Harrogate and District NHS Foundation Trust

Quality Account 2021/22

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1.1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

I am pleased to present the Harrogate District NHS Foundation Trust's Quality Account.

The Quality Account is an annual report, which reviews our performance and progress against the quality of services we provide and sets out our key quality and safety improvement priorities for 2021/22. 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.

In Part 5 of this report we set out the quality and safety improvement priorities for 2022-23. 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.

Comments from the 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 staff and stakeholders because their comments help us acknowledge achievements made and identify further improvements to be made.

I can confirm that the Board of Directors has reviewed the 2021/22 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

1.2 What is a Quality Account

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 2010/2011).
The toolkit can be accessed via: https://www.gov.uk/government/news/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 at the previous financial year's performance

Organisation priorities for quality improvement for the previous financial year

A series of statements from the Board for which the format and information required is prescribed and set out in the regulations and the toolkit

Part 3: Priorities for the coming financial year

A review of the quality of services in the organisation for the coming financial year. This must be presented under three domains; patient safety, clinical effectiveness and patient experience

What does it mean for Harrogate and District NHS Foundation Trust?

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 e.g. 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 Accounts should assure the Trust's patients, members of the public and its stakeholders that as an NHS healthcare 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 also make them available on our own website: www.hdft.nhs.uk/about/trust

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE

2.1 Priorities for improvement 2021/22

We had reduced opportunities to progress the priorities identified for improvement during this period as a result of the Covid-19 pandemic, however we are committed to ensuring that the quality and safety of our patients has been at the forefront of all that we do.

We have considered the range of services provided by Harrogate and District NHS Foundation Trust (HDFT) and the impact of the Covid-19 pandemic on these, and will be continuing some of the work identified for improvement during 2021/22 into 2022/23. These indicators reflect national and local priorities for improvement, current performance and objectives, and have been approved by the Board of Directors. We have set targets for achievement and will monitor progress regularly at the Quality Committee.

The priorities and our progress are listed below in 2.2.

2.2 Progress against quality priorities identified in 2021-22

In the 2021/22 Quality Report we identified the following priorities for work during 2021/22:

1. To develop an integrated clinical service for inpatient unplanned care - ensuring patients see the right clinician at the right time in the right place 7 days a week
2. To improve the responsiveness and effectiveness of our communication with external partners and our patients by delivering a paper-light system in outpatients
3. To embed the Medical Examiner system and refresh our learning from deaths framework
4. To ensure quality, safety and confidentiality in virtual consultations
5. Ensuring we provide a high quality and developmentally appropriate service for our children and young people up to the age of 18 years across services within the acute setting.
6. To enhance the service offered to our patients and colleagues with autism and autism spectrum disorders, by appointing an autism champion, embedding learning and training, and agreeing a Trust-wide approach.

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

1. To develop an integrated clinical service for inpatient unplanned care - ensuring patients see the right clinician at the right time in the right place 7 days a week

Introduction

In order to provide safe, caring and effective service for patients whose hospital admission is unplanned it is important to us that we develop our pathways to enable them to be seen by the most appropriate clinician at all times, from their arrival in the Emergency Department or other departments, through admission pathways onto the wards and through to discharge, utilizing same day pathways whenever appropriate.

What were we aiming to achieve?

This quality priority, initially scheduled for 2020/21 was delayed by a year due to the COVID-19 pandemic. It commenced in April 2021 and is expected to run over 3 years with an overall aim of integrating current processes during the patient's entire visit to ensure they can be seen by the right type of clinician, in the right place and at the right time. This aims to result in increased numbers of patients being effectively treated and discharged on the same day, fewer patients needing to use the Emergency Department to access inpatient services and those patients who need to be admitted will stay in hospital for shorter lengths of time. Key outcome measures will be reduction in the unplanned length of stay, reduction in single night stays and achievement of key indicators for 7 day services including the 14 hour consultant review target.

What have we done?

In the initial year of this quality priority, work has focused on:

1. Publishing defined admission pathways for patients presenting with certain conditions so that they are consistently cared for by the most appropriate clinical teams in the most appropriate wards, facilitating the use of shared care models when necessary. This involved adapting and permanently embedding some effective new pathways developed urgently during the first COVID-19 pandemic waves, as well as defining additional pathways.
2. Successful procurement of and the initial rollout stages of an electronic job planning system for Consultant and SAS grade doctors to facilitate the recording of annual job plan agreements and enable accurate reporting on the utilisation of clinician time resource. Once fully implemented in Autumn 2022 this information will be used to more effectively report on job planning status and plan medical staffing models trust-wide in conjunction with the 14 th Consultant review audit planned for bullet point 3 2022/23.
3. Evaluating unplanned admission pathways for surgical patients and initial planning for improved processes and workforce models to support the increased opportunities for surgical same day emergency care.
4. Junior Doctor workforce models. A deep dive "Kaizen" quality improvement event evaluating post-pandemic junior medical workforce models was undertaken which identified opportunities to reduce requirement for agency medical staff through diversification of the workforce. This includes increased utilization of Advance Clinical Practitioner (ACP) roles as well as creating attractive fixed term locally employed doctor posts with dedicated time for quality improvement, research and teaching. The significant benefits of electronic rostering for medical staff were also identified.

This work significantly benefitted from the appointment in August 2021 of HDFT's first Royal College of Physician's "Chief Registrar" who has been instrumental in the trusts ability to engage with our junior medical workforce about caring for unplanned admissions and co-develop improved processes for patients, as well as ensuring our doctors in training have a positive experience working and training at HDFT.

These longer-term projects will progress over the next two years, guided by reporting enabled by the implementation of the electronic workforce systems and according to requirements highlighted in the Urgent and Emergency Care Transformation programme.

2. To improve the responsiveness and effectiveness of our communication with external partners and our patients by delivering a paper-light system in outpatients

Introduction

After a patient attends our services it is really important that we share the outcome of this with both the patient and others involved in their healthcare. Where this is not completed effectively or rapidly there is an increased risk of errors to duplication which may affect a patients treatment.

What were we aiming to achieve?

Through the move to paperlight processes and a greater level of digital integration we aimed to make available to patients and other professionals involved in their care, details of the care delivered/ confirmation of treatment plans/ any actions required. With a digital signoff process, patient portal and instant digital transfer of information this information will be available to all involved at the same time and within hours of the patient being seen.

What have we done?

- Text to speech and digital dictation system implemented allowing richer and quicker information capture.
- A move away from paper records in outpatients, which is now progressing through specialties
- Patient portal (where information can be stored and retrieved at any time by a patient) was piloted with anticipated roll out over the next 12 months.
- Paper letters where appropriate, were replaced with digital delivery
- Established a working group to ensure information at discharge is shared in the same way.
- Delays associated with sending out paper letters have all but disappeared.
- Turnaround times for letters has improved with digital dictation, speech to text and digital sign off.

Summary

Paperlight progress has been slower than intended with the COVID-19 pandemic but continues to grow. The success we have achieved so far will continue to be built on over the next 12 months as the rollout continues but also as the technology evolves allowing better integration and easier sharing between patients and healthcare teams

3. To embed the Medical Examiner system and refresh our learning from deaths framework

Introduction

All acute trusts in England were instructed to set up Medical Examiner offices. Initially the focus was to review all deaths that occur in their own organisation on a non-statutory basis. In February 2021, the government published Working together to improve health and social care for all, a parliamentary white paper which includes provisions for medical examiners to be put on a statutory footing.

The purpose of the medical examiner system is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- Ensure the appropriate direction of deaths to the coroner
- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- Improve the quality of death certification
- Improve the quality of mortality data, and to identify cases for the trust/GP practices to review as part of their Governance structures

Within the next 1-2 years, a Medical Examiner (ME) will scrutinise all deaths occurring in England, both in hospital and the community, unless they are examined by a coroner. This will become a statutory function.

What were we aiming to achieve?

Our aim was to scrutinise all deaths which occurred in Harrogate District Hospital during 2021-2022. We decided to utilize the non-statutory period to develop working practices to ensure prompt scrutiny of deaths, explanation of the cause of death to the bereaved and collection of comments (both positive and negative) which can be used by the Trust to provide ongoing improvements. We also planned to pilot the service in the community.

What have we done?

- We now have a fully staffed team of 7 Medical Examiners (5 Consultants in HDFT and 2 General Practitioners) and 2 Medical Examiner Officers (both highly experienced, having worked previously in the Coroner's Office).
- We have utilized our bespoke electronic patient record (WebV) to record interactions with the ME office, together with processes to highlight compliments or concerns. If an individual case raises concerns, the appropriate team in the Trust is contacted so that further investigation and learning can progress.
- Every quarter we send anonymised comments received from the bereaved to each ward area, the majority of which have been extremely complimentary about the care received.

In conjunction with our GP Liaison and the local GP Practice Mangers, we have developed an electronic referral system for deaths which occur in the Harrogate and Richmondshire Borough Council footprints. This enables GP practices to send in copies of medical records

for scrutiny in a prompt and secure manner. This is now being rolled out incrementally across the region.

What are the results?

In 2021-2022 our activity was:

- 100% of inpatient deaths were reviewed by the ME Office
- 753 deaths were scrutinized or referred to the Coroner
- 710 had the Medical Certificate of the Cause of Death or coronial referral completed within 72 hours of death (43 were delayed due to weekend and bank-holidays)
- 733 bereaved families were successfully contacted
- 9 cases were escalated to the Trust where the ME had concerns about care
- 13 cases were escalated where the bereaved had concerns about care

Summary

We achieved our goal for 2021-2022 in ensuring all death in Harrogate District Hospital were examined by a Medical Examiner. In doing so, we have provided the bereaved with an independent opinion on the cause of death and care received, provided them with an explanation of the circumstances of the death and enabled them to comment or raise any questions they may have at a difficult time. Informal feedback from the bereaved about the ME service has been very positive. We also have developed and successfully piloted a process to roll this service out to deaths in the community in the coming months.

4. To ensure quality, safety and confidentiality in virtual consultations

Introduction

Traditionally most clinical consultations have been undertaken face-to-face, with both patient and clinician present in an inpatient, outpatient or domiciliary setting. Increasingly remote consultations will become common, particularly for outpatient work and might utilise telephone or video technology.

The Covid 19 Pandemic required the implementation of virtual consultations to happen at pace. This quality priority was ensuring that we had the correct governance arrangements in place to do this safely.

What were we aiming to achieve?

The aims of this quality priority were:

- **To ensure HDFT had governance arrangements in place to ensure that where remote consultations are carried out this is done safely.**
- **To ensure that where video consultations are carried out, this is on an appropriate clinical platform by clinicians who have received training to use the platform and that those using it do have access to the patient record**

What have we done?

- **The Remote and Agile Working Policy – which outlines the Confidentiality and Data Protection requirements when colleagues are providing virtual consultations from their own home**
- **The remote consultation guidelines which were developed at the beginning of the Covid pandemic and have been reviewed and are deemed fit for purpose to continue.**

Results:

The information provided below gives the details of the work that has been carried out to reach these outcomes.

ACTION	OUTCOME
Review & develop a criteria-based process for Acute Paediatric Outpatients pathway	Complete – informed the high level Virtual Consultation Assessment Criteria
Review the process undertaken by the Adult Chronic Pain team (May 2021)	Complete - informed the high level Virtual Consultation Assessment Criteria
Review existing HDFT policy, guidance & training documentation relating to VC	Complete - each service within CCs was given the opportunity to feedback on the Trust policy with no current requirement to amend. HDFT policy AA training pack

ACTION	OUTCOME
	Whatsapp Guidance
Review existing use of virtual platforms and utilisation	Complete - High level set out in this paper and in further detail as part of the OTG options appraisal paper Analysis of Attend Anywhere usage shared across the directorate leads
Review against recommendations framework for, Quality, Safety and Confidentiality	Complete – The analysis/recommendations has been shared with Directorate Clinical Leads and Operational Directors
Identify platform(s) for virtual consultations	Complete - Digital Strategy Board approved MS Teams as the preferred platform in Oct 2021 . Project Group established to transition existing Attend Anywhere users and commence training considering the QSC framework set out in this paper.

Summary

To conclude the work carried out has met the original aims of this paper and furthermore there has been no identification of any areas of concern in relation to the Quality, Safety and Confidentiality of existing virtual consultation practice across the trust. The ongoing oversight and assurance of this work will be carried out at service and directorate level and via the following project groups linked to virtual working/programmes of work; Outpatient Transformation Group and the Patient Virtual Consultation project team (transition to MS Teams platform).

5. Ensuring we provide a high quality and developmentally appropriate service for our children and young people up to the age of 18 years across services within the acute setting.

Introduction

The 2018 CQC report stated, “The trust should ensure that staff who care for children and young people in areas outside of the children’s services (for example, theatre, radiology, adult outpatients and the emergency department) receive appropriate training and complete relevant competencies to enable them to care for this patient group.”

The Community and Children’s (CC) directorate is responsible for the care delivered to children and young people (CYP) within its portfolio. Many CYP attend other departments within the acute trust that provide primarily adult focused services. The CC directorate have made good progress in the implementation of the Executive approved ‘Hopes for Healthcare’ standards for CYP, developed collaboratively with the Youth Forum, within the services it delivers. The next stage is to progress this within the services delivered in the other directorates.

What were we aiming to achieve?

To achieve operational assurance that the needs of CYP are considered in the way services are delivered in all directorates across the Trust.

- Children’s services to be outstanding at our next CQC inspection with consistently high quality care being delivered.
- Colleagues working in primarily adult services that are caring for CYP are competent and confident in caring for our younger patients.
- Implement the Hopes for Healthcare standards across the organisation in order that the voice of the child is heard in every service they access.
- Quality of Care meetings cover CYP across all services and directorates with any issues identified being escalated to the executive board

The enablers to achieve this are ensuring that the needs of CYP are:

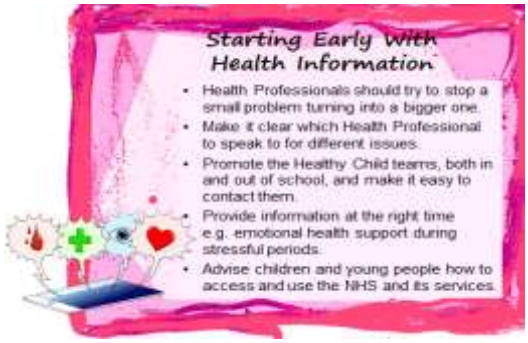
- Included as a standard agenda item on quality of care meetings in theatre, radiology, adult outpatients and the emergency department. The voice of the child needs to be recorded.
- Included as a standard agenda item at senior management team meetings every quarter to ensure that the development of services for children outside of the directorate, are safe, effective, caring, responsive and well lead.

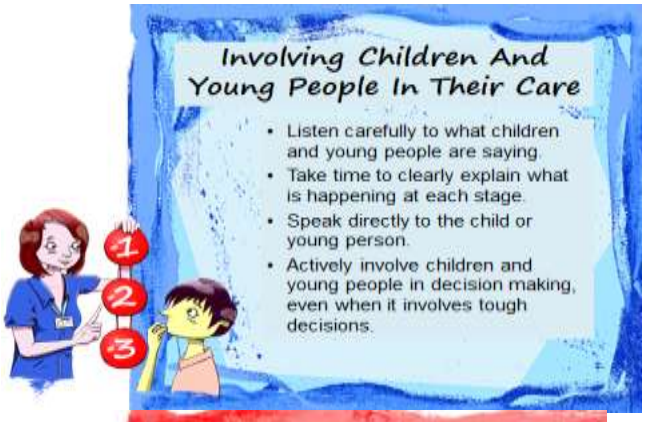
This will provide a strategy that ensures that the voice of this vulnerable and unique patient group is heard and that we are assured that high quality care is delivered and the developmental needs of CYP are considered across the whole trust.

What have we done?

Paediatric Champion Groups

To engage ED, radiology, theatres and adult outpatients into considering the needs of CYP, paediatric champion groups have been established in each area and each of these champion groups will work through the Hopes for Healthcare standards. The expectation is that these groups will help to raise the profile of, and be the voice for CYP. These groups will be supported by a senior paediatric registered nurse and a play therapist. The first meetings took place in June 2021, and it was proposed that these groups would feed into their department's quality of care meetings where CYP will be a set agenda item. As these groups and meetings become embedded and progress is made, the Heads of Nursing will feedback to directorate governance meetings every quarter on the action plans and progress made on delivery of the Hopes for Healthcare. The HDFT Youth Forum and CC directorate produced seven hopes that need to be embedded.





What are the results?

The Emergency Department and theatres have successfully established their champion groups with regular meetings, all groups have produced action plans to progress “Our Hopes for Healthcare”. Achievements through theatres include activity packs and distraction boxes created for the day unit and main theatres, extra DVD’s obtained, welcome banners, wall art in the children’s day unit, competency packs for staff updated with new access to training relating to children’s surgery delivered by the Yorkshire and Humberside Children’s Surgery network. Theatres have introduced a rotation process into paediatric day surgery unit for main theatre staff to increase experience caring for children. A communication tool of CLEAR has been introduced:

C Connect with child
L Listen to their problem
E Empathise with child and parent
A Answer any questions
R Review that they understand

In adult outpatients they have started to observe different clinic appointments to feedback areas of good practice for children and areas to improve on, they want to adapt the “Little Journey” app for children’s surgery to include journeys through outpatients. The Emergency Department has developed a paediatric study day which includes distraction techniques, fluid intake, common illnesses and pain management to increase colleague’s confidence and competency with children. They have increased resources for CYP regarding external services within the community, now have increased information leaflets supplied as a QR code and renovation ideas with donated money to improve the environment. Radiology are planning to do similar with a new children’s waiting corner with wipe clean books and child friendly wall art. Reviewing appoint slots to bring children’s appointments together where ever possible.

Summary

During 2021-22, progress has been made in ensuring CYP seen in primarily adult services are provided with a high quality and developmentally appropriate service. There is still work to do and embed but the paediatric champion groups are progressing with their action plans for “Our Hopes for Healthcare”. Children are on the agenda at quality of care meetings in primarily adult areas, this priority is ongoing but will grow as the group’s progress through their action plans.

6. To enhance the service offered to our patients and colleagues with autism and autism spectrum disorders, by appointing an autism champion, embedding learning and training, and agreeing a Trust-wide approach.

What were we aiming to achieve?

To enhance the service offered to our patients and colleagues with autism and autism spectrum disorders, by appointing an autism champion, embedding learning and training, and agreeing a Trust-wide approach.

Autism is a lifelong neurodevelopmental condition characterised by difficulties in social interaction social communication and restricted/repetitive behaviours. Many people with autism also experiences sensory differences and hypersensitivities.

Although autism and learning disability can co-occur, they are distinct separately defined conditions. Many people with autism are capable of high levels of educational attainment, living independently and can be an asset to employers because of specific ways in which they see and interpret situations. Many autistic people prefer to view their autism as a difference rather than a disability and could find it pejorative or offensive if offered similar support to someone with a learning disability.

Many aspects of accessing health services are likely to be challenging for autistic people. These include

- being out of their ordinary routine
- being in an unfamiliar place
- talking to a new person
- background noise from other people nearby or the surrounding environment
- uncomfortable sensory experiences such as sounds, textures and smells

In addition to the above an autistic person is likely to find it harder to follow advice or recommendations given by health professionals unless it clearly makes sense to their own frame of reference. An autistic person may have a pragmatic or overly literal interpretation of advice or may feel that they need any advice to be backed up by a comprehensive scientific justification.

The prevalence of autism continues to increase as more becomes known about what autism is. The current estimated prevalence of autism in England 1.76%.

Type of contact	Total number of patient contacts with HDFT services	Estimated number of HDFT contacts with autistic people
Hospital elective day cases	27691	487
Hospital elective inpatients	2297	40
Hospital non-elective inpatients	22486	396
Outpatient appointments	278304	4898
TOTAL	330778	5821

That's approximately 7600 clinical contacts a year where somebody with autism might benefit from additional support in accessing their healthcare and there may be more people who are not attending for their healthcare appointments if they do not feel adequately supported to do so in a way that they don't find distressing.

Many people with autism in situations of intense stress experience what is described as a "meltdown" this is a type of emotional dis-regulation which may take the form of shouting throwing things or acting aggressively towards other people. Such behaviour is not a choice and is best interpreted as an anxiety-based reaction to an overwhelming situation.

Autism can make social contact more challenging and it therefore may be harder for autistic people who have had an adverse experience of healthcare to report it or ask for things to be done differently

Steps that must be taken to meet the needs of people with autism were outlined by NHSE/I in 2018 in 'The learning disability improvement standards for NHS trusts'. These standards are underpinned by the Equality Act (2010) and the Autism Act (2009).

Comments made by patients with autism accessing HDFT services include:

'In the past, health professionals have got angry with me. They says things, like "Why can't you just settle down and go to sleep"? "What is wrong with you now?"'

'Inside the hospital because of the texture, and smell of cold toast, I rather go hungry than eat?'.

'The constant chattering, of everyone on the ward, make me irritated, and then I get very confused. Then if someone is then trying to talk to me, I cannot focus on their voice. Health Professions, don't understand this? They can say things like "are you listening to me". Which in turn makes me even more anxious'.

'I am not always able, to speak for myself and can go completely none verbal, only able to speak one or two words or not at all. When I'm not well, or if I get very upset/ anxious or have a meltdown.'

'My whole body hypersensitivity to touch I struggle to be touched. Want to run away at the thought of having my blood taken, or a cannula being put in place'.

'My pray/wish, now, it never happens to another young person, to feel so abandoned and alone? hopefully, this could have, been prevented if there was an autism nurse inside Harrogate District Hospital if I had a question? I wish there had been someone to ask. As I sit here, writing this, with tears running down my check. You will never have any idea, and understand how hard it is'.

Work has continued in year to develop our support for service uses. The focus has been on assisting in patient choice and improving the environment for people as much as possible. Work has continued with the local authorities to assess and support service uses. Learning disability and autism training has been developed and roll out has begun. This will continue into 2022-23. This training will be mandated and the details of the national packages remain under evaluation. Tier 1 training will be required for the entire workforce and might be achieved through an e-learning package. Tier 2 training will be required for staff with responsibility for providing care for people with a learning disability or autism. It is likely that this training will be required for all registered nurses, doctors and AHPs and be delivered by a minimum of 1 day face-to-face training.

2.3 Statements of assurance from the Board

1. Provision of relevant health services and income

During 2020/21 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 2020/21 represents 99% of the total income generated from the provision of relevant health services by HDFT for 2020/21.

2. National Audits

During 2021/22, 35 national clinical audits and 2 national confidential enquiries and clinical outcome review programmes (3 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 28 mandatory audit programmes on the National Clinical Audit and Patient Outcome Programme (NCAPOP), 23 of which were relevant to HDFT; 21 of which remained active and open to submissions during the Covid-19 pandemic. The trust participated in 20 (95%) of the open NCAPOP programmes which it was eligible to participate in.

There were also 21 non-NCAPOP audits listed, 14 of which were relevant to HDFT; all of which remained active and open to submissions during the Covid-19 pandemic. The trust participated in 13 (93%) of open non-NCAPOP programmes which it was eligible to do so.

