Harrogate and District NHS Foundation Trust’s

Quality Account

2015/16
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1. STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

As Chief Executive of Harrogate and District Foundation Trust it is my responsibility to ensure that the care and services we provide are safe, effective, and responsive to people’s needs and delivered with care and compassion at all times. As an organisation, we are intensely proud of our reputation for quality and we strive to create the conditions for outstanding care to be the norm across all of our services, at all times.

This quality account describes the things we have done to drive up quality over the last twelve months and the areas we have identified as priorities for the year ahead. It illustrates how we have worked to sustain high quality care in hospital and community services, from Harrogate to Leeds, Ripon to Scarborough and other parts of North Yorkshire. In a changing NHS it also touches on the importance of partnerships as we seek to offer truly patient-centred care.

The last 12 months has been another strong year for the Trust. Importantly, when people who use our services have responded to national surveys the Trust has consistently rated as amongst the best nationally. When our own staff completed the national staff survey the results placed the Trust in the top three when compared to its peers.

Here are some of the quality headlines for the year overall:

- The Trust achieved all national waiting time targets for cancer services and referral to treatment times for elective care. More than 95% of people were seen within 4 hours in our Emergency Department;
- We achieved our best ever NHS safety thermometer score of 97.9% in February. This is a national method of reporting the percentage of people experiencing harm free care. A score above 95% is considered good and comparable trusts on average report scores around 94-95%;
- The Trust was rated as ‘good’ and ranked 47th out of 230 in the new National Learning League. This is designed to illustrate the safety culture in NHS Providers;
- Our maternity service was rated in the top three nationally by service users.
- In the 2015 survey of inpatients administered by Picker, HDFT scored significantly better than other trusts in 18 out of 62 questions.
- Our laboratories have gained UKAS accreditation to ISO 15189:2012 [Medical laboratories — Requirements for quality and competence] in Blood Sciences, Histopathology and Microbiology. This accreditation is an internally recognised mark of quality and is objective proof that a laboratory is not only competent, but safe, patient-focused, efficient and reliable. Few laboratories in the country have all their services accredited to this level.

Getting the fundamentals of care right is a crucial part of any NHS providers role. A strong focus on improving care in inpatient areas this year has led to a substantial reduction in the number of patients suffering harm as a result of a fall while in our care. We have also improved the detection and prevention of pressure ulcers with a 36% reduction in the number of pressure ulcers arising in our care. Our ambition is to reduce to zero the number of avoidable hospital acquired pressure ulcers in the next 12 months. We identified more cases of the infection Clostridium difficile during 2015/16 than in the previous year. In seven of these cases a lapse in care was identified as the root cause and for 2016/17 we are determined to bring this down to zero.

Last year we selected the following three key areas for quality improvement:

- Creating the conditions for safety by improving communication;
- Improving patients’ experience of using our services;
• Becoming a centre of excellence for the care of the frail elderly.

Over the coming pages you can read about how we went about making improvements and the benefits which patients are now experiencing. The work started in 2015/16 will be carried forward during 2016/17 alongside the new priorities we have selected for this year. These are:

1. To reduce morbidity and mortality related to sepsis;
2. To improve the care of people with learning disabilities;
3. To provide high quality stroke care - demonstrated by improvement in national indicators;
4. To improve the management of inpatients on insulin.

In February 2016 the Trust was inspected by the Care Quality Commission as part of its routine programme of inspections. Sixty three inspectors spent a week at the Trust and visited services far and wide to talk to patients, carers, staff and other stakeholders. No serious matters of concern were raised at the time of the inspection. At the time of writing the results of this important inspection are awaited.

The single most powerful determinant of care quality is the collective knowledge, skills and behaviours of the people who provide the care. Our vision is to deliver “Excellence Every Time” and we do this by ensuring that colleagues working across the organisation are capable and motivated, that they have the right skills and abilities to do their work and that we have a culture of openness and learning. You can read more about the overall performance of the Trust in our Annual Report for 2015/16 which this Quality Account complements.

Finally I would like to record my thanks to colleagues in every part of the Trust whose unwavering focus on the quality of care has made these results possible.

Dr Ros Tolcher (Chief Executive)  
Date: 20 May 2016
2. PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE

2.1 Priorities for improvement 2016/17

We have consulted with our external stakeholders and within the Trust about the priorities for quality improvement during 2016/17. The final indicators reflect national and local priorities for improvement, current performance and objectives and have been approved by the Board of Directors. We will set targets for achievement and will monitor progress regularly at the Quality Committee. We aim to:

1. **Reduce morbidity and mortality related to sepsis**

Sepsis is a life-threatening response of the body to infection. There is a national focus on reducing morbidity and mortality related to sepsis, with inclusion in the national Commissioning for Quality and Innovation (CQUIN) scheme for 2015/16 and 2016/17. We will be aiming to achieve the national CQUIN requirements relating to sepsis screening, treatment and review. The metrics that will be used to monitor performance and improvement are:

- CQUIN audit data;
- Case note review of patient deaths resulting from sepsis;
- Sepsis mortality rate.

2. **Improve the care of people with learning disabilities**

This relates to the Trust’s Equality and Diversity objectives and we aim to increase the identification of people with learning disabilities by using, with their consent, electronic flags on electronic patient systems. This will enable staff to identify people who may need additional support and to use that information to deliver high quality, personalised care. The metrics that can be used to monitor performance and progress are:

- Number of learning disability flags on hospital systems;
- Demonstration of using information about people with learning disabilities to provide personalised care;
- Patient and carer feedback from the Friends and Family Test and other surveys, complaints, compliments;
- Staff training levels.

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

Whilst some of our Sentinel Stroke National Audit Programme (SSNAP) results have improved recently, we are not making as much progress as we would like with others, and we want to focus during 2016/17 on improving our performance in relation to the provision of high quality stroke care. The quarterly SSNAP dataset will be used to monitor performance and progress.

4. **Improve the management of inpatients on insulin**

We are focusing on this because of increasing medicines safety incidents including serious incidents requiring investigation (SIRI) that relate to insulin prescribing and administration. The metrics for monitoring performance and progress include:
• Datix (patient safety and risk management software) reports relating to insulin management;
• Actions taken as a result of abnormal results e.g. inpatients with an episode of hypoglycaemia, raised capillary blood glucose as indicated on the insulin dashboard;
• Staff training.

It has been noted that the Trust will consider the extended range of community services across Darlington, County Durham and Middlesbrough from 1 April 2016, and across North Yorkshire, when the quality priorities for 2017/18 are considered.

2.2 Progress against quality priorities identified in 2014/15 Quality Account

In the 2014/15 Quality Account we identified the following priorities:

• Creating the conditions for safety by improving communication;
• Improving patients’ experience of using our services;
• Becoming a centre of excellence for the care of the frail elderly.

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

2.2.1 Creating the conditions for safety by improving communication

Poor communication is an underlying root cause of many patient safety incidents and complaints. This may be as a result of insufficient or unclear information being communicated to staff, patients and relatives, or as a result of poor attitude or tone.

Our aim was to create a culture in which it is the norm to communicate with our patients, their relatives and our colleagues in a way that best meets their needs and expectations, and improves patient safety and experience. We hoped to reduce the number of complaints relating to poor communication.

What have we done?

Each clinical directorate within the Trust has promoted actions relevant to their services. These have included:

• Using ‘Every Patient, Every Time’ training and ‘Barbara’s Story’, a short film developed by Guy’s and St. Thomas’ NHS Foundation Trust as an innovative training programme about dementia, to impress on our staff the importance of getting communication right;
• Empowering staff to feel confident to say sorry and explain to patients if something unexpected has happened or gone wrong;
• “Hello my name is…..” briefings. This is a national campaign started by Dr Kate Granger for person-centred, compassionate care;
• Work undertaken in Pharmacy to respond to patient feedback by improving the provision of medicines information to patients (verbal, written and through the patient helpline). This will improve patient safety by optimising medicines use and improving adherence. Pharmacists are using the concept of “Every Contact Counts” to increase the contact time with patients to ensure patients are well informed about their medicines and any potential side effects;
• Work to improve end of life care during the last 12 months of life. One focus has been to facilitate patients and their families to achieve their choices regarding care in
the last days of life. We have also focused on training staff on the five Priorities of Care for the dying person, launched by the Department of Health in 2014, investing time to embed the training into practice. Some of these priorities relate specifically to communication. See section 2.5.3 in this report for further detail;

- A monthly newsletter produced by and shared with staff across the Podiatry Department. It has proved to be an excellent way to communicate with staff and share information and learning across a service that is geographically spread across North Yorkshire;
- An initiative called “Let's Talk” which used a questionnaire to gather feedback on issues of communication with patients and their families. Whilst most feedback was positive we discovered that families did not know how to arrange to talk to their relative's consultant. We have made this information available on our elderly care wards so relatives know how to book a meeting with a consultant;
- The introduction of new visiting times from 11.00-19.00 which has allowed more time for our staff to speak to patients relatives, friends and carers. This also provides valuable information which improves patient safety whilst in hospital and when discharge is being planned;
- Improving the verbal handover of patient information between teams by the use of "safety huddles" on the two elderly care wards and the respiratory ward. These are short team discussions focused on the safety needs of patients and are having a positive impact;
- The introduction of safety briefings in all inpatient areas. This briefing document is updated during each shift and completed by the nurse in charge. The content is discussed with other staff at handover which ensures all staff are aware of patients at risk of falls, infection control issues, patients with a pressure ulcer or high risk of developing one, patients who are nutritionally at risk, patients with a “do not attempt cardio-pulmonary resuscitation” order, patients with a Deprivation of Liberty Safeguard application, any patient with a learning disability, and any other issues that involve patient safety. All nursing staff receive a copy so they have the information they need to provide appropriate care;
- The introduction of a structured daily ward assurance process which involves ward managers talking to all staff and patients and ensuring patient safety is assessed across their area of responsibility. Areas of concern are escalated to the matrons. In addition to promoting patient safety, this also enables the matrons to talk to any patient or relative who is unhappy with any aspect of their care in order to try to resolve their concerns as quickly as possible. We believe that this has been particularly effective in reducing patient complaints;
- Displaying posters in ward areas to encourage patients and relatives to raise any concerns about their care whilst still in hospital so we can try to resolve them rapidly. The posters emphasise that this will not adversely affect their ongoing care;
- Development of new multidisciplinary admission documentation that we expect to start using early in 2016/17. With the whole multidisciplinary team using the same document, it is anticipated that vital patient safety information will be shared more effectively, unnecessary duplication will be reduced, communication between staff will improve and this will have a positive impact on patient safety;
- Work to improve communication within operating theatres following an audit that showed poor compliance with the use of the WHO (World Health Organisation) Surgical Safety Checklist;
- Seconding a midwife to progress our safety improvement plan developed for the national “Sign up to Safety” campaign, which is focused on using awareness of human factors in patient care to improve communication, team working and leadership in maternity.
What are the results?

Better communication is difficult to measure. However we feel confident that patients, relatives and carers are now more able to have discussions with our staff about what is important to them, and our staff have a greater understanding of their patients’ needs.

It will be clear in other parts of this report (see particularly section 2.5.1) that patient safety has improved this year with improvement in communication regarding medicines and a reduction in the number of our patients who suffer harm from falls and pressure ulcers. The results of other work to improve communication are given below.

1. Complaints relating to poor communication

Data shows a positive reduction in complaints relating to poor communication across the Trust during 2015/16.

![Complaints relating to poor communication for 2015/16](image)

*Figure 1: Complaints relating to poor communication 2015/16*

2. “Hello, my name is…”

An audit was conducted in Podiatry to see if patients report that the Podiatrist or Assistant introduce themselves. There was an excellent outcome with approximately 94% of patients reporting that the staff either introduced themselves, or that they already knew the staff member and therefore there was no need for introductions.

<table>
<thead>
<tr>
<th>“Hello, my name is…”</th>
<th>No of responses</th>
<th>% response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients responding</td>
<td>380</td>
<td>97.4</td>
</tr>
<tr>
<td>&quot;Yes&quot; response</td>
<td>322</td>
<td>84.7</td>
</tr>
<tr>
<td>&quot;No&quot; response</td>
<td>58</td>
<td>15.2</td>
</tr>
<tr>
<td>&quot;But I knew them&quot;</td>
<td>34</td>
<td>8.9</td>
</tr>
</tbody>
</table>

*Table 1: “Hello, my name is…” Podiatry survey response*

In addition 93.5% of patients surveyed were satisfied when asked “Were you happy with how they explained your foot problem and how they explained the treatment they were going to give?”
3. **End of Life Care**

There is detail of the work that has been undertaken to improve end of life care in section 2.5.3 of this report. Some results specific to communication are:

**National Care of the Dying Audit of Hospitals (NCDAH)**

The aim of this Royal College of Physicians audit is to identify and communicate learning that can help to improve the care of dying patients and their relatives or carers in hospital settings.

In 2014 standards of care were evaluated using clinical and organisational key performance indicators (KPIs), by which trusts could benchmark themselves for future performance. These were based on national policy and the audit questions were informed by the 44 recommendations of the 2013 Independent Review of the Liverpool Care Pathway. For the 2015 audit, as a result of changing healthcare landscape and terminology, the NCDAH has defined quality indicators (QIs) rather than KPIs. Essentially, they retain the same function and are derived from the actual audit results of participating trusts, but due to this change in terminology the results from the 2015 audit cannot be compared directly with the 2014 audit results.

The results of the 2014 and 2015 audits pertinent to communication are summarised below:

<table>
<thead>
<tr>
<th>National Care of the Dying Audit of Hospitals 2014: Key results HDFT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key findings</strong></td>
</tr>
<tr>
<td>Organisational KPIs related to communication achieved</td>
</tr>
<tr>
<td>Organisational KPIs related to communication not achieved</td>
</tr>
</tbody>
</table>

Table 2: NCDAH 2014 HDFT Key results

<table>
<thead>
<tr>
<th>National Care of the Dying Audit of Hospitals 2015: Key results for HDFT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key findings</strong></td>
</tr>
<tr>
<td>Organisational QIs related to communication achieved</td>
</tr>
<tr>
<td>The clinical QI with the highest score of achievement (largest percentage difference)</td>
</tr>
</tbody>
</table>

Table 3: NCDAH 2015 Harrogate and District NHS Foundation Trust (HDT) key results

*Achieved means the % of cases that achieved the KPI / QI at HDFT were greater than that of the % achieved at the national average.
Bereavement survey

Whilst we value feedback and seek to use this to improve the end of life care we provide, we are very aware that it is a difficult time for anyone recently bereaved and we approach this work as sensitively as possible. We undertook a survey of bereaved relatives in 2013 as part of the national audit, and are now undertaking a continuous local survey to gain more feedback and a richer understanding of end of life care. We write to the next of kin about seven weeks after their relative’s death to ask if they would complete a questionnaire.

A preliminary report has been completed in February 2016 and the results pertinent to communication are mainly positive.

The nurses had time to listen and discuss his/her condition with me.

<table>
<thead>
<tr>
<th></th>
<th>2013 survey (n=11)</th>
<th>Current survey (n=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>6 (55%)</td>
<td>5 (50%)</td>
</tr>
<tr>
<td>Agree</td>
<td>4 (36%)</td>
<td>4 (40%)</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>1 (9%)</td>
<td>1 (10%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The doctors had time to listen and discuss his/her condition with me.

<table>
<thead>
<tr>
<th></th>
<th>2013 survey (n=11)</th>
<th>Current survey (n=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>6 (55%)</td>
<td>6 (60%)</td>
</tr>
<tr>
<td>Agree</td>
<td>4 (36%)</td>
<td>3 (30%)</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>1 (9%)</td>
<td>1 (10%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

During the last two days, how involved were you with the decisions about his/her care and treatment?

<table>
<thead>
<tr>
<th></th>
<th>2013 survey (n=11)</th>
<th>Current survey (n=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very involved</td>
<td>6 (55%)</td>
<td>8 (80%)</td>
</tr>
<tr>
<td>Fairly involved</td>
<td>4 (36%)</td>
<td>2 (20%)</td>
</tr>
<tr>
<td>Not involved</td>
<td>1 (9%)</td>
<td>0</td>
</tr>
</tbody>
</table>

Did the healthcare team explain his/her condition and/or treatment in a way you found easy or difficult to understand?

<table>
<thead>
<tr>
<th></th>
<th>2013 survey (n=11)</th>
<th>Current survey (n=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very easy</td>
<td>8 (73%)</td>
<td>6 (60%)</td>
</tr>
<tr>
<td>Fairly easy</td>
<td>3 (27%)</td>
<td>4 (40%)</td>
</tr>
<tr>
<td>Fairly difficult</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Very difficult</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>They did not explain it</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 4: Bereavement survey results
However there is still work needed to further improve communication and understanding.

Did a member of the healthcare team talk to you about what to expect when s/he was dying (e.g. symptoms that may arise)?

<table>
<thead>
<tr>
<th></th>
<th>2013 survey (n=11)</th>
<th>Current Survey (n=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>7 (64%)</td>
<td>6 (60%)</td>
</tr>
<tr>
<td>No</td>
<td>4 (36%)</td>
<td>4 (40%)</td>
</tr>
</tbody>
</table>

Table 5: Further bereavement survey results

Some examples of comments from the surveys include:

- I was impressed with this and felt that almost all the team was warm and open to us - I was not made to ever feel unwelcome and could always talk to someone when I needed to.

- Immediate help from the ward staff to have the Hospital Chaplain and our own Pastor visit at any time, much appreciated. Annette, from the Hospice, helped us to understand what would happen as the end drew near.

- Please don't take this as a criticism, as I realise the nature of the care given within a hospital environment. But, spending time with mum on her death - we were asked after a considerable time when mum could be taken down to the "morgue" by a care assistant. I completely understand the "rigour" of a ward, but think carefully chosen words could have been implemented. Please - no-one is at fault here as afterwards everyone was so caring. It's just a suggestion as to how people communicate their needs in such extraordinary times, for the people concerned.

- Dr Cath Siller was most informative and caring in her talk with my sister, my father and myself. A difficult time made a tad easier because of the caring conversation we had with her.

- I was not made to ever feel unwelcome and could always talk to someone when I needed to.

Figure 2: Bereavement survey comments

4. SAGE & THYME ® Communication Skills Training

The SAGE & THYME ® model was developed by a patient and clinical staff at the University Hospital of South Manchester NHS Foundation Trust in 2006. It was designed to train all grades of staff how to listen and respond to patients/clients or carers who are distressed or concerned. It places published research evidence about effective communication skills within a memorable structure for clinical practice.

There are advanced plans to implement the SAGE & THYME ® communication skills training across the Trust. A number of multidisciplinary team members attended the “train the trainer” communication skills training courses in January 2016. Five staff members have completed their training, and the communication programme will be available for HDFT staff to attend from April 2016.
5. **Anticoagulant patient survey results**

It is vital that patients on anticoagulants (medicines used to prevent the formation of blood clots) understand why they are taking these medicines, and the graph below from the anticoagulant patient satisfaction survey shows that patients have a good understanding. Results also demonstrate that patients would recommend this service to their friends and family.

![Graph showing anticoagulant patient survey results](image)

**Figure 3: Anticoagulant patient survey results**

6. **Phlebotomy service**

As a result of patient feedback through satisfaction surveys and recommendations form the Patient Voice Group, we implemented a new phlebotomy service in Sainsbury’s Harrogate. In June 2015 we captured very positive feedback about the new service.

The comments included:

- Early opening time is good;
- Would prefer longer opening times;
- Would prefer larger room as I suffer from small spaces, so would use hospital in future;
- Parking is good.

![Graph showing phlebotomy service patient feedback](image)

**Figure 4: Sainsbury’s phlebotomy service patient feedback**
7. WHO Surgical Safety Checklist audit

The WHO (World Health Organisation) Surgical Safety Checklist is a tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases of perioperative care. It identifies three phases of an operation, each corresponding to a specific period in the normal flow of work: Before the induction of anaesthesia (“sign in”), before the incision of the skin (“time out”) and before the patient leaves the operating room (“sign out”). In each phase, it must be confirmed that the operating team has completed the listed tasks before it proceeds with the next stage of the operation.

An initial audit of the “sign out” section of the WHO checklist demonstrated that this was not being used consistently, and was only signed in 32% of cases. In addition, an internal audit report undertaken during July 2015 highlighted a number of deficiencies in compliance with the WHO checklist in the operating theatres.

This coincided with a report into national safety standards for invasive procedures. The principle is that organisations will review their current local processes for invasive procedures and ensure that they are compliant with the new national standards. Organisations are expected to work in collaboration with staff to develop their own set of local safety standards for invasive procedures.

This work would take many months and it was essential that compliance with the current checklist was improved in the meantime. Clear guidance was implemented for staff on the use of the checklist and a re-audit was conducted in December 2015. This showed improvement in completion of all sections of the checklist.

<table>
<thead>
<tr>
<th>Section of WHO Surgical Safety Checklist</th>
<th>December 2015</th>
<th>July 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% complete (n=87)</td>
<td>% complete (n=43)</td>
</tr>
<tr>
<td>Sign in</td>
<td>86%</td>
<td>47%</td>
</tr>
<tr>
<td>Time out</td>
<td>97%</td>
<td>85%</td>
</tr>
<tr>
<td>Sign out</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Sign out</td>
<td>72%</td>
<td>47%</td>
</tr>
<tr>
<td>All sections complete</td>
<td>64%</td>
<td>8%</td>
</tr>
</tbody>
</table>

*Table 6: WHO Surgical Safety Checklist audit results*

The Elective Care Directorate are working on the development of local safety standards for invasive procedures which will replace the WHO Surgical Safety Checklist in 2016/17. These local safety standards will streamline the process of perioperative checks, reduce duplication and focus the teams on safety. Continued reinforcement of the existing guidance will be maintained until the new checking procedures are fully implemented.

**Summary**

The focus on communication has been a broad one, but we are seeing improvements in communication within teams and with patients. The reduction in complaints has been striking and work continues to address concerns proactively and to resolve issues early, and we have taken steps to improve safety through improving the way we communicate.

Improving communication is an ongoing priority for the Trust. Our ambition is to have a culture where our staff communicate with patients in a way that meets their individual needs and expectations. We will continue to work hard to gather patient feedback in order that we can measure patient experience and use the learning to improve patient care.
2.2.2 Improving patients’ experience of using our services

We wanted to improve arrangements for admission, discharge and delivery of community services as evidence suggests that enhancing patient flow also increases patient safety and is essential to ensuring that patients receive the right care, in the right place, at the right time, all of the time. This also improves patient experience.

We were aiming to ensure that people who attend our Emergency Department receive timely assessment. Then if they need admission or assessment by specialty teams, they will move promptly through the system and only stay in hospital for as long as is indicated by their clinical need. Discharge planning will also begin on admission and delays to discharge will be prevented by clearly defined and understood pathways linking secondary care and community services.

On discharge, medications will be prescribed correctly. The discharge letter that is sent to the GP and taken home by the patient will be clear and concise and the patient will leave hospital with the right medicines, information and any required support packages thereby avoiding re-admission.

To support people to recover more effectively we were aiming to increase the number of people who are offered and receive rehabilitation following a hospital stay. Rehabilitation and reablement in both inpatient and home based environments has been shown to improve a person’s quality of life and maintain independence. This also reduces the number of patients who need to be readmitted to hospital after they have been discharged.

What have we done?

- Patients who present to the Emergency Department and who require specialty assessment or admission are seen promptly and assessed or admitted within 4 hours. A protocol has been developed by the Emergency Department and specialty consultants working at Harrogate District Hospital to ensure patients are managed through the optimum pathway and do not experience delays;
- A dashboard has been developed to help operational staff understand the pressures in the different parts of the Emergency Department;
- A patient flow screen is being re-launched to assist with bed allocation. The Emergency Department and other staff involved in maintaining the flow of patients will have real time visibility of bed availability and patients who potentially require specialty assessment or admission;
- We have redesigned the space on our acute admissions floor – where the acute admissions wards are located - to improve patient flow and patient experience. This was called the “Flip” project and has involved co-locating the Clinical Assessment Triage Clinic with the Clinical Assessment Triage and Treatment Ward. The Acute Medical Unit has been relocated with the Coronary Care Unit and the End of Life Care room. We have invested in additional staff to support this acute floor;
- We have included a section relating to previous admissions the patient has had within the new multidisciplinary admissions documentation being developed. When in place, there will be a targeted focus within multidisciplinary team discussions relating to patients whose latest admission could have been avoided if something different had been done at the previous discharge;
- A pilot took place in October on Jervaulx and Nidderdale Wards to assess the benefits of pharmacists writing up medications on discharge letters, rather than doctors in training. The aim was to assess any benefits in terms of clinical accuracy, the speed of the discharge process and any reduction in patient waiting times on discharge;
• The assessment of acute gynaecology referrals on Nidderdale Ward was improved by:
  o Directing all GP and Emergency Department referrals to the second on call doctor enabling telephone advice to be given when appropriate;
  o Establishing a band 3 rota Monday to Friday 12.30–20.30, responsible for undertaking initial observations on ward attenders and ensuring timely medical review.
• We have improved the assessment of acute paediatric referrals by establishing a paediatric clinical assessment team (CAT) model on Woodlands Ward. This Children’s Assessment Unit commenced on February 29th 2016 and is operating daily 10.30–23.00;
• The Day Surgery Unit transformation group implemented a ‘default to day case strategy’ with the aim of reducing variance in overnight admissions for patients suitable for day case surgery;
• Other ongoing projects in Elective Care include increased involvement of general surgical consultants in the review of emergency admissions and the provision of physiotherapy at home, allowing earlier discharge for some orthopaedic patients;
• As part of the New Care Models ‘Vanguard’ there are an additional four beds at Ripon Community Hospital which will enable additional rehabilitation and reablement to be offered to patients. We are working with partner agencies to develop a specification for community beds including the criteria for admissions, and a more effective intermediate care bed based service linking with Station View Rehabilitation Unit (a North Yorkshire County Council care home). The model for therapy support into community beds has been reviewed;
• To help to understand the impact of the rehabilitation programme patients undertake on the ward, the Adapted Therapy Outcome Measure has been introduced as a means of measuring a change in a patient’s independence. This tool is used to score the patient’s independence based on their activities of daily living prior to their illness. Their functionality is assessed and scored on admission to Trinity Ward and again at the end of their stay. We are in the process of analysing the effectiveness of this tool in assessing the impact of the rehabilitation;
• A rapid process improvement workshop has reviewed and made improvements to the pathway for managing urinary catheters in the community. In future this work will be managed by the Community Nursing Team thereby reducing admissions to hospital.

What are the results?

There are results reported in other areas of this report relating to improvements in urinary catheter management in the community (section 3.5), and pharmacist rather than doctor written discharge letters (section 2.5.1).

1. Flip project

The Flip project was implemented in October 2015 following a period of preparation during September. The result is that we have improved patient flow. Patients admitted through the Emergency Department or from GPs are seen by a consultant acute physician more quickly and provided with a plan of care which enables them to be either discharged home or transferred to a medical ward with a plan of medical care already in place.

The length of stay for a significant number of admissions has reduced to 0 – 2 days and we have seen a reduction in the number of longer admissions. This has enabled us to safely manage the increased number of patient admissions.
% of patients admitted as an emergency via the acute admissions floor who stayed 2 days or less

Figure 5: Patients admitted as an emergency via the acute floor who stayed 2 days or less

2. Gynaecology ward referrals

Following the introduction of all GP and Emergency Department (ED) gynaecology ward referrals being directed to the second on call doctor, an audit was undertaken in February 2016. The results show that the assessment of acute gynaecology referrals on Nidderdale Ward has improved, and are summarised below:

- A third (6/18) of GP referrals and a quarter (7/28) of ED referrals were managed with telephone advice only;
- Of the 33 patients reviewed during the study period only 11 were admitted. 75% of GP referrals and 62% of ED referrals were discharged with advice. 73% of patients were seen within 30 minutes and 88% within 1 hour.

Compared with an audit the previous year, the number of patients reviewed was reduced (33 patients compared with 54), suggesting that the middle grade doctor triaging the calls was resulting in fewer emergency referrals.

Summary

Improving the experience patients have of our services is an ongoing priority for the Trust, and good patient flow is a key element of this. With resource in the hospital being used more effectively, we will see a positive impact on the 4 hour Emergency Department target, and a reduction in avoidable admissions.

The work we have done redesigning our acute admissions floor has meant that patients are only admitted to hospital when this is clinically needed and the length of time they need to stay in hospital is reduced. We have implemented plans to improve the flow of patients referred for an emergency gynaecology review, and have introduced a Children’s Assessment Unit. The Day Surgery Unit transformation group has implemented a ‘default to day case’ list with the aim of increasing the number of day case procedures. A business case has been approved for an eighth surgical consultant, which will enable a consultant of the week model in general surgery and greater consultant involvement in the assessment and review of acute surgical admissions. We will be implementing the new multidisciplinary admissions documentation, and increasing pharmacist cover on the wards to write up medications on discharge letters, improving clinical safety and communication of information, further improving patient experience.
2.2.3 Becoming a centre of excellence for the care of the frail elderly

Older people living with frailty are at risk of dramatic deterioration in their physical and mental wellbeing after an apparently small event which challenges their health e.g. infection, new medication or a fall.

