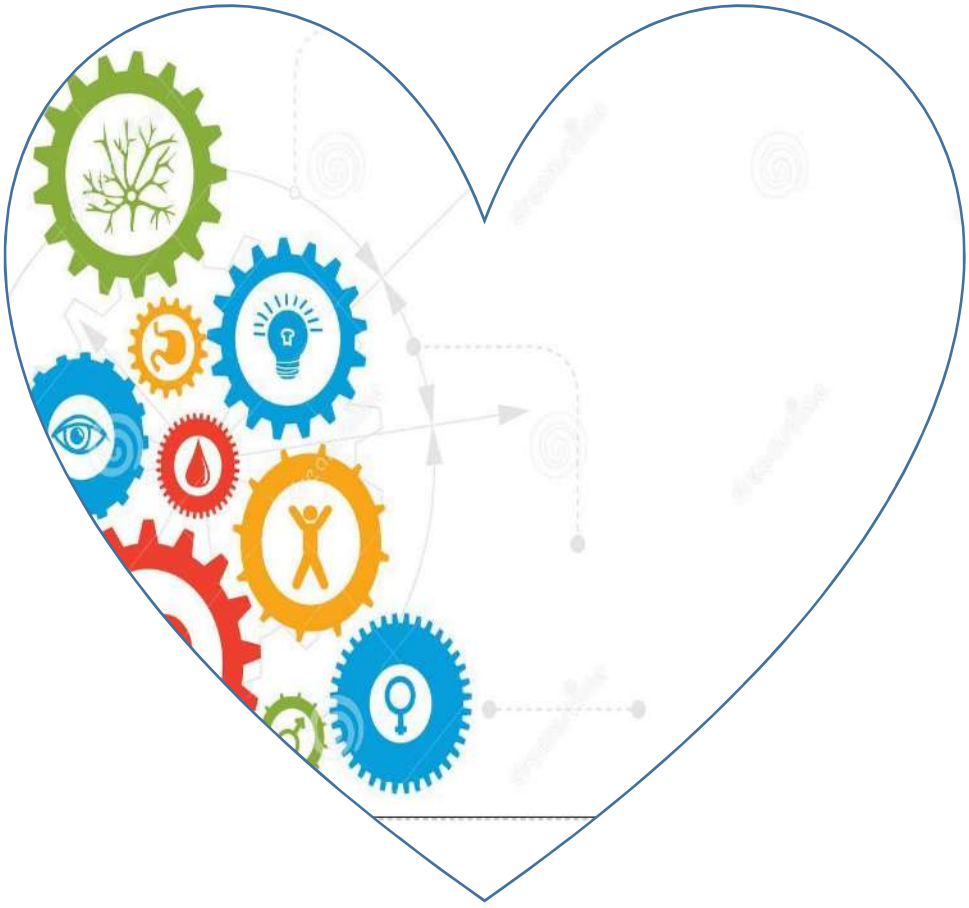
NHS
Harrogate and District
NHS Foundation Trust



Harrogate and District NHS Foundation Trust

Quality Account 2022-2023

teamHDFT
At our best

Contents

PART 1

The Quality Account is an annual report, which reviews our performance and progress against the quality of services we provided. In 2022 – 2023 and sets out our key quality and safety improvement priorities for 2023 - 2024. It demonstrates our commitment to continue improving our services and provide high quality, safe and effective care to our patients, their carers and their families. This means that it is essential that we focus on the right quality and safety priorities for the forthcoming year.

Introducing our Quality Accounts

Welcome to the 2022-23 HDFT Quality Accounts.

Thank you for your interest in reading our 2022-23 Quality Accounts.

At HDFT we have worked incredibly hard during 2022-23 to review, renew and reinvigorate the work we do with regards to Quality and Safety.

In this report, we set out what we have achieved in 2022-23 with regards to the priorities we set. These priorities were identified via the Trust's learning systems to identify areas of our work where we could improve the quality and safety of the care we provide, the effectiveness of our services or the experience people have whilst working with us or accessing our services.

We also set out the quality and safety improvement priorities for 2023-24.

Comments from our stakeholders on the content of the Quality Account are included in full in the Annex of this report.

We welcome involvement and engagement from all colleagues and stakeholders because their comments help us acknowledge our achievements and identify further improvements to be made.

I can confirm that the Board of Directors has reviewed the 2022-23 Quality Account and can confirm that to the best of my knowledge, the information contained within this report is an accurate and fair account of our performance.

We hope that you enjoy reading this year's Quality Account.

With best wishes

Jonathan Coulter

Chief Executive

What is a Quality Account?

The Quality Account is an annual report published for the public from providers of NHS healthcare about the quality of the services it provides. The report provides details on progress and achievements against the Trust's quality and safety priorities for the previous year and what the Trust will focus on in the next year.

What should a Quality Account look like?
Some parts of the Quality Account are mandatory and are set out in regulations (NHS Quality Account Regulations 2010 and Department of Health – Quality Accounts Toolkit).

The Quality Account must include:

Part 1: Introduction
A statement from the Board of the organisation summarising the quality of NHS Services provided.

Part 2: Looking Back
Looking back at the previous year's performance.
A series of statements from the Board for which the format and information required is prescribed and set out in the regulations and toolkit.

Part 3: Looking Forward
A review of the quality of services in the organisation for the coming financial year. This is presented under three domains: Patient Safety, Clinical Effectiveness and Patient Experience.

What does it mean for Harrogate and District NHS Foundation Trust (HDFT)?
The Quality Account allows NHS healthcare organisations to demonstrate its commitment to continuous, evidence-based quality improvement and to explain its progress against agreed quality and safety priorities, how the organisation performed in other quality areas eg service delivery and to inform the public of its future quality plans and priorities.

What does it mean for patients, members of the public and stakeholders?
By putting information about the quality of services into the public domain, NHS Healthcare Organisations are offering their approach to quality for scrutiny, debate and reflection. The Quality Account should assure the Trust's patients, members of the public and its stakeholders that as an NHS organisation, it is scrutinising each and every one of its services, providing particular focus on those areas that require the most attention.

How will the Quality Account be published?
The Quality Accounts are published electronically on the NHS Choices website and we will also make them available on our own website: www.hdft.nhs.uk

About Us

Our Services

Acute and Community Services for Harrogate and District and wider North Yorkshire:

- Harrogate District Hospital which includes an Emergency Department, comprehensive medical and surgical specialities, an oncology centre, maternity services and extensive outpatient facilities
- Community Services which includes podiatry, district and community nursing, therapy services and community dental services

Children's Public Health (0-25) Services

- 9 local authorities in North East and Yorkshire
- Looking after over 500,000 children
- The largest provider of 0 – 19 services in England

HDFT in Numbers

3 INTEGRATED CARE SYSTEMS	OVER **5,000** COLLEAGUES	**21,000** VIRTUAL OUTPATIENT ATTENDANCES
118,000 HOME VISITS	HOSPITAL CATCHMENT AREA **c200,000**	**£300M** TURNOVER
LOOKING AFTER OVER **500,000** CHILDREN	COMMUNITY SERVICES POPULATION **c620,000**	LARGEST **EMPLOYER** IN HARROGATE AND DISTRICT
55,000 EMERGENCY DEPARTMENT ATTENDANCES		OVER **2,000** CANCER TREATMENTS

Part 2: Priorities for Improvement 2022-23 and Statements of Assurance from the Board

The information presented in this Quality Account represents information which has been monitored over the last 12 months by the Trust Board, Council of Governors, Quality Committee and the Executive led Quality Governance Management Committee.

The majority of the Account represents information from all of our Directorates presented as total figures for the Trust. The indicators to be presented and monitored were selected following discussions with the Trust Board. They were agreed by the Executive Team and have been developed over the last 12 months following guidance from senior clinical staff.

The Trust has consulted widely with members of the public and local committees to ensure that the indicators presented in this document are what the public expect to be reported.

2022-2023 has been an exciting time for quality and safety at HDFT with significant work to transition towards a new approach to the quality agenda. Key activities during the year have been:

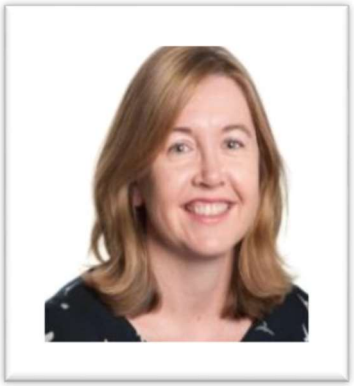
- The development of a new Trust Strategy that puts quality and safety at the heart of everything we do
- The development of a revised Board Assurance Framework that complements the Trust Strategy
- A full scale review and implementation of a revised Quality Framework which includes a new structure in our Quality Team to ensure it is fit for purpose and future proofed, as well as full scale revision to our governance structures.
- Ensuring we have processes, structures and frameworks in place to transition from the Serious Incident Framework to the new Patient Safety Incident Response Framework
- Clear and dedicated improvement projects for our quality priorities which are monitored and reviewed continuously through our revised governance structures.
- A full scale review of quality improvement and decision to implement a revised continuous improvement model.

We approach 2023-2024 with a strong grounding in our quality framework, which will enable us to move forward proactively with the challenges and opportunities that the next 12 months will bring, to ensure that HDFT can implement the necessary changes for key initiatives such as:

- The Patient Safety Incident Reponses Framework
- The NHS Complaints Standard Framework
- The Care Quality Commission revised inspection Framework
- Three Year delivery plan for maternity and neonatal safety
- NHS delivery and continuous improvement review

We hope that our Quality Account provides you with an overview of the work that we have undertaken during 2022-2023 as well as highlighting where we will go next in our continuous improvement journey.

Emma Nunez
Executive Director Of Nursing, Director And AHPs / Deputy Chief Executive



Jackie Andrews
Executive Medical Midwifery

Our Quality System

We have reviewed our local system to understand the people who are involved in patient safety activities across HDFT, as well as the systems and mechanisms that support them.

Our commitment is that each patient is treated with equality, respect and dignity and, most importantly of all, as a person. HDFT is a complex system with many interrelated components that are crucial to ensuring that everything works. Our core internal system is made up of:

3 **CLINICAL DIRECTORATES**	**LTUC** **LONG TERM AND UNPLANNED CARE**	**PSC** **Planned and Surgical Care**
CC **CHILDREN**	**1** **CORPORATE DIRECTORATE**	**HIF** **HARROGATE INTEGRATED FACILITIES (SUBSIDURY COMPANY)**

The corporate Quality Team consists of the Patient Experience Team, the Patient Safety Team and the Compliance Team under the leadership of the Associate Director of Quality and Corporate Affairs, reporting in to the Executive Director of Nursing, Midwifery and Allied Health Professionals with support from the Executive Medical Director.

Over the past 18 months, the Quality Team in HDFT has been in a transitional period during which time a complete review of the functions and structure of the team has taken place. The new structure is now almost complete and operates under new leadership.

Core quality activities undertaken at HDFT include:

- Risk Management
- NHS Patient Safety Strategy
- Central Alerts system
- Incident Management
- Legal SLA / Budget
- Learning from Events, Claims and Complaints
- Serious Incidents
- Patient Safety Framework
- LFPSE [Formally NRLS]
- Claims Management
- Coroners Management
- Oversight of Datix system
- Clinical Effectiveness
- NICE
- Management of CQC Regulations and all CQC related activity
- Policy Management

- Friends and Family
- Complaints & PALs
- Patient engagement activities

Other activities within the Trust that provide insights to patient safety include Structured Judgement Reviews, Learning from Deaths and Quality Improvement projects, as well as our day to day activities such as safety huddles, hot de-briefs and governance meetings.

Our colleagues within each of the directorates predominantly own the operational 'work-as-done' for these patient safety activities. Largely the respective directorate Triumvirate Leads, Clinical Leads and Quality Assurance Leads, who are in turn supported by the central Quality Team who provide a strategic overview.

The emergent Quality Team has been built to fit and respond to both the hospital and also the extensive size of our community footprint and the nuances of the teams, services and structures we work in. The HDFT Quality Team will be integral in facilitating our patient safety journey and patient safety culture on our road to implementing PSIRF.

In 2022-2023 we have also embarked on an ambitions continuous improvement journey:

- HDFT has been using a lean, quality improvement approach for over 10 years – we know this approach works and we've seen the improvements it can bring.
- Now we want to take our approach to improvement to the next level – to embed improvement at the centre of our culture and operating model.
- We're partnering with Catalysis and KPMG, international leaders in improving healthcare with extensive experience supporting NHS trusts.
- Over the next 18 months they will support us to develop our own improvement operating model, to train and coach our teams, and to build our capacity and capability to sustain our improvement journey.
- It will be **our** team HDFT approach, based on tried and tested principles, but tailored to our strategy, our culture, our needs.
- The first stage is to understand our readiness for this journey by examining our processes and systems, meeting colleagues throughout the Trust and observing how we work at every level from frontline to the Board

Performance Against Priorities 2022-2023

In 2022-2023 at HDFT we revised our Trust Strategy. Within it one of our Key Ambitions is: Best Quality, Safest Care.

Our ambition is to provide the best quality, safest care, where quality is defined by safety, effectiveness and patient experience.

Ever Safer Care

Through continuous learning and improvement we will make our processes and systems ever safe – we will never stop seeking improvement. Our quality programmes for 2022-2023 within this are:

- Emergency Department
- Theatres Safety
- Inpatient Falls
- Pressure Ulcers

Excellent Outcomes

We want excellent outcomes for our patients and the children and young people we support which improve their health, wellbeing and quality of life – we will do this by providing effective care based on best practice standards. Our quality programmes for 2023-2023 within this are:

- Acting on Missed Results
- Medication Errors – with a focus on Insulin

A Positive Experience

We want every patient, child and young person to have a positive experience of care – we will do this by listening and acting on their feedback to continuously improve. Our quality programme for 2022 – 2023 for this area is a focus on the implementation of the new NHS Patient Experience Framework

SAFE: Best Quality, Safest Care: Ever Safer Care through Continuous Learning and Improvement

Quality Programme: Emergency Department

Why The Emergency Department?

Following a number of incidents in our Emergency Departments in 2021-2022 a review of process was undertaken that identified there were areas for improvement. We therefore selected this as a quality priority for 2022-2023.

What were we aiming to achieve?

As part of the project we aimed to:

- Improve our streaming model to improve patient experience, flow through the department and improve performance
- Reconfigure the department including a “fit to sit” area
- Improve flow with further development of the acute medicine model
- Improve the Urgent Care Response
- Increase our Virtual Ward capacity

What did we achieve?

Significant work has been undertaken to ensure the success of this improvement priority. Key areas have included:

- Streaming model developed and in place. Recruitment completed to ensure sustainable staffing model.
- Acute referral triage pathway developed
- Reconfiguration of the department has included the introduction of a fit to sit area and a major refurbishment of the majors area of the department
- Acute medicines model in progress with an acute medicine staffing review being complement, new colleagues in post and revised training plan implemented.
- The Urgent Care Response pathway was approved and key colleagues recruited to.
- The capacity of virtual wards has been completed with an increase in elderly medicine consultant capacity in place.

SAFE: Best Quality, Safest Care: Ever Safer Care through Continuous Learning and Improvement

Quality Programme: Theatres Safety

Why Theatres?

Following a number of incidents in our Theatres in 2021-2022 a review of process was undertaken that identified there were areas for improvement. We therefore selected this as a quality priority for 2022-2023.

During 2022 - 2023 much work was done to identify areas requiring improvement, investment and review within both Main theatres and the Day Surgery Unit. 5 specific areas were focused on:

- Patient experience and safety
- Reduction in agency staff
- Recruitment
- Staff retention
- Theatre utilisation

What were we aiming to achieve?

As part of the project we aimed to:

- Devise patient feedback bespoke to theatres to capture patient experience within our service.
- Remove outsourced agency with permanent staff, maintaining safety and competence to deliver best care.
- Review the safe staffing levels as defined nationally by the AFPP (the Association of Perioperative Practice).
- Form an education team to support all staff with training, development and progression to retain skills and knowledge within the departments.
- Explore the capacity for surgery in the current theatres, focusing on utilisation and flow.

What did we achieve?

Patient experience and safety

During the year we launched a project called 'Keeping the patients voice in the room'. This included designing a patient feedback questionnaire, bespoke to the theatre pathway, from arriving in the suite, to anaesthetic room, theatre and recovery room. Capturing rich information of patient perception of how we deliver our service.

Using the PDSA (Plan, Do, Study, Act) model, the team then reviewed results, shared and enhanced the questionnaires to aid the ability to get the pertinent information to help us improve further.

Two children's versions were created, 2-9 years and 10-16 years, again designed with paediatric input and asking questions that will help improve the service going forward.

In addition, parents are now asked to complete the adult version as to their experience as the parent/carer.

Other key workstreams have included:

- Accountable Items Policy – this is a document that includes information on counting of all procedural items such as surgical swabs, instruments and sharps. The Policy has been adapted and updated to create standardised practice, this has removed variation in practice and reduced the risk of mistakes – this in now fully embedded.
- Tendable audits – audits have been created that are bespoke to theatre, covering all safety metrics for assurance

- Stop Before You Block Policy – this is a policy that details the process to follow prior to administering an anaesthetic block. This policy has been implemented along side a new prep stop block process. A multi disciplinary team (MDT) approach has been introduced to reduce variations in practice and allow opportunity to check before performing any invasive procedure.
- Daily documented de-briefs – as part of compliance with 5 steps to safer surgery, the 5th step is to record a narrative of what went well and things to learn or escalate. This has been updated and enhanced in the year.
- Lessons learned board, never events and datix feedback – shared with all the team on platforms, boards, and digital TV email and team meetings to ensure staff are aware of areas needing improvements or concern
- Hot topic board, highlighting areas to focus on for a month. Discussed at huddles and team meetings to raise awareness. Datix used to aid a topic.
- Project to transfer instrument trays into tins, to reduce risk of holes and de-sterilisation has commenced and is ongoing.

Reduction in agency

Reduction of outsourced agency to one team in February and total removal by 31st March 2023 due to recruitment drive.

Recruitment and retention

Establishment reviewed performed, aligning to AFPP safe staffing levels was completed and approved. This included:

- Uplift of 18 Band 5 to Band 6 to align leadership and clinical experience
- Formation of Education team – including an additional 2 Band 6 nurses
- 3 ATP (assistant theatre practitioner (B3) introduced
- Increased resource for the administrative team
- 1 Deputy Matron introduced

Further opportunities available to staff to develop and progress with the introduction of:

- Surgical first assistants
- Anaesthetic nurse training
- Surgical Care Practitioner
- ODP apprenticeships
- Band 2-3 progression ATP training

In addition the following workstreams have been undertaken:

- Roles & responsibilities shared – ie. Safeguarding, IPC and Tissue viability lead
- Leadership training, NHS Leadership Academy, almost 30 staff completed Edward Jenner Programme. In house first line leaders training
- Cultural workshops – discover barriers and opportunities to be our best
- Incident / Safety Event handling training
- Core team skills – using clinical leadership within specialities to create a core set of expertise that new staff can rotate through
- Personal developed plans with the support of the Education team
- Speciality workshops in surgery and anaesthetics
- 3 day Induction workshop for every new starter regardless of experience to ensure expectations are clear, shared objectives and support networks in place

Theatre Utilisation

- Prompt start trials – elective procedures, ophthalmology, obstetrics and Trauma – new ways of working discussed and some major changes in Trauma and Obstetrics, ongoing work in other areas to achieve better start times.
- Saturday working – in orthopaedic
- Evening sessions, aim to return to pre-pandemic. Working with anaesthetics to create a model that is sustainable within workforce
- Flow within theatres, to and from wards, better communication and support to aid transfer of patients where wards may be understaffed and struggling

SAFE: Best Quality, Safest Care: Ever Safer Care through Continuous Learning and Improvement

Quality Programme: Inpatient Falls

Why Falls?

Nationally, falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 1 in 3 people older than 65, and 1 in 2 people older than 80 falling at least once a year. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality.

Work is ongoing around our own demographic of 65 years and older, with a specific focus on personalised risk assessment and implementation of the national quality standards for Falls. However, we are aware that around 77% of falls within the Trust currently, involve someone who has a confirmed diagnosis of Dementia, and that this can influence not only their physical but also their mental wellbeing. Similarly, this has a significant impact on the family members and carers of people who fall.

Harrogate is known to have a greater than average number of elderly population, and this is set to increase by 2025 for the number of residents present aged 65 and over.

Therefore as a Trust, we are aware that falls can have a significant impact on quality of life, health and healthcare costs and have made the prevention of falls a Trust priority for 2022 - 2023. There is a direct focus on staff education, the introduction of safety huddles, the employment of specialist nurses, regular completion of risk assessments with interventions, and learning from previous incidents.