The national clinical audits and national confidential enquiries that HDFT was eligible to participate in during 2021/22 are as follows:

1. Case Mix Programme (CMP)
2. *Child Health Clinical Outcome Review Programme:*
    - *Transition from child to adult health services*
3. Chronic Kidney Disease Registry (previously listed under UK Renal Registry)
4. Elective Surgery (National PROMs Programme)
5. Emergency Medicine QIPs (Did not participate)
    - *Pain in Children (care in Emergency Departments)*
    - *Severe sepsis and septic shock (care in Emergency Departments)*
6. Falls and Fragility Fracture Audit Programme (FFFAP)
    - FFFAP b. National Audit of Inpatient Falls
    - FFFAP c. National Hip Fracture Database
7. Inflammatory Bowel Disease (IBD) Audit
8. LeDeR - Learning Disabilities Mortality Review
9. Maternal, Newborn and Infant Clinical Outcome Review Programme
    - Perinatal confidential enquiries
    - Perinatal mortality surveillance
    - Maternal mortality surveillance and confidential enquiry
10. Medical and Surgical Clinical Outcome Review Programme
    - Crohns disease - Medical and Surgical Clinical Outcome Review Programme
    - Epilepsy study - Medical and Surgical Clinical Outcome Review Programme
11. National Adult Diabetes Audit (NDA)
    - National Diabetes Core Audit ,
    - National Pregnancy in Diabetes Audit
    - National Diabetes Footcare Audit
    - National Inpatient Diabetes Audit including National Diabetes In-patient Audit – Harms
12. 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)

13. National Audit of Breast Cancer in Older People (NABCOP)
14. National Audit of Cardiac Rehabilitation
15. National Audit of Care at the End of Life (NACEL)
16. National Audit of Dementia (NAD)
    - NAD - Care in general hospitals (Postponed)
17. National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)
18. National Cardiac Arrest Audit (NCAA)
19. 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
20. National Child Mortality Database (NCMD)
21. National Comparative Audit of Blood Transfusion
    - 2021 Audit of Blood Transfusion against NICE Guidelines
    - 2021 Audit of the perioperative management of anaemia in children undergoing elective surgery *(postponed)*
22. National Early Inflammatory Arthritis Audit (NEIAA)
23. National Emergency Laparotomy Audit (NELA)
24. National Gastro-intestinal Cancer Audit Programme (GICAP)
    - National Oesophago-Gastric Cancer Audit (NOGCA)
    - National Bowel Cancer Audit (NBOCA)
25. National Joint Registry
26. National Lung Cancer Audit Programme
27. National Maternity and Perinatal Audit (NMPA)
28. National Neonatal Audit Programme (NNAP)
29. National Paediatric Diabetes Audit (NPDA)
30. National Perinatal Mortality Review Tool
31. National Prostate Cancer Audit (NPCA)
32. Respiratory Audits
    - National Outpatient Management of Pulmonary Embolisms Audit
    - National Smoking Cessation Audit
33. Sentinel Stroke National Audit Programme (SSNAP)
34. Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
35. Society for Acute Medicine Benchmarking Audit
36. Transurethral REsection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery.
37. Trauma Audit & Research Network

Full details can be found at Annex 8

The national clinical audits and national confidential enquiries that HDFT participated in and for which data collection was completed during 2020/21 are as follows:

1. Case Mix Programme (CMP)
2. Chronic Kidney Disease Registry (previously listed under UK Renal Registry)
3. Elective Surgery (National PROMs Programme)
4. Falls and Fragility Fracture Audit Programme (FFFAP)

5. Inflammatory Bowel Disease (IBD) Audit
6. LeDeR - Learning Disabilities Mortality Review
7. Maternal, Newborn and Infant Clinical Outcome Review Programme
8. Medical and Surgical Clinical Outcome Review Programme
9. National Adult Diabetes Audit (NDA)
10. National Asthma and COPD Audit Programme (NACAP)
11. National Audit of Breast Cancer in Older People (NABCOP)
12. National Audit of Cardiac Rehabilitation
13. National Audit of Care at the End of Life (NACEL)
14. National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)
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18. National Comparative Audit of Blood Transfusion
19. National Early Inflammatory Arthritis Audit (NEIAA)
20. National Emergency Laparotomy Audit (NELA)
21. National Gastro-intestinal Cancer Audit Programme (GICAP)
22. National Joint Registry
23. National Lung Cancer Audit Programme
24. National Maternity and Perinatal Audit (NMPA)
25. National Neonatal Audit Programme (NNAP)
26. National Paediatric Diabetes Audit (NPDA)
27. National Perinatal Mortality Review Tool
28. National Prostate Cancer Audit (NPCA)
29. Respiratory Audits
30. Sentinel Stroke National Audit Programme (SSNAP)
31. Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
32. Society for Acute Medicine Benchmarking Audit
33. Trauma Audit & Research Network

The national clinical audits and national confidential enquiries that HDFT participated in, and for which data collection was completed during 2021/22 are listed at Annex 3, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

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

During 2021/22 a joint audit programme between the Clinical Effectiveness Department and Internal Audit was in place, as per previous years, which focused on the high priority areas for the Trust in order to provide assurance through the governance structure. This ensured there was no duplication of work and that resources were used more efficiently. Joint audit planning has been undertaken again in preparation for 2022/23.

The following 6 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 Vascular Registry

5. Neurosurgical National Audit Programme
6. 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
- National Audit of Dementia - Spotlight audit in memory services
- 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

Please note that the National Audit of Dementia and the Child Health Clinical Outcome Review Programme which were all included in the NHS England Quality Accounts List 2021/22 did not have data collection during the 2021/22 financial year and therefore we are unable to report on participation.

Local Audit 1: Re-audit of the Usage of the Daily Dental Huddle

Background

In 2013 the NHS improvement academy started to develop the 'Huddle Up for Safer Healthcare' (HUSH) project. This demonstrated that a daily safety huddle within a healthcare setting enhances teamwork through co-operative problem solving and communication, ensures focus and shared understanding of the day's priorities, improves the team's situational awareness of safety concerns and significantly reduces the chance of patient harm.

In 2019, working alongside the NHS improvement academy and the HUSH team, the concept of a 'Daily Dental Huddle' was introduced across the whole HDFT Community Dental Service following a successful pilot within Malton Community Dental Department.

The overall aim of implementing the 'Daily Dental Huddle' was to:

- Improve teamwork, communication and safety culture
- Improve patient safety

A 'Daily Dental Huddle' proforma was developed for guidance and management support given to allow 15 minutes of protected clinical time to ensure the huddle could be completed every morning (when patient care was being delivered in clinic that day). Huddle champions were identified to help to facilitate the huddle implementation within all 12 North Yorkshire Community Dental Service clinics.

In 2020, a few months after the daily huddle had been implemented, a clinical audit was completed to audit the usage of the huddle. Results showed that on average when a clinic was delivering patient care, the Daily Dental Huddle was being used 77% of the time. However, this range varied widely between clinics from 25% to 100%.

Following a service evaluation and huddle re-design, a re-audit was carried out in 2021 to ascertain if utilization had increased.

Re-audit results

Clinic number	Huddle proforma completed/expected level of performance	Re-audit performance (%)	Audit performance (%)	Percentage shift (%)
1	19/20	95%	71%	↑ (24)
2	26/26	100%	95%	↑ (5)
3	15/25	60%	44%	↑ (16)
4	12/12	100%	80%	↑ (20)
5	29/29	100%	90%	↑ (10)
6	9/9	100%	75%	↑ (25)
7	24/24	100%	56%	↑ (44)
8	31/32	97%	89%	↑ (8)

9	8/8	100%	25%	↑ (75)
10	24/25	96%	100%	↓ (-4)
11	6/6	100%	100%	- (0)
12	36/36	100%	97%	↑ (3)

Key Successes

- A huddle was held on 96% of possible occasions (an increase of 19% from the original audit)
- Eight clinics performed a huddle on every possible occasion (an increase of five from the original audit
- It was encouraging to see that the huddle had been led by a mix of staff roles; particularly admin colleagues as staff feedback following the original audit found that admin staff had felt less engaged

Key Concerns

- One clinic continued to show results which were significantly lower than the other eleven clinics; although here had been an improvement from the original audit results.

Future Improvement and Action Plan

- The results of the re-audit were shared with the whole dental service at a peer-review meeting in September 2021.
- The Locality Manager and Clinical Lead are considering how to implement strategies to increase compliance at clinic 3 whose results fell below the expected level of performance
- The huddle project leads continue to liaise with the huddle champions across the service
- The huddle proforma content will be reviewed to ensure that it is fit for purpose
- Further re-audit will be undertaken if there is a perception that engagement with the huddle is waning.

Local Audit 2: Hypokalaemia audit – adherence to HDFT guidelines

Hypokalaemia is a common diagnosis in hospital inpatients and inadequate management can potentially lead to fatal complications such as cardiac arrhythmias. As such, appropriate monitoring and prompt action are vital.

There was anecdotal evidence that patients at HDFT were being left on potassium replacement with inadequate monitoring and a group of junior doctors decided to investigate by carrying out a service evaluation, with a series of audits and interventions. The aim of their project was to assess adherence to HDFT hypokalaemia guidelines, identify areas for improvement and implement recommendations.

Initial findings in September 2020 demonstrated that adherence to the guidance was lower than would be expected, and they embarked on an education programme. This included a Microsoft Teams teaching session as part of the scheduled programme for foundation trainees at the Trust, as well as development of an educational poster which was displayed

in clinical areas and urged clinicians to stop and check they were following the guidelines prior to prescribing potassium.

A further audit was carried out in February 2021, which showed compliance had improved, but there were still issues, particularly in relation to dose frequency.

The team then looked to address this and implemented an Electronic Prescribing and Medicines Administration (EPMA) protocol designed to guide prescriptions of potassium. This protocol was designed by the authors and implemented by the lead pharmacist to ensure potassium could be prescribed with the correct frequency and dose in correspondence to potassium level. A prompt was added for the prescriber to set a duration of treatment before finalising the prescription. This was rolled out across the Trust.

A final audit was carried out in September 2021 to assess the impact of both the education and protocol. This demonstrated adherence to the guidelines had increased although there was still room for improvement in a number of areas. The team developed a detailed action plan to ensure the recommendations they identified were clearly set out, improvements put in place and learning embedded.

The project was nominated for the new Exemplary Audit of the Quarter Award, which was established to highlight good practice in carrying out quality improvement projects. Following a rigorous scoring process endorsed up by the Clinical Effectiveness Forum, the Hypokalaemia audit scored very highly and was declared the winner for:

- Clearly setting out the aims and objectives of the project with well-defined criteria, clear recommendations and an action plan that related directly to the findings and key concerns.
- Being comprehensive and well-written, using jargon free language with a range of charts that helped clearly to show the results
- Identifying a middle grade doctor and Consultant to take responsibility for implementing the improvements after they were rotated out of HDFT to other Trusts, GP surgeries and in one case, another country.

The actions the team identified are being implemented and a re-audit is planned for October 2022 to measure improvements.

3. Participation in Clinical Research

This section highlights our research activity across the Trust, 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.

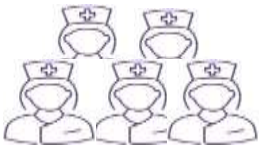
It is well recognised that NHS organisations partaking in research deliver better care and outcomes for their patients and access to research attracts and retains highly qualified and competent staff. The Trust is fully committed to making sure that everyone has the chance to take part in research and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

Between April 2021 and March 2022, the Trust had 95 clinical trials or studies 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. 76 clinicians supported by 31 research delivery staff led these studies.
The number of patients receiving relevant health services by HDFT in 2021/22, who were recruited to participate in research was 1593. This included 782 recruited into NIHR portfolio research 'urgent public health studies' related to the Covid pandemic. HDFT contributed significantly to the national research trial 'RECOVERY' by recruiting over 10 % of all Covid patients admitted to HDFT into this study.

1593
Participants recruited

6
Recruited to Urgent Public Health studies relating to the Covid pandemic

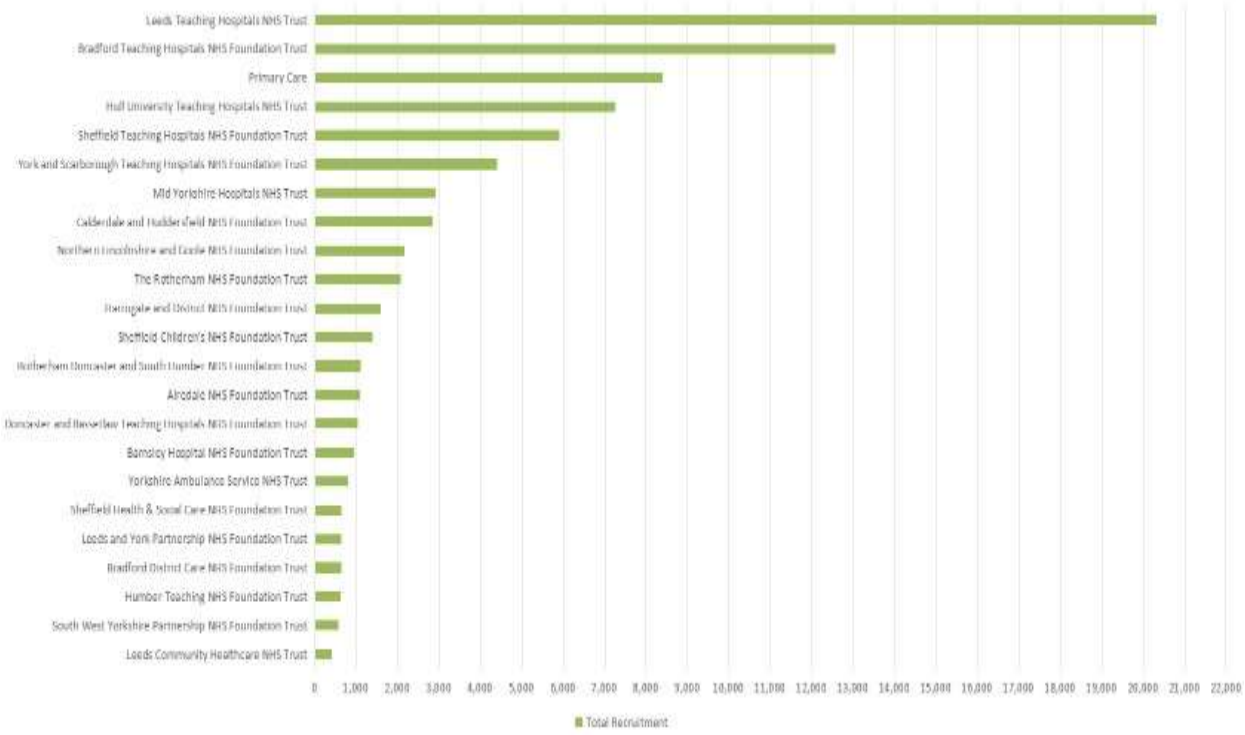
RESEARCH ACTIVITY HARROGATE HOSPITAL



76 Clinicians participated in recruitment

31
Research staff supported recruitment

The trust is an active member of the Yorkshire and Humber Clinical Research Network and contributed to the overall recruitment for the regional network as the 11th most active trust of the partner organisations. (See graph below) .



<u>Research Governance and Good Clinical Practice</u>.
The research department continues to ensure that all research conducted at The Trust 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 2021/22 and an external audit has been conducted. This audit identified a high level of compliance with all required standards. Areas for improvement were suggested including additional storage space for archived research materials and additional dedicated space to deliver and grow research. Both these aspects are being addressed.

All research staff continue to achieve competence in research through experience, competency framework standards, Good Clinical Practice (GCP) and the Trust mandatory training programme. A newly appointed R&I manager and research matron during this year has reviewed areas for staff development and training and is supporting a trust wide approach of continuous learning. The research matron is participating in a national group project to look at and compile new nurse competencies for research, including those for matrons.

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 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 Clinical Effectiveness forum also reviews safety and governance issues for research and looks at emerging issues across all three quality assurance areas. Issues can be escalated and reported from this group into the Medical Director's report to the Board.

HDFT research in the wider context

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 the Trust have forged and continue with successful working relationships with our primary care providers (GPs, GP confederations, Clinical Commissioning Groups (ICS) and third parties), to increase the opportunities for communities to be involved in health research. This year our aim is to significantly grow research in our community and forge more partnership and collaborations with our social care and public health providers. We have secured funding recently and appointed new staff to lead this initiative. As a consequence, allied health professionals working in our trust are increasing becoming 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.

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).

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.

Summary

In summary, despite the challenges of conducting research during the pandemic when resources were diverted elsewhere or focused on urgent public health studies, 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 reviewed and implemented robust key quality and safety assurance measures to continue research safety. Newly established staff training and development programmes will also ensure anyone working in the trust involved in research will understand, comply with, and lead research effectively.

The department has ambitions to grow significantly over the forthcoming year and work towards being able to be self-funding through the development of further commercial research and collaborations with local providers. The research strategy will align 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.

4. Use of the Commissioning for Quality and Innovation Framework

HDFT income in 2020/21 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because of the changes to the approach to contracting through the Covid-19 response.

5. Registration with the Care Quality Commission

The Trust is required to register with the Care Quality Commission and its current registration status is unconditional. The Trust had the following sites registered during 2021/22:

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

The Care Quality Commission has not taken enforcement action against the Trust during 2021/22. The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

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

The overall rating remains good for the Trust, good for acute services and outstanding for community services.

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

Table 5: CQC ratings for HDFT March 2019 * Services inspected in 2018

6. Information on the Quality of Data

The Trust submitted records during 2021/22 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

https://hscic365.sharepoint.com/sites/SUSDataQualityDashboardsAndReports/SUSDashboards/default.aspx

The percentage of records in the published data:

Which included the patient's valid NHS number was:

- 99.9% for admitted patient care;
- 100.0% for outpatient care;
- 99.5% 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.

7. Information Governance

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 to the 30th June. The levels of assurance are:

- Standards met
- Standards exceeded

The results of the 2020-21 year submission was: Standards Met

During 2020-21 NHS Digital commissioned an audit of 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 Moderate

A number of the standards are audited each year by Internal Audit.

8. Payment by Results

The Trust was subject to the Payment by Results clinical coding audit during 2021/22 by the Audit Commission.

The Trust commissioned an external Payment by Results clinical coding audit by D&A during 2021/22 and the accuracy rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnosis = 98.0%
- Secondary Diagnosis = 91.9%
- Primary Procedure = 96.2%
- Secondary Procedure = 93.9%

Results should not be extrapolated further than the actual sample audited. Specialties audited were Trauma & Orthopaedics, General Medicine and Obstetrics.

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).

9. Learning from Deaths

During 2021/22, 715 of The Trust inpatients died compared to 645 in 2020/2021. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 144 in the first quarter;
- 170 in the second quarter;
- 198 in the third quarter;
- 203 in the fourth quarter.

By 01/04/2022, 54 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:

- 14 in the first quarter;
- 16 in the second quarter;
- 10 in the third quarter;
- 14 in the fourth quarter.

- 1 case in the first quarter received poor care in the first 24 hours of admission but it did not contribute to the death.
- 1 case in the second quarter had poor note-keeping but it did not contribute to the death.
- 0 cases were identified in the third quarter where an aspect of care was poor.
- 1 case in the fourth quarter received poor care in the first 24 hours of admission which may have contributed to the death and was already being investigated as a Serious Incident. 1 (different) case in the fourth quarter had poor note-keeping but it did not contribute to the death.

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

In 2021/2022, 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.

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 sepsis
- The cause of death was pneumonia
- The cause of death was due to a stroke
- Deaths which occurred over a weekend

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:

- Processes in the Emergency Department have been modified to ensure regular oversight by senior staff
- 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
- Cases where there is learning for a specific department are discussed in their Quality and Governance meetings
- Cases where there is broader learning are discussed at our Learning Summit for broader sharing

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
- We are relaunching our Mortality Review Group where common themes and learning are identified

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.

2.4 Reporting against core indicators

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

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

Summary Hospital Mortality Index (SHMI)

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

SHMI (Summary Hospital Level Mortality Indicator)

	Data period	
	Dec 20 - Nov 21	**Jan 21 - Dec 21**
HDFT value	1.037	1.052
HDFT banding	2 (as expected)	2 (as expected)
National average	1.000	1.000
Highest value for any acute Trust	1.195	1.190
Lowest value for any acute Trust	0.716	0.713

Jan 21 to Dec 21 data due to be published 12/05/22

Note - highest and lowest trust scores include all providers with data published by IC
Note - figures for table 2 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 SHMI data is reviewed and signed off by the Medical Director.

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

- Actively using the Healthcare Evaluation Data tool that enables the Trust to clinically review and analyse mortality data in detail on an on-going basis. This has been rolled out across the organisation;
- Implementing the learning from deaths processes within the Trust and contributing to the national database using Datix mortality review tool. This methodology has been rolled out nationally across England and Scotland. It is an excepted methodology for

case note review and in line with recommendations in National Guidance on Learning from Deaths (National Quality Board March 2017). In addition to specialty specific case note reviews, focused reviews of situation specific deaths are undertaken as required;

- Individual specialty alerts are investigated as deemed appropriate, either through the mortality review process, coding anomalies or discharge processes or a combination of these. The overall Trust SHMI remains below expected levels.

Palliative care coding

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

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

	Data period	
	Dec 20 - Nov 21	Jan 21 - Dec 21
HDFT value	39	38
National average	39	39
Highest value for any acute Trust	64	64
Lowest value for any acute Trust	11	11

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

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

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

- Independent clinical coding audits are carried out on an annual basis by accredited clinical coding auditors to provide assurance of the accuracy of coded data;
- The data is reviewed and signed off on a quarterly basis by the Medical Director;
- This data originates from the clinical coding of specialist palliative care input by the Palliative Care Team (PCT) and is based on evidence documented in patient records;
- The PCT record all face-to-face and telephone contacts on an electronic patient system called SystmOne, whilst the clinical coders base their coding on information in the paper medical record. If there is telephone contact only, documentation in patients' paper medical records will be by the ward team, but may not always be recorded clearly as PCT input and therefore may be difficult for clinical coders to identify. Previously the Information Services team also extracted activity data from SystmOne for accurate submission of mortality data, but due to reduced capacity in the Information Services team, this did not happen for some months. This was resumed in May 2019;
- PCT clinical nurse specialist (CNS) staffing is 0.63 whole time equivalent (WTE) per 100 beds, well below the national average (mean 3.27, median 1.02) (National Audit of Care at the End of Life 2019);

- The 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 on Clinical Assessment Triage and Treatment (CATT), Granby, Jervaulx and Byland Wards, taking referrals and giving advice where necessary;
- Improving ease of access to the PCT, with all team members' now carrying mobile phones and taking phone referrals as well as electronic, written, or posted referrals.

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

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

PROMs – Patient Reported Outcome Measures

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

PROMs - Patient Reported Outcome Measures

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

	Data period		
	2018/19 (final)	**2019/20 (final)**	**2020/21 (final)**
HDFT value	0.433	0.448	0.483
National average	0.457	0.453	0.465
Highest value for any acute Trust	0.546	0.524	0.574
Lowest value for any acute Trust	0.348	0.372	0.393

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

	Data period		
	2018/19 (final)	**2019/20 (final)**	**2020/21 (final)**
HDFT value	0.366	0.342	0.329
National average	0.337	0.334	0.315
Highest value for any acute Trust	0.377	0.403	0.389
Lowest value for any acute Trust	0.262	0.221	0.181

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

2020/21 (final) data published by NHS Digital February 2022

Data source:

Patient Reported Outcome Measures (PROMs) - NHS Digital

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

- We have participated in the PROMs scheme since inception, routinely analysing and reviewing the results;

- The data is formed from pre- and post-operative patient surveys and therefore reflects patients' perception of the improvement in their health following surgery;
- The Trust considers the scores indicate it is not an outlier from the national position.

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

- Continuing to actively participate in the scheme, reviewing and analysing the results to ensure a clear understanding of the data to inform future programmes of work;
- Continuing to investigate any areas of below average health gain scores by sharing the patient-level data extract with the relevant department, in order that where there are worsening scores that this can be discussed with individual patients.
- Put in place a MDT on local and regional level to discuss problem or difficult cases.
- Actively looking at infections rates and the impact that covid may have had on increased infections
- Audit over the past 5 years has been undertaken to correlate infection rates for joint replacements and if Covid has had an impact on this

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.

Emergency readmissions within 30 days - HDFT (unstandardised) data

	2019/20	2020/21	2021/22
Total number of emergency readmissions within 30 days	4852	3328	4218
As a percentage of all emergency admissions	20.23%	16.98%	18.76%
Number of emergency readmissions within 30 days (Payment by Results exclusions applied)	3352	2445	2861
As a percentage of all emergency admissions	13.97%	12.48%	12.72%

Data source:
http://harrogatedata/Reports/Pages/Report.aspx?ItemPath=%2fFinance%2fEmergency+Readmissions

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

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

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

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

3. Ensuring that people have a positive experience of care

Inpatient survey – responsiveness to patients' personal needs

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

Inpatient survey - responsiveness to inpatients' personal needs

Average weighted score of 5 questions relating to responsiveness to inpatients' personal needs (Score out of 100)

	Data period		
	2018/19	**2019/20**	**2020/21**
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

Combined scores for 2021/22 due to be published by NHS Digital in mid-March 2023.

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

March 2022 – As of the 2020-21 survey, changes have been made to the wording of the 5 questions, as well as the corresponding scoring regime, which underpin the indictor. As a result, 2020-21 results are not comparable with those of previous years. Please refer to the specification document for further details of the changes.

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

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

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

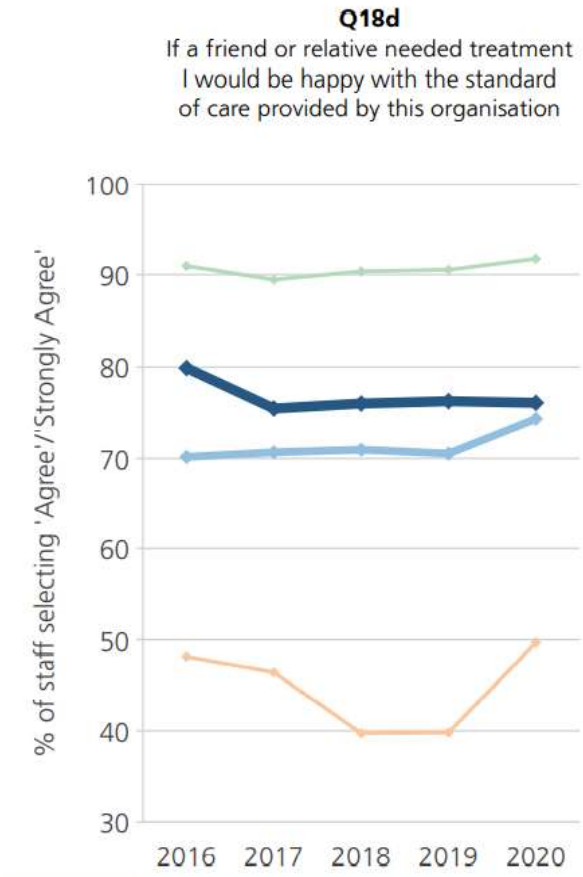
- Focusing resources on addressing those indicators which, following analysis of the 2018 result, identified areas to focus on which made the biggest impact to overall patient experience;

National Staff Survey – Standard of Care Provided

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

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

The data below shows the proportion of staff completing the NHS Staff Survey who responded "strongly agree" or "agree" to the question "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation" compared to the total number of staff that responded to the question.



	2016	2017	2018	2019	2020
Best	90.9%	89.4%	90.4%	90.5%	91.7%
Your org	79.9%	75.5%	76.0%	76.3%	76.1%
Average	70.2%	70.7%	71.0%	70.5%	74.3%
Worst	48.2%	46.4%	39.7%	39.8%	49.7%

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

Proportion of staff who responded "strongly agree" or "agree".

	Data period		
	2019	**2020**	**2021**
HDFT value	76	76	67
National average	71	74	68
Highest value for any acute Trust	90	92	89
Lowest value for any acute Trust	41	50	44

Note - this was Q21d in 2018 and 2019 and 2021 surveys (and Q18d in the 2020 survey) and is now worded:
If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.