Last year, we had started on the journey towards creating a centre of excellence for the care of older people with frailty on two of our inpatient wards. We aimed to continue this work to provide excellent care to the increasing number of elderly patients with complex needs whenever they access our services, to continue to focus on dementia care and to support the carers of the frail elderly. We are developing New Care Models which promote integrated teams and patient care at home where possible, which is less disorientating for the frail elderly and helps maintain their independence.

Please see the sections of this report on dementia (section 2.5.3), innovation and New Care Models (section 3.5), mental capacity (section 3.14), falls and pressure ulcers (section 2.5.1).

What have we done?

- As research in the relationship between declining health and mental agility recommends a constant touchstone of mental stimulation for patients with dementia, our Occupational Therapists arrange weekly coffee mornings and staff have linked with volunteers who are delivering arts and crafts sessions associated with national and local events such as crocheting poppies for Remembrance Day. Patients continue to enjoy the Pat-a-dog visits which help patients communicate and relax, as well as stimulating memory and emotional response;
- Students from Ripon Grammar School are working with patients with dementia to create booklets on 'My Life'; an example of how patients' mental stimulation is encouraged;
- There has been work towards achieving a more ‘dementia friendly’ environment;
- From October 2015 the Community Fast Response and Rehabilitation Team (CFRRT) has been screening patients over 75 who are referred to the service for dementia, aiming to screen at least 90% of patients. The team are also investing time in creating screening tools and updating falls assessment tools in conjunction with North Yorkshire County Council Falls Coordinator and Harrogate and Rural District Clinical Commissioning Group (HaRD CCG). The impact of this will be measured by the number of referrals, admissions avoided and estimated number of bed days saved;
- Doctors in training in the Emergency Department have been working to ensure patients aged over 75 are assessed for cognitive impairment. The target was to achieve 75% of people having a documented cognitive assessment by the end of 2015/16;
- We have reintroduced the Butterfly Scheme. This is a pathway of care for people living with dementia, confusion or forgetfulness. When a patient or carer opts into the scheme a discreet butterfly symbol is used to identify their needs to ensure that an appropriate response is given;
- We have provided training for staff on the Mental Capacity Act and Deprivation of Liberties safeguards to ensure patients are assisted in making decisions about their care whenever possible. Equally we aim to ensure staff recognise when they do not have capacity to do this and ensure their needs are supported;
- Pharmacy staff are working on a pilot project with the HaRD CCG which enables them to refer elderly patients for follow up after discharge to help them manage their medicines at home. The team are also exploring work developed by a team from Lancashire that enables direct electronic transfer of the patient’s discharge letters to
their designated community pharmacy as there is evidence to show that including the community pharmacy improves outcomes for all patients, especially the frail elderly;

- We have focused on improving our clinical care with work relating to reducing the risk of patient falls and pressure ulcers described in section 2.5.1;
- We have strengthened our discharge planning team to facilitate the discharge of patients with complex needs in conjunction with social care;
- We have piloted the use of a urinary continence care bundle to increase the identification of continence issues and ensure that patients are referred to the continence practitioner for specialist advice;
- We offer more support to carers by using carer’s passports. This allows the carer to visit any time that is needed by the person they are caring for;
- We have reviewed policies to ensure appropriate consideration of carers and have developed a carers leaflet that highlights support for carers in the community;
- Elective Care are seeking to improve the peri-operative care of frail elderly patients by the appointment of a second specialist Consultant in Medicine for the Care of the Elderly, to support the Orthogeriatric Consultant and to develop a more robust service for elderly patients in General Surgery. The business case has been approved and the post advertised. We expect that in future years we will see the proportion of frail elderly patients receiving specialist peri-operative care from an elderly care specialist increase;
- At Ripon Community Hospital, Trinity Ward’s main focus is on the rehabilitation of elderly patients following a stay in hospital or surgery. The team strives to deliver patient centred care tailored to meet the needs of the patient, and are supported by a weekly multidisciplinary team meeting and Consultant in Medicine for the Care of the Elderly review.

What are the results?

The results of work relating to dementia, innovation and New Care Models, mental capacity, falls and pressure ulcers are included in the reports previously referenced.

1. Emergency Department

The findings from the initial audit in the Emergency Department (ED) demonstrated only 5% of patients had a documented cognitive assessment.

The following recommendations were made:

- Change the ED card for patients > 75 years to ensure documentation;
- Provide training of cognitive assessment using the Abbreviated Mental Test;
- Ensure greater awareness of the need to ask carers if they feel supported.

The results show a vast improvement in compliance, with the department achieving 62% of patients with a documented assessment by the end of December 2015, and 86% by the end of March 2016. Further work is required to ensure this continues to improve and becomes embedded as routine practice.

2. Community Fast Response and Rehabilitation Team

The Community Fast Response and Rehabilitation Team (CFRRT) has exceeded the target of screening 90% of patients over the age of 75 for cognitive impairment since they started in October 2015. This enables the CFRRT to refer patients with suspected dementia to their GP for further investigation and support.
Table 7: Patients over 75 who have had dementia screening carried out following referral to CFRRT

<table>
<thead>
<tr>
<th></th>
<th>Question 1 - Dementia Case Finding</th>
<th>Question 2 - Diagnostic Assessment for Dementia</th>
<th>Question 3 - Referral for Specialist Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>October – December 2015</td>
<td>99% (125/126)</td>
<td>92% (23/25)</td>
<td>100% (13/13)</td>
</tr>
<tr>
<td>January – March 2016</td>
<td>98% (105/107)</td>
<td>94% (15/16)</td>
<td>100% (6/6)</td>
</tr>
</tbody>
</table>

3. Pharmacy

To date eight referrals have been made to the HaRD CCG Medicines Management Team to provide a domiciliary medication review service to high risk patients identified at discharge by HDFT pharmacists. As a result 27 medicines related problems were highlighted including lack of patient understanding of their medication regimen, worsening symptoms after discharge and discrepancies between discharge letter prescription and GP repeat prescription. This enabled stopped medications to be removed in some situations and poor understanding of medicines to be addressed with the use of compliance aids and increased counselling.

Pharmacy is looking into an electronic referral system to allow swifter and simpler referral of patients to community pharmacies, CCG pharmacists and ‘Vanguard’ pharmacists alike. IT infrastructure is being assessed to allow identification of funding required to enable introduction of this service.

Summary

Much of the work reported in this quality account is relevant to our aspiration to provide excellent care to the increasing number of elderly patients with complex needs whenever they access our services and to ensure that their individual needs are met.

National drivers advocate proactively targeting patients with complex ongoing needs such as the frail elderly, and working much more intensively with them. There is strong evidence to suggest that a strategy for older people with frailty should be centred on community based care with multidisciplinary assessments. This could reduce hospital admissions, improve the timeliness of interventions, improve the flow through acute services and facilitate earlier discharges (Patterson, 2014).

Improving the care of our frail elderly patients is an ongoing priority for the Trust. We aim to ensure that every patient always receives the right care at the right time and that we meet their individual needs. During this year we have been developing a five year strategy to support us in becoming a centre of excellence for the holistic care of older people with frailty. The strategy focuses on older people with frailty across our whole organisation not just specific parts of it.

We are committed through our Vanguard programme to work on new models of providing care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients. The aim will be to identify frailty earlier and with a focus on prevention we could see a positive impact on the quality of life of our frail elderly population.
2.3 Statements of assurance from the Board

1. Provision of relevant health services and income

During 2015/16 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 2015/16 represents 100% of the total income generated from the provision of relevant health services by HDFT for 2015/16.

2. National & Local Audits

National Audits

During 2015/16, 33 national clinical audits and six national confidential enquiries and clinical outcome review programmes covered relevant health services that HDFT provides. The national clinical audits comprised 42 individual work streams.

During that period HDFT participated in 89% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

To provide further context, there were 28 mandatory audit programmes on the National Clinical Audit and Patient Outcome Programme (NCAPOP), 21 of which were relevant to HDFT. Of these, the trust participated in 100%.

There were also 21 non-NCAPOP audits, three of which were not relevant and four of which did not run during 2015/16, leaving 14 which were relevant to HDFT. The Trust participated in ten (71%) of those which were relevant.

The national clinical audits and national confidential enquiries that HDFT was eligible to participate in during 2015/16 are as follows:

National audits:

1. Acute coronary syndrome or Acute myocardial infarction (MINAP)
2. Bowel cancer (NBOPACAP)
3. Cardiac Rhythm Management
4. Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC)
5. Diabetes (Adult)
6. Diabetes (Paediatric)
7. Elective surgery National PROMS programme
8. Emergency Use of Oxygen
9. Falls & Fragility Fractures Audit Programme (FFFAP)
10. Inflammatory Bowel Disease (IBD) programme
11. Lung cancer (NLCA)
12. Major Trauma: The Trauma Audit & Research Network (TARN)
13. Maternal, New-born and Infant Clinical Outcome review Programme (MBRRACE-UK)
14. National Audit of Intermediate Care
15. National Cardiac Arrest Audit (NCAA)
16. National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
17. National Comparative Audit of Blood Transfusion programme
Clinical Outcome Review Programmes

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

1. Gastrointestinal Haemorrhage
2. Sepsis
3. Acute Pancreatitis
4. Mental Health

Child health clinical outcome review programme:

1. Chronic neurodisability
2. Young people’s mental health

The national clinical audits and national confidential enquiries that HDFT participated in during 2015/16 are as follows:

National audits:

1. Acute coronary syndrome or Acute myocardial infarction (MINAP)
2. Bowel cancer (NBOCAP)
3. Cardiac Rhythm Management
4. Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC)
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10. Inflammatory Bowel Disease (IBD) programme
11. Lung cancer (NLCA)
12. Major Trauma: The Trauma Audit & Research Network (TARN)
13. Maternal, New-born and Infant Clinical Outcome review Programme (MBRRACE-UK)
14. National Cardiac Arrest Audit (NCAA)
15. National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
16. National Comparative Audit of Blood Transfusion programme
17. National Emergency Laparotomy Audit (NELA)
18. National Heart Failure Audit
19. National Joint Registry (NJR)
20. National Ophthalmology Audit
21. Prostate Cancer
22. Neonatal intensive and special care (NNAP)
23. Oesophago-gastric cancer (NAOGC)
24. Procedural Sedation in Adults (CEM)
25. Rheumatoid and early inflammatory arthritis
26. Sentinel Stroke National Audit Programme (SSNAP)
27. UK Parkinson’s Audit (previously known as National Parkinson’s Audit)
28. Vital signs in Children (CEM)
29. VTE risk in lower limb immobilisation (CEM)

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

1. Gastrointestinal Haemorrhage
2. Sepsis
3. Acute Pancreatitis
4. Mental Health

Child health clinical outcome review programme

1. Chronic neurodisability
2. Young People’s mental health

The national clinical audits and national confidential enquiries that HDFT participated in, and for which data collection was completed during 2015/16 are listed at Annex 3, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of ten of the national clinical audits and two of the NCEPOD reports were reviewed during 2015/16, and HDFT intends to take the following actions to improve the quality of healthcare provided.

National Cardiac Arrest Audit

Harrogate District Hospital data has previously shown survival to discharge statistics following cardiac arrest that are lower than the majority of participating trusts, and this area has been the focus of considerable improvement work over the last year. Significant work has gone into ensuring discussion with patients and relatives in relation to “do not attempt cardiopulmonary resuscitation” (DNACPR) decisions, but early identification of patients for whom resuscitation would be futile is clearly important. Work by the Resuscitation Training Officer to improve the situation is ongoing and discussions are being held regarding advanced care planning and DNACPR orders. A local re-audit and detailed case note review were undertaken during 2015 in response to the national data, and results were scrutinised at the Resuscitation Committee and Improving Patient Safety Steering Group.

The latest reports show more favourable outcomes for patients in cardiac arrest that are above the national average. However there is more work to be done to ensure we always consider DNACPR decisions at the earliest opportunity and thus only attempt the resuscitation of those patients for whom it is appropriate. There is an action plan in place being led by the resuscitation team and work will continue in this important area during 2016/17.
Audit of Patient Blood Management in Adults undergoing Elective Scheduled Surgery

This audit was undertaken to document and understand the current use of red cell transfusion by clinical staff and patient blood management approaches in adults undergoing elective, scheduled surgery in relation to 11 audit standards. The Trust undertook 21 transfusions in the audit period.

The aim is to limit transfusions to the minimum required for symptom relief, and whilst HDFT has good rates of single unit transfusions, this could be further improved. Post-operative ‘top-up’ transfusions is recommended if the haemoglobin (Hb) is <70g/L, however the audit showed that transfusions continue to be undertaken at Hb >70g/L without a reason for this being recorded. The HDFT Red Cell Policy highlights the threshold for transfusion.

Actions to be taken as a result of this audit include:
• Identifying a method of obtaining an early Hb when a patient is listed for elective surgery, and to develop healthcare pathways to enable anaemia screening, investigation and correction before surgery;
• Disseminating the Red Cell Policy to medical staff and highlighting at targeted medical staff education sessions;
• Highlighting to clinical staff the need to record the reason for transfusion in the patient’s case notes and a justification if outside the guideline threshold for transfusion.

In addition, some reports and action plans from older national clinical audits and confidential enquiries were reviewed by HDFT in 2015/16 (due to delays in national reporting timescales and the fact that some action plans remained open). The following are examples of actions for improvement that have been taken.


A business plan is in development for a second surgical geriatrician which is anticipated to enable the Trust to meet a number of the outstanding recommendations, although there is still an outstanding action around the audits of delays to surgery.

NCEPOD - Tracheostomy Care: On the Right Trach? (2014)

A review of progress was received in May 2015 where it was noted that the remaining actions related to ongoing monitoring of staff training. The action plan was closed, but it was expected that tracheostomy training would be made essential training for staff in areas managing patients with tracheostomies i.e. Intensive Therapy Unit/High Dependency Unit (ITU/HDU), Lascelles Unit, Oakdale and Granby Wards. Progress with this is monitored by the Critical Care Delivery Group.

National Joint Registry

The National Joint Registry (NJR) is a mandatory data set and all eligible joint operations must be submitted. The compliance report for 2014/15 data was reviewed by the Orthopaedics Team which included identification by consultant. Steps are being taken to ensure robust systems are in place to guarantee that a minimum dataset form is generated for all NJR procedures.
Local Audits

During 2015/16 a joint audit programme between Clinical Effectiveness 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 that there was no duplication of work and therefore utilised resources more efficiently. Joint audit planning has been undertaken again in preparation for 2016/17.

213 projects (excluding national audits) were registered with the Clinical Effectiveness Department during 2015/16. 65 of these were contained on the ‘priority’ programme developed at the start of the year, and 148 were ad-hoc projects identified and registered throughout the year. This includes projects aimed at improving quality by using service evaluation and patient experience surveys. Some of these were for completion during the financial year and some had extended timescales which will remain open into 2016/17.

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

The reports of 88 local projects (clinical audits, service evaluations and patient surveys) were reviewed by relevant audit or governance groups at HDFT during 2015/16. HDFT also continued to review completed audits which had been registered and commenced during 2014/15. HDFT intends to take the following actions to improve the quality of healthcare provided.

Information sharing patient survey

An information sharing survey was undertaken during 2015 to satisfy the requirements of the Information Governance Toolkit in relation to NICE (National Institute for Health and Care Excellence) Clinical Guideline 138 and Quality Standard 15. In general terms, results from those people who had been inpatients were more favourable than those treated as outpatients. An inpatient stay, by its very nature, allows more time for discussions with the patient regarding information governance. The table below provides a side by side comparison of performance.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>LEVEL OF PERFORMANCE</th>
<th>INPATIENTS</th>
<th>OUTPATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% and number of respondents (n)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you aware of the different uses of your information?</td>
<td>83% (n=70)</td>
<td>76% (n=138)</td>
<td></td>
</tr>
<tr>
<td>Are you aware of your choices with regard to sharing your information?</td>
<td>87% (n=70)</td>
<td>71% (n=136)</td>
<td></td>
</tr>
<tr>
<td>Were you asked about your preferences regarding the healthcare staff sharing information with your partner, family members and/or carer?</td>
<td>62% (n=68)</td>
<td>44% (n=137)</td>
<td></td>
</tr>
<tr>
<td>If yes, do you feel those preferences were respected?</td>
<td>95% (n=42)</td>
<td>93% (n=60)</td>
<td></td>
</tr>
</tbody>
</table>

Table 8: Information sharing patient survey results
Actions were identified as follows:

1. Update the patient documentation for inpatients to remove reference to 'next of kin' and to add a section regarding whether the primary and secondary contact can be given information about the patient’s care;
2. Consideration should be given to how this information can be made more accessible to outpatients;
3. Ensure that the information on the HDFT website regarding uses of information is easily accessible and up to date.

Patient satisfaction with Medical Day Unit

During 2015 the Integrated Care Directorate management team reviewed the clinics that take place on the Elmwood Unit and relocated some to the newly-refurbished Medical Day Unit (MDU). Following this change there had been conflicting anecdotal information received relating to patient satisfaction with the new location of the clinics so a survey was undertaken. 150 surveys were completed by patients attending the MDU in September, and results were overwhelmingly positive with the facilities generally highly rated. The majority of patients found the area easy to find, were greeted at reception on arrival and were informed which area to wait in. Patients gave some suggestions for improvement including improving signage for the unit, ensuring that reception staff are aware of any delays so that they can inform patients on arrival or as delays become apparent, and the use of fans on hot days.

Antibiotic prophylaxis for urological procedures at Harrogate District Hospital re-audit

The aim of this audit was to determine if the guidelines produced by the Microbiology Department on the use of prophylactic antibiotics for patients undergoing urological surgery are being adhered to.
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Expected performance</th>
<th>Actual performance 2013</th>
<th>Actual performance 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients undergoing transurethral resection of the prostate (TURP) receive prophylactic antibiotics</td>
<td>95%</td>
<td>87%</td>
<td>93%</td>
</tr>
<tr>
<td>All patients undergoing transurethral resection of bladder tumours (TURBT) receive prophylactic antibiotics</td>
<td>95%</td>
<td>80%</td>
<td>89%</td>
</tr>
<tr>
<td>All prophylactic antibiotics are administered within the hour before surgery starts</td>
<td>100%</td>
<td>8%</td>
<td>40%</td>
</tr>
<tr>
<td>Where gentamicin is used, the correct dose is administered</td>
<td>100%</td>
<td>36%</td>
<td>64%</td>
</tr>
</tbody>
</table>

Table 9: Use of prophylactic antibiotics re-audit results

There has been some significant improvement however the audit has generated some further recommendations regarding clear documentation of administration times on the electronic record.

Audit of non-visible haematuria referrals

This audit was based on the updated NICE guidelines on referral for suspected cancer (NG12: Suspected Cancer: Recognition and Referral 2015). There was clinical concern about the potential for missing a serious pathology if the new guidelines were followed by GPs if they had a patient with non-visible haematuria (blood in the urine).

An audit was undertaken of the 358 patients with non-visible haematuria patients referred in a 12 month period. Ten patients that had been referred under the previous guidelines and found to have a diagnosis of cancer would not have been referred under the 2 week wait rule if the new NICE guidelines had been followed.

Based on these audit findings, HDFT recommended that the local non-visible haematuria investigation guidelines should be updated and disseminated to local GPs with education to ensure that these patients continue to be referred urgently.

Audit of time to antibiotics in suspected neutropenic sepsis

Neutropenic sepsis is caused by neutropenia, when the number of white blood cells in the blood is low. NICE Guidance for Management of Neutropenic Sepsis (2014) and the National Cancer Standards Peer Review for Acute Oncology (2012) recommend all patients with suspected neutropenic sepsis receive their first dose of antibiotics within one hour of them being clinically diagnosed, and that this is audited. At HDFT the clinical management is described in our Suspected Neutropenic Sepsis Pathway.

Previous audits had demonstrated poorer results for time to antibiotics outside normal working hours, and we implemented an action plan to improve our performance. This included intensive education and awareness raising in the acute medicine on-call teams and nursing staff, whilst enabling some nursing staff to give the first dose of antibiotics using a patient group direction. This is a written instruction for the administration of medicines to patients. Performance has continued to improve year on year.
### Yearly Performance of Antibiotic Administration

<table>
<thead>
<tr>
<th>Year</th>
<th>% of patients receiving their first dose of antibiotic within 60 minutes of diagnosis</th>
<th>Expected level of performance</th>
<th>Actual level of performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>100%</td>
<td>100%</td>
<td>67%</td>
</tr>
<tr>
<td>2013</td>
<td>100%</td>
<td>100%</td>
<td>75%</td>
</tr>
<tr>
<td>2014</td>
<td>100%</td>
<td>100%</td>
<td>78%</td>
</tr>
<tr>
<td>2015</td>
<td>100%</td>
<td>100%</td>
<td>87%</td>
</tr>
</tbody>
</table>

*Table 10: Antibiotic administration in neutropenic sepsis audit results*

Further improvements have been identified as follows:

1. All acute medicine nursing staff to be trained to take bloods and place intravenous cannulae (tube inserted into a vein to enable delivery of intravenous medication);
2. Continue induction sessions by consultants for each speciality for the foundation year doctors;
3. Continue to roll out the patient group direction that enables nurses to give the first dose of antibiotics;
4. Continue awareness raising and education;
5. Add a neutropenic sepsis reminder in the sepsis screening tool in the medical assessment clerking document;
6. Provide ready-made preparation for the first dose of Piperacillin with Tazobactam (antibiotic).

### 3. Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by HDFT in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 3151.

HDFT is committed to the promotion of evidence informed practice with the aim of continuous improvement to quality and patient outcomes and as of March 2016, the number of studies open and recruiting at HDFT was 78. 107 clinicians covering 22 clinical areas offer patients the opportunity to be part of research studies; they are supported by 32 National Institute for Health Research (NIHR) funded delivery staff.

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

### Training and education

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

### Matching research to national prerogatives and working with partners to ensure high quality studies are conducted

The national and local agenda is to promote more community based healthcare with particular emphasis on the facilitation of patient self-management for long term conditions. HaRD CCG is one of the new NHS England New Care Models Vanguard sites with well-
developed plans to join up GP, hospital and community based services. The Trust has started to examine research projects that are exploring integrated care pathways and will provide intelligence and expertise for the Trust as well as delivering best practice evidence. NIHR funds health and social care research recognising that these service delivery platforms are inextricably linked. HDFT appreciate the benefits to be achieved if the services work cooperatively.

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

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

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

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

**Research governance and performance**

R&D Unit staff conduct pragmatic research governance via a suite of usable standard operating procedures (SOP) for research. Activity is overseen monthly by a multidisciplinary R&D Group, chaired by the Trust’s Medical Director. SOPs have been amended in line with the Health Research Authority national process for research approvals and will be continually developed in 2016/17. Performance is monitored and managed locally within the Trust; additionally performance against the high level objectives is managed by the Clinical Research Network at a regional and national level. Research metrics have been shared with Trust Board within the report from the Chief Operating Officer. An annual presentation is also delivered to the Board.

**Monitoring, measuring service quality and sharing the impact of research**

HDFT has two Patient Research Ambassadors bringing a patient perspective. The Patient Research Ambassadors are involved in project feasibility assessment, quality assurance via the participant survey, performance via team meetings and raising awareness about research opportunities. The annual survey assesses the quality of service delivery as
perceived by research participants. Findings are shared and acted upon. The intention is this will feed into a national survey of research participants in future. A public facing HDFT research community on the cloud based NIHR platform has been implemented with a link from the Trust website. HDFT research staff will seek out findings of projects and ensure these are shared with individual participants but that the findings are also available to all the population HDFT serves and clinical teams.

4. **Use of the Commissioning for Quality and Innovation Framework**

A proportion of HDFT income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between HDFT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at: [http://www.hdft.nhs.uk/about-us/commissioning-for-quality-and-innovation-cqin/](http://www.hdft.nhs.uk/about-us/commissioning-for-quality-and-innovation-cqin/)

The monetary total for the amount of income in 2015/16 conditional upon achieving quality improvement and innovation goals was £2,863,000. The monetary total for the associated payment in 2014/15 was £2,625,000.

5. **Registration with the Care Quality Commission**

HDFT is required to register with the Care Quality Commission and its current registration status is unconditional. HDFT has no conditions on registration.

HDFT had the following sites registered during 2015/16:

- Harrogate District Hospital
- Lascelles Unit
- Ripon Community Hospital

The Care Quality Commission has not taken enforcement action against Harrogate and District NHS Foundation Trust during 2015/16.

HDFT is subject to periodic reviews by the Care Quality Commission and the last review was on 2 February 2016. The CQC have not yet published its findings and no rating exists yet.

We have included below the Trust’s view on the five key questions used by the Care Quality Commission in their inspections of services:

1. Are they safe?
2. Are they effective?
3. Are they caring?
4. Are they responsive to people’s needs?
5. Are they well-led?
<table>
<thead>
<tr>
<th>Service</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and emergency services</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Medical care (including older people's care)</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Surgery</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Critical care</td>
<td>Good</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Outstanding</td>
</tr>
<tr>
<td>Maternity and gynaecology</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>End of life care</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Outpatients and diagnostic imaging</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community inpatients</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Services for Children &amp; Young People</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Community services for adults</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
</tr>
</tbody>
</table>

Table 11: HDFT self-assessment against the five key questions for each core service

HDFT has not participated in any special reviews or investigations by the Care Quality Commission during 2015/16.

6. Information on the Quality of Data

HDFT submitted records during 2015/16 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS number was:
  - 99.8% for admitted patient care
  - 99.9% for outpatient care
  - 98.7% for accident and 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 accident and emergency care.

[Note – figures above are for the period April 2015 – January 2016 (latest available data)].

7. Information Governance

HDFT's overall score for the Information Governance Toolkit for 2015/16 was 84% and was graded green/satisfactory with all standards at level two or above (there are three levels with level three being the highest).

8. Payment by Results

HDFT was subject to a Payment by Results clinical coding audit in April 2015 commissioned by Monitor. An audit sample of 200 episodes was reviewed for the period July – September 2014, focusing on two specific areas of Healthcare Resource Groups (HRG): HB (Orthopaedic non-trauma procedures), and EB (Cardiac disorders). The results showed an
overall error rate (coding errors affecting the HRG) of 3.5% compared to the latest published national average error rate of around 7%. This result should not be extrapolated further than the actual sample audited. The error rates reported for diagnoses and treatment coding (clinical coding) in the audit sample were:

- Primary procedures 2.0%
- Secondary procedures 6.0%
- Primary diagnoses 4.0%
- Secondary diagnoses 5.0%
- An overall combined diagnostic and procedural error rate 4.25%

The Trust also commissioned an external clinical coding audit to meet Information Governance requirements during 2015/16. The audit was carried out in February 2016 by nationally registered clinical coding auditors from D & A Clinical Coding Consultancy Limited. An audit sample of 200 episodes was reviewed, 50 episodes from Breast Surgery, 75 from both Urology and General Medicine were randomly selected from across the whole range of activity for the period July – September 2015. The results showed an overall error rate (coding errors affecting the HRG) of 5.5% compared to the latest published national average error rate of around 7%. This result should not be extrapolated further than the actual sample audited. The error rates reported for diagnoses and treatment coding (clinical coding) in the audit sample were:

- Primary procedures 3.4%
- Secondary procedures 5.1%
- Primary diagnoses 5.0%
- Secondary diagnoses 5.3%
- An overall combined diagnostic and procedural error rate 4.7%

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

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

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. The Health & Social Care Information Centre 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.

<table>
<thead>
<tr>
<th></th>
<th>Data period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jul 14 to Jun 15</td>
</tr>
<tr>
<td>HDFT value</td>
<td>0.957</td>
</tr>
<tr>
<td>HDFT banding</td>
<td>2 (as expected)</td>
</tr>
<tr>
<td>National average</td>
<td>1.000</td>
</tr>
<tr>
<td>Highest value for any acute Trust</td>
<td>1.209</td>
</tr>
<tr>
<td>Lowest value for any acute Trust</td>
<td>0.661</td>
</tr>
</tbody>
</table>

January 2015 to December 2015 data due for publication late June 2016

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

Data source: http://www.hscic.gov.uk/SHMI

Table 12: Summary Hospital Level Mortality Index (SHMI)

HDFT’s latest published score of 0.977 is within the normal range.

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 an evaluation 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;
- The Trust has now adopted a regional structured case note review template. This will be rolled out across the organisation except where national protocols dictate alternative methods of analysis and review. In addition to specialty specific case note reviews, focused reviews of situation specific deaths will also be undertaken (such as maternal deaths, deaths from sepsis, and deaths of patients with learning disabilities);
- The Trust has recently submitted data to NHS England on potentially avoidable deaths for the purpose of national benchmarking.
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 before 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.

<table>
<thead>
<tr>
<th></th>
<th>Data period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jul 14 to Jun 15</td>
</tr>
<tr>
<td>HDFT value</td>
<td>16.6</td>
</tr>
<tr>
<td>National average</td>
<td>26.0</td>
</tr>
<tr>
<td>Highest value for any acute Trust</td>
<td>52.9</td>
</tr>
<tr>
<td>Lowest value for any acute Trust</td>
<td>0.0</td>
</tr>
</tbody>
</table>

January 2015 to December 2015 data due for publication late June 2016

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

Data source: http://www.hscic.gov.uk/SHMI

Table 13: Percentage of patient deaths with palliative care coded at either diagnosis or specialty level

HDFT’s latest published score of 18.1% is below the national average.

