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Harrogate and District
NHS Foundation Trust

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
ANNUAL REPORT AND ACCOUNTS 2017 / 2018

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

CONTENTS TABLE

1. CHAIRMAN'S WELCOME

It is a pleasure and a privilege to introduce the Annual Report and Accounts for the financial year 1 April 2017 to 31 March 2018. I took up my appointment as Chairman in November 2017 following on from Sandra Dodson who had been Chairman for nine years. I would like to pay tribute to Sandra's extremely effective leadership of the Trust and thank her for her support in introducing me to the role.

The Annual Report gives us an opportunity to reflect on the last financial year and to look ahead to our priorities for 2018/19. It is an important element of our accountability to our members and others we serve. I hope that you will find the contents interesting and informative. We are always pleased to receive feedback and suggestions for how we can improve.

Harrogate and District NHS Foundation Trust is a values-led Trust. We completely embrace our values of 'Responsible, Passionate, Respectful' and would wish everyone who has contact with our services and teams to feel that you have been treated in accordance with our overarching aim of 'You Matter Most'. I have been extremely impressed with the great care and professionalism shown by members of staff. They are tremendously hardworking as demonstrated by the way we continued to maintain high standards throughout the pressures of winter. One of my more happy duties is to present Making A Difference Awards to individuals and Team Of The Month Awards to teams who have gone the extra mile to ensure that the Trust lives up to these values. They are proud and enthusiastic about their considerable achievements.

I would like to thank the Board of Directors for their leadership of the Trust during a year which has presented a number of challenges, and in particular Mr Neil McLean, who left us on 30 April 2018 after three years of exceptional service to the Trust. We are all most grateful to the Council of Governors for their oversight of the work of the Board and their fantastic support for the work of the Trust. They provide a vital link with our Foundation Trust Members who are very generous with their comments, suggestions and feedback.

I cannot commend enough the individuals and teams who work and volunteer for the Trust – they are all amazing.

Dr Ros Tolcher, Chief Executive, has provided an overview of the Trust's performance and a wider introduction to this Annual Report. We are also taking this opportunity to highlight plans we have for the future which will build on our commitment to improve the health and wellbeing of children and young people, enhance safety for patients and further our commitment to Excellence Every Time.

Mrs Angela Schofield
Chairman
Harrogate and District NHS Foundation Trust
23 May 2018

Angela Schofield

2. CHIEF EXECUTIVE'S INTRODUCTION

I'm delighted to introduce our 2017/18 Annual Report. Everyone at Harrogate and District NHS Foundation Trust (HDFT) wants people who use our services to feel safe, to be treated with dignity and compassion and to have an excellent outcome. HDFT staff work tirelessly to live up to our 'You Matter Most' pledge and ensure care and services of the highest quality. This report summarises our achievements and challenges over the past 12 months, our ambitions for 2018/19 and describes a little of the context in which we have operated. It also includes our Quality Account, which I commend to you as a fabulous representation of our approach to quality and our improvement priorities.

The past 12 months have been described as the most challenging year in the NHS's 70 year history. The continued financial squeeze in all sectors, coupled with growing levels of demand, has culminated in unprecedented occupancy rates in hospitals and a steady decline in financial and operational performance. A shortage of qualified staff to fill important roles, and the impact of Brexit, has compounded this position.

I am immensely proud of the outstanding care provided by colleagues in our hospital and community services throughout the year, made all the more remarkable in the face of these challenges.

Once again HDFT has delivered all four of the key national operational performance standards including the A&E 4-hour access target, the national 18 week referral to treatment time, the national cancer 62 day waiting time and the cancer diagnostic waits. The Trust's year end surplus of £1.1m is some £4.5m less than planned. A number of factors contributed to this position, the most significant of which was the requirement for additional staffing to ensure a safe level of care in our hospital services. This is a further reflection of the Trust's ongoing commitment to sustain high quality care.

As in previous years, the annual NHS Staff Survey ranked the Trust in the top group nationally and the feedback we have from patients – in national surveys and the 'Friends and Family Test' remains excellent. Our Children's Community Services have also performed extremely well, ensuring that children and families are supported and achieve the best possible start in life.

The past 12 months have been important to us in other ways too. Working in partnership with other providers, commissioners, GPs and local authorities is ever more important as we strive to offer joined up, resilient services. HDFT is part of the West Yorkshire and Harrogate Health and Care Partnership and the West Yorkshire Association of Acute Trusts through which we are working on a range of initiatives designed to improve quality, sustainability and more integrated care.

HDFT is unusual in having a large portfolio of Children's Community Services and we have enjoyed further success in bidding for additional services to deliver our successful Healthy Child Programme. I am particularly proud of the HDFT Youth Forum and the work it is doing to help us drive continual improvement.

At the start of the year we commenced exploring the benefits of creating a new, wholly-owned subsidiary company to run our estates and facilities management (E&FM) services. This culminated in the creation of Harrogate Healthcare Facilities Management which took over our E&FM work, and all of the staff providing those services at the end of the year. Having a standalone company dedicated solely to the provision of outstanding services to the Trust is already benefiting patients.

Our Quality Charter is now entering its third year. We already have more than 200 bronze, silver and gold Quality of Care Champions and have made dozens of 'Making a Difference' awards as well as a monthly 'Team of the Month' award. In June 2017 we hosted our first Quality Conference which was immensely successful, setting the bar for further annual events.

In November 2017 we welcomed our new Chairman, Angela Schofield. Angela is already bringing her wealth of experience in working in the NHS and driving service improvements to bear, helping us to make the right decisions and keeping the focus of the Trust Board firmly on the wellbeing of our patients and our staff.

The year ahead will present ongoing challenges and opportunities for new ways of working. The population for whom we provide hospital services is older than the national average – indeed almost one in twelve of those admitted is aged over 85. People aged over 85 stay on average 50 per cent longer in hospital after being admitted, when very often they would prefer to be at home or in another environment. We will continue working with partners in Harrogate to help develop enduring alternatives to hospitalisation.

Finally, I would like to pay tribute to the people who make our ambition for Excellence Every Time a reality for people in our care, day in, day out. My thanks go out to staff in all of our community and hospital services in whatever capacity they contribute. Thanks are also due to our Non-Executive Directors and Governors who have helped, supported and challenged constructively throughout the year.

Dr Ros Tolcher
Chief Executive
Harrogate and District NHS Foundation Trust
23 May 2018

3. PERFORMANCE REPORT

3.1. Overview of Performance

3.1.1. Introduction

The Performance Report provides information about Harrogate and District NHS Foundation Trust (the Trust), the Trust's objectives, strategies and the principle risks that the organisation faces. This overview section will help readers to understand the Trust, its purpose, key risks to achievement of objectives and details about how the organisation performed during 2017/18.

3.1.2. 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 for the acute hospital of approximately 720,000. In addition, the Trust provides some community services across North Yorkshire (with a population of 400,000) and provides Children's Services to North Yorkshire, County Durham, Darlington, Stockton-On-Tees, and Middlesbrough which represents a total population of 1.4m.

Harrogate District Hospital has an Emergency Department, extensive outpatient facilities, an Intensive Therapy Unit and a High Dependency Unit, a Coronary Care Unit, plus five main theatres and a Day Surgery Unit with three further theatres. The Sir Robert Ogden Macmillan Centre (SROMC) provides assessment and treatment, for the diagnosis and treatment of patients with cancer. Dedicated purpose built facilities are also provided on site for Cardiology, Endoscopy, Pathology, Pharmacy, Radiology and Therapy Services, as well as a Child Development Centre, Stroke Unit and Women's Unit. The Trust provides Maternity Services with an Antenatal Unit, central Delivery Suite, Special Care Baby Unit (SCBU) and Post Natal ward, together with an Early Pregnancy Assessment Unit. The Lascelles Neurological Rehabilitation Unit provides care for inpatients with a range of neurological conditions and brain injuries.

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

The Trust also acts as the first contact for access to more specialist services through alliance based working with neighbouring hospitals. These extended services are provided by visiting consultants, or alternatively, by the patient travelling to hospitals in York or Leeds. The range of hospital services that are provided in partnership with York Teaching Hospital NHS Foundation Trust (YTHFT) include Breast and Cervical Screening, Dermatology, Ear Nose and Throat (ENT), Neurophysiology, Non-Surgical Oncology, Ophthalmology, Oral and Maxillofacial Surgery, Orthodontics, Renal Medicine, Rheumatology, Urology, Vascular Services and a Satellite Renal Unit. The renal unit is managed by YTHFT, but provided at a facility on the Harrogate District Hospital site.

In addition, the Trust has a number of established clinical links with the Leeds Teaching Hospitals NHS Trust (LTHT). These include Coronary Heart Disease, Neurology, Plastic Surgery, Specialist Paediatrics and access to specialist Cancer Services. Links have also been strengthened with commissioners in Leeds, providing further services in Orthopaedics and General Surgery and an outpatient clinic for ENT services at Chapeltown Health Centre.

Further outpatient outreach clinics are held at Wetherby Primary Care Centre and Yeadon Health Centre for the specialities of Dermatology, Gastroenterology, General Surgery, Gynaecology, Maternity, Neurology, Paediatrics, Respiratory, Rheumatology, Urology, and Vascular clinics. Endoscopy and Gastroenterology services are provided at Wharfedale General Hospital. An additional outreach clinic facility operates at Alwoodley Medical Centre which includes the specialties of Audiology, ENT, General Surgery, Gynaecology, Orthopaedics, Rheumatology and Urology clinics. There is also a dedicated Radiology service providing plain film x-ray and ultrasound services to support the above mentioned clinics, as well as providing GP Direct Access for the surrounding practices.

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

The Trust also provides a range of community services in Harrogate and the local area as well as across North Yorkshire and Leeds. Our dedicated and experienced staff, who are based in the communities they serve, offer expertise across a variety of disciplines and work closely with GPs, hospital based staff and other healthcare professionals to provide a high quality of care. Services include:

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

The Trust provides Children's Services in County Durham, Darlington, Middlesbrough and Stockton-On-Tees, making it the largest provider by geographical area of such services in the country. These are universal services where the needs and voice of children, young people and families are at the core of the service that will identify and address need at the earliest opportunity, recognise and build on the strengths that are within individuals to enable them to be part of the solution to overcome challenges and identify and develop resources within communities so that children, young people and families have access to support when and where they need it.

In February 2018 the Trust established a wholly owned subsidiary company; Harrogate Healthcare Facilities Management Limited (company number 11048040). The company provides estates and facilities services to the Trust.

3.1.3. Purpose and activities of the Trust

The Trust's vison is to achieve 'Excellence Every Time' for patients and service users, with the organisation's mission statement to be an exceptional provider of healthcare for the benefit of our communities, our staff and our partners.

In order to achieve our mission and vision the Trust has set out three key strategic objectives:

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

These complement the Trust's key Quality Priorities which are set out in the Quality Account contained within this Annual Report at Section 5.0.

The Trust recognises the need to work with partner organisations across the patch through alliances and networks to achieve these key strategic objectives. The Trust's primary partners include:

- West Yorkshire and Harrogate Health and Care Partnership (HCP);
- West Yorkshire Association of Acute Trusts (WYAAT);
- Clinical Alliances with York Teaching Hospitals NHS Foundation Trust (YTHT) and Leeds Teaching Hospitals NHS Trust (LTHT);
- Organisations in the Harrogate 'place', including Harrogate and Rural District CCG (HaRD CCG);
- Local Provider collaboration with other providers including Tess Esk and Wear Valley NHS Foundation Trust (TEWV) North Yorkshire County Council (NYCC), and the local GP Federation; and,
- Harrogate Healthcare Facilities Management Limited (the Trust's wholly owned subsidiary company providing estates and facilities services).

The Trust continues to seek to expand its catchment population into North Leeds, across North Yorkshire and, in relation to community children's services, into the North East of England in County Durham, Darlington, Middlesbrough and Stockton-On-Tees, and in addition from July 2018 in Sunderland and Gateshead.

3.1.4. Strategic Risks

The Trust records strategic risks to the organisation in the Board Assurance Framework (BAF) and operational risks to the organisation on the corporate risk register, both of which are reviewed by the Board monthly in outline and quarterly in detail.

During 2017/18 the strategic risks identified on the BAF included risk of:

- Lack of medical, nursing and clinical staff;
- High levels of frailty in local population;
- Failure to learn from feedback and incidents;
- Standards of care and the organisation's reputation for quality fall because quality does not have a sufficient priority in the Trust;
- Failure to deliver integrated models of care;
- Misalignment of strategic plans;

- Service sustainability;
- Failure to deliver the Operational Plan;
- Breaching the terms of the Trust's Licence to operate from NHS Improvement;
- External funding constraints;
- Lack of fit for purpose critical infrastructure; and
- Insufficient senior leadership capacity.

The risks on the corporate risk register for 2017/18 and going forward relate to the:

- Risk to the quality of service delivery in Medicine due to gaps in rotas following the Deanery allocation process;
- Risk to service delivery due to the lack of experienced registered nurses due to national labour market shortage;
- Capacity to support timely discharge for community ready patients;
- Risk of financial deficit and impact on service delivery due to failure to deliver the Trust annual plan by having excess expenditure or a shortfall in income;
- Risk of patient harm as a result of being lost to follow-up as a result of current processes;
- Risk of patient harm as a result of being lost to follow-up as a result of historic processes;
- Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down;
- Risk to patient safety, quality, experience, reputation, staff well-being due to reduced capacity in the community care teams;
- Risk to quality of care due to lack of capacity in the acute and community services to meet anticipated increased demand during winter months;
- Risk of inadequate antenatal care and patients being lost to follow-up due to inconsistent process for monitoring attendance at routine antenatal appointments in the community;
- Risk to service delivery due to failure to have sufficient cash to support the capital programme including replacement of equipment due to delay in payment from commissioners or shortfall in delivering the financial plan; and,
- Risk of harm to the quality of the service due to staff shortages in ophthalmology clinics.

The BAF is reviewed by the Board of Directors, Audit Committee and the Trust's Corporate Risk Review Group to ensure appropriate triangulation of issues across the organisation. The Board's committees carry out 'deep dives' into individual areas of responsibility to ensure that the strategic risks are mitigated as far as possible, and that gaps in assurance and control are identified. In addition the Board undertakes a 'deep dive' on strategic risks at its development days to ensure appropriate oversight and understanding of the internal and external environment, and its impact on the Trust.

3.1.5. Going Concern Disclosure

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.

3.2. Performance Analysis

The Board of the Trust has agreed a suite of key performance indicators which are monitored on a monthly basis through the 'Integrated Board Report'. This report brings together measures related to quality, operational performance and finance. It includes measures of operational performance which the Trust is required to report to NHS Improvement, NHS England and Harrogate and Rural District CCG.

In addition the Board has agreed a suite of strategic key performance indicators which are reported and considered on a bi-annual basis. These strategic key performance indicators include measures focused on high quality care, working with partners, clinical and financial sustainability and regulatory compliance. They have been mapped to the BAF in order to further support the Board in seeking assurance on achievement of the Trust's strategic objectives.

3.2.1 Regulatory Ratings

The Trust's regulatory performance against NHS Improvement's (NHSI) Single Oversight Framework from April to September 2017 was Green in all categories in line with risk ratings contained in the Operational Plan. In quarter three and quarter four, HDFT's performance was below the required level for two of the four key operational performance metrics; the A&E 4-hour standard and the 18 weeks standard. However the Trust achieved all four standards for the overall year 2017/18.

No formal regulatory action has been taken or is planned. The Trust continues to have robust measures in place to monitor performance and quickly address areas of concern. The table in Section 4.5 indicates the Trust's regulatory ratings for 2017/18.

3.2.2 Performance Summary of 2017/18

The Trust achieved all applicable Cancer Waiting Times standards for each quarter of 2017/18, with the exception of the 2 week wait standard for breast symptomatic patients where the Trust was below the 90% standard in quarter four.

Overall Trust performance against the A&E (Emergency Department) 4-hour waiting time standard was above 95% for seven out of 12 months throughout the year and was above 95% for the year overall. However, sustained delivery of this standard remained challenging over the winter period.

There was one ambulance handover delay of over 60 minutes reported in 2017/18 (eight the previous year) and 85 handover delays of over 30 minutes (104 the previous year). Emergency Department attendances were 4.4% higher than for the same period last year.

Activity levels at the Trust have increased during 2017/18. Elective (waiting list) admissions were 2.5% higher in 2017/18 when compared to 2016/17 and non-elective admissions increased by 3.9%. Outpatient attendances remained static with a total of 283,000 outpatient attendances in 2017/18.

The Trust reported seven cases of hospital acquired Clostridium Difficile in 2017/18, compared to 29 in 2017/18. Root Cause Analysis (RCA) results indicated that four of these cases were not due to lapses in care, and therefore, these would be discounted from the Trust's trajectory for 2017/18. Root cause analysis have not yet been

completed for three cases. No cases of hospital acquired MRSA (Methicillin-resistant Staphylococcus aureus) were reported in 2017/18.

The following table demonstrates the Trust's performance against the key indicators for each quarter in 2017/18:

Indicator description	Target	Q1	Q2	Q3	Q4	2017/18
Referral to Treatment Times admitted pathways (% within 18 weeks)	>=92%	93.8%	92.3%	91.9%	90.4%	92.1%
Diagnostic waiting times - maximum wait of 6 weeks	>=99%	99.8%	99.6%	99.7%	99.4%	99.6%
A&E: Total time spent in A&E is less than 4 hours	>=95%	96.7%	96.0%	94.9%	92.8%	95.2%
Cancer - Maximum waiting time of 14 days from urgent GP referral to date first seen for all urgent suspect cancer referrals (%)*	>=93%	96.4%	98.4%	98.8%	96.6%	97.5%
Cancer - maximum waiting time of 14 days for symptomatic breast patients (cancer not initially suspected)*	>=93%	95.7%	96.7%	96.3%	89.4%	94.4%
Cancer - 31 day wait for second or subsequent treatment: Surgery*	>=94%	98.1%	97.1%	96.3%	97.6%	97.3%
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	>=98%	100.0%	100.0%	100.0%	99.1%	99.8%
Cancer - 31 day wait for second or subsequent treatment: Radiotherapy*	>=94%	NA	NA	NA	NA	N/A
Cancer - Maximum waiting time of 31 days from diagnosis to treatment for all cancers (%)	>=96%	99.6%	98.8%	98.9%	99.6%	99.2%

Indicator description	Target	Q1	Q2	Q3	Q4	2017/18
Cancer - 62 day wait for first treatment from urgent GP referral to treatment: all cancers	>=85%	86.0%	88.9%	90.5%	90.6%	89.0%

Cancer - 62 day wait for first treatment from consultant screening service referral: all cancers*	>=90%	91.7%	88.9%	90.5%	100.0%	92.9%
Clostridium difficile – cases due to a lapse in care (cumulative)	<= 12 cases in year	0	2	3	2	7
Community services data completeness - RTT information	>=50%	80.8%	77.7%	80.6%	82.1%	80.3%
Community services data completeness - Referral information	>=50%	72.8%	72.2%	72.0%	72.2%	72.3%
Community services data completeness - Treatment activity information	>=50%	91.5%	91.0%	92.5%	91.4%	91.6%

3.2.3 Performance 2017/18

The Trust completed 2017/18 with a Financial Use of Resource Rating of three and a Green Governance rating, in line with NHSI's Single Oversight Framework. In 2018/19 the Trust aims to achieve a surplus of £4m and to maintain the current level of performance against the performance targets as laid out in the framework. The surplus relates to the achievement of an underlying breakeven position, supported by Sustainability and Transformation funding.

The Trust will begin the year with a rating of three with a plan to return to a rating of one by the end of the financial year and has detailed in its Operational Plan to NHSI, the ways in which this will be achieved. The five year Strategic Plan also details the longer term organisational strategy, as well as the strategic opportunities and risks for the Trust.

3.2.4 Detailed analysis development and performance of the Trust

3.2.4.1 Significant Developments during 2017/18

In line with the Trust's Operational Plan for 2017/18, the significant developments over the last 12 months can be summarised as follows.

Development of Community Children's Services

The Trust is now the largest provider of community children's services in the country following successfully securing contracts across the North East of England in 2017/18, the most recent in Stockton-On-Tees, Gateshead and Sunderland. During 2017/18 the key focus was on successfully mobilising these services to ensure their safe transfer to the Trust.

The acquisition of these community children's services has given the Trust the ability to manage services at scale with the opportunity to implement transformational work and shared learning across contracts. Work will continue in 2018/19 to build on the implementation of the delivery model across the new contracts in Stockton-On-Tees,

Gateshead and Sunderland as well as continue to engage with our commissioners for our other 0-19 Children's Services contracts to continue to deliver high quality services.

Acute Services

In relations to hospital services the Trust has successfully appointed to Consultants posts in Acute Medicine, General Surgery, Anaesthetics and Radiology. Work has continued to support the development of new roles e.g. Advanced Nurse Practitioners, Associate Nurses, Apprenticeships for Health Care Assistants and Physician Associates.

West Yorkshire and Harrogate Health and Care Partnership

The Trust is part of the West Yorkshire and Harrogate Health and Care Partnership (HCP) which is built up from the work of the six health and care economies in West Yorkshire and Harrogate. As part of the HCP the vision for West Yorkshire and Harrogate is for everyone to have the best possible outcomes for their health and wellbeing.

Closer partnership working is at the very core of the HCP and the Trust continues to be actively engaged with our partners across the region.

During the year a draft Memorandum of Understanding was developed to strengthen joint working arrangements across the HCP and to support the next stage of development. The Memorandum of Understanding builds on the existing partnership arrangements to establish more robust mutual accountability and break down barriers between each separate organisation.

The HCP attracted additional funding for cancer diagnostics, diabetes and a new child and adolescent mental health unit during 2017/18, as well as developing a strategic case for change for stroke from prevention to after care and are identifying and treating people at high risk of having a stroke.

West Yorkshire Association of Acute Trusts (WYAAT)

Complementing and working closely with the HCP is the West Yorkshire Association of Acute Trusts, which is an innovative collaboration bringing together the NHS Trusts who deliver acute hospital services across West Yorkshire and Harrogate. The Trust is an active member of this network.

The WYAAT has a joint work programme focussed around four clear work streams:

- Specialist services – a review of the way some of the specialist services are delivered and whether these could be provided in a better way.
- Clinical standardisation and networks – looking to standardise the way organisations work across trusts to reduce variation and duplication.
- Clinical support – reviewing pathology, radiology and pharmacy systems and processes to identify benefits of working together and in the same ways.
- Corporate services – looking at back office functions to share learning and identify any benefits of bringing together ways of working, teams and services.

Within the WYATT programme, the Trust has focused on a number of initiatives across a range of different areas. It is recognised that in order to remain a sustainable organisation, the Trust needs to work in partnership with other provider trusts to deliver new models of working and financial efficiencies. In addition there may be occasions when there is a need to provide support to other WYAAT Trusts that impacts upon the Trust position but improves the quality, performance or safety of the collective. Equally there may be occasions when the Trust benefits from support in this way from other WYAAT Trusts. A summary of the key work streams which were taken forward during 2017/18 are detailed below:

Harrogate PLACE

The Trust has worked closely with Harrogate and Rural District CCG (HaRD CCG) to ensure that organisations within the local health economy can continue to provide high quality services within agreed financial resources. Both organisations recognise the level of financial challenge that this presents but are fully committed to working together to meet this objective. Discussions have been ongoing regarding the development of an 'Aligned Incentive Contract' (AIC) ensuring that we live within our agreed level of resources. A contract variation has been signed to this effect and came into effect from 1 April 2018.

The following principles have been agreed with HaRD CCG as follows:

- Sustainability of both HaRD CCG and the Trust, both financially and clinically;
- A reduction in the cost of healthcare provision for the Harrogate population;
- Delivery of the best possible outcomes within the resources available – delivery of value for money;
- Maximising the resource that is available to the Harrogate system, including provider and commissioner sustainability funds;
- A commitment that any potential changes in service or pathway provision that increase costs will be jointly discussed before any resource commitment is made;
- A joint effort to repatriate Harrogate activity that is currently delivered out of area or transfer patient activity from other CCGs into Harrogate where this is beneficial to do so; and,
- Efficiency in the contracting process and a focus of available staffing support resources on delivering the clinical changes required.

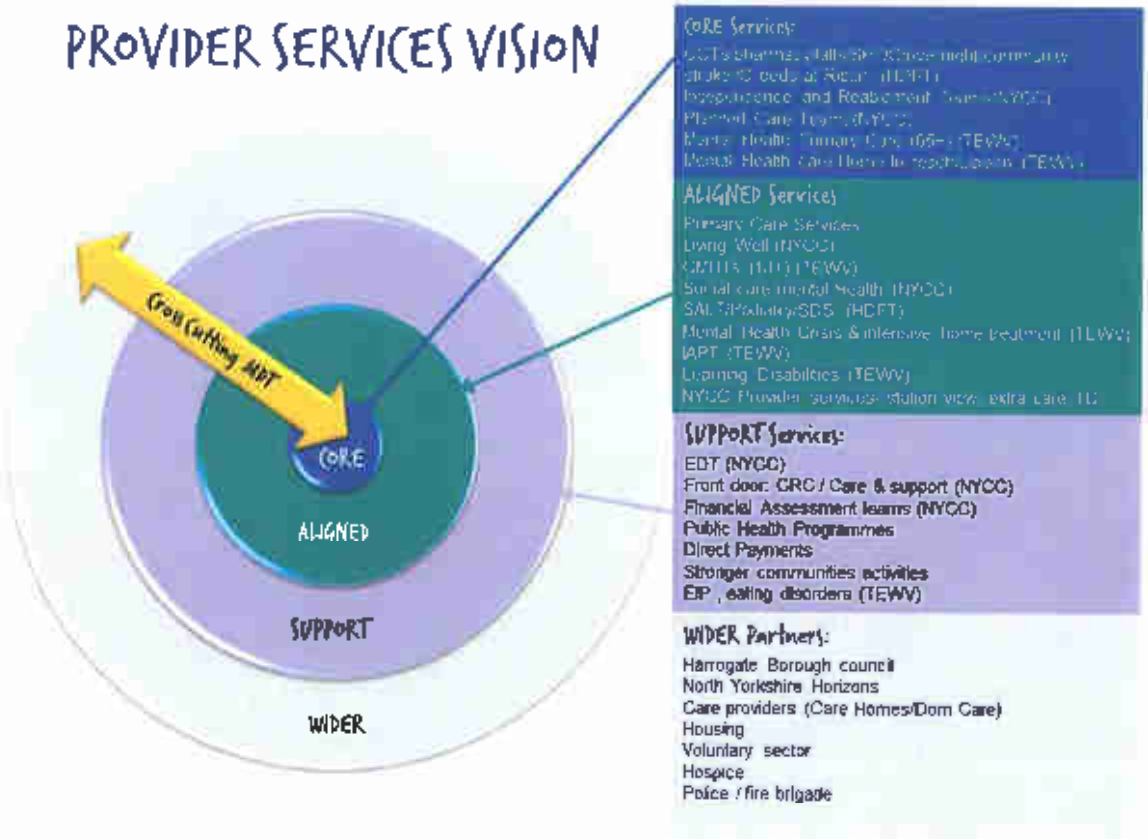
Provider Collaborative

During the year the Trust became a founding member of the Provider Collaborative which includes representatives from TEWV, NYCC and the Harrogate GP Federation Yorkshire Health Network and is focused on developing a new collaborative model for care outside of hospital.

The Provider Services Vision aspires to:

- Have the person and community at the centre of services;
- Design services around the needs of patients through an assets/strengths based approach;
- Support and champion community services, managers and staff;
- Be realistic and ambitious in exploring how organisations can work together;
- Make joint working and leadership the norm rather than an exception or an initiative;
- Recognise and address the very real pressures of service delivery in and around Harrogate and the surrounding areas; and,
- Achieve Successful collaboration whilst maintaining each organisation's identity.

The vison for provider services can be summarised as:



Quality

The Trust is fully committed to high quality care. The Quality Account, included within this Annual Report at Section 5.0, details progress made on quality priorities during 2017/18 and outlines the agreed quality priorities for the coming year. The priorities for quality improvement are agreed with staff and stakeholders and will have clear and measurable targets, with performance against these monitored regularly through the Trust's Quality Committee.

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

3.2.4.2Operating and Financial Review of the Trust

The income and expenditure position for the Trust for 2017/18 was a surplus of £951k.

The table below provides a high level comparison of the income and expenditure account for 2017/18.

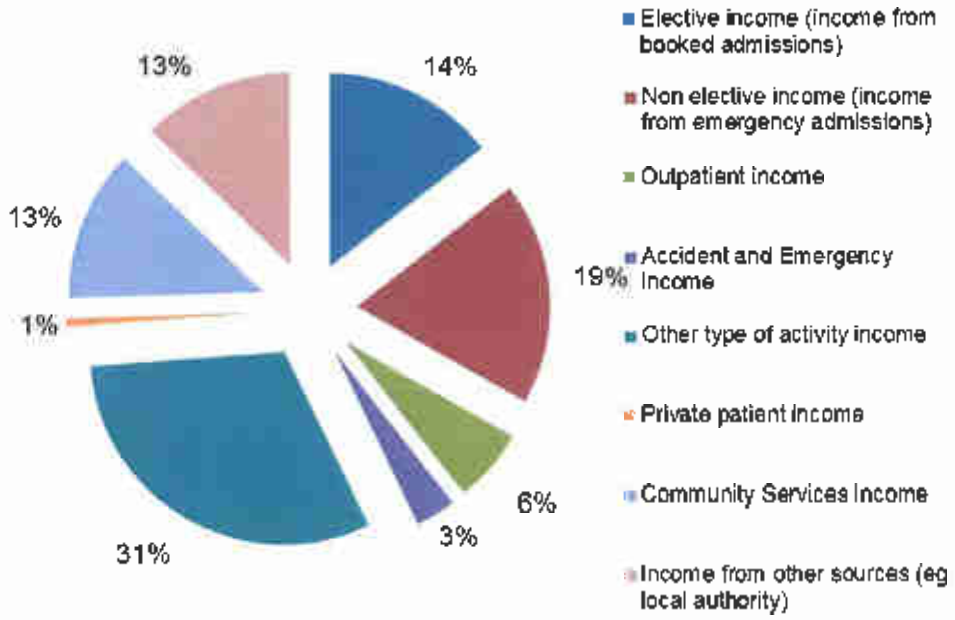
	2016/17 actual £000s	2017/18 actual £000s
Income	217,401	216,545

Expenditure	(213,713)	(215,594)
Surplus	**3688**	**951**

Income Generated from Continuing Activities

Total income from continuing activities for the year 2017/18 was £199,637k. This represented 92.2% of total income for the year. An analysis of this income is shown below:

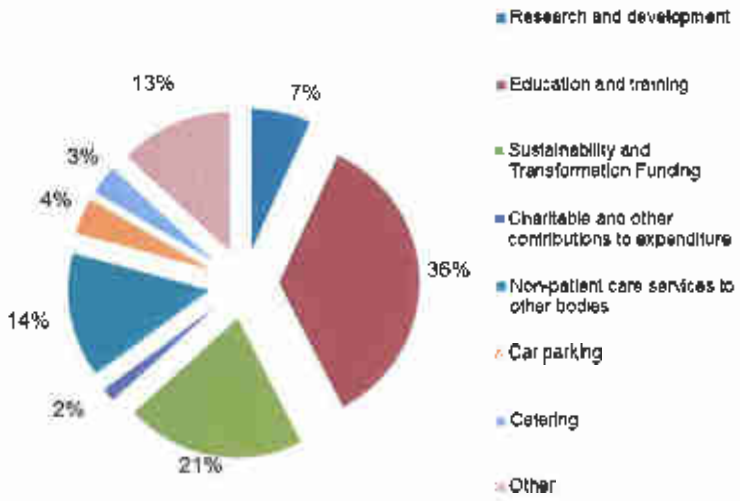
Income from continuing activities



Other Operating Income

Other operating income totalled £16,958k during 2017/18. This represented 7.8% of total income for the year and an analysis of this income is shown below:

Analysis of other operating income



Cash

The Trust had a cash balance of £5.4m at the close of the financial year.

NHSI Use of Resource Metric

The Trust received a Use of Resource Rating of three at the end of 2017/18. Financial Risk is assessed on a scale of one (low risk) to four (high risk).

Overall Financial Challenge 2018/19

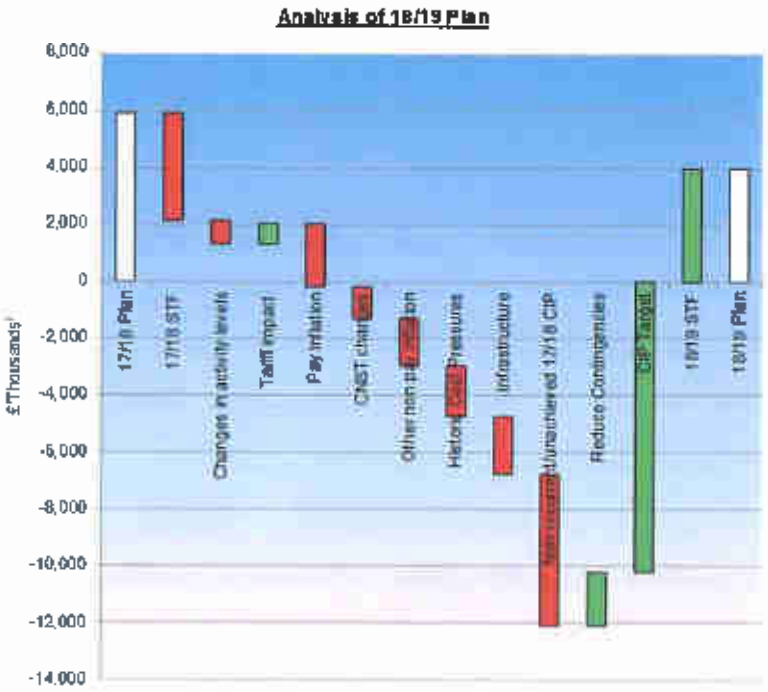
In line with all NHS Providers, there will be significant financial challenges to be faced in 2018/19, with key drivers being the availability of appropriate workforce and the management of urgent care. As a local Harrogate health community, we are currently spending more on healthcare than is available, with the CCG recording a deficit in 2017/18 and forecasting a deficit into 2018/19 plans. We are working collectively across the system to manage financial risk, including the agreement of an Aligned Incentive Contract, in order to create a framework for the necessary difficult decisions and prioritisation that will have to take place through the year.

The priority of the Trust and the Harrogate system is to deliver financial sustainability for both organisations and principles have been agreed to this effect. This recognises that the best way of meeting the overall significant financial challenges is to work collaboratively to reduce the costs of healthcare for the local population.

The following table describes the risks within the 2018/19 financial plan:

2018/19 Planning Assumptions

	£'000s
17/18 Plan	5,909
17/18 STF	3,777
Changes in activity levels	- 820
Tariff impact	725
Pay inflation	- 2,235
CNST changes	- 1,103
Other non pay inflation	- 1,673
Historic Cost Pressures	- 1,763
Infrastructure	- 2,041
Non recurrent/unachieved 17/18 CIP	- 5,324
Reduce Contingencies	1,902
CIP Target	10,200
18/19 STF	3,983
18/19 Plan	3,983



Further Details of the Trust's Strategic Plans

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

Approval by the Board of Directors of the Performance Report

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

3.2.5 Environmental Matters

The Trust is committed to meeting the provisions in its carbon management program which sets an ambitious target of reducing its carbon emissions by 30% from a 2010/11 baseline by 2020.

Reducing CO_2 emissions will not only meet harmful emission targets and help reduce environmental damage, it also has the potential to deliver financial efficiency savings. There is substantial evidence that carbon reduction initiatives also have a direct and positive effect on health and wellbeing – particularly through increasing physical activity, promoting a better diet, improving mental health and wellbeing and reducing obesity.

A recent investment of £7 million in making Harrogate District Hospital more energy efficient means that an estimated £625,000 per year for the next 25 years (a total of £15,625,000) can be redirected to direct patient care. This investment facilitated an overhaul of the hospital's facilities, thereby helping ensure that it is best placed to meet patient needs into the future e.g. two of the original hospital inefficient steam boilers, have been replaced along with new heating equipment across the site. The project was completed in 2017 and in its first year of full operation energy consumption of both gas and electricity has significantly reduced together with the corresponding CO_2e. During the year this project reduced the Trust's carbon emissions by 25%.

Additionally other non carbon energy fund sustainability initiatives included:

- Provision of additional cycle storage facilities at Harrogate District Hospital.
- Introduction of a lift sharing scheme for staff members at Harrogate District Hospital and the Lascelles Unit. The scheme links drivers and passengers to free up spare capacity and reduce CO2 emissions by sharing lifts and reducing the number of vehicles on roads and the Trust's sites.

Procurement

NHS Supply Chain, the organisation which supplies and contracts on behalf of the Trust and other NHS organisations, reaffirmed its broad sustainability commitments for 2017/18 include carbon, waste, ethics, responsibility and natural resources. Specific examples of achievements during the year included a reduction in direct CO_2 emissions from the NHS Supply Chain transport fleet (by 2.5% year on year), working with suppliers to reduce the use of raw materials in product packaging, and supporting the government's pledge to achieve sustainable palm oil within food and other products.

The Trust's Sustainability Group has introduced processes around checking energy ratings on targeted products such as fridges, whilst sustainability continues to be taken

into account as part of the selection process for medical equipment. The Trust has also started implementation of a theatre management stock module system, which when fully implemented will reduce wastage in addition to achieving other benefits. In addition the Trust's Equipment Group has recently introduced a sustainability section into documentation that must be completed for all prospective purchases of medical equipment

The Trust continued the roll out of a desk top mailing service thus extending the range of patient letters that are now being sent electronically to a service provider to distribute, rather than being printed and mailed locally.

Food Waste

The Trust now has an established contractor for the recycling of its food waste from the Harrogate District Hospital site. The food waste is recycled to generate renewable energy and power. In addition to this, it is also used to produce a high quality organic based fertiliser rich in nutrients such as nitrogen, phosphate and potash.

With all food waste recycling handled in this manner, the Trust has an environmentally friendly way of diverting this waste from landfill. A brief summary of Kw Hours of electricity produced & total tonnes of CO2 displaced for the financial year ending 31 March 2018 can be found in the table below:

12 MONTHS ENDING 31 MARCH 2018		
QUARTER	**KW HOURS PRODUCED**	**TOTAL TONNES CO_2 SAVED**
One	7861.86	13.39
Two	9099.00	13.50
Three	8221.50	14.01
Four	9490.50	16.17
Total	**34,672.86**	**57.07**

Clinical and General Waste

Waste		2016/17	2017/18
Recycling	(tonnes)	151.28	86.01
	tCO_2e	3.2	1.8
High Temp recovery	(tonnes)	391.28	371.21
	tCO_2e	8.2	7.8
High Temp disposal	(tonnes)	340.29	313.98
	tCO_2e	7	6.6
Landfill	(tonnes)	18.55	67.92

	tCO_2e	4.5	16.5
Total Waste (tonnes)		**901.40**	**836.12**
% Recycled or Re-used		**60.2%**	**54.68%**
Total Waste tCO_2e		**22.9**	**32.7**

Energy Usage

Resource		2016/17	2017/18
Gas	Use (kWh)	28725280	27072959
	tCO_2e	5286	4982
Oil	Use (kWh)	66208	144876
	tCO_2e	18	39.3
Coal	Use (kWh)	0	0
	tCO_2e	0	0
Electricity	Use (kWh)	5,288,113.90	3,699,906.50
	tCO_2e	544	380.7
Total Energy CO_2e		**5848**	**5402**
Total Energy Spend		**£ 1,033,959**	**£ 1,014,969**

3.2.6 Overseas Operations

The Trust does not have any overseas operations.

3.2.7 Social, community, anti-bribery and human rights Issues

The Trust has a significant profile in the local areas it serves and sees its community role as important both as a health care provider and potential local employer.

The Trust has a popular education liaison programme supported by strong relationships with local schools. The programme includes careers events, current NHS careers information, advice and guidance and real life input into the school curriculum.

Complementing the education liaison programme the Trust has a highly successful work experience programme. During 2017/18 the Trust supported 115 work experience

placements for students from local schools and colleges. The students, many of whom are hoping to pursue careers in medicine, support staff with a range of activities both in clinical and non–clinical areas.

During the year the Trust has developed a range of apprenticeship schemes. As at 31 March 2018 the Trust employs 35 apprentices, with plans to increase this during 2018/19.

We have a number of policies in place which cover social, community and human rights matters. A process is in place to ensure that none of our policies have an adverse or discriminatory effect on patients or staff. We continue to provide positive support to people with a disability who wish to secure employment with the Trust through the guaranteed interview scheme and comply with the two ticks requirements. There are policies in place which support staff who may become disabled during their employment.

The Trust's anti bribery and counter fraud arrangements are in compliance with the NHS Counter Fraud Authority's Counter Fraud Standards for Providers. These arrangements are underpinned by the appointment of accredited Local Counter Fraud Specialists and the introduction of a Trust-wide Anti-Fraud, Bribery and Corruption Policy.

The Trust's Audit Committee reviews and approves an annual counter fraud plan identifying the actions to be undertaken to create an anti-fraud culture, deter prevent, detect and, where not prevented, investigate suspicions of fraud. The counter fraud team also produces an annual report and regular progress reports for the review and consideration of the Finance Director and Audit Committee.

The Counter Fraud Team also completes an annual self-assessment of compliance against the Counter Fraud Standards for Providers, which is reviewed and approved by the Finance Director prior to submission to NHS Counter Fraud Authority. The 2017/18 assessment was completed and submitted in March 2018 with an overall assessment of green, confirming the Trust was compliant against the majority of standards.

3.2.8 Events since the end of the financial year

There have been no significant events since the end of the financial year on 31 March 2018.

Signed

Dr Ros Tolcher
Chief Executive
Date: 23 May 2018

4. ACCOUNTABILITY REPORT

4.1. Director's Report

4.1.1 Directors 2017/18

The Directors of the Trust during the year 2017/18 were:

Mr Jonathan Coulter	Finance Director and Deputy Chief Executive
Mrs Sandra Dodson	Chairman (Non-Executive Director) (left 31/10/2017)
Mrs Jill Foster	Chief Nurse
Mr Robert Harrison	Chief Operating Officer
Mrs Angela Schofield	Chairman (Non-Executive Director) (joined 01/11/2017)
Mr Phillip Marshall	Director of Workforce and Organisational Development
Mr Neil McLean	Non-Executive Director (left 30/04/2018)
Ms Laura Robson	Non-Executive Director (joined 01/09/2017)
Dr David Scullion	Medical Director
Mrs Maureen Taylor	Non-Executive Director and Chairman of Finance Committee
Mr Chris Thompson	Non-Executive Director, Vice Chairman and Chairman of Audit Committee
Dr Ros Tolcher	Chief Executive
Mr Ian Ward	Non-Executive Director and Senior Independent Director
Mrs Lesley Webster	Non-Executive Director and Chairman of Quality Committee

4.1.2 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.

4.1.3 Accounting Policies

The Trust prepares its financial statements under direction from NHSI, in exercising the statutory functions conferred on Monitor, in accordance with the Department of Health Group Accounting Manual 2017/18 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.

4.1.4 Charitable and Political Donations

During 2017/18 no charitable or political donations were made by the Trust.

4.1.5 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 2017	Numbers	Year to 31 March 2018
53,867	Number of Bills Paid to Date	51,454
9,447	Number of Bills Paid in 30 Days	8,080
18%	% of Bills Paid in 30 Days	16%

Year to 31 March 2017	Values	Year to 31 March 2018
76,491	£K Value of Bills Paid to Date	95,920
39,404	£K Value of Bills Paid in 30 Days	53,827
52%	% of Bills Paid in 30 Days	56%

4.1.6 NHS Improvement Well Led Framework

The Trust has arrangements in place to ensure that services are well led. Further details about these arrangements are included within this Annual Report at Section 4.7 (Annual Governance Statement).

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

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

4.1.8 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 2017/18.

4.1.9 Patient care activities

Improvements in Patient/Carer Information

The Trust launched a new website in 2016, following extensive engagement with users. This delivered an improved user experience, clearer information and a much more modern look and feel which better reflects the Trust's vision and values. There is a clearer focus given to the key information that people want the most – how to find us, contact details, car parking, and visiting hours, and a new consultants area which features a short biography and photograph of all the consultants working at the Trust. All service pages were updated and refreshed.

In line with all NHS trusts, the Trust has starting implementing the Accessible Information Standard (AIS) which aims to improve the lives and life expectancy of people

who need information to be communicated in a specific way. The AIS is based on the requirement to implement:

1. Identification of needs;
2. Recording needs as part of patient / service user records and PAS systems;
3. Flagging of needs using e-flags or alerts to indicate that an individual has a recorded information and/or communication need and to prompt staff to take appropriate action;
4. Sharing of needs as part of existing data-sharing processes and as routine part of referral, discharge and handover; and,
5. Meeting of needs.

We have made progress in relation to people with learning difficulties, and are progressing systems and processes to enable us to support all patients with specific information and communication needs.

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

Over the year, significant support and guidance has been provided to teams across the Trust who wish to have their own service page. There are approximately 30 Trust social media accounts in place, with more due to come online. This process has been supported by the development of a Trust-wide Social Media Policy and a clear process for the approval of accounts based around need and objectives.

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

Complaints Handling

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

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

In order to publicise the service, leaflets and posters are available in all departments across the Trust and in community locations. Patient Experience Volunteers work to publicise the Making Experiences Count Policy and the process by which the public can

share feedback regarding the Trust services. They are based at the front of Harrogate hospital in the Main Reception during normal working hours.

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

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

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

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

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

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

There is no time limit for giving feedback to the Trust for those issues which fall outside the Complaints Regulations. All feedback will be received and acted upon wherever possible to ensure learning and improvement for the organisation. Where the issue is coded as a complaint, the regulations set a time limit of 12 months from the event or awareness of the event, for making the complaint. The Trust, however, adopts a flexible attitude to complaints about incidents occurring outside this timescale.

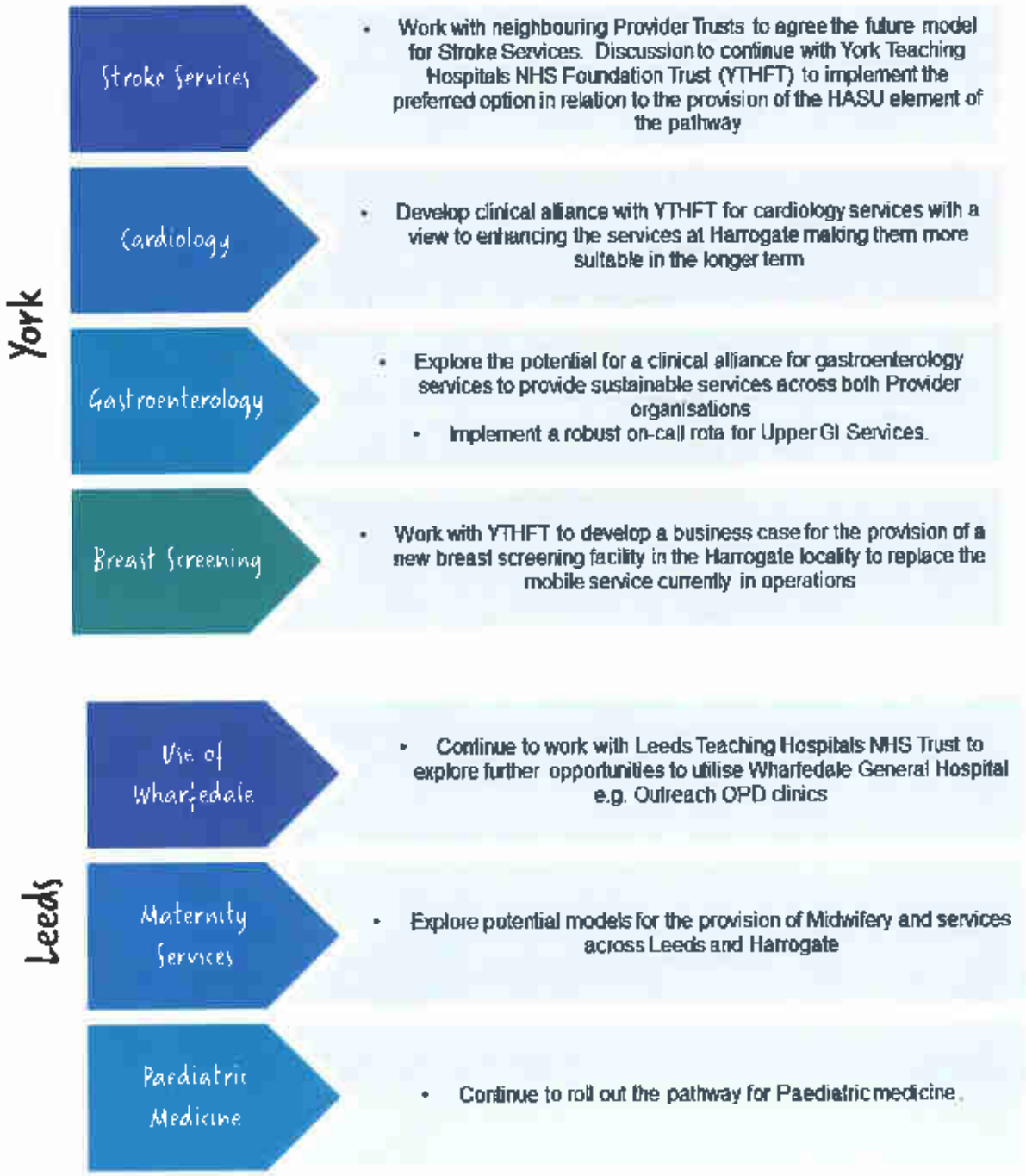
Action plans are considered by the Directorates for each complaint which is raised. Action plans are required for all issues that have been upheld following investigation and quality assurance by the Directorate. Complaint trends and action plans, including those developed in response to Health Service Ombudsman reviews are reported to the Learning from Patient Experience Group (LPEG) and the Quality Committee on a quarterly basis and in turn to the Board of Directors.

4.1.10 Stakeholder Relations

Partnerships and Alliances/Relationship Management

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

Over the last 12 months the Trust has engaged with YTHFT and LTHT to explore opportunities for greater collaboration across key specialties, these have included:



The Trust is also a member of WYAAT which has formalised governance arrangements to enable greater collaboration. A high level programme structure linked to the West

Yorkshire and Harrogate HCP and WYAAT Committee in Common is now established. A work programme has been developed which will be rolled out in 2018/19.

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

Significant Activities in the Field of Research and Development

Information on research and development within the Trust is contained within the Quality Account, which is included at Section 5.0.

New Services and Developments

The Trust has been actively taking forward the implementation of the Business Development Strategy. We have been successful in 2017/18 in taking forward a number of key initiatives including:

- Successfully secured contracts for the 0 – 19 Community Children's Services in Stockton-On-Tees, Gateshead and Sunderland and progressed with the mobilisation of these contracts during the year;
- Successfully secured the contract for the Childhood Vaccination and Immunisation Services in North Yorkshire and York and progressed with the mobilisation of this contract during the year;
- Successfully secured the contract for the Childhood Influenza Immunisation Service in Leeds and progressed with the mobilisation of this contract during the year;
- Successfully secured the Any Qualified Provider contract for the ENT and Adult Hearing Loss Service in Leeds and progressed with the mobilisation of this contract during the year; and,
- Successfully secured the Any Qualified Provider contract for the Endoscopy Service in Bradford and progressed with the mobilisation of this contract during the year.

Work will continue to roll out our Business Development Strategy. This will include consolidation of our new services contracts, continuing to increase services for Leeds and the continued rollout of the Private Healthcare and Communications and Marketing Strategies, which will form part of our work programme in the coming months.

Approval by the Directors of the Accountability Report

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

Signed

Dr Ros Tolcher
Chief Executive
Date: 23 May 2018

4.2. Remuneration Report

4.2.1 Annual Statement on Remuneration

The Trust recognises that the remuneration policy is important to ensure that the organisation can attract and retain skilled and experienced leaders. At the same time it is important to recognise the broader economic environment and the need to ensure we deliver value for money.

The report outlines the approach adopted by the Remuneration Committee when setting the remuneration of the executive directors who have authority or responsibility for directing or controlling the major activities of the organisation. The following posts have been designated as fitting the criteria by the committee and are collectively referred to as the executives within this report:

- Chief Executive
- Deputy Chief Executive / Director of Finance
- Chief Operating Officer
- Chief Nurse
- Medical Director
- Director of Workforce and Organisational Development

There have been no major decisions or substantial changes related to executive director or non executive remuneration made during the year.

4.2.1.1 The Remuneration Committee

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

Date of Meeting	24 April 2017	25 Sept 2017	20 Dec 2017
Sandra Dodson Chairman*	✓	✓	-
Neil McLean Non-Executive Director**	x	✓	✓
Angela Schofield*** Chairman	-	-	✓
Laura Robson Non-Executive Director****	-	x	✓
Maureen Taylor Non-Executive Director	✓	✓	✓
Chris Thompson Non-Executive Director	x	✓	✓
Ian Ward Non-Executive Director and Senior Independent Director	✓	x	✓
Lesley Webster Non-Executive Director	✓	x	✓

Notes:
** Sandra Dodson left the Trust on 31 October 2017.*
*** Neil McLean left the Trust on 30 April 2018.*
**** Angela Schofield joined the Trust on 1 November 2017.*
***** Laura Robson joined the Trust on 1 September 2017.*

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

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

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

The Committee provides advice to the Board of Directors on pay policy and other contractual matters for the Chief Executive and all Executive Directors. Comparative sources of guidance used by the Remuneration Committee for the determination of Directors' remuneration have been the NHS Providers Remuneration Survey and the CAPITA NHS Foundation Trust Board Remuneration Report. Decisions regarding uplifts of basic salaries for inflation purposes are only taken when consideration of the approach taken with all other employees has been made. External benchmarking information is used wherever possible so that decisions on remuneration are objective, fair, and proportionate.

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

4.2.2 Remuneration Policy

The Trust's remuneration policy applies equally to Non-Executive Director and Executive Director posts and is based upon open, transparent and proportionate pay decisions. All pay decisions are based on market intelligence and are designed to be capable of responding flexibly to recruitment imperatives to secure high calibre people.

When setting levels of remuneration, the Remuneration Committees take into account the remuneration policies and practices applicable to other employees, along with any guidance received from the sector regulator and the Department of Health. The Committees also receive professional independent reports based on objective evidence of pay benchmarking across a range of industry comparators. The conclusion reached in professional independent reports is that 'weightings accredited to the various posts in relation to market comparisons had resulted in remuneration that is in line with current pay practice.'

The Trust has well established performance management arrangements. Each year the Chief Executive undertakes an appraisal for each of the Executive Directors and the Chief Executive is appraised by the Chairman.

The Trust does not have a system of performance-related pay and therefore in any discussion on remuneration an individual's performance is considered alongside the performance of the Executive Directors and the organisation as a whole.

The Executive Directors are employed on permanent contracts with a six month notice period. In any event where a contract is terminated without the executive receiving full notice, compensation would be limited to the payment of the salary for the contractual notice period. There would be no provision for any additional benefit over and above standard pension arrangements in the event of early retirement. Non-Executive Directors are requested to provide six months' notice should they wish to resign before the end of their tenure. They are not entitled to any compensation for early termination. The Trust has no additional service contract obligations.

In accordance with NHS Improvement guidance the Trust will seek an opinion concerning remuneration of any director who is paid more than £142,500. The Trust consulted NHS Improvement on one occasion during 2017/18.

Information on the salary and pensions contributions of all Executive and Non Executive directors are provided in the tables on the following pages. The information in these tables has been subject to audit by our external auditors KPMG LLP.

4.2.3 Annual Report on Remuneration

4.2.3.1 Senior Manager Remuneration

Name and Title	2017/18						2016/17					
	Salary (bands of £5,000) £'000s	Taxable benefits Rounded to the nearest £	Total Salary and taxable benefits (bands of £5,000) £'000s	Pension related benefits (bands of £2,500) £'000s	Total (bands of £5,000) £'000s	Ratio of Total Salary to Median for All Staff (1)	Salary (bands of £5,000) £'000s	Taxable benefits Rounded to the nearest £100	Total Salary and taxable benefits (bands of £5,000) £'000s	Pension related benefits (bands of £2,500) £'000s	Total (bands of £5,000) £'000s	Ratio of Total Salary to Median for All Staff (1)
Dr R Tolcher - Chief Executive (2)	220-225	-	220-225	-	220-225	6.81	210-215	-	210-215	-	210-215	6.67
Mr. J Coulter - Deputy Chief Executive	140-145	-	140-145	72.5-75	215-220	5.00	135-140	-	135-140	125-127.5	265-270	5.04
Dr D Scullion - Medical Director (3)	205-210	0	205-210	-115- -117.5	90-95	7.29	180-185	5,669	190-195	57.5-60	245-250	6.45
Mrs. J Foster - Chief Nurse	110-115	-	110-115	77.5-80	190-195	3.97	105-110	-	105-110	87.5-90	195-200	3.91
Mr. R Harrison - Chief Operating Officer	125-130	-	125-130	57.5-60	185-190	4.45	120-125	-	120-125	67.5-70	190-195	4.48
Mr. P Marshall - Director of Workforce and Organisational Development	115-120	0	115-120	60-62.5	175-180	4.13	110-115	2837	110-115	75-77.5	185-190	4.11
Mrs. S Dodson - Chairman (4)	25-30	-	25-30	-	25-30	-	45-50	-	45-50	-	45-50	-
Mrs. A Schofield - Chairman (5)	20-25	-	20-25	-	20-25	-	-	-	-	-	-	-
Prof. S Proctor - Senior Independent Director of the Board of Directors (6)	-	-	-	-	-	-	15-20	-	15-20	-	15-20	-
Mrs. M Taylor - Non-Executive Director	10-15	-	10-15	-	10-15	-	10-15	-	10-15	-	10-15	-
Mr. I Ward - Senior Independent Director of the Board of Directors	15-20	-	15-20	-	15-20	-	15-20	-	15-20	-	15-20	-
Mrs. L Webster - Non-Executive Director	10-15	-	10-15	-	10-15	-	10-15	-	10-15	-	10-15	-
Mr. N McLean - Non-Executive Director (7)	10-15	-	10-15	-	10-15	-	10-15	-	10-15	-	10-15	-
Ms. L Robson - Non-Executive Director (8)	5-10	-	5-10	-	5-10	-	-	-	-	-	0	-
Mr. C Thompson - Non-Executive Director/ Audit Committee Chairman	20-25	-	20-25	-	20-25	-	15-20	-	15-20	-	15-20	-

Notes:
(1) The median salary for all staff in 2017/18 was £28,746. The median salary for all staff in 2016/17 was £27,631. The median calculation is the annualised full time remuneration of all staff in the Trust as at 31 March 2018 (excluding agency staff), excluding the highest paid Director. The ratio is based on the total salary and benefits in year..
(2) For individuals employed by the Trust who are reaching or exceeding their pension Lifetime Allowance, the Trust has a policy which allows individuals to apply for a discretionary Pensions Restructuring Payment as a retention scheme. This payment is typically equal to the employer's contribution to the NHS Pension Scheme, paid net of employer's National Insurance contribution. This is a financially neutral model for the Trust. The Chief Executive's application for a pension restructuring payment was approved by the Trust's Remuneration Committee in 2016 and the salary quoted above therefore includes a pensions restructuring payment.
(3) The Medical Director remuneration includes payment to Dr Scullion for both this role and his clinical post as Consultant Radiologist. The Medical Director proportion of his salary equates to 25% of the salary outlined above.
(4) Mrs. S Dodson ceased as Chairman on 31 October 2017
(5) Mrs. A Schofield commenced as Chairman on 1 November 2017
(6) Prof. S Proctor ceased as Non-Executive Director on 31 March 2017
(7) Mr. N McLean ceased as Non-Executive Director on 30 April 2018
(8) Ms. L Robson commenced as Non-Executive Director on 1 September 2017

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

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

4.2.3.2 Expenses

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 details about expenses paid during 2017/18:

	Number in post on 31 March 2018	Number claiming expenses	Total value claimed (rounded to £00)	Number in post on 31 March 2017	Number claiming expenses	Total value claimed (rounded to £00)
Board of Directors	13	9	6,800	13	10	7,300
Council of Governors	20	3	700	22	2	500

4.2.3.3 Pension related benefits

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2018 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2018 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Real Change in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension to nearest £100
Dr Rosamond Tolcher - Chief Executive	£Nil	£Nil	£Nil	£Nil	£Nil	£Nil	£Nil	£Nil
Mr. Jonathan Coulter - Deputy Chief Executive	2.5-5	0-2.5	45-50	115-120	683	776	93	£Nil
Dr David Scullion - Medical Director	-5- -7.5	-15- -17.5	30-65	180-185	1,371	1,343	-28	£Nil
Mrs. Jill Foster - Chief Nurse	2.5-5	10-12.5	45-50	140-145	810	934	124	£Nil
Mr. Robert Harrison - Chief Operating Officer	2.5-5	0-2.5	25-30	60-65	270	319	49	£Nil
Mr. Phillip Marshall - Director of Workforce and Organisational Development	2.5-5	0-2.5	45-50	120-125	676	763	87	£Nil

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

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

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

4.2.3.4 Fair Pay Multiple

The median salary for all staff in 2017/18 was £28,746. The ratio between this and the mid-point of the banded remuneration of the highest paid director was 6.81.

4.2.4 Approval

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

Signed

Dr Ros Tolcher
Chief Executive
Date: 23 May 2018

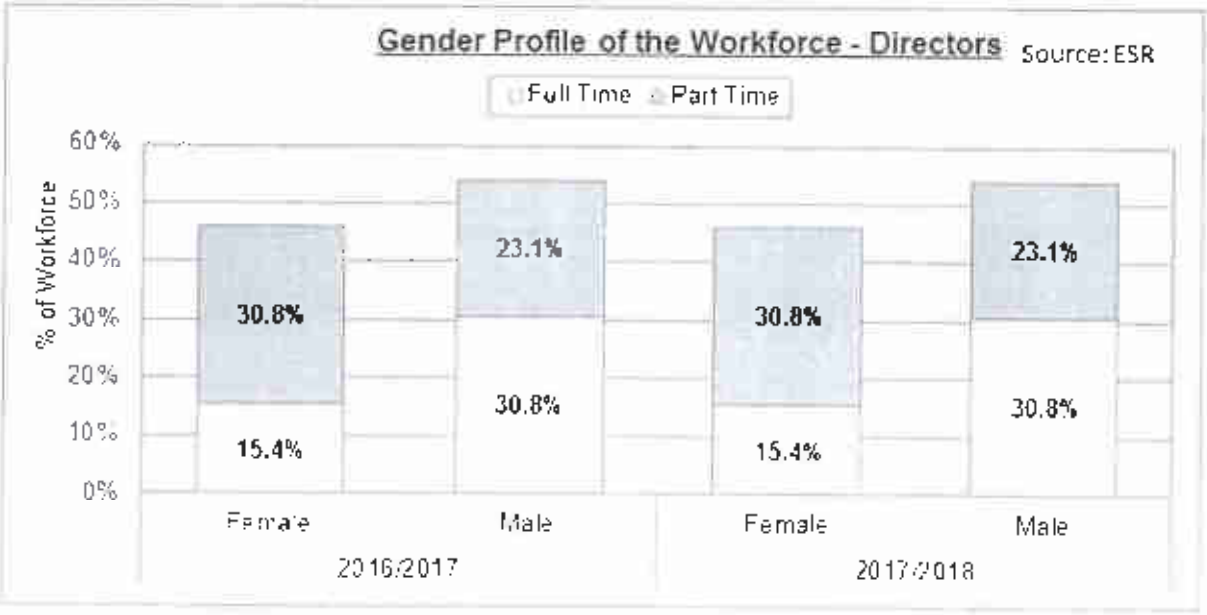
4.3. Staff Report

All of the data profiles of the Trust's staff in the charts below have been collated from the Trust's Electronic Staff Record (ESR) system and provides a comparison between 2016/17 and 2017/18. All figures are taken for the end of the financial year and include all staff employed within the Trust's group; the Trust, the charitable fund and Harrogate Healthcare Facilities Management (a wholly owned subsidiary).