Benchmark data includes both "acute trusts" and "combined acute and community trusts"
Note - nationally there has ben a dcline of over 6% in this question between 2020 and 2021
Data is unweighted.

Data source:
http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2016/

2021 data published Sep-21

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

- Providing high quality patient services and the provision of excellent care, every time is our priority
- Colleague advocacy for, and confidence in the care we deliver is a key indicator of engagement and there is direct correlation between employee engagement and patient outcomes. .

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

- Increased investment in colleague Health & Wellbeing support including the recruitment of a Clinical Psychologist to support colleague mental health and the deployment of a number of programmes and initiatives which line managers and all colleagues can access.
- A Board of Director led commitment to team HDFT becoming an Anti-Racist organisation, with a significant programme of work to support this scheduled.
- Commenced the At Our Best Culture Change programme, to ensure that there is a clear understanding and demonstration of the behaviours that we value, of Kindness, Integrity, Teamwork and Equality. A programme is underway to ensure that these behaviours are embedded in our processes and procedures and education, learning and development.
- Developed the Caring At our Best programme – which is in initial stages of implementation, to strengthen our care provision as detailed below:

Caring at Our Best: 3 Programme Objectives

Caring at Our Best

Deliver high quality care with collective responsibility for our patients...so that...

we work as one team and deliver outstanding patient experience.

Learning at Our Best

Create and embed a Continuous Learning & Improvement System...so that...

we learn from our mistakes and listen to our patients and staff.

Leading at Our Best

Define and embed new leadership standards, training and performance management...so that...

we identify quickly when standards slip and we hold ourselves to account.

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

Venous thromboembolism (VTE) risk assessment

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

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

	Data period							
	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22
HDFT value	94.56	95.85	96.89	97.30	96.62	96.27	96.73	96.04
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

Q3 2019/20 national data was published Mar-20. Collection has been suspended since then due to Covid-19

Data now archived by NHSE: https://webarchive.nationalarchives.gov.uk/20210401163623/https://www.england.nhs.uk/mat-transformation/venous-thromboembolism-vte-risk-assessment-201920/

The VTE data collection and publication remains suspended (as at Apr-22) to release capacity in providers and commissioner was communicated via this letter on 28th March 2020.

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

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

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

- Continuing to identify wards with poorer performance and examining whether there are issues with completion of the risk assessment or inputting of information onto iCS.

Clostridium difficile rates

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

C.diff - rate per 100,000 bed days of cases of hospital onset C.diff infection reported within the trust amongst patients aged 2 or over

	Data period		
	2018/19	**2019/20**	**2020/21**
HDFT value	19.07	22.84	25.73
National average	12.20	13.63	15.40
Highest value for any acute Trust	79.81	51.01	80.65
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

2021/22 data due for publication Sep-22?

Note - above is all hospital onset cases - in line with historical data. Also available now as separate data is "hopsital onset, hospital acquired" etc.

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).
- Over the course of this year, we have detected only one case of patient-to-patient transmission of *C.difficile.*
- 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:

	Apr 19 - Sep 19			Oct 19 - Mar 20			2020/21		
	Rate of incidents reported (per 1,000 bed days)	Incidents that resulted in severe harm or death		Rate of incidents reported (per 1,000 bed days)	Incidents that resulted in severe harm or death		Rate of incidents reported (per 1,000 bed days)	Incidents that resulted in severe harm or death	
		Number	Rate (per 1,000 bed days)		Number	Rate (per 1,000 bed days)		Number	Rate (per 1,000 bed days)
HDFT value	75.65	8	0.164	73.27	27	0.521	100.70	34	0.460
National position (all acute trusts)	48.68	2524	0.151	49.62	2536	0.150	57.33	6828	0.252
Highest value for any acute Trust	103.84	95	0.675	110.21	93	0.521	118.74	261	1.083
Lowest value for any acute Trust	26.29	0	0.000	15.69	0	0.000	27.18	4	0.033

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.

table 17: Patient safety incidents reported to the NRLS
**Please see explanation below*
Data source: https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports

3. REVIEW OF OTHER QUALITY PERFORMANCE

This section provides an overview of the quality of care offered by HDFT based on performance in 2021/22 against indicators selected by the Board of Directors in consultation with stakeholders, including three priorities for the three elements of quality covering patient safety, patient experience and effective care.

3.1 Patient Safety

1. Medicines Safety

Introduction

The Trust Medicines Quality and Safety Group aims to address all issues around medication associated risk to patients. It reviews all medication related incidents and assures compliance with key national standards such as NHSE/I Patient Safety Alerts involving medicines, MHRA drug alerts and CQC medicines management standards including safe storage and security of medicines and safer management of Controlled Drugs. Issues around medical gas associated risk to patients are addressed via the Trust Medical Gas Group.

What were we aiming to achieve?

The Trust aims to provide harm free care associated with the use of medicines. The aims of the medicines quality and safety strategy is to ensure and improve safety through policy, audit, education and learning from incidents and near miss events, and provide assurance against the regulatory CQC standards for medicines management, RPS Professional Standards for the Safe and Secure Handling of Medicines and Medical gases Health Technical Memorandum.

What have we done?

The Covid-19 pandemic continues to have a significant impact upon planned activities, as a result medicines safety initiatives have been adapted in response to the pandemic. Significant changes in leadership around the medicines quality and safety agenda has provided an opportunity to strengthen work in this area.

Medicines quality and safety initiatives have included:

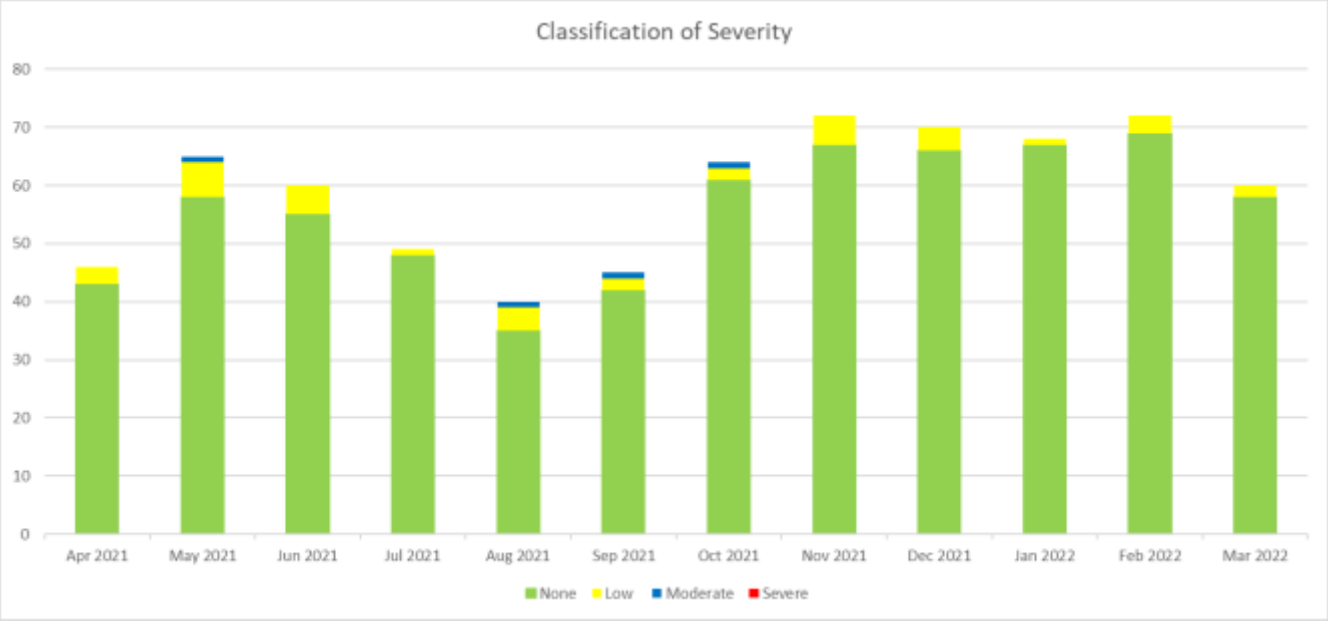
- Appointment of Lead Pharmacist – Medicines Quality and Safety who is the named Medication Safety Officer for the Trust;
- Clearly defined Medicines Quality and Safety Group work plan and audit programme;
- Updating the Medicines Policy and other associated policies linked to medicines safety;
- Continuing to review, report and learn from incidents relating to medicines use through the use of learning summaries and Medication Safety Bulletins;
- Insulin safety and oxygen prescribing Task and Finish Groups set-up to lead on the development and implementation of improvement initiatives;
- Embedding the use of dashboards to target patients on high risk medicines especially insulin and warfarin, and identify patients whose allergy status is not completed;
- Measure safe use of medicines against a range of metrics, including missed doses and event reporting rates;

- Implementing actions from new Patient Safety Alerts involving medicines and re-audited actions from previous Patient Safety Alerts;
- Completion of outstanding actions from CQC action plan relating to fridge temperature monitoring;
- Implement actions arising from the audit of safer handling of Controlled Drugs and provide additional supportive measures to those clinical areas with poor compliance;
- Implement actions arising from Internal audit – Medicines Management, safe storage and security;
- Development of an e-learning package and e-assessment for medicines management;
- Continued use of a critical medicines tracker to ensure robustness of the medicine supply chain during the Covid-19 pandemic;
- Optimise digital technology using ePMA (electronic Prescribing and Medicines Administration) to aid prioritisation of high risk patients;
- Implement actions arising from the Medical Gas Pipeline System Authorising Engineer Audit Report 2021;
- Lead on the medicines governance and safe delivery of the Covid-19 vaccination programme to all frontline health and social care staff, members of the public and 12-15 year olds.

What are the results?

Reporting and learning from medication safety incidents

There is a high ratio of no harm/low harm to moderate/severe harm incidents, indicating that the Trust has a good reporting culture and the level of harm associated with medication incidents remains low.



The main trends observed in 2021/22 were: allergy status not confirmed when prescribing or administering medicines, errors in insulin prescribing and administration, errors in oxygen prescribing and discrepancies in Controlled Drugs stock balances. In response to these trends improvement initiatives are being taken forward via the relevant task and finish

groups together with optimising the use of EPMA to reduce the risk of medication incidents and providing appropriate support to clinical areas from a learning and development perspective.

Audit programme

The audit programme has been re-designed to provide assurance against the regulatory CQC standards for medicines management, RPS Professional Standards for the Safe and Secure Handling of Medicines and Medical gases Health Technical Memorandum.

Audit	**Frequency**
Safer handling of Controlled Drugs	Quarterly
Controlled Drugs Occurrence Report	Quarterly
Internal Audit – Medicines Management (2020/21)	Alternate years
Internal Audit – Controlled Drugs (2021/22)	Alternate years
Oxygen prescribing	Six-monthly
Audit of the Medical Gas Pipeline System	Annual
Antimicrobial audits	Various
Any audit as a result of a medicine Serious Incident investigation action plan	Ad-hoc
Any audit as a result of a National Patient Safety Alert concerning medicines	Ad-hoc
Safe and secure storage of medicines	Six-monthly (under development)
Delayed and omitted doses of critical medicines	To be confirmed (under development)
Safer use of injectables	Annual (under development)
Any re-audit as a result of a National Patient Safety Alert concerning medicines	One per quarter (under development

Safer handling of Controlled Drugs

The audit template and reporting structure has been revised following consultation with clinical areas, with a view to providing audit results and recommendations which are more helpful for Ward Managers and Matrons.

The main trend identified across all directorates is the standard of record keeping and amendments to entries. This is being addressed with appropriate supportive measures and actions plans for those areas with poor compliance.

Discrepancies in balances of codeine have been identified in the Emergency Department. These discrepancies have been fully investigated and are due to poor housekeeping regarding the use of the Omnicell automated medicine cabinets. The risk of this is being mitigated by managing codeine as a full Schedule 2 Controlled Drug in the Emergency Department and increasing training support on how to use to Omnicell cabinets correctly.

Internal audit of Medicines management – safe storage and security of medicines
An Internal Audit of Medicines Management was conducted in Quarter 4 of 2020/21. Overall the audit provided "Significant" assurance that an effective control framework was in place for safe and secure management of medicines. However, the audit did find some areas of non-compliance with Trust policy in relation to the security and storage of medicines in clinical areas. All audit actions are either complete or on track with their completion dates.

Oxygen prescribing audit
The oxygen prescribing audit was undertaken in October 2021 and March 2022. Whilst there has been an improvement in the percentage of patients being prescribed oxygen, there has been a deterioration in the percentage of patients achieving target oxygen saturations. Quality improvement initiatives are being taken forward via the oxygen prescribing sub-group and include educational support on the prescribing, administering and weaning of oxygen and further optimisation of EPMA to improve prescribing. Face to face training has been delivered in the short-term, however the intention is to develop an e-learning and e-assessment package.

Audit of the medical gas pipeline system
The Trust undergo an external audit of their medical gas pipeline system. There were no high risk actions identified. There has been significant progress with the action plan, and all immediate safety concerns have been addressed. All remaining audit actions are low risk and in progress; none of the outstanding actions pose any clinical risk.

Medicines management training
Medicines management training sessions have historically been delivered via face to face sessions. During the Covid-19 pandemic all face to face training was suspended, this resulted in a significant drop in mandatory training compliance to approximately 40%. Even though face to face training has resumed, training capacity has been reduced due to the need for social distancing. Operational pressures make it challenging for clinical staff to access training that is only available as face to face. In response to this, medicines management training is available as a virtual face to face to increase capacity in each training session, and an e-learning and e-assessment package is near completion to improve access to training. This has provided an opportunity to refresh the content of the training to make it more relevant and up to date. The training covers the core aspects of medicines management: safe storage and security, prescribing and administration, discharge process, high risk medicines and Controlled drugs. We envisage that the refreshed content and availability of e-learning will help improve compliance rates and also reduce the incidence of medication errors associated with prescribing and administration.

Summary
The medicines safety agenda continues to make significant progress around providing assurance against the regulatory CQC standards for medicines management, RPS Professional Standards for the Safe and Secure Handling of Medicines and Medical gases Health Technical Memorandum.

There has been a conscious focus on learning from medication incidents and designing improvement initiatives around trends reported. It is probably too early to comment on the

effectiveness of these interventions, however there is a maturing culture of learning from incidents.

There is further work to be undertaken regarding audits of medicines safe storage and security and delayed and omitted doses of critical medicines. There is further work to be undertaken to update the Medicines Policy to ensure safe medicines management practice in clinical areas using automated medicine cabinets as part of the Scan 4 Safety programme.

With improved visibility of evidence of assurance around medicines safety, the Trust are in a better position to understand the level of medicines safety risk and identify appropriate actions to mitigate these risks.

Supporting a safety culture around the use of medicines is a key component of the Medicines Optimisation and Pharmacy Services Strategy 2021-24. The priorities for the coming year will be: disseminating learning from medication incidents, optimising digital technology to improve medicines safety, improving compliance with medicines management mandatory training, developing e-learning and e-assessment packages for the safe use of medical gases and providing greater assurance around CQC standards for medicines.

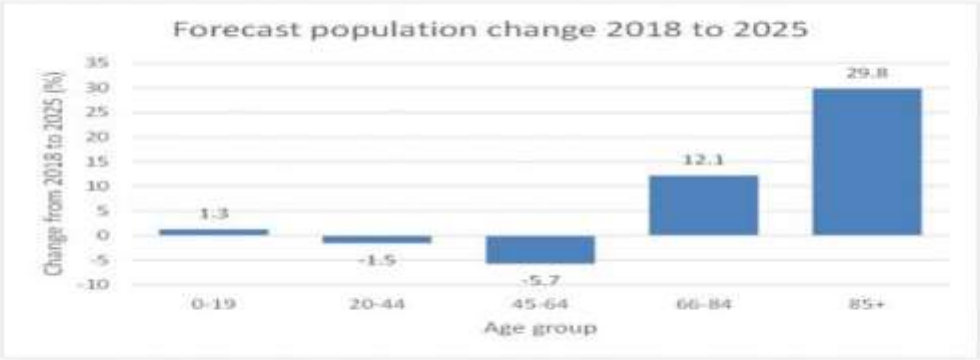
2. Falls

Introduction

A fall is defined as an event which causes a person to, unintentionally, rest on the ground or lower level, and is not a result of a major intrinsic event (such as a stroke) or overwhelming hazard (Falls: Applying All Our Health 31 January 2020.)

In 2018, Public Health England projected a 42% increase in the number of adults aged over 65 years in North Yorkshire by 2025. See Bar Chart 1. (Public Health England 2018.)
In 2019 there were more than 600,000 people aged 90 years living in the UK, with twice as many women as men aged 90 years and over. (Office for National Statistics; Estimates of the very old, including centenarians, UK: 2002 to 2019). Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. (NICE CG 161.)

Bar Chart 1. Population/Demographic for North Yorkshire from 2018 to 2025.



A high proportion of Harrogate's older demographic reflects these trends, where affluence, a healthy lifestyle, it's appeal as a retirement location have contributed to a cohort of the older population who may be supported at home, living with frailty, and only admitted into hospital when a major event occurs such as a fall or an acute illness. On admission assessment by a geriatrician often confirms a patient's complex medical presentation and the need for enhanced care.

"Falls are the most frequently reported incident affecting hospital inpatients, with 247,000 falls occurring in inpatient settings each year in England alone. Reported falls among older patients are more likely to result in some degree of harm and, where harm does occur, it is three times more likely to be severe. One such severe harm is hip fracture. It is the commonest reason for emergency surgery and injury related death in older people. Over 2000 people over the age of 60 fell and fractured their hip while staying in hospital in England and Wales in 2020." (National Audit of Inpatient Falls (NAIF) 2020 Audit Report).

Inpatient falls are costly, even where life-changing injuries are not sustained. Such events lead to increased length of stay, loss of confidence, restriction of physical activity, functional impairment, diminished independence and an increased risk of further falls. All of which affect patients' quality of life.

The evidence as to the best way to prevent inpatient falls is not yet conclusive. However, current best practice in the NICE clinical guideline *Falls in older people: assessing risk and prevention* (CG161) calls for an individualised multi-factorial falls risk assessment (MFRA) for all inpatients aged over 65yrs (and in those aged 50–64yrs who are clinically judged to be at risk) leading to interventions tailored to address identified risk factors." HDFT works throughout each year to improve fall prevention and post fall care through audit, learning from complaints and harmful events and quality improvement. This report will summarise our work throughout 2020/21.

The reasons why people fall often is a complex interplay between functional decline, medical decline, social factors and the environment, making fall prevention a clinical matter not just a safety issue. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years. One definition of Frailty is:

'A distinctive health state related to the aging process in which multiple body systems gradually lose their in-built reserves.' (British Geriatric Society. 2014).

Many older people live with frailty, the Rockwood Frailty Scale (RFS) is a measure used to describe a person's ability to complete daily living activities and it is being adopted across the trust at the point of admission and in community. Living with Frailty often means you are more likely to have or be at risk of: falls, reduced mobility, delirium/ dementia, incontinence, susceptibility to side effects of medication, nutritional needs and visual impairment.

During the 2 years of the Covid19 pandemic, a national increase in the number of falls has been observed in both hospitals and in community, as some older people became deconditioned due to decreased levels of activity or through illness less and this has affected their general levels of mobility, balance and stability.

What were we aiming to achieve?

At the start of 2021/22 our aim in hospital and community was to improve fall prevention and post fall care using audit and quality improvement.
In 2019/20 HDFT was able to report a 50% decrease in inpatient falls resulting in a hip fracture and 25% decrease in harmful falls. Our ambition was to build on this success.

In 2020/21, we reported an increase of 1.46 in the rate of inpatient falls per 1000 bed days when compared to the previous year as the trust responded to Covid19 pressures. This figure reflected an increase in: multiple falls experienced by a small number of inpatients, unwitnessed falls, use of side rooms to isolate patients, unassisted mobilisation, the number of older patients with enhanced needs, the break-up of traditional ward teams with specific skill sets and an absence of inpatient visitors.

What have we done?

Key changes in community settings.
In 2021/22 HDFTs response to national directives relating to decreasing hospital admissions and providing a "Home First" care strategy led to the formation of a large multi-disciplined ARCHs Team (Acute Response & Rehabilitation in Community and Hospital settings). They work closely with our SDEC (Same Day Emergency Care) team, the ED (Emergency Department) and a focused patient Supportive Discharge Team (SDS). These teams work across traditional care divide borders and inform GPs, frailty clinics, community complex falls multidisciplinary team and community based organisations working towards providing an integrated network of support to enable people to collaborate with care providers and remain as independent at home for as long as safely possible. E.g. Sight Support Service or Brimhams Active Health.

Key changes in Hospital settings
HDFT's response to the admission and care of people throughout the pandemic was agile due to the size of the organisation. The key changes related to repurposing and reorganisation ward settings along with their traditional and expert teams. The number of patients admitted to each ward reduced and those patients admitted with Covid19 were cared for in specific receiving wards where patients were placed in side-rooms whilst tests were completed. A negative or positive Covid19 test and the availability of a hospital bed determined a patient's location within the hospital.

Safety Huddles
Some wards, despite disruptions throughout the Covid 19 pandemic, have maintained a daily safety huddle and found that this was a useful point during the day to regroup, identify patients at risk, introduce new staff members, check the team's status and update the team quickly. Other wards have found the introduction difficult due to operational issues.

As waits have increased for patients within ED they have started a new safety huddle to address the needs of those patients experiencing an extended stay of over 6 hours. Those patients who needed extra supervision or help with mobility were provided with a pair of yellow socks as identification. The huddle is well led and continues to address issues associated with potential falls and reported a run of 20 days with no reported falls in the first month.

Home First
Emergency Department (ED) team has worked closely with the Supported Discharge Service (SDS) throughout 2020/21, as SDS have managed increased numbers of patients who would have been at high risk of inpatient falls within the community using a "Home First " approach. Together they have been successful in reducing the length of time spent in hospital for some of those patients who were at risk of falls.

Community Complex Falls MDT Clinics and Rapid Access Frailty clinics
Frailty and geriatric medicine clinics restarted in May 2020 to include remote consultation, where appropriate, as people were advised not to attend hospital appointments in person. A new community Complex Falls multidisciplinary team (MDT) clinic started in December 2020, and included face-to-face appointments with a geriatrician and a remote MDT; this was in recognition that community teams had complex patients who needed medical falls assessments combined with a MDT review. These referrals are made via community falls teams/MDT who have already been managing these patients, but conclude there may be additional risk factors relating to falls which have not been addressed or need medical

assessment. Although feedback was good initially the numbers of referrals have reduced since Dec 2021 and the MDT clinic will not be continuing but ARCHs will continue to be able to access rapid access frailty clinics.

Patients who fall in community are often referred to ARCHs via a Single Point of Access for a falls review that often includes home/environmental and strength and balance assessments. If a further medical assessment is required older patients can be referred onto specialist clinics: rapid access frailty, geriatrics, polypharmacy, continence, Parkinson's, Dizzy clinic York, syncope clinics (cardiology).

Community Guidance Pathway

In response to teams working in different ways in community we have co-developed a falls guidance pathway, providing a range of recommendations around actions and referrals that could enhance the care and management of older people in community who have experience a fall or who are unsteady. The guidance is written to include GPs, ED, Yorkshire Ambulance Service and AHPs in community. It will be available on HDFT intranet 2022.

Fall Prevention Training

Following recommendations made by the NAIF 2020 the trust completed a Training Needs Analysis to include any member of staff who engaged with older people aged over 65 this included more staff in community based settings and increased the training cohort by 40% to a total of 1100 people who could complete Fall prevention Training. The training was also designated as "mandatory" rather than "essential". A generic ELearning package is available throughout the year, however dedicated face to face and Teams fall prevention & huddle sessions were restarted through February to April to address training needs of care support workers, Allied Health Professionals and medical and nursing staff. In May 2021, a targeted community training session to support the newly formed ARCHs team was delivered by the Fall Prevention Lead and the Podiatry Team.

A similar session was provided across the whole community for all podiatrists during a dedicated Falls Awareness Week that ran in September 2021 as well as 10 sessions delivered by Teams or face to face where over 120 staff members attended.

A 2 hour Falls prevention & Safety Huddle training has been included in a newly developed Care Support Workers induction programme, which has been very well received, attendance at this session provides confirmation of the mandatory training that lasts 3 years. A similar programme is provided during the induction of all preceptor nurses in HDFT.

Links with Sunderland University/New College Durham were maintained as a second cohort of 3rd year podiatry students attended a Teams presentation on Fall Prevention in older people and Frailty

Falls Awareness Week

This was well supported by a team of newly appointed Practice Educators who worked on the wards training people in the measurement of Lying and Standing Blood Pressure (L/S BP) and recording the results on a system called Patientrak. Over 80 members of nursing staff were included in this event. ARCHS also held a falls awareness stall within Ripon Market where many people took an interest to discuss falls risk factors and actions they could take. It was well received and many were keen for information re: regarding strength and balance exercises and had their walking aids reviewed.

Equipment

Training related to safe and competent use of the newly purchased Molift Flat Scoop Hoists has been slow and difficult and will hopefully be resolved in the early part of 2022/3.

The trust has also purchased 12 sets of Bed and Chair Fall alarm systems. Training for these has also been difficult to complete due to availability of staff. This training has been high-lighted as a priority for the new Band 6 team member.

Audits

Although participation in the National Audit for Inpatient Falls/ Hip Fracture (NAIF 2020/21) continued throughout the pandemic, a CQUIN (Commissioning for Quality and Innovation) audit related to preventing falls was paused, with the intention of restarting in 2021/22, this did not happen. HDFT has continued to address the 3 key audit domains related to admission of patients related to: timely recording of L/S BP; provision of walking aids and medication review.

