Harrogate and District NHS Foundation Trust's

Quality Account 2017/18

You matter most

Contents

1. STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

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

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

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

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

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

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

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

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

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

Dr Ros Tolcher (Chief Executive) Date: 23 May 2018

2. PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE

2.1. PRIORITIES FOR IMPROVEMENT 2018/19

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Improve learning from incidents, complaints and good practice

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

What were we aiming to achieve?

Two of the key metrics we wanted to improve are:

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

What have we done?

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

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

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

#chattermatters

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

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

What are the results?

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

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

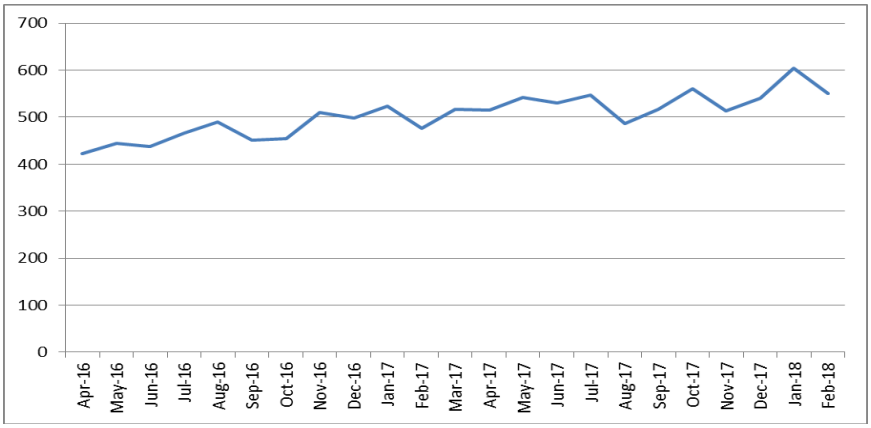

Figure 1: Incidents reported per month April 2016 - February 2018

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

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

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

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

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

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

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

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

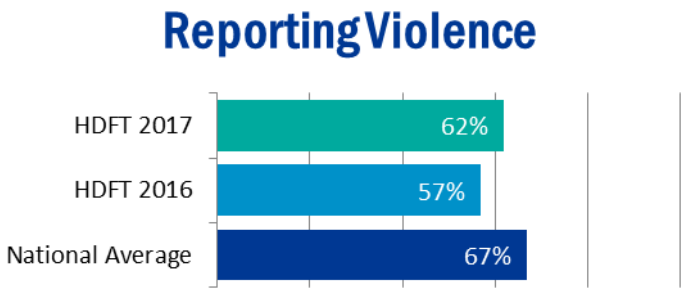

Figure 3: NHS Staff Survey 2017 results: staff reporting violence

Summary

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

2. Improve the patient experience of discharge processes

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

What were we aiming to achieve?

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

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

What have we done?

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

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

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

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

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

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

What are the results?

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

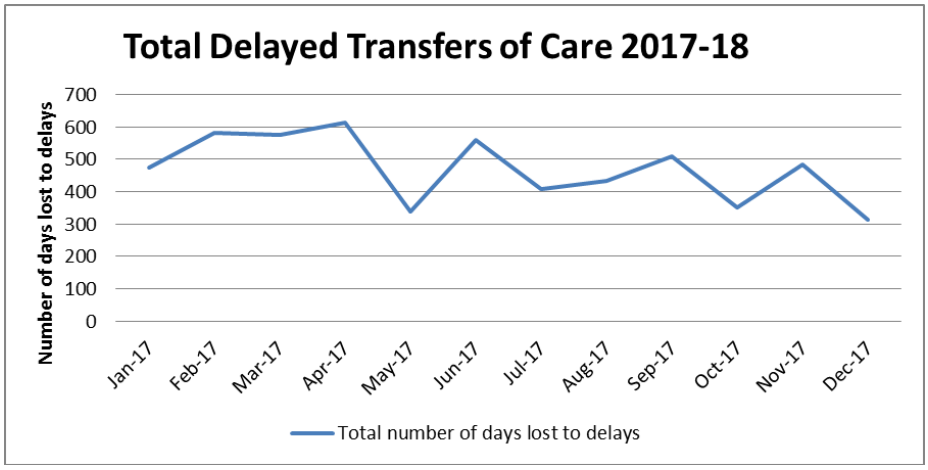

Figure 4: Delayed transfers of care 2017-18

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

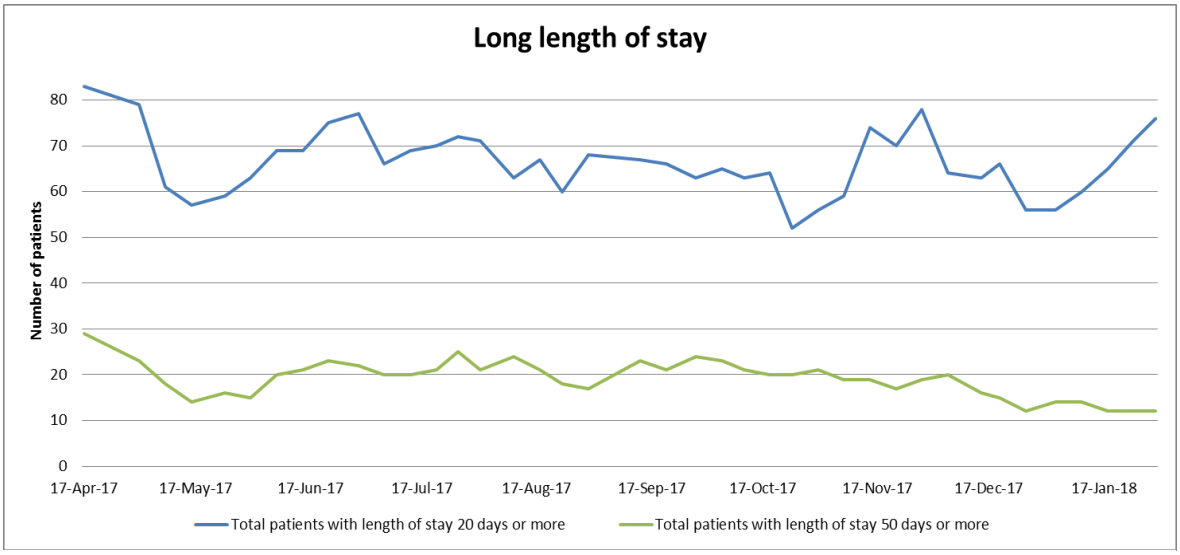

Figure 5: Long lengths of stay 2017-18

Summary

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

3. Reduce the morbidity and mortality related to sepsis

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

What were we aiming to achieve?

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

What have we done?

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

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

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

What are the results?

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

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

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

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

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

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

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

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

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

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

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

Summary

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

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

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

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

What were we aiming to achieve?

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

What have we done?

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

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

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

What are the results?

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

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

Table 6: SSNAP data 2014-2017

Summary

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

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

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

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

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

What are we aiming to achieve?

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

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

What have we done and what are the results?

Promotion of the Youth Forum

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

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

Figure 6: Members of HDFT Youth Forum

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Youth Forum

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

<u>Promote the inclusion of the voice of children, young people and families</u>

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

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

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

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

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

Summary

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

2.3. STATEMENTS OF ASSURANCE FROM THE BOARD

1. Provision of relevant health services and income

During 2017/18 HDFT provided and/or sub-contracted 61 relevant health services.

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

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

2. National and local audits

National audits

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

During that period HDFT participated in 97% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

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

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

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

National audits:

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

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

Clinical Outcome Review Programmes:

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

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

Child health clinical outcome review programme:

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

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

National audits:

1. Acute coronary syndrome or Acute myocardial infarction (MINAP)
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Clinical Outcome Review Programmes

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

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

Child health clinical outcome review programme:

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

The national clinical audits and national confidential enquiries that HDFT participated in, and for which data collection was completed during 2017/18 are listed at Annex 3, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of 16 of the national clinical audits and one of the NCEPOD reports were reviewed during 2017/18, and HDFT intends to take the following actions to improve the quality of healthcare provided.

National Maternity and Perinatal Audit

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

National Diabetes Foot Care Audit

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

College of Emergency Medicine – Asthma

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

College of Emergency Medicine – Consultant Sign off

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

NCEPOD Treat as One

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

Presentation to hospital

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

Liaison psychiatry review

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

Supporting care issues

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

Ongoing patient care

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

Training

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

Local Audits

During 2017/18 a joint audit programme between the Clinical Effectiveness Department and Internal Audit was in place, as per previous years, which focused on the high priority areas for the Trust in order to provide assurance through the governance structure. This ensured there was no duplication of work and that resources were used more efficiently. Joint audit planning has been undertaken again in preparation for 2018/19.

151 projects (excluding national audits) were registered with the Clinical Effectiveness Department during 2017/18. This includes projects aimed at improving quality by using service evaluation and patient experience surveys. Some of these were for completion during the financial year and some had extended timescales which will remain open into 2018/19.

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

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

Confirmation of nasogastric tube position

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

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

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

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

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

Swallowing recommendations audit

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

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

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

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

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

Neutropenic sepsis (re-audit)

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

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

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

*Audit was undertaken in 2017 using 2016 data

Table7: Neutropenic sepsis audit data.

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

Carbon monoxide monitoring in pregnancy (re-audit)

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

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

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

Table 8: Carbon monoxide monitoring in pregnancy audit data

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

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

Community Podiatry clinic audits

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

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

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

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

Enhanced recovery audit and re-audit

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

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

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

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

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

C. difficile booklet and card patient surveys

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

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

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

3. Participation in Clinical Research

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

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

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

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

Research and Development: Quality assurance

<u>Training and education</u>

Core competencies have been and continue to be identified for all staff and these are adapted to align with specialist areas. A process is in place to ensure 'Good Clinical Practice' training is up to date for all staff involved in research. The Trust has implemented induction packages for research posts which involve new members of staff spending time in each clinical area, the Research and Development (R&D) office and in support departments. Student practitioner placements are encouraged and facilitated by student mentors. Quality and compliance systems have been reviewed and a new suite of standard operating procedures was launched in March 2018.

<u>Matching research to national prerogatives and working with partners to ensure high quality studies are conducted</u>

The national and local agenda is to promote more community based healthcare with particular emphasis on the facilitation of patient self-management for long term conditions. The Trust encourages and aims to identify research projects that are exploring integrated care pathways and will provide intelligence and expertise for the Trust as well as delivering evidence based practice. The NIHR funds health and social care research recognising that these service delivery platforms are inextricably linked. HDFT appreciate the benefits to be achieved if the services work co-operatively.

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

We have used our links with academic partners to explore focused development of our workforce and to ensure we attract high quality studies to the Trust. Current partners include Bradford Institute for Health Research and University of York (reproductive health and healthcare delivery); Centre of Evidence-based Dermatology; Centre of Immunology and Infection; Clinical Trials Units in York, Leeds and Sheffield. NIHR supported studies have been conducted within the Trust over the last year as a result of these collaborative working arrangements thus enabling our patients to have access to high quality research.

The Trust is an active member of the Academic Health Science Network which brings together organisations in Yorkshire and Humber which have an interest in the health and wealth of the region. The area has a history of organisational collaboration including the academic White Rose Consortium, Leeds University, Bradford Teaching Hospitals, Local Education and Training Boards (LETB), Collaboration for Leadership in Applied Health Research and Care (CLAHRC) and Hull and York Medical School. HDFT also actively works in partnership with Medipex Ltd for the development, protection and exploitation of Trust generated intellectual property.

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

Research governance and performance

R&D Unit staff conduct pragmatic research governance via a suite of usable standard operating procedures for research which have recently been reviewed and substantially rewritten. Activity is overseen monthly by a multidisciplinary R&D Group, chaired by the Trust's Medical Director. Performance is monitored and managed locally within the Trust; additionally performance against the high level objectives is managed by the Clinical Research Network at a regional and national level. Research metrics have been shared with Trust Board within the report from the Chief Operating Officer. An annual presentation is also delivered to the Board.

Monitoring, measuring service quality and sharing the impact of research

HDFT has four Patient Research Ambassadors (PRA), bringing a patient perspective to research delivery. PRAs are involved in project feasibility assessment, quality assurance via

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

4. Use of the Commissioning for Quality and Innovation Framework

A proportion of HDFT income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between HDFT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at: https://www.hdft.nhs.uk/about/trust/statutory-info/

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

5. Registration with the Care Quality Commission

HDFT is required to register with the Care Quality Commission and its current registration status is unconditional. HDFT has no conditions on registration. HDFT had the following sites registered during 2017/18:

Harrogate District Hospital
Lascelles Unit
Ripon Community Hospital

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

6. Information on the Quality of Data

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

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

The percentage of records in the published data:

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

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

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

7. Information Governance

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

8. Payment by Results

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

The Trust however commissioned an external clinical coding audit to meet Information Governance requirements during 2017/18. The audit was carried out in March 2018 by nationally registered clinical coding auditors from D & A Clinical Coding Consultancy Limited. An audit sample of 200 episodes was reviewed, 75 episodes from Trauma & Orthopaedics, 75 episodes from Elderly Care and 50 episodes from Urology were randomly selected from across the whole range of activity for the period July – September 2017. The results showed an overall error rate of coding errors affecting the healthcare resource group (HRG) of 1.52% compared to the latest published national average error rate of around 7%. This result should not be extrapolated further than the actual sample audited. The error rates reported for diagnoses and treatment coding (clinical coding) in the audit sample were:

Primary procedures	5.5%
Secondary procedures	6.1%
Primary diagnoses	4.7%
Secondary diagnoses	3.9%

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

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

9. Learning from Deaths

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

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

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

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

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

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

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

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

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

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

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

Summary of learning points identified

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

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

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

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

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

Actions

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

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

The impact has been:

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

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

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

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

2.4. REPORTING AGAINST CORE INDICATORS

Set out in the tables below are the quality indicators that Trusts are required to report in their Quality Accounts this year. The data given in this section, unless otherwise stated, has been taken from the data made available to the Trust by NHS Digital.

1. Preventing people from dying prematurely and enhancing quality of life for people with long-term conditions

Summary Hospital Mortality Index (SHMI)

This measure looks at deaths in hospital or within 30 days of discharge and is standardised to allow for variations in the patient mix in different hospitals. NHS Digital publish a value for each Trust every quarter. The national score is set at 1.000 – a Trust score significantly above 1.000 indicates higher than expected death rates, whereas a score significantly below 1.000 indicates lower than expected death rates.

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

Table 9: Summary Hospital Level Mortality Index

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

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

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

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

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

Palliative care coding

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

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

Table 10: Summary Hospital Level Mortality Index

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

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

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

However:

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

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

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

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

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

PROMs – Patient Reported Outcome Measures

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

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

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

Table 11: PROMS – Hip replacement surgery

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

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

Table 12: PROMS – Knee replacement surgery

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

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

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

- We have participated in the PROMs scheme since inception, routinely analysing and reviewing the results;
- HDFT is not a vascular surgery centre and this is reflected in the data suppression for varicose vein surgery due to small numbers;

- The data is formed from pre- and post-operative patient surveys and therefore reflects their perception of the improvement in their health following surgery;
- An analysis of the data shows that HDFT has a pre-operative score above the England average for the elements it participates in, which might indicate that patients who rate their pre-op health highly have a reduced chance of a health gain. Patient perception is a useful but subjective measure of performance;
- The Trust considers the scores indicate it is not an outlier from the national position.

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

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

Emergency readmissions to hospital within 28 days

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

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

Age 0-15

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

Table 13: Emergency readmission to hospital within 28 days (age 0-15)

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

Age 16+

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

Table 14: Emergency readmission to hospital within 28 days (age 16+)

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

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

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

- The source data used is taken from the Secondary Uses Service dataset; this is a national system and data quality indicators linked to this system indicate an excellent compliance rate.

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

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

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

Emergency readmissions within 30 days

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

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

Table 15: Emergency readmissions within 30 days

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

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

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

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

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

3. Ensuring that people have a positive experience of care

Inpatient survey – responsiveness to inpatients' personal needs

This measure is the average weighted score of five questions from the national inpatient survey relating to responsiveness to inpatients' personal needs. The scores are an average weighted score of five questions relating to responsiveness to inpatients' personal needs, presented out of 100 with a high score indicating good performance.

	Data period		
	2014	2015	2016
HDFT value	72.6	73.3	72.4
National average	68.9	69.6	68.1
Highest value for any acute Trust	86.1	86.2	85.2
Lowest value for any acute Trust	59.1	58.9	60.0

Table 16: Inpatient survey results 2014, 2015, 2016 (Combined scores for 2017 due to be published by NHS Digital in August 2018.)

Data source: NHS Digital, NHS Outcomes Framework indicator 4.2
Ind ref: P01779
https://digital.nhs.uk/data-and-information

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

- Driving improvement for the delivery of high quality fundamental care continues to be a major priority for the Trust. We have had wide engagement from hospital based nursing staff who have led the implementation and monitoring of rigorous standards of fundamental care, for example in the areas of communication, nutrition, prevention of falls and pressure ulcers and infection prevention and control; We have also reviewed our inpatient nursing admission documentation including relevant risk assessments.
- These standards are monitored through a governance system which includes daily safety assurance checks by matrons, extended senior nurse presence in the evenings and at weekends, unannounced director led inspections, patient safety visits and local quality of care teams;
- A well-established system of seeking objective feedback via external bodies and groups including the Trust's Patient Voice Group, governors and lay representatives is in place.

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

- Focussing resources on addressing those indicators which, following analysis of the 2016 result, identified areas which are both in need of improvement and are most important to patients and have the biggest impact on overall experience, including:

    - Asked to give your views on the quality of your care (Q75)
    - How clean were the toilets and bathrooms that you used in hospital? (Q18)

- Did you find someone on the hospital staff to talk to about your worries and fears? (Q38)
- Information given about condition or treatment (Q37).
- Did you know which nurse was in charge of looking after you? (Q32)
- Call button response times (Q44)
- Length of time on the waiting list before admission to hospital (Q6)
- Operation/procedure risks and benefits explained in a way you could understand (Q46)
- Discharge delays on the day Q57 and discharge advice information (Q66)

National Staff Survey – Standard of Care Provided

Staff who would recommend the trust to their family or friends as a place to be treated Question 12d

Proportion of staff who responded "strongly agree" or "agree".	Data period		
	2015	2016	2017
HDFT value	78	80	76
National average	68	69	69
Highest value for any acute Trust	93	91	89
Lowest value for any acute Trust	46	48	48

Table 17: National staff survey results

Benchmark data for 2017 includes both "acute trusts" and "combined acute and community trusts"
Data source: http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2016/

The data shows the proportion of staff completing the NHS Staff Survey who responded “strongly agree” or “agree” to the question “If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation” compared to the total number of staff that responded to the question. The scores are presented out of 100 with a high score indicating good performance. Whilst there has been a slight decrease in our score since 2016, the highest performing Trusts have also seen a decrease year on year. Our score remains higher than the national average for Trusts within our benchmarked group.

This question forms part of key finding 1: Staff recommendation of the Trust as a place to work and/or receive treatment, in the National Staff Survey for 2017. The Trust achieved a ranking of 6th out of 39 when compared with all acute and community Trusts for this key finding. The full report can be found at http://www.nhsstaffsurveys.com/ and there is further detail in section 3.5 of this report.

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

- The Trust has continued to focus on our values which hold patient care at the heart of everything we do;
- The Trust has embedded its Quality Charter which is built on the goals of setting our ambition for quality and safety, promoting staff engagement, providing assurance on care quality and supporting a positive culture. This allows staff to help suggest and deliver improvements to the services we provide as well as sharing best practice. We also held our first ever Quality Conference in June 2017, where staff shared their ideas and learned about other initiatives to support the effective delivery of patient care;
- The Trust continues to research and implement health and wellbeing programmes for staff; examples of which include showcasing our ‘emotional and mental health’ offer to staff, which includes a programme of Schwartz Rounds (which allows staff to share

their experiences of providing healthcare); and development of business cases to deliver innovative personal resilience training and a fast-track physiotherapy model for staff to improve their own wellbeing;
- The Trust has launched the Clinical Workforce Strategy, through which we are creating and developing new roles within the Trust to support the delivery of a sustainable workforce for the future;
- The Trust is continuing our proactive recruitment strategy including embracing social media with targeted recruitment for specific work areas or staff groups, and recruitment days for nurses.

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

- Holding an RPIW in November 2017 to review the tools and systems for reporting near misses, low harm and more serious incidents. A new form is being piloted to support the development of a new reporting model, focused on learning;
- Reviewing the establishment and skill mix on the acute inpatient wards and implementing this in July 2017 to support the safe delivery of patient care;
- Promoting the role of the Freedom to Speak Up Guardian within the Trust and implementing the new Speaking Up Policy;
- Using the Calderdale Framework to review clinical roles and implement new roles on inpatient wards;
- Implementing values-based recruitment for staff and an assessment process for the recruitment of care support workers to increase retention;
- Approving a business case for the second cohort of advanced care practitioners; the first cohort are now in post;
- Implementing a theatre staffing strategy to train and retain operating department practitioners;
- Reviewing incidents reported through risk management processes to ensure that these are investigated and appropriate action is taken;
- Piloting a Quality Team Charter within the Intensive Care Unit and the Resuscitation Team; this aligns to our Quality Charter;
- Implementing an appraisal on a page and an appraisal window to support to achievement of annual appraisals for all staff.

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

Venous thromboembolism (VTE) risk assessment

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

	Data period			
	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18
HDFT value	96.7	96.0	96.2	95.3
National average	95.7	95.1	95.2	95.2
Highest value for any acute Trust	100.0	100.0	100.0	100.0
Lowest value for any acute Trust	80.6	51.4	71.9	76.1

Table 18: Percentage of eligible patients risk assessed for VTE

Note - national values exclude independent providers.
Data source: https://improvement.nhs.uk/resources/vte/
Q4 2016/17 data reported in the absence of Q4 2017/18 data (to be published early Jun-18).

HDFT's published scores are consistently above the national average.

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

- There is a well-established protocol for VTE risk assessment on admission;
- Data is recorded onto the Trust's main patient administrative system, iCS, and collected via reliable IT systems;
- Education on VTE risk assessment is part of the Trust's essential training so staff understand the importance of it.

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

- Continuing to identify wards with poorer performance and examining whether there are issues with completion of the risk assessment or inputting of information onto iCS;
- Exploring the option of electronic VTE risk assessment with the roll out of Web-V across the Trust.

Clostridium difficile rates

The table shows the number of cases of *C. difficile* infection (CDI) per 100,000 bed days reported from hospital inpatients aged two years or over.

	Data period		
	2014/15	2015/16	2016/17
HDFT value	9	33.8	28.4
National average	15.0	14.9	13.2
Highest value for any acute Trust	62.2	66.0	82.7
Lowest value for any acute Trust	0	0	0

Table 19: Number of cases (rate) of CDI per 100,000 bed days (2017/18 data due for publication July 2018)

Data source: https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data (Table 8b is used)

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

- The number of Trust-apportioned *C. difficile* apparently increased dramatically in 2015/2016 compared with previous years. We felt that this was most likely to have represented an under-ascertainment in previous years, although it was difficult to gauge the extent of this over a genuine increase in numbers;
- In August 2015 HDFT changed its stool sampling policy to lower the threshold of "looseness" for sending stool samples for *C. difficile* investigation;
- In August 2015 the laboratory changed its testing policy to test all stools that were submitted as "loose" (i.e. including Bristol Stool Types 5 and 6) rather than only testing stools that were liquid on receipt;
- Following these changes the number of stool samples received and tested for *C. difficile* increased by 32.6% and 59.4% respectively compared with the corresponding months in 2014/2015;
- There was no suggestion or evidence of a community-wide outbreak of CDI and minimal evidence of in-hospital transmission;
- During 2016/17 we:
    - Reviewed the prescribing of antimicrobials. Overall, the use of antimicrobials at HDFT is now below the regional and national average;
    - Reviewed our cleaning and decontamination strategy. We have:
        - Reappraised the role of the ward hygienists and clarified what they do;
        - Renewed our aging Bioquell HPV machines with two new ones from Hygiene Solutions;
        - Delivered an enhanced cleaning programme to Trinity ward and Lascelles, particularly concerning cleaning of commodes;
    - Developed whole day educational "Masterclasses" for nursing staff;
- Our data shows that the number of CDI cases has fallen from 29 in 2016/2017 to seven in 2017/18, with only one case agreed with the CCG to be as a result of a lapse in care, compared with twelve cases in 2016/2017.

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

- Continuing to review the prescribing of antimicrobials, particularly of the "4 C" antibiotics, namely the cephalosporins, clindamycin, the quinolones and co-amoxiclav;
- Continuing to review our cleaning and decontamination strategy, as the evidence for the role of the environment in the transmission of healthcare associated infection (HCAI) including CDI is now overwhelming;
- Continuing to provide the whole day educational "Masterclasses" for nursing staff, which includes a module on *C. difficile* and the role of the nurse. We believe that our educational drive may be partly responsible for the reduction in the number of lapses in care.

<u>Patient safety incidents</u>

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

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

- The number and percentage of reported incidents that resulted in the death of a patient. A low score is good.

HDFT's latest published scores are below.

	Oct 16 - Mar 17			Apr 17 - Sep 17		
	Rate of incidents reported (per 1,000 bed days)	Incidents that resulted in severe harm or death		Rate of incidents reported (per 1,000 bed days)	Incidents that resulted in severe harm or death	
		Number	Rate (per 1,000 bed days)		Number	Rate (per 1,000 bed days)
HDFT value	46.42	4	0.076	48.56	4	0.080
National position (all acute trusts)	40.52	2623	0.153	42.23	2482	0.149
Highest value for any acute Trust	68.97	92	0.532	111.69	121	0.636
Lowest value for any acute Trust	23.13	1	0.008	23.47	0	0.000

Table 20: Patient safety incidents reported to the NRLS

Data source: https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports

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

- The data relating to patient safety incidents is reported by front line staff;
- There is a robust policy and process within the Trust to ensure that all incidents are identified, managed, reported and investigated in accordance with national guidance;
- The Trust ensures that there are appropriate measures in place to prevent recurrence and also promotes organisational learning;
- All of the severe harm incidents reported were robustly investigated in line with the Trust's policy and processes and actions to address the findings have been put in place.

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

- Continuing to promote patient safety as a key objective across the organisation and implementing a number of mechanisms to ensure compliance with, and delivery of national frameworks;
- Implementing improvements in line with the quality priority focussing on the learning from incidents and complaints, including changes to the web based incident reporting system (Datix);
- Ensuring there is a continued focus on quality at an organisational, directorate and front line level through a variety of structures, for example quality of care teams, quality governance groups at corporate and directorate level, patient safety visits, quarterly monitoring reports, case conferences and learning events.

3. REVIEW OF OTHER QUALITY PERFORMANCE

This section provides an overview of the quality of care offered by HDFT based on performance in 2017/18 against indicators selected by the Board of Directors in consultation with stakeholders, including three priorities for the three elements of quality covering patient safety, patient experience and effective care.

3.1. PATIENT SAFETY

1. Medicines Safety

Medicines play an integral role in the management of disease. They are pivotal to achieving good patient outcomes but there is room for improvement in the way patients take their medicines. 30-50% of patients do not take their medicines as intended by the prescriber. 30% of patients state they do not receive appropriate information about their medicines. 8-10% of hospital admissions are associated with a medicine related event. The NHS wastes £300-£400 million per annum on unused medicines (50% of which is deemed avoidable) and around 200,000 medicines incidents are reported to the NHS England Patient Safety Division through the National Reporting and Learning System (NRLS). The greater the number of medicines a patient takes the greater their risk of suffering an adverse event. 98% of patients admitted to hospital take one or more medicines, with 95% taking four or more.

HDFT administers over 2 million medicines doses per annum and dispenses around 150,000 medicine packs (items) per year, and over recent years has been working to use medicines more safely and effectively. This work is supported by a multi-professional, multi-agency national medicines optimisation work programme and a Board approved Hospital Pharmacy Transformation Plan.

What were we aiming to achieve?

The aim of our medicines safety work in 2017/18 was to consolidate improvements made in previous years and seek to further improve patient safety by reducing errors in prescribing, dispensing and administration of medicines, and also to improve the information given to patients about their medicines. We also commenced implementation of the Hospital Pharmacy Transformation as part of the Lord Carter review of Hospital Pharmacy and Medicines Administration. Specifically we intended to:

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

What have we done?

We have embarked on a wide ranging programme to use medicines safely and effectively by:

- Implementing actions as identified in the Board approved Hospital Pharmacy Transformation plan;
- Completing the roll out of the ePMA system across the whole organisation and commencing the complex infusions project;
- Embedding the use of dashboards using ePMA to target patients on high risk medicines especially insulin, identifying patients whose allergy status is not completed and developing protocols to aid acute asthma and COPD management;
- Monitoring against a range of metrics to measure safe use of medicines;
- Consolidating our medicines reconciliation processes and rates;
- Continuing to adapt and deliver medicines management training for nursing and care support workers;
- Continuing to review, report and learn from incidents relating to medicines use;
- Proactively seeking to inform patients about their medicines.

Whilst this is not an exhaustive list of the programme it does summarise some of the fundamental elements. The metrics agreed included:

- The number of incident reports classified as prescribing, dispensing or administration errors with a defined denominator to allow comparison;
- Missed doses of medicines;
- Medicines reconciliation rates;
- National inpatient survey data;
- Training compliance rates.

The targets are to continue to demonstrate improvement against baseline regarding the number of errors and missed doses, and to increase the information given to patients. Regarding dispensing errors, regional and national benchmarking data identify HDFT as already achieving low numbers of errors per items dispensed, and therefore maintaining the current low level of errors continues to be the target for this metric.

What are the results?

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

Board approved Hospital Pharmacy Transformation Plan

In line with NHS England and NHS Improvement requirements, the HDFT Board of Directors agreed and approved the HDFT Hospital Pharmacy Transformation Plan (HPTP) which was submitted to NHS Improvement in February 2017. The key elements of the HPTP are focused around

- Increasing the number of pharmacist prescribers;
- Improving medicines stock holding, e-trading and supply chain opportunities;
- Further roll out of e-prescribing (complex infusions and outpatients);
- Building on the already high performing front line core clinical service provision for pharmacists and non-pharmacist staff supporting medicines optimisation for our patients;
- Continuing and further developing collaboration of key pharmacy infrastructure services in order to maximise productivity and efficiency.

Key achievements in this programme have seen:

- An increase in the number of prescribing pharmacists from 11% to 30% with further increases planned during 2018/19;
- A reduction in medicines stockholding, from 34 days to 23 days;
- An increase to 90% of the patients who receive a medicines reconciliation within 24 hours of admission, and 100% at 72 hours;
- An increase in the proportion of time pharmacists spend on patient facing activities to 80%.

The overall programme of work is summarised below:

Figure 9: Hospital Pharmacy Transformation Plan

Roll out of ePMA

ePMA is now used on all wards with the final roll out to the Emergency Department in May 2016. This has made a significant improvement in the safe use of medicines across the Trust. We are one of only a few Trusts in the UK to have full ePMA use in all clinical areas.

Planning for the complex infusions module has commenced in 2017/18. A project board and team have been set up, a clinical lead is in place, protocols are in the process of being developed and the software is currently in the test environment. We aim to introduce this software into clinical practice in 2018/19.

Safer prescribing for inpatients

We have analysed the impact of ePMA on safe prescribing since implementation in 2011/12. The data below demonstrates the progress that has been made in this regard. There has been a substantial year on year reduction in prescribing errors from 2011/12 to 2014/15 with a slight rise in 2015/16, accounted for by an increase in insulin prescribing errors. We have seen an improvement on the 2015/16 position during 2016/17, and in 2017/18 we have seen a further reduction again nearing the lowest reported rate in 2014/15.

Year	Number of adjusted prescribing errors per 100,000 prescribed doses reported via Datix
2011/12 (Pre ePMA)	3.43
2012/13	3.25
2013/14	3.19
2014/15	2.12
2015/16	3.34
2016/17	3.12
2017/18	**2.86**

Table 21: Number of adjusted prescribing errors

In addition we have seen a positive move in the levels of harm associated with prescribing errors with a significant increase in the proportion of no: low harm errors and a reduction in the moderate harm errors. We had no severe harm errors in 2016/17 or 2017/18. The number of moderate errors increased to six in 2017/18 compared to five in 2016/17, resulting in a slight increase to 9%.

Year	Levels of harm (%)		
	No or low harm	Moderate harm	Severe harm
2012/13	87%	13%	0%
2013/14	89%	11%	0%
2014/15	85%	15%	0%
2015/16	88%	11%	1%
2016/17	93%	7%	0%
2017/18	**91%**	**9%**	**0%**

Table 22: Levels of harm

Safe administration of medicines

We have analysed the impact of ePMA on the safe administration of medicines since implementation in 2011/12. The data below demonstrates the progress that has been made in this regard.