4.3.1 Analysis of staff numbers

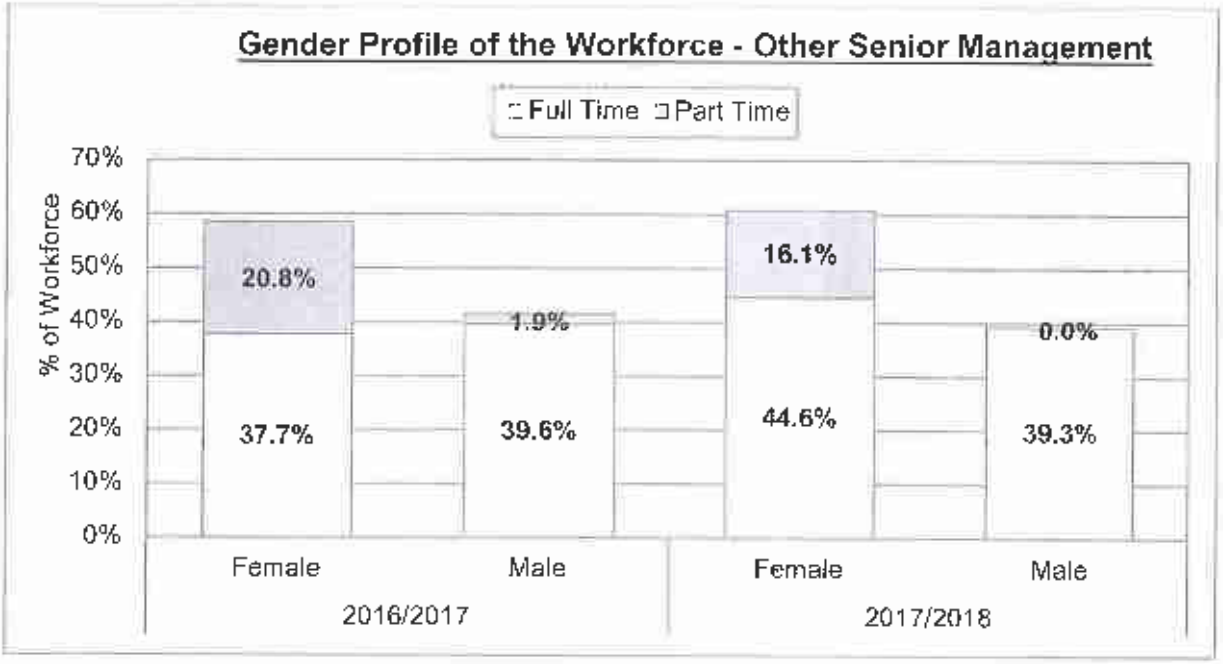
Average number of employees (WTE basis)	Total	Permanent	Other	Total	Permanent	Other
	2017/18	2017/18	2017/18	2016/17	2016/17	2016/17
	No.	No.	No.	No.	No.	No.
Medical and dental	335	324	11	351	315	36
Ambulance staff	2	2	0	2	2	0
Administration and estates	630	629	1	622	615	7
Healthcare assistants and other support staff	425	377	48	412	379	33
Nursing, midwifery and health visiting staff	1,519	1,504	15	1,488	1,472	16
Nursing, midwifery and health visiting learners	21	21	0	22	22	0
Scientific, therapeutic and technical staff	461	460	1	461	460	1
Healthcare science staff	95	95	0	95	95	0
Social care staff	0	0	0	0	0	0
Agency and contract staff	0			0		
Bank staff	0			0		
Other	4	4	0	3	3	0
Total average numbers	3,492	3,416	76	3,456	3,363	93

4.3.2 Analysis of the Male and Female Directors, Other Senior Managers and Employees as at 31 March 2018



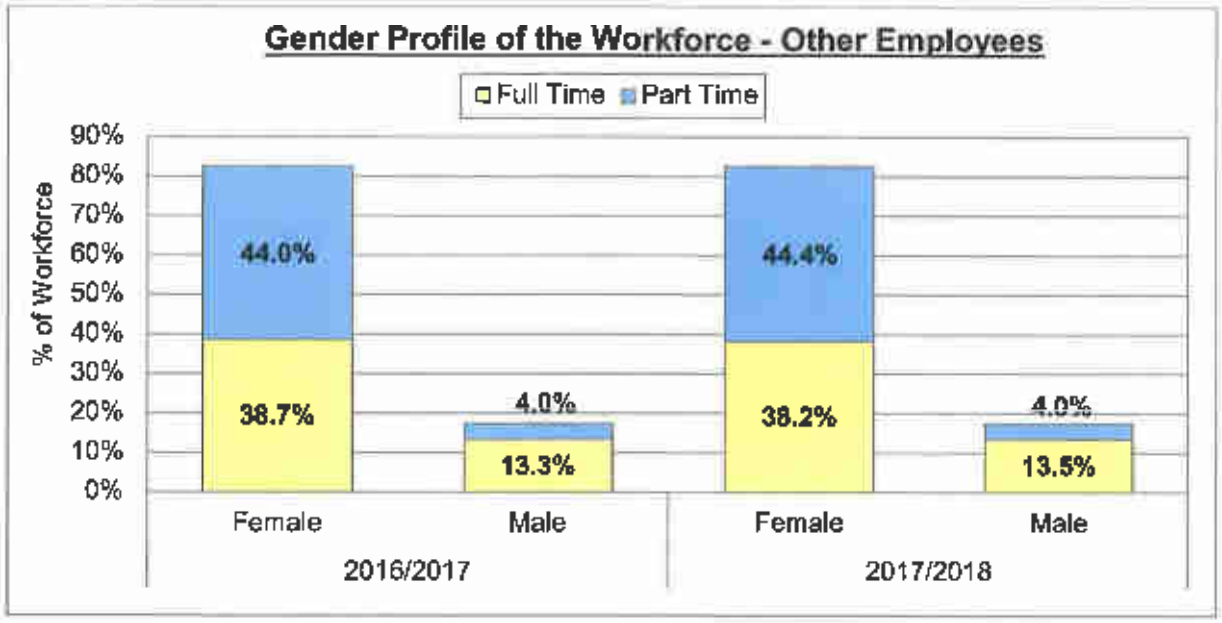
The table below gives a breakdown of the number of Directors, including Non-Executive Directors, by gender, as at 31 March 2018.

DIRECTORS		2016/2017	2017/2018
Gender	Category		
Female	Full Time	2	2
	Part Time	4	4
Male	Full Time	4	4
	Part Time	3	3
TOTAL		13	13



The table below gives a breakdown of the number of other senior management, by gender, as at 31 March 2018.

Gender	Category	2016/2017	2017/2018
OTHER SNR MANAGEMENT		Headcount	Headcount
Female	Full Time	20	25
	Part Time	11	9
Male	Full Time	21	22
	Part Time	1	0
TOTAL		53	56



The table below gives a breakdown of the number of other employees, by gender, as at 31 March 2018.

Gender	Category	2016/2017	2017/2018
Other Employees		**Headcount**	**Headcount**
Female	**Full Time**	1561	1543
	Part Time	1775	1794
Male	**Full Time**	538	544
	Part Time	162	161
TOTAL		**4,036**	**4,042**

4.3.3 Sickness absence data

The table below shows the Trust's sickness absence data for each quarter during the 2017/18 financial year.

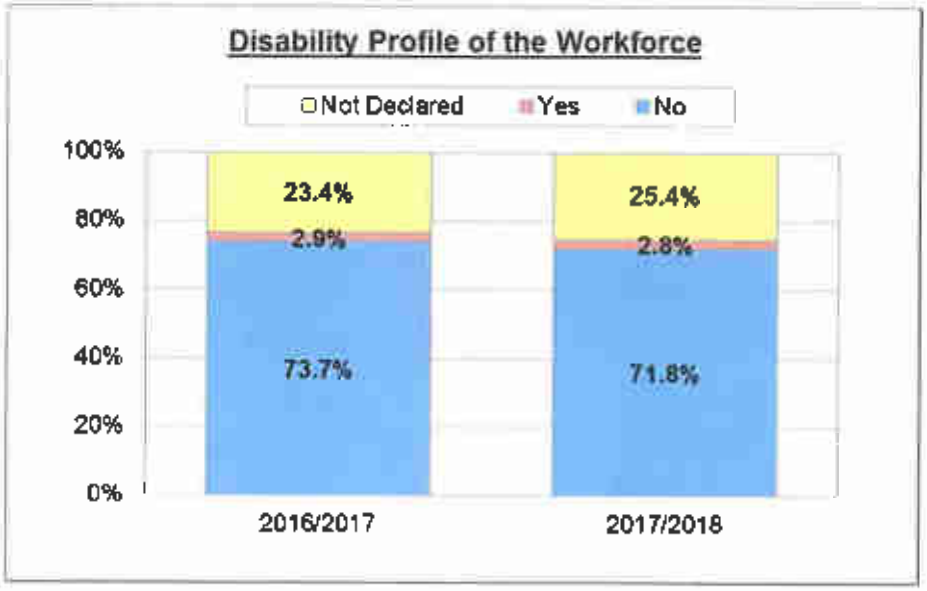
Directorate	17/18 Q1 % Absence Rate (FTE)	17/18 Q2 % Absence Rate (FTE)	17/18 Q3 % Absence Rate (FTE)	17/18 Q4 % Absence Rate (FTE)	Cumulative % Abs Rate
Children's and County Wide Community Care	3.75%	4.05%	4.33%	5.01%	4.28%
Corporate Services	2.85%	2.42%	3.24%	3.23%	2.92%
Long Term and Unscheduled Care	3.93%	3.77%	4.95%	4.76%	4.35%
Planned and Surgical Care	4.41%	4.69%	5.55%	5.53%	5.04%

TOTAL	3.81%	3.83%	4.64%	4.82%	4.27%

Key
17/18 Q1 – April 2017 to June 2017
17/18 Q2 – July 2017 to September 2017
17/18 Q3– October 2017 to December 2017
17/18 Q4 – January 2018 to March 2018

Analysis of the Disability Profile of the Workforce as at 31 March 2018

	2016/2017		2017/2018	
Age Band	**Headcount**	**% of Workforce**	**Headcount**	**% of Workforce**
16-20 Years	35	0.90%	22	0.50%
21-30 Years	621	15.10%	621	15.10%
31-40 Years	954	23.30%	944	23.00%
41-50 Years	1,137	27.70%	1,105	26.90%
51-60 Years	1,092	26.60%	1,117	27.20%
60+ Years	262	6.40%	301	7.30%
TOTAL	**4,101**		**4,110**	



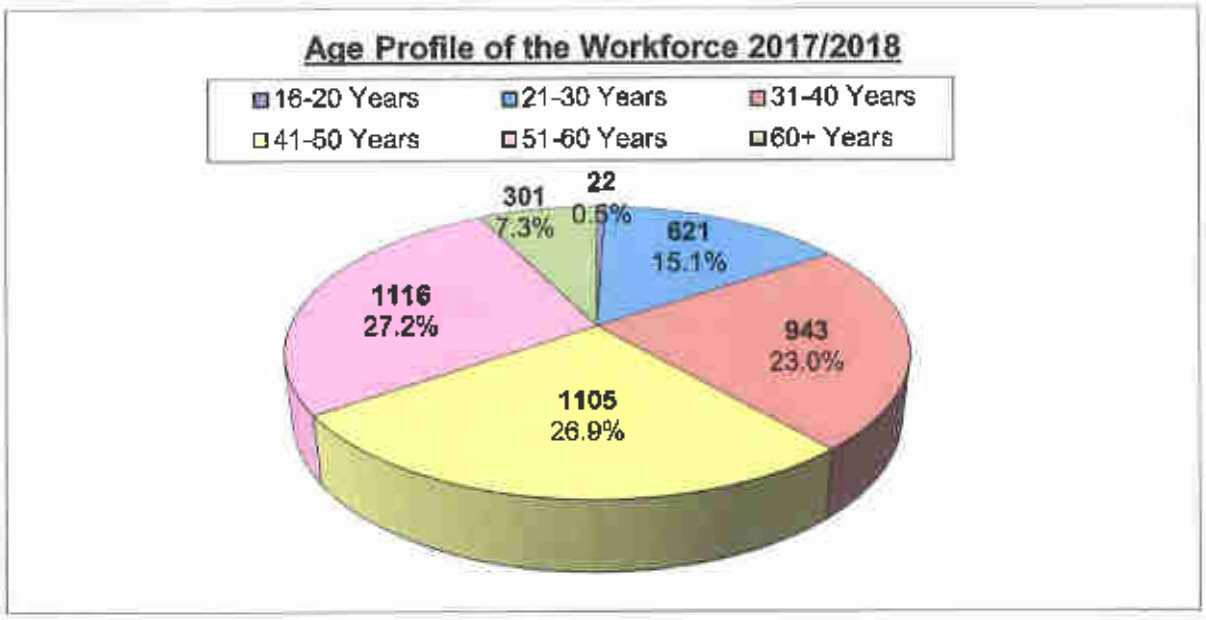
The table below gives a breakdown of the number of employees registered as having a disability as at 31 March 2018.

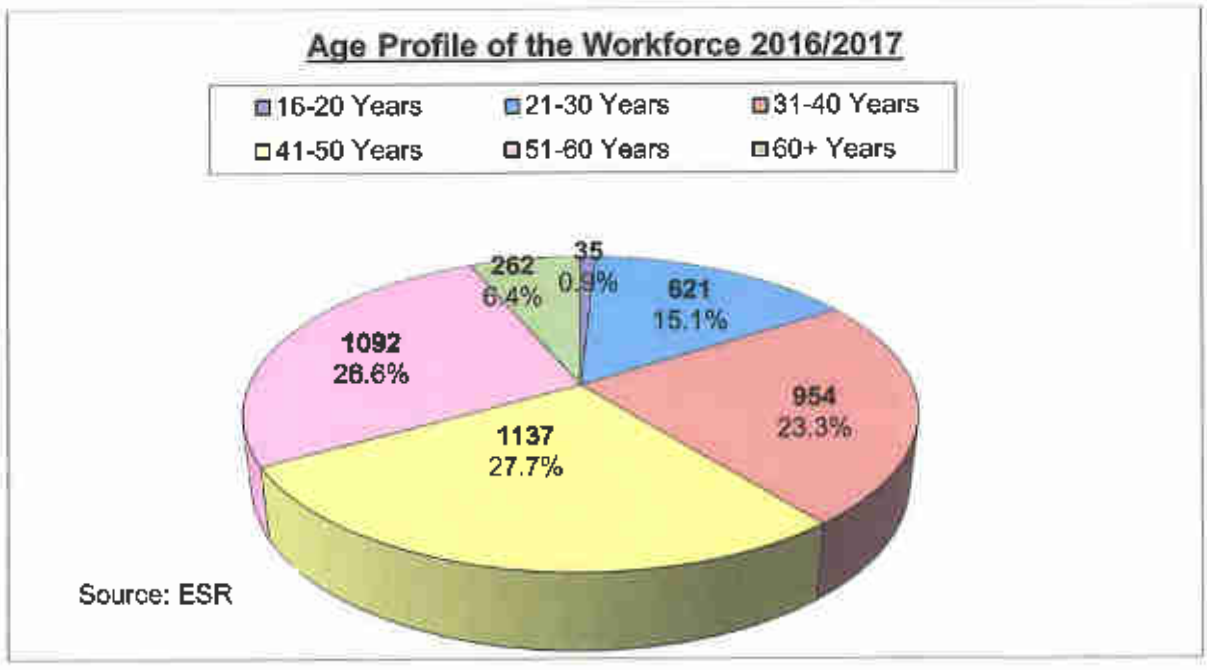
Disabled	**2016/2017**	**2017/2018**
	Headcount	**Headcount**
No	3,022	2,951
Yes	119	114
Not	960	1,045

Declared		
TOTAL	**4,101**	**4,110**

Analysis of the Age Profile of the Workforce as at 31 March 2018

The table below gives a breakdown of the number of employees, by age, as at 31 March 2018.



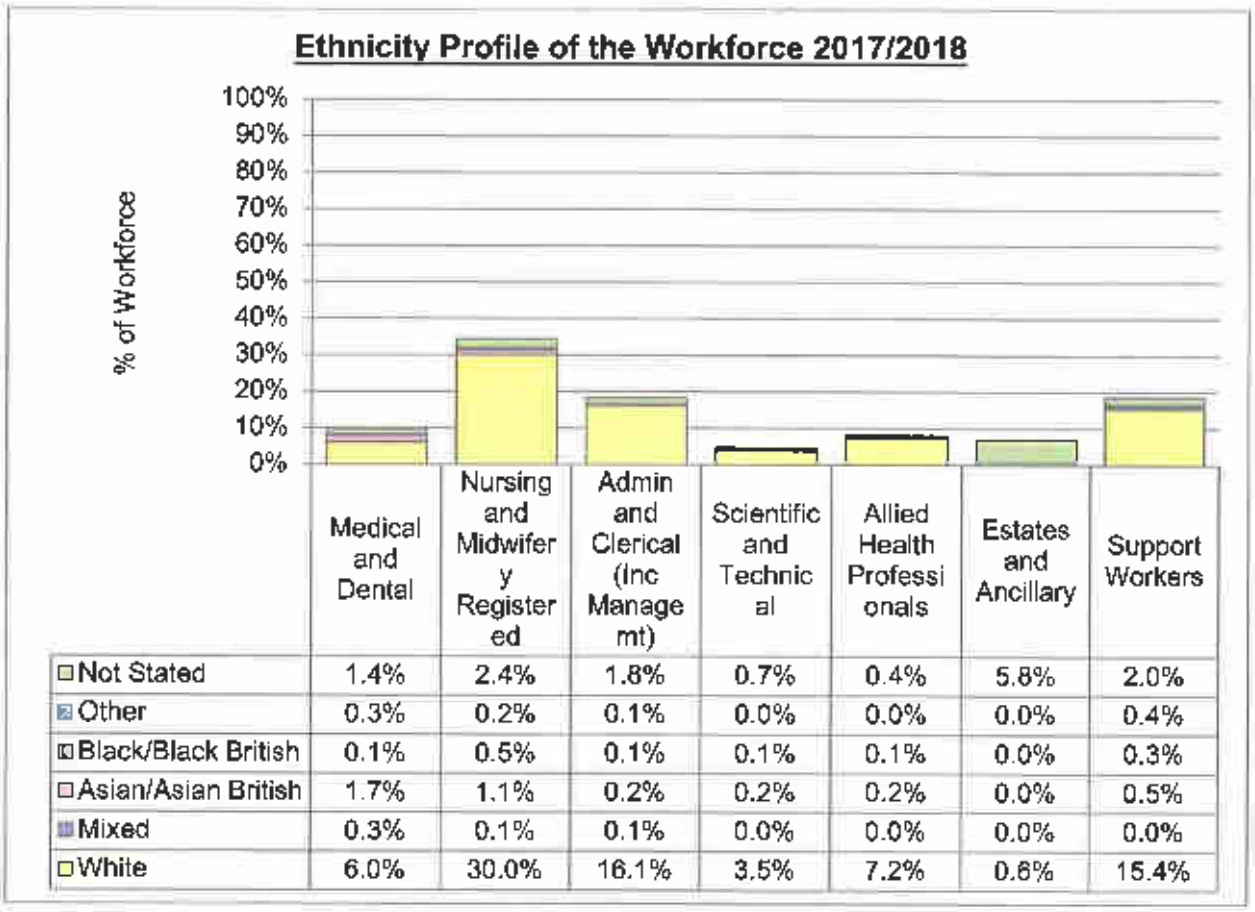


Source: ESR

Equality and Diversity and Human Rights

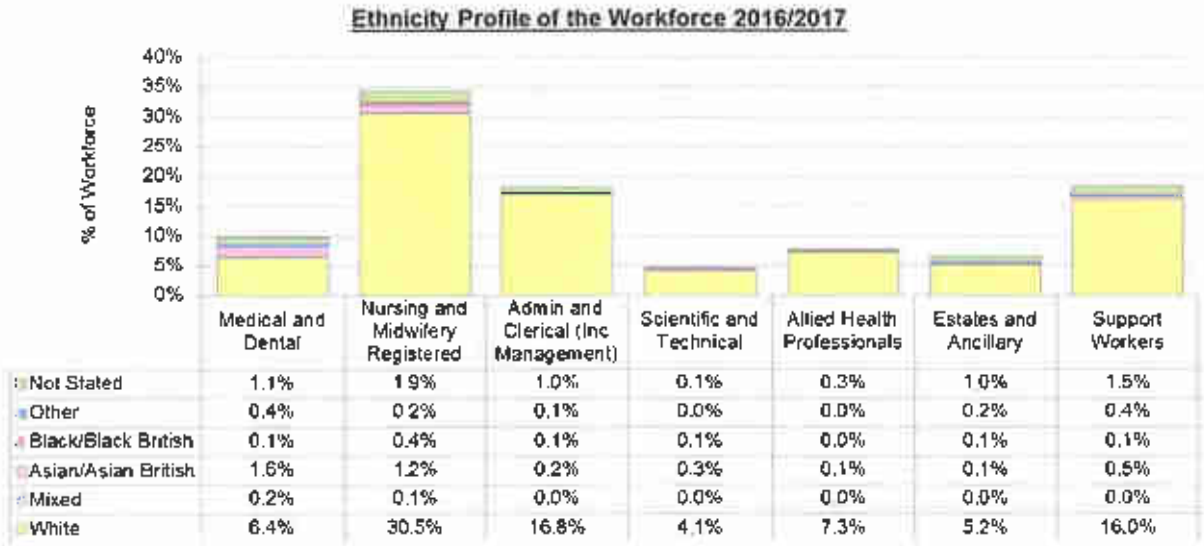
The Trust continues to meet its requirements with regard to the Equality Duty and the Equality Act 2010. This year, evidence in support of the Trust's compliance included publishing the Trust's third Annual Workforce Race Equality Standard (WRES) report in November 2017, followed by the Equality Delivery System (EDS2) assessment in

January 2018. Both of these reports are available to download via the equality and diversity pages of the Trust website. To improve governance arrangements, the stakeholder and workforce equality groups are now in place attended by officers of the Trust, service users, stakeholders, and interested volunteers from the workforce. Actions identified from the Workforce Race Equality Standard are being taken forward and implemented by the Workforce Equality Group.



	Medical and Dental	Nursing and Midwifery Registered	Admin and Clerical (Inc Management)	Scientific and Technical	Allied Health Professionals	Estates and Ancillary	Support Workers
Not Stated	1.4%	2.4%	1.8%	0.7%	0.4%	5.8%	2.0%
Other	0.3%	0.2%	0.1%	0.0%	0.0%	0.0%	0.4%
Black/Black British	0.1%	0.5%	0.1%	0.1%	0.1%	0.0%	0.3%
Asian/Asian British	1.7%	1.1%	0.2%	0.2%	0.2%	0.0%	0.5%
Mixed	0.3%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%
White	6.0%	30.0%	16.1%	3.5%	7.2%	0.6%	15.4%

HEADCOUNT	Medical and Dental	Nursing and Midwifery Registered	Admin and Clerical (Inc Management)	Scientific and Technical	Allied Health Professionals	Estates and Ancillary	Support Workers	TOTAL
White	245	1235	661	144	297	26	631	**3,239**
Mixed	11	3	5	0	0	0	2	**21**
Asian/Asian British	68	47	8	9	9	1	21	**163**
Black/Black British	3	21	3	4	4	2	11	**48**
Other	13	9	3	2	0	0	17	**44**
Not Stated	57	99	72	29	15	240	83	**595**
TOTAL	**397**	**1,414**	**752**	**188**	**325**	**269**	**765**	**4,110**



Headcount	Medical and Dental	Nursing and Midwifery Registered	Admin and Clerical (Inc. Management)	Scientific and Technical	Allied Health Professionals	Estates and Ancillary	Support Workers	TOTAL
Not Stated	45	78	42	5	14	43	60	**287**
Other	16	10	3	2	0	8	16	**55**
Black/Black British	5	18	4	4	1	3	5	**40**
Asian/Asian British	64	48	7	12	6	3	20	**160**
Mixed	8	5	2	1	0	1	1	**18**
White	262	1,252	690	167	300	214	656	**3,541**
TOTAL	**400**	**1,411**	**748**	**191**	**321**	**272**	**758**	**4,101**

4.3.4 Gender Pay Gap Data

Due to legislation enacted in 2017, the Trust has a duty to report on its gender pay gap.

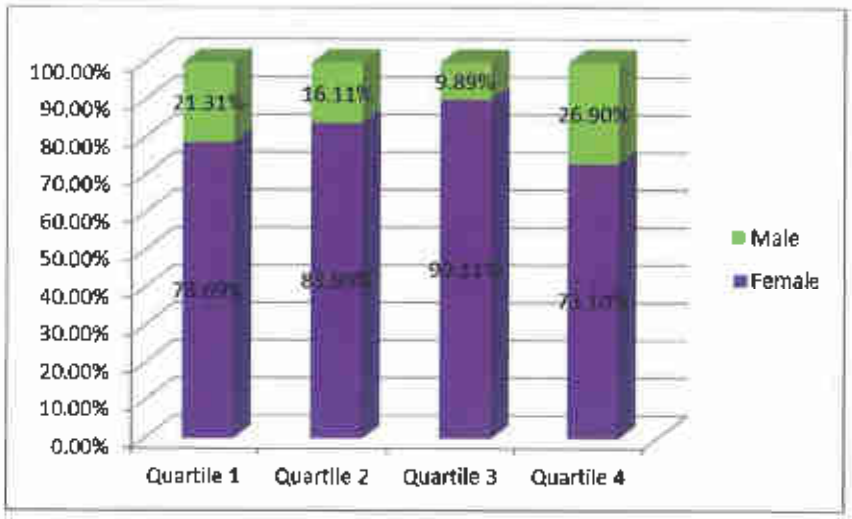
It is important when doing this to highlight the difference between equal pay and a gender pay gap. Equal pay is lawful and relates to men and women receiving different pay for work of equal value, whereas gender pay analyses the differences in average pay for men and women within an organisation. It is entirely possible to have a significant gender pay gap whilst having complete pay equality.

The Trust does have a gender pay gap. One of the main reasons for the gap is that a high proportion of the males employed by the Trust act as very senior managers and Consultants. These individuals earn higher wages and bonuses than many other staff, resulting in males being, on average, paid more than females. Below are our key metrics for the gender pay gap.

The mean and median gender pay gap in hourly pay between males and females:

Gender	Mean Hourly Rate	Median Hourly Rate
Male (£)	21.06	14.56
Female (£)	15.71	14.56
Difference (£)	5.35	0.00
Pay Gap %	25.39	0.00

Proportion of males and females in each pay quartile (1 is low, 4 is high):



The mean and median bonus gender pay gap:

Gender	Mean Bonus	Median Bonus
Male (£)	11,418.23	7,458.97
Female (£)	8,704.60	4,363.54
Difference (£)	2,713.63	3,095.44
Pay Gap %	23.77	41.50

Proportion of males and females receiving a bonus payment:

4.66% of females received a bonus compared to 9.11% of males. To address the gender pay gap the Trust is going to action the following:

- Raise awareness of and be more responsive to flexible working opportunities through internal communications and training;
- Explore options for a female leaders programme to encourage women to progress more quickly into managerial and leadership senior roles;
- Evaluate current recruitment practices, to ensure that the Trust does all it can to encourage applications to achieve a more even gender balance; and,.
- Consider the use of additional training for staff, such as unconscious bias training.

Starters and Leavers during 2017/2018

	Headcount	FTE
Starters	1109	805.33
Starters of which HHFM	330	251.35
Leavers*	731	591.89
Leavers of which HHFM	291	244.83

Exclusions applied to leavers:

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

4.3.5 Staff policies and actions during the year

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

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

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

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

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

The Trust has a number of mechanisms through which it communicates information to its employees. These include a weekly all user e-mail, monthly Team Brief, departmental meetings, *ad hoc* briefings, Twitter and Facebook accounts, personal letters, and pay slip messages and attachments. The Trust continues to offer the 'Ask a Director' facility which enables staff to ask questions of the senior team (anonymously if desired) with the questions and answers being published on the intranet. The method(s) used will be the most appropriate for the particular information to be conveyed but one or more methods will be used for all matters of importance. The Trust also runs a staff intranet providing information regarding the latest changes and developments as well as routine information. The Trust understands that not all clinical and support staff use electronic communication methods and managers are asked to make all staff aware of information communicated by electronic means.

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

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

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

Quality Charter

The Trust recognises that valuing and celebrating the achievements of the workforce is essential to enable the future growth and development of the organisation and the individuals who are part of it. This is recognised through the Quality Charter. The approach is to drive continuous quality improvement through staff engagement. The Quality Charter has been built on four 'joining' elements:

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

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

Health and Safety, and Occupational Health

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

The work of the Occupational Health Department includes:

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

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

A high level of collaborative working with other regional NHS occupational health services ensures that Trust staff working in the various locations throughout the Yorkshire and North East regions are able to access services locally when required, and ensures access to advice from a consultant in occupational medicine when required. In addition, multidisciplinary collaboration via the Trust Flu Steering Group continues to develop initiatives to enhance delivery of seasonal influenza vaccination to front line staff. Collaboration with the Trust's Moving and Handling Co-ordinator ensures a co-ordinated approach to musculo-skeletal/ergonomic assessment, advice and training requirements. Joint working with the Trust's Health and Wellbeing lead and Human Resources colleagues led to the delivery of a staff health and wellbeing promotional event.

The Department continues to hold contracts for the provision of Occupational Health services to other NHS and non-NHS organisations in the local community, supporting the working population and their employers and generating income for the Trust. We are proud to have maintained successful relationships with significant local employers in both the private and public sectors.

The Department maintained membership of the NHS Health at Work Network, a national network of NHS occupational health providers, enabling benchmarking against other providers and involvement in both national and regional initiatives for development of the specialism and collaborative working.

The Staff Counselling Service is a confidential service accessible by employee self-referral which provides support to NHS employees in the Trust. It can support employees through periods of change and uncertainty assisting them to deal with issues in either work or personal life. The service is pro-active in enabling people to deal with change and make appropriate decisions in managing their own lives. It offers help to alleviate stress, and can assist in life and career coaching for staff. In addition to focussed short term work, comprehensive assessment sessions assist staff with more complex, severe or enduring issues to access long term services.

The service is registered with the British Association for Counselling and Psychotherapy (BACP) and is a member of the Association for Counselling at Work. Counsellors working in the service are required to be BACP members and work to the Ethical Framework for Good Practice in Counselling and Psychotherapy. In line with the Trust's Health and Wellbeing Strategy for addressing workplace mental health, the service has continued to support Schwartz Rounds to provide an opportunity for both clinical and non-clinical workers to share experiences of healthcare work and explore the emotional impact within a safe and supportive environment; a team of Mental Health Champions trained in mental health first aid, Mentally Healthy Workplace training sessions and implementation of Building Personal Resilience training courses.

'Mindful Employer'

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

which are made available. The Trust is also exploring the Time to Change Pledge and hopes to have signed up to this during the financial year.

Countering Fraud and Corruption

The Trust has robust arrangements to counter fraud and corruption. These arrangements include the appointment of accredited Local Counter Fraud Specialists and an Anti-Fraud, Bribery and Corruption Policy which is promoted to all staff and available via the Trust's intranet.

4.3.6 National Staff Survey Results

The Trust undertook the staff survey between October and November 2017. The Trust provided staff with either online surveys or paper copies to enable as many staff as possible to take part in the survey. Staff were encouraged to complete the survey through various forms of promotion in the pre-launch and throughout the live survey period.

Overall the results of the 2017 staff survey were extremely positive, demonstrating that Trust staff take pride in the care they deliver, and recommend the Trust as a place to work and receive treatment. The Trust had the second highest response rate to the survey in the country, in the category of Combined Acute and Community Trusts. The Staff Engagement score of 3.83 (on a scale of 1 being poorly engaged and 5 being highly engaged), is ranked above average, which is the highest rank possible in the category of Combined Acute and Community Trusts. 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:

- 19 were above (better than) average;
- 10 were average; and
- 3 were below (worse than) average.

The response rate is as follows:

Overall Response rate	2016		2017	
	Trust	National Average	Trust	National Average
	54%	42%	52%	43%

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

Top 5 ranking scores compared with combined acute and community trusts in England.	HDFT 2017	National Average
Staff satisfied with the opportunities for flexible working patterns	61%	51%
Staff experiencing discrimination at work in the last 12 months	7%	10%
Staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	20%	27%
Staff experiencing physical violence from staff in last 12 months	1%	2%
Staff witnessing potentially harmful errors, near misses or	25%	29%

incidents in last month		

Bottom 5 ranking scores compared with combined acute and community trusts in England.	**HDFT 2017**	**National Average**
Staff reporting errors, incidents and near misses	90%	91%
Staff satisfaction with the quality of work and care they are able to deliver	3.84	3.90
Staff working extra hours	71%	71%
Staff satisfaction with quality of non-mandatory training, learning or development	4.04	4.06
Staff reporting their most recent experience of violence	62%	67%

One area has improved significantly since the 2016 Staff Survey, this is:

- Percentage of staff appraised in the last 12 months (from 85% to 90%)

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

- Percentage of staff reporting errors, near misses or incidents witnessed in the last month; (HDFT 90%, national average 91%)
- Percentage of staff/colleagues reporting most recent experience of violence. (HDFT 62%, national average 67%)
- Staff satisfaction with the quality of work and care they are able to deliver (HDFT 3.84, national average 3.90)

Summary Details of Any Local Surveys and Results

The Trust takes part in the quarterly NHS Staff Friends and Family Test, which asks staff *"How likely are you to recommend the Trust to friends and family as a place to work?"* During 2017/18 the Trust surveyed all staff in each quarter. As with the NHS Staff Survey, the Trust utilises both online and paper surveys to ensure accessibility for all staff.

How likely are you to recommend the Trust to friends and family as a place to work?	**Extremely likely/ Likely**
Quarter 1 (June 2017)	69.2%
Quarter 2 (September 2017)	64.7%
Quarter 3	Survey not required – National Staff Survey
Quarter 4 (February- March 2018)	65%

Future Priorities and Targets

The Trust is working with key stakeholders to develop a Trust wide action plan focusing on the key areas for improvement. Each Directorate will use its own results to develop

local action plans. By communicating this information clearly, staff can be assured that the Trust has understood their feedback and subsequent action will be taken.

The results of the 2017 National Staff Survey and quarterly NHS Staff Friends and Family Test will be utilised to monitor progress in overall staff engagement and against the key areas above.

Investors in People

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

The Trust has held IiP accreditation for seven years. Accreditation is 'for life' subject to reviews at least every three years and the Trust will undergo a review by 31 March 2020.

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

Celebrating Success Awards

Following nine extremely successful events since 2008, the Trust promoted the Celebrating Success Awards in 2017 which aim to celebrate good practice and innovation across the Trust and share new ways of working. The Awards are an opportunity to celebrate the success of innovative approaches to working and be appropriately rewarded for the effort involved. There is significant evidence across the Trust of existing good practice to be acknowledged, celebrated and shared with colleagues. Celebrating Success seeks to recognise this outstanding work.

The six categories of Awards are:

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

In 2017 the Trust held an afternoon tea party for long serving staff incorporating the Celebrating Success awards. From 2018 the awards have merged together with the Quality Charter to embed the Celebrating Success Awards scheme ethos in to the 'Making a Difference' and 'Team of the Month' awards.

4.3.7 Expenditure on consultancy

Consultancy costs during 2017/18 were £437,000, this compares with £430,000 in 2016/17.

4.3.8 Off payroll engagements

The decision to appoint Board members or senior officials with significant financial responsibility through an off-payroll arrangement would be made, if required, at a very senior level and only for exceptional operational reasons. The Trust can confirm that there were no off-payroll engagements of Board members and/or senior officials with significant financial responsibility during 2017/18.

4.3.9 Exit Packages

No exit packages were paid during 2017/18.

Approval by the Directors of the Accountability Report

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

Signed 

Dr Ros Tolcher
Chief Executive
Date: 23 May 2018

4.4. NHS Foundation Trust Code of Governance

The Board of Directors and Council of Governors

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

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

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

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

The Board of Directors

The Board of Directors is collectively responsible for exercising all of the powers of the Trust; however, it has the option to delegate these powers to senior management and other committees. The Board meets in public 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 Accounting Officer. The Standing Orders of the Board detail the decisions reserved for the Board and are available on request.

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

Executive Directors

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

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

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

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

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

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

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

Children's Services, Executive Champion for Maternity Services and Baby Friendly Initiative.

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

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

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

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

The Chief Operating Officer is responsible for the day to day operational management of the Trust's clinical services, the achievement of national, regional and Trust performance targets and translating Trust strategy, business, and policy development into operational reality. Duties also include responsibility for IT, Information, Estates and Facilities. In addition, Mr Harrison is the Chief Operating Officer lead for Elective services on behalf of the WYAAT.

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

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

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

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

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

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

Mr Marshall was awarded the Healthcare People Management Association NHS HR Director of the Year 2017.

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

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

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

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

Dr Tolcher became Chief Executive at Harrogate and District NHS Foundation Trust in 2014 having previously been the Chief Executive of a large community and mental health trust in the South of England.

Prior to her first CEO appointment Dr Tolcher was a Consultant in Reproductive Health holding posts as Clinical Director of sexual health services; Primary Care Trust Medical Director and Managing Director of PCT provider services. In this role, she successfully led the creation of a new standalone Community and Mental Health NHS Trust as part of the national Transforming Community Services programme.

Throughout her career, Ros has maintained an unwavering focus on patient safety and the quality of care provided. She has extensive experience of strategic leadership and partnership working across acute, community and primary care, and has been at the forefront of developing new models of integrated health and social care. Dr Tolcher has a particular interest in workforce, service improvement and innovation.

Non-Executive Directors

Non-Executive Director appointments are for a term of three years. Non-Executive Directors can be re-appointed for up to three terms of office (i.e. a maximum of nine years) with any final term of three years subject to annual reappointment in line with the

requirements of the NHS Foundation Trust Code of Governance. The Council of Governors carries the responsibility of terminating the contract for a Non-Executive Director where this is believed to be appropriate, in accordance with the Trust Constitution and Foundation Trust Code of Governance.

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

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

* A one month extension to Mrs Dodson's third term of office was approved by the Council of Governors in August 2017.
** Mrs Dodson left the Board on 31 October 2017.
*** Mr McLean left the Board on 30 April 2018.

- ***Mrs Sandra Dodson, Chairman (Non-Executive Director) – appointed 1 October 2008 and left on 31 October 2017***

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

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

She worked for 16 years in a senior role for Marks and Spencer and was highly involved in the initiation and implementation of significant changes to both working practices and processes. Mrs Dodson is currently Chairman of the Members of the Red Kite Multi Academy Trust, having previously been a Governor and later Chairman of Governors at Harrogate Grammar School between 2000 and 2010.

In addition to her other charitable roles, Mrs Dodson is a Trustee of the Masiphumelele Trust, the UK arm of a South African charity raising funds for education and business support for the Masiphumelele township.

Mrs Dodson was reappointed as Chairman and Non-Executive Director on 3 August 2016 and ceased to be the Chairman on 31 October 2017 at the end of her third and final term.

- ***Mr Neil McLean, Non-Executive Director – appointed 1 May 2015 and left in April 2018***

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

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

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

Mr McLean left the Board on 30 April 2018.

- ***Mrs Laura Robson, Non-Executive Director – appointed 1 September 2017***

Having lived in Sunderland all her life, Laura moved to Ripon in 2016 to enjoy the Yorkshire life. She trained as a nurse and midwife in Sunderland before going on to work in clinical and managerial roles for various hospitals in the North East. She is a qualified midwifery teacher and has masters degrees in Management and Communication Studies. From 1996 until retiring in 2012, she was Executive Nurse on the Board of County Durham and Darlington Foundation Trust. She has worked as a Clinical advisor to the CQC and the Health Service Ombudsman. With special interest in the care of people with dementia in acute hospitals she has a passion for patient safety, midwifery and maternity services.

Laura was a non executive director of North Cumbria University Hospitals from 2014 until 2017, working with the Board to help them come out of special measures by improving the quality and efficiency of their services to the people of Cumbria.

Laura is a member of the Quality Committee and the Audit Committee.

- ***Mrs Angela Schofield, Chairman – appointed 1 November 2017***

Angela Schofield has worked in the NHS and with the NHS for over 40 years. Initially she was a health service administrator in her home town of Sheffield and became a general manager in the mid 1980's. After working in the NHS in Sheffield, North Derbyshire and Manchester, she went to work for the University of Manchester undertaking development work in quality of care and integrated care. She was then appointed Chief Executive of the NHS Trust in Calderdale. Following a move to Dorset

she was appointed Head of the Institute for Health and Community Services at Bournemouth University.

Angela became Chairman of Bournemouth and Poole Primary Care Trust in 2006 and Chairman of Poole Hospital NHS Foundation Trust in 2011. She moved to Harrogate in 2017.

She had been the trustee of a number of charities and a committee member of the League of Friends of a community hospital. She is a volunteer with "Supporting Older People" a charity in Harrogate.

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

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

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

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

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

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

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

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

He is a member of the Council of the University of York, where he is also a member of the Audit, Remuneration and Subsidiary Management committees. Inside the Trust, he is Chairman of the Audit Committee and a member of the Remuneration and Nomination Committees.

- ***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 in August 2011. He moved to Knaresborough in 1996, shortly after taking this position, and still lives in the town.

In a non-executive capacity, Mr Ward is director of Newcastle Building Society, a member of its Group Risk Committee, and Chairman of both its Information Technology and Financial Advice subsidiary companies. He is also a non-executive director of the FTSE250 Company, Charter Court Financial Services (which includes Charter Savings Bank), where he chairs both the Remuneration and Nomination Committees and sits on the Audit and Risk Committees. Additionally, he is an independent member of the Leeds Kirkgate Market Management Board.

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). Additionally, he was a Director and Chairman of the Audit Committee of Leeds Training and Enterprise Council (TEC).

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

Mrs Webster is in her second term as a Non-Executive Director and is Chairman of the Quality Committee and nominated Non-Executive lead on learning from deaths, she is also a member of the Finance Committee and Remuneration/Nomination Committees.

Lesley has had a professional involvement with the NHS in the UK for over 35 years, starting as a Registered Nurse, she later moved into the Medical Supply Industry in 1987.

Working for both International and UK based Medical Companies, Lesley has held Senior Executive and Board level posts, where she has been influential in leading strategic business development and Directing Sales, Marketing, Customer Care and Engineering functions.

Lesley left the Medical Supply Industry in 2012 and in addition to working at the Trust she is a volunteer Business Mentor. She lives near Wetherby with her husband, who is a retired Diagnostic Radiographer who trained in Harrogate.

Performance Evaluation of the Board of Directors

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

- Appraisal of Executive Director performance by the Chief Executive and Chairman on an annual basis;
- Appraisal of Non-Executive Director performance by the Chairman and Deputy Chairman/Lead Governor of the Council of Governors on an annual basis;
- Appraisal of the Chairman by the Council of Governors, led by the Senior Independent Director and Deputy Chair of the Council of Governors, after seeking views and comments of the full Council of Governors, as well as other Board colleagues;
- Appraisal of the Chief Executive by the Chairman;

- An annual Board development programme; and
- An annual review of the effectiveness of each sub-committee.

In November 2015, the Board of Directors commissioned an independent review against NHS Improvement's 'well led framework for governance'. This provided the Board of Directors with assurance that systems and process were in place to ensure that the Board and Senior Leadership Team had good oversight of quality of care, operations and finances.

The Board recognises the importance of good governance in delivery of the Trust's vision to provide 'Excellence Every Time', and although a positive response was received following the independent review, the Board has undertaken a number of actions during 2017/18 to improve even further the governance systems in the Trust. A further self-assessment against the refreshed NHS Improvement well led framework was completed in early 2018.

The information below details the Executive and Non-Executive Director attendance at Board of Directors meetings in 2017/18. The Board of Directors met 12 times in 2017/18. Although no public Board meetings were held in August or December 2017 the Board did hold private meetings.

Individual attendance	Board of Director meeting dates 2017/18										
	27/04/17	25/05/17	29/06/17	27/07/17	28/09/17	26/10/17	30/11/17	21/12/17	25/01/18	22/02/18	29/03/18
Mrs S Dodson*	Y	Y	Y	Y	Y	Y	-	-	-	-	-
Mrs A Schofield**	-	-	-	-	Y	Y	Y	Y	Y	Apologies provided	Y
Mr I Ward	Apologies provided	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mrs L Webster	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Apologies provided
Mr C Thompson	Y	Y	Y	Y	Y	Y	Y	Y	Apologies provided	Y (C)	Y
Mrs M Taylor	Y	Y	Y	Apologies provided	Y	Apologies provided	Y	Y	Y	Y	Y
Mr N McLean***	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ms L Robson****	-	-	-	-	Apologies provided	Y	Y	Y	Y	Y	Y
Dr R Tolcher	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mr J Coulter	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Dr D Scullion	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mrs J Foster	Y	Y	Y	Y	Y	Y	Y	Y	Y	Apologies provided	Y
Mr R Harrison	Y	Apologies provided	Y	Y	Y	Y	Y	Y	Y		Y
Mr P Marshall	Y	Y	Y	Y	Y	Y	Apologies provided	Y	Y	Y	Y

* Sandra Dodson left the Trust on 31 October 2017.
** Angela Schofield joined the Trust on 1 November 2017.
***Neil McLean left the Trust on 30 April 2018.
**** Laura Robson joined the Trust on 1 September 2017.

Statement of Compliance with the NHS Foundation Trust Code of Governance

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

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

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

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

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

Audit Committee

The Audit Committee met formally on six occasions during 2017/18. Audit Committee members attendance is set out in the table below. In addition, all Audit Committee members attended an informal meeting in late April 2017 to undertake a detailed review of the draft accounts (relating to the 2016/17 financial year). Members of the Committee also attended relevant Audit Committee training events during the course of the year.

Audit Committee Members' Attendance:

	4 May 2017	18 May 2017	7 Sept 2017	7 Dec 2017	6 Feb 2018	8 Mar 2018
Mr Chris Thompson	Y	Y	Y	Y	Y	Y
Ms Laura Robson			Y	Y	Y	N
Mr Ian Ward	N	Y	Y	N	Y	N
Mrs Maureen Taylor	Y	Y	Y	Y	Y	Y

The Audit Committee had a membership of four Non-Executive Directors and during the 2017/18 financial year this comprised of:

- Mr Chris Thompson (Chairman)
- Mr Ian Ward
- Ms Laura Robson
- Mrs Maureen Taylor

The Committee is supported at all of its meetings by:

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

Other representatives (e.g. Chief Nurse, Local Counter Fraud Specialist and Local Security Management Specialist) attend the Audit Committee as and when required.

The attendance details of all attendees at Audit Committee Meetings during 2017/18 were reported to the Committee and presented to the Board of Directors in May 2018.

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

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

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

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

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

Duties of the Audit Committee

Following a review of the Audit Committee's terms of reference in January 2018, the key duties of the Audit Committee could be categorised as follows:

Governance, Risk Management & 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 & Reporting	Review of the Foundation Trust's Financial Statements and Annual Report, including the Annual Governance Statement, before submission to the Board of Directors. Review of the Charitable Trust's Financial Statements and Annual Report before submission to the Board of Directors acting in its role as Corporate Trustee. Ensuring that systems for financial reporting are subject to review to ensure completeness and accuracy of information and compliance with relevant legislation and requirements. Review of the Trust's Treasury Management Policy, Standing Financial Instructions and systems in place to ensure robust financial management.
Internal Audit & Counter-Fraud Service	Ensuring an effective internal audit and counter-fraud service that meets mandatory standards and provides appropriate, independent assurance to management and the Audit Committee. Review of the conclusion and key findings and recommendations from all Internal Audit reports and review of regular reports from the Local Counter Fraud Specialist. Monitoring of the implementation of Internal Audit and Counter Fraud recommendations.
Local Security Management Services (LSMS)	Ensuring an effective LSMS service that meets mandatory standards and provides appropriate assurance to management and the Audit Committee. Review the annual report and plan for the following year.
External Audit	Ensuring that the organisation benefits from an effective external audit service. Review of the work and findings of external audit and monitoring the implementation of any action plans arising.

Clinical & Other Assurance Functions	Review of the work of the Quality committee within the organisation, whose work provides relevant assurance over clinical practice and processes. Review of the findings of other significant assurance functions, both internal and external to the organisation, and consideration of the implications for the governance of the organisation.

Work Performed

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

Financial Management

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 2017/18 were the establishment of a wholly owned subsidiary company Harrogate Healthcare Facilities Management (HHFM) to manage Estates and Facilities services.

The Committee oversees and monitors the production of the Trust's financial statements. During the 2017/18 financial year this included:

- An informal but detailed review of the draft accounts prior to submission to Monitor and External Audit on 25 April 2017;
- A formal Committee meeting to discuss the draft accounts and External Audit's findings on 4 May 2017; and,
- A formal Committee meeting on 18 May 2017 to review the final accounts and Annual Report for 2016/17 (including the Quality Account) prior to submission to the Board of Directors and Monitor.

[Note: similar meetings have occurred during April and May 2018 relating to the 2017/18 financial statements, Annual Report and Quality Account].

In January 2018 the Committee formally reviewed and approved the Trust's accounting policies (to be used in relation to the 2017/18 financial statements), considering consistency over time and compliance with the Foundation Trust Financial Reporting Manual. At the same meeting, the Audit Committee also considered the plan and timetable for the production of the Trust's 2017/18 financial statements and annual report.

The Committee also oversees and monitors the production of the Charitable Trust's financial statements. The final Charitable Funds accounts and Annual Report for 2016/17 were reviewed by the Committee on 18 May 2017 prior to submission to the Corporate Trustee.

The Audit Committee also reviewed and approved:

- Single Tender Actions;
- The Trust's Losses & Special Payments register in May 2017;
- The Annual Procurement Savings Report in September 2017;
- Revisions to the Trust's Treasury Management Policy in September 2017; and,
- The recommendation to the Trust Board of the use of the going concern principle as the basis for the preparation of the 2016/17 accounts in May 2017.

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.

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 18 May 2017.

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 2017/18:

- Assessment of Audit Committee Effectiveness in January 2018, the findings of which were presented to the Board of Directors.
- Review and approval of Audit Committee Terms of Reference in December 2017 which were presented to the Board of Directors for approval in January 2018.
- Ongoing review and revision of the Audit Committee's timetable.

Clinical Assurance

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

Internal Audit and Counter Fraud Service

Internal Audit and Counter Fraud Services are provided by Audit Yorkshire. The Chair of the Audit Committee sits on the Audit Yorkshire Board which oversees Audit Yorkshire at a strategic level. The Board met on four occasions during 2017/18.

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 2017.

The Audit Committee approved the planning methodology to be used by Internal Audit to create the Internal Audit Plan for 2017/18, and gave formal approval of the Internal Audit Operational Plan in March 2017.

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 HDFT staff and the Audit Committee in February 2018, resulting in a satisfactory evaluation. The action plan arising from the review is monitored via the Internal Audit Periodic Report to the Audit Committee.

External Audit

External Audit services are provided by KPMG.

During the 2017/18 financial year the Audit Committee reviewed External Audit's Annual Governance Report and Management Letter in relation to the 2016/17 financial statements. Work was undertaken during 2017/18 to provide guidance on the accounting treatment to be adopted in respect of certain financial arrangements in place at the 31 March 2018.

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 2017/18 financial statements and the related audit fee in February 2018.

The effectiveness of External Audit was reviewed by HDFT staff and the Audit Committee in 4 May 2017, resulting in a satisfactory evaluation which was reported to the Council Governors.

Specific Significant Issues discussed by the Audit Committee during 2017/18

The following additional significant issues have been discussed by the Audit Committee during 2017/18:

- Ongoing compliance issues with IV Cannula Care and nurse staff rostering;
- The Falls Management follow up audit and consideration at the Quality Committee;
- The launch of HHFM and impact on governance arrangements;
- The timeliness of Post Project Evaluations (PPE's); and,
- The timeliness of response by management to internal audit draft reports and the implementation of outstanding internal audit recommendations.

Audit Committee Effectiveness Survey

It is recommended corporate governance best practice for committees of the board of directors to undertake annual self-assessment of effectiveness. A survey of committee members and regular attendees at the committee meetings was undertaken in December 2017. Survey results have confirmed the following areas of strength:

- Committee members contribute regularly across the range of topics;
- With regards to mitigating the key risks to the Trust, the Committee is fully aware of key sources of assurance;
- The committee has the right balance of experience, knowledge and skills;
- The Committee is briefed, via the assurance framework, about key risks and assurances received and any gaps in control/assurance in a timely fashion;
- Members feel sufficiently comfortable within the committee environment to be able to express their views, doubts and opinions;
- The Committee understands the messages being given by the Trust's assurance advisors; and,
- Members provide real and genuine challenge - they do not just seek clarification and/or reassurance.

Conclusion

The Audit Committee conducted itself in accordance with its Terms of Reference and work plan during 2017/18. And this summary report is consistent with the Annual Governance Statement and the Head of Internal Audit Opinion.

Council of Governors

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

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

Governors are elected by staff (Staff Governors) and the membership (Public Governors), or nominated by partner organisations, for example, North Yorkshire County Council (Stakeholder Governors). The Council of Governors consists of 18 elected and seven nominated Governors.[1]

The Council of Governors has specific statutory responsibilities to:

- Hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors;

- Represent the interests of the members of the Trust as a whole and the interests of the public;
- Appoint, or remove the Chairman and the other Non-Executive Directors;
- Decide the remuneration of the Chairman and Non-Executive Directors;
- Approve the appointment (by the Non-Executive Directors) of the Chief Executive;
- Appoint, reappoint or remove the Trust's external auditor;
- Consider the Trust's annual accounts, auditor's report and annual report;
- Bring their perspective in determining the strategic direction of the Trust;
- Be involved in the Trust's forward planning processes;
- Approve any merger, acquisition, separation or dissolution application and the entering into of any significant transactions;
- Approve any proposals to increase by 5% or more of the Trust's proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England; and,
- Approve any amendments to the Trust's Constitution.

The following table highlights the composition of the Council of Governors and includes each Governor's term of office and attendance at the quarterly public Council of Governor meetings held during the year 1 April 2017 to 31 March 2018.

Constituency	Name	Term of office	May 2017	May 2017 *	Aug 2017	Sept 2017 **	Nov 2017	Feb 2018
Harrogate and surrounding villages – publicly elected	Mr Tony Doveston	January 2016 to December 2018	Y	Y	N	Y	Y	N
	Mrs Pat Jones	January 2011 to December 2013 January 2014 to December 2016 January 2017 to December 2019	Y	Y	Y	Y	Y	N
	Dr Sally Blackburn	August 2011 to July 2014 August 2014 to July 2017 (extended to December 2017)	Y	Y	Y	Y	Y	N/A
	Mrs Rosemary Marsh	January 2018 to December 2020	N/A	N/A	N/A	N/A	N/A	Y
	Ms Pamela Allen, Deputy Chair of Governors/Lead Governor from January 2016	January 2014 to December 2016 January 2017 to December 2019	Y	Y	Y	Y	Y	Y

	Mrs Liz Dean	December 2014 to December 2015 (remainder of term following resignation of Sara Spencer) January 2016 to December 2018	Y	Y	Y	Y	N	N
Knaresborough and East District – publicly elected	Mrs Zoe Metcalfe	January 2016 to December 2018	Y	Y	N	Y	N	Y
	Mrs Ann Hill	January 2017 to December 2019 (Stood down 26 October 2017)	Y	N	N	Y	N/A	N/A

Constituency	Name	Term of office	May 2017	May 2017 *	Aug 2017	Sept 2017 **	Nov 2017	Feb 2018
Rest of North Yorkshire and York – publicly elected	Mrs Cath Clelland	January 2015 to December 2017 January 2018 to December 2020	N	N	Y	N	N	Y
Ripon and West District – publicly elected	Mr Peter Pearson	August 2014 to July 2017 (extended to December 2017)	Y	Y	Y	N	Y	N/A
	Miss Sue Eddleston	January 2017 to December 2019	Y	Y	Y	Y	N	Y
Wetherby and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley Wards – publicly elected	Mrs Jane Hedley	July 2011 to June 2014 July 2014 to June 2017 (extended to December 2017)	Y	N	Y	N	Y	N/A
	Dr Sheila Fisher	January 2018 to December 2020	N/A	N/A	N/A	N/A	N/A	Y
	Mr Steve Treece	January 2017 to December 2019	Y	Y	Y	N	Y	Y
Rest of England***	Vacant Seat							

* *Extra Council of Governors' meeting 31 May 2017 to discuss the recommendation of the Remuneration Committee.*

** *Extra Council of Governors' meeting (held in private) 25 September 2017 to ratify the appointment of the new Trust Chairman.*

*** *A 'Rest of England' constituency was approved in February 2016. Despite elections, this seat remains vacant.*

Staff Constituency	Name	Term of office	May 2017	May 2017 *	Aug 2017	Sept 2017 **	Nov 2017	Feb 2018
Medical Practitioners Staff Class – staff elected	Dr Daniel Scott	January 2013 to December 2015 January 2016 to December 2018	Y	Y	Y	Y	Y	Y
Non-Clinical Staff Class – staff elected	Mrs Yvonne Campbell	January 2016 to December 2018 (Stood down 11 May 2017)	N	N/A	N/A	N/A	N/A	N/A
	Mrs Mikalle Lord	January 2018 to December 2020	N/A	N/A	N/A	N/A	N/A	Y
Nursing and Midwifery Staff Class – staff elected	Mrs Emma Edgar	January 2011 to December 2013 January 2014 to December 2016 January 2017 to December 2019	N	N	Y	N	Y	Y
	Mrs Sally Margerison	January 2014 to December 2016 January 2017 to December 2019 (Stood down 3 July 2017)	Y	N	N/A	N/A	N/A	N/A
	Mr Andy Masters	January 2018 to December 2020	N/A	N/A	N/A	N/A	N/A	Y
Other Clinical Staff Class – staff elected	Ms Clare Cressey	January 2016 to December 2018 (Stood down 28 February 2018)	Y	Y	Y	Y	Y	Y

* *Extra Council of Governor meeting 31 May 2017 to discuss the recommendation of the Remuneration Committee.*

** *Extra Council of Governors' meeting (held in private) 25 September 2017 to ratify the appointment of the new Trust Chairman.*

*** *A 'Rest of England' constituency was approved in February 2016. Despite elections, this seat remains vacant.*

Nominating Organisation	Name	Term of office	May 2017	May 2017 *	Aug 2017	Sept 2017 **	Nov 2017	Feb 2018
North Yorkshire County Council	Cllr. Bernard Bateman	Nominated from January 2014 to December 2016 Second term from January 2017 to December 2019 (Stood down May 2017)	Y	N/A	N/A	N/A	N/A	N/A
	Cllr. John Mann	Nominated from 23 May 2017 to 31 December 2019 (remainder of term)	N/A	N/A	N	Y	Y	N
Harrogate Borough Council	Cllr Phil Ireland	Nominated from November 2016 to May 2017 (remainder of term) Second term from 1 June 2017 to 31 May 2020	Y	Y	Y	N	N	Y
University of Bradford	Dr Pamela Bagley	Nominated from 19 June 2017 to 31 December 2019 (remainder of term	N/A	N/A	Y	N	Y	N
Harrogate Division YOR Local Medical Committee	Dr Jim Woods	Nominated from June 2011 to May 2014 Second term	Y	N	Y	N	N	N

		from June 2014 to May 2017 Third term from June 2017 to May 2020						

Nominating Organisation	Name	Term of office	May 2017	May 2017 *	Aug 2017	Sept 2017 **	Nov 2017	Feb 2018
Voluntary sector	Mrs Beth Finch	February 2016 to June 2016 (remainder of term following resignation of Jane Farquharson) Second term July 2016 to June 2019	N	N	N	N	N	N
Patient Experience	Ms Carolyn Heaney	Nominated from 21 September 2017 to 20 September 2020	N/A	N/A	N/A	Y	Y	Y

* *Extra Council of Governor meeting 31 May 2017 to discuss the recommendation of the Remuneration Committee.*

** *Extra Council of Governors' meeting (held in private) 25 September 2017 to ratify the appointment of the new Trust Chairman.*

*** *A 'Rest of England' constituency was approved in February 2016. Despite elections, this seat remains vacant.*

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

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

The 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 2017 to March 2018.

Board member individual attendance	Position	Council of Governor meeting dates 2017/18			
		May 2017	August 2017	November 2017	February 2018
Mrs Sandra Dodson (Chairman until 31.10.17)	Chairman	Y	Y	N/A	N/A
Mrs Angela Schofield (Chairman from 01.11.17)	Chairman	N/A	N/A	Y	Y
Mr Ian Ward	Non-Executive Director/Senior Independent Director (from 25.02.15)	N	N	Y	N
Mr Chris Thompson	Non-Executive Director/Vice Chair (from 04.05.17)	Y	Y	Y	Y
Mrs Lesley Webster	Non-Executive Director	Y	Y	Y	Y
Mrs Maureen Taylor	Non-Executive Director	Y	Y	Y	Y
Mr Neil McLean	Non-Executive Director (Commenced in post 01.05.15)	Y	N	Y	N
Ms Laura Robson (from 01.09.17)	Non-Executive Director	N/A	N/A	Y	Y

Board member individual attendance	Position	Council of Governor meeting dates 2017/18			
		May 2017	August 2017	November 2017	February 2018
Dr Ros Tolcher	Chief Executive	Y	Y	N	Y
Mr Jonathan Coulter	Deputy Chief Executive / Finance Director	Y	Y	Y	N
Dr David Scullion	Medical Director	Y	Y	Y	Y
Mrs Jill Foster	Chief Nurse	Y	Y	Y	Y
Mr Robert Harrison	Chief Operating Officer	Y	Y	N	Y
Mr Phillip Marshall	Director of Workforce and Organisational Development	N	N	Y	Y

Council of Governors' Nominations Committee

The Nominations Committee is a formally constituted sub-committee of the Council of Governors and has responsibility for overseeing the recruitment and selection processes to secure the appointments of Non-Executive Directors (including the 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 reappointment 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 Chair of the Trust or the Senior Independent Director, where the Chair has a conflict of interest, for example when the Committee is considering the Chair's re-appointment. The Nominations Committee is supported by the Chief Executive, Director of Workforce and Organisational Development, Company Secretary and Corporate Affairs and Membership Manager, in an advisory capacity.

The Nominations Committee met on four occasions during 2017/18 as follows:

- 12 April 2017 to discuss the recruitment process for a new Non-Executive Director to replace Professor Sue Proctor and the appointment of a new Vice Chairman;
- 19 July 2017 to review the re-appointment of Mrs Maureen Taylor, Non-Executive Director, to a second term of office. The Nominations Committee also discussed the extension of the Chairman's term of office by one month following the unsuccessful recruitment of a new Chairman. This extension to the Chairman's term of office was in line with the Trust's Constitution.[2:]
- 26 July 2017 to progress the recruitment process for a new Chairman; and,
- 13 March 2018 to discuss the recruitment process for two new Non-Executive Directors to replace Mr Neil McLean and Mr Ian Ward.

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

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 Chair 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 Chair of Harrogate and District NHS Foundation Trust. The Remuneration Committee is supported by the Chief Executive, the Director of Finance, the Director of Workforce and Organisational Development, the Company Secretary and Corporate Affairs and Membership Manager, in an advisory capacity.

The Remuneration Committee met once during 2017/18 and held a detailed discussion regarding the role of the Non-Executive Directors, salary details, guidance received and current financial challenges. The recommendation submitted to, and subsequently approved by the Council of Governors, was as follows:

1. Remuneration:

- Non-Executive Director to remain at the basic salary of £13,130 per annum.
- The additional responsibility payment for Non-Executive Directors who chair the Quality Committee and Finance Committee to be increased by £500 from £1,010 to

£1,510. The total payment for these individuals will therefore increase to £14,640 per annum.

- The additional responsibility payment for Non-Executive Directors with statutory responsibilities for the Audit Committee, SID and Vice Chair will remain at £3,535. The total payment will remain at £16,665 per annum.
- The Committee recognised the current Chair of the Audit Committee has also undertaken the additional statutory responsibility of the Vice Chair and recommended remuneration to reflect both positions. Therefore, two additional responsibility allowances of £3,535 will be paid to reflect the two roles and will increase the total payment for this individual to £20,200.
- Chairman to remain at £48,985.

2. To apply a cost of living uplift of 1% to the Non-Executive Directors and Chair of the Trust, consistent with the Agenda for Change terms and conditions of service and medical and dental terms of service from 1 April 2017.

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 2018 the Trust had 17,632 members; people who have chosen to become a member, who are interested in the NHS and want the opportunity to get more involved in their local health services. Members can become involved in a variety of different ways; by receiving updates and newsletters, attending open days, meetings and events, volunteering, and being consulted on with plans for future developments, to name a few.

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

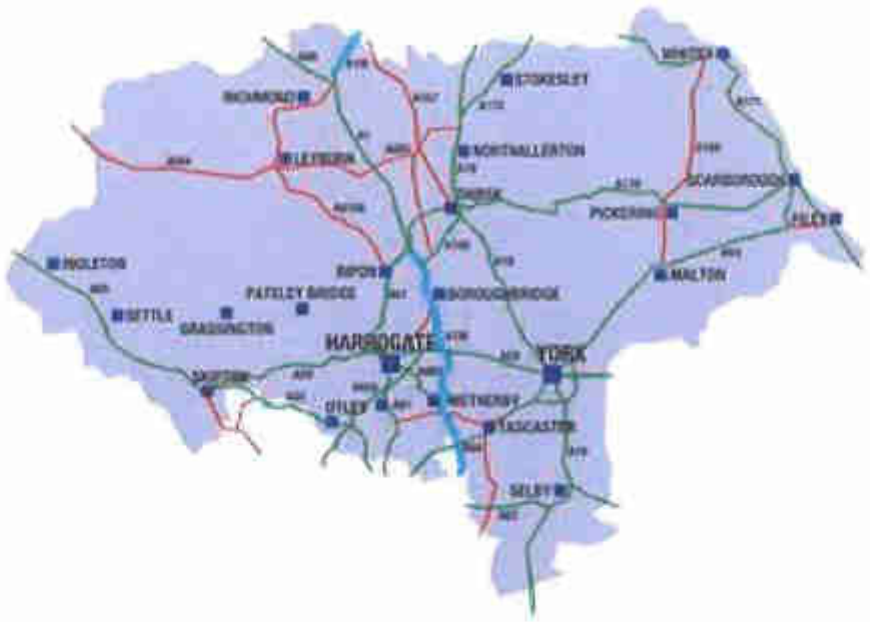
Eligibility to be a Member

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

Public constituencies are:

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

The Rest of England constituency will represent those people who access Trust services but do not live in the Trusts 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 2017/18 we have continued to actively engage with, and recruit, members between the ages of 16 and 21 years through our unique Education Liaison Programme, Work Experience Scheme, Youth Forum, 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 continues to drive the focus on quality membership engagement activity.