A newly reviewed Falls Prevention Medication Review,(in-line with NICE GC 161), was produced by the lead pharmacist. This document is available via the intranet and will be included into the Doctors Induction Pack.

HDFT continues to participate in the NAIF audit, and presented a Gap Analysis of Compliance Checklist and Action Plan for 2021. The recommendations and actions are embedded into the Falls Prevention Strategy Improvement Plan for 2022/23.

An audit of falls assessments completed for those attending ED was completed and presented in July 2022. Most of those admitted had frailty score of 5-7 (mild – severe frailty). Falls assessments were more thoroughly completed if the patient was admitted to hospital and more domains but not all were completed if seen within geriatric medicine. It highlights more QI work is required across all departments to ensure timely and appropriate multifactorial falls assessments and actions for patients.

From Q4 of 2021/22 a digital audit tool called “Tendable” is now being used on wards that are able to provide data in real time. A falls prevention audit is in use, and although it will need some refinement, is already providing valuable “snapshots” of when or if screening, assessment and action plan documentation is completed for individual patients.

New Networks

Links with Brimhams Active (who are able to provide strength and balance classes for patients at risk of falls (at a small cost to patient of £3-5) have continued when HDFT presented a fall prevention update at the Harrogate Conference Centre for their launch in May 21. A representative also attends falls strategy meetings.
The falls prevention lead has continued to attend meetings with the Improvement Academy (HUSH) in an effort to keep up to date with Huddle developments.
Regular and well attended meeting with the York and Humber Falls & Deconditioning Network has proved very beneficial. HDFT will participate in a North Yorkshire wide Falls Prevention Week in September 22 where themes and resources will be shared.
Attendance with the Yorkshire & York Frailty Clinical Engagement Group is also proving valuable, and links will be maintained by the new Band 6 falls practitioner.

Meetings

The Fall Prevention Steering Group continued to meet throughout the pandemic and was quorate for 50% of schedule meetings. Throughout the year key meetings of Fundamental Care, Safety & Governance & Quality of Care meeting were this year often cancelled due to staffing issues, making timely escalation of issues difficult.

What are the results?

All Inpatient Falls for HDFT.

Inpatient Falls for HDFT from April 2016/17 to end of March 2021/22 Table 1.

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Inpatient falls - all	697	700	674	694	601	769
Inpatient falls - all - per 1,000 bed days	6.10	6.16	6.01	6.20	7.46	6.95
Inpatient falls - moderate harm, severe harm or death (RCA)	15	21	19**	15*	12	14****
Severe #NOF recorded since 2018/19	-	-	10	5	4	3
Inpatient falls - moderate/severe/death - per 1,000 bed days	0.13	0.19	0.17	0.13	0.17	0.11
Inpatient falls - resulting in fracture	14	20	17***	13	12	13

** Two events recorded as "moderate" were not fractures.*
*** Three events recorded as "moderate and above harm" were not fractures*
**** Includes one low harm fall that resulted in a fracture*
***** Includes one inpatient death*

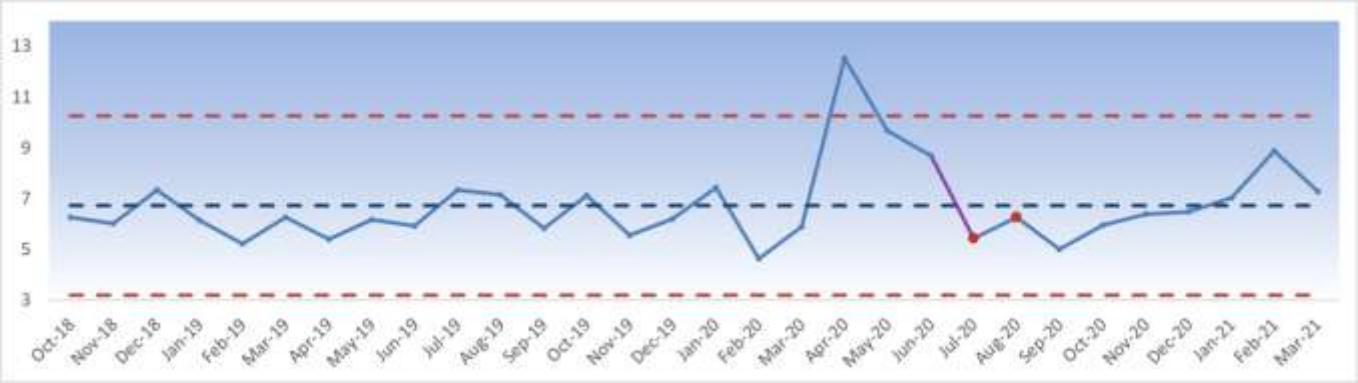
In 2021/22, data for inpatient falls causing fracture or significant injury recorded 14 reports consisting 13 inpatients who suffered a moderate or severe harm and one patient who died as a result of a fall. The total number of inpatient falls in 2021/22 was 769, with 13 inpatient falls resulting in a fracture, three of these patients suffered a neck of femur hip fracture. When compared to the previous year 2020/21 there is a 22% decrease in the total number of inpatient falls; a increase of 8% in both the number of inpatient falls with moderate/severe/death harm and a decrease of 25% in the number of inpatients reported with hip fracture; and an 8% increase in inpatient falls with fracture.

This year the trust reported one inpatient and outpatient who sustained a fall, and both sadly died whilst in our care. Each of these incidents have been investigated and referred to the coroner.

It is useful to consider the figures reported “per 1000 Occupied Bed Days” (OBD), as this is an indication of the rate or frequency of inpatient falls and can be seen as a measure of risk. The rates calculated used the number of inpatient falls related to the level of bed occupancy on each ward. In 2021/22, the rate of inpatient falls decreased by 0.51, and the level of inpatient falls with harm decreased by 0.06. There were 6 months in 2021/22, (April, May, July, September, December 21 and Feb 22) when no inpatient falls of moderate harm or above were reported.

In Graph 1, the peak in April 2021 shows a rate of 12.54 and demonstrates the impact Covid19 has had on the increase in inpatient falls during this period. The average rate for HDFT is normally between 6.0 and 7.0 per 1000/OBD. (Occupied Bed Days.) The line represented in this graph seem to reflect the impact of lockdown and increased infection amongst the Harrogate population.

The rate of Inpatient Falls per 1000 OBD for HDFT from Oct 2018 to March 2021
Graph 1. (Extract from Integrated Board Report March 2021, Trend Chart/Safe/Falls)



Learning from Events

In 2021/22 the trust has completed 10 investigations related to harmful falls. This includes a total of 6 Serious Incident investigations (SI) involving 3 deaths related to falls and other factors, and 1 death with fractured neck of femur; a total of 3 fractured neck of femurs reported as severe harm, 4 Concise investigations related to moderate harm. Each SI is reported and if the patient has died as a consequence referred to the coroner, the outcome of each of these is yet to be reported at the writing of this report. Once conclusions are reached and agreed learning and action plan is published where actions and recommendations must be completed. The process is monitored by the CCG and HDFT Risk Management Team.

Actions completed during 2021/22 include: updating Post Fall management documentation, updating the Falls Prevention Policy and bed rails policy, updating training content and buying safety equipment.

Summary

In 2019/20, before the advent of Covid19, we were able to report a 50% decrease in inpatient falls resulting in a hip fracture and 25% decrease in harmful falls and had planned to build on this success. In 2020/21 we have reported a decrease in the rate of falls/1000 OBD and in the rate of harm /1000 OBD but are noticing an upward trend in falls rate in the latter part of the year when bed occupancy has become very high. The full impact of pandemic still remains to be calculated and appreciated. What has become clear during Covid19 and in the conclusion of several investigations related to harmful falls is the value of a Comprehensive Geriatric Assessment (CGA) for older people on admission, as patient's care have been compromised when they have not been able to take place. Audit has also shown that if patients are seen by a consultant geriatrician more domains of the falls assessment are likely to be completed.

The remit for the Falls Steering Group for 2022/23 is to ensure that any recommendations and learning presented by the Yorkshire CCG and Coroner Reports are embedded into our daily management and care of older people at risk of falls. This includes ensuring current policies are guidelines related to reducing inpatient falls are fit for purpose which include: bed rail policy and post fall management and falls guidelines. Enhanced care guidelines have previously been highlighted as an area which is in need for review previously within SI and this has previously been escalated unfortunately a RPIW around this area this was cancelled Spring 2022.

The formation of the new ARCHs community team will provide the Trust with feedback around the increased need for rehabilitation in community where it is anticipated that the future need for public education and resources will also grow as we encourage all ages, but especially the older population, to become more proactive in adopting a healthy and active lifestyle.

The confirmation of a new role of "Quality Matron" was seen as a positive step towards integrating five key areas of safety and care of those people at risk of inpatient harms who are often living with frailty. Those domains include Falls, Pressure Ulcers, Dementia & Delirium, Nutrition and Continence. A Band 6 lead for Dementia has recently been appointed, but the loss of the post of the Quality Matron presents a gap in leadership which risks reduced opportunity for safety culture change, coordination and use of QI to help reduce harm across safety domains.

The delivery of a new fall prevention eLearning package has been well received with excellent feedback. There is intention to bring a new range of online, tiered frailty packages into staff training which will mean there is a need to review existing falls training content to ensure that repetition is avoided. Early indications of the Frailty packages is that fall prevention is included and provides a level of detail not seen in existing fall prevention packages. This is unlikely to be able to be completed within the next year without further staff appointed to falls prevention leadership and coordination.

At the end of 2021/22 our priority aim to reduce the number of falls and the harm they cause has been achieved and this aim will continue to shape our work in 2022/23 as we work towards continual improvement of assessment & post fall care through training, audit and quality improvement projects.

3. Pressure ulcers

Introduction

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 graded by severity according to a classification by the European Pressure Ulcer Advisory Panel from category one (least severe) to category four (most severe). They are more likely to occur in people who are ill, have a neurological condition, poor mobility, impaired nutrition, 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. The prevention of pressure ulcers has been a specific part of our quality improvement work at HDFT since 2012/13 and despite the challenges of the ongoing Covid-19 pandemic, this focus has continued during 2021/22 through:

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

What were we aiming to achieve?

The Trust 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?

Despite the challenges posed by covid-19, there has been a continued strong focus on the reduction of omissions in care regarding pressure ulcers in 2021/22. We have revised the

current root cause analysis documentation process and paperwork to ensure thorough, robust, and timely investigation. The RCA panel process (quality review panel) has been revised to provide assurance of pressure ulcers Trust-wide. These are now bi-monthly, chaired by senior nurses and attended by CCG representatives, Tissue Viability Specialist Nurse, Safeguarding Nurse, and the relevant department colleagues to allow investigation and identification of common themes for learning.

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 newly implemented real time audit application (Tendable) provides assurance and highlights areas for improvement.

In 2021, work was undertaken to ensure the Trust were accurately capturing pressure ulcers that occurred in our care and that reporting was in line with neighbouring organisations whilst awaiting revised guidance from the National Wound Care Strategy. Definitions of hospital, community and present on admission pressure ulcers were revised and embedded within the organisation.

A service review undertaken in April 2021 by an external subject matter expert, led to the appointment of 3 Tissue Viability Nurses, increasing the establishment of the team to 3.6 Whole time equivalent band 6 Registered Nurses and 1 WTE band 7 Service Lead.

An audit of category 2 pressure ulcers and moisture associated skin damage (MASD) commenced in April 2022 to capture accurate reported data and identify areas for development and support across acute and community services. Data will be used to explore how the service can work effectively to reduce hospital and community acquired pressure ulcers and deterioration of low harm skin damage.

Although there have been periods of redeployment, work of the service has been focused on two broad areas, education and training including learning from the quality improvement panels, and documentation and risk assessment.

Education and training

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

Although temporarily ceased due to Covid-19, pressure ulcer prevention training was adapted to be delivered via Microsoft Teams and continues to be delivered bi-monthly for all Trust registered and unregistered colleagues.

The Tissue Viability Nurses and Trust Clinical Educators work cohesively to deliver training on skin care and pressure ulcer prevention, recognition, and management in the classroom, virtually and at the bedside. 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.

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 joined forces on International Stop the Pressure Day in November 2021 to facilitate training in all clinical areas to raise awareness and gather pledges from colleagues to Stop the Pressure. This was well received and raised the profile of both services across the organisation.

The service undertook training across the Trust alongside specialist continence colleagues on the inaugural Moisture Associated Skin Damage (MASD) awareness day in March 2022 to raise awareness of MASD which can predispose individuals to pressure damage. Work is underway to revise the current MASD pathway available across HDFT to ensure the implementation of evidence based and timely care for patients in both acute and community services.

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

Documentation and risk assessment

The Skin Inspection and Repositioning Record replaced the SSKIN bundle within the acute Trust in December 2016. This has now been fully embedded and continues to be monitored. Feedback has been positive, and some improvement noted in the quality of documentation which continues to be audited monthly as part of the Tendable app.

We continue to use and monitor an evidence-based pressure ulcer risk assessment tool and associated management plan within our community areas and inpatient areas. In 2019 this was extended further for use within paediatrics with a revised pressure ulcer risk assessment tool and associated documentation suitable for this area, work continues to develop a similar tool in neonates. The pressure ulcer risk assessment tool and pressure ulcer management plan are now completed on electronic patient records across all HDFT clinical areas.

Electronic referrals to the service are now fully embedded across community and acute services and aim to ensure timely review by the team whilst reducing administration for colleagues when referring.

What are the results?

The data from 2021/2022 shows a significant increase in pressure ulcers across acute services, with a slight reduction in community acquired pressure ulcers. Whilst the increase in acute services is disappointing compared to the 2020/21 data, it must be noted that there has been increased reporting due to the additional training, earlier recognition of pressure ulcers and an increase in TVN presence across the organisation ensuring increased vigilance. Initial findings of the current category 2 and MASD audit highlight inconsistencies of the accuracy of reporting which will also lead to skewed data.

There must be consideration to the impact of the Covid-19 pandemic which has led to an increase in patients presenting to services acutely unwell, with reduced mobility and risk factors predisposing them to pressure ulcer development, this is reflected nationally.

The decrease in community acquired pressure ulcers is positive and provides assurance that the increase in education and learning from undertaking RCA, has informed training needs and strengthened the documentation to support care.
The pressure ulcer data presented below is reported through the HDFT event reporting system.

Pressure Ulcer Data - Category 3 or above

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Hospital acquired PU	3	9	9	3	5	9	10	13	8	14	5
Community acquired PU	12	14	12	6	11	13	16	15	19	21	11

The above table demonstrates the challenges regarding hospital and community acquired pressure ulcers. Although the number of reported pressure ulcers is due, in part, to better and earlier identification and reporting as a result of continued education around the recognition and categorisation of pressure ulcers, consideration must also be made to the impact of the Covid-19 pandemic. Following the discontinuation of the Safety Thermometer, national data collection of the prevalence of pressure ulcers is limited, however work in progress by the National Wound Care Strategy data workstream and the implementation of the Model Health System will lead to improved data capture and subsequent benchmarking.

Summary

Despite the challenges of the current climate, a significant amount of work has been undertaken during 2021 and is underway in 2022. The learning through Quality Review Panels and continued education has been strengthened. New documentation and guidance has been

embedded within the community and acute settings. The quality improvement pressure ulcer group meetings ensure that initiatives and projects are reviewed regularly. The increased establishment of TVN across HDFT will ensure that further work required to ensure the high profile of pressure ulcer prevention within the Trust is maintained.

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

Key ambitions for 2022/23 include:

- Continuing to embed the revised pressure ulcer definitions and accurately benchmark reporting performance following the new pressure ulcer definitions
- Improve the data set to accurately monitor performance Trust-wide and agree set trajectories
- Further strengthening of the Quality Review Panels to ensure assurance
- Further strengthening of training and education with alternate year face-to-face training and the implementation of training programme which follows National Wound Care Strategy Core Capability Framework to standardise education
- Implementation of electronic learning package via National Wound Care Strategy
- To re-establish pressure ulcer prevention link nurses (pressure ulcer champions) to empower and engage colleagues
- To continue to strengthen relationships between TVN and all clinical areas to ensure individualised training needs are met.
- Embed monthly pressure ulcer audits using a real time audit
- Work closely with newly appointed Continence Nurse for MASD/Hypospadias
- Present at Fundamentals of Care forum monthly to feed into Patient Safety Forum as part of the Trust Governance Structure
- Adopt and embed the use of the Model Health System to accurately capture pressure ulcer prevalence data and reduce unwarranted variation in quality, safety, and productivity.

3.2 Patient Experience

1. Learning disabilities

Introduction

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

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

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

People with a learning disability face many health inequalities, often resulting in worse health than the general population. On average people with a learning disability die 16 years earlier than the general population (Department of Health, 2013).

Mencap's Treat Me Well Campaign highlighted the need for learning disability awareness training to all hospital staff.

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

The four standards concern:

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

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

What were we aiming to achieve?

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

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

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

What have we done?

1. Learning disability awareness training continues to be available through an e-learning package. Due to changes in software licensing, an alternative package was required. HDFT collaborated with other trusts within West Yorkshire and Harrogate to develop an e-learning package that met the competencies of Tier 1 training as outlined by Health Education England

   Facilitator-led level 2 training was suspended due to COVID-19. A decision was taken to permanently remove this training from learning accounts in anticipation of the mandated Oliver McGowan learning disability awareness training which is expected in 2022.

2. We continue to promote LD flagging both internally and externally to enable the provision of appropriate support. A particular focus in 2021/22 has been on identifying people with learning disabilities who have begun accessing services in recent years. This has been achieved through reminding local care providers and partner agencies of the benefits of flagging all users.

3. The Trust continue to engage with NHS England and NHS Improvement's annual benchmarking exercise. Areas of focus in 2021/22 have been on
   a. Addressing reliance on an individual Acute Liaison Nurse for the provision of specialist support and advice.
   b. Raising awareness of the duty to provide necessary reasonable adjustments to patients with learning disabilities.
   c. Introduced in 2016, the Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It aims to help reduce premature mortality and health inequalities for people with learning disabilities.

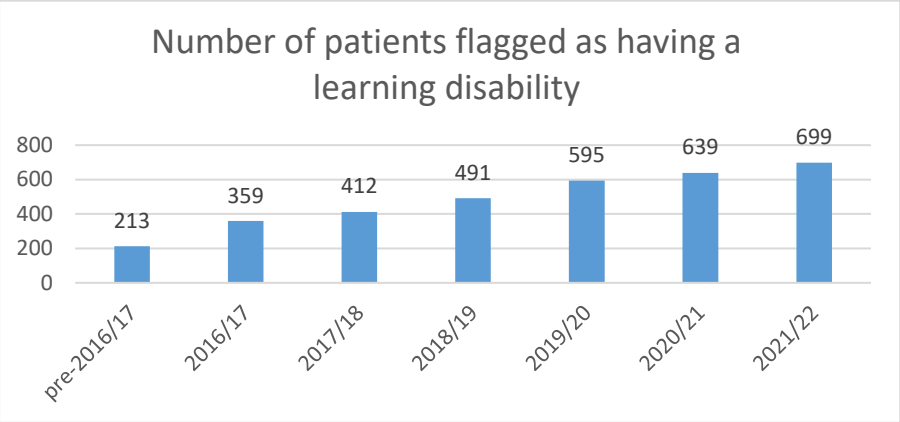
      We continue to engage with the LeDeR programme by

      i. Notifying the LeDeR pogramme of any deaths of any inpatients with learning disabilities or those who died in the Emergency Department.
      ii. Engaging with the local LeDeR steering group

What are the results?

1. The Learning Disabilities Level 1 e-learning package was launched in November 2018. Compliance with this training has fallen from 94% last year to 77% in 2021/22. This reflects the fast uptake in training when it was first launched as these staff have now reached the three year renewal period. It is expected that this will increase throughout 2022/23.

2. The number of patient records flagged as having a learning disability continues to increase with a further 60 LD flags added in 2021/22.



3. We have made progress with various recommendations, outlined by NHS Improvement in the learning disabilities Improvement Standards. These are described below.

    a. We have recruited a fulltime clinical advisor with a joint role in the learning disabilities and adult safeguarding teams.
    b. To raise awareness of the duty to provide reasonable adjustments and the adjustments routinely available, this became the focus of LD week 2021 with the 'Stop, Think, Adjust' Campaign. This included an awareness raising videos, which were shared through Trust communications and social media. A tool was devised to support staff to explore the changes that could be made to their areas of practice in order to improve accessibility..

    c. LeDeR engagement
        i. In 2021/22, 6 patient's died whilst either an inpatient or in the Emergency Department. The Trust notified the LeDeR programme of 4 deaths, with the other two being notified by the community learning disabilities team. The Trust provided information to allocated reviewers in all 6 cases in the form of structured judgement reviews. The overall standard of care in 5 cases was assessed as 'good' with 1 case rated as 'adequate'.
        ii. It is expected that an HDFT representative attends 50% of the local LeDeR steering group meetings. The learning disability acute liaison nurse has attended all four meetings that were held in 2021/22.

Summary

The Trust has continued to make progress with the identification and flagging of patients with learning disabilities records in order to support the provision of reasonable adjustments.

The compliance rate for level 1 training will be closely monitored to ensure that this increases over the coming 12 months. However, the training needs analysis will need to be updated in light of the government's response to the proposed mandatory learning disability training for all health and social care providers. It is expected that learning disability and autism training will become mandatory in 2022/23. The Trust will need to consider how compliance with this training requirement will be achieved.

The Trust will continue to engage with the LeDeR programme and will review the outputs of the 4th national benchmarking exercise, considering any actions to be taken moving forwards.

2. Cancer Care

Introduction

Cancer services offered by HDFT have continued to work hard at maintaining safe, high quality services to patients and their families we have focussed on:

1. Best outcomes
2. Local care provision
3. The HDFT experience
4. Raising the profile.

What were we aiming to achieve?
Our Objectives have been centred on:

- Offering personalised care and support to patients and their families to address individual needs and concerns and support patient health and wellbeing as an integral part of their cancer treatment plan.
- Ensuring continued use NHS England guidance to prioritise the safe delivery of cancer services throughout the COVID-19 pandemic, to ensure the safety of both our staff and patients
- Building on and developing the Serious Non-specific Symptoms (SNSP) Rapid Diagnostic Centre, with the aim of improving the experience and reducing the time to diagnosis for this subset of patients
- The continued roll out of technological advances in bowel cancer diagnostics. For example Faecal Immunochemical Testing (FIT), capsule endoscopy
- Continuing to work closely with Leeds and York Teaching Hospitals to provide substantial and robust oncology services for patients locally within Harrogate
- Continuing to look at ways of expanding capacity within our purpose built Systemic Anti-Cancer Treatment Unit (Sir Robert Ogden Macmillan Centre SROMC) to ensure we can continue to provide treatment locally for a growing number of patients over the coming years
- Re-establishing our Patient Education Programmes to enable patients to live well with or beyond cancer and enable them to self-manage and become active partners in their treatment and care
- Reintroducing volunteers within SROMC who have provided support and added value to so many of our services over recent years
- The continued development of the Active Against Cancer service which provides a unique platform for patients to benefit from exercise during from diagnosis onwards

What have we done and what are the results?

Cancer Information

Covid restrictions affected the Macmillan Cancer Information and Support service (MCISS) throughout 2021/22. Face to face and ad hoc user visits were restricted to only those attending the unit for Systemic Anti-Cancer Treatment (SACT) or clinic consultation. The MCISS service manager played a significant role in supporting the unit with the production, display and dissemination of national guidance information.
To mitigate the loss of free access to MCISS, a designated helpline was set throughout the first lockdown. Open Monday to Friday 8.30 -5pm it supported the general public and

existing patients with any cancer related physical or emotional concerns. Trained healthcare workers from across the Harrogate cancer service undertook the provision of this service. Patients who were accessing health and wellbeing support services prior to lockdown received welfare calls from health and wellbeing services throughout this period. This included the welfare and benefits service, complementary therapy and Active Against Cancer.

Personalised care and Support

At diagnosis, patients are offered an opportunity to discuss their main concerns related to their diagnosis of cancer and how it affects them and their families. This had informed our patient education programmes along with the regular supportive care services we offer, for example, welfare and benefits, Clinical psychology and psychosexual support.

Patient Education Programmes (PEP)

- Healthy Eating and Weight Management (underweight or overweight);
- Managing fatigue
- Mindfulness and Mindfit; psychoeducation sessions run by the clinical psychologists
- Continence and Erectile dysfunction;
- Managing the effects of hormone therapy
- Physical health and activity
- Welfare and Benefits
- Relaxation sessions
- Thinking ahead Programme for patient and carers with incurable cancer

The Macmillan Welfare and Benefits Service

The Macmillan Welfare Benefit Adviser forms part of the Macmillan Cancer Information Support Service (MCISS). Unlike MCISS models used elsewhere across the UK, the SROMC Macmillan Welfare and Benefit Adviser is employed by the Trust and is fully integrated within the Information Service. This integration ensures the service is accessible, responsive and flexible to meet individual patient needs.

The quality and impact of the service is reflected in patient feedback, service evaluations and successful financial awards received to service users. The service now operates over five days, and continues to hold 'Alternative Office Status' awarded by the Pension's Service. This enables the verification of documents on behalf of the Department of Work and Pensions by the Macmillan Welfare and Benefits Adviser on SROMC premises and so reduces an unnecessary stress burden on cancer patients.

