Harrogate and District NHS Foundation Trust

Board of Directors (held in Public)
30 September 2020
Supplementary Pack Contents

Harrogate and District NHS Foundation Trust

CONFLICTS OF INTEREST POLICY

Version	Date	Purpose of Issue/Description of Change	Review Date
1.0	25 January 2018	Replaced Standards of Business Conduct Policy – introduced following new requirements from NHS England	January 2021
2.0	27 November 2018	Updated forms	November 2021
3.0	16 September 2020	Updated to reflect: • recommendations of internal audit on Gifts and Hospitality: one form/electronic submission for declaration of interests, all gifts and hospitality offered to be declared and any offers approved by line manager/Executive Director prior to acceptance; and • recommendations of the Deloitte Cultural Assessment independent review: expanding the management of loyalty interests to include relationships at work requiring all staff from pre-employment to declare interests as well as throughout the recruitment process. Supporting Risk Assessments to be completed by line managers and/or Executive Directors as appropriate.	September 2021

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APPENDICES

1. INTRODUCTION

Harrogate and District NHS Foundation Trust (the 'Trust'), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients.

These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As a NHS Trust and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

This policy replaces and extinguishes the Standards of Business Conduct for NHS Staff (HSG(93)5) and the Trust's Policy that covered this.

To help staff members to understand what they need to do and how the guidance applies to them NHS England have published some Q&As for provider managers, secondary care clinicians and secondary care medics.

Conflicts of Interests Q&A for NHS Providers
https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-questions-and-answers/

Conflicts of Interests Q&A for Clinical Staff
https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-questions-and-answers/

Conflicts of Interests Q&A for Medical Staff
https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-questions-and-answers/

1.1. Purpose

The honesty and impartiality of all employees of the Trust should be above suspicion, especially in any contact with organisations and individuals with which the Trust has or might have dealings. The policy should be understood in the light of this principle.

The Trust's Constitution and Standing Orders require conflicts of interest to be declared and a register of interests to be maintained. This is a publicly disclosable document.

This policy will help HDFT staff manage conflicts of interest risks effectively. It:

- Introduces consistent principles and rules;
- Provides simple advice about what to do in common situations, including the acceptance of gifts, hospitality, honours, charitable donations, sponsorship and the award of contracts for goods and/or services; and
- Supports good judgement about how to approach and manage interests.

This policy should be considered alongside these other Trust policies:

- Anti Fraud, Bribery and Corruption Policy;
- Speaking Up Policy;
- Disciplinary Policy.

1.2. Scope

This policy applies to all members of Trust staff; it is incorporated into every individual's contract of employment (it was formerly referred to as the Standards of Business Conduct).

Further details are included in sections 3 and 4 of this policy.

1.3. Definitions

A 'conflict of interest' is:

> *"A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."*

A conflict of interest may be:

- Actual – there is a material conflict between one or more interests;
- Potential – there is the possibility of a material conflict between one or more interests in the future.

Staff may hold interests and/or have personal relationships in the workplace for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

2. ROLES AND RESPONSIBILITIES

2.1. Chief Executive

The Chief Executive is responsible for ensuring that these guidelines are brought to the attention of all employees; also that systems are put in place for ensuring that they are effectively implemented and monitored including periodic examination of the "gifts and hospitality" registers maintained by the Company Secretary, and periodic examination of recruitment and employment practice.

2.2 Director of Workforce and Organisational Development

The Director of Workforce and Organisational Development is responsible for ensuring systems and processes are in place in relation to compliance with this policy. Specifically, in relation to relationships at work/loyalty interests, the recruitment practice and secondary employment. The Director of Workforce and OD will provide advice, training and support for staff, ensure interests are collected and considered pre-employment and through the continuous recruitment process, monitoring Risk Assessments and mitigating action in place.

2.3 Company Secretary

The Company Secretary is responsible for:

- Reviewing the Organisation policy and bringing it in line with national guidance;
- Providing advice, training and support for staff on how interests should be managed;
- Maintaining register(s) of interests;
- Compiling an annual report about management of Conflicts of Interest which will be presented to the Audit Committee;
- Auditing this policy and associated process and procedures at least every three years.

2.4 Line Managers/Executive Directors

All line managers and/or Executive Directors are responsible for:

- Ensuring all staff are aware of their responsibilities under this policy;
- Conduct matters involving close personal relationships at work in a fair and consistent way;
- Undertake risk assessments to ensure any potential conflicts of interest arising from personal relationships at work can be avoided.

3. STAFF

At Harrogate and District NHS Foundation Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

- All salaried employees;
- The Board of Directors, including Executive and Non Executive Directors;
- All prospective employees – who are part-way through recruitment;
- Contractors and sub-contractors;
- Agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the Trust).

All members of staff are required to:

- Follow this policy; it is incorporated into all contracts of employment;
- Declare actual and potential conflicts of interests, and take relevant steps to manage these;
- Consider whether they meet the definition of 'decision making staff';
- Declare gifts and hospitality, outside employment, including private clinical practice current and any offered;
- Not accept gifts that may affect, or be seen to affect, their professional judgement;
- Declare any shareholdings in companies with which the Organisation would reasonably expected to do business;
- Declare patents and other intellectual property rights they hold;
- Declare donations made to the Organisation (not the hospital charity), include sponsorship for events, research or staff posts; and
- Report concerns about breaches of this policy.

4. DECISION MAKING STAFF

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff.'

Decision making staff in this Organisation are:

- Executive and Non Executive Directors;
- Senior administrative and clinical staff, specifically including consultants, ***all procurement staff*** and those at *Agenda for Change band 7* and above;
- Budget holders;
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services;
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation; and,
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment, and formulary decisions.

5. INTERESTS CATEGORIES

Interests fall into the following categories:

- **Financial interests:**
  Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.
- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- **Indirect interests:**
  Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

  (A common sense approach should be applied to the term 'close association'. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.)

[1] This may be a financial gain, or avoidance of a loss.

6. IDENTIFICATION, DECLARATION AND REVIEW OF INTERESTS

6.1. Identification & declaration of interests (including gifts and hospitality)

All staff should identify and declare interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered. Further details about the definition of conflicts of interest are included at section 5 above in this policy, and advice can be sought from the Company Secretary.

Declarations should be made:

- On appointment with the Organisation;
- Pre-employment and during all recruitment processes;
- When staff move to a new role or their responsibilities change significantly;
- At the beginning of a new project/piece of work; and
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

Interests should be declared using the standard declaration form; available [INSERT LINK]

The form includes the following information:

- The returnee's name;
- Their role with the Organisation;
- Their grade;
- The category (financial interest; indirect interest; non-financial personal interest);
- The situation (clinical private practice; donations, gifts, hospitality, relationships at work/loyalty interest, outside employment, patents, shareholder and other ownership interests, sponsored events, sponsored posts, sponsored research);
- A description of the interest declared;
- Relevant dates from and to relating to the interest;
- Any comments, including any action taken to mitigate the conflict; and
- Signature of line manager and/or Executive Director, and date.

After expiry, an interest will remain on the registers for a minimum of 6 months and a private record of historic interests will be retained by the Organisation for a minimum of 6 years.

6.2. Proactive review of interests

We will prompt decision making staff annually to review declarations they have made and, as appropriate, update them or make a nil return.

7. RECORDS AND PUBLICATION

7.1. Maintenance

The Company Secretary is responsible for the upkeep and publication of the registers.

The Organisation will maintain:
- a register of interests; and,
- a register of gifts and hospitality.

7.2. Publication

The Organisation will publish the interests declared by decision making staff in the register of interests. The register of interests will be refreshed at least annually. The Trust will make this information available via the Trust's website.

If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact the Company Secretary to explain why.

In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference. This is a national requirement.

7.3. Wider transparency initiatives

The Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These "transfers of value" include payments relating to:
- Speaking at and chairing meetings;
- Training services;
- Advisory board meetings;
- Fees and expenses paid to healthcare professionals;
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK; and
- Donations, grants and benefits in kind provided to healthcare organisations.

Further information about the scheme can be found on the ABPI website:
http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx

8. MANAGEMENT OF INTERESTS – GENERAL

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:
- restricting staff involvement in associated discussions and excluding them from decision making;
- removing staff from the whole decision making process;
- removing staff responsibility for an entire area of work;
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant.

Each case will be different and context-specific, and the Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

Further advice about the most appropriate actions to manage conflicts of interest can be sought from the Company Secretary.

9. MANAGEMENT OF INTERESTS – COMMON SITUATIONS

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

9.1. Gifts

Staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value, and should be declared;
- Low cost branded promotional aids such as pens or post-it notes may, however, can be accepted where they are under the value of £6[2] in total, and need not be declared.

Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined;
- Staff should not ask for any gifts;
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the Harrogate Hospital and Community Charity (i.e. as a charitable donation) not in a personal capacity. *These should be declared by staff;*
- Modest gifts accepted under a value of £50 do not need to be declared;
- A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value);
- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

9.1.1. What should be declared

- Staff name and their role with the organisation.
- A description of the nature and value of the gift, including its source *that is being offered*;
- Date offered;
- Date that line manager and/or Executive Director approved staff acceptance/refusal of the gift;

[2] The £6 value has been selected with reference to existing industry guidance issued by the ABPI: http://www.pmcpa.org.uk/thecode/Pages/default.aspx

- Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

9.2. Hospitality

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement;
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event;
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable.

Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared;
- Of a value between £25 and £75[3] - may be accepted and must be declared with;
- The Date offered;
- Date that line manager and/or Executive Director approved staff acceptance/refusal of the hospitality;
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given by *an Executive Director*. A clear reason should be recorded on the Trust's register(s) of interest as to why it was permissible to accept;
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

Travel and accommodation:

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted but must always be declared;
- Offers which go beyond modest, or are of a type that the Trust itself might not usually offer, need approval by *an Executive Director*, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the Trust's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
  - offers of business class or first class travel and accommodation (including domestic travel);
  - offers of foreign travel and accommodation.

9.2.1. What should be declared

- Staff name and their role with the organisation;
- The nature and value of the hospitality including the circumstances;
- The Date offered;
- Date that line manager and/or Executive Director approved staff acceptance/refusal of the travel and accommodation;
- Date of receipt;
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

[3] The £75 value has been selected with reference to existing industry guidance issued by the ABPI http://www.pmcpa.org.uk/thecode/Pages/default.aspx

9.3 Senior Approval

For the Board of Directors and Council of Governors, approval should be obtained from the Chief Executive.

For all other staff, senior approval is to be obtainable from an Executive Director.

9.4 Outside Employment

- Staff should declare to their line manager any existing outside employment on appointment and any plans to taken on new outside employment before this is accepted;
- Employees are advised not to engage in outside employment that may conflict with their NHS work, or be detrimental to it. *Approval of any new outside employment must be granted by line managers and relevant Director before individuals accept;*
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks. This includes making a declaration of interest;
- Staff must formally advise their line manager of any income that is received or earned in relation to, or through contacts made as part of their employment with the Trust, that are additional to their salary and expenses paid via the Trust's payroll system. Where deemed appropriate the line manager must obtain the approval of an Executive Director and in such cases the interest should be declared;
- Employees are responsible for complying with the Working Time Directive obligations when undertaking secondary employment and must notify the Trust via their line manager when secondary employment is undertaken;
- The above information also applies to *private practice* and *self-employment*.

9.4.1 What should be declared

- Staff name and their role with the organisation;
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment);
- Relevant dates, including start date of outside employment or planned start date.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy);
- Approval by a line manager and/or Executive Director.

9.5 Shareholdings and other ownership issues

- Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation;
- Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks;
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

9.5.1 What should be declared

- The returnee's name;
- Their role with the Organisation;
- Their grade;
- The category (financial interest; indirect interest; non-financial personal interest);
- The situation (nature of the shareholder/other ownership interest);
- A description of the interest declared ;
- Relevant dates from and to relating to the interest;
- Any comments, including any action taken to mitigate the conflict details of any approvals given to depart from the terms of this policy; and
- Signature of line manager and/or Executive Director, and date.

9.6 Patents

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation;
- Staff should seek prior permission from an *Executive Director* before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the Trust's own time, or uses its equipment, resources or intellectual property;
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

9.6.1 What should be declared

- The returnee's name;
- Their role with the Organisation;
- Their grade;
- The category (financial interest; indirect interest; non-financial personal interest);
- The situation (and description of the patent);
- Relevant dates from and to relating to the interest;
- Any comments, including any action taken to mitigate the conflict details of any approvals given to depart from the terms of this policy; and
- Signature of line manager and/or Executive Director, and date.

9.7 Managing Relationship at Work/Loyalty interests

All members of staff, regardless of their decision making responsibilities and powers, must declare to their line manager and on the electronic portal 'Conflicts of Interest' (ADD LINK) any existing or new personal relationships they have with other members of staff, close family members and relatives, close friends and associates, and business partners, which may give rise to an actual or potential conflict of interest, trust or breach of confidentiality. The line manager will treat these matters in confidence and in consultation with the member(s) of staff, find ways in which potential conflicts can be avoided.

All members of staff must complete a declaration form (ADD LINK) and their line manager and/or Executive Director in consultation with the member(s) of staff will complete a risk assessment (Risk Assessment Link To Be ADDED) to be retained on the employee's personal file and a copy submitted to the HR Department at hdft.hr@nhs.net.

Relationships at Work/Loyalty interests should be declared by all staff where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role;
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money;
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners;
- Are related to a Trust member of staff who is classed as a 'Decision maker' as described in this policy;
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

9.7.1 What should be declared

- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

- The returnee's name;
- Their role with the Organisation;
- Their grade;
- The category (financial interest; indirect interest; non-financial personal interest);
- The situation (relationships at work/loyalty interest);
- A description of the interest declared;
- The date when discussed with line manager and HR manager;
- Relevant dates from and to relating to the interest;
- Any comments, including confirmation that a Risk Assessment has been carried out and any action taken to mitigate the conflict, details of any approvals given to depart from the terms of this policy; and
- Signature of line manager and/or Executive Director, and date.

9.8 Donations

- Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value;
- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain.

- Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own;
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued;
- Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

9.8.1 What should be declared

- The Organisation will maintain records in line with the above principles and rules and relevant obligations under charity law.

9.9 Sponsored events

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit the organisations and the NHS;
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation;
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied;
- At the Organisation's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event;
- The involvement of a sponsor in an event should always be clearly identified;
- Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event;
- Staff arranging sponsored events must declare this to the Organisation.

9.9.1 What should be declared

- The organisation will maintain records regarding sponsored events in line with the above principles and rules.

9.10 Sponsored research

- Funding sources for research purposes must be transparent;
- Any proposed research must go through the relevant health research authority or other approvals process;
- There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services;
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service;
- Staff should declare involvement with sponsored research to the Organisation.

9.10.1 What should be declared

- The Organisation will retain written records of sponsorship of research, in line with the above principles and rules.
- Staff need to declare:
  - Their name and their role with the organisation;
  - Nature of their involvement in the sponsored research;
  - Relevant dates: start or planned start and end dates;
  - Date discussed with line manager and/or Executive Director;
  - Date and signature confirming Director approval;
  - Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

9.11 Sponsored posts

- External sponsorship of a post requires prior approval from the Organisation;
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate;
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise;
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided;
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

9.11.1 What should be declared

- The Organisation will retain written records of sponsorship of posts, in line with the above principles and rules;
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

9.12 Clinical private practice

As described with their terms and conditions, Clinical staff should declare all private practice on appointment, and/or any new private practice *as it arises*[4] *and prior to acceptance* including:

- Where they practise (name of private facility);
- What they practise (specialty, major procedures);
- When they practise (identified sessions/time commitment).

[4] Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their Organisation line manager and/or Executive Director before taking up private practice;
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work;[5]
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

9.12.1 What should be declared

- The returnee's name;
- Their role with the Organisation;
- Their grade;
- The category (financial interest; indirect interest; non-financial personal interest);
- The situation (clinical private practice);
- A description of the interest declared ;
- Relevant dates from and to relating to the interest;
- Any comments, including any action taken to mitigate the conflict; and
- Signature of line manager and/or Executive Director, and date.

10 MANAGEMENT OF INTERESTS – ADVICE IN SPECIFIC CONTEXTS

10.1 Strategic decision making groups

In common with other NHS bodies the Organisation uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts;
- Awarding grants;
- Making procurement decisions;
- Selection of medicines, equipment, and devices.

The interests of those who are involved in these groups should be well known so that they can be managed effectively. For Harrogate and District NHS Foundation Organisation these groups are:

- The Board of Directors;
- Committees of the Board;
- The Council of Governors;
- Council of Governor Committees and Working Groups;

[5] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)

- The Senior Management Team;
- Clinical Directorate Boards;
- Harrogate Integrated Facilities Ltd; and
- Any meetings where staff are involved in appraising different suppliers for goods, and services; including Clinical Procurement Group.

These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests;
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise;
- Any new interests identified should be added to the organisation's register(s);
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting;
- Excluding the member from receiving meeting papers relating to their interest;
- Excluding the member from all or part of the relevant discussion and decision;
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate;
- Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

10.2 Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

All staff are required to comply with Organisation policies and procedures for procurement. Further advice is available from the Head of Procurement.

11 DEALING WITH BREACHES

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

11.1 Identifying and reporting breaches

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to the Director of Workforce and Human Resources, the Company Secretary or the Local Counter Fraud Specialist. Further details are available in the Anti Fraud, Bribery and Corruption Policy.

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised please refer to the Organisation's Speaking Up Policy.

The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

Following investigation the organisation will:

- Decide if there has been or is potential for a breach and if so the what severity of the breach is;
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum;
- Consider who else inside and outside the organisation should be made aware;
- Take appropriate action as set out in the next section.

11.2 Taking action in response to breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures;
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others;
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Counter Fraud Authority, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include:
  - Informal action (such as reprimand, or signposting to training and/or guidance);
  - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal);
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be;
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach;
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

11.3 Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be considered regularly by the Audit Committee, as a minimum at least annually.

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published on the Organisation's website as appropriate, or made available for inspection by the public upon request.

11.3 Roles and Responsibilities

- All staff to be aware of the policy, declare any interests promptly (within 28 days) of the interest occurring and report breaches;
- All staff are required to complete a return upon employment and during the course of their employment in relation to any relationship at work/loyalty interests as part of the recruitment process;
- Decision making staff are required to complete a return upon employment, as and when interests change and annually (nil returns are also required to be submitted for all decision making staff);
- Strategic decision making staff are also required to declare any interests at the start of their meetings.

12 POLICY DEVELOPMENT AND EQUALITY

12.1 Identification of Stakeholders

The stakeholders of this policy are all employees of the Organisation. They are represented by elected Trade Union Members and are involved in the development and review process of all HR Policies and Procedures through partnership.

12.2 Equality Impact Assessment

This policy has undergone Stage 1 Equality Impact Assessment Screening.

The Organisation is committed to creating a culture that fully respects equality and diversity and aims to ensure that all its services are accessible, appropriate and sensitive to the needs of the whole community. It believes in fairness, equity and above all values diversity in all its dealings, both as a provider of health services and an employer of people.

This policy has been developed to reinforce the Organisation's vision in this respect and to give direction for the pursuit of the highest standards of equality and diversity in all our services. This policy reflects the following:

- Opportunities for employment, promotion, training and development are open to all on an equal basis;
- Access to services are sensitive to individual needs irrespective of colour, disability, ethnic origin, age, gender, illness (such as HIV/AIDS), marital status, nationality, race, religion, sexual orientation and social background;
- All future service developments take into account the needs of all groups within the community;
- Patients, staff, volunteers and all other service users and providers are treated with dignity and respect;
- Every member of staff has a role to play in recognizing and respecting Equality and Diversity in others;
- Staff are able to carry out their duties effectively without fear of discrimination, harassment or bullying of any kind.

The Organisation will continue to embed its equality and diversity values into all of its policies, procedures and everyday practice, so that equality and diversity is the norm.

13 CONSULTATION, APPROVAL AND RATIFICATION PROCESS

13.1 Consultation Process

This policy was drafted and updated by the Company Secretary and the Director of Workforce and Organisational Development, based on cross NHS guidance issued by NHS England, lessons learned following audits and independent reviews.

The Policy Advisory Group (PAG) which is composed of management, HR and staff side representatives considers all draft HR policies and guidance. All members have the opportunity to make comments and suggestions on the document content which is debated within the group and amendments made and agreed. Any additional individuals or groups that are relevant to include in the consultation process will be identified in Appendix 2.

13.2 Approval Process

Once discussions on all HR policies and guidance have been concluded and amendments made they are re-submitted and approved at PAG.

13.3 Ratification Process

All HR policies approved by the PAG are submitted for ratification by the Partnership Forum.

14 DOCUMENT CONTROL

14.1 Publication

The policy will be published in the electronic document library i.e. on the Organisation's intranet under the HR Department, in the Policies/Guidance section.

Details of the issue of the document will be communicated to all staff, through the all users e-mail circulation list.

14.2 Archiving Arrangements

Where the policy replaces a previous version, the old policy will be archived as evidence of a previous policy. The front page of the policy will indicate the version number, the approving body and date of approval along with the next review date.

14.3 Access

The policy should be accessed from the electronic document library. Copies of this document should not be printed unless it is absolutely necessary as there is a risk that out of date copies may be in circulation. Requests for this policy in an alternative language or format (such as Braille, audiotape, large print etc) will be considered and obtained whenever possible.

14.4 Protective Marking

The front page of the policy will indicate the version number, the approving body and date of approval along with the next review date.

15 DISSEMINATION AND IMPLEMENTATION

15.1 Dissemination and Communication

The policy will be published in the electronic document library i.e. on the Organisation's intranet under the HR Department, in the Policies/Guidance section.

Details of the issue of this policy will be communicated to all staff, through the all user e-mail circulation list.

15.2 Implementation

Senior Managers will have responsibility for ensuring that their staff members are aware of the new/revised policy. The policy will be sent to all members of the HR team and discussed at the HR team meeting to ensure all members of the HR team are fully aware of any changes to the policy.

15.3Training and Support

Any relevant training or advice in relation to the implementation of the policy will be specified and provided by the HR Department where appropriate.

16 MONITORING COMPLIANCE AND EFFECTIVENESS

16.1 Standards/Key Performance Indicators

The monitoring standards/key performance indicators for this policy can be found at Appendix 1.

16.2 Process for Monitoring Compliance

An annual report will be presented to the Audit Committee, this will summarise the Organisation's approach to managing conflicts of interest and detail associated assurance.

17 REFERENCE DOCUMENTS

- Freedom of Information Act 2000
- ABPI: The Code of Practice for the Pharmaceutical Industry (2014)
- ABHI Code of Business Practice
- NHS Code of Conduct and Accountability (July 2004)
- Bribery Act 2010

18 ASSOCIATED DOCUMENTATION

- Anti Fraud, Bribery and Corruption Policy;
- Speaking Up Policy;
- Disciplinary Policy.

APPENDICES

Appendix 1: Monitoring, Audit and Feedback Summary & Consultation Summary
Appendix 2: Risk Assessment for Relationships at Work/Loyalty Interests
Appendix 3: Declaration of Interests Form

Appendix 1

Monitoring, Audit and Feedback Summary

KPIs	Audit / Monitoring required	Audit / Monitoring performed by	Audit / Monitoring frequency	Audit / Monitoring reported to	Concerns with results escalated to
Staff awareness of interests that need to be declared.	Check staff are aware of the guidance and what needs to be declared.	As part of Local Counter Fraud surveys/awareness	Annually	Audit Committee	Chief Executive
System in place to record staff declarations in the register of interest/hospitality	Check that staff declare their interests on the approved system.	Company Secretary	Annually	Audit Committee	Chief Executive
	Introduce process for staff to complete declarations as part of their pre-employment checks and throughout all recruitment processes	Director of Workforce and OD	Quarterly	Audit Committee	Chief Executive
Public Disclosure: Register of interests and Register of Gifts and Hospitality for Decision Making Staff published	Registers have been published on the Organisation's website and include all 'decision making staff'	Company Secretary	Annually	Audit Committee	Chief Executive
Strategic decision making groups	Check staff are declaring their interests at the start of meetings which is recorded in meeting minutes	Company Secretary	Annually	Audit Committee	Chief Executive
System in place to record staff declarations of personal relationships at work	Number of declarations and risk assessments made.	Director of Workforce & OD	Annually	Audit Committee	Chief Executive
Breaches	Company Secretary and Director of Workforce and OD to discuss any breaches with the Chief Executive and as appropriate with Local Counter Fraud	Company Secretary/ Director of Workforce and OD	Annually	Audit Committee	Chief Executive

Consultation Summary

Those listed opposite have been consulted and any comments/actions incorporated as appropriate. The author must ensure that relevant individuals/groups have been involved in consultation as required prior to this document being submitted for approval.	**List Groups and/or Individuals Consulted**
	Policy Advisory Group (Date: TO BE ADDED)
	Partnership Forum (Date: TO BE ADDED)

Version 3.0 – September 2020
Conflicts of Interest Policy

Approved by

…… Date ……
Angela Wilkinson, Management side

…… Date ……
Hilary Levitt, Trade Union representatives

…… Date ……
T Metcalfe, BMA

Appendix 2

PERSONAL RELATIONSHIP AT WORK/LOYALTY INTERESTS
(CONFLICTS OF INTEREST POLICY)

Employee Declaration Form (Part A)

To be completed by Employee

In accordance with the Conflicts of Interest Policy all employees are required to declare to their line manager any existing or new personal relationships they have with other members of staff, stakeholders or partners, which may give rise to an actual or potential conflict of interest, trust or breach of confidentiality.

What type of relationship at work and/or loyalty interests should be declared:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are related to a Trust member of staff who is classed as a 'Decision maker' as described in this policy.
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

Name:	:
Position:	
Department:	
Directorate/Hosted Organisation Unit:	
Name of Line Manager:	

Name of person with whom you have a close personal relationship as detailed above

Name:	
Position:	
Department:	
Nature of Personal Relationship:	

Sign and date the section applicable:

a. Is the person named above in the same line management chain as you at either first or second tier?

Yes No □

I understand that where a close personal relationship exists between me and another employee in the same line management chain, at first or second tier second tier that alternative line management arrangements must be made and this may result in one or other of us being moved to a different area/department/site after discussion and based on service requirements.

Signed: ..... Dated: .....

b. Do you and the person named above work in the same team/department (i.e. report to the same line manager)? Yes □ No □

I understand that where I work in the same team or department as someone with whom I have a close personal relationship outside of work, a risk assessment must be undertaken to mitigate any possible risk to myself or the service. I understand that if it is not possible to mitigate the risk it may be necessary to consider the transfer of one or other of us to another team/department or location after discussion.

Signed: ..... Dated: .....

c. Is the person named above classed as a Decision Maker, an Executive or a Director or Senior Management Team member?

.

This must be declared and a register of this relationship will be maintained by the relevant Workforce & OD department.

Signed: ..... Dated: .....

Risk Assessment (Part B)

To be completed by the line manager in conjunction with Employee by using the scoring matrix below to identify the severity of the risk:

Detail of the named employee's positions in Trusts ie line management report, same team/department or Decision Maker, Executive or a Director or Senior Management member:

Description of Risk	Presence/ Significance of Risk	Options available to control risk	Mitigating actions agreed
Line Management e.g. Appraisal, employee relations investigation etc.			
Team working e.g. Allocation of duties /annual leave/rostering			
Recruitment & Selection Are or could be, involved in the recruitment of close family members and relatives, close friends and associates and business partners associates and business partners			
Financial governance e.g. Sign off of expenditure			
Other To be specified (e.g. Relationship with Decision Maker/Executive Director/Senior Manager/Recruitment officer)			
Where concerns regarding conflicts of interest arising from a personal relationship are identified, please score the impact below. The scoring methodology is the same used for risk assessments.			

Likelihood	Consequence				
	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost Certain (5)
Line Management					
Team Working					
Recruitment & Selection					
Financial Governance					
Are related to a Trust member who is classed as a 'decision maker'					
Are aware that the Trust does business with an organization in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities					
Other:					

A copy of the completed form must be signed by the employee and line manager and retained on their personal file and a copy submitted to the HR Department at hr.hdft@nhs.net

Signed (Employee)..... Date.....

Print name (Employee).....

Signed (Manager)..... Date.....

Print name (Manager).....

Risk Assessment Scoring Matrix

Likelihood	Consequence				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Almost Certain (5)	5	10	15	20	25

Likelihood descriptors

Likelihood	Broad descriptor	Probability descriptor	Time-framed descriptor
Rare (1)	This will probably never happen/recur	<0.1%	Not expected to occur for years
Unlikely (2)	Do not expect it to happen/recur but it is possible it may do so	0.1-1%	Expected to occur at least annually
Possible (3)	Might happen or recur occasionally	1-10%	Expected to occur at least monthly
Likely (4)	Will probably happen/recur, but it is not a persisting issue / circumstance	10-50%	Expected to occur at least weekly
Almost certain (5)	Will undoubtedly happen/recur, possibly frequently	>50%	Expected to occur at least daily

NHS
Harrogate and District
NHS Foundation Trust

(Appendix 3)

Example of Electronic Form for the Declaration of Interests

Name	Role	Grade	Category	Situation	Description of Interest	Relevant Dates		Comments
						From	To	
		1. Decision making staff (AfC 7/equivalent and above) 2. Below AfC7	1. Financial Interest 2. Indirect Interest 3. Non-financial personal interest 4. Non-financial professional interest 5. I have no interest to declare	1. Clinical private practice 2. Donations 3. Gifts 4. Hospitality 5. Relationships at Work/ Loyalty Interests 6. Outside Employment 7. Patents 8. Shareholders and other ownership interests 9. Sponsored events 10. Sponsored posts 11. Sponsored research				

The information submitted will be held by Harrogate and District NHS Foundation Trust (the Trust) for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the Trust holds.

I confirm that the information provided above is complete and correct. I acknowledged that any changes in these declarations must be notified to the Trust as soon as practicable and no later than 28 days after the interest arises/changes. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, internal disciplinary, or professional regulatory action may result.

I do/do not [*delete as applicable*] give my consent for this information to be published on registers that the Trust holds.

In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference. This is a national requirement.

If consent is NOT given you are required to give reasons below:

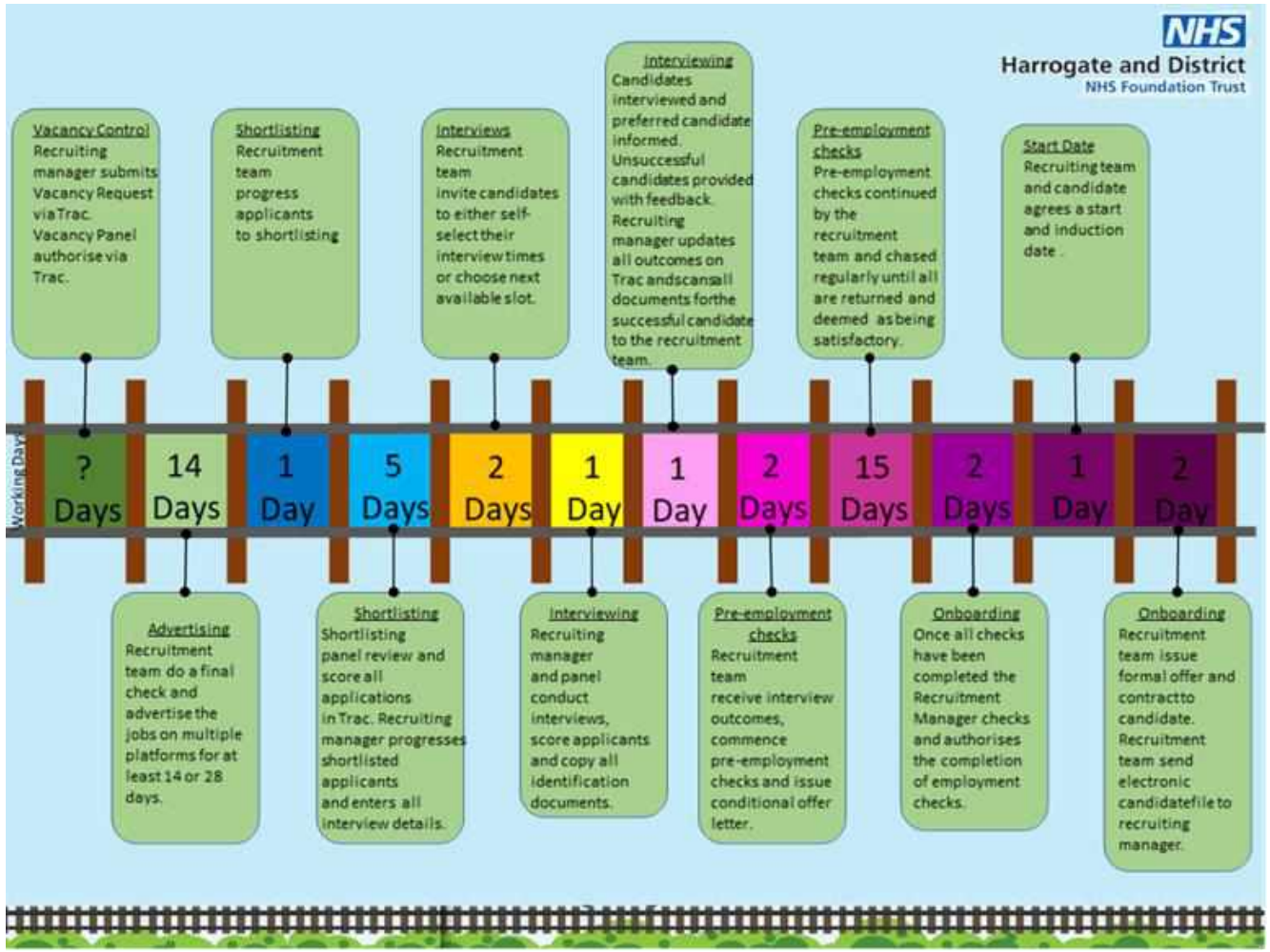
Signed by Staff Member: …… Date: ……..

Print Name: ……

Signed by Line Manager: …… Date: ……...
AND/OR

Signed by Executive Director: …… Date: ……...

Appendix A – TRAC Recruitment


NHS
Harrogate and District
NHS Foundation Trust
Vacancy Control
Recruiting manager submits Vacancy Request via Trac.
Vacancy Panel authorise via Trac.
Shortlisting
Recruitment team progress applicants to shortlisting
Interviews
Recruitment team invite candidates to either self-select their interview times or choose next available slot.
Interviewing
Candidates interviewed and preferred candidate informed.
Unsuccessful candidates provided with feedback.
Recruiting manager updates all outcomes on Trac and scans all documents for the successful candidate to the recruitment team.
Pre-employment checks
Pre-employment checks continued by the recruitment team and chased regularly until all are returned and deemed as being satisfactory.
Start Date
Recruiting team and candidate agrees a start and induction date .
Working Days
? Days
14 Days
1 Day
5 Days
2 Days
1 Day
1 Day
2 Days
15 Days
2 Days
1 Day
2 Day
Advertising
Recruitment team do a final check and advertise the jobs on multiple platforms for at least 14 or 28 days.
Shortlisting
Shortlisting panel review and score all applications in Trac. Recruiting manager progresses shortlisted applicants and enters all interview details.
Interviewing
Recruiting manager and panel conduct interviews, score applicants and copy all identification documents.
Pre-employment checks
Recruitment team receive interview outcomes, commence pre-employment checks and issue conditional offer letter.
Onboarding
Once all checks have been completed the Recruitment Manager checks and authorises the completion of employment checks.
Onboarding
Recruitment team issue formal offer and contract to candidate.
Recruitment team send electronic candidate file to recruiting manager.

Appendix B

Facility Time Publication Requirements Report

Reporting Period - 1st April 2019 to 31st March 2020

Introduction

The Trade Union (Facility Time Publication Requirements) Regulations 2017, enacted in April 2017, require specified public-sector employers, including NHS Trusts, to report annually a range of data in relation to their usage and spend on trade union facility time within the organisation.

The cost of facility time in the public sector is paid for out of public funds. The objective of the legislation is to ensure that taxpayers' money is spent on trade union facility time in the public sector is properly monitored and reported. It is felt that this transparency will enable Government employers and taxpayers to verify whether taxpayer's money is only spent on appropriate and accountable trade union work that represents value for money.

The regulations do not apply to HIF.

Annual Reporting Requirements

The duty to report covers specific information (set out in detail in Schedule 2 of the regulations) relating to time off taken for trade union duties and activities. Due to the COVID-19 pandemic, the cabinet office has extended the reporting portal deadline date to 30th September 2020.

Facility Time is the provision of paid or unpaid time off from an employee's normal role to undertake Trade Union duties and activities as a Trade Union representative. There is a statutory entitlement to reasonable paid time off for undertaking Trade Union duties. Employers may also grant paid time off for trade union activities for which there is no statutory right to paid time off.

Examples of trade union duties are duties connected with collective bargaining, representing members in the workplace.

Examples of trade union activities can include discussing internal union matters, dealing with internal administration of the union.

By 30th September 2020 the data must be reported on:

- Gov.uk using its online trade union facility time reporting service
- Publish the data on the Trust's website
- Include the data in the Trust's annual report

Trust Data 2019/2020

The Trust's data for the reporting period 1st April 2019 to 31st March 2020 is reported in the tables below. Whether in providing support to individual members of the Trust at a departmental level, or by playing a valuable role in contributing to Trust-wide agendas for example: Partnership Forum, Local Negotiation Committee, Health and Safety committees) the Trust recognises that the participation of trade union representatives supports the partnership process and contributes to delivering improved services to service users.

The Trust will continue to monitor and evaluate the amount of money spent on facility time, in the interests of transparency and accountability. A significant change from the previous reporting year 2018/2019, is an increase in the time spent on trade union activities, from 12.97% to 24.74%, as displayed in Table 4.

Table 1: Relevant Union Officials

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

Number of employees who were relevant union officials during the reporting period 1st April 2019 to 31st March 2020	**Full-time equivalent employee number**
37	32.73

Table 2: Percentage of Time Spent on Facility Time

Harrogate and District NHS Foundation Trust employees, who were relevant union officials employed during the relevant period spent a) 0%, b) 1-50%, c) 51%-99% or d) 100% of their working hours on facility time:

Percentage of Time	**Number of Employees**
0%	15
1-50%	21
51-99%	1
100%	0

Table 3: Percentage of Pay Bill Spent on Facility Time

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

First Column	Figures
Provide the total cost of facility time	£38,357
Provide the total pay bill	£164,575,324
Provide the percentage of the total pay bill spend on facility time, calculated as: (total cost of facility time divided by total pay bill) x 100	0.02%

Table 4: Paid Trade Union Activities

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

First Column	Figures
Total spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spend on paid trade union activities by relevant union officials during the relevant period divided by total paid facility time hours) x 100	24.74%

Appendix C- WRES Action Plan

Across all metrics in the Action Plan to highlight the BME Staff Network and the role of the EDI Lead/WRES Expert and that this is an ongoing working document which will be a standard item on the BME Staff Network Agenda and the Staff Network will report into Senior Management Team (SMT)

Staff Engagement – collaborative decision-making, listening forums.

Staff Networks – catalyst to empower, encourage and promote equitable opportunities for BME staff. Hold 'Be Yourself' events, learn about each others culture, food etc.

Staff Stories – help to define the narrative on lived experiences

NHS Long Term Plan, NHS People Plan Actions, Culture Change Programme, WRES Experts learning

Indicator	2019 Narrative and Action Plan	2020 Action Plan
1 (Becki)	**Percentage of staff in each of the Agenda for Change (AfC) bands 1 – 9 and very senior managers (VSM) (including executive board members) compared with the percentage of staff in the overall workforce** *The data indicated that a greater understanding of progression routes and career pathways may be required in relation to BAME staff.* • *A new starter questionnaire to be rolled out to understand the experiences of new starters and their views on recruitment process. Consideration will be given to how we can include individuals who were not appointed following shortlisting.* • *Following the initial work for listening events within Fair and Just Culture further*	1. <u>Ethnicity declaration through the NHS Electronic Staff Record</u> Promote ESR self-service – eg leaflet to explain why we need data. Awareness to support staff to feel more confident in declaring ethnicity – eg Black History Month. Staff Network to encourage colleagues to declare ethnicity status – 'Nothing About Us Without Us'. Used to better understand the diversity of the Trust's workforce and identify actions that will support BME staff in the workplace. Covid-19 has highlighted that data is vital in highlighting inequalities (priority in keeping colleagues safe).

	engagement work to identify and determine what actions need to be taken forward to encourage progression within the organisation. • *The Workforce Equality Group to discuss the experiences of BME colleagues across the organisation.*	

	Black	White	Unknown
Non-Clinical 2020	3.1%	94.3%	2.6%
Clinical (non-medical) 2020	7.3%	86.4%	6.3%
Medical and Dental 2020	29.2%	68%	2.8%
2020 %	9%	85.7%	5.3%

Local:

- North East and Yorkshire trusts - BME 10.9%

National:

- NHS Trusts and CCGs in England – BME 19.7%

2. <u>Under-representation at Bands 7 and above – Undertake detailed findings into disability workforce statistics / breakdown by Directorates/pay bands/job role e.g. nursing</u>

A need to accelerate improvement in BME staff representation at senior levels across the workforce as set out in the NHS Long Term Plan. BME talent pipeline.

3. <u>Set plans for workforce targets*</u>

		Look at Trust workforce in relation to NHS workforce and local population across Trust catchment area (Harrogate population 8.33%). Simon Stevens set target 5 years 19% NHS therefore 19% representation at every pay band level by 2025. 4. <u>Incorporate WRES on Integrated Board Report</u> Regular update on WRES performance throughout year – measure outcomes of Action Plan. 5. <u>Work Experience Programme</u> 6. <u>Volunteering</u> 7. <u>Trust commitment to EDI</u> Promote the organisation's commitment to EDI – website, recruitment and induction (understanding and appreciating our differences)
2 (Andrea /Becki)	**Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants.** *This shows that a BAME applicant is less likely to be appointed following shortlisting than a white candidate. This has improved from 2.14 times in 2018.* • *Consider different advertising methods can be used to access underrepresented groups.* • *Assess the impact of unconscious bias training for managers in Pathway to Management and continue to consider a wider roll out.* • *Review and consider alternative shortlisting and appointment techniques to include*	White applicants were 1.96 (nearly twice) as likely to be appointed from shortlisting compared to that of BME applicants. National – 1.46. Regional - North East and Yorkshire – 1.40. 1. <u>Recruitment Review/Campaigns (speak to Lee-anne / Andrea / Emily:</u> • RPIW for recruitment • *Look at criteria for appointment* • *Recruitment panel – agree appointable score and right fit for team* • *Management of unsuccessful candidates* • *Promotions, Acting Up and Secondments*

	consideration of internal and external processes. Consider the introduction of a standing shortlisting panel to reduce bias.	• *Job adverts – length of advert, communications about the advert, wording, some adverts on bulletin – where else….via Staff Networks….via Y&H EDI Leads network…..via regional networks….via E&D Stakeholder Group/local groups!* • *JD/Person specifications – does the wording cause a barrier for BME applicants – 'sticky floor, glass ceiling'* • *Complaints about recruitment practices* • *Work in partnership with WY&H BME Network* 2. Review of Pathway to Management re recruitment and unconscious bias (speak to Karen Hatch for timeline on this) 3. First Line Leaders re unconscious bias (checking with Vanessa) 4. Liaise with Trusts where data suggests the relative likelihood of white staff being appointed from shortlisting is similar to that compared to BME applicants (pg 27 NHS WRES AR)
3 (Becki)	**Relative likelihood of BME staff entering the formal disciplinary process compared to white staff.** *This shows a BAME member of staff is less likely to enter a formal disciplinary process than a white member of staff. This has reduced since 2018 to 0.92 times from 2.36 times.* • *Review the impact of the unconscious bias training for managers.* • *Continue to monitor the BAME staff entering the Disciplinary process and outcomes.* • *Continue with the Improving People Practices work to ensure that HR policies are fit for*	The relative likelihood of BME staff entering the formal disciplinary process compared to white staff is 1.19 times greater. Data is based on a two year period as numbers may be small. National - 1.22. Regional – North East and Yorkshire - 1.18 1. Talk to HR Business Partners 2. See above re Pathway to Management 3. See above re First Line Leaders 4. Liaise with Trusts where data suggests the relative likelihood of BME staff entering the formal disciplinary process is similar compared to white staff (pg 32 NHS WRES AR).

	purpose and support the principles of fairness and equality.	
4 (Katie / Emma / Becki)	**Relative likelihood of BME staff accessing non-mandatory training and CPD compared to white staff.** *This shows that BAME members of staff are less likely to access non-mandatory training and CPD compared to white staff and has fallen slightly from 0.03 in 2018* ***This was reported incorrectly as the actual data showed a result of white 0.91 (see below table)*** *The Trust will continue listening events to explore staff experiences across the Trust and determine whether more can be done to encourage progression and development within the organisation* *Team Talk* *First Line Leaders Staff Survey Action Plan Event* *BME Listening Events*	The relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff was 0.80. This means that BME staff are more likely to access non-mandatory training and CPD National – 1.15. Regional – North East and Yorkshire – 1.05 (white staff more likely) 1. <u>Review capture of non-mandatory training and CPD</u> Including shadowing, secondments, coaching as per technical guidance suggestion. Think about asking for training – accepted v rejected Undertake detailed analysis of data by Directorte/professions and departments.
5	**Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.** *BAME staff report higher levels of bullying and harassment from patients, relatives and the public in the last 12 months than white staff. 2018 survey saw an increased response to this question with*	**39.8%** of 113 BME staff experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. 23.8% of 1502 white staff experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. National – BME 29.8%, White 27.8%

	1420 white respondents and 108 BAME respondents. • *Workforce Equality Group to engage with BAME staff to understand the response rates for all staff survey responses. Link with staff network once established.* • *The Trust People Plan contains work relating to fair and just culture, this will include the experiences of BAME staff.* • *The Trusts Pathway to Management training is being developed to give line managers more confidence in dealing with concerns early and aligning this to the values and behaviours framework across the Trust*	Regional – North East and Yorkshire 26.0%, White 26.1 % 1. <u>Improve Staff Survey response rate to give a more accurate picture of staff experience</u> 2. <u>Culture Change Programme</u> Drivers – Deloitte, EDI Strategy, NHS Staff Survey 3. <u>NHS People Plan Actions - National data / Public awareness / Zero tolerance</u> National – BME 29.8%, White 27.8% BME staff were more likely to experience harassment, bullying or abuse from patients/service users, their relatives or other members of the public, in all regions across England except London. Prevent and tackle bullying, harassment and abuse against staff, and create a culture of civility and respect. *4.* <u>Freedom to Speak Up Guardians and Fairness Champions</u> 5. <u>Triangulate Staff Survey Results with other data eg FTSUG data and formal grievance data, sickness and absence rates, exit questionnaires to assess HBA towards BME staff</u> 6. <u>Promote reporting - Datix – racist incident</u> Following listening event, an additional sub-category has been added to Datix for reporting racist incidents. 7. <u>Liaise with Trusts where data suggests practice may be better on indicator 5 (pg 39 NHS WRES AR).</u>

6	**Percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months.** *BAME staff report higher levels of bullying and harassment from staff in the last 12 months than white staff. There is a recued % differential between white and BAME staff respondents and a reduction in BAME staff reporting bullying and harassment from colleagues. Increased respondents in 2018 survey saw 1425 white respondents to this question and 109 BAME staff responding.* • *Workforce Equality Group to engage with BAME staff to drive participation in the National Staff Survey.* • *The focus on the Fair and Just culture in relation to Bullying and Harassment, which will pay particular attention to the experiences of BAME staff.* • *The Trusts Freedom to Speak up Guardian has recruited Fairness Champions who support individuals who may be experiencing harassment or bullying and embed the Speaking Up principles across the Trust* • *Workforce Equality Group to identify how staff with protected characteristics feel about working at the organisation to then create actions.* • *Workforce Equality Group to interrogate the staff survey further to identify if there are key professional groups or departments where this is occurring.*	**23%** of 113 BME staff experienced harassment, bullying or abuse from staff in the last 12 months 26.4% of 1513 white staff experienced harassment, bullying or abuse from staff in the last 12 months. National – BME 20.0%, White 24.2% Regional – North East and Yorkshire – BME 26.1% White 21.6% <u>Actions as above</u>

	• *Workforce Equality Group to promote equality so staff feel able to speak up via team talks and promotional materials.*	
7	**Percentage of BME staff believing that the Trust provides equal opportunities for career progression or promotion.** *A greater percentage of white staff than BAME staff believe that the Trust does not offer them equal opportunities for career progression. This has seen a worsening factor for BAME staff and a slight reduction for White staff. 2018 survey saw an increase in respondents to this question with 969 white staff and 66 BAME staff responding.* • *The Workforce Equality Group to engage with BAME staff to drive participation in the National Staff Survey.* • *Review the impact of unconscious bias training in the Trust's Pathway to Management programme.* • *Specific work is being undertaken across the Trust to educate managers in how to support progression.* • *Workforce Equality Group to obtain the views of disabled staff on working for the Trust.*	**79.4%** of 68 BME staff believes the Trust provides equal opportunities for career progression or promotion. 88.5% of 998 white staff believes the Trust provides equal opportunities for career progression or promotion. National – BME 69.9%, White 86.3% Regional – North East and Yorkshire – BME 74.5%, White 88.3% 1. Improve Staff Survey response rate to give a more accurate picture of staff experience 2. ? Career Development Strategy 3. Reciprocal Mentoring 4. BME First Line Leaders 5. Liaise with Trusts where data suggests practice may be better on indicator 7 (pg 52 NHS WRES AR).
8	**Percentage of BME staff personally experiencing discrimination at work from a manager/team leader or other colleagues.** *A greater percentage of BAME staff than white staff believe that they have experienced discrimination from their manager or other*	**13.5%** of 111 BME staff have personally experienced discrimination at work from their manager/team leader or other colleague 7% of 1497 white staff have personally experienced discrimination at work from their manager/team leader or other colleague. National – BME 15.3%, White 6.4%

	colleagues. White staff have increased by 4% while BAME has increased significantly to 17%. White respondents to this question were 1406 with BAME being 106 in the 2018 Staff survey. • *Continue training for new line managers with the Trust's Pathway to Management program with regards to equality and employment law.* • *Evaluate the Trust's Pathway to Management training programme for managers on unconscious bias training and having difficult conversation in order to address matters at an early stage.* • *Workforce Equality Group to engage with BAME staff to drive participation in the National Staff Survey.* • *The Trusts Freedom to Speak up Guardian has introduced Fairness Champions who will be able to support individuals who may be experiencing discriminatory behaviour and embed the Speaking Up principles across the Trust*	Regional – North East and Yorkshire – BME 12.8%, White 5.5% 1. Improve Staff Survey response rate to give a more accurate picture of staff experience 2. Pathway to Management 3. First Line Leaders 4. Freedom to Speak Up / Fairness Champions 5. Culture Change Programme 6. Liaise with Trusts where data suggests practice may be better on indicator 8 (pg 57 NHS WRES AR).
9 (Becki)	**Percentage difference between the organisations' Board voting membership and its overall workforce.** *This shows that white board members are overrepresented compared to the demography of the workforce and BAME board members are underrepresented compared to the demography of the workforce* • *Ensure board level positions are broadly advertised when they arise.*	Total Board members - 12 of which 2 are BME. The Trust has 9% BME workforce and 2 of its 12 Board voting members are of BME origin (16.7%). The percentage difference between the organisations' Board voting membership and its overall workforce is +7.7%. National – BME Board members 8.4% Regional – North East and Yorkshire – 5.8% Ensure there are no unknown ethnicity! See indicator 1 above –

	• *Review and consider alternative shortlisting and appointment techniques to improve diversity*	https://www.england.nhs.uk/wp-content/uploads/2019/01/wres-leadership-strategy.pdf

Timetable – HDFT WRES

Date	Item	Comments
25.09.20	WRES Deadline to publish data and action plan on website	
23.09.20	Sign-off at People and Culture Committee	
04.09.20	Discuss development of Action Plan at BME Staff Network meeting	
04.09.20	Present to P&SC Directorate	
01.09.20	Present to Emergency Department Quality Board	
31.08.20	Submission Deadline for WRES and WDES	
27.08.20	Present to Partnership Forum	
W/C 24.08.20	Targeted awareness emails: All Staff 27.08.20 BME Staff Network Staff Governors FTSUG and Fairness Champions Disability and Long-Term Illness Staff Network LGBT+ Staff Network LT&UC Directorate P&SC Directorate C&CC Directorate	

	Corporate Directorate Occupational Health	
21.08.20	Present to HIF Board	
19.08.20	Present to Senior Management Team	
31.07.20	Update Director Team	
30.07.20	Presented WRES at BME Staff Network meeting	
15.07.20	Introduce WRES at BME Staff Network meeting	

Appendix D

WDES Action Plan

Across all metrics in the Action Plan to highlight the Disability and Long-Term Illness Staff Network and the role of the EDI Lead and that this is an ongoing working document which will be a standard item on SN Agenda and the SN will report into SMT

Staff Engagement – collaborative decision-making

Staff Networks – catalyst to empower, encourage and promote equitable opportunities for staff with disabilities. Hold focus groups Staff Stories – help to define the narrative on lived experiences

Promote NHS People Plan Actions, Culture Change Programme, WRES Experts learning

Across all metrics in the Action Plan take into account responses provided on the On-line Reporting Form below

Metric	2019 Narrative and Action Plan	2021 Action Plan
1 (Becki)	**Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce**. *The figures have identified a number of staff do not declare to the Trust if they have a disability.* *The Workforce Equality Group to encourage staff to declare if they have a disability through their promotion of diversity at the Trust.* *The Workforce equality group to discuss the experiences of disabled colleagues across the Trust.*	8. <u>Disability declaration through the NHS Electronic Staff Record</u> Promote ESR self-service – eg leaflet to explain why we need data. Raising disability awareness to support staff to feel more confident in declaring a disability or long-term condition – eg Disability awareness dates throughout the year. Promote the organisation's commitment to EDI – website, recruitment and induction, Used to better understand the diversity of the Trust's workforce and identify actions that will support Disabled staff in the workplace. Staff Network to encourage colleagues to declare disability status – 'Nothing About Us Without Us'.