What were we aiming to achieve?

We were aiming to achieve a reduction in falls causing moderate to severe harm. Our plan to achieve this was by:

- The implementation of safety huddles on the wards.
- Increased education for falls prevention and the importance of keeping patients moving when in hospital.
- Improved awareness around the requirement for timely medication reviews when patients are at risk of falling.
- Launching the national Yellow Sock Scheme and improving awareness around safe footwear.
- Ensuring all patients had a personalised toilet plan for continence.
- Developing new, up to date falls and bedrail guidance.
- Increased awareness around the new falls and bedrails guidance.
- Education around the importance lying and standing blood pressures, and improving overall compliance in completing these.
- Introduce a new lying and standing blood pressure teaching session with competency sign off.
- Identifying that the process and documentation for reporting and reviewing falls required a different approach to ensure that learning was being shared within the directorates.
- Identify any learning following the falls investigation process and implements actions accordingly. This is to then feed into the different forums such as Fundamentals of Care, Patient Safety Forum and the Quality Summit.
- The development and completion of a monthly audit, to monitor the above and implement specific actions accordingly.

What did we achieve?

A Trust wide Falls Action Plan consisted of nine different domains. Initially, the falls specialist service chose to focus on three key areas for 2022 – 2023. These were; the completion of lying and standing blood pressures on all of the patients over 65 within 48 hours of admission, ensuring all patients were assessed for a walking aid within 24 hours of admission in order to assist with mobility and reduce deconditioning. Finally, checking that all patients had a falls risk assessment completed on admission, transfer to a different ward and updated every seven days. This would include individualised actions to increase mobility and reduce the risk of a fall.

- There has been a significant improvement on the monthly falls audit, showing an increase in the completion of Multifactorial Falls Risk Assessments (MFRA's), lying and standing Blood Pressure (BP) and assessments for walking aids for those aged 65 and over.
- Achieved funding for the Trust to work alongside the Improvement Academy around falls.
- A quality improvement project has been successfully launched known as the Yellow sock scheme. This has had good feedback from staff and patients and has increased awareness around the risk of falls.
- A new electronic learning module was created, specifically targeting falls prevention, and is mandatory for staff to complete every three years currently.
- A new process has been developed for falls learning tools, and will allow more individualised learning actions to be developed following incidents.
- Key performance indicators have been developed for falls. This will allow senior management to review compliance levels regularly and allow for learning to be developed for each ward.

The falls data is captured via our Tendable app (real time audit), and is viewed in graph form showing each departments compliance rates. This is available for all senior management teams to view and is shared as part of the Integrated Care Board report, at Matron and Ward Manager meetings, via the Fundamentals of Care meeting and Patient Safety Forum. This is then fed up to the Quality Summit. This ensures rapid learning across the whole of the Trust.

The ward managers and matrons set 'days without falls targets' for their departments which consisted of targets to achieve bronze, silver, gold and platinum awards. These awards have proved popular with colleagues, and allow the trust to showcase the departments that have worked hard to achieve their falls prevention targets.

SAFE: Best Quality, Safest Care: Ever Safer Care through Continuous Learning and Improvement

Quality Programme: Pressure Ulcers

Why Pressure Ulcers?

Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair the blood supply. They cause pain and distress, can lead to longer stays in hospital, increased care in the community and cost the NHS a significant amount of money. They are categorised 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, poor posture, or a medical device.

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. Pressure ulcers can have a significant impact on patients and as such, the prevention of pressure ulcers has been a specific part of our quality improvement work at HDFT since 2012/13 and this focus has continued during 2022 - 2023 through:

- Education and support
- Risk assessment and documentation
- Learning from incidents

What were we aiming to achieve?

The Trust currently has a Quality Review Panel which meets bi-monthly. The objectives of this group being to drive continual improvement of pressure ulcer prevention and to ensure that if omissions in care are identified for pressure ulcers acquired by patients receiving either HDFT hospital or community provided care, there are timely and appropriate action plans in place to prevent recurrence and provide assurance of the learning process.

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 have 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 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?

Education has been a key focus for the Tissue Viability team throughout 2022-2023, both in community and across our inpatient acute services. Challenges with releasing time for colleagues to access education have been overcome by the Tissue Viability Nurse (TVN) team attending clinical areas to undertake ad hoc

education at the patients bedside. This has ensured a connection between classroom learning and practical patient care and has been well received.
The Tissue Viability Nurses work closely with the Trust Clinical Skills Educators to ensure all workforce groups have tailored, role specific education on skin care and pressure ulcer recognition and prevention. This training is also delivered to preceptorship groups as part of the trusts 2-year support programme for newly registered nurses and as part of the induction for healthcare support workers.

Mandatory training “Preventing Pressure Ulcers” is delivered every month, using a hybrid method of face to face and virtual training and covers all aspects of pressure ulcer development, management, and strategies to prevent occurrence or deterioration of existing pressure ulcers. The training offers colleagues hands on, interactive and engaging sessions which highlight the significant impact pressure ulcers have on patients, carers and the workforce. Feedback is consistently positive and any recommendations for amendments considered.

We continue to work closely with our specialist podiatry team which has been invaluable to ensuring appropriate treatment is provided to patients in HDFT care. Podiatry and TVN once again joined forces on International Stop the Pressure Day in November 2022 to facilitate a full day drop in training event open to all clinical colleagues.

Pressure ulcer incidence data is displayed on the Trust’s dashboards and shared through reports to our senior management teams and as part of the Integrated Board Report. Data is displayed on quality boards in both acute and community services and monthly audit via a real time audit application (Tendable) provides assurance and highlights areas for improvement.

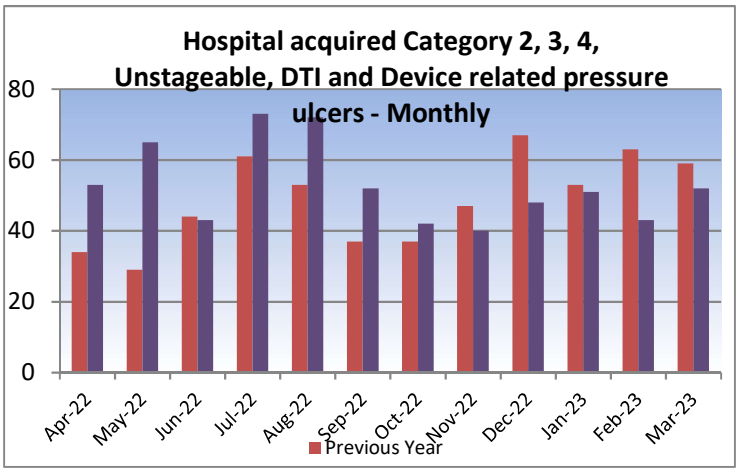
We continue to use and monitor an evidence-based pressure ulcer risk assessment tool (Purpose T) and associated management plan within our community areas and inpatient areas, and this has been extended to our paediatric patients. The pressure ulcer risk assessment tool and pressure ulcer management plan are now completed on electronic patient records across all HDFT clinical areas.

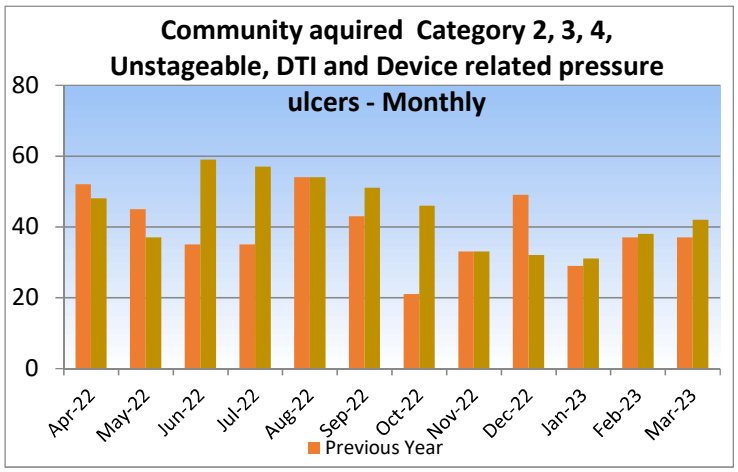
A monthly newsletter “Tissue Viability News” focusing on a different topic each month has been well received by colleagues and highlights areas for improvement identified through the pressure ulcer investigation process. A TVN colleague of the month award has proved popular, showcasing colleagues who go the extra mile to prevent pressure ulcers.

What are the results?

The data from 2022-2023 shows an increase in pressure ulcers across acute and community services at HDFT. Whilst this increase is disappointing, it must be noted that there has been recognised, increased reporting due to the additional training, earlier recognition of pressure ulcers and an increase in TVN presence across the organisation ensuring increased vigilance. The number of pressure ulcers with omissions in care, identified through the root cause analysis process, have decreased with only one community acquired pressure ulcer showing omissions in care, a notable improvement from 12 recorded in 2021 - 2022.

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





OUTCOMES: Best Quality, Safest Care: Excellent outcomes through effective, best practice

Quality Programme: Missed Results

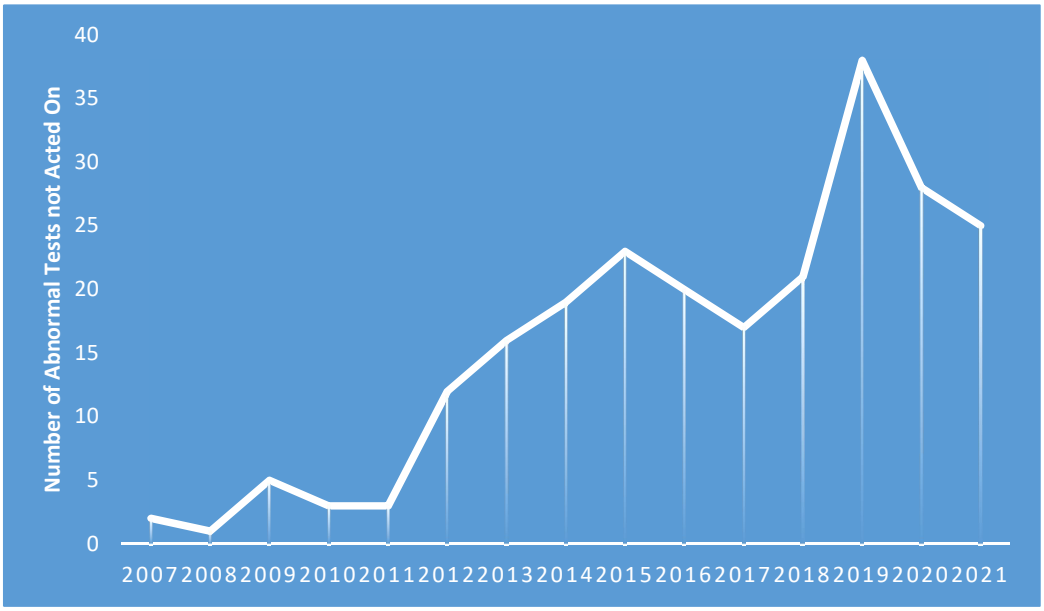
HDFT performs many thousands of investigations every year, and the number continues to increase. These tests include blood tests, x-rays, scans and other specialist investigations such as specific tests of the heart and lungs. Each investigation is always performed for a specific purpose – sometimes to diagnose or exclude a medical condition, to monitor its progress and in response to treatment or part of overall health surveillance.

It is important that every test performed has its result acted on appropriately. Although this happens correctly for the overwhelming number of tests, unfortunately sometimes an investigation result is missed and the correct action therefore not taken. Although this often results in low or no harm occurring, it can occasionally have significant consequences and therefore it is important that we try to eliminate such occurrences.

Why Missed Results?

In 2021, we undertook 2 investigations to see how many tests are missed, what impact they had and were there any common themes we could learn from to prevent such errors happening again.

The graph below shows how the number of cases where abnormal test results were not acted on and how this has increased over the last 15 years. Part of this rise will be due to the improved reporting of errors over this period, together with the increased number of tests being performed. However we felt it important to ensure our systems and process were as robust as possible:



What were we aiming to achieve?

We wish to ensure that all results are seen promptly and appropriately actioned. In doing so, we will expect to reduce the number of cases where patients have come to harm due to avoidable delays in their treatment or investigation.

What have we done?

We looked back at all the cases since 2007 where a missed result had led to patient harm. Many of these had been investigated as Serious Incidents, and action plans implemented to prevent a similar recurrence. The specific causes in each case were often unique, but 2 themes were identified:

1) Occasions where the correct test had been performed but the requesting health professional did not see the result or failed to identify some concerning features in a long report (such as following a scan)
2) Correct procedures were followed by the requesting health professional, but further actions did not occur (when being referred on to specialist team meetings)

In the summer of 2022, a 3 day rapid improvement workshop (RPIW) was held, facilitated by our Quality Improvement team. This brought together individuals from a variety of clinical teams and departments, together with secretarial team members, IT experts, consultants, junior doctors and other allied healthcare professionals. Following the workshop, 25 potential actions were identified.

Over the rest of 2022-2023, each of these actions was either implemented or further explored as to whether they could be introduced. Overall, specific actions implemented during that year included:

1) Enabling results to be visible immediately in the Emergency Department on screens and on hand-held devices
2) Refining which results are telephoned from the laboratory when they are abnormal
3) Empowering appropriate members of the team to action or file results, which enables more senior members to focus on abnormal results
4) Sharing practices across teams to embed daily result reviewing as part of normal practice
5) Introduction of new tracking software – the Cancer multi-disciplinary teams now use a new software solution to ensure agreed actions are followed up
6) Certain teams have increased their allotted time for administrative duties

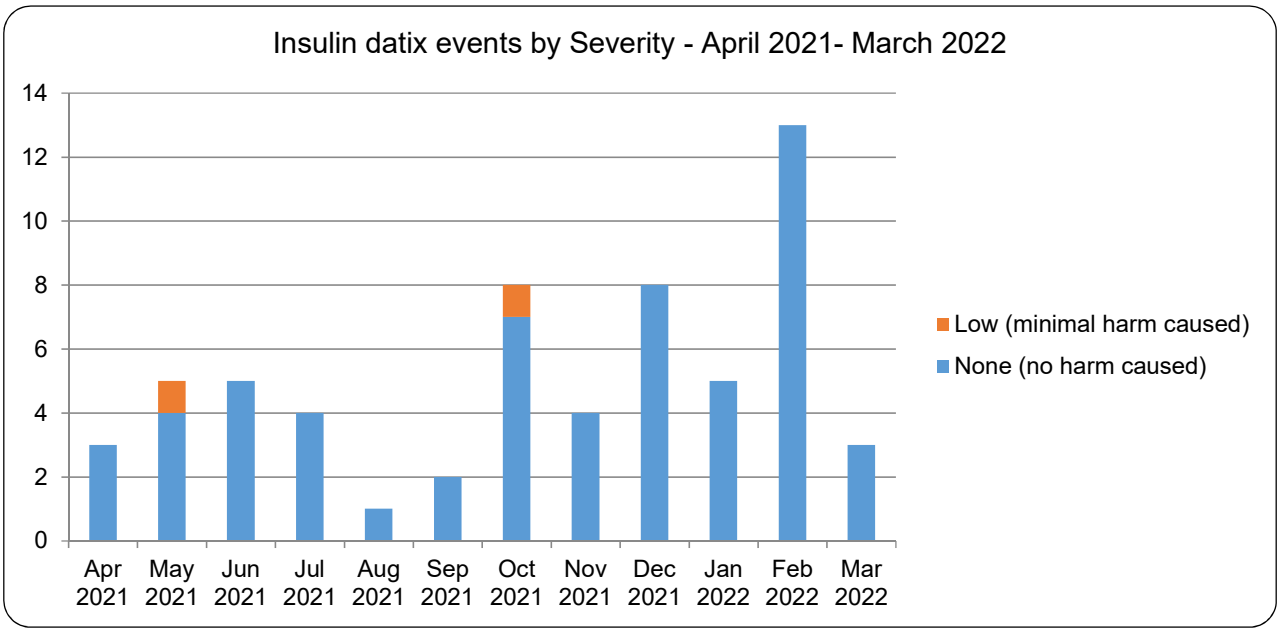
OUTCOMES: Best Quality, Safest Care: Excellent outcomes through effective, best practice

Quality Programme: Medication Errors – A Focus on Insulin

Why Insulin Medication Errors?

Insulin is a high-risk medicine. High-risk medicines are defined as medicines that have a high risk of causing injury or harm if they are misused or used in error. The Medicines Quality and Safety Group regularly reviews trends in reported medication incidents and noted high reported number of insulin medication incidents in October 2021, this led to the formation of the Insulin Safety Group in December 2021. This group explored the types of incident that were happening and what interventions they could implement to reduce the number of insulin medication incidents and reduce patient harm. As reported insulin medication incidents remained high at the end of 2021 - 2022, the Trust chose to adopt this as one of the Quality Priorities for 2022 - 2023.

What were we aiming to achieve?



The overall aim of this Quality Priority was to reduce the number of reported insulin medication errors and reduce harm to patients. To do this, there was a more in-depth piece of work to understand the trends in reported insulin medication incidents to help target interventions to improve patient safety.

Data from 2021 - 2022 showed that the most common reasons for insulin medication incidents were prescribing and administration errors, with the incorrect insulin medicine or dose being the most common prescribing incident.

What have we done?

The Insulin Safety Group sought feedback from staff to understand what improvement ideas they had for reducing insulin medication incidents. The following ideas were implemented:

- Insulin safety e-learning for all medical, nursing and pharmacy staff

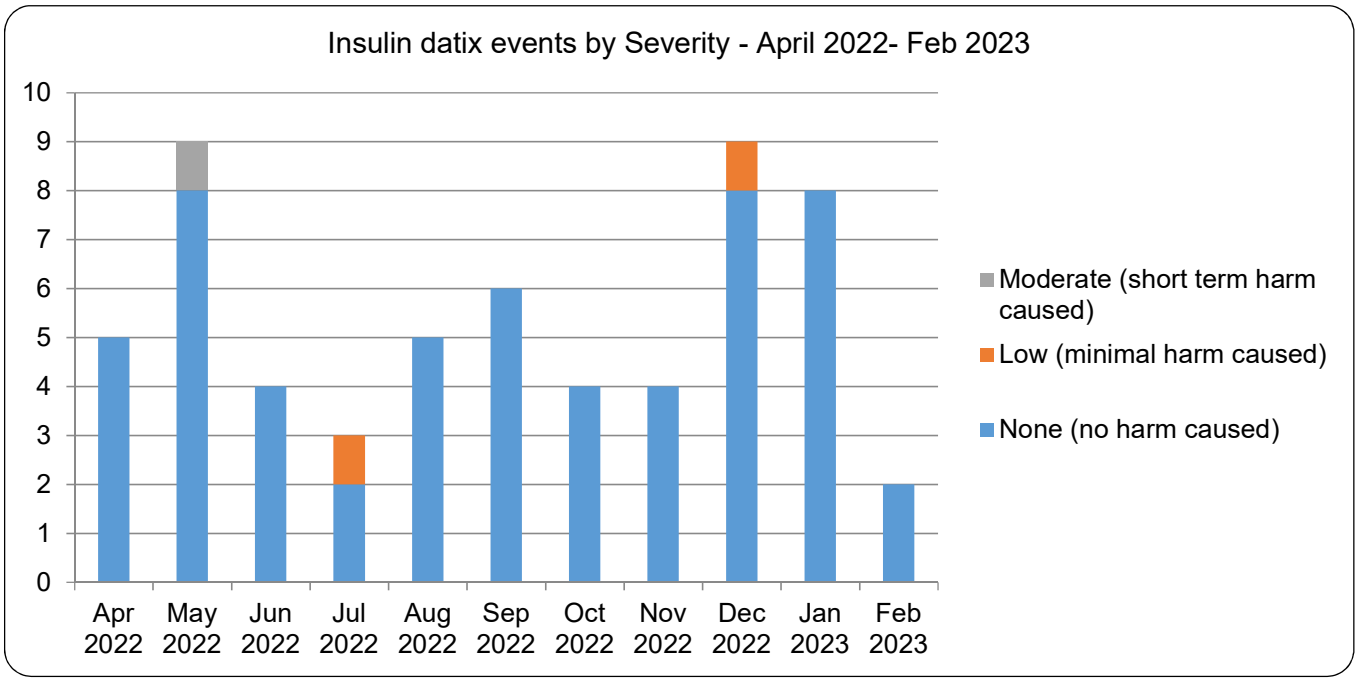
- Electronic Prescribing Medicines Administration (EPMA) insulin protocols updated to reduce the risk of selection of the incorrect insulin when prescribing
- Insulin teaching sessions to medical, nursing and pharmacy staff

What are the results?

