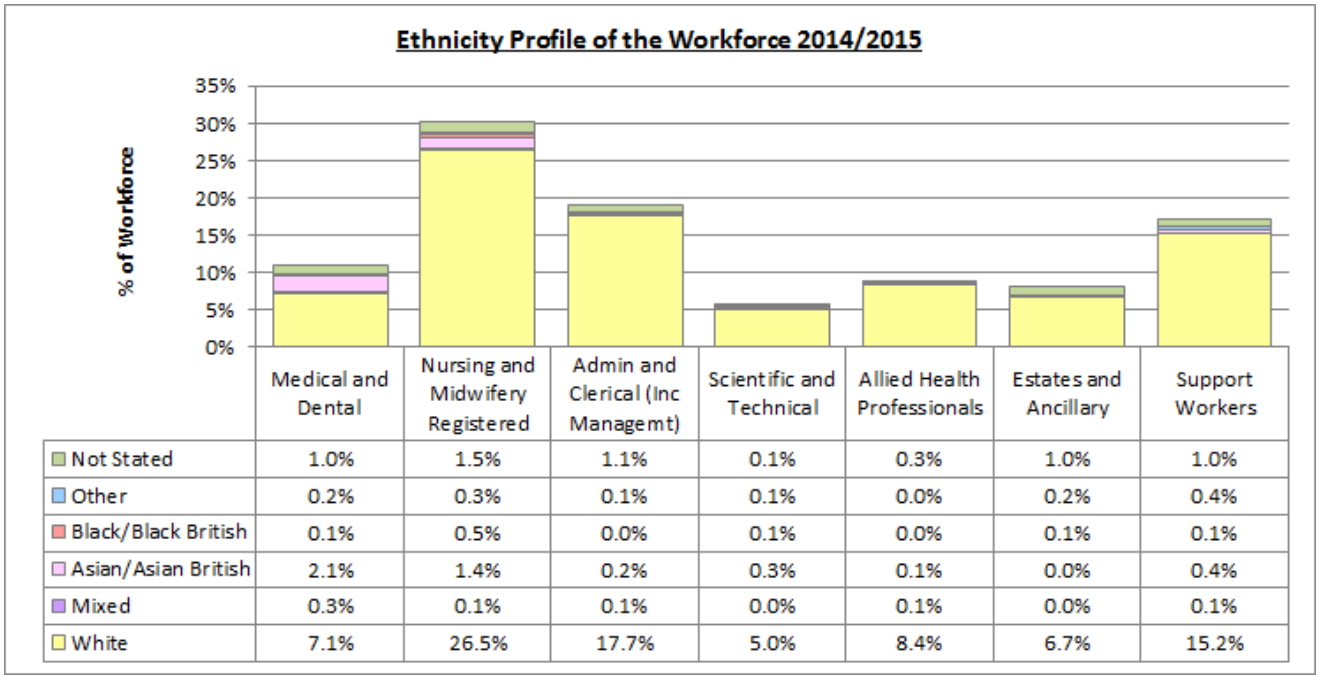
The table below shows the Trust's sickness absence data for each quarter during the 2015/16 financial year.

DIRECTORATE	15/16 Q1 % Abs Rate (FTE)	15/16 Q2 % Abs Rate (FTE)	15/16 Q3 % Abs Rate (FTE)	15/16 Q4 % Abs Rate (FTE)	Cumulative % Abs Rate
Corporate Services	3.93%	4.21%	4.40%	4.14%	**4.17%**
Elective Care	4.52%	4.18%	4.83%	3.93%	**4.37%**
Integrated Care	3.58%	3.02%	3.58%	4.37%	**3.64%**
Urgent, Community and Cancer Care	3.00%	3.53%	3.86%	4.23%	**3.66%**
TOTAL	**3.79%**	**3.72%**	**4.18%**	**4.16%**	**3.96%**

Key
15/16 Q1 – April 2015 to June 2015
15/16 Q2 – July 2015 to September 2015
15/16 Q3 – October 2015 to December 2015
15/16 Q4 – January 2016 to March 2016

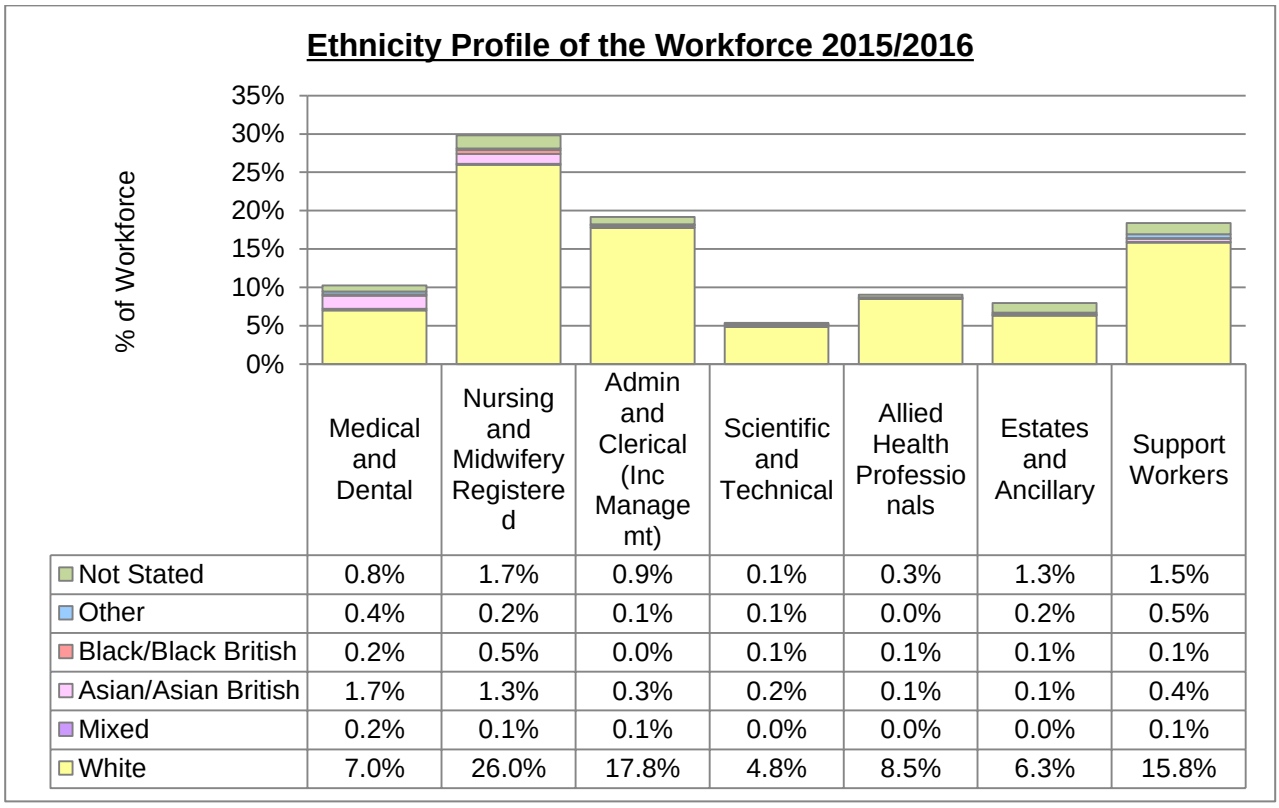
Equality and Diversity and Human Rights

The Trust continues to meet its requirements with regard to the Equality Duty and the Equality Act 2010. This year, evidence in support of our compliance included publishing our first annual Workforce Race Equality Standard (WRES) report in July 2015, followed by our Equality Delivery System (EDS2) assessment in January 2016. Both of these reports are available to download via the equality and diversity pages of our website. Furthermore we have taken significant steps this year to improve our governance arrangements with the formation of new stakeholder and workforce equality groups which are attended by officers of the Trust, service users, stakeholders, and interested volunteers from of the workforce respectively.



	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	1.0%	1.5%	1.1%	0.1%	0.3%	1.0%	1.0%
Other	0.2%	0.3%	0.1%	0.1%	0.0%	0.2%	0.4%
Black/Black British	0.1%	0.5%	0.0%	0.1%	0.0%	0.1%	0.1%
Asian/Asian British	2.1%	1.4%	0.2%	0.3%	0.1%	0.0%	0.4%
Mixed	0.3%	0.1%	0.1%	0.0%	0.1%	0.0%	0.1%
White	7.1%	26.5%	17.7%	5.0%	8.4%	6.7%	15.2%

Headcount	Medical and Dental	Nursing and Midwifery Registered	Admin and Clerical inc Mgt)	Scientific and Technical	AHPs	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**



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

Human Resource (HR) policies and staff information

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

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

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

Trust policy in respect of disabled applicants who clearly indicate that they wish to be considered for a post under the 'Positive about Disability Scheme' is that they will be shortlisted and invited for interview where they meet the requirements for the post.

All staff have access to the local workforce development programme and the training courses provided through the programme. Staff are able to discuss their training needs with their line manager during their appraisal or at other times as arranged locally.

The Trust continues to strive for continuous improvement and continues to give priority to engaging with staff, setting high standards, learning from staff experience, and strengthening partnership working. Ensuring active staff involvement in the management and direction of services at all levels is achieved through valuing staff, listening and responding to their views and monitoring quality workforce indicators. Equally, the Trust acknowledges that staff should have confidence that their input is valued and that the Trust is responsive to their views in the decisions it takes, building on that positive relationship.

The Trust has a number of mechanisms through which it communicates information to its employees. These include a daily all user e-mail, team brief, departmental meetings, ad hoc briefings, twitter accounts, personal letter, and pay slip messages and attachments. The Trust continues to offer the 'Ask a Director' facility which enables staff to ask questions of the senior team 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 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.

The Trust works to engage with staff and obtain their feedback on matters being communicated. This occurs through the 'Team Brief' process and through the regular meetings of the Partnership Forum and Local Negotiating Committee where Trade Unions and professional association representatives meet with senior managers to discuss issues affecting staff and local conditions of service. There are two sub groups of the Partnership Forum; the Policy Advisory Group and the Pay, Terms and Conditions Group. The Policy Advisory Group agrees and updates HR policies in line with current employment law and ensures they have broad agreement within the organisation. The Pay, Terms and Conditions Group negotiates on local issues affecting staff pay 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 wellbeing of medical and dental employees and contributes to the efficient management of the Trust.

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

Health and Safety, and Occupational Health

The Occupational Health Department provides a first class service to maintain a high standard of health within the workforce of the Trust 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; and
- provision of staff counselling services (see wellbeing service report below).

Occupational Health staff are included in the membership of various formal steering groups and other working groups which manage services and introduce improvements; thus ensuring a staff health perspective is considered and contributing to staff health, safety and wellbeing in order to enhance delivery of safe, effective and compassionate patient care. These groups include: Health and Safety; Asbestos; Infection Prevention and Control; Workforce Equality; and, Workforce and Organisational Development.

A high level of collaborative working with other regional NHS occupational health services ensures that Trust staff working in the various locations throughout the region 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. Jointly authored policies on Staff Communicable Disease Screening and Immunisation, and Blood-borne Virus and Inoculation Incidents, were reviewed and updated with the Infection Prevention and Control Team. Collaboration with the Trust Moving and Handling Co-ordinator ensures a co-ordinated

approach to musculo-skeletal/ergonomic assessment, advice, and training requirements. Joint working with the Trust Health and Wellbeing Team and HR colleagues contributes to development of initiatives to address physical and mental health issues in the workplace, such as implementation of a pilot project to deliver individualised health and wellness assessments, identification of personal action plans, and outcome monitoring for interested staff.

Work has continued on a major project to identify and update the work-related immunisation records of those staff who commenced in post prior to the implementation of the current Department of Health standards.

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. During the year the department participated in an internal audit of occupational health clearance procedures relating to new employees, a clinical audit of the quality of clinical health records, and repeated its annual employer/employee feedback survey.

National Staff Survey 2015

The Trust undertook the staff survey between September and December 2015. The Trust provided staff with both online surveys and paper copies, to enable as many staff as possible to take part in the process. This year the Trust moved from the Acute Trusts category to the Combined Acute and Community Trusts category, which more accurately reflects the acute and community services that the Trust provides.

Overall the results of the 2015 staff survey were extremely positive, demonstrating that our staff take pride in the care they deliver, and recommend the Trust as a place to work and receive treatment. Staff engagement continues to be better than average, and has increased from 2014. Nationally we rank joint third against the other Acute and Community Trusts. From the staff survey benchmarking analysis out of the 32 key findings, the Trust's ratings against other combined Acute and Community Trusts were ranked as follows:

- 23 were above (better than) average of which two were the highest scores in our group'
- eight were average; and
- one was below (worse than) average

The response rate is detailed on the following page.

Harrogate and District NHS Foundation Trust National Staf Survey 2015 – Response Rate					
Overall Response rate	**2015**		**2014**		**Trust improvement/ deterioration**
	Trust	**National Average**	**Trust**	**National Average**	
	59%	41%	57%	42%	Increased by 2%
Top 4 ranking scores	**2015**		**2014**		**Trust improvement/ deterioration**
	Trust	**National Average**	**Trust**	**National Average**	
Percentage of staff satisfied with the opportunities for flexible working patterns	59%	50%	N/A	N/A	Not comparable with 2014 data
Recognition and value of staff by managers and the organisation	3.63	3.42	N/A	N/A	Not comparable with 2014 data
Support from immediate managers	3.87	3.72	3.68	3.65	Increased by 0.19. 2014 data for Acute Trusts category.
Staff satisfaction with level of responsibility and involvement	4.01	3.93	3.90	N/A	Trust improvement of 0.11 since 2014. New KF for 2015, so national comparator data not available, but Trust data re-calculated for 2014.
Bottom 4 ranking scores	**2015**		**2014**		**Trust improvement/ deterioration**
	Trust	**National Average**	**Trust**	**National Average**	
Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	17%	14%	12%	14%	Deterioration of 5% 2014 data for Acute Trusts category.
Quality of non-mandatory training, learning or development	4.01	4.04	N/A	N/A	Not comparable with 2014 data
Percentage of staff agreeing that their role makes a difference to patients/service users	90%	91%	N/A	N/A	Not comparable with 2014 data
Staff satisfaction with the quality of work and patient care they are able to deliver	3.92	3.94	N/A	N/A	Not comparable with 2014 data

There are three areas which the Trust has improved significantly since the 2014 Staff Survey, they are:

- support from immediate mangers;
- staff satisfaction with the level of responsibility and involvement; and
- staff recommending the organisation as a place to work or receive treatment.

The one area that has deteriorated the most since the 2014 survey and has been categorised as worse than average, related to staff experiencing physical violence from patients, relatives, or the public in the last 12 months. This has increased from 11% to 16%.

Other areas where the Trust compares less favourably in comparison with other combined Acute and Community Trusts in England are:

- quality of non-mandatory training, learning or development;
- staff agreeing that their role makes a difference to patients / service users;
- staff satisfaction with the quality of work and patient care they are able to deliver; and
- staff experiencing discrimination at work in the last 12 months

Summary details of any local surveys and results

The Trust also takes part in the quarterly NHS Staff Friends and Family Test, which asks staff "*How likely are you to recommend the Trust to friends and family as a place to work?"*. During 2015/16 the Trust surveyed individual Directorates in each quarter, with the exception of Quarter 3 when all staff were surveyed in order to gain views from across the organisation. As with the NHS Staff Survey, the Trust utilises both online and paper surveys to ensure accessibility for all staff.

Quarter 4 showed 73.8% of staff would recommend the Trust as a place to work. This was an increase compared to the Quarter 1 which showed 69.5% of staff would recommend the Trust as a place to work.

From Quarter 1, 2016/17 the Trust plans to ask all staff to complete the NHS Staff Friends and Family Test. The Trust hopes this will allow greater levels of feedback and engagement from all staff and will allow monitoring of the impact of actions taken as a result of previous surveys.

Staff Survey - future priorities and targets

In previous years a Trust-wide action plan has been developed and each Directorate has used their own results to develop local action plans. This year, each Directorate will focus on three overarching issues and develop action plans around the following areas:

- staff experiencing physical violence and discrimination;
- staff satisfaction with the quality of work and patient care they are able to deliver; and
- quality of non-mandatory training, learning or development.

By concentrating on these three areas a greater focus can be given to them and a consistent message can be shared. By communicating this information clearly, staff can be assured that the Trust has understood their feedback and subsequent action will be taken. The HR Business Partners are working with Directorate management teams to translate these overarching issues into local actions.

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

Celebrating Success awards

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

- The Mark Kennedy Award for Excellence in Enabling Care Closer to Home;
- The Anne Lawson Award for Outstanding Contribution to High Quality Care;
- The Governors' Award for Outstanding Contribution from a Team;
- The Richard Ord Award for Outstanding Contribution from an Individual;
- The Award for Outstanding Partnership Working; and
- The Chris Skeels Award for Living the Trust Values.

Off-payroll arrangements

The decision to appoint Board members or senior officials with significant financial responsibility through an off-payroll arrangement is made at a very senior level for exceptional operational reasons. The Trust can confirm that there were no off-payroll engagements of board members and/or senior officials with significant financial responsibility during 2015/16.

Approval by the Directors of the Performance Report

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

Signed

Mr Jonathan Coulter
Acting Chief Executive
25 May 2016

4.3. REMUNERATION REPORT – EXECUTIVE AND NON-EXECUTIVE DIRECTORS

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

Date of Meeting	21 May 2015	16 October 2015
Sandra Dodson, Chairman	✓	✓
Professor Sue Proctor, Non-Executive Director and Vice-Chair	✓	✓
Ian Ward, Non-Executive Director and Senior Independent Director	X	✓
Lesley Webster, Non-Executive Director	✓	X
Christopher Thompson, Non-Executive Director	✓	X
Maureen Taylor, Non-Executive Director	✓	✓
Neil McLean, Non-Executive Director	X	✓

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

The details of remuneration of individual Directors are included within this report. There was no uplift to basic salaries of Directors in 2015/16 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 Directors and there are no special provisions regarding early termination of employment. Either party can waive the rights to notice or accept payment in lieu of notice. Trust policy would work within the principles contained in HM Treasury Guidance on how to manage public funds in respect of 'special payments' and the Code of Governance for NHS Foundation Trusts.

The role of the Remuneration Committee is to make such recommendations to the Board of Directors on remuneration, allowances and terms of service as to ensure that Directors are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national agreements where appropriate.

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

The Committee provides advice to the Board of Directors on pay policy and other contractual matters for the Chief Executive and all Executive Directors. Comparative sources of guidance used by the Remuneration Committee for the determination of Directors' remuneration have been the NHS Providers Remuneration Survey, and CAPITA NHS Foundation Trust Board Remuneration Reports.

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.

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. The Chief Executive and all Directors are entitled to six months' notice ordinarily to terminate their employment.

Any decisions regarding uplifts of basic salaries for inflation purposes are only taken when consideration of the approach taken with all other employees has been made. External benchmarking information is used wherever possible so that decisions on remuneration are objective, fair, and proportionate.

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

Under the requirement to disclose where one or more senior managers are paid more than £142,500, Harrogate and District NHS Foundation Trust can confirm that the salary of Dr Tolcher, Chief Executive, is the only officer of the Trust to exceed this value.

In respect of the Chief Executive's salary, the Remuneration Committee agreed to mirror as close as possible the post holder's existing salary although the Chief Executive took a slight pay reduction in order to take up the post at Harrogate and District NHS Foundation Trust. This decision was taken as the Committee did not wish to penalise her financially for taking up the position of Chief Executive and they wanted to attract her to the post. In addition and in advance of the appointment, the Committee had given consideration to the salary range that would be considered for the new appointment in light of pay benchmark information available at that time. The Chief Executive was appointed to the maximum of the previously agreed salary range based on the aforementioned reasons.

There were no meetings of the Nomination Committee held during 2015/16.

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

Name and Title	2015/16						2014/15					
	Salary (bands of £5,000) £'000s	Other remuneration (bands of £5,000) £'000s	Taxable benefits Rounded to the nearest £100	Total (bands of £5,000) £'000s	Pension related benefits (bands of £2,500) £'000s	Ratio of Total remuneration to Median for All Staff (1)	Salary (bands of £5,000) £'000s	Other remuneration (bands of £5,000) £'000s	Taxable benefits Rounded to the nearest £100	Total (bands of £5,000) £'000s	Pension related benefits (bands of £2,500) £'000s	Ratio of Total remuneration to Median for All Staff (1)
Mr R Ord - Chief Executive (2) (3)	-	-	-	-	-	-	25-30	-	-	25-30	-	3.11
Dr R Tolcher - Chief Executive (4)	160-165	-	1,000	160-165	30-32.5	5.97	105-110	-	1000	105-110	92.5-95	6
Mr. J Coulter - Deputy Chief Executive/Finance Director	120-125	-	-	120-125	35-37.5	4.63	120-125	-	-	120-125	2.5-5.0	4.63
Dr D Scullion - Medical Director	45-50	140-145	-	190-195	92.5-95	1.78	40-45	140-145	-	185-190	0-2.5	1.56
Mrs. A Monaghan - Chief Nurse (5)	-	-	-	-	-	-	25-30	-	500	25-30	-	4.02
Mrs. J Foster - Chief Nurse (6)	95-100	-	-	95-100	5-7.5	3.73	75-80	-	-	75-80	(20)-(22.5)	3.74
Mr. R Harrison - Chief Operating Officer	110-115	-	-	110-115	55-57.5	4.19	105-110	-	-	105-110	30-32.5	4.01
Mr. P Marshall - Director of Workforce and Organisational Development	105-110	-	200	105-110	27.5-30	4.01	105-110	-	1,800	105-110	45-47.5	4.01
Mrs. S Dodson - Chairman	45-50	-	-	45-50	-	-	45-50	-	-	45-50	-	-
Prof. S Proctor - Vice-Chairman	15-20	-	-	15-20	-	-	15-20	-	-	15-20	-	-
Ms. S Symington - Non-Executive Director, Vice-Chair (7)	10-15	-	-	-	-	-	10-15	-	-	10-15	-	-
Mrs. M Taylor - Non-Executive Director (8)	10-15	-	-	-	-	-	5-10	-	-	5-10	-	-
Mr. I Ward - Non-Executive Director/Senior Independent Director	15-20	-	-	15-20	-	-	10-15	-	-	10-15	-	-
Mrs. L Webster - Non-Executive Director	10-15	-	-	-	-	-	10-15	-	-	10-15	-	-
Mr. N McLean - Non-Executive Director	10-15											
Mr. C Thompson - Non-Executive Director/ Audit Committee Chairman	15-20	-	-	15-20	-	-	15-20	-	-	15-20	-	-

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(1) The median salary for all staff in 2015/16 was £26,041. The median salary for all staff in 2014/15 was £26,822. The median calculation is the annualised full time remuneration of all staff in the Trust as at 31 March 2014 (excluding agency staff), excluding the highest paid Director.
(2) 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) Ms S Symington ceased as Non-Executive Director 28 February 2015.
(8) Mrs. M Taylor commenced as Non-Executive Director on 3 November 2014.
(9) Mr. N McLean commenced as Non-Executive Director on 1 May 2015.

The Trust does not pay any performance related bonuses or payments.
The nature of 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 2016	Number claiming expenses	Total value claimed (Rounded to £00)	Number in post on 31st March 2015	Number claiming expenses	Total value claimed (Rounded to £00)
Board of Directors	15	6	4,900	16	10	17,000
Council of Governors	22	8	500	23	6	500

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 2016 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Real Change in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension to nearest £100
Mr Richard Ord - Chief Executive	£Nil	£Nil	£Nil	£Nil	£Nil	£Nil
Dr Rosamond Tolcher - Chief Executive	5-7.5	210-215	1,007	1,056	37	£Nil
Mr Jonathan Coulter - Deputy Chief Executive/Finance Director	0-2.5	135-140	546	571	19	£Nil
Dr David Scullion - Medical Director	15-17.5	245-250	1,154	1,260	106	£Nil
Mrs Angela Monaghan - Chief Nurse	£Nil	£Nil	£Nil	£Nil	£Nil	£Nil
Mrs Jill Foster - Chief Nurse	0-2.5	150-155	685	707	13	£Nil
Mr Robert Harrison - Chief Operating Officer	2.5-5	70-75	201	226	22	£Nil
Mr Phillip Marshall - Director of Workforce and Organisational Development	0-2.5	145-150	583	603	14	£Nil

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

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated

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

Mr Jonathan Coulter
Acting Chief Executive
25 May 2016

4.4. NHS FOUNDATION TRUST CODE OF GOVERNANCE

The Board of Directors and Council of Governors

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

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

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

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

The Board of Directors

The Board of Directors is collectively responsible for exercising all of the powers of the Trust; however, it has the option to delegate these powers to senior management and other committees. The Board meets in public 10 times per year. Its role is to provide active leadership within a framework of prudent and effective controls which enable risk to be assessed and managed. The Board is responsible for the allocation of resources to support the achievement of organisational objectives, ensure clinical services are safe, of a high quality, patient focused and effective.

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

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

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

Balance, completeness and appropriateness of the Board of Directors

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

Decision making and operational management of the Trust is led by the Executive Directors, reporting to the Chief Executive as 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 deemed to be independent. The information below describes the skills, expertise and experience of each Board member and demonstrates the independence of the Non-Executive Directors.

Executive Directors

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

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

Dr Tolcher's initial clinical training included rotational Senior House Officer posts as part of a GP vocational training scheme. She later switched focus to specialise in community reproductive health. In 1994 Dr Tolcher became a Consultant and Clinical Director of sexual health services. She went on to work as a Primary Care Trust 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, Dr Tolcher has maintained an unwavering focus on patient experience and the quality of care provided. She brings to the role extensive experience of working across acute, community, and primary care and has been at the forefront of developing new models of integrated health and social care.

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

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

Mr Coulter became Finance Director for North Bradford PCT in 2000, gaining valuable experience of leadership and management of community-based services. Following a successful period in North Bradford, during which time he undertook additional responsibility in the role of Finance Director for Airedale PCT, Mr Coulter was appointed as Finance Director at the Trust in March 2006.

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

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

Dr Scullion trained in Medicine at St Mary's Hospital in London, qualifying in 1985. An initial career in General Medicine was followed by Radiology training in both London and North America. He was appointed Consultant Radiologist in Harrogate in 1997, and has been Clinical Lead for Radiology, Deputy Medical Director and, since September 2012, Medical Director. He divides his week 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. Dr Scullion is aided in this role by both clinical and managerial colleagues.

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

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

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

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

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

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

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

The Chief Operating Officer is responsible for the day to day operational management of the Trust's clinical services, the achievement of national, regional and Trust performance targets and translating

Trust strategy, business, and policy development into operational reality. Duties also include responsibility for IT, Information, Estates and Facilities.

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

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

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

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

The Director of Workforce and Organisational Development is responsible for providing the Trust with strategic and operational human resource leadership. Mr Marshall has the Lead Board Director responsibility for associated areas including Medical Education, Health and Well Being and Military Health. He 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 are for a term of three years. Non-Executive Directors can be re-appointed for up to three terms of office (i.e. a maximum of nine years) with any final term of three years subject to annual reappointment in line with the requirements of the NHS Foundation Trust Code of Governance. The Council of Governors carries the responsibility of terminating the contract for a Non-Executive Director where this is believed to be appropriate, in accordance with the Trust Constitution and Foundation Trust Code of Governance.

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

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

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

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

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

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

There have been no changes in the Chairman's significant commitments during 2015/16.

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.

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

Mr Ward has spent over 40 years in financial services including his role as Chief Executive of Leeds Building Society (LBS) for 16 years until his retirement from that role in August 2011. In a Non-Executive capacity, Mr Ward is now a Director of Newcastle Building Society, a member of its Group Risk Committee, and a Director of its Information Technology subsidiary. He also undertakes consultancy work for some other businesses.

Mr Ward was a Director and Vice-President of Leeds, York and North Yorkshire Chamber of Commerce and Chairman of its Property Forum. He was also a member of the National Council of the Building Societies Association (BSA) and a former Chairman of the Northern Association. Additionally, he was a Director and Chairman of the Audit Committee of Leeds Training and Enterprise Council (TEC). He moved to Knaresborough in 1996, shortly after taking up his Chief Executive position at LBS. He is particularly interested in how the Trust's strategy will evolve to ensure its continued success and delivery of high quality care.

He is a member of the Audit Committee and Remuneration and Nomination Committees.

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

Professor Proctor 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.

Professor Proctor 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 is also a lay member of the Royal College of Veterinary Surgeons' Nursing Council. She also chaired the Leeds Teaching Hospitals NHS Trust Inquiry into Jimmy Savile.

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

Professor Proctor has an MSc in Nursing and a PhD in Health Services Research. In 2009 she was awarded a Visiting Professorship by Leeds 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.

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

For over 30 years Mrs Webster has had a professional involvement with the NHS in the UK. Starting as a Registered Nurse, she later moved into the Medical Supply Industry in 1987.

Working for a range of both international and UK based medical companies has meant that she has had much interaction with the NHS and through this has become knowledgeable in NHS issues relating to wound, continence and stoma care and latterly worked with the leading infection control business Vernacare Ltd. In addition, she has developed a strong network of relationships with clinical, procurement, and senior management contacts across the UK.

For the last 16 years, Mrs Webster 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 Mrs Webster in various ways; it has been important to her to always research carefully to ensure that products and services she has been involved with worked well and have been genuinely beneficial to patient outcomes. Furthermore, it has given her an informed view and influenced her approach in dealing with new product development which she has been actively involved with from concept to launch.

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

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

Mrs Webster is chair of the Quality Committee and is a member of the Audit Committee and Remuneration and Nomination Committees.

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

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

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

Inside the Trust, Mr Thompson is chair of the Audit Committee and a member of the Remuneration and Nomination Committees.

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

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

As part of her council role Mrs Taylor held three directorship positions being public sector Director of Community Ventures Leeds Limited, Director at Norfolk Property Services (Leeds) Limited, and Alternate Director for the Leeds Local Education Partnership. She left her full time post in the spring of 2015 and is looking forward to continuing to contribute to the success of the Trust.

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

Mrs Taylor is chair of the Finance Committee and is a member of the Audit Committee and Remuneration and Nomination Committees.

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

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

Mr McLean has also chaired the Board of Leeds City College, the Leeds City Region Local Enterprise Partnership and the White Rose Academies Trust.

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

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

Performance evaluation of the Board of Directors

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

- Appraisal of Executive Director performance by the Chief Executive and Chairman on an annual basis;
- Appraisal of Non-Executive Director performance by the Chairman and Deputy 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.
- An annual review of the effectiveness of each sub-committee.

In November 2015, the Board of Directors commissioned an independent review against Monitor's 'Well-led framework for governance.' This provided the Board of Directors with assurance that systems and process were in place to ensure that the Board and Senior Leadership Team had good oversight of quality of care, operations and finances. The Board recognises the importance of good governance in delivery of the Trust's vision to provide excellence every time, and although a positive response was received following the independent review, the Board is undertaking a number of actions during 2016/17 to improve even further the governance systems in the Trust.

The information below details the Executive and Non-Executive Director attendance at Board of Directors meetings in 2015/16. The Board of Directors met 10 times in 2015/16. No Board meeting was held in August or December 2015.

Individual attendance	Board of Director meeting dates 2015/16									
	22/4/15	27/5/15	24/6/15	22/7/15	23/9/15	28/10/15	25/11/15	27/1/16	24/2/16	30/3/16
Mrs S Dodson	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mr I Ward	Apologies provided	Y	Y	Y	Y	Y	Y	Y	Y	Y
Professor S Proctor	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mrs L Webster	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mr C Thompson	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mrs M Taylor	Y	Apologies provided	Y	Y	Y	Y	Y	Y	Y	Y
Mr N McLean	N/A*	Y	Y	Y	Y	Y	Y	Apologies provided	Y	Y
Dr R Tolcher	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mr J Coulter	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Dr D Scullion	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mrs J Foster	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mr R Harrison	Apologies provided	Apologies provided	Y	Y	Y	Apologies provided	Y	Y	Y	Y
Mr P Marshall	Y	Y	Y	Y	Apologies provided	Y	Y	Y	Y	Y

** Mr McLean commenced in his role as Non-Executive Director on 1 May 2016*

Statement of Compliance with the NHS Foundation Trust Code of Governance

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

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

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

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

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

Provision	Reference
A.1.1	Included in the Annual Report – section 4.4
A.1.2	Included in the Annual Report – section 4.1
A.5.3	Included in the Annual Report – section 4.4
B.1.1	Included in the Annual Report (and see table above)
B.1.4	Included in the Annual Report – section 4.4
B.2.10	Included in the Annual Report – section 4.3
B.3.1	Included in the Annual Report – section 4.4
B.5.6	Included in the Annual Report – section 4.4
B.6.1	Included in the Annual Report – section 4.4
B.6.2	Included in the Annual Report – section 4.1 and 4.4
C.1.1	Included in the Annual Report – section 4.4
C.2.1	Included in the Annual Report – section 4.7
C.2.2	Included in the Annual Report – section 4.7
C.3.5	Not applicable – would be included in the Annual Report if required
C.3.9	Included in the Annual Report – section 4.4
D.1.3	Not applicable – would be included in the Remuneration Report if required
E.1.4	Included in the Annual Report – section 4.4
E.1.5	Included in the Annual Report – section 4.4
E.1.6	Included in the Annual Report – section 4.4

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 Risk Management Policy. 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 (NHS Improvement as of 1 April 2016) and the Care Quality Commission 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; and
- integrated governance encompassing financial, clinical, quality, corporate, information, performance and research governance systems.

The Chief Nurse and Medical Director have provided leadership at Board level for implementation of integrated governance and risk management. The Board of Directors places a strong emphasis on

effective communication from “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.

Quality of Care Teams are in place across the organisation and report to each Clinical Directorate. The focus of these teams is continual service improvement. Detail of quality performance is described in the Quality Report, and further detail of quality governance is included in the Annual Governance Statement.

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 statutory sub-committee of the Board of Directors. This committee provides independent assurance on governance, mechanisms for internal control, and financial stewardship, and includes representation from independent colleagues from Internal and External Audit.

Over the past 12 months the Trust has developed and strengthened the Quality Committee, a formally constituted sub-committee of the Board of Directors. The Quality Committee is the primary mechanism by which the Board gains assurance regarding the safety and quality of services. Its purpose is to seek assurance on the systems and processes in place to deliver high quality care and provide: scrutiny of outcomes in relation to quality; direction on behalf of the Board regarding the delivery of the Trusts quality improvement priorities and strategic objectives in respect of quality; and oversight and seek assurance on regulatory compliance. Further strengthening of the Finance Committee has also been undertaken throughout the year and further detail on the work of individual committees is provided in the Annual Governance Statement in Section 4.7.

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

The Board Assurance Framework provides the Board with visibility of those strategic risks which might impact on the Trust’s strategic objectives and quality priorities. In 2015/16 the Board of Directors ensured that detailed controls were in place to mitigate risks and support assurance. The Board of Directors will ensure going forward that detailed controls will continue to be in place to support assurance and mitigate risks. All risks, mitigation, and progress against actions are monitored formally at Directorate, Corporate, and Board level every month.

The Board Assurance Framework is subject to be review by the Board of Directors on a monthly basis and in detail on a quarterly basis. The Board also undertake a deep dive on each strategic risk as part of the Board Development Programme to ensure the strategic risks remain under constant review.

The Board Assurance Framework is also reviewed by the Audit Committee, Finance Committee, Corporate Risk Review Group, and the Internal Audit Team to ensure appropriate triangulation of issues across the organisation.

During 2015/16, Deloitte LLP was commissioned by the Trust to undertake an independent assessment of the Trust against Monitor’s Well-Led Framework for Governance. The review comprised of a self-assessment against the requirements of the framework, attendance by Deloitte at meetings, interviews with members of the Board, senior managers, Governors, and members of staff.

The review resulted in a positive report from Deloitte highlighting the many areas of good practice within the Trust to ensure strong leadership and governance arrangements, however, there were areas highlighted as recommendations to help the Trust strengthen their governance arrangements even further, and work will continue during 2016/17 in this regard.

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.

Audit Committee

The Audit Committee met formally on six occasions during 2015/16. Audit Committee members attendance is set out in the table below. In addition, all Audit Committee members attended an informal meeting in late April 2015 to undertake a detailed review of the draft accounts (relating to the 2014/15 financial year). Members of the Committee also attended relevant Audit Committee training events during the course of the year.

Individual attendance	**Audit Committee meeting dates 2015/16**					
	7/5/15	**21/5/15**	**8/9/15**	**10/12/15**	**2/1/16**	**10/3/16**
Mr Chris Thompson, Non-Executive Director Chair	Y	Y	Y	Y	Y	Y
Prof Sue Proctor, Non-Executive Director	Y	Y	Y	Y	Y	Apologies provided
Mr Ian Ward, Non-Executive Director	Y	Apologies provided	Y	Y	Y	Y
Mrs Maureen Taylor, Non-Executive Director		Y	Y	Y	Y	Y
Mr Jonathan Coulter, Deputy Chief Executive/ Finance Director	Y	Y	Y	Y	Y	Y
Mr Jordan McKie, Deputy Director of Finance	Y	Y	Apologies provided	Y	Y	Apologies provided
Mr Thomas Morrison, Head of Financial Accounts	Y	Y	Apologies provided	Y	Apologies provided	Apologies provided
Mr Andrew, Forsyth, Interim Head of Corporate Affairs	Y	Y	Y	Y	Apologies provided	Apologies provided
Dr Sylvia Wood, Deputy Director of Governance	Y	Y	Y	Y	Y	Y
Dr Claire Hall, Deputy Medical Director*	Y	Apologies provided	Apologies provided			
Dr Ros Tolcher, Chief Executive		Y				
Ms Helen Kemp-Taylor, Head of Internal Audit	Y	Apologies provided	Y	Y	Apologies provided	Y
Mr Tom Watson, Internal Audit Manager	Y	Y	Y	Y	Y	Y
Mr Steve Moss, Local Counter Fraud Manager		Y		Y		Y
Ms Clare Partridge, Director, KPMG LLP	Apologies provided	Y	Apologies provided	Y	Y	Apologies provided
Mr Andrew Smith, Director, KPMG LLP	Y	Y	Y	Apologies provided	Apologies provided	Y

**Dr Claire Hall no longer attended the Audit Committee as of September 2015 due to changes across the Trust*

The Audit Committee has a membership of four Non-Executive Directors and is supported at all of its meetings by the:

- Deputy Chief Executive / Finance Director;
- Deputy Director of Finance;
- Deputy Director of Governance;
- Head of Financial Accounts;
- Company Secretary;
- Interim Head of Corporate Affairs;
- Internal Audit (Head of Internal Audit and Internal Audit Manager); and
- External Audit (Director)

The Chief Executive attends one meeting per year to undertake the review of the Annual Report and Accounts. Other representatives attend the Audit Committee as and when required. Audit Committee members meet in private prior to the start of each meeting. Separate, private sessions are held with Internal Audit and External Audit prior to Audit Committee meetings as required, and no less than once a year.

There is a documented Audit Committee forward plan which schedules the key tasks to be undertaken by the Committee over the course of the year and which is reviewed at each meeting. Detailed minutes are taken of all Audit Committee meetings and are reported to the Board of Directors, and action lists are prepared after each meeting and details of cleared actions and those carried forward are presented at the following meeting.

Duties of the Audit Committee

Following a review of the Audit Committee's terms of reference in January 2016, the key duties of the Audit Committee are categorised as follows:

- Governance, risk management and internal control
    - Review of the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives, primarily through the assurances provided by internal and external audit and other assurance functions.

- Financial management and reporting
    - Review of the Foundation Trust's Financial Statements and Annual Report, including the Annual Governance Statement, before submission to the Board of Directors;
    - Review of the Charitable Trust's Financial Statements and Annual Report before submission to the Board of Directors acting in its role as Corporate Trustee;
    - Ensure that systems for financial reporting are subject to review to ensure completeness and accuracy of information and compliance with relevant legislation and requirements; and
    - Review of the Trust's Treasury Management Policy, Standing Financial Instructions and systems in place to ensure robust financial management.

- Internal Audit and Counter Fraud Service

    - Ensure an effective internal audit and counter-fraud service that meets mandatory standards and provides appropriate, independent assurance to management and the Audit Committee;
    - Review the conclusion and key findings and recommendations from all Internal Audit reports and review of regular reports from the Local Counter Fraud Specialist; and
    - Monitor of the implementation of Internal Audit and Counter Fraud recommendations.

- Local Security and Management Services (LSMS)

    - Ensure an effective LSMS service that meets mandatory standards and provides appropriate assurance to management and the Audit Committee, and review the annual report and plan for the following year.

- External Audit

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

- Clinical and other assurance functions

    - Review of the findings of other significant assurance functions, both internal and external to the organisation, and consideration of the implications for the governance of the organisation; and
    - Review of the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work, specifically, the Quality Committee.

Work undertaken during 2015/16

The Audit Committee has organised its work under five headings as follows:

Financial management and reporting

The Committee regularly receives updates and reports from the Finance Director on the Trust's financial position and any issues arising. Items discussed in particular during 2015/16 were the implications of the Carter Review and the report following the CAPITA review of reference costing. The Committee oversees and monitors the production of the Trust's financial statements. During the 2015/16 financial year, this included:

- An informal but detailed review of the draft accounts prior to submission to Monitor and External Audit on 21 April 2015;
- A formal Committee meeting to discuss the draft accounts and External Audit's findings on 7 May 2015;
- A formal Committee meeting on 21 May 2015 to review the final accounts and Annual Report for 2014/15 (including the Quality Account) prior to submission to the Board of Directors and Monitor;

- In January 2016 a formal review and approval of the Trust's accounting policies (to be used in relation to the 2015/16 financial statements), considering consistency over time and compliance with the Foundation Trust Financial Reporting Manual;
- Consideration of the plan and timetable for the production of the Trust's 2015/16 financial statements and annual report; and
- Oversight and monitoring of the production of the Charitable Trust's financial statements. The final Charitable Funds accounts and Annual Report for 2014/15 were reviewed by the Committee on 21 May 2015 prior to submission to the Corporate Trustee.

The Audit Committee also reviewed and approved: Single Tender Actions; the Trust's Losses and Special Payments register; the Annual Procurement Savings report; revisions to the Trust's Treasury Management Policy;, and the recommendation to the Board of the use of the going concern principle as the basis for the preparation of the 2014/15 accounts.

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

Governance, risk management and internal control

The Audit Committee receives the minutes of the Corporate Risk Review Group. These minutes provide detail of the changes to the Corporate Risk Register and new risks considered. In addition the Audit Committee receives the minutes of the Quality Committee, which is a formal sub-committee of the Board of Directors. These changes took affect from the 1 April 2015 as a result of the review undertaken by the Trust of its quality governance structure.

The Board Assurance Framework, Corporate Risk Register and mechanisms for reporting strategic risks to the Board are reviewed on a periodic basis alongside the review of the Corporate Risk Review Group minutes. Additionally the Staff Registers of Interests and Gifts and Hospitality were reported to the Audit Committee in 21 May 2015.

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 2015/16:

- Assessment of Audit Committee Effectiveness in December 2015, the findings of which were presented to the Board of Directors;
- Review and approval of Audit Committee Terms of Reference in January 2016 which were presented to the Board of Directors for approval; and
- Ongoing review and revision of the Audit Committee's timetable.

Clinical assurance

From 1 April 2015 the Trust implemented its new quality governance structure. The new structure added a Quality Committee, a formal sub-committee of the Board of Directors with its primary focus being providing assurance on the safety and quality of services. The scope of the Quality Committee's terms of reference overlapped with some of the clinical assurance items on the agenda of the Audit Committee. A review of the Audit Committee's Terms of Reference took place during November 2015 and was approved at the December Audit Committee meeting. A number of clinical assurance items were removed as it was agreed that these areas would be covered by the Quality Committee. As a

result it was agreed that the Deputy Medical Director would no longer attend the Audit Committee meetings.

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 2015/16. 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 2015/16 by the Committee. The revised quality governance structure means that the Audit Committee receives assurance on the effectiveness of Clinical Audit through the Annual Clinical Audit Report received by the Quality Committee.

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 2015/16.

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 2015. The Audit Committee approved the planning methodology to be used by Internal Audit and Clinical Audit to create a joint Audit Plan for 2015/16, and gave formal approval of the Internal Audit Operational Plan in March 2015.

The conclusions (including the assurance level and the corporate importance and corporate risk ratings) as well as all findings and recommendations of finalised Internal Audit reports are shared with the Audit Committee. The Committee can, and does, challenge Internal Audit on assurances provided, and requests additional information, clarification or follow-up work if considered necessary. All Internal Audit reports are discussed individually with the Audit Committee. A system whereby all Internal Audit recommendations are followed-up on a quarterly basis is in place. Progress towards the implementation of agreed recommendations is reported (including full details of all outstanding recommendations) to the Director Team and the Audit Committee on a quarterly basis. This has been an area of focus by the Committee during the year and Trust management have worked hard to ensure that the process for responding to internal audit recommendations has been improved.

The Counter Fraud Plan was reviewed and approved by the Audit Committee and the Local Counter-Fraud Specialist (LCFS) presented 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 Trust staff and the Audit Committee in January 2016, 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

In 2011/12, the Trust carried out a tender exercise, resulting in the Council of Governors' decision to appoint KPMG LLP as the Trust's External Auditors. KPMG were appointed for a primary term of three years with an option to extend into secondary terms of a further two years. At the end of both the three year primary term the Trust, through the Audit Committee and subsequent approval by the Council of Governors, reviewed the effectiveness of the incumbent External Auditor and recommended to the Trust's Governors approval of entering into a secondary term. The Trust will be required to commence a tender process to facilitate the Governors' appointment of External Auditors for 2016/17 and beyond.

External Audit services are provided by KPMG. During the 2015/16 financial year, the Audit Committee reviewed External Audit's Annual Governance Report and Management Letter in relation to the 2014/15 financial statements. Work was 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 2015/16 financial statements and the related audit fee in January 2016.

The assessment of External Auditors is carried out using an assessment tool focusing on areas including: independence and objectivity; knowledge of organisational risks; relationships with Internal Audit and the Trust; quality of work; engagement; and knowledge and expertise. Scores are rated on a scale measuring satisfaction from low (1) to high (5).The effectiveness of External Audit was reviewed by Trust staff and the Audit Committee in May 2015, resulting in a satisfactory evaluation which was reported to the Council Governors.

In terms of non-audit work, KPMG LLP provided an accounting opinion on the treatment of the Carbon Energy and Fund project during 2015/16, the fee for which was £5,000 and was approved by Audit Committee in March 2016. Whilst a service provided outside of the normally audit fee, it related to an area which impacted directly upon the audit and the fee is significantly lower than the external audit fee and therefore there are no concerns around the objectivity and independence of the External Auditor.

Specific significant issues discussed by the Audit Committee during 2015/16

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 2016. During the year the committee critically addressed the issues around the appropriateness of the Accounting Policies that have been adopted and was satisfied that the policies were reasonable and appropriate. As part of the full year reporting process, the External Auditors, KPMG, consider the key areas of accounting judgement and disclosure. For each of these areas, the committee critically review and assess the policies and judgements that have been applied, the consistency of policy application from year to year and the appropriateness of the relevant disclosures made, together with the compliance with applicable accounting standards.

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

- NHS Income Recognition

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 exercise has been undertaken on a diligent and comprehensive basis. The committee has also confirmed that effective income cut-off procedures were applied around the year end.

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

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

- Valuation of Land and Buildings

The valuation of land and buildings that is incorporated in the financial statements represents an estimate of market value at the date of the Trust's balance sheet. It has been determined using the 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 within the Trust's Accounting Policies.

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

The committee has also been able to satisfy itself as to the basis on which the external valuation was undertaken and has confirmed that it was undertaken on a basis consistent with the terms of the Accounting Policy referred to above. In addition the committee has relied upon work carried out by Internal Audit during a number of pieces of work that have provided reassurance on the way in which asset costs and valuations have been reflected within the Trust's underlying books and records.

The following additional significant issues have been discussed by the Audit Committee during 2015/16:

- Ongoing compliance issues with IV Cannula Care and nurse staff rostering;
- changes in respect of the Trust's Quality and Governance framework;
- implications of the Well Led Review and CQC inspection; and
- the production of the Trust's financial statements.

<u>Conclusion</u>

The Audit Committee considers that it has conducted itself in accordance with its Terms of Reference and work plan during 2015/16, and considers that this annual report is consistent with the draft Annual Governance Statement and the Head of Internal Audit Opinion.

Council of Governors

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

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

Governors are elected by staff (Staff Governors) and the membership (Public Governors), or nominated by partner organisations, for example, North Yorkshire County Council (Stakeholder Governors). The Council of Governors consists of 17 elected and six nominated Governors. The Council of Governors has increased to 18 elected following a review of the Constitution in February 2016, to include one position for a Public Governor to represent a 'Rest of England' constituency. The review was subsequently approved by the Council of Governors and Board of Directors in February 2016. The Council of Governors has specific statutory responsibilities to:

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

The following table highlights the composition of the Council of Governors and includes each Governor's term of office and attendance at the quarterly public Council of Governor meetings held during the year 1st April 2015 to 31st March 2016.

