HARROGATE AND DISTRICT NHS FOUNDATION TRUST
ANNUAL REPORT AND ACCOUNTS 2018-2019

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

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1. CHAIRMAN'S WELCOME

It is a pleasure and a privilege to introduce the Annual Report and Accounts for the financial year 1 April 2018 to 31 March 2019. On behalf of the Board of Directors and Council of Governors I am very proud to report that we have achieved our financial target and many of our key performance objectives.

The Annual Report gives us an opportunity to reflect on the last financial year and to look ahead to our priorities for 2019-20. 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 'Respectful, Passionate, Responsible' 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'. The teams who work throughout the Trust are caring, professional and dedicated. They are proud and enthusiastic about their considerable achievements.

In 2018-19 we have continued to develop our partnership working, in particular with the West Yorkshire and Harrogate Integrated Care System, the West Yorkshire Association of Acute Trusts, the Harrogate and Rural Alliance and the North Yorkshire and York Leadership Group. We have been very pleased to welcome to our Trust the 0-19 Services for Stockton on Tees, Gateshead and Sunderland. These services for healthy children and their families bring an important dimension to the Trust and remind us of the importance of a good start in life and the impact of the public health ethos.

I would like to thank the Board of Directors for their leadership of 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, volunteer and raise funds for the Trust – they are amazing.

I would like to pay tribute to Dr Ros Tolcher, Chief Executive, who retired on 31 March 2019. She was an outstanding leader and ensured that the Trust remained true to our values and served all our communities with compassion and respect. It gives me great pleasure to introduce to you Steve Russell who became our new Chief Executive on 1 April 2019. He will provide more information about the success and challenges of the Trust in this Report.

Mrs Angela Schofield
Chairman
Harrogate and District NHS Foundation Trust
24 May 2019

2. CHIEF EXECUTIVE'S INTRODUCTION

It is with great pride that I write this introduction to the Harrogate and District NHS Foundation Trust Annual Report for the last time. I will retire at the end of March 2019, forty years after my first NHS job in a small district general hospital medical records department. So much has changed during those four decades - which add up to more than half the lifetime of the NHS. It has been a tremendous privilege to work as an NHS Chief Executive, both in HDFT since 2014 and in my prior CEO role at Solent NHS Trust.

My overriding priority has always been to ensure that those who rely upon the care we provide are treated with dignity and respect, and experience care of the highest quality. While much has changed about the 'what' and the 'how' of health care over those 40 years, the one constancy has been the pivotal role of people in making this happen.

2018-19 has been another extraordinary year for the Trust - and for the NHS as a whole.

Once again, demand for care has grown and we have seen and treated more people than ever before. Workforce shortages and growing demand has generated particular challenges in terms of meeting NHS Constitution standards and for the first time, despite remaining consistently above national averages, we are unable to report full attainment on all standards. The Trust attained 94.51% against the 95% national standard for four-hour waiting times in the Emergency Department (the NHS Improvement trajectory was 94.47%) and 90.2% against the national Referral to Treatment Time (RTT) target of 92%. However, we exceeded the 85% national standard for cancer 62-day treatment (at 86%) and also achieved 99.2% against the national standard of 90% for diagnostics.

Financially, despite significant challenges throughout the year, the Trust achieved its planned control total of an underlying break-even position. As result of this the Trust received an additional £7.7m of Provider Sustainability Funding.

We were delighted to retain a 'Good' overall rating from the Care Quality Commission following inspection at the end of 2018. Our community services achieved a well-deserved 'Outstanding' rating overall and we also retained 'Outstanding' for 'Caring'. All HDFT services are now rated either Outstanding or Good. This recognition of the quality of care provided is both hard-earned and well-deserved by the colleagues working in every part of the Trust.

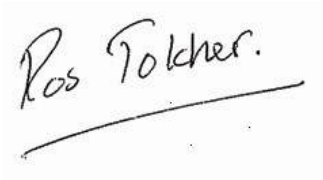
Our staff survey results for the year presented a very positive picture. The Trust once again has scores above those of our peers and we continue to have one of the top scores for overall engagement nationally. We were particularly pleased this year to record a significant improvement in the overall score for safety culture.

A particular focus in my work in my final year has been on promoting a Fair and Just culture across the Trust. This is the bedrock of safe and resilient services and key to ensuring that the NHS is a great place to work. We have introduced 'Fairness Champions' across the Trust and we are striving to ensure that feedback from people using services, and from staff who witness events, is used for continuous learning and improvement.

The Trust also benefited from some important improvements to equipment and environment over the year. Our Emergency Department benefited from some upgrading, with the creation of new capacity and a dedicated waiting area for children; we opened a

fantastic state of the art Endoscopy centre and, thanks to the generosity of local donors, purchased a new Gamma camera to enable earlier diagnosis. Each of these improvements will benefit both patients and staff over years to come.

Finally, I wish to record my personal thanks to everyone who has worked so hard for the Trust both over the last 12 months and during the almost five years of my tenure as CEO - including staff in all areas, Governors, Non-Executive Directors and volunteers. HDFT has a strong and positive future ahead and I hand over the Accountable Officer reins to Steve Russell with complete confidence.



Dr Ros Tolcher
Chief Executive
Harrogate and District NHS Foundation Trust
31 March 2019

CHIEF EXECUTIVE'S INTRODUCTION

I was delighted to join HDFT on 1 April, and wanted to take the opportunity to thank everyone across our range of services, and our geography, for their warm welcome. I also wanted to thank Ros for helping me to learn about the huge range and her generosity with her time to handover and help me acclimatise to HDFT. I hope I am able to continue with and build on her work at HDFT.

The route to achievements in 2018-19 and to achieving our future priorities is through our 4,300 colleagues at HDFT – every single person and every single role in #teamHDFT has played and will play an equally important part. We know that when our people are supported, listened to, and cared for by us, they will in turn do the same for our patients. So we will continue to strengthen our focus on making HDFT the very best place to work, paying attention to the health and wellbeing of our colleagues, and trying to make it easy for everyone to do their work, and to do it well. That means nurturing effective and supportive teamwork, and learning from each other and all of our experiences, good and bad. There is a well-known phrase – 'those that do the work know how to improve it', and our role is to empower and support them to do so. I hope that in a year we'll be able to show how much we can do when we focus on these things.

Steve Russell
Chief Executive
Harrogate and District NHS Foundation Trust
24 May 2019

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 principal 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 2018-19.

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 between birth and up to 19 years of age in North Yorkshire, County Durham, Darlington, Middlesborough, Stockton-on-Tees (from1 April 2018), Sunderland and Gateshead (both from1 July 2018), covering a total population of around 1.75m.

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 and Renal Services. The renal unit is provided at a facility on the Harrogate District Hospital site but managed by YTHFT.

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.

Additional 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 outreach clinic facility also operates at Alwoodley Medical Centre and includes clinics for the specialties of Audiology, ENT, General Surgery, Gynaecology, Orthopaedics, Rheumatology and Urology. There is also a dedicated Radiology service providing plain film x-ray and ultrasound services to support the clinics listed above, 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 frequently 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 high quality 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, Middlesborough and Stockton-On-Tees, making it the largest provider by geographical area of such services in the country. During the year the Healthy Child Programme also started in Gateshead and Sunderland. These are universal services where the needs and voice of children, young people and families are at the core of the service designed to identify and address their needs at the earliest opportunity, and to recognise and build on the strengths that are within individuals. This enables 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.

3.1.3. Purpose and activities of the Trust

The Trust's Vision 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 Vision and Mission the Trust has set out three key strategic objectives:

- To deliver high quality care
- To work with our partners to deliver integrated care
- 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 that to deliver our Vision we will continue to work with partner organisations across the footprint 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);
- Commissioners of Children's Services across North Yorkshire, County Durham, Darlington, Middlesbrough, Stockton-On-Tees, Sunderland and Gateshead;
- 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).

Whilst working in co-operation with other Trusts and organisations as part of the West Yorkshire and Harrogate health 'system', and a member of the WYAAT Committee-in-Common, the Trust retains full control and governance and has not delegated any decision-making powers to any other organisation.

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, Stockton-On-Tees, 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 2018-19 the strategic risks identified on the BAF included risk of:

- Lack of medical, nursing and clinical staff;
- High levels of frailty in the 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;
- Integrated models of care are compromised because of the complexity of the landscape;
- Misalignment of Commissioner/partner strategic plans;
- Senior leadership capacity
- Service sustainability;
- Failure to deliver the Operational Plan;
- Breaching the terms of the Trust's NHS Improvement Licence to operate;
- External funding constraints and
- Lack of fit for purpose critical infrastructure.

The risks on the Corporate Risk Register at the end of 2018-19 relate to the:

- Risk to the quality of service delivery in Medicine due to unfilled and vacant rota gaps across grades, reduction in numbers of doctors in training, agency cap rate, variable allocation from Deanery, medium term sickness, availability and quality of locums and no-deal EU Exit;
- Risk to the quality of service delivery and patient care due to failure to fill registered nurse vacancies due to the national labour market shortage;
- Risk of financial deficit and impact on the quality of service delivery due to failure to deliver the Trust annual plan by having excess expenditure or a shortfall in income;
- Risk to provision of service and not achieving national standards in cardiology - risk to quality of service and risk of patient safety. Potential to breach national waiting times due to cancellations arising from not being able to provide a cardiology testing service due to potential for lab equipment breaking down.
- Risk of inadequate antenatal care and patients being lost to follow up - due to inconsistent process for monitoring attendance at routine antenatal appointments in community
- Risk to the quality of 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
- Financial risk from major sporting events due to cost of contingency arrangements and loss of income and
- Risk to quality of care by not meeting NICE guidance in relation to the completion of autism assessment within 3 months of referral.

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 Directors 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 biannual 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 Board Assurance Framework in order to further support the Board in seeking assurance on achievement of the Trust's strategic objectives.

3.2.1 Regulatory Ratings

Regulatory Ratings

The Trust's regulatory performance against NHS Improvement's (NHSI) Single Oversight Framework were green in all quarters for four of the seven standards, green in three of the four quarters for one standard, and red in all four quarters for two of the standards. The Trust achieved a financial sustainability risk rating of one (best).

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 2018-19.

3.2.2 Performance Summary of 2018-19

The Trust achieved five of the seven operational standards included in the Operational Performance Metrics section of NHSI's Single Oversight Framework for the full year 2018-19. In addition, the cancer 62-day waiting times standard was 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 five out of twelve months throughout the year. However, sustained delivery of this standard remained challenging over the winter period, with the full year performance at 94.5%. The development and implementation of plans to enable the Trust to move back to a positive performance position continued throughout the year, including improved staffing deployment and requirements.

The full year position for the 18 week standard was 90.2% against the 92% standard.

All other cancer waiting time standards were achieved for each quarter overall with the exception of the 14-day standard for breast symptomatic patients where performance was above the 93% standard for Q3 only, and 62-day screening where performance was above the 90% standard for Q1 and Q2.

There were 10 ambulance handover delays of over 60 minutes reported in 2018-19 and 159 handover delays of over 30 minutes. Emergency Department attendances were 3.2% higher than for the same period last year.

Activity levels at the Trust have increased during 2018-19. Elective (waiting list) admissions were 9.5% higher in 2018-19 when compared with 2017-18 and non-elective admissions increased by 1%. Outpatient attendances were also higher with a total of 289,809 outpatient attendances in 2018-19 compared with 283,768 in 2017-18.

Although there was a 3% increase in face to face contacts recorded by the adult community nursing teams during 2018-19, the teams have become much smarter in the way they work; a growing number of patients are being discharged after treatment and given a contact number if they have problems, rather than being kept on the caseloads.

Provisional data suggests that the stroke performance standard (the percentage of stroke patients who spend over 90% of their stay on the stroke unit) was above the 80% standard in 2018-19 with 84% of patients meeting the standard. Delivery of the Transient Ischaemic Attack (TIA) standard was at 75% against the 60% national standard.

The Trust reported 19 cases of hospital acquired *Clostridium difficile* in 2018-19, compared with seven in 2017-18. Root Cause Analysis (RCA) has been completed on 17 cases and indicated that 16 of these were not due to lapses in care, and therefore would be discounted from the Trust's trajectory for 2018-19; Root Cause Analysis has not yet been completed for two cases. No cases of hospital acquired MRSA (Methicillin-resistant *Staphylococcus aureus*) were reported in 2018-19.

The following table demonstrates the Trust's performance against the key indicators for each quarter in 2018-19:

Indicator description	Target	Q1	Q2	Q3	Q4	2018/19
Referral to Treatment Times admitted pathways (% within 18 weeks)	>=92%	90.8%	90.9%	90.4%	88.5%	90.2%
Diagnostic waiting times - maximum wait of 6 weeks	>=99%	98.4%	99.0%	99.5%	99.8%	99.2%
A&E: Total time spent in A&E is less than 4 hours	>=95%	94.9%	94.7%	93.9%	94.5%	94.5%
Cancer - Maximum waiting time of 14 days from urgent GP referral to date first seen for all urgent suspect cancer referrals (%)*	>=93%	96.1%	98.0%	98.5%	97.4%	97.5%
Cancer - maximum waiting time of 14 days for symptomatic breast patients (cancer not initially suspected)*	>=93%	87.4%	89.4%	98.2%	88.7%	91.3%
Cancer - 31 day wait for second or subsequent treatment: Surgery*	>=94%	100.0%	100.0%	97.9%	100.0%	99.5%
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	>=98%	100.0%	99.1%	100.0%	100.0%	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%	99.2%	99.6%	99.6%	98.6%	99.3%
Indicator description	**Target**	**Q1**	**Q2**	**Q3**	**Q4**	**2018/19**
Cancer - 62 day wait for first treatment from urgent GP referral to treatment: all cancers	>=85%	87.3%	85.4%	85.1%	86.4%	86.0%
Cancer - 62 day wait for first treatment from consultant screening service referral: all cancers*	>=90%	94.7%	83.3%	88.9%	76.0%	87.2%
Clostridium difficile – cases due to a lapse in care (cumulative)	<= 12 cases in year	0	1	0	0	1
Community services data completeness - RTT information	>=50%	80.0%	82.5%	80.2%	79.4%	80.5%
Community services data completeness - Referral information	>=50%	72.3%	74.6%	73.8%	73.3%	73.5%
Community services data completeness - Treatment activity information	>=50%	90.9%	88.3%	91.2%	91.4%	90.5%

3.2.4 Detailed analysis development and performance of the Trust

3.2.4.1 Significant Developments during 2018-19

In line with the Trust's Operational Plan for 2018-19, the significant developments over the last 12 months can be summarised as follows.

- **Adult community services - Development of the Harrogate and Rural Alliance (HARA)**

The Trust is part of the Harrogate partnership alliance, HARA. The alliance brings together primary care and 270 colleagues employed by the Trust and North Yorkshire County Council, as well as a wider network of NHS, local government, voluntary and independent sector partners. This initiative will enable us to work in partnership to create an integrated service that is owned by the community and by all colleagues, with the person and community at the centre and delivers good outcomes and value for money. Work has progressed to develop a new integrated care model which is to be implemented in 2019-20.

- **Introduction of our new Supported Discharge Service (SDS)**

The Trust introduced the SDS in 2018-19 to provide treatment and rehabilitation to patients in their own home and other care settings in Harrogate and the local community. It adopts a 'home first' approach, utilising ward-based assessments to initially screen/assess patients in hospital and, whenever possible, facilitate discharge to their place of residence. Following the patient's discharge, the team will then complete a full assessment, provide short-term intervention and rehabilitation and - when required - referral to other agencies for ongoing support.

This service has enabled an increasing number of patients to be treated out of hospital, rather than having to be admitted as inpatients.

- **Capital Developments**

These projects have contributed to helping the continuous improvement of patient care within the organisation.

During 2018-19 the Trust completed a number of capital projects including:

- provision of a new purpose built endoscopy unit
- A new clinical assessment unit
- A new nuclear medicine scanner

- **Trust News and Awards**

<u>NHS Natural Health School</u>

The Trust launched the Natural Health School in 2018-19 which is the very first training school in the UK approved by the NHS to offer training in complementary therapies to help people with a diagnosis of cancer has been launched in Harrogate.

NHS Natural Health School is based at Harrogate District Hospital's Sir Robert Ogden Macmillan Centre, and provides a range of courses at different grades and for different levels of experience.

The School is committed to training the 'Next Generation of Complementary Therapy Experts' able to meet the complex needs of an increasing number of patients

CHKS Top Hospital

Harrogate District Hospital was identified as one of the Top 40 Hospitals for 2018, according to healthcare improvement specialists CHKS. The prestigious award was based on an analysis of over 20 indicators of performance from all hospital Trusts in England, Wales and Northern Ireland.

The performance indicators covered safety, clinical effectiveness, health outcomes, efficiency, patient experience and quality of care.

UNICEF Baby Friendly Recognition

The Growing Healthy 0-5 Health Visiting services in County Durham and Darlington were successful in securing the Gold Baby Friendly assessment by UNICEF. The Baby Friendly Initiative, set up by UNICEF and the World Health Organization, is a global programme which provides a practical and effective way for health services to improve the care provided for mothers and babies.

Development of Community Children's Services

The Trust is now the largest provider of community children's services in the England following successfully securing and mobilising contracts across the North East of England in 2018-19. The Trust now provides Children's Services in North Yorkshire, Middlesbrough, Darlington, County Durham, Stockton-On-Tees, Sunderland and Gateshead.

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 2018-19 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 are governance and reporting frameworks 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.

3.2.4.2 Operating and Financial Review of the Trust

The income and expenditure position for the Trust for 2018-19 is described below. The consolidated position for the group was a surplus of £7.7m

	2017-18 actual £000s	2018-19 actual £000s
Income	213,233	242,140
Expenditure	(215,994)	(242,248)
Net Surplus	-2,761	-108
Provider Sustainability Fund (PSF)	3,528	7,853
Reported surplus for financial year	767	7,745

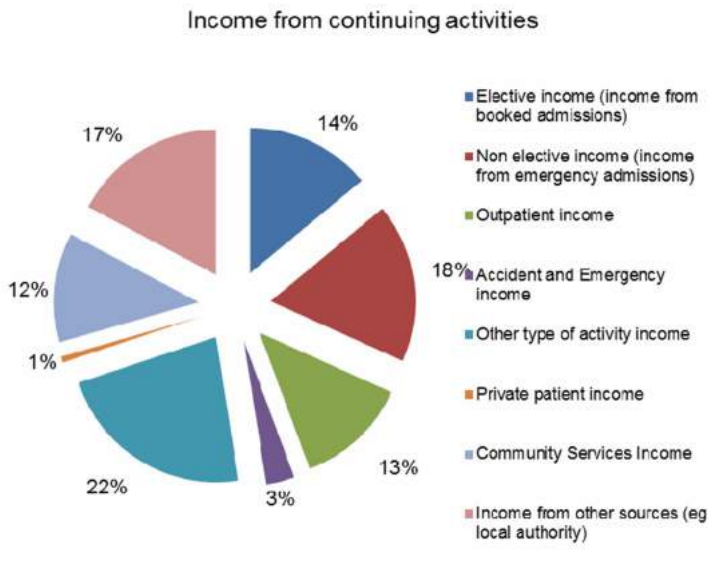
It should be noted that the subsidiary will report a 13 month period to account for performance since 1 March 18.

PSF was given to Trusts from NHSI for achievement of control totals. The table below outlines the level of PSF the Trust will receive as a result of this financial performance.

Provider Sustainability Funding	£000
PSF - core	3,983
PSF - Incentive Scheme (finance) - accrual	1,057
PSF - Incentive Scheme (bonus)	992
PSF - Incentive Scheme (general distribution)	1,821
Total	**7,853**

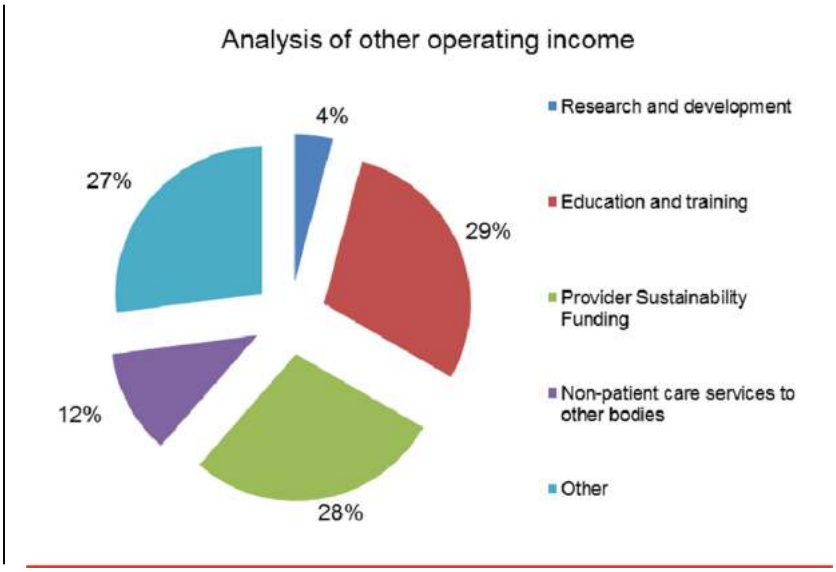
Income Generated from Continuing Activities

Total income from continuing activities for the year 2018-19 was £221,906k. This represented 88.8% of total income for the year. An analysis of this income is shown below:



Other Operating Income

Other operating income totalled £27,888k during 2018-19. This represented 11.2% of total income for the year and an analysis of this income is shown below:



Cash

The Trust has a cash balance of £2,912k at the close of the financial year.

NHSI Use of Resource Metric

The Trust received a Use of Resource Rating of 1 at the end of 2018-19. Financial Risk is assessed on a scale of 1 (low risk) to 4 (high risk).

Financial Outlook 2019-20

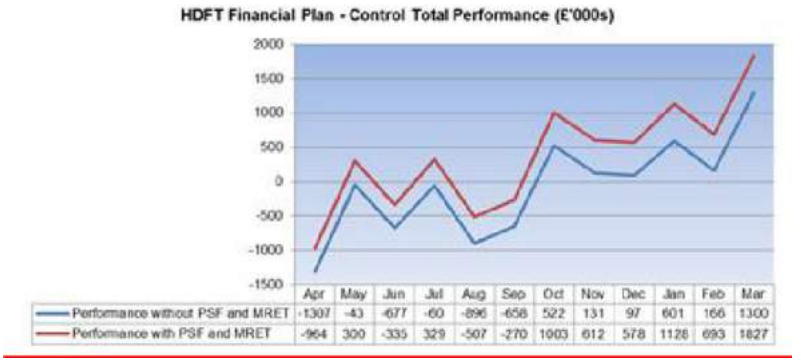
The Trust recognises the continued financial challenges both within the NHS and across the public sector as a whole. The Trust also recognises the opportunity to provide further resilience through the Provider Sustainability Funding (PSF) offer, and through working with our local and regional partners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

In order to achieve the Control Total in 2019-20 set by NHS Improvement, the Trust requires a deficit position of £0.8m. By agreeing to this it is anticipated that £5.2m will be received in the Marginal Rate Emergency Tariff and PSF funding, supporting a £4.4m surplus overall. The following high level assumptions have been made in relation to the plan:

Financial framework impact	£m
Benefit from control total change	0.8
Net tariff change incl. PSF in Urgent Care	7.3
loss of pay award 18/19 funding (now in tariff)	-2.3
	5.8

Pressures	
Clinical Negligence Scheme for Trusts	-0.2
Road Traffic Accident income/valuation impact	-1.5
Pay Award 19/20 and Income Drift	-5.0
Other Inflation	-1.0
Non-Recurrent CIP 18/19	-3.0
SDS/Winter/Drugs	-3.5
	-14.2
Efficiency	**8.4**
MRET abolition	2.45
PSF Benefit	2.76

As result of managing these issues, the plan is anticipated to have the following phasing:



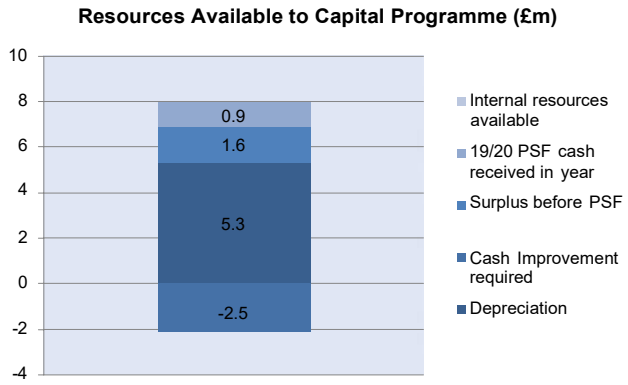
Capital Service Cover rating	2
Liquidity rating	1
I&E Margin rating	1
Variance From Control total rating	1
Agency rating	1
Plan Risk Ratings after overrides	**1**

This in turn resulted in a Use of Resources Rating of 1 for the year as highlighted above.

The graph below outlines the cash profile planned for 2019-20. Cash continues to be an issue for the Trust, with the current contractual position adding significant pressure from the start of April. In 2019-20 we aim to bring payment timescales back to historic levels and address the significant level of aged debtors the Trust is owed.

Capital Investment Activity

A number of schemes have been identified subject to delivery of the financial plan, which will create the necessary internally generated cash to allow investment during 2019-20. The following resources have been identified to support the Capital Programme of £5.3m in 2019-20.



This resource will support key developments such as the Cardiac Cath Lab, Emergency Department X-ray facility, Web V and additional CT capacity.

Land Interests

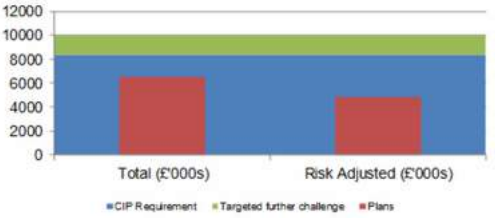
During the financial year ending 31 March 2019, the Trust's land and buildings were re-valued by the Valuation Office Agency (Royal Institute of Chartered Surveyors qualified) which is an Executive Agency of HM Revenue and Customs (HMRC). This valuation, in line with the Trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a valuation of the Trust's land and buildings of £78,540k, which has been incorporated into the accounts.

Details of Activities Designed to Improve Value for Money

The current position in respect of the 2019-20 efficiency programme is shown in the table below. Efficiency schemes continue to be risk assessed and subject to a Quality Impact Assessment before implementation.

	Identified Schemes		Unidentified/Developing Schemes	
Current Plans	Total Plans (£'000s)	Risk Rated Plans (£'000s)	Total Plans (£'000s)	Risk Rated Plans (£'000s)
Workforce (Medical)	428	321	852	170
Workforce (Nursing)	860	725		
Workforce (AHP)	96	20		
Workforce (Other)	946	798		
Procurement	1,218	1,029		
Hospital Medicine and Pharmacy	744	607		
Pathology	444	383		
Estates and Facilities	732	147	176	35
Corporate and Admin	144	78		
Imaging	22	10		
Other Savings plans	716	625	852	170
RightCare	32	7		
Specialised Commissioning	144	106		
Total Plans Identified	**6,526**	**4,856**	**1,880**	**376**

Current CIP Position	
Target	8,406
Variance - Plans to Target %	78%
Variance - RA Plans to Target %	58%
Further internal challenge	1,594
System plans included in submission but not reported above -	£1,207,000



Our internal process for 2019-20 has an emphasis on setting budgets at the start of the year and ensuring that budget holders deliver within budget, ensuring an absolute focus on actual performance. This integrates the efficiency requirement and actions into the day to day budget management process, requiring plans to be in place by 1 April 2019 and budgets signed off accordingly.

Our further efficiency challenge relates to the ambition to create contingency for financial risk, improve the cash position of the Trust and provide flexibility in terms of both control total achievement and future capital funding.

The Trust continues to utilise the information from various sources of benchmarking to support identifying opportunities for efficiency savings, with the Model Hospital being a key element of this. Workforce, Estates and Procurement were previously identified as key areas of opportunity, and while we have identified significant plans in these areas there is still further work to be undertaken.

While Other Savings Plans may look significant, these predominantly relate to efficiencies required to support the wider systems we work in, predominantly supporting the Quality, Innovation, Productivity and Prevention Programme (QIPP) programme of our local Commissioner.

In terms of delivery and oversight, we adjusted our governance arrangements following an NHSI review in 2018-19 and created a Savings Delivery and Oversight Group chaired by the Chief Executive to oversee delivery and hold our Directorates to account. This arrangement has been reviewed to include oversight of the overall financial position (not just CIP delivery) in line with the emphasis internally of 'living within our budgets' at each level. Our new Directorate Resource Group meetings will mirror the Board Resources Committee and ensure a robust focus in one place on delivering the financial plan, workforce plan, and activity plan for each area of the Trust.

Further Details of the Trust's Strategic Plans

A range of actions is planned over the next few years to deliver the Trust's strategy. These are contained within the Trust's Operational Plan for 2019-2020 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 programme, which set an ambitious target of reducing carbon emissions by 30% from a 2010/11 baseline by 2020.

In 2018-19 the Trust has seen the benefit of the investment in the engineering infrastructure made in previous years. The result of this has been a further reduction in the consumption of imported electricity by 12%, as the optimisation of the combined heat and power plant has increase the onsite generation. This increase in onsite electrical generation has been achieved with only a minor increase in gas consumption of less than 0.05%.

Since the commitment to reduce its carbon emissions in 2013 the Trust has achieved a 26% reduction in its emissions.

Procurement

This year has been a transitional one for procurement in the NHS, as the national reorganisation of the NHS Supply Chain Logistics & Contracting service has been phased in towards a fully operational live date of 1 April 2019.One of the consequences of this is the contract for the NHS logistics/transport service was awarded to Unipart, who took over providing the service from DHL in February 2019.It is likely that the new contractor will be required to meet similar sustainability commitments around carbon waste, ethics and responsibility to that previously pledged. Similarly the national contracting function has been split into various "category towers" each of whom will be required to comply with Government sustainability requirements/commitments.

Rationalisation and the reduction of choice via the Nationally Contracted Products Programme has continued, including the change to a recycled copy paper manufactured using best environmental practices which do not allow any harmful bleaching in the process and does not contain Optical Brightening agents to whiten the paper, as these are not biodegradable and do not break down in the environment.

Locally, capital build developments in areas such as Endoscopy and the ED, have facilitated the improvement of storage facilities and order processes which should help in reducing waste, whilst there have been upgrades to hand-held ordering devices enabling Wi–Fi download, thus enhancing efficiency. A work plan has been developed across the WYAAT Trusts, focused on rationalising medical and surgical consumable

products, whilst planning has started locally for the implementation of the Scan for Safety programme across WYAAT, which should improve efficiency and reduce waste whilst also improving patient safety.

Food waste

The Trust has retained its established contractor for the recycling of its food waste from the Harrogate District Hospital site.

With all food waste recycling handled in this manner, the Trust has an environmentally-friendly way of diverting this from landfill. A brief summary of Kw Hours of electricity produced & total tonnes of CO2 displaced for the financial year ending 31 March 2019 can be found in the table below:

12 MONTHS ENDING 31 MARCH 2019		
QUARTER	**KW HOURS PRODUCED**	**TOTAL TONNES CO2 SAVED**
One	9585.00	16.33
Two	10111.50	17.23
Three	8802.00	15.00
Four	6507.00	11.09
Total	**35,005.50**	**59.65**

CLINICAL AND GENERAL WASTE

Waste		2017-18	2018-19
Recycling	(tonnes)	86.01	151.61
	tCO_2e	1.8	3.17
High Temp recovery	(tonnes)	371.21	380.39
	tCO_2e	7.8	7.99
High Temp disposal	(tonnes)	313.98	264.64
	tCO_2e	6.6	5.56
Landfill	(tonnes)	67.92	5.29
	tCO_2e	16.5	1.28
Total Waste (tonnes)		**836.12**	**801.93**

% Recycled or Re-used		**54.68%**	**66.39%**
Total Waste tCO_2e		**32.7**	**18**

Note, due to issues with the clinical waste contract in 2018-19, no data is available for the months of July, August, September 2018 and March 2019.

ENERGY

Resource		2017-18	2018-19
Gas	Use (kWh)	27,072,959	27,086,243
	tCO_2e	4982	4984
Oil	Use (kWh)	144876	163950
	tCO_2e	39.3	44.56
Coal	Use (kWh)	0	0
	tCO_2e	0	0
Electricity	Use (kWh)	3,699,906.5	3,277,675
	tCO_2e	380.7	337.3
Total Energy CO_2e		**5402**	**5366**
Total Energy Spend		**£ 1,014696**	**£979,887**

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 2018-19 the Trust supported 117 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. In addition, the Trust has a thriving Youth Forum, composed of young people who meet at least monthly. During the year they have developed a programme of Hopes for Healthcare which have been agreed by the Board of Directors and will be implemented in 2019-20.

During the year the Trust has continued with the development of programmes for a range of apprenticeship schemes. As at 31 March 2019 the Trust employs 47 apprentices, with plans to increase this further during 2019-20.

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 facilitates an annual self-assessment of compliance against the Counter Fraud Standards for Providers, which is reviewed and approved by the Director of Finance prior to submission to NHS Counter Fraud Authority. The 2018-19 assessment was completed and submitted in March 2019 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 2019.

Signed

Steve Russell
Chief Executive
Date: 24 May 2019

4. ACCOUNTABILITY REPORT

4.1. Director's Report

4.1.1 Directors 2018-19

The Directors of the Trust during the year 2018-19 were:

Mrs Sarah Armstrong	Non-Executive Director (from 1 October 2018)
Mr Jonathan Coulter	Director of Finance and Deputy Chief Executive
Mrs Jill Foster	Chief Nurse
Mrs Joanne Harrison	Interim Director of Workforce and Organisational Development (between 8 September and 4 November 2018)
Mr Robert Harrison	Chief Operating Officer
Mr Neil McLean	Non-Executive Director (left 30 April 2018)
Mr Phillip Marshall	Director of Workforce and Organisational Development (left 7 September 2018)
Ms Laura Robson	Non-Executive Director (and Chairman of Quality Committee from I October 2018)
Mrs Angela Schofield	Chairman (Non-Executive Director)
Dr David Scullion	Medical Director
Mr Richard Stiff	Non-Executive Director (from 14 May 2018)
Mrs Maureen Taylor	Non-Executive Director and Chairman of Finance/Resources 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 (left 30 September 2018)
Mrs Lesley Webster	Non-Executive Director (and Chairman of Quality Committee until 30 September 2018, Senior Independent Director from 1 October 2018)
Ms Angela Wilkinson	Director of Workforce and Organisational Development (from 5 November 2018)

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. Mr Coulter and Mr Thompson have been appointed by the Trust as Non-Executive Board members of the wholly-owned subsidiary, Harrogate Healthcare Facilities Management Limited (HHFM Ltd). This is declared at the start of all meetings which they attend (in both the Trust and HHFM Ltd) and is recorded in the appropriate registers; when issues concerning HHFM Ltd are discussed a decision is made as to whether or not they may participate in any such discussion, and on what basis.

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 2018-19 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 2018-19 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 2018	Numbers	Year to 31 March 2019
51,454	No of invoices Paid to Date	42,897
8,080	No of invoices Paid in 30 Days	2,713
16%	% of invoices Paid in 30 Days	6%

Year to 31 March 2018	Values	Year to 31 March 2019
95,920	£K Value of invoices Paid to Date	50,335
53,827	£K Value of invoices Paid in 30 Days	9,162
56%	% of invoices Paid in 30 Days	18%

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

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 External 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 2018-19.

4.1.9 Patient care activities

Improvements in patient / carer information

The Trust website delivers clear information and reflects the Trust's Vision and values. There is a clear focus given to the key information that people want the most – how to find us, contact details, car parking, and visiting hours, service pages and an area about our consultants which features a short biography and photograph of all the consultants working at the Trust.

The Trust has been working to provide a more consistent approach to the Accessible Information Standard (AIS) which aims to improve the lives 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 further progress in relation to people with learning difficulties, and are progressing systems and processes to enable us to support all patients with information and communication needs. This is reported within the Quality Report (section 3.2: Learning disabilities; and section 4.10: Equality and Diversity objectives).

The Trust has continued to develop its social media presence through 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 (PEV), based at the front of Harrogate hospital in the Main Reception during normal working hours, work to publicise the Making Experiences Count Policy and the process by which the public can share feedback regarding the Trust services.

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

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

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

Where a complaint is graded as 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 through well-established clinical alliances with York Teaching Hospital Foundation Trust (YTHFT) and Leeds Teaching Hospital Trust (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 implementation of a new pathway for Stroke services with YTHFT and the development of a Breast Screening facility in the Harrogate locality to replace the mobile service currently in operation.

The Trust is continuing to work with LTHT to explore opportunities for further collaboration.

Provider Collaborative

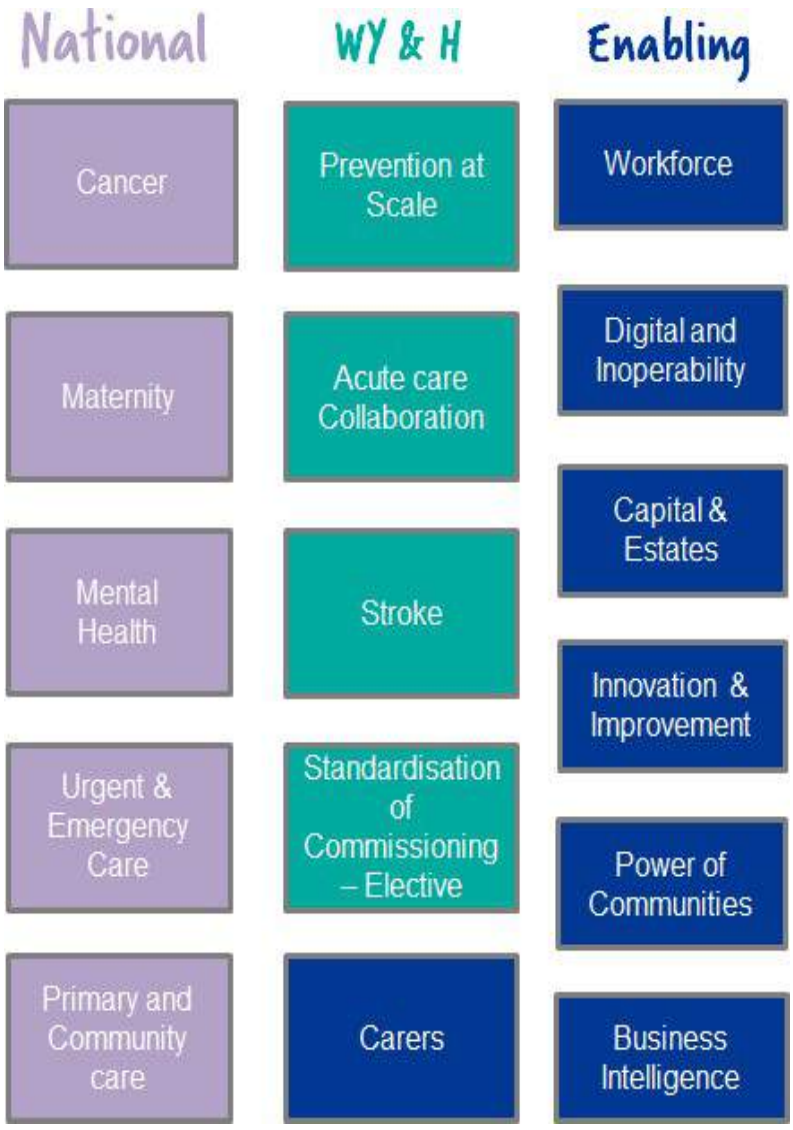
During the year the Trust became a founding member of the Provider Collaborative which includes representatives from Tees, Esk and Wear Valley Foundation Trust, NYCC and the Harrogate GP Federation Yorkshire Health Network and is focused on developing a new collaborative model for care outside of hospital.

West Yorkshire and Harrogate Health and Care Partnership (HCP)

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.

The HCP attracted additional funding for cancer diagnostics, diabetes and a new child and adolescent mental health unit, 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.



Significant Activities in the Field of Research and Development

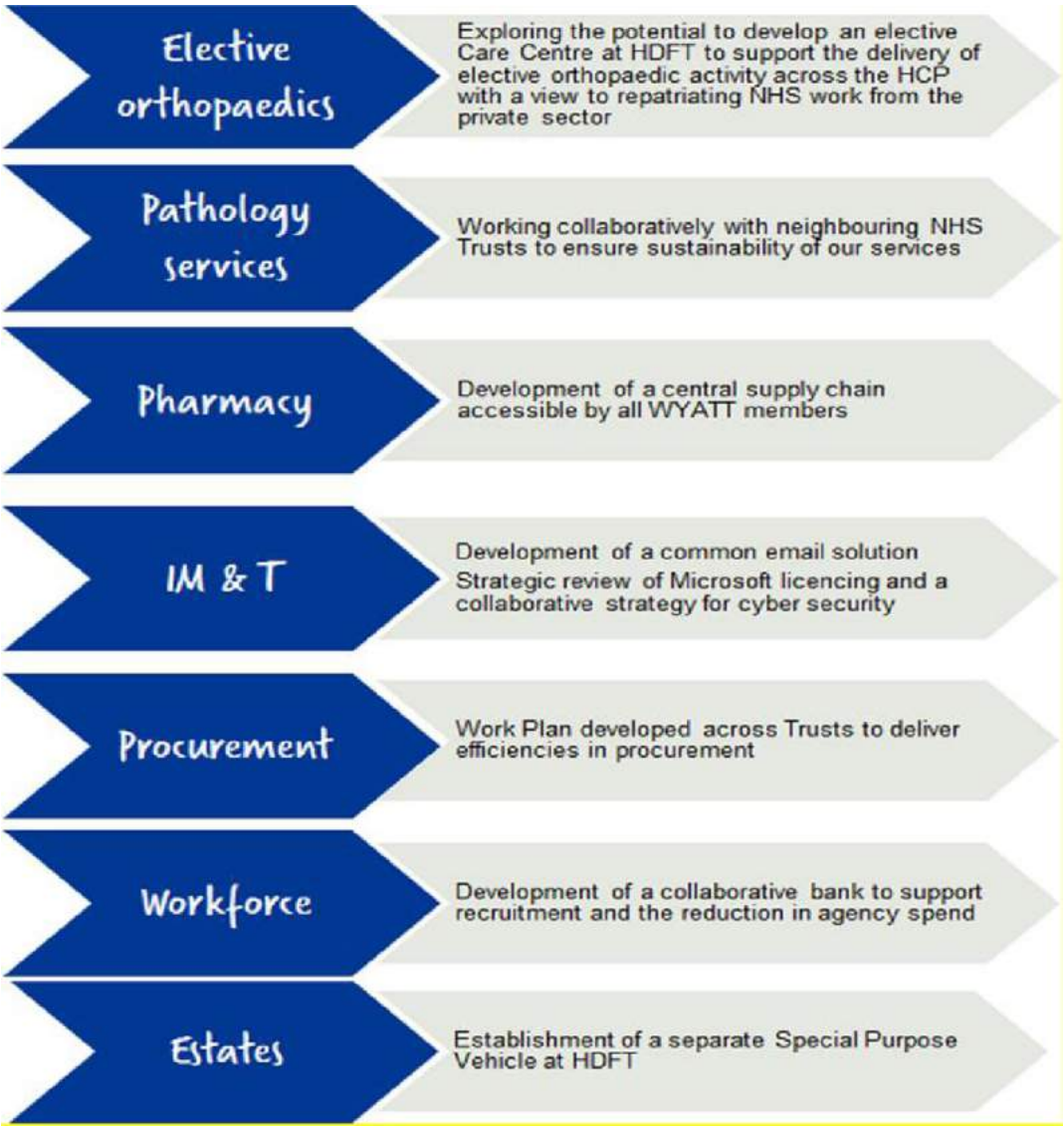
Information on research and development within the Trust is contained within the Quality Account, which is included at Section 5.0.

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.



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:

Steve Russell
Chief Executive
Date: 24 May 2019

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. The remuneration of the incoming Chief Executive (from 1 April 2019) was discussed and agreed in advance of the commencement of the recruitment process in autumn 2019. Advice was sought and received from NHS Improvement.

4.2.1.1The Remuneration Committee

The Remuneration Committee for Executive Directors meets as and when required. In 2018/2019 the Committee met three times. Attendance at each meeting is shown below. The meetings discussed an annual Cost of Living salary increase and issues around the recruitment of the incoming Director of Workforce and Organisational Development and the Chief Executive.

Date of Meeting	27 June 2018	26 Sept 2018	28 Nov 2018
Angela Schofield	√	√	√
Sarah Armstrong Non-Executive Director*	-	-	√
Ian Ward** Non-Executive Director and Senior Independent Director	√	√	-
Richard Stiff*** Non-Executive Director	√	√	√
Laura Robson Non-Executive Director	√	√	√
Maureen Taylor Non-Executive Director	√	√	√

Chris Thompson Non-Executive Director and Vice Chairman	√	√	√
Lesley Webster Non-Executive Director and Senior Independent Director (from 1 October 2018)	√	√	√

Notes:
** Sarah Armstrong joined the Trust 1 October 2018*
*** Ian Ward left the Trust on 30 September 2018*
**** Richard Stiff joined the Trust on 14 May 2018*

The Remuneration Committee is a Committee of the Board of Directors and the key outcomes from this Committee are shared with the full Board of Directors. Dr Ros Tolcher (Chief Executive), Mr Phillip Marshall and Ms Angela Wilkinson (Directors of Workforce and Organisational Development) and Mrs Joanne Harrison (Deputy Director of Workforce and Organisational Development), attended meetings of the Committee in an advisory capacity, where appropriate.

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 Committee takes 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 Director 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 £150,000. The Trust consulted NHS Improvement on one occasion during 2018-19.

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 the external auditors, KPMG LLP.

4.2.3 Annual Report on Remuneration

4.2.3.1 Senior Manager Remuneration

Name and Title	2018/19							
	Salary	Taxable benefits	Annual Performance Related Bonuses	Long Term Performance Related Bonuses	Total Salary and taxable benefits in year	Pension related benefits	Total	Ratio of Total Salary to Median for All Staff (1)
	(bands of £5,000) £'000s	Rounded to the nearest £100	(bands of £5,000) £'000s	(bands of £5,000) £'000s	(bands of £5,000) £'000s	(bands of £2,500) £'000s	(bands of £5,000) £'000s	
Dr R Tolcher - Chief Executive (2) (3)	225-230	-	-	-	225-230	-	225-230	7.67
Mr. J Coulter - Deputy Chief Executive / Finance Director	140-145	-	-	-	140-145	7.5-10	150-155	4.86
Dr D Scullion - Medical Director (2) (4)	240-245	-	-	-	240-245	-	240-245	8.12
Mrs. J Foster - Chief Nurse	120-125	-	-	-	120-125	37.5-40	155-160	4.05
Mr. R Harrison - Chief Operating Officer	125-130	-	-	-	125-130	15-20	145-150	4.32
Mr. P Marshall - Director of Workforce and Organisational Development (5)	50-55	-	-	-	50-55	5-7.5	55-60	1.74
Ms A Wilkinson - Director of Workforce and Organisational Development (6)	35-40	-	-	-	35-40	12.5-15	50-55	1.32
Mrs J Harrison - Interim Director of Workforce and Organisational Development (7)	10-15	-	-	-	10-15	2.5-5	15-20	0.41
Mrs. S Dodson - Chairman (8)	-	-	-	-	-	-	-	-
Mrs. A Schofield - Chairman (9)	45-50	-	-	-	45-50	-	45-50	-
Mr P Severs - Subsidiary Chairman (10)	0-5	-	-	-	0-5	-	0-5	-
Mr R Stiff - Non-Executive Director (11)	10-15	-	-	-	10-15	-	10-15	-
Mrs L Hind - Subsidiary Non-Executive Director (12)	0-5	-	-	-	0-5	-	0-5	-
Mrs S Armstrong - Non-Executive Director (13)	5-10	-	-	-	5-10	-	5-10	-
Mrs. M Taylor - Non-Executive Director	15-20	-	-	-	15-20	-	15-20	-
Mr. I Ward - Senior Independent Director of the Board of Directors (14)	5-10	-	-	-	5-10	-	5-10	-
Mrs. L Webster - Senior Independent Director of the Board of Directors (15)	15-20	-	-	-	15-20	-	15-20	-
Mr. N McLean - Non-Executive Director (16)	0-5	-	-	-	0-5	-	0-5	-
Ms. L Robson - Non-Executive Director (17)	15-20	-	-	-	15-20	-	15-20	-
Mr. C Thompson - Non-Executive Director/ Audit Committee Chairman	20-25	-	-	-	20-25	-	20-25	-

Name and Title	2017/18							
	Salary	Taxable benefits	Annual Performance Related Bonuses	Long Term Performance Related Bonuses	Total Salary and taxable benefits in	Pension related benefits	Total	Ratio of Total Salary to Median for All Staff (1)
	(bands of £5,000) £'000s	Rounded to the nearest £100	(bands of £5,000) £'000s	(bands of £5,000) £'000s	(bands of £5,000) £'000s	(bands of £2,500) £'000s	(bands of £5,000) £'000s	
Dr R Tolcher - Chief Executive (2) (3)	220-225	-	-	-	220-225	-	220-225	6.81
Mr. J Coulter - Deputy Chief Executive / Finance Director	140-145	-	-	-	140-145	72.5-75	215-220	5.00
Dr D Scullion - Medical Director (2) (4)	205-210	-	-	-	205-210	-115- -117.5	90-95	7.29
Mrs. J Foster - Chief Nurse	110-115	-	-	-	110-115	77.5-80	190-195	3.97
Mr. R Harrison - Chief Operating Officer	125-130	-	-	-	125-130	57.5-60	185-190	4.45
Mr. P Marshall - Director of Workforce and Organisational Development (5)	115-120	-	-	-	115-120	60-62.5	175-180	4.13
Ms A Wilkinson - Director of Workforce and Organisational Development (6)	-	-	-	-	-	-	-	-
Mrs J Harrison - Interim Director of Workforce and Organisational Development (7)	-	-	-	-	-	-	-	-
Mrs. S Dodson - Chairman (8)	25-30	-	-	-	25-30	-	25-30	-
Mrs. A Schofield - Chairman (9)	20-25	-	-	-	20-25	-	20-25	-
Mr P Severs - Subsidiary Chairman (10)	-	-	-	-	-	-	-	-
Mr R Stiff - Non-Executive Director (11)	-	-	-	-	-	-	-	-
Mrs L Hind - Subsidiary Non-Executive Director (12)	-	-	-	-	-	-	-	-
Mrs S Armstrong - Non-Executive Director (13)	-	-	-	-	-	-	-	-
Mrs. M Taylor - Non-Executive Director	10-15	-	-	-	10-15	-	10-15	-
Mr. I Ward - Senior Independent Director of the Board of Directors (14)	15-20	-	-	-	15-20	-	15-20	-
Mrs. L Webster - Senior Independent Director of the Board of Directors (15)	10-15	-	-	-	10-15	-	10-15	-
Mr. N McLean - Non-Executive Director (16)	10-15	-	-	-	10-15	-	10-15	-
Ms. L Robson - Non-Executive Director (17)	5-10	-	-	-	5-10	-	5-10	-
Mr. C Thompson - Non-Executive Director/ Audit Committee Chairman	20-25	-	-	-	20-25	-	20-25	-

(1) The median salary for all staff in 2018/19 was £29,608. The median salary for all staff in 2017/18 was £28,746. 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 now offers a Pensions Restructuring Payment. This payment is typically equal to the employer's contribution to the NHS Pension Scheme, paid net of employer's National Insurance contribution. This is a financially neutral model for the Trust. The Chief Executive and Medical Director's application for a pension restructuring payment was approved by the Trust's Remuneration Committee.

(3) Dr R Tolcher ceased as Chief Executive on 31 March 2019

(4) 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.

(5) Mr P Marshall ceased as Director of Workforce and Organisational Development on 7 September 2018

(6) Ms A Wilkinson commenced as Director of Workforce and Organisational Development on 5 November 2018

(7) Mrs J Harrison commenced as Interim Director of Workforce and Organisational Development on 8 September 2018, ceasing the role on 4 November 2018

(8) Mrs. S Dodson ceased as Chairman on 31 October 2017

(9) Mrs. A Schofield commenced as Chairman on 1 November 2017

(10) Mr Severs commenced as Chairman of the Trust's Subsidiary on 1 April 2018

(11) Mr Stiff commenced as Non-Executive Director on 14 May 2018

(12) Mrs Hind commenced as Non-Executive Director for the Trust's Subsidiary on 1 January 2019

(13) Mrs S Armstrong commenced as Non-Executive Director on 1 October 2018

(14) Mr I Ward ceased as Senior Independent Director of the Board on 30 September 2018

(15) Mrs L Webster commenced as Senior Independent Director of the Board on 1 October 2018

(16) Mr. N McLean ceased as Non-Executive Director on 30 April 2018

(17) Ms. L Robson commenced as Non-Executive Director on 11 September 2017

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

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 further information on the expenses claimed.