The data below shows that these interventions were successful in achieving an improvement in the short-term; however, an increase in reported insulin medication incidents was seen again in December and January 2023. The reasons for this were explored in more detail and the Insulin Safety Group identified a specific trend relating to management of Diabetic Ketoacidosis on acute admission. This will form the focus on a new quality improvement initiative in 2023-2024.

April 2022 – February 2023

No Harm Events reported: 56
Low Harm Events reported: 2
Moderate Harm Events reported: 1



EXPERIENCE: Best Quality, Safest Care: A positive experience for every patient by listening and acting on feedback

Quality Programme: A focus on patient experience

HDFT Patient Experience and Engagement - At a Glance

172 COMPLAINTS	**1134** CONCERNS AND QUERIES	**338** COMPLIMENTS AND THANK YOU'S RECEIVED CENTALLY
75% OF COMPLAINTS ON AVERAGE RESPONDED TO WITHIN 25 DAY TIMEFRAME (AGAINST A KPI of 95% - increased from 56% in 2021-2022)	**35-40** TOTAL OPEN CONCERNS ON AVERAGE, REDUCED FROM **150**	**14** COMPLAINTS REFERRED TO PARLIMAENTARY HEALTH SERVICE OMBUDSMAN
55, 724 FRIENDS AND FAMILY TEST RESPONSES	**92%** OF PATIENTS OVERALL THINK THEIR EXPERIENCE OF CARE AT HDFT WAS VERY GOOD OR GOOD OVERALL	**1** PHSO COMPLAINT TO INVESTIGATION

FRIENDS AND FAMILY TEST (FFT)

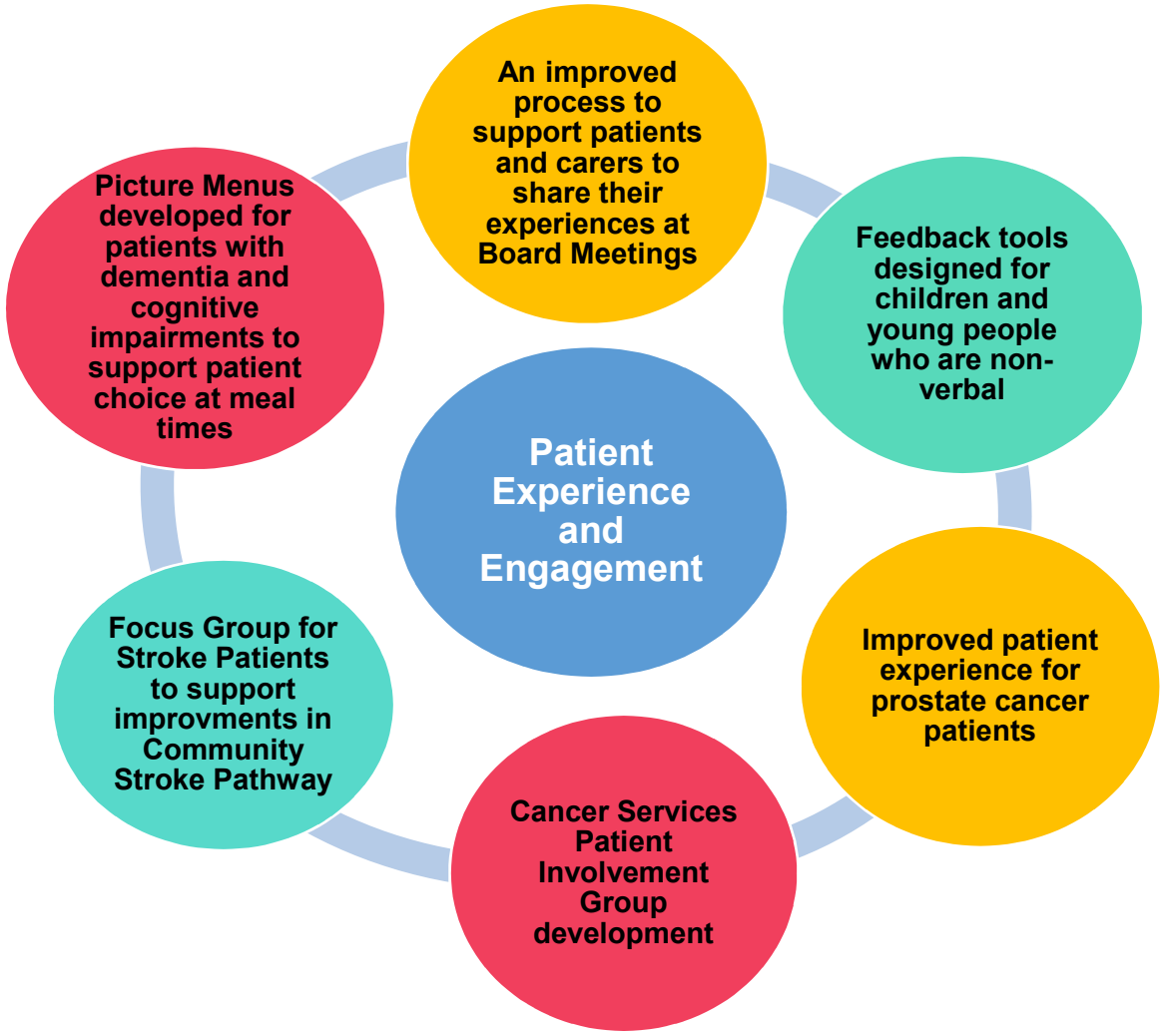
The Friends and Family Test was created by NHS England and is a quick, anonymous way for patients, carers, families, children and young people to give feedback about their experience after receiving NHS care or treatment.

It provides a valuable insight into how people feel about our services and is integral to our desire to ensure continuous learning and improvement from patient experience, based on real-time feedback.

Patients, carers, families, children and young people should have the opportunity to give regular feedback about their experience of care from all HDFT Services, and the Patient Experience Team have introduced new collection methods to ensure accessible access to feedback;

- Updated easy-read feedback forms, with a children and young person's version designed with help from Specialist Children's Services
- A new online FFT, available in standard and easy-read versions. Accessible via QR (Quick Read) codes displayed on posters through HDFT departments. The URL can also be shared via email, text message or shared in virtual consultation chats and is also found on the HDFT website.

KEY PROJECTS 2022 – 2023



We have selected two projects to provide further information on in greater depth:

FEEDBACK TOOLS DEVELOPED FOR NON-VERBAL CHILDREN & YOUNG PEOPLE

Specialist Children's Services (SCS) identified a gap in making sure children and young people with complex communication needs are able to give feedback about their experience of care at HDFT. With commissioning support from the Integrated Care Board (ICB), Specialist Children's Services co-produced three feedback tools, working with children and young people, parents, carers, staff and teachers to develop and evaluate each feedback method.

The three methods are;

1). An online survey for children and young people who have the capacity to read and answer questions using a touch pad, supported by the use of pictures and emojis to help them give feedback. Including free

text options for Children and Young People to type comments and specific questions asking how they felt during their appointment, e.g. happy, scared, fun, boring.

2). A talking survey using a touch pad and symbols/emojis that allow Children and Young People to point and indicate how their appointment has felt, what was good and what could be improved.

3). Method 3 has been designed as an observational feedback tool for parents and carers of Children and Young Peole with profound and/or multiple learning disabilities. This asks parents and carers to feedback by observing their child's verbal cues, mannerisms and body language during the appointment to help staff understand what works well and what they can do differently to ensure these appointments are supportive and meeting the children's needs.

These feedback tools are now being implemented in SCS, with support from the Patient Experience Team to assess feedback and the take up of each tool to monitor initial success.

SCS have also been one of the first HDFT services to implement the new Children and Young People's Friends and Family Test, which includes a new character named Jif, who was created by Children and Young People from SCS teams. Jif is a passionate NHS champion and is now a firm feature on our feedback forms, helping children to recognise feedback for HDFT services!

IMPROVED EXPERIENCE FOR PROSTATE CANCER PATIENTS

The Macmillan Urology Nurse Team noticed that some patients were being asked to attend multiple appointments and blood tests, increasing their attendance to hospital, often unnecessarily.

Not only was this not a good use of nursing time having to perform multiple tests, prescribing and dispensing medications, it also meant that patients were attending hospital more often than they needed, to collect medication that rarely had an impact on their health outcomes.

Jess, one of the Macmillan Urology Nurse, was keen to streamline their pathway, reduce their appointments, interactions and prescribing, and improve overall patient experience.

By implementing her Quality Improvement training, Jess created a new clinic run by Macmillan Urology Specialist Nurses. With greater knowledge and experience of metastatic prostate cancer, these clinics provide a more specialist service to patients, and hopefully help to relieve some of their anxiety during treatment.

Early patient feedback has been really positive. Patients feel that this way of care delivery is less intrusive in their day to day lives, due to the reduced hospital visits and blood tests. They are also grateful for the specialist knowledge the nursing team are able to provide in regard to PSA (a prostate specific antigen) trends and red flag symptoms that they did not have before.

The Patient Experience Team are working with the nursing team to develop a patient survey to more formally evaluate the new clinics and ensure patient feedback continues to help shape and develop the clinics.

PATIENT AND CARER SURVEYS

23

PATIENT SURVEYS SET UP IN 2022-2023

16

ONGOING PATIENT & CARER SURVEYS

Services Include

End of Life Care, Radiology, Theatres, Specialist Children's Services, Woodlands and SCBU

IN FOCUS

Theatres and Day Surgery

Feedback opportunities are available to all patients who are looked after in Theatres and Day Surgery Unit (DSU), including a specific survey for children and young people aged 2-10. Theatres and DSU understand how vital patient feedback and focus is, and employ the ethos "Keeping the patient voice in the room", particularly as they care for people often at their most vulnerable.

There is a "You Said, We Did" board present in both Theatres and DSU, displaying feedback, comments and ideas for improvements from patients and staff.

Feedback from the patient surveys is also disseminated to the teams during Safety Huddles each week.

Woodlands and Special Care Baby Unit

Woodlands ward and the Special Care Baby Unit (SCBU) have ongoing patient surveys, to gather feedback to ensure continuous improvement and learning and quality care.

There are paper versions of the survey available in all rooms and bays, along with QR (Quick Read) codes displayed on posters around the wards to encourage those who can to leave feedback via the online version of the survey.

Feedback from the survey is largely positive;

- "Our time is hospital was absolutely amazing. Every single person we saw were friendly professional and went above and beyond which is so important especially when it comes to children/babies that may be unwell. I found the whole experience comforting and I felt my child received the best care possible and he was in very safe hands. Thank you to each and every one of you. You're all incredible."
- "The staff were just so lovely, caring and clearly experienced. It inspire confidence that your child is well looked after"
- "Very efficient and supportive staff. Very thorough with examinations and explanations"
- "Thorough and listened to mothers' instinct which is so important."

Where feedback is identified that can be used to inform learning and improvements, these are shared with the ward staff and wider team via email.

Some examples of actions for improvement in 2022 – 2023 have included;

Improvement point	Action
Poor communication with families around what procedures and tests are taking place.	Please can we makes sure that families are kept up to date with their children's care. Please ensure that we are sharing information such as what tests/procedures will be done, why and how long this may take.
Patient felt that staff needed to ask more frequently about their pain score.	Current system is under review. New routine to be implemented shortly.
Curtains broken or not fitting.	Inspected curtains, and found the curtains were not hung up correctly, in bed 8, 14 and 15. Curtains have been rehung and replace where necessary today.
Staff did not introduce themselves.	Please remember to introduce yourself to families first thing on a shift whilst you are completing your safety checks.

Performance Against Other Quality and Safety Indicators

This section of the Quality Account provides an update on:

- Seven day services within the NHS
- Patient Safety Incidents
- Serious Incidents and Never Events
- Duty of Candour
- Patient Safety Alert Compliance
- NHS Staff Survey Results
- Whistleblowing
- Freedom to Speak Up
- Guardian of Safe Working

Seven Day Services Within the NHS

What do we mean by seven day services?

Seven-day services in the NHS is ensuring all patients who are admitted to hospital as an emergency, receive high quality and consistent care no matter what day or time of the week they enter a hospital. . The seven-day services programme is designed to improve hospital care with the introduction of seven-day consultant-led services that are delivered consistently over the coming years.

Ten clinical standards for seven-day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven-day services should achieve, no matter when or where patients are admitted.

Monitoring of the Clinical Standards at HDFT

Whilst formal monitoring of the seven day service was suspended nationally due to Covid-19, HDFT have continued to make strides in ensuring our services are fit for purpose. During 2022-2023 HDFT has undertaken stakeholder engagement to create our new Clinical Services Strategy which is due to be launched in Quarter 2 of 2023-2024. This strategy will have a key focus on the growth of the HDFT@Home Integrated Care Services and increased networked acute service to ensure resilience of our seven day services. Below is a summary of key activities for 2022-2023:

Urgent 2 Hour Response

This service was established in 2022-2023, as part of Harrogate and Rural Alliance (HARA), to provide a response within 2 hours from referral in the Community to anyone over 18 and suffering a crisis (mental health crisis is excluded).

There are 9 pathways included and the primary purpose of the service is to prevent avoidable admissions and readmissions into the hospital, treating people within their own home. The service operates from 8am to 8pm seven days a week, accepting referrals from GPs, YAS, Care Homes and other community providers.

Where appropriate, patients may then be referred into the Hospital at Home consultant to avoid admission to Hospital whilst ‘stepping up’ acuity of care. The UCR team also work closely with the Trust’s Palliative team.

7 Day Community Discharge Hub

Responding to national guidance, we created a Community Discharge Hub that operates 7 days a week. The Hub is an integrated service within the HARA alliance, with both HDFT and North Yorkshire County Council colleagues meeting daily to organise timely supported discharge and ensure smooth transfer of care. This work has built on the existing Discharge Planning Team, Adult Community team and the North Yorkshire County Council Social workers and transfer of care coordinators who work together to ensure early identification of patients who will require support on discharge and ensure they are discharged to the most appropriate pathway as soon as they no longer require treatment that can only be provided in hospital.

ARCH (Acute Response and Rehabilitation - Community and Hospital)

This team brings together: the Supported Discharge Service; Acute and Frailty inpatient therapy services; Community therapy and Intermediate Care bed based rehabilitation.

The service operates seven days a week delivering 35 ‘virtual beds’ of capacity to support patients leaving hospital sooner with additional short-term support in their home environment.

Over the last few months the service has expanded its offer to include a ‘Hospital at Home’ ward that allows 10 of these virtual beds to be occupied by a higher acuity of patients under the care of a dedicated Geriatrician.

The Hospital at Home service does not yet have consultant cover 7 days a week, however there is a dedicated Night Nursing team across the 7 days to support the admission of higher acuity patients onto the Hospital at Home (HaH) ward. We have applied for further funding to hire further medical staff into the HaH team, including more nurses and ACPs, so that cover can be brought up to 7 days a week.

The Trust is working closely with the ICB to expand the capacity of ARCH to manage 43 ‘virtual beds’ in the Community, of which: 25 will be intermediate care/ Community rehab/ reablement beds, 10 UCR beds and 10 higher acuity ‘Hospital at Home’ beds under the care of Geriatricians (18 trajectory by December 2023 has been submitted but yet to be confirmed - subject to funding).

The model is based on a ‘pull’ approach from both the wards and Community, with the team actively finding and tracking suitable cases from ED, the Acute Frailty Unit and Frailty Wards. It also takes referrals from therapy and clinical teams on other inpatient wards.

The ARCH model works across the following three discharge pathways. These should make up 50% of the discharges from the hospital for patients aged 65+ years, with the other 50% of patients leaving on Pathway.

- Pathway 1 - Patients that go back to their own home some short term reablement or other personalised community-based support to help with their recovery and care. Pathway 1 is also for people who have a home care package that is being restarted at the same level as that delivered prior to admission to hospital after lapsing during their hospital stay.
- Pathway 2 - Patients that require short term rehabilitation and potentially reablement in a community bedded facility or care home with therapeutic and nursing support to help with their recovery. The intention must still be to get the person back to their home (or usual place of residence) following the period of rehabilitation.
- Pathway 3 - Patients who require bed-based 24-hour care following discharge from hospital, which will include people discharged to a care home for the first time.

Patient Safety Events

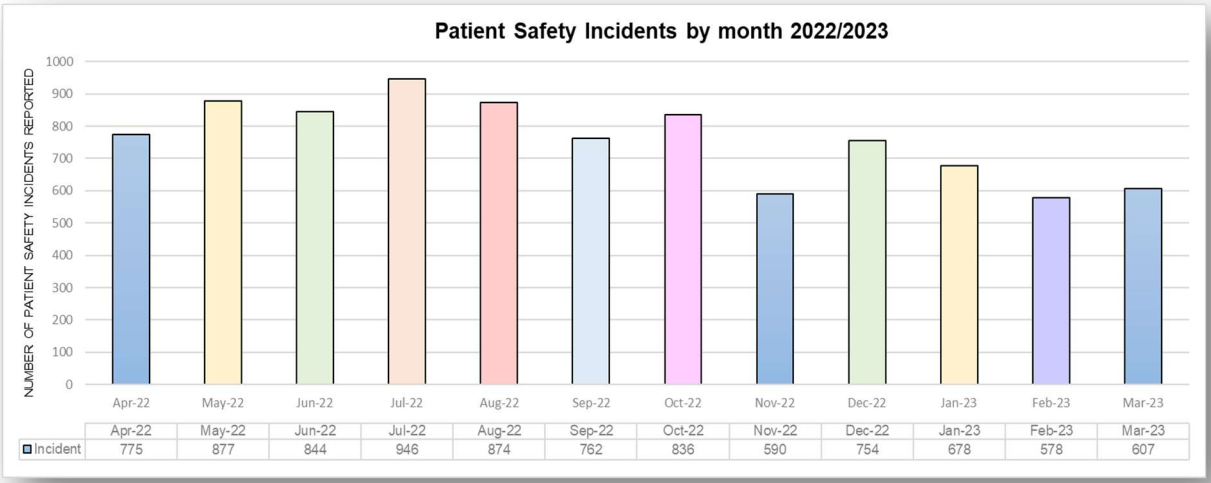
What is a patient safety event?

Patient safety events are any unintended or unexpected events which could have, or did, lead to harm for one or more patients receiving healthcare. HDFT encourages events to be reported and believes that a strong reporting culture (i.e. a high level of events reported), is a sign of a good patient safety culture and provides an opportunity to learn, prevent recurrence and improve patient safety.

What has 2022-2023 looked like for patient safety events at HDFT?

The Quality Team coordinates patient safety review and reporting at HDFT and this year the team has undergone significant changes which have included the appointment of the Associate Director of Quality and Corporate Affairs, and further specialised roles to help strengthen and change processes in relation to patient safety, event reporting, and encouraging a positive learning culture.

The number of Patient Safety Events reported at the Trust, per month, during the year is noted below. The Trust has a robust policy and process to ensure that all events are identified, managed, reported and investigated in accordance with national guidance.



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Incident	775	877	844	946	874	762	836	590	754	678	578	607

Learning from events is shared following investigations at the Serious Incident Committee, Directorate Quality and Safety Governance Meetings and The Quality and Learning Summit. Learning is also embedded throughout our monthly learning newsletter, “Quality Street News” and any immediate patient safety learning is shared through our own internal patient safety alert process. The Quality and Learning Summit has dedicated time to ensure cross directorate learning is identified, discussed and then shared effectively across the organisation. This learning is identified from all safety events, including no and low harm, as well as moderate and above.

Action plans from investigations are actively monitored for compliance and to ensure appropriate evidence of completion is gained.

This year, the Datix Cloud (DCIQ) project commenced to provide the Trust with an updated safety and risk management system that has the capability to record and report on information required to meet mandatory requirements. Introduction of brand-new modules to support additional mandated external reporting requirements, ensuring HDFT is compliant with regulations as well as increasing staff satisfaction and engagement creating an open and just culture.

Serious Incidents and Never Events

What is serious incident (event) and a Never Event?

A Serious Incident (SI) is an incident or accident involving a patient, a member of NHS staff (including those working in the community), or member of the public who face either the risk of, or experience actual, serious injury, major permanent harm or unexpected death in hospital, other health service premises or other premises where health care is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern. These are all events that the Trust believes to be worthy of investigation by an Independent Panel and/or fall into the category of an incident that must be reported to the local Commissioning agencies.

Some Serious Incidents are called Never Events (NE). Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

What has 2022-2023 looked like for serious incidents (events) and Never Events at HDFT?

HDFT is committed to identifying, reporting and investigating serious events, and ensuring that learning is shared across the organisations, and actions are taken and embedded to reduce the risk of recurrence. Our serious events were used to help inform our quality priorities and their associated improvement plans.