Public Governor Constituency	Name	Term of office	Council of Governors meetings 2015/16				
			*Apr 2015	May 2015	Jul 2015	Nov 2015	Feb 2016
Harrogate and surrounding villages – publicly elected	Rev Dr. Mervyn Willshaw, Deputy Chair of Governors/Lead Governor up to December 2015	Jan 2010 – Dec 2012 Jan 2013 – Dec 2015	Y	Y	Y	Y	N/A
	Mr Tony Doveston	Jan 2016 – Dec 2018	N/A	N/A	N/A	N/A	Y
	Mrs Pat Jones	Jan 2011 – Dec 2013 Jan 2014 Dec 2016	N	Y	Y	N	Y
	Dr Sally Blackburn	Aug 2011 – Jul 2014 Aug 2014 – Jul 2017	N	Y	Y	Y	Y
	Miss Sara Spencer	Jan 2013 – Dec 2015 *(stood down Oct 2014)*	N/A	N/A	N/A	N/A	N/A
	Ms Pamela Allen, Deputy Chair of Governors/Lead Governor from January 2016	Jan 2014 – Dec 2016	**R	Y	Y	Y	Y
	Mrs Liz Dean	Dec 2014 – Dec 2015 *(remainder of term following resignation of Sara Spencer)* Jan 2016 – Dec 2018	Y	N	Y	N	N
Knaresborough and East District – publicly elected	Mrs Jane Hare	Jan 2013 – Dec 2015	N	Y	Y	Y	N/A
	Mrs Zoe Metcalfe	Jan 2016 – Dec 2018	N/A	N/A	N/A	N/A	N
	Mrs Joyce Purkis	Jan 2014 – Dec 2016	**R	Y	Y	Y	Y

Rest of North Yorkshire and York – publicly elected	Mrs Cath Clelland	Jan 2015 – Dec 2017	Y	N	N	Y	Y
Ripon and West District – publicly elected	Mr Andy Robertson	Jul 2013 – Jun 2016 *(Stood down February 2016)*	Y	N	Y	N	N
	Mr Peter Pearson	Aug 2014 – Jul 2017	Y	N	Y	Y	Y
Wetherby and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley Wards – publicly elected	Mrs Jane Hedley	Jul 2011 – Jun 2014 Jul 2014 – Jun 2017	N	N	Y	Y	Y
	Mr Michael Armitage	Jan 2014 – Dec 2016	N	N	Y	Y	Y

** Additional Council of Governor meeting held 17 April 2015 to discuss the recommendation of the Nominations Committee*
*** Vote submitted via fellow Governor*

Staff Governor Constituency	**Name**	**Term of office**	**Council of Governor meetings 2015/16**				
			***Apr 2015**	**May 2015**	**Jul 2015**	**Nov 2015**	**Feb 2016**
Medical Practitioners Staff Class – staff elected	Dr Daniel Scott	Jan 2013 – Dec 2015 Jan16 – Dec 18	Y	Y	Y	Y	Y
Non-Clinical Staff Class – staff elected	Mrs Carol Cheesebrough	Jan 2013 – Dec 2015	Y	N	N	N	N/A
	Mrs Yvonne Campbell	Jan 2016 – Dec 2018	N/A	N/A	N/A	N/A	Y
Nursing and Midwifery Staff Class – staff elected	Mrs Emma Edgar	Jan 2011 – Dec 2013 Jan 2014 – Dec 2016	Y	Y	N	Y	Y
	Mrs Sally Margerison	Jan 2014 – Dec 2016	Y	Y	Y	Y	Y

Other Clinical Staff Class – staff elected	Mrs Fiona Wilson	Jan 2007 – Dec 2009 Jan 2010 – Dec 2012 Jan 2013 – Dec 2015	Y	Y	Y	Y	N/A
	Ms Clare Cressey	Jan 2016 – Dec 2018	N/A	N/A	N/A	N/A	N

Appointed Governor/ Nominating Organisation	**Name**	**Term of office**	**Council of Governor meetings 2015/16**				
			***Apr 2015**	**May 2015**	**Jul 2015**	**Nov 2015**	**Feb 2016**
North Yorkshire County Council	Cllr. Bernard Bateman	Nominated from January 2014	N	Y	Y	Y	N
Harrogate Borough Council	Mr John Ennis	Nominated from June 2011	N	N	Y	N	Y
University of Leeds	Dr Sarah Crawshaw	Nominated from January 2014	N	Y	Y	N	Y
Harrogate Division YOR Local Medical Committee	Dr Jim Woods	Nominated from June 2011	Y	Y	Y	Y	N
Voluntary sector	Ms Jane Farquharson	Nominated from July 2013 *(Stood down October 2015)*	N	N	N	N/A	N/A
	Mrs Beth Finch	Nominated from February 2016 – June 2016 *(remainder of term following resignation of Jane Farquharson)*	N/A	N/A	N/A	N/A	Y
Patient Experience	Mrs Joanna Parker	Nominated from February 2015	N	Y	Y	N	N

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

Council of Governor meetings are attended by the Chairman, Chief Executive, Deputy Chief Executive, 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 2015 to March 2016.

Board member individual attendance	Council of Governor meeting dates 2015/16			
	16/5/15	29/7/15	4/11/15	6/2/16
Mrs S Dodson	Y	Y	Y	Y
Mr I Ward	Apologies provided	Y	Apologies provided	Apologies provided
Professor S Proctor	Y	Y	Y	Apologies provided
Mrs L Webster	Y	Y	Y	Y
Mr C Thompson	Y	Apologies provided	Apologies provided	Y
Mr M Taylor	Apologies provided	Apologies provided	Y	Y
Mr N McLean	Apologies provided	Y	Apologies provided	Apologies provided
Dr R Tolcher	Y	Y	Apologies provided	Y
Mr J Coulter	Apologies provided	Apologies provided	Y	Y
Dr D Scullion	Y	Apologies provided	Apologies provided	Y
Mrs J Foster	Apologies provided	Y	Y	Apologies provided
Mr R Harrison	Apologies provided	Y	Y	Y
Mr P Marshall	Apologies provided	Y	Apologies provided	Y

Council of Governors' Nomination Committee

The Nomination Committee is a formally constituted sub-committee of the Council of Governors and has responsibility for overseeing the recruitment and selection processes to secure the appointments of Non-Executive Directors (including the Chair). The Committee takes into consideration the knowledge, skills and experience on the Board of Directors and is responsible for making recommendations to the Council of Governors on the appointment and re-appointment of Non-Executive Directors (including the Chair) of the Trust. The Committee is comprised of members of the Council of Governors and is chaired by the Deputy Chair of Governors.

The Nomination Committee met on one occasion during 2015/16 to review the reappointment of Mr Ian Ward, Non-Executive Director to a second term of office and review the annual reappointment of Mrs Sandra Dodson, Chairman. The meeting was chaired by Mrs Dodson and Professor Sue Proctor, Non-Executive Director Vice-Chair for the item relating to Mrs Dodson's re-appointment.

The Chairman and Deputy Chair of Governors met with Mr Ward to conduct an annual review and set objectives for 2016/17. The Deputy Chair of Governors and the Senior Independent Director met with Mrs Dodson to conduct an annual review and set objectives for 2016/17. The Committee was satisfied

that both Mr Ward and Mrs Dodson continued to conducted their duties with high competence and a recommendation was presented to, and subsequently approved by, the Council of Governors to re-appoint Mr Ward for a further term of office and re-appoint Mrs Dodson for a further 12 months. Attendance at the meeting was as follows:

Mrs Sandra Dodson – Chairman (Chair)
Professor Sue Proctor – Vice-Chair (Interim Chair)
Rev. Dr Mervyn Willshaw, Public Governor/Deputy Chair of Governors
Ms Pamela Allen – Public Governor
Dr Sally Blackburn – Public Governor
Mrs Liz Dean – Public Governor
Mrs Jane Hedley – Public Governor
Mrs Joyce Purkis, Public Governor
Mrs Fiona Wilson, Staff Governor
Mrs Emma Edgar – Staff Governor
Mrs Sally Margerison, Staff Governor

The Committee was supported by: Dr Ros Tolcher, Chief Executive, Mr Jonathan Coulter, Deputy Chief Executive/Finance Director; Mr Andrew Forsyth, Interim Head of Corporate Affairs; and Miss Polly McMeekin, Deputy Director of Workforce and Organisational Development, in an advisory capacity.

Council of Governors Remuneration Committee

The Remuneration Committee is a formally constituted sub-committee of the Council of Governors and is responsible for setting the remuneration of the Chairman and other Non-Executive Directors. The Committee is chaired by the Deputy Chair of Governors and conducts an annual review of, and makes a recommendation to the Council of Governors in relation to, the remuneration of the Non-Executive Directors and Chairman of Harrogate and District NHS Foundation Trust.

The Committee met once during 2015/16 and held a detailed discussion regarding the role of the Non-Executive Directors, salary details, guidance received and current financial challenges. The recommendation submitted to, and subsequently approved by the Council, was not to apply a pay uplift to the salaries of the Chairman and Non-Executive Directors for the financial year 2015/16, in keeping with very senior managers and Executive Directors. Attendance at the meeting was as follows:

Rev. Dr Mervyn Willshaw, Public Governor/Deputy Chair of Governors (Chair)
Ms Pamela Allen – Public Governor
Dr Sally Blackburn – Public Governor
Mrs Liz Dean – Public Governor
Mrs Jane Hedley – Public Governor
Mrs Joyce Purkis, Public Governor
Mrs Fiona Wilson, Staff Governor
Mrs Emma Edgar – Staff Governor
Mrs Sally Margerison, Staff Governor

The Committee was supported by: Dr Ros Tolcher, Chief Executive, Mr Jonathan Coulter, Deputy Chief Executive/Finance Director; Mr Andrew Forsyth, Interim Head of Corporate Affairs; and Miss Polly McMeekin, Deputy Director of Workforce and Organisational Development, in an advisory capacity.

Membership development and engagement

- 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 2016 the Trust had 17,399 members; people who have chosen to become a member, who are interested in the NHS and want the opportunity to get more involved in their local health services. Members can become involved in a variety of different ways; by receiving updates and newsletters, attending open days, meetings and events, volunteering, and being consulted on with plans for future developments to name a few.

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

- Eligibility to be a Member

As of 1 March 2016, public membership, by constituency, applies to residents aged 16 or over, across the whole of England, following the inclusion of a 'Rest of England' Governor position. As the Trust is providing services further afield, and patients have the right to choose where to receive treatment, we hope to encourage a membership which reflects the wider population. Public Constituencies are:

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

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

The Trust has no patient constituency.

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

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

- Membership by constituency and volume

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

Throughout 2015/16 we have continued to actively engage with, and recruit, members between the ages of 16 and 21 years old 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 figures below are based on the Trust's catchment area prior to the change in Constitution to include membership from the Rest of England.

The public membership profile		**Total population**	**% of population**
Harrogate	6,779	82,599	8.5%
Ripon and West District	2,031	37,571	5.4%
Knaresborough and East District	2,447	37,699	6.5%
Harewood and Wetherby (including Otley and Yeadon, Adel and Wharfedale and Alwoodley wards)	2,224	102,771	2.2%
Rest of North Yorkshire and York	340	638,559	0.05%
TOTAL	**13,821**	**899,199**	**1.54%**

The staff membership profile		**Total workforce**	**% of total workforce**
Medical Practitioners*	358	463	77.3%
Nursing and Midwifery	1,412	1,543	91.5%
Other Clinical	811	817	99.3%
Non-Clinical**	997	957	98.4%
TOTAL	**3,578**	**3,780**	**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.*

*** Due to the inconsistencies between the Trust's Electronic Staff Record and the membership database managed in-house, there are discrepancies in the figures for non-clinical staff.*

The volume of members has reduced following a data cleanse exercise. This resulted in the removal of members who had deceased and the removal of members who have moved address and not notified the Foundation Trust Office. The membership of the Rest of North Yorkshire and York continues to grow year on year.

Although the number of public members is reported as 13,821, the review of the Constitution in February 2016 and the addition of a constituency for The Rest of England means we are in the process of transferring approximately 350 people, currently on our database as 'Affiliates', to members so they receive the benefits of full membership including voting rights.

Affiliates are 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 were not counted within our membership numbers for the purposes of this report.

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.

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

- Deliver high quality care;
- Work with partners to deliver integrated care; and,
- To ensure clinical and financial sustainability.

During the forthcoming year, the Trust will continue to actively recruit members across the catchment area; in particular, from the rest of North Yorkshire and York where our membership representation is at its lowest and from the new Rest of England constituency, focussing particularly on areas where the Trust is providing new services in County Durham, Darlington and Middlesbrough and in North and West Leeds. 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 49.8% females and 50.1% males, with 0.1% unknown. This demonstrates a year on year shift towards an equal balance between males and females and moves closer to matching the eligible male/female population percentage.

Membership broken down by gender as a at 31 March 2016			
Gender	**Number of members**	**Eligible membership**	**Percentage**
Male	6,924	440,383	1.6%
Female	6,883	458,816	1.5%
Not specified	14	N/A	N/A
TOTAL	**13,821**	**899,199**	**1.54%**

Ethnic origin of the public membership as at 31 March 2016		
Ethnicity	**Number of members**	**Eligible membership**
White	2,489	863,226
Mixed	15	9,110
Asian or Asian British	49	19,196
Black or Black British	17	4,599
Unknown	11,251	3,068
TOTAL	**13,821**	**899,199**

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

- How we develop our Membership

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

Our annual target membership figure for 2016/17 is 18,000 members. This is an increase of 500 members which takes into account new staff joining the Trust to deliver Children's Services in County Durham, Darlington and Middlesbrough, active targeted public recruitment and natural loss. Recruitment, communication and membership activities are delivered in the following ways:

- distribution of a welcome pack to all new members 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;
- distribution of the 'Foundation News' membership magazine (approximately every eight months)*;*
- distribution of a 'Chairman's Letter' or alternative communication, i.e. a postcard (approximately every eight months;
- notification of meetings and events on the Trust's website and social media platforms;
- use of press releases and the local media to publicise member events;
- invitations to membership events, for example 'Medicine for Members' lectures;
- invitations to community events in partnership with stakeholders;
- invitation to attend the public Council of Governor meetings;
- invitation to attend Governor public sessions i.e., speaking at local committees and groups;
- invitation to attend the Annual Members' Meeting;
- invitation to attend the annual Trust open event;
- opportunity to vote in, and stand for election to the Council of Governors;
- access to the Members' notice board;
- access to Trust strategic documents, including the Annual Report and Accounts, Quality account, Operational Plan and Strategic Plan;
- internal staff communications i.e., staff induction and Team Brief (a monthly briefing session for staff focusing on key topics, service developments, operational and financial performance);
- leaflets and posters in community premises and in GP practices; and,

- invitations to be involved with consultations, to take part in surveys and to be involved on focus groups.

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

- The Foundation Trust Office

The Foundation Trust Office continues to be a central point of contact for all members and the public to make contact with the Trust, the Council of Governors and Board of Directors. The Foundation Trust Office is open during office hours, Monday to Friday at:

Harrogate and District NHS Foundation Trust
Harrogate District Hospital
Lancaster Park Road
Harrogate
HG2 7SX

Tel: 01423 554489
Email: nhsfoundationTrust@hdft.nhs.uk

4.5. Regulatory ratings

The Trust's regulatory performance during the year has remained Green in all categories, in line with risk ratings contained in the Operational Plan and the Trust has met its infection control targets. 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 Monitor Risk Assessment Framework uses a wide range of metrics and data sources to assess the Trust's governance rating, including information from the Care Quality Commission (CQC) and other third party reports. The Trust reported a Green governance rating for each quarter of 2015/16.

Risk Assessment Framework	**Regulatory Ratings comparison**							
	2014/2015				**2015/16**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Financial Sustainability Risk Rating	3	3	3	3	4	3	3	3
Governance Rating	Green	Green	Green	Green	Green	Green	Green	Green

Further information on the Trust's performance can be found in the Performance Report.

4.6. STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF THE HARROGATE AND DISTRICT NHS FOUNDATION TRUST

The 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

Mr Jonathan Coulter
Acting Chief Executive
25 May 2016

4.7. ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Harrogate and District NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Harrogate and District NHS Foundation Trust (the Trust) for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

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

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

- Staff in dealing with specific everyday risks, e.g. basic risk management information including an overview of patient safety, incident reporting and investigation, complaints investigation and development of measures to improve patient experience, fire safety, information governance, health and safety, moving and handling, infection control, and security; and

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

The Trusts Human Resources Department monitors all mandatory and essential training and reports directly to the Board of Directors. 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 Trust supports an "open" culture, meaning that we are open with service users, carers and staff when things go wrong. A significant emphasis is placed upon ensuring that we comply with the requirements of the statutory duty of candour that came into force on 27 November 2014. This follows the introduction of a number of new standards that NHS boards need to comply with including not only duty of candour, but also the fit and proper person's test and improving openness and transparency. The Board receives regular updates to ensure compliance in these areas.

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

Whilst equality impact assessments are integrated into core Trust business, further work will be undertaken during 2016/17 to improve the information that the Board and its committees receive in terms of equality related impacts, risks and how these will be managed.

The risk and control framework

The key objectives regarding risk and control are to achieve:

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

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

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

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

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

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

1. Departmental

Quality of Care Teams ensure risk assessments of their areas are carried out routinely as part of the health and safety process as well as from incidents, complaints, local reviews, patient feedback and information contained in relevant quality, safety, workforce and financial dashboards. The departmental risk registers will reflect these risk assessments, including all residual medium and high risks from the health and safety control books.
All risks that are scored 9 or above on departmental risk registers are escalated to directorate risk registers.

2. Directorate

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

The directorate risk register will reflect departmental risk registers where relevant by including risks that are scored 9 or above or form a trend across departmental registers. It is the responsibility of the directorate leads to review and where appropriate, challenge scores applied to risks on departmental registers at least quarterly. At this level risk assessment is performed alongside objective setting and business planning.

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

3. Corporate

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

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

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

4. Board Assurance Framework

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

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

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

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

Some gaps in controls or assurances will also feature on the corporate risk register as they present a current risk which requires mitigation. The highest scoring risks on the corporate risk register for 2015/16 and going forward relate to:

- Risk to business objectives due to non-delivery of integrated Electronic Patient Record and Digital Roadmap requirements;
- Risk to the quality of service delivery in Medicine due to reduction in trainee numbers; and
- Risk of patient harm and risk to service delivery due to lack of experienced qualified nurses due to national shortage in registered nurses.

During 2015/16 the risks associated with the following were mitigated and removed from the corporate risk register to continue being managed on directorate or corporate functions risk registers:

- Risk of harm to patients and staff due to gaps in assurance on building safety for non-Trust owned premises;
- Harm to ophthalmology patients and risk to reputation due to the high number of follow up patients who have passed due follow up date;
- Patient harm due to failure to identify and manage mental health and mental capacity needs;
- Risk to the quality of service delivery due to failures of medical devices and equipment;
- Risk of delays to patient care due to failure of chemo isolator;
- Risk of 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; and
- Risk of loss of Clinical Pathology Accreditation (CPA) due to non-conformity with ISO15189 CPA standard in the transfusion laboratory.

During 2015/16 the strategic risks identified on the Board Assurance Framework included:

- Risk of a lack of medical, nursing and clinical staff;
- Risk of high levels of frailty in local population;
- Risk of failure to learn from feedback and incidents;
- Risk of insufficient focus on quality in the Trust;
- Risk of failure to deliver integrated models of care;
- Risk of a lack of interoperable systems across New Models of Care partners to enable access by all concerned to a single shared record;
- Risk of misalignment of Commissioner/partner strategic plans;
- Risk of service sustainability;
- Risk of a lack of understanding of the market;
- Risk of a lack of robust approach to new business;
- Risk of a lack of visibility and impact on reputation;
- Risk to current business;
- Risk of failure to deliver the Operational Plan;
- Risk of loss of Monitor Provider Licence; and
- Risk of the impact of external funding constraints.

In 2015/16 the Board of Directors ensured that detailed controls were in place to mitigate risks and support assurance. The Board of Directors will ensure going forward that detailed controls will

continue to be in place to support assurance and mitigate risks. All risks, mitigation and progress against actions are monitored formally at Directorate, Corporate and Board level every month.

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

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

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

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

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

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

Internal Audit most recently assessed compliance with Monitor's Licence conditions in November 2014 and with CQC fitness to register in April 2016 and gave significant assurance for both. The Audit Committee reviews the evidence for compliance with CQC registration requirements annually.

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

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

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

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

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

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

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

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

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

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

- More explicit tracking and monitoring of progress against strategic objectives and milestones at Board, committee and Directorate Board meetings;
- Restating the roles of the Board committees to ensure that they have sufficient time to cover the accountabilities set out in their terms of reference, and that the expectations of assurance reporting into them from directorates are both clarified and standardised; and
- An acknowledged need to increase the opportunities for engagement with staff working in community services.

Work has been undertaken to address each of these recommendations.

The Trust was inspected by the Care Quality Commission as part of its routine programme of inspections in February 2016. No serious matters of concern were raised as a result of the inspection. At the time of writing this statement the results of the inspection are awaited.

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

During 2015/16 there have been five formally constituted sub-committees of the Board; the Audit Committee, the Quality Committee, the Nomination Committee, the Remuneration Committee and the Finance Committee.

The Audit Committee

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

The key responsibilities of the Audit Committee are to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. The Committee ensures that there is an effective Internal Audit function that meets mandatory NHS Internal Audit Standards. Internal Audit's primary role is to provide an opinion and assurances on the adequacy and effectiveness of the systems of internal control and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. The Committee also reviews the work and findings of the External Auditors appointed by the Council of Governors and considers the implications and management's responses to their work. The Audit Committee receives reports from Internal and External Audit, the Quality Committee and the Corporate Risk Review Group which enable it to provide independent assurance on governance and controls to the Board. This also enables triangulation of key issues to enhance the Board and Committee's oversight and assurance role. The Annual Audit Plans for Clinical Audit and Internal Audit are approved by the Audit Committee and is prioritised to focus on areas of risk and concern.

The Quality Committee

The Quality Committee is a new committee commissioned following the review of quality governance during 2015 and is now the primary mechanism by which the Board gains assurance regarding the safety and quality of services. It is chaired by a Non-Executive Director, and two other Non-Executive Directors are members including one who is a member of the Audit Committee. There is senior representation from the clinical directorates and corporate functions including the Chief Nurse, Director of Workforce and Organisational Development, Chief

Operating Officer, Clinical Directors, Deputy Medical Director, Deputy Director of Governance and Head of Risk Management. On behalf of the Board, it seeks assurance on the systems and processes in place to deliver high quality care and provides scrutiny of the outcomes of these systems and processes in relation to quality. It also provides direction regarding the delivery of the Trusts quality improvement priorities and strategic objectives in respect of quality, and provides oversight and seeks assurance on regulatory compliance. Governor representatives sit on the Quality Committee as observers.

The Finance Committee

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

The Remuneration Committee

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

The Nomination Committee

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

The Senior Management Team

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

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

The clinical directorates and the subgroups of the Senior Management Team ensure delivery of the Trust's objectives through a broad framework of groups that manage and deliver work, for example: the Mortality Review Group; Information Technology Steering Group; End of Life Care Steering Group; Infection Prevention and Control Steering Group. Information Governance is managed by the Data and Information Governance Steering Group. The Complaints and Risk Management Group (CORM) comprising senior staff meets weekly to monitor and ensure active risk management is in place. Concerns identified from incidents, claims, complaints and risk assessments are investigated to ensure that lessons are learnt.
Each Directorate Board oversees quality and governance within the directorate, ensures appropriate representation on groups within the governance framework and reports to the Senior Management Team. The directorates work within an accountability framework which ensures that the systems of control are in place and adhered to. The Executive Director Team regularly review the work of the directorates against the accountability framework.

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

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

There are regular meetings with Commissioners at the Contract Management Board to review performance and quality.

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

The robust risk and control framework described enables the Trust to declare assurance against the validity of its Corporate Governance Statement, which will be submitted to NHS Improvement (formerly Monitor) in June 2016 in line with the requirements of the Risk Assessment Framework.

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

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

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

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

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

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

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

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

During 2015/16 the Trust conducted a carbon efficiency scheme to deliver reductions in carbon emissions and to deliver significant energy efficiency.

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

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

There is 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 2015/16.

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. They are approved by the Senior Management Team and the Board of Directors. A framework for reporting data and progress against local targets to the Quality Committee is in place. This has enabled a regular and routine review of the progress with quality improvement throughout the year.

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

Internal Audit provides further assurance regarding the systems in place to ensure that the Quality Account is compliant with national guidance and that adequate data quality controls are in place to ensure that performance data is accurate and complete. Internal Audit has examined the quality and accuracy of A&E 4 hour waits and 28 days readmission indicators. An opinion of significant assurance has been given for the Quality Account 2015/16.

Review of effectiveness

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

Complaints and Risk Management Group (CORM) and Corporate Risk Review Group, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I have also reviewed the systems for writing and validating the Quality Account and for the involvement of stakeholders therein.
The Board of Directors has concluded that the systems of internal control are effective, and evidenced by:

- NHS improvement (formerly Monitor), the regulator of NHS Foundation Trusts financial sustainability risk rating (FSRR) for the Trust is currently 3. (Risk ranges from 1, the most serious risk, to 4, the lowest risk);
- The governance risk rating, issued by NHS Improvement (formerly Monitor), is green;
- Last CQC intelligent monitoring report (2015) showed a risk score of six. This indicates the lowest priority for CQC inspection;
- CQC registration with no conditions;
- The Board Assurance Framework and the Corporate Risk Register;
- Presentation of the Annual Governance Statement to the Audit Committee by the Accountable Officer;
- The Audit Committee Annual Report, which includes Internal Audit and assurance relating to Corporate Risk Review Group;
- The Quality Committee Annual Report;
- Annual report from Senior Management Team and subgroups and directorates;
- Internal and Clinical Audit Plan, prioritised on areas of risk and concern;
- Clinical Audit Annual Report;
- Internal Audit periodic reports and follow up of Internal Audit recommendations;
- Internal Audit Annual Report and Head of Internal Audit opinion;
- ISA260 Audit Highlights Memorandum (External Audit Report);
- Independent review of governance against the Well-led Framework by Deloitte (December 2015).

I am assured adequate and well-designed systems are in place, but there remain some control weaknesses in the operational compliance with these systems, evidenced by Internal Audit and the Head of Internal Audit opinion in relation to intravenous cannula care, staff rostering and safety netting (ensuring that all patients are appropriately followed up).

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 2016/17.

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.

Mr Jonathan Coulter
Acting Chief Executive
25 May 2016

5. Harrogate and District NHS Foundation Trust Quality Account 2015 – 2016

Harrogate and District NHS
NHS Foundation Trust

Harrogate and District NHS Foundation Trust's

Quality Account 2015/16




RESPECTFUL PASSIONATE RESPONSIBLE

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Contents

1. STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

As Chief Executive of Harrogate and District Foundation Trust it is my responsibility to ensure that the care and services we provide are safe, effective, and responsive to people's needs and delivered with care and compassion at all times. As an organisation, we are intensely proud of our reputation for quality and we strive to create the conditions for outstanding care to be the norm across all of our services, at all times.

This quality account describes the things we have done to drive up quality over the last twelve months and the areas we have identified as priorities for the year ahead. It illustrates how we have worked to sustain high quality care in hospital and community services, from Harrogate to Leeds, Ripon to Scarborough and other parts of North Yorkshire. In a changing NHS it also touches on the importance of partnerships as we seek to offer truly patient-centred care.

The last 12 months has been another strong year for the Trust. Importantly, when people who use our services have responded to national surveys the Trust has consistently rated as amongst the best nationally. When our own staff completed the national staff survey the results placed the Trust in the top three when compared to its peers.

Here are some of the quality headlines for the year overall:

- The Trust achieved all national waiting time targets for cancer services and referral to treatment times for elective care. More than 95% of people were seen within 4 hours in our Emergency Department;
- We achieved our best ever NHS safety thermometer score of 97.9% in February. This is a national method of reporting the percentage of people experiencing harm free care. A score above 95% is considered good and comparable trusts on average report scores around 94-95%;
- The Trust was rated as 'good' and ranked 47th out of 230 in the new National Learning League. This is designed to illustrate the safety culture in NHS Providers;
- Our maternity service was rated in the top three nationally by service users.
- In the 2015 survey of inpatients administered by Picker, HDFT scored significantly better than other trusts in 18 out of 62 questions.
- Our laboratories have gained UKAS accreditation to ISO 15189:2012 [Medical laboratories — Requirements for quality and competence] in Blood Sciences, Histopathology and Microbiology. This accreditation is an internally recognised mark of quality and is objective proof that a laboratory is not only competent, but safe, patient-focused, efficient and reliable. Few laboratories in the country have all their services accredited to this level.

Getting the fundamentals of care right is a crucial part of any NHS providers role. A strong focus on improving care in inpatient areas this year has led to a substantial reduction in the number of patients suffering harm as a result of a fall while in our care. We have also improved the detection and prevention of pressure ulcers with a 36% reduction in the number of pressure ulcers arising in our care. Our ambition is to reduce to zero the number of avoidable hospital acquired pressure ulcers in the next 12 months. We identified more cases of the infection *Clostridium difficile* during 2015/16 than in the previous year. In seven of these cases a lapse in care was identified as the root cause and for 2016/17 we are determined to bring this down to zero.

Last year we selected the following three key areas for quality improvement:

- 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.

Over the coming pages you can read about how we went about making improvements and the benefits which patients are now experiencing. The work started in 2015/16 will be carried forward during 2016/17 alongside the new priorities we have selected for this year. These are:

1. To reduce morbidity and mortality related to sepsis;
2. To improve the care of people with learning disabilities;
3. To provide high quality stroke care - demonstrated by improvement in national indicators;
4. To improve the management of inpatients on insulin.

In February 2016 the Trust was inspected by the Care Quality Commission as part of its routine programme of inspections. Sixty three inspectors spent a week at the Trust and visited services far and wide to talk to patients, carers, staff and other stakeholders. No serious matters of concern were raised at the time of the inspection. At the time of writing the results of this important inspection are awaited.

The single most powerful determinant of care quality is the collective knowledge, skills and behaviours of the people who provide the care. Our vision is to deliver “Excellence Every Time” and we do this by ensuring that colleagues working across the organisation are capable and motivated, that they have the right skills and abilities to do their work and that we have a culture of openness and learning. You can read more about the overall performance of the Trust in our Annual Report for 2015/16 which this Quality Account complements.

Finally I would like to record my thanks to colleagues in every part of the Trust whose unwavering focus on the quality of care has made these results possible.

Ros Tolcher.

Dr Ros Tolcher (Chief Executive) Date: 20 May 2016

2. PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE

2.1 Priorities for improvement 2016/17

We have consulted with our external stakeholders and within the Trust about the priorities for quality improvement during 2016/17. The final indicators reflect national and local priorities for improvement, current performance and objectives and have been approved by the Board of Directors. We will set targets for achievement and will monitor progress regularly at the Quality Committee. We aim to:

1. Reduce morbidity and mortality related to sepsis

Sepsis is a life-threatening response of the body to infection. There is a national focus on reducing morbidity and mortality related to sepsis, with inclusion in the national Commissioning for Quality and Innovation (CQUIN) scheme for 2015/16 and 2016/17. We will be aiming to achieve the national CQUIN requirements relating to sepsis screening, treatment and review. The metrics that will be used to monitor performance and improvement are:

- CQUIN audit data;
- Case note review of patient deaths resulting from sepsis;
- Sepsis mortality rate.

2. Improve the care of people with learning disabilities

This relates to the Trust's Equality and Diversity objectives and we aim to increase the identification of people with learning disabilities by using, with their consent, electronic flags on electronic patient systems. This will enable staff to identify people who may need additional support and to use that information to deliver high quality, personalised care. The metrics that can be used to monitor performance and progress are:

- Number of learning disability flags on hospital systems;
- Demonstration of using information about people with learning disabilities to provide personalised care;
- Patient and carer feedback from the Friends and Family Test and other surveys, complaints, compliments;
- Staff training levels.

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

Whilst some of our Sentinel Stroke National Audit Programme (SSNAP) results have improved recently, we are not making as much progress as we would like with others, and we want to focus during 2016/17 on improving our performance in relation to the provision of high quality stroke care. The quarterly SSNAP dataset will be used to monitor performance and progress.

4. Improve the management of inpatients on insulin

We are focusing on this because of increasing medicines safety incidents including serious incidents requiring investigation (SIRI) that relate to insulin prescribing and administration. The metrics for monitoring performance and progress include:

- Datix (patient safety and risk management software) reports relating to insulin management;
- Actions taken as a result of abnormal results e.g. inpatients with an episode of hypoglycaemia, raised capillary blood glucose as indicated on the insulin dashboard;
- Staff training.

It has been noted that the Trust will consider the extended range of community services across Darlington, County Durham and Middlesbrough from 1 April 2016, and across North Yorkshire, when the quality priorities for 2017/18 are considered.

2.2 Progress against quality priorities identified in 2014/15 Quality Account

In the 2014/15 Quality Account we identified the following priorities:

- 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.

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

2.2.1 Creating the conditions for safety by improving communication

Poor communication is an underlying root cause of many patient safety incidents and complaints. This may be as a result of insufficient or unclear information being communicated to staff, patients and relatives, or as a result of poor attitude or tone.

Our aim was to create a culture in which it is the norm to communicate with our patients, their relatives and our colleagues in a way that best meets their needs and expectations, and improves patient safety and experience. We hoped to reduce the number of complaints relating to poor communication.

What have we done?

Each clinical directorate within the Trust has promoted actions relevant to their services. These have included:

- Using 'Every Patient, Every Time' training and 'Barbara's Story', a short film developed by Guy's and St. Thomas' NHS Foundation Trust as an innovative training programme about dementia, to impress on our staff the importance of getting communication right;
- Empowering staff to feel confident to say sorry and explain to patients if something unexpected has happened or gone wrong;
- "Hello my name is….." briefings. This is a national campaign started by Dr Kate Granger for person-centred, compassionate care;
- Work undertaken in Pharmacy to respond to patient feedback by improving the provision of medicines information to patients (verbal, written and through the patient helpline). This will improve patient safety by optimising medicines use and improving adherence. Pharmacists are using the concept of "Every Contact Counts" to increase the contact time with patients to ensure patients are well informed about their medicines and any potential side effects;
- Work to improve end of life care during the last 12 months of life. One focus has been to facilitate patients and their families to achieve their choices regarding care in

the last days of life. We have also focused on training staff on the five Priorities of Care for the dying person, launched by the Department of Health in 2014, investing time to embed the training into practice. Some of these priorities relate specifically to communication. See section 2.5.3 in this report for further detail;

- A monthly newsletter produced by and shared with staff across the Podiatry Department. It has proved to be an excellent way to communicate with staff and share information and learning across a service that is geographically spread across North Yorkshire;
- An initiative called “Let’s Talk” which used a questionnaire to gather feedback on issues of communication with patients and their families. Whilst most feedback was positive we discovered that families did not know how to arrange to talk to their relative’s consultant. We have made this information available on our elderly care wards so relatives know how to book a meeting with a consultant;
- The introduction of new visiting times from 11.00-19.00 which has allowed more time for our staff to speak to patients relatives, friends and carers. This also provides valuable information which improves patient safety whilst in hospital and when discharge is being planned;
- Improving the verbal handover of patient information between teams by the use of “safety huddles” on the two elderly care wards and the respiratory ward. These are short team discussions focused on the safety needs of patients and are having a positive impact;
- The introduction of safety briefings in all inpatient areas. This briefing document is updated during each shift and completed by the nurse in charge. The content is discussed with other staff at handover which ensures all staff are aware of patients at risk of falls, infection control issues, patients with a pressure ulcer or high risk of developing one, patients who are nutritionally at risk, patients with a “do not attempt cardio-pulmonary resuscitation” order, patients with a Deprivation of Liberty Safeguard application, any patient with a learning disability, and any other issues that involve patient safety. All nursing staff receive a copy so they have the information they need to provide appropriate care;
- The introduction of a structured daily ward assurance process which involves ward managers talking to all staff and patients and ensuring patient safety is assessed across their area of responsibility. Areas of concern are escalated to the matrons. In addition to promoting patient safety, this also enables the matrons to talk to any patient or relative who is unhappy with any aspect of their care in order to try to resolve their concerns as quickly as possible. We believe that this has been particularly effective in reducing patient complaints;
- Displaying posters in ward areas to encourage patients and relatives to raise any concerns about their care whilst still in hospital so we can try to resolve them rapidly. The posters emphasise that this will not adversely affect their ongoing care;
- Development of new multidisciplinary admission documentation that we expect to start using early in 2016/17. With the whole multidisciplinary team using the same document, it is anticipated that vital patient safety information will be shared more effectively, unnecessary duplication will be reduced, communication between staff will improve and this will have a positive impact on patient safety;
- Work to improve communication within operating theatres following an audit that showed poor compliance with the use of the WHO (World Health Organisation) Surgical Safety Checklist;
- Seconding a midwife to progress 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 in maternity.

What are the results?

Better communication is difficult to measure. However we feel confident that patients, relatives and carers are now more able to have discussions with our staff about what is important to them, and our staff have a greater understanding of their patients' needs.

It will be clear in other parts of this report (see particularly section 2.5.1) that patient safety has improved this year with improvement in communication regarding medicines and a reduction in the number of our patients who suffer harm from falls and pressure ulcers. The results of other work to improve communication are given below.

1. Complaints relating to poor communication

Data shows a positive reduction in complaints relating to poor communication across the Trust during 2015/16.

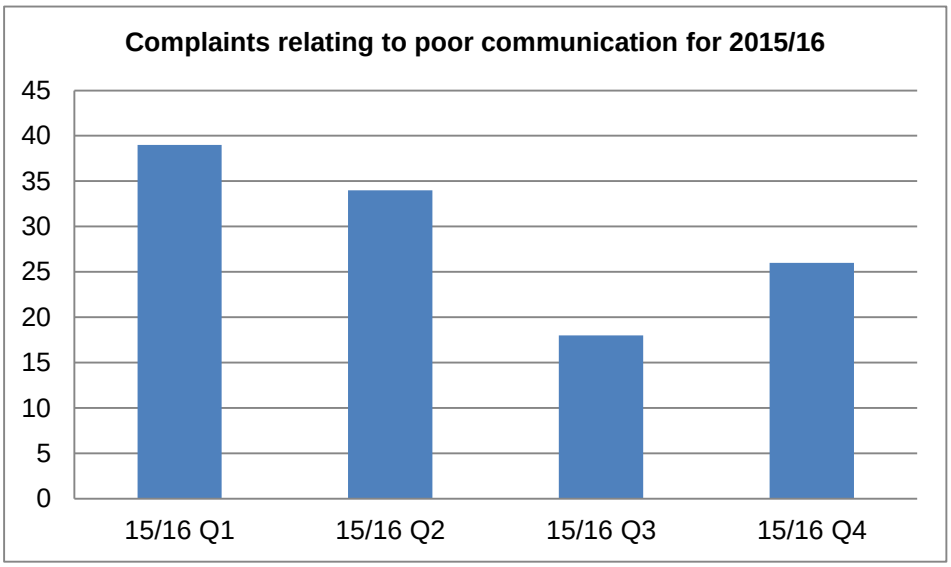

Figure 1: Complaints relating to poor communication 2015/16

2. "Hello, my name is…"

An audit was conducted in Podiatry to see if patients report that the Podiatrist or Assistant introduce themselves. There was an excellent outcome with approximately 94% of patients reporting that the staff either introduced themselves, or that they already knew the staff member and therefore there was no need for introductions.

"Hello, my name is…"	No of responses	% response
Patients responding	380	97.4
"Yes" response	322	84.7
"No" response	58	15.2
"But I knew them"	34	8.9

Table 1: "Hello, my name is…" Podiatry survey response

In addition 93.5% of patients surveyed were satisfied when asked "Were you happy with how they explained your foot problem and how they explained the treatment they were going to give?"

3. End of Life Care

There is detail of the work that has been undertaken to improve end of life care in section 2.5.3 of this report. Some results specific to communication are:

National Care of the Dying Audit of Hospitals (NCDAH)

The aim of this Royal College of Physicians audit is to identify and communicate learning that can help to improve the care of dying patients and their relatives or carers in hospital settings.

In 2014 standards of care were evaluated using clinical and organisational key performance indicators (KPIs), by which trusts could benchmark themselves for future performance. These were based on national policy and the audit questions were informed by the 44 recommendations of the 2013 Independent Review of the Liverpool Care Pathway. For the 2015 audit, as a result of changing healthcare landscape and terminology, the NCDAH has defined quality indicators (QIs) rather than KPIs. Essentially, they retain the same function and are derived from the actual audit results of participating trusts, but due to this change in terminology the results from the 2015 audit cannot be compared directly with the 2014 audit results.

The results of the 2014 and 2015 audits pertinent to communication are summarised below:

National Care of the Dying Audit of Hospitals 2014: Key results HDFT	
Key findings	Achieved 3 out of 7 organisational KPIs and 8 out of 10 clinical KPIs*
Organisational KPIs related to communication achieved	Formal feedback processes regarding bereaved relatives/friends views of care delivery
Organisational KPIs related to communication not achieved	Access to information relating to death and dying

Table 2: NCDAH 2014 HDFT Key results

National Care of the Dying Audit of Hospitals 2015: Key results for HDFT	
Key findings	Achieved 2 out of 8 organisational QIs and all 5 clinical QIs*
Organisational QIs related to communication achieved	Did your Trust seek bereaved relatives' or friends' views during the last two financial years (i.e. from 1st April 2013 to 31st March 2015)?
The clinical QI with the highest score of achievement (largest percentage difference)	Is there documented evidence that the needs of the person(s) important to the patient were asked about?

Table 3: NCDAH 2015 Harrogate and District NHS Foundation Trust (HDFT) key results

**Achieved means the % of cases that achieved the KPI / QI at HDFT were greater than that of the % achieved at the national average.*

Bereavement survey

Whilst we value feedback and seek to use this to improve the end of life care we provide, we are very aware that it is a difficult time for anyone recently bereaved and we approach this work as sensitively as possible. We undertook a survey of bereaved relatives in 2013 as part of the national audit, and are now undertaking a continuous local survey to gain more feedback and a richer understanding of end of life care. We write to the next of kin about seven weeks after their relative's death to ask if they would complete a questionnaire.

A preliminary report has been completed in February 2016 and the results pertinent to communication are mainly positive.

The nurses had time to listen and discuss his/her condition with me.

	2013 survey (n=11)	Current survey (n=10)
Strongly agree	6 (55%)	5 (50%)
Agree	4 (36%)	4 (40%)
Neither agree nor disagree	1 (9%)	1 (10%)
Disagree	0	0
Strongly disagree	0	0

The doctors had time to listen and discuss his/her condition with me.

	2013 survey (n=11)	Current survey (n=10)
Strongly agree	6 (55%)	6 (60%)
Agree	4 (36%)	3 (30%)
Neither agree nor disagree	1 (9%)	1 (10%)
Disagree	0	0
Strongly disagree	0	0

During the last two days, how involved were you with the decisions about his/her care and treatment?

	2013 survey (n=11)	Current survey (n=10)
Very involved	6 (55%)	8 (80%)
Fairly involved	4 (36%)	2 (20%)
Not involved	1 (9%)	0

Did the healthcare team explain his/her condition and/or treatment in a way you found easy or difficult to understand?

	2013 survey (n=11)	Current survey (n=10)
Very easy	8 (73%)	6 (60%)
Fairly easy	3 (27%)	4 (40%)
Fairly difficult	0	0
Very difficult	0	0
They did not explain it	0	0

Table 4: Bereavement survey results

However there is still work needed to further improve communication and understanding.

Did a member of the healthcare team talk to you about what to expect when s/he was dying (e.g. symptoms that may arise)?

	2013 survey (n=11)	Current Survey (n=10)
Yes	7 (64%)	6 (60%)
No	4 (36%)	4 (40%)

Table 5: Further bereavement survey results

Some examples of comments from the surveys include:

Figure 2: Bereavement survey comments

4. SAGE & THYME ® Communication Skills Training

The SAGE & THYME ® model was developed by a patient and clinical staff at the University Hospital of South Manchester NHS Foundation Trust in 2006. It was designed to train all grades of staff how to listen and respond to patients/clients or carers who are distressed or concerned. It places published research evidence about effective communication skills within a memorable structure for clinical practice.

There are advanced plans to implement the SAGE & THYME ® communication skills training across the Trust. A number of multidisciplinary team members attended the “train the trainer” communication skills training courses in January 2016. Five staff members have completed their training, and the communication programme will be available for HDFT staff to attend from April 2016.

5. Anticoagulant patient survey results

It is vital that patients on anticoagulants (medicines used to prevent the formation of blood clots) understand why they are taking these medicines, and the graph below from the anticoagulant patient satisfaction survey shows that patients have a good understanding. Results also demonstrate that patients would recommend this service to their friends and family.

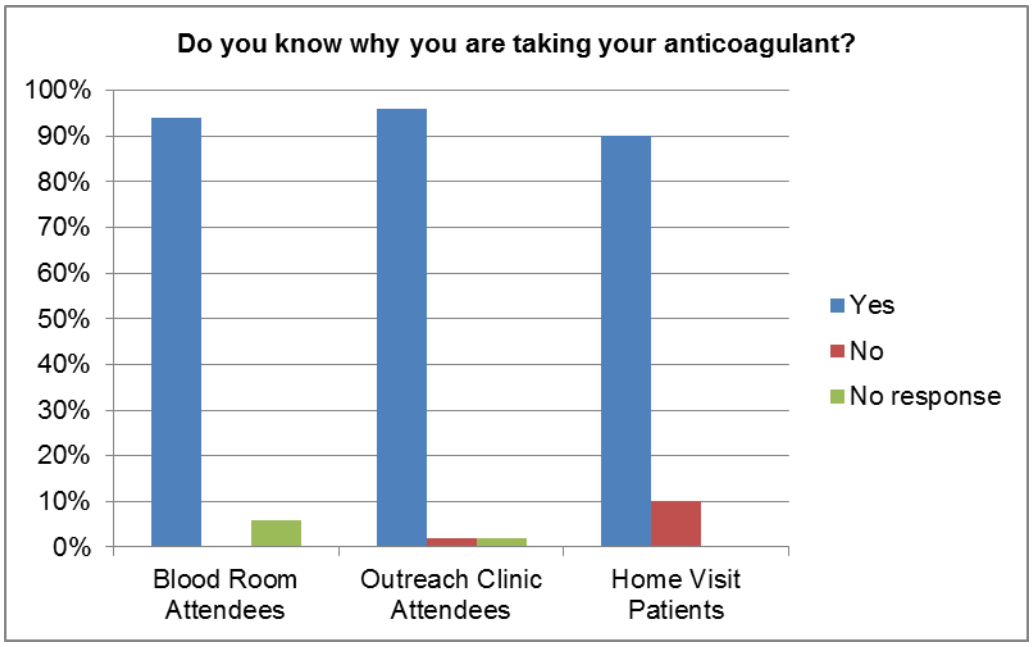

Figure 3: Anticoagulant patient survey results

6. Phlebotomy service

As a result of patient feedback through satisfaction surveys and recommendations form the Patient Voice Group, we implemented a new phlebotomy service in Sainsbury's Harrogate. In June 2015 we captured very positive feedback about the new service.

The comments included:

- Early opening time is good;
- Would prefer longer opening times;
- Would prefer larger room as I suffer from small spaces, so would use hospital in future;
- Parking is good.

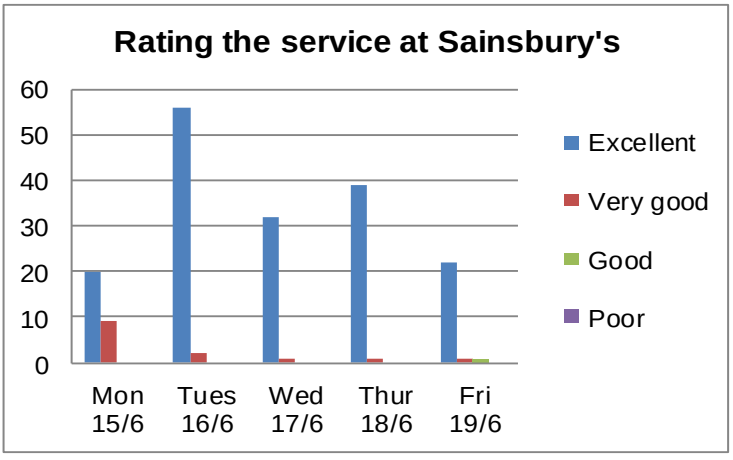

Figure 4: Sainsbury's phlebotomy service patient feedback

7. WHO Surgical Safety Checklist audit

The WHO (World Health Organisation) Surgical Safety Checklist is a tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases of perioperative care. It 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 operating team has completed the listed tasks before it proceeds with the next stage of the operation.

An initial audit of the "sign out" section of the WHO checklist demonstrated that this was not being used consistently, and was only signed in 32% of cases. In addition, an internal audit report undertaken during July 2015 highlighted a number of deficiencies in compliance with the WHO checklist in the operating theatres.

This coincided with a report into national safety standards for invasive procedures. The principle is that organisations will review their current local processes for invasive procedures and ensure that they are compliant with the new national standards. Organisations are expected to work in collaboration with staff to develop their own set of local safety standards for invasive procedures.

This work would take many months and it was essential that compliance with the current checklist was improved in the meantime. Clear guidance was implemented for staff on the use of the checklist and a re-audit was conducted in December 2015. This showed improvement in completion of all sections of the checklist.

Section of WHO Surgical Safety Checklist		December 2015 % complete (n=87)	July 2015 % complete (n=43)
Sign in	Tick	86%	47%
	Sign	86%	
Time out	Tick	97%	85%
	Sign	95%	
Sign out	Tick	72%	47%
	Sign	71%	
All sections complete		64%	8%

Table 6: WHO Surgical Safety Checklist audit results

The Elective Care Directorate are working on the development of local safety standards for invasive procedures which will replace the WHO Surgical Safety Checklist in 2016/17. These local safety standards will streamline the process of perioperative checks, reduce duplication and focus the teams on safety. Continued reinforcement of the existing guidance will be maintained until the new checking procedures are fully implemented.

Summary

The focus on communication has been a broad one, but we are seeing improvements in communication within teams and with patients. The reduction in complaints has been striking and work continues to address concerns proactively and to resolve issues early, and we have taken steps to improve safety through improving the way we communicate.