	Number in post on 31st March 2019	Number claiming expenses	Total value claimed (Rounded to £00)	Number in post on 31st March 2018	Number claiming expenses	Total value claimed (Rounded to £00)
Board of Directors	15	6	1,700	13	9	6,800
Council of Governors	21	0	0	20	3	700

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 2018 £000	Cash Equivalent Transfer Value at 31 March 2019 £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	0-2.5	-5-2.5	45-50	115-120	776	917	117	£Nil
Dr David Scullion - Medical Director	£Nil	£Nil	£Nil	£Nil	£Nil	£Nil	£Nil	£Nil
Mrs. Jill Foster - Chief Nurse	0-2.5	5-7.5	50-55	150-155	934	1,121	158	£Nil
Mr. Robert Harrison - Chief Operating Officer	0-2.5	-2.5-0	25-30	60-65	319	405	76	£Nil
Mr. Phillip Marshall - Director of Workforce and Organisational Development	0-2.5	-2.5-0	45-50	120-125	763	891	105	£Nil
Ms Angela Wilkinson - Director of Workforce and Organisational Development	0-2.5	0-2.5	0-5	0-2.5	75	117	40	£Nil
Mrs Joanne Harrison - Interim Director of Workforce and Organisational Develop	0-2.5	0-2.5	5-10	15-20	81	119	35	£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. Fair Pay Multiple

The median salary for all staff in 2018-19 was £29,608. The ratio between this and the mid-point of the banded remuneration of the highest paid director was 8.12.

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:

Steve Russell
Chief Executive
Date: 24 May 2019

4.3 Staff Report

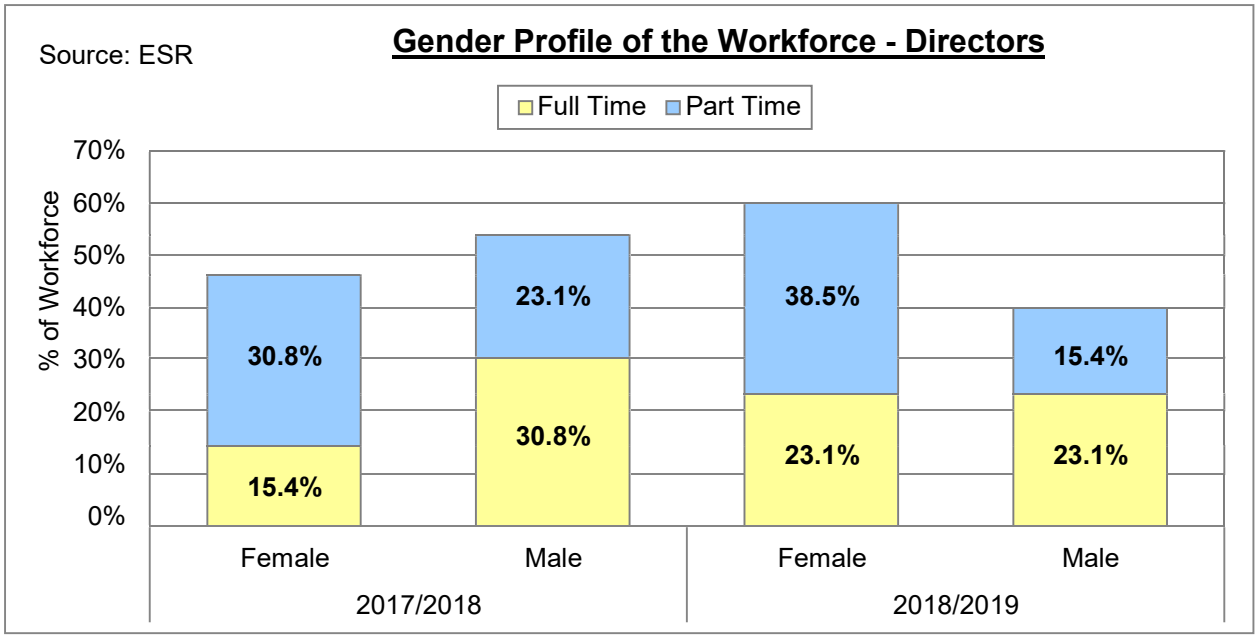
All of the data profiles of the Trust's staff in the charts below have been collated from the Trust's Electronic Staff Record (ESR) system and provides a comparison between 2017-18 and 2018-19. All figures are taken for the end of the financial year and include all staff employed by the Trust, with the exception of bank only contracts.

4.3.1 Analysis of staff numbers as at 31 March 2019

Staff Group	2017/2018		2018/2019	
	Headcount	**WTE**	**Headcount**	**WTE**
Administrative and Clerical	752	630.72	784	673.54
of which Senior Management	*67*	*65.03*	*71*	*69.36*
Allied Health Professionals	325	270.47	335	273.48
Estates and Ancillary	269	221.52	34	23.60
Medical and Dental	397	319.98	413	339.06
Nursing and Midwifery Registered	1,414	1,184.63	1,693	1,419.54
Scientific and Technical	188	167.24	167	145.46
Support Workers	765	618.96	841	682.20
TOTAL	**4,110**	**3,413.53**	**4,267**	**3,556.89**

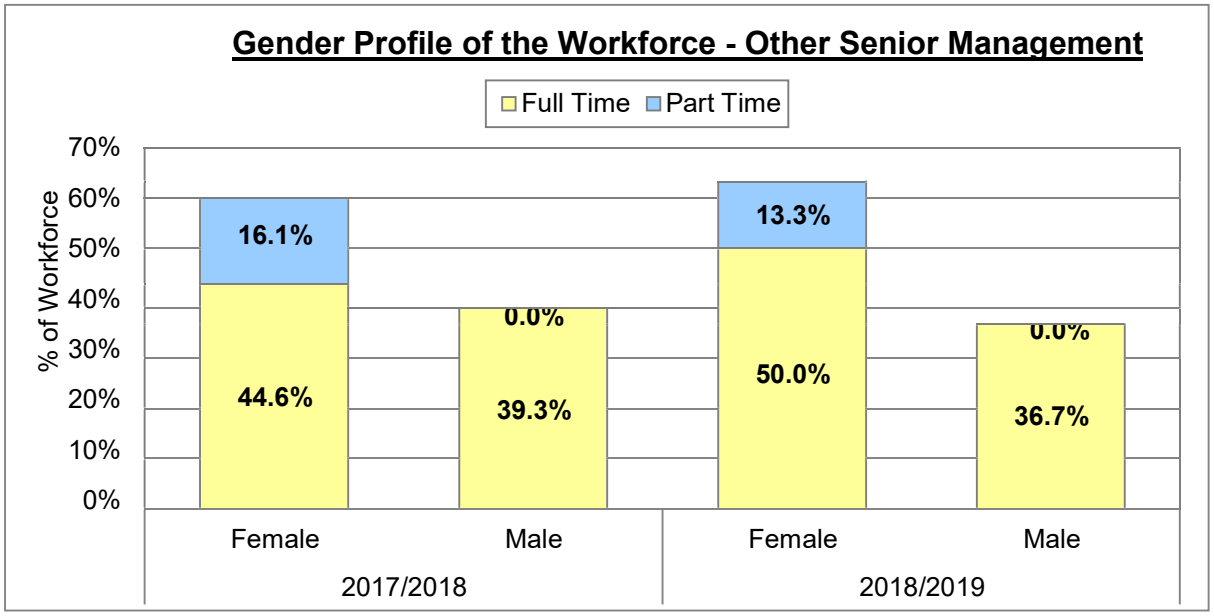
*Headcount is based on the employee's primary assignment to avoid duplication of headcount.
**Senior Management relates to Administrative and Clerical staff, Band 8a and above.

4.3.2 Analysis of the Male and Female Directors, Other Senior Managers and Employees as at 31 March 2019



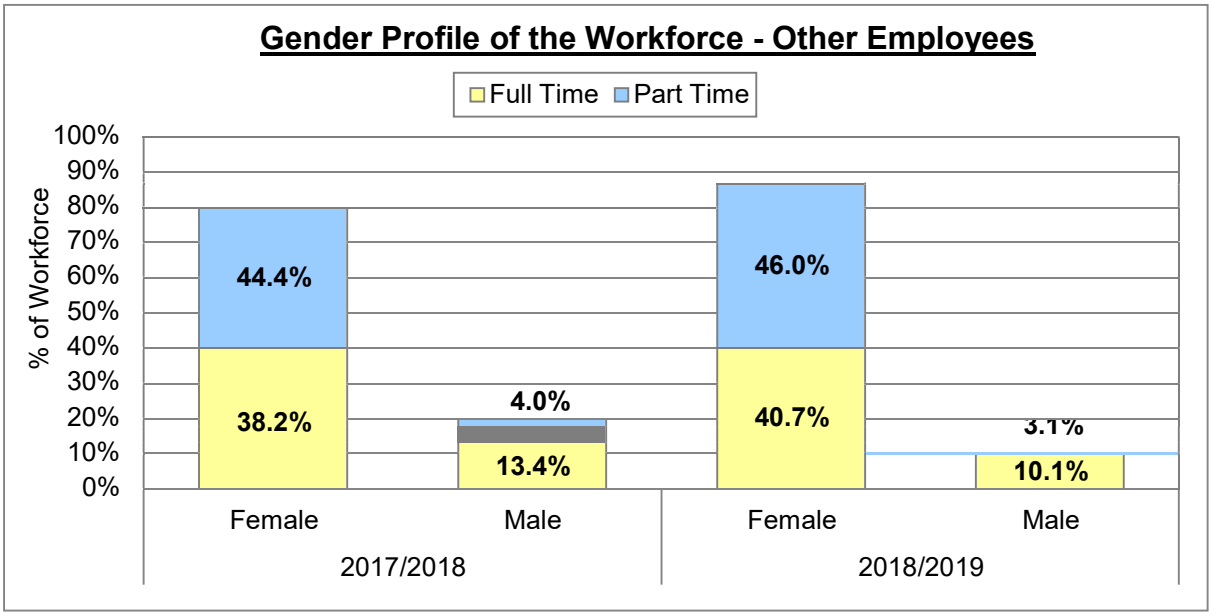
The table below gives a breakdown of the number of Directors, including Non-Executive Directors, by gender, as at 31 March 2019.

Gender	Category	2017/2018	2018/2019
DIRECTORS		**Headcount**	**Headcount**
Female	Full Time	2	3
	Part Time	4	5
Male	Full Time	4	3
	Part Time	3	2
TOTAL		**13**	**13**



The table below gives a breakdown of the number of other senior management, by gender, as at 31 March 2019.

Gender	Category	2017/2018	2018/2019
OTHER SNR MANAGEMENT		**Headcount**	**Headcount**
Female	Full Time	25	30
	Part Time	9	8
Male	Full Time	22	22
	Part Time	0	0
TOTAL		**56**	**60**



The table below gives a breakdown of the number of other employees, by gender, as at 31 March 2019.

Gender	Category	2017/2018	2018/2019
Other Employees		**Headcount**	**Headcount**
Female	**Full Time**	1,543	1,709
	Part Time	1,794	1,930
Male	**Full Time**	543	425
	Part Time	161	130
TOTAL		**4,041**	**4,194**

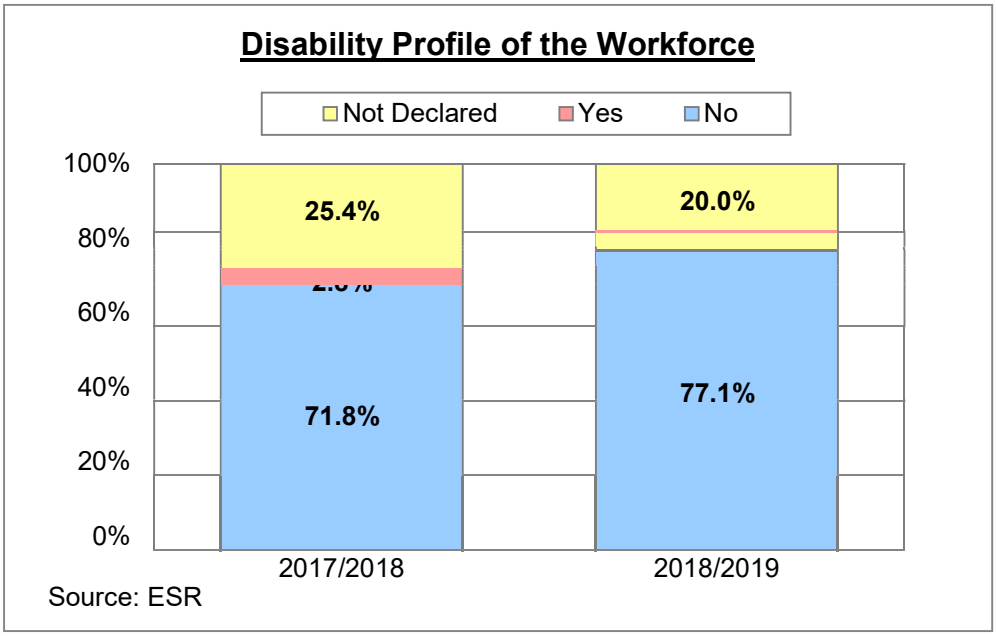
4.3.3 Sickness absence data

The table below shows the Trust's sickness absence data for each quarter during the 2018-19 financial year.

Directorate	18/19 Q1 % Absence Rate (FTE)	18/19 Q2 % Absence Rate (FTE)	18/19 Q3 % Absence Rate (FTE)	18/19 Q4 % Absence Rate (FTE)	Cumulative % Abs Rate
Children's and County Wide Community Care	4.46%	3.86%	4.93%	5.49%	**4.70%**
Corporate Services	1.82%	1.98%	1.97%	2.54%	**2.08%**
Long Term and Unscheduled Care	4.55%	4.30%	4.32%	4.82%	**4.49%**
Planned and Surgical Care	4.12%	4.10%	4.71%	4.85%	**4.44%**
TOTAL	**4.12%**	**3.86%**	**4.38%**	**4.81%**	**4.30%**

Key
18/19 Q1 – April 2018 to June 2018
18/19 Q2 – July 2018 to September 2018
18/19 Q3– October 2018 to December 2018

4.3.4 Analysis of the Disability Profile of the Workforce as at 31 March 2019



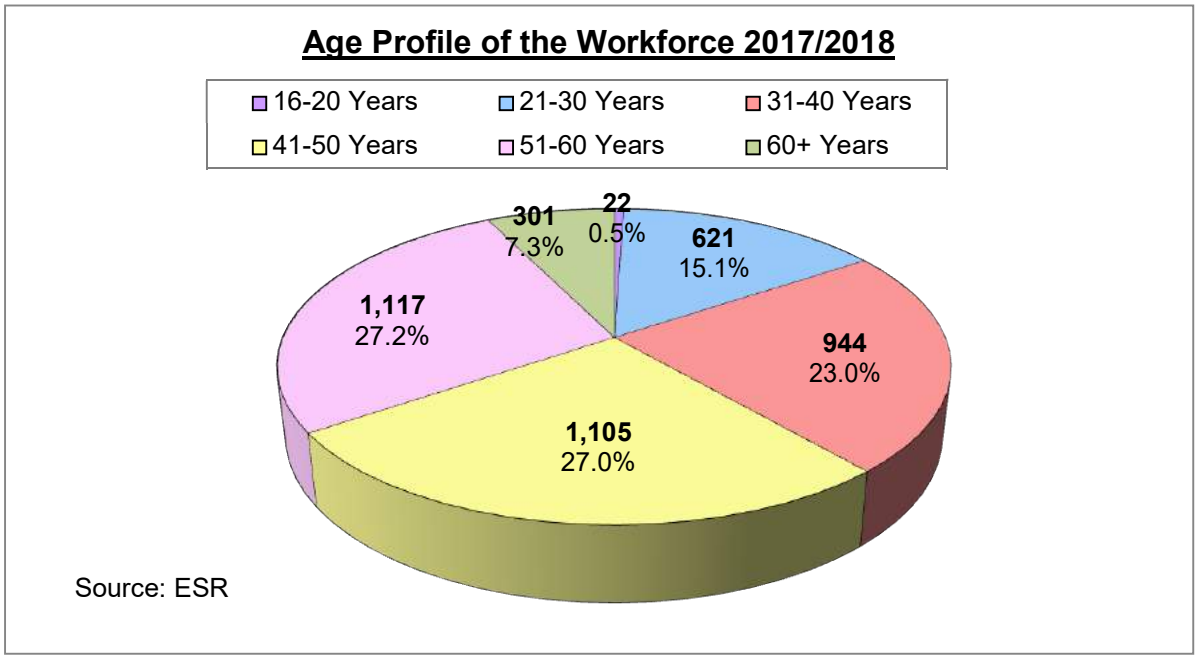
The table below gives a breakdown of the number of employees registered as having a disability as at 31 March 2019.

Disabled	2017/2018	2018/2019
	Headcount	Headcount
No	2,951	3,290
Yes	114	125
Not Declared	1,045	852
TOTAL	4,110	4,267

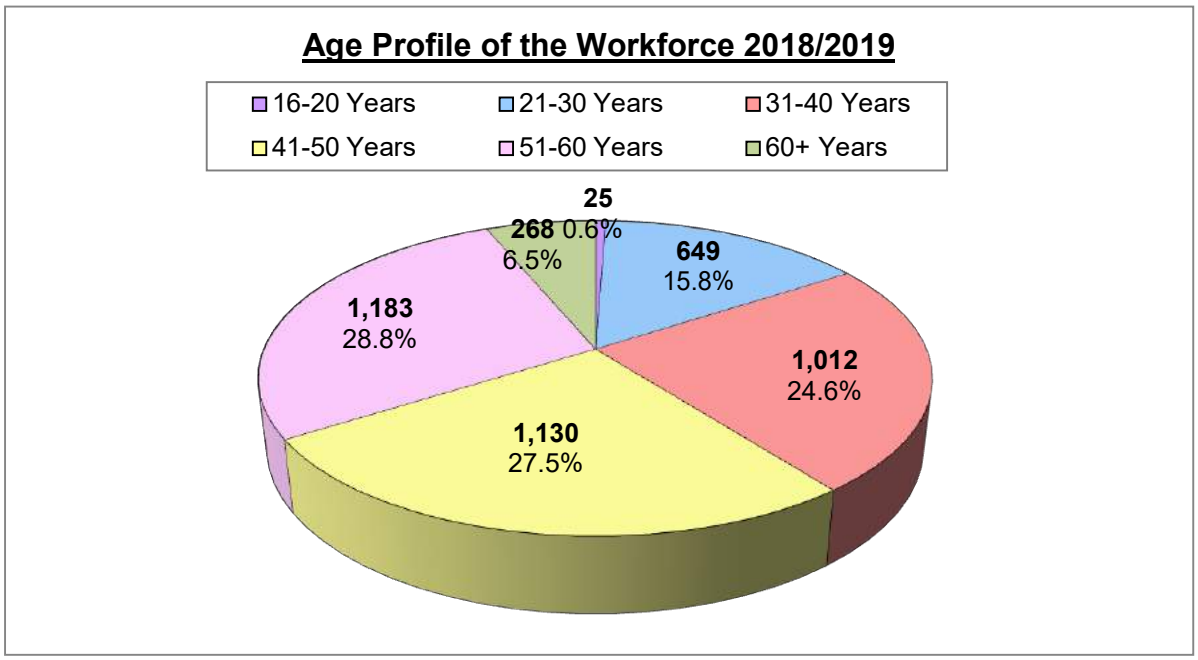
4.3.5 Analysis of the Age Profile of the Workforce as at 31 March 2019

The table below gives a breakdown of the number of employees, by age, as at 31 March 2019.

	2017/2018		2018/2019	
Age Band	Headcount	% of Workforce	Headcount	% of Workforce
16-20 Years	22	0.5%	25	0.6%
21-30 Years	621	15.1%	649	15.8%
31-40 Years	944	23.0%	1,012	24.6%
41-50 Years	1,105	27.0%	1,130	27.5%
51-60 Years	1,117	27.2%	1,183	28.8%
60+ Years	301	7.3%	268	6.5%
TOTAL	4,110		4,267	



Source: ESR

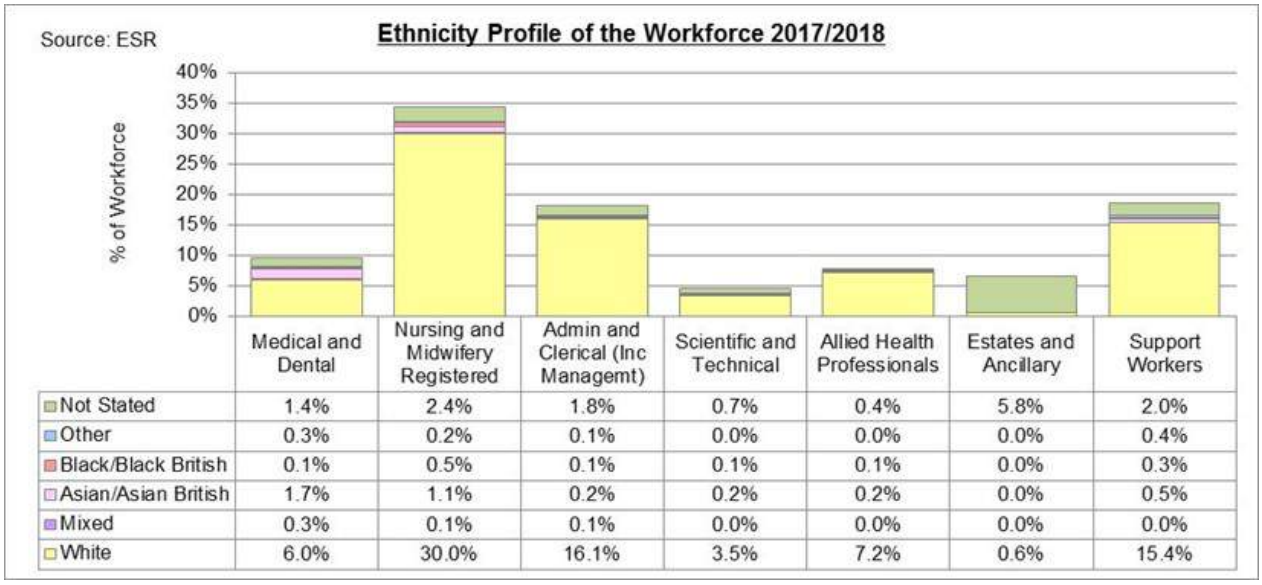


4.3.6 Analysis of the Ethnicity Profile of the Workforce as at 31 March 2019

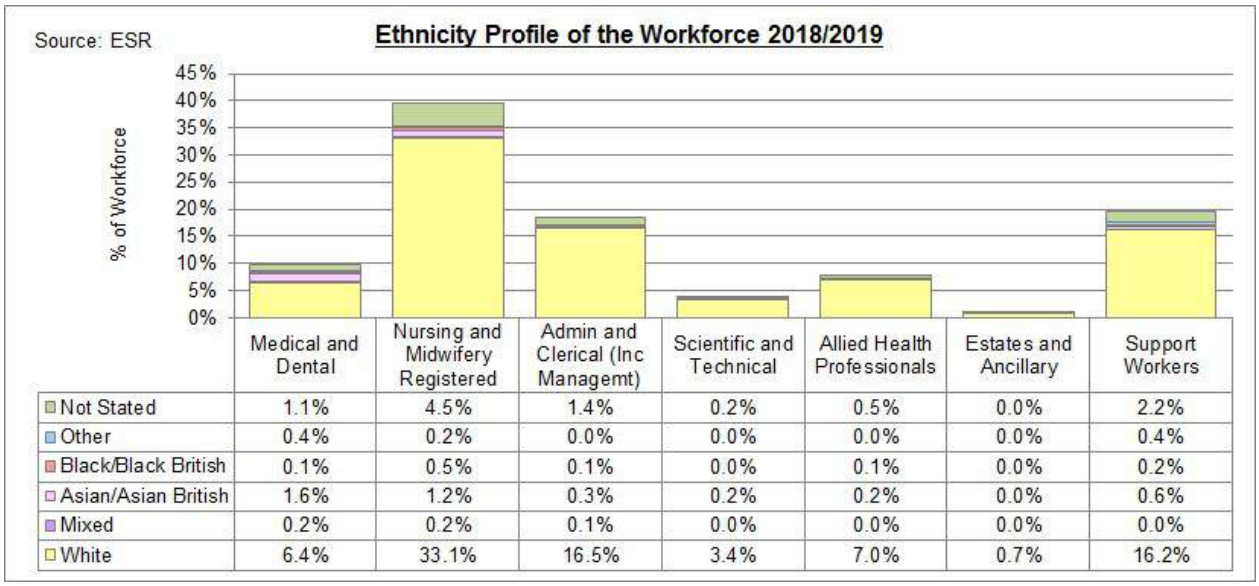
Equality and Diversity and Human Rights

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 fourth Annual Workforce Race Equality Standard (WRES) report in September 2018, and the Equality Delivery System (EDS2) assessment in January 2019. 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.



HEADCOUNT 2017/2018	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	1,235	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 2018/2019	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	272	1,414	705	144	298	29	692	**3,554**
Mixed	10	7	4	1	1	1	2	**26**
Asian/Asian British	67	52	11	10	10	1	26	**177**
Black/Black British	4	21	4	2	5	2	10	**48**
Other	15	9	2	1	1	0	18	**46**
Not Stated	45	190	58	9	20	1	93	**416**
TOTAL	**413**	**1,693**	**784**	**167**	**335**	***34**	**841**	**4,267**

*The significant reduction in Estates and Ancillary staff in 2018/2019 is due to the transfer of many of these staff in to the Trust's Subsidiary company, Harrogate Healthcare Facilities Management in 2018.

4.3.7 Gender Pay Gap Data

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

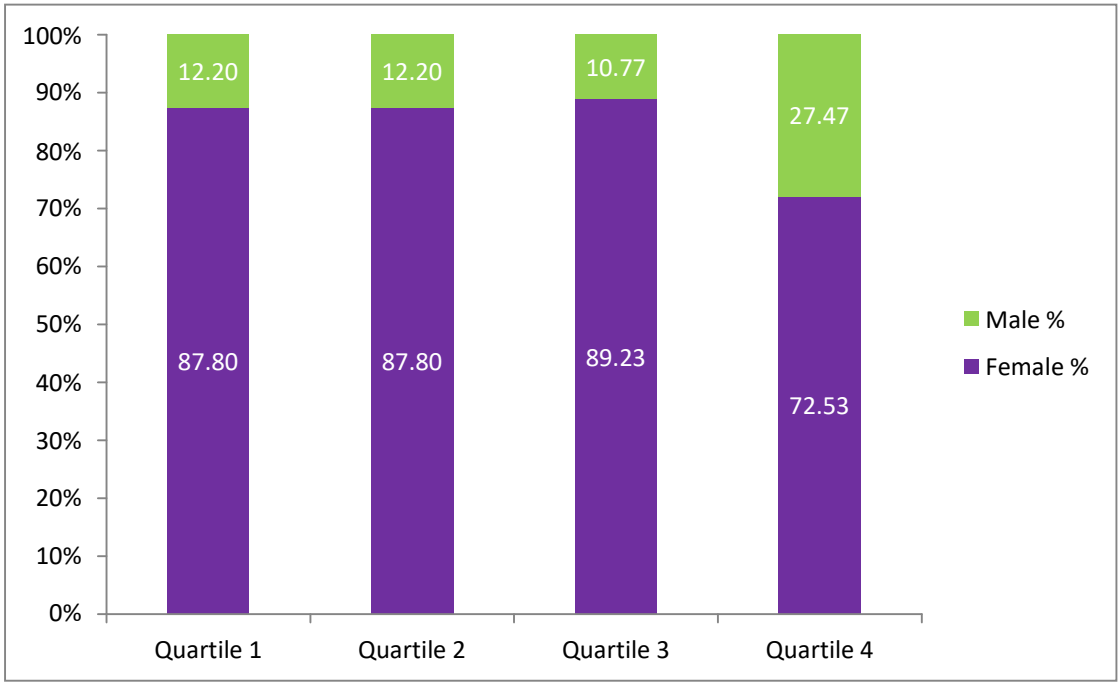
It is important when doing this to highlight the difference between equal pay and a gender pay gap. Equal pay is lawful and relates to men and women receiving different pay for work of equal value, whereas gender pay analyses the differences in average pay for men and women within an organisation. It 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 (£)	23.80	17.35
Female (£)	16.23	14.70
Difference (£)	7.57	2.64
Pay Gap %	31.80	15.24

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 (£)	11,164.04	6,051.97
Female (£)	9,034.83	5,542.72
Difference (£)	2,129.21	509.26
Pay Gap %	19.07	8.41

Proportion of males and females receiving a bonus payment:

Taking both clinical excellence awards and long service awards into account, as a proportion 3.52% of females (146) received a bonus compared to 10.4% of males (59). This is influenced by the ratio of males in receipt of bonus to the overall number of males.

To address the gender pay gap the Trust is going to action the following:

- Raise awareness 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.
- Consider the use of additional training, e.g. unconscious bias training
- Establish a staff network to explore the findings; this network will be open to all staff.

It is also recognised that the actions taken in the last 12 months have had a positive effect but it is recommended that the Trust continues with the following:

- Continue in its efforts to encourage more female applicants, both internal and external, to senior medical positions. There has been an improvement since 2017 in the number of female consultants, and they are now in the majority.
- Continue work in relation to encouraging more applications for Clinical Excellence awards from women and providing support for individuals who have submitted unsuccessful applications in the past. The 2018 submission shows a larger number of females being awarded CEA but these are still at the lower level.

Starters and Leavers during 2018-19

	Headcount	**FTE**
Starters	402	351.67
Leavers	456	357.28

Exclusions applied:

- Retire and Returns
- Locum Medical and Dental staff
- Bank Staff
- Doctors in training
- Fixed Term Contracts
- TUPE Transfers in/out

4.3.8 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:

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.

Disability Confident Charter

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 and personal letters. 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 Trust 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 runs an 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. In the last year Listening events have also taken place with the Chief Executive encouraging Staff to come and feedback their views.

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 Trust website for staff health, benefits and wellbeing offering an extensive range of discounts and contacts enabling staff to access at all times as well as sources for support, development and training on the intranet.

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,

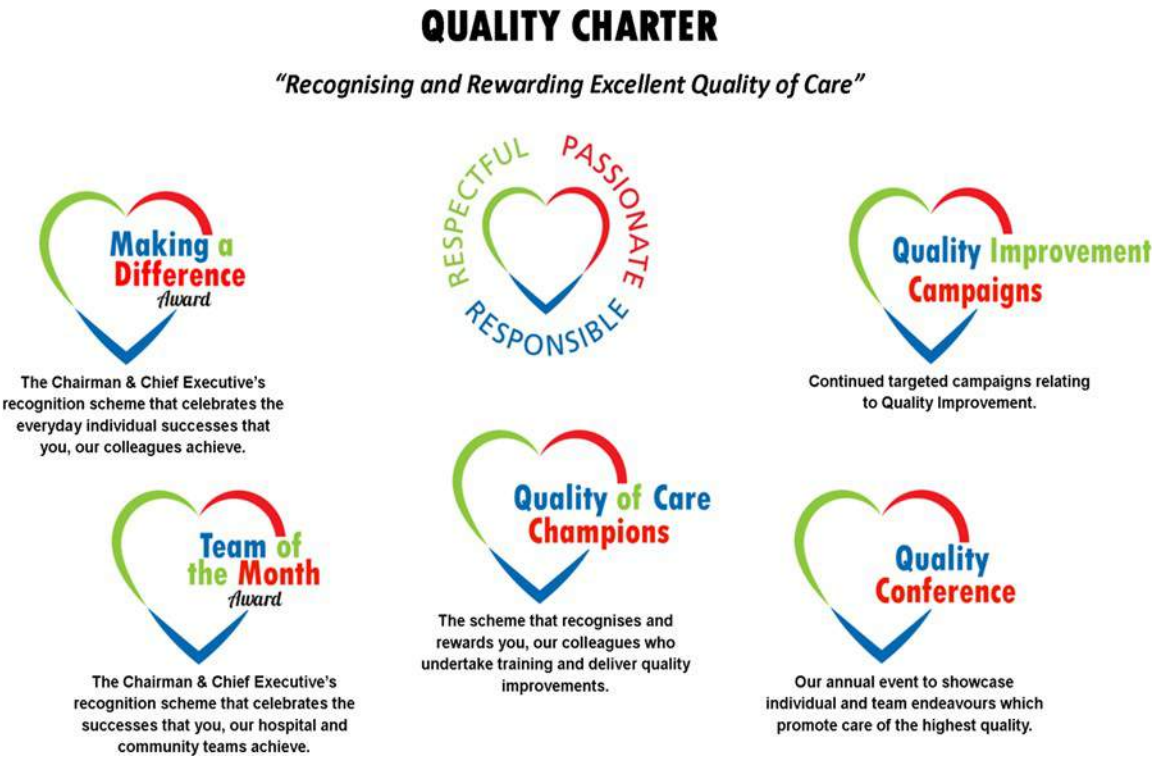
Managing Attendance and Promoting Health and Wellbeing Policy, Speaking Up Policy (also known as the Whistleblowing policy) and Shared Parental Leave Policy.

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. 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:



Quality of Care Champions

This scheme is open to all staff across the Trust – in every job role and at every location. There are four levels: Bronze, Silver, Gold and Platinum, which can be worked through. At each level, there are just two requirements: training and action. Training is completely free and the action element varies at each level, from proposing a project right at Bronze level through to leading a series of rapid process improvement events at Platinum level. Once staff have completed the training and action of the level they are working towards, they receive full accreditation as a HDFT Quality of Care Champion – getting a certificate and Pin Badge.

Year to date (April 2018 – February 2019), the following numbers of Quality of Care Champions have been accredited:

- At Bronze level – 327 champions
- At Silver level – 15 champions
- At Platinum level – 4 champions

Making a Difference and Team of the Month Award

This is the Chairman and Chief Executive's award scheme that celebrates and highlights great quality of care across the Trust. Absolutely anyone can nominate and any staff member can be nominated.
They are open to individuals and teams who work or take action in a way which: goes above and beyond, shows how they are living the Trust values, makes a difference, and uses our resources with care
There may be multiple winners every month for the Making a Difference Award but only one winning team every month for the Team of the Month Award.
Year to date (April 2018 – February 2019), we have received 278 nominations and of those, 215 were for Making a Difference and 63 for Team of the Month. Of those:

- 136 individuals have received Making a Difference Awards
- 11 teams have received Team of the Month Awards

Health and Safety, and Occupational Health

The Occupational Health (OH) 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 OH 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 OH 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, 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 occupational health advice and consultations 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 ergonomic assessments, 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 OH 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.

In January 2019 a pilot Musculo-Skeletal (MSK) rapid access service was implemented for staff requiring physiotherapy interventions, regardless of their work and home locations. To date this has begun to point to successes in both preventing sickness absence with MSK injuries and conditions, as well as in helping staff who were off sick at the time of injury / flare-up of condition to return to work earlier after accessing rapid intervention.

A supervised training scheme through the School of Natural Therapies in conjunction with Occupational Health will shortly enable HDFT staff to access Complementary Therapies to enhance their physical and mental health and wellbeing.

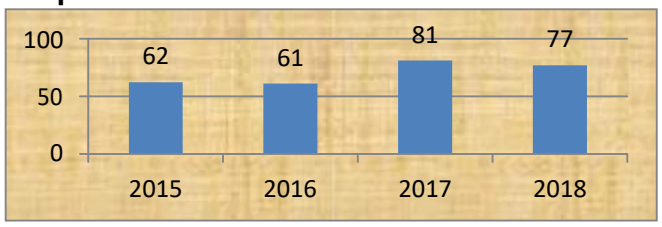
Staff Counselling & Support Service Report 2018

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 their 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.

Referrals

Referrals into the counselling service have dropped slightly this calendar year, while remaining significantly higher than 2015/6 (see graph below). The drop in referrals is due to change in staff and recruitment, resulting in the wait for counselling increasing significantly.

Graph 1



Counselling Team Developments

This year the Trust recruited to a 15-hours per week staff counselling post. In addition, two placement counsellors joined in October, who will be with us for a minimum of a year on honorary contracts and have increased capacity within the team by six appointments per week.

Staff Wellbeing Initiatives

In line with the Trust's Health and Wellbeing Strategy for addressing workplace mental health, the counselling service has continued to be proactive in supporting Schwartz Rounds, providing 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.

Time to Change Pledge

The Trust has signed the Time To Change, pledge undertaking an organisational pledge to "raise awareness that mental health is as important as physical health: this will be embedded throughout our organisation – in our values, behaviours, practice, policies and guidance. The Trust is dedicated to ensuring a package of support is available for colleagues to help maintain positive health and mental wellbeing. Our aim of reducing stigma and changing behaviour and attitudes towards mental ill health is supported through a comprehensive awareness raising programme including: training; openness; dialogue and promotion of national campaigns".

Mental Health First Aid two day training is ongoing, with a particularly good uptake of training cohorts from 0-19yrs Children's Services in Stockton and North Yorkshire.

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.

4.3.9 Trade Union Facility Time Disclosure

The Trade Union (Facility Time Publications Requirements) Regulations 2017 implement the requirement introduced by the Trade Union Act 2017 for specified public-sector employers, including NHS Trust's to report annually a range of data in relation to their usage and spend on trade union facility time.

Facility time generates benefits for employees, managers and the wider community from effective joint working between union representatives and employers. Whether in

providing support to individual members of Trust staff at a departmental level, or by playing a valuable role in contributing to Trust-wide agendas for example (Partnership Forum, Local negotiating Committee, Health and Safety Committee) the Trust recognises that the participation of trade union representatives supports the partnership process and contributes to delivering improved services to patients and users.

At a time when the whole public sector needs to ensure it delivers value for money, the Trust will continue to monitor and evaluate the amount of money spent on facility time, in the interests of transparency and accountability.

The Trust's data for the first reporting period 1 April 2017 to 31 March 2018 is listed below.

Table 1: Relevant union officials
Total number of Trust employees who were relevant union officials during the relevant period:

Number of employees who were relevant union officials during the reporting period 1 April 2017 to 31 March 2018	**Full-time equivalent employee number**
36	32.42

Table 2: Percentage of time spent on facility time
Employees who were relevant union officials employed during the relevant period spent the following percentage of time of their working hours:

Percentage of Time	**Number of Employees**
0%	15
1-50%	20
51-99%	1
100%	0

Table 3: Percentage of pay bill spent on facility time
The percentage of the Trust's total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period:

Provide the total cost of facility time	£23,962
Provide the total pay bill	£148,202,784
Provide the percentage of the total pay bill spend on facility time, calculated as: (total cost of facility time divided by total pay bill) x 100	0.02%

Table 4: Paid trade union activities
As a percentage of total paid facility time hours, the number of staff hours spent by employees who were relevant union officials during the relevant period on paid trade union activities:

Total spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spend on paid trade union	12.97%

activities by relevant union officials during the relevant period divided by total paid facility time hours) x 100	

The figures have been calculated using the standard methodologies used in the Trade Union (Facility Time Publication Requirements) Regulations 2017.

Trade Union Continuing Professional Development (CPD)

The Trust is committed to creating and maintaining a positive employee relations climate. Partnership working of management and staff representatives underpins and facilitates the development of sound and effective employee relations throughout the NHS. The Trust recognises that the participation of trade union representatives in the partnership process can contribute to delivering improved services to patients and service users.

In order to further develop our approach to partnership working, we held two CPD sessions with our Trade Union colleagues. These have focused on items of key importance to the Trust. The first session focused on: Human Factors training, Safeguarding and General Data Protection Regulations (GDPR). The second session focused on Fair and Just Culture work, an up-date from our Freedom to Speak up Champion, and our 2018 Staff Survey results. The session resulted in some commitments from Trade Union colleagues to develop these agendas with the Trust.

4.3.10 National Staff Survey Results

The Trust undertook the staff survey between October and November 2018. 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.

In total, 4,056 surveys were distributed to members of Trust staff and 1,576 were completed, which represents a 39% response rate. The average response rate of our benchmarking group was 41% and the national average was 43%.

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

Overall the results of the 2018 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 Staff Engagement score of 7.2 (on a scale of 0 being poorly engaged and 10 being highly engaged), is above average for the category of Combined Acute and Community Trusts.

From the staff survey benchmarking analysis out of the 10 themes, the Trust's ratings against other combined Acute and Community Trusts are detailed below. Nine themes were rated above average and one theme met the average. The ratings are on a scale of 0 – 10, 10 being the best score.

Themes	HDFT 2016	Average 2016	HDFT 2017	Average 2017	HDFT 2018	Average 2018
Equality, diversity & inclusion	9.4	9.3	9.4	9.2	9.4	9.2
Health & wellbeing	6.3	6.1	6.1	6.0	6.0	5.9
Immediate managers	6.9	6.8	6.9	6.8	7.0	6.8
Morale	N/A	N/A	N/A	N/A	6.3	6.2
Quality of appraisals	5.8	5.4	5.6	5.3	5.7	5.4
Quality of care	7.8	7.5	7.4	7.5	7.4	7.4
Bullying & harassment	8.3	8.2	8.5	8.1	8.3	8.1
Safe environment – Violence	9.5	9.5	9.6	9.5	9.6	9.5
Safety culture	7.0	6.7	6.7	6.7	6.9	6.7
Staff engagement	7.3	7.0	7.1	7.0	7.2	7.0

The scores for four themes have improved since the 2017 Staff Survey:

- Staff Engagement
- Safety Culture
- Immediate Managers
- Quality of Appraisals

The scores for two themes have declined since the 2017 Staff Survey:

- Health & Wellbeing
- Safe Environment – Bullying & Harassment

Of the specific questions asked, the five most improved and declined scores since 2017 are detailed in the tables below:

Top five most improved scores compared with the Trust's 2017 results	HDFT 2017	HDFT 2018	Combined acute & community Trust avg. 2018
Staff satisfied with the level of pay	32.8%	41.3%	38.4%
Staff knowing who the senior managers are here	80.2%	85.5%	82.9%
Staff satisfied with the extent to which the organisation values their work	47.3%	51.2%	45.8%
Staff recommending the organisation as a place to work	59.7%	63.2%	61.1%
Staff able to make improvements happen in their area of work	56.9%	60.4%	56.5%

Five most declined scores compared with the Trust's 2017 results	HDFT 2017	HDFT 2018	Combined acute & community Trust avg. 2018
Staff undertaking (non-mandatory) training, learning or development in the last 12 months	72.4%	68.6%	70.2%
Staff witnessing errors, near misses, or incidents that could have hurt staff in the last month	12.5%	15.5%	16.9%

Staff agreeing the organisation takes positive action on health and well-being	30.5%	27.6%	27.8%
Staff agreeing their immediate manager can be counted on to help with a difficult task at work	74.7%	71.9%	70.1%
Staff agreeing their immediate manager gives clear feedback on their work	66%	63.6%	61.1%

Action plans

The Trust is developing action plans with a specific focus on:

- **Safe Environment – Bullying & Harassment; Safe Environment – Violence; Equality, Diversity & Inclusion**

Continue the ongoing work in relation to a fair and just culture and zero tolerance to bullying, harassment, abuse or violence to encourage reporting and action on incidents. There needs to be a clear focus on Equality, Diversity and Inclusion as part of this work and more widely, to improve experiences for all, in all areas of working life.

- **Health & Wellbeing**

Focus on communication of the health and wellbeing initiatives already available to staff, in particular those relating to MSK and stress as well as identifying any gaps in our current provision to help target these areas.

- **Safety Culture**

Continuing the ongoing work to promote a learning culture within the organisation

- **Immediate Managers; Your managers and Your Personal Development**

Continue to focus on leadership development and talent management within the organisation as well as supporting managers with day to day line management, including meaningful appraisals. There will be links with other areas of focus outlined above and how we support managers to support staff with these issues.

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 2018-19 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 – July 2018)	70.1%
Quarter 2 (September 2018)	65%
Quarter 3	Survey not required – National Staff Survey
Quarter 4 (February 2019)	68.7%

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 2018 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.

4.3.11 Expenditure on consultancy

Consultancy costs for 2018-19 were £473,000; this compares with £437,000 in 2017-18.

4.3.12 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 2018-19.

4.3.13 Exit Packages

There was one compulsory redundancy during 2018-19. The total resource cost was £4293.

During 2018-19 there were two non-compulsory departure payments; one Mutually Agreed Resignation (MARS) with contractual costs of £14,865 and one contractual payment in lieu of notice valuing £16,056.

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:

Steve Russell
Chief Executive
24 May 2019

4.4 NHS Foundation Trust Code of Governance

4.4.1 Audit Committee

1. Introduction

The Audit Committee met formally on six occasions during 2018-19. Audit Committee members attendance is set out in the table below. In addition, all Audit Committee members attended an informal meeting in late May 2018 to undertake a detailed review of the draft accounts (relating to the 2017-18 financial year). Members of the Committee also attended relevant Audit Committee training events during the course of the year.

Audit Committee Members' Attendance:

	3 May 2018	17 May 2018	6 Sept 2018	5 Dec 2018	28 Jan 2019	8 Mar 2019
Mr Chris Thompson	Y	Y	Y	Y	Apologies received	Y
Ms Laura Robson	Y	Apologies received	Y	-	-	-
Mr Ian Ward	Y	Y	Y	-	-	-
Mrs Maureen Taylor	Y	Y	Y	Y	Y	Y
Mrs L Webster	-	-	-	Apologies received	Y	Y
Mr R Stiff	-	-	-	Y	Y	Apologies received

The Audit Committee had a membership of four Non-Executive Directors and during the 2018-19 financial year this comprised of:

- Mr Chris Thompson (Chairman)
- Mr Ian Ward – until 30 September 2018
- Ms Laura Robson – until 30 September 2018
- Mrs Maureen Taylor
- Mr Richard Stiff – from 1 October 2018
- Mrs Lesley Webster – from 1 October 2018

The Committee is supported at all of its meetings by:

- The Deputy Chief Executive / Director of Finance
- 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 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. Detailed minutes are taken of all Audit Committee meetings and are reported to the Board of Directors.

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.

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

2. Duties of the Audit Committee

Following a review of the Audit Committee's Terms of reference in January 2019, the key duties of the Audit Committee have been 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.
  Ensure 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

  Ensure an effective internal audit and counter-fraud service that meets mandatory standards and provides appropriate, independent assurance to management and the Audit Committee.

Review the conclusion and key findings and recommendations from all Internal Audit reports and review of regular reports from the Local Counter Fraud Specialist.
Monitor the implementation of Internal Audit and Counter Fraud recommendations.

- Local Security Management Services (LSMS)

  Ensure 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

  Ensure 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.

3. Work Performed

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

3.1 Financial Management

The Committee receives regular updates and reports from the Director of Finance on the Trust’s financial position and any issues arising. Items discussed in particular during 2018-19 were in relation to the Trust’s interaction with its wholly-owned subsidiary company Harrogate Healthcare Facilities Management Limited (HHFM Ltd).

The Committee oversees and monitors the production of the Trust’s financial statements.
During the 2018-19 financial year, this included:

- an informal but detailed review of the draft accounts prior to submission to Monitor and External Audit on 23 April 2018;
- a formal Committee meeting to discuss the draft accounts and External Audit’s findings on 3 May 2018;
- a formal Committee meeting on 17 May 2018 to review the final accounts and Annual Report for 2017-18 (including the Quality Account) prior to submission to the Board of Directors and Monitor. *[Note: similar meetings have occurred during April and May 2019 relating to the 2018-19 financial statements, Annual Report and Quality Account].*

In March 2019 the Committee reviewed formally and approved the Trust's accounting policies (to be used in relation to the 2018-19 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 2018-19 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 2017-18 were reviewed by the Committee on 17 May 2018 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 2018,
- The Annual Procurement Savings Report in September 2018,
- Revisions to the Trust's Treasury Management Policy in September 2018, and
- The recommendation to the Trust Board of the use of the going concern principle as the basis for the preparation of the 2017-18 accounts in May 2018.

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

3.2 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 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 17 May 2018.

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 2018-19:

- Assessment of Audit Committee Effectiveness in January 2019, the findings of which were presented to the Board of Directors;
- Review and approval of Audit Committee Terms of Reference in January 2019, which were presented to the Board of Directors for approval;
- Ongoing review and revision of the Audit Committee's timetable.

3.3 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.

3.4 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 2018-19.

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 2018.

The Audit Committee approved the planning methodology to be used by Internal Audit to create the Internal Audit Plan for 2018-19, and gave formal approval of the Internal Audit Operational Plan in March 2018.

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 January 2019, resulting in a satisfactory evaluation. The action plan arising from the review is monitored via the Internal Audit Periodic Report to the Audit Committee.

3.5 External Audit

External Audit services are provided by KPMG.

During the financial year 2018-19 the Audit Committee reviewed External Audit’s Annual Governance Report and Management Letter in relation to the 2017-18 financial statements. Work was undertaken during 2018-19 to provide guidance on the accounting treatment to be adopted in respect of certain financial arrangements in place at the 31 March 2019.

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 2018-19 financial statements and the related audit fee in January 2019.

The effectiveness of External Audit was reviewed by HDFT staff and the Audit Committee on 3 May 2018, resulting in a satisfactory evaluation which was reported to the Council Governors.

4. Specific Significant Issues discussed by the Audit Committee during 2018-19

The following additional significant issues have been discussed by the Audit Committee during 2018-19:

- The issues regarding evening security
- The timeliness of Post Project Evaluations (PPE's)
- The timeliness of response by management to internal audit draft reports and the implementation of outstanding internal audit recommendations

5. 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 Audit Committee members and regular attendees at the Committee meetings was undertaken in December 2018 and January 2019. Survey results 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 confident that the audit plan is derived from a clear risk assessment process
- The Committee has evaluated whether internal audit complies with the Public Sector Internal Audit Standards
- 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;
- The Committee reviews the External Auditor's ISA 260 report (the report to those charged with governance)
- Members provide real and genuine challenge - they do not just seek clarification and/or reassurance and
- The Committee receives appropriate assurance from the relevant Committee on the monitoring of clinical governance

6. 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.

4.4.2 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.

4.4.2.1 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. 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 now meets in public in Harrogate District Hospital seven times per year, with the change from 10 meetings being made during 2018-19. In intervening months the Board of Directors holds closed workshops at sites around the Trust's footprint. In 2018-19 the Board workshops were held in Northallerton (August), Scarborough (October), Harrogate (December) and Ripon (February). As part of these peregrinations, the Board members have extended visits to services in the local area. These have proved to be mutually beneficial to Directors and staff alike.

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 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 are 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. This applies to both Executive and Non-Executive Directors.

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

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

Executive Directors

- ***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 and left the Trust 7 September 2018***

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.

- ***Ms Angela Wilkinson, Director of Workforce and Organisational Development (Executive Director) appointed 5 November 2018***

Ms Wilkinson became the Director of Workforce and Organisational Development following her previous appointment as Deputy Director of Workforce and Organisational Development at Mid-Yorkshire NHS Hospitals Trust, where she had latterly been the Interim Executive Director of Workforce and Organisational Development for a period of five months.

Prior to taking up that role in 2013, Angela had spent three years as Director of Organisational Development and Human Resources at Leeds City College, following almost two years as head of Human Resources and Organisational Development at City of York Council. She started her career as a graduate hotel manager in the hospitality industry before joining the NHS through her first role in the now defunct NHS Purchasing and Supplies Agency, based in Harrogate, and subsequently working in Bradford and Leeds.

Angela's role includes strategic and operational human resources leadership for the Trust and supporting the Board of Directors in decisions in respect of workforce policy, planning and organisational development.

Non-Executive Directors

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

The table below sets out the names, appointment dates and tenure of the Chairman, Vice 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 A Schofield	1 November 2017	31 October 2020	N/A	N/A
Mrs S Armstrong	1 October 2018	30 September 2021	N/A	N/A
Mr N McLean	1 May 2015	30 April 2018	N/A	M/A

Ms L Robson	1 September 2017	31 August 2020	N/A	N/A
Mr R Stiff	14 May 2018	13 May 2021	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

Mr McLean left the Board on 30 April 2018
Mr Ward left the Board on 30 September 2018

- ***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 Sarah Armstrong, Non-Executive Director – appointed 1 October 2018***

Sarah Armstrong is an experienced leader in the charity sector, having also been a senior manager for a national charity leading in volunteering policy and practice and a regional lead for a charity raising aspirations for young people with a disability. In a previous role, she was Chief Executive of York CVS, an ambitious social action organisation. She is now the Chief Executive of a national charity concerned with children's health.

Sarah is passionate about the value of volunteering and the unique contribution volunteers can make, especially within a healthcare setting.

- ***Mr Neil McLean, Non-Executive Director – appointed 1 May 2015; left the Trust on 30 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.

- ***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 became the Chairman of the Quality Committee on 1 October 2018 and was previously a member of the Quality and Audit Committees.

- ***Mr Richard Stiff, Non-Executive Director – appointed 14 May 2018***

Mr Stiff joined the Trust following his retirement from the role of Chief Executive of Angus Council in Scotland in May 2017. Prior to Angus he enjoyed a long career in English local government, mainly in education and children's services departments, holding senior posts with North Lincolnshire, Leeds and Dudley Councils.

Born and raised near Bury St Edmunds in Suffolk, Richard and his wife now live near Selby. He has two grown up sons and two grandchildren. He is a governor of Selby College, a director of a local authority-owned company and a Trustee of TCV, the conservation charity. Away from work his interests include club cricket (at Hemingbrough in North Yorkshire), Ipswich Town FC, being outside and motorcycles.