The Trust has declared a total of 30 comprehensive serious events this year, this includes two external investigations completed by HSIB, and 3 Never Events. This is in comparison to 21 in 2021-2022. The Never Events that occurred have been a key focus on the improvement work that has been undertaken in our theatres environment. Further detail on this can be found in the Theatres Improvement section of this report.

The process of how serious events are investigated was reviewed following the restructure of the Quality Team, and included the introduction of a new governance structure. As part of this review, an internal audit was undertaken which provided significant assurance of changes embedded.

HDFT''s Serious Incidents in Numbers:

25
Serious Events

2
HSIB Investigations

3
Never Events

Duty of Candour

What is Duty of Candour?

The Care Quality Commission (CQC) introduced the Duty of Candour regulation in November 2015. Duty of Candour sets out specific requirements that providers must follow when things go wrong with a patient's care and treatment. Requirements include informing people about the incident, providing a truthful apology and providing feedback to patients following the investigation of the incident.

What has 2022-2023 looked like for Duty of Candour at HDFT?

HDFT is committed to promoting an open and honest culture and staff are encouraged to report patient safety events that have occurred. New monitoring processes have been implemented to ensure statutory duty of candour is carried out effectively and timely.

The number of events triggering statutory duty of candour is 180. In 150 of these cases, the duty was followed, in 19 cases the decision was made not to apply the duty of candour – the reasons for this have been documented and reviewed, all of which were appropriate. Six cases are in the process of being completed.

Patient Safety Alerts Compliance

What is a Patient Safety Alert?

Patient safety alerts are used to inform the healthcare system of recognised safety risks and offer appropriate guidance for the prevention of incidents that may result in severe harm or death to patients.

These alerts are issued by NHS England / Improvement through the Central Alerting System (CAS) which is a web-based cascade tool utilised for issuing alerts, public health messages and useful safety information to the NHS and other healthcare organisations. Patient safety alerts are developed with input, advice and guidance from the National Patient Safety Response Advisory Panel, which assembles frontline healthcare staff, patients and their families, safety experts, royal colleges and other professional and national bodies. The panel discuss and advise on approaches to respond to patient safety issues through the publication of alerts which are identified through the clinical review of incidents reported to the NRLS and Strategic Executive Information System by NHS Trust and other health care providers and also from concerns raised by members of the public.

Alerts can also be issued where there is a common problem occurring throughout the NHS and can be an important part of a wider programme of work. Systems and equipment are commonly subject to patient safety alerts where there are recognised errors or faults and would therefore require action to be taken to reduce the risk to patient safety.

What has 2022-2023 looked like for Patient Safety Alerts at HDFT?

Coordination of patient safety alerts is carried out by the Patient Safety Team (part of the Quality Team) who work with various Trust departments and Directorates to facilitate compliance, and monitor on-going work or action plans used to address the issues raised.

The Trust has implemented a new streamlined process relating to Patient Safety Alerts. All alerts are now captured and monitored through our Datix Reporting System.

The Trust received two NatPSAs within 22/23.

- NatPSA/2023/001/NHSPS – Use of Oxygen cylinders where patients do not have access to medical gas pipeline systems
- NatPSA_2022_003_NHSPS - Inadvertent oral administration of potassium permanganate

These alerts were assessed and both deemed applicable to HDFT. Actions were completed within the required timescale, and appropriately overseen by the relevant governance groups.

NHS Staff Survey Results

What is the NHS Staff Survey?

The NHS Staff Survey is one of the largest workforce surveys and has been conducted every year since 2003. All staff working in the NHS are invited to take part in the NHS Staff Survey. The survey offers a snapshot in time of how people experience their working lives and information is gathered at the same time each year. The survey captures a national picture alongside local detail, enabling organisations to understand what it is like for staff across different parts of the NHS and to support further improvements.

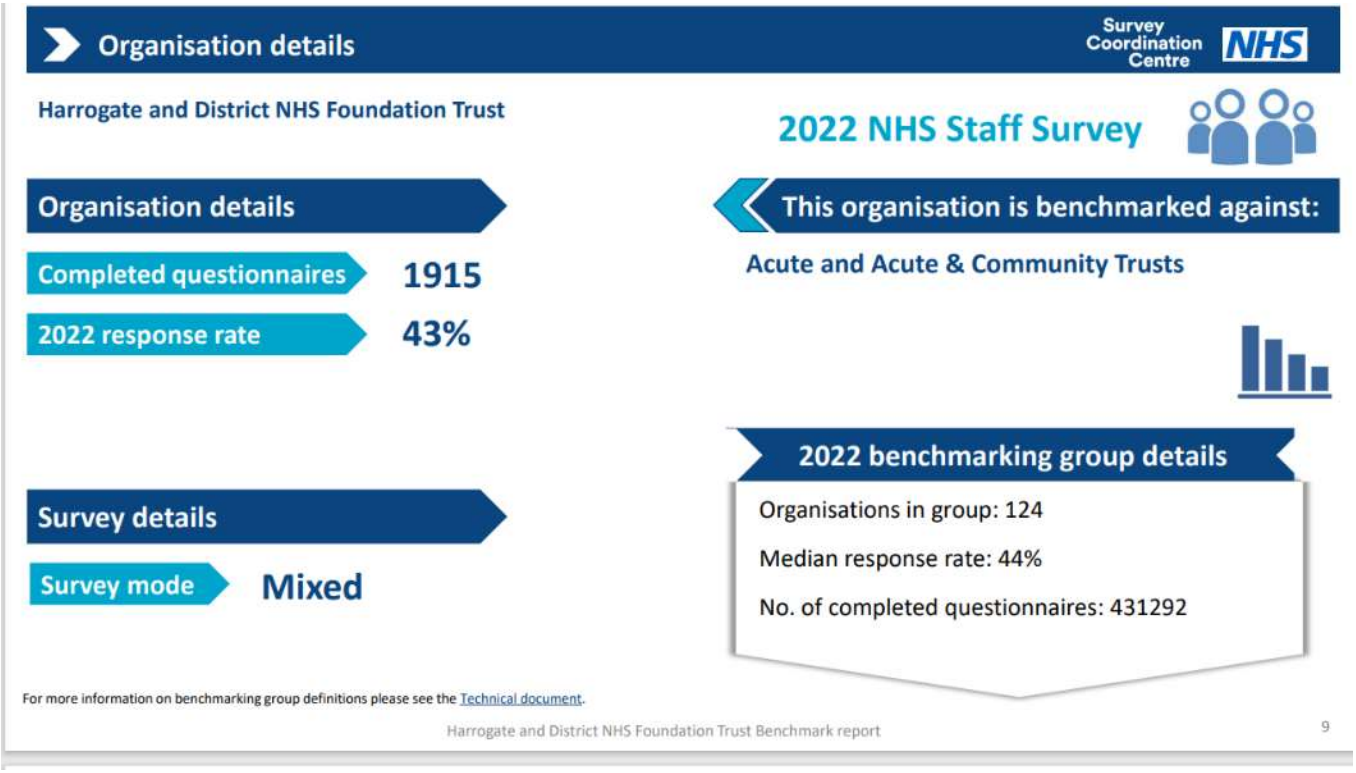
What has 2022-2023 looked like for the NHS Staff Survey at HDFT?

In September 2022, all NHS trusts in England were required to participate in the National NHS Staff Survey. The survey was designed to collect the views of staff about their work and the healthcare organisation they work for.

The aim of the survey is to gather information that will help improve the working lives of NHS Staff and enable them in turn to provide better care for patients. Obtaining feedback from staff and taking account of their views and priorities is vital for driving service improvements in the NHS.

At HDFT; survey invites were distributed to staff by email as well as through the post (using a mixed mode approach i.e. web and paper based).

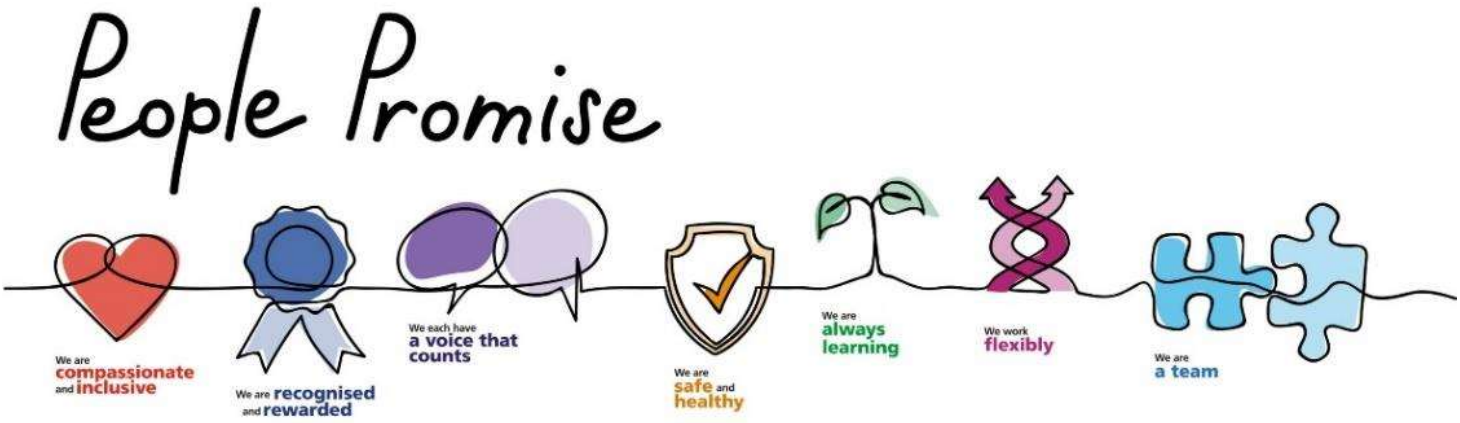
A total of 1915 staff completed the survey questionnaires. Based on the 4495 staff invited to participate this provides a response rate of 43%, representing a significant increase since the start of the pandemic. In 2021 the Trust achieved a response rate of 39%.



Themes

From 2021 onwards, the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience and is made up of seven elements:

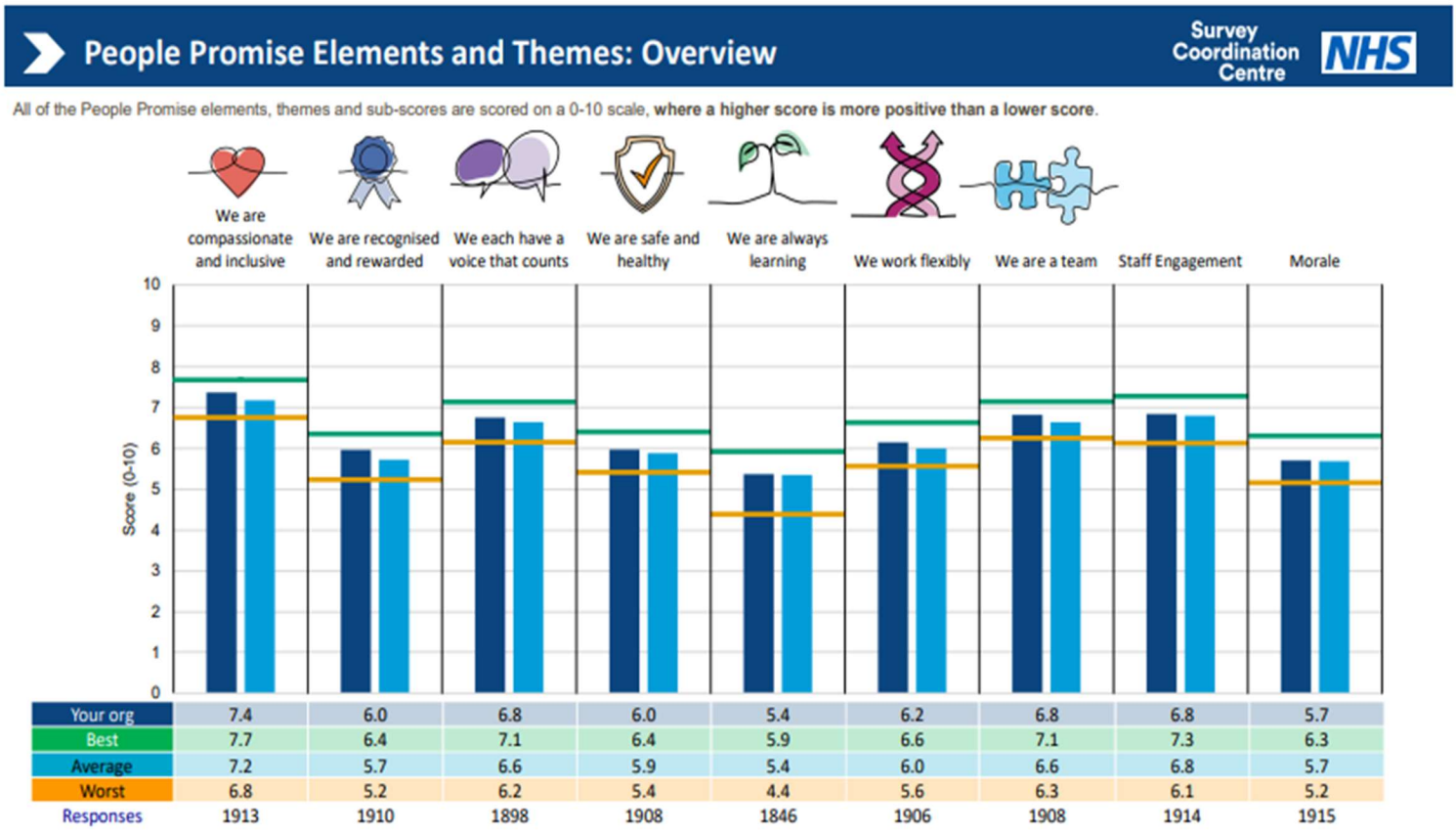
In support of this, the results of the NHS Staff Survey are measured against the seven People Promise



elements and against two of the themes reported in previous years (Staff Engagement and Morale).

Results

The People Promise Elements and Theme results overview is shown below. This table compares our scores to the best, the average and the worst scores within our comparator group. HDFT is above average for our benchmarking group in 6/7 elements, and meets the average in one element (We are always learning) and the two themes (Staff Engagement, and Morale).



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.4	6.0	6.8	6.0	5.4	6.2	6.8	6.8	5.7
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	1913	1910	1898	1908	1846	1906	1908	1914	1915

Compared to last year's results, our scores have increased in all nine of the People Promise elements and themes.

Areas to Celebrate

- Line management results have all moved upwards and are above average – steady improvements
- Teamworking results have all shown improvement in 2022
- Organisational support for home life balance, flexible working and flexible shift patterns have all increased and are above the benchmarking group average
- All questions related to learning development opportunities have shown improvement since 2021, with many reaching or exceeding the benchmarking group average
- Appraisals have improved in terms of numbers conducted and benefits of these, but it is worth noting the numbers are still below the levels achieved in 2018 and 2019.

Areas to Focus On

- The percentage of staff who feel able to meet the conflicting demands on their time has improved slightly to 37.8% in 2022 from 35.0% in 2021. However this is well below the benchmarking group average of 42.9% in 2022.
- The number of staff saying that they have worked additional unpaid hours is significantly higher than the average for comparable organisations (65.1% compared with the average of 56.3%). This is also notable when viewed against the number of staff saying that they work additional paid hours. The HDFT figures are significantly lower than the comparable average (25.8% compared with the average of 40.4%).

Whistleblowing

What is Whistleblowing?

Whistleblowing occurs 'when a worker raises a concern about dangerous or illegal activity that they are aware of through their work' (Public Concern at Work). A 'protected disclosure' is one where a worker must have a reasonable belief and in good faith believes that their disclosure is in the public interest.

What has 2022-2023 looked like for Whistleblowing at HDFT?

HDFT is committed to achieving the highest possible standards of quality, honesty, openness and accountability in all of our practices. An important aspect of accountability and openness is a mechanism to enable employees, workers and volunteers to voice their concerns in a responsible and effective manner and for them to feel valued for doing so.

Confidentiality is a fundamental term of every contract of employment, however, where an individual discovers information which they believe shows serious malpractice or wrongdoing within the Trust, this information should be disclosed without fear of reprisal. To qualify for the protection (a 'qualified disclosure') afforded by The Public Interest Disclosure Act 1998, staff must have a reasonable belief that one or more of the following matters is either happening, has taken place or is likely to happen in the future:

- A criminal offence
- The breach of a legal obligation
- A miscarriage of justice
- A danger to the health and safety of any individual
- Damage to the environment
- Deliberate attempt to conceal any of the above

In addition to the legal framework, in 2010 the NHS Staff Council agreed that 'Employees in the NHS have a contractual right and duty to raise genuine concerns they have with their employer about malpractice, patient safety, financial impropriety or any other serious risk they consider to be in the public interest'. This change has been incorporated into the Terms and Conditions of Service Handbook for staff employees.

The Francis Report 'Freedom to Speak Up – A review of whistleblowing in the NHS' published in February 2015, clearly indicated that NHS staff did not feel safe raising their concerns about patient care that was being delivered. A key theme of the report was the requirement for openness, transparency and candour about matters of concern; the need for a 'just culture' as opposed to a 'no blame culture'. Sir Francis also recommended the introduction of a 'Freedom to Speak Up Guardian' post as an additional person staff can raise concerns with and at HDFT Joanna Cann, currently fulfils this role.

At HDFT we have a wide range of avenues for colleagues to raise their concerns:

- DATIX (Incident Reporting tool)
- Line Manager
- Lead Clinician
- Matron
- Staff Side Representative
- Human Resources
- Occupational Health
- Chaplains

- Freedom to Speak Up Guardian
- Guardian of Safe Working
- Associate Director of Quality and Corporate Affairs
- Safeguarding Team

Concerns may also be raised to the next level of management; for example:

- A member of a Directorate Triumvirate
- A Deputy/Assistant Director
- A Divisional General Manager/Divisional Nurse/Clinical Director
- Heads of Service
- An Executive Director
- The Chief Executive
- A Non-Executive Director (NED) – the Senior Independent Director (Laura Robson) in particular has a role to support staff who need to utilise the whistleblowing process.

If colleagues feel unable to report at any of these levels for any reason, or feels their concerns have not been addressed adequately at an earlier level, they may choose to report their concerns externally. Concerns may be raised with an external regulatory body (which includes prescribed bodies or persons).

HDFT would urge staff to allow the Trust the opportunity to investigate and resolve the concerns prior to reporting externally if at all possible. If the investigation finds the allegation is unsubstantiated and all internal procedures have been exhausted, but the member of staff is not satisfied with the outcome, the Trust recognises the lawful rights of employees to make disclosures to prescribed persons. In order to maintain the protection afforded by the Act, disclosure other than to the Trust must be made to prescribed bodies or persons and the Trust encourages staff to notify the Chief Executive of their intention to disclose their concerns externally. The Trust also encourages staff considering this course of action to seek advice from the Trust's Freedom to Speak up Guardian.

Freedom to Speak Up

What is Freedom to Speak Up (FTSU)?

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).

What has 2022-2023 looked like for Freedom to Speak Up at HDFT?

At HDFT, our Freedom to Speak Up Guardian works 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, Quality Team, or to other staff e.g. staff governors, chaplains, Trade Union representatives, executive or non-executive Directors. The Freedom to Speak Up Team provide advice and support to staff who raise concerns, work to support a culture of speaking up, providing challenge where required.

What were we aiming to achieve?

At HDFT we aim to make it as easy as possible for every colleague to speak up safely when they want to raise a concern that they do not feel they can do through the usual methods of speaking to their line manager. We aim for speaking up to be business as usual at HDFT and to have Fairness Champions in each clinical and non-clinical area to support with signposting and championing speaking up. We aim for colleagues and ex-colleagues, whether employed directly or as contractors, students or volunteers to be able to speak up about anything that gets in the way of doing a good job.

What have we done?

We have continued to embed the Freedom to Speak Up values of courage, impartiality, empathy and learning into 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.

2. Diversity, inclusivity, trust and respect: ensuring people are treated fairly regardless of ethnicity, gender, disability or other 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. Trust Values and behaviours: ensuring we promote and expect positive behaviours that improve patient safety and colleague 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.

Over the last 2 years we have trained 22 additional Fairness Champions across the organisation and have confirmed ongoing commitment from the existing champions. We are rolling out the inclusion of the National Guardian Office's training "Speak Up" for all colleagues employed by the organisation, "Listen Up" for all leaders and Fairness Champions and "Follow Up" for all senior management. Mobile App developments are under consideration to improve access remotely for colleagues to Speak Up as well as to support with data collection which is reported quarterly to the NGO.

What are the results?

Currently, the Freedom to Speak Up Team includes:

- 1 x Freedom to Speak Up Guardian
- 1 x Freedom to Speak Up Associate Guardian
- 42 x Fairness Champions across the organisation.