		Covid-19 has highlighted that data is vital in highlighting inequalities (priority in keeping colleagues safe). Pay band clusters, Non-Clinical staff: • Under Band 1, Bands 1-4 – Disabled 3.6%, non-disabled 81.1% • Bands 5-7 - Disabled 1.4%, non-disabled 81.4% • Bands 8a-8b - Disabled 3.6%, non-disabled 85.5% • Bands 8c-9 &VSM - Disabled 0%, non-disabled 80% Pay band clusters, Clinical staff: • Clinical Staff • Under Band 1, Bands 1-4 - Disabled 3.3%, non-disabled 78.84% • Bands 5-7 – Disabled 3.36%, non-disabled 79.47% • Bands 8a-8b - Disabled 5.79%, non-disabled 73.55% • Bands 8c-9 &VSM – Disabled 0%. Non-disabled 66.67% • Medical & Dental Staff, Consultants – Disabled 1.28%, non-disabled 68.59% • Medical & Dental Staff, Non-Consultants career grade – Disabled 0%, non-disabled 76.92% • Medical & Dental Staff, Medical % Dental trainee grades – Disabled 3.87%, non-disabled 88.39% Local: • 3.1% Non-clinical • 3.4% Clinical (excl. medical and dental) • 3.87%, 0%, 1.28% Trainee Grades, Non-consultants career grade, Consultants respectively National: • 3.6% Non-clinical • 2.9% Clinical (excl. medical and dental)

		• 1.94%, 1.2%, 0.8% Trainee Grades, Non-Consultants career grade, Consultants respectively 9. <u>Under-representation at Bands 7 and above – Undertake detailed findings into disability workforce statistics / breakdown by Directorates/pay bands/job role e.g. nursing</u> 10. <u>Set targets</u> Look at Trust workforce in relation to NHS workforce and local population across Trust catchment area. Page 6, Annual Report refers to UK Government strategy to support Disabled people into employment by 2027. 11. <u>Incorporate WDES on Integrated Board Report</u> Regular update on WDES performance throughout year – measure outcomes of Action Plan. 12. <u>Project Search</u> A model for supported internships for young people with Learning Disabilities 13. <u>Work Experience Programme</u> 14. <u>Volunteering</u>
2 (Andrea / Becki**)**	**Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts**. *A figure below 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to be appointed from*	1.55 – Disabled people are less likely than non-disabled people to be appointed from shortlisting. National – 1.23, North East and Yorkshire had the biggest disparity in relative likelihood – 1.44.

	shortlisting. The figures show currently disabled candidates are less likely than non-disabled candidates to be appointed from shortlisting. *• Consider different advertising methods which can be used to access underrepresented groups.* *• Assess the impact of unconscious bias training for managers in Pathway to Management and continue to consider a wider roll out.* *• Review the recruitment training on Pathway to Management to ensure recruiting managers are aware of the process for the guaranteed interview scheme. . Consider the introduction of a standing shortlisting panel to reduce bias*	5. <u>Recruitment Review/Campaigns (speak to Lee-anne / Andrea / Emily:</u> • RPIW for recruitment • *Look at criteria for appointment* • *Recruitment panel – agree appointable score and right fit for team* • *Management of unsuccessful candidates* • *Promotions, Acting Up and Secondments* • *Job adverts – length of advert, communications about the advert, wording, some adverts on bulletin – where else….via Staff Networks….via Y&H EDI Leads network…..via regional networks….via E&D Stakeholder Group/local groups!* • *JD/Person specifications – does the wording cause a barrier for Disabled people to apply – 'sticky floor, glass ceiling'* • *Complaints about recruitment practices* 6. <u>Review of Pathway to Management re recruitment and UB (speak to Karen Hatch for timeline on this)</u> 7. <u>First Line Leaders re UB (checking with Vanessa)</u> 8. <u>Move from Disability Confident Committed Level 1 to Disability Confident Employer Level 2</u>
3 (Becki)	**Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure**.	No Disabled member of staff has entered the formal capability process this year. Data is based on a two year period as numbers may be small.

	A figure above 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process and reports disabled staff are more likely to enter the Capability Process. *Review the impact of the unconscious bias training for managers and monitor the number of disabled staff entering the Capability process and outcomes.* *Continue with the Improving People Practices work to ensure that HR policies are fit for purpose and support the principles of fairness and equality.*	Nationally Disabled staff are 1.1 times more likely to go through capability processes on the basis of performance compared to non-disabled staff. 1. Talk to HR Business Partners 2. See above re Pathway to Management 3. See above re First Line Leaders
4 (Katie / Emma / Becki**)**	**Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse.** *The percentage of disabled staff who report having experienced bullying and harassment is high. Staff report feeling able to speak up either for themselves or on behalf of a colleague. Further actions are required to encourage staff to speak up.* *Workforce Equality Group to identify how staff with protected characteristics feel about working at the organisation to then create actions.* *Workforce Equality Group to interrogate the staff survey further to identify if there are key professional groups or departments where this is occurring.* *Workforce Equality Group to promote equality so staff feel able to speak up via team talks and promotional materials.* *The Trust's Freedom to Speak up Guardian has recruited Fairness Champions who support individuals who may be*	a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: Patients/Services Users, their relatives or other members of the public – • **2019/20** – **28.1% of 295 Disabled staff** and **24.1% of 1265 non-disabled staff** • National 33.8% Managers – • **2019/20** – **20% of 295 Disabled staff** and **10.6% of 1269 non-disabled staff** • National 19.8% Other colleagues – • **2019/20 – 25.7% of 292 Disabled staff** and **17.6% of 1264 non-disabled staff** • National 26.8%

	experiencing harassment or bullying and embed the Speaking Up principles across the Trust	b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it: • **2019/20 – 54.3% of 127 Disabled staff** and **45.9% of 423 non-disabled staff** • National 47.8% 8. <u>Culture Change Programme</u> Drivers – Deloitte, EDI Strategy, NHS Staff Survey 9. <u>NHS People Plan Actions - National data / Public awareness / Zero tolerance</u> Disabled staff were more likely to experience harassment, bullying or abuse from patients/service users, their relatives or other members of the public, in all regions across England. Prevent and tackle bullying, harassment and abuse against staff, and create a culture of civility and respect *10.* <u>Freedom to Speak Up Guardians and Fairness Champions</u> 11. <u>Triangulate Staff Survey Results with other data eg FTSUG data and formal grievance data, sickness and absence rates, exit questionnaires to assess HBA towards staff with disabilities</u>
5	**Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.** *Disabled staff do feel the there are equal opportunities for progression. More work can be undertaken to understand*	**85.6%** of 201 Disabled staff believe that the Trust provides equal opportunities for career progression or promotion. **88.5%** of 826 non-disabled staff believe that the Trust provides equal opportunities for career progression or promotion.

	from those disabled staff that do not believe there are opportunities. *The Trust will continue to obtain feedback through events to see what else can be done to improve training opportunities for disabled staff.* *Workforce Equality Group to obtain the views of disabled staff on working for the Trust.*	National – 75.3% of Disabled staff across England felt that their trust provided equal opportunities for career progression or promotion. 6. <u>? Career Development Strategy</u> National data demonstrates that trusts with targeted career development policies more staff with disabilities felt they were provided with equal opportunities. Pilot training initiatives/additional bespoke training 7. <u>Reciprocal Mentoring</u>
6	**Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.** *This is a similar score reported from non-disabled staff off which 21% also feel under pressure to come in when not well.* *Managers to be trained through absence master classes and the HR Pathway to Management training on how to manage absences correctly to support staff and identify reasonable adjustments.*	**26.5%** of 200 Disabled staff felt pressure from their manager to come to work despite not feeling well enough to perform their duties. 19.5% of 637 non-disabled staff felt pressure from their manager to come to work despite not feeling well enough to perform their duties. National – 32% 1. <u>Pathway to Management</u> 2. <u>First Line Leaders</u> 3. <u>Culture Change Programme</u> 4. <u>Review of Policies (speak to Sarah Wilson)</u> Flexible working, reasonable adjustments, 5. <u>Health and Wellbeing</u> Conversations at appraisal Staff Wellbeing and Support Intranet Page

		Employee Assistance Programme (EAP) Wellbeing Group participation (Vaness)
7	**Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.** *Disabled staff score lower than non-disabled staff of which 52% of non-disabled staff report being satisfied with their work.* *Workforce Equality Group to host events to understand how staff with protected characteristics see their role.*	*46.1%* of 293 Disabled staff say that they are satisfied with the extent to which their organisation values their work. 55% of 1271 non-disabled staff say that they are satisfied with the extent to which their organisation values their work compared. National – 37.2% 1. <u>Leadership</u> Analysis of the NHS WDES data suggests that inclusive leadership is key in recognising and valueing the contribution that Disabled people can make, and more likely to have workplace cultures that are supportive of Disabled staff. The appointment of Board champions for disability equality have made a positive impact in areas such as recruitment. Invite Board Champion onto Disability and Long-Term Illness Staff Network.
8	**Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work** *This metric was worded differently last year – based on engagement.*	**81.8%** of 170 Disabled staff say their employer has made adequate adjustments to enable them to carry out their work. National – 72.4% 1. <u>Disability Passports ?? speak with Staff Network</u>
9 (Becki)	**NHS Staff Survey and the engagement of Disabled staff** *The engagement score is slightly lower for disabled staff compared against the Trusts overall engagement score of 7.2.*	9a Staff engagement score remains the same this year for Disabled staff at 6.9. This has increased slightly for non-disabled staff to 7.3. National – 6.64

	Workforce Equality Group to host events and create promotional materials to understand how staff with protected characteristics see their role. *Different actions include:* *Signing up to the Disability Confident charter* *Workforce Equality Group* *Managing Attendance and Promoting Health and Wellbeing Policy relating to supporting individuals with a disability or long-term health condition.* *Health and Wellbeing Strategy Group* *The Trust will continue to develop actions to ensure disabled staff are able to speak up.*	9b – Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard Yes. If yes, please provide one practical example of current action being taken in the relevant section of your WDES report – Disability and Long-Term Illness Staff Network 1. 'Nothing about us, without us' Improve engagement with staff with disabilities, listening to and recognising their lived experiences. 2. Equality Stakeholder Group Removing any social model barriers that may impact on the delivery of high-quality patient care for all. Through insights of people with disabilities across the workforce, many of whom will be patients or service users, we will be able to think in new and innovative ways about how to deliver high quality compassionate care that have inclusion at their heart.
10	**Percentage difference between the organisation's board voting membership and its organisation's overall workforce** *This shows that disabled board members are under* *represented compared to the demography of the workforce.* *Ensure Board level positons are broadly advertised when they arise.*	As at 31 March 2020 there were no members of the Trust Board with a disability. National – 2.1%

	• *Review and consider alternative shortlisting and appointment techniques to improve diversity*.	

On-line Reporting Form

1 Name of organisation:

Harrogate and District NHS Foundation Trust

2 Date of completing this report:

26/08/2020

3 Name, job title and email address of the lead compiling this report:

Angie Colvin, Equality, Diversity and Inclusion Lead - angie.colvin@nhs.net

4 Name of the clinical commissioning group (CCG) that the trust's 2020 WDES annual report (metrics data and action plan) will be sent to:

North Yorkshire Clinical Commissioning Group

5 Unique URL link or existing web page on which the trust's 2020 WDES annual report (metrics data and action plan) will be published:

https://www.hdft.nhs.uk/about/equality-and-diversity/

6 Date of board meeting at which the trust's 2020 WDES annual report (metrics data and action plan) were, or will be, ratified

23/09/2020

7 Does your trust participate in any programmes or initiatives that are focused on disability equality and inclusion?

Yes

If yes, please provide details::

Disability Confident Committed Accreditation - *The Disability Confident scheme supports employers to make the most of the talents disabled people can bring to your workplace.*

https://www.gov.uk/guidance/disability-confident-how-to-sign-up-to-the-employer-scheme#level-2-disability-confident-employer

Guaranteed Interview Scheme - *The Guaranteed Interview scheme was introduced by Jobcentre Plus and it requires employers to guarantee to interview anyone with a disability whose application meets a minimum set of criteria for the post. ... This was replaced in 2013 by the Disability Confident Employer symbol or statement.*

Disability and long-term illness Staff Network

Metric 1 - Workforce representation

8 Did your trust's 2020 data for WDES Metric 1 include any of the following groups of staff? 1) Bank staff, 2) Agency staff, 3) Apprentices

4) Subsidiary group staff:

Yes

If yes, please detail which staff groups::

1) Yes, our internal bank data has been used for any bank-only staff

2) No

3) Yes (recorded under the 'Under Band 1' category)

4) No

9 Do your staff have access to the ESR self-service portal?

Yes

10 Please share any examples of actions taken in the last 12 months to increase the disability declaration rates in your trust:

Our local 'new starter' form continues to keep the 'Disability Status' field set as mandatory, which must be completed to allow the form to be printed and sent to Payroll. This enables the Trust to capture disability related declarations for all new starters.

The ESR self-service portal gives all staff the ability to update their personal details as required and in a confidential manner.

Metric 2 - Shortlisting

11 What level of Disability Confident accreditation does your trust currently hold? (Level 1, 2 or 3):

Level 1

12 Does your trust use the Guaranteed Interview Scheme?

Yes

13 Please share any examples of actions that the trust has taken in the past 12 months to improve the recruitment of Disabled staff:

When candidates are invited for interview they are able to request reasonable adjustments which we would always look to accommodate.

Metric 3 - Capability

14 Did your trust experience any issues with providing the data for Metric 3, which was voluntary last year and mandatory this year?

No

Metric 4 - Harassment, bullying and abuse

15 Please summarise any actions taken in the last 12 months to reduce harassment, bullying and abuse in relation to Disabled staff:

Promotion and awareness of :

Freedom to Speak up Guardian and Fairness Champions.

Bullying and Harassment Advisers

Bullying and Harassment Policy and Procedures

Metric 5 - Career promotion and progression

16 Does your Trust provide any targeted career development opportunities for Disabled staff?

No

Metric 6 - Presenteeism

17 Has your trust planned any targeted actions to reduce presenteeism?

No

Metric 7 - Staff satisfaction

18 Has your trust planned any targeted actions to increase the workplace satisfaction of Disabled staff?

Yes

If yes, or planned, please provide examples::

Listening to the lived experience of staff via the Disability and long-term illness Staff Network.

Metric 8 - Reasonable adjustments

19 Does your organisation have a reasonable adjustments policy?

Yes

20 Are costs for reasonable adjustments met through centralised or local budgets within the trust?

Local

21 Please summarise any actions taken in the last 12 months to improve the reasonable adjustments process?

Increased support available for staff with rapid access to physio treatment and complimentary therapies being introduced.

Flexibility within the policy around absence triggers .

More proactive in the use of managing work pressures toolkit to support employees in the workplace .

Metric 9 - Disabled staff engagement

22 Does your Trust have a Disabled Staff Network (or similar)?

Yes

23 Was your trust's 2019/20 WDES action plan co-developed with Disabled staff?

Yes

If yes, please provide details on how Disabled staff were involved::

Engagement with a wide-range of staff across the organisation to ensure the voices of all staff are included, in particular Disabled staff and staff who do not with

to declare their disability status:

Staff Networks/All staff via email bulletin

Directorates

Staff Governors

Communications and Marketing Manager

Occupational Health Department

Freedom to Speak Up Guardians / Fairness Champions

Unions

Equality Stakeholder Group members

The action plan is to be co-produced with the Disability and long-term illness Staff Network.

Metric 10 - Board representation

24 Please describe any challenges that your organisation has experienced in collecting and reporting data for this metric:

None.

25 Name and job title of the Board lead for the Workforce Disability Equality Standard:

Angela Wilkinson, Director of Workforce and Organisational Development

26 Please summarise any actions taken in the last 12 months to improve Board representation:

None.

Supplementary

27 Are there plans for your trust to merge with another trust in the next 12 months?

No

28 Do you have any further comments about the WDES data collection 2020?

As a new EDI Lead, thank you to the WDES Implementation Team for their support and for providing guidance via webinars which were extremely helpful

Notes –

Whilst collecting the data should involve no more work than is currently undertaken, what will require more work is understanding the data and listening to staff so that effective strategies to improve outcomes against the indicators can be reached.

Humanise data – tell stories – positive end, learning, call to action

- https://www.youtube.com/watch?v=PnDgZuGIhHs Love Has No Labels

Ask Staff Network to include a statement as part of the WDES Annual Report

NHS WDES Annual Report – ideas for actions – in particular pg 53 Action Plans and look at some good examples

Compare data with other comparable Trusts – Model Hospital

Directorate Actions

Go back to Lucy H for a pictoral

'Well-led' domain – CQC

Work with FTSUG

Interview panels – LAH

Minimise number of nulls/unknown

Taylor Review (pg 6 Annual report) H&W etc

Pg 6 Annual report UK Gov strategy to support D people into employment by 2027 – set targets

Timetable – HDFT WDES

Date	Item	Comments
31.10.20	WDES Deadline to publish data and action plan on Website	
23.09.20	Sign-off at People and Culture Committee	
	Check if to go to DT/SMT before PCC?	
09.09.20	NHS WDES Webinar – Developing WDES Annual Reports and Action Plans	Angie booked to attend
04.09.20	Present to P&SC Directorate	
03.09.20	Discuss development of Action Plan at Disability and Long-Term Illness Staff Network	
01.09.20	Present to Emergency Department Quality Board	
31.08.20	**Submission of WDES Online Reporting**	**Through this online reporting form we aim to understand the experiences that NHS trusts have had in collecting and reporting the WDES Metrics data this year.** **Trusts are mandated to complete this online reporting form, as well as report their metrics data spreadsheet.** **The information submitted via this online reporting form, along with the metrics data, will be analysed for the national WDES**

		Annual Report 2020 and in turn will help us to identify whether trusts are making year on year improvements in supporting the workplace and career experiences of Disabled staff. **In completing this online reporting form please summarise with key points, detailed information is not required.**
31.08.20	**Submission Deadline for WDES**	
27.08.20	Present to Partnership Forum	
Wk comm 24.08.20	Targeted awareness emails: All Staff 27.08.20 Disability and Long-Term Illness Staff Network Staff Governors FTSUG and Fairness Champions BME Staff Network LGBT+ Staff Network LT&UC Directorate P&SC Directorate C&CC Directorate Corporate Directorate	

	Occupational Health	
21.08.20	Present to HIF Board	
19.08.20	Present to Senior Management Team	
08.08.20	Introduce WDES to Disability and Long-Term Illness Staff Network	
31.07.20	Update Director Team	

S Wilson, HR Business Partner

Harrogate and District NHS Foundation Trust

Corporate Nursing

Adult Safeguarding Annual Report 2019/20

Author	Janet Farnhill, Named Nurse Adult Safeguarding
Date	June 2020
Approval	Supporting Vulnerable People Steering Group

You matter most

Introduction

The purpose of this report is to describe the work undertaken over the last year with regard to Adult Safeguarding at Harrogate and District NHS Foundation Trust (HDFT). This report will also provide an update on the Prevent agenda.

This report provides assurance that HDFT has appropriate safeguarding structures in place and that our Adult Safeguarding policies and procedures are fit for purpose and comply with external safeguarding requirements. It also provides an overview of the work of the Adult Safeguarding team and information about safeguarding concerns raised both by and against the Trust.

At HDFT we understand that safeguarding is everyone's business and strive to support the Department of Health's six principles of Safeguarding:

> **Empowerment** - People feel safe and in control, give consent to decisions and actions about them. They should be helped to manage risk of harm either to themselves;
> **Protection** - Support and help for those adults who are vulnerable and most at risk of harm;
> **Prevention** - Working on the basis that it is better to take action before harm happens;
> **Proportionality** - Responding in line with the risks and the minimum necessary to protect from harm or manage risks;
> **Partnership** - working together to prevent or respond to incidents of abuse; and
> **Accountability** - focusing on transparency with regard to decision making.

Aims of HDFT Adult Safeguarding Service

The principle aims of the Adult Safeguarding Service are to:

- Ensure we keep our patients safe and protect them from harm;
- Ensure staff are aware of their responsibilities with regard to Adult Safeguarding;
- Provide expert opinion with regard to safeguarding;
- Ensure we have appropriate structures in place to manage and take forward the Adult Safeguarding agenda;
- Provide assurance to external agencies that our safeguarding policies and procedures are robust and fit for purpose;
- Ensure HDFT is represented at Adult Safeguarding multi-agency meetings including the North Yorkshire Safeguarding Adults Board (NYSAB) sub groups and help to deliver the SAB strategic plan;
- Seek opportunities to raise the profile of safeguarding adults and ensure staff are aware of their responsibilities with regard to the safeguarding agenda;

- Continue to strengthen and align safeguarding processes and practice across hospital and community services;
- Ensure appropriate training is available at all levels and monitor this. Seek opportunities to improve staff training and identify and address any gaps;
- Strengthen and support the adult safeguarding link worker network so it is used to its full advantage across all HDFT areas;
- Support arrangements for working with Matrons and Managers to investigate incidents and support staff where a concern is raised about care provided by the Trust or where Trust staff have raised concerns about care in other parts of the care system or at home;
- Use the safeguarding adult's database to provide information from which we can monitor trends, learn lessons and share good practice; and
- Take forward work allied to Adult Safeguarding as required e.g. Prevent.

Responsibilities of HDFT staff with regard to Safeguarding Adults

Each member of HDFT staff has a duty to ensure they:

- Work within the 6 key principles of Adult Safeguarding;
- Are up to date with their safeguarding adults training commensurate with their position in the Trust;
- Understand how to raise a concern within their area of work;
- Know where to get help and support with a safeguarding issue;
- Assist with safeguarding investigations as required
- Embrace a culture of learning from concerns

Report for 2019/20

The HDFT Adult Safeguarding Service

The Adult Safeguarding team consists of a Named Nurse Adult Safeguarding who works 30 hours/week. The Trust is also required to have a Doctor with a Specific Interest (Dr Rebecca Watt) who is available for advice. The Named Nurse manages the Acute Learning Disability/Mental Capacity Act (LD/MCA) Liaison Nurse who works 34 hours/week. The Named Nurse Adult Safeguarding and the Acute LD/MCA Liaison Nurse provide cover for each other on days off and annual leave. The Named Nurse Adult Safeguarding is managed by the Head of Nursing for Long Term and Unscheduled Care although adult safeguarding itself sits within the Corporate Nursing function.

Representation at external Adult Safeguarding meetings

The Safeguarding Adults Board (SAB) continues to be attended by the Chief Nurse (who represents Health Providers at this North Yorkshire wide meeting).

The Named Nurse Adult Safeguarding represents HDFT at the following SAB sub-groups: Policies, Practice Development and Legislation Group (PPDL), the Performance and Quality Improvement (PQI) sub-group; the Local Safeguarding Adults Group which has now amalgamated with the similar group for children's safeguarding and is known as the Local Safeguarding Partnership Group, and the Learning and Review Group (LAR). She also attends the Health Partnership Group (HPG) which is chaired by the CCG Designated Nurses for Adult Safeguarding. All these groups are held quarterly.

Agendas and minutes for these meetings attended are stored on the shared drive: 'Adult Safeguarding' on the intranet.

Representation at individual safeguarding strategy and case conference meetings is by the Named Nurse Adult Safeguarding or relevant Matrons with other clinical staff as appropriate.

Supporting Vulnerable People Steering Group

The Named Nurse Adult Safeguarding reports directly to the Supporting Vulnerable People Steering Group, and provides an up to date report at each monthly meeting. This includes details of safeguarding concerns and outcomes, learning required from safeguarding concerns, feedback from relevant internal and external groups, training updates, action plan update and information about the wider adult safeguarding arena.

The Supporting Vulnerable People Steering Group continues to oversee arrangements for safeguarding adults within HDFT ensuring they are robust, fit for purpose and compliant with national and local standards.

Named Nurse- Adult Safeguarding

The Named Nurse for Adult Safeguarding supports and advises staff with regard to adult safeguarding across the whole of the HDFT footprint. This includes attending strategy meetings and case conferences to represent the Trust and support staff who attend as required. The Named Nurse also assists partner agencies with information gathering across HDFT for safeguarding enquires and investigations.

If a safeguarding concern is raised against HDFT, the matron/manager for that area is involved in the safeguarding meetings whenever possible to ensure that staff are supported and this also ensures ownership is taken at a local level for any actions/learning that are identified as a result of a safeguarding incident/concern.

Information regarding each concern is stored on the safeguarding database and related notes/minutes of meetings are also kept for reference. Documentation includes referrer area; whether the alert has been raised by HDFT or against the HDFT; type of abuse; whether it is a pressure ulcer; whether it was investigated via safeguarding and the outcome.

The Named Nurse Adult Safeguarding provides reports and information for the Supporting Vulnerable People Steering Group and co-chairs the link worker's meetings. She also maintains the adult safeguarding action plan and the intranet webpage.

The Named Nurse also provides information and reports as required for the PPDL, PQI, LAR and HPG and this year has provided information and represented HDFT at a panel for a Safeguarding Adult Review. These reviews are held when there is reasonable cause for concern about how the NYSAB partners worked together to safeguard an adult with care and support needs who has died, or if it is suspected that the adult experienced serious abuse or neglect.

The Named Nurse Adult Safeguarding manages the Acute Learning Disabilities Nurse/Mental Capacity Act Liaison Nurse and provides leadership support for this role.

Safeguarding Adults/Learning Disability Link Workers

The Named Nurse Adult Safeguarding and Learning Disability Liaison Nurse manage a link worker network which has representation from all hospital and community areas. The meetings continue to be held quarterly and a dial in facility is available at meetings to facilitate participation from staff who find it difficult to travel to the meetings. All areas have a link worker although attendance at meetings remains variable. This year we have introduced a different safeguarding and learning disability topic at each meeting, and following that, the meetings are used to provide support and guidance, share good practice, and discuss any issues. Safeguarding focus's this year include an overview of the annual report, the work of North Yorkshire Horizons, the new Multi-Agency Safeguarding Policies and Procedures and Doorstep crime.

Safeguarding and Governance

HDFT provides assurance and demonstrates compliance to the CCG and the North Yorkshire Safeguarding Adults Board by completing the Adult Safeguarding self-assessment framework annually. This includes information with regard to policies and guidelines for safe recruitment, governance, training statistics. We have continued to provide information regarding safeguarding concerns on a quarterly basis to the Performance and Quality Improvement (PQI) sub-group.

There is a clear process for ensuring safeguarding concerns are incorporated within the HDFT governance framework, which is detailed in the Adult Safeguarding Policy. This allows any safeguarding alerts raised against HDFT to be monitored and provides assurance at a senior level that appropriate actions are taken to prevent reoccurrence.

Datix incident reports are also monitored for any safeguarding concerns and actions taken forward if required. The Risk Management Team identify any events which are externally reportable to the National Reporting and Learning

System (NRLS) and these can then be accessed by the Care Quality Commission (CQC).

Meetings continue to be held regularly with NYCC Health and Adult Services to provide assurance that any learning from safeguarding alerts has been actioned and completed as required by HDFT.

Training

We are working towards compliance with the recommendations of the national intercollegiate document 'Adult Safeguarding: Roles and Competencies for Healthcare Staff' This guidance outlines the minimum training requirements for all staff groups. Roles and competencies have been mapped and there are plans to amend staff learning competencies to ensure they are doing the correct level of training, however the guidance recommends that at least 50% of training for all staff should be participatory and we are not currently in a position to provide this within existing resources.
Our training figures are produced monthly and are reviewed and monitored by the Named Nurse Adult Safeguarding and the Supporting Vulnerable People Steering Group.

Figures for the end of March 2020 are as follows:

Competence Name	***Total requiring training Trust***	***Percentage trained Trust***	***Total requiring training HIF***	***Percentage Trained HIF***
Safeguarding Adults Awareness	1840 (86 bank/locum)	96% (87% bank/locum)	244 (38 bank/locum)	97% 89 bank/locum)
Safeguarding Adults (level 1)	2361 (208 bank/locum)	92% (75% bank/locum)	55 (1 bank/locum)	84% (100% bank/locum)
Safeguarding Adults (level 2)	244 (n/a bank/locum)	67%		

All the training figures demonstrate an increase compared to March 2019. The percentage of staff who have undertaken Safeguarding responder (level 2) is gradually increasing which is reassuring. Feedback on these in-house face to face sessions is consistently positive.

Additional training continues to be given on an ad hoc basis to staff groups as requested.

Volunteers

Face to face Adult Safeguarding awareness training is given on request to volunteers on induction. Information about adult safeguarding and their responsibilities with regard to this is also given to them in the volunteer handbook. The number of volunteers who are in date with training at the end of March 2020 is 327

Audit

The audits carried out this year relate to baseline information for the proposed Liberty Protection Safeguards; Consent for safeguarding referrals prior to the introduction of Making Safeguarding Personal; and knowledge of the Mental Capacity Act following training.

Prevent (Preventing radicalisation)

The 'Prevent' element of the Government's counter terrorism strategy remains within the safeguarding agenda and is overseen by the Supporting Vulnerable People Steering Group. The Named Nurse Adult Safeguarding is the Trust Prevent Lead.

Training has been rolled out as defined by the NHS England Prevent Training and Competencies Framework. The number of staff trained this year has continued to rise and we have therefore maintained our compliance with the national target of 85% for all staff groups.

An annual update for level 3 compliant staff in the form of an information leaflet as recommended in the Training and Competencies Framework was produced again this year.

Prevent training figures

Competence Name	***Total requiring training (Trust)***	***Percentage trained***
Preventing radicalisation level 1 and 2 (Basic Prevent awareness)	3264	91%
Preventing Radicalisation level 3 WRAP or equivalent	1514	94%

The Named Nurse Adult Safeguarding continues to maintain links with the North Yorkshire Channel Panel and provides information as required, however the monthly meetings are now attended by a representative of the Safeguarding Children's team. The Named Nurse continues to complete the quarterly Prevent return for NHS Digital and the CCG and attend the Local (Bronze) Prevent and NHS England Regional Prevent meetings. At the end of this financial year funding for the Regional Prevent Coordinators has been withdrawn so this post which provided support and ongoing development for Leads no longer exists.

Our HDFT Prevent guidance has also been updated to include further information for all areas of HDFT and in particular our children's services footprint.

Safeguarding awareness week

Safeguarding awareness week was w/c 24th June. HDFT adult and children's safeguarding teams joined together to provide training and information on Modern Slavery and Domestic Abuse.

Other Developments

The new Multi-Agency Adult Safeguarding Policies and Procedures were introduced in North Yorkshire in October 2019. Our HDFT policies and procedures have been aligned with these and face to face training has been updated to reflect the changes.

The Pressure Ulcer Decision Support Tool has now been finalised and has been embedded in our Root Cause Analysis paperwork. This risk tool relates to the interface between safeguarding and pressure ulcers and has resulted in a much more proportionate response to pressure ulcers that have developed in the care of Trust staff.

The safeguarding team have been involved a Safeguarding Adults Review and Domestic Homicide Review.

This year the Safeguarding Adults and Children's teams at HDFT have continued to work more closely, seeking out at opportunities for joint working and shared learning.

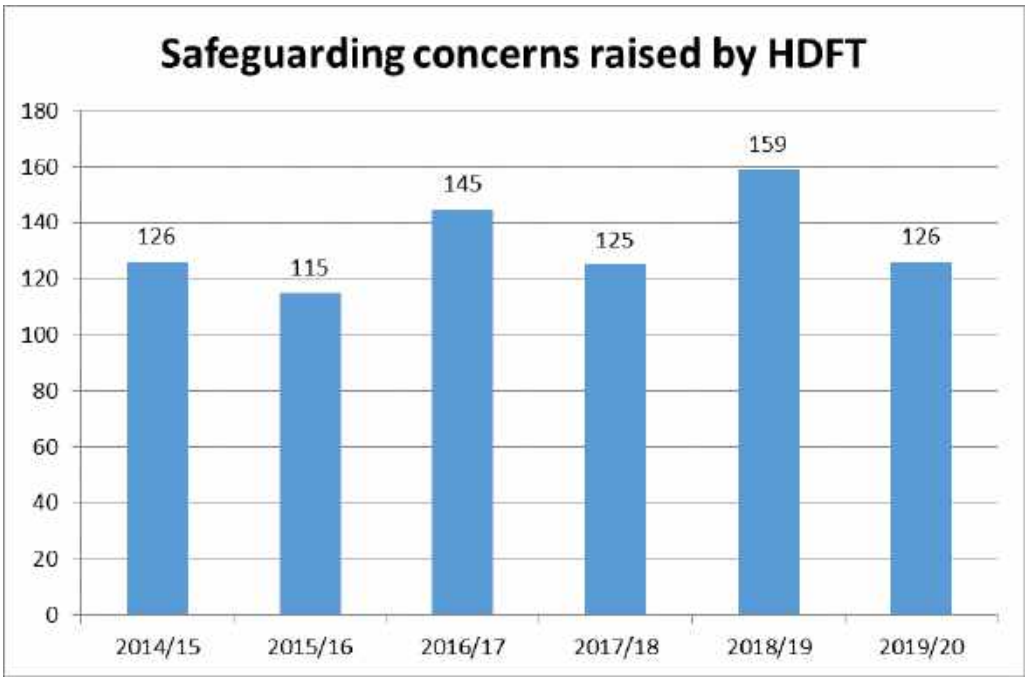
In November/December the Adults and Children's safeguarding teams took part in the 16 days of action against domestic abuse. Within HDFT this included information displays; awareness raising; mass signing of a pledge; collection of donations to the Women's Refuge; cake sale with proceeds going to IDAS (Local Independent Domestic Abuse Service); showing of a film highlighting coercion and control specially commissioned for the event and the training of 16 domestic abuse champions. Our updated Domestic Abuse guidance was also launched during this event.

The face to face safeguarding training has been updated to include information about vulnerable overseas visitors.

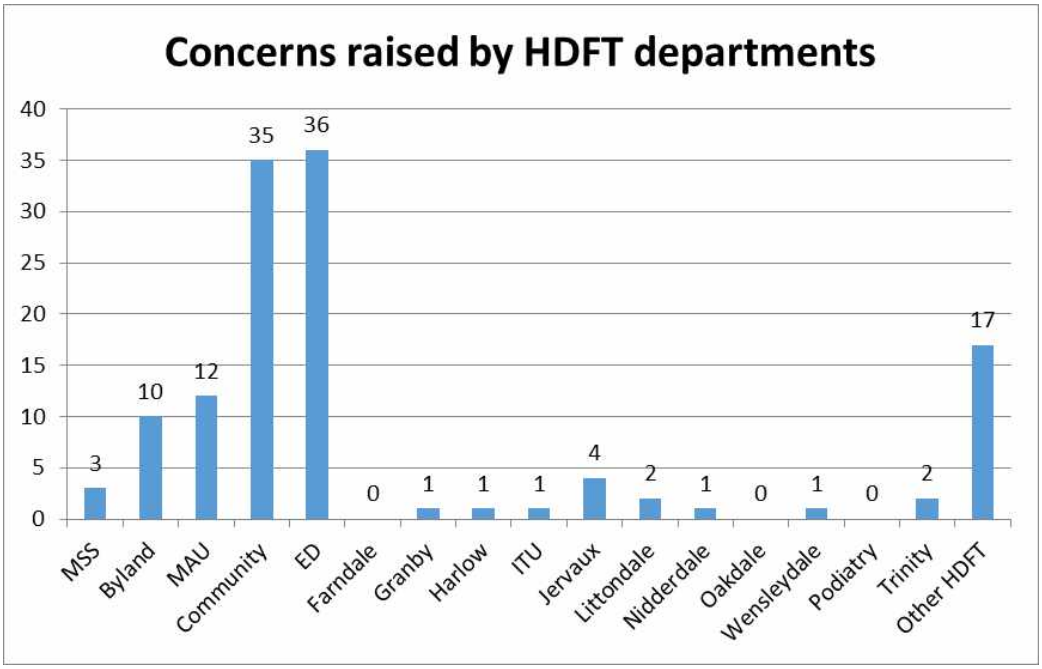
Person in a position of Trust (PIPOT) guidance has been developed by the safeguarding Adults Board with a requirement that it is included in our Disciplinary Policy

Analysis of concerns raised by HDFT staff for 2019/20 (April 2019 - March 2020 inclusive)

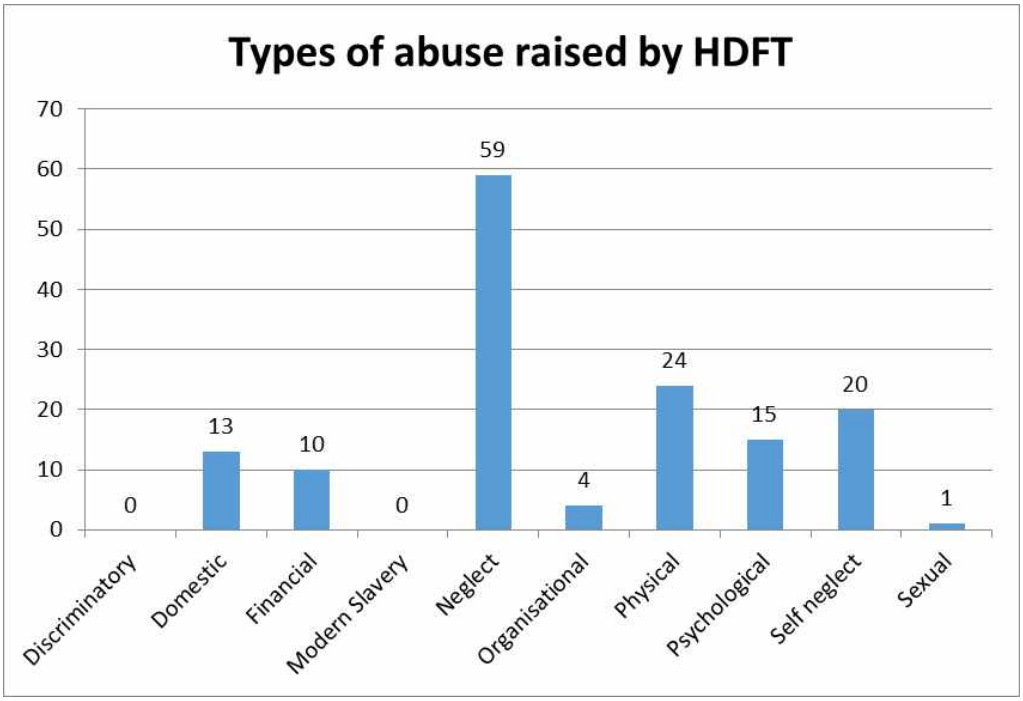
The total number of concerns raised by HDFT staff this year (April 2019-March 2020) is 126. This does not include concerns raised by us against ourselves as these are recorded separately.



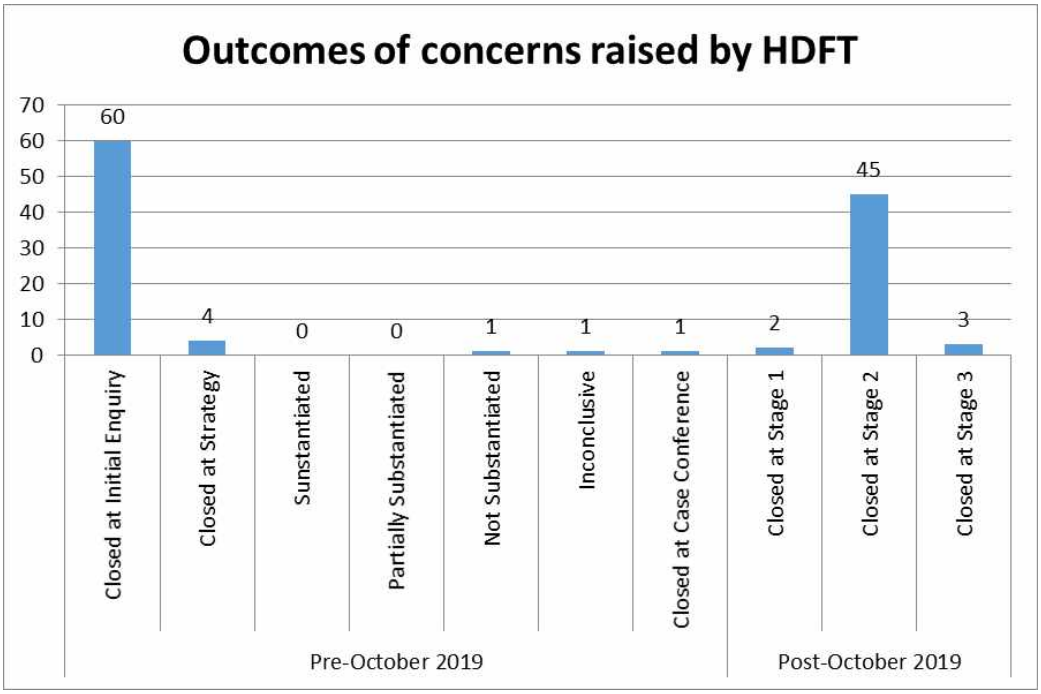
This year there has been a decrease of 33 in the number of safeguarding concerns raised by Trust staff. There isn't an obvious reason for this, however last year's figures were the highest reported and so this years are nearer the average and the same as 5 years ago.



There has been a marked decrease this year in the number of referrals sent by community staff (35 this year compared to 66 last year). This may reflect the changes in the revised adult safeguarding procedures introduced in the second half of the year making safeguarding more proportionate and personal (i.e. people were asked if they wanted a safeguarding concern to be raised and may have refused). Also, the community teams are now co located and working alongside social services colleagues so issues may be able to be dealt with at a more local level rather than raise a safeguarding concern.
As in previous years, departments where patients first present in the hospital are the areas where most concerns are raised e.g. Emergency Department (ED) and the Medical Admissions Unit (MAU). The 'Other HDFT' relates to other HDFT services, for example Orthopaedic outpatients, Ripon Minor Injuries Unit, Community Speech and Language Therapy.



Allegations of neglect continue to be the main type of abuse reported. This is to be expected as neglect is the most obvious type of abuse in care settings, and many of our patients are in receipt of some type of care out of the hospital. Incidents of self-neglect have decreased this year; this may be because Yorkshire Ambulance Service now raise a large number of these prior to admission. A number of concerns cite more than one type of abuse.



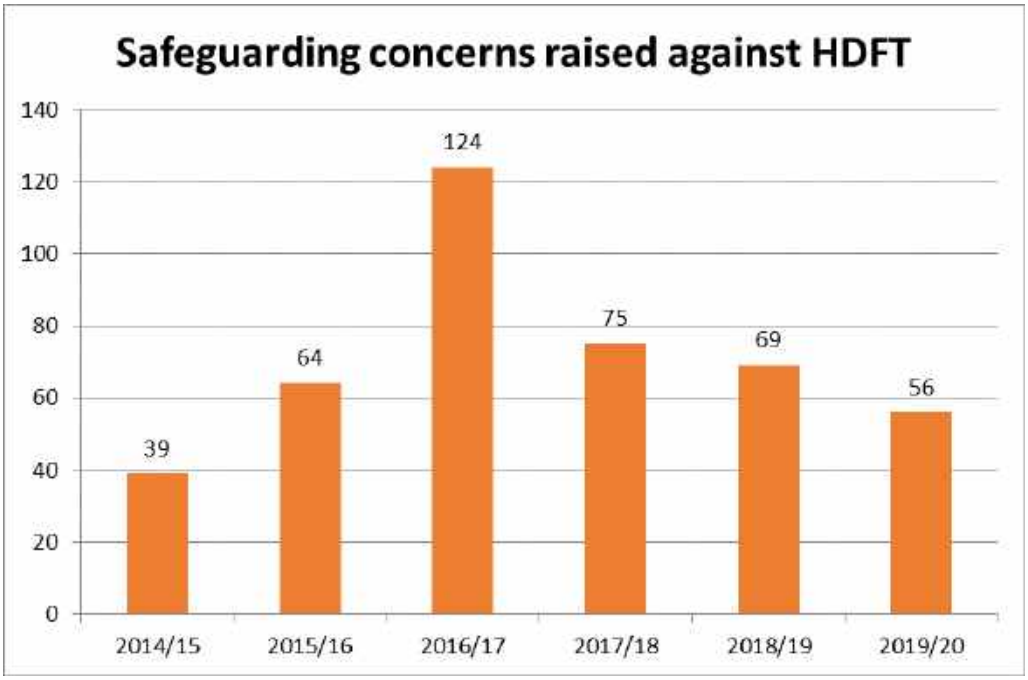
The outcomes have been divided into pre October which is prior to the new policies and procedures and post October. In October the practice for dealing with safeguarding concerns changed from a 7 stage process to a 4 stage one. Safeguarding outcomes are now based on learning and supporting the adult rather than substantiating abuse on the balance of probability. The stages that are referred to after 1st October are as follows:

Stage 1: Report a concern
Stage 2: Respond to the concern/information gathering
Stage 3: Safeguarding response
Stage 4: Outcomes and closure

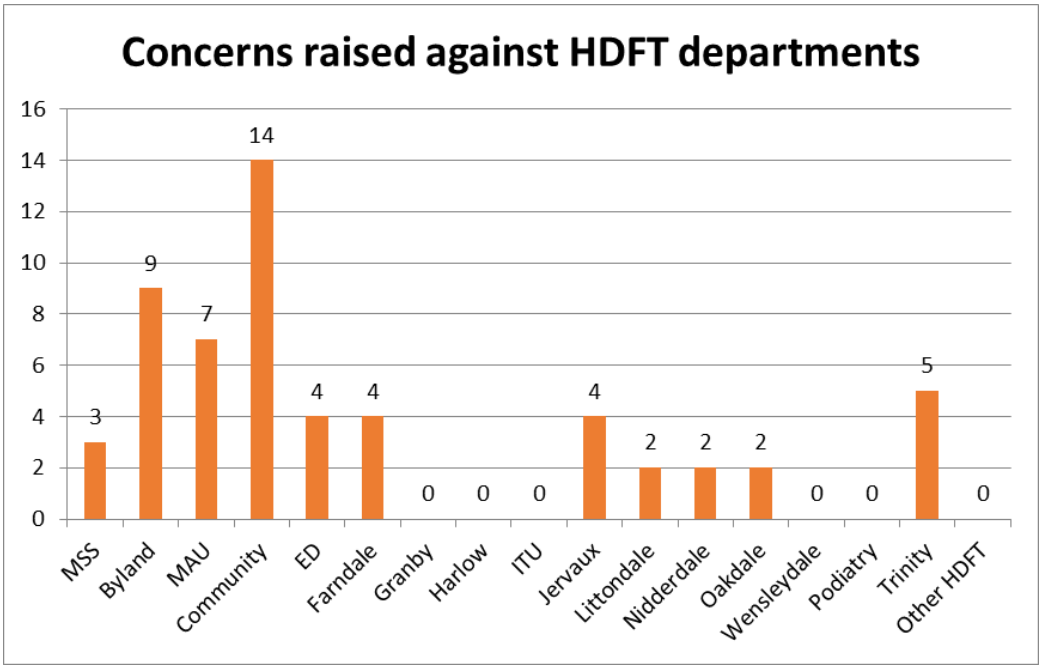
The numbers in the graph do not add up to the number of safeguarding concerns raised as some are still open cases. The majority of concerns are now closed at stage 2, once information gathering has taken place and measures have been out in place to reduce the risk.

Concerns raised against the Trust

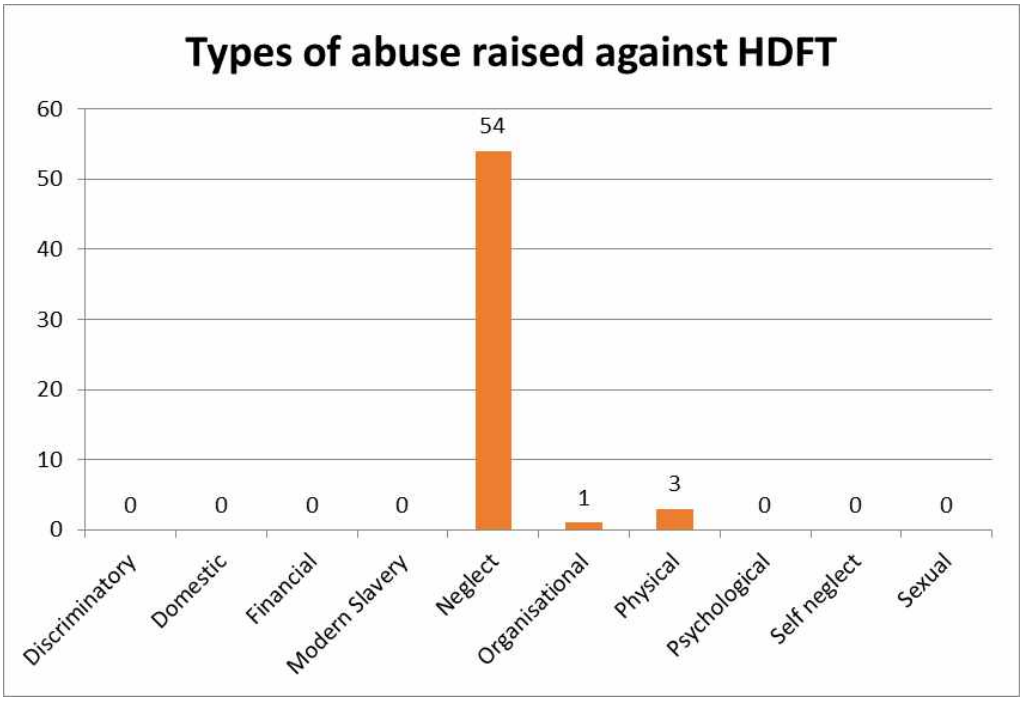
The number of concerns raised against HDFT in 2019/209 is 56 compared to 69 in 2018/9.



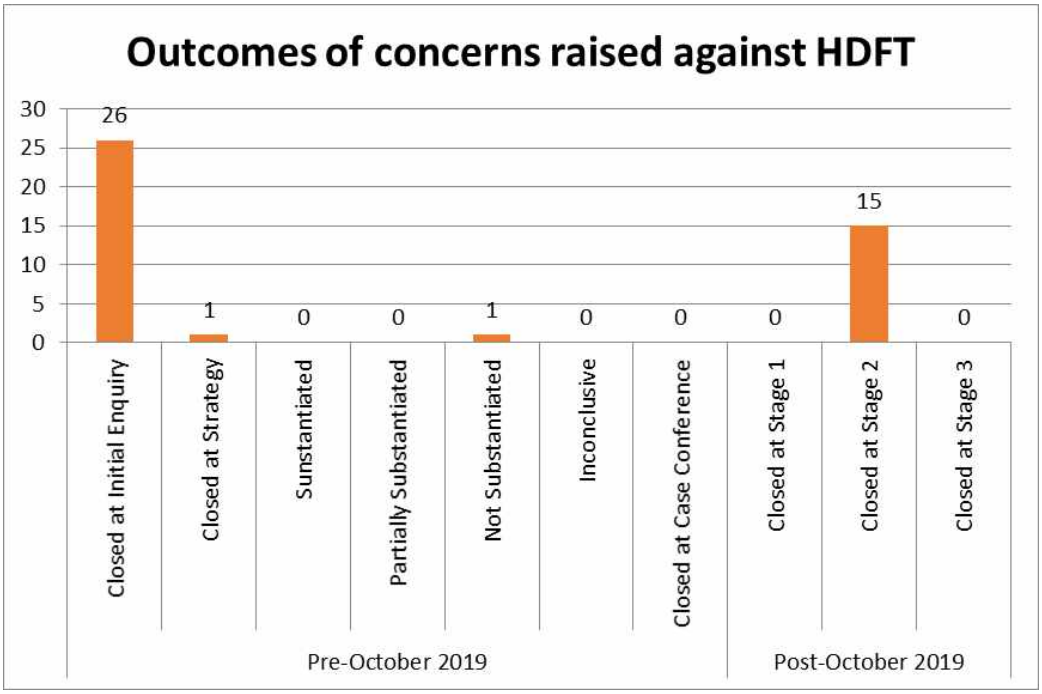
Of the 56 concerns raised against the Trust, 49 were raised by ourselves for either an allegation against staff or following a root cause analysis for a grade 3, 4 or unstageable pressure ulcer/ fall resulting in a fracture, which were deemed to be due to omissions in care. 7 concerns were raised against the Trust by others for a variety of reasons such as poor discharge arrangements and allegations of missed fractures. The vast majority of concerns raised against staff were closed at the initial enquiry (Pre October 1st) or at stage 2 (post October 1st). One was closed at a strategy meeting and another was found to be unsubstantiated at a case conference.



Again the greatest number of safeguarding concerns has been raised against our community staff, however like last year the number of concerns has fallen. (14 compared to 19). These concerns relate to pressure area damage. The Safeguarding Adults Board has introduced a Pressure Ulcer Decision Support Tool which has been incorporated into our root cause analysis paperwork, ensuring that there is a more proportionate response to raising a safeguarding concern for pressure damage.



Neglect is the main type of abuse recorded and principally this is in relation to pressure ulcers or falls that have been deemed to be due to omissions in care. In these cases, an action plan is developed following the root cause analysis, and these are monitored and reviewed within the Trust and shared as required with the Local Authority.



Almost all safeguarding concerns raised against the Trust were closed following an initial enquiry prior to October 1st or at stage 2 after October 1st. This may have been prior to or on receipt of a root cause analysis and action plan for pressure ulcers and falls resulting in a fracture. For other safeguarding concerns we provided information from documentation in the patients notes to the local authority which enabled them to make an informed decision about the safeguarding concern.

Future plans:

Work with new Safeguarding Children's Nurse in ED to look at how her role could support some aspects of adult safeguarding e.g. domestic abuse Participation in clinical supervision with colleagues from the Health Partnership Group.

Develop a safeguarding policy on a page

Ongoing work to develop bespoke training for Directors with specific roles and responsibilities with regard to adult safeguarding.

Ongoing development of bespoke training packages for certain staff groups/ areas/ departments e.g. knowledge of doorstep crime for community staff; Modern Slavery for the Emergency Department.

Further work to embed flagging systems relevant to adult safeguarding

Scoping of other Trusts to see how they are implementing the recommended 50% participatory aspect of training

Development of a network of Domestic Abuse Champions to include a support group for staff

Ongoing consideration of future resource requirements and succession planning within the safeguarding team, taking into account the implications of the 'Adult Safeguarding: Roles and Competencies for Healthcare Staff' and the roll out of Liberty Protection Safeguards, currently due in October 2020.

Outstanding risks

The outstanding risks within adult safeguarding are:

Size and robustness of the team. Currently there is a Named Nurse who works 30 hours/week over 4 days. Cover is provided for days off, annual leave and sickness by the Acute Learning Disability Liaison Nurse who works 34 hours/ week over 4 days. During annual leave and sickness there are days with no HDFT adult safeguarding cover.

As there is only one member of staff specifically for adult safeguarding there is no opportunity for succession planning within the service.

As learning accounts are not up to date staff in Children's Services are out of date with adult safeguarding training.

There is no capacity within the team to undertake work with regard to Liberty Protection Safeguards

Harrogate and District NHS Foundation Trust

Harrogate and District NHS Foundation Trust's Quality Report 2019/20

Contents

1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

We have thousands of colleagues at HDFT; hundreds of different roles and many different backgrounds and experiences that all come together in one team and one 'frontline' to help deliver our vision of excellence every time to those whose care is entrusted to us. I am incredibly proud of the passion, commitment and enthusiasm that so many colleagues bring to their role and the kindness they show to each other and to patients and their families.

This quality report aims to describe what we've achieved, learnt and where we intend to focus next. HDFT is a great organisation, and most patients speak positively about the care they received, but as the saying goes – better never stops; we do not always get things right, and there is always more we can do to continuously improve. Being open to feedback, looking at things from the perspective of others and being inquisitive are traits that we're confident will ultimately improve quality of care.

We know that when our colleagues are supported, empowered to make improvement and work in teams with a positive culture, patients get better care. You will see throughout the report references to improvements that have been made using our Quality Improvement approach and this is something we intend to make much more part of our 'DNA' over the coming years.