Improving communication is an ongoing priority for the Trust. Our ambition is to have a culture where our staff communicate with patients in a way that meets their individual needs and expectations. We will continue to work hard to gather patient feedback in order that we can measure patient experience and use the learning to improve patient care.

2.2.2 Improving patients' experience of using our services

We wanted to improve arrangements for admission, discharge and delivery of community services 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. This also improves patient experience.

We were aiming to ensure that people who attend our Emergency Department receive timely assessment. Then if they need admission or assessment by speciality teams, they will move promptly through the system and only stay in hospital for as long as is indicated by their clinical need. Discharge planning will also begin on admission and delays to discharge will be prevented by clearly defined and understood pathways linking secondary care and community services.

On discharge, medications will be prescribed correctly. The discharge letter that is sent to the GP and taken home by the patient will be clear and concise and the patient will leave hospital with the right medicines, information and any required support packages thereby avoiding re-admission.

To support people to recover more effectively we were aiming to increase the number of people who are offered and receive rehabilitation following a hospital stay. Rehabilitation and reablement in both inpatient and home based environments has been shown to improve a person's quality of life and maintain independence. This also reduces the number of patients who need to be readmitted to hospital after they have been discharged.

What have we done?

- Patients who present to the Emergency Department and who require specialty assessment or admission are seen promptly and assessed or admitted within 4 hours. A protocol has been developed by the Emergency Department and specialty consultants working at Harrogate District Hospital to ensure patients are managed through the optimum pathway and do not experience delays;
- A dashboard has been developed to help operational staff understand the pressures in the different parts of the Emergency Department;
- A patient flow screen is being re-launched to assist with bed allocation. The Emergency Department and other staff involved in maintaining the flow of patients will have real time visibility of bed availability and patients who potentially require specialty assessment or admission;
- We have redesigned the space on our acute admissions floor – where the acute admissions wards are located - to improve patient flow and patient experience. This was called the "Flip" project and has involved co-locating the Clinical Assessment Triage Clinic with the Clinical Assessment Triage and Treatment Ward. The Acute Medical Unit has been relocated with the Coronary Care Unit and the End of Life Care room. We have invested in additional staff to support this acute floor;
- We have included a section relating to previous admissions the patient has had within the new multidisciplinary admissions documentation being developed. When in place, there will be a targeted focus within multidisciplinary team discussions relating to patients whose latest admission could have been avoided if something different had been done at the previous discharge;
- A pilot took place in October on Jervaulx and Nidderdale Wards to assess the benefits of pharmacists writing up medications on discharge letters, rather than doctors in training. The aim was to assess any benefits in terms of clinical accuracy, the speed of the discharge process and any reduction in patient waiting times on discharge;

- The assessment of acute gynaecology referrals on Nidderdale Ward was improved by:
    - Directing all GP and Emergency Department referrals to the second on call doctor enabling telephone advice to be given when appropriate;
    - Establishing a band 3 rota Monday to Friday 12.30–20.30, responsible for undertaking initial observations on ward attenders and ensuring timely medical review.
- We have improved the assessment of acute paediatric referrals by establishing a paediatric clinical assessment team (CAT) model on Woodlands Ward. This Children's Assessment Unit commenced on February 29th 2016 and is operating daily 10.30–23.00;
- The Day Surgery Unit transformation group implemented a 'default to day case strategy' with the aim of reducing variance in overnight admissions for patients suitable for day case surgery;
- Other ongoing projects in Elective Care include increased involvement of general surgical consultants in the review of emergency admissions and the provision of physiotherapy at home, allowing earlier discharge for some orthopaedic patients;
- As part of the New Care Models 'Vanguard' there are an additional four beds at Ripon Community Hospital which will enable additional rehabilitation and reablement to be offered to patients. We are working with partner agencies to develop a specification for community beds including the criteria for admissions, and a more effective intermediate care bed based service linking with Station View Rehabilitation Unit (a North Yorkshire County Council care home). The model for therapy support into community beds has been reviewed;
- To help to understand the impact of the rehabilitation programme patients undertake on the ward, the Adapted Therapy Outcome Measure has been introduced as a means of measuring a change in a patient's independence. This tool is used to score the patient's independence based on their activities of daily living prior to their illness. Their functionality is assessed and scored on admission to Trinity Ward and again at the end of their stay. We are in the process of analysing the effectiveness of this tool in assessing the impact of the rehabilitation;
- A rapid process improvement workshop has reviewed and made improvements to the pathway for managing urinary catheters in the community. In future this work will be managed by the Community Nursing Team thereby reducing admissions to hospital.

What are the results?

There are results reported in other areas of this report relating to improvements in urinary catheter management in the community (section 3.5), and pharmacist rather than doctor written discharge letters (section 2.5.1).

1. Flip project

The Flip project was implemented in October 2015 following a period of preparation during September. The result is that we have improved patient flow. Patients admitted through the Emergency Department or from GPs are seen by a consultant acute physician more quickly and provided with a plan of care which enables them to be either discharged home or transferred to a medical ward with a plan of medical care already in place.

The length of stay for a significant number of admissions has reduced to 0 – 2 days and we have seen a reduction in the number of longer admissions. This has enabled us to safely manage the increased number of patient admissions.

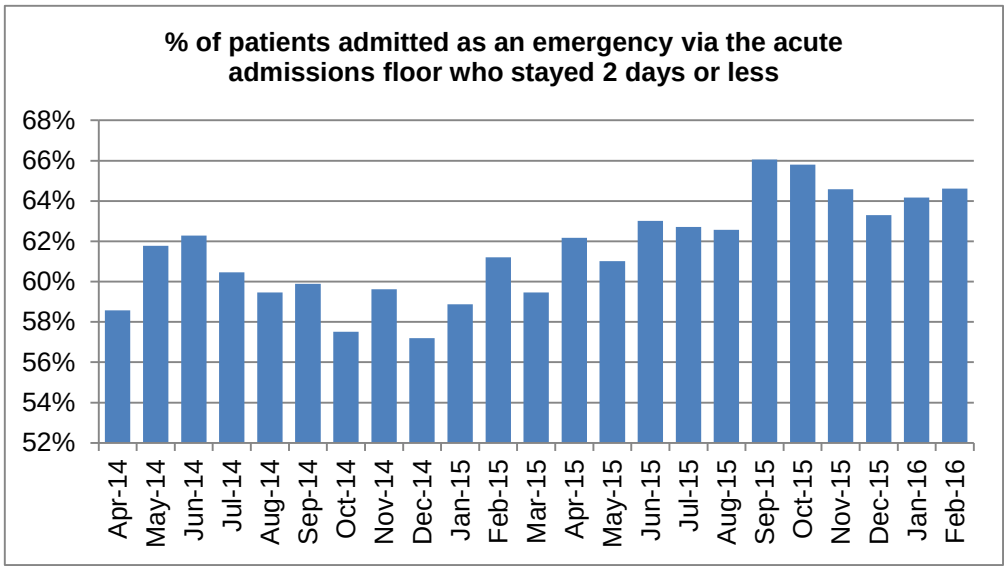

Figure 5: Patients admitted as an emergency via the acute floor who stayed 2 days or less

2. Gynaecology ward referrals

Following the introduction of all GP and Emergency Department (ED) gynaecology ward referrals being directed to the second on call doctor, an audit was undertaken in February 2016. The results show that the assessment of acute gynaecology referrals on Nidderdale Ward has improved, and are summarised below:

- A third (6/18) of GP referrals and a quarter (7/28) of ED referrals were managed with telephone advice only;
- Of the 33 patients reviewed during the study period only 11 were admitted. 75% of GP referrals and 62% of ED referrals were discharged with advice. 73% of patients were seen within 30 minutes and 88% within 1 hour.

Compared with an audit the previous year, the number of patients reviewed was reduced (33 patients compared with 54), suggesting that the middle grade doctor triaging the calls was resulting in fewer emergency referrals.

<u>Summary</u>

Improving the experience patients have of our services is an ongoing priority for the Trust, and good patient flow is a key element of this. With resource in the hospital being used more effectively, we will see a positive impact on the 4 hour Emergency Department target, and a reduction in avoidable admissions.

The work we have done redesigning our acute admissions floor has meant that patients are only admitted to hospital when this is clinically needed and the length of time they need to stay in hospital is reduced. We have implemented plans to improve the flow of patients referred for an emergency gynaecology review, and have introduced a Children's Assessment Unit. The Day Surgery Unit transformation group has implemented a 'default to day case' list with the aim of increasing the number of day case procedures. A business case has been approved for an eighth surgical consultant, which will enable a consultant of the week model in general surgery and greater consultant involvement in the assessment and review of acute surgical admissions. We will be implementing the new multidisciplinary admissions documentation, and increasing pharmacist cover on the wards to write up medications on discharge letters, improving clinical safety and communication of information, further improving patient experience.

2.2.3 Becoming a centre of excellence for the care of the frail elderly

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 or a fall.

Last year, we had started on the journey towards creating a centre of excellence for the care of older people with frailty on two of our inpatient wards. We aimed to continue this work to provide excellent care to the increasing number of elderly patients with complex needs whenever they access our services, to continue to focus on dementia care and to support the carers of the frail elderly. We are developing New Care Models which promote integrated teams and patient care at home where possible, which is less disorientating for the frail elderly and helps maintain their independence.

Please see the sections of this report on dementia (section 2.5.3), innovation and New Care Models (section 3.5), mental capacity (section 3.14), falls and pressure ulcers (section 2.5.1).

What have we done?

- As research in the relationship between declining health and mental agility recommends a constant touchstone of mental stimulation for patients with dementia, our Occupational Therapists arrange weekly coffee mornings and staff have linked with volunteers who are delivering arts and crafts sessions associated with national and local events such as crocheting poppies for Remembrance Day. Patients continue to enjoy the Pat-a-dog visits which help patients communicate and relax, as well as stimulating memory and emotional response;
- Students from Ripon Grammar School are working with patients with dementia to create booklets on ‘My Life’; an example of how patients’ mental stimulation is encouraged;
- There has been work towards achieving a more ‘dementia friendly’ environment;
- From October 2015 the Community Fast Response and Rehabilitation Team (CFRRT) has been screening patients over 75 who are referred to the service for dementia, aiming to screen at least 90% of patients. The team are also investing time in creating screening tools and updating falls assessment tools in conjunction with North Yorkshire County Council Falls Coordinator and Harrogate and Rural District Clinical Commissioning Group (HaRD CCG). The impact of this will be measured by the number of referrals, admissions avoided and estimated number of bed days saved;
- Doctors in training in the Emergency Department have been working to ensure patients aged over 75 are assessed for cognitive impairment. The target was to achieve 75% of people having a documented cognitive assessment by the end of 2015/16;
- We have reintroduced the Butterfly Scheme. This is a pathway of care for people living with dementia, confusion or forgetfulness. When a patient or carer opts into the scheme a discreet butterfly symbol is used to identify their needs to ensure that an appropriate response is given;
- We have provided training for staff on the Mental Capacity Act and Deprivation of Liberties safeguards to ensure patients are assisted in making decisions about their care whenever possible. Equally we aim to ensure staff recognise when they do not have capacity to do this and ensure their needs are supported;
- Pharmacy staff are working on a pilot project with the HaRD CCG which enables them to refer elderly patients for follow up after discharge to help them manage their medicines at home. The team are also exploring work developed by a team from Lancashire that enables direct electronic transfer of the patient’s discharge letters to

their designated community pharmacy as there is evidence to show that including the community pharmacy improves outcomes for all patients, especially the frail elderly;
- We have focused on improving our clinical care with work relating to reducing the risk of patient falls and pressure ulcers described in section 2.5.1;
- We have strengthened our discharge planning team to facilitate the discharge of patients with complex needs in conjunction with social care;
- We have piloted the use of a urinary continence care bundle to increase the identification of continence issues and ensure that patients are referred to the continence practitioner for specialist advice;
- We offer more support to carers by using carer's passports. This allows the carer to visit any time that is needed by the person they are caring for;
- We have reviewed policies to ensure appropriate consideration of carers and have developed a carers leaflet that highlights support for carers in the community;
- Elective Care are seeking to improve the peri-operative care of frail elderly patients by the appointment of a second specialist Consultant in Medicine for the Care of the Elderly, to support the Orthogeriatric Consultant and to develop a more robust service for elderly patients in General Surgery. The business case has been approved and the post advertised. We expect that in future years we will see the proportion of frail elderly patients receiving specialist peri-operative care from an elderly care specialist increase;
- At Ripon Community Hospital, Trinity Ward's main focus is on the rehabilitation of elderly patients following a stay in hospital or surgery. The team strives to deliver patient centred care tailored to meet the needs of the patient, and are supported by a weekly multidisciplinary team meeting and Consultant in Medicine for the Care of the Elderly review.

What are the results?

The results of work relating to dementia, innovation and New Care Models, mental capacity, falls and pressure ulcers are included in the reports previously referenced.

1. Emergency Department

The findings from the initial audit in the Emergency Department (ED) demonstrated only 5% of patients had a documented cognitive assessment.

The following recommendations were made:

- Change the ED card for patients > 75 years to ensure documentation;
- Provide training of cognitive assessment using the Abbreviated Mental Test;
- Ensure greater awareness of the need to ask carers if they feel supported.

The results show a vast improvement in compliance, with the department achieving 62% of patients with a documented assessment by the end of December 2015, and 86% by the end of March 2016. Further work is required to ensure this continues to improve and becomes embedded as routine practice.

2. Community Fast Response and Rehabilitation Team

The Community Fast Response and Rehabilitation Team (CFRRT) has exceeded the target of screening 90% of patients over the age of 75 for cognitive impairment since they started in October 2015. This enables the CFRRT to refer patients with suspected dementia to their GP for further investigation and support.

	Question 1 - Dementia Case Finding	Question 2 - Diagnostic Assessment for Dementia	Question 3 - Referral for Specialist Diagnosis
October – December 2015	99% (125/126)	92% (23/25)	100% (13/13)
January – March 2016	98% (105/107)	94% (15/16)	100% (6/6)

Table 7: Patients over 75 who have had dementia screening carried out following referral to CFRRT

3. Pharmacy

To date eight referrals have been made to the HaRD CCG Medicines Management Team to provide a domiciliary medication review service to high risk patients identified at discharge by HDFT pharmacists. As a result 27 medicines related problems were highlighted including lack of patient understanding of their medication regimen, worsening symptoms after discharge and discrepancies between discharge letter prescription and GP repeat prescription. This enabled stopped medications to be removed in some situations and poor understanding of medicines to be addressed with the use of compliance aids and increased counselling.

Pharmacy is looking into an electronic referral system to allow swifter and simpler referral of patients to community pharmacies, CCG pharmacists and 'Vanguard' pharmacists alike. IT infrastructure is being assessed to allow identification of funding required to enable introduction of this service.

Summary

Much of the work reported in this quality account is relevant to our aspiration to provide excellent care to the increasing number of elderly patients with complex needs whenever they access our services and to ensure that their individual needs are met.

National drivers advocate proactively targeting patients with complex ongoing needs such as the frail elderly, and working much more intensively with them. There is strong evidence to suggest that a strategy for older people with frailty should be centred on community based care with multidisciplinary assessments. This could reduce hospital admissions, improve the timeliness of interventions, improve the flow through acute services and facilitate earlier discharges (Patterson, 2014).

Improving the care of our frail elderly patients is an ongoing priority for the Trust. We aim to ensure that every patient always receives the right care at the right time and that we meet their individual needs. During this year we have been developing a five year strategy to support us in becoming a centre of excellence for the holistic care of older people with frailty. The strategy focuses on older people with frailty across our whole organisation not just specific parts of it.

We are committed through our Vanguard programme to work on new models of providing care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients. The aim will be to identify frailty earlier and with a focus on prevention we could see a positive impact on the quality of life of our frail elderly population.

2.3 Statements of assurance from the Board

1. Provision of relevant health services and income

During 2015/16 HDFT provided and/or sub-contracted 61 relevant health services.

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

The income generated by the relevant health services reviewed in 2015/16 represents 100% of the total income generated from the provision of relevant health services by HDFT for 2015/16.

2. National & Local Audits

National Audits

During 2015/16, 33 national clinical audits and six national confidential enquiries and clinical outcome review programmes covered relevant health services that HDFT provides. The national clinical audits comprised 42 individual work streams.

During that period HDFT participated in 89% 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 28 mandatory audit programmes 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 21 non-NCAPOP audits, three of which were not relevant and four of which did not run during 2015/16, leaving 14 which were relevant to HDFT. The Trust participated in ten (71%) of those which were relevant.

The national clinical audits and national confidential enquiries that HDFT was eligible to participate in during 2015/16 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)
5. Diabetes (Adult)
6. Diabetes (Paediatric)
7. Elective surgery National PROMS programme
8. Emergency Use of Oxygen
9. Falls & Fragility Fractures Audit Programme (FFFAP)
10. Inflammatory Bowel Disease (IBD) programme
11. Lung cancer (NLCA)
12. Major Trauma: The Trauma Audit & Research Network (TARN)
13. Maternal, New-born and Infant Clinical Outcome review Programme (MBRRACE-UK)
14. National Audit of Intermediate Care
15. National Cardiac Arrest Audit (NCAA)
16. National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
17. National Comparative Audit of Blood Transfusion programme

18. National Complicated Diverticulitis Audit (CAD)
19. National Emergency Laparotomy Audit (NELA)
20. National Heart Failure Audit
21. National Joint Registry (NJR)
22. National Ophthalmology Audit
23. Prostate Cancer
24. Neonatal intensive and special care (NNAP)
25. Oesophago-gastric cancer (NAOGC)
26. Paediatric Asthma
27. Procedural Sedation in Adults (CEM)
28. Pulmonary Hypertension
29. Rheumatoid and early inflammatory arthritis
30. Sentinel Stroke National Audit Programme (SSNAP)
31. UK Parkinson's Audit (previously known as National Parkinson's Audit)
32. Vital signs in Children (CEM)
33. VTE risk in lower limb immobilisation (CEM)

Clinical Outcome Review Programmes

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

1. Gastrointestinal Haemorrhage
2. Sepsis
3. Acute Pancreatitis
4. Mental Health

Child health clinical outcome review programme:

1. Chronic neurodisability
2. Young people's mental health

The national clinical audits and national confidential enquiries that HDFT participated in during 2015/16 are as follows:

National audits:

1. Acute coronary syndrome or Acute myocardial infarction (MINAP)
2. Bowel cancer (NBOCAP)
3. Cardiac Rhythm Management
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14. National Cardiac Arrest Audit (NCAA)
15. National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
16. National Comparative Audit of Blood Transfusion programme
17. National Emergency Laparotomy Audit (NELA)
18. National Heart Failure Audit

19. National Joint Registry (NJR)
20. National Ophthalmology Audit
21. Prostate Cancer
22. Neonatal intensive and special care (NNAP)
23. Oesophago-gastric cancer (NAOGC)
24. Procedural Sedation in Adults (CEM)
25. Rheumatoid and early inflammatory arthritis
26. Sentinel Stroke National Audit Programme (SSNAP)
27. UK Parkinson's Audit (previously known as National Parkinson's Audit)
28. Vital signs in Children (CEM)
29. VTE risk in lower limb immobilisation (CEM)

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

1. Gastrointestinal Haemorrhage
2. Sepsis
3. Acute Pancreatitis
4. Mental Health

Child health clinical outcome review programme

1. Chronic neurodisability
2. Young People's mental health

The national clinical audits and national confidential enquiries that HDFT participated in, and for which data collection was completed during 2015/16 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 ten of the national clinical audits and two of the NCEPOD reports were reviewed during 2015/16, and HDFT intends to take the following actions to improve the quality of healthcare provided.

National Cardiac Arrest Audit

Harrogate District Hospital data has previously shown survival to discharge statistics following cardiac arrest that are lower than the majority of participating trusts, and this area has been the focus of considerable improvement work over the last year. Significant work has gone into ensuring discussion with patients and relatives in relation to "do not attempt cardiopulmonary resuscitation" (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 DNACPR orders. A local re-audit and detailed case note review were undertaken during 2015 in response to the national data, and results were scrutinised at the Resuscitation Committee and Improving Patient Safety Steering Group.

The latest reports show more favourable outcomes for patients in cardiac arrest that are above the national average. However there is more work to be done to ensure we always consider DNACPR decisions at the earliest opportunity and thus only attempt the resuscitation of those patients for whom it is appropriate. There is an action plan in place being led by the resuscitation team and work will continue in this important area during 2016/17.

Audit of Patient Blood Management in Adults undergoing Elective Scheduled Surgery

This audit was undertaken to document and understand the current use of red cell transfusion by clinical staff and patient blood management approaches in adults undergoing elective, scheduled surgery in relation to 11 audit standards. The Trust undertook 21 transfusions in the audit period.

The aim is to limit transfusions to the minimum required for symptom relief, and whilst HDFT has good rates of single unit transfusions, this could be further improved. Post-operative 'top-up' transfusions is recommended if the haemoglobin (Hb) is <70g/L, however the audit showed that transfusions continue to be undertaken at Hb >70g/L without a reason for this being recorded. The HDFT Red Cell Policy highlights the threshold for transfusion.

Actions to be taken as a result of this audit include:

- Identifying a method of obtaining an early Hb when a patient is listed for elective surgery, and to develop healthcare pathways to enable anaemia screening, investigation and correction before surgery;
- Disseminating the Red Cell Policy to medical staff and highlighting at targeted medical staff education sessions;
- Highlighting to clinical staff the need to record the reason for transfusion in the patient's case notes and a justification if outside the guideline threshold for transfusion.

In addition, some reports and action plans from older national clinical audits and confidential enquiries were reviewed by HDFT in 2015/16 (due to delays in national reporting timescales and the fact that some action plans remained open). The following are examples of actions for improvement that have been taken.

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

A business plan is in development for a second surgical geriatrician which is anticipated to enable the Trust to meet a number of the outstanding recommendations, although there is still an outstanding action around the audits of delays to surgery.

NCEPOD - Tracheostomy Care: On the Right Trach? (2014)

A review of progress was received in May 2015 where it was noted that the remaining actions related to ongoing monitoring of staff training. The action plan was closed, but it was expected that tracheostomy training would be made essential training for staff in areas managing patients with tracheostomies i.e. Intensive Therapy Unit/High Dependency Unit (ITU/HDU), Lascelles Unit, Oakdale and Granby Wards. Progress with this is monitored by the Critical Care Delivery Group.

National Joint Registry

The National Joint Registry (NJR) is a mandatory data set and all eligible joint operations must be submitted. The compliance report for 2014/15 data was reviewed by the Orthopaedics Team which included identification by consultant. Steps are being taken to ensure robust systems are in place to guarantee that a minimum dataset form is generated for all NJR procedures.

Local Audits

During 2015/16 a joint audit programme between Clinical Effectiveness and Internal Audit was in place, as per previous years, which focused on the high priority areas for the Trust in order to provide assurance through the governance structure. This ensured that there was no duplication of work and therefore utilised resources more efficiently. Joint audit planning has been undertaken again in preparation for 2016/17.

213 projects (excluding national audits) were registered with the Clinical Effectiveness Department during 2015/16. 65 of these were contained on the 'priority' programme developed at the start of the year, and 148 were ad-hoc projects identified and registered throughout the year. This includes projects aimed at improving quality by using service evaluation and patient experience surveys. Some of these were for completion during the financial year and some had extended timescales which will remain open into 2016/17.

The results of local audits are presented at the relevant directorate or specialty audit or governance meetings where the results, recommendations and an action plan are discussed. Audits are defined as complete when a report identifying recommendations and actions for improvement is produced. In order to close the "audit loop" and complete the audit cycle, re-audits should be completed as evidence that improvements have been made, where appropriate.

The reports of 88 local projects (clinical audits, service evaluations and patient surveys) were reviewed by relevant audit or governance groups at HDFT during 2015/16. HDFT also continued to review completed audits which had been registered and commenced during 2014/15. HDFT intends to take the following actions to improve the quality of healthcare provided.

Information sharing patient survey

An information sharing survey was undertaken during 2015 to satisfy the requirements of the Information Governance Toolkit in relation to NICE (National Institute for Health and Care Excellence) Clinical Guideline 138 and Quality Standard 15. In general terms, results from those people who had been inpatients were more favourable than those treated as outpatients. An inpatient stay, by its very nature, allows more time for discussions with the patient regarding information governance. The table below provides a side by side comparison of performance.

QUESTION	LEVEL OF PERFORMANCE % and number of respondents (n)	
	INPATIENTS	OUTPATIENTS
Are you aware of the different uses of your information?	83% (n=70)	76% (n=138)
Are you aware of your choices with regard to sharing your information?	87% (n=70)	71% (n=136)
Were you asked about your preferences regarding the healthcare staff sharing information with your partner, family members and/or carer?	62% (n=68)	44% (n=137)
If yes, do you feel those preferences were respected?	95% (n=42)	93% (n=60)

Table 8: Information sharing patient survey results

Actions were identified as follows:

1. Update the patient documentation for inpatients to remove reference to 'next of kin' and to add a section regarding whether the primary and secondary contact can be given information about the patient's care;
2. Consideration should be given to how this information can be made more accessible to outpatients;
3. Ensure that the information on the HDFT website regarding uses of information is easily accessible and up to date.

Patient satisfaction with Medical Day Unit

During 2015 the Integrated Care Directorate management team reviewed the clinics that take place on the Elmwood Unit and relocated some to the newly-refurbished Medical Day Unit (MDU). Following this change there had been conflicting anecdotal information received relating to patient satisfaction with the new location of the clinics so a survey was undertaken. 150 surveys were completed by patients attending the MDU in September, and results were overwhelmingly positive with the facilities generally highly rated. The majority of patients found the area easy to find, were greeted at reception on arrival and were informed which area to wait in. Patients gave some suggestions for improvement including improving signage for the unit, ensuring that reception staff are aware of any delays so that they can inform patients on arrival or as delays become apparent, and the use of fans on hot days.

Figure 6: Medical Day Unit patient feedback

Antibiotic prophylaxis for urological procedures at Harrogate District Hospital re-audit

The aim of this audit was to determine if the guidelines produced by the Microbiology Department on the use of prophylactic antibiotics for patients undergoing urological surgery are being adhered to.

Criteria	Expected performance	Actual performance 2013	Actual performance 2015
All patients undergoing transurethral resection of the prostate (TURP) receive prophylactic antibiotics	95%	87%	93%
All patients undergoing transurethral resection of bladder tumours (TURBT) receive prophylactic antibiotics	95%	80%	89%
All prophylactic antibiotics are administered within the hour before surgery starts	100%	8%	40%
Where gentamicin is used, the correct dose is administered	100%	36%	64%

Table 9: Use of prophylactic antibiotics re-audit results

There has been some significant improvement however the audit has generated some further recommendations regarding clear documentation of administration times on the electronic record.

Audit of non-visible haematuria referrals

This audit was based on the updated NICE guidelines on referral for suspected cancer (NG12: Suspected Cancer: Recognition and Referral 2015). There was clinical concern about the potential for missing a serious pathology if the new guidelines were followed by GPs if they had a patient with non-visible haematuria (blood in the urine).

An audit was undertaken of the 358 patients with non-visible haematuria patients referred in a 12 month period. Ten patients that had been referred under the previous guidelines and found to have a diagnosis of cancer would not have been referred under the 2 week wait rule if the new NICE guidelines had been followed.

Based on these audit findings, HDFT recommended that the local non-visible haematuria investigation guidelines should be updated and disseminated to local GPs with education to ensure that these patients continue to be referred urgently.

Audit of time to antibiotics in suspected neutropenic sepsis

Neutropenic sepsis is caused by neutropenia, when the number of white blood cells in the blood is low. NICE Guidance for Management of Neutropenic Sepsis (2014) and the National Cancer Standards Peer Review for Acute Oncology (2012) recommend all patients with suspected neutropenic sepsis receive their first dose of antibiotics within one hour of them being clinically diagnosed, and that this is audited. At HDFT the clinical management is described in our Suspected Neutropenic Sepsis Pathway.

Previous audits had demonstrated poorer results for time to antibiotics outside normal working hours, and we implemented an action plan to improve our performance. This included intensive education and awareness raising in the acute medicine on-call teams and nursing staff, whilst enabling some nursing staff to give the first dose of antibiotics using a patient group direction. This is a written instruction for the administration of medicines to patients. Performance has continued to improve year on year.

Year	% of patients receiving their first dose of antibiotic within 60 minutes of diagnosis	
	Expected level of performance	Actual level of performance
2012	100%	67%
2013	100%	75%
2014	100%	78%
2015	100%	87%

Table 10: Antibiotic administration in neutropenic sepsis audit results

Further improvements have been identified as follows:

1. All acute medicine nursing staff to be trained to take bloods and place intravenous cannulae (tube inserted into a vein to enable delivery of intravenous medication);
2. Continue induction sessions by consultants for each speciality for the foundation year doctors;
3. Continue to roll out the patient group direction that enables nurses to give the first dose of antibiotics;
4. Continue awareness raising and education;
5. Add a neutropenic sepsis reminder in the sepsis screening tool in the medical assessment clerking document;
6. Provide ready-made preparation for the first dose of Piperacillin with Tazobactam (antibiotic).

3. Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by HDFT in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 3151.

HDFT is committed to the promotion of evidence informed practice with the aim of continuous improvement to quality and patient outcomes and as of March 2016, the number of studies open and recruiting at HDFT was 78. 107 clinicians covering 22 clinical areas offer patients the opportunity to be part of research studies; they are supported by 32 National Institute for Health Research (NIHR) funded delivery staff.

There is absolute commitment to ensure every patient has opportunity to be involved in research and the Trust continues to embed a culture such that the offer of trial participation is considered part of standard care.

Training and education

Core 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. The Trust has implemented induction packages for research posts which involve new members of staff spending time in each clinical area, the Research and Development (R&D) office and in support departments. Student practitioner placements are encouraged and facilitated by student mentors.

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

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. HaRD CCG is one of the new NHS England New Care Models 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.

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 and University of York (reproductive health and healthcare delivery); Centre of Evidence-based Dermatology; Centre of Immunology and Infection; Clinical Trials Units in York, Leeds and Sheffield. 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 local 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.

Research governance and performance

R&D Unit staff conduct pragmatic research governance via a suite of usable standard operating procedures (SOP) for research. Activity is overseen monthly by a multidisciplinary R&D Group, chaired by the Trust's Medical Director. SOPs have been amended in line with the Health Research Authority national process for research approvals and will be continually developed in 2016/17. Performance is monitored and managed locally within the Trust; additionally performance against the high level objectives is managed by the Clinical Research Network at a regional and national level. Research metrics have been shared with Trust Board within the report from the Chief Operating Officer. An annual presentation is also delivered to the Board.

Monitoring, measuring service quality and sharing the impact of research

HDFT has two Patient Research Ambassadors bringing a patient perspective. The Patient Research Ambassadors are involved in project feasibility assessment, quality assurance via the participant survey, performance via team meetings and raising awareness about research opportunities. The annual survey assesses the quality of service delivery as

perceived by research participants. Findings are shared and acted upon. The intention is this will feed into a national survey of research participants in future. 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.

4. Use of the Commissioning for Quality and Innovation Framework

A proportion of HDFT income in 2015/16 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 2015/16 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 2015/16 conditional upon achieving quality improvement and innovation goals was £2,863,000. The monetary total for the associated payment in 2014/15 was £2,625,000.

5. Registration with the Care Quality Commission

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

HDFT had the following sites registered during 2015/16:

- Harrogate District Hospital
- Lascelles Unit
- Ripon Community Hospital

The Care Quality Commission has not taken enforcement action against Harrogate and District NHS Foundation Trust during 2015/16.

HDFT is subject to periodic reviews by the Care Quality Commission and the last review was on 2 February 2016. The CQC have not yet published its findings and no rating exists yet.
We have included below the Trust's view on the five key questions used by the Care Quality Commission in their inspections of services:

1. Are they safe?
2. Are they effective?
3. Are they caring?
4. Are they responsive to people's needs?
5. Are they well-led?

	Safe	Effective	Caring	Responsive	Well-led
Urgent and emergency services	Good	Good	Outstanding	Good	Good
Medical care (including older people's care)	Good	Good	Outstanding	Good	Good
Surgery	Good	Good	Outstanding	Good	Good
Critical care	Good	Outstanding	Outstanding	Outstanding	Outstanding
Maternity and gynaecology	Good	Good	Outstanding	Good	Good
Services for children and young people	Good	Good	Outstanding	Good	Good
End of life care	Good	Good	Outstanding	Good	Good
Outpatients and diagnostic imaging	Good	Good	Outstanding	Good	Good

	Safe	Effective	Caring	Responsive	Well-led
Community inpatients	Good	Good	Outstanding	Good	Good
Services for Children & Young People	Good	Good	Outstanding	Good	Good
End of Life Care	Good	Good	Outstanding	Good	Good
Community services for adults	Good	Good	Outstanding	Good	Good

Table 11: HDFT self-assessment against the five key questions for each core service

HDFT has not participated in any special reviews or investigations by the Care Quality Commission during 2015/16.

6. Information on the Quality of Data

HDFT submitted records during 2015/16 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
  - 99.9% for outpatient care
  - 98.7% for accident and emergency care

- Which included the patient's valid General Practitioner Registration Code was:
  - 100.0% for admitted patient care
  - 100.0% for outpatient care
  - 100.0% for accident and emergency care.

[Note – figures above are for the period April 2015 – January 2016 (latest available data)].

7. Information Governance

HDFT's overall score for the Information Governance Toolkit for 2015/16 was 84% and was graded green/satisfactory with all standards at level two or above (there are three levels with level three being the highest).

8. Payment by Results

HDFT was subject to a Payment by Results clinical coding audit in April 2015 commissioned by Monitor. An audit sample of 200 episodes was reviewed for the period July – September 2014, focusing on two specific areas of Healthcare Resource Groups (HRG); HB (Orthopaedic non-trauma procedures), and EB (Cardiac disorders). The results showed an

overall error rate (coding errors affecting the HRG) of 3.5% 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 2.0%
- Secondary procedures 6.0%
- Primary diagnoses 4.0%
- Secondary diagnoses 5.0%
- An overall combined diagnostic and procedural error rate 4.25%

The Trust also commissioned an external clinical coding audit to meet Information Governance requirements during 2015/16. The audit was carried out in February 2016 by nationally registered clinical coding auditors from D & A Clinical Coding Consultancy Limited. An audit sample of 200 episodes was reviewed, 50 episodes from Breast Surgery, 75 from both Urology and General Medicine were randomly selected from across the whole range of activity for the period July – September 2015. The results showed an overall error rate (coding errors affecting the HRG) of 5.5% 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 3.4%
- Secondary procedures 5.1%
- Primary diagnoses 5.0%
- Secondary diagnoses 5.3%
- An overall combined diagnostic and procedural error rate 4.7%

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

- The Trust will continue its comprehensive training programme to enable all Clinical Coding staff to achieve the national Clinical Coding Accreditation qualification;
- The Trust will continue to annually review its Clinical Coding Audit and Training programmes to ensure both are sufficient to identify and reduce coding errors.
- The Clinical Coding Team will continue to meet with individual consultants to review and explain the clinical coding process and discuss specific operations;
- The Trust will continue to routinely review and analyse all 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	
	Jul 14 to Jun 15	Oct 14 to Sep 15
HDFT value	0.957	0.977
HDFT banding	2 (as expected)	2 (as expected)
National average	1.000	1.000
Highest value for any acute Trust	1.209	1.177
Lowest value for any acute Trust	0.661	0.652

January 2015 to December 2015 data due for publication late June 2016
***Note** - highest and lowest trust scores include all providers with data published by HSCIC*
Data source: http://www.hscic.gov.uk/SHMI

Table 12: Summary Hospital Level Mortality Index (SHMI)

HDFT's latest published score of 0.977 is within the normal 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 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 has now adopted a regional structured case note review template. This will be rolled out across the organisation except where national protocols dictate alternative methods of analysis and review. In addition to specialty specific case note reviews, focused reviews of situation specific deaths will also be undertaken (such as maternal deaths, deaths from sepsis, and deaths of patients with learning disabilities);
- The Trust has recently submitted data to NHS England on potentially avoidable deaths for the purpose of national benchmarking.

Palliative care coding

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

	Data period	
	Jul 14 to Jun 15	Oct 14 to Sep 15
HDFT value	16.6	18.1
National average	26.0	26.6
Highest value for any acute Trust	52.9	53.5
Lowest value for any acute Trust	0.0	0.2

January 2015 to December 2015 data due for publication late June 2016
***Note -** highest and lowest trust scores include all providers with data published by HSCIC*
Data source: http://www.hscic.gov.uk/SHMI

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

HDFT's latest published score of 18.1% 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 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:

- Having regular education sessions for the Specialist Palliative Care Team as part of their business/multidisciplinary team meetings;
- Promoting a development programme in end of life care called Rethinking Priorities. Six Trust consultants and one GP have taken forward a piece of work to improve end of life care within their own specialty;
- Developing guidance to prioritise the discharge of patients at end of life to enable them to die in their preferred place of choice;
- Meeting staff training needs identified from staff surveys. Over 750 staff have attended in-house face to face training on the five priorities for care of the dying, and we are in the process of implementing the e-ELCA package to provide further education. Training is now covered on the care support worker induction programme and this includes education on nutrition and hydration at the end of life;
- Piloting a Care Plan for Last Days document to help support the individual needs of the dying person and their significant others;
- Providing all adult wards with a resource box containing the Care Plan for Last Days document, information leaflets, car park passes and "Just B" bereavement leaflets;
- Seeking feedback using a validated questionnaire from all bereaved relatives;
- Supporting staff to provide person centred high quality care, by preparing to include one page profiles on admission into hospital as part of the general nursing assessment;
- Preparing to take forward the 'Transform' programme to create a clear framework for improving end of life care across the organisation.

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	
	2013/14 (final)	2014/15 (provisional)
HDFT value	0.073	0.076
National average	0.085	0.084
Highest value for any acute Trust	0.132	0.154
Lowest value for any acute Trust	0.039	0.000

Table 14: PROMS – Groin hernia surgery

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

	Data period	
	2013/14 (final)	2014/15 (provisional)
HDFT value	Data suppressed due to small numbers	Data suppressed due to small numbers
National average	0.093	0.095
Highest value for any acute Trust	0.150	0.154
Lowest value for any acute Trust	0.022	-0.002

Table 15: PROMs – Varicose vein surgery

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

	Data period	
	2013/14 (final)	2014/15 (provisional)
HDFT value	0.411	0.423
National average	0.436	0.437
Highest value for any acute Trust	0.477	0.487
Lowest value for any acute Trust	0.311	0.331

Table 16: PROMs – Hip replacement surgery

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

	Data period	
	2013/14 (final)	2014/15 (provisional)
HDFT value	0.327	0.304
National average	0.323	0.315
Highest value for any acute Trust	0.396	0.384
Lowest value for any acute Trust	0.215	0.204

Table 17: PROMs – Knee replacement surgery

Data looks at primary hip and knee procedures only
2013/14 (final) data published by HSCIC August 2015. 2014/15 (provisional) data published by HSCIC February 2016
***Note** - 2015/16 (April 2015 to September 2015) provisional data published February 2016 but not included as incomplete. Data source: http://www.hscic.gov.uk/proms*

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

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

- We have participated in the PROMs scheme since inception, routinely analysing and reviewing the results;
- HDFT is not a vascular surgery centre and this is reflected in the data suppression for varicose vein surgery due to small numbers;
- The data is formed from pre- and post-operative patient surveys and therefore reflects their perception of the improvement in their health following surgery;
- An analysis of the data shows that HDFT has a pre-operative score above the England average in all cases, which might indicate that patients who rate their pre-op health highly have a reduced chance of a health gain. Patient perception is a useful but subjective measure of performance;
- The Trust considers the scores indicate it is not an outlier from the national position.

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

- Continuing to actively participate in the scheme, reviewing and analysing the results to ensure a clear understanding of the data to inform future programmes of work;
- Continuing to investigate any areas of below average health gain scores by sharing the patient-level data extract with the relevant department, with the aim of contacting patients with worsened scores and establishing in more detail the key issues affecting their health state.

Emergency readmissions to hospital within 28 days

Note – the data for this section has not been published by HSCIC since December 2013. The data below and comments were from 2013/14 but are required to be included.

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

Age 0-15

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

Table 18: Emergency readmission to hospital within 28 days (age 0-15)

2011/12 data published December 2013. No data published by HSCIC since.

Age 16+

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

Table 19: Emergency readmission to hospital within 28 days (age 16+)

2011/12 data published December 2013. 2012/13 data due December 2014.
2013/14 data due December 2015

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 action to improve this rate and so the quality of its services, by:

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

We have included below our internal data for readmissions to provide more recent information. The data shows the total number of emergency readmissions within 30 days and then the number after applying the national Payment by Results exclusions. The aim of the Payment by Results exclusions is to remove readmissions that were likely to have been unavoidable. Both figures are then expressed as a percentage of all emergency admissions.

Emergency readmissions within 30 days

	2013/14	2014/15	2015/16
Total number of emergency readmissions within 30 days	3235	3593	3895
As a percentage of all emergency admissions	18.3%	18.1%	18.9%
Number of emergency readmissions within 30 days (Payment by Results exclusions applied)	2155	2482	2696
As a percentage of all emergency admissions	12.2%	12.5%	13.1%

Table 20: Emergency readmissions within 30 days (data source: Integrated Board Report Mar-16)

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

- The data presented is taken from the Trust's main patient administration system, iCS;
- The data is sourced from the admitted patient care spells data set. The data quality of this data is routinely assessed and published nationally by the Health and Social

Care Information Centre. HDFT's latest data quality results are presented in section 2.3 (item 6);
- The excluded readmissions are based on national definitions. These are identified by clinically coded data and the Trust consistently performs better than average in external clinical coding audits, as detailed in section 2.3 (item 8) of this report.

HDFT has taken the following actions to improve this rate and so the quality of its services, by:
- Overall, our readmission rates have been increasing slightly over the last few years. However we are in the process of carrying out a number of clinical audits to understand this further;
- The Trust recently carried out a clinical audit on a random sample of emergency readmissions during January and February 2016. The themes from this audit and being collated, actions drawn up and implemented;
- Emergency readmissions information is routinely presented to the Trust Board each month.

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		
	2012	2013	2014
HDFT value	71.8	71.8	72.6
National average	68.1	68.7	68.9
Highest value for any acute Trust	84.4	84.2	86.1
Lowest value for any acute Trust	57.4	54.4	59.1

Data source: HSCIC indicator portal, NHS Outcomes Framework indicator 4.2. Indicator reference: P01779 (NB. different reference to last year)
https://indicators.hscic.gov.uk/webview/

Table 21: Inpatient survey – responsiveness to inpatients' personal needs

HDFT considers that this data is as described for the following reasons:
- Driving improvement for the delivery of high quality fundamental care has been a major priority for the Trust for the last three years. We have had wide engagement from hospital based nursing staff who have led the implementation and monitoring of rigorous standards of fundamental care, for example in the areas of communication, nutrition, prevention of falls and pressure ulcers and infection prevention and control;
- These standards are monitored through a governance system which includes daily safety assurance checks by matrons, extended senior nurse presence in the evenings and at weekends, unannounced director led inspections, patient safety visits and local quality of care teams;
- A well-established system of seeking objective feedback via external bodies and groups including the Trust's Patient Voice Group, governors and lay representatives.

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

- Focusing on five questions from the national inpatient survey where the Trust would like to improve the care offered to patients.

National Staff Survey – Standard of Care Provided

Staff who would recommend the trust to their family or friends as a place to be treated

	Data period				
	2011	2012	2013	2014	2015
HDFT value	76	73	77	72	78
National average	60	63	65	65	68
Highest value for any acute Trust	89	86	94	89	93
Lowest value for any acute Trust	33	35	40	38	46

Data source: http://www.nhsstaffsurveys.com/Page/1019/Latest-Results/Staff-Survey-2015-Detailed-Spreadsheets/

Table 22: 2015 National staff survey published February 2016

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.

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 7th out of 39 when compared with all acute and community Trusts for this key finding.

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

- Significant engagement from staff was sought to develop the Trust's values and behaviours framework which was ratified at the Board of Directors in February 2015 and this has been rolled out trust wide with significant publicity and awareness sessions such that it forms part of the recruitment, management and retention of staff. The values hold patient care at the heart of everything we do;
- Updated and improved appraisal documentation to incorporate and revolve around the Trust Values;
- 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 frontline staff;
- The introduction of a Health and Wellbeing section on the Trust intranet to promote and raise awareness of individual health care within the staff;
- The delivery of personal resilience training and awareness sessions to support staff in recognising and addressing stress in their lives;
- A continuation of our proactive recruitment strategy including embracing social media with targeted recruitment for specific work areas or staff groups, 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 inpatient and other patient related surveys.

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

- Reviewing and investing in increased staffing levels within the Emergency Department and ward based services;
- Regularly reporting on safer staffing levels within the Trust;
- Implementing the Staff Friends and Family Test to ensure real time feedback every quarter;
- Reviewing incidents reported through risk management processes to ensure that these are investigated and appropriate action is taken;
- Providing training to all staff regarding escalation of risks;
- Communicating on how to report incidents;
- Working on sharing outcomes of investigations with learning between directorates;
- Including a message on payslips about the Being Open Policy.

Friends and Family Test – Patient

The Friends and Family Test (FFT) is a feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. People are also given an opportunity to leave a comment about their response.

Response rate

	January 2016		February 2016	
Month	Inpatient wards	A&E	Inpatient wards	A&E
HDFT value	31.8%	10.3%	38.7%	13.1%
National average	23.5%	12.9%	24.1%	13.3%
Highest value for any acute Trust	100.0%	39.9%	100.0%	46.4%
Lowest value for any acute Trust	4.6%	0.4%	6.1%	0.2%

Percentage who would recommend

	January 2016		February 2016	
Month	Inpatient wards	A&E	Inpatient wards	A&E
HDFT value	92.4%	90.0%	91.3%	90.9%
National average	95.5%	86.3%	95.4%	84.9%
Highest value for any acute Trust	99.5%	100.0%	100.0%	100.0%
Lowest value for any acute Trust	72.7%	52.5%	74.2%	46.3%

Note: England figures exclude independent providers
NHS England now publishes FFT data for additional services to inpatients and A&E (Accident and Emergency).
Data source: https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/

Table 23: Patient FFT results

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

- We promote the completion of a questionnaire by inpatients at discharge and the responses are collated by our volunteers;
- We use an automated telephone service to contact patients who have attended A&E, the Day Surgery Unit, outpatient clinics and community services. The capacity of this service has limited the response rate we have been able to achieve;

- We have also recently identified evidence that some patients are selecting the wrong response from the options described by the automated telephone call and we believe this is affecting the results. For example, the inpatient data includes the Day Surgery Unit results. In February 2016 the proportion of patients who would recommend the inpatient wards was 95%, whilst the proportion of patients who would recommend the Day Surgery Unit was 87.6%. There were eight verbal comments left by patients associated with negative responses for the Day Surgery Unit however all comments were actually positive, reporting a high standard of care.

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

- The results of the FFT are shared widely each week and staff in each area use these to reflect on their service and implement improvement whenever possible;
- Recent negative comments from some inpatient areas have noted noise at night. Wards can be noisy at night for many reasons including new emergency admissions, patients being unsettled and confused, staff attending to patients and taking their observations to ensure safe care, and patients ringing their bells for assistance. When we admit patients we do explain that the ward can be busy and offer ear plugs. Ward managers are working to ensure their nursing staff are aware of how difficult this is for patients and that noise at night is minimised;
- The Trust is starting to explore other ways of seeking patient FFT feedback that will promote a higher response rate and reliable data that we can use more effectively with other patient feedback to improve services and delivery of care.

4. Treating and caring for people in a safe environment and protecting them from avoidable harm

Venous thromboembolism (VTE) risk assessment

The National Institute for Clinical Excellence (NICE) recommends that all patients in hospital should be assessed for their risk of developing VTE (blood clots). This measure shows the percentage of eligible inpatients who were risk assessed. A high percentage score is good.

	Data period		
	Q1 2015/16	Q2 2015/16	Q3 2015/16
HDFT value	98.4	98.1	97.5
National average	96.0	95.9	95.5
Highest value for any acute Trust	100.0	100.0	100.0
Lowest value for any acute Trust	86.1	75.0	61.5

Q4 data to be published June 2016 by NHS England
Data source: http://www.england.nhs.uk/statistics/statistical-work-areas/vte/

Table 24: 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 Trust's main patient administrative system, iCS, and collected via reliable IT systems;
- Education on VTE risk assessment is part of the Trust's essential training so staff understand the importance of it.

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

- Continuing to identify wards with poorer performance and examining whether there are issues with completion of the risk assessment or inputting of information onto iCS;
- Exploring the option of moving VTE risk assessment to an electronic system or patient record as part of a Trust-wide piece of work.

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		
	2012/13	2013/14	2014/15
HDFT value	20.8	14	9
National average	17.4	14.7	15.1
Highest value for any acute Trust	31.2	37.1	62.2
Lowest value for any acute Trust	0	0	0

2015/16 data released in June 2016
Data source: http://www.hpa.org.uk/

Table 25: Number of cases (rate) of C. difficile infection (CDI) per 100,000 bed days reported from hospital inpatients aged two years or over.

Until 2015/16 HDFT believed that the data were as described for the reasons given in the 2014/15 Quality Account. However, it is now considered likely that the data up to 2014/15 may have represented under-ascertainment. HDFT considers that this data is as described for the following reasons:

- In August 2015 HDFT changed its stool sampling policy to lower the threshold of "looseness" for sending stool samples for *C. difficile* investigation;
- In August 2015 the laboratory changed its testing policy to test all stools that were submitted as "loose" (i.e. including Bristol Stool Types 5 and 6) rather than only testing stools that were liquid on receipt;
- Following these changes the number of stool samples received and tested for *C. difficile* increased by 32.6% and 59.4% respectively compared with the corresponding months in 2014/2015;
- In December 2015 HDFT removed the requirement for a provisional positive sample to be positive by a second method before being tested for cytotoxin;
- The number of hospital-attributed CDI cases reported is 34, compared with 30 community-attributed cases. Of the latter, 12 were diagnosed after admission to hospital. The comparable figures for the same time in 2014/15 were nine and 11 cases respectively;
- There is no suggestion or evidence of a community-wide outbreak of CDI and minimal evidence of in-hospital transmission.