Year	Number of adjusted administration errors per 100,000 administered doses reported via Datix
2011/12 (Pre ePMA)	8.34
2012/13	3.44
2013/14	3.56
2014/15	5.34
2015/16	6.24
2016/17	3.80
2017/18	**3.31**

Table 23: Number of adjusted administration errors

We have seen a substantial reduction in the number of medicines administration errors since the introduction of ePMA. Of note was the slight increase in 2014/15 and 2015/16 (though this was still less than the pre ePMA baseline). We refreshed our training for nurses and focused on increased support. In 2016/17 we saw a significant reduction in administration errors to the lowest level since 2013/14 and this remains over a 50% reduction compared with the pre ePMA position in 2011/12. In 2017/18 we have seen a further reduction to the lowest reported administration error rates since the implementation of ePMA.

In addition we have seen a positive move in the levels of harm associated with administration errors with a significant increase in the proportion of no or low harm errors and a reduction in the moderate harm errors. We have had no severe medication harm errors in 2016/17 or 2017/18.

Year	Levels of harm (%)		
	No or low harm	Moderate harm	Severe harm
2012/13	85%	15%	0%
2013/14	91%	7%	2%
2014/15	88%	8%	4%
2015/16	88%	11%	1%
2016/17	94%	6%	0%
2017/18	**97%**	**3%**	**0%**

Table 24: Levels of harm caused by medicine administration errors

Progress on reducing missed doses and ensuring the timeliness of medicines administration

Over the last five years we have seen a steady reduction in the percentage of medicine administrations delayed to patients; meaning more patients are getting their medicines in a timely manner. We have continued to see reductions in missed doses over this period, with 2017/18 delivering the lowest % missed doses since the implementation of ePMA.

Year	% Delayed doses	% Missed doses
2012/13	2.6	2.99
2013/14	2.9	3.17
2014/15	2.6	2.13
2015/16	2.0	0.96
2016/17	2.0	0.83
2017/18	**2.0**	**0.76**

Table 25: Delayed and missed medicine administrations

Development of an ePMA dashboard to target patients on high risk medicines

The ePMA system captures all medicines prescribed and administered to our patients. Interrogation of the system has facilitated the development of a live dashboard that identifies patients on high risk medicines in order to allow early intervention and help to avoid errors and harm arising from the use of these medicines.

It is well documented nationally through the National Reporting and Learning System (NRLS) that a small number of medicines are more likely to cause harm to patients. Using this data we have developed a live dashboard for a number of patient groups

- Patients prescribed insulin;
- Patients prescribed warfarin;
- Patients prescribed antibiotics;
- Patients with an unknown allergy status;
- We also are able to identify any patient awaiting medicine reconciliation or a level 2 clinical review.

The consequence of these reports means we are now able to identify and prioritise clinical intervention to ensure optimal prescribing and avoid harm. There are several case examples of this.

In 2017/18 we developed new protocols for the prescribing against national recommendations in acute asthma and COPD, helping junior medical prescribing staff to prescribe safely and against best evidence in these domains.

Reduction in "potential" prescribing errors through pharmacist activity and implementation of ePMA

Potential prescribing errors are "those errors that are near misses that did not result in a wrong dose/medicine etc. given to a patient". These errors are identified by a ward clinical pharmacist before any level of harm is caused. We undertake an annual intervention audit to demonstrate the activity that pharmacists undertake.

At HDFT our pharmacists perform over 20,000 interventions per annum ensuring the safe prescribing and administration of medicines. Since the introduction of ePMA we have also seen a reduction in the number of potential major and life threatening interventions made by pharmacists. In 2017/18 we undertook the most robust intervention audit to date, using a new database to collect data, resulting in a significantly increased capture of pharmacist activity. The majority of interventions (86%) are minor / moderate, with just over 11% major or potentially life threatening interventions compared to 31% pre ePMA.

Year	Total number of:				Levels of potential harm			
	pharmacist interventions	potential harm interventions	unclassified interventions	actual harm, interventions	Minor	Moderate	Major	Severe or life threatening
2011 /12	254	206	30	14	127	0	68 (27%)	11 (4%)
2015 /16	250	250	0	0	133	84	31 (12%)	2 (0.8%)
2016 /17	190	190	0	0	81	100	17 (9%)	0 (0%)
2017/18	**481**	**481**	**4**	**0**	**295**	**121**	**51 (11%)**	**2 (0.4%)**

Table 26: Pharmacist intervention audit data

Maintaining low numbers of dispensing errors

Our dispensing errors in 2017/18 (13/100,000) continue to be well below the regional average (18/100,000) and some of the lowest across the Yorkshire and Humber region. They have reduced slightly compared to 2016/17 (14/100,000). HDFT data for 2017/18 has fallen compared to previous years from a high of 16/100,000 dispensed items to 13/100,000 dispensed items. Only three Trusts (range 9-11/100,000 dispensed items) demonstrate a lower rate.

Our error rates in aseptic services (preparation of IV medicines including chemotherapy) are also extremely low and one of the two lowest Trusts in the region. This has also further reduced from 5/100,000 dispensed items in 2014/15 to 3.5/100,000 dispensed items in 2017/18.

Trust	Inpatient dispensing error rate / 100,000 dispensed items	Aseptic dispensing error rate / 100,000 dispensed items
HDFT	13	3.5
Y&H average	18	10
Y&H range	9-30	3-30
National average	~20	Unknown

Table 27: Dispensing errors

Learning from medicines errors

In 2014/15 we started to build a database of all Datix reported medicines errors. This now covers seven years from 2011/12 through to 2017/18. This allows us to identify common themes and errors, map trends and analyse progress. All reported errors are investigated and actions put into practice to learn from such events. All errors are discussed at the monthly Medicines Safety Review Group meetings.

We have focused on a number of areas, with three included in this report. These include:

1. Progress on the management of missed doses

The graph below demonstrates the progress being made with reducing missed doses. We have seen a consistent year on year reduction in the percentage of missed doses and the proportion of delayed doses meaning patients are receiving medicines in a more timely manner. There was slight increase in 2017/18 in the percentage of Datix reports of more critical medicines being delayed (from 4% to 6%). However this is still well below the pre ePMA baseline.

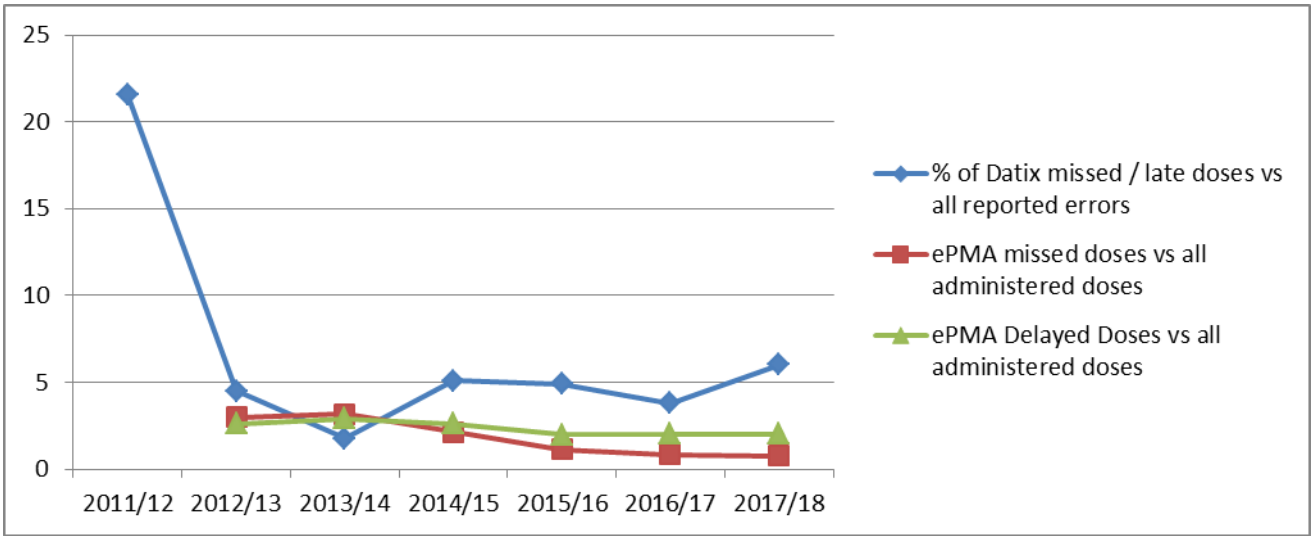


Figure 10: % missed and late doses from Datix reports and ePMA (2011/12 – 2017/18)

2. Patient identity errors

Patient identify errors are defined as “Patient A is mistakenly given Patient B’s medicines”. An analysis of the database has highlighted a reduction post ePMA, though there was a small rise in 2015/16. Further work has reduced this level again in 2017/18. The level remains significantly below the pre ePMA level.

Year	Number (and % of all medicine errors) of patient identity errors reported via Datix
2011/12 (Pre ePMA)	15 (6.1%)
2012/13	4 (1.12%)
2013/14	4 (1%)
2014/15	8 (1.95%)
2015/16	8 (1.78%)
2016/17	5 (1.45%)
2017/18	**5 (1.23%)**

Table 28:Patient identity errors from Datix reports

3. Safe use of insulin

Analysis of the error database during 2015/16 highlighted an increase in the number and type of insulin related errors (see figure 11). This prompted a specific task and finish group to be convened and a quality improvement programme to be initiated. This group implemented a range of actions including the development of an insulin safety dashboard and the addition of safe use of insulin competency to the essential skills training programme.

Since 2015/16 we have seen significant improvement in the safe use of insulin at HDFT. The total number of incidents and errors has fallen slightly. The percentage of insulin reported errors has slightly increased and is now maintained around 9-10% of all reports, demonstrating an improving reporting culture.

In 2017/18 we have seen a significant reduction in the number of hospital reported errors, down from 35 in 2016/17 to 17 in 2017/18 (consistently with the National Adult Diabetes Audit data reported below). We also continue to proactively use the insulin dashboard. Using this tool, the diabetes team and pharmacists are able to intervene early.

In 2017/18 we have seen an increase in the number of community reported insulin errors. Over 40% of these relate to timely administration of insulin as a direct consequence of the pressure experienced by the community care teams during the last 12 months and delays in visiting patients.

We continue however to see an improvement in the levels of harm caused by all hospital and community reported insulin errors.

Year	No: Low Harm	Moderate Harm	Severe Harm
2015/16	83%	12%	2%
2016/17	92%	8%	0%
2017/18	**100%**	**0%**	**0%**

Table 29: Levels of harm caused by all reported insulin errors

These are substantial improvements on previous years and we have had zero severe harms with insulin since 2015/16 when the quality improvement initiative was launched.

The National Adult Diabetes Inpatient Audit (NADIA) 2016/17 has just been published and has confirmed the reduction in insulin errors for HDFT. This is a really strong performance moving HDFT from one of the worst performing Trusts to one of the best performing Trusts.

Year	HDFT	Quartile	England
2010	27.3%	Quartile 3	25.8%
2011	46.2%	Quartile 4	22.7%
2012	20.0%	Quartile 2	21.8%
2013	30.0%	Quartile 4	20.7%
2015	34.4%	Quartile 4	22.6%
2016	25.0%	Quartile 3	22.7%
2017	**4.8%**	**Quartile 1**	**18.6%**

Table 30: National Adult Diabetes Inpatient Audit (NADIA) Report 2016/17 – Insulin Errors 2010-2017

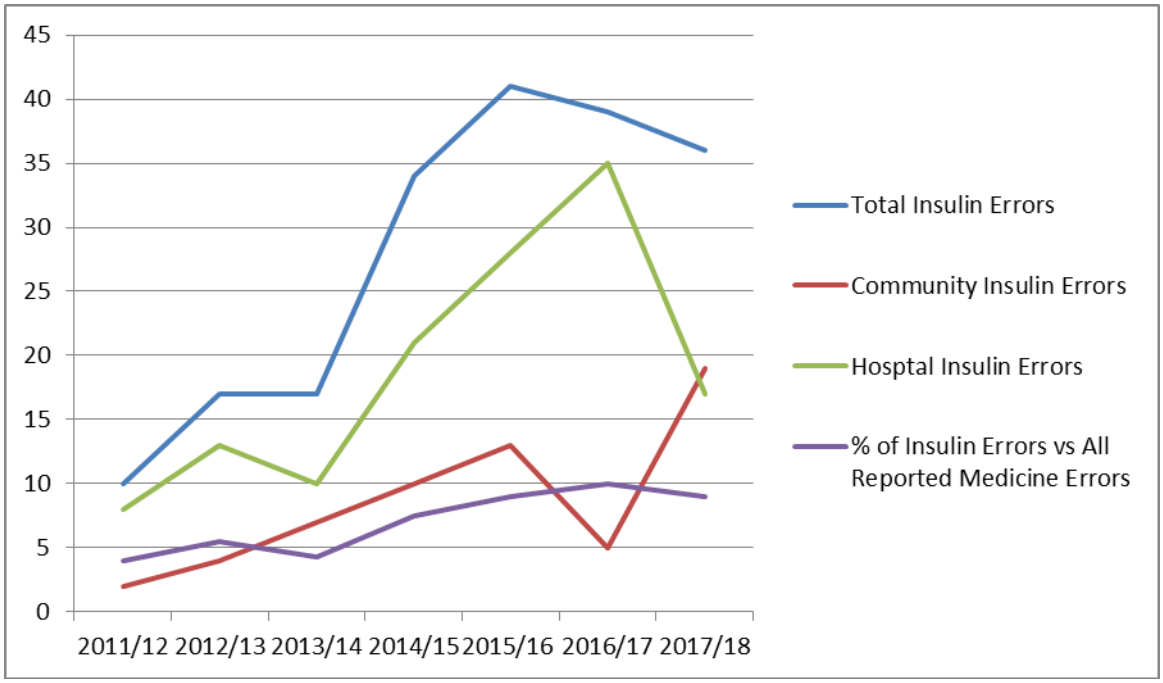


Figure 11: Number of Datix reported insulin errors from community and hospital HDFT locations from 2011/12 - 2017/18

Medicines reconciliation

Medicines reconciliation is the process by which the accuracy and completeness of a patients medicines history is checked and verified when a patient is admitted to hospital. NICE guidance recommends all patients have a medicines reconciliation undertaken within 24 hours of admission by a competent practitioner. Evidence demonstrates an improvement in morbidity and mortality when this occurs.

Audit data below demonstrates our improvement and sustained performance over the last five years. The Model Hospital benchmark remains around 70%.

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

Table 31: Medicines reconciliation audit data

Medicines management training for doctors, nurses and pharmacists

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

Compliance rates with training continue to reach high levels though with some fluctuations in 2017/18. We have seen a slight dip in compliance with antibiotic stewardship and fluid prescribing training during 2017/18 and this will be addressed in 2018/19.

Training competency	Renewal	% compliance 1.3.2016	% compliance 1.2.2017	% compliance 31.3.2018
ePMA	Once only	94%	97%	94% ↓
Antibiotic stewardship	2 yearly	87%	86%	78% ↓
Medicines management for community nursing	3 yearly	70%	52%	75%↑
Medicines management for hospital based nurses	3 yearly	73%	73%	79% ↑
Safe prescribing toolkit	Once only	85%	85%	88% ↑
Safe fluid prescribing toolkit (introduced Dec.2015)	Once only	n/a	85%	82% ↓

Table 32: Medicines management training compliance data

Patient engagement and providing information to patients

Information provision to patients and the perception of patients receiving relevant information about their medicines has generally improved over the years. In 2017 we saw a slight worsening of performance below the national Picker average for three domains. We remain in the upper quartile in the Model Hospital Dashboard.

National Inpatient Survey	% of patients							Better than national / Picker average
	2012	2013	2014	2015	2016	2017	National / Picker average	
Question 1: Not fully told purpose of medicines	22	17	18	22	20	26	25	No
Question 2: Not fully told side effects of medicines	58	57	59	57	55	65	61	No
Question 3: Not told how to take medication clearly	21	19	19	25	20	22	24	Yes
Question 4: Not given completely clear written/printed information about medicines	22	23	22	26	21	26	27	No

Table 33: Medicines management training compliance data

Summary

The medicines safety programme has made a further step forward in terms of safety improvements in 2017/18 and continues to build on previous quality improvements relating to medicines optimisation and safety. During 2017/18 we have seen:

- An increase in the number of prescribing pharmacists from 11% to 30% with further increases planned during 2018/19;
- A reduction in medicines stockholding from 34 days to 23 days, ensuring medicines are handled optimally;
- Maintaining 90% of the patients who receive a medicines reconciliation within 24 hrs and achieving 100% at 72 hours, well above the Model Hospital benchmark;
- An increase in the proportion of time pharmacists spends on patient facing activities to 80%.

There have been further reductions during 2017/18 compared to 2016/17 of:

- Prescribing errors (from 3.12 to 2.86 / 100,000 prescribed doses);
- Administration errors (from 3.80 to 3.31 / 100,000 administered doses);
- Missed doses (from 0.83% to 0.76% / 100,000 prescribed doses);
- Dispensing errors (from 14 to 13 / 100,000 dispensed items);
- Patient Identity errors (from 1.45% to 1.23%);
- Hospital insulin errors (from 35 to 17).

We have seen improvements in 'no or low harm' to 'moderate or severe harm' ratios with 96.5% in 2017/18 compared to 94.9% in 2016/17, and a reduction in moderate harm errors to 3.5% (n=14) in 2017/18 compared to 5.1% (n=19) in 2016/17. We have had *no* serious harm incidents relating to the use of medicines during 2016/17 and 2017/18.

We have improved and/or maintained good levels of training compliance through the year despite the pressures on nurse staffing and have trained more hospital and community nursing staff on the safe use of medicines than ever before.

In the 2017 National Inpatient Survey (Picker results) we have seen a slight deterioration in the provision of information and explanation to patients about their medicines, and this will become a focus of attention in 2018/19.

The improvements in medicines safety as HDFT have been facilitated through the roll out of ePMA, the active engagement of doctors, nurses and pharmacy staff in this programme of work, development of live medicines dashboards, improved medicines reconciliation rates, pharmacy activity at ward level, reviewing and acting on trends in medicines administration, dispensing and prescribing errors and medicines management teaching and training for prescribers and nurses.

The summary data relating to error in 2011/12 which was pre-ePMA and 2017/18 is impressive.

Error type reported	Pre ePMA 2011/12	Post ePMA 2017/18	% reduction
Prescribing errors (Datix) – per 100,000 doses	3.43	2.86	**16%**
Administration errors (Datix) – per 100,000 doses	8.34	3.31	**60%**
Missed doses (Datix)	2.99%	0.76%	**75%**
Major, severe and life threatening Pharmacist interventions (*Pharmacy data)*	31%	11.4%	**63%**
Patient identity medicines administration errors	15	5	**66%**
Insulin errors *(NADIA data)*	46.2%	4.8%	**90%**
No and low : Moderate harm % ratio	85% : 15%	96.5% : 3.5%	N/A

Table 34: Comparative medicine safety error data pre and post-ePMA

Whilst significant improvements are being demonstrated, we will continue to work to optimise the use of medicines at HDFT as highlighted by 'The Report of the Short Life Working Group on reducing medication related harm'. This report will form the basis of further work in 2018/19.

2. Falls

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. Falls can impact on quality of life, health and healthcare costs causing distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall, and is estimated to cost the NHS more than £2.3 billion per year.

North Yorkshire has a population who are fit and live longer than many other areas in England. People aged between 55 and 78 years of age are described as a "Baby Boomer", and those aged 65 or over are defined by NICE as an "older person". Two thirds of the population growth in North Yorkshire over the last ten years has been a result of increased numbers of people aged 65 and over and Baby Boomers account for 97% of this increase. Older people make up 23.3% of the total North Yorkshire population compared with 17.7% across England in 2015, and the Office for National Statistics projections indicate that the population of older people aged 65 and over in North Yorkshire will rise to over 169,000 (27.6%) by 2025. Local services currently provide care for nearly 6% more older people than other regions in the UK, a population who are often frail and have complex medical needs when they are admitted into our hospital, and this trend is likely to increase.

Inpatient falls are associated with increased length of stay, additional surgery and unplanned treatment, however multiple interventions by the multidisciplinary team tailored to the patient can reduce falls by 20-30% (NICE CG 161). The interventions referred to are simple elements such as making sure that during a hospital stay older people are individually assessed and have access to a call bell that works and a walking stick; are able to hear and see in a safe environment when they want to walk around; are assessed for conditions such as delirium and dementia; and also have their medications checked and reviewed to ensure that they are beneficial.

In addition, in 2015 we became aware of work done by the Yorkshire and Humber Academic Health Science Network (AHSN) Improvement Academy (IA) to reduce falls by the introduction of a short daily ward meeting called a "fall safety huddle", and the National Audit for Inpatient Falls (NAIF) 2015 report made recommendations around elements of patient care that could be improved.

The fall safety huddle is where a multidisciplinary team gathers daily and identifies patients they are concerned about, and agrees and actions a range of interventions as an individual care plan to reduce the risk of the patient falling.

Figure 12 shows the key prompts within a safety huddle. HDFT has added "distraction", which means providing confused patients with individualised activities to engage them and reduce agitation, and this has been adopted by the Improvement Academy to use with other trusts.

Figure 12 Safety huddle prompts

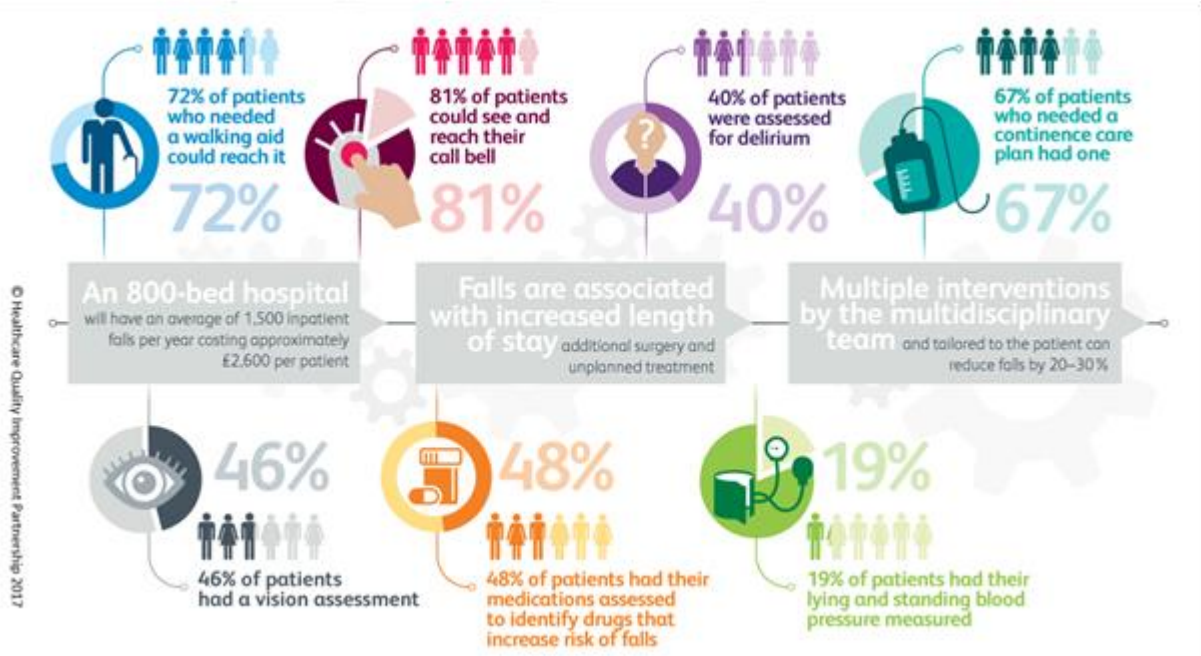


Figure 13: Key measures for preventing falls in hospital (National Audit of Inpatient Falls report 2017)

What were we aiming to achieve?

The aims of the HDFT Falls Prevention Group are simple: reduce the number of falls in the Trust; ensure staff are trained and know how to keep people safe; and ensure all policies related to patient and staff safety are kept up to date and in line with clinical evidence and research provided by NICE and other governing bodies.

We decided to see if we could reduce falls by 30% by introducing a daily range of practical and medical interventions for individual patients who had been identified as a potential falls risk by the ward team.

What have we done?

The Falls Prevention Group introduced a daily falls safety huddle as a means of ensuring that a range of interventions were put in place for individual patients identified each day as a "falls risk". The interventions highlighted to improve were:

1. the timely assessment of delirium and dementia;
2. review of medications;
3. the measurement of lying and standing blood pressure (BP); and
4. the availability of walking aids.

Jervaulx ward was the first team to hold a daily fall safety huddle, and their first goal was to achieve ten consecutive days without reporting a patient fall. The initial success on Jervaulx ward then encouraged the adoption of the methodology across other wards.

In addition, training for all new nursing staff and doctors in their foundation years has been introduced using competencies recommended by the Royal College of Physicians, to promote a standardised protocol for the measurement of lying and standing BP.

In response to Yorkshire's changing demographic, budgets and resources the multidisciplinary community team has been subject to several restructures, and is still under

review. However it continues to work with GPs, care homes and the voluntary sector to raise awareness about falls, multifactorial assessments and interventions in an effort to keep older people as safe and steady as possible. A community falls pathway has been reviewed to support these processes.

Harrogate Borough Council has been working closely with Sport England and Public Health Yorkshire to provide instructor training and a range of exercise programmes that meet NICE guidelines and recommendations, and are designed to target key groups within the community.

What are the results?

By the start of 2018 fall safety huddles were taking place and embedded on six different wards. The impact of the work has been significant in reducing the number of falls and level of harm across the whole Trust.

Jervaulx ward has achieved a significant reduction of 38% falls in 12 months, and Byland ward achieved a second statistically significant step down in the reduction of falls on the ward. This sustained team effort has been recognised and they will each be accredited by the Improvement Academy in May 2018.

Trinity ward has been able to celebrate a record 94 fall free days this year, Jervaulx ward 64 days and Byland ward over 30 days. Farndale ward have achieved records of over 40 days, and AMU have already extended their record from 16 to 18 fall free days in just a few months. CATT ward is the latest team to start a huddle in February 2018, and they are working towards achieving ten consecutive fall free days. Some wards have now expanded the safety model to include other elements of care that are specific to their team and their patients' needs.

We have seen a significant increase in the recording of lying and standing BP from 6% in 2015 to 29% in 2017, a result well above the national average. There have also improvements in assessments of delirium and mobility / walking aids on admission, but a disappointing 10% decrease in medication reviews since the 2015 audit.

Key Indictors	HDFT 2015	National Results 2015	HDFT 2017	National Results 2017
Delirium	25%	36.7%	68% *	39.7%
Continence	83%	69.4%	50%	66.9%
LS/BP	6%	16.1%	29%*	19.1%
Medication	52%	45.9%	42%	47.8%
Vision	55%	48.3%	43%	46.2%
Call Bell	90%	82.3%	74%	81.3%
Mobility	77%	67.5%	100%*	94.8%

***** Improvements in three of the four areas identified for improvement

Table 35: National Audit of Inpatient Falls: comparison of HDFT/national results for 2015 and 2017

The Trust level data shows that the total number of inpatient falls decreased for three consecutive years until 2016/17, before the number of falls plateaued during 2017/18.

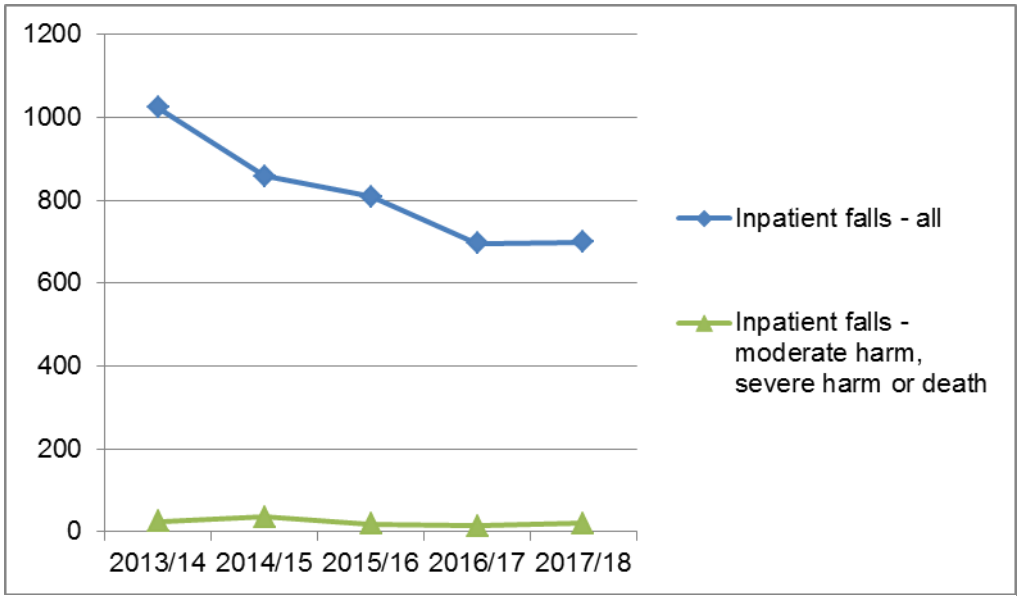


Figure 14: Inpatient falls reported at HDFT 2013/14 to 2017/18

	2013/14	2014/15	2015/16	2016/17	2017/18
Inpatient falls - all	1024	859	809	697	700
Inpatient falls – all per 1000 bed days	8.95	7.49.	7.04	6.10	6.1
Inpatient falls – moderate or severe harm or death	25	36	20	15	21
Moderate or severe harm or death per 1000 bed days	0.22	0.31	0.17	0.13	0.19
Inpatient falls resulting in fracture	16	17	16	14	20

Table 36: Inpatient falls, rate and harm reported at HDFT 2013/14 to 2017/18

However the number of harmful falls reported has risen in the last year including 20 falls resulting in fracture. A number of factors have clearly influenced and challenged our services, especially over the winter months of 2017.

Summary

It is an accepted fact that we will never be able to stop all falls in hospital, but the Trust has been able to demonstrate that we are able to make a significant difference to the number of falls and the harm they can cause. We are very proud of our staff teams who make these initiatives work on a daily basis despite difficult and often testing times, but we have been able to demonstrate that falls can be reduced significantly when multifactorial interventions are made for people at risk of falls.

It is anticipated that a falls safety huddle will be used by several other wards in 2018/19 and this could have an impact of reducing the Trust's total number of falls as the culture of safety changes the premise that old people will fall. The group will continue to promote the benefits of this methodology in improving patient safety at annual Trust wide events such as the Allied Health Professionals and Trust Quality Conferences and in cooperation with the Improvement Academy.

The Falls Prevention Group works to achieve the objectives set out in an action plan that is shaped by recommendations made in NICE guidelines, guided by the CCG and supported by the Trust and working with community groups. It intends to continue to address recommendations outlined in the NAIF reports of 2015 and 2017 and support community

initiatives proposed in the Public Health Yorkshire report 2017. Improving vision assessments is a target for 2018/19.

3. Pressure ulcers

Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair the blood supply. They cause pain and distress, can mean longer stays in hospital and cost the NHS a significant amount of money. They are graded by severity according to a classification by the European Pressure Ulcer Advisory Panel (EPUAP) from category one (least severe) to category four (most severe). They are more likely to occur in people who are ill, have a neurological condition, poor mobility, impaired nutrition or poor posture.

Pressure ulcers are usually preventable with good assessment of individual risk and effective application of preventative measures such as the use of effective equipment to reduce pressure, regular position change, good nutrition and hydration and good skin care.

The prevention of avoidable pressure ulcers has been a specific part of our quality improvement work at HDFT since 2012/13 and there has been a significant amount of work undertaken at the Trust with the aim of reducing avoidable HDFT acquired pressure ulcers. For the year 2017/18 we reported a significant reduction in avoidable pressure ulcers in the community setting. We also achieved an increase in unavoidable pressure ulcers across both acute and community settings.

What were we aiming to achieve?

The Trust has a Pressure Ulcer Group that meets on monthly basis. The objectives of this group are to drive continual improvement of pressure ulcer prevention with the overall aim of no avoidable pressure ulcers acquired by patients receiving either HDFT hospital or community provided care. Pressure ulcers are defined as unavoidable if all reasonable care and treatment has been provided to prevent or minimise damage to skin through pressure.

Our aims have been to:

- Reduce the incidence of category two, three and four pressure ulcers acquired by people whilst in HDFT care;
- Promote best practice in prevention and management of pressure ulcers;
- Understand if a pressure ulcer was avoidable or unavoidable and to learn from investigations into the root cause of pressure ulcers;
- Continue with our programme of pressure ulcer training and education for staff;
- Continue to support a “zero tolerance” approach to avoidable pressure ulcer development in people who are receiving HDFT care, which will be supported by our pressure ulcer prevention strategies including training and investigation processes.

What have we done?