To support our work on culture we commissioned an external assessment to help us understand where we could do more to improve the experience of our staff, and the environment in which they work, as well as launching our First Line Leaders programme. This is the start of a journey to further improve the experience of our staff, and the environment in which they care for patients and families, and for each other.

Finally, although the majority of the year represented a reasonably 'normal' year for the NHS it would be remiss not to recognise the impact the start of the COVID19 pandemic had. It marked the start of one of the most significant tragedies I have seen in my lifetime, and one of the most incredible efforts across the NHS that showed the very best of human spirit. This was of course not limited to the NHS and we could not have played our part without the contribution of so many people and organisations both who we work with regularly, and with whom we have not worked before.

Unsurprisingly much of our work in 2020/21 and beyond will be framed in what has happened to our society since the start of the pandemic. Every one of us here at HDFT would like to thank our communities across North Yorkshire and the North East for your support and kindness during this time.

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

With best wishes

Steve Russell, Chief Executive

2 PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE

2.1 PRIORITIES FOR IMPROVEMENT 2020/21

We started work to consider the priorities for improvement for 2020/21 early in 2020 but the impact of the coronavirus (COVID-19) pandemic has meant that we have had to revise our plans. We have reviewed national and local priorities for improvement, taking into account the work needed to adapt to the impact of the pandemic on the NHS and on Harrogate and District NHS Foundation Trust (HDFT). We have consulted with stakeholders within the Trust and our external stakeholders.

The proposed quality priorities for 2020/21 are:

Effective care priorities

1. To develop an integrated clinical service for inpatient unplanned care - ensuring patients see the right clinician at the right time in the right place 7 days a week;
2. To improve the responsiveness and effectiveness of our communication with external partners and our patients by delivering a paper-light system in outpatients;

Safe care priorities

3. To embed the Medical Examiner system and refresh our learning from deaths framework;
4. To ensure quality, safety and confidentiality in virtual consultations;

Patient and colleague experience priorities

5. To ensure we provide a high quality and developmentally appropriate service for our younger patients aged 13-18 years across the organisation; and
6. To enhance the service offered to our patients and colleagues with autism and autism spectrum disorders, by appointing an autism champion, embedding learning and training, and agreeing a Trust-wide approach.

These priorities reflect current performance and objectives, and have been approved by the Board of Directors. We will define specific areas of work, set indicators to be measured, targets for achievement, and will monitor progress regularly at the Quality Committee. The results of the work done will be reported in the next Quality Report.

2.2 PROGRESS AGAINST QUALITY PRIORITIES IDENTIFIED IN 2018/19 FOR REPORTING IN 2019/20 QUALITY REPORT

Each year we identify some priorities for improvement, and we report on progress in the following year's report. In the 2018/19 Quality Report, we identified the following priorities for work during 2019/20:

1. Embedding new reporting processes and the culture of learning from events, complaints and deaths;
2. Developing a sustainable model of acute care;
3. Increasing patients and the public participation in the development of services;
4. Promoting equality and reducing inequalities in access to services and information for staff and patients.

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

2.2.1 Embedding new reporting processes and the culture of learning

This quality priority started in 2017 as a two-year work stream, aiming to ensure that staff view near misses, incidents (now referred to as events), errors and complaints as opportunities to learn and improve patient safety.

The first part of the project focused on the culture and process for reporting and learning from events and near misses within the organisation. The process was redesigned so that information is captured in a more efficient and responsive way and those reporting events receive early feedback. This has resulted in more events being reported which enables reflection, learning and improvement.

The second part commenced in September 2019 and reviewed how the Trust receives, responds to, and learns from patient and public feedback about experiences.

Work stream 1: Events

What were we aiming to achieve?

The targets set at the beginning of this journey were to:

- Increase the number of events reported to the National Reporting & Learning System (NRLS). We knew from previous NHS Staff Survey results that staff do not always report all of the events they witness. The number of events reported is a proxy measure of 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;
- Achieve NRLS reporting results that compare favourably with other Trusts, particularly relating to the ratio of no and low harm events compared to moderate and above harm events;
- Maintain favourable results from the NHS Staff Survey for key findings relating to staff reporting errors, near misses or incidents (sic) witnessed, perceived fairness and effectiveness of procedures for reporting errors, near misses and incidents (sic), and staff confidence and security in reporting unsafe clinical practice.

What have we done?

Over the last year we have built on the work undertaken during 2017/18 and 2018/19 to make further positive improvements to the Datix event reporting system with the aim of improving usability for staff, and with a focus on providing feedback to those reporting events. We continue to use the 'tree of learning' visual designed by front line staff to promote the positive impact of event reporting and to represent the Trust's improved safety culture. The #ChatterMatters newsletter was produced quarterly (now on issue 8) and has showcased learning from events, learning from deaths, complaints, good practice, audits, and work around speaking up and human factors. See section 4.9 in this report for further detail on the work undertaken in relation to a fair, just and safe culture.

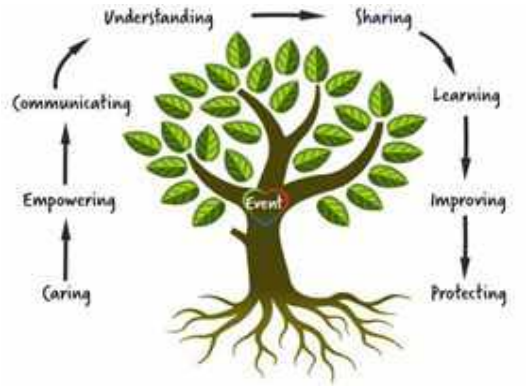


Figure 1: Image for growing our safety culture

What are the results?

We have seen an increase in the overall number of events reported on Datix since the launch of the new form in March 2019. This trend has continued into the first quarter of 2020.

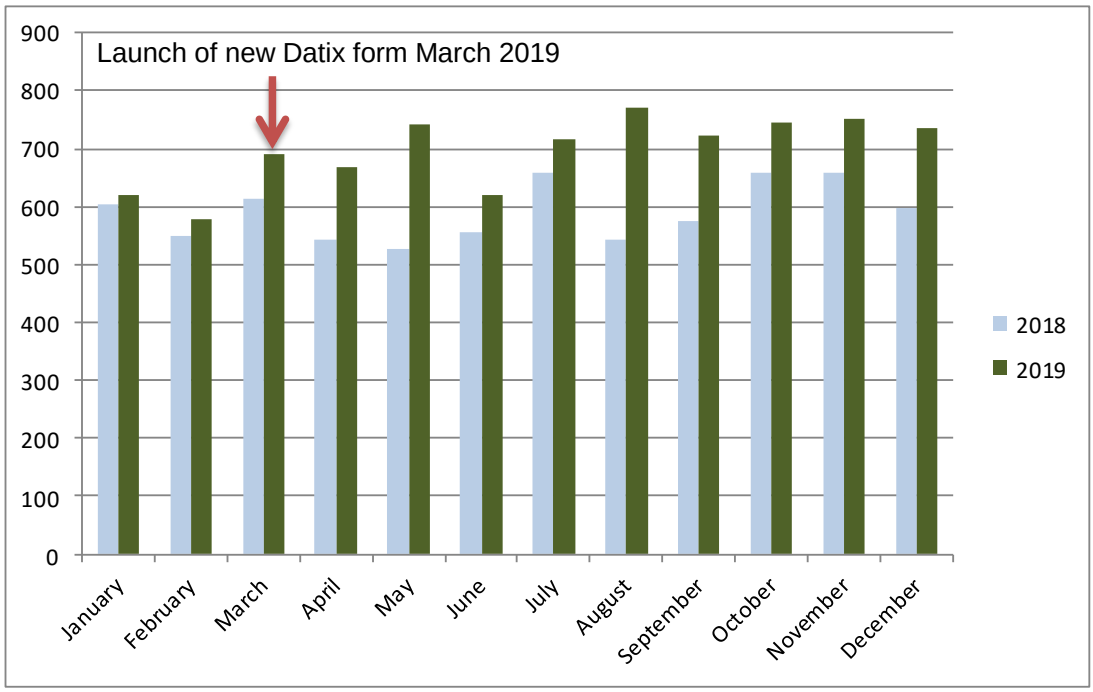


Figure 2: Number of events report on Datix in 2018 and 2019

When we started on this improvement journey, our reporting rate was in the middle 50% of other similar trusts. This has improved such that HDFT is now in the top 5% of similar trusts for reporting patient safety incidents (referred to internally as events) to the NRLS.

	Comparative reporting position*	Number of events reported in period	Event reporting rate
01/10/15 to 31/03/16	Middle 50%	2,058	39.86
01/04/16 to 30/09/16	Middle 50%	2,182	43.85
01/10/16 to 31/03/17	Top 25%	2,436	46.42
01/04/17 to 30/09/17	Top 25%	2,416	48.56
01/10/17 to 31/03/18	Top 25%	2,539	47.09
01/04/18 to 30/09/18	Top 25%	2,696	55.6
01/10/18 to 31/03/19	Top 15%	3,018	59.02
01/04/19 to 30/09/19	Top 5%	3,700	75.65

Table 1: HDFT reporting of patient safety incidents (sic) to NRLS Oct 2015 to Sept 2019
**per 1,000 bed days for acute (non-specialist) organisations*

One of the key improvements that staff asked for in the design of the new Datix form was for automatic feedback about the outcome to those who report an event. A new field was added into the form to facilitate this when the new form was launched. During 2019/20, 75% of events reported and closed contained automatic feedback to reporters in this new 'summary of investigation' field. We are continuing to promote the importance of event owners completing this field so reporters receive this feedback when the event is closed.

The data from the recently published NHS Staff Survey 2019 shows a small improvement in people feeling that they are given feedback about changes made following an event.

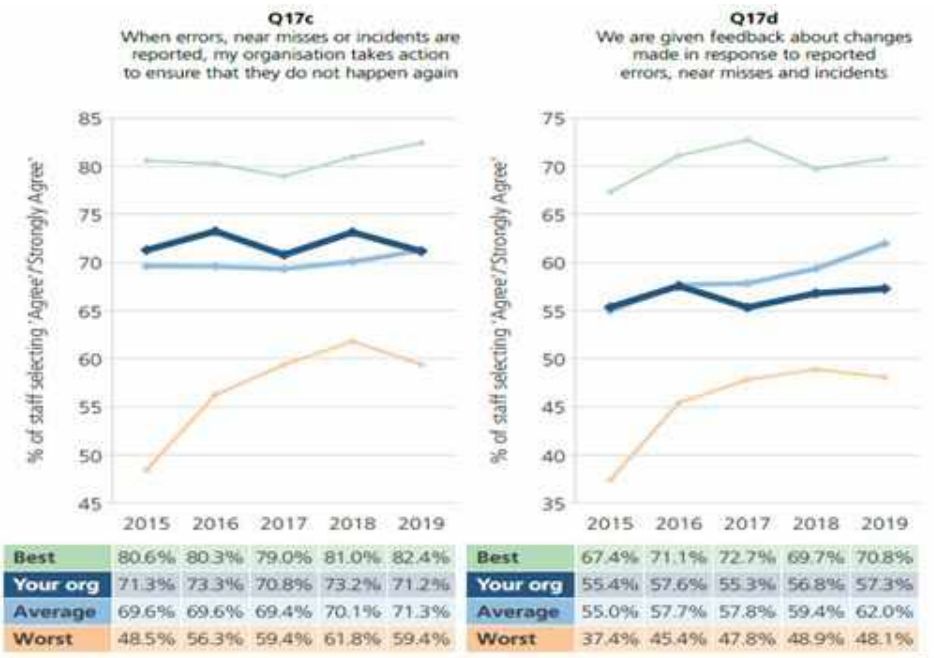


Figure 3: Results from the NHS Staff Survey 2019

Unfortunately the response to the question about whether staff feel that the organisation takes action after events are reported to ensure they do not happen again has deteriorated back to 2017 levels. We have more work to do in this crucial area.

Work stream 2: Complaints

What were we aiming to achieve?

We aimed to review our Making Experiences Count Policy and process to support the delivery of effective, efficient and robust responses to feedback that stand up to scrutiny and challenge in order to 'make experiences count'.

We wanted to improve the complaints process from notification of complaint to resolution, by engaging and invigorating all staff to optimise feedback in a positive way in order to deliver:

- Shorter lead times to resolution;
- More timely action completion;
- Robust depth and breadth in responses that stand up to scrutiny;
- Optimised flow through the process;
- Stronger performance on key metrics in the future; and
- Learning.

The targets that we agreed at the start of the project included:

- Review of the current policy, toolkit and standard model for investigation, response, identification of sustained learning, and an evaluation of the process for complainants and support for staff;
- Establishing a regular communication huddle to enable a performance monitoring snapshot report each week;
- Increasing the number of complaints investigated and resolved within the timescales set out in the Making Experiences Count Policy;
- Increasing to 100% the percentage of actions identified as a result of a complaint that are completed within the target time;
- Reducing to zero the number of re-opened complaints that require complete re-investigation;
- Devising a process to monitor complainant and colleague satisfaction with complaints.

What have we done?

A 3-day rapid process improvement workshop in September 2019 was attended by colleagues from across the organisation and members of the Patient Voice Group.

The aims and principles of our Making Experiences Count process were fully explored together with the process for investigating concerns and complaints, in order to improve the experience of patients – getting it right next time. A number of tools and methods for investigation and response were redesigned and piloted over subsequent months. The goal was to ensure complaint responses are accurate, comprehensive and written in a way that is ready to be received by the complainant straight from the Lead Investigator without the need for editing or revisions within the organisation's timeframe.

A user evaluation survey was designed and plans were made for the Patient Voice Group to seek individual feedback on the process and quality of reply. In light of COVID-19 this work will need to be reviewed.

A learning wheel was designed to illustrate the range of tools to promote learning becoming organisational wide wisdom that prevents repeat experiences and leads to improved care.

#GettingItRightNextTime

Figure 4: #GettingItRightNextTime learning wheel

What are the results?

The pilot phase of this project is yet to be completed and therefore not all results are available. Early indications show that the changes have had a positive impact and the limited data available is provided below. The restrictions and change in approach during the COVID-19 peak required a change in the Trust's approach in line with national guidance.

The response rate has improved to 57% responded to by the deadline. Whilst we recognise we are not yet achieving our key performance indicator (KPI) of 95%, the average length of delay beyond the deadline has greatly improved from 29 working days in quarter 4 (Q4) 2018/19 to ten working days in Q4 2019/20.

The goal was to achieve a standard of investigation and response that was ready to be received by the complainant when it left the lead investigator, and would not need further

revisions. At the start of the pilot only 24% of responses achieved this standard, but by March 2020 this had increased to 41%.

The percentage of cases re-opened and requiring complete re-investigation was 13% overall in 2018/19 and 4% in 2019/20. In Q4 of 2019/20, no cases required complete re-investigation. The percentage of actions completed within deadline has also improved in Q4 2019/20 to 74% from around 50% in the previous years.

COMPLAINT METRICS						
Quarter Data	18/19	19/20	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20
Total Number of formal complaints*	238	236	50	63	64	59
% responded to by deadline (target 95%**)	44%	49%	32%	57%	48%	57%
% upheld	59%	57%	58%	51%	60%	62%
Number returned for further local resolution***	31	28	8	12	6	2
Number of reopened cases requiring reinvestigation	4	1	0	1	0	0
Number of complaint actions developed	326	301	89	58	95	59
% of actions completed within deadline (target 100%)	51%	49%	49%	45%	38%	74%

* Number of complaints compared with average of complaints received in previous year. (Green if below HDFT average for 2018/19 Amber if above HDFT average for 2018/19)
** Of those deadlines reached at time of report. Target rate set in January 2016
*** Please note in Q4 we changed how we record re-opened cases. Now all cases where further contact is received are classed as reopened.

Table 2: Complaint metrics

Summary

In summary, we have made excellent strides over the last three years but there is still further work to do, specifically focusing on complaints and ensuring that cultural changes are made and embedded.

2.2.2 Developing a sustainable model of acute care

We wanted to continue work started in 2018/19 to develop a sustainable clinical model of care for acute services that would improve the quality of care and outcomes for patients. There is significant evidence to show that longer stays in hospital can lead to complications such as reduced mobility and reduced independence, particularly for frail elderly patients. There were several elements to this work.

What were we aiming to achieve, what have we done, and what are the results?

1. Increased same day assessment facilities

We focused on increasing same day assessment and treatment facilities for patients who can be treated without a hospital admission, by expanding the physical capacity and skill mix of the Combined Assessment Team (CAT). The aim was to increase the number of people seen and treated on the same day without a hospital admission.

- We continued to build improved patient pathways from the Emergency Department (ED) into ambulatory care, allowing more patients to be seen and treated on the same day.
- Construction work is under way to convert an additional area to be used by CAT.
- Surgical and medical acute assessment pathways will be combined to create a single point of entry, where a multi-specialty team will provide the initial assessment. This will release both nursing and medical time and provide senior clinical input at the appropriate time to direct the patient to the correct service.
- The service hours will be expanded to allow a longer period to meet the needs of patients and to increase the number of same day discharges.

We monitor the number of all non-elective patients who are admitted with a zero length of stay and the percentage of people with a zero length of stay compared to the total number of non-elective admissions. Zero length of stay means that the patient has been admitted to a ward or CAT after midnight (00:00) and discharged before midnight the following day (23:59). This same day emergency care is similar to the concept of day surgery, where patients are not admitted overnight for less complex surgical procedures.

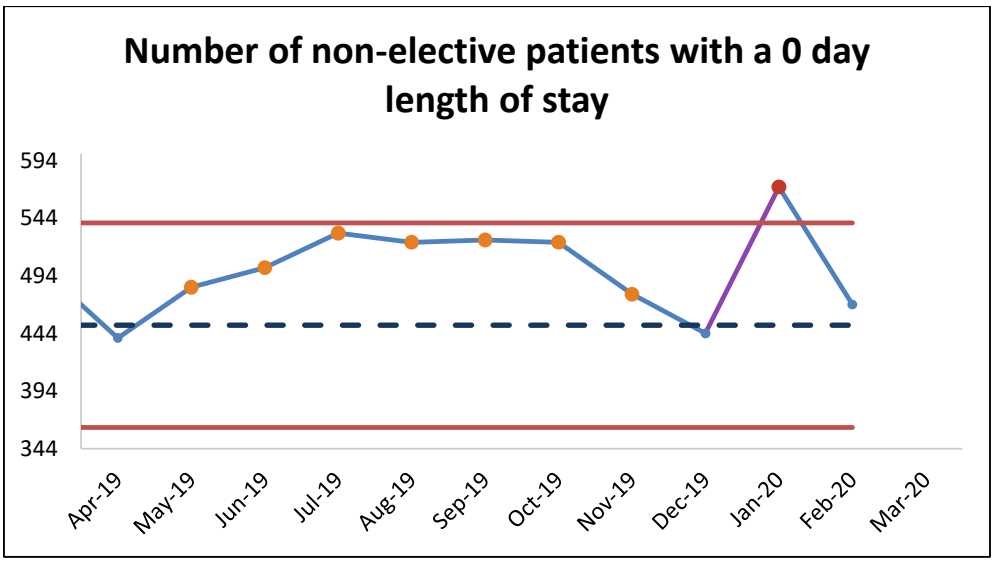


Figure 5: Total number of non-elective patients with a zero day length of stay

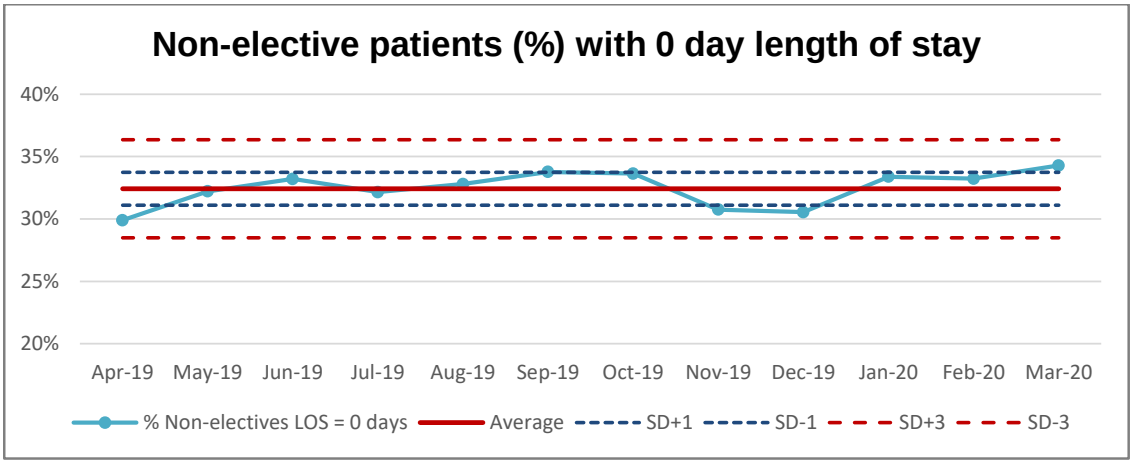


Figure 6: Percentage of non-elective patients with a zero day length of stay

During 2019/20, we saw an increase in the actual number of patients who we treated within one day. We did not see a significant change in the percentage of patients treated within one day, which may be due to the overall increase in non-elective admissions.

We also monitor the number of non-elective patients who have a short length of stay (1-3 days). We have seen this gradually increase with more people having shorter stays in hospital. During quarter 1 to quarter 3 of 2019/20 we saw a consistent number of patients with shorter stays in hospital. COVID-19 has impacted on the number of short-term patients in hospital due to waits for test results, isolation, and 14 day waits before being able to step down to non-NHS rehabilitation beds.

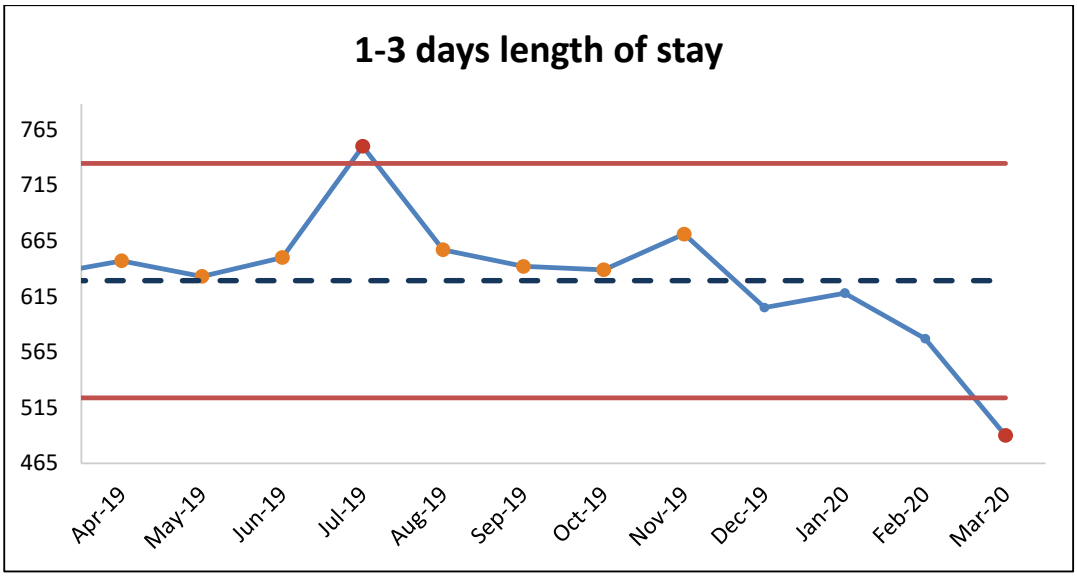


Figure 7: Number of non-elective patients with length of stays between 1 – 3 days

2. <u>A sustainable model of acute medical input for the Medical Admissions Unit (MAU) and the Combined Assessment Team (CAT)</u>

We wanted to establish additional acute medical input for the Medical Admissions Unit (MAU) and CAT. We aimed to establish additional acute physician resource and advanced care practitioners (ACPs) to support the timely assessment of acutely unwell patients presenting to hospital with medical problems. The following improvements have been undertaken:

- We have explored different models of providing additional acute medical input to best suit our population.
- Two new ACPs have completed their training making a total of four ACPs who provide clinical time to CAT and MAU.
- A nurse-led referral management process called the Acute Referral Team (ART) is now in place. This enables general practitioners (GPs) to arrange attendances and admissions with a clinically skilled individual who can direct patients to the most appropriate place for assessment and care. There are plans to develop the ART to further support admission avoidance.
- Additional consultant posts to support the expansion of the acute medicine service have been approved and the posts are currently out to advert.

The additional capacity and breadth of experience will allow us to create a more resilient service with a wider range of clinical staff to deliver care across seven days in both our inpatient and ambulatory areas. Larger numbers of clinicians will facilitate faster review times and improve compliance with the seven-day clinical standards around consultant review. See section 4.9 (Priority Clinical Standards for Seven Day Hospital Services) for more information.

3. Developing a Hospital at Night model for Harrogate to support resilience and safety

We wanted to prioritise further work on the Hospital at Night model of care, which uses a multi-professional and multi-speciality approach to delivering care at night and out of hours. We aimed to review existing overnight provision and explore a new Hospital at Night model.

A project group was established to develop a model for Hospital at Night at HDFT and has:

- Reviewed current overnight medical provision;
- Audited surgical and medical workload overnight;
- Attended junior doctor forums to understand their pressures, and approaches undertaken at other trusts;
- Agreed an approach to combine medicine and mixed surgical rotas (Urology, General Surgery, Trauma and Orthopaedics) for second year foundation level doctors (FY2) at night;
- Implemented a situational huddle at night for medical and surgical doctors, and the Clinical Site Manager.

The outbreak of COVID-19 prevented the planned trial of these initiatives, but did free up junior doctors from surgery that allowed us to establish an expanded team approach at night. This was very well received by the junior doctors who found it a more supportive way of working. As part of the Phase 2 recovery from COVID-19, we are looking at how we can retain elements of this team working when the recommencement of elective work reduces the availability of junior doctors.

4. Achieving the national target of 40% reduction in the 2017/18 baseline for the number of long-stay patients (those in hospital over 21 days)

We wanted to reduce the length of stay of patients admitted to hospital, particularly the proportion that have a long stay. We aimed to maximise the efficiencies of the recently developed discharge pathways and improve links with the emerging Harrogate and Rural Alliance work in order to reduce long stay patients. HARA brings together the NHS commissioners (who buy health services), service providers including HDFT, and North Yorkshire County Council (which has responsibility for public health and adult social care). Achievements include:

- Establishing a steering group to oversee this agenda;

- Implementation of best practice long length of stay meetings on the wards, with a multi-disciplinary team (MDT) and senior manager working with ward teams to agree plans for patients in hospital for over 20 days;
- Maximising Supported Discharge Service (SDS) capacity with a daily presence in ED to support admission avoidance. The service is also now tracking patients initially not suitable for the SDS to ensure they still go home as soon as possible once they meet the service criteria;
- Identifying areas where further improvements can be made to reduce length of stay and development of detailed action plans with suitable leads assigned.

Throughout 2019/20, we have reduced the number of patients each week staying in hospital over 20 days. We were given a 40% reduction target that equated to 50 patients. During Q1 we saw an average of 55 patients each week staying in hospital over 20 days, which was sustained throughout Q1, Q2 and Q3. The increase in Q4 was due to winter pressures on the system and the dramatic decrease from March 2020 was the impact of COVID-19 and revised discharge guidance.

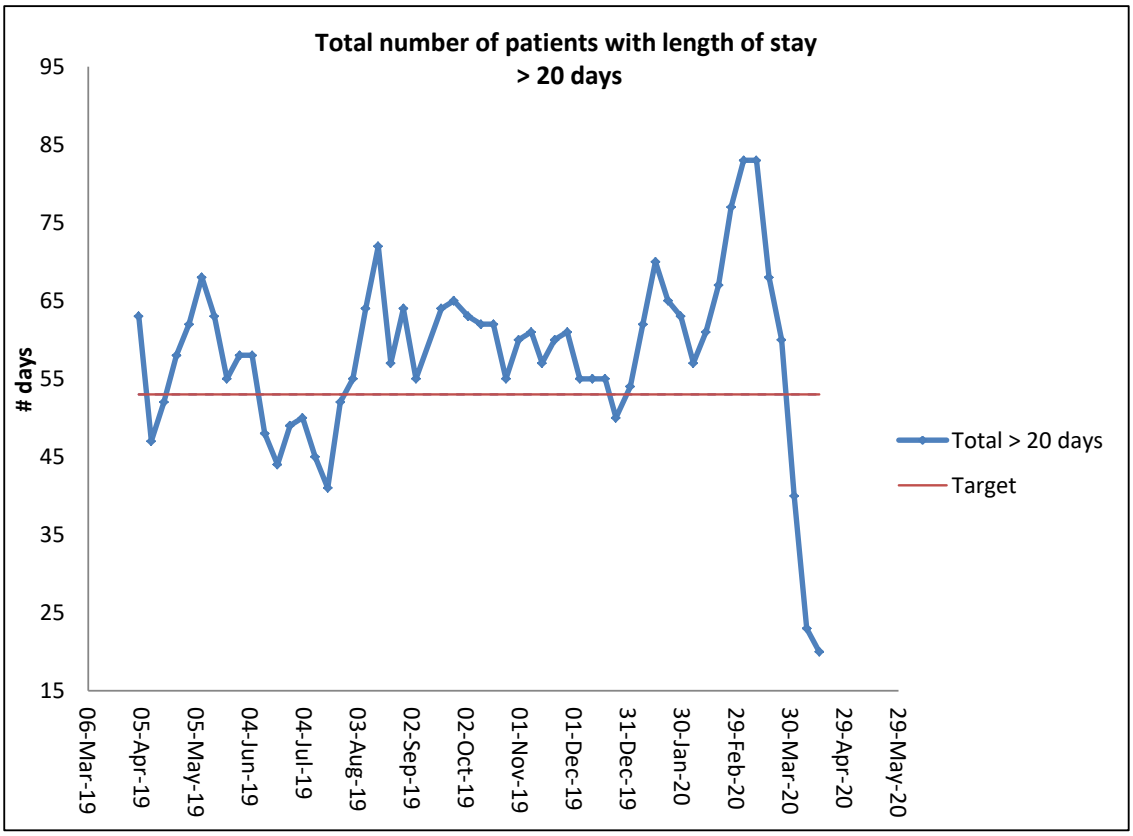


Figure 8: Total number of patients with a length of stay over 20 days

Summary

During 2019/20, progress has been made to see and treat patients more quickly once admitted to hospital, helping to improve the number of patients who are admitted with a very short length stay. Work will continue in 2020/21 to increase the number of patients seen and treated with a zero day length of stay. Improvements have been made to reduce the number of patients who have long stays in hospital and work will continue in 2020/21 to make sure our patients do not have unnecessary stays in hospital.

2.2.3 Increasing patient and public participation in service development

During 2018/19, work was undertaken to clarify what patient and public participation involves, what participation was already in place and what our expectation was for participation in the future. The Trust committed to deliver client centred services, and therefore continued with this as a quality priority into 2019/20 to ensure we develop opportunities to hear from those who use our services and in turn see how our services can use that feedback in further development.

The three clinical directorates have approached this in different ways because engaging with the public about services may be different depending on how people access services. For example how someone feedbacks on an Emergency Department may be different to how a young person discusses the service they receive from their school nurses, so the mechanisms for engagement will need to be different.

Children's and Countywide Community Care (CCCC) Directorate

The CCCC patient engagement rapid process improvement workshop (RPIW) in March 2019 was the foundation for the work on this quality priority in 2019/20 for the Directorate. A complete description of the current state of patient engagement activity across the services at that time was completed in advance of the RPIW. In summary, the objectives of that RPIW were to begin and then establish:

- Standardised approaches and a toolkit to enable consistent application of service user engagement and methods across the directorate (including data capture and analysis). This would include as part of the toolkit a component that supports services to demonstrate their response to feedback;
- A streamlined service user experience governance process to facilitate consistent engagement with the Learning from Patient Experience Group, including standardised reporting;
- A directorate-wide recognition of and response to service user feedback that is timely and effective. For example:

Figure 9: Examples of "You said, we did" from Durham 5-19 Service

Two key leads within the directorate have driven the work on patient engagement with champions in each of the services (often those who were at the RPIW). This has proved very effective in maintaining the momentum and enthusiasm generated via the RPIW.

Some exciting work was tested in the RPIW, which made use of a QR code (see left), which was added to posters. Service users who scan the code with their mobile phone will open a SurveyMonkey questionnaire and can then answer a series of questions. The questions were standardised, short and simple based on feedback from young people and SurveyMonkey would collate reports.

1. How did you hear about our service?

- ❍ We were referred by another Health Professional eg. midwife
- ❍ Social Media
- ❍ Work of mouth
- ❍ Other

2. Did the staff member introduce themselves by name?

- ❍ Yes
- ❍ No
- ❍ Unsure

3. Was your appointment with our service at a convenient time?

- ❍ Yes
- ❍ No

4. Was your appointment confidential?

- ❍ Yes
- ❍ No

5. Do you feel the service meets your expectations?

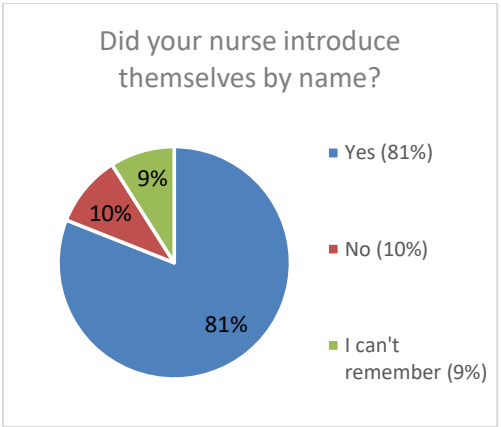
- ❍ Yes
- ❍ No
- ❍ Partially

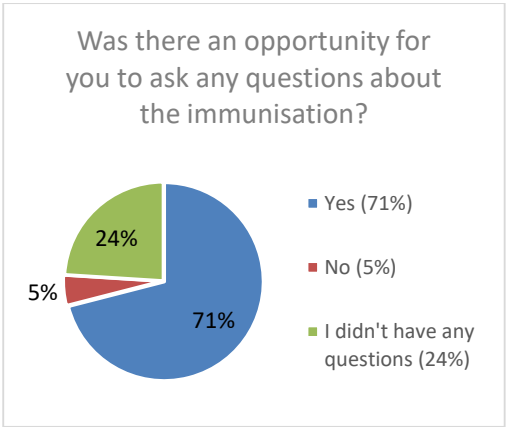
6. How would you rate the service overall?

□□□□□

Figure 10: SurveyMonkey questions and QR code

Most HDFT community teams have used this effectively in a variety of ways. For example during a rapid response by the HDFT Children's Immunisation Team to an outbreak of Hepatitis A within a school, 138 responses were captured directly from young people. See Figure 11 below.





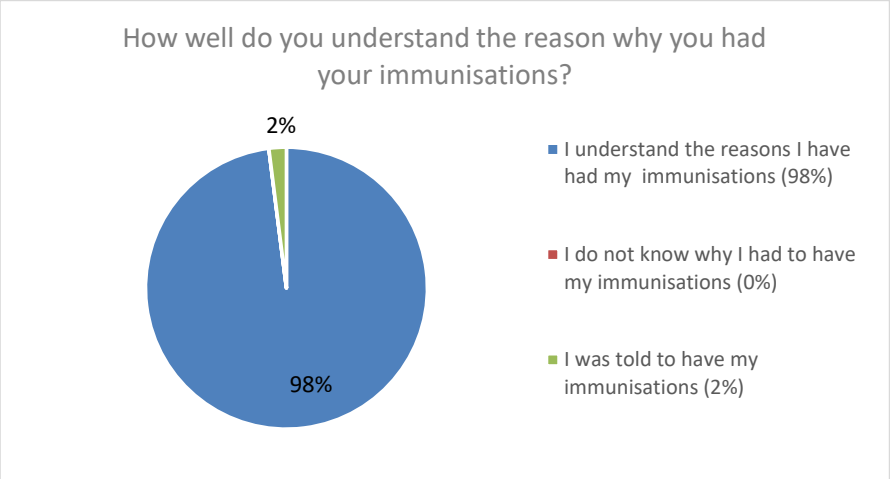


Figure 11: SurveyMonkey feedback from children and young people

This technological approach provided a high response rate from young people in what were very difficult circumstances. It showed that the service was of high quality, with a high level of satisfaction and that staff followed the Trust values. We used this feedback as part of a wider analysis for a senior meeting with Public Health England (PHE), as a learning event for rapidly mobilising immunisation services for community infection outbreaks. The Children's Immunisation Team has subsequently purchased a number of iPads, which young people can use at the time of their vaccinations to provide feedback.

It was recognised that whilst standardising engagement through technology would increase reach, detailed qualitative feedback would still be needed. The use of focus groups has been piloted in a number of the HDFT 0-19 services (services for patients and service-users aged 0 to 19 years of age) in the North East. These have proved effective particularly with groups who may struggle to access and comment on mainstream services, such as those in the youth justice system.

While much of the focus for the Directorate has been on developing the capability to engage in the community sector, we have also focused on Woodlands ward, our paediatric ward in Harrogate District Hospital, and our paediatric outpatient area. As a result of feedback from children and young people, the outpatient and acute areas have been decorated with a Woodland animal theme, transforming this space to be much more child centered.

Figure 12: New artwork in Woodlands ward.

As with the community teams, Woodlands ward has adopted a “You said, we did” approach, which they put on their service user board near the entrance to the ward.

You’re Welcome

‘You’re Welcome’ is a set of quality criteria for young people friendly health services. It provides a systematic framework to help improve the suitability, accessibility, quality and safety of health services for young people. The benefits of ‘You’re Welcome’ include:

- Enabling young people to gain a greater understanding of services, how they work and how they can utilise them more, through participation;
- Encouraging young people to engage positively with their own treatment and care, therefore improving their own health outcomes;
- Improving access for more marginalised groups by engaging with young people;
- Empowering health staff to become more inclusive, giving them the confidence to engage with young people.

We have developed an action plan to support the 0-19 service to progress ‘You’re Welcome’ quality standards for all service users.

Hopes for Healthcare

HDFT’s vision is to provide ‘Excellence Every Time’. In collaboration with young people, HDFT has developed seven standards or ‘hopes’ as a means to assess child centered services. The 0-19 service has developed an action plan to help achieve the seven standards by working in collaboration with each Local Authority where HDFT delivers 0-19 services as well as young people and other stakeholders, with the aim of improving the quality of services and to make healthcare more accessible to children and young people. The HDFT Patient Experience Working Group will facilitate and monitor progress in relation to ‘You’re Welcome’ and Hopes for Healthcare.

As we continuously seek to improve, we shall aim to:

- Promote further the use of SurveyMonkey. We hope to introduce a texting service to enable more service users to have a say in how services work and what can be improved;
- Agree a quality metric that can be used to demonstrate improved engagement about patient experience across the CCCC Directorate;
- Include a “You said, we did” page on Facebook;
- Provide regular staff updates about patient experience using a monthly newsletter;
- Encourage better use of Datix event reporting across the 0-19 service;
- Develop co-production, by encouraging young person involvement in recruitment;
- Develop Outcome Rating Scale and Child Outcome Rating Scale measures to monitor service users’ progress;
- Work more closely with Local Authority colleagues to consult with young people using Youth Forums, Young People Forums or Groups, and other events;
- Share patient experience outcomes with wider stakeholders i.e. schools, GPs, midwives, ED etc.

Long Term and Unscheduled Care Directorate

The Long Term and Unscheduled Care Directorate (LTUC) aims to involve patients and the public in the development of our services in order to ensure that any changes we make benefit service users. We aim to involve patients and the public in a variety of ways, from seeking feedback to having service user input as part of a project or working group.

During 2019/20, we have:

- Held a public consultation followed by a service user workshop to gain feedback and input into the design of Harrogate and Rural Alliance (HARA);
- Ensured service user input into the refurbishment of the mortuary viewing facilities and the phlebotomy suite;
- Worked with members of the public to shape the development of the Policy for Supporting Transgender Patients, Service Users and Staff, and in the review of the warfarin service;
- Invited a patient representative to take part in the interview process for the role of general manager within the directorate;
- Developed a role for End of Life and Cancer Volunteers to support patients, following service user feedback. Education programmes for people living with and beyond cancer have been co-produced; these sessions advise patients about the consequences of their cancer diagnosis and treatment, and provide the knowledge and confidence to self-manage and access professional support when required.

During 2019/20 we have involved service users in some of the changes and improvements to our services; we hope to build on this and develop more collaborative ways to work together.

Planned and Surgical Care Directorate

During 2019/20, the Planned and Surgical Care Directorate (PSC) aimed to introduce and embed the Patient and Public Engagement Strategy, and Hopes for Healthcare, across all services. This was achieved through patient and public engagement events as part of service reviews, and specific work to implement Hopes for Healthcare across PSC services.

Patient engagement

To build on previous work to involve people in their care and our service provision within the directorate, we undertook two patient and public engagement events as part of service reviews during 2019.

Ophthalmology outpatients

A service review of the cataract pathway was undertaken because of a number of issues. The service was short-staffed which, combined with a difficulty in recruiting staff, resulted in the service carrying a number of vacancies leading to patients' appointments and treatment being postponed. The pathway also involved four areas of one department. A patient participation event took place in March 2019 and 12 members of the public attended. The event focused on specific questions around patient experience including:

a) What went well
b) What did not go so well
c) What would you change
d) What information did you get as part of your patient journey and were there any gaps

e) Choose a word from the 'feeling wheel' to describe your experience of pre- and post-operative visits.

Areas highlighted for improvement were waiting times and delays; communication, particularly regarding timescales; more written information/leaflets; and the number of times patients have to come to the hospital for appointments. The event informed a restructuring of the cataract service to streamline and improve the patient experience. The hospital pre-assessment team now carry out the pre-operative assessment instead of ophthalmology staff; and trained staff in theatres now provide both pre- and post-operative cataract care on the day of surgery.

Following the success of the cataract service review, the directorate is now hoping to restructure the ophthalmology and optical services, which have been largely separate until now. The aim is to bring the two teams together as one, which will ensure suitable skills, better support for staff leading to improved staff morale, and a seamless service for patients.

Orthopaedic outpatients

In May 2019, we held a similar event to seek feedback from patients about their experience of attending the orthopaedic outpatient department. Ten members of the public attended. The feedback described good 'flow' from ED, decisions made quickly, and that the staff were caring and empathetic. Issues that were brought up by the participants for improvement included waiting times from referral to appointment and surgery, long waits in clinic, lack of communication especially around who to contact if there are problems, lack of space in the waiting room, an inefficient signing-in process, and lack of sufficient support services e.g. orthotics. Suggestions for change included making it easier to contact the department, simplifying the checking in procedure, a more unified process for working with orthotics and physiotherapy, more space, and a separate area for paediatric patients.

We also held a staff listening session to review the patient feedback and to gain input from staff working in the department. Staff suggested improvements including an increase in space, better chairs in the waiting room, a separate waiting area for children, a reduction in the number of over-booked clinics, ensuring sufficient staff to support nurse-led phone clinics, electronic announcements in the waiting room, and more virtual clinics.

The Matron for the Orthopaedic Outpatient Department began planning work around the physical environment in early 2020. Unfortunately, this work was paused at the start of the COVID-19 pandemic, and the department was rapidly moved into Therapy Services. Whilst this had its challenges, it has worked very well with outpatients based alongside physiotherapy and orthotics. Two consultants began virtual fracture clinic which have been well received by patients and the department will be looking to expand these in future.

We are planning a staff time-out session to explore further improvements to the service and the patient pathway, to address the learning from the public events including separate paediatric clinics, and to develop new ways of working established during COVID-19.

As a result of these events, the directorate has established three 'Change Champions' in both the ophthalmology and orthopaedic outpatient departments to initiate conversations about change within their teams, to feedback from time-out sessions and to act as a link for improvements within their area. We plan to establish Change Champions across the directorate to share ideas and provide support to those leading change within teams.

<u>Hopes for Healthcare</u>

The HDFT Children's Surgery and Anaesthetic Governance Group (CS&AGG) is leading work to improve compliance with standards for paediatric surgery and has overseen the implementation of Hopes for Healthcare in PSC. The group invited the Youth Forum to visit Main Theatres, and Day Surgery Unit (DSU) on a dedicated paediatric surgical day. Seven

members of the Forum attended a tour of DSU in November 2019. During their visit, Forum members were able to ask questions about the department, to feedback on what they saw, and make suggestions on how they would adapt the ward to create a more welcoming and overall positive experience for children and young people.

The Matron for Outpatients is progressing Hopes for Healthcare across the outpatient services that care for children and has been liaising with the Youth Forum members to arrange visits to outpatient areas. One member of the Youth Forum is to be invited to become a standing member of the CS&AGG and to attend quarterly meetings.

Each service area was to consider how it would demonstrate making a difference to services based on the feedback of young people. We were unable to complete any further planned activities due to winter pressures, the availability of the Matron and Youth Forum members, and the COVID-19 pandemic, but those involved are keen to make further progress as soon as circumstances allow and schools re-open.

Following two successful patient engagement events, the directorate will seek to carry out future service reviews following a similar process, enabling staff as well as patients and the public to have input into the design of our services. We are currently considering how we can complete the Hopes for Healthcare work in 2020/21 and plan future activity to ensure children and young people are engaged in developing our services. A new cohort of students will join the Youth Forum once schools re-open following the COVID-19 pandemic and the Matron for Outpatients will pick up the outstanding work in her area.

2.2.4 Promoting equality and reducing inequalities

All public bodies have an obligation under the Public Sector Equality Duty, a key measure of the Equality Act 2010, to promote a fairer society by tackling discrimination and providing equality of opportunity for all. It ensures the needs of all individuals are considered in shaping policy, in delivering services, and in relation to employees.

The Trust is committed to building a valued workforce which reflects the diversity of the community it serves and to ensure the needs of patients and service users are met when designing and delivering our services irrespective of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. Equality and diversity is at the heart of our organisation and it is essential to enable us to successfully fulfil our role and our duty to the patients we treat, and as an employer.

Our ongoing work in relation to equality and diversity is planned around the NHS Equality Delivery System (EDS2). This is a system that helps NHS organisations improve the services they provide for local communities and provide better working environments free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. It is structured around four goals with 18 outcomes to asses and grade against, asking the question: 'How well do people from protected groups fare compared with people overall?'

What were we aiming to achieve

The Trust equality objectives for 2018-20 are based around the following four goals:

1. Better health outcomes - to ensure that our services provide effective and safe treatment and care that is sensitive to people's personal and cultural needs, as well as appropriate to their clinical condition.
2. Improved patient access and experience - to strengthen our systems and processes to meet the requirements of the Accessible Information Standard, to continue to work with patients with learning disabilities to provide even better patient access and experience, and to introduce the Patient Participation Strategy.
3. A representative and supported workforce - to utilise the Workforce Equality Group to deliver action plans focused on improving the availability of workforce equality information to assess our progress towards ensuring we have a representative and supported workforce.
4. Inclusive leadership - to ensure that Trust leaders have the right information and skills to promote equality within and beyond the organisation and to support their staff to work in a fair, diverse, and inclusive environment.

The focus of work during 2019-20 was to:

- Ensure consistent and effective compliance with the Accessible Information Standard;
- Provide guidance and staff awareness in relation to transgender patients, service users and staff;
- Provide resources and staff awareness to support patients with hearing and visual impairment.

What have we done and what are the results?

Accessible Information

Whilst we can meet the information and communication needs of some of our patients, we continue working to achieve a consistent approach to identifying, recording, flagging, sharing and meeting the needs of patients and service users with a disability, impairment, or sensory loss.

Work has continued to progress the identification and flagging process with the development of a form for patients or carers to complete. We have established a process for entering information from the form into a 'capture and share module' that enables appointment letters to be sent out in an appropriate format for a patient's communication needs i.e. large font, braille, or by email. This module can also link the patient record to a carer record and can send appointment letters to both patient and carer in different formats if required. In addition, when an appointment letter is generated, an email alert is sent to a member of staff which contains information regarding the patient's communication needs. This additional information ensures the patient is supported appropriately during the appointment booking process and during their appointment. We have already established a Learning Disabilities flag and Certificate of Visual Impairment (CVI) flag, which are used to monitor admissions, and provide support and adjustments for patients to meet their needs whilst in hospital.

Further work is ongoing to enable a systematic capture of the information and communication needs of all relevant patients on to our electronic patient systems, in order that frontline staff are aware and can act appropriately to meet these needs.

Guidance and staff awareness in relation to transgender patients, service users and staff

We have worked with transgender patients, staff, and a local lesbian, gay, bisexual and trans (LGBT+) group to develop staff understanding and increased awareness of legislation and the issues faced by transgender people.

We have launched a Procedure Document for Supporting Transgender Patients, Service Users and Staff across the Trust and cascaded this guidance in conjunction with the launch of the NHS Rainbow Badge initiative. By choosing to wear an NHS Rainbow Badge, our staff are promoting that the Trust is an open, non-judgemental and inclusive place for people who identify as LGBT+.

Figure 13: NHS rainbow badge

We have also provided a number of dedicated training sessions for hospital based and community staff on transgender awareness and terminology. Further bespoke training is planned and guidance and support for staff is available on the Trust's intranet.

Figure 14: Quick guide to supporting transgender patients, service users and staff

Supporting patients with hearing and visual impairment

We continue to improve services for patients with hearing impairment by promoting staff training and highlighting the facilities we have available. This now includes video remote interpreting for British Sign Language and ten core languages. We have also improved the availability and use of hearing loops within the Trust.

Our Ophthalmology Advanced Nurse Practitioner has been leading the work to support inpatients with visual impairment. We have focused on:

- Supporting staff to recognise and meet the needs of patients.
    - The identification and flagging of the clinical records of people with a Certificate of Visual Impairment (CVI) has enables the automated notification of the admission of patients with visual impairment to those who can support their care, ensuring an awareness of their risk of falls in order that preventive measures can be put in place;
    - A part time Eye Clinic Liaison Officer funded by Vision Support is also providing support to patients on inpatient wards.

- Developing relevant resources and communications to increase staff awareness.
    - An intranet page has been started and some of the content prepared;
    - A visual impairment conditions information pack is in development for wards;
    - We will need to communicate the messages about supporting people with visual impairment. This will be included in the communication plan relating to the Accessible Information Standard.

- Falls prevention work.
    - A streamlined process for a bedside assessment of sight using the Royal College of Physician's bedside sight test has been progressed;
    - A revised falls assessment documentation which now includes more questions around visual impairment has been implemented;
    - A fact-finding and audit of inpatients on Jervaulx Ward has been undertaken to assess patients' needs and arrangements in place, and to work with staff.

Staff Networks

The Trust is committed to creating a fairer and more diverse workplace and can support this through the ongoing development of Staff Networks.

Staff Networks will drive the importance of an inclusive work environment where all staff are listened to, feel valued and respected, and will be key in enabling improvements in practice impacting on both staff and patient care.

We have recently launched two new Staff Networks; a Black and Minority Ethnic (BME) Staff Network, and a Lesbian, Gay, Bisexual and Transgender (LGBT+) Staff Network. Further Staff Networks are currently being developed including a Disability and Long-term Illness Staff Network.

Workforce equality and diversity data and engagement

During the year, we have continued to listen and act upon a wide range of feedback and workforce data from various sources including the Staff Survey, Staff Friends and Family Test (FFT), the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard.

We continued with the inclusion of a full census in the Staff Survey in 2019, which provides the Trust with a valuable and in-depth analysis of the results across the differing protected

characteristics and allows a greater understanding of the experience of staff across the organisation. Good practice and positive staff experience is recognised and celebrated however we continue to strive for further improvements by valuing the voice of our staff and through detailed action plans.

The Trust has now recruited an Equality, Diversity and Inclusion (EDI) Lead who will coordinate all activities relating to the EDI agenda for service delivery and workforce. The EDI Lead will support the activities of the Staff Networks, champion actions and provide feedback on progress, and engage with communities and external stakeholders to improve the experience of the diverse groups who access and work within out services.

In participating in NHS England's WRES Experts Programme, the EDI Lead will support and drive improvements in workforce race equality and embed the WRES across the organisation.

Summary

Whilst we are making progress in some areas, the Trust is ambitious to continue driving further improvements for our patients, service users and staff in relation to access to services and information. As a result, we will continue to focus on promoting equality and reducing inequalities in access to services and information for staff and patients as a key priority for 2020//21.

Equality, diversity and inclusion is at the heart of our organisation and it is essential to enable us to provide high quality care to the patients we treat, and to be an exemplary employer.

2.3 STATEMENTS OF ASSURANCE FROM THE BOARD

1. Provision of relevant health services and income

During 2019/20 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 2019/20 represents 99% of the total income generated from the provision of relevant health services by HDFT for 2019/20.

2. National and local audits

National audits

During 2019/20, 38 national clinical audits and three national confidential enquiries and clinical outcome review programmes (nine studies) covered relevant health services that HDFT provides.

During that period, HDFT participated in 95% 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 26 mandatory audit programmes on the National Clinical Audit and Patient Outcome Programme (NCAPOP), 21 of which were relevant to HDFT. The trust participated in all 21 (100%) of the programmes in which it was eligible to do so. There were also 31 non-NCAPOP audits listed, 11 of which were not relevant to HDFT. The Trust participated in 18 of the 20 which were relevant (90%).