[1] Data source: Official Statistics Clostridium difficile infection: annual data <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/443719/Clostridium_difficile_annual_data_FY_2014_2015_revised.ods>

HDFT intends to take the following actions to improve this rate, and so the quality of its services, by increasing the speed at which potential cases are diagnosed and isolated, and increasing a sense of ownership amongst clinical staff. Specific actions which have been identified include:

- Mounting a staff awareness campaign to stress the importance of washing hands with soap and water after any contact with bodily fluid, including faeces;
- Mounting a patient hand hygiene campaign to improve the rate of hand hygiene amongst patients before meals and after using the toilet and formulate an audit tool to measure this;
- Develop and implement a simplified loose stool decision tool to remind staff of the actions required when a patient develops loose stool. These include isolation within two hours, testing for *C. difficile* toxin, and a daily medical review;
- The Director of Infection Prevention and Control (DIPC) and lead Infection Control Nurse (ICN) will visit each ward area individually to look at individual facilities, and discuss with the ward manager any specific issues on that ward which might be relevant to infection prevention and control;
- The DIPC and ICNs will meet with individual professional staff groups to discuss areas of infection control that are pertinent to their work area, and develop individualised infection prevention and control guidelines for those particular groups;
- Review the sluice facilities across the Trust, and revise and re-issue the "Sluice House Rules" to ward staff;
- Introduce in-house culture of *C. difficile* in the Microbiology Laboratory, in order that we can properly ascertain the environmental load of *C. difficile* spores in ward environments;
- Review the cleaning of equipment across the Trust and decide and document who is responsible for cleaning what;
- Review the system and process for decontaminating equipment used to transport patients around the hospital, e.g. wheelchairs and trolleys;
- Review the system and process for cleaning and decontaminating ward food trolleys.

<u>Patient safety incidents</u>

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.

HDFT's latest published scores are below.

	Oct 14 - Mar 15			Apr 15 - Sep 15		
	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	34.51	2	0.039	38.41	6	0.116
National position (all acute trusts)	36.24	3089	0.180	38.11	2717	0.164
Highest value for any acute Trust	82.21	128	1.533	74.67	89	1.120
Lowest value for any acute Trust	3.57	2	0.021	18.07	2	0.029

Data for period September 2015 - March 2016 due to be published September 2016
***Note:** an error was identified in the data presented in last year's Quality Account for the "rate (per 1,000 bed days) of incidents that resulted in severe harm or death"*
It incorrectly showed a rate "per 100 bed days" instead of "per 1,000 bed days". This has been corrected in the table above.
Data source: http://www.nrls.npsa.nhs.uk/resources/

Table 26: Patient safety incidents

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:
    - Implementation of medical escalation chart for units not on the main acute hospital site;
    - Introduction of customised growth charts for small for gestational age babies;
    - Review of the process for replacing and monitoring opiate patches;
    - Improving safety of insulin prescription and monitoring for inpatients;
    - Review of safety netting processes for follow up appointments.

2.5 Review of other quality performance

This section provides an overview of the quality of care offered by HDFT based on performance in 2015/16 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

2.5.1 Patient Safety

1. Medicines Safety

Medicines play an integral role in the management of disease but there is room for improvement in the way patients take their medicines. 30-50% of patients do not take their medicines as intended by the prescriber. 30% of patients state they do not receive appropriate information about their medicines. 8-10% of hospital admissions are associated with a medicine related event. The NHS wastes £300-£400 million per annum on unused medicines (50% of which is deemed avoidable) and around 200,000 medicines incidents are reported to the NHS England Patient Safety Division through the 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.

The aim of our medicines safety work is 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.

Specifically during 2015/16 we aimed to:

- Extend the functionality of the electronic Prescribing and Medicines Administration (ePMA) system into the Emergency Department;
- Commence preparations to implement prescribing complex infusions using ePMA:
- Commence preparations to implement ePMA in outpatients in 2016/17;
- Develop and implement the ePMA dashboard to target interventions to patients on high risk medicines;
- Continue the focus on safe prescribing, dispensing and administration of medicines.

Whilst this is not an exhaustive list of the programme it does summarise some of the fundamental elements. The metrics agreed included:

- The number of incident reports classified as prescribing, dispensing or administration errors with a defined denominator to allow comparison;
- Number of missed doses of medicines;
- Medicines reconciliation rates;
- National inpatient survey data;
- Training compliance rates.

The targets were to demonstrate improvement against baseline regarding the number of errors and missed doses, and to increase the information given to patients. Regarding dispensing errors, regional and national benchmarking data identify HDFT as already achieving low numbers of errors per items dispensed, and therefore maintaining the current low level of errors was the target for this metric.

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;
- Accelerating the roll out of ePMA further across the organisation;
- Developing a dashboard using ePMA to target patients on high risk medicines (warfarin, insulin, antimicrobials);
- Further developing a range of metrics to measure safe use of medicines;
- Enhancing 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.

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 to all wards and departments has now been completed, with implementation into the Emergency Department undertaken in April 2016. The planning for this has been undertaken during the last year, building prescribing protocols, working with Emergency Department staff, testing and piloting the system in the department.

We are one of only a handful of Trusts in the UK to have full ePMA use in all clinical areas. It has made a significant improvement in the safe use of medicines across the Trust.

Safer prescribing for inpatients

We have analysed the impact of ePMA on safe prescribing since implementation in 2011/12. The data below demonstrates the progress that has been made in this regard. There has been a substantial year on year reduction in prescribing errors from 2011/12 to 2014/15 with a slight rise in 2015/16. This is still below the pre ePMA baseline. Insulin prescribing errors account for the recent increase and additional information is provided below.

Year	Number of adjusted prescribing errors per 100,000 prescribed doses reported via Datix
2011/12 (Pre ePMA)	3.43
2012/13	3.25
2013/14	3.19
2014/15	2.12
2015/16	3.34

Table 27: Number of adjusted prescribing errors per 100,000 prescribed doses

Safe prescribing at discharge

During 2015/16 we piloted a programme of pharmacist writing TTO ("to take out") discharge prescriptions. Evidence from two other trusts suggested that the accuracy, quality and timeliness of discharge prescription writing could be improved if this was undertaken by pharmacists. The benefits of pharmacist written discharge letters have been assessed to see how this contributes to patient flow.

- The results showed a marked improvement in the accuracy of the medication information on the discharge letter when completed by a pharmacist. 70% of letters required intervention when completed by a doctor compared with 2% when completed by a pharmacist.
- There were savings made in terms of time by the doctor not having to review the letters - this equated to 16 minutes per TTO and released approximately 2.5 whole time equivalent in doctor time.

Indicators	Doctor written TTO	Pharmacist written TTO	Improvement
% prescriptions requiring a pharmacist intervention (one or more) prior to authorisation	70%	2%	Yes
Total number of interventions made by a second checking pharmacist prior to authorisation	60	2	Yes
Level of potential harm avoided by intervention of second checking pharmacist	Moderate = 11 Severe = 4	Moderate = 0 Severe = 0	Yes
Average time taken for completion of the medicines list of the TTO	16 minutes	12 minutes	Yes
Percentage of TTOs written and submitted **before 11am** for discharges on the same day	31%	57%	Yes
Percentage of TTOs written and submitted **before 1pm** for discharges on the same day	69%	84%	Yes
Percentage of TTOs written and submitted after 3pm for discharges on the following day	10%	17%	Yes

Table 28: Results of pilot programme of pharmacist compared to doctor written TTOs

These results demonstrate that the quality, accuracy and timeliness of TTO writing can be improved when this activity is undertaken by HDFT pharmacists. This work is now subject to a business case to roll out across the organisation.

Electronic prescribing at discharge and interface with ePMA

The interface with the discharge letter created in ICE (our requesting and reporting software system) was tested and went live in 2015. An audit in December 2015 demonstrated that all clinical areas using ePMA and discharging patients are using this interface with the exception of ward attenders, CAT patients and some paediatric patients. In all these cases it is clinically appropriate to maintain current systems as these patients do not have an inpatient chart.

This interface has been well received and helps to maintain the rapid turnaround of TTOs. The average dispensing turnaround time for a TTO medicine is 18 minutes with the majority

(over 70%) of TTOs being fulfilled at ward level (i.e. not having to leave the ward to go to Pharmacy).

Safe administration of medicines

We have analysed the impact of ePMA on the safe administration of medicines since implementation in 2011/12. The data below demonstrates the progress that has been made in this regard.

Year	Number of adjusted administration errors per 100,000 administered doses reported via Datix
2011/12 (pre ePMA)	8.34
2012/13	3.44
2013/14	3.56
2014/15	5.34
2015/16	6.24

Table 29: Number of adjusted administration errors per 100,000 administered doses

We have seen a substantial reduction in the number of medicines administration errors since the introduction of ePMA. Of note is the slight increase in the last two years (though this is still less than the pre ePMA baseline). This is subject to further analysis and refresher training with staff.

Progress on reducing missed doses and ensuring the timeliness of medicines administration

Year	% delayed doses	% missed doses
2012/13	2.6	2.99
2013/14	2.9	3.17
2014/15	2.6	2.13
2015/16	2.4	1.01

Table 30: Medicines administration - delayed and missed doses

Over the last four years (data from 2011/12 is not comparable) we have seen a steady reduction in the percentage of medicine administrations to patients that are delayed, meaning more patients are getting their medicines in a timely manner. We have also seen a very substantial reduction in the percentage of missed doses.

Reduction in "potential" prescribing errors through pharmacist activity and implementation of ePMA

Potential prescribing errors are those errors that are near misses that did not result in a wrong dose or medicine etc. given to a patient. These errors are identified by a ward clinical pharmacist before any level of harm is caused. We undertake an annual intervention audit to demonstrate the activity that pharmacists undertake.

At HDFT our pharmacists perform over 20,000 interventions per annum ensuring the safe prescribing and administration of medicines. Since the introduction of ePMA we have also seen a reduction in the number of potential major and life threatening interventions made by pharmacists.

Year	Total number of Pharmacist interventions	Total number of potential harm interventions	Total number of unclassified interventions	Total number of actual harm interventions	Levels of potential harm			
					Minor	Moderate	Major	Severe or life threatening
2011 /12	254	206	30	14	127	0	68	11
2015 /16	250	250	0	0	133	84	31	2

Table 31: Pharmacist intervention audit results

Development of an ePMA dashboard to target patients on high risk medicines

The ePMA system captures all medicines prescribed and administered to our patients. Interrogation of the system has thus facilitated the development of a live dashboard that identifies patients on high risk medicines in order to allow early intervention and help to avoid errors and harm arising from the use of these medicines.

It is well documented nationally through the National Reporting and Learning System (NRLS) that a small number of medicines are more likely to cause harm to patients. Using this data we have developed a live dashboard for a number of patient groups:

- Patients prescribed insulin;
- Patients prescribed warfarin;
- Patients prescribed antibiotics.

We also are able to identify patients with an unknown allergy status, any patient awaiting medicine reconciliation or a level 2 clinical review. The consequence of these reports means we are now able to identify and prioritise clinical intervention to ensure optimal prescribing and avoid harm.

Maintaining low numbers of dispensing errors

Our dispensing errors continue to be well below the regional average and some of the lowest across the Yorkshire and Humber region. HDFT data for 2014/15 (the last data set we have at regional level) has remained consistent with previous years running at a rate of 16/100,000 dispensed items. Only three trusts (range 9-11/100,000 dispensed items) demonstrate a lower rate.

Trust	Dispensing error rate / 100,000 dispensed items	
	Inpatient	Aseptic
HDFT	16	5
Yorkshire and Humber average	18	10
Yorkshire and Humber range	9-30	3-30
National average	20	Unknown

Table 32: Dispensing errors compared to local and national averages

Our error rates in aseptic services (preparation of IV medicines including chemotherapy) are also extremely low and one of the two lowest trusts in the region.

Learning from medicines errors

This year we have built a database of all Datix reported medicines errors over five years from 2011/12 to 2015/16. This allows us to identify common themes and errors, map trends and analyse progress. All reported errors are discussed at the monthly Medicines Safety Review Group, investigated and actions put into practice to learn from such events. We have undertaken analyses of three areas so far. These include:

a. Progress on the management of missed doses

The graph below demonstrates the progress being made with reducing missed doses.

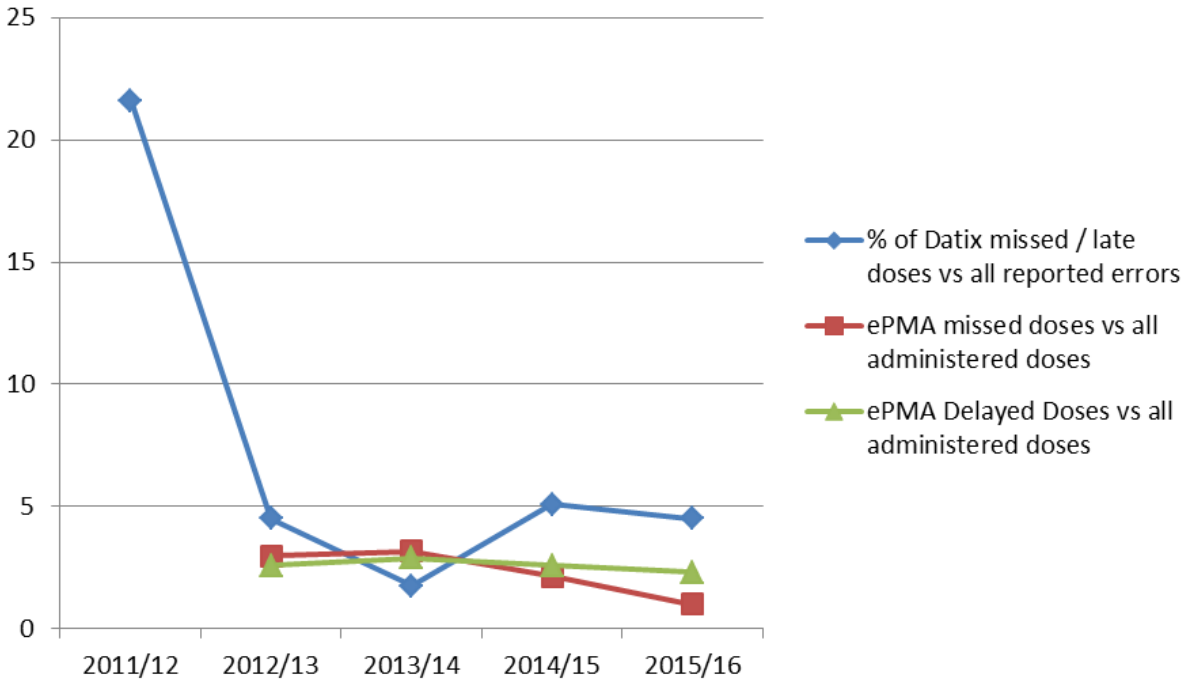


Figure 7: Percentage of missed and late doses from Datix reports and ePMA (2011/12 – 2015/16)

b. Patient identity errors

Patient identity errors are defined as “patient A is mistakenly given patient B’s medicines”. An analysis of the database has highlighted a reduction post ePMA, but a recent small rise in these errors. This is now subject to further work.

Year	Number (and %) of all medicine patient identity errors reported via Datix
2011/12 (Pre ePMA)	15 (6.1%)
2012/13	4 (1.12%)
2013/14	4 (1%)
2014/15	8 (1.95%)
2015/16	8 (1.78%)

Table 33: Patient identity errors

c. Safe use of insulin

Analysis of the error database and clinical knowledge has highlighted an increase in the number and type of insulin related errors. This has prompted a specific task and finish group to be convened, currently implementing a whole range of actions including the development

of an insulin safety dashboard and the addition of safe use of insulin competency to the essential skills training programme.

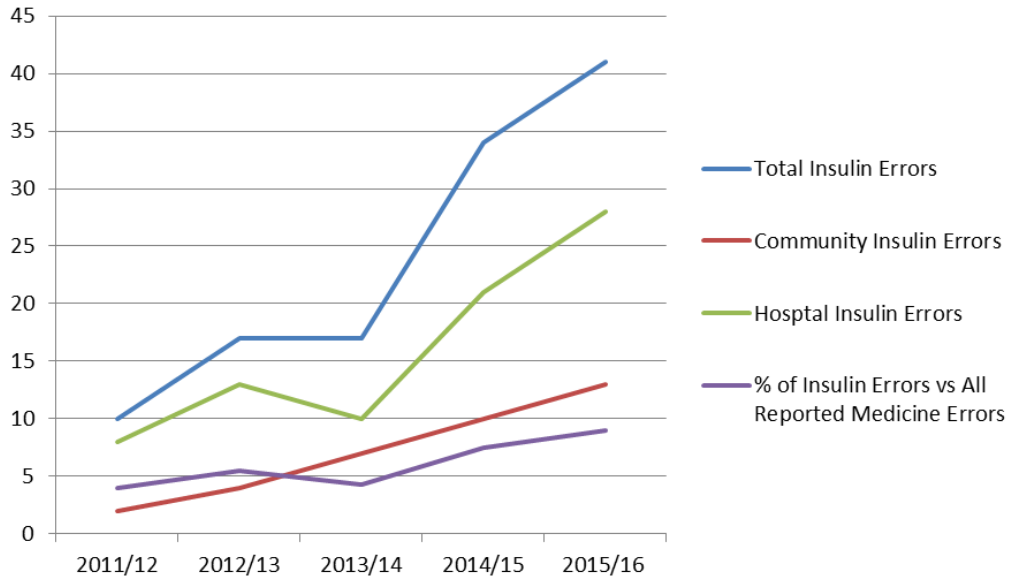


Figure 8: Number of Datix reported insulin errors from Community and Hospital HDFT locations from 2011-2016

Medicines reconciliation

Medicines reconciliation is the process by which the accuracy and completeness of a patients medicines history is checked and verified when a patient is admitted to hospital. NICE guidance recommends all patients have a medicines reconciliation undertaken within 24 hours of admission by a competent practitioner. Evidence demonstrates an improvement in morbidity and mortality when this occurs. The national benchmark is around 70%.

Audit data below demonstrates our improvement over the last 3 years.

Year	% of patients receiving a medicines reconciliation within 24 hours of admission
2013/14	75%
2014/15	80%
2015/16	90%

Table 34: Patients receiving medicines reconciliation within 24 hours of admission

Medicines management training for doctors, nurses and pharmacists

Medicines management training for clinical staff has been in place for four years and continues to be updated to reflect changes to the management of medicines in the Trust, receiving positive feedback from staff on improving their understanding of medicines use. Compliance rates with training have improved year on year and are detailed below.

Training competency	Renewal	Percentage compliance
ePMA	Once only	94%
Antibiotic stewardship	2 yearly	87%
Medicines management for community nursing	3 yearly	70%
Medicines management for hospital based nurses	3 yearly	73%
Safe prescribing toolkit	Once only	85%

Table 35: Medicines management training competency

Patient engagement and providing information to patients

Information provision to patients is included in four national inpatient survey questions. The perception of patients receiving relevant information about their medicines has improved over the last four years and we are consistently above the national average.

National Inpatient Survey	% of patients					Better than national average
	2012	2013	2014	2015	National Average	
Question 1: Not fully told purpose of medicines	22	17	18	22	25	Yes
Question 2: Not fully told side effects of medicines	58	57	59	57	59	Yes
Question 3: Not told how to take medication clearly	21	19	19	25*	24	No * for 2015 only
Question 4: Not given completely clear written/printed information about medicines	22	23	22	26	27	Yes

Table 36: Medicines information provision - national inpatient survey questions results

Summary

The medicines safety programme continues to build on previous quality improvements relating to medicines optimisation and safety. This has been facilitated through the roll out of ePMA, development of the live dashboard, improved medicines reconciliation rates, pharmacy activity at ward level, reviewing and acting on trends in medicines administration, dispensing and prescribing errors and medicines management teaching and training. Whilst significant improvements are being demonstrated, we will continue to work to optimise the use of medicines at HDFT.

The safe use of insulin has been selected as a quality improvement priority for 2016/17, so that as a Trust we focus on reducing the recent increase in insulin related errors.

2. Falls

Falls are generally the result of a complex interplay between ageing and frailty, medical decline, social factors and the environment. Up to one in three people aged over 65, and around 50% of people over 80 who live in the community have a fall each year. Falls can have serious consequences including injury, pain, impaired function, loss of confidence and loss of independence. Falls and injuries due to a fall also affect family members and carers of people who fall, and are a public health issue that cause a significant impact on health and care services.

Following national research NICE produced a guideline in 2013 with recommendations for the assessment and prevention of falls in older people. NICE predicts that if a range of individualised preventions are introduced for patients and proactively reviewed, falls can be reduced by up to 30%. All policies and pathways related to the prevention of falls at HDFT are based on this guideline.

Nationally:

- Over 3,600 people over 65 died from having a fall in 2013 (England and Wales);
- Hip fracture is the most common reason for admission to an orthopaedic trauma ward – most of these occur as a result of a fall;
- About 70,000 - 75,000 (2012) hip fractures occur annually in the UK with a cost (including medical and social care) of around £2.3 billion a year;
- About one in ten people with a hip fracture die within one month and about one in three within 12 months. 50% of people suffering a hip fracture are permanently disabled and only 30% fully recover;
- Falls account for 10 – 25% of ambulance all-outs for people aged 65 and over, costing £115 per call-out.

In North Yorkshire:

- 30% of people aged 65 and older and 50% of people older than 80, fall at least once each year. This is the equivalent of over 42,000 falls in people over 65 each year in North Yorkshire alone[2];
- During the period 2012/2013 there were 1,296 reported falls in North Yorkshire for people aged over 65, with a total direct health delivery cost of £4,235,593.00;
- There were an estimated 140,900 people aged 65 and older in North Yorkshire in 2015, some 23% of North Yorkshire's total population. North Yorkshire has 19,087 people aged over 85 years. The number of people aged over 85 in North Yorkshire is projected to increase by 19.8% by 2020[3].

Successful reduction of falls relies on the education of staff, patients and their families, clear policies for staff to follow in preventing falls and post fall management, and workable reliable pathways to enhance patient care and safety. A sustained reduction relies upon integrated care between health care professionals in the community, Emergency Department, admission wards, hospital wards and the patient discharge team. In particular we are aiming to:

- Reduce the number of inpatient falls occurring in hospital;
- Improve the completion of patient falls assessments and individualised interventions;
- Increase the number of staff who complete falls prevention training.

What have we done?

1. Falls Coordinator

A falls prevention co-ordinator was appointed to a part time (18.5 hours) permanent post in January 2016. The role is largely educational in falls prevention, assessment and risk factor reduction and includes chairing the Falls Steering Group.

[2] ONS Mortality Statistics: Deaths Registered in England and Wales (Series DR), 2013; Published October 2014
[3] North Yorkshire JSNA (2015) www.nypartnerships.org.uk/jsna

2. Introduction of falls safety huddles

This is a patient safety initiative in collaboration with the Yorkshire and Humber Academic Health Science Network (AHSN) Improvement Academy.

Huddles are a short daily meeting lead by a senior clinician and involving the participation of all staff working on the ward. They become a vehicle for ward teams to continually learn and improve. Falls safety huddles identify any patients who are at high risk of falls and agree an appropriate individual patient intervention plan for that day. Data is collected and processed by the Improvement Academy and reports are produced on reduction of falls and the number of days between falls.

The safety huddle started on Jervaulx Ward in June 2015 and has had a significant impact in reducing falls on this ward. In December 2015 all reported falls had been reduced by 43%. We have been able to demonstrate a statistical correlation with initiating the project, and we are working closely with the Improvement Academy to support and encourage other wards to adopt this safety initiative. In March 2016 Byland and Farndale Wards also initiated a daily huddle.

3. Introduction of falls sensors

A new initiative using a falls safety sensor was piloted on Byland Ward in December 2015 and the staff achieved 23 falls free days in the month. The early indications of the impact of this safety intervention are therefore positive and a further two wards have started using the system following staff training.

Photo 1: Use of falls safety sensor on Jervaulx Ward

4. Staff falls prevention training

Falls prevention training is an essential training requirement for various groups of clinical staff. Staff training levels remains fairly constant with 83-85% of staff being up to date with their falls prevention training every month between December 2014 and December 2015.

Post fall patient care is also of high priority. A new e-learning package called “Carefall” will be piloted in April 2016. The content of this package has been written by doctors in training and includes specific learning on the post fall management of patients. Feedback will be sought from those doctors in training that have received falls training and if well received, it will be extended to key nursing staff. This year a falls risk factor identification prompt card was included in all induction packs for doctors in training.

5. Participation in the National Audit for Inpatient Falls

The Royal College of Physicians conducted a national audit involving NHS trusts and health boards in England and Wales during May 2015 to provide a national snapshot of the landscape of falls prevention from an organisational and clinical perspective. The aim was to provide reliable, relevant and timely data to facilitate local improvements in clinical practice and patient safety work in acute hospitals in order to reduce inpatient falls. This included:

- An organisational audit;
- Case note review;
- Bedside/patient environment observation.

The results for HDFT showed staff met five of the seven criteria. Two areas for improvement were identified; the measurement of lying and standing blood pressure and the assessment of delirium, and these will be targeted for improvement in the next year.

Seven key recommendations were reported as a result of this audit and each of these has been considered and included in new patient assessment care plan documents.

6. Learning from harmful falls

When a patient suffers a fracture as a result of a fall, a more in depth investigation called a root cause analysis (RCA) is undertaken. This process aims to reduce inpatient falls by identifying if a fall was preventable, and to implement and monitor any learning opportunities. Some of the actions from recent RCAs include the introduction of a new e-learning package, and training doctors in patient medication review and post fall assessment and management.

7. Falls Steering Group meetings

Attendance at the bi-monthly Falls Prevention Steering Group has consistently increased. Membership includes the Falls Prevention Coordinator, two elderly medicine consultants, the Falls Multidisciplinary Team (MDT), the Deputy Chief Nurse and inpatient matrons. There are also representatives from the Community Fast Response & Rehabilitation Team (CFRRT), the Discharge Team, HaRD CCG, Yorkshire County Council, Age UK, the Yorkshire Ambulance Service, Age Concern, the Red Cross, the Improvement Academy and the Patient Voice Group. The group has been involved in the following:

- **Walking aids:** In response to recommendations made in the 2015 National Audit of Inpatient Falls, we have worked with the Trust Equipment Library and the Physiotherapy Department to ensure that walking aids are available for the immediate use of newly admitted patients who need them;

- **Staff training for falls sensor alarms:** The Falls Prevention Coordinator has been working closely with all staff to ensure that they are able to use this system confidently. In the near future all training will be competency led and linked to the continuing professional development and appraisal of staff;
- **Development of a falls pathway:** In order to enhance patient care and safety a multidisciplinary group started work in March 2016 to review and update the existing community falls pathway. It will be used in the Emergency Department and by GPs and other healthcare professionals in the community. This will provide a clear set of instructions of what to do and who to contact when older people have had a fall;
- **Development of a podiatry referral request form:** The Falls Prevention Coordinator has worked closely with the Podiatry Team to devise and launch a new referral form. The "Best Foot for Ward" initiative took place in February 2016, successfully raising staff awareness about the new referral form, conditions to refer and how to access community podiatry following patient discharge.

8. Community links

York and North Yorkshire Public Health Project: This is a two year project to consider the impact an increase in referrals may have on GPs and their resources, and the wider remit of community needs in the short, medium and long-term. Current issues include the development and use of screening tools and associated pathways in line with the latest NICE clinical guideline (CG 161) in both community and hospital environments.

Falls screening in the Emergency Department (ED): HDFT have been asked to support a pilot project in ED for six months, involving the introduction of a falls screening tool and the monitoring of patient interventions or referrals related to prevention of falls. The project is supported by HaRD CCG, the Falls MDT and the CFRRT. The first step is to agree a falls pathway that can be used by GPs and ED.

Community exercise classes: The established relationship between Age UK and the Falls Prevention Steering Group has led to HDFT supporting a community "Posture and Stability" exercise class funded through Public Health and HDFT. We are monitoring the referrals to this resource in order to feedback about suitability and the outcome of those referrals. Although the number of people attending this class is lower than expected, patient outcomes and feedback are good with participants who have completed the course showing significant increases in mobility, stability and confidence. The team is working to increase the referral rate and to establish stronger links with existing exercise programmes delivered by the Harrogate Borough Council.

Open Day: Representatives of the Falls MDT and Age UK took part in HDFT's Open Day in September 2015. The team were able to raise public awareness on falls prevention, and the impact of fractures caused by falls. Age UK provided a rolling programme of exercise and launched a community "walking for health" initiative.

What were the results?

The total number of inpatient falls, the number of harmful falls when a patient sustains an injury but no fracture, and the number of inpatient falls that resulted in a fracture over the last three years are reported below. There has been a significant reduction in the total number of inpatient falls and in falls resulting in an injury.

	2013/14	2014/15	2015/16	Changes 2014/15 to 2015/16
All reported (inpatient) falls	967	859	725	-134
Harmful falls (no fracture)	246	235	182	-53
Falls causing fracture	16	17	13	-4

Table 37: Total number of inpatient falls over the past 3 years

The graph below shows the steady decline in the total number of inpatient falls for 2015/16 compared to 2014/15 and shows the reduction in low harm falls where no injury is sustained. In December 2015 the falls rate was nearly 50% lower than the previous year.

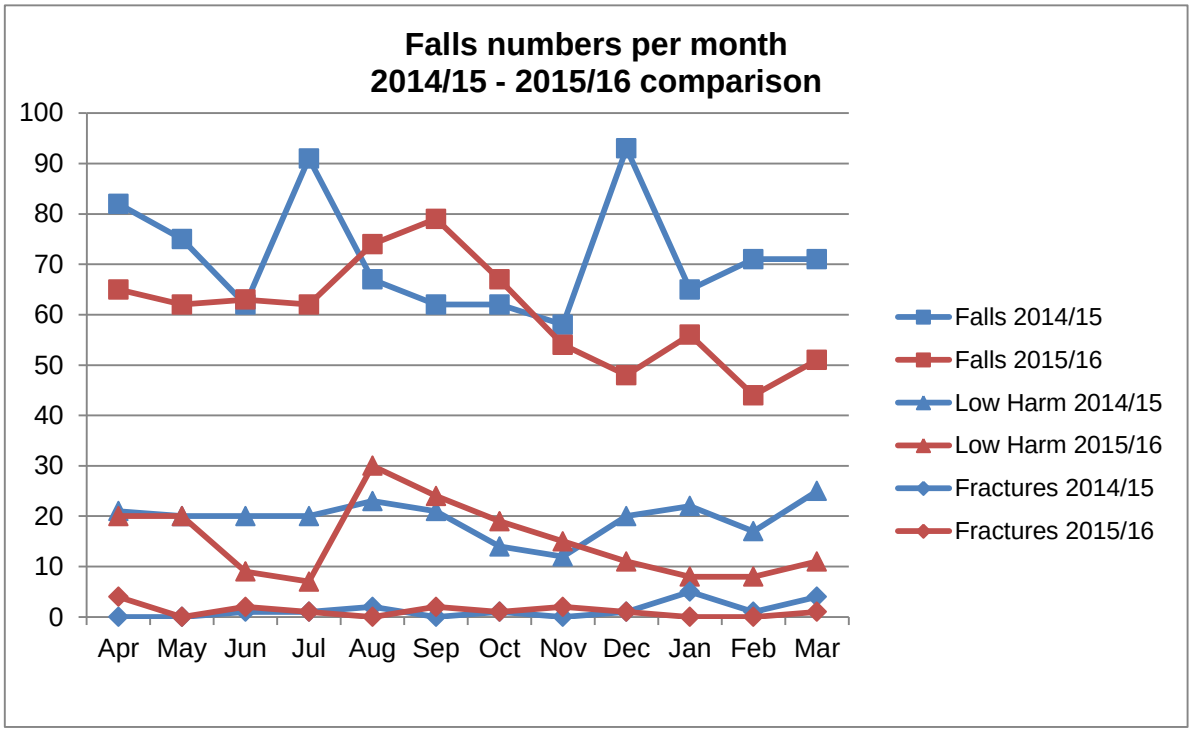


Figure 9: Falls data 2014/15 & 2015/16 comparisons

Summary

HDFT is working hard in the hospital and community to respond to the needs of the aging population in North Yorkshire. We continue to incorporate evidence based information and initiatives to support our aim of reducing falls in older people. We are developing training programmes to ensure staff are able to contribute to patient safety through increased awareness and can provide confident assessment and management of older people.

The total number of inpatient falls and the number of harmful falls have reduced over the last year. We are continuing to analyse and monitor our data to establish exactly where and how we have been able to make the most significant impact, and also to learn from those times when patients suffer an injury because they have fallen whilst in our care. The introduction of safety huddles and fall sensors will be closely monitored as early indications suggest that these simple interventions have had a real and measurable impact on patient safety.

The Falls Prevention Steering Group will continue to support older people in the hospital and community by growing its network and sharing good practice.

3. Sepsis management

Sepsis has recently been redefined as a life-threatening response of the body to infection. It is one of the commonest causes of death in the UK, affecting all age ranges from neonates to the elderly. There is increasing evidence that early identification, rapid treatment and appropriate escalation of care can significantly improve outcomes. A national drive is now underway to educate not only health care providers at all levels, but also the general public so they may seek help at an early stage.

Screening for sepsis and prompt antibiotic use has been a national CQUIN (Commissioning for Quality and Innovation) indicator for 2015/16. We have been collecting monthly data on how many acute admissions are appropriately screened for sepsis, and those who received antibiotics in a timely manner.

What have we done?

In HDFT we have implemented national guidelines for over 5 years. We were early adopters of a "septic bundle" which is a strict protocol for the management of patients identified as having sepsis. From November 2015, all new admissions are screened by nurses and doctors to see if sepsis is present. To support this, there has been an educational drive amongst doctors in training (to whom this condition presents most frequently), nursing staff (who take patient observations on arrival) and throughout the Emergency Department. We are now looking to extend this screening using our Patientrack computer system for recording vital signs and observations. This will screen every patient whenever a set of bedside observations is taken, and will automatically call a doctor to review if concerns are highlighted.

What are the results?

We have made significant progress in ensuring that screening is carried out on appropriate admissions.

Month 2015/16	Performance by month	Performance by quarter
April	44%	40%
May	36%	
June	21%	
July	75%	68%
August	90%	
September	50%	
October	69%	72%
November	75%	
December	75%	
January	81%	84%
February	83%	
March	88%	

Table 38: Sepsis screening CQUIN performance

Unfortunately the number of patients receiving antibiotics promptly (within one hour of arriving at hospital) is still less than we would like. On average we are only identifying around five patients per month who fulfil the criteria for immediate antibiotics, so an individual doctor is unlikely to encounter any patients even over many months. Consequently, despite an educational campaign, it is difficult to ensure robust adherence. It is expected that this will improve when the Patientrack module contacts doctors directly with a strong prompt of the importance of early antibiotic administration.

Month 2015	Case notes reviewed	Patients with recorded evidence of severe sepsis, Red Flag sepsis or septic shock	Patients meeting exclusion criteria	Patients requiring antibiotics within 1 hour	Patients receiving intravenous antibiotics within 1 hour of presenting
July	13	2	11	2	1 (50%)
August	18	2	16	2	0
September	20	5	15	5	3 (60%)
October	14	3	12	2	0
November	19	6	14	5	4 (80%)
December	22	4	18	4	2 (50%)
January	25	9	16	9	3 (33%)
February	15	3	12	3	2 (67%)
March	30	15	16	14	7 (50%)
TOTAL	**176**	**49**	**130**	**46**	**22 (47%)**

Criteria	Performance in 2015/16					
	Expected	Q1	Q2	Q3	Q4	Overall
Patients with severe sepsis, Red Flag sepsis or septic shock should receive intravenous antibiotics within 1 hour of presentation	100%	40%	44%	56%	46%	47%

Table 39: Antibiotic administration within 1 hour of presentation for patients with severe sepsis

Summary

In summary, we have made good progress on screening but still have work to do on antibiotic administration. For the next year we are rolling out the screening to every set of ward observations taken, as we know that sepsis can develop whilst patients are already in hospital. It is hoped that our new electronic system will provide a robust safety net to ensure that all patients are screened and promptly treated if necessary.

The Trust has identified reducing morbidity and mortality from sepsis as a quality priority for 2016/17 in order to focus on ensuring further progress.

4. Pressure ulcers

Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair the blood supply. They cause pain and distress, can mean longer stays in hospital and cost the NHS a significant amount of money. They are graded by severity according to a classification by the European Pressure Ulcer Advisory Panel (EPUAP) from category 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 and poor posture.

Pressure ulcers are usually preventable with good assessment of individual risk and effective application of preventative measures such as use of effective equipment to reduce pressure, regular position change, good nutrition and hydration, and good skin care.

The prevention of avoidable pressure ulcers has been a quality improvement priority at HDFT since 2012/13 and the reduction of inpatient newly acquired preventable pressure ulcers was a national indicator under the Commissioning for Quality and Innovation (CQUIN) scheme for 2014/15.

The Trust has a Pressure Ulcer Group that meets on a monthly basis. The objectives of this group are to drive continual improvement of pressure ulcer prevention to prevent avoidable pressure ulcers being acquired by patients receiving either HDFT hospital or community nursing care. Avoidable pressure ulcers are defined as all reasonable care and treatment has been provided to prevent or minimise damage to skin through pressure. 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. Continue our programme of pressure ulcer management training and education for staff.

The overall target for the Trust is to eliminate all avoidable hospital acquired category 3 and 4 pressure ulcers. The ambition for 2015/16 was:

- 50% reduction in category 3 and 4 avoidable hospital acquired pressure ulcers;
- 20% reduction in all category 2, 3 and 4 hospital acquired pressure ulcers based on 2014/15. This would mean 195 or fewer pressure ulcers.

What have we done?

There has been a significant amount of work undertaken during 2014/15 and 2015/16 with the aim of reducing avoidable HDFT acquired pressure ulcers.

Some of the key initiatives in 2014/15

- 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. This was supported with a SSKIN bundle educational package and educational posters to aid the identification and categorisation of pressure ulcers for clinical staff. A pressure ulcer skin inspection sticker was developed to assist registered nursing staff in the documentation of skin inspection. Changes were made to the nursing documentation to emphasise the need to repeat pressure ulcer risk assessment on transfer between wards.
- 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 then purchased. All patients identified with heels at risk of pressure damage can now be referred to Podiatry for an assessment, and the provision of heel casts to protect the skin if appropriate.
- Work was 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.
- Training for staff has been a priority. Since January 2015 an e-learning package for pressure ulcers has been essential annual training for general and paediatric registered nurses and three yearly training for midwives. Training on skin care and pressure ulcer prevention, recognition and management has been delivered by the

Tissue Viability Nurses during the mandatory training course for care support workers.

- Since June 2014 all category 3 and 4 pressure ulcers have been reported as serious incidents requiring investigation (SIRIs). 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). Each RCA generates recommendations and an action plan.

Key initiatives during 2015/16

- The Tissue Viability Service covers both our hospital and community services and this provision has been strengthened by extra staffing investment in 2015. The team will be working alongside senior nurses across HDFT to further support staff.
- An intranet page has been developed to ensure staff have improved access to a range of information and learning resources.
- Following an audit of inpatient bedside chairs we have established a rolling programme for the purchase of chairs that have inbuilt pressure relieving cushions.
- In 2015 we launched our Wound Dressing Guideline and updated our Pressure Ulcer Prevention and Management Policy in accordance with NICE (2014) guidance. We also updated our pressure ulcer patient and carer information leaflet.
- Our focus on education and training of registered and unregistered nursing staff has continued throughout 2015/16. There are plans to develop more in-depth competency based training for senior staff including a workbook concerning pressure ulcer prevention and management.
- The Trust participated in STOP - Pressure Ulcer Day on 19 November 2015 with a mobile educational event and equipment demonstrations.
- An online non-prescription ordering service was established in the community during 2015 and has now being rolled out across the remaining community nursing bases, improving the quality and efficiency of service for patients.
- We have been trialling a new pressure ulcer risk assessment tool & associated documentation for use in our Emergency Department and community areas.

What are the results?

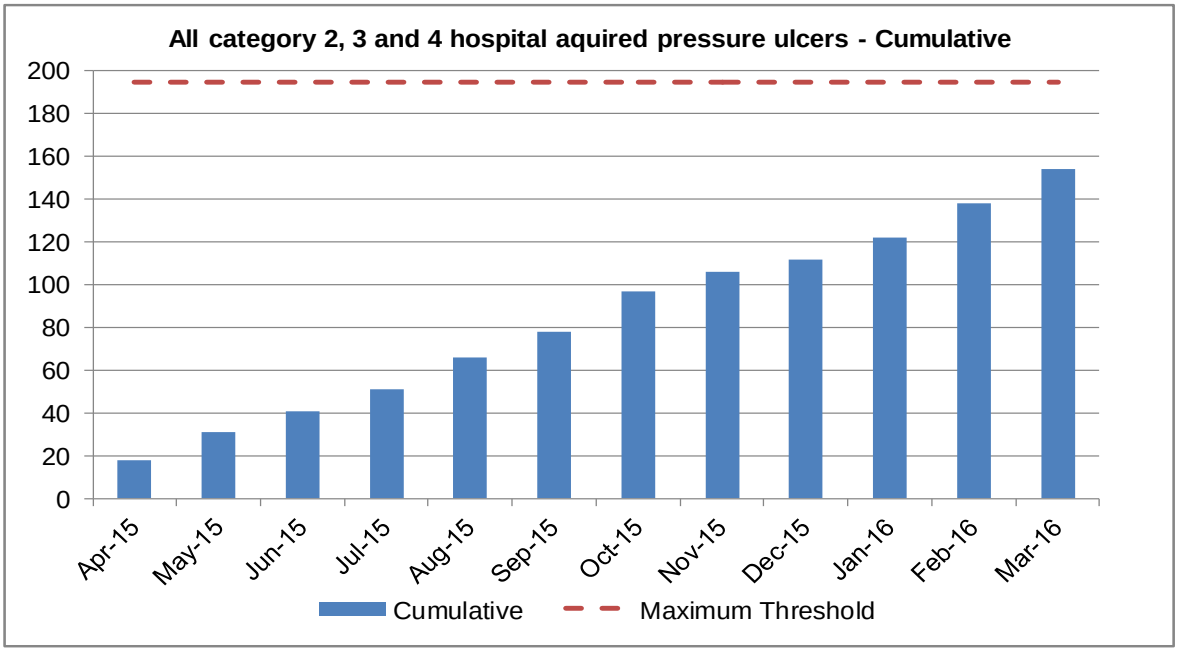


Figure 10: Hospital acquired pressure ulcers

The total number of category 2, 3 and 4 pressure ulcers for 2015/16 is 155 representing a reduction of 36% from 2014/15.

This overall improvement reflects a marked reduction in category 2 hospital acquired pressure ulcers. Category 4 pressure ulcers have decreased from two in 2014/15 to one in 2015/16. However we have seen an increase in category 3 hospital and community acquired pressure ulcers which we believe is due to better reporting as a result of increased awareness, education and recognition.

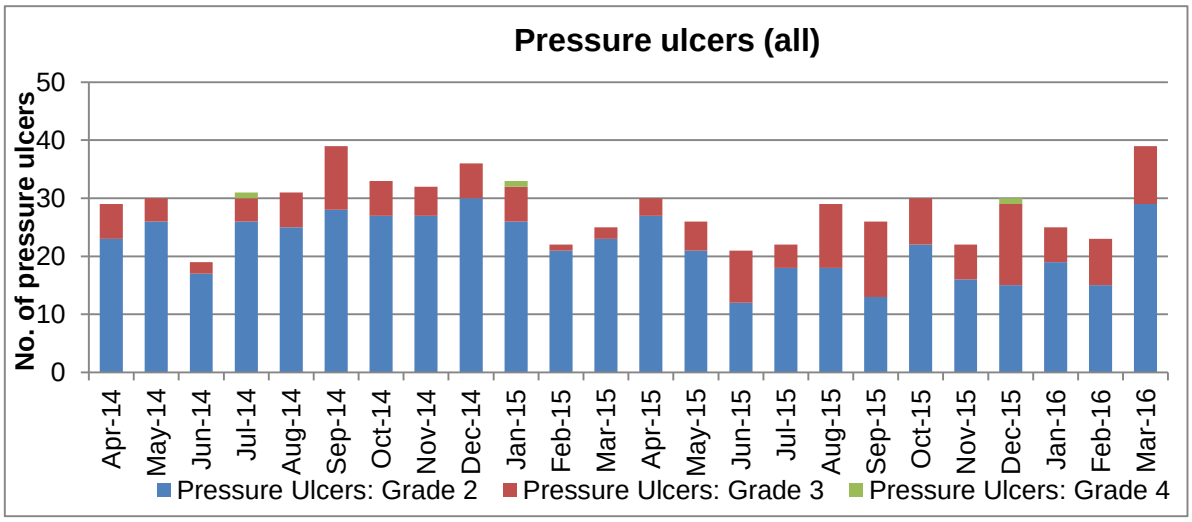


Figure 11: All pressure ulcers reported between 2014 and 2016

The two graphs below show the results of the NHS safety thermometer data since July 2012 until February 2016, 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.

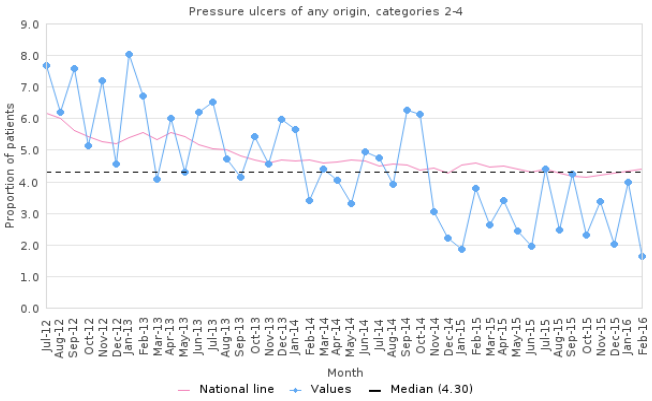


Figure 12: All pressure ulcers

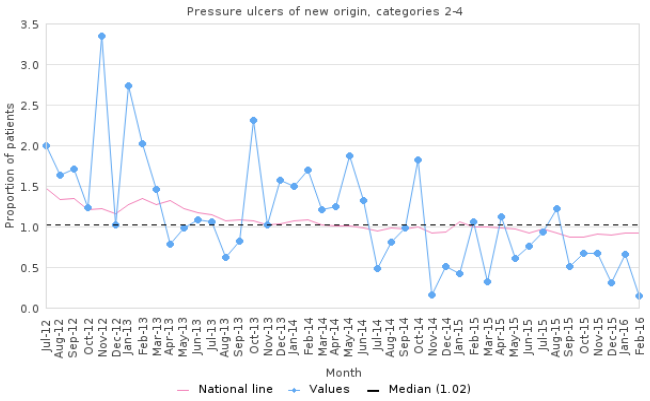


Figure 13: New pressure ulcers

Data source: https://www.safetythermometer.nhs.uk/

The funnel plots below compare the Trust's performance over a 12 month rolling period of harm caused by pressure ulcers per 1000 patients surveyed against other trusts that provide both acute and community services. Funnel plot charts get their name by the lines running across the chart creating a funnel. These are called 'upper' and 'lower control limits'. Each dot represents an organisation. Organisations inside the funnel lines are regarded as average or statistically indistinguishable. Organisations outside of these lines are called

outliers, which can be either positive or negative. In this case lower is positive and therefore HDFT has low harm compared to other trusts providing acute and community services.

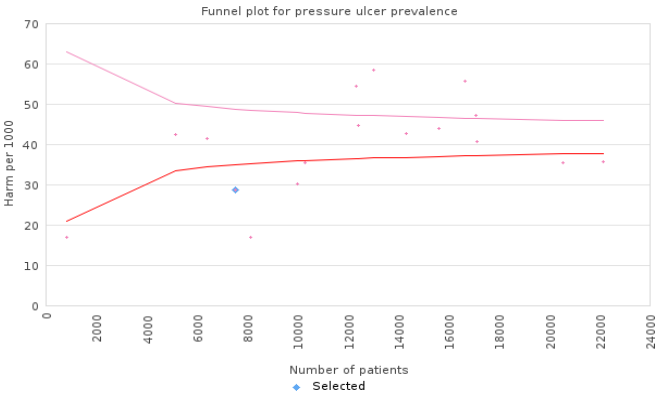


Figure 14: Prevalence of all pressure ulcers

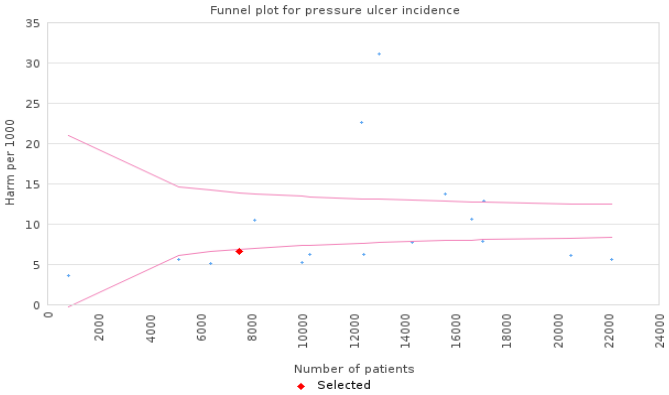


Figure 15: Incidence of new pressure ulcers

♦ *represents HDFT*
Data source: https://www.safetythermometer.nhs.uk/

Summary

There has been a significant amount of work undertaken during 2015/16 with the aim of reducing avoidable HDFT acquired pressure ulcers. The numbers of category 2 hospital acquired pressure ulcers have seen a marked reduction compared to 2014/15.