Since October 2022 there have been 16 formal contacts made and recorded with the FTSU Guardian. Out of these 16, they are broken down by the following staff groups:

- Medical: 1 contact
- Registered Nurses, Midwives and AHPs: 11 contacts
- Administration, Clerical, Maintenance and Ancillary: 3 contacts
- Non-registered clinical support staff: 1 contact

Themes are analysed and reported to the National Guardian Office quarterly.

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 all colleagues, 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 colleagues 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. We must continue to train colleagues to be positive and compassionate leaders and effective members of teams, where they can reinforce a culture of honesty, authenticity and safe conflict. We continue 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.

Guardian of Safe Working

What is a Guardian of Safe Working Hours (GSW)?

The safety of patients is a paramount concern for the NHS. Significant staff fatigue is a hazard both to patients and to the staff themselves. The safeguards around working hours of doctors and dentists in training are outlined in the terms and conditions of service (TCS) and are designed to ensure that this risk is effectively mitigated and that this mitigation is assured.

The guardian is a senior person, independent of the management structure within the organisation, for whom the doctor in training is working and/or the organisation by whom the doctor in training is employed. The guardian is responsible for protecting the safeguards outlined in the 2016 TCS for doctors and dentists in training. The guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and /or employer, as appropriate; and will provide assurance to the trust board or equivalent body that doctors' working hours are safe.

What has 2022-2023 looked like for the Guardian of Safe Working Hours at HDFT?

At Harrogate, as for the wider NHS, safe, patient focused care is at the centre of everything we strive to achieve. Sadly staff fatigue is a hazard to patients and the staff themselves. The Junior Doctors Contract introduced in 2016; enshrined safeguards around doctors' working hours to ensure that this risk is effectively mitigated.

As a part of the new contract, the trust has appointed Dr Matthew Milsom, Director of Undergraduate Education, as Guardian of Safe working, a role independent of the management structure of the trust with these primary responsibilities:

1) To act as the champion of safe working hours for doctors in approved training programmes within the Trust.
2) Provide assurance to doctors and employers that doctors are safely rostered and enabled to work hours that are safe and in compliance with Schedules 3, 4 and 5 of the new terms and conditions of service.

As Guardian of Safe Working Hours Dr Milsom monitors exception reports from junior doctors of breaches in agreed work schedules, whether this is working over hours, covering more than one bleep, or missing educational opportunities. These exception reports serve as a barometer of junior doctor sentiment towards working conditions and provide valuable information enabling me to look for repeating patterns and solutions.

Dr Milsom is able to liaise with supervisors to agree time off in lieu or additional payment for the extra time worked. He can levy fines against the Trust if there are major breaches and is tasked with using these funds to improve conditions for the junior doctors. Dr Milsom works with HR, medical education, and with doctors in training through a Junior Doctors Forum, used to highlight any concerns.

Dr Milsom states "*I see the role as much more than a statutory safeguard, and rather as one part of the jigsaw of patient safety that links quality of training for doctors with the safety and well-being of our patients*".

As Guardian, Dr Milsom provides the Board of Directors with a Guardian of Safe Working Report each quarter. Its purpose is to convey the state of safe working of doctors in training ('junior doctors') and ensure that any issues of compliance with hours or rota patterns are addressed by the doctor and the trust as appropriate. All rota patterns, in all specialties at Harrogate are compliant. Dr Milsom is also a member of the HDFT People and Culture Sub-Committee of the Board.

The 2022-2023 year has seen an increase in the number of exception reports submitted, predominantly around workload pressures and the need to work beyond scheduled hours to maintain safe patient care.

Ten fines for significant breaches of contract have been issued in 2022-2023. Following each fine, a focused investigation and analysis is conducted by the Guardian of Safe Working and the directorate leadership to understand what happened and more importantly what learning can be taken from the event to prevent further breaches from occurring. Recognition of excessive workload within medicine led to the recruitment of 6 fellows to bolster the workforce. This is a fantastically positive outcome and highlights the importance of the exception reporting process and the beneficial actions they can lead to.

Statements of Assurance from the Board

This section of the Quality Account provides an update on:

- A Review of Services
- Participation in Clinical Audits
- Participation in Clinical Research
- Goals agreed with our Commissioners
- What others say about the Trust: CQC
- Secondary Uses Service
- Information Governance
- Payment by Results Clinical Coding Audit
- Learning from Deaths Update
- Reporting Against Core Indicators

Review of Services

During 2022/23 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 2022/23 represents 99% of the total income generated from the provision of relevant health services by HDFT for 2022/23.

Clinical Audit

What is Clinical Audit?

A clinical audit is a way to find out if healthcare is being provided in line with standards. This informs care providers and patients where services are doing well and where improvements could be made. The aim is to allow quality improvement to take place where it will be most effective and improve outcomes for patients. Clinical audits can look at care both nationwide via national audits; and locally where healthcare is provided via local audits.

What has 2022-2023 looked like for Clinical Audit at HDFT?

National Audits

During 2022/23, 39 national clinical audits and 2 national confidential enquiries and clinical outcome review programmes (6 individual topics) covered relevant health services that HDFT provides.

During that period, HDFT participated in 97% of national clinical audit programmes and 100% of national confidential enquiries which were open and it was eligible to participate in.

To provide further context, there were 42 mandatory audit programmes on the National Clinical Audit and Patient Outcome Programme (NCAPOP), 36 of which were relevant to HDFT. The trust participated in all 36 (100 %) of the open NCAPOP programmes which it was eligible to participate in.

There were also 30 non-NCAPOP audits listed, 18 of which were relevant to HDFT: The trust participated in 15 (83%) of open non-NCAPOP programmes which it was eligible to do so.

The national clinical audits and national confidential enquiries that HDFT participated in, and for which data collection was completed during 2022/23 are listed in the Annex, 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 30 of the national clinical audits and studies and 2 NCEPOD reports were reviewed by HDFT during 2022/23. This included national audits for which data was collected in earlier years with the resultant report being published in 2022/23. In response to the findings, quality improvement actions have been identified, monitored and completed to improve the safety and quality of healthcare provide by HDFT.

Local Audits

During 2022-2023 a joint audit programme between the Clinical Effectiveness Department and Internal Audit was in place. As per previous years, this focused on the high priority areas for HDFT 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 2023-2024.

The reports of 40 local projects (clinical audits, service evaluations and patient surveys) were completed and reviewed by relevant audit or governance groups at HDFT during 2022-2023 and HDFT intends to take the relevant actions to improve the quality of healthcare provided.

Examples of Quality Improvement as a result of local clinical effectiveness projects

Local Audit 1: It's all in the timing – a service evaluation

In 2019 there were up to 5 different clocks or pieces of medical equipment displaying time in anaesthetics rooms, operating theatres and the recovery room in Harrogate District Hospital. Staff noticed that most were telling different times and almost none were accurate. The aim of this project was to ensure that we avoided any possible issues that could affect patient or staff safety due to faulty time-keeping.

Locating the Problem

An initial audit was carried out to check and compare against GMT all clocks and time displaying equipment in each of the five anaesthetic rooms and theatres, the recovery area and the storage room. This clearly demonstrated inaccuracy and inconsistency in the time displayed.

Understanding the Impact

A survey was carried out to assess if staff felt there had been situations where the display of inaccurate time had caused any problems or had affected them or their patients. 49 members of staff responded: 50% said they had been in a situation where this had almost caused a problem; 10% felt it had caused delays in list flow; 8% felt patient safety had been affected; 16% felt it affected staff in terms of breaks and wellbeing. 50% said they used their own phone or watch as they did not trust the clocks. Comments from staff included that incorrect times were documented in patient records, there was confusion over how long procedures had actually taken, one staff member considered a change of surgical technique and there was agitation among staff as they felt it was later than it actually was. The survey showed there was a negative impact on staff wellbeing and potentially patient safety in time-critical procedures as a result of inaccurate time-keeping.

What next…

A clear plan for improvement was developed:

- All unnecessary clocks were removed
- Each of the existing clocks were corrected and the Department Equipment Officer regularly checked for possible errors
- Staff were advised always to check the time on the main computer which was wired to the network and is self-maintained.

In the longer term, it was recommended the Department Equipment Officer should work with supplies to ensure network powered digital wall clocks are installed in all main theatres, DSU and the labour ward

Re-audit

Following the improvements recommended in the initial audit, a re-audit was completed and these results showed:

- 93% of the clocks audited were showing the correct time (all but one are network powered digital clocks)
- I clock (7%) was analogue and was 3 minutes late
- 3 anaesthetic rooms did not have a wall mounted clock

Further actions are planned to replace the remaining two analogue clocks and to install more network powered clocks in the three anaesthetics rooms that do not yet have them.

Local Audit 2: Audit on patient records for IV sedation against standards of the commissioning guidance in conscious sedation

The 2017 Guidance 'Commissioning Dental Services: Service Standards for conscious sedation in a primary care setting' clarifies guidance issued by the Royal College of Surgeons. It is to support commissioners with the implementation and monitoring of contemporaneous standards in conscious sedation practice and outline NHS England commissioning intentions.

Locating the Problem

An initial audit was carried out in April 2020 to ensure HDFT Community Dental Service was meeting standards in safety and excellent patient care whilst undergoing IV sedation.

The audit looked at patient assessment, information and consent, sedation delivery and patient recovery and discharge. In total there 29 criteria against which the service was measured.

Understanding the Impact

In 58% of those criteria, the service achieved 80% or above compliance, with 17% achieving 100% compliance. Compliance of less than 80% occurred in 13 areas, of which 24% was less than 50%.

What next…

The results were presented and discussed at a peer review meeting and, whilst the service was either meeting or close to meeting the 100% target in many areas, other criteria were likely being met, but were not being correctly recorded. A number of recommendations for improvement were identified and an action plan was developed.

Specific changes highlighted included redesigning the paperwork to ensure criteria were correctly recorded; ensuring the same paperwork was used across all sedation clinics; ensuring notes were computerised/scanned on to the SOEL dental software system prior to being sent to archive and educating staff on the importance of correct documentation. The results and action plan were discussed with dentists who perform IV sedation at the Peer Review audit meeting.

Re-audit

A re-audit took place in April 2022 which demonstrated significant improvement in record keeping compliance with the commissioning guidance and local standards.

Clinical Research

What is Clinical Research?

Clinical research is an arm of medical science that establishes the safety and effectiveness of Medication, Diagnostics products, Medical devices and Treatment regimes' which may be used for prevention, treatment, diagnosis or relieving symptoms of a disease.

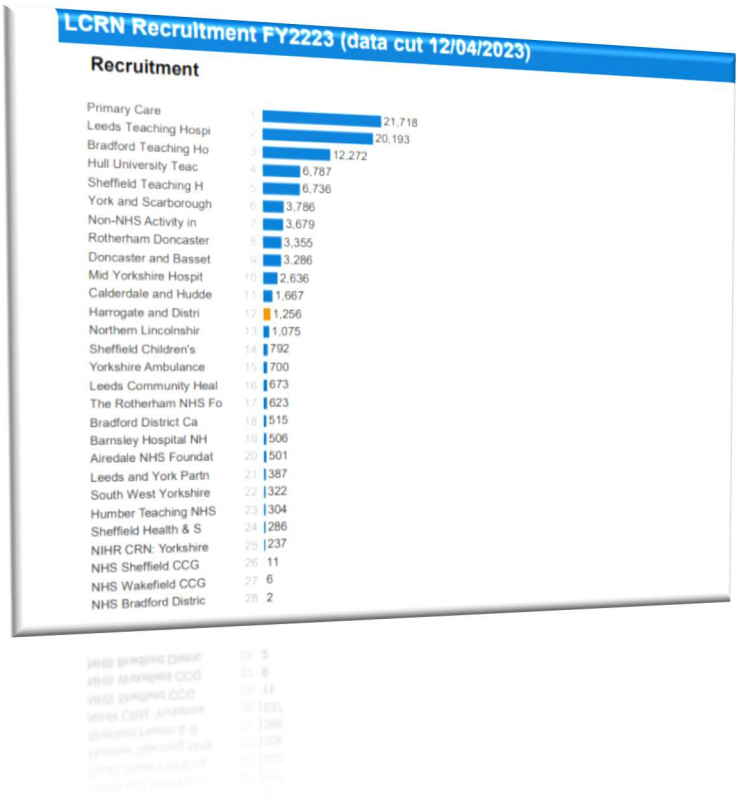
What has 2022-2023 looked like for Clinical Research at HDFT?

This section highlights our research activity across HDFT, providing information on our performance, the safety and quality assurance processes in place and some of the wider projects the department is aiming to achieve.

It is well recognised that NHS organisations partaking in research deliver better care and outcomes for their patients and access to research attracts and retains highly qualified and competent staff. HDFT is fully committed to making sure that everyone has the chance to take part in research and continues to drive a culture where an offer to participate in research is considered part of everyday standard care.

Between April 2022 and March 2023, the Trust had **95 clinical trials** or studies open or in follow up across **21 clinical and non-clinical areas** inviting suitable participants to take part. This included 5 commercial studies and 90 non-commercial trials with 2% of patients involved in commercial trials and 98% in non-commercial trials. **41** clinicians supported by **31** research delivery and administrative staff led these studies.

The number of patients receiving relevant health services by HDFT in 2022-2023, who were recruited to participate into high quality National Institute for Health and Care Research (NIHR) portfolio research studies was 1238. HDFT recruited the highest number of patients to a national trial known as SAFA . This trial repurposed the drug spironolactone for the treatment of adult acne and the results will inform NICE guidelines . Utilising spironolactone as a treatment for acne will reduce the prescribing of antibiotics for this condition.



HDFT is an active member of the Yorkshire and Humber Clinical Research Network and contributed to the overall recruitment for the regional network as the 12th most active trust of the partner organisations. Compared with 27 other trusts and health organisations in the Yorkshire and Humber region (See graph)

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. The research department has reviewed its systems for quality assurance during 2021-2022 and an internal audit was conducted. Suggested areas for improvement included additional storage space for archived research materials and additional dedicated space to deliver and grow research. Both these aspects have been addressed in 2022-2023.

All research staff continue to achieve competence in research through experience, competency framework standards, Good Clinical Practice (GCP) courses and a doctor's induction and nurse preceptorship programme. The Research and Innovation Manager and Research Matron surveyed all nurses and AHPs in 2022 to establish the training needs of these professional groups in relation to research. They are currently looking at how the department can support a trust wide approach of continuous learning and is hoping to introduce a research internship programme in 2023-2024 for nurses and AHPs . In her capacity as Research Matron she continues to participate in a national group project to look at a how research can be better represented and included in the matrons handbook.

Patient and Public Involvement

The National Institute for Health Research (NIHR) sets targets for HDFT to complete a number of surveys of research participants. This year the Trust actively engaged with the Participant In Research Experience Survey (PRES) and not only exceeded the set target but demonstrated a high level of patient satisfaction with trust research services.

HDFT research has a dedicated presence on social media platforms such as Facebook and Twitter to ensure research continues to be connected to patients across our communities. The community of users (HDFT and public) is growing and the use of 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.

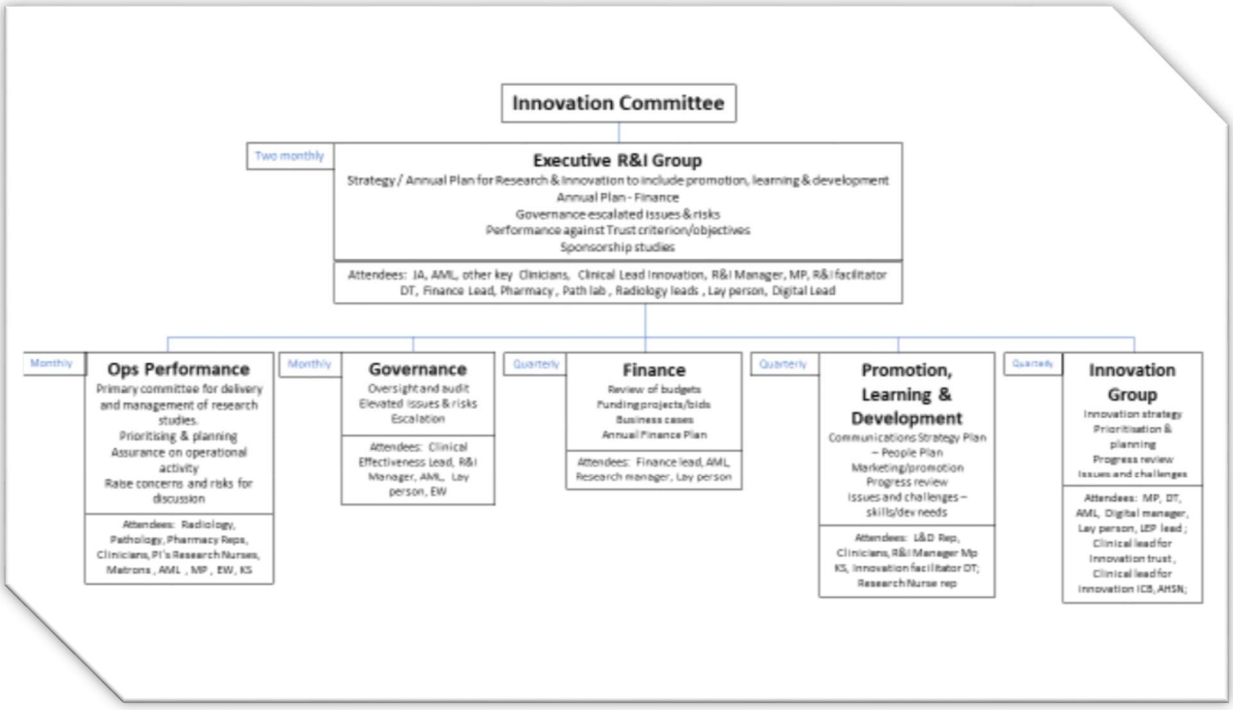
Research Performance and Safety

All research studies undertaken at the Trust are performance managed against set targets. These performance metrics are regularly presented to our main funder, the Yorkshire and Humber Clinical Research Network (YHCRN).

The Research and Innovation (R&I) Group chaired by the Executive Medical Director, review safety monitoring and financial performance. 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. The group embraces a multidisciplinary team and includes several lay representatives to ensure independent and diverse views are reflected in reviews of performance.

The newly formed Sub-Committee of the Trust Board, the Innovation Committee has been implemented and new governance structures enacted ensuring robust reporting. Issues can be escalated and reported from this Committee the Trust Board. (See diagram). The R&I team also engage with the clinical

effectiveness forum to support safety and governance issues for research and looks at emerging issues across all three quality assurance areas.



Our research aims to feed into and align with the Department of Health and Social Care themes, such as greater community based service research, collaboration with social care partners and co-morbidity self-directed care programmes.

The research teams at HDFT have forged and continue with successful working relationships with our primary care providers (GPs, GP confederations, Clinical Commissioning Groups, Integrated Care Boards and third parties), to increase the opportunities for communities to be involved in health research and to grow research in our community and forge more partnership and collaborations with our social care and public health providers. Funding secured from the Y&H CRN allowed for the appointment of new staff which has led to a number of novel initiatives. As a consequence, allied health professionals working in the trust have become more involved in leading research and we are able to offer more research to potential participants accessing our 0-19 service, care homes, schools, community dentists and other social care settings. For example we have successfully opened and run a community dentistry study this year looking at whether patients would accept weight management and dietary advice from dentists and a podiatry study testing the effectiveness of Orthotics and exercise for the treatment of Symptomatic Flat Feet in Children. One of our community physiotherapy practitioners has also been supported and sponsored by the trust to open his own study looking at patient perceptions and outcomes of utilising community physios on site in GP practices.

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, immunology and infection, health sciences, health visitor, podiatry, and evidence-based studies), University of Sheffield (dermatology and diabetes), University of Southampton and Drug Safety Research Unit and University of Newcastle (0-19 services). A newly developed Skin Research Centre in

York has provided significant opportunity to align with research strengths within the University of York including opportunities for Science Discovery, Mental health and skin cancer.

HDFT is an active member of the YHCRN, Yorkshire and Humber Academic Health Sciences Network. 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 executive have supported opportunities to engage with innovation and have committed to developing an Innovation HUB led by the R&I team in Harrogate on behalf of the region. Accommodation for the HUB has been secured and an Innovation facilitator has been appointed and a Clinical Lead for innovation is about to be appointed. These positions will support Harrogate becoming a lead trust for innovation in healthcare and a test bed for novel approaches.