The public membership profile		Rep. of public	
Harrogate	6,441	82,599	7.8%
Ripon and west district	1,972	37,571	5.2%
Knaresborough and east district	2,349	37,699	6.2%
Wetherby and Harewood including Otley and Yeadon, Adel and	2,181	102,771	2.1%

Wharfedale and Alwoodley wards			
Rest of North Yorkshire and York	376	638,559	0.06%
Rest of England	410	52.1m*	
TOTAL	**13,729**	***899,199****	***1.5%****

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

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

The staff constituency membership profile		Rep. of total staff	
TOTAL	**3,903**	**4,564**	***85.5%***

The volume of members has decreased; this is due to members requesting to be removed from the database and the removal of deceased members from a recent data cleanse.

On 31 March 2018, the Trust had 31 'Affiliates'; people who have an interest in the Trust but do not qualify to be a member, either due to their age (i.e. they are below 16 years of age) or because they live outside of the Trust's catchment area. Affiliates are not counted within our membership numbers.

Staff membership is via an opt-out scheme and 85.5% 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 Rest of England constituency, focussing particularly on areas where the Trust is providing services in Darlington, Durham and Middlesbrough, Stockton-On-Tees 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, promoting membership to local employers and schools, attendance at community events, distributing membership flyers to GP practices and local community premises such as libraries and voluntary organisations, and social media platforms. The focus will also be to promote membership and active inclusion to people from protected and disadvantaged groups alongside the Trust's Equality and Diversity work streams.

Gender and ethnicity

The public membership is made up of 51.24% females and 48.62% males, with 0.13% unknown; these figures continue to demonstrate a similar balance to the male/female population in England (*50.8% females and 49.2% males, Office for National Statistics, Census 2011).*

Gender	Number of Members	*Eligible membership	Percentage
Male	6,676	*440,383	*1.5%
Female	7,035	*458,816	*1.5%
Not specified	18		
Total	**13,729**	***899,199**	***1.5%**

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

Ethnic origin of the public membership

Ethnicity	Number of Members	*Eligible membership
White	2,802	*863,226
Mixed	25	*9,110
Asian or Asian British	70	*19,196
Black or Black British	27	*4,599
Unknown	10,805	*3,068
Total	**13,729**	***899,199**

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

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

How we develop our Membership

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

Recruitment, communication and membership activities are delivered in the following ways:

- A welcome pack including a welcome letter from the members' elected Governor(s), a membership card, a questionnaire and a discount card to use with local and national companies;
- 'Foundation News' membership newsletter;
- Notification of meetings and events on the Trust's website;

- Social media platforms;
- Media;
- Invitations to membership events, for example 'Medicine for Members' lectures;
- Invitations to community events in partnership with stakeholders;
- Public Council of Governor meetings;
- Governor public sessions, for example speaking at local committees and groups;
- Annual Members' Meeting;
- Elections to the Council of Governors;
- Members' notice board;
- Access to Trust strategic documents, including the annual report and accounts, quality account and annual plan;
- Internal staff communications, for example, staff induction and Team Brief (a monthly briefing session for staff focusing on key topics, including developments in services, the Trust's performance against its targets and finance);
- Leaflets and posters in community premises and in GP practices; and,
- Invitations to be involved with consultations, to take part in surveys and to be involved on focus groups.

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

The Foundation Trust Office

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

1. Trust's Constitution, paragraph 11.2.3
2. Trust's Constitution, paragraph 16.3.1

4.5. NHS Improvement's Single Oversight Framework

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

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

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

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

The Trust is recognised as being in segment three as at 31 March 2018. This segmentation information is the Trust's position as at 31 March 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and Use of Resources

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

The table below outlines the Trust's performance in 2017/18

Area	Metric	2017/18 Q1 score	2017/18 Q2 score	2017/18 Q3 score	2017/18 Q4 score	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	Capital service capacity	4	4	1	3	1	1
	Liquidity	1	1	1	1	1	1
Financial efficiency	I&E margin	4	4	1	2	1	1
Financial controls	Distance from financial plan	4	4	1	4	2	3
	Agency spend	1	1	1	1	1	1
Overall scoring		**3**	**3**	**1**	**3**	**1**	**1**

4.6. Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's Responsibilities as the Accounting Officer of Harrogate and District NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Harrogate and District NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Harrogate and District NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and the NHS Foundation Trust Annual Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the NHS foundation Trust Reporting Manual and the Department of Health and Social Care Group Accounting Manual have been followed, and disclose and explain any material departures in the financial statements;
- Assess the Group and NHS Foundation Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- Use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the NHS foundation trust without the transfer of its services to another public sector entity.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed 

Dr Ros Tolcher
Chief Executive
Date: 23 May 2018

4.7. Annual Governance Statement

4.7.1 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.*

4.7.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Harrogate and District NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Harrogate and District NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

4.7.3 Capacity to handle risk

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

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

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

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

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

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

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

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

The Trust also supports a "learning" culture, and we share and embed learning from incidents following an objective investigation or review. We recognise the importance of human factors promoting safety and in the genesis of incidents. 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 monthly "Making a Difference" awards for staff. 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.

The Trust has appointed a Freedom to Speak Up Guardian who reports to the Board on a six-monthly basis. This provides the Board with an opportunity to reflect on themes and learning identified by the Guardian. During the year Internal Audit completed a review of the Trust's Freedom to Speak Up arrangements and found significant assurance that effective processes are in place to enable staff to raise a concern and whistle blow in accordance with the findings of the 'Freedom to Speak Up' report.

A review of quality and equality impact assessments by Internal Audit during 2017/18 revealed weaknesses in the quality impact assessment of Cost Improvement Programmes (CIPs) and Financial Recovery Plan (FRP) schemes. The associated risks have been recognised on the corporate risk register and additional controls are being established. It has been agreed that in future the Quality Committee will have increased scrutiny of the quality impact assessment process.

4.7.4 The risk and control framework

The key objectives regarding risk and control are to achieve:

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

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

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

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

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

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

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

a) Departmental

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

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

b) Directorate

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

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

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

c) Corporate

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

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

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

month, and a more detailed report together with the complete corporate risk register on a quarterly basis.

d) 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 Trust's 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 Trust's 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. The Audit Committee also receives regular updates on the BAF and the Board of Directors receive an update each month, and a more detailed report together with the complete BAF on a quarterly basis.

The risks on the corporate risk register for 2017/18 and going forward relate to the:

- Risk to the quality of service delivery in Medicine due to gaps in rotas following the Deanery allocation process;
- Risk to service delivery due to the lack of experienced registered nurses due to national labour market shortage;
- Capacity to support timely discharge for community ready patients;
- Risk of financial deficit and impact on service delivery due to failure to deliver the Trust's annual plan by having excess expenditure or a shortfall in income;
- Risk of patient harm as a result of being lost to follow-up as a result of current processes;
- Risk of patient harm as a result of being lost to follow-up as a result of historic processes;
- Risk to provision of service and not achieving national standards in cardiology due to potential for laboratory equipment breaking down;
- Risk to patient safety, quality, experience, reputation, staff well-being due to reduced capacity in the community care teams;
- Risk to quality of care due to lack of capacity in the acute and community services to meet anticipated increased demand during winter months;
- Risk of inadequate antenatal care and patients being lost to follow up due to inconsistent process for monitoring attendance at routine antenatal appointments in the community;

- Risk to service delivery due to failure to have sufficient cash to support the capital programme including replacement of equipment due to delay in payment from commissioners or shortfall in delivering the financial plan;
- Risk of harm to the quality of the service due to staff shortages in ophthalmology clinics.

During 2017/18 the strategic risks identified on the BAF included risk of:
- Lack of medical, nursing and clinical staff;
- High levels of frailty in local population;
- Failure to learn from feedback and incidents;
- Standards of care and the organisation's reputation for quality fall because quality does not have a sufficient priority in the Trust;
- Failure to deliver integrated models of care;
- Misalignment of strategic plans;
- Service sustainability;
- Failure to deliver the Operational Plan;
- Breaching the terms of the Trust's Licence to operate from NHS Improvement;
- External funding constraints;
- Lack of fit for purpose critical infrastructure; and
- Insufficient senior leadership capacity.

In 2017/18 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. During 2017/18 the Trust has undertaken robust preparations for implementation of the new General Data Protection Regulations from May 2018.

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 46 RAG (red, amber, green) rated indicators of which 17 relate to quality, 16 to finance and efficiency and 13 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 2018 and gave significant assurance for both. The Audit Committee reviews the evidence for compliance with CQC registration requirements annually.

Principal risks to compliance with the NHS Provider 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 the Provider Licence in its entirety via annual and in-year submission as required by NHS Improvement's Single Oversight Framework. These submissions include detailed information on financial performance, plans and forecasts, and third party information, in order to assess the risk to continuity of services and governance.

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

In order to mitigate the risks to compliance with Monitor's Licence Condition 4, the Trust has in place a well defined governance framework with clear accountability and reporting to ensure integrated governance, to deliver the Trust's 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 Trust's 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 and other stakeholders are key participators in many of the Trust's committees.

During 2017/18 the Board completed a self-assessment against NHS Improvement's well led framework for governance reviews. The self-assessment drew upon an independent review of the well led framework which was completed in 2015. The

independent (external) review noted a number of areas of strength and good practice including:

- A board which was 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 were 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.

Neither the self-assessment nor the external review highlighted any material areas of concern in relation to the board and the governance arrangements in place at the Trust. Current areas identified for further progress and improvement include:

- Development of a Patient and Public Participation Strategy for the Trust;
- Further work to cascade and embed Strategic Key Performance Indicators within directorates.

Work has been undertaken to address these recommendations.

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

During 2017/18 the executive team completed a self-assessment against the CQC's well led framework. This identified all key lines of enquiry as 'outstanding' or 'good', with one aspect (are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services) assessed as 'requires improvement'. Work is ongoing to further strengthen the Trust's arrangements for patient and public participation.

The Board of Directors is responsible for exercising all of the powers of the Trust; however, it has the option to delegate these powers to senior management and other committees. The Board:

- sets the strategic direction for the Trust;
- allocates resources;
- monitors performance against organisational objectives;
- ensures that clinical services are safe, of a high quality, patient-focused and effective;
- ensures high standards of clinical and corporate governance; and
- along with the Council of Governors, engages members and stakeholders to ensure effective dialogue with the communities it serves.

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

During 2017/18 there have been five formally constituted committees of the Board; the Audit Committee, the Quality Committee, the Nomination Committee, the Remuneration Committee and the Finance Committee.

The Audit Committee

Four Non-Executive Directors comprise the Audit Committee, and one of these is the Chair. The Deputy Chief Executive/Finance Director, Deputy Director of Governance and Company Secretary 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 provide appropriate independent assurance to the Audit Committee, Chief Executive and Board. The Committee also reviews the work and findings of the External Auditors appointed by the Council of Governors and considers the implications and management's responses to their work. The Audit Committee receives reports from Internal and External Audit, the Quality Committee and the Corporate Risk Review Group which enable it to provide independent assurance on governance and controls to the Board. This also enables triangulation of key issues to enhance the Board and Committee's oversight and assurance role. The annual audit plans for Internal Audit are approved by the Audit Committee and are prioritised to focus on areas of risk and concern. Governor representatives attend the Audit Committee as observers.

The Quality Committee

The Quality Committee is the primary mechanism by which the Board gains assurance regarding the safety and quality of services. It is chaired by a Non-Executive Director, and the Chairman (on an interim basis until a new Non-Executive Director is appointed in May 2018) and one other Non-Executive Director (who is also a member of the Audit Committee) are members. 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 Trust's quality improvement priorities and strategic objectives in respect of quality, and provides oversight and seeks assurance on regulatory compliance. The annual clinical audit plans are approved and monitored by the Quality Committee. Governor representatives attend the Quality Committee as observers.

The Finance Committee

During 2017/18 the key responsibilities of the Finance Committee were 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 five year financial plan and two

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 attend the Finance Committee as observers.

The Remuneration Committee

The key responsibilities of the Remuneration Committee is to make recommendations to the Board on the remuneration, allowances and terms of service for the Executive Directors, to ensure that they are fairly rewarded for their individual contribution to the organisation, having proper regard to the organisation's 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 for part of the meeting, by invitation and in an advisory capacity.

The Nomination Committee

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

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 Information Technology Steering Group; End of Life Care Steering Group; Infection Prevention and Control Committee. 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. Public governors have been encouraged to form alliances with some of the teams.

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

The Trust has conducted a self-assessment against the conditions set out in the NHS Provider Licence 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 Trust 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 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.

4.7.5 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 Operating Plan details how the Trust will utilise its resources throughout the year, identifies the principal risks to the delivery of the Operating 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's objectives, quality improvement priorities and identified risks.

During 2017/18 the Trust continued to implement a carbon efficiency scheme to deliver reductions in carbon emissions and to deliver significant energy efficiency.

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

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

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

4.7.6 Information governance

Any potential information governance incidents are reported internally and reviewed by the Data and Information Governance Steering Group. The Trust has reported one Level 2 incident to the ICO during 2017/18. This incident was where information was shared with the wrong person. The ICO reviewed our investigation and closed it as it did not meet the criteria set out in their Data Protection Regulatory Action Policy necessitating further action by them.

4.7.7 Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each

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

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

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

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

Internal Audit provides further assurance regarding the systems in place to ensure that the Quality Account is compliant with national guidance and that adequate data quality controls are in place to ensure that performance data is accurate and complete. Internal Audit has found that robust processes are in place to collect, validate and monitor performance data in relation to both the A&E four-hour wait and the 14-day cancer wait targets. Data included in the Quality Account for both targets was consistent with data reported internally and externally by NHS England. An opinion of high assurance has been given for the Quality Account 2017/18.

4.7.8 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, the Audit Committee 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:

- The governance risk rating, issued by NHS Improvement is green;
- CQC rating for the Trust following comprehensive inspection in 2016 is "good";
- The BAF and the Corporate Risk Register;
- Presentation of the Annual Governance Statement to the Audit Committee by the Accountable Officer;
- The Audit Committee Annual Report, which includes Internal Audit and assurance relating to Corporate Risk Review Group;
- The Quality Committee Annual Report;
- The Finance 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 (2015) and self-assessment by the Board during early 2018.

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;
- safety netting for patients receiving follow-up appointments; and,
- the Trust's quality Impact Assessment process.

It is pleasing that progress has been made during the year to address gaps in control identified regarding intravenous cannula care and safety netting for patients receiving follow-up appointments. However work is ongoing to fully mitigate these gaps in control.

Following a new audit gaps in control were highlighted relating to the Trust's quality Impact Assessment processes, as detailed earlier in this statement the associated risks have been recognised on the corporate risk register and controls are being established.

This is an area of constant vigilance for myself as Accounting Officer and the Board of Directors, and progress will be monitored and subject to further audit during 2018/19.

4.7.9 Conclusion

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

Signed.....

Dr Ros Tolcher
Chief Executive
Date: 23 May 2018

Harrogate and District NHS Foundation Trust's

Quality Account 2017/18

You matter most

Contents

1. STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

Our ambition is to achieve Excellence Every Time for our patients and for the children and families who use our services. The last 12 months has been an extraordinary year for the NHS and in times of austerity it is more important than ever that we maintain an unwavering focus on the quality of care we provide. I am humbled and inspired by the commitment of colleague across our hospital and community services and I wish to place on record my thanks for their care and dedication throughout the year.

This Quality Account forms part of the Harrogate and District NHS Foundation Trust's Annual Report. It illustrates our approach to quality improvement and describes our achievements over the last twelve months.

It starts with a description of the five quality priorities we identified for 2017/18 and summarises the progress we have made in each of these areas. A culture of continuous learning and improvement is fundamental to patient safety and our first priority for 2017/18 related to learning from incidents, complaints and good practice. This is a two year workstream and our 2017 Staff Survey results reflect the positive progress made so far. We will further progress this in 2018/19 with a growing focus on human factors as a cause of errors, and promoting a just culture across the Trust. Reducing the morbidity and mortality associated with sepsis was a further priority for 2017/18. Excellent progress continues to be made including 93% of patients being treated within an hour in the last three months of the year.

The Trust administers over 2 million medicine doses per annum and dispenses around 150,000 items per year. The importance of optimising medicines safety cannot be overstated and the evidence in respect of medicines safety is particularly noteworthy. HDFT is one of the few Trusts nationally to have implemented electronic prescribing and medicine administration in all areas and this has contributed to year on year improvements including, for example, a 90% reduction in the number of insulin administration errors since 2011/12.

Quality is at the heart of everything we do and a great example of this is our Pathology service. The service is now in its 4th annual accredited cycle by the United Kingdom Accreditation Service (UKAS) against international standard ISO 15189:2012 'Medical laboratories — Requirements for quality and competence'. The service is also very proud of its Point of Care Testing (POCT) team who provide the only NHS service currently accredited to ISO 22870:2006. These are in addition to our statutory requirements to be fully compliant with the Blood Safety & Quality regulations and the Human Tissue Act.

A strong focus on engaging with people to whom we provide care or services is another essential element of delivering high quality care and this is as true for children and young people as it is for adults. As well as our children's ward and newly refurbished children's outpatient department at Harrogate General Hospital the Trust provides community children's services to an ever growing area including North Yorkshire; County Durham; Darlington; Middlesbrough and Stockton. This report describes the valuable contribution being made by our Youth Forum. Their energy and enthusiasm is making a real difference to how we provide services.

My overriding aim is to create the conditions for outstanding care quality and the HDFT Quality Charter underpins this approach. It is designed to promote and enable continuous improvements in care quality by giving colleagues the skills and freedom to innovate, rewarding and valuing those who live our values and behaviours and 'go the extra mile' and celebrate teams who excel. Now in its second year there is growing evidence of the effectiveness of the Charter – we have a growing army of bronze, silver, gold and now platinum Quality of Care Champions committed to continuous quality Improvement.

I am extremely grateful to everyone who has contributed to the excellent results described in this report and to colleagues who work tirelessly to support and enable innovation so that our patients experience safe, effective, caring, responsive and well led services- in short, Excellence Every Time.

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

Ros Tolcher.

Dr Ros Tolcher (Chief Executive)

Date: 23 MAY 2018

2. PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE

2.1. PRIORITIES FOR IMPROVEMENT 2018/19

We have consulted with our external stakeholders and within the Trust about the priorities for quality improvement during 2018/19. We have considered the range of services provided by Harrogate and District NHS Foundation Trust (HDFT) including the extended range of children's community services in Stockton, Gateshead and Sunderland that will join the Trust during 2018.

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. The priorities are:

1. **Ensuring effective learning from incidents, complaints and good practice**

   We will continue the work started in 2017/18 but with more focus on staff engagement, promoting a "just culture" locally and increasing understanding of human factors and the role they play in patient safety.

2. **Reducing the morbidity and mortality related to sepsis**

   Sepsis is a life-threatening response of the body to infection. There has been a national and local focus on reducing morbidity and mortality related to sepsis for a number of years. We will continue the work progressed during 2017/18, aiming to consistently achieve the target set for rapid administration of antibiotics within the national Commissioning for Quality and Innovation indicator.

3. **Improving the clinical model of care for acute services**

   We will continue the work undertaken during 2017/18 to enable people to be discharged from hospital as soon as possible, but will also review the way patients are cared for by clinicians with a focus on safety and effective care. This work will include improving the management of medical outliers (inpatients with medical care needs who are placed on a non-medical ward during their hospital admission) to ensure appropriate and timely medical review and access to therapists, and a re-consideration of a Hospital at Night model of care which uses both a multi-professional and multi-speciality approach to delivering care at night and out of hours.

4. **Increasing patients and the public participation in the development of services**

   We will continue the work undertaken during 2017/18 to include the voice of children, young people and families but will also incorporate the development of a public and patient participation strategy. This work will involve people whose voices are rarely heard by us or are at risk of discrimination and disadvantage, including those with accessible information requirements and mental health needs.

5. **Promoting safer births, with a specific focus on reducing stillbirths**

   We will continue work already started in maternity to implement "Saving Babies Lives: A care bundle for reducing stillbirths" (NHS England 2016). The Care Bundle brings together four elements of care that are recognised as evidence-based and/or best practice: reducing smoking in pregnancy; risk assessment and surveillance for fetal

growth restriction; raising awareness of reduced fetal movement; and effective fetal monitoring during labour.

Harrogate currently has a lower rate than the national average of stillbirth and has made good progress on the four recommendations. The maternity unit will be focusing on completion of audits to assess compliance and will continue to work on a business case to support serial ultrasound assessment of fetal growth throughout the third trimester of pregnancy in line with the Royal College of Obstetricians and Gynaecologists Green-top Guideline.

2.2. PROGRESS AGAINST QUALITY PRIORITIES IDENTIFIED IN 2016/17 QUALITY ACCOUNT

In the 2016/17 Quality Account we identified the following priorities for work during 2017/18:

1. Improve learning from incidents, complaints and good practice
2. Improve the patient experience of discharge processes
3. Reduce the morbidity and mortality related to sepsis
4. Provide high quality stroke care demonstrated by improvement in national indicators
5. Include the voice of children, young people and families in the development of services

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

1. Improve learning from incidents, complaints and good practice

We have worked with staff to promote the reporting of incidents, near misses and concerns, and to enable the identification of the factors that contribute to these and maximise the learning to prevent recurrence. It is important to us for staff to feel supported and able to report anything, whether it was a positive or a negative event, and to view these as opportunities to learn and improve patient safety. The aim is to improve the organisation's culture of reporting and learning.

What were we aiming to achieve?

Two of the key metrics we wanted to improve are:

- An increase in the number of incidents reported to the National Reporting & Learning System (NRLS); we knew from previous National Staff Survey results that staff do not always report all of the incidents they witness. The number of incidents reported is a proxy measure which helps us to understand the patient safety culture of an organisation, with higher reporting reflecting a more mature and positive culture. If reports are not made, we miss our opportunity to learn from them.
- An improvement in our ratio of "low or no harm" incidents to "moderate or above harm" incidents; reporting "low or no harm" incidents enables learning and action before a potentially more serious outcome.

What have we done?

We undertook a staff survey to better understand the barriers to reporting incidents and identify key areas for improvement within the Datix system. This confirmed that we needed to review the tools and system for reporting incidents, and review how these are managed within the directorates to ensure robust feedback to reporters and identification of remedial action to prevent recurrence. A Rapid Process Improvement Workshop (RPIW) in November 2017 generated several work streams focusing on functionality of Datix, how the system is managed, training and education, and communication.

A pilot of a new simplified Datix form took place on the Acute Medical Unit (AMU) during March 2018 and feedback gathered from the staff involved. The intention is to make any further necessary revisions, pilot the revised form in other areas then roll out across the Trust. This should make it quicker and easier for staff to report an incident.

We are also working on our communications to staff using emails, briefings, newsletters and presentations and have developed a logo '#chattermatters' to use in these communications. We are aiming to encourage people to report all events that we can learn from, to provide feedback to staff who have reported events and to ensure that the learning is shared across the organisation,

#chattermatters

Work Stream	Key Milestone	Target Completion Date	Latest Progress
1. Improving the Datix reporting system	Secure support for an RPIW from Transformation Board	31/07/2017	Complete. RPIW held week commencing 20/11/2017.
	Field work in preparation for RPIW. • review of current forms for Datix and statutory requirements • collation of intelligence from other Trusts / experts	01/10/2017	Complete. RPIW held week commencing 20/11/2017.
2. Improving reporting and learning culture	Undertake a staff survey & analyse results	31/08/2017	Complete. Results from the staff survey included in the RPIW.
	Through RPIW methodology to review the process for reporting and learning and pilot a new form	31/12/2017	Following RPIW a new form has been developed and is being piloted on AMU in March 2018.
3. Learning from deaths	Implement a Trust Responding to Deaths Policy	30/09/2017	Complete. Policy now published on Trust website.
	Publication of review of deaths and implementation of processes for learning	31/12/2017	Complete. Policy and processes implemented and quarterly reports to Board since Q2.
4. Implementing learning	Develop model for organisational briefings/sharing of learning	31/10/2017 Revised to 31/12/2017	Model and newsletter design under development following RPIW *#ChatterMatters*
	Implement the new process including training, briefing, publicity campaign	01/01/2018-01/03/2018	The RPIW developed three work streams: • systems, • functionality • culture and communications. Publicity and training materials are under development.

Table 1: Learning from incidents complaints and good practice work plan

What are the results?

Whilst an actual increase in incidents, change in harm ratio and ability to demonstrate learning will take some time to be realised, we have made good progress against this quality priority and have already started to see some improvements.

The graph below details the number of incidents reported on the Datix system by month since April 2016, which shows a small upward trajectory. This is inclusive of both staff and patient incidents.

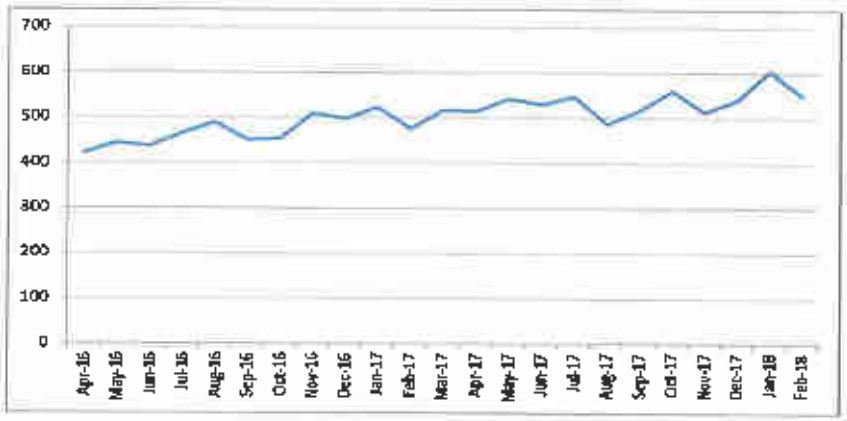


Figure 1: Incidents reported per month April 2016 - February 2018

The table below shows the incident reporting rate (patient safety incidents only) to the NRLS compared to other similar Trusts.

Reporting period	01/10/15 to 31/03/16	01/04/16 to 30/09/16	01/10/16 to 31/03/17	01/04/17 to 30/09/17
Comparative reporting position*	Middle 50%	Middle 50%	Top 25%	Top 25%
Number of incidents reported in period	2,058	2,182	2,436	2,416
Incident reporting rate	39.86	43.85	46.42	48.56

*per 1,000 bed days for 136 acute (non-specialist) organisations

Table 2: Incident reporting rate (patient safety incidents only) to the NRLS

The data from the recently published NHS Staff Survey 2017 shows some improvements; the number of staff at HDFT witnessing potentially harmful errors, near misses or incidents has reduced since the previous survey in 2016, whilst at the same time the percentage of staff reporting errors, near misses or incidents witnessed has improved. The figures below show the percentage of HDFT staff providing these answers in 2016 and 2017, and the national average in 2017.

Figure 2: NHS Staff Survey 2017 results: staff witnessing and reporting errors, incidents and near misses

We work to reduce staff exposure to violence, and would want any incidents of violence to be reported. The percentage of staff reporting their most recent experience of violence has also

improved since the 2016 survey. However, staff reporting incidents and violence remains below the national average, so this will continue to be an area of focus to drive further improvement.

Figure 3: NHS Staff Survey 2017 results: staff reporting violence

Summary

This was originally identified as a 2 year work stream, and as such remains a quality priority for the coming year 2018/19, with more focus on staff engagement, promoting a "just culture" locally and increasing the focus on human factors and the role they play in patient safety.

2. Improve the patient experience of discharge processes

The Trust has continued with a series of initiatives which aim to optimise the safe and efficient discharge of patients who are medically fit to transfer and no longer require an acute hospital bed.

What were we aiming to achieve?

From May 2017 the Discharge Steering Group merged with the SAFER Patient Flow Group to be responsible for two separate but linked objectives:

1. To reduce the length of stay for patients admitted to hospital as an emergency, by reducing delays in the coordination of their care and treatment within the hospital.
2. To reduce delays in the discharge and transfer of patients who no longer require an acute hospital bed.

What have we done?

We have improved the way we coordinate discharge whilst patients are in hospital. The Trust has launched welcome letters for every patient staying in hospital overnight, to encourage patients to think about how they and their families can help to prepare for going home and what support they may need. During the busy winter months the Trust has been allocated some extra money to help manage the higher number of patients coming into hospital. Part of the money has been used to employ additional discharge coordinators in the Discharge Planning Team to ensure that suitable plans are in place for patients who are leaving hospital.

The Supported Discharge Service (SDS) was launched in July 2017. The aim of the service is to reduce the length of stay in hospital by helping patients home after an admission. The service carries out physiotherapy assessments and occupational therapy assessments in the patient's own home rather than in the hospital environment. This can give a more accurate picture of how the person will cope at home. The service has been welcomed by patients

and staff at the hospital, with over 250 people supported to get home sooner in the last seven months with the SDS. During January and February 2018 the Trust opened additional rehabilitation beds in the community on a temporary basis and the team also provided therapy to patients using these beds.

In January 2018, criteria-led discharge was launched for patients under the care of respiratory consultants on Granby ward. The process ensures the consultant and the rest of the ward team set clear goals that need to be reached in order for the patient to be ready for discharge. The patient can then be discharged by a suitably qualified and experienced member of the ward team, including nurses, physiotherapists and occupational therapists once the goals have been achieved. In January 2018 approximately a third of all patients who left the hospital from the respiratory ward were discharged using this protocol. The Trust hopes to roll out criteria-led discharge to other wards during 2018.

The Trust has agreed a smoother process with North Yorkshire County Council (NYCC) for patients who are wearing a plaster cast to stabilise a fracture while it heals. Sometimes the cast can significantly restrict patients' mobility which means they struggle to look after themselves at home. The council has committed to provide support to those patients who need help with personal care at home whilst a plaster cast is in place. This means that patients do not need to stay in hospital whilst their fracture heals.

Finally, we have been working closely with Harrogate and Rural District (HaRD) Clinical Commissioning Group (CCG) and NYCC to improve the discharge process for patients who are likely to need long-term packages of care in their own home or who require 24-hour care in a nursing or residential home. This work comes under the name 'discharge to assess' as there is strong evidence that patients long-term health and social needs are most accurately assessed outside hospital. In December 2017, HDFT and our partner agencies started to design how best to undertake these assessments in the community. In January and February 2018 we have worked with HaRD CCG and NYCC to implement the new pathways. This will mean that more patients will have their assessment outside of hospital and HaRD CCG are monitoring the patients and their families experience of this new pathway.

What are the results?

The Trust has seen a reduction over the last 12 months in the total number of days patients discharge from hospital is delayed. Delays most commonly occur because patients are waiting for a package of care in their own home to start, waiting for a transfer to a care home or nursing home or waiting for a rehabilitation bed in the community. Nationally these delays are termed "delayed transfers of care" (DTOC), referring to the fact that the patient no longer requires hospital care and could be appropriately transferred to another setting to continue their care. Our work with NYCC and HaRD CCG and the internal changes we have made within the hospital has helped to reduce the delays.

Figure 4: Delayed transfers of care 2017-18

The number of patients who have a stay in hospital of 50 days or more has decreased over the last 12 months, although the number of patients who have a stay in hospital greater than 20 days has increased over the pressured winter period. However we have seen an increase in the proportion of patients admitted as an emergency who are then discharged to their usual place of residence within seven days of admission. This has increased from 32.1% in quarter four 2016-17 to 36.5% in quarter three of 2017-18.

Figure 5: Long lengths of stay 2017-18

Summary

The Trust has made progress with improving discharge; however, there is still work to continue in 2018/19. This includes refinement of the "discharge to assess" pathways and processes and roll out of criteria-led discharge to more wards in the hospital.

3. Reduce the morbidity and mortality related to sepsis

Sepsis is one of the UK's biggest killers, with over 250,000 cases annually and around 50,000 deaths. We believe that with early diagnosis, prompt treatment and close monitoring, many of these deaths are preventable.

What were we aiming to achieve?

We are trying to improve a number of aspects of sepsis care for our patients. Firstly, we aim to ensure that it is diagnosed early using tools to screen all at risk patients for the condition. We then aim to ensure that antibiotics are admitted promptly to those who need them, and that the choice of antibiotics is appropriate.

What have we done?

We have focused on improving sepsis care for the last few years, with frequent educational events and packages for clinical staff. This year, we delivered a "Medicine for Members" event aimed at raising awareness of sepsis amongst the general public, so that they can present early if they or their family believe they may have sepsis. In hospital, we have introduced an electronic screening system called Patientrack which looks at patients' clinical signs to see if sepsis is possible, and will automatically alert doctors if likely. There is a daily report of sepsis screening to ward managers, matrons and others with ongoing nursing education and supervision.

Our sepsis screening trigger on Patientrack is more sensitive than that recommended by the Royal College of Physicians (RCP). A patient with a national early warning score (NEWS) score of 5 which is the trigger for a sepsis screen recommended by the RCP guidelines will automatically get a review by a doctor. Those who score 4 trigger the local sepsis screening. We are therefore confident that higher risk patients do receive a clinical review for possible sepsis.

Patients with certain 'red flag' observations are highlighted as having 'red flag sepsis'. This is a time critical condition where immediate action is required. We have modified systems to enable prompt antibiotic administration where this is indicated.

What are the results?

At the start of 2017 only 68% of adults were being screened for sepsis. By January 2018, this had risen to 80%, with 94% of our highest risk patients in the Emergency Department (ED) being screened.

Sepsis screening for relevant patients	2016/17			2017/18			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ED patients	88% (43/49)	94% (61/65)	94% (153/162)	90% (142/157)	93% (153/165)	94% (163/174)	98% 169/173
Inpatients	80% (4/5)	67% (10/15)	41% (65/159)	54% (83/152)	67% (103/154)	64% (97/152)	55.9% (85/152)
Total	87% (47/54)	89% (71/80)	68% (218/321)	73% (225/309)	80% (256/319)	80% (260/326)	78% (254/325)

Table 3: Sepsis screening performance 2016/17 and 2017/18

Please note the massive increase in numbers screened from Q2 2016/17 (47 patients) rising to around 250 per quarter now, reflecting the fact that Patientrack identifies many more patients at risk.

For patients with red flag sepsis, we have made really significant progress in ensuring prompt delivery of intravenous (IV) antibiotics.

Timely antibiotic administration for patients with red flag sepsis	2016/17			2017/18			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Patients receiving IV antibiotics within 1 hour	62% (13/21)	62% (23/37)	50% (19/38)	54% (26/48)	78% (29/37)	77% (24/31)	93% (25/27)
Median time for antibiotic administration	2 hours 20 minutes	1 hour 25 minutes	1 hour 21 minutes	49 minutes	50.5 minutes	30 minutes	40 minutes

Table 4: Sepsis antibiotic administration for patients with red flag sepsis

The reduction in the median time to administer IV antibiotics to these patients over the last year shows the progress we were making, but we achieved our target in Q4 with 93% of patients receiving antibiotics within our target time of 1 hour. This is a really significant improvement in clinical care and patient safety. To maintain this and ensure all patients are treated to our target, we will be continuing current work and putting further measures in place. We are implementing new blood culture packs which highlight what constitutes red flag sepsis in an easily visible form. We continue to contact all individual doctors who fail to achieve the target of IV antibiotics for severe sepsis within 1 hour to ensure learning, which is in addition to the education sessions for doctors in training and mandatory e-learning on fluids, sepsis and acute kidney injury.

Senior review of antibiotics within 72 hours	2016/17			2017/18			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Total	100% (23/23)	100% (36/36)	100% (37/37)	100% (48/48)	100% (51/51)	92% (54/59)	100% (46/46)

Table 5: Senior review of antibiotics within 72 hours of prescribing

We continue to perform well in relation to senior staff reviewing the use of antibiotics within 72 hours of prescribing.

Summary

Sepsis is a condition which is rightly in the public spotlight after many decades of it not receiving the profile and focus this devastating condition deserves. Although we are making significant strides forward in improving care, we need to continue to ensure consistent, prompt antibiotic administration for every patient once sepsis is suspected. This work will therefore continue to be a quality priority for the Trust in 2018/19.

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

The Trust currently provides a stroke service comprising of a HASU (hyperacute stroke unit), ASU (acute stroke unit) and a rehabilitation service to the population of patients in the HaRD CCG area. The quality and performance of stroke services are measured nationally and are reported via the Sentinel Stroke National Audit Programme (SSNAP). Other measures of performance can also be indicative of quality. These include feedback from staff and patients and measures such as length of stay in hospital.

The Trust is part of the West Yorkshire and Harrogate (WY) sustainability and transformation partnership (STP), and there is ongoing work to look at the provision of stroke services across the region. There are significant challenges within the STP to the provision of high quality stroke services due to limited availability of specialist staff and resources.

What were we aiming to achieve?

Our long term ambition is to improve the score on SSNAP data to a "B" across all domains, which would be a reflection of good care. However the initial focus was on two specific domains, time to computerised tomography (CT) scan and time to thrombolysis. Thrombolysis is treatment for a stroke caused by a blood clot (ischaemic stroke), using a clot-busting drug to try to restore the blood supply to the brain.

What have we done?

The sustainability of the stroke service is being reviewed by the WYSTP, taking into account significant medical and nurse staffing challenges. The service has had limited ability to improve on some of the SSNAP key performance indicators, and the overall score has been between "C" and "D" for the last four years. Over the last year, medical staffing has been made more resilient by employing a specialty doctor to assist with cover for the service whilst the single consultant is on leave. However this has not added additional resource to the thrombolysis rota, which is reliant on a regional rota involving three consultants.

Other indicators such as CT and thrombolysis have not improved so measures have been put in place to enable ED to take on the first part of the pathway to assist with some of the staffing challenges that are present on the stroke unit. Patients are now not waiting in ED for a stroke nurse to attend and can move more swiftly to a CT scan. We have yet to see the outcomes of this approach.

In addition work has begun to look at forming an alliance with York to see if there are common ways of working that can support the Harrogate stroke service in the short to medium term.

What are the results?

The most recent SSNAP data has been added to the table below. This data is reported every four months.

Domain	Jan to Mar 2014	Apr to Jun 2014	Jul to Sept 2014	Oct to Dec 2014	Jan to Mar 2015	Apr to Jun 2015	Jul to Sept 2015	Oct to Dec 2015	Jan to Mar 2016	Apr to Jul 2016	Aug to Nov 2016	Dec to March 2016-2017	April to July 2017	Aug-Nov 2017
SSNAP level	D	D	C	D	C	D	D	C	D	C	D	D	D	D
SSNAP score	52.7	58.9	63.9	59.8	60.8	56.7	45.6	64.0	54.2	61.8	57	55.1	56	49.3
Case ascertainment band	C	A	A	A	A	A	A	A	A	A	A	A	B	C
Audit compliance band	A	B	C	B	B	C	B	A	B	B	B	B	B	B
Combined Total Key Indicator level	C	C	B	C	C	C	D	C	D	C	C	D	C	C
Combined Total Key Indicator score	62	62.0	71	63	64	63	48	64.0	57	65	60	58	62	61
1) Scanning	C	C	D	D	E	E	D	D	D	D	D	D	D	D
2) Stroke unit	B	C	B	C	B	C	D	B	C	B	C	C	C	C
3) Thrombolysis	D	D	C	C	E	D	D	D	D	E	D	C	C	D
4) Specialist Assessments	B	C	B	C	B	C	C	C	C	B	D	D	C	D
5) Occupational therapy	C	A	A	B	A	A	C	B	B	A	B	B	A	B
6) Physiotherapy	C	B	B	B	B	B	D	B	D	B	B	C	B	B
7) Speech and Language therapy	E	E	C	D	D	C	E	C	D	D	C	D	D	C
8) MDT working	B	C	C	B	B	C	D	C	C	B	C	C	D	B
9) Standards by discharge	B	B	B	B	B	B	B	B	B	B	B	B	B	B
10) Discharge processes	C	C	C	C	C	C	C	C	C	C	C	C	C	C

Table 6: SSNAP data 2014-2017

Summary

We have achieved some of the improvements we had hoped to achieve in terms of resilience for medical staffing cover. We have implemented new ways of working and are collaborating with other providers to continue to improve the resilience of the service and other performance measures. Speech and language therapy input still needs further investment.

5. Include the voice of children, young people and families in the development of services

This was chosen as a priority due to the significant expansion of children's services within HDFT, contributing to the formation of a new Children and Countywide Community Care directorate. This directorate aligns HDFT's paediatric pathways from acute services through to a large number of diverse communities. This expansion of services means that it is critical that the organisation demonstrates its strategic intent towards children and young people, and their carers and families, and it is important to provide opportunities for these children and young people to feedback on their care and influence the services that serve them.

As Ros Tolcher, Chief Executive, noted in launching the consultation for the HDFT 'Hopes for Healthcare':

> "Our Trust vision is to provide Excellence Every Time when we care for children and young people. To gain an understanding of the needs and expectations of young people, in terms of their health and healthcare provision, in 2016 HDFT created a Youth Forum. Over the past year, the HDFT Youth Forum, in consultation with other children and young people from a range of backgrounds and experiences, have worked hard to develop seven standards by which we can assess our services in providing child and young person centered care.
>
> Each year we will tell you how we measure up to these standards and what we are doing to continually improve our service for children and young people who use our services."
>
> November 2017

What are we aiming to achieve?

There were three broad aims for the quality priority over the 12 month period:

1. To further promote the emerging Youth Forum within the organisation and its communities;
2. To co-produce a children's and young people's strategy for HDFT;
3. To promote the inclusion of the voice of children, young people and families in relation to accessibility to children's services, engaging their views in a patient centred manner.

What have we done and what are the results?

Promotion of the Youth Forum

The HDFT Youth Forum was in its infancy at the start of the year and has since gone from strength to strength. They have met regularly and are now a vibrant and strong group, keen to increase their frequency of contact. Sessions are facilitated by key HDFT staff and have included workshops in school holidays to work on key issues. The group has agreed their collective title; has work plans for the year, and is working on the branding. They have been supported to spend time in services that are of interest to them and the forum sessions have been regularly attended by staff from the Trust who are keen to meet them. They have their own Facebook page and use social media to keep in contact and there has been a steady supply of new delegates within the forum. At a recent event they introduced themselves:

"We are a group of young people aged 13-19 who are passionate about giving young people a voice in decision making about the future of healthcare in this area. Every 4-6 weeks we gather to discuss the key

Figure 6: Members of HDFT Youth Forum

aspects of healthcare for young people, and together we decide the best ways of tackling any issues we feel are important to us."

There is now a strong and active group of young people, who have their own identity but have an affinity with HDFT and want to make a difference to healthcare. They have been involved in a range of initiatives including:

- Developing a set of standards for all services to ensure delivery of services is child and young person centred;
- Commenting on the design of the new outpatient environment for paediatrics;
- Presenting at a HDFT equality and diversity forum for staff, governors and stakeholders;
- Providing an information table at the HDFT Annual Members Meeting;
- Attending and supporting a stall at the North Yorkshire Youth Voice Conference;
- Attending a number of other Youth Forums within North Yorkshire as part of a wider engagement regarding building the voice of children and young people;
- Conducting a secret shopping experience within the Emergency Department.

The forum is now sustainable and will start to agree the work plan for the next year, where they will be ambitious about what they want to do.

Co-produce a children's and young people's strategy for HDFT

With the considerable expansion of HDFT children's services, the organisational intent was to develop a "children's strategy" for the organisation. Working in a child and young person centred manner, it was quickly determined that this would need to be co-produced for it to have any significant meaning for children and young people.

The Youth Forum has worked very hard over the last nine months in developing the strategy. The young people felt strongly that for this to be accessible to all and in particular children and young people, then the strategy would need to be short, have a clear message designed by young people, and "eye grabbing" graphics. The next iteration was for the strategy to become a series of (seven) standards, which services can assess themselves against which then became the illustrative – 'Hopes for Healthcare'. The Youth Forum best describe the process themselves:

"Since Easter last year, we've been focused on developing our Hopes for Healthcare. We came in during our Easter, summer and Christmas holidays to have longer sessions where we talked through the different ways that young people use the Health Service. We thought about the

Figure 7: The Youth Forum's hopes for healthcare at HDFT

qualities which make a healthcare professional young person friendly. We also looked at the rights that young people have in the NHS Constitution. We also spoke about our own experiences and those of our friends and siblings. Staff from different teams who work with children came to our meetings so we could ask them questions and talk about our ideas. Throughout the process we've identified areas of healthcare that are important to young people of all ages.

Figure 8: The Youth Forum's hopes for healthcare at HDFT continued.

"It has been a long process but each meeting moved us forward.

"We initially came up with 14 things that we thought were important for children and young people. Through the process of discussion and prioritisation we moved towards seven improvement areas or standards. Then Nicholas Burgoyne from Sterile Services offered to design the graphics and the whole project came to life. A few weeks ago we came up with the name Our Hopes for Healthcare at HDFT. We feel this name best fits what this document describes.

We recognise that there's excellent practice throughout HDFT, and by working towards achieving our hopes for healthcare, we can help shape future services for children and young people to ensure that they get the healthcare they need in the right place at the right time."

Youth Forum

We now have a draft of 'Hopes for Healthcare' each with its own highly illustrative graphics. The Forum launched these as part of a wider consultation on 6th March 2018. The intention is to consult and test the Hopes with children and young people between March and June, targeting as diverse a group of children and young people as possible. We aim to finalise the Hopes for Healthcare in July with the Youth Forum, develop a set of auditable standards over the summer and then launch in October 2018. HDFT services will then be reviewed in relation to the Hopes for Healthcare.

Promote the inclusion of the voice of children, young people and families

The Children's and Countywide Community Care Directorate has reviewed the way it accesses feedback from children, young people and families. There are some excellent examples, with a young person "take over day" in County Durham, and Woodlands ward involving children in the design of a ward logo. Some examples of good practice were

shared at the Directorate's – Celebration of Innovation event in June 2017, showing how feedback from families was being used regularly in performance supervision with staff.

There have also been some initial conversations and several meetings with the Patient Voice Group (PVG) who are an independent group of volunteers who focus on the patient voice and experience within the hospital. We are looking into how they may better access the voice of children and young people and several events have been planned later in the year to start to test this out.

The directorate is also increasing their use of social media, using closed Facebook accounts for healthy child services in North Yorkshire. These are predominantly used by adults in families but the directorate's social media group is starting to look how social media can be used by young people, with a focus on the use of Twitter.

Reviewing the way the directorate accesses feedback from children, young people and families was a useful exercise and highlighted some excellent examples of creative engagement. However this is not consistent across the whole directorate and into the wider organisation. We have a better understanding of what some of the challenges are; for example some services would like to use iPads with young people to get feedback but this is costly. There is more work to do to build upon the pockets of good practice.

Summary

The Youth Forum has proven to be an incredible process with an amazing group of young people keen to make a difference. The Hopes for Healthcare have materialised into a successful piece of co-productive work with young people and the next stage is to complete the consultation and finalise them. We have pockets of excellent practice in community services regarding engaging the voice of children and young people, but these need to be consistent across all of the community services.

2.3. STATEMENTS OF ASSURANCE FROM THE BOARD

1. Provision of relevant health services and income

During 2017/18 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 2017/18 represents 100% of the total income generated from the provision of relevant health services by HDFT for 2017/18.

2. National and local audits

National audits

During 2017/18, 37 national clinical audits and 2 national confidential enquiries and clinical outcome review programmes (5 studies) covered relevant health services that HDFT provides.

During that period HDFT participated in 97% 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 35 mandatory audit programmes on the National Clinical Audit and Patient Outcome Programme (NCAPOP), 26 of which were relevant to HDFT. Three of these did not have any data collection during 2017/18, so in total the trust participated in all 23 (100%) of the programmes in which it was eligible to do so and which collected data during 2017/18.

There were also 23 non-NCAPOP audits listed, 10 of which were not relevant to HDFT. The Trust participated in 12 of the 13 which were relevant (92%).

The national clinical audits and national confidential enquiries that HDFT was eligible to participate in during 2017/18 are as follows:

National audits:

1. Acute coronary syndrome or acute myocardial infarction (MINAP)
2. BAUS urology audits: Female stress urinary incontinence
3. Bowel cancer (NBOCAP)
4. Cardiac Rhythm Management
5. Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC)
6. Child health clinical outcome review programme (see below)
7. Diabetes (Paediatric) (NPDA)
8. Elective Surgery (National PROMs programme)
9. Falls and Fragility Fractures Audit programme (FFFAP)
10. Fractured neck of femur (Royal College of Emergency Medicine - CEM)
11. Inflammatory Bowel Disease (IBD) programme
12. Learning Disability Mortality Review Programme (LeDeR)
13. Major Trauma Audit (Trauma Audit & Research Network - TARN)

14. Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK)
15. Medical and Surgical Clinical Outcome Review Programme (see below)
16. National Audit of Breast Cancer in Older Patients (NABCOP)
17. National Audit of Dementia
18. National Audit of Intermediate Care
19. *National Audit of Rheumatoid and Early Inflammatory Arthritis (Did not run)*
20. *National Audit of Seizures & Epilepsies in Children and Young People (Did not run)*
21. National Cardiac Arrest Audit (NCAA)
22. National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
23. National Comparative Audit of Blood Transfusion programme
24. National Diabetes Audit (Adults)
25. National Emergency Laparotomy Audit (NELA)
26. *National End of Life Care Audit (Did not run)*
27. National Heart Failure Audit
28. National Joint Registry (NJR)
29. National Lung Cancer Audit (NLCA)
30. National Maternity and Perinatal Audit
31. National Neonatal Audit Programme (NNAP - Neonatal Intensive and Special Care)
32. National Ophthalmology Audit
33. Oesophago-gastric cancer (NAOGC)
34. Pain in Children (CEM)
35. Procedural Sedation in Adults (care in emergency departments) (CEM)
36. Prostate Cancer Audit
37. Sentinel Stroke National Audit Programme (SSNAP)
38. Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
39. UK Parkinson's Audit

Clinical Outcome Review Programmes:

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

1. Chronic Neurodisability
2. Acute Heart Failure
3. Perioperative Diabetes

Child health clinical outcome review programme:

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

The national clinical audits and national confidential enquiries that HDFT participated in during 2017/18 are as follows:

National audits:

1. Acute coronary syndrome or Acute myocardial infarction (MINAP)
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5. Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC)
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18. National Cardiac Arrest Audit (NCAA)
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25. National Lung Cancer Audit (NLCA)
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33. Sentinel Stroke National Audit Programme (SSNAP)
34. Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
35. UK Parkinson's Audit

Clinical Outcome Review Programmes

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

1. Chronic Neurodisability
2. Acute Heart Failure
3. Perioperative Diabetes

Child health clinical outcome review programme:

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

The national clinical audits and national confidential enquiries that HDFT participated in, and for which data collection was completed during 2017/18 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 16 of the national clinical audits and one of the NCEPOD reports were reviewed during 2017/18, and HDFT intends to take the following actions to improve the quality of healthcare provided.

National Maternity and Perinatal Audit

We have previously identified concerns about the increasing post-partum haemorrhage (PPH) risk and are undertaking improvement work to tackle this. A review of the potential for increased use of midwife-led settings in Harrogate will be undertaken in 2018.

National Diabetes Foot Care Audit

Podiatry is shown to be an accessible service for patients with earlier access preventing less serious wounds developing and better than average outcomes in terms of patients being alive and ulcer free. There are still issues across the service in decreasing minor amputation rates and with this in mind the process of root cause analysis for minor and major amputation will continue in order to identify areas for improvement and learning.

College of Emergency Medicine – Asthma

The results of this audit were disappointing given the timely care given to patients in the Harrogate ED. The Harrogate ED admits a low proportion of asthma patients and also has a low re-attendance rate which suggests that the poor performance in the audit relates to our ability to record the interventions given. Since this audit took place we have implemented ePMA and Patientrack in the ED which are better able to prompt and ensure the documentation of medications and observations respectively. We have also recently implemented a condition specific ED card for patients with asthma which prompts clinicians to take a step wise approach to therapy and we expect this to result in improved compliance with the standards set out in this audit.

College of Emergency Medicine – Consultant Sign off

It can be seen from the local and national data that emergency departments are not currently able to evidence that the management of patients with high risk conditions is reviewed or 'signed off' by consultants or experienced middle grade doctors. Locally we are performing well against the national position and we believe that much of the gap represents the difficulty in using the current ED system to record the senior review of a patient, rather than senior reviews not being performed. The shop floor presence of middle grade and consultant doctors in the ED in Harrogate is the highest it has ever been. The dependence of doctors in training on support from senior doctors is also higher. To take this forward the department is to follow a single, simpler approach to identifying senior involvement. This will be through the application of the senior doctor's name stamp into the notes; this is to endorse management plans and will serve as a simple and identifiable mark for audit purposes.

NCEPOD Treat as One

This report highlights the quality of mental health and physical healthcare for patients aged 18+ with a significant mental disorder who are admitted to a general hospital. A detailed action plan has been developed which includes the following actions for improvement in relation to a number of situations:

Presentation to hospital

- To add a prompt for mental health diagnoses on clerking proformas (ED card) and nursing admission proforma;
- To consider incorporating a prompt on the Web-V admission screen. Web-V is the integrated electronic patient record solution that the Trust is implementing for the recording, viewing and sharing of clinical and non-clinical patient information that has traditionally been held in paper health records and on multiple clinical IT systems;
- Depending on the reason for presenting at Minor Injuries Units (MIU), to ensure the reason for current injury and any associated mental health needs are addressed, by adding into MIU documentation.

Liaison psychiatry review

- To develop a document to clarify and agree expectations of the acute hospital liaison service (AHLS) such as how to access the service; timeliness of review; process for accessing mental health beds; management of common conditions;
- To improve the visibility of mental health liaison documentation in HDFT notes to help ensure mental health issues and diagnoses documented during admission are picked up by our clinical coders so the information is appropriately recorded.

Supporting care issues

- To adopt the term "fit for assessment" (FFA) and include in AHLS guidance document;
- To include FFA flag on ward whiteboards in order that this is visible to ward staff.

Ongoing patient care

- To add to the discharge summary template whether AHLS have been involved with acute inpatient care, ongoing plans, and a prompt to ensure copies are shared with specialties providing ongoing mental and physical healthcare.

Training

- To develop a focus of training on clinical staff and to develop a network of mental health champions;
- To extend the successful buddying of care support workers from HDFT acute inpatient wards with those on Tees, Esk and Wear Valley (TEWV) NHS Foundation Trust's Rowan and Cedar wards in the Briary Wing;
- To include AHLS and the Crisis Team in the induction and training programme for foundation year 1 and 2 doctors;
- To develop a basic awareness of mental health e-learning module for all staff.

Local Audits

During 2017/18 a joint audit programme between the Clinical Effectiveness Department 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 there was no duplication of work and that resources were used more efficiently. Joint audit planning has been undertaken again in preparation for 2018/19.

151 projects (excluding national audits) were registered with the Clinical Effectiveness Department during 2017/18. 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 2018/19.

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 complete the audit cycle, re-audits should be completed as evidence that improvements have been made, where appropriate.

The reports of 36 local projects (clinical audits, service evaluations and patient surveys) were reviewed by relevant audit or governance groups at HDFT during 2017/18 and HDFT intends to take the following actions to improve the quality of healthcare provided.

Confirmation of nasogastric tube position

The misinterpretation of the position of nasogastric tubes on chest x-rays is a major risk factor for patient harm and death, if feeding is commenced when the position of the nasogastric tube is unsafe. Competency based training is now mandatory for all staff who may be required to confirm the position of a nasogastric tube. Our Trust expects all chest x-rays requested from inpatient wards to check the position of a nasogastric feeding tube to be interpreted by a trained radiologist prior to use. Intensive Care Unit (ICU) patients often require timely use of a nasogastric tube for essential medications and feeding, and waiting for formal radiology reporting may not be feasible in these patients, especially out of hours. Therefore ICU was required to implement specific training and competency assessment for relevant staff.

They provided a teaching session for 22 ICU doctors on the safety issues related to nasogastric tubes; the approved methods for confirming nasogastric tube position; and the 'four criteria' technique of x-ray interpretation. Doctors completed a written assessment immediately after training and at 8 weeks. We also completed a 4-week audit of all nasogastric tubes inserted on ICU that required x-ray confirmation of position. Doctors had 100% recall of the correct methods for confirming nasogastric tube position immediately after training and at 8 weeks. However, there was a significant reduction in recall of the 'four criteria' technique at 8 weeks.

There was a significant time delay for radiology reporting of x-rays compared with the ICU doctors. Nasogastric tubes inserted out of hours (44%) represented the longest delays in reporting and also had poorer compliance with clinical documentation compared to tubes inserted during normal working hours.

This project has shown that knowledge of the 'four criteria' technique for x-ray interpretation is not retained over time, and this highlights the potential for x-ray misinterpretation. This risk should be balanced with the evidence that radiology reporting takes significantly longer and in at least some cases may affect patient care if relied upon.

In response to this, our nasogastric tube documentation will now include a 'tick-box' reminder of the 'four criteria' technique for x-ray interpretation. Furthermore, nasogastric tubes requiring x-ray confirmation of their position will only be interpreted during normal working hours by an ICU consultant and preferably a second doctor. The audit, training outcomes and actions taken have contributed to a significant locally-driven piece of work to improve patient safety.

Swallowing recommendations audit

It is essential patients are sent home from hospital with the correct recommendations regarding swallowing to avoid choking or aspiration in the community and to prevent further hospital admissions.

33 patient notes belonging to speech and language therapists (SALT) and associated nurse discharge reports were audited:

- 12 (36%) had complied with SALT recommendations;
- 11 (33%) had included incorrect recommendations and therefore the patient was discharged with incorrect information on their discharge report;
- 10 (30%) had not written anything on the discharge report when there were recommendations from SALT, which meant the patient was discharged without advice or instruction regarding their feeding routine.

Current practice is not in line with national guidelines regarding information shared between hospital and the place of discharge. This puts patients at risk of choking and aspiration in the community and increases the potential for further hospital admissions. Adaptations to the current nurse discharge report system are required to improve the accuracy and consistency of SALT swallowing recommendations. The outcome of the audit is to implement actions to:

- Introduce mandatory inclusion of SALT recommendations on nurse discharge reports;
- Ensure clear and accurate recommendations are made by SALT in medical notes;
- Provide additional SALT information for the patient to be given with the nurse discharge report i.e. thickened fluid and textured diet leaflets.

Neutropenic sepsis (re-audit)

Neutropenic sepsis is a life threatening complication of anticancer treatment; the term is used to describe a significant inflammatory response to a presumed bacterial infection in a person with or without fever. NICE Guidance for Management of Neutropenic Sepsis (2014) states that antibiotics should be delivered within 60 minutes.

The Quality Surveillance Programme for Acute Oncology (2017) requires an audit of patients with suspected neutropenic sepsis (febrile neutropenia), to measure the percentage who receive their first dose of antibiotics within one hour of them being clinically diagnosed. At HDFT this is encompassed in an audit of our suspected neutropenic sepsis pathway which sets out the management of suspected neutropenic sepsis. This is the sixth time that these standards have been audited at HDFT and the table below details the results:

Criteria	2012	Re-audit 2012	Re-audit 2013	Re-audit 2014	Re-audit 2015	Audit 2016*
Minutes between arrival and assessment ≤10	Not measured	Not measured	Not measured	38%	65%	62%
Minutes between arrival and antibiotics ≤ 60 minutes	67%	75%	78%	87%	89%	85%

*Audit was undertaken in 2017 using 2016 data

Table7: Neutropenic sepsis audit data.

Despite staff changes and pressures on services, the re-audit shows that overall 85% of patients receive their first dose of antibiotics within 60 minutes of arrival. The figures do however highlight the need to continue with ongoing education in key areas of the suspected neutropenic sepsis pathway and encouraging staff to give the first dose of antibiotics immediately. The audit particularly identifies focusing on ongoing education in the ED and on Clinical Assessment, Triage and Treatment (CATT) ward. The action plan to improve care following the audit will focus on addressing these outcomes.

Carbon monoxide monitoring in pregnancy (re-audit)

Exposure to carbon monoxide (CO) is especially dangerous during pregnancy because it deprives the baby of oxygen, slows its growth and development, and increases the risk of miscarriage, stillbirth and sudden infant death. It is therefore important that all pregnant women are tested for CO at the booking appointment and defined appointments in both antenatal clinic and community settings.

An audit of 123 patient hand held records showed that there had been an increase in women who received CO testing at booking since March 2017 but improvements are still needed to reach 100% compliance.

Criteria	Initial audit Sept 2016 – March 2017	Re-audit March 2017 – June 2017
% of women with smoking status recorded	99%	100%
% of women with CO testing at booking	22%	78%
% of women who smoke/ smoker in the household tested at all follow up visits	67%	100%

Table 8: Carbon monoxide monitoring in pregnancy audit data

The reason for CO testing not being performed was usually due to a broken machine. The outcomes of the audit were for all midwives completing bookings in the community and antenatal clinic to improve the CO monitoring, and to audit CO monitors for faults. Managers were to remind midwives to test at booking and follow up appointments as required and to file smoke free referral forms in the hospital notes. The department has now:

- Invested in CO machines and all community midwives now have a monitor;
- Increased education for midwives about smoking cessation and referral criteria is now included in mandatory training for midwives, with annual updates;
- Developed a staff information leaflet about smoking cessation in pregnancy, relevant investigations and referral criteria.

Community Podiatry clinic audits

The main emphasis for successful infection prevention and control in a healthcare setting is on standard precautions including hand hygiene. The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance states that "care providers must provide and maintain a clean and appropriate environment which facilitates the prevention and control of healthcare associated infection" (Department of Health, July 2015).

A series of individual audits were undertaken across the four localities to provide assurance that these national standards of infection prevention and control (IPC) are achieved throughout all community Podiatry Clinics managed by HDFT. During the audit verbal feedback on the IPC issues raised were provided to the lead podiatrists. A written report was provided for each visit to the appropriate Team Lead with recommendations and an individual action plan. The outcomes are:

- Feedback provided by the Community IPC team affirmed that overall podiatry staff had a positive attitude to infection prevention and control;
- The audit process provided the Team Leads with the evidence required to support environmental changes which were previously unsuccessful such as removal of carpets in the podiatry room and redecoration of some clinical rooms;

- All service level agreement issues (cleaning and maintenance) are now escalated to senior management within HDFT and highlighted as issues on the Podiatry Department risk register;
- Three Podiatry Team Leads have attended a "Preventing Infection" course with a view to becoming IPC Link Practitioners.

Enhanced recovery audit and re-audit

Enhanced recovery aims to improve patient experience by getting patients better sooner and to make care safer and more efficient through changes in clinical practice. The NHS Improving Quality's publication 'Enhanced recovery care pathway: A better journey for patients seven days a week and better deal for the NHS (2013)' explains that enhanced recovery consists of identifying the many steps in the whole care pathway where marginal gains can be made, leading to much better quality outcomes.

In 2016, a pilot study established current practice with regards to enhanced recovery after hip and knee replacement surgery within the Trust. Analysis of the results provided discussion and agreement of key performance indicators for optimum enhanced recovery pathway practice after orthopaedic surgery. The initial audit identified that documentation and use of the pathway was very poor. The Enhanced Recovery Working Group decided that further improvements to both training and design of documentation should be made to allow for the programme to become better established.

The aims of the re-audit were to measure performance of key performance indicators and establish whether the newly developed enhanced recovery pathway (ERP) document was being utilised correctly. Results indicated that the orthopaedic ERP was now fully embedded in practice. However, overall documentation again needed further improvement and a lack of mobilisation for patients on day zero remained a concern. The outcomes of the re-audit are:

- The Elective Admissions and Discharge Unit (EADU) is now open on a Saturday, ensuring that all patients can now be admitted on the same day as their surgery;
- The ERP document has been re-designed to better capture of day zero clinical information including a specific physiotherapy sheet for mobilisation on day zero;
- Key performance indicators have been revised to reflect different expectations for patients having morning or afternoon surgery;
- The Acute Pain Nurse now delivers a training course to cover the orthopaedic ERP, including training of existing staff on wards using the pathway.

A gynaecological and orthopaedic survey is currently underway to measure satisfaction and gain feedback from patients on the ERP pathway.