The national clinical audits and national confidential enquiries that HDFT was eligible to participate in during 2019/20 are as follows:

1. BAUS urology audits: Female stress urinary incontinence
2. National Cardiac Audit Programme (NCAP):
    a) Myocardial Ischaemia National Audit Project (MINAP)
    b) Cardiac Rhythm Management (CRM)
    c) National Heart Failure Audit
3. Case Mix Programme - Adult Critical Care (ICNARC)
4. Child health clinical outcome review programme (NCEPOD):
    a) Long-term ventilation in children, young people and young adults
5. College of Emergency Medicine (CEM): Assessing Cognitive Impairment in Older People/Care in Emergency Departments
6. CEM: Care of Children in Emergency Departments
7. CEM: Mental Health - Care in Emergency Departments
8. Elective Surgery: National Patient Reported Outcome Measures (PROMs) programme
9. Falls & Fragility Fractures Audit Programme (FFFAP)
    a) FFFAP - National Hip Fracture Database
    b) FFFAP - National Audit of Inpatient Falls
10. Inflammatory Bowel Disease (IBD) programme
    a) IBD Service Standards

    b) IBD Biological Therapies Audit
11. Major Trauma: Trauma Audit & Research Network (TARN)
12. Mandatory surveillance of bloodstream infections and Clostridium difficile infection
13. Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)
    a) Perinatal Mortality Surveillance (reports annually)
    b) Perinatal morbidity and mortality confidential enquiries (reports alternate years)
    c) Maternal Mortality surveillance and mortality confidential enquiries (reports annually)
    d) Maternal morbidity confidential enquiries (reports annually)
14. Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
    a) Dysphagia in Parkinson's Disease
    b) In-hospital management of out-of-hospital cardiac arrest
    c) Acute bowel obstruction
    d) Long term ventilation
15. National Asthma and Chronic obstructive pulmonary disease (COPD) Audit Programme
    a) COPD Secondary Care Audit
    b) Adult Asthma
    c) Pulmonary Rehab
    d) Children and Young People Asthma Audit
16. National Audit of Breast Cancer in Older Patients (NABCOP)
17. National Audit of Cardiac Rehabilitation
18. National Audit of Care at the End of Life (NACEL)
19. National Audit of Dementia
20. National Audit of Seizure Management in Hospitals (NASH3)
21. National Audit of Seizures & Epilepsies in Children & Young People (Epilepsy 12)
22. National Cardiac Arrest Audit (NCAA)
23. National Early Inflammatory Arthritis Audit (NEIAA) -National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis
24. National Diabetes Audit (Adults)
    a) Inpatient audit – NaDIA
    b) NaDIA - Harms
    c) National core audit
    d) Diabetes Footcare Audit
    e) Pregnancy in Diabetes
25. National Emergency Laparotomy Audit (NELA)
26. National Gastro-Intestinal Audit Programme
    a) National Bowel Cancer Audit (NBOCAP)
    b) National Oesophago-gastric cancer (NAOGC)
27. National Joint Registry
28. National Lung Cancer Audit (NLCA)
29. National Maternity and Perinatal Audit (NMPA)
30. National Neonatal Audit Programme - Neonatal Intensive & Special Care (NNAP)
31. National Ophthalmology Audit
32. Diabetes (Paediatric) - NPDA
33. National Prostate Cancer Audit
34. Perioperative Quality Improvement Programme (PQIP)
35. Reducing the impact of serious infections (antimicrobial resistance and sepsis)
    a) Antibiotic Consumption
    b) Antimicrobial Stewardship
36. National Smoking Cessation Audit
37. Sentinel Stroke National Audit Programme (SSNAP)
38. Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme

39. Society for Acute Medicine's Benchmarking Audit (SAMBA)
40. Surgical site infection surveillance service
41. UK Parkinson's Audit

The national clinical audits and national confidential enquiries that HDFT participated in during 2019/20 are as follows:

1	BAUS urology audits: Female stress urinary incontinence
2	National Cardiac Audit Programme (NCAP)
3	Case Mix Programme - Adult Critical Care (ICNARC)
4	Child health clinical outcome review programme (NCEPOD)
5	CEM: Assessing Cognitive Impairment in Older People/Care in Emergency Departments
6	CEM: Care of Children in Emergency Departments
7	CEM: Mental Health - Care in Emergency Departments
8	Elective Surgery (National PROMs programme)
9	Falls & Fragility Fractures Audit Programme (FFFAP)
10	Inflammatory Bowel Disease (IBD) programme
11	Major Trauma: Trauma Audit & Research Network (TARN)
12	Mandatory surveillance of bloodstream infections and Clostridium difficile infection
13	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)
14	Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
15	National Asthma & COPD Audit Programme
16	National Audit of Breast Cancer in Older Patients (NABCOP)
17	National Audit of Cardiac Rehabilitation
18	National Audit of Care at the End of Life (NACEL)
19	National Audit of Dementia
20	National Audit of Seizures & Epilepsies in Children & Young People (Epilepsy 12)
21	National Cardiac Arrest Audit (NCAA)
22	National Early Inflammatory Arthritis Audit (NEIAA) - National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis
23	National Diabetes Audit (Adults)
24	National Emergency Laparotomy Audit (NELA) Year 5
25	National Gastro-Intestinal Audit Programme
26	National Joint Registry
27	National Lung Cancer Audit (NLCA)
28	National Maternity and Perinatal Audit (NMPA)
29	National Neonatal Audit Programme - Neonatal Intensive & Special Care (NNAP)
30	National Ophthalmology Audit
31	Diabetes (Paediatric) - NPDA
32	National Prostate Cancer Audit
33	Perioperative Quality Improvement Programme (PQIP)
34	Reducing the impact of serious infections (antimicrobial resistance and sepsis)
35	National Smoking Cessation Audit
36	Sentinel Stroke National Audit Programme (SSNAP)
37	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
38	Society for Acute Medicine's Benchmarking Audit (SAMBA)
39	Surgical site infection surveillance service

The national clinical audits and national confidential enquiries that HDFT participated in, and for which data collection was completed during 2019/20 are listed at Annex 3, alongside the

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

The reports of ten of the national clinical audits and five NCEPOD reports were reviewed during 2019/20, and HDFT intends to take the following actions to improve the quality of healthcare provided. It should be noted that HDFT also continued to review published reports from audits and enquiries undertaken in previous years.

National Maternity and Perinatal Audit (NMPA)

The NMPA uses electronic records of patient care to produce information that can inform and support the improvement of maternity and perinatal care. Although HDFT provides an obstetric and home-birth service, it does not currently provide a midwife led unit (MLU) either alongside or freestanding. The development of a business case to support the implementation of an alongside MLU is underway. The Trust is the only maternity unit within the West Yorkshire and Humber local maternity system, which does not have an electronic maternity system to ensure sharing of information. As a result of this audit the purchase of a system and the on-going costs are being considered. Improvement work is also ongoing for a Community and Continuity of Carer (CofC) model, designed to provide support to women on this pathway. Neonatal transitional care is provided on the postnatal ward, however numbers are small and there is no designated area. Suggested developments are ongoing, including changes to the Special Care Baby Unit environment such as facilities for parents to enable them to be with their babies on a longer term basis.

National Asthma and COPD Audit Programme (NACAP)

The National Asthma and COPD Audit Programme aims to improve the quality of care, services and clinical outcomes for patients with asthma (adults, children and young people) and chronic obstructive pulmonary disease (COPD). Review of this 2019 national data found that the priorities defined in previous years still stand and that further improvement is required. It is recognised that action is needed to ensure that all patients requiring non-invasive ventilation (NIV) on presentation receive it within 120 minutes of arrival for those patients who present acutely. In relation to smoking cessation and support services for patients admitted to HDFT, a pilot study is soon to be carried out where staff will be trained in very brief interventions in order to offer support and advice to smokers. There is also a Commissioning for Quality and Innovation (CQUIN) scheme looking at service provision. This will enable more patients to be supported with nicotine replacement therapy and smoking cessation advice.

National Adult Diabetes Audit

The National Diabetes Audit was developed to improve the quality of diabetes care by enabling participating NHS services and organisations to benchmark performance, identify where we are performing well and where improvements can be made. This report identified that more people with type 1 diabetes achieve target HbA1c (glycated haemoglobin) than nationally but there remains considerable scope for improvement both for insulin pump and non-pump users. Much wider access to the NHS funded blood glucose monitoring system Freestyle Libre has started to have an impact on this. Improved access to and uptake of structured education was clear; during the data collection period we had a structured education co-ordinator funded through time-limited national monies which led to the much improved offering and uptake of structured education and robust data recording. Since funding for this post has gone, we have had to make alternative arrangements for inviting people with diabetes to the appropriate structured education offering. The next round of published data will help us determine whether these new arrangements have been successful in maintaining our performance.

National Audit of Dementia

The National Audit of Dementia assesses the quality of care provided to people living with dementia when they are in hospital. Results of the 2018-2019 audit indicated that improvements were required, and as a result, various local actions were taken including a rapid process improvement workshop (RPIW) in October 2018.

The audit had indicated that improvements were required to engage with carers and help them with their role; a team was put into place to work with people with dementia and their carers to provide advice and support. Results had also highlighted issues with the collection of personal information (about the patient) from the carer or next of kin. Whilst an "All About Me" form was utilised, increased effort was required to collect information fully; in particular knowledge about recurring factors which cause distress and support, or actions which can calm a patient. The All About Me form was relaunched after the RPIW. Dementia training became mandatory at HDFT for nurses, doctors and healthcare assistants with the opportunity for e-learning available from the time of induction. Furthermore, Dementia Champions were identified at directorate and ward level with access to specialist advice seven days a week from the Acute Hospital Liaison Service. A care pathway for delirium was developed with a policy put in place to minimize the risk of bed moves for patients living with dementia. The care pathway is integrated with pathways for stroke, delirium and fractured neck of femur.

Measures were also taken to improve the number of dementia patients receiving both an occupational therapy assessment and cognitive testing using a validated tool. A delirium screening tool was developed for inclusion in the medical admissions document. Documentation of discharge planning within 24 hours of admission was found to require improvement, as well as in the recording of cognitive testing results on discharge. A single plan for discharge from hospital was therefore introduced which contains clear updated information, with support needs documented in the summary. The discharge liaison team now takes responsibility for coordinating the discharge process and plan, which is also available to the GP. If the patient lacks mental capacity around discharge planning, a best interests decision is recorded showing how this decision has been reached and any interested parties consulted. The Trust also has access to intermediate care services who will admit patients with dementia. These include Station View, a North Yorkshire County Council (NYCC) facility, and Community Intermediate Care beds in Leeds.

Local Audits

During 2019/20 as per previous years, a joint audit programme between the Clinical Effectiveness Department and Internal Audit was in place, 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 2020/21.

The reports of 153 local projects (clinical audits, service evaluations and patient surveys) were reviewed by relevant audit or governance groups at HDFT during 2019/20 and HDFT intends to take the following actions to improve the quality of healthcare provided.

Idiopathic constipation in children and young people

Estimates for the prevalence of idiopathic constipation, a type of chronic constipation that has no obvious cause, vary from 5% to 30% of children and young people depending on the criteria used for diagnosis, and are at their highest in toddlers. It is estimated that 1 in 100 children and young people aged between 11 and 18 years have idiopathic constipation. The NICE guidance on managing constipation in children and young people provides strategies based on the best available evidence to support early identification, positive diagnosis and timely, effective management. Implementation of this guidance will provide a consistent, coordinated approach and improve outcomes for children and young people.

Prior to undertaking the audit, it had been identified that the Trust was compliant with three of five relevant quality statements in the quality standard on constipation in children and young people (QS62). The aim of this audit was to look at compliance with the remaining statements:

- Quality statement 3: Children and young people with idiopathic constipation starting dis-impaction therapy have their treatment reviewed by a healthcare professional within one week.
- Quality statement 5: Children and young people with idiopathic constipation starting laxative treatment, or their parents or carers, receive written information about laxatives.

The audit demonstrated that not all children were reviewed within one week. In addition, whilst there is anecdotal evidence to suggest that written information is given, documentation of it being provided was not always achieved. Several recommendations were actioned as a result of this audit:

- ✓ A paediatric continence assessment booklet is under development which will improve documentation and aid assessment;
- ✓ It has been acknowledged that the service will continue to review children within one week when possible and the introduction of telephone follow-up has helped to improve compliance with quality statement 3;
- ✓ Additional teaching sessions have also been proposed as part of the ward study days to keep staff updated and to work with the ward link nurse to provide better communication;
- ✓ There is also a plan to ensure information leaflets are available on the intranet for clinicians to access for use with patients and families.

<u>HDFT Community Dental Infection Prevention and Control Audits</u>

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 self-audits were undertaken in 2018 to provide assurance that these national standards of infection prevention and control (IPC) were achieved throughout the 13 North Yorkshire Community Dental Clinics provided by HDFT. In 2019, a re-audit of each of the Dental Clinics was performed by the IPC Team to monitor progress in improving IPC standards. The aim of the project was to benchmark and improve the quality and effectiveness of IPC practices, and ensure that the dental clinic environment and staff comply with Infection Prevention and Control Policies designed to help prevent and take action to prevent healthcare associated infection.

The results identified good practice with infection control in the general environment, with good hand hygiene practice and suitable provision and use of personal protective equipment (PPE). However, most clinics audited showed a drop in overall compliance since the previous year's audit. The action plan focused around ensuring that:

- ✓ Infection control issues that could not be immediately addressed should be included on the department's risk register;
- ✓ Standard operating procedures were updated e.g. clinic managers to source wipe-able keyboard covers or waterproof keyboards;

- ✓ Clinic managers were encouraged to raise environmental cleaning issues with the cleaning service provider and monitor the standard of cleanliness with weekly cleaning standards audits;
- ✓ To embed improvements and training into practice the community IPC team provided local managers with a tool to enable a self-audit within six months. It is the responsibility of the clinic managers to ensure these are undertaken and documentation kept locally.

Re-audit of the nasogastric feeding tube care pathway 2019

Nasogastric (NG) feeding is a common procedure that has been used for many years to feed those unable to consume an oral diet. The majority of NG feeding tubes are placed correctly with no incident; however, there is a risk of tube misplacement and misinterpretation of x-rays which could lead to serious consequences for the patient. The National Patient Safety Agency (NPSA) and NHS England have published several patient safety alerts about this.

A cycle of audit and re-audit has been undertaken with the aim of assessing and improving practice within HDFT in relation to NG tube insertion. Following early audits and analysis, changes were made to the NG tube care pathway. However, the 2018 re-audit continued to show areas of non-compliance and results suggested that staff education rather than further revision of the documentation was required. This latest re-audit therefore assessed the degree of compliance after a period of staff education.

The results established that whilst all patients being considered for NG feeding had a care pathway initiated with the majority including a reason for NG tube insertion, there were still some issues identified with documentation. However, it was concluded that revision of the HDFT Nasogastric Feeding Tube Care Pathway in 2017 appeared to have been well received by staff and, in comparison with previous audits, documentation surrounding nasogastric tube feeding within the Trust had improved, reflecting a positive outcome regarding staff education.

There were some actions identified to prompt further improvement. Extra space on the care pathway to enable clear documentation of the staff signature was recommended. Other clinical documents that require doctors' signatures have achieved higher levels of compliance when ward clerks add a prompt on the case notes to indicate the parts of the document that need to be completed. Highlighting this to ward clerks and senior ward staff as a reminder on busy wards was proposed to increase compliance from the doctors. Staff education will continue to be an ongoing process and a further re-audit is underway for 2020.

Non-Invasive Ventilation (NIV) in the form of Bi-Level Positive Airway Pressure (BiPAP) outside the Critical Care Unit.

The British Thoracic Society guidance mandates a yearly audit of patients receiving NIV. Patients receiving NIV are high-risk patients; hospital mortality rates are high with a mortality rate of 33% nationally. Inspiring Change, the report from an NCEPOD study (2017) made a number of recommendations for practice, and this audit reviewed adherence to these. This included appropriateness of NIV prescription, timeliness of monitoring, compliance with recommended pressures, previous NIV treatment, weaning protocol compliance, and outcome. The aim was to identify whether patients who receive NIV in the form of the BiPAP outside of the Critical Care Unit are receiving a high standard of care that adheres to local policy and national guidance.

The audit results identified several areas where care for these patients was falling below expected standards. As a result, it was recommended that ward based NIV ceased with immediate effect, and consideration given to alternative models of delivery. During the

COVID-19 pandemic, patients on NIV have been managed in high dependency areas and future arrangements will be planned to ensure safe and effective care.

Audit of the usage of the Daily Dental Huddle: a service-wide review

In May 2019, the concept of a daily huddle for the Community Dental Service was introduced following a successful pilot project. A huddle is a short multidisciplinary briefing held at a predictable time and place (NHS Improvement, 2019) and has been shown to enhance communication and improve the safety, quality and coordination of patient care (Improvement Academy). The huddle received support from the service's management team and was implemented into daily practice for every clinic that delivered patient care, with a small number of staff nominated as huddle 'champions' to support implementation.

The Community Dental Service management team set the following standard and presented the audit findings at the service-wide peer review meeting in May 2019.

Criteria	Expected level of performance
For every day that a Community Dental Service clinic delivers patient care a huddle should have been performed and documented on the huddle proforma	100%

Figure 15: Community Dental Service audit criteria

The audit results demonstrated that a huddle was held on 77% of possible occasions overall. Acknowledging that the number of days of patient care varied between clinics, it was very positive that two clinics performed a huddle on every possible occasion (100%) and four other clinics achieved 90–97% compliance. It was also encouraging that a mix of staff roles had led the huddles, as inclusivity of the project was seen as fundamental to its success. Of some concern, was that three clinics results showed compliance of only 25–56%.

Actions agreed to be taken were:

- ✓ Rota coordinators to highlight huddle time on the computer system to act as a prompt and a brief intervention which may improve usage;
- ✓ Re-engagement of huddle champions to strengthen support in individual clinics;
- ✓ Staff survey to be carried out to establish perceptions of huddle value;
- ✓ Review, revision and re-audit of the huddle format to ensure that it is fit for purpose and achieving expected level of performance.

Re-audit of Completion of Consent Form 4 in Orthopaedics

Consent form 4 is an ethical and legally binding form that guides us in caring for those who cannot consent for themselves, and is often used in orthopaedics and orthogeriatrics. An audit of the satisfactory completion of consent form 4 was undertaken following a complaint received by the Trust regarding a patient taken to theatre without consideration given to whether there was a person with a registered health and welfare Lasting Power of Attorney or a Court appointed Deputy, with authority for the required decision.

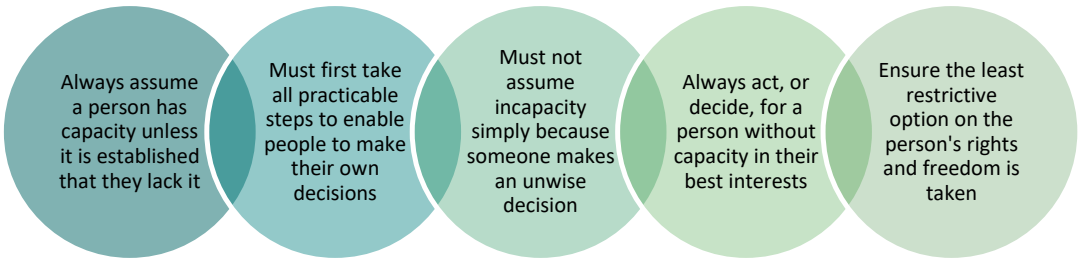


Figure 16: Based on the five principles of the Mental Capacity Act 2005

The aim of the project was to assess the satisfactory completion of the following sections of consent form 4 in patient notes:

- Section A - detailing the planned procedure;
- Section B – assessment of the patient's capacity to give or withhold consent to the procedure;
- Section D – involvement of the patient's family, carer, supporter or advocate, or attorney under a Lasting Power of Attorney or a Court Appointed Deputy.

The initial audit of 12 sets of notes took place in 2018 and the results are presented below. The findings were presented to the surgical team along with teaching on the Mental Capacity Act (MCA), correct assessment of capacity and satisfactory completion of all sections of the form. A re-audit took place in 2019, assessing a further 12 forms on the same wards, and comparing the results with those of the first audit.

Re-audit results showed a 17% improvement on the first audit regarding completion of Sections B and D. The reasoning in relation to capacity assessment was generally more detailed with better use of descriptions of patient conversations, and in some cases detailed description of injuries and cognitive state over time.

Criteria	Actual level of performance 2018	Actual level of performance 2019
Satisfactory completion of **Section A** detailing the planned procedure	100% (12)	100% (12)
Clear documentation of capacity assessment in **Section B**, with supportive reasoning in the free text box	75% (9)	92% (11)
Documented evidence in **Section D** of contact with the family, carer, supporter, advocate or attorney, or documentation of attempts to contact them if unable	58% (7)	75% (9)

Figure 17: Results of consent form 4 audit

The MCA teaching appeared to have a positive effect on the quality of capacity assessments and the understanding of the importance of family discussions. However, there are still improvements to be made in the documentation of the assessment of capacity and attempts to contact the family. The action plan is therefore focused on further teaching regarding the MCA and assessment of capacity especially for surgical registrars and other doctors in training and on designing a more user-friendly consent form 4 to be used across the Trust.

3. Participation in Clinical Research

HDFT is committed to making sure every patient has the chance to take part in research and continues a culture where an offer to participate in research is considered part of standard care. Between April 2019 and March 2020, the Trust had 172 clinical trials or studies across 23 clinical and non-clinical areas inviting suitable participants to take part. 81 clinicians supported by 38 research delivery staff led these studies. The number of patients receiving relevant health services provided or sub-contracted by HDFT in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 1303.

Research Governance and Good Clinical Practice

The research department continues to ensure that all research conducted at HDFT fully complies with Good Clinical Practice (GCP), the UK Policy Framework for Health and Social Care Research standards and the Health Research Authority approval conditions. To achieve this, the research department has established systems for quality assurance and internal monitoring for safety, data completion and compliance. Both external and internal monitoring has shown a high level of compliance with required standards. 10% of research studies were monitored using a risk-based approach and no major or critical non-conformances were found. In August 2019, independent auditors of a commercial study running in two specialties (ophthalmology and diabetes) commended our site for high quality and the high level of coordination between the two specialties. All research staff continue to achieve competence through experience, competency framework standards, GCP and the Trust mandatory training programme.

Patient and Public Involvement

It is a continuing aim of the research department to fully support and implement patient and public involvement. The Trust now has four patient research ambassadors (PRAs) bringing a patient perspective to research design and delivery. PRAs are involved in development of patient-facing research documents such as information leaflets, trial or study feasibility assessment, quality assurance via the participant survey, performance via team meetings, taking part in competency assessments for research staff and raising awareness about research opportunities. PRAs are currently working with research nurses on the VICTOR project where they are trying to explore and document the benefits that research brings to the Trust and to the local population. The annual participant survey seeks feedback from the patients who take part in research to provide information about service delivery. Findings are shared and acted upon. This feeds into a National Institute for Health Research (NIHR) survey of research participants. The recent survey has shown a high level of satisfaction with the research service that Trust provides.

Research Performance and Safety

All studies are performance managed and the Research and Innovation (R&I) Group chaired by the Medical Director, review safety monitoring. The R&I Group feeds into the Improving Patient Safety Steering Group and reports, via the Medical Director's report, to the Board. Performance metrics are also presented to the Yorkshire and Humber Clinical Research Network (YHCRN). Research publications to which HDFT has contributed are also presented to the R&I Group and distributed to the Trust community via the Communications Team.

HDFT in the wider context

Research activities also feed into and align with Department of Health and Social Care themes and aims, such as greater community based service research, collaboration with social care partners and co-morbidity self-directed care programmes. HDFT is an active

member of the YHCRN, Yorkshire and Humber Academic Health Sciences Network and Collaboration of Leadership in Applied Health Research and Care. HDFT is also an active member of Medipex ensuring that all intellectual property (research originated or not) generated by the Trust is appropriately protected, developed and exploited. The research teams have forged and continue with successful working relationships with our primary care providers (GPs, GP confederations, Clinical Commissioning Groups and third parties), to increase the opportunities for communities to be involved in health research. Our collaborations with commercial partners allow new and innovative treatments to be offered to the Harrogate and Rural District (HaRD) population. We have extensive links with local academic partners enabling research activity across our Trust services portfolio. These include the University of Leeds (acute and dental services), the Bradford Institute of Health Research (patient safety and hospital experience), the University of York (reproductive, dermatology, health visitor, podiatry and evidence-based studies), University of Sheffield (diabetes), University of Southampton and Drug Safety Research Unit and University of Newcastle (0-19 services).

Research and patient connectivity

HDFT research has a dedicated presence on social media platforms such as Facebook and Twitter. The community of users (HDFT and public) is growing and the use these mediums is proving to be an excellent method of result dissemination, recruitment to studies and increasing knowledge of the research activity of the Trust.

4. Use of the Commissioning for Quality and Innovation Framework

HDFT income in 2019/20 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because we agreed an aligned incentive contract with our commissioners. While income was not dependant on achievement, there remained a focus on driving forward changes which were most relevant to improving the quality of care for our patients.

5. Registration with the Care Quality Commission

HDFT is required to register with the Care Quality Commission and its current registration status is unconditional. HDFT has no conditions on registration. HDFT had the following sites registered during 2019/20:

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

The Care Quality Commission has not taken enforcement action against the Trust during 2019/20. HDFT has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

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

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

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

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

Figure 18: CQC ratings for HDFT March 2019. (Services inspected in 2018)*

6. Information on the Quality of Data

HDFT submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data at 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;
  - 99.9% for outpatient care;
  - 99.2% for accident and emergency care.

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

7. Information Governance

The Data Security and Protection Toolkit is an online self-assessment tool that enables organisations to measure and publish their performance against the National Data Guardian's ten data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good

data security and that personal information is handled correctly. HDFT has met all of the mandatory standards.

8. Payment by Results

HDFT was not subject to the Payment by Results clinical coding audit during 2019/20 by the Audit Commission. HDFT commissioned an external Payment by Results clinical coding audit by D&A during 2019/20, however owing to the COVID-19 outbreak had to defer the audit until later in the year. 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 2019/20, 665 of HDFT's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 177 in the first quarter;
- 139 in the second quarter;
- 177 in the third quarter;
- 172 in the fourth quarter.

By 1 April 2020, 18 case record reviews and seven investigations had been carried out in relation to 23 of these deaths. In two cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 5 in the first quarter;
- 4 in the second quarter;
- 9 in the third quarter;
- 5 in the fourth quarter.

Three, representing 0.45% 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
- 3 representing 1.7% for the third quarter
- 0 representing 0% for the fourth quarter

The three deaths judged more likely than not to have been due to problems in the care provided to the patients were recognised and investigated as serious incidents, with the outcomes reported to the family involved, the Board of Directors, commissioners, HM Coroner and the Care Quality Commission (CQC). Detailed recommendations, including changes of clinical practice and policy have been agreed and action plans produced in order

that appropriate steps are taken to address problems in care and to share learning. Discussions are ongoing as to how learning is most effectively shared across acute trusts within the integrated care system. There are an additional two cases where investigations are continuing and therefore it is yet known whether the deaths will be judged to be more likely than not to have been due to problems in the care provided.

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. For those patient deaths meeting the criteria for a detailed review of case notes, the Medical Director appoints a clinician with appropriate expertise to undertake a structured judgement review (SJR). Whenever possible, the clinician will not have been involved in the care of the patient who died. A case note review is to determine not only examples of good practice, but also whether there were any problems in the care provided to the patient who died in order to learn from what happened.

In addition to this process, during 2019/20 some specific focused reviews have been undertaken:

- The deaths of eight patients coded as dying following pathological fracture from December 2017 to November 2018 were reviewed. This identified that one patient was coded as having a cancer-related fracture and seven patients were coded as having an osteoporotic fracture. A pathological fracture is defined as a fracture through bone which is affected by an underlying disease, usually neoplasm (cancer) or osteoporosis. All cases were therefore correctly coded, and the quality of care was good or excellent in all. Whilst two patients died after discharge from hospital for unknown reasons, the deaths of the other six patients were expected.

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

- All cases of a patient with learning disabilities dying in hospital are automatically referred to the national Learning Disabilities Mortality Review (LeDeR) programme. This is the national multi-agency programme for review of death in patients with learning disabilities commissioned by NHS England. Ten patient deaths were referred during 2019/20.

Summary of learning points identified

The number of deaths in hospital that can be unequivocally shown to be truly avoidable are fortunately rare. The mortality review process however provides a rich seam of learning which, albeit not necessarily affecting outcomes, will allow us to improve end of life care for many patients. The SJRs continue to emphasise the 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. The key learning points were to:

- Improve oncology documentation and sharing of palliative care advance plans with the hospital;

- Address delays with death certification and documentation following unsuccessful resuscitation;
- Promote the need to gain collateral information and ascertain relatives' difficulties with home circumstances quicker;
- Promote clear documentation in medical records of roles and designation of clinical staff, and dates and times of entries;
- Implement the requirement for all patients returning after discharge (or self-discharge) to be seen by an ED doctor, and if being considered for direct return to a ward there must be a doctor to doctor handover prior to patient moving;
- Ensure reflection by individual staff members on any identified lack of documentation and deficiencies in clinical management;
- Highlight the importance of good medical handover, completion of investigations planned on post take ward rounds and senior review;
- Continue to promote better communication with patients about treatment escalation and resuscitation alongside an infrastructure to make it easy to share information appropriately. This has highlighted the need for dedicated staff training regarding treatment escalation and do not attempt cardiopulmonary resuscitation (DNACPR) discussion;
- Undertake an audit of patients with learning disabilities and DNACPR decisions.

The number of deaths being reviewed by SJR has reduced. It is hoped that the introduction of the Medical Examiner role during 2020 will result in more deaths being reviewed, which would provide a larger sample of cases to ensure learning.

Actions taken

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

- A poster has been developed for all wards and department to share learning from the LeDeR report and a summary communicated to all medical staff;
- Staff training clarifies that learning disabilities including autism are never an acceptable rationale for a DNACPR order, acknowledging and addressing any unconscious bias;
- Items identified from our learning from deaths processes are shared in the staff newsletter #ChatterMatters;
- An RPIW is planned this year to progress better communication with patients and their families about treatment escalation and resuscitation, and a tool to make it easy to share information with patients, colleagues at HDFT and across primary and secondary care.

The impact has been to continue to share and embed the learning identified from ongoing review of deaths, including people with learning disabilities and therefore improve patient care.

12 case record reviews and 0 investigations completed after 1 April 2019 related to deaths which took place before the start of the reporting period (during 2018/19).

One representing 0.16% 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. Three, representing 0.5% of the patient deaths during 2018/19, 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 Reports 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 publishes a value for each Trust every quarter. The national score is set at 1.000 – a Trust score significantly above 1.000 indicates higher than expected death rates, whereas a score significantly below 1.000 indicates lower than expected death rates.

	Data period							
	Jul 15 to Jun 16	Oct 15 to Sep 16	Jul 16 to Jun 17	Oct 16 to Sep 17	Jul 17 to Jun 18	Oct 17 to Sep 18	Jul 18 to Jun 19	Oct 18 to Sep 19
HDFT value	0.963	0.925	0.909	0.925	0.920	0.930	0.973	0.958
HDFT banding (2 = as expected)	2	2	2	2	2	2	2	2
National average	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Highest value for any acute trust	1.171	1.164	1.228	1.247	1.257	1.268	1.192	1.188
Lowest value for any acute trust	0.694	0.690	0.726	0.727	0.698	0.692	0.696	0.698

Table 3: Summary Hospital Level Mortality Index (SHMI)

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

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

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

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

- Actively using the Healthcare Evaluation Data tool that enables the Trust to clinically review and analyse mortality data in detail on an on-going basis. This has been rolled out across the organisation;
- Implementing the learning from deaths processes within the Trust and contributing to the national database using Datix mortality review tool. This methodology has been rolled out nationally across England and Scotland. It is an excepted methodology for case note review and in line with recommendations in National Guidance on Learning from Deaths (National Quality Board March 2017). In addition to specialty specific case note reviews, focused reviews of situation specific deaths are undertaken as required;
- Individual specialty alerts are investigated as deemed appropriate, either through the mortality review process, coding anomalies or discharge processes or a combination of these. The overall Trust SHMI remains below expected levels.

Palliative care coding

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

	Data period					
	Jul 16 to Jun 17	Oct 16 to Sep 17	Jul 17 to Jun 18	Oct 17 to Sep 18	Jul 18 to Jun 19	Oct 18 to Sep 19
HDFT value	20.4	20.3	24.6	26.2	30.9	31.1
National average	31.1	31.5	33.1	33.6	35.8	36.2
Highest value for any acute Trust	58.6	59.8	58.7	59.6	59.6	58.7
Lowest value for any acute Trust	11.2	11.5	13.4	14.3	14.6	12.0

Table 4: Palliative care coding - % of patient deaths with palliative care coded at either diagnosis or specialty level

Note - highest and lowest trust scores include all providers with data published by NHS Digital

Data source: https://www.digital.nhs.uk/SHMI

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

- Independent clinical coding audits are carried out on an annual basis by accredited clinical coding auditors to provide assurance of the accuracy of coded data;
- The data is reviewed and signed off on a quarterly basis by the Medical Director;
- This data originates from the clinical coding of specialist palliative care input by the Palliative Care Team (PCT) and is based on evidence documented in patient records;
- The PCT record all face-to-face and telephone contacts on an electronic patient system called SystmOne, whilst the clinical coders base their coding on information in the paper medical record. If there is telephone contact only, documentation in patients' paper medical records will be by the ward team, but may not always be recorded clearly as PCT input and therefore may be difficult for clinical coders to identify. Previously the Information Services team also extracted activity data from SystmOne for accurate submission of mortality data, but due to reduced capacity in the Information Services team, this did not happen for some months. This was resumed in May 2019;
- The PCT's activity data indicates that referrals to the team continue to rise year on year: they increased by 18% between 2017/18 and 2018/19, and by 3% between 2018/19 and 2019/20;
- PCT clinical nurse specialist (CNS) staffing is 0.63 whole time equivalent (WTE) per 100 beds, well below the national average (mean 3.27, median 1.02) (National Audit of Care at the End of Life 2019);
- The hospital PCT has had 1 WTE vacancy since 2018;
- For staffing reasons as above, the PCT has been unable to expand from a 5 day Monday-Friday service to offer a 7 day service. Nationally, 43% of acute hospital trusts offer a 5 day service, and 47% offer a 7 day service (National Audit of Care at the End of Life 2019);
- The use of the HDFT Care Plan for Last Days and Hours of Life is well established on adult wards. This supports ward staff to care for dying patients and in theory means that fewer patients require referral to the PCT.

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

- Making several attempts to recruit to the PCT CNS vacancies to enable a seven day service for both hospital and community services. Due to the speciality and size of the team, the requirements of the posts in terms of expertise, skills and knowledge, as well as national nursing shortages including within the specialist palliative care arena, recruitment remains an ongoing challenge. Consideration has been given to several different approaches including development posts, different banding, different roles within the team and use of resources. It is also important to note that hospital inpatient referrals to the PCT have increased by 50% from 378 in 2016/2017 when the business case for additional staffing was finalised, to 567 in 2019/20;
- Continued PCT attendance at multi-disciplinary team (MDT) meetings on Clinical Assessment Triage and Treatment (CATT), Granby, Jervaulx and Byland Wards, taking referrals and giving advice where necessary;
- Improving ease of access to the PCT, with all team members now carrying mobile phones and taking phone referrals as well as electronic, written, or posted referrals.

In addition 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

Patient Reported Outcome Measures (PROMs)

PROMs calculate the health gain after elective surgical treatment using pre- and post-operative patient surveys. Four common elective surgical procedures were included in the survey: groin hernias, hip replacements, knee replacements and varicose vein operations. However the mandatory varicose vein surgery and groin-hernia surgery national PROM collections ended on 1 October 2017. A high health gain score is good.

	Data period				
	2014/15 (final)	2015/16 (final)	2016/17 (final)	2017/18 (final)	2018/19 (final)
HDFT value	0.423	0.442	0.425	0.440	0.433
National average	0.436	0.438	0.437	0.458	0.457
Highest value for any acute Trust	0.487	0.492	0.533	0.550	0.546
Lowest value for any acute Trust	0.331	0.320	0.329	0.357	0.348

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

	Data period				
	2014/15 (final)	2015/16 (final)	2016/17 (final)	2017/18 (final)	2018/19 (final)
HDFT value	0.302	0.324	0.329	0.338	0.366
National average	0.315	0.320	0.323	0.337	0.337
Highest value for any acute Trust	0.385	0.374	0.398	0.417	0.377
Lowest value for any acute Trust	0.204	0.198	0.237	0.234	0.262

Table 6: PROMs - Knee replacement surgery - adjusted average health gains (EQ-5D index)

Data source: https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms

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

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

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

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

- Continuing to actively participate in the scheme, reviewing and analysing the results to ensure a clear understanding of the data to inform future programmes of work;
- Continuing to investigate any areas of below average health gain scores by sharing the patient-level data extract with the relevant department, in order that where there are worsening scores that this can be discussed with individual patients.

Emergency readmissions to hospital within 28 days

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

Age 16+	Data period		
	2009/10	2010/11	2011/12
HDFT value	9.19	10.02	9.96
National average	11.18	11.43	11.45
Highest value for any acute Trust	15.26	17.1	17.15
Lowest value for any acute Trust	0	0	0

Table 8: Emergency readmission to hospital within 28 days (age 16+)

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

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.

Emergency readmissions within 30 days

This data is the percentage of emergency admissions to any hospital in England occurring within 30 days of the most recent discharge from hospital, indirectly standardised with 95% confidence intervals. The published data shows the lower tier local authority data for Harrogate rather than for HDFT however this enables a comparison against average and highest / lowest values in England.

	Data period				
	2014/15	2015/16	2016/17	2017/18	2018/19
Harrogate local authority (LA)	12.0	13.0	13.6	13.6	14.1
National average	12.8	13.2	13.3	13.7	14.3
Highest value for any LA	15.4	16.5	17.1	18.1	17.8
Lowest value for any LA	10.3	9.3	10.4	10.4	11.3

Table 9: Emergency readmissions within 30 days

Data Source: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-3-helping-people-to-recover-from-episodes-of-ill-health-or-following-injury-nof/3b-emergency-readmissions-within-30-days-of-discharge-from-hospital

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

- The indicator values and confidence intervals are calculated by NHS Digital using the methodology described in the NHS Outcomes Framework specification document;
- All the data is sourced from the Hospital Episode Statistics (HES) Continuous Inpatient Spells database, which is held and managed by NHS Digital;
- The source data used for HES is taken from the Secondary Uses Service dataset; this is a national system and data quality indicators are presented in section 2.3 item 6.

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

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

3. Ensuring that people have a positive experience of care

Inpatient survey – responsiveness to patients' personal needs

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

	Data period				
	2014/15	2015/16	2016/17	2017/18	2018/19
HDFT value	72.6	73.3	72.4	68.4	71.4
National average	68.9	69.6	68.1	68.6	67.2
Highest value for any acute Trust	86.1	86.2	85.2	85.0	86.2
Lowest value for any acute Trust	59.1	58.9	60.0	60.5	54.4

Table 10: Inpatient survey results 2014/15 to 2018/19.

Data source: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4-2-responsiveness-to-inpatients-personal-needs

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

- Driving improvement for the delivery of high quality fundamental care continues to be a major priority for the Trust. We continue to monitor fundamental care standards for example in the areas of communication, nutrition, prevention of falls and pressure ulcers and infection prevention and control;
- These standards are monitored through a governance system which includes daily safety assurance checks by matrons, fundamental care audits for; pressure ulcers, falls, nutrition and fluid balance, extended senior nurse presence in the evenings and at weekends, unannounced director led inspections, patient safety visits and local quality of care teams;
- A well-established system of seeking objective feedback via external bodies and groups including the Trust's Patient Voice Group, governors and lay representatives is in place.

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

- Focusing resources on addressing those indicators which, following analysis of the 2018 result, identified areas to focus on which made the biggest impact to overall patient experience;
- See section 4.1 in this report for further detail.

National Staff Survey – Standard of Care Provided

Staff who would recommend the trust to their family or friends as a place to be treated Question 21d

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

Proportion of staff who responded "strongly agree" or "agree".	Data period				
	2015	2016	2017	2018	2019
HDFT value	78	80	76	76	76
National average	71	71	70	70	71
Highest value	89	91	89	90	90
Lowest value	45	48	48	49	41

Table 11: National staff survey results

Confirmed as comparable question to previous Q12d. Benchmark data includes both "acute trusts" and "combined acute and community trusts". Data is unweighted. Data source: http://www.nhsstaffsurveyresults.com/

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

- The Trust maintains focus on our values which hold patient care at the heart of everything we do;
- The Trust understands the clear link between employee engagement and the quality of patient care and actively works to seek feedback from colleagues on their experience of working at the Trust through the national staff survey, quarterly family and friends test and other local initiatives. Action plans are developed to improve on the areas highlighted through feedback;
- The Trust has embedded its Quality Charter which is built on the goals of setting our ambition for quality and safety, promoting staff engagement, providing assurance on care quality and supporting a positive culture. This allows staff to help suggest and deliver improvements to the services we provide as well as sharing best practice. We hold an annual Quality Conference, where staff share their ideas and learn about other initiatives to support the effective delivery of patient care.

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

- The development of a Head of Employee Experience role, to provide an increased focus on improving the daily lived experience of colleagues;
- An increased focus on employee health and wellbeing, including mental health, with the addition of an Employee Assistance Programme to provide all colleagues and their spouse/partner with access to on-line, telephone and face to face support, across a range of topics including mental health, parenting guidance and financial guidance;
- The development of a lead for Equality, Diversity and Inclusion, together with the creation of Staff Networks, including a Black and Minority Ethnic (BME) Staff Network;
- Promotion of the role of the Freedom to Speak Up Guardian within the Trust and recruiting a number of Fairness Champions across the organisation to support staff to raise concerns;
- The development and implementation of the First Line Leader programme, a three-day programme to support leaders across the Trust to develop their skills in leading individuals and teams.

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

	Data period						
	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20
HDFT value	95.9	95.4	95.5	96.9	96.7	96.2	95.5
National average	95.6	95.4	95.6	95.7	95.6	95.4	95.3
Highest value for any acute Trust	100.0	100.0	100.0	100.0	100.0	100.0	100
Lowest value for any acute Trust	75.8	68.7	54.9	74.0	69.8	71.7	71.6

Table 12: Percentage of eligible admitted patients risk assessed for VTE

Note - national values exclude independent providers.

Data source: https://improvement.nhs.uk/resources/vte/

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

- There is a well-established protocol for VTE risk assessment on admission;
- Data is recorded onto the Trust's main patient administrative system (iCS) and collected via reliable information technology (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.

Clostridium difficile rates

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

	Data period				
	2014/15	2015/16	2016/17	2017/18	2018/19
HDFT value	9	33.8	28.4	6.8	14.3
National average	15.0	14.9	13.2	13.7	12.1
Highest value for any acute Trust	62.2	66.0	82.7	91.0	79.7
Lowest value for any acute Trust	0	0	0	0	0

Table 13: C. difficile - rate per 100,000 bed days amongst patients aged 2 or over

Data source: https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data

Table 8b is used.

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

- We continued our tight monitoring of antibiotic prescribing, in particular regarding the "4 C" antibiotics, namely the cephalosporins, clindamycin, the quinolones and co-amoxiclav;

- We introduced some new hydrogen peroxide vapour (HPV) machines, and our ward hygienists were active in training and promoting good cleaning practices of the environment and equipment on the wards;
- We continued to encourage the testing for *C. difficile* of all patients with loose stool, regardless of whether the patient had an alternative explanation for having them;
- This means that patients are tested at HDFT who probably would not be tested for *C. difficile* elsewhere, but it does mean that more people who are excreting spores into the environment are identified, and the risk of transmission can then be controlled.

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

- Continuing to review the prescribing of antimicrobials. Overall, the use of antimicrobials at HDFT and in the local community is below both the regional and national average;
- Continuing to review our cleaning and decontamination strategy as the evidence for the role of the environment in the transmission of healthcare associated infection including CDI is now overwhelming;
- Continuing to provide the whole day educational "Masterclasses" for nursing staff, which includes a module on *C. difficile* and the role of the nurse. We believe that our educational drive may be partly responsible for the reduction in the number of lapses in care.

Patient safety incidents

Whilst patient safety incidents are referred to internally as events, this data looks at two measures related to patient safety incidents reported to the National Reporting and Learning System (NRLS) compared to all acute non-specialist trusts.

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

HDFT's latest published scores are below.

	Oct 18 - Mar 19			Apr 19 - Sep 19		
	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	59.02	5	0.098	75.65	8	0.164
National position (all acute trusts)	45.25	2458	0.145	48.68	2524	0.151
Highest value for any acute Trust	95.94	72	0.492	103.84	95	0.675
Lowest value for any acute Trust	16.9	1	0.007	26.29	0	0.000

Table 14: 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 events or patient safety incidents is reported by front line staff;
- There is a robust policy and process within the Trust to ensure that all events and serious incidents are identified, managed, reported and investigated in accordance with national guidance;
- The Trust ensures that there are appropriate measures in place to prevent recurrence and also promotes organisational learning;
- The Trust reports all falls resulting in fractured neck of femur as 'severe harm' following a recommendation in the National Audit of Inpatient Falls 2017, as these patients rarely recover to their full level of mobility;
- Since 1 April 2019 the Trust has reported all 'present on admission' pressure ulcers to the NRLS in line with national guidance;
- All of the severe harm and death incidents reported were robustly investigated in line with the Trust's policy and processes and actions to address the findings have been put in place.

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 events and complaints, including changes to the web based event reporting system (Datix);
- Ensuring there is a continued focus on quality at an organisational, directorate and front line level through a variety of structures, for example quality of care teams, quality governance groups at corporate and directorate level, patient safety visits, quarterly monitoring reports, case conferences and learning events.

3 REVIEW OF OTHER QUALITY PERFORMANCE

This section provides an overview of the quality of care offered by HDFT based on performance in 2019/20 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

3.1.1 Medicines Safety

Medicines continue to play a pivotal role in disease management and are the most common intervention in healthcare. Optimising medicines use is increasingly important as more people are taking more medicines in order to prevent, treat or manage illnesses or conditions. Only 16% of patients who are prescribed a new medicine take it as prescribed, have no adverse effects and report receiving as much information as they require. It follows therefore that, whilst the benefit of medicines use is well recognised, there are also risks associated with this use.

The Royal Pharmaceutical Society sets out four guiding principles for Medicines Optimisation to improve patient outcomes and it is these four principles that have formed the basis of HDFT's medicines priorities:

- Understanding the patient's experience;
- Evidence based choice of medicines;
- Medicines optimisation part of routine practice;
- Ensure medicines use is as safe as possible.

In addition, these principles underpin priorities outlined in the Board approved Hospital Pharmacy Transformation Plan.

What were we aiming to achieve?

The aim of our medicines safety strategy is to consolidate on improvements seen over previous years and continue to reduce medicines associated errors in prescribing, dispensing and administration.

This work has also built upon the actions identified as part of the Lord Carter Review of Hospital Pharmacy and Medicines Optimisation. Specifically we intended to continue to:

- Reduce the number of incorrectly prescribed medicines;
- Reduce the number of medicines not administered as intended by the prescriber;
- Reduce the number of medicines not administered at the time intended by the prescriber;
- Embed the use of the electronic prescribing and medicines administration (ePMA) system dashboard to highlight patients prescribed high-risk medicines.

What have we done?

We have a number of initiatives to use medicines safely and effectively including:

- Implementing actions as identified in the Board approved Hospital Pharmacy Transformation Plan;

- Embedding the use of dashboards to target patients on high risk medicines especially insulin and warfarin, and identify patients whose allergy status is not completed;
- Measure safe use of medicines against a range of metrics, including missed doses and event reporting rates;
- 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 events relating to medicines use.

What are the results?

Hospital Pharmacy Transformation Plan

The key elements of the HDFT Hospital Pharmacy Transformation Plan focus on:

- Increasing the number of pharmacist prescribers;
- Supporting medicines optimisation for our patients by continuing to develop the high performing, front line core clinical services.

Key achievements in this area have been:

- 75% of our frontline clinical pharmacists that have been practicing long enough to become independent prescribers are qualified and are regularly prescribing;
- Medicines reconciliation rates consistently maintained at approximately 80% within 24 hours and 94% within 48 hours.

Safer prescribing for inpatients

Levels of harm associated with prescribing errors remains low. The proportion of these errors classified as moderate harm has increased, however, low levels of reporting of no and low harm events has been recognised as an issue across many areas of Datix reporting, not just medicines. The Trust has recently developed a new reporting system in an effort to increase reporting of all incidences of this type.

Year	Levels of harm (%)		
	No and low harm	Moderate harm	Severe harm
2012/13	87	13	0
2013/14	89	11	0
2014/15	85	15	0
2015/16	88	11	1
2016/17	93	7	0
2017/18	91	9	0
2018/19	96	4	0
2019/20	86	13	0

Table 15: Level of harm associated with prescribing errors

Safe administration of medicines

Levels of harm associated with administration errors remains low. As previously mentioned, the proportion of these errors classified as moderate harm has increased, however, low reporting of no and low harm events has been recognised as an issue across many areas of Datix reporting, not just medicines. The Trust has recently developed a new reporting system in an effort to increase reporting of all incidences of this type.

Year	Levels of harm (%)		
	No and low harm	Moderate harm	Severe harm
2012/13	85	15	0
2013/14	91	7	2
2014/15	88	8	4
2015/16	88	11	1
2016/17	94	6	0
2017/18	97	3	0
2018/19	94	6	0
2019/20	90	10	0

Table 16: Level of harm associated with administration errors

Reduction in missed doses and ensuring the timeliness of medicines administration

There has been a slight increase in the medicines administrations that were delayed or missed. We undertook a piece of work to encourage a dose to be marked as delayed rather than withheld in some circumstances, in order that the dose can be given when it is available for administration. Further work will be undertaken to give clarity to the reasons for administration delays.

Year	% Delayed doses	% Missed doses
2012/13	2.6	2.99
2013/14	2.9	3.17
2014/15	2.6	2.13
2015/16	2.0	0.96
2016/17	2.0	0.83
2017/18	2.0	0.76
2018/19	2.27	0.62
2019/2020	2.46	0.72

Table 17: Medicines administration delayed or missed

Summary

The Medicines Safety Programme continues to make progress in terms of safety improvements, building upon and consolidating previous low error rates. In addition, the monitoring that is undertaken continues to identify areas for greater review and deeper analysis.

The integration of pharmacy, nursing and medical teams has allowed this continued success in relation to medicines safety. Development of prescribing and administration dashboards has facilitated targeted review of high risk prescribing as has the consistently high rates of medicines reconciliation.

Whilst these improvements have been maintained we will continue to further optimise the use of medicines at HDFT with a particular focus this coming year on capturing detailed information regarding missed and delayed doses and improving the medicines information provided to patients.

3.1.2 Falls Prevention

Falls are the most frequently reported incident affecting hospital inpatients, with 247,000 falls occurring in inpatient settings each year in England alone. Reported falls among older patients are more likely to result in some degree of harm and, where harm does occur, it is three times more likely to be “severe”. One such severe harm is hip fracture. It is the most common reason for emergency surgery and injury related death in older people.

Reducing inpatient falls and any harm they may cause is always high on our agenda as they adversely affect peoples’ quality of life and are costly. Although we can calculate the cost of care related to an increased length of stay in hospital, it is much more difficult to put a price on how much a person’s life has been changed by a fall that has diminished their level of independence and increased their risk of further falls.

The evidence regarding the best way to prevent inpatient falls is not yet conclusive. However, current best practice in the NICE clinical guideline *Falls in older people: assessing risk and prevention* (CG161) calls for an individualised multi-factorial falls risk assessment for all inpatients aged over 65 (and in those aged 50–64 who are clinically judged to be at risk) leading to interventions tailored to address identified risk factors. The following report demonstrates how we embed these guidelines into our daily practice in the Trust.

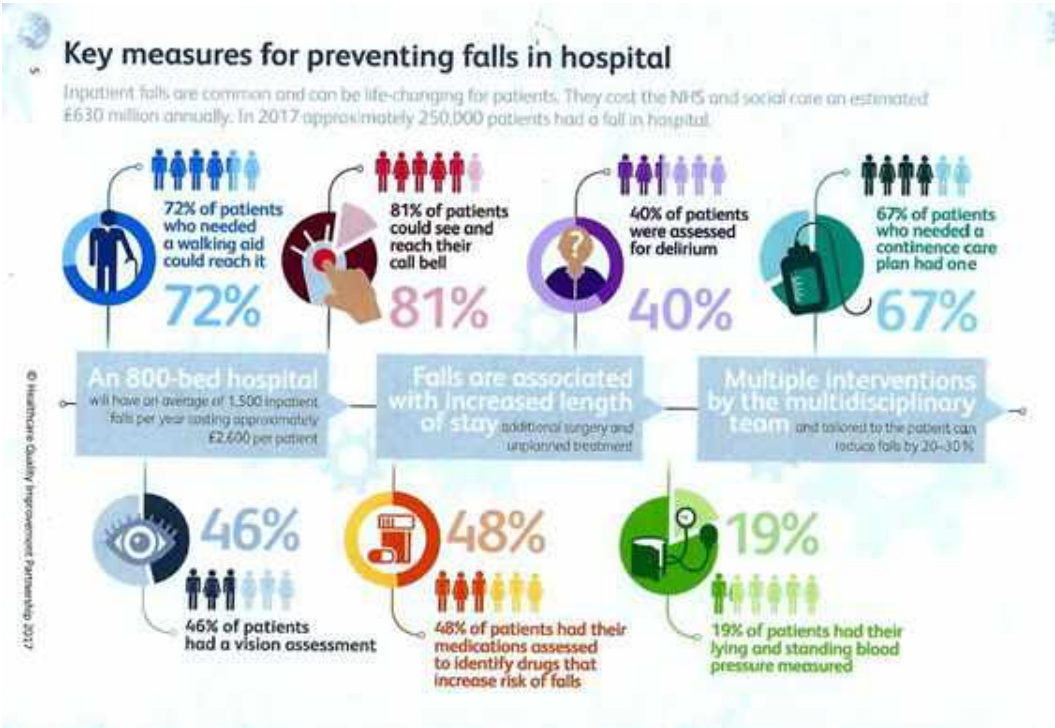


Figure 19: Key measures from preventing falls in hospital

The seven domains shown in the poster form the basis of our work and the focus of two national audits we have been involved in this year. Although the majority of inpatient falls result in no injury, a small number of falls record injuries to the head, bruises or tears to the skin, bone fractures that typically include the hand, knee, small bones of the spine and pelvis or more seriously the hip. We define these events as “no injury”, “low”, “medium” or “severe” harm. The definition of a severe harm is one causing permanent disability where the patient is unlikely to regain their former level of independence. In 2018/19, 17 patients who fell fractured a bone of which ten sustained hip fractures requiring surgery.

In 2019/20, we focused on reducing harmful falls and worked to reduce the number of people who have their lives dramatically changed because of a harmful fall in hospital and the associated costs.

What have we done?

Training

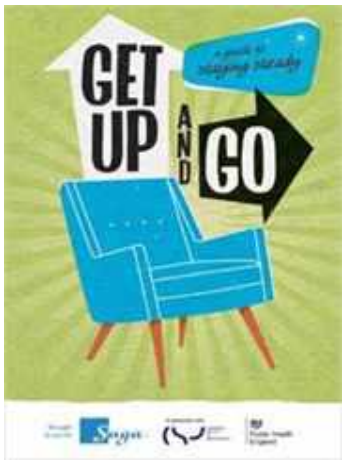
A drop in blood pressure on standing is a key risk factor for falls in older people and can be related to combinations of medications regularly prescribed. One of our Clinical Educators has developed and delivered a standardised clinical training programme, which has been instrumental in the Trust's efforts to meet audit criteria throughout the last year. Ongoing falls prevention training has been delivered as part of the induction programme for care support workers, allied health professionals, clinical and medical staff, preceptor nurse programme, associate nurses, occupational therapists, and podiatrists working in the hospital and community.

Participation in National Audits

There has been a Commissioning for Quality and Innovation (CQUIN) indicator related to preventing inpatient falls in 2019/20. This required quarterly audits of patient care around the time of admission related to the provision of walking aids, the recording of a lying and standing blood pressure and completion of a medication review. In addition, the National Audit of Inpatient Falls (NAIF) 2019/20 required data collection about inpatients who had experienced a fall with hip fracture and existing post fall protocols. The results of each of these audits will be available in the first quarter of next year when the Trust will reflect of the results and act on key recommendations.