Summary

In summary, HDFT research department has managed to offer a wide range of research to patients in many clinical areas in a safe and effective manner. The department has re-established itself as an important part of the care pathway within the trust and provided many benefits to patients and staff. The department this year has implemented robust key quality and safety assurance measures to continue research safety. Newly established staff training and development programmes ensure anyone working in the trust involved in research will understand, comply with, and lead research effectively.

The department has ambitions to grow more commercial research and to drive the innovation agenda over the next year towards supporting a process of self-funding through the development of further commercial research and collaborations with local providers. The research strategy aligns with the novel trust clinical strategy. These ambitions will increase opportunities for participation in research and provide additional access to novel treatments whilst also expanding opportunities for staff within the trust to engage in research.

Goals Agreed with Commissioners (CQUINS)

What is CQUIN?

The Commissioning for Quality and Innovation (CQUIN) framework is about improving the quality of healthcare. Commissioners reward excellence by linking a proportion of income to the achievement of locally set and agreed improvement goals. These goals are embedded into contracts and are essential for the implementation of National Institute for Health and Care Excellence (NICE) Quality Standards, resulting in improved patient care, experience and improvements against outcomes.

What will CQUINS look like in 2023-2024 at HDFT?

NHS England have identified a small number of clinical priority areas, where improvement is expected across 2023-2024. Many of these are short-term clinical improvements that have been selected due to their ongoing importance in the context of COVID-19 recovery. The selected priorities are:

CQUIN01: Staff flu vaccinations	
Applicability: Acute, Specialised Acute, Community, Mental Health, Specialised Mental Health, Ambulance **CQUIN goal:** 75% to 80% **Supporting ref**: NICE NG1031	Staff flu vaccinations are critical in reducing the spread of flu during winter months; protecting those in clinical risk groups and reducing the risk of contracting both flu and COVID-19 at the same time and the associated worse outcomes, and reducing staff absence and the risk for the overall safe running of NHS services. The proportion of patient-facing NHS staff accessing seasonal flu vaccinations declined dramatically in the 2021/22 flu season and it is important that we do all we can to reverse this to protect staff and patients. Section 1.7 of NICE guideline NG103 makes recommendations for increasing the uptake of vaccination amongst healthcare staff. The green book is clear that this should include non-clinical staff who have contact with patients.
Rationale for HDFT National and local reduction in uptake in 2022-2023 - additional support to recover levels to 2021-2022 and beyond being worked up	

CQUIN03: Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria	
Applicability: Acute CQUIN goal: 60% to 40% (NB lower % = more compliant) Supporting ref: NICE NG153	There are significant benefits to IVOS interventions demonstrated in research literature including: increasing hospital bed capacity to support recovery from the COVID-19 pandemic; reducing exposure to broadspectrum antibiotics; increasing nursing workforce capacity; reducing drug expenditure; reducing carbon footprint of medicines; and reducing healthcare-associated bloodstream infections. This CQUIN aligns with a commitment in NHS England's 2022-23 Priorities and Operational Planning Guidance to support reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary.
Rationale for HDFT Identified as a potential CIP and quality improvement programme by our IPCC	

CQUIN04: Compliance with timed diagnostic pathways for cancer services	
Applicability: Acute CQUIN goal: 35% to 55% Supporting ref: Rapid cancer diagnostic and assessment pathways4	Faster diagnosis is proven to improve clinical outcomes: patients are more likely to receive successful treatment when diagnosed earlier. This indicator sets out key elements of the timed pathways for colorectal, lung, oesophago-gastric, prostate, head & neck and gynaecological cancers, which have been identified by a clinical expert group as crucial to achieving faster diagnosis targets. There is currently a lack of focus on the pathways. In many cases the required diagnostic tests and actions are happening, but not within the required timeframes and in some cases possibly not in the right order, making achievement of faster diagnosis standards less likely.
Rationale for HDFT Slippage in performance due to pandemic - new community diagnostic centres and other pathway changes being brought on line	

CQUIN05: Identification and response to frailty in emergency departments	
Applicability: Acute CQUIN goal: 10% to 30% Supporting ref: SDEC guide to frailty5	There are well-evidenced links between frailty and adverse health outcomes including deconditioning, malnutrition and irreversible cognitive decline which may all lead to increased health and care requirements. Early identification of frailty can mitigate some of these risks. Under the NHS Long Term Plan, every acute hospital with a Type 1 Emergency Department (ED) was asked to provide acute frailty services for at least 70 hours a week. Patients with grades of frailty CFS 6 or above should be assessed for frailty associated syndromes via a comprehensive geriatric assessment and/or be referred to the acute frailty service.
Rationale for HDFT Due to HDFT district demographic this is a priority focus for us- new acute frailty unit recently opened	

CQUIN12: Assessment and documentation of pressure ulcer risk	
Applicability: Acute; Community hospital inpatients CQUIN goal: 70% to 85% Supporting ref: NICE CG17916 NICE QS8917	NICE clinical guideline CG179 sets out clear best practice for assessing the risk of pressure ulcer development and acting upon any risks identified. It is fully aligned with the recently republished NPIAP (National pressure injury advisory panel) international clinical practice guidelines. This indicator has been expanded for 2022/23 to include inpatients in acute settings as well as community hospitals. This is expected to contribute to reducing the number of pressure ulcers nationally, improving standards of care for patients in both settings.
Rationale for HDFT Ongoing HDFT local Quality Priority	

What Others Say About the Trust: CQC

What is the CQC?

The Care Quality Commission (CQC) regulates and inspects health and social care services in England. They check that services meet the Health and Social Care Act 2008 ('the Act') and the CQC Fundamental Standards. If they feel that an organisation provides good, safe care the CQC registers it without conditions. The CQC provides assurance to the public and commissioners about the quality of care through a continuous monitoring of a Trust's performance across a whole range of core services.

What did the CQC note in 2022-2023 for HDFT?

HDFT is required to register with the Care Quality Commission and our current registration status is: "***Registered without Conditions***".

The Care Quality Commission has not taken enforcement action against HDFT during 2022-2023.

HDFT have not received a full inspection of services since 2016 – 2018, however in 2022-2023 our Maternity Services were inspected in the Safe (Requires Improvement) and Well-Led (Good) Domains.

HDFT have not taken part in any special reviews or investigations during 2022-2023.

The current overall ratings for HDFT are **GOOD**.

Secondary Service Users

What is a Secondary Users Service?

The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

What has Secondary Users Service looked like in 2022-2023 for HDFT?

The Trust submitted records during 2022/23 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:
Which included the patient's valid NHS number was:

- **99.9%** for admitted patient care;
- **100.0%** for outpatient care;
- **99.3%** for emergency care.

Which included the patient's valid General Practitioner Registration Code was:

- **100.0%** for admitted patient care;
- **100.0%** for outpatient care;
- **100.0%** for emergency care.

Information Governance

What is Information Governance?

The legal framework governing the use of personal confidential data in a health care setting is complex and includes the NHS Act 2006, the Health and Social Care Act 2012, the Data Protection Act 2018, and the Human Rights Act. The law allows personal data to be shared between those offering cares directly to patients, but it protects patients' confidentiality when data about them are used for other purposes.

What has Information Governance looked like in 2022-2023 for HDFT?

The Data Security and Protection Toolkit (DPST) is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 Data Security Standards.

The assessment year runs from 1st July 2021 to the 30th June 2022. The levels of assurance are:

- Standards Met
- Standards Exceeded

The results of this years submission was: **Standards Met**

During the year Internal Audit audited 13 of the 33 mandatory standards. The levels of assurance were:

- Unsatisfactory
- Limited
- Moderate
- Substantial

The overall assurance level across all 10 NDG Standards was rated as **Substantial,** this was an improvement from the previous year where the level of assurance was Moderate.

Payment by Results Clinical Coding Audit

What is Clinical Coding?

Clinical coding is the process whereby information from medical records for each patient is expressed as a code. This may include the operation, treatment provided, a diagnosis, any complications and comorbidities. These codes are processed to result in one of a number of possible health resource group codes, each of which has a specific payment tariff that the hospital then receives.

What has Clinical Coding looked like in 2022-2023 for HDFT?

The Trust was subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

The Trust commissioned an external Payment by Results clinical coding audit by D&A Consultancy during 2022-2023 and the accuracy rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnosis = **97%**
- Secondary Diagnosis = **93%**
- Primary Procedure = **95%**
- Secondary Procedure = **94%**

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

The Trust will be taking the following actions to improve data quality:

- Continue to engage with clinical colleagues to ensure high-quality coded clinical data which is reliable, fit for purpose and effective for statistical analysis.
- Continue to deliver a programme of clinical coding standards and standards refresher training for all staff involved in the clinical coding process, and provide an assessment framework which supports coders to gain Accredited Clinical Coder (ACC) status by passing the National Clinical Coding Qualification (UK).

Learning from Deaths

What is Learning from Deaths?

CQC published its report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England in December 2016, making recommendations about how the approach to learning from deaths could be standardised across the NHS. The Secretary of State accepted all these recommendations and a framework was developed for the NHS on identifying, reporting, investigating and learning from deaths in care.

What has Learning from Deaths looked like in 2022-2023 for HDFT?

During 2022- 2023, **837** of the Trust inpatients died compared to **715** in 2021 - 2022. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- **191** in the first quarter;
- **179** in the second quarter;
- **225** in the third quarter;
- **242** in the fourth quarter.

By 01/04/2023, 75 case record reviews had been carried out in relation to these deaths.

The number of deaths in each quarter for which a case record review was carried out was:

- **19** in the first quarter;
- **18** in the second quarter;
- **17** in the third quarter;
- **21** in the fourth quarter.

4 cases out of the 75 were assessed to have received suboptimal care. Learning was identified and shared where appropriate.

These cases were analysed using the Structured Judgement Review (SJR) tool, as described in the National Mortality Case Record Review Programme by the Royal College of Physicians.

In 2022 - 2023, no cases were identified by the SJR tool that required formal investigation, providing assurance that incident reporting and the Medical Examiner scrutiny both provide early identification of cases warranting such inquiry. (The case triggering a Serious Incident investigation had been highlighted prior to the SJR).

Cases chosen for SJR during this year were selected from the following groups:

- Highlighted by the Medical Examiner as possible poor care
- The patient had a learning disability or autism
- The cause of death was linked to aspiration pneumonia
- Patient who were admitted with injuries to scalp or limbs (indicating they had a fall at home)
- The cause of death was due to a stroke
- Deaths where modelling suggested the chance of death was low

Summary of learning points identified

These case reviews have highlighted that in the majority of cases, the standard of clinical care delivered is of good or excellent quality, with frequent consultant reviews of the majority of our inpatients. Areas for improvement include note-keeping and early senior input in complex cases.

Actions taken

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

- Cases with deficiencies in care have been discussed in detail at departmental Quality of Care meetings
- We have trained more staff to perform SJRs so that a higher number of cases can be scrutinised
- We have purchased a new IT system which will enable better analysis of trends in care quality
- We have continued to emphasise the need for senior involvement in complex or difficult cases
- We have set up a new governance group to coordinate between Palliative Care, the Medical Examiner, bereavement care and organ and tissue donation teams.
- Cases are presented at the Mortality Review Group which is a virtual meeting open to all trust employees.

The impact has been:

- A greater number of cases are now being examined by the SJR processes
- We have the ability to triangulate SJR findings with other sources such as complaints, incident reports and claims

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.

Reporting Against Core Indicators: NHS Digital

What is NHS Digital?

NHS digital support NHS staff at work through design, developing and operating the national Information Technology (IT) and data services that support clinicians and NHS staff at work, help patients get the best care, and use data to improve health and care.

What have the Core Indicators like in 2022-2023 for HDFT?

Since 2012/13 HDFT has been required to report on performance against a core set of indicators using data made available by NHS Digital. The core set of indicators are prescribed in the NHS Outcomes Framework (NHS OF) developed by the Department of Health and Social Care to monitor the health outcomes of adults and children in England. The framework provides an overview of how NHS Trusts are performing and uses comparative data against the national average and other NHS organisations with the lowest and highest scores.

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

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

SHMI (Summary Hospital Level Mortality Indicator)

	Data period	
	Dec 20 - Nov 21	**Dec 21 - Nov 22**
HDFT value	1.037	1.013
HDFT banding	2 (as expected)	2 (as expected)
National average	1.000	1.000
Highest value for any acute Trust	1.195	1.222
Lowest value for any acute Trust	0.716	0.717

Jan 22 to Dec 22 data due to be published 11/05/23

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

Data source:
https://digital.nhs.uk/data-and-information/publications/ci-hub/summary-hospital-level-mortality-indicator-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 accepted 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.

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

	Data period	
	Dec 20 - Nov 21	**Dec 21 - Nov 22**
HDFT value	39	39
National average	39	40
Highest value for any acute Trust	64	66
Lowest value for any acute Trust	11	13

Note - highest and lowest trust scores include all providers with data published by NHS England
Note - figures now only published to 0 decimal places
Data source:
https://digital.nhs.uk/data-and-information/publications/ci-hub/summary-hospital-level-mortality-indicator-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 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:

- Continued PCT attendance at multi-disciplinary team (MDT) meetings

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

PROMs – Patient Reported Outcome Measures

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

Data for PROMS has not be collected or submitted at a national level since 2020-2021.

Emergency readmissions within 30 days

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

	2020/21	2021/22	2022/23
Total number of emergency readmissions within 30 days	3328	4218	4243
As a percentage of all emergency admissions	16.98%	18.76%	18.34%
Number of emergency readmissions within 30 days (Payment by Results exclusions applied)	2445	2861	2887
As a percentage of all emergency admissions	12.48%	12.72%	12.48%

Data source – local data collection

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

- Data presented is locally derived non-standardised readmission rates as the standardised readmission rates are no longer published by NHS England.
- Data is recorded onto the Trust's main patient administrative system (PCS) and collected via reliable information technology (IT) systems.

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.

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.

Inpatient survey - responsiveness to inpatients' personal needs

	Data period			
	2018/19	**2019/20**	**2020/21**	**2021-2022**
HDFT value	71.4	68.7	77.1	-
National average	67.2	67.1	74.5	-
Highest value for any acute Trust	85	84.2	85.4	-
Lowest value for any acute Trust	58.9	59.5	67.3	-

Results for 2021-2022 and for 2022-2023 are yet to be published nationally

Data source:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4.2-responsiveness-to-inpatients-personal-needs

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

Venous thromboembolism (VTE) risk assessment

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

VTE (venous thromboembolism) risk assessment - % eligible admitted patients risk assessed for VTE

	Data period							
	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23
HDFT value	96.62	96.27	96.73	96.04	96.02	95.80	95.49	93.91
National average	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Highest value for any acute Trust	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Lowest value for any acute Trust	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Data source – local data collection

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 (PCS) 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 PCS.

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		
	2019/20	2020/21	2021/22
HDFT value	22.84	25.73	26.74
National average	13.60	15.39	16.24
Highest value for any acute Trust	51.01	80.65	53.62
Lowest value for any acute Trust	0.00	0.00	0.00

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

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

- We actively encourage the testing for *C.difficile* in all patients with loose stool unless they is a very clear clinical reason not to sample (an example of this would be not sampling a patient who has been given an enema or laxative for the management of acute constipation).
- We continue to conduct twice-weekly antimicrobial stewardship rounds in particular to detect and restrict prescribing of high risk antibiotics.
- Post infection reviews are conducted for all healthcare acquired cases of *C.difficile* in order to determine lapses in care and extract learning which can be used to prevent future cases.

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;
- Continue to undertake post infection review's and effectively communicate the lessons learnt from these investigations with all Trust Directorates.

Patient safety incidents

The data looks at two measures related to patient safety incidents reported to the National Reporting and Learning System (NRLS) compared to all acute non-specialist trusts:

- The rate of incidents reported per 1,000 bed days. A 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 those 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:

	2020/21		
	Rate of incidents reported (per 1,000 bed days)	**Incidents that resulted in severe harm or death**	
		Number	**Rate (per 1,000 bed days)**
HDFT value	100.70	34	0.460
National position (all acute trusts)	57.33	6828	0.252
Highest value for any acute Trust	118.74	261	1.083
Lowest value for any acute Trust	27.18	4	0.033

	2021/22		
	Rate of incidents reported (per 1,000 bed days)	Incidents that resulted in severe harm or death	
		Number	Rate (per 1,000 bed days)
HDFT value	95.20	32	0.329
National position (all acute trusts)	54.88	7116	0.221
Highest value for any acute Trust	205.52	216	0.846
Lowest value for any acute Trust	23.67	3	0.016

Data source:

NHS England » Organisation patient safety incident reports

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

- The data relating to patient safety incidents is reported by front line staff;
- There is a robust policy and process within the Trust to ensure that all incidents are identified, managed, reported and investigated in accordance with national guidance;
- The Trust ensures that there are appropriate measures in place to prevent recurrence and also promotes organisational learning;
- 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;
- Commencing development of a continuous learning and improvement programme whereby output from events and complaints is disseminated to targeted staff groups in a manner which maximises learning;
- 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;
- Undertaking a restructure of the Trust's quality governance framework including development of a Patient Safety Forum supporting implementation of the National Patient Safety Strategy, which aims to continuously improve patient safety.
- Purchasing Datix IQ which will be implemented and rolled out across the Trust over the next financial year to assist in the robust reporting and monitoring of incidents.

Performance against indicators in the Single Oversight Framework

The following table demonstrates HDFT's performance against the national standards included in the Operational Performance Metrics section of NHS Improvement's Single Oversight Framework for each quarter in 2022/23

April 2022 – March 2023

Performance Indicator Description	Q1	Q2	Q3	Q4	YTD
RTT - incomplete - % in 18 weeks	68.2%	64.6%	61.9%	63.2%	63.2%
Diagnostic waiting times - maximum wait of 6 weeks	68.7%	50.4%	62.7%	60.8%	60.8%
Trust total - Total time in A&E - % within 4 hours	68.7%	67.2%	65.8%	78.7%	70.1%
All Cancers: 14 Days Target	83.2%	54.6%	58.7%	63.0%	64.4%
All Cancers: 14 Days Target All Breast Referrals	85.6%	24.0%	8.4%	25.3%	35.3%
All Cancers: 31 Day Target - 1st Treatment	97.6%	98.0%	99.3%	99.6%	98.6%
All Cancers: 31 Day Target - Subsequent Treatment - Surgery	95.6%	96.0%	91.8%	100.0%	95.9%
All Cancers: 31 Day Target - Subsequent Treatment - Drug treatment	100.0%	99.2%	99.2%	99.1%	99.4%
All Cancers: 62 Day Target	82.0%	76.8%	80.3%	79.8%	79.8%
All Cancers: 62 Day Target Screening	58.3%	47.7%	44.4%	50.0%	51.2%
All Cancers: 62 Day Target Cons Upgrade	86.6%	83.2%	85.9%	69.6%	83.1%
Incidence of hospital acquired C-Difficile (Cumulative)	11	16	21	23	23
Incidence of hospital acquired C-Difficile (Cumulative cases due to a lapse in care)	0	0	2	2	2

Key performance to note:

- Overall in 2022/23, 63.2% of patients were waiting less than 18 weeks for consultant led treatment. The overall RTT waiting list increased in March to 25,500. The increase was largely due to operational pressures within the Trust, including the number of Covid inpatients during the month and the first wave of industrial action, impacting our ability to deliver elective activity. However the focus on clearing the 78+ week waiters continues with the number of 78+ week waiters and the number of 52+ week waits both reducing throughout the year. The Trust has reported zero 104+ week waits since July 2022;
- The Trust did not achieve the diagnostic waiting times standard in 2022/23 with on average, 61% of patients being seen within 6 weeks. Whilst the standard is not being achieved, mainly driven by a Covid-19 driven DEXA waiting list, progress in reducing long waiting patients has been made across all diagnostic modalities;
- Performance against the A&E 4-hour standard remains below the 95% standard but has seen a sustained significant improvement during Quarter 4 2022/23. Performance reflects the continuing significant pressures with high bed occupancy relating to discharge challenges and staff absenses, coupled with the current building works which is impacting ED capacity;
- There were 290 ambulance handover delays of over 60 minutes reported in 2022/23 (45 in the previous year) and 465 handover delays of over 30 minutes (212 in the previous year). Prevention of ambulance handover delays continues to be a focus with the Trust operational processes being

shared across the region by NHS England. Despite the high bed occupancy, acuity and activity, the lost hours to handover in Harrogate remains very low and in the top quartile nationally;

- 3 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, the 62 day treatment standard and the 62 day screening standard;
- The Trust reported 23 cases of hospital acquired C. difficile in 2022/23, compared to 36 in 2021/22. Root cause analysis has been completed on all cases and indicated that 21 of these were not due to lapses in care. 2 cases were deemed to be due to lapses in care. 2 cases of hospital acquired MRSA (methicillin-resistant staphylococcus aureus) were reported in 2022/23.