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.

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

- Having regular education sessions for the Specialist Palliative Care Team as part of their business/multidisciplinary team meetings;
- Promoting a development programme in end of life care called Rethinking Priorities. Six Trust consultants and one GP have taken forward a piece of work to improve end of life care within their own specialty;
- Developing guidance to prioritise the discharge of patients at end of life to enable them to die in their preferred place of choice;
- Meeting staff training needs identified from staff surveys. Over 750 staff have attended in-house face to face training on the five priorities for care of the dying, and we are in the process of implementing the e-ELCA package to provide further education. Training is now covered on the care support worker induction programme and this includes education on nutrition and hydration at the end of life;
- Piloting a Care Plan for Last Days document to help support the individual needs of the dying person and their significant others;
- Providing all adult wards with a resource box containing the Care Plan for Last Days document, information leaflets, car park passes and “Just B” bereavement leaflets;
- Seeking feedback using a validated questionnaire from all bereaved relatives;
- Supporting staff to provide person centred high quality care, by preparing to include one page profiles on admission into hospital as part of the general nursing assessment;
- Preparing to take forward the ‘Transform’ programme to create a clear framework for improving end of life care across the organisation.
2. Helping people to recover from episodes of ill health or following injury

PROMs – Patient Reported Outcome Measures

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

**Groin hernia surgery - adjusted average health gains (EQ-5D index)**

<table>
<thead>
<tr>
<th></th>
<th>Data period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013/14 (final)</td>
</tr>
<tr>
<td>HDFT value</td>
<td>0.073</td>
</tr>
<tr>
<td>National average</td>
<td>0.085</td>
</tr>
<tr>
<td>Highest value for any acute Trust</td>
<td>0.132</td>
</tr>
<tr>
<td>Lowest value for any acute Trust</td>
<td>0.039</td>
</tr>
</tbody>
</table>

*Table 14: PROMS – Groin hernia surgery*

**Varicose vein surgery - adjusted average health gains (EQ-5D index)**

<table>
<thead>
<tr>
<th></th>
<th>Data period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013/14 (final)</td>
</tr>
<tr>
<td>HDFT value</td>
<td>Data suppressed due to small numbers</td>
</tr>
<tr>
<td>National average</td>
<td>0.093</td>
</tr>
<tr>
<td>Highest value for any acute Trust</td>
<td>0.150</td>
</tr>
<tr>
<td>Lowest value for any acute Trust</td>
<td>0.022</td>
</tr>
</tbody>
</table>

*Table 15: PROMs – Varicose vein surgery*

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

<table>
<thead>
<tr>
<th></th>
<th>Data period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013/14 (final)</td>
</tr>
<tr>
<td>HDFT value</td>
<td>0.411</td>
</tr>
<tr>
<td>National average</td>
<td>0.436</td>
</tr>
<tr>
<td>Highest value for any acute Trust</td>
<td>0.477</td>
</tr>
<tr>
<td>Lowest value for any acute Trust</td>
<td>0.311</td>
</tr>
</tbody>
</table>

*Table 16: PROMs – Hip replacement surgery*

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

<table>
<thead>
<tr>
<th></th>
<th>Data period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013/14 (final)</td>
</tr>
<tr>
<td>HDFT value</td>
<td>0.327</td>
</tr>
<tr>
<td>National average</td>
<td>0.323</td>
</tr>
<tr>
<td>Highest value for any acute Trust</td>
<td>0.396</td>
</tr>
<tr>
<td>Lowest value for any acute Trust</td>
<td>0.215</td>
</tr>
</tbody>
</table>

*Table 17: PROMs – Knee replacement surgery*

Data looks at primary hip and knee procedures only

HDFT’s latest published health gain scores for groin hernias, hip replacements and knee replacements were below the national average.

HDFT considers that this data is as described for the following reasons:
- We have participated in the PROMs scheme since inception, routinely analysing and reviewing the results;
- HDFT is not a vascular surgery centre and this is reflected in the data suppression for varicose vein surgery due to small numbers;
- The data is formed from pre- and post-operative patient surveys and therefore reflects their perception of the improvement in their health following surgery;
- An analysis of the data shows that HDFT has a pre-operative score above the England average in all cases, which might indicate that patients who rate their pre-op health highly have a reduced chance of a health gain. Patient perception is a useful but subjective measure of performance;
- The Trust considers the scores indicate it is not an outlier from the national position.

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

Emergency readmissions to hospital within 28 days

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

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

**Age 0-15**

<table>
<thead>
<tr>
<th></th>
<th>Data period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009/10</td>
</tr>
<tr>
<td>HDFT value</td>
<td>10.95</td>
</tr>
<tr>
<td>National average</td>
<td>10.01</td>
</tr>
<tr>
<td>Highest value for any acute Trust</td>
<td>56.38</td>
</tr>
<tr>
<td>Lowest value for any acute Trust</td>
<td>0</td>
</tr>
</tbody>
</table>

*Table 18: Emergency readmission to hospital within 28 days (age 0-15)*

2011/12 data published December 2013. No data published by HSCIC since.
Age 16+

<table>
<thead>
<tr>
<th></th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>HDFT value</td>
<td>9.19</td>
<td>10.02</td>
<td>9.96</td>
</tr>
<tr>
<td>National average</td>
<td>11.18</td>
<td>11.43</td>
<td>11.45</td>
</tr>
<tr>
<td>Highest value for any acute Trust</td>
<td>15.26</td>
<td>17.1</td>
<td>17.15</td>
</tr>
<tr>
<td>Lowest value for any acute Trust</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 19: Emergency readmission to hospital within 28 days (age 16+)


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

HDFT considers that this data is as described for the following reasons:
- The source data used is taken from the Secondary Uses Service dataset; this is a national system and data quality indicators linked to this system indicate an excellent compliance rate.

HDFT has taken the following action to improve this rate and so the quality of its services, by:
- Using an evaluation tool that enables us to review and analyse a range of clinical and outcome indicators including emergency readmissions in detail on an on-going basis. This enables local clinical teams to identify and review ways in which services can be improved to reduce re-admissions wherever possible.

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

**Emergency readmissions within 30 days**

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of emergency readmissions within 30 days</td>
<td>3235</td>
<td>3593</td>
<td>3895</td>
</tr>
<tr>
<td>As a percentage of all emergency admissions</td>
<td>18.3%</td>
<td>18.1%</td>
<td>18.9%</td>
</tr>
<tr>
<td>Number of emergency readmissions within 30 days (Payment by Results exclusions applied)</td>
<td>2155</td>
<td>2482</td>
<td>2696</td>
</tr>
<tr>
<td>As a percentage of all emergency admissions</td>
<td>12.2%</td>
<td>12.5%</td>
<td>13.1%</td>
</tr>
</tbody>
</table>

Table 20: Emergency readmissions within 30 days (data source: Integrated Board Report Mar-16)

HDFT considers that this data is as described for the following reasons:
- The data presented is taken from the Trust’s main patient administration system, iCS;
- The data is sourced from the admitted patient care spells data set. The data quality of this data is routinely assessed and published nationally by the Health and Social
Care Information Centre. HDFT’s latest data quality results are presented in section 2.3 (item 6);

- The excluded readmissions are based on national definitions. These are identified by clinically coded data and the Trust consistently performs better than average in external clinical coding audits, as detailed in section 2.3 (item 8) of this report.

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

- Overall, our readmission rates have been increasing slightly over the last few years. However we are in the process of carrying out a number of clinical audits to understand this further;
- The Trust recently carried out a clinical audit on a random sample of emergency readmissions during January and February 2016. The themes from this audit and being collated, actions drawn up and implemented;
- Emergency readmissions information is routinely presented to the Trust Board each month.

3. Ensuring that people have a positive experience of care

Inpatient survey – responsiveness to inpatients’ personal needs

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

<table>
<thead>
<tr>
<th></th>
<th>Data period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
</tr>
<tr>
<td><strong>HDFT value</strong></td>
<td>71.8</td>
</tr>
<tr>
<td><strong>National average</strong></td>
<td>68.1</td>
</tr>
<tr>
<td><strong>Highest value for any acute Trust</strong></td>
<td>84.4</td>
</tr>
<tr>
<td><strong>Lowest value for any acute Trust</strong></td>
<td>57.4</td>
</tr>
</tbody>
</table>

Data source: HSCIC indicator portal, NHS Outcomes Framework indicator 4.2. Indicator reference: P01779 (NB. different reference to last year)

https://indicators.hscic.gov.uk/webview/

Table 21: Inpatient survey – responsiveness to inpatients’ personal needs

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

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

HDFT intends to take the following actions to improve this score and so the quality of its services by:
• Focusing on five questions from the national inpatient survey where the Trust would like to improve the care offered to patients.

National Staff Survey – Standard of Care Provided

| Staff who would recommend the trust to their family or friends as a place to be treated | Data period |
|---|---|---|---|---|---|
| | 2011 | 2012 | 2013 | 2014 | 2015 |
| HDFT value | 76 | 73 | 77 | 72 | 78 |
| National average | 60 | 63 | 65 | 65 | 68 |
| Highest value for any acute Trust | 89 | 86 | 94 | 89 | 93 |
| Lowest value for any acute Trust | 33 | 35 | 40 | 38 | 46 |

Data source: [http://www.nhsstaffsurveys.com/Page/1019/Latest-Results/Staff-Survey-2015-Detailed-Spreadsheets/](http://www.nhsstaffsurveys.com/Page/1019/Latest-Results/Staff-Survey-2015-Detailed-Spreadsheets/)

Table 22: 2015 National staff survey published February 2016

The data looks at 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.

This question forms part of key finding 24, ‘Staff recommendation of the Trust as a place to work and/or receive treatment’ in the National Staff Survey for 2014. The Trust achieved a ranking of 7th out of 39 when compared with all acute and community Trusts for this key finding.

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

• Significant engagement from staff was sought to develop the Trust’s values and behaviours framework which was ratified at the Board of Directors in February 2015 and this has been rolled out trust wide with significant publicity and awareness sessions such that it forms part of the recruitment, management and retention of staff. The values hold patient care at the heart of everything we do;
• Updated and improved appraisal documentation to incorporate and revolve around the Trust Values;
• Reaccreditation of Investors in People; areas of continuous improvement were identified and the link between training and development and patient outcomes and safety are clearly demonstrated by staff who were interviewed;
• The Innovation and Improvement Strategy was launched in July 2014 and subsequently staff have been actively involved in scoping and implementing improvement projects many of which are based on ideas from frontline staff;
• The introduction of a Health and Wellbeing section on the Trust intranet to promote and raise awareness of individual health care within the staff;
• The delivery of personal resilience training and awareness sessions to support staff in recognising and addressing stress in their lives;
• A continuation of our proactive recruitment strategy including embracing social media with targeted recruitment for specific work areas or staff groups, streamlining of processes and review of notice periods have enabled the recruitment and retention of staff;
• Training provided to all staff regarding escalation of risks. This includes communication on how to report incidents, sharing outcomes of investigations with learning between directorates, and the Being Open Policy;
- Overall, the Trust has received positive results in the national inpatient and other patient related surveys.

HDFT has taken the following actions to improve this score, and so the quality of its services by:
- Reviewing and investing in increased staffing levels within the Emergency Department and ward based services;
- Regularly reporting on safer staffing levels within the Trust;
- Implementing the Staff Friends and Family Test to ensure real time feedback every quarter;
- Reviewing incidents reported through risk management processes to ensure that these are investigated and appropriate action is taken;
- Providing training to all staff regarding escalation of risks;
- Communicating on how to report incidents;
- Working on sharing outcomes of investigations with learning between directorates;
- Including a message on payslips about the Being Open Policy.

Friends and Family Test – Patient

The Friends and Family Test (FFT) is a feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. People are also given an opportunity to leave a comment about their response.

**Response rate**

<table>
<thead>
<tr>
<th>Month</th>
<th>January 2016</th>
<th>February 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient wards</td>
<td>A&amp;E</td>
</tr>
<tr>
<td>HDFT value</td>
<td>31.8%</td>
<td>10.3%</td>
</tr>
<tr>
<td>National average</td>
<td>23.5%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Highest value for any acute Trust</td>
<td>100.0%</td>
<td>39.9%</td>
</tr>
<tr>
<td>Lowest value for any acute Trust</td>
<td>4.6%</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

**Percentage who would recommend**

<table>
<thead>
<tr>
<th>Month</th>
<th>January 2016</th>
<th>February 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient wards</td>
<td>A&amp;E</td>
</tr>
<tr>
<td>HDFT value</td>
<td>92.4%</td>
<td>90.0%</td>
</tr>
<tr>
<td>National average</td>
<td>95.5%</td>
<td>86.3%</td>
</tr>
<tr>
<td>Highest value for any acute Trust</td>
<td>99.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Lowest value for any acute Trust</td>
<td>72.7%</td>
<td>52.5%</td>
</tr>
</tbody>
</table>

**Note:** England figures exclude independent providers

NHS England now publishes FFT data for additional services to inpatients and A&E (Accident and Emergency).


**Table 23: Patient FFT results**

HDFT considers that this data is as described for the following reasons:
- We promote the completion of a questionnaire by inpatients at discharge and the responses are collated by our volunteers;
- We use an automated telephone service to contact patients who have attended A&E, the Day Surgery Unit, outpatient clinics and community services. The capacity of this service has limited the response rate we have been able to achieve;
• We have also recently identified evidence that some patients are selecting the wrong response from the options described by the automated telephone call and we believe this is affecting the results. For example, the inpatient data includes the Day Surgery Unit results. In February 2016 the proportion of patients who would recommend the inpatient wards was 95%, whilst the proportion of patients who would recommend the Day Surgery Unit was 87.6%. There were eight verbal comments left by patients associated with negative responses for the Day Surgery Unit however all comments were actually positive, reporting a high standard of care.

HDFT has taken the following actions to improve this score, and so the quality of its services by:
• The results of the FFT are shared widely each week and staff in each area use these to reflect on their service and implement improvement whenever possible;
• Recent negative comments from some inpatient areas have noted noise at night. Wards can be noisy at night for many reasons including new emergency admissions, patients being unsettled and confused, staff attending to patients and taking their observations to ensure safe care, and patients ringing their bells for assistance. When we admit patients we do explain that the ward can be busy and offer ear plugs. Ward managers are working to ensure their nursing staff are aware of how difficult this is for patients and that noise at night is minimised;
• The Trust is starting to explore other ways of seeking patient FFT feedback that will promote a higher response rate and reliable data that we can use more effectively with other patient feedback to improve services and delivery of care.

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.

<table>
<thead>
<tr>
<th></th>
<th>Data period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1 2015/16</td>
</tr>
<tr>
<td>HDFT value</td>
<td>98.4</td>
</tr>
<tr>
<td>National average</td>
<td>96.0</td>
</tr>
<tr>
<td>Highest value for any acute Trust</td>
<td>100.0</td>
</tr>
<tr>
<td>Lowest value for any acute Trust</td>
<td>86.1</td>
</tr>
</tbody>
</table>

Q4 data to be published June 2016 by NHS England

Table 24: Percentage of eligible admitted patients risk assessed for venous thromboembolism (VTE)

HDFT’s published scores have been above the national average for the whole year to date.

HDFT considers that this data is as described for the following reasons:
• There is a well-established protocol for VTE risk assessment on admission;
• Data is recorded onto the Trust’s main patient administrative system, iCS, and collected via reliable IT systems;
• Education on VTE risk assessment is part of the Trust’s essential training so staff understand the importance of it.
HDFT intends to take the following actions to improve this and so the quality of its services, by:

- Continuing to identify wards with poorer performance and examining whether there are issues with completion of the risk assessment or inputting of information onto iCS;
- Exploring the option of moving VTE risk assessment to an electronic system or patient record as part of a Trust-wide piece of work.

**Clostridium difficile rates**

The table shows the number of cases of *C. difficile* infection (CDI) per 100,000 bed days reported from hospital inpatients aged two years or over.¹

<table>
<thead>
<tr>
<th></th>
<th>Data period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012/13</td>
</tr>
<tr>
<td><strong>HDFT value</strong></td>
<td>20.8</td>
</tr>
<tr>
<td><strong>National average</strong></td>
<td>17.4</td>
</tr>
<tr>
<td><strong>Highest value for any acute Trust</strong></td>
<td>31.2</td>
</tr>
<tr>
<td><strong>Lowest value for any acute Trust</strong></td>
<td>0</td>
</tr>
</tbody>
</table>

2015/16 data released in June 2016
Data source: [http://www.hpa.org.uk/](http://www.hpa.org.uk/)

Table 25: Number of cases (rate) of *C. difficile* infection (CDI) per 100,000 bed days reported from hospital inpatients aged two years or over.

Until 2015/16 HDFT believed that the data were as described for the reasons given in the 2014/15 Quality Account. However, it is now considered likely that the data up to 2014/15 may have represented under-ascertainment. HDFT considers that this data is as described for the following reasons:

- In August 2015 HDFT changed its stool sampling policy to lower the threshold of “looseness” for sending stool samples for *C. difficile* investigation;
- In August 2015 the laboratory changed its testing policy to test all stools that were submitted as “loose” (i.e. including Bristol Stool Types 5 and 6) rather than only testing stools that were liquid on receipt;
- Following these changes the number of stool samples received and tested for *C. difficile* increased by 32.6% and 59.4% respectively compared with the corresponding months in 2014/2015;
- In December 2015 HDFT removed the requirement for a provisional positive sample to be positive by a second method before being tested for cytotoxin;
- The number of hospital-attributed CDI cases reported is 34, compared with 30 community-attributed cases. Of the latter, 12 were diagnosed after admission to hospital. The comparable figures for the same time in 2014/15 were nine and 11 cases respectively;
- There is no suggestion or evidence of a community-wide outbreak of CDI and minimal evidence of in-hospital transmission.

¹ Data source: Official Statistics Clostridium difficile infection: annual data
HDFT intends to take the following actions to improve this rate, and so the quality of its services, by increasing the speed at which potential cases are diagnosed and isolated, and increasing a sense of ownership amongst clinical staff. Specific actions which have been identified include:

- Mounting a staff awareness campaign to stress the importance of washing hands with soap and water after any contact with bodily fluid, including faeces;
- Mounting a patient hand hygiene campaign to improve the rate of hand hygiene amongst patients before meals and after using the toilet and formulate an audit tool to measure this;
- Develop and implement a simplified loose stool decision tool to remind staff of the actions required when a patient develops loose stool. These include isolation within two hours, testing for *C. difficile* toxin, and a daily medical review;
- The Director of Infection Prevention and Control (DIPC) and lead Infection Control Nurse (ICN) will visit each ward area individually to look at individual facilities, and discuss with the ward manager any specific issues on that ward which might be relevant to infection prevention and control;
- The DIPC and ICNs will meet with individual professional staff groups to discuss areas of infection control that are pertinent to their work area, and develop individualised infection prevention and control guidelines for those particular groups;
- Review the sluice facilities across the Trust, and revise and re-issue the “Sluice House Rules” to ward staff;
- Introduce in-house culture of *C. difficile* in the Microbiology Laboratory, in order that we can properly ascertain the environmental load of *C. difficile* spores in ward environments;
- Review the cleaning of equipment across the Trust and decide and document who is responsible for cleaning what;
- Review the system and process for decontaminating equipment used to transport patients around the hospital, e.g. wheelchairs and trolleys;
- Review the system and process for cleaning and decontaminating ward food trolleys.

**Patient safety incidents**

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

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

<table>
<thead>
<tr>
<th></th>
<th>Oct 14 - Mar 15</th>
<th>Apr 15 - Sep 15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rate of incidents</strong></td>
<td><strong>Incidents that resulted in severe harm or death</strong></td>
<td><strong>Rate of incidents</strong></td>
</tr>
<tr>
<td><strong>reported</strong> (per 1,000 bed days)</td>
<td>Number</td>
<td>Rate (per 1,000 bed days)</td>
</tr>
<tr>
<td>HDF value</td>
<td>34.51</td>
<td>2</td>
</tr>
<tr>
<td>National position (all acute trusts)</td>
<td>36.24</td>
<td>3089</td>
</tr>
<tr>
<td>Highest value for any acute Trust</td>
<td>82.21</td>
<td>128</td>
</tr>
<tr>
<td>Lowest value for any acute Trust</td>
<td>3.57</td>
<td>2</td>
</tr>
</tbody>
</table>

Data for period September 2015 - March 2016 due to be published September 2016

**Note:** an error was identified in the data presented in last year's Quality Account for the "rate (per 1,000 bed days) of incidents that resulted in severe harm or death"

It incorrectly showed a rate "per 100 bed days" instead of "per 1,000 bed days". This has been corrected in the table above.

Data source: [http://www.nrls.npsa.nhs.uk/resources/](http://www.nrls.npsa.nhs.uk/resources/)

**Table 26: Patient safety incidents**

HDFT considers that this data is as described for the following reasons:
- The data is collated by front line staff in relation to patient safety incidents;
- 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.

HDFT has taken the following actions to improve this score and so the quality of its services, by:
- Promoting patient safety as a key objective across the organisation and implementing a number of mechanisms to ensure compliance with, and delivery of national frameworks;
- There is a continual 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;
- Key themes and lessons learnt from incidents include:
  - Implementation of medical escalation chart for units not on the main acute hospital site;
  - Introduction of customised growth charts for small for gestational age babies;
  - Review of the process for replacing and monitoring opiate patches;
  - Improving safety of insulin prescription and monitoring for inpatients;
  - Review of safety netting processes for follow up appointments.
2.5 Review of other quality performance

This section provides an overview of the quality of care offered by HDFT based on performance in 2015/16 against indicators selected by the Board of Directors in consultation with stakeholders, including three priorities for the three elements of quality covering each of:

- Patient safety
- Patient experience
- Effective care

2.5.1 Patient Safety

1. Medicines Safety

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

Consequently HDFT has been working over the last few years to use medicines more safely and effectively, especially as we administer over 2 million medicines doses per annum and dispense around 150,000 medicine packs (items) per year. This work is supported by a multi professional, multi-agency national Medicines Optimisation work programme.

The aim of our medicines safety work is to improve patient safety by reducing errors in prescribing, dispensing and administration of medicines and also to improve the information given to patients about their medicines.

Specifically during 2015/16 we aimed to:

- Extend the functionality of the electronic Prescribing and Medicines Administration (ePMA) system into the Emergency Department;
- Commence preparations to implement prescribing complex infusions using ePMA;
- Commence preparations to implement ePMA in outpatients in 2016/17;
- Develop and implement the ePMA dashboard to target interventions to patients on high risk medicines;
- Continue the focus on safe prescribing, dispensing and administration of medicines.

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

- The number of incident reports classified as prescribing, dispensing or administration errors with a defined denominator to allow comparison;
- Number of missed doses of medicines;
- Medicines reconciliation rates;
- National inpatient survey data;
- Training compliance rates.
The targets were to demonstrate improvement against baseline regarding the number of errors and missed doses, and to increase the information given to patients. Regarding dispensing errors, regional and national benchmarking data identify HDFT as already achieving low numbers of errors per items dispensed, and therefore maintaining the current low level of errors was the target for this metric.

What have we done?

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

- Adopting the Royal Pharmaceutical Society Medicines Optimisation Principles;
- Accelerating the roll out of ePMA further across the organisation;
- Developing a dashboard using ePMA to target patients on high risk medicines (warfarin, insulin, antimicrobials);
- Further developing a range of metrics to measure safe use of medicines;
- Enhancing our medicines reconciliation processes and rates. Medicines reconciliation is the process of obtaining an up to date and accurate medication list that has been compared to the most recently available information and has documented any discrepancies, changes, deletions and additions;
- Continuing to adapt and deliver medicines management training for nursing staff;
- Continuing to review, report and learn from incidents relating to medicines use;
- Proactively seeking to inform patients about their medicines.

What are the results?

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

Roll out of ePMA

The roll out of ePMA to all wards and departments has now been completed, with implementation into the Emergency Department undertaken in April 2016. The planning for this has been undertaken during the last year, building prescribing protocols, working with Emergency Department staff, testing and piloting the system in the department.

We are one of only a handful of Trusts in the UK to have full ePMA use in all clinical areas. It has made a significant improvement in the safe use of medicines across the Trust.

Safer prescribing for inpatients

We have analysed the impact of ePMA on safe prescribing since implementation in 2011/12. The data below demonstrates the progress that has been made in this regard. There has been a substantial year on year reduction in prescribing errors from 2011/12 to 2014/15 with a slight rise in 2015/16. This is still below the pre ePMA baseline. Insulin prescribing errors account for the recent increase and additional information is provided below.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of adjusted prescribing errors per 100,000 prescribed doses reported via Datix</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12 (Pre ePMA)</td>
<td>3.43</td>
</tr>
<tr>
<td>2012/13</td>
<td>3.25</td>
</tr>
<tr>
<td>2013/14</td>
<td>3.19</td>
</tr>
<tr>
<td>2014/15</td>
<td>2.12</td>
</tr>
<tr>
<td>2015/16</td>
<td>3.34</td>
</tr>
</tbody>
</table>

Table 27: Number of adjusted prescribing errors per 100,000 prescribed doses
Safe prescribing at discharge

During 2015/16 we piloted a programme of pharmacist writing TTO (“to take out”) discharge prescriptions. Evidence from two other trusts suggested that the accuracy, quality and timeliness of discharge prescription writing could be improved if this was undertaken by pharmacists. The benefits of pharmacist written discharge letters have been assessed to see how this contributes to patient flow.

- The results showed a marked improvement in the accuracy of the medication information on the discharge letter when completed by a pharmacist. 70% of letters required intervention when completed by a doctor compared with 2% when completed by a pharmacist.
- There were savings made in terms of time by the doctor not having to review the letters - this equated to 16 minutes per TTO and released approximately 2.5 whole time equivalent in doctor time.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Doctor written TTO</th>
<th>Pharmacist written TTO</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>% prescriptions requiring a pharmacist intervention (one or more) prior to authorisation</td>
<td>70%</td>
<td>2%</td>
<td>Yes</td>
</tr>
<tr>
<td>Total number of interventions made by a second checking pharmacist prior to authorisation</td>
<td>60</td>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>Level of potential harm avoided by intervention of second checking pharmacist</td>
<td>Moderate = 11, Severe = 4</td>
<td>Moderate = 0, Severe = 0</td>
<td>Yes</td>
</tr>
<tr>
<td>Average time taken for completion of the medicines list of the TTO</td>
<td>16 minutes</td>
<td>12 minutes</td>
<td>Yes</td>
</tr>
<tr>
<td>Percentage of TTOs written and submitted before 11am for discharges on the same day</td>
<td>31%</td>
<td>57%</td>
<td>Yes</td>
</tr>
<tr>
<td>Percentage of TTOs written and submitted before 1pm for discharges on the same day</td>
<td>69%</td>
<td>84%</td>
<td>Yes</td>
</tr>
<tr>
<td>Percentage of TTOs written and submitted after 3pm for discharges on the following day</td>
<td>10%</td>
<td>17%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Table 28: Results of pilot programme of pharmacist compared to doctor written TTOs

These results demonstrate that the quality, accuracy and timeliness of TTO writing can be improved when this activity is undertaken by HDFT pharmacists. This work is now subject to a business case to roll out across the organisation.

Electronic prescribing at discharge and interface with ePMA

The interface with the discharge letter created in ICE (our requesting and reporting software system) was tested and went live in 2015. An audit in December 2015 demonstrated that all clinical areas using ePMA and discharging patients are using this interface with the exception of ward attenders, CAT patients and some paediatric patients. In all these cases it is clinically appropriate to maintain current systems as these patients do not have an inpatient chart.

This interface has been well received and helps to maintain the rapid turnaround of TTOs. The average dispensing turnaround time for a TTO medicine is 18 minutes with the majority
(over 70%) of TTOs being fulfilled at ward level (i.e. not having to leave the ward to go to Pharmacy).

**Safe administration of medicines**

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of adjusted administration errors per 100,000 administered doses reported via Datix</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12 (pre ePMA)</td>
<td>8.34</td>
</tr>
<tr>
<td>2012/13</td>
<td>3.44</td>
</tr>
<tr>
<td>2013/14</td>
<td>3.56</td>
</tr>
<tr>
<td>2014/15</td>
<td>5.34</td>
</tr>
<tr>
<td>2015/16</td>
<td>6.24</td>
</tr>
</tbody>
</table>

*Table 29: Number of adjusted administration errors per 100,000 administered doses*

We have seen a substantial reduction in the number of medicines administration errors since the introduction of ePMA. Of note is the slight increase in the last two years (though this is still less than the pre ePMA baseline). This is subject to further analysis and refresher training with staff.

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

<table>
<thead>
<tr>
<th>Year</th>
<th>% delayed doses</th>
<th>% missed doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>2.6</td>
<td>2.99</td>
</tr>
<tr>
<td>2013/14</td>
<td>2.9</td>
<td>3.17</td>
</tr>
<tr>
<td>2014/15</td>
<td>2.6</td>
<td>2.13</td>
</tr>
<tr>
<td>2015/16</td>
<td>2.4</td>
<td>1.01</td>
</tr>
</tbody>
</table>

*Table 30: Medicines administration - delayed and missed doses*

Over the last four years (data from 2011/12 is not comparable) we have seen a steady reduction in the percentage of medicine administrations to patients that are delayed, meaning more patients are getting their medicines in a timely manner. We have also seen a very substantial reduction in the percentage of missed doses.