C. difficile booklet and card patient surveys

Healthcare professionals in hospitals and in the community are working together to help reduce the impact of *C. difficile* and prevent recurrence or re-infection of patients who have recently been diagnosed with *C. difficile* colonisation or infection. Because a further course of antibiotics can trigger a relapse of *C. difficile*, patients diagnosed with *C. difficile* are given a '*C. difficile* card'. Patients are advised to show the card to any healthcare professional involved in their care e.g. doctors, nurses, pharmacists, dentists and other healthcare workers such as those in care homes, or on admission to hospital, so that doctors can avoid prescribing medication which is particularly likely to cause a relapse. An accompanying booklet provides information on *C. difficile* to patients and how to prevent the spread of *C. difficile*.

A survey was designed to gain feedback from community patients with a new diagnosis of *C. difficile*. The results indicated that whilst the majority of patients were happy with the service provided, patients believe that once they are asymptomatic, they are 'clear' – and therefore may not consider showing their *C. difficile* card to healthcare professionals in the future. In addition almost half of patients felt that that the difference between colonisation and infection was not clearly explained. There were also suggestions received that the hand washing guide could have been provided to patients earlier to be more effective. The outcomes are:

- At the first telephone consultation, community infection control nurses now provide further explanation and reiterate the importance of carrying the card for a year after a positive test result even if asymptomatic;
- At the first telephone consultation, community infection control nurses provide further explanation and reiterate the difference between colonisation and infection;
- The *C. difficile* leaflet has been reviewed and re-designed in order to clarify the difference between colonisation and infection.

3. Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by HDFT in 2017/18 that were recruited during that period to participate in research approved by a Health Research Authority was 3218.

HDFT is committed to the promotion of evidence informed practice with the aim of continuous improvement to quality and patient outcomes. As of the end of March 2018 the number of studies open, recruiting or where patients were involved in research activity at HDFT was 210. 75 clinicians, covering 25 clinical areas, offer patients the opportunity to be part of research studies, and they are supported by 43 research funded delivery staff.

The team works closely with three Patient Research Ambassadors (PRAs) who are hospital volunteers with an interest in research. In the last year the PRAs have assisted with staff training, helped with awareness raising and been involved in an action research project aiming to find better ways for ward staff to use patient experience data.

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

Research and Development: Quality assurance

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. Quality and compliance systems have been reviewed and a new suite of standard operating procedures was launched in March 2018.

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. The Trust encourages and aims to identify research projects that are exploring integrated care pathways and will provide intelligence and expertise for the Trust as well as delivering evidence based practice. The 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 General Practice Federations to ensure patients have the opportunity to take part in diabetes research. This aligns with the diabetes service into clinics based in general 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 general practitioners (GP) to identify suitable participants in a systematic way using information from the GP database. This model has been extended to other therapeutic areas and facilitates 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 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 the 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 also actively works in partnership with Medipex Ltd for the development, protection and exploitation of Trust generated intellectual property.

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

Research governance and performance

R&D Unit staff conduct pragmatic research governance via a suite of usable standard operating procedures for research which have recently been reviewed and substantially rewritten. Activity is overseen monthly by a multidisciplinary R&D Group, chaired by the Trust's Medical Director. 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 four Patient Research Ambassadors (PRA), bringing a patient perspective to research delivery. PRAs are involved in project feasibility assessment, quality assurance via

the participant survey, performance via team meetings, conducting competency assessments for research staff 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. This feeds into a national NIHR survey of research participants. A public facing HDFT research community on the cloud based NIHR platform is available for patients who have or are taking part in research at HDFT. Trust research staff will seek out findings of projects and ensure not only that these are shared with individual participants but that the findings are also available to all the population HDFT serves and clinical teams via the HDFT online community and website. Work to share the impact of research generally has included a joint initiative with Harrogate Lions at the Great Yorkshire Show and video newsletters which have been shared locally and nationally.

4. Use of the Commissioning for Quality and Innovation Framework

A proportion of HDFT income in 2017/18 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 2017/18 and for the following 12 month period are available electronically at: https://www.hdft.nhs.uk/about/trust/statutory-info/

The monetary total for the amount of income in 2017/18 conditional upon achieving quality improvement and innovation goals was £2,991,571.08. The monetary total for the associated payment in 2016/17 was £3,048,803.30

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 2017/18:

Harrogate District Hospital
Lascelles Unit
Ripon Community Hospital

The Care Quality Commission has not taken enforcement action against the Trust during 2017/18. HDFT has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

6. Information on the Quality of Data

HDFT submitted records during 2017/18 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

https://groups.ic.nhs.uk/SUSDataQualityDashboardsAndReports/default.aspx

The percentage of records in the published data:

- Which included the patient's valid NHS number was:
  - 99.9% for admitted patient care
  - 100% for outpatient care
  - 98.9% for accident and emergency care

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

100% for outpatient care
100% for accident and emergency care.

7. Information Governance

HDFT's Information Governance Assessment Report overall score for 2017/18 was 83% and was graded green/satisfactory with all standards at level two or above (there are three levels with level three being the highest).

8. Payment by Results

HDFT was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

The Trust however commissioned an external clinical coding audit to meet Information Governance requirements during 2017/18. The audit was carried out in March 2018 by nationally registered clinical coding auditors from D & A Clinical Coding Consultancy Limited. An audit sample of 200 episodes was reviewed, 75 episodes from Trauma & Orthopaedics, 75 episodes from Elderly Care and 50 episodes from Urology were randomly selected from across the whole range of activity for the period July – September 2017. The results showed an overall error rate of coding errors affecting the healthcare resource group (HRG) of 1.52% 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	5.5%
Secondary procedures	6.1%
Primary diagnoses	4.7%
Secondary diagnoses	3.9%

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.

9. Learning from Deaths

During 2017/18 657 of HDFTs patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 145 in the first quarter
- 140 in the second quarter
- 167 in the third quarter
- 205 in the fourth quarter

By 31 March 2018, 31 case record reviews and one investigation have been carried out in relation to 31 of these deaths.

In one case a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 3 in the first quarter
- 8 in the second quarter
- 14 in the third quarter
- 6 in the fourth quarter

One representing 0.15% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter
- 0 representing 0% for the second quarter
- 1 representing 0.6% for the third quarter
- 0 representing 0% for the fourth quarter

These numbers have been estimated using the validated National Mortality Case Record Review methodology available from National Mortality Case Record Review (NMCRR) programme resources | RCP London. The Trust has a number of clinicians trained to undertake the structured judgement review using the proforma. It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.

For those patient deaths meeting the criteria for a detailed review of case notes, the Medical Director appoints a clinician with appropriate expertise to undertake a structured judgement review (SJR). Whenever possible, the clinician will not have been involved in the care of the patient who died. All cases of a patient with learning disabilities dying in hospital are automatically referred to the national LeDeR programme. This is the national multi-agency programme for review of death in patients with learning disabilities commissioned by NHS England. A case note review is to determine not only examples of good practice, but also whether there were any problems in the care provided to the patient who died in order to learn from what happened.

In addition to this process, during 2017/18 some specific focused reviews have been undertaken:

- Deaths of patients as a result of cerebrovascular disease as the Trust was identified as a potential outlier by the Care Quality Commission in 2016;
- Deaths of patients with chronic obstructive pulmonary disease identified during the 2014 national audit. This was a recommendation from the audit for each hospital to undertake a deep-dive into the care received by patients who died during the audit period, to look for both deficiencies in care and examples of good practice end-of-life care that might be used for learning and quality improvement purposes;
- Review of elderly medical deaths in response to a rising hospital standardised mortality ratio (HSMR).

Summary of learning points identified

The numbers of deaths in hospital that can be unequivocally shown to be truly avoidable are fortunately rare. The mortality review process is reproducible and provides a rich seam of learning which, albeit not necessarily affecting outcomes, will allow us to improve end of life care in many patients.

The case record reviews emphasise the increasing frailty and complexity of medical elderly patients in particular, and confirm the excellent care received by the great majority of patients

whose death in hospital is expected. In a smaller proportion of cases, examples of where practice could be improved were documented. The great majority of these did not affect the eventual outcome. For example:

1. Highlighting monitoring to assist in the evaluation of deteriorating patients;
2. Reinforcing specific elements of clinical management ;
3. The value of post-mortem examination in clarifying the cause of death;
4. More consistent use of advanced care plans;
5. Stopping unnecessary medications when patients are close to end of life;
6. Ensuring an alternative mode of administration of certain medications for patients who are nil by mouth (NBM);
7. Measures for admission avoidance at end of life with advanced care planning in the community, and more anticipation of the likelihood and type of final illness;
8. Improving pre-operative management of elective surgery in frail elderly patients, with early scheduling on elective theatre lists and minimising the length of time NBM pre-operatively.

The one case judged to be more likely than not to have been due to problems in the care provided to the patient was reported through Datix and has been investigated as a serious incident (SI). The SI report was presented to the Board of Directors in April 2018.

Actions

The following actions have been taken as a result of the learning points identified to date:

1. Local dissemination through feedback to teams and across the organisation where appropriate. This is led through the Improving Patient Safety Steering Group;
2. At national level through the implementation of a new web based methodology for documentation of SJR which will enable more effective identification of themes and further opportunities for learning;
3. Combining outcomes and learning from reviews of deaths following attempted cardio-pulmonary resuscitation to inform resuscitation training, resuscitation decision making training materials and implementation of the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) process in the Trust. This aims to improve advanced care planning and discussion of resuscitation for patients and relevant others across all care areas, ideally in partnership with GPs.

The impact has been:

- Increased awareness of the mortality review process and the benefits of reviewing deaths to inform learning;
- Increased awareness of the processes and regulations for discussion of deaths with the Office of HM Coroner;
- Engagement with the national roll-out programme for Medical Examiners.

29 case record reviews and 0 investigations completed after 1 April 2017 related to deaths which took place before the start of the reporting period (during 2016/17).

1 representing 0.15% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the validated National Mortality Case Record Review methodology.

1 representing 0.15% of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient.

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 NHS Digital.

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. NHS Digital publish a value for each Trust every quarter. The national score is set at 1.000 – a Trust score significantly above 1.000 indicates higher than expected death rates, whereas a score significantly below 1.000 indicates lower than expected death rates.

	Data period			
	Jul 15 to Jun 16	Oct 15 to Sep 16	Jul 16 to Jun 17	Oct 16 to Sep 17
HDFT value	0.963	0.925	0.909	0.925
HDFT banding	2 (as expected)	2 (as expected)	2 (as expected)	2 (as expected)
National average	1.000	1.000	1.000	1.000
Highest value for any acute Trust	1.171	1.164	1.228	1.247
Lowest value for any acute Trust	0.694	0.690	0.726	0.727

Table 9: Summary Hospital Level Mortality Index

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

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

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

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

- Actively using the Healthcare Evaluation Data (HED) tool that enables the Trust to clinically review and analyse mortality data in detail on an on-going basis. This has been rolled out across the organisation;
- Implementing the learning from deaths processes within the Trust and contributing to the national database using Datix mortality review tool. This methodology has been rolled out nationally across England and Scotland. It is an excepted methodology for case note review and in line with recommendations in: National Guidance on Learning from Deaths (National Quality Board March 2017). In addition to specialty specific case note reviews, focused reviews of situation specific deaths will also be undertaken (such as maternal deaths, death in childhood, deaths from sepsis, elective surgical deaths and deaths of patients with learning disabilities);
- Individual specialty alerts are investigated as deemed appropriate, either through the mortality review process, coding anomalies or discharge processes or a combination of these. Currently no alerts have been received and the SHMI is below expected levels.

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 during the hospital admission that ended in 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		Data period	
	Jul 15 to Jun 16	Oct 15 to Sep 16	Jul 16 to Jun 17	Oct 16 to Sep 17
HDFT value	22.6	23.0	20.4	20.3
National average	29.2	29.7	31.1	31.5
Highest value for any acute Trust	54.8	56.3	58.6	59.8
Lowest value for any acute Trust	0.6	0.4	11.2	11.5

Table 10: Summary Hospital Level Mortality Index

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

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

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

However:

- This data originates from the clinical coding of specialist palliative care input by the Palliative Care Team (PCT) and is based on evidence documented in patient records;
- The PCT record all face-to-face and telephone contacts on an electronic patient system called SystmOne, whilst the clinical coders base their coding on information in the paper medical record. If there is telephone contact only, documentation in patients' paper medical records will be by the ward team, but may not always be recorded clearly as PCT input and therefore may be difficult for clinical coders to identify. Previously the Information Services team also extracted activity data from SystmOne for accurate submission of mortality data, but due to reduced capacity in the Information Services team, this has not happened for some months. It is planned that this will resume soon;
- The PCTs activity data for 2017-18 indicates that referrals to the team increased by 21% compared to 2016/17 with the number of contacts increasing by 34%. The majority of this increase seems to be from August 2017 onwards, and the data above to September 2017 does not reflect that increase for the reasons suggested;
- The new Care Plan for Last Days and Hours of Life was rolled out across the Trust at the end of 2017. This is designed to support ward staff to care for dying patients and in theory means that fewer patients require referral to the PCT. It is being used significantly more than the old version; in 81% of patients identified as dying in Jan 2018 compared to 36% of patients in Nov 2015.

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

- Expansion of the PCT by 0.6 WTE clinical nurse specialist in August 2017, so the establishment is now 0.6 WTE consultant, 0.4 WTE specialty doctor and 1.2 WTE clinical nurse specialist;
- PCT attendance at MDTs on AMU, Granby, Jervaulx and Byland wards, taking referrals and giving advice where necessary;
- Improving ease of access to the PCT: all team members now carry mobile phones and take phone referrals as well as written, faxed or posted referrals.

In addition several actions have been taken to improve the quality of End of Life Care. These are described in this report in section 3.3.

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

PROMs – Patient Reported Outcome Measures

PROMs calculate the health gain after elective surgical treatment using pre- and post-operative patient surveys. Four common elective surgical procedures are included in the survey: groin hernias, hip replacements, knee replacements and varicose vein operations. HDFT do not perform significant numbers of varicose vein operations and so this procedure has been excluded from the results. A high health gain score is good.

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

	Data period		
	2014/15 (final)	2015/16 (final)	2016/17 (provisional)
HDFT value	0.423	0.442	0.433
National average	0.436	0.438	0.445
Highest value for any acute Trust	0.487	0.492	0.495
Lowest value for any acute Trust	0.331	0.320	0.310

Table 11: PROMS – Hip replacement surgery

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

	Data period		
	2014/15 (final)	2015/16 (final)	2016/17 (provisional)
HDFT value	0.302	0.324	0.323
National average	0.315	0.320	0.324
Highest value for any acute Trust	0.385	0.374	0.391
Lowest value for any acute Trust	0.204	0.198	0.242

Table 12: PROMS – Knee replacement surgery

***Note** - highest and lowest trust scores exclude independent sector providers. Data looks at primary hip and knee procedures only*

Data source: http://content.digital.nhs.uk/proms

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 for the elements it participates in, 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 NHS Digital since December 2013. The data below and comments were from 2013/14 but are still 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 NHS Digital 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 13: Emergency readmission to hospital within 28 days (age 0-15)

2011/12 data published December 2013. No data published by NHS Digital 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 14: 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

This data looks at the percentage of all patients who are readmitted to hospital as an emergency within 30 days of being discharged. A low percentage score is good.

	Data period		
	2015/16	2016/17	2017/18 Feb YTD
Total number of emergency readmissions within 30 days	3895	4183	4044
As a percentage of all emergency admissions	18.90%	19.38%	19.59%
Number of emergency readmissions within 30 days (Payment by Results exclusions applied)	2696	2739	2690
As a percentage of all emergency admissions	13.10%	12.69%	13.03%

Table 15: Emergency readmissions within 30 days

Data source:
http://harrogatedata/Reports/Pages/Report.aspx?ItemPath=%2fFinance%2fEmergency+Readmissions
Data for the full year 2017/18 not available at time of publication

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

- The data presented is taken from the Trust's main patient administration system, iCS;
- The data is sourced from the admitted patient care spells data set. The data quality of this data is routinely assessed and published nationally by NHS Digital. HDFT's latest data quality results are presented in section 2.3 (item 6);
- The excluded readmissions are based on national definitions. These are identified by clinically coded data and the Trust consistently performs better than average in external clinical coding audits, as detailed in section 2.3 (item 8) of this report.

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

- Routinely presenting emergency readmissions information to the Trust Board each month;
- Continuing to periodically carry out a number of clinical audits to understand this further;
- Using national benchmark data to review how HDFT performs compared to local trusts and a benchmark group of similar trusts.

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		
	2014	2015	2016
HDFT value	72.6	73.3	72.4
National average	68.9	69.6	68.1
Highest value for any acute Trust	86.1	86.2	85.2
Lowest value for any acute Trust	59.1	58.9	60.0

Table 16: Inpatient survey results 2014, 2015, 2016 (Combined scores for 2017 due to be published by NHS Digital in August 2018.)

Data source: NHS Digital, NHS Outcomes Framework indicator 4.2
Ind ref: P01779
https://digital.nhs.uk/data-and-information

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

- Driving improvement for the delivery of high quality fundamental care continues to be a major priority for the Trust. 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; We have also reviewed our inpatient nursing admission documentation including relevant risk assessments.
- 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 is in place.

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

- Focussing resources on addressing those indicators which, following analysis of the 2016 result, identified areas which are both in need of improvement and are most important to patients and have the biggest impact on overall experience, including:
    - Asked to give your views on the quality of your care (Q75)
    - How clean were the toilets and bathrooms that you used in hospital? (Q18)

- Did you find someone on the hospital staff to talk to about your worries and fears? (Q38)
- Information given about condition or treatment (Q37).
- Did you know which nurse was in charge of looking after you? (Q32)
- Call button response times (Q44)
- Length of time on the waiting list before admission to hospital (Q6)
- Operation/procedure risks and benefits explained in a way you could understand (Q46)
- Discharge delays on the day Q57 and discharge advice information (Q66)

National Staff Survey – Standard of Care Provided

Staff who would recommend the trust to their family or friends as a place to be treated Question 12d

Proportion of staff who responded "strongly agree" or "agree".	Data period		
	2015	2016	2017
HDFT value	78	80	76
National average	68	69	69
Highest value for any acute Trust	93	91	89
Lowest value for any acute Trust	46	48	48

Table 17: National staff survey results

Benchmark data for 2017 includes both "acute trusts" and "combined acute and community trusts"
Data source: http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2016/

The data shows the proportion of staff completing the NHS Staff Survey who responded "strongly agree" or "agree" to the question "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation" compared to the total number of staff that responded to the question. The scores are presented out of 100 with a high score indicating good performance. Whilst there has been a slight decrease in our score since 2016, the highest performing Trusts have also seen a decrease year on year. Our score remains higher than the national average for Trusts within our benchmarked group.

This question forms part of key finding 1: Staff recommendation of the Trust as a place to work and/or receive treatment, in the National Staff Survey for 2017. The Trust achieved a ranking of 6th out of 39 when compared with all acute and community Trusts for this key finding. The full report can be found at http://www.nhsstaffsurveys.com/ and there is further detail in section 3.5 of this report.

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

- The Trust has continued to focus on our values which hold patient care at the heart of everything we do;
- The Trust has embedded its Quality Charter which is built on the goals of setting our ambition for quality and safety, promoting staff engagement, providing assurance on care quality and supporting a positive culture. This allows staff to help suggest and deliver improvements to the services we provide as well as sharing best practice. We also held our first ever Quality Conference in June 2017, where staff shared their ideas and learned about other initiatives to support the effective delivery of patient care;
- The Trust continues to research and implement health and wellbeing programmes for staff; examples of which include showcasing our 'emotional and mental health' offer to staff, which includes a programme of Schwartz Rounds (which allows staff to share

their experiences of providing healthcare); and development of business cases to deliver innovative personal resilience training and a fast-track physiotherapy model for staff to improve their own wellbeing;

- The Trust has launched the Clinical Workforce Strategy, through which we are creating and developing new roles within the Trust to support the delivery of a sustainable workforce for the future;
- The Trust is continuing our proactive recruitment strategy including embracing social media with targeted recruitment for specific work areas or staff groups, and recruitment days for nurses.

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

- Holding an RPIW in November 2017 to review the tools and systems for reporting near misses, low harm and more serious incidents. A new form is being piloted to support the development of a new reporting model, focused on learning;
- Reviewing the establishment and skill mix on the acute inpatient wards and implementing this in July 2017 to support the safe delivery of patient care;
- Promoting the role of the Freedom to Speak Up Guardian within the Trust and implementing the new Speaking Up Policy;
- Using the Calderdale Framework to review clinical roles and implement new roles on inpatient wards;
- Implementing values-based recruitment for staff and an assessment process for the recruitment of care support workers to increase retention;
- Approving a business case for the second cohort of advanced care practitioners; the first cohort are now in post;
- Implementing a theatre staffing strategy to train and retain operating department practitioners;
- Reviewing incidents reported through risk management processes to ensure that these are investigated and appropriate action is taken;
- Piloting a Quality Team Charter within the Intensive Care Unit and the Resuscitation Team; this aligns to our Quality Charter;
- Implementing an appraisal on a page and an appraisal window to support to achievement of annual appraisals for all staff.

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

Venous thromboembolism (VTE) risk assessment

The National Institute for Clinical Excellence (NICE) recommends that all patients in hospital should be assessed for 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			
	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18
HDFT value	96.7	96.0	96.2	95.3
National average	95.7	95.1	95.2	95.2
Highest value for any acute Trust	100.0	100.0	100.0	100.0
Lowest value for any acute Trust	80.6	51.4	71.9	76.1

Table 18: Percentage of eligible patients risk assessed for VTE

Note - national values exclude independent providers.
Data source: https://improvement.nhs.uk/resources/vte/
Q4 2016/17 data reported in the absence of Q4 2017/18 data (to be published early Jun-18).

HDFT's published scores are consistently above the national average.

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

- There is a well-established protocol for VTE risk assessment on admission;
- Data is recorded onto the Trust's main patient administrative system, iCS, and collected via reliable IT systems;
- Education on VTE risk assessment is part of the Trust's essential training so staff understand the importance of it.

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

- Continuing to identify wards with poorer performance and examining whether there are issues with completion of the risk assessment or inputting of information onto iCS;
- Exploring the option of electronic VTE risk assessment with the roll out of Web-V across the Trust.

Clostridium difficile rates

The table shows the number of cases of *C. difficile* infection (CDI) per 100,000 bed days reported from hospital inpatients aged two years or over.

	Data period		
	2014/15	2015/16	2016/17
HDFT value	9	33.8	28.4
National average	15.0	14.9	13.2
Highest value for any acute Trust	62.2	66.0	82.7
Lowest value for any acute Trust	0	0	0

Table 19: Number of cases (rate) of CDI per 100,000 bed days (2017/18 data due for publication July 2018)

Data source: https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data (Table 8b is used)

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

- The number of Trust-apportioned *C. difficile* apparently increased dramatically in 2015/2016 compared with previous years. We felt that this was most likely to have represented an under-ascertainment in previous years, although it was difficult to gauge the extent of this over a genuine increase in numbers;
- In August 2015 HDFT changed its stool sampling policy to lower the threshold of "looseness" for sending stool samples for *C. difficile* investigation;
- In August 2015 the laboratory changed its testing policy to test all stools that were submitted as "loose" (i.e. including Bristol Stool Types 5 and 6) rather than only testing stools that were liquid on receipt;
- Following these changes the number of stool samples received and tested for *C. difficile* increased by 32.6% and 59.4% respectively compared with the corresponding months in 2014/2015;
- There was no suggestion or evidence of a community-wide outbreak of CDI and minimal evidence of in-hospital transmission;
- During 2016/17 we:
    - Reviewed the prescribing of antimicrobials. Overall, the use of antimicrobials at HDFT is now below the regional and national average;
    - Reviewed our cleaning and decontamination strategy. We have:
        - Reappraised the role of the ward hygienists and clarified what they do;
        - Renewed our aging Bioquell HPV machines with two new ones from Hygiene Solutions;
        - Delivered an enhanced cleaning programme to Trinity ward and Lascelles, particularly concerning cleaning of commodes;
    - Developed whole day educational "Masterclasses" for nursing staff;
- Our data shows that the number of CDI cases has fallen from 29 in 2016/2017 to seven in 2017/18, with only one case agreed with the CCG to be as a result of a lapse in care, compared with twelve cases in 2016/2017.

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

- Continuing to review the prescribing of antimicrobials, particularly of the "4 C" antibiotics, namely the cephalosporins, clindamycin, the quinolones and co-amoxiclav;
- Continuing to review our cleaning and decontamination strategy, as the evidence for the role of the environment in the transmission of healthcare associated infection (HCAI) including CDI is now overwhelming;
- Continuing to provide the whole day educational "Masterclasses" for nursing staff, which includes a module on *C. difficile* and the role of the nurse. We believe that our educational drive may be partly responsible for the reduction in the number of lapses in care.

Patient safety incidents

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

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

- The number and percentage of reported incidents that resulted in the death of a patient. A low score is good.

HDFT's latest published scores are below.

	Oct 16 - Mar 17			Apr 17 - Sep 17		
	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	46.42	4	0.070	48.50	4	0.080
National position (all acute trusts)	40.52	2623	0.153	42.23	2482	0.149
Highest value for any acute Trust	68.97	92	0.532	111.69	121	0.636
Lowest value for any acute Trust	23.13	1	0.008	23.47	0	0.000

Table 20: Patient safety incidents reported to the NRLS

Data source: https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports

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

- The data relating to patient safety incidents is reported by front line staff;
- There is a robust policy and process within the Trust to ensure that all incidents are identified, managed, reported and investigated in accordance with national guidance;
- The Trust ensures that there are appropriate measures in place to prevent recurrence and also promotes organisational learning;
- All of the severe harm incidents reported were robustly investigated in line with the Trust's policy and processes and actions to address the findings have been put in place.

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

- Continuing to promote patient safety as a key objective across the organisation and implementing a number of mechanisms to ensure compliance with, and delivery of national frameworks;
- Implementing improvements in line with the quality priority focussing on the learning from incidents and complaints, including changes to the web based incident reporting system (Datix);
- Ensuring there is a continued focus on quality at an organisational, directorate and front line level through a variety of structures, for example quality of care teams, quality governance groups at corporate and directorate level, patient safety visits, quarterly monitoring reports, case conferences and learning events.

3. REVIEW OF OTHER QUALITY PERFORMANCE

This section provides an overview of the quality of care offered by HDFT based on performance in 2017/18 against indicators selected by the Board of Directors in consultation with stakeholders, including three priorities for the three elements of quality covering patient safety, patient experience and effective care.

3.1. PATIENT SAFETY

1. Medicines Safety

Medicines play an integral role in the management of disease. They are pivotal to achieving good patient outcomes but there is room for improvement in the way patients take their medicines. 30-50% of patients do not take their medicines as intended by the prescriber. 30% of patients state they do not receive appropriate information about their medicines. 8-10% of hospital admissions are associated with a medicine related event. The NHS wastes £300-£400 million per annum on unused medicines (50% of which is deemed avoidable) and around 200,000 medicines incidents are reported to the NHS England Patient Safety Division through the National Reporting and Learning System (NRLS). The greater the number of medicines a patient takes the greater their risk of suffering an adverse event. 98% of patients admitted to hospital take one or more medicines, with 95% taking four or more.

HDFT administers over 2 million medicines doses per annum and dispenses around 150,000 medicine packs (items) per year, and over recent years has been working to use medicines more safely and effectively. This work is supported by a multi-professional, multi-agency national medicines optimisation work programme and a Board approved Hospital Pharmacy Transformation Plan.

What were we aiming to achieve?

The aim of our medicines safety work in 2017/18 was to consolidate improvements made in previous years and seek to further improve patient safety by reducing errors in prescribing, dispensing and administration of medicines, and also to improve the information given to patients about their medicines. We also commenced implementation of the Hospital Pharmacy Transformation as part of the Lord Carter review of Hospital Pharmacy and Medicines Administration. Specifically we intended to:

- Extend functionality of the ePMA (electronic prescribing and medicines administration) system and to commence the planning to implement prescribing of complex infusions;
- Embed into practice the ePMA dashboard to target interventions to patients on high risk medicines specifically insulin and respiratory medicines;
- Make progress on actions identified in the Hospital Pharmacy Transformation Plan;
- Continue the focus on safe, prescribing, dispensing and administration of medicines to include:
    - reducing the number of incorrectly prescribed medicines;
    - reducing the number of medicines not prescribed that should be;
    - reducing the number of medicines not administered as intended by the prescriber;
    - reducing the number of medicines not administered at the time intended by the prescriber;
    - reducing the number of dispensing errors leaving the pharmacy department;
    - increasing the number of patients receiving relevant information about their medicines.

What have we done?

We have embarked on a wide ranging programme to use medicines safely and effectively by:

- Implementing actions as identified in the Board approved Hospital Pharmacy Transformation plan;
- Completing the roll out of the ePMA system across the whole organisation and commencing the complex infusions project;
- Embedding the use of dashboards using ePMA to target patients on high risk medicines especially insulin, identifying patients whose allergy status is not completed and developing protocols to aid acute asthma and COPD management;
- Monitoring against a range of metrics to measure safe use of medicines;
- Consolidating our medicines reconciliation processes and rates;
- Continuing to adapt and deliver medicines management training for nursing and care support workers;
- Continuing to review, report and learn from incidents relating to medicines use;
- Proactively seeking to inform patients about their medicines.

Whilst this is not an exhaustive list of the programme it does summarise some of the fundamental elements. The metrics agreed included:

- The number of incident reports classified as prescribing, dispensing or administration errors with a defined denominator to allow comparison;
- Missed doses of medicines;
- Medicines reconciliation rates;
- National inpatient survey data;
- Training compliance rates.

The targets are to continue to demonstrate improvement against baseline regarding the number of errors and missed doses, and to increase the information given to patients. Regarding dispensing errors, regional and national benchmarking data identify HDFT as already achieving low numbers of errors per items dispensed, and therefore maintaining the current low level of errors continues to be the target for this metric.

What are the results?

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

Board approved Hospital Pharmacy Transformation Plan

In line with NHS England and NHS Improvement requirements, the HDFT Board of Directors agreed and approved the HDFT Hospital Pharmacy Transformation Plan (HPTP) which was submitted to NHS Improvement in February 2017. The key elements of the HPTP are focused around

- Increasing the number of pharmacist prescribers;
- Improving medicines stock holding, e-trading and supply chain opportunities;
- Further roll out of e-prescribing (complex infusions and outpatients);
- Building on the already high performing front line core clinical service provision for pharmacists and non-pharmacist staff supporting medicines optimisation for our patients;
- Continuing and further developing collaboration of key pharmacy infrastructure services in order to maximise productivity and efficiency.

Key achievements in this programme have seen:

- An increase in the number of prescribing pharmacists from 11% to 30% with further increases planned during 2018/19;
- A reduction in medicines stockholding, from 34 days to 23 days;
- An increase to 90% of the patients who receive a medicines reconciliation within 24 hours of admission, and 100% at 72 hours;
- An increase in the proportion of time pharmacists spend on patient facing activities to 80%.

The overall programme of work is summarised below:

Figure 9: Hospital Pharmacy Transformation Plan

Roll out of ePMA

ePMA is now used on all wards with the final roll out to the Emergency Department in May 2016. This has made a significant improvement in the safe use of medicines across the Trust. We are one of only a few Trusts in the UK to have full ePMA use in all clinical areas.

Planning for the complex infusions module has commenced in 2017/18. A project board and team have been set up, a clinical lead is in place, protocols are in the process of being developed and the software is currently in the test environment. We aim to introduce this software into clinical practice in 2018/19.

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, accounted for by an increase in insulin prescribing errors. We have seen an improvement on the 2015/16 position during 2016/17, and in 2017/18 we have seen a further reduction again nearing the lowest reported rate in 2014/15.

Year	Number of adjusted prescribing errors per 100,000 prescribed doses reported via Datix
2011/12 (Pre ePMA)	3.43
2012/13	3.25
2013/14	3.19
2014/15	2.12
2015/16	3.34
2016/17	3.12
2017/18	**2.86**

Table 21: Number of adjusted prescribing errors

In addition we have seen a positive move in the levels of harm associated with prescribing errors with a significant increase in the proportion of no: low harm errors and a reduction in the moderate harm errors. We had no severe harm errors in 2016/17 or 2017/18. The number of moderate errors increased to six in 2017/18 compared to five in 2016/17, resulting in a slight increase to 9%.

Year	Levels of harm (%)		
	No or low harm	Moderate harm	Severe harm
2012/13	87%	13%	0%
2013/14	89%	11%	0%
2014/15	85%	15%	0%
2015/16	88%	11%	1%
2016/17	93%	7%	0%
2017/18	**91%**	**9%**	**0%**

Table 22: Levels of harm

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
2016/17	3.80
2017/18	**3.31**

Table 23: Number of adjusted administration errors

We have seen a substantial reduction in the number of medicines administration errors since the introduction of ePMA. Of note was the slight increase in 2014/15 and 2015/16 (though this was still less than the pre ePMA baseline). We refreshed our training for nurses and focused on increased support. In 2016/17 we saw a significant reduction in administration errors to the lowest level since 2013/14 and this remains over a 50% reduction compared with the pre ePMA position in 2011/12. In 2017/18 we have seen a further reduction to the lowest reported administration error rates since the implementation of ePMA.

In addition we have seen a positive move in the levels of harm associated with administration errors with a significant increase in the proportion of no or low harm errors and a reduction in the moderate harm errors. We have had no severe medication harm errors in 2016/17 or 2017/18.

Year	Levels of harm (%)		
	No or low harm	Moderate harm	Severe harm
2012/13	85%	15%	0%
2013/14	91%	7%	2%
2014/15	88%	8%	4%
2015/16	88%	11%	1%
2016/17	94%	6%	0%
2017/18	**97%**	**3%**	**0%**

Table 24: Levels of harm caused by medicine administration errors

Progress on reducing missed doses and ensuring the timeliness of medicines administration

Over the last five years we have seen a steady reduction in the percentage of medicine administrations delayed to patients; meaning more patients are getting their medicines in a timely manner. We have continued to see reductions in missed doses over this period, with 2017/18 delivering the lowest % missed doses since the implementation of ePMA.

Year	% Delayed doses	% Missed doses
2012/13	2.6	2.99
2013/14	2.9	3.17
2014/15	2.6	2.13
2015/16	2.0	0.96
2016/17	2.0	0.83
2017/18	**2.0**	**0.76**

Table 25: Delayed and missed medicine administrations

Development of an ePMA dashboard to target patients on high risk medicines

The ePMA system captures all medicines prescribed and administered to our patients. Interrogation of the system has facilitated the development of a live dashboard that identifies patients on high risk medicines in order to allow early intervention and help to avoid errors and harm arising from the use of these medicines.

It is well documented nationally through the 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;
- Patients with an unknown allergy status;
- We also are able to identify 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. There are several case examples of this.

In 2017/18 we developed new protocols for the prescribing against national recommendations in acute asthma and COPD, helping junior medical prescribing staff to prescribe safely and against best evidence in these domains.

Reduction in "potential" prescribing errors through pharmacist activity and implementation of ePMA

Potential prescribing errors are "those errors that are near misses that did not result in a wrong dose/medicine etc. given to a patient". These errors are identified by a ward clinical pharmacist before any level of harm is caused. We undertake an annual intervention audit to demonstrate the activity that pharmacists undertake.

At HDFT our pharmacists perform over 20,000 interventions per annum ensuring the safe prescribing and administration of medicines. Since the introduction of ePMA we have also seen a reduction in the number of potential major and life threatening interventions made by pharmacists. In 2017/18 we undertook the most robust intervention audit to date, using a new database to collect data, resulting in a significantly increased capture of pharmacist activity. The majority of interventions (86%) are minor / moderate, with just over 11% major or potentially life threatening interventions compared to 31% pre ePMA.

Year	Total number of:				Levels of potential harm			
	pharmacist interventions	potential harm interventions	unclassified interventions	actual harm interventions	Minor	Moderate	Major	Severe or life threatening
2011 /12	254	206	30	14	127	0	68 (27%)	11 (4%)
2015 /16	250	250	0	0	133	84	31 (12%)	2 (0.8%)
2016 /17	190	190	0	0	81	100	17 (9%)	0 (0%)
2017/18	**481**	**481**	**4**	**0**	**295**	**121**	**51 (11%)**	**2 (0.4%)**

Table 26: Pharmacist intervention audit data

Maintaining low numbers of dispensing errors

Our dispensing errors in 2017/18 (13/100,000) continue to be well below the regional average (18/100,000) and some of the lowest across the Yorkshire and Humber region. They have reduced slightly compared to 2016/17 (14/100,000). HDFT data for 2017/18 has fallen compared to previous years from a high of 16/100,000 dispensed items to 13/100,000 dispensed items. Only three Trusts (range 9-11/100,000 dispensed items) demonstrate a lower rate.

Our error rates in aseptic services (preparation of IV medicines including chemotherapy) are also extremely low and one of the two lowest Trusts in the region. This has also further reduced from 5/100,000 dispensed items in 2014/15 to 3.5/100,000 dispensed items in 2017/18.

Trust	Inpatient dispensing error rate / 100,000 dispensed items	Aseptic dispensing error rate / 100,000 dispensed items
HDFT	13	3.5
Y&H average	18	10
Y&H range	9-30	3-30
National average	~20	Unknown

Table 27: Dispensing errors

Learning from medicines errors

In 2014/15 we started to build a database of all Datix reported medicines errors. This now covers seven years from 2011/12 through to 2017/18. This allows us to identify common themes and errors, map trends and analyse progress. All reported errors are investigated and actions put into practice to learn from such events. All errors are discussed at the monthly Medicines Safety Review Group meetings.

We have focused on a number of areas, with three included in this report. These include:

1. Progress on the management of missed doses

The graph below demonstrates the progress being made with reducing missed doses. We have seen a consistent year on year reduction in the percentage of missed doses and the proportion of delayed doses meaning patients are receiving medicines in a more timely manner. There was slight increase in 2017/18 in the percentage of Datix reports of more critical medicines being delayed (from 4% to 6%). However this is still well below the pre ePMA baseline.

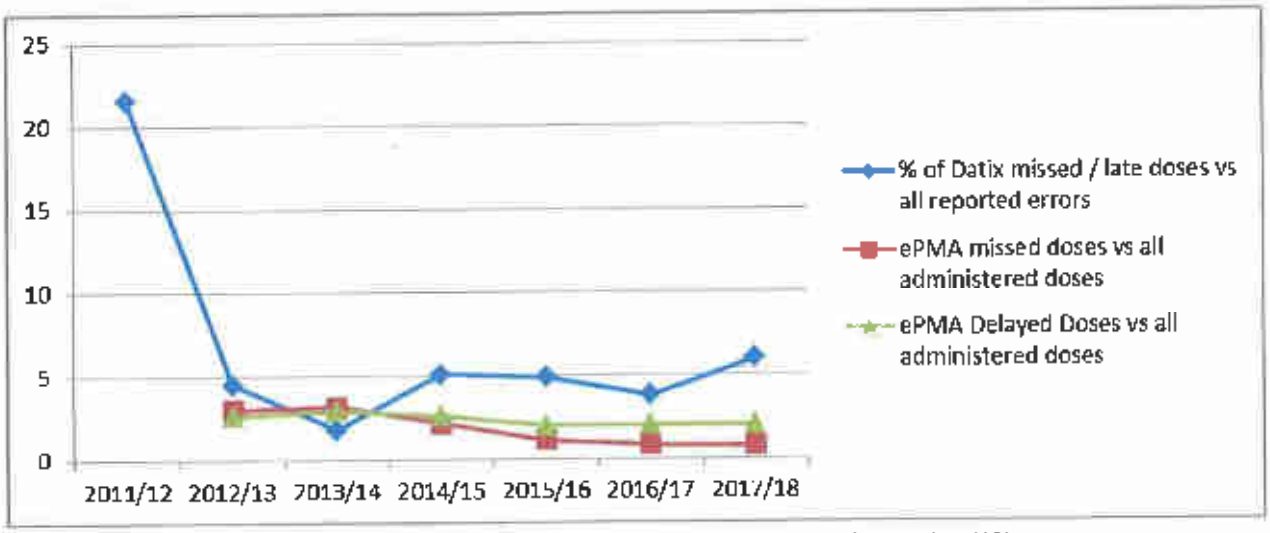


Figure 10: % missed and late doses from Datix reports and ePMA (2011/12 – 2017/18)

2. Patient identity errors

Patient identify errors are defined as "Patient A is mistakenly given Patient B's medicines". An analysis of the database has highlighted a reduction post ePMA, though there was a small rise in 2015/16. Further work has reduced this level again in 2017/18. The level remains significantly below the pre ePMA level.

Year	Number (and % of all medicine errors) of patient identity errors reported via Datix
2011/12 (Pre ePMA)	15 (6.1%)
2012/13	4 (1.12%)
2013/14	4 (1%)
2014/15	8 (1.95%)
2015/16	8 (1.78%)
2016/17	5 (1.45%)
2017/18	**5 (1.23%)**

Table 26:Patient identity errors from Datix reports

3. Safe use of insulin

Analysis of the error database during 2015/16 highlighted an increase in the number and type of insulin related errors (see figure 11). This prompted a specific task and finish group to be convened and a quality improvement programme to be initiated. This group implemented a 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.

Since 2015/16 we have seen significant improvement in the safe use of insulin at HDFT. The total number of incidents and errors has fallen slightly. The percentage of insulin reported errors has slightly increased and is now maintained around 9-10% of all reports, demonstrating an improving reporting culture.

In 2017/18 we have seen a significant reduction in the number of hospital reported errors, down from 35 in 2016/17 to 17 in 2017/18 (consistently with the National Adult Diabetes Audit data reported below). We also continue to proactively use the insulin dashboard. Using this tool, the diabetes team and pharmacists are able to intervene early.

In 2017/18 we have seen an increase in the number of community reported insulin errors. Over 40% of these relate to timely administration of insulin as a direct consequence of the pressure experienced by the community care teams during the last 12 months and delays in visiting patients.

We continue however to see an improvement in the levels of harm caused by all hospital and community reported insulin errors.

Year	No: Low Harm	Moderate Harm	Severe Harm
2015/16	83%	12%	2%
2016/17	92%	8%	0%
2017/18	**100%**	**0%**	**0%**

Table 29: Levels of harm caused by all reported insulin errors

These are substantial improvements on previous years and we have had zero severe harms with insulin since 2015/16 when the quality improvement initiative was launched.

The National Adult Diabetes Inpatient Audit (NADIA) 2016/17 has just been published and has confirmed the reduction in insulin errors for HDFT. This is a really strong performance moving HDFT from one of the worst performing Trusts to one of the best performing Trusts.

Year	HDFT	Quartile	England
2010	27.3%	Quartile 3	25.8%
2011	46.2%	Quartile 4	22.7%
2012	20.0%	Quartile 2	21.8%
2013	30.0%	Quartile 4	20.7%
2015	34.4%	Quartile 4	22.6%
2016	25.0%	Quartile 3	22.7%
2017	**4.8%**	**Quartile 1**	**18.6%**

Table 30: National Adult Diabetes Inpatient Audit (NADIA) Report 2016/17 – Insulin Errors 2010-2017

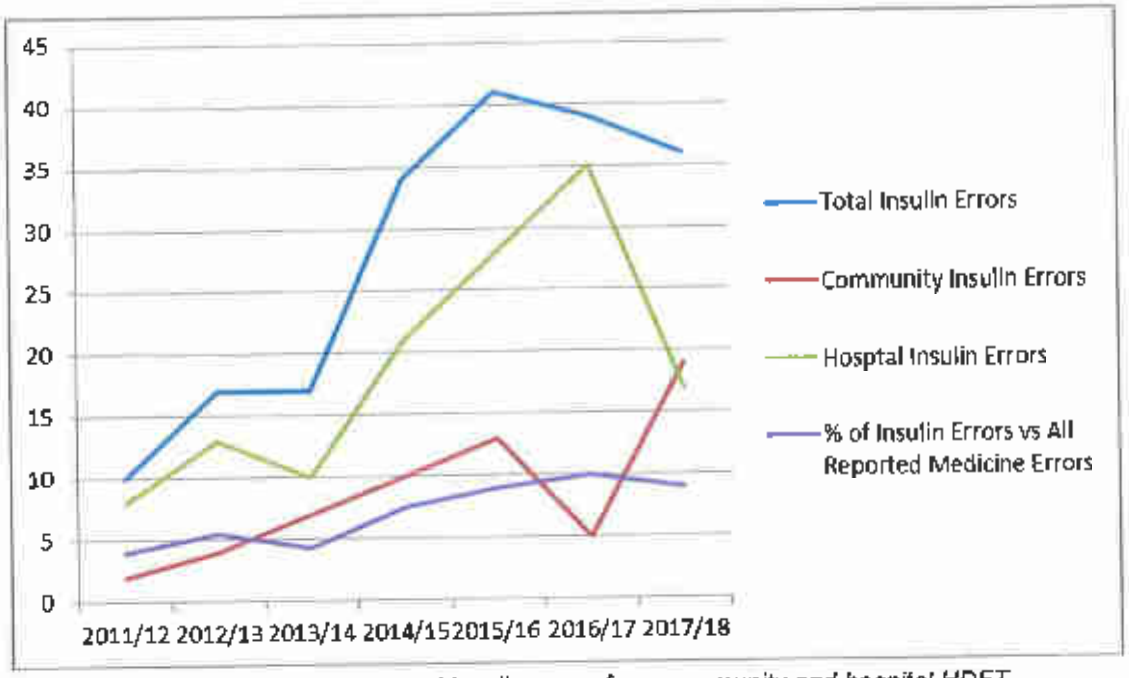


Figure 11: Number of Datix reported insulin errors from community and hospital HDFT locations from 2011/12 - 2017/18

Medicines reconciliation

Medicines reconciliation is the process by which the accuracy and completeness of a patients medicines history is checked and verified when a patient is admitted to hospital. NICE guidance recommends all patients have a medicines reconciliation undertaken within 24 hours of admission by a competent practitioner. Evidence demonstrates an improvement in morbidity and mortality when this occurs.

Audit data below demonstrates our improvement and sustained performance over the last five years. The Model Hospital benchmark remains around 70%.

	2013/14	2014/15	2015/16	2016/17	2017/18
% of patients receiving a medicines reconciliation within 24 hours of admission	75%	80%	90%	90%	90%

Table 31: Medicines reconciliation audit data

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 continue to reach high levels though with some fluctuations in 2017/18. We have seen a slight dip in compliance with antibiotic stewardship and fluid prescribing training during 2017/18 and this will be addressed in 2018/19.

Training competency	Renewal	% compliance 1.3.2016	% compliance 1.2.2017	% compliance 31.3.2018
ePMA	Once only	94%	97%	94% ↓
Antibiotic stewardship	2 yearly	87%	86%	78% ↓
Medicines management for community nursing	3 yearly	70%	52%	75%↑
Medicines management for hospital based nurses	3 yearly	73%	73%	79% ↑
Safe prescribing toolkit	Once only	85%	85%	88% ↑
Safe fluid prescribing toolkit (introduced Dec.2015)	Once only	n/a	85%	82% ↓

Table 32: Medicines management training compliance data

Patient engagement and providing information to patients

Information provision to patients and the perception of patients receiving relevant information about their medicines has generally improved over the years. In 2017 we saw a slight worsening of performance below the national Picker average for three domains. We remain in the upper quartile in the Model Hospital Dashboard.

National Inpatient Survey	% of patients							Better than national / Picker average
	2012	2013	2014	2015	2016	2017	National / Picker average	
Question 1: Not fully told purpose of medicines	22	17	18	22	20	26	25	No
Question 2: Not fully told side effects of medicines	58	57	59	57	55	65	61	No
Question 3: Not told how to take medication clearly	21	19	19	25	20	22	24	Yes
Question 4: Not given completely clear written/printed information about medicines	22	23	22	26	21	26	27	No

Table 33: Medicines management training compliance data

Summary

The medicines safety programme has made a further step forward in terms of safety improvements in 2017/18 and continues to build on previous quality improvements relating to medicines optimisation and safety. During 2017/18 we have seen:

- An increase in the number of prescribing pharmacists from 11% to 30% with further increases planned during 2018/19;
- A reduction in medicines stockholding from 34 days to 23 days, ensuring medicines are handled optimally;
- Maintaining 90% of the patients who receive a medicines reconciliation within 24 hrs and achieving 100% at 72 hours, well above the Model Hospital benchmark;
- An increase in the proportion of time pharmacists spends on patient facing activities to 80%.

There have been further reductions during 2017/18 compared to 2016/17 of:

- Prescribing errors (from 3.12 to 2.86 / 100,000 prescribed doses);
- Administration errors (from 3.80 to 3.31 / 100,000 administered doses);
- Missed doses (from 0.83% to 0.76% / 100,000 prescribed doses);
- Dispensing errors (from 14 to 13 / 100,000 dispensed items);
- Patient Identity errors (from 1.45% to 1.23%);
- Hospital insulin errors (from 35 to 17).

We have seen improvements in 'no or low harm' to 'moderate or severe harm' ratios with 96.5% in 2017/18 compared to 94.9% in 2016/17, and a reduction in moderate harm errors to 3.5% (n=14) in 2017/18 compared to 5.1% (n=19) in 2016/17. We have had *no* serious harm incidents relating to the use of medicines during 2016/17 and 2017/18.

We have improved and/or maintained good levels of training compliance through the year despite the pressures on nurse staffing and have trained more hospital and community nursing staff on the safe use of medicines than ever before.

In the 2017 National Inpatient Survey (Picker results) we have seen a slight deterioration in the provision of information and explanation to patients about their medicines, and this will become a focus of attention in 2018/19.

The improvements in medicines safety as HDFT have been facilitated through the roll out of ePMA, the active engagement of doctors, nurses and pharmacy staff in this programme of work, development of live medicines dashboards, improved medicines reconciliation rates, pharmacy activity at ward level, reviewing and acting on trends in medicines administration, dispensing and prescribing errors and medicines management teaching and training for prescribers and nurses.

The summary data relating to error in 2011/12 which was pre-ePMA and 2017/18 is impressive.

Error type reported	Pre ePMA 2011/12	Post ePMA 2017/18	% reduction
Prescribing errors (Datix) – per 100,000 doses	3.43	2.86	**16%**
Administration errors (Datix) – per 100,000 doses	8.34	3.31	**60%**
Missed doses (Datix)	2.99%	0.76%	**75%**
Major, severe and life threatening Pharmacist interventions (*Pharmacy data*)	31%	11.4%	**63%**
Patient identity medicines administration errors	15	5	**66%**
Insulin errors *(NADIA data)*	46.2%	4.8%	**90%**
No and low : Moderate harm % ratio	85% : 15%	96.5% : 3.5%	N/A

Table 34: Comparative medicine safety error data pre and post-ePMA

Whilst significant improvements are being demonstrated, we will continue to work to optimise the use of medicines at HDFT as highlighted by 'The Report of the Short Life Working Group on reducing medication related harm'. This report will form the basis of further work in 2018/19.

2. Falls

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. Falls can impact on quality of life, health and healthcare costs causing distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall, and is estimated to cost the NHS more than £2.3 billion per year.

North Yorkshire has a population who are fit and live longer than many other areas in England. People aged between 55 and 78 years of age are described as a "Baby Boomer", and those aged 65 or over are defined by NICE as an "older person". Two thirds of the population growth in North Yorkshire over the last ten years has been a result of increased numbers of people aged 65 and over and Baby Boomers account for 97% of this increase. Older people make up 23.3% of the total North Yorkshire population compared with 17.7% across England in 2015, and the Office for National Statistics projections indicate that the population of older people aged 65 and over in North Yorkshire will rise to over 169,000 (27.6%) by 2025. Local services currently provide care for nearly 6% more older people than other regions in the UK, a population who are often frail and have complex medical needs when they are admitted into our hospital, and this trend is likely to increase.

Inpatient falls are associated with increased length of stay, additional surgery and unplanned treatment, however multiple interventions by the multidisciplinary team tailored to the patient can reduce falls by 20-30% (NICE CG 161). The interventions referred to are simple elements such as making sure that during a hospital stay older people are individually assessed and have access to a call bell that works and a walking stick; are able to hear and see in a safe environment when they want to walk around; are assessed for conditions such as delirium and dementia; and also have their medications checked and reviewed to ensure that they are beneficial.

In addition, in 2015 we became aware of work done by the Yorkshire and Humber Academic Health Science Network (AHSN) Improvement Academy (IA) to reduce falls by the introduction of a short daily ward meeting called a "fall safety huddle", and the National Audit for Inpatient Falls (NAIF) 2015 report made recommendations around elements of patient care that could be improved.

The fall safety huddle is where a multidisciplinary team gathers daily and identifies patients they are concerned about, and agrees and actions a range of interventions as an individual care plan to reduce the risk of the patient falling.

Figure 12 shows the key prompts within a safety huddle. HDFT has added "distraction", which means providing confused patients with individualised activities to engage them and reduce agitation, and this has been adopted by the Improvement Academy to use with other trusts.

Figure 12 Safety huddle prompts

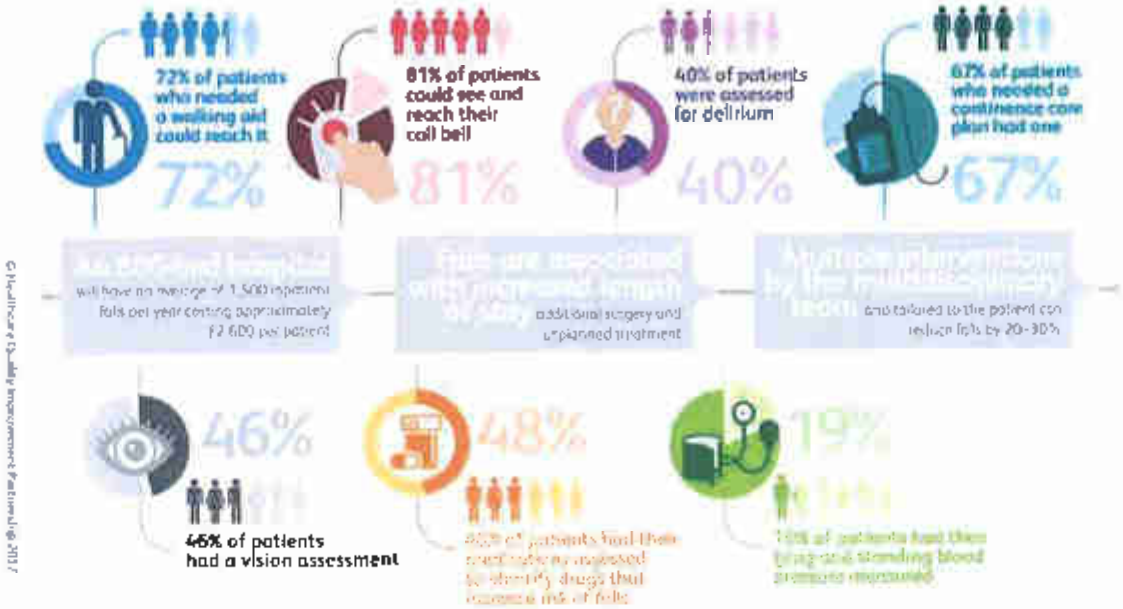


Figure 13: Key measures for preventing falls in hospital (National Audit of Inpatient Falls report 2017)

What were we aiming to achieve?

The aims of the HDFT Falls Prevention Group are simple: reduce the number of falls in the Trust; ensure staff are trained and know how to keep people safe; and ensure all policies related to patient and staff safety are kept up to date and in line with clinical evidence and research provided by NICE and other governing bodies.

We decided to see if we could reduce falls by 30% by introducing a daily range of practical and medical interventions for individual patients who had been identified as a potential falls risk by the ward team.

What have we done?

The Falls Prevention Group introduced a daily falls safety huddle as a means of ensuring that a range of interventions were put in place for individual patients identified each day as a "falls risk". The interventions highlighted to improve were:

1. the timely assessment of delirium and dementia;
2. review of medications;
3. the measurement of lying and standing blood pressure (BP); and
4. the availability of walking aids.

Jervaulx ward was the first team to hold a daily fall safety huddle, and their first goal was to achieve ten consecutive days without reporting a patient fall. The initial success on Jervaulx ward then encouraged the adoption of the methodology across other wards.

In addition, training for all new nursing staff and doctors in their foundation years has been introduced using competencies recommended by the Royal College of Physicians, to promote a standardised protocol for the measurement of lying and standing BP.

In response to Yorkshire's changing demographic, budgets and resources the multidisciplinary community team has been subject to several restructures, and is still under

review. However it continues to work with GPs, care homes and the voluntary sector to raise awareness about falls, multifactorial assessments and interventions in an effort to keep older people as safe and steady as possible. A community falls pathway has been reviewed to support these processes.

Harrogate Borough Council has been working closely with Sport England and Public Health Yorkshire to provide instructor training and a range of exercise programmes that meet NICE guidelines and recommendations, and are designed to target key groups within the community.

What are the results?

By the start of 2018 fall safety huddles were taking place and embedded on six different wards. The impact of the work has been significant in reducing the number of falls and level of harm across the whole Trust.

Jervaulx ward has achieved a significant reduction of 38% falls in 12 months, and Byland ward achieved a second statistically significant step down in the reduction of falls on the ward. This sustained team effort has been recognised and they will each be accredited by the Improvement Academy in May 2018.

Trinity ward has been able to celebrate a record 94 fall free days this year, Jervaulx ward 64 days and Byland ward over 30 days. Farndale ward have achieved records of over 40 days, and AMU have already extended their record from 16 to 18 fall free days in just a few months. CATT ward is the latest team to start a huddle in February 2018, and they are working towards achieving ten consecutive fall free days. Some wards have now expanded the safety model to include other elements of care that are specific to their team and their patients' needs.

We have seen a significant increase in the recording of lying and standing BP from 6% in 2015 to 29% in 2017, a result well above the national average. There have also improvements in assessments of delirium and mobility / walking aids on admission, but a disappointing 10% decrease in medication reviews since the 2015 audit.

Key Indictors	HDFT 2015	National Results 2015	HDFT 2017	National Results 2017
Delirium	25%	36.7%	68% *	39.7%
Continence	83%	69.4%	50%	66.9%
LS/BP	6%	16.1%	29%*	19.1%
Medication	52%	45.9%	42%	47.8%
Vision	55%	48.3%	43%	46.2%
Call Bell	90%	82.3%	74%	81.3%
Mobility	77%	67.5%	100%*	94.8%

* Improvements in three of the four areas identified for improvement

Table 35: National Audit of Inpatient Falls: comparison of HDFT/national results for 2015 and 2017

The Trust level data shows that the total number of inpatient falls decreased for three consecutive years until 2016/17, before the number of falls plateaued during 2017/18.

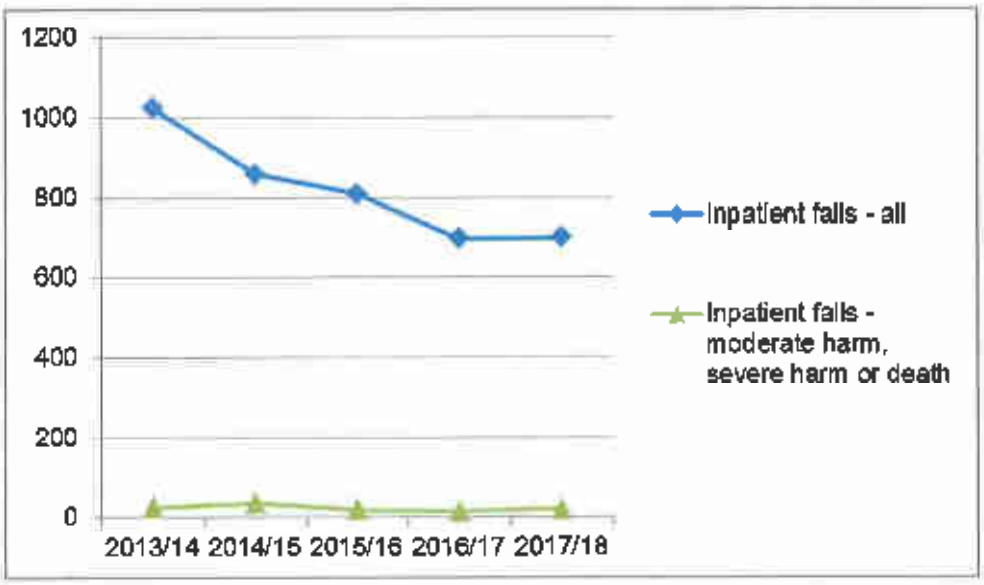


Figure 14: Inpatient falls reported at HDFT 2013/14 to 2017/18

	2013/14	2014/15	2015/16	2016/17	2017/18
Inpatient falls - all	1024	859	809	697	700
Inpatient falls – all per 1000 bed days	8.95	7.49	7.04	6.10	6.1
Inpatient falls – moderate or severe harm or death	25	36	20	15	21
Moderate or severe harm or death per 1000 bed days	0.22	0.31	0.17	0.13	0.19
Inpatient falls resulting in fracture	16	17	16	14	20

Table 36: Inpatient falls, rate and harm reported at HDFT 2013/14 to 2017/18

However the number of harmful falls reported has risen in the last year including 20 falls resulting in fracture. A number of factors have clearly influenced and challenged our services, especially over the winter months of 2017.

Summary

It is an accepted fact that we will never be able to stop all falls in hospital, but the Trust has been able to demonstrate that we are able to make a significant difference to the number of falls and the harm they can cause. We are very proud of our staff teams who make these initiatives work on a daily basis despite difficult and often testing times, but we have been able to demonstrate that falls can be reduced significantly when multifactorial interventions are made for people at risk of falls.

It is anticipated that a falls safety huddle will be used by several other wards in 2018/19 and this could have an impact of reducing the Trust's total number of falls as the culture of safety changes the premise that old people will fall. The group will continue to promote the benefits of this methodology in improving patient safety at annual Trust wide events such as the Allied Health Professionals and Trust Quality Conferences and in cooperation with the Improvement Academy.

The Falls Prevention Group works to achieve the objectives set out in an action plan that is shaped by recommendations made in NICE guidelines, guided by the CCG and supported by the Trust and working with community groups. It intends to continue to address recommendations outlined in the NAIF reports of 2015 and 2017 and support community

initiatives proposed in the Public Health Yorkshire report 2017. Improving vision assessments is a target for 2018/19.

3. Pressure ulcers

Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair the blood supply. They cause pain and distress, can mean longer stays in hospital and cost the NHS a significant amount of money. They are graded by severity according to a classification by the European Pressure Ulcer Advisory Panel (EPUAP) from category one (least severe) to category four (most severe). They are more likely to occur in people who are ill, have a neurological condition, poor mobility, impaired nutrition or poor posture.

Pressure ulcers are usually preventable with good assessment of individual risk and effective application of preventative measures such as the use of effective equipment to reduce pressure, regular position change, good nutrition and hydration and good skin care.

The prevention of avoidable pressure ulcers has been a specific part of our quality improvement work at HDFT since 2012/13 and there has been a significant amount of work undertaken at the Trust with the aim of reducing avoidable HDFT acquired pressure ulcers. For the year 2017/18 we reported a significant reduction in avoidable pressure ulcers in the community setting. We also achieved an increase in unavoidable pressure ulcers across both acute and community settings.

What were we aiming to achieve?

The Trust has a Pressure Ulcer Group that meets on monthly basis. The objectives of this group are to drive continual improvement of pressure ulcer prevention with the overall aim of no avoidable pressure ulcers acquired by patients receiving either HDFT hospital or community provided care. Pressure ulcers are defined as unavoidable if all reasonable care and treatment has been provided to prevent or minimise damage to skin through pressure.

Our aims have been to:

- Reduce the incidence of category two, three and four pressure ulcers acquired by people whilst in HDFT care;
- Promote best practice in prevention and management of pressure ulcers;
- Understand if a pressure ulcer was avoidable or unavoidable and to learn from investigations into the root cause of pressure ulcers;
- Continue with our programme of pressure ulcer training and education for staff;
- Continue to support a "zero tolerance" approach to avoidable pressure ulcer development in people who are receiving HDFT care, which will be supported by our pressure ulcer prevention strategies including training and investigation processes.

What have we done?

Key successes to date have surrounded two broad areas, these being education and training, and documentation and risk assessment.

1. Education and training

Training for staff has been a priority since January 2015. An e-learning package for pressure ulcer prevention was made essential annual training for all general and paediatric registered

nurses and three yearly training for midwives. There are plans to further improve the existing training programme so that staff receive face-to-face training alternate years in addition to the existing e-learning package.

Training on skin care, pressure ulcer prevention, recognition and management is currently delivered by the Tissue Viability Nurses and Trust Clinical Educators, both in the classroom and at the bedside. The frequency of the classroom face-to-face training package has been increased to monthly. Training has also been previously delivered to senior ward and community registered nurses to enable them to effectively investigate pressure ulcer incidents, undertake root cause analysis and generate an action plan with recommendations. There are plans to refresh and update this training programme.

The Trust has actively participated in the national STOP - Pressure Ulcer Days, holding an educational event for residential homes and healthcare support workers. In addition the NHS England 'React to Red' training package has been delivered to residential homes by a Clinical Educator.

Information leaflets produced for patients, carers, families, residential, nursing and home care services, explaining shared care in relation to pressure ulcer prevention and management are being used to raise awareness.