- ***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 (now Resources) Committee and is a member of the Audit Committee and Remuneration and 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. Within 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; left the Trust on 30 September 2018***

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; appointed Senior Independent Director on 1 October 2018***

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.

Lesley is a member of the Audit and Resources Committees.

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 of the Board of Directors and the Deputy Chair of the Council of Governors, after seeking views and comments of the full Council of Governors and Board colleagues;
- Appraisal of the Chief Executive by the Chairman;
- An annual Board development programme; and
- An annual review of the effectiveness of each Board 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. In November 2018 the Trust undertook a Well-Led self-assessment from which an action plan was developed. The Care Quality Commission, as part of its inspection in 2018, assessed the Trust as 'Good' against its Well-Led standard.

The Board recognises the importance of good governance in delivery of the Trust's vision to provide 'Excellence Every Time', and a number of actions will be taken during 2019-20 to ensure that the small number of recommendations made in the Care Quality Commission report and the self-assessment, are taken forward. A further self-assessment will be undertaken later in the year.

The information below details the Executive and Non-Executive Director attendance at Board of Directors meetings in 2018-19. The Board of Directors met 12 times in 2018-19. When the Board of Directors met in public there was also a private meeting. Where Board workshops were held, these were in private.

Individual attendance	Board of Director Public meeting dates 2018-19							
	25/04/18	30/05/18	27/06/18	25/07/18	26/09/18	28/11/18	30/01/19	27/03/19
Mrs A Schofield	Y	Y	Y	Y	Y	Y	Y	Y
Mrs Armstrong*	-	-	-	-	-	Y	Y	Y
Mr N McLean**	Apologies received	-	-	-	-	-	-	-
Ms L Robson	Y	Y	Y	Y	Y	Y	Y	Apologies received
Mr R Stiff***	-	Y	Y	Apologies received	Y	Y	Apologies received	Y
Mrs M Taylor	Y	Apologies received	Y	Y	Y	Y	Y	Y
Mr C Thompson	Y	Y	Y	Y	Y	Y	Apologies received	Y
Mr I Ward****	Apologies received	Y	Y	Apologies received	Y	-	-	-
Mrs L Webster	Y	Y	Y	Y	Y	Y	Y	Y
Dr R Tolcher	Y	Y	Y	Y	Y	Y	Y	Y
Mr J Coulter	Y	Y	Y	Y	Y	Y	Y	Y
Dr D Scullion	Y	Y	Y	Y	Y	Y	Apologies received	Y
Mrs J Foster	Y	Y	Y	Apologies received	Y	Y	Y	Y
Mr R Harrison	Y	Y	Y	Y	Y	Y	Y	Y
Mr P Marshall*****	Y	Y	Apologies received	Y	-	-	-	-
Ms A Wilkinson******	-	-	-	-	-	Y	Y	Y

* Mrs Armstrong joined the Trust on 1 October 2018 **Mr McLean left the Trust on 30 April 2018 *** Mr Stiff joined the Trust on 14 May 2018
**** Mr Ward left the Trust on 30 September 2018 *****Mr Marshall left the Trust on 7 September 2018
******Ms Wilkinson joined the Trust on 5 November 2018

4.4.2.2 Council of Governors

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

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

Governors are elected by staff (Staff Governors) and the membership (Public Governors), or nominated by partner organisations, for example, North Yorkshire County Council (Stakeholder Governors). The Council of Governors consists of 18 elected and six nominated Governors.[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.
- 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 2018 to 31 March 2019.

Constituency	Name	Term of office	May 2018	Aug 2018	Nov 2018	Dec 2018*	Jan 2019
Harrogate and surrounding villages – publicly elected	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
	Mrs Liz Dean	December 2014 to December 2015 (remainder of term following resignation of Sara Spencer) January 2016 to December 2018	Y	N	Y	Y	N/A
	Mr Martin Dennys	January 2019 to December 2021	N/A	N/A	N/A	N/A	Y
	Mr Tony Doveston	January 2016 to December 2018 January 2019 to December 2021	N	Y	N	Y	Y
	Mrs Pat Jones	January 2011 to December 2013 January 2014 to December 2016 January 2017 to December 2019	Y	Y	N	Y	N
	Mrs Rosemary Marsh	January 2018 to December 2020 Deceased March 2019	Y	Y	Y	Y	Y
Knaresborough and East District – publicly elected	Mr John Batt	January 2019 to December 2021	N/A	N/A	N/A	N/A	Y
	Mr Robert Cowans	July 2018 to June 2021	N/A	Y	Y	Y	N
	Mrs Zoe Metcalfe	January 2016 to December 2018	N	N	N	N	N/A

Constituency	Name	Term of office	May 2018	Aug 2018	Nov 2018	Dec 2018*	Jan 2019
Rest of North Yorkshire and York – publicly elected	Mrs Cath Clelland	January 2015 to December 2017 January 2018 to December 2020	Y	Y	Y	N	Y
Ripon and West District – publicly elected	Miss Sue Eddleston	January 2017 to December 2019	Y	Y	Y	Y	Y
	Dr Christopher Mitchell	July 2018 to June 2021	N/A	Y	Y	Y	N
Wetherby and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley Wards – publicly elected	Dr Sheila Fisher	January 2018 to December 2020	N	Y	Y	Y	Y
	Mr Steve Treece	January 2017 to December 2019	N	Y	Y	Y	Y
Rest of England	Mr Ian Barlow	July 2018 to June 2021	N/A	Y	N	Y	N

Staff Constituency	Name	Term of office	May 2018	Aug 2018	Nov 2018	Dec 2018*	Jan 2019
Medical Practitioners Staff Class – staff elected	Dr Daniel Scott	January 2013 to December 2015 January 2016 to December 2018	Y	N	Y	Y	N/A
Non-Clinical Staff Class – staff elected	Mrs Mikalie Lord	January 2018 to December 2020	Y	N	N	Y	N
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	Y	Y	Y	Y	N
	Mr Andy Masters	January 2018 to December 2020 (Stood down December 2018)	Y	N	Y	Y	N/A
	Mrs Helen Stewart	January 2019 to December 2021	N/A	N/A	N/A	N/A	N
Other Clinical Staff Class – staff elected	Mr Neil Lauber	July 2018 to June 2021	N/A	Y	Y	N	N

Nominating Organisation	Name	Term of office	May 2018	Aug 2018	Nov 2018	Dec 2018*	Jan 2019
North Yorkshire County Council	Cllr. John Mann	Nominated from 23 May 2017 to 31 December 2019 (remainder of term)	N	Y	N	N	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 (stood down May 2018)	N	N/A	N/A	N/A	N/A
	Cllr Samantha Mearns	Nominated from 1 July 2018 to 31 May 2020 (remainder of term)	N/A	Y	Y	N	Y
University of Bradford	Dr Pamela Bagley	Nominated from 19 June 2017 to 31 December 2019 (remainder of term	Y	N	Y	N	Y
Harrogate Division YOR Local Medical Committee (Constitutional Review – removed Stakeholder Governor for LMC August 2018)	Dr Jim Woods	Nominated from June 2011 to May 2014 Second term from June 2014 to May 2017 Third term from June 2017 to May 2020 (stood down July 2017)	N	N/A	N/A	N/A	N/A

Nominating Organisation	Name	Term of office	May 2018	Aug 2018	Nov 2018	Dec 2018*	Jan 2019
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 (stood down May 2018)	N	N/A	N/A	N/A	N/A
Patient Experience	Ms Carolyn Heaney	Nominated from 21 September 2017 to 20 September 2020	Y	N	Y	Y	Y
Harrogate Healthcare Facilities Management (new Stakeholder organisation approved in Constitution August 2018)	Ms Clare Cressey	Nominated from 1 August 2018 to 31 July 2021	N/A	Y	Y	Y	N

* *Extra Council of Governor meeting 19 December 2018 to approve the appointment of the Chief Executive made by the Non-Executive Directors.*

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 and two Executive Directors. 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 2018 to March 2019.

Board member individual attendance	Position	Council of Governor meeting dates 2018-19			
		May 2018	August 2018	November 2018	January 2019
Mrs Angela Schofield	Chairman	Y	Y	Y	Y
Mrs Sarah Armstrong (NED from 01.10.18)	Non-Executive Director	N/A	N/A	Y	N
Ms Laura Robson	Non-Executive Director	Y	Y	Y	Y
Mr Richard Stiff (NED from 14.05.18)	Non-Executive Director	N/A	Y	Y	Y
Mrs Maureen Taylor	Non-Executive Director	Y	N	Y	Y
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
Mr Ian Ward (NED until 30.09.18)	Non-Executive Director/Senior Independent Director (from 25.02.15)	Y	Y	N/A	N/A

Board member individual attendance	Position	Council of Governor meeting dates 2018-19			
		May 2018	August 2018	November 2018	January 2019
Dr Ros Tolcher	Chief Executive	Y	Y	N	Y
Mr Jonathan Coulter	Deputy Chief Executive / Finance Director	Y	N	Y	Y
Dr David Scullion	Medical Director	Y	N	Y	N
Mrs Jill Foster	Chief Nurse	Y	Y	N	Y
Mr Robert Harrison	Chief Operating Officer	Y	N	Y	N
Mr Phillip Marshall (ED until September 2018)	Director of Workforce and Organisational Development	N	Y	N/A	N/A
Ms Angela Wilkinson (ED from November 2018)	Director of Workforce and Organisational Development	N/A	N/A	Y	N

Remuneration, Nominations and Conduct Committee

The Remuneration, Nominations and Conduct Committee (the Committee) was formed following a review, and approval, of the Trust's Constitution on 1 August 2018. Previous to this date the Remuneration Committee and Nominations Committee were separate sub-committees of the Council of Governors. The Committee is a formally constituted sub-committee of the Council of Governors for the purposes of:

- Setting the remuneration of the Chairman and other Non-Executive Directors.
- Carrying out the duties of Governors with respect to the appointment, re-appointment and removal of the Chairman and other Non-Executive Directors.
- Receiving reports from the Trust Chairman on issues of Governor conduct, eligibility and removal.

The membership of the Committee consists of:

- The Chairman (subject to any conflict of interest, for example when the Committee is considering the Chairman's re-appointment or remuneration).
- A minimum of five Governors, including the Deputy Chair of Governors, at least two being public.

The Committee is supported in an advisory capacity by:

- The Chief Executive.
- The Senior Independent Director (subject to any conflicts of interest, for example when the Committee is considering Non-Executive Director re-appointment or remuneration).
- The Director of Workforce and Organisational Development.
- The Company Secretary.
- The Corporate Affairs and Membership Manager.

There has been no requirement for the Committee to meet since its establishment in August 2018.

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 2019 the Trust had 18,209 members; these are 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 meetings and events, volunteering, and being consulted on with plans for future developments, to name just 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.

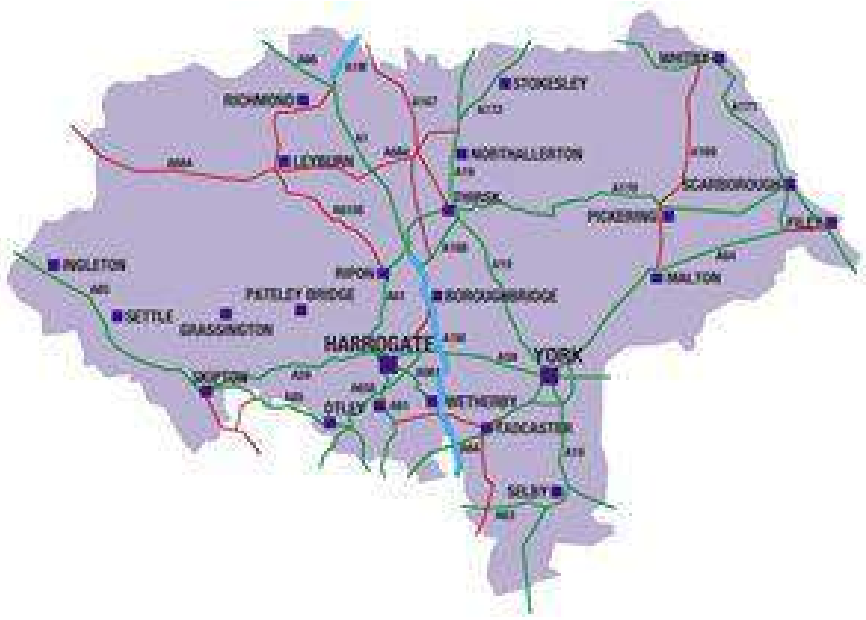
- **Eligibility to be a Member**

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.
- Rest of England.

The Rest of England constituency represents those people who access Trust services but do not live in the Trust's previous (local) 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.

The Staff Constituency includes the following Staff Classes:

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

- **Membership by constituency and number**

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

Throughout 2018-19 we have continued to engage actively 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	6,330	82,599	7.7%
Ripon and west district	1,992	37,571	5.3%
Knaresborough and east district	2,258	37,699	6.0%
Wetherby and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley wards	2,151	102,771	2.1%
Rest of North Yorkshire and York	375	638,559	0.06%
Rest of England	419	52.1m*	
TOTAL	**13,525**	***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	**4,682**	**4,736**	***98.9%***

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 healthcare.
- To work with partners to deliver integrated care.
- To ensure clinical and financial sustainability.

During the forthcoming year, the Trust will continue to actively recruit members across the catchment area, and where possible, encourage membership to those people residing in the rest of North Yorkshire and York where our membership representation is at its lowest. In terms of membership from people residing in the Rest of England constituency, the focus will be on areas where the Trust provides children's services in County Durham, Darlington and Teesside, Middlesbrough, Sunderland, Stockton-on-Tees, Gateshead and in North and West Leeds and this can be promoted through our established Youth Forum. These plans will be overseen by the Governor Working Group for Membership Development and Engagement and will form part of the Membership Development Strategy. Membership recruitment plans include promoting membership to local employers and schools, attendance at community events, communicating with GP practices, publicising membership at local community premises such as libraries and voluntary organisations, and through social media platforms. The focus will also be to promote membership and active inclusion to people from protected characteristics and disadvantaged groups alongside the Trust's Equality and Diversity work streams.

- **Gender and ethnicity**

The public membership is made up of 51.6% females and 48.8% males, with 0.1% unknown; these figures continue to demonstrate a similar balance to the female/male population in England (*50.8% females and 49.2% males, Office for National Statistics, Census 2011).*

Gender	Number of Members	*Eligible membership	Percentage
Male	6,535	*440,383	*1.5%
Female	6,972	*458,816	*1.5%
Not specified	18		
Total	**13,525**	***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	2,848	*863,226
Mixed	24	*9,110
Asian or Asian British	68	*19,196
Black or Black British	27	*4,599
Unknown	10,558	*3,068
Total	**13,525**	***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 includes action 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 Engagement highlights key areas from the Strategy to the public Council of Governors' meetings.

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

- On joining, a welcome pack is sent out which includes a welcome letter from the members' elected Governor(s), a questionnaire, and details about a discount card which can be used 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 Report 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).
- Posters in community premises and in GP practices.
- Invitations to be involved with consultations, to take part in surveys and to be involved on focus groups.

The Education Liaison and Work Experience Programmes, Youth Forum, and Young Volunteers 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 Membership Development and Engagement.

The Foundation Trust Office

The Foundation Trust office continues to be a central point of contact for all members and the general 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

4.4.3 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 in April 2019 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

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 Trust is recognised as being in segment two as at 31 March 2019. This equates to a Targeted Support Offer. 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 2018-19:

Area	Metric	2018-19 Q4 score	2018-19 Q3 score	2018-19 Q2 score	2018-19 Q1 score	2017-18 Q4 score	2017-18 Q3 score	2017-18 Q2 score	2017-18 Q1 score
Financial sustainability	Capital service capacity	1	3	4	4	3	1	4	4
	Liquidity	1	1	1	1	1	1	1	1
Financial efficiency	I&E margin	1	3	4	4	2	1	4	4
Financial controls	Distance from financial plan	1	1	1	1	4	1	4	4
	Agency spend	1	1	2	2	1	1	1	1
Overall scoring		**1**	**2**	**3**	**3**	**3**	**1**	**3**	**3**

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, items of other comprehensive income 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 Annual 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;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy;
- assess the Group and parent Trust's ability to continue as a going concern, disclosing, as applicable, matters relating 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 Group and parent Trust without the transfer of its services to another public body entity.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of Harrogate and District 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 such internal control as they determine is necessary to enable the preparation of financial statements which are free from material misstatement, whether due to fraud or error, and for safeguarding the assets of Harrogate and District NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities. The Accounting Officer is also responsible for ensuring

that the use of public funds complies with the relevant legislation, delegated authorities and guidance.

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:

Steve Russell
Chief Executive
24 May 2019

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 Harrogate and District 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 Harrogate and District 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 2019 and up to the date of approval of the Annual Report and Accounts.

4.7.3 Capacity to handle risk

As Accounting Officer, and supported by fellow members of the Board of Directors, 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 a central part of its philosophy, practices and business plans rather than being viewed or practised as a separate programme; 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. Board Directors and Directorate and departmental managers ensure that all staff (including those promoted or acting up, contractors, locum, agency and bank staff) undergo corporate, and specific local, induction training appropriate to their area of work; this includes but is not confined to 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 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 Workforce and Organisational Development 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 for some time (in advance of new national arrangements in the 2018 Pay Award) by linking pay progression to the completion of essential and mandatory training, and completion of subordinate staff appraisals for managers. An 'appraisal on a page' has been developed and implemented during 2018-19 to increase appraisal completion.

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 transparent 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 with which NHS Boards need to comply, including not only Duty of Candour, but also the Fit and Proper Person's test and improving openness and transparency throughout the Trust. 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 Datix system has been upgraded during 2018-19 to better support the incident reporting process.

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 in promoting safety and in the origin of incidents and there has been an increasing emphasis on this during the year. 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, the independent Patient Voice Group, 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's Freedom to Speak Up Guardian reports to the Board on a biannual basis. This provides the Board with an opportunity to reflect on themes and learning identified by the Guardian. In addition we have appointed a number of Fairness Champions to support the Guardian and the process to appoint a second Guardian is underway.

Actions to address the shortcomings in quality impact assessments, which were identified in the audit in 2017-18, have been completed. The new process will assist the Trust in meeting obligations under the public sector equality duty introduced in April 2011 and is in accordance with the National Quality Board guidance produced in 2012 on assessing cost improvement plans.

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, including:

    - 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 existing risks, their likelihood of occurrence and their potential impact(s) and the ability of the Trust to mitigate those risks,. Risk assessment is a continuous process with risks assessed at ward, team and departmental level in line with risk assessment guidance. This is carried out proactively as part of health and safety processes, as well as reactively when risks are identified from, for example, incidents, complaints, local reviews and patient feedback.

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 for 2018-19 was 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 mitigated or removed. 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.

The Corporate Risk Register therefore identifies key organisational risks. The Corporate Risk Register is itself reviewed at the monthly Corporate Risk Review Group meeting, 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 its meetings and the Board of Directors receives an update bimonthly, 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 receives an update bimonthly and a more detailed report, together with the complete BAF, on a quarterly basis.

The risks on the Corporate Risk Register for the end of 2018/19 relate to the:

- Risk to the quality of service delivery in Medicine due to unfilled and vacant rota gaps;
- Risk to the quality of service delivery and patient care due to failure to fill registered nurse vacancies due to the national labour market shortage;
- Risk of financial deficit and impact on the quality of service delivery due to failure to deliver the Trust annual plan by having excess expenditure or a shortfall in income;
- Risk to provision of service and not achieving national standards in cardiology;
- Risk of inadequate antenatal care and patients being lost to follow up due to inconsistent process for monitoring attendance at routine antenatal

appointments in community;
- Risk to the quality of service delivery due to failure to have sufficient cash to support the capital programme;
- Financial risk from major sporting events due to cost of contingency arrangements and loss of income and
- Risk to quality of care by not meeting NICE guidance in relation to the completion of autism assessment within 3 months of referral.

During 2018-19 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;
- Integrated models of care are compromised due to the complexity of the landscape;
- Misalignment of Commissioner/partner 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
- Senior leadership capacity is insufficient to meet the needs of the complex environment.

In 2018-19 the Board of Directors ensured that detailed controls were in place to mitigate risks and support assurance and will ensure 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.

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 2018-19 the Trust implemented the new General Data Protection Regulations.

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. At the end of 2018-19 the report included 55 RAG (red, amber, green) rated indicators of which nine related to the Safe domain, three to the Effective domain, three to the Caring domain, 18 to the Responsive domain, five to Workforce, 13 to finance and efficiency and four to Activity (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; it is also available to each of the 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. 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.

The Trust was inspected by the Care Quality Commission (CQC), as part of its routine programme of inspections, in November 2018. The rating of the Trust remained as 'Good'. It was rated it as good because:

- Effective, Responsive and Well-Led were rated as 'Good', Safe as 'Requires Improvement' and Caring as 'Outstanding';
- The current ratings of the six core services across one acute location and three community services not inspected at this time remained unchanged. Hence, five acute services across the Trust are rated overall as 'Good' and three are rated as 'Outstanding; three community services are rated as 'Good' and two are rated as 'Outstanding';
- The overall rating for the Trust's acute location remained the same. Harrogate District Hospital was rated as 'Good';
- Community services improved and were rated as 'Outstanding'.
- The Use of Resources was rated as 'Good'

During 2018-19 the Board of Directors completed a self-assessment against NHS Improvement's Well-Led framework for governance reviews. The self-assessment drew upon a previous self-assessment, undertaken in 2017-18. In addition the CQC undertook a Well-Led assessment of the Trust during its inspection in late 2018.

Neither the self-assessment nor the CQC review highlighted any material areas of concern in relation to the Board and the governance arrangements in place at the Trust. The areas identified for further progress and improvement were:

- There was a lack of diversity at senior level, specifically BME; both the Executive and Non-Executive Board members acknowledged this and had strategies in place to help address it;
- Senior leaders were aware that they needed to undertake more work in relation to the Workforce Race Equality Standard and an action plan, with appropriate monitoring at Board level, was in place and
- Although there was a comprehensive complaints policy, the average time taken to close complaints was not in line with this policy.

Work has been set in train to address these recommendations.

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
- in conjunction 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 2018-19 there have been five formally constituted Committees of the Board; the Audit Committee, the Quality Committee, the Finance Committee, the Remuneration Committee and the Nomination Committee. The Finance Committee was reviewed (and the membership increased) in September 2018, and it was renamed the Resources 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 principal mechanism by which the Board gains assurance regarding the safety and quality of services. It is chaired by a Non-Executive Director, and two other Non-Executive Directors (one of whom 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 Resources Committee

During 2018-19 the key responsibilities of the Resources 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 annual operational and 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 composition of the Resources Committee was reviewed during 2018-19 as part of a review of financial governance undertaken by NHS Improvement. As a result of this review, and following discussion with NHS Improvement, the Committee membership now comprises three Non-Executive Directors, one of whom is the Chair. The Chief Executive, Deputy Chief Executive/Finance Director, Chief Operating Officer, and Director of Workforce and Organisational Development attend each meeting, and other Trust representatives, such as deputy Directors also attend. Other Trust staff may be requested to attend to discuss particular items. Governor representatives attend the Resources Committee as observers. The remit of the Committee has been strengthened to incorporate workforce plan delivery as well as financial and activity plan delivery, and meets monthly.

The Remuneration Committee

The key responsibilities of the Remuneration Committee are to make recommendations to the Board of Directors on the remuneration, allowances and terms of service for the Executive Directors and 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 only.

The Nomination Committee

The key responsibilities of the Nomination Committee are 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, Workforce Efficiency 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 including, for example the Information Technology Steering Group, the End of Life Care Steering Group and the Infection Prevention and Control Committee. Information Governance is managed by the Data and Information Governance Steering Group. The Complaints and Risk Management Group (CORM), comprised of 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 Directors where operational matters are discussed in detail and actions agreed.

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 Improvement, NHS England and Public Health Commissioners to review performance and quality.

The Trust 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 compliance with all the Trust's obligations under equality, diversity and human rights legislation, including modern slavery.

The Trust has well-developed workforce strategies which are reviewed by the Board of Directors on a regular and frequent basis. The Human Resources Strategy and the Clinical Workforce Strategy are the key ways in which the Trust reviews and plans to address short, medium and long-term workforce issues and ensure that safe staffing systems are both in place and planned. This not only provides assurance to the Board of Directors that current staffing levels are safe and effective but also that they are sustainable into the future.

The Foundation Trust has published an up-to-date register of interests for decision-making staff on a bimonthly basis as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

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 to ensure economy, efficiency and effectiveness of the use of resources. The cost improvement plans are scrutinised and approved by the Medical Director and Chief Nurse via the process of Quality Impact Assessments to ensure the quality of services is maintained.

The capital programme and the prioritisation of revenue resources to form the annual Operating Plan are informed by the Trust Objectives, Quality Improvement priorities and identified risks.

During 2018-19 the Trust continued to implement a carbon efficiency scheme to deliver reductions in carbon emissions and to deliver significant energy efficiency. These are proving to be successful year-on-year. The Foundation Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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.

In 2018-19, the Trust had its first Use of Resources assessment undertaken by NHS Improvement on behalf of the CQC. The outcome was a rating of 'Good'.

During this year the Trust implemented a new Oracle ledger version (the 'Cloud'). This went live on 1 October 2018. This transfer reduced the availability of historic financial information prior to 1 October. To mitigate this risk a number of compensating controls were in place, including internal audit review of the ledger, internal audit review of the balance transfers on 1 October, and the budgetary control system whereby monthly variances were scrutinised to ensure appropriate financial management and action through the year.

4.7.6 Information governance

There were no serious incidents relating to information governance including data loss or confidentiality breach during 2018-19.

4.7.7 Annual Quality Report

The following steps have been put in place to assure the Board of Directors that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data. The Quality Committee (QC) has continued its work to gain assurance in relation to the CQC quality domains ensuring compliance with fundamental standards of care in acute and community services.

The work-plan focuses on the following seven key headings:

1. To identify current concerns
2. Quality improvement strategy
3. Quality reports
4. Patient safety
5. Effective care and outcomes
6. Patient experience
7. Regulatory and compliance

<u>Identify Current Concerns</u> – the following three measures are in place:

1. 'Hot Spots' - The QC can hear from members about current issues that are impacting upon the ability of the Trust to deliver quality care and to gain assurances that suitable actions / activity is underway to address these. Examples of this are:

a) Impact on quality care as a result of the financial recovery plan, added as a

standing item under this section during the year;

b) Impact of the recruitment situation on quality of care;

c) Impact of equipment failure on quality of care.

This section also includes items that the Board of Directors require the QC to scrutinise on its behalf. An example of this being the decision of the Trust not to implement the ReSPECT documentation and ensure that alternative process gives the best quality of care to patients at the end of life.

2. A new section was introduced after the workshop relating to the Quality Improvement Strategy. This reviews the current progress and celebrates the success of some of the projects undertaken by the Trust Quality Champions. The Committee has received three presentations from champions. These have demonstrated real improvement in patient focused care and shown how small improvements can make a big difference to patient experience and staff satisfaction.

3. The QC reviews the Quality Dashboard and Integrated Board Reports (quality section) in depth each month and pursues areas of concern and seeks further assurance where necessary. QC initiated a review of this report, the data it contains, who uses the data and how this could be improved to add value at Ward and Directorate level. As a result of this a new Dashboard was introduced during Quarter 1 of 2018-19. The dashboard provides a good insight into quality issues and concern but there are still improvements to make to its content. Providing consistent data between reports and the dashboard has been highlighted as a concern and is being reviewed by the responsible teams. Where there are concerns individuals are requested to attend the committee to provide valuable insight and explanation.

Quality Reports – Throughout the year the QC has heard regular updates from the leads on their progress to deliver the Trusts 2018-19 quality priorities which were:

a) Reduce morbidity and mortality related to sepsis

b) Ensuring effective learning from incidents, complaints and good practice

c) Improving the clinical models of care for acute services

d) Promoting safer births, with a specific focus on reducing still births.

Directorate Quality Governance reports These are presented to the committee on a rolling monthly basis and provide assurance that the quality priorities are embedded from the Board to the front line across the Trust

Annual Quality Account Report – The QC retains oversight of this annual account.

Patient Experience Report – The Patient Experience Report is received quarterly – this comprehensive report provides details of a wide range of areas relating to patient experience. The committee has approved the Patient Experience Strategy and is awaiting the monitoring and action plan for its implementation. Dealing with complaints in a timely manner remains a focus of the committee.

Patient Safety Report - The QC receives a quarterly report on untoward events and issues of patient safety. The report looks for concerns or trends that may require further scrutiny. Serious Incidents are reported directly to the Board of Directors. The review of the Datix system has been a focus of the year. The objective was to improve

incident reporting and make the system more user-friendly and intuitive. The amendments have now been completed although the impact is still to be demonstrated.

Effective Care and Outcomes – Quarterly reports are received on the Clinical Effectiveness Audit programme and the committee receives and approves the annual audit plan for the FY.

External Reports Received – The system for recording receipt of external reports and a log for the lead individual responsible to action these remains robust. Where we consider that a plan requires support or focus we invite the lead to provide an update on progress on action plans to provide the level of assurance required.

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 Directors, Clinical Directors and Clinical Leads within Harrogate and District 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 the Head of Internal Audit Opinion and comments made by the external auditors in their 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 the Quality Committee and a plan to address shortcomings and ensure continuous improvement of the system is in place.

Conclusion

No significant internal control issues have been identified. 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:

Steve Russell

Chief Executive

Date: 24 May 2019

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Quality Report 2018/19

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1. STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

I am pleased to introduce our Quality Report for the year 2018/19. Harrogate and District NHS Foundation Trust (HDFT) strives to deliver care of the very highest quality to all of our patients, and to those who use our services far and wide. We are proud of our reputation for quality and restless to sustain and improve.

This report gives an account of our performance on quality, and the quality priorities we have worked on for the last twelve months. Our organisational vision - to achieve 'Excellence Every Time' and our principle of 'You Matter Most' encapsulate our approach. We are clear about the importance of ambition and we set the bar high for ourselves in terms of our ambition for quality. Staff throughout the Trust are empowered to lead for quality and we have a range of initiatives which collectively are part of the HDFT Quality Charter, which are designed to ensure we create the conditions for quality in all areas.

This year the Trust underwent a full CQC (Care Quality Commission) inspection, the report of which was published on 14th March 2019. We retained an overall Trust rating of 'Good' at Trust level, and a 'good' rating for Use of Resources. I am tremendously proud of the report which recognises again and again the care, compassion and innovation of colleagues working in our services. All of the services inspected improved their ratings and indeed all of our services are now rated as either outstanding or good overall. It was particularly pleasing to achieve an 'outstanding' rating for Community Services overall. Caring also continues to be rated 'outstanding' overall.

I will retire at the end of March 2019 so this will be the last time I write this introduction. I would like to pay tribute to the people who have made such a positive and uplifting report possible, namely the staff who work in our hospital, community and support services. Their commitment and determination to deliver the best care possible in the face of so many challenges is fantastic. I also wish to recognise and thank the many volunteers who support us, our Governors and Non-Executive colleagues who hold us to account through support, challenge and encouragement.

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

Ros Tolcher.

Dr Ros Tolcher (Chief Executive) Date: 12 March 2019

I was delighted to join HDFT on 1st April, and wanted to take the opportunity to thank everyone across our range of services, and our geography for their warm welcome. I have been fortunate to be able to spend time with our 0-19 services across the North East and North Yorkshire, with our adult community services in North Yorkshire, and with colleagues in many different parts of Harrogate and Ripon Hospitals. I've been inspired and humbled by what our 4,500 colleagues do 24/7 to help people get the best start in life, to help people live healthily and happily at home, and to care for them with kindness and compassion when hospital care or treatment is needed.

The route to achieving the quality priorities that we've set out here, and others, is through our people – every single person and every single role in #teamHDFT will play an equally important part. We know that when our people are supported, listened to, and cared for by us, they will in turn do the same for our patients. So we will continue to strengthen our focus on making HDFT the very best place to work, paying attention to the health and wellbeing of our 4,500 colleagues, and trying to make it easy for everyone to do their work, and to do it well. That means supporting effective, and supportive teamwork, and learning from each other and all of our experiences, good and bad. There is a well-known phrase – 'those that do the work know how to improve it', and our role is to empower and support them to do so. I hope that in a year we'll be able to show how much we can do when we focus on these things.

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

With best wishes

Steve Russell, Chief Executive

Date: 6 May 2019

2. PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE

2.1. PRIORITIES FOR IMPROVEMENT 2019/20

We have consulted with our external stakeholders and within the Trust about the priorities for quality improvement during 2019/20. 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 that joined 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. **Embedding new reporting processes and the culture of learning from events, complaints and deaths**

We will continue work to embed the new reporting processes, encouraging learning from events and increased awareness of the human factors involved in patient safety. There will be a greater focus this year on improving our responses to complaints, and ensuring learning from complaints and reviews of deaths.

2. **Developing a sustainable model of acute care**

We will continue work started during 2018/19 to improve the clinical model of care for acute services including:

- Increased same day assessment facilities;
- A sustainable model of acute medical input for the Medical Admissions Unit (MAU) and the Clinical Assessment Team (CAT);
- Developing a Hospital at Night model for Harrogate to support resilience and safety;
- Achieving the national target of 40% reduction in the 2017/18 baseline for long stay patients (those in hospital over 21 days) by maximising the efficiencies of the recently developed discharge pathways and improving links with the emerging Harrogate and Rural Alliance work.

3. **Increasing patient and public participation in the development of services**

We will be introducing and embedding the new Patient and Public Participation Strategy, and the Hopes for Healthcare across services.

4. **Promoting equality and reducing inequalities in access to services and information for staff and patients**

We will be clarifying the specific workstreams but will be aiming to progress work already started including:

- Ensuring consistent and effective compliance with the Accessible Information Standard;
- Guidance and staff awareness in relation to transgender patients and staff;
- Resources and staff awareness to support patients with hearing and visual impairment.

2.2. PROGRESS AGAINST QUALITY PRIORITIES IDENTIFIED IN 2017/18 QUALITY REPORT

In the 2017/18 Quality Report we identified the following priorities for work during 2018/19:

1. Ensuring effective learning from incidents, complaints and good practice;
2. Reducing the morbidity and mortality related to sepsis;
3. Improving the clinical model of care for acute services;
4. Increasing patients and the public participation in the development of services;
5. Promoting safer births, with a specific focus on reducing stillbirths.

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

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

#chattermatters

This quality priority was started in 2017 as a two year work stream, aiming to ensure staff view near misses, incidents (now referred to as events), errors and complaints as opportunities to learn and improve patient safety. We were aiming initially to review the tools and system for reporting events and managing these within the directorates, to ensure robust feedback to reporters and identification of achievable improvements and remedial action to prevent recurrence. During 2018/19 we have made real strides with this work and started to realise some of our ambitions but there is still more work to be done. The focus to date has been mostly on incidents and events, and we are keen to ensure this also encompasses learning from complaints, and good practice, which will further support the focus on improving the organisational safety culture.

What were we aiming to achieve?

The targets set at the beginning of this journey were:

- An increase in the number of incidents reported to the National Reporting and 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;
- Achieving results of reporting data from NRLS that compare favourably with other trusts, particularly relating to the ratio of no and low harm incidents compared to those graded as moderate and above harm;
- Maintaining favourable results from the NHS Staff Survey for key findings relating to staff reporting errors, near misses or incidents witnessed, perceived fairness and effectiveness of procedures for reporting errors, near misses and incidents, and staff confidence and security in reporting unsafe clinical practice.

What have we done?

We have built on the work undertaken during 2017/18 to make changes to the Datix event reporting system with the aim of improving usability for staff, and a focus on ensuring feedback is provided to those reporting events. Alongside this we have provided training and

developed a 'tree of learning' visual which was designed by front line staff, to promote the positives of event reporting and to represent the Trust's improved safety culture.

The #ChatterMatters newsletter was produced quarterly (now on issue 4) and has showcased learning from events, complaints, good practice, audits, work around Freedom to Speak Up and Human Factors. There has been some focused work in relation to promoting a fair and just culture to ensure staff feel safe to report concerns and events. See section 4.12 in this report for more information about this work.

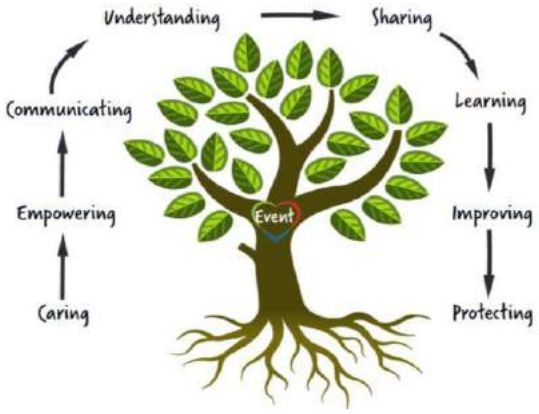
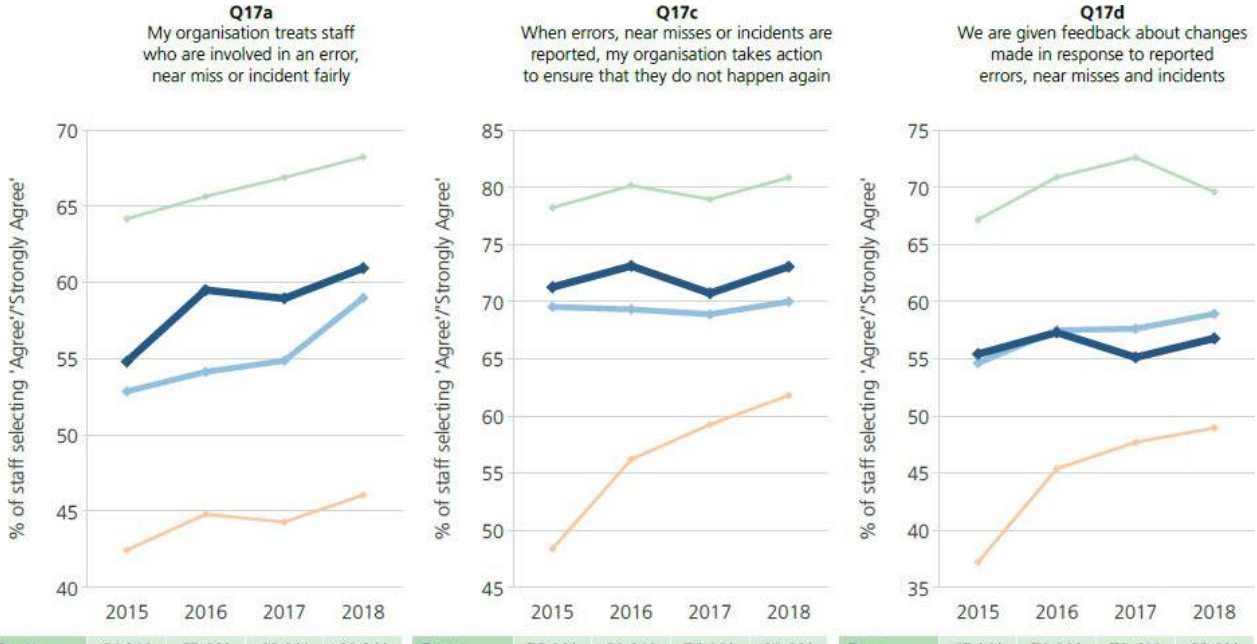


Figure 1: Image for growing our safety culture

What are the results?

The data from the recently published NHS Staff Survey 2018 indicate an improvement in culture, with all of the indicators relating to incident reporting having improved since the previous round.



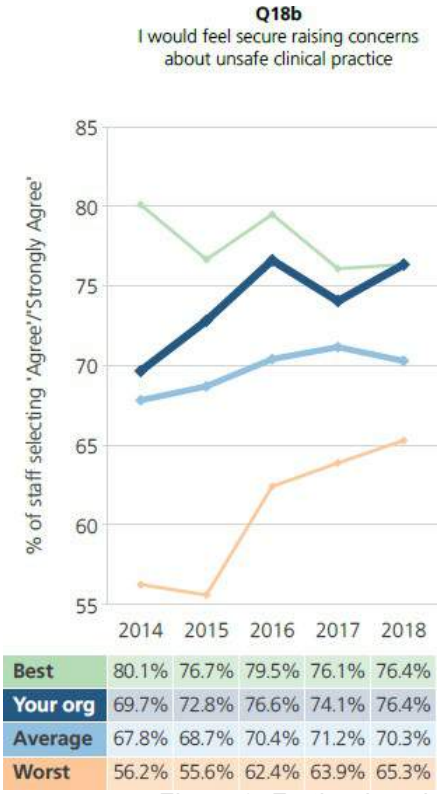
	2015	2016	2017	2018
Best	64.2%	65.6%	66.9%	68.2%
Your org	54.8%	59.5%	59.0%	60.9%
Average	52.9%	54.1%	54.9%	59.0%
Worst	42.4%	44.8%	44.3%	46.1%

	2015	2016	2017	2018
Best	78.2%	80.2%	79.0%	80.9%
Your org	71.3%	73.1%	70.7%	73.1%
Average	69.5%	69.3%	68.9%	70.0%
Worst	48.4%	56.2%	59.2%	61.8%

	2015	2016	2017	2018
Best	67.2%	70.9%	72.6%	69.6%
Your org	55.4%	57.3%	55.1%	56.8%
Average	54.6%	57.5%	57.6%	58.9%
Worst	37.2%	45.4%	47.7%	48.9%

Figure 2: Benchmarked results from the national Staff Survey 2018

The Trust now has the highest score nationally for staff feeling secure about raising concerns about unsafe clinical practice which is something to be really proud of.



	2014	2015	2016	2017	2018
Best	80.1%	76.7%	79.5%	76.1%	76.4%
Your org	69.7%	72.8%	76.6%	74.1%	76.4%
Average	67.8%	68.7%	70.4%	71.2%	70.3%
Worst	56.2%	55.6%	62.4%	63.9%	65.3%

Staff comments on the new event reporting form have also been really positive:

Figure 3: Further benchmarked results from the national Staff Survey 2018

The table below shows the HDFT reporting rate of patient safety incidents 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	01/10/17 to 31/03/18	01/04/18 to 30/09/18
Comparative reporting position*	Middle 50%	Middle 50%	Top 25%	Top 25%	Top 25%	Top 25%
Number of incidents reported in period	2,058	2,182	2,436	2,416	2,539	2,696
Incident reporting rate	39.86	43.85	46.42	48.56	47.09	55.6

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

Table 1: Incident reporting rate (patient safety incidents only) to the NRLS

Summary

In summary, we have made some really positive improvements over the last year but there is still further work to do in order to further embed these cultural changes and realise the full impact of the changes to the Datix event reporting system.

2. Reducing the morbidity and mortality related to sepsis

Sepsis is one of the major causes of morbidity and mortality across all age ranges. There has been an international recognition that sepsis care has not always been focused, and that by identifying patients with sepsis promptly, and delivering treatments in a timely manner, the impact of this devastating condition can be significantly reduced.

What were we aiming to achieve?

Most importantly, we have been looking to maintain a low mortality rate for sepsis. We can demonstrate this by survival data, but monitor the robustness of our systems by looking at how best we identify patients with sepsis by screening, and how quickly they then receive life-saving antibiotics.

What have we done?

Most of this project relates to ongoing education and raising awareness amongst clinical teams including GPs, ambulance crews, and doctors and nurses in the Emergency Department and on the wards. We also have introduced a new screening tool for paediatric patients.

What are the results?

The graph below shows the changes over the last two years in the care of adult patients. Most pleasingly, the percentage of patients receiving antibiotics within one hour of sepsis being diagnosed has risen significantly, with around 90% of patients now receiving them within the desired timeframe.

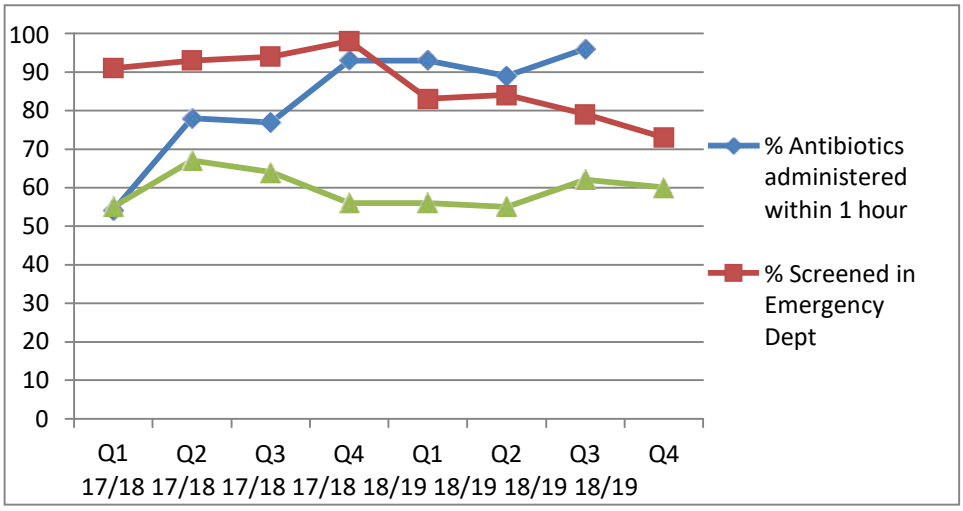


Figure 4: Treatment and screening of adult patients (Q4 data for antibiotics received within one hour is not yet available).

Performance with sepsis screening is unfortunately more disappointing, with only around 60% of ward patients having an electronic sepsis assessment completed by nursing staff. It should be noted, however, that all patients in this group have a doctor called to attend within the hour but the current electronic observation system does not record if sepsis was specifically looked at. The dip in the Emergency Department performance in 2018/19 reflects

a change in audit methodology. In 2017/18, a small sample of medical notes was interrogated; now, all observations on all patients are included.

In Paediatrics there has been a significant improvement in screening for sepsis on Woodlands Ward. This has come about as a result of the introduction of new admission documentation, with sepsis screening highlighted on the opening page. The slight drop in the Emergency Department performance reflects the relatively small number of children seen and is not significant.

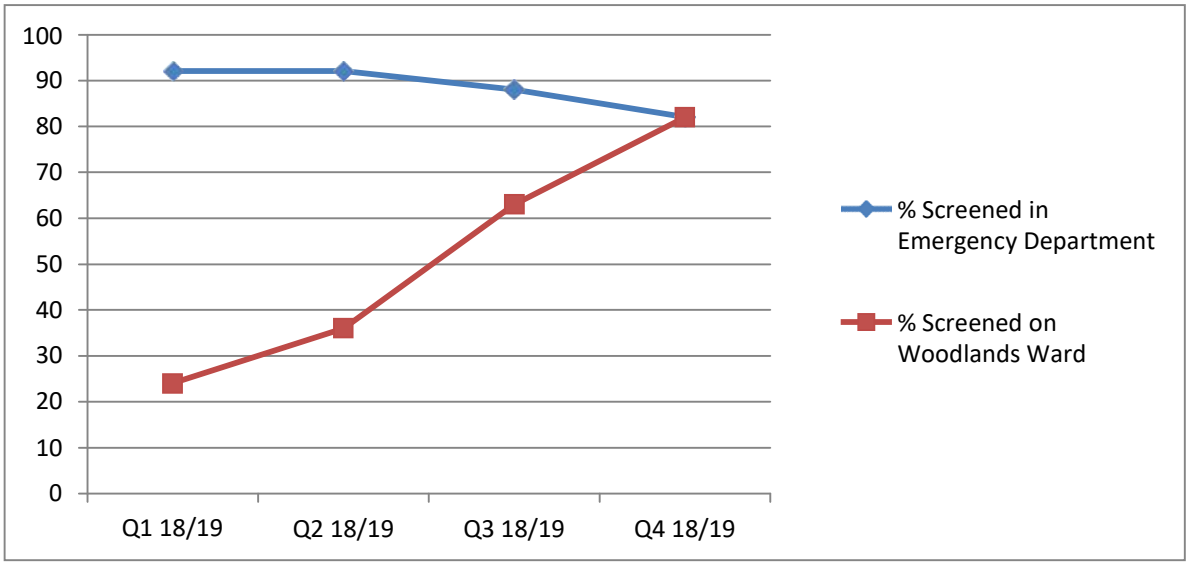


Figure 5: Screening for paediatric patients

The most important data we have regarding sepsis comes from our continuous Intensive Care National Audit and Research Centre (ICNARC) audit data which records all critical care admissions. Our most recent report covers April to December 2018, during which 38% of all our critical care admissions have sepsis, compared to 34% in similar units. This suggests we are not missing cases on the wards. Of those coming to the unit, 17.5% have only one organ failure compared to 9.8% nationally, and only 1.4% have four or more organ failures compared to 2% nationally. This would imply that sepsis cases are being detected early and treated before more significant illness develops. Most reassuringly, our mortality from sepsis is currently 21.3% compared to a national rate of 26.1%.

Summary

We have made good and sustained progress in delivering timely antibiotics to patients. Improvements in screening for paediatric patients have been made whereas the process for screening adults remains challenging. However our escalation and mortality data suggests clinical care is not affected. Over the next year we will be looking to improve our adult screening performance by modifying the electronic systems we use to identify patients at risk and give clinical teams the information they need to make a prompt diagnosis.

3. Improving the clinical model of care for acute services

HDFT identified the clinical model of care for acute services as a priority for development during 2018/19. The ambition was to review and improve the way patients are cared for by clinicians within a focus on safety and effective care. The work has included creating a more robust acute medical admission service to improve the quality of care and outcomes for patients, and to support the delivery of the seven day service standards. There is more information about these in section 4.11 of this report. It is hoped that by making improvements to the acute medical admissions pathway, the trust can reduce patients' length of stay in hospital. There is significant evidence that longer stays in hospital can lead to complications such as reduced mobility and reduced independence, particularly for frail elderly patients.

This work has also involved improving the management of medical outliers. These are inpatients with medical care needs who are placed on a non-medical ward during their hospital admission, with a risk that they might not receive appropriate and timely medical review and access to therapists.

We also wanted to re-consider a Hospital at Night model of care. This uses a multi-professional and multi-speciality approach to delivering care at night and out of hours. In addition we wanted to review and improve the safe and timely access to information and care for patients at end of life.

What were we aiming to achieve?

The aims for each workstream are detailed below:

Acute Medical Admissions

- To relocate the clinical assessment team (CAT) clinic to the front of the hospital, closer to the Emergency Department (ED) and Radiology Department;
- To establish additional acute physician resource and advanced care practitioners (ACPs) to support timely assessment of acutely unwell patients presenting to hospital with medical problems;
- To increase the number of short admissions; both for zero days and one to three days stay.

Medical Outliers

- To identify the number of patients under each specialty and ensure equitable workload and timely access to review;
- To monitor the time from a patient being admitted, to being allocated to a specialty, and then to having a clinical review. The staff working on this were exploring the capabilities of a module within one of our clinical IT systems, WebV, to capture and then use this data.

Hospital at Night model of care

- To review the number and types of tasks allocated to doctors in training;
- To monitor the time between the logging of a task request and the completion of the task;
- To review the cost of medical cover out of hours;
- To consider the educational feedback from doctors in training.

End of life care

- To ensure patients, relatives and carers can make informed choices;
- To enable safe and timely discharge from hospital in last weeks or days of life to support patients to die in their preferred place of death (PPoD);

- To enable safe and timely access to care and support, including medicines and equipment, in last weeks, days or hours of life to support patients to die in their PPoD.

What have we done?

Acute medical admissions

The following improvements have been undertaken;

1. A new base for the clinical assessment team (CAT) has been created near the front of the hospital and closer to ED and Radiology, where it is now called the combined assessment team (CAT) in anticipation of combining medical and surgical assessment;
2. The new base for CAT provides more space and upgraded facilities for patient care, which delivers an improved patient experience as well as better working conditions for staff. The location has improved pathways from ED into ambulatory care, created stronger links with ED and has led to easier access to diagnostics for ambulatory patients. The move has also had a very positive impact on the Medical Admission Unit (MAU) where ambulatory care was previously based, due to the quieter environment and lower footfall during the day;
3. An additional day of consultant time has been secured;
4. Two new trainee advanced care practitioners (ACPs) are now halfway through training. They provide additional clinical time into CAT and will participate in an ACP rota once qualified;
5. Referral management processes have been reviewed and we are currently trialling a new nurse-led referral management process which enables our GP partners to arrange attendances and admissions directly with a clinically skilled individual who can direct the patient to the right place, first time.

In addition, a nurse-to-nurse referral pathway for a specified cohort of patients has been implemented which releases medical time on the acute ward, which can be directed to hands on care of patients.

Going forward the Trust aims to implement a new acute care model which will incorporate a further increase in acute consultant provision, four more ACPs and a new on-call model. The additional capacity and breadth of experience will allow us to create a more resilient service with a wider range of clinical staff who can deliver care across seven days in both our inpatient and ambulatory areas. Larger numbers of clinicians will facilitate faster review times and improve compliance with the seven day clinical standards around consultant review.