The Complementary Therapy Service

Referral for treatment has remained high due in part to both its reputation and the benefits of the evidence-based interventions offered. Clinical activity has been restricted in 2021/22 by the impact of Covid and subsequent government guidance. All hands on therapies ceased. The complementary therapists provided triage and screening procedures to patients/visitors to the unit. They also provided support on the SACT Unit with patient meal times and refreshments.

	N0' of Patients Treated	**N0' of treatments**
2020/21	213	963
2018/2019	498	1455
Activity Comparison in %	**43% (decrease)**	**66% (decrease)**

SASH (Scarves and Stylish Headwear)

Wig Fitting Service

'Feel More Like You' Beauty Therapy Sessions

The Oesophageal Patient Association (OPA) Support Group
The OPA provide local support to patients and carers affected by cancer of the oesophagus. The monthly meetings attract a good number of attendees throughout a three-hour session. It is particularly useful to patients from the Harrogate area as it provides a local drop in facility for patients before or after their clinic appointments. The Trust Colorectal and Upper Gastrointestinal Cancer Care Co-ordinator supports the group. This group's meetings in the SROMC discontinued in 2020/21 due to infection control and prevention measures during the pandemic. OPA continued to provide patient support with oesophageal cancer by telephone throughout 2021, and online support and information via opa.org.uk

SROMC Volunteers
The value and quality that all volunteers supporting the SROMC give to both service provision and patient experience across a wide range of roles cannot be underestimated and we are extremely grateful to them. Prior to the pandemic, 17 volunteers supported services provided in the SROMC. These services stopped as the national restrictions prevented volunteers attending the unit. The volunteers are now back working within the SROMC and we have attendance Monday to Friday. We are extremely grateful for the support they give to our patents.

Staff Wellbeing
The MCISS and Chemotherapy Unit Managers have remained committed to support the health and wellbeing of SROMC staff during 2021//22. Staff have been signposted to HDH FT wellbeing services and external mental health support.
Clinical supervision and reflective practice provided for all members of staff within the SROMC changed where possible to online.

The HDFT NHS Natural Health School
The patient need and demand for complementary therapy services has been a critical driver for the development of the NHS Natural Health School. Our mission; provide complementary therapy diplomas and continuing professional development (CPD) courses that will uniquely practical experience and clinical supervision within an NHS setting.

Early and Faster Diagnosis of Cancer
As part of the national objective to detect cancers earlier, with an ambition to have three-quarters of all cancers diagnosed at an early stage by 2028 and patients who are referred urgently receiving a definitive diagnosis or ruling out of cancer within 28 days, HDFT now have a well-established Rapid Diagnostic Service. The Rapid Diagnostic Service (RDS) is designed to investigate patients with vague (non-specific) symptoms quickly in an effort to diagnose cancer or other serious conditions earlier. The pathway at Harrogate District Hospital is called the Serious, Non-specific Symptoms Pathway (SNSP)
The RDS team is made up of a Multidisciplinary Team (MDT) who work together to diagnose and identify the best course of treatment for each patients.

Active Against Cancer

In July 2019, we opened a unique health and wellbeing service, Active Against Cancer, to cancer patients in the Trust. The service has exercise at its core, but also provides the opportunity for early patient education, social and peer-to-peer interaction to support patients at what can be a challenging time. All patients with a new diagnosis of cancer are referred to the service to receive one-to-one consultations to discuss and assess their health, wellbeing and physical activity levels. The vast majority of patients will take up the opportunity to attend.

Expanding Capacity for Day Case treatments within Sir Robert Ogden Macmillan Centre (SROMC) I through charitable funding

Technological Advances

By working in partnership with the West Yorkshire and Harrogate Cancer Alliance we are able to offer patients referred urgently with worrying bowel symptoms Feacal immunochemical test (FIT) testing and colon capsule endoscopy. The FIT test enables doctors to assess for the presence of blood in a patient's stool sample and which provides vital information in assessing a patient for bowel cancer. The colon capsule endoscopy enable some patients to undergo a much less invasive investigation to assess for abnormalities in the bowel.

Summary

In spite of the challenges that the pandemic has brought us all, we have managed to find ways to enhance the experience for a patient with cancer. The challenge of diagnosing patients with cancer at an early stage remains a key objective and we continue to work closely with our partners nationally, regionally and locally along with our own staff and most importantly with our patients and their families.

3.3 Effective Care

1. End of Life Care

Introduction

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

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

The aim is to improve patient and family experience at the end of life across Harrogate and Rural District (HaRD) in both community and hospital settings.

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

What were we aiming to achieve?

The main aims and achievements during 2021/2022 were supporting our trust, colleagues, patients and their families clinically through the pandemic and the recovery period (which is ongoing). The pandemic has continued to highlight the need for:

- integrated end of life care across all settings
- ongoing training and education
- adaption of the specialist palliative care service to meet demand

We have aimed to:

- Provide high quality responsive and timely specialist palliative care clinical support, advice and care for patients and those important to them in all settings, especially those in the last days of life, in both hospital and community
- Continue to deliver end of life training to the key groups of staff who care for patients in the last days and hours of life
- Work with Clinical Effectiveness and the Resuscitation Lead to support audit of DNACPR in hospital and community and demonstrate quality assurance in decision making and discussions with patients and families (Protect, respect, connect report CQC 2021)
- Continue to work with Information Services to improve data analysis and reporting to demonstrate effectiveness of the service
- Undertake re-audit of anticipatory prescribing and syringe drivers within the hospital and community setting

- Participate in the third round National Audit of Care at the End of Life (2021) which includes a staff reported measure
- Identify executive lead for EoLC and restructure EoL Operational Board in line with revised trust governance structure
- Ensure HDFT representation at new CCG and ICS level PEoLC groups
- Work with North East & Yorkshire Palliative and End of Life care (PEoLc) Strategic Clinical Network to explore solutions to recruitment and retention within specialist palliative care services. Explore new models of working with Health Education England including opportunities around skill mix within the team to enable move to seven-day service provision
- Work with newly established Medical Examiner roles to continue to improve care after death in HDFT.
- Continue ongoing Bereaved Carers Survey across Harrogate locality

What have we done?

a) Provision of specialist palliative care and leadership on end of life care within HDFT

The PCT takes a lead role in delivering and supporting others to provide EoL care in both the hospital and community setting. The team ethos within the organisation is to work collaboratively with many agencies across health and social care, and providing a timely and responsive specialist service.

During the last year, the team has continued to provide responsive face to face clinical support and advice 5 days a week in both settings which also now includes provision of an urgent face to face CNS service on the Bank Holiday days. Due to the increasing referrals and workload the trust has supported additional funding since January 21 to allow temporary increased clinical support from the local hospice speciality doctor (4 PAs/week) into the community service and ad-hoc additional sessions into the hospital service from our hospital speciality doctor. This has supported continued safe and timely service delivery and ensured maintenance of the wellbeing of the team who were working increased overtime to provide timely clinical care.

The annual audit of response times for the PCT demonstrated that in January 2022 98% referrals for hospital assessment were seen within 1 working day of referral and 96% referrals for community assessment had documented contact within 2 working days as per the standards in the current Operational Policy.

The PCT had a total of 1406 referrals in 2021-2022. Referrals to both the hospital and community teams increased last year, most markedly by 33% in the hospital setting. The hospital team were involved in over 50% of all the patients who died in HDH last year, an increase from 37%.

It was noted that the complexity of patients referred remained high in 2021-22, with reduced ability to refer patients to other services e.g. Saint Michaels Hospice day therapy, volunteer visitor service, chaplain, and face-to-face psychological support; this is not captured in referral numbers. The community team have also taken on additional GP practice from 01/04/2022, making the total of 17 practices across the locality, with no additional resource at present.

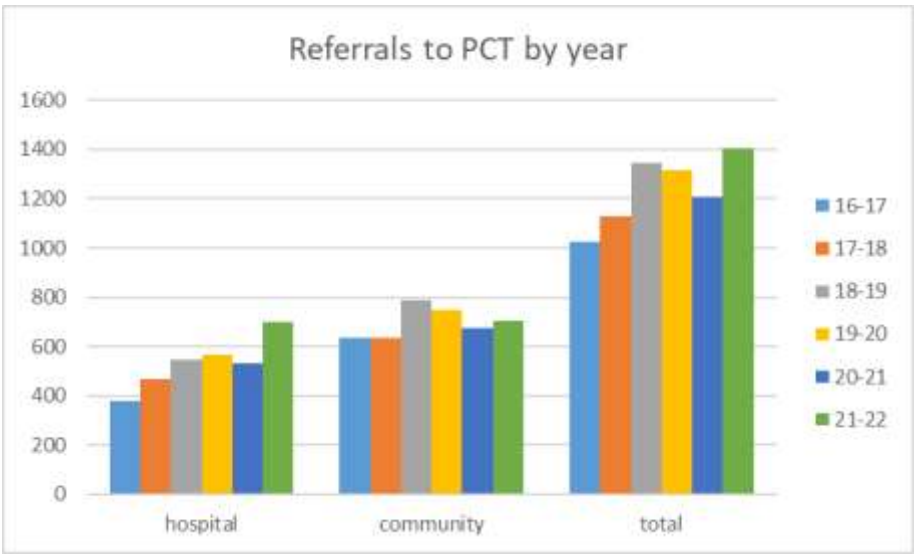


Figure 1: HDFT PCT Referrals by year (DATA for 2021/22)

The number and percentage of patients with non-malignant disease referred to the hospital team had been fairly stable over preceding years and remains at around 43% with the community demonstrating an increase of 5% to 24% in 2021-22. This hopefully reflects an increased awareness and identification of palliative care needs of those patients with non-malignant disease

The Lead Nurse for Palliative and End of Life Care continues to support workforce initiatives at an ICS, regional and national level around PEoLC. The community consultant is also funded by NHS England for four hours per week as Clinical Lead for the development and implementation of the Palliative and End of Life Care Information Standard, working with the Professional Records Standards.

b) <u>End of Life Care</u>

Hospital setting

During the coronavirus pandemic there has been a necessary focus on end of life care in the hospital setting however there has also been an increase in end of life care in the community, as the usual patients were supported to remain out of hospital.

Staff across the organisation have been redeployed and many staff were caring for dying patients and their families when this was not their usual area of expertise. Wards such as Rowan ward (rehabilitation unit – previously based at Lascelles) also now accept and care for patients in their last days of life from the main hospital site to improve patient flow and experience which has had very positive feedback from families.

Key areas of improvement:

- Update of individualised Care Plans for last days /hours of life and associated symptom management guidance across all the adult wards to include covid specific symptom management
- Review of anticipatory medication doses in community and hospital to ensure best practice

Care after death

The Trust undertook a rapid process improvement workshop (RPIW) Care after death in hospital in October 2019 and a plan was underway to streamline and improve many processes related to care after death due to variation in:

- practice across ward settings
- coordination of key tasks required after a patient dies
- communication and information given to families;
- delays in timely completion of the Medical Certificate of Cause of Death (MCCD)
- delays in families receiving MCCD leading to increased distress and increased complaints.

The Covid specific documentation implemented in 2020 has been amended in light of the updated Emergency Coronavirus laws April 2022. Relevant documentation is due to be updated and relaunched in May 2022 across HDFT

Key changes implemented in 2021/2022:

- Introduction of the Lead Medical Examiners team
- Reorganisation of the bereaved families single point of contact to the Medical Examiners officer team
- Creation of a Bereavement Information Pack for families /carers available across hospital and community setting (due for launch in May 22). These are also accessible online via Trust internet site by RNS Publications

Figure 2: *Additional information for families & carers of loves ones* and *Someone I care about has died. What do I do next?*

Embedding an Electronic Palliative Care Co-ordination System (EPaCCS)

We continue to embed the shared template to record key information about patients at the EoL in the majority of GP practices, the PCT, community care teams, hospice, respiratory and heart failure teams. Four further practices moved to SystmOne in 2021 and we have rolled out the use of EPaCCS to two these practices.

The information in EPaCCS is based on the national End of Life Care Information Standard which is currently in the final stages of a refresh. The template contains links to relevant clinical guidelines and a variety of forms that improves efficiency for healthcare professionals. Further information is available at https://www.hdft.nhs.uk/services/palliative-care/epaccs/ Work is being done at a regional (Yorkshire & Humber) and ICS level (West Yorkshire & Harrogate) to widen access to the information through the Yorkshire and Humber Care Record (YHCR)(Shared Care Records Programme). Harrogate will be the pilot site in 2022 for the direct share of EPaCCS information recorded by the SPCT in S1 with the YHCR. If successful this model will be used throughout the region to widen access to EPaCCS with the potential to share this information across HaRD including the acute hospital.

Single point of access for palliative care referrals, advice and end of life co-ordination (Fast Track care at home)

The End-of-Life Coordination Service was launched on the 1st September 2019 by Harrogate and District NHS Foundation Trust through commissioning by North Yorkshire CCG. This service is a single point of contact, referral and co-ordination for care and equipment provision in the home setting across Harrogate and Rural locality for patients who are rapidly deteriorating and likely in the last weeks of their life (often called Fast track), whose preferred place of care is home. The service is complementary to the service provided by Saint Michael's HOME Service who provide the rapid packages of personal care and Marie Curie who provide night sits for people. During April 2020, the trust brought together the EoL Co-ordination team and the Palliative Care Administrator role to create a single central point (7 days a week during office hours) for all palliative care referrals, fast track referrals in home setting and access to advice/support from the palliative care team (PCT only available 5 days a week at present).

Workforce Development of staff in care of patients and families at the end of life (community and hospital)

The PCT continue to deliver a wide range of bespoke education and training to new doctors, registered nurses, pharmacists and health care support workers, and take trainee placements within the team. Dr V Barros D'Sa (Consultant in Palliative Medicine) is the Subject Matter Expert for Palliative and EoL Care.

Essential skills for the Last Days of Life training and Medicines Management (includes session on PRN anticipatory medications) has restarted and is provided for registered nurses across the organisation on a monthly basis face to face. Palliative and End of Life care education sessions are also included in the medical training, trainee pharmacists and bespoke sessions have been provided over the last year for Allied Health professionals.

In early 2022 a new Trust competency-based programme of education for Health Care Support Workers (HCSW) commenced for new HDFT HCSW, existing HCSW and care home HCSW across Harrogate. This includes sessions on care in the last hours and days of life and difficult conversations at end of life.

End of Life Social Finance Integrator Project: Harrogate Locality

The EoLCI was set up in 2016 in partnership with the Department of Health, NHS England and the NHS Confederation, with support from Professor Bee Wee CBE. Its aim was to test whether an outcomes-based approach to End of Life Care (EoLC) would improve people's quality of life in the last 12 months of life and increase the number of people who 'die well' by aligning system incentives. With funding from Big Society Capital, Macmillan Cancer Support and funding from the Health Foundation and The National Lottery Community Fund, the EoLCI has worked in partnership with systems to design, mobilise and deliver EoLC projects.

In July 2021, Harrogate Locality submitted a successful expression of interest to the EOLI to proceed in developing a business case, with social finance funding from the EOLI fund on behalf of HDFT. Work on the business case is ongoing with an aim for final submission in early summer 2022.

Aims of the project are:

- Increase **quality and experience of care** provided for patients and families
- Increase **compliance with national standards**
- Create a **sustainable and cost effective model** to reduce system pressures across the Harrogate locality and support system recovery from the pandemic
- Reduced length of stay in hospital in last year of life,
- Reduced number of admissions and proportion of patients in hospital that are in the last year of life
- Reduced pressure on OOH GP/CCT
- Reduce health inequalities across the local system in palliative and end of life care

These will be achieved by 3 co-dependent elements

a) Increasing Identification of patients in last year of life
b) Increasing access to personalised care and support planning and sharing of clinically-led advance care plans
c) Commissioning of a responsive 24/7 advice and support for patients, carers and health care professionals who have been identified as being in the last year of life (GoldLine)

c) Measuring quality and using data in end of life care

The trust uses a range of methods to seek assurance, monitor palliative and end of life care and guide future education and training initiatives including:

- National Audit of Care at the End of Life (NACEL) in Hospitals
- Medical examiner feedback
- Complaints, incidents, concerns and compliments related to EoL (collated 6 monthly across organisation)
- Risk register (EoLC and PCT)
- Identified work programme (EoLC and PCT)
- Clinical guidelines and policies
- Data and business intelligence
- PCT Annual Report
- PCT response times

Key Local audits undertaken in 2021 included

- Audit of anticipatory prescribing in community and hospital
- Bereaved carers survey
- DNACPR audit

Anticipatory and syringe driver prescribing audit in hospital and community

Anticipatory prescribing for patients at the end of life is established practice, as recommended by NICE Guideline NG31 and Quality Standard QS144. It is the prescription and dispensing of injectable medications to a named patient in advance of clinical need for administration by suitably trained individuals if symptoms arise in the final days of life.

A re-audit was undertaken in 2021 to review prescribing and administration of anticipatory medications and prescribing of syringe drivers for HDFT both in community setting and hospital inpatients in order to ensure that practice is in line with standards set in local, regional and national guidance.

This provided assurance of generally safe and appropriate prescribing of anticipatory medication and syringe driver use across settings but there were some actions identified for improvement.

Key recommendations:

- Continue education and training on safe opioid prescribing
- Increase emphasis on the importance of the administration of the lowest dose first where a dose range is prescribed in essential skills training in Care in the Last Days of Life and mandatory Medicines Management training for RNs
- PCT and Pharmacy to discuss importance of administration of the lowest dose first with ward teams during day to day work on an individual patient basis as the need arises

DNACPR discussions and documentation in hospital and community

"Cardiopulmonary resuscitation (CPR) is an emergency procedure that aims to restart a person's heart if their heart stops beating or they stop breathing" (CQC, 2020). It can involve external chest compressions, artificial respiration and defibrillation. The proportion of people who survive following CPR is relatively low. Furthermore, even if CPR is successful in

restarting a person's breathing/heart, it can carry "harmful side effects such as rib fracture and damage to internal organs; adverse clinical outcomes such as hypoxic brain damage; and other consequences for the patient such as increased physical disability" (GMC, 2010).

Summary

Despite the pandemic, there has continued to be progress in improving end of life care across the organisation to improve the care and support of patients and their families with a focus on the priorities that the pandemic has presented.

As the trust moves into recovery the key areas to focus on over the next year are:

- Finalise and submit the business case for End of Life Social Finance Integrator Project: Harrogate Locality
- Summarise recommendations from 2021 NACEL report and participate in the NACEL 2022 audit
- Restructure HDFT End of Life Operational group in line with revised governance structure
- Work with commissioners to develop an agreed locality End of Life strategy following the merger of HaRD into North Yorkshire CCG and from July 2022 into Humber, Coast and Vale Integrated care Board
- Introduction of the electronic CPLD across hospital setting
- Work with Medical Examiner Team to continue to improve care after death in HDFT including
    - Update of the SOP Care after death and Care after Death Checklist within hospital
    - Introduction of Bereavement Information Packs for families across community and hospital setting
    - Update of the Information leaflet ' 'Someone I care about has died: What do I do next?' to take into account the update of the recent updated laws
- Complete Calderdale Framework review of Palliative care team activity and make recommendations for action
- Explore funding opportunities to develop virtual end of life ward within hospital setting to improve experience of end of life care and ensure specialist resources focused on the complex needs
- Continue to work with Information Services to obtain timely data

2. Promoting equality and reducing inequalities

Introduction

Equality is about equal opportunities and preventing discrimination while diversity is about **recognizing respecting and valuing differences in people**. Inclusion, on the other hand, refers to an individual's experience within his or her workplace and in wider society, and the extent to which he or she feels valued and included.

What are we aiming to achieve?

HDFT is working to become an anti-racist organisation. This forms part of our ambitious At Our Best programme, which works to improve culture within HDFT, and will help to further embed the behaviours we value around kindness, integrity, teamwork and equality.

There are overriding moral reasons why we are seeking to become and anti-racist organisation. We also know that diverse teams, where members feel a sense of belonging, are more likely to be able to provide high quality care. There are legal reasons why this is important, too, including our general duty under the Equality Act 2010 to have due regard to the need to eliminate discrimination; to advance equality of opportunity; and to foster good relations.

What have we done?

Change is already been seen and commented on by colleagues as we start to celebrate a wide range of events that have significance within different cultures. A recent example is our celebration of Eid with a special menu being served in our Herriot's restaurant, and the permanent inclusion of Halal food on the menu. Initiatives of this kind are a great start, but we know there is much work to do.

In addition to establishing a BAME, LGBT+ and Disability and Long-term conditions networks, we have undertaken consultation with BAME colleagues to determine how the Trust can be more inclusive. This workshop was followed by a Board Workshop, attended by BAME colleagues and the Board of Directors.

What are the results?

It was both challenging and inspiring to hear the lived experience of BAME colleagues working at the Trust, and fruitful discussions were held to support the development of a programme of work to support the Trust to become an organisation that has equality, diversity and inclusivity as a golden thread that runs through everything, and is an Anti-Racist Organisation.

3. Safeguarding Children

Introduction

The Safeguarding Children Quality Report provides an overview of the quality priorities for 2021-22.

Children who need help and protection deserve high quality and effective support as soon as a need is identified (Working Together to Safeguard Children, 2018) As a forward thinking Trust, and as the largest provider of 0-19 community services in the country is to provide a children's safeguarding service which is innovative, integrated and efficient to ensure that colleagues are able to identify safeguarding issues early, provide the right care and support to children and families and feel confident to professionally challenge partners to protect children and young people. The service has continued with the planned proactive service innovation and transformation and has adapted to implement the learning and improvement from local and national children's safeguarding practice and learning lessons reviews. The directorate has reviewed and strengthened the governance processes to ensure that the learning from external and internal influences can be shared across the acute and the community footprint of HDFT.

What were we aiming to achieve?

Compliance with:

1. The Care Quality Commission (CQC) Essential Standards for Quality and Safety
2. Section 11 of the Children Act 1989 / 2004
3. Working Together to Safeguard Children 2018 in line with the new partnership arrangements

All priorities in both the acute and community settings focus on the key areas of:

- Advice and Support
- Supervision
- Training
- Role of the Specialist Team

Ensuring delivery on the core objectives

- Trust staff knowing who the safeguarding team are and how to contact them.
- Providing a Single Point of Contact (SPOC) for staff to have contact with a specialist nurse child protection for immediate advice and support.
- Provide specific services with safeguarding supervision to support service delivery and support for complex cases.
- Participate in and disseminate learning and development from Child Safeguarding Practice Reviews as appropriate.
- Hearing and promoting the voice of the child and the lived experience of the child.
- Delivering up to date, relevant and specialist training to identified cohorts of personnel up to level 3 safeguarding adults and children including Workshops to raise awareness of Prevent, (WRAP).
- To ensure all safeguarding relevant policies / procedures are regularly reviewed and updated to remain fit for purpose.
- Ensuring the safeguarding team have personal resilience and professional motivation to support staff with emotive and sometimes disturbing safeguarding issues.

- Ensure robust relationships with our Named GP, Designated Doctor's and Designated Nurses are maintained and developed to support safeguarding service delivery across all levels.

What have we done?

The team have ensured delivery of the core objectives, evidenced through rigorous performance and quality management whilst implementing the proposed new objectives.

The team have focused on the priorities identified in the Safeguarding Children Annual Plan 2020-21 which builds on the 5-19 Safeguarding Transformation agenda to integrate Children's Safeguarding into management and operational teams to increase capacity of children's safeguarding to meet increased demand.

Key Quality Achievements

- There has been a focus on raising the profile of children's safeguarding at a strategic level to ensure the "Voice of the Child" is represented at all levels of the organisation.
- Escalation Process for safeguarding with increased oversight by named nurses for complex cases
- New roles in safeguarding for non-SCPHN (Health Visitor/ School Nurses) to increase recruitment and retention. Improved preceptorship and support to facilitate staff development and retention.
- The Children's Safeguarding Procedures have been updated and rationalised.
- Implementation of Student Safeguarding Supervision process to improve retention of staff.
- Development and implementation of innovative safeguarding model in North Yorkshire – from 1/7/21
- Improved multi-agency partnership working through HDFT processes in MAPPA, MARAC and Channel Panels
- Enhanced pre and post ICPC supervision to support staff in safeguarding surge
- Training from learning from complaints CSPR - Redaction training, Development of Honour Based Violence training and SOP, Development of a safeguarding needs assessment including the HEEADSSS tool following strategy.
- The team submitted a successful business case to expand the Specialist Safeguarding Team including 1.0 Floating Specialist Nurse for Child Protection to work across the footprint to meet surges in demand and 3.0 Band 6 Strategy Nurses to ensure HDFT representation at Strategy Meetings.

What are the results?

The key objectives for 2019-20 as set out in the annual plan have been achieved. Transforming safeguarding in 5-19 workforce has been implemented across all community contracts and specialist safeguarding capacity has been increased and established in the acute sector.

Improved the "Voice of the Child" – demonstrated through audit and supervision
Challenging Assumptions - supported through Level 3 Training and Supervision
Unlocking Fixed Thinking – supported through Training, Supervision and Deep Dive Audit

Specific Objectives for 2021
The development of a Safeguarding Children Business Case to secure 6 additional posts to work within the Safeguarding Children's Team (SCT) across a band range of B8a – B6.
The implementation of B6 Safeguarding Strategy Nurse roles within the SCT to provide additional resilience within the team and to fulfil the ongoing safeguarding surge requirements.
The implementation of a tripartite preceptorship safeguarding and children in care process to support newly qualified and new staff employed by HDFT to support with their emotional well-being and confidence in working with safeguarding children and children in care. This is offered by a locality manager of the 0-19 service and a named SNCP.

Specific Objectives for 2022
Information sharing processes agreed between HDFT and local authorities to identify those children entering into or leaving the care system.
The implementation of a Fostering and Adoption Pathway that will offer individualised, targeted intervention.
Overview of new processes, embedding procedures into practice and measuring outcomes for children.