2. Documentation and risk assessment

In 2014 we introduced SSKIN (skin, surface, keep moving, incontinence, and nutrition) bundles across all adult inpatient wards, for patients assessed as being at risk of pressure ulcer development. This was supported with a SSKIN bundle educational package and educational posters for clinical staff to aid the identification and categorisation of pressure ulcers. Changes were made to the nursing documentation to emphasise the need to repeat pressure ulcer risk assessment on transfer between wards. In response to themes from our root cause analyses regarding documentation, the SSKIN bundle chart has now been replaced by a new skin inspection and repositioning record in December 2016.

We have implemented a new pressure ulcer risk assessment tool and associated documentation for use in our community areas, with plans to extend this to our adult inpatient areas in 2018/19. Work on a pressure ulcer risk assessment tool and associated documentation for use in paediatrics continues to progress.

What are the results?

A reduction in hospital acquired pressure ulcers was achieved in 2015/16, which plateaued in 2016/17. Whilst an increase has been reported for 2017/18, more pressure ulcers have been found to be unavoidable following investigation.

Community acquired pressure ulcers, defined as pressure ulcers acquired by patients in receipt of HDFT community care, remained a challenge during 2016/17. The new risk assessment document implemented in the community setting has been embedded during 2017/18. To date, there has been a significant reduction in the number of community acquired pressure ulcers deemed to be avoidable during 2017/18.

Pressure ulcer data reported through the HDFT incident reporting system

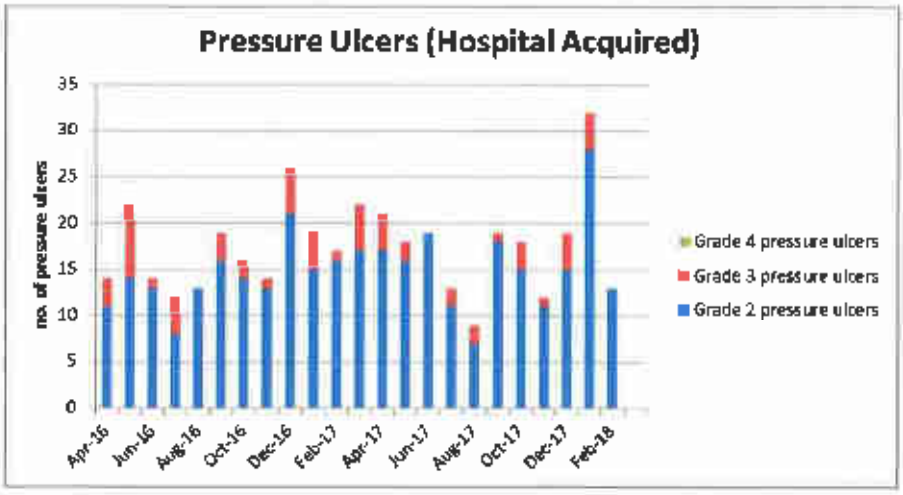


Figure 15: Hospital acquired pressure ulcers April 2016 to Feb 2018

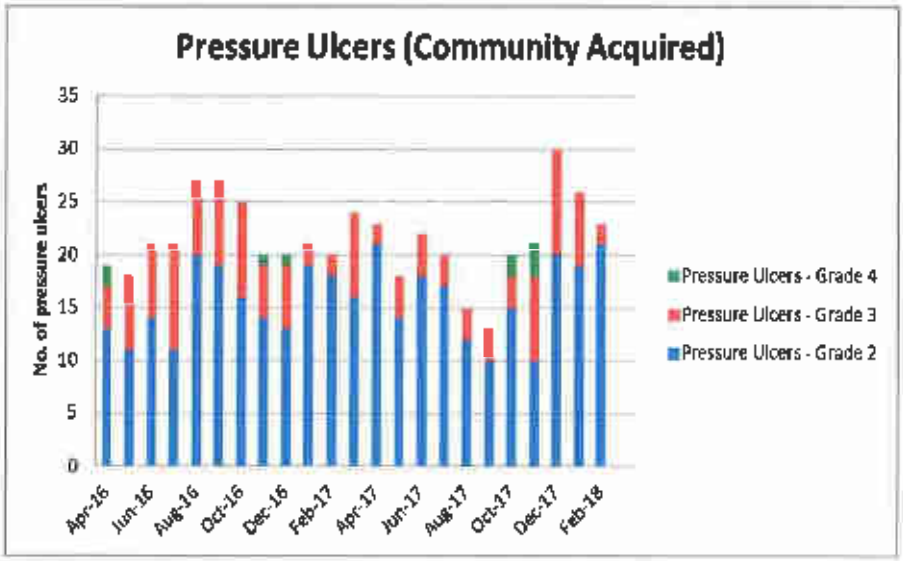


Figure 16: Community acquired pressure ulcers April 2016 to Feb 2018

Figures 15 and 16 demonstrate the challenges with regards to hospital and community acquired pressure ulcers. In part we believe this is due to better and earlier identification, reporting and continued education around the recognition and categorisation of pressure ulcers. We have also have observed a 2% activity increase in hospital admissions during 2017/18 and a 6% increase in referrals to the community care teams compared to the previous year.

The data is displayed on the Trust's dashboards shared through reports to our senior management teams. Our inpatient wards display data on their quality and safety boards.

NHS Safety Thermometer data for HDFT

Developed as a point of care survey instrument, the NHS Safety Thermometer provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for our patients. We submit data every month in relation to care provided by our acute and community teams.

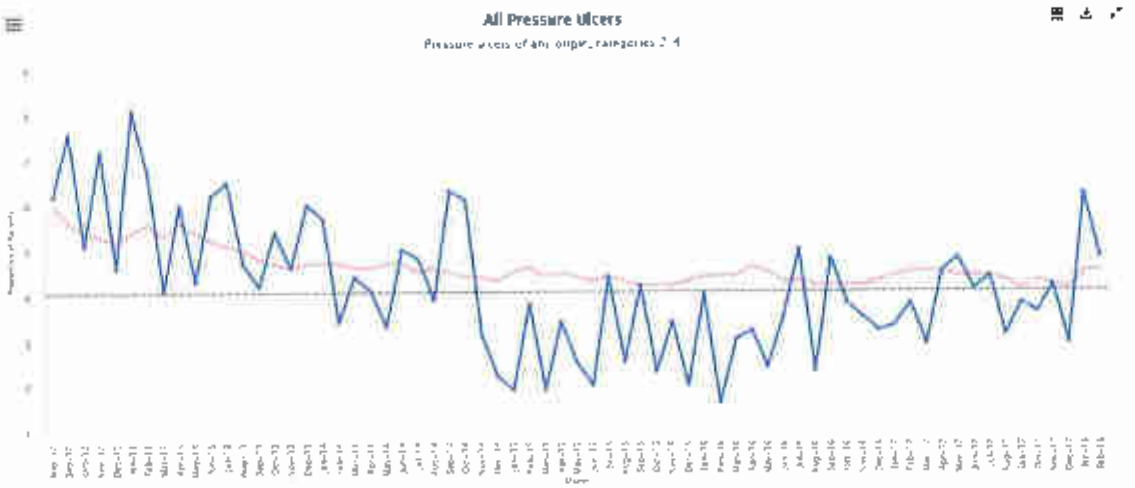


Figure17: Safety thermometer data for all pressure ulcers for HDFT (2012-2018)

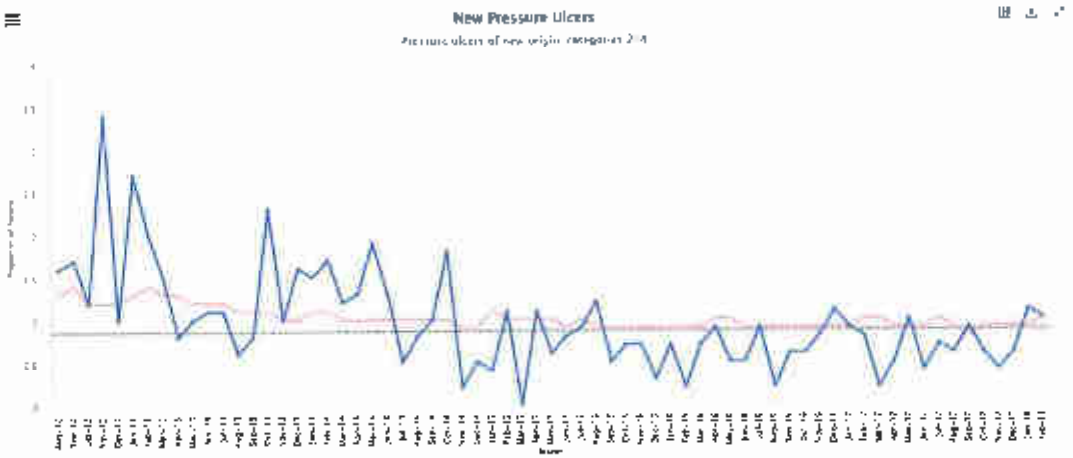
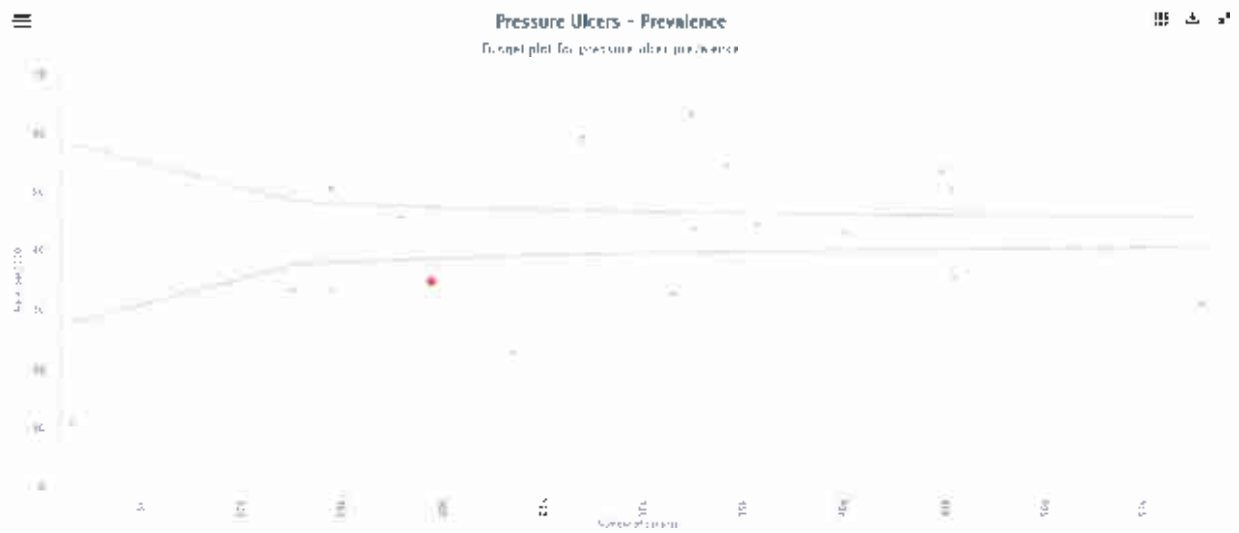


Figure 18: Safety thermometer data for new pressure ulcers for HDFT (2012-2018)

Figure 17 and 18 above show the results of the NHS Safety Thermometer data from August 2012 to February 2018 for all pressure ulcers identified and for new pressure ulcers. There has been a steady reduction in new pressure ulcers over this period.

NHS Safety Thermometer funnel plots

The funnel plot compares 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 lower harm compared to other trusts providing acute and community services.



♦ represents HDFT
Data source: https://www.safetythermometer.nhs.uk/
Figure 19: Safety thermometer funnel plot for pressure ulcer prevalence

Summary

A significant amount of work has been undertaken during 2017/18. We have introduced some new initiatives such as the revised skin inspection and repositioning chart on our inpatient wards and the new community risk assessment document that we will further embed in 2018/19.

The Trust aims to eliminate avoidable pressure ulcer development in people who are receiving HDFT care, and will continue to develop pressure ulcer prevention strategies including training and investigation processes. Key ambitions for 2018/19 include:

- Further strengthening of training and education with alternate year face-to-face training;
- Implementation of a new pressure ulcer risk assessment tool and associated documentation across our adult inpatient areas;
- A revised "panel" approach to investigations into the root cause of pressure ulcers, which will also offer a new approach to sharing learning.

Progress will be monitored by the directorate teams and the Pressure Ulcer Group.

3.2. PATIENT EXPERIENCE

1. Pain management

Evidence shows that up to 80% of patients may suffer pain following surgery with 20% experiencing severe pain. In addition, there are over 14 million people in the UK who are living with persistent, chronic pain. Effective pain management should be viewed as a priority by all healthcare workers.

What were we aiming to achieve?

Our aim is to continue to promote high standards of pain assessment and management throughout the Trust. This is achieved by ensuring patients are asked regularly about their pain and its severity both at rest and on movement. Empowering staff to have the confidence to assess and implement treatment should improve access to pain relief, improving the quality of patient experience and reducing suffering.

What have we done?

A repeat pain score audit was completed that included looking at the patients' pain scores recorded on Patientrack, as well as 'Asking the Patient' questions at the bedside. This enabled us to monitor improvements in pain assessment in comparison to previous audits and better identify patients' experience of pain management within the hospital.

Since November 2014 we have incorporated questions about pain into our inpatient Friends and Family Test (FFT). We have monitored and shared the results and comments from patients with ward staff in order to promote learning and reflection.

Education has always been central to the role of the Acute Pain Service and we have recently introduced a teaching programme known as EPM Lite (essential pain management) to improve staff knowledge of pain assessment, and both non-pharmacological and pharmacological treatments. This programme is supported by the Faculty of Pain Medicine, the Royal College of Anaesthetists and was originally implemented by anaesthetists in Australia and New Zealand as a way of teaching pain management in deprived countries. However the programme has now been implemented in 14 medical schools in the UK and recently introduced into HDFT. Sessions based on the EPM Lite model have been given to junior doctors, anaesthetists, student nurses, newly qualified and experienced nurses.

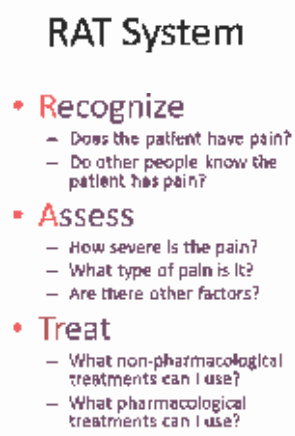


Figure 20: RAT system: a systematic approach to assessment and treatment.

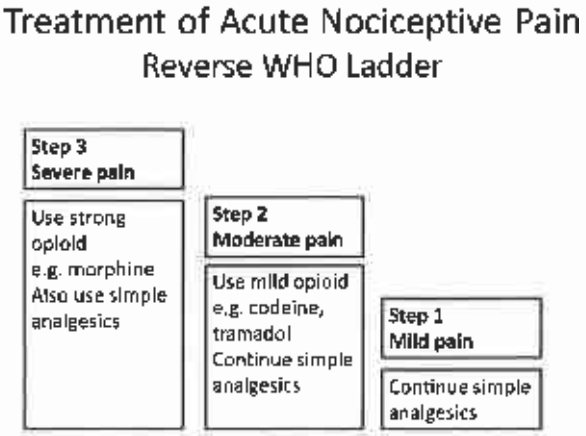


Figure 21: Reverse World Health Organisation (WHO) analgesic ladder

What are the results?

A pain score audit was undertaken on all the surgical wards, and Harlow and Granby wards with patients asked how they felt their pain had been managed overall. The majority (90%) of patients considered that it had been well managed, with 47 patients (77%) reporting pain management as good or excellent.

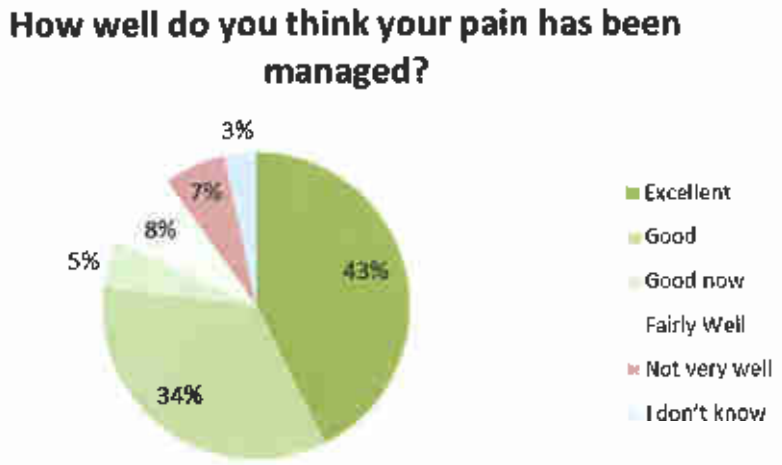


Figure 22: Pain score audit results

Whilst the introduction of pain scores on Patientrack has clearly had an impact on pain score assessment, the audit showed that only 5% of high scoring patients (pain score of >7) had documentation of re-assessment within an acceptable time frame. However, anecdotes suggest that nurses are going back and making informal assessments but this is not easily recorded on Patientrack without also taking a full set of observations.

Patients are asked a series of four questions about pain on our inpatient FFT and are encouraged to leave comments. All comments are fed back to ward sisters. A selection of comments is provided. Any negative comments relate to the time taken to prescribe and administer analgesia.

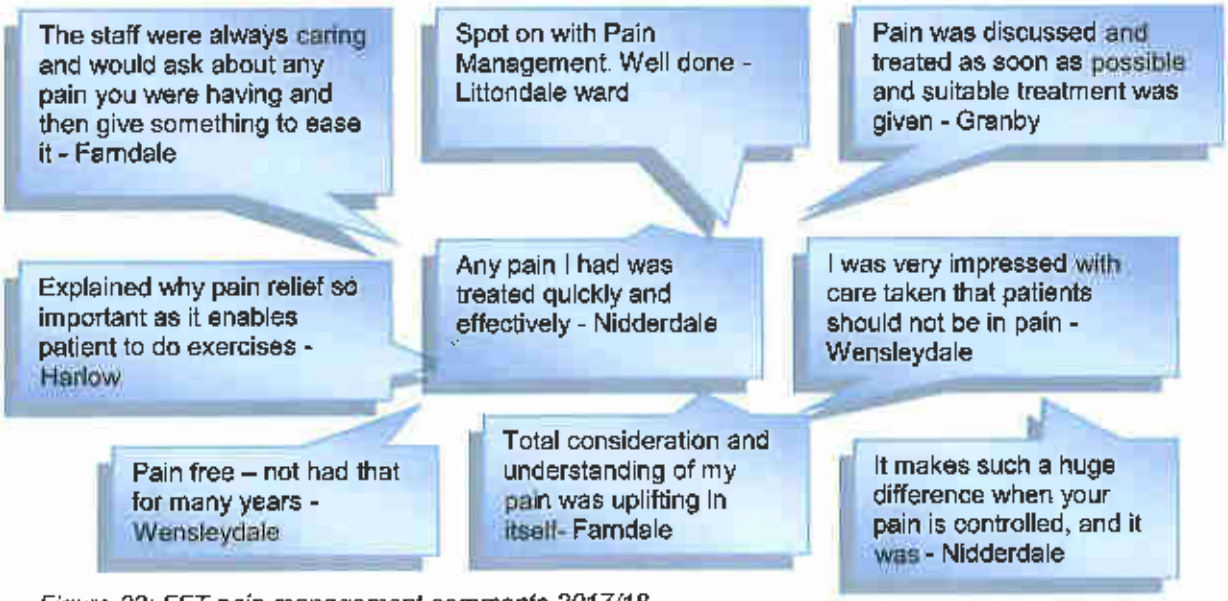


Figure 23: FFT pain management comments 2017/18

The responses to the four pain questions are monitored and are provided below by ward for January 2018.

Ward	Do our staff ask you about pain regularly?		If you have pain, are you offered pain relief?		If you were offered pain relief, did the staff give that in a reasonable time?		If you had pain relief, was it effective?	
	Yes	No	Yes	No	Yes	No	Yes	No
AMU	12	0	7	0	7	0	7	0
Byland ward	8	0	8	0	8	0	8	0
CAT Clinic	4	0	2	0	1	0	2	0
Farndale	17	0	17	0	15	1	15	0
Granby	35	0	28	1	27	1	26	0
Harlow	18	0	18	0	16	0	16	0
Littondale	2	0	2	0	1	0	1	0
Nidderdale	31	3	34	0	30	2	28	2
Oakdale	2	0	1	0	1	0	1	0
Wensleydale	67	0	66	0	66	0	62	3
Total	**196**	**3**	**183**	**1**	**172**	**4**	**166**	**5**

Table 37: January 2018 Friends and Family Test results

Results suggest that the majority of our patients are satisfied with their pain management. Overall, 196 patients were asked about their pain, all patients said they were offered pain relief, only 4 patients felt they had to wait longer than necessary and 5 patients felt their analgesia was ineffective.

Since the introduction of EPM Lite training in May 2017, the Acute Pain Team have utilised the training programme for a variety of staff groups, ranging from students to experienced staff. Student feedback from these sessions include comments such as 'a fantastic, well delivered session', 'informative, great teaching session with group work and participation', 'good pace', and 'I loved it, very full of knowledge'.

EPM Lite Teaching at HDFT	Numbers
Medical Students	16
Junior Doctors	40
Student Nurses/physiotherapist	5
Newly qualified nurses (Preceptorship)	57
Experienced Qualified nurses (Deteriorating Patient course)	58

Table 38: Training figures for EPM Lite since May 2017

Summary and next steps

Results show that we appear to be achieving a high standard of pain assessment and management within the Trust and that the majority of patients are satisfied. There remains room for improvement in areas such as the re-assessment of pain scores but through the introduction of new training programs we hope to educate and empower the staff to treat patients in pain effectively and with dignity and compassion.

2. Maternity

During 2017/18 the Maternity Department has continued to work hard to maintain safe and high quality midwifery care to all women who choose to have their babies in Harrogate, and to use the results of patient feedback to further improve services. We also focused on improvement in relation to some specific maternity quality objectives.

What were we aiming to achieve?

The service has been working towards:

- Reducing the elective caesarean section rate (LSCS);
- Reducing the postpartum haemorrhage (PPH) rate;
- Reducing 3rd/4th degree tears;
- Reducing term admissions to Special Care Baby Unit (SCBU);
- Improving handover of information between midwifery staff;
- Extending the links between maternity services and Improving Access to Psychological Therapies (IAPT).

Progress with these and other ongoing work is reported below.

What have we done and what are the results?

- An audit of elective caesarean sections was undertaken against the NICE Guideline on Caesarean Section (2011) to understand more about the reasons for women choosing elective caesarean section. The recommendations were to:
    - promote the external cephalic version clinic (ECV) for women with breech presentations;
    - promote the Birth Revisited clinic attendance to ensure women have the opportunity to discuss their anxieties on a 1:1 basis and to continue to de-brief women after delivery as it shows this is having a positive effect;

  We have a clear process for maternal request for elective LSCS by ensuring women are fully informed prior to making this decision, and the rate has reduced slightly in 2017/18 compared to 2016/17.
- The PPH rate has remained relatively static over the last 3 years. The implementation of a PPH risk assessment tool did not show a significant reduction in the overall PPH rate, and we have now reintroduced the use of syntometrine for the active management of the 3rd stage of labour.
- There have been training sessions for both midwifery and medical staff in performing episiotomy. Midwives are now documenting the position of mother at delivery, and all midwives are delivering "hands on" in order to control delivery of the baby's head. The 3rd/4th degree tear rate has reduced in 2017/8 compared to 2016/17.
- During the last year we have continued to aim to keep babies with their mothers on the postnatal ward instead of admitting the babies to SCBU and to support the ATAIN programme (avoiding term admissions into neonatal units). The further development of this transitional care type model will remain a focus for the department in 2018/19.
- Midwives are continuing to use the SBAR (situation, background, assessment, recommendation; a technique used to facilitate prompt and appropriate communication) handover sticker to improve the communication of information from one shift to another. Handover in labour is predominantly performed in the presence of the woman and her partner.
- We have extended the IAPT service in the antenatal clinic from half to a full day each week. The service continues to be well received by all services within the department.

Maternity Satisfaction Survey

The Maternity Department took part in a further national survey of women's experiences of maternity services in 2017. This survey is part of a series of national patient surveys undertaken by the CQC, and is for all NHS acute trusts with maternity services in England. The survey includes the whole patient journey from the first booking appointment to labour, delivery and discharge from the community midwife to the health visitor. Women were eligible for the survey if they had a live birth during January and February 2017, were aged 16 years or older, and either gave birth in a hospital maternity unit or had a home birth. The response rate at HDFT was 49% (national average was 35.8%). The survey has previously been undertaken in alternate years; from 2018 this will be an annual survey. We have an action plan in place to address some of the themes highlighted as important to the women, which are to:

- Improve the continuity of carer in the antenatal and postnatal period;
- Review of the length of antenatal appointments;
- Discuss the availability of consulting rooms for community midwives to work in with local GP practices;
- Consider extended use of children's centres as another option for antenatal appointments;
- Consider a more flexible approach to antenatal appointments, including weekends and evenings;
- Consider the use of appropriately trained maternity support workers for postnatal care at home to support the community midwifery staff.

Maternity Friends and Family Test

The FFT in maternity services enables women to provide feedback at the 36 week antenatal appointment, after delivery, on discharge from hospital and from the community midwife.

	Service	Q1	Q2	Q3	Q4	Full Year	National data 17/18*
Q1: Antenatal	% Recommend	98.1%	98.7%	97.6%	97.2%	**97.9%**	**96.3%**
	% Not Recommend	0.6%	0.0%	0.3%	2.2%	**0.8%**	**1.5%**
	Response rate	25.8%	19.4%	36.4%	41.1%	**30.7%**	-
	Number Of Responses	130	103	236	193	**662**	-
Q2: Labour	% Recommend	99.4%	99.6%	99.2%	99.5%	**99.4%**	**96.6%**
	% Not Recommend	0.0%	0.0%	0.0%	0.5%	**0.1%**	**1.3%**
	Response rate	34.9%	49.6%	50.6%	45.5%	**45.2%**	**22.9%**
	Number Of Responses	163	245	237	251	**896**	-
Q3: Postnatal	% Recommend	98.7%	100.0%	98.3%	97.7%	**98.7%**	**94.5%**
	% Not Recommend	1.3%	0.0%	0.4%	1.0%	**0.7%**	**2.0%**
	Response rate	36.6%	50.6%	48.5%	45.7%	**45.4%**	-
	Number Of Responses	171	181	242	186	**780**	-
Q4: Community Postnatal	% Recommend	97.2%	100.0%	100.0%	100.0%	**99.3%**	**98.0%**
	% Not Recommend	0.0%	0.0%	0.0%	0.0%	**0.0%**	**1.0%**
	Response rate	19.2%	15.5%	18.7%	4.1%	**14.4%**	-
	Number Of Responses	59	120	66	12	**257**	-

*National data is an average of published national results between April 17 - February 18

Table 39: Maternity FFT results 2017/18

Due to low response rates in 2017 for antenatal care, which might take place in the GP surgery, Children's Centre, home or hospital, we have introduced a new form which is given to women on the postnatal ward and covers the antenatal appointment, labour and delivery, and postnatal care in hospital. The response rates have improved as a consequence of this, and HDFT achieves a higher proportion of women recommending each element of the service than the national average. Response rates for postnatal care have continued to be low and this will be our focus during 2018.

The response rate and scores are monitored closely by senior midwifery managers and there is feedback of both positive and negative comments to staff. The department monitors the results to identify any themes and trends; predominantly the feedback is very positive. These are some themes and actions taken as a result:

You said	We did
There is a lack of facilities for partners staying for long periods.	• We created a new bathroom area with a shower on the postnatal ward to be used by partners and visitors. • The Friends of Harrogate Hospital and Community Charity have funded more recliner chairs for partners to use when staying overnight.
There is frequent disturbance for separate mums and babies observations.	We have synchronised observations for mums and babies whenever possible.
Emergency care for pregnant women between 12-20 weeks is confusing.	We have reviewed care provision and care pathways for pregnant women; • from 14 weeks women will now be seen on the Maternity Assessment Centre (previously 18 weeks) • The Early Pregnancy Assessment unit will see women until 13 weeks+6 days (previously 11 weeks+6 days)
Waterproof hand held foetal heart rate monitors are needed for community midwives.	Two have been ordered through charitable funds
The HDFT website does not state that children and young people under 16 are unable to visit unless siblings of the baby.	Website to be updated to show this information

Table 40: Maternity FFT "You said, we did"

Maternity Facebook page

This continues to be very well received and we receive large numbers of very positive feedback from the women who use the maternity services in Harrogate.

Advocating for Education and Quality Improvement (AEQUIP)

The decision was made to remove supervision from statute from March 2017 and the new model; Advocating for Education and Quality Improvement (AEQUIP) was introduced with the introduction of Professional Midwifery Advocates (PMAs) to replace the role of Supervisors of Midwives (SOMs). This employer led model includes a continuous improvement process that builds personal and professional resilience, enhances quality of care for women and their babies, and supports preparedness for appraisal and professional revalidation.

All six HDFT midwives that were previously SOMs have continued to support midwives and women during the interim period and three have undertaken the shortened bridging course to become PMAs in February 2018. We plan to send at least two midwives on the longer

course to become PMAs later in 2018. Once there is more understanding of this model we will implement it within the department.

Unicef Baby Friendly accreditation – Gold award

The Maternity Department has maintained Unicef UK Baby Friendly accreditation (BFI) since 2002 with several external assessments taking place over the years. In 2016 new standards were introduced by Baby Friendly for facilities that had maintained these core standards over time. To apply for the new gold award we had a full reassessment by a team of Baby Friendly assessors. This involved a range of staff being interviewed on their knowledge and skills, mothers being audited about the care they had received from booking to transfer to the health visiting service, and assessment of our documentation and mechanisms. This assessment took place over three days with four external assessors. There were two recommendations from the assessment which were addressed within three months. This result then allowed us to apply for the gold award within the next 12 months. Evidence for the gold award was submitted in November 2017. This included:

- **Leadership:** This involved the Head of Midwifery, Matron, managers from all areas and our new guardian (Chief Nurse) being interviewed around their knowledge of the standards, and how they would take proportionate responsibility and accountability for maintaining the standards and ensure full compliance with the international code of marketing of breast milk substitutes.
- **Culture:** Evidence of support for ongoing staff training and mechanisms to foster a culture that protects the Baby Friendly standards.
- **Monitoring:** Robust monitoring processes to support the standards.
- **Progression:** Evidence that the service is responsive to change, that the needs of babies and their mothers and families are met through effective integrated working and there is evidence to demonstrate improved outcomes.

Following further telephone interviews with the Head of Midwifery, the infant feeding lead and guardian and a detailed submission of evidence for the above standards we were awarded the gold award. We were the second maternity unit (third service) in the UK to achieve this.

Photo 1: HDFT Maternity Department Team were pleased to be awarded the Unicef Baby Friendly accreditation – Gold award

Safety monies from Health Education England

In December 2016 the Maternity Department received £40,000 for maternity safety training from Health Education England (HEE). This provided an excellent opportunity to support additional multidisciplinary training for the department and enhance maternity safety within the organisation. This has included:

- Labour ward leaders workshop: designed to address some of the current challenges in maternity services around leadership on delivery suite. The workshop supports labour ward leaders to work collaboratively together to develop cohesive teams delivering effective and safe care. The six staff who attended have introduced a daily multidisciplinary safety huddle on delivery suite.
- Human factors in healthcare training: this 'train the trainer' training aims to spread the impact, awareness and importance of human factors in multidisciplinary training in the department and share this knowledge and experience with the wider Trust.
- Emergency skills training: for community midwives.
- Arranging study days for internal and external staff: these cover breech presentations, parent education and perinatal mental health.
- Train the trainer Prompt (PRactical Obstetric Multi-Professional Training): this is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working. The monies were also used to purchase Prompt specific equipment.
- Regional neonatal life support training: this ensures that all delivery suite coordinators are up to date with neonatal resuscitation.

Collaborative working – maternity services, Emergency Department and ambulance staff

We have introduced combined continuing professional development (CPD) sessions facilitated by a consultant from the Emergency Department and senior midwives to support HDFT and Yorkshire Ambulance Service staff in the management of obstetric emergencies,

covering the patient journey from the pre-hospital phase to hospital care. The aim is to support staff who may be required to provide care to pregnant women outside the Maternity Department. The first session in October 2017 was attended by over 60 members of staff and focused on shoulder dystocia and cord prolapse. A second session in November was on the management of postpartum haemorrhage and breech delivery. A further session took place in March 2018 on pre-eclampsia, managing miscarriage, gynaecological emergencies and 'top tips' for delivery. These events are free and open to paramedics, emergency medical technicians, ED and obstetric middle grade and senior clinical staff, and midwifery staff. The feedback has been really positive:

- Enjoyed the evening - more reading now to be done;
- Very helpful insight into maternity emergencies;
- Could do with some events closer to our area – Scarborough;
- Thanks for everyone's time and effort for putting on these events, much appreciated;
- Alison extremely knowledgeable and enthusiastic about topic Very grateful for training and time taken to organise event, very informative;
- Great venue, please keep up the good work.

All staff who have attended have found the sessions really useful in their roles and we plan to continue with these events in the future.

Summary and next steps

There continues to be a significant amount of ongoing quality improvement work within the Maternity Department with some real achievements during 2017/18. As always there is more work to do and the quality objectives for the maternity service for 2018/19 are to:

- Improve the quality of and compliance with CTG (cardio-tocograph – continuous foetal monitoring) training for both midwifery and medical staff;
- Improve smoking cessation rates by improving the smoking cessation service available for women and the training for all staff within the department;
- Improve compliance with the national stillbirth bundle elements;
- Develop public and patient participation in service development by implementing a Maternity Voice Partnership Group, in line with the Better Births document and the National Maternity Safety Strategy and Clinical Negligence Scheme for Trusts incentive scheme for 2018/19;
- Implement the ATAIN (Avoiding Term Admissions to Neonatal units) programme to further develop the transitional care type model on the postnatal ward to keep babies with their mothers;
- Maintain BFI accreditation and the gold award, with annual audits and submission of a portfolio of evidence to support the gold accreditation in November 2018 and then every three years.

The work we have started to implement "Saving Babies Lives: A care bundle for reducing stillbirths" (NHS England 2016) will be a Trust quality priority for 2018/19. Although HDFT currently has a lower rate than the national average of stillbirth and has made good progress on the four recommendations, we want to progress audits to assess compliance and a business case to support serial ultrasound assessment of fetal growth throughout the third trimester of pregnancy in line with the Royal College of Obstetricians and Gynaecologists Green-top Guideline.

3. Enhanced Recovery

Enhanced recovery is an evidence-based approach that helps patients recover more quickly after having major surgery. The pathways aim to ensure that patients:

- Are as healthy as possible before receiving treatment;
- Receive the best care during their operation; and
- Receive appropriate and timely care while recovering.

By adopting the enhanced recovery model, we are able to keep patients' length of stay as short as possible, mitigating the risk of deconditioning and enabling them to return to their normal daily routine sooner rather than later.

What were we aiming to achieve?

We aimed to review compliance with existing enhanced recovery practice for hip and knee surgery and revise documentation accordingly, as well as improve the quality of patient information in relation to the Enhanced Care Pathway, and introduce the pathway to gynecology services.

What have we done?

A clinical audit in 2017 identified considerable good practice, but also a number of areas where documentation could be improved by amending the Enhanced Care Pathway. This was done and a recent re-audit has demonstrated improved quality of the documentation.

Meanwhile, a very different set of documentation was developed for the gynecology pathways. A communication strategy was established to ensure that staff were well informed about the planned introduction of enhanced care practice to the department. An informal check to identify any problems in completing the documentation was conducted in January 2018 and a formal audit is scheduled later in the year.

Extensive, full colour patient information leaflets were produced and posters created to enhance staff understanding of the principles of enhanced recovery. We have also prepared a script for use in a training video that we intend to produce over the coming months.

What are the results?

We set out to improve the quality of documentation in hip and knee surgery enhanced recovery as well as introducing the model to gynecology. This has been done, along with producing material aimed at both staff and patients in order to promote awareness and understanding of the pathway. The leaflets have been well received by patients.

Summary

While we have achieved what we set out to do, there remains more work to:

- Audit compliance with the gynaecology enhanced recovery documentation; dependent upon the outcome of this audit, there may be some revision of the documentation in order to make it as user-friendly as possible for the staff using it;
- Support colorectal services to develop their own patient information leaflets. Although they have been applying the pathway for a number of years, we identified that they do not have high quality patient information and that patients are sometimes getting mixed messages regarding their operation;
- Finish the training script and liaise with an external agent to create the training film that will be used to educate staff regarding enhanced recovery;
- Commence work to introduce the enhanced recovery pathway into further procedures including fracture neck of femur and caesarean sections.

3.3. EFFECTIVE CARE

1. End of Life Care

Good end of life care is the responsibility of all staff within HDFT. Patients are 'approaching the end of life' (EoL) when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:

a. advanced, progressive, incurable conditions;
b. general frailty and co-existing conditions that mean they are expected to die within 12 months;
c. existing conditions if they are at risk of dying from a sudden acute crisis in their condition;
d. life-threatening acute conditions caused by sudden catastrophic events.[1]

The aim is to improve patient and family experience at the end of life across HaRD in both community and hospital settings. Specialist palliative care is required by people with progressive life-limiting illness where the focus of care is on quality of life, and who have unresolved complex needs that cannot be met by the capability of their current generalist care team e.g. GP, district nurses, care home staff, consultants, hospital ward teams. Specialist palliative care in HaRD is delivered by the Palliative Care Team (PCT), a multidisciplinary team (MDT) of staff with the requisite qualifications, expertise and experience in offering care for this group of people. The PCT also leads on the implementation of quality initiatives to improve EoL care across the organisation.

What were we aiming to achieve?

The main aims and achievements during 2017/18 have been about setting the foundations for improving patient and family experience at the end of life and ensuring collection of robust data to provide the evidence.

The focus has also been on creating a culture of talking about death and dying so that it is easier for people to communicate their wishes to their family about what they want at the end of their life. We have aimed to:

- Ensure the PCT take on the lead for EoL care within HDFT;
- Enhance the support and care for patients in the last days of life in hospital including developing initiatives to improve patient and carer experience in hospital;
- Develop a systematic process for identifying all complaints, incidents and compliments relating to EoL care within HDFT;
- Establish a multi-agency working group to review fast track discharges for rapid discharge from hospital in last days of life;
- Produce a business case providing options for a seven day 9am-5pm face-to-face PCT assessment;
- Collect data and agreed metrics for monitoring improvements in EoL care in hospital and community;
- Implement an Electronic Palliative Care Co-ordination System within SystmOne across community care teams and GP practices to improve identification, recording and sharing of key information for patients who may be in the last year of life.

1. *Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020* (Sept 2015). National Palliative and End of Life Care Partnership: www.endoflifecareambitions.org.uk

What have we done and what are the results?

Lead on end of life care within HDFT

The PCT takes a lead role in delivering and supporting others to provide EoL care in both the hospital and community setting, as agreed within the HDFT End of Life Strategy. The team ethos within the organisation is to work collaboratively with many agencies across health and social care, integrating working and providing immediate specialist advice. The team has focused on regular attendance at key clinical MDTs including wards, GP palliative care meetings and community care teams. This proactively guides and supports professionals on the care of patients who may be approaching end of life. The result has shown a significant increase in the number of inpatient referrals.

The team has recruited additional clinical nurse specialists including an Education Lead for EoL care. The Education Lead has undertaken a scoping exercise of all palliative and EoL care education provided in the locality, covering hospital, community including care homes, and hospice. A strategy is being developed to meet the training needs of all staff groups across the organisation based on the NHS England End of Life Care Learning Outcomes (2017).

Enhance the support and care for patients in the last days of life in hospital

The team, in partnership with nursing and medical staff, has developed new guidance and documentation to support care in the last days and hours of life in hospital. This enables ward staff to provide sensitive, individualised care for the patient and their loved ones.

Practical initiatives include:

- Comfort bags for relatives and carers who are staying overnight or for long periods in hospital with their dying relative to ensure their stay is as comfortable as possible (includes blanket, pillow, toiletries, meal voucher, eye mask, ear plugs);
- Reclining bed / chair for carers staying overnight with dying patients;
- End of life volunteers available in hospital to support families and patients in their last days and hours. Volunteers can sit with patients for a period of time if there is no family present or if the family need respite during the day;
- Improved written information for relatives both before and after death;
- Dying Matters events and links with the local community including schools to encourage talking about death and dying so that we can articulate our wishes at the end of our life.

Figure 24: Comfort bags and reclining chairs

All of the new initiatives have been well received by patients, families and ward staff. The pilot for the three EoL volunteers is coming to an end and it is expected that further volunteers will be recruited so that the service can be provided on more days.
During Dying Matters Week we discussed many aspects of dying in the local papers, on local radio and social media. Subjects covered included arranging a funeral, bereavement counselling, dementia, making a will, and caring for someone at home during their last days. This generated debate and discussion within the local community. We continue to maintain

links with local schools and are keen to keep the conversation going about death, dying and bereavement.

Process for identifying all complaints, incidents and compliments relating to EoL care

A quarterly summary report is produced of all EoL complaints, concerns, incidents and compliments from across the organisation. The hospital bereavement survey is ongoing and sent out to all consenting bereaved families for feedback on their experience of EoL care before and after death. The prime aim of all of this is to monitor emerging themes and to use the information to support improvements in EoL care and guide relevant training and education.

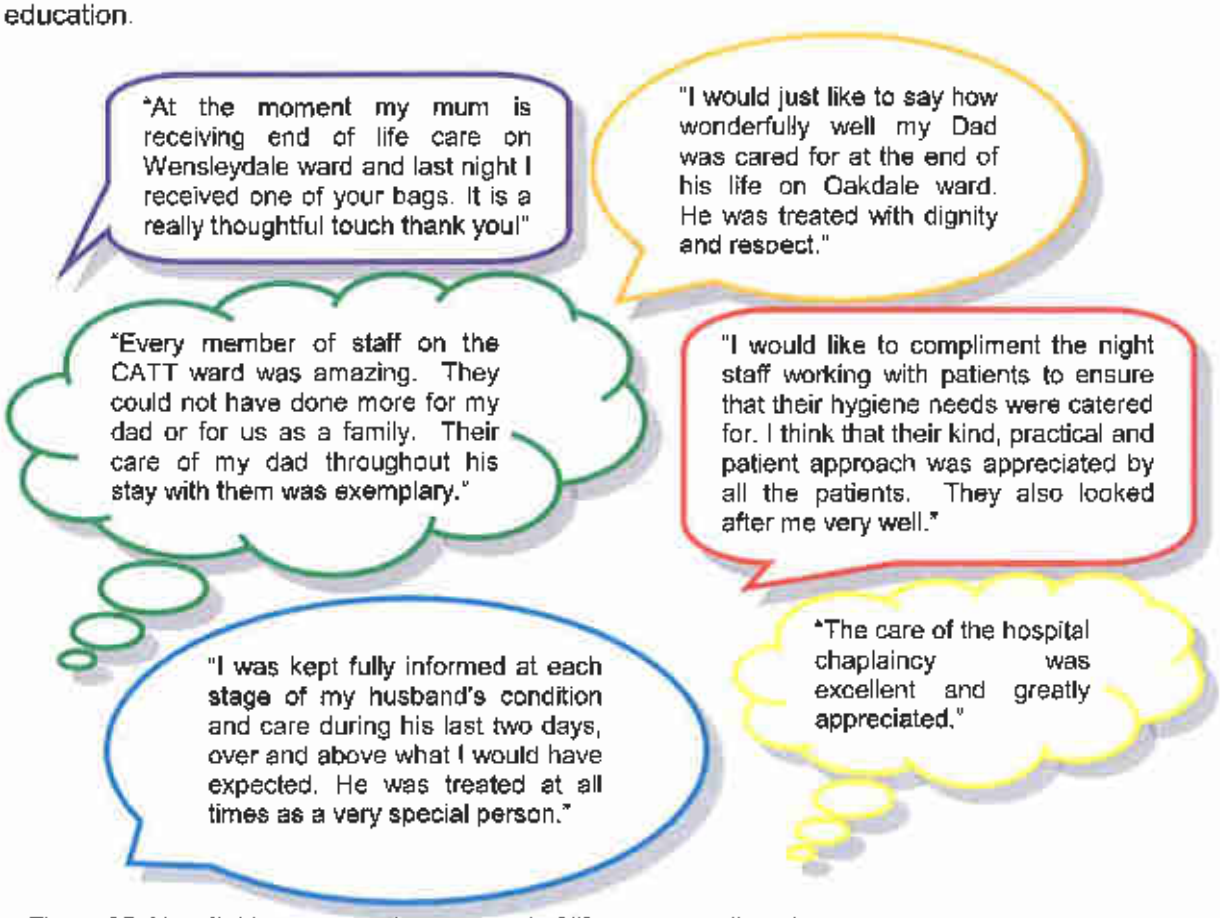


Figure 25: Hospital bereavement survey end of life care compliments

Multi-agency working group to enable rapid discharge from hospital in last days of life

Key health and social care professionals from the hospital, hospice, CCG, community care teams and Marie Curie have met regularly to evaluate the process of fast track rapid discharge and fast track processes at home. The agreed outcomes have been to ensure:

- Patients and carers have informed choices about preferred place of care and death;
- Safe and timely discharge with access to medicines and equipment;
- Safe and timely discharge to care and support;
- Reduce unnecessary bed days/admissions to hospital.

The working group has identified current issues and agreed actions to improve processes. Significant progress has been made in improving the documentation required between the agencies involved. The CCG have also agreed to implement the proposed service redesign which includes establishing an EoL coordinator for all fast track patients to act as a single

point of access. This will enhance the process and reduce delays and is based on evidence from other service models across the region. Further progress is required in other areas but the group continues to be committed to achieving the objectives.

Options for a seven day 9am - 5pm face-to-face Palliative Care Team assessment

A proposal paper was developed addressing modelling options and cost requirements for access to face-to-face assessments by the PCT 9am – 5pm seven days a week in hospital and community. From this a business case was written and an application submitted to Macmillan for initial funding. These have now been agreed and we are beginning the recruitment process and hope to implement the seven day service in 2018.

Data and metrics for monitoring improvements in EoL care in hospital and community

Baseline data collection has been agreed. A selection of this includes:

- Recording of patients' preferred place of death (PPoD) and the percentage of those dying in their PPoD;
- Number of people who were discharged on a rapid discharge;
- Number of admissions of patients in their last year of life;
- Number of deaths in hospital and community;
- Organ and tissue donation;
- Mortality data.

Baseline data has been obtained and our Information Services team will provide regular monthly reports which will help inform future practice in a timely manner.

Implementing an Electronic Palliative Care Co-ordination System

With funding from NHS Harnessing Technology a six month project to roll out the Electronic Palliative Care Co-ordination System across GP practices and Community Care teams has commenced. A shared template has been rolled out to record key information about patients at the EoL in the majority of GP practices, the PCT, community care teams, hospice, respiratory and heart failure teams. The information is based on a national End of Life Care Information Standard. The template contains links to relevant clinical guidelines and a variety of forms that improves efficiency for healthcare professionals. Further information is available at: https://www.hdft.nhs.uk/services/palliative-care/epaccs/

Summary and next steps

There has been significant progress on implementing the objectives in the HDFT EoL Strategy and this has led to improvements in the care and support of patients and their families. Timely data analysis has been difficult but it is anticipated this will be resolved this coming year. Key areas to focus on over the next year are to:

- Establish the new seven day 9am - 5pm face-to-face assessment by the PCT;
- Improve data analysis to demonstrate effectiveness of the service;
- Agree metrics for measurement of improvements in EoL care and reporting processes;
- Continue the work on rapid discharge and preferred place of care and death;
- Participate in the National Audit of Care at the End of Life (2018);
- Finalise the HDFT EoL Education Strategy and agree actions for implementation;
- Deliver training and education to a range of healthcare professionals around care for patients at the end of life;

- Include education and training in 'essential skills training' for key staff as agreed by the strategy;
- Review the HDFT Care of the Dying Adult and Bereavement Policy for hospital and community;
- Refurbish quiet rooms identified for the use of patients and families at the end of life;
- Establish the feasibility of an ongoing bereavement survey to be sent out to all consenting bereaved families for feedback on their experience of EoL care in community settings;
- Develop documentation to support care in the last days and hours of life for patients in their homes or care homes.

2. Dementia care

Dementia remains a government priority in England and Wales. The Prime Minister's Challenge on Dementia 2020 emphasised the need to improve hospital care for people with dementia and make hospital environments more 'dementia friendly'. HDFT cares for a large number of patients living with dementia. On the frailty wards (Jervaulx and Byland) about 50% of patients have a diagnosis of dementia or, as yet undiagnosed, cognitive impairment.

Patients living with dementia can present to any of our services and departments and so it is important that all staff have awareness and skills in caring for this group of patients.

What were we aiming to achieve?

During 2017/18 we have set out to reinvigorate the Dementia Working Group, which has begun to meet on a monthly basis in order to take forward work from the dementia action plan. The group includes the dementia champions from all wards as well as matrons, the Clinical Lead for Dementia, and representatives from Workforce and Development, and Clinical Effectiveness and Audit.

We have set out to ensure that all relevant staff receive adequate dementia training. At present this is delivered as e-learning for most staff. Results from the National Audit of Dementia Care suggest that we are unusual in relying entirely on e-learning to deliver training and that staff would prefer some face-to-face training. This has resulted in collaboration from the Tees, Esk and Wear Valley (TEWV) NHS Foundation Trust Acute Hospital Liaison Service (AHLS) who are assisting in our training programme.

What have we done and what were the results?

We have completed the National Audit for Dementia Care in General Hospitals 2016-17 which included analysis of care notes, an organisational checklist, and staff and carer questionnaires. Results were reported in July 2017 and have formed the basis of the work that the Dementia Working Group is setting out to achieve. Subsequently we participated in the National Audit of Dementia spotlight audit on delirium. The results of this are awaited.

The Butterfly Scheme was re-launched in November 2017 with input and support from its founder, Barbara Hodkinson.

AHLS staff have developed an education programme for HDFT staff, with specialist teaching on dementia, delirium and depression delivered on a monthly basis. We provide training for any staff who wish to become "Dementia Friends". We also have an ongoing programme of teaching about the diagnosis and management of dementia and delirium for doctors in training.

Level of training	Frequency	Number of staff requiring training	Number of staff trained	Percentage achieved
Dementia awareness	3 yearly	2044	1706	83%
Dementia tier 1	2 yearly	1814	1410	78%

Table 41: Dementia training compliance

We have also participated in the 'end PJ paralysis' campaign, whereby we try to reduce deconditioning due to immobility while in hospital. On Byland ward, one of the frailty wards, we now aim to get as many patients as possible up and out of bed, and changed from pyjamas (PJs) into their own clothes, and keep a visual record of this each day.

Photo 2: End PJ Paralysis campaign launch August 2017

The premise of the 'end PJ paralysis' campaign is simple. Once patients arrive in hospital they normally stay in their pyjamas or hospital gown until they are discharged. Research indicates that ten days of bed rest in patients over 80 can lead to 10 years of muscle wastage. It can then take double the amount of time to recondition, resulting in increased dependency, longer length of stays and an increase in 24-hour care placements. By promoting independence and enabling patients to get up, get dressed and get moving we reduce the risk of deconditioning, enhance patients' dignity and promote an active recovery to return home. Encouraging patients living with dementia to wear their own clothes further enhances their sense of identity. This may aid their transition of having to be in hospital.

A Carer's Passport was launched in January 2018. This gives support to carers who are looking after patients while they are in hospital and gives them the opportunity to work with doctors and nurses. The passport gives carers privileges such as out-of-hours visiting and overnight stays, as well as discounted food and drink in Harrogate District Hospital. *John's Campaign* has gathered

Photo 3: Carer's passport launch January 2018

examples of hospitals with some sort of carer friendly initiative- Based on this review there are 103 NHS trusts that have a carers passport scheme which has been identified to support carers caring for patients living with dementia. Feedback from people who care for those living with dementia have said they wanted more information on visiting their loved ones out of hours to be able to support them in their treatment. The Carer passport offers this opportunity to our relatives.

Friends of Harrogate Hospital and Community Charity organised an Old Time Music Hall event at the Royal Hall in Harrogate in October 2017 with proceeds from the event given to support dementia projects within the Trust.

We continue to have daily safety huddles on the two frailty wards, focusing on falls prevention and prevention of pressure sores. This includes a brief assessment of whether patients are living with dementia or have delirium and what measures can be put in place to ameliorate distress and challenging behavior.

The Trust has also been identified as one of five pilot sites across the West Yorkshire and Harrogate STP to roll out the 'Think Delirium' campaign which was launched in October 2017 by the Yorkshire and Humber Clinical Network. The basis of the campaign is that we aim to:

- Prevent delirium by calculating risk, assessing for clinical factors which might lead to delirium and formulate a daily care plan that is relevant to the patient;
- Suspect delirium if we find a patient with new or worsening confusion;
- Stop delirium by treating causes, offering explanation and reassurance and attending to a patient's physical needs.

Summary and next steps

Some of our aspirations for this year have been achieved, namely the re-launch of the Dementia Working Group, collaboration with the AHLS to deliver staff training, and our involvement as a pilot site for the 'Think Delirium' campaign. The Dementia Working Group action plan will continue to promote work to ensure:

- Improvement in delirium screening and recording, and improving the collection of personal information on 'All About Me' forms;
- Appropriate food is always available for patients living with dementia;
- Staff can access specialist dementia care out of hours;
- The views of patients are taken into consideration when decisions are being made about hospital discharge and that this is appropriately recorded;
- Patients are weighed as part of their nutritional assessment;
- Discussion and peer learning between staff who are involved in caring for patients living with dementia;
- Medical staff are trained to repeat the Abbreviated Mental Test Score prior to discharge;
- Information about the care of patients with dementia is fed back to the Trust Board.

Other plans are to:

- Investigate resources for training staff who require Tier 2 and Tier 3 Dementia training;
- Launch the "Think Delirium" campaign once resources are available from Yorkshire and Humber Research Network;
- Participate in round four of the National Audit of Dementia Care in General Hospitals;
- Incorporate training about delirium into junior doctors' induction.

- Delirium has been identified as a focus for an Rapid Process Improvement Workshop (RPIW) with the facilitated by the Improvement and Transformation Team for the week commencing 9th July 2018

3. Nutrition

The Trust is committed to providing high quality nutritional care and adequate hydration for patients across all acute and community locations. The Trust Nutrition Group which is chaired by the Professional Lead for Nutrition and Dietetics co-ordinates this work. Evidence both locally and nationally shows that one third of patients admitted to hospital are at risk of malnutrition. Malnourished patients require more frequent and prolonged admissions, therefore it is vitally important that the Trust ensures it can identify those patients who are at risk and have appropriate support in place to meet their needs.

The Trust also recognises the need for a healthy workforce, therefore the Nutrition Group is also responsible for ensuring the organisation can meet national targets for provision of healthy food for staff and visitors as well as sustainable, local procurement of products used within the catering service.

What were we aiming to achieve?

In 2017/18 the Nutrition Group aimed to complete the HDFT Food and Drink Strategy which would outline activities and initiatives for the next five years. This would include plans to achieve national targets, a framework for nutrition audits and a nutrition action plan. We also wanted to ensure that all our nutrition related policies and pathways were up to date, in line with NICE guidance and realistic to ensure patient safety and quality of nutritional care, and we wanted to continue with training in the importance of nutrition screening and action planning for frontline staff.

What have we done?

Trust Food and Drink Strategy

The Trust Food and Drink Strategy has been completed and ratified. An action plan has been developed to move forward with the new initiatives. These include the development of:

- a Trust-wide nutrition audit plan, so that we have oversight of all nutrition audits and can ensure that specific issues are identified and actions implemented;
- a more robust method of recording all nutrition related incidents via the Datix system, so that themes can be identified and escalated quickly to improve patient care and safety;
- improved compliance with weighing patients following admission as evidenced by matron assurance checks.

National targets

Catering, Dietetics and Human Resources Departments have worked together to ensure compliance with the national Commissioning for Quality and Innovation (CQUIN) targets. We achieved the year two targets for pre-packed sandwiches and sweets and confectionary by the end of year one in March 2018. Therefore 80% of pre-packed sandwiches available to purchase in the Trust managed outlets, such as Herriot's restaurant and the Café Bar, contain a maximum of 400 kcals and less than 5% saturated fat. Also 80% of sweets and confectionary available contain less than 250 kcals. Our snack vending machines are also compliant with this target. We also signed up to the voluntary NHS England Sugar-Sweetened Beverages initiative, requiring us to reduce sales of sugar containing drinks to 10% of total sales. To ensure we met this initiative we have stopped selling any drinks

containing greater than 5 g of sugar/100mls in Herriot's or the Café Bar. We are working with other providers such as Coca Cola, who provide our vending machines on site, to aim to achieve this reduction in the future. Currently 11% of product lines stocked in the vending machines contain more than 5g sugar/ 100mls. We have therefore met the national CQUIN year two target for reducing the availability of sugar containing drinks already, however, we need to continue to work with Coca Cola to reduce the sales of these products down to 10% to achieve compliance with the NHS England voluntary scheme.

Nasogastric feeding policy and pathway

The Trust nasogastric feeding policy and pathway was updated to ensure compliance with recent patient safety alerts and the new documentation to support this was launched in July 2017. The use of this is being audited in 2018.

Thickened fluids

New guidance has been written and signage developed to ensure that patients who require thickened fluids have safe access to appropriately thickened drinks.

This process will also be audited in 2018.

Figure 26: Thickened fluid signage

Coloured crockery and finger foods

We have identified funding via the Friends of Harrogate Hospital and Community Charity to enable us to purchase coloured crockery to help with promoting increased oral intake in patients with dementia and a new finger food menu will also be available for this group of patients.

Summary

Completion of the Food and Drink Strategy was a major piece of work for the Trust. This has allowed us to develop a framework for future improvements. Our audit plan allows us to monitor compliance with nutrition policies and initiatives, and the reporting structure allows us to ensure that any risks to patient safety related to nutrition are escalated and resolved quickly.

Other plans for the next year include closer working with the tissue viability nurses around the causes and treatment of pressure ulcers, improved training for both community and hospital based staff on nutrition screening and management of gastrostomies, and the development of a business case to support the recruitment of a trust-wide nutrition nurse specialist.

3.4. PERFORMANCE AGAINST INDICATORS IN THE SINGLE OVERSIGHT FRAMEWORK

The following table demonstrates HDFT's performance against the national standards included in the Operational Performance Metrics section of NHS Improvement's Single Oversight Framework for each quarter in 2017/18.

Standard	Minimum performance standard	Q1	Q2	Q3	Q4	YTD
RTT incomplete pathways	92%	93.8%	92.3%	91.9%	90.5%	92.1%
A&E 4 hour standard	95%	96.7%	96.0%	94.9%	92.8%	95.2%
Cancer - 62 days	85%	86.1%	88.9%	90.5%	90.2%	88.9%
Diagnostic waits	99%	99.8%	99.6%	99.7%	99.4%	99.6%

Table 42: Performance against indicators in the Single Oversight Framework

Key performance to note:

- The Trust achieved all four national standards included in the Operational Performance Metrics section of NHS Improvement's Single Oversight Framework for the full year 2017/18;
- In addition, the cancer 62 day waiting times standard and the diagnostic waiting times standard were achieved for each quarter of the year;
- Overall Trust performance against the A&E (Emergency Department) 4-hour waiting time standard was above 95% for seven out of 12 months throughout the year;
- The Trust achieved the 18 week standard for eight out of 12 months throughout the year;
- All other cancer waiting times standards were achieved for each quarter overall with the exception of the 14 day standard for beast symptomatic patients where performance was at 89.4% for Q4, against the minimum standard of 93%;
- There was one ambulance handover delay of over 60 minutes reported in 2017/18 (8 last year) and 85 handover delays of over 30 minutes (104 last year). Emergency Department attendances were 4.4% higher than for the same period last year;
- Activity levels at the Trust have increased during 2017/18. Elective (waiting list) admissions were 2.5% higher in 2017/18 when compared to 2016/17 and non-elective admissions increased by 3.9%. Outpatient attendances remained static with a total of 283,000 outpatient attendances in 2017/18;
- The Trust reported seven cases of hospital acquired *Clostridium Difficile* in 2017/18, compared to 29 in 2016/17. Five cases have had a completed root cause analysis (RCA). Results indicate that four of these cases were not due to lapses in care, and therefore, these would be discounted from the Trust's trajectory for 2017/18. One case has been agreed with the CCG to be as a result of a lapse in care and RCAs have yet to be completed for two cases. No cases of hospital acquired MRSA (Methicillin-resistant Staphylococcus aureus) were reported in 2017/18.

4. OTHER QUALITY INFORMATION

HDFT has identified additional elements of service quality to highlight in this Quality Account.

4.1. SUMMARY OF NATIONAL PATIENT SURVEY RESULTS

Emergency Department (ED) Survey 2016

Results from the National ED Survey were published on the CQC website in October 2017. As expected from the initial Picker results, performance for HDFT was excellent and the Trust was identified as performing 'better' than expected compared to other trusts. This was because a higher proportion of patients responded positively about the care they had received. This is a brilliant result for the staff in the department.

Children and Young People's Inpatient and Day Case Survey 2016

Results from the National Children and Young People's Survey 2016 were published on the CQC website in November 2017. We performed better than other trusts on four questions, and worse on three questions.

Questions on which we performed better:

- Did you like the hospital food?
- Did the hospital staff answer your questions?
- Before the operations or procedures, did hospital staff explain to you what would be done?
- Before your child had any operations or procedures did a member of staff explain to you what would be done?

Questions on which we performed worse:

- Did members of staff treating your child communicate with them in a way that your child could understand?
- When you left hospital, did you know what was going to happen next with your care?
- When you left hospital, did you know what was going to happen next with your child's care?

A multidisciplinary workshop was held with staff to review the results and pull together an action plan to address the areas for improvement.

National Cancer Survey 2016

The National Cancer Patient Experience Survey 2016 is the sixth iteration of the survey first undertaken in 2010. In all surveys we have been one of the top performing trusts in the country. The consistency of such attainments provides us with assurance regarding the sustained provision of high quality cancer care.

Asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating of 9.0. The following questions are also included in phase one of the Cancer Dashboard developed by Public Health England and NHS England:

- 84% of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment;
- 97% of respondents said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment;

- 93% of respondents said that it had been 'quite easy' or 'very easy' to contact their clinical nurse specialist;
- 88% of respondents said that, overall, they were always treated with respect and dignity while they were in hospital;
- 96% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital;
- 64% of respondents said that they thought the GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment.

For some cancer sites the report does not provide any site specific data regarding quality of the service i.e. sites with less than 20 respondents, or where we only provide diagnostic facilities, or in the case of skin cancer where treatment is provided as an outpatient procedure. We have no reason to believe that these results would not be replicated due to culture and approach to cancer care across the Trust; however we cannot be complacent and local methods of gaining service user views are therefore being implemented for these areas.

National Maternity Survey 2017

Results from the National Maternity Survey 2017 were published on the CQC website in January 2018. Our 2017 banding compared to the 'expected range' is better for five questions and as expected for all others. The questions where we performed better than expected are:

- Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?
- Thinking about your care during labour and birth, were you treated with respect and dignity?
- Did you have confidence and trust in the staff caring for you during your labour and birth?
- Would you have liked to have seen a midwife: More often? Less often? etc.
- Did a midwife tell you that you would need to arrange a postnatal check-up of your own health with your GP? (Around 6-8 weeks after the birth).

Our performance has worsened since the 2015 survey on four questions:

- Were you offered any of the following choices about where to have your baby?
- During your antenatal check-ups, did the midwives appear to be aware of your medical history?
- Did the midwife or midwives that you saw appear to be aware of the medical history of you and your baby?
- Were you given information or offered advice from a health professional about contraception?

Our performance has improved since the 2015 survey on two questions:

- Did you have confidence and trust in the staff caring for you during your labour and birth?
- In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?

4.2. NATIONAL STAFF SURVEY AND STAFF FRIENDS AND FAMILY TEST

National Staff Survey 2017

The anonymous national survey was carried out among a sample of Trust staff between October and November 2017. 1,250 surveys were distributed to members of staff and 638 were completed. HDFT had the second highest response rate in the country for our benchmark category at 52%. The average return rate in the Combined Acute and Community Trusts category was 43%.

Results are presented in 32 key areas known as 'key findings' as well as a measure of overall staff engagement. The Trust scored above average (which is the highest rank possible in the category of Combined Acute and Community Trusts) in 19 out of 32 areas.

The figure below shows how the Trust compares with other Combined Acute and Community Trusts on an overall indicator of staff engagement. Possible scores range from one to five, with one indicating that staff are poorly engaged (with their work, their team and their trust) and five indicating that staff are highly engaged. The Trust's overall Staff Engagement score of 3.83 is ranked above average in the Combined Acute and Community Trusts category. This is the highest rank possible.