PART 3: Plans for the Future and Priorities for Improvement

This section of the Quality Account provides an update on:

- Consultation
- 2023-2024 Priorities
  - Best Quality, Safest Care: Ever safer care through continuous learning
  - Best Quality, Safest Care: Excellent outcomes through effective, best practice care
  - Best Quality, Safest Care: A positive experience for every patient by listening and acting on feedback
- Our plans for the Patient Safety Incident Response Framework (PSIRF)

Plans for the Future - Consultation

Our Commitment

At HDFT we are committed to ensure we focus on the areas of quality and safety that will make a real difference to the people we serve. Whilst improvement projects can sometimes make a big impact over a short period of time, we have committed to a three year development programme across our key quality priorities. 2023-2024 sees us enter our second year of this ambitious programme.

As such following consultation with colleagues across the Trust, the region and nationally as well as with our governors and a wide range of individuals and stakeholders who took part in the development of our Trust Strategy. We can confirm that our Quality Priorities will continue to focus on:

- Theatres Safety
- Inpatient Falls
- Pressure Ulcers
- Missed Results
- Medication Errors
- Patient Experience

This does not mean that we did not make the steps forward and progress we wished in 2022-2023, it means that we have achieved our goals across the majority of the priorities and we will now implement further step changes over the next 12 months to take these improvement projects to the next level.

SAFE: Best Quality, Safest Care: Ever Safer Care through Continuous Learning and Improvement

Quality Programme: Theatres Safety

Aims for 2023-2024

The aim for 2023-2024 is to continue to progress at pace with the improvement workstreams for theatres.

Objectives

The objectives for 2023-2024 include:

- Continuous improvement projects
- WHO Safety Checklist Review and digitisation of documentation
- Cataract one stop shop developed, reviewed and embedded
- Hand Hygiene campaign completed to include on the 5th May 2023 World hand hygiene day
- Development of a staff engagement group
- Designing career road map from Band 2 to Band 8a
- Wellbeing room – opened and to expand to other areas
- Ongoing training and education programmes, including orthopaedic and urology workshops
- Review theatre module – to include updating purpose T documentation
- Reduce high use of agency, exception being short notice sickness
- Green theatre project – more sustainability and waste reduction projects
- Procedure room in endoscopy suite, kit ordered, collaborative work
- TIF 1 – vanguard theatres utilised
- TIF1 Wharfedale – business case in development
- TIF2 – phased recruitment
- Review and align NATSSipS with anaesthetic colleagues
- ACSA review in November 2023, ongoing work ready for re-accreditation

Performance measures

- Number of Never Events
- Agency spend

SAFE: Best Quality, Safest Care: Ever Safer Care through Continuous Learning and Improvement

Quality Programme: Inpatient Falls

Aims for 2023-2024

National guidance from NAIF, suggests if specific interventions are implemented, such as a Multi-Factorial Risk Assessment (MFRA) for all those aged 65 and over, then the Trust should be able to reduce the number of inpatient falls by 20-30%. Therefore, as a Trust, we will look to ensure those suggestions are met, and do so by ensuring the suggested preventative measures are in put into place and then measured accordingly.

Evidence based interventions will be implemented via the multidisciplinary team, with an aim of preventing falls. Any learning from incidents will be robust and measurable, with actions that are meaningful and embedded across the organisation. Finally, falls will remain a trust quality priority.

Objectives

- A reduction in the number of inpatient falls, which resulted in moderate to severe harm, in comparison with 2022/23.
- Embed a new, directorate led, investigation process for falls resulting in moderate to severe harm.
- Improve compliance in ensuring all patients admitted with a fall, or who are 65 and older, receive an evidence based, MFRA within 6 hours of admission.
- Improve compliance rates of the number of patients 65 and older to receive a lying and standing blood pressure, within 48hours of admission.
- Develop new robust documentation for post falls and risk assessments.
- Work closely with multi-disciplinary teams to reduce the number of deconditioned patients within HDFT.
- Continue with evidence based staff education, around the prevention of falls.
- Continue to monitor data and implement meaningful and measurable actions that improves patient safety.

Performance measures

- A designated staff member with a specialist interest in falls, will complete a monthly Tendable audit on five random patients per ward, and then disseminate the findings via the Ward Manager and Matron meeting's and the monthly Fundamentals of Care meeting.
- A Team Lead for falls, will monitor Key Performance Indicators (KPI's) monthly, using data from the monthly falls audit, and the trust incident reporting system and then feed this in to the relevant forums such as Patient Safety Forum, Professional Practice Forum, and the Quality Committee.
- Matron's audits will also monitor the completion of MFRA'a and lying and standing blood pressures.

SAFE: Best Quality, Safest Care: Ever Safer Care through Continuous Learning and Improvement

Quality Programme: Pressure Ulcers

The prevention of pressure ulcers has been a specific part of our quality improvement work at HDFT since 2012/13 and as one of the Trusts Quality Priorities for 2023/24, this focus will sharpen and intensify.

Aims for 2023-2024

All colleagues at HDFT will be committed to ensuring all preventative measures are in place and monitored to reduce the incidence of pressure ulcers occurring, or deteriorating in HDFT care, across both acute and community settings. Learning from incidents will be robust, measurable, and meaningful and will be monitored to ensure actions are fully embedded across the organisation to improve the quality of care delivered.

Objectives

- Rule out pressure ulcers acquired or deteriorating in HDFT services which result from omissions in care.
- Zero tolerance for hospital acquired category 4 pressure ulcers.
- A reduction in the incidence of category 3 and medical device related pressure ulcers acquired in HDFT hospital care in comparison with 2022/23.
- Embed a new, directorate led, investigation process for any pressure ulcers resulting in moderate or severe harm.
- Achieve 100% compliance with pressure ulcer risk assessment and associated care planning.
- Focus on **preventing** pressure ulcers rather than **treating** them.
- Continue to guide and advise colleagues, patients and carers through high quality education and support.
- Make meaningful, and measurable changes based on data unique to HDFT which directly improves patient care.

Improvement work in progress or scheduled

- Development of new information leaflets for patients, carers, families, residential, nursing and home care services, explaining shared care in relation to pressure ulcer prevention and management.
- Increased education opportunities from TVN team – ad hoc and planned.
- Implementation of Statistical Process Control (SPC) data capture.
- Mock coroners court Summer 2023 and Spring 2024 to highlight and embed the importance of accurate and thorough documentation.
- TVN attendance at Theatre, ED, maternity and paediatric training and induction days

Performance measures

- TVN team have commenced monthly Tendable audits for assurance regarding PU risk assessment and care planning - results reported to fundamentals of care group and directorate QoC meetings.
- Tendable audits to monitor pressure ulcer risk assessments:
    - Weekly ward manager
    - Monthly Matrons
    - Implementation of revised PULT process to involve directorate Heads of Nursing, Matrons and quality assurance leads.

OUTCOMES: Best Quality, Safest Care: Excellent outcomes through effective, best practice

Quality Programme: Missed Results

Aims for 2023-2024

Fundamentally, we wish to reduce the number of results which are not acted upon appropriately. As previously noted, the numbers of cases reported as incidents is dependent on many other factors, making tracking of our progress difficult. We also record instances where a missed result has unfortunately led to harm, but these cases are fortunately low in number and sporadic, so a reduction in patient harm may take many years to demonstrate. Therefore we have chosen to monitor our progress by looking at how many investigation results have not been documented as actioned, or "filed", on our ICE electronic results system. The act of "filing" indicates that a health professional has looked at the result and decided whether further action is needed or not. This acts as a final safety net to ensure that every result is viewed in a timely manner.

Objectives

To help achieve our aims we plan to introduce the following changes in the next year:

1) Each clinician will get a list of all results not filed on a weekly basis. This will also be shared with each Clinical Directorate, so that if individual clinicians or teams have a backlog it can be promptly addressed.
2) Each test which is suspicious of malignancy will trigger an email direct to the clinician in charge. This is in addition to visual alerts on the ICE system and automatic referral to the cancer team meetings.
3) We will continue to explore whether normal results can be filed automatically. This reduces the burden on individual clinicians and lessens the likelihood of an abnormal test being missed. Our current IT systems do not allow enough flexibility to do this currently, but we are investigating whether artificial intelligence (AI) processes could provide a solution.
4) We will ensure that as we work to introduce our new Electronic Patient Record, it includes processes which enable prompt filing with appropriate safety netting features.

Performance measures

Reviewing the number of investigation results that have not been documented as action, or "filed" on our ICE electronic results system.

OUTCOMES: Best Quality, Safest Care: Excellent outcomes through effective, best practice

Quality Programme: Medication Errors – A Focus on Insulin

Aims for 2023-2024

Medication incidents remain a priority for the organisation and are the fourth most common type of reported incident, and account for 8-12% of total reported incidents. The National Medicines Safety Improvement Programme (MedSIP) addresses the most important causes of severe harm associated with medicines. The overall ambitions of MedSIP align with the Medicines Quality and Safety Programme and the Quality Priority to reduce medication errors.

Objectives

The proposed ambitions for MedSIP at HDFT are:

- to reduce medicine administration errors in by 50% by March 2024
    - implementation of Omnicell automated cabinets will be an enabler
- to reduce harm from opioid medicines by reducing high dose prescribing (>120mg oral Morphine equivalent), for non-cancer pain by 50%, by March 2024
    - need to define specific programme to reduce harm from opioid medicines
- to reduce harm from insulin prescribing and administration errors by 50%, by March 2024
    - propose insulin safety group to oversee this workstream
- to reduce harm from infusion medicine prescribing and administration errors by 50%, by March 2024
    - propose EPMA infusions project

Performance Measures

A significant piece of learning from the 2022/23 Quality Priority for medication incidents was around how you use data effectively to demonstrate an improvement and the limitations of comparing trends in absolute reported incidents.

There will be a stronger focus on how we use Statistical Process Control tools as a means of understanding natural variation and help enable us to understand whether the changes we are making are resulting in improvement. This is very difficult to do with when comparing absolute data.

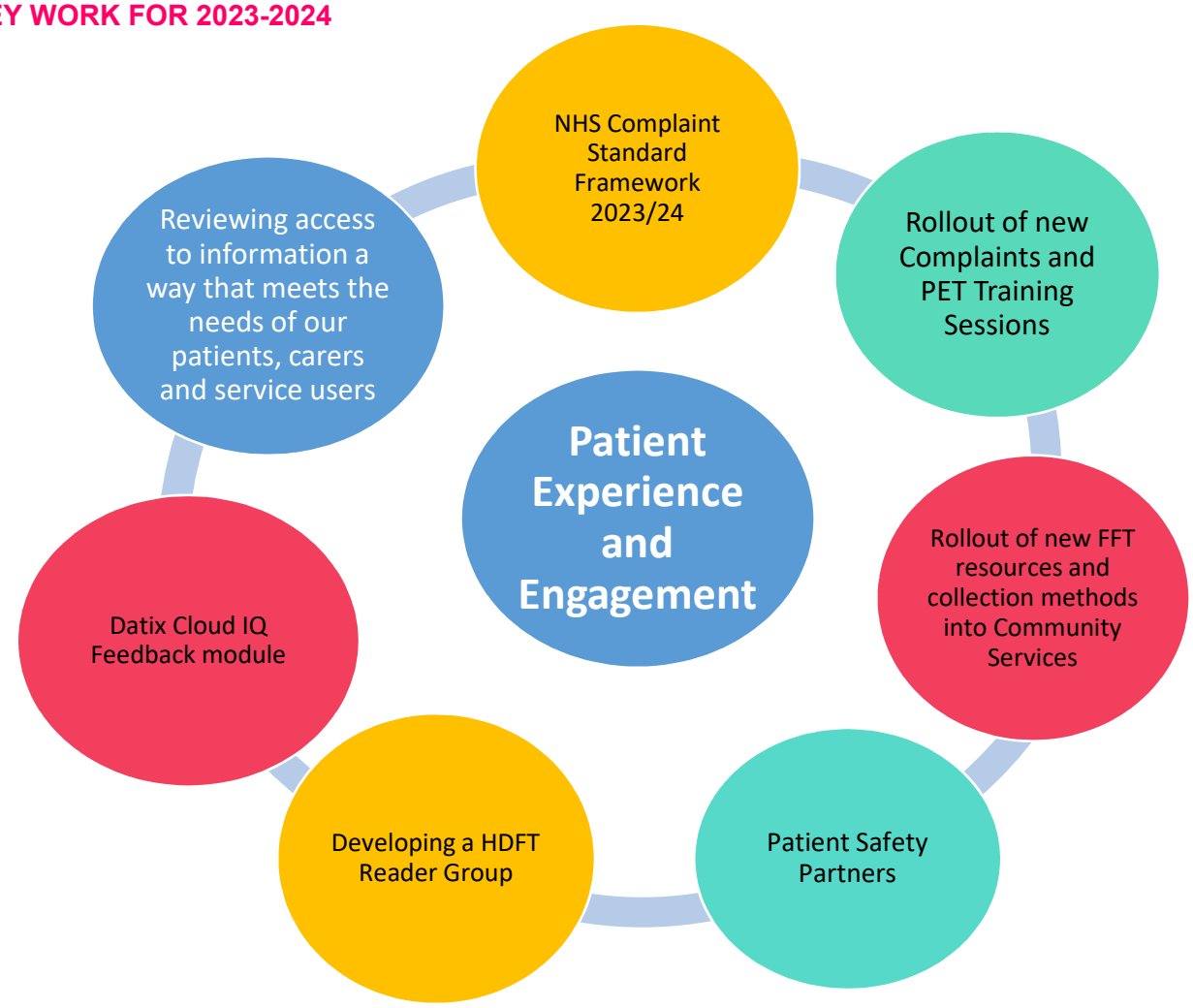
Insulin medication incidents will remain a priority due to the recent trends we have observed. Interventions will continue to optimise digital technology to reduce the human factors associated with medication incidents.

EXPERIENCE: Best Quality, Safest Care: A positive experience for every patient by listening and acting on feedback

Quality Programme: A focus on patient experience

Aims for 2023-2024
To continue to focus on the development of patient experience at HDFT.

KEY WORK FOR 2023-2024



IN FOCUS 2023 - 2024

HDFT Reader Group development
As part of a wider Patient Experience review, looking at how HDFT ensures the patient voice helps to tangibly influence and shape services and patient information, it has been identified that would be significant benefit to introduce a Patient and Carer Reader Group that would underpin all services in the Trust.

The purpose of the group would be to provide a patient/carer perspective on patient information and literature, such as posters, leaflets and webpages.

Currently, HDFT services can access reader groups through Healthwatch North Yorkshire and the Humber and North Yorkshire HCP.

It would allow us to increase our patient and public engagement however, if we were to develop our own group within the Trust.

The purpose of the group will be to help review and develop patient literature, to improve the quality of information and accessibility.

The Patient Experience Team are currently putting together a role descriptor and guidance to support the development of a HDFT Reader Group, and this will be one of our priorities over the next 12 months.

Datix Cloud IQ System

2023 will see the introduction of the new Datix Cloud IQ system to include a new feedback module that has been configured and developed in partnership between the Patient Experience Team, Quality Team and Datix.

The purpose of this new system is to allow for a more joined up, robust approach in capturing patient feedback and as well as formal complaints and concerns, the Patient Experience Team will be capturing compliments and thanks you's, general enquiries and signposting enquiries through the new system.

The outcome of this work will ensure all feedback is recorded, triaged and shared using a consistent approach through the PET, allowing staff and services easier access to feedback to support continuous quality improvement, learning, listening to patients, carers and families about what matters most and support staff development by having access to feedback to support appraisals, THIRVE conversations and revalidation where appropriate.

This work will support our commitment to Involvement, Learning and Governance as by implementing this new system module, we expect to have access to more robust data, themes, trends and insights around the patient experience at the Trust that will allow us to understand what we get right and also where improvements can be made.

PSIRF: A focus on the next 12 months

What is PSIRF?

The NHS Patient Safety Strategy 2019 describes the Patient Safety Incident Response Framework (PSIRF) as “a foundation for change” and as such, it challenges us to think and respond differently when a patient safety event occurs.

Unlike previous frameworks, PSIRF is not a tweak or adaptation of what came before. PSIRF is a whole system change to how we think and respond when an event happens to reduce the risk of recurrence.

Previous frameworks have described when and how to investigate a serious incident, PSIRF focuses on learning and continuous improvement. With PSIRF we are responsible for the entire process, including what to investigate and how. We will work collaboratively with our commissioners and regulators during this process. There are no set timescales or organisations to approve what we do. There are a set of principles that we should work to but besides that it is up to us to determine how we want to investigate and learn. This makes it exciting, innovative but can also make us feel some level of trepidation.

Over the past 18 months HDFT has focused on improving our approach to patient safety events, with many examples of learning and involvement. Essential to this is about promoting a *just culture* in which people feel safe to talk. Having conversations with people relating to a patient safety event can be difficult and we will continue to explore how we can equip and support our colleagues to best hear the voice of those involved. In doing so, we will also support our core ambition of working in partnership with patients to improve safety.

The challenge for us is to develop an approach to investigations that facilitates thematic insights to inform ongoing improvement. Our approach must acknowledge the importance of organisational culture and what it feels like to be involved in a patient safety event. Along with our HR colleagues we must look to further develop and foster a restorative just culture in which people feel psychologically safe. We recognise that changing culture is complex and we are passionate about being an organisation that lives and breathes a safety culture in which people feel safe to speak.

What will PSIRF look like in 2023 - 2024 for HDFT?

At Harrogate and District Hospital NHS Foundation Trust (HDFT) we are fully committed to ensuring the development, implementation and success of the Patient Safety Investigation Response Framework (PSIRF). As a Trust Board we have welcomed the changes from the Serious Incident Framework to PSIRF. This gives us the opportunity to focus our efforts on learning and continuous improvement. The organisation has spent the last 12 months ensuring that we are prepared both with our systems and processes as well as our culture to ensure that we can fully immerse ourselves in the new framework. As a Trust Board, we now make a pledge to fully support the implementation of the PSIRF Plan for HDFT.

Emma Nunez

Executive Director of Nursing, Midwifery and AHPs / Deputy Chief Executive

Sarah Armstrong

Chair of HDFT

ANNEXES

This section of the Quality Account provides an update on:

Annex 1:

- Statements from Key Stakeholders

Annex 2:

- Statement of directors responsibilities

Annex 3:

- Abbreviations and definitions
- Clinical Audit
- How to provide feedback
- Other formats

ANNEX 1: Statements from Key Stakeholders

Statement from Council of Governors:

I am delighted to provide our response to the Quality Account on behalf of the Council of Governors. We appreciate the comprehensive reporting on various aspects of service quality and would like to express our appreciation for the aesthetically pleasing presentation of the Quality Account. The document's core objectives align perfectly with our vision for quality and safety, showcasing the considerable work underway to continually improve the services we provide.

We would like emphasise the council of governors' active engagement in seeking assurance on the impact of critical areas such as safeguarding of children, industrial action and mitigation and the maternity inspection, recovery of services and adverse patient feedback in the PLACE report. Our inquiries and attendance at Board sub-committees will continue to underline our genuine concern for maintaining and enhancing quality priorities.

The Quality Account also sheds light on the challenges faced during the COVID-19 pandemic. While certain aspects may have experienced setbacks, we firmly believe that these issues primarily stem from external factors beyond our control and not from any deficiencies on our side. We remain optimistic that, with time and collective effort, we can work towards re-establishing a solid foundation and restoring any lost ground.

While the report outlines various process changes aimed at enhancing outcomes, we encourage the inclusion of more specific evidence demonstrating actual improvements in outcomes achieved. We are confident that our service is steadily progressing towards the desired level of excellence, and we remain dedicated to reaching our goals.

I can confirm that Governors observe and have an opportunity to review the data and information presented within the Quality Committee and Board Meetings; I therefore can confirm that, the information contained within this report is an accurate and fair account of the Trusts performance and progress to the best of my knowledge.

Kind Regards

On Behalf of the Council of Governors: Clare Illingworth, Lead Governor

Feedback Statement from Humber & North Yorkshire Integrated Care Board

Humber and North Yorkshire Health and Care Partnership (HNY) would like to thank Harrogate and District Foundation Trust (HDFT) for the opportunity to read and comment on their Quality Account for 2022/23. This well written and inviting account clearly sets out the key progress made over the last year in the context of the continued pressures facing all services nationally.

The HNY would also like to extend our gratitude to all staff at the Trust for their ongoing commitment to improvement and dedication to patient care.
The revised Quality Team structure, leadership and improved Quality framework reinforces a solid commitment to continuous improvements in terms of culture and safety. This is underpinned by cross service collaboration, learning from audit and clinical trial.