Summary

Safeguarding demand continues to increase and this is reflected in demand on front line staff, particularly in the 0-19 teams and in the Specialist Safeguarding Teams. Quality Priorities are aimed at increasing safeguarding knowledge in acute and community teams, promoting the "Voice of The Child" at all levels of the organization and a "Think Family "Approach in all areas – even where children are not the patient. The focus for the next year will be on Unlocking Fixed Thinking and Challenging Assumptions to ensure the quality priorities for 2022 have impact on keeping children safe.

3.4 Performance against indicators in the Single Oversight Framework

The following table demonstrates HDFT's performance against the national standards included in the Operational Performance Metrics section of NHS Improvement's Single Oversight Framework for each quarter in 2021/22

April 2020 – March 2021

Performance Indicator Description	Q1	Q2	Q3	Q4	YTD
RTT - incomplete - % in 18 weeks	74.2%	73.7 %	69.5%	68.9 %	71.4 %
Diagnostic waiting times - maximum wait of 6 weeks	79.2%	80.5 %	82.4%	81.9 %	81.0 %
Trust total - Total time in A&E - % within 4 hours	83.6%	81.1 %	73.6%	66.1 %	76.3 %
All Cancers: 14 Days Target	85.4%	87.2 %	84.4%	88.4 %	86.3 %
All Cancers: 14 Days Target All Breast Referrals	11.0%	49.3 %	63.3%	87.4 %	53.8 %
All Cancers: 31 Day Target - 1st Treatment	98.1%	98.0 %	98.9%	98.1 %	98.2 %
All Cancers: 31 Day Target - Subsequent Treatment – Surgery	88.7%	97.1 %	94.8%	89.8 %	92.8 %
All Cancers: 31 Day Target - Subsequent Treatment - Drug treatment	100.0 %	99.3 %	100.0 %	99.2 %	99.6 %
All Cancers: 62 Day Target	89.2%	87.8 %	82.4%	83.8 %	86.0 %
All Cancers: 62 Day Target Screening	48.1%	35.8 %	53.4%	78.7 %	51.3 %
All Cancers: 62 Day Target Cons Upgrade	92.4%	87.1 %	87.2%	83.7 %	87.7 %
Incidence of hospital acquired C-Difficile (Cumulative)	8	19	29	36	36
Incidence of hospital acquired C-Difficile (Cumulative cases due to a lapse in care)	1	2	5	5	5

Key performance to note:

- Due to the Covid-19 pandemic and the ceasing of elective work, waiting times have risen significantly. Overall in 2021/22, 71.4% of patients were waiting less than 18 weeks for consultant led treatment. The number waiting over 52 weeks at end March 2022 was 1,140. Risks remain in two main specialties of T&O and Community Dental (which together account for 78% of the over 52 week waiters). The Trust has plans in place to reduce this number to 500 by March 2023. There has however been a large reduction in the number waiting over 104 weeks since November 2021;
- The Trust did not achieve the diagnostic waiting times standard in 2021/22 with on average, 81% of patients being seen within 6 weeks. The main areas of concern were Dexa scans, audiology tests, MRI scans and non-obstetric ultrasound
- The Trust did not achieve the A&E 4-hour standard for each quarter of the year. Performance reflects the continuing significant pressures with high bed occupancy relating to discharge challenges and staff absences. The Trust continued to support

the HCV (Humber Coast & Vale) system during 2021/22 with regular diverts of ambulance patients to Harrogate - this negatively impacts on HDFT's 4 hour performance and length of stay;

- There were 45 ambulance handover delays of over 60 minutes reported in 2021/22 (2 in the previous year) and 266 handover delays of over 30 minutes (105 in the previous year);
- 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 31 day standard for subsequent surgical treatments and the 62 day screening standard;
- The Trust reported 36 cases of hospital acquired C. difficile in 2021/22, compared to 22 in 2020/21. Root cause analysis has been completed on all cases and indicated that 30 of these were not due to lapses in care. One case was classified as inconclusive and 5 cases were deemed to be due to lapses in care. No cases of hospital acquired MRSA (methicillin-resistant staphylococcus aureus) were reported in 2021/22.

4. OTHER QUALITY INFORMATION

4.1 National Staff Survey and Staff Friends and Family Test

Introduction

In September 2020, 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 overall aim of the survey was to gather information that would help improve the working lives of NHS Staff and so provide better care for patients. Obtaining feedback from staff and taking account of their views and priorities is vital for driving real service improvements in the NHS.

It was recognised that 2020 has not been “business as usual” for the NHS workforce. The NHS has never experienced a year like this one. However, it remains vital to understand the unique impact on NHS staff experience during the COVID-19 pandemic.

The focus for the survey this year was very much on understanding the different experiences of staff and learning from those experiences, rather than on performance management or comparisons against other organisations.

The Trust surveyed all staff in 2020; 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). In a change to previous years, those receiving a paper invitation had the option to take part online instead of returning a completed paper questionnaire. All staff had the option to complete the survey questionnaire over the telephone.

A total of 1,283 staff completed the survey questionnaires. Based on the 4,159 staff invited to participate this provides a response rate of 31%.

In 2019 the Trust achieved a response rate of 41%.

Results

The Theme results overview is shown below. This table compares our scores to the best within our comparator group, the average and the worst score within our group.

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.1	5.9	6.7	6.1	7.3	8.1	9.7	6.7	6.9	6.5
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	1,268	1,282	1,282	1,279	1,112	1,274	1,280	1,277	1,283	1,275

There are 3 areas where our scores have improved over the previous years' score as shown below:

- Health and Wellbeing
- Quality of Care
- Safety Culture

There are 7 areas where our scores have gone down over the previous years' scores as shown below:

- Equality, Diversity and Inclusion
- Immediate Managers
- Morale
- Safe Environment – Bullying and Harassment
- Safe Environment - Violence
- Staff Engagement
- Team Working

Note – Appraisals were paused during 2020 due to COVID-19

Of the specific questions asked, the most improved and declined scores since 2019 are detailed in the tables below:

Most improved scores compared with the Trust's 2019 results	HDFT 2019	HDFT 2020
My organisation takes positive action on health and well-being	89%	90%
In the last 12 months I have never personally experienced physical violence at work from patients / service users, their relatives or other members of the public	89%	92%
In the last 12 months I have never personally experienced harassment, bullying or abuse at work from other colleagues	80%	51%
In the last 12 months I have never personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public	75%	76%
I do not have unrealistic time pressures	21%	23%

Most declined scores compared with the Trust's 2019 results	HDFT 2019	HDFT 2020
The team I work in often meets to discuss the team's effectiveness	68%	59%
My immediate manager asks for my opinion before making decisions that affect my work	61%	54%

The 2020 staff survey included the following two questions requesting written responses.

Q21a - Thinking about your experience of working through the Covid-19 pandemic, what lessons should be learned from this time?

Q21b - What worked well during Covid-19 and should be continued?

Responses to Q21a include:

- 244 comments related to Health and Wellbeing of which 107 were negative, 85 positive and 52 neutral comments
- 183 comments related to working arrangements of which 90 were positive, 55 negative and 38 neutral comments

Responses to Q21b include:

- 209 comments related to working arrangements of which 104 were negative, 97 positive and 8 neutral comments.

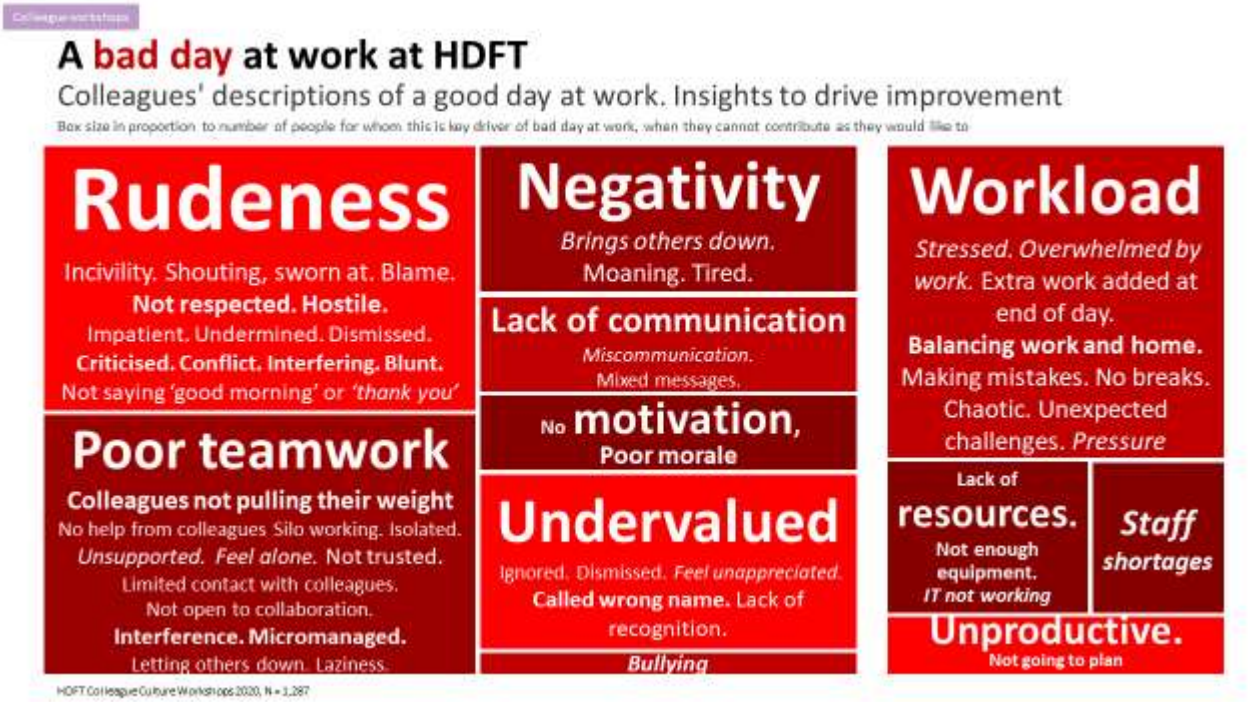
- 198 comments related to communication methods of which 119 were neutral, 70 were positive and 8 were negative

What have we done?

The lower response rate of 31% in the most recent NHS Staff Survey is reflective of the fact that we chose to focus our employee engagement activity on the At Our Best Culture Change programme, which involved 2600 employees in completing a questionnaire and attendance at workshops to identify 'What Makes a Good Day at Work?' and 'What Makes a Bad Day at Work?'

What are the results?

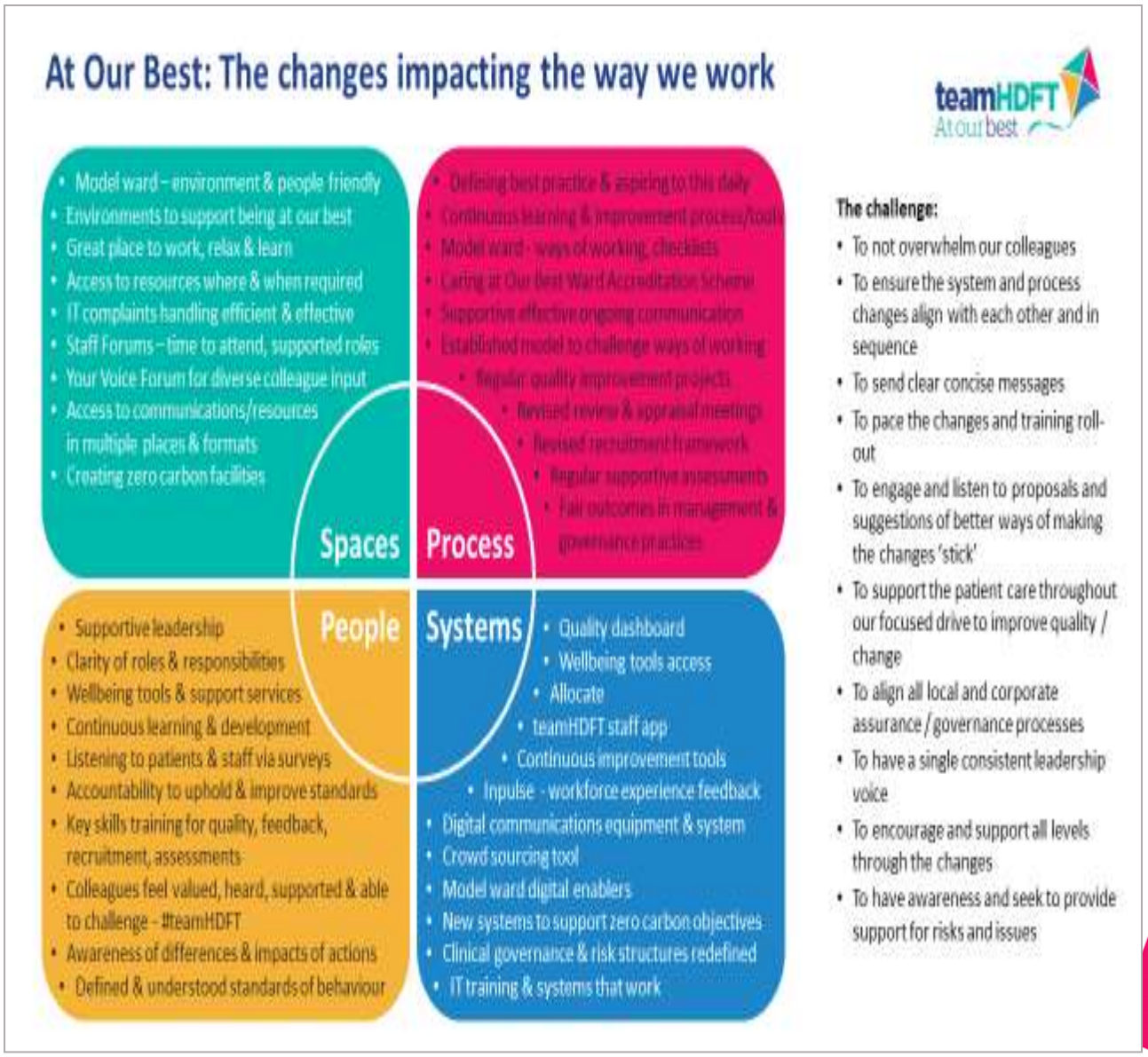
The summary of the feedback from this consultation is shown below:



Summary

The consultation is enabled us to become very clear about the behaviours we value as an organisation, and these are embodied as our KITE behaviours: shown below:

A programme of work outlined in the table below is underway to ensure that our behaviours become truly embedded, as “the way we do things at teamHDFT”. This programme will run throughout 2021/22 and beyond


At Our Best: The changes impacting the way we work
teamHDFT At our best
Spaces
• Model ward – environment & people friendly
• Environments to support being at our best
• Great place to work, relax & learn
• Access to resources where & when required
• IT complaints handling efficient & effective
• Staff Forums – time to attend, supported roles
• Your Voice Forum for diverse colleague input
• Access to communications/resources in multiple places & formats
• Creating zero carbon facilities
Process
• Defining best practice & aspiring to this daily
• Continuous learning & improvement process/tools
• Model ward - ways of working, checklists
• Caring at Our Best Ward Accreditation Scheme
• Supportive effective ongoing communication
• Established model to challenge ways of working
• Regular quality improvement projects
• Revised review & appraisal meetings
• Revised recruitment framework
• Regular supportive assessments
• Fair outcomes in management & governance practices
People
• Supportive leadership
• Clarity of roles & responsibilities
• Wellbeing tools & support services
• Continuous learning & development
• Listening to patients & staff via surveys
• Accountability to uphold & improve standards
• Key skills training for quality, feedback, recruitment, assessments
• Colleagues feel valued, heard, supported & able to challenge - #teamHDFT
• Awareness of differences & impacts of actions
• Defined & understood standards of behaviour
Systems
• Quality dashboard
• Wellbeing tools access
• Allocate
• teamHDFT staff app
• Continuous improvement tools
• Inpulse - workforce experience feedback
• Digital communications equipment & system
• Crowd sourcing tool
• Model ward digital enablers
• New systems to support zero carbon objectives
• Clinical governance & risk structures redefined
• IT training & systems that work
The challenge:
• To not overwhelm our colleagues
• To ensure the system and process changes align with each other and in sequence
• To send clear concise messages
• To pace the changes and training roll-out
• To engage and listen to proposals and suggestions of better ways of making the changes 'stick'
• To support the patient care throughout our focused drive to improve quality / change
• To align all local and corporate assurance / governance processes
• To have a single consistent leadership voice
• To encourage and support all levels through the changes
• To have awareness and seek to provide support for risks and issues

4.2 Complaints and compliments

Introduction

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

The Patient Experience Team (PET) facilitate the resolution of issues and this could include offering the opportunity of meeting with clinical staff, speaking with service managers, the heads of nursing, clinical directors, or members of the executive team including the Executive Director of Nursing, Midwifery & Allied Health Professionals and/or the Executive Medical Director to discuss issues in more detail to help to address concerns and provide information and explanations. In all cases the feedback is reviewed to identify opportunities for improving patient care.

Compared to the number of patient contacts to the Trust, the number of complaints about care delivered is very small, however each complaint is a valuable source of feedback and treated as an opportunity to improve our services and care so that the care of future patients / carers and relatives is improved.

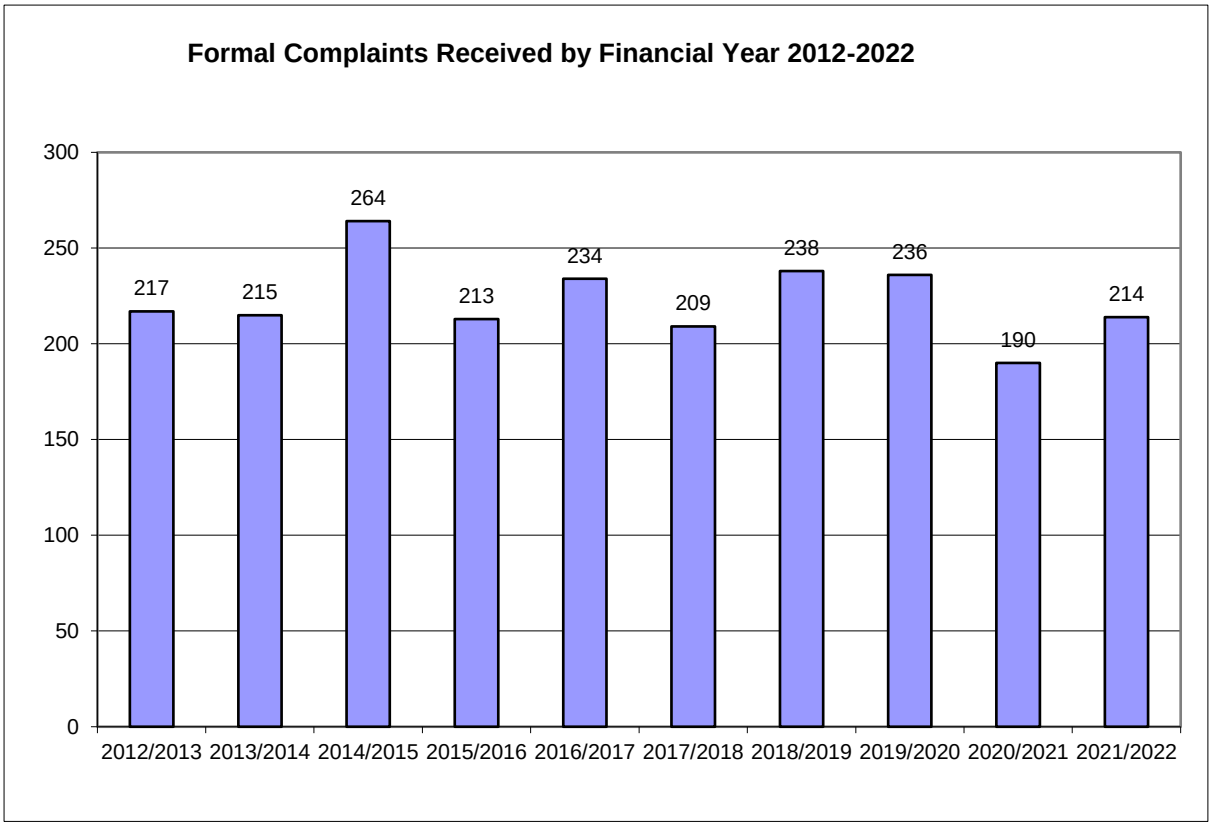
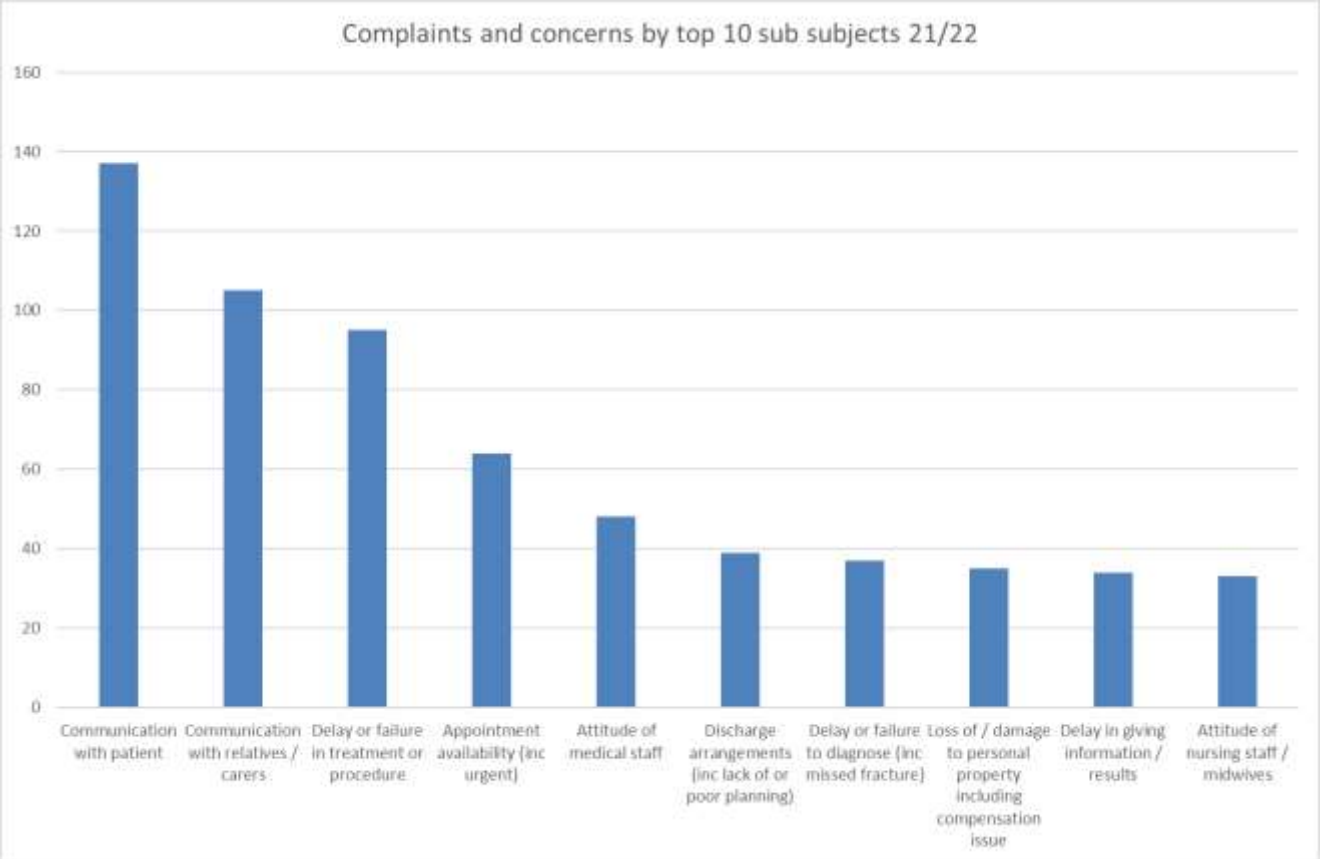


Figure XX: Local patient feedback data since 2012

The number of complaints received is more than the previous year. The organisation noted a significant reduction in complaints received during April- June 2021 which coincided with the first wave of the COVID 19 pandemic. The total number of complaints this year is in line with our usual numbers.

The Trust welcomes feedback from patients, families and carers, and encourages staff to resolve as many issues and concerns at the front line informally and as soon as possible to prevent the escalation into a formal complaint. The resolution of these informal "PALS" (Patient Advice and Liaison Service) type contacts includes concerns, information requests and comments. In 2021/22, 1294 enquiries were received by PET compared to 984 in 2020/21, 953 in 2019/20, 871 in 2018/19. This is a 32% increase in PALS contacts across the year. Of these 1294, 1033 were concerns, 261 were requests for information or comments. The aim is for all staff to address concerns before they escalate into more serious issues and we encourage members of the public to use the Patient Experience Team as a first point of contact to resolve any emerging concerns.

The top ten themes for complaints and concerns can be seen in the graph below. The main themes have consistently included issues around poor communication and attitude. This year concerns about delay or failure in treatment / diagnosis, appointment availability, discharge arrangements and loss of personal property, are also in the top ten.