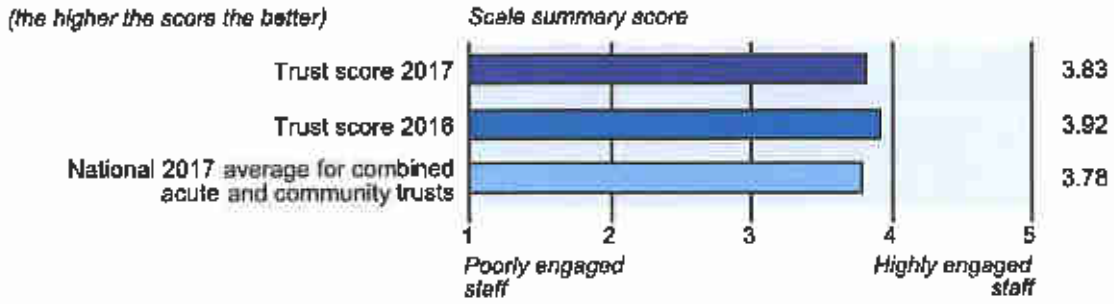


Figure 27: National Staff Survey 2017 staff engagement score

The top five ranking scores for HDFT were as follows:

Top five ranking scores compared with Combined Acute and Community Trusts in England.	HDFT 2017	National average
Percentage of staff satisfied with the opportunities for flexible working patterns	61%	51%
Percentage of staff experiencing discrimination at work in the last 12 months	7%	10%
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	20%	27%
Percentage of staff experiencing physical violence from staff in last 12 months	1%	2%
Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	25%	29%

Table 43: National Staff Survey 2017 top five ranking scores for HDFT

Our score for the key finding: percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months improved from 2016 (21% versus 22% in 2016) and is better than the national average of 24%.

The largest local change for HDFT was for the key finding: percentage of staff appraised in the last 12 months. Our score increased from 85% in 2016 to 90% in 2017, which reflects

the positive approach to managing appraisals through an 'appraisal window' this financial year.

Five areas for improvement were identified from last year's survey. Two of these areas have shown improvement in this year's survey.

Area for improvement	2016	2017
Percentage of staff experiencing physical violence from staff in last 12 months	2%	1%
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	13%	11%
Staff confidence and security in reporting unsafe clinical practice (1 = lowest 5 = highest)	3.84	3.74
Percentage of staff working extra hours	71%	71%
Percentage of staff feeling unwell due to work related stress in the last 12 months	36%	38%

Table 44: National Staff Survey 2017 five areas for improvement

HDFT scored below average in three out of the 32 key findings:

- Percentage of staff reporting errors, near misses or incidents witnessed in the last month *(HDFT 90%, national average 91%);*
- Staff satisfaction with the quality of work and care they are able to deliver *(HDFT 3.84, national average 3.90);*
- Percentage of staff reporting most recent experience of violence *(HDFT 62%, national average 67%).*

Two other areas were also highlighted as areas for improvement in the report. These are scored as average when compared with other combined acute and community trusts:

- Quality of non-mandatory training, learning or development (reduction from 4.15 to 4.04);
- Percentage of staff working extra hours (71% in 2016 and 2017).

We have also identified that the following key findings should form part of our staff engagement action plan for 2018/19:

- Staff recommendation of the organisation as a place to work or receive treatment (reduction from 3.96 to 3.79);
- Percentage of staff able to contribute towards improvements at work (reduction from 75% to 70%).

The percentage of staff believing that the Trust provides equal opportunities for career progression or promotion in key finding 21 showed deterioration at 90% versus 92% in 2016, although HDFT scores better than the national average of 85%.

The full report can be found at http://www.nhsstaffsurveys.com/

The key themes from the 2017 survey will be incorporated into our 2018/19 Staff Engagement Action Plan.

Staff Friends and Family Test

The Staff Friends and Family Test (FFT) is a feedback tool for staff, predominately to support and influence local improvement work. It allows us to take a 'temperature check' on how staff are feeling and is a complementary engagement activity to the annual National Staff Survey. The Staff FFT asks the following two questions:-

1. How likely are you to recommend the Trust to friends and family if they needed care or treatment?
2. How likely are you to recommend the Trust to friends and family as a place to work?

The Staff FFT for Quarter 2 2017/18 was open from 11 to 22 September 2017, with 4493 staff being invited to participate. We adopted a multi-mode approach to the survey, using an open-URL and paper questionnaire methodology for Q2, which enabled staff who traditionally would not have access to the electronic survey e.g. ward based staff to contribute. There were 1067 respondents which is the equivalent to a 24% response rate. This was a 5% point increase in response rate from Q1, equating to 336 more respondents.

The results highlighted that 83.7% of staff would recommend the Trust to friends and family to receive care or treatment against a national average of 80%, and that 64.7% would recommend the Trust as a place to work in comparison to a national average of 64%.

The survey provides the opportunity for staff to provide additional comments and the results are reviewed each quarter by the directorates to ensure continuous service development. The key reasons for staff recommending the Trust as a place to receive treatment or care is due to the skilled and caring staff, the high standards of care and the friendliness of the hospital whilst the reasons given for not recommending care or treatment at our Trust is due to concerns around staffing levels.

The fundamental reasons given by staff for recommending the Trust as a place to work was related to the enjoyment of work, working within a caring, friendly and supportive team whilst the reasons given for not recommending the Trust as a place to work were due to staffing levels and high workloads.

The key themes from the Staff FFT are fed into our staff engagement action plan, which incorporates the themes arising from the National Staff Survey to ensure these are aligned.

4.3. COMPLAINTS AND COMPLIMENTS

The Trust welcomes patient feedback including positive as well as negative experiences. Front line staff are encouraged and empowered to respond to patient feedback, receive compliments and resolve minor problems informally as quickly as possible. The Trust has a Making Experiences Count process and policy to resolve all concerns and complaints locally (within the Trust).

The Patient Experience Team (PET) facilitate the resolution of issues and this could include offering the opportunity of meeting with clinical staff, speaking with service managers or meeting the Medical Director and/or the Chief Nurse to discuss issues in more detail to help to address concerns and provide information and explanations. In all cases the feedback is reviewed to identify opportunities for improving patient care.

The Trust has an estimated 1.8 million patient contacts per annum, which equates to around 4,900 per day. Whilst every individual complaint is very important, especially to the

complainant, the average rate of around 17 complaints per month in 2017/18 is relatively small and has decreased from the average in 2016/17 (19 per month).

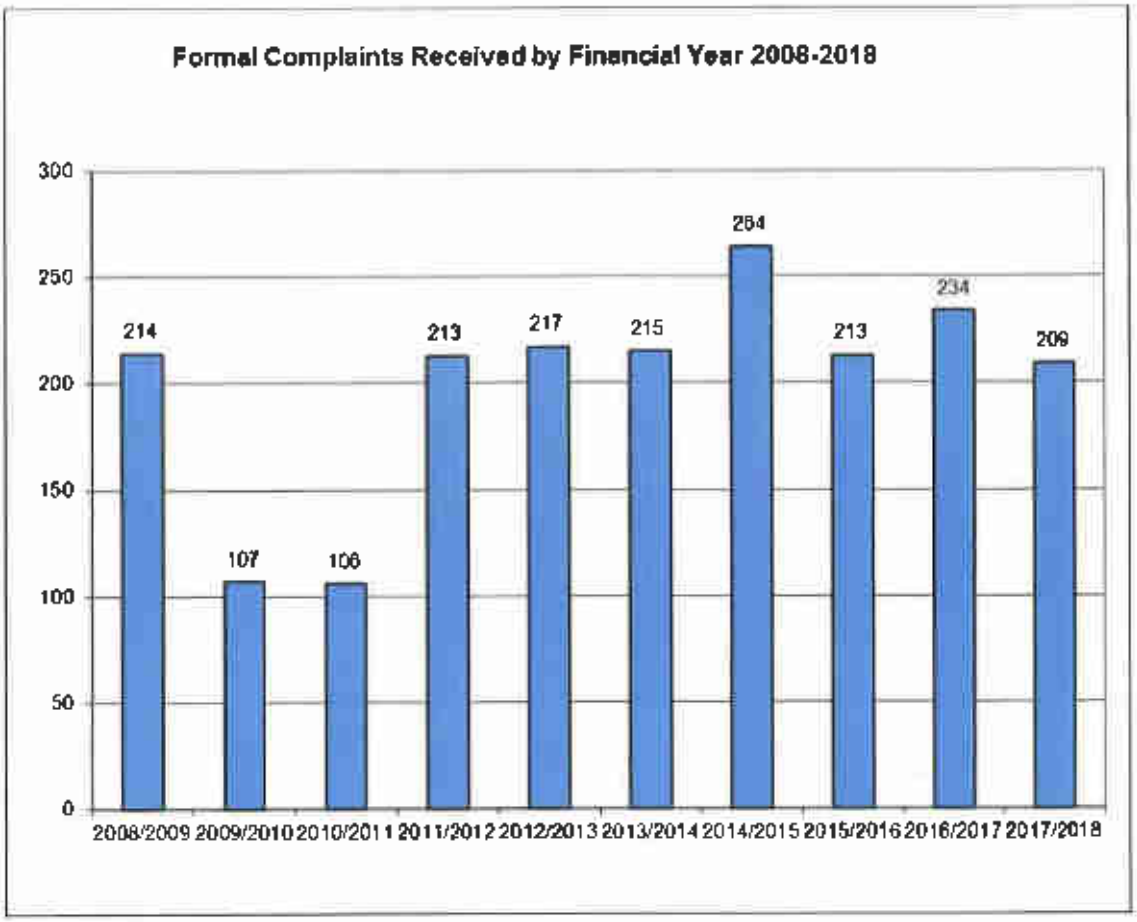


Figure 28: Local patient feedback data since 2008

The data from April 2008 to March 2011 refers only to acute hospital services, whilst the data from April 2011 represents both acute and community services following the integration of community services into the Trust. The Trust increased in size associated with the delivery of a significant number of new services.

The Trust uses a grading matrix for complaints raised, which is based on severity of concerns and timescales for response. This includes four levels of formal complaint (green, yellow, amber and red). The breakdown of complaints received in 2017/18 is presented below by grade and quarter in which it was received, compared to 2016/17.

Complaints Total	2016/17 Total	2017/18				
		Q1	Q2	Q3	Q4	Total
Complaint - green	55	17	8	16	16	57
Complaint - yellow	178	33	40	32	44	149
Complaint - amber	1	2	1	0	0	3
Complaint - red	0	0	0	0	0	0
Total	234	52	49	48	60	209

Table 45: Local patient feedback data showing complaints by quarter during 2017/18 and grade

The number of complaints received is less than the previous year but the number of cases indicating very poor experience which are graded amber is higher than last year. Quarter 4

received the most numbers of complaints and it should be noted that this was during the winter pressures experienced across the NHS as a whole when staffing and activity levels were challenging.

The Trust welcomes feedback from patients, families and carers and encourages staff to resolve 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 these informal "PALS" (Patient Advice and Liaison Service) type contacts includes concerns, information requests and comments. In total in 2017/18, 1056 were received by the Patient Experience Team (PET) compared to 936 in 2016/17, and 676 in 2015/16. Of these 1056, 653 were concerns, 223 were requests for information and 180 were comments. The continued increase in cases dealt with informally demonstrates the ambition of all staff to address concerns before they escalate into more serious issues and the successfully signposting and publicity of the work of the PET to the general public.

The top five themes for complaints and concerns can be seen in the graph below. The main themes have consistently included issues around poor communication and attitude.

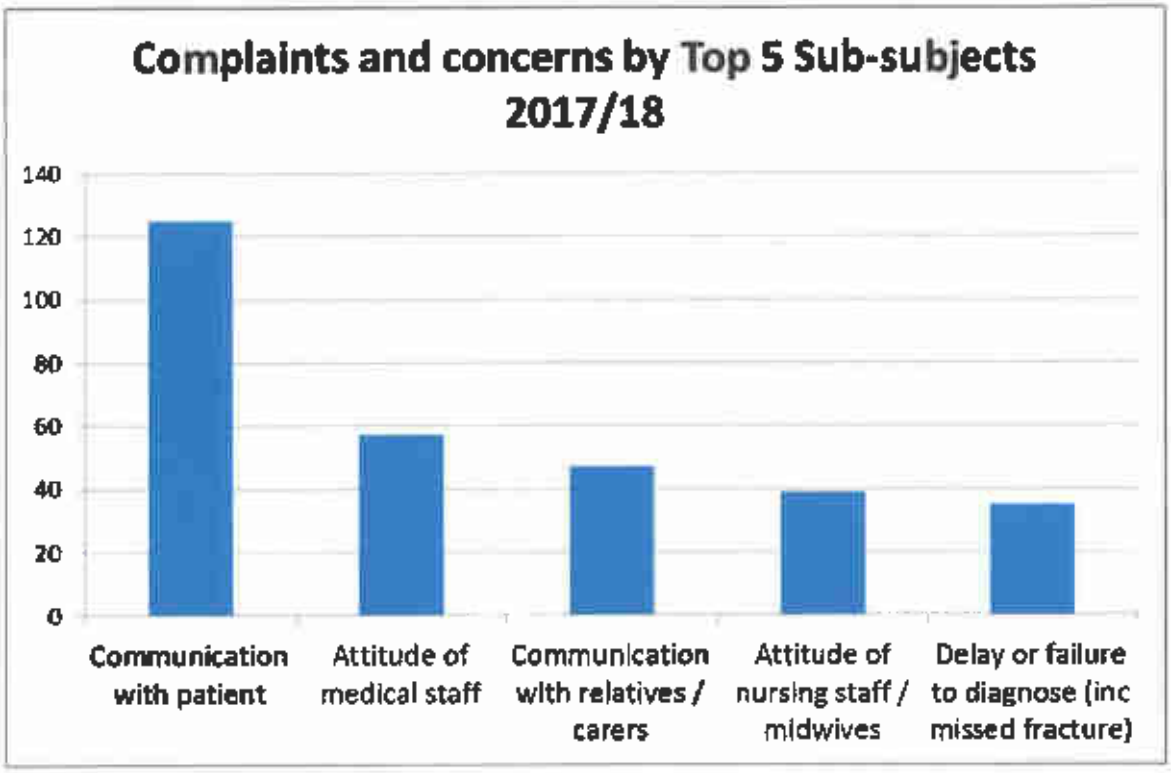


Figure 29: Local patient feedback data showing the main themes in complaints and concerns

The Trust investigates all complaints and concerns and provides appropriate feedback to the contact (after consent is established if the feedback is to a third party).

A lead investigator is expected to make early contact with the complainant to agree the issues being investigated, the method of resolution and timeframe for reply based upon the Trust's grading matrix. The investigation focuses on what happened, what should have happened and where appropriate, what the actions will be to prevent it from happening again. The investigation is then quality assured by the operational director or clinical lead for the area to determine whether the investigation and response is robust and whether the issues complained about have been upheld. It should be noted that not all complaints or concerns received are upheld.

Response timeframes for complaints are guided by the severity of the case and are agreed at the outset. The Trust introduced a complaints performance metric in 2016/17 which includes monitoring of complaints responses against a target of 95% within deadline set and monitoring of completion of action plans. The Trust met the defined timescale for reply in 56% of cases in 2017/18 (of those deadlines reached at the time of reporting) and sought extensions where the deadline could not be reached. This is an increase from 38% in 2016/17. The Trust is keen to improve this performance next year and this is being monitored closely on a quarterly basis. Further training sessions to increase the pool of lead investigators has been delivered this year including staff from all three clinical directorates and the corporate services directorate.

Action plans are developed to improve patient care as a result of feedback and these are monitored regularly. Learning from patient feedback is at the heart of our Making Experiences Count Policy, and clinical directorates share themes and learning from these via their governance groups and front line quality of care teams.

Five cases were referred to the Health Service Ombudsman in the period. Of the five cases referred this current financial year:

- 2 cases were closed without any investigation;
- 2 have been investigated and found to be not upheld;
- 1 case is undergoing initial review by the Ombudsman.

In 2016/17 the Ombudsman investigated four cases and none of these were upheld. In one case the Ombudsman decided not to investigate following the initial review of the file.

Cloverleaf Advocacy Services (Independent Health Complaints Advocacy Service) is an organisation that provides support (known as advocacy services) to help people across the North Yorkshire 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 PET to review frameworks for communication and to promote the model of advocacy services. The Trust continues to promote the advocacy services that are available for supporting complaints and patient feedback. Since the Trust started delivering 0-19 services in the North of England we have begun working with the Carers Federation who provide advocacy for the North East.

Compliments are received at ward and team level by the PET and reported in the local media.

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Compliments received by the Patient Experience Team	354	291	330	315	340	325	316

Table 46: Local data showing compliments received by the Patient Experience Team

4.4. THE PATIENT VOICE GROUP

The Patient Voice Group (PVG) is an independent group of volunteers who work in partnership with the Trust. Our purpose is to listen to patients and relatives experiences of using HDFT services and communicate these in a meaningful way to managers and staff, so that the quality of patient care continues to improve.

The PVG Patient Voice Group

The workload of the PVG is based on the domains set by the CQC around safety, the patient experience, dignity and respect, communications and the flow of the patient journey through the different services including plans to go home. This provides opportunities to share excellent practice and also learn where improvements could be made. We do not want to appear a threat to hard working staff but to work with them. We do this by talking to patients and relatives at the most appropriate time, on the wards, at home or by telephone.

This year the PVG took a different, less formal approach and 'befriended' 10 wards. Informal visits were made over a period of 3-6 months. This provided continuity and relationships developed between PVG members and staff. Comments and observations were discussed with matrons, sisters and staff before a summary paper was presented at the Learning From Patient Experience Group for comment. Through discussions with staff there were opportunities for staff to make small changes and clarified some comments we received. This was a positive experience.

2017/18 has been a busy year visiting:

- Four wards within the Long Term and Unscheduled Care Directorate (Lascelles, Granby, Byland and Jervaux);
- Four wards within Planned and Surgical Care Directorate (Wensleydale, Littondale, Farndale and Nidderdale);
- Woodlands, the children's ward;
- Maternity and Special Care Baby Unit.

The Patient Voice Group findings (patients' and relatives' comments and our observations) are presented at the Learning from Patient Experience Group to promote discussion among managers and staff. Responses from HDFT have included;

- Managers have thanked the PVG for the positive findings e.g. patient care and staff kindness.
- Actions have been put in place to improve the patient experience e.g. Volunteers to provide activities for patients, improvements to the environment (redecorations to the children's ward)
- Reminders that sometimes what is thought to be embedded e.g. staff introductions and explanations to patients need addressing

Work is ongoing to ensure the voice of children and young people are heard and PVG members are continuing to develop relationships with the Youth Forum and will develop a work programme for 2018/19.

Results

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 has become increasingly difficult to talk to patients in hospital as they are very poorly and vulnerable and we continue to investigate different ways of collating honest feedback. It is a continuous challenge to find the most appropriate time to talk to patients.

Conclusions

Developing trusting relationships with staff through 'befriending' areas has been successful in that dialogue and discussions has brought about small changes in areas visited. The PVG need to raise awareness of their role within the Trust.

4.5. CLINICAL TRANSFORMATION PROGRAMME

The aim of our clinical transformation programme is to:

> Achieve best care for the people who receive care and treatment from HDFT whilst at the same time realise financial savings with improved systems and controls.

Figure 30 shows how we deliver rapid improvement activity to facilitate the "breakthrough" transformations that we need in order to meet this aim. 80% of rapid improvement activity is directed in this way, with the remaining 20% being used to help address operational challenges or inefficiencies on a reactive basis.

Figure 30: How the Trust delivers rapid improvement activity to facilitate the "breakthrough" transformations

Work to deliver quality improvement activity and realise clinical transformation is more likely to succeed when it occurs in a receptive context. Our Quality Charter is helping to deliver culture change in the Trust by engaging staff in delivering improvements in their work and by recognising and rewarding those who do so. The Quality Charter comprises the schemes outlined below.

Figure 31: Schemes of the HDFT Quality Charter

What were we aiming to achieve?

During 2017/2018 the Charter aimed to:

- Recognise twelve Teams of the Month;
- Grow the number of Making a Difference awards made across the whole Trust;
- Create more new Quality of Care Champions at every level of the Scheme;
- Stage a successful Quality Conference;
- Deliver effective quality campaigns.

In delivering rapid improvement activity, we aimed to:

- Increase the pace of delivery through the engagement of Quality of Care Champions;
- Better complement existing approaches to service reviews and "hotspot" reviews.

In delivering our clinical transformation programme, we aimed to:

- Continue to deliver an agreed programme of projects across four workstreams;
- Scope the "size of the opportunity" for a refreshed and refocused programme to deliver during 2018/23.

What have we done and what were the results?

Quality Charter

There is growing evidence that the Charter is changing our culture in a way that is not only creating a receptive context, but helping to directly facilitate needed improvement and transformation projects through the activity of our growing movement of Quality of Care Champions. There is information below about the performance of the Charter's constituent schemes.

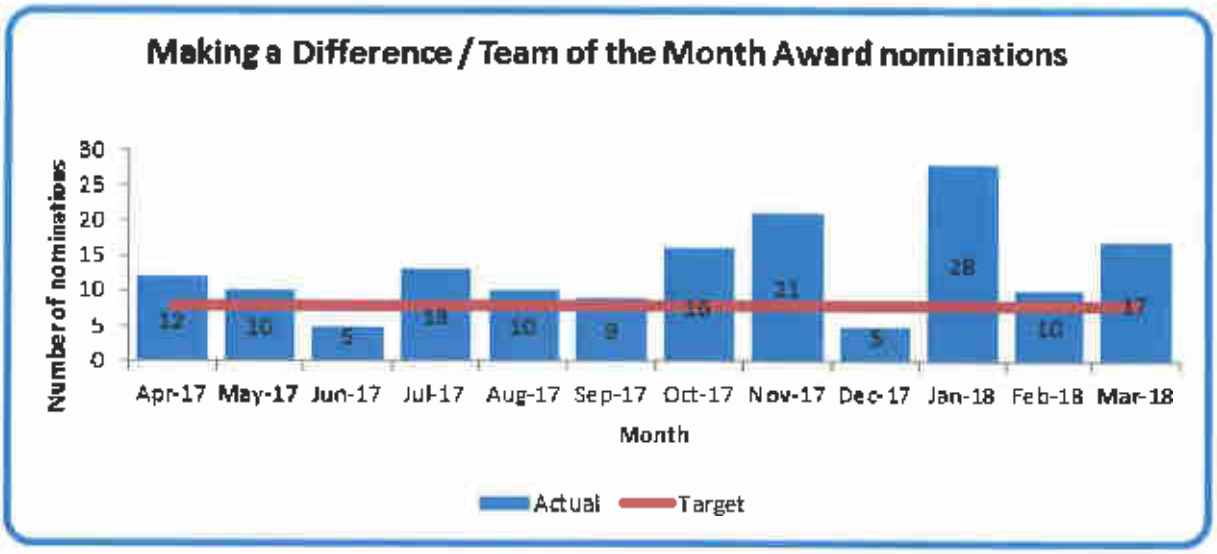


Figure 32: Team of the Month and Making a Difference Schemes

There is further information on our website at Our Making a Difference winners - Harrogate and District NHS Foundation Trust.

We now have:

- 123 Bronze Quality of Care Champions accredited
- 16 Silver Quality of Care Champions accredited
- 1 Gold Quality of Care Champion accredited
- 3 Platinum Quality of Care Champions accredited

A vacant post has contributed to performance being generally behind the challenging targets set for the Quality of Care Champions Scheme, but this is expected to be remedied by the second quarter of 2018/19.

Quality Conference

The Trust's first multidisciplinary Quality Conference delivered content to over 150 direct participants at the main venue at Harrogate Pavilions and at satellite venues in Scarborough, Northallerton and Ferryhill. On the day of the conference there were 19,000 Twitter impressions, the busiest ever day on the @HDFT_Innovation account. Delegates heard speakers from our own Trust alongside inspirational key note speakers from the worlds of healthcare, air safety and customer service.

Technical problems on the day impaired the delegate experience at some satellite venues, but the results shown in the "would you recommend a future event?" pie charts speak for themselves. Detailed lessons have been learnt for the 2018 conference.

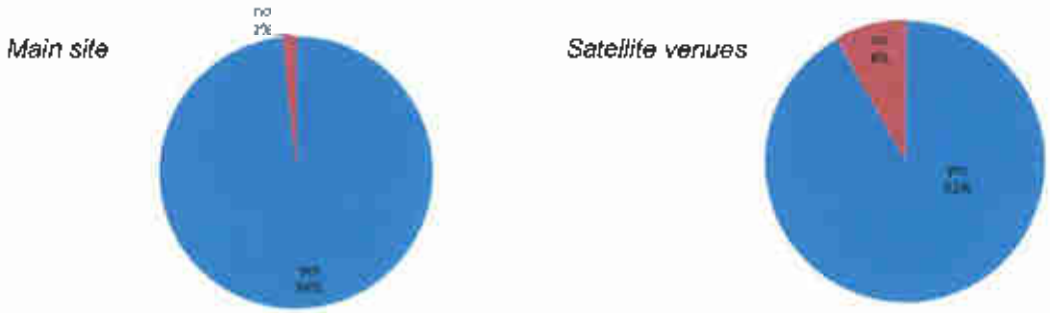


Figure 33: Staff feedback: Would you recommend future conferences to your colleagues?

Figure 34: Staff feedback from the satellite venues: What was the most useful part of the conference?

Photo 4: Quality Conference 2017 photo collage

'Hammer down Haemolysis' Quality Campaign

Haemolysis is the breakdown of red cell membranes and this may happen when blood specimens are taken as a result of poor technique. The haemolysed sample may not be possible to analyse, requiring the patient to need a repeat sample, wasting time and resources and impacting negatively on patient experience. Careful specimen collection can reduce haemolysis significantly, and the Trust's first Quality Campaign, "Hammer down Haemolysis", made a big impact in September 2017 when average haemolysis rates almost halved across the eight participating wards and partners. However, since this was not sustained in most areas in subsequent months, the campaign went on to deliver further campaign activity by:

- Revamping and recirculating campaign materials, specifically a "dos and don'ts" poster designed by Blood Sciences and clinical colleagues;
- Winning external sponsorship for branded campaign mugs to raise awareness of the campaign at desks and in kitchen areas of participating wards and partners;
- Offering informal phlebotomy refresher training to colleagues who take blood samples;
- Offering tours of the blood science laboratory to these seeking to understand more about how blood samples are processed.

Performance on haemolysis rates will continue to be reviewed quarterly.

Rapid Improvement Programme

A couple of highlights from the 2017/18 programme are given below. The pace of delivery of improvement projects increased and a review of our approaches to service reviews, rapid improvement and "hotspot reviews" was produced. Recommendations for further improving our deployment of these approaches future have been adopted.

Evidence shows that actions from the theatre scheduling rapid process improvement workshop (RPIW) in May 2017 led to:

- A reduction in the cancellation of operations in participating areas in orthopaedics and general surgery;
- The number of steps in the scheduling process being reduced to increase efficiency of administration and bring benefit to patients;
- The batching of booking forms being reduced;
- The development of a theatres dashboard to enable a more in-depth understanding of theatre productivity;
- Better standardisation of theatre schedules (start and finish times).

The challenge now is introduce streamlined pre-operative assessments to other specialities in order to roll-out this benefit to a larger number of patients.

Podiatry colleagues worked on ideas to reduce set-up time for appointments as part of the Podiatry RPIW in February 2018. Work is on track to:

- Increase the organisation and efficiency of key podiatry clinics, office and store rooms;

Photo 5: Podiatry RPIW in action

- Ensure 100% of received referrals either by phone call, email or fax for active diabetic foot problems and high risk patients are triaged within 1 day (in line with NICE guidelines);
- Ensure 95% of patients receive a domestic visit by their due date.

Clinical Transformation Programme

Benefiting from the receptive context created by the Quality Charter schemes and the "hands on" facilitation of rapid improvement activity, the programme continued to deliver projects across four workstreams, attaining the outputs described below.

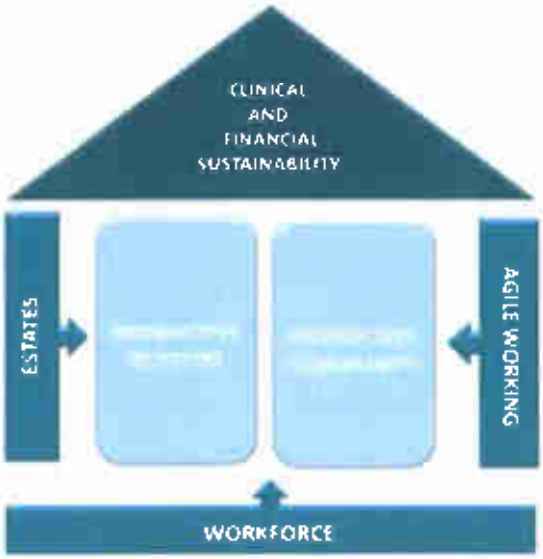
The 2017/18 programme had an ambition to achieve £3m in cost improvement programmes; just over £1m has been realised to date. Despite this shortfall, the programme has delivered a number of successful projects that has resulted in positive quality improvements for staff and patients:

- Discharge was one of the key projects within the Unplanned Care Workstream which focused upon avoiding unnecessary admissions, improving patient flow and reducing length of stay by discharging patients to more appropriate care settings. Following the establishment of a Supported Discharge Service team, more than 200 referrals have been managed by the team and more than two thirds of those patients were supported to return home ahead of their planned date of discharge. The Supported Discharge Service has also been able to reduce length of stay by an average of 3.0 bed days per patient and 409 bed days overall.

- Colleagues from the corporate team, and clinical directorates attended a half-day workshop to review workforce challenges and identify priorities for years one and two of the Clinical Workforce Strategy implementation plan. The session was neatly balanced with a learning & development session, which complemented the collaborative conversation and thinking by considering individual impact and approaches to working practice. The Improvement & Transformation Team have since been working with the Children's and County-Wide Community Care directorate management team to develop meaningful workforce plans incorporating the themes and feedback from the development day and by reviewing this with the individual teams and stakeholders. As a result the workforce plans will be taken forward in 2018/19.

- The 2017/18 Planned Care programme saw the permanent opening of the Swaledale unit as the new Elective Admissions and Discharge Unit (EADU) in March 2017, with the Discharge Lounge transferring onto the unit in June 2017. This was initially a six month project as part of the Planned Care Transformation programme – overall a great success! Work still continues in promoting a criteria basis to support use of the lounge primarily from inpatient wards.

Work to scope the size of the opportunity for a refreshed and refocused programme was completed, yielding a new programme structure to deliver our "productive house" model.



CORE	
PRODUCTIVE HOSPITAL	… requires lean service delivery including productive operating theatres and effective bed management. There will be a focus on avoiding unnecessary admissions, reducing length of stay and expediting safe discharge.
PRODUCTIVE COMMUNITY SERVICES	… now accounts for over half of the Trust's activity. With a developing improvement culture, there is further potential to improve productivity and utilise innovative solutions to the provision of care.
ACCELERATOR	
AGILE WORKING	… needs IT hardware and software, training and a cultural shift to enable greater efficiencies in community, acute and corporate services.
WORKFORCE	… challenges - and our ability to meet them - will be a key enabler of the rest of the programme. These include our ability to attract and retain students, apprentices and skilled staff and to develop a resilient workforce for the future.
ESTATES	…. Such as capital projects to align our infrastructure with that of clinical need and rationalising community estate will facilitate the improved productivity of acute and community services.

Figure 35: HDFT's "productive house" model

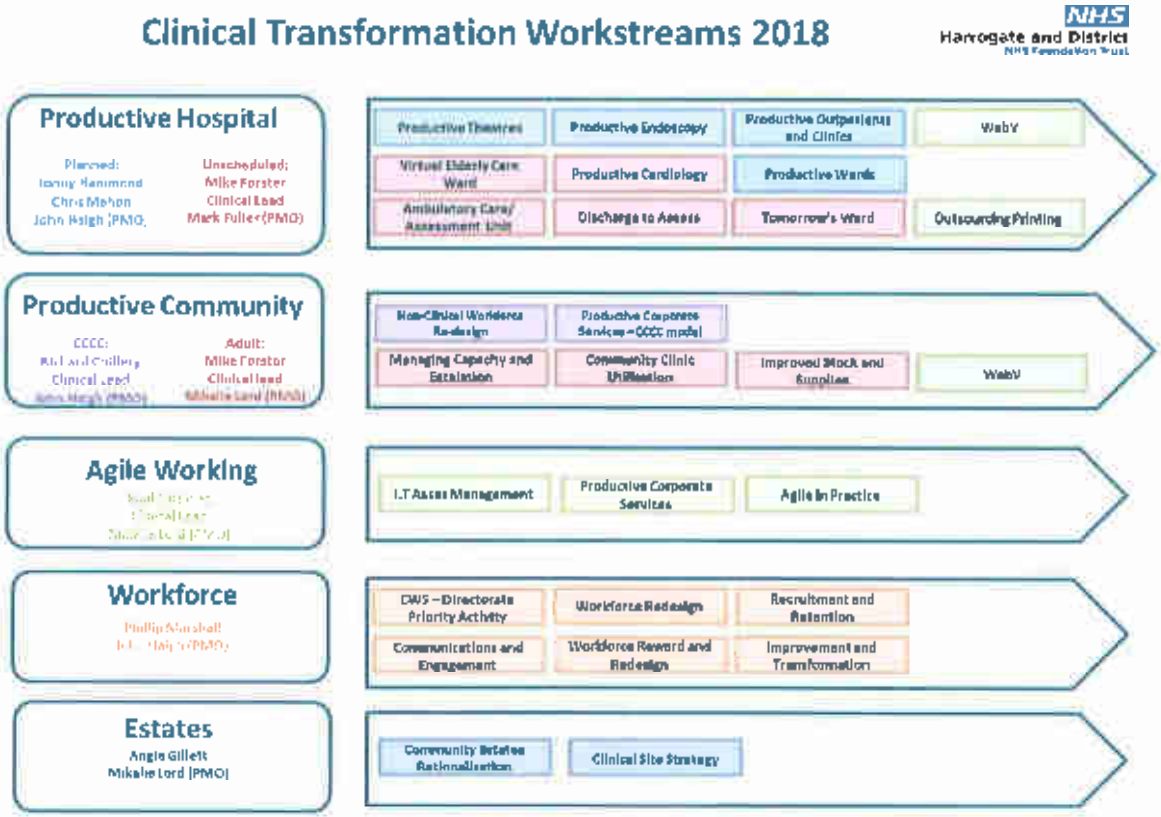


Figure 36: Clinical Transformation Workstreams 2018

Productive Hospital

The productive hospital workstream will focus on six areas:

- Continue to improve theatre productivity on-site;
- Improve productivity in general surgery and day surgery in satellite sites (North Leeds);
- Improve productivity in diagnostic services in satellite sites (Wharfedale);
- Expand diagnostic provision on-site (orthopaedics, ophthalmology, cancer);
- Reduce length of stay and delayed transfers of care(virtual ward: diagnostics);
- Utilisation of new WebV software modules to improve flow and discharge.

Productive Community

The productive community workstream will seek to support the expansion of our community services through the business development strategy, with the application of large-scale productivity measures and will focus on:

- Utilisation of WebV software modules to facilitate discharge of patients;
- Re-design of corporate services to support community teams;
- Improve admissions avoidance and re-admission within 30 days of discharge;
- Non-clinical workforce re-design within the Children's and Countywide Community Care directorate.

Agile working

To enable the productive hospital and productive community model, agile working technologies and practices need to be employed. Investment in mobile phones, laptops and VPN (virtual private network) tokens for the right staff at the right time will support the drive to increase activity, generate efficiencies and deliver a better service for patients and users. The development of an asset management system for low value goods will allow for greater Information Technology (IT) budget management and could lead to development of shared procurement arrangements with other partners in West Yorkshire and Harrogate.

Workforce

The development of the Clinical Workforce Strategy and its key performance indicators will be led by directorates. Additional strategies, such as the Nursing Recruitment and Retention Strategy, will complement the overarching strategy and ensure that the organisation is being responsive to its immediate recruitment needs. These strategies will require the introduction of more efficient and effective recruitment activities, such as the electronic applicant management system, marketing and social media activities. Directorate and service workforce models and retention will be supported by initiatives such as the Health and Wellbeing Strategy, which will support preventative measures for staff sickness absence and long-term absences, and Reward and Redesign which will develop incentives to attract and retain staff.

Estates

For Productive Community, as the delivery of community services are reviewed and preferred ways of working identified, the rationalisation of community estate can be undertaken. Conversely, for Productive Hospital the Clinical Site Strategy will support growth in agile working, for example exploring opportunities for hot-desking arrangements in dedicated areas within the Trust.

Summary and next steps

Three years into our clinical transformation programme, new momentum is being gained as financial and quality gains are achieved and the ever-present need to secure best value from limited NHS resources increases in acuity.

During 2018/19 we plan to up the pace of the corporate programme of rapid improvement activity to deliver projects at a rate exceeding one per month. And our mission to create a movement of Quality of Care Champions and turn dozens of champions into hundreds will continue.

4.6. VOLUNTEERS

Volunteers at Harrogate and District NHS Foundation Trust (which includes Ripon Community Hospital and community sites in Northallerton, Scarborough, Durham, Darlington and Middlesborough) continue to enhance our patient experience with their enthusiasm, commitment and the generosity of the giving of their time, which totals over 2,000 hours per month. We currently have 590 active volunteers helping us!

Photo 6: Just some of our 590 active volunteers!

Volunteers provide invaluable assistance throughout the Trust in areas such as:

- Meal time volunteers, assisting patients with their lunch and evening meals on many wards;
- Chaplaincy ward visitors;
- Meet and greet volunteers for Main Reception, Out Patient clinics, the Sir Robert Ogden Macmillan Centre and at Ripon Community Hospital;
- Volunteer fundraisers;
- Maternity volunteers;
- Woodlands ward volunteers;
- Harrogate Hospital Radio;
- Café;
- Gardening volunteers;
- Administration volunteers throughout the Trust;
- Check-in engagement volunteers;
- Volunteer drivers for patients living in Nidderdale;

- Complementary therapy volunteers;
- Breast feeding peer support volunteers in Durham, Darlington and Middlesbrough;
- Therapy dogs at both Harrogate and Ripon hospitals;
- Craft volunteers at both Lascelles and Trinity wards;
- Activity volunteers on Trinity ward at Ripon Community Hospital.

Volunteers also assist in many "one off" roles such as assisting with conducting surveys, and helping at Medicine for Members lectures.

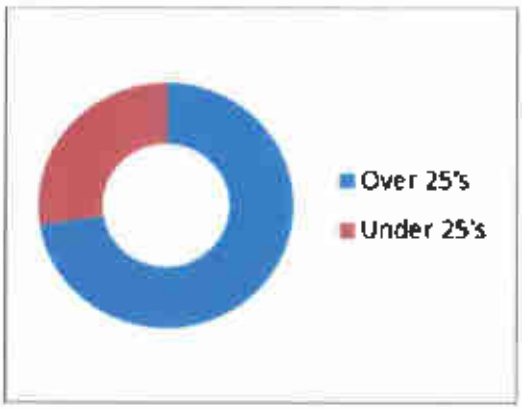


Figure 37: Breakdown in volunteer ages

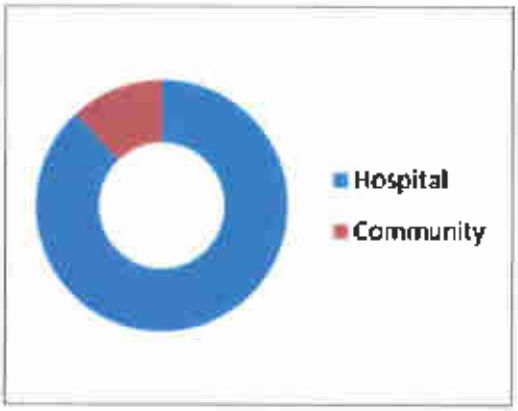


Figure 38: Breakdown in volunteer areas

4.7. CANCER SERVICES

Cancer services remain a significant priority for this Trust. It is hugely important that we can offer patients and their families high quality, safe, local and timely access to the appropriate treatment and care. We continue to work closely with our partner organisations within the Harrogate and West Yorkshire Cancer Alliance to ensure that our patients receive the best evidence based treatment.

Photo 6: Sir Robert Ogden Macmillan Cancer Centre

We have based our local objectives around the national vision for what cancer patients should expect from the health service which is set out in the strategy document 'Achieving World Class Outcomes: A strategy for England 2015-20'.

We continue to receive excellent patient feedback from the National Cancer Patient Experience Survey and other local sources but are mindful of areas for improvement. We recognise the need to offer an equitable service for all and continue to work with all healthcare professionals within the hospital and community setting to ensure excellent access to services for all.

We are aware that with an ageing population we will see a rise in the incidence of cancers over the coming years and we are mindful of the need to work more efficiently and innovatively to be able to offer an excellent, timely service that meets the needs of the individual and their family.

What were we aiming to achieve?

Our aim for cancer services in 2017/18 was to:

- Continue to achieve the 31 and 62 day cancer targets on a quarterly basis;
- Continue further implementation of the Cancer Recovery Package;
- Provide further support within the specialist cancer nursing teams;
- Provide more timely psychological support for patients and their families diagnosed with and living with cancer;
- Continue to develop the Macmillan Patient Information and Health and Wellbeing Service.

What have we done and what are the results?

Achieving the 31 and 62 day cancer targets on a quarterly basis

To continue the assurance around patients' timely access to services we evaluate our cancer waiting times performance regularly. The Cancer Tracking Team work closely with Information Services to ensure accurate data is collected and acted upon. We also work closely with our partner organisations such as Leeds and York Trusts to ensure that patients are transferred to those hospitals for investigations and treatment as quickly as possible with all the necessary information. Achieving the cancer targets remains challenging and will continue to be the case as we see the continual rise in referrals. We appreciate the efforts of all our clinical teams who support timely access for patients.

Type	Target	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2017/18
14 Day Breast Symptomatic	93%	95.7%	96.7%	96.3%	89.4%	94.4%
14 Day Suspected Cancer	93%	96.4%	98.4%	98.8%	96.5%	97.5%
31 Days First Treatment	96%	99.6%	98.8%	98.9%	99.6%	99.2%
31 Days Subsequent - Anti-Cancer Drugs	98%	100.0%	100.0%	100.0%	99.2%	99.8%
31 Days Subsequent - Surgery	94%	98.1%	97.1%	96.2%	97.5%	97.3%
62 Days	85%	86.0%	88.9%	90.5%	90.2%	88.9%
62 Days Consultant Upgrades	85%	100.0%	100.0%	100.0%	91.7%	96.4%
62 Days Screening	90%	91.7%	88.9%	90.5%	100.0%	93.0%

Table 47: HDFT performance against 14, 31 and 32 cancer targets

Table 47 above demonstrates the continued success for HDFT in meeting the required targets for 2017/18 overall. The need for patients to be seen, investigated and treated in a timely manner is so important to all the clinicians who work across this organisation.

Implementation of the Cancer Recovery Package

Implementing the cancer recovery package continues to be a huge focus for each of the cancer teams. This is a key recommendation from the National Cancer Strategy and the Trust is committed to full implementation by 2020. The recovery package has four main components:

- Electronic holistic needs assessment (eHNA). This has increased the focus upon ensuring patient-centred care plans are developed;
- Treatment summary. Following completion of treatment, ensuring patients understand any lasting consequences or side effects of treatment, is vital. It is also important that warning signs of potential recurrence are recognised and patients can access timely advice and support. Understanding the plan for continued follow up is crucial. All this information will be contained within the summary;
- Health and wellbeing sessions. The health and wellbeing event focuses on any lasting impact of their cancer treatment, promoting self-management and new healthy lifestyles, with a view to both maximising recovery from cancer and reducing risks of other lifestyle associated health problems;
- Cancer care review. Patient reviews are carried out in primary care within six months of receiving notification of a diagnosis.

The Health and Wellbeing Programme funded by Macmillan has been developed and expanded over the last two years and has demonstrated real benefit to a patient's experience. It has centred around having maximum impact on the greatest number of patients and so the priority areas were the patients diagnosed with the commonest cancers such as colorectal, breast and prostate cancer. It has ensured innovation in the process of how we follow patients up after treatment. We have made huge strides forward for these patients and still have further work to do.

With funding from the Harrogate and West Yorkshire Cancer Alliance we are beginning to roll out the main components of the cancer recovery package to other cancer sites so that we can offer an equitable service to all with the main aim of providing patients and their families with evidence based, individualised care leading to an improved experience.

Photo 7: Janet, Living with and Beyond Cancer Programme Manager and Julie, Cancer Care Coordinator

We now have a Living with and Beyond Cancer Programme Manager and Cancer Care Coordinator to lead on implementing the key components within each cancer team.

Enhancing specialist cancer nursing provision

The numbers of patients diagnosed with cancer continues to increase overall which is likely due to an increasingly ageing population. We also know that people are living much longer with their diagnosis of cancer as there are more treatments available for them. Both of these factors mean that the specialist nursing teams are offering more patients advice, information and support at diagnosis and whilst living with and beyond cancer. This has added significantly to their workload and so looking at different ways of working is important.

With this in mind we have recruited two more cancer care coordinators to the Lung Cancer Team and the Women's Health Team. This gives patients more opportunities to speak to someone when they need advice. The coordinators have the skills to support patients on the phone and signpost them to other services if necessary so that their queries are addressed in a timely manner. They also have the skills to recognise when to refer to the specialist nurse for more specialist information and advice. This allows specialist nurses the time and opportunities to develop their services and provide more nurse led clinics so more patients have timely, individualised care alongside their treatment. It enables the teams to better collect data and demonstrates the benefit of a varied workforce.

Provision of more timely psychological support for patients and their families diagnosed with and living with cancer

Anxiety and depression related to a diagnosis of cancer may impair adherence to anticancer treatments and potentially reduce survival. It impedes a return to normal living after effective cancer treatment. It is therefore vital that there is good access to psychological support from the appropriate professionals. We are very proud of the service that patients and their families can access here in Harrogate. The clinical psychologists based in Cancer Services provide a comprehensive assessment of the psychological needs of patients and/or relatives of patients with cancer, and will support them to work through their difficulties. With better assessment of patients concerns throughout their treatment pathway and beyond, the clinical nurse specialists and other healthcare professionals are identifying more patients who would benefit from this service. This inevitably means more referrals to the service with a finite resource.

The feedback from patients tells us this is a valued and necessary service. Examples of feedback from service users are:

- *"It is such a relief to be able to tell someone how you are really feeling, to be able to describe your thoughts and emotions. It is good to feel safe."*
- *"I liked being able to talk about my problems. Somehow they don't feel too overwhelming when you talk to someone about them."*
- *"The discussions about finding out who I really am. Talking about problems never discussed with anyone before. The finding of having a heavy load lifted!"*
- *"Felt more able to cope afterwards."*

When asked how they would rate the clinical psychologist the patients who were surveyed gave us this feedback below:

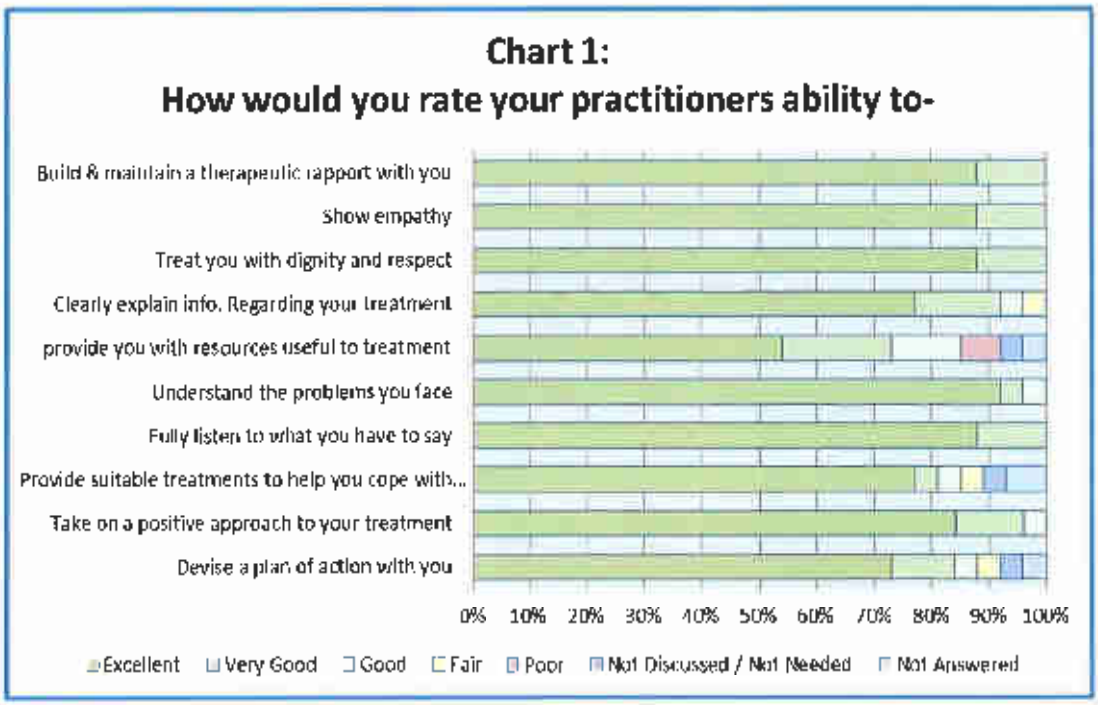


Figure 39: Feedback from patients with cancer about clinical psychologists

We are aware that caring for patients with cancer is emotionally challenging work for the nurses and other healthcare professionals. The need for clinical supervision offered by the clinical psychologists is of paramount importance to ensure the emotional wellbeing of the staff caring for patients with cancer.

Following production of a robust business case and in partnership with Macmillan Cancer Support we are in the process of recruiting another full time team member to join the Clinical Psychology cancer service. This will enable us to continue to see all the patients and family members who require support but in a more timely manner and continue to offer staff the necessary clinical supervision that they require.

Continue to develop the Macmillan Patient Information and Health and Wellbeing Service

The Macmillan Patient Information and Health and Wellbeing Service offers a range of multidisciplinary advisory, practical and self-management support services for both hospital and community patients and carers who have been affected by a cancer diagnosis. The service aims to provide the highest quality of support and information services in-line with the National Cancer Survivorship Initiative (NCSI) to maximise wellbeing across all stages of the patient pathway for patients and carers. The Macmillan Patient Information and Health and Wellbeing Service provide a non-clinical, calm and relaxed environment.

Activity data is collected and submitted to Macmillan Cancer Support, although it has become increasingly difficult to capture and record every activity or intervention due to conflicting time pressures caused by the expansion and increasing demands of the Health and Wellbeing services and lack of administrative support. Data is woefully under recorded.

The total number of recorded patient contacts for the year was down from 361 to 207 in 2017.

Information provision

The information service has ordered 2551 Macmillan leaflets and booklets, with additional information booklets supplied by:

- Myeloma UK
- The Lymphoma Association
- Prostate UK
- Breast Cancer Care
- The Roy Castle Foundation
- Dying Matters
- Carers Resource
- Age UK
- Harrogate Borough Council

Patient information leaflets have also been produced detailing the services provided within the SROMC and HDFT, and provide another source of information available to service users.

A library of cancer information books suitable for children was created in the final quarter of 2016. More books have been added to the stock during 2017 and this continues to be a well-used resource.

The SROMC page on the Trust website has continued to be updated throughout the year with the support of the Trust communications officer. All the patient information and health and wellbeing services are now available at; https://www.hdft.nhs.uk/services/cancer-services/sromc/. SROMC information and support services are also accessible via the website for Macmillan Cancer Support; www.macmillan.org and information is available via the SROMC Facebook page https://www.facebook.com/SROMCHarrogate/. This page is also linked to the HDFT and Macmillan Cancer Support Twitter and Facebook pages.

The SROMC Facebook page has been really well used during 2017 and has generated a lot of interest and positivity for the Centre. It has been used to publicise services, fundraising, celebrate staff and Trust achievements and to share valuable cancer information and other support resources across the region.

The Macmillan Welfare and Benefits Service

The Macmillan Welfare Benefit Adviser continues to operate a high quality flexible and easily accessible service, and has maintained the provision of an invaluable source of support for patients and carers affected by a cancer diagnosis living within the Harrogate and Rural District community. The service has seen increases in both the number of referrals and benefits income (see table 47) and is at saturation level by way of capacity. One new reason for this has been the impact of Universal Credit. Patients now require online assistance from the Benefits Adviser in helping make their claim as they feel overwhelmed by going through the online instruction.

The service operates Monday to Thursday. The greatest benefit of this service is it's accessibility for patients to have contact with the advisor, either face-to-face, email or over the telephone. Due to increasing room capacity pressures within the SROMC, the Macmillan Welfare Benefit Adviser began to work remotely on Wednesdays at the end of 2017. Patient and user feedback has not reflected any reduction in the quality of the service being provided, but this will continue to be monitored in 2018.

Service Activity	Activity in 2015	Activity in 2016	Activity in 2017
Numbers of new referrals	404	415	468
Total claimed in annualised benefits	£1,517,588	£1,404,215	£1,776,543
Total in backdated benefit arrears claimed	£67,024	£214,319	£206,608
Total of Macmillan grants claimed	£13,400	£16,630	£19,525
Other charitable grants	£3,336	£4,250	£6,500

Table 48: Service activity between 2015 and 2017

Numbers of referrals

There are approximately 500 newly diagnosed cancer patients referred to the SROMC chemotherapy unit each year. During 2017 96% of these newly diagnosed patients were referred to the Macmillan Welfare and Benefits Service. It had previously been believed from the demographic data that just under a fifth of all new patients attending the unit from this locality would not have any welfare benefit needs, however during 2017 that has changed dramatically with only 7% not requiring referral to the service.

It should be noted that only the numbers of new referrals are captured above. The lack of any administrative support available to the service does reduce the capacity for data collection to be undertaken. Many of the referrals received from the previous three years still remain part of an active caseload and require regular intervention from the Macmillan Welfare and Benefits Adviser. This remains additional activity which is not currently captured.

Total annualised benefits

This is the actual total amount awarded to patients who have accessed the SROMC Macmillan Welfare and Benefits Service in 2017, unlike the predicted figures provided by the Macmillan Cancer Support Line. Due to service pressure it is becoming increasingly hard to follow up benefit claims so these figures are at risk of being under reported in the future. This difficulty is caused by the increasing workload demand being placed on the role of the Macmillan Welfare and Benefits post holder and the lack of administrative support available to follow up and record successful claims. Volunteers have been able to provide some support with this during 2017, but it has been proven not to be a robust approach.

Service development

In a move to a 'paperlite' approach to documentation in accordance with the Trust's environmental policy, where possible at the end of a patient episode paper caseload notes are now scanned and stored onto an electronic patient system. This provides not only a solution to case note storage which has a financial benefit, but also enables other healthcare professionals involved in a patient's care to access benefit and welfare records. Multi-professional access to this patient information has prevented some repeat referrals and enabled a greater approach to holistic care. However the lack of administrative support available to the service, has prevented case notes being uploaded on to the electronic system in a timely manner throughout the year

The Complementary Therapy Service

The Complementary Therapy Service has continued to operate under increasing pressure as a result of increasing demand, due in part to its fantastic reputation and the benefits of the interventions offered. During 2016 the average wait for the first treatment from referral was 61 days; this has increased significantly in 2017 to 85, with a maximum wait of 422 days from referral to the first treatment. At the close of 2017 there were 160 patients on the waiting list, 60 of those were classified as urgent. To mitigate negative feedback due to the long waiting times being experienced by patients, the number of treatments offered to patients has been reduced from six to four in line with the number offered to carers.

A volunteer therapist has provided some treatments with reflexology and massage during 2017, and this will be resuming again later in 2018. Careful recruitment, supervision and planning is undertaken. A newly qualified therapist is now in post and auricular acupuncture is now available. This will enable up to ten patients to be treated during a morning session. Provision of auricular acupuncture has been chosen specifically as there is lots of evidence to support its benefit for patients suffering from the effects of chemotherapy and hormone treatments. It is particularly helpful in the management of hot flushes, peripheral neuropathy, pain, nausea and insomnia.

	2015	2016	2017	% difference between 2017 & 2015
Number of referrals received	134	187	229	+59%
Number of treatments given	502	704	939	+53%
Number of patients treated	82	95	127	+64%
Number of carers treated	17	13	16	-2%
Number of men treated	32	23	53	+60%
Number of women treated	67	85	176	+38%

Table 49: Breakdown of those treated and numbers of treatments

The most common reason for treatment is stress, with pain and insomnia as other key reasons.

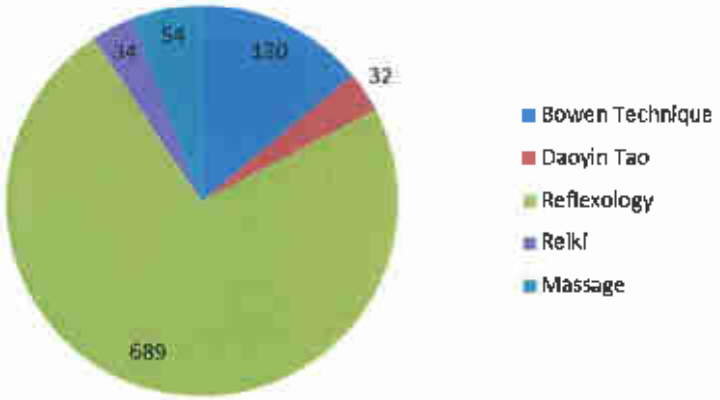


Figure 40: Breakdown of the type of complementary therapy treatments given

Reflexology continues to be the most common treatment given. The reason for this is most likely due to the benefit this treatment has on a wide range of physical symptoms and side effects experienced by patients undergoing cancer treatments. Reflexology is often combined with guided visualisation, used to reduce anxiety. This self-management practice is particularly useful for those patients undergoing stressful procedures or scans etc.

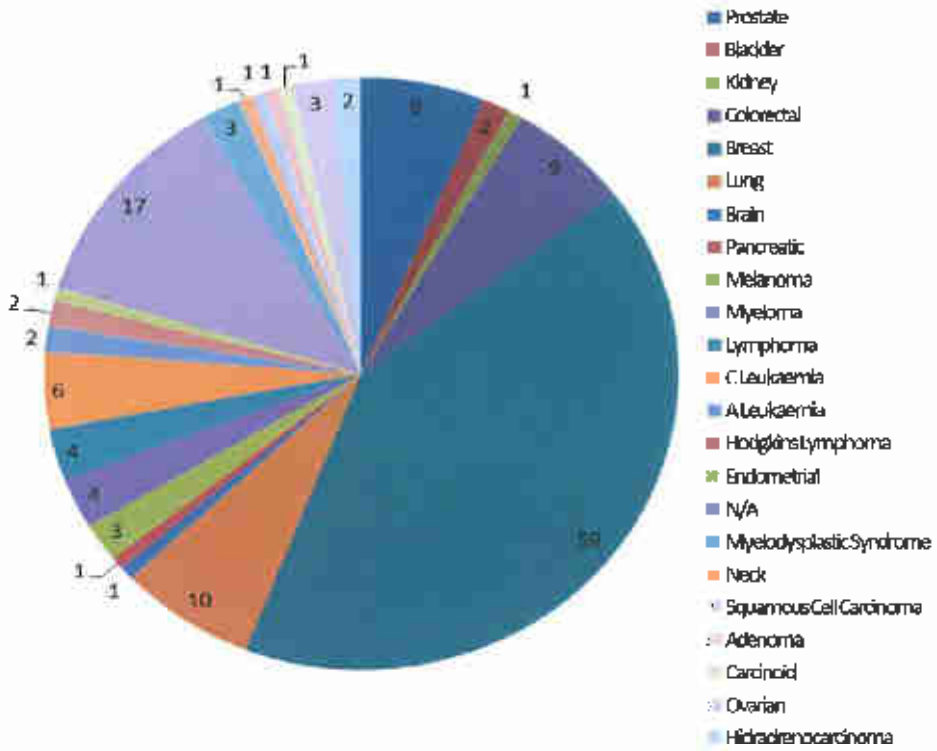


Figure 41: Cancer type treated with complementary therapy

Breast cancer is the most common cancer type being treated in the chemotherapy unit and so continues to generate the most referrals to the complementary therapy service.

Fundraising to sustain the service has grown through the efforts of staff within the unit. Two events were held specifically in aid of the complementary therapy charitable fund, and raised a total of £18,000 towards the current annual £30,000 cost. A single donation of £10,000 was also given to benefit the service in April 2017.

A commitment to explore options to facilitate future expansion of the service continues.

A business case has also been presented and agreed to develop the first NHS approved Complementary Therapy Training School. Income generated form the training courses will be reinvested back into the complementary therapy service to enable sustainability and further expansion. Students will be required to undertake a clinical placement under supervision in an NHS healthcare setting. These placements can be used to help reduce current waiting time demands and expand access to the service in other areas of the Trust.

The Hair Loss Support Service

During 2017 the Macmillan Patient Information and Health and Wellbeing Manager undertook a comprehensive service review of the hair loss support services provided through the SROMC. Meetings and visits were held with stakeholders, suppliers, staff and patients. A new supplier of headwear was sourced to add to the collections already provided. Since the introduction of this new range, sales have begun to increase again. A new 'drop in' session started in January 2018 combined with beauty demonstrations, post-surgery bra ranges and mini spa treatments. The changes made to the services provided by the SROMC were led by the findings of the service review, and they will continue to be re-evaluated regularly to ensure they meet user need, offer value for money and are efficient.

Wig Fitting Service

Orthotics has continued to hold the wig fitting service within the SROMC during 2017. A clinic is held fortnightly and wig fitting is provided by a representative from 'Hair Plus' based in Leeds. The service is also accessed by dermatology patients requiring wig fitting for alopecia.

During 2017 the Macmillan Patient Information Manager and a Chemotherapy Unit Sister visited 'Betty Brown' an alternative NHS wig fitting provider in York. Patients can now be signposted here if it is logistically easier for them or they would like an alternative choice.

SASH (Silks and Scarves of Harrogate)

A review of the SASH service was undertaken as it was becoming increasingly quiet with very little stock being sold at the weekly drop in sessions. The volunteers, many of whom had supported the service for a significant period of time were also now struggling to cover the rota due to changes in personal circumstances. Attempts were made to improve the attendance of patients using a range of approaches, from piloting sessions on other days, increased publicity and moving a display of headwear into the Macmillan Cancer Information and Support Service (MCISS). Whilst headwear sales increased slightly during the week from the MCISS, the changes made little difference to the number of people attending the sessions. Following consultation with the volunteers it was agreed to discontinue the Wednesday drop in session. The service is funded through the SASH charitable fund and it continues to be sustainable through the reinvestment of headwear sales and the charitable donations it receives.

Volunteer Hairdresser

Patients who have been affected by hair loss caused by their cancer treatment continue to be referred and signposted to the SROMC volunteer hairdresser consultation service. The consultation remains a free service and patient feedback continues to reflect a high quality service.

Boots 'Feel More Like You' Beauty Therapy Sessions

The partnership between the SROMC and Boots UK in Harrogate has continued to grow and strengthen over the course of the year. The programme of monthly beauty therapy sessions has remained a popular and beneficial service for women receiving cancer treatments. It offers professional beauty advice on skincare, make-up, eye make-up and nail care.

Having delivered the programme in the same way for the last three years, we were keen to review the format with the Boots No7 beauticians. From January 2018 beauty demonstrations by Boots No7 beauticians will be part of a 'One Stop, Beauty and Hair Loss Session' held fortnightly within the SROMC, and run alongside hair loss support and mini spa treatments.

Rudding Spa and Jennifer Young

The SROMC health and wellbeing services were invited to work Rudding Park Hotel and Spa to support the training and development of their Spa therapy services in the hotel's brand new £9 million luxury spa.

During 2017 we have worked with the staff at Rudding Park and Jennifer Young who has created a range of beauty therapy products safe for cancer patients to use within a spa setting. Patients from the SROMC have been able to experience the treatments while the therapists receive the training needed to practice. Jennifer has also been very supportive in the plans for the SROMC Complementary Therapy Service to develop an NHS approved complementary therapy training school. Rudding Park Hotel and Spa has generously agreed to provide a spa therapist trained in these cancer treatments twice a month as part of our 'One Stop, Beauty and Hair loss Session'.

The Oesophageal Patient Association (OPA) Support Group

This group has continued to meet once a month within the SROMC throughout 2017. The OPA provide local support to patients and carers affected by cancer of the oesophagus. The group continued to go from strength to strength during 2017 with the meetings attracting a good number of attendees throughout the three hour session. It is particularly useful to patients from the Harrogate area, as it provides a local drop in facility for patients before or after their clinic appointments. The group is also supported by the Colorectal and Upper Gastrointestinal Cancer Care Co-Ordinator within the Trust.

TLC (Talking and Listening Club)

TLC is a patient led support group. It offers support sessions available to anyone affected by a cancer diagnosis and is held in the SROMC. The group meets once a month and is supported by the Macmillan Patient Information and Health and Wellbeing Manager and the Macmillan Health and Wellbeing Programme Manager. User feedback is collected for evaluation and to identify topics of interest that may require a guest speaker.