**Reduction in “potential” prescribing errors through pharmacist activity and implementation of ePMA**

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

At HDFT our pharmacists perform over 20,000 interventions per annum ensuring the safe prescribing and administration of medicines. Since the introduction of ePMA we have also seen a reduction in the number of potential major and life threatening interventions made by pharmacists.
Development of an ePMA dashboard to target patients on high risk medicines

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

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

- Patients prescribed insulin;
- Patients prescribed warfarin;
- Patients prescribed antibiotics.

We also are able to identify patients with an unknown allergy status, any patient awaiting medicine reconciliation or a level 2 clinical review. The consequence of these reports means we are now able to identify and prioritise clinical intervention to ensure optimal prescribing and avoid harm.

Maintaining low numbers of dispensing errors

Our dispensing errors continue to be well below the regional average and some of the lowest across the Yorkshire and Humber region. HDFT data for 2014/15 (the last data set we have at regional level) has remained consistent with previous years running at a rate of 16/100,000 dispensed items. Only three trusts (range 9-11/100,000 dispensed items) demonstrate a lower rate.

<table>
<thead>
<tr>
<th>Trust</th>
<th>Dispensing error rate / 100,000 dispensed items</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient</td>
</tr>
<tr>
<td>HDFT</td>
<td>16</td>
</tr>
<tr>
<td>Yorkshire and Humber average</td>
<td>18</td>
</tr>
<tr>
<td>Yorkshire and Humber range</td>
<td>9-30</td>
</tr>
<tr>
<td>National average</td>
<td>20</td>
</tr>
</tbody>
</table>

Our error rates in aseptic services (preparation of IV medicines including chemotherapy) are also extremely low and one of the two lowest trusts in the region.
Learning from medicines errors

This year we have built a database of all Datix reported medicines errors over five years from 2011/12 to 2015/16. This allows us to identify common themes and errors, map trends and analyse progress. All reported errors are discussed at the monthly Medicines Safety Review Group, investigated and actions put into practice to learn from such events. We have undertaken analyses of three areas so far. These include:

a. Progress on the management of missed doses

The graph below demonstrates the progress being made with reducing missed doses.

![Graph showing percentage of missed and late doses from Datix reports and ePMA (2011/12 – 2015/16)](image)

Figure 7: Percentage of missed and late doses from Datix reports and ePMA (2011/12 – 2015/16)

b. Patient identity errors

Patient identity errors are defined as “patient A is mistakenly given patient B’s medicines”. An analysis of the database has highlighted a reduction post ePMA, but a recent small rise in these errors. This is now subject to further work.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number (and %) of all medicine patient identity errors reported via Datix</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12 (Pre ePMA)</td>
<td>15 (6.1%)</td>
</tr>
<tr>
<td>2012/13</td>
<td>4 (1.12%)</td>
</tr>
<tr>
<td>2013/14</td>
<td>4 (1%)</td>
</tr>
<tr>
<td>2014/15</td>
<td>8 (1.95%)</td>
</tr>
<tr>
<td>2015/16</td>
<td>8 (1.78%)</td>
</tr>
</tbody>
</table>

Table 33: Patient identity errors

c. Safe use of insulin

Analysis of the error database and clinical knowledge has highlighted an increase in the number and type of insulin related errors. This has prompted a specific task and finish group to be convened, currently implementing a whole range of actions including the development
of an insulin safety dashboard and the addition of safe use of insulin competency to the essential skills training programme.

Figure 8: Number of Datix reported insulin errors from Community and Hospital HDFT locations from 2011-2016

Medicines reconciliation

Medicines reconciliation is the process by which the accuracy and completeness of a patients medicines history is checked and verified when a patient is admitted to hospital. NICE guidance recommends all patients have a medicines reconciliation undertaken within 24 hours of admission by a competent practitioner. Evidence demonstrates an improvement in morbidity and mortality when this occurs. The national benchmark is around 70%.

Audit data below demonstrates our improvement over the last 3 years.

<table>
<thead>
<tr>
<th>Year</th>
<th>% of patients receiving a medicines reconciliation within 24 hours of admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>75%</td>
</tr>
<tr>
<td>2014/15</td>
<td>80%</td>
</tr>
<tr>
<td>2015/16</td>
<td>90%</td>
</tr>
</tbody>
</table>

Table 34: Patients receiving medicines reconciliation within 24 hours of admission

Medicines management training for doctors, nurses and pharmacists

Medicines management training for clinical staff has been in place for four years and continues to be updated to reflect changes to the management of medicines in the Trust, receiving positive feedback from staff on improving their understanding of medicines use. Compliance rates with training have improved year on year and are detailed below.
<table>
<thead>
<tr>
<th>Training competency</th>
<th>Renewal</th>
<th>Percentage compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ePMA</td>
<td>Once only</td>
<td>94%</td>
</tr>
<tr>
<td>Antibiotic stewardship</td>
<td>2 yearly</td>
<td>87%</td>
</tr>
<tr>
<td>Medicines management for community nursing</td>
<td>3 yearly</td>
<td>70%</td>
</tr>
<tr>
<td>Medicines management for hospital based nurses</td>
<td>3 yearly</td>
<td>73%</td>
</tr>
<tr>
<td>Safe prescribing toolkit</td>
<td>Once only</td>
<td>85%</td>
</tr>
</tbody>
</table>

Table 35: Medicines management training competency

**Patient engagement and providing information to patients**

Information provision to patients is included in four national inpatient survey questions. The perception of patients receiving relevant information about their medicines has improved over the last four years and we are consistently above the national average.

<table>
<thead>
<tr>
<th>National Inpatient Survey</th>
<th>% of patients</th>
<th>Better than national average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 1: Not fully told purpose of medicines</td>
<td>22 17 18 22 25</td>
<td>Yes</td>
</tr>
<tr>
<td>Question 2: Not fully told side effects of medicines</td>
<td>58 57 59 57 59</td>
<td>Yes</td>
</tr>
<tr>
<td>Question 3: Not told how to take medication clearly</td>
<td>21 19 25* 24</td>
<td>No  * for 2015 only</td>
</tr>
<tr>
<td>Question 4: Not given completely clear written/printed information about medicines</td>
<td>22 23 22 26 27</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Table 36: Medicines information provision - national inpatient survey questions results

**Summary**

The medicines safety programme continues to build on previous quality improvements relating to medicines optimisation and safety. This has been facilitated through the roll out of ePMA, development of the live dashboard, improved medicines reconciliation rates, pharmacy activity at ward level, reviewing and acting on trends in medicines administration, dispensing and prescribing errors and medicines management teaching and training. Whilst significant improvements are being demonstrated, we will continue to work to optimise the use of medicines at HDFT.

The safe use of insulin has been selected as a quality improvement priority for 2016/17, so that as a Trust we focus on reducing the recent increase in insulin related errors.

**2. Falls**

Falls are generally the result of a complex interplay between ageing and frailty, medical decline, social factors and the environment. Up to one in three people aged over 65, and around 50% of people over 80 who live in the community have a fall each year. Falls can have serious consequences including injury, pain, impaired function, loss of confidence and loss of independence. Falls and injuries due to a fall also affect family members and carers of people who fall, and are a public health issue that cause a significant impact on health and care services.
Following national research NICE produced a guideline in 2013 with recommendations for the assessment and prevention of falls in older people. NICE predicts that if a range of individualised preventions are introduced for patients and proactively reviewed, falls can be reduced by up to 30%. All policies and pathways related to the prevention of falls at HDFT are based on this guideline.

**Nationally:**

- Over 3,600 people over 65 died from having a fall in 2013 (England and Wales);
- Hip fracture is the most common reason for admission to an orthopaedic trauma ward – most of these occur as a result of a fall;
- About 70,000 - 75,000 (2012) hip fractures occur annually in the UK with a cost (including medical and social care) of around £2.3 billion a year;
- About one in ten people with a hip fracture die within one month and about one in three within 12 months. 50% of people suffering a hip fracture are permanently disabled and only 30% fully recover;
- Falls account for 10 – 25% of ambulance all-outs for people aged 65 and over, costing £115 per call-out.

**In North Yorkshire:**

- 30% of people aged 65 and older and 50% of people older than 80, fall at least once each year. This is the equivalent of over 42,000 falls in people over 65 each year in North Yorkshire alone;
- During the period 2012/2013 there were 1,296 reported falls in North Yorkshire for people aged over 65, with a total direct health delivery cost of £4,235,593.00;
- There were an estimated 140,900 people aged 65 and older in North Yorkshire in 2015, some 23% of North Yorkshire’s total population. North Yorkshire has 19,087 people aged over 85 years. The number of people aged over 85 in North Yorkshire is projected to increase by 19.8% by 2020.

Successful reduction of falls relies on the education of staff, patients and their families, clear policies for staff to follow in preventing falls and post fall management, and workable reliable pathways to enhance patient care and safety. A sustained reduction relies upon integrated care between health care professionals in the community, Emergency Department, admission wards, hospital wards and the patient discharge team. In particular we are aiming to:

- Reduce the number of inpatient falls occurring in hospital;
- Improve the completion of patient falls assessments and individualised interventions;
- Increase the number of staff who complete falls prevention training.

**What have we done?**

1. **Falls Coordinator**

A falls prevention co-ordinator was appointed to a part time (18.5 hours) permanent post in January 2016. The role is largely educational in falls prevention, assessment and risk factor reduction and includes chairing the Falls Steering Group.

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2 ONS Mortality Statistics: Deaths Registered in England and Wales (Series DR), 2013; Published October 2014
2. **Introduction of falls safety huddles**

This is a patient safety initiative in collaboration with the Yorkshire and Humber Academic Health Science Network (AHSN) Improvement Academy.

Huddles are a short daily meeting lead by a senior clinician and involving the participation of all staff working on the ward. They become a vehicle for ward teams to continually learn and improve. Falls safety huddles identify any patients who are at high risk of falls and agree an appropriate individual patient intervention plan for that day. Data is collected and processed by the Improvement Academy and reports are produced on reduction of falls and the number of days between falls.

The safety huddle started on Jervaulx Ward in June 2015 and has had a significant impact in reducing falls on this ward. In December 2015 all reported falls had been reduced by 43%. We have been able to demonstrate a statistical correlation with initiating the project, and we are working closely with the Improvement Academy to support and encourage other wards to adopt this safety initiative. In March 2016 Byland and Farndale Wards also initiated a daily huddle.

3. **Introduction of falls sensors**

A new initiative using a falls safety sensor was piloted on Byland Ward in December 2015 and the staff achieved 23 falls free days in the month. The early indications of the impact of this safety intervention are therefore positive and a further two wards have started using the system following staff training.

*Photo 1: Use of falls safety sensor on Jervaulx Ward*
4. **Staff falls prevention training**

Falls prevention training is an essential training requirement for various groups of clinical staff. Staff training levels remains fairly constant with 83-85% of staff being up to date with their falls prevention training every month between December 2014 and December 2015.

Post fall patient care is also of high priority. A new e-learning package called “Carefall” will be piloted in April 2016. The content of this package has been written by doctors in training and includes specific learning on the post fall management of patients. Feedback will be sought from those doctors in training that have received falls training and if well received, it will be extended to key nursing staff. This year a falls risk factor identification prompt card was included in all induction packs for doctors in training.

5. **Participation in the National Audit for Inpatient Falls**

The Royal College of Physicians conducted a national audit involving NHS trusts and health boards in England and Wales during May 2015 to provide a national snapshot of the landscape of falls prevention from an organisational and clinical perspective. The aim was to provide reliable, relevant and timely data to facilitate local improvements in clinical practice and patient safety work in acute hospitals in order to reduce inpatient falls. This included:

- An organisational audit;
- Case note review;
- Bedside/patient environment observation.

The results for HDFT showed staff met five of the seven criteria. Two areas for improvement were identified; the measurement of lying and standing blood pressure and the assessment of delirium, and these will be targeted for improvement in the next year.

Seven key recommendations were reported as a result of this audit and each of these has been considered and included in new patient assessment care plan documents.

6. **Learning from harmful falls**

When a patient suffers a fracture as a result of a fall, a more in depth investigation called a root cause analysis (RCA) is undertaken. This process aims to reduce inpatient falls by identifying if a fall was preventable, and to implement and monitor any learning opportunities. Some of the actions from recent RCAs include the introduction of a new e-learning package, and training doctors in patient medication review and post fall assessment and management.

7. **Falls Steering Group meetings**

Attendance at the bi-monthly Falls Prevention Steering Group has consistently increased. Membership includes the Falls Prevention Coordinator, two elderly medicine consultants, the Falls Multidisciplinary Team (MDT), the Deputy Chief Nurse and inpatient matrons. There are also representatives from the Community Fast Response & Rehabilitation Team (CFRRT), the Discharge Team, HaRD CCG, Yorkshire County Council, Age UK, the Yorkshire Ambulance Service, Age Concern, the Red Cross, the Improvement Academy and the Patient Voice Group. The group has been involved in the following:

- **Walking aids:** In response to recommendations made in the 2015 National Audit of Inpatient Falls, we have worked with the Trust Equipment Library and the Physiotherapy Department to ensure that walking aids are available for the immediate use of newly admitted patients who need them;
• **Staff training for falls sensor alarms:** The Falls Prevention Coordinator has been working closely with all staff to ensure that they are able to use this system confidently. In the near future all training will be competency led and linked to the continuing professional development and appraisal of staff;

• **Development of a falls pathway:** In order to enhance patient care and safety a multidisciplinary group started work in March 2016 to review and update the existing community falls pathway. It will be used in the Emergency Department and by GPs and other healthcare professionals in the community. This will provide a clear set of instructions of what to do and who to contact when older people have had a fall;

• **Development of a podiatry referral request form:** The Falls Prevention Coordinator has worked closely with the Podiatry Team to devise and launch a new referral form. The “Best Foot for Ward” initiative took place in February 2016, successfully raising staff awareness about the new referral form, conditions to refer and how to access community podiatry following patient discharge.

8. **Community links**

**York and North Yorkshire Public Health Project:** This is a two year project to consider the impact an increase in referrals may have on GPs and their resources, and the wider remit of community needs in the short, medium and long-term. Current issues include the development and use of screening tools and associated pathways in line with the latest NICE clinical guideline (CG 161) in both community and hospital environments.

**Falls screening in the Emergency Department (ED):** HDFT have been asked to support a pilot project in ED for six months, involving the introduction of a falls screening tool and the monitoring of patient interventions or referrals related to prevention of falls. The project is supported by HaRD CCG, the Falls MDT and the CFRRT. The first step is to agree a falls pathway that can be used by GPs and ED.

**Community exercise classes:** The established relationship between Age UK and the Falls Prevention Steering Group has led to HDFT supporting a community “Posture and Stability” exercise class funded through Public Health and HDFT. We are monitoring the referrals to this resource in order to feedback about suitability and the outcome of those referrals. Although the number of people attending this class is lower than expected, patient outcomes and feedback are good with participants who have completed the course showing significant increases in mobility, stability and confidence. The team is working to increase the referral rate and to establish stronger links with existing exercise programmes delivered by the Harrogate Borough Council.

**Open Day:** Representatives of the Falls MDT and Age UK took part in HDFT’s Open Day in September 2015. The team were able to raise public awareness on falls prevention, and the impact of fractures caused by falls. Age UK provided a rolling programme of exercise and launched a community “walking for health” initiative.

**What were the results?**

The total number of inpatient falls, the number of harmful falls when a patient sustains an injury but no fracture, and the number of inpatient falls that resulted in a fracture over the last three years are reported below. There has been a significant reduction in the total number of inpatient falls and in falls resulting in an injury.
<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>Changes 2014/15 to 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>All reported (inpatient) falls</td>
<td>967</td>
<td>859</td>
<td>725</td>
<td>-134</td>
</tr>
<tr>
<td>Harmful falls (no fracture)</td>
<td>246</td>
<td>235</td>
<td>182</td>
<td>-53</td>
</tr>
<tr>
<td>Falls causing fracture</td>
<td>16</td>
<td>17</td>
<td>13</td>
<td>-4</td>
</tr>
</tbody>
</table>

Table 37: Total number of inpatient falls over the past 3 years

The graph below shows the steady decline in the total number of inpatient falls for 2015/16 compared to 2014/15 and shows the reduction in low harm falls where no injury is sustained. In December 2015 the falls rate was nearly 50% lower than the previous year.

Figure 9: Falls data 2014/15 & 2015/16 comparisons

Summary

HDFT is working hard in the hospital and community to respond to the needs of the aging population in North Yorkshire. We continue to incorporate evidence based information and initiatives to support our aim of reducing falls in older people. We are developing training programmes to ensure staff are able to contribute to patient safety through increased awareness and can provide confident assessment and management of older people.

The total number of inpatient falls and the number of harmful falls have reduced over the last year. We are continuing to analyse and monitor our data to establish exactly where and how we have been able to make the most significant impact, and also to learn from those times when patients suffer an injury because they have fallen whilst in our care. The introduction of safety huddles and fall sensors will be closely monitored as early indications suggest that these simple interventions have had a real and measurable impact on patient safety.

The Falls Prevention Steering Group will continue to support older people in the hospital and community by growing its network and sharing good practice.
3. **Sepsis management**

Sepsis has recently been redefined as a life-threatening response of the body to infection. It is one of the commonest causes of death in the UK, affecting all age ranges from neonates to the elderly. There is increasing evidence that early identification, rapid treatment and appropriate escalation of care can significantly improve outcomes. A national drive is now underway to educate not only health care providers at all levels, but also the general public so they may seek help at an early stage.

Screening for sepsis and prompt antibiotic use has been a national CQUIN (Commissioning for Quality and Innovation) indicator for 2015/16. We have been collecting monthly data on how many acute admissions are appropriately screened for sepsis, and those who received antibiotics in a timely manner.

**What have we done?**

In HDFT we have implemented national guidelines for over 5 years. We were early adopters of a “septic bundle” which is a strict protocol for the management of patients identified as having sepsis. From November 2015, all new admissions are screened by nurses and doctors to see if sepsis is present. To support this, there has been an educational drive amongst doctors in training (to whom this condition presents most frequently), nursing staff (who take patient observations on arrival) and throughout the Emergency Department. We are now looking to extend this screening using our Patientrack computer system for recording vital signs and observations. This will screen every patient whenever a set of bedside observations is taken, and will automatically call a doctor to review if concerns are highlighted.

**What are the results?**

We have made significant progress in ensuring that screening is carried out on appropriate admissions.

<table>
<thead>
<tr>
<th>Month 2015/16</th>
<th>Performance by month</th>
<th>Performance by quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>44%</td>
<td>40%</td>
</tr>
<tr>
<td>May</td>
<td>36%</td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>July</td>
<td>75%</td>
<td>68%</td>
</tr>
<tr>
<td>August</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>September</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>October</td>
<td>69%</td>
<td>72%</td>
</tr>
<tr>
<td>November</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>December</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>January</td>
<td>81%</td>
<td>84%</td>
</tr>
<tr>
<td>February</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>March</td>
<td>88%</td>
<td></td>
</tr>
</tbody>
</table>

*Table 38: Sepsis screening CQUIN performance*

Unfortunately the number of patients receiving antibiotics promptly (within one hour of arriving at hospital) is still less than we would like. On average we are only identifying around five patients per month who fulfil the criteria for immediate antibiotics, so an individual doctor is unlikely to encounter any patients even over many months. Consequently, despite an educational campaign, it is difficult to ensure robust adherence. It is expected that this will improve when the Patientrack module contacts doctors directly with a strong prompt of the importance of early antibiotic administration.
July 13 2 11 2 1 (50%)
August 18 2 16 2 0
September 20 5 15 5 3 (60%)
October 14 3 12 2 0
November 19 6 14 5 4 (80%)
December 22 4 18 4 2 (50%)
January 25 9 16 9 3 (33%)
February 15 3 12 3 2 (67%)
March 30 15 16 14 7 (50%)
TOTAL 176 49 130 46 22 (47%)

Table 39: Antibiotic administration within 1 hour of presentation for patients with severe sepsis

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Performance in 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with severe sepsis, Red Flag sepsis or septic shock should receive intravenous antibiotics within 1 hour of presentation</td>
<td>100% 40% 44% 56% 46% 47%</td>
</tr>
</tbody>
</table>

Summary

In summary, we have made good progress on screening but still have work to do on antibiotic administration. For the next year we are rolling out the screening to every set of ward observations taken, as we know that sepsis can develop whilst patients are already in hospital. It is hoped that our new electronic system will provide a robust safety net to ensure that all patients are screened and promptly treated if necessary.

The Trust has identified reducing morbidity and mortality from sepsis as a quality priority for 2016/17 in order to focus on ensuring further progress.

4. Pressure ulcers

Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair the blood supply. They cause pain and distress, can mean longer stays in hospital and cost the NHS a significant amount of money. They are graded by severity according to a classification by the European Pressure Ulcer Advisory Panel (EPUAP) from category 1 (least severe) to category 4 (most severe). They are more likely to occur in people who are ill, have a neurological condition, poor mobility, impaired nutrition and poor posture.

Pressure ulcers are usually preventable with good assessment of individual risk and effective application of preventative measures such as use of effective equipment to reduce pressure, regular position change, good nutrition and hydration, and good skin care.
The prevention of avoidable pressure ulcers has been a quality improvement priority at HDFT since 2012/13 and the reduction of inpatient newly acquired preventable pressure ulcers was a national indicator under the Commissioning for Quality and Innovation (CQUIN) scheme for 2014/15.

The Trust has a Pressure Ulcer Group that meets on a monthly basis. The objectives of this group are to drive continual improvement of pressure ulcer prevention to prevent avoidable pressure ulcers being acquired by patients receiving either HDFT hospital or community nursing care. Avoidable pressure ulcers are defined as all reasonable care and treatment has been provided to prevent or minimise damage to skin through pressure. Our aims have been to:

1. Reduce the incidence of category 2, 3 and 4 pressure ulcers acquired by people whilst in HDFT care;
2. Promote best practice in prevention and management of pressure ulcers;
3. Understand if a pressure ulcer was avoidable or unavoidable and to learn from investigations into the root cause of pressure ulcers;
4. Continue our programme of pressure ulcer management training and education for staff.

The overall target for the Trust is to eliminate all avoidable hospital acquired category 3 and 4 pressure ulcers. The ambition for 2015/16 was:

- 50% reduction in category 3 and 4 avoidable hospital acquired pressure ulcers;
- 20% reduction in all category 2, 3 and 4 hospital acquired pressure ulcers based on 2014/15. This would mean 195 or fewer pressure ulcers.

What have we done?

There has been a significant amount of work undertaken during 2014/15 and 2015/16 with the aim of reducing avoidable HDFT acquired pressure ulcers.

Some of the key initiatives in 2014/15

- The introduction of SSKIN (skin, surface, keep moving, incontinence, and nutrition) bundles from November 2014 across all adult inpatient wards for patients assessed as being at risk of pressure ulcer development. This was supported with a SSKIN bundle educational package and educational posters to aid the identification and categorisation of pressure ulcers for clinical staff. A pressure ulcer skin inspection sticker was developed to assist registered nursing staff in the documentation of skin inspection. Changes were made to the nursing documentation to emphasise the need to repeat pressure ulcer risk assessment on transfer between wards.
- Pressure ulcers affecting heels were a particular concern and work has been undertaken between nursing and podiatry staff. Specific heel pressure relief equipment was trialled then purchased. All patients identified with heels at risk of pressure damage can now be referred to Podiatry for an assessment, and the provision of heel casts to protect the skin if appropriate.
- Work was has also focused on patients being cared for in the community, with new pressure relieving equipment being available from the Community Equipment Stores, and the implementation of a more efficient electronic equipment tracking system in July 2014.
- Training for staff has been a priority. Since January 2015 an e-learning package for pressure ulcers has been essential annual training for general and paediatric registered nurses and three yearly training for midwives. Training on skin care and pressure ulcer prevention, recognition and management has been delivered by the
Tissue Viability Nurses during the mandatory training course for care support workers.

- Since June 2014 all category 3 and 4 pressure ulcers have been reported as serious incidents requiring investigation (SIRIs). Training has been delivered to senior ward and community registered nurses to enable them to effectively investigate these incidents and undertake root cause analysis (RCA). Each RCA generates recommendations and an action plan.

**Key initiatives during 2015/16**

- The Tissue Viability Service covers both our hospital and community services and this provision has been strengthened by extra staffing investment in 2015. The team will be working alongside senior nurses across HDFT to further support staff.
- An intranet page has been developed to ensure staff have improved access to a range of information and learning resources.
- Following an audit of inpatient bedside chairs we have established a rolling programme for the purchase of chairs that have inbuilt pressure relieving cushions.
- In 2015 we launched our Wound Dressing Guideline and updated our Pressure Ulcer Prevention and Management Policy in accordance with NICE (2014) guidance. We also updated our pressure ulcer patient and carer information leaflet.
- Our focus on education and training of registered and unregistered nursing staff has continued throughout 2015/16. There are plans to develop more in-depth competency based training for senior staff including a workbook concerning pressure ulcer prevention and management.
- The Trust participated in STOP - Pressure Ulcer Day on 19 November 2015 with a mobile educational event and equipment demonstrations.
- An online non-prescription ordering service was established in the community during 2015 and has now being rolled out across the remaining community nursing bases, improving the quality and efficiency of service for patients.
- We have been trialling a new pressure ulcer risk assessment tool & associated documentation for use in our Emergency Department and community areas.

**What are the results?**

![Figure 10: Hospital acquired pressure ulcers](image-url)
The total number of category 2, 3 and 4 pressure ulcers for 2015/16 is 155 representing a reduction of 36% from 2014/15.

This overall improvement reflects a marked reduction in category 2 hospital acquired pressure ulcers. Category 4 pressure ulcers have decreased from two in 2014/15 to one in 2015/16. However we have seen an increase in category 3 hospital and community acquired pressure ulcers which we believe is due to better reporting as a result of increased awareness, education and recognition.

**Figure 11: All pressure ulcers reported between 2014 and 2016**

The two graphs below show the results of the NHS safety thermometer data since July 2012 until February 2016, for all pressure ulcers identified and for new pressure ulcers. There has been a steady reduction over this period, but the reduction since November 2014 appears to be particularly significant.

**Data source:** [https://www.safetythermometer.nhs.uk/](https://www.safetythermometer.nhs.uk/)

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

![Funnel plot for pressure ulcer prevalence](image1)

![Funnel plot for pressure ulcer incidence](image2)

**Figure 14: Prevalence of all pressure ulcers**  **Figure 15: Incidence of new pressure ulcers**

♦ represents HDFT

Data source: [https://www.safetythermometer.nhs.uk/](https://www.safetythermometer.nhs.uk/)

**Summary**

There has been a significant amount of work undertaken during 2015/16 with the aim of reducing avoidable HDFT acquired pressure ulcers. The numbers of category 2 hospital acquired pressure ulcers have seen a marked reduction compared to 2014/15.

However the numbers of category 3 and 4, preventable hospital and community acquired pressure ulcers (community being those patients in receipt of HDFT community nursing care) remain a challenge and will continue to be an area of increased focus during 2016/17. The Trust supports a “zero tolerance” approach to avoidable pressure ulcer development in people who are receiving nursing care, and this will be supported by our pressure ulcer prevention strategies including training and investigation processes.

2.5.2 Patient Experience

1. Pain management

Since the assessment and management of pain within the Trust was highlighted by the Care Quality Commission in 2013 and local audits revealed that the recording of pain scores in post-operative patients was sub optimal, work has been ongoing to ensure that pain assessment and management remains a vital element of care.

What have we done?

We have continued to focus on improving the consistency of pain assessment across the Trust together with staff awareness and knowledge of pain management, and aimed to be able to demonstrate this by improving our audit results.

Last year’s pain score audit showed that since the introduction of Patientrack for recording vital signs electronically, pain is assessed on admission for 100% of patients. However, the audit also highlighted that the re-assessment of high pain scores, within a 30 minute window was low (0-8%). Further changes to Patientrack to include a high pain ‘alert’ system are expected in the future.
An assessment tool for patients with dementia and communication or learning disabilities was also introduced. The PAINAD (Pain Assessment in Advanced Dementia Scale) tool relies on assessment of non-verbal expression of pain, such as body posture, vocalisation and facial expression. An audit was undertaken in August 2015 which included assessment of patients’ pain using the PAINAD tool and a staff questionnaire.

The education of nursing and medical staff remains essential and training activities include the establishment of a training day for surgical nurses, pain link nurse meetings and additional training for doctors in training. An electronic referral system has been implemented on the hospital intranet to assist in the management of pain.

There are new methods of providing pain relief to patients which are now used routinely within the Trust. These include fascia iliaca nerve blocks which is a technique advocated by NICE guidelines and the Association of Anaesthetists of Great Britain and Ireland (AAGBI) for post-operative pain relief for procedures and injuries involving the hip, anterior thigh, and knee. A nurse led project was introduced in 2013, with the trauma co-ordinator and acute pain nurse being trained to take on the extended role of performing this regional block to patients following a fractured neck of femur. A further training programme has been developed with the anaesthetists to teach Foundation Year 2 (FY2) doctors to administer blocks to this group of vulnerable patients.