However the numbers of category 3 and 4, preventable hospital and community acquired pressure ulcers (community being those patients in receipt of HDFT community nursing care) remain a challenge and will continue to be an area of increased focus during 2016/17. 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 pressure ulcer prevention strategies including training and investigation processes.

2.5.2 Patient Experience

1. Pain management

Since the assessment and management of pain within the Trust was highlighted by the Care Quality Commission in 2013 and local audits revealed that the recording of pain scores in post-operative patients was sub optimal, work has been ongoing to ensure that pain assessment and management remains a vital element of care.

What have we done?

We have continued to focus on improving the consistency of pain assessment across the Trust together with staff awareness and knowledge of pain management, and aimed to be able to demonstrate this by improving our audit results.

Last year's pain score audit showed that since the introduction of Patientrack for recording vital signs electronically, pain is assessed on admission for 100% of patients. However, the audit also highlighted that the re-assessment of high pain scores, within a 30 minute window was low (0-8%). Further changes to Patientrack to include a high pain 'alert' system are expected in the future.

An assessment tool for patients with dementia and communication or learning disabilities was also introduced. The PAINAD (Pain Assessment in Advanced Dementia Scale) tool relies on assessment of non-verbal expression of pain, such as body posture, vocalisation and facial expression. An audit was undertaken in August 2015 which included assessment of patients' pain using the PAINAD tool and a staff questionnaire.

The education of nursing and medical staff remains essential and training activities include the establishment of a training day for surgical nurses, pain link nurse meetings and additional training for doctors in training. An electronic referral system has been implemented on the hospital intranet to assist in the management of pain.

There are new methods of providing pain relief to patients which are now used routinely within the Trust. These include fascia iliaca nerve blocks which is a technique advocated by NICE guidelines and the Association of Anaesthetists of Great Britain and Ireland (AAGBI) for post-operative pain relief for procedures and injuries involving the hip, anterior thigh, and knee. A nurse led project was introduced in 2013, with the trauma co-ordinator and acute pain nurse being trained to take on the extended role of performing this regional block to patients following a fractured neck of femur. A further training programme has been developed with the anaesthetists to teach Foundation Year 2 (FY2) doctors to administer blocks to this group of vulnerable patients.

Further improvements to patient care include the introduction of pectoralis (PECs) blocks for patients undergoing routine breast surgery.

What are the results?

The PAINAD audit showed that 53% of the Patientrack data matched the scores generated through the use of PAINAD, with the remainder varying by up to 6 points. Results from the staff questionnaire show that 66% of staff had awareness of the tool with 55% saying they felt comfortable using it (see table 39). Feedback from the staff and the patient data suggested that further support, training and incorporation of the tool into Patientrack would be useful.

Criteria	Expected level of performance	Actual level of performance
To have an awareness of the PAINAD tool	100%	66%
To understand what the PAINAD tool is used to assess	100%	66%
To understand which patient groups should be assessed using the PAINAD tool	100%	32%
To feel comfortable using the PAINAD tool when needed	100%	55%
Scores obtained using the PAINAD tool should match those recorded on patient track	100%	53%

Table 40: PAINAD audit results August 2015

Evaluation of the fascia iliaca block project recorded 100% staff satisfaction with the pain relief provided when moving patients onto bed pans, changing bedding, and positioning for dietary requirements. However the results also showed that only 20% (24/116) of patients with a fractured neck of femur (NOF) in a six month period were receiving blocks with 90% being performed during normal working hours.

To increase patients' access to the block service, teaching was extended to include FY2s working within the surgical rotation in November 2015. During the period of November 2015 to February 2016 31/92 (34%) patients' with fractured neck of femur received a fascia iliaca

block with 35% being performed out of hours. These results illustrate a clear improvement over a short period of time. Further evaluation is needed to understand the reasons for not performing blocks on more patients.

In addition 32 patients undergoing mastectomy, wide local excision, breast implantation or reduction were studied. Nine were given a PECs block alongside their general anaesthetic (GA) and although figures were small, a reduction in pain scores was demonstrated (see below) with an overall reduction in opiate requirements and post-operative nausea. The charts indicate the highest pain score for each individual patient studied. Further studies, with larger numbers is required but the PECs block is now routinely used in the Trust.

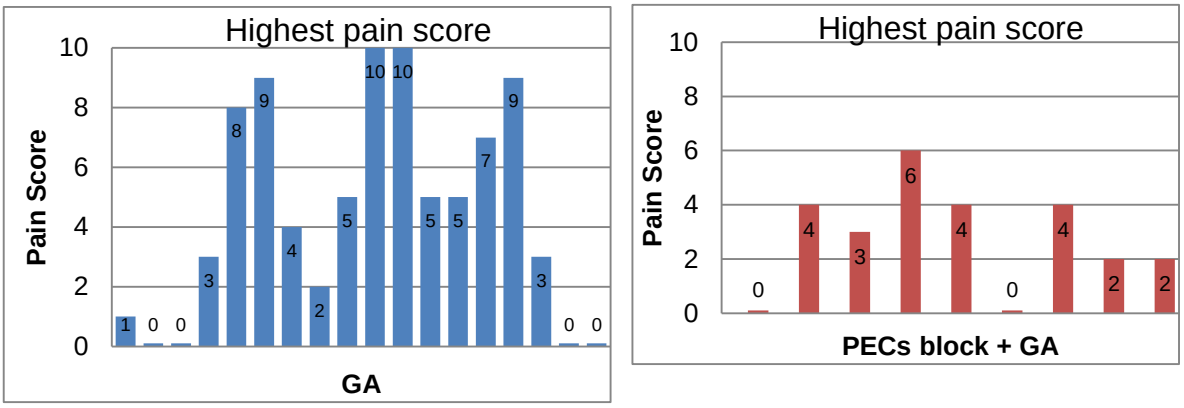


Figure 16: Pain scores following breast surgery - GA (general anaesthetic) v PECs block + GA

Since November 2014 we have incorporated four questions about pain into our inpatient Friends and Family test (FFT) and have monitored and shared the results and comments provided by patients with ward staff in order to promote learning. The questions are:

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

Results remain positive, indicating that overall patients appear satisfied with pain management.

Ward	QUESTION 1		QUESTION 2		QUESTION 3		QUESTION 4	
	RESPONDED YES	%	RESPONDED YES	%	RESPONDED YES	%	RESPONDED YES	%
AMU - ACUTE MEDICAL UNIT	17	100.0%	15	100.0%	13	100.0%	14	100.0%
BYLAND WARD	7	100.0%	5	100.0%	5	100.0%	4	100.0%
CATT WARD	45	93.8%	36	100.0%	33	97.1%	31	93.9%
FARNDALE WARD	27	100.0%	25	100.0%	25	100.0%	24	96.0%
GRANBY WARD	38	100.0%	23	95.8%	22	95.7%	22	100.0%
HARLOW SUITE	13	100.0%	12	100.0%	10	100.0%	11	100.0%
JERVAULX WARD	25	100.0%	18	100.0%	18	100.0%	16	100.0%
LITTONDALE WARD	47	100.0%	33	100.0%	30	96.8%	29	96.7%
NIDDERDALE WARD	28	100.0%	27	100.0%	27	100.0%	26	96.3%
OAKDALE STROKE AND REHAB UNIT	16	100.0%	13	100.0%	11	91.7%	11	100.0%
TRINITY WARD RCH	6	85.7%	4	80.0%	4	100.0%	7	100.0%
WENSLEYDALE WARD	60	98.4%	62	100.0%	59	98.3%	63	100.0%

Table 41: Friends and Family Test, January 2016

Staff opinion on how well we manage pain has been examined in the Integrated Care Directorate using a staff survey based on questions asked in the FFT. This concluded that the majority of staff felt that they dealt with pain well and had good knowledge. However, some felt that we did not always give pain relief in a reasonable time and sometimes forget to return to reassess a patient. Plans are in place to extend this survey to the Elective Care Directorate and we will use the results to continue to focus on improving pain management.

Summary

In summary we continue to work towards improving the management of pain for patients under our care. Various educational events continue to teach doctors, nurses and associated healthcare professionals the importance of assessing and managing pain proactively. Results from the FFT and staff survey remain positive and will continue to be shared appropriately.

2. Maternity

This year we have completed the refurbishment of the Maternity Department. We have participated in the 2015 Maternity Patient Satisfaction Survey, and are continuing to use the results of this patient feedback and the Maternity Friends and Family Test to improve services. We have worked to maintain safe and high quality midwifery care which is assessed by the Local Supervising Authority audit, and have trained and assessed staff in the use of customised growth charts. We also launched the Harrogate Maternity Mums and Midwives Facebook page.

Following the 2013 Maternity Survey we developed an action plan focused on three areas identified for improvement: reviewing customer care training for all staff, training all staff in supporting patients in relation to breast feeding, and ensuring information is available for pregnant women.

What are the results?

Maternity refurbishment

The main aim of Maternity refurbishment project was to improve the privacy and dignity for the women who use our services. We wanted to create a calm, relaxed atmosphere that would reduce the anxiety and stress that women and their partners may feel when they come into hospital.

- The birthing pool has been replaced and the delivery room has been redecorated to create a calm and relaxing atmosphere, to promote normality in childbirth;
- All the delivery rooms now have ensuite facilities in the form of wet rooms;
- The Maternity Assessment Centre (MAC) has been created on Pannal Ward to ensure appropriate triage of women. This reduces the number of unnecessary admissions to hospital and ensures continuity of care and information provision to women in the early stages of labour. The MAC is currently open 08.00-20.00 Monday-Friday but due to its success we are considering extending the opening hours to include weekends initially;
- All of the carpets throughout the Maternity Unit have been replaced with vinyl wooden effect flooring, including the entrance to the department creating a welcoming environment. The walls have been redecorated with some feature walls painted purple;
- There is a new midwives station on Delivery Suite.

The planned work commenced in March 2015 and was completed in August. We managed to maintain a normal service and this is credit to the staff and the workmen who were presented with some challenging situations especially during periods of high activity.

Photo 2: Helen Woollatt, Delivery Suite Coordinator and Supervisor of Midwives

Photo 3: The new Maternity Department

Regular updates on progress were provided during the refurbishment for staff and service users by letter and information on the website. The finished product is better than any of us could have imagined and we have the Capital Planning and Design Team to thank for this.

We arranged a launch of the refurbished unit in October, this was attended by service users and their families (both those who had delivered during the refurbishment and those due to deliver), Maternity staff, other key Trust staff and Cathy Warwick, Chief Executive Officer at the Royal College of Midwives.

Breast feeding advice

The department has invested in a further one day workshop for all staff in breast feeding to ensure that all advice given to new mothers is up to date, consistent and in line with the new Baby Friendly UNICEF standards. This training was commenced in January 2015 and 98% of the midwives have attended.

Information available for pregnant women

We had discussions with Baby TV but decided not to go ahead with this in the Antenatal Clinic. We are reviewing how we deliver key messages to women at parent education, on the maternity section of the Trust internet and within the information given during the pregnancy and postnatal period.

Maternity Patient Satisfaction Survey 2015

This survey involved 133 NHS acute trusts and is part of a series of national patient surveys by the Care Quality Commission (CQC) for all NHS Acute Trusts with Maternity Services in England. The survey for HDFT was carried out by the Picker Institute Europe.

Women were eligible for the survey if they had a live birth during February 2015, were aged 16 years or older, gave birth in a hospital, birth centre, maternity unit, or who had a home birth. Responses nationally were received from more than 20,631 service users, a response rate of 41%. Responses were received from 152 patients at Harrogate and District NHS Foundation Trust with a response rate of 51%.

Women were asked to answer a total of 51 questions about their care, with the response for each question in the survey converted into scores, where the best possible score is ten. Each trust received a rating of better; about the same; or worse, on how it performs for each question compared with most other trusts. We have included below the scores for the CQC maternity care pathway reports: labour and birth.

Results for HDFT	Score /10	Rating
Labour and birth	9.2	Better
Staff	9.0	About the same
Care in hospital after the birth	8.6	Better

Table 42: Maternity patient survey 2015 summary results for HDFT

Key messages from the 2015 survey in relation to the results from the Picker Institute were:

- HDFT had significantly improved on one particular question: Postnatal care at home - personal circumstances not taken into account;
- HDFT results were significantly better than the Picker average on 27 questions;
- No scores had worsened since 2013;
- None were significantly worse than the Picker average;
- Scores showed no significant difference from 2013 on 43 questions.

Areas for improvement and therefore inclusion in the action plan for 2015 are:

- Labour and delivery - did not have confidence and trust in staff;
- Feeding - did not receive consistent advice;
- Feeding - did not receive support/encouragement;
- Postnatal care at home - mother not given enough information about recovery after birth;
- Mother did not receive enough help/advice about emotional changes after birth.

It is important to note that this survey was directed at women who delivered in February and March 2015, and the extra study day for all staff on breast feeding started in January 2015, and therefore there was not enough time to see the benefit of this training reflected in these results. We plan to survey women during 2016 about breast feeding advice.

Review of customer care training for all staff

We have updated the Trust customer care training, "Every Patient, Every Time" to be more specific to maternity services, with some of the key areas identified from the patient survey incorporated into the presentation. 58 (68.23%) midwives, 14 (89%) maternity support workers and 11 medical staff had received the training by February 2016.

Friends and Family Test - Maternity

The Friends and Family Test is an opportunity for women to complete a short questionnaire at four stages of their care pathway. They are asked whether they would recommend the service to friends and family and the feedback enables staff to understand what has worked well and where necessary, make improvements. Women are surveyed:

- 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.

Maternity FFT	January 2016		February 2016		March 2016	
	HDFT	National average	HDFT	National average	HDFT	National average
Antenatal	100.0% / 0.0%	95.9% / 1.4%	95.2% / 0.0%	95.3% / 1.7%	100.0% / 0.0%	-
Birth	100.0% / 0.0%	96.6% / 1.3%	98.0% / 0.0%	96.3% / 1.2%	98.5% / 0.0%	-
Postnatal ward	100.0% / 0.0%	94.2% / 1.8%	95.7% / 0.0%	93.7% / 2.2%	98.5% / 0.0%	-
Postnatal community	100.0% / 0.0%	98.2% / 0.6%	100.0% / 0.0%	98.0% / 0.7%	100.0% / 0.0%	-

Table 43: % recommend/not recommend for January-March 2016 for HDFT and available national average results

Our response rates are nearly always above 20% and recommendation scores are very high showing that women are pleased with the level of care they receive in pregnancy, labour and post-delivery. The results are collected each month with response rate and scores monitored closely by senior midwifery managers and displayed in the Maternity Unit for staff and women to see. Both positive and negative feedback is given when individual staff are named.

Facebook page

Harrogate Maternity Mums and Midwives Facebook page was launched on 26th June 2015. The aim is to communicate information regarding the maternity services provided at HDFT, provide important public health information relating to maternal and child health and wellbeing, and to gain service user feedback in an alternative forum. The page is monitored and managed by three Supervisors of Midwives, and there is a clear process to respond to any negative feedback received.

Women send photographs and their birth experience stories almost daily via the private inbox and these are posted on the page with their consent. The page is not intended to give individual clinical advice but the private inbox enables us to identify women who need sign posting to areas within the maternity service. This has enabled us to identify a few women needing support and counselling which has surpassed the intentions of the page.

The page has proved to be a phenomenal success with a current total of 1,484 people 'liking' the page. Our posts are viewed widely, with a recent post reaching 25,845 people. Our target audience respond best to the personal stories and photos, and are particularly receptive to our 'meet the team' posts, where staff photographs and brief profiles of multidisciplinary team members are shared. Women have informed us that recognising staff from their profiles has put them at ease when using the service, particularly when attending Delivery Suite. However public health messages currently receive the least views, likes and shares, and we are keen to change this. Our intention is to use our service users personal experiences to deliver key public health messages.

The success of the page has now elevated service user engagement to such an extent that we are now in a position to re-form a Maternity Service Liaison Committee, which will enable us to work in partnership with women to shape and design our maternity services in the future. Our approach has also been recognised regionally by neighbouring maternity units, who have approached us for support in establishing similar pages for their own services.

Local Supervising Authority audit report

Supervisors of Midwives are appointed by the Local Supervising Authority (LSA). The main responsibility of the LSA is to protect the public by monitoring the quality of midwifery practice through statutory supervision for midwives, with the Nursing and Midwifery Council setting the rules and standards.

The Local Supervising Authority Midwifery Officer (LSAMO) is professionally accountable to the Nursing and Midwifery Council, and ensures that statutory supervision of midwives is in place to deliver safe and high quality midwifery care to women. Audits of statutory supervision are completed by the LSAMO 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 evidence that the standards for supervision in midwifery are being met;
- Ensure systems and processes are in place for the safety of mothers and babies;
- Review the impact of supervision of midwives on midwifery practice;
- Ensure midwifery practice is evidence based and responsive to the needs of women.

The LSA audit is carried out annually and the LSAMO provides an audit report with recommendations for the local supervisory team to complete before the next audit. The LSA audit at Harrogate in July 2015 was again very successful:

> "The Supervisors of Midwives (SOM) team at Harrogate and District NHS Foundation Trust have shown great commitment and determination to the implementation of the findings following their last LSA audit visit on 11 November 2014. The team have added to their number with new supervisors joining the team as part of their succession plan. The stability of the current team is a key strength and this was evident to the LSA audit team as they meet women and their families and midwives on the maternity unit during the visit. The updating and upgrading of the clinical environment has allowed the team to further focus their work as SOMs on promoting the 'normality of birth' for women in their locality and despite the disruption seen on the day of the audit visit this was not affecting the care received by women and their families which is a credit to the whole team at the Trust. The finished work will see some significant improvement for women and their families.
>
> On the day of the audit visit the team were highly motivated and well prepared to meet with the LSA audit team and had prepared an excellent pre-audit submission of data. The LSA audit team were able to triangulate this evidence with evidence provided by service users and their families and by staff on the day of the visit. Apart from a very small number of areas a very high level of compliance was achieved, evidence and seen at the audit visit".

Some recommendations have already been addressed and an action plan to deliver other recommendations will be monitored through the Maternity Risk Management Group.

The future of supervision is uncertain following the publication of The Report of the Morecambe Bay Investigation by Dr Bill Kirkup. Changes to supervision are planned to take place from April 1st 2017. In the interim there is agreement and commitment from local SOMs that it is business as usual and they are working hard to continue to provide an effective 24 hour service to the women and their families who access our services and as support to the midwifery staff.

Customised growth charts

We have been training staff to use customised growth charts following three failures to detect babies who are small for gestational age last year. These were fully investigated and actions put in place to address the root causes. Our detection rate has increased from 28% to 42%, making HDFT one of the top performing units in the country. This is really positive news and demonstrates that the Saving Babies in North England (SaBiNE) project work has become embedded and gives huge assurance of changes in practice.

Summary

It has been a busy year in the Maternity Department. The refurbishment of the department has resulted in an environment that offers privacy and dignity, and a calm and relaxed atmosphere. Patient feedback remains positive, but we continue to seek all opportunities to learn and improve. Staff training and ensuring standards for supervision in midwifery are maintained has been a focus, and the success of the Facebook page in improving service user engagement contributed to us being one of only four maternity units in the UK, nominated for the Royal College of Midwives Midwifery Service of the Year Award 2015.

3. Food for staff and patients

Introduction

It is widely recognised that the service of good hospital food is an integral part of good patient care; a better diet is known to improve patient outcomes and public health, delivering multiple benefits for hospitals and their patients.

The Catering Mark, awarded by the Soil Association, is an independently audited framework that hospitals can use to take steps to improve the food they serve to patients, staff and visitors. The bronze, silver and gold awards provide an independent endorsement that food is fresh, trustworthy and traceable, and free from harmful additives and trans fats.

What were we aiming to achieve?

The Catering Service aimed to achieve a bronze award catering mark as an independent endorsement that the Trust is taking steps to improve the food it serves, using fresh ingredients which are free from undesirable additives and trans fats, are better for animal welfare, and comply with national nutrition standards.

The Catering Mark has been cited by NHS England as a way to improve hospital food, and by the Department of Education as a national framework to support caterers to increase uptake of quality school meals.

The Food for Life Catering Mark Bronze Standards are:

- Caterers in hospitals can demonstrate their compliance with national standards or guidelines on food and nutrition;
- At least 75% of dishes on the menu are freshly prepared (on site or at a local hub kitchen) from unprocessed ingredients;
- All meat is from farms, which satisfy UK animal welfare standards;
- No fish are served from the Marine Conservation Society ‘fish to avoid’ list;
- Eggs are from free range hens;

- No undesirable additives or artificial trans fats are used;
- No genetically modified ingredients are used.
- Drinking water is prominently available;
- Menus are seasonal and in-season produce is highlighted;
- Information is on display about food provenance;
- Menus provide for all dietary and cultural needs;
- All suppliers have been verified to ensure they apply appropriate food safety standards;
- Catering staff are supported with skills training in fresh food preparation and the Catering Mark.

What have we done?

Over a period of nine months, the Catering Service worked closely with suppliers and the Soil Association to ensure that the produce purchased and the 1500 meals provided daily for patients, visitors and staff met the requirements of the Soil Association.

What are the results?

The Trust was awarded the Soil Association Food for Life Catering Mark Bronze, on the 8th February 2016. The award recognised the Trust's push for fresh meals and good food at Harrogate District Hospital, encompassing Herriot's Restaurant serving outpatients, visitors and staff, and the inpatient meals service.

> "The Catering Mark is the result of lots of dedicated effort by the team at Harrogate and District NHS Foundation Trust. Achieving this endorsement is an exceptional achievement in the healthcare sector and a demonstration of the hospital's dedication to serving fresh, ethical, sustainable food that meets nutritional guidelines. Healthy places must be serving food that is good for the environment and good for us."
>
> Richard Watts of the Soil Association

Photo 4: Staff at HDFT with the Soil Association Food for Life Catering Mark Bronze certificate

Summary

The Catering Mark recognises the effort our Catering Team has made to provide patients and visitors with access to tasty and nutritious food. It helps us understand much more about where our food is sourced from and we are proud to share that with people who eat with us. Anyone visiting the hospital restaurant or eating inpatient meals will be assured of healthy, sustainable food, produced by fully-trained staff on-site with fresh ingredients. Local people will know that all the meat achieves UK animal welfare standards, dishes contain only free-range eggs, no undesirable additives or trans fats; and patients and visitors can easily be told where their food comes from, with much of it being sourced locally from the Yorkshire region using NHS accredited suppliers.

2.5.3 Effective Care

1. End of Life Care

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 that the care they receive is of the highest quality wherever it is delivered.

How we care for the dying is an indicator of how we care for all sick and vulnerable people. It is a measure of society as a whole and it is a litmus test for health and social care services (Department of Health End of Life Care Strategy, 2008). At Harrogate and District NHS Foundation Trust, we are committed to developing excellence within end of life care.

It is the aim of the Trust to ensure that events preceding and following the death of a patient are managed sensitively, efficiently and with the knowledge and understanding of the relatives and carers. Patients, relatives and carers have the right to receive a high standard of care, advice and support from well informed staff. Local objectives clearly highlight the need to care for people in a timely way with their care coordinated and delivered in accordance with their wishes through a personalised care plan. This aims to enhance dignity, choice and equality, to increase the likelihood that death will occur in the patient's preferred place of care, to palliate symptoms and to improve communication between patient, families and professionals.

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 needs are met. 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.

Education and training

End of life care is seen as a core responsibility of all clinical teams, and a significant component of the services provided by community nursing, respiratory care, elderly care etc. Whilst end of life care training is currently not mandated, work is underway to provide a range of education to meet the needs of varying staff groups. In the last year there has been a significant increase in education and training provided by the Specialist Palliative Care Team. This has been in formal and informal formats in hospital and in the community, as

part of attendance on medical wards when reviewing patients, and also through one-off teaching events and on-going programmes.

Staff surveys were undertaken in 2015 asking staff if they feel they would benefit from more training on end of life care and if so, what training was required. As a result:

- Over 750 trust staff members have undergone training in the Five Priorities of Care for the dying person;
- Care of the dying is now covered on the care support worker induction programme and this includes education on nutrition and hydration at the end of life;
- There are advanced plans to implement the SAGE & THYME ® communication skills training across the Trust, to support all grades of staff to listen and respond to patients or carers who are distressed or concerned as described in section 2.2.1;
- End of Life Care learning outcomes have recently been developed by Health Education Yorkshire and the Humber. E-ELCA is a library of e-learning sessions designed to enhance the training and education of all those involved in delivering end of life care to individuals who have been diagnosed with life limiting illnesses and are usually within the last 12 months of their life. We are in the process of developing an e-learning package to provide further education.

Senior clinician development programme - Rethinking Priorities

Six consultants and a GP participated in the Rethinking Priorities programme, which aims to enable patients approaching the end of life to have their wishes met regarding their care in the future. This 12 month programme, supported by Health Education Yorkshire and the Humber, encouraged senior clinicians to engage with end of life care issues, undertake learning about end of life care, improve communication skills, identify improvements within their own practice, share and spread learning to colleagues within their departments and generate service improvements. Common themes included planning to use tools to identify patients who may be at risk of deteriorating or dying, introducing advance care planning conversations into routine practice, and improving communication and information sharing between primary and secondary care. At the end of the programme, participants reported increased confidence in all aspects of delivery of end of life care. The group presented a summary of the year's activity to the Trust Board in January 2016, and it is hoped that some of this work will be taken forward as part of the Transforming End of Life Care in Acute Hospitals Programme.

Bereavement survey

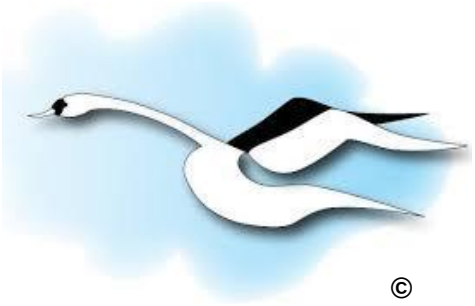
We also recognise the importance of gathering and acting upon feedback from patients and relatives in order to ensure we are delivering a holistic and patient-focused service, and to identify any areas for improvement. The Care of the Dying Evaluation (CODE^{TM}) bereavement survey was first piloted within the Trust in 2013. The outcomes of this survey helped to inform the educational needs and plans for staff. The survey is now being repeated with data collection underway. We write to the next of kin approximately seven weeks after their relative's death to ask if they would complete a questionnaire. Questionnaires are distributed with a pre-paid envelope so the response can be sent back to the Clinical Effectiveness Team. A preliminary report has been completed in February 2016. The results are mainly positive, with a small improvement against the 2013 results in some areas. See section 2.2.1 of this report for further detail relating to communication.

There are a few areas where relatives felt the care received could have been better, in particular dealing with pain relief and restlessness, noisy breathing, and the emotional and spiritual support provided to both the dying patient and their relatives. The decision has been

made to keep this as a rolling survey to gain a richer understanding of the care we are providing in this area.

The use of the Swan Symbol

Harrogate and District NHS Foundation Trust are in the process of adopting a 'swan logo' to promote heightened dignity, respect and compassion for the dying person and their significant others, at the end of life and after death. The swan logo will be included on all relevant documentation and a comfort/memory box will be available to families.



©

Redecoration of bereavement room

The room used by the General Office for meeting bereaved relatives and to provide a death certificate has recently been redecorated to create a more informal and relaxed environment.

Support for relatives - care in the last days of life

Relatives of patients who are at the end of their life are provided with free parking and open visiting. A booklet is available which provides written information, advice and guidance for family and friends. A section is also available for them if they have thoughts or comments they wish to document and later discuss.

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 of Hospitals / End of Life Care Audit: Dying in Hospital and we will be analysing the latest report published 31 March 2016 and ensuring we act on any recommendations.

In the relatives bereavement survey the overall question, "In your opinion, were you adequately supported during his/her last two days of life?" has scored 100% in both 2013 and 2015, indicating that in general people are happy with the level of support being received. The 2013 survey was a local survey conducted as part of the national audit at that time, and the 2015 survey was the initial results from the local rolling survey (using the CODE^{TM} questionnaire).

We have continued to build on the progress that we have made in recent years, however we can always improve the care we deliver and we intend to do so.

Summary

During 2015/2016 we hoped to launch a revised HDFT End of Life Strategy, which would be used as a framework to develop skills further, but we are not yet at the stage of producing a final strategy plan. However a full stakeholder meeting was held in September 2015 to identify key areas that need to inform the strategic plan. Stakeholder representatives included GPs, district nurses, social care, the voluntary sector, and St Michael's Hospice. Work within the Trust has also been undertaken to gather the views from front line staff in all clinical areas regarding their areas of concern and ideas for improving end of life care services – both within the hospital and in a local GP practice.

We have agreed with our commissioners that the recently published End of Life Care Strategy: New Ambitions document will be used as a framework for future service development, building on the principles that:

- Each person is seen as an individual;
- Each person gets fair access to care;
- Maximising comfort and wellbeing;
- Care is coordinated;
- All staff are prepared to care;
- Each community is prepared to help.

These principles are supported by:

- Having a shared understanding and purpose for end of life care;
- Patients and carers feeling supported and able to cope;
- Professionals feeling supported and able to learn and to care;
- Addressing inequity and variations in practice;
- Developing systems that support efficient and effective palliative and end of life care.

During 2016/17 we will be focusing on:

- Supporting staff to provide person centred high quality care, by preparing to include one page profiles on admission into hospital as part of the general nursing assessment;
- Preparing to take forward the 'Transform' programme to create a clear framework for improving end of life care across the organisation, with key metrics to provide transparency and Board assurance regarding the quality of end of life care.
- Prioritising the discharge of patients who are considered to be in the last week of life and who require Continuing Health Care funding, to enable them to die in their preferred place of choice
- Supporting the individual needs of the dying person and their significant others and ensuring that the five Priorities of Care for the dying person are met, by establishing and implementing a document to provide care plans for the last days.

2. Dementia care

Dementia is a progressive disease for which there is no known cure. The aim of the Government's National Dementia Strategy is that all people with dementia and their carers should live well with dementia. At HDFT we aspire to become a dementia friendly hospital; this involves considering the environment in which we care for patients, how we educate our staff to care for patients and assessing the quality of the care we deliver to patients living with dementia.

What have we done?

Improving the environment and becoming Dementia Friendly

Work has been completed on Byland and Jervaulx Wards with the use of pictures, the fitting of large clocks with day and time display and improved day room facilities, with some reminiscence features in both of these areas which care for elderly patients.

Research has shown that dementia changes a person's perception of distances, objects, and colours. The painting of toilet door frames in red is a recommendation from the

Alzheimer's Society and other leading experts in dementia care, and there is evidence that this can reduce the use of continence aids by 50%. During January 2016 the door frames to toilet areas across all clinical areas of the organisation were painted red. In addition we have started a programme of fitting dementia friendly clocks across the organisation.

Through the reinvigorated Dementia Working Group and the re-launch of the Dementia Champions we have agreed a number of service improvement projects to achieve in 2016/17.

These include:

- Dementia friendly signage on wards;
- Welcome boards for patients on wards to orientate them to place i.e. "Welcome to Harrogate District Hospital, this is Byland Ward ";
- Coloured crockery for patients with a cognitive impairment;
- Using coloured pillowcases to visibility identify patients with cognitive impairment and increased needs if their families agree;
- Exploring the potential of having therapeutic support workers on the elderly care wards to provide support to patients living with dementia and our staff;
- Staff on Trinity Ward created a memory box to use with patients to improve their cognitive function.

Photo 5: Memory box on Trinity Ward

Education and training

The Trust currently provides three levels of training and this has been a particular focus of work in 2015/16.

An innovative way of learning about early onset dementia was utilised in February 2016 when the organisation commissioned Brian Daniels to screen his play "Don't Leave Me Now". 41 members of staff and 18 members of the public attended a production and learnt about the carer's perspective through the use of theatre. The evaluations regarding the play were extremely positive, including:

"Everyone should see this"
"I thought it was sensitively and beautifully written play and extremely well-acted – it moved me to tears"
"Excellent, powerful and well delivered"
"Amazing, very powerful learning tool"
"Certainly something that all should attend"
"Great for students"
"I am a volunteer at the hospital and appreciated the opportunity to come"

In November 2015 the Trust embraced the re-launch of the Butterfly Scheme and Barbara Hodkinson, founder of the Butterfly Scheme came to the hospital to assist with the training. 135 people attended the training sessions and the Head of Nursing in Integrated Care and the Dementia Champions continue to embed the Butterfly Scheme across the organisation.

Photo 6: Re-launch of the Butterfly Scheme November 2015

We now have 63 of our staff who have become a Dementia Friend, learning more about what it is like to live with dementia and then turning that understanding into action. This training has been delivered by our colleague Belinda Goode from Tees, Esk and Wear Valley NHS Foundation Trust (TEWV).

We also provided further training for staff on the Mental Capacity Act and Deprivation of Liberty Safeguards legislation during 2015/16. See section 3.14 for further detail.

Collaboration with other organisations and partners

Last year HDFT joined the Dementia Action Alliance and shorty after we were partnered with the Norfolk and Norwich University Hospitals NHS Foundation Trust. This organisation is highly innovative in the way that dementia care is delivered to patients and their carers. We have an invitation to visit in order to benchmark dementia care, observe their Dementia Support Workers and discuss service improvement projects that we can replicate.

We have joined the regional Dementia Network facilitated by the Quality Improvement Manager from the Yorkshire and the Humber Strategic Clinical Network and Senate. There are regional meetings that provide education, quality improvement ideas, share research in dementia care and enable networking with colleagues across the region.

Our consultant in Medicine for the Care of the Elderly who leads work on dementia has established a close working relationship with the TEWV Acute Hospital Liaison Team in Old Age Psychiatry, ensuring patients are being referred, assessed and appropriately treated in an efficient way so they are cared for in the right environment by staff with the right skills and competence. The Acute Hospital Liaison Team provide ongoing advice and support for both medical and nursing staff and contribute to dementia training for our doctors.

Commissioning for Quality and Innovation (CQUIN) - Dementia

The key aim of the CQUIN framework is to support a shift towards the vision set out in ‘High Quality Care for All’ of an NHS where quality is the organising principle. The Trust has been working to compliance in relation to each element of the national CQUIN indicator associated with the care of people living with dementia. These include:

- Case finding or screening, so that everyone admitted to hospital as an emergency or for unplanned care who is 75 or older, is asked about whether they have been having

problems with their memory. If this has been a feature, investigations are carried out to exclude treatable causes of memory problems. The patient's GP receives a summary of their stay in hospital and would be asked to refer the patient to local memory services if their memory had not improved over the following weeks;
- Discharge summaries of patients with dementia, suspected dementia and/or delirium, have a clear plan for these conditions included in their discharge letter from hospital or community services to their GP;
- Improving dementia training;
- Undertaking regular carers surveys in order to ensure carers of patients living with dementia are well supported during the hospital stay and at the time of discharge from hospital.

What are the results?

Informal feedback from relatives has told us that they appreciate the difference we have made to the environment.

HDFT consistently ensures more than 90% of patients aged 75 years and over admitted to hospital for emergency or unplanned care are screened, assessed and referred as required. We have seen significant improvement in ensuring all of the required elements of the discharge letter are completed to support patients' management once out of hospital.

During 2015/16 we delivered higher level training to 63 members of HDFT staff. Results of dementia awareness training and tier one training are below.

Level of training	Renewal	Total Employees	Total Trained	Overall Percentage (%)	
				% Outstanding	% Completed
Dementia Awareness	3 Yearly	1614	1329	18	**82**
Dementia Tier 1	2 Yearly	1780	1566	12	**88**

Table 44: Dementia training completed (January 2015)

Regarding the results of the carers' survey:

- 63% reported feeling supported while their relatives was in hospital;
- 63% felt confident to leave the person in our care;
- 100% thought our visiting times were flexible enough to meet their needs;
- 88% felt that the staff had an understanding of dementia;
- 63% felt staff respected personal routines and preferences while their relative was in hospital.

Less positive results related to promotion of the Butterfly Scheme, carers feeling involved in the care being given, whether staff asked about any difficulties they were having caring, and being given information about agencies in the area who may be able to provide carer support.

Carers were also asked for suggestions on how we may improve the care that we give. The issues raised were about communication, staff not being aware of the personal needs of the patient, the lack of practicality of the NHS 111 system and not being aware of sources of support available to them. The Dementia Working Group will be working to address carers concerns and to bring about improvement in the experience of patients and carers.

Summary

There has been significant progress with the environment, training and understanding more about the needs of carers of people living with dementia. We want to continue this work in 2016/17 by:

- Working to continue to improve the hospital environment with the use of dementia friendly signage, dementia friendly crockery and painting to be in line with The Kings Fund: Enhancing the Healing Environment programme;
- Progressing a business case to have therapeutic support workers working on the elderly care wards to support patients living with dementia and carers;
- Working in partnership with John's Campaign, and launch this at HDFT. John's Campaign was founded to promote the right for families and carers of people with dementia to be allowed to remain with them in hospital for as many hours as they are needed, and as they are able to give;
- Increasing the number of clinical staff who have had higher level training by 50%;
- Launching the dementia strategy for the Trust;
- Re-launching the "all about me" information in a card;
- Having a carers passport to formalise visiting arrangements and parking concessions;
- Training staff on the elderly care wards in reminiscence therapy.

3. Stroke care

Good stroke care reduces mortality and disability. 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), which is a threatened stroke.

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 favourably with other providers.

What have we done?

We have contributed data for all of our stroke admissions to the national 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 the Humber stroke accreditation process and the ongoing peer review for stroke services by the Yorkshire and the Humber Strategic Clinical Network. For TIA performance we report monthly to HaRD CCG 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?

The latest published SSNAP results are for Quarter 3 2015/16. HDFT has been rated C this quarter, an improvement on the previous quarter (D). Our overall score has increased significantly this quarter to 64, compared to 48 the previous quarter. Also we have scored an A for both data quality metrics this quarter meaning that our score is not adjusted down as it has been in previous quarters.

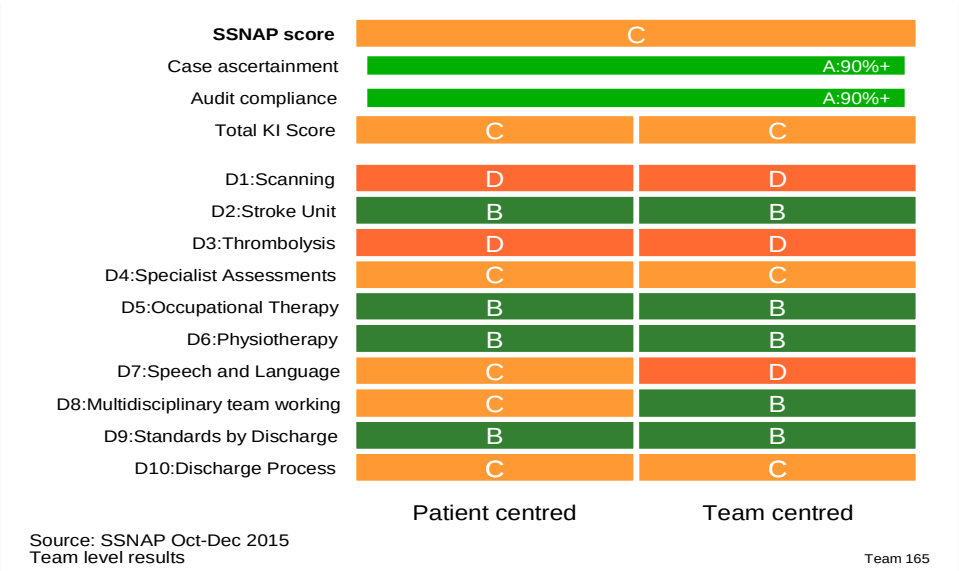


Figure 17: SSNAP results Quarter 3 2015/16

Of the ten domains in the SSNAP data set, five have seen a score improvement this quarter:

- Stroke unit (D to B)
- Occupational Therapy (C to B)
- Physiotherapy (D to B)
- Speech & Language Therapy (E to C)
- MDT working (D to C)

Many domains do better when we get patients with stroke directly to the Stroke Unit quickly, and this improved from 58% to 71% in the last quarter. This means patients get quicker assessments and the results relating to the therapy domains have improved. Two factors affecting further improvement are the availability of beds on the Stroke Unit and the availability of therapists.

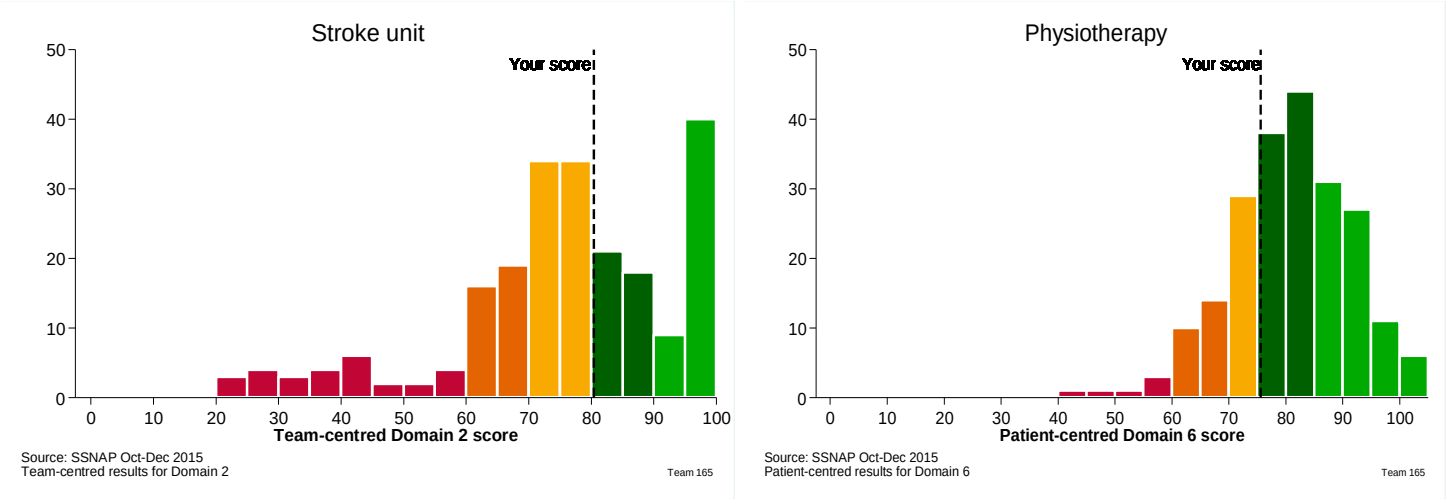


Figure 18: Stroke unit and Physiotherapy SSNAP data sets

The other five domains all stayed at the same score. No domains have seen a reduced score this quarter. The domains where progress has been particularly difficult are D1: scanning and D3: thrombolysis.

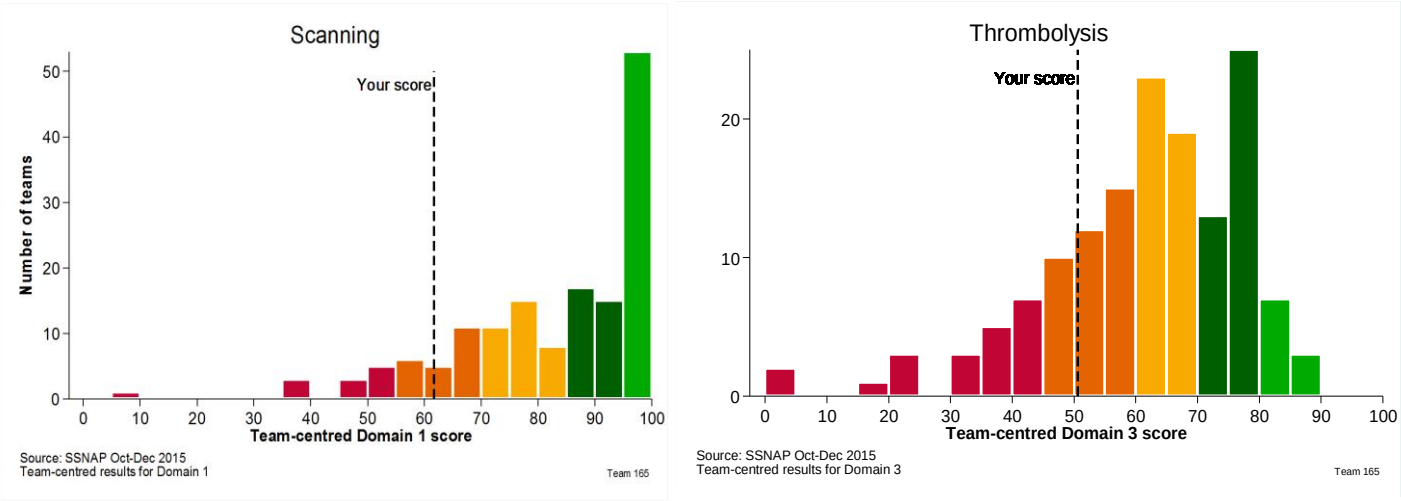


Figure 19: Scanning and Thrombolysis domains SSNAP data sets

In terms of thrombolysis, all nine eligible patients were thrombolysed this quarter but only one (11%) within an hour. The average time to thrombolysis was 1 hour 40 minutes. 27% of patients were scanned within 1 hour and 82% within 12 hours. To improve these we need to ensure all the related services and staff in ED, stroke team, porters, CT scanning etc are working so seamlessly that delays are brief.

Summary

We have participated fully with all national and regional stroke performance monitoring and have achieved a high level patient data entry for SSNAP in 2015/16. 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.

Whilst some of our SSNAP audit results have improved recently, we are not making as much progress as we would like with others, and we want to focus during 2016/17 on improving our performance in relation to the provision of high quality stroke care. The quarterly SSNAP dataset will be used to monitor performance and progress.

2.6 Performance against indicators in the Risk Assessment Framework

The following table demonstrates HDFT's performance against the indicators in Monitor's Compliance and Risk Assessment Frameworks for each quarter in 2015/16.

Indicator description	Target	Q1	Q2	Q3	Q4
RTT incomplete pathways (% within 18 weeks)	>=92%	96.2%	95.7%	95.0%	95.6%
A&E: Total time spent in A&E	>=95%	96.6%	95.7%	95.4%	94.7%
Cancer - Maximum waiting time or 14 days from urgent GP ref to date first seen for all urgent suspect cancer	>=93%	93.7%	97.5%	98.4%	97.3%
Cancer - maximum waiting time of 14-days for symptomatic breast patients (cancer not initially	>=93%	95.3%	96.9%	98.2%	95.5%
Cancer - 31 day wait for second or subsequent treatment: Surgery*	>=94%	100.0%	100.0%	100.0%	100.0%
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug*	>=98%	100.0%	100.0%	100.0%	100.0%
Cancer - 31 day wait for second or subsequent treatment: Radiotherapy*	>=94%	NA	NA	NA	NA
Cancer - Maximum waiting time of 31 days from diagnosis to treatment for all cancers (%)	>=96%	100.0%	99.6%	99.0%	99.6%
Cancer - 62 day wait for first treatment from urgent GP ref to treatment: all cancers	>=85%	88.9%	87.7%	93.4%	89.2%
Cancer - 62 day wait for first treatment from consultant screening service referral: all cancers*	>=90%	100.0%	50.0%	95.8%	93.1%
C-Difficile - cases due to a lapse in care (cumulative)	<= 12 cases in year	0	4	4	7 (tbc)
Community services data completeness - RTT information	>=50%	79.6%	80.6%	80.4%	79.9%
Community services data completeness - Referral information	>=50%	71.3%	72.7%	73.0%	68.2%
Community services data completeness - Treatment activity information	>=50%	81.4%	81.6%	81.4%	80.8%
Note					
* The target does not apply to trusts with five or fewer cases in a quarter - the number of cases reported by the Trust during Q1 and Q2 was below this level					

Table 45: HDFT performance against indicators in Monitor's Compliance and Risk Assessment Frameworks 2015/16

Key performance to note:

- HDFT's governance rating as reported to Monitor was green for each quarter of 2015/16. The Trust's performance against the A&E 4 hour standard was below 95% for Q4. However this does not affect the Trust's overall governance rating as long as the Trust reports performance above the 95% standard next quarter;
- The Trust achieved all seven applicable cancer waiting times standards for each quarter of 2015/16;
- 18 weeks performance was also above the required 92% for each quarter;
- Overall Trust performance against the A&E 4 hour standard was above 95% for eight out of 12 months during the financial year. However, sustained delivery of this standard remains challenging and Quarter 4 is the first time that the Trust has been below the 95% standard for the quarter overall. The development and implementation of plans to enable the Trust to move back to a positive performance position continue, including reviewing staffing deployment and requirements, co-location with the GP Out of Hours Service, and a review of departmental physical clinical capacity;
- There were two ambulance handover delays of over one hour reported in 2015/16 and 101 handover delays of over 30 minutes. The two handover delays of over one hour occurred on the same day which was an exceptionally busy day for the Emergency Department;

- No cases of hospital acquired MRSA were reported in 2015/16; the last one was reported in September 2013;
- 34 cases of hospital acquired *C. difficile* infection (CDI) were reported during 2015/16 meaning that the Trust exceeded its annual objective of a maximum 12 cases. Of these 34 cases, eight were agreed with the CCGs to have been caused by lapses in care. At the time of writing (11/5/16) we are still awaiting a decision of the appeals process on the remaining three cases. Three of the lapses in care are related to an outbreak of one strain of *C. difficile* 078 ribotype on Oakdale Ward in February 2016. Measures have been put in place to address *C. difficile* going forward (see section 2.4). The CDI objective for 2016/2017 has also been set at just 12;
- Activity levels at HDFT have increased during 2015/16. Elective (waiting list) admissions were 2.8% higher in 2015/16 when compared to 2014/15. Outpatient attendances also increased by 2.8%. Non-elective admissions increased by 4.0% and A&E attendances by 1.4%. However the number of avoidable admissions (as per the national CQUIN definition) decreased by 3.4% over the same period;
- During 2015/16, there was a 13.6% increase in face to face contacts recorded by the community nursing teams. This increase may be partly due to improved data capture but is also reflective of increased activity within these services.