Rapid Improvement Workshop Project: Frailty

In June 2019, three areas of work were identified at the end of this successful project:



- Falls screen pilot in the Combined Assessment Team (CAT) to identify and sign post those who require a multifactorial falls risk assessment and action plan;
- Introduction of the Rockwood Clinical Frailty Score in the Emergency Department. This is a tool used to identify a person's level of frailty "at the front door" and relates to their care plan and if they may benefit from a interventions including a comprehensive geriatric assessment;
- Introduction and distribution across the Trust of a new falls prevention information booklet "Get Up and Go" for patients and carers.

Figure 20: Get Up & Go patient information leaflet

Introduction of Post Fall Initial Assessment Documentation

The Trust investigates every inpatient fall that causes harm and concludes by providing recommendations and opportunities for learning. In response to recent findings, a new post fall document has been designed by our clinicians to ensure that all assessments, referrals and information were completed and recorded in line with NICE guidance. This was piloted and improved on two frailty wards and is now in place across the Trust following training for clinical staff.

Raising Awareness about Visual Impairment and Eye Clinic Liaison Officer Support

Our Falls Prevention Lead and Advanced Nurse Practitioner in Ophthalmology have continued to work together to raise awareness about the needs of patients with visual impairment.

This project provided an opportunity to introduce Lauren Kaptain, the Trust's new Eye Clinic Liaison Officer (ECLO) who is based at the Harrogate District Visual Support Group. Lauren is able to respond to referrals, meet with staff on wards, help them in supporting patients with a visual impairment, and enhance the inpatient experience to maximise safety and comfort. Most importantly, Lauren is able to provide a vital link between health and social care and the community to assist patients in the transition from discharge from hospital to home. Vision Support, Harrogate District funds the ECLO, and HDFT is very fortunate to benefit from this vital support for the local community and hospital services.

Figure 21: Visual impairment ward sign

"I am very grateful to Lauren; she was so kind and introduced me to talking books, helped with my menus and to eat my meals. Her visits made me feel much better about my stay in hospital and less anxious about coping with things when I go home." Patient feedback, Jervaulx Ward.

"We have recently had a couple of patients on the Supported Discharge Service caseload with significant visual impairment which is impacting on their ability to function at home and causing an increased risk of falling. We have referred them to Lauren Kaptain who has been extremely helpful in arranging to support them in their own homes. We see her work as a really useful resource to draw on in the future and have actually arranged for her to come and visit the team tomorrow to explore further how we can work together." Dr H Fishlock and Dr L Ralston, Consultants in Elderly Medicine.

Oakdale Ward's Safety Huddle

In 2018/19, we were able to report on Oakdale Ward's success in reducing inpatient falls following the introduction of a safety huddle and an Enhanced Score Risk Assessment tool. In October 2019 an invitation from the Improvement Academy to attend and participate in an Improving Patient Safety conference, was accepted by Oakdale Ward and they went on to present a poster about their safety improvement initiative.

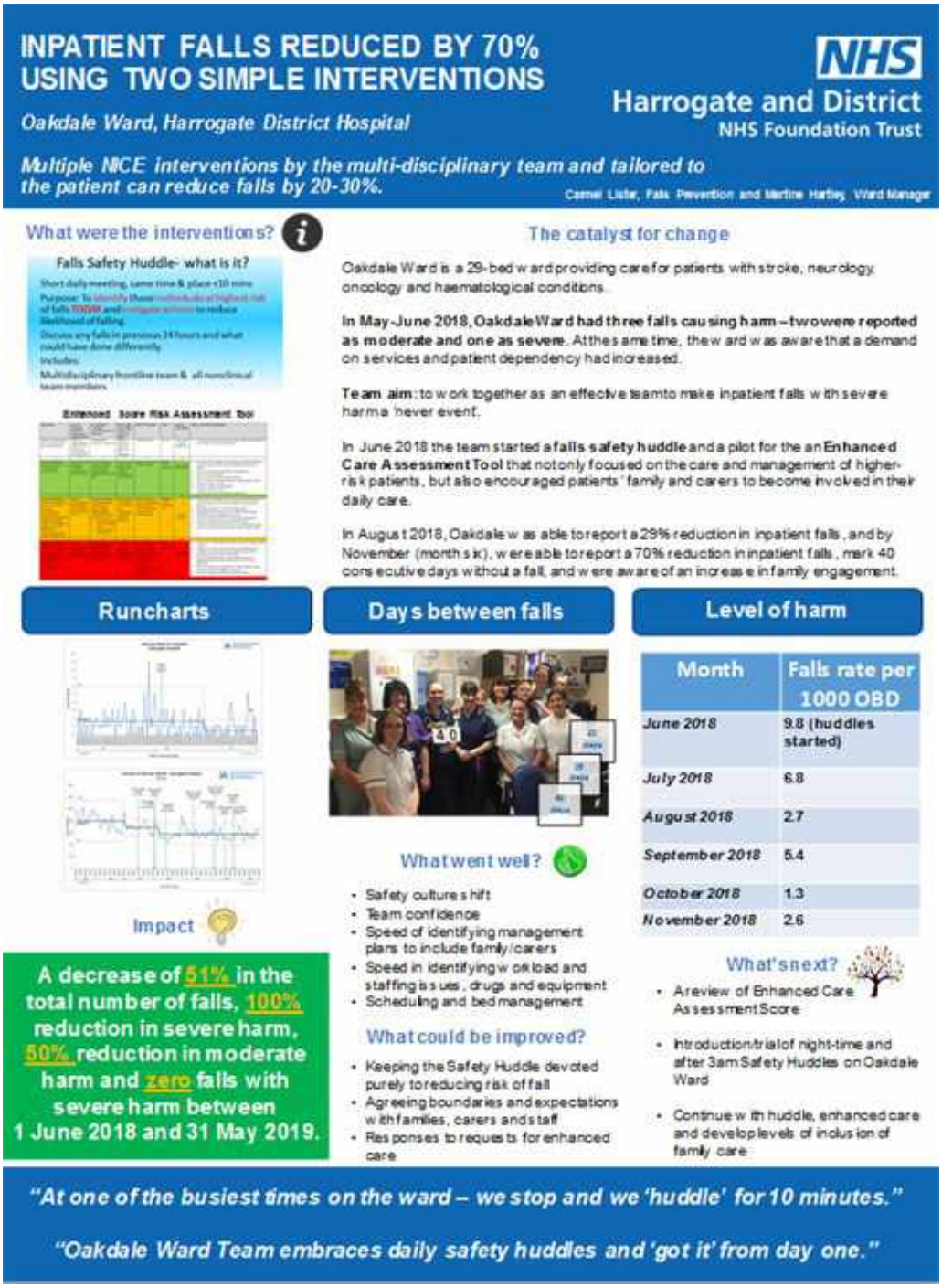


Figure 22: Poster showing impact of interventions on inpatient falls

Reducing falls in community with strength and balance training

Community links with Harrogate Borough Council continue to grow as hospital and community teams refer people to an Active Health Programme developed by the council in association with Public Health and Sport England. Ian Salvin and his team provide a successful, affordable community based schedule. The programmes include tailored small group exercise aiming to increase strength, balance and spacial awareness, all of which help to protect older people from falling.

Linking with Carers in Community
An Oral Health Conference provided an opportunity to place falls prevention and the benefits of safety huddles on the agenda of a well-attended event for carers in community in March 2019.

Developing existing relationships
A second invitation to present a Falls Prevention and Associated Medications Workshop to the Yorkshire Pharmacy Postgraduate Education Group was accepted by one of our Consultant Geriatricians and Falls Prevention Lead in June 2019.

Suspension of the Multi-Disciplinary (MDT) Falls Clinic
The MDT Falls Clinic consisted of a consultant geriatrician, advanced clinical practitioner, occupational therapist, physiotherapist and podiatrist. The clinic was suspended in October 2019, as the Trust was unable to provide support from physiotherapy and occupational therapy. Patients can now be referred for medical review to outpatient clinics for older or frail people and podiatry, and for physical and occupational assessments within their own home, and referral to the community falls team.

What are the results?

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
All inpatient falls	859	809	697	700	682	694
All inpatient falls per 1,000 bed days	7.49	7.04	6.10	6.16	6.01	6.20
Inpatient falls resulting in moderate harm, severe harm or death	36	20	15	21	19**	15*
Falls causing inpatient hip fracture (recorded since 2018/19)	-	-	-	-	10	5
Inpatient falls resulting in moderate harm, severe harm or death per 1,000 bed days	0.31	0.17	0.13	0.19	0.17	0.13
Inpatient falls resulting in fracture	17	16	14	20	17***	13

Table 18: Inpatient falls and falls with harm 2014/15-2019/20
** Two events recorded as "moderate" were not fractures.*
*** Three events recorded as "moderate or above harm" were not fractures*
**** Includes one low harm fall that resulted in a fracture*

In 2019/20 the total number of inpatient falls was 694, with a total of 13 inpatient falls resulting in fracture. Five of these patients suffered a neck of femur hip fracture. When compared to the previous year we see a 1.76% increase in the total number of falls; a decrease of 21% in the number of inpatient falls with moderate or severe harm; a 50% decrease in the number of inpatients reported with hip fracture; and a decrease of 24% in the number of inpatients who fell with a resulting fracture. However, it is useful to consider the figures reported "per 1000 bed days" as this is an indication of the rate, or frequency, of inpatient falls, and can be thought of as a measure of risk. The figures are calculated using the number of inpatient falls related to the level of bed occupancy on each ward. In 2019/20, the rate of inpatient falls increased by 0.19, but the level of inpatient falls with harm decreased by 0.04. The line graph below compares the number of falls per month with the

previous year 2018/19. It should be noted that there were four months when there were no falls of moderate or above harm in 2019/20.

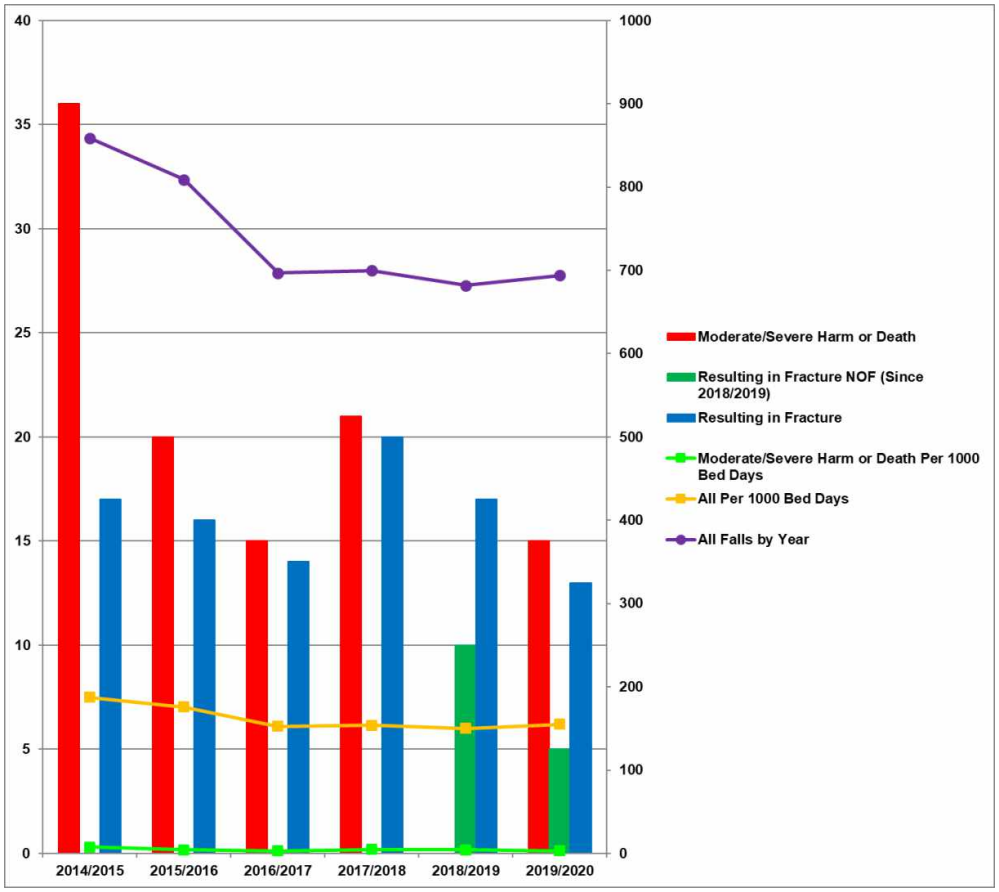


Figure 23: The rate and level of inpatient falls related to level of bed occupancy

Summary

Falls and the harm they can cause to patients in our care are always important to us. We work hard to reduce the number of inpatient falls by decreasing risks and increasing safety for every patient admitted onto our wards. In 2019/20, we have kept the patient and their individual needs at the centre of our care by maintaining daily safety huddles. The impact of introducing safety huddles in 2015/16 can be seen in Figure 23. We are confident that the work completed this year has had a positive impact in raising awareness around the needs of older and frail people and actively reducing risks to prevent predictable falls. In 2020/21, recommendations relating to the recently completed audits will involve:

- Maintaining the benefits of daily safety huddles on our wards;
- A regular review of inpatient harm and addressing any associated issues;
- Work with HaRD Commissioning Group (CCG) and partners in primary and secondary care to agree a community pathway for falls;
- Continued development of IT systems to make recording and interpreting patient information easier for staff and auditors;
- Investing in additional equipment for safe retrieval from the floor and associated staff training;
- Promoting Active Health in the hospital and community;
- Updating policies and refining documentation in line with national standards.

3.1.3 Pressure Ulcer Prevention

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 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 this focus has continued during 2019/20 through:

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

What were we aiming to achieve?

The Trust has a Pressure Ulcer Group that meets monthly. The objectives of this group are to drive continual improvement of pressure ulcer prevention, to ensure there are no omissions in care identified for pressure ulcers acquired by patients receiving either HDFT hospital or community provided care. Pressure ulcers are defined to have no omissions in care 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, four, unstageable and deep tissue injury pressure ulcers acquired by people whilst in HDFT care;
- Promote best practice in prevention and management of pressure ulcers;
- Understand if there has been any identifiable omissions in care or not when a pressure ulcer is investigated, and to learn from investigations into the root cause of pressure ulcers;
- Continue with our programme of pressure ulcer training and education for staff;
- Continue to support a “zero tolerance” approach to avoidable pressure ulcer development in people who are receiving HDFT care, which will be supported by our pressure ulcer prevention strategies including training and investigation processes.

What have we done?

There has been a continued strong focus on the reduction of omissions in care regarding pressure ulcers in 2019/20. We have revised the current root cause analysis documentation paperwork and made changes to support a new pressure ulcer learning tool which is being trialled in a specific area. Pressure ulcer RCA panels, chaired by senior nurses have been established to review the RCA investigations and identify common themes for learning. Education has also been strengthened to support this. The monthly Pressure Ulcer Group meetings ensure that initiatives and projects are regularly reviewed and that the high profile of pressure ulcer prevention within the Trust is maintained. Pressure ulcer incidence data is displayed on the Trust’s dashboards and shared through reports to our senior management teams. Our inpatient wards display data on their quality and safety boards.

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

Education and training

Training for staff has been a priority since January 2015. An e-learning package for pressure ulcer prevention was made essential annual training for all general and paediatric registered nurses and three yearly training for midwives. This was further improved in 2019 with the introduction of compulsory alternate yearly face-to-face pressure ulcer training for registered and unregistered nursing and midwifery staff and relevant allied health professionals.

The Tissue Viability Nurses and Trust Clinical Educators deliver training on skin care and pressure ulcer prevention, recognition and management in the classroom and at the bedside. The frequency of the classroom face-to-face training package has been increased to approximately twice monthly. Training has also been delivered to senior ward and community registered nurses to enable them to effectively investigate pressure ulcer events, undertake RCA and generate an action plan to address any recommendations. Further training and educational material has been provided to the clinical areas in 2019/20 to support the implementation of 'Pressure ulcers: revised definition and measurement' (NHS Improvement) from 1 April 2019.

We have worked closely with our specialist podiatry team and introduced single use red pillowcases to ensure visual prompts are in place for staff to ensure offloading, measures to reduce weight and pressure, for patients with vulnerable heels.

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

Documentation and risk assessment

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

We continue to use and monitor a pressure ulcer risk assessment tool and associated documentation within our community areas and inpatient areas. In 2019 we have extended this further for use within paediatrics with a revised pressure ulcer risk assessment tool and associated documentation suitable for this area.

What are the results?

Whilst it is disappointing that there has not been a reduction in the total number of HDFT acquired pressure ulcers in 2019/20, it must be noted that there has been increased reporting due to the additional training and earlier recognition of pressure ulcers. We are now reporting more categories than in previous years since the implementation of 'Pressure ulcers: revised definition and measurement' (NHS Improvement) from 1 April 2019, which has presented a difficulty in benchmarking this year. Despite this, there has been a lot of learning from undertaking RCA, which has informed training needs and strengthened the documentation to support care.

The pressure ulcer data presented below is reported through the HDFT event reporting system.

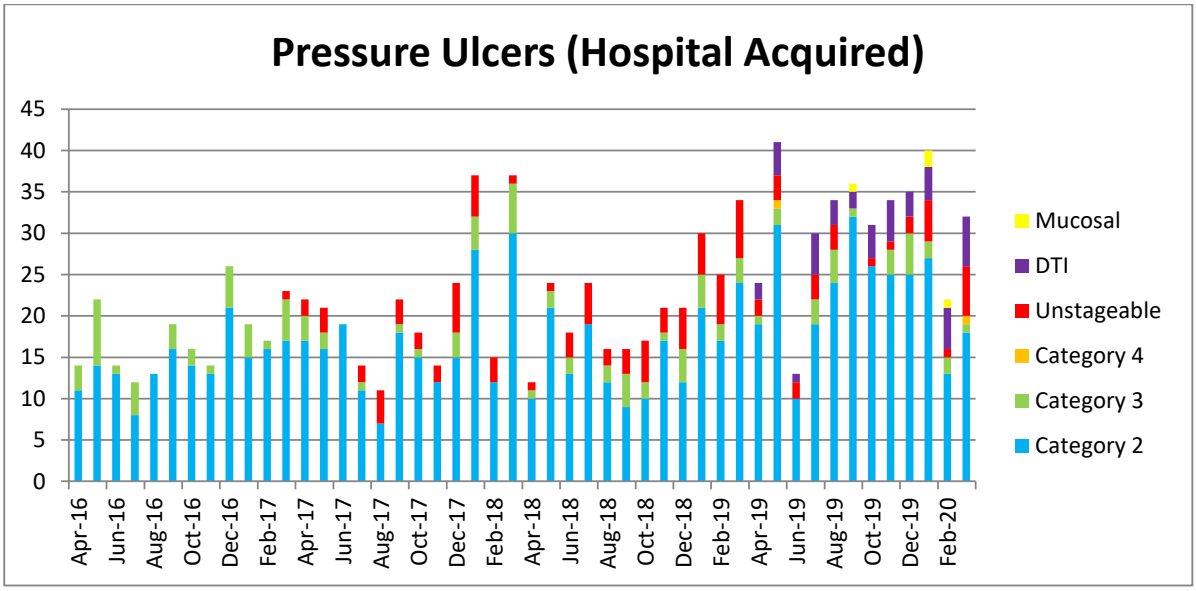


Figure 24: Hospital acquired pressure ulcers April 2016 – February 2020

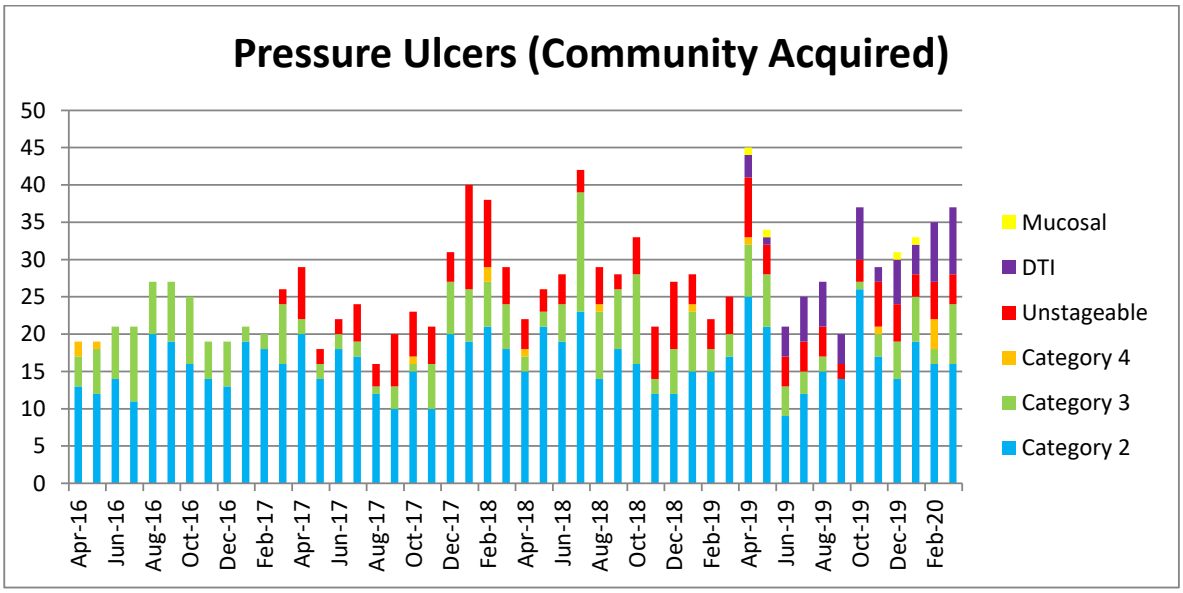


Figure 25: Community acquired pressure ulcers April 2016 – February 2020

Figures 24 and 25 demonstrate the challenges regarding hospital and community acquired pressure ulcers. We believe that the number of reported pressure ulcers is due, in part, to better and earlier identification and reporting as a result of continued education around the recognition and categorisation of pressure ulcers.

Summary

A significant amount of work has been undertaken during 2019/20. The learning through pressure ulcer panels and continued education has been strengthened. New documentation and guidance has been embedded within the community and acute settings. The monthly pressure ulcer group meetings ensure that initiatives and projects are reviewed on a monthly basis and that the high profile of pressure ulcer prevention within the Trust is maintained.

The Trust ambition is to eliminate omissions in care that result in pressure ulcer development in people who are receiving HDFT care, and we will continue to develop strategies for pressure ulcer prevention to support this. Key ambitions for 2020/21 include:

- Continuing to embed the revised pressure ulcer definitions that commenced in April 2019 and accurately benchmark reporting performance following the new pressure ulcer definitions;
- Further strengthening training and education with alternate year face-to-face training;
- Introduction of a new “Pressure Ulcer Learning Tool” for investigating pressure ulcers that are reported for patients in receipt of care;
- Continuing to learn from themes highlighted in the investigations, which will be monitored through pressure ulcer panels and guide future initiatives.

3.2 PATIENT EXPERIENCE

3.2.1 Learning Disabilities

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

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

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

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

In June 2018, NHS Improvement published the Learning Disability Improvement Standards for NHS Trusts. The standards have been developed with a number of outcomes created by people and families which clearly state what they expect from the NHS. The four standards concern:

- respecting and protecting rights;
- inclusion and engagement;
- workforce;
- learning disability services standard (aimed solely at specialist mental health trusts providing care to people with learning disabilities, or autism, or both).

The standards are intended to help organisations measure quality of service and ensure consistency across the NHS in how we approach and treat people with learning disabilities, autism or both. They are prominent in the learning disability ambitions in the NHS Long Term Plan and included in the NHS standard contract 2019/20.

What were we aiming to achieve and what have we done?

1. Continue to deliver learning disability awareness training to identified staff groups.

   The acute learning disability liaison nurse continues to deliver face-to-face learning disabilities training to relevant staff. A bespoke level 2 training package has been developed and delivered to paediatric staff, as it was felt that the standard level 2 provision was not appropriate for this staff group. The acute learning disability liaison nurse and the children's community learning disability nurses developed and delivered this training package. A learning disability knowledge audit was undertaken in 2019/20. The aim of this was to reflect on the 2018/19 knowledge audit and explore the impact that training has had on the workforce.

2. Ensure that people with learning disabilities' hospital records are flagged to support the provision of reasonable adjustments and appropriate communication support.

   We continue to promote LD flagging both internally and externally to enable the provision of appropriate support. A particular focus in 2019/20 has been on identifying patients who may access HDFT services and who reside within West Yorkshire. This has been achieved through raising awareness with local care providers and partner agencies.

3. Continue to work towards achieving compliance with the Learning Disabilities Improvement Standards.

The learning disability acute liaison nurse provides regular updates to the supporting vulnerable people group. Areas of focus in 2019/20 have been on:

a. Supporting patients with learning disabilities and their families / carers to give feedback, using principles outlined by NHS England through the Ask Listen Do project.

   Ask Listen Do was incorporated into the easy read friends and family test that is sent out following an inpatient stay to all patients whose patient record has a learning disability flag. The easy read Patient Experience Team leaflet has also been updated to include Ask Listen Do.

b. The Trust engaged with an NHS Improvement benchmarking exercise, providing organisational data and seeking the views of staff and patients.

c. Introduced in 2016, the Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England. It aims to help reduce premature mortality and health inequalities for people with learning disabilities.

Figure 26: Easy read friends and family test

We continue to notify the LeDeR programme of any deaths of any inpatients with learning disabilities or those who died in the Emergency Department, engage with the local LeDeR steering group, and share local and national learning from the LeDeR programme. In 2019/20, we notified the LeDeR programme of ten patient deaths.

The improvement standards highlight the importance of engaging and consulting with people with learning disabilities and those who support them. The learning disability acute liaison nurse attends the local self-advocates consulting group and the regional health task group, a user-led sub-group of the North Yorkshire Learning Disability Partnership Board. A member of local self-advocacy group has also been identified to attend equality and diversity stakeholder group.

What are the results?

Training

The Learning Disabilities training was launched in November 2018 and to date 2732 staff, 93% of those who need the training, have completed the level 1 e-learning package. 232 staff require the level 2 training, a three hour classroom session once over a three year programme and 142 (61%) of those staff have completed this. In addition, 27 staff members attended bespoke paediatric sessions. These were well received and Woodlands ward have requested that this training is included in their annual training programme.

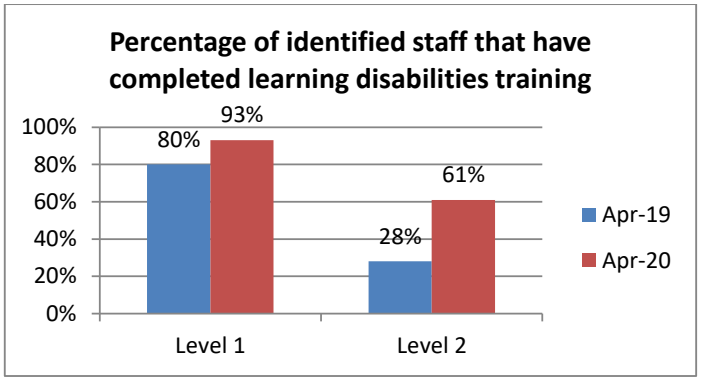


Figure 27: Percentage of identified staff that have completed learning disabilities training

An audit of staff knowledge in July 2019 demonstrated that on average staff scored their confidence in caring for patients with learning disabilities at 7.5 out of 10. 85.3% of those surveyed were aware of the acute liaison nurse and 74.7% were aware of the resources available on the learning disabilities intranet page.

Flagging of records

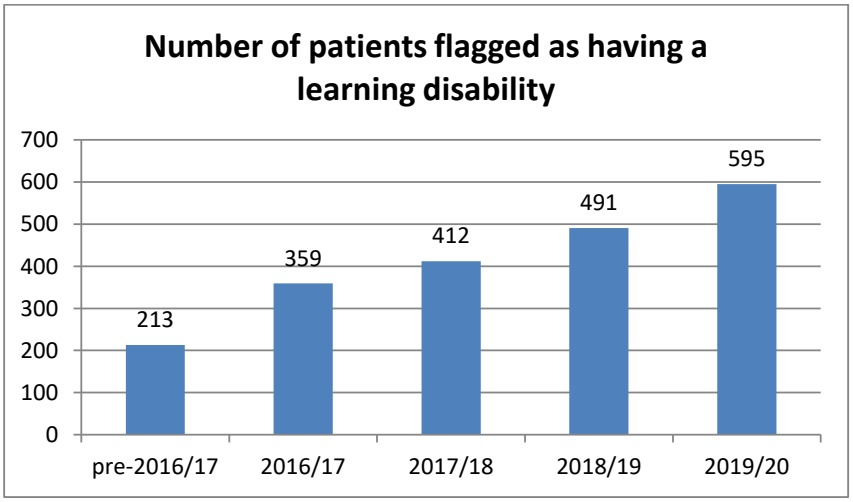
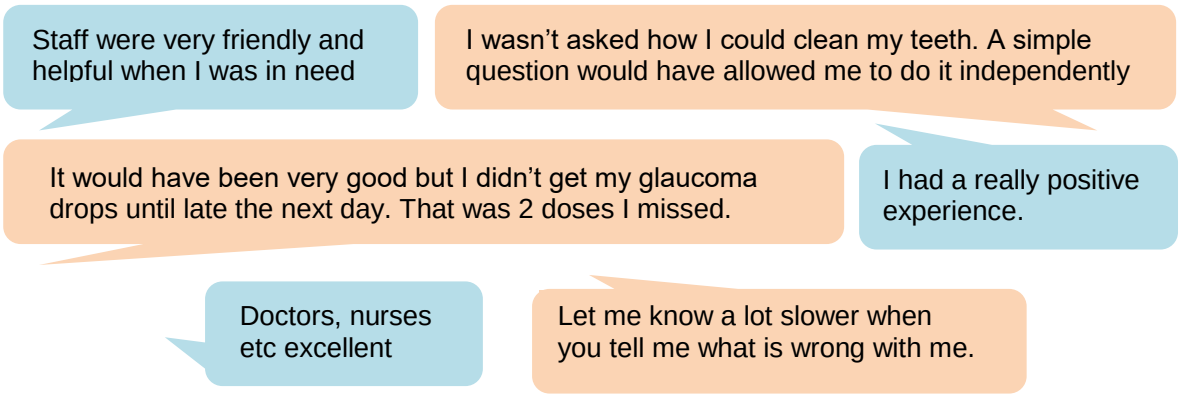


Figure 28: Number of patients flagged as having a learning disability

Prior to April 2019 there were 491 patient records flagged as having a learning disability and a further 104 LD flags have been added in 2019/20.

Learning Disabilities Improvement Standards
We have made progress with various recommendations, outlined by NHS Improvement in the Learning Disabilities Improvement Standards.

We have had a good response from the Ask Listen Do questions that have been added to the friends and family test. This feedback has been forwarded directly to the appropriate wards or departments. Comments include:



We are currently awaiting the results of the NHS Improvement benchmarking exercise. The Supporting Vulnerable People Steering Group will oversee any actions identified as a result of these outputs.

In 2019/20 the Learning Disability Mortality Review (LeDeR) Programme shared feedback regarding the care and treatment provided by the Trust in two of the reviewed cases. Learning has related to staff training and recording DNACPR decisions. Best practice was also identified, including the provision of familiar care staff, the use of hospital passports, high quality end of life care and reasonable adjustments to dental treatment.

It is expected that an HDFT representative attends 50% of the local LeDeR steering group meetings. The learning disability acute liaison nurse has attended four out of the five meetings that were held in 2019/20.
The third annual report of the LeDeR programme was published in May 2019. Key themes from the report include poor management of constipation and inappropriate recording of DNACPR forms. This has been highlighted in training and communicated to staff through link workers. An audit of patient records was undertaken to challenge any inappropriate terminology that was present on existing DNACPR forms.

A poster was developed, highlighting the key themes from the report and was displayed at the 2019 Quality Conference and distributed throughout the Trust. A summary of the report was also produced and shared with medical staff.

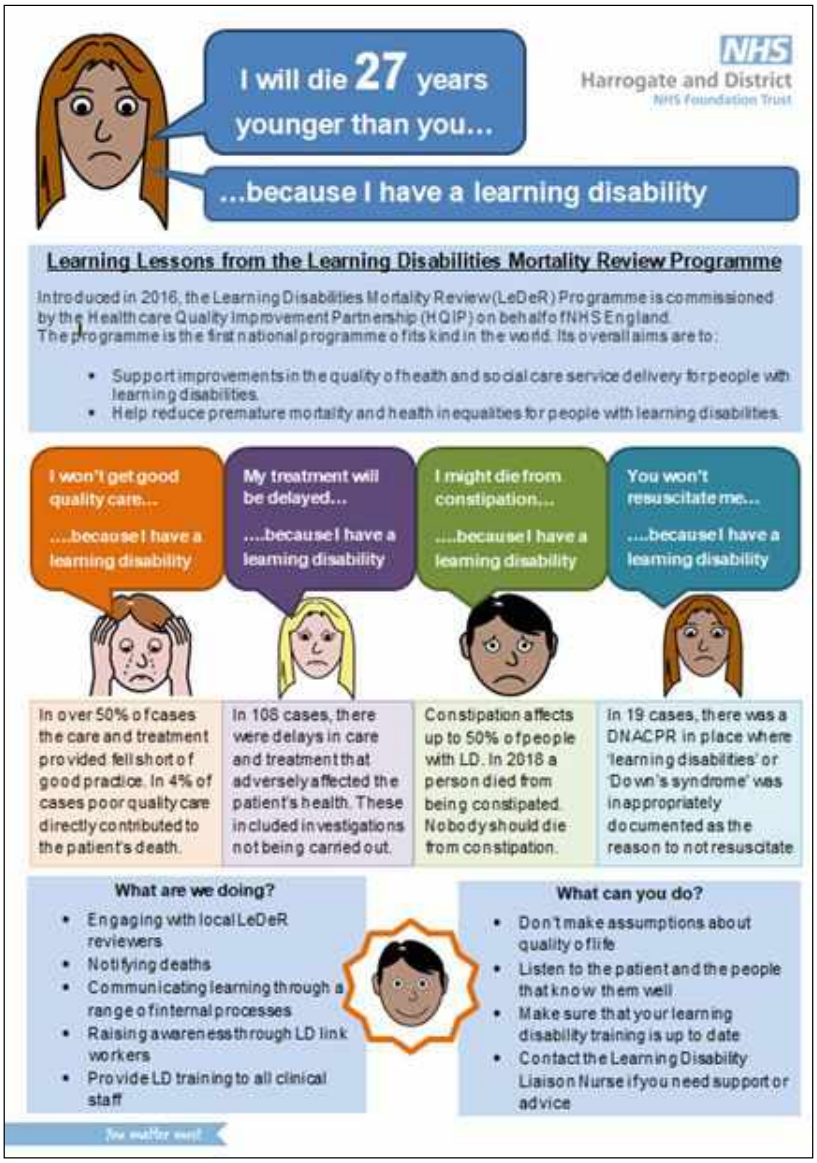


Figure 29: Learning lessons from the Learning Disabilities Mortality Review Programme

Summary

The Trust has continued to make progress with the identification and flagging of patients with learning disabilities records in order to support the provision of reasonable adjustments. The training figures continue to be reassuring and it is expected that all staff will have completed the required learning within the planned three-year period. However, the training needs analysis will need to be updated in light of the government's response to the proposed mandatory learning disability training for all health and social care providers. It is expected that learning disability and autism training will become mandatory in 2021. The Trust will need to consider how compliance with this training requirement will be achieved.

In 2020/21 we will use the Improvement Toolkit produced by NHS Improvement to assess our current performance and generate a quality improvement action plan. The Improvement Standards align the needs of people with autism with those with learning disabilities. The Trust will work towards compliance with improvement standards with regard to improving the care of patients with autism.

3.2.2 Maternity

During 2019/20, the Maternity Department has continued to work hard in maintaining safe and high quality care to women who choose to have their babies in Harrogate, and their families. We have focused on improvement in relation to some specific maternity quality objectives.

What were we aiming to achieve?

The quality objectives we set during 2018/19 were to:

- Expand the provision of the continuity of carer (CofC) model within the Maternity Department, in line with Better Births (2016), to implement a second CofC team, and work towards achieving the national trajectory of 35% of women being booked on the pathway by March 2020;
- Continue to work closely with and improve public and patient participation in service development by the Maternity Voices Partnership (MVP), in line with the Better Births, the National Maternity Safety Strategy and Maternity incentive scheme (year 2, 2019/20); and to continue to collect women's experiences of the maternity care they have received and use the results of patient feedback and national maternity surveys to further improve local services with the support of the MVP;
- Support the Prevention of Cerebral Palsy in Preterm Labour (PreCePT) programme. NICE recommends administration of magnesium sulphate in preterm deliveries to reduce substantially the risk of cerebral palsy by 30%, based on evidence in support of its brain protective potential;
- Work towards achieving full compliance with all ten safety actions within the NHS Resolution Maternity Incentive Scheme – year 2 by the summer of 2019;
- Fully implement the Professional Midwifery Advocates (PMA) model with plans to send another midwife on training in autumn 2019. 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;
- Continue to work closely in supporting the work of the West Yorkshire and Harrogate Partnership (WY&H) Local Maternity System (LMS) in delivering the LMS plan;
- Prioritise recommendations from Saving Babies Lives Care Bundle version 2 at local level to include:
  - Continuing the quality improvement as part of the National Maternal and Neonatal Safety Collaborative work agreed locally in reducing smoking rates of women and their partners by improving the smoking cessation service available to women and to continue training for all members of the multi-disciplinary team working in the maternity department;
  - Agreeing how we improve the risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction by providing additional scanning capacity for at risk women;
  - Reduction in preterm birth; and
  - Effective fetal monitoring in labour.

What have we done and what are the results?

Better Births (NHS England, 2015)
This report set out what the vision means for the planning, design and safe delivery of services; how women, babies and families will be able to get the type of care they want; and how staff will be supported to deliver such care. There are several actions included in the

report; personalised care, continuity of care, safer care, better postnatal and perinatal mental health, multi-professional working, working across boundaries and a payment system.

1. Continuity of Carer (CofC)

The report introduces the CofC model to ensure safer care based on a relationship of mutual trust and respect in line with the woman's decisions. This includes women knowing the midwives who are providing them with antenatal, intrapartum and postnatal care. Research has shown that this improves outcomes for both mothers and babies. A national target has been set for 35% of women to be on a CofC pathway by March 2020 and a further trajectory of 51% of women by March 2021.

With funding from the WY&H LMS, we appointed a project manager (band 7 midwife) in October 2018 to oversee implementation of this model at local level. HDFT have introduced two teams who are geographically based, and aligned to women from GP practices in Harrogate. Staff work rostered shifts (days and nights) providing care to women from a small number of GP practices. The first team started in mid-January 2019 and feedback received has been very positive for both women and the midwives involved. In January 2020 there were 16-22% women booked on this pathway of care.

The national trajectory is to increase to 51% by March 2021 and there is a clear plan on how this model of care for all women will be fully implemented in Harrogate and the surrounding area to achieve this trajectory. Two maternity support workers have recently been recruited to support both teams.

There is understandably some anxiety for some midwives about this change to working patterns and the need to upskill to be able to work confidently in all areas of the service. We are working closely with Human Resources and the unions in supporting midwives through this transition.

2. Harrogate Maternity Voices Partnership

The Maternity Voices Partnership (MVP) is an NHS working group: a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care. We established a small group in November 2018, there is an appointed chairperson who has had the opportunity to attend meetings to network with other MVPs in the region. Regular meetings have been held at a local children's centre. The group has agreed terms of reference and have completed user feedback exercises, undertaken the "15 Steps Challenge" in all areas of the department and planned events to gain feedback from recent users of the service.

This small group of women are really enthusiastic and although the feedback from women and their families has been predominantly very positive, they are genuinely very interested in being involved in making any improvements to the service. We are pleased to be working collaboratively with local women with the aim of improving maternity services further and we hope that the group will continue to develop and attendance at meetings to grow. An annual report is in progress describing the journey of the Harrogate MVP and the achievements it has made during this first year.

<u>Unicef Baby Friendly reaccreditation</u>

The Maternity Department has maintained United Nations International Children's Fund (UNICEF) UK Baby Friendly accreditation 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

Figure 30: UNICEF accreditation

over time.

The Special Care Baby Unit (SCBU) has been accredited in January 2020 and achieved the gold award with support from the Maternity Department. Harrogate is the first hospital to have achieved the gold award in both maternity and neonatal services.

Prevention of Cerebral Palsy in Preterm Labour

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

NICE recommends administration of magnesium sulphate in preterm deliveries to reduce the risk of cerebral palsy by 30%, based on evidence in support of its brain protective potential. The West Yorkshire and Harrogate (WY&H) Local Maternity System (LMS) has supported the secondment of a midwife for PreCePT across the LMS, which was extended to March 2020. This midwife has a substantive contract with Harrogate, providing the midwife with an opportunity to work within the WY&H LMS, ensuring compliance and consistency. As a result of the success of this post and the increase in hours allocated to work with all units within the WY&H LMS, the compliance of administration of magnesium sulphate to women has improved substantially in the last few months.

Advocating for Education and Quality Improvement

After the removal of statutory supervision in March 2017, the new model Advocating for Education and Quality Improvement (AEQUIP) was implemented with the introduction of Professional Midwifery Advocates (PMAs) to replace the role of Supervisors of Midwives (SOMs). This employer-led model includes a continuous improvement process that builds personal and professional resilience, enhances quality of care for women and their babies, and supports preparedness for appraisal and professional revalidation.

Within the Maternity Department, there are four PMAs and a further two midwives currently attending the extended course. The model is not fully embedded in the Maternity Department due to a lack of time available to allocate to the role. However, there is now a PMA session on mandatory training to increase staff understanding of this model and the benefits in clinical practice and the feedback from staff has been positive. The focus in 2020 will be to engage with midwives on the quality improvement aspect of the AEQUIP model.

National CQC Maternity Survey 2019

The CQC maternity satisfaction survey is now an annual survey of women's experiences of maternity care. A standard survey methodology is used and reflects the priorities and concerns of women using maternity services. Women were eligible for the survey if they had a live birth during January and February 2019, were aged 16 years or older, who gave birth in hospital or at home. Postal questionnaires were sent to women between April and August 2019. The survey questions include the whole pregnancy journey from the first booking appointment, to discharge from the community midwife after delivery, to the health visitor. Women are asked to answer 74 questions about their care, and results are compared with all other trusts in England.

The report received in January 2020 was positive. Please see section 4.1 in this report for the detailed results of National Patient Surveys. Maternity Department is in the process of looking at the areas that we feel could be improved and this will be incorporated in an action plan that will be monitored by the Maternity Services Forum.

Saving Babies Lives care bundle

This document provides detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice: reducing smoking in pregnancy, risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction, raising awareness of reduced fetal movements, effective fetal monitoring in labour and reducing pre-term birth.

Reducing smoking in pregnancy

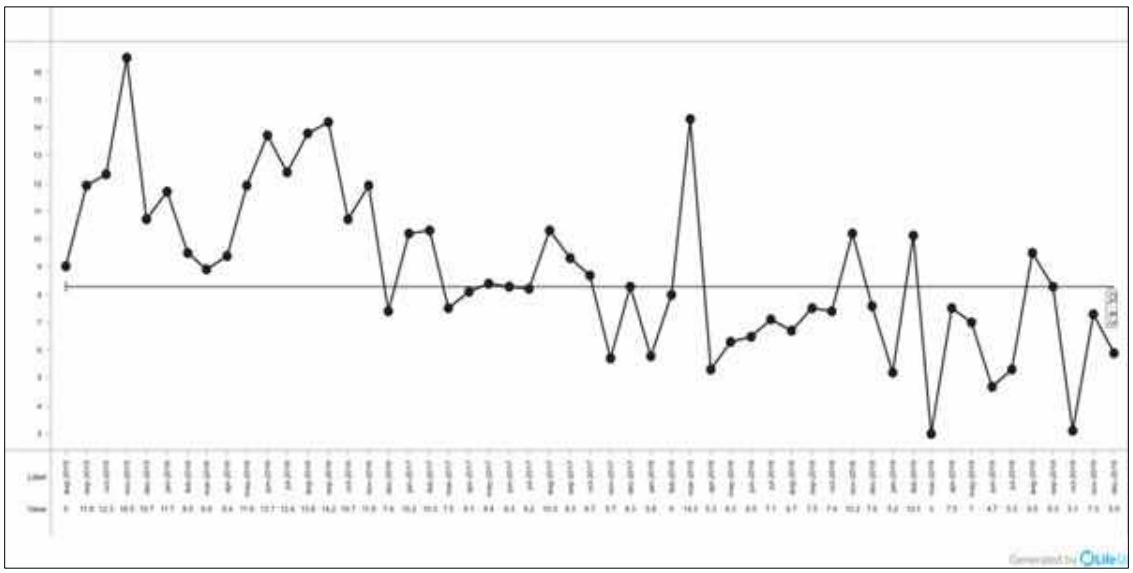


Figure 31: Run chart showing the reduction in smoking during pregnancy

Figure 31 shows the reduction in smoking during pregnancy since August 2015 with the interventions made as part of the Maternity and Neonatal Safety Collaborative quality improvement work. The data shown represents smoking rates at time of delivery as percentage of deliveries by month. The data supports a general decline in smoking rates following the interventions, though small numbers demonstrate a degree of error in the data. Reducing smoking in pregnancy continues to have focus. Carbon monoxide testing and the giving of very brief advice is now embedded in practice. All qualified and unqualified maternity staff are trained as part of mandatory training. All medical staff are also compliant.

The local smoking cessation service has had many structural changes. Since January 2020, there has been a full complement of staff, which will ensure further commitment to smoking cessation support in the community. The Trust is working towards the availability of nicotine replacement at source rather than via the local authority voucher scheme. This will mean the two services can implement a more robust system. All smokers are scanned and booked through a high risk consultant pathway with smoking cessation present at the 'high risk smoking clinic'. A bespoke individualised management plan is implemented which the obstetricians follow throughout a pregnancy.

The maternal neonatal safety collaborative work and innovation of the patient pledge scheme has been recognised at a national level. The improvement leads presented at the national learning event in March 2019, with the patient pledge scheme shortlisted for the RCM innovation awards to be held May 2020. A regional smoking provider alliance has been established as a consequence of the quality improvement work done. Membership includes local authority public health representation, drug and rehabilitation service, community pharmacists, the smoking cessation service and general practitioners.

Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction
£66,000 from the first year of the Maternity Incentive Scheme has been utilised and invested into providing additional scanning for high-risk women. A room in the Maternity Assessment Centre was identified and will be fully equipped to provide third trimester scans with the sonographers providing a Twilight machine as a temporary measure. All the required scanning pathways have been put into place with a sonographer employed on a fixed term contact whilst a midwife completes her training to provide third trimester scan. Further training will commence this year for sonographers to ensure they are able to perform uterine artery doppler scanning. Whilst the initial funding enabled the initiation of this project, a business case is in progress to enable the department to continue to meet this standard.

Raise awareness of reduced fetal movements
Midwives give all women information about recognising reduced fetal movements along with the Tommy's leaflet, before 21 weeks gestation. The use of a recommended checklist has been implemented to inform practice and ensure all episodes of reduced fetal movements are acted on in line with national evidence based guidance. An audit has been undertaken to check women's understanding of reduced fetal movements, and to consider what further advice we could offer to reduce the risk of stillbirth.

Effective fetal monitoring in labour
Cardiotocography (CTG) training continues to be an important focus for the department with an update to the existing annual study day to incorporate human factors training within the multidisciplinary team, to encourage the sharing of knowledge, learning and experiences with a physiological approach to CTG interpretation.

Friends and Family Test
The Friends and Family Test (FFT) in maternity services enables women to provide feedback at the 36 week antenatal appointment, after delivery, on discharge from hospital and from the community midwife. Senior midwives monitor the response rate and scores to identify themes, trends and any opportunities for improvement. The feedback is predominantly extremely positive and comments are shared with staff. Current response rates are between 24% and 38% and as an overall percentage have remained fairly static since the introduction of the combined form in 2017. Midwives continue to encourage women to complete the form to enable improvements to be identified and actioned

A development project has been completed to improve the FFT and make it a more useful tool for driving service improvement and these changes will take effect from 1 April 2020. These are some examples of comments that we have used to improve the service:

You said ….	We did ….
Having better access to an electric breast pump.	The maternity department had a very generous donation from one of our patients and she requested this money would be used to purchase breast pumps for loan. We have recently purchased ten pumps and they are now being utilised on a regular basis.
More support when I first went into labour as the midwife was sure I was in the early stages but when examined I was 6cm dilated! Better listening to each woman in labour as we are all different.	We have recently introduced a latent phase of labour guideline to support staff in making individual plans of care as well as updated the latent phase of labour patient information leaflet to guide women during this stage of labour.
It would be better to be able to see the same midwife each time to build up a	HDFT maternity are committed to the Better Births national agenda to provide Continuity of Carer to a

better relationship.	minimum of 51% of our women. We have two teams already providing care in the antenatal, intrapartum and postnatal period with plans to roll out further teams this year.
The metal bins were noisy.	We purchased new plastic soft close bins.
You said that you felt visiting hours were too long on the ward.	We reduced visiting hours.
Protected bed if my baby was on special care.	Agreement with infant feeding, special care baby unit (SCBU) and Pannal ward, that a bed be available on Pannal ward for a 7 day period before transferring parents to parent room on SCBU. This has enabled 100% of parents in the last year to stay with their baby at all times if they have chosen.
No facilities for dads to shower.	Allow partners to use the shower in Maternity Assessment Unit when not in use (evenings and weekends).
More focus on post birth depression in mums and dad and wish the default wasn't antidepressants.	We recognise the importance of both physical and mental health. We now have an additional consultant specialising in perinatal mental health with women also referred to the Improving Access to Psychological Therapies programme at any time from booking into the postpartum period.

Figure 32: Maternity FFT "You said, we did"

Summary and next steps

There continues to be a significant amount of ongoing quality improvement work within the Maternity Department with some real achievements during 2019/20. The quality objectives we have set for 2020/21 are to:

- To achieve full implementation of the continuity of carer model to all women living in the Harrogate and surrounding area to achieve the 51% trajectory set by the national team by March 2021;
- To continue to support staff who are and will be involved in the CofC model as they transition from the traditional to the newer model of care;
- To achieve full compliance Saving Babies Lives Care Bundle version 2 at local level to include the provision of additional scanning capacity on a more permanent basis for women with raised BMI, women who smoke, women 40 years and above at booking and low pregnancy-associated plasma protein (PAPP-A). This will be done by completing a business case to support this;
- Work towards achieving full compliance with all ten safety actions within the NHS Resolution Maternity Incentive Scheme year 3 by September of 2020;
- Ensure full implementation of the role of the PMA and ensure that time is allocated for this group of staff to fulfil the role. Two midwives will complete the course mid-2020 and a further 2 midwives to commence the course towards the end of the year;
- Continue to support the work of the WY&H LMS;
- Adopt changes to the FFT from April 2020 to make it a more useful tool to drive service improvement, aiming to implement a paperless system to support this feedback and improvement.

3.2.3 Cancer Care

Cancer services offered by HDFT continue to put the patient and their family at the centre of everything we do. We aim to develop our services by working with service users, ensuring that patients and their families influence our services through feedback. We continually aim to offer treatment and support which is personalised to the individual from diagnosis and throughout their pathway. Care is planned in a way that addresses the unique concerns of the patient and their family.

Safety is paramount and we continually review our services through the National Quality Surveillance Standards, national cancer targets and Cancer Outcomes and Services Dataset. Our Trust values and strategic objectives are at the centre of our work. We engage with the West Yorkshire and Harrogate Cancer Alliance across many work streams to ensure our services are robust and that we learn from each other.

Managing the consequences of a cancer diagnosis and the treatment is central to enhancing the lived experience of patients who are living with and beyond cancer and we are mindful of this from diagnosis. Earlier diagnosis of cancer remains fundamental to all we do to improve patient outcomes and ensuring efficiently run, timely diagnostic pathways will help achieve this goal and enhance the patient experience.

What were we aiming to achieve?

The main aims and achievements during 2019/20 have been to build on and sustain the services we already offer and at the same time planning to develop new services to ensure patient safety and improve patient experience and outcomes which may be based on national and regional guidance. These include:

- Continuing to achieve the 31 and 62 day cancer targets on a quarterly basis. In particular identifying specific diagnostic pathways that are complex and continually prove challenging to meet the targets set;
- Building on the work from the recovery package through implementation of personalised care as set out in the Long Term Plan;
- Increasing the cancer nursing and supportive care workforce to ensure patients receive timely support which we know improves the patient experience and enhances patient safety;
- Developing and expanding cancer information services across the organisation and into the community so that patients access information when they want and through a number of different media;
- Increasing patient access to patient education programmes by developing generic education sessions alongside the site specific programmes;
- Building on the work already achieved through the serious nonspecific symptoms pathway pilot programme to apply the principles of a rapid diagnostic centre to other cancer sites;
- Continuing the development of the Acute Oncology Nursing Service to achieve the goal of a seven day service;
- Implementation of the Active Against Cancer programme.

What have we done?

Cancer Targets

Achieving the 31 and 62 day cancer targets is increasingly challenging as the number of urgent referrals continues to increase on an annual basis. The challenge to our diagnostics departments in arranging timely investigations has been significant, together with the commitment to ensure treatment is commenced in a timely manner by all clinicians within Harrogate District Hospital and within the tertiary sites. The introduction of timed pathways helped us plan where we can make small improvements that would influence overall

outcomes. The recruitment of Pathway Navigators with the support of the Cancer Alliance will enable work to achieve the targets in more complex diagnostic pathways and data collection will support the impact of these posts.

Personalised Care and Support

Personalised care means people have choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs. We have made huge advances in achieving this through increasing the number of holistic needs assessments performed for patients with a cancer diagnosis across all tumour sites so that patients concerns are factored in to their care plan.

Patients have access to the clinical psychology and psychosexual counselling services to promote good mental health during a difficult time and patients can now access resilience training for them and their partners, designed to enhance psychological health, personal resilience and general meaning in life. Feedback has been very positive and we hope this will help us to shape similar group work moving forwards. Some of the attendees indicated the desire for more frequent or "top up" psycho-educational sessions. Social prescribing and community based support is implicit within this and we have begun plans to hold outreach services across Harrogate and Rural District.

LEAR fitness work in close partnership with the Sir Robert Ogden Macmillan Cancer Centre (SROMC) and our Health and Wellbeing Team to continually improve the patient experience. A course of free Pilates based activity programmes is offered for patients with cancer. These are specifically designed to help maximise recovery, regain physical strength, balance and improve overall stamina. The specially trained cancer rehabilitation physiotherapists carry out individual assessments with all patients to fully understand their needs and take into account any pre-existing limitations. Their service includes:

- Lymphoedema management;
- Scar management;
- Range of motion stretches;
- Pelvic floor strengthening;
- Fatigue management;
- Exercise prescription.

There is evidence that since the introduction of this service two years ago referrals to our hospital based traditional physiotherapy department have significantly decreased.