We will review our acute assessment provision, currently CAT and the Surgical Assessment Unit (SAU) and aim to combine both assessment pathways to create a single point of entry, where initial assessment will be delivered by a multi-specialty team. Both nursing and medical time will be released and senior clinical review will be provided at the appropriate time to enable the patient to be directed to the correct service. The service hours will be expanded to allow patients a longer period of time to have their needs met and increase the number of same day discharges.

Medical outliers

During 2018/19 a draft process has been developed for the allocation of medical patients to support even distribution between teams. This was tested during the winter period and whilst the number of medical patients outlying to a different specialty was significantly lower this year, the feedback from the specialty teams is that the new process has worked well.

This draft process has been updated further and shared with the physicians but it was felt Christmas was not the time to make a more fundamental change to our approach to managing outliers. This draft process will be discussed again with the physicians with a view to being adopted in time for next winter and included within the Patient Flow Policy.

Hospital at Night model of care

A working group had been established to look at and learn from other hospitals including Warwick Hospital. A review of the current resource provided by the multiple rotas at night is planned, together with an audit to capture current arrangements and workload which will be used to inform the requirement for night time staffing and the case for change. The project is currently working toward implementation of a revised model by August 2019.

End of life care

The End of Life Care Steering Group has developed an action plan and the following actions have been progressed to date:

- Paperwork for fast track referrals has been modified to reduce duplication of information and delays;
- A preferred provider of fast track packages of care has been identified and agreed, which has helped to build relationships between services and enables a more consistent quality of care;
- The employment of a Band 3 End of Life Coordinator role to act as a single point of contact and coordinator for fast track packages of care is being explored.

What are the results?

Acute medical admissions

We monitor the number of patients who are admitted with a zero length of stay and a length of stay between one to three days.

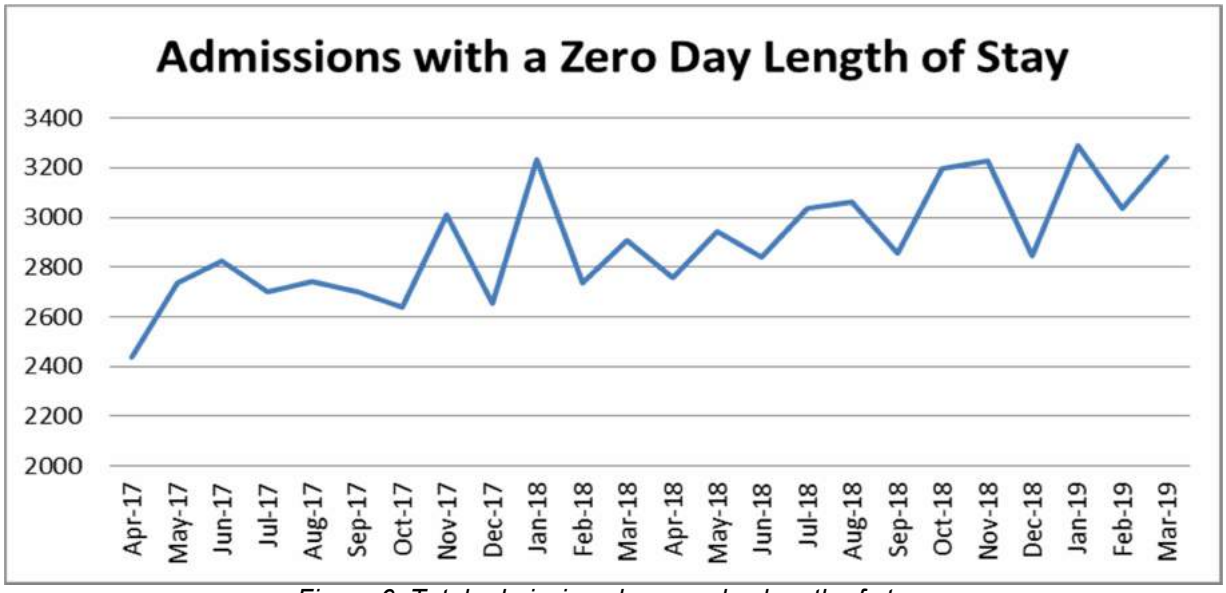


Figure 6: Total admissions by zero day length of stay

Zero length of stay means that the patient has been admitted to a ward, CAT or SAU after midnight (00:00) and discharged before midnight the following day (23:59). This same day emergency care is similar to the concept of day surgery, where patients do not have to be admitted overnight for less complex surgical procedures.

We were aiming to increase the number of short admissions; both for zero days and one to three days stay.The total number of patients admitted with a zero day length of stay has increased in 2018/19. In 2018/19 the number of patients admitted with a length of stay of one to three days has been similar to 2017/18 with 8246 admissions compared to 8261 respectively.

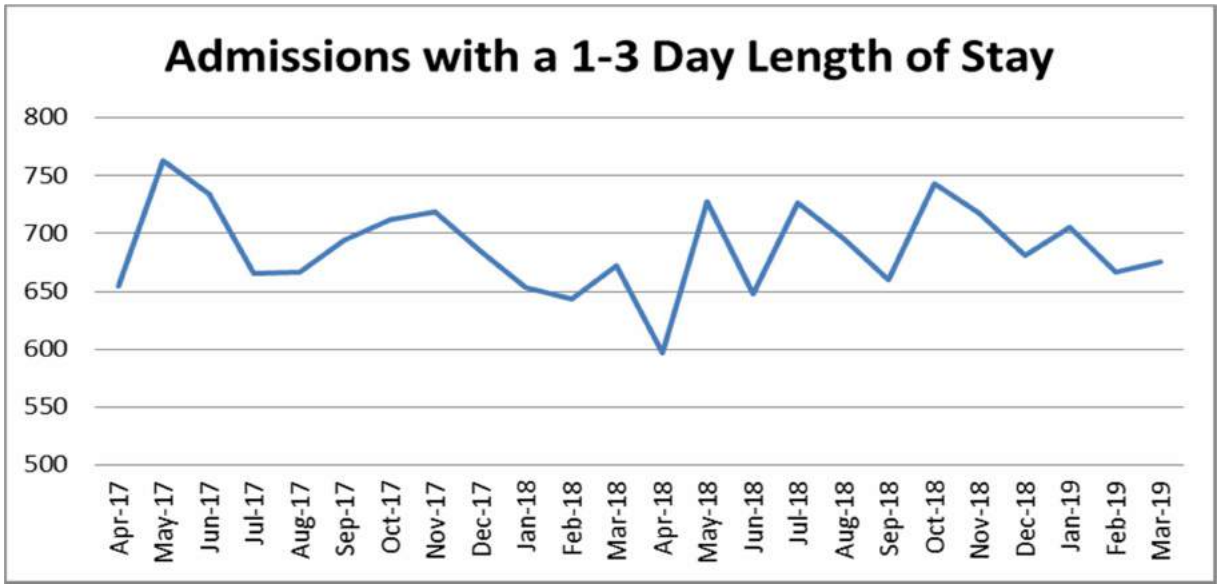


Figure 7: Total admissions by 1-3 days length of stay

Medical outliers

The total number of days medical inpatients spent on a non-medical ward has decreased with patients spending 566 fewer days outlying to a non-medical ward in 2018/19.

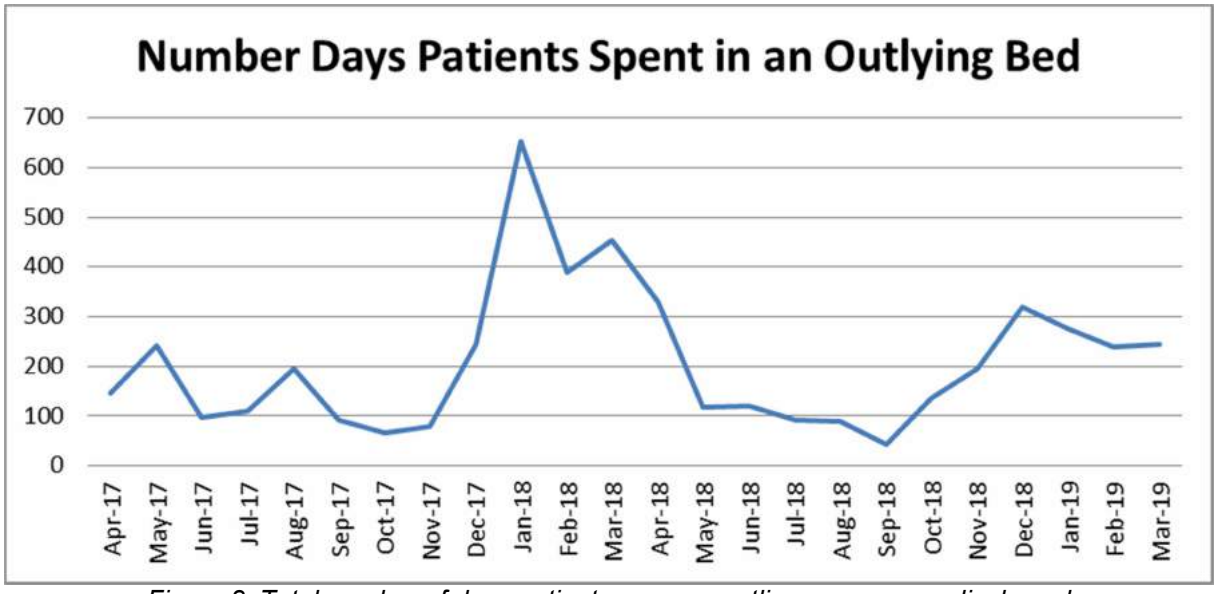


Figure 8: Total number of days patients were an outlier on a non-medical ward

Hospital at night

The project is in the early stages and therefore there are not yet any results to report.

End of life care

Harrogate and Rural District (HaRD) Clinical Commissioning Group (CCG) has agreed the specification for the new end of life (EoL) Coordination Service. HDFT is leading this piece of work. Recruitment processes are underway within community services for both a project manager and band 3 staffing in order to set up the specified service. We currently have no data results as the new service is not yet in place but the following are an early suggestion of what could be measured:

- Number of patients discharged from HDFT to their preferred place of care under fast track criteria;
- 100% patients referred via the HDFT EoL Coordination Service to have a recorded preferred place of care and death on an electronic palliative care co-ordination system (EPaCCS);
- 75% patients discharged from Harrogate District Hospital within 48 working hours of referral to the EoL Coordination Service.

There is more information about this in section 3.3 of this report.

Summary

In summary, progress has been made to see and treat patients more quickly once admitted to hospital, helping to improve the number of patients who are admitted with a very short length stay. Work will continue to 2019/20 to embed the new process for medical reviews of patients who are cared for on a non-medical ward, implement the Hospital at Night service and embed the End of Life Coordination Service.

4. Increasing patients and public participation in service development

The Trust recognised that it wanted to support people using our services to be at the centre of decision making at an individual level, and when there are plans to change or develop services at scale, and has been working to develop a Patient and Public Participation Strategy. In addition, with the significant growth of HDFT children's services and emergence of the Children and Countywide Community Care directorate, it was advisable to develop an organisational strategy to ensure HDFT can establish and evidence child and young person centred services.

What were we aiming to achieve?

Our ambition is to deliver excellence every time for our patients and the people who use our services. At HDFT we believe patient and public participation is about continuous improvement of our services and define participation as 'the active participation of people, patients, service users, carers and our members in the development of health services'. Our approach to patient and public involvement will be constantly evolving and we aim to continuously learn from many forms of participation. The Patient and Public Participation Strategy needed to set out our ambition of strengthening participation and how we intend to achieve it, and aimed to be a significant enabler of HDFT's strategic narrative and overall objectives.

Regarding services delivered to children, young people and families and carers, it was agreed at the outset that the most child and young person centered approach would be to co-produce this 'strategy' with the then burgeoning HDFT Youth Forum. The Youth Forum has subsequently gone from strength to strength and is now a well-established group of young people who are keen to make a difference to healthcare.

Meaningful co-production takes time to ensure ownership by those developing the product but the Youth Forum has worked diligently on this piece of work. A three month consultation was undertaken to ensure the voices of children and young people from different communities and with different experiences were included in the development of the Hopes.

What have we done?

The development of the Patient and Public Participation Strategy has involved work to clarify what participation involves, what participation is already in place and what our expectation is for participation in the future.

Participation covers a spectrum of activities, which might also be called engagement or involvement, with the intention to capture continuous and 'live' feedback as well as structured engagement activities. We want to prioritise the active inclusion of all those who use our services in the shaping of those services, and recognise this may involve many small steps which collectively create the conditions for innovation, learning and improvement. The Trust and individual services currently use patient feedback from a variety of sources to make improvements but believe we can build on how we currently involve people in their care and service provision by focusing on:

- Encouraging individuals to participate in decisions about their care and treatment;
- Creating the conditions where meaningful patient and public participation and engagement is embedded in service planning and development;
- Supporting staff to develop their awareness and understanding so they can contribute to patient and public participation;
- Ensuring effective monitoring and evaluation of patient and public participation;

- Promoting active participation between HDFT, and other statutory agencies and voluntary organisations.

The process to develop a strategy for child and young person centered care started out as developing a series of standards. However the Youth Forum quickly felt that was too rigid and came up with the idea of their 'Hopes for Healthcare' as they were more aspirational and set the vision for how the young people would like to see health services delivered. The Youth Forum developed the Hopes through a variety of mechanisms, including a series of workshops, often combined with visiting services on the hospital site.

The forum was intent on being inclusive and wanted the Hopes to be accessible. They quickly identified medical language as a barrier and were keen to ensure that the Hopes were "jargon busted". There were many learning points on the way; for example the young people were not always aware of the range of health services, and while they were sure children and young people would want to access health through digital technology and social media, they also realised that a trusting relationship with health professional was critical.

Once the series of Hopes had been worked through, the Forum was clear that they had to be engaging and eye catching. The group started to work with a member of Trust staff with graphic skills, who could visually bring the Hopes to life after much discussion and a series of iterations of the images.

The Forum presented their work to a range of key stakeholders within the Trust and externally. This was the start of the wider consultation through social media, schools and HDFT staff who were in contact with children and young people, to get feedback on the Hopes. The consultation was open for three months and led to a number of changes.

Figure 9: The Hopes for Healthcare – a strategy for child and young person centred care

Once the final seven Hopes were agreed, the next stage was to develop a set of 'standards'. These were worked on through a number of workshops in the summer holidays and were established to help provide services with a framework for delivery of the Hopes.

The Forum is keen to be involved in the delivery of the standards and implementation of the Hopes within services across the Trust, and is considering developing training videos and undertaking spot checks to help support this ongoing work.

What are the results?

What has been developed is:

- The Patient and Public Participation Strategy which was approved by the Board of Directors in January 2019. Work has started to consider how we will deliver this strategy;
- The Hopes for Healthcare (wording and graphics) which are available on the Youth Forum webpage at http://www.hdft.nhs.uk/about/education-liaison/youth-forum/hopes-for-healthcare/;
- The standards which provides a framework for how the Hopes may be evidenced;
- Explanation and posters for the Hopes.

Some examples of the Hopes

This Hope is about communicating clearly the steps and choices available for a young person in their care. Details of the standards to make this a reality include:

- Care plans, which describe what care is in place and planned, are developed with young people and take into account all aspects of their life and how they would like their parent or carer to be involved in their care;
- Feedback about care is actively sought in a range of ways, including electronic feedback, and then reviewed and acted upon.

Figure 10: One example of an HDFT Hope for Healthcare

Ideas developed to demonstrate how services can show that this Hope has been implemented include:

- Young people can tell you about their treatment and plan of care;
- Leaflets are available explaining what young people should expect;
- Anonymous and independent feedback is encouraged by staff.

A two-sided paper feedback form has been designed by the Youth Forum - one side with smiley face feedback for younger children and the other side with written questions for young people.

Another Hope is about promoting a seamless transition for young people to adult services to minimise stress on the patient and families. Various standards have been identified to make this a reality including:

- All young people who are moving ('transitioning') from children to adult health services have at least one 'transition talk' to discuss what the move will be like;

- All young people will have a written 'transition care plan' and the young person will have a copy of it. The plan will include a named key worker who will provide continuity during the move and beyond;

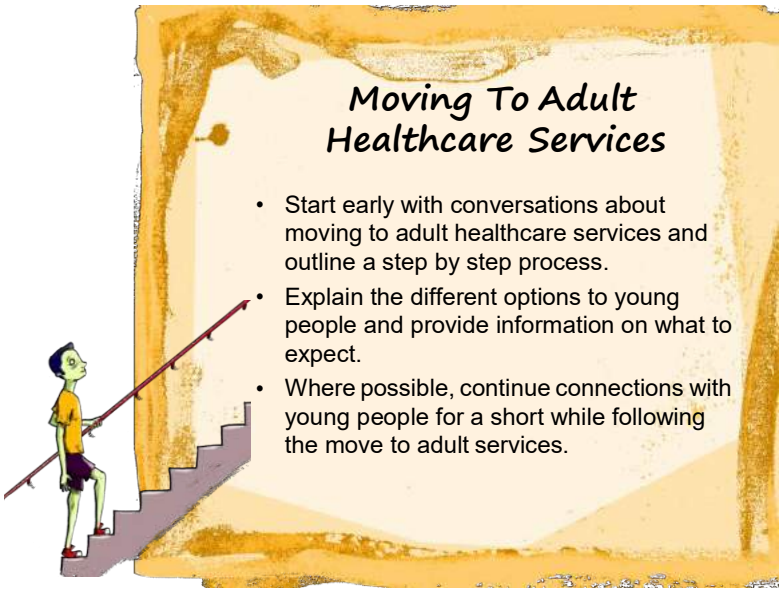


Figure 11: Another example of an HDFT Hope for Healthcare

- Clear transition protocols and procedures are in place;
- All young people who are transitioning from children's to adult healthcare receive an easy to understand booklet with a step by step guide on transitions, and local support services available for adults;
- Specialist children's services establish closer links with the equivalent adult service so that information about young people who are moving across is passed on.

Ideas developed to demonstrate that these have been implemented include:

- Services are identifying young people who will be moving into adult services over the next few years;
- A 'transition talk' is recorded in patient notes;
- A checklist is developed for health professionals of what to talk about in the transition meeting;
- Asking young people if they have a copy of their transition plan;
- Asking for feedback before and after transition and acting on information gathered;
- Including a survey question about whether the young person understands what will happen when they move to adult services;
- Protocols and/or procedures are in place;
- All young people who will move to adult services will be given a booklet.

Summary

Considerable work has been undertaken to develop a Patient and Public Participation Strategy, and a separate innovative organisational strategy to establish and evidence child and young person centred services.

The Patient and Public Participation Strategy has been approved by the Board of Directors and work has started to consider how we will deliver this strategy. The Hopes for Healthcare have also been approved and there was a lively meeting of the Board of Directors and the Youth Forum on the 19th March 2019 to formerly launch the Hopes and celebrate the work done to date. The Forum will be involved in the implementation and delivery of the standards and Hopes for Healthcare within services across the Trust.

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

Reducing stillbirths was a Trust quality priority for 2018/19 and the work was focused on ensuring full implementation of the NHS England Saving Babies' Lives Care Bundle including a process for ongoing monitoring. The Saving Babies' Lives Care Bundle brings together four elements of care that are recognised as evidence-based and/or best practice. These are:

1. Reducing smoking in pregnancy;
2. Risk assessment and surveillance for fetal growth restriction;
3. Raising awareness of reduced fetal movements;
4. Effective fetal monitoring during labour.

What were we aiming to achieve?

Improvement work has been undertaken through the national Maternal and Neonatal Health Safety Collaborative. This was launched in February 2017 and is led by a patient safety team and covers all maternity and neonatal services across England. The aims of the programme are to:

- Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England;
- Contribute to the national ambition, set out in Better Births (NHS England, 2016) of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020.

The primary aim of the local work was to:

- Reduce the percentage of women smoking at delivery to 5% by 1st April 2020;
- Increase accuracy of data entry to 99% by 1st April 2020;
- Improve the detection of small for gestational age babies by improving compliance with the scanning algorithm from the Saving Babies' Lives Care Bundle.

What have we done and what are the results?

Reducing smoking in pregnancy

The maternity team at HDFT were part of the second wave of the national Maternal and Neonatal Health Safety Collaborative which started in March 2018 and concentrated on smoking in pregnancy. Locally four main issues were identified: data collection; carbon monoxide monitoring; poor engagement with smoking cessation services; staff training.

Data collection has improved through more rigorous data input, a focus on education for midwives about the importance of correct data entry, and removing smoking 'history unknown' codes to encourage staff to ask the appropriate questions.

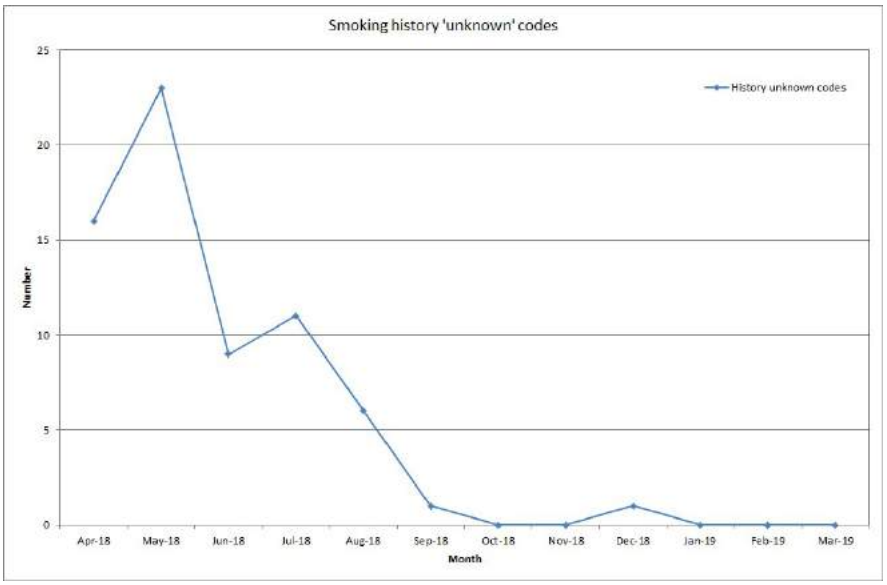


Figure 12: Reduction in smoking history 'unknown' codes used indicating improved data collection

There has been a real focus on carbon monoxide monitoring during pregnancy and the purchase of equipment for staff in all areas of the department. Training on the risks of smoking and on carbon monoxide monitoring is now included in the maternity mandatory training days, and as a result of work undertaken during this period, the recording of carbon monoxide monitoring for all women at booking has improved from 55% to 96%.

There is still more work to do on the accuracy of history taking, with ongoing discrepancies between records made at the time of pregnancy booking and delivery. During January to March 2019, 31 patients were identified as 'ex-smokers' at booking but were recorded as having 'never smoked' at the time of delivery, and a further nine patients who were listed as 'never smoked' at time of booking, but by time of delivery were recorded as 'ex-smokers'.

From 1st October 2018 the Smoking Cessation Service in Harrogate was brought into the antenatal clinic to run alongside a consultant clinic. Identified pregnant smokers living in Harrogate are now booked under the consultant leading this clinic, and patient engagement with Smoking Cessation Services for this cohort has improved from 55% (May – September 2018) to 66% (October 2018 – February 2019). The plan is to extend this model of care to women referred from rural districts and out of area.

93% of midwifery staff and 87.5% of obstetricians have now received training on the risks of smoking and the value of carbon monoxide monitoring. This training is now part of the maternity mandatory training days.

Risk assessment and surveillance for fetal growth restriction

Full implementation of the algorithm for screening for growth restriction has been prevented by resource limitations for ultrasound scanning. A group has been set up to work towards improving ultrasound capacity in order to deliver against this priority. However in March 2019 version 2 of the Saving Babies' Lives Care Bundle has been published and the maternity service will be focusing on compliance with the updated algorithm for screening for growth restriction.

Raising awareness of reduced fetal movements

A local checklist for women presenting with reduced fetal movements has been implemented, and an audit commenced in the Maternity Assessment Centre to assess women's perception of fetal movement advice.

Effective fetal monitoring during labour

Cardiotocography (CTG) is a technical means of monitoring the fetus during labour, by recording the fetal heartbeat and the uterine contractions. Improvements have been made in the quality of fetal monitoring training for staff who interpret the CTG. The content of local face-to-face training has been updated to include the recognition of the types of hypoxia, and a more physiological approach to CTG interpretation, with an emphasis on the importance of communication, escalation and situational awareness. The face-to-face training has been extended from one to three hours in duration and is now multidisciplinary, with midwives and obstetricians learning alongside each other, sharing knowledge and experience.

The percentage of doctors and midwives attending face-to-face training within the past 12 months has improved to 93.5% and 93% respectively.

Summary

Progress has been made against all elements of the Saving Babies' Lives Care Bundle, and the local team presented progress at the National Learning Set in March 2019. The main challenge is around provision of ultrasound scanning for all at risk groups. During 2019/20 the service will be working to make progress towards full compliance with the latest version of the Saving Babies' Lives Care Bundle.

2.3. STATEMENTS OF ASSURANCE FROM THE BOARD

1. Provision of relevant health services and income

During 2018/19 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 2018/19 represents 100% of the total income generated from the provision of relevant health services by HDFT for 2018/19.

2. National and local audits

National audits

During 2018/19, 43 national clinical audits and two national confidential enquiries and clinical outcome review programmes (seven studies) covered relevant health services that HDFT provides.

During that period HDFT participated in 98% 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. The Trust participated in all 26 (100%) of the programmes in which it was eligible to do so. There were also 29 non-NCAPOP audits listed, 10 of which were not relevant to HDFT. The Trust participated in 18 of the 19 which were relevant (95%).

The national clinical audits and national confidential enquiries that HDFT was eligible to participate in during 2018/19 are as follows:

1. Acute Myocardial Ischaemia National Audit Project (MINAP)
2. Adult Community Acquired Pneumonia
3. BAUS Urology Audits: Female stress urinary incontinence
4. Bowel Cancer (NBOCA)
5. Cardiac Rhythm Management (CRM)
6. Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC)
7. Child Health Clinical Outcome Review Programme
    (i) Young People's Mental Health
    (ii) Cancer in Children, Teens and Young Adults
    (iii) Long term ventilation in Children and Adults
8. Diabetes (Paediatric) (NPDA)
9. Elective Surgery National PROMS programme (2018/19)
10. Falls and Fragility Fractures Audit Programme (FFFAP)
    (i) National Audit of Inpatient Falls
    (ii) National Hip Fracture Database
11. Feverish Children (care in emergency departments) – CEM
12. Inflammatory Bowel Disease (IBD) programme
13. Learning Disability Mortality Review Programme (LeDeR)

14. Major Trauma: The Trauma Audit and Research Network (TARN)
15. Mandatory surveillance of bloodstream infections and clostridium difficile infection
16. Maternal, New-born and Infant Clinical Outcome review Programme (MBRRACE-UK)
17. Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
    (i) Acute Heart Failure
    (ii) Perioperative Diabetes
    (iii) Pulmonary Embolism
    (iv) Acute Bowel Obstruction
18. National Audit of Breast Cancer in Older Patients (NABCOP)
19. National Audit of Dementia (Delirium Spotlight Audit)
20. National Audit of Intermediate Care (NAIC)
21. National Audit of Rheumatoid and Early Inflammatory Arthritis
22. National Audit of Seizures and Epilepsies in Children and Young People
23. National Cardiac Arrest Audit (NCAA)
24. National Asthma and COPD Audit Programme (NACAP)
    (i) Secondary Care
    (ii) Adult Asthma
    (iii) Pulmonary Rehabilitation
25. National Comparative Audit of Blood Transfusion Programme
    (i) Use of Fresh Frozen Plasma
    (ii) Major Haemorrhage 2018
26. National Diabetes Audit (Adults)
    (i) National Footcare Audit
    (ii) National Inpatient Audit (NADIA)
    (iii) National Pregnancy in Diabetes Audit
    (iv) Secondary Care Audit
27. National Emergency Laparotomy Audit (NELA)
28. National Audit of Care at the End of Life (NACEL)
29. National Heart Failure Audit
30. National Joint Registry (NJR)
31. National Lung Cancer Audit (NLCA)
32. National Maternity and Perinatal Audit
33. National Neonatal Audit Programme (NNAP - intensive and special care)
34. National Ophthalmology Audit
35. Non-Invasive Ventilation – Adults
36. Oesophago-gastric cancer (NAOGC)
37. Prostate Cancer Audit
38. Reducing the impact of serious infections (antimicrobial resistance and sepsis): Antibiotic consumption
39. Reducing the impact of serious infections (antimicrobial resistance and sepsis): Antibiotic stewardship
40. Sentinel Stroke National Audit Programme (SSNAP)
41. Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
42. Seven Day Hospital Services
43. Surgical site infection surveillance service
44. Vital signs in Adults (care in emergency departments) – CEM
45. VTE risk in lower limb immobilisation (care in emergency department) - CEM

The national clinical audits and national confidential enquiries that HDFT participated in during 2018/19 are as follows:

1. Acute Myocardial Ischaemia National Audit Project (MINAP)
2. BAUS Urology Audits: Female stress urinary incontinence
3. Bowel Cancer (NBOCA)
4. Cardiac Rhythm Management (CRM)
5. Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC)
6. Child Health Clinical Outcome Review Programme
7. Diabetes (Paediatric) (NPDA)
8. Elective Surgery National PROMS programme (2018/19)
9. Falls and Fragility Fractures Audit Programme (FFFAP)
10. Feverish Children (care in emergency departments) – CEM
11. Inflammatory Bowel Disease (IBD) programme
12. Learning Disability Mortality Review Programme (LeDeR)
13. Major Trauma: The Trauma Audit and Research Network (TARN)
14. Mandatory surveillance of bloodstream infections and clostridium difficile infection
15. Maternal, New-born and Infant Clinical Outcome review Programme (MBRRACE-UK)
16. Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
17. National Audit of Breast Cancer in Older Patients (NABCOP)
18. National Audit of Dementia (Delirium Spotlight Audit)
19. National Audit of Intermediate Care (NAIC)
20. National Audit of Rheumatoid and Early Inflammatory Arthritis
21. National Audit of Seizures and Epilepsies in Children and Young People
22. National Cardiac Arrest Audit (NCAA)
23. National Asthma and COPD Audit Programme (NACAP)
24. National Comparative Audit of Blood Transfusion Programme
    (i) Major Haemorrhage 2018 only
25. National Diabetes Audit (Adults)
26. National Emergency Laparotomy Audit (NELA)
27. National Audit of Care at the End of Life (NACEL)
28. National Heart Failure Audit
29. National Joint Registry (NJR)
30. National Lung Cancer Audit (NLCA)
31. National Maternity and Perinatal Audit
32. National Neonatal Audit Programme (NNAP - intensive and special care)
33. National Ophthalmology Audit
34. Non-Invasive Ventilation – Adults
35. Oesophago-gastric cancer (NAOGC)
36. Prostate Cancer Audit
37. Reducing the impact of serious infections (antimicrobial resistance and sepsis) Antibiotic Consumption
38. Reducing the impact of serious infections (antimicrobial resistance and sepsis) Antibiotic stewardship
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40. Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
41. Seven Day Hospital Services
42. Surgical site infection surveillance service
43. Vital signs in Adults (care in emergency departments) – CEM
44. VTE risk in lower limb immobilisation (care in emergency department) - CEM

The national clinical audits and national confidential enquiries that HDFT participated in, and for which data collection was completed during 2018/19 are listed at Annex Three, alongside

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

The reports of 14 of the national clinical audits and 0 of the NCEPOD reports were reviewed during 2018/19, and HDFT intends to take the following actions to improve the quality of healthcare provided.

It should be noted that neither of the national confidential enquiries during the period have been published yet. HDFT continued to review published reports from other audits and enquiries undertaken in previous years. If we look at previous NCEPOD studies, six reports have been reviewed in the period.

Acute Myocardial Ischaemia National Audit Project (MINAP)

This is an audit about the care provided to patients who are admitted to hospital with acute coronary syndromes (heart attack). Although patients with acute myocardial ischaemia are seen by a Cardiologist at Harrogate District Hospital, patients are referred for angiogram with possible angioplasty to the Leeds General Infirmary or James Cook University Hospital, Middlesbrough. Capacity issues in those centres mean that patients often have to wait longer than national guidelines stipulate before being transferred. Access to inpatient echocardiography for patients following attack is sometimes difficult due to staffing issues in the echo service. Training of staff is taking place to improve staffing in this service and improvements are already being seen. This is a high priority issue in cardiology and is under constant review.

National Audit of Dementia (NAD)

The NAD assesses the quality of care provided to people living with dementia when they are in hospital. Work is needed to improve the recording of body mass index (BMI) or weight of patients with a diagnosis of dementia, and performing cognitive testing using a validated structured instrument, and delirium assessments. Care assessments need to include a section dedicated to collecting information from the carer or next of kin. Improvement is also needed in initiating discharge planning within 24 hours of admission and completing cognitive testing using a validated structured instrument at the point of discharge. These are all areas of focus for the Care of the Elderly team over the coming year.

National Audit of Intermediate Care (NAIC)

The National Audit of Intermediate Care aims to take a whole system view of the effectiveness of intermediate care, to develop quality standards and patient outcome measures and to assess local performance against the agreed, national standards.

It can be seen from the data that the standard response time for our crisis response service is 4 hours, almost twice the national average of 2.3 hours. NICE guidelines (NG74) advise crisis response services to assess service users within 2 hours of referral, which we are not currently meeting. There are also issues with 56% of our patients waiting over two days for assessment by the intermediate care service, compared to the national average of 37%.

Within the local specification, the current standard commissioned for our crisis response service is 4 hours. We are having discussions with HaRD CCG around admission avoidance services and crisis response. The Harrogate and Rural Alliance will be considering crisis response services as part of its operating model but currently we are only resourced to deliver a 4 hour response.

National Emergency Laparotomy Audit (NELA)

NELA supports the improvement of the quality of care for patients undergoing emergency laparotomy. This is a surgical operation that is used for people with severe abdominal pain to find the cause of the problem and in many cases to treat it. The HDFT audit results indicate that improvements are needed regarding the documentation before surgery of the risk of death, and postoperative assessments by a Care of the Elderly specialist for patients aged over 70 years. The number of patients with an unplanned return to theatre after emergency laparotomy is higher than the national average, as is the number of unplanned admissions to critical care. The postoperative length of stay in patients surviving to discharge is five days longer than the national mean.

A new emergency laparotomy pathway is being produced which will promote better documentation, facilitate audit, and hopefully improve the quality of care for patients. The main obstacle to improving performance is capacity within the Care of the Elderly service to take on additional clinical work. A business case is being written to support a proposal for more Care of the Elderly consultants to fill this gap.

Sentinel Stroke National Audit Programme (SSNAP)

SSNAP measures both the processes of care provided to stroke patients, as well as the structure of stroke services against evidence based standards. Improvements have been made in Occupational Therapy provision for patients and a more consistent proportion of time being spent on Oakdale Stroke Unit. However the results of the audit showed no improvement in time to computerised tomography (CT) scan, time to thrombolysis, or Speech and Language Therapy provision.

Local NHS hospital Trusts, ambulance services and commissioners have been working co-operatively together to develop a new model of hyper-acute stroke services consistent with recommended best practice. Evidence shows that people who receive care in hyper-acute stroke units (HASUs) that see a minimum of 600 new admissions per year are likely to have better outcomes, even if the travel time is increased. The HASU at Harrogate District Hospital was never likely to meet this threshold. From 1 April 2019 if someone is thought to be having a stroke, they will be taken by rapid ambulance transfer to either York or Leeds HASU for their initial treatment. Patients will be transferred back to Harrogate District Hospital as soon as possible after initial treatment or discharged directly home, and will receive their ongoing rehabilitation locally.

Local Audits

During 2018/19 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 2019/20.

The reports of 157 local projects (clinical audits, service evaluations and patient surveys) were reviewed by relevant audit or governance groups at HDFT during 2018/19 and HDFT intends to take the following actions to improve the quality of healthcare provided.

Venous Thromboembolism Information on Admission and Discharge (Re-audit)

Thromboprophylaxis guidelines at HDFT advise that all patients (both medical and surgical) should receive an assessment of venous thromboembolism (VTE) risk, and be given verbal and written information on VTE prevention as part of the admission process. In addition,

patients and/or carers should be offered verbal and written information on VTE prevention as part of the discharge process. This is in line with NICE guidance and NICE quality standards.

A baseline assessment of both the delivery and documentation of VTE advice at HDFT was undertaken in 2017. The project found that documentation of information provided on admission fell below the expected level. Improvement measures put into practice included the development of areas for staff to document provision of VTE information on admission and discharge in the new universal admission document for both medical and surgical patients. The audit also highlighted that an automatic footnote comment about VTE on discharge letters was not being applied to letters for patients attending the Clinical Assessment, Triage and Treatment (CATT) Unit and Day Surgery, an issue which was immediately rectified.

This re-audit was designed to investigate whether the changes were fully embedded and effective. Results showed that the majority of patients and carers are given verbal and/or written information relating to VTE on discharge as a result of appropriate information being automatically added to every discharge letter. However, only 17% of patients had evidence that verbal and/or written information had been provided on admission. Whilst performance was well below the expected level, anecdotal evidence suggested that this re-audit has highlighted errors in documentation rather than failures in practice. Verbal discussion and written information regarding VTE risk does take place, but this is simply not being recorded on the admission and discharge checklists. The requirement to confirm VTE prophylaxis actions is currently positioned at the bottom of the admission checklist, after various optional assessments. The document is to be restructured to position the VTE prophylaxis actions, with the actions applicable to all patients e.g. welcome letter provided, identification bracelet fitted. After this has been implemented there will be a further audit of the VTE information documentation process.

Audits of the Assessment of Lying and Standing Blood Pressure

Lying and standing blood pressure measurement for postural hypotension is a vital part of a falls assessment in the elderly patients; however, it was noted that not all patients who fit the criteria had a documented blood pressure recording.

An audit was designed to measure the number of lying and standing blood pressure recordings being undertaken with the aim to produce recommendations which would increase the number of lying and standing blood pressure recordings for patients in whom it is indicated (i.e. admitted with falls, light-headedness, syncope, dizziness), to aid in falls risk assessment and to help staff with any difficulties encountered. After the implementation of these recommendations, a rapid re-audit was planned to review whether these changes had led to improvements in practice.

Initial audit confirmed the observation that both lying and standing blood pressure measurement was not being performed. Recommendations implemented included regular discussion and education of staff on Byland and Jervaulx Wards regarding issues encountered most commonly on the wards to improve blood pressure recordings; posters on the wards to encourage timely blood pressure measurements, and advice given to measure lying and standing blood pressure at the time of first transfer to ward or at the time of first observation recording.

A re-audit undertaken one month after these recommendations were actioned showed significant improvement; however, still only 57% of patients had both recorded. Difficulties reported included inadequate staffing on both wards to help record blood pressure; non-compliance of patients (especially if admitted with delirium) and the issue that nursing staff would want to wait for clearance from the physiotherapists and occupational therapists

before asking the patient to stand for a blood pressure measurement. Results were shared and discussed with ward matrons and the HDFT Falls Co-ordinator. Further actions and recommendations suggested include:

- Regular education and encouragement of nursing staff and especially student nurses and care support workers to help nursing staff perform this test;
- Staff to seek ways of encouraging patients to agree to lying and standing blood pressure, such as performing the test when their family are visiting if patients seem more comfortable with them present;
- Recording blood pressure recording during initial physiotherapy or occupational therapy assessment;
- Introduction of lying and standing blood pressure charts for each bay.

A re-audit of the lying and standing blood pressure process will take place after the recommended actions have been implemented and fully embedded.

Management of Pain in Patients with Fractured Neck of Femur

Fractured neck of femur is a serious public health problem and a major cause of post injury death. The management of pain post admission and prior to definitive surgical treatment crosses the boundary between emergency and surgical teams and is vital for a quality patient journey through the hospital.

NICE and local guidelines provide a pathway to follow to ensure the best possible management of pain. Effective adherence to this pathway, assured by high quality handover between teams, is essential to achieving the best patient outcomes. This process was previously audited in 2014; this re-audit sought to assess whether significant improvement has been achieved, and identify key strategies for further improvement.

Data was collected from patients' case notes, historical prescribing records from the electronic prescribing and medicines administration system (ePMA), Emergency Department (ED) pathway documents when present in the notes, and observations recorded on Patientrack, the electronic system to record observations and alert clinicians, in-line with policy.

Criteria - expected compliance 100%	Previous Performance	Current Performance	Change
Patients' pain assessed and scored on arrival in ED	50%	55%	+5%
Patients' pain reassessed within 30 minutes of initial analgesia	7.1%	15%	+7.9%
Patients' pain score recorded hourly in ED	0%	16%	+16%
Patients' pain score recorded with each set of observations on the ward prior to surgery	30%	45%	+15%
Analgesia on ED for those in moderate or severe pain within 60 minutes	25%	77.7%	+52.7%
Analgesia on the ward for those in moderate or severe pain within 60 minutes	75%	100%	+25%
Patients' cognitive function assessed on admission	25%	85%	+60%

Table 2: Results of the management of pain in patients with fractured neck of femur audit

Improvement was shown in all domains. Carrying out the audit outlined a problem with the note keeping in cases of neck of femur (NOF) fracture. It was apparent that for seven of the 20 patients, a fascia iliaca block was indicated in the notes but was not prescribed on ePMA,

or the ED pathway. The ED pathway was absent from the notes in six out of the 20 (30%) patients. Nursing notes were missing from two (10%) of the 20 patients.

Outcomes:

- Addition of printed NOF fracture pathway into surgical clerking booklet to standardise recording post acceptance by orthopaedics;
- Presence of ED documentation in notes to be a specific part of nursing ward admission checks to ensure that missing paperwork is spotted early, at a point where it can be found and salvaged. It could be part of the handover procedure to transpose the relevant parts of the ED paperwork onto the ward nursing documents, this would give continuity and make sure ward staff are aware of pain scores;
- Require initial analgesia to be prescribed on ePMA, rather than on paper, to avoid the possibility of lost documentation denying the patient pain relief;
- Further repeat audit to follow up on the above points.

Audit of Enhanced Gynaecology Recovery Programme

Enhanced recovery is a model of care for elective surgery, combining elements of care to form a pathway which reduces the physiological stress response and organ dysfunction due to surgery. The ultimate aim is rapid return of normal physiology which translates to quick post-operative recovery and discharge.

This audit aimed to assess impact on length of stay of patients undergoing hysterectomies at Harrogate District Hospital, regardless of route. The first 30 hysterectomies during 2017 were sampled; this was then repeated in 2018. The objectives were to:

- Assess local adherence to principles set out in the Enhanced Gynaecology Recovery Protocol;
- Evaluate the average length of stay six months prior to this being introduced, and to compare the same metric six months after its implementation.

Post-operative paracetamol is being prescribed to all patients. Whilst adherence to all the other criteria is short of target, this is not by a large margin. This is especially commendable as this is a very new protocol. The mean length of stay has been reduced by 43.6%, from approximately 2.9 days in 2017 to 1.6 days in 2018. However, prescribing of thromboembolism deterrent (TED) stockings is very poor. There is a discrepancy between intra-operative and post-operative prescriptions of nonsteroidal anti-inflammatory drugs. There is non-uniform prescribing of laxatives, dependant on the consultant performing the hysterectomy. Extended thromboprophylaxis with (Tinzaparin for seven days on discharge) is not on the protocol, but is being done for two-thirds of patients. There were some discrepancies between nursing actions and their documentation (i.e. varying levels of compliance with completing the Enhanced Recovery booklet).

Outcomes:

- Extended Thromboprophylaxis to be added to the protocol;
- Email to be sent to all junior doctors to remind them about prescribing TED stockings and laxatives for all patients undergoing hysterectomy (unless contra-indicated);
- Pharmacy to add TED stockings to EPMA Enhanced Gynaecology Recovery Protocol;
- Disseminate information about using the Enhanced Gynaecology Recovery Protocol to the ward nurses on Nidderdale Ward.

Radiograph Film Quality Audit (Community Dental Services)

Dental imaging is essential to dentists for diagnosis, treatment planning, monitoring treatment, and monitoring lesion development. There needs to be a rigorous quality assurance plan in place to ensure radiographs are of the best possible quality. Films should be graded when they are reported. The quality ratings of films should be regularly reviewed to ensure they are within national guidelines, and the consistency of grading should also be monitored to ensure we are working in line with these national standards. This audit was undertaken in two parts.

Part a

Film grading was audited over a 12 month period and compared to the National Radiological Protection Board (NRPB) Film Quality Gold standards. A total of 4578 films were reviewed. Quality rating of radiographs is done according to the guidance notes for dental practitioners on the safe use of x-ray equipment:

1. Excellent. No errors of patient preparation, exposure, positioning, processing or firm handling (> 70%);
2. Diagnostically acceptable. Some errors of patient preparation, exposure, positioning, processing or firm handling, but which do not detract from the diagnostic utility of the radiograph (< 20%);
3. Unacceptable. Errors of patient preparation, exposure, positioning, processing or firm handling which render the radiograph diagnostically unacceptable (< 10%).

	Gold standard	Percentage of total films		Percentage of graded films	
		2017	2018	2017	2018
Grade 1	70%	63%	67%	79%	78%
Grade 2	20%	15%	17%	19%	20%
Grade 3	10%	2%	2%	2%	2%
Ungraded	0	19%	14%	N/a	N/a

Table 3: Review of graded films and total films against quality standards 2017 and 2018

The results show:

- A reduction in ungraded films from 19% in the 2017 audit to 14% in the most recent cycle, but 14% of films still have no grading recorded on the dental health record system (SOEL);
- 98% of graded films had a diagnostic value, being either grade 1 or 2;
- The total films achieving grade 1 (67%) has improved from the previous audit (63%) but is still failing to meet the NRPB quality target of 70%.

Part b

To ensure that radiographs are graded consistently, clinicians examined radiographs and assigned them a quality grading, which was then compared to the quality grading recorded for that film on SOEL.

	Total no of films reviewed	SOEL grade match	SOEL grade higher e.g. grade 2 film graded as 1	SOEL grade lower e.g. grade 1 film recorded as grade 2	No grade recorded on SOEL
2017	119	49 (40%)	20 (16%)	0	50 (41)%
2018	50	38 (76%)	5 (10%)	0	7 (14%)

Table 4: Results of the recorded grading compared to grading at review for the 2017 and 2018 audit

The results show:

- An increase in the proportion of films where the grade assigned on review matched the SOEL grade with 76% in 2018 compared to 40% in 2017;
- A reduction in the proportion of films where the SOEL grade is higher than the grade assigned on review with 10% in 2018 compared to 16% in 2017;
- A reduction in the proportion of films ungraded on SOEL with 14% in 2018 versus 41% in 2017;
- In 2018 in 24% of cases the grade assigned to the film on review did not match that recorded on SOEL, an improvement from 57% in 2017.

The radiographs taken within the Community Dental service meet the national guidance for diagnostically acceptable quality (Grade 1 and 2 combined) however, fall short of meeting the criteria for films graded as totally error-free (Grade 1). It is likely that this may relate to the patient group being more challenging than the cohort upon which the NRPB grading targets were designed. Lack of recorded grade may also contribute to failure to meet the necessary standard as when only films with a recorded grade are analysed all standards are met.

The action plan is focused around ensuring all radiographs are of the highest standard, all radiographs have a quality grading assigned and that quality grading is assigned in a standardised way. The actions are to:

- Reinforce with staff the importance of grading each film;
- Focus training on staff with high levels of ungraded films;
- Reinforce the importance of careful radiograph positioning and technique;
- Ensure all clinics have access to appropriate radiograph film holders and positioning aids;
- Install digital radiography equipment to reduce the incidence of grade 2 and 3 films related to processing and developing errors;
- Introduce further training to reinforce the importance of recording a grade for all radiographs taken and documenting this in patients' notes;
- Introduce further training on the grading criteria to ensure that all are grading consistently according to the NRPB guidelines.

<u>Re-audit of community beds supplied to children on the Occupational Therapy (OT) caseload</u>

Many children with complex physical needs use electric profiling beds. The aim of a bed is to provide the child with a safe sleeping area that enables them to be positioned correctly using the functions of the bed, encourages independence through the height adjustment, and enables carers to adjust the bed in order to carry out essential care tasks.

In the past some adult beds had been issued which did not meet the standard for children under the age of 12 or people under 145cm in height. This meant that there were beds in the community which presented both an entrapment risk and also a risk for children who might be able to climb over the bed rails.

The sample selected for audit was extracted from the caseload database in August 2018. The criterion for inclusion was that the child has an electric profiling bed on loan from Medequip stores. The results showed that all children who are in electric profiling beds have now been provided with a product which meets the standard for this type of provision.

All children should still be able to have an assessment for and be provided with an electric profiling bed which meets the British Standard. It is clear however, that some children may now be older or taller than the prescribed measure in the standard and that their provision

may need to be reviewed. It was also noticed when reviewing the list of children who have beds that some have gained extra skills and may have more independence than when first assessed. No new actions are currently required as it was felt that good practice is now embedded into provision.

3. Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by HDFT in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 2777.

Harrogate and District NHS Foundation Trust (HDFT) is committed to making sure every patient has the chance to take part in research and continues a culture where an offer to participate in research is considered part of standard care. Between April 2018 and February 2019, the Trust had 176 clinical trials or studies across 25 clinical and non-clinical areas inviting suitable participants to take part. 75 clinicians supported by 43 research delivery staff funded by the National Institute for Health Research (NIHR) led these studies. The Trust has consistently recruited over 3000 participants per year over the last five years. This means HDFT is the most research active acute non-academic affiliated trust in the Yorkshire and Humber region, remaining committed to the promotion of evidence-based practice and aiming to keep on improving by high-quality research both its high standards and patient outcomes.

Research Department: Restructuring

The Research Department consists of the Research and Development (R&D) Office and research delivery staff that includes research nurses, clinical trial assistants, and clinicians. It also embraces medical and allied health professionals, all supporting individual trials or studies. Strategically, the Associate Medical Director for Research leads the Research Department, the R&D Manager manages the R&D office staff and the Lead Research Nurse leads the clinical delivery staff.

Over the last five years there has been significant growth in research development and delivery within the Trust. This increased demand, seen in the context of senior staff reduction in hours, identified a need and provided the chance to reorganise the management team structure. A four day per week senior research nurse role shared by two staff to support delivery staff and a dedicated quality and safety manager to join the R&D office were appointed to meet these requirements.

Research and Development Office: Quality Assurance

Research Governance and Performance

All research activity must comply with the NIHR Good Clinical Practice (GCP) standard and the UK Policy Framework for Health and Social Care Research standards. The Research Health Authority (HRA) is responsible nationally for ensuring that research carried out in the NHS is safe and sound.

Locally R&D office staff carry out checks to make sure that any research trials or studies taken up by the Trust have gone through appropriate approvals. The R&D office also makes sure that all research activity is in line with GCP. A multi-disciplinary R&D Group, chaired by the Trust Medical Director, oversees this. Performance is monitored and managed both locally within the Trust and at a regional and national level by the Clinical Research Network.

Good Clinical Practice (GCP) compliance

Since the time of the last quality report, the Research Department has carried out a full review of its processes and procedures and as a result has set up a new Quality Management System. This means we have:

- Translated the most current national and international regulations and standards into useable local Standard Operating Procedures (SOPs);
- Established a process for setting objectives;
- Improved communication flow;
- Set up a process for continuous staff training and competence;
- Maintained improvement through ongoing auditing and monitoring.

It also means we promote and continue to achieve:

- Safety for patients taking part in research and staff supporting research;
- Adoption of appropriate and well-designed research;
- High quality and reliable research data as the basis of future health care.

Patient and Public Involvement (PPI)

It is an ongoing aim of the research department to fully support and implement Patient and Public Involvement (PPI). The Trust now has four Patient Research Ambassadors (PRAs) bringing a patient perspective to research design and delivery. PRAs are involved in development of patient-facing research documents such as information leaflets, trial or study feasibility assessment, quality assurance via the participant survey, performance via team meetings, taking part in competency assessments for research staff and raising awareness about research opportunities.

The annual participant survey seeks feedback from the patients who take part in research to provide information about service delivery. Findings are shared and acted upon. This feeds into a national NIHR survey of research participants.

An article published in November 2018 in the Journal of Evaluation in Practice shows that patients admitted to more research-active hospitals have greater confidence in staff and are better informed about their condition and medication. This is a theme that strongly resonates within our organisation.

HDFT Research Department is on Facebook and Twitter and both platforms are popular with the number of followers growing steadily. HDFT research staff continually seek out findings of completed trials or studies and ensure not only that these are shared with individual participants, but that the findings are also available to the whole of the public served by HDFT as well as to the clinical teams. Initiatives to share the impact of research generally have included a joint venture with Harrogate Lions at the Great Yorkshire Show and video newsletters which have been shared locally and nationally.

Matching research to national aims and working with partners to ensure high quality research is carried out

The national and local agenda is to promote more community-based healthcare with particular emphasis on making patient self-management easier 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. NIHR funds health and social care research recognising that these service delivery platforms are inextricably linked. HDFT appreciates the benefits to be achieved if the services work co-operatively.