Art Therapy

A new art therapy service was introduced during 2017. A qualified volunteer art therapist has provided fortnightly sessions in the SROMC. Art therapy is proven to be effective in helping patients and carers affected by a cancer diagnosis. It provides them with an alternative approach to work through emotional issues using a range of creative art techniques. This service is directly linked to the Clinical Psychology Service, and referral is made by the clinical psychologists. Some patients on the waiting list to see a clinical psychologist have been offered art therapy, and in some cases it has relieved pressure from the clinical psychology service. Each fortnight the art therapist is able offer three hour long sessions to individuals, or one hour long group session for up to four people. The service is funded through charitable funds donated to the SROMC. The testimonial below demonstrates the benefit of this therapy;

"You really did make a huge difference at the hardest of times, so very grateful to you"

Citizen Advice Bureau

The SROMC developed a new partnership with Citizens Advice Bureau (CAB) in 2017 to pilot a satellite venue for an outreach CAB in the SROMC twice a month. The clinic began in the last quarter of 2017 and offers help with:

- Money and credit problems;
- Employment;
- Consumer rights;
- Housing;
- Neighbourhood disputes;
- Education and healthcare;
- Immigration and residency issues;
- Human rights;
- Family and personal issues.

To date six patients have received support and help, and the service is set to continue through 2018.

SROMC Volunteers

The number of volunteers supporting the services provided within the SROMC has reduced in 2017 from 21 to 14 at the year end. This has been in part due to changes to the service delivery of SASH and changes in a number of the volunteers' personal circumstances. Five new volunteers have joined the unit to provide supportive roles. Volunteer roles in 2017:

- Serving lunches and beverages to patients attending for cancer treatments;
- Administration support to CNS, MCISS and the benefit service;
- Patient information support;
- Meeting and greeting patients;
- Gardening;
- Hair loss support services;
- Beauty therapy;
- Complementary therapy.

The added value and quality that the volunteers supporting the SROMC have provided to both service provision and the patient experience across a wide range of roles throughout 2017 cannot be underestimated. New roles with specific skill sets that would be beneficial to support services within the SROMC are being explored for 2018/19.

Summary and next steps

The overarching aim for cancer services at HDFT is to provide individualised patient treatment and care. We are passionate about providing services as close to home as possible and continually aspire to put the necessary resources into ensuring we can treat and support an ever increasing number of patients in our local hospital. We are keen to ensure that patient feedback influences our services and that we listen to what our community is telling us. Over the last year we have:

- Achieved timely access to services;
- Recognised and implemented the varied levels of support required by patients to live with and beyond cancer;
- Recruited a number of skilled and experienced individuals to enhance our services to the benefit of our patients;

- Continued to work positively with our partners across the Yorkshire region.

For the future we need to be aware of the many new challenges we face locally and nationally and recognise clearly what our plan will be. Key areas to focus on next year are:

- Provision of a robust Acute Oncology Service with seven day cover;
- Holistic needs assessments by all cancer nursing teams for patients newly diagnosed with cancer;
- Stratifying the follow up of patients who have undergone cancer treatment;
- Offering treatment summaries to patients at the end of their treatment;
- Obtaining timely patient feedback in more innovative ways.

4.8. DUTY OF CANDOUR

A statutory duty of candour was introduced by the CQC in March 2015 with detailed guidance for providers on how to meet the regulations. The aim of the duty of candour is to ensure that providers are open and transparent with people who use services in relation to care and treatment. There are specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology. The Trust promotes a culture that encourages candour, openness and honesty at all levels, and a culture of safety that supports organisational and personal learning.

This year, the processes for duty of candour have continued to be further embedded throughout the Trust. Weekly monitoring of outstanding cases and quarterly assurance monitoring continues to ensure that all relevant cases have the duty applied. This is reported to the Improving Patient Safety Steering Group in the quarterly patient safety report.

	Q1	Q2	Q3	Q4	2017/18 total
Number of moderate or above incidents	68	66	91	122	**347**
Number not triggering DoC (staff/not HDFT)	23	16	35	42	**116**
Number where trigger unclear due to lack of confirmation of severity	0	0	0	1	1
Number where DoC triggered	45	50	56	79	**230**
Of those where DoC triggered:					
Number where DoC clearly applied	**44 (98%)**	**48 (96%)**	**55 (98%)**	**71 (90%)**	**218 (94.8%)**
Number where a decision has been made NOT to apply DoC for documented reasons (e.g. patient lacks capacity, no NoK details)	1 (2%)	2 (4%)	1 (2%)	7 (9%)	**11 (4.8%)**
Number where DoC outstanding	0 (0%)	0 (0%)	0 (0%)	1 (1%)	**1 (0.4%)**

Table 50: HDFT Duty of Candour incident 2017/18 (Data correct as at 25/04/2018)

4.9. PUBLIC AND PATIENT PARTICIPATION STRATEGY

A guiding principle for HDFT is to put patients first;

You matter most

In support of this we seek to secure the involvement of the patients, service users, families carers and the public in our work to deliver excellent healthcare.

What were we aiming to achieve?

Public and patient participation is defined as the active participation of citizens, patients and carers and their representatives, and Foundation Trust members in the development of health services and as partners in their own healthcare. We have an aspiration to embed a culture of genuine patient and public participation in the organisation.

What have we done?

During the year we have commenced work on the preparation of a Public and Patient Participation Strategy for the period 2018 to 2021. The strategy will include pledges to strengthen public and patient participation over the coming years. The strategy will build on and seek to expand the many ways the Trust already seeks participation from the public.

Figure 42: Youth Forum's hoped for Healthcare at HDFT

As reported in detail in section 2.2 item 5 of this report, the HDFT Youth Forum are a group of young people aged 13-19 who are passionate about giving young people a voice in decision making about the future of healthcare in this area.

Over the past year, the HDFT Youth Forum have worked hard to develop seven standards or 'hopes' by which we as a Trust can assess our services in providing child and young person centred care. The document *'Our Hopes for Healthcare at HDFT'* was a fully co-produced piece of work between the Youth Forum and the Children's and County Wide Community Care Directorate.

The Youth Forum is now consulting with other children and young people to see if the 'hopes' represent their views too. An online survey, paper questionnaires and discussion groups will be used to reach out to children and young people from a range of backgrounds and experiences.

The results and the final version of Our Hopes for Healthcare at HDFT will be published in summer 2018 and then the Youth Forum will work with HDFT staff to turn their hopes into reality.

4.10. MENTAL HEALTH

The National Enquiry into Patient Outcome and Death (NCEPOD) report, Mental Health in General Hospitals: Treat as One (2017) highlights the quality of mental health and physical healthcare for patients aged 18 years or older with a significant mental disorder who are admitted to a general hospital. The report takes a critical look at areas where the care of patients might have been improved. The report states;

> 'The integration of all healthcare professionals to provide care as needed for each patient is a crucial part of the solution to providing a higher quality of care to all patients'.

Figure 43: NCEPOD study report into the treatment of mental health patients in general hospitals: Treat as One.

Key findings from the NCEPOD: Treat as One report 2017 are:

- 118/175 (67.4%) hospitals with an ED had a specific assessment room for mental health patients;
- 185/230 (80.4%) hospitals had a liaison psychiatry service with 145/185 (78.4%) on-site;
- Self-harm patients were automatically referred to the liaison psychiatry team in 122/178 (68.5%) hospitals;
- There was a protocol for the treatment of patients with mental health conditions in 123/211 (58.3%) hospitals. This included details of mental capacity assessment in 106/121 (87.6%), self-harm management in 91/117 (77.8%) and 1:1 mental health observations in 88/116 (75.9%);
- 21/190 (11%) hospitals shared complete access to mental health community records;
- The discharge summary was routinely copied to the patient's mental health team (for patients with mental health conditions) in 33/203 (16.3%) hospitals and to the patient's named psychiatrist in 20/198 (10.1%) hospitals;
- Inadequate mental health history was taken in 101/471 (21.4%) patients at initial assessment and 208/424 (49.1%) during consultant review;
- Mental health risk issues were recorded in 161/476 (33.8%); of those not recorded 140/261 (53.6%) should have been.

There is also a national CQUIN indicator for 2017/19 to improve services for people with mental health needs who present to emergency departments. The NCEPOD report and the CQUIN indicator are to improve understanding and the response to people with mental health needs in general hospitals. As a result work is being promoted nationally and progressed locally to identify and support people who use emergency departments frequently to access mental healthcare during periods of relapse or distress. This may be an appropriate way to access care but in some circumstances patients would be better served by a collaborative care planning approach which clearly states how the person presents during periods of relapse, what the patient is likely to need and how best to access it before it becomes an emergency need.

What were we aiming to achieve?

Mental health and acute hospital providers aimed to work together with other partners (primary care, police, ambulance, substance misuse, social care, voluntary sector) to ensure that people presenting at ED with mental health or psychosocial needs have these needs assessed, recorded and met more effectively through improved collaborative working.

We would like to enable patients to access the most appropriate service for their needs quickly and for all services to have access to relevant information to support that individual.

Patients who have a frequent need for help and support and usually attend the ED should have a plan in place which has been agreed with the individual, their community workers, GP, and family or carers where appropriate. The plan should be available to the patient and to all professionals who might need to support the patient to access the right service at the right time and should include relevant history, risk and crisis plans.

For this to be effectively implemented services such as ED, mental health, social care and other providers need to share plans and information so people do not have to tell their information to many different professionals when they need help.

Regarding Treat as One, we aimed to review the report, undertake a gap analysis and develop an action plan to deliver improvement in the care of patients with a significant mental disorder who are admitted to the acute general hospital.

What have we done?

In order to measure the potential impact of this collaborative approach we have created a method to identify an initial group of patients who frequently attend ED with mental health needs. We have worked with our local mental health provider Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust to implement a process to ensure collaborative crisis plans are developed with the patient and their primary health worker and shared with the relevant professionals. These plans clearly state the actions preferred by the patient to meet their needs including who should be contacted, where the best place is to get assistance and what risks the patient might experience during a relapse.

We have reviewed how often this group of individuals attended ED, the reasons for the attendances and whether a crisis care plan is in place which meets their needs.

HDFT and TEWV staff have worked together to review the Treat as One report and we have developed an action plan with named leads and timescales for action.

What are the results?

In December 2017 the working group leading on the CQUIN reviewed the initial list of people who frequently attended ED and confirmed that nine of the original cohort of 14 had attended ED more than once since initial identification. The number of attendances for those patients had almost all reduced and overall visits to ED for this group had reduced by 36%. Local mental health services were involved in the care of all 14 and plans were in place to support them in the community. ED and the hospital based Mental Health Liaison Service had access to the plans and could refer to them in the event of the patient presenting.

The next cohort of patients has now been identified and discussed with our mental health partners in order that they can create collaborative plans with patients who are developing an ongoing need as early as possible. The process will be undertaken monthly via a

collaborative Safe Focus Meeting which will enable cross organisational planning for people who frequently access services and need support.

Summary and next steps

In summary, the initial phase of the national CQUIN was very successful and demonstrated the positive effect of coordinated, collaborative working for patients and their families. Access to the relevant information to support direct access to the most appropriate service for that individual the first time is better for the patient, better for their families and carers and more cost effective overall.

We are still embedding the process and working with partner agencies to make further improvements in how we share information and reduce delays and repetition for people accessing services. We will be working on the NCEPOD: Mental Health in General Hospitals: Treat as One action plan in 2018/19 and we hope to have further evidence of impact later this year.

4.11. COMMUNITY TEAMS AND SUPPORTED DISCHARGE

In 2017, the Trust held a week-long initiative called "Every Hour Matters" in March. The week focused on inpatient care with the aim of testing a number of ideas which would safely reduce the amount of time patients spent in hospital. During this week community occupational therapists and physiotherapists conducted two small trials to "reach into" the acute hospital setting. They tested whether community teams could support earlier discharge home and perform functional assessments in a patient's home environment. Following the success of these trials a pilot Supported Discharge Service (SDS) team was created and launched in July 2017.

What were we aiming to achieve?

The aim of SDS is to reduce the length of stay in hospital by helping patients home after an admission. The service carries out physiotherapy assessments and occupational therapy assessments in the patient's own home rather than the hospital environment. This can give a more accurate picture of how the person will cope at home, as assessments which take place in an unfamiliar environment such as hospital lead to poorer results, especially for patients with cognitive deficits. The team also provide support visits providing rehabilitation for up to 72 hours after discharge.

The ongoing development of the SDS service has been underpinned using the principles of the growing body of evidence and government initiatives such as the NHS Five Year Forward View (2014), and Quick Guide: Discharge to Assess; Transforming Urgent and Emergency Care Services in England (2016). The discharge to assess guide and NICE guidelines confirm that the transition from the inpatient hospital setting to a community setting is the 'right thing to do'.

Patients who remain in hospital for periods of more than 24-48 hours experience physical de-conditioning and deterioration in their function leading to poor outcomes. This is especially relevant to frail elderly people and creates further health and social care needs which may be avoided if early assessment and care is delivered in the patient's own, familiar environment. SDS intends to promote patient flow through hospital so that patients suffer fewer complications from hospital admission.

What have we done?

SDS is a small therapy led team consisting of physiotherapists, occupational therapists and support workers. Since July 2017 they have supported over 350 patients home, saving approximately 2-3 hospital bed days per patient. Community ready or medically fit patients are assessed for their suitability for the service on the ward in collaboration with ward based therapists. If suitable they are discharged home the same day. Assessments take place once at home and the appropriate rehabilitation or support programme is put in place for the next 72 hours. If ongoing support is required patients are referred to an appropriate team or service.

Links have been developed and improved between community and hospital based therapies by trialling ways of linking discharge pathways at the earliest opportunity. SDS has also reduced the number of referrals between services and avoided the delays that come with multiple referrals to different teams and agencies. They have also worked well with voluntary services such as the Red Cross and Age Concern. The service allows patients immediate access to support in their own homes which enables timely, safe discharge which benefits both patient and the services supporting them.

During January and February 2018 to manage winter pressures the Trust opened additional community beds in which patients have been case managed and provided with therapy interventions by SDS. They have tested new ways of working and managing therapy interventions in community beds together with colleagues from North Yorkshire County Council.

What are the results?

SDS has demonstrated its success in promoting early discharge and improving flow through the hospital. It has had a positive impact on patient experience and decreased the risk of deconditioning. The patient and family are at the forefront of any decisions made about discharge and feedback from them has been positive. Ward staff also feel the benefit and they value the contribution their colleagues in SDS make on a daily basis

Figure 44: Word cloud of patient and family feedback about the Supported Discharge Service

Summary and next steps

Despite only functioning since July 2017 the team is fully operational between the hours of 8am and 6pm and ready to operate beyond March 2018. We are currently working on a business plan to secure the future of the SDS team on a permanent basis as its success has been widely recognised.

The work it has done has informed the future development of discharge pathways, therapy provision in hospitals and community and the management of community rehabilitation beds. Its close work with other agencies has allowed further integration with other services such as NYCC and the voluntary sector and will continue to develop closer links between hospital and community.

4.12. BEING READY FOR WINTER

The Trust proactively plans for periods of increased pressure. It is known that during the winter period more patients attend ED and more patients are admitted to hospital. Therefore, the Trust works with HaRD CCG and other partners to ensure we have plans in place to care for more patients.

This year as well as the usual winter planning, we analysed previous winters and identified the first week following the New Year bank holiday as being a time when we might experience the most severe pressures on the hospital. To minimise the impact of this we planned a *Breaking the Cycle* week, a National initiative to shift the focus of the Trust to acute flow over planned work. The Trust named its own initiative, *Every Hour Matters* week

What were we aiming to achieve?

During the winter period from December 2017 to March 2018, we aimed to reduce the number of patients who were delayed transferring out hospital to either their own home with a package of care, or to a residential or nursing home. We also expected to see an increase in the number of attendances to the ED and the number of emergency admissions. A key aim was to increase the number of clinical staff available to care for and treat more patients.

The main aim of this Every Hour Matters week was to ensure the wider health and social care system supported the hospital to recover after two long holidays at Christmas and New Year. We aimed to achieve a number of outcomes during the week:

Flow

- 90% bed occupancy by Sunday 7 January 2018;
- 98% of patients discharged from the ED within four hours of arrival;
- 5 empty CATT beds at 8am each day.

Discharge

- 33% of all patients discharged to leave the wards by noon with the first discharge going from the ward by 10am;
- Reduction in the number of patients in hospital seven days or longer;
- 20% of patients who have triggered for Continuing Healthcare (CHC) assessments to be transferred to the community for Decision Support Tool (DST).

Quality

- No operations cancelled due to lack of availability of a bed;
- No more than five medical patients outlying in surgical beds at any one time.

What have we done?

Using additional money allocated by either the government or by the Trust itself we took the following actions:

Urgent and Emergency Care

The ED was allocated an additional nurse and consultant in the evenings to help at busy times in the department. An additional Emergency Nurse Practitioner was also allocated to shifts to see and treat patients attending with minor injuries.

Additional nurses were allocated to CATT ward to support the expected increase in emergency admissions to hospital. An additional acute physician was also recruited on a temporary basis to provide extra medical cover to CATT ward. It is known that at times of extreme pressure, patients are not always able to be admitted to the specialty ward they require and may be admitted to an alternative ward. With this in mind, the Trust recruited a doctor on a temporary basis to oversee the care of patients on alternative wards.

Wards

Over the winter period an additional agency pharmacy technician was made available to the wards to dispense discharge medications. The Trust also took the decision to book bank and agency nursing staff on the wards, and an additional locum registrar was appointed to medical patients who, due to bed pressures, were placed on surgical wards. Additional resource was placed in the Speech and Language Therapy (SALT) Team to support timely assessment of patients on wards.

A transfer team was set up to support the movement of patients and preparation of bed spaces. This team linked to the Clinical Site Management Team and focused predominately on maintaining flow through CATT ward.

Discharge from the hospital

A number of actions were taken to support timely discharge home from hospital over the winter period:

- Extra support from the Red Cross to help transport patients home and undertake small jobs such as shopping and making appointments;
- Extra ambulances from Yorkshire Ambulance Service (YAS) were paid for to transport patients to residential and nursing homes;
- The Trust increased the number of community rehabilitation beds by opening eight additional beds at Ripon Community Hospital and purchasing eight places at a local nursing home. To support more rehabilitation in the community, the Trust increased the number of therapists in the Supported Discharge Service. This team also supported the identification of patients to be managed in the additional beds and supported their rehabilitation needs and discharge planning once they were moved into the out of hospital beds;
- Additional staff were recruited to the Discharge Planning Team to help plan for and organise the discharge home of patients;
- The CCG worked to improve the discharge process for patients who are likely to need long-term packages of care in their own home or require 24 hour care in nursing or residential home. A new pathway has been developed which means that patients will no longer have their long-term needs assessed in hospital. Instead, patients will be supported to an interim care placement whilst health and social care work with the

patient and their family to assess what type of care will be most suitable in the longer-term.

Every Hour Matters

For the duration of the first week of January 2018, HDFT cancelled all non-essential meetings so all staff could be available to help the wards. Wards were supported by a ward liaison officer each weekday from 9am until 5pm. This role was undertaken by matrons, general managers and service managers and they supported the wards with actions for discharges and helped to resolve or escalate delays in patient care. A number of staff from non-clinical services also volunteered for a couple of hours each day to offer practical help with activities such as handing out meals and drinks, helping to put stores away, filing records and chatting with patients.

The Trust hosted a silver command with representatives from partner organisations including NYCC, HaRD CCG and TEWV NHS Foundation Trust. The silver command was based at Harrogate District Hospital, with members making themselves available to resolve issues escalated via the ward liaison officers. They attended ward rounds and focused on helping to safely but rapidly discharge patients who had been in hospital for more than seven days.

What are the results?

Overall, the Trust has seen a reduction in delayed transfers of care. Like many trusts across England, HDFT had a surge of influenza cases in December 2017 which affected admissions and discharges from the hospital. The hospital had an increase of approximately 4.95% admissions in December compared to the same period in 2016, but approximately 10% fewer discharges.

Summary

The Trusts winter plans included additional staff allocated to the ED and wards. The Trust has also used additional money provided by the Department of Health to fund extra community rehabilitation beds and transport home from hospital. Like other trusts locally and nationally, HDFT has had a challenging winter period. However, we have maintained flow through the hospital and have achieved 95% of patients seen and treated or admitted within 4 hours for the whole year.

4.13. EQUALITY AND DIVERSITY OBJECTIVES

On 5 April 2011, the public sector equality duty (the equality duty) came into force. The equality duty was created under the Equality Act 2010. There is an obligation on public authorities to positively promote equality, not merely to avoid discrimination. Public sector organisations are required to demonstrate that they are giving 'due regard' to the needs of protected groups. This means that equality issues must be considered and evidenced in the decision making process.

The refreshed Equality Delivery System for the NHS (EDS2) was published in 2013 to help local NHS organisations in discussion with local people, review performance for people with characteristics protected by the Equality Act 2010 and improve performance for patients, public and staff. At the heart of EDS2 are 4 goals and 18 outcomes to assess and grade against, asking the question:

"How well do people from protected groups fare compared with people overall?"

In addition, the Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. The Accessible Information Standard is based on the requirement to implement:

1. **Identification of needs:** a consistent approach to identification of patients, carers and parents information and communication needs where they relate to a disability, impairment or sensory loss.
2. **Recording of needs:** as part of patient / service user records and systems.
3. **Flagging of needs:** establishing and using e-flags or alerts to indicate that an individual has a recorded information and/or communication need and to prompt staff to take appropriate action and/or trigger auto-generation of information in an accessible format.
4. **Sharing of needs**: inclusion of recorded data as part of existing data-sharing processes and as routine part of referral, discharge and handover.
5. **Meeting of needs**: taking steps to ensure the individual receives information in an accessible format and any communication support which they need.

It is now the law for the NHS and adult social care services to comply with the Accessible Information Standard.

Figure 44: Protected characteristics and disadvantaged groups as defined in EDS2

What were we aiming to achieve?

At HDFT, we have been aiming to improve our understanding of how well people from protected groups fare compared with people overall in relation to the wide variety and location of services and staff. We established equality objectives and have been progressing a plan of work. Regarding the accessible information standard, we have focused initially on patients with learning disabilities (LD) and were aiming to:

1. Ensure that people with learning disabilities' hospital records are flagged to allow the provision of appropriate communication support.
2. Ensure that easy read information is readily available to staff and patients to support communication with those that would benefit from this format.
3. Provide easy read appointment letters for all patients flagged as having learning disabilities.

What have we done?

Key areas of progress during 2017/18 have been:

- Work to achieve better health outcomes for patients with learning disabilities with:
  - Promotion of the LD flag on hospital records both internally and externally. Flagging is prompted on the new 'Enhanced Admission Proforma for Patients with Learning Disabilities';
  - Provision of LD community services for children in Harrogate and raising awareness of LD flagging;
  - Establishing a link to 'easy health' from the LD page on the Trust's website.
  - The LD Liaison Nurse providing bespoke easy read information for individual patients and specialist communication support where required;
  - Involvement in the review of sample easy appointment letters. Feedback from the LD liaison nurse and the Trust's Symbolic Language Advisor has raised concerns regarding their suitability, and there will be wider consultation, targeted specifically at patients with learning disabilities that use easy read information;
- Working with disadvantaged groups e.g. the Gypsy, Roma and Traveller Communities in County Durham;
- Highlighting to staff the resources available for people with hearing impairment;
- Development of a systematic approach to full compliance with the Accessible Information Standard;
- Dementia friendly signage on Jervaulx and Byland wards, and re-establishing dementia training and a matron for patients with dementia;
- Development of an equality impact assessment toolkit for all service improvement, transformation and cost improvement programmes;
- The identification of a location that we hope will provide Changing Places facilities within working hours in the new Endoscopy Unit;
- Engagement with a wide variety of local stakeholders via the Equality Stakeholder Group;
- The re-launch of the Workforce Equality Group which now meets quarterly with a revised terms of reference;
- Further implementation of the Armed Forces Covenant;
- Informing the Board of Directors about the drivers for improving impact assessments and ensuring a focus on equality;
- Incorporating equality into our patient and public participation strategy work;
- Promoting information about equality and diversity at our Annual Members Meeting.

What are the results?

1. We currently have 412 patient records that have a learning disabilities flag;
2. The link to easy read information on the website is active. This allows patients, their families or their carers to access easy read resources.
3. Bespoke easy read information continues to be available from the LD Liaison Nurse;
4. The updated EDS2 self-assessment, which contains the equality objectives, is on the Trust website at https://www.hdft.nhs.uk/about/equality-and-diversity/;
5. HDFT has been recognised as one of the country's leading employers for their support of Armed Forces personnel.

Summary and next steps

Much of this work will continue during 2018/19 and we are progressing:

- A generic risk flag on electronic records to indicate an "accessible information need".
- Linking this flag to a register of the patient's detailed information and communication needs using a specific module within our appointment letter software. This will enable the recording of specific needs including:
    - Specific contact method - to indicate alternative communication / contact methods e.g. people who are d/Deaf may not be able to use a telephone to book / amend appointments and alternatives including email, text messaging, telephone and text relay can be specified;
    - Specific information format e.g. need to send correspondence or provide information in an alternative, non-standard format;
    - Communication professional needed: e.g. British sign language interpreter, lipspeaker, interpreter for Deaf/blind people;
    - Communication support: use of aids or equipment e.g. hearing aids, hearing loop etc;
    - Alternative formats for information for the patient and the carer.

The aim is to flag and register people we are already aware of and then start to identify others with communication needs. Some technical work is required, and then we need to establish a process to ask for this information, apply the flag and add the detail of information needs. Once in place there will need to be a patient and staff awareness raising campaign.

4.14. PRIORITY CLINICAL STANDARDS FOR SEVEN DAY HOSPITAL SERVICES

The key drivers for seven day working were aimed at improving patients' experience and addressing the inequalities in outcomes based upon the day of the week that a patient was admitted to hospital. The ten clinical standards for seven day services in hospitals were developed in 2013, and founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven day services should achieve, no matter when or where patients are admitted.

With the support of the AoMRC, four of the ten clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

There is further information at Seven day services: clarification of the four priority clinical standards | NHS Improvement.

By March 2017 HDFT had already undertaken a significant amount of work to begin moving towards the delivery of seven day services with:

- 8am to 8pm consultant acute physician presence on the acute medical wards Monday to Friday;
- Morning and evening post-take medical rounds on Saturdays and Sundays;

- Additional consultant physician ward presence on base medical wards for half day on Saturdays and Sundays;
- Specific Stroke Unit ward cover 8am to 2pm on Saturdays and Sundays, with a telemedicine stroke rota staffed by an alliance arrangement with neighbouring organisations ensuring that any stroke patient admitted is seen by a stroke physician at any time of day or night;
- Increased consultants in emergency medicine to ensure a consultant presence in the department seven days a week during the day and throughout the evening (Monday to Friday);
- General surgical consultant of the week model, ensuring that there is dedicated acute consultant cover seven days per week, with no elective commitments.

Audits for standards 2, 5, 6 and 8 were undertaken in 2016 and repeat audits were undertaken in 2017.

Clinical Standard	Requirement	Target	2016		2017	
			HDFT Weekday	HDFT Weekend	HDFT Weekday	HDFT Weekend
2 (revised 2017)	Consultant review within 14 hours of *admission* at hospital	90%	60%	59%	59%	66%
5	Access to diagnostics – *Immediate* clinical need – 1 hour	90%	93%	57%	*These standards have now changed and rely on self-declaration from each Trust - see below.*	
5	Access to diagnostics – *Urgent* clinical need – 12 hours	90%	93%	55%		
6	24 hour access to consultant directed interventions	90%	87%	74%		
8	Twice daily reviews by appropriate member of team (consultant or delegate)	90%	100%	100%	100%	100%
8	Daily review by appropriate member of team (consultant or delegate)	90%	100%	93%	100%	85%

Table 51: Results of audits of priority clinical standards 2016 and 2017

Standard 5: Access to diagnostics

"Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?"

Service	Weekday	Weekend
	March 2017	March 2017
CT	Yes	Yes
Echocardiograph	Yes	No
Microbiology	Yes	Yes
MRI	Yes	Yes
Ultrasound	Yes	Yes
Upper GI Endoscopy	Yes	Yes

Table 52: HDFT Standard 5 declaration by service March 2017

Standard 6: Access to interventions

"Do inpatients have 24 hour access to consultant directed interventions 7 days a week, either on site or via formal network arrangements?"

Intervention	Weekday			Weekend		
	March 2016	September 2016	March 2017	March 2016	September 2016	March 2017
Critical Care	Yes	Yes	Yes	Yes	Yes	Yes
Primary Percutaneous Coronary Intervention	Yes	Yes	Yes	Yes	Yes	Yes
Cardiac Pacing	Yes	Yes	Yes	Yes	Yes	Yes
Thrombolysis for Stroke	Yes	Yes	Yes	Yes	Yes	Yes
Emergency General Surgery	Yes	Yes	Yes	Yes	Yes	Yes
Interventional Endoscopy	Yes	Yes	Yes	Yes	Yes	Yes
Interventional Radiology	Yes	Yes	Yes	Yes	Yes	Yes
Renal Replacement	Yes	Yes	Yes	Yes	Yes	Yes
Urgent Radiotherapy	Yes	Yes	Yes	Yes	Yes	Yes

Table 53: HDFT Standard 6 declaration by service March 2017

5. ANNEX ONE: STATEMENTS FROM STAKEHOLDERS

In accordance with the NHS Quality Accounts Regulations, Harrogate and District NHS Foundation Trust sent a copy of the draft Quality Account to its lead Clinical Commissioning Group, Harrogate and Rural District, Healthwatch North Yorkshire, North Yorkshire County Council Scrutiny of Health Committee, the Council of Governors and the Health and Wellbeing Board for comment prior to publication and received the following statements:

HARROGATE AND RURAL DISTRICT CLINICAL COMMISSIONING GROUP QUALITY ACCOUNT STATEMENT 2017/18

NHS
Harrogate and Rural District
Clinical Commissioning Group

Email: j.crewe@nhs.net
Direct Tel: 01423 799334
Reference: HaRD.046-18

LETTER SENT VIA EMAIL

Jill Foster
Chief Nurse
Harrogate and District NHS Foundation Trust

Harrogate and Rural District
Clinical Commissioning Group
1 Grimbald Crag Court
St James Business Park
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8 May 2018

Dear Jill

Quality Account for Harrogate and District NHS Foundation Trust for 2017-18.

Harrogate and Rural District Clinical Commissioning Group (HARDCCG) welcomes the opportunity to review and provide a statement for the Trust's Quality Account for 2017/18. This Quality Account has been reviewed in accordance with the Department of Health and Social Care (Quality Accounts) Amendment Regulations 2017.

This report has been shared with key individuals across HARDCCG and their views have been collated into my response.

HARDCCG remains committed to ensuring, with its partner organisations, that the services it commissions provide the highest of standards in respect to clinical quality, safety and patient experience.

It is recognised by the Commissioner that the Trust and its staff demonstrate resilience and dedication to ensure they deliver safe and effective services as referenced throughout the Quality Account and we congratulate the Trust in consistently maintaining improvements in:

- Mortality performance and continuing to build on the lessons learnt from the reviews of deaths. It would be helpful to describe how learning from all deaths and those falling into the LeDeR process is captured.
- Participation in research with an increase in the total number recruited to clinical trials and the use of Patient Research Ambassadors (PRAs) to enable a strong patient perspective to research, feasibility and quality assurance. It would be

helpful to see some examples of these research project findings and how they link to quality improvements.

- Improvements made throughout maternity services including effective smoking cessation in pregnancy and reduced smoking rates at delivery.
- Providing services that effectively meet the needs of our most vulnerable people including those with learning disabilities and mental health problems.
- Improved sepsis management especially within the Emergency Department. The Trust recognises that there is further work to do on administration of antibiotics and screening relevant inpatients. The Trust has recognised this as a quality priority for 2018/19.
- Reduction in medicine prescribing and administration errors including those causing harm and the extensive Hospital Pharmacy Transformation plan.
- Collaborative work with the voluntary sector, especially in cancer care and the significant contribution volunteers make to the patient experience, particularly in the inpatient areas. We would like to have seen more examples of where there is similar work or developments in community.
- The number of local and national audits being carried out in the Trust is commendable and it would be helpful to see more information with a focus on the measurable improvement as a result of the audit recommendations and actions.

The Trust experienced some challenges as referenced in their Quality Account due to a high demand for healthcare over a protracted winter period. However the focus on flow through the hospital was maintained and the Trust achieved a year end position which resulted in less than 4% of patients waiting to be seen and admitted or discharged from A&E. This is a strong performance position and demonstrates the impact of a focus on a number of system wide improvements and success of the local initiatives 'Every Hour Matters', work on discharge pathways including Transfer to Access and the Supported Discharge Service (SDS).

The Supported Discharge Service appears to have had an impact on reducing bed days for the patients included in the pilot service and reducing length of stay ahead of the planned discharge date. It would be helpful to see patient experience data as part of the evaluation and we would welcome this approach as part of the Improving Discharge Processes quality priority for 2018/19.

The Dementia care section is clearly documented, although there seems to be more of a focus on what is going to be done to improve the experience of people with dementia in this section e.g. 'What have we done and what were the results' has no mention of any results.

HARDCCG believe 'PJ Paralysis' is a very real and important concept but it is not an initiative just targeted at people with dementia as it is applicable to all patients, particularly the frail elderly. The same applies to the Carer's Passport and as such it would have been helpful to see the results of how this initiative had an impact on patients and their carers. The focus on delirium is really good to see and we look forward to finding out how the planned training has improved patient care at the end of 2018/19.

The Trust appears to have a real commitment through this report to patient/service user involvement. This is really evident in how the Trust are implementing their overarching strategy around hearing the voice of children and young people and their commitment to prioritising this in the development of the Youth Forum which is very welcome. This will enable us all to have a system view of young peoples' 'Hopes for Healthcare'.

Partnership working is evident throughout the report and some good examples of where improvements have been made to support patients and their carers. Of particular note should be the work in cancer care and care of the dying. This work demonstrates the improvement in information sharing and pathways. It will have a positive impact on the patient and relatives' experience.

On another positive note, the Trust should be congratulated on their results from the NHS Staff Survey 2017. We look forward to the Trust's continued progress during 2018/19.

We acknowledge the work undertaken by the Trust to improve stroke care as a priority for 2017/18. We also note reference to the limited opportunity for improvement and sustainability of the local stroke service which is being considered with system partners and the West Yorkshire and Harrogate Health Care Partnership. We would have expected a reference to a safety improvement plan developed by the Trust to support this ongoing work.

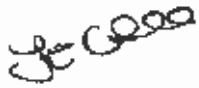
The Trust reported the progress on improving learning from the incidents, complaints and good practice 2017/18 quality priority. We were pleased to read about the number of measures which have been put in place to improve reporting of incidents. We would have expected more emphasis and progress on learning the lessons from incidents or complaints and how these will be monitored across the Trust. We recognise this priority will also be a focus for 2018/19 and look forward to seeing more significant progress particularly where there remains recurrent evidence of poor patient experience.

The Trust reported a similar number of serious incidents causing severe harm or death as reported in 2016/17. We would have liked to see more reference to the learning from these included in the narrative of the Quality Account.

The key successes of the 2017/18 quality priorities are clearly reflected in the Quality Account. We would ask the Trust to revisit the limited reference to Pathology services and Infection Prevention Control (IPC) in the report. The evidence of improvement in these areas are limited and it would be helpful to see some additional narrative of work across the hospital and community services.

We welcome the opportunity to review progress on the Trust's quality improvements and hope that our feedback is accepted as a fair reflection of the report and look forward to working alongside the Trust to achieve the objectives of the 2018/19 priorities.

Yours sincerely



Joanne Crewe
Director of Quality and Governance/Executive Nurse
Harrogate and Rural District Clinical Commissioning Group

LEEDS CLINICAL COMMISSIONING GROUP QUALITY ACCOUNT STATEMENT 2017/18

NHS
Leeds
Clinical Commissioning Group

Mrs Jill Foster
Chief Nurse
Harrogate and District NHS Foundation Trust
Lancaster Park Road
Harrogate
North Yorkshire
HG2 7SX

19 April 2018

Dear Jill,

Thank you for providing the opportunity to feedback on the Quality Account for Harrogate and District NHS Foundation Trust for 2017-18.

This report has been shared with key individuals across the newly formed Leeds Clinical Commissioning Group (formerly Leeds West CCG, North CCG and South & East CCG) and this response is on behalf of the new organisation.

We acknowledge that the report you provided for review and comment is in draft form and additional information will be added and amendments made before final publication, so please accept our observations on that basis.

The report provides some interesting information across a wide range of activities and demonstrates some very positive innovations and thoughtful reflections around the organisation's aspirations and challenges.

It is encouraging to see the organisation move into the top 25% of reporters for incidents and the positive focus on learning from these.

The organisation demonstrates commitment through this report to patient/service user involvement and in particular the engagement work with young people. The development of the Youth Forum is impressive, welcomed and to be commended. We would encourage the organisation to continue to listen to feedback and to learn any lessons from this valuable work going forward.

Partnership working is evident in the report in relation to cancer care and we were pleased to note the positive work on care of dying patients and support for their relatives. The high take up of the benefits adviser within the Cancer team is positive, and we note your collaboration with the voluntary sector to support this work.

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There are some good examples given of work that has shown a positive impact on the quality of services and care for patients such as criteria led discharge, the reduction in Delayed Transfers of Care, the focus on medical outliers and ensuring patients care and treatment is reviewed and the access to easy read material for people with a Learning Disability.

The work undertaken to improve identification and treatment of sepsis also appears to be demonstrating success especially within the Emergency Department. However there is clear progress and the Trust acknowledges that there are further improvements to be made regarding the administration of antibiotics. We would also encourage the Trust to focus on actions to improve its screening of relevant inpatients, which shows a comparatively lower performance of screening than the Emergency Department, and we look forward to seeing the continued progress.

It is good to see details of the outcome and learning from local audits included in the report and there is good evidence of data embedded within the report which gives assurance of the focus on evaluation of the impacts of various innovations. We are also pleased to see that the Trust is committed to research and development and has a large amount of clinical studies ongoing. It would be helpful to see some examples of the research projects and how they link to quality improvements.

The progress noted in the report relating to the medicines safety initiative is impressive. The work on reducing missed doses of medication, patient identity errors and medicine reconciliation in 24 hours is welcomed and the Trust is to be commended on the improvements made. In relation to insulin errors; the report states the increase since 2013/14 is related to the proactive use of the insulin dashboard, but it is not clear how this conclusion has been reached or why there has been a fall in the number of community errors.

The work on reducing falls is also to be commended. Although the data from the National Audit of Inpatient Falls indicates a reduction in compliance for some elements of falls risk assessment, the overall impact that the work is having is positive and to be welcomed.

There is evidence of some good work on Dementia care and the addition of dementia considerations into patient safety huddles is to be welcomed, along with the addition of a carer's passport to support carers.

We are pleased to see some good work relating to the improvement in quality in maternity care. Including mothers and partners in the handover process during labour is a good example of transparency in care and the collaborative working with partners in maternity is to be applauded. Although the national maternity implementation programme Better Births is referenced, the report doesn't detail the progress with this work. The opportunity

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to invest in training clearly helped to support the department and we hope that the benefits from this work will continue to help ensuring safety within maternity.

The work undertaken on the review and learning from deaths is welcomed, although the mechanisms for reviewing could be made clearer and assurance given that learning from all deaths and those falling into the LeDeR process is captured.

The Three Year Clinical Transformation Programme has had some successes and also some delays but the programme appears to have momentum and the report details the attention to the plans clearly. References to a shift in culture are present throughout the report and it would be good to see some lessons from sustained cultural change as this is particularly hard to achieve. We hope the organisation maintains the commitment and resource to support such cultural changes.

The report demonstrates in various sections, how the organisation has listened and learned from others. Sharing and learning from other projects across the locality and beyond is to be commended. Being transparent about where ideas have come from and applying them to your own setting is a very effective approach to sustaining positive change which is to be encouraged.

We note that the priorities going forward for 2018/19 are building on a lot of the good work commenced in 2017/18 and hope that the Trust commits to the areas still requiring improvement and can demonstrate the same improvements in quality for next year.

We welcome the opportunity to review the report and hope that this is accepted as a fair reflection. We look forward to seeing the progress made over the coming year.

Yours sincerely,

Dr Simon Stockill
Medical Director

Jo Harding
Executive Director of Quality and Safety/Governing Body Nurse

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COUNCIL OF GOVERNORS QUALITY ACCOUNT STATEMENT 2017/18

The Council of Governors is delighted to have the opportunity to comment on this detailed and comprehensive Quality Account.

Again, the Trust can be justifiably proud of its achievements over the last year and the Council of Governors recognise the commitment to deliver high quality care by all staff across the organisation.

Governors, as in previous years, have been extensively consulted on the Trust's Operational Plan, have contributed to the development of the quality priorities for the coming year, and have reviewed the Quality Account. Individual Governors sit on, and triangulate information from, the Learning from Patient Experience Group, departmental Quality of Care Teams, and Patient Safety visits, all of which enable them to personally experience the challenges of maintaining quality of care in different areas of the Trust's services.

Governors have in-depth formal meetings with the Board of Directors twice a year and with Non-Executive Directors three times a year. Both Executive and Non-Executive members of the Board of Directors regularly attend the quarterly public Council of Governors' meetings. In addition, Governors regularly attend as observers at Board of Directors' meetings and Board sub-committee meetings; in particular the Quality Committee, which has delegated responsibility and oversight of the Trust's progress towards achieving the quality priorities.

The Council of Governors supports and fully endorses the 2017/18 Quality Account and the quality priorities selected for particular focus during 2018/19.

Pamela Allen
Deputy Chair of Governors/Lead Governor
on behalf of the Council of Governors

NORTH YORKSHIRE SCRUTINY OF HEALTH COMMITTEE

Over the past 12 months, the North Yorkshire Scrutiny of Health Committee has continued to liaise with Harrogate and District NHS Foundation Trust to better understand some of the pressures that they face.

It is recognised that staff shortages, particularly in emergency medicine, nursing and anaesthesia can have a significant impact upon what services can be delivered from what site and for how long. The trust contributed to an in-depth investigation into health and social care workforce pressures that was undertaken by the Scrutiny of Health Committee in the autumn of 2017. The information, data and analysis provided helped the committee to appreciate the issue across the whole system and the support of the trust was much appreciated.

It is also recognised that the rural nature of the county and the length of time that it can take to travel to and from appointments can have an impact upon how services are planned and delivered. The committee, however, remains committed to ensuring that people are not excluded from services based upon where they live. The presumption is that you should be able to access the same type and quality of care no matter where you live in North Yorkshire.

The current financial pressures within the health system in North Yorkshire are of great concern. Whilst there are doubts as to whether the funding formula for health is fair and concerns that it disadvantage rural areas, we need to work together to find a way to make

the money that we have work the hardest and result in good outcomes across the health and social care system.

The Scrutiny of Health Committee remains committed to a system-wide view of services that helps to ensure that decisions on the planning and delivery of health care are not made in isolation and that the key role that a broad base of community services have to play is not overlooked. This will not be easy going forward as the health commissioners and providers in the county are pulled in three different directions as the new NHS integrated systems for planning and delivery in the West, South and North of the county are put in place.

County Councillor Jim Clark
North Yorkshire Scrutiny of Health Committee

6. ANNEX TWO: STATEMENT OF DIRECTORS' RESPONSIBILITIES

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2017 to April 2018
    - Papers relating to quality reported to the Board over the period April 2017 to April 2018
    - Feedback from the commissioners dated 08 May 2018
    - Feedback from Governors dated 12 April 2018
    - Feedback from Healthwatch North Yorkshire was requested 6 April but no comment was received
    - Feedback from North Yorkshire County Council Scrutiny of Health Committee dated 15 May 2018
    - The Trust's draft complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 16 May 2018
    - The 2016 national patient survey dated 20 July 2017
    - The 2017 national staff survey dated 6 March 2018
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated April 2018
    - CQC inspection report dated 27 July 2016
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS improvements annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board on 23 May 2018.

Angela Schofield

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Mrs Angela Schofield
Chairman

Ros Tolcher

.....

Dr Ros Tolcher
Chief Executive

7. ANNEX THREE: NATIONAL CLINICAL AUDITS 2016/17

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2017/18	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	222	100%
2	BAUS Urology Audits: Female stress urinary incontinence	No	19	100%
3	Bowel Cancer (NBOCAP) *This relates to data submitted for 2016/17. The Trust has not yet submitted any patient data for 2017/18 as the deadline for this will be in April 2019*	Yes	145	117% (Based on expected total of 124)
4	Cardiac Rhythm Management	Yes	New PPM - 130 PPM box change - 23 CRT implant - 4 Reveal - 63	100%
5	Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC) *This figure is for April to December 2017*	No	331	100%
6	Child Health Clinical Outcome Review Programme	Yes		
	Young People's Mental Health		5	100%
	Cancer in Children, Teens and Young Adults *Please note this study is still open and figures have not been finalised*		Organisational questionnaire returned	N/A
7	Diabetes (Paediatric) (NPDA) *This figure is for the latest round of the audit which relates to patients seen from 1 April 2016 to 31 March 2017.*	Yes	89	100%
8	Elective Surgery National PROMS	No		

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2017/18	Data submitted as a percentage of the number of registered cases required for that audit
	programme (2016/17)			
	Hip replacement *(provisional data)*		334 (pre-op) 258 (post-op)	105.7% 77.9%
	Knee replacement *(provisional data)*		440 (pre-op) 322 (post-op)	133.7% 73.7%
	Groin hernia *(final data)*		262 (pre-op) 173 (post-op)	87.9% 66.3%
	Varicose vein		N/A	N/A
	Elective surgery National PROMS programme (April - September 2017)	No		
	Hip replacement		Not yet published	Not yet published
	Knee replacement		Not yet published	Not yet published
	Groin hernia		134 (pre-op) 29 (post-op)	94.4% 40.8%
	Varicose vein		N/A	N/A
9	Falls & Fragility Fractures Audit Programme (FFFAP)	Yes		
	National Audit of Inpatient Falls		30	100%
	National Hip Fracture Database		214	100%
10	Fractured neck of femur (CEM)	No	50	100%
11	Inflammatory Bowel Disease (IBD) programme *New patients 01/04/2017 to 31/03/2018*	No	35	N/A (rolling database)
12	Learning Disability Mortality Review Programme (LeDeR)	Yes	7	100%
13	Major Trauma: The Trauma Audit & Research Network (TARN)	No	187	Awaiting confirmation
14	Maternal, New-born and Infant Clinical Outcome review Programme (MBRRACE-UK)	Yes	Stillbirths = 7 Late Miscarriages = 1 Termination of pregnancy (for severe fetal	100%

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2017/18	Data submitted as a percentage of the number of registered cases required for that audit
			abnormality) = 1 Maternal death = 1 (Patient died within first year after giving birth - not post-partum related)	
15	Medical & Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome & Death (NCEPOD)	Yes		
	(i) Chronic Neurodisability		2	100%
	(ii) Acute Heart Failure		5	100%
	(iii) Perioperative Diabetes *Please note this study is still open and figures have not been finalised*		4	100%
16	National Audit of Breast Cancer in Older Patients (NABCOP) *Please note that data for March 2018 is still to be submitted*	Yes	59	Not stated
17	National Audit of Dementia (Delirium Spotlight Audit)	Yes	20 +5 reliability cases	100%
18	National Audit of Intermediate Care	No	Did not participate	Did not participate
19	National Audit of Rheumatoid and Early Inflammatory Arthritis	Yes	No data collection during 2017/18	No data collection during 2017/18
20	National Audit of Seizures and Epilepsies in Children and Young People	Yes	No data collection during 2017/18	No data collection during 2017/18
21	National Cardiac Arrest Audit (NCAA) *Figures are for April to December 2017 (Q4 data not yet available)*	No	48	100%
22	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes		

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2017/18	Data submitted as a percentage of the number of registered cases required for that audit
	(I) Secondary Care *Please note this is a continuous audit which commenced on 1 February 2017. Data is being collected retrospectively following clinical coding.*		227	99.6%
23	National Comparative Audit of Blood Transfusion Programme	No		
	(i) Re-Audit of Red Cell & Platelet Transfusion in Adult Haematology Patients		35	100%
	(ii) Audit of the management of patients at risk of Transfusion Associated Circulatory Overload (TACO)		40	100%
24	National Diabetes Audit (Adults)	Yes		
	National Footcare Audit *Relates to records submitted between 01/04/2017 and 31/03/2018*		476	N/A (rolling database)
	National Inpatient Audit (NADIA)		33	100%
	National Pregnancy in Diabetes Audit		Did not participate	Did not participate
	Secondary Care Audit *Audit period 1 January 2016 to 31 March 2017*		1017	Not stated
25	National Emergency Laparotomy Audit (NELA) *Data refers to year 4 of the audit (01/12/2016 to 30/11/2017)*	Yes	42	96%
26	National End of Life Care Audit	Yes	No data collection during 2017/18	No data collection during 2017/18
27	National Heart Failure Audit	Yes	234	100%

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2017/18	Data submitted as a percentage of the number of registered cases required for that audit
	Please note that due to delays in coding this is a preliminary figure and additional patients may be identified from March 2018			
28	National Joint Registry (NJR)	Yes	1004	Not stated
29	National Lung Cancer Audit (NLCA) *Please note that submission for this audit is undertaken retrospectively and data from July 2017 onwards has not yet been validated*	Yes	151	Not stated
30	National Maternity and Perinatal Audit *Please note this relates to 2016/17 data*	Yes	1,933	100%
31	National Neonatal Audit Programme (NNAP - intensive and special care) *Data for 2017*	Yes	132	100%
32	National Ophthalmology Audit *Reporting period 01/09/2016 to 31/08/2017*	Yes	1,450	100%
33	Oesophago-gastric cancer (NAOGC) *This relates to data submitted for 2016/17. The Trust has not yet submitted any patient data for 2017/18 as the deadline for this will be April 2019, therefore reporting will always be one year in arrears.*	Yes	46	118% (based on expected total of 39)
34	Pain in Children (CEM)	No	35	100%
35	Procedural Sedation in Adults (care in emergency departments)	No	23	100%

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2017/18	Data submitted as a percentage of the number of registered cases required for that audit
	(CEM)			
36	Prostate Cancer Audit *Financial year data up to end of February 2018 (28 February 2018) – cases from March onwards still to be validated and registered.*	Yes	151	Not stated – case ascertainment is not currently measured for prostate patients but will be in future. The cancer registry has run its own analysis on our data and have confirmed our figures are as expected.
37	Sentinel Stroke National Audit Programme (SSNAP)	Yes	311	100%
38	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	No	Anti D – 2 Transfusion reaction – 3 Storage – 2	100%
39	UK Parkinson's Audit	No	Neurology: 23 OT: 10 Physio: 10 SLT: 10	>100% 100% 100% 100%

For information, the Trust also participated in the following audits:

Data submitted to National Audits not included in NHS England's Quality Accounts List	Number of patients for which data submitted 2017/18	Data submitted as a percentage of the number of registered cases required for that audit
Breast & Cosmetic Implant Registry *Please note HDFT only started submitting to this Registry part way through the year.*	11	Not stated
National Audit of Cardiac Rehabilitation	169	100%

The following nine NCAPOP audits were not relevant to HDFT due to the Trust not providing the service:

- Adult Cardiac Surgery
- Congenital Heart Disease (CHD)
- 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 Audit of Anxiety and Depression
- National Audit of Psychosis
- National Clinical Audit of Specialist Rehabilitation for patients with complex needs following major injury (NCASRI)
- National Vascular Registry
- Paediatric Intensive Care Audit Network (PICANet)

Furthermore, the Fracture Liaison Service Database (FLSD) element of the Falls & Fragility Fractures Audit Programme (FFFAP) is not relevant to the Trust as we do not have a dedicated Fracture Liaison Service.

The following 10 non-NCAPOP audits were not relevant to HDFT due to the trust not providing the service:

- BAUS urology audits: Cystectomy
- BAUS urology audits: Nephrectomy
- BAUS urology audits: Percutaneous nephrolithotomy
- BAUS urology audits: radical prostatectomy
- BAUS urology audits: Urethroplasty
- Endocrine & Thyroid National Audit
- Head & Neck Cancer (HANA)
- National Bariatric Surgery Registry (NBSR)
- Neurosurgical National Audit Programme
- Prescribing Observatory for Mental Health (POMH-UK) (all work streams)

Please note that the National Audit of Rheumatoid and Early Inflammatory Arthritis, National Audit of Seizures and Epilepsies in Children and Young People and the National End of Life Care Audit which were all included in the NHS England Quality Accounts List 2017/18 did not have data collection during the 2017/18 financial year and therefore we are unable to report on participation.

8. ANNEX FOUR: GLOSSARY

AMU	Acute Medical Unit
CAT	Clinical Assessment Team
CATT	Clinical Assessment, Triage & Treatment
CCG	Clinical Commissioning Group
CEM	Royal College of Emergency Medicine
CHC	Continuing Healthcare
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
DST	Decision Support Tool
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
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
NEWS	National Early Warning Score
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

KPMG

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 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 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
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

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 requirements for quality reports for foundation trusts 2017/18* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18.*

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from commissioners, dated 08 May 2018;
- feedback from governors, dated 12 May 2018;
- feedback from Healthwatch North Yorkshire, requested 6 April 2018;
- feedback from Overview and Scrutiny Committee, requested 6 April 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2016 national patient survey, dated 20 July 2017;

- the 2017 national staff survey, dated 6 March 2018;
- Care Quality Commission Inspection, dated 27 July 2016;
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated April 2018; and
- any other information included in our review.

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 2018, 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 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.

Limitations

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 2018:

- 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 indicators 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 and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
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25 May 2018

Harrogate and District NHS
NHS Foundation Trust

If you require this document in an alternative language or format (such as Braille, audiotape or large print), please contact our Patient Experience Team: thepatientexperienceteam@hdft.nhs.uk or 01423 555499.

Electronic copies of this Quality Account can be obtained from our website (www.hdft.nhs.uk). If you have any feedback or suggestions on how we could improve our Quality Account, please do let us know by emailing bulletin@hdft.nhs.uk.

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Harrogate and District NHS
NHS Foundation Trust

Harrogate and District NHS Foundation Trust Consolidated Financial Statements 31 March 2018.

Contents **Page**

FOREWORD TO THE ACCOUNTS

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

The accounts for the year ended 31 March 2018 are set out on the following pages and comprise the Consolidated Statement of Comprehensive Income, the Consolidated Statement of Financial Position, the Consolidated Statement of Changes in Tax Payers' Equity, the Consolidated Statement of Cash Flows and the Notes to the Consolidated Accounts.

The accounts have been prepared by the Harrogate and District NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7, to the National Health Service Act 2006 in the form in which NHS Improvement, in exercise of the powers conferred on Monitor, the Independent Regulator of NHS Foundation Trusts, has, with the approval of HM Treasury, directed.

Signed: ..... Dr Ros Tolcher - Chief Executive

Date: 23 May 2018.

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 (NHS Act 2006) states that the Chief Executive is the Accounting Officer of the NHS foundation trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officers' Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Harrogate and District NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Harrogate and District NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and the NHS Foundation Trust Annual Reporting Manual in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual and the Department of Health Group Accounting Manual have been followed, and disclose and explain any material departures in the financial statements;
- assess the Group and NHS foundation trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the NHS foundation trust without the transfer of its services to another public sector entity.

The Accounting Officer is responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officers' Memorandum.

Signed: ..... Dr Ros Tolcher - Chief Executive

Date: 23 May 2018.

KPMG

Independent auditor's report

to the Council of Governors of Harrogate and District NHS Foundation Trust

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Harrogate and District NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which comprise the Group and Trust Statements of Comprehensive Income, Consolidated and Trust Statements of Financial Position, Consolidated and Trust Statements of Changes in Taxpayers' Equity, Consolidated Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

- the financial statements give a true and fair view of the state of the Group and the Trust's affairs as at 31 March 2018 and of the Group and Trust's income and expenditure for the year then ended; and
- the Group and the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion..

Overview	
Materiality: Group financial statements as a whole	£4.005m (2017:£4.005m) 1.8% (2017: 1.8%) of total income
Coverage	100% (2017:100%) of group income

Risks of material misstatement		vs 2017
Recurring risks	Valuation of Land and Buildings	◄►
	Recognition of NHS Income and Receivables	◄►
	Medium to long term financial sustainability	▲
Event driven	**New:** Accounting for and related disclosures as a result of implementing the Alternative Service Delivery Model	▲

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows.

All of these key audit matters relate to the Group and the parent Trust.

	The risk	Our response
Valuation of Land and Buildings (£83.3 million; 2017: £85.7 million) *Refer to Note 1.5 (accounting policy) and Note 9.1 (financial disclosures)*	**Subjective valuation:** Land and buildings are initially recognised at cost. Non-specialised property assets in operational use are subsequently measured at current value in existing use (EUV). Specialised assets (such as hospitals) where a market value is not readily ascertainable, are subsequently measured at the depreciated replacement cost (DRC) of a modern equivalent asset that has the same service potential as the existing property. Trusts are responsible for ensuring their land and buildings are held at fair value. Guidance from GAM has suggested that Trusts typically achieve this by performing an annual review for impairment, a periodic desk top valuation (usually every three years) and a full valuation (usually in five year intervals). The asset valuation and impairment review processes both use estimates and assumptions and therefore present a significant risk to the audit. There is significant judgement involved in determining the appropriate basis (EUV or DRC) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation. In 2016/17, the value of land and buildings in the financial statements was £85.7m. This consisted land value of £3.4m and building valuation of £82.3m. In line with GAM, the Trust has undertaken a desktop valuation of its land and buildings during 2017/18. The Trust communicated with their valuer regarding scope and timing of this valuation, which was completed by 31 March 2018.	Our procedures included: — **Assessing the valuer's credentials:** We assessed the competence, capability, objectivity and independence of the Trust's external valuer to carry out the valuation objectively and competently; — **Data comparisons:** We agreed the information provided to the valuer by the Trust to underlying records of the NHS Estate held by the Trust to assess whether all land and buildings had been valued; — **Benchmarking assumptions:** We critically assessed the valuation method and the reasonableness of the assumptions used by the valuer to arrive at the final valuations; — **Our sector experience:** We inspected the valuation report, terms of engagement of, and the instructions issued to the valuer to confirm consistency with the requirements of the GAM; — **Test of detail:** We agreed the valuer's report to the financial statements to assess whether valuation movements are applied correctly both in total and at an individual asset level; — **Test of detail:** We tested material additions and disposals during the year to supporting documentation including invoices; and — Test of detail: We assessed whether the impairments and revaluations had been correctly accounted for in line with applicable accounting standards and the GAM.

The risk	Our response
	— **Assessing transparency:** We assessed the adequacy of the disclosures about the key judgements and degree of estimation involved in arriving at the valuation and the related sensitivities — **Methodology choice:** We critically assessed the valuations of land and buildings subject to lease arrangements as part of the Alternative Service Delivery Model implementation — **Methodology choice:** We assessed the appropriateness of land and buildings valuations net of VAT and retrospective application of such valuations within the financial statements.
NHS Income and Receivables (NHS Income £184.9 million; 2017: £180.5 million) (NHS Receivables: £14.7 million; 2017: £13.5 million). *Refer to Note 1.3 (accounting policy) and Note 3.1 and 13.1 (financial disclosures)*	**Subjective estimate** Of the Group's reported total income, £184.9 million (2016/17: £180.5 million) came from the provision of healthcare services to the public under contracts with NHS commissioners. This represents 85% (2016/17: 83%) of income from activities. The Group participates in the national Agreement of Balances (AoB) exercise for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department of Health's resource accounts. The AoB exercise identifies mismatches between receivable and payable balances recognised by the Group and its commissioners, which will be resolved after the date of approval of these financial statements. For these financial statements the Group identifies the specific cause, and accounts for the expected future resolution, of each individual difference. Mis-matches can occur for a number of reasons, but the most significant arise where : • Activity levels are higher or lower than planned and the Group is in discussion with its commissioners over contract variations; • the Group and commissioners record different accruals for completed spells of healthcare which have not yet been invoiced; • income relating to partially completed spells of healthcare is apportioned across the financial years and the commissioners and the Group make different apportionment assumptions • there is a lack of agreement over proposed contract penalties for sub-standard performance. Where there is a lack of agreement, mis-matches can also be classified as formal disputes and referred to NHS England Area Teams for resolution	Our procedures included the following **Tests of detail**: — We inspected the information provided by the Trust as part of the 2017/18 AoB exercise to agree that it is consistent with the information in the accounts covering both NHS income and NHS receivables ; — We identified any mismatches (both income and receivables) with Commissioners and obtained explanations for the mismatches; — We agreed any disputed NHS income or receivables to documentation which supported the Trust's estimates, including contract documentation and evidence of the achievement of required activity levels or performance measures; — We assessed whether any adjustments to balances agreed with other NHS organisations had been appropriately reflected in the accounts; and — We agreed any accrued or deferred income balances to supporting documentation to confirm they had been recorded appropriately; and — We agreed the receipt the STF monies, including the basis for agreement of Quarter 4 funding based on relevant financial and performance measures, and confirmed the treatment is in line with guidance from NHS Improvement

The risk	Our response
Accounting for and related disclosures as a result of implementing the Alternative Service Delivery Model (ASDM) (£2.0 million; 2017: £0million) *Refer to Note 1.2 (accounting policy) and Note 11 (financial disclosures)*	**Accounting treatment** In November 2017, the final business case was approved by the Board of Directors to create an ASDM for the delivery of the Trust's estates and facilities services from 1 March 2018 and a subsidiary company was created to undertake this role. The leases that have been agreed between the Trust and the newly treated subsidiary needed to be correctly classified as operating leases and then appropriately accounted for. The classification of leases can involve significant judgement. The process to transfer staff from the Trust to the newly created subsidiary requires completeness and accuracy in making changes to payroll systems – there is a risk if this process is not complete and accurate, errors in the financial statements may be made.	Our procedures included: — **Accounting analysis:** We critically assessed the classification of leases and accounting treatment applied to the assets. — **Tests of details:** We agreed the change in payroll expenditure resulting from the transfer of staff from the Trust to the newly created subsidiary. — **Assessing transparency:** We assessed the adequacy of the disclosures about the transactions associated with the ASDM.

3. Our application of materiality and an overview of the scope of our audit

Materiality for the Group financial statements as a whole was set at £4.005 million (2016/17: £4.005 million), determined with reference to a benchmark of total income (of which it represents approximately 1.8% (2016/17: 1.8%)). We consider total income to be more stable than a surplus- or deficit-related benchmark.

Materiality for the parent Trust's financial statements as a whole was set at £4 million (2016/17: £4 million), determined with reference to a benchmark of total income (of which it represents approximately 1.8% (2016/17: 1.8%)).

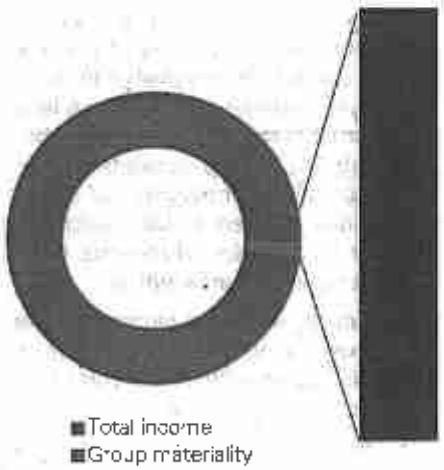
We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.20025 million (2016/17:(£0.20025 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Of the Group's 3 (2017: 2) reporting components, we subjected 2 (2017: 2) to full scope audits for group purposes.

The remaining one reporting component, none of which individually represented more than 0.5% of any of total group revenue, group profit before tax or total group assets. For the residual component, we performed analysis at an aggregated group level to re-examine our assessment that there were no significant risks of material misstatement within this component.

Total income
£216.8m (2017: £217.8m)

Group Materiality
£4.005m (2017: £4.005m)



£4.005m
Whole financial statements materiality (2017: £4.005m)

£4 m
Range of materiality at 2 components (£0.07m-£4m) (2017: £0.07 m to £4m)

£0.2 m
Misstatements reported to the audit committee (2017: £0.2m)

4. We have nothing to report on going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Group's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, 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.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities. As explained more fully in the statement on page 2 the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and parent Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and parent Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') 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 these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources..

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources..

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the 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 the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out below together with the findings from the work we carried out on each area.