Further improvements to patient care include the introduction of pectoralis (PECs) blocks for patients undergoing routine breast surgery.

What are the results?

The PAINAD audit showed that 53% of the Patientrack data matched the scores generated through the use of PAINAD, with the remainder varying by up to 6 points. Results from the staff questionnaire show that 66% of staff had awareness of the tool with 55% saying they felt comfortable using it (see table 39). Feedback from the staff and the patient data suggested that further support, training and incorporation of the tool into Patientrack would be useful.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Expected level of performance</th>
<th>Actual level of performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>To have an awareness of the PAINAD tool</td>
<td>100%</td>
<td>66%</td>
</tr>
<tr>
<td>To understand what the PAINAD tool is used to assess</td>
<td>100%</td>
<td>66%</td>
</tr>
<tr>
<td>To understand which patient groups should be assessed using the PAINAD tool</td>
<td>100%</td>
<td>32%</td>
</tr>
<tr>
<td>To feel comfortable using the PAINAD tool when needed</td>
<td>100%</td>
<td>55%</td>
</tr>
<tr>
<td>Scores obtained using the PAINAD tool should match those recorded on patient track</td>
<td>100%</td>
<td>53%</td>
</tr>
</tbody>
</table>

Table 40: PAINAD audit results August 2015

Evaluation of the fascia iliaca block project recorded 100% staff satisfaction with the pain relief provided when moving patients onto bed pans, changing bedding, and positioning for dietary requirements. However the results also showed that only 20% (24/116) of patients with a fractured neck of femur (NOF) in a six month period were receiving blocks with 90% being performed during normal working hours.

To increase patients’ access to the block service, teaching was extended to include FY2s working within the surgical rotation in November 2015. During the period of November 2015 to February 2016 31/92 (34%) patients’ with fractured neck of femur received a fascia iliaca
block with 35% being performed out of hours. These results illustrate a clear improvement over a short period of time. Further evaluation is needed to understand the reasons for not performing blocks on more patients.

In addition 32 patients undergoing mastectomy, wide local excision, breast implantation or reduction were studied. Nine were given a PECs block alongside their general anaesthetic (GA) and although figures were small, a reduction in pain scores was demonstrated (see below) with an overall reduction in opiate requirements and post-operative nausea. The charts indicate the highest pain score for each individual patient studied. Further studies, with larger numbers is required but the PECs block is now routinely used in the Trust.

Figure 16: Pain scores following breast surgery - GA (general anaesthetic) v PECs block + GA

Since November 2014 we have incorporated four questions about pain into our inpatient Friends and Family test (FFT) and have monitored and shared the results and comments provided by patients with ward staff in order to promote learning. The questions are:

Q1. Did our staff ask you about pain regularly?
Q2. If you had pain, were you offered pain relief?
Q3. If you were offered pain relief, did the staff give it in a reasonable time?
Q4. If you had pain relief, was it effective?

Results remain positive, indicating that overall patients appear satisfied with pain management.

<table>
<thead>
<tr>
<th>Ward</th>
<th>QUESTION 1 %</th>
<th>QUESTION 2 %</th>
<th>QUESTION 3 %</th>
<th>QUESTION 4 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMU - ACUTE MEDICAL UNIT</td>
<td>17 100.0%</td>
<td>15 100.0%</td>
<td>13 100.0%</td>
<td>14 100.0%</td>
</tr>
<tr>
<td>BYLAND WARD</td>
<td>7 100.0%</td>
<td>5 100.0%</td>
<td>5 100.0%</td>
<td>4 100.0%</td>
</tr>
<tr>
<td>CATT WARD</td>
<td>45 93.8%</td>
<td>36 100.0%</td>
<td>33 97.1%</td>
<td>31 93.3%</td>
</tr>
<tr>
<td>FARNDALE WARD</td>
<td>27 100.0%</td>
<td>25 100.0%</td>
<td>25 100.0%</td>
<td>24 96.0%</td>
</tr>
<tr>
<td>GRANBY WARD</td>
<td>38 100.0%</td>
<td>23 95.8%</td>
<td>22 95.7%</td>
<td>22 100.0%</td>
</tr>
<tr>
<td>HARLOW SUITE</td>
<td>13 100.0%</td>
<td>12 100.0%</td>
<td>10 100.0%</td>
<td>11 100.0%</td>
</tr>
<tr>
<td>JERVAULX WARD</td>
<td>25 100.0%</td>
<td>18 100.0%</td>
<td>18 100.0%</td>
<td>16 100.0%</td>
</tr>
<tr>
<td>LITTONDALE WARD</td>
<td>47 100.0%</td>
<td>33 100.0%</td>
<td>30 96.8%</td>
<td>29 96.7%</td>
</tr>
<tr>
<td>NIDDERDALE WARD</td>
<td>28 100.0%</td>
<td>27 100.0%</td>
<td>27 100.0%</td>
<td>26 96.3%</td>
</tr>
<tr>
<td>OAKDALE STROKE AND REHAB UNIT</td>
<td>16 100.0%</td>
<td>13 100.0%</td>
<td>11 91.7%</td>
<td>11 100.0%</td>
</tr>
<tr>
<td>TRINITY WARD RCH</td>
<td>6 85.7%</td>
<td>4 80.0%</td>
<td>4 100.0%</td>
<td>7 100.0%</td>
</tr>
<tr>
<td>WENSLEYDALE WARD</td>
<td>60 98.4%</td>
<td>62 100.0%</td>
<td>59 98.3%</td>
<td>63 100.0%</td>
</tr>
</tbody>
</table>

Table 41: Friends and Family Test, January 2016
Staff opinion on how well we manage pain has been examined in the Integrated Care Directorate using a staff survey based on questions asked in the FFT. This concluded that the majority of staff felt that they dealt with pain well and had good knowledge. However, some felt that we did not always give pain relief in a reasonable time and sometimes forget to return to reassess a patient. Plans are in place to extend this survey to the Elective Care Directorate and we will use the results to continue to focus on improving pain management.

Summary

In summary we continue to work towards improving the management of pain for patients under our care. Various educational events continue to teach doctors, nurses and associated healthcare professionals the importance of assessing and managing pain proactively. Results from the FFT and staff survey remain positive and will continue to be shared appropriately.

2. Maternity

This year we have completed the refurbishment of the Maternity Department. We have participated in the 2015 Maternity Patient Satisfaction Survey, and are continuing to use the results of this patient feedback and the Maternity Friends and Family Test to improve services. We have worked to maintain safe and high quality midwifery care which is assessed by the Local Supervising Authority audit, and have trained and assessed staff in the use of customised growth charts. We also launched the Harrogate Maternity Mums and Midwives Facebook page.

Following the 2013 Maternity Survey we developed an action plan focused on three areas identified for improvement: reviewing customer care training for all staff, training all staff in supporting patients in relation to breast feeding, and ensuring information is available for pregnant women.

What are the results?

Maternity refurbishment

The main aim of Maternity refurbishment project was to improve the privacy and dignity for the women who use our services. We wanted to create a calm, relaxed atmosphere that would reduce the anxiety and stress that women and their partners may feel when they come into hospital.

- The birthing pool has been replaced and the delivery room has been redecorated to create a calm and relaxing atmosphere, to promote normality in childbirth;
- All the delivery rooms now have ensuite facilities in the form of wet rooms;
- The Maternity Assessment Centre (MAC) has been created on Pannal Ward to ensure appropriate triage of women. This reduces the number of unnecessary admissions to hospital and ensures continuity of care and information provision to women in the early stages of labour. The MAC is currently open 08.00-20.00 Monday-Friday but due to its success we are considering extending the opening hours to include weekends initially;
- All of the carpets throughout the Maternity Unit have been replaced with vinyl wooden effect flooring, including the entrance to the department creating a welcoming environment. The walls have been redecorated with some feature walls painted purple;
- There is a new midwives station on Delivery Suite.
The planned work commenced in March 2015 and was completed in August. We managed to maintain a normal service and this is credit to the staff and the workmen who were presented with some challenging situations especially during periods of high activity.

Regular updates on progress were provided during the refurbishment for staff and service users by letter and information on the website. The finished product is better than any of us could have imagined and we have the Capital Planning and Design Team to thank for this.

We arranged a launch of the refurbished unit in October, this was attended by service users and their families (both those who had delivered during the refurbishment and those due to deliver), Maternity staff, other key Trust staff and Cathy Warwick, Chief Executive Officer at the Royal College of Midwives.

**Breast feeding advice**

The department has invested in a further one day workshop for all staff in breast feeding to ensure that all advice given to new mothers is up to date, consistent and in line with the new Baby Friendly UNICEF standards. This training was commenced in January 2015 and 98% of the midwives have attended.

**Information available for pregnant women**

We had discussions with Baby TV but decided not to go ahead with this in the Antenatal Clinic. We are reviewing how we deliver key messages to women at parent education, on the maternity section of the Trust internet and within the information given during the pregnancy and postnatal period.

**Maternity Patient Satisfaction Survey 2015**

This survey involved 133 NHS acute trusts and is part of a series of national patient surveys by the Care Quality Commission (CQC) for all NHS Acute Trusts with Maternity Services in England. The survey for HDFT was carried out by the Picker Institute Europe.

Women were eligible for the survey if they had a live birth during February 2015, were aged 16 years or older, gave birth in a hospital, birth centre, maternity unit, or who had a home birth. Responses nationally were received from more than 20,631 service users, a response rate of 41%. Responses were received from 152 patients at Harrogate and District NHS Foundation Trust with a response rate of 51%.
Women were asked to answer a total of 51 questions about their care, with the response for each question in the survey converted into scores, where the best possible score is ten. Each trust received a rating of better; about the same; or worse, on how it performs for each question compared with most other trusts. We have included below the scores for the CQC maternity care pathway reports: labour and birth.

<table>
<thead>
<tr>
<th>Results for HDT</th>
<th>Score /10</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>9.2</td>
<td>Better</td>
</tr>
<tr>
<td>Staff</td>
<td>9.0</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>8.6</td>
<td>Better</td>
</tr>
</tbody>
</table>

*Table 42: Maternity patient survey 2015 summary results for HDT*

Key messages from the 2015 survey in relation to the results from the Picker Institute were:

- HDFT had significantly improved on one particular question: Postnatal care at home - personal circumstances not taken into account;
- HDFT results were significantly better than the Picker average on 27 questions;
- No scores had worsened since 2013;
- None were significantly worse than the Picker average;
- Scores showed no significant difference from 2013 on 43 questions.

Areas for improvement and therefore inclusion in the action plan for 2015 are:

- Labour and delivery - did not have confidence and trust in staff;
- Feeding - did not receive consistent advice;
- Feeding - did not receive support/encouragement;
- Postnatal care at home - mother not given enough information about recovery after birth;
- Mother did not receive enough help/advice about emotional changes after birth.

It is important to note that this survey was directed at women who delivered in February and March 2015, and the extra study day for all staff on breast feeding started in January 2015, and therefore there was not enough time to see the benefit of this training reflected in these results. We plan to survey women during 2016 about breast feeding advice.

**Review of customer care training for all staff**

We have updated the Trust customer care training, "Every Patient, Every Time" to be more specific to maternity services, with some of the key areas identified from the patient survey incorporated into the presentation. 58 (68.23%) midwives, 14 (89%) maternity support workers and 11 medical staff had received the training by February 2016.

**Friends and Family Test - Maternity**

The Friends and Family Test is an opportunity for women to complete a short questionnaire at four stages of their care pathway. They are asked whether they would recommend the service to friends and family and the feedback enables staff to understand what has worked well and where necessary, make improvements. Women are surveyed:

- At the 36 week antenatal appointment (GP surgery, Children’s Centre, home or hospital);
- After delivery;
- On discharge from hospital;
- On discharge from the community midwife.
Table 43: % recommend/not recommend for January-March 2016 for HDFT and available national average results

<table>
<thead>
<tr>
<th>Maternity FFT</th>
<th>January 2016</th>
<th>February 2016</th>
<th>March 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HDT</td>
<td>National average</td>
<td>HFT</td>
</tr>
<tr>
<td>Antenatal</td>
<td>100.0% / 0.0%</td>
<td>95.9% / 1.4%</td>
<td>95.2% / 0.0%</td>
</tr>
<tr>
<td>Birth</td>
<td>100.0% / 0.0%</td>
<td>96.6% / 1.3%</td>
<td>98.0% / 0.0%</td>
</tr>
<tr>
<td>Postnatal ward</td>
<td>100.0% / 0.0%</td>
<td>94.2% / 1.8%</td>
<td>95.7% / 0.0%</td>
</tr>
<tr>
<td>Postnatal community</td>
<td>100.0% / 0.0%</td>
<td>98.2% / 0.6%</td>
<td>100.0% / 0.0%</td>
</tr>
</tbody>
</table>

Our response rates are nearly always above 20% and recommendation scores are very high showing that women are pleased with the level of care they receive in pregnancy, labour and post-delivery. The results are collected each month with response rate and scores monitored closely by senior midwifery managers and displayed in the Maternity Unit for staff and women to see. Both positive and negative feedback is given when individual staff are named.

Facebook page

Harrogate Maternity Mums and Midwives Facebook page was launched on 26th June 2015. The aim is to communicate information regarding the maternity services provided at HDFT, provide important public health information relating to maternal and child health and wellbeing, and to gain service user feedback in an alternative forum. The page is monitored and managed by three Supervisors of Midwives, and there is a clear process to respond to any negative feedback received.

Women send photographs and their birth experience stories almost daily via the private inbox and these are posted on the page with their consent. The page is not intended to give individual clinical advice but the private inbox enables us to identify women who need sign posting to areas within the maternity service. This has enabled us to identify a few women needing support and counselling which has surpassed the intentions of the page.

The page has proved to be a phenomenal success with a current total of 1,484 people ‘liking’ the page. Our posts are viewed widely, with a recent post reaching 25,845 people. Our target audience respond best to the personal stories and photos, and are particularly receptive to our ‘meet the team’ posts, where staff photographs and brief profiles of multidisciplinary team members are shared. Women have informed us that recognising staff from their profiles has put them at ease when using the service, particularly when attending Delivery Suite. However public health messages currently receive the least views, likes and shares, and we are keen to change this. Our intention is to use our service users personal experiences to deliver key public health messages.

The success of the page has now elevated service user engagement to such an extent that we are now in a position to re-form a Maternity Service Liaison Committee, which will enable us to work in partnership with women to shape and design our maternity services in the future. Our approach has also been recognised regionally by neighbouring maternity units, who have approached us for support in establishing similar pages for their own services.
Local Supervising Authority audit report

Supervisors of Midwives are appointed by the Local Supervising Authority (LSA). The main responsibility of the LSA is to protect the public by monitoring the quality of midwifery practice through statutory supervision for midwives, with the Nursing and Midwifery Council setting the rules and standards.

The Local Supervising Authority Midwifery Officer (LSAMO) is professionally accountable to the Nursing and Midwifery Council, and ensures that statutory supervision of midwives is in place to deliver safe and high quality midwifery care to women. Audits of statutory supervision are completed by the LSAMO and a small group of external assessors for all maternity units and supervisory teams on an annual basis.

The aim of the LSA audit is to:

- Review evidence that the standards for supervision in midwifery are being met;
- Ensure systems and processes are in place for the safety of mothers and babies;
- Review the impact of supervision of midwives on midwifery practice;
- Ensure midwifery practice is evidence based and responsive to the needs of women.

The LSA audit is carried out annually and the LSAMO provides an audit report with recommendations for the local supervisory team to complete before the next audit. The LSA audit at Harrogate in July 2015 was again very successful:

“The Supervisors of Midwives (SOM) team at Harrogate and District NHS Foundation Trust have shown great commitment and determination to the implementation of the findings following their last LSA audit visit on 11 November 2014. The team have added to their number with new supervisors joining the team as part of their succession plan. The stability of the current team is a key strength and this was evident to the LSA audit team as they meet women and their families and midwives on the maternity unit during the visit. The updating and upgrading of the clinical environment has allowed the team to further focus their work as SOMs on promoting the ‘normality of birth’ for women in their locality and despite the disruption seen on the day of the audit visit this was not affecting the care received by women and their families which is a credit to the whole team at the Trust. The finished work will see some significant improvement for women and their families.

On the day of the audit visit the team were highly motivated and well prepared to meet with the LSA audit team and had prepared an excellent pre-audit submission of data. The LSA audit team were able to triangulate this evidence with evidence provided by service users and their families and by staff on the day of the visit. Apart from a very small number of areas a very high level of compliance was achieved, evidence and seen at the audit visit”.

Some recommendations have already been addressed and an action plan to deliver other recommendations will be monitored through the Maternity Risk Management Group.

The future of supervision is uncertain following the publication of The Report of the Morecambe Bay Investigation by Dr Bill Kirkup. Changes to supervision are planned to take place from April 1st 2017. In the interim there is agreement and commitment from local SOMs that it is business as usual and they are working hard to continue to provide an effective 24 hour service to the women and their families who access our services and as support to the midwifery staff.
Customised growth charts

We have been training staff to use customised growth charts following three failures to detect babies who are small for gestational age last year. These were fully investigated and actions put in place to address the root causes. Our detection rate has increased from 28% to 42%, making HDFT one of the top performing units in the country. This is really positive news and demonstrates that the Saving Babies in North England (SaBiNE) project work has become embedded and gives huge assurance of changes in practice.

Summary

It has been a busy year in the Maternity Department. The refurbishment of the department has resulted in an environment that offers privacy and dignity, and a calm and relaxed atmosphere. Patient feedback remains positive, but we continue to seek all opportunities to learn and improve. Staff training and ensuring standards for supervision in midwifery are maintained has been a focus, and the success of the Facebook page in improving service user engagement contributed to us being one of only four maternity units in the UK, nominated for the Royal College of Midwives Midwifery Service of the Year Award 2015.

3. Food for staff and patients

Introduction

It is widely recognised that the service of good hospital food is an integral part of good patient care; a better diet is known to improve patient outcomes and public health, delivering multiple benefits for hospitals and their patients.

The Catering Mark, awarded by the Soil Association, is an independently audited framework that hospitals can use to take steps to improve the food they serve to patients, staff and visitors. The bronze, silver and gold awards provide an independent endorsement that food is fresh, trustworthy and traceable, and free from harmful additives and trans fats.

What were we aiming to achieve?

The Catering Service aimed to achieve a bronze award catering mark as an independent endorsement that the Trust is taking steps to improve the food it serves, using fresh ingredients which are free from undesirable additives and trans fats, are better for animal welfare, and comply with national nutrition standards.

The Catering Mark has been cited by NHS England as a way to improve hospital food, and by the Department of Education as a national framework to support caterers to increase uptake of quality school meals.

The Food for Life Catering Mark Bronze Standards are:

- Caterers in hospitals can demonstrate their compliance with national standards or guidelines on food and nutrition;
- At least 75% of dishes on the menu are freshly prepared (on site or at a local hub kitchen) from unprocessed ingredients;
- All meat is from farms, which satisfy UK animal welfare standards;
- No fish are served from the Marine Conservation Society ‘fish to avoid’ list;
- Eggs are from free range hens;
• No undesirable additives or artificial trans fats are used;
• No genetically modified ingredients are used.
• Drinking water is prominently available;
• Menus are seasonal and in-season produce is highlighted;
• Information is on display about food provenance;
• Menus provide for all dietary and cultural needs;
• All suppliers have been verified to ensure they apply appropriate food safety standards;
• Catering staff are supported with skills training in fresh food preparation and the Catering Mark.

What have we done?

Over a period of nine months, the Catering Service worked closely with suppliers and the Soil Association to ensure that the produce purchased and the 1500 meals provided daily for patients, visitors and staff met the requirements of the Soil Association.

What are the results?

The Trust was awarded the Soil Association Food for Life Catering Mark Bronze, on the 8th February 2016. The award recognised the Trust’s push for fresh meals and good food at Harrogate District Hospital, encompassing Herriot’s Restaurant serving outpatients, visitors and staff, and the inpatient meals service.

“The Catering Mark is the result of lots of dedicated effort by the team at Harrogate and District NHS Foundation Trust. Achieving this endorsement is an exceptional achievement in the healthcare sector and a demonstration of the hospital’s dedication to serving fresh, ethical, sustainable food that meets nutritional guidelines. Healthy places must be serving food that is good for the environment and good for us.”

Richard Watts of the Soil Association

Photo 4: Staff at HDFT with the Soil Association Food for Life Catering Mark Bronze certificate
Summary

The Catering Mark recognises the effort our Catering Team has made to provide patients and visitors with access to tasty and nutritious food. It helps us understand much more about where our food is sourced from and we are proud to share that with people who eat with us. Anyone visiting the hospital restaurant or eating inpatient meals will be assured of healthy, sustainable food, produced by fully-trained staff on-site with fresh ingredients. Local people will know that all the meat achieves UK animal welfare standards, dishes contain only free-range eggs, no undesirable additives or trans fats; and patients and visitors can easily be told where their food comes from, with much of it being sourced locally from the Yorkshire region using NHS accredited suppliers.

2.5.3 Effective Care

1. End of Life Care

The provision of compassionate care is critical for patients at the end of life. We have only one chance to get this right for an individual, and ensuring that their family and carers are supported is key to our success. Our patients may wish to be cared for in hospital, in their own home or in a variety of community settings, and we must work with our partner agencies to ensure that the care they receive is of the highest quality wherever it is delivered.

How we care for the dying is an indicator of how we care for all sick and vulnerable people. It is a measure of society as a whole and it is a litmus test for health and social care services (Department of Health End of Life Care Strategy, 2008). At Harrogate and District NHS Foundation Trust, we are committed to developing excellence within end of life care.

It is the aim of the Trust to ensure that events preceding and following the death of a patient are managed sensitively, efficiently and with the knowledge and understanding of the relatives and carers. Patients, relatives and carers have the right to receive a high standard of care, advice and support from well informed staff. Local objectives clearly highlight the need to care for people in a timely way with their care coordinated and delivered in accordance with their wishes through a personalised care plan. This aims to enhance dignity, choice and equality, to increase the likelihood that death will occur in the patient’s preferred place of care, to palliate symptoms and to improve communication between patient, families and professionals.

What have we done?

We have built on our successes from previous years and our partnership with Saint Michael’s Hospice continues to positively influence the care that we provide. Excellent end of life care is often reliant on a combination of clinical skill and expertise, to ensure that all of the patient’s needs are met. Communication skills are used to ensure that the patient’s wishes are understood and acted upon, and each stage of the process is explained clearly. Our focus has consequently been on education and training across the Trust.

Education and training

End of life care is seen as a core responsibility of all clinical teams, and a significant component of the services provided by community nursing, respiratory care, elderly care etc. Whilst end of life care training is currently not mandated, work is underway to provide a range of education to meet the needs of varying staff groups. In the last year there has been a significant increase in education and training provided by the Specialist Palliative Care Team. This has been in formal and informal formats in hospital and in the community, as
part of attendance on medical wards when reviewing patients, and also through one-off teaching events and on-going programmes.

Staff surveys were undertaken in 2015 asking staff if they feel they would benefit from more training on end of life care and if so, what training was required. As a result:

- Over 750 trust staff members have undergone training in the Five Priorities of Care for the dying person;
- Care of the dying is now covered on the care support worker induction programme and this includes education on nutrition and hydration at the end of life;
- There are advanced plans to implement the SAGE & THYME ® communication skills training across the Trust, to support all grades of staff to listen and respond to patients or carers who are distressed or concerned as described in section 2.2.1;
- End of Life Care learning outcomes have recently been developed by Health Education Yorkshire and the Humber. E-ELCA is a library of e-learning sessions designed to enhance the training and education of all those involved in delivering end of life care to individuals who have been diagnosed with life limiting illnesses and are usually within the last 12 months of their life. We are in the process of developing an e-learning package to provide further education.

Senior clinician development programme - Rethinking Priorities

Six consultants and a GP participated in the Rethinking Priorities programme, which aims to enable patients approaching the end of life to have their wishes met regarding their care in the future. This 12 month programme, supported by Health Education Yorkshire and the Humber, encouraged senior clinicians to engage with end of life care issues, undertake learning about end of life care, improve communication skills, identify improvements within their own practice, share and spread learning to colleagues within their departments and generate service improvements. Common themes included planning to use tools to identify patients who may be at risk of deteriorating or dying, introducing advance care planning conversations into routine practice, and improving communication and information sharing between primary and secondary care. At the end of the programme, participants reported increased confidence in all aspects of delivery of end of life care. The group presented a summary of the year’s activity to the Trust Board in January 2016, and it is hoped that some of this work will be taken forward as part of the Transforming End of Life Care in Acute Hospitals Programme.

Bereavement survey

We also recognise the importance of gathering and acting upon feedback from patients and relatives in order to ensure we are delivering a holistic and patient-focused service, and to identify any areas for improvement. The Care of the Dying Evaluation (CODE™) bereavement survey was first piloted within the Trust in 2013. The outcomes of this survey helped to inform the educational needs and plans for staff. The survey is now being repeated with data collection underway. We write to the next of kin approximately seven weeks after their relative’s death to ask if they would complete a questionnaire. Questionnaires are distributed with a pre-paid envelope so the response can be sent back to the Clinical Effectiveness Team. A preliminary report has been completed in February 2016. The results are mainly positive, with a small improvement against the 2013 results in some areas. See section 2.2.1 of this report for further detail relating to communication.

There are a few areas where relatives felt the care received could have been better, in particular dealing with pain relief and restlessness, noisy breathing, and the emotional and spiritual support provided to both the dying patient and their relatives. The decision has been
made to keep this as a rolling survey to gain a richer understanding of the care we are providing in this area.

The use of the Swan Symbol

Harrogate and District NHS Foundation Trust are in the process of adopting a ‘swan logo’ to promote heightened dignity, respect and compassion for the dying person and their significant others, at the end of life and after death. The swan logo will be included on all relevant documentation and a comfort/memory box will be available to families.

Redecoration of bereavement room

The room used by the General Office for meeting bereaved relatives and to provide a death certificate has recently been redecorated to create a more informal and relaxed environment.

Support for relatives - care in the last days of life

Relatives of patients who are at the end of their life are provided with free parking and open visiting. A booklet is available which provides written information, advice and guidance for family and friends. A section is also available for them if they have thoughts or comments they wish to document and later discuss.

What are the results?

Providing a definitive quantitative measure of our provision of end of life care is difficult, and we continue to work on ways in which to define a ‘good death’ and monitor our progress in achieving this.

We regularly participate in the National Care of the Dying Audit of Hospitals / End of Life Care Audit: Dying in Hospital and we will be analysing the latest report published 31 March 2016 and ensuring we act on any recommendations.

In the relatives bereavement survey the overall question, “In your opinion, were you adequately supported during his/her last two days of life?” has scored 100% in both 2013 and 2015, indicating that in general people are happy with the level of support being received. The 2013 survey was a local survey conducted as part of the national audit at that time, and the 2015 survey was the initial results from the local rolling survey (using the CODE™ questionnaire).

We have continued to build on the progress that we have made in recent years, however we can always improve the care we deliver and we intend to do so.

Summary

During 2015/2016 we hoped to launch a revised HDFT End of Life Strategy, which would be used as a framework to develop skills further, but we are not yet at the stage of producing a final strategy plan. However a full stakeholder meeting was held in September 2015 to identify key areas that need to inform the strategic plan. Stakeholder representatives included GPs, district nurses, social care, the voluntary sector, and St Michael’s Hospice. Work within the Trust has also been undertaken to gather the views from front line staff in all clinical areas regarding their areas of concern and ideas for improving end of life care services – both within the hospital and in a local GP practice.
We have agreed with our commissioners that the recently published End of Life Care Strategy: New Ambitions document will be used as a framework for future service development, building on the principles that:

- Each person is seen as an individual;
- Each person gets fair access to care;
- Maximising comfort and wellbeing;
- Care is coordinated;
- All staff are prepared to care;
- Each community is prepared to help.

These principles are supported by:

- Having a shared understanding and purpose for end of life care;
- Patients and carers feeling supported and able to cope;
- Professionals feeling supported and able to learn and to care;
- Addressing inequity and variations in practice;
- Developing systems that support efficient and effective palliative and end of life care.

During 2016/17 we will be focusing on:

- Supporting staff to provide person centred high quality care, by preparing to include one page profiles on admission into hospital as part of the general nursing assessment;
- Preparing to take forward the ‘Transform’ programme to create a clear framework for improving end of life care across the organisation, with key metrics to provide transparency and Board assurance regarding the quality of end of life care.
- Prioritising the discharge of patients who are considered to be in the last week of life and who require Continuing Health Care funding, to enable them to die in their preferred place of choice
- Supporting the individual needs of the dying person and their significant others and ensuring that the five Priorities of Care for the dying person are met, by establishing and implementing a document to provide care plans for the last days.

2. Dementia care

Dementia is a progressive disease for which there is no known cure. The aim of the Government’s National Dementia Strategy is that all people with dementia and their carers should live well with dementia. At HDFT we aspire to become a dementia friendly hospital; this involves considering the environment in which we care for patients, how we educate our staff to care for patients and assessing the quality of the care we deliver to patients living with dementia.

What have we done?

Improving the environment and becoming Dementia Friendly

Work has been completed on Byland and Jervaulx Wards with the use of pictures, the fitting of large clocks with day and time display and improved day room facilities, with some reminiscence features in both of these areas which care for elderly patients.