The research team continues to work closely with Clinical Commissioning Groups and GP Federations to make sure patients have the chance to take part in research. Pharmaceutical companies in collaboration with clinical teams around the country, including those at HDFT, are exploring several new potential therapies through large clinical trials. The diabetes research team at Harrogate has demonstrated an ability to work with GPs to identify suitable participants in a systematic way using information from the GP database. This model 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, University of York (Reproductive Health and Healthcare Delivery, and Centre for Immunology and Infection), UK Dermatology Clinical Trials Network and Clinical Trials Units in York, Leeds, Sheffield and Southampton. 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 the Yorkshire and Humber region which have an interest in the health and wealth of the region. The area has a history of organisational collaboration including academic (White Rose Consortium), Leeds University, Bradford Teaching Hospitals, Local Education and Training Boards (LETB), Collaboration for Leadership in Applied Health Research and Care (CLAHRC) and Hull and York Medical School. HDFT also actively works in partnership with Medipex Ltd for the development, protection and exploitation of Trust-generated Intellectual Property.

The Trust is participating in the Quality in Surgical Teams (QIST) patient safety initiative funded by Northumbria NHS Vanguard, NHS Improvement, and Industry (Vifor and Schulke). Its aim is to scale up two successful quality improvement initiatives across 40 organisations to reduce major complications from surgery in two evidence based domains, infection and anaemia. It supports the NHS Improvement ‘Getting It Right First Time’ approach, and has provided an opportunity through collaborative working to improve surgical outcomes through the pre-operative treatment of mild anaemia and decolonisation of carriers of Methicillin Sensitive Staphylococcus aureus (MSSA). It is also hoped to lead to improvements locally in how we monitor rates of infection and transfusion for quality and performance.

HDFT has a long history of engagement with commercial research organisations such as device and 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 its reputation for being able to deliver to time and to target.

4. Use of the Commissioning for Quality and Innovation Framework

HDFT income in 2018/19 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because we agreed an aligned incentive contract with our commissioners. While income was not dependant on achievement, there remained a focus on driving forward changes which were most relevant to improving the quality of care for our patients.

5. Registration with the Care Quality Commission

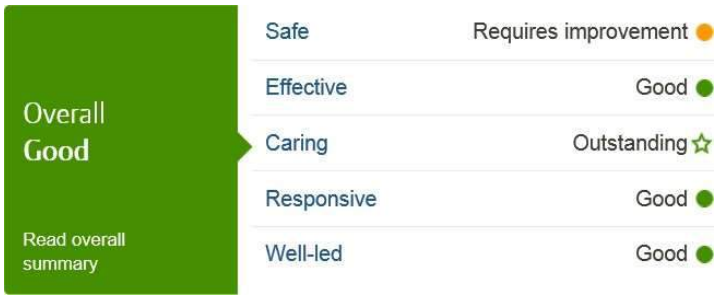
HDFT is required to register with the Care Quality Commission and its current registration status is unconditional. HDFT has no conditions on registration. HDFT had the following sites registered during 2018/19:

- Harrogate District Hospital;
- Lascelles Unit;
- Ripon Community Hospital.

The Care Quality Commission has not taken enforcement action against the Trust during 2018/19. HDFT has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Care Quality Commission completed a routine inspection of the Trust during 2018. This comprised unannounced inspections of four services, an inspection of the well-led domain at Trust level and a review of the use of resources. The report was published on 14 March 2019 and is available from Harrogate and District NHS Foundation Trust. All services inspected improved their overall ratings. Services not inspected retain the rating from the previous inspection in 2016.

The overall rating remains good for the Trust, good for acute services and outstanding for community services. All services are now rated as good or better, with five services rated as outstanding.



CQC inspections and ratings of specific services			
Acute services		**Community services**	
Medical care (including older people's care)	Good	*Urgent care services	Good
*Services for children and young people	Good	*Community inpatient services	Good
Critical care	Outstanding	Community health services for children, young people and families	Good
End of life care	Good	Community health services for adults	Outstanding
Maternity and gynaecology	Good	Community dental services	Outstanding
Outpatients and diagnostic imaging	Outstanding	Overall	Outstanding
*Surgery	Outstanding		
Urgent and emergency services	Good		
Overall	Good		

Use of resources	Good
Trust level well-led	Good
Combined rating	Good

Table 5: CQC ratings for HDFT March 2019

* Services inspected in 2018

6. Information on the Quality of Data

HDFT submitted records during 2018/19 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:

99.8% for admitted patient care;
99.9% for outpatient care;
97.5% 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

The Data Security and Protection Toolkit has replaced the previous Information Governance toolkit from April 2018. The Data Security and Protection Toolkit is an online self-assessment tool that enables organisations to measure and publish their performance against the National Data Guardian's ten data security standards.

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly.

HDFT has met all of the National Data Guardian Standards.

8. Payment by Results

HDFT was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

HDFT commissioned an external Payment by Results clinical coding audit by D&A during 2018/19 and the accuracy rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnosis = 95.0%
- Secondary Diagnosis = 97.1%
- Primary Procedure = 95.6%
- Secondary Procedure = 97.0%

Results should not be extrapolated further than the actual sample audited. Specialties audited were General Surgery and General Medicine.

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 2018/19, 641 of HDFTs patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 142 in the first quarter;
- 140 in the second quarter;
- 177 in the third quarter;
- 182 in the fourth quarter.

By 01/04/2019, 29 case record reviews and three investigations had been carried out in relation to 30 of these deaths.

In two cases 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:

- 8 in the first quarter;
- 8 in the second quarter;
- 10 in the third quarter;
- 4 in the fourth quarter.

Two, representing 0.3% 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:

- 1 representing 0.7% for the first quarter
- 1 representing 0.7% for the second quarter
- 0 representing 0% for the third quarter
- 0 representing 0% for the fourth quarter

The two deaths judged more likely than not to have been due to problems in the care provided to the patient were recognised and investigated as serious incidents, with the outcome reported to the families involved, the Board of Directors, commissioners, HM Coroner and the Care Quality Commission. Detailed recommendations, including change of clinical practice and policy have been agreed and action plans produced in order that appropriate steps are taken to address problems in care and to share learning. Discussions are ongoing as to how learning is most effectively shared across acute trusts within the integrated care system.

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. 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 2018/19 some specific focused reviews have been undertaken:

- The specialty of Trauma and Orthopaedics was flagged as a negative outlier for hospital standardised mortality ratio (HSMR) for the first time in relation to the period February 2017 to January 2018. The patients who died during this period were identified and 26 cases were reviewed and a SJR completed. For this reason a significant proportion of cases reviewed during 2018/19 related to deaths during 2017/18. The main theme was of good or excellent care. In six cases a problem with some aspect of care was identified but there was no associated harm. Examples included:
    - Recognising frailty and anticipatory planning as a result, but this would not have changed the outcome;
    - Delay in assessment by medical team due to work load;
    - More aggressive antibiotic regime indicated on presentation of a septic patient.

  This focused review is now complete.

- Further learning is sought by case notes reviews of all in-hospital cardiac arrests which are reviewed by the Resuscitation Committee to identify any areas of learning to share and determine whether the resuscitation is deemed appropriate or inappropriate. This is in addition to reporting all hospital cardiac arrests to the National Cardiac Arrest Audit (NCAA) to monitor and report on the incidence of, and outcome from, in-hospital cardiac arrest in order to foster improvements in the prevention, care delivery and outcomes from cardiac arrest. This is a joint initiative between the Resuscitation Council (UK) and ICNARC (Intensive Care National Audit and Research Centre).

All cases of a patient with learning disabilities dying in hospital are automatically referred to the national Learning Disabilities Mortality Review (LeDeR) programme, and five cases were referred during 2018/19. This is the national multi-agency programme for review of death in patients with learning disabilities commissioned by NHS England.

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 for many patients.

The case record reviews continue to 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 number of cases, examples of where practice could be improved were documented. The great majority of these did not affect the eventual outcome. For example:

- Ensuring patients assessed in ED as having a stroke are not given oral intake prior to swallow assessment;
- Ensuring patients with a stroke are admitted to the stroke unit, not other medical wards;
- Ensuring patients transferred back from other hospitals have a timely medical assessment;
- Considering input from orthogeriatric colleagues at the pre-assessment clinic to manage frailty and start advanced care planning;
- Ensuring correct procedures regarding certification of death, and correct Coronial procedures are followed;
- Improving Neurosurgical advice available when the online referral system is not sufficient and holistic and contextual decision-making is indicated;
- Ensuring delays related to percutaneous endoscopic gastrostomy (PEG) tube insertion to feed patients who need this are minimised;
- Ensuring post mortem examination is considered in all relevant cases;
- Improving recognition of the dying phase at end of life to enable unnecessary treatments to be stopped at an appropriate time.

Actions taken

The following actions have been taken as a result of the learning 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. We have used our #ChatterMatters newsletter to share findings;
2. At national level through the implementation of a 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, and resuscitation decision making training materials.

The impact has been:

- Increased awareness of the mortality review process and the benefits of reviewing deaths to inform learning;
- Further education of doctors in training within the Trust regarding Coronial processes and correct certification of deaths;
- Amending our SJR process to encourage the clinician completing the case review to report any specific problem regarding care that is identified as an event on Datix, so this can be followed up. General problems and themes will continue to be identified following the SJRs and reported to the Improving Patient Safety Steering Group where appropriate actions are agreed and progressed.

31 case record reviews and zero investigations completed after 1 April 2018 related to deaths which took place before the start of the reporting period (during 2017/18).

Zero representing 0% 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.

One representing 0.15% of the patient deaths during 2017/18 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	Jul 17 to Jun 18	Oct 17 to Sep 18
HDFT value	0.963	0.925	0.909	0.925	0.920	0.930
HDFT banding	2 (as expected)	2 (as expected)	2 (as expected)	2 (as expected)	2 (as expected)	2 (as expected)
National average	1.000	1.000	1.000	1.000	1.000	1.000
Highest value for any acute Trust	1.171	1.164	1.228	1.247	1.257	1.268
Lowest value for any acute Trust	0.694	0.690	0.726	0.727	0.698	0.692

Table 6: Summary Hospital Level Mortality Index (SHMI)

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 are undertaken as required;
- Individual specialty alerts are investigated as deemed appropriate, either through the mortality review process, coding anomalies or discharge processes or a combination of these. In March 2019 an alert was received regarding deaths associated the diagnostic group of pathological fracture, and nine cases are currently subject to a

case note review by the consultants of care. The overall Trust SHMI remains 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					
	Jul 15 to Jun 16	Oct 15 to Sep 16	Jul 16 to Jun 17	Oct 16 to Sep 17	Jul 17 to Jun 18	Oct 17 to Sep 18
HDFT value	22.6	23.0	20.4	20.3	24.6	26.2
National average	29.2	29.7	31.1	31.5	33.1	33.6
Highest value for any acute Trust	54.8	56.3	58.6	59.8	58.7	59.6
Lowest value for any acute Trust	0.6	0.4	11.2	11.5	13.4	14.3

Table 7: Palliative care coding - % patient deaths with palliative care coded at either diagnosis or specialty level

Note - highest and lowest trust scores include all providers with data published by NHS Digital
Data source: 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;
- 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 had not happened for some months. This was resumed in May 2019;
- The PCT's activity data for 2018/19 indicates that referrals to the team continue to rise steadily, and increased by 18% compared to 2017/18, with the number of contacts rising by 31%;
- Prior to an additional clinical nurse specialist (CNS) post being filled in September 2018 (see below), PCT CNS staffing was 0.38 whole time equivalent (WTE) per 100 beds, well below the national average of 2.55 (National Audit of Care at the End of Life 2019);
- 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 January 2018 compared to 36% of patients in November 2015.

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

- Expansion of the PCT by 0.8 WTE clinical nurse specialist in September 2018, so the establishment is now 0.6 WTE consultant, 0.4 WTE specialty doctor and two WTE clinical nurse specialists, bringing CNS staffing to 0.63 per 100 beds;
- Continued PCT attendance at multidisciplinary team (MDT) meetings 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 electronic, written, 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 were included in the survey: groin hernias, hip replacements, knee replacements and varicose vein operations. However the mandatory varicose vein surgery and groin-hernia surgery national PROM collections ended on 1 October 2017. A high health gain score is good.

	Data period			
	2014/15 (final)	2015/16 (final)	2016/17 (final)	2017/18 (final)
HDFT value	0.423	0.442	0.425	0.440
National average	0.436	0.438	0.437	0.458
Highest value for any acute Trust	0.487	0.492	0.533	0.550
Lowest value for any acute Trust	0.331	0.320	0.329	0.357

Table 8: PROMS - Hip replacement surgery - adjusted average health gains (EQ-5D index)

	Data period			
	2014/15 (final)	2015/16 (final)	2016/17 (final)	2017/18 (final)
HDFT value	0.302	0.324	0.329	0.338
National average	0.315	0.320	0.323	0.337
Highest value for any acute Trust	0.385	0.374	0.398	0.417
Lowest value for any acute Trust	0.204	0.198	0.237	0.234

Table 9: PROMS - Knee replacement surgery - adjusted average health gains (EQ-5D index)

Note - highest and lowest trust scores exclude independent sector providers and PCT 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;
- The data is formed from pre- and post-operative patient surveys and therefore reflects patients' perception of the improvement in their health following surgery;

- An analysis of the data shows that HDFT has a pre-operative score slightly 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, in order that where there are worsening scores that this can be discussed with individual patients.

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

Age 16+

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

Table 11: Emergency readmission to hospital within 28 days (age 16+)

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

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

- The source data used is taken from the 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	2018/19 (To February 2019)
Total number of emergency readmissions within 30 days	3895	4196	4403	4145
As a percentage of all emergency admissions	18.89%	19.36%	19.60%	20.05%
Number of emergency readmissions within 30 days (Payment by Results exclusions applied)	2696	2737	2933	2756
As a percentage of all emergency admissions	13.08%	12.67%	13.06%	13.33%

Table 12: Emergency readmissions within 30 days

Data source:
http://harrogatedata/Reports/Pages/Report.aspx?ItemPath=%2fFinance%2fEmergency+Readmissions
Data for the full year 2018/19 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 patients' 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			
	2014/15	2015/16	2016/17	2017/18
HDFT value	72.6	73.3	72.4	68.4
National average	68.9	69.6	68.1	68.6
Highest value for any acute Trust	86.1	86.2	85.2	85.0
Lowest value for any acute Trust	59.1	58.9	60.0	60.5

Table 13: Inpatient survey results 2014/15 to 2017/18.

Data source: NHS Digital, NHS Outcomes Framework indicator 4.2
Indicator ref: P01779 https://indicators.hscic.gov.uk/webview/

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

- Driving improvement for the delivery of high quality fundamental care continues to be a major priority for the Trust. We continue to monitor fundamental care standards 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:

- Focusing resources on addressing those indicators which, following analysis of the 2017 result, identified areas where our performance could be improved to make the biggest impact on overall patient experience.
- See section 4.1 in this report for further detail.

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 21d

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.

Proportion of staff who responded "strongly agree" or "agree".	Data period				
	2014	2015	2016	2017	2018
HDFT value	71	78	80	76	76
National average	65	71	71	70	70
Highest value	88	89	91	89	90
Lowest value	45	45	48	48	49

Table 14: National staff survey results

The source of the data has changed since the last report. The data presented is taken from the new data source and there are some minor changes from data previously presented.
Data source: http://nhsstaffsurveys2018.com/sections/38

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

- The Trust maintains 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 hold an annual Quality Conference, where staff share their ideas and learn about other initiatives to support the effective delivery of patient care;
- The Trust researches and implements health and wellbeing programmes for staff; examples of which include the delivery of innovative personal resilience training which has shown to improve individual's wellbeing and the launch of a fast-track physiotherapy model for staff to improve their own wellbeing;
- The Trust's Clinical Workforce Strategy supports the creation and development of new roles within the Trust to support the delivery of a sustainable workforce for the future;
- The Trust is delivering 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:

- Embedding a culture of learning, through the development of a new reporting model for near misses and incidents, ensuring feedback is given and actions and improvements are identified to prevent recurrence;
- Signing the Time to Change pledge, outlining the organisation's commitment to normalise conversations about mental health and developing a clear action plan to deliver on this;
- Promotion of the role of the Freedom to Speak Up Guardian within the Trust and recruiting a number of Fairness Champions across the organisation to support staff to raise concerns;
- Utilisation of values-based recruitment to ensure the Trust's values are well-embedded across the organisation;
- Recruitment of a second cohort of trainee Nurse Associates to support our ward areas;
- Further recruitment of Practice Educators to support skills development for our staff;
- Launch of the Quality Improvement Team Accreditation across the organisation;
- Developing and launching the RCN Leadership Programme to promote leadership skills across our clinical workforce.

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 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19
HDFT value	95.4	95.9	95.4	95.5
National average	95.2	95.6	95.4	95.6
Highest value for any acute Trust	100.0	100.0	100.0	100.0
Lowest value for any acute Trust	67.0	75.8	68.7	54.9

Table 15: Percentage of eligible admitted patients risk assessed for VTE

Note - national values exclude independent providers.
Data source: https://improvement.nhs.uk/resources/vte/

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;
- Extending VTE risk assessment to include 16 and 17 year olds admitted to hospital, in line with updated NICE guidance (NG89).

Clostridium difficile rates

The table shows the number of Trust apportioned 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	2017/18
HDFT value	9	33.8	28.4	6.8
National average	15.0	14.9	13.2	13.7
Highest value for any acute Trust	62.2	66.0	82.7	91.0
Lowest value for any acute Trust	0	0	0	0

Table 16: C.difficile - rate per 100,000 bed days amongst patients aged 2 or over

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:

- In 2017/2018, the number of CDI cases fell from 28 in 2016/2017 to seven. Our *C. difficile* objective for this period was twelve, with an objective for 2018/2019 of eleven;
- One of the cases was agreed with the CCG to be a lapse in care (compared with twelve cases in 2016/2017);
- We continued our tight monitoring of antibiotic prescribing, in particular regarding the "4 C" antibiotics, namely the cephalosporins, clindamycin, the quinolones and co-amoxiclav;
- We introduced some new hydrogen peroxide vapour (HPV) machines, and our ward hygienists were active in training and promoting good cleaning practices of the environment and equipment on the wards;
- We continued to encourage the testing for *C. difficile* of all patients with loose stool, regardless of whether the patient had an alternative explanation for having them;
- This means that patients are tested at HDFT who probably wouldn't be tested for *C. difficile* elsewhere, but it does mean that more people who are excreting spores into the environment are identified, and the risk of transmission can then be controlled.

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. Overall, the use of antimicrobials at HDFT and in the local community is below both the regional and national average;
- 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 two measures related to patient safety incidents reported to the National Reporting and Learning System (NRLS) compared to all acute non-specialist trusts:

- The rate of incidents reported per 1,000 bed days. A low rate is good; however incident reporting rates may vary between trusts and this will impact on the ability to draw a fair comparison between organisations;
- The number and percentage of reported incidents that resulted in severe harm or the death of a patient. A low score is good;

HDFT's latest published scores are below.

	October 2017 – March 2018			April 2018 – September 2018		
	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	47.09	10*	0.185	55.6	13	0.268
National position	42.1	2522	0.145	44.1	2477	0.149
Highest value	124	99	0.547	107.4	87	0.191
Lowest value	24.19	0	0	13.1	0	0

Table 17: Patient safety incidents reported to the NRLS
**Please see explanation below*

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 frontline staff;
- There is a robust policy and process within the Trust to ensure that all incidents are identified, managed, reported and investigated in accordance with national guidance;
- The Trust ensures that there are appropriate measures in place to prevent recurrence and also promotes organisational learning;
- The Trust revised its policy with regard to reporting severity of incidents of fractured neck of femur following a recommendation in the national audit inpatient falls report that all of these types of incidents should be reported as at least severe harm, as patients rarely recover to their full level of mobility;
- All of the severe harm and death 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;
- *The Trust held data differs from that published by the NRLS. According to Datix, during the period October 2017 to March 2018, we reported to NRLS seven incidents resulting in severe harm and one resulting in death, which gave rise to a rate of 0.148 (per 1,000 bed days). Two cases were downgraded from severe following investigation to moderate harm but were not resubmitted to the NRLS which accounts for the additional two cases in the published NRLS data compared to the HDFT held value. Unfortunately provisional data checks failed to pick up this anomaly prior to publication.

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 focusing on the learning from incidents and complaints, including changes to the web based event 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 2018/19 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% of patients taking four or more.

Consequently HDFT has been working over the last few years to use medicines more safely and effectively, especially as we administer over 2 million medicines doses per annum and dispense around 150,000 medicine packs (items) per year.

This work is supported by a multi professional, multi-agency national Medicines Optimisation work programme and a Board approved Hospital Pharmacy Transformation Plan.

What were we aiming to achieve?

The aim of our medicines safety priority in 2018/19 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 to improve the information given to patients about their medicines. We also commenced implementation of the Hospital Pharmacy Transformation Plan as part of the Lord Carter Review of Hospital Pharmacy and Medicines Optimisation. Specifically we intended to:

- Extend functionality of the electronic prescribing and medicines administration (ePMA) system and to commence the planning to implement prescribing complex infusions;
- Embed into practice the ePMA dashboard to target interventions to patients on high risk medicines, specifically insulin and warfarin;
- Make progress on actions identified in the Hospital Pharmacy Transformation Plan;
- Continue the focus on safe, prescribing, dispensing and administration of medicines;
- Reduce the number of incorrectly prescribed medicines;
- Reduce the number of medicines not administered as intended by the prescriber;
- Reduce the number of medicines not administered at the time intended by the prescriber;
- Reduce the number of dispensing errors leaving the pharmacy department;
- Increase the number of patients receiving relevant information about their medicines.

What have we done?

Medicines safety programme

We have a wide ranging programme to use medicines safely and effectively including:

- Implementing actions as identified in the Board approved Hospital Pharmacy Transformation Plan;
- Completing the roll out of ePMA 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 and warfarin, identifying patients whose allergy status is not completed and developing protocols to aid acute asthma and chronic obstructive pulmonary disease (COPD) management;
- Monitoring against a range of metrics to measure safe use of medicines;
- Consolidating our medicines reconciliation processes and rates. Medicines reconciliation is the process of obtaining an up to date and accurate medication list that has been compared to the most recently available information and has documented any discrepancies, changes deletions and additions;
- Continuing to adapt and deliver medicines management training for nursing and care support workers;
- Continuing to review, report and learn from incidents relating to medicines use;
- Proactively seeking to inform patients about their medicines.

The metrics agreed include:

- 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 and subsequently refreshed in 2018/19. The key elements of the HDFT 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 of complex infusions and in 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:

- A further increase in the number of prescribing pharmacists from 38% in 2017/18 to around 60% in 2018/19;
- A further reduction in medicines stockholding from 34 days in 2016, 23 days in 2017/18 and now 16 days in 2018/19, ensuring medicines are then handled optimally;
- Maintaining 90% of patients who receive medicines reconciliation within 24 hours, and 100% at 72 hours;
- Maintaining 80% for the proportion of time pharmacists spend on patient facing activities.

Roll out of ePMA

The roll out of ePMA to all wards has now been completed with the final introduction into the Emergency Department in May 2016. This has enabled a significant improvement in the safe use of medicines across the Trust, and we remain one of only a handful of trusts in the UK to have full ePMA use in all clinical areas.

Planning for the complex infusions module 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. There have been some software delays with the project but we are aiming to introduce this software into clinical practice in 2019/20.

Safer prescribing for inpatients

We have analysed the impact of ePMA on safe prescribing since implementation in 2011/12. The data below demonstrates the substantial year on year reduction in prescribing errors. The slight rise in 2015/16 was due to an increase in insulin prescribing errors. We have seen an improvement on the 2015/16 position during 2016/17 and 2017/18 and broadly maintained this in 2018/19.

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
2018/19	**2.96**

Table 18: 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 and low harm errors and a reduction in the moderate harm errors. We have had no severe harm prescribing errors since 2015/16, and the moderate harm rate has fallen to its lowest proportion recorded at 4% (three cases).

Year	Levels of harm (%)		
	No and 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
2018/19	**96**	**4**	**0**

Table 19: Levels of harm for reported prescribing errors

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
2018/19	**4.11**

Table 20: Number of adjusted administration errors

We have seen a substantial reduction in the number of medicines administration errors since the introduction of ePMA. There was a slight increase in 2014/15 and 2015/16 although this was still less than the pre-ePMA baseline. We refreshed our training for nurses and focused on increased support. In 2016/17 we 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 2018/19 we have seen a slight rise to 4.11 compared to 2017/18 but this is still a 50% reduction compared to pre-ePMA and less than 2014/15 and 2015/16. There are no clear reasons for the marginal increase but this will continue to be monitored.

We continue to see low levels of harm associated with administration errors with a significant increase in the proportion of no and low harm errors and a general reduction in the moderate harm and severe harm errors. We have had no severe medication administration harm errors since in 2015/16.

Year	Levels of harm (%)		
	No and 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
2018/19	**94**	**6**	**0**

Table 21: 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 medicines administrations delayed to patients, meaning more patients are getting their medicines in a timely manner. In 2018/19 we saw a slight rise of 0.27% and this will continue to be monitored. We have continued to see reductions in missed doses with this figure falling again for the 5th year in succession 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
2018/19	**2.27**	**0.62**

Table 22: Delayed and missed medicine administration

Reduction in "potential" prescribing errors through pharmacist activity and 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 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 since 2015/16 (89% average) are minor / moderate potential harm, with around 11% major or potentially life threatening harm interventions compared to 38% pre ePMA. The 2018/19 data was not available at the time of publication.

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 (62%)	0	68 (33%)	11 (5%)
2015/16	250	250	0	0	133 (53%)	84 (34%)	31 (12%)	2 (1%)
2016/17	198	198	0	0	81 (41%)	100 (50%)	17 (9%)	0 (0%)
2017/18	481	481	4	0	303 (63%)	125 (26%)	51 (10.6%)	2 (0.4%)

Table 23: Pharmacist intervention audit data

Embedding the 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. We have continued to use the dashboards developed for:

- Patients prescribed insulin;
- Patients prescribed warfarin;
- Patients prescribed antibiotics;
- Patients with an unknown allergy status;
- Patients awaiting medicine reconciliation or level 2 clinical review.

The consequence of these reports means we are able to identify and prioritise clinical intervention to ensure optimal prescribing and avoid harm and this is now routine practice.

Maintaining low numbers of dispensing errors

Our dispensing errors in 2018/19 (14/100,000) were well below the regional average (18/100,000) and some of the lowest across the Yorkshire and Humber region. Only three Trusts (range 9-11/100,000 dispensed items) demonstrated a lower rate.

Our error rates in aseptic services (preparation of intravenous medicines including chemotherapy) are also extremely low and one of the two lowest Trusts in the region. This has also further reduced from 5/100,000 dispensed items in 2014/15 to 3.5/100,000 dispensed items in 2017/18. The data is not available to provide a full update for 2018/19.

Learning from medicines errors

In 2014/15 we built a database of all Datix reported medicines errors. This now covers eight years from 2011/12 through to 2018/19. This allows us to identify common themes and errors, map trends and analyse progress. All reported errors are discussed at the monthly Medicines Safety Review Group, investigated and actions put into practice to learn from such events. We have focused on a number of areas including:

1. Progress on the management of missed doses

Figure 9 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 timelier manner. The percentage of Datix reports of more critical medicines being delayed has stayed static at 5% - 6% since 2014/15. This is well below the pre ePMA baseline.

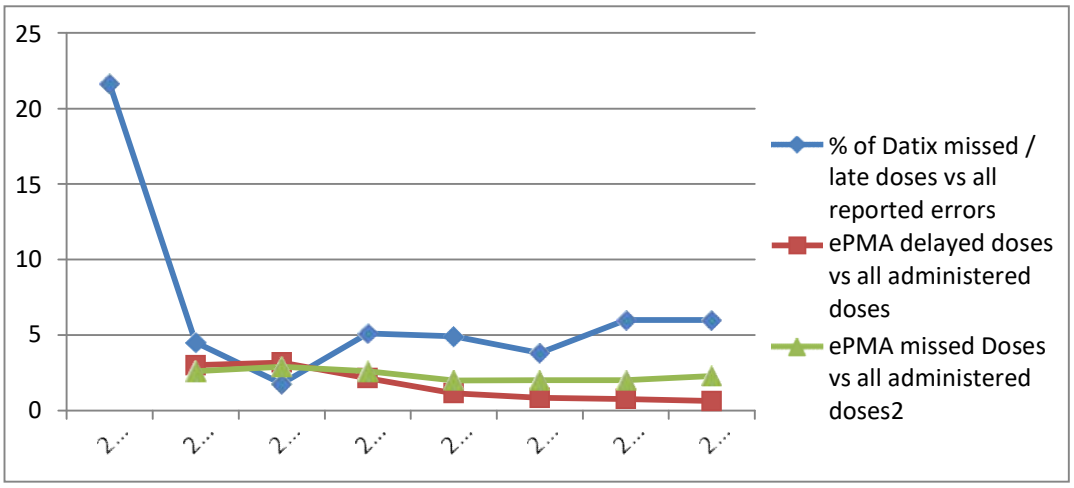


Figure 9: % missed and late doses from Datix reports and ePMA 2011/12 to 2018/19

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. Further work has reduced this level again in 2018/19. 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%)
2018/19	**5 (0.9%)**

Table 24: 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 10).

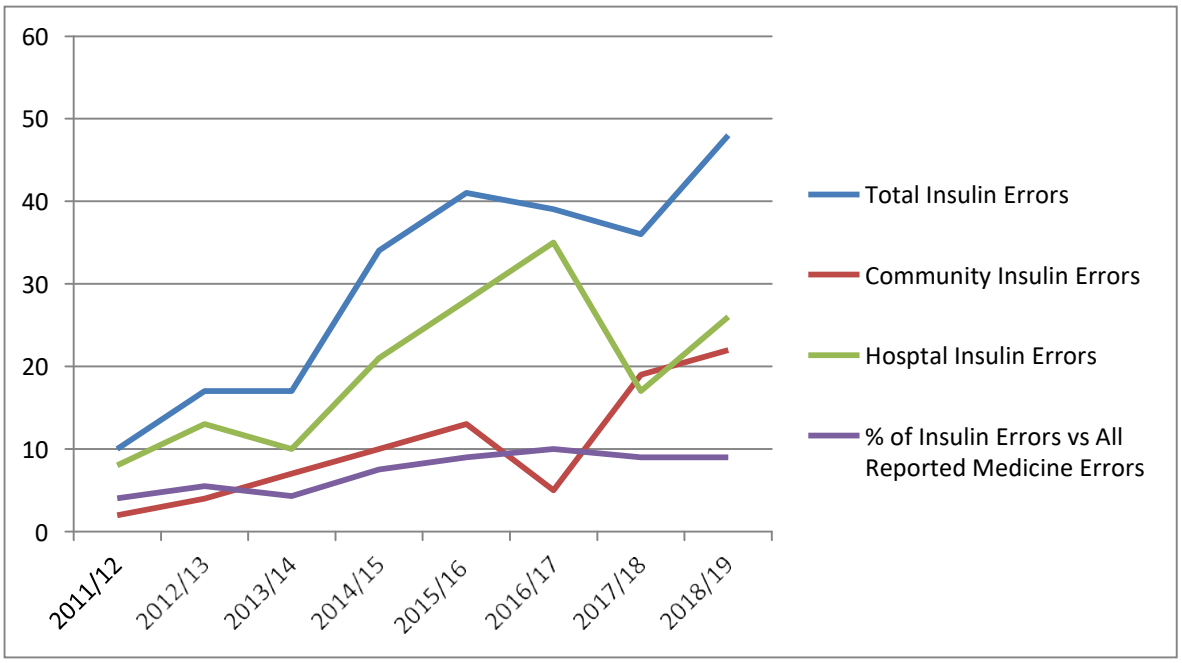


Figure 10: Number of Datix reported insulin errors from community and hospital HDFT locations from 2011/12 to 2018/19

This prompted a specific task and finish group to be convened and a quality improvement programme to be initiated. This group implemented a whole range of actions including the development of an insulin safety dashboard and the addition of safe use of insulin competency to the essential skills training programme for doctors, nurses and pharmacy staff.

The total number of incidents and errors has increased slightly in 2018/19 compared to previous years. However the % of insulin reported errors has remained around 9-10% of all reports in the last three years, demonstrating a good reporting culture. We have seen an increase in the number of hospital reported errors from 17 in 2017/18 (47%) to 26 (54%) in 2018/19. This is felt to be due to the proactive use the insulin dashboard; using this tool, the diabetes team and pharmacists are able to intervene early.

In 2018/19 we have seen a further increase in the number of community reported insulin errors. Over 40% of these relate to the wrong dose being administered.

We continue to see sustained improvement in the levels of harm caused by all hospital and community reported insulin errors, though there was a slight increase in moderate harm events in 2018/19.

Year	No and low harm	Moderate harm	Severe harm
2015/16	83%	12%	2%
2016/17	92%	8%	0%
2017/18	100%	0%	0%
2018/19	**96%**	**4%**	**0%**

Table 25: Levels of harm caused by all reported insulin errors

These are substantial improvements on previous years and we have had no incidents of severe harm with insulin since 2015/16 when the quality improvement initiative was launched.

The National Adult Diabetes Inpatient Audit (NADIA) for 2018 is due to be published in May 2019. Previous audits have shown significant improvement in the reduction in insulin errors for HDFT. This has been a really strong performance moving HDFT from one of the worst performing Trusts to the best performing Trusts in the UK.

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 26: National Adult Diabetes Inpatient Audit (NADIA) Report: Insulin errors 2010 – 2017. There was no audit in 2014

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 six years. The Model Hospital benchmark remains around 70%.

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
% patients with a medicines reconciliation within 24 hours of admission	75	80	90	90	90	90

Table 27: Medicines reconciliation within 24 hours of admission

Medicines management training for doctors, nurses and pharmacists

Medicines management training for clinical staff has been in place for five 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 with improvements again in 2018/19. ePMA training consistently achieves well over 90%. We have seen an increase in community nurse training rates but a reduction in hospital nurse training rates. We have seen an improvement in compliance with antibiotic stewardship and a slight reduction in fluid prescribing training during 2018/19.

Training competency	Renewal	Compliance 1.3.2016	Compliance 1.2.2017	Compliance 1.2.2018	Compliance 1.2.2019
ePMA	Once only	94%	97%	94%	97% ↑
Antibiotic Stewardship	2 yearly	87%	86%	78%	82% ↑
Medicines management for community nursing	3 yearly	70%	52%	71%	79% ↑
Medicines management for hospital nurses	3 yearly	73%	73%	83%	74% ↓
Safe Prescribing toolkit	Once only	85%	85%	89%	90% ↑
Safe Fluid Prescribing Toolkit *Introduced 2015*	Once only	Not applicable	85%	79%	72% ↓

Table 28: Compliance with medicines training

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 2018 we saw a significant improvement in performance compared to previous years, and we are now above the Picker average for the three domains. The Picker Institute was commissioned by 77 inpatient organisations to run their inpatient survey in 2018. Preliminary analysis for the Picker trusts indicates that HDFT is better than the average for the three questions related to medicines. We have previously included *Question 3: Not told how to take medication clearly*, but this was removed from the 2018 survey.

We remain in the upper quartile in the Model Hospital Dashboard and in the top five trusts nationally for informing patients about side effects associated with their medicines, although there is still room for further improvement.

National Inpatient Survey	% of patients								Better than Picker average 2018
	2012	2013	2014	2015	2016	2017	2018	Picker average 2018	
Question 1: *Not* fully told purpose of medicines	22	17	18	22	20	26	8	9	Yes
Question 2: *Not* fully told side effects of medicines	58	57	59	57	55	65	34	43	Yes
Question 4: *Not* given completely clear written or printed information about medicines	22	23	22	26	21	26	14	15	Yes

Table 29: Results of National Inpatient Survey questions related to medicines 2012 - 2018

Summary

The medicines safety programme has made further significant steps forward in terms of safety improvements in 2018/19 and continues to build on previous quality improvements relating to medicines optimisation and safety. During 2018/19 we have:

- Further increased the number of prescribing pharmacists from 38% in 2017/18 to around 60% in 2018/19;
- Reduced medicines stockholding from 23 days to 16 days;
- Maintained around 90% of patients receiving medicines reconciliation within 24 hours and 100% at 72 hours, well above the Model Hospital benchmark;
- Maintained 80% for the proportion of time pharmacists spend on patient facing activities;
- We have seen improvements in prescribing safety during 2018/19. Whilst there has been a very marginal increase in reported errors (2.96/100,000 prescribed doses in 2018/19 compared to 2.86 / 100,000 prescribed doses in 2017/18) we have seen:
    - An increase in the proportion of no: low harms associated with any prescribing errors, 96% compared to 91% in 2017/18;
    - A reduction in levels of moderate harm prescribing errors at 4% compared to 9% in 2017/18;
- Whilst administration errors have increased slightly from 3.80 to 4.11/100,000 administered doses, we have seen

  - Patient identity errors (i.e. the wrong patient being administered a medicine), reduce from 1.23% in 2017/18 to 0.9% in 2018/19;
  - Missed doses further decreasing from 0.76% to 0.62%;
  - Zero severe harms associated with insulin in 2018/19, with no severe insulin harms since 2015/16;
- Finally, we have had no serious harm incidents relating to the use of any medicine since 2016/17 with zero again in 2018/19.

We have improved and/or maintained good levels of medicines training compliance through the year, although we have seen a slight reduction in the proportion of hospital based nurses receiving medicines training and prescribers receiving safer fluid prescribing training.

In the 2018 National Inpatient Survey, we saw a significant improvement in performance compared to previous years, and we are now above the Picker average for the three medicines domains. We remain in the upper quartile in the Model Hospital Dashboard and in the top five trusts nationally for informing patients about side effects associated with their medicines.

The improvements in medicines safety at 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, pharmacy staff and nurses. Whilst significant improvements are being demonstrated, we will continue to work to optimise the use of medicines at HDFT.

2. Falls

As a Trust we are committed to an ongoing focus on falls prevention. Falls in hospital can be very distressing with a human cost that includes pain and injury, and an impact on quality of life with loss of mobility, confidence and independence. Falls also affect the family and carers of people who fall, and result in significant cost to trusts and the wider health and social care system. Falls rarely happen because of one cause; they are often the result of several factors. If they occur in hospital they generally result in an increased length of hospital stay and increased care cost post discharge.

Data collected in 2015/16 found that around 250,000 falls were reported across acute, mental health and community hospital settings in England. 77% of all reported inpatient falls happen to patients over the age of 65, with an estimated total cost of reported inpatient falls of £630 million (2015/16) which equates to approximately 25% of the £2.3 billion total cost of falls among older people (NICE).

What were we aiming to achieve?

Following recommendations made in NICE (2013) guidelines and the National Audit of Inpatient Falls 2017, the Falls Prevention Steering Group identified three main objectives in reducing the number of inpatient falls:

- To reduce the rate of harmful falls occurring in hospital;
- To improve compliance with falls prevention interventions; and
- To increase the number of staff completing falls prevention training.

The Trust introduced a falls safety huddle with an ambition to reduce inpatient falls by up to 30%.

What have we done?

The Trust started to work with the Improvement Academy in 2014/15 and safety huddles were first introduced on two of our wards caring for frail elderly patients. A safety huddle is a short meeting that takes place every day on a ward and includes medical, nursing and therapy staff, and non-clinical teams. The team identifies all patients that they feel concerned about that day and then work together to identify how they can keep those patients safe. This may include a medical review or a change in medicines, supplying a walking aid, or making sure the patient is eating and drinking regularly. Safety huddles are now normal practice on ten wards.

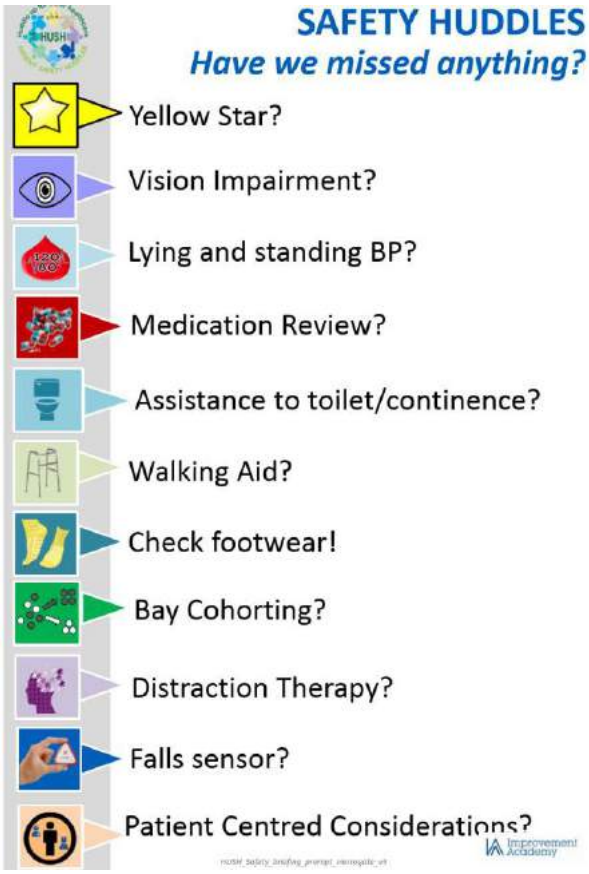


Figure 10: Updated safety huddles prompts

Acute illness, particularly in frail elderly people or those recovering from serious injury or surgery increases the risk of a fall in hospital. Patients are vulnerable to delirium, dehydration and deconditioning, all of which affect balance and mobility. A drop in blood pressure (BP) on standing (orthostatic hypotension) is a common occurrence in acutely unwell hospitalised patients and is a risk factor for falls, as is visual impairment, especially in unfamiliar surroundings.

In response to the recommendations made by the National Audit of Inpatient Falls (NAIF) we have concentrated our efforts on the timely recording of lying and standing BP readings and vision assessments for all older patients admitted onto our wards. These areas of focus have been added to the safety huddles prompts poster shown above. We have prioritised training our preceptor nurses and nursing associates to become proficient in these areas and to take actions to increase patient safety.

An Internal Audit of falls prevention in 2017 presented the Trust with a set of recommendations where improvements could be made in policy and protocols. Work has been progressed and a re-audit in March 2019 has highlighted the improvements made, confirmed good systems and processes and provided an opinion of ‘significant assurance’ in relation to falls prevention.

A new vision impairment assessment poster has been introduced across the Trust in an effort to raise awareness about the link between visual impairment and inpatient falls. This poster has also caught the interest of the North Yorkshire Pharmacists Centre for Pharmacy Postgraduate Education who is now adapting it to raise publicawareness in community pharmacies.

Figure 11: Poster – What can your patient see?

The Falls Prevention Steering Group has continued to respond to recommendations made as part of investigations completed following any inpatient falls resulting in patient harm, for example a fractured wrist. As a direct result of these reports the falls team has designed new documentation for a post fall summary and action plan, and huddle prompts have been amended and redesigned to reflect the needs of different wards. The Trust has also taken delivery of some new fall sensor equipment.

In January 2019, the Trust commenced participation in the continuous NAIF which is now focused on inpatient falls resulting in hip fracture. The Trust has actively engaged with Harrogate Borough Council and the Sports Council, and also Health and Wellbeing groups to promote access to community exercise.

What are the results?

The impact of the huddles in reducing inpatient falls can be seen in figures 12 and 13.

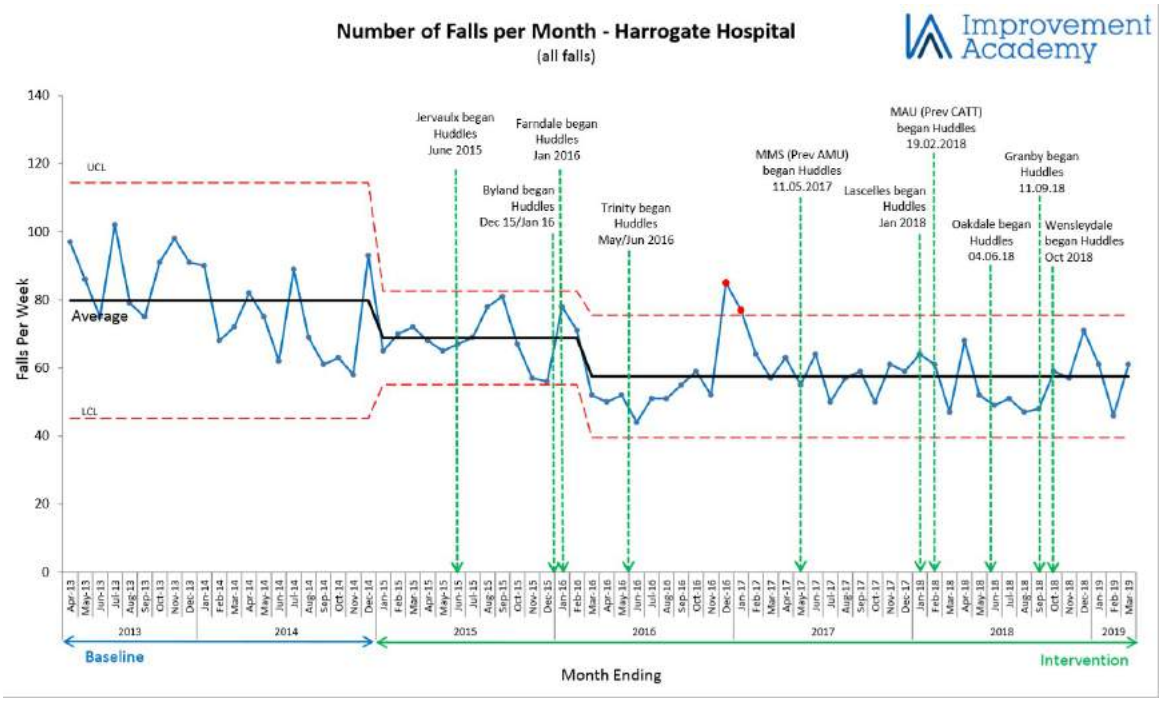


Figure 12: Number of falls per month at Harrogate District Hospital (Improvement Academy)

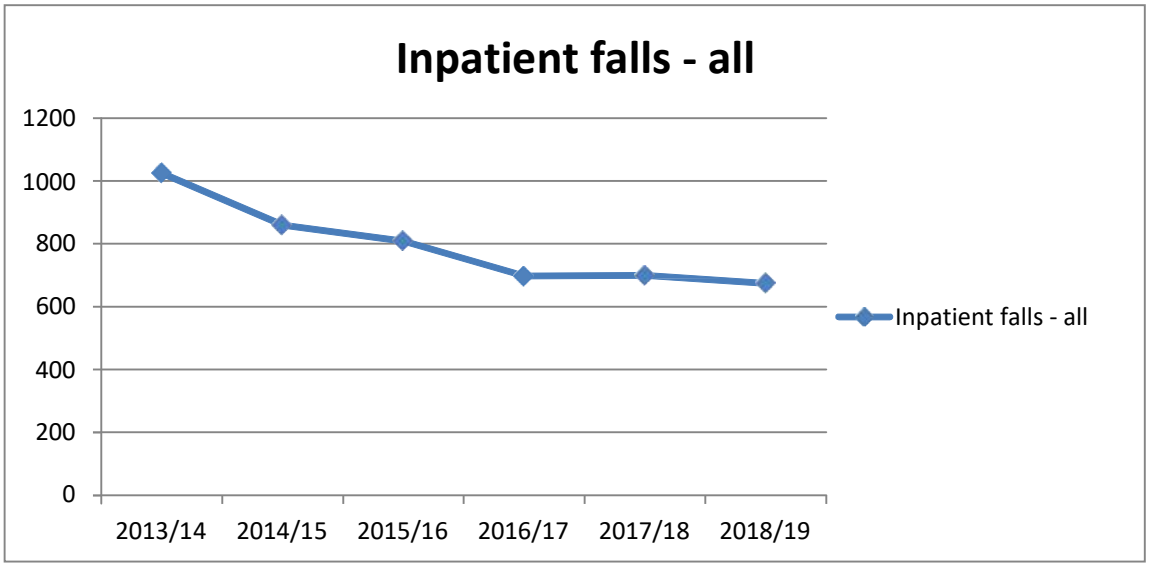


Figure 13: Reduction of inpatient falls from 2013/14 to 2018/19.

The graphs above show the decrease in the total number of inpatient falls since 2013/14; the number of inpatient falls has decreased by 34% during that time.

When we compare the total number of inpatient falls in 2018/19 with last year we can report a 4% decrease, which represents 26 fewer inpatient falls, and three fewer inpatient falls resulting in a bone fracture. NICE estimate that the cost of an average fall is £2,600 and this equates to a saving of nearly £67,600 during 2018/19 that can be used elsewhere in the Trust.

The figures in the table below provide more detail about the type of falls reported this year and show that we had a total of 674 inpatient falls and the majority of them resulted in no harm to the patients in our care. However 20 inpatients did experience a fall which required external reporting. Of these 17 resulted in a fracture and 12 of these patients suffered a hip

fracture. In 2018/19 we have recorded a 10% decrease in falls with moderate or above harm and a 15% decrease in falls resulting in a fracture. A hip fracture as a result of a fall can have an extreme impact on older people who often struggle to regain their previous levels of mobility and independence, and for that reason it is considered a serious event. The Trust completed a detailed investigation for each of the 20 externally reportable falls and implemented a range of safety recommendations into our daily care of patients.

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Inpatient falls - all	1024	859	809	697	700	674
Inpatient falls - all per 1,000 bed days	8.95	7.49	7.04	6.10	6.16	6.01
Inpatient falls - moderate harm, severe harm or death	25	36	20	15	21	19
Inpatient falls – moderate harm, severe harm or death per 1,000 bed days	0.22	0.31	0.17	0.13	0.19	0.17
Inpatient falls - resulting in fracture	16	17	16	14	20	17

Table 30: Total number and rate of inpatient falls in HDFT 2013/14 to 2018/19

The whole team on Oakdale Ward started a daily safety huddle in June 2018 and can report an impressive 70% reduction in inpatient falls since they started their huddle nine months ago. In 2018/19 the ward reported 19 inpatient falls and over the same period in 2017/18, they reported 64 inpatient falls. Oakdale Ward were also the first ward to use a new tool of enhanced patient care and this initiative has had a positive impact on managing patient safety on the ward. The graph below charts their success in decreasing the number of inpatient falls.

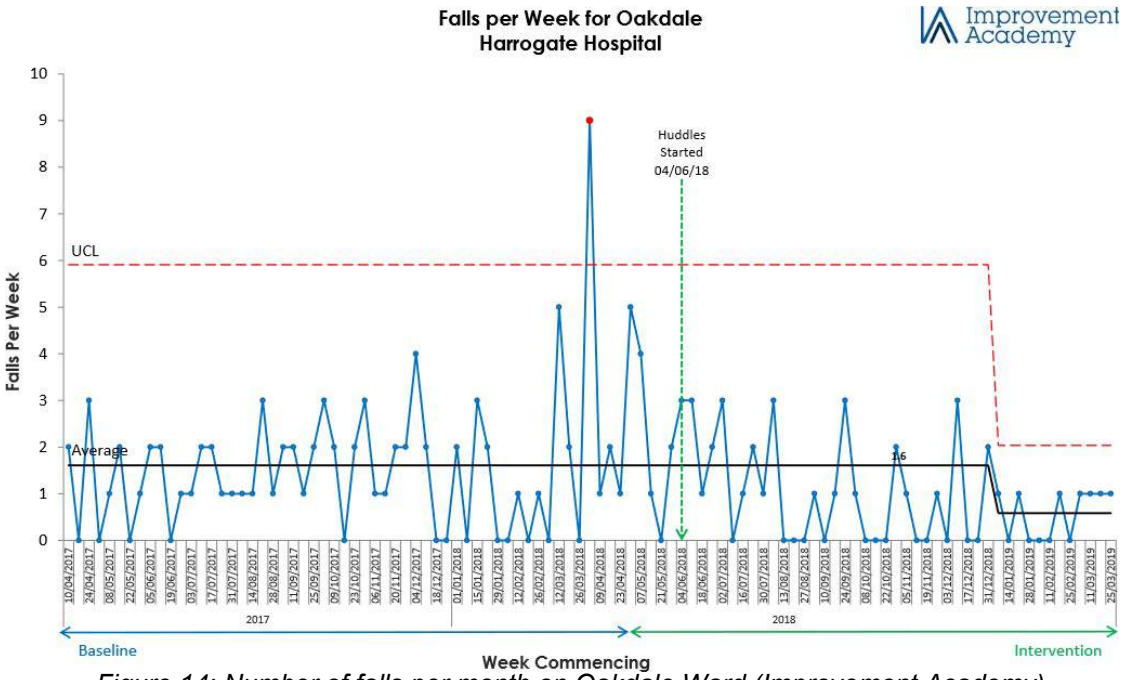


Figure 14: Number of falls per month on Oakdale Ward (Improvement Academy)

Summary

There is always more work to do but embedding the safety huddle has been a great success for the Trust and has contributed to the safety of our patients. NICE published that most falls were predictable and preventable and if patients at risk were identified and provided with an individualised falls action plan, then inpatient falls could be significantly reduced. We have been able to demonstrate that this ambition is achievable and we have been able to reduce inpatient falls by 34% since 2013/14.