Cancer Workforce

We have recruited a band 7 acute oncology nurse and cancer care coordinator and along with further nursing recruitment, this has enabled us to plan for implementation of a seven day nursing service later this year. This will ensure a specialist practitioner in acute oncology assesses all patients within 24 hours of admission. The aim would also be to prevent hospital admissions by managing patients at home where possible with input over 7 days and also to be proactive in implementing treatment and care which may shorten length of stay in hospital.

Cancer Information

The Macmillan Cancer Information Support Service (MCISS) manager introduced a new data collection tool in collaboration with York Cancer Care Information and Support Service to improve the relevance of the activity and interventions information collected during 2019. The volume of information enquiries generated through the MCISS range from 150 to 250 per month, an average of 2400 information enquiries throughout 2019. Unlike other MCISSs across the country, this total does not include the additional 1000 enquiries generated by

welfare and benefits and complementary therapy as these are directed via a designated pathway.

Service activity	Activity in 2015	Activity in 2019	Percentage activity increase since 2015
Number of information enquiries	385	2400	523%
Total of information booklets ordered	2963	4069	37%

Table 19: Increase in MCISS activity 2015-2019

Macmillan Leaflets and Booklets
The total of Macmillan information material ordered through the information service increased by 27% in 2019 from 2963 to 4069. This demonstrates that the information service is continuing to increase engagement with users and awareness of the service.

Additional information booklets have been 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
- Harrogate and District Foundation NHS Trust Natural Health School

Patient information leaflets are also produced by the MCISS; these detail additional services provided within the SROMC and HDFT and offer another source of information available to service users. A library of cancer information books suitable for children held within the MCISS area has continued to be a valuable resource. During 2019, additional self-help and support books written for cancer patients and carers have been added.

Main Hospital Outpatient Department
The MCISS manager held information sessions with staff working in Harrogate District Hospital's Outpatient Department to improve the knowledge of cancer information and support services available to patients attending clinics. The SROMC cancer services directory and information slides for the outpatient waiting room screens were also provided to increase awareness and accessibility.

Website Pages
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/

The website for the HDFT NHS Natural Health School is managed by the MCISS manager and available at https://nhsnaturalhealthschool.co.uk/. SROMC information and support services are also accessible via the national websites for Macmillan Cancer Support www.macmillan.org and the Cancer Care Map, launched by Dimbleby Cancer Care https://www.cancercaremap.org/

SROMC Cancer Services Directory
A SROMC cancer services directory is also available for both patients and healthcare professionals in hard copy, and an electronic copy is linked to the Trust website.

Social Media

The MCISS manager maintains and manages the information available via the SROMC social media forums via Facebook and Twitter accounts. These are also linked to the HDFT and Macmillan Cancer Support Twitter and Facebook pages. The MCISS manager has developed a strong relationship with the HDFT communications team ensure adherence to the Trust Social Media Policy. Additional accounts are held for the SROMC Strutting for Cancer Charity Fashion Show and the HDFT NHS Natural Health School. The SROMC social media pages have continued to be a valuable resource to share information and to enable a wider range of topic matter to be shared. In 2019, additional publishing rights were extended to key post holders identified within the Health and Wellbeing service and chemotherapy unit. Social media has generated a lot of interest and positivity in 2019. It has been used to publicise services, fundraising, celebrate SROMC staff and Trust achievements, advertise courses and to share valuable cancer information and other support resources locally, regionally and nationally.

	Facebook	Twitter
Followers	**1700**	**191**
Posts reached	**537,659**	**107,800**

Table 20: SROMC Social media engagement at 31 December 2019

https://www.facebook.com/SROMCHarrogate/ https://twitter.com/sromc_hdft

The Macmillan Welfare and Benefits Service

The Macmillan Welfare Benefit Adviser forms part of the Macmillan Cancer Information Support Service (MCISS). Unlike MCISS models used elsewhere across the UK, the SROMC Macmillan Welfare and Benefit Adviser is employed by the Trust and is fully integrated within the Information Service. This integration ensures the service is accessible, responsive and flexible to meet individual patient needs.

The quality of the service is reflected in patient feedback, service evaluations and successful financial awards received to service users. The service now operates over five days, and continues to hold 'Alternative Office Status' awarded by the Pension's Service. This enables the verification of documents on behalf of the Department of Work and Pensions by the Macmillan Welfare and Benefits Adviser on SROMC premises and so reduces an unnecessary stress burden on cancer patients.

The Welfare and Benefits Adviser has provided education sessions and increased awareness of benefits, welfare services and developments across a wide range of forums and audiences. These have included:

- Benefits talk to Prosper Support Group;
- Benefits talk to Breast Cancer Care Support Group;
- Teaching sessions to chemotherapy staff;
- Thinking ahead and Wellbeing Programme;
- Benefits overview presentations to Clinical Nurse Specialists.

	Activity in 2015	Activity in 2018	Activity in 2019	Activity increase since 2015 (%)
Numbers of new referrals	**404**	**484**	**604**	**50%**
Total claimed in annualised benefits	**£1,517,588.00**	**£1,869,958.90**	**£1,930,697.30**	**27%**
Total in backdated benefit arrears claimed	**£67,024.00**	**£204,014.00**	**£186,962.84**	**179%**
Total of Macmillan grants claimed	**£13,400.00**	**£24,876.00**	**£18,666.00**	**39%**
Other charitable grants	**£3,336.00**	**£12,280.00**	**£14,337.00**	**330%**

Table 21: The increase in Welfare and Benefits Service activity between 2015 and 2019

Numbers of referrals

In 2019, there were approximately 1200 newly diagnosed cancer patients where HDFT was involved with the patients care. Not all of these patients required cancer treatment within the SROMC; around 700 were treated surgically. The majority of these patients did not require access to services within the SROMC because of the stratified pathway relating to their disease. This explains why only 50% of those diagnosed are referred to the Welfare and Benefit Service. However, there has been a 50% increase in the number of referrals to the service since 2015. This clearly demonstrates the rising pressure on service capacity being experienced by the post holder.

The decrease of over £6000 in the financial total of Macmillan grants claimed in 2019 compared with 2018 reflects the decision by Macmillan Cancer Support to reduce the amount it awards. The maximum grant we are now seeing issued has significantly reduced from £500 to £250-300.

Total Annualised Benefits

This is the actual total amount awarded to patients who have accessed the SROMC Macmillan Welfare and Benefits Service in 2019. Nearly £2 million of financial benefit support has been successfully claimed in 2019 with a direct benefit to the local economic community. This has been a phenomenal achievement as there have been significant cuts to the benefit system, which has affected both eligibility to claim and the financial award given in 2019. Harrogate has also been one of the first national localities to introduce Universal Credit; this has dramatically reduced the financial support available to many of those referred to this service. The average time to complete a Universal Credit application requires a consultation of 1.5 hours per claimant.

Due to service pressure, it has become increasingly hard to follow up benefits claims to confirm an award has been made. There is a risk that these figures will be under reported more and more in the future. A volunteer has been able to provide some valuable support with this during 2019 and it is hoped that additional administrative support from the cancer services team will also help in 2020.

Service Development

The service review highlighted the increasing capacity pressures faced by the Macmillan Welfare and Benefit Adviser. Changes to the benefit and social care system in 2019 have continued to reveal gaps in the social care and benefit system, requiring greater specialist expertise when providing intervention and support to the patient and carer. The current post holder is highly skilled and possesses the knowledge required to navigate this highly complex system on behalf of the patient.

The combined Macmillan service review identified areas where competing demands of essential low-level administrative tasks are preventing the Welfare and Benefits Adviser from fully identifying all potential sources of support. The gaps identified within unmet social care needs have a financial implication for length of hospital inpatient stay, avoidable admission and inappropriate use of services.

The Complementary Therapy Service

This service has continued to operate to capacity in spite of the added operational demands from the HDFT NHS Natural Health School. Referrals for treatments have remained high due in part to both its reputation and the benefits of the evidence-based interventions offered. The clinical activity has been restricted in 2019 by the lack of space available to perform more treatments. This has been due to competing cancer service capacity pressures within the SROMC. The addition of students providing clinically supervised practice has been very positive in meeting the clinical service demand. Two students are interested in offering complementary therapy as SROMC volunteers on completion of the NHS Certificate. Complementary therapy volunteers are a source of great benefit to the service but their integration does require careful supervision and planning to ensure the governance, quality and equitable aspects of the service are maintained.

	2015	2019	Activity increase since 2015 (%)
Total number of referrals received to the service	**200**	**636**	**218%**
Number of patients treated	**82**	**498**	**507%**
Number of carers referred	**5**	**34**	**580%**
Number of staff referred	**33**	**104**	**215%**
No of treatments given	**917**	**1455**	**59%**

Table 22: Complementary therapy referral and treatment activity

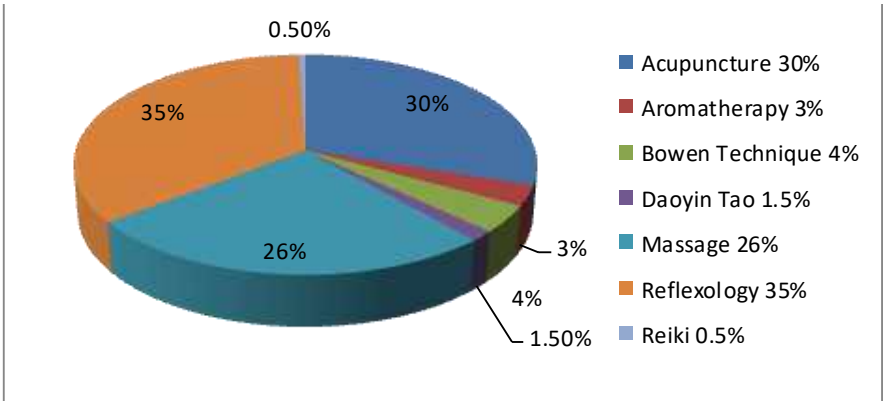


Figure 33: Breakdown of the type of complementary therapy treatments given in 2019

SROMC Wellbeing Services and Volunteers

SASH (Scarves and Stylish Headwear)

The supplier of headwear to the SROMC has consistently met user need, with contemporary ranges at a heavily discounted NHS rate whilst providing high quality customer service. The service is funded through the SASH charitable fund 1045. It continues to be sustainable through the reinvestment of headwear sales and the charitable donations it receives. The MCISS manager undertakes headwear sales, advice and tips with support from volunteers. In response to patient feedback a card payment facility has now been installed in the MCISS office.

Wig Fitting Service

The SROMC has continued to provide Orthotics with a clinic room to hold the wig fitting service within the SROMC during 2019. A clinic is held fortnightly and a representative from 'Hair Plus' based in Leeds provides wig fitting. Dermatology patients requiring wig fitting for conditions of dermatological alopecia also access the service. Links have also been developed with local professional hair loss services to offer more choice and flexibility to service users.

'Feel More Like You' Beauty Therapy Sessions

The partnership between the SROMC and Boots in Harrogate was sadly discontinued in 2019 after five years of amazing support. Although Boots No7 are no longer providing a service on the SROMC premises, patients are still regularly signposted to local Boots stores to seek advice and one to one consultations. A programme of monthly beauty therapy sessions has thankfully been able to continue within the SROMC, and is delivered by beauty therapists from Rudding Hotel Spa. These sessions will be evaluated in 2020, but feedback received so far shows it to be a popular and beneficial service for women during and after cancer treatment. It offers professional beauty advice on skincare, make-up, eye make-up and nail care as well as a general pamper. Service evaluation and user feedback undertaken in 2019 demonstrated the difference this service makes to quality of life issues and sense of wellbeing for those patients affected by cancer.

The Oesophageal Patient Association (OPA) Support Group

This group has continued to meet once a month within the SROMC throughout 2019. The OPA provide local support to patients and carers affected by cancer of the oesophagus. The meetings attracted 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 Trust Colorectal and Upper Gastrointestinal Cancer Care Co-ordinator supports the group. Following the success of the group in Harrogate, the OPA have now rolled out this model across other areas of the country.

Art Therapy

A qualified volunteer art therapist in the SROMC provides the service fortnightly. Art therapy is proven to be highly effective in helping patients and carers to manage the emotional distress caused by a cancer diagnosis. It provides an alternative approach to work through emotional issues using a range of creative art techniques. Each fortnight the art therapist is able offer three-hour sessions to individuals, or a one-hour group session for up to four people. The service is funded through charitable funds donated to the SROMC.

Figure 34: SROMC art therapy activities

SROMC Volunteers

The added value and quality that all the volunteers supporting the SROMC have given to both service provision and patient experience across a wide range of roles throughout 2019 cannot be underestimated and we are extremely grateful to them. 17 volunteers supported the services provided in the SROMC during 2019 with:

- Serving lunches and beverages to patients attending for cancer treatments;
- Administration support;
- Patient information support;
- Meet and greeting patients;
- Gardening and art therapy;
- Beauty therapy and spa therapies;
- Complementary therapy.

Figure 35: Two of our SROMC volunteers

New volunteer roles and opportunities that will enable cancer information and support services to be more accessible across the organisation and the wider community will be explored further in 2020.

Cancer Information Support Volunteer Team

A new volunteer service was introduced in 2019. Following an initial cancer diagnosis many cancer patients within the Harrogate locality do not require or access cancer treatment within the SROMC; instead the type of cancer or treatment they require may have to be provided at Leeds or York. For those patients there is a risk that they be unaware of the range of support and information services that are still available to them on their doorstep. The role of the cancer information support volunteers has been set up to address this.

The volunteers provide a friendly face and a valuable visiting service to cancer patients admitted to hospital via the acute oncology team. They raise awareness of the SROMC and encourage patients who may have not been aware they could access the services that are on offer to visit the MCISS if they have any information or support concerns or wish to find out more, regardless of where they are receiving their specific anti-cancer treatment. Two exceptional volunteers were recruited to provide this visiting support service for those cancer patients who are admitted acutely unwell to Harrogate District Hospital. The feedback from patients and clinical staff on the impact of the service has been extremely positive.

	Number of patient visits	% of visits lasting 20 minutes – to an hour
October – December 2019	37	68%

Table 23: Cancer Information Support Volunteer Activity

The length of time spent on the visits demonstrates how well the volunteers have been able to engage with the patients and bestow valuable time with them that is not often possible for clinical staff to do. Patient feedback has included:

> *"It was really nice to chat with someone, I found the visit helpful"*
>
> *"Steve really helped me with donating my record collection, which had been bothering me for a while"*

"I was very interested to hear about the complementary therapy treatments that might help"

"The lady I saw was very helpful and bought me back some more information"

Initially started as a pilot the service will be reviewed and evaluated in 2020. The aim is to set it up permanently with the acute oncology service working with the MCISS manager to take over the day-to-day co-ordination of the volunteers and provide monthly reflective supervision. HDFT does not have a designated cancer ward, so patients can be admitted to any adult ward within the hospital. The majority of admissions are considered to be medical rather than surgical and most volunteer visits are undertaken within the four medical wards of Granby, Oakdale, Jervaulx and Medical Short Stay.

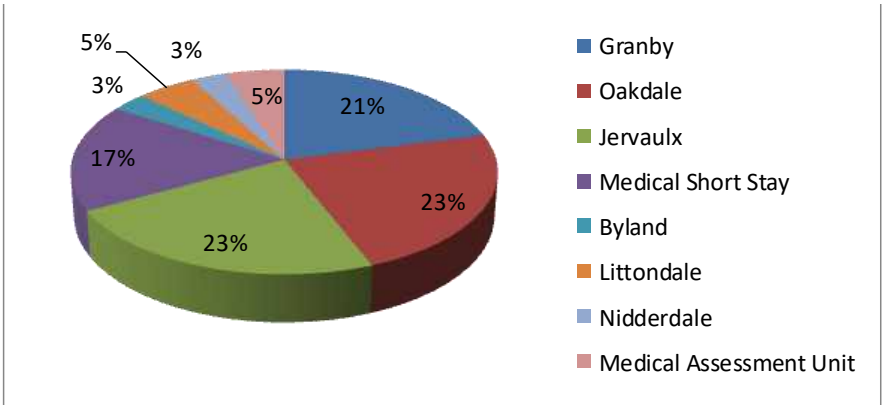


Figure 36: Number of visits to each hospital ward October – December 2019

Service feedback has shown the volunteers have improved the experience of cancer patients admitted acutely to Harrogate District Hospital. They have identified areas of concern during patient admissions that would previously have been missed, and these have then been fed back to the clinical teams co-ordinating their care. The holistic benefit of this new volunteer service has also been recognised within the acute oncology and cancer of unknown primary feedback from the national Quality Surveillance Programme review held in 2019.

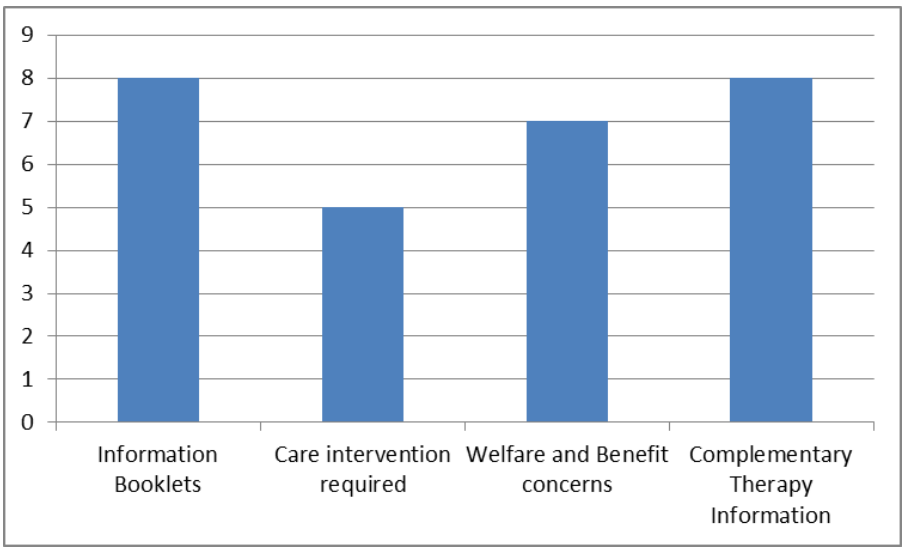


Figure 37: Cancer Information Support Volunteer Visit Outcomes

Staff Wellbeing

The MCISS and Chemotherapy Unit Managers have remained committed to support the health and wellbeing of SROMC staff. With the advent of the HDFT NHS Trust Natural Health School, students undertaking the Occupational Health Pathway Certificate have been able to treat staff referred into the service for support.

- Yoga sessions for staff has continued to be held weekly after work in the SROMC during 2019, funded through the Staff Wellbeing and Educational Charitable Fund;
- Clinical supervision and reflective practice is provided for all members of staff within the SROMC. The MCISS Manager attends joint clinical supervision with the chemotherapy unit manager;
- Monthly clinical supervision is provided to all staff working within the MCISS;
- The End of Life Support Volunteers receive monthly clinical supervision from the MCISS Manager;
- The Band 7 for Acute Oncology and Cancer of Unknown Primary will facilitate clinical supervision for the cancer information visiting volunteers in 2020;
- Clinical supervision can be accessed by all the SROMC volunteers if they wish to receive it.

The HDFT NHS Natural Health School

The patient need and demand for complementary therapy services has been a critical driver for the development of the NHS Natural Health School.

Figure 38: Natural Health School logo

Our mission; *provide complementary therapy diplomas and continuing professional development (CPD) courses that will uniquely practical experience and clinical supervision within an NHS setting.*

The benefits of complementary therapies within NHS services are becoming increasingly accepted when used in combination with biomedicine. Complementary therapy should never be seen as an alternative treatment to prescribed medical treatments, but when integrated can be a cost efficient and effective way to improve overall wellbeing and quality of life, manage many day to day ailments and improve symptom management for those living with chronic and long term conditions.

With the advent of social prescribing, many therapists are questioning how they might engage with local hospitals, hospices and GP practices to offer their services. The numbers of people living with long-term conditions including poor mental health, neurological problems, heart disease and diabetes as well as cancer occurrence are set to double to almost 50% of the population within the next decade. The development of an NHS Trust based complementary therapy school has been a huge leap forward in enabling therapists to train and specialise in the safe management of some of our sickest and most complex patients.

Nationally there is limited training available that focuses on meeting the clinical demands within a healthcare environment. The unique training developed and offered by the HDFT NHS Natural Health School will lead to a generation of highly skilled and confident

practitioners who are able to offer a range of therapies to an increasingly complex population.
As well as offering Level 3 Diploma courses in massage, reflexology and aromatherapy, short course certificates and CPDs, the prospectus includes a revolutionary course, which requires students to undertake clinically supervised placements in an NHS healthcare setting. The NHS Certificate in Complementary Therapies has been created to enable qualified therapists at diploma level 3 to meet increasing complex health care needs in accordance with the standards expected in NHS clinical practice. The student clinical placements have helped to reduce the patient service waiting list, which at its most pressured had escalated to over 160.

The total income from courses held in 2019 was £79,433.

Patient Education Programmes (PEP)
These have been modified to ensure greater accessibility by all patients with cancer from diagnosis onwards so that there is greater awareness of services. The programmes include a range of group support sessions to help patients manage the emotional and physical effects of cancer treatments. These are held in the SROMC and other venues around Harrogate. Initially programmes were designed to address common side effects experienced by different site-specific cancer groups e.g. breast, colorectal, skin, prostate, and lung. These were very well evaluated in the main, but feedback over a two-year period has led us to redesign our education programmes. The new PEPs allow patients to choose which sessions they feel would benefit them most, thus supporting a self-managed approach. Some of the sessions patients can now access include:

- Healthy Eating and Weight Management (underweight or overweight);
- Heart Health (Post Chemotherapy & Immunotherapy);
- Managing fatigue (in partnership with Active Against Cancer and LEAR fitness);
- Yoga and Mindfulness;
- Continence and Erectile dysfunction;
- Managing the effects of hormone therapy;
- Art Therapy;
- Bone Health.

Thinking Ahead
This is a programme for patients and carers whose cancer cannot be cured. It is delivered by a multi professional team of specialists including the Palliative Care Team and the Clinical Psychology Team. The programme aims to keep patients as well as possible for as long as possible, living life to the full in a supported, self-managed way. It also allows an opportunity to consider future planning towards the end of life and meet key people who may be able to help.

Early Diagnosis
As part of the national objective to improve early diagnosis of cancer, HDFT set up a ‘vague symptoms’ pilot pathway. This commenced in a phased approach where GP practices within the Harrogate and Rural District referred patients on a urgent serious non-specific symptoms pathway (SNSP). A SNSP multi-disciplinary team meeting was developed and we have set up clinical engagement with other specialities in the hospital. A nurse led triage of referrals was developed and patients reviewed in a nurse led clinic with MDT agreement for the most appropriate investigations. Whilst the number of referrals started low these are increasing and the feedback from patients and GPs has been very positive. We are now beginning to build on this and with the Cancer Alliance are integrating established urgent referral pathways and this is the beginning of a rapid diagnostic centre in HDFT.

Active Against Cancer

In July 2019, we opened a unique health and wellbeing service, Active Against Cancer, to cancer patients in the Trust. Active Against Cancer is funded as a two year pilot by Yorkshire Cancer Research and is run from Harrogate Sports and Fitness Centre. The service has exercise at its core, but also provides the opportunity for early patient education, social and peer-to-peer interaction to support patients at what can be a challenging time.

The service received approximately 550 referrals in the first seven months of opening. Patients referred to the service receive one-to-one consultations to discuss and assess their health, wellbeing and physical activity levels. 99% of new referrals are offered an initial consultation within three working days and following referral, the service has an uptake rate of 91.1%. Patients are then provided with individualised activity programmes, delivered in the form of group-based exercise classes. These programs are designed to support patients during prehabilitation, whilst undergoing treatment and during rehabilitation. Patients are recommended to attend two to three times a week and each patient's progress is assessed at regular intervals throughout this pathway. The service currently sees around 230 patients visits per week, approximately 65% of capacity, a number which has been steadily increasing since opening.

Those attending exercise classes rate the service at 4.9/5 for overall patient experience and 96% of patients would 'strongly agree' that they feel safe and well looked after whilst exercising; the remaining 4% would 'agree' (based on 51 anonymous patient reviews). In collaboration with Sheffield Hallam University, the service is collecting evidence to demonstrate the impact of the service on physical and clinical outcomes, psychological and behavioural change outcomes and economic outcomes. The first results of this study are anticipated in September 2020.

Summary

We have achieved excellent results and feedback reflecting the service provision, patient safety and experience in accordance with the Trust values of respectful, passionate and responsible. Whilst we have remained committed to ensuring the standards and quality of the services we deliver continue to be high, our focus will continue to be on areas in which we can further improve.

3.3 EFFECTIVE CARE

3.3.1 End of Life Care

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

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

The aim is to improve patient and family experience at the end of life across Harrogate and Rural District (HaRD) in both community and hospital settings.

Specialist palliative care is required by people with progressive life-limiting illness where the focus of care is on quality of life, and who have unresolved complex needs that cannot be met by the capability of their current generalist care team e.g. GP, district nurses, care home staff, consultants, hospital ward teams. Specialist palliative care in HaRD is delivered by the HDFT Palliative Care Team (PCT): a multi-disciplinary team 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 2019/20 have been about building on the foundations for improving patient and family experience at the end of life and ensuring collection of robust data to provide the evidence of improvements. We have aimed to:

- Continue to enhance the support and care for patients in the last days of life in both hospital and community;
- Develop electronic systems and guidance within SystmOne electronic patient record to support the delivery of high quality care in last days and hours of life in the home settings;
- Agree the implementation of an essential skills training package for care in last weeks and days of life;
- Recruit staff and establish the new seven day 9am - 5pm face-to-face assessment by the PCT;
- Continue to refurbish quiet rooms identified for the use of patients and families at the end of life, where possible;
- Work with North Yorkshire County Council to deliver coordinated approach to Dying Matters week;
- Continue to develop and deliver the Thinking Ahead programme and explore options for implementation in other palliative disease groups;
- Continue to work in partnership within a multi-agency working group to review fast track discharges for rapid discharge from hospital in last days of life and care in last weeks of life in community, to ensure the preferred place of death is achieved along with high quality patient and carer experience;

- Embed the Electronic Palliative Care Co-ordination System (EPaCCS) within SystmOne across community care teams and GP practices to improve identification, recording and sharing of key information for patients who may be in the last year of life;
- Obtain regular robust feedback through a variety of means about patient and carer experience before and after death in all settings (hospital, home, care home, hospice);
- Participate in the second round of the National Audit for Care at End of Life (2019);
- Implement recommendations from the improvement work around immediate care in community after an expected death;
- Continue to work with Information Services to improve data analysis and reporting to demonstrate effectiveness of the service;
- Identify opportunities to expand the EoL volunteer service within the Trust.

What have we done?

a) Provision of specialist palliative care and leadership 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, and providing immediate specialist advice. Alongside direct patient assessment, the team has focused on regular attendance at key clinical MDTs on wards, GP palliative care meetings, linking with community care teams and care homes. This proactively guides and supports professionals on the care of patients who may be approaching end of life.

There was a significant increase in referrals to the PCT in 2018/19 compared to previous years (18% increase in hospital and 25% in community). Referrals are expected to remain similar for 2019/2020. There has also been a significant increase in the number of patients referred with non-malignant disease from 62 to 137 in community (121% increase), and from 144 to 180 in hospital (25% increase). The Lead Nurse for Palliative and End of Life Care continues to be funded two hours a week to lead end of life at a regional level across Yorkshire and Humber, and link with the national end of life team. The community consultant is also funded for two hours per week for clinical leadership into the West Yorkshire and Harrogate Health and Social Partnership work around end of life care.

Figure 39: HDFT Palliative Care Team:
Top from left: Dr Kath Lambert, Sarah Davie, Dr Viv Barros D'Sa, Dr Cath Siller, Trudi Newcombe, Kelly Barnes. Bottom from left: Jo Neiland, Charlotte Rock, Clare Hudson

A business case was agreed in the Trust with initial funding for three years from Macmillan Cancer Support to increase the specialist nursing staff within the PCT in order to expand the service and enable delivery of a seven day 9am – 5pm face-to-face specialist palliative care assessment. This would be provided as a normal weekday service and an urgent service at the weekend only. Workforce recruitment and retention has continued to be very challenging and the team have been unable to move to a seven day service. Other specialist palliative care teams are experiencing similar challenges.

A stakeholder event with representation from across organisations in January 2020 considered the current issues across palliative and end of life care and the vision for the future. Consideration has also been given to the current model of provision of specialist palliative care and how services could be delivered in the future within the changing NHS. Work is ongoing to explore solutions that will eventually lead the move to a successful implementation of a seven day service.

b) End of Life in the Hospital setting

The team, in partnership with nursing and medical staff, has continued to embed the guidance and documentation to support care in the last days and hours of life in hospital. This enables ward staff to provide sensitive, individualised care for the patient and their loved ones. Some of the practical initiatives implemented in 2019/20 continue to grow and include:

End of life volunteers

EoL volunteers are available in hospital to support families and patients in their last days and hours on Tuesdays, Wednesdays and Thursdays. Volunteers can sit with patients if there is no family present or if the family need respite during the day. This is now led in partnership with the Sir Robert Ogden Macmillan Information Manager and there has been further recruitment and training to extend this service. The current EoL volunteers won Volunteering Team of the Year award at Harrogate District Volunteering Oscars and have recently been awarded a national award 'Macmillan: The Service Team of the Year Award (for passionate and determined teams supporting people affected by cancer) which is due to be presented in June 2020;

Figure 40: End of Life Volunteers: Dianne Laing, Liz Rochester, Liz McCarthy and Belinda Goode (note: Liz Rochester has now left).

Care after death in hospital

A rapid process improvement workshop looking at how we could improve care after death and the experience for families in our hospital was held over a week in October 2019. The event had the full support of the executive team and was sponsored by the Medical Director. The project leads are the Lead Nurse for Palliative and End of Life Care and the General Manager. The workshop was facilitated and supported by the HDFT Improvement and

Transformation Team and had wide participation and enthusiasm from across staff within the organisation. Several key issues were identified. These included variation in practice across ward settings and the coordination of key tasks required after a patient dies; variation in communication and information given to families; delays in timely completion of the Medical Certificate of Cause of Death (MCCD); and delays in families receiving MCCD leading to increased distress and increased complaints. Key outcomes were:

- Review and production of better written information for families;
- Care after death staff information folder for each ward;
- Standard operating procedure on personal care required after someone dies;
- Improved facilities for families with soft furnishing for the Mortuary and for the Bereavement and Family Liaison Room;
- Dedicated space for doctors to complete the MCCD and letter;
- Reintroduction of registered nurse verification across hospital through development of a policy and training package;
- Redesigned pathway to ensure a centrally co-ordinated process and communication with families around MCCD.

The new process was piloted on our Medical Short Stay ward.

Figure 41: Improved facilities in Harrogate District Hospital Mortuary waiting room for viewings

Improving the environment

There has been continued investment in improving facilities to ensure quiet spaces for patients and families in key areas: Medical Short Stay, Granby, Medical Assessment Unit. All of the initiatives have been well received by patients, families and ward staff.

Figure 42: Medical Short Stay: Patient and relative room: Darley

c) End of Life in the Community Setting

Embedding an Electronic Palliative Care Co-ordination System (EPaCCS)
We continue to embed the shared template 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/

Community (home setting) care plan for last days and hours of life (electronic template using SystmOne)
An electronic version of the care plan for the last days of life created by Dr Kath Lambert within SystmOne enables better recording of care and therefore improve communication across key providers. Working in collaboration with the community care teams, an audit is underway to measure current documentation with a view to implement the new tool within the community care teams within the next six months.

d) Developing staff in all settings in care of patients and families at the end of life
The PCT continue to deliver a wide range of bespoke education and training to new doctors, new registered nurses, pharmacists and health care support workers, Yorkshire Ambulance Service staff, and take student placements within the team. Essential skills training has now been agreed from January 2020 for registered nurses and health care support workers in community and hospital settings across the organisation, and the role of the Subject Matter Expert for Palliative and EoL Care has been established. This training focuses on care in the last hours and days of life. Nursing home staff are also able to access this training for a small fee. We are working in partnership with Saint Michael's Hospice to continue to provide these sessions on an ongoing basis. A palliative care lead for each ward and community setting has been identified with the aim of sharing good practice, championing end of life care within their setting and linking with specialist palliative care services.

e) Talking about end of life care and promoting advance care planning
During Dying Matters Week we discussed many aspects of dying on local radio and social media. Subjects covered included arranging a funeral, bereavement counselling, dementia, making a will, and caring for someone at home during their last days. This generated debate and discussion within the local community.

There are many potential benefits to early introduction to palliative care and advance care planning in a patient's treatment. It can improve quality of life and mood, reduce the use of aggressive treatment at the end of life, support delivery of preferences including place of death, improve pain control, reduce emergency hospital admissions and even extend life expectancy. The HDFT Thinking Ahead Programme was designed for patients with a palliative cancer diagnosis and their carers to begin to consider advance care planning and choices for end of life care in a group environment, supported by health care professionals. In 2019, a range of professionals in collaboration with the PCT and the Macmillan Health and Wellbeing Team continued to deliver this cancer programme. Feedback remains very positive. The programme was highlighted as an example of good practice in the report 'Supporting Patients Living with a Palliative Cancer Diagnosis across West Yorkshire and Harrogate Cancer Alliance' and has subsequently been rolled out in other trusts.

A similar pilot programme has also been delivered in partnership with the respiratory clinical nurse specialists for patients, and their families, with a non-malignant palliative respiratory diagnosis.

The West Yorkshire and Harrogate Health and Social Partnership Dementia Network are implementing a project specifically around improving conversations and advance care planning for patients with dementia and their families based on a similar project in North West of England. Four facilitators have been trained across the locality including two health professionals from within HDFT, a Consultant in Elderly Medicine and an Advanced Nurse Practitioner. They are delivering an agreed programme of education regularly within the organisation to increase the knowledge and skills of our staff. The project is being evaluated by the network.

f) Multi-agency working to enable rapid discharge from hospital in last days of life and improve care in the last weeks of life in community setting

In 2018 key health and social care professionals from the hospital, hospice, Clinical Commissioning Group, community care teams and Marie Curie met regularly to evaluate the process of fast track rapid discharge and fast track processes at home. This group redesigned the services and processes across the patient pathway, aiming to improve coordination, communication and ensure access to timely services and equipment in last days of life in home setting. In 2019, the CCG commissioned HDFT to provide a new End of Life Co-ordination service. The team of two band 3 support workers and a project lead for the first six months has implemented the new streamlined process across the locality.

The end of life coordinators receive referrals from both community and hospital health care professionals. Patients and their families are supported by the district nursing teams, the palliative care team, Saint Michael's Hospice home care and Marie Curie along with other key stakeholders. The End of Life Coordination service liaises with all these services to ensure seamless and responsive care provision. They provide a central coordination point to link all those involved in a person's end of life care.

The End of Life Coordinators and their project lead have developed referral processes, SystmOne documentation, care pathways and communication and coordination channels to work between relevant services. They have worked closely with community and hospital teams to promote the service and have developed leaflets to inform patients and their families. In February 2020, they were awarded the Bronze Quality Improvement Team Accreditation award, one of the first teams in HDFT to receive this award for their efforts in continually improving service provision.

Figure 43: The End of Life Coordination Team being awarded their Team Accreditation Award

Early quality data is very positive showing timely access to appropriate services and support. There are some ongoing challenges regarding other processes in the pathway that impact on this service. Solutions are currently being explored across the health economy and with commissioners. There are plans to extend this model over the next year as a single point of contact for referrers, patients and families known to specialist palliative care.

g) Measuring quality and using data

Audit of Community Palliative Care Prescription Charts
Anticipatory prescribing for patients at the end of life is established practice, as recommended by NICE Guideline NG31 and Quality Standard QS144. It is the prescription and dispensing of injectable medications to a named patient in advance of clinical need for administration by suitably trained individuals if symptoms arise in the final days of life. Four injectable medications are typically prescribed for five common symptoms; an opioid for pain and shortness of breath, an antiemetic for nausea and vomiting, a sedative for agitation and an anti-secretory to manage respiratory secretions. It is promoted to optimise symptom control in community settings to prevent crisis hospital admissions as it ensures rapid access to medications, particularly out of hours when sourcing of medication can be delayed, and enables administration to manage symptoms when needed. An audit of prescribing of anticipatory medication and syringe drivers in community settings (home and residential home only) was undertaken this year. This provided assurance of generally safe and appropriate prescribing of anticipatory medication and syringe driver use in the community setting in HaRD. An action plan has been agreed and results will be used to support ongoing education and strategy in palliative end of life care. A similar audit will be undertaken in 2020/21 within the hospital setting.

Patient and carer experience of end of life
We are committed to obtaining and using robust feedback to support ongoing improvements in end of life care, learning from what we did not do well and guiding education and training priorities across the Trust.

We have continued to work in partnership with the Registrar for Births, Deaths and Marriages to provide access to a continuous bereaved carers survey across the whole locality. This survey aims to gather information from bereaved families on their experience of care in the two days before death, and after death, for expected deaths in any setting. In 2019, the paper-based survey was redesigned into an online survey by the consultants in palliative medicine in partnership with the HDFT Clinical Effectiveness team. A six monthly report is produced summarising the key themes. Further work needs to be undertaken over the next year to promote the online survey and encourage completion.

We continue to produce quarterly summary reports of all EoL complaints, concerns, events and compliments from across the organisation.

The second round of the National Audit of Care at the End of Life (NACEL) took place in 2019 and HDFT participated in this. The overarching aim of the audit is to improve the quality of care of people at the end-of-life in acute, mental health and community hospitals. The audit monitors progress against the Five Priorities for Care set out in *One Chance To Get It Right* and *NICE Quality Standard 144* which addresses last days of life care. The audit comprises an organisational level questionnaire, case note reviews and a quality survey. More information can be found at https://www.nhsbenchmarking.nhs.uk/nacel. The individual Trust report is due in March 2020 with national recommendations to be released later this year. The third round of the audit is taking place in 2020.

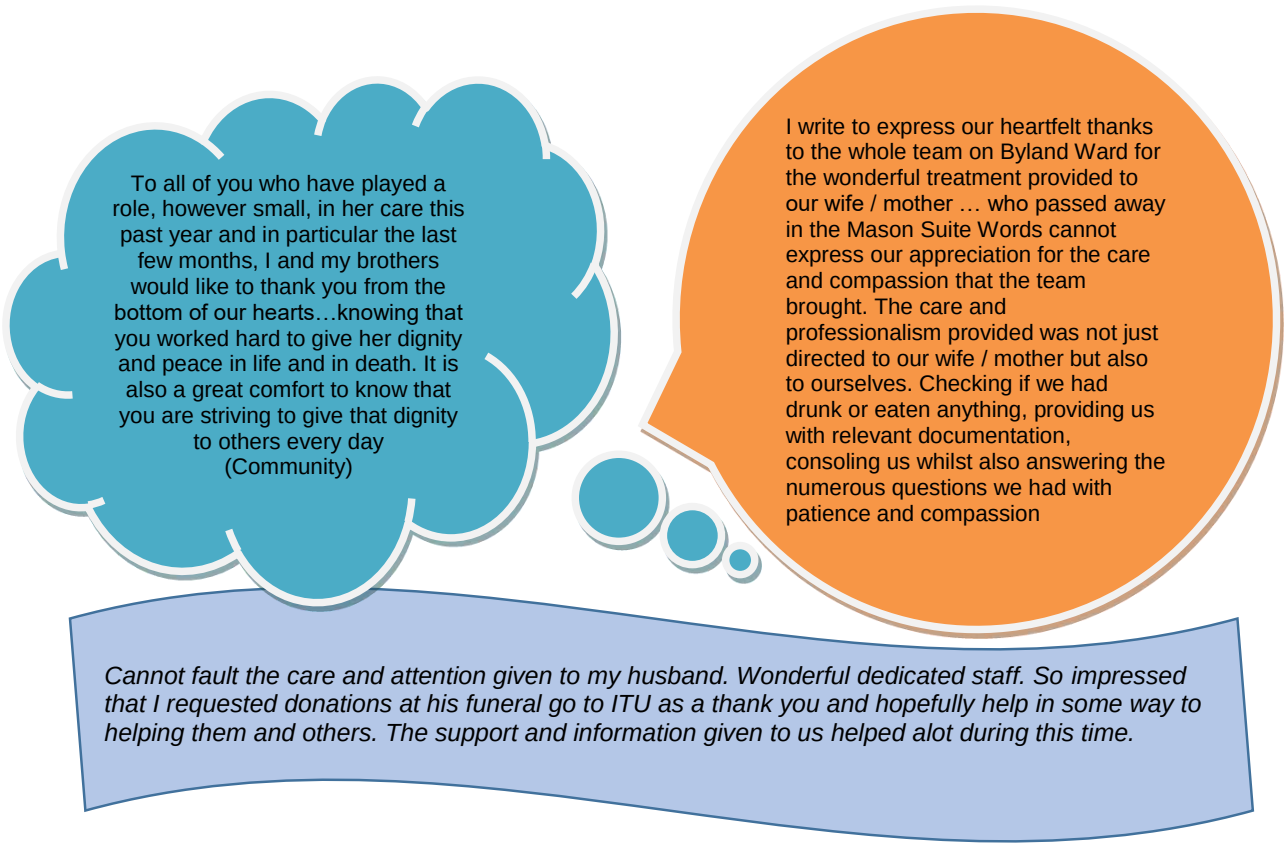


Figure 44: Some comments from across the organisation and NACEL report 2019

Interpreting data

We continue to work with Information Services to develop regular data reporting to better understand and measure key metrics around end of life care across the organisation and within the PCT. These include total numbers of deaths by ward and setting, admissions in the last 90 days of life, place of death and length of stay for patients in last 90 days of life and data on the impact of the PCT.

Summary

There has been significant progress on implementing the objectives in the HDFT EoL Strategy and this has led to improvements in the care and support of patients and their families. Key areas to focus on over the next year are to:

- Implement the recommendations from the Care after Death RPIW including work to identify quiet areas for use for patients and families at the end of life, where possible;
- Implement nurse verification of death within the hospital setting in collaboration with the Advanced Nurse Practitioners to improve timely verification of death;
- Continue to support the delivery of high quality care in last days and hours of life in home settings through the implementation of the electronic care plan for the last days and hours of life and associated guidance;
- Continue to develop and deliver the Thinking Ahead programme;
- Deliver essential skills training to the key groups of staff identified around care for patients in the last days and hours of life;
- Development of HDFT End of Life Education Strategy;
- Work with commissioners and stakeholders to explore solutions to recruitment and retention within palliative care team. Explore new models of working including

opportunities around skill mix within the team to enable move to seven day service provision;

- Work with commissioners to develop a locality End of Life strategy;
- Continue the collaborative work with the EoL Coordination Team and pilot single point of contact access;
- Participate in the third round National Audit of Care at the End of Life (2020) which includes a staff survey;
- Continue to work with Information Services to improve data analysis and reporting to demonstrate effectiveness of the service;
- Undertake audit of anticipatory prescribing and syringe drivers within the hospital setting;
- Celebrate the success of the EoL volunteers and continue to expand the EoL volunteer service within the Trust;
- Undertake audit of care in last days of life in community to demonstrate current practice;
- Review of guidelines around anticipatory medications in line with regional and national guidance.

3.3.2 Improvements in Gastroenterology

With the retirement of senior gastroenterologist Dr Gareth Davies in June 2019, the Gastroenterology service made two consultant appointments, bringing in Dr Deven Vani as Gastroenterology Transformation Lead.

What were we aiming to achieve and what have we done?

A number of service level changes were proposed, aimed at enhancing the service provision and increasing the efficiency of the Gastroenterology Department. Throughout this process Dr Vani worked to ensure he had the full support of his fellow consultants. He developed links with key contacts in the Clinical Commissioning Group (CCG) and established regular meetings to discuss the development of the service within HDFT.

Faecal Calprotectin Pathway

The first action was the introduction of a new Faecal Calprotectin (FCP) Care Pathway for GPs. Calprotectin is a protein released into the gastrointestinal tract when it is inflamed, such as in inflammatory bowel disease (IBD). Previously the test was done at York Teaching Hospital NHS Foundation Trust. Dr Vani worked in close collaboration with Dr Nuthar Jassan, Consultant Clinical Biochemist at HDFT, to introduce in-house faecal calprotectin testing in October 2019. This has streamlined the process, which is now directly available to GPs via the Trust's Sunquest ICE requesting and reporting system. This links GP practices to the Trust laboratories, allowing GPs both to request tests electronically and to view the results. This has reduced the administrative burden on the Gastroenterology Department and expedited the process for GPs and patients.

Fibroscan

A fibroscan is a non-invasive procedure that measures the health of the liver using a type of ultrasound scan. Previously York Teaching Hospital NHS Foundation Trust was commissioned to provide a hepatology clinic in Harrogate and consultants would bring the York fibroscanner with them. With the agreement of the York consultants a new fibroscanner was jointly funded by the Trust and CCG and a scanning service established in Harrogate. An additional hepatology clinic now supports patients with liver, gallbladder and pancreatic conditions and a business case is being developed for a part-time hepatology liaison nurse to lead the fibroscan service. This will further enhance the hepatology service for patients and free up consultant time to run clinics.

Figure 45: Dr Vani and his team with the new fibroscanner

Paperless working

The department had previously relied on paper referrals, which were circulated to consultants prior to being triaged and sent back to the booking team. A system has been

established whereby referrals are made via the NHS e-Referral service (e-RS). In addition, clinic letters are now produced electronically so all clinic information is available for other clinicians to view.

Advice and guidance
The provision of advice and guidance to GPs was reviewed and a robust system developed to ensure a timely response. GPs now request advice via e-RS and the service has been able ensure a turnaround time of 48 hours, which has resulted in an increase in referrals.

Gastroenterology COVID-19 Rota
At the beginning of the COVID-19 pandemic, surgeons were redeployed into a separate surgical rota, which meant there were gaps in the out of hours gastrointestinal bleed service. The Consultant Gastroenterology Team worked to establish a rota to cover this service, which was over and above their commitment to maintain a comprehensive inpatient gastroenterology service during the pandemic.

Summary

Dr Vani and his colleagues have ensured transformation and improvement within the Gastroenterology Department in 2019/20. There is ongoing work to develop the fibroscan service and to ensure a fully paperless working environment. A priority for the coming year will be to transform outpatient clinics. The COVID-19 pandemic required significant changes in the way the department worked and by embracing technology, the team was able to continue providing clinics using remote consultations. During 2020/21 we shall seek to build on this and to expand remote service provision.

3.3.3 Nutrition

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

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

What were we aiming to achieve?

In 2019/20 the Nutrition Group aimed to consolidate the work from previous years and continue to work towards the aims outlined in the HDFT Food and Drink Strategy 2017-2021:

1. To meet the nutrition and hydration needs of patients;
2. Healthier eating for the whole hospital community, including staff and visitors;
3. Sustainable procurement of food and catering services.

What have we done?

We have a Trust-wide nutrition audit plan, co-ordinated by Clinical Effectiveness and Dietetics, so that we have oversight of all nutrition audits and can ensure that specific issues are identified and actions implemented. Nutrition screening is also one of the matrons' audits that takes place as part of their rolling audit programme. Speech and Language Therapy undertook an audit of the new International Dysphagia Diet Standardisation Initiative meals as provided by catering, following their introduction last year. This resulted in a few minor modifications to the modified textures menu.

Nutrition related events and complaints are co-ordinated and a report brought to the Nutrition Group so that we can identify any themes. We also identified an issue around the allergen labelling of meals, which has been rectified.

The Eat Move Improve project was launched in September combining the skills of all therapists on the frailty wards to support patients' progression to discharge. Food fortification has also been introduced at ward level to supplement the nutritional intake of patients under the supervision of the ward nutrition assistants.

Summary

Throughout the last year we have continued to build on the initiatives highlighted by the Food and Drink Strategy. Our audit work has shown us where we can make improvements and move forward with improvements in quality. We have reintroduced quarterly meetings to look at the operational aspects of catering in the hospital and will be introducing finger food menus on the frailty wards in 2020. We will also look to ensure a robust pathway is developed for the management of patients with gastrostomy tubes on admission to acute care and establish a community nutrition support pathway.

3.4 PERFORMANCE AGAINST INDICATORS IN THE OVERSIGHT FRAMEWORK

The following table demonstrates HDFT's performance against the national standards included in the Operational Performance Metrics section of NHS Improvement's Oversight Framework for each quarter in 2019/20.

Indicator	Minimum performance standard	Q1	Q2	Q3	Q4	2019/20
RTT incomplete pathways	92%					
A&E 4-hour standard	95%	94.2%	92.8%	88.5%	87.2%	90.9%
Cancer - 62 days	85%	85.5%	84.5%	91.8%	92.5%	88.5%
C. difficile cases due to a lapse in care	<= 19 cases	1	0	0	0	1
Summary Hospital-level Mortality Indicator (SHMI)	Within expected range	95.9	95.73	96.38	97.5 *(End Feb-20)*	97.5 *(End Feb-20)*
Diagnostic waits	99%	99.4%	98.9%	99.2%	98.4%	99.0%
Venous thromboembolism (VTE) risk assessment	95%	96.7%	96.2%	95.5%	95.8%	96.1%

Table 24: Performance against NHS Improvement's Oversight Framework April 2019 – March 2020

Key performance to note:

- The Trust achieved four of the national standards included in the Operational Performance Metrics section of NHS Improvement's Oversight Framework for the full year 2019/20. Diagnostic waits was achieved for the year overall, despite two quarters being slightly below the required level;
- The Trust did not achieve the A&E 4-hour standard for each quarter of the year;
- The Trust is one of the twelve national elective Clinical Review Standards test sites taking part in the evaluation of waiting time targets and are therefore not able to publish any referral to treatment (RTT) waiting time data;
- 4 out of 7 cancer waiting time standards were achieved for the year overall with the exceptions being the 14 day standards for suspected cancer and breast symptomatic referrals and the 62 day screening standard;
- There were 18 ambulance handover delays of over 60 minutes reported in 2019/20 (13 in the previous year) and 340 handover delays of over 30 minutes (157 in the previous year);
- Activity levels at the Trust were impacted by the COVID-19 pandemic in the final month of 2019/20. Following the standing down of elective work owing to the COVID-19 pandemic, elective referrals, outpatient attendances, elective inpatients and A&E attendances were all well below March plan resulting in the year end position being below plan and the previous year. Non elective activity remained above plan and also above the previous year;
- The Trust reported 29 cases of hospital acquired C. difficile in 2019/20, compared to 19 in 2018/19. Root cause analysis has been completed on 17 cases and indicated that 16 of these were not due to lapses in care, and therefore these would be discounted from the Trust's trajectory for 2019/20. No cases of hospital acquired MRSA (methicillin-resistant staphylococcus aureus) were reported in 2019/20.

4 OTHER QUALITY INFORMATION

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

4.1 SUMMARY OF NATIONAL PATIENT SURVEY RESULTS

National Inpatient Survey 2018

The 2018 inpatient survey was published in June 2019. 624 HDFT inpatients discharged in July 2018 participated in the survey which equates to a response rate of 52.17% (higher than the national response rate of 45%). For each question in the survey, the individual (standardised) responses are converted into scores on a scale from zero to ten. A score of ten represents the best possible response and a score of zero the worst.

Good news!

Overall HDFT was ranked 48th out of the 147 participating trusts with an overall score of 7.9, whilst the best performing Trust had an overall score of 8.7. In relation to other participating trusts, HDFT scored:

- 'About the same' on 58/63 questions;
- 'Better' on 5/63 questions:
  - How would you rate the hospital food?
  - Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?
  - Did a member of staff tell you about medication side effects to watch for when you went home?
  - Did a member of staff tell you about any danger signals you should watch for after you went home?
  - Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
- 'Worse' on 0/63 questions.

In terms of historical performance, our results were significantly better this year for three questions:

- Were you ever bothered by noise at night from other patients?
- Were you ever bothered by noise at night from hospital staff?
- Did a member of staff tell you about medication side effects to watch for when you went home?

Areas for improvement

Our results were significantly worse this year for two questions:

- Was your admission date changed by the hospital?
- During your hospital stay, were you ever asked to give your views on the quality of your care?

The National Inpatient Survey 2019 results are expected to be published in June 2020.

National Cancer Survey 2018

The National Cancer Patient Experience Survey 2018 (published September 2019) is the eighth annual iteration of this survey of adults with cancer who were treated as an inpatient or day case between April and June 2018. Questions follow the patient journey from their initial GP referral through to diagnostics, treatment and discharge.

323 completed questionnaires were taken into account, giving a response rate of 71% compared to a national response rate of 64%. Asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave HDFT an average rating of 9.2, an improvement from 9.0 in 2017. We also consistently scored above the national average on individual questions.

Good news!

Key findings as part of the survey include:

- 86% of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment;
- 96% of respondents said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment;
- 91% of respondents said that it had been ‘quite easy’ or ‘very easy’ to contact their Clinical Nurse Specialist;
- 93% of respondents said that, overall, they were always treated with dignity and respect while they were in hospital;
- 98% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital;
- 66% 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.

These results alongside those from previous surveys show that year on year, Harrogate consistently provides excellent care to patients receiving treatment for cancer at the Trust.

National Maternity Survey 2019

The National Maternity Survey 2019 results were published on the CQC website in January 2020. In Harrogate, 111 responses were received from women who used the Trust’s maternity services, a response rate of 39.93% compared to a national response rate of 36.5%. The survey asked women about their experiences of care across the pregnancy pathway from antenatal care, labour and birth, through to postnatal care.

Good news!

HDFT scored ‘better than most trusts’ for five questions:

- During your pregnancy, did you have a telephone number for a member of the midwifery team that you could contact?
- Would you have liked to have seen a midwife... (more often)?
- Did a midwife or health visitor ask you about your mental health?
- Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?
- Were you given information about your own physical recovery after the birth?

The result was significantly higher this year compared to last year for one question:

- Did the midwife or midwifery team that you saw appear to be aware of the medical history of you and your baby?

Results were about the same as other trusts for the remaining 41 questions.

Areas for improvement

The result was worse than most trusts for one question:

- During your labour, did staff help to create a more comfortable atmosphere for you in a way you wanted?

Results were significantly lower this year compared to last year for three questions:

- If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?
- Thinking about your care during labour and birth, were you treated with respect and dignity?
- Thinking about your stay in hospital, how clean was the hospital room or ward you were in?

There were no statistically significant differences between last year's and this year's results for 24 questions. Please note that due to significant amendments to the questionnaire in 2019 a number of questions are not historically comparable with 2018.

4.2 NATIONAL STAFF SURVEY

National Staff Survey 2019

This was the seventeenth NHS National Staff Survey, designed to collect the views of staff about their work and the healthcare organisation they work for. The overall aim of the survey is to improve the working lives of NHS staff and so provide better care for patients. The survey was distributed in October 2019 with a closure date of 29th November 2019. HDFT surveyed all staff in 2019; survey invitations were distributed to staff by email and by post. Staff also had the option to complete the survey questionnaire over the telephone.