Research has shown that dementia changes a person's perception of distances, objects, and colours. The painting of toilet door frames in red is a recommendation from the
Alzheimer’s Society and other leading experts in dementia care, and there is evidence that this can reduce the use of continence aids by 50%. During January 2016 the door frames to toilet areas across all clinical areas of the organisation were painted red. In addition we have started a programme of fitting dementia friendly clocks across the organisation.

Through the reinvigorated Dementia Working Group and the re-launch of the Dementia Champions we have agreed a number of service improvement projects to achieve in 2016/17.

These include:

- Dementia friendly signage on wards;
- Welcome boards for patients on wards to orientate them to place i.e. “Welcome to Harrogate District Hospital, this is Byland Ward “;
- Coloured crockery for patients with a cognitive impairment;
- Using coloured pillowcases to visibility identify patients with cognitive impairment and increased needs if their families agree;
- Exploring the potential of having therapeutic support workers on the elderly care wards to provide support to patients living with dementia and our staff;
- Staff on Trinity Ward created a memory box to use with patients to improve their cognitive function.

**Education and training**

The Trust currently provides three levels of training and this has been a particular focus of work in 2015/16.

An innovative way of learning about early onset dementia was utilised in February 2016 when the organisation commissioned Brian Daniels to screen his play “Don’t Leave Me Now”. 41 members of staff and 18 members of the public attended a production and learnt about the carer’s perspective through the use of theatre. The evaluations regarding the play were extremely positive, including:

“Everyone should see this”  
“I thought it was sensitively and beautifully written play and extremely well-acted – it moved me to tears”  
“Excellent, powerful and well delivered”  
“Amazing, very powerful learning tool”  
“Certainly something that all should attend”  
“Great for students”  
“I am a volunteer at the hospital and appreciated the opportunity to come”

In November 2015 the Trust embraced the re-launch of the Butterfly Scheme and Barbara Hodkinson, founder of the Butterfly Scheme came to the hospital to assist with the training. 135 people attended the training sessions and the Head of Nursing in Integrated Care and the Dementia Champions continue to embed the Butterfly Scheme across the organisation.
We now have 63 of our staff who have become a Dementia Friend, learning more about what it is like to live with dementia and then turning that understanding into action. This training has been delivered by our colleague Belinda Goode from Tees, Esk and Wear Valley NHS Foundation Trust (TEWV).

We also provided further training for staff on the Mental Capacity Act and Deprivation of Liberty Safeguards legislation during 2015/16. See section 3.14 for further detail.

Collaboration with other organisations and partners

Last year HDFT joined the Dementia Action Alliance and shortly after we were partnered with the Norfolk and Norwich University Hospitals NHS Foundation Trust. This organisation is highly innovative in the way that dementia care is delivered to patients and their carers. We have an invitation to visit in order to benchmark dementia care, observe their Dementia Support Workers and discuss service improvement projects that we can replicate.

We have joined the regional Dementia Network facilitated by the Quality Improvement Manager from the Yorkshire and the Humber Strategic Clinical Network and Senate. There are regional meetings that provide education, quality improvement ideas, share research in dementia care and enable networking with colleagues across the region.

Our consultant in Medicine for the Care of the Elderly who leads work on dementia has established a close working relationship with the TEWV Acute Hospital Liaison Team in Old Age Psychiatry, ensuring patients are being referred, assessed and appropriately treated in an efficient way so they are cared for in the right environment by staff with the right skills and competence. The Acute Hospital Liaison Team provide ongoing advice and support for both medical and nursing staff and contribute to dementia training for our doctors.

Commissioning for Quality and Innovation (CQUIN) - Dementia

The key aim of the CQUIN framework is to support a shift towards the vision set out in ‘High Quality Care for All’ of an NHS where quality is the organising principle. The Trust has been working to compliance in relation to each element of the national CQUIN indicator associated with the care of people living with dementia. These include:

- Case finding or screening, so that everyone admitted to hospital as an emergency or for unplanned care who is 75 or older, is asked about whether they have been having
problems with their memory. If this has been a feature, investigations are carried out to exclude treatable causes of memory problems. The patient’s GP receives a summary of their stay in hospital and would be asked to refer the patient to local memory services if their memory had not improved over the following weeks;

- Discharge summaries of patients with dementia, suspected dementia and/or delirium, have a clear plan for these conditions included in their discharge letter from hospital or community services to their GP;
- Improving dementia training;
- Undertaking regular carers surveys in order to ensure carers of patients living with dementia are well supported during the hospital stay and at the time of discharge from hospital.

What are the results?

Informal feedback from relatives has told us that they appreciate the difference we have made to the environment.

HDFDT consistently ensures more than 90% of patients aged 75 years and over admitted to hospital for emergency or unplanned care are screened, assessed and referred as required. We have seen significant improvement in ensuring all of the required elements of the discharge letter are completed to support patients’ management once out of hospital.

During 2015/16 we delivered higher level training to 63 members of HDFDT staff. Results of dementia awareness training and tier one training are below.

<table>
<thead>
<tr>
<th>Level of training</th>
<th>Renewal</th>
<th>Total Employees</th>
<th>Total Trained</th>
<th>Overall Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 Yearly</td>
<td>1614</td>
<td>1329</td>
<td></td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td></td>
<td></td>
<td></td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td>2 Yearly</td>
<td>1780</td>
<td>1566</td>
<td>12%</td>
</tr>
<tr>
<td>Dementia Tier 1</td>
<td></td>
<td></td>
<td></td>
<td>88%</td>
</tr>
</tbody>
</table>

Table 44: Dementia training completed (January 2015)

Regarding the results of the carers’ survey:

- 63% reported feeling supported while their relatives was in hospital;
- 63% felt confident to leave the person in our care;
- 100% thought our visiting times were flexible enough to meet their needs;
- 88% felt that the staff had an understanding of dementia;
- 63% felt staff respected personal routines and preferences while their relative was in hospital.

Less positive results related to promotion of the Butterfly Scheme, carers feeling involved in the care being given, whether staff asked about any difficulties they were having caring, and being given information about agencies in the area who may be able to provide carer support.

Carers were also asked for suggestions on how we may improve the care that we give. The issues raised were about communication, staff not being aware of the personal needs of the patient, the lack of practicality of the NHS 111 system and not being aware of sources of support available to them. The Dementia Working Group will be working to address carers concerns and to bring about improvement in the experience of patients and carers.
Summary

There has been significant progress with the environment, training and understanding more about the needs of carers of people living with dementia. We want to continue this work in 2016/17 by:

- Working to continue to improve the hospital environment with the use of dementia friendly signage, dementia friendly crockery and painting to be in line with The Kings Fund: Enhancing the Healing Environment programme;
- Progressing a business case to have therapeutic support workers working on the elderly care wards to support patients living with dementia and carers;
- Working in partnership with John’s Campaign, and launch this at HDFT. John’s Campaign was founded to promote the right for families and carers of people with dementia to be allowed to remain with them in hospital for as many hours as they are needed, and as they are able to give;
- Increasing the number of clinical staff who have had higher level training by 50%;
- Launching the dementia strategy for the Trust;
- Re-launching the “all about me” information in a card;
- Having a carers passport to formalise visiting arrangements and parking concessions;
- Training staff on the elderly care wards in reminiscence therapy.

3. Stroke care

Good stroke care reduces mortality and disability. There has been a national and local campaign to improve performance in particular measures of care following both acute stroke and transient ischaemic attack (TIA), which is a threatened stroke.

By participating fully in national audits and local accreditation processes we wished to demonstrate good compliance with all stroke performance measures and have a fully accredited stroke service which compares favourably with other providers.

What have we done?

We have contributed data for all of our stroke admissions to the national Sentinel Stroke National Audit Programme (SSNAP) to allow quarterly reporting of performance, which is subsequently released into the public domain. We have participated in the Yorkshire and the Humber stroke accreditation process and the ongoing peer review for stroke services by the Yorkshire and the Humber Strategic Clinical Network. For TIA performance we report monthly to HaRD CCG on the management of high risk patients within 24 hours of presentation. Within the Trust this work is overseen by the Stroke Steering Group, chaired by an executive lead for stroke and attended by clinicians, Yorkshire Ambulance Service, commissioners, voluntary agencies and patient representatives.

What are the results?

The latest published SSNAP results are for Quarter 3 2015/16. HDFT has been rated C this quarter, an improvement on the previous quarter (D). Our overall score has increased significantly this quarter to 64, compared to 48 the previous quarter. Also we have scored an A for both data quality metrics this quarter meaning that our score is not adjusted down as it has been in previous quarters.
Of the ten domains in the SSNAP data set, five have seen a score improvement this quarter:

- Stroke unit (D to B)
- Occupational Therapy (C to B)
- Physiotherapy (D to B)
- Speech & Language Therapy (E to C)
- MDT working (D to C)

Many domains do better when we get patients with stroke directly to the Stroke Unit quickly, and this improved from 58% to 71% in the last quarter. This means patients get quicker assessments and the results relating to the therapy domains have improved. Two factors affecting further improvement are the availability of beds on the Stroke Unit and the availability of therapists.
Figure 19: Scanning and Thrombolysis domains SSNAP data sets

In terms of thrombolysis, all nine eligible patients were thrombolysed this quarter but only one (11%) within an hour. The average time to thrombolysis was 1 hour 40 minutes. 27% of patients were scanned within 1 hour and 82% within 12 hours. To improve these we need to ensure all the related services and staff in ED, stroke team, porters, CT scanning etc are working so seamlessly that delays are brief.

Summary

We have participated fully with all national and regional stroke performance monitoring and have achieved a high level patient data entry for SSNAP in 2015/16. This has allowed us to reflect on good quality performance data to look for areas of improvement in how we manage our patients after acute stroke. SSNAP is a continuous audit and it has taken time to embed it within our routines but it will continue to provide important information on the quality of our stroke care.

Whilst some of our SSNAP audit results have improved recently, we are not making as much progress as we would like with others, and we want to focus during 2016/17 on improving our performance in relation to the provision of high quality stroke care. The quarterly SSNAP dataset will be used to monitor performance and progress.
2.6 Performance against indicators in the Risk Assessment Framework

The following table demonstrates HDFT’s performance against the indicators in Monitor’s Compliance and Risk Assessment Frameworks for each quarter in 2015/16.

<table>
<thead>
<tr>
<th>Indicator description</th>
<th>Target</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT incomplete pathways (% within 18 weeks)</td>
<td>&gt;=92%</td>
<td>96.2%</td>
<td>95.7%</td>
<td>95.0%</td>
<td>95.6%</td>
</tr>
<tr>
<td>A&amp;E: Total time spent in A&amp;E</td>
<td>&gt;=95%</td>
<td>96.6%</td>
<td>95.7%</td>
<td>95.4%</td>
<td>94.7%</td>
</tr>
<tr>
<td>Cancer - Maximum waiting time or 14 days from urgent GP ref to date first seen for all urgent suspect cancer</td>
<td>&gt;=93%</td>
<td>93.7%</td>
<td>97.5%</td>
<td>98.4%</td>
<td>97.3%</td>
</tr>
<tr>
<td>Cancer - maximum waiting time of 14-days for symptomatic breast patients (cancer not initially)</td>
<td>&gt;=93%</td>
<td>95.3%</td>
<td>96.9%</td>
<td>98.2%</td>
<td>95.5%</td>
</tr>
<tr>
<td>Cancer - 31 day wait for second or subsequent treatment: Surgery*</td>
<td>&gt;=94%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug*</td>
<td>&gt;=98%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Cancer - 31 day wait for second or subsequent treatment: Radiotherapy*</td>
<td>&gt;=94%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Cancer - Maximum waiting time of 31 days from diagnosis to treatment for all cancers (%)</td>
<td>&gt;=96%</td>
<td>100.0%</td>
<td>99.6%</td>
<td>99.0%</td>
<td>99.6%</td>
</tr>
<tr>
<td>Cancer - 62 day wait for first treatment from urgent GP ref to treatment: all cancers</td>
<td>&gt;=85%</td>
<td>88.9%</td>
<td>87.7%</td>
<td>93.4%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Cancer - 62 day wait for first treatment from consultant screening service referral: all cancers*</td>
<td>&gt;=90%</td>
<td>100.0%</td>
<td>50.0%</td>
<td>95.8%</td>
<td>93.1%</td>
</tr>
<tr>
<td>C-Difficile - cases due to a lapse in care (cumulative)</td>
<td>&lt;= 12 cases in year</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>7 (tbc)</td>
</tr>
<tr>
<td>Community services data completeness - RTT information</td>
<td>&gt;=50%</td>
<td>79.6%</td>
<td>80.6%</td>
<td>80.4%</td>
<td>79.9%</td>
</tr>
<tr>
<td>Community services data completeness - Referral information</td>
<td>&gt;=50%</td>
<td>71.3%</td>
<td>72.7%</td>
<td>73.0%</td>
<td>68.2%</td>
</tr>
<tr>
<td>Community services data completeness - Treatment activity information</td>
<td>&gt;=50%</td>
<td>81.4%</td>
<td>81.6%</td>
<td>81.4%</td>
<td>80.8%</td>
</tr>
</tbody>
</table>

Note
* The target does not apply to trusts with five or fewer cases in a quarter - the number of cases reported by the Trust during Q1 and Q2 was below this level

Table 45: HDFT performance against indicators in Monitor’s Compliance and Risk Assessment Frameworks 2015/16

Key performance to note:

- HDFT’s governance rating as reported to Monitor was green for each quarter of 2015/16. The Trust’s performance against the A&E 4 hour standard was below 95% for Q4. However this does not affect the Trust’s overall governance rating as long as the Trust reports performance above the 95% standard next quarter;
- The Trust achieved all seven applicable cancer waiting times standards for each quarter of 2015/16;
- 18 weeks performance was also above the required 92% for each quarter;
- Overall Trust performance against the A&E 4 hour standard was above 95% for eight out of 12 months during the financial year. However, sustained delivery of this standard remains challenging and Quarter 4 is the first time that the Trust has been below the 95% standard for the quarter overall. The development and implementation of plans to enable the Trust to move back to a positive performance position continue, including reviewing staffing deployment and requirements, co-location with the GP Out of Hours Service, and a review of departmental physical clinical capacity;
- There were two ambulance handover delays of over one hour reported in 2015/16 and 101 handover delays of over 30 minutes. The two handover delays of over one hour occurred on the same day which was an exceptionally busy day for the Emergency Department;
• No cases of hospital acquired MRSA were reported in 2015/16; the last one was reported in September 2013;
• 34 cases of hospital acquired *C. difficile* infection (CDI) were reported during 2015/16 meaning that the Trust exceeded its annual objective of a maximum 12 cases. Of these 34 cases, eight were agreed with the CCGs to have been caused by lapses in care. At the time of writing (11/5/16) we are still awaiting a decision of the appeals process on the remaining three cases. Three of the lapses in care are related to an outbreak of one strain of *C. difficile* 078 ribotype on Oakdale Ward in February 2016. Measures have been put in place to address *C. difficile* going forward (see section 2.4). The CDI objective for 2016/2017 has also been set at just 12;
• Activity levels at HDFT have increased during 2015/16. Elective (waiting list) admissions were 2.8% higher in 2015/16 when compared to 2014/15. Outpatient attendances also increased by 2.8%. Non-elective admissions increased by 4.0% and A&E attendances by 1.4%. However the number of avoidable admissions (as per the national CQUIN definition) decreased by 3.4% over the same period;
• During 2015/16, there was a 13.6% increase in face to face contacts recorded by the community nursing teams. This increase may be partly due to improved data capture but is also reflective of increased activity within these services.
3. OTHER QUALITY INFORMATION

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

3.1 National Inpatient Survey 2015

621 HDFT inpatients discharged in July participated in the 2015 national inpatient survey carried out by Picker Institute Europe. The HDFT response rate was 52%, compared to a national average of 45%. Of the 621 HDFT inpatients who responded to the survey, 36% of patients were on a waiting list so admission was planned in advance and 60% came as an emergency or urgent case. 53% of HDFT respondents were aged 70+.

Picker highlighted the following positive points for HDFT:

- 87% rated care at HDFT as at least 7 out of 10;
- 85% of respondents felt they were treated with respect and dignity;
- 83% always had confidence and trust in doctors;
- 98% felt their room or ward was very or fairly clean;
- 98% felt the toilets and bathrooms were very or fairly clean;
- 91% felt there was always enough privacy when being examined or treated.

The survey contained 65 questions in total. In 18 out of the 65 questions, HDFT scored significantly better than average, about the same as average for 46 questions and significantly below average for one question which was ‘Not asked to give views on quality of care’. 73% of HDFT patients agreed with this question compared to a 69% national average. In the section relating to admissions to hospital, HDFT attained a score of significantly better than average for six out of the seven questions.

Compared to the previous year’s results, HDFT had improved in 28 out of 62 questions that remained the same in both surveys, remained the same for 12 questions and gained a lower score in 22 questions. However in only one question was it deemed that HDFT had performed significantly worse than the previous year: “Hospital: not offered a choice of food” where 22% of patients felt they were not offered a choice of food in 2015 compared to 17% in 2014.

The current arrangements to help ensure that patients receive their choice of meal comprise:

- Menu choice cards are returned to the Catering Service from wards, one meal in advance, for example by 4pm for the next day’s meal service;
- The admissions menu is designed to offer patients a choice of food, for their first meal when admitted to hospital, rather than offering them a meal ordered for a patient who has been discharged;
- The standard patient menu or dietary menu for all other meal requirements is available to patients.

However, there can sometimes be difficulty in enabling patients to be given their choice e.g. when they are admitted to wards such as Clinical Assessment, Triage and Treatment. This is due to patients’ short lengths of stay and the logistics associated with their meal following them to their next location. To help address this the Catering Service is working closely with the Trust’s Nutrition Group. The group will consider the options available to help improve the arrangements for ensuring that patients receive the meal of their choice and thereafter will monitor the situation.

At present the full national data set is not available so it is not possible to see how HDFT ranks compared to other trusts.
3.2 National Staff Survey 2015

Every autumn the Trust participates in the national NHS annual staff survey. The results are published nationally and can be obtained from the national NHS staff survey web site.

Overall we have some extremely positive messages arising from the 2015 survey. The response rate for the Trust increased from 56% in 2014 to 59% in 2015, which is the highest response rate achieved in the combined acute and community trusts category in 2015.

The rankings that can be achieved by combined acute and community trusts are ‘better than average’, ‘average’ or ‘below average’. Out of the 32 key findings (KF) the Trust’s ratings against other combined acute and community trusts were ranked as follows:

- 23 were above (better than) average of which two were the highest scores in our group;
- Eight were average;
- One was below (worse than) average.

The figure below shows how the Trust compares with other combined acute and community trusts on an overall indicator of staff engagement. Possible scores range from one to five, with one indicating that staff are poorly engaged (with their work, their team and their trust) and five indicating that staff are highly engaged. The trust's score of 3.92 was above (better than) average when compared with trusts of a similar type. This is the highest ranking possible for combined acute and community trusts and ranks the trust joint third nationally in this category.

![Figure 20: National Staff Survey engagement](image)

Overall staff engagement comprises three key findings within the survey: staff members’ perceived ability to contribute to improvements at work; their willingness to recommend the trust as a place to work or receive treatment; and the extent to which they feel motivated and engaged with their work.

The Trust is at the top of our benchmarked group for:

- Staff satisfied with the opportunities for flexible working patterns (59%);
- Recognition and value of staff by managers and the organisation (3.63).

The Trust has improved significantly since the 2014 staff survey regarding:

- Support from immediate managers (3.68 to 3.87);
- Staff satisfaction with the level of responsibility and involvement (3.90 to 4.01);
- Staff recommending the organisation as a place to work or receive treatment (3.81 to 3.92).

Regarding the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (National Staff Survey KF26) the HDFT score was 21% (the lower the score the better) which was an improvement from the 2014 survey result. The 2015 national average for combined acute and community trusts was 24%.
Regarding the percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (National Staff Survey KF21) the HDFT score was 92% (the higher the score the better). The national average for combined acute and community trusts was 87%. This was one of the five key findings for which HDFT compares most favourably with other combined acute and community trusts in England.

For both KF21 and KF26 the survey scores achieved by HDFT rank the Trust when compared nationally as ‘better than average’. This is the highest ranking available.

The one area that has deteriorated the most since the 2014 survey and has been categorised as worse than average is:

- Staff experiencing physical violence from patients, relatives or the public in the last 12 months. This has increased from 11% to 16%.

**Staff Friends and Family Test**

Every quarter, members of staff are invited to take part the NHS Staff Friends and Family Test and answer the question: *How likely are you to recommend the Trust to friends and family as a place to work?* The results in Quarter 3 were:

- 87.8% of staff would recommend care or treatment at our Trust;
- 71.4% of staff would recommend the Trust as a place to work.

12.3% of staff would not recommend the Trust as a place to work, and 2.7% of staff would not recommend the Trust as a place to receive care or treatment.

The survey provides the opportunity for staff to provide additional comments and the results are reviewed each quarter by the directorates to ensure continuous service development. The key reasons for the responses were due to the impact of perceived staff shortages and increased workloads, whilst the main reasons given for staff not recommending care or treatment at our Trust to family and friends were that their family and friends do not live in the area, and that recommendation would depend on the type of care or service needed as other hospitals specialise in certain treatments.

**Actions to improve**

In previous years a Trust wide action plan has been developed and each directorate has used their own results to develop local action plans. This year we are asking directorates to focus on three overarching issues and develop action plans around the following areas:

1. Staff experiencing physical violence and discrimination;
2. Staff satisfaction with the quality of work and patient care they are able to deliver;
3. Quality of non-mandatory training, learning or development.

By concentrating on these three areas a greater focus can be given to them and a consistent message to be shared. By communicating this information clearly staff can be assured that the Trust has understood their feedback and subsequent action is being taken. The Human Resources Business Partners are working with directorate management teams to translate these overarching issues into local actions.
3.3 Complaints and compliments

The Trust welcomes patient feedback including positive as well as negative experiences. Front line staff are 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, the Medical Director and/or the Chief Nurse to discuss issues in more detail to help to address concerns and provide information and explanations. In all cases the feedback is reviewed to identify opportunities for improving patient care.

The Trust has an estimated 1.5 million patient contacts per annum, which equates to around 2,700 per day. Whilst every individual complaint is very important, especially to the complainant, the average rate of around 18 complaints per month in 2015/16 is relatively small at one per 7,000 patient contacts and is less than the average of 22 complaints per month for 2014/15.

![Formal Complaints Received by Financial Year 2007-2016](image)

*Figure 21: Local patient feedback data since 2007*

The data from April 2007 to March 2011 refers only to acute hospital services and from April 2011, the data represents both acute and community services following the integration of community services into the Trust. The Trust increased in size associated with the delivery of a significant number of new services.

The Trust introduced a detailed grading matrix for negative feedback during 2011, which is based on severity of concerns and timescales for response. This includes four levels of formal complaint (green, yellow, amber and red). The breakdown of complaints received in 2015/16 is presented below by grade and quarter in which it was received, compared to 2014/15.
<table>
<thead>
<tr>
<th>Complaints Total</th>
<th>2014/15 Total</th>
<th>2015/16</th>
<th>2015/16 Q1</th>
<th>2015/16 Q2</th>
<th>2015/16 Q3</th>
<th>2015/16 Q4</th>
<th>2015/16 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaint Green</td>
<td>94</td>
<td>26</td>
<td>8</td>
<td>18</td>
<td>31</td>
<td>140</td>
<td>66</td>
</tr>
<tr>
<td>Complaint Yellow</td>
<td>163</td>
<td>46</td>
<td>42</td>
<td>21</td>
<td>31</td>
<td>140</td>
<td>213</td>
</tr>
<tr>
<td>Complaint Amber</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Complaint Red</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>265</td>
<td>74</td>
<td>58</td>
<td>32</td>
<td>49</td>
<td>213</td>
<td>213</td>
</tr>
</tbody>
</table>

Table 45: Local patient feedback data showing complaints by quarter during 2015/16 and grade

The number of complaints received is less than the previous year and the number of cases indicating poor experience in several areas which are graded as moderate (yellow) or high (amber) is lower than last year. Quarters 1 and 2 received the most numbers of complaints. The Trust experienced high levels of patient activity during this period as did many hospitals across the NHS. The Trust also refocused efforts to resolving 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 informal “PALS” (Patient Advice and Liaison Service) type contacts includes concerns, information requests and comments. In total in 2015/16, 676 were received by the Patient Experience Team (PET) compared to 902 in 2014/15. Of these 676, 373 were concerns, 156 were requests for information and 147 were comments. The data demonstrates a reduction in the number of cases presented to the PET and an indication that front line staff are responding to and handling patient feedback swiftly in the wards and departments.

The top five themes for complaints and concerns can be seen in the graph below. The main themes have consistently included issues around aspects of medical care, diagnosis, medical and nursing communication.

Figure 22: 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 revised complaint handling and investigation process was implemented in 2013/14 whereby a lead investigator is appointed who has not been involved in the provision of care.
The 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 methodology is the same for all complaints. It focuses on what happened, what should have happened and where appropriate, what the actions will be to prevent it from happening again. The investigation is then quality assured by the operational director or clinical lead for the area to determine whether the investigation and response is robust and whether the issues complained about have been upheld. It should be noted that not all complaints or concerns received are upheld.

Response timeframes for complaints are guided by the severity of the case and are agreed at the outset. The Trust met the defined timescale for reply in 54% of cases in 2015/16 and sought extensions where the deadline could not be reached. The Trust is keen to improve this performance and establish a robust mechanism for capturing response rate against agreed deadline. A complaints performance metric has been introduced for 2016/17 and will include monitoring of complaints responses against a target of 95% within deadline set and monitoring of completion of action plans.

Action plans are developed to improve patient care as a result of feedback and these are monitored regularly. In response to concerns relating to communication, the Trust provides a communications and customer care training programme, “Every Patient, Every Time”. Learning from patient feedback is at the heart of our Making Experiences Count Policy, and clinical directorates share themes and learning from these via their governance groups and front line quality of care teams.

Five cases were referred to the Health Service Ombudsman in the period, which is less than 2014/15 when nine cases were referred. Of the five cases referred this current financial year:
- 1 has been investigated by the Ombudsman and partially upheld. An apology and action plan to address the findings has been completed;
- 2 have been investigated by the Ombudsman and not upheld;
- 2 are under review by the Ombudsman.

In 2014/15 the Ombudsman upheld two cases, found five were not upheld and referred two back for further local resolution.

Cloverleaf Advocacy Services is an organisation that provides support (known as advocacy services) to help people across the North of England to speak up and express their views, and help services to listen to and learn from people who use their services. During the year representatives from Cloverleaf Advocacy Services met with colleagues from the Trust including the Patient Experience Team to develop frameworks for communication and to promote the model of advocacy services. The Trust continues to promote the advocacy services that are available for supporting complaints and patient feedback.

Compliments are received at ward and team level, by the Patient Experience Team and reported in the local media.

| Table 46: Local data showing compliments received by the Patient Experience Team |
|---------------------------------|--------|--------|--------|--------|--------|--------|--------|
| Compliments received by the Patient Experience Team | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 |
| Compliments received by the Patient Experience Team | 233 | 354 | 354 | 291 | 330 | 315 | 340 |
3.4 The Patient Voice Group (PVG)

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

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

2015 has been a year of change. Along with changes to senior managers within HDFT the PVG welcomed a new Chair and new members to the group. The start of 2015 was a time of reflection to ensure all projects add value to the Quality Improvement Programme for the Trust. We also asked ourselves ‘do we really influence change to improve the patient experience?’ It has become increasingly difficult to talk to patients in hospital as they are very poorly and vulnerable and we want to collate honest feedback.

The projects undertaken by the PVG include:

- A telephone survey of the Patient Experience Team;
- Visits to Emergency Department to talk to 50 patients attending the department;
- Shadowing five patients through their journey of Radiology;
- Talking to more than 30 children and young people accessing many different children’s services;
- Visits to four wards talking to patients and relatives about their experiences with an emphasis on nutrition;
- Follow up visits to Lascelles Unit and Acute Medical Unit (previously Fountains Ward).

Reports on each project are provided for the Trust.

The majority of patients and relatives are very appreciative of the excellent care received and kindness shown by staff. The negative comments received are about staff being very busy and not having time to talk; patients are not aware or involved in their treatment plans; discharges are often delayed; appointments are not flexible and problems with car parking. It is a continuous challenge to find the most appropriate time to talk to patients.

The PVG need to ensure that there are good working relationships between the PVG and the Trust to ensure there is an effective two way communication. The PVG need to raise their awareness within the Trust, and improvements need to be made to ensure PVG reports are responded to, acted upon where appropriate and monitored through the Learning from Patient Experience Steering Group.

Judy Lennon (Chair) March 2015
3.5 Innovation work

Delivering more care in the community and in peoples homes

Health and social care partners in Harrogate and Rural District recognise that a sustainable health and social care economy is dependent on transforming the way that services are delivered for local people. Having become a Vanguard site the Trust has the opportunity to work with our partners to ensure that local people are able to access services that are joined up and support them to remain healthy, well and independent.

We are shifting care closer to home and working as a whole system across acute, primary, community health, social care, the voluntary and community sector and wider universal services to make this happen. Our aim is to ensure more people stay healthier and independent for longer, have choice and control over their lives and care, and that costs are reduced across the system.