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. This focus has continued during 2018/19 through:

- Education and support;
- Risk assessment and documentation;
- Learning from root cause analysis.

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?

There has been a continued strong focus on the reduction of avoidable pressure ulcers in 2018/19. Pressure ulcer root cause analysis panels, chaired by senior nurses have been established to review the root cause analysis investigations and identify common themes for learning. Education has also been strengthened to support this. The monthly Pressure Ulcer Group meetings ensure that initiatives and projects are regularly reviewed and that the high profile of pressure ulcer prevention within the Trust is maintained. Pressure ulcer incidence data is displayed on the Trust's dashboards and shared through reports to our senior management teams. Our inpatient wards display data on their quality and safety boards.

Work has been focused on two broad areas, education and training including learning from the root cause analysis panels, and documentation and risk assessment.

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. In 2019 this has been further improved with the introduction of alternate yearly face-to-face pressure ulcer training for registered and unregistered nursing and midwifery staff and some allied health professionals.

Training on skin care, and 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 approximately twice monthly. Training has also been delivered to senior ward and community registered nurses to enable them to effectively investigate pressure ulcer incidents, undertake root cause analysis and generate an action plan to address any recommendations. Further training and educational material has been provided to the clinical areas in 2018/19 to support the implementation of the NHS Improvement guidance, Pressure ulcers: revised definition and measurement, from 1 April 2019.

Learning from root cause analysis (RCA) continues at all professional levels. Many of the changes and initiatives implemented during 2018/19 have been a result of the findings from RCA investigations.

Information leaflets produced for patients, carers, families, residential, nursing and home care services, explaining shared care in relation to pressure ulcer prevention and management continue to be used to raise awareness.

Documentation and risk assessment

The Skin Inspection and Repositioning Record replaced the SSKIN bundle within the acute Trust in December 2016. This has now been fully embedded and continues to be monitored. Feedback has been positive and some improvement noted in the quality of documentation. Improvements have been made to the document in response to root cause analysis findings, staff engagement and feedback and the latest NHS Improvement (2018) recommendations.

We previously implemented a new pressure ulcer risk assessment tool and associated documentation for use in our community areas and in 2018 this was extended to our adult inpatient areas. Work on a pressure ulcer risk assessment tool and associated documentation for use in paediatrics continues to progress.

What are the results?

Whilst it is disappointing that there has not been a reduction in the total number of HDFT acquired pressure ulcers in 2018/19, there has been a lot of learning from undertaking the root cause analysis which has informed training needs and strengthened the documentation to support care.

Pressure ulcer data reported through the HDFT incident reporting system

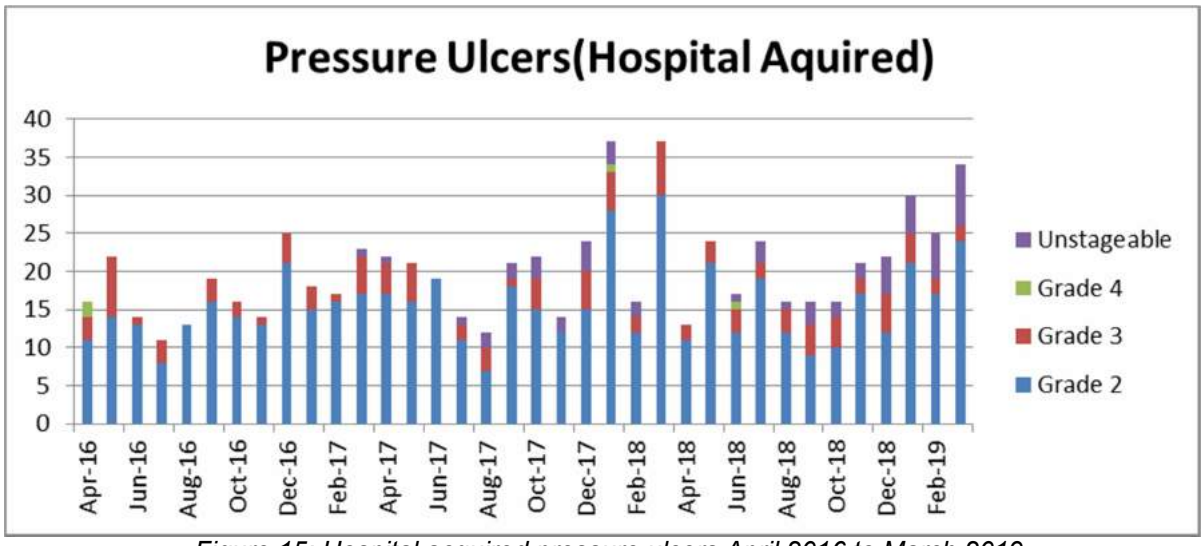


Figure 15: Hospital acquired pressure ulcers April 2016 to March 2019

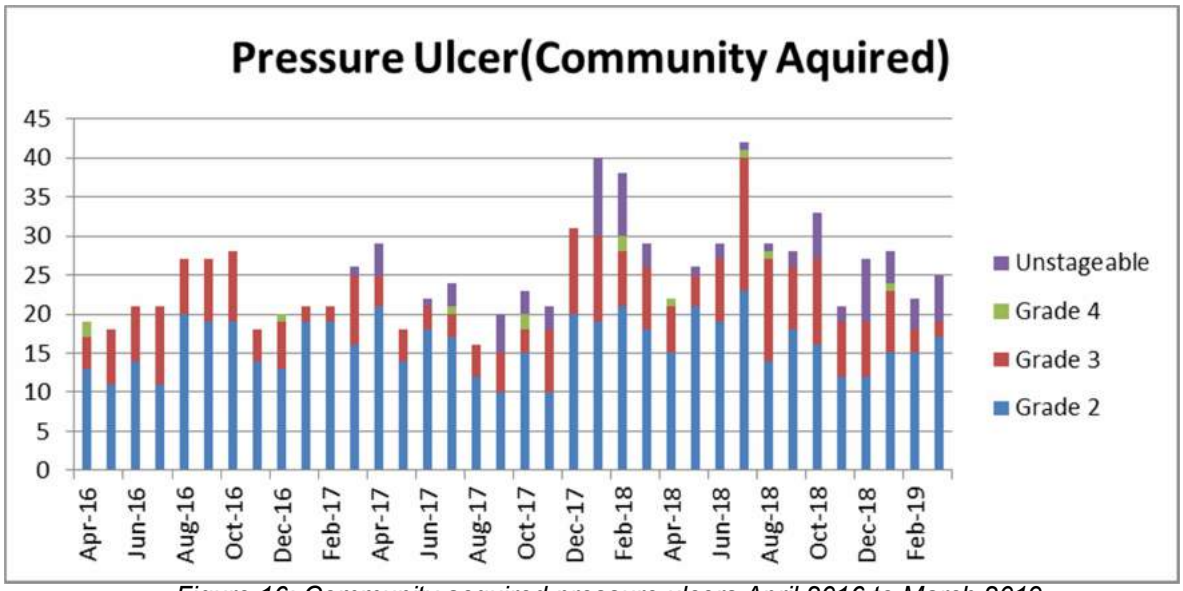


Figure 16: Community acquired pressure ulcers April 2016 to March 2019

Figures 15 and 16 demonstrate the challenges with regards to hospital and community acquired pressure ulcers. We believe that the number of reported pressure ulcers is due, in part, to better and earlier identification and reporting, as a result of continued education around the recognition and categorisation of pressure ulcers.

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.

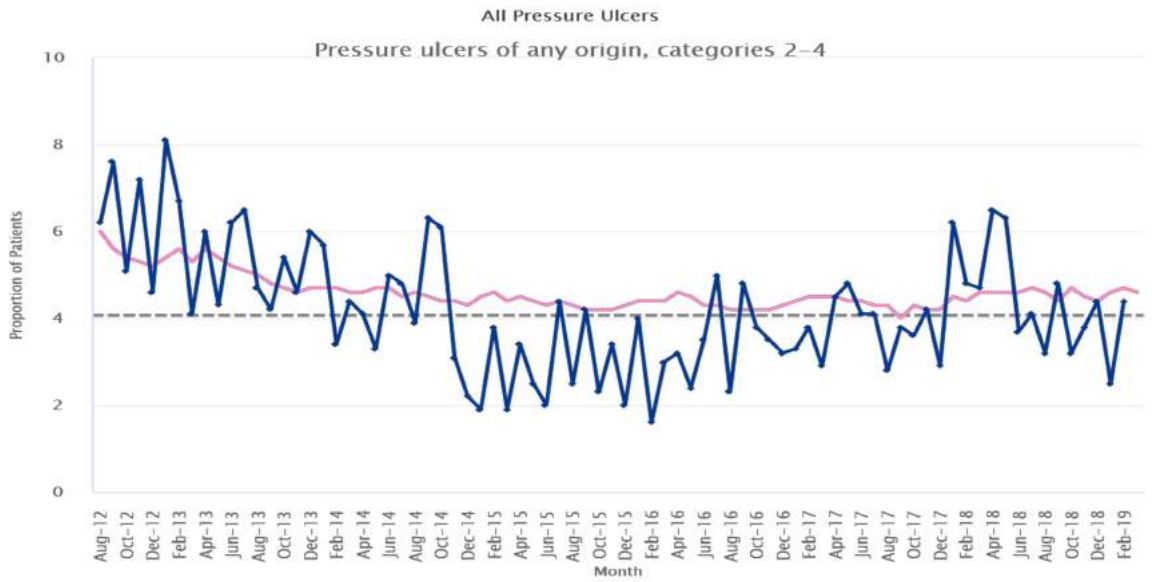


Figure 17: Safety thermometer data for all pressure ulcers for HDFT (August 2012 to February 2019)

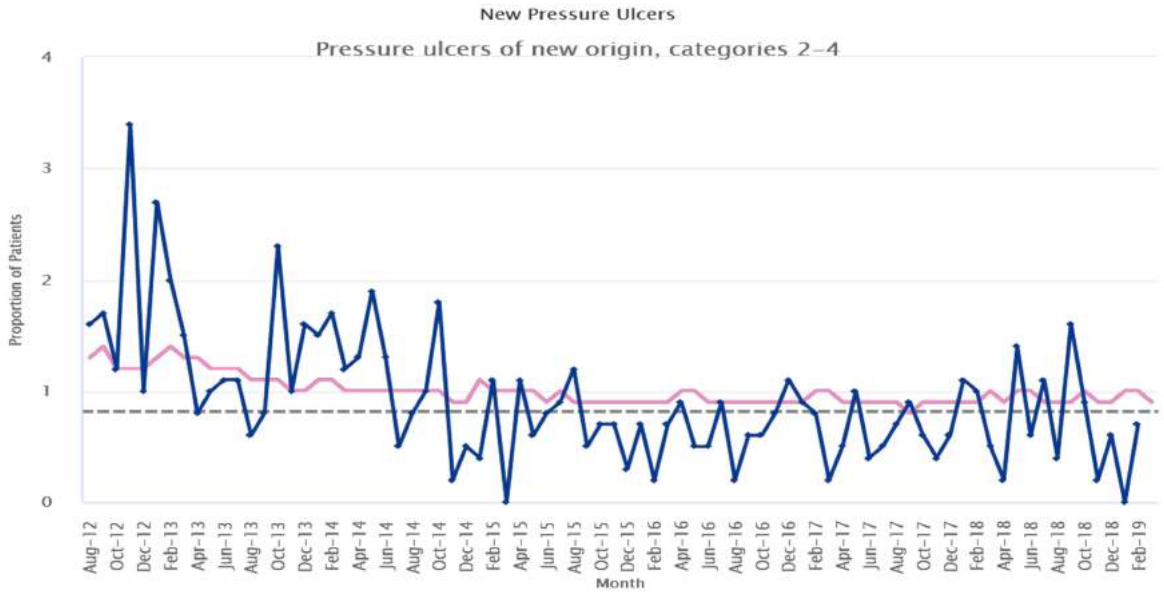


Figure 18: Safety thermometer data for new pressure ulcers for HDFT (August 2012 to February 2019)

The funnel plot in figure 19 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.

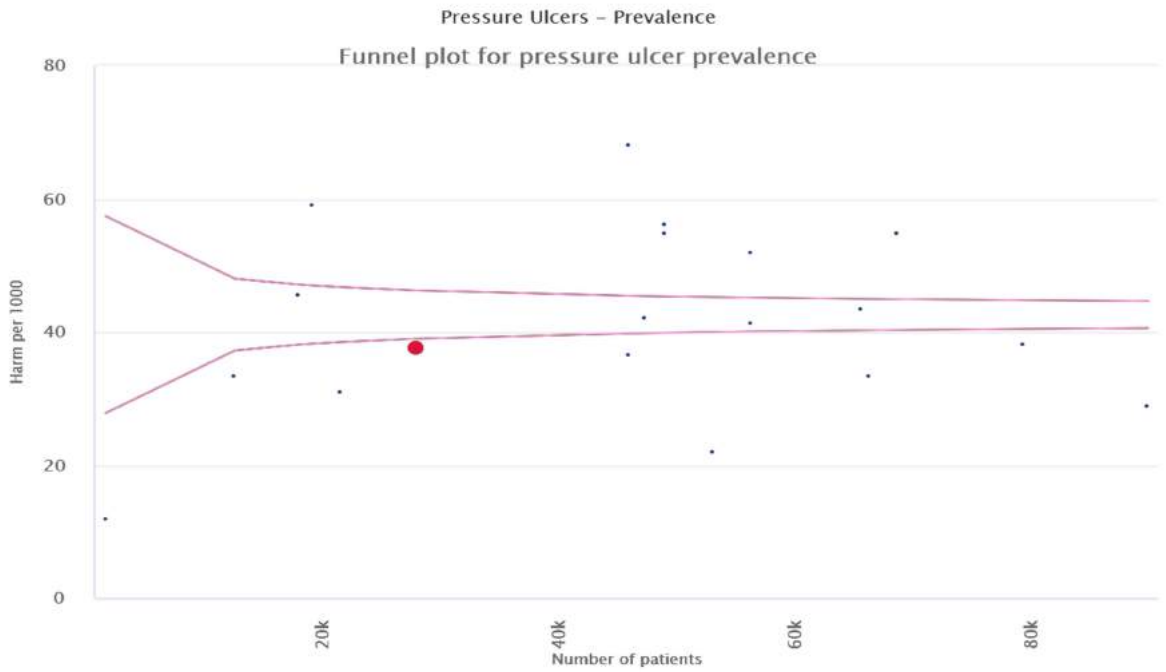


Figure 19: Safety thermometer funnel plot for pressure ulcer prevalence

● represents HDFT
Data source: https://www.safetythermometer.nhs.uk/

Summary

A significant amount of work has been undertaken during 2018/19. The learning through pressure ulcer panels and continued education has been strengthened. New documentation and guidance has been embedded within the community and acute settings. The monthly pressure ulcer group meetings ensure that initiatives and projects are reviewed on a monthly basis and that the high profile of pressure ulcer prevention within the Trust is maintained.

The Trust ambition is to eliminate avoidable pressure ulcer development in people who are receiving HDFT care, and will continue to develop pressure ulcer prevention strategies to support this. Key ambitions for 2019/20 include:

- Embedding the revised pressure ulcer definitions from April 2019;
- Further strengthening training and education with alternate year face-to-face training;
- Continuing to learn from themes highlighted in RCAs, which will be monitored through pressure ulcer panels and guide future initiatives.

3.2. PATIENT EXPERIENCE

1. Learning disabilities

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

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

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

People with a learning disability face many health inequalities, often resulting in worse health than the general population. On average people with a learning disability die 16 years earlier than the general population (Department of Health, 2013). Mencap's Treat Me Well Campaign highlighted the need for learning disability awareness training to all hospital staff.

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. It is now the law for the NHS and adult social care services to comply with Accessible Information Standard.

What were we aiming to achieve?

1. Design and deliver learning disability awareness training to identified staff groups;
2. Ensure that people with learning disabilities' hospital records are flagged to allow the provision of appropriate communication support;
3. Ensure that easy read information is readily available to staff and patients to support communication with those that would benefit from this format;
4. Offer reasonable adjustments to information to all patients flagged as having a learning disability.

What have we done and what are the results?

Learning disabilities training

A bespoke learning disability (LD) awareness e-learning package has been developed and was launched in November 2018. It is now essential training for all staff with patient contact, with a total of 2774 staff identified as requiring this training. By April 2019 2396 (80%) of these have completed the training.

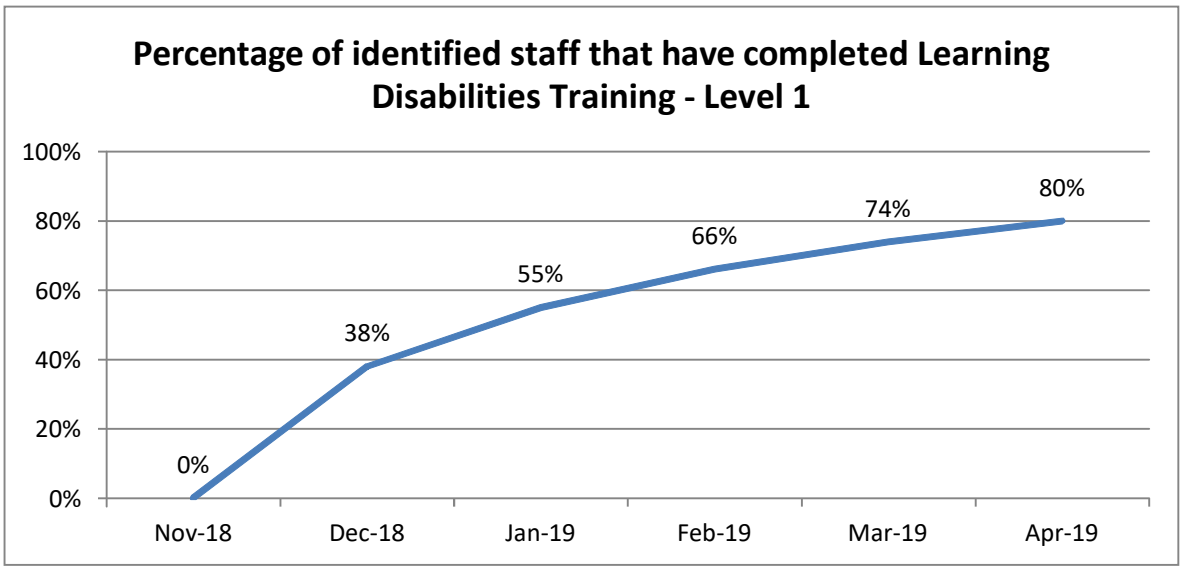


Figure 20: Percentage of staff who have completed LD training level 1 since introduction

A higher level package has been developed as essential training for identified nursing staff and allied health professionals with leadership responsibilities. This was launched in November 2018. A total of 240 staff have been identified as requiring this and would be expected to attend a three hour classroom session once over a three year programme. To date this has been completed by 61 (28%) of those identified.

Flagging hospital records to identify people with learning disabilities

We continue to promote LD flagging both internally and externally to enable the provision of appropriate support. Flagging is prompted on the enhanced admission proforma for patients with learning disabilities. The Community LD Service for children in Harrogate is also raising the awareness of LD flagging with a particular focus on those in transition between children and adult services. Prior to April 2018 there were 412 patient records flagged as having a learning disability and a further 83 LD flags have been added in 2018/19.

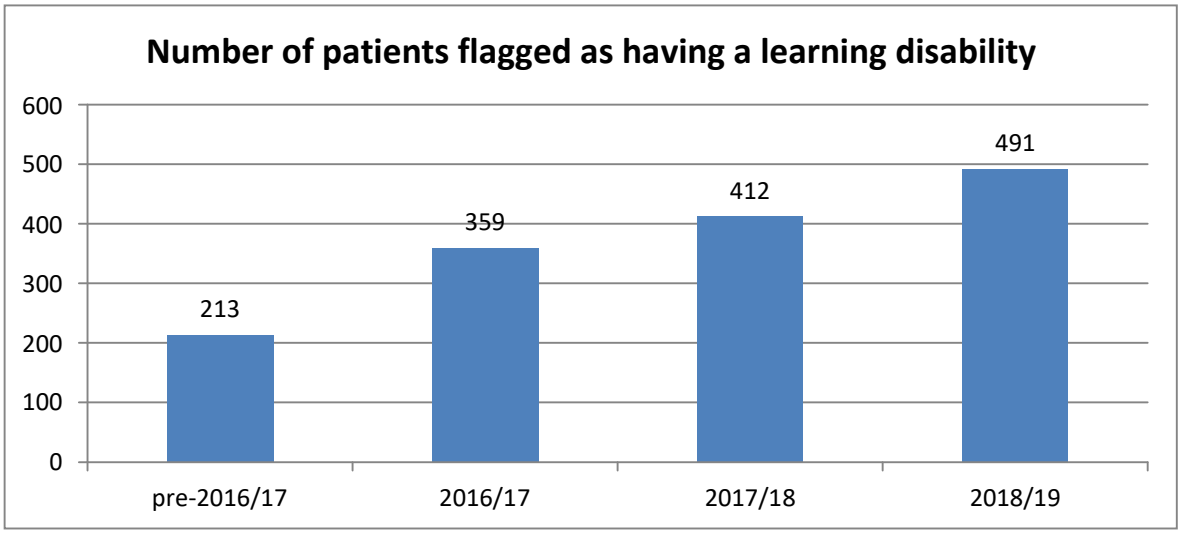


Figure 21: Number of patients flagged as having a learning disability

Provision of Easy Read information

A library of easy read information has been collated and 94 easy read leaflets are available to staff on the Trust intranet.

A link has been published on the Trust website to easyhealth.org; a web-based resource offering the public a range of easy read resources. The LD Liaison Nurse provides bespoke easy read information for individual patients and specialist communication support where required.

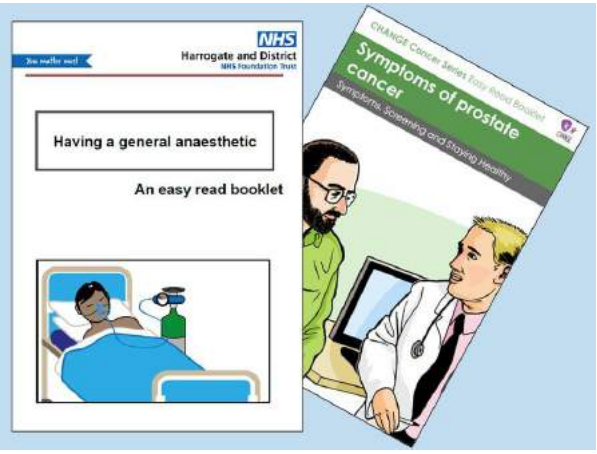


Figure 22: Example of easy read leaflets

Adjustments to written information provision

A total of 465 letters have been sent to patients flagged as having a learning disability, offering reasonable adjustments to written information. Examples including appointment letters in easy read, large print or addressed to an identified representative. There have been 124 responses to date with 68 respondents requesting that a copy of appointment letters be sent to a nominated person and 39 people requesting easy read appointment letters.

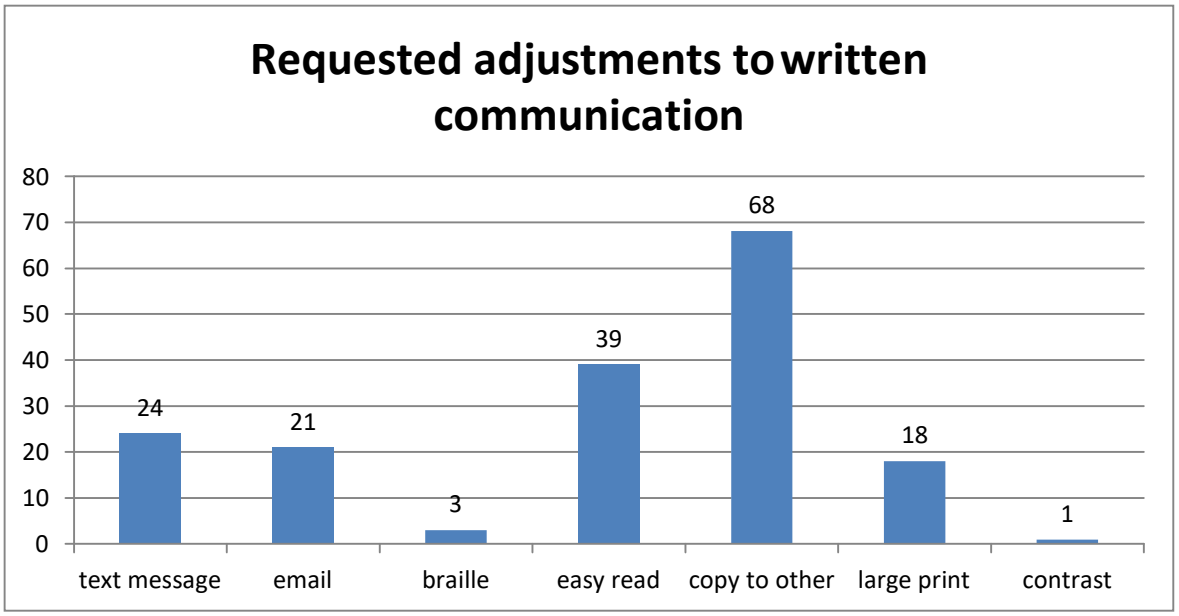


Figure 23: Requested adjustments to written communication

Summary

The Trust has made progress in ensuring that patients with learning disabilities are offered information that is appropriate to their individual needs and preferences and that easy read resources are available to both staff and patients.

The training figures are reassuring and it is expected that all staff will have completed the required learning within the planned three year period. However, the training needs analysis may need to be updated in light of the government's proposed mandatory learning disability training for all health and social care providers. This is currently in the consultation stage and the Trust will be engaging with this consultation.

2. Maternity

During 2018/19, the Maternity Department has continued to work hard in maintaining safe and high quality care to women who choose to have their babies in Harrogate and their families. We have focused on improvement in relation to some specific maternity quality objectives. Some of the work has already been reported in section 2.2 item 5 of this report.

What were we aiming to achieve?

The service aimed to:

- Improve the quality of and compliance with cardiotocography (CTG), continuous fetal monitoring training for both midwifery and medical staff. See section 2.2 item 5;
- Improve smoking cessation rates by improving the smoking cessation service available to women and training for all staff working in the maternity department. See section 2.2 item 5;
- Develop public and patient participation in service development by implementing a Maternity Voices Partnership, in line with the Better Births document and the National Maternity Safety Strategy and Maternity Incentive Scheme for 2018/19;
- Implement the ATAIN (avoiding term admissions to neonatal units) programme to further develop the transitional care model on the postnatal ward to keep babies with their mothers;
- Maintain BFI (Baby Friendly Initiative) accreditation with the gold award, with annual audits and submission of a portfolio in November 2018 and then every three years thereafter;
- Support the Prevention of Cerebral Palsy in Preterm Labour (PReCePT) project to reduce the risk of cerebral palsy by administration of magnesium sulphate in preterm deliveries;
- Implement Advocating for Education and Quality Improvement (AEQUIP), an employer led model to build personal and professional resilience, enhance quality of care for women and their babies, and support preparedness for appraisal and professional revalidation;
- Continue to collect women's experiences of the maternity care they have received and use the results of patient feedback to further improve services.

What have we done and what are the results?

Better Births (NHS England, 2015)

This report sets out what the vision for Better Births means for the planning, design and safe delivery of services; how women, babies and families will be able to get the type of care they want; and how staff will be supported to deliver such care. There are several actions included in the report; personalised care, continuity of care, safer care, better postnatal and perinatal mental health, multi-professional working, working across boundaries and a payment system.

1. Continuity of Carer

The report introduces the Continuity of Carer (CoC) model to ensure safer care based on a relationship of mutual trust and respect in line with the woman's decisions. This includes women knowing the midwives who are providing them with antenatal, intrapartum and postnatal care. Research has shown that this improves outcomes for mothers and babies. A national target has been set for 20% of women to be on a CoC pathway by March 2019. HDFT have introduced team models who are on rostered shifts (days and nights) providing care to women from three GP practices in Harrogate. The team started in mid-January 2019

and initial feedback has been positive for both women and the midwives involved. The national trajectory is to increase to 35% by March 2020 and discussions are taking place locally about how we extend this model.

2. Harrogate Maternity Voices partnership

A Maternity Voices Partnership (MVP) is an NHS working group: a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care. This is a new concept for Harrogate and we established a small group in November 2018. A chairperson was recruited and they have attended a recent regional Maternity Services Forum event. Several meetings have been held and the group is in the process of planning work streams for the rest of this year. The group have completed a user feedback exercise and is in the process of looking at themes and trends.

The group is very much in its infancy but this small group of women are really enthusiastic. We are really pleased to be working collaboratively with local women with the aim of improving maternity services further and we hope that the group will continue to develop.

Avoiding Term Admissions to Neonatal Units

To implement the Avoiding Term Admissions to Neonatal Units (ATAIN) programme, a multi-disciplinary panel reviews all cases of unexpected term admissions to the Special Care Baby Unit (SCBU) to identify themes and trends, and to ensure that an appropriate decision has been made to transfer the baby to SCBU. We are looking at ways to improve the management of jaundice, hypoglycaemia, hypothermia, infection and respiratory disease. The infant feeding coordinator also reviews all readmissions of babies to ensure these are appropriate and themes and trends are identified if applicable.

Unicef Baby Friendly reaccreditation – 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.

The ‘gold’ award was achieved by maternity services in Harrogate in November 2017 and was successfully reaccredited in December 2018. This followed submission of detailed evidence and telephone interviews with the Head of Midwifery, infant feeding lead and Baby Friendly Guardian.

Prevention of Cerebral Palsy in Preterm Labour

The prevention of cerebral palsy in preterm labour (PReCePT) project has been selected by the Health Foundation to be part of an ambitious £3.5 million improvement programme. It has been designed to help reduce cerebral palsy in babies by administering magnesium sulphate to mothers during preterm labour, at a cost of around £1 per individual dose. Preterm birth is the leading cause of brain injury and cerebral palsy, and has a lifelong impact on children and families.

NICE recommends administration of magnesium sulphate in preterm deliveries to substantially reduce the risk of cerebral palsy by 30%, based on evidence in support of its brain protective potential. However, the uptake of magnesium sulphate in the UK remains

relatively low, compared with the leading countries in the developed world. The West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS) has supported the secondment of a midwife to support PreCePT across the LMS for nine months. This midwife has a substantive contract with Harrogate, providing the midwife with an opportunity to work within the WY&H LMS and ensuring compliance and consistency across the LMS.

Advocating for Education and Quality Improvement

The decision was made to remove supervision from statute from March 2017 and the new model, Advocating for Education and Quality Improvement (AEQUIP) was implemented 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.

Within the Maternity Department, there are now three ex-Supervisors of Midwives who have completed the shortened course to become Professional Midwifery Advocates (PMAs) and two midwives who have completed the extended course. The model offers midwives access to a PMA one full day a week for restorative clinical supervision with plans to offer two half days per week to improve accessibility. Once this is fully embedded the PMAs next focus will be to engage with midwives on the quality improvement aspect of the AEQUIP model.

National CQC Maternity Patient Survey 2018

The CQC maternity patient survey is now an annual survey of women's experiences of maternity care. A standard survey methodology is used and reflects the priorities and concerns of women using maternity services. Women were eligible for the survey if they had a live birth during January and February 2018, were aged 16 years or older, gave birth in a hospital, birth centre, maternity unit or at home. Postal questionnaires were sent to women between April and August 2018. The survey questions include the whole pregnancy journey from the first booking appointment, to discharge from the community midwife after delivery, to the health visitor. Women are asked to answer 51 questions about their care, and results are compared with all other trusts in England.

The report received in January 2019 was extremely positive with HDFT being identified as performing 'better than expected' compared to other trusts within the survey. This was because a higher proportion of people responded positively about the care they had received than in most other trusts. In addition, our response rate was 51% in 2018, compared to 49% in 2017 (average response rate 36%).

HDFT results were not worse than most trusts for any questions. Results were about the same as other trusts for 43 questions, and better than most trusts for the following questions:

Labour and birth

- C1. At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?
- C16. If you needed attention during labour and birth, were you able to get a member of staff to help you within a reasonable time?
- C19. Thinking about your care during labour and birth, were you treated with respect and dignity?

Care in hospital

- D5. If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you within a reasonable time?

- D6. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?

Feeding your baby

- E4. Did you feel that midwives and other health professional gave you active support and encouragement about feeding your baby?

Care at home after the birth

- F2. When you were at home after the birth of your baby, did you have the telephone number for a midwife or midwifery team that you could contact?
- F21. Did a midwife tell you that you would need to arrange a postnatal check-up of your own health with your own GP (6-8 weeks after birth)?

When the results were compared with last year's survey, there was no statistically significant difference between last year's and this year's results for 47 questions. Due to amendments to the questionnaire between the 2017 and 2018 surveys, two questions are not historically comparable, but the Trust's results were significantly higher this year for two questions:

- B12. During your antenatal check-ups, did a midwife ask you how you were feeling emotionally?
- D9. Thinking about your stay in hospital, how clean was the hospital room or ward you were in?

The survey was extremely positive. The Maternity Department is in the process of looking at any areas that we feel could be improved but these will be a very small number.

Friends and Family Test

The Friends and Family Test (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.

The response rate and scores are monitored closely by senior midwifery managers to identify any themes and trends and any opportunities for improvement; the feedback is predominantly very positive but positive and negative comments are shared with staff. Current response rates are between 28% and 41% and as an overall percentage have remained fairly static since the introduction of the combined form in 2017. These are some examples of comments that we have used to improve the service:

You said	We did ....
Better continuity of care. I only saw my named midwife a couple of times and for the last 3 appointments saw 3 different midwives.	We launched our first 'Continuity of Carer team' in January 2019. So far 20% of our women are on this pathway of care with a plan to increase this to 35% by March 2020.
Better access to information	All patient leaflets are now on our webpage and families are given information on how to access these pages.
Baby checks delayed due to lack of paediatric doctors	We currently have two more midwives on the New-born and Infant Physical Examination (NIPE) course. This will increase NIPE trained midwives to 10 and a further two nurses on SCBU are to start the training in September.
Chairs in antenatal clinic uncomfortable	All chairs in antenatal clinic were changed last year with positive feedback from users.

Table 31: Maternity FFT "You said, we did"

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 2018/19. The quality objectives we have set for 2019/20 are to:

- Develop the continuity of carer model further and extend the model across maternity services to achieve the 35% trajectory set by the national team by March 2020;
- Prioritise recommendations from Saving Babies Lives Care Bundle version 2 at local level;
- Work towards achieving full compliance with all ten safety actions within the NHS Resolution Maternity Incentive Scheme – year 2 by the summer of 2019;
- Fully implement the PMAs model with plans to send another midwife on training in autumn 2019;
- Continue to support the work of the WY&H Local Maternity System.

3. Cancer Care

Cancer services offered by HDFT aim to put the patient at the centre of everything we do. Our aim is to offer treatment and support which is personalised to the individual from diagnosis and throughout their pathway. Care is planned in a way which addresses the unique concerns of each patient and their family.

Managing the consequences of a cancer diagnosis and the treatment is central to enhancing the lives of patients who are living with and beyond cancer and we are mindful of this from diagnosis onwards.

Earlier diagnosis of cancer improves patients' outcomes and so raising awareness of worrying symptoms and ensuring efficiently run, timely diagnostic pathways will help achieve this goal and enhance the patient experience.

Figure 24: Sir Robert Ogden Macmillan Cancer Centre

What were we aiming to achieve?

The main aims and achievement during 2018/19 have been to build on and sustain the services we already offer and at the same time planning to develop new services to ensure patient safety and improve patient experience. These include:

- Continue to achieve the 31 and 62 day cancer targets on a quarterly basis. To support this development of timed urgent cancer pathways in collaboration with the multi-disciplinary teams has been a priority;
- Ensure further implementation of the Recovery Package;
- Increase the workforce in clinical nurse specialist cancer teams to ensure patients receive timely support which we know improves the patient experience;
- Increase the workforce in support services to address the individual concerns of patients with a cancer diagnosis;
- Develop and expand cancer information services across the organisation to ensure all patients with cancer have access;
- Increase patient access to health and wellbeing sessions;
- Development of a vague symptoms pathway to provide appropriate and easier access to investigations for patients with serious but not specific symptoms;
- Develop a business case to provide a seven day acute oncology nursing service to ensure more timely assessment and treatment of patients with complications from their treatment.

What have we done?

Achieving cancer targets

Achieving the 31 and 62 day cancer targets has been something Harrogate has been proud of however this has become more challenging with each year with a significant rise in urgent cancer referrals. The data below demonstrates that HDFT continue to meet the national target of treating 85% of urgent cancer referrals. The development of timed pathways aims to shorten the length of time taken to diagnose patients and we hope to see the impact of this work over the coming years. Working with other organisations within the West Yorkshire and Harrogate Cancer Alliance has been crucial to ensure that the majority of patients are seen and treated within the acceptable time frame.

Type	Target	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4	2018/19
14 Day Breast Symptomatic	**93%**	87.37%	89.40%	98.21%	88.67%	**91.28%**
14 Day Suspected Cancer	**93%**	96.13%	98.05%	98.55%	97.16%	**97.47%**
31 Days First Treatment	**96%**	99.20%	99.64%	99.65%	98.62%	**99.28%**
31 Days Subsequent - Anti-Cancer Drugs	**98%**	100.00%	99.04%	100.00%	100.00%	**99.77%**
31 Days Subsequent - Surgery	**94%**	100.00%	100.00%	97.92%	100.00%	**99.49%**
62 Days	**85%**	87.27%	85.42%	85.12%	86.40%	**86.01%**
62 Days Consultant Upgrades	**85%**	100.00%	100.00%	100.00%	85.71%	**95.45%**
62 Days Screening	**90%**	94.74%	83.33%	88.89%	76.00%	**83.33%**

Table 32: Cancer performance targets 2018/19

Implementation of the Recovery Package

Implementation of the Recovery Package by 2020 is part of the national cancer agenda and HDFT continues to offer patients most of the key elements which include:

- A holistic needs assessment to identify the concerns most important to the individual and their family. This forms the basis of a care plan for each patient;
- An end of treatment summary ensures the patient has written information about the treatment they have received and what the treatment aimed to achieve. It also provides information about lasting consequences of treatment and symptoms which

may indicate recurrent disease and how to re access the system. This ensures patients are better informed;

- Health and wellbeing sessions that focus on the impact of treatment and promotion of a healthier lifestyle. They provide education to promote self-management so that patients can resume control over what is happening with them. The sessions are now offered to all patients who undergo treatment for breast, gynecological, colorectal, prostate and lung cancer and are evaluated as extremely valuable;
- Cancer care reviews that are offered in the primary care setting and check on a patients progress adjusting back to life living with or beyond cancer.

The data collected for the West Yorkshire and Harrogate Cancer Alliance demonstrates a significant upward trend of numbers of patients receiving each of the components of the Recovery Package. These components ensure that the psychological, spiritual, emotional and financial needs of the patients are addressed and not just their physical needs.

Increase in Workforce

We have successfully recruited a new clinical nurse specialist for patients with skin cancer who can provide the necessary advice, information and support that is expected by patients and their families. Further recruitment to the Cancer Clinical Psychology team means more patients can have timely access to psychological support. A new dietician for cancer services offers more equitable nutritional support and advice to patients throughout their pathway to promote wellbeing.

Information Services

The aim is to provide the highest quality of support and information services in-line with the National Cancer Survivorship Initiative (NCSI) and to maximise wellbeing across all stages of the patient pathway for patients and carers (DoH et al 2013). The Macmillan Patient Information and Health and Wellbeing Service is provided within a non-clinical, calm and relaxed environment within the Sir Robert Ogden Macmillan Centre (SROMC). The National Cancer Patient Experience Survey (NCPES) will also be used to review and inform service delivery.

The Macmillan leaflets and booklets ordered through the information service increased by 14% in 2018 to 2963. This demonstrates that the service is continuing to increase its engagement and that awareness of information services is growing.

The Macmillan Welfare and Benefits Service

The Macmillan Welfare and Benefit Adviser continues to operate a high quality, flexible, responsive and easily accessible service. The post holder 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 in spite of capacity demands continuing to increase again during 2018. The service has seen increases in both the number of referrals and benefits income and is at saturation level by way of capacity. One new reason for this has been the impact of Universal Credit.

Service activity	Activity in 2015	Activity in 2016	Activity in 2017	Activity in 2018	% Activity increase since 2015
Numbers of New Referrals	404	415	468	484	17
Total claimed in Annualised Benefits	£1,517,588.00	£1,404,215.00	£1,776,543.00	£1,869,958.90	19
Total in backdated benefit arrears claimed	£67,024.00	£214,319.00	£206,608.00	£204,014.00	79
Total of Macmillan Grants Claimed	£13,400.00	£16,630.00	£19,525.00	£24,876.00	54
Other Charitable Grants	£3,336.00	£4,250.00	£6500.00	£12,280.00	73

Table 33: Macmillan Welfare and Benefits Service Activity

Complementary Therapy Service

The Complementary Therapy Service continues to offer patients support alongside their medical treatment. These therapies help patients with symptoms of the cancer and the treatment. The therapies offered include acupuncture, reiki, hypnotherapy, massage and reflexology among others. The service has expanded to opening up an NHS Natural Health School which is the first in the country. It is proving very successful and aims to train many therapists to offer complementary therapies to patients with a cancer diagnosis.

Art Therapy

The service is provided fortnightly by a qualified volunteer art therapist 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 through the Clinical Psychology Service. 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 to 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.

Citizen Advice Bureau

The SROMC developed a new partnership with Citizens Advice Bureau (CAB) at the end of 2017 to pilot a satellite venue in the SROMC twice a month. The service offered help with:

- Money and credit problems;
- Employment;
- Consumer rights;
- Housing;
- Neighbourhood disputes;
- Education and healthcare;
- Immigration and residency rights;
- Human rights;
- Family and personal issues.

The service received very few referrals and evaluation of the pilot after six and nine months it was decided to cancel any further clinics at the SROMC. Instead a referral process allowing appointments to be directly booked at the CAB by the Macmillan Welfare and Benefits Advisor was implemented. Where this has been required it appears to have worked well.

SROMC Volunteers

15 volunteers supported the services provided within the SROMC during 2018. These roles have included:

- Serving lunches and beverages to patients attending for cancer treatments;
- Administrative support to the Clinical Nurse Specialist, and Macmillan Cancer Information Support, and Welfare and Benefits Services;
- Patient information support;
- Meeting and greeting patients;
- Gardening;
- Beauty therapy;
- Spa therapies;
- 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 2018 cannot be underestimated. New roles with specific skill sets which would be beneficial to extend cancer information services across the organisation are being explored for 2019.

Serious but Non-specific Symptoms Pathway

This forms part of the work around earlier diagnosis of people with cancer. We know that a number of people will present to their GP a number of times before being diagnosed with a cancer. Often their symptoms are non-specific and do not fit with the red flag symptoms. Working in collaboration with the West Yorkshire and Harrogate Cancer Alliance we have developed a pilot project for patients with concerning but non-specific symptoms to be referred in urgently to the hospital for further investigations. It is expected that the majority of patients will not have cancer but the minority of patients who have, we hope to diagnose earlier thereby giving them a better chance of a good outcome from treatment. We will gather data over the coming year on this project and evaluate our findings.

Seven Day Nurse Led Acute Oncology Service

A business case was compiled to develop a seven-day nurse led acute oncology service in line with the Quality Surveillance Measures. This was agreed by the Trust's Operational Delivery Group and we have begun the process of recruitment by advertising for a senior clinical nurse specialist to support the acute oncology and cancer of unknown primaries service. Further recruitment will follow in a phased approach. This will ensure that in 2021 all patients admitted with an acute oncological condition will be assessed by a member of the acute oncology nursing team seven days a week. This ensures safer more coordinated care with better communication which reduces patient anxiety and improves patient experience.

Health and Exercise Programme

In collaboration with Yorkshire Cancer Research we have developed and will deliver and evaluate an exercise and health referral service for all patients in the Harrogate area who are diagnosed with cancer. We understand the health benefits of exercise and activities so this two year project will offer patients and their families the opportunity to take part in activities that will not only help them physically but hopefully psychologically and socially. It is hoped that it will give the community the opportunity to understand the benefits of a healthier lifestyle.

Summary

Listening to what the local community wants their cancer services to look like along with national guidance is what we base our aims on. We have achieved much over the last year in spite of the challenges faced by the NHS. We always aim to keep patients safe and offer the best experience we can, keeping in mind the Trust values of respect, responsibility and passion. We continue to build on our previous years' achievements but look forward to developing our new objectives. The main areas of focus this year will be:

- Developing the role of the volunteer in cancer services to address some of the findings in the National Cancer Patient Experience Survey;
- Progress the earlier diagnosis project by further engaging with clinical teams to embed the timed cancer pathways; implementing the non-specific symptoms pathway project and evaluate; and further stratify traditional medical follow up for patients following treatment based on risk of recurrence;
- Start the exercise and health referral service and monitor its impact over the next two years;
- Train and develop the new staff within the acute oncology service in preparation for the seven day service next year;
- Continue the plans for the one stop breast investigation unit.

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:

- Advanced, progressive, incurable conditions;
- General frailty and co-existing conditions that mean they are expected to die within 12 months;
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition;
- Life-threatening acute conditions caused by sudden catastrophic events.

The aim is to improve patient and family experience at the end of life across Harrogate and Rural District (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, community care team, care home staff, consultants, hospital ward teams. Specialist palliative care in HaRD is delivered by the HDFT 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 2018/19 have been about building on the foundations for improving patient and family experience at the end of life and ensuring collection of robust data to provide the evidence of improvements. We have aimed to:

- Ensure the PCT take on the lead for EoL care within HDFT;
- Continue to enhance the support and care for patients in the last days of life in both hospital and community;
- Agree the implementation of an essential skills training package for care in last weeks and days of life;
- Submit a business case for seven day 9am to 5pm face-to-face specialist palliative care service and recruit to posts to enable us to implement a seven day service across the organisation;
- Promote open discussion and advance care planning across services by actively engaging in the annual Dying Matters Week and delivering a new patient and carer education programme entitled 'Thinking Ahead';
- Continue to work in partnership within a multi-agency working group to review fast track discharges for rapid discharge from hospital in the last days of life, and care in the last weeks of life in the community, to ensure the preferred place of death is achieved and a high quality patient and carer experience;
- Embed the Electronic Palliative Care Co-ordination System (EPaCCS) 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;

- Obtain regular robust feedback through a variety of means about patient, relative and carer experience before and after death in all settings (hospital, home, care home, hospice);
- Participate in the National Audit for Care at End of Life.

What have we done?

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. Alongside direct patient assessment, the team has focused on regular attendance at key clinical MDTs on wards, GP palliative care meetings, linking with community care teams and care homes. This proactively guides and supports professionals on the care of patients who may be approaching end of life. The Lead Nurse for End of Life Care role has been transferred into the structure of the palliative care team to ensure a better strategic and implementation overview locally, regionally and nationally.

Figure 25: HDFT Palliative Care Team: bottom from left: Kelly Barnes, Charlotte Rock, Clare Hudson, Mel Scott. Top from left: Sarah Davie, Carol Shulver, Emma Harvey, Tracey Goldsbrough, Dr Kath Lambert, Dr Viv Barros D'Sa

Enhance the support and care for patients in the last days of life

a) Hospital Setting

The team, in partnership with nursing and medical staff, has continued to embed the 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. The HDFT Care of the Dying Adult and Bereavement Policy has been rewritten during this year. Some of the practical initiatives that were implemented in 2017/18 continue to grow and 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);
- Purchase of two further reclining bed / chairs for carers staying overnight with dying patients, giving a total of eight chairs now, including one for Trinity Ward at Ripon Hospital;
- End of life volunteers available in hospital to support families and patients in their last days and hours on Tuesdays. Wednesdays and Thursdays. 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.

There has been investment in improving facilities to ensure quiet spaces for patients and families in key priority areas:

- Mason's Suite, Byland Ward. Following a generous donation of £25,000 from the Masonic Province of Yorkshire, West Riding, and £5,000 from the Friends of Harrogate Hospital and Community Charity, a side room on Byland Ward, one of our elderly care wards, has been created to improve the patient experience for patients, including those in last days of life or with dementia and learning disabilities. It includes reminiscence features and mood lighting and provides a comforting non-clinical environment to patients;
- Granby Ward have used donated funds to create a space for patients or relatives to have sensitive discussions.

Figure 26: Representatives from the Masonic Province of Yorkshire, West Riding, joined Chief Executive, Dr Ros Tolcher, and Matron, Tammy Gotts, for the Mason Suite's official opening

All of the initiatives have been well received by patients, families and ward staff.

b) Community Setting

We have set up a multi-professional working group to review current processes following expected death in community following several incidents and complaints around communication, verification of expected death and support to families. Our priority is to provide high quality support and guidance after death. The group is gathering information and will report back to the Trust in the next six months with key recommendations.

Policies and guidance for patient and/or carer administration of subcutaneous medication in adult palliative care have been developed elsewhere within the United Kingdom. Studies have shown that with appropriate education and support, carers can confidently administer

subcutaneous medication to relieve breakthrough symptoms, document appropriately, provide the right medication for the particular symptom, and monitor effectiveness. In a recent survey by Dying Matters, six out of ten people said that they would feel comfortable giving a pain relief injection to someone who was dying and wanted to stay at home. Carers have a significant role in symptom management and commonly administer or assist with the administration of oral medication. In palliative care there are occasions when it may be helpful to train a patient or carer to give other subcutaneous medication. We have worked jointly with Leeds colleagues to develop a locality-wide policy for both areas which has been approved and implemented across the community setting. Evaluation will be ongoing.

Developing staff in all settings in care of patients and families at the end of life

The PCT continue to deliver a wide range of bespoke education and training to new doctors, new registered nurses, pharmacists and healthcare support workers, Yorkshire Ambulance Service staff and take student placements within the palliative care team. Whilst not essential skills training yet, we have established regular quarterly education sessions for nurses around care in the last days of life which have been well attended and evaluated by hospital nurses, care home staff and community nursing. We are working in partnership with Saint Michael's Hospice to continue to provide these sessions on an ongoing basis.

A palliative care lead for each ward and community setting has been identified with the aim of sharing good practice, championing end of life care within their setting and linking with specialist services. A regular newsletter is being produced to share practice and knowledge around end of life care.

Access to seven day 9am - 5pm face-to-face Palliative Care Team assessment

A business case was successfully agreed in the Trust with initial funding for three years from Macmillan Cancer Support to increase the specialist nursing staff within the PCT in order to expand the service and enable delivery of a seven day 9am – 5pm face-to-face specialist palliative care assessment. This would be provided as a normal weekday service and an urgent service at the weekend only. Workforce recruitment has been challenging to the additional posts. Discussions are ongoing to enable successful long term recruitment and implementation of the seven day service.

Talking about end of life care and promoting advance care planning

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.

There are many potential benefits to early introduction to palliative care and advance care planning in a patient's treatment. It can improve quality of life and mood, reduce the use of aggressive treatment at the end of life, support delivery of preferences including place of death, improve pain control, reduce emergency hospital admissions and even extend life expectancy. The HDFT 'Thinking Ahead' programme was designed for patients with a palliative cancer diagnosis and their carers to begin to consider advance care planning and choices for end of life care in a group environment, supported by health care professionals.

In 2018 four programmes were delivered by a range of professionals, with the content spread over three sessions. The positive feedback has given us encouragement to continue. Some have reported initial anxiety about attending and uncertainty about what to expect. With this in mind some patients and carers agreed to be produce a video that can be shown to other patients and carers: Harrogate Thinking Ahead Video

For 2019 and with ongoing increasing demand we are increasing the number of programmes to seven over the course of this year. Other areas across the West Yorkshire and Harrogate Health and Care Partnership are also considering implementing a similar education programme following the success of Harrogate.

Multi-agency working group to enable rapid discharge from hospital in last days of life and improve care in the last weeks of life in community setting

Key health and social care professionals from the hospital, hospice, commissioners, 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;
- Reduced unnecessary bed days and admissions to hospital.

Following on from significant progress in 2017/18, the HaRD Clinical Commissioning Group with HDFT are now planning the implementation of 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 to evaluate the changes once implemented.

Implementing an Electronic Palliative Care Co-ordination System (EPaCCS)

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 and support to embed this process has continued over the year. 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/

Changes at the GP Out of Hours (OOH) service in 2018 to allow access to the Summary Care Record in Adastra, the IT system used by the service, ensures there is the potential for viewing the information recorded in EPaCCS. Work is ongoing to raise awareness in primary care to record consent to share information for this purpose. Regionally work is progressing towards more widespread sharing of EPaCCS, particularly with NHS 111 and the Yorkshire Ambulance Service.

Measuring quality and using data

We are committed to obtaining and using robust feedback to support ongoing improvements in end of life care, learning from what we didn't do well and guiding education and training priorities across the Trust.

This year, we have worked in partnership with the Registrar for Births, Deaths and Marriages to expand the hospital bereavement survey across the whole locality, to include feedback in all settings (hospital, home, care home, hospice). The Bereaved Carers survey is given to the person registering any expected death to gather information from the bereaved family on their experience of care in the two days before death, and after death. A six monthly report is produced summarising the key themes.