3. OTHER QUALITY INFORMATION

HDFT has identified additional elements of service quality to highlight in this Quality Account.

3.1 National Inpatient Survey 2015

621 HDFT inpatients discharged in July participated in the 2015 national inpatient survey carried out by Picker Institute Europe. The HDFT response rate was 52%, compared to a national average of 45%. Of the 621 HDFT inpatients who responded to the survey, 36% of patients were on a waiting list so admission was planned in advance and 60% came as an emergency or urgent case. 53% of HDFT respondents were aged 70+.

Picker highlighted the following positive points for HDFT:

- 87% rated care at HDFT as at least 7 out of 10;
- 85% of respondents felt they were treated with respect and dignity;
- 83% always had confidence and trust in doctors;
- 98% felt their room or ward was very or fairly clean;
- 98% felt the toilets and bathrooms were very or fairly clean;
- 91% felt there was always enough privacy when being examined or treated.

The survey contained 65 questions in total. In 18 out of the 65 questions, HDFT scored significantly better than average, about the same as average for 46 questions and significantly below average for one question which was 'Not asked to give views on quality of care'. 73% of HDFT patients agreed with this question compared to a 69% national average. In the section relating to admissions to hospital, HDFT attained a score of significantly better than average for six out of the seven questions.

Compared to the previous year's results, HDFT had improved in 28 out of 62 questions that remained the same in both surveys, remained the same for 12 questions and gained a lower score in 22 questions. However in only one question was it deemed that HDFT had performed significantly worse than the previous year: "Hospital: not offered a choice of food" where 22% of patients felt they were not offered a choice of food in 2015 compared to 17% in 2014.

The current arrangements to help ensure that patients receive their choice of meal comprise:

- Menu choice cards are returned to the Catering Service from wards, one meal in advance, for example by 4pm for the next day's meal service;
- The admissions menu is designed to offer patients a choice of food, for their first meal when admitted to hospital, rather than offering them a meal ordered for a patient who has been discharged;
- The standard patient menu or dietary menu for all other meal requirements is available to patients.

However, there can sometimes be difficulty in enabling patients to be given their choice e.g. when they are admitted to wards such as Clinical Assessment, Triage and Treatment. This is due to patients' short lengths of stay and the logistics associated with their meal following them to their next location. To help address this the Catering Service is working closely with the Trust's Nutrition Group. The group will consider the options available to help improve the arrangements for ensuring that patients receive the meal of their choice and thereafter will monitor the situation.

At present the full national data set is not available so it is not possible to see how HDFT ranks compared to other trusts.

3.2 National Staff Survey 2015

Every autumn the Trust participates in the national NHS annual staff survey. The results are published nationally and can be obtained from the national NHS staff survey web site.

Overall we have some extremely positive messages arising from the 2015 survey. The response rate for the Trust increased from 56% in 2014 to 59% in 2015, which is the highest response rate achieved in the combined acute and community trusts category in 2015.

The rankings that can be achieved by combined acute and community trusts are 'better than average', 'average' or 'below average'. Out of the 32 key findings (KF) the Trust's ratings against other combined acute and community trusts were ranked as follows:

- 23 were above (better than) average of which two were the highest scores in our group;
- Eight were average;
- One was below (worse than) average.

The figure below shows how the Trust compares with other combined acute and community trusts on an overall indicator of staff engagement. Possible scores range from one to five, with one indicating that staff are poorly engaged (with their work, their team and their trust) and five indicating that staff are highly engaged. The trust's score of 3.92 was above (better than) average when compared with trusts of a similar type. This is the highest ranking possible for combined acute and community trusts and ranks the trust joint third nationally in this category.

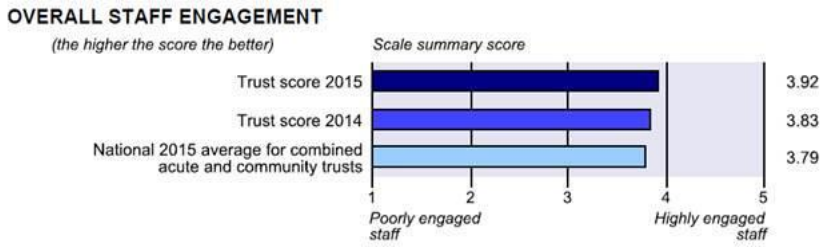


Figure 20: National Staff Survey engagement

Overall staff engagement comprises three key findings within the survey: 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.

The Trust is at the top of our benchmarked group for:

- Staff satisfied with the opportunities for flexible working patterns (59%);
- Recognition and value of staff by managers and the organisation (3.63).

The Trust has improved significantly since the 2014 staff survey regarding:

- Support from immediate mangers (3.68 to 3.87);
- Staff satisfaction with the level of responsibility and involvement (3.90 to 4.01);
- Staff recommending the organisation as a place to work or receive treatment (3.81 to 3.92).

Regarding the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (National Staff Survey KF26) the HDFT score was 21% (the lower the score the better) which was an improvement from the 2014 survey result. The 2015 national average for combined acute and community trusts was 24%.

Regarding the percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (National Staff Survey KF21) the HDFT score was 92% (the higher the score the better). The national average for combined acute and community trusts was 87%. This was one of the five key findings for which HDFT compares most favourably with other combined acute and community trusts in England.

For both KF21 and KF26 the survey scores achieved by HDFT rank the Trust when compared nationally as 'better than average'. This is the highest ranking available.

The one area that has deteriorated the most since the 2014 survey and has been categorised as worse than average is:

- Staff experiencing physical violence from patients, relatives or the public in the last 12 months. This has increased from 11% to 16%.

Staff Friends and Family Test

Every quarter, members of staff are invited to take part the NHS Staff Friends and Family Test and answer the question: *How likely are you to recommend the Trust to friends and family as a place to work?* The results in Quarter 3 were:

- 87.8% of staff would recommend care or treatment at our Trust;
- 71.4% of staff would recommend the Trust as a place to work.

12.3% of staff would not recommend the Trust as a place to work, and 2.7% of staff would not recommend the Trust as a place to receive care or treatment.

The survey provides the opportunity for staff to provide additional comments and the results are reviewed each quarter by the directorates to ensure continuous service development. The key reasons for the responses were due to the impact of perceived staff shortages and increased workloads, whilst the main reasons given for staff not recommending care or treatment at our Trust to family and friends were that their family and friends do not live in the area, and that recommendation would depend on the type of care or service needed as other hospitals specialise in certain treatments.

Actions to improve

In previous years a Trust wide action plan has been developed and each directorate has used their own results to develop local action plans. This year we are asking directorates to focus on three overarching issues and develop action plans around the following areas:

1. Staff experiencing physical violence and discrimination;
2. Staff satisfaction with the quality of work and patient care they are able to deliver;
3. Quality of non-mandatory training, learning or development.

By concentrating on these three areas a greater focus can be given to them and a consistent message to be shared. By communicating this information clearly staff can be assured that the Trust has understood their feedback and subsequent action is being taken. The Human Resources Business Partners are working with directorate management teams to translate these overarching issues into local actions.

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 locally (within the Trust).

The Patient Experience Team (PET) facilitate the resolution of issues and this could include offering the opportunity of meeting with clinical staff, 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 18 complaints per month in 2015/16 is relatively small at one per 7,000 patient contacts and is less than the average of 22 complaints per month for 2014/15.

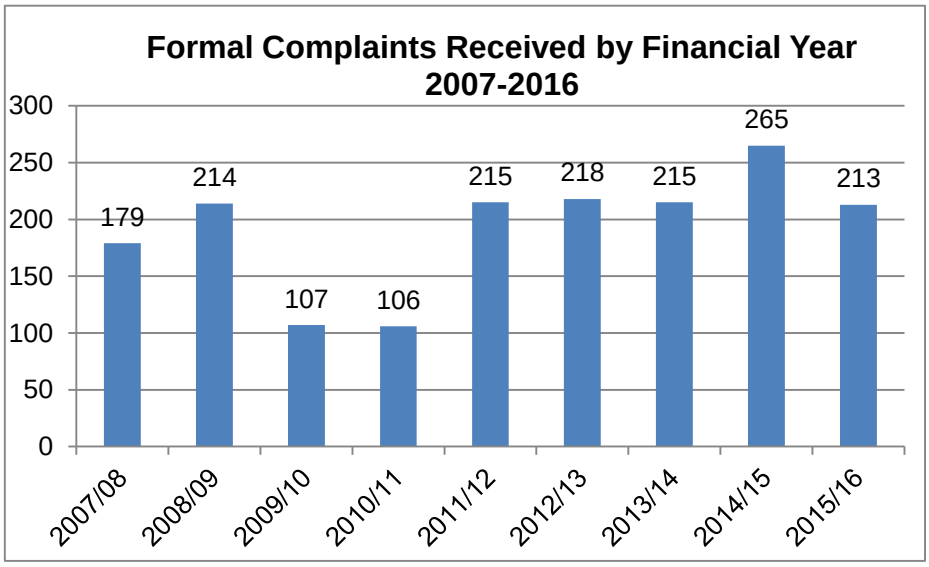


Figure 21: Local patient feedback data since 2007

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 2015/16 is presented below by grade and quarter in which it was received, compared to 2014/15.

Complaints Total	2014/15 Total	2015/16				
		Q1	Q2	Q3	Q4	Total
Complaint Green	94	26	14	8	18	66
Complaint Yellow	163	46	42	21	31	140
Complaint Amber	8	2	2	3	0	7
Complaint Red	0	0	0	0	0	0
Total	**265**	**74**	**58**	**32**	**49**	**213**

Table 45: Local patient feedback data showing complaints by quarter during 2015/16 and grade

The number of complaints received is less than the previous year and the number of cases indicating poor experience in several areas which are graded as moderate (yellow) or high (amber) is lower than last year. Quarters 1 and 2 received the most numbers of complaints. The Trust experienced high levels of patient activity during this period as did many hospitals across the NHS. The Trust also refocused efforts to resolving as many issues and concerns at the front line informally and as soon as possible to prevent the escalation into a formal complaint.

The resolution of informal "PALS" (Patient Advice and Liaison Service) type contacts includes concerns, information requests and comments. In total in 2015/16, 676 were received by the Patient Experience Team (PET) compared to 902 in 2014/15. Of these 676, 373 were concerns, 156 were requests for information and 147 were comments. The data demonstrates a reduction in the number of cases presented to the PET and an indication that front line staff are responding to and handling patient feedback swiftly in the wards and departments.

The top five themes for complaints and concerns can be seen in the graph below. The main themes have consistently included issues around aspects of medical care, diagnosis, medical and nursing communication.

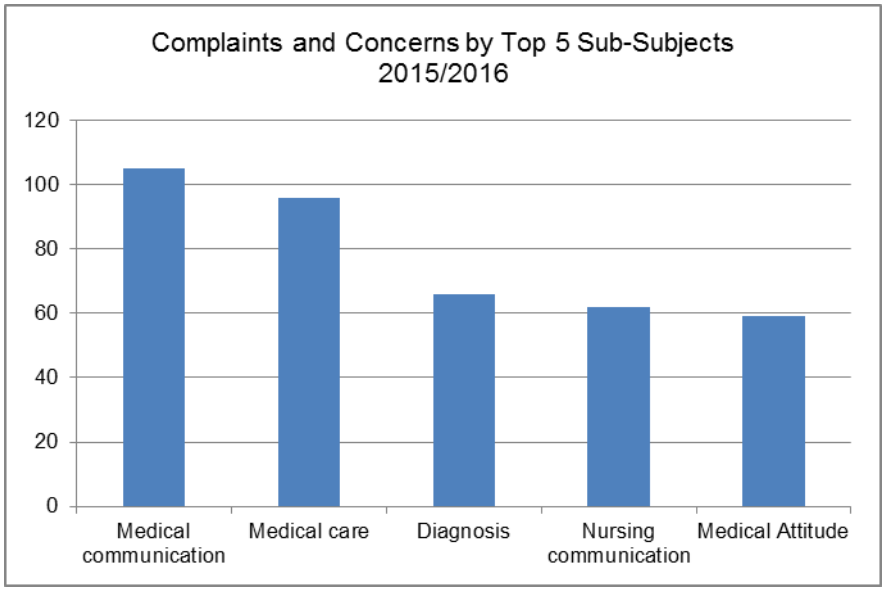


Figure 22: Local patient feedback data showing the main themes in complaints and concerns

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 54% of cases in 2015/16 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. A complaints performance metric has been introduced for 2016/17 and will include monitoring of complaints responses against a target of 95% within deadline set and monitoring of completion of action plans.

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.

Five cases were referred to the Health Service Ombudsman in the period, which is less than 2014/15 when nine cases were referred. Of the five 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;
- 2 have been investigated by the Ombudsman and not upheld;
- 2 are under review by the Ombudsman.

In 2014/15 the Ombudsman upheld two cases, found five were not upheld and referred two back for further local resolution.

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.

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Compliments received by the Patient Experience Team	233	354	354	291	330	315	340

Table 46: Local data showing compliments received by the Patient Experience Team

3.4 The Patient Voice Group (PVG)

The PVG is an independent group of volunteers who work in partnership with the Trust. Our purpose is to listen to patients and relatives experiences of using HDFT services and communicate these in a meaningful way to managers, so that the quality of patient care continues to improve.

The workload of the PVG is based on the domains set by the Care Quality Commission around safety, the patient experience, dignity and respect, communications and the flow of the patient journey through the different services including plans to go home. This provides opportunities to share excellent practice and also learn where improvements could be made. We do not want to appear a threat to hard working staff but to work with them. We do this by talking to patients at the most appropriate time, on the wards, at home or by telephone.

2015 has been a year of change. Along with changes to senior managers within HDFT the PVG welcomed a new Chair and new members to the group. The start of 2015 was a time of reflection to ensure all projects add value to the Quality Improvement Programme for the Trust. We also asked ourselves 'do we really influence change to improve the patient experience?' It has become increasingly difficult to talk to patients in hospital as they are very poorly and vulnerable and we want to collate honest feedback.

The projects undertaken by the PVG include;

- A telephone survey of the Patient Experience Team;
- Visits to Emergency Department to talk to 50 patients attending the department;
- Shadowing five patients through their journey of Radiology;
- Talking to more than 30 children and young people accessing many different children's services;
- Visits to four wards talking to patients and relatives about their experiences with an emphasis on nutrition;
- Follow up visits to Lascelles Unit and Acute Medical Unit (previously Fountains Ward).

Reports on each project are provided for the Trust.

The majority of patients and relatives are very appreciative of the excellent care received and kindness shown by staff. The negative comments received are about staff being very busy and not having time to talk; patients are not aware or involved in their treatment plans; discharges are often delayed; appointments are not flexible and problems with car parking.
It is a continuous challenge to find the most appropriate time to talk to patients.

The PVG need to ensure that there are good working relationships between the PVG and the Trust to ensure there is an effective two way communication. The PVG need to raise their awareness within the Trust, and improvements need to be made to ensure PVG reports are responded to, acted upon where appropriate and monitored through the Learning from Patient Experience Steering Group.

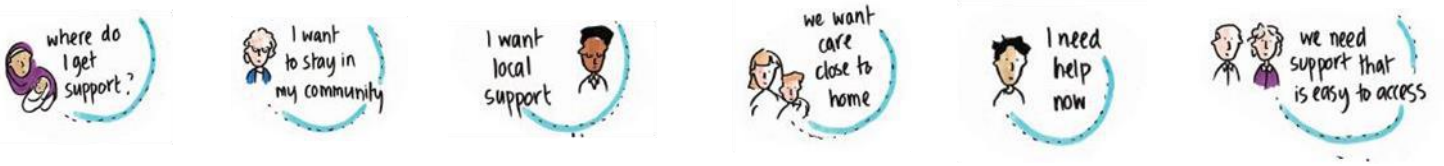
Judy Lennon (Chair) March 2015

3.5 Innovation work

Delivering more care in the community and in peoples homes

What matters to us
Improving health and wellbeing across Harrogate District

Health and social care partners in Harrogate and Rural District recognise that a sustainable health and social care economy is dependent on transforming the way that services are delivered for local people. Having become a Vanguard site the Trust has the opportunity to work with our partners to ensure that local people are able to access services that are joined up and support them to remain healthy, well and independent.



We are shifting care closer to home and working as a whole system across acute, primary, community health, social care, the voluntary and community sector and wider universal services to make this happen. Our aim is to ensure more people stay healthier and independent for longer, have choice and control over their lives and care, and that costs are reduced across the system.

What we aim to do;

- Support individuals to stay well and independent for as long as possible
- Provide the right care, in the right location at the right time to promote wellbeing and prevent deterioration
- Avoid unnecessary hospital admissions by creating community based alternatives
- Allow people to be more in control of their own health and wellbeing
- Provide services which are connected and which reduce delays in care delivery
- Create faster pathways to care
- Enable individuals to achieve their potential through innovative and creative care

The New Care Model

HDFT already provides the Adult Community Nursing services and Community Fast Response and Rehabilitation services for the HaRD area. These teams are part of the transformation along with our ward at Ripon Community Hospital and will have the opportunity to influence how the new model operates. Closer collaboration with our partners, including local GPs, social care, mental health services and voluntary organisations is key to the success, and we are all working together to design the New Care Model to enable local people to remain independent and at home for as long as possible.

We have already started working toward these goals which will be delivered via locally based Community Care Teams and a Response and Overnight Service. The first team started work as a pilot in February 2016 in Knaresborough, Green Hammerton and Boroughbridge area.

Figure 23: The New person centred Care Model

Photo 7: Staff from the Knaresborough and Boroughbridge Community Care Team.

Although it is still early days, the team have made a number of improvements to care delivery to date including:

- Making it easier for people to be referred to the service, so they receive the support they need more promptly;
- Improved relationships and collaboration with partner organisations, encouraging joint working to make faster decisions;
- Developing joint assessments which reduce the number of times people have to answer the same questions;
- Identifying opportunities for staff to be trained to complete different competencies allowing us to reduce the number of people attending one home, carrying out separate tasks e.g. our mental health team member can administer eye drops which has saved a small number of additional visits.

All of the partners are committed to working with our local communities, voluntary organisations and our staff to design and introduce new ways of delivering care and support to local people in a way that works for them. We are keen to continually receive feedback from the communities which will shape how the programme will work and encourage anyone who has innovative ideas and suggestions to contact us.

Clinical Transformation Programme

The aim of our Clinical Transformation Programme is to: “Achieve best care for the people who receive care and treatment from Harrogate and District NHS Foundation Trust, whilst at the same time realise financial savings with improved systems and controls”. A number of objectives guide this approach:

- All contacts are cost-effective and add value to the patient;
- People only come to hospital when there is no community alternative;
- People only stay in hospital for as long as they need to;
- People only receive on-going care for as long as they need it.

The diagram below summarises the four workstreams and associated projects which together compromise the current programme. The scale of the challenge is to deliver quality improvements whilst realising £25m of cost improvements over the coming five years. A small Programme Management Office has been established to support projects to have the best chance of success.

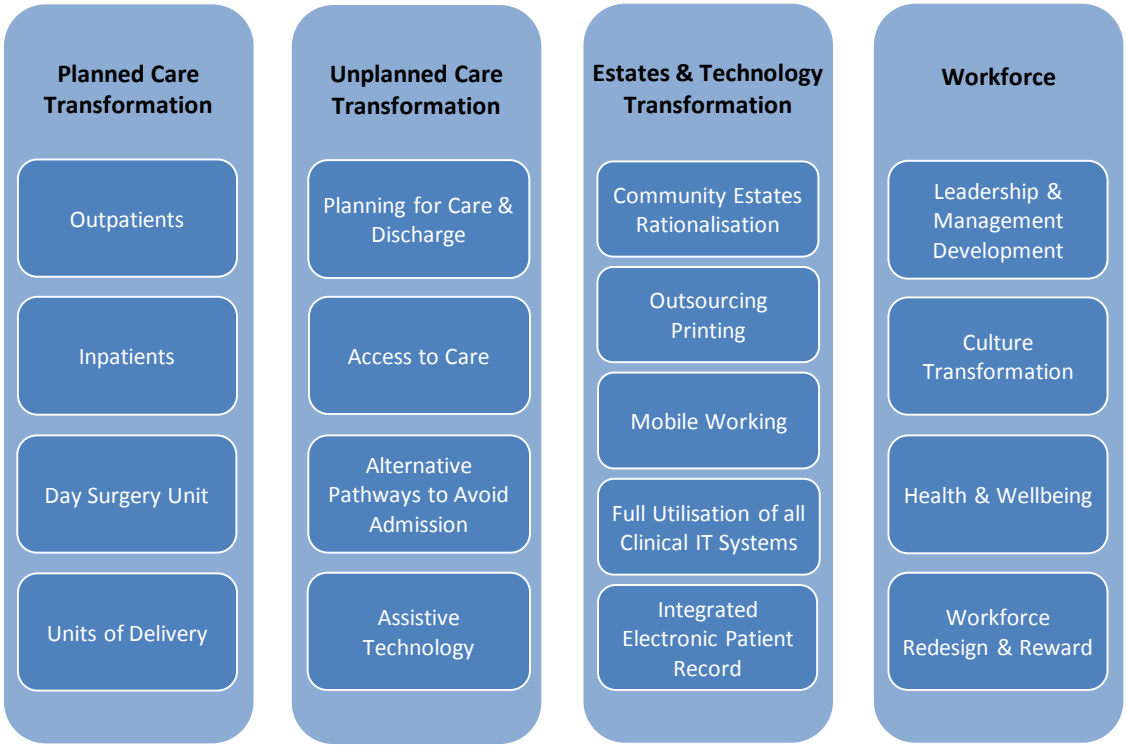


Figure 24: The workstreams and projects of the Clinical Transformation Programme

Extensive planning during 2015/16 has moved eight of the projects through idea development, approval and planning phases into implementation. Three projects are now moving to completion.

A bespoke dashboard has been developed for the Clinical Transformation Board who oversee the programme, which shows clearly the status of each workstream, the projects within and the financial savings planned and realised. Collectively, the projects have reached 84 milestones in 2015/16. Highlights include:

- The first phase of outsourcing of printing and posting of patient appointment letters has been delivered and work to monitor the realisation of financial benefit started;
- Extensive data collection in Planned Care has enabled the Units of Delivery project to now focus on the top 10% of loss-making procedures;
- Observations of patient flow through main operating theatres have started. This will inform the delivery of a rapid process improvement workshop in 2016/17;
- Two “Flowopoly” events have been delivered with participants from across the Harrogate and District health and social care system to model hospital flows of patients who require unplanned care. In a highly structured and highly participative way, this enables NHS staff to see how patient flow does and does not work in a complex system. Findings from these events are informing the further delivery of the Unplanned Care workstream;
- Two promising trials of joint triage between GP out-of-hours health services and Harrogate District Hospital’s Emergency Department have run, with patients being more positive about returning for a GP out-of-hours appointment than expected;

- A personal resilience training programme has helped to deliver a continuing trend of reductions in stress-related sickness absence, with January 2016 figures showing that this type of absence is costing the Trust £80,000 a year less than it was in June 2015;
- External funding for the delivery of some aspects of the new Leadership Development Strategy has been secured and the strategy agreed;
- A new approach to values-based employee appraisal has been rolled out to support the delivery of organisational culture change.

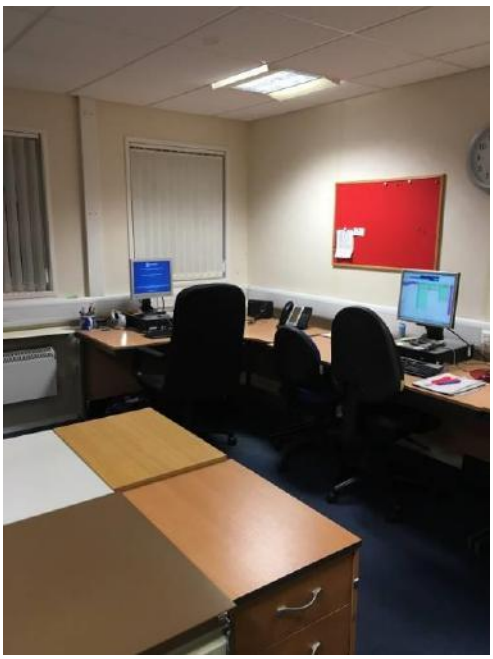
Spotlight on rapid process improvement workshops (RPIW)

More than 80% of improvement activity is now being focused on supporting the delivery of the Clinical Transformation Programme described above. Two recent RPIWs are profiled below.

Enabling productive mobile working

Sponsored by the Chief Operating Officer, this workshop engaged the Children's Services 5-19 years vaccination service based at Selby in enabling staff to work more productively through the use of mobile technology. A number of measurable improvements were secured:

- The lead-time for immunisation sessions administration was reduced from 172 minutes to 118 minutes;
- The number of immunisation sessions delivered not following a standard protocol was reduced from 100% to 0;
- The workplace organisation of the office, storeroom and fridges was improved from 5S level 1 to level 4. 5S is a systematic approach to workplace organisation;
- The number of children whose data is not on SystmOne has reduced from 50% to 20%.



Photos: 8 & 9: Children's Services office, Selby: Workplace organisation before (left) and after (right)

New Care Models patient pathway – catheter management

Sponsored by Deputy Medical Director, Dr Claire Hall, this workshop focused on stopping patients coming into hospital unnecessarily for the management of their urinary catheter. A number of measurable improvements were secured.

- The lead time taken from patient contact to catheter intervention was reduced by 57% to under two hours and forty minutes;
- The number of unnecessary attendances at the Emergency Department was reduced from four to zero;
- The use of information available in the catheter management passport was increased;
- Phone calls from district nurses to GPs to gain referral access to a hospital ward were eliminated.

The achievements made in both workshops were celebrated at a report-out to a warm and supportive audience in a packed Board Room on 27th November, 2015.

3.6 Volunteers

Volunteers play a vital role in the delivery of patient services throughout the Trust. Whilst they do not replace paid members of staff, they do enhance and compliment the work that staff undertake and contribute to the overall patient experience.

Volunteers are not just based at Harrogate District Hospital; we also have volunteers based at Ripon Community Hospital and within in the last year this has expanded to community volunteers at sites in Northallerton and Scarborough.

The Trust is incredibly fortunate to have the assistance of over 400 volunteers who span the generations, ranging in age from 16 right up to 92 years of age! On average they provide over 2,000 hours per month of help in many different ways. We have a steady intake of new volunteers year round, with two specific sixth form intakes from local schools and colleges in April and November.

Photo 11 & 12: Just two of over 400 volunteers at the Trust!

Volunteers continue to help in so many ways, such as:

Meal time volunteers; assisting patients with their lunch and evening meals; Chaplaincy; Discharge Lounge; Outpatient's clinics; activity volunteering; administrative assistance; Pharmacy assistance; meet and greet volunteers; volunteer drivers (who provide an

invaluable transport service for patients living in Nidderdale, bringing them to and from their hospital appointments); Hospital Radio; undertaking patient surveys; assisting in the Sir Robert Ogden Macmillan Centre; assisting at fund raising events, the annual Open Event and at Medicine for Members lectures.

Our team of gardening volunteers have made a huge difference to the courtyards and gardens by planting, pruning and general tidying up. Carolyn Rothwell our lead volunteer gardener was awarded Wildlife Volunteer of the Year in the Harrogate and District Volunteering Oscars.

Photo 10: Young meal time volunteer

A new initiative for November 2015 involved training young volunteers to go onto wards to prepare patients for their evening meal, by ensuring their hands and tables are clean. So far 48, sixth form students have undertaken the role and have proved to be a welcome asset to the ward staff. New roles have also included assisting an Occupational Therapy led Parkinson's Support Group, evening meet and greet volunteers for the Acute Medical Unit and the Clinical Assessment, Triage & Treatment Ward.

Volunteers are thanked officially at the annual Celebration of Volunteering in December, with a tea party and invited guest speakers and musical entertainment.

3.7 Health Visitors and Healthy Child Programme

The Healthy Child Programme (HCP) for the early life stages focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. The HCP for 5 to 19 year olds sets out the recommended framework of universal and progressive services for children and young people to promote optimal health and wellbeing.

We ensure that we deliver the HCP across North Yorkshire, and in the future Middlesbrough, County Durham and Darlington, in a way that ensures equality of access, taking in to consideration:

- The geographical spread of the counties and the varying community needs;
- 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. An action plan is actively

monitored which demonstrates our performance activity and identifies any areas for development and improvement.

What were we aiming to achieve?

Working collaboratively with partner agencies we aim to:

- Support children being ready for school;
- Support families to ensure children enjoy a happy family life, with a safe reduction in the looked after child population;
- Ensure a healthy start to life (improve immunisation uptake, reduce smoking prevalence and obesity, and improve the emotional wellbeing of families, children and young people).

The Health Visiting Service in partnership with North Yorkshire Children's Centres are working towards UNICEF breast feeding initiative (BFI) status and have almost completed the first stage. This is in recognition of the profound importance of early relationships to future health and well-being and the significant contribution that breastfeeding makes to good physical and emotional health outcomes for children and mothers. We aim to ensure that all care is mother and family centred, non-judgemental and that mothers' decisions are supported and respected. We work across disciplines and organisations to improve mothers' and parents' experiences of care.

The 5-19 Healthy Child Team continue to deliver the preschool vaccinations and immunisation programme to the 5 to 19 year old population. The service is delivered in line with national guidelines supported by effective risk management processes, storage and cold chain procedures and regular monitoring and reporting. We have an excellent track record of delivering the required uptake targets; we achieved 97.8% for HPV (human papilloma virus) vaccination in 2015/16 and were identified as being in the top four organisations for the highest uptake. The service also successfully delivered the influenza vaccination programme across North Yorkshire and was awarded the contract for the delivery of influenza vaccination in the City of York.

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. We have introduced proactive follow up to help support families where their children are struggling to maintain a healthy weight.

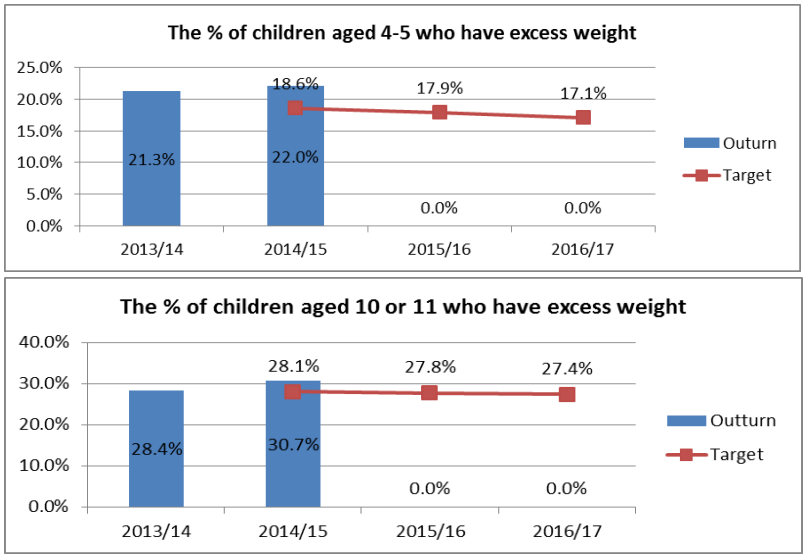


Figure 25 & 26: National Child Measurement Programme results

To support the reduction in teenage pregnancy the 5-19 practitioners work with children and young people to support heathy relationships and offer sexual health advice, support and onward referral. We have recently employed three health visitors to work in partnership with North Yorkshire County Council (NYCC) to develop a teenage parenting model which is due to be launched early April 2016. Our 5-19 practitioners are trained to offer sexual health support to the children and young people they work with.

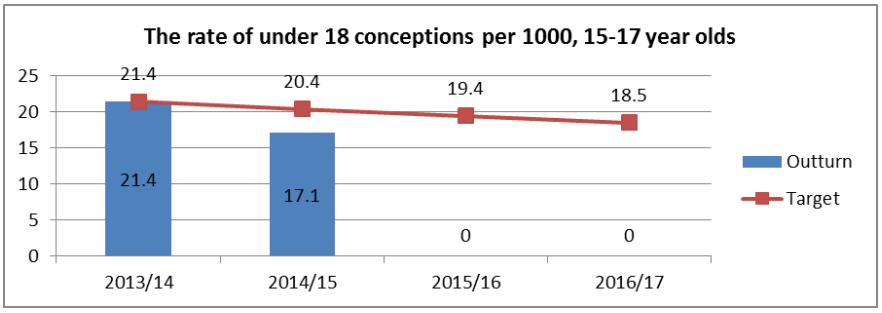


Figure 27: Rate of under 18 conceptions per 1000

Summary

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.

Over the last 12 months we have strengthened the training of the 0-19 workforce to ensure they remain skilled, competent practitioners who deliver an evidence base service to the population. We have co-located the majority of the 0-19 workforce with NYCC prevention and early intervention teams to ensure we maximise resources to meet the needs of families. We achieve our key performance indicators and service specific related performance standards, ensuring a high quality standard and delivery of care. This is achieved through the robust performance management and quality of care processes that are well embedded within the organisation.

3.8 Speech and Language Therapy

People with speech, language and communication needs (SLCN) have difficulties in communicating with others. This may be because they cannot say what they want to, have difficulty understanding what is being said to them or do not understand social rules of communication. This may be minor or temporary for some young people, whilst for others their needs will be complex and long-term.

Studies have found that young people who have offended are likely to be at significant risk of previously unrecognised language impairment (Gregory and Bryan, 2009). There is evidence shown by other teams such as in the Leeds Youth Offending Team (Bryan and Mackenzie, 2008) that speech and language therapy targeted at improving the language skills of individuals can significantly reduce the numbers who re-offend.

Many children with SLCN do not have their needs correctly identified or supported at secondary school. As children get older and have to cope with different people, timetables and complex social situations, there is more demand on their communication skills. Although there are a significant number of young people in secondary schools with SLCN, the associated behaviours or literacy difficulties are often the most prominent and are the focus

instead. There is a lack of speech and language therapy support and limited knowledge about typical language development which means it is difficult for schools to provide or be confident in their assessment of delay.

The aim of the Youth Communication Team is that young people with speech, language and communication needs will be identified earlier, with the aim of increasing their ability to be involved in education and work and thus preventing them from becoming disengaged and becoming involved in offending behaviour.

What were we aiming to achieve?

This three year project, funded by North Yorkshire County Council (NYCC) since November 2013, is a radical approach to working with young people with multiple vulnerabilities aged from 11 to 25 years. The project has speech and language therapists (SLT), employed by the Trust, co-located in the Youth Justice Service in Harrogate, Scarborough and Selby areas.

We also have been contracted by NYCC from March 2015 to provide speech and language therapy to the 'No Wrong Door' (NWD) project until November 2016. This service model focuses on a specific key worker that stays with each young person "no matter how they move through care". The model enables young people in care (or on the edge of care) to access the right services at the right time and ultimately aims to support achievement, reduce high risk behaviour and ensures that young people in crisis receive well organised and appropriate support.

The NWD project has speech and language therapists who are co-located in the East and West NWD hubs. They work within the NWD project team but also work as part of the whole North Yorkshire Youth Communication Team.

The first year of the project focused on setting up a service for young people who are involved in the Youth Justice Service. The SLTs screen all the young people to identify if they have speech, language and communication needs. Therapy is provided during their involvement with the Youth Justice Service and beyond that if required. Training is provided to staff so they can recognise speech, language and communication needs and adapt their own communication and intervention packages. Presentations to raise awareness have given to a number of other groups including police, youth panels, volunteers and providers of educational and work.

The second year has expanded to include those young people who are attending specialist educational provision, starting with Forest Moor School, Harrogate and moving on to Brompton Hall School, Scarborough. We were also tasked to start input to the Pupil Referral Services in North Yorkshire, starting in September 2015.

What have we done?

In the schools and Pupil Referral setting we have:

- Screened young people for SLCN and carried out a more in-depth assessment where required. Summarised individual screens were embedded in school reports;
- Delivered training for staff about speech, language and communication skills at an introductory level;
- Advised regarding the communication environment, made resources accessible and given support to implement changes;
- Identified staff that could be communication champions and trained them in order to them to cascade knowledge and skills.

What are the results?

Youth Justice Service

From December 2015 to February 2016, 261 young people have been screened. 120 (46%) of the young people had SLCN, with nine (7.5%) previously diagnosed with SLCN.

Pupil Referral Units

Training took place for Hambleton & Richmondshire Pupil Referral Service; The Grove, Harrogate; and Rubicon, Selby in November 2015 and ROOSE, Pickering and Scarborough Pupil Referral Service in January and February 2016. Screening is still ongoing.

Forest Moor School

14 young people were screened. 88% were identified as having SLCN with 79% previously undiagnosed. The school is investigating an increase in SLT provision.

Brompton Hall School

39 young people were screened with 66% identified as having SLCN. The NHS SLT is to follow up referrals now one day a month and the school are investigating an increase in SLT provision.

No Wrong Door

From the early stages of NWD, the SLTs liaised with the SLTs based at Youth Justice to share information and avoid duplication. The NWD SLTs quickly became established members of the NWD team and contributed to team meetings and complex case discussions.

SLTs are continuing to work closely with NWD hub workers and managers to complete communication assessments with young people (both residential and outreach) who are newly referred to the service. The benefits of the embedded nature of the role are very clear, with young people commenting that they come to the SLTs not only for direct help with communication, but also general support and advice. The staff see them as established members of the NWD team and they are approaching them for specialist advice when needed.

Early data shows that 62% of the young people who have been directly assessed have presented with SLCN.

Suggestions about how to make both homes more communication friendly are on-going and additions to the homes have been made such as visual timetables that depict which staff members are on shift, menu boards in the kitchens etc. Feedback received includes:

> *"You have both been so amazingly supportive and talking to the SLT has really cleared my mind of doubt."* Parent of young person.
>
> *"A really helpful and informative piece of work which has benefitted both staff and students. We have never had such intensive support. Great credit to the SLT's – excellent and professional at all times."* Head teacher, Hambleton & Richmondshire Pupil Referral Service.

"*A SLT report was written with strategies to use with the young person. As a result college tutors felt that they could communicate more effectively with the young person, pitch information at a more appropriate level and make classes more meaningful for him."* Case Study report.

"Having a speech and language therapist involved in the Decider Skills Group gave guidance and clarity regarding language used, for example, breaking down the meaning of the metaphors so young people could understand them better. Use of pictorial aids helped to engage young people and aid comprehension." Child and Adolescent Mental Health Services (CAMHS) Youth Justice Health Worker.

"I just wanted to say thank you so much for your input yesterday. We thoroughly enjoyed the input and I know that it will be beneficial for us when dealing with offenders on the autistic spectrum." Feedback from Police training.

Summary

The project aims are being met and some of the work is ongoing. There will be a gap when this project is completed in November 2016 so discussion with NYCC is underway regarding this.

3.9 Cancer Services

The quality of our cancer services has always been a significant priority for the Trust. Each year we build upon previous years' achievements. Since the opening of our Sir Robert Ogden Macmillan Centre (SROMC) in March 2014 we have continued to focus upon redesign and improvement of our services. In 2015 we published our Cancer Strategy for 2015-2020 which was developed with colleagues across all specialities and with our commissioners. It reflects the Cancer Task Force publication – Achieving World Class Cancer Outcomes, A Strategy for England 2015-20 – and describes how we plan to develop our cancer services locally, in line with national direction.

Photo 11: The Sir Robert Ogden Macmillan Centre

What were we aiming to achieve?

The key priority areas for cancer services in 2015/16 were to:

- Enhance consultant oncologist and nursing provision;
- Further develop our cancer of unknown primary (CUP) service;
- Develop enhanced holistic care assessments;
- Improve access to psychological care;
- Grow our Health and Wellbeing service.

What have we done?

Enhance consultant oncologist and nursing provision

As numbers of diagnosed cancers continue to grow and options for treatment and lines of subsequent treatments continue to expand so does the need for more oncologist and nurse time. This year we have been successful in a bid to Macmillan for an additional clinical nurse specialist post in the Urology service along with some co-ordinator support roles for haematology and colorectal specialities. These co-ordinator roles will assist the clinical nurse specialists in their duties, enabling them to spend more time with direct patient contact work.

We will be seeking to appoint another consultant oncologist to join Dr Dugdale and our team to enable us to increase clinic provision for currently treated cancers as well as start to treat more patients locally who currently go to Leeds for chemotherapy. We plan to repatriate patients for treatment of ovarian cancer in the first instance and are working closely with our colleagues in gynaecology to ensure pathways for service provision on both an inpatient and outpatient basis are clear in advance of patients moving back from Leeds.

Development of our cancer of unknown primary (CUP) service

Over the last two years we have transformed our service. The pathway is now more streamlined with increased support to patients and families at all stages. The presence 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 or end of life care.

This year we have worked closely with our GP lead for cancer and increased the profile of the service so that GPs are aware how to make contact to refer or receive advice on patients they are concerned about.

Develop enhanced holistic care assessments

In 2015 we were successful in a bid to Macmillan to introduce electronic holistic needs assessment (e-HNA). 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. Better understanding the needs of patients will help us plan future capacity and better direct our support services to patients' needs.

What the patients say ……

> In general patients have responded very well and found the tablet simple to use. Very few people have not wanted to participate. Some patients have said that seeing an improvement in their condition or level of anxiety in between assessments is very reassuring.

What the staff say ……

Although time consuming, going through a structured assessment is really valuable. Issues that patients may not otherwise have mentioned have come to light, some quite longstanding, and have now been addressed. The number of phone calls from patients has reduced, as concerns are being aired and discussed more fully during the care planning process. The 'end of treatment' assessments have proved most valuable – providing the opportunity to start a conversation about topics which would not formerly have been discussed in a follow-up appointment.

Future plans include roll out to other cancer sites and uploading the care plans to electronic systems so all professionals have access to them when treating cancer patients.

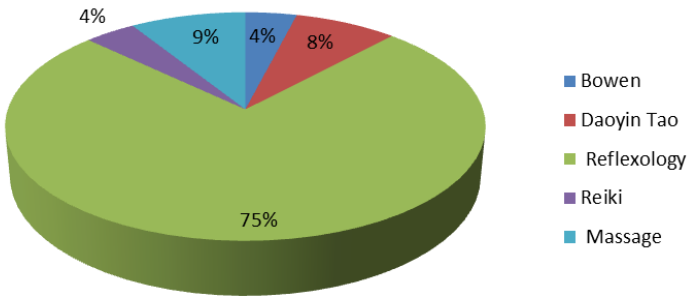
Grow our Health and Wellbeing Service

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.

	2015	Increase on 2014
Number of referrals	404	20%
Total claimed in annualised benefits	£1,517,588	23.6%
Total in backdated benefit arrears claimed	£67,024	29.8%
Total of Macmillan grants claimed	£13,400	73.1%
Total of other charitable grants	£3,336	N/A (1st year counted)

Table 47: Macmillan Welfare and Benefits service activity



The complementary therapy service has undergone further expansion in 2015 to meet the increasing demands on its service. A donation from the SROMC Ball Committee enabled the complementary therapist post to be expanded from 22.5 hours to 30 hours a week.

Figure 28: Breakdown of complementary therapy treatments available

The Hair Loss Support Service has also seen significant growth this year.

	2015	Increase on 2014
Wig fitting referrals	98	96%
Headwear support	132	13.7%

Table 48: Hair Loss Support Service activity

The Boots 'Feel More Like You' sessions offer professional beauty advice on skincare, make-up and nail care. Its popularity has grown, with 57 patients seen this year.

Improve access to psychological care

Continuing to improve access to psychology services for patients is crucial alongside their physical treatment, whilst providing for their wider holistic needs. Our clinical nurse specialists 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 or palliative disease.

Whilst the Cancer Clinical Psychology service has grown considerably over the last couple of years, provision continues to remain under capacity, as more patients are seen to benefit from the service so more are referred. In 2015/16 the provision will further increase by three more clinics a week with the intention of reducing the waiting list to a matter of a couple of weeks, ensuring the best level of support to our patients.

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 the National Cancer Patient Experience Survey, the National Chemotherapy Survey and local surveys.

We have achieved our cancer waiting times targets this year for all quarters and have a high level of compliance against our peer review measures. We are currently third nationally in the Cancer Patient Experience Survey and await the results of the 2015 survey which are due later this year.

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 12: Royal visit to SROMC February 2016

3.10 Community Equipment and Wheelchair Services

Community Equipment Service

The service was redesigned in 2014 and a fully electronic ordering system was introduced. Since then the service has continued to monitor performance and maintained collaborative engagement with all stakeholders. The service continues to report in detail against new specification delivery speeds of standard (within seven days), priority (next day) and urgent (within six hours).

During the last year, 100% of 'priority' and 'urgent' orders have been achieved within timescales. Overall, the service has exceeded the 95% target each quarter and has consistently scored over 97% performance for each month during quarter 4.

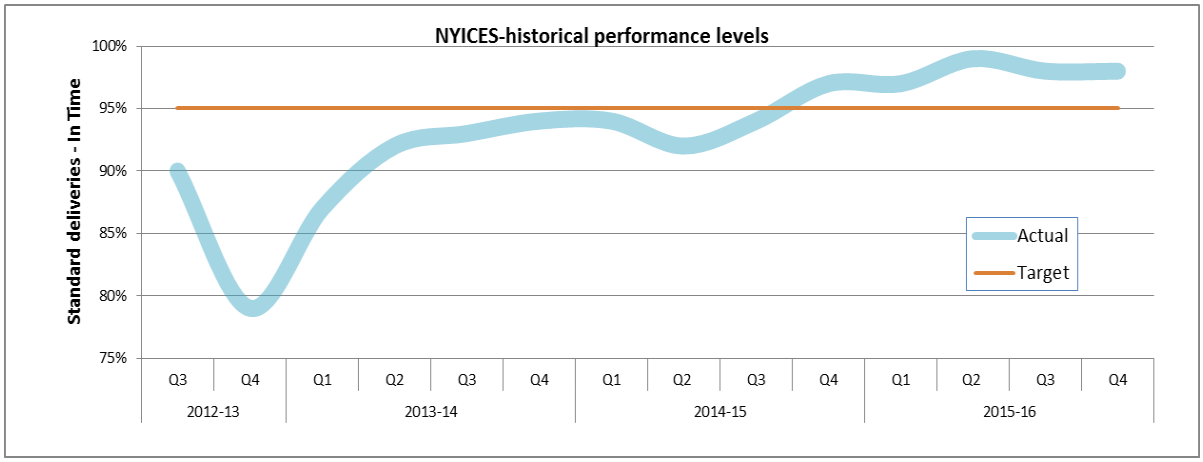


Figure 29: Percentage of requests for equipment meeting the delivery standards

Wheelchair Service

The North Yorkshire Wheelchair Service has been under considerable pressure with increasing demands for the provision of chairs in particular power chairs. In June 2015 Healthwatch published a report based on the reported experiences of users of the York Wheelchair Service which highlighted a number of areas of concern. The service was aware of many of these issues and had already started a review. Following consultation in the autumn of 2015 a new structure was proposed with a more clinically focused service with a clinical lead.

The Healthwatch report also highlighted some areas which related to the commissioning of the service. This fed into a review of the service specification which was undertaken in conjunction with the commissioners, and introduced specific key performance indicators.

July 2015 also saw the launch of the National Wheelchair Charter with ten quality pledges.

In October and November 2015 the Clinical Commissioning Group facilitated a number of events led by NHS Improving Quality which involved wheelchair users, commissioners, and the service in defining good practice and future objectives.

The service is seeing 99% of referrals within 18 weeks and the response time for repairs is consistently good with 99% of repairs, deliveries and collections within the targets. From quarter 3 the repair service left feedback cards with wheelchair users when repairs were undertaken; the results are shown in the chart below.

Part of service	Excellent	Very Good	Good	Satisfactory	Poor	Very Poor
Standard of repair	34	16	7	4		
Field Service Engineer level of care	41	13	7	4		
Administrative Service	33	15	11	3		
Response Speed	32	16	9	4		
Total	**140**	**60**	**34**	**12**	**0**	**0**

Table 49: Wheelchair repair service patient feedback Data source: Ross Care

The service also introduced the Friends and Family Test (FFT) at all four wheelchair centres in March 2016. The initial results show:

Wheelchair centre	% recommend	% not recommend	Comments
Harrogate	99%	0	"Very efficient and effective service with lots of advice and able to ask questions" "Brilliant service"
Scarborough	99%	0	"Very professional and friendly staff" "Staff so friendly and helpful"
York	94%	2%	"Therapist was very helpful and made sure the patient was comfortable in his new wheelchair" "Excellent and meticulous attention to detail".
Northallerton	100%	0	"Very helpful" "XXX has always been so warm and friendly and given us fantastic service thank you as always".

Table 50: Wheelchair Service FFT results

Summary

Significant progress has been made with the provision of community equipment in the last year. The Wheelchair Service has been an area of concern but work has been undertaken to define standards and ensure measurement of performance and patient experience. We are continuing to work through areas to help improve standards and consistency across the four localities, and are hoping to have a new clinical lead in post soon.

3.11 Duty of candour

We adopt the principles of being open and fully support our staff to apologise to patients and share investigations into incidents where appropriate. Duty of candour guidance has been rolled out across the organisation via a task and finish group, staff leaflet, toolkit on the intranet and bespoke training slides that are available throughout directorates.

The duty of candour process is triggered following identification of an incident where the severity (degree of harm to patient) is moderate or above together with significant harm.