Respondents

In total, 4,073 surveys were distributed to members of HDFT staff and 1,654 were completed, which represents a 41% response rate. The average response rate of our benchmarking group was 46%. The HDFT response rate shows an increase on our 2018 response rate of 39%, and given that our headcount has increased, we had more participants included in the total percentage. The 1654 participants in 2019 is a 4.94% increase of actual participants on the 1576 respondents in 2018.

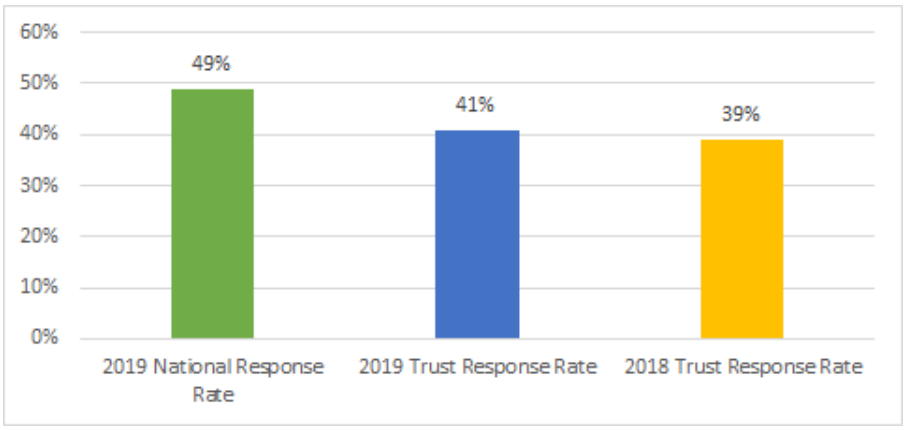


Figure 46: Staff survey percentage response rate

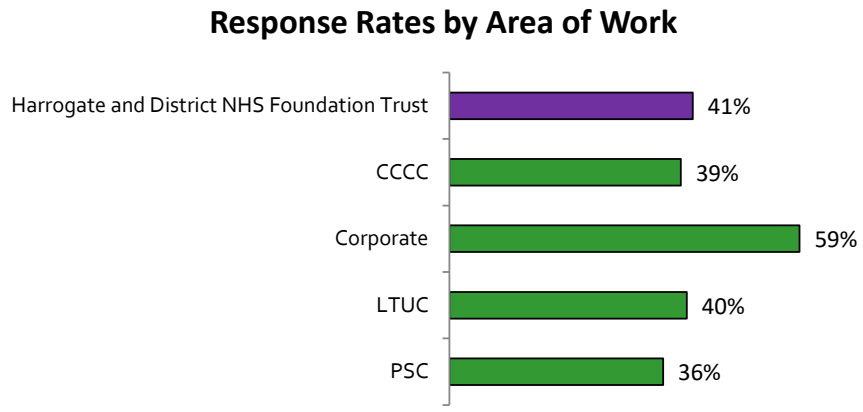


Figure 47: Response rate by Directorate

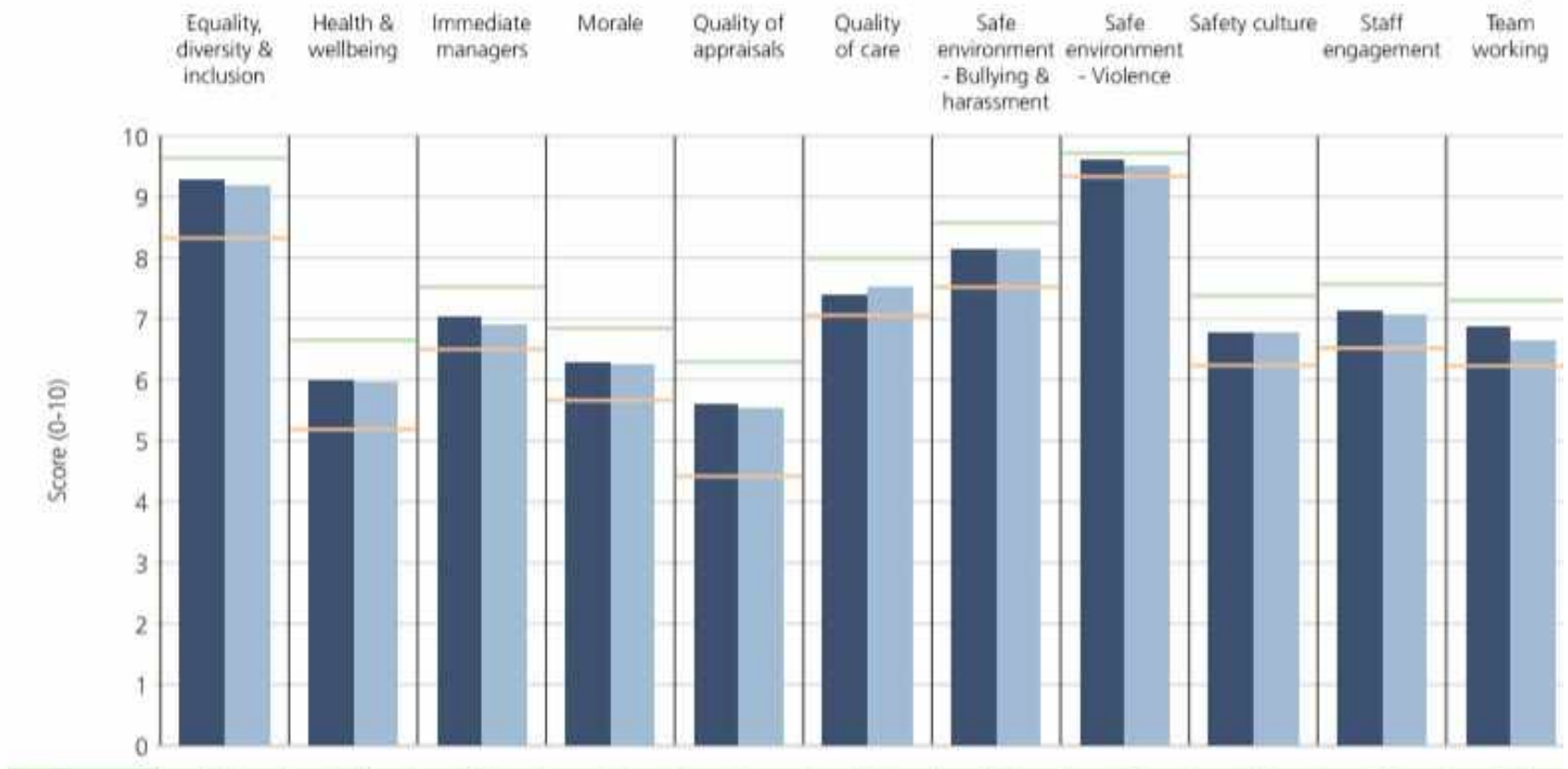
Themes and results

A summary of our results from the 2019 National Staff Survey is outlined below. These have been benchmarked nationally against other Combined Acute and Community Trusts and have been weighted by the Department of Health and Social Care, for fair comparisons between organisations.

Survey Coordination Centre

2019 NHS Staff Survey Results > Theme results > Overview

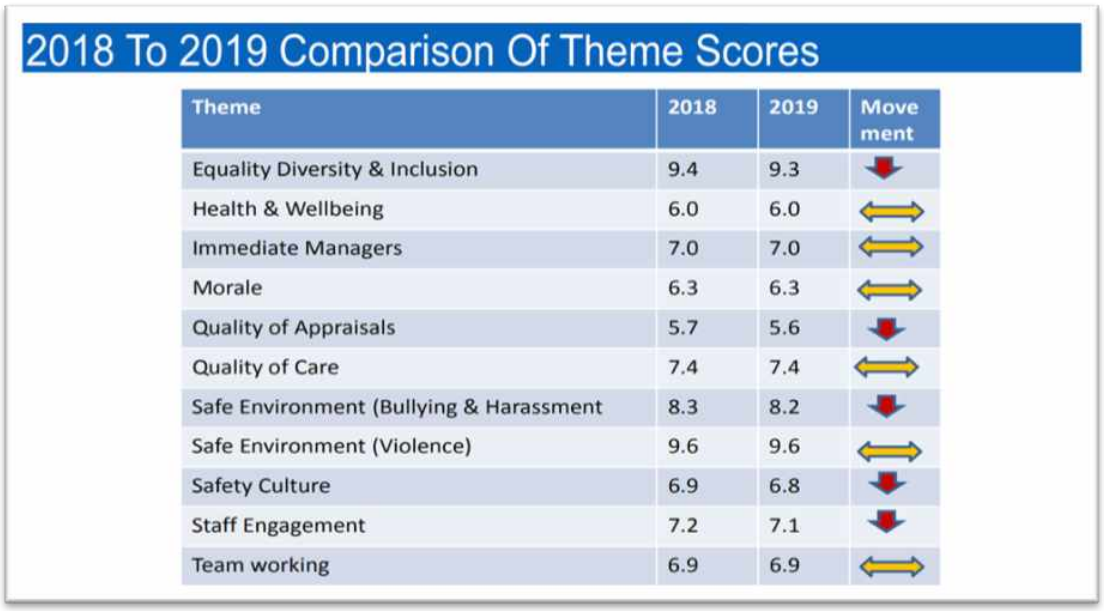
NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.6	6.7	7.5	6.8	6.3	8.0	8.6	9.7	7.4	7.6	7.3
Your org	9.3	6.0	7.0	6.3	5.6	7.4	8.2	9.6	6.8	7.1	6.9
Average	9.2	6.0	6.9	6.2	5.5	7.5	8.2	9.5	6.8	7.1	6.7
Worst	8.3	5.2	6.5	5.7	4.4	7.1	7.5	9.3	6.2	6.5	6.2
Responses	1,642	1,653	1,647	1,649	1,471	1,494	1,645	1,649	1,650	1,653	1,642

Comparison of theme scores

The 2019 results are presented in 11 themes. 2018 was the first year in which this format was used, meaning we can directly compare ourselves in these areas with results reported last year. Year on year comparison of themes with HDFT Staff Survey results from 2018 are summarised below:



2018 To 2019 Comparison Of Theme Scores

Theme	2018	2019	Movement
Equality Diversity & Inclusion	9.4	9.3	↓
Health & Wellbeing	6.0	6.0	↔
Immediate Managers	7.0	7.0	↔
Morale	6.3	6.3	↔
Quality of Appraisals	5.7	5.6	↓
Quality of Care	7.4	7.4	↔
Safe Environment (Bullying & Harassment	8.3	8.2	↓
Safe Environment (Violence)	9.6	9.6	↔
Safety Culture	6.9	6.8	↓
Staff Engagement	7.2	7.1	↓
Team working	6.9	6.9	↔

Figure 49: Comparison of theme scores

Next steps

A workshop to review the results of the staff survey took place on Tuesday 3 March 2020, attended by alumni from our leadership development programme, First Line Leaders. The purpose of this was to develop an action plan to address the findings of the survey, which is co-created by colleagues to support improving working lives at HDFT. Key themes from the staff FFT will also be incorporated into the staff engagement action plan.

This work has been paused as a result of COVID-19 and will be restarted at an appropriate time.

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 1.5 million patient contacts per annum, which equates to around 4100 per day. Whilst every individual complaint is very important, especially to the complainant, the average rate of around 20 complaints per month in 2019/20 is relatively small and has remained consistent with the average in 2018/19. The Trust increased in size associated with the delivery of a significant number of new children's services in 2018/19.

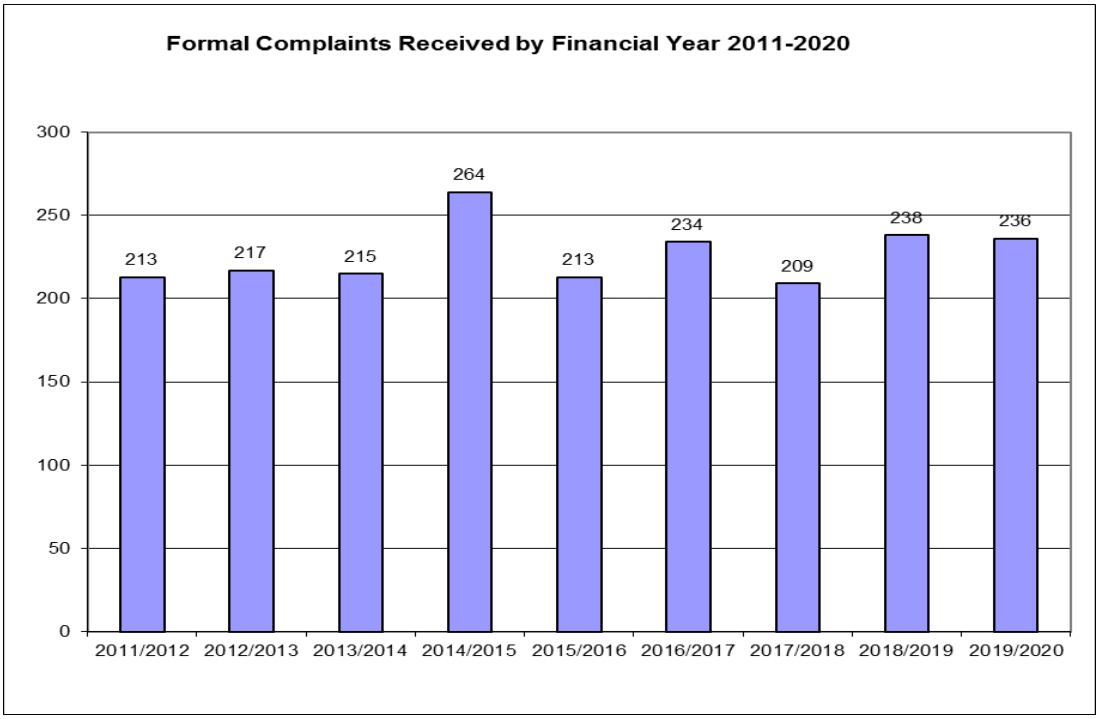


Figure 50: Local patient feedback data since 2011

The Trust uses a grading matrix for complaints raised, which is based on severity of concerns and timescales for response. This includes four levels of formal complaint (green, yellow, amber and red). The breakdown of complaints received in 2019/20 is presented below by grade and quarter in which it was received, compared to 2018/19.

Total number of complaints	2018/19	2019/20				
	Total	Q1	Q2	Q3	Q4	Total
Green complaint	40	11	14	18	14	57
Yellow complaint	198	37	48	44	45	174
Amber complaint	0	2	1	2	0	5
Red complaint	0	0	0	0	0	0
Total	**238**	**50**	**63**	**64**	**59**	**236**

Table 25: Local patient feedback data showing complaints by quarter during 2019/20 and grade

The number of complaints received is similar to the previous year but five cases graded amber and indicating very poor experience were received compared with none the previous year. This increase may be due to a more robust approach use of the grading matrix in the past 12 months. The five amber complaints were in relation to various specialties - elderly medicine, general medicine and gynaecology. Three cases were upheld following investigation; in one case all care and treatment was deemed appropriate and one case is still currently under investigation. Action plans have been developed for those cases which were identified as requiring learning and these are monitored through the Complaints and Risk Management Group.

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 2019/20, 953 were received by PET compared to 871 in 2018/19, 1061 in 2017/18, and 936 in 2016/17. Of these 953, 731 were concerns, 222 were requests for information or comments. The aim is for all staff to address concerns before they escalate into more serious issues, and the overall increase in the number of informal contacts is in line with this aim.

The top ten themes for complaints and concerns can be seen in the graph below. The main themes have consistently included issues around poor communication and attitude. This year concerns about length of waiting lists, appointment delays and cancellations, delay or failure in treatment or procedure and discharge arrangements are also in the top ten.

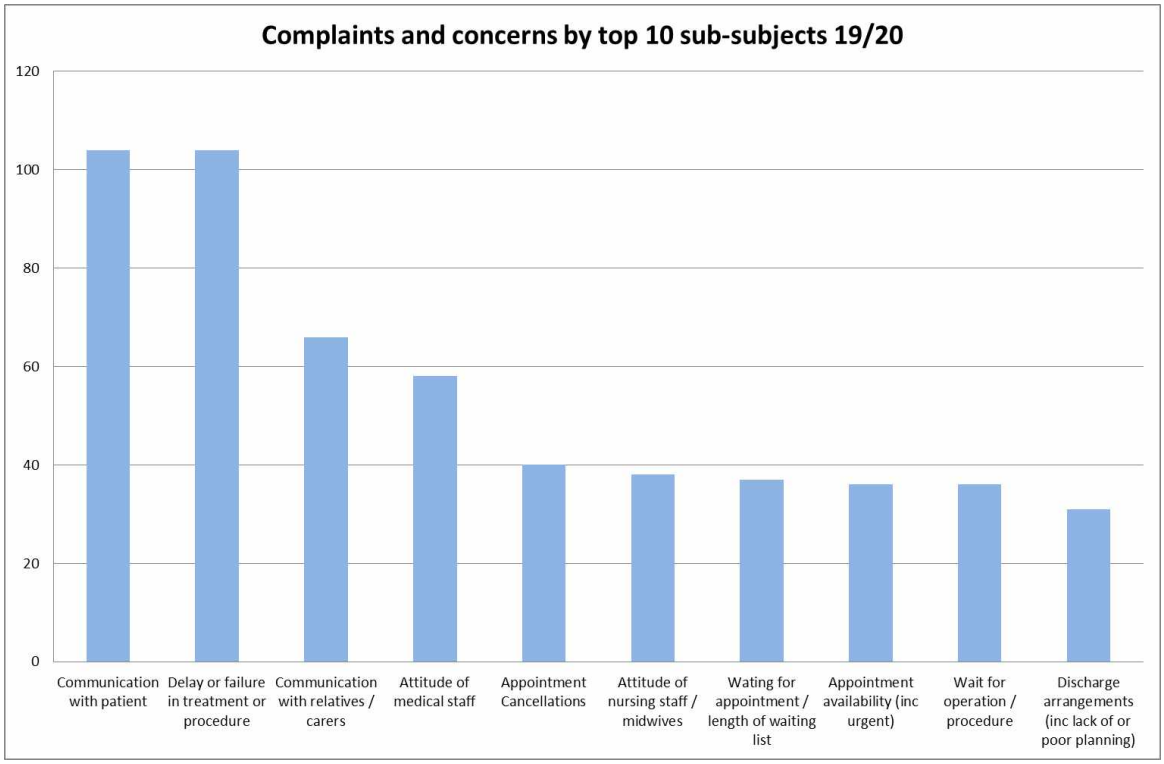


Figure 51: Local patient feedback data showing the main themes in complaints and concerns

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 actions will be undertaken 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 the 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 49% of cases in 2019/20 *(of those deadlines reached at the time of reporting)* and kept the complainant updated where the deadline could not be reached. This is a slight increase from 44% in 2018/19.

In September 2019 the Trust held an improvement event with staff including representatives from the clinical and corporate directorates and lay members, to look at the internal complaints process and consider changes to reduce the delays and duplication in process. Part of this event was also focused on improving the quality of the experience of the complainant. A number of new and revised tools were developed to improve performance. These have been piloted in Q4 of 2019/20 and a further review was scheduled to take place in April 2020 to determine if the revised process was fit for purpose and whether the changes were helping to improve performance. However in light of the challenges COVID-19 has placed on the organisation, this review has been postponed until later in the year.

Further training sessions to increase the pool of lead investigators was provided in 2019 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.

Two complaints were referred to the Parliamentary and Health Service Ombudsman (PHSO) in 2019/20. The Ombudsman closed one case without investigation. The other was partially upheld and the Trust was asked to provide financial reimbursement to the complainant and provide an update on actions and improvements made since the period of care (2014). One case was reported to the PHSO in 2018/19 and the Ombudsman is still investigating this case.

Cloverleaf Advocacy Services (Independent Health Complaints Advocacy Service) is an organisation that provides support (known as advocacy services) to help people across 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 liaised with colleagues from the Trust including PET to discuss individuals' cases and promote the model of advocacy. The Trust continues to promote the advocacy services that are available for supporting complainants and gathering 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 area.

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

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Number of compliments received by the Patient Experience Team	315	340	325	316	339	325

Table 26: Local data showing compliments received by the Patient Experience Team

4.4 QUALITY IMPROVEMENT

4.4.1 Improvement and Transformation Team

The Improvement and Transformation Team lead on the Trust's Quality Improvement Strategy, primarily through:

- Management and delivery of the Trust's Quality Charter;
- Development and facilitation of our annual Improvement Schedule;
- Responding to ad hoc quality improvement needs of the organisation.

What were we aiming to achieve?

Since our Quality Charter was introduced in 2016, we have witnessed a significant step-change in the organisation's appetite to engage with quality improvement as a discipline. The Charter brings together six schemes that focus upon encouraging, empowering, recognising and rewarding quality improvement. Our aims for 2019/20 remained similar to previous years, but with increasingly ambitious targets to:

- Train more than 300 Quality of Care Champions across the four levels of the scheme;
- Engage colleagues in practical improvement activity through a series of 24 events;
- Stage a third Quality Conference following the success of our first two;
- Recognise a further 12 Teams of the Month;
- Build upon the Quality Improvement Team Accreditation scheme, launched in 2018;
- Continue to develop effective quality campaigns;

And finally, we wanted to ensure we had the capacity and skills necessary to continue providing a responsive service to the changing needs of the organisation, as and when areas for improvement are identified outside of the Improvement Schedule.

What have we done and what did we achieve?

Practical Improvement Activity
Against a target of 24, we delivered 27 separate improvement events including eight rapid process improvement workshops (RPIWs). Some key outputs from those larger events include:

- User-guides, flow charts, new templates, training plans and audits and a complete overhaul of the Recruiting Manager and New Candidate Toolkits, from our Recruitment RPIW;
- An RPIW on Autism Pathways completely revised assessment processes and resulted in an 18-month initiative to reduce waiting times down from two years to three months;
- The "Tomorrow's Ward" RPIW included development of a framework that any ward can use to define their future staffing model and standard work;
- Our #ClearTheClutter RPIW included a business case and first phase of roll out to overhaul stock management on wards; new signage, labelling and processes for reporting faulty equipment, dedicated space for trolleys and wheelchairs outside each ward and relocation of storage areas for broken beds and equipment;

- Improved process and care, transfer of deceased patients from ward to mortuary and process for ensuring timeliness of death certification were all outcomes from our Care after Death RPIW.

In early 2019, eight senior colleagues participated in our Platinum Quality Improvement training. This demanding qualification comprises four days of classroom-based teaching, a revision day and an assessment day to test knowledge and presenting skills. Since then, we have been working with all of them to support them through the process of facilitating RPIWs in order to achieve full accreditation.

Ad hoc work undertaken by the team included support in relation to pre-operative assessment, a musculoskeletal (MSK) service review, a Human Resources policy review, prolonged jaundice in infants service redesign and neonate scanning capacity, to name but a few.

To further promote our colleagues' work on quality improvement and transformation we have continued to issue a monthly e-newsletter which is circulated throughout the Trust. As well as promoting some of the events and training we facilitate, it also plays a strong role in informing colleagues about the changes to practice that quality improvement delivers. We have also circulated two issues of "Innovation Extra", an additional newsletter aimed at showcasing and celebrating the improvement work taking place across our services.

We have now hosted two Quality Improvement Forums for our Champions and other interested colleagues, to discuss tools and share learning.

Silver level Quality of Care Champions continue to present their projects to the Quality Committee each month and updates on our improvement events are provided to the Senior Management Team meeting, raising the profile of the work and supporting colleagues to overcome any barriers.

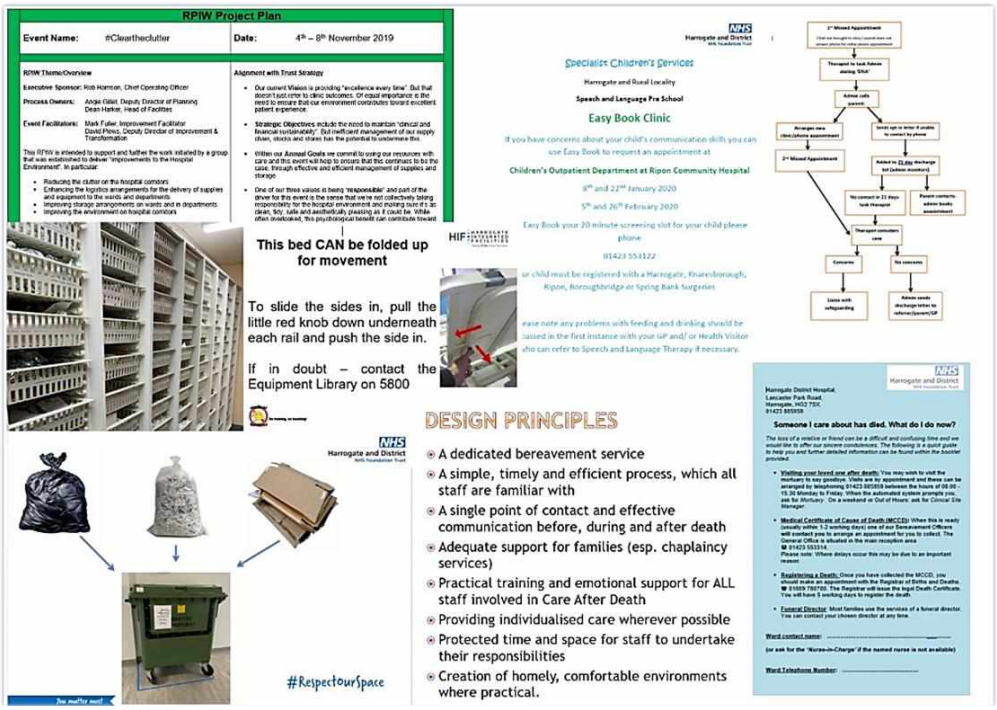


Figure 52: Example outputs from recent improvement work

Quality of Care Champions

Our Quality of Care Champions scheme continues to expand; we now have 734 Champions at Bronze level, 280 staff trained at Silver level and nearly a quarter of those have full accreditation, through delivery of a project in their area of practice. There is every confidence that this will continue to grow, as we know that the average time to complete projects takes 12-18 months.

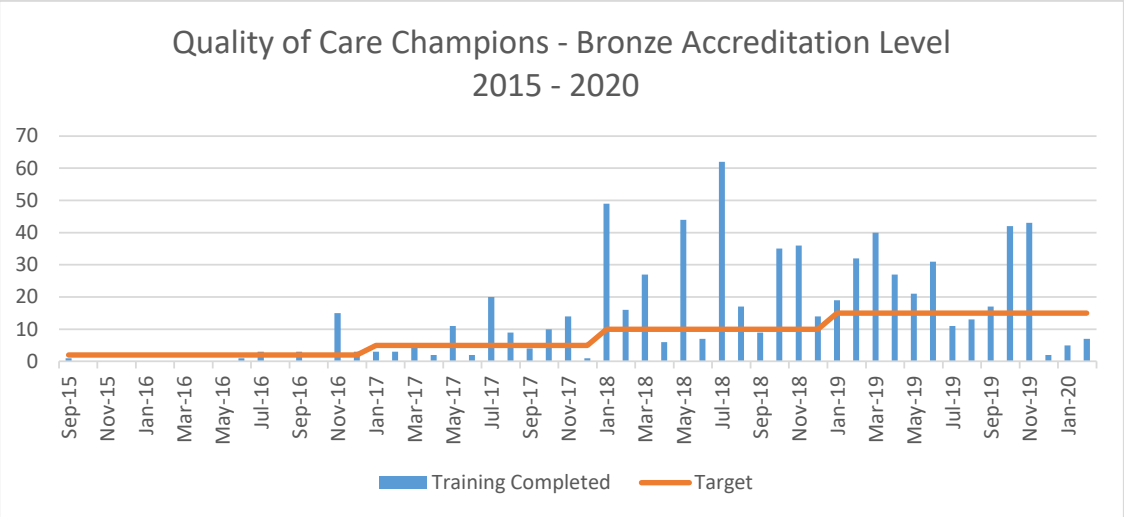


Figure 53: Number of Bronze Quality of Care Champions

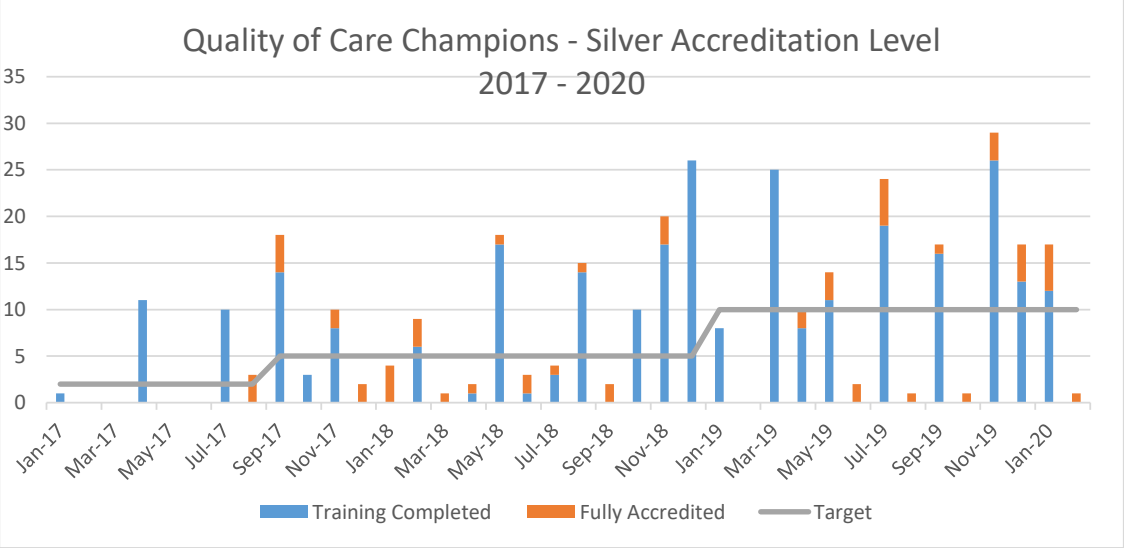


Figure 54: Number of Silver Quality of Care Champions

Although we are keen for colleagues to move from Bronze to Silver level training, it is a considerable jump from an e-learning module (or participating in an improvement event), to a full day of training with the delivery of an improvement project. In that respect, there will always be a gap between the two, but we strive to have as many staff as possible trained at Bronze Level, so that understanding the fundamentals of quality improvement forms part of everyone's role at HDFT.

Figure 55 shows that 31% of staff trained at Bronze level went on to attend Silver level training in 2019 and currently 58% of Bronze level accredited staff have completed their Silver level training since 2017.

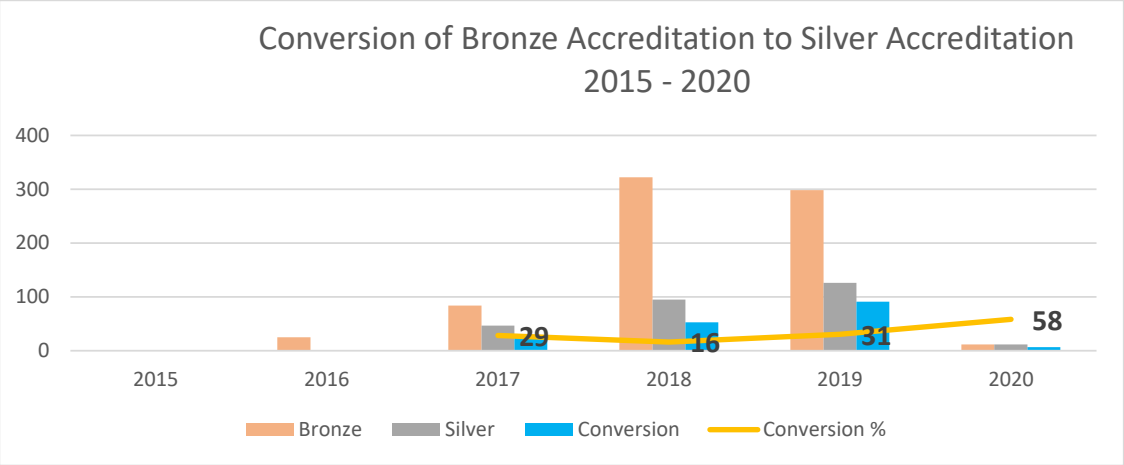


Figure 55: Number of Bronze to Silver Quality of Care Champions

Some example Silver Level Projects include:

- A drop-in wound care clinic that was established by a GP specialist trainee. This more responsive service negates the need for patients to present to their GP or ED should a wound require attention, taking pressure off other parts of the system whilst providing a much improved patient experience;
- Introduction of acupuncture for the purposes of pain management for patients with neurological conditions;
- Work by a colleague in our Speech and Language community service that successfully reduced the lead time from referral to first contact from an average of 7-10 weeks (24 weeks at the worst) to less than three weeks;
- The launch of a superb website to educate patients on MSK rehabilitation by one of our physiotherapists that was recognised at last year's Quality Conference. Providing a wealth of educational resources, it empowers patients to take greater responsibility for their own recovery;
- Work by one of our specialist registrars to significantly reduce the number of bleeps that interrupted some medical staff with such frequency that it was heavily detracting from their ability to work effectively;
- A comprehensive directory of local community services set up by an occupational therapist to highlight the huge array of free and paid-for services available to patients.

Teams of the Month and Making a Difference Nominations

Knowing only too well how committed and hardworking many staff are, this scheme has been running for several years now and allows anyone – including the public – to nominate individuals or teams in recognition of their efforts. With members of our executive team presenting certificates badges and letters of commendation we aim to celebrate going 'above and beyond', living the Trust values, making the difference and using our resources with care.

Making a Difference and Team of the Month Award nominations over the past three years have consistently reached their targets, with August 2019 showing the most nominations ever, with a total of 37. Approximately half of those go on to receive an award, with many others receiving letters of commendation.

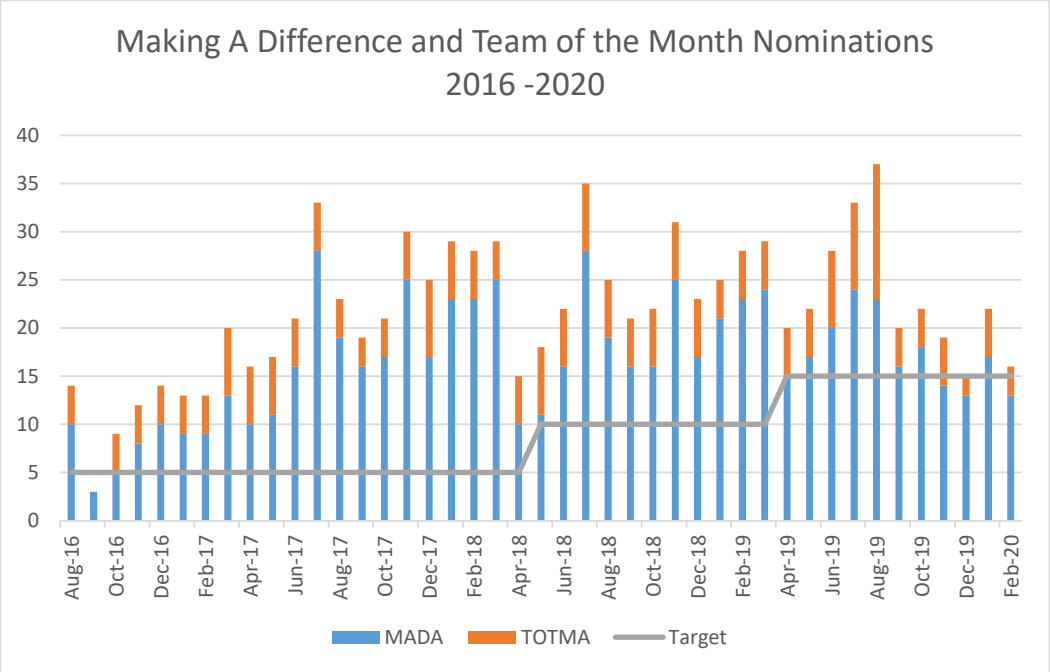


Figure 56: Number of nominations for Making a Difference and Team of the Month

		
Rhys Edwards Service Delivery Matron Main Theatres and ITU	Beth Fisher Continuity of Carer Project Lead Midwifery	Caroline Watkins Supported Discharge Service Occupational Therapy
		
Emma Edgar Cardiology Nurse (Interim Lead) Staff Governor	Rob Watt Procurement Officer Supplies Department	Infant Feeding Team Growing Healthy 0-19 Service County Durham

Figure 57: Some of our recent award winners

Quality Improvement Team Accreditation

We launched the Quality Improvement Team Accreditation in April 2018, aimed at recognising and rewarding teams to adopt a culture and practice underpinned by the principles of quality improvement. Tiered in a similar manner to our Quality of Care

Champions scheme (Bronze, Silver and Gold), accreditation lasts between 12-24 months and needs to be revalidated annually in order to maintain it.

More of a marathon than a sprint, we expect the journey of accreditation to take several years but have to date have accredited (or reaccredited) more than twenty teams at bronze level, and seen the first few applications for Silver Accreditation come through.

Figure 58: Some of the "visions" from teams who have been accredited through the scheme in 2019/20.

Quality Conference

Our 2019 Quality Conference went ahead and was as well received as the previous two. The event provides a platform to share, learn and celebrate success relating to quality improvement, clinical audit, service evaluation and research initiatives across the Trust. Over 130 colleagues attended in person, with more than eight thousand Twitter impressions generated over the following weeks.

Figure 59: Images from the 2019 Quality Conference

Quality Campaigns

The Quality Campaign for 2019/20 was around smoking cessation and aimed to promote the benefits from stopping smoking. A recent grant of £2,000 from NYCC was awarded to HDFT to fund smoking cessation information leaflets, champion pins and lanyards, new signage for around the building and exterior signage for hotspot areas and additional handheld carbon monoxide monitors. Working in partnership with Living Well North Yorkshire to deliver training around Very Brief Advice and Very Brief Intervention, we aim to have 10% of all patient-facing HDFT staff (i.e. 200 ward staff) trained in one of these by the end of 2020.

Summary

This has been another productive and successful year for the Improvement and Transformation Team. For the most part, we have either met or exceeded targets set for our work or the improvement events that we have facilitated.

Now into the second year of our Five Year Quality Improvement Strategy, we know that in order to maintain the pace and momentum of growth seen in recent years, we need to develop more in-house trainers and facilitators, introduce training for event sponsors and look at other ways to increase our capacity. We are in consultation about our bold plans to take quality improvement to the next level in 2020/21.

4.4.2 Children's and Countywide Community Care Directorate change programme

The Children's and Countywide Community Care Directorate (CCCC) 'Doing It Differently' (DID) Group is a subgroup of the CCCCs Board and oversees the strategic plan for delivering quality improvement, cost improvement programmes and service reviews across all of our services.

What we were aiming to achieve?

Our directorate aim is to deliver a high quality experience for all service users and to support all our staff in delivering safe, effective and sustainable services. We measure our achievements through listening to what our staff say in terms of learning and sharing best practice and most importantly through our 'You're Welcome' standards aligned to the patient experience.

What have we done	Results
Q1 2019/20	
500 virtual private network (VPN) activations in 0-19 Children's Services. VPN allows staff remote access onto our network. A series of activation sessions were run across North Yorkshire, Middlesbrough, Darlington and Durham to support our health visitors in their day-to-day role, allowing access to clinical and non-clinical systems from an increased range of sites and settings. These sessions aimed to share the 'How to Guide', set out consistent ways of working and to offer a Q&A with the staff.	1. Implementation was completed ahead of the planned project timeline, with the exception of Stockton due to contract terms; 2. Dashboards were developed to demonstrate the impact on performance metrics and staff feedback; 3. Performance levels were maintained across key areas of services; 4. Feedback demonstrated improvements in staff stress and anxiety by supporting a more flexible, safe and efficient approach to working.
Autism Assessment Rapid Process Improvement Workshop (RPIW). As part of the Service Review in Specialist Children's Services (SCS) that commenced in January 2019, this RPIW enabled the first of the sub specialities to review its core provision of service.	1. We agreed a 12 month waiting list initiative process with our commissioners to start in August 2019 to support and manage the existing demand. This aimed to reduce the wait from referral to assessment from over two years to three months. 2. We were recommissioned to deliver our new Autistic Spectrum Disorder (ASD) assessment pathway following on from this in August 2020.
Q2 2019/20	
Dental 'improvement' workshops. Two workshops were held, one to review the general anaesthetic (GA) pathway, and the other to consider with the full community dental teams ways to develop a plan for continuous improvement, standardisation and more efficient ways of delivering the service. Another programme of work has been requested for 2020/21 to extend this with a more in depth review of the dental administration processes.	1. GA pathway rolled out by the end of Q2; 2. Quick wins delivered to support standardising working environments across the localities; 3. Actions delivered to improve IT systems; 4. Allocated support to review and deliver quality improvement programme in 2020/21. This is to be reviewed in light of COVID-19.
Online School Questionnaires (NDL software). As part of a project to work with NDL to provide online access to school questionnaires and flu	1. Approximately 130,000 documents returned online in 2019/20; 2. Positive feedback from parents/carers in terms

What have we done	Results
and other immunisation consent forms, removing the need for an extensive paper based process, the questionnaires for Reception and Year 6 parents and students were launched in September 2019. This provided a platform of learning as we develop the next wave for the 2020/21 school year. The project also explored the use of robotic process automation (RPA) for appending information onto the clinical records.	of usability and online experience; 3. Lessons learned workshops held in Q4 to support improvements for 2020/21 process; 4. The RPA process proved to be a challenge and additional support is required to resolve these issues to support future work.
Launch of CCCC's 'Doing It Differently' (DID) Group. Set up by our Programme Manager for Change and Innovation Lead, these bi-monthly meetings aim to bring together ideas for service change, innovation and to provide a sounding board to support overall quality led continuous improvement across all of the directorate services.	1. The DID Group planned for an end of year 'Doing It Differently' conference, which was due to engage with around 200 stakeholders across our children's services to share and learn from the year's developments; however, due to COVID-19 we have had to postpone and this will take place at a future date.
Q3 2019/20	
VPN activation in additional 0-19 Children's Services. Team champions from Sunderland and Gateshead completed the activations for their areas. We tested the VPN benefits dashboards that had been developed over the summer to look at key feedback from staff as well as the benefits proposed in the original business case.	1. One of the highlights included initial improved perceptions relating to stress and anxiety of staff. We continue to monitor the benefits of remote working for staff and services.
Specialist Children's Service (SCS) workshops. Following the earlier Autism Assessment RPIW in Q1, we held additional workshops in relation to Occupational Therapy and Physiotherapy service provision, and an RPIW for Speech and Language Therapy in late November.	1. These sessions continue to develop and set out the optimum delivery of our services in relation to a future SCS Service Specification; 2. The Executive Board is to receive a 365 day update following the RPIW in July 2020.
Adult Chronic Pain. A one day workshop was held to consider new ways of working and to develop a standardised approach to allied health professional (AHP) led services with medical input.	1. Decision made to sustain an AHP led approach to the service (with medical input); 2. Plan to support virtual working with VPN; 3. Review of referral criteria and refinement of the referral form and process.
Family Action Team (Stockton). Following on from a series of summer workshops, a final session was held in December to consider the team identity and to finalise a clear outline of this newly developed service.	1. Family Action Team created an 'identity' to share with the commissioner/service users
Q4 2019/20	
Specialist Children's Community Nursing. Early January saw the last in a series of Service Review workshops in relation to Community Nursing, follow up work in Community Paediatrics and Psychology and a review of the management and administration structure. This completes the Service Review project, with development of task	1. Final outcomes of the recommendations paper to be presented to the Executive Board; 2. Commissioners have been sighted on each sub-service workshop and autism assessment is already recommissioned.

What have we done	Results
and finish groups planned.	
Flu and immunisation workshop. The North Yorkshire and North East teams initially brought together to develop the online consent process, reviewed standardised practice and shared process learning. The aim was to increase the efficiency of the teams and improve engagement with parents, schools and students.	1. Revised process flow to provide efficient service approach; 2. Improvements to online forms process; 3. Platform that has supported a flexible approach during the response to COVID-19.
DID Annual Conference. Considerable work went into planning this event for 25th March 2020 in Northallerton. Key external speakers were booked and with the HDFT Board in attendance, this was to be an opportunity for our Children's services teams to share and learn about their service change and innovation, and consider 'what next?'	1. Due to COVID-19 the conference was postponed. We look forward to reorganising and hosting this event in 2020/21.
COVID 19 response. It is a great reflection on all the directorate staff, and staff across the organisation, that we can adapt and be flexible in delivering high quality services under immense pressure, be it an increase in demand or when simply 'doing it differently' is required. Following the 500 health visitor VPNs rolled out in 2019/20 we have rapidly rolled out over 600 further activations during March and April 2020. This was achieved by utilising the knowledge and processes developed by the health visitor project.	1. VPN roll out along with other remote working solutions (Attend Anywhere/Whatsapp for Community/MS Teams) have been put in place as part of our COVID-19 response. We will consider these for future working as we continue to develop and improve our services.

Figure 60: CCCC Directorate Change Programme

Summary

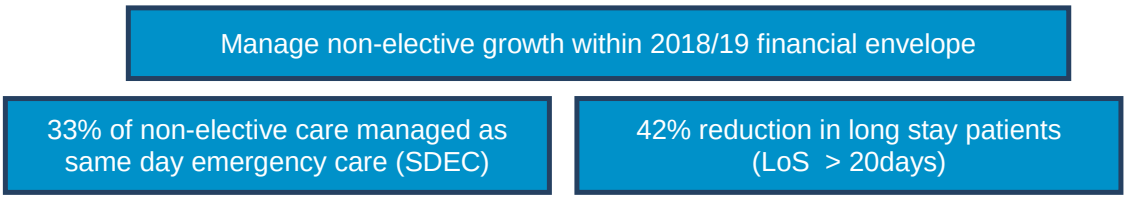
In summary, the 2019/21 cost improvement and service improvement plan was reported as delivered to the Board. The DID Group continue to review feedback and learning from each area of service change and/or improvement and in response to COVID-19 will be supporting all services to consider how we continue to innovate and adapt services to maintain a high level of quality led services.

4.4.3 Long Term and Unscheduled Care Directorate non-elective transformation

During 2019/20 we aimed to manage the non-elective growth with the same resources we had available in 2018/19; this required pathways and approaches to be reviewed to ensure our resources were used in the most effective ways. The key areas we wanted to improve were:

- Ensuing that there were pathways to enable people to be seen and treated on the same day where it was appropriate for them, in order to avoid long stays in hospital, and that:
- When it is necessary for someone to come into hospital, we have pathways and processes in place to ensure they are discharged as soon as they are well enough to go home.

What we were aiming to achieve and what have we done?



Discharge Programme

The Discharge Programme aims to reduce the time patients wait unnecessarily in the wrong care setting by reducing lengths of stay, delayed transfers of care (DTOC) and the number of long stay patients. We planned to achieve this by developing a 'home first' culture, out of hospital capacity to support discharge to assess (D2A), awareness of discharge planning processes and ward-based long stay patient reviews. The Supported Discharge Service have been working in ED as part of the Acute Frailty work, and embedding a 'home first' culture, 'where best next'. Ward based long stay reviews have been implemented, a Care Home Trusted Assessor model trailed where we look at ensuring we are able to respond quickly and appropriately to any increased needs and/or service demands experienced because of winter pressures, and a revised long stay action plan agreed.

Acute Frailty Service

We developed an acute frailty service to give frail patients prompt, targeted management based on a comprehensive geriatric assessment. This would allow screening and treatment to start with the appropriately skilled multi-disciplinary team (MDT) as soon as the patient arrives in hospital. This would also improve the number of frail patients treated via specialised same day services and safe discharge home, with links to community services, enhanced recovery and associated care planning (which can include End of Life care planning). An RIPW has taken place and a project group and service model established.

Expansion of Combined Assessment Team (CAT) and Acute Medical Model

This was to allow an effective ambulatory care service delivering care and treatment within the same day, allowing patients to return home and recover in their own environment, and a seven day same day emergency care (SDEC) service. Implementation of an Enhanced Acute Medical model provides robust acute medical rotas, acute medial leadership, improved continuity of care, and more rapid access to senior decision makers on admission.

Acute Referral Team

We aimed to deliver a single point of contact for GP referrals, which will direct them to the most appropriate place first time, such as CAT, Surgical Assessment, or Outpatients. There

was a successful trial in March 2019 and the service commenced in November 2019. The next stage will be to develop access to community services and step up community beds.

Harrogate and Rural Alliance (HARA) – Integrated Community Provision and Primary Care Networks

We have been working towards more joined up adult community services based around primary care networks (PCNs). The purpose is to support patients to stay well in their own homes for longer, reduce admissions to hospital, and to support discharge once acute care that can only be provided in hospital is no longer required. The service was launched in October 2019 and enablers are in place to facilitate joint working across adult health and social care with unified teams and management structure. MDTs and huddles have been established to discuss 'hot' cases initially involving NYCC / HDFT / PCN, with work started to reengage with Tees, Esk and Wear Valleys NHS Foundation Trust around their input into the HARA model.

Results

We have seen and treated on average 32.4% of non-elective admissions per month on the same day. As we have seen a rise in non-elective activity this means we been able to treat more patients without a stay in hospital.

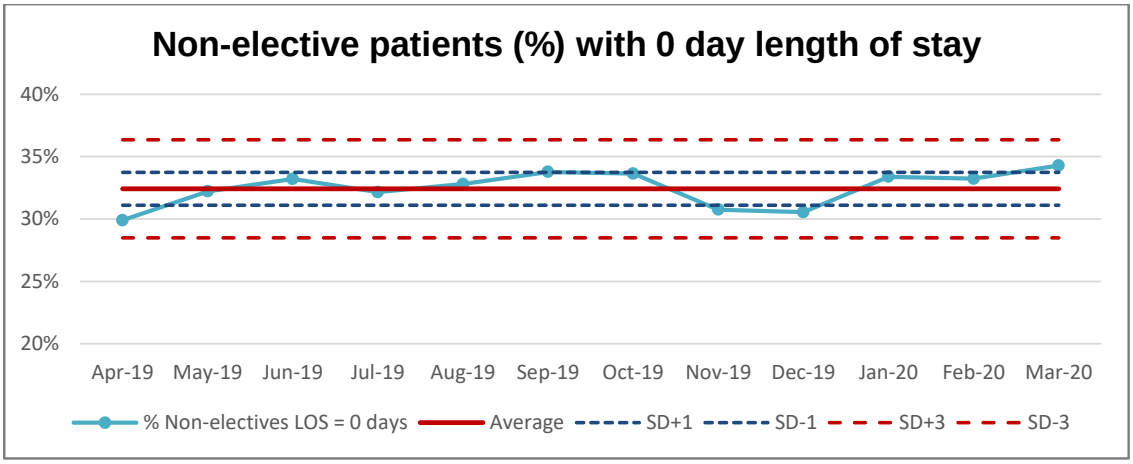


Figure 61: Percentage of non-elective patients treated on the same day

Throughout 2019/20, we have reduced the number of patients staying in hospital over 20 days. Whilst we have not reached the target of 50 patients in hospital over 20 days, during Q1 we saw an average of 55 patients staying in hospital over 20 days which was sustained throughout Q1, Q2 and Q3. The increase in Q4 was due to winter pressures on the system.

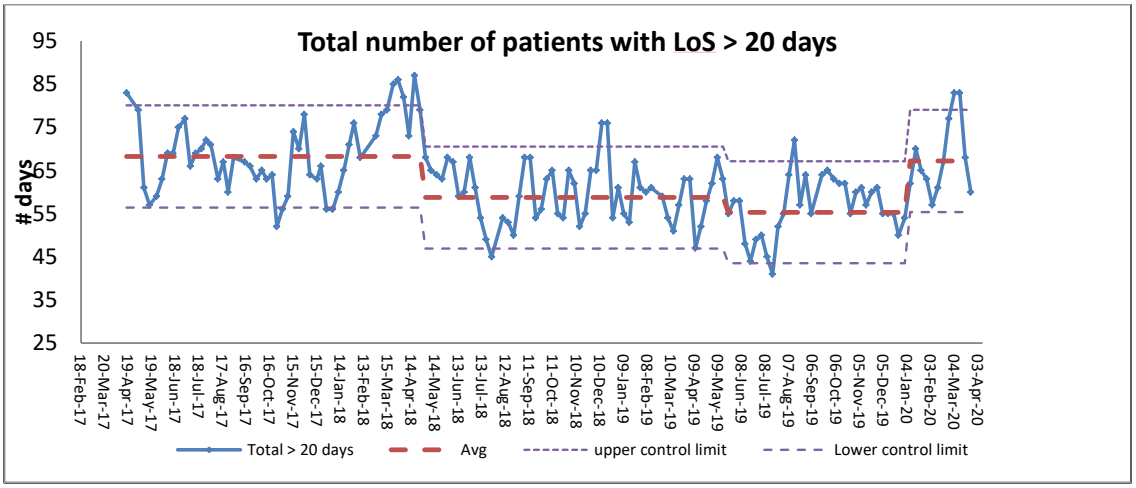


Figure 62: Number of patients with a length of stay greater than 20 days

Delays most commonly occur because patients are waiting for a package of care in their own home to start, waiting for a transfer to a care home or nursing home or waiting for a rehabilitation bed in the community. Nationally these delays are termed delayed transfers of care (DTOC), referring to the fact that the patient no longer requires hospital care and could be appropriately transferred to another setting to continue their care. Throughout 2019/20, we saw an improvement in DTOC until reporting was suspended in March 2020 as part of the response to the COVID-19 pandemic.

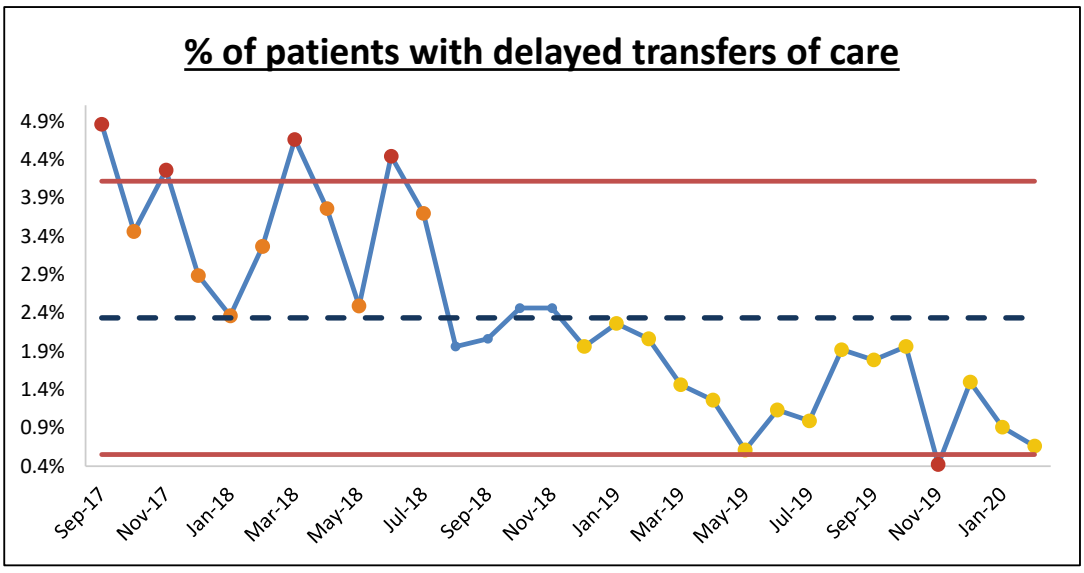


Figure 63: Percentage of DTOC September 2017 to February 2020

Summary

During 2019/20, we have reviewed and developed pathways and processes that have enabled us to see and treat more patients on the same day, therefore, avoiding the need for an overnight stay in hospital. When patients do need to have an overnight stay in hospital we have improved processes to reduce the amount of time they stay in hospital and improved the pathways for supporting them to be discharged home.