Key successes to date have surrounded two broad areas, these being education and training, and documentation and risk assessment.

1. Education and training

Training for staff has been a priority since January 2015. An e-learning package for pressure ulcer prevention was made essential annual training for all general and paediatric registered

nurses and three yearly training for midwives. There are plans to further improve the existing training programme so that staff receive face-to-face training alternate years in addition to the existing e-learning package.

Training on skin care, pressure ulcer prevention, recognition and management is currently delivered by the Tissue Viability Nurses and Trust Clinical Educators, both in the classroom and at the bedside. The frequency of the classroom face-to-face training package has been increased to monthly. Training has also been previously delivered to senior ward and community registered nurses to enable them to effectively investigate pressure ulcer incidents, undertake root cause analysis and generate an action plan with recommendations. There are plans to refresh and update this training programme.

The Trust has actively participated in the national STOP - Pressure Ulcer Days, holding an educational event for residential homes and healthcare support workers. In addition the NHS England 'React to Red' training package has been delivered to residential homes by a Clinical Educator.

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

2. Documentation and risk assessment

In 2014 we introduced SSKIN (skin, surface, keep moving, incontinence, and nutrition) bundles across all adult inpatient wards, for patients assessed as being at risk of pressure ulcer development. This was supported with a SSKIN bundle educational package and educational posters for clinical staff to aid the identification and categorisation of pressure ulcers. Changes were made to the nursing documentation to emphasise the need to repeat pressure ulcer risk assessment on transfer between wards. In response to themes from our root cause analyses regarding documentation, the SSKIN bundle chart has now been replaced by a new skin inspection and repositioning record in December 2016.

We have implemented a new pressure ulcer risk assessment tool and associated documentation for use in our community areas, with plans to extend this to our adult inpatient areas in 2018/19. Work on a pressure ulcer risk assessment tool and associated documentation for use in paediatrics continues to progress.

What are the results?

A reduction in hospital acquired pressure ulcers was achieved in 2015/16, which plateaued in 2016/17. Whilst an increase has been reported for 2017/18, more pressure ulcers have been found to be unavoidable following investigation.

Community acquired pressure ulcers, defined as pressure ulcers acquired by patients in receipt of HDFT community care, remained a challenge during 2016/17. The new risk assessment document implemented in the community setting has been embedded during 2017/18. To date, there has been a significant reduction in the number of community acquired pressure ulcers deemed to be avoidable during 2017/18.

Pressure ulcer data reported through the HDFT incident reporting system

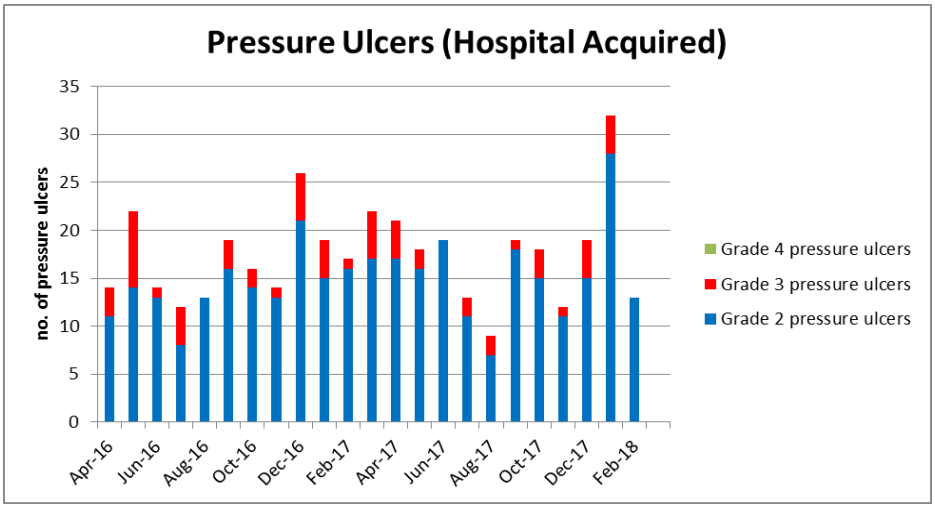


Figure 15: Hospital acquired pressure ulcers April 2016 to Feb 2018

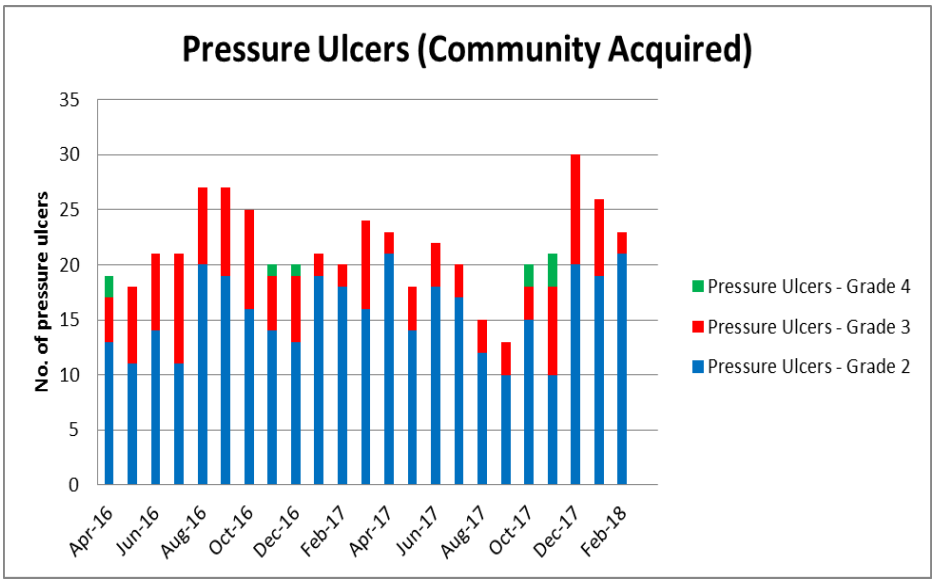


Figure 16: Community acquired pressure ulcers April 2016 to Feb 2018

Figures 15 and 16 demonstrate the challenges with regards to hospital and community acquired pressure ulcers. In part we believe this is due to better and earlier identification, reporting and continued education around the recognition and categorisation of pressure ulcers. We have also have observed a 2% activity increase in hospital admissions during 2017/18 and a 6% increase in referrals to the community care teams compared to the previous year.

The data is displayed on the Trust's dashboards shared through reports to our senior management teams. Our inpatient wards display data on their quality and safety boards.

NHS Safety Thermometer data for HDFT

Developed as a point of care survey instrument, the NHS Safety Thermometer provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for our patients. We submit data every month in relation to care provided by our acute and community teams.

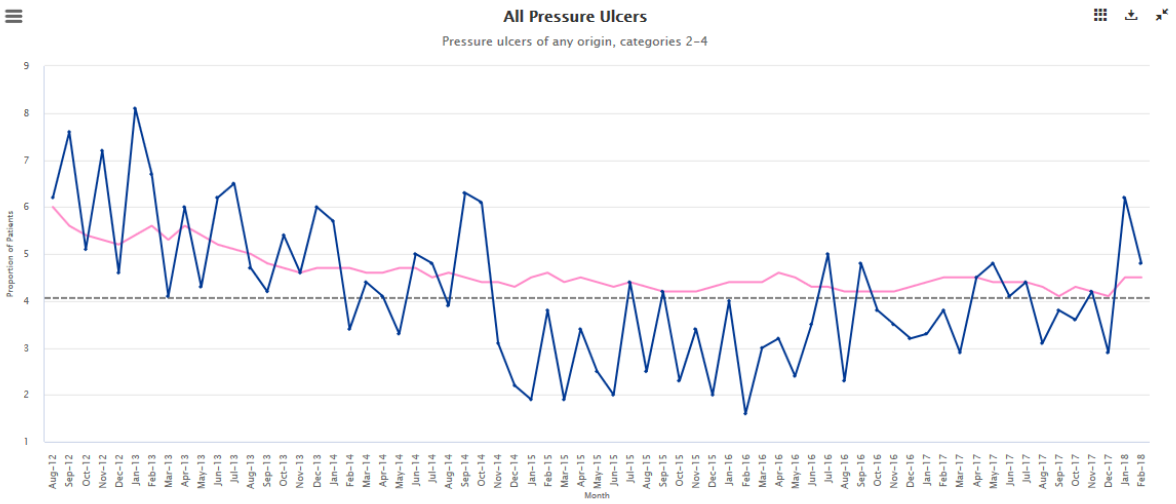


Figure17: Safety thermometer data for all pressure ulcers for HDFT (2012-2018)

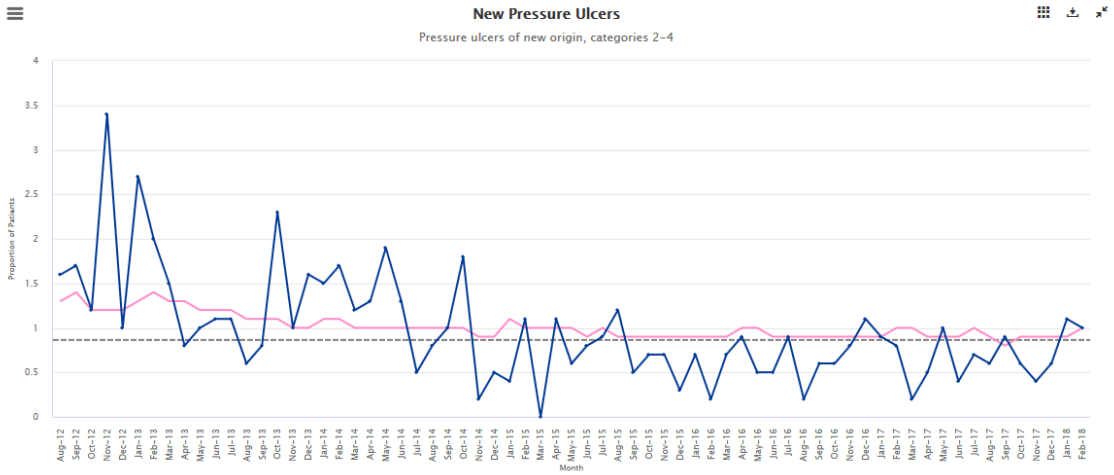
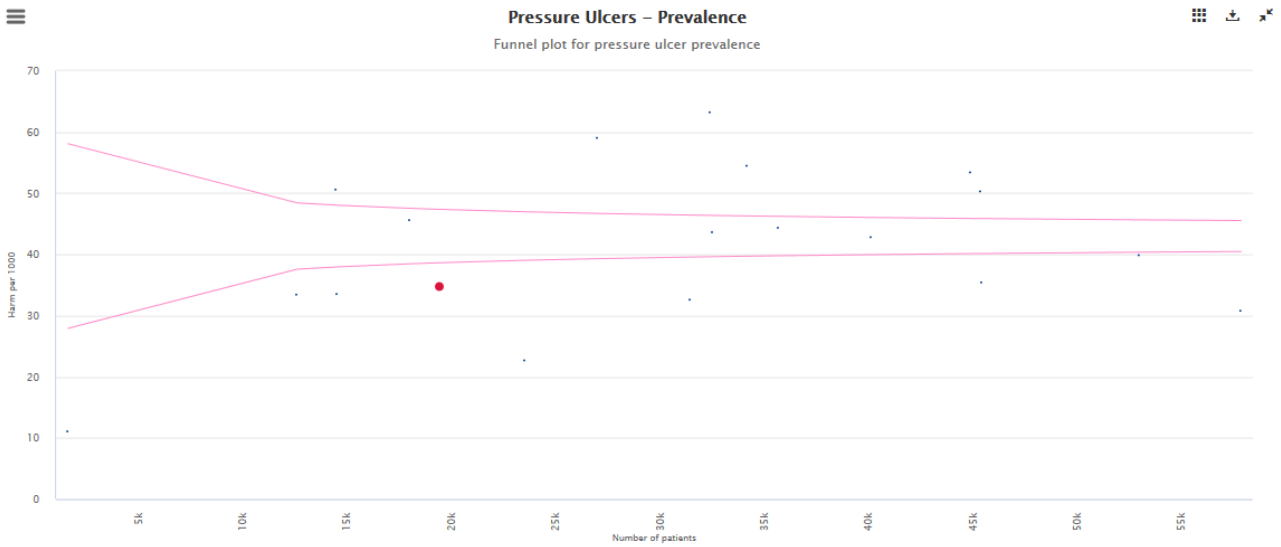


Figure 18: Safety thermometer data for new pressure ulcers for HDFT (2012-2018)

Figure 17 and 18 above show the results of the NHS Safety Thermometer data from August 2012 to February 2018 for all pressure ulcers identified and for new pressure ulcers. There has been a steady reduction in new pressure ulcers over this period.

NHS Safety Thermometer funnel plots

The funnel plot compares the Trust's performance over a 12 month rolling period of harm caused by pressure ulcers per 1000 patients surveyed, against other Trusts that provide both acute and community services. Funnel plot charts get their name by the lines running across the chart creating a funnel. These are called 'upper' and 'lower control limits'. Each dot represents an organisation. Organisations inside the funnel lines are regarded as average or statistically indistinguishable. Organisations outside of these lines are called outliers, which can be either positive or negative. In this case lower is positive and therefore HDFT has lower harm compared to other trusts providing acute and community services.



♦ represents HDFT
Data source: https://www.safetythermometer.nhs.uk/
Figure 19: Safety thermometer funnel plot for pressure ulcer prevalence

Summary

A significant amount of work has been undertaken during 2017/18. We have introduced some new initiatives such as the revised skin inspection and repositioning chart on our inpatient wards and the new community risk assessment document that we will further embed in 2018/19.

The Trust aims to eliminate avoidable pressure ulcer development in people who are receiving HDFT care, and will continue to develop pressure ulcer prevention strategies including training and investigation processes. Key ambitions for 2018/19 include:

- Further strengthening of training and education with alternate year face-to-face training;
- Implementation of a new pressure ulcer risk assessment tool and associated documentation across our adult inpatient areas;
- A revised “panel” approach to investigations into the root cause of pressure ulcers, which will also offer a new approach to sharing learning.

Progress will be monitored by the directorate teams and the Pressure Ulcer Group.

3.2. PATIENT EXPERIENCE

1. Pain management

Evidence shows that up to 80% of patients may suffer pain following surgery with 20% experiencing severe pain. In addition, there are over 14 million people in the UK who are living with persistent, chronic pain. Effective pain management should be viewed as a priority by all healthcare workers.

What were we aiming to achieve?

Our aim is to continue to promote high standards of pain assessment and management throughout the Trust. This is achieved by ensuring patients are asked regularly about their pain and its severity both at rest and on movement. Empowering staff to have the confidence to assess and implement treatment should improve access to pain relief, improving the quality of patient experience and reducing suffering.

What have we done?

A repeat pain score audit was completed that included looking at the patients' pain scores recorded on Patientrack, as well as 'Asking the Patient' questions at the bedside. This enabled us to monitor improvements in pain assessment in comparison to previous audits and better identify patients' experience of pain management within the hospital.

Since November 2014 we have incorporated questions about pain into our inpatient Friends and Family Test (FFT). We have monitored and shared the results and comments from patients with ward staff in order to promote learning and reflection.

Education has always been central to the role of the Acute Pain Service and we have recently introduced a teaching programme known as EPM Lite (essential pain management) to improve staff knowledge of pain assessment, and both non-pharmacological and pharmacological treatments. This programme is supported by the Faculty of Pain Medicine, the Royal College of Anaesthetists and was originally implemented by anaesthetists in Australia and New Zealand as a way of teaching pain management in deprived countries. However the programme has now been implemented in 14 medical schools in the UK and recently introduced into HDFT. Sessions based on the EPM Lite model have been given to junior doctors, anaesthetists, student nurses, newly qualified and experienced nurses.

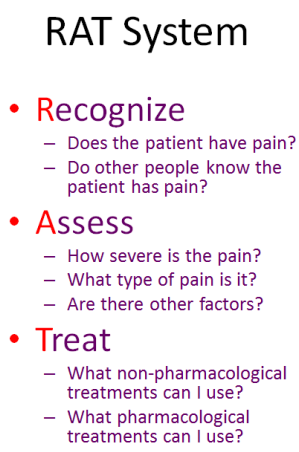


Figure 20: RAT system: a systematic approach to assessment and treatment.

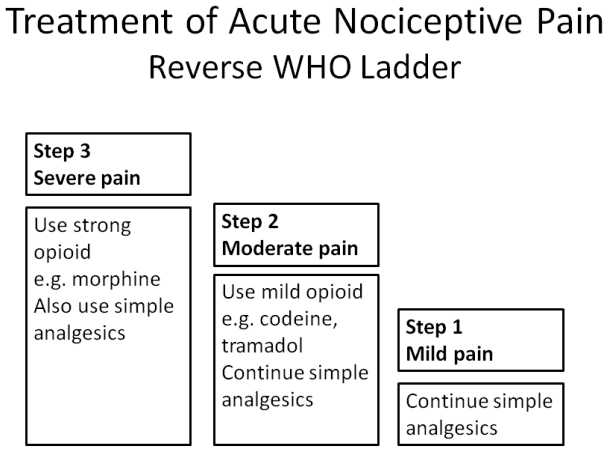


Figure 21: Reverse World Health Organisation (WHO) analgesic ladder

What are the results?

A pain score audit was undertaken on all the surgical wards, and Harlow and Granby wards with patients asked how they felt their pain had been managed overall. The majority (**90**%) of patients considered that it had been well managed, with 47 patients (77%) reporting pain management as good or excellent.

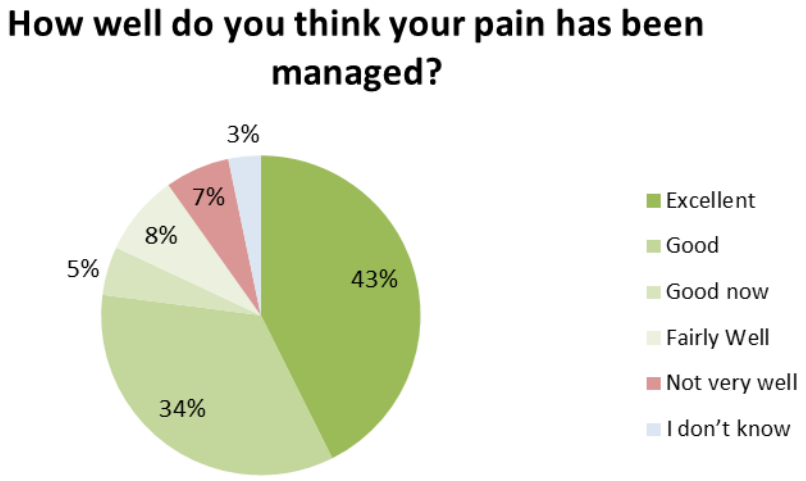


Figure 22: Pain score audit results

Whilst the introduction of pain scores on Patientrack has clearly had an impact on pain score assessment, the audit showed that only 5% of high scoring patients (pain score of >7) had documentation of re-assessment within an acceptable time frame. However, anecdotes suggest that nurses are going back and making informal assessments but this is not easily recorded on Patientrack without also taking a full set of observations.

Patients are asked a series of four questions about pain on our inpatient FFT and are encouraged to leave comments. All comments are fed back to ward sisters. A selection of comments is provided. Any negative comments relate to the time taken to prescribe and administer analgesia.

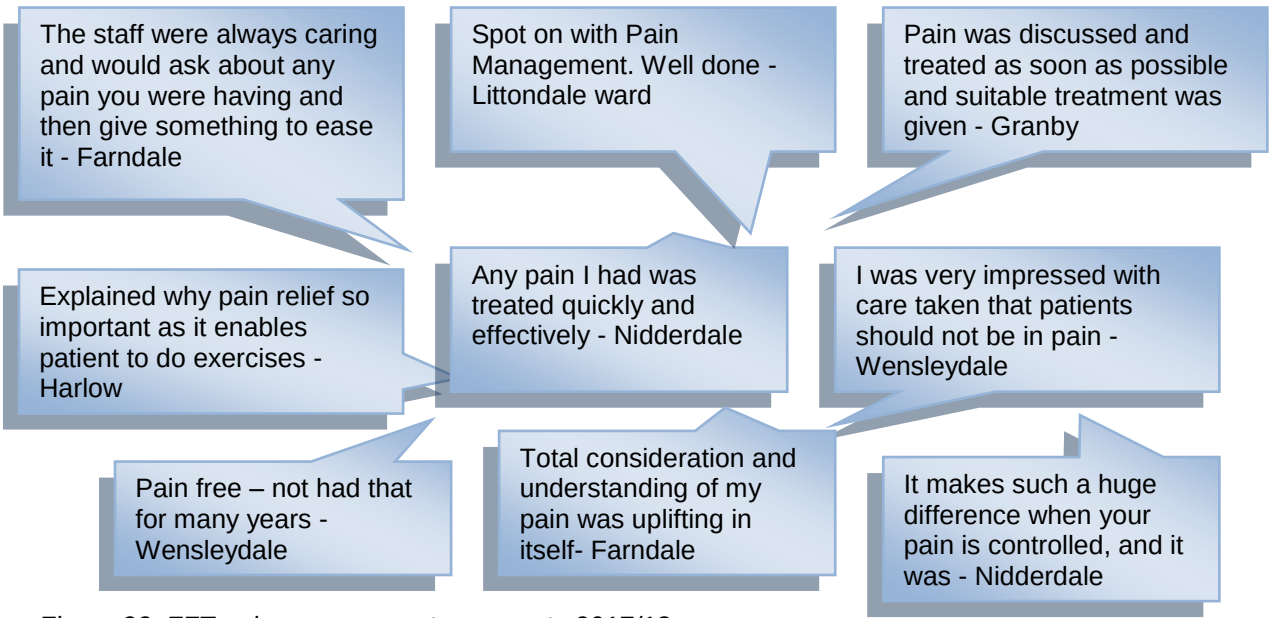


Figure 23: FFT pain management comments 2017/18

The responses to the four pain questions are monitored and are provided below by ward for January 2018.

Ward	Do our staff ask you about pain regularly?		If you have pain, are you offered pain relief?		If you were offered pain relief, did the staff give that in a reasonable time?		If you had pain relief, was it effective?	
	Yes	No	Yes	No	Yes	No	Yes	No
AMU	12	0	7	0	7	0	7	0
Byland ward	8	0	8	0	8	0	8	0
CAT Clinic	4	0	2	0	1	0	2	0
Farndale	17	0	17	0	15	1	15	0
Granby	35	0	28	1	27	1	26	0
Harlow	18	0	18	0	16	0	16	0
Littondale	2	0	2	0	1	0	1	0
Nidderdale	31	3	34	0	30	2	28	2
Oakdale	2	0	1	0	1	0	1	0
Wensleydale	67	0	66	0	66	0	62	3
Total	**196**	**3**	**183**	**1**	**172**	**4**	**166**	**5**

Table 37: January 2018 Friends and Family Test results

Results suggest that the majority of our patients are satisfied with their pain management. Overall, 196 patients were asked about their pain, all patients said they were offered pain relief, only 4 patients felt they had to wait longer than necessary and 5 patients felt their analgesia was ineffective.

Since the introduction of EPM Lite training in May 2017, the Acute Pain Team have utilised the training programme for a variety of staff groups, ranging from students to experienced staff. Student feedback from these sessions include comments such as ‘a fantastic, well delivered session’, ‘informative, great teaching session with group work and participation’, ‘good pace’, and ‘I loved it, very full of knowledge’.

EPM Lite Teaching at HDFT	Numbers
Medical Students	16
Junior Doctors	40
Student Nurses/physiotherapist	5
Newly qualified nurses (Preceptorship)	57
Experienced Qualified nurses (Deteriorating Patient course)	58

Table 38: Training figures for EPM Lite since May 2017

Summary and next steps

Results show that we appear to be achieving a high standard of pain assessment and management within the Trust and that the majority of patients are satisfied. There remains room for improvement in areas such as the re-assessment of pain scores but through the introduction of new training programs we hope to educate and empower the staff to treat patients in pain effectively and with dignity and compassion.

2. Maternity

During 2017/18 the Maternity Department has continued to work hard to maintain safe and high quality midwifery care to all women who choose to have their babies in Harrogate, and to use the results of patient feedback to further improve services. We also focused on improvement in relation to some specific maternity quality objectives.

What were we aiming to achieve?

The service has been working towards:

- Reducing the elective caesarean section rate (LSCS);
- Reducing the postpartum haemorrhage (PPH) rate;
- Reducing 3rd/4th degree tears;
- Reducing term admissions to Special Care Baby Unit (SCBU);
- Improving handover of information between midwifery staff;
- Extending the links between maternity services and Improving Access to Psychological Therapies (IAPT).

Progress with these and other ongoing work is reported below.

What have we done and what are the results?

- An audit of elective caesarean sections was undertaken against the NICE Guideline on Caesarean Section (2011) to understand more about the reasons for women choosing elective caesarean section. The recommendations were to:
    - promote the external cephalic version clinic (ECV) for women with breech presentations;
    - promote the Birth Revisited clinic attendance to ensure women have the opportunity to discuss their anxieties on a 1:1 basis and to continue to de-brief women after delivery as it shows this is having a positive effect;

  We have a clear process for maternal request for elective LSCS by ensuring women are fully informed prior to making this decision, and the rate has reduced slightly in 2017/18 compared to 2016/17.
- The PPH rate has remained relatively static over the last 3 years. The implementation of a PPH risk assessment tool did not show a significant reduction in the overall PPH rate, and we have now reintroduced the use of syntometrine for the active management of the 3rd stage of labour.
- There have been training sessions for both midwifery and medical staff in performing episiotomy. Midwives are now documenting the position of mother at delivery, and all midwives are delivering “hands on” in order to control delivery of the baby’s head. The 3rd/4th degree tear rate has reduced in 2017/8 compared to 2016/17.
- During the last year we have continued to aim to keep babies with their mothers on the postnatal ward instead of admitting the babies to SCBU and to support the ATAIN programme (avoiding term admissions into neonatal units). The further development of this transitional care type model will remain a focus for the department in 2018/19.
- Midwives are continuing to use the SBAR (situation, background, assessment, recommendation; a technique used to facilitate prompt and appropriate communication) handover sticker to improve the communication of information from one shift to another. Handover in labour is predominantly performed in the presence of the woman and her partner.
- We have extended the IAPT service in the antenatal clinic from half to a full day each week. The service continues to be well received by all services within the department.

Maternity Satisfaction Survey

The Maternity Department took part in a further national survey of women's experiences of maternity services in 2017. This survey is part of a series of national patient surveys undertaken by the CQC, and is for all NHS acute trusts with maternity services in England. The survey includes the whole patient journey from the first booking appointment to labour, delivery and discharge from the community midwife to the health visitor. Women were eligible for the survey if they had a live birth during January and February 2017, were aged 16 years or older, and either gave birth in a hospital maternity unit or had a home birth. The response rate at HDFT was 49% (national average was 35.8%). The survey has previously been undertaken in alternate years; from 2018 this will be an annual survey. We have an action plan in place to address some of the themes highlighted as important to the women, which are to:

- Improve the continuity of carer in the antenatal and postnatal period;
- Review of the length of antenatal appointments;
- Discuss the availability of consulting rooms for community midwives to work in with local GP practices;
- Consider extended use of children's centres as another option for antenatal appointments;
- Consider a more flexible approach to antenatal appointments, including weekends and evenings;
- Consider the use of appropriately trained maternity support workers for postnatal care at home to support the community midwifery staff.

Maternity Friends and Family Test

The FFT in maternity services enables women to provide feedback at the 36 week antenatal appointment, after delivery, on discharge from hospital and from the community midwife.

	Service	Q1	Q2	Q3	Q4	Full Year	National data 17/18*
Q1: Antenatal	% Recommend	98.1%	98.7%	97.6%	97.2%	**97.9%**	**96.3%**
	% Not Recommend	0.6%	0.0%	0.3%	2.2%	**0.8%**	**1.5%**
	Response rate	25.8%	19.4%	36.4%	41.1%	**30.7%**	-
	Number Of Responses	130	103	236	193	**662**	-
Q2: Labour	% Recommend	99.4%	99.6%	99.2%	99.5%	**99.4%**	**96.6%**
	% Not Recommend	0.0%	0.0%	0.0%	0.5%	**0.1%**	**1.3%**
	Response rate	34.9%	49.6%	50.6%	45.5%	**45.2%**	**22.9%**
	Number Of Responses	163	245	237	251	**896**	-
Q3: Postnatal	% Recommend	98.7%	100.0%	98.3%	97.7%	**98.7%**	**94.5%**
	% Not Recommend	1.3%	0.0%	0.4%	1.0%	**0.7%**	**2.0%**
	Response rate	36.6%	50.6%	48.5%	45.7%	**45.4%**	-
	Number Of Responses	171	181	242	186	**780**	-
Q4: Community Postnatal	% Recommend	97.2%	100.0%	100.0%	100.0%	**99.3%**	**98.0%**
	% Not Recommend	0.0%	0.0%	0.0%	0.0%	**0.0%**	**1.0%**
	Response rate	19.2%	15.5%	18.7%	4.1%	**14.4%**	-
	Number Of Responses	59	120	66	12	**257**	-

*National data is an average of published national results between April 17 - February 18

Table 39: Maternity FFT results 2017/18

Due to low response rates in 2017 for antenatal care, which might take place in the GP surgery, Children's Centre, home or hospital, we have introduced a new form which is given to women on the postnatal ward and covers the antenatal appointment, labour and delivery, and postnatal care in hospital. The response rates have improved as a consequence of this, and HDFT achieves a higher proportion of women recommending each element of the service than the national average. Response rates for postnatal care have continued to be low and this will be our focus during 2018.

The response rate and scores are monitored closely by senior midwifery managers and there is feedback of both positive and negative comments to staff. The department monitors the results to identify any themes and trends; predominantly the feedback is very positive. These are some themes and actions taken as a result:

You said	We did
There is a lack of facilities for partners staying for long periods.	• We created a new bathroom area with a shower on the postnatal ward to be used by partners and visitors. • The Friends of Harrogate Hospital and Community Charity have funded more recliner chairs for partners to use when staying overnight.
There is frequent disturbance for separate mums and babies observations.	We have synchronised observations for mums and babies whenever possible.
Emergency care for pregnant women between 12-20 weeks is confusing.	We have reviewed care provision and care pathways for pregnant women; • from 14 weeks women will now be seen on the Maternity Assessment Centre (previously 18 weeks) • The Early Pregnancy Assessment unit will see women until 13 weeks+6 days (previously 11 weeks+6 days)
Waterproof hand held foetal heart rate monitors are needed for community midwives.	Two have been ordered through charitable funds
The HDFT website does not state that children and young people under 16 are unable to visit unless siblings of the baby.	Website to be updated to show this information

Table 40: Maternity FFT "You said, we did"

Maternity Facebook page

This continues to be very well received and we receive large numbers of very positive feedback from the women who use the maternity services in Harrogate.

Advocating for Education and Quality Improvement (AEQUIP)

The decision was made to remove supervision from statute from March 2017 and the new model; Advocating for Education and Quality Improvement (AEQUIP) was introduced with the introduction of Professional Midwifery Advocates (PMAs) to replace the role of Supervisors of Midwives (SOMs). This employer led model includes a continuous improvement process that builds personal and professional resilience, enhances quality of care for women and their babies, and supports preparedness for appraisal and professional revalidation.

All six HDFT midwives that were previously SOMs have continued to support midwives and women during the interim period and three have undertaken the shortened bridging course to become PMAs in February 2018. We plan to send at least two midwives on the longer

course to become PMAs later in 2018. Once there is more understanding of this model we will implement it within the department.

Unicef Baby Friendly accreditation – Gold award

The Maternity Department has maintained Unicef UK Baby Friendly accreditation (BFI) since 2002 with several external assessments taking place over the years. In 2016 new standards were introduced by Baby Friendly for facilities that had maintained these core standards over time. To apply for the new gold award we had a full reassessment by a team of Baby Friendly assessors. This involved a range of staff being interviewed on their knowledge and skills, mothers being audited about the care they had received from booking to transfer to the health visiting service, and assessment of our documentation and mechanisms. This assessment took place over three days with four external assessors. There were two recommendations from the assessment which were addressed within three months. This result then allowed us to apply for the gold award within the next 12 months. Evidence for the gold award was submitted in November 2017. This included:

- **Leadership:** This involved the Head of Midwifery, Matron, managers from all areas and our new guardian (Chief Nurse) being interviewed around their knowledge of the standards, and how they would take proportionate responsibility and accountability for maintaining the standards and ensure full compliance with the international code of marketing of breast milk substitutes.
- **Culture:** Evidence of support for ongoing staff training and mechanisms to foster a culture that protects the Baby Friendly standards.
- **Monitoring:** Robust monitoring processes to support the standards.
- **Progression:** Evidence that the service is responsive to change, that the needs of babies and their mothers and families are met through effective integrated working and there is evidence to demonstrate improved outcomes.