What we aim to do;
• Support individuals to stay well and independent for as long as possible
• Provide the right care, in the right location at the right time to promote wellbeing and prevent deterioration
• Avoid unnecessary hospital admissions by creating community based alternatives
• Allow people to be more in control of their own health and wellbeing
• Provide services which are connected and which reduce delays in care delivery
• Create faster pathways to care
• Enable individuals to achieve their potential through innovative and creative care

The New Care Model

HDFT already provides the Adult Community Nursing services and Community Fast Response and Rehabilitation services for the HaRD area. These teams are part of the transformation along with our ward at Ripon Community Hospital and will have the opportunity to influence how the new model operates. Closer collaboration with our partners, including local GPs, social care, mental health services and voluntary organisations is key to the success, and we are all working together to design the New Care Model to enable local people to remain independent and at home for as long as possible.

We have already started working toward these goals which will be delivered via locally based Community Care Teams and a Response and Overnight Service. The first team started work as a pilot in February 2016 in Knaresborough, Green Hammerton and Boroughbridge area.

Figure 23: The New person centred Care Model
Although it is still early days, the team have made a number of improvements to care delivery to date including:

- Making it easier for people to be referred to the service, so they receive the support they need more promptly;
- Improved relationships and collaboration with partner organisations, encouraging joint working to make faster decisions;
- Developing joint assessments which reduce the number of times people have to answer the same questions;
- Identifying opportunities for staff to be trained to complete different competencies allowing us to reduce the number of people attending one home, carrying out separate tasks e.g. our mental health team member can administer eye drops which has saved a small number of additional visits.

All of the partners are committed to working with our local communities, voluntary organisations and our staff to design and introduce new ways of delivering care and support to local people in a way that works for them. We are keen to continually receive feedback from the communities which will shape how the programme will work and encourage anyone who has innovative ideas and suggestions to contact us.

**Clinical Transformation Programme**

The aim of our Clinical Transformation Programme is to: “Achieve best care for the people who receive care and treatment from Harrogate and District NHS Foundation Trust, whilst at the same time realise financial savings with improved systems and controls”. A number of objectives guide this approach:

- All contacts are cost-effective and add value to the patient;
- People only come to hospital when there is no community alternative;
- People only stay in hospital for as long as they need to;
- People only receive on-going care for as long as they need it.
The diagram below summarises the four workstreams and associated projects which together compromise the current programme. The scale of the challenge is to deliver quality improvements whilst realising £25m of cost improvements over the coming five years. A small Programme Management Office has been established to support projects to have the best chance of success.

Extensive planning during 2015/16 has moved eight of the projects through idea development, approval and planning phases into implementation. Three projects are now moving to completion.

A bespoke dashboard has been developed for the Clinical Transformation Board who oversee the programme, which shows clearly the status of each workstream, the projects within and the financial savings planned and realised. Collectively, the projects have reached 84 milestones in 2015/16. Highlights include:

- The first phase of outsourcing of printing and posting of patient appointment letters has been delivered and work to monitor the realisation of financial benefit started;
- Extensive data collection in Planned Care has enabled the Units of Delivery project to now focus on the top 10% of loss-making procedures;
- Observations of patient flow through main operating theatres have started. This will inform the delivery of a rapid process improvement workshop in 2016/17;
- Two “Flowopoly” events have been delivered with participants from across the Harrogate and District health and social care system to model hospital flows of patients who require unplanned care. In a highly structured and highly participative way, this enables NHS staff to see how patient flow does and does not work in a complex system. Findings from these events are informing the further delivery of the Unplanned Care workstream;
- Two promising trials of joint triage between GP out-of-hours health services and Harrogate District Hospital’s Emergency Department have run, with patients being more positive about returning for a GP out-of-hours appointment than expected;
A personal resilience training programme has helped to deliver a continuing trend of reductions in stress-related sickness absence, with January 2016 figures showing that this type of absence is costing the Trust £80,000 a year less than it was in June 2015;

External funding for the delivery of some aspects of the new Leadership Development Strategy has been secured and the strategy agreed;

A new approach to values-based employee appraisal has been rolled out to support the delivery of organisational culture change.

**Spotlight on rapid process improvement workshops (RPIW)**

More than 80% of improvement activity is now being focused on supporting the delivery of the Clinical Transformation Programme described above. Two recent RPIWs are profiled below.

**Enabling productive mobile working**

Sponsored by the Chief Operating Officer, this workshop engaged the Children’s Services 5-19 years vaccination service based at Selby in enabling staff to work more productively through the use of mobile technology. A number of measurable improvements were secured:

- The lead-time for immunisation sessions administration was reduced from 172 minutes to 118 minutes;
- The number of immunisation sessions delivered not following a standard protocol was reduced from 100% to 0;
- The workplace organisation of the office, storeroom and fridges was improved from 5S level 1 to level 4. 5S is a systematic approach to workplace organisation;
- The number of children whose data is not on SystmOne has reduced from 50% to 20%.

*Photos: 8 & 9: Children’s Services office, Selby: Workplace organisation before (left) and after (right)*
New Care Models patient pathway – catheter management

Sponsored by Deputy Medical Director, Dr Claire Hall, this workshop focused on stopping patients coming into hospital unnecessarily for the management of their urinary catheter. A number of measurable improvements were secured.

- The lead time taken from patient contact to catheter intervention was reduced by 57% to under two hours and forty minutes;
- The number of unnecessary attendances at the Emergency Department was reduced from four to zero;
- The use of information available in the catheter management passport was increased;
- Phone calls from district nurses to GPs to gain referral access to a hospital ward were eliminated.

The achievements made in both workshops were celebrated at a report-out to a warm and supportive audience in a packed Board Room on 27th November, 2015.

3.6 Volunteers

Volunteers play a vital role in the delivery of patient services throughout the Trust. Whilst they do not replace paid members of staff, they do enhance and compliment the work that staff undertake and contribute to the overall patient experience.

Volunteers are not just based at Harrogate District Hospital; we also have volunteers based at Ripon Community Hospital and within the last year this has expanded to community volunteers at sites in Northallerton and Scarborough.

The Trust is incredibly fortunate to have the assistance of over 400 volunteers who span the generations, ranging in age from 16 right up to 92 years of age! On average they provide over 2,000 hours per month of help in many different ways. We have a steady intake of new volunteers year round, with two specific sixth form intakes from local schools and colleges in April and November.

Volunteers continue to help in so many ways, such as:

- Meal time volunteers; assisting patients with their lunch and evening meals;
- Chaplaincy;
- Discharge Lounge; Outpatient’s clinics; activity volunteering; administrative assistance;
- Pharmacy assistance; meet and greet volunteers; volunteer drivers (who provide an

Photo 11 & 12: Just two of over 400 volunteers at the Trust!
invaluable transport service for patients living in Nidderdale, bringing them to and from their hospital appointments; Hospital Radio; undertaking patient surveys; assisting in the Sir Robert Ogden Macmillan Centre; assisting at fund raising events, the annual Open Event and at Medicine for Members lectures.

Our team of gardening volunteers have made a huge difference to the courtyards and gardens by planting, pruning and general tidying up. Carolyn Rothwell our lead volunteer gardener was awarded Wildlife Volunteer of the Year in the Harrogate and District Volunteering Oscars.

A new initiative for November 2015 involved training young volunteers to go onto wards to prepare patients for their evening meal, by ensuring their hands and tables are clean. So far 48, sixth form students have undertaken the role and have proved to be a welcome asset to the ward staff. New roles have also included assisting an Occupational Therapy led Parkinson’s Support Group, evening meet and greet volunteers for the Acute Medical Unit and the Clinical Assessment, Triage & Treatment Ward.

Photo 10: Young meal time volunteer

Volunteers are thanked officially at the annual Celebration of Volunteering in December, with a tea party and invited guest speakers and musical entertainment.

### 3.7 Health Visitors and Healthy Child Programme

The Healthy Child Programme (HCP) for the early life stages focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. The HCP for 5 to 19 year olds sets out the recommended framework of universal and progressive services for children and young people to promote optimal health and wellbeing.

We ensure that we deliver the HCP across North Yorkshire, and in the future Middlesbrough, County Durham and Darlington, in a way that ensures equality of access, taking in to consideration:

- The geographical spread of the counties and the varying community needs;
- The diverse population and range of needs;
- Proactive communication and engagement to ensure that families, children and young people have the ability and desire to proactively engage with the HCP service, including those who experience physical, language and/or cultural barriers;
- The need to expand availability of the service throughout the year and in terms of daily access, including expanded hours and weekend working when this meets the needs of communities.

We work closely with our commissioners to agree monitoring arrangements for each of the performance indicators for the HCP by developing an agreed dashboard based on the specification. We have a quarterly review meeting to discuss our performance from a quantitative, qualitative and continual improvement perspective. An action plan is actively
monitored which demonstrates our performance activity and identifies any areas for development and improvement.

What were we aiming to achieve?

Working collaboratively with partner agencies we aim to:

- Support children being ready for school;
- Support families to ensure children enjoy a happy family life, with a safe reduction in the looked after child population;
- Ensure a healthy start to life (improve immunisation uptake, reduce smoking prevalence and obesity, and improve the emotional wellbeing of families, children and young people).

The Health Visiting Service in partnership with North Yorkshire Children’s Centres are working towards UNICEF breast feeding initiative (BFI) status and have almost completed the first stage. This is in recognition of the profound importance of early relationships to future health and well-being and the significant contribution that breastfeeding makes to good physical and emotional health outcomes for children and mothers. We aim to ensure that all care is mother and family centred, non-judgemental and that mothers’ decisions are supported and respected. We work across disciplines and organisations to improve mothers’ and parents’ experiences of care.

The 5-19 Healthy Child Team continue to deliver the preschool vaccinations and immunisation programme to the 5 to 19 year old population. The service is delivered in line with national guidelines supported by effective risk management processes, storage and cold chain procedures and regular monitoring and reporting. We have an excellent track record of delivering the required uptake targets; we achieved 97.8% for HPV (human papilloma virus) vaccination in 2015/16 and were identified as being in the top four organisations for the highest uptake. The service also successfully delivered the influenza vaccination programme across North Yorkshire and was awarded the contract for the delivery of influenza vaccination in the City of York.

The Healthy Child Team have been successfully coordinating and delivering the National Child Measurement Programme (NCMP) since this was established in 2005. The programme involves measuring the weight and height of Reception and Year 6 children in 260 state maintained and academy primary schools across North Yorkshire. We have introduced proactive follow up to help support families where their children are struggling to maintain a healthy weight.

![Graph showing the % of children aged 4-5 who have excess weight](image1)

**Figure 25 & 26: National Child Measurement Programme results**
To support the reduction in teenage pregnancy the 5-19 practitioners work with children and young people to support healthy relationships and offer sexual health advice, support and onward referral. We have recently employed three health visitors to work in partnership with North Yorkshire County Council (NYCC) to develop a teenage parenting model which is due to be launched early April 2016. Our 5-19 practitioners are trained to offer sexual health support to the children and young people they work with.

Figure 27: Rate of under 18 conceptions per 1000

Summary

We ensure the delivery of the service is fully integrated between all professionals supporting children and young people, having well established relationships with schools and GPs. Our local knowledge, effective systems and culture for learning and improvement mean we have a strong track record of delivering the key performance indicators and healthy child outcomes for the service.

Over the last 12 months we have strengthened the training of the 0-19 workforce to ensure they remain skilled, competent practitioners who deliver an evidence base service to the population. We have co-located the majority of the 0-19 workforce with NYCC prevention and early intervention teams to ensure we maximise resources to meet the needs of families. We achieve our key performance indicators and service specific related performance standards, ensuring a high quality standard and delivery of care. This is achieved through the robust performance management and quality of care processes that are well embedded within the organisation.

3.8 Speech and Language Therapy

People with speech, language and communication needs (SLCN) have difficulties in communicating with others. This may be because they cannot say what they want to, have difficulty understanding what is being said to them or do not understand social rules of communication. This may be minor or temporary for some young people, whilst for others their needs will be complex and long-term.

Studies have found that young people who have offended are likely to be at significant risk of previously unrecognised language impairment (Gregory and Bryan, 2009). There is evidence shown by other teams such as in the Leeds Youth Offending Team (Bryan and Mackenzie, 2008) that speech and language therapy targeted at improving the language skills of individuals can significantly reduce the numbers who re-offend.

Many children with SLCN do not have their needs correctly identified or supported at secondary school. As children get older and have to cope with different people, timetables and complex social situations, there is more demand on their communication skills. Although there are a significant number of young people in secondary schools with SLCN, the associated behaviours or literacy difficulties are often the most prominent and are the focus
instead. There is a lack of speech and language therapy support and limited knowledge about typical language development which means it is difficult for schools to provide or be confident in their assessment of delay.

The aim of the Youth Communication Team is that young people with speech, language and communication needs will be identified earlier, with the aim of increasing their ability to be involved in education and work and thus preventing them from becoming disengaged and becoming involved in offending behaviour.

What were we aiming to achieve?

This three year project, funded by North Yorkshire County Council (NYCC) since November 2013, is a radical approach to working with young people with multiple vulnerabilities aged from 11 to 25 years. The project has speech and language therapists (SLT), employed by the Trust, co-located in the Youth Justice Service in Harrogate, Scarborough and Selby areas.

We also have been contracted by NYCC from March 2015 to provide speech and language therapy to the ‘No Wrong Door’ (NWD) project until November 2016. This service model focuses on a specific key worker that stays with each young person “no matter how they move through care”. The model enables young people in care (or on the edge of care) to access the right services at the right time and ultimately aims to support achievement, reduce high risk behaviour and ensures that young people in crisis receive well organised and appropriate support.

The NWD project has speech and language therapists who are co-located in the East and West NWD hubs. They work within the NWD project team but also work as part of the whole North Yorkshire Youth Communication Team.

The first year of the project focused on setting up a service for young people who are involved in the Youth Justice Service. The SLTs screen all the young people to identify if they have speech, language and communication needs. Therapy is provided during their involvement with the Youth Justice Service and beyond that if required. Training is provided to staff so they can recognise speech, language and communication needs and adapt their own communication and intervention packages. Presentations to raise awareness have given to a number of other groups including police, youth panels, volunteers and providers of educational and work.

The second year has expanded to include those young people who are attending specialist educational provision, starting with Forest Moor School, Harrogate and moving on to Brompton Hall School, Scarborough. We were also tasked to start input to the Pupil Referral Services in North Yorkshire, starting in September 2015.

What have we done?

In the schools and Pupil Referral setting we have:

- Screened young people for SLCN and carried out a more in-depth assessment where required. Summarised individual screens were embedded in school reports;
- Delivered training for staff about speech, language and communication skills at an introductory level;
- Advised regarding the communication environment, made resources accessible and given support to implement changes;
- Identified staff that could be communication champions and trained them in order to them to cascade knowledge and skills.
What are the results?

Youth Justice Service

From December 2015 to February 2016, 261 young people have been screened. 120 (46%) of the young people had SLCN, with nine (7.5%) previously diagnosed with SLCN.

Pupil Referral Units

Training took place for Hambleton & Richmondshire Pupil Referral Service; The Grove, Harrogate; and Rubicon, Selby in November 2015 and ROOSE, Pickering and Scarborough Pupil Referral Service in January and February 2016. Screening is still ongoing.

Forest Moor School

14 young people were screened. 88% were identified as having SLCN with 79% previously undiagnosed. The school is investigating an increase in SLT provision.

Brompton Hall School

39 young people were screened with 66% identified as having SLCN. The NHS SLT is to follow up referrals now one day a month and the school are investigating an increase in SLT provision.

No Wrong Door

From the early stages of NWD, the SLTs liaised with the SLTs based at Youth Justice to share information and avoid duplication. The NWD SLTs quickly became established members of the NWD team and contributed to team meetings and complex case discussions.

SLTs are continuing to work closely with NWD hub workers and managers to complete communication assessments with young people (both residential and outreach) who are newly referred to the service. The benefits of the embedded nature of the role are very clear, with young people commenting that they come to the SLTs not only for direct help with communication, but also general support and advice. The staff see them as established members of the NWD team and they are approaching them for specialist advice when needed.

Early data shows that 62% of the young people who have been directly assessed have presented with SLCN.

Suggestions about how to make both homes more communication friendly are on-going and additions to the homes have been made such as visual timetables that depict which staff members are on shift, menu boards in the kitchens etc. Feedback received includes:

“You have both been so amazingly supportive and talking to the SLT has really cleared my mind of doubt.” Parent of young person.

“A really helpful and informative piece of work which has benefitted both staff and students. We have never had such intensive support. Great credit to the SLT’s – excellent and professional at all times.” Head teacher, Hambleton & Richmondshire Pupil Referral Service.
“A SLT report was written with strategies to use with the young person. As a result college tutors felt that they could communicate more effectively with the young person, pitch information at a more appropriate level and make classes more meaningful for him.” Case Study report.

“Having a speech and language therapist involved in the Decider Skills Group gave guidance and clarity regarding language used, for example, breaking down the meaning of the metaphors so young people could understand them better. Use of pictorial aids helped to engage young people and aid comprehension.” Child and Adolescent Mental Health Services (CAMHS) Youth Justice Health Worker.

“I just wanted to say thank you so much for your input yesterday. We thoroughly enjoyed the input and I know that it will be beneficial for us when dealing with offenders on the autistic spectrum.” Feedback from Police training.

Summary

The project aims are being met and some of the work is ongoing. There will be a gap when this project is completed in November 2016 so discussion with NYCC is underway regarding this.

3.9 Cancer Services

The quality of our cancer services has always been a significant priority for the Trust. Each year we build upon previous years’ achievements. Since the opening of our Sir Robert Ogden Macmillan Centre (SROMC) in March 2014 we have continued to focus upon redesign and improvement of our services. In 2015 we published our Cancer Strategy for 2015-2020 which was developed with colleagues across all specialities and with our commissioners. It reflects the Cancer Task Force publication – Achieving World Class Cancer Outcomes, A Strategy for England 2015-20 – and describes how we plan to develop our cancer services locally, in line with national direction.

Photo 11: The Sir Robert Ogden Macmillan Centre

What were we aiming to achieve?

The key priority areas for cancer services in 2015/16 were to:
Enhance consultant oncologist and nursing provision;
Further develop our cancer of unknown primary (CUP) service;
Develop enhanced holistic care assessments;
Improve access to psychological care;
Grow our Health and Wellbeing service.

What have we done?

Enhance consultant oncologist and nursing provision

As numbers of diagnosed cancers continue to grow and options for treatment and lines of subsequent treatments continue to expand so does the need for more oncologist and nurse time. This year we have been successful in a bid to Macmillan for an additional clinical nurse specialist post in the Urology service along with some co-ordinator support roles for haematology and colorectal specialities. These co-ordinator roles will assist the clinical nurse specialists in their duties, enabling them to spend more time with direct patient contact work.

We will be seeking to appoint another consultant oncologist to join Dr Dugdale and our team to enable us to increase clinic provision for currently treated cancers as well as start to treat more patients locally who currently go to Leeds for chemotherapy. We plan to repatriate patients for treatment of ovarian cancer in the first instance and are working closely with our colleagues in gynaecology to ensure pathways for service provision on both an inpatient and outpatient basis are clear in advance of patients moving back from Leeds.

Development of our cancer of unknown primary (CUP) service

Over the last two years we have transformed our service. The pathway is now more streamlined with increased support to patients and families at all stages. The presence of a CUP team enables patients to have more rapid personalised decision making, avoidance of unnecessary investigations and earlier access to appropriate diagnostics and potential treatment or transfer into palliative or end of life care.

This year we have worked closely with our GP lead for cancer and increased the profile of the service so that GPs are aware how to make contact to refer or receive advice on patients they are concerned about.

Develop enhanced holistic care assessments

In 2015 we were successful in a bid to Macmillan to introduce electronic holistic needs assessment (e-HNA). This involves the use of a computerised tablet whereby the patient completes a questionnaire which identifies their main concerns. The Clinical Nurse Specialist then uses this information to develop a care plan to meet the identified needs. Better understanding the needs of patients will help us plan future capacity and better direct our support services to patients’ needs.

What the patients say ……

In general patients have responded very well and found the tablet simple to use. Very few people have not wanted to participate. Some patients have said that seeing an improvement in their condition or level of anxiety in between assessments is very reassuring.

What the staff say ……
Although time consuming, going through a structured assessment is really valuable. Issues that patients may not otherwise have mentioned have come to light, some quite longstanding, and have now been addressed. The number of phone calls from patients has reduced, as concerns are being aired and discussed more fully during the care planning process. The ‘end of treatment’ assessments have proved most valuable – providing the opportunity to start a conversation about topics which would not formerly have been discussed in a follow-up appointment.

Future plans include roll out to other cancer sites and uploading the care plans to electronic systems so all professionals have access to them when treating cancer patients.

**Grow our Health and Wellbeing Service**

Our Macmillan Welfare and Benefits Service has enabled more patients to have support by:

- Providing a full welfare and benefit assessment;
- Completing benefit and grant applications;
- Undertaking benefit appeals to the Department of Work and Pensions (DWP);
- Providing low level debt advice and signposts on to relevant agencies;
- Giving social care advice;
- Being awarded ‘Alternative Office Status’ by the DWP;
- Providing guest advice and support at cancer support groups.

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>Increase on 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals</td>
<td>404</td>
<td>20%</td>
</tr>
<tr>
<td>Total claimed in annualised benefits</td>
<td>£1,517,588</td>
<td>23.6%</td>
</tr>
<tr>
<td>Total in backdated benefit arrears claimed</td>
<td>£67,024</td>
<td>29.8%</td>
</tr>
<tr>
<td>Total of Macmillan grants claimed</td>
<td>£13,400</td>
<td>73.1%</td>
</tr>
<tr>
<td>Total of other charitable grants</td>
<td>£3,336</td>
<td>N/A (1st year counted)</td>
</tr>
</tbody>
</table>

*Table 47: Macmillan Welfare and Benefits service activity*

The complementary therapy service has undergone further expansion in 2015 to meet the increasing demands on its service. A donation from the SROMC Ball Committee enabled the complementary therapist post to be expanded from 22.5 hours to 30 hours a week.

*Figure 28: Breakdown of complementary therapy treatments available*

The Hair Loss Support Service has also seen significant growth this year.

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>Increase on 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wig fitting referrals</td>
<td>98</td>
<td>96%</td>
</tr>
<tr>
<td>Headwear support</td>
<td>132</td>
<td>13.7%</td>
</tr>
</tbody>
</table>

*Table 48: Hair Loss Support Service activity*
The Boots ‘Feel More Like You’ sessions offer professional beauty advice on skincare, make-up and nail care. Its popularity has grown, with 57 patients seen this year.

**Improve access to psychological care**

Continuing to improve access to psychology services for patients is crucial alongside their physical treatment, whilst providing for their wider holistic needs. Our clinical nurse specialists for all common cancer sites are skilled to deliver level 2 psychological support. Above this it becomes the remit of counsellors at level 3 and Psychologist / Psychiatry at level 4. There is national evidence that approximately 10% of all patients diagnosed with cancer will require input from psychology, and this figure increases to 15% when a patient is diagnosed with advanced or palliative disease.

Whilst the Cancer Clinical Psychology service has grown considerably over the last couple of years, provision continues to remain under capacity, as more patients are seen to benefit from the service so more are referred. In 2015/16 the provision will further increase by three more clinics a week with the intention of reducing the waiting list to a matter of a couple of weeks, ensuring the best level of support to our patients.

**What are the results?**

We seek assurance regarding the quality of our services from a range of sources. These include:

- Cancer Waiting Times performance i.e. ensuring our patients are seen and treated within a timely way and within the national standards;
- Compliance levels with the National Cancer Peer Review Measures;
- Patient reported experience through the National Cancer Patient Experience Survey, the National Chemotherapy Survey and local surveys.

We have achieved our cancer waiting times targets this year for all quarters and have a high level of compliance against our peer review measures. We are currently third nationally in the Cancer Patient Experience Survey and await the results of the 2015 survey which are due later this year.

**Summary**

There have been many achievements in continuing to develop high quality cancer services and we will continue to prioritise high quality care and services particularly in the areas described above.

*Photo 12: Royal visit to SROMC February 2016*
3.10 Community Equipment and Wheelchair Services

Community Equipment Service

The service was redesigned in 2014 and a fully electronic ordering system was introduced. Since then the service has continued to monitor performance and maintained collaborative engagement with all stakeholders. The service continues to report in detail against new specification delivery speeds of standard (within seven days), priority (next day) and urgent (within six hours).

During the last year, 100% of ‘priority’ and ‘urgent’ orders have been achieved within timescales. Overall, the service has exceeded the 95% target each quarter and has consistently scored over 97% performance for each month during quarter 4.

![Figure 29: Percentage of requests for equipment meeting the delivery standards](chart)

Wheelchair Service

The North Yorkshire Wheelchair Service has been under considerable pressure with increasing demands for the provision of chairs in particular power chairs. In June 2015 Healthwatch published a report based on the reported experiences of users of the York Wheelchair Service which highlighted a number of areas of concern. The service was aware of many of these issues and had already started a review. Following consultation in the autumn of 2015 a new structure was proposed with a more clinically focused service with a clinical lead.

The Healthwatch report also highlighted some areas which related to the commissioning of the service. This fed into a review of the service specification which was undertaken in conjunction with the commissioners, and introduced specific key performance indicators.

July 2015 also saw the launch of the National Wheelchair Charter with ten quality pledges.

In October and November 2015 the Clinical Commissioning Group facilitated a number of events led by NHS Improving Quality which involved wheelchair users, commissioners, and the service in defining good practice and future objectives.

The service is seeing 99% of referrals within 18 weeks and the response time for repairs is consistently good with 99% of repairs, deliveries and collections within the targets. From quarter 3 the repair service left feedback cards with wheelchair users when repairs were undertaken; the results are shown in the chart below.
The service also introduced the Friends and Family Test (FFT) at all four wheelchair centres in March 2016. The initial results show:

<table>
<thead>
<tr>
<th>Wheelchair centre</th>
<th>% recommend</th>
<th>% not recommend</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harrogate</td>
<td>99%</td>
<td>0</td>
<td>“Very efficient and effective service with lots of advice and able to ask questions” “Brilliant service”</td>
</tr>
<tr>
<td>Scarborough</td>
<td>99%</td>
<td>0</td>
<td>“Very professional and friendly staff” “Staff so friendly and helpful”</td>
</tr>
<tr>
<td>York</td>
<td>94%</td>
<td>2%</td>
<td>“Therapist was very helpful and made sure the patient was comfortable in his new wheelchair” “Excellent and meticulous attention to detail”.</td>
</tr>
<tr>
<td>Northallerton</td>
<td>100%</td>
<td>0</td>
<td>“Very helpful” “XXX has always been so warm and friendly and given us fantastic service thank you as always”.</td>
</tr>
</tbody>
</table>

Table 50: Wheelchair Service FFT results

Summary

Significant progress has been made with the provision of community equipment in the last year. The Wheelchair Service has been an area of concern but work has been undertaken to define standards and ensure measurement of performance and patient experience. We are continuing to work through areas to help improve standards and consistency across the four localities, and are hoping to have a new clinical lead in post soon.

3.11 Duty of candour

We adopt the principles of being open and fully support our staff to apologise to patients and share investigations into incidents where appropriate. Duty of candour guidance has been rolled out across the organisation via a task and finish group, staff leaflet, toolkit on the intranet and bespoke training slides that are available throughout directorates.

The duty of candour process is triggered following identification of an incident where the severity (degree of harm to patient) is moderate or above together with significant harm.

At HDFT we have developed a process for clinicians to form a view guided by Risk Management on whether the duty applies which includes guidance on what to do and timescales for conversations with patient or their representatives, template letters and investigative toolkits. A duty of candour letter would usually be signed by the Chief Executive or the patient’s consultant depending on each individual case. The letter is drafted based on the content of the discussion.
On identification of the incident an investigation is undertaken and root cause analysis may be completed using the Trust’s concise or comprehensive template. All investigation reports are reviewed by the Trust’s Complaints and Risk Management Group (CORM) which is chaired by the Medical Director. Disclosure to patients and/or relatives who have indicated that they wish to see the findings of the investigation is then concluded with the offer of a meeting via the Chief Executive.

Quarterly monitoring of compliance for all incidents triggering the duty of candour requirements is undertaken and reported to the Learning from Patient Experience Steering Group and Quality Committee as part of the patient experience and incident report. Results up to quarter 3 demonstrate 94% compliance.

In addition, during 2015 a baseline audit of the process was conducted by the Clinical Effectiveness and Audit Department in order to provide feedback on the pilot process that was implemented via the task and finish group and identify any areas for improvement. The results have indicated that the process requires further refinement in order that we can comprehensively demonstrate compliance with all aspects of the duty.

### 3.12 Sign up to Safety campaign

The Trust was awarded funding from the NHS Litigation Authority to support our safety improvement plan which was developed as part of the national Sign Up to Safety campaign. Sign up to Safety is a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible.

The funding was to be prioritised for the Maternity Department where we were aiming to achieve a measurable improvement in the quality of patient focused care in relation to human factors that contribute to a positive safety culture i.e. embedding reporting and learning from incidents and near misses, leadership, communication, escalation, and team working. We aim to then share learning across other specialities.