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

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

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

Response timeframes for complaints are set out in a matrix and are agreed at the outset. Previously the matrix focused on the grade of the complaint (severity of issues raised), however during the year the matrix was revised to focus on the type of complaint - those complaints which required a multi-agency response, those that required a meeting to feed back the findings and those which were to be responded to within the standard 25 working days. The Trust aims to respond to all complaints by the agreed deadline set and a key performance indicator of 95% of responses to the standard 25 working day deadline is monitored. Over the last half of the year an improvement project has been underway to improve the current response rate to deadline. This included a detailed month on month improvement trajectory with the aim of meeting the 95% target by the end of the year. Although we have not met this target, improvement has been noted with the response rate increasing to an average of 59% across the year (compared to 41% overall last year), with an achievement of 77% in November and 100% in February. In addition the backlog of complaints has been eradicated. Work will continue with this across the forthcoming year.

Learning from patient feedback is at the heart of our Making Experiences Count Policy, and clinical directorates use every complaint as an opportunity to reflect on experience and identify how care can be improved. Actions developed as a result of complaints are shared with the complainant and monitored. Services also share themes and learning from via their governance groups and front line quality of care teams.

If complainants are not happy with the Trust complaints response they are able to approach the Parliamentary and Health Service Ombudsman (PHSO) to consider further review. Six complaints were referred to the PHSO in 2021/22. The Ombudsman are currently reviewing these complaints to determine if they meet their criteria for investigation. The PHSO are also still reviewing two complaints from 2020/21 to determine if they will investigate them. There has been a delay in the processing of cases with the PHSO due to their services being suspended during the Covid -19 pandemic.

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

A number of compliments are shared via the Chief Executive, Chairman and PET which are all acknowledged and shared with the staff involved

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Number of compliments received by Chief Executive, Chair and Patient Experience Team	325	316	339	325	267	279

4.3 Quality improvement

Introduction

The Improvement and Transformation Team lead on the Trust's Quality Improvement Strategy, primarily through:

- Management and delivery of the Trust's quality priorities
- Training colleagues in the principles of quality improvement
- Development and facilitation of our annual Improvement Schedule
- Responding to ad hoc quality improvement needs of the organisation

The advent of Covid-19 caused significant disruption to our team, but we promptly repositioned ourselves to design and deliver a complex and ambitious culture improvement programme called "At Our Best". Commencing in 2020, it remains a significant component of our work, although we have also seen a return to business as usual activities since Q3 2021.

What were we aiming to achieve?

"At Our Best" included a review the organization's visions and values, and a complete rebranding, which we used as an opportunity to refresh the quality improvement aspect of our work. It still includes all of the original components, but in a refreshed, modern framework:

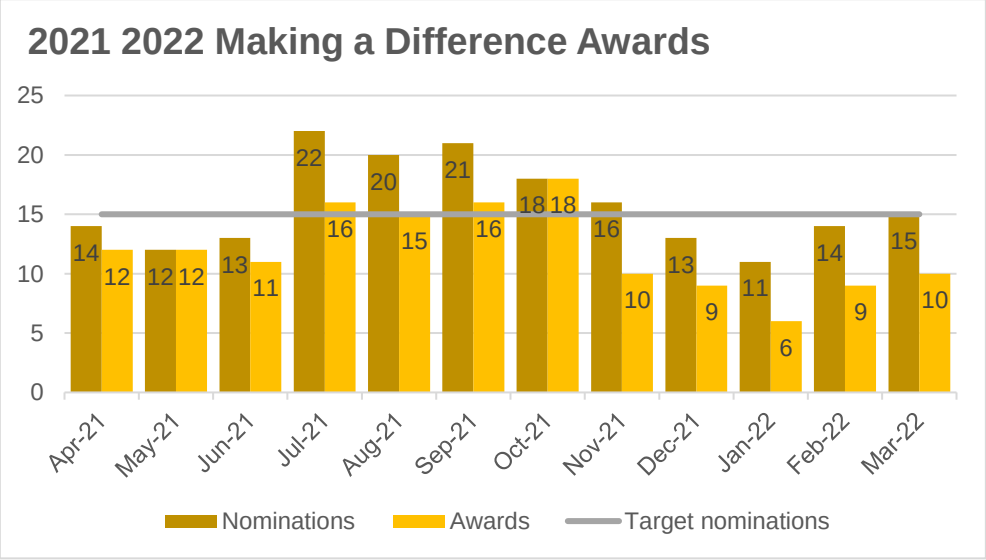
Underpinning this are a series of targets, but as with last year we chose to maintain these rather than increase them, due to the impact of the pandemic:

- Sustain the Making a Difference and Team of the Month nominations and awards
- Recognise a further 12 Teams of the Month
- Train more than 300 Quality of Care Champions across the four levels of the scheme
- Engage colleagues in practical improvement activity through a series of 24 events
- Stage a third Quality Conference following the success of our first two
- Build upon the Quality Improvement Team Accreditation scheme, launched in 2018
- Continue to develop effective quality campaigns
- Provide coaching support to Quality Champions at silver level and above as they devise and deliver their quality improvement projects

The “At Our Best” programme had its own targets, key ones of which are highlighted here:

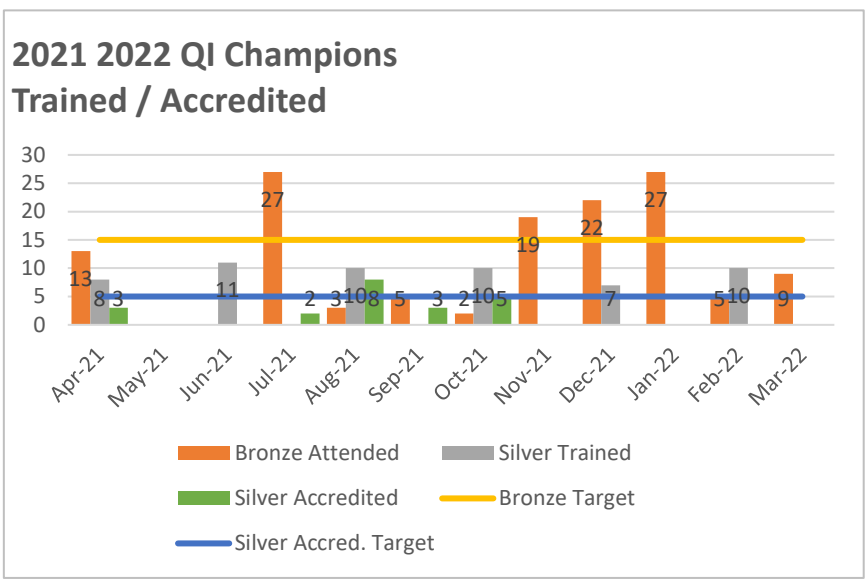
- From the second survey onwards, engage over 1,000 colleagues each quarter in our values-led colleague experience surveys
- Create 50 values tools superusers
- Distribute branding to every team at HDFT
- Involve 100 people in our Your Voice Colleague Panel
- Clinical governance structure to be improved, tested and further refined
- Increase direct engagement levels with the equality, diversity and inclusion agenda by tripling involvement in workshops.
- Improve the fairness of recruitment processes for applicants from Black and Minority Ethnic Groups.

What are the results?



Deserving award recipients

Some of our recent Teams of the Month



- Here are just ten examples of improvement projects from recently accredited Silver Level Champions:

  - Creating an audit tool and process that improves oversight of the caseload for community teams and ensures new referrals are responded to in a more timely manner.
  - Encouraging app-based meditation amongst colleagues, supporting their health and wellbeing in the workplace, reducing burnout and work-related absence.
  - Establishing an appointment reminder service for patients engaged with Active Against Cancer, reducing DNAs and ensuring that staff time is utilised to best effect.

- Reconfiguration of working patterns within one of our support services to increase productivity and reduce the lead time between referral and undertaking patient investigations.
- Introducing a home delivery service for group of cancer patients in receipt of a specific treatment, eliminating more invasive treatment and reducing the footfall in SROMC in response to Covid.
- Improving awareness and understanding of the correct purpose and disposal methods for various sharps, reducing waste and improving colleague safety.
- Developing a series of pathways for the purposes of following-up on patients recovering from Covid and undertaking research into the long-term effects of the disease.
- Introducing a daily chest drain checklist and monitoring process to improve the care and safety of patients requiring drainage of pleural fluid.
- Filming a series of exercise videos to support the work of Active Against Cancer, making the service more accessible to those who are unable to attend in person.
- Transferring Gastroenterology prescribing of biologics from paper prescriptions onto the e-prescribing system, reducing waste and improving efficiency

Launched in April 2018, our Team Accreditation scheme recognises and rewards teams who identify, work towards, achieve and then sustain a vision for providing high quality services. Any team, clinical or non-clinical, permanent or temporary as well as those including non-HDFT members working in collaboration with us, is eligible to seek accreditation by putting themselves forward. There are three levels: Bronze, Silver and Gold. As of March 2022, we had 11 teams accredited at Bronze Level, 2 at Silver and 8 pending applications.

Heavily disrupted by Covid, we have continued to deliver our Smoking Cessation campaign, albeit at a pace that is slower than we would have preferred.

Unsurprisingly, the annual conference was once again stepped-down due to the pandemic but we sincerely hope we will be able to resume these fantastic events during the coming year.

More recently, we have been able to resume our annual Quality Improvement Schedule, delivering a variety of events and QI interventions to help support colleagues in enhancing the services we provided. Social distancing, staffing capacity and pressing operational concerns meant that this had to be largely paused for c. 14 months. But since April 2021, we have delivered the following planned events

<u>AT Our Best</u>

We know that when our experience is better at work – we are able to provide even safer, higher quality care. We want to make HDFT the best place it can be to work and to be cared for. All the work we are doing together around culture is called teamHDFT – At our Best. With Covid causing some of the team's regular work to be paused, this program has been a key focus of work for the Improvement and Transformation team over the last year.

Comprising six workstreams and more than two dozen individual projects, we have an established governance system including weekly updates to our Executive Team in order to maintain oversight. As we moved into the new financial year, this has evolved into further programmes – Caring at Our Best, Learning at Our Best and Leading at Our Best.

Some of the key milestones in 2021/22 include:

- New values agreed for the Trust after extensive consultation with colleagues – 11 workshops engaging +1200 colleagues, followed by alignment workshops with +130 colleagues
- More than 700 Line Managers trained on leading with the new values and how to use the extensive range of tools introduced to support recruitment, appraisals, difficult conversations, etc
- 55 managers across sectors and roles trained as super-users to support the embedding of the new leading with values tools. This includes a Respectful Resolution process which has been introduced to provide early support to colleagues experiencing challenging behavior from others.
- All colleagues received personal letters with the values and a thank you related to Covid working, followed by line manager distribution of new lanyards, branded pens and items
- Launched the Impulse Survey platform to gather local colleague feedback quarterly, at a team level subject to sufficient responses, whilst meeting the National Quarterly Pulse Survey requirements. Survey numbers have increased with each survey as colleagues see line managers getting actively involved. 1,026 colleagues joined in the January 2021 survey.
- Active involvement, in a variety of key activities, by the members of the Your Voice Colleague Forum, now numbering 76 members.
- The Clinical Governance structure was completely revamped with extensive consultation, with updates made after a 6-month trial period
- Introduction of the teamHDFT colleague app to improve access to useful information and update, with more than 50% of colleagues accessing, and downloads continuing to rise weekly
- Equality, Diversity and Inclusion workshops held with senior management and directors resulted in a priority list of Rooting out Racism activities being defined. Regular colleague workshops to explore and implement ways to root out racism, have identified changes and ideas to improve
- A “fair recruitment” trial has been undertaken to validate the impact of reducing bias during the recruitment process
- HIF terms and conditions have aligned to HDFT terms along with significant work to raise manager capability and support for colleagues in these teams
- New leadership programmes designed to capture the new ways of working and align to the needs of different leadership roles

Summary

We have:

- Facilitated the devising and delivery of a major culture change programme, At Our Best, with over 2,000 colleagues joining in with surveys and workshops that shaped the behaviours of kindness, integrity, teamwork and equality that we now value.
- Continued with the Making a Difference and Team of the Month Awards momentum
- Increased the numbers of Quality Champions
- Provided ad hoc expert advice to Quality Champions working hard and smart to respond to the challenges they faced
- Assisted with preparedness and operational responses to Covid19
- Researched, published and communicated teamHDFT's lessons learned from Covid19
- Increased the numbers of teams receiving Quality Improvement Team Accreditation
- Helped to establish and deliver the Root out Racism programme.

We know that strong engagement from our colleagues in culture improvement and quality improvement is the best route to providing sustainable high-quality care. We look forward to further progressing these agendas next year.

4.4 Volunteers

Introduction

Over the last 12 months, the Volunteer Service has continued to grow and transform following the significant changes outlined in last year's report. The service dovetailed with the Harrogate Hospital and Community Charity Team. We currently have 502 enthusiastic and committed active volunteers of varying ages providing invaluable assistance to staff, patients and visitors across #teamHDFT. We are proud to support Volunteers who may have additional needs and those who are on a recovery pathway in addition to our standard volunteering offer.

Volunteering can make a difference to anyone, irrespective of age. Our Volunteers have the opportunity to gain experience and develop skills whilst helping enhance the service we provide to staff, patients and their families.

Volunteers play a vital role in the everyday operation of the hospital such as raising money for Harrogate Hospital & Community Charity (HHCC), supporting big events, undertaking administrative tasks, helping people to find their way around the hospital, supporting the chaplaincy, cancer services, outpatient clinics and improving the atmosphere in public areas.

Volunteers complement our current services in a variety of ways:

- Meeting, greeting and checking in patients and visitors for our Mask Station; Main Reception; Out Patient Clinics, the Sir Robert Ogden Macmillan Centre and at Ripon Community Hospital;
- Supporting
  - Patients at meal times
  - The Chaplaincy
  - Maternity Services
  - Therapy Services
  - Pharmacy
  - The Charity and Fundraising Team
  - Harrogate Hospital Radio
  - Complementary Therapy Services
  - Patients at the end of life
  - Administration services
  - Catering and Restaurant facilities
  - Mask station
- Offering a wonderful gardening service so the hospital areas are a place of comfort for staff and patients to sit in.
- Breast feeding peer support volunteers in our community sites.

Jeff Scaife – Helping out on the return of the Salad Bar post Covid in Herriots Restaurant

Peter Hunt – One of our Meal Delivery Volunteers

David Upton – Volunteer Driver, delivering Cakes for staff as part of NHS Big Tea celebrations July 2021

Mary Quinn – On our Mask Station at Harrogate District Hospital

Carolyn Rothwell and Team – Our Amazing Gardening Volunteers

We regularly hold thank you events for our volunteers, recognising the impact that they make for our patients, staff and their families. In addition we recognise their number of years' service to #teamHDFT with a certificate and small gift at specific milestones. The average number of hours of volunteering a month by our incredible team of volunteers is 750 hours!

Harrogate Hospital & Community Charity (HHCC) and Volunteer Team

The HHCC and Volunteer Team work together to fund specialist equipment, training and services, to go above and beyond the provision of the NHS. Working with a wide range of supporters across our communities fundraising and holding a wide range of exciting events across the year including our Summer Extravaganza featuring It's A Knockout, Pop–up Christmas Market and physical challenges including the Three Peaks, Total Warrior and Stepping up for HHCC.

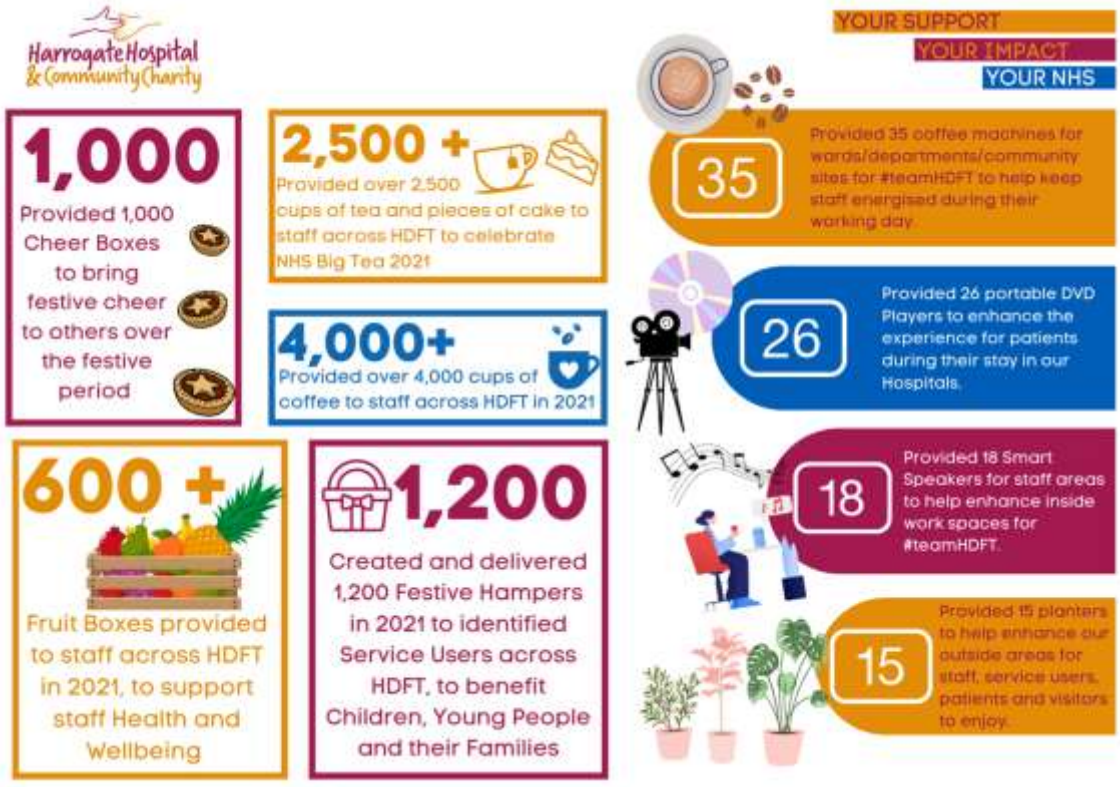
HHCC Support

A top priority for the HHCC and Volunteer Team over the year was continuing to support the health and wellbeing of staff, patients, service users and their families across #teamHDFT. A number of initiatives were established in 2020-21 and these have continued into 2021-22, many of which would not have been possible without the support of the amazing volunteer community groups. Enhancements to staff areas have continued, with colleagues able to take their breaks with the introduction of tables and chairs, coffee machines and coffee pods, microwaves, smart speakers and wellbeing books into staff wellbeing areas. The Outdoor spaces at the district hospital site have had pods installed for staff and patients to use as sheltered outdoor space to take a break in a relaxing atmosphere with the addition of planters, wind chimes and plants. The Team together with local businesses and sponsors created and distributed 1200 hampers for service users as well as 1000 cheer boxes to

spread festive cheer. Our patients have benefitted from the introduction of personal DVD players and a library of DVDs to access whilst receiving treatment in our wards, together with the tablets for keeping in touch with loved ones.

HHCC, thank you!

Thanks to our wonderful supporters, donors and fundraisers who help to make a positive impact and change patients, staff and families lives at Harrogate and District NHS Foundation Trust. Below is a small snapshot of the impact made to staff, patients and their families following donations received through the HHCC and Volunteer Team throughout 2021/22:



The funding is going towards an air source heat pump, which extracts heat from the air which can then be used to provide heating and hot water across the site reducing the consumption of natural gas

The funding will also address some of the long-standing backlog maintenance matters relating to the hospital building including repairing and replacing flat roofs that leak and old windows, both of these have impacted on the experience of patients and staff.

As part of the roofing replacement works photovoltaic panels will be installed to provide a sustainable green source for electricity and reduce the reliance on grid electricity.

4.5 Duty of candour

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

Processes for duty of candour are now well embedded throughout the Trust. Regular monitoring of outstanding cases by the Directorates continues to try and ensure that all relevant cases have the duty applied. In the new financial year this will be monitored and reported in the monthly Quality Report to Board.

Overall for the year, of the 341 events graded moderate or above harm, 187 events clearly triggered the duty of candour. In 147 of these cases the duty was followed, in 17 cases the decision was made not to apply the duty of candour for documented reasons, and 24 cases are still in progress.

4. 6 Priority Clinical Standards For Seven Day Hospital Services

7 Day Discharge Command Centre

Responding to the national guidance, we created a Community Discharge Hub that operates 7 days a week. The hub is managed by a HARA Service Manager and has colleagues from HDFT Trust and North Yorkshire county council working together to deliver the national guidance. This work has built on the existing discharge planning team, adult community teams and the NYCC social workers and transfer of care coordinators who work together to ensure early identification of patients who require support on discharge and ensure they are discharged to the most appropriate pathways as soon as they no longer require treatment that can only be provided in hospital.

ARCHS (Acute response and rehabilitation in the community hospital and home)

The Supported Discharge Service has, at its heart, a 'home first' and 'Why not home? Why not today?' approach to discharge planning. Underpinned by the belief that assessment and care which takes place in a patient's own familiar environment improves patient outcomes, the service has developed and shown to positively impact on patient experience, promoting early discharge and supporting hospital flow. Prior to the pandemic the service was able to support 15 out of hospital beds in a community 'Virtual Ward'.

At the start of the pandemic there was a rapid realization that managing patient in the community would be the key to avoiding hospitalservices becoming overwhelmed. As part of the Phase 2 Covid-19 response the Trust needed to run at reduced bed occupancy to manage the impact of reduced nurse staffing and to support distancing on the wards. To support this we combined the; supported discharge service, acute and frailty inpatient therapy services, community therapy, and bed based rehab under the umbrella of ARCH. With additional resource the service has expand the cohort of patients who can be identified to leave hospital sooner with additional short-term support in their home environment (with up to 35 virtual beds of patients being managed in the community rather than a hospital bed)

This reduces the need for inpatient rehabilitation, risk of deconditioning and interim placements. The current model expands the 'pull' approach with the team actively finding and tracking suitable cases from ED and admission wards as well as inpatient wards.

The ARCH model works across all three discharge pathways;

- ***Pathway one -*** supporting patients back to their own home for assessment and intensive therapy for post transfer from hospital
- ***Pathway two -*** supporting bed based rehabilitation to discharge patients home as soon as they no longer require overnight care
- ***Pathway three -*** some functions of the model (Frailty and Acute) support patients being discharged on pathway 3 whilst they are treated as inpatients enabling identification and plans for supported discharge and management at home as part of the virtual ward to be made at the earliest point.

ARCH creates an integrated pathway from attendance at hospital through to discharge and care in the community enabling patients to be provided with a joined up service, using shared assessments and reducing duplication and variation in care.

Summary

The Covid-19 pandemic and resultant National guidance gave us an opportunity to transform services by implementing new and innovative ways of working.

The Discharge Command Centre is currently in the process of transforming into a Community Discharge Hub, bringing together health and social care to support the discharge of patients at the point they no longer require care that can only be received in hospital. The hub will use a new system called 'Vital Hub' which has now been purchased and is being rolled out on our wards to identify and track patients who require support and pull them into the correct discharge pathway with the ethos being "home first" wherever possible. The aligned services in the hub will work as one team to minimise duplication and maximise resource to deliver services over 7 days.

A consultation how now been completed to make the four services under the ARCH umbrella into one substantive team working across acute and community patient pathways and supporting the discharge to assess and frailty agendas. The ARCH service will continue to develop and extend its offer which will include increased consultant input into the service and improved night cover for patients. Its impact on improving patient flow and reducing length of stay will continue and it will offer greater opportunity for rehabilitation in the home setting and increased numbers of patients being able to continue to live independent lives.

4.7 Speaking up

Introduction

The National Guardian's Office and the role of the Freedom to Speak Up (FTSU) Guardian were created in response to recommendations made in Sir Robert Francis' report "The Freedom to Speak Up" (2015). These recommendations were made as Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result. The ambition across the NHS is to effect the cultural change that ensures speaking up becomes business as usual. Workplace culture is the character and personality of our organisation. It is made up of our organisation's leadership, values, traditions and beliefs, and the behaviours and attitudes of the people in it. We know that: "If leaders and managers create positive, supportive environments for staff, they in turn create caring, supportive environments and deliver high-quality care for patients. Such leadership cultures encourage staff engagement". The King's Fund: Improving NHS culture At HDFT, our Freedom to Speak Up Guardians work alongside existing systems and processes for staff to raise concerns e.g. directly with managers, lead clinicians or tutors, to other departments e.g. Human Resources, Risk Management, or to other staff e.g. staff governors, chaplains, Trade Union representatives, executive or non-executive Directors. The guardians provide advice and support to staff who raise concerns, work to challenge and change the culture within the organisation, and identify and address any barriers to speaking up.

What 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.

What have we done?