Following further telephone interviews with the Head of Midwifery, the infant feeding lead and guardian and a detailed submission of evidence for the above standards we were awarded the gold award. We were the second maternity unit (third service) in the UK to achieve this.

Photo 1: HDFT Maternity Department Team were pleased to be awarded the Unicef Baby Friendly accreditation – Gold award

Safety monies from Health Education England

In December 2016 the Maternity Department received £40,000 for maternity safety training from Health Education England (HEE). This provided an excellent opportunity to support additional multidisciplinary training for the department and enhance maternity safety within the organisation. This has included:

- Labour ward leaders workshop: designed to address some of the current challenges in maternity services around leadership on delivery suite. The workshop supports labour ward leaders to work collaboratively together to develop cohesive teams delivering effective and safe care. The six staff who attended have introduced a daily multidisciplinary safety huddle on delivery suite.
- Human factors in healthcare training: this 'train the trainer' training aims to spread the impact, awareness and importance of human factors in multidisciplinary training in the department and share this knowledge and experience with the wider Trust.
- Emergency skills training: for community midwives.
- Arranging study days for internal and external staff: these cover breech presentations, parent education and perinatal mental health.
- Train the trainer Prompt (PRactical Obstetric Multi-Professional Training): this is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working. The monies were also used to purchase Prompt specific equipment.
- Regional neonatal life support training: this ensures that all delivery suite coordinators are up to date with neonatal resuscitation.

Collaborative working – maternity services, Emergency Department and ambulance staff

We have introduced combined continuing professional development (CPD) sessions facilitated by a consultant from the Emergency Department and senior midwives to support HDFT and Yorkshire Ambulance Service staff in the management of obstetric emergencies,

covering the patient journey from the pre-hospital phase to hospital care. The aim is to support staff who may be required to provide care to pregnant women outside the Maternity Department. The first session in October 2017 was attended by over 60 members of staff and focused on shoulder dystocia and cord prolapse. A second session in November was on the management of postpartum haemorrhage and breech delivery. A further session took place in March 2018 on pre-eclampsia, managing miscarriage, gynaecological emergencies and 'top tips' for delivery. These events are free and open to paramedics, emergency medical technicians, ED and obstetric middle grade and senior clinical staff, and midwifery staff. The feedback has been really positive:

- Enjoyed the evening - more reading now to be done;
- Very helpful insight into maternity emergencies;
- Could do with some events closer to our area – Scarborough;
- Thanks for everyone's time and effort for putting on these events, much appreciated;
- Alison extremely knowledgeable and enthusiastic about topic Very grateful for training and time taken to organise event, very informative;
- Great venue, please keep up the good work.

All staff who have attended have found the sessions really useful in their roles and we plan to continue with these events in the future.

Summary and next steps

There continues to be a significant amount of ongoing quality improvement work within the Maternity Department with some real achievements during 2017/18. As always there is more work to do and the quality objectives for the maternity service for 2018/19 are to:

- Improve the quality of and compliance with CTG (cardio-tocograph – continuous foetal monitoring) training for both midwifery and medical staff;
- Improve smoking cessation rates by improving the smoking cessation service available for women and the training for all staff within the department;
- Improve compliance with the national stillbirth bundle elements;
- Develop public and patient participation in service development by implementing a Maternity Voice Partnership Group, in line with the Better Births document and the National Maternity Safety Strategy and Clinical Negligence Scheme for Trusts incentive scheme for 2018/19;
- Implement the ATAIN (Avoiding Term Admissions to Neonatal units) programme to further develop the transitional care type model on the postnatal ward to keep babies with their mothers;
- Maintain BFI accreditation and the gold award, with annual audits and submission of a portfolio of evidence to support the gold accreditation in November 2018 and then every three years.

The work we have started to implement "Saving Babies Lives: A care bundle for reducing stillbirths" (NHS England 2016) will be a Trust quality priority for 2018/19. Although HDFT currently has a lower rate than the national average of stillbirth and has made good progress on the four recommendations, we want to progress audits to assess compliance and a business case to support serial ultrasound assessment of fetal growth throughout the third trimester of pregnancy in line with the Royal College of Obstetricians and Gynaecologists Green-top Guideline.

3. Enhanced Recovery

Enhanced recovery is an evidence-based approach that helps patients recover more quickly after having major surgery. The pathways aim to ensure that patients:

- Are as healthy as possible before receiving treatment;
- Receive the best care during their operation; and
- Receive appropriate and timely care while recovering.

By adopting the enhanced recovery model, we are able to keep patients' length of stay as short as possible, mitigating the risk of deconditioning and enabling them to return to their normal daily routine sooner rather than later.

What were we aiming to achieve?

We aimed to review compliance with existing enhanced recovery practice for hip and knee surgery and revise documentation accordingly, as well as improve the quality of patient information in relation to the Enhanced Care Pathway, and introduce the pathway to gynecology services.

What have we done?

A clinical audit in 2017 identified considerable good practice, but also a number of areas where documentation could be improved by amending the Enhanced Care Pathway. This was done and a recent re-audit has demonstrated improved quality of the documentation.

Meanwhile, a very different set of documentation was developed for the gynecology pathways. A communication strategy was established to ensure that staff were well informed about the planned introduction of enhanced care practice to the department. An informal check to identify any problems in completing the documentation was conducted in January 2018 and a formal audit is scheduled later in the year.

Extensive, full colour patient information leaflets were produced and posters created to enhance staff understanding of the principles of enhanced recovery. We have also prepared a script for use in a training video that we intend to produce over the coming months.

What are the results?

We set out to improve the quality of documentation in hip and knee surgery enhanced recovery as well as introducing the model to gynecology. This has been done, along with producing material aimed at both staff and patients in order to promote awareness and understanding of the pathway. The leaflets have been well received by patients.

Summary

While we have achieved what we set out to do, there remains more work to:

- Audit compliance with the gynaecology enhanced recovery documentation; dependent upon the outcome of this audit, there may be some revision of the documentation in order to make it as user-friendly as possible for the staff using it;
- Support colorectal services to develop their own patient information leaflets. Although they have been applying the pathway for a number of years, we identified that they do not have high quality patient information and that patients are sometimes getting mixed messages regarding their operation;
- Finish the training script and liaise with an external agent to create the training film that will be used to educate staff regarding enhanced recovery;
- Commence work to introduce the enhanced recovery pathway into further procedures including fracture neck of femur and caesarean sections.

3.3. EFFECTIVE CARE

1. End of Life Care

Good end of life care is the responsibility of all staff within HDFT. Patients are 'approaching the end of life' (EoL) when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:

a. advanced, progressive, incurable conditions;
b. general frailty and co-existing conditions that mean they are expected to die within 12 months;
c. existing conditions if they are at risk of dying from a sudden acute crisis in their condition;
d. life-threatening acute conditions caused by sudden catastrophic events.[1]

The aim is to improve patient and family experience at the end of life across HaRD in both community and hospital settings. Specialist palliative care is required by people with progressive life-limiting illness where the focus of care is on quality of life, and who have unresolved complex needs that cannot be met by the capability of their current generalist care team e.g. GP, district nurses, care home staff, consultants, hospital ward teams. Specialist palliative care in HaRD is delivered by the Palliative Care Team (PCT), a multidisciplinary team (MDT) of staff with the requisite qualifications, expertise and experience in offering care for this group of people. The PCT also leads on the implementation of quality initiatives to improve EoL care across the organisation.

What were we aiming to achieve?

The main aims and achievements during 2017/18 have been about setting the foundations for improving patient and family experience at the end of life and ensuring collection of robust data to provide the evidence.

The focus has also been on creating a culture of talking about death and dying so that it is easier for people to communicate their wishes to their family about what they want at the end of their life. We have aimed to:

- Ensure the PCT take on the lead for EoL care within HDFT;
- Enhance the support and care for patients in the last days of life in hospital including developing initiatives to improve patient and carer experience in hospital;
- Develop a systematic process for identifying all complaints, incidents and compliments relating to EoL care within HDFT;
- Establish a multi-agency working group to review fast track discharges for rapid discharge from hospital in last days of life;
- Produce a business case providing options for a seven day 9am-5pm face-to-face PCT assessment;
- Collect data and agreed metrics for monitoring improvements in EoL care in hospital and community;
- Implement an Electronic Palliative Care Co-ordination System within SystmOne across community care teams and GP practices to improve identification, recording and sharing of key information for patients who may be in the last year of life.

1. *Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020* (Sept 2015). National Palliative and End of Life Care Partnership: www.endoflifecareambitions.org.uk

What have we done and what are the results?

Lead on end of life care within HDFT

The PCT takes a lead role in delivering and supporting others to provide EoL care in both the hospital and community setting, as agreed within the HDFT End of Life Strategy. The team ethos within the organisation is to work collaboratively with many agencies across health and social care, integrating working and providing immediate specialist advice. The team has focused on regular attendance at key clinical MDTs including wards, GP palliative care meetings and community care teams. This proactively guides and supports professionals on the care of patients who may be approaching end of life. The result has shown a significant increase in the number of inpatient referrals.

The team has recruited additional clinical nurse specialists including an Education Lead for EoL care. The Education Lead has undertaken a scoping exercise of all palliative and EoL care education provided in the locality, covering hospital, community including care homes, and hospice. A strategy is being developed to meet the training needs of all staff groups across the organisation based on the NHS England End of Life Care Learning Outcomes (2017).

Enhance the support and care for patients in the last days of life in hospital

The team, in partnership with nursing and medical staff, has developed new guidance and documentation to support care in the last days and hours of life in hospital. This enables ward staff to provide sensitive, individualised care for the patient and their loved ones.

Practical initiatives include:

- Comfort bags for relatives and carers who are staying overnight or for long periods in hospital with their dying relative to ensure their stay is as comfortable as possible (includes blanket, pillow, toiletries, meal voucher, eye mask, ear plugs);
- Reclining bed / chair for carers staying overnight with dying patients;
- End of life volunteers available in hospital to support families and patients in their last days and hours. Volunteers can sit with patients for a period of time if there is no family present or if the family need respite during the day;
- Improved written information for relatives both before and after death;
- Dying Matters events and links with the local community including schools to encourage talking about death and dying so that we can articulate our wishes at the end of our life.

Figure 24: Comfort bags and reclining chairs

All of the new initiatives have been well received by patients, families and ward staff. The pilot for the three EoL volunteers is coming to an end and it is expected that further volunteers will be recruited so that the service can be provided on more days.
During Dying Matters Week we discussed many aspects of dying in the local papers, on local radio and social media. Subjects covered included arranging a funeral, bereavement counselling, dementia, making a will, and caring for someone at home during their last days. This generated debate and discussion within the local community. We continue to maintain

links with local schools and are keen to keep the conversation going about death, dying and bereavement.

Process for identifying all complaints, incidents and compliments relating to EoL care

A quarterly summary report is produced of all EoL complaints, concerns, incidents and compliments from across the organisation. The hospital bereavement survey is ongoing and sent out to all consenting bereaved families for feedback on their experience of EoL care before and after death. The prime aim of all of this is to monitor emerging themes and to use the information to support improvements in EoL care and guide relevant training and education.

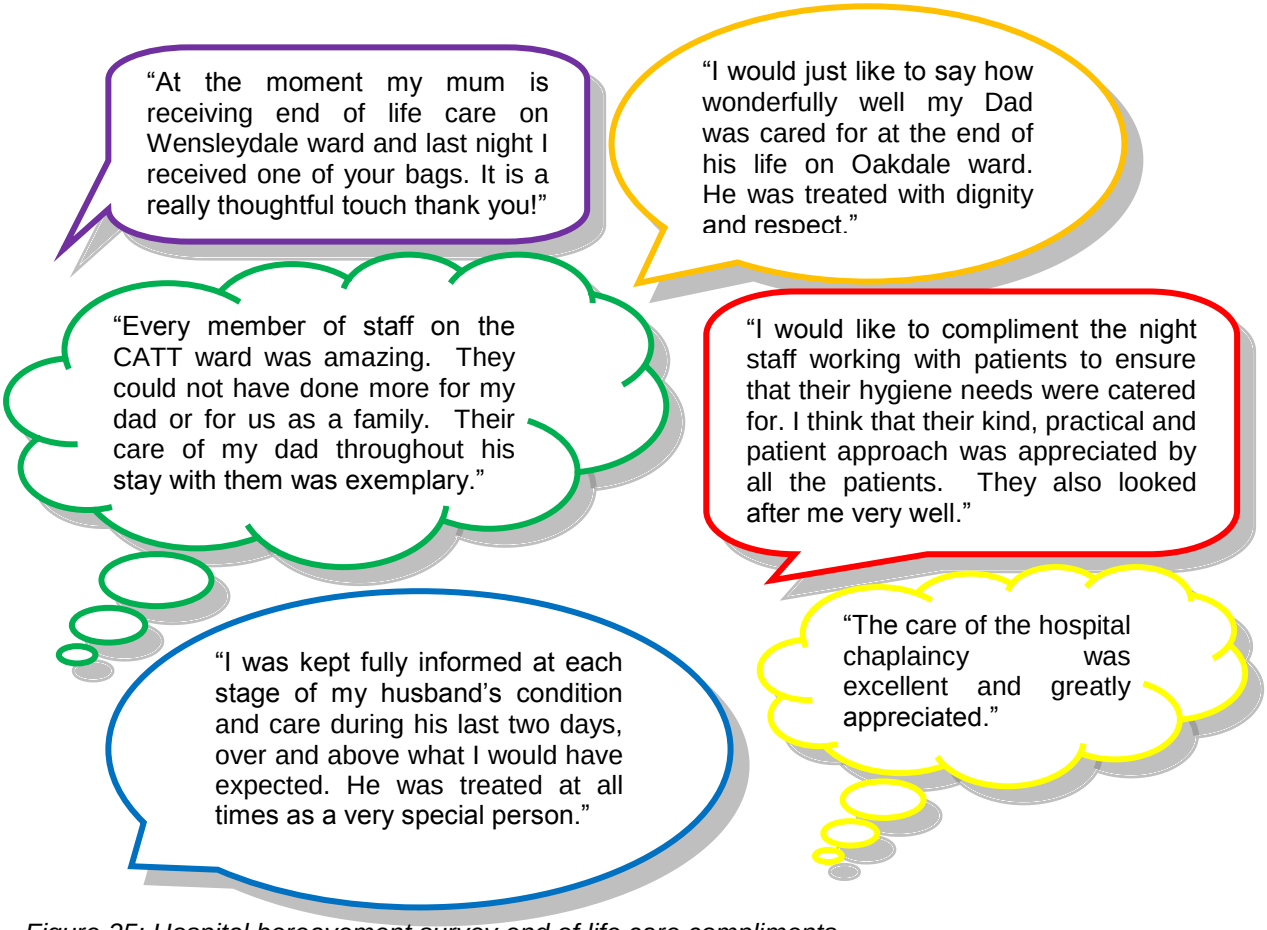


Figure 25: Hospital bereavement survey end of life care compliments

Multi-agency working group to enable rapid discharge from hospital in last days of life

Key health and social care professionals from the hospital, hospice, CCG, community care teams and Marie Curie have met regularly to evaluate the process of fast track rapid discharge and fast track processes at home. The agreed outcomes have been to ensure:

- Patients and carers have informed choices about preferred place of care and death;
- Safe and timely discharge with access to medicines and equipment;
- Safe and timely discharge to care and support;
- Reduce unnecessary bed days/admissions to hospital.

The working group has identified current issues and agreed actions to improve processes. Significant progress has been made in improving the documentation required between the agencies involved. The CCG have also agreed to implement the proposed service redesign which includes establishing an EoL coordinator for all fast track patients to act as a single

point of access. This will enhance the process and reduce delays and is based on evidence from other service models across the region. Further progress is required in other areas but the group continues to be committed to achieving the objectives.

Options for a seven day 9am - 5pm face-to-face Palliative Care Team assessment

A proposal paper was developed addressing modelling options and cost requirements for access to face-to-face assessments by the PCT 9am – 5pm seven days a week in hospital and community. From this a business case was written and an application submitted to Macmillan for initial funding. These have now been agreed and we are beginning the recruitment process and hope to implement the seven day service in 2018.

Data and metrics for monitoring improvements in EoL care in hospital and community

Baseline data collection has been agreed. A selection of this includes:

- Recording of patients' preferred place of death (PPoD) and the percentage of those dying in their PPoD;
- Number of people who were discharged on a rapid discharge;
- Number of admissions of patients in their last year of life;
- Number of deaths in hospital and community;
- Organ and tissue donation;
- Mortality data.

Baseline data has been obtained and our Information Services team will provide regular monthly reports which will help inform future practice in a timely manner.

Implementing an Electronic Palliative Care Co-ordination System

With funding from NHS Harnessing Technology a six month project to roll out the Electronic Palliative Care Co-ordination System across GP practices and Community Care teams has commenced. A shared template has been rolled out to record key information about patients at the EoL in the majority of GP practices, the PCT, community care teams, hospice, respiratory and heart failure teams. The information is based on a national End of Life Care Information Standard. The template contains links to relevant clinical guidelines and a variety of forms that improves efficiency for healthcare professionals. Further information is available at: https://www.hdft.nhs.uk/services/palliative-care/epaccs/

Summary and next steps

There has been significant progress on implementing the objectives in the HDFT EoL Strategy and this has led to improvements in the care and support of patients and their families. Timely data analysis has been difficult but it is anticipated this will be resolved this coming year. Key areas to focus on over the next year are to:

- Establish the new seven day 9am - 5pm face-to-face assessment by the PCT;
- Improve data analysis to demonstrate effectiveness of the service;
- Agree metrics for measurement of improvements in EoL care and reporting processes;
- Continue the work on rapid discharge and preferred place of care and death;
- Participate in the National Audit of Care at the End of Life (2018);
- Finalise the HDFT EoL Education Strategy and agree actions for implementation;
- Deliver training and education to a range of healthcare professionals around care for patients at the end of life;

- Include education and training in 'essential skills training' for key staff as agreed by the strategy;
- Review the HDFT Care of the Dying Adult and Bereavement Policy for hospital and community;
- Refurbish quiet rooms identified for the use of patients and families at the end of life;
- Establish the feasibility of an ongoing bereavement survey to be sent out to all consenting bereaved families for feedback on their experience of EoL care in community settings;
- Develop documentation to support care in the last days and hours of life for patients in their homes or care homes.

2. Dementia care

Dementia remains a government priority in England and Wales. The Prime Minister's Challenge on Dementia 2020 emphasised the need to improve hospital care for people with dementia and make hospital environments more 'dementia friendly'. HDFT cares for a large number of patients living with dementia. On the frailty wards (Jervaulx and Byland) about 50% of patients have a diagnosis of dementia or, as yet undiagnosed, cognitive impairment.

Patients living with dementia can present to any of our services and departments and so it is important that all staff have awareness and skills in caring for this group of patients.

What were we aiming to achieve?

During 2017/18 we have set out to reinvigorate the Dementia Working Group, which has begun to meet on a monthly basis in order to take forward work from the dementia action plan. The group includes the dementia champions from all wards as well as matrons, the Clinical Lead for Dementia, and representatives from Workforce and Development, and Clinical Effectiveness and Audit.

We have set out to ensure that all relevant staff receive adequate dementia training. At present this is delivered as e-learning for most staff. Results from the National Audit of Dementia Care suggest that we are unusual in relying entirely on e-learning to deliver training and that staff would prefer some face-to-face training. This has resulted in collaboration from the Tees, Esk and Wear Valley (TEWV) NHS Foundation Trust Acute Hospital Liaison Service (AHLS) who are assisting in our training programme.

What have we done and what were the results?

We have completed the National Audit for Dementia Care in General Hospitals 2016-17 which included analysis of care notes, an organisational checklist, and staff and carer questionnaires. Results were reported in July 2017 and have formed the basis of the work that the Dementia Working Group is setting out to achieve. Subsequently we participated in the National Audit of Dementia spotlight audit on delirium. The results of this are awaited.

The Butterfly Scheme was re-launched in November 2017 with input and support from its founder, Barbara Hodkinson.

AHLS staff have developed an education programme for HDFT staff, with specialist teaching on dementia, delirium and depression delivered on a monthly basis. We provide training for any staff who wish to become "Dementia Friends". We also have an ongoing programme of teaching about the diagnosis and management of dementia and delirium for doctors in training.

Level of training	Frequency	Number of staff requiring training	Number of staff trained	Percentage achieved
Dementia awareness	3 yearly	2044	1706	83%
Dementia tier 1	2 yearly	1814	1410	78%

Table 41: Dementia training compliance

We have also participated in the 'end PJ paralysis' campaign, whereby we try to reduce deconditioning due to immobility while in hospital. On Byland ward, one of the frailty wards, we now aim to get as many patients as possible up and out of bed, and changed from pyjamas (PJs) into their own clothes, and keep a visual record of this each day.

Photo 2: End PJ Paralysis campaign launch August 2017

The premise of the 'end PJ paralysis' campaign is simple. Once patients arrive in hospital they normally stay in their pyjamas or hospital gown until they are discharged. Research indicates that ten days of bed rest in patients over 80 can lead to 10 years of muscle wastage. It can then take double the amount of time to recondition, resulting in increased dependency, longer length of stays and an increase in 24-hour care placements. By promoting independence and enabling patients to get up, get dressed and get moving we reduce the risk of deconditioning, enhance patients' dignity and promote an active recovery to return home. Encouraging patients living with dementia to wear their own clothes further enhances their sense of identity. This may aid their transition of having to be in hospital.

A Carer's Passport was launched in January 2018. This gives support to carers who are looking after patients while they are in hospital and gives them the opportunity to work with doctors and nurses. The passport gives carers privileges such as out-of-hours visiting and overnight stays, as well as discounted food and drink in Harrogate District Hospital. *John's Campaign* has gathered

Photo 3: Carer's passport launch January 2018

examples of hospitals with some sort of carer friendly initiative- Based on this review there are 103 NHS trusts that have a carers passport scheme which has been identified to support carers caring for patients living with dementia. Feedback from people who care for those living with dementia have said they wanted more information on visiting their loved ones out of hours to be able to support them in their treatment. The Carer passport offers this opportunity to our relatives.

Friends of Harrogate Hospital and Community Charity organised an Old Time Music Hall event at the Royal Hall in Harrogate in October 2017 with proceeds from the event given to support dementia projects within the Trust.

We continue to have daily safety huddles on the two frailty wards, focusing on falls prevention and prevention of pressure sores. This includes a brief assessment of whether patients are living with dementia or have delirium and what measures can be put in place to ameliorate distress and challenging behavior.

The Trust has also been identified as one of five pilot sites across the West Yorkshire and Harrogate STP to roll out the 'Think Delirium' campaign which was launched in October 2017 by the Yorkshire and Humber Clinical Network. The basis of the campaign is that we aim to:

- Prevent delirium by calculating risk, assessing for clinical factors which might lead to delirium and formulate a daily care plan that is relevant to the patient;
- Suspect delirium if we find a patient with new or worsening confusion;
- Stop delirium by treating causes, offering explanation and reassurance and attending to a patient's physical needs.

Summary and next steps

Some of our aspirations for this year have been achieved, namely the re-launch of the Dementia Working Group, collaboration with the AHLS to deliver staff training, and our involvement as a pilot site for the 'Think Delirium' campaign. The Dementia Working Group action plan will continue to promote work to ensure:

- Improvement in delirium screening and recording, and improving the collection of personal information on 'All About Me' forms;
- Appropriate food is always available for patients living with dementia;
- Staff can access specialist dementia care out of hours;
- The views of patients are taken into consideration when decisions are being made about hospital discharge and that this is appropriately recorded;
- Patients are weighed as part of their nutritional assessment;
- Discussion and peer learning between staff who are involved in caring for patients living with dementia;
- Medical staff are trained to repeat the Abbreviated Mental Test Score prior to discharge;
- Information about the care of patients with dementia is fed back to the Trust Board.

Other plans are to:

- Investigate resources for training staff who require Tier 2 and Tier 3 Dementia training;
- Launch the "Think Delirium" campaign once resources are available from Yorkshire and Humber Research Network;
- Participate in round four of the National Audit of Dementia Care in General Hospitals;
- Incorporate training about delirium into junior doctors' induction.

- Delirium has been identified as a focus for an Rapid Process Improvement Workshop (RPIW) with the facilitated by the Improvement and Transformation Team for the week commencing 9th July 2018

3. Nutrition

The Trust is committed to providing high quality nutritional care and adequate hydration for patients across all acute and community locations. The Trust Nutrition Group which is chaired by the Professional Lead for Nutrition and Dietetics co-ordinates this work. Evidence both locally and nationally shows that one third of patients admitted to hospital are at risk of malnutrition. Malnourished patients require more frequent and prolonged admissions, therefore it is vitally important that the Trust ensures it can identify those patients who are at risk and have appropriate support in place to meet their needs.

The Trust also recognises the need for a healthy workforce, therefore the Nutrition Group is also responsible for ensuring the organisation can meet national targets for provision of healthy food for staff and visitors as well as sustainable, local procurement of products used within the catering service.

What were we aiming to achieve?

In 2017/18 the Nutrition Group aimed to complete the HDFT Food and Drink Strategy which would outline activities and initiatives for the next five years. This would include plans to achieve national targets, a framework for nutrition audits and a nutrition action plan. We also wanted to ensure that all our nutrition related policies and pathways were up to date, in line with NICE guidance and realistic to ensure patient safety and quality of nutritional care, and we wanted to continue with training in the importance of nutrition screening and action planning for frontline staff.

What have we done?

Trust Food and Drink Strategy

The Trust Food and Drink Strategy has been completed and ratified. An action plan has been developed to move forward with the new initiatives. These include the development of:

- a Trust-wide nutrition audit plan, so that we have oversight of all nutrition audits and can ensure that specific issues are identified and actions implemented;
- a more robust method of recording all nutrition related incidents via the Datix system, so that themes can be identified and escalated quickly to improve patient care and safety;
- improved compliance with weighing patients following admission as evidenced by matron assurance checks.

National targets

Catering, Dietetics and Human Resources Departments have worked together to ensure compliance with the national Commissioning for Quality and Innovation (CQUIN) targets. We achieved the year two targets for pre-packed sandwiches and sweets and confectionary by the end of year one in March 2018. Therefore 80% of pre-packed sandwiches available to purchase in the Trust managed outlets, such as Herriot's restaurant and the Café Bar, contain a maximum of 400 kcals and less than 5% saturated fat. Also 80% of sweets and confectionary available contain less than 250 kcals. Our snack vending machines are also compliant with this target. We also signed up to the voluntary NHS England Sugar-Sweetened Beverages initiative, requiring us to reduce sales of sugar containing drinks to 10% of total sales. To ensure we met this initiative we have stopped selling any drinks

containing greater than 5 g of sugar/100mls in Herriot's or the Café Bar. We are working with other providers such as Coca Cola, who provide our vending machines on site, to aim to achieve this reduction in the future. Currently 11% of product lines stocked in the vending machines contain more than 5g sugar/ 100mls. We have therefore met the national CQUIN year two target for reducing the availability of sugar containing drinks already, however, we need to continue to work with Coca Cola to reduce the sales of these products down to 10% to achieve compliance with the NHS England voluntary scheme.

Nasogastric feeding policy and pathway

The Trust nasogastric feeding policy and pathway was updated to ensure compliance with recent patient safety alerts and the new documentation to support this was launched in July 2017. The use of this is being audited in 2018.

Thickened fluids

New guidance has been written and signage developed to ensure that patients who require thickened fluids have safe access to appropriately thickened drinks.

This process will also be audited in 2018.

Figure 26: Thickened fluid signage

Coloured crockery and finger foods

We have identified funding via the Friends of Harrogate Hospital and Community Charity to enable us to purchase coloured crockery to help with promoting increased oral intake in patients with dementia and a new finger food menu will also be available for this group of patients.

Summary

Completion of the Food and Drink Strategy was a major piece of work for the Trust. This has allowed us to develop a framework for future improvements. Our audit plan allows us to monitor compliance with nutrition policies and initiatives, and the reporting structure allows us to ensure that any risks to patient safety related to nutrition are escalated and resolved quickly.

Other plans for the next year include closer working with the tissue viability nurses around the causes and treatment of pressure ulcers, improved training for both community and hospital based staff on nutrition screening and management of gastrostomies, and the development of a business case to support the recruitment of a trust-wide nutrition nurse specialist.

3.4. PERFORMANCE AGAINST INDICATORS IN THE SINGLE OVERSIGHT FRAMEWORK

The following table demonstrates HDFT's performance against the national standards included in the Operational Performance Metrics section of NHS Improvement's Single Oversight Framework for each quarter in 2017/18.

Standard	Minimum performance standard	Q1	Q2	Q3	Q4	YTD
RTT incomplete pathways	92%	93.8%	92.3%	91.9%	90.5%	92.1%
A&E 4-hour standard	95%	96.7%	96.0%	94.9%	92.8%	95.2%
Cancer - 62 days	85%	86.1%	88.9%	90.5%	90.2%	88.9%
Diagnostic waits	99%	99.8%	99.6%	99.7%	99.4%	99.6%

Table 42: Performance against indicators in the Single Oversight Framework

Key performance to note:

- The Trust achieved all four national standards included in the Operational Performance Metrics section of NHS Improvement's Single Oversight Framework for the full year 2017/18;
- In addition, the cancer 62 day waiting times standard and the diagnostic waiting times standard were achieved for each quarter of the year;
- Overall Trust performance against the A&E (Emergency Department) 4-hour waiting time standard was above 95% for seven out of 12 months throughout the year;
- The Trust achieved the 18 week standard for eight out of 12 months throughout the year;
- All other cancer waiting times standards were achieved for each quarter overall with the exception of the 14 day standard for beast symptomatic patients where performance was at 89.4% for Q4, against the minimum standard of 93%;
- There was one ambulance handover delay of over 60 minutes reported in 2017/18 (8 last year) and 85 handover delays of over 30 minutes (104 last year). Emergency Department attendances were 4.4% higher than for the same period last year;
- Activity levels at the Trust have increased during 2017/18. Elective (waiting list) admissions were 2.5% higher in 2017/18 when compared to 2016/17 and non-elective admissions increased by 3.9%. Outpatient attendances remained static with a total of 283,000 outpatient attendances in 2017/18;
- The Trust reported seven cases of hospital acquired *Clostridium Difficile* in 2017/18, compared to 29 in 2016/17. Five cases have had a completed root cause analysis (RCA). Results indicate that four of these cases were not due to lapses in care, and therefore, these would be discounted from the Trust's trajectory for 2017/18. One case has been agreed with the CCG to be as a result of a lapse in care and RCAs have yet to be completed for two cases. No cases of hospital acquired MRSA (Methicillin-resistant Staphylococcus aureus) were reported in 2017/18.

4. OTHER QUALITY INFORMATION

HDFT has identified additional elements of service quality to highlight in this Quality Account.

4.1. SUMMARY OF NATIONAL PATIENT SURVEY RESULTS

Emergency Department (ED) Survey 2016

Results from the National ED Survey were published on the CQC website in October 2017. As expected from the initial Picker results, performance for HDFT was excellent and the Trust was identified as performing 'better' than expected compared to other trusts. This was because a higher proportion of patients responded positively about the care they had received. This is a brilliant result for the staff in the department.

Children and Young People's Inpatient and Day Case Survey 2016

Results from the National Children and Young People's Survey 2016 were published on the CQC website in November 2017. We performed better than other trusts on four questions, and worse on three questions.

Questions on which we performed better:

- Did you like the hospital food?
- Did the hospital staff answer your questions?
- Before the operations or procedures, did hospital staff explain to you what would be done?
- Before your child had any operations or procedures did a member of staff explain to you what would be done?

Questions on which we performed worse:

- Did members of staff treating your child communicate with them in a way that your child could understand?
- When you left hospital, did you know what was going to happen next with your care?
- When you left hospital, did you know what was going to happen next with your child's care?

A multidisciplinary workshop was held with staff to review the results and pull together an action plan to address the areas for improvement.

National Cancer Survey 2016

The National Cancer Patient Experience Survey 2016 is the sixth iteration of the survey first undertaken in 2010. In all surveys we have been one of the top performing trusts in the country. The consistency of such attainments provides us with assurance regarding the sustained provision of high quality cancer care.

Asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating of 9.0. The following questions are also included in phase one of the Cancer Dashboard developed by Public Health England and NHS England:

- 84% of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment;
- 97% of respondents said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment;

- 93% of respondents said that it had been 'quite easy' or 'very easy' to contact their clinical nurse specialist;
- 88% of respondents said that, overall, they were always treated with respect and dignity while they were in hospital;
- 96% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital;
- 64% of respondents said that they thought the GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment.

For some cancer sites the report does not provide any site specific data regarding quality of the service i.e. sites with less than 20 respondents, or where we only provide diagnostic facilities, or in the case of skin cancer where treatment is provided as an outpatient procedure. We have no reason to believe that these results would not be replicated due to culture and approach to cancer care across the Trust; however we cannot be complacent and local methods of gaining service user views are therefore being implemented for these areas.