Figure 27: Comments from Bereaved Carers Survey

We continue to produce quarterly summary reports of all EoL complaints, concerns, incidents and compliments from across the organisation.

The National Audit of Care at the End of Life (NACEL) took place in 2018 and HDFT participated in this. The national audit was commissioned in October 2017 by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh government. Delivery of this audit is managed by the NHS Benchmarking Network. The overarching aim of the audit is to improve the quality of care of people at the end of life in acute, mental health and community hospitals. The audit monitors progress against the five Priorities for Care set out in 'One Chance to Get it Right' and 'NICE Quality Standard 31' which addresses last days of life care. The audit comprises of an organisational level audit, case note reviews and a quality survey. More information can be found at: https://www.nhsbenchmarking.nhs.uk/nacel. The individual Trust report was received in February 2019 and this is currently being interpreted. National recommendations will be released later this year. The second round of the audit is taking place in 2019.

We are working with HDFT Information Services and HaRD CCG to develop regular data reporting to better understand and measure key metrics around end of life care across the organisation. These include total numbers of deaths by ward and setting, admissions in the last 90 days of life, place of death and length of stay for patients in last 90 days of life.

Summary

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. Key areas to focus on over the next year are to:

- Continue to refurbish quiet rooms identified for the use of patients and families at the end of life, where possible;
- Share key guidance and resources to support care in the last days and hours of life for patients in care homes. Develop electronic systems and guidance within SystmOne electronic patient record to support the delivery of high quality care in last days and hours of life in home settings;
- Implement recommendations from the improvement work around immediate care in community after an expected death;
- Work with North Yorkshire County Council to deliver coordinated approach to Dying Matters week;
- Continue to develop and deliver the Thinking Ahead programme and explore options for implementation in other palliative disease groups;

- Include education and essential skills training for key staff as agreed in the strategy;
- Deliver training and education to a range of healthcare professionals around care for patients at the end of life;
- Recruit staff and establish the new seven day 9am - 5pm face-to-face assessment by the PCT;
- Continue the work on implementation of service redesign improvements to enable rapid discharge from hospital in last days of life, and improve care in the last weeks of life in community setting;
- Participate in the second round National Audit of Care at the End of Life (2019);
- Continue to work with HDFT Information Services to improve data analysis and reporting to demonstrate effectiveness of the service;
- Identify opportunities to expand the EoL volunteer service within the Trust.

2. Improving the Management of Parkinson's Disease

Results from the recently published UK Parkinson's Audit demonstrated that there are many areas where HDFT is delivering excellent care to our patients with Parkinson's disease, including:

- We have a Parkinson's disease specialist nurse and regular MDT meetings;
- Evidence of medicines reconciliation in 100% of cases audited;
- A standardised assessment tool is available to assess cognitive functioning.

Furthermore, the patient reported experience measure (PREM) results showed that patients were generally positive about the care received:

- 98% of our patients believe we treat them as individuals and respect their unique concerns;
- 92% of patients state that the service is improving or was already good to begin with;
- 85% of our patients feel they are listened to;
- 85% reported that they usually received their medication on time when admitted to the hospital in the last 12 months;
- 74% ranked the quality of Parkinson's Disease Service in general between good and excellent;
- Of those that needed occupational therapy or physiotherapy input, "accessibility" of these services was higher than the national average.

The results, alongside those of local audits and surveys, have also helped us build a better picture of aspects for improvement.

Figure 28: Patient feedback about the Parkinson's Disease Service

Areas of focus for the coming year include:

- Improving the documentation regarding side effects of Parkinson's disease medications;
- Undertaking activities of daily living assessments and screening for non-motor symptoms for all patients with Parkinson's disease;
- Ensuring we signpost patients to other agencies and resources;
- Telling patients with Parkinson's disease to inform the Driver and Vehicle Licensing Agency (DVLA) of their diagnosis, and discussing any driving issues they may face;
- Supporting patients to self-medicate where appropriate;
- Continuing to focus on advanced care planning with relevant patients.

Parkinson's "Medication on Time" Project

The team have also recently embarked on a quality improvement project to improve the timeliness of medication administration including learning from other Trusts who have implemented similar projects. The actions we are trying to implement are:

- Improving staff education and understanding regarding the time-critical element of Parkinson's medications;
- Ensuring patients are supported where appropriate to self-medicate when admitted as an inpatient;
- Annual assessments of daily living by the Parkinson's disease nurse during outpatient clinics. This will help ensure discussions occur regarding driving and informing the DVLA about the Parkinson's disease diagnosis, autonomic symptoms and any side effects of medications.

3. Nutrition

The Trust is committed to providing high quality nutritional care and optimum 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 2018/19 the Nutrition Group aimed to consolidate the work from previous years and continue to work towards the aims outlined in the HDFT Food and Drink Strategy (2017-2021):

1. To meet the nutrition and hydration needs of patients;
2. Healthier eating for the whole hospital community, including staff and visitors;
3. Sustainable procurement of food and catering services.

It was also a requirement for all NHS trusts to be compliant with the International Dysphagia Diet Standardisation Initiative (IDDSI) by 31st March 2019.

What have we done?

We have a Trust-wide nutrition audit plan, co-ordinated by Clinical Effectiveness and Dietetics, so that we have oversight of all nutrition audits and can ensure that specific issues are identified and actions implemented. This year, an audit into protected mealtimes led to a campaign as part of Nutrition and Hydration Week to raise awareness and to establish how we can make this initiative more effective. This will form part of our project work for 2019/20.

Nutrition related incidents and complaints are co-ordinated and a report brought to the Nutrition Group so that we can identify any themes. We have identified several issues around the management of patients with gastrostomy tubes and we have already begun to develop pathways to improve this.

We implemented the IDDSI guidance for thickened fluids in September 2018 and modified texture diets in March 2019. All dietary patient information, menus, referral forms and discharge letters have been changed to reflect the new descriptors. The modified texture menus were completely changed, as a result of patient feedback, to provide a weekly cycle that reflects the choices on the main hospital menu.

We have continued to maintain our compliance with previous Commissioning for Quality and Innovation (CQUIN) targets ensuring that healthier alternatives are available in all retail outlets on the Harrogate District Hospital site.

Summary

Throughout the last year we have continued to build on the initiatives highlighted by the Food and Drink Strategy. Our audit work has shown us where we can make improvements and move forward with improvements in quality. We will continue to work on these in 2019/20, specifically establishing more bespoke, ward based protocols for protected mealtimes and reviewing the impact of the new IDDSI recommendations and meal provision. We will also look to ensure a robust pathway is developed for the management of patients with gastrostomy tubes on admission to acute care and establish a community nutrition support pathway.

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 2018/19.

Indicator	Minimum performance standard	Q1	Q2	Q3	Q4	2018/19
RTT incomplete pathways	92%	90.8%	90.9%	90.4%	88.5%	90.2%
A&E 4-hour standard	95%	94.99%	94.72%	93.86%	94.47%	94.51%
Cancer - 62 days	85%	87.3%	85.4%	85.1%	86.4%	86.0%
Diagnostic waits	99%	98.4%	99.0%	99.5%	99.8%	99.2%

Table 34: April 2018 – March 2019

Key performance to note:

- The Trust achieved two of the national standards included in the Operational Performance Metrics section of NHS Improvement's Single Oversight Framework for the full year 2018/19;
- In addition, the cancer 62 day waiting times standard was 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 five out of twelve months throughout the year;
- The Trust did not achieve the 18 week standard throughout the year;
- All other cancer waiting time standards were achieved for each quarter overall with the exception of the 14 day standard for breast symptomatic patients where performance was above the 93% standard for Q3 only, and 62 day screening where performance was above the 90% standard for Q1 only;
- There were 13 ambulance handover delays of over 60 minutes reported in 2018/19 (one last year) and 157 handover delays of over 30 minutes (85 last year). Emergency Department attendances were 3.2% higher than for the same period last year;
- Activity levels at the Trust have increased during 2018/19. Elective (waiting list) admissions were 9.5% higher in 2018/19 when compared to 2017/18 and non-elective admissions increased by 1.0%. Outpatient attendances were also higher with a total of 289,809 outpatient attendances in 2018/19 compared to 283,768 in 2017/18;
- The Trust reported 19 cases of hospital acquired *C. Difficile* in 2018/19, compared to seven in 2017/18. Root cause analysis has been completed on 17 cases and indicated that 16 of these were not due to lapses in care, and therefore these would be discounted from the Trust's trajectory for 2018/19. Root cause analysis has not yet been completed for two cases. No cases of hospital acquired MRSA (*methicillin-resistant staphylococcus aureus*) were reported in 2018/19.

4. OTHER QUALITY INFORMATION

HDFT has identified additional elements of service quality to highlight in this Quality Report.

4.1. SUMMARY OF NATIONAL PATIENT SURVEY RESULTS

National Inpatient Survey 2017

The 2017 inpatient survey was published in June 2018. 570 HDFT inpatients discharged in July 2017 participated in the survey which equates to a response rate of 47% (higher than the national response rate of 41%). For each question in the survey, the individual (standardised) responses are converted into scores on a scale from zero to ten. A score of ten represents the best possible response and a score of zero the worst.

Good news!

Overall HDFT was ranked 48th out of the 147 participating trusts with an overall score of 7.9, whilst the best performing Trust had an overall score of 8.7. In relation to other participating trusts, HDFT scored:

- 'About the same' on 59/62 questions;
- 'Better' on 3/62 questions:
  - Was your admission date changed by the hospital?
  - How would you rate the hospital food?
  - Did doctors talk in front of you as if you weren't there?
- 'Worse' on 0/62 questions.

Areas for improvement

Our performance worsened since the 2016 survey on nine questions:

- In your opinion, were there enough nurses on duty to care for you in hospital?
- Did you feel you were involved in decisions about your discharge from hospital?
- After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?
- When you left hospital, did you know what would happen next with your care?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Were you given clear written or printed information about your medicines?
- Did hospital staff take your family or home situation into account when planning your discharge?
- Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?
- Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector).

As well as these questions, we have also identified questions where our score was less than seven as areas for improvement:

- Did you know which nurse was in charge of looking after you? This would have been a different person after each shift change.
- Did a member of staff tell you about any danger signals you should watch for after you went home?
- Did you see or were given any information explaining how to complain to the hospital about the care you received?
- Was your discharge delayed due to wait for medicines/to see doctor/for ambulance?

The National Inpatient Survey 2018 results are expected to be published in June 2019.

National Cancer Survey 2017

The National Cancer Patient Experience Survey 2017 (published September 2018) is the seventh annual iteration of this survey of adults with cancer who were treated as an inpatient or day case between April and June. Questions follow the patient journey from their initial GP referral through to diagnostics, treatment and discharge.

276 completed questionnaires were taken into account. Asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave HDFT an average rating of 9. We also consistently scored above the national average on individual questions.

Key findings as part of the survey include:

- 86% 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 dignity and respect while they were in hospital;
- 97% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital.

These results alongside those from previous surveys show that year on year, Harrogate consistently provides excellent to patients receiving treatment for cancer at the Trust.

National Maternity Survey 2018

Results from the National Maternity Survey 2018 were published on the CQC website in January 2019. The CQC identified HDFT as performing ‘better than expected’ compared to other trusts within the survey. This was because a higher proportion of people responded positively about the care they had received than in most other trusts.

In Harrogate, 135 responses were received from women who used the Trust’s maternity services, with a response rate of 51%. The survey asked women about their experiences of care across the pregnancy pathway from antenatal care, labour and birth, through to postnatal care.

HDFT scored ‘better than most trusts’ for eight questions – with new mothers scoring the Trust 10/10 on a question relating to them being able to contact the service once they were home. These better results are:

- At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital? Rated 9.4/10
- If you needed attention during labour and birth, were you able to get a member of staff to help you within a reasonable time? Rated 9.4/10
- Thinking about your care during labour and birth, were you treated with respect and dignity? Rated 9.8/10
- If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you within a reasonable time? Rated 8.4/10
- Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed? Rated 8.6/10
- Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby? Rated 8.5/10
- When you were at home after the birth of your baby, did you have a telephone number for a midwife or midwifery team that you could contact? Rated 10/10
- Did a midwife tell you that you would need to arrange a postnatal check-up of your own health with your GP? (Around six to eight weeks after the birth). Rated 9.8/10

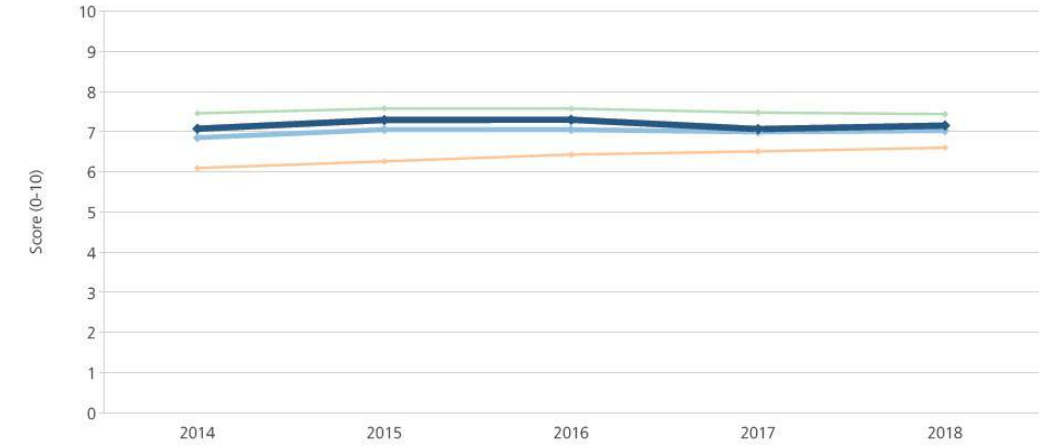
The results also show that in the ‘Labour and birth’ and ‘Care in hospital after the birth’ sections of the survey, the HDFT Maternity Service is performing better when compared with our results from the previous year. The results of the survey show that the hard work and dedication of our maternity staff is recognised by new mums who have used our services and given birth with us.

4.2. NATIONAL STAFF SURVEY AND STAFF FRIENDS AND FAMILY TEST

National Staff Survey 2018

The anonymous national survey was carried out between 8 October and 30 November 2018, with a full census of our staff being offered to participate. In total, 4,056 surveys were distributed to members of HDFT staff and 1,576 were completed, which represents a 39% response rate. The average return rate in the Combined Acute and Community Trusts category was 41%.

Results are presented this year in ten key themes, including a measure of overall staff engagement. The Trust scored above the average for the Combined Acute and Community Trusts benchmarking group in nine out of ten of these themes, and scored the average in the final theme. The figure below shows how the Trust compares with other Combined Acute and Community Trusts on an overall theme of staff engagement, showing the best, worst and average score year on year. Possible scores range from zero to ten, with zero indicating that staff are poorly engaged (with their work, their team and their trust) and ten indicating that staff are highly engaged. The Trust's overall Staff Engagement score of 7.2 is above average in the Combined Acute and Community Trusts category.



	2014	2015	2016	2017	2018
Best	7.5	7.6	7.6	7.5	7.4
Your org	7.1	7.3	7.3	7.1	7.2
Average	6.8	7.1	7.0	7.0	7.0
Worst	6.1	6.3	6.4	6.5	6.6
Responses	465	483	653	633	1,570

Figure 29: HDFT National Staff Survey staff engagement score, Survey Coordination Centre Benchmarking Report

The top five most improved scores for HDFT were as follows:

Top five most improved scores compared with the Trust's 2017 results	HDFT 2017	HDFT 2018	Benchmark average 2018
Percentage of staff satisfied with their level of pay	32.8%	41.3%	38.4%
Percentage of staff who know who the senior managers are	80.2%	85.5%	82.9%
Percentage of staff satisfied with the extent to which the organisation values their work	47.3%	51.2%	45.8%
Percentage of staff who would recommend the organisation as a place to work	59.7%	63.2%	61.1%
Percentage of staff who are able to make improvements happen in their area of work	56.9%	60.4%	56.5%

Table 35: National Staff Survey 2018 - top five most improved scores for HDFT

HDFT made a statistically significant improvement on our 2017 score for the safety culture theme and are above the benchmark average (*HDFT 2017: 6.7, HDFT 2018: 6.9, Group average: 6.7)*.

We also achieved the top score in our benchmarking group for the percentage of staff feeling secure in raising concerns about unsafe clinical practice (*HDFT 2018: 76.4%)*.

The following areas have been identified for improvement:

Safe Environment – Bullying, Harassment and Violence; Equality, Diversity and Inclusion

- Percentage of staff experiencing harassment, bullying or abuse at work from:
    - Patients or service users, their relatives or other members of the public (*HDFT 2017: 20.3%, HDFT 2018: 23.3%).*
    - Managers (*HDFT 2017: 9.4%, HDFT 2018: 12.3%).*
    - Other colleagues (*HDFT 2017: 15.7%, HDFT 2018: 17.1%)*.
- Percentage of staff who have personally experienced physical violence at work from managers in the last 12 months (*HDFT 2017: 0.3%, HDFT 2018: 1.0%).*
- Percentage of staff who have personally experienced discrimination at work from their manager/team leader or other colleagues in the last 12 months (*HDFT 2017: 3.9%, HDFT 2018: 5.7%).*

Health and Wellbeing

- Percentage of staff who believe the organisation takes positive action on health and well-being *(HDFT 2017: 30.5%, HDFT 2018: 27.6%).*
- Percentage of staff who have experienced musculoskeletal problems as a result of work activities in the last 12 months (*HDFT 2018: 30.4%, Group average: 27.4%).*
- Percentage of staff feeling unwell as a result of work related stress during the last 12 months (*HDFT 2017: 38.2%, HDFT 2018: 39.8%).*

Safety Culture

- Percentage of staff agreeing they are given feedback about changes made in response to reported errors, near misses and incidents (*HDFT 2018: 56.8%, Group average: 58.9%).*
- Percentage of staff who, in the last month, have seen errors, near misses, or incidents that could have hurt staff (*HDFT 2017: 12.5%, HDFT 2018: 15.5%).*

Management, Leadership and Personal Development

- Percentage of staff who have had training, learning or development in the last 12 months (*HDFT 2018: 68.6%; Group average: 70.2%).*
- Percentage of staff who feel their immediate manager can be counted on to help with a difficult task at work (*HDFT 2017: 30.5%, HDFT 2018: 27.6%).*
- Percentage of staff who feel their immediate manager gives them clear feedback on their work (HDFT 2017: 66%, *HDFT 2018: 63.6%).*

The full report can found at http://www.nhsstaffsurveys.com

The key themes from the 2018 survey will be incorporated into our 2019/20 staff engagement action plan, which includes the ongoing work to develop and embed the Trust's fair, just and learning culture.

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 2018/19 was open from 10 to 30 September 2018, with 4445 staff being invited to participate. We adopted a multi-mode approach to the survey, using a closed URL and paper questionnaire, which enabled staff to contribute who traditionally would not have access to the electronic survey e.g. ward based staff. There were 644 respondents which is the equivalent to a 15% response rate. This was a 1% point decrease in response rate from quarter 1.

The results highlighted that 83.5% of staff would recommend the Trust to friends and family to receive care or treatment against a national average of 81%, and that 65% 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 were related to the friendly atmosphere, supportive colleagues and well embedded values, 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. Frontline 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 1.5 million patient contacts per annum, which equates to around 4100 per day. Whilst every individual complaint is very important, especially to the complainant, the average rate of around 20 complaints per month in 2018/19 is relatively small and has increased from an average in 2017/18 of 17 per month. The Trust increased in size associated with the delivery of a significant number of new children's services in 2018/19.

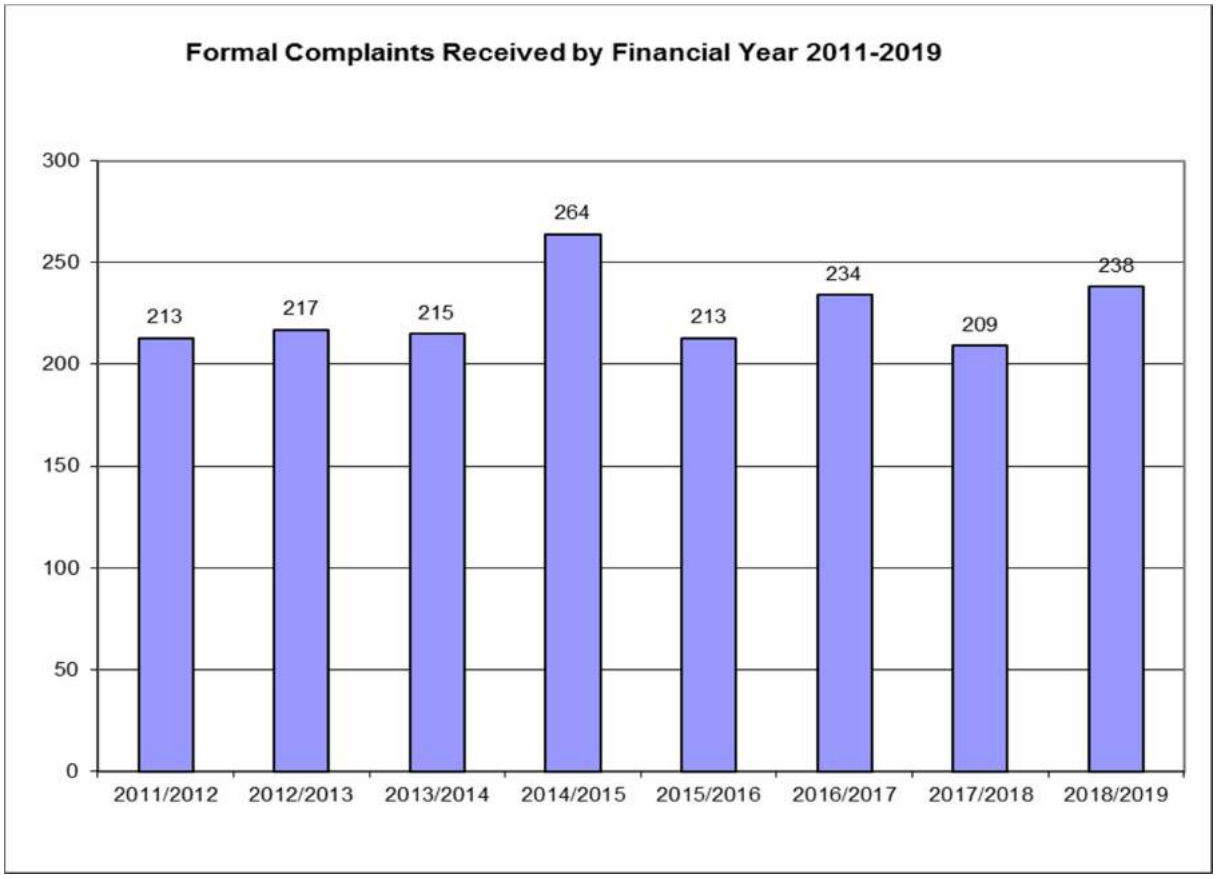


Figure 30: Local patient feedback data since 2011

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 2018/19 is presented below by grade and quarter in which it was received, compared to 2017/18.

Complaint grade	2017/18 total	2018/19				
		Q1	Q2	Q3	Q4	Total
Complaint - green	57	9	14	10	7	40
Complaint - yellow	149	43	59	45	51	198
Complaint - amber	3	0	0	0	0	0
Complaint - red	0	0	0	0	0	0
Total	209	52	73	55	58	238

Table 36: Local patient feedback data showing complaints by quarter during 2018/19 and grade

The number of complaints received in 2018/19 is higher than the previous year with the highest number of complaints received in quarter 2. There were no cases graded amber, indicating very poor experience, in 2018/19 compared with three in 2017/18.

The Trust welcomes feedback from patients, families and carers and encourages staff to resolve as many issues and concerns at the frontline informally and as soon as possible to prevent 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 2018/19, 871 were received by the Patient Experience Team (PET) compared to 1061 in 2017/18, 936 in 2016/17, and 676 in 2015/16. Of these 871, 617 were concerns, 254 were requests for information or comments. The aim is for all staff to address concerns before they escalate into more serious issues. Although the overall number of informal contacts has dropped this is mainly due to a decrease in comments or information requests, which may be as a result of better signposting and communication from other Trust services.

The top ten themes for complaints and concerns can be seen in the graph below. The main themes have consistently included issues around poor communication and attitude. This year concerns about length of waiting lists, appointment delays, and delay or failure in diagnosis, treatment or procedure are also in the top five.

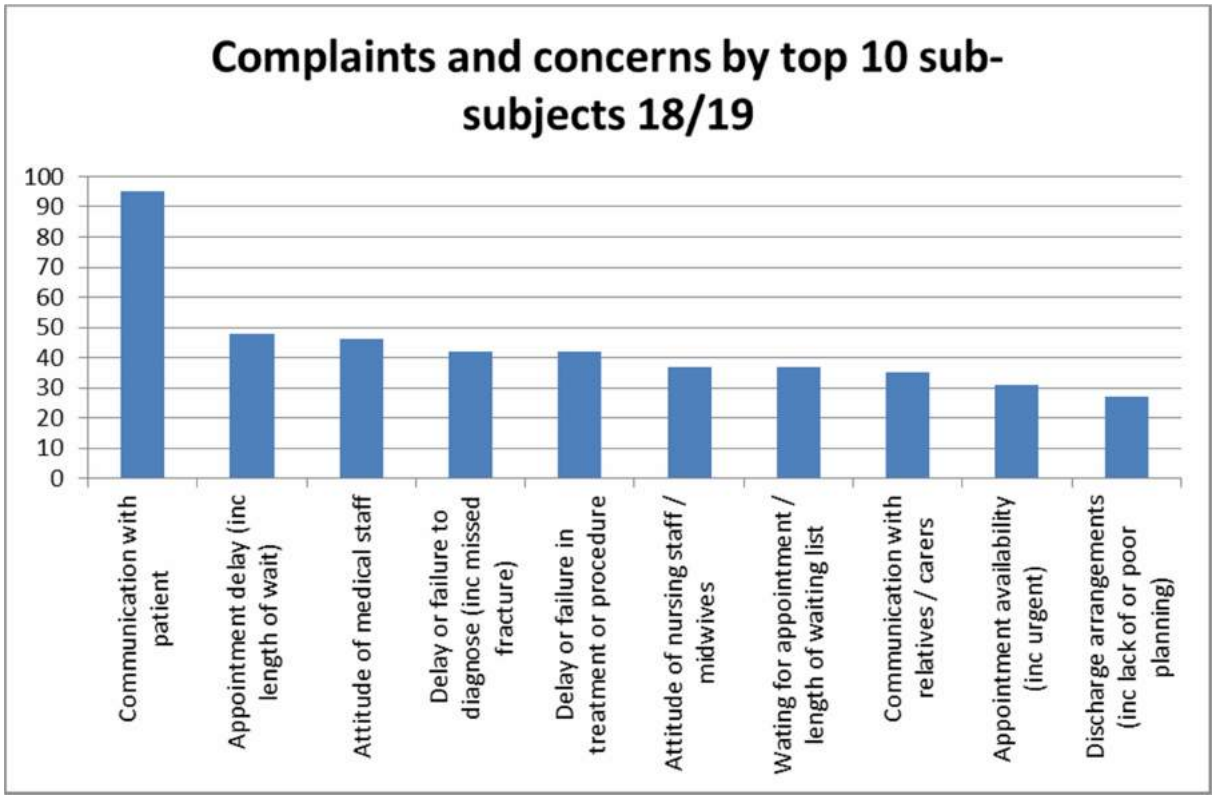


Figure 31: Local patient feedback data showing the main themes in complaints and concerns

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 42% of cases in 2018/19 *(*of those deadlines reached at the time of reporting). The complainant was kept information and updated where the deadline could not be reached. This is a decrease from 55% in 2017/18. The Trust has is aware that we need to improve this performance and complaint response performance is part of a quality improvement priority for 2019/20. Performance will be monitored closely on a quarterly basis. Further training sessions to increase the pool of lead investigators is also planned for 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.

One case was referred to the Health Service Ombudsman in the period and is currently under investigation.

In 2017/18 the Ombudsman investigated 5 cases and none of these were upheld. In 2 of these cases 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 Patient Experience Team to review frameworks for communication and to promote the model of advocacy services. The Trust continues to promote the advocacy services that are available for supporting complaints and patient feedback. 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 Patient Experience Team and reported in the local media.

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Compliments received by the Patient Experience Team	330	315	340	325	316	339

Table 37: 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, contributing to continuous improvements for patients.

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 by providing patients stories. We do this by talking to patients and relatives at the most appropriate time, on the wards, in the community, schools, at home or by telephone.

Individual stories from patients accessing HDFT services over time provide rich and qualitative feedback, with comments and observations discussed with matrons, sisters and staff. These discussions provide opportunities for staff to make small changes in order to improve things and they also clarify some of the comments we receive. This was a positive experience.

2018/19 has been a busy year:

- Visiting patients at home with the Community Care Teams in Harrogate North and South, Knaresborough/Boroughbridge and Ripon;
- Visiting children's outpatients, the children's ward, two primary schools and one secondary school, and children with families or with groups at Beamish Museum. Over 200 children and young people (0-19 years) were involved, talking about what being healthy means and how to stay healthy - physically, emotionally and mentally;
- Visiting Maternity and Special Care Baby Unit. Byland, Littondale, Nidderdale, Granby and Lascelles Wards;
- Visiting Outreach Clinics at Wetherby;
- Visiting Pre-assessment and the Discharge Lounge;
- Following the journey of a patient living with cancer.

The PVG members have also 'befriended' some areas, developing trusting relationships with staff that have enabled dialogue and discussions that have brought about small improvements in areas visited.

The majority of patients and relatives are very appreciative of the excellent care received and kindness shown by staff. The children and young people we talked to were very articulate and in the main had ideas and solutions to some of the issues which were discussed. The support needs of patients with cancer following treatment were highlighted. The negative comments received were about staff being very busy and not having time to talk; patients not being aware or involved in their treatment plans; discharges that are delayed; appointments that are inflexible; and problems with car parking.

The PVG findings (patients' and relatives' comments and our observations) are presented at the Learning from Patient Experience Group. Responses from HDFT have included:

- Thanks from managers for the positive findings about patient care and staff kindness;
- Feedback to confirm actions have been put in place to improve the patient experience, for example by Community Care Teams, and for children accessing general outpatient appointments following comments gathered by members;

- Reminders to staff about things that are thought to be embedded in good practice but occasionally get overlooked e.g. staff introductions, communication and explanations to patients.

The PVG is keen to continue to raise awareness of their role within the Trust. 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 2019/20. Work is also ongoing to develop relationships with patients who have long term needs.

Judy Lennon, Chair of PVG
April 2019

4.5. CLINICAL TRANSFORMATION PROGRAMME

The Improvement and Transformation Team lead on the Trust's Quality Improvement Strategy, primarily through:

- Management and delivery of the Trust's Quality Charter;
- Development and facilitation of our annual improvement schedule;
- Responding to ad hoc improvement needs of the organisation.

What were we aiming to achieve?

Following its inception in 2016, considerable progress has been made toward embedding our Quality Charter within the culture and practice of the organisation. The Charter brings together six schemes that focus upon encouraging, empowering, recognising and rewarding quality improvement. Our aims were similar to 2017/18, but with more ambitious targets. We aimed to:

- Recognise a further 12 Teams of the Month;
- Grow the number of Making a Difference nominations received from across the whole Trust by 25%;
- Train more than 200 Quality of Care Champions across the four levels of the scheme;
- Stage a second Quality Conference following the success of our first in 2017;
- Launch a sixth component to the Charter – Quality Improvement Team Accreditation;
- Deliver effective quality campaigns;
- Engage colleagues in practical improvement activity through a series of 21 events.

And finally, we wanted to ensure we had the capacity and skills necessary to continue providing a responsive service to the changing needs of the organisation, as and when areas for improvement are identified outside of the Improvement Schedule.

What have we done and what did we achieve?

Teams of the Month and Making a Difference nominations

The Team of the Month programme has been maintained, with 66 nominations during 2018/19 - more than ever. This has really raised the bar for quality and makes the judging process ever more challenging.

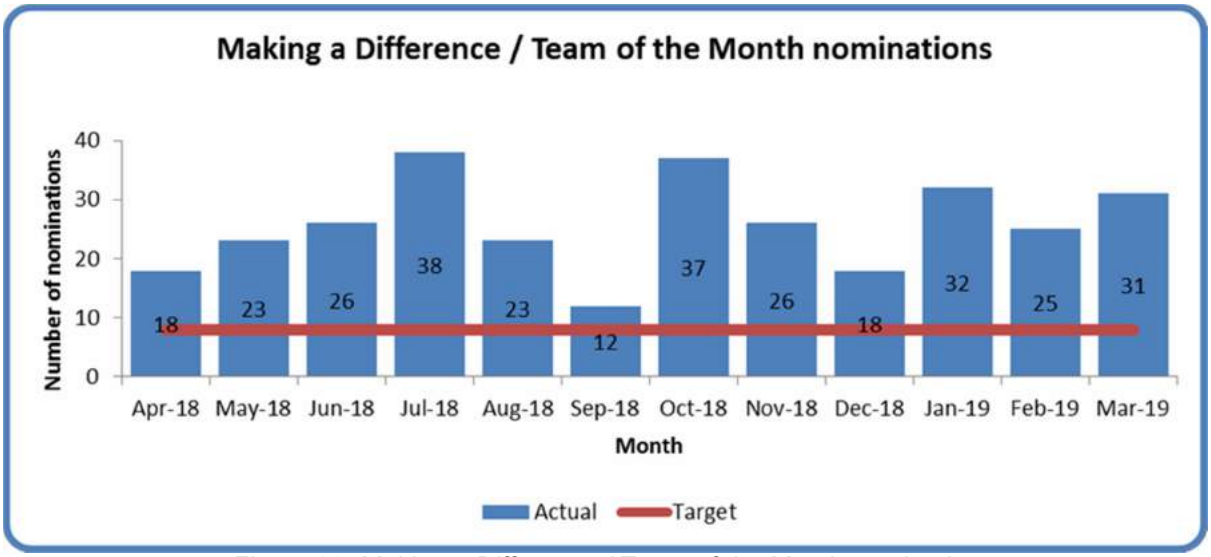


Figure 32: Making a Difference / Team of the Month nominations

We set out to issue approximately 100 Making a Difference Awards and ultimately presented more than 150, which is just a fraction of the total nominations. This figure has increased by 164%, from 92 in 2017/18 to 243 in 2018/19.

Quality of Care Champions

Our Quality of Care Champions scheme continued to expand and we now have over 400. Bronze level accreditation has increased by 285%, from 98 staff in 2017/18, to 373 in 2018/19. Silver level accreditation has increased by 154%, from 46 staff in 2017/18, to 117 in 2018/19.

16 of those Silver Quality of Care Champions gained accreditation having delivered an improvement project. Of those recently trained, the majority did so through the standard full day course, while 18 received an abridged version delivered as part of a ten week RCN Leadership Development Programme. We now have approximately 100 staff at any point in time working toward their full Silver level accreditation. Some recently accredited or current projects include:

- Introduction of acupuncture for the purposes of pain management;
- Development and implementation of a new 'Equality Impact Assessment' for Trust wide cost improvement programmes, improvement and transformation initiatives;
- Revision of pathways and system-wide education to reduce the number of inappropriate referrals to occupational therapists within our Community Care Teams;
- Redesign of documentation to record and support improved practice of neonatal resuscitation;
- Improving processes for children's blood tests, increasing clinics and phlebotomy trained staff;
- Setting up unique clinics to ensure that children missing vaccinations for various reasons including needle phobia, were recognised and given the support needed to engage with healthcare professionals;
- Improving physiotherapy for anterior knee injury in children which has in turn eliminated the waiting list and resulted in vastly fewer follow-up appointments;
- Setting up routine Matron drop-in clinics on several wards for patients and their relatives or carers;
- Implementation of the International Dysphagia Diet Standardisation Initiative across all inpatient services.

We also supported eight senior colleagues through our Platinum course. Only delivered every few years, this demanding qualification uses teaching material from the North East Transformation Network. It comprises four days of classroom based teaching, a revision day and an assessment day to test knowledge and presenting skills. Candidates must then co-facilitate two, week-long Rapid Process Improvement Workshops (RPIWs) with support in order to gain full accreditation.

Quality Conference

Our Quality Conference 2018 went ahead and was as well received as the last. Open to all colleagues, the event provided a platform to share, learn and celebrate success relating to quality improvement, clinical audit, service evaluation and research initiatives across the Trust. Over 150 colleagues attended in person, with over 22,000 Twitter impressions generated over the following weeks.

Quality Improvement Team Accreditation

We launched the Quality Improvement Team Accreditation in April 2018, aimed at recognising and rewarding teams to adopt a culture and practice underpinned by the principles of quality improvement. Tiered in a similar manner to our Champions scheme (Bronze, Silver and Gold), accreditation lasts between 12-24 months and needs to be revalidated in order to maintain it. More of a marathon than a sprint, we expect the journey of accreditation to take years but have to date been able to award ten teams with the Bronze Quality Improvement Award.

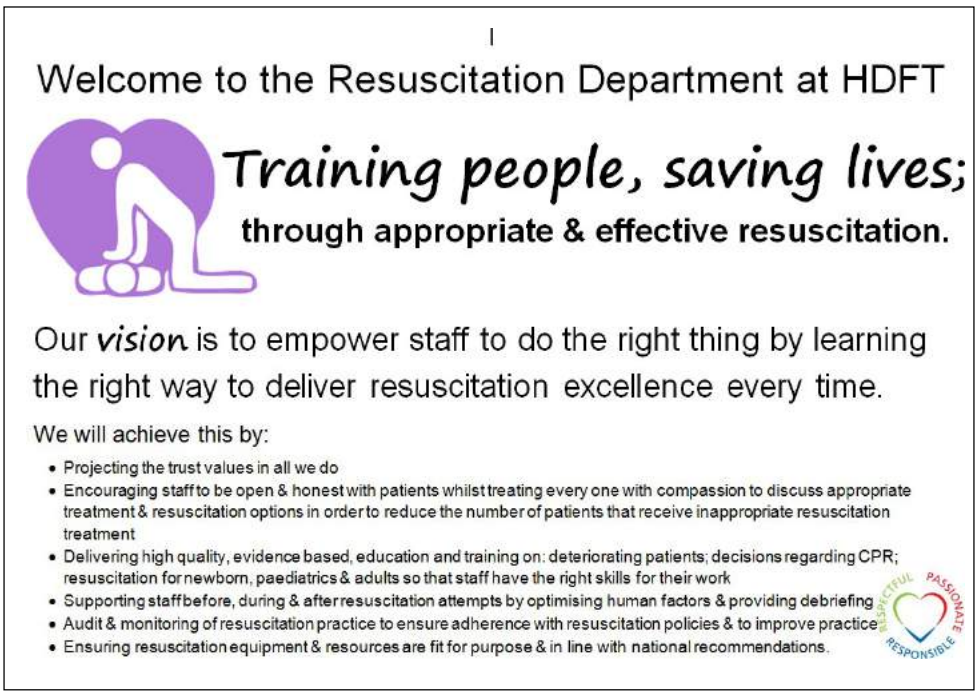


Figure 33: The 'vision' from one of the teams to have been accredited through the scheme.

Quality Campaigns

The Quality Campaign in this financial year has been in relation to public health and aimed to promote awareness amongst colleagues that we all share an obligation to educate and encourage healthy lifestyle choices for patients and service users. Delivery of this will run into 2019/20.

Practical Improvement Activity

Against a target of 21, we delivered 30 separate improvement events including rapid process improvement workshops (RPIWs). Some of the key outputs include:

- Introduction of a new incident reporting system;
- Improved compliance with the "two week wait" standard for cancer diagnosis;
- New nursing documentation for dementia patients and accessible information for carers and relatives;
- Reducing the average time to recruit staff from 77 days to less than 60;
- Standardising work in Podiatry leading to urgent cases being seen sooner;
- Establishing a visual control dashboard to monitor compliance with 'You're welcome' standards for service user engagement;
- Improving the lead time to respond to service user feedback from eight months to less than three.

Ad hoc work undertaken by the team included support in relation to reducing 'did not attend' rates, improving the timeliness of administering medication for inpatients with Parkinson's disease, increasing scanning capacity for expectant mothers and expanding our Supported Discharge Service, to name but a few.

To further promote the work of our team, we introduced a monthly e-newsletter which is circulated throughout the Trust. As well as promoting some of the events and training we facilitate, it also plays a strong role in informing colleagues about the changes to practice that service improvement delivers. We also hosted a Quality Improvement Forum for our Champions and other interested colleagues, to discuss tools and share learning.

Summary

This has been a productive and successful year for the Improvement and Transformation Team. For the most part, we have either met or exceeded targets set for our work or the improvement events that we have facilitated. We recently developed a revised strategy, directing our work through until 2024 and this has provided us with an opportunity to reflect upon areas in which we could deliver more effectively:

- We now appreciate that many Silver Level quality improvement projects take longer to complete. So although we've trained more staff than we aimed to, it will take us longer to fully accredited them and reach the target we set ourselves;
- We are likely to struggle to develop Gold Level Champions within our existing workforce because of the onus that training places upon already busy colleagues. This knowledge has influenced targets set for 2019/20;
- As a result we have adopted a more structured and disciplined approach to the Improvement Schedule for 2019.

Otherwise, the new strategy is broadly aimed at supporting "more of the same" because of the encouraging results that we have built upon year on year. Evidence from our recent CQC report suggests that our focused efforts continue to support a maturing culture of quality improvement.

4.6. VOLUNTEERS

We currently have 603 enthusiastic and committed volunteers ranging in age from 16 to 93 years young providing invaluable assistance to staff, patients and visitors throughout the Trust. They all greatly enhance our patient experience. The majority of our volunteers are based at Harrogate District Hospital; however, there are community volunteers who are based at Ripon Community Hospital, and other community sites in Durham, Darlington, Middlesbrough and Scarborough. On average our volunteers provide an amazing 2,000 hours of help per month.

Volunteers assist in the following areas:

- Meal time volunteers, assisting patients with their meals;
- 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;
- Harrogate Hospital Radio;
- Café;
- Gardening volunteers;
- Administration volunteers throughout the Trust;
- Check-In Engagement volunteers;
- Volunteer drivers for patients living in Nidderdale;
- Pharmacy volunteers;
- Complementary therapy volunteers;
- Breast feeding peer support volunteers in our community sites;
- Therapy dogs;
- Craft volunteer on Lascelles;
- End of Life Support volunteers.

Photos: One of our wonderful volunteers!

Volunteers also assist in many “one off” roles such as assisting with surveys and helping at Medicine for Member lectures.

We coincided our annual volunteer thank you party with the NHS@70 celebrations in July, with a 1940’s style theme, complete with entertainer and food typical of the era. Long Service Awards were also presented by the Chairperson, Mrs Angela Schofield.

Figure 34: Annual volunteer thank you party and Long Service Awards presented by Mrs Angela Schofield

Photos: Just a few more of our wonderful volunteers!

4.7. DUTY OF CANDOUR

A statutory duty of candour (DoC) 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.

Processes for duty of candour are now well embedded throughout the Trust. Weekly monitoring of outstanding cases and quarterly assurance monitoring continues to try and 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	2018/19 Year Total
Number of moderate or above harm events	85	114	121	114	434
Number not triggering DoC (staff/not HDFT)	37	42	45	47	171
Number where trigger unclear due to lack of confirmation of severity	0	1	0	1	2
Number where DoC triggered	48	71	76	66	261
Of those where DoC triggered:					
Number where DoC clearly applied	47 (98%)	67 (94%)	70 (92%)	58 (88%)	242 (93%)
Number where a decision has been made NOT to apply DoC for documented reasons (e.g. patient lacks capacity, no next of kin details)	1 (2%)	4 (6%)	6 (8%)	5 (8%)	16 (6%)
Number where DoC outstanding	0 (0%)	0 (0%)	0 (0%)	3 (4%)	3 (1%)

Table 37: Monitoring of the application of the duty of candour (DoC) 2018/19

Please note: data is correct as at 24/04/2019. The table shows the latest position in relation to level of harm and totals may differ to figures previously reported.

For quarter 4, of the 114 events graded moderate or above harm, 66 events clearly triggered the duty of candour. In 58 of these cases the duty was followed, in five cases the decision was made not to apply the duty of candour for documented reasons, and three cases are still in progress and are being followed up. There is also one event where it is unclear if the duty of candour has been triggered. In quarter 2 there was one event where it is unclear if the duty of candour has been triggered. This event was not reported until quarter 3 and relates to another trust who have been chased for a response.

4.8. MENTAL CAPACITY AND MENTAL HEALTH

The Mental Capacity Act (2005) provides the legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The Trust recognised that a nominated lead nurse for Mental Capacity would support compliance with the Mental Capacity Act and the development of appropriate training. This role was taken up by the Trust's Learning Disability Liaison Nurse in September 2018.

In addition we have been working to improve the care we provide for patients with mental health needs. Whilst HDFT has in place a contract with Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) for the provision of Mental Health Act support, our staff provide care to people with mental health needs as well as physical health needs.

What were we aiming to achieve?

1. Increase awareness of the Mental Capacity Act;
2. Provide staff with support and guidance in completing assessments of mental capacity and in determining what is in the best interests of the patient;
3. Ensuring a robust process for recording the decision making in relation to the use of hand control mittens. These are padded gloves used to prevent patients from removing tubes that are needed to provide essential nutrition, hydration or medication. The mittens are comfortable to wear and can be put on and removed easily, and are only used when a patient does not understand the need to keep these tubes in place;
4. Improving the care of adults, and children and young people with mental health needs who regularly attend the Emergency Department.

What have we done and what are the results?

Mental Capacity Act awareness

A bespoke Mental Capacity Act (MCA) awareness e-learning package has been developed and is now essential training for all staff with patient contact. A higher level package has been developed and is essential training for identified nursing staff and allied health professionals with leadership responsibilities.

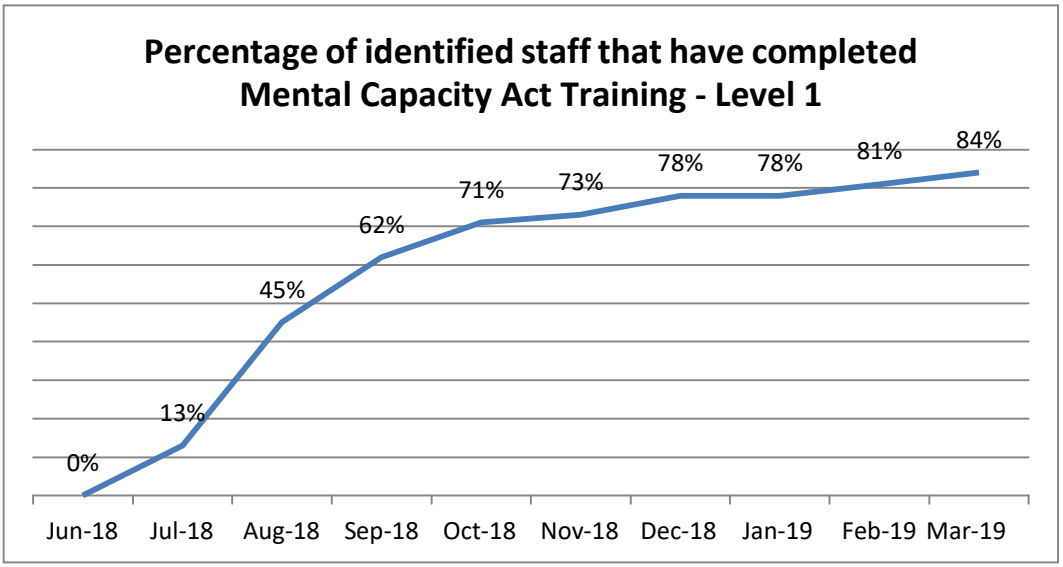


Figure 35: Mental Capacity Act level 1 training completion since introduction

The MCA level 1 awareness training was launched in May 2018. A total of 2766 staff required this training and 2315 (84%) had completed it by March 2019.

The Mental Capacity Act level 2 training was launched in January 2019. A total of 283 staff have been identified as requiring this training and would be expected to attend a three hour classroom session once over a three year programme. To date this has been completed by 26 (9%) of those identified.

Capacity assessment and best interest decision documentation

The Trust documentation for recording capacity assessments and best interest decisions was reviewed by the Learning Disability Liaison Nurse and shared with key stakeholders for comment. Feedback regarding the amended documentation was positive, with clinicians commenting that it provided clear guidance and a structured process. These were approved by the Supporting Vulnerable People Steering Group in December 2018 and are to be rolled out across the Trust in the near future.

Assessment tool and care plan

An assessment tool for the use of hand control mittens was developed to ensure that mental capacity was assessed and that all less restrictive options had been considered. This was supported by a care plan to ensure that the use of these devices as a therapeutic restriction considers the patient's safety, rights and comfort. Feedback regarding the proposed assessment tool and care plan was positive and these were approved by the Supporting Vulnerable People Group in December 2018. These are now available to staff when considering the use of this particular restriction.

Caring for people with mental health needs who regularly attend the Emergency Department

Some of our clinicians have been working closely with the Children and Adolescent Mental Health (CAMHs) service, the CAMHs crisis team and the safeguarding team to review the cases of children and young people who regularly attend the Emergency Department (ED). This has resulted in better information sharing and communication, the development of care plans for a number of young people in order to provide a consistent and joined up approach, and has supported the mental health teams in their delivery of care to these young people.

At the same time we have been working with TEWV and other agencies to understand and meet the needs of people who are involved with multiple services and who regularly attend the ED. Work is also ongoing within TEWV to improve their response times to patients in ED who require a mental health assessment and/or a psychiatric inpatient bed. These vulnerable people often have the longest waits in the department creating an inequality and also not providing optimum care.

The ED mental health card has been amended to better capture potential risks for the patient (including absconding) and risk for the staff, to actively consider the patients capacity to decide to leave before assessment and to capture the basic information required by the Mental Health team with a view to expediting the patients referral and mental health assessment . The card is currently being piloted and the results of the pilot will contribute to a similar change in the children's ED card.

Summary

The Mental Capacity Act training figures are reassuring and it is expected that all staff will have completed the required learning within the planned three year period. A knowledge

audit is planned for October 2019; this will be used alongside the 2017 knowledge audit to measure effectiveness of training.

Recording of capacity assessments and best interests decision making will be audited in the 2019/20 consent audit. This will then inform further actions required to continue to improve compliance with the Mental Capacity Act.

Documentation around the use of hand control mittens will also be audited in 2019/20. This has highlighted the need to raise awareness of therapeutic restrictions and how these should be carefully considered in practice. Specific content relating to therapeutic restrictions will be developed and incorporated into the existing Mental Capacity Act level 2 training.

Work across the various agencies involved with the care of patients with mental health needs has resulted in improved information sharing and communication, care plans that provide a consistent and joined up approach from the agencies involved, and improved delivery of care to these vulnerable people.

4.9. DISCHARGE FROM HOSPITAL

A Trust priority is to 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 stable and no longer require an acute hospital bed.

What were we aiming to achieve?

The discharge project had the following aims:

1. To reduce the rate of delayed transfers of care;
2. To reduce the proportion of patients with a length of stay of seven days or longer;
3. To reduce the number of patients who make a decision about their long term care needs in hospital.

What have we done?

Supported Discharge Service

The Supported Discharge Service (SDS) was launched as a pilot 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 the hospital environment which can give a more accurate picture of how the person will manage at home. The service was welcomed by patients and staff at the hospital, and in July 2018 a business case to create a permanent service was approved by the Trust board. The team have expanded the scope of the service since December 2018 and have supported over 700 people home between December 2018 and February 2019.

Discharge Hub

Examples of good practice in other local trusts showed that collaborative working across hospital and community services in conjunction with social care services can improve the process and experience of discharge from hospital. In November 2018, an integrated Discharge Hub was created. The Hub included the hospitals Discharge Planning Team, SDS and the re-ablement team from North Yorkshire County Council, co-located at the hospital. Representatives meet each morning to discuss discharge plans for patients who need additional support when leaving hospital. The Hub forms part of longer-term strategy to plan for discharge with the patients and their families early on in an admission to hospital. In the last year HDFT have worked closely with Hambleton and Richmond CCG to learn from their discharge model and share good practice across North Yorkshire. We will continue this work into 2019/20, particularly to build upon the Discharge to Assess pathways with our local CCG.

Rehabilitation at Ripon Community Hospital

Trinity Ward at Ripon Community Hospital is a 16 bedded rehabilitation unit. Over the last year the team have worked hard to improve the therapeutic interventions offered at the unit by improving how the rehabilitation goals are set jointly between the patients and staff on the ward and increasing the number of hours therapists are on the ward each day. The team have also recruited a discharge nurse who supports the patients and their families to prepare for discharge from hospital. The ward has seen a significant reduction in their length of stay as a result of their improvements. The CQC inspection in 2018 found that the team has made significant improvements in the focus on patient rehabilitation, holistic care and therapy planning, and staffs were seen to be compassionate and caring in their approach.