We have continued to develop our shared understanding of the key elements of a fair, just and safe culture, which are:

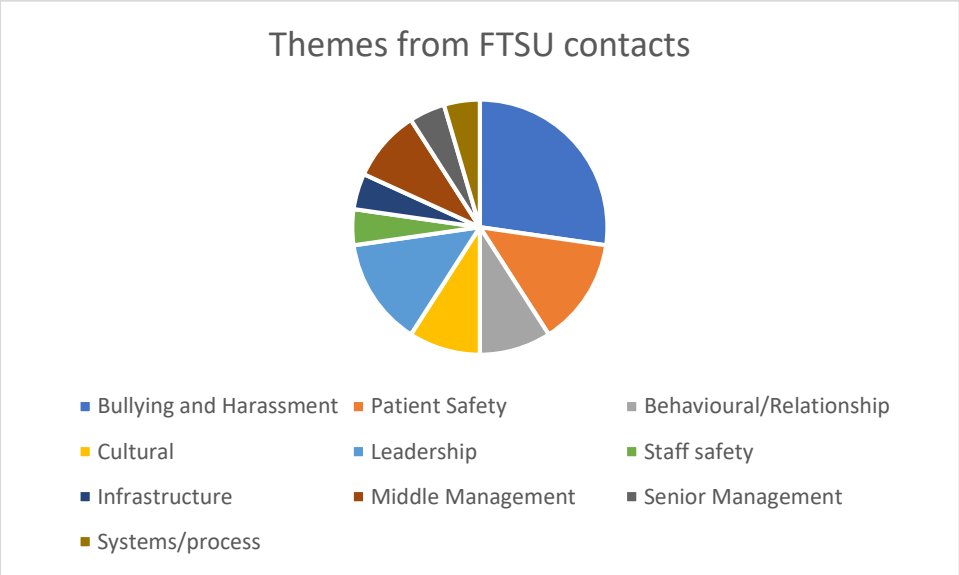
1. Fairness, compassion and psychological safety; ensuring each individual knows they will be treated fairly and compassionately by the group if things go wrong or they speak up to stop problems occurring.
2. Diversity, inclusivity, trust and respect; ensuring people are treated fairly regardless of ethnicity, gender, disability or otherl 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 12 months we have trained twenty additional Fairness Champions across the organisation. We have included the National Guardian Office training “Speak Up” for all colleagues employed by the organisation, “Listen Up” for leaders and Fairness Champions and “Follow Up” for the senior management team. Mobile App developments are underway to improve access remotely for colleagues to Speak Up as well as to support with data collection which is reported quarterly to the NGO.
Following a successful Speak Up week in October 2021, HDFT communications team are supporting with FTSU branding as part of HDFT “Listening at Our Best”.

What are the results?
15 new Fairness Champions trained, totaling 46 Fairness Champions across the organisation.

Since June 2021 there have been 22 formal contacts made and recorded with the FTSU guardian. Out of these 22 they are broken down by the following staff groups:

Nursing and Midwifery – 10
Allied Health Professionals – 6
Admin/Clerical – 3
Corporate Services – 2
Doctors – 1



These themes are analyzed and reported to the NGO 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.

4.8 NHS doctors and dentists in training Rota gaps

HDFT has a Doctor in Training (DiT) scheme which provides us with a number of DiTs throughout the year from Health Education England (HEE). Our establishment is 146 trainees. If HEE is not able to provide a full complement the Medical staffing team work closely with the department to fill the gaps.

6 gaps were identified in the August 2020 rotation which are detailed below:-

Department	Grade Establishment	Action Taken
Acute Medicine	ST3+	Filled the gap through local recruitment
Diabetes and Endocrinology	CT 1/2	Filled the gap through local recruitment
Rheumatology	CT 1/2	Filled the gap through local recruitment
Dermatology	ST 3+	Remained unfilled due to arrangement with Leeds Teaching Hospital (LTHT)
Paediatrics x 2	ST4 +	1 gap was filled through local recruitment and 1 remained unfilled. Staff within the department covered the gap.

In the February/March 2021 rotations the Trust identified 7 gaps which are detailed below:-

Department	Grade Establishment	Action Taken
Elderly Medicine	ST3 +	Unsuccessful recruitment campaigns still left the department with a gap
Emergency Medicine	ST3 +	Gap for six months which remained unfilled
Anaesthetics	ST 1/2	Maternity leave gaps with was filled through local recruitment
Anaesthetics	CT1/2	Unsuccessful recruitment campaigns still left the department with a gap
Obstetrics and Gynaecology	ST3 +	Successful recruitment but late start left the department with a 6 month gap.
Paediatrics	ST4 +	4 month gap due to candidate applying for a permanent post at HDFT

Two gaps were within GP surgeries as part of the GP training scheme and the Trust is not required to fill these vacancies.

5. QUALITY & SAFETY IMPROVEMENT PRIORITIES 22/23

Safe

1. **Theatres Improvement –** following a number of incidents within our surgical and theatres environment, a theatres improvement plan has been developed. The aim of this project is to improve patient safety and quality of care within this environment. It will focus on a series of enhanced cultural events, training and education and bespoke pieces of work on the safety checks we undertake.

2. **Emergency Department Improvement –** following a number of incidents within our Emergency Department, an improvement plan has been developed. The aim of the project is to review the patient pathways into the department, consider new ways of working, implement an enhanced safety regime and undertake a range of training and development initiatives.

3. **Pressure Ulcers –** the work undertaken in previous years in relation to our pressure ulcers improvement programme will continue into 2022-23. This will build on the work achieved in previous years as well as continue to implement new ways of working and ensure care is in line with our national framework.

4. **Falls** – the work undertaken in previous years in relation to our Falls improvement programme will continue into 2022-23. This will build on the work achieved in previous years as well as continue with the implementation of our falls action plan.

Effective

1. **Failure to Act on Results -** The failure to act on tests results is a significant patient safety issue across the NHS; errors and oversights in this area have resulted in delays in diagnosing and treating patients, some with tragic consequences. Following a number of incidents where failure to act on results or a delay in acting on results has been a primary cause of harm to our patients, this area has been selected as an improvement priority. The aim of this priority is to reduce the incidents of harm where failure to act or delaying in acting on results has contributed to patient harm.

2. **Medication** - the work undertaken in previous years in relation to our medication improvement programme will continue into 2022-23. This will build on the work achieved in previous years as well as continue to implement new ways of working and ensure care is in line with our national framework.

Experience

1. **Patient Experience –** the organisation has recently reviewed the national patient experience framework. This improvement plan will focus on the implementation of the actions noted following this review.

6. ANNEX ONE: STATEMENTS FROM STAKEHOLDERS

In accordance with the NHS Quality Accounts Regulations, Harrogate and District NHS Foundation Trust sent a copy of the draft Quality Account to its lead Clinical Commissioning Group, North Yorkshire, Healthwatch North Yorkshire, North Yorkshire County Council Scrutiny of Health Committee, the Council of Governors and the Health and Wellbeing Board for comment prior to publication and received the following statements:

NORTH YORKSHIRE CLINICAL COMMISSIONING GROUP QUALITY ACCOUNT STATEMENT 2021/22

This report has been shared with key individuals across NYCCG and their views have been collated into my response. We are committed to ensuring the provision of high-quality services for our population and take seriously our responsibility to commission services that not only meet quality and safety standards, but also listen and respond to patient feedback to help inform service developments.

Firstly, we would like to take this opportunity to thank all staff at HDFT for their hard work and dedication during the on-going COVID19 pandemic, which we acknowledge has had an impact on the achievement of some of the priorities and targets set for 2021/22. The system response to this issue has been incredible and we have seen a requirement for a flexible approach to patient care and we would like to express our appreciation to HDFT for your part in the local NHS and wider system response and subsequent response to recovery.
NYCCG believe that it is important to commend the good work that the Trust and its staff has been delivering for the North Yorkshire population during this challenging year.

NYCCG acknowledge the Trust's learning and improvement focus including the clear support to all staff disciplines and the progress made over the past 12 months in training "Fairness champions". This demonstrates the promotion of an open and honest culture and is to be commended.

NYCCG recognise that a comprehensive approach to falls and pressure ulcers is indicative of key priority areas in patient safety and learning from incidents, with subsequent actions and education to minimise future recurrence. The highlighting of the Trust's reporting in relation to pressure ulcer incidents to the quality board is representative of a robust approach to quality improvement in this area and reflects a sound governance structure for internal reporting and monitoring.
From the six quality priorities identified for 21/22 the CCG would particularly like to mention the appointment of the Chief Registrar which will continue to support Junior medical staff to shape the patient journey and experience and will play an integral role over the next 2 years.
NYCCG note the establishment of a fully staffed Medical Examiners team and concur that 100% of deaths scrutinised is indicative of the Trusts dedication to its core values.

Progress against priority areas and improvements in relation to End of life care is also acknowledged. NYCCG note plans going forwards to agree end of life and palliative care strategies with the ICB and have appreciated the HDFT's palliative care team's collaboration over the past year in terms of support to partner organisations as well as the wider network. The continued focus on key priorities and issues is apparent and NYCCG value the progress made against the areas of quality of care after death and the enhancements to the end of life coordination service to include a seven day single point of access. Over the next year we welcome further collaborative approaches to improving the patient and carer experience in palliative and end of life care including the developments in respect of the end of life social finance integrator project.

NYCCG acknowledge progress in relation to Hopes for Healthcare for which Paediatric Champion roles will be integral going forwards. We also note endeavours to maintain and improve safeguarding standards with a "Think Family" approach, both of these strategies to involve families, children and young people in being part of the development of how future services are to be delivered are commended.

We support the restructure of the Quality Governance Framework. This will undoubtedly feed into the comprehensive work done both to date and planned for the year ahead regarding falls and pressure ulcers. Commissioners welcome the opportunity to continue working collaboratively with the Trust on patient safety topics.

Despite the continued challenges of the Covid pandemic in to 2021/22 NYCCG are assured to see the progress made in relation to the integrated clinical service for inpatient unplanned care and look forward to seeing key updates and progress continuing in 2022/23.

The development of the Emergency Department and Theatre Improvement plans are also acknowledged and we would appreciate updates on progress across 2022/23.

NYCCG note the "Caring, Learning and Leading - At Our Best" programmes have demonstrated key achievements in implementing a positive culture at work which feeds into Quality and Safety Champions, meaningful audits and research participation across the Trust. The reported 97% national clinical audit project participation is to be commended. Key Quality achievements are also to be commended, particularly the involvement of over 1200 staff in workshops, leadership focus, equality and Diversity and fair recruitment.

We fully support the identified quality priorities for 22/23 and acknowledge that these will underpin continued progress by the Trust in meeting their overall quality and patient safety improvement goals.

NYCCG welcome the opportunity to review the Quality Account for 2021/22 and confirm that the account is a fair reflection of the Trust's performance and acknowledges the progress made to improve patient safety and experience despite the challenges brought about by the past year. The key successes and challenges are reflected accurately in the Quality Account.

As we transition into the Integrated Care System we, as commissioners, remain committed to working collaboratively with the Trust, system partners, and regulators to improve the quality and safety of services available for our population.

HEALTHWATCH NORTH YORKSHIRE

Healthwatch North Yorkshire has worked effectively with Harrogate District NHS Foundation Trust over the last year, for example by inputting into the development of the Trust's new strategy, by supporting their engagement activities to hear from people from the LGBTQ+ communities, and working with staff via the Making Experiences Count group to review how the Trust meets its obligations for the Accessible Information Standard.

COUNCIL OF GOVERNORS QUALITY ACCOUNT STATEMENT 2021/22

On behalf of the Council of Governors it is firstly important to acknowledge the difficulty in progressing the 2021/22 priorities due to the Covid-19 pandemic, however much progress has been made with these and significant benefits being realised with longer term projects progressing well or being planned. It is especially impressive to see the results from the first year of embedding the new Medical Examiner system & learning from deaths framework resulting in 100% of deaths reviewed by the Medical Examiner and very positive feedback received from the bereaved.

It is very reassuring to see that the delivery of the core objectives for the Safeguarding of Children are being delivered and these continue to be the focus of the teams as the demand continues to increase.

Despite a turbulent time for everyone the Trust remain committed in ensuring the quality and safety of patients are at the forefront of everything they do. Staff continue to rise to unimaginable challenges to ensure the safety and high quality care for patients. It is paramount for staff to feel supported and that they don't feel inhibited to speak up; therefore the reviewed Freedom to Speak Up arrangements are very welcome and I hope that an approach of fairness and compassion is promoted to reinforce Team HDFT's ambition of a culture of honesty, authenticity and safe conflict.

We acknowledge the reduced response rate of 31% to the staff survey but feel encouraged to see the ongoing 'At Our Best' programme has gathered a more encouraging response; it is hoped that this programme has paved the way for both an alternative and more meaningful response to review in the future. Staff are at the forefront of what we do, a contented workforce will naturally achieve improved patient outcomes therefore, it is also essential that the Trust do all within their power to explore, execute and prioritise plans that focus on recruiting and retaining a valued workforce.

Whilst not meeting the standard of 95% it is pleasing to see that progress, improvements have helped to reduce response times to complaints, and the backlog of complaints now eradicated.

Despite the challenges that Covid-19 has posed there has been a lot of continued hard work at maintaining safe and high quality cancer services, it is no wonder with the breadth of

services available for patients this is helping to enhance the experience of patients with cancer.

We acknowledge whilst there is considerable work ongoing across all domains as there is still much to do in many areas. The quality priorities for 2022/23 are set across three domains of Safe; Effective and Experience and are set to work on areas where more focus and learning is required

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.

As the world begins to return to a new sense of 'normal' the governors will welcome the opportunity once more in being involved and engaged in Quality Priorities and objective setting.

NORTH YORKSHIRE SCRUTINY OF HEALTH COMMITTEE STATEMENT 2021/22

The North Yorkshire County Council Scrutiny of Health Committee has been in regular contact with the Harrogate and District NHS Foundation Trust for a number of years and appreciates the open and constructive dialogue that has been maintained as health services in the county have gone through a significant number of changes.
The Committee has been interested in looking at the Trusts response to, and recovery from, the pandemic and the ways in which this has changed and developed service delivery and subsequent investment. It is encouraging to see the progress made against the quality priorities identified for 2021/22 and the areas where there is still work to do over the next 12 months.
It is particularly encouraging to see the Trusts plans to enhance the service offered to patients with autism as this is something the Scrutiny of Health Committee is particularly interested in, and are currently developing plans to gain more knowledge and understanding of this area. We therefore look forward to working collaboratively with the Trust and the autism champion in achieving this.
We recognise the huge amount of work that the Foundation Trust has done over the past year to support service users and staff and implement new ways of working. The committee has been kept informed of the plans that have been developed and implemented, which has been appreciated.

7. ANNEX TWO: STATEMENT OF DIRECTORS' RESPONSIBILITIES

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2021/22 and supporting guidance;
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2021 to March 2022;
    - Papers relating to quality reported to the Board over the period April 2021 to March 2022;
    - Feedback from the commissioners dated x;
    - Feedback from Governors dated x;
    - Feedback from Healthwatch North Yorkshire was requested x;
    - Feedback from North Yorkshire County Council Scrutiny of Health Committee dated x;
    - The Trust's draft complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated x;
    - The [latest] national patient survey dated x;
    - The [latest] national staff survey dated x;
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated x;
    - CQC inspection report dated 14 March 2019.
- the quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with NHS improvements annual reporting manual and supporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board on x.

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Sarah Armstrong
Chair

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Jonathan Coulter
Chief Executive

8.ANNEX THREE: NATIONAL CLINICAL AUDITS 2021/22

7.	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2021/22	Data submitted as a percentage of the number of registered cases required for that audit
1	Case Mix Programme (CMP)	No	354	100%
2	Chronic Kidney Disease Registry (previously listed under UK Renal Registry)	No	TBC	TBC
3	Elective Surgery (National PROMs Programme)	No		
3a	*Hip replacement*		xxx (pre-op) xxx (post-op)	xxx.x% xxx.x%
3b	*Knee replacement*		xxx (pre-op) xxx (post-op)	xxx.x% xxx.x%
4	Falls and Fragility Fracture Audit Programme (FFFAP)	Yes		
4a	*National Audit of Inpatient Falls*		Participated	100%
4b	*National Hip Fracture Database*		324	100%
5	Inflammatory Bowel Disease (IBD) Audit **Refers to all new patients on biologics Cumulative total = 168*	No	41	100%
6	LeDeR - Learning Disabilities Mortality Review NB Continuous Data Collection	No	4	100%
7	Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes		

	NB Continuous Data Collection			
7a	Perinatal confidential enquiries		TBC	TBC
7b	Perinatal mortality surveillance		TBC	TBC
7c	Maternal mortality surveillance and confidential enquiry		TBC	TBC
8	Medical and Surgical Clinical Outcome Review Programme NB Continuous Data Collection	Yes		
8a	*Epilepsy Study*		5	100%
8b	*Crohns Study*		Participation ongoing	
9	National Adult Diabetes Audit (NDA)	Yes		
9a	*National Diabetes Core Audit*		*TBC – June 2022*	100%
9b	*National Pregnancy in Diabetes Audit*		8	73%
9c	*National Diabetes Footcare Audit*		*TBC 17/06/2022*	100%
9d	*National Inpatient Diabetes Audit including National Diabetes In-patient Audit – Harms*		6	100%
10	National Asthma and COPD Audit Programme (NACAP)	Yes		
10a	*NACAP - Adult asthma secondary care*		*TBC 13/05/2022*	*To include no: excluded*
10b	*NACAP - Paediatric - Children and young people asthma secondary care*		31	100%

10c	*NACAP - Pulmonary Rehabilitation*		5	Unable to ascertain
10d	*NACAP - Chronic Obstructive Pulmonary Disease (COPD)*		*TBC 13/05/2022*	*To include no: excluded*
11	National Audit of Breast Cancer in Older People (NABCOP)	Yes	TBC	TBC
12	National Audit of Cardiac Rehabilitation	No	276 *(currently only 190 as patients from Feb and March 2022 won't be finalised until 30/06/2022)*	100%
13	National Audit of Care at the End of Life (NACEL)	Yes	36	90%
14	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	TBC	TBC
15	National Cardiac Arrest Audit (NCAA)	No	46	100%
16	National Cardiac Audit Programme (NCAP)	Yes		
16a	*NCAP-Myocardial Ischaemia National Audit Project (MINAP)*		TBC 30/06/2022 – Michelle Culpin	
16b	*NCAP-National Audit of Cardiac Rhythm Management Devices and Ablation*		186 implants 818 follow-ups	100%
16c	*NCAP-National Heart Failure Audit*		TBC	TBC
17	National Child Mortality Database (NCMD)	Yes	TBC	TBC
18	National Comparative Audit of Blood Transfusion	No		

18a	*Audit of Blood Transfusion against NICE Guidelines*		37	100%
19	National Early Inflammatory Arthritis Audit (NEIAA) **refers to patients recruited to the study in timeframe.*	Yes	19	Unable to ascertain
20	National Emergency Laparotomy Audit (NELA)	Yes	61	98%
21	National Gastro-intestinal Cancer Audit Programme (GICAP)	Yes		
21a	*National Oesophago-Gastric Cancer Audit (NOGCA)* **provisional data based on diagnoses in 2021/22. Final submission date is in 2023.*		*55**	100%
21b	*National Bowel Cancer Audit (NBOCA)* **provisional data based on diagnoses in 2021/22. Final submission date is in 2023.*		200	100%
22	National Joint Registry	No	TBC	
23	National Lung Cancer Audit Programme ** based on diagnoses in 2021/22*	Yes	129*	100%
24	National Maternity and Perinatal Audit (NMPA)	Yes	TBC	TBC
25	National Neonatal Audit Programme (NNAP)	Yes	130	100%
26	National Paediatric Diabetes Audit (NPDA)	Yes	*TBC – 28/05/2022*	
27	National Perinatal Mortality Review Tool	Yes	TBC	TBC
28	National Prostate Cancer Audit (NPCA) ** based on diagnoses in 2021/22*	Yes	205*	100%
29	Respiratory Audits	No		

29a	*National Outpatient Management of Pulmonary Embolisms Audit*		5	100%
29b	*National Smoking Cessation Audit*		181	100%
30	Sentinel Stroke National Audit Programme (SSNAP)	Yes	*TBC 02/05/2022 – Becci Vickers*	
31	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	No	4	100%
32	Society for Acute Medicine Benchmarking Audit	No	TBC	TBC
33	Trauma Audit & Research Network	No	204	100%

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

For information, the Trust also participated in the following National audits and registries which were not listed on the 2021/22 Quality Accounts List:

Name of Audit	Part of NCAPOP?	Number of patients for which data submitted 2021/22	Data submitted as a percentage of the number of registered cases required for that audit
Breast & Cosmetic Implant Registry	No	25	100%
UK National Hand Registry	No	TBC	TBC
Bone and Joint Infection Registry (BAJIR)	No	TBC	TBC
NHSE and NHSI Learning Disabilities Audit	No	TBC	TBC

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2021/22	Data submitted as a percentage of the number of registered cases required for that audit
1	Case Mix Programme (CMP)	No	354	100%
2	Chronic Kidney Disease Registry (previously listed under UK Renal Registry)	No	TBC	TBC
3	Elective Surgery (National PROMs Programme)	No		
3a	*Hip replacement*		xxx (pre-op) xxx (post-op)	xxx.x% xxx.x%
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6	LeDeR - Learning Disabilities Mortality Review NB Continuous Data Collection	No	4	100%
7	Maternal, Newborn and Infant Clinical Outcome Review Programme NB Continuous Data Collection	Yes		

7a	Perinatal confidential enquiries		TBC	TBC
7b	Perinatal mortality surveillance		TBC	TBC
7c	Maternal mortality surveillance and confidential enquiry		TBC	TBC
8	Medical and Surgical Clinical Outcome Review Programme NB Continuous Data Collection	Yes		
8a	*Epilepsy Study*		5	100%
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10c	*NACAP - Pulmonary Rehabilitation*		5	Unable to ascertain

10d	*NACAP - Chronic Obstructive Pulmonary Disease (COPD)*		*TBC 13/05/2022*	*To include no: excluded*
11	National Audit of Breast Cancer in Older People (NABCOP)	Yes	TBC	TBC
12	National Audit of Cardiac Rehabilitation	No	276 *(currently only 190 as patients from Feb and March 2022 won't be finalised until 30/06/2022)*	100%
13	National Audit of Care at the End of Life (NACEL)	Yes	36	90%
14	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	TBC	TBC
15	National Cardiac Arrest Audit (NCAA)	No	46	100%
16	National Cardiac Audit Programme (NCAP)	Yes		
16a	*NCAP-Myocardial Ischaemia National Audit Project (MINAP)*		TBC 30/06/2022 – Michelle Culpin	
16b	*NCAP-National Audit of Cardiac Rhythm Management Devices and Ablation*		186 implants 818 follow-ups	100%
16c	*NCAP-National Heart Failure Audit*		TBC	TBC
17	National Child Mortality Database (NCMD)	Yes	TBC	TBC
18	National Comparative Audit of Blood Transfusion	No		
18a	*Audit of Blood Transfusion against NICE Guidelines*		37	100%

19	National Early Inflammatory Arthritis Audit (NEIAA) **refers to patients recruited to the study in timeframe.*	Yes	19	Unable to ascertain
20	National Emergency Laparotomy Audit (NELA)	Yes	61	98%
21	National Gastro-intestinal Cancer Audit Programme (GICAP)	Yes		
21a	*National Oesophago-Gastric Cancer Audit (NOGCA)* **provisional data based on diagnoses in 2021/22. Final submission date is in 2023.*		*55**	100%
21b	*National Bowel Cancer Audit (NBOCA)* **provisional data based on diagnoses in 2021/22. Final submission date is in 2023.*		200	100%
22	National Joint Registry	No	TBC	
23	National Lung Cancer Audit Programme ** based on diagnoses in 2021/22*	Yes	129*	100%
24	National Maternity and Perinatal Audit (NMPA)	Yes	TBC	TBC
25	National Neonatal Audit Programme (NNAP)	Yes	130	100%
26	National Paediatric Diabetes Audit (NPDA)	Yes	*TBC – 28/05/2022*	
27	National Perinatal Mortality Review Tool	Yes	TBC	TBC
28	National Prostate Cancer Audit (NPCA) ** based on diagnoses in 2021/22*	Yes	205*	100%
29	Respiratory Audits	No		
29a	*National Outpatient Management of*		5	100%

	Pulmonary Embolisms Audit			
29b	*National Smoking Cessation Audit*		181	100%
30	Sentinel Stroke National Audit Programme (SSNAP)	Yes	*TBC 02/05/2022 – Becci Vickers*	
31	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	No	4	100%
32	Society for Acute Medicine Benchmarking Audit	No	TBC	TBC
33	Trauma Audit & Research Network	No	204	100%

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

For information, the Trust also participated in the following National audits and registries which were not listed on the 2021/22 Quality Accounts List:

Name of Audit	Part of NCAPOP?	Number of patients for which data submitted 2021/22	Data submitted as a percentage of the number of registered cases required for that audit
Breast & Cosmetic Implant Registry	No	25	100%
UK National Hand Registry	No	TBC	TBC
Bone and Joint Infection Registry (BAJIR)	No	TBC	TBC
NHSE and NHSI Learning Disabilities Audit	No	TBC	TBC

9.ANNEX FOUR: GLOSSARY

ACP	Advanced Care Practitioner
AMU	Acute Medical Unit
BAME	Black and minority ethnic
BSL	British sign language
CAT	Clinical Assessment Team – changed to Combined Assessment Team (December 2018)
CATT	Clinical Assessment, Triage and Treatment
CCG	Clinical Commissioning Group
CEM	Royal College of Emergency Medicine
CHC	Continuing Healthcare
CNS	Clinical Nurse Specialist
COPD	Chronic obstructive pulmonary disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CTG	Cardiotocography
CVI	Certificate of visual impairment
Dashboard	Data visualisation tool that displays the current status of metrics and key performance indicators
ED	Emergency Department
EoL	End of life
EPaCCS	Electronic palliative care co-ordination system
ePMA	Electronic prescribing and medicines administration system
FFT	Friends and Family Test
GP	General practitioner
HaRD	Harrogate and Rural District
HDFT	Harrogate and District NHS Foundation Trust
ICE	Requesting and reporting software
ICNARC	Intensive care national audit and research centre
LD	Learning disabilities
MAU	Medical Admissions Unit
MCA	Mental Capacity Act
MDT	Multidisciplinary team
NCAPOP	National Clinical Audit and Patient Outcome Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NICE	The National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System
PVG	Patient Voice Group
RTT	Referral to treatment
SAU	Surgical Assessment Unit
SJR	Structured judgement review
SSNAP	Sentinel Stroke National Audit Programme
VTE	Venous thromboembolism
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole time equivalent

If you require this document in an alternative language or format (such as Braille, audiotape or large print), please contact our Patient Experience Team: 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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