National Maternity Survey 2017

Results from the National Maternity Survey 2017 were published on the CQC website in January 2018. Our 2017 banding compared to the 'expected range' is better for five questions and as expected for all others. The questions where we performed better than expected are:

- Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?
- Thinking about your care during labour and birth, were you treated with respect and dignity?
- Did you have confidence and trust in the staff caring for you during your labour and birth?
- Would you have liked to have seen a midwife: More often? Less often? etc.
- Did a midwife tell you that you would need to arrange a postnatal check-up of your own health with your GP? (Around 6-8 weeks after the birth).

Our performance has worsened since the 2015 survey on four questions:

- Were you offered any of the following choices about where to have your baby?
- During your antenatal check-ups, did the midwives appear to be aware of your medical history?
- Did the midwife or midwives that you saw appear to be aware of the medical history of you and your baby?
- Were you given information or offered advice from a health professional about contraception?

Our performance has improved since the 2015 survey on two questions:

- Did you have confidence and trust in the staff caring for you during your labour and birth?
- In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?

4.2. NATIONAL STAFF SURVEY AND STAFF FRIENDS AND FAMILY TEST

National Staff Survey 2017

The anonymous national survey was carried out among a sample of Trust staff between October and November 2017. 1,250 surveys were distributed to members of staff and 638 were completed. HDFT had the second highest response rate in the country for our benchmark category at 52%. The average return rate in the Combined Acute and Community Trusts category was 43%.

Results are presented in 32 key areas known as 'key findings' as well as a measure of overall staff engagement. The Trust scored above average (which is the highest rank possible in the category of Combined Acute and Community Trusts) in 19 out of 32 areas.

The figure below shows how the Trust compares with other Combined Acute and Community Trusts on an overall indicator of staff engagement. Possible scores range from one to five, with one indicating that staff are poorly engaged (with their work, their team and their trust) and five indicating that staff are highly engaged. The Trust's overall Staff Engagement score of 3.83 is ranked above average in the Combined Acute and Community Trusts category. This is the highest rank possible.

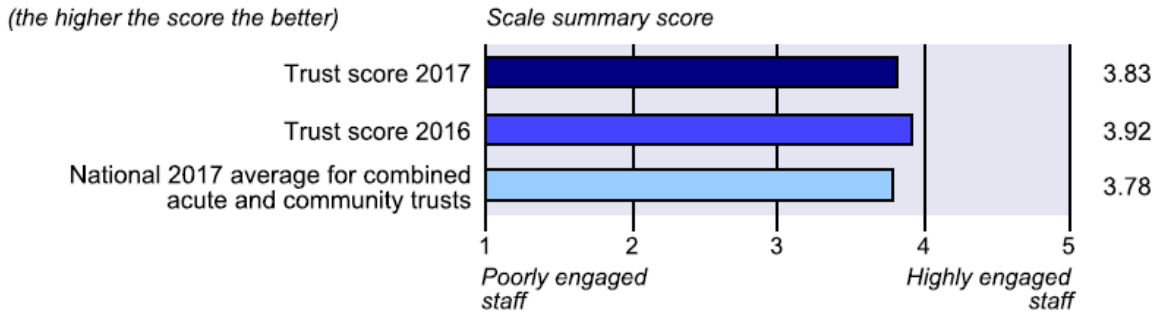


Figure 27: National Staff Survey 2017 staff engagement score

The top five ranking scores for HDFT were as follows:

Top five ranking scores compared with Combined Acute and Community Trusts in England.	HDFT 2017	National average
Percentage of staff satisfied with the opportunities for flexible working patterns	61%	51%
Percentage of staff experiencing discrimination at work in the last 12 months	7%	10%
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	20%	27%
Percentage of staff experiencing physical violence from staff in last 12 months	1%	2%
Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	25%	29%

Table 43: National Staff Survey 2017 top five ranking scores for HDFT

Our score for the key finding: percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months improved from 2016 (21% versus 22% in 2016) and is better than the national average of 24%.

The largest local change for HDFT was for the key finding: percentage of staff appraised in the last 12 months. Our score increased from 85% in 2016 to 90% in 2017, which reflects

the positive approach to managing appraisals through an 'appraisal window' this financial year.

Five areas for improvement were identified from last year's survey. Two of these areas have shown improvement in this year's survey.

Area for improvement	2016	2017
Percentage of staff experiencing physical violence from staff in last 12 months	2%	1%
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	13%	11%
Staff confidence and security in reporting unsafe clinical practice (1 = lowest 5 = highest)	3.84	3.74
Percentage of staff working extra hours	71%	71%
Percentage of staff feeling unwell due to work related stress in the last 12 months	36%	38%

Table 44: National Staff Survey 2017 five areas for improvement

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

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

Two other areas were also highlighted as areas for improvement in the report. These are scored as average when compared with other combined acute and community trusts:

- Quality of non-mandatory training, learning or development (reduction from 4.15 to 4.04);
- Percentage of staff working extra hours (71% in 2016 and 2017).

We have also identified that the following key findings should form part of our staff engagement action plan for 2018/19:

- Staff recommendation of the organisation as a place to work or receive treatment (reduction from 3.96 to 3.79);
- Percentage of staff able to contribute towards improvements at work (reduction from 75% to 70%).

The percentage of staff believing that the Trust provides equal opportunities for career progression or promotion in key finding 21 showed deterioration at 90% versus 92% in 2016, although HDFT scores better than the national average of 85%.

The full report can be found at http://www.nhsstaffsurveys.com/

The key themes from the 2017 survey will be incorporated into our 2018/19 Staff Engagement Action Plan.

Staff Friends and Family Test

The Staff Friends and Family Test (FFT) is a feedback tool for staff, predominately to support and influence local improvement work. It allows us to take a 'temperature check' on how staff are feeling and is a complementary engagement activity to the annual National Staff Survey. The Staff FFT asks the following two questions:-

1. How likely are you to recommend the Trust to friends and family if they needed care or treatment?
2. How likely are you to recommend the Trust to friends and family as a place to work?

The Staff FFT for Quarter 2 2017/18 was open from 11 to 22 September 2017, with 4493 staff being invited to participate. We adopted a multi-mode approach to the survey, using an open-URL and paper questionnaire methodology for Q2, which enabled staff who traditionally would not have access to the electronic survey e.g. ward based staff to contribute. There were 1067 respondents which is the equivalent to a 24% response rate. This was a 5% point increase in response rate from Q1, equating to 336 more respondents.

The results highlighted that 83.7% of staff would recommend the Trust to friends and family to receive care or treatment against a national average of 80%, and that 64.7% would recommend the Trust as a place to work in comparison to a national average of 64%.

The survey provides the opportunity for staff to provide additional comments and the results are reviewed each quarter by the directorates to ensure continuous service development. The key reasons for staff recommending the Trust as a place to receive treatment or care is due to the skilled and caring staff, the high standards of care and the friendliness of the hospital whilst the reasons given for not recommending care or treatment at our Trust is due to concerns around staffing levels.

The fundamental reasons given by staff for recommending the Trust as a place to work was related to the enjoyment of work, working within a caring, friendly and supportive team whilst the reasons given for not recommending the Trust as a place to work were due to staffing levels and high workloads.

The key themes from the Staff FFT are fed into our staff engagement action plan, which incorporates the themes arising from the National Staff Survey to ensure these are aligned.

4.3. COMPLAINTS AND COMPLIMENTS

The Trust welcomes patient feedback including positive as well as negative experiences. Front line staff are encouraged and empowered to respond to patient feedback, receive compliments and resolve minor problems informally as quickly as possible. The Trust has a Making Experiences Count process and policy to resolve all concerns and complaints locally (within the Trust).

The Patient Experience Team (PET) facilitate the resolution of issues and this could include offering the opportunity of meeting with clinical staff, speaking with service managers or meeting the Medical Director and/or the Chief Nurse to discuss issues in more detail to help to address concerns and provide information and explanations. In all cases the feedback is reviewed to identify opportunities for improving patient care.

The Trust has an estimated 1.8 million patient contacts per annum, which equates to around 4,900 per day. Whilst every individual complaint is very important, especially to the

complainant, the average rate of around 17 complaints per month in 2017/18 is relatively small and has decreased from the average in 2016/17 (19 per month).

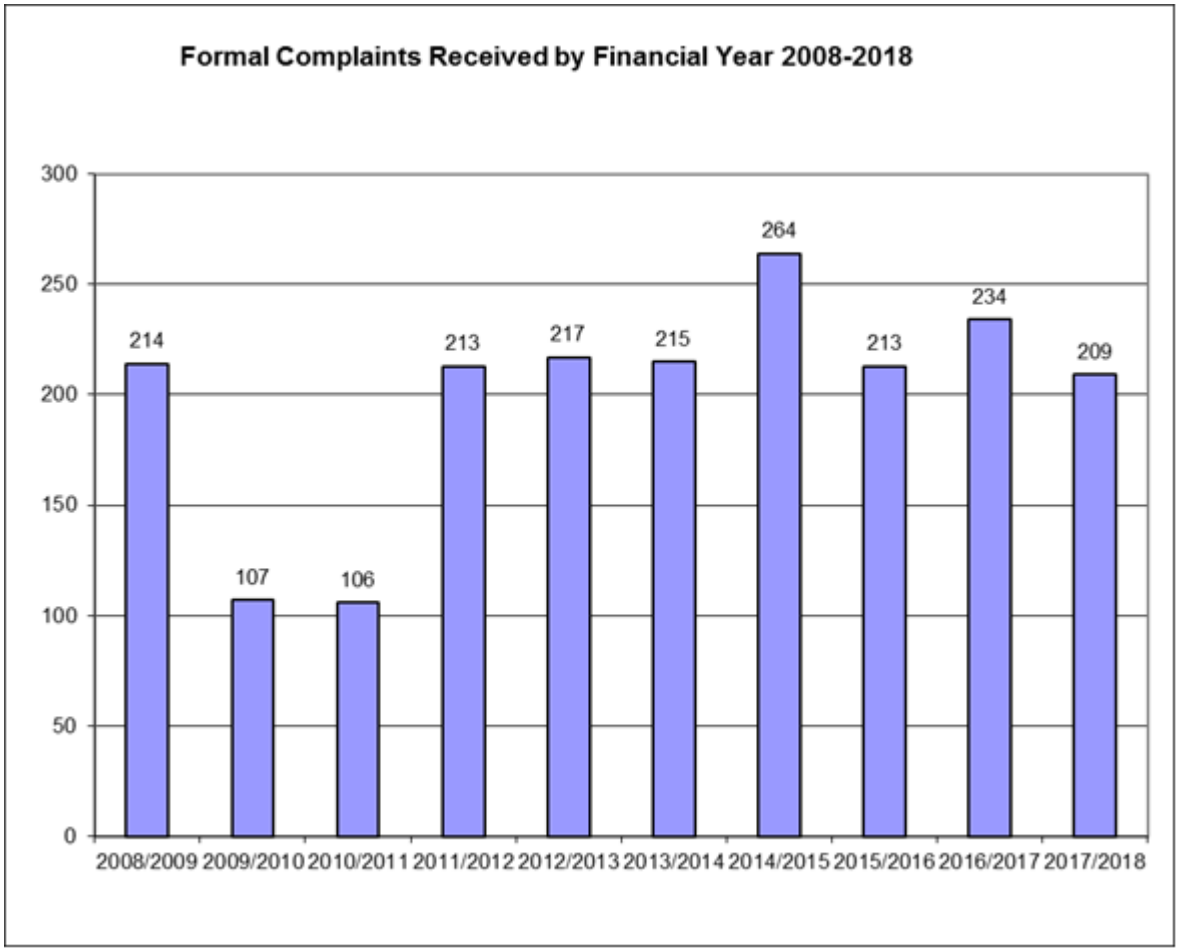


Figure 28: Local patient feedback data since 2008

The data from April 2008 to March 2011 refers only to acute hospital services, whilst the data from April 2011 represents both acute and community services following the integration of community services into the Trust. The Trust increased in size associated with the delivery of a significant number of new services.

The Trust uses a grading matrix for complaints raised, which is based on severity of concerns and timescales for response. This includes four levels of formal complaint (green, yellow, amber and red). The breakdown of complaints received in 2017/18 is presented below by grade and quarter in which it was received, compared to 2016/17.

Complaints Total	2016/17 Total	2017/18				
		Q1	Q2	Q3	Q4	Total
Complaint - green	55	17	8	16	16	57
Complaint - yellow	178	33	40	32	44	149
Complaint - amber	1	2	1	0	0	3
Complaint - red	0	0	0	0	0	0
Total	**234**	**52**	**49**	**48**	**60**	**209**

Table 45: Local patient feedback data showing complaints by quarter during 2017/18 and grade

The number of complaints received is less than the previous year but the number of cases indicating very poor experience which are graded amber is higher than last year. Quarter 4

received the most numbers of complaints and it should be noted that this was during the winter pressures experienced across the NHS as a whole when staffing and activity levels were challenging.

The Trust welcomes feedback from patients, families and carers and encourages staff to resolve as many issues and concerns at the front line informally and as soon as possible to prevent the escalation into a formal complaint. The resolution of these informal "PALS" (Patient Advice and Liaison Service) type contacts includes concerns, information requests and comments. In total in 2017/18, 1056 were received by the Patient Experience Team (PET) compared to 936 in 2016/17, and 676 in 2015/16. Of these 1056, 653 were concerns, 223 were requests for information and 180 were comments. The continued increase in cases dealt with informally demonstrates the ambition of all staff to address concerns before they escalate into more serious issues and the successfully signposting and publicity of the work of the PET to the general public.

The top five themes for complaints and concerns can be seen in the graph below. The main themes have consistently included issues around poor communication and attitude.

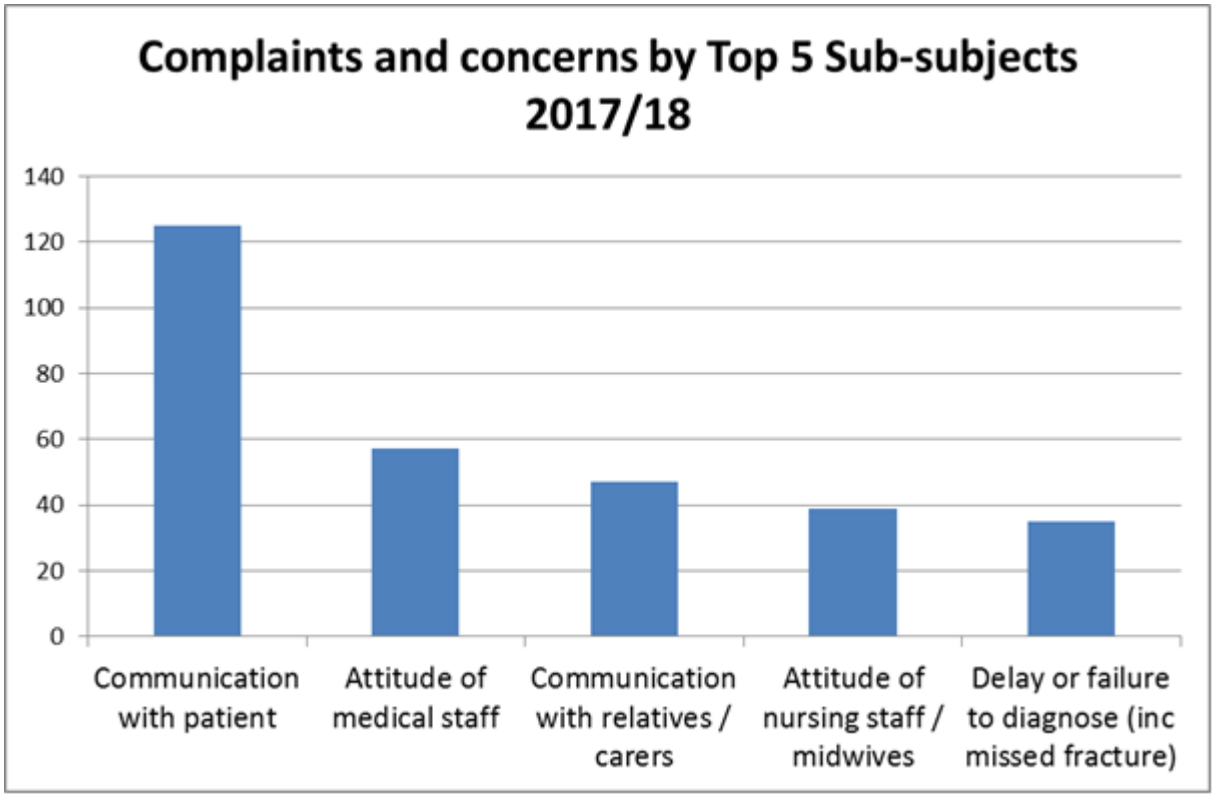


Figure 29: Local patient feedback data showing the main themes in complaints and concerns

The Trust investigates all complaints and concerns and provides appropriate feedback to the contact (after consent is established if the feedback is to a third party).

A lead investigator is expected to make early contact with the complainant to agree the issues being investigated, the method of resolution and timeframe for reply based upon the Trust's grading matrix. The investigation focuses on what happened, what should have happened and where appropriate, what the actions will be to prevent it from happening again. The investigation is then quality assured by the operational director or clinical lead for the area to determine whether the investigation and response is robust and whether the issues complained about have been upheld. It should be noted that not all complaints or concerns received are upheld.

Response timeframes for complaints are guided by the severity of the case and are agreed at the outset. The Trust introduced a complaints performance metric in 2016/17 which includes monitoring of complaints responses against a target of 95% within deadline set and monitoring of completion of action plans. The Trust met the defined timescale for reply in 56% of cases in 2017/18 *(*of those deadlines reached at the time of reporting*)* and sought extensions where the deadline could not be reached. This is an increase from 38% in 2016/17. The Trust is keen to improve this performance next year and this is being monitored closely on a quarterly basis. Further training sessions to increase the pool of lead investigators has been delivered this year including staff from all three clinical directorates and the corporate services directorate.

Action plans are developed to improve patient care as a result of feedback and these are monitored regularly. Learning from patient feedback is at the heart of our Making Experiences Count Policy, and clinical directorates share themes and learning from these via their governance groups and front line quality of care teams.

Five cases were referred to the Health Service Ombudsman in the period. Of the five cases referred this current financial year:

- 2 cases were closed without any investigation;
- 2 have been investigated and found to be not upheld;
- 1 case is undergoing initial review by the Ombudsman.

In 2016/17 the Ombudsman investigated four cases and none of these were upheld. In one case the Ombudsman decided not to investigate following the initial review of the file.

Cloverleaf Advocacy Services (Independent Health Complaints Advocacy Service) is an organisation that provides support (known as advocacy services) to help people across the North Yorkshire to speak up and express their views, and help services to listen to and learn from people who use their services. During the year representatives from Cloverleaf Advocacy Services met with colleagues from the Trust including the PET to review frameworks for communication and to promote the model of advocacy services. The Trust continues to promote the advocacy services that are available for supporting complaints and patient feedback. Since the Trust started delivering 0-19 services in the North of England we have begun working with the Carers Federation who provide advocacy for the North East.

Compliments are received at ward and team level by the PET and reported in the local media.

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Compliments received by the Patient Experience Team	354	291	330	315	340	325	316

Table 46: Local data showing compliments received by the Patient Experience Team

4.4. THE PATIENT VOICE GROUP

The Patient Voice Group (PVG) is an independent group of volunteers who work in partnership with the Trust. Our purpose is to listen to patients and relatives experiences of using HDFT services and communicate these in a meaningful way to managers and staff, so that the quality of patient care continues to improve.

The workload of the PVG is based on the domains set by the CQC around safety, the patient experience, dignity and respect, communications and the flow of the patient journey through the different services including plans to go home. This provides opportunities to share excellent practice and also learn where improvements could be made. We do not want to appear a threat to hard working staff but to work with them. We do this by talking to patients and relatives at the most appropriate time, on the wards, at home or by telephone.

This year the PVG took a different, less formal approach and 'befriended' 10 wards. Informal visits were made over a period of 3-6 months. This provided continuity and relationships developed between PVG members and staff. Comments and observations were discussed with matrons, sisters and staff before a summary paper was presented at the Learning From Patient Experience Group for comment. Through discussions with staff there were opportunities for staff to make small changes and clarified some comments we received. This was a positive experience.

2017/18 has been a busy year visiting:

- Four wards within the Long Term and Unscheduled Care Directorate (Lascelles, Granby, Byland and Jervaux);
- Four wards within Planned and Surgical Care Directorate (Wensleydale, Littondale, Farndale and Nidderdale);
- Woodlands, the children's ward;
- Maternity and Special Care Baby Unit.

The Patient Voice Group findings (patients' and relatives' comments and our observations) are presented at the Learning from Patient Experience Group to promote discussion among managers and staff. Responses from HDFT have included;

- Managers have thanked the PVG for the positive findings e.g. patient care and staff kindness.
- Actions have been put in place to improve the patient experience e.g. Volunteers to provide activities for patients, improvements to the environment (redecorations to the children's ward)
- Reminders that sometimes what is thought to be embedded e.g. staff introductions and explanations to patients need addressing

Work is ongoing to ensure the voice of children and young people are heard and PVG members are continuing to develop relationships with the Youth Forum and will develop a work programme for 2018/19.

Results

The majority of patients and relatives are very appreciative of the excellent care received and kindness shown by staff.

The negative comments received are about staff being very busy and not having time to talk; patients are not aware or involved in their treatment plans; discharges are often delayed; appointments are not flexible and problems with car parking.

It has become increasingly difficult to talk to patients in hospital as they are very poorly and vulnerable and we continue to investigate different ways of collating honest feedback. It is a continuous challenge to find the most appropriate time to talk to patients.

Conclusions

Developing trusting relationships with staff through 'befriending' areas has been successful in that dialogue and discussions has brought about small changes in areas visited. The PVG need to raise awareness of their role within the Trust.

4.5. CLINICAL TRANSFORMATION PROGRAMME

The aim of our clinical transformation programme is to:

> Achieve best care for the people who receive care and treatment from HDFT whilst at the same time realise financial savings with improved systems and controls.

Figure 30 shows how we deliver rapid improvement activity to facilitate the "breakthrough" transformations that we need in order to meet this aim. 80% of rapid improvement activity is directed in this way, with the remaining 20% being used to help address operational challenges or inefficiencies on a reactive basis.

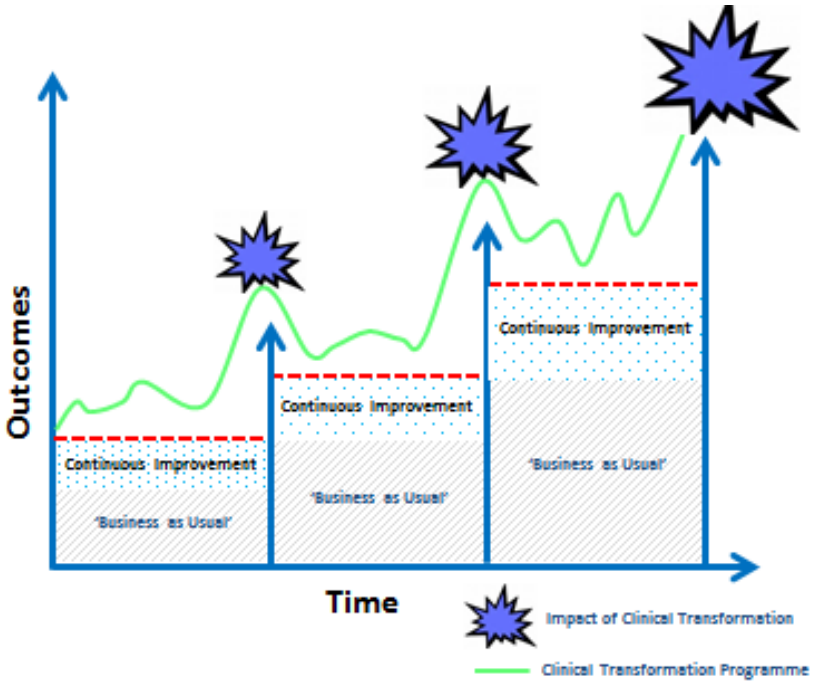


Figure 30: How the Trust delivers rapid improvement activity to facilitate the "breakthrough" transformations

Work to deliver quality improvement activity and realise clinical transformation is more likely to succeed when it occurs in a receptive context. Our Quality Charter is helping to deliver culture change in the Trust by engaging staff in delivering improvements in their work and by recognising and rewarding those who do so. The Quality Charter comprises the schemes outlined below.

Figure 31: Schemes of the HDFT Quality Charter

What were we aiming to achieve?

During 2017/2018 the Charter aimed to:

- Recognise twelve Teams of the Month;
- Grow the number of Making a Difference awards made across the whole Trust;
- Create more new Quality of Care Champions at every level of the Scheme;
- Stage a successful Quality Conference;
- Deliver effective quality campaigns.

In delivering rapid improvement activity, we aimed to:

- Increase the pace of delivery through the engagement of Quality of Care Champions;
- Better complement existing approaches to service reviews and "hotspot" reviews.

In delivering our clinical transformation programme, we aimed to:

- Continue to deliver an agreed programme of projects across four workstreams;
- Scope the "size of the opportunity" for a refreshed and refocused programme to deliver during 2018/23.

What have we done and what were the results?

Quality Charter

There is growing evidence that the Charter is changing our culture in a way that is not only creating a receptive context, but helping to directly facilitate needed improvement and transformation projects through the activity of our growing movement of Quality of Care Champions. There is information below about the performance of the Charter's constituent schemes.

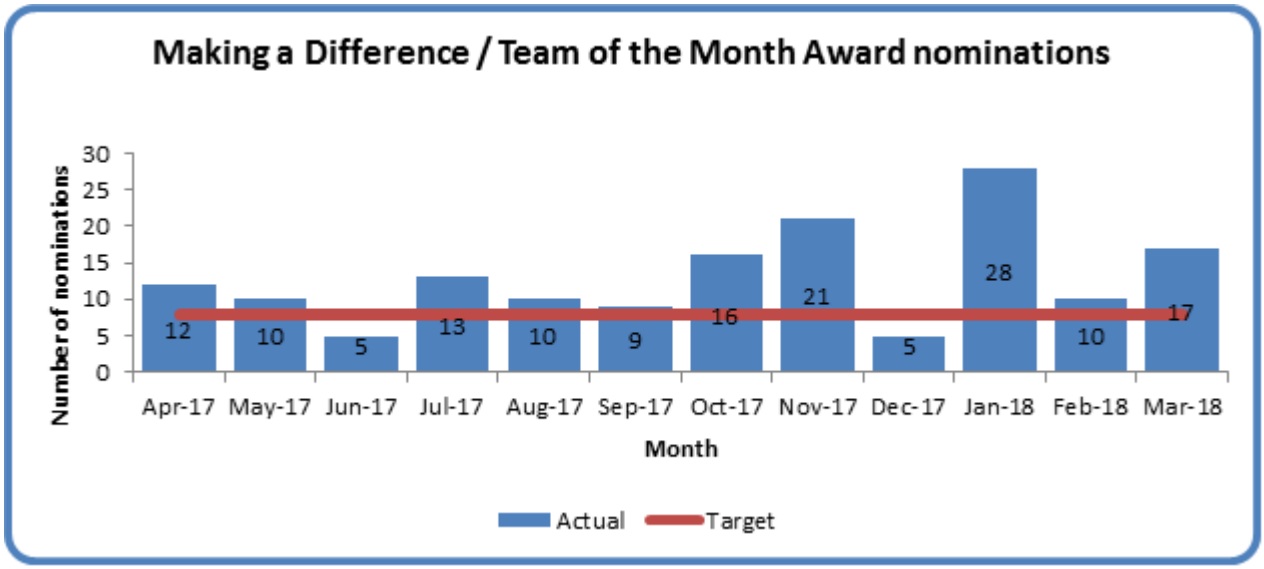


Figure 32: Team of the Month and Making a Difference Schemes

There is further information on our website at Our Making a Difference winners - Harrogate and District NHS Foundation Trust.

We now have:

- 123 Bronze Quality of Care Champions accredited
- 16 Silver Quality of Care Champions accredited
- 1 Gold Quality of Care Champion accredited
- 3 Platinum Quality of Care Champions accredited

A vacant post has contributed to performance being generally behind the challenging targets set for the Quality of Care Champions Scheme, but this is expected to be remedied by the second quarter of 2018/19.

Quality Conference

The Trust's first multidisciplinary Quality Conference delivered content to over 150 direct participants at the main venue at Harrogate Pavilions and at satellite venues in Scarborough, Northallerton and Ferryhill. On the day of the conference there were 19,000 Twitter impressions, the busiest ever day on the @HDFT_Innovation account. Delegates heard speakers from our own Trust alongside inspirational key note speakers from the worlds of healthcare, air safety and customer service.

Technical problems on the day impaired the delegate experience at some satellite venues, but the results shown in the "would you recommend a future event?" pie charts speak for themselves. Detailed lessons have been learnt for the 2018 conference.

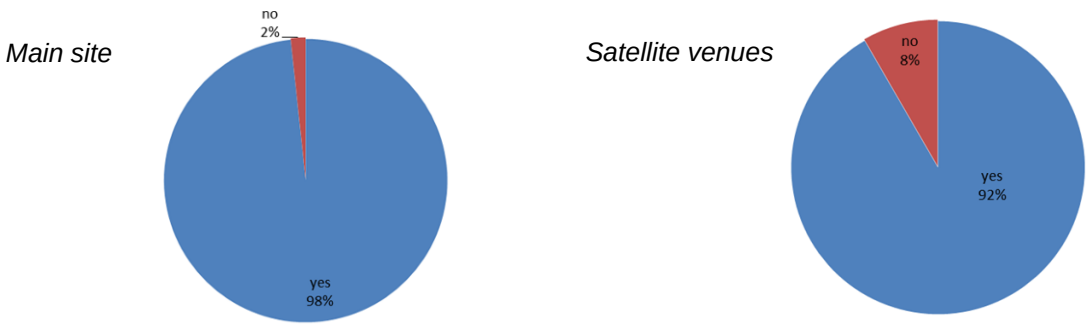


Figure 33: Staff feedback: Would you recommend future conferences to your colleagues?

Figure 34: Staff feedback from the satellite venues: What was the most useful part of the conference?

Photo 4: Quality Conference 2017 photo collage

‘Hammer down Haemolysis’ Quality Campaign

Haemolysis is the breakdown of red cell membranes and this may happen when blood specimens are taken as a result of poor technique. The haemolysed sample may not be possible to analyse, requiring the patient to need a repeat sample, wasting time and resources and impacting negatively on patient experience. Careful specimen collection can reduce haemolysis significantly, and the Trust’s first Quality Campaign, “Hammer down Haemolysis”, made a big impact in September 2017 when average haemolysis rates almost halved across the eight participating wards and partners. However, since this was not sustained in most areas in subsequent months, the campaign went on to deliver further campaign activity by:

- Revamping and recirculating campaign materials, specifically a “dos and don’ts” poster designed by Blood Sciences and clinical colleagues;
- Winning external sponsorship for branded campaign mugs to raise awareness of the campaign at desks and in kitchen areas of participating wards and partners;
- Offering informal phlebotomy refresher training to colleagues who take blood samples;
- Offering tours of the blood science laboratory to these seeking to understand more about how blood samples are processed.

Performance on haemolysis rates will continue to be reviewed quarterly.

Rapid Improvement Programme

A couple of highlights from the 2017/18 programme are given below. The pace of delivery of improvement projects increased and a review of our approaches to service reviews, rapid improvement and “hotspot reviews” was produced. Recommendations for further improving our deployment of these approaches future have been adopted.

Evidence shows that actions from the theatre scheduling rapid process improvement workshop (RPIW) in May 2017 led to:

- A reduction in the cancellation of operations in participating areas in orthopaedics and general surgery;
- The number of steps in the scheduling process being reduced to increase efficiency of administration and bring benefit to patients;
- The batching of booking forms being reduced;
- The development of a theatres dashboard to enable a more in-depth understanding of theatre productivity;
- Better standardisation of theatre schedules (start and finish times).

The challenge now is introduce streamlined pre-operative assessments to other specialities in order to roll-out this benefit to a larger number of patients.

Podiatry colleagues worked on ideas to reduce set-up time for appointments as part of the Podiatry RPIW in February 2018. Work is on track to:

- Increase the organisation and efficiency of key podiatry clinics, office and store rooms;

Photo 5: Podiatry RPIW in action

- Ensure 100% of received referrals either by phone call, email or fax for active diabetic foot problems and high risk patients are triaged within 1 day (in line with NICE guidelines);
- Ensure 95% of patients receive a domestic visit by their due date.

Clinical Transformation Programme

Benefiting from the receptive context created by the Quality Charter schemes and the "hands on" facilitation of rapid improvement activity, the programme continued to deliver projects across four workstreams, attaining the outputs described below.