The risk	Our response and findings
Medium to long term financial sustainability: There are a number of risks associated with the sector and Trust's financial position, which make medium to long term financial sustainability a risk for the Trust. Specifically there are risks relating to the Trust's arrangements to: - work with key stakeholders; and - manage cost improvement plans.	Our procedures included: — **Critical assessment of how the Trust has engaged with key stakeholders:** We critically assessed how the Trust works with key stakeholders to plan for medium to long term financial sustainability — **Critical assessment of the Trust's Cost Improvement Programme:** We assessed the arrangements the Trust has in place to identify, develop, manage, monitor and deliver recurrent cost improvements which have been identified and incorporated into the financial plans for 2018/19. **Our findings on this risk area:** The Trust is now part of various regional groups which are focused on working in partnership. The Trust's Strategic Plan 2014-19 provides detail of how the Trust will work with its partners to help meet the sustainability challenges which the Trust and wider health economy face. Furthermore, during the year the Trust became a founding member of the Provider Collaborative which includes representatives from relevant regional stakeholders and is focused on developing a new collaborative model for care. The Trust has agreed a plan surplus of £6.7m for the 2018/19 financial year, which includes £5.3m of STF income and is predicated on the achievement of a challenging CIP target of £10.2m. A further £0.5m is to be added to this target as a recognition of some of the planning pressures being faced in 2018/19, however, this will need to be considered further depending on cost pressures and service developments. Whilst this is challenging target, the Trust has risk adjusted plans in place. The Trust works on delivering these targets through its governance and monitoring structures. Monitoring of performance against these plans is undertaken as part of the monthly finance and activity meetings with each directorate. The Board also receives a monthly report from the Finance Director on financial performance in its entirety supported by a quarterly report specifically on the achievement against the CIP. The Trust's approach to CIP delivery is driven by the Clinical Transformation Board (CTB) and Business Development Strategy supporting Directorates to deliver Cost Improvements (CIPs) We concluded that the Trust had adequate arrangements in place to deliver medium to long term financial sustainability.

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 and the terms of our engagement by the Trust. 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 the further matters we are required to state to them in accordance with the terms agreed with the Trust, 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.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Harrogate and District NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Rashpal Khangura
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
1, Sovereign Square
Sovereign Street
Leeds
LS1 4DA

25 May 2018

KPMG

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Annual Governance Statement 2017/18

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Harrogate and District NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Harrogate and District NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

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

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

- Staff in dealing with specific everyday risks, e.g. basic risk management information including an overview of patient safety, incident reporting and investigation, complaints investigation and development of measures to improve patient experience, fire safety, information governance, health and safety, moving and handling, infection control, and security: and
- Specific staff involved in the maintenance of risk registers at directorate and department level, investigation and root cause analysis, the investigation of serious incidents (SIs) and risk assessment for health and safety.

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

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

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

The Trust also supports a 'learning" culture, and we share and embed learning from incidents following an objective investigation or review. We recognise the importance of human factors promoting safety and in the genesis of incidents. 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 monthly "Making a Difference" awards for staff. 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.

The Trust has appointed a Freedom to Speak Up Guardian who reports to the Board on a six-monthly basis. This provides the Board with an opportunity to reflect on themes and learning identified by the Guardian. During the year Internal Audit completed a review of the Trust's Freedom to Speak Up arrangements and found significant assurance that effective processes are in place to enable staff to raise a concern and whistle blow in accordance with the findings of the 'Freedom to Speak Up' report.

A review of quality and equality impact assessments by Internal Audit during 2017/18 revealed weaknesses in the quality impact assessment of Cost Improvement Programmes (CIPs) and Financial Recovery Plan (FRP) schemes. The associated risks have been recognised on the corporate risk register and additional controls are being established. It has been agreed that in future the Quality Committee will have increased scrutiny of the quality impact assessment process.

The risk and control framework

The key objectives regarding risk and control are to achieve:

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

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

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

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

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

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

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

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

a. Departmental

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

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

b. Directorate

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

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

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

c. Corporate

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

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

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

d. 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 Trust's 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. The Audit Committee also receives regular updates on the BAF and the Board of Directors receive an update each month, and a more detailed report together with the complete BAF on a quarterly basis.

The risks on the corporate risk register for 2017/18 and going forward relate to the:

- Risk to the quality of service delivery in Medicine due to gaps in rotas following the Deanery allocation process;
- Risk to service delivery due to the lack of experienced registered nurses due to national labour market shortage;
- Capacity to support timely discharge for community ready patients;
- Risk of financial deficit and impact on service delivery due to failure to deliver the Trust's annual plan by having excess expenditure or a shortfall in income;
- Risk of patient harm as a result of being lost to follow-up as a result of current processes;
- Risk of patient harm as a result of being lost to follow-up as a result of historic processes;
- Risk to provision of service and not achieving national standards in cardiology due to potential for laboratory equipment breaking down;
- Risk to patient safety, quality, experience, reputation, staff well-being due to reduced capacity in the community care teams;
- Risk to quality of care due to lack of capacity in the acute and community services to meet anticipated increased demand during winter months;
- Risk of inadequate antenatal care and patients being lost to follow up due to inconsistent process for monitoring attendance at routine antenatal appointments in the community;
- Risk to service delivery due to failure to have sufficient cash to support the capital programme including replacement of equipment due to delay in payment from commissioners or shortfall in delivering the financial plan;
- Risk of harm to the quality of the service due to staff shortages in ophthalmology clinics.

During 2017/18 the strategic risks identified on the BAF included risk of:

- Lack of medical, nursing and clinical staff;
- High levels of frailty in local population;
- Failure to learn from feedback and incidents;
- Standards of care and the organisation's reputation for quality fall because quality does not have a sufficient priority in the Trust;
- Failure to deliver integrated models of care;
- Misalignment of strategic plans;
- Service sustainability;
- Failure to deliver the Operational Plan;
- Breaching the terms of the Trust's Licence to operate from NHS Improvement;
- External funding constraints;
- Lack of fit for purpose critical infrastructure; and
- Insufficient senior leadership capacity.

In 2017/18 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. During 2017/18 the Trust has undertaken robust preparations for implementation of the new General Data Protection Regulations from May 2018.

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 46 RAG (red, amber, green) rated indicators of which 17 relate to quality, 16 to finance and efficiency and 13 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 2018 and gave significant assurance for both. The Audit Committee reviews the evidence for compliance with CQC registration requirements annually.

Principal risks to compliance with the NHS Provider 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 the Provider Licence in its entirety via annual and in-year submission as required by NHS Improvement's Single Oversight Framework. These submissions include detailed information on financial performance, plans and forecasts, and third party information, in order to assess the risk to continuity of services and governance.

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

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

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

Executive directors, non-executive directors, governors and other stakeholders are key participators in many of the Trust's committees.

During 2017/18 the Board completed a self-assessment against NHS Improvement's well led framework for governance reviews. The self-assessment drew upon an independent review of the well led framework which was completed in 2015. The independent (external) review noted a number of areas of strength and good practice including:

- A board which was 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 were 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.

Neither the self-assessment nor the external review highlighted any material areas of concern in relation to the board and the governance arrangements in place at the Trust. Current areas identified for further progress and improvement include:

- Development of a Patient and Public Participation Strategy for the Trust;
- Further work to cascade and embed Strategic Key Performance Indicators within directorates.

Work has been undertaken to address these recommendations.

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

During 2017/18 the executive team completed a self-assessment against the CQC's well led framework. This identified all key lines of enquiry as 'outstanding' or 'good', with one aspect (are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services) assessed as 'requires improvement'. Work is ongoing to further strengthen the Trust's arrangements for patient and public participation.

The Board of Directors is responsible for exercising all of the powers of the Trust; however, it has the option to delegate these powers to senior management and other committees. The Board:

- sets the strategic direction for the Trust;
- allocates resources;
- monitors performance against organisational objectives;
- ensures that clinical services are safe, of a high quality, patient-focused and effective;
- ensures high standards of clinical and corporate governance; and
- along with the Council of Governors, engages members and stakeholders to ensure effective dialogue with the communities it serves.

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

During 2017/18 there have been five formally constituted committees of the Board; the Audit Committee, the Quality Committee, the Nomination Committee, the Remuneration Committee and the Finance Committee.

The Audit Committee

Four Non-Executive Directors comprise the Audit Committee, and one of these is the Chair. The Deputy Chief Executive/Finance Director Deputy Director of Governance and Company Secretary 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 assurance on the adequacy and effectiveness of the systems of internal control and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. The Committee also reviews the work and findings of the External Auditors appointed by the Council of Governors and considers the implications and management's responses to their work. The Audit Committee receives reports from Internal and External Audit, the Quality Committee and the Corporate Risk Review Group which enable it to provide independent assurance on governance and controls to the Board. This also enables triangulation of key issues to enhance the Board and Committee's oversight and assurance role. The annual audit plans for Internal Audit are approved by the Audit Committee and are prioritised to focus on areas of risk and concern. Governor representatives attend the Audit Committee as observers.

The Quality Committee

The Quality Committee is the primary mechanism by which the Board gains assurance regarding the safety and quality of services. It is chaired by a Non-Executive Director, and the Chairman (on an interim basis until a new Non-Executive Director is appointed in May 2018) and one other Non-Executive Director (who is also a member of the Audit Committee) are members. There is senior representation from the clinical directorates and corporate functions including the Chief Nurse, Director of Workforce and Organisational Development, Chief Operating Officer, Clinical Directors, Deputy Medical Director, Deputy Director of Governance and Head of Risk Management. On behalf of the Board, it seeks assurance on the systems and processes in place to deliver high quality care and provides scrutiny of the outcomes of these systems and processes in relation to quality. It also provides direction regarding the delivery of the Trusts quality improvement priorities and strategic objectives in respect of quality, and provides oversight and seeks assurance on regulatory compliance. The annual clinical audit plans are approved and monitored by the Quality Committee. Governor representatives attend the Quality Committee as observers.

The Finance Committee

During 2017/18 the key responsibilities of the Finance Committee were 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 five year financial plan and two 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 attend the Finance Committee as observers.

The Remuneration Committee

The key responsibilities of the Remuneration Committee is to make recommendations to the Board on the remuneration, allowances and terms of service for the Executive Directors, to ensure that they are fairly rewarded for their individual contribution to the organisation, having proper regard to the organisation's 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 for part of the meeting, by invitation and in an advisory capacity.

The Nomination Committee

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

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 Information Technology Steering Group; End of Life Care Steering Group; Infection Prevention and Control Committee. 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. Public governors have been encouraged to form alliances with some of the teams.

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

The Trust has conducted a self-assessment against the conditions set out in the NHS Provider Licence 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 Trust 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 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 Operating Plan details how the Trust will utilise its resources throughout the year, identifies the principal risks to the delivery of the Operating 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's objective, quality improvement priorities and identified risks.

During 2017/18 the Trust continued to implement a carbon efficiency scheme to deliver reductions in carbon emissions and to deliver significant energy efficiency.

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

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

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

Information governance

Any potential information governance incidents are reported internally and reviewed by the Data and Information Governance Steering Group. The Trust has reported one Level 2 incident to the ICO during 2017/18. This incident was where information was shared with the wrong person. The ICO reviewed our investigation and closed it as it did not meet the criteria set out in their Data Protection Regulatory Action Policy necessitating further action by them.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

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

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

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

Internal Audit provides further assurance regarding the systems in place to ensure that the Quality Account is compliant with national guidance and that adequate data quality controls are in place to ensure that performance data is accurate and complete. Internal Audit has found that robust processes are in place to collect, validate and monitor performance data in relation to both the A&E four-hour wait and the 14-day cancer wait targets. Data included in the Quality Account for both targets was consistent with data reported internally and externally by NHS England. An opinion of high assurance has been given for the Quality Account 2017/18.

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, the Audit Committee 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:

- The governance risk rating, issued by NHS Improvement is green;
- The BAF and the Corporate Risk Register;
- Presentation of the Annual Governance Statement to the Audit Committee by the Accountable Officer;
- The Audit Committee Annual Report, which includes Internal Audit and assurance relating to Corporate Risk Review Group;
- The Quality Committee Annual Report;
- The Finance 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 (2015) and self-assessment by the Board during early 2018.

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;
- safety netting for patients receiving follow-up appointments; and
- the Trust's quality Impact Assessment process.

It is pleasing that progress has been made during the year to address gaps in control identified regarding intravenous cannula care and safety netting for patients receiving follow-up appointments. However work is ongoing to fully mitigate these gaps in control.

Following a new audit gaps in control were highlighted relating to the Trust's quality Impact Assessment processes, as detailed earlier in this statement the associated risks have been recognised on the corporate risk register and controls are being established.

This is an area of constant vigilance for myself as Accounting Officer and the Board of Directors, and progress will be monitored and subject to further audit during 2018/19.

Conclusion

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

Signed: ..... Dr Ros Tolcher - Chief Executive
Date: 23 May 2018.

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2018

	Note	Group 2017/18 Total £000	Group 2016/17 Total £000
Operating income from continuing operations	3	**216,761**	217,782
Operating expenses of continuing operations	4	**(213,093)**	(211,094)
OPERATING SURPLUS		**3,668**	6,688
FINANCE COSTS			
Finance income	6.1	**81**	65
Finance expense - financial liabilities	7	**(253)**	(233)
Finance expense - unwinding of discount on provisions	16.2	**(6)**	(8)
Public Dividend Capital - dividends payable		**(2,721)**	(2,746)
NET FINANCE COSTS		**(2,899)**	(2,922)
Losses on disposal of assets		**(7)**	-
Movement in fair value of investments	10	**5**	251
SURPLUS FOR THE YEAR		**767**	4,017
Other comprehensive income			
Revaluations	9.1 & 9.3	**(4,701)**	1,968
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**(3,934)**	5,985

The notes on pages 31 to 62 form part of these financial statements.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
as at 31 March 2018

	Note	Group 31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	8	**277**	402
Property, plant and equipment	9	**101,511**	100,440
Other investments	10	**1,905**	1,906
Trade and other receivables	13.1	**2,273**	294
Total non-current assets		**105,966**	103,042
Current assets			
Inventories	12.1	**2,456**	2,427
Trade and other receivables	13.1	**21,635**	18,932
Cash and cash equivalents	14	**5,441**	4,688
Total current assets		**29,532**	26,047
Current liabilities			
Trade and other payables	15	**(18,005)**	(16,495)
Borrowings	18	**(2,011)**	(999)
Provisions	16.1	**(118)**	(131)
Other liabilities	17	**(1,832)**	(2,142)
Total current liabilities		**(21,966)**	(19,767)
Total assets less current liabilities		**113,532**	109,322
Non-current liabilities			
Borrowings	18	**(18,379)**	(10,776)
Provisions	16.1	**(184)**	(238)
Total non-current liabilities		**(18,563)**	(11,014)
Total assets employed		**94,969**	98,308
Financed by taxpayers' equity:			
Public Dividend Capital		**80,263**	79,668
Revaluation reserve		**12,100**	16,801
Income and expenditure reserve		**697**	(254)
HDFT charitable fund reserves	25	**1,909**	2,093
Total taxpayers' equity (see page 25)		**94,969**	98,308

The notes on pages 31 to 62 form part of these financial statements.

Signed: ..... Dr Ros Tolcher - Chief Executive

Date: 23 May 2018

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2018

	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 2017	2,093	79,668	16,801	(254)	98,308
Surplus for the financial year (Page 23)	244	-	-	523	767
Revaluations (Note 9.1)	-	-	(4,701)	-	(4,701)
Public Dividend Capital received	-	595	-	-	595
Other reserve movements - charitable funds consolidation adjustment	(428)	-	-	428	-
Balance at 31 March 2018	1,909	80,263	12,100	697	94,969

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2017

	HDFT charitable fund reserve	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Group Total
	£000	£000	£000	£000	£000
Balance as at 1 April 2016	1,764	78,678	14,833	(3,942)	91,333
Surplus for the financial year (Page 23)	662	-	-	3,355	4,017
Revaluations (Note 9.3)	-	-	1,968	-	1,968
Public Dividend Capital received	-	990	-	-	990
Other reserve movements - charitable funds consolidation adjustment	(333)	-	-	333	-
Balance at 31 March 2017	2,093	79,668	16,801	(254)	98,308

The notes on pages 31 to 62 form part of these financial statements.

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2018

	Note	Group 2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus from continuing operations		**3,668**	6,688
		3,668	6,688
Non-cash income and expense			
Depreciation and amortisation	4.1	**2,569**	4,657
Impairments and reversals	9.1	**208**	(159)
Increase in trade and other receivables		**(4,486)**	(3,663)
(Increase)/Decrease in inventories	12.1	**(29)**	194
Decrease in trade and other payables		**(106)**	(79)
Decrease in other liabilities	17	**(310)**	(565)
Decrease in provisions		**(73)**	(29)
HDFT Charitable Funds - net adjustments for working capital		**107**	(149)
NET CASH GENERATED FROM OPERATIONS		**1,548**	6,895
Cash flows from investing activities			
Interest received		**21**	17
Purchase of Intangible assets	8	**(7)**	(94)
Purchase of Property, Plant and Equipment		**(6,811)**	(4,828)
HDFT Charitable funds - net cash flows from investing activities		**65**	144
Net cash used in investing activities		**(6,732)**	(4,761)
Cash flows from financing activities			
Public dividend capital received		**595**	990
Loans received from the Department of Health	18	**9,614**	-
Loans repaid to the Department of Health		**(999)**	(999)
Interest paid		**(250)**	(234)
PDC dividend paid		**(3,023)**	(2,771)
Net cash generated/(used) in financing activities		**5,937**	(3,014)
Net increase/(decrease) in cash and cash equivalents	14	**753**	(880)
Cash and cash equivalents at 1 April 2017	14	**4,688**	5,568
Cash and cash equivalents at 31 March 2018	14	**5,441**	4,688

The notes on pages 31 to 62 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2018

	Note	Foundation Trust 2017/18 Total £000	Foundation Trust 2016/17 Total £000
Operating income from continuing operations	3	**216,595**	217,385
Operating expenses of continuing operations	4	**(212,802)**	(210,726)
OPERATING SURPLUS		**3,793**	6,659
FINANCE COSTS			
Finance income	6.2	**22**	**16**
Finance expense - financial liabilities	7	**(253)**	(233)
Finance expense - unwinding of discount on provisions	16.2	**(6)**	(8)
Public Dividend Capital - dividends payable		**(2,721)**	(2,746)
NET FINANCE COSTS		**(2,958)**	(2,971)
Losses on disposal of assets		**(7)**	-
SURPLUS FOR THE YEAR		**828**	3,688
Other comprehensive income			
Revaluations	9.2 & 9.3	**(4,701)**	1,968
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**(3,873)**	5,656

The notes on pages 31 to 62 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF FINANCIAL POSITION
as at 31 March 2018

	Note	Foundation Trust 31 March 2018 £000	Foundation Trust 31 March 2017 £000
Non-current assets			
Intangible assets	8	**277**	402
Property, plant and equipment	9	**100,519**	100,440
Investment in Subsidiary	11	**1,000**	-
Loan to Subsidiary	11	**800**	-
Trade and other receivables	13.1	**2,273**	294
Total non-current assets		**104,869**	101,136
Current assets			
Inventories	12.1	**2,353**	2,427
Loan to Subsidiary	11	**200**	-
Trade and other receivables	13.1	**21,589**	18,803
Cash and cash equivalents	14	**4,995**	4,555
Total current assets		**29,137**	25,785
Current liabilities			
Trade and other payables	15	**(18,545)**	(16,420)
Borrowings	18	**(2,011)**	(999)
Provisions	16.1	**(118)**	(131)
Other liabilities	17	**(1,832)**	(2,142)
Total current liabilities		**(22,506)**	(19,692)
Total assets less current liabilities		**111,500**	107,229
Non-current liabilities			
Borrowings	18	**(18,379)**	(10,776)
Provisions	16.1	**(184)**	(238)
Total non-current liabilities		**(18,563)**	(11,014)
Total assets employed		**92,937**	96,215
Financed by taxpayers' equity:			
Public Dividend Capital		**80,263**	79,668
Revaluation reserve		**12,100**	16,801
Income and expenditure reserve		**574**	(254)
Total taxpayers' equity (see page 29)		**92,937**	96,215

The notes on pages 31 to 62 form part of these financial statements.

Signed: ..... Dr Ros Tolcher - Chief Executive

Date: 23 May 2018.

FOUNDATION TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2018

	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Foundation Trust Total
	£000	£000	£000	£000
Balance as at 1 April 2017	79,668	16,801	(254)	96,215
Surplus for the financial year (see page 27)	-	-	828	828
Revaluations (Note 9.2)	-	(4,701)	-	(4,701)
Public Dividend Capital received	595	-	-	595
Balance at 31 March 2018	80,263	12,100	574	92,937

FOUNDATION TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2017

	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Foundation Trust Total
	£000	£000	£000	£000
Balance as at 1 April 2016	78,678	14,833	(3,942)	89,569
Surplus for the financial year (see page 27)	-	-	3,688	3,688
Revaluations (Note 9.3)	-	1,968	-	1,968
Public Dividend Capital received	990	-	-	990
Balance at 31 March 2017	79,668	16,801	(254)	96,215

The notes on pages 31 to 62 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2018

	Note	Foundation Trust 2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus from continuing operations		3,793	6,659
		3,793	6,659
Non-cash income and expense			
Depreciation and amortisation	4.1	2,569	4,657
Impairments and reversals	9.2	208	(159)
Increase in trade and other receivables		(4,462)	(3,824)
Decrease in inventories	12.1	74	194
Increase in trade and other payables		511	14
Decrease in other liabilities	17	(310)	(565)
Decrease in provisions		(73)	(29)
NET CASH GENERATED FROM OPERATIONS		2,310	6,947
Cash flows from investing activities			
Interest received		21	17
Purchase of intangible assets	8	(7)	(94)
Purchase of Property, Plant and Equipment		(6,815)	(4,828)
Acquisition of subsidiary		(1,000)	-
Proceeds from asset sales to subsidiary		994	-
Net cash used in investing activities		(6,807)	(4,905)
Cash flows from financing activities			
Public dividend capital received		595	990
Loans received from the Department of Health		9,614	-
Loans repaid to the Department of Health		(999)	(999)
Loan to subsidiary		(1,000)	-
Interest paid		(250)	(234)
PDC dividend paid		(3,023)	(2,771)
Net cash generated/(used) in financing activities		4,937	(3,014)
Net increase/(decrease) in cash and cash equivalents	14	440	(972)
Cash and cash equivalents at 1 April 2017	14	4,555	5,527
Cash and cash equivalents at 31 March 2018	14	4,995	4,555

The notes on pages 31 to 62 form part of these financial statements.

1 GROUP ACCOUNTING POLICIES AND OTHER INFORMATION

NHS Improvement (NHSI), in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHSI has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the financial statements have been prepared in accordance with the DH GAM 2017/18 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to the NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property and investments.

International Accounting Standard (IAS) 1 requires management to assess, as part of the accounts preparation process, the NHS foundation trust's ability to continue as a going concern. In accordance with the DH GAM the financial statements have been prepared on a going concern basis as the trust's management does not intend to apply to the Secretary of State for the dissolution of the NHS foundation trust, nor have management been informed by the relevant national body of the intention of dissolution.

1.2 Consolidation

The NHS foundation trust is the corporate trustee to the Harrogate and District NHS Foundation Trust Charitable Fund (registered charity number 1050008). The NHS foundation trust has assessed its relationship with the charitable fund and determined it to be a subsidiary because the NHS foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable funds statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the NHS foundation trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

The NHS foundation trust launched Harrogate Healthcare Facilities Management Ltd (HHFM) a wholly owned subsidiary with effect from the 1 March 2018 (registered company number 11048040). The income, expenses, assets, liabilities equity and reserves of HHFM are consolidated in full into the appropriate financial statement lines. The amounts consolidated are drawn from the management accounts of HHFM as the accounting year end will not be aligned to the parent organisation until 31 March 2019.

1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the NHS foundation trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.4 Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.4 Expenditure on employee benefits (continued)

Pension costs - NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust (consistent with all participating members of the scheme) to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the Scheme, except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the NHS foundation trust commits itself to the retirement, regardless of the method of payment.

Pension costs - National Employment Savings Trust (NEST) Pension Scheme

The Pensions Act 2008 requirements created a duty for the NHS foundation trust to provide a pension scheme for employees who are ineligible to join the NHS Pension Scheme. The NHS foundation trust selected NEST as it's partner to meet this duty. The scheme operated by NEST on the NHS foundation trust's behalf is a defined contribution scheme, employers contributions are charged to operating expenses as and when they become due.

1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the NHS foundation trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- individually has a cost of at least £5 000; or
- collectively has a cost of at least £5,000 and individually has a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Capitalised set up costs and grouped assets are reviewed annually and if fully depreciated are removed from the Fixed Asset Register and the Accounts.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

1.6 Property, plant and equipment (continued)

Valuation

Land and buildings used for the NHS foundation trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the statement of financial position date. Fair values are determined as follows:

Land and specialised buildings – depreciated replacement cost
Non specialised buildings – existing use value

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. All valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS). The NHS foundation trust had a full valuation of its land and buildings carried out as at 31 March 2017 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 desktop valuation should be carried out as at 31 March 2018 ensuring that land and buildings are held at fair value. The desktop valuation was also based on an alternative site inline with HM Treasury's approach, this revised valuation has been incorporated in the financial statements.

An item of property, plant and equipment which is surplus with no plan to bring back into use is valued at fair value under IFRS 13.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Costs include professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by International Accounting Standard (IAS) 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as a proxy for fair value.

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income. Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of "Other Comprehensive Income".

In accordance with the DoH GAM, impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment. Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.6 Property, plant and equipment (continued)

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Plant and equipment assets are depreciated on a straight line basis over the following asset life ranges:

	Years
Plant and machinery	5-15
Transport equipment	10
Information technology	5-10
Furniture and fittings	5-10
Buildings and Dwellings (Assessed by a RICS qualified valuer when a valuation takes place)	1-90

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met.

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.
  - management is committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsecuently accounted for in the same manner as other items of property, plant and equipment.

1.7 Intangible assets

Intangible assets are capitalised when they have a cost of at least £5,000. Intangible assets acquired separately are initially recognised at fair value. The NHS foundation trust does not recognise any internally generated assets and associated expenditure is charged to the statement of comprehensive income in the period in which it is incurred. Expenditure on research activities is recognised as an expense in the period in which it is incurred.

1.7 Intangible assets (continued)

Following initial recognition, intangible assets are carried at amortised historic cost as this is not considered to be materially different from fair value. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13. The NHS foundation trust's intangible fixed assets are wholly software licences which are purchased and are deemed to have a finite life determined by the licence agreement. The NHS foundation trust does not hold a revaluation reserve for intangible assets.

1.8 Leases

Finance Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating Leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight line basis over the term of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.9 Inventories

Pharmacy inventories are valued at weighted average historical cost. Other inventories are valued at the lower of cost and net realisable value using the first in, first out method.

1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.11 Provisions

The NHS foundation trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted at a discount rate of 2.9% in real terms.

1.12 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to operating expenses. Although NHS Resolution 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 NHS Resolution on behalf of the NHS foundation trust is disclosed in note 16.3.

1.13 Non-clinical risk pooling

The NHS foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS foundation trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in the financial statements, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.15 Value Added Tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable the amounts are stated net of VAT.

1.16 Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange profits and losses are taken to the Statement of Comprehensive Income. At the Statement of Financial Position date, monetary items denominated in foreign currencies are retranslated at the rates prevailing.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. Details of third party assets are given in note 20 to the accounts.

1.18 Public Dividend Capital (PDC) and PDC dividend

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of International Accounting Standard (IAS) 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets, cash held with the Government Banking Service (GBS), excluding cash balances held in GBS accounts that relate to a short term working capital facility and any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average net assets as set out in the "pre-audit" version of the annual accounts. The dividend so calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.19 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the Statement of Comprehensive Income on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.20 Corporation Tax

The NHS foundation trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this but the trust is potentially within the scope of corporation tax in respect of activities where income is received from a non public sector source.

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. However Harrogate Healthcare Facilities Management Ltd is a wholly owned subsidiary of NHS foundation trust and is subject to corporation tax on its profits.

1.21 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the NHS foundation trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described in note 1.8 above.

Purchase or sales are recognised and derecognised, as applicable, using the trade date.

All other financial assets and financial liabilities are recognised when the NHS foundation trust becomes party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the NHS foundation trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as loans and receivables.

Financial liabilities are classified as other financial liabilities.

1.21 Financial instruments and financial liabilities (continued)

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The NHS foundation trust's loans and receivables comprise: cash and cash equivalents, NHS receivables and other receivables.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income. Loans from the Department of Health are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

Impairment of financial assets

At the Statement of Financial Position date, the NHS foundation trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the assets carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly or through the use of a bad debt provision. Bad debt provisions are used when there is some uncertainty that the debt will be paid. Bad debts are written off directly only when there is certainty that the debt will not be paid.

1.22 Critical accounting estimates and judgements

The preparation of financial statements under IFRS requires the trust to make estimates and assumptions that affect the application of policies and reported amounts. Estimates and judgements are continually evaluated and are based on historical experience and other factors that are considered to be relevant.

Revisions to accounting estimates are recognised in the period that the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

1.22 Critical accounting estimates and judgements (continued)

Although the NHS foundation trust makes estimates within these financial statements such as incomplete patient spells, accrued income, annual leave accrual and provisions e.g. early retirements, the amounts involved would not cause a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

In relation to incomplete patient spells the NHS foundation trust makes an assessment of activity for work in progress at 31 March, based on bed occupancy at midnight. The methodology used is to assess the value of income due, to be accounted for in the period between admission and month end, based on an average daily price at speciality/point of delivery, this is calculated and used as the basis of the accrual.

In relation to estimations for uncoded NHS income at the financial yearend, the NHS foundation trust runs a forecast for income relating to March based on the average income received by specialty and point of delivery, all uncoded activity is then priced using an average. This methodology is used throughout the year and has proven to be robust with only very minor variances showing once the activity is coded and then costed.

In addition, a revaluation of the NHS foundation trust's land and buildings was undertaken at a prospective date of 31 March 2018, for the first time this valuation excludes the cost of VAT. As during the financial year the NHS foundation trust created a subsidiary company "Harrogate Healthcare Facilities Management Ltd". The subsidiary company became responsible for the provision of a Managed Healthcare Facility to the NHS foundation trust, a consequence of this was that VAT became recoverable under an MEA alternative site valuation (see 1.6). The NHS foundation trust relies on the professional services of the Valuation Office for the accuracy of such valuations.

1.23 Non current investments

Investments are stated at market value as at the statement of financial position date. The statement of comprehensive income includes the net gains and losses arising on revaluation and disposals throughout the year.

1.24 Accounting standards and amendments that have been issued but have not yet been adopted

The following table presents a list of recently issued accounting standards and amendments which have not yet been adopted within HM Treasury's Financial Reporting Manual (FReM), and are therefore not applicable to Department of Health group accounts in 2017/18.

Change published	
IFRS 9 Financial Instruments	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 14 Regulatory Deferral Accounts	Not yet EU endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to Department of Health group bodies.
IFRS 15 Revenue from contracts with customers	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 16 Leases	Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 17 Insurance Contracts	Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted
IFRIC 22 Foreign Currency Transactions and Advance Consideration.	Application required for accounting periods beginning on or after 1 January 2018.
IFRIC 23 Uncertainty over Income Tax Treatments	Application required for accounting periods beginning on or after 1 January 2019.

It is not practical to assess the impact on the NHS foundation trust of the above Accounting Standards and Amendments until HM Treasury adopts them within the FReM.

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 2017/18 £000	**Charity 2017/18 £000**	Healthcare 2016/17 £000	Charity 2016/17 £000
Operating Surplus/(Deficit)	**3,916**	**(248)**	6,659	29
Net Finance (Costs)/Income	**(2,958)**	**59**	(2,971)	49
Movement in fair value of investments	**(7)**	**5**	-	251
SURPLUS/(DEFICIT) FOR THE YEAR	**951**	**(184)**	3,688	329
Non-current assets	**104,061**	**1,905**	101,136	1,906
Current assets	**29,491**	**41**	25,785	262
Current liabilities	**(21,929)**	**(37)**	(19,692)	(75)
Non-current liabilities	**(18,563)**	**-**	(11,014)	-
TOTAL ASSETS EMPLOYED	**93,060**	**1,909**	96,215	2,093
Financed by taxpayers' equity:				
Public Dividend Capital	**80,283**	**-**	79,668	-
Revaluation reserve	**12,100**	**-**	16,801	-
Income and expenditure reserve	**697**	**-**	(254)	-
HDFT Charitable fund reserves	**-**	**1,909**	-	2,093
TOTAL TAXPAYERS' EQUITY	**93,060**	**1,909**	96,215	2,093

3 Operating Income from continuing operations

3.1 Analysis of operating income

	Foundation Trust & Group	
	2017/18	2016/17
	£000	£000
Income from activities by classification:		
Elective Income	29,003	28,076
Non elective income	37,325	32,859
Outpatient income	12,404	11,220
Follow up outpatient income	14,219	15,593
Accident and Emergency income	6,770	5,708
High cost drugs income from commissioners	7,380	7,161
Other NHS clinical income	40,343	43,803
Community services income from CCGs and NHS England	25,443	27,871
Community services income from other sources (e.g. local authorities)	25,313	26,776
Private patient income	1,437	1,243
Total income from activities	199,637	200,310

	Foundation Trust & Group	
	2017/18	2016/17
	£000	£000
Income from activities by source:		
NHS Foundation Trusts	495	546
NHS Trusts	56	99
NHS England	19,518	20,074
Clinical commissioning groups	151,846	150,514
Local Authorities	25,313	26,776
Department of Health	53	9
NHS Other	86	80
Non NHS: Private Patients	1,437	1,243
Non-NHS: Overseas patients (chargeable to patient)	68	77
NHS injury scheme (see below*)	496	541
Non NHS: Other	269	351
Total income from activities	199,637	200,310

	Group	
	2017/18	2016/17
	£000	£000
Group other operating income:		
Research and development	1,172	1,929
Education and training	6,026	5,147
Education and training - notional income from apprenticeship fund	32	-
Non-patient care services to other bodies	2,439	2,431
Sustainability and Transformation Fund income	3,528	3,450
Rental revenue from operating leases (see note 3.4)	168	184
Staff recharges (secondments)	501	645
HDFT Charitable Funds: Incoming Resources excluding investment income	644	730
Other (see note 3.2)	2,614	2,956
Group total other operating income	17,124	17,472
Group total operating income	216,761	217,782

* NHS injury scheme income is subject to a provision for doubtful debts of 22.84% (2017: 22.94%) to reflect expected rates of collection.

3.1 Analysis of operating income (continued)

	Foundation Trust	
	2017/18	2016/17
	£000	£000
Total income from activities	**199,637**	200,310
Foundation Trust other operating income:		
Research and development	**1,172**	1,929
Education and training	**5,026**	5,147
Education and training - notional income from apprenticeship fund	**32**	-
Received from NHS charities: Receipt of grants/donations for capital acquisitions	**276**	236
Non-patient care services to other bodies	**2,439**	2,528
Sustainability and Transformation Fund income	**3,528**	3,450
Rental revenue from operating leases (see note 3.4)	**261**	184
Staff recharges (secondments)	**501**	645
Other (see note 3.2)	**2,723**	2,956
Foundation Trust total other operating income	**16,958**	17,075
Foundation Trust total operating income	**216,595**	217,385

3.2 Analysis of Other Operating Income: Other

	Group		Foundation Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Car Parking	**749**	777	**716**	777
Estates recharges	3	8	**3**	8
Pharmacy Sales	**12**	11	**12**	11
Staff accommodation rentals	**91**	124	**90**	124
Clinical Tests	**381**	435	**381**	435
Catering	**648**	384	**575**	384
Property Rentals	-	5	-	5
Other income*	**730**	1,212	**946**	1,212
	2,614	2,956	**2,723**	2,956

NHS Improvement requires the NHS foundation trust to provide an analysis of other operating income using the categories above (see note 3.1).

*Other "Other" income includes for example Finance Staff Development levies (hosted service for the region), Mortuary fee income and income from the Trust's Staff Lottery.

3.3 Analysis of income from activities by Commissioner Requested Services (CRS) and Non-Commissioner Requested Services (Non-CRS).

	Foundation Trust & Group	
	2017/18	2016/17
	£000	£000
Commissioner Requested Services	**112,817**	106,153
Non-Commissioner Requested Services	**86,820**	94,157
Total	**199,637**	200,310

3.4 Operating lease income and future annual lease receipts

	Group	
	2017/18	2016/17
	£000	£000
Operating lease income	**168**	184
	168	184
Future minimum lease receipts due on buildings expiring		
- not later than one year;	**160**	161
- later than one year and not later than five years;	**555**	387
- later than five years.	**500**	612
	1,215	1,160

3.5 Operating lease income and future annual lease receipts

	Foundation Trust	
	2017/18	2016/17
	£000	£000
Operating lease income	**261**	184
	261	184
Future minimum lease receipts due on buildings expiring		
- not later than one year;	**1,279**	161
- later than one year and not later than five years;	**4,476**	387
- later than five years.	**22,285**	612
	28,040	1,160

3.6 - Overseas visitors (relating to patients charged directly by the foundation trust)

Income recognised in year relating to overseas visitors was £68k (2017 £77k) cash payments received in year (relating to invoices raised in current and previous years) was £98k (2016 £36k) and amounts written off in year (relating to invoices raised in current and previous years) was £0k (2017 £4k).

4. Operating Expenses from continuing operations

4.1 Group operating expenses comprise:

	Group	
	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	**1,892**	1,655
Purchase of healthcare from non-NHS and non-DHSC bodies	**61**	19
Staff and executive directors costs	**156,320**	151,862
Non-executive directors	**150**	152
Drug costs (see note 12.2)	**14,316**	14,061
Supplies and services - clinical	**16,174**	17,598
Supplies and services - general	**2,784**	2,684
Establishment	**1,805**	1,780
Research and development	**79**	24
Transport (including Patients' travel)	**825**	901
Premises - business rates payable to local authorities*	**(921)**	851
Premises - other	**8,891**	6,843
Increase in provision for irrecoverable debts	**197**	143
Rentals under operating leases	**734**	2,708
Depreciation on property, plant and equipment (see note 9.1)**	**2,437**	4,522
Amortisation on intangible assets (see note 8)	**132**	135
Impairments of property, plant and equipment	**208**	(159)
Audit services- statutory audit	**48**	65
NHS Resolution contribution - Clinical Negligence	**4,196**	2,997
Legal fees	**197**	111
Consultancy costs	**437**	430
Internal audit costs	**166**	166
Education and training	**735**	739
Education and training - notional expenditure funded from apprenticeship fund	**32**	-
Redundancy	**-**	31
Early retirements	**-**	7
Hospitality	**1**	-
Insurance	**278**	266
Other services, eg external payroll	**-**	18
Losses, ex gratia and special payments (see note 20)	**24**	75
Other	**431**	42
HDFT Charitable funds: Other resources expended	**464**	368
Group total operating expenses	**213,093**	211,094

*The NHS foundation trust is part of a Group Action with a number of other NHS organisations relating to the ratcable value of the properties utilised for the provision of healthcare. This action applies retrospectively and therefore the anticipated benefit has resulted in negative expenditure during 2017/18.

**The NHS foundation trust became eligible for a retrospective VAT claim during 2017/18 relating to VAT suffered on building schemes. Accounting for this VAT claim during the financial year has resulted in a one off reduction (£2.4m) to the annual depreciation charge (also see note 9.1).

4. Operating Expenses from continuing operations (Continued)

4.2 Foundation Trust operating expenses comprise:

	Foundation Trust	
	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	**1,892**	1,655
Purchase of healthcare from non-NHS and non-DHSC bodies	**61**	19
Staff and executive directors costs	**155,726**	151,862
Non-executive directors	**150**	152
Drug costs (see note 12.2)	**14,316**	14,061
Supplies and services - clinical	**16,085**	17,598
Supplies and services - general	**3,909**	2,684
Establishment	**1,799**	1,780
Research and development	**22**	24
Transport (including Patients' travel)	**822**	901
Premises - business rates payable to local authorities*	**(921)**	851
Premises - other	**8,651**	6,843
Increase in provision for irrecoverable debts	**197**	143
Rentals under operating leases	**734**	2,708
Depreciation on property, plant and equipment (see note 9.1)**	**2,437**	4,522
Amortisation on intangible assets (see note 8)	**132**	135
Impairments of property, plant and equipment	**208**	(159)
Audit services- statutory audit	**48**	65
NHS Resolution contribution - Clinical Negligence	**4,196**	2,997
Legal fees	**196**	111
Consultancy costs	**435**	430
Internal audit costs	**164**	166
Education and training	**792**	739
Education and training - notional expenditure funded from apprenticeship fund	**32**	
Redundancy	**-**	31
Early retirements	**-**	7
Hospitality	**1**	-
Insurance	**271**	266
Other services, eg external payroll	**-**	18
Losses, ex gratia and special payments (see note 20)	**24**	75
Other	**423**	42
Foundation Trust total operating expenses	**212,802**	210,726

*The NHS foundation trust is part of a Group Action with a number of other NHS organisations relating to the rateable value of the properties utilised for the provision of healthcare. This action applies retrospectively and therefore the anticipated benefit has resulted in negative expenditure during 2017/18.

**The NHS foundation trust became eligible for a retrospective VAT claim during 2017/18 relating to VAT suffered on building schemes. Accounting for this VAT claim during the financial year has resulted in a one off reduction (£2.4m) to the annual depreciation charge (also see note 9.1).

4.3 Operating lease expenditure and future annual lease payments

	Foundation Trust & Group	
	2017/18	2016/17
	£000	£000
Minimum lease payments	734	2,708
	734	2,708
Future minimum lease payments due expiring;		
Within 1 year	1,817	1,860
Between 1 and 5 years	344	337
	2,161	2,197

4.4 Limitation on external auditor's liability

	Foundation Trust & Group	
	2017/18	2016/17
	£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

	2017/18	Group Permanently Employed	Other	2016/17	Group Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	125,446	122,936	2,510	122,458	120,135	2,323
Social Security costs	11,305	11,305	-	10,680	10,680	-
Apprenticeship levy	595	595	-	-	-	-
Employer contributions to NHS Pensions Agency	14,826	14,826	-	14,313	14,313	-
Termination benefits	-	-	-	38	38	-
Agency/contract staff	4,529	-	4,529	4,594	-	4,594
Total employee expenses	156,701	149,662	7,039	152,083	145,166	6,917
Less costs capitalised as part of assets	(381)	(381)	-	(183)	(183)	-
Total employee costs excluding capitalised costs	156,320	149,281	7,039	151,900	144,983	6,917

5. Employee costs and numbers (continued)

5.2 Employee costs

	Foundation Trust			Foundation Trust		
	2017/18	Permanently Employed	Other	2016/17	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	124,970	122,460	2,510	122,458	120,135	2,323
Social Security costs	11,270	11,270	-	10,680	10,680	-
Apprenticeship levy	592	592	-	-	-	-
Employer contributions to NHS Pensions Agency	14,774	14,774	-	14,313	14,313	-
Termination benefits	-	-	-	38	38	-
Agency/contract staff	4,501	-	4,501	4,594	-	4,594
Total employee expenses	156,107	149,096	7,011	152,083	145,166	6,917
Less costs capitalised as part of assets	(381)	(381)		(183)	(183)	-
Total employee costs excluding capitalised costs	155,726	148,715	7,011	151,900	144,983	6,917

5.3 Average number of employees (WTE basis)

	Group			Group		
	2017/18	Permanently Employed	Other	2016/17	Permanently Employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	331	320	11	351	315	36
Ambulance staff	2	2	-	2	2	-
Administration and estates	633	632	1	622	615	7
Healthcare assistants and other support staff	416	368	48	412	379	33
Nursing, midwifery and health visiting staff	1,532	1,517	15	1,488	1,472	16
Nursing, midwifery and health visiting learners	21	21	-	22	22	-
Scientific, therapeutic and technical staff	455	454	1	461	460	1
Healthcare science staff	94	94	-	95	95	-
Other	5	5	-	3	3	-
Total	3,489	3,413	76	3,456	3,363	93
Less capitalised employees	(11)	(11)	-	(6)	(6)	-
Total excluding capitalised WTE	3,478	3,402	76	3,450	3,357	93

5.4 Average number of employees (WTE basis)

	Foundation Trust			Foundation Trust		
	2017/18	Permanently Employed	Other	2016/17	Permanently Employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	331	320	11	351	315	36
Ambulance staff	2	2	-	2	2	-
Administration and estates	590	589	1	622	615	7
Healthcare assistants and other support staff	211	164	47	412	379	33
Nursing, midwifery and health visiting staff	1,531	1,516	15	1,488	1,472	16
Nursing, midwifery and health visiting learners	21	21	-	22	22	-
Scientific, therapeutic and technical staff	455	454	1	461	460	1
Healthcare science staff	94	94	-	95	95	-
Other	5	5	-	3	3	-
Total	3,240	3,165	75	3,456	3,363	93
Less capitalised employees	(11)	(11)	-	(6)	(6)	-
Total excluding capitalised WTE	3,229	3,154	75	3,450	3,357	93

WTE = Whole time equivalents

5.5 Pensions 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 each scheme is taken as equal to the contributions payable to that 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:

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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 report of the scheme actuary, 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 employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this "employer cost cap" assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

5.6 Retirements due to ill-health

During the year ended 31 March 2018 there were 2 (2017: 8) 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 £137,000 (2017: £625,000). The cost of ill-health retirements are borne by the NHS Business Services Authority Pensions Division.

5.7 Staff exit costs

NHS Improvement requires NHS foundation trusts to disclose summary information regarding redundancy and mutually agreed resignation scheme (MARS) staff costs agreed in the financial year.

	Foundation Trust & Group		Foundation Trust & Group	
Exit cost band	**2017/18 Number of compulsory redundancies**	**2017/18 Number of MARS departures agreed**	2016/17 Number of compulsory redundancies	2016/17 Number of MARS departures agreed
<£10,000	-	-	-	-
£10,001 - £25,000	-	-	-	-
£25,001 - £50,000	-	-	-	1
£50,001 - £100,000	-	-	-	-
£100,001 - £150,000	-	-	-	-
£150,001 - £200,000	-	-	-	-
>£200,000	-	-	-	-
Total number of exits by type	-	-	-	1
Total resource cost	**£0**	**£0**	£0	£31,000

5.8 Analysis of termination benefits

	Foundation Trust & Group		Foundation Trust & Group	
	2017/18 Number	**2017/18 £000**	2016/17 Number	2016/17 £000
No of Cases	-	-	1	-
Cost of Cases	-	-	-	31
	-	-	1	31

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	
	2017/18	2016/17
	£000	£000
Interest income:		
Interest on bank accounts	**22**	16
HDFT Charitable funds: investment income	**59**	49
	81	65

6.2 Foundation Trust finance revenue received during the year is as follows:

Finance revenue received during the year is as follows:

	Foundation Trust	
	2017/18	2016/17
	£000	£000
Interest income:		
Interest on bank accounts	**22**	16
	22	16

7. Finance expenses

Finance expenses incurred during the year are as follows:

	Foundation Trust & Group	
	2017/18	2016/17
	£000	£000
Interest expense:		
Capital Loans from the Department of Health (formerly ITFF see note 18)	**253**	233
	253	233

8. Current year intangible fixed assets

	Foundation Trust & Group	
	Software Licences	Total
	£000	£000
Gross cost at 1 April 2017	760	760
Additions - purchased	7	7
Disposals	-	-
Gross cost at 31 March 2018	**767**	**767**
Amortisation at 1 April 2017	358	358
Provided during the year	132	132
Disposals	-	-
Amortisation at 31 March 2018	**490**	**490**
Net book value		
- Purchased at 31 March 2018	277	277
- Total at 31 March 2018	**277**	**277**

8.1 Prior year intangible fixed assets

	Foundation Trust & Group	
	Software Licences	Total
	£000	£000
Gross cost at 1 April 2016	681	681
Additions - purchased	94	94
Disposals	(15)	(15)
Gross cost at 31 March 2017	**760**	**760**
Amortisation at 1 April 2016	238	238
Provided during the year	135	135
Disposals	(15)	(15)
Amortisation at 31 March 2017	**358**	**358**
Net book value		
- Purchased at 31 March 2017	402	402
- Total at 31 March 2017	**402**	**402**

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 2017	3,200	82,674	1,783	813	18,043	135	8,613	806	116,067
Additions - purchased	-	61	-	5,430	2,276	6	632	19	8,424
Impairments charged to operating expenses	-	(208)	-	-	-	-	-	-	(208)
Reclassifications	-	251	-	(262)	-	-	11	-	-
Transfer to revaluation reserve	-	(4,372)	(113)	-	-	-	-	-	(4,485)
Disposals	-	-	-	-	(411)	-	(171)	(27)	(609)
Cost or valuation At 31 March 2018	**3,200**	**78,406**	**1,670**	**5,981**	**19,908**	**141**	**9,085**	**798**	**119,189**
Depreciation at 1 April 2017	-	-	-	-	10,111	69	4,992	455	15,627
Provided during the year (see note 4.1)	-	(292)	76	-	1,517	13	1,044	79	2,437
Transfer to revaluation reserve	-	292	(76)	-	-	-	-	-	216
Disposals	-	-	-	-	(405)	-	(170)	(27)	(602)
Depreciation at 31 March 2018	-	-	-	-	11,223	82	5,866	507	17,678
Net book value									
- Purchased at 31 March 2018	3,200	74,135	1,670	5,981	7,670	59	3,191	279	96,185
- Donated at 31 March 2018	-	4,271	-	-	1,015	-	28	12	5,326
Net book value at 31 March 2018	3,200	78,406	1,670	5,981	8,685	59	3,219	291	101,511

At 31 March 2017, of the Net Book Value £3,200,000 related to land valued at open market value and £78,406,000 related to buildings valued at open market value and £1,670,000 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 2018. This desktop valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a decrease in value of £4,701 000.

9. Property, plant and equipment

9.2 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 Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	3,200	82,674	1,783	813	18,043	135	8,613	806	**116,067**
Additions - purchased	-	61	-	5,430	2,276	-	633	25	**8,425**
Impairments charged to operating expenses	-	(208)	-	-	-	-	-	-	**(208)**
Reclassifications	-	251	-	(261)	-	-	10	-	**-**
Transfer to revaluation reserve	-	(4,372)	(113)	-	-	-	-	-	**(4,485)**
Disposals	-	-	-	-	(2,049)	(135)	(172)	(34)	**(2,390)**
Cost or valuation At 31 March 2018	**3,200**	**78,406**	**1,670**	**5,982**	**18,270**	**-**	**9,084**	**797**	**117,409**
Depreciation at 1 April 2017	-	-	-	-	10,111	69	4,992	455	**15,627**
Provided during the year (see note 4.2)	-	(292)	76	-	1,517	13	1,044	79	**2,437**
Transfer to revaluation reserve	-	292	(76)	-	-	-	-	-	**216**
Disposals	-	-	-	-	(1,110)	(82)	(171)	(27)	**(1,390)**
Depreciation at 31 March 2018	-	-	-	-	**10,518**	**-**	**5,865**	**507**	**16,890**
Net book value									
- Purchased at 31 March 2018	3,200	74,135	1,670	5,982	6,737	-	3,191	278	**95,193**
- Donated at 31 March 2018	-	4,271	-	-	1,015	-	28	12	**5,326**
Net book value at 31 March 2018	**3,200**	**78,406**	**1,670**	**5,982**	**7,752**	**-**	**3,219**	**290**	**100,519**

At 31 March 2017, of the Net Book Value £3,200,000 related to land valued at open market value and £78,406,000 related to buildings valued at open market value and £1,670,000 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 2018. This desktop valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a decrease in value of £4,701,000.

9. Property, plant and equipment (continued)

9.3 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 2016	3,400	80,511	1,762	256	17,242	128	8,894	951	113,144
Additions - purchased	-	1,891	-	632	1,150	27	984	60	4,744
Reversal of impairments credited to operating expenses	-	159	-	-	-	-	-	-	159
Reclassifications	-	60	-	(75)	15	-	-	-	-
Transfer to revaluation reserve	(200)	53	21	-	-	-	-	-	(126)
Disposals	-	-	-	-	(364)	(20)	(1,265)	(205)	(1,854)
Cost or valuation At 31 March 2017	**3,200**	**82,674**	**1,783**	**813**	**18,043**	**135**	**8,613**	**806**	**116,067**
Depreciation at 1 April 2016	-	-	-	-	9,085	75	5,310	583	15,053
Provided during the year	-	2,006	88	-	1,390	14	947	77	4,522
Transfer to revaluation reserve	-	(2,006)	(88)	-	-	-	-	-	(2,094)
Disposals	-	-	-	-	(364)	(20)	(1,265)	(205)	(1,854)
Depreciation at 31 March 2017	**-**	**-**	**-**	**-**	**10,111**	**69**	**4,992**	**455**	**15,627**
Net book value									
- Purchased at 31 March 2017	3,200	78,131	1,783	813	6,926	66	3,586	337	94,842
- Donated at 31 March 2017	-	4,543	-	-	1,006	-	35	14	5,598
Net book value at 31 March 2017	**3,200**	**82,674**	**1,783**	**813**	**7,932**	**66**	**3,621**	**351**	**100,440**

At 31 March 2017, of the Net Book Value £3,200,000 related to land valued at open market value and £82,674,000 related to buildings valued at open market value and £1,783,000 related to dwellings valued at open market value. The land and buildings (including dwellings) of the trust were revalued by the Valuation Office Agency which is a government agency of Her Majesty's Revenue and Customs (RICS qualified) as at 31 March 2017. This valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a increase in value of £1,968,000.

10. Investments

	Group	
	2017/18	2016/17
	£000	£000
Carrying value at 1 April 2017	**1,906**	1,750
Acquisitions in year - other	**308**	256
Movement in fair value of investments	**5**	251
Disposals	**(314)**	(351)
Carrying value at 31 March 2018	**1,905**	1,906

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 Report and Accounts.

11. Subsidiary Undertaking - Harrogate Healthcare Facilities Management Ltd.

	Foundation Trust	
	2017/18	2016/17
	£000	£000
Non-current assets		
Shares in Subsidiary	**1,000**	-
Loan to Subsidiary	**800**	-
	1,800	-
Current assets		
Loan to Subsidiary	**200**	-
	2,000	-

The shares in the subsidiary company Harrogate Healthcare Facilities Management Ltd comprises a 100% holding of the share capital.

The principal activity of Harrogate Healthcare Facilities Management Ltd is to provide estate management and facilities services.

12. Inventories

12.1 Analysis of inventories

	Group		Foundation Trust	
	2017/18	2016/17	**2017/18**	2016/17
	£000	£000	**£000**	£000
Drugs	**950**	739	**950**	739
Consumables	**1,506**	1,688	**1,403**	1,688
Total	**2,456**	2,427	**2,353**	2,427

12.2 Inventories recognised in expenses

	Foundation Trust & Group	
	2017/18	2016/17
	£000	£000
Drug Inventories recognised as an expense in the year	**14,316**	14,061
Total	**14,316**	14,061

13. Trade and other receivables

13.1 Trade and other receivables are made up of:

	Group	
	2017/18	2016/17
Current	£000	£000
NHS Trade receivables	14,707	14,651
PDC Dividend receivable (Department of Health)	355	53
Provision for the impairment of receivables (see note 13.2)	(487)	(532)
Interest receivable	2	1
Prepayments	1,773	1,849
VAT receivables	491	386
Other receivables (*See below and note 4.1)	4,794	2,524
Total	21,635	18,932

	Foundation Trust	
	2017/18	2016/17
Current	£000	£000
NHS Trade receivables	14,847	14,651
PDC Dividend receivable (Department of Health)	355	53
Provision for the impairment of receivables (see note 13.2)	(487)	(532)
Interest receivable	2	1
Prepayments	1,653	1,849
VAT receivables	695	386
Other receivables (*See below and note 4.2)	4,524	2,395
Total	21,589	18,803

*The increase in the NHS foundation trust's "Other Receivables" mainly refers to a Group Action claim - see note 4.1 & 4.2.

	Foundation Trust & Group	
	2017/18	2016/17
Non-Current	£000	£000
Other receivables	395	381
VAT receivables	1,968	-
Provision for the impairment of receivables (see note 13.2)	(90)	(87)
Total	2,273	294

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	
13.2 Movements in the provision for impairments of receivables	2017/18	2016/17
	£000	£000
Balance at 1 April 2017	619	1,073
Increase in provision	197	143
Amounts utilised	(239)	(597)
Balance at 31 March 2018	577	619

NHS Injury Benefit Scheme income is subject to a provision for impairment of 22.84% (2017: 22.94%) to reflect expected rates of collection. Other debts are assessed by management considering age of debt and the probability of collection.

13. Trade and other receivables (continued)

13.3 Ageing of the provision for impaired receivables

	Foundation Trust & Group	
	2017/18	2016/17
	£000	£000
0-30 Days	**28**	9
30-60 Days	**12**	5
60-90 Days	**21**	19
90-180 Days	**19**	23
Over 180 Days	**497**	563
	577	619

13.4 Ageing of non-impaired receivables

	Group		Foundation Trust	
	2017/18	2016/17	**2017/18**	2016/17
	£000	£000	**£000**	£000
0-30 Days	**14,139**	12,642	**14,093**	12,525
30-60 Days	**329**	529	**329**	529
60-90 Days	**143**	454	**143**	454
90-180 Days	**649**	715	**649**	715
Over 180 Days	**2,597**	2,597	**2,597**	2,597
	17,857	16,937	**17,811**	16,820

14. Cash and cash equivalents

	Group		Foundation Trust	
	2017/18	2016/17	**2017/18**	2016/17
	£000	£000	**£000**	£000
Balance at 1 April 2017	**4,688**	5,568	**4,555**	5,527
Net change in year	**753**	(880)	**440**	(972)
Balance at 31 March 2018	**5,441**	4,688	**4,995**	4,555
Made up of:				
Cash with Government Banking Service	**4,993**	4,667	**4,978**	4,543
Cash at commercial banks and in hand	**433**	12	**17**	12
Other current investments	**15**	9	**-**	-
Cash and cash equivalents	**5,441**	4,688	**4,995**	4,555

15. Trade and other payables

	Group		Foundation Trust	
	2017/18	2016/17	**2017/18**	2016/17
Current	**£000**	£000	**£000**	£000
Receipts in advance	**15**	20	**15**	20
NHS Trade payables	**4,742**	6,832	**4,666**	6,832
Other trade payables - capital	**3,150**	1,537	**3,150**	1,537
Social Security costs	**1,668**	1,631	**1,603**	1,631
Other tax payable	**1,468**	1,358	**1,425**	1,358
Other payables	**5,413**	4,295	**6,296**	4,220
Accrued interest on loans	**68**	65	**68**	65
Accruals	**1,481**	757	**1,322**	757
Total	**18,005**	16,495	**18,545**	16,420

16. Provisions

16.1 Provisions current and non current

	Foundation Trust & Group Current		Foundation Trust & Group Non current	
	2017/18	2016/17	**2017/18**	2016/17
	£000	£000	**£000**	£000
Pensions relating to the early retirement of staff pre 1995	**38**	45	**105**	143
Legal claims	**60**	66	**-**	-
*Other	**20**	20	**79**	95
	118	131	**184**	238

*Other provisions total £99,000 (2017: £115,000) referring to the NHS Injury Benefit Scheme.

16.2 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 2017	188	66	115	**369**
Arising during the year	4	40	2	**46**
Utilised during the year	(43)	(4)	(20)	**(67)**
No longer required	(10)	(42)	-	**(52)**
Unwinding of discount	4	-	2	**6**
At 31 March 2018	**143**	**60**	**99**	**302**

*Other provisions total £99,000 (2017: £115,000) referring to the NHS Injury Benefit Scheme.

16.3 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	38	60	20	**118**
Between one and five years	78	-	62	**140**
After five years	27	-	17	**44**
	143	60	99	**302**

£93,368,656 is included in the provisions of NHS Resolution (formerly the NHS Litigation Authority) at 31 March 2018 in respect of clinical negligence liabilities of the NHS foundation trust (31 March 2017 - £55,401,560). Please see note 1.12.

17. Other liabilities

	Foundation Trust & Group	
	2017/18	2016/17
Current	£000	£000
Deferred income	1,832	2,142
Total	1,832	2,142

18. Borrowings

	Foundation Trust & Group	
	2017/18	2016/17
Current	£000	£000
Capital loans from Department of Health (formerly ITFF)*	2,011	999
Total	2,011	999
Non-Current		
Capital loans from Department of Health (formerly ITFF)*	18,379	10,776
Total	18,379	10,776

*During 2012/13, the Trust signed a 10 year loan agreement for £3.4m from the Independent Trust Financing Facility (ITFF) to fund the provision of additional theatre capacity, the loan was drawn down in full during the financial year. During 2013/14, the Trust signed an additional 10 year loan for £1.5m from the ITFF to fund the replacement of an MRI Scanner. The loan was drawn down in full during the financial year. During 2014/15 the NHS foundation trust did not undertake any additional borrowing. During 2015/16 the Trust signed a 25 year loan agreement from the Department of Health for £7.5m to fund a Carbon Efficiency capital scheme and a 10 year loan agreement from the Department of Health for £1.5m to fund the purchase of a Mobile MRI Scanner both of these loans were drawn down in full during the financial year. The NHS foundation trust did not undertake any additional borrowing during 2016/17. During 2017/18, the Trust signed two loan agreements (both with 10 year terms). Replacement of automatic endoscope reprocessors for £3.8m and a modular build endoscopy suite for £6.9m.

The interest rates on the NHS foundation trust's loans are:-

Additional theatre capacity loan £3.4m is fixed at 0.93% per annum (10 year term).
Replacement MRI loan £1.5m is fixed at 1.75% per annum (10 year term).
Carbon efficiency capital scheme loan £7.5m is fixed at 2.5% per annum (25 year term).
Mobile MRI Scanner loan £1.5m is fixed at 0.90% per annum (10 year term).
Replacement of Automated Endoscope Reprocessors scheme loan £3.8m is fixed at 0.76% per annum (10 year term).
Modular Build Endoscopy Suite loan £6.9m is fixed at 0.56% per annum (10 year term).

Interest accrued is paid every six months see finance expense note 7.

There have been no defaults or breaches in relation to the Department of Health (formerly ITFF) loans.

19. Finance lease obligations

The NHS foundation trust does not have any finance leases obligations either as a lessee or lessor.

20. Losses and special payments

	Foundation Trust & Group			
	2017/18 Total number of cases	2017/18 Total value of cases £000	2016/17 Total number of cases	2016/17 Total value of cases £000
Losses:				
Other loss of cash	3	3	-	-
Bad debts private patients	17	8	60	7
Bad debts overseas visitors	2	-	8	4
Bad debts other	196	8	363	27
Damage to buildings, property stores losses	-	-	-	-
Total losses	218	19	431	38
Special payments:				
Compensation under legal obligation	-	-	3	32
Ex gratia payment loss of personal effects	6	1	10	5
Ex gratia payment other	5	4	-	-
Total special payments	11	5	13	37
Total losses and special payments	229	24	444	75

21. Third Party Assets

The NHS foundation trust held £1,483 cash at bank and in hand at 31 March 2018 which related to monies held by the NHS foundation trust on behalf of patients (31 March 2017: £428).

22. Contractual Capital Commitments

Commitments under capital expenditure contracts at 31 March 2018 were £2,955,000 (31 March 2017: £2,546,000).

23. Related Party Transactions

23.1 Transactions with key management personnel

IAS 24 requires disclosure of transactions with key management personnel during the year. Key management personnel is defined in IAS 24 as "those persons having authority and responsibility for planning, directing and controlling the activities of the entity, directly or indirectly, including any director (whether executive or otherwise) of that entity". The Trust has deemed that its key management personnel are the board members (voting and non-voting directors and non-executive directors) of the NHS foundation trust.

However the DH GAM states the requirement in IAS 24 to disclose the compensation paid to management, expenses allowances and similar items paid in the ordinary course of an entity's operations will be satisfied with the disclosures in the Remuneration Report. There were no transactions with board members or parties related to them other than those from the ordinary course the NHS foundation trust's operations.

23.2 Transactions with other related parties

The Department of Health and Social Care is the parent department of Harrogate and District NHS Foundation Trust, paragraph 25 of IAS 24 allows entities which are related parties because they are under the same government control to reduce the volume of detailed disclosures.

The DH GAM interprets this as requiring the disclosure of the main entities within the public sector with which the NHS foundation trust has had dealings, but no information needs to be given about these transactions. These entities are listed below:-

County Durham Unitary Authority
Darlington Borough Council
Department of Health (PDC dividend only)
Health Education England
HMRC
Leeds Teaching Hospitals NHS Trust
Middlesbrough Council
NHS Airedale, Wharfdale And Craven CCG
NHS England
NHS Hambleton, Richmondshire And Whitby CCG
NHS Harrogate And Rural District CCG
NHS Leeds North CCG
NHS Leeds South And East CCG
NHS Leeds West CCG
NHS Resolution
NHS Pension Scheme
NHS Property Services
NHS Scarborough And Ryedale CCG
NHS Vale Of York CCG
North Yorkshire County Council
Tees, Esk And Wear Valleys NHS Foundation Trust
York Hospitals NHS Foundation Trust

24. Financial instruments.

	Group		Foundation Trust	
	2017/18	2016/17	**2017/18**	2016/17
	£000	£000	**£000**	£000
Financial assets				
Loans and receivables (including cash and cash equivalents)	**24,044**	20,875	**23,406**	20,875
Investments	**1,915**	1,906	**1,000**	1,906
	25,959	22,781	**24,406**	22,781
Financial liabilities				
Other financial liabilities	**33,209**	23,250	**33,862**	23,250

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.

25. 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	
	2017/18	2016/17
	£000	£000
Unrestricted income funds	**292**	496
Restricted funds	**57**	41
Endowment fund	**1,560**	1,556
	1,909	2,093

26. Ultimate parent.

As an entity operating in the National Health Service in England, the ultimate parent holding is considered as the Department of Health and Social Care.