Discharge to Assess

We have supported the CCG to implement Discharge to Assess pathways which ensure that patients who are likely to require long-term care for complex needs are assessed in the community rather than in hospital. This means that individuals have more recovery time in a residential setting, and health and social care services can more accurately assess the needs of the individual for the long-term.

What are the results?

The number of patients who have stayed in hospital seven days or longer and 20 days or longer has decreased over the last 12 months.

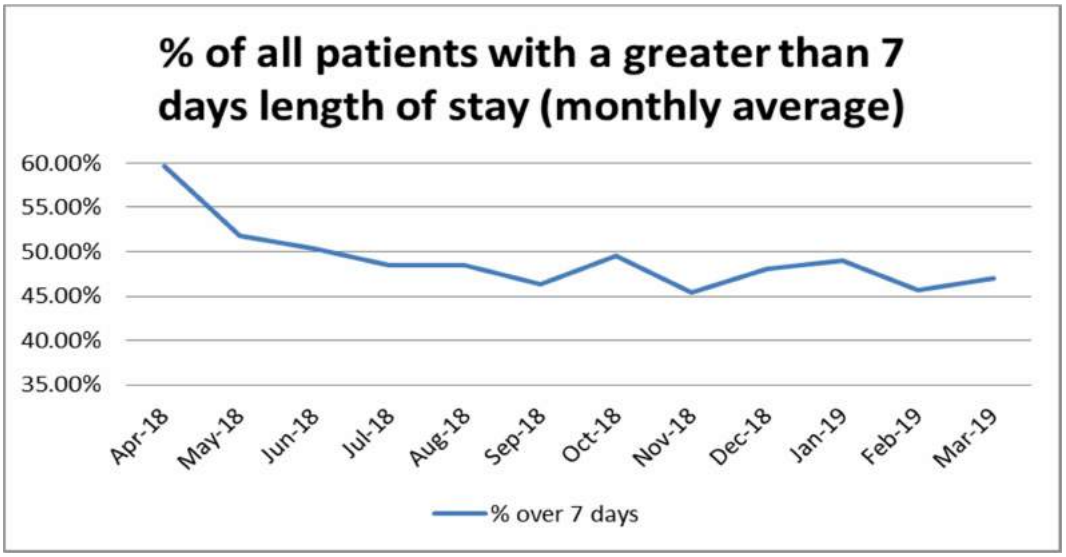


Figure 36: Percentage of all patients with length of stay greater than seven days

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.

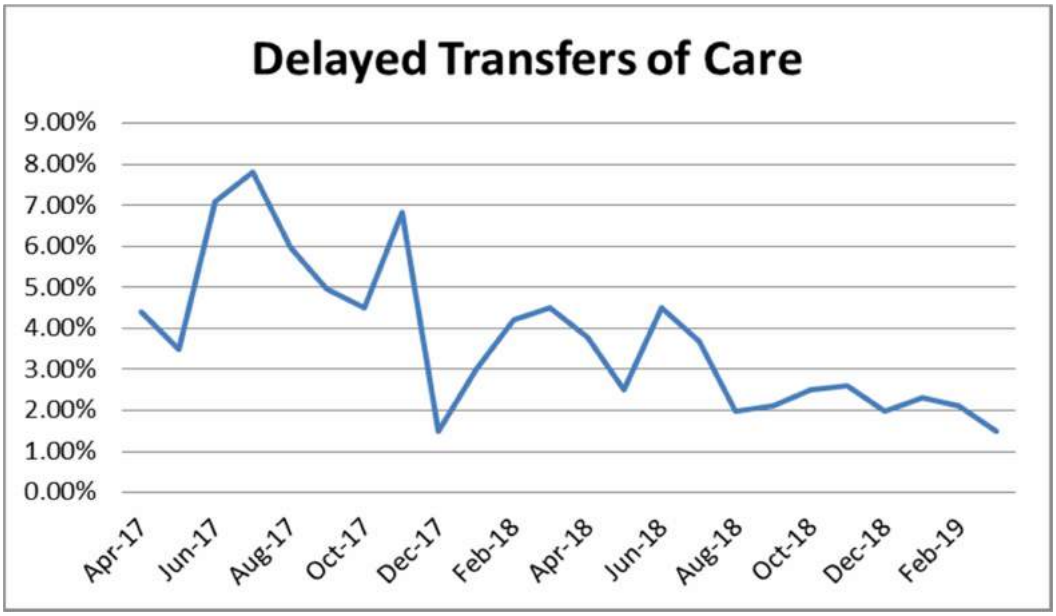


Figure 37: Delayed transfers of care April 2017 to February 2019

The Supported Discharge Service, Discharge Hub and the Discharge to Assess pathways developed by the CCG have contributed to this reduction in DTOC.

Summary

The Trust has made progress with improving discharge; however, there is still work to continue in 2019/20. This includes refinement of the Discharge to Assess pathways and processes to ensure the Trust is in line with partner organisations across the region.

4.10. EQUALITY AND DIVERSITY OBJECTIVES

There is an obligation on public authorities to positively promote equality, not merely to avoid discrimination. The Trust is committed to providing equality of access to services and an inclusive workplace for our staff, giving due regard to the needs of protected groups.

Our ongoing work in relation to equality and diversity is planned around the NHS Equality Delivery System 2. This is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. It is structured around four goals with 18 outcomes to assess and grade against, asking the question:

> "How well do people from protected groups fare compared with people overall?"

What were we aiming to achieve?

The Trust equality objectives for 2018/20 are based around the four goals:

1. Better health outcomes

To ensure that our services provide effective and safe treatment and care that is sensitive to people's personal and cultural needs as well as appropriate to their clinical condition.

2. Improved patient access and experience

To strengthen our systems and processes to meet the requirements of the Accessible Information Standard, to continue to work with patients with learning disabilities to provide even better patient access and experience, and to introduce the Patient Participation Strategy.

3. A representative and supported workforce

To utilise the workforce equality group to deliver action plans focused on improving the availability of workforce equality information to assess our progress towards ensuring we have a representative and supported workforce.

4. Inclusive leadership

To ensure that Trust leaders have the right information and skills to promote equality within and beyond the organisation and to support their staff to work in a fair, diverse and inclusive environment.

The focus of work during 2018/19 was to:

- Achieve a consistent approach to delivery of the Accessible Information Standard;
- Continue work to achieve better health outcomes for patients with learning disabilities;
- Support patients with hearing and sight impairment;
- Continue work to understand and meet the needs of people with gender identity issues and gender reassignment;
- Establish a suitable "Changing Places" facility within HDFT;
- Complete and implement the Patient and Public Participation Strategy, ensuring this promotes positive practice and values the diversity of all individuals and communities;
- Embed equality impact assessment processes;
- Use workforce equality and diversity data, particularly Workforce Race Equality Standard (WRES) data to improve engagement, and prepare for the Workforce Disability Equality Standard (WDES) which is to be established nationally.

What have we done and what are the results?

Accessible Information

Whilst we can meet the information and communication needs of some of our patients, we have been working to achieve a consistent approach to identifying, recording, flagging, sharing and meeting needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

We have described work related to accessible information for patients with learning disabilities in section 3.2. We have established an identification and flagging process for people with a certificate of visual impairment (CVI) on iCS, the patient administration system, which enables staff to recognise and meet their needs. More recently we have implemented an automated notification of the admission of a patient with a CVI flag to our Advanced Nurse Practitioner in Ophthalmology and others, in order that they can support the needs of these patients whilst they are in an unfamiliar environment.

We flag the records of patients who require a British Sign Language (BSL) interpreter in order that this information can be used to anticipate the need for an interpreter for these patients. We are also working to provide an improved BSL service for patients, carers and visitors during 2019.

We are working towards a process that will enable a systematic capture of the information and communication needs of all relevant patients on to our electronic patient systems, in order that frontline staff are aware and can act appropriately to meet these needs. We have developed a form for patients to use to tell us about their information and communication needs that is ready to implement as soon as the clinical systems are ready to use for this purpose, early in 2019. Communication campaigns for staff and patients are planned to support effective implementation.

Supporting patients with hearing impairment

We have been working to ensure greater awareness of the needs of patients with hearing impairment, promoting staff training, highlighting the facilities we have available to meet patients' needs and have been installing additional hearing loops at reception areas across the Trust.

Supporting inpatients with sight impairment

Regarding patients with sight impairment, we have been working to ensure patients admitted to hospital are assessed and supported, and that there is awareness of their risk of falls and preventive measures put in place. We have:

- Placed posters on inpatient wards to inform staff about the CVI flag;
- Implemented the automated notification of the admission of patients with visual impairment to those who can support their care, as described above;
- Established a part time Eye Clinic Liaison Officer funded by Vision Support, who is also providing support to patients on inpatient wards;
- Incorporated input from the Advanced Nurse Practitioner in Ophthalmology into training for Falls Link Workers and Therapy Service staff.

We are continuing work to:

- Develop an intranet page for staff with all relevant information and resources;

- Progress a streamlined process for a bedside assessment of sight using the Royal College of Physician's bedside sight test;
- Implement revised falls assessment documentation which now includes more questions around visual impairment;
- Undertake a fact finding and audit of inpatients on Jervaulx Ward to assess patients' needs and arrangements in place, and to work with staff;
- Finalise a visual impairment conditions information pack for wards;
- Understand how people with visual impairment use IT to support their information and communication needs;
- Increase staff awareness.

Gender identity

We have worked with transgender patients, staff and other LGBT groups to develop increased staff understanding and awareness of transgender patients and legislation. We have a draft Procedure Document for Supporting Transgender Patients, Service Users and Staff which has been widely consulted on within and outside the Trust. We are hoping to ratify this soon and extensive staff communication and awareness raising is planned.

Facility registered on 'Changing Places'

Within our new Endoscopy Unit we have toilet facilities that can be used by people who cannot use standard accessible toilets, such as people with profound and multiple learning disabilities, as well people with other physical disabilities such as spinal injuries, muscular dystrophy and multiple sclerosis. We now provide a ceiling hoist, an adult-sized changing bench, and enough space in the changing area and toilet for the disabled person and carers in a safe and clean environment. These are registered in the 'Other Facilities' section of the 'Changing Places' website.

Workforce equality and diversity data and engagement

During the year we have reviewed staff survey, staff FFT, Workforce Race Equality Standard (WRES) and other workforce data and have identified positives, and areas for further work. The 2017 staff survey identified some concern about a disproportionately higher proportion of our black, Asian and minority ethnic (BAME) staff experiencing bullying and harassment from colleagues. As part of the national call to action to tackle bullying behaviours, a series of interviews were undertaken with individuals from departments across the Trust. There was a conscious decision taken to include a higher proportion of BAME colleagues in this sample to ensure that views were heard.

In further support of this agenda our Chief Executive, Dr Ros Tolcher, sent a message to all staff to raise awareness of key results from the staff survey in relation to BAME colleagues. A series of listening events open to all staff were undertaken, with BAME colleagues encouraged to attend the events to discuss their experiences.

The inclusion of a full census in the staff survey in 2018 has allowed a more in-depth analysis of the results across the differing protected characteristics to allow a fuller understanding of the experience of staff across the Trust. This has been in conjunction with work undertaken to further understand the experience of staff, and to promote a fair and just culture in the Trust.

The work done initially was to understand where and how bullying, harassment and abuse affects staff in the Trust and also learning from examples where problems have been dealt

with well. A number of findings have been identified that will be taken forward with the Workforce Equality Group.

The Trust has revised the Pathway to Management training, to ensure a focus on the fair and just culture and unconscious bias. Unconscious bias awareness was delivered to the Trust's senior management and leaders as part of the agenda for the leadership group during 2018. Work is also underway to develop a BAME staff network to enable staff to come together to share information, support and raise the visibility of these staff, in order to ensure we promote a comfortable and fully inclusive environment in which all can flourish.

Impact Assessment Policy and Processes

We have quality and equality impact assessment processes in place but have been working to strengthen these. We have an Impact Assessment Policy that describes the processes to undertake impact assessments when these are triggered. We have an equality impact assessment toolkit to support staff with this process, and have been improving systems to ensure robust documentation and evidence.

Patient and Public Participation Strategy

Please see section 2.2 item 4.

Learning disabilities

We have continued work to achieve better health outcomes for patients with learning disabilities. See section 3.2 for detail.

Summary

Whilst we are making progress in some areas, the Trust is ambitious to achieve more for patients, service users and staff in relation to access to services and information. As a result this work has been identified as a key priority for 2019/20.

The workforce equality, diversity and inclusion agenda is evolving with the addition of the Workforce Disability Equality Standard (WDES) submission in 2019. The Workforce Equality Group is growing and will take on more of this important work, planning and championing actions and feeding back progress to the organisation.

4.11. PRIORITY CLINICAL STANDARDS FOR SEVEN DAY HOSPITAL SERVICES

The seven day standard measures have been set out to ensure that patients receive the same level of high quality care every day of the week. Four priority standards were selected:

- Clinical Standard 2: Access to consultant-directed assessment. 90% of patients should have received a consultant review within 14 hours of hospital admission;
- Clinical Standard 5: Access to diagnostics - requires a 'yes' or 'no' for compliance;
- Clinical Standard 6: Access to consultant-directed interventions - requires a 'yes' or 'no' for compliance;
- Clinical Standard 8: Ongoing review. 90% of patients should receive ongoing twice daily and daily reviews.

What have we done?

During 2018/19, work has been focused on a number of specialties, with reviews of job plans, changes to pathways, and investments into facilities. These areas were:

Acute Internal Medicine
Throughout this year the on-call rota has been under review as we have attempted to improve the responsiveness in Acute Medicine, although success depends upon our ability to recruit to consultant level posts in the relevant specialties. Changes have included the relocation of the Combined Assessment Team (CAT) into a new facility at the front of the hospital. This has improved patient flow, offered greater capacity for accepting patients from ED, and enabled patients to be assessed and treated faster. An additional day of consultant time has been secured, providing a second acute consultant to work within the unit.

General Surgery
A 'consultant of the week' model remains in place. There has been recruitment of two consultant surgeons, the retirement of one consultant and one other coming off the on-call rota, maintaining a one in eight rota. Three of the eight consultants undertake elective work on Saturdays. A number of reviews within General Surgery are undertaken by senior clinicians who are currently not eligible for entry onto the Specialist Register for doctors with a certificate of completion of training (CCT) after completing an approved training programme in the UK. This does not meet the national guidelines for this clinical standard.

Paediatric Medicine
A business case has been developed to increase consultant availability out of hours. The consultants are currently adjusting the way in which they undertake their ward rounds, and this will ensure that every patient admitted will be discussed with the consultant. The consultants also phone the ward out of hours following handovers. An audit is planned to determine how many times they have had to return to the ward following the call, and to review note keeping within the patients' records.

Trauma and Orthopaedics
The service still requires the addition of evening and weekend consultant ward rounds, with work ongoing to review how job plans can be constructed to achieve a cost-effective evening ward round. The team hold a handover meeting every morning to review all trauma admissions, with an update provided to the Orthogeriatrician following this. Following handover at 19:30 the consultant on call will phone in to a member of the team and talk through the patients, and will return to the hospital to assess any patients that require this.

Audits of performance against the standards have been completed.

What are the results?

Clinical Standard 2

The audit results show a steady improvement overall from 2016 to April 2018. The audit results by specialty show an improvement in April 2018 against the 2017 results for all specialities with exception of the stroke service.

			Combined HDFT audit results (%)					
			2016		2017		April 2018	
Clinical Standard	Requirement	Target (%)	Weekday	Weekend	Weekday	Weekend	Weekday	Weekend
2	Consultant review within 14 hours of admission to hospital	90	60	59	59	66	71	74

Table 38: Clinical Standard 2: Audit results 2016, 2017, April 2018

	HDFT audit results by specialty (%)					
	2017			April 2018		
Admitted Specialty	Weekday	Weekend	Total %	Weekday	Weekend	Total %
Acute Internal Medicine	53	88	58	60	75	64
Cardiology	50	67	56	75	50	67
General Surgery	77	50	71	86	75	83
Geriatric Medicine	71	63	67	80	80	80
Obstetrics and Gynaecology	*Not included in 2017 audit*			100	*	100
Paediatric Medicine	71	100	76	75	100	89
Respiratory (Thoracic) Medicine	*	100	50	100	100	100
Stroke Medicine	100	0	100	0	*	0
Trauma and Orthopaedic Surgery	50	40	47	80	50	71
Urology	50	50	50	75	0	50
Grand Total	59	66	61	71	74	72

Table 39: Clinical Standard 2: Audit results 2017 and April 2018 by specialty

**No relevant patients were admitted during the audit period*

The latest audit of a small number of specialities was undertaken between 17 and 23 December 2018 using the same methodology as previously. The overall results of this limited audit are detailed below.

	HDFT audit results December 2018 (%)		
Admitted Specialty	Weekday	Weekend	Total
Acute Internal Medicine	78%	86%	80%
General Surgery	45%	58%	50%
Paediatric Medicine	35%	50%	37%
Trauma and Orthopaedic Surgery	71%	80%	73%

Table 40: Clinical Standard 2: December 2018 audit results for selected specialties

The results for Acute Medicine show the weekday performance of 60% in April improving to 78% in December, and the weekend performance of 75% in April improving to 86% in December, with a significant overall improvement in consultant review within 14 hours from

64% in April to 80% in December. Of the admissions that failed the standard in the December audit, 66% of patients were seen by a senior doctor but more than 14 hours following admission.

The audit of Paediatrics showed 19 children were admitted during the audit period in December compared to nine patients in April. 12 of the 19 admissions in December 2018 failed the 14 hour review clinical standard for consultant review; six children were seen within 14 hours but they were seen by a senior specialty trainee (ST5) doctor and not a consultant, two further admissions failed the standard as times of review were not logged in the notes and the remaining four were not reviewed by a senior doctor within 14 hours of admission.

Clinical Standard 5: Access to Diagnostics

Diagnostic testing and reporting are always or usually available in the appropriate timescales on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs.

	April 2018	
	Weekday	Weekend
Computerised tomography (CT) scanning	Yes	Yes
Echocardiography	Yes	No
Microbiology	Yes	Yes
Magnetic resonance imaging (MRI) scanning	Yes	Yes
Ultrasound scanning	Yes	Yes
Upper gastrointestinal endoscopy	Yes	Yes

Table 41: HDFT declaration for Clinical Standard 5

The gap in weekend Echocardiography provision is being addressed by exploring a network approach with York Teaching Hospital NHS Foundation Trust; however the trusts need to recruit additional cardiologists, and to date recruitment into vacancies has been a challenge.

Clinical Standard 6: Access to Consultant-directed interventions

Inpatients have 24 hour access to consultant directed interventions seven days a week, either on site or via formal network arrangements.

	April 2018	
	Weekday	Weekend
Critical Care	Yes	Yes
Primary Percutaneous Coronary Intervention	Yes	Yes
Cardiac Pacing	Yes	Yes
Thrombolysis for Stroke	Yes	Yes
Emergency General Surgery	Yes	Yes
Interventional Endoscopy	Yes	Yes
Interventional Radiology	Yes	Yes
Renal Replacement	Yes	Yes
Urgent Radiotherapy	Yes	Yes

Table 42: HDFT declaration for Clinical Standard 6

Clinical Standard 8

Clinical Standard	Requirement	Target (%)	Combined HDFT audit results (%)					
			2016		2017		April 2018	
			Weekday	Weekend	Weekday	Weekend	Weekday	Weekend
8	Twice daily reviews by appropriate member of team (consultant or delegate)	90	100	100	100	100	100	
8	Daily review by appropriate member of team (consultant or delegate)	90	100	93	100	65	97	74

Table 43: Clinical Standard 8: Summary audit results 2016 - 2018

On review of our April audit the significant area that impacted on our weekend position was Acute Medicine with 18 out of the 163 patients (11%) not receiving a once daily review. 14 (78%) of those were over a weekend.

	Ongoing review	Review took place	Percentage			
			Achievement	Failed	Failed at weekday	Failed at weekend
Acute Internal Medicine	163	145	89	11	22	78
Cardiology	24	19	79	21	0	100
General Surgery	42	42	100	0	0	0
General Medicine	18	16	89	11	50	50
Obstetrics and Gynaecology	9	9	100	0	0	0
Paediatrics	13	13	100	0	0	0
Stoke	10	10	100	0	0	0
Trauma and Orthopaedic Surgery	25	23	92	8	0	100
Urology	12	10	83	17	100	0

Table 44: Clinical Standard 8: Detailed audit results April 2018 by specialty

Summary

Although progress has been made throughout the year against Clinical Standard 2, a number of specialty areas are still not able to meet the required standard of 90% of patients to receive a consultant review within 14 hours of admission. Actions are underway to improve compliance through reviews of consultant job plans and extending consultant cover into the evenings, continued efforts to appoint into consultant vacancies, moving services to improve patient flow, and redesigning pathways for faster clinical review. Business cases are being developed as appropriate to seek the funding to support these service changes.

We are also promoting good documentation of clinical review so this is easily identifiable in patient records during future clinical audits.

4.12. SPEAKING UP

In 2017 Sir Robert Francis wrote in the National Guardian's Office Annual Report:

> "It became clear to me from the Mid-Staffordshire inquiries and the Freedom to Speak Up review that poor standards of care can proliferate unless both patients and staff are listened to by the leaders of our health services and their concerns welcomed and acted upon."

This resonates with the findings of the Gosport Independent Panel Report published in June 2018. As a response to the Mid-Staffordshire inquiries, the National Guardian's Office (NGO) was established in April 2016 and has the remit of:

- Developing, leading and supporting a network of Freedom to Speak Up Guardians in provider organisations subject to the NHS standard contract;
- Carrying out case reviews where there are instances of speaking up not being handled according to best practice;
- Challenging and supporting the system on all matters related to speaking up.

What have we done?

At HDFT, our first Freedom to Speak Up Guardian was appointed in October 2016. The guardian works alongside many existing systems and processes for staff to raise concerns. The guardian provides advice and support to staff who raise concerns via this route, and also works to challenge and change culture within the organisations so that barriers to speaking up, whatever they are and wherever they are, are identified and addressed.

Initial work involved developing our Speaking Up Policy to reflect national policy, then highlighting the role and availability of the guardian, the advice available via the policy, and intranet resources to support this. A variety of opportunities were taken to communicate with staff – Team Brief, staff bulletin, and newsletter updates; attending staff meetings; inclusion in training programmes. There are a variety of ways that staff can speak up, which are highlighted in our policy, on our intranet and on posters distributed throughout the Trust:

- Line manager, lead clinician or tutor;
- Human Resources advisor or business partner;
- Risk Management, using our event reporting process or directly to the team;
- Staff Governors;
- Chaplaincy;
- Trade Union representatives;
- Executive and Non-executive Directors, including the Senior Independent Director with responsibility for whistleblowing;
- Freedom to Speak Up Guardian.

A key requirement is to ensure that staff who raise concerns about quality of care, patient safety or bullying and harassment within the trust do not suffer detriment as a result of speaking up. Whilst policies and processes make it clear that this is not acceptable, the culture at team and department level also needs to ensure that speaking up is welcomed and viewed as a positive opportunity to learn and improve. During 2018/19 we have focused on opportunities to understand the issues that concern staff, and have started work to promote a fair and just culture, with relevant work including:

- Staff listening events led by the Chief Executive to encourage staff who find it difficult to speak up to have their voices heard in a safe environment;

- Staff communications about the value of a fair and just culture; promoting speaking up, kindness and civility; and highlighting campaigns such as Tackling Bullying Call to Action; Civility saves lives; Royal College of Surgeons (Edinburgh) Anti-bullying and Undermining Campaign; Sign up to Safety;
- Development of Fairness Champions with defined roles and responsibilities to promote listening positively, an expectation of fairness, and who can signpost staff to other help and advice. We have appointed 34 Fairness Champions during the year, staff who have volunteered for this role;
- Triangulating intelligence from speaking up with other data relating to teams, to identify hot-spots of concerns, and enable focused work to improve the culture of speaking up, learning and improvement;
- A review of our conflict of interest policy and guidance for staff regarding loyalty conflicts;
- Work to start appointing a second independent Freedom to Speak up Guardian in line with good practice;
- Using the Quality Charter work to reward individuals and teams who live the Trust values and behaviours;
- Focusing on WRES data to understand and address underlying issues affecting BAME colleagues.

What are the results?

We have identified the key elements of a fair and just culture:

1. Fairness: people are treated fairly and equally, regardless of ethnicity, gender, disability or other personal characteristics;
2. Feeling safe about speaking up: speaking up about concerns, incidents, errors or poor behaviour is welcomed and seen not just as safe, but the right thing to do;
3. Kindness, respect and civility: behaviour which is at odds with our values is called out and challenged;
4. Trust and justice: high levels of trust between individuals even when under pressure.

Year / quarter	Summary data			
	Total number of cases	Number of cases raised anonymously	Number of cases with patient safety element	Number of cases with bullying and harassment element
2016/17 total	1	0	0	0
2017/18 total	8	0	1	5
Q1 2018/19	4	0	0	3
Q2 2018/19	11	0	2	8
Q3 2018/19	16	2	1	10
Q4 2018/19	8	1	0	2
2018/19 total	39	3	3	21

Table 45: Contacts made to the FTSU Guardian at HDFT 2016/17 to 2018/19

The data shows that the number of staff contacting the FTSU Guardian has significantly increased during 2018/19. This was an expected result of raising awareness but reflects underlying and sometimes longstanding staff concerns. Key findings include:

- Staff speaking up represent nursing, allied health professionals, support services and administration staff, and a range of levels from Band 2 to senior staff;
- Concerns have been raised by more than one member of staff from some teams;

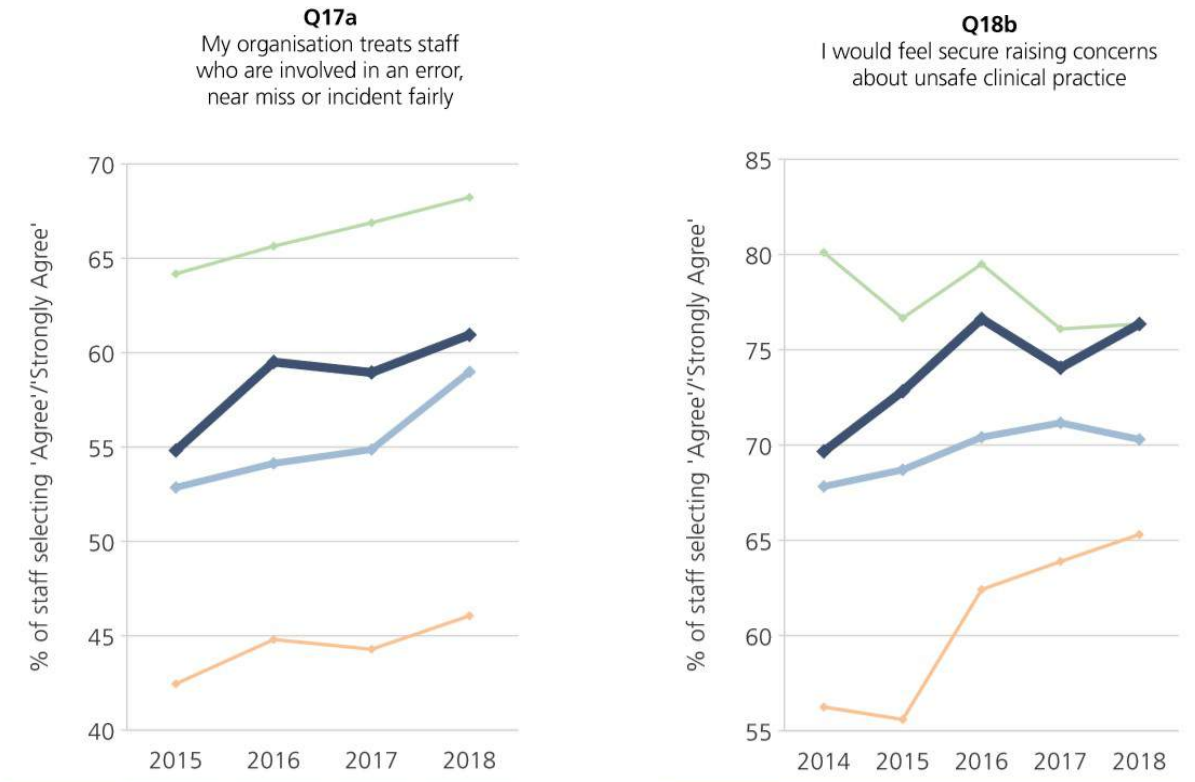
- Staff have been based in acute and community services; HDFT and Harrogate Integrated Facilities, the wholly-owned subsidiary company of HDFT;
- A small number of contacts are anonymous, with a significant proportion wanting their concern to be managed confidentially;
- Just over half the cases have an element of perceived bullying and harassment – either impacting on the member of staff raising the concern or on their colleagues;
- A small number of cases have had a direct element of concern about patient safety.

When a case is closed, the staff member is asked for feedback. This information is reported quarterly to the NGO, together with themes identified from the feedback question.

Year / quarter	Feedback questionnaire		
	No. of questionnaires received in quarter	No. responding 'yes' to "Given your experience, would you speak up again?"	No. indicating detriment as result of speaking up
Q1 2018/19	1	1	0
Q2 2018/19	1	1	1
Q3 2018/19	5	5	1*
Q4 2018/19	6	6	0
2018/19 total	13	13	2

* Not clear why. Feedback was anonymous so unable to find out more

Table 46: Responses to the feedback questionnaire to staff who have contacted the FTSU Guardian



	2015	2016	2017	2018
Best	64.2%	65.6%	66.9%	68.2%
Your org	54.8%	59.5%	59.0%	60.9%
Average	52.9%	54.1%	54.9%	59.0%
Worst	42.4%	44.8%	44.3%	46.1%

	2014	2015	2016	2017	2018
Best	80.1%	76.7%	79.5%	76.1%	76.4%
Your org	69.7%	72.8%	76.6%	74.1%	76.4%
Average	67.8%	68.7%	70.4%	71.2%	70.3%
Worst	56.2%	55.6%	62.4%	63.9%	65.3%

Figure 38: Benchmarked results from the national Staff Survey 2018

The 2018 staff survey shows some positive progress with the safety culture, particularly in relation to staff feeling secure about raising concerns about unsafe clinical practice.

Changing the culture of an organisation takes time but the Trust recognises that nurturing a fair and just culture is a critical success factor for achieving our vision of 'Excellence Every Time'. Having gathered and analysed data and information from a wide range of sources, a number of actions are being developed to further strengthen the fair and just culture within our teams, services and organisation.

4.13. NHS DOCTORS AND DENTISTS IN TRAINING ROTA GAPS

HDFT has a Trust establishment of 143 trainees and had 14 gaps within this establishment during 2018/19. As a Trust we were able to recruit into four of these gaps via successful recruitment campaigns undertaken by the Medical Workforce Team. Two gaps remained unfilled as the department were happy to continue without a trainee or a locum fixed-term fill. Five gaps were within GP surgeries as part of the GP training scheme and the Trust is not required to fill these vacancies. All the GP vacancies were due to maternity leave. Three still remain unfilled with continuous recruitment campaigns.

Department	Grade Establishment
Acute Medicine	ST3+
Acute Medicine	CT1/2 (ACCS)
Chemical Pathology	ST3+
Elderly Medicine	GP STS
Respiratory	ST3+
Anaesthetics	CT1/2/3 (ACCS)
Anaesthetics	ST2 (ACCS)
Obstetrics and Gynaecology	ST1/2
Dental	CT1/ 2
Crossley Street Surgery	GP STS
Eastgate Surgery	GP STS
Nidderdale Birstwith	GP STS
Nidderdale Dacre	GP STS
Boston Spa Surgery	GP STS

Table 47: Identification of gaps in the rota for each speciality

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 2018/19

NHS
Harrogate and Rural District
Clinical Commissioning Group

Email: j.crewe@nhs.net
Direct Tel: 01423 799334
Reference: HaRD.038-19

LETTER SENT VIA EMAIL

Andrew Forsyth
Interim Company Secretary
Harrogate and District NHS Foundation Trust

Harrogate and Rural District
Clinical Commissioning Group
1 Grimbald Crag Court
St James Business Park
Knaresborough
HG5 8QB

Tel: 01423 799300
Fax: 01423 799301
hardccg.enquiries@nhs.net
www.harrogateandruraldistrictccg.nhs.uk

25th April 2019

Dear Andrew

Quality Report for Harrogate and District NHS Foundation Trust for 2018-19.

Harrogate and Rural District Clinical Commissioning Group (HaRD CCG) welcomes the opportunity to review and provide a statement for the Trust's Quality Report for 2018/19. 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 HaRD CCG and their views have been collated into my response. The draft report did have gaps where information was awaited, therefore it has not been possible to comment on all apsects of the report e.g. maternity, medicines safety, complaints.

HaRD CCG 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, effective and caring services as referenced throughout the Quality Report. In addition we congratulate the Trust in consistently maintaining improvements which have most recently been evidenced through the CQC Inspection whereby the Trust received an overall rating of 'good' with all services inspected improving their ratings with all now being rated as 'good' or 'outstanding'.

The Quality Report clearly identfied the priorities for 2018/19 and the work undertaken to achieve these.

Highlights of continued improvement and development are noted as follows :

MINDFUL EMPLOYER

- Work undertaken to improve the safety culture. This is evident within the recent staff survey showing staff feel secure about raising concerns about unsafe clinical practice. Whilst incident reporting rates have been included, demonstrating an increase in the reporting of incidents which is positive, there is no detail currenttly within the report regarding any themes and actions arising from incident reporting.

- Continued improvements in the management of sepsis are clearly described. The dip in performance in sepsis screening is recognised in the Emergency Department as being due to the introduction of a different method and more robust method of audit, however key actions to improve are still required. Work to implement new screening in paediatrics is noted and the significant improvements in screening on Woodlands ward are commended.

- Significant work has been undertaken to improve the clinical model in acute services in recognition of the challenges being faced to ensure patients are cared for in the right place, and in order to make continued progress towards delivering against the standards for 7 day working. Due consideration of the wider workforce and the continued development of Advanced Care Practitioners is recognised as progressive. Ambitions for continued development in 2019/20 are clearly described.

- The revised Patient and Public Involvement strategy is noted and has been shared with the CCG in its development phase. The work of the Youth Forum to develop their strategy as the '7 Hopes for Healthcare' is to be commended. Representatives from the Youth Forum have in addition shared their work within the CCG at both our Governing Body and Patient Partner meetings. This will continue to influence healthcare for young people outside of acute care.

- The number of local and national audits being carried out in the Trust remains at a high level with summaries of key outcomes and learning identified for ongoing improvements where needed. Specific action and progress against actions where these directly relate to potential patient safety would be valuable to include.

- The collaboration between the Trust and other providers and commissioners, to develop a new model to deliver a robust hyper acute stroke service, ensuring the best possible outcomes for patients and local rehabilitation, is recognised as a significant achievement. Early evaluation of patient experience and outcomes would be welcomed.

- Examples of local audit outcomes are welcomed. Positively there have been significant improvements in administration of pain relief for patients with a fractured neck of femur, however whilst some improvements have been seen within pain assessment , overall performance requires further improvement.

- Work to improve the provision of suitable community beds for children is noted.

- The work of the Trust to be the most research active acute, non-academic affiliated, Trust in the region is testament to the Trust's continued drive to contribute to high quality research and improve patients outcomes. Whilst we recognise the overall value and improved outcomes for patients who are entered into clinical trials, it would be helpful to see examples whereby outcomes from research have also been put into clinical practice and quality improvements.

- Learning from deaths remains a clear priority with examples provided of how learning from reviews has been taken forward across the Trust. It would be helpful to know how many cases have been referred for a LeDeR review. Two deaths are reported as 'more than likely than not to have been due to problems in the care provided to the patient'. Could we clarify whether these were Serious Incidents whereby our understanding is that these deaths would have been avoidable. The description in the report may require amendment.

- We welcome the increased focus and improvements in the prevention of falls. Audits however, continue to show that a key component of falls prevention with the assessment for lying and standing blood pressure remains an area for improvement. The development of huddles in the prevention of falls is also noted, with evidence of how wards effectively using huddles have reduced their incidence of their falls. These wards are to be congratulated. We would like to see how these huddles can be implemented in all clinically appropriate wards as a priority.

- Continued improvements in the care of people with Learning Disabilities is evident, with a focus on improving both patient experience and significantly helping to reduce health inequalities for this patient group. The introduction of essential training in Learning Disabilities is noted and will no doubt continue to make a positive difference.

- We recognise the collaborative work with the voluntary sector, especially in cancer and end of life care, and the significant contribution volunteers make to the patient experience within the hospital. We note the work to continue to develop individualised care in the last days and hours of life in hospital. As was commented last year, we would like to have seen more examples of where there is similar work or development in community services.

- The work to support improved discharged is clearly described, with key contributions made at varying stages through to supported discharge, Discharge to Assess and improvements in the way Trinity Ward functions to focus upon rehabilitation goals and improve patient flow. These quality improvements were also significant contirbutors to the improved community CQC rating.

- The Trust continues to show a real commitment throughout this report to patient/service user involvement. The outcomes of National Patient Surveys all reflect positively as testament to the quality of care delivered.

- In addition to the priority upon direct patient care, the Trust has continued to focus upon listening to its staff and its aim to create a fair and just culture. The expansion and development of networks of 'Freedom to Speak Up Guardians' and CEO led staff listening events, alongside the promotion of qualities of kindness and civility between staff are thoroughly welcomed. These will no doubt be key enablers in the journey to embedding the culture desired, which in turn will have a further impact upon both staff and patient experience.

On page 27 entitled 'Use of the Commissioning for Quality and Innovation Framework' it is noted that HDFT income was not conditional upon achieving the the quality improvements. Whilst this is correct, we would expect to see how the agreed CQUINS were delivered and improvements made. We request that these are included within the final report.

The key successes of the 2018/19 quality priorities are clearly reflected in the Quality Report. We would ask the Trust to reconsider the limited reference to wider core services which contribute to the overall Trust services. There is significant emphasis upon acute hospital services (whilst these are recognised as the key areas of priority) with limited reference to other services i.e. community. The evidence of improvement in this area is 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 the report and hope that our feedback is accepted as a fair reflection of the report. We look forward to seeing the progress made over the coming year and working alongside the Trust to see and achieve progress on the 2019/20 priorities.

Yours sincerely

pp

Joanne Crewe
Director of Quality and Governance/Executive Nurse
Harrogate and Rural District Clinical Commissioning Group

LEEDS CLINICAL COMMISSIONING GROUP QUALITY ACCOUNT STATEMENT 2018/19

Thank you for providing the opportunity for NHS Leeds CCG to feedback on the Quality Account for Harrogate and District NHS Foundation Trust (2018/2019).

This report has been shared with key individuals within Leeds Clinical Commissioning Group (CCG) and this response is on behalf of the organisation.

We acknowledge final editing is to be made before publication. Given NHS Leeds CCG is not the lead commissioner, please accept our observations of your report on this basis and our comments are:

- We like how the majority of narrative started with a positions statement in effect, what the gaps were and how improvements were to be made to benefit the patient's experience of healthcare.
- We are encouraged to read the work implemented to support children transitioning from paediatric to adult services.
- The involvement of patients in research projects is refreshing and very welcome.
- We note the organisation is going to refresh its performance against indicators in the Single Oversight Framework as the data supplied does not meet the 4 hour wait target for Accident & Emergency.
- We wonder if the Quality Account needs to be specific about the level 1 e-learning training for staff around Learning Disabilities e.g. identifying those staff groups who require this level of training.
- It is suggested page 70 relating to Duty of Candour (DoC) is reviewed. The account states "Number where a decision has been made NOT to apply DoC for documented reasons (e.g. patient lacks capacity, no NoK details)". Even if a patient lacks capacity it would be good practice to inform the next of kin (if there is one). It maybe this paragraph just needs rewording.
- The Quality Account acknowledges the MacMillan Service is near saturation but has not captured what is going to be done to support capacity. A service reaching saturation may well be a significant factor when a patient/carer reflects back the experience of the service.

We welcome the opportunity to review the latest Quality Account, which throughout demonstrates a culture of respect for the service users, and we hope that these comments are a fair reflection.

Kind regards

#hello my name is...

Stuart Emsley

Quality Manager
NHS Leeds Clinical Commissioning Group

COUNCIL OF GOVERNORS QUALITY ACCOUNT STATEMENT 2018/19

I am pleased to comment on behalf of the Council of Governors on the Quality Report 2018/2019. This is a comprehensive and thorough over view of the quality of care delivered by the Trust and demonstrates the commitment to quality improvement in all services. The depth and breadth of the report is remarkable and it was a pleasure to read.

The Governors have once again been closely involved in and consulted on the development of quality priorities, have attended Quality Committee meetings and received feedback from the Patient Experience group and from a variety of other sources. Formal and informal meetings have taken place with the non-executive directors and other board members to seek assurance on quality and governance issues throughout the year.

In this Quality Report I am pleased to note particularly the results of the Care Quality Commission inspection which rated all services as good or better with five services rated as outstanding. This independent review reflects the hard work undertaken to continually aim for improvement and consistency in the quality of service delivery.

The Governors are also delighted that the Youth Forum is now playing a role in shaping service delivery and have actioned their idea of their ‘Hopes for Healthcare’ with an aim to set the vision for how the young people would like to see health services delivered. Involving young people, who represent a large group of service users, is a welcome innovation to the Trust’s quality agenda.

Also of note is the Quality Improvement Programme, encouraging members of staff at all levels across the organisation to identify projects for quality improvement and embed the quality improvement agenda throughout the whole staff group.

I could, of course, comment on many other aspects of the report which is a great testament to the work of this Trust. I am pleased to say that the Council of Governors supports and fully endorses the 2018/2109 Quality Report and commends its comprehensive overview of quality improvement and the identification of areas for future focus.

Emma Edgar

Interim Lead Governor on behalf of the Council of Governors.

May 2019

NORTH YORKSHIRE SCRUTINY OF HEALTH COMMITTEE

Over the past 12 months, the North Yorkshire Scrutiny of Health Committee has continued to work with the Harrogate and District NHS Foundation Trust to better understand the financial, workforce and clinical pressures within the local health system and the measures that have been put in place to respond to them.

The Scrutiny of Health Committee has scrutinised the changes to hyper acute stroke provision at Harrogate District Hospital, the proposed changes to mental health in-patient provision at the Harrogate District Hospital, and new ways of working across health and social care that are being developed to deliver services in a large, rural and sparsely populated county like North Yorkshire. As in previous years, the trust has been highly supportive of this scrutiny work, which has been much appreciated. I would particularly like to thank Dr Ros Tolcher, the outgoing Chief Executive, for her commitment to the work of the committee.

The NHS nationally, regionally and locally is undergoing a sustained period of change both planned and reactive. The Scrutiny of Health Committee is committed to maintaining a system-wide view of services that helps to ensure that individual responses to individual problems do not lead to variations in health care provision which mean that people are disadvantaged by where they live in the county.

Over the next year, the Scrutiny of Health Committee looks forward to working with commissioners and providers on the development of integrated and sustainable systems of care in rural areas that use the assets that are currently available in new ways.

County Councillor Jim Clark
Chairman, North Yorkshire Scrutiny of Health Committee
23 April 2019

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 2018/19 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 2018 to April 2019;
    - Papers relating to quality reported to the Board over the period April 2018 to April 2019;
    - Feedback from the commissioners dated 25 April 2019;
    - Feedback from Governors dated 3 May 2019;
    - Feedback from Healthwatch North Yorkshire was requested 8 April 2019 but no comment was received;
    - Feedback from North Yorkshire County Council Scrutiny of Health Committee dated 23 April 2019;
    - The Trust's draft complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 14 May 2019;
    - The 2017 national patient survey dated 13 June 2018;
    - The 2018 national staff survey dated 28 February 2019;
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 16 May 2019;
    - CQC inspection report dated 14 March 2019.

- the quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with NHS improvements annual reporting manual and supporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board on 24 May 2019.

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Mrs Angela Schofield
Chairman

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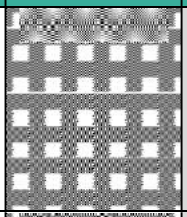
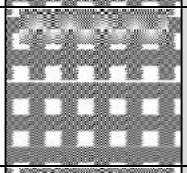
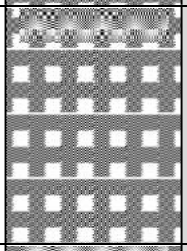
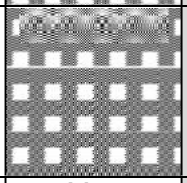
Steve Russell
Chief Executive

7. ANNEX THREE: NATIONAL CLINICAL AUDITS 2018/19

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2018/19	Data submitted as a percentage of the number of registered cases required for that audit
1	Acute Myocardial Ischaemia National Audit Project (MINAP)	Yes	247	100%
2	Adult Community Acquired Pneumonia	No	Did not participate	Did not participate
3	BAUS Urology Audits: Female stress urinary incontinence **Data for 2018 prepared but not yet submitted*	No	0	0%
4	Bowel Cancer (NBOCA) **period used is diagnosis date between 1st April 2017-31st March 2018. 2018/19 data not available until 31st March 2020.*	Yes	135*	100%** ***expected no. of cases 124 so actually 109% compliance.*
5	Cardiac Rhythm Management (CRM)	Yes	149	100%
6	Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC)	No	489	100%
7	Child Health Clinical Outcome Review Programme	Yes		
	(i) Young People's Mental Health		0 *No patients selected for inclusion*	
	(ii) Cancer in Children, Teens and Young Adults		0 *No qualifying cases*	N/A
	(iii) Long term ventilation in Children and Adults		0 *No patients selected for inclusion*	N/A
8	Diabetes (Paediatric) (NPDA)	Yes	333	100%
9	Elective Surgery National PROMS programme (2017/18)	No		
	Hip replacement		399 (pre-op) 278 (post-op)	120.9% 69.7%
	Knee replacement		466 (pre-op)	109.9%

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2018/19	Data submitted as a percentage of the number of registered cases required for that audit
			365 (post-op)	78.5%
	Groin hernia (April-Sep 2017)		134 (pre-op) 89 (post-op)	94.4% 66.4%
	Varicose vein (April-Sep 2017)		0	N/A
	NB: collection of PROMs data for varicose vein and groin hernia procedures ceased on 1 October 2017 following national consultation.			
10	Falls and Fragility Fractures Audit Programme (FFFAP)	Yes		
	(i) National Audit of Inpatient Falls		2	100%
	(ii) National Hip Fracture Database **Data collection period Jan – Dec 2018*		257*	100%
11	Feverish Children (care in emergency departments) - CEM	No	147	100%
12	Inflammatory Bowel Disease (IBD) programme **Refers to data updated in 2018 – 2019 for all patients on biologics - accumulative database*	No	77*	100%
13	Learning Disability Mortality Review Programme (LeDeR) **4 patients notified by HDFT LD Liaison Nurse, 1 patient notified by Community LD Nurse (TEWV)*	Yes	5*	100%
14	Major Trauma: The Trauma Audit and Research Network (TARN)	No	17	100%
15	Mandatory surveillance of bloodstream infections and clostridium difficile infection	No	263	*Unknown*
16	Maternal, New-born and Infant Clinical Outcome review Programme (MBRRACE-UK)	Yes	17	100%
17	Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes		
	(i) Acute Heart Failure		5	100%
	(ii) Perioperative Diabetes		4	100%

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2018/19	Data submitted as a percentage of the number of registered cases required for that audit
	(iii) Pulmonary Embolism		6	100%
	(iv) Acute Bowel Obstruction		2	100%
18	National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	59	100%
19	National Audit of Dementia (Delirium Spotlight Audit)	Yes	50	100%
20	National Audit of Intermediate Care (NAIC)	No	38	100%
21	National Audit of Rheumatoid and Early Inflammatory Arthritis	Yes	86	76%
22	National Audit of Seizures and Epilepsies in Children and Young People **To date only one first paediatric assessment form has been completed and locked for cohort 1.*	Yes	11	9%*
23	National Cardiac Arrest Audit (NCAA)	No	29	100%
24	National Asthma and COPD Audit Programme (NACAP)	Yes		
	(i) Secondary Care		425	NACAP case ascertainment:75% HDFT case ascertainment (*153 exclusions*):100%
	(ii) Adult Asthma		46	100%
	(iii) Pulmonary Rehabilitation		2	100%
25	National Comparative Audit of Blood Transfusion Programme	No		
	(i) Use of Fresh Frozen Plasma Cryoprecipitate and other Blood Components in Neonates and Children		Did not participate due to negligible levels of transfusion	
	(ii) Major Haemorrhage 2018 ** No patients had haemorrhages between 1st-31st October 2018*		0*	100%
26	National Diabetes Audit (Adults)	Yes		

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2018/19	Data submitted as a percentage of the number of registered cases required for that audit
	(i) National Footcare Audit *Refers to all new records submitted between 01/04/2018 and 14/03/2019*		593	100%
	(ii) National Inpatient Audit (NADIA) *Asked to submit inpatient harms to the National Audit Team*		5	100%
	(iii) National Pregnancy in Diabetes Audit *Refers to all new records submitted between 01/04/2018 and 14/03/2019*		17	100%
	(iv) Secondary Care Audit *Audit period 1 January 2017 to 31 March 2018*		1072	Not stated
27	National Emergency Laparotomy Audit (NELA)	Yes	44	86%
28	National Audit of Care at the End of Life (NACEL)	Yes	32	100%
29	National Heart Failure Audit	Yes	265	100%
30	National Joint Registry (NJR)	Yes	1077	100%
31	National Lung Cancer Audit (NLCA)	Yes	139	100%
32	National Maternity and Perinatal Audit	Yes	1686	100%
33	National Neonatal Audit Programme (NNAP - intensive and special care)	Yes	134	100%
34	National Ophthalmology Audit *Sept 2017-Aug 2018* *2018-19 report due August 2019*	Yes	1150	100%
35	Non-Invasive Ventilation – Adults	No	13	100%

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2018/19	Data submitted as a percentage of the number of registered cases required for that audit
36	Oesophago-gastric cancer (NAOGC) **Period used is diagnosis date between 1st April 2017-31st March 2018*	Yes	43*	100%
37	Prostate Cancer Audit	Yes	194	100%
38	Reducing the impact of serious infections (antimicrobial resistance and sepsis): Antibiotic Consumption	No	All required data submitted to PHE	100%
39	Reducing the impact of serious infections (antimicrobial resistance and sepsis): Antibiotic stewardship **Q3-Q4 data collection currently ongoing. Data collection is 3 months in arrears. Will be 100% once data collection completed*	No	75*	63%
40	Sentinel Stroke National Audit Programme (SSNAP)	Yes	287	100%
41	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	No	9 SHOT reports 5 SABRE reports	100%
42	Seven Day Hospital Services	No		
	(i) Spring 2018		128 *(2 records unavailable for audit)*	98%
	(ii) Autumn 2018		100 (Locally determined)	100%
43	Surgical site infection surveillance service	No	117	100%
44	Vital signs in Adults (care in emergency departments) - CEM	No	114	97%
45	VTE risk in lower limb immobilisation (care in emergency department) - CEM	No	136	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 2018/19	Data submitted as a percentage of the number of registered cases required for that audit
Breast and Cosmetic Implant Registry	43*	100%
National Audit of Cardiac Rehabilitation	205	100%

**17 further patients will be included once consent has been sought.*

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)

The following ten 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
- UK Cystic Fibrosis Registry
- National Audit of Percutaneous Coronary Interventions (PCI)
- National Audit of Pulmonary Hypertension
- National Bariatric Surgery Registry (NBSR)
- Neurosurgical National Audit Programme
- Prescribing Observatory for Mental Health (POMH-UK) (all work streams)

8. ANNEX FOUR: GLOSSARY

ACP	Advanced Care Practitioner
AMU	Acute Medical Unit
BAME	Black and minority ethnic
BSL	British sign language
CAT	Clinical Assessment Team – changed to Combined Assessment Team (December 2018)
CATT	Clinical Assessment, Triage and Treatment
CCG	Clinical Commissioning Group
CEM	Royal College of Emergency Medicine
CHC	Continuing Healthcare
CNS	Clinical Nurse Specialist
COPD	Chronic obstructive pulmonary disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CTG	Cardiotocography
CVI	Certificate of visual impairment
Dashboard	Data visualisation tool that displays the current status of metrics and key performance indicators
ED	Emergency Department
EoL	End of life
EPaCCS	Electronic palliative care co-ordination system
ePMA	Electronic prescribing and medicines administration system
FFT	Friends and Family Test
GP	General practitioner
HaRD	Harrogate and Rural District
HDFT	Harrogate and District NHS Foundation Trust
ICE	Requesting and reporting software
ICNARC	Intensive care national audit and research centre
LD	Learning disabilities
MAU	Medical Admissions Unit
MCA	Mental Capacity Act
MDT	Multidisciplinary team
NCAPOP	National Clinical Audit and Patient Outcome Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
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
RTT	Referral to treatment
SAU	Surgical Assessment Unit
SJR	Structured judgement review
SSNAP	Sentinel Stroke National Audit Programme
VTE	Venous thromboembolism
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole time equivalent

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 the 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 hello@hdft.nhs.uk.

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