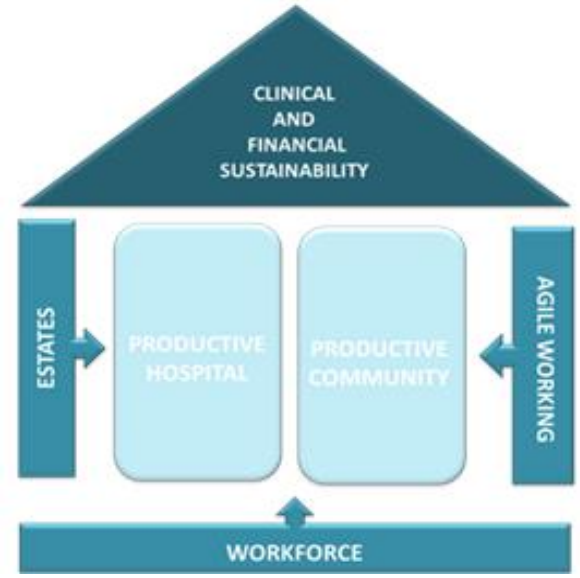
The 2017/18 programme had an ambition to achieve £3m in cost improvement programmes; just over £1m has been realised to date. Despite this shortfall, the programme has delivered a number of successful projects that has resulted in positive quality improvements for staff and patients:

- Discharge was one of the key projects within the Unplanned Care Workstream which focused upon avoiding unnecessary admissions, improving patient flow and reducing length of stay by discharging patients to more appropriate care settings. Following the establishment of a Supported Discharge Service team, more than 200 referrals have been managed by the team and more than two thirds of those patients were supported to return home ahead of their planned date of discharge. The Supported Discharge Service has also been able to reduce length of stay by an average of 3.0 bed days per patient and 409 bed days overall.

- Colleagues from the corporate team, and clinical directorates attended a half-day workshop to review workforce challenges and identify priorities for years one and two of the Clinical Workforce Strategy implementation plan. The session was neatly balanced with a learning & development session, which complemented the collaborative conversation and thinking by considering individual impact and approaches to working practice. The Improvement & Transformation Team have since been working with the Children's and County-Wide Community Care directorate management team to develop meaningful workforce plans incorporating the themes and feedback from the development day and by reviewing this with the individual teams and stakeholders. As a result the workforce plans will be taken forward in 2018/19.

- The 2017/18 Planned Care programme saw the permanent opening of the Swaledale unit as the new Elective Admissions and Discharge Unit (EADU) in March 2017, with the Discharge Lounge transferring onto the unit in June 2017. This was initially a six month project as part of the Planned Care Transformation programme – overall a great success! Work still continues in promoting a criteria basis to support use of the lounge primarily from inpatient wards.

Work to scope the size of the opportunity for a refreshed and refocused programme was completed, yielding a new programme structure to deliver our "productive house" model.



CORE	
PRODUCTIVE HOSPITAL	… requires lean service delivery including productive operating theatres and effective bed management. There will be a focus on avoiding unnecessary admissions, reducing length of stay and expediting safe discharge.
PRODUCTIVE COMMUNITY SERVICES	… now accounts for over half of the Trust's activity. With a developing improvement culture, there is further potential to improve productivity and utilise innovative solutions to the provision of care.
ACCELERATOR	
AGILE WORKING	… needs IT hardware and software, training and a cultural shift to enable greater efficiencies in community, acute and corporate services.
WORKFORCE	… challenges - and our ability to meet them - will be a key enabler of the rest of the programme. These include our ability to attract and retain students, apprentices and skilled staff and to develop a resilient workforce for the future.
ESTATES	…. Such as capital projects to align our infrastructure with that of clinical need and rationalising community estate will facilitate the improved productivity of acute and community services.

Figure 35: HDFT's "productive house" model

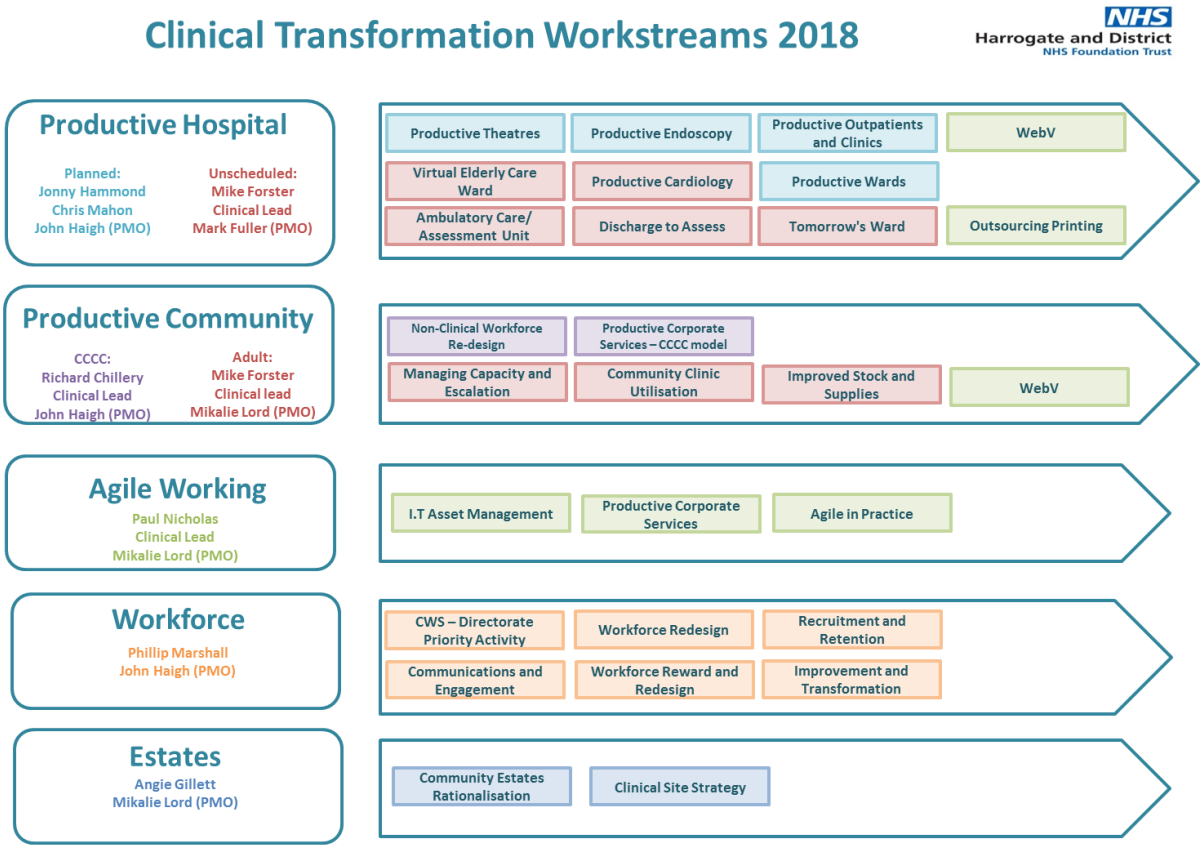


Figure 36: Clinical Transformation Workstreams 2018

Productive Hospital

The productive hospital workstream will focus on six areas:

- Continue to improve theatre productivity on-site;
- Improve productivity in general surgery and day surgery in satellite sites (North Leeds);
- Improve productivity in diagnostic services in satellite sites (Wharfedale);
- Expand diagnostic provision on-site (orthopaedics, ophthalmology, cancer);
- Reduce length of stay and delayed transfers of care(virtual ward: diagnostics);
- Utilisation of new WebV software modules to improve flow and discharge.

Productive Community

The productive community workstream will seek to support the expansion of our community services through the business development strategy, with the application of large-scale productivity measures and will focus on:

- Utilisation of WebV software modules to facilitate discharge of patients;
- Re-design of corporate services to support community teams;
- Improve admissions avoidance and re-admission within 30 days of discharge;
- Non-clinical workforce re-design within the Children's and Countywide Community Care directorate.

Agile working

To enable the productive hospital and productive community model, agile working technologies and practices need to be employed. Investment in mobile phones, laptops and VPN (virtual private network) tokens for the right staff at the right time will support the drive to increase activity, generate efficiencies and deliver a better service for patients and users. The development of an asset management system for low value goods will allow for greater Information Technology (IT) budget management and could lead to development of shared procurement arrangements with other partners in West Yorkshire and Harrogate.

Workforce

The development of the Clinical Workforce Strategy and its key performance indicators will be led by directorates. Additional strategies, such as the Nursing Recruitment and Retention Strategy, will complement the overarching strategy and ensure that the organisation is being responsive to its immediate recruitment needs. These strategies will require the introduction of more efficient and effective recruitment activities, such as the electronic applicant management system, marketing and social media activities. Directorate and service workforce models and retention will be supported by initiatives such as the Health and Wellbeing Strategy, which will support preventative measures for staff sickness absence and long-term absences, and Reward and Redesign which will develop incentives to attract and retain staff.

Estates

For Productive Community, as the delivery of community services are reviewed and preferred ways of working identified, the rationalisation of community estate can be undertaken. Conversely, for Productive Hospital the Clinical Site Strategy will support growth in agile working, for example exploring opportunities for hot-desking arrangements in dedicated areas within the Trust.

Summary and next steps

Three years into our clinical transformation programme, new momentum is being gained as financial and quality gains are achieved and the ever-present need to secure best value from limited NHS resources increases in acuity.

During 2018/19 we plan to up the pace of the corporate programme of rapid improvement activity to deliver projects at a rate exceeding one per month. And our mission to create a movement of Quality of Care Champions and turn dozens of champions into hundreds will continue.

4.6. VOLUNTEERS

Volunteers at Harrogate and District NHS Foundation Trust (which includes Ripon Community Hospital and community sites in Northallerton, Scarborough, Durham, Darlington and Middlesborough) continue to enhance our patient experience with their enthusiasm, commitment and the generosity of the giving of their time, which totals over 2,000 hours per month. We currently have 590 active volunteers helping us!

Photo 6: Just some of our 590 active volunteers!

Volunteers provide invaluable assistance throughout the Trust in areas such as:

- Meal time volunteers, assisting patients with their lunch and evening meals on many wards;
- Chaplaincy ward visitors;
- Meet and greet volunteers for Main Reception, Out Patient clinics, the Sir Robert Ogden Macmillan Centre and at Ripon Community Hospital;
- Volunteer fundraisers;
- Maternity volunteers;
- Woodlands ward volunteers;
- Harrogate Hospital Radio;
- Café;
- Gardening volunteers;
- Administration volunteers throughout the Trust;
- Check-in engagement volunteers;
- Volunteer drivers for patients living in Nidderdale;

- Complementary therapy volunteers;
- Breast feeding peer support volunteers in Durham, Darlington and Middlesbrough;
- Therapy dogs at both Harrogate and Ripon hospitals;
- Craft volunteers at both Lascelles and Trinity wards;
- Activity volunteers on Trinity ward at Ripon Community Hospital.

Volunteers also assist in many “one off” roles such as assisting with conducting surveys, and helping at Medicine for Members lectures.

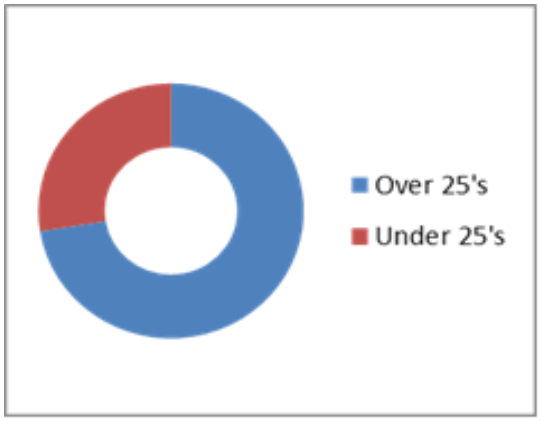


Figure 37: Breakdown in volunteer ages

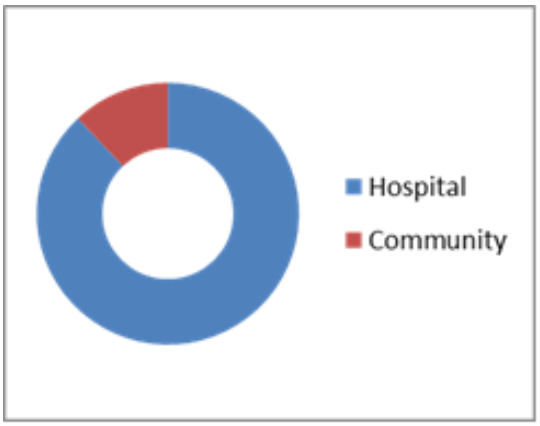


Figure 38: Breakdown in volunteer areas

4.7. CANCER SERVICES

Cancer services remain a significant priority for this Trust. It is hugely important that we can offer patients and their families high quality, safe, local and timely access to the appropriate treatment and care. We continue to work closely with our partner organisations within the Harrogate and West Yorkshire Cancer Alliance to ensure that our patients receive the best evidence based treatment.

Photo 6: Sir Robert Ogden Macmillan Cancer Centre

We have based our local objectives around the national vision for what cancer patients should expect from the health service which is set out in the strategy document ‘Achieving World Class Outcomes: A strategy for England 2015-20’.

We continue to receive excellent patient feedback from the National Cancer Patient Experience Survey and other local sources but are mindful of areas for improvement. We recognise the need to offer an equitable service for all and continue to work with all healthcare professionals within the hospital and community setting to ensure excellent access to services for all.

We are aware that with an ageing population we will see a rise in the incidence of cancers over the coming years and we are mindful of the need to work more efficiently and innovatively to be able to offer an excellent, timely service that meets the needs of the individual and their family.

What were we aiming to achieve?

Our aim for cancer services in 2017/18 was to:

- Continue to achieve the 31 and 62 day cancer targets on a quarterly basis;
- Continue further implementation of the Cancer Recovery Package;
- Provide further support within the specialist cancer nursing teams;
- Provide more timely psychological support for patients and their families diagnosed with and living with cancer;
- Continue to develop the Macmillan Patient Information and Health and Wellbeing Service.

What have we done and what are the results?

Achieving the 31 and 62 day cancer targets on a quarterly basis

To continue the assurance around patients' timely access to services we evaluate our cancer waiting times performance regularly. The Cancer Tracking Team work closely with Information Services to ensure accurate data is collected and acted upon. We also work closely with our partner organisations such as Leeds and York Trusts to ensure that patients are transferred to those hospitals for investigations and treatment as quickly as possible with all the necessary information. Achieving the cancer targets remains challenging and will continue to be the case as we see the continual rise in referrals. We appreciate the efforts of all our clinical teams who support timely access for patients.

Type	Target	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2017/18
14 Day Breast Symptomatic	**93%**	95.7%	96.7%	96.3%	89.4%	**94.4%**
14 Day Suspected Cancer	**93%**	96.4%	98.4%	98.8%	96.5%	**97.5%**
31 Days First Treatment	**96%**	99.6%	98.8%	98.9%	99.6%	**99.2%**
31 Days Subsequent - Anti-Cancer Drugs	**98%**	100.0%	100.0%	100.0%	99.2%	**99.8%**
31 Days Subsequent - Surgery	**94%**	98.1%	97.1%	96.2%	97.5%	**97.3%**
62 Days	**85%**	86.0%	88.9%	90.5%	90.2%	**88.9%**
62 Days Consultant Upgrades	**85%**	100.0%	100.0%	100.0%	91.7%	**96.4%**
62 Days Screening	**90%**	91.7%	88.9%	90.5%	100.0%	**93.0%**

Table 47: HDFT performance against 14, 31 and 32 cancer targets

Table 47 above demonstrates the continued success for HDFT in meeting the required targets for 2017/18 overall. The need for patients to be seen, investigated and treated in a timely manner is so important to all the clinicians who work across this organisation.

Implementation of the Cancer Recovery Package

Implementing the cancer recovery package continues to be a huge focus for each of the cancer teams. This is a key recommendation from the National Cancer Strategy and the Trust is committed to full implementation by 2020**.** The recovery package has four main components:

- Electronic holistic needs assessment (eHNA). This has increased the focus upon ensuring patient-centred care plans are developed;
- Treatment summary. Following completion of treatment, ensuring patients understand any lasting consequences or side effects of treatment, is vital. It is also important that warning signs of potential recurrence are recognised and patients can access timely advice and support. Understanding the plan for continued follow up is crucial. All this information will be contained within the summary;
- Health and wellbeing sessions. The health and wellbeing event focuses on any lasting impact of their cancer treatment, promoting self-management and new healthy lifestyles, with a view to both maximising recovery from cancer and reducing risks of other lifestyle associated health problems;
- Cancer care review. Patient reviews are carried out in primary care within six months of receiving notification of a diagnosis.

The Health and Wellbeing Programme funded by Macmillan has been developed and expanded over the last two years and has demonstrated real benefit to a patient's experience. It has centred around having maximum impact on the greatest number of patients and so the priority areas were the patients diagnosed with the commonest cancers such as colorectal, breast and prostate cancer. It has ensured innovation in the process of how we follow patients up after treatment. We have made huge strides forward for these patients and still have further work to do.

With funding from the Harrogate and West Yorkshire Cancer Alliance we are beginning to roll out the main components of the cancer recovery package to other cancer sites so that we can offer an equitable service to all with the main aim of providing patients and their families with evidence based, individualised care leading to an improved experience.

Photo 7: Janet, Living with and Beyond Cancer Programme Manager and Julie, Cancer Care Coordinator

We now have a Living with and Beyond Cancer Programme Manager and Cancer Care Coordinator to lead on implementing the key components within each cancer team.

Enhancing specialist cancer nursing provision

The numbers of patients diagnosed with cancer continues to increase overall which is likely due to an increasingly ageing population. We also know that people are living much longer with their diagnosis of cancer as there are more treatments available for them. Both of these factors mean that the specialist nursing teams are offering more patients advice, information and support at diagnosis and whilst living with and beyond cancer. This has added significantly to their workload and so looking at different ways of working is important.

With this in mind we have recruited two more cancer care coordinators to the Lung Cancer Team and the Women's Health Team. This gives patients more opportunities to speak to someone when they need advice. The coordinators have the skills to support patients on the phone and signpost them to other services if necessary so that their queries are addressed in a timely manner. They also have the skills to recognise when to refer to the specialist nurse for more specialist information and advice. This allows specialist nurses the time and opportunities to develop their services and provide more nurse led clinics so more patients have timely, individualised care alongside their treatment. It enables the teams to better collect data and demonstrates the benefit of a varied workforce.

Provision of more timely psychological support for patients and their families diagnosed with and living with cancer

Anxiety and depression related to a diagnosis of cancer may impair adherence to anticancer treatments and potentially reduce survival. It impedes a return to normal living after effective cancer treatment. It is therefore vital that there is good access to psychological support from the appropriate professionals. We are very proud of the service that patients and their families can access here in Harrogate. The clinical psychologists based in Cancer Services provide a comprehensive assessment of the psychological needs of patients and/or relatives of patients with cancer, and will support them to work through their difficulties. With better assessment of patients concerns throughout their treatment pathway and beyond, the clinical nurse specialists and other healthcare professionals are identifying more patients who would benefit from this service. This inevitably means more referrals to the service with a finite resource.

The feedback from patients tells us this is a valued and necessary service. Examples of feedback from service users are:

- *"It is such a relief to be able to tell someone how you are really feeling, to be able to describe your thoughts and emotions. It is good to feel safe."*
- *"I liked being able to talk about my problems. Somehow they don't feel too overwhelming when you talk to someone about them."*
- *"The discussions about finding out who I really am. Talking about problems never discussed with anyone before. The finding of having a heavy load lifted!"*
- *"Felt more able to cope afterwards."*

When asked how they would rate the clinical psychologist the patients who were surveyed gave us this feedback below*:*

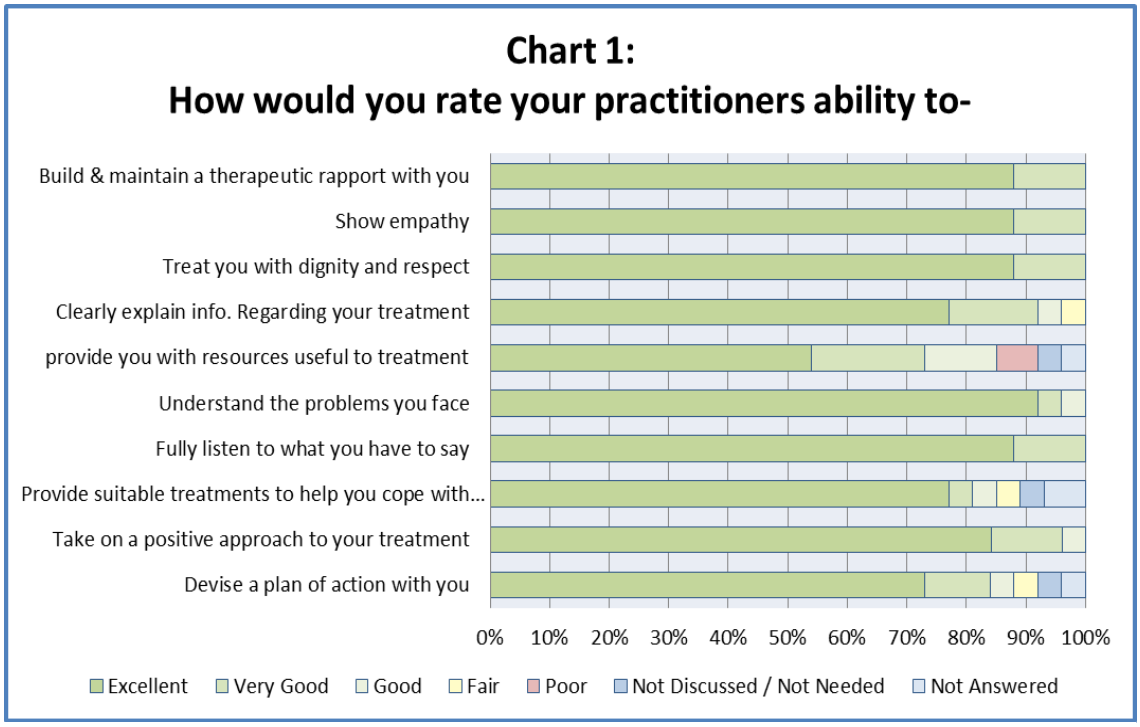


Figure 39: Feedback from patients with cancer about clinical psychologists

We are aware that caring for patients with cancer is emotionally challenging work for the nurses and other healthcare professionals. The need for clinical supervision offered by the clinical psychologists is of paramount importance to ensure the emotional wellbeing of the staff caring for patients with cancer.

Following production of a robust business case and in partnership with Macmillan Cancer Support we are in the process of recruiting another full time team member to join the Clinical Psychology cancer service. This will enable us to continue to see all the patients and family members who require support but in a more timely manner and continue to offer staff the necessary clinical supervision that they require.

<u>Continue to develop the Macmillan Patient Information and Health and Wellbeing Service</u>

The Macmillan Patient Information and Health and Wellbeing Service offers a range of multidisciplinary advisory, practical and self-management support services for both hospital and community patients and carers who have been affected by a cancer diagnosis. The service aims to provide the highest quality of support and information services in-line with the National Cancer Survivorship Initiative (NCSI) to maximise wellbeing across all stages of the patient pathway for patients and carers. The Macmillan Patient Information and Health and Wellbeing Service provide a non-clinical, calm and relaxed environment.

Activity data is collected and submitted to Macmillan Cancer Support, although it has become increasingly difficult to capture and record every activity or intervention due to conflicting time pressures caused by the expansion and increasing demands of the Health and Wellbeing services and lack of administrative support. Data is woefully under recorded.

The total number of recorded patient contacts for the year was down from 361 to 207 in 2017.

Information provision

The information service has ordered 2551 Macmillan leaflets and booklets, with additional information booklets supplied by:

- Myeloma UK
- The Lymphoma Association
- Prostate UK
- Breast Cancer Care
- The Roy Castle Foundation
- Dying Matters
- Carers Resource
- Age UK
- Harrogate Borough Council

Patient information leaflets have also been produced detailing the services provided within the SROMC and HDFT, and provide another source of information available to service users.

A library of cancer information books suitable for children was created in the final quarter of 2016. More books have been added to the stock during 2017 and this continues to be a well-used resource.

The SROMC page on the Trust website has continued to be updated throughout the year with the support of the Trust communications officer. All the patient information and health and wellbeing services are now available at; https://www.hdft.nhs.uk/services/cancer-services/sromc/. SROMC information and support services are also accessible via the website for Macmillan Cancer Support; www.macmillan.org and information is available via the SROMC Facebook page https://www.facebook.com/SROMCHarrogate/. This page is also linked to the HDFT and Macmillan Cancer Support Twitter and Facebook pages.

The SROMC Facebook page has been really well used during 2017 and has generated a lot of interest and positivity for the Centre. It has been used to publicise services, fundraising, celebrate staff and Trust achievements and to share valuable cancer information and other support resources across the region.

The Macmillan Welfare and Benefits Service

The Macmillan Welfare Benefit Adviser continues to operate a high quality flexible and easily accessible service, and has maintained the provision of an invaluable source of support for patients and carers affected by a cancer diagnosis living within the Harrogate and Rural District community. The service has seen increases in both the number of referrals and benefits income (see table 47) and is at saturation level by way of capacity. One new reason for this has been the impact of Universal Credit. Patients now require online assistance from the Benefits Adviser in helping make their claim as they feel overwhelmed by going through the online instruction.

The service operates Monday to Thursday. The greatest benefit of this service is it's accessibility for patients to have contact with the advisor, either face-to-face, email or over the telephone. Due to increasing room capacity pressures within the SROMC, the Macmillan Welfare Benefit Adviser began to work remotely on Wednesdays at the end of 2017. Patient and user feedback has not reflected any reduction in the quality of the service being provided, but this will continue to be monitored in 2018.

Service Activity	Activity in 2015	Activity in 2016	Activity in 2017
Numbers of new referrals	404	415	468
Total claimed in annualised benefits	£1,517,588	£1,404,215	£1,776,543
Total in backdated benefit arrears claimed	£67,024	£214,319	£206,608
Total of Macmillan grants claimed	£13,400	£16,630	£19,525
Other charitable grants	£3,336	£4,250	£6,500

Table 48: Service activity between 2015 and 2017

Numbers of referrals

There are approximately 500 newly diagnosed cancer patients referred to the SROMC chemotherapy unit each year. During 2017 96% of these newly diagnosed patients were referred to the Macmillan Welfare and Benefits Service. It had previously been believed from the demographic data that just under a fifth of all new patients attending the unit from this locality would not have any welfare benefit needs, however during 2017 that has changed dramatically with only 7% not requiring referral to the service.

It should be noted that only the numbers of new referrals are captured above. The lack of any administrative support available to the service does reduce the capacity for data collection to be undertaken. Many of the referrals received from the previous three years still remain part of an active caseload and require regular intervention from the Macmillan Welfare and Benefits Adviser. This remains additional activity which is not currently captured.

Total annualised benefits

This is the actual total amount awarded to patients who have accessed the SROMC Macmillan Welfare and Benefits Service in 2017, unlike the predicted figures provided by the Macmillan Cancer Support Line. Due to service pressure it is becoming increasingly hard to follow up benefit claims so these figures are at risk of being under reported in the future. This difficulty is caused by the increasing workload demand being placed on the role of the Macmillan Welfare and Benefits post holder and the lack of administrative support available to follow up and record successful claims. Volunteers have been able to provide some support with this during 2017, but it has been proven not to be a robust approach.

Service development

In a move to a ‘paperlite’ approach to documentation in accordance with the Trust’s environmental policy, where possible at the end of a patient episode paper caseload notes are now scanned and stored onto an electronic patient system. This provides not only a solution to case note storage which has a financial benefit, but also enables other healthcare professionals involved in a patient’s care to access benefit and welfare records. Multi-professional access to this patient information has prevented some repeat referrals and enabled a greater approach to holistic care. However the lack of administrative support available to the service, has prevented case notes being uploaded on to the electronic system in a timely manner throughout the year

The Complementary Therapy Service

The Complementary Therapy Service has continued to operate under increasing pressure as a result of increasing demand, due in part to its fantastic reputation and the benefits of the interventions offered. During 2016 the average wait for the first treatment from referral was 61 days; this has increased significantly in 2017 to 85, with a maximum wait of 422 days from referral to the first treatment. At the close of 2017 there were 160 patients on the waiting list, 60 of those were classified as urgent. To mitigate negative feedback due to the long waiting times being experienced by patients, the number of treatments offered to patients has been reduced from six to four in line with the number offered to carers.

A volunteer therapist has provided some treatments with reflexology and massage during 2017, and this will be resuming again later in 2018. Careful recruitment, supervision and planning is undertaken. A newly qualified therapist is now in post and auricular acupuncture is now available. This will enable up to ten patients to be treated during a morning session. Provision of auricular acupuncture has been chosen specifically as there is lots of evidence to support its benefit for patients suffering from the effects of chemotherapy and hormone treatments. It is particularly helpful in the management of hot flushes, peripheral neuropathy, pain, nausea and insomnia.

	2015	2016	2017	% difference between 2017 & 2015
Number of referrals received	134	187	229	+59%
Number of treatments given	502	704	939	+53%
Number of patients treated	82	95	127	+64%
Number of carers treated	17	13	16	-2%
Number of men treated	32	23	53	+60%
Number of women treated	67	85	176	+38%

Table 49: Breakdown of those treated and numbers of treatments

The most common reason for treatment is stress, with pain and insomnia as other key reasons.

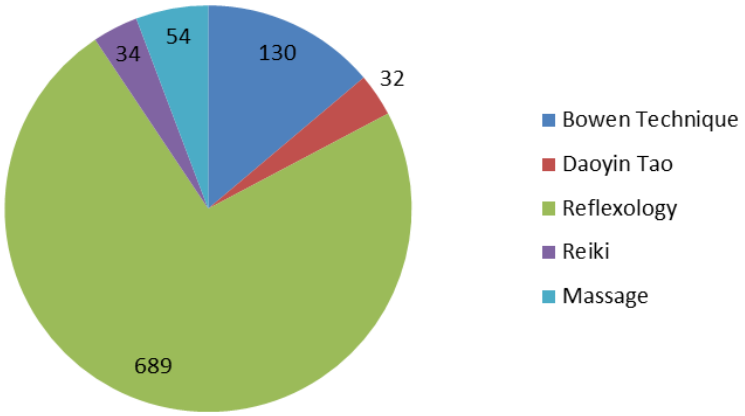


Figure 40: Breakdown of the type of complementary therapy treatments given

Reflexology continues to be the most common treatment given. The reason for this is most likely due to the benefit this treatment has on a wide range of physical symptoms and side effects experienced by patients undergoing cancer treatments. Reflexology is often combined with guided visualisation, used to reduce anxiety. This self-management practice is particularly useful for those patients undergoing stressful procedures or scans etc.

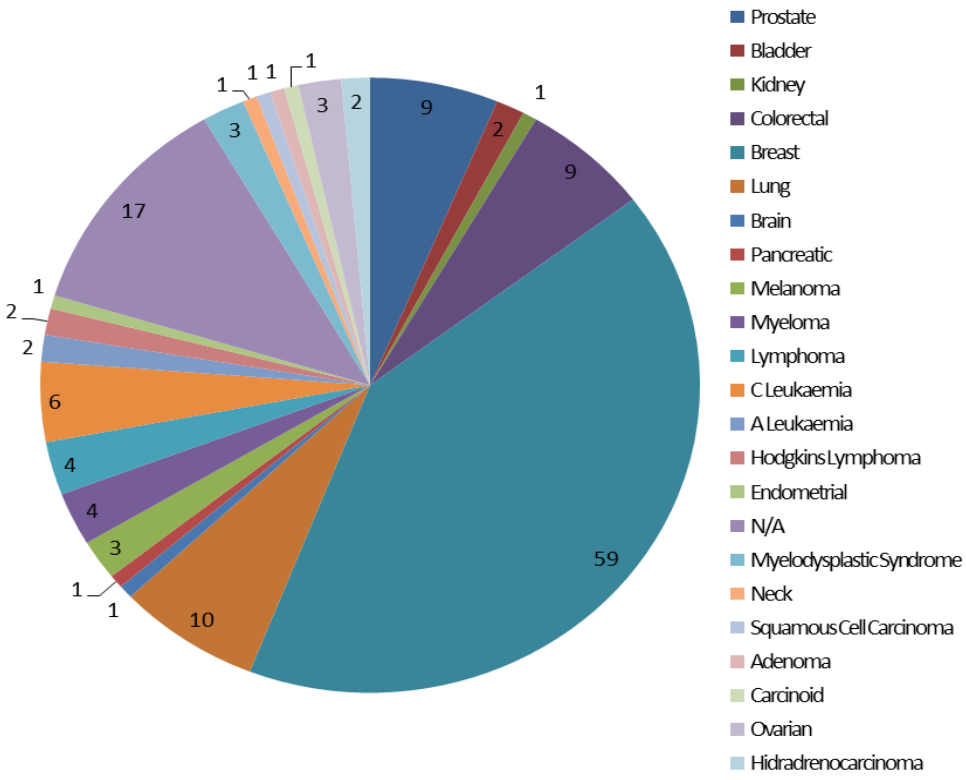


Figure 41: Cancer type treated with complementary therapy

Breast cancer is the most common cancer type being treated in the chemotherapy unit and so continues to generate the most referrals to the complementary therapy service.