At HDFT we have developed a process for clinicians to form a view guided by Risk Management on whether the duty applies which includes guidance on what to do and timescales for conversations with patient or their representatives, template letters and investigative toolkits. A duty of candour letter would usually be signed by the Chief Executive or the patient's consultant depending on each individual case. The letter is drafted based on the content of the discussion.

On identification of the incident an investigation is undertaken and root cause analysis may be completed using the Trust's concise or comprehensive template. All investigation reports are reviewed by the Trust's Complaints and Risk Management Group (CORM) which is chaired by the Medical Director. Disclosure to patients and/or relatives who have indicated that they wish to see the findings of the investigation is then concluded with the offer of a meeting via the Chief Executive.

Quarterly monitoring of compliance for all incidents triggering the duty of candour requirements is undertaken and reported to the Learning from Patient Experience Steering Group and Quality Committee as part of the patient experience and incident report. Results up to quarter 3 demonstrate 94% compliance.

In addition, during 2015 a baseline audit of the process was conducted by the Clinical Effectiveness and Audit Department in order to provide feedback on the pilot process that was implemented via the task and finish group and identify any areas for improvement. The results have indicated that the process requires further refinement in order that we can comprehensively demonstrate compliance with all aspects of the duty.

3.12 Sign up to Safety campaign

The Trust was awarded funding from the NHS Litigation Authority to support our safety improvement plan which was developed as part of the national Sign Up to Safety campaign. Sign up to Safety is a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible.

The funding was to be prioritised for the Maternity Department where we were aiming to achieve a measurable improvement in the quality of patient focused care in relation to human factors that contribute to a positive safety culture i.e. embedding reporting and learning from incidents and near misses, leadership, communication, escalation, and team working. We aim to then share learning across other specialities.

We engaged with maternity staff and measured the patient safety culture using the Manchester Patient Safety Framework. 48 colleagues participated in this structured assessment and analysis demonstrated that investment was needed in communications tools, techniques and hardware as well as some specific training and communication around foetal heart rate monitoring. Feedback suggested that reporting and learning from incidents was well embedded.

The department will focus on human factors training and adapting this training to maternity, promoting a positive safety culture, learning from incidents, implementation of the new NICE guidance on cardiotocography (CTG) interpretation (electronic monitoring of foetal heartbeat and uterine contractions during pregnancy), and reviewing our current daily multidisciplinary case review discussion.

A Band 7 midwife has been appointed to lead this work for one day a week for one year. The midwife has a critical care and palliative care background, and is ideally positioned to see how skills and behaviours may be transferred. She will start by completing a human factors course to enable her to be a master trainer to develop other local trainers. She will consider modifying the maternity specific skills and drills course to incorporate this training, and will look at how this model can be rolled out to non-maternity areas.

This is a really exciting opportunity both for the appointed midwife and for the Maternity Department that we hope we will be able to share in the future with other departments within the Trust. We provide regular updates on progress of this project at the Improving Patient Safety Steering Group.

3.13 Patients with Learning Disabilities

We care for many patients who have a learning disability both as inpatients and outpatients and we want to ensure that they are cared for appropriately and in a way that meets their individual needs, whatever they may be.

What were we aiming to achieve?

Our aim is that all patients with learning disabilities have their individual needs meet by knowledgeable and informed staff, who will make reasonable adjustments for each patient as required. We will do this by working with individuals, groups and carers to better understand their needs and help them make choices. We will also improve staff training opportunities, so that our workforce have the knowledge and skills to provide the best care possible for people with learning disabilities.

What have we done?

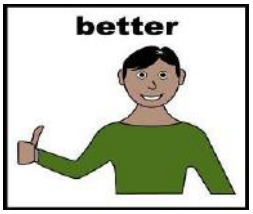
Our senior nurse adult safeguarding is now also our named nurse for learning disabilities. Developments and initiatives that have been introduced include:

- A learning disabilities webpage on the intranet with information and resources for staff;
- Identification of patients with learning disabilities on electronic patient systems using electronic flags;
- Daily email to matrons to inform them of patients with a learning disability in their area;
- Communication tools including one for pain;
- Easy read leaflets;
- Easy read Friends and Family Test posted out on discharge;
- All appropriate audits now include a cohort of patients with a learning disability;
- Reasonable adjustments information and checklists on webpage;
- Links to learning disabilities advocacy and relevant external agencies/professional groups;
- Learning disability guidance;
- Use of a vulnerable inpatient (VIP) symbol and passport for inpatients;
- Mental Capacity Act awareness raising;
- Carers accompanying patients to theatre.

What are the results?

Currently we have 208 patients with a learning disabilities flag. When any patient with a flag is admitted, they are checked on daily by the matron. We have received feedback from learning disability advocates that suggests people with a learning disability feel their care has improved since flagging was introduced, and now staff are more aware that reasonable adjustments may need to be made. Staff awareness of the needs of patients with a learning disability has also increased.

Summary



We have introduced a number of initiatives but there is much more work to be done. Although we have made significant progress over the last year, we recognise that our current provision is insufficient to reach the standard of care we are aiming for.

We are therefore recruiting a learning disabilities liaison nurse four days a week to support individual patients and carers, provide staff support and training and resources and develop and lead a high quality service to meet the needs of all people with a learning disability in our care.

Improving the care of people with learning disabilities has been identified as a quality priority for the Trust for 2016/17.

3.14 Mental Capacity and Deprivation of Liberty Safeguards

The Mental Capacity Act 2005 ("the Act") was passed by Parliament in 2005 and came into force during 2007. The Deprivation of Liberty Safeguards (DOLS) were then added to the Act and came into force in April 2009. It put the old common law on mental capacity and consent to care and treatment on a statutory footing for the first time, and added a number of extra provisions.

The Act has a direct impact upon patient care at all levels, both in hospital and in the community. All healthcare professionals, without exception, are under a legal obligation to follow the principles set out in the Act, and to have regard to the Mental Capacity Act Code of Practice, whenever dealing with a patient who may lack capacity to consent to the care or treatment they are offered.

Our staff employ a proactive approach to seeking consent and aim to maximise the person's involvement in decision-making about their care and treatment. For many patients this is straightforward but an increasing number of patients have impaired capacity to make a decision about their care and treatment. Conditions that may affect someone's mental capacity for decision making include dementia, learning disabilities, delirium and mental health illnesses.

Staff need to be able to recognise when someone's decision making could be impaired and know how to continue to provide care and treatment for them within the legal framework of the Act. However an initial staff survey demonstrated a lack of knowledge and understanding regarding the Act and DOLS.

In October 2015 we set up a task and finish group to define training requirements, update and review guidance and implement the necessary training.

Awareness events were undertaken between December 2015 and January 2016 to promote understanding of the Act and DOLS process to clinicians.

Photo 13: Staff promoting the Act and DOLS during awareness events

Clinical and nursing members of the task and finish group went to each ward to speak with front line staff and to distribute Mental Capacity Act prompt cards as well as holding lunchtime drop in sessions in Herriot's Restaurant where staff could ask questions about the Act and DOLS.

The prompt cards include practical decision making tools which could be used by medical and nursing staff to carry out capacity assessments, best interest and DOLS assessments as well as containing the principals of the Mental Capacity Act 2005.

A number of master classes were also arranged in December 2015 and January 2016. These were delivered by Helen Kingston of DAC Beachcroft solicitors and aimed at senior clinical and nursing staff and managers. These were well received by those in attendance, and further training will be arranged through 2016/17.

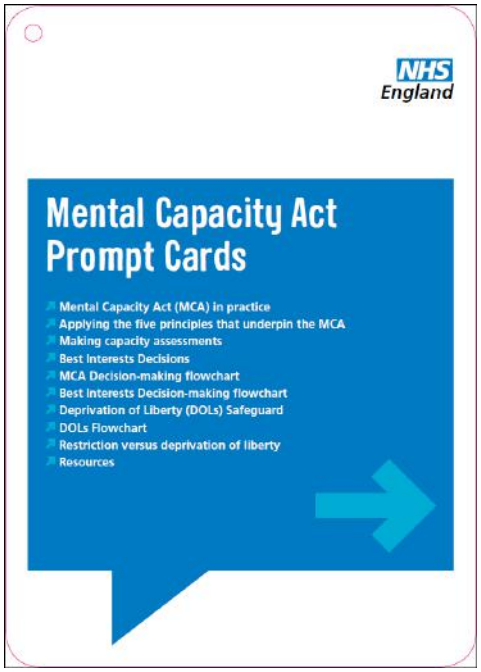


Figure 30: MCA Prompt cards

What are the results?

As of 11th March 2016, over 686 employees have received prompt cards and 95 staff had attended a master class.

Following the awareness events, master class sessions and additional pieces of work a follow up survey was undertaken which demonstrated an improvement in overall confidence with the Mental Capacity Act. The survey also demonstrated a significant improvement in the proportion of staff who felt able to describe stages 1 and 2 of the mental capacity test, and name the five principles of the Mental Capacity Act following training.

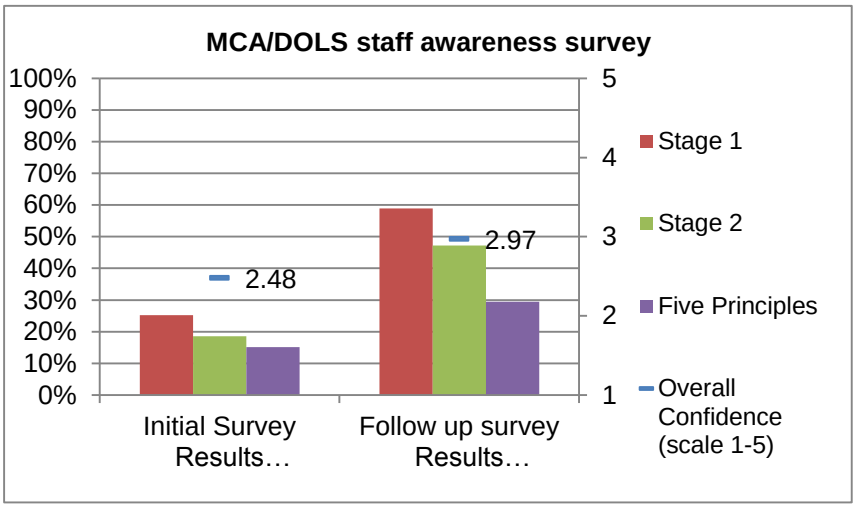


Figure 31: MCA/DOLS Staff awareness survey results

Summary

The task and finish group will continue to progress work to promote awareness around the Mental Capacity Act and DOLS process. The Integrated Care Directorate are in the process of developing a business plan to appoint a Mental Capacity Act/Deprivation of Liberty Safeguards/Mental Health Act specialist advisor to support this work.

3.15 Transfusion sample labelling audit

Prior to a blood transfusion, a blood sample is taken from the patient to test the blood group of the patient and to match it with donor blood. Errors in the labelling of blood samples are a potential cause of harm for transfusion if they are not detected and corrected. As a result of ongoing work by our transfusion team the numbers of transfusion sample labelling errors have reduced significantly over the past five years. All mislabelled samples are rejected and a repeat sample is requested so there is no harm to the patient from a mismatched transfusion.

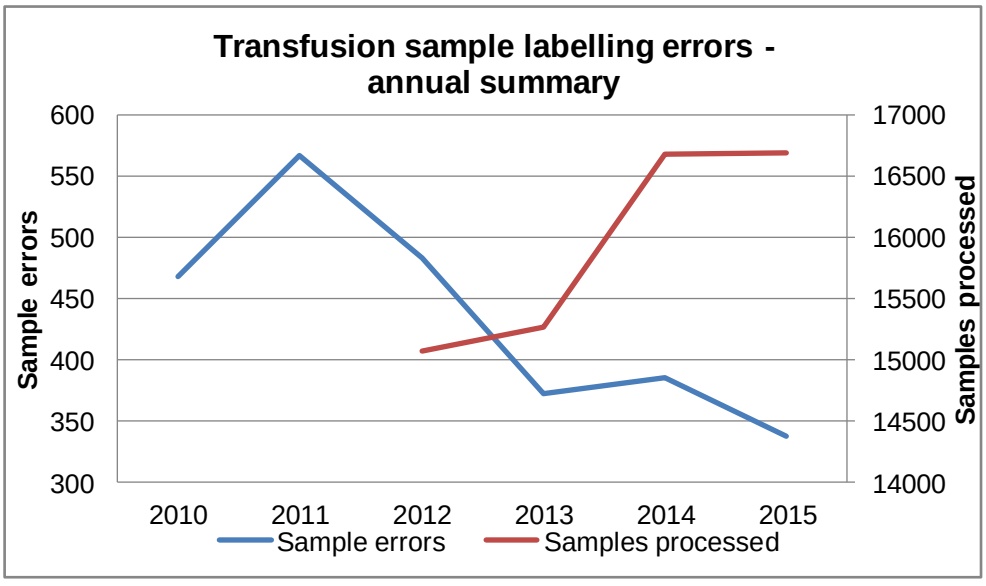


Figure 32: Annual summary of sample labelling errors

The processes involved in dealing with the labelling errors have included;

1. Identifying trends in errors e.g. repeated errors from certain staff or locations;
2. Discussing the error with the individual when possible, identifying the root cause of error and educating at the same time;
3. Any persistent offenders (three or more errors) are referred for reassessment using the national skills for health standard;
4. Disseminating four monthly reports to relevant clinical and governance staff;
5. Sending monthly reports to the clinical lead in the Emergency Department to discuss with staff;
6. Reporting any serious errors (wrong blood in tube) to Serious Hazards of Transfusion (SHOT) and reassessing the member of staff;
7. Reviewing all reports at the Harrogate Transfusion Committee.

Summary

As a result of diligent work by our transfusion team the numbers of transfusion sample labelling errors have reduced significantly over the past five years, despite a significant increase in the number of samples processed. This is an example of ongoing work to improve the safety and quality of clinical processes.

4. ANNEX ONE: STATEMENTS FROM STAKEHOLDERS

In accordance with the NHS Quality Accounts Regulations, Harrogate and District NHS Foundation Trust sent a copy of the draft Quality Account to its lead Clinical Commissioning Group, Harrogate and Rural District, Healthwatch North Yorkshire, North Yorkshire County Council Scrutiny of Health Committee, the Council of Governors and the Health and Wellbeing Board for comment prior to publication and received the following statements:

NHS HARROGATE AND RURAL DISTRICT CLINICAL COMMISSIONING GROUP QUALITY ACCOUNT STATEMENT 2015/16

The Harrogate and Rural District Clinical Commissioning Group (CCG) are pleased to be able to review and comment on the Quality Account for 2015/16.

Over the past 12 months we have worked together as Commissioners and Providers to improve the quality of patient services for the residents of the Harrogate and Rural District. Through the contract management process the Trust has provided assurance to the CCG, by sharing a breadth of data and quality metrics which have assured us of the quality of patient services. Through our meetings with the Trust, the CCG is assured that the Trust takes its responsibility seriously to learn from findings such as those from serious incident reviews and infection control meetings.

The Quality Account for Harrogate and District NHS Foundation Trust provides a very comprehensive, accurate and honest account of the quality of patient care provided. We are pleased to note the following achievements:-

- Achievement of the Soil Association Food for Life Catering Mark Bronze Standard – the catering mark being a recognised way of improving hospital food.
- Excellent outcomes with Support for Relatives with care in the last days of life - the Trust scored 100% in response to the overall question in the National Care of the Dying Audit, 'In your opinion, were you adequately supported during his/her last two days of life?'
- The Trust continues to have good overall results for the NHS Staff Friends and Family Test – 87.8% of staff would recommend care or treatment at the Trust and 71.4% of staff would recommend the Trust as a place to work
- High Quality Cancer Care - the Trust is currently third nationally in the Cancer Patient Experience Survey and is awaiting the results for the 2015 survey.

Harrogate & District NHS Foundation Trust met all the requirements of the CQUIN Scheme in 2015/16 (subject to final confirmation) and achieved financial payment. We are currently in discussion with the Trust regarding CQUIN indicators for 2016/17.

The priorities detailed in the Quality Account for 2016/17 clearly identify the three elements of quality i.e. patient safety, clinical effectiveness and patient experience and have a real synergy with the New Care Model 'What matters to us – Improving health and wellbeing across Harrogate District'. The Trust has consulted with various stakeholders and CCG colleagues and have identified the following priorities for 2016/17:-

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

The CCG is pleased to be able to work with the Trust and other provider organisations towards more integrated care as part of the necessary sustainability and transformational approach needed to withstand the increasing financial pressures on the overall system.

We recognise that Harrogate & District NHS Foundation Trust works hard to deliver quality outcomes and would like to commend them on their performance within the NHS constitution. We look forward to working collaboratively with the organisation in 2016/17.

Amanda Bloor
Chief Officer Harrogate and Rural District Clinical Commissioning Group

HEALTHWATCH NORTH YORKSHIRE QUALITY ACCOUNT STATEMENT 2015/16

Healthwatch North Yorkshire is assured that it has not received any issues of concern around the services provided by Harrogate District NHS Foundation Trust. We are reassured to see that there has been a drop of 20% in the number of complaints in comparison to data from the year before. The Trust's friends and family test results continue to show strong performance, consistently above 90% across all services with especially strong results in Maternity. In terms of performance the Trust is strong in terms of operational performance achieving the majority of targets. Quality indicator targets, while not as strong, are still very good and finance and efficiency is good but shows room for improvement. The Trust board have shown a willingness to engage with Healthwatch North Yorkshire and we are confident they are focused on delivering the best quality of care and working with Healthwatch to achieve this.

Nigel Ayre
Delivery Manager
Healthwatch North Yorkshire

NORTH YORKSHIRE COUNTY COUNCIL SCRUTINY OF HEALTH COMMITTEE QUALITY ACCOUNT STATEMENT 2015/16

On behalf of County Councillor Jim Clark (Chairman, NY Scrutiny of Health Committee) I confirm that while he appreciates the opportunity to comment on the Trust's Quality Account he will not be offering any comments this year.

Bryon Hunter
Scrutiny Team Leader
Policy and Partnerships Unit
Central Services Directorate
North Yorkshire County Council

COUNCIL OF GOVERNORS QUALITY ACCOUNT STATEMENT 2015/16

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 operational plan, have contributed to the development of the quality priorities for the coming year, 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 and committee meetings, particularly the newly constituted Quality Committee which have delegated responsibility and oversight of the Trust's progress towards achieving the quality priorities. The Council of Governors have in-depth discussions with Executive Directors and Non-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.

Pamela Allen
Lead Governor

HEALTH AND WELLBEING BOARD QUALITY ACCOUNT STATEMENT 2015/16

Health and Wellbeing Board were sent a copy of the Quality Account on 1 April 2016. No comment was received.

5. ANNEX TWO: STATEMENT OF DIRECTORS' RESPONSIBILITIES

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

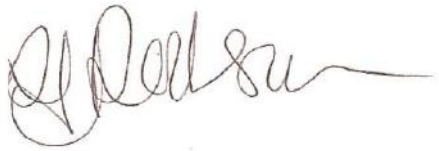
Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

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 2015/16;
- 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 2015 to March 2016
    - Papers relating to Quality reported to the Board over the period April 2015 to March 2016
    - Feedback from the commissioners dated 28 April 2016
    - Feedback from Governors dated 29 April 2016
    - Feedback from Healthwatch North Yorkshire dated 19 May 2016
    - Feedback from North Yorkshire County Council Scrutiny of Health Committee dated 3 May 2016
    - The Trust's draft complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated May 2016
    - The 2014 national patient survey dated 21 May 2015
    - The 2015 national staff survey dated 22 March 2016
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2016
    - 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 25 May 2016



Mrs Sandra Dodson
Chairman

Mr Jonathan Coulter
Acting Chief Executive

6. ANNEX THREE: NATIONAL CLINICAL AUDITS 2015/16

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2015/16	Data submitted as a percentage of the number of registered cases required for that audit
1	Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	270	100%
2	Bowel cancer (NBOCAP) *This relates to data submitted for 2014/15. The Trust has not yet submitted any patient data for 2015/16 as the deadline for this is November after the end of the financial year, therefore reporting will always be one year in arrears.*	Yes	133	122% (based on expected total of 109)
3	Cardiac Rhythm Management	Yes	209 procedures 2207 follow-ups	100%
4	Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC)	No	July to December 2014 243	100%
			January to June 2015 219	100%
5	Child health clinical outcome review programme			
	(i) Chronic neurodisability	Yes	Both are 3 year work streams so this information is not currently available	
	(ii) Young People's mental health	Yes		
6	Diabetes (Adult)			
	National Footcare Audit *Relates to records submitted between 14 July 2014 and 31 July 2015.*	Yes	30	Not stated
	National Inpatient Audit	Yes	42	100%
	National Pregnancy in Diabetes Audit	Yes	No eligible patients	No eligible patients
	National Core	Yes	Data not submitted*	Data not submitted*
7	Diabetes (Paediatric)	Yes	80	Not known

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2015/16	Data submitted as a percentage of the number of registered cases required for that audit
	This figure is for the latest round of the audit which relates to patients seen from 1 April 2014 to 31 March 2015.			
8	Elective surgery National PROMS programme (2014/15)	No	1,218 (pre-op) 933 (post-op)	114.2% 76.8%
	Elective surgery National PROMS programme (April - September 2015)	No	607 (pre-op) 114 (post-op)	115.8% 40.4%
9	Emergency Use of Oxygen	No	6	100%
10	Falls & Fragility Fractures Audit Programme (FFFAP)			
	(i) Falls	Yes	30	100%
	(ii) Fracture Liaison Service (FLS) database	Yes	Organisational questionnaire submitted only – clinical audit not relevant as we do not have a dedicated FLS	Not relevant
	(iii) National Hip Fracture Database	Yes	245	100%
11	Inflammatory Bowel Disease (IBD) programme – biologics audit	Yes	9	100%
12	Lung cancer (NLCA)	Yes	117	100%
13	Major Trauma: The Trauma Audit & Research Network (TARN)	No	132	Awaiting 2015 HES data
14	Maternal, New-born and Infant Clinical Outcome review Programme (MBRRACE-UK)	Yes	8 stillbirths 8 terminations for foetal abnormalities 6 late miscarriages 2 Neonatal deaths There have been no maternal mortality or morbidity cases to report 2015/16	100%

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2015/16	Data submitted as a percentage of the number of registered cases required for that audit
15	Medical & Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome & Death (NCEPOD)			
	(i) Gastrointestinal Haemorrhage[4]	Yes	4	100%
	(ii) Sepsis	Yes	5	100%
	(iii) Acute Pancreatitis	Yes	5	100%
	(iv) Mental Health	Yes	4	100%
16	National Audit of Intermediate Care	No	Did not participate	Did not participate
17	National Cardiac Arrest Audit (NCAA) *Figures are for April to December 2015 (Quarter 4 data not yet available)*	No	41	100%
18	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme			
	(i) Pulmonary rehabilitation *NB: Organisational questionnaires also submitted*	Yes	11	85% (13 eligible, 12 consented)
	(ii) Secondary Care *This audit took place between 1 February and 31 May 2014, and the results were reported in last year's Quality Account. There has been no further data collection during 2015/16.*	Yes	66	100%
19	National Comparative Audit of Blood Transfusion programme			
	(i) Lower GI Bleeding and the use of blood	No	Organisational questionnaire submitted only	N/A

[4] As reported in 2014/15 Quality Account - Six sets of patient data requested- 2 excluded prior to submission. 2 excluded following submission

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2015/16	Data submitted as a percentage of the number of registered cases required for that audit
	(ii) Audit of Patient Blood Management in Scheduled Surgery	No	21	100%
	(iii) Red Cell & Platelet Transfusion in Adult Haematology Patients	No	24	100%
20	National Complicated Diverticulitis Audit (CAD)	No	Did not participate	Did not participate
21	National Emergency Laparotomy Audit (NELA) *Data refers to year 2 of the audit (01/12/2014 to 30/11/2015)*	Yes	61	100%
22	National Heart Failure Audit	Yes	261	100%
23	National Joint Registry (NJR)	Yes	1020	Not known
24	National Ophthalmology Audit	Yes	First prospective data extraction not until September 2016	On-going
25	Prostate Cancer *Financial year data up to Q3 (31 December 2015) – cases from January onwards still to be validated and registered.*	Yes	118	Not stated[5]
26	Neonatal intensive and special care (NNAP) *This figure is for 2014 data published in the November 2015 annual report.*	Yes	Number of completed episodes of care included – 151 Number of distinct babies included - 137	Not stated

[5] *Please note, case ascertainment is not currently measured for prostate patients at the moment but will be in future. The cancer registry have run their own analysis on our data and have confirmed that our figures are as expected.*

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2015/16	Data submitted as a percentage of the number of registered cases required for that audit
27	Oesophago-gastric cancer (NAOGC) *This relates to data submitted for 2014/15. The Trust has not yet submitted any patient data for 2015/16 as the deadline for this is November after the end of the financial year, therefore reporting will always be one year in arrears.*	Yes	56	144% (based on expected total of 39)
28	Paediatric Asthma	No	Did not participate	Did not participate
29	Procedural Sedation in Adults (CEM)	No	33	100%
30	Pulmonary Hypertension	No	Did not participate	Did not participate
31	Rheumatoid and early inflammatory arthritis *This includes patients recruited between 1 April and 30 October 2015 when data collection was put on hold nationally until the next phase of the audit resumes.*	Yes	5	Not identified due to coding
32	Sentinel Stroke National Audit Programme (SSNAP)	Yes	366	100%
33	UK Parkinson's Audit (previously known as National Parkinson's Audit)			
	Occupational Therapy	No	10	100%
	Speech and Language Therapy	No	10	100%
	Physiotherapy	No	11	110% (10 minimum requirement)
	Patient Management, elderly care and neurology	No	33	165% (20 minimum requirement)
34	Vital signs in Children (CEM)	No	52	100%
35	VTE risk in lower limb immobilisation (CEM)	No	42	100%

For information, the Trust also participated in the following audits:

Data submitted to National Audits not included in Healthcare Quality Improvement Partnership's (HQIP) Quality Accounts List	Number of patients for which data submitted 2015/16	Data submitted as a percentage of the number of registered cases required for that audit
End of Life Care Audit: Dying in Hospital	46	100%

The following seven NCAPOP audits were not relevant to HDFT due to the Trust not providing the service:

- Adult Cardiac Surgery
- Chronic Kidney Disease in primary care
- Congenital Heart Disease (both paediatric and adult work streams)
- Coronary Angioplasty/National Audit of PCI
- Mental Health Clinical Outcome Review Programme/National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH) (all work streams)
- National Vascular Registry
- Paediatric Intensive Care Audit Network (PICANet)

The following 3 non-NCAPOP audits were not relevant to HDFT due to the Trust not providing the service:

- Prescribing Observatory for Mental Health (POMH-UK) (all work streams)
- Renal replacement therapy (Renal Registry)
- UK Cystic Fibrosis Registry (paediatric and adult)

The following non-NCAPOP audits, which were initially included in HQIP's Quality Accounts list, or were included in a mid-year update, did not end up running during 2015/16 and so are not included in the table above:

- Adult Asthma
- Non Invasive Ventilation (adults)
- Paediatric Pneumonia
- Adult Bronchiectasis

**Data was prepared but not submitted due to an administrative error. The report and recommendations will be analysed and learning implemented as usual.*

7. ANNEX FOUR: GLOSSARY

AMU	Acute Medical Unit
CAHMS	Child and Adolescent Mental Health Services
CAT	Clinical Assessment Team
CATT	Clinical Assessment, Triage & Treatment
CCG	Clinical Commissioning Group
CEM	Royal College of Emergency Medicine
CFRRT	Community Fast Response and Rehabilitation Team
CNS	Clinical Nurse Specialist
CQUIN	Commissioning for Quality and Innovation
Dashboard	Data visualisation tool that displays the current status of metrics and key performance indicators
DNACPR	Do not attempt cardiopulmonary resuscitation
DOLS	Deprivation of liberty safeguards
ED	Emergency Department
ePMA	Electronic prescribing and medicines administration system
FFT	Friends and Family Test
HaRD	Harrogate and Rural District
HDFT	Harrogate and District NHS Foundation Trust
HDU	High Dependency Unit
HQIP	Healthcare Quality Improvement Partnership
ICE	Requesting and reporting software
ITU	Intensive Therapy Unit
KPI	Key performance indicator
LD	Learning disabilities
MCA	Mental Capacity Act
MDT	Multidisciplinary team
NCDAH	National Care of the Dying Audit of Hospitals
NCAPOP	National Clinical Audit and Patient Outcome Programme
NCEPOD	National Confidential Enquiry into Patient Outcome & Death
NatSSIP	National Safety Standards for Invasive Procedures
NICE	The National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System
PVG	Patient Voice Group
QI	Quality indicator
RTT	Referral to treatment
SIRI	Serious incident requiring investigation
SSNAP	Sentinel Stroke National Audit Programme
TTO	To take out (medicines)
VIP	Vulnerable inpatient
WHO	World Health Organisation

If you require this document in an alternative language or format (such as Braille, audiotape or large print), please contact our Patient Experience Team: thepatientexperienceteam@hdft.nhs.uk or 01423 555499.

Electronic copies of this Quality Account can be obtained from our website (www.hdft.nhs.uk). If you have any feedback or suggestions on how we could improve our Quality Account, please do let us know by emailing bulletin@hdft.nhs.uk.

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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 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge;

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 and supporting guidance 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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2015/16 ('the Guidance'); and
- the indicator 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, supporting guidance 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 supporting guidance 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 and papers for the period April 2015 to May 2016;
- papers relating to quality reported to the board over the period April 2015 to May 2016;
- feedback from commissioners;
- feedback from governors;
- feedback from local Healthwatch organisations;
- feedback from Overview and Scrutiny Committee;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2014 national patient survey;

- the 2015 national staff survey;
- the 2015/16 Head of Internal Audit's annual opinion over the trust's control environment; and
- the May 2015 CQC Intelligent Monitoring Report.

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 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. 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 indicator;
- 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 and supporting guidance to the categories reported in the Quality Report; and
- 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 and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was 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 2016:

- 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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual, supporting guidance and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
Manchester

26 May 2016

Harrogate and District NHS
NHS Foundation Trust

Harrogate and District NHS Foundation Trust Consolidated Financial Statements 31 March 2016.

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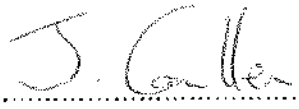
FOREWORD TO THE ACCOUNTS

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

The accounts for the year ended 31 March 2016 are set out on the following pages and comprise the Consolidated Statement of Comprehensive Income, the Consolidated Statement of Financial Position, the Consolidated Statement of Changes in Tax Payers' Equity, the Consolidated Statement of Cash Flows and the Notes to the Consolidated Accounts.

The accounts have been prepared by the Harrogate and District NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7, to the National Health Service Act 2006 in the form in which Monitor, the Independent Regulator of NHS Foundation Trusts, has, with the approval of HM Treasury, directed.

Signed:  Jonathan Coulter - Chief Executive (Acting)

Date: 25 May 2016.

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF THE HARROGATE AND DISTRICT NHS FOUNDATION TRUST

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS foundation trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officers' Memorandum issued by 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 them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officers' Memorandum.

Signed: ..... Jonathan Coulter - Chief Executive (Acting)

Date: 25 May 2016.

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 2016 set out on pages 17 to 56. 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 2016 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 2015/16.

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 have been included below. There have been no changes to the risks included in this report compared with the independent auditor's report issued in respect of the 2014/15 financial statements.

Valuation of Land and Buildings - £85.7 million (2014/15: £76.9m)

Refer to page 75 of the Annual Report (Specific significant issues discussed by the Audit Committee during 2015/16), page 26 of the Consolidated Financial Statements (accounting policy) and pages 46 to 47 of the Consolidated Financial Statements (financial disclosures).

The risk: Land and building valuation is an estimate, arrived at 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 operations use, and, for specialised assets where no market value is readily ascertainable, the depreciated replaced cost (DRC) of a modern equivalent asset that has the same service potential as the existing property. There is significant judgement involved in determining the appropriate basis (EUV or DRC for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation, including the condition of the assets. In particular the DRC 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 2015/16 an interim "desk –top" revaluation of all the land and buildings, which did not involve the physical inspection of the assets, was undertaken by the 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 out 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 accounts for in line with applicable accounting standards and the FT ARM; and

- Assessing the adequacy of the disclosures about the key judgements and degree of estimation involved in arriving at the valuation and the related sensitivities.
- Checking the revaluation basis and considering its appropriateness in line with NHS FT ARM guidance.
- Assessing, in the light of our knowledge of the Trust's assets whether the selection of land and buildings covered by the valuation included all assets

NHS Income Recognition - £168.2 million (2014/15: £168.8m)

Refer to page 74 of the Annual Report (Specific significant issues discussed by the Audit Committee during 2015/16), page 25 of the Consolidated Financial Statements (accounting policy) and pages 35 to 37 of the Consolidated Financial Statements (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 Departments of Health's resource accounts. The AoB exercise identifies mismatches between income and expenditure and receivable and payable balances recognised by the Group and its commissioners 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 Trust's 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 £3.7 million (2014/15: £4 million), determined with reference to a benchmark of income from operations (of which it represents 2% (2014/15: 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 £185,000 (2014/15: £200,000), in addition to other identified misstatements that warrant reporting on qualitative grounds.

The Group has two reporting components and all of them were subject to audits for group reporting purposes performed by the Group audit team at one location in Harrogate. These audits covered

100% of group income, deficit for the year and total assets. The audits performed for group reporting purposes were all performed to materiality levels set individually for each component and ranged from £3.7 million to £70,000. (2014/15: £4 million to £50,000)

4 Our opinion on other matters prescribed by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

5 We have nothing to report in respect of the matters on which we are required to report by exception

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 entitled 'Work of the Audit Committee', which described the work of the audit committee, does not appropriately address matters communicated by us to the audit committee.

Under the Code of Audit Practice we are required to report to you if in our opinion:

- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16, 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.

In addition we are required to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in respect of the above responsibilities.

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 Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Respective responsibilities of the accounting officer and auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page 2 of the Consolidated Financial Statements 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.

Respective responsibilities of the Trust and auditor in respect of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General (C&AG), as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The C&AG determined this criterion as necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

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.

Andrew Smith, for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants

KPMG LLP

1 St Peter's Square

Manchester

M2 3AE

26th May 2016

Annual Governance Statement 2015/16

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Harrogate and District NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Harrogate and District NHS Foundation Trust (the Trust) for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

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

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

- Staff in dealing with specific everyday risks, e.g. basic risk management information including an overview of patient safety, incident reporting and investigation, complaints investigation and development of measures to improve patient experience, fire safety, information governance, health and safety, moving and handling, infection control, and security; and
- Specific staff involved in the maintenance of risk registers at directorate and department level, investigation and root cause analysis, the investigation of serious incidents requiring investigation (SIRIs) and risk assessment for health and safety.

The Trusts Human Resources Department monitors all mandatory and essential training and reports directly to the Board of Directors. 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 Trust supports an "open" culture, meaning that we are open with service users, carers and staff when things go wrong. A significant emphasis is placed upon ensuring that we comply with the requirements of the statutory duty of candour that came into force on 27 November 2014.

This follows the introduction of a number of new standards that NHS boards need to comply with including not only duty of candour, but also the fit and proper person's test and improving openness and transparency. The Board receives regular updates to ensure compliance in these areas.

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

Whilst equality impact assessments are integrated into core Trust business, further work will be undertaken during 2016/17 to improve the information that the Board and its committees receive in terms of equality related impacts, risks and how these will be managed.

The risk and control framework

The key objectives regarding risk and control are to achieve:

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

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

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

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

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

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

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

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

1. Departmental

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

All risks that are scored 9 or above on departmental risk registers are escalated to directorate risk registers.

2. Directorate

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

The directorate risk register will reflect departmental risk registers where relevant by including risks that are scored 9 or above or form a trend across departmental registers. It is the responsibility of the directorate leads to review and where appropriate, challenge scores applied to risks on departmental registers at least quarterly. At this level risk assessment is performed alongside objective setting and business planning.

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

3. Corporate

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

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

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

4. Board Assurance Framework

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

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

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

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

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

The highest scoring risks on the corporate risk register for 2015/16 and going forward relate to:

- Risk to business objectives due to non-delivery of integrated Electronic Patient Record and Digital Roadmap requirements;
- Risk to the quality of service delivery in Medicine due to reduction in trainee numbers; and
- Risk of patient harm and risk to service delivery due to lack of experienced qualified nurses due to national shortage in registered nurses.

During 2015/16 the risks associated with the following were mitigated and removed from the corporate risk register to continue being managed on directorate or corporate functions risk registers:

- Risk of harm to patients and staff due to gaps in assurance on building safety for non-Trust owned premises;
- Harm to ophthalmology patients and risk to reputation due to the high number of follow up patients who have passed due follow up date;
- Patient harm due to failure to identify and manage mental health and mental capacity needs;
- Risk to the quality of service delivery due to failures of medical devices and equipment;
- Risk of delays to patient care due to failure of chemo isolator;
- Risk of 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; and
- Risk of loss of Clinical Pathology Accreditation (CPA) due to non-conformity with ISO15189 CPA standard in the transfusion laboratory.

During 2015/16 the strategic risks identified on the Board Assurance Framework included:

- Risk of a lack of medical, nursing and clinical staff;
- Risk of high levels of frailty in local population;
- Risk of failure to learn from feedback and incidents;
- Risk of insufficient focus on quality in the Trust;
- Risk of failure to deliver integrated models of care;
- Risk of a lack of interoperable systems across New Models of Care partners to enable access by all concerned to a single shared record;
- Risk of misalignment of Commissioner/partner strategic plans;
- Risk of service sustainability;
- Risk of a lack of understanding of the market;
- Risk of a lack of robust approach to new business;
- Risk of a lack of visibility and impact on reputation;
- Risk to current business;
- Risk of failure to deliver the Operational Plan;
- Risk of loss of Monitor Provider Licence; and
- Risk of the impact of external funding constraints.

In 2015/16 the Board of Directors ensured that detailed controls were in place to mitigate risks and support assurance. The Board of Directors will ensure going forward that detailed controls will continue to be in place to support assurance and mitigate risks. All risks, mitigation and progress against actions are monitored formally at Directorate, Corporate and Board level every month.

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

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

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

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

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

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

Internal Audit most recently assessed compliance with Monitor's Licence conditions in November 2014 and with CQC fitness to register in April 2016 and gave significant assurance for both. The Audit Committee reviews the evidence for compliance with CQC registration requirements annually.

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

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

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

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

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

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

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

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

- A Board which is composed of high calibre individuals from a broad spectrum of backgrounds which were observed to bring insightful challenge and debate to all aspects of the Trust's business;
- Clear processes for holding people to account for delivery which are widely considered by the workforce to be effective in practice;

- Robust succession planning which is in place several tiers below executive level; and
- The fostering of a positive culture within the Trust, with good engagement from the wider workforce in the success and sustainability of the organisation.

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

- More explicit tracking and monitoring of progress against strategic objectives and milestones at Board, committee and Directorate Board meetings;
- Restating the roles of the Board committees to ensure that they have sufficient time to cover the accountabilities set out in their terms of reference, and that the expectations of assurance reporting into them from directorates are both clarified and standardised; and
- An acknowledged need to increase the opportunities for engagement with staff working in community services.

Work has been undertaken to address each of these recommendations.

The Trust was inspected by the Care Quality Commission as part of its routine programme of inspections in February 2016. No serious matters of concern were raised as a result of the inspection. At the time of writing this statement the results of the inspection are awaited.

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

During 2015/16 there have been five formally constituted sub-committees of the Board; the Audit Committee, the Quality Committee, the Nomination Committee, the Remuneration Committee and the Finance Committee.

The Audit Committee

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

The key responsibilities of the Audit Committee are to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. The Committee ensures that there is an effective Internal Audit function that meets mandatory NHS Internal Audit Standards. Internal Audit's primary role is to provide an opinion and assurances on the adequacy and effectiveness of the systems of internal control and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. The Committee also reviews the work and findings of the External Auditors appointed by the Council of Governors and considers the implications and management's responses to their work. The Audit Committee receives reports from Internal and External Audit, the Quality Committee and the Corporate Risk Review Group which enable it to provide independent assurance on governance and controls to the Board. This also enables triangulation of key issues to enhance the Board and Committee's oversight and assurance role. The Annual Audit Plans for Clinical Audit and Internal Audit are approved by the Audit Committee and is prioritised to focus on areas of risk and concern.

The Quality Committee

The Quality Committee is a new committee commissioned following the review of quality governance during 2015 and is now the primary mechanism by which the Board gains assurance regarding the safety and quality of services.

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

The Finance Committee

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

The Remuneration Committee

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

The Nomination Committee

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

The Senior Management Team

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

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

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

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

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

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

There are regular meetings with Commissioners at the Contract Management Board to review performance and quality.

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

The robust risk and control framework described enables the Trust to declare assurance against the validity of its Corporate Governance Statement, which will be submitted to NHS Improvement (formerly Monitor) in June 2016 in line with the requirements of the Risk Assessment Framework.

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

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

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

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

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

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

The Trust produces an annual Operating Plan that is underpinned by detailed plans produced by the directorates. The Plan details how the Trust will utilise its resources throughout the year, identifies the principal risks to the delivery of the Plan and the mitigation and is supported by detailed financial forecasting.

Each directorate is required to deliver cost improvement plans in order to ensure economy, efficiency and effectiveness of the use of resources. The cost improvement plans are scrutinised and approved by the Medical Director and Chief Nurse via the process of Quality Impact Assessments to ensure the quality of services is maintained.

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

During 2015/16 the Trust conducted a carbon efficiency scheme to deliver reductions in carbon emissions and to deliver significant energy efficiency.

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

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

There is 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 2015/16.

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. They are approved by the Senior Management Team and the Board of Directors. A framework for reporting data and progress against local targets to the Quality Committee is in place. This has enabled a regular and routine review of the progress with quality improvement throughout the year.

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

Internal Audit provides further assurance regarding the systems in place to ensure that the Quality Account is compliant with national guidance and that adequate data quality controls are in place to ensure that performance data is accurate and complete. Internal Audit has examined the quality and accuracy of A&E 4 hour waits and 28 days readmission indicators. An opinion of significant assurance has been given for the Quality Account 2015/16.

Review of effectiveness

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

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

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

- NHS improvement (formerly Monitor), the regulator of NHS Foundation Trusts financial sustainability risk rating (FSRR) for the Trust is currently 3. (Risk ranges from 1, the most serious risk, to 4, the lowest risk);
- The governance risk rating, issued by NHS Improvement (formerly Monitor), is green;
- Last CQC intelligent monitoring report (2015) showed a risk score of six. This indicates the lowest priority for CQC inspection;
- CQC registration with no conditions;
- The Board Assurance Framework and the Corporate Risk Register;
- Presentation of the Annual Governance Statement to the Audit Committee by the Accountable Officer;
- The Audit Committee Annual Report, which includes Internal Audit and assurance relating to Corporate Risk Review Group;
- The Quality Committee Annual Report;
- Annual report from Senior Management Team and subgroups and directorates;
- Internal and Clinical Audit Plan, prioritised on areas of risk and concern;
- Clinical Audit Annual Report;
- Internal Audit periodic reports and follow up of Internal Audit recommendations;
- Internal Audit Annual Report and Head of Internal Audit opinion;
- ISA260 Audit Highlights Memorandum (External Audit Report);
- Independent review of governance against the Well-led Framework by Deloitte (December 2015).

I am assured adequate and well-designed systems are in place, but there remain some control weaknesses in the operational compliance with these systems, evidenced by Internal Audit and the Head of Internal Audit opinion in relation to intravenous cannula care, staff rostering and safety netting (ensuring that all patients are appropriately followed up).

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 2016/17.

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: ..... Jonathan Coulter - Chief Executive (Acting)
Date: 25 May 2016.

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2016

	Note	Group 2015/16 Total £000	Group 2014/15 Total £000
Operating income from continuing operations	3	**188,913**	186,810
Operating expenses of continuing operations	4	**(186,611)**	(185,114)
OPERATING SURPLUS		**2,302**	1,696
FINANCE COSTS			
Finance income	6.1	**104**	77
Finance expense - financial liabilities	7	**(118)**	(54)
Finance expense - unwinding of discount on provisions	15.2	**(10)**	(11)
Public Dividend Capital - dividends payable		**(2,260)**	(2,530)
NET FINANCE COSTS		**(2,284)**	(2,518)
Movement in fair value of investments	10	**(106)**	143
DEFICIT FOR THE YEAR		**(88)**	(679)
Other comprehensive income			
Revaluations	9.1 & 9.2	**2,892**	2,698
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**2,804**	2,019

The notes on pages 20 to 56 form part of these financial statements.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
as at 31 March 2016

	Note	Group 31 March 2016 £000	31 March 2015 £000
Non-current assets			
Intangible assets	8	**443**	345
Property, plant and equipment	9	**98,091**	87,588
Other Investments	10	**1,750**	2,003
Trade and other receivables	12.1	**316**	360
Total non-current assets		**100,600**	90,296
Current assets			
Inventories	11.1	**2,621**	2,574
Trade and other receivables	12.1	**15,119**	10,607
Cash and cash equivalents	13	**5,568**	5,146
Total current assets		**23,308**	18,327
Current liabilities			
Trade and other payables	14	**(16,703)**	(14,577)
Borrowings	17	**(999)**	(545)
Provisions	15.1	**(101)**	(113)
Other liabilities	16	**(2,707)**	(689)
Total current liabilities		**(20,510)**	(15,924)
Total assets less current liabilities		**103,398**	92,699
Non-current liabilities			
Borrowings	17	**(11,776)**	(3,810)
Provisions	15.1	**(289)**	(360)
Total non-current liabilities		**(12,065)**	(4,170)
Total assets employed		**91,333**	88,529
Financed by taxpayers' equity:			
Public Dividend Capital		**78,678**	78,680
Revaluation reserve		**14,833**	11,922
Income and expenditure reserve		**(3,942)**	(4,302)
HDFT charitable fund reserves	24	**1,764**	2,229
Total taxpayers' equity (see page 17)		**91,333**	88,529

The notes on pages 25 to 56 form part of these financial statements.

Signed: ..... Jonathan Coulter - Chief Executive (Acting)

Date: 25 May 2016.

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2016

	HDFT charitable fund reserve	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Group Total
	£000	£000	£000	£000	£000
Balance as at 1 April 2015	2,229	78,680	11,922	(4,302)	88,529
(Deficit) for the financial year (Page 15)	20	-	-	(108)	(88)
Transfers between reserves	-	(2)	19	(17)	-
Revaluations (Note 9.1)	-	-	2,892	-	2,892
Other reserve movements - charitable funds consolidation adjustment	(485)	-	-	485	-
Balance at 31 March 2016	1,764	78,678	14,833	(3,942)	91,333

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2015

	HDFT charitable fund reserve	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Group Total
	£000	£000	£000	£000	£000
Balance as at 1 April 2014	2,331	77,409	9,301	(3,802)	85,239
(Deficit) for the financial year (Page 15)	316	-	-	(995)	(679)
Transfers between reserves	-	-	(76)	76	-
Revaluations (Note 9.2)	-	-	2,698	-	2,698
Public Dividend Capital received	-	1,271	-	-	1,271
Other reserve movements	-	-	(1)	1	-
Other reserve movements - charitable funds consolidation adjustment	(418)	-	-	418	-
Balance at 31 March 2015	2,229	78,680	11,922	(4,302)	88,529

The notes on pages 25 to 56 form part of these financial statements.

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2016

	Note	Group 2015/16 £000	2014/15 £000
Cash flows from operating activities			
Operating surplus from continuing operations		2,302	1,696
		2,302	1,696
Non-cash income and expense			
Depreciation and amortisation	4.1	4,572	4,092
Impairments	9	-	587
Reversals of impairments	9.1	(350)	-
Loss on disposal of property, plant and equipment	3 & 4	339	34
(Increase)/Decrease in trade and other receivables		(4,463)	1,565
(Increase)/Decrease in inventories	11.1	(47)	189
Increase/(Decrease) in trade and other payables		1,685	(2,119)
Increase/(Decrease) in other liabilities	16	2,018	(48)
(Decrease) in provisions		(93)	(148)
HDFT Charitable Funds - net adjustments for working capital		39	250
NET CASH GENERATED FROM OPERATIONS		6,002	6,098
Cash flows from investing activities			
Interest received		46	20
Purchase of Intangible assets	8	(204)	(170)
Purchase of Property, Plant and Equipment		(11,709)	(4,389)
Sales of Property, Plant and Equipment		-	25
HDFT Charitable funds - net cash flows from investing activities		205	59
Net cash used in investing activities		(11,662)	(4,455)
Cash flows from financing activities			
Public dividend capital received		-	1,271
Loans received from the Department of Health	17	8,965	-
Loans repaid to the Department of Health		(545)	(545)
Interest paid		(73)	(59)
PDC dividend paid		(2,265)	(2,586)
Net cash generated/(used) in financing activities		6,082	(1,919)
Net increase/(decrease) in cash and cash equivalents	13	422	(276)
Cash and cash equivalents at 1 April 2015	13	5,146	5,422
Cash and cash equivalents at 31 March 2016	13	5,568	5,146

The notes on pages 25 to 56 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2016

	Note	Foundation Trust 2015/16 Total £000	Foundation Trust 2014/15 Total £000
Operating income from continuing operations	3	**188,996**	186,685
Operating expenses of continuing operations	4	**(186,277)**	(184,687)
OPERATING SURPLUS		**2,719**	1,998
FINANCE COSTS			
Finance income	6	**46**	20
Finance expense - financial liabilities	7	**(118)**	(54)
Finance expense - unwinding of discount on provisions	15.2	**(10)**	(11)
Public Dividend Capital - dividends payable		**(2,260)**	(2,530)
NET FINANCE COSTS		**(2,342)**	(2,575)
SURPLUS/(DEFICIT) FOR THE YEAR		**377**	(577)
Other comprehensive income			
Revaluations	9.1 & 9.2	**2,892**	2,698
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**3,269**	2,121

The notes on pages 25 to 56 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF FINANCIAL POSITION
as at 31 March 2016

	Note	Foundation Trust 31 March 2016 £000	31 March 2015 £000
Non-current assets			
Intangible assets	8	**443**	345
Property, plant and equipment	9	**98,091**	87,588
Trade and other receivables	12.1	**316**	360
Total non-current assets		**98,850**	88,293
Current assets			
Inventories	11.1	**2,621**	2,574
Trade and other receivables	12.1	**15,000**	10,580
Cash and cash equivalents	13	**5,527**	4,898
Total current assets		**23,148**	18,052
Current liabilities			
Trade and other payables	14	**(16,557)**	(14,528)
Borrowings	17	**(999)**	(545)
Provisions	15.1	**(101)**	(113)
Other liabilities	16	**(2,707)**	(689)
Total current liabilities		**(20,364)**	(15,875)
Total assets less current liabilities		**101,634**	90,470
Non-current liabilities			
Borrowings	17	**(11,776)**	(3,810)
Provisions	15.1	**(289)**	(360)
Total non-current liabilities		**(12,065)**	(4,170)
Total assets employed		**89,569**	86,300
Financed by taxpayers' equity:			
Public Dividend Capital		**78,678**	78,680
Revaluation reserve		**14,833**	11,922
Income and expenditure reserve		**(3,942)**	(4,302)
Total taxpayers' equity (see page 21)		**89,569**	86,300

The notes on pages 25 to 56 form part of these financial statements.