We engaged with maternity staff and measured the patient safety culture using the Manchester Patient Safety Framework. 48 colleagues participated in this structured assessment and analysis demonstrated that investment was needed in communications tools, techniques and hardware as well as some specific training and communication around foetal heart rate monitoring. Feedback suggested that reporting and learning from incidents was well embedded.

The department will focus on human factors training and adapting this training to maternity, promoting a positive safety culture, learning from incidents, implementation of the new NICE guidance on cardiotocography (CTG) interpretation (electronic monitoring of foetal heartbeat and uterine contractions during pregnancy), and reviewing our current daily multidisciplinary case review discussion.

A Band 7 midwife has been appointed to lead this work for one day a week for one year. The midwife has a critical care and palliative care background, and is ideally positioned to see how skills and behaviours may be transferred. She will start by completing a human factors course to enable her to be a master trainer to develop other local trainers. She will consider modifying the maternity specific skills and drills course to incorporate this training, and will look at how this model can be rolled out to non-maternity areas.
This is a really exciting opportunity both for the appointed midwife and for the Maternity Department that we hope we will be able to share in the future with other departments within the Trust. We provide regular updates on progress of this project at the Improving Patient Safety Steering Group.

### 3.13 Patients with Learning Disabilities

We care for many patients who have a learning disability both as inpatients and outpatients and we want to ensure that they are cared for appropriately and in a way that meets their individual needs, whatever they may be.

#### What were we aiming to achieve?

Our aim is that all patients with learning disabilities have their individual needs meet by knowledgeable and informed staff, who will make reasonable adjustments for each patient as required. We will do this by working with individuals, groups and carers to better understand their needs and help them make choices. We will also improve staff training opportunities, so that our workforce have the knowledge and skills to provide the best care possible for people with learning disabilities.

#### What have we done?

Our senior nurse adult safeguarding is now also our named nurse for learning disabilities. Developments and initiatives that have been introduced include:

- A learning disabilities webpage on the intranet with information and resources for staff;
- Identification of patients with learning disabilities on electronic patient systems using electronic flags;
- Daily email to matrons to inform them of patients with a learning disability in their area;
- Communication tools including one for pain;
- Easy read leaflets;
- Easy read Friends and Family Test posted out on discharge;
- All appropriate audits now include a cohort of patients with a learning disability;
- Reasonable adjustments information and checklists on webpage;
- Links to learning disabilities advocacy and relevant external agencies/professional groups;
- Learning disability guidance;
- Use of a vulnerable inpatient (VIP) symbol and passport for inpatients;
- Mental Capacity Act awareness raising;
- Carers accompanying patients to theatre.
What are the results?

Currently we have 208 patients with a learning disabilities flag. When any patient with a flag is admitted, they are checked on daily by the matron. We have received feedback from learning disability advocates that suggests people with a learning disability feel their care has improved since flagging was introduced, and now staff are more aware that reasonable adjustments may need to be made. Staff awareness of the needs of patients with a learning disability has also increased.

Summary

We have introduced a number of initiatives but there is much more work to be done. Although we have made significant progress over the last year, we recognise that our current provision is insufficient to reach the standard of care we are aiming for.

We are therefore recruiting a learning disabilities liaison nurse four days a week to support individual patients and carers, provide staff support and training and resources and develop and lead a high quality service to meet the needs of all people with a learning disability in our care.

Improving the care of people with learning disabilities has been identified as a quality priority for the Trust for 2016/17.

3.14 Mental Capacity and Deprivation of Liberty Safeguards

The Mental Capacity Act 2005 ("the Act") was passed by Parliament in 2005 and came into force during 2007. The Deprivation of Liberty Safeguards (DOLS) were then added to the Act and came into force in April 2009. It put the old common law on mental capacity and consent to care and treatment on a statutory footing for the first time, and added a number of extra provisions.

The Act has a direct impact upon patient care at all levels, both in hospital and in the community. All healthcare professionals, without exception, are under a legal obligation to follow the principles set out in the Act, and to have regard to the Mental Capacity Act Code of Practice, whenever dealing with a patient who may lack capacity to consent to the care or treatment they are offered.

Our staff employ a proactive approach to seeking consent and aim to maximise the person’s involvement in decision-making about their care and treatment. For many patients this is straightforward but an increasing number of patients have impaired capacity to make a decision about their care and treatment. Conditions that may affect someone’s mental capacity for decision making include dementia, learning disabilities, delirium and mental health illnesses.

Staff need to be able to recognise when someone’s decision making could be impaired and know how to continue to provide care and treatment for them within the legal framework of the Act. However an initial staff survey demonstrated a lack of knowledge and understanding regarding the Act and DOLS.
In October 2015 we set up a task and finish group to define training requirements, update and review guidance and implement the necessary training.

Awareness events were undertaken between December 2015 and January 2016 to promote understanding of the Act and DOLS process to clinicians.

Clinical and nursing members of the task and finish group went to each ward to speak with front line staff and to distribute Mental Capacity Act prompt cards as well as holding lunchtime drop in sessions in Herriot's Restaurant where staff could ask questions about the Act and DOLS.

The prompt cards include practical decision making tools which could be used by medical and nursing staff to carry out capacity assessments, best interest and DOLS assessments as well as containing the principals of the Mental Capacity Act 2005.

A number of master classes were also arranged in December 2015 and January 2016. These were delivered by Helen Kingston of DAC Beachcroft solicitors and aimed at senior clinical and nursing staff and managers. These were well received by those in attendance, and further training will be arranged through 2016/17.

What are the results?

As of 11th March 2016, over 686 employees have received prompt cards and 95 staff had attended a master class.

Following the awareness events, master class sessions and additional pieces of work a follow up survey was undertaken which demonstrated an improvement in overall confidence with the Mental Capacity Act. The survey also demonstrated a significant improvement in the proportion of staff who felt able to describe stages 1 and 2 of the mental capacity test, and name the five principles of the Mental Capacity Act following training.
Summary

The task and finish group will continue to progress work to promote awareness around the Mental Capacity Act and DOLS process. The Integrated Care Directorate are in the process of developing a business plan to appoint a Mental Capacity Act/Deprivation of Liberty Safeguards/Mental Health Act specialist advisor to support this work.

3.15 Transfusion sample labelling audit

Prior to a blood transfusion, a blood sample is taken from the patient to test the blood group of the patient and to match it with donor blood. Errors in the labelling of blood samples are a potential cause of harm for transfusion if they are not detected and corrected. As a result of ongoing work by our transfusion team the numbers of transfusion sample labelling errors have reduced significantly over the past five years. All mislabelled samples are rejected and a repeat sample is requested so there is no harm to the patient from a mismatched transfusion.
The processes involved in dealing with the labelling errors have included:

1. Identifying trends in errors e.g. repeated errors from certain staff or locations;
2. Discussing the error with the individual when possible, identifying the root cause of error and educating at the same time;
3. Any persistent offenders (three or more errors) are referred for reassessment using the national skills for health standard;
4. Disseminating four monthly reports to relevant clinical and governance staff;
5. Sending monthly reports to the clinical lead in the Emergency Department to discuss with staff;
6. Reporting any serious errors (wrong blood in tube) to Serious Hazards of Transfusion (SHOT) and reassessing the member of staff;
7. Reviewing all reports at the Harrogate Transfusion Committee.

Summary

As a result of diligent work by our transfusion team the numbers of transfusion sample labelling errors have reduced significantly over the past five years, despite a significant increase in the number of samples processed. This is an example of ongoing work to improve the safety and quality of clinical processes.
4. ANNEX ONE: STATEMENTS FROM STAKEHOLDERS

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

NHS HARROGATE AND RURAL DISTRICT CLINICAL COMMISSIONING GROUP QUALITY ACCOUNT STATEMENT 2015/16

The Harrogate and Rural District Clinical Commissioning Group (CCG) are pleased to be able to review and comment on the Quality Account for 2015/16.

Over the past 12 months we have worked together as Commissioners and Providers to improve the quality of patient services for the residents of the Harrogate and Rural District. Through the contract management process the Trust has provided assurance to the CCG, by sharing a breadth of data and quality metrics which have assured us of the quality of patient services. Through our meetings with the Trust, the CCG is assured that the Trust takes its responsibility seriously to learn from findings such as those from serious incident reviews and infection control meetings.

The Quality Account for Harrogate and District NHS Foundation Trust provides a very comprehensive, accurate and honest account of the quality of patient care provided. We are pleased to note the following achievements:

- Achievement of the Soil Association Food for Life Catering Mark Bronze Standard – the catering mark being a recognised way of improving hospital food.
- Excellent outcomes with Support for Relatives with care in the last days of life - the Trust scored 100% in response to the overall question in the National Care of the Dying Audit, ‘In your opinion, were you adequately supported during his/her last two days of life?’
- The Trust continues to have good overall results for the NHS Staff Friends and Family Test – 87.8% of staff would recommend care or treatment at the Trust and 71.4% of staff would recommend the Trust as a place to work
- High Quality Cancer Care - the Trust is currently third nationally in the Cancer Patient Experience Survey and is awaiting the results for the 2015 survey.

Harrogate & District NHS Foundation Trust met all the requirements of the CQUIN Scheme in 2015/16 (subject to final confirmation) and achieved financial payment. We are currently in discussion with the Trust regarding CQUIN indicators for 2016/17.

The priorities detailed in the Quality Account for 2016/17 clearly identify the three elements of quality i.e. patient safety, clinical effectiveness and patient experience and have a real synergy with the New Care Model ‘What matters to us – Improving health and wellbeing across Harrogate District’. The Trust has consulted with various stakeholders and CCG colleagues and have identified the following priorities for 2016/17:

- Reduce morbidity and mortality related to sepsis
- Improve care of people with learning disabilities
- Provide high quality stroke care – demonstrated by improvement in national indicators
- Improve the management of inpatients on insulin
The CCG is pleased to be able to work with the Trust and other provider organisations towards more integrated care as part of the necessary sustainability and transformational approach needed to withstand the increasing financial pressures on the overall system.

We recognise that Harrogate & District NHS Foundation Trust works hard to deliver quality outcomes and would like to commend them on their performance within the NHS constitution. We look forward to working collaboratively with the organisation in 2016/17.

Amanda Bloor
Chief Officer Harrogate and Rural District Clinical Commissioning Group

HEALTHWATCH NORTH YORKSHIRE QUALITY ACCOUNT STATEMENT 2015/16

Healthwatch North Yorkshire is assured that it has not received any issues of concern around the services provided by Harrogate District NHS Foundation Trust. We are reassured to see that there has been a drop of 20% in the number of complaints in comparison to data from the year before. The Trust’s friends and family test results continue to show strong performance, consistently above 90% across all services with especially strong results in Maternity. In terms of performance the Trust is strong in terms of operational performance achieving the majority of targets. Quality indicator targets, while not as strong, are still very good and finance and efficiency is good but shows room for improvement. The Trust board have shown a willingness to engage with Healthwatch North Yorkshire and we are confident they are focused on delivering the best quality of care and working with Healthwatch to achieve this.

Nigel Ayre
Delivery Manager
Healthwatch North Yorkshire

NORTH YORKSHIRE COUNTY COUNCIL SCRUTINY OF HEALTH COMMITTEE QUALITY ACCOUNT STATEMENT 2015/16

On behalf of County Councillor Jim Clark (Chairman, NY Scrutiny of Health Committee) I confirm that while he appreciates the opportunity to comment on the Trust’s Quality Account he will not be offering any comments this year.

Bryon Hunter
Scrutiny Team Leader
Policy and Partnerships Unit
Central Services Directorate
North Yorkshire County Council

COUNCIL OF GOVERNORS QUALITY ACCOUNT STATEMENT 2015/16

The Council of Governors is pleased that the Trust continues to provide high quality care, as evidenced by this comprehensive Quality Account.
Governors have been extensively consulted on the Trust’s operational plan, have contributed to the development of the quality priorities for the coming year, and have reviewed the Quality Account. They continue to be involved directly in the Quality of Experience and Patient Voice Groups, departmental Quality of Care teams, PLACE inspection teams and Patient Safety visits, all of which enable them to see at first hand the challenges of maintaining quality at a high level on an enduring basis.

In addition, Governors have regular meetings with Non-Executive Directors and attend, in an observer role, Board of Directors meetings and committee meetings, particularly the newly constituted Quality Committee which have delegated responsibility and oversight of the Trust’s progress towards achieving the quality priorities. The Council of Governors have in-depth discussions with Executive Directors and Non-Executive Directors, both formally at Council of Governor meetings and more informally. The Council of Governors supports and endorses the Quality Account and the priorities selected for particular focus over the coming year.

Pamela Allen
Lead Governor

HEALTH AND WELLBEING BOARD QUALITY ACCOUNT STATEMENT 2015/16

Health and Wellbeing Board were sent a copy of the Quality Account on 1 April 2016. No comment was received.
5. 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.

Monitor 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 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 2015/16;
- 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 2015 to March 2016
  - Papers relating to Quality reported to the Board over the period April 2015 to March 2016
  - Feedback from the commissioners dated 28 April 2016
  - Feedback from Governors dated 29 April 2016
  - Feedback from Healthwatch North Yorkshire dated 19 May 2016
  - Feedback from North Yorkshire County Council Scrutiny of Health Committee dated 3 May 2016
  - The Trust’s draft complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated May 2016
  - The 2014 national patient survey dated 21 May 2015
  - The 2015 national staff survey dated 22 March 2016
  - The Head of Internal Audit’s annual opinion over the Trust’s control environment dated May 2016
  - CQC Intelligent Monitoring report dated May 2015

- 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 Monitor’s annual reporting 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 25 May 2016

Mrs Sandra Dodson
Chairman

Mr Jonathan Coulter
Acting Chief Executive
### 6. ANNEX THREE: NATIONAL CLINICAL AUDITS 2015/16

<table>
<thead>
<tr>
<th>Name of Audit/Clinical Outcome Review Programme</th>
<th>Part of NCAPOP?</th>
<th>Number of patients for which data submitted 2015/16</th>
<th>Data submitted as a percentage of the number of registered cases required for that audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Acute coronary syndrome or Acute myocardial infarction (MINAP)</td>
<td>Yes</td>
<td>270</td>
<td>100%</td>
</tr>
<tr>
<td>2 Bowel cancer (NBOCAP)</td>
<td>Yes</td>
<td>133</td>
<td>122% (based on expected total of 109)</td>
</tr>
<tr>
<td>3 Cardiac Rhythm Management</td>
<td>Yes</td>
<td>209 procedures 2207 follow-ups</td>
<td>100%</td>
</tr>
<tr>
<td>4 Case Mix Programme - Intensive Care National Audit Research Centre (ICNARC)</td>
<td>No</td>
<td>July to December 2014 243 January to June 2015 219</td>
<td>100%</td>
</tr>
<tr>
<td>5 Child health clinical outcome review programme</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Chronic neurodisability</td>
<td>Yes</td>
<td>Both are 3 year work streams so this information is not currently available</td>
<td></td>
</tr>
<tr>
<td>(ii) Young People’s mental health</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Diabetes (Adult)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Footcare Audit</td>
<td>Yes</td>
<td>30</td>
<td>Not stated</td>
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<td>National Inpatient Audit</td>
<td>Yes</td>
<td>42</td>
<td>100%</td>
</tr>
<tr>
<td>National Pregnancy in Diabetes Audit</td>
<td>Yes</td>
<td>No eligible patients</td>
<td>No eligible patients</td>
</tr>
<tr>
<td>National Core</td>
<td>Yes</td>
<td>Data not submitted*</td>
<td>Data not submitted*</td>
</tr>
<tr>
<td>7 Diabetes (Paediatric)</td>
<td>Yes</td>
<td>80</td>
<td>Not known</td>
</tr>
<tr>
<td>Name of Audit/Clinical Outcome Review Programme</td>
<td>Part of NCAPOP?</td>
<td>Number of patients for which data submitted 2015/16</td>
<td>Data submitted as a percentage of the number of registered cases required for that audit</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----------------</td>
<td>----------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>This figure is for the latest round of the audit which relates to patients seen from 1 April 2014 to 31 March 2015.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Elective surgery National PROMS programme (2014/15)</td>
<td>No</td>
<td>1,218 (pre-op) 933 (post-op)</td>
<td>114.2% 76.8%</td>
</tr>
<tr>
<td>Elective surgery National PROMS programme (April - September 2015)</td>
<td>No</td>
<td>607 (pre-op) 114 (post-op)</td>
<td>115.8% 40.4%</td>
</tr>
<tr>
<td>9 Emergency Use of Oxygen</td>
<td>No</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>10 Falls &amp; Fragility Fractures Audit Programme (FFFAP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Falls</td>
<td>Yes</td>
<td>30</td>
<td>100%</td>
</tr>
<tr>
<td>(ii) Fracture Liaison Service (FLS) database</td>
<td>Yes</td>
<td>Organisational questionnaire submitted only – clinical audit not relevant as we do not have a dedicated FLS</td>
<td>Not relevant</td>
</tr>
<tr>
<td>(iii) National Hip Fracture Database</td>
<td>Yes</td>
<td>245</td>
<td>100%</td>
</tr>
<tr>
<td>11 Inflammatory Bowel Disease (IBD) programme – biologics audit</td>
<td>Yes</td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td>12 Lung cancer (NLCA)</td>
<td>Yes</td>
<td>117</td>
<td>100%</td>
</tr>
<tr>
<td>13 Major Trauma: The Trauma Audit &amp; Research Network (TARN)</td>
<td>No</td>
<td>132</td>
<td>Awaiting 2015 HES data</td>
</tr>
<tr>
<td>14 Maternal, New-born and Infant Clinical Outcome review Programme (MBRRACE-UK)</td>
<td>Yes</td>
<td>8 stillbirths 8 terminations for foetal abnormalities 6 late miscarriages 2 Neonatal deaths</td>
<td>There have been no maternal mortality or morbidity cases to report 2015/16</td>
</tr>
<tr>
<td>Name of Audit/Clinical Outcome Review Programme</td>
<td>Part of NCAPOP?</td>
<td>Number of patients for which data submitted 2015/16</td>
<td>Data submitted as a percentage of the number of registered cases required for that audit</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>----------------</td>
<td>-----------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>15 Medical &amp; Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome &amp; Death (NCEPOD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Gastrointestinal Haemorrhage[^4]</td>
<td>Yes</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>(ii) Sepsis</td>
<td>Yes</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>(iii) Acute Pancreatitis</td>
<td>Yes</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>(iv) Mental Health</td>
<td>Yes</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>16 National Audit of Intermediate Care</td>
<td>No</td>
<td>Did not participate</td>
<td>Did not participate</td>
</tr>
<tr>
<td>17 National Cardiac Arrest Audit (NCAA)</td>
<td>No</td>
<td>41</td>
<td>100%</td>
</tr>
<tr>
<td>Figures are for April to December 2015 (Quarter 4 data not yet available)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Pulmonary rehabilitation</td>
<td>Yes</td>
<td>11</td>
<td>85% (13 eligible, 12 consented)</td>
</tr>
<tr>
<td>NB: Organisational questionnaires also submitted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Secondary Care</td>
<td>Yes</td>
<td>66</td>
<td>100%</td>
</tr>
<tr>
<td>This audit took place between 1 February and 31 May 2014, and the results were reported in last year’s Quality Account. There has been no further data collection during 2015/16.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 National Comparative Audit of Blood Transfusion programme</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Lower GI Bleeding and the use of blood</td>
<td>No</td>
<td>Organisational questionnaire submitted only</td>
<td>N/A</td>
</tr>
</tbody>
</table>

[^4]: As reported in 2014/15 Quality Account - Six sets of patient data requested- 2 excluded prior to submission. 2 excluded following submission
<table>
<thead>
<tr>
<th>Name of Audit/Clinical Outcome Review Programme</th>
<th>Part of NCAPOP?</th>
<th>Number of patients for which data submitted 2015/16</th>
<th>Data submitted as a percentage of the number of registered cases required for that audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>(ii) Audit of Patient Blood Management in Scheduled Surgery</td>
<td>No</td>
<td>21</td>
<td>100%</td>
</tr>
<tr>
<td>(iii) Red Cell &amp; Platelet Transfusion in Adult Haematology Patients</td>
<td>No</td>
<td>24</td>
<td>100%</td>
</tr>
<tr>
<td>20 National Complicated Diverticulitis Audit (CAD)</td>
<td>No</td>
<td>Did not participate</td>
<td>Did not participate</td>
</tr>
<tr>
<td>21 National Emergency Laparotomy Audit (NELA)</td>
<td>Yes</td>
<td>61</td>
<td>100%</td>
</tr>
<tr>
<td><em>Data refers to year 2 of the audit (01/12/2014 to 30/11/2015)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 National Heart Failure Audit</td>
<td>Yes</td>
<td>261</td>
<td>100%</td>
</tr>
<tr>
<td>23 National Joint Registry (NJR)</td>
<td>Yes</td>
<td>1020</td>
<td>Not known</td>
</tr>
<tr>
<td>24 National Ophthalmology Audit</td>
<td>Yes</td>
<td>First prospective data extraction not until September 2016</td>
<td>On-going</td>
</tr>
<tr>
<td>25 Prostate Cancer</td>
<td>Yes</td>
<td>118</td>
<td>Not stated⁵</td>
</tr>
<tr>
<td><em>Financial year data up to Q3 (31 December 2015) – cases from January onwards still to be validated and registered.</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 Neonatal intensive and special care (NNAP)</td>
<td>Yes</td>
<td>Number of completed episodes of care included – 151 Number of distinct babies included - 137</td>
<td>Not stated</td>
</tr>
<tr>
<td><em>This figure is for 2014 data published in the November 2015 annual report.</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

⁵ Please note, case ascertainment is not currently measured for prostate patients at the moment but will be in future. The cancer registry have run their own analysis on our data and have confirmed that our figures are as expected.
<table>
<thead>
<tr>
<th>Name of Audit/Clinical Outcome Review Programme</th>
<th>Part of NCAPOP?</th>
<th>Number of patients for which data submitted 2015/16</th>
<th>Data submitted as a percentage of the number of registered cases required for that audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oesophago-gastric cancer (NAOGC)</td>
<td>Yes</td>
<td>56</td>
<td>144% (based on expected total of 39)</td>
</tr>
<tr>
<td>This relates to data submitted for 2014/15. The Trust has not yet submitted any patient data for 2015/16 as the deadline for this is November after the end of the financial year, therefore reporting will always be one year in arrears.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatric Asthma</td>
<td>No</td>
<td>Did not participate</td>
<td>Did not participate</td>
</tr>
<tr>
<td>Procedural Sedation in Adults (CEM)</td>
<td>No</td>
<td>33</td>
<td>100%</td>
</tr>
<tr>
<td>Pulmonary Hypertension</td>
<td>No</td>
<td>Did not participate</td>
<td>Did not participate</td>
</tr>
<tr>
<td>Rheumatoid and early inflammatory arthritis</td>
<td>Yes</td>
<td>5</td>
<td>Not identified due to coding</td>
</tr>
<tr>
<td>This includes patients recruited between 1 April and 30 October 2015 when data collection was put on hold nationally until the next phase of the audit resumes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP)</td>
<td>Yes</td>
<td>366</td>
<td>100%</td>
</tr>
<tr>
<td>UK Parkinson’s Audit (previously known as National Parkinson’s Audit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>No</td>
<td>10</td>
<td>100%</td>
</tr>
<tr>
<td>Speech and Language Therapy</td>
<td>No</td>
<td>10</td>
<td>100%</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>No</td>
<td>11</td>
<td>110% (10 minimum requirement)</td>
</tr>
<tr>
<td>Patient Management, elderly care and neurology</td>
<td>No</td>
<td>33</td>
<td>165% (20 minimum requirement)</td>
</tr>
<tr>
<td>Vital signs in Children (CEM)</td>
<td>No</td>
<td>52</td>
<td>100%</td>
</tr>
<tr>
<td>VTE risk in lower limb immobilisation (CEM)</td>
<td>No</td>
<td>42</td>
<td>100%</td>
</tr>
</tbody>
</table>
For information, the Trust also participated in the following audits:

<table>
<thead>
<tr>
<th>Data submitted to National Audits not included in Healthcare Quality Improvement Partnership’s (HQIP) Quality Accounts List</th>
<th>Number of patients for which data submitted 2015/16</th>
<th>Data submitted as a percentage of the number of registered cases required for that audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of Life Care Audit: Dying in Hospital</td>
<td>46</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

- Adult Cardiac Surgery
- Chronic Kidney Disease in primary care
- Congenital Heart Disease (both paediatric and adult work streams)
- Coronary Angioplasty/National Audit of PCI
- Mental Health Clinical Outcome Review Programme/National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH) (all work streams)
- National Vascular Registry
- Paediatric Intensive Care Audit Network (PICANet)

The following 3 non-NCAPOP audits were not relevant to HDFT due to the Trust not providing the service:

- Prescribing Observatory for Mental Health (POMH-UK) (all work streams)
- Renal replacement therapy (Renal Registry)
- UK Cystic Fibrosis Registry (paediatric and adult)

The following non-NCAPOP audits, which were initially included in HQIP’s Quality Accounts list, or were included in a mid-year update, did not end up running during 2015/16 and so are not included in the table above:

- Adult Asthma
- Non Invasive Ventilation (adults)
- Paediatric Pneumonia
- Adult Bronchiectasis

*Data was prepared but not submitted due to an administrative error. The report and recommendations will be analysed and learning implemented as usual.*
7. ANNEX FOUR: GLOSSARY

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMU</td>
<td>Acute Medical Unit</td>
</tr>
<tr>
<td>CAHMS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CAT</td>
<td>Clinical Assessment Team</td>
</tr>
<tr>
<td>CATT</td>
<td>Clinical Assessment, Triage &amp; Treatment</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CEM</td>
<td>Royal College of Emergency Medicine</td>
</tr>
<tr>
<td>CFRRT</td>
<td>Community Fast Response and Rehabilitation Team</td>
</tr>
<tr>
<td>CNS</td>
<td>Clinical Nurse Specialist</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
</tr>
<tr>
<td>Dashboard</td>
<td>Data visualisation tool that displays the current status of metrics and key performance indicators</td>
</tr>
<tr>
<td>DNACPR</td>
<td>Do not attempt cardiopulmonary resuscitation</td>
</tr>
<tr>
<td>DOLS</td>
<td>Deprivation of liberty safeguards</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>ePMA</td>
<td>Electronic prescribing and medicines administration system</td>
</tr>
<tr>
<td>FFT</td>
<td>Friends and Family Test</td>
</tr>
<tr>
<td>HaRD</td>
<td>Harrogate and Rural District</td>
</tr>
<tr>
<td>HDFT</td>
<td>Harrogate and District NHS Foundation Trust</td>
</tr>
<tr>
<td>HDU</td>
<td>High Dependency Unit</td>
</tr>
<tr>
<td>HQIP</td>
<td>Healthcare Quality Improvement Partnership</td>
</tr>
<tr>
<td>ICE</td>
<td>Requesting and reporting software</td>
</tr>
<tr>
<td>ITU</td>
<td>Intensive Therapy Unit</td>
</tr>
<tr>
<td>KPI</td>
<td>Key performance indicator</td>
</tr>
<tr>
<td>LD</td>
<td>Learning disabilities</td>
</tr>
<tr>
<td>MCA</td>
<td>Mental Capacity Act</td>
</tr>
<tr>
<td>MDT</td>
<td>Multidisciplinary team</td>
</tr>
<tr>
<td>NCDAH</td>
<td>National Care of the Dying Audit of Hospitals</td>
</tr>
<tr>
<td>NCAPOP</td>
<td>National Clinical Audit and Patient Outcome Programme</td>
</tr>
<tr>
<td>NCEPOD</td>
<td>National Confidential Enquiry into Patient Outcome &amp; Death</td>
</tr>
<tr>
<td>NatSSIP</td>
<td>National Safety Standards for Invasive Procedures</td>
</tr>
<tr>
<td>NICE</td>
<td>The National Institute for Health and Care Excellence</td>
</tr>
<tr>
<td>NIHR</td>
<td>National Institute for Health Research</td>
</tr>
<tr>
<td>NRLS</td>
<td>National Reporting and Learning System</td>
</tr>
<tr>
<td>PVG</td>
<td>Patient Voice Group</td>
</tr>
<tr>
<td>QI</td>
<td>Quality indicator</td>
</tr>
<tr>
<td>RTT</td>
<td>Referral to treatment</td>
</tr>
<tr>
<td>SIRI</td>
<td>Serious incident requiring investigation</td>
</tr>
<tr>
<td>SSNAP</td>
<td>Sentinel Stroke National Audit Programme</td>
</tr>
<tr>
<td>TTO</td>
<td>To take out (medicines)</td>
</tr>
<tr>
<td>VIP</td>
<td>Vulnerable inpatient</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
If you require this document in an alternative language or format (such as Braille, audiotape or large print), please contact our Patient Experience Team: thepatientexperienceteam@hdft.nhs.uk or 01423 555499.

Electronic copies of this Quality Account can be obtained from our website (www.hdft.nhs.uk). If you have any feedback or suggestions on how we could improve our Quality Account, please do let us know by emailing bulletin@hdft.nhs.uk.

www.hdft.nhs.uk
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F: www.facebook.com/HarrogateDistrictNHS

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