Fundraising to sustain the service has grown through the efforts of staff within the unit. Two events were held specifically in aid of the complementary therapy charitable fund, and raised a total of £18,000 towards the current annual £30,000 cost. A single donation of £10,000 was also given to benefit the service in April 2017.

A commitment to explore options to facilitate future expansion of the service continues.

A business case has also been presented and agreed to develop the first NHS approved Complementary Therapy Training School. Income generated form the training courses will be reinvested back into the complementary therapy service to enable sustainability and further expansion. Students will be required to undertake a clinical placement under supervision in an NHS healthcare setting. These placements can be used to help reduce current waiting time demands and expand access to the service in other areas of the Trust.

<u>The Hair Loss Support Service</u>

During 2017 the Macmillan Patient Information and Health and Wellbeing Manager undertook a comprehensive service review of the hair loss support services provided through the SROMC. Meetings and visits were held with stakeholders, suppliers, staff and patients. A new supplier of headwear was sourced to add to the collections already provided. Since the introduction of this new range, sales have begun to increase again. A new ‘drop in’ session started in January 2018 combined with beauty demonstrations, post-surgery bra ranges and mini spa treatments. The changes made to the services provided by the SROMC were led by the findings of the service review, and they will continue to be re-evaluated regularly to ensure they meet user need, offer value for money and are efficient.

Wig Fitting Service

Orthotics has continued to hold the wig fitting service within the SROMC during 2017. A clinic is held fortnightly and wig fitting is provided by a representative from 'Hair Plus' based in Leeds. The service is also accessed by dermatology patients requiring wig fitting for alopecia.

During 2017 the Macmillan Patient Information Manager and a Chemotherapy Unit Sister visited 'Betty Brown' an alternative NHS wig fitting provider in York. Patients can now be signposted here if it is logistically easier for them or they would like an alternative choice.

SASH (Silks and Scarves of Harrogate)

A review of the SASH service was undertaken as it was becoming increasingly quiet with very little stock being sold at the weekly drop in sessions. The volunteers, many of whom had supported the service for a significant period of time were also now struggling to cover the rota due to changes in personal circumstances. Attempts were made to improve the attendance of patients using a range of approaches, from piloting sessions on other days, increased publicity and moving a display of headwear into the Macmillan Cancer Information and Support Service (MCISS). Whilst headwear sales increased slightly during the week from the MCISS, the changes made little difference to the number of people attending the sessions. Following consultation with the volunteers it was agreed to discontinue the Wednesday drop in session. The service is funded through the SASH charitable fund and it continues to be sustainable through the reinvestment of headwear sales and the charitable donations it receives.

Volunteer Hairdresser

Patients who have been affected by hair loss caused by their cancer treatment continue to be referred and signposted to the SROMC volunteer hairdresser consultation service. The consultation remains a free service and patient feedback continues to reflect a high quality service.

Boots 'Feel More Like You' Beauty Therapy Sessions

The partnership between the SROMC and Boots UK in Harrogate has continued to grow and strengthen over the course of the year. The programme of monthly beauty therapy sessions has remained a popular and beneficial service for women receiving cancer treatments. It offers professional beauty advice on skincare, make-up, eye make-up and nail care.

Having delivered the programme in the same way for the last three years, we were keen to review the format with the Boots No7 beauticians. From January 2018 beauty demonstrations by Boots No7 beauticians will be part of a 'One Stop, Beauty and Hair Loss Session' held fortnightly within the SROMC, and run alongside hair loss support and mini spa treatments.

Rudding Spa and Jennifer Young

The SROMC health and wellbeing services were invited to work Rudding Park Hotel and Spa to support the training and development of their Spa therapy services in the hotel's brand new £9 million luxury spa.

During 2017 we have worked with the staff at Rudding Park and Jennifer Young who has created a range of beauty therapy products safe for cancer patients to use within a spa setting. Patients from the SROMC have been able to experience the treatments while the therapists receive the training needed to practice. Jennifer has also been very supportive in the plans for the SROMC Complementary Therapy Service to develop an NHS approved complementary therapy training school. Rudding Park Hotel and Spa has generously agreed to provide a spa therapist trained in these cancer treatments twice a month as part of our 'One Stop, Beauty and Hair loss Session'.

The Oesophageal Patient Association (OPA) Support Group

This group has continued to meet once a month within the SROMC throughout 2017. The OPA provide local support to patients and carers affected by cancer of the oesophagus. The group continued to go from strength to strength during 2017 with the meetings attracting a good number of attendees throughout the three hour session. It is particularly useful to patients from the Harrogate area, as it provides a local drop in facility for patients before or after their clinic appointments. The group is also supported by the Colorectal and Upper Gastrointestinal Cancer Care Co-Ordinator within the Trust.

TLC (Talking and Listening Club)

TLC is a patient led support group. It offers support sessions available to anyone affected by a cancer diagnosis and is held in the SROMC. The group meets once a month and is supported by the Macmillan Patient Information and Health and Wellbeing Manager and the Macmillan Health and Wellbeing Programme Manager. User feedback is collected for evaluation and to identify topics of interest that may require a guest speaker.

Art Therapy

A new art therapy service was introduced during 2017. A qualified volunteer art therapist has provided fortnightly sessions in the SROMC. Art therapy is proven to be effective in helping patients and carers affected by a cancer diagnosis. It provides them with an alternative approach to work through emotional issues using a range of creative art techniques. This service is directly linked to the Clinical Psychology Service, and referral is made by the clinical psychologists. Some patients on the waiting list to see a clinical psychologist have been offered art therapy, and in some cases it has relieved pressure from the clinical psychology service. Each fortnight the art therapist is able offer three hour long sessions to individuals, or one hour long group session for up to four people. The service is funded through charitable funds donated to the SROMC. The testimonial below demonstrates the benefit of this therapy;

"*You really did make a huge difference at the hardest of times, so very grateful to you"*

Citizen Advice Bureau

The SROMC developed a new partnership with Citizens Advice Bureau (CAB) in 2017 to pilot a satellite venue for an outreach CAB in the SROMC twice a month. The clinic began in the last quarter of 2017 and offers help with:

- Money and credit problems;
- Employment;
- Consumer rights;
- Housing;
- Neighbourhood disputes;
- Education and healthcare;
- Immigration and residency issues;
- Human rights;
- Family and personal issues.

To date six patients have received support and help, and the service is set to continue through 2018.

SROMC Volunteers

The number of volunteers supporting the services provided within the SROMC has reduced in 2017 from 21 to 14 at the year end. This has been in part due to changes to the service delivery of SASH and changes in a number of the volunteers' personal circumstances. Five new volunteers have joined the unit to provide supportive roles. Volunteer roles in 2017:

- Serving lunches and beverages to patients attending for cancer treatments;
- Administration support to CNS, MCISS and the benefit service;
- Patient information support;
- Meeting and greeting patients;
- Gardening;
- Hair loss support services;
- Beauty therapy;
- Complementary therapy.

The added value and quality that the volunteers supporting the SROMC have provided to both service provision and the patient experience across a wide range of roles throughout 2017 cannot be underestimated. New roles with specific skill sets that would be beneficial to support services within the SROMC are being explored for 2018/19.

Summary and next steps

The overarching aim for cancer services at HDFT is to provide individualised patient treatment and care. We are passionate about providing services as close to home as possible and continually aspire to put the necessary resources into ensuring we can treat and support an ever increasing number of patients in our local hospital. We are keen to ensure that patient feedback influences our services and that we listen to what our community is telling us. Over the last year we have:

- Achieved timely access to services;
- Recognised and implemented the varied levels of support required by patients to live with and beyond cancer;
- Recruited a number of skilled and experienced individuals to enhance our services to the benefit of our patients;

- Continued to work positively with our partners across the Yorkshire region.

For the future we need to be aware of the many new challenges we face locally and nationally and recognise clearly what our plan will be. Key areas to focus on next year are:

- Provision of a robust Acute Oncology Service with seven day cover;
- Holistic needs assessments by all cancer nursing teams for patients newly diagnosed with cancer;
- Stratifying the follow up of patients who have undergone cancer treatment;
- Offering treatment summaries to patients at the end of their treatment;
- Obtaining timely patient feedback in more innovative ways.

4.8. DUTY OF CANDOUR

A statutory duty of candour was introduced by the CQC in March 2015 with detailed guidance for providers on how to meet the regulations. The aim of the duty of candour is to ensure that providers are open and transparent with people who use services in relation to care and treatment. There are specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology. The Trust promotes a culture that encourages candour, openness and honesty at all levels, and a culture of safety that supports organisational and personal learning.

This year, the processes for duty of candour have continued to be further embedded throughout the Trust. Weekly monitoring of outstanding cases and quarterly assurance monitoring continues to ensure that all relevant cases have the duty applied. This is reported to the Improving Patient Safety Steering Group in the quarterly patient safety report.

	Q1	Q2	Q3	Q4	2017/18 total
Number of moderate or above incidents	68	66	91	122	**347**
Number not triggering DoC (staff/not HDFT)	23	16	35	42	**116**
Number where trigger unclear due to lack of confirmation of severity	0	0	0	1	1
Number where DoC triggered	45	50	56	79	**230**
Of those where DoC triggered:					
Number where DoC clearly applied	44 (98%)	48 (96%)	55 (98%)	71 (90%)	**218 (94.8%)**
Number where a decision has been made NOT to apply DoC for documented reasons (e.g. patient lacks capacity, no NoK details)	1 (2%)	2 (4%)	1 (2%)	7 (9%)	**11 (4.8%)**
Number where DoC outstanding	0 (0%)	0 (0%)	0 (0%)	1 (1%)	**1 (0.4%)**

Table 50: HDFT Duty of Candour incident 2017/18 (Data correct as at 25/04/2018)

4.9. PUBLIC AND PATIENT PARTICIPATION STRATEGY

A guiding principle for HDFT is to put patients first;

You matter most

In support of this we seek to secure the involvement of the patients, service users, families carers and the public in our work to deliver excellent healthcare.

What were we aiming to achieve?

Public and patient participation is defined as the active participation of citizens, patients and carers and their representatives, and Foundation Trust members in the development of health services and as partners in their own healthcare. We have an aspiration to embed a culture of genuine patient and public participation in the organisation.

What have we done?

During the year we have commenced work on the preparation of a Public and Patient Participation Strategy for the period 2018 to 2021. The strategy will include pledges to strengthen public and patient participation over the coming years. The strategy will build on and seek to expand the many ways the Trust already seeks participation from the public.

As reported in detail in section 2.2 item 5 of this report, the HDFT Youth Forum are a group of young people aged 13-19 who are passionate about giving young people a voice in decision making about the future of healthcare in this area.

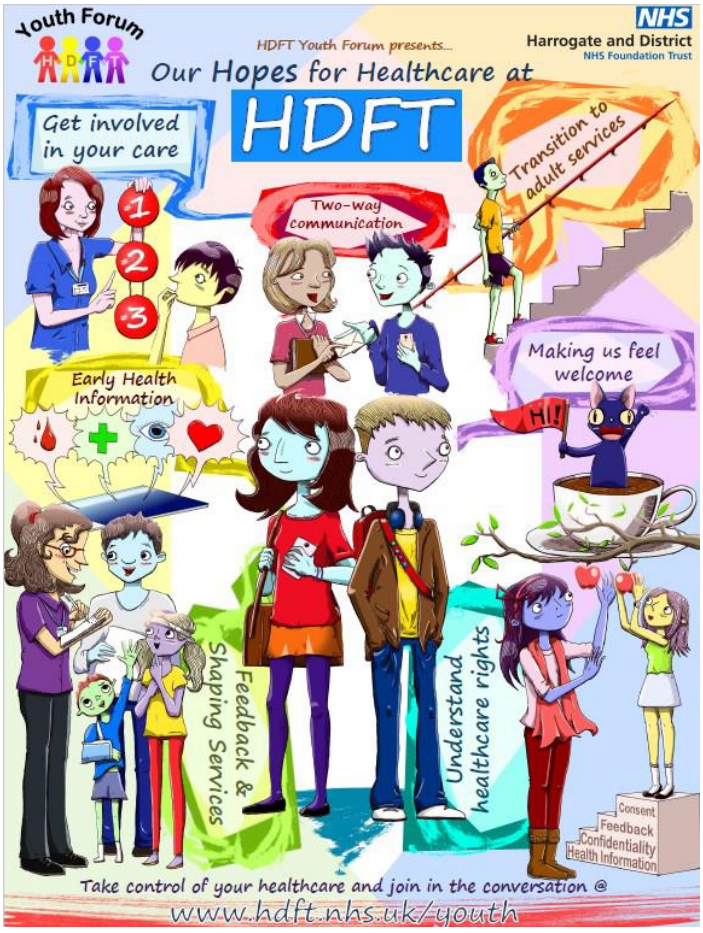


Figure 42: Youth Forum's hoped for Healthcare at HDFT

Over the past year, the HDFT Youth Forum have worked hard to develop seven standards or 'hopes' by which we as a Trust can assess our services in providing child and young person centred care. The document '*Our Hopes for Healthcare at HDFT*' was a fully co-produced piece of work between the Youth Forum and the Children's and County Wide Community Care Directorate.

The Youth Forum is now consulting with other children and young people to see if the 'hopes' represent their views too. An online survey, paper questionnaires and discussion groups will be used to reach out to children and young people from a range of backgrounds and experiences.

The results and the final version of Our Hopes for Healthcare at HDFT will be published in summer 2018 and then the Youth Forum will work with HDFT staff to turn their hopes into reality.

4.10. MENTAL HEALTH

The National Enquiry into Patient Outcome and Death (NCEPOD) report, Mental Health in General Hospitals: Treat as One (2017) highlights the quality of mental health and physical healthcare for patients aged 18 years or older with a significant mental disorder who are admitted to a general hospital. The report takes a critical look at areas where the care of patients might have been improved. The report states;

> 'The integration of all healthcare professionals to provide care as needed for each patient is a crucial part of the solution to providing a higher quality of care to all patients'.

Figure 43: NCEPOD study report into the treatment of mental health patients in general hospitals: Treat as One:

Key findings from the NCEPOD: Treat as One report 2017 are:

- 118/175 (67.4%) hospitals with an ED had a specific assessment room for mental health patients;
- 185/230 (80.4%) hospitals had a liaison psychiatry service with 145/185 (78.4%) on-site;
- Self-harm patients were automatically referred to the liaison psychiatry team in 122/178 (68.5%) hospitals;
- There was a protocol for the treatment of patients with mental health conditions in 123/211 (58.3%) hospitals. This included details of mental capacity assessment in 106/121 (87.6%), self-harm management in 91/117 (77.8%) and 1:1 mental health observations in 88/116 (75.9%);
- 21/190 (11%) hospitals shared complete access to mental health community records;
- The discharge summary was routinely copied to the patient's mental health team (for patients with mental health conditions) in 33/203 (16.3%) hospitals and to the patient's named psychiatrist in 20/198 (10.1%) hospitals;
- Inadequate mental health history was taken in 101/471 (21.4%) patients at initial assessment and 208/424 (49.1%) during consultant review;
- Mental health risk issues were recorded in 161/476 (33.8%); of those not recorded 140/261 (53.6%) should have been.

There is also a national CQUIN indicator for 2017/19 to improve services for people with mental health needs who present to emergency departments. The NCEPOD report and the CQUIN indicator are to improve understanding and the response to people with mental health needs in general hospitals. As a result work is being promoted nationally and progressed locally to identify and support people who use emergency departments frequently to access mental healthcare during periods of relapse or distress. This may be an appropriate way to access care but in some circumstances patients would be better served by a collaborative care planning approach which clearly states how the person presents during periods of relapse, what the patient is likely to need and how best to access it before it becomes an emergency need.

What were we aiming to achieve?

Mental health and acute hospital providers aimed to work together with other partners (primary care, police, ambulance, substance misuse, social care, voluntary sector) to ensure that people presenting at ED with mental health or psychosocial needs have these needs assessed, recorded and met more effectively through improved collaborative working.

We would like to enable patients to access the most appropriate service for their needs quickly and for all services to have access to relevant information to support that individual.

Patients who have a frequent need for help and support and usually attend the ED should have a plan in place which has been agreed with the individual, their community workers, GP, and family or carers where appropriate. The plan should be available to the patient and to all professionals who might need to support the patient to access the right service at the right time and should include relevant history, risk and crisis plans.

For this to be effectively implemented services such as ED, mental health, social care and other providers need to share plans and information so people do not have to tell their information to many different professionals when they need help.

Regarding Treat as One, we aimed to review the report, undertake a gap analysis and develop an action plan to deliver improvement in the care of patients with a significant mental disorder who are admitted to the acute general hospital.

What have we done?

In order to measure the potential impact of this collaborative approach we have created a method to identify an initial group of patients who frequently attend ED with mental health needs. We have worked with our local mental health provider Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust to implement a process to ensure collaborative crisis plans are developed with the patient and their primary health worker and shared with the relevant professionals. These plans clearly state the actions preferred by the patient to meet their needs including who should be contacted, where the best place is to get assistance and what risks the patient might experience during a relapse.

We have reviewed how often this group of individuals attended ED, the reasons for the attendances and whether a crisis care plan is in place which meets their needs.

HDFT and TEWV staff have worked together to review the Treat as One report and we have developed an action plan with named leads and timescales for action.

What are the results?

In December 2017 the working group leading on the CQUIN reviewed the initial list of people who frequently attended ED and confirmed that nine of the original cohort of 14 had attended ED more than once since initial identification. The number of attendances for those patients had almost all reduced and overall visits to ED for this group had reduced by 36%. Local mental health services were involved in the care of all 14 and plans were in place to support them in the community. ED and the hospital based Mental Health Liaison Service had access to the plans and could refer to them in the event of the patient presenting.

The next cohort of patients has now been identified and discussed with our mental health partners in order that they can create collaborative plans with patients who are developing an ongoing need as early as possible. The process will be undertaken monthly via a

collaborative Safe Focus Meeting which will enable cross organisational planning for people who frequently access services and need support.

Summary and next steps

In summary, the initial phase of the national CQUIN was very successful and demonstrated the positive effect of coordinated, collaborative working for patients and their families. Access to the relevant information to support direct access to the most appropriate service for that individual the first time is better for the patient, better for their families and carers and more cost effective overall.

We are still embedding the process and working with partner agencies to make further improvements in how we share information and reduce delays and repetition for people accessing services. We will be working on the NCEPOD: Mental Health in General Hospitals: Treat as One action plan in 2018/19 and we hope to have further evidence of impact later this year.

4.11. COMMUNITY TEAMS AND SUPPORTED DISCHARGE

In 2017, the Trust held a week-long initiative called “Every Hour Matters” in March. The week focused on inpatient care with the aim of testing a number of ideas which would safely reduce the amount of time patients spent in hospital. During this week community occupational therapists and physiotherapists conducted two small trials to “reach into” the acute hospital setting. They tested whether community teams could support earlier discharge home and perform functional assessments in a patient’s home environment. Following the success of these trials a pilot Supported Discharge Service (SDS) team was created and launched in July 2017.

What were we aiming to achieve?

The aim of SDS is to reduce the length of stay in hospital by helping patients home after an admission. The service carries out physiotherapy assessments and occupational therapy assessments in the patient’s own home rather than the hospital environment. This can give a more accurate picture of how the person will cope at home, as assessments which take place in an unfamiliar environment such as hospital lead to poorer results, especially for patients with cognitive deficits. The team also provide support visits providing rehabilitation for up to 72 hours after discharge.

The ongoing development of the SDS service has been underpinned using the principles of the growing body of evidence and government initiatives such as the NHS Five Year Forward View (2014), and Quick Guide: Discharge to Assess; Transforming Urgent and Emergency Care Services in England (2016). The discharge to assess guide and NICE guidelines confirm that the transition from the inpatient hospital setting to a community setting is the ‘right thing to do’.

Patients who remain in hospital for periods of more than 24-48 hours experience physical de-conditioning and deterioration in their function leading to poor outcomes. This is especially relevant to frail elderly people and creates further health and social care needs which may be avoided if early assessment and care is delivered in the patient’s own, familiar environment. SDS intends to promote patient flow through hospital so that patients suffer fewer complications from hospital admission.

What have we done?

SDS is a small therapy led team consisting of physiotherapists, occupational therapists and support workers. Since July 2017 they have supported over 350 patients home, saving approximately 2-3 hospital bed days per patient. Community ready or medically fit patients are assessed for their suitability for the service on the ward in collaboration with ward based therapists. If suitable they are discharged home the same day. Assessments take place once at home and the appropriate rehabilitation or support programme is put in place for the next 72 hours. If ongoing support is required patients are referred to an appropriate team or service.

Links have been developed and improved between community and hospital based therapies by trialling ways of linking discharge pathways at the earliest opportunity. SDS has also reduced the number of referrals between services and avoided the delays that come with multiple referrals to different teams and agencies. They have also worked well with voluntary services such as the Red Cross and Age Concern. The service allows patients immediate access to support in their own homes which enables timely, safe discharge which benefits both patient and the services supporting them.

During January and February 2018 to manage winter pressures the Trust opened additional community beds in which patients have been case managed and provided with therapy interventions by SDS. They have tested new ways of working and managing therapy interventions in community beds together with colleagues from North Yorkshire County Council.

What are the results?

SDS has demonstrated its success in promoting early discharge and improving flow through the hospital. It has had a positive impact on patient experience and decreased the risk of deconditioning. The patient and family are at the forefront of any decisions made about discharge and feedback from them has been positive. Ward staff also feel the benefit and they value the contribution their colleagues in SDS make on a daily basis

Figure 44: Word cloud of patient and family feedback about the Supported Discharge Service

Summary and next steps

Despite only functioning since July 2017 the team is fully operational between the hours of 8am and 6pm and ready to operate beyond March 2018. We are currently working on a business plan to secure the future of the SDS team on a permanent basis as its success has been widely recognised.

The work it has done has informed the future development of discharge pathways, therapy provision in hospitals and community and the management of community rehabilitation beds. Its close work with other agencies has allowed further integration with other services such as NYCC and the voluntary sector and will continue to develop closer links between hospital and community.

4.12. BEING READY FOR WINTER

The Trust proactively plans for periods of increased pressure. It is known that during the winter period more patients attend ED and more patients are admitted to hospital. Therefore, the Trust works with HaRD CCG and other partners to ensure we have plans in place to care for more patients.

This year as well as the usual winter planning, we analysed previous winters and identified the first week following the New Year bank holiday as being a time when we might experience the most severe pressures on the hospital. To minimise the impact of this we planned a *Breaking the Cycle* week, a National initiative to shift the focus of the Trust to acute flow over planned work. The Trust named its own initiative, *Every Hour Matters* week

What were we aiming to achieve?

During the winter period from December 2017 to March 2018, we aimed to reduce the number of patients who were delayed transferring out hospital to either their own home with a package of care, or to a residential or nursing home. We also expected to see an increase in the number of attendances to the ED and the number of emergency admissions. A key aim was to increase the number of clinical staff available to care for and treat more patients.

The main aim of this Every Hour Matters week was to ensure the wider health and social care system supported the hospital to recover after two long holidays at Christmas and New Year. We aimed to achieve a number of outcomes during the week:

Flow
- 90% bed occupancy by Sunday 7 January 2018;
- 98% of patients discharged from the ED within four hours of arrival;
- 5 empty CATT beds at 8am each day.

Discharge
- 33% of all patients discharged to leave the wards by noon with the first discharge going from the ward by 10am;
- Reduction in the number of patients in hospital seven days or longer;
- 20% of patients who have triggered for Continuing Healthcare (CHC) assessments to be transferred to the community for Decision Support Tool (DST).

Quality
- No operations cancelled due to lack of availability of a bed;
- No more than five medical patients outlying in surgical beds at any one time.

What have we done?

Using additional money allocated by either the government or by the Trust itself we took the following actions:

Urgent and Emergency Care

The ED was allocated an additional nurse and consultant in the evenings to help at busy times in the department. An additional Emergency Nurse Practitioner was also allocated to shifts to see and treat patients attending with minor injuries.

Additional nurses were allocated to CATT ward to support the expected increase in emergency admissions to hospital. An additional acute physician was also recruited on a temporary basis to provide extra medical cover to CATT ward. It is known that at times of extreme pressure, patients are not always able to be admitted to the specialty ward they require and may be admitted to an alternative ward. With this in mind, the Trust recruited a doctor on a temporary basis to oversee the care of patients on alternative wards.

Wards

Over the winter period an additional agency pharmacy technician was made available to the wards to dispense discharge medications. The Trust also took the decision to book bank and agency nursing staff on the wards, and an additional locum registrar was appointed to medical patients who, due to bed pressures, were placed on surgical wards. Additional resource was placed in the Speech and Language Therapy (SALT) Team to support timely assessment of patients on wards.

A transfer team was set up to support the movement of patients and preparation of bed spaces. This team linked to the Clinical Site Management Team and focused predominately on maintaining flow through CATT ward.

Discharge from the hospital

A number of actions were taken to support timely discharge home from hospital over the winter period:

- Extra support from the Red Cross to help transport patients home and undertake small jobs such as shopping and making appointments;
- Extra ambulances from Yorkshire Ambulance Service (YAS) were paid for to transport patients to residential and nursing homes;
- The Trust increased the number of community rehabilitation beds by opening eight additional beds at Ripon Community Hospital and purchasing eight places at a local nursing home. To support more rehabilitation in the community, the Trust increased the number of therapists in the Supported Discharge Service. This team also supported the identification of patients to be managed in the additional beds and supported their rehabilitation needs and discharge planning once they were moved into the out of hospital beds;
- Additional staff were recruited to the Discharge Planning Team to help plan for and organise the discharge home of patients;
- The CCG worked to improve the discharge process for patients who are likely to need long-term packages of care in their own home or require 24 hour care in nursing or residential home. A new pathway has been developed which means that patients will no longer have their long-term needs assessed in hospital. Instead, patients will be supported to an interim care placement whilst health and social care work with the

patient and their family to assess what type of care will be most suitable in the longer-term.

Every Hour Matters

For the duration of the first week of January 2018, HDFT cancelled all non-essential meetings so all staff could be available to help the wards. Wards were supported by a ward liaison officer each weekday from 9am until 5pm. This role was undertaken by matrons, general managers and service managers and they supported the wards with actions for discharges and helped to resolve or escalate delays in patient care. A number of staff from non-clinical services also volunteered for a couple of hours each day to offer practical help with activities such as handing out meals and drinks, helping to put stores away, filing records and chatting with patients.

The Trust hosted a silver command with representatives from partner organisations including NYCC, HaRD CCG and TEWV NHS Foundation Trust. The silver command was based at Harrogate District Hospital, with members making themselves available to resolve issues escalated via the ward liaison officers. They attended ward rounds and focused on helping to safely but rapidly discharge patients who had been in hospital for more than seven days.

What are the results?

Overall, the Trust has seen a reduction in delayed transfers of care. Like many trusts across England, HDFT had a surge of influenza cases in December 2017 which affected admissions and discharges from the hospital. The hospital had an increase of approximately 4.95% admissions in December compared to the same period in 2016, but approximately 10% fewer discharges.

Summary

The Trusts winter plans included additional staff allocated to the ED and wards. The Trust has also used additional money provided by the Department of Health to fund extra community rehabilitation beds and transport home from hospital. Like other trusts locally and nationally, HDFT has had a challenging winter period. However, we have maintained flow through the hospital and have achieved 95% of patients seen and treated or admitted within 4 hours for the whole year.

4.13. EQUALITY AND DIVERSITY OBJECTIVES

On 5 April 2011, the public sector equality duty (the equality duty) came into force. The equality duty was created under the Equality Act 2010. There is an obligation on public authorities to positively promote equality, not merely to avoid discrimination. Public sector organisations are required to demonstrate that they are giving ‘due regard’ to the needs of protected groups. This means that equality issues must be considered and evidenced in the decision making process.

The refreshed Equality Delivery System for the NHS (EDS2) was published in 2013 to help local NHS organisations in discussion with local people, review performance for people with characteristics protected by the Equality Act 2010 and improve performance for patients, public and staff. At the heart of EDS2 are 4 goals and 18 outcomes to assess and grade against, asking the question:

“How well do people from protected groups fare compared with people overall?”

In addition, the Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. The Accessible Information Standard is based on the requirement to implement:

1. **Identification of needs**: a consistent approach to identification of patients, carers and parents information and communication needs where they relate to a disability, impairment or sensory loss.
2. **Recording of needs**: as part of patient / service user records and systems.
3. **Flagging of needs**: establishing and using e-flags or alerts to indicate that an individual has a recorded information and/or communication need and to prompt staff to take appropriate action and/or trigger auto-generation of information in an accessible format.
4. **Sharing of needs**: inclusion of recorded data as part of existing data-sharing processes and as routine part of referral, discharge and handover.
5. **Meeting of needs**: taking steps to ensure the individual receives information in an accessible format and any communication support which they need.

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

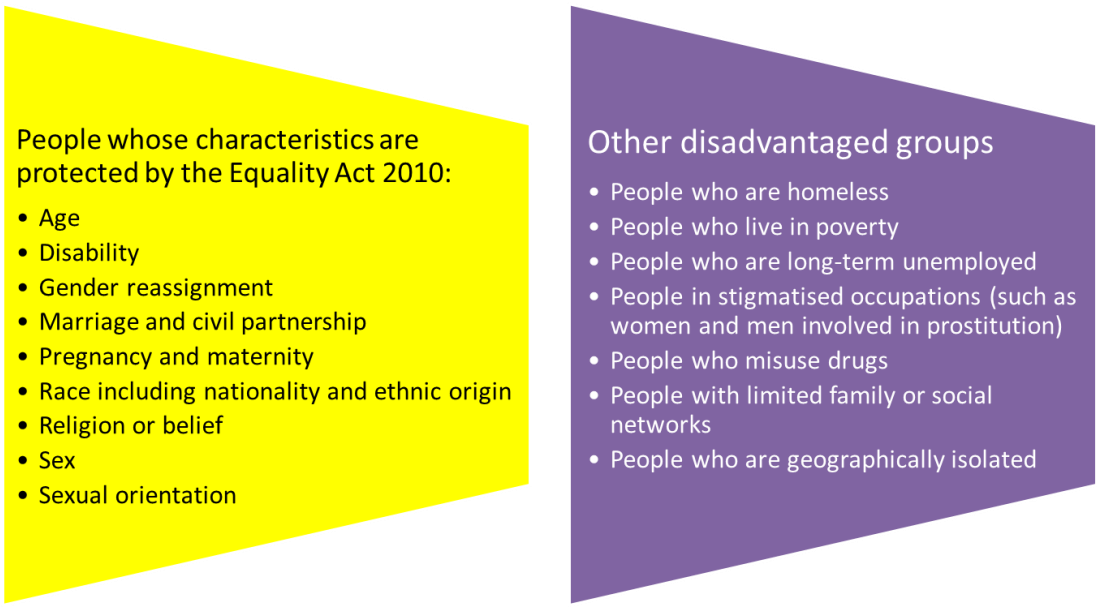


Figure 44: Protected characteristics and disadvantaged groups as defined in EDS2

What were we aiming to achieve?

At HDFT, we have been aiming to improve our understanding of how well people from protected groups fare compared with people overall in relation to the wide variety and location of services and staff. We established equality objectives and have been progressing a plan of work. Regarding the accessible information standard, we have focused initially on patients with learning disabilities (LD) and were aiming to:

1. Ensure that people with learning disabilities' hospital records are flagged to allow the provision of appropriate communication support.
2. Ensure that easy read information is readily available to staff and patients to support communication with those that would benefit from this format.
3. Provide easy read appointment letters for all patients flagged as having learning disabilities.

What have we done?