The revised Trust strategy for 22/23 based on "Best Quality, Safest Care" demonstrates improvements made across the last year in relation to Emergency Departments and Theatres, particularly a review of pathways with staffing to underpin delivery. HNY is reassured to see staffing and patient experience as a Quality improvement priority, being thematic across Theatres also. In particular, work around "Stop before you block" and "Accountable items policy" over the last year reinforces implementing learning from patient safety incidents.

HNY acknowledge the ongoing commitment to reduce and prevent falls and pressure ulcers within the Trust. We look forward to collaboration regarding future work around the 9 domain areas in relation to Falls. A key focus on education and training for tissue viability is indicative of a comprehensive approach to tackling pressure ulcer incident and management.

HNY note the investigation work completed around missed results with an emphasis on cross departmental learning. The rapid improvement workshop highlights the work of the Quality strategy in action.

The Trust's aims to reduce insulin related incidents portrays a focus on patient safety while utilising staff at the point of service delivery to inform improvement actions. Including this as a future priority in 23/24 based on incidents identified in the Insulin Safety Group underpins the efficacy of the group in responding to real time trends.

Specific work to enhance patient feedback and understanding in Children and Young people is supported by HNY. We are impressed to read of Specialist Children's Service being one of the first to implement the new Children and Young People friends and family test. A development of a patient and carer reader group in 22/23 is to be commended.

Key activities in relation to the Clinical services strategy is also noted, with particular reference to the Clinical discharge Hub and Hospital at home highlighting the importance and benefits of multi-agency working.

HDFT recognition of staff wellbeing is acknowledged. HNY applaud the work by the Guardian for safe working hours and subsequent recommendations and recruitment. This reinforces a positive culture within the trust for speaking up and prioritising staff wellbeing and patient safety.

A key achievement following the learning from deaths reviews, which highlighted the majority of care being of good or excellent quality, is to be celebrated. Subsequent links to the increase in Structured Judgement Review processes will serve as a crucial foundation to the introduction of PSIRF going forwards. The report outlines how reporting, data analysis and coding is instrumental in triangulating learning and improvement. Of note is a significant reduction in *clostridium difficile* cases over the last year.

HNY look forward to working in synergy with the Trust in relation to the implementation of PSIRF over the coming year in line with National changes to the way incidents are reviewed as a system approach.

The Quality Account for 22/23 is complemented as a representation of both performance over the last 12 months and how this has informed the setting of key priorities in the next.

ANNEX 2: Statement of Directors Responsibilities

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Accounts presents a balanced picture of the trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Chair of HDFT: Sarah Armstrong

Signature:

Date:

Chief Executive of HDFT: Jonathan Coulter

Signature:

Date:

ANNEX 3: Abbreviations and Definitions

Abbreviation / Name	Definition
ACP	Advanced Care Practitioner
Audit	An audit is a way to find out if healthcare is being provided in line with standards and lets care providers and patients know where their service is doing well, and where there could be improvements.
AMU	Acute Medical Unit
BAME	Black and minority ethnic
BSL	British sign language
CAT	Clinical Assessment Team – changed to Combined Assessment Team (December 2018)
CATT	Clinical Assessment, Triage and Treatment
CAS	The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.
CCG	Clinical Commissioning Group Clinical Commissioning Groups (CCGs) commission a majority of the hospital and community NHS services in the local areas for which they are responsible. Commissioning involves deciding what services are needed for diverse local populations and ensuring that they are provided.
CEM	Royal College of Emergency Medicine
CHC	Continuing Healthcare
Clinical Audit	This is a quality improvement process that looks at improving patient care and outcomes through a review of care against a set of criteria. This helps to ensure that what should be done in a Trust is being done.
Clinical Outcome	A clinical outcome is the “change in the health of an individual, group of people or population which is attributable to an intervention or series of interventions.
Clinical Research	Clinical research is a branch of medical science that determines the safety and effectiveness of medication, diagnostic products, devices and treatment regimes. These may be used for prevention, treatment, diagnosis or relieving symptoms of a disease.
CNS	Clinical Nurse Specialist
COPD	Chronic obstructive pulmonary disease
Covid-19	A highly contagious respiratory disease caused by the SARS-CoV-2 virus.
CQC	Care Quality Commission Care Quality Commission (CQC) regulates and monitors the Trust’s standards of quality and Safety.
CQUIN	Commissioning for Quality and Innovation A payment framework which enables commissioners to reward excellence, by linking a proportion of payments to the achievement of targets
CTG	Cardiotocography
CVI	Certificate of visual impairment
Dashboard	Data visualisation tool that displays the current status of metrics and key performance indicators
Data Quality	Ensuring that the data used by the organisation is accurate, timely and informative.
Datix	DATIX is the Trust wide incident reporting system
ED	Emergency Department

	The Emergency Department (ED) assesses and treats people with serious injuries and those in need of emergency treatment. Its open 24 hours a day, 365 days of the year.
EoL	End of life
EPaCCS	Electronic palliative care co-ordination system
ePMA	Electronic prescribing and medicines administration system
FFT	Friends and Family Test The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.
GP	General practitioner
HaRD	Harrogate and Rural District
HDFT	Harrogate and District NHS Foundation Trust
ICE	Requesting and reporting software
ICNARC	Intensive care national audit and research centre
Just Culture	A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution.
LD	Learning disabilities
MAU	Medical Admissions Unit
MCA	Mental Capacity Act
MDT	Multidisciplinary team
NCAPOP	National Clinical Audit and Patient Outcome Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
Never Event	A Never Event is a type of serious incident (SI). These are defined as 'serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'
NEWS	National Early Warning Score (NEWS) is based on a simple scoring system in which a score is allocated to six physiological measurements already taken in hospitals – respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate Hull University Teaching Hospitals NHS Trust - Quality Accounts 21/22 Page 89 of 92 Abbreviation Definition and level of consciousness. NEWS2 is the latest version of the National Early Warning Score (NEWS), first produced in 2012 and updated in December 2017, which advocates a system to standardise the assessment and response to acute illness.
NICE	The National Institute for Health and Care Excellence The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to health and social care organisations to ensure the service provided is safe, effective and efficient.
NPSA	National Patient Safety Agency Through analysis of reports of patient safety incidents, and safety information from other sources, the National Reporting and Learning Service (NRLS) develops advice for the NHS that can help to ensure the safety of patients. Advice is issued to the NHS as and when issues arise, via the Central Alerting System in England and directly to NHS organisations in Wales. Alerts cover a wide range of topics, from vaccines to patient identification. Types of alerts include Rapid Response Reports, Patient Safety Alerts, and Safer Practice Notices.
NIHR	National Institute for Health Research The National Institute for Health Research commissions and funds research in the NHS and in social care.

NMC	The Nursing and Midwifery Council (NMC) are the professional regulator for nurses and midwives in the UK, and nursing associates in England.
NRLS	National Reporting and Learning System National Reporting and Learning Service is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted.
PPE	Personal Protective Equipment is equipment that will protect the user against health or safety risks at work. It can include items such as safety helmets, gloves, eye protection, high-visibility clothing, safety footwear and safety harnesses. It also includes respiratory protective equipment.
PVG	Patient Voice Group
RCEM	The Royal College of Emergency Medicine (RCEM) is an independent professional association of emergency physicians in the United Kingdom which sets standards of training and administers examinations for emergency medicine in the United Kingdom and Ireland.
RTT	Referral to treatment
SI	Serious Incident An SI is an incident or accident involving a patient, a member of NHS staff (including those working in the community), or member of the public who face either the risk of, or experience actual, serious injury, major permanent harm or unexpected death in hospital, other health service premises or other premises where health care is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern.
SAU	Surgical Assessment Unit
SJR	Structured judgement review
SHMI	Standardised Hospital Mortality Indictor - is a hospital-level indicator which measures whether mortality associated with hospitalisation was in line with expectations.
SSNAP	Sentinel Stroke National Audit Programme
VTE	Venous thromboembolism
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole time equivalent

ANNEX 3: Clinical Audit

The national clinical audits and national confidential enquiries that HDFT was eligible to participate in during 2022-2023 are as follows:

1. Breast and Cosmetic Implant Registry
2. Case Mix Programme (CMP)
3. Child Health Clinical Outcome Review Programme
    - *Transition from child to adult health services*
    - *Testicular Torsion*
4. Chronic Kidney Disease Registry (previously listed under UK Renal Registry)
5. Elective Surgery (National PROMs Programme)
6. Emergency Medicine QIPs (*did not participate*)
    - *Pain in Children (care in Emergency Departments)*
    - *Assessing for cognitive impairment in older people*
    - *Mental health self harm*
7. Falls and Fragility Fracture Audit Programme (FFFAP)
    - FFFAP b. National Audit of Inpatient Falls
    - FFFAP c. National Hip Fracture Database
8. Inflammatory Bowel Disease (IBD) Audit
9. LeDeR - Learning Disabilities Mortality Review
10. Maternal, Newborn and Infant Clinical Outcome Review Programme
    - Perinatal confidential enquiries
    - Perinatal mortality surveillance
    - Maternal mortality surveillance and confidential enquiry
11. Medical and Surgical Clinical Outcome Review Programme
    - Crohns disease
    - Epilepsy study
    - Community Acquired Pneumonia
    - Endometriosis
12. Muscle Invasive Bladder Cancer Audit
13. National Adult Diabetes Audit (NDA)
    - National Diabetes Core Audit ,
    - National Pregnancy in Diabetes Audit
    - National Diabetes Foot care Audit
    - National Diabetes Inpatient Safety Audit
14. National Asthma and COPD Audit Programme (NACAP)
    - NACAP - Adult asthma secondary care
    - NACAP - Paediatric - Children and young people asthma secondary care
    - NACAP - Pulmonary Rehabilitation
    - NACAP - Chronic Obstructive Pulmonary Disease (COPD)
15. National Audit of Breast Cancer in Older People (NABCOP)
16. National Audit of Cardiac Rehabilitation
17. National Audit of Care at the End of Life (NACEL)
18. National Audit of Dementia (NAD)
    - NAD - Care in general hospitals
19. National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)
20. National Cardiac Arrest Audit (NCAA)
21. National Cardiac Audit Programme (NCAP)
    - NCAP - Myocardial Ischaemia National Audit Project (MINAP)
    - NCAP - National Audit of Cardiac Rhythm Management Devices and Ablation
    - NCAP - National Heart Failure Audit
22. National Child Mortality Database (NCMD)
23. National Comparative Audit of Blood Transfusion
    - Acute Upper GI Bleed (AUGIB)

24. National Early Inflammatory Arthritis Audit (NEIAA)
25. National Emergency Laparotomy Audit (NELA)
26. National Gastro-intestinal Cancer Audit Programme (GICAP)
    - National Oesophago-Gastric Cancer Audit (NOGCA)
    - National Bowel Cancer Audit (NBOCA)
27. National Joint Registry
28. National Lung Cancer Audit Programme
29. National Maternity and Perinatal Audit (NMPA)
30. National Neonatal Audit Programme (NNAP)
31. National Ophthalmology Database Audit
32. National Paediatric Diabetes Audit (NPDA)
33. National Perinatal Mortality Review Tool
34. National Prostate Cancer Audit (NPCA)
35. Perioperative Improvement Programme
36. Renal Audits
    - National Acute Kidney Injury Audit
37. Respiratory Audits
    - Adult Respiratory Support Audit
    - Smoking Cessation Audit – Maternity and Mental Health Services
38. Sentinel Stroke National Audit Programme (SSNAP)
39. Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
40. Society for Acute Medicine Benchmarking Audit
41. Trauma Audit & Research Network
42. UK Parkinsons Audit

The national clinical audits and national confidential enquiries that HDFT participated in and for which data collection was completed during 2022/23 are as follows:

1. Breast and Cosmetic Implant Registry
2. Case Mix Programme (CMP)
3. Child Health Outcome Review Programme
4. Chronic Kidney Disease Registry (previously listed under UK Renal Registry)
5. Elective Surgery (National PROMs Programme)
6. Falls and Fragility Fracture Audit Programme (FFFAP)
7. Inflammatory Bowel Disease (IBD) Audit
8. LeDeR - Learning Disabilities Mortality Review
9. Maternal, Newborn and Infant Clinical Outcome Review Programme
10. Medical and Surgical Clinical Outcome Review Programme
11. Muscle Invasive Bladder Cancer Audit
12. National Adult Diabetes Audit (NDA)
13. National Asthma and COPD Audit Programme (NACAP)
14. National Audit of Breast Cancer in Older People (NABCOP)
15. National Audit of Cardiac Rehabilitation
16. National Audit of Care at the End of Life (NACEL)
17. National Audit of Dementia (NAD)
18. National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)
19. National Cardiac Arrest Audit (NCAA)
20. National Cardiac Audit Programme (NCAP)
21. National Child Mortality Database (NCMD)
22. National Comparative Audit of Blood Transfusion
23. National Early Inflammatory Arthritis Audit (NEIAA)
24. National Emergency Laparotomy Audit (NELA)
25. National Gastro-intestinal Cancer Audit Programme (GICAP)
26. National Joint Registry
27. National Lung Cancer Audit Programme
28. National Maternity and Perinatal Audit (NMPA)
29. National Neonatal Audit Programme (NNAP)
30. National Ophthalmology Database Audit
31. National Paediatric Diabetes Audit (NPDA)
32. National Perinatal Mortality Review Tool
33. National Prostate Cancer Audit (NPCA)
34. Perioperative Improvement Programme
35. Renal Audits
36. Respiratory Audits
37. Sentinel Stroke National Audit Programme (SSNAP)
38. Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
39. Society for Acute Medicine Benchmarking Audit
40. Trauma Audit & Research Network
41. UK Parkinsons Audit

NATIONAL CLINICAL AUDITS 2022-2023

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2022/23	Data submitted as a percentage of the number of registered cases required for that audit
1	Breast and Cosmetic Implant Registry	No	28	100%
2	Case Mix Programme (CMP)	No	354	100%
3	Child Health Clinical Outcome Review Programme	Yes	TBC	TBC
4	Chronic Kidney Disease Registry (previously listed under UK Renal Registry)	No	638	100%
5	Elective Surgery (National PROMs Programme)	No		
5a	*Hip replacement*		Participated	Unable to ascertain
5b	*Knee replacement*		Participated	Unable to ascertain
6	Falls and Fragility Fracture Audit Programme (FFFAP)	Yes		
6a	*National Audit of Inpatient Falls*		6	100%
6b	*National Hip Fracture Database*		316	100%
7	Inflammatory Bowel Disease (IBD) Audit **Refers to all new patients on biologics Cumulative total = 168Check this*	No	783	100%
8	LeDeR - Learning Disabilities Mortality Review NB Continuous Data Collection	No	11	100%
9	Maternal, Newborn and Infant Clinical Outcome Review Programme NB Continuous Data Collection	Yes		
9a	Perinatal confidential enquiries		18	100%
9b	Perinatal mortality surveillance		18	100%

9c	Maternal mortality surveillance and confidential enquiry		1	100%
10	Medical and Surgical Clinical Outcome Review Programme	Yes		
10a	*Epilepsy Study*		5	100%
10b	*Crohns Study*		5	100%
11	Muscle Invasive Bladder Cancer Audit			
12	National Adult Diabetes Audit (NDA)	Yes		
12a	*National Diabetes Core Audit*		*1811*	100%
12b	*National Pregnancy in Diabetes Audit*		*12*	100%
12c	*National Diabetes Footcare Audit*		*445*	100%
12d	*National Inpatient Diabetes Audit including National Diabetes In-patient Audit – Harms*		7	100%
13	National Asthma and COPD Audit Programme (NACAP)	Yes		
13a	*NACAP - Adult asthma secondary care*		106	Unable to ascertain
13b	*NACAP - Paediatric - Children and young people asthma secondary care*		27	100%
13c	*NACAP - Pulmonary Rehabilitation*		11	Unable to ascertain
13d	*NACAP - Chronic Obstructive Pulmonary Disease (COPD)*		294	Unable to ascertain
14	National Audit of Breast Cancer in Older People (NABCOP) *(data submitted April 22- Sept 22)*	Yes	Participated	100%
15	National Audit of Cardiac Rehabilitation	No	199	100%
16	National Audit of Care at the End of Life (NACEL)	Yes	50	100%

17	National Audit of Dementia	Yes	TBC	TBC
18	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	12	85%
19	National Cardiac Arrest Audit (NCAA)	No	53	100%
20	National Cardiac Audit Programme (NCAP)	Yes		
20a	*NCAP-Myocardial Ischaemia National Audit Project (MINAP)*		259	96%
20b	*NCAP-National Audit of Cardiac Rhythm Management Devices and Ablation*		101	100%
20c	*NCAP-National Heart Failure Audit*		265	100%
21	National Child Mortality Database (NCMD)	Yes	Participated	Unable to ascertain
22	National Comparative Audit of Blood Transfusion	No		
22a	*Upper Acute GI bleed*		37	100%
23	National Early Inflammatory Arthritis Audit (NEIAA) **refers to patients recruited to the study in timeframe.*	Yes	15	Unable to ascertain
24	National Emergency Laparotomy Audit (NELA)	Yes	63	Unable to ascertain
25	National Gastro-intestinal Cancer Audit Programme (GICAP)	Yes		
25a	*National Oesophago-Gastric Cancer Audit (NOGCA)*		54	100%
25b	*National Bowel Cancer Audit (NBOCA)*		205	100%
26	National Joint Registry	No	605	Unable to ascertain
27	National Lung Cancer Audit Programme ** based on diagnoses in 2022/23*	Yes	119	100%
28	National Maternity and Perinatal Audit (NMPA)	Yes	1705	100%

29	National Neonatal Audit Programme (NNAP)	Yes	13	100%
30	National Ophthalmology Database Audit	No	TBC	TBC
31	National Paediatric Diabetes Audit (NPDA)	Yes	*1308*	100%
32	National Perinatal Mortality Review Tool	Yes	TBC	TBC
33	National Prostate Cancer Audit (NPCA) ** based on diagnoses in 2022/23*	Yes	208	100%
34	Perioperative Improvement Programme	No	TBC	TBC
35	Renal Audit	No		
35a	National Acute Kidney Injury Audit		TBC	TBC
36	Respiratory Audits	No		
36a	*Adult Respiratory Support Audit*		TBC	TBC
36b	*Smoking Cessation Audit – Maternity & Mental Health Services*		Audit delayed until further notice **	
37	Sentinel Stroke National Audit Programme (SSNAP)	Yes	272	90+%
38	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	No	15	100%
39	Society for Acute Medicine Benchmarking Audit	No	30	100%
40	Trauma Audit & Research Network	No	243	100%
41	UK Parkinsons Audit	No	20	100%

Please note: data for all continuous projects continues to be reviewed and validated therefore final figures may change.

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For information, the Trust also participated in the following National audits and registries which were not listed on the 2022/23 Quality Accounts List:

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Name of Audit	Part of NCAPOP?	Number of patients for which data submitted 2022/23	Data submitted as a percentage of the number of registered cases required for that audit
UK National Hand Registry	No	TBC	TBC
Bone and Joint Infection Registry (BAJIR)	No	TBC	TBC
Post Colonoscopy Colorectal Cancer (PCCRC) National Audit	No	TBC	TBC

The following 7 NCAPOP audits were not relevant to HDFT due to the Trust not providing the service:

1. Mental Health Clinical Outcome Review Programme
2. National Audit of Cardiovascular Disease Prevention in Primary care
3. National Clinical Audit of Psychosis
4. National Obesity Audit
5. Neurosurgical National Audit Programme
6. National Vascular Registry
7. Paediatric Intensive Care Audit Network (PICANet)

The following individual NCAPOP audits within relevant work streams were not relevant to HDFT due to the Trust not providing the service

- Falls & Fragility Fractures Audit Programme (FFFAP): Fracture Liaison Service Database
- Medical and Surgical Clinical Outcome Review Programme (NCEPOD): Physical Health in Mental Health Hospitals
- NCAP - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)
- NCAP - National Adult Cardiac Surgery Audit
- NCAP - National Congenital Heart Disease Audit (NCHDA)

The following 6 non-NCAPOP audits were not relevant to HDFT due to the Trust not providing the service:

1. Cleft Registry and Audit Network (CRANE)
2. National Audit of Pulmonary Hypertension (NAPH)
3. Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry
4. Prescribing Observatory for Mental Health
5. UK Cystic Fibrosis Registry
6. Urology Audits
7. National Bariatric Surgery Registry

** Please note that the *Smoking Cessation Audit – Maternity & Mental Health Services* which was included in the NHS England Quality Accounts List 2022/23 has been delayed until further notice by the British Thoracic Society. Hence there was no data collection for 2022/2023

ANNEX 3: How to Provide Feedback and Other Formats

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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