4.4.4 Planned and Surgical Care (PSC) Directorate transformation programme

The PSC directorate has had a Planned Care Transformation Programme since April 2019. The aim of the programme is to deliver improved efficiency of the delivery of planned care across the Harrogate system (primary and secondary care) by:

- Reducing demand to secondary care;
- Reducing the cost of the provision of secondary care;
- Reducing the 'cost per patient pathway' and where direct costs cannot be removed, change will ensure that more is delivered for the same cost;
- Meeting the requirements of the NHS Long Term Plan to reduce face-to-face appointments by 30% over the next five years.

New and innovative digital technology will play a fundamental role in delivering these efficiencies; as such, we are in the process of developing in partnership with an external company/companies a one to three year proposed strategy to fundamentally change the way outpatients is delivered with clarity on the digital requirements and in line with the HDFT Digital Strategy.

What were we aiming to achieve?

The key work streams to support the programme are identified below:

Work stream	Measurable	Success Criteria
Transition from the Referral Management System to secondary care consultant or clinician triage, using NHS e-Referral service (e-RS) direct booking model for speed of roll out.	• Volume of GP referrals into secondary care. • Proportion of referrals accepted, rejected or redirected (i.e. straight to test).	• Reduction in number of inappropriate or unnecessary referrals through improved education in primary care following advice and guidance, and referral feedback. • Reduction in number of new patient appointments as a result of the above.
Clinical pathway review and streamlining with a focus on interventions 'adding value.'	• Trends in new patient to follow up ratios across specialties and clinicians. • Number of diagnostic tests per patient and the point at which they are carried out in the patient pathway. • Number of appointments per patient across specialties.	• Improved new patient to follow up ratios. • Reduction in the number of appointments per patient pathway.
One Stop Clinics; combining diagnostics and outpatient appointments in the same clinic.	• Number of procedures carried out at the first appointment. • Number of follow up appointments compared to new patient appointments.	• Reduction in number of appointments per patient pathway and quicker progress with treatment plans.
MSK Single Point of Access and First Contact Practitioners (FCP); triaging non-urgent routine conditions with specialist practitioner input early in the patient's pathway.	• Number of FCP appointments. • Outcomes of FCP appointments. • Number of GP appointments. • Number of secondary care referrals.	• Reduced waiting lists and improved referral to treatment times (RTT). • Reduction in GP appointments for specific conditions. • Reduction in new patient appointments. • Improved conversion rates of

Work stream	Measurable	Success Criteria
		MSK referrals to orthopaedic surgery.
Initiate the development of an enhanced 'local' website	• Patient feedback (surveys). • Number of recorded hits per page.	• Patients reporting that they feel empowered to self-manage their condition through access to clinical advice, support groups, wellbeing activities etc.
Initiate roll out of a patient portal booking system	• % uptake of patients invited to participate. • % of patients opting for digital letters. • Did not attend (DNA) rates within pilot specialties.	• High proportion of patients signing up to the portal. • Reduction in costs for appointment letters and postage. • Improved clinic utilisation through reduced DNA rates. (It is anticipated that patients will have greater control over their appointments and will receive reminders through the portal).

Roll out of non-face to face appointments for routine and urgent appointments (not requiring physical examination)	• Number of:
	  ○ Video consultations
	  ○ Telephone consultations
	  ○ Face to face consultations
	• Average length of each type of appointment.
	• Average waiting list times.
	• Patient feedback (survey).
	• Consultant feedback (survey).
		• Reduction in face-to-face appointments by 30% over next five years.
		• Reduction in waiting lists.
		• Improved patient and clinician experience.
		• Reduction in DNAs.

Roll out of Patient Reported Outcomes Measures (PROMS) through digital means.	• % uptake of patients invited to participate. • Number of postponed or cancelled FU appointments made by clinician. Compared to patients not using the app (control group). • Number of requests by clinician to see the patient in clinic sooner (compared to the app control group). • Patient and clinician feedback surveys.	• Reduction in follow up appointments. • Better patient health outcomes through earlier health detection and adjustments to treatment plans.

Figure 64: Planned Care Transformation Programme work streams

The Planned Care Transformation Programme will continue to integrate the programme of work focused on transformation of cancer services. We will also conduct a further review of the method of triage and transition away from e-RS direct booking where indicated to gain further benefits. This will closely link with integrating GP referrals with WebV, a system designed to improve the way patients are managed on hospital wards, as part of the longer-term plan.

What have we done?

We have over 30 individual projects or schemes linked to the above work streams which are either completed, in progress or ideas which have been generated.

A strategy planning session was undertaken with operational leads, clinical leads, the Trust's Project Management Office, the CCG, and a third party supplier of digital technology, DrDoctor. The outputs of the session included the development of a broad vision, the identification of key IT schemes required to support fundamental change and broad timelines. A brief overview of the roadmap is provided below:

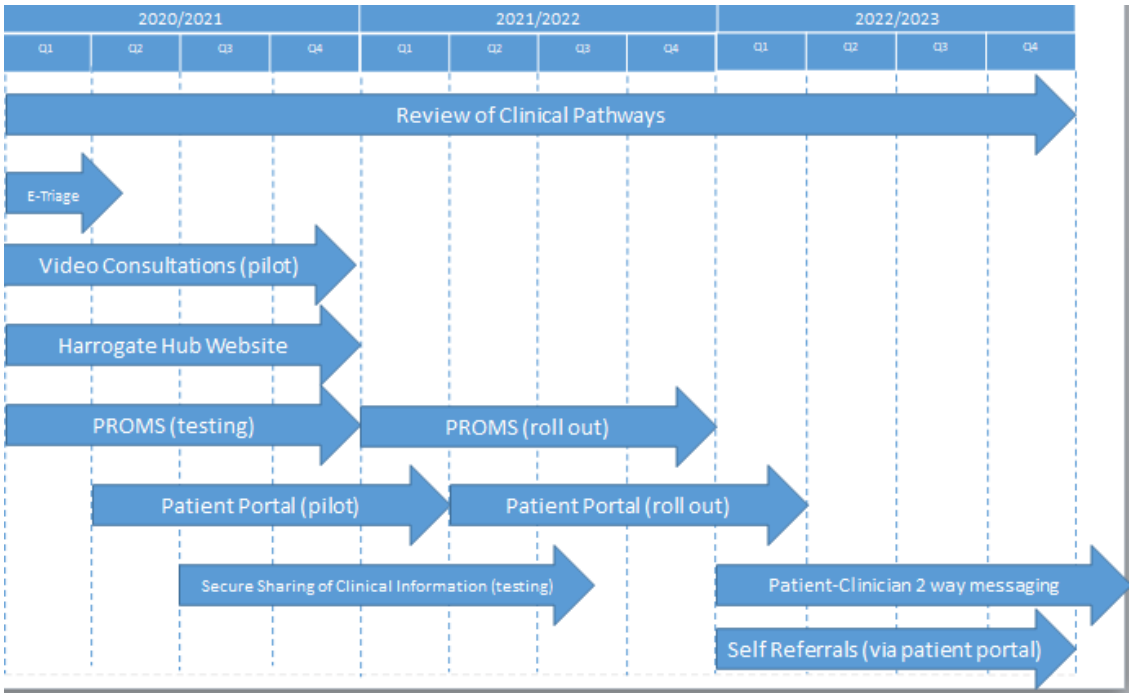


Figure 65: Planned Care Transformation Programme developments.

We have shared the above roadmap with clinicians in two open invitation sessions in July. The sessions included a presentation outlining traditional outpatient pathways from referral to discharge; how this pathway can be improved digitally; promotion of what we currently have available to support new ways of working and what is in the pipeline all of which dovetails with the Trusts Digital Strategy.

We have arranged in September for a number of suppliers to pitch to the Trust on how their products can best meet our digital requirements and find a best fit with our roadmap.

One of the most significant changes we have implemented as a result of COVID-19, is the rapid roll out of non-face-to-face clinics across acute and community services. We have been presented with an opportunity in the face of adversity to embrace this new way of working to help respond to the crisis, and this has been achieved through a combination of telephone and video clinics. We intend to build on this by continuing to promote non-face-to-face as the default way of offering outpatient appointments where clinically appropriate. We have engaged with NHS England and NHS Improvement, and Attend Anywhere to pilot their web-based video consultation platform so we can test and learn from the use of video consultations per se, and measure the benefits of the Attend Anywhere platform. This has functionalities including virtual waiting areas, options for surveying patients, messaging patients, options for inviting guests, screen sharing etcWe are also working with a digital supplier and are in the process of testing their product in Rheumatology (Living with

Rheumatology App for patient reported outcome measures) over a 12 month period. Approximately 40 patients have been invited to connect to the Rheumatology clinic via the Living With Rheumatoid Arthritis app.This allows the clinician to review real-time patient condition activity data and track patient progress through HAQ-DI and RAPID-3 PROMS. The plans are to increase volumes on an incremental basis up to 250 patients with outcome measures defined and tracked.

App benefits for clinicians:

- ✓ Improved patient outcomes
- ✓ Increase patient engagement
- ✓ Reduce consultation time
- ✓ Reduce waiting lists

App benefits for patients:

- ✓ Increase engagement and self-management
- ✓ Increase adherence to prescribed programmes
- ✓ Improve condition awareness
- ✓ Improve outcomes

What are the results?

Consultant Led Triage (CLT)

Outcomes from pilots in Gastroenterology and Urology suggest that local triage reduces cost in the healthcare system with no negative impact on quality, outcomes or patient safety. The triage pilots have provided sufficient data to evidence how referrals can be managed differently, avoiding unnecessary outpatient attendances. Data from both pilots suggested between 21-25% of referrals could be redirected to the right place, first time, which is a 6-10% improvement on the Referral Management System triage that was in place for these services at the time.

We have rolled out CLT in Urology, Gastroenterology, Rheumatology and Paediatrics, and are progressing in Gynaecology, General Surgery and Cardiology.

Patient Pathways Reviews

The urgent colorectal pathway has been reviewed following implementation of the ACE programme guidance (**accelerates** progress, **coordinates** implementation and consistently **evaluates** best practice and innovative approaches to early diagnosis of cancer). There are new referral criteria, a hospital triage model, and follow up only of confirmed cancer or unexplained anaemia. The results over a 6-month period show a reduction of 125 new patient appointments and 59 follow up appointments.

The implementation of the new guidelines from the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) has shown to reduce surveillance colonoscopies by up to 70% nationally. For HDFT this equates to 394 patients in 2019/20 who will not need a surveillance colonoscopy.

First Contact Practitioners (FCPs)

We have piloted 0.6 whole time equivalent FCPs across two local GP practices to improve the management of patients with musculoskeletal (MSK) conditions. FCPs provide expert advice early on in the patient pathway, provide guidance on self-management and where appropriate through clinical triage ensure the patient is referred to the right service first time. The results of the pilot in Figure 65 show a reduction in referrals to secondary care over a 3 month period from 2018/19 (baseline) and 2019/20 (pilot).

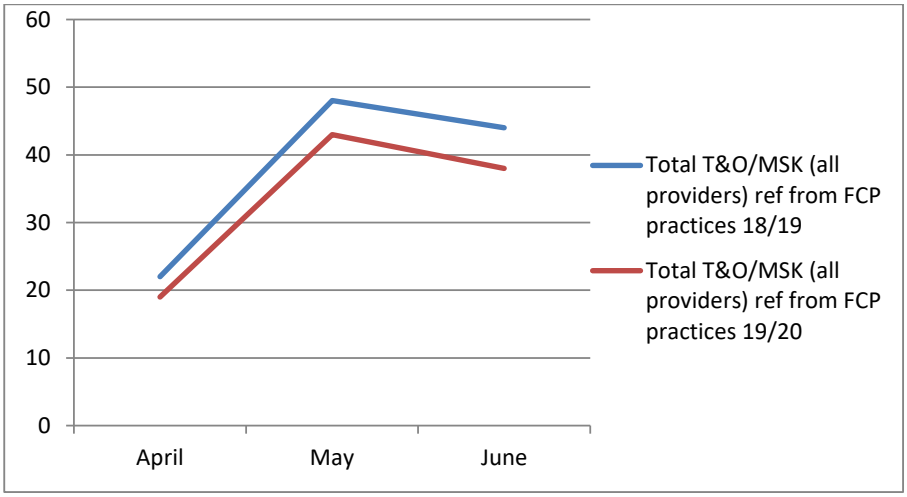


Figure 66: Trauma and orthopedic (T&O) and MSK referrals to secondary care for 3 months in 2018/19 and 2019/20

Based on success of the above, the FCP pilot is the process of being rolled out across all GP practices across HaRD.

Video Consultations (Attend Anywhere)

The following dashboard shows the video consultation activity since the first clinic was created on 23 March 2020. In summary, there have been 130 waiting areas (clinics) created of which 505 service providers (clinicians) have been trained and assigned to the clinics. 271 of the 505 clinicians have participated in patient consultations of which there have been 2400 consultations in total from 23rd March 2020 to 26th August 2020.

Figure 67: Attend Anywhere clinic provision and consultations 23/03/20 to 26/08/20

Our main focus is to continue to roll out Attend Anywhere which is a key priority for the recovery of activity in light of COVID-19 and also supports our digitial strategy. It should be noted that due to the additional costs associated with video consultation, we aim only to use it where it adds additional benefit compared to telephone. i.e aids in preventing further face to face appointments where telephone cannot.

Summary

Following the learning from 2019/20, the Planned Care Transformation Programme has identified a three-year road map to build on the significant progress to date with testing and learning from new ways of working.

We have been faced with some challenges along the way; it goes without saying that COVID-19 has meant a number of projects have been placed on hold. Other challenges and delays we were faced with prior to the pandemic include one stop clinics requiring business case approval for additional equipment; funding disputes for the FCP roll out; limited project resource; and issues with some patient systems being unable to meet reporting requirements. These problems will need working through as we move into the next year of the programme whilst also dealing with the complexities of the recovery of activity during COVID-19.

We have recently issued a survey to clinicians in view of the current crisis to understand what has worked well, not so well and what our new service requirements are going forward. We feel the clinician survey will further influence the Planned Care Transformation Strategy by helping shape the priorities for further roll out of the digital roadmap and ultimately to support the NHS response to COVID-19. In addition, we will be implementing the learning identified in a review undertaken with staff to learn from COVID-19.

4.5 VOLUNTEERS

The last 12 months has been a period of significant change for the volunteer service for a variety of reasons. In April 2019 the Volunteer Manager unfortunately became unwell and has not been able to return to the role. In January 2020, the volunteer service was transferred to the Planning Department so the service would dovetail with the Communication, Marketing, Charity and Fundraising team. At the same time and over subsequent weeks the organisation strategically planned how they would manage the increasing impact of COVID-19. The volunteer service undertook a huge recruitment campaign to ensure there were adequate volunteers to be able to respond effectively to the needs of the hospital and community services, and recruited over 250 new volunteers. However, this had to be abruptly halted in line with government guidelines as the organisation responded day-by-day to the growing number of COVID-19 cases and made the difficult decision to stop all volunteers and visitors from coming into the hospital.

We currently have 583 enthusiastic and committed active volunteers of varying ages providing invaluable assistance to staff, patients and visitors across the organisation. The majority of our volunteers are based at Harrogate District Hospital; however, there are community volunteers who are based at various sites such as Ripon Community Hospital, County Durham, Darlington, Middlesbrough and Scarborough. The support our volunteers offer is invaluable to our colleagues and patients improving quality and enhancing their overall experience. Volunteers complement our current services in a variety of ways:

- Supporting:
    - Patients at meal times;
    - The Chaplaincy Service;
    - Maternity Services;
    - Therapy Services;
    - Pharmacy;
    - The Charity and Fundraising Team;
    - Harrogate Hospital Radio;
    - Complementary Therapy Services;
    - Patients at the end of life;
    - Patients on Lascelles with a variety of craft activities;
    - Administration services;

Figure 68: One of our SROMC volunteers

- Meeting, greeting and checking in patients and visitors for Main Reception; Outpatient Clinics, the Sir Robert Ogden Macmillan Centre and at Ripon Community Hospital;
- Offering a wonderful gardening service so the hospital areas are a place of comfort for staff and patients to sit in;
- Driving patients living in Nidderdale to and from hospital;
- Breast feeding peer support volunteers in our community sites;
- Therapy dogs.

Volunteers also assist in many ‘one off’ roles such as assisting with patient experience surveys and helping at Medicine for Member lectures. We are looking forward to linking with Harrogate Hospital and Community Charity further and increasing volunteer numbers. We are planning a thank you event to all our volunteers as soon as we are able to.

Figure 69: SROMC Volunteers receiving their Volunteer Team of the Year Oscar Award, November 2019.

Figure 70: A few more photographs of our wonderful volunteers and activities

4.6 DUTY OF CANDOUR

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

Processes for duty of candour are now well embedded throughout the Trust. Weekly monitoring of outstanding cases and quarterly assurance monitoring continues to try 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	2019/20 Year Total
Number of moderate or above harm events	150	132	145	118	**545**
Number not triggering DoC (staff/not HDFT)	77	68	63	43	**251**
Number where trigger unclear due to lack of confirmation of severity	0	0	0	2	**2**
Number where DoC triggered	73	64	82	73	**292**
Of those where DoC triggered:					
Number where DoC clearly applied	70 (96%)	58 (91%)	79 (96%)	55 (75%)	**262 (90%)**
Number where a decision has been made NOT to apply DoC for documented reasons (e.g. patient lacks capacity, no next of kin details)	3 (4%)	5 (8%)	2 (2%)	6 (8%)	**16 (5%)**
Number where DoC outstanding	0 (0%)	1 (1%)	1 (1%)	12 (16%)	**14 (5%)**

Table 27: Monitoring of the application of the duty of candour (DoC) 2019/20

Please note: data is correct as at 12/05/2020. The table shows the latest position in relation to level of harm and totals may differ to figures previously reported.

Overall for the year, of the 545 events graded moderate or above harm, 292 events clearly triggered the duty of candour. In 262 of these cases the duty was followed, in 16 cases the decision was made not to apply the duty of candour for documented reasons, and 14 cases are still in progress and are being followed up. There are also two events from Quarter 4 where it is unclear if the duty of candour has been triggered as severity of harm has not yet been confirmed.

4.7 MENTAL CAPACITY

The Mental Capacity Act (2005) provides the legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. During 2019/20 we were aiming to continue to increase awareness of the Mental Capacity Act (MCA).

What have we done?

A bespoke MCA awareness e-learning package was developed and introduced in May 2018, and is now essential skills training for all staff with patient contact. A higher level package was developed and launched in January 2019 and is essential skills training for identified nursing staff and AHPs with leadership responsibilities. This is delivered as a three-hour classroom based session once over a three-year programme. To test the effectiveness of the training, an audit of staff knowledge was completed in February 2020.

What are the results?

Since the MCA Level 1 e-learning package was launched 2724 of the 2766 (93%) staff identified as requiring this learning have completed it. Of the 283 staff identified as requiring the MCA Level 2 training, 122 (46%) have attended.

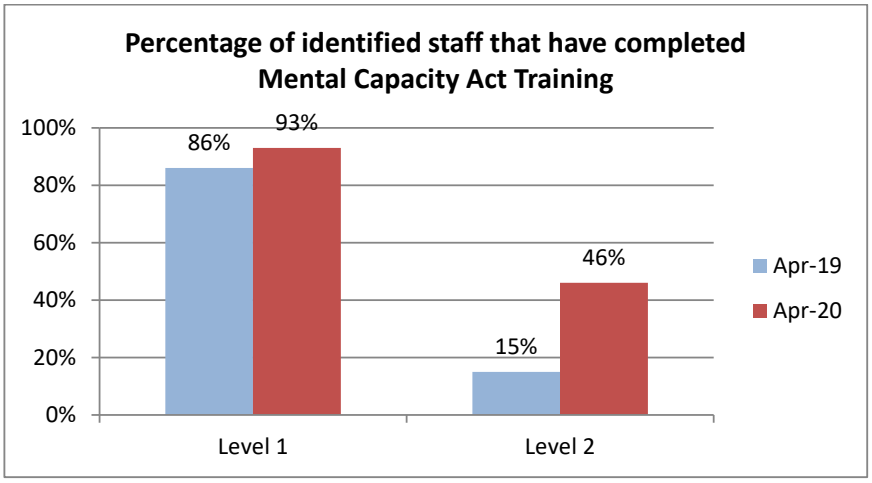


Figure 71: Percentage of staff completing Mental Capacity Act training

The knowledge audit indicated that staff would benefit from an assessment document that can be completed online and guide them through the process. A draft assessment document has been developed in consultation with medical and nursing staff and it is expected that this will be available to users in 2020/21. Further work planned for 2020/21 is to increase awareness of the role of a person with a registered health and welfare Lasting Power of Attorney, or a Court appointed Deputy, with authority for a required decision by someone who lacks the capacity to make that decision.

Summary

The training figures are reassuring and it is expected that all staff will have completed the required learning within the planned three year period. Guidelines and a flagging system to record that a person has a registered health and welfare Lasting Power of Attorney or a Court appointed Deputy will be considered in 2020/21. Liberty Protection Safeguards (LPS) will replace the Deprivation of Liberty Safeguards (DoLS) as the system to lawfully deprive

somebody of their liberty. When the new Code of Practice is published, the Trust will establish a process to ensure compliance with these new safeguards.

4.8 PRIORITY CLINICAL STANDARDS FOR SEVEN DAY HOSPITAL SERVICES

The seven-day standard measures have been set out to ensure that patients receive the same level of high quality care every day of the week. There are four priority standards:

- Clinical Standard 2: Access to consultant-directed assessment. 90% of patients should have received a consultant review within 14 hours of hospital admission;
- Clinical Standard 5: Access to diagnostics;
- Clinical Standard 6: Access to consultant-directed interventions;
- Clinical Standard 8: Ongoing review. 90% of patients should receive ongoing twice daily and daily reviews.

During 2019/20, work has been focused on a number of specialties, with reviews of job plans, changes to pathways, and investments into facilities. These areas were acute medicine, general surgery and paediatrics. Audits of performance against the standards have been completed.

What have we done and what are the results?

Clinical Standard 2

This standard specifies that all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours from the time of admission to hospital. A suitable consultant is a doctor who has completed all of their specialist training and has their certificate of completion of training (CCT) or equivalent and is therefore trained and competent in dealing with emergency and acute presentations in the specialty.

		Dec-18 (%)			Apr-19 (%)			August / Sep-19 (%)		
Admitted speciality	Target	Weekday	Weekend	Total	Weekday	Weekend	Total	Weekday	Weekend	Total
Acute medicine	90%	78	86	80	40	60	46	78	50	67
General Surgery	90%	45	58	50	61	33	54	82	83	82
Paediatrics	90%	35	50	37	18	43	32	32	34	33

Table 28: Clinical Standard 2: Audit results 2018-19 by specialty

The latest audit included in this report was undertaken between 31 August and 14 September 2019. None of the specialities met the target of 90% compliance; however there was a significant improvement against the 14 hour standard between April and September for acute medicine and general surgery.

Medicine

Overall, acute medicine saw an improved position in September, which was due to an improvement on weekdays from 40% to 78% compliance. This is mainly due to more robust consultant cover during the week. The majority of cases of non-compliance were for patients

admitted late morning, and it is likely that these patients arrived during the ward round and were reviewed by a consultant at the next ward round, which falls outside of the 14-hour period. Work is ongoing as part of a wider Acute Care Transformation Programme for specific specialty areas to agree clinical presentations that would be appropriate for a non-consultant or CCT registered member of the team to review.

General Surgery
The audit data shows a significant improvement in compliance from 50% to 82%. There is a need for a system of flagging patients that require review to the consultants so they can be prioritised for review on the morning ward round.

Paediatrics
The acute paediatric team have focused on improving compliance within the hours that the consultant of the week (COW) is job planned to be present within the department. Whilst weekday performance improved, weekend performance deteriorated. A retrospective 'deep dive' was undertaken for ten patients where the standard was not met to try and understand the reasons for non-compliance in more detail. The biggest factors around non-compliance were administrative, with non-documentation of review times featuring highly. A more detailed audit by the paediatric team is planned to capture these reasons as close to real-time as possible. Actions include:

1. Changing home leave administrative processes;
2. A prompt for consultant review in the paediatric admission booklet;
3. An electronic mandatory field to be added for emergency admissions and to appear as a flag on the patient screen;
4. Review processes for shared care patients with general surgery and orthopaedics;
5. Future audits by the paediatric team.

<u>Clinical Standard 5: Access to Diagnostics</u>
Clinical Standard 5 stipulates that hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting should be available seven days a week:

- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

Evidence has been provided previously for this standard and continues to be relevant for all inpatients. Testing and reporting are always or usually available in the appropriate timescales on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs. There are variations in access to diagnostics for acute paediatric patients, predominantly for MRI and ultrasound. The diagnostic pathway for cardiac diagnostics (echocardiograms, EEGs) would require patients to go to Leeds – this is the same on weekdays or weekends if needed urgently.

Table 29: HDFT declaration for Clinical Standard 5

	October 2019	
	Weekday	Weekend
Computerised tomography (CT) scanning	Yes	Yes
Echocardiography	Yes	No
Microbiology	Yes	Yes
Magnetic resonance imaging (MRI) scanning	Yes	Yes
Ultrasound scanning	Yes	Yes
Upper gastrointestinal endoscopy	Yes	Yes

Clinical Standard 6: Access to Consultant-directed interventions

Hospital inpatients must have timely 24-hour access, seven days a week, to consultant directed interventions, either on site or via formally agreed network arrangements with clear written protocols. These interventions would typically be:

	October 2019	
	Weekday	Weekend
Critical Care	Yes	Yes
Primary Percutaneous Coronary Intervention	Yes	Yes
Cardiac Pacing	Yes	Yes
Thrombolysis for Stroke	Yes	Yes
Emergency General Surgery	Yes	Yes
Interventional Endoscopy	Yes	Yes
Interventional Radiology	Yes	Yes
Emergency Renal Replacement Therapy	Yes	Yes
Urgent Radiotherapy	Yes	Yes

Table 30: HDFT declaration for Clinical Standard 6

Evidence has been reported previously for this standard although the provision for patients requiring thrombolysis for stroke is now provided by arrangements with Leeds and York.

Clinical Standard 8

This standard states that all patients with high dependency needs should be seen and reviewed by a consultant twice daily. Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patent's care pathway.

Based on our previous submissions the Trust did not undertake a further review of twice daily reviews due to the consistent achievement of this standard. The following information relates to the once daily reviews within 24 hours, seven days a week, although the information is not easy to interpret and illustrate.

	April 2019			Sept 2019		
	Weekday	Weekend	Total	Weekday	Weekend	Total
Acute Medicine	63%	17%	40%	42%	23%	35%
General Surgery	97%	97%	97%	98%	100%	96%
Total	80%	57%	69%	83%	58%	77%

Table 31: HDFT declaration for Clinical Standard 8

Whilst the standard was achieved for general surgery with an overall compliance of 96%, it was not achieved for medicine.

In acute medicine, there should have been in total 106 'ongoing' consultant reviews. In 21 cases, there was no record of a review (20%). In 39 cases, reviews were undertaken by 'others' (37%). Where reviews were undertaken by 'others', there was no evidence of formal delegation and as such they were counted as fails. The consultant team have been asked to consider a method of evidencing delegation to ensure clarity in addition to further work being undertaken to improve overall documentation of medical reviews.

Summary

Although progress has been made throughout the year against Clinical Standard 2, none of specialty areas reviewed met the required standard of 90% of patients to receive a consultant review within 14 hours of admission. Actions are underway to improve compliance through reviews of consultant job plans and extending consultant cover into the evenings, continued efforts to appoint into consultant vacancies, moving services to improve patient flow, and redesigning pathways for faster clinical review. Business cases are being developed as appropriate to seek the funding to support these service changes. We are also promoting good documentation of clinical review so this is easily identifiable in patient records during future clinical audits.

The outcome of our self-assessment and declared compliance against the priority clinical standards is below.

Standard	Description	Self-assessment	Progress
Standard 2	14 hour review	Non-compliant	Please see above
Standard 5	Access to diagnostics	Compliant	No change
Standard 6	Access to consultant-directed interventions	Compliant	No change
Standard 8	Once daily review	Non-compliant	Please see above
Standard 8	Twice daily review	Compliant	No change

Table 32: HDFT declaration for priority clinical standards October 2019

4.9 SPEAKING UP

The National Guardian's Office and the role of the Freedom to Speak Up (FTSU) Guardian were created in response to recommendations made in Sir Robert Francis' report "The Freedom to Speak Up" (2015). These recommendations were made as Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result. The ambition across the NHS is to effect the cultural change that ensures speaking up becomes business as usual.

Workplace culture is the character and personality of our organisation. It is made up of our organisation's leadership, values, traditions and beliefs, and the behaviours and attitudes of the people in it. We know that:

> "If leaders and managers create positive, supportive environments for staff, they in turn create caring, supportive environments and deliver high-quality care for patients. Such leadership cultures encourage staff engagement".
>
> The King's Fund: Improving NHS culture

At HDFT, our Freedom to Speak Up Guardians work alongside existing systems and processes for staff to raise concerns e.g. directly with managers, lead clinicians or tutors, to other departments e.g. Human Resources, Risk Management, or to other staff e.g. staff governors, chaplains, Trade Union representatives, executive or non-executive Directors. The guardians provide advice and support to staff who raise concerns, work to challenge and change the culture within the organisation, and identify and address any barriers to speaking up.

What have we done?

We have continued to develop our shared understanding of the key elements of a fair, just and safe culture, which are:

1. Fairness, compassion and psychological safety; ensuring each individual knows they will be treated fairly and compassionately by the group if things go wrong or they speak up to stop problems occurring. Staff should not feel the need to behave defensively to protect themselves;
2. Diversity, inclusivity, trust and respect; ensuring people are treated fairly regardless of ethnicity, gender, disability or other personal characteristics;
3. Speaking up and listening; ensuring speaking up about concerns, events, errors or poor behaviour is welcomed, and seen not just as safe, but the right thing to do;
4. Leadership and teamwork; ensuring supportive, effective and ideally multidisciplinary teamwork alongside compassionate and collective leadership to reinforce a sense of care and belonging, a culture of honesty, authenticity and safe conflict;
5. Values and behaviours, including kindness and civility; ensuring we promote and expect positive behaviours that improve patient safety and staff experience, and that behaviour which is at odds with our values is called out and challenged;
6. Open to learning and improvement; ensuring that when things go wrong there is focus on no blame, a just culture, an understanding of human factors, supporting staff, and learning.

Using this developing model, the feedback from staff who have spoken up, and feedback from the staff survey we have:

- Appointed 38 fairness champions with another nine awaiting induction. These staff want to support the development of a fair, just and safe culture and have volunteered

to promote this. They aim to listen positively to colleagues, signpost them to other help and advice, and share resources and ideas to promote a positive workplace culture.

- Introduced a first line leaders programme in September 2019 for anyone who leads people, be they clinical or non-clinical staff. It aims to develop staff to lead with care and compassion, to build and maintain personal and team resilience, hold difficult conversations well, and lead change. Almost 250 staff have completed this and it has been very positively evaluated.
- Taken actions to overcome the barriers to speaking up by progressing staff networks, and developing staff engagement and inclusion.
- Held a workshop entitled "Creating a Fair, Just and Safe Culture at #teamHDFT" for the Board of Directors in October 2019. The Board of Directors also reviewed the new Freedom to Speak Up: guidance for NHS trust and NHS foundation trust boards individually and as a team at the workshop.
- Reviewed a number of our Human Resources policies and procedures to ensure they support our work on promoting a fair, just, compassionate and learning culture. One of the FTSU Guardians was part of this review and aimed to ensure the work incorporated recommendations from NHS England » A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce.
- Staff communications have continued about the value of a fair and just culture; promoting speaking up, kindness and civility; and highlighting campaigns such as Tackling Bullying Call to Action; Civility saves lives; Royal College of Surgeons (Edinburgh) Anti-bullying and Undermining Campaign; Sign up to Safety.

What are the results?

Year / quarter	Summary data			
	Total number of cases	Number of cases raised anonymously	Number of cases with patient safety element	Number of cases with bullying and harassment element
2016/17	**1**	**0**	**0**	**0**
2017/18	**8**	**0**	**1**	**5**
2018/19	**39**	**3**	**3**	**21**
Q1 2019/20	7	0	2	4
Q2 2019/20	15	1	4	7
Q3 2019/20	12	0	1	6
Q4 2019/20	10	0	0	2
2019/20	**44**	**1**	**7**	**19**

Table 33: Contacts made to the FTSU Guardians at HDFT 2016/17 to 2019/20

The data shows that the number of staff contacting the FTSU Guardians increased again during 2019/20. This reflects underlying and sometimes longstanding staff concerns. Key findings include:

- Staff speaking up represent doctors, nurses, allied health professionals, support services and administration staff, and a range of levels from Band 2 to senior staff;
- Concerns have been raised by more than one member of staff from some teams;
- Staff have been based in acute and community services; HDFT and Harrogate Integrated Facilities, the wholly-owned subsidiary company of HDFT;
- It is positive that only a very small number of contacts are anonymous, however a significant proportion want their concern to be managed confidentially;

- Less than half of the cases this year have had an element of perceived bullying and harassment either impacting on the member of staff raising the concern or on their colleagues;
- A small number of cases have had a direct element of concern about patient safety.

When a case is closed, the staff member is asked for feedback. This information is reported quarterly to the National Guardian's Office, together with themes identified from the feedback question.

Year / quarter	Feedback questionnaire		
	Number of questionnaires received in quarter	Number responding 'yes' to "Given your experience, would you speak up again?"	Number indicating detriment as result of speaking up
2018/19	**13**	**13**	**2**
Q1 2019/20	1	1	0
Q2 2019/20	3	2	1
Q3 2019/20	2	1	1
Q4 2019/20	1	1	0
2019/20	**7**	**5**	**2**

Table 34: Responses to the feedback questionnaire to staff who have contacted the FTSU Guardians

We have reviewed the results of the 2019 national staff survey in detail and some of the relevant results are provided below. Although the changes since last year are small, these indicate that there is more work to be done to ensure consistent positive progress with the safety culture.

Figure 72: Benchmarked results from the National Staff Survey 2019

Summary

A culture that inhibits speaking up because of recrimination and blame acts as a significant barrier to staff wellbeing and patient safety. The work to promote a fair, just and safe culture is focused on ensuring our leaders and managers create positive, supportive environments for staff, knowing that they will then create caring, supportive environments and deliver high-quality care for patients.

We must promote and expect positive behaviours that improve patient safety and staff experience, constructively challenging behaviour that is at odds with our values to enable people to learn about the impact of their words or actions. All of our staff need to be confident that they will be treated fairly and compassionately, and that speaking up about concerns, events, errors or poor behaviour is welcomed, the right thing to do and an opportunity to learn. When things go wrong, we must not allow blame to replace a just culture and an understanding of human factors. Our workforce policies and practices must also reflect this. We must continue to train our staff to be positive and compassionate leaders and effective members of teams, where they can reinforce a culture of honesty, authenticity and safe conflict. We are on a journey towards ensuring all of our staff work in positive and supportive environments that enable them to deliver the highest quality of care for our patients.

4.10 NHS DOCTORS AND DENTISTS IN TRAINING ROTA GAPS

HDFT has a trainee establishment of 143 trainees and had 11 gaps within this establishment during 2019/20. As a Trust, we were able to recruit into five of these gaps via successful recruitment campaigns undertaken by the Medical Workforce Team for commencement at the beginning of the August rotation. Our paediatrics gaps were all due to maternity absence or less than full-time working, and we were able to fill these gaps but only in February 2020. Two gaps remained unfilled as the relevant department was happy to continue without a trainee or a locum fixed-term fill. Two gaps were within GP surgeries as part of the GP training scheme and the Trust is not required to fill these vacancies.

Department	Grade Establishment
Elderly Medicine	GP Speciality Trainee
Anaesthetics	Core Trainee Year 1/2
Orthopaedics	Clinical Fellow
Paediatrics	Core Trainee Year 1/2
Paediatrics	GP Speciality Trainee
Paediatrics	Specialty Trainee Year 1/2
Paediatrics	Higher Specialty Trainee
Kingswood Surgery	GP Speciality Trainee
The Spa Surgery Harrogate	GP Speciality Trainee
Chemical Pathology	Higher Specialty Trainee
Microbiology	Higher Specialty Trainee

Figure 73: HDFT trainee rota gaps

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 other stakeholders for comment prior to publication and received the following statements:

NORTH YORKSHIRE CLINICAL COMMISSIONING GROUP QUALITY REPORT STATEMENT 2019/20

NHS
North Yorkshire
Clinical Commissioning Group

E-mail: suepeckitt@nhs.net
Direct Tel: 01723 343660
Reference: 1339-2020-SP-JLS

Scarborough Town Hall - York House
St Nicholas Street
Scarborough
North Yorkshire
YO11 2HG
Tel: 01723 343660

Ms Lynn Hughes
Interim Company Secretary
Harrogate and District NHS
Foundation Trust
lynn.hughes8@nhs.net

Tuesday 1st September 2020

Dear Colleague

North Yorkshire Clinical Commissioning Group is pleased to provide comments on Harrogate and District NHS Foundation Trust's (HDFT's) Quality Report 2019/20. As the lead commissioner for the Trust we have also been asked by Leeds Clinical Commissioning Group to incorporate their comments into our response which we have done.

Overall, the Quality Account is well presented and the information included in the report provides a balanced view of the Trust's performance. The report demonstrates the progress made against the priorities for 2019/20 and identifies where there are actions required to improve the quality of patient care. We are pleased to see the CQC rating of overall good, with 5 areas rated outstanding within the inspection report published in March 2019.

We applaud the work being done to improve the culture of learning. The account references events as the new term for incidents but subsequently refers to both events and incidents interchangeably. This could imply that incidents still exist and events are something different, creating confusion. However, it is pleasing to see that the improved reporting rate of patient safety events has taken the Trust from the middle 50% of similar Trusts in 2016 to the top 5% in 2019. It is disappointing that the staff survey results, relating to actions taken following events has deteriorated. Along with measureable improvement this is a key indicator of improved culture so it is good to see HDFT have recognised that this requires more work.

It is good to see the work being done to reduce the length of hospital stay, increase the same day assessment and the development of discharge pathways which all contribute to improving the quality of care and outcomes for patients.

Continued....

NHS
North Yorkshire
Clinical Commissioning Group

It is essential to involve patients and the public in the development of services and it is notable to see the innovative approach to using new technologies to improve engagement of service users, particularly children, in different ways.

The use of rapid process improvement workshops (RIPW) across a variety of services is supportive of identifying required improvements and acting upon them swiftly. We have seen this be particularly successful in the review of children's services.

We are pleased to see the positive work being done to reduce inequalities and promote an inclusive culture for transgender patients and staff which is really supportive of the equality and diversity agenda. It is reassuring to see this as an ongoing priority even when progress is evident as recognition of the continuous improvement is important

The learning from deaths work is important and it will be good to follow progress of the outputs from the RPIW relating to communication with patients and families regarding escalation and resuscitation to see how this may impact on the patient experience and safety.

The continued efforts in reducing harm from pressure ulcers and falls and work around the learning disability standards is worthy of noting.

The layout of the national inpatient survey result is helpful as it sets out exactly where improvement has been made and where it could be made going forward. Particularly reference to the quality improvement work and demonstrating the results to show the focus on outcomes is helpful.

We appreciate the challenges that the Covid-19 pandemic has had on the Trust and note the revised priorities for 2020/21 but are pleased to see that these include learning from Covid-19 to establish new ways of working and deliver quality improvements.

Finally, North Yorkshire CCG confirms that it is satisfied with the accuracy of this Quality Account. The Clinical Commissioning Group looks forward to continuing to work collaboratively with the Trust in 2020-21

Yours sincerely

Sue Peckitt
Chief Nurse

CC: Jill Foster HDFT
Lynn Parsons HDFT

NHS North Yorkshire Clinical Commissioning Group
Head Office, 1 Grimbald Crag Court, St James Business Park, Knaresborough, HG5 8QB

Clinical Chair: Dr Charles Parker
Accountable Officer: Amanda Bloor

COUNCIL OF GOVERNORS QUALITY ACCOUNT STATEMENT 2019/20

The Council of Governors wish to acknowledge so many good things being achieved and covered within this excellent comprehensive report and the extent to which staff have gone to deliver these, at whichever care setting within the organisation.

Governors regularly observe Board and sub-committee meetings to gain assurance of the Trust's progress towards achieving the quality priorities. Additionally, the Governors have observed the Board of Directors in attendance at the public Council of Governors meetings and are kept up to date with comprehensive informal briefings by the Board.

The Governors were consulted with and fully endorses the 2019/20 Quality Account, however due to the COVID19 pandemic the regulators changed the requirements whereby Governors were not involved in the quality priority process for 2020/21.

The Governors have been made aware of the six quality priorities set for 2020/21, in addition it will also be of interest to the Governors to hear about the progress being made in relation to the 2019/20 priorities. This will include complaints resolution, learning from incident reporting, and in addition the recovery in the levels of elective care, especially in priority areas such as cancer etc due to Covid-19.

Clare Cressey
Lead Governor, on behalf of the Council of Governors

22 September 2020

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 2019/20 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 2019 to March 2020;
    - Papers relating to quality reported to the Board over the period April 2019 to March 2020;
    - Feedback from the commissioners dated 1 September 2020;
    - Feedback from Governors dated 22 September 2020;
    - Feedback from Healthwatch North Yorkshire was requested 26 June 2020;
    - Feedback from North Yorkshire County Council Scrutiny of Health Committee was requested 26 June 2020;
    - The Trust's draft complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 29 July 2020;
    - The 2018 national patient survey dated 20 June 2019;
    - The 2018 national staff survey dated 18 February 2020;
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 19 June 2020;
    - CQC inspection report dated 14 March 2019.
- the quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with NHS improvements annual reporting manual and supporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board on x.

.....

Mrs Angela Schofield
Chairman

.....

Mr Steve Russell
Chief Executive

7 ANNEX THREE: NATIONAL CLINICAL AUDITS 2019/20

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2019/20	Data submitted as a percentage of the number of registered cases required for that audit
1	**BAUS urology audits: Female stress urinary incontinence** *NB Continuous data collection*	No	6	100%
2	**National Cardiac Audit Programme (NCAP)**	Yes		
	Myocardial Ischaemia National Audit Project (MINAP) ** a further 12 patients will be included from this period once data entry resumes*		224*	100%
	Cardiac Rhythm Management (CRM)		161	100%
	National Heart Failure Audit ** a further 60 patients will be included from this period once data entry resumes*		279*	100%
3	**Case Mix Programme - Adult Critical Care (ICNARC)** *NB Continuous data collection*	No	469	100%
4	**Child health clinical outcome review programme (NCEPOD)**	Yes		
	a) Long-term ventilation in children, young people and young adults		0 *No patients selected for inclusion*	NA
5	CEM: Assessing Cognitive Impairment in Older People/Care in Emergency Departments	No	85	100%
6	CEM: Care of Children in Emergency Departments	No	172	100%
7	CEM: Mental Health - Care in Emergency Departments	No	71	100%
8	**Elective Surgery (National PROMs programme)** (2018/19) *NB Continuous data collection*	No		
	Hip replacement		450 (pre-op) 336 (post-op)	102% 75%
	Knee replacement		440 (pre-op) 346 (post-op)	102.8% 79.2%
9	**Falls & Fragility Fractures Audit Programme (FFFAP)**	Yes		
	FFFAP - National Hip Fracture Database *NB Continuous data collection*		254	100%
	FFFAP - National Audit of Inpatient Falls *NB Continuous data collection*		7	100%
10	**Inflammatory Bowel Disease (IBD) programme**	No		
	IBD Service Standards		Participated (Service assessment)	N/A

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2019/20	Data submitted as a percentage of the number of registered cases required for that audit
	IBD Biological Therapies Audit *NB Continuous data collection* **Refers to all new patients on biologics.* *Cumulative total = 135*		44*	100%
11	**Major Trauma: Trauma Audit & Research Network (TARN)** *NB Continuous data collection*	No	138	100%
12	**Mandatory surveillance of bloodstream infections and Clostridium difficile infection** *NB Continuous data collection*	No	267	case ascertainment not stated
13	**Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)** a) Perinatal Mortality Surveillance (reports annually) b) Perinatal morbidity and mortality confidential enquiries (reports alternate years) c) Maternal Mortality surveillance and mortality confidential enquiries (reports annually) d) Maternal morbidity confidential enquiries (reports annually)	Yes	9	100%
14	**Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)**	Yes		
	a) Dysphagia in Parkinson's Disease		3	100%
	b) In-hospital management of out-of-hospital cardiac arrest		4	100%
	c) Acute bowel obstruction		5	100%
15	**National Asthma & COPD Audit Programme**	Yes		
	a) COPD Secondary Care Audit *NB Continuous data collection* **Data is being collected retrospectively following clinical coding. Cumulative Database*		511*	NACAP case ascertainment: not available HDFT case ascertainment (169 exclusions): 100%
	b) Adult Asthma		113	100%
	c) Pulmonary Rehabilitation		66	100%
	d) Children and Young People Asthma Audit **Data for patients admitted 1 June 2019 – 31st Jan 2020. Data for patients discharged Feb-July 2020 will be submitted 11th September 2020*		33*	100%

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2019/20	Data submitted as a percentage of the number of registered cases required for that audit
16	**National Audit of Breast Cancer in Older Patients (NABCOP)**	Yes	143	100%
17	**National Audit of Cardiac Rehabilitation** *NB Continuous data collection*	No	198	100%
18	**National Audit of Care at the End of Life (NACEL)**	Yes	20	100%
19	**National Audit of Dementia** *Psychotropic medication spotlight audit*	Yes	40	100%
20	**National Audit of Seizure Management in Hospitals (NASH3)**	No	Did not participate	Did not participate
21	**National Audit of Seizures & Epilepsies in Children & Young People (Epilepsy 12)**	Yes	18	100%
22	**National Cardiac Arrest Audit (NCAA)** *NB Continuous data collection*	No	45	100%
23	**National Early Inflammatory Arthritis Audit (NEIAA) - National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis**	Yes	51	case ascertainment not stated
24	***National Diabetes Audit (Adults)***	Yes		
	a) Inpatient audit - NaDIA		58	100%
	b) NaDIA - Harms		10	100%
	c) National core audit (secondary care) *NB Continuous collection* **Audit data period 1 January 2018 to 31 March 2019 – cumulative database*		1459*	100%
	d) Diabetes Footcare Audit *NB Continuous data collection*		382	100%
	e) Pregnancy in Diabetes *NB Continuous data collection* **Refers to all eligible pregnancies ending by 31st December 2019*		12*	100%
25	**National Emergency Laparotomy Audit (NELA)** ****predicted 70 cases***	Yes	59	*84%
26	***National Gastro-Intestinal Audit Programme***	Yes		
	a) Bowel Cancer (NBOCAP)		159	100%
	b) National Oesophago-gastric cancer (NAOGC) *NB Continuous data collection*		56	100%
27	**National Joint Registry** *NB Continuous data collection*	No	843	100%
28	**National Lung Cancer Audit (NLCA)**	Yes	123	100%
29	**National Maternity and Perinatal Audit (NMPA)** ***** refers to all HDFT registrable births submitted to the Maternity Services Database (MSDS) / NHS Digital for audit use	Yes	1787*	case ascertainment not stated
30	**National Neonatal Audit Programme - Neonatal Intensive & Special Care (NNAP)**	Yes	98	100%

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2019/20	Data submitted as a percentage of the number of registered cases required for that audit
31	**National Ophthalmology Audit** **1 September 2018 to 31 August 2019**	Yes	795	100%
32	**Diabetes (Paediatric) – NPDA** *2018/19 audit round*	Yes	103	100%
33	**National Prostate Cancer Audit**	Yes	189	100%
34	**Perioperative Quality Improvement Programme (PQIP)** *NB Continuous data collection* ** 2 patients recruited to the study but both failed to remain involved for follow up data collection.*	No	0*	NA
35	***Reducing the impact of serious infections (antimicrobial resistance and sepsis)***	No		
	a) Antibiotic Consumption		Work stream closed & removed	
	b) Antimicrobial Stewardship		Work stream closed & removed	
36	**National Smoking Cessation Audit**	No	149 (in order to obtain sample of 20 current smokers)	100%
37	**Sentinel Stroke National Audit Programme (SSNAP)**	Yes	281	100%
38	**Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme** *NB Continuous data collection*	No	7	100%
39	**Society for Acute Medicine's Benchmarking Audit (SAMBA)**	No	39	100%
40	**Surgical site infection surveillance service** *Data entered July – September 2019	No	116*	100%
41	**UK Parkinson's Audit**	No	Did not participate	Did not participate

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 2019/20	Data submitted as a percentage of the number of registered cases required for that audit
Breast & Cosmetic Implant Registry **a further 4 patients will be included from this period once data entry resumes*	*30	100%

The following five NCAPOP audits were not relevant to HDFT due to the Trust not providing the service:

1. National Clinical Audit of Anxiety and Depression
2. National Clinical Audit of Psychosis
3. Mental Health Clinical Outcome Review Programme
4. National Vascular Registry
5. Paediatric Intensive Care Audit Network (PICANet)

The following five NCAPOP audits within work streams were not relevant to HDFT due to the Trust not providing the service:

- NCAP: Adult Cardiac Surgery
- NCAP: Congenital Heart Disease (CHD)
- NCAP: Coronary Angioplasty/National Audit of PCI
- Falls & Fragility Fractures Audit Programme (FFFAP): Fracture Liaison Service Database
- Medical and Surgical Clinical Outcome Review Programme (NCEPOD) Physical Health in Mental Health Hospitals

The following 11 non-NCAPOP audits were not relevant to HDFT due to the Trust not providing the service:

1. BAUS urology audits: Cystectomy
2. BAUS urology audits: Nephrectomy
3. BAUS urology audits: Percutaneous nephrolithotomy
4. BAUS urology audits: radical prostatectomy
5. UK Cystic Fibrosis Registry
6. National Audit of Pulmonary Hypertension
7. National Bariatric Surgery Registry (NBSR)
8. Neurosurgical National Audit Programme
9. Prescribing Observatory for Mental Health (POMH-UK) (all work streams)
10. Mental Health Care Pathway - CYP Urgent & Emergency Mental Health Care & Intensive CiS
11. Endocrine and Thyroid National Audit

8 ANNEX FOUR: GLOSSARY

ACP	Advanced Care Practitioner
AHP	Allied Health Professional
AMU	Acute Medical Unit
ART	Acute Referral Team
BiPAP	Bi-Level Positive Airway Pressure
BME	Black and minority ethnic
CAT	Clinical Assessment Team – changed to Combined Assessment Team (December 2018)
CCCC	Children's and Countywide Community Care
CCG	Clinical Commissioning Group
CEM	College of Emergency Medicine
CIP	Cost Improvement Programmes
CLT	Consultant Led Triage
CNS	Clinical Nurse Specialist
CofC	Continuity of carer
COPD	Chronic obstructive pulmonary disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CS&AGG	Children's Surgery and Anaesthetic Governance Group
CTG	Cardiotocography
CVI	Certificate of visual impairment
Dashboard	Data visualisation tool that displays the current status of metrics and key performance indicators
DID	Doing It Differently
DNACPR	Do not attempt cardiopulmonary resuscitation
DOC	Duty of candour
DSU	Day Surgery Unit
DTOC	Delayed transfers of care
ECLO	Eye Clinic Liaison Officer
ED	Emergency Department
EDI	Equality, Diversity and Inclusion
EoL	End of life
EPaCCS	Electronic palliative care co-ordination system
ePMA	Electronic prescribing and medicines administration system
FFT	Friends and Family Test
GCP	Good Clinical Practice
CDI	*C. difficile* infection
GP	General practitioner
HARA	Harrogate and Rural Alliance
HaRD	Harrogate and Rural District
HDFT	Harrogate and District NHS Foundation Trust
HES	Hospital Episode Statistics
IBD	Inflammatory Bowel Disease
ICE	Requesting and reporting software
ICNARC	Intensive care national audit and research centre

IPC	Infection prevention and control
LD	Learning disabilities
LeDeR	Learning Disabilities Mortality Review
LMS	Local Maternity System
LOS	Length of stay
LPS	Liberty Protection Safeguards
LTUC	Long Term and Unscheduled Care
MAU	Medical Admissions Unit
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
MCA	Mental Capacity Act
MCCD	Medical Certificate of Cause of Death
MCISS	Macmillan Cancer Information Support Service
MDT	Multidisciplinary team
MLU	Midwife-led unit
MSK	Musculoskeletal
MVP	Maternity Voices Partnership
NCAPOP	National Clinical Audit and Patient Outcome Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NEL	Non-Elective Transformation
NG	Nasogastric
NICE	The National Institute for Health and Care Excellence
NIV	Non-invasive ventilation
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System
NYCC	North Yorkshire County Council
OPA	Oesophageal Patient Association
PCN	Primary Care Network
PCT	Palliative Care Team
PET	Patient Experience Team
PHSO	Parliamentary and Health Service Ombudsman
PMA	Professional Midwifery Advocate
PRA	Patient research ambassadors
PreCePT	Prevention of Cerebral Palsy in Preterm Labour
PROMs	Patient Reported Outcome Measures
PSC	Planned and Surgical Care
R&I Group	Research and Innovation Group
RCA	Root cause analysis
RPIW	Rapid Process Improvement Workshop
RTT	Referral to treatment
SDEC	Same day emergency care
SDS	Supported Discharge Service
SHNI	Summary Hospital Mortality Index
SJR	Structured judgement review
SNSP	Serious non-specific symptoms pathway
SROMC	Sir Robert Ogden Macmillan Centre

SUS	Secondary Uses Service
VTE	Venous thromboembolism
WRES	Workforce Race Equality Standard
WTE	Whole time equivalent
WY&H	West Yorkshire and Harrogate Partnership
YHCRN	Yorkshire and Humber Clinical Research Network

If you require this document in an alternative language or format (such as Braille, audiotape or large print), please contact our Patient Experience Team: hdft.patientexperience@nhs.net or 01423 555499.

Electronic copies of the Quality Account can be obtained from our website (www.hdft.nhs.uk). If you have any feedback or suggestions on how we could improve our Quality Account, please do let us know by emailing hdft.hello@nhs.net.

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