Key areas of progress during 2017/18 have been:

- Work to achieve better health outcomes for patients with learning disabilities with:
  - Promotion of the LD flag on hospital records both internally and externally. Flagging is prompted on the new 'Enhanced Admission Proforma for Patients with Learning Disabilities';
  - Provision of LD community services for children in Harrogate and raising awareness of LD flagging;
  - Establishing a link to 'easy health' from the LD page on the Trust's website.
  - The LD Liaison Nurse providing bespoke easy read information for individual patients and specialist communication support where required;
  - Involvement in the review of sample easy appointment letters. Feedback from the LD liaison nurse and the Trust's Symbolic Language Advisor has raised concerns regarding their suitability, and there will be wider consultation, targeted specifically at patients with learning disabilities that use easy read information;
- Working with disadvantaged groups e.g. the Gypsy, Roma and Traveller Communities in County Durham;
- Highlighting to staff the resources available for people with hearing impairment;
- Development of a systematic approach to full compliance with the Accessible information Standard;
- Dementia friendly signage on Jervaulx and Byland wards, and re-establishing dementia training and a matron for patients with dementia;
- Development of an equality impact assessment toolkit for all service improvement, transformation and cost improvement programmes;
- The identification of a location that we hope will provide Changing Places facilities within working hours in the new Endoscopy Unit;
- Engagement with a wide variety of local stakeholders via the Equality Stakeholder Group;
- The re-launch of the Workforce Equality Group which now meets quarterly with a revised terms of reference;
- Further implementation of the Armed Forces Covenant;
- Informing the Board of Directors about the drivers for improving impact assessments and ensuring a focus on equality;
- Incorporating equality into our patient and public participation strategy work;
- Promoting information about equality and diversity at our Annual Members Meeting.

What are the results?

1. We currently have 412 patient records that have a learning disabilities flag;
2. The link to easy read information on the website is active. This allows patients, their families or their carers to access easy read resources.
3. Bespoke easy read information continues to be available from the LD Liaison Nurse;
4. The updated EDS2 self-assessment, which contains the equality objectives, is on the Trust website at https://www.hdft.nhs.uk/about/equality-and-diversity/;
5. HDFT has been recognised as one of the country's leading employers for their support of Armed Forces personnel.

Summary and next steps

Much of this work will continue during 2018/19 and we are progressing:

- A generic risk flag on electronic records to indicate an "accessible information need".
- Linking this flag to a register of the patient's detailed information and communication needs using a specific module within our appointment letter software. This will enable the recording of specific needs including:
    - Specific contact method - to indicate alternative communication / contact methods e.g. people who are d/Deaf may not be able to use a telephone to book / amend appointments and alternatives including email, text messaging, telephone and text relay can be specified;
    - Specific information format e.g. need to send correspondence or provide information in an alternative, non-standard format;
    - Communication professional needed: e.g. British sign language interpreter, lipspeaker, interpreter for Deaf/blind people;
    - Communication support: use of aids or equipment e.g. hearing aids, hearing loop etc;
    - Alternative formats for information for the patient and the carer.

The aim is to flag and register people we are already aware of and then start to identify others with communication needs. Some technical work is required, and then we need to establish a process to ask for this information, apply the flag and add the detail of information needs. Once in place there will need to be a patient and staff awareness raising campaign.

4.14. PRIORITY CLINICAL STANDARDS FOR SEVEN DAY HOSPITAL SERVICES

The key drivers for seven day working were aimed at improving patients' experience and addressing the inequalities in outcomes based upon the day of the week that a patient was admitted to hospital. The ten clinical standards for seven day services in hospitals were developed in 2013, and founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven day services should achieve, no matter when or where patients are admitted.

With the support of the AoMRC, four of the ten clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

There is further information at Seven day services: clarification of the four priority clinical standards | NHS Improvement.

By March 2017 HDFT had already undertaken a significant amount of work to begin moving towards the delivery of seven day services with:

- 8am to 8pm consultant acute physician presence on the acute medical wards Monday to Friday;
- Morning and evening post-take medical rounds on Saturdays and Sundays;

- Additional consultant physician ward presence on base medical wards for half day on Saturdays and Sundays;
- Specific Stroke Unit ward cover 8am to 2pm on Saturdays and Sundays, with a telemedicine stroke rota staffed by an alliance arrangement with neighbouring organisations ensuring that any stroke patient admitted is seen by a stroke physician at any time of day or night;
- Increased consultants in emergency medicine to ensure a consultant presence in the department seven days a week during the day and throughout the evening (Monday to Friday);
- General surgical consultant of the week model, ensuring that there is dedicated acute consultant cover seven days per week, with no elective commitments.

Audits for standards 2, 5, 6 and 8 were undertaken in 2016 and repeat audits were undertaken in 2017.

			2016		2017	
Clinical Standard	**Requirement**	**Target**	**HDFT Weekday**	**HDFT Weekend**	**HDFT Weekday**	**HDFT Weekend**
2 (revised 2017)	Consultant review within 14 hours of *admission* at hospital	**90%**	60%	59%	59%	66%
5	Access to diagnostics – *Immediate* clinical need – 1 hour	**90%**	93%	57%	*These standards have now changed and rely on self-declaration from each Trust - see below.*	
5	Access to diagnostics – *Urgent* clinical need – 12 hours	**90%**	93%	55%		
6	24 hour access to consultant directed interventions	**90%**	87%	74%		
8	Twice daily reviews by appropriate member of team (consultant or delegate)	**90%**	100%	100%	100%	100%
8	Daily review by appropriate member of team (consultant or delegate)	**90%**	100%	93%	100%	65%

Table 51: Results of audits of priority clinical standards 2016 and 2017

Standard 5: Access to diagnostics

"Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?"

Service	**Weekday**	**Weekend**
	March 2017	**March 2017**
CT	Yes	Yes
Echocardiograph	Yes	No
Microbiology	Yes	Yes
MRI	Yes	Yes
Ultrasound	Yes	Yes
Upper GI Endoscopy	Yes	Yes

Table 52: HDFT Standard 5 declaration by service March 2017

Standard 6: Access to interventions

"Do inpatients have 24 hour access to consultant directed interventions 7 days a week, either on site or via formal network arrangements?"

Intervention	Weekday			Weekend		
	March 2016	September 2016	March 2017	March 2016	September 2016	March 2017
Critical Care	Yes	Yes	Yes	Yes	Yes	Yes
Primary Percutaneous Coronary Intervention	Yes	Yes	Yes	Yes	Yes	Yes
Cardiac Pacing	Yes	Yes	Yes	Yes	Yes	Yes
Thrombolysis for Stroke	Yes	Yes	Yes	Yes	Yes	Yes
Emergency General Surgery	Yes	Yes	Yes	Yes	Yes	Yes
Interventional Endoscopy	Yes	Yes	Yes	Yes	Yes	Yes
Interventional Radiology	Yes	Yes	Yes	Yes	Yes	Yes
Renal Replacement	Yes	Yes	Yes	Yes	Yes	Yes
Urgent Radiotherapy	Yes	Yes	Yes	Yes	Yes	Yes

Table 53: HDFT Standard 6 declaration by service March 2017

5. ANNEX ONE: STATEMENTS FROM STAKEHOLDERS

In accordance with the NHS Quality Accounts Regulations, Harrogate and District NHS Foundation Trust sent a copy of the draft Quality Account to its lead Clinical Commissioning Group, Harrogate and Rural District, Healthwatch North Yorkshire, North Yorkshire County Council Scrutiny of Health Committee, the Council of Governors and the Health and Wellbeing Board for comment prior to publication and received the following statements:

HARROGATE AND RURAL DISTRICT CLINICAL COMMISSIONING GROUP QUALITY ACCOUNT STATEMENT 2017/18

NHS
Harrogate and Rural District
Clinical Commissioning Group

Email: j.crewe@nhs.net
Direct Tel: 01423 799334
Reference: HaRD.046-18

LETTER SENT VIA EMAIL

Harrogate and Rural District
Clinical Commissioning Group
1 Grimbald Crag Court
St James Business Park
Knaresborough
HG5 8QB

Jill Foster
Chief Nurse
Harrogate and District NHS Foundation Trust

Tel: 01423 799300
Fax: 01423 799301
Email: hardccg.enquiries@nhs.net
Web: www.harrogateandruraldistrictccg.nhs.uk

8 May 2018

Dear Jill

Quality Account for Harrogate and District NHS Foundation Trust for 2017-18.

Harrogate and Rural District Clinical Commissioning Group (HARDCCG) welcomes the opportunity to review and provide a statement for the Trust's Quality Account for 2017/18. This Quality Account has been reviewed in accordance with the Department of Health and Social Care (Quality Accounts) Amendment Regulations 2017.

This report has been shared with key individuals across HARDCCG and their views have been collated into my response.

HARDCCG remains committed to ensuring, with its partner organisations, that the services it commissions provide the highest of standards in respect to clinical quality, safety and patient experience.

It is recognised by the Commissioner that the Trust and its staff demonstrate resilience and dedication to ensure they deliver safe and effective services as referenced throughout the Quality Account and we congratulate the Trust in consistently maintaining improvements in:

- Mortality performance and continuing to build on the lessons learnt from the reviews of deaths. It would be helpful to describe how learning from all deaths and those falling into the LeDeR process is captured.
- Participation in research with an increase in the total number recruited to clinical trials and the use of Patient Research Ambassadors (PRAs) to enable a strong patient perspective to research, feasibility and quality assurance. It would be

helpful to see some examples of these research project findings and how they link to quality improvements.

- Improvements made throughout maternity services including effective smoking cessation in pregnancy and reduced smoking rates at delivery.
- Providing services that effectively meet the needs of our most vulnerable people including those with learning disabilities and mental health problems.
- Improved sepsis management especially within the Emergency Department. The Trust recognises that there is further work to do on administration of antibiotics and screening relevant inpatients. The Trust has recognised this as a quality priority for 2018/19.
- Reduction in medicine prescribing and administration errors including those causing harm and the extensive Hospital Pharmacy Transformation plan.
- Collaborative work with the voluntary sector, especially in cancer care and the significant contribution volunteers make to the patient experience, particularly in the inpatient areas. We would like to have seen more examples of where there is similar work or developments in community.
- The number of local and national audits being carried out in the Trust is commendable and it would be helpful to see more information with a focus on the measurable improvement as a result of the audit recommendations and actions.

The Trust experienced some challenges as referenced in their Quality Account due to a high demand for healthcare over a protracted winter period. However the focus on flow through the hospital was maintained and the Trust achieved a year end position which resulted in less than 4% of patients waiting to be seen and admitted or discharged from A&E. This is a strong performance position and demonstrates the impact of a focus on a number of system wide improvements and success of the local initiatives 'Every Hour Matters', work on discharge pathways including Transfer to Access and the Supported Discharge Service (SDS).

The Supported Discharge Service appears to have had an impact on reducing bed days for the patients included in the pilot service and reducing length of stay ahead of the planned discharge date. It would be helpful to see patient experience data as part of the evaluation and we would welcome this approach as part of the Improving Discharge Processes quality priority for 2018/19.

The Dementia care section is clearly documented, although there seems to be more of a focus on what is going to be done to improve the experience of people with dementia in this section e.g. 'What have we done and what were the results' has no mention of any results.

HARDCCG believe 'PJ Paralysis' is a very real and important concept but it is not an initiative just targeted at people with dementia as it is applicable to all patients, particularly the frail elderly. The same applies to the Carer's Passport and as such it would have been helpful to see the results of how this initiative had an impact on patients and their carers. The focus on delirium is really good to see and we look forward to finding out how the planned training has improved patient care at the end of 2018/19.

The Trust appears to have a real commitment through this report to patient/service user involvement. This is really evident in how the Trust are implementing their overarching strategy around hearing the voice of children and young people and their commitment to prioritising this in the development of the Youth Forum which is very welcome. This will enable us all to have a system view of young peoples' 'Hopes for Healthcare'.

Partnership working is evident throughout the report and some good examples of where improvements have been made to support patients and their carers. Of particular note should be the work in cancer care and care of the dying. This work demonstrates the improvement in information sharing and pathways. It will have a positive impact on the patient and relatives' experience.

On another positive note, the Trust should be congratulated on their results from the NHS Staff Survey 2017. We look forward to the Trust's continued progress during 2018/19.

We acknowledge the work undertaken by the Trust to improve stroke care as a priority for 2017/18. We also note reference to the limited opportunity for improvement and sustainability of the local stroke service which is being considered with system partners and the West Yorkshire and Harrogate Health Care Partnership. We would have expected a reference to a safety improvement plan developed by the Trust to support this ongoing work.

The Trust reported the progress on improving learning from the incidents, complaints and good practice 2017/18 quality priority. We were pleased to read about the number of measures which have been put in place to improve reporting of incidents. We would have expected more emphasis and progress on learning the lessons from incidents or complaints and how these will be monitored across the Trust. We recognise this priority will also be a focus for 2018/19 and look forward to seeing more significant progress particularly where there remains recurrent evidence of poor patient experience.

The Trust reported a similar number of serious incidents causing severe harm or death as reported in 2016/17. We would have liked to see more reference to the learning from these included in the narrative of the Quality Account.

The key successes of the 2017/18 quality priorities are clearly reflected in the Quality Account. We would ask the Trust to revisit the limited reference to Pathology services and Infection Prevention Control (IPC) in the report. The evidence of improvement in these areas are limited and it would be helpful to see some additional narrative of work across the hospital and community services.

We welcome the opportunity to review progress on the Trust's quality improvements and hope that our feedback is accepted as a fair reflection of the report and look forward to working alongside the Trust to achieve the objectives of the 2018/19 priorities.

Yours sincerely

Joanne Crewe
Director of Quality and Governance/Executive Nurse
Harrogate and Rural District Clinical Commissioning Group

LEEDS CLINICAL COMMISSIONING GROUP QUALITY ACCOUNT STATEMENT 2017/18

NHS
Leeds
Clinical Commissioning Group

Mrs Jill Foster
Chief Nurse
Harrogate and District NHS Foundation Trust
Lancaster Park Road
Harrogate
North Yorkshire
HG2 7SX

19 April 2018

Dear Jill,

Thank you for providing the opportunity to feedback on the Quality Account for Harrogate and District NHS Foundation Trust for 2017-18.

This report has been shared with key individuals across the newly formed Leeds Clinical Commissioning Group (formerly Leeds West CCG, North CCG and South & East CCG) and this response is on behalf of the new organisation.

We acknowledge that the report you provided for review and comment is in draft form and additional information will be added and amendments made before final publication, so please accept our observations on that basis.

The report provides some interesting information across a wide range of activities and demonstrates some very positive innovations and thoughtful reflections around the organisation's aspirations and challenges.

It is encouraging to see the organisation move into the top 25% of reporters for incidents and the positive focus on learning from these.

The organisation demonstrates commitment through this report to patient/service user involvement and in particular the engagement work with young people.The development of the Youth Forum is impressive, welcomed and to be commended. We would encourage the organisation to continue to listen to feedback and to learn any lessons from this valuable work going forward.

Partnership working is evident in the report in relation to cancer care and we were pleased to note the positive work on care of dying patients and support for their relatives. The high take up of the benefits adviser within the Cancer team is positive, and we note your collaboration with the voluntary sector to support this work.

NHS Leeds Clinical Commissioning Group
Suites 2–4, WIRA House, West Park Ring Road, Leeds, LS16 6EB
T: 0113 843 5470 W: www.leedsccg.nhs.uk facebook.com/nhsleeds @nhsleeds

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There are some good examples given of work that has shown a positive impact on the quality of services and care for patients such as criteria led discharge, the reduction in Delayed Transfers of Care, the focus on medical outliers and ensuring patients care and treatment is reviewed and the access to easy read material for people with a Learning Disability.

The work undertaken to improve identification and treatment of sepsis also appears to be demonstrating success especially within the Emergency Department. However there is clear progress and the Trust acknowledges that there are further improvements to be made regarding the administration of antibiotics. We would also encourage the Trust to focus on actions to improve its screening of relevant inpatients, which shows a comparatively lower performance of screening than the Emergency Department, and we look forward to seeing the continued progress.

It is good to see details of the outcome and learning from local audits included in the report and there is good evidence of data embedded within the report which gives assurance of the focus on evaluation of the impacts of various innovations. We are also pleased to see that the Trust is committed to research and development and has a large amount of clinical studies ongoing. It would be helpful to see some examples of the research projects and how they link to quality improvements.

The progress noted in the report relating to the medicines safety initiative is impressive. The work on reducing missed doses of medication, patient identity errors and medicine reconciliation in 24 hours is welcomed and the Trust is to be commended on the improvements made. In relation to insulin errors; the report states the increase since 2013/14 is related to the proactive use of the insulin dashboard, but it is not clear how this conclusion has been reached or why there has been a fall in the number of community errors.

The work on reducing falls is also to be commended. Although the data from the National Audit of Inpatient Falls indicates a reduction in compliance for some elements of falls risk assessment, the overall impact that the work is having is positive and to be welcomed.

There is evidence of some good work on Dementia care and the addition of dementia considerations into patient safety huddles is to be welcomed, along with the addition of a carer's passport to support carers.

We are pleased to see some good work relating to the improvement in quality in maternity care. Including mothers and partners in the handover process during labour is a good example of transparency in care and the collaborative working with partners in maternity is to be applauded. Although the national maternity implementation programme Better Births is referenced, the report doesn't detail the progress with this work. The opportunity

NHS Leeds Clinical Commissioning Group
Suites 2–4, WIRA House, West Park Ring Road, Leeds, LS16 6EB
T: 0113 843 5470 W: www.leedsccg.nhs.uk facebook.com/nhsleeds @nhsleeds

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to invest in training clearly helped to support the department and we hope that the benefits from this work will continue to help ensuring safety within maternity.

The work undertaken on the review and learning from deaths is welcomed, although the mechanisms for reviewing could be made clearer and assurance given that learning from all deaths and those falling into the LeDeR process is captured.

The Three Year Clinical Transformation Programme has had some successes and also some delays but the programme appears to have momentum and the report details the attention to the plans clearly. References to a shift in culture are present throughout the report and it would be good to see some lessons from sustained cultural change as this is particularly hard to achieve. We hope the organisation maintains the commitment and resource to support such cultural changes.

The report demonstrates in various sections, how the organisation has listened and learned from others. Sharing and learning from other projects across the locality and beyond is to be commended. Being transparent about where ideas have come from and applying them to your own setting is a very effective approach to sustaining positive change which is to be encouraged.

We note that the priorities going forward for 2018/19 are building on a lot of the good work commenced in 2017/18 and hope that the Trust commits to the areas still requiring improvement and can demonstrate the same improvements in quality for next year.

We welcome the opportunity to review the report and hope that this is accepted as a fair reflection. We look forward to seeing the progress made over the coming year.

Yours sincerely,

Dr Simon Stockill
Medical Director

Jo Harding
Executive Director of Quality and Safety/Governing Body Nurse

NHS Leeds Clinical Commissioning Group
Suites 2–4, WIRA House, West Park Ring Road, Leeds, LS16 6EB
T: 0113 843 5470 W: www.leedsccg.nhs.uk facebook.com/nhsleeds @nhsleeds

COUNCIL OF GOVERNORS QUALITY ACCOUNT STATEMENT 2017/18

The Council of Governors is delighted to have the opportunity to comment on this detailed and comprehensive Quality Account.

Again, the Trust can be justifiably proud of its achievements over the last year and the Council of Governors recognise the commitment to deliver high quality care by all staff across the organisation.

Governors, as in previous years, have been extensively consulted on the Trust's Operational Plan, have contributed to the development of the quality priorities for the coming year, and have reviewed the Quality Account. Individual Governors sit on, and triangulate information from, the Learning from Patient Experience Group, departmental Quality of Care Teams, and Patient Safety visits, all of which enable them to personally experience the challenges of maintaining quality of care in different areas of the Trust's services.

Governors have in-depth formal meetings with the Board of Directors twice a year and with Non-Executive Directors three times a year. Both Executive and Non-Executive members of the Board of Directors regularly attend the quarterly public Council of Governors' meetings. In addition, Governors regularly attend as observers at Board of Directors' meetings and Board sub-committee meetings; in particular the Quality Committee, which has delegated responsibility and oversight of the Trust's progress towards achieving the quality priorities.

The Council of Governors supports and fully endorses the 2017/18 Quality Account and the quality priorities selected for particular focus during 2018/19.

Pamela Allen
Deputy Chair of Governors/Lead Governor
on behalf of the Council of Governors

NORTH YORKSHIRE SCRUTINY OF HEALTH COMMITTEE

Over the past 12 months, the North Yorkshire Scrutiny of Health Committee has continued to liaise with Harrogate and District NHS Foundation Trust to better understand some of the pressures that they face.

It is recognised that staff shortages, particularly in emergency medicine, nursing and anaesthesia can have a significant impact upon what services can be delivered from what site and for how long. The trust contributed to an in-depth investigation into health and social care workforce pressures that was undertaken by the Scrutiny of Health Committee in the autumn of 2017. The information, data and analysis provided helped the committee to appreciate the issue across the whole system and the support of the trust was much appreciated.

It is also recognised that the rural nature of the county and the length of time that it can take to travel to and from appointments can have an impact upon how services are planned and delivered. The committee, however, remains committed to ensuring that people are not excluded from services based upon where they live. The presumption is that you should be able to access the same type and quality of care no matter where you live in North Yorkshire.

The current financial pressures within the health system in North Yorkshire are of great concern. Whilst there are doubts as to whether the funding formula for health is fair and concerns that it disadvantage rural areas, we need to work together to find a way to make

the money that we have work the hardest and result in good outcomes across the health and social care system.

The Scrutiny of Health Committee remains committed to a system-wide view of services that helps to ensure that decisions on the planning and delivery of health care are not made in isolation and that the key role that a broad base of community services have to play is not overlooked. This will not be easy going forward as the health commissioners and providers in the county are pulled in three different directions as the new NHS integrated systems for planning and delivery in the West, South and North of the county are put in place.

County Councillor Jim Clark
North Yorkshire Scrutiny of Health Committee

6. ANNEX TWO: STATEMENT OF DIRECTORS' RESPONSIBILITIES

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2017 to April 2018
    - Papers relating to quality reported to the Board over the period April 2017 to April 2018
    - Feedback from the commissioners dated 08 May 2018
    - Feedback from Governors dated 12 April 2018
    - Feedback from Healthwatch North Yorkshire was requested 6 April but no comment was received
    - Feedback from North Yorkshire County Council Scrutiny of Health Committee dated 15 May 2018
    - The Trust's draft complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 16 May 2018
    - The 2016 national patient survey dated 20 July 2017
    - The 2017 national staff survey dated 6 March 2018
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated April 2018
    - CQC inspection report dated 27 July 2016
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS improvements annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board on 23 May 2018.

.....

Mrs Angela Schofield
Chairman

.....

Dr Ros Tolcher
Chief Executive

7. ANNEX THREE: NATIONAL CLINICAL AUDITS 2016/17

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2017/18	Data submitted as a percentage of the number of registered cases required for that audit
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	222	100%
2	BAUS Urology Audits: Female stress urinary incontinence	No	19	100%
3	Bowel Cancer (NBOCAP) *This relates to data submitted for 2016/17. The Trust has not yet submitted any patient data for 2017/18 as the deadline for this will be in April 2019*	Yes	145	117% (Based on expected total of 124)
4	Cardiac Rhythm Management	Yes	New PPM - 130 PPM box change - 23 CRT implant - 4 Reveal - 63	100%
5	Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC) *This figure is for April to December 2017*	No	331	100%
6	Child Health Clinical Outcome Review Programme	Yes		
	Young People's Mental Health		5	100%
	Cancer in Children, Teens and Young Adults *Please note this study is still open and figures have not been finalised*		Organisational questionnaire returned	N/A
7	Diabetes (Paediatric) (NPDA) *This figure is for the latest round of the audit which relates to patients seen from 1 April 2016 to 31 March 2017.*	Yes	89	100%
8	Elective Surgery National PROMS	No		

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2017/18	Data submitted as a percentage of the number of registered cases required for that audit
	programme (2016/17)			
	Hip replacement *(provisional data)*		334 (pre-op) 258 (post-op)	105.7% 77.9%
	Knee replacement *(provisional data)*		440 (pre-op) 322 (post-op)	133.7% 73.7%
	Groin hernia *(final data)*		262 (pre-op) 173 (post-op)	87.9% 66.3%
	Varicose vein		N/A	N/A
	Elective surgery National PROMS programme (April - September 2017)	No		
	Hip replacement		Not yet published	Not yet published
	Knee replacement		Not yet published	Not yet published
	Groin hernia		134 (pre-op) 29 (post-op)	94.4% 40.8%
	Varicose vein		N/A	N/A
9	Falls & Fragility Fractures Audit Programme (FFFAP)	Yes		
	National Audit of Inpatient Falls		30	100%
	National Hip Fracture Database		214	100%
10	Fractured neck of femur (CEM)	No	50	100%
11	Inflammatory Bowel Disease (IBD) programme *New patients 01/04/2017 to 31/03/2018*	No	35	N/A (rolling database)
12	Learning Disability Mortality Review Programme (LeDeR)	Yes	7	100%
13	Major Trauma: The Trauma Audit & Research Network (TARN)	No	187	Awaiting confirmation
14	Maternal, New-born and Infant Clinical Outcome review Programme (MBRRACE-UK)	Yes	Stillbirths = 7 Late Miscarriages = 1 Termination of pregnancy (for severe fetal	100%

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2017/18	Data submitted as a percentage of the number of registered cases required for that audit
			abnormality) = 1 Maternal death = 1 (Patient died within first year after giving birth - not post-partum related)	
15	Medical & Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome & Death (NCEPOD)	Yes		
	(i) Chronic Neurodisability		2	100%
	(ii) Acute Heart Failure		5	100%
	(iii) Perioperative Diabetes *Please note this study is still open and figures have not been finalised*		4	100%
16	National Audit of Breast Cancer in Older Patients (NABCOP) *Please note that data for March 2018 is still to be submitted*	Yes	59	Not stated
17	National Audit of Dementia (Delirium Spotlight Audit)	Yes	20 +5 reliability cases	100%
18	National Audit of Intermediate Care	No	Did not participate	Did not participate
19	National Audit of Rheumatoid and Early Inflammatory Arthritis	Yes	No data collection during 2017/18	No data collection during 2017/18
20	National Audit of Seizures and Epilepsies in Children and Young People	Yes	No data collection during 2017/18	No data collection during 2017/18
21	National Cardiac Arrest Audit (NCAA) *Figures are for April to December 2017 (Q4 data not yet available)*	No	48	100%
22	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes		

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2017/18	Data submitted as a percentage of the number of registered cases required for that audit
	(i) Secondary Care *Please note this is a continuous audit which commenced on 1 February 2017. Data is being collected retrospectively following clinical coding.*		227	99,6%
23	National Comparative Audit of Blood Transfusion Programme	No		
	(i) Re-Audit of Red Cell & Platelet Transfusion in Adult Haematology Patients		35	100%
	(ii) Audit of the management of patients at risk of Transfusion Associated Circulatory Overload (TACO)		40	100%
24	National Diabetes Audit (Adults)	Yes		
	National Footcare Audit *Relates to records submitted between 01/04/2017 and 31/03/2018*		476	N/A (rolling database)
	National Inpatient Audit (NADIA)		33	100%
	National Pregnancy in Diabetes Audit		Did not participate	Did not participate
	Secondary Care Audit *Audit period 1 January 2016 to 31 March 2017*		1017	Not stated
25	National Emergency Laparotomy Audit (NELA) *Data refers to year 4 of the audit (01/12/2016 to 30/11/2017)*	Yes	42	96%
26	National End of Life Care Audit	Yes	No data collection during 2017/18	No data collection during 2017/18
27	National Heart Failure Audit	Yes	234	100%

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2017/18	Data submitted as a percentage of the number of registered cases required for that audit
	Please note that due to delays in coding this is a preliminary figure and additional patients may be identified from March 2018			
28	National Joint Registry (NJR)	Yes	1004	Not stated
29	National Lung Cancer Audit (NLCA) *Please note that submission for this audit is undertaken retrospectively and data from July 2017 onwards has not yet been validated*	Yes	151	Not stated
30	National Maternity and Perinatal Audit *Please note this relates to 2016/17 data*	Yes	1,933	100%
31	National Neonatal Audit Programme (NNAP - intensive and special care) *Data for 2017*	Yes	132	100%
32	National Ophthalmology Audit *Reporting period 01/09/2016 to 31/08/2017*	Yes	1,450	100%
33	Oesophago-gastric cancer (NAOGC) *This relates to data submitted for 2016/17. The Trust has not yet submitted any patient data for 2017/18 as the deadline for this will be April 2019, therefore reporting will always be one year in arrears.*	Yes	46	118% (based on expected total of 39)
34	Pain in Children (CEM)	No	35	100%
35	Procedural Sedation in Adults (care in emergency departments)	No	23	100%

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2017/18	Data submitted as a percentage of the number of registered cases required for that audit
	(CEM)			
36	Prostate Cancer Audit *Financial year data up to end of February 2018 (28 February 2018) – cases from March onwards still to be validated and registered.*	Yes	151	Not stated – case ascertainment is not currently measured for prostate patients but will be in future. The cancer registry has run its own analysis on our data and have confirmed our figures are as expected.
37	Sentinel Stroke National Audit Programme (SSNAP)	Yes	311	100%
38	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	No	Anti D – 2 Transfusion reaction – 3 Storage – 2	100%
39	UK Parkinson's Audit	No	Neurology: 23 OT: 10 Physio: 10 SLT: 10	>100% 100% 100% 100%

For information, the Trust also participated in the following audits:

Data submitted to National Audits not included in NHS England's Quality Accounts List	Number of patients for which data submitted 2017/18	Data submitted as a percentage of the number of registered cases required for that audit
Breast & Cosmetic Implant Registry *Please note HDFT only started submitting to this Registry part way through the year.*	11	Not stated
National Audit of Cardiac Rehabilitation	169	100%

The following nine NCAPOP audits were not relevant to HDFT due to the Trust not providing the service:

- Adult Cardiac Surgery
- Congenital Heart Disease (CHD)
- Coronary Angioplasty/National Audit of PCI
- Mental Health Clinical Outcome Review Programme/National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH) (all work streams)
- National Audit of Anxiety and Depression
- National Audit of Psychosis
- National Clinical Audit of Specialist Rehabilitation for patients with complex needs following major injury (NCASRI)
- National Vascular Registry
- Paediatric Intensive Care Audit Network (PICANet)

Furthermore, the Fracture Liaison Service Database (FLSD) element of the Falls & Fragility Fractures Audit Programme (FFFAP) is not relevant to the Trust as we do not have a dedicated Fracture Liaison Service.

The following 10 non-NCAPOP audits were not relevant to HDFT due to the trust not providing the service:

- BAUS urology audits: Cystectomy
- BAUS urology audits: Nephrectomy
- BAUS urology audits: Percutaneous nephrolithotomy
- BAUS urology audits: radical prostatectomy
- BAUS urology audits: Urethroplasty
- Endocrine & Thyroid National Audit
- Head & Neck Cancer (HANA)
- National Bariatric Surgery Registry (NBSR)
- Neurosurgical National Audit Programme
- Prescribing Observatory for Mental Health (POMH-UK) (all work streams)

Please note that the National Audit of Rheumatoid and Early Inflammatory Arthritis, National Audit of Seizures and Epilepsies in Children and Young People and the National End of Life Care Audit which were all included in the NHS England Quality Accounts List 2017/18 did not have data collection during the 2017/18 financial year and therefore we are unable to report on participation.

8. ANNEX FOUR: GLOSSARY

AMU	Acute Medical Unit
CAT	Clinical Assessment Team
CATT	Clinical Assessment, Triage & Treatment
CCG	Clinical Commissioning Group
CEM	Royal College of Emergency Medicine
CHC	Continuing Healthcare
CNS	Clinical Nurse Specialist
CQUIN	Commissioning for Quality and Innovation
Dashboard	Data visualisation tool that displays the current status of metrics and key performance indicators
DST	Decision Support Tool
ED	Emergency Department
ePMA	Electronic prescribing and medicines administration system
FFT	Friends and Family Test
HaRD	Harrogate and Rural District
HDFT	Harrogate and District NHS Foundation Trust
HQIP	Healthcare Quality Improvement Partnership
ICE	Requesting and reporting software
ITU	Intensive Therapy Unit
KPI	Key performance indicator
LD	Learning disabilities
MCA	Mental Capacity Act
MDT	Multidisciplinary team
NCDAH	National Care of the Dying Audit of Hospitals
NCAPOP	National Clinical Audit and Patient Outcome Programme
NCEPOD	National Confidential Enquiry into Patient Outcome & Death
NatSSIP	National Safety Standards for Invasive Procedures
NEWS	National Early Warning Score
NICE	The National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System
PVG	Patient Voice Group
QI	Quality indicator
RTT	Referral to treatment
SIRI	Serious incident requiring investigation
SSNAP	Sentinel Stroke National Audit Programme
TTO	To take out (medicines)
VIP	Vulnerable inpatient
WHO	World Health Organisation

Harrogate and District NHS
NHS Foundation Trust

If you require this document in an alternative language or format (such as Braille, audiotape or large print), please contact our Patient Experience Team: thepatientexperienceteam@hdft.nhs.uk or 01423 555499.

Electronic copies of this Quality Account can be obtained from our website (www.hdft.nhs.uk). If you have any feedback or suggestions on how we could improve our Quality Account, please do let us know by emailing bulletin@hdft.nhs.uk.

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F: www.facebook.com/HarrogateDistrictNHS

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

01423 885959