Signed: ..... Jonathan Coulter - Chief Executive (Acting)

Date: 25 May 2016.

FOUNDATION TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2016

	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Foundation Trust Total
	£000	£000	£000	£000
Balance as at 1 April 2015	78,680	11,922	(4,302)	86,300
Surplus for the financial year	-	-	377	377
Transfers between reserves	(2)	19	(17)	-
Revaluations (Note 9.1)	-	2,892	-	2,892
Balance at 31 March 2016	78,678	14,833	(3,942)	89,569

FOUNDATION TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2015

	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Foundation Trust Total
	£000	£000	£000	£000
Balance as at 1 April 2014	77,409	9,301	(3,802)	82,908
(Deficit) for the financial year	-	-	(577)	(577)
Transfers between reserves	-	(76)	76	-
Revaluations (Note 9.2)	-	2,698	-	2,698
Public Dividend Capital received	1,271	-	-	1,271
Other reserve movements	-	(1)	1	-
Balance at 31 March 2015	78,680	11,922	(4,302)	86,300

The notes on pages 25 to 56 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2016

	Note	Foundation Trust 2015/16 £000	2014/15 £000
Cash flows from operating activities			
Operating surplus from continuing operations		2,719	1,998
		2,719	1,998
Non-cash income and expense			
Depreciation and amortisation	4.1	4,572	4,092
Impairments	9	-	587
Reversals of impairments	9.1	(350)	-
Loss on disposal of property, plant and equipment	3 & 4	339	34
(Increase)/Decrease in trade and other receivables		(4,371)	1,602
(Increase)/Decrease in inventories	11.1	(47)	189
Increase/(Decrease) in trade and other payables		1,627	(2,162)
Increase/(Decrease) in other liabilities	16	2,018	(48)
(Decrease) in provisions		(93)	(148)
NET CASH GENERATED FROM OPERATIONS		6,414	6,144
Cash flows from investing activities			
Interest received		46	21
Purchase of Intangible assets	8	(204)	(170)
Purchase of Property, Plant and Equipment		(11,709)	(4,389)
Sales of Property, Plant and Equipment		-	25
Net cash used in investing activities		(11,867)	(4,513)
Cash flows from financing activities			
Public dividend capital received		-	1,271
Loans received from the Department of Health	17	8,965	-
Loans repaid to the Department of Health		(545)	(545)
Interest paid		(73)	(59)
PDC dividend paid		(2,265)	(2,586)
Net cash generated/(used) in financing activities		6,082	(1,919)
Net increase/(decrease) in cash and cash equivalents	13	629	(288)
Cash and cash equivalents at 1 April 2015	13	4,898	5,186
Cash and cash equivalents at 31 March 2016	13	5,527	4,898

The notes on pages 25 to 56 form part of these financial statements.

1 GROUP ACCOUNTING POLICIES AND OTHER INFORMATION

Monitor is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (FT ARM) which shall be agreed with the Secretary of State. Consequently, the financial statements have been prepared in accordance with the 2015/16 FT ARM issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to the NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property and investments.

1.2 Consolidation

The NHS foundation trust is the corporate trustee to the Harrogate and District NHS Foundation Trust Charitable Fund (registered charity number 1050008). The NHS foundation trust has assessed its relationship with the charitable fund and determined it to be a subsidiary because the NHS foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable funds statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the NHS foundation trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the NHS foundation trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.4 Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs - NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust (consistent with all participating members of the scheme) to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

1.4 Expenditure on employee benefits (continued)

Additional pension liabilities arising from early retirements are not funded by the Scheme, except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the NHS foundation trust commits itself to the retirement, regardless of the method of payment.

Pension costs - National Employment Savings Trust (NEST) Pension Scheme

The Pensions Act 2008 requirements created a duty for the NHS foundation trust to provide a pension scheme for employees who are ineligible to join the NHS Pension Scheme. The NHS foundation trust selected NEST as it's partner to meet this duty. The scheme operated by NEST on the NHS foundation trust's behalf is a defined contribution scheme, employers contributions are charged to operating expenses as and when they become due.

1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the NHS foundation trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- individually has a cost of at least £5,000; or
- collectively has a cost of at least £5,000 and individually has a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Capitalised set up costs and grouped assets are reviewed annually and if fully depreciated are removed from the Fixed Asset Register and the Accounts.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

Land and buildings used for the NHS foundation trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the statement of financial position date. Fair values are determined as follows:

Land and specialised buildings – depreciated replacement cost
Non specialised buildings – existing use value

1.6 Property, plant and equipment (continued)

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. All valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS). The NHS foundation trust had a valuation of its land buildings carried out as at 31 March 2015 based on an alternative site in-line with HM Treasury's approach. The NHS foundation trust's management having taken advice from professionally qualified valuers, determined that a further valuation should be carried out as at 31 March 2016 ensuring that land and buildings are held at fair value. This revised valuation has been incorporated in the financial statements.

An item of property, plant and equipment which is surplus with no plan to bring back into use is valued at fair value under IFRS 13.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Costs include professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by International Accounting Standard (IAS) 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as a proxy for fair value.

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income. Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of "Other Comprehensive Income".

In accordance with the FT ARM, impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment. Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

1.6 Property, plant and equipment (continued)

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Plant and equipment assets are depreciated on a straight line basis over the following asset life ranges:

	Years
Plant and machinery	5-15
Transport equipment	10
Information technology	5-10
Furniture and fittings	5-10
Buildings and Dwellings (Assessed by a RICS qualified valuer when a valuation takes place)	1-90

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.
  - management is committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.7 Intangible assets

Intangible assets are capitalised when they have a cost of at least £5,000. Intangible assets acquired separately are initially recognised at fair value. The NHS foundation trust does not recognise any internally generated assets and associated expenditure is charged to the statement of comprehensive income in the period in which it is incurred. Expenditure on research activities is recognised as an expense in the period in which it is incurred.

Following initial recognition, intangible assets are carried at amortised historic cost as this is not considered to be materially different from fair value. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13. The NHS foundation trust's intangible fixed assets are wholly software licences which are purchased and are deemed to have a finite life determined by the licence agreement. The NHS foundation trust does not hold a revaluation reserve for intangible assets.

1.8 Leases

Finance Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating Leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight line basis over the term of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.9 Inventories

Pharmacy inventories are valued at weighted average historical cost. Other inventories are valued at the lower of cost and net realisable value using the first in, first out method.

1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.11 Provisions

The NHS foundation trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted a discount rate of 2.9% in real terms.

1.12 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to operating expenses. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed in note 15.

1.13 Non-clinical risk pooling

The NHS foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS foundation trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in the financial statements, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.15 Value Added Tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable the amounts are stated net of VAT.

1.16 Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange profits and losses are taken to the Statement of Comprehensive Income. At the Statement of Financial Position date, monetary items denominated in foreign currencies are retranslated at the rates prevailing.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. Details of third party assets are given in note 20 to the accounts.

1.18 Public Dividend Capital (PDC) and PDC dividend

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of International Accounting Standard (IAS) 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets, cash held with the Government Banking Service (GBS), excluding cash balances held in GBS accounts that relate to a short term working capital facility and any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average net assets as set out in the "pre-audit" version of the annual accounts. The dividend so calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.19 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

1.19 Losses and Special Payments (continued)

Losses and special payments are charged to the relevant functional headings in the Statement of Comprehensive Income on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.20 Corporation Tax

The NHS foundation trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this but the trust is potentially within the scope of corporation tax in respect of activities where income is received from a non public sector source.

However the NHS foundation trust has determined that it has no corporation tax liability, as all activities are either ancillary to healthcare or below the de minimus level of profit at which tax is payable.

1.21 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the NHS foundation trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described in note 1.8 above.

Purchase or sales are recognised and derecognised, as applicable, using the trade date.

All other financial assets and financial liabilities are recognised when the NHS foundation trust becomes party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the NHS foundation trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as loans and receivables.

Financial liabilities are classified as other financial liabilities.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The NHS foundation trust's loans and receivables comprise: cash and cash equivalents, NHS receivables and other receivables.

1.21 Financial instruments and financial liabilities (continued)

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income. Loans from the Department of Health are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

Impairment of financial assets

At the Statement of Financial Position date, the NHS foundation trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the assets carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly or through the use of a bad debt provision. Bad debt provisions are used when there is some uncertainty that the debt will be paid. Bad debts are written off directly only when there is certainty that the debt will not be paid.

1.22 Critical accounting estimates and judgements

The preparation of financial statements under IFRS requires the trust to make estimates and assumptions that affect the application of policies and reported amounts. Estimates and judgements are continually evaluated and are based on historical experience and other factors that are considered to be relevant.

Revisions to accounting estimates are recognised in the period that the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Although the NHS foundation trust makes estimates within these financial statements such as incomplete patient spells, accrued income, annual leave accrual and provisions e.g. early retirements, the amounts involved would not cause a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

In relation to incomplete patient spells the NHS foundation trust makes an assessment of activity crossing over the 30 September each year as a proxy for work in progress at 31 March. September is a similar month to March both in terms of the number of working days and also matches crossover days. The methodology used is to assess the value of income accounted for in the period 1 October to 31 March of that financial year which relates to activity pre-dating 30 September, this is calculated and used as the basis of the accrual.

1.22 Critical accounting estimates and judgements (continued)

In relation to estimations for uncoded NHS income at the financial yearend, the NHS foundation trust runs a forecast for income relating to March based on the average income received by specialty and point of delivery, all uncoded activity is then priced using an average. This methodology is used throughout the year and has proven to be robust with only very minor variances showing once the activity is coded and then costed.

In addition, a revaluation of the NHS foundation trust's land and buildings was undertaken at a prospective date of 31 March 2016 (see 1.6). The NHS foundation trust relies on the professional services of the Valuation Office for the accuracy of such valuations.

1.23 Non current investments

Investments are stated at market value as at the statement of financial position date. The statement of comprehensive income includes the net gains and losses arising on revaluation and disposals throughout the year.

1.24 Accounting standards and amendments that have been issued but have not yet been adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC and are required by Monitor to be adopted according to the timetable below:

Change published	Date published by IASB	Financial year for which changes first applies
IFRS 9 Financial Instruments	July 2014	Not yet EU adopted. Expected to be effective from 2018/19.
IFRS 11 Joint arrangements (amendment)	May 2014	Not yet EU adopted. Expected to be effective from 2016/17.
IFRS 15 Revenue from contracts with customers	May 2014	Not yet EU adopted. Expected to be effective from 2017/18.
IAS 16 and IAS 38 Depreciation and amortisation (amendments)	May 2014	Not yet EU adopted. Expected to be effective from 2016/17.
IAS 16 and IAS 41 Bearer plants (amendments)	June 2014	Not yet EU adopted. Expected to be effective from 2016/17.
IAS 27 Equity method in separate financial statements (amendments)	August 2014	Not yet EU adopted. Expected to be effective from 2016/17.
IFRS 10 and IAS 28 Sale or contribution of assets (amendments)	September 2014	Not yet EU adopted. Expected to be effective from 2016/17.
IFRS 10 and IAS 28 Investment entities applying the consolidation exception (amendments)	December 2014	Not yet EU adopted. Expected to be effective from 2016/17.
IAS 1 Disclosure initiative (amendment)	December 2014	Not yet EU adopted. Expected to be effective from 2016/17.
Annual Improvements to IFRS: 2012-15 cycle	September 2014	Not yet EU adopted. Expected to be effective from 2017/18.

2 Operating segments

2.1 Group operating segments

The NHS foundation trust's management has reviewed IFRS 8 (Operating Segments) and has determined that the consolidated financial statements consist of two segments "Healthcare" and "Charity".

	Group		Group	
	Healthcare 2015/16 £000	**Charity 2015/16 £000**	Healthcare 2014/15 £000	Charity 2014/15 £000
Operating Surplus/(Deficit)	**2,719**	**(417)**	1,998	(302)
Net Finance (Costs)/Income	**(2,342)**	**58**	(2,575)	57
Movement in fair value of investments	**-**	**(106)**	-	143
SURPLUS/(DEFICIT) FOR THE YEAR	**377**	**(465)**	(577)	(102)
Non-current assets	**98,850**	**1,750**	88,293	2,003
Current assets	**23,148**	**160**	18,052	275
Current liabilities	**(20,364)**	**(146)**	(15,875)	(49)
Non-current liabilities	**(12,065)**	**-**	(4,170)	-
TOTAL ASSETS EMPLOYED	**89,569**	**1,764**	86,300	2,229
Financed by taxpayers' equity:				
Public Dividend Capital	**78,678**	**-**	78,680	-
Revaluation reserve	**14,833**	**-**	11,922	-
Income and expenditure reserve	**(3,942)**	**-**	(4,302)	-
HDFT Charitable fund reserves	**-**	**1,764**	-	2,229
TOTAL TAXPAYERS' EQUITY	**89,569**	**1,764**	86,300	2,229

3 Operating Income from continuing operations

3.1 Analysis of operating income

	Foundation Trust & Group	
	2015/16	2014/15
	£000	£000
Income from activities by classification:		
Elective income	27,986	29,610
Non elective income	30,582	32,356
Outpatient income	25,442	24,238
Accident and Emergency income	5,335	5,046
Other NHS clinical income	45,739	42,809
Community services income from CCGs and NHS England	33,601	35,322
Community services income from other sources (e.g. local authorities)	6,969	4,034
Private patient income	1,446	1,419
Total income from activities	177,100	174,834

	Foundation Trust & Group	
	2015/16	2014/15
	£000	£000
Income from activities by source:		
NHS Foundation Trusts	506	359
NHS Trusts	4	3
CCGs and NHS England	166,990	167,718
Local Authorities	6,969	4,034
NHS Other	142	123
Non NHS: Private Patients	1,446	1,419
Non-NHS: Overseas patients (chargeable to patient)	55	37
NHS injury scheme (see below*)	548	584
Non NHS: Other	440	557
Total Income from activities	177,100	174,834

	Group	
	2015/16	2014/15
	£000	£000
Group other operating income:		
Research and development	1,347	1,240
Education and training	4,155	4,323
Received from other bodies: Cash donations / grants for the purchase of capital assets	-	141
Non-patient care services to other bodies	2,618	2,854
Profit on disposal of other tangible fixed assets	-	15
Reversal of impairments of property, plant and equipment	350	-
Rental revenue from operating leases (see note 3.4)	185	238
Staff recharges (secondments)	435	560
HDFT Charitable Funds: Incoming Resources excluding investment income	402	543
Other (see note 3.2)	2,321	2,062
Group total other operating income	11,813	11,976
Group total operating income	188,913	186,810

*NHS injury scheme income is subject to a provision for doubtful debts of 21.99% (2015: 18.9%) to reflect expected rates of collection.

3.1 Analysis of operating income (continued)

	Foundation Trust	
	2015/16	2014/15
	£000	£000
Total income from activities	**177,100**	174,834
Foundation Trust other operating income:		
Research and development	**1,347**	1,240
Education and training	**4,155**	4,323
Received from NHS charities: Receipt of grants/donations for capital acquisitions	**412**	392
Received from other bodies: Receipt of grants/donations for capital acquisitions	**-**	141
Non-patient care services to other bodies	**2,691**	2,880
Profit on disposal of other tangible fixed assets	**-**	15
Reversal of impairments of property, plant and equipment	**350**	-
Rental revenue from operating leases (see note 3.4)	**185**	238
Staff recharges (secondments)	**435**	560
Other (see note 3.2)	**2,321**	2,062
Foundation Trust total other operating income	**11,896**	11,851
Foundation Trust total operating income	**188,996**	186,685

3.2 Analysis of Other Operating Income: Other

	Foundation Trust & Group	
	2015/16	2014/15
	£000	£000
Car Parking	**762**	705
Estates recharges	**10**	44
IT Recharges	**-**	23
Pharmacy Sales	**12**	26
Staff accommodation rentals	**119**	114
Clinical Tests	**399**	383
Catering	**364**	350
Property Rentals	**30**	92
Other income*	**625**	325
	2,321	2,062

Monitor requires the NHS foundation trust to provide an analysis of other operating income using the categories above (see note 3.1).

*Other "Other" income includes for example Finance Staff Development levies (hosted service for the region), Mortuary fee income and income from the Trust's Staff Lottery.

3.3 Analysis of income from activities by Commissioner Requested Services (CRS) and Non-Commissioner Requested Services (Non-CRS).

	Foundation Trust & Group	
	2015/16	2014/15
	£000	£000
Commissioner Requested Services	**100,391**	98,472
Non-Commissioner Requested Services	**76,709**	76,362
Total	**177,100**	174,834

3.4 Operating lease income and future annual lease receipts

	Foundation Trust & Group	
	2015/16	2014/15
	£000	£000
Operating lease income	**185**	238
	185	238
Future minimum lease receipts due on buildings expiring		
- not later than one year;	**158**	184
- later than one year and not later than five years;	**219**	289
- later than five years.	**20**	20
	397	493

3.5 - Overseas visitors (relating to patients charged directly by the foundation trust)

Income recognised in year relating to overseas visitors was £55k (2015 £37k), cash payments received in year (relating to invoices raised in current and previous years) was £54k (2014 £36k) and amounts written off in year (relating to invoices raised in current and previous years) was £0k (2015 £5k).

4. Operating Expenses from continuing operations

4.1 Group operating expenses comprise:

	Group	
	2015/16	2014/15
	£000	£000
Services from NHS Foundation Trusts	**736**	693
Services from NHS Trusts	**809**	925
Services from CCGs and NHS England	**326**	2
Services from other NHS bodies	**5**	163
Purchase of healthcare from non NHS Bodies	**14**	18
Employee Costs - Executive directors	**904**	806
Non-executive directors	**141**	135
Employee Costs - Staff	**127,472**	128,050
Drug costs (see note 11.2)	**13,829**	13,605
Supplies and services - clinical	**17,789**	18,206
Supplies and services - general	**2,478**	2,338
Establishment	**1,358**	1,338
Research and Development	**-**	17
Transport	**807**	939
Premises - business rates payable to local authorities	**926**	805
Premises - other	**5,919**	4,997
Increase in provision for irrecoverable debts	**978**	147
Rentals under operating leases	**2,030**	1,668
Depreciation on property, plant and equipment (see note 9.1)	**4,466**	4,029
Amortisation on intangible assets (see note 8)	**106**	63
Impairments of property, plant and equipment	**-**	587
Audit services- statutory audit	**79**	67
Other auditor remuneration (external auditor only)	**6**	6
NHS Litigation Authority contribution - Clinical Negligence	**2,562**	2,641
Loss on disposal of other property, plant and equipment	**339**	49
Legal fees	**90**	147
Consultancy costs	**518**	411
Internal audit costs	**166**	166
Training, courses and conferences	**766**	723
Patients' travel	**16**	15
Redundancy	**45**	255
Early retirements	**(15)**	(14)
Hospitality	**7**	1
Insurance	**212**	234
Losses, ex gratia and special payments (see note 19)	**34**	26
Other	**359**	429
HDFT Charitable funds: Other resources expended	**334**	427
Group total operating expenses	**186,611**	185,114

4. Operating Expenses from continuing operations (Continued)

4.2 Foundation Trust operating expenses comprise:	Foundation Trust	
	2015/16	2014/15
	£000	£000
Services from NHS Foundation Trusts	736	693
Services from NHS Trusts	809	925
Services from CCGs and NHS England	326	2
Services from other NHS bodies	5	163
Purchase of healthcare from non NHS Bodies	14	18
Employee Costs - Executive directors	904	806
Non-executive directors	141	135
Employee Costs - Staff	127,472	128,050
Drug costs (see note 11.2)	13,829	13,605
Supplies and services - clinical	17,789	18,206
Supplies and services - general	2,478	2,338
Establishment	1,358	1,338
Research and Development	-	17
Transport	807	939
Premises - business rates payable to local authorities	926	805
Premises - other	5,919	4,997
Increase in provision for irrecoverable debts	978	147
Rentals under operating leases	2,030	1,668
Depreciation on property, plant and equipment (see note 9.1)	4,466	4,029
Amortisation on intangible assets (see note 8)	106	63
Impairments of property, plant and equipment	-	587
Audit services- statutory audit	79	67
Other auditor remuneration (external auditor only)	6	6
NHS Litigation Authority contribution - Clinical Negligence	2,562	2,641
Loss on disposal of other property, plant and equipment	339	49
Legal fees	90	147
Consultancy costs	518	411
Internal audit costs	166	166
Training, courses and conferences	766	723
Patients' travel	16	15
Redundancy	45	255
Early retirements	(15)	(14)
Hospitality	7	1
Insurance	212	234
Losses, ex gratia and special payments (see note 19)	34	26
Other	359	429
Foundation Trust total operating expenses	186,277	184,687

4.3 Current year operating lease expenditure and future annual lease payments

	Foundation Trust & Group			
	2015/16	Buildings	Plant & Machinery	Other
	£000	£000	£000	£000
Minimum lease payments	2,030	1,090	304	636
	2,030	1,090	304	636
Future minimum lease payments due expiring;				
Within 1 year	1,352	1,090	189	73
Between 1 and 5 years	256	-	192	64
After 5 years	-	-	-	-
	1,608	1,090	381	137

4.4 Prior year operating lease expenditure and future annual lease payments

	Foundation Trust & Group			
	2014/15	Buildings	Plant & Machinery	Other
	£000	£000	£000	£000
Minimum lease payments	1,668	883	287	498
	1,668	883	287	498
Future minimum lease payments due expiring:				
Within 1 year	1,228	883	265	80
Between 1 and 5 years	327	-	251	76
After 5 years	-	-	-	-
	1,555	883	516	156

4.5 Limitation on external auditor's liability

	Foundation Trust & Group	
	2015/16	2014/15
	£000	£000
Limitation on external auditor's liability	1,000	1,000
	1,000	1,000

5. Employee costs and numbers

5.1 Employee costs

	Foundation Trust & Group			Foundation Trust & Group		
	2015/16	Permanently Employed	Other	2014/15	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	104,418	102,699	1,719	105,823	105,308	515
Social Security costs	7,247	7,247	-	7,517	7,517	-
Employer contributions to NHS Pensions Agency	12,355	12,355	-	12,128	12,128	-
Termination benefits	30	30	-	241	241	-
Agency/contract staff	4,508	-	4,508	3,817	-	3,817
Total employee expenses	128,558	122,331	6,227	129,526	125,194	4,332
Less costs capitalised as part of assets	(152)	(152)	-	(429)	(429)	-
Total employee costs excluding capitalised costs	128,406	122,179	6,227	129,097	124,765	4,332

5.2 Average number of employees (WTE basis)

	Foundation Trust & Group			Foundation Trust & Group		
	2015/16	Permanently Employed	Other	2014/15	Permanently Employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	316	297	19	319	300	19
Ambulance staff	2	2	-	1	1	-
Administration and estates	556	553	3	559	558	1
Healthcare assistants and other support staff	359	359	-	358	358	-
Nursing, midwifery and health visiting staff	1,155	1,155	-	1,152	1,152	-
Nursing, midwifery and health visiting learners	12	12	-	13	13	-
Scientific, therapeutic and technical staff	448	448	-	457	457	-
Healthcare science staff	94	94	-	94	94	-
Bank and agency staff	66	-	66	57	-	57
Other	2	2	-	1	1	-
Total	3,010	2,922	88	3,011	2,934	77
Less capitalised employees	(3)	(3)	-	(12)	(12)	-
Total excluding capitalised WTE	3,007	2,919	88	2,999	2,922	77

WTE = Whole time equivalents

5.3 Pension costs

Past and present employees are covered by the provisions of the two NHS Pensions Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the Financial Reporting Manual (FReM) requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

5.3 Pensions costs (continued)

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend the contribution rates payable by employees and employers. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

5.4 Retirements due to ill-health

During the year ended 31 March 2016 there were 3 (2015: 2) early retirements from the NHS foundation trust agreed on the grounds of ill-health. The estimated additional pension liability of the ill-health retirement is £211,000 (2015: £68,000). The cost of ill-health retirements are borne by the NHS Business Services Authority Pensions Division.

5.5 Staff exit costs

Monitor requires NHS foundation trusts to disclose summary information regarding redundancy and mutually agreed resignation scheme (MARS) staff costs agreed in the financial year.

	Foundation Trust & Group		Foundation Trust & Group	
Exit cost band	2015/16 Number of compulsory redundancies	2015/16 Number of MARS departures agreed	2014/15 Number of compulsory redundancies	2014/15 Number of MARS departures agreed
<£10,000	-	-	-	1
£10,001 - £25,000	1	-	2	-
£25,001 - £50,000	1	-	-	-
£50,001 - £100,000	-	-	-	-
£100,001 - £150,000	-	-	-	-
£150,001 - £200,000	-	-	-	-
>£200,000	-	-	1	-
Total number of exits by type	2	-	3	1
Total resource cost	£45,000	£0	£250,000	£5,000

5.6 Analysis of termination benefits

	Foundation Trust & Group		Foundation Trust & Group	
	2015/16 Number	2015/16 £000	2014/15 Number	2014/15 £000
No of Cases	2	-	4	-
Cost of Cases	-	45	-	255
	2	45	4	255

6. Finance revenue

6.1 Group finance revenue received during the year is as follows:

Finance revenue received during the year is as follows:	Group	
	2015/16	2014/15
	£000	£000
Interest income:		
Interest on bank accounts	**46**	20
HDFT Charitable funds: investment income	**58**	57
	104	77

6.2 Foundation Trust finance revenue received during the year is as follows:

Finance revenue received during the year is as follows:	Foundation Trust	
	2015/16	2014/15
	£000	£000
Interest income:		
Interest on bank accounts	**46**	20
	46	20

7. Finance expenses

Finance expenses incurred during the year are as follows:	Foundation Trust & Group	
	2015/16	2014/15
	£000	£000
Interest expense:		
Capital Loans from the Department of Health (formerly ITFF see note 17)	**118**	54
	118	54

8. Current year intangible fixed assets

	Foundation Trust & Group	
	Software Licences	Total
	£000	£000
Gross cost at 1 April 2015	477	477
Additions - purchased	204	204
Disposals	-	-
Gross cost at 31 March 2016	**681**	**681**
Amortisation at 1 April 2015	132	132
Provided during the year	106	106
Disposals	-	-
Amortisation at 31 March 2016	**238**	**238**
Net book value		
- Purchased at 31 March 2016	443	443
- Total at 31 March 2016	**443**	**443**

8.1 Prior year intangible fixed assets

	Foundation Trust & Group	
	Software Licences	Total
	£000	£000
Gross cost at 1 April 2014	339	339
Additions - purchased	170	170
Disposals	(32)	(32)
Gross cost at 31 March 2015	**477**	**477**
Amortisation at 1 April 2014	101	101
Provided during the year	63	63
Disposals	(32)	(32)
Amortisation at 31 March 2015	**132**	**132**
Net book value		
- Purchased at 31 March 2015	345	345
- Total at 31 March 2015	**345**	**345**

9. Property, plant and equipment

9.1 Current year property, plant and equipment comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Foundation Trust & Group Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2015	3,400	71,901	1,652	92	15,109	128	9,313	983	102,578
Additions - purchased	-	8,047	-	192	2,504	-	1,301	22	12,066
Reversal of impairments credited to operating income	-	350	-	-	-	-	-	-	350
Additions - donated	-	-	-	-	-	-	-	-	-
Reclassifications	-	16	-	(28)	10	-	2	-	-
Transfer to revaluation reserve	-	550	110	-	-	-	-	-	660
Disposals	-	(353)	-	-	(381)	-	(1,722)	(54)	(2,510)
Cost or valuation At 31 March 2016	**3,400**	**80,511**	**1,762**	**256**	**17,242**	**128**	**8,894**	**951**	113,144
Depreciation at 1 April 2015	-	-	-	-	8,206	62	6,187	535	14,990
Provided during the year	-	2,175	81	-	1,250	13	845	102	4,466
Transfer to revaluation reserve	-	(2,151)	(81)	-	-	-	-	-	(2,232)
Disposals	-	(24)	-	-	(371)	-	(1,722)	(54)	(2,171)
Depreciation at 31 March 2016	-	-	-	-	**9,085**	**75**	**5,310**	**583**	15,053
Net book value									
- Purchased at 31 March 2016	3,400	76,055	1,762	256	7,132	53	3,573	365	92,596
- Donated at 31 March 2016	-	4,456	-	-	1,025	-	11	3	5,495
Net book value at 31 March 2016	**3,400**	**80,511**	**1,762**	**256**	**8,157**	**53**	**3,584**	**368**	98,091

At 31 March 2016, of the Net Book Value £3,400,000 related to land valued at open market value and £80,511,000 related to buildings valued at open market value and £1,762,000 related to dwellings valued at open market value. The land and buildings (including dwellings) of the trust were revalued by the Valuation Office Agency which is a government agency of Her Majesty's Revenue and Customs (RICS qualified) as at 31 March 2016. This valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a increase in value of £2,892,000.

9. Property, plant and equipment (continued)

9.2 Prior year property, plant and equipment comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Foundation Trust & Group Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2014	3,400	70,050	1,625	350	14,209	148	7,977	1,100	98,859
Additions - purchased	-	1,711	-	25	1,396	-	1,414	6	4,552
Additions - donated	-	67	-	-	314	-	11	-	392
Reclassifications	-	186	-	(283)	-	-	97	-	-
Impairments charged to operating expenses	-	(587)	-	-	-	-	-	-	(587)
Revaluations	-	474	27	-	-	-	-	-	501
Disposals	-	-	-	-	(810)	(20)	(186)	(123)	(1,139)
Cost or valuation At 31 March 2015	**3,400**	**71,901**	**1,652**	**92**	**15,109**	**128**	**9,313**	**983**	**102,578**
Depreciation at 1 April 2014	-	-	-	-	7,938	60	5,694	546	14,238
Provided during the year	-	2,119	78	-	1,027	14	679	112	4,029
Transfer to revaluation reserve	-	(2,119)	(78)	-	-	-	-	-	(2,197)
Disposals	-	-	-	-	(759)	(12)	(186)	(123)	(1,080)
Depreciation at 31 March 2015	**-**	**-**	**-**	**-**	**8,206**	**62**	**6,187**	**535**	**14,990**
Net book value									
- Purchased at 31 March 2015	3,400	68,245	1,652	92	6,139	66	3,114	448	83,156
- Donated at 31 March 2015	-	3,656	-	-	764	-	12	-	4,432
Net book value at 31 March 2015	**3,400**	**71,901**	**1,652**	**92**	**6,903**	**66**	**3,126**	**448**	**87,588**

At 31 March 2015, of the Net Book Value £3,400,000 related to land valued at open market value and £71,901,000 related to buildings valued at open market value and £1,652,000 related to dwellings valued at open market value. The land and buildings (including dwellings) of the trust were revalued by the Valuation Office Agency which is a government agency of Her Majesty's Revenue and Customs (RICS qualified) as at 31 March 2015. This valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a increase in value of £2,698,000.

10. Investments

	Group	
	2015/16	2014/15
	£000	£000
Carrying value at 1 April 2015	**2,003**	1,860
Acquisitions in year - other	**320**	254
Movement in fair value of investments	**(106)**	143
Disposals	**(467)**	(254)
Carrying value at 31 March 2016	**1,750**	2,003

Investments held are wholly attributable to the Harrogate and District NHS Foundation Trust Charitable Fund (registered charity number 1050008), for further information please see the charity's Annual Accounts and Report.

11. Inventories

11.1 Analysis of inventories

	Foundation Trust & Group	
	2015/16	2014/15
	£000	£000
Drugs	**827**	925
Consumables	**1,794**	1,649
Total	**2,621**	2,574

11.2 Inventories recognised in expenses

	Foundation Trust & Group	
	2015/16	2014/15
	£000	£000
Drug Inventories recognised as an expense in the year	**13,829**	13,605
Total	**13,829**	13,605

12. Trade and other receivables

12.1 Trade and other receivables are made up of:

	Group	
	2015/16	2014/15
Current	£000	£000
NHS receivables	11,699	7,762
Other receivables with related parties	609	987
PDC Dividend receivable (Department of Health)	28	23
Provision for the impairment of receivables (see note 12.2)	(984)	(190)
Interest receivable	2	2
Prepayments	1,313	1,010
VAT receivables	324	214
Other receivables	2,128	799
Total	15,119	10,607

	Foundation Trust	
	2015/16	2014/15
Current	£000	£000
NHS receivables	11,699	7,762
Other receivables with related parties	609	987
PDC Dividend receivable (Department of Health)	28	23
Provision for the impairment of receivables (see note 12.2)	(984)	(190)
Interest receivable	2	2
Prepayments	1,313	1,010
VAT receivables	324	214
Other receivables	2,009	786
Total	15,000	10,594

	Foundation Trust & Group	
	2015/16	2014/15
	£000	£000
Non-Current		
Other receivables	405	444
Provision for the impairment of receivables (see note 12.2)	(89)	(84)
Total	316	360

The majority of the NHS foundation trust's trade is with Commissioners for NHS patient care services which are funded by the Government to buy NHS patient care services therefore no credit scoring for them is considered necessary.

	Foundation Trust & Group	
12.2 Movements in the provision for impairments of receivables	2015/16	2014/15
	£000	£000
Balance at 1 April 2015	274	253
Increase in provision	978	147
Amounts utilised	(179)	(126)
Balance at 31 March 2016	1,073	274

NHS Injury Benefit Scheme income is subject to a provision for impairment of 21.99% (2015: 18.9%) to reflect expected rates of collection. Other debts are assessed by management considering age of debt and the probability of collection.

12. Trade and other receivables (continued)

12.3 Ageing of the provision for impaired receivables

	Foundation Trust & Group	
	2015/16	2014/15
	£000	£000
0-30 Days	**46**	24
30-60 Days	**26**	14
60-90 Days	**95**	13
90-180 Days	**85**	37
Over 180 Days	**998**	186
	1,250	274

12.4 Ageing of non-impaired receivables

	Group		Foundation Trust	
	2015/16	2014/15	**2015/16**	2014/15
	£000	£000	**£000**	£000
0-30 Days	**9,945**	8,700	**9,932**	8,687
30-60 Days	**872**	615	**872**	615
60-90 Days	**705**	57	**705**	57
90-180 Days	**687**	1,451	**687**	1,451
Over 180 Days	**3,226**	144	**3,226**	144
	15,435	10,967	**15,422**	10,954

13. Cash and cash equivalents

	Group		Foundation Trust	
	2015/16	2014/15	**2015/16**	2014/15
	£000	£000	**£000**	£000
Balance at 1 April 2015	**5,146**	5,422	**4,898**	5,186
Net change in year	**422**	(276)	**629**	(288)
Balance at 31 March 2016	**5,568**	5,146	**5,527**	4,898
Made up of:				
Cash with Government Banking Service	**5,558**	5,117	**5,517**	4,888
Cash at commercial banks and in hand	**10**	10	**10**	10
Other current investments	**-**	19	**-**	-
Cash and cash equivalents	**5,568**	5,146	**5,527**	4,898

14. Trade and other payables

	Group		Foundation Trust	
	2015/16	2014/15	**2015/16**	2014/15
Current	**£000**	£000	**£000**	£000
Receipts in advance	**8**	64	**8**	64
NHS payables	**3,634**	2,698	**3,634**	2,698
Amounts due to other related parties	**1,726**	1,740	**1,726**	1,740
Other trade payables - capital	**1,621**	1,264	**1,621**	1,264
Social Security costs	**1,119**	1,115	**1,119**	1,115
Other tax payable	**1,146**	1,207	**1,146**	1,207
Other payables	**4,364**	4,455	**4,218**	4,406
Accruals	**3,085**	2,034	**3,085**	2,034
Total	**16,703**	14,577	**16,557**	14,528

15. Provisions

15.1 Provisions current and non current

	Foundation Trust & Group Current		Foundation Trust & Group Non current	
	2015/16	2014/15	**2015/16**	2014/15
	£000	£000	**£000**	£000
Pensions relating to the early retirement of staff pre 1995	**45**	48	**179**	233
Legal claims	**37**	46	**-**	3
*Other	**19**	19	**110**	124
	101	113	**289**	360

*Other provisions total £129,000 (2015: £143,000) referring to the NHS Injury Benefit Scheme.

15.2 Provisions by category

	Pensions relating to the early retirement of staff pre 1995	Legal claims	*Other	**Foundation Trust & Group Total**
	£000	£000	£000	**£000**
At 1 April 2015	281	49	143	**473**
Arising during the year	6	9	2	**17**
Utilised during the year	(46)	(7)	(19)	**(72)**
No longer required	(24)	(14)	-	**(38)**
Unwinding of discount	7	-	3	**10**
At 31 March 2016	**224**	**37**	**129**	**390**

*Other provisions total £129,000 (2015: £143,000) referring to the NHS Injury Benefit Scheme.

15.3 Expected timing of cashflows by category:

	Pensions relating to the early retirement of staff pre 1995	Legal claims	*Other	**Foundation Trust & Group Total**
	£000	£000	£000	**£000**
Within one year	45	37	19	**101**
Between one and five years	145	-	78	**223**
After five years	34	-	32	**66**
	224	37	129	**390**

£46,133,704 is included in the provisions of the NHS Litigation Authority at 31 March 2016 in respect of clinical negligence liabilities of the NHS foundation trust (31 March 2015 - £31,128,028). Please see note 1.12.

16. Other liabilities

	Foundation Trust & Group	
	2015/16	2014/15
Current	**£000**	£000
Deferred income	**2,707**	689
Total	**2,707**	689

17. Borrowings

	Foundation Trust & Group	
	2015/16	2014/15
Current	**£000**	£000
Capital loans from Department of Health (formerly ITFF)*	**999**	545
Total	**999**	545
Non-Current		
Capital loans from Department of Health (formerly ITFF)*	**11,776**	3,810
Total	**11,776**	3,810

*During 2012/13, the Trust signed a 10 year loan agreement for £3.4m from the Independent Trust Financing Facility (ITFF) to fund the provision of additional theatre capacity, the loan was drawn down in full during the financial year. During 2013/14, the Trust signed an additional 10 year loan for £1.5m from the ITFF to fund the replacement of an MRI Scanner. The loan was drawn down in full during the financial year. During 2014/15 the NHS foundation trust did not undertake any additional borrowing. During 2015/16 the Trust signed a 25 year loan agreement from the Department of Health for £7.5m to fund a Carbon Efficiency capital scheme and a 10 year loan agreement from the Department of Health for £1.5m to fund the purchase of a Mobile MRI Scanner, both of these loans were drawn down in full during the financial year.

The interest rates on the NHS foundation trust's loans are:-

Additional theatre capacity loan £3.4m is fixed at 0.93% per annum.
Replacement MRI loan £1.5m is fixed at 1.75% per annum.
Carbon efficiency capital scheme loan £7.5m is fixed at 2.5% per annum.
Mobile MRI Scanner loan £1.5m is fixed at 0.90% per annum.

Interest accrued is paid every six months see finance expense note 7.

There have been no defaults or breaches in relation to the Department of Health (formerly ITFF) loans.

18. Finance lease obligations

The NHS foundation trust does not have any finance leases obligations either as a lessee or lessor.

19. Losses and special payments

	Foundation Trust & Group			
	2015/16 Total number of cases	**2015/16 Total value of cases**	2014/15 Total number of cases	2014/15 Total value of cases
		£000		£000
Losses:				
Other loss of cash	**5**	**1**	-	-
Bad debts private patients	**17**	**2**	74	8
Bad debts overseas visitors	**3**	**-**	4	5
Bad debts other	**181**	**4**	268	3
Damage to buildings, property stores losses	**30**	**21**	-	-
Total losses	**236**	**28**	346	16
Special payments:				
Compensation under legal obligation	**2**	**3**	3	5
Ex gratia payment loss of personal effects	**9**	**2**	12	4
Clinical negligence with advice	**-**	**-**	1	1
Other employment payments	**-**	**-**	1	-
Ex gratia payment other	**5**	**1**	2	-
Total special payments	**16**	**6**	19	10
Total losses and special payments	**252**	**34**	365	26

20. Third Party Assets

The NHS foundation trust held £891 cash at bank and in hand at 31 March 2016 which related to monies held by the NHS foundation trust on behalf of patients (31 March 2015: £883).

21. Contractual Capital Commitments

Commitments under capital expenditure contracts at 31 March 2016 were £1,633,000 (31 March 2015: £744,000).

22. Related Party Transactions

22.1 Transactions with key management personnel

IAS 24 requires disclosure of transactions with key management personnel during the year. Key management personnel is defined in IAS 24 as "those persons having authority and responsibility for planning, directing and controlling the activities of the entity, directly or indirectly, including any director (whether executive or otherwise) of that entity". The Trust has deemed that its key management personnel are the board members (voting and non-voting directors and non-executive directors) of the NHS foundation trust.

The transactions with board members are as follows:

	Foundation Trust & Group			
	2015/16		2014/15	
	Income	Expenditure	Income	Expenditure
	£000	£000	£000	£000
Value of transactions with board members	-	1,045	-	941

The expenditure above, is key management personnel compensation which is analysed as follows:

Short term employee benefits*	937	845
Post employment benefits **	108	96
	1,045	941

* Short term employee benefits include salaries, employer's social security contributions and benefits in kind.
** Post employment benefits include employer's contributions to the NHS Pension Scheme.

The remuneration of individual board members is disclosed within the NHS foundation trust's annual report. There were no outstanding balances with directors at 31 March 2016 (2015: £nil).

Other than key management personnel compensation as shown above, none of the board members or parties related to them has undertaken any material transactions with the NHS foundation trust.

22.2 Transactions with other related parties

Harrogate and District NHS Foundation Trust is a public benefit corporation authorised by Monitor. Monitor has determined that all bodies within the scope of "Whole Government Accounts" are related parties, as ultimately they are under common control.

	Foundation Trust & Group			
	2015/16		2014/15	
	Income	Expenditure	Income	Expenditure
	£000	£000	£000	£000
Department of Health	13	2,260	18	2,531
*Other NHS Bodies	175,521	8,972	176,214	7,381
*Other WGA Bodies	7,147	20,365	4,181	21,399
	182,681	31,597	180,413	31,311
	Receivables	**Payables**	Receivables	Payables
	£000	£000	£000	£000
Department of Health	29	-	23	1
*Other NHS Bodies	11,665	3,605	7,688	2,654
*Other WGA Bodies	966	4,020	1,275	4,105
	12,660	7,625	8,986	6,760

* The Other NHS and Other WGA bodies with which the NHS foundation trust considers material transactions have taken place are included in note 22.3.

22. Related Party Transactions (continued)

22.3 Material transactions with other NHS bodies and Other WGA bodies

	Foundation Trust & Group			
	2015/16		2014/15	
	Income	Expenditure	Income	Expenditure
	£000	£000	£000	£000
Tees, Esk And Wear Valleys NHS Foundation Trust	949	33	1,057	33
York Hospitals NHS Foundation Trust	1,036	2,475	915	1,106
NHS Airedale, Wharfdale And Craven CCG	1,538	-	1,811	-
NHS Hambleton, Richmondshire And Whitby CCG	5,892	-	5,550	-
NHS Harrogate And Rural District CCG	105,375	576	100,753	352
NHS Leeds North CCG	19,600	-	20,217	-
NHS Leeds South And East CCG	1,176	-	1,302	-
NHS Leeds West CCG	3,676	-	3,470	-
NHS Scarborough And Ryedale CCG	2,417	-	2,161	-
NHS Vale Of York CCG	6,638	-	9,285	-
NHS England	18,193	80	20,777	5
Health Education England	4,362	-	4,499	-
NHS Litigation Authority	-	2,674	-	2,750
Department of Health (PDC dividend only)	-	2,260	-	2,530
North Yorkshire County Council	5,954	71	3,411	(20)
HMRC	-	7,247	-	7,517
NHS Property Services	104	1,083	16	1,067
NHS Pension Scheme	-	12,355	-	12,128

	Foundation Trust & Group			
	Receivables	Payables	Receivables	Payables
	£000	£000	£000	£000
Tees, Esk And Wear Valleys NHS Foundation Trust	19	12	-	19
York Hospitals NHS Foundation Trust	1,112	999	303	503
NHS Airedale, Wharfdale And Craven CCG	87	-	231	-
NHS Hambleton, Richmondshire And Whitby CCG	1,348	-	282	-
NHS Harrogate And Rural District CCG	5,146	255	3,307	351
NHS Leeds North CCG	69	-	693	-
NHS Leeds South And East CCG	71	-	-	-
NHS Leeds West CCG	172	-	72	-
NHS Scarborough And Ryedale CCG	441	-	260	-
NHS Vale Of York CCG	727	-	222	-
NHS England	1,580	82	1,465	-
Health Education England	36	-	33	-
NHS Litigation Authority	-	-	-	-
Department of Health (PDC dividend only)	28	-	23	-
North Yorkshire County Council	605	-	816	-
HMRC	324	2,265	214	2,322
NHS Property Services	84	1,429	8	1,116
NHS Pension Scheme	-	1,726	-	1,740

In addition, the NHS foundation trust has had a number of transactions with other Government Departments and other central and local Government bodies.

23. Financial instruments.

	Group		Foundation Trust	
	2015/16	2014/15	**2015/16**	2014/15
	£000	£000	**£000**	£000
Financial assets				
Loans and receivables (including cash and cash equivalents)	**18,695**	14,172	**18,654**	13,924

The NHS foundation trust's financial assets all fall under the category 'loans and receivables'.

Financial liabilities				
Other financial liabilities	**25,479**	14,806	**25,479**	14,806

The NHS foundation trust's financial liabilities all fall under the category 'other financial liabilities'.

Management consider that the carrying amounts of financial assets and financial liabilities recorded at amortised cost in the financial statements approximate to their fair value.

The majority of the NHS foundation trust's income is from NHS Commissioners of patient care services which are funded by the Government to purchase NHS patient care therefore NHS foundation trusts are not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies. The NHS foundation trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS foundation trust in undertaking its activities.

24. Charitable funds reserve.

Unrestricted income funds comprise those funds which the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include designated funds, where the donor has made known their non binding wishes or where the Corporate Trustee, at its discretion, has created a fund for a specific purpose.

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by the donor.

The charity has one permanent endowment fund. The income of the Elsie Sykes Endowment Fund can be used for medical equipment or medical research (excluding transplant or vivisection work).

	Group	
	2015/16	2014/15
	£000	£000
Unrestricted income funds	**391**	706
Restricted funds	**22**	97
Endowment fund	**1,351**	1,426
	1,764	2,229

25. Ultimate parent.

As an entity operating in the National Health Service in England, the ultimate parent holding is considered as the Department of Health.

26. Events after the reporting period.

The NHS foundation trust has successfully tendered for 3 contracts to provide a range of children's services across Middlesbrough, Durham and Darlington, the contracts for providing these additional services commences on 1 April 2016 and they have a collective annual value of £18m. The NHS foundation trusts 2016/17 Statement of Comprehensive Income will include the income from these contracts and the associated expenditure for providing these additional services. Under Transfer of Undertakings Protection of Employment (TUPE) circa 500 employees transferred to the NHS foundation trust on 1 April 2016. The NHS foundation trust is not receiving any property, plant or equipment to provide the additional services, however some property leases will novate to the organisation associated with the provision of these services.

FTC Summarisation Schedules for Harrogate and District NHS Foundation Trust

Summarisation schedules numbers FTC01 to FTC40 and the accompanying WGA sheets for 2015/16 are attached.

Finance Director Certificate

1. I certify that the attached FTC schedules have been compiled and are in accordance with:

   - The financial records maintained by the NHS foundation trust; and
   - Accounting standards and policies which comply with the *NHS Foundation Trust Annual Reporting Manual* 2015/16 issued by Monitor.

2. I certify that the FTC schedules are internally consistent and that there are no validation errors.

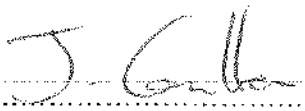
3. I certify that the information in the FTC schedules is consistent with the financial statements of the Harrogate and District NHS Foundation Trust.

.....
Jordan Mckie, Finance Director (Acting)
25 May 2016

Chief Executive Certificate

1. I acknowledge the attached FTC schedules, which have been prepared and certified by the Finance Director, as the FTC schedules which the Foundation Trust is required to submit to Monitor.

2. I have reviewed the schedules and agree the statements made by the Finance Director above.



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Jonathan Coulter, Chief Executive (Acting)
25 May 2016