Harrogate and District NHS
NHS Foundation Trust

You matter most

Quality Account 2013/14

Contents

1. STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

The purpose of this report is to provide information to the public on the quality of our services, to demonstrate progress and improvements from last year and to inform you of our priorities for next year. Where further work is needed on previous priorities, the document details further work agreed to make the required progress. The quality priorities have been agreed through consultation with patients and the public as well as staff, Governors and other stakeholders.

Harrogate and District NHS Foundation Trust ('HDFT' or 'the Trust') is a high-performing Trust, performing well against all national indicators. Quality of care for every patient, every time, is the first objective of the Trust and we are committed to continuous improvement.

I, as the Chief Executive, am accountable for all that happens within HDFT and am also the sponsor for ensuring quality of care. The Executive Director lead for quality is the Chief Nurse, Mrs Angela Monaghan. Our Board of Directors and Council of Governors are fully committed to ensuring that the Trust's top priority is the delivery of high quality care.

The Trust's governance structure was reviewed in October 2013, following a previous review in 2011. This structure is clear and fit for purpose and ensures that appropriate reporting and scrutiny takes place in relation to quality matters.

The Quality and Governance Group played a key role in monitoring the quality priorities and initiatives that were identified in the last Quality Account and will continue to monitor and drive a strong programme of quality improvement initiatives for 2014/15. The work plan includes the identified priorities for next year as well as continuing the work of the priorities from last year. A Non-Executive Director is a member of this group in order to provide additional assurance to the Board of Directors of the effectiveness of the group.

The Board of Directors meets in public on a monthly basis and receives performance and benchmarking reports which include measures of quality. The Chief Nurse's report includes a quality and safety dashboard that details a large number of areas that are measured in relation to the quality of care. This dashboard has been further developed over the past year to include ward level data.

Harrogate District Hospital was inspected by the Care Quality Commission (CQC) in November 2013. This was as part of wave one of the CQC's remodelled inspection regime. There were 18 hospitals identified as part of the first wave; six low risk, six medium risk and six high risk. Harrogate District Hospital was one of the six low risk hospitals inspected. I am pleased to say that the outcome of the inspection was a positive one, identifying that the hospital delivers services that are safe, effective, caring, responsive and well led. We were delighted with this report and the outcome was testament to the dedicated hard working staff of the Trust. Further detail is provided in part three of this document, and the full report can be accessed from our website following the link below:

http://www.hdft.nhs.uk/about-us/news/cqc-report/

We reported in last year's Quality Account that the Trust had responded to the Final Report on the Inquiry into Mid Staffordshire NHS Foundation Trust (Francis Report II) and had carried out a gap analysis against the recommendations in the report. A progress update was carried out on this report in late 2013. In addition, a self assessment was undertaken against the report produced by Sir Bruce Keogh: *Review into the quality of care and treatment provided by 14 hospital trusts in England*. Both of these assessments were shared publically through our Board of Directors meeting and with our Council of Governors.

I am pleased to report that within HDFT, there has been investment in front line ward nursing in each of the last three years. This will continue throughout 2014/15 with further investment in nursing and medical staff on our medical elderly wards.

HDFT promotes a culture of openness in reporting incidents, claims and complaints, investigating them and learning from mistakes. The Trust has however identified over the past year that it could be more responsive to patients who complain to us about the care they received. In order to achieve this, a major review was undertaken of the complaints process during 2012/13. The result of the review was a significant change to the process that devolved complaints investigations into the Trust's Directorates. A case handler is now assigned to each complaint, and contact is made with complainants within three days of the Trust receiving the complaint. The aim of the change is to make the Trust more responsive to complainants, and we are closely reviewing the new process to ensure it is delivering a significantly improved service.

We work hard to communicate efficiently and effectively with people who use our services and staff. Over the last year we have continued the 'Listening Events' led by Directors, at which staff can share good practice and raise any concerns and we have introduced learning events where staff can learn from mistakes Trust that have led to any serious untoward incidents. These are extremely important listening events that will continue to be developed.

Quality of Care Teams at ward or department level across community and hospital settings provide the forum for ensuring the local delivery of quality care. They are multi-disciplinary and meet regularly. Some of the teams have a linked Public Governor. The organisation aims to ensure the values and ethos of the Trust are understood by all staff, and work continues to develop and strengthen the work of the Quality of Care Teams. This ensures local actions are taken in response to feedback and identified risks and to ensure consistent reporting.

The Trust continues with its successful programme of patient safety visits and revisits to hospital departments, wards and community based settings. In addition, to drive forward the quality agenda, the Board of Directors undertake Directors' inspections on a monthly basis. These visits are unannounced and are led by an Executive and Non-Executive Director. The outcomes of the visits are reported to the Board of Directors on a monthly basis in the Chief Nurse's report. Further detail about these visits and inspections can be found in part two of this document.

In our Quality Account last year we stated that the Trust had increased its incident reporting rates, and I am pleased to confirm that we have maintained this and that the Trust continues match the average reporting rate for NHS Trusts.

In 2013/14, the Trust reported eight serious untoward incidents on the NHS Strategic Electronic Reporting System (STEIS) and also informed the local commissioner, Harrogate and Rural District Clinical Commissioning Group (HaRD CCG). Of the eight incidents, one was categorised as a Never Event relating to a wrong prosthesis, three related to delayed diagnosis, two related to a delay in treatment, one related to safeguarding and one related to maternity screening.

Each of these incidents has been thoroughly investigated. Investigation teams include Non-Executive Directors and external professional advice as appropriate. The findings from all investigations are scrutinised by the Board of Directors and are used across the organisation to ensure that learning from these events takes place and that the possibility of recurrence of similar events is minimised. In turn, these incidents have been externally scrutinised by the Clinical Commissioning Group and the Commissioning Support Unit (CSU). We sincerely regret all incidents at the Trust. Over the past year there have been two significant coroners inquests relating to incidents that occurred during 2012. These identified failings in the

Trust's delivery of care. Considerable work has been done in response to these incidents and detailed action plans have been completed.

The Trust is appreciative of the patient and public feedback it receives and uses this proactively to drive improvements in care. HDFT is fortunate to have strong public engagement through the Trust's Members, the Governors and the lay representatives who serve on Trust Committees. The Trust's Patient Voice Group is a pro active and highly respected group that carries out visits to departments in the hospital and community. Its excellent work was highlighted by the CQC at its recent inspection as an example of good practice.

This will be my final opening statement to a Quality Account, as I retire in August 2014. I believe that HDFT delivers high quality care to the people that use its services, facilitated by committed, excellent staff. I have been extremely proud to work for this organisation for the past 30 years and wish it well moving forward.

I would also like to thank our Chief Nurse, Mrs Angela Monaghan, for her commitment to the organisation, as she retires in June 2014.

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

Signed

Richard Ord (Chief Executive) Date

2. PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE

2.1. Priorities for Improvement 2014/15

In seeking to identify its quality priorities for 2014/15, the Trust involved staff, Governors and other stakeholders, including:

- Harrogate and Rural District Clinical Commissioning Group.
- Healthwatch
- North Yorkshire County Council Scrutiny of Health Committee
- The Trust's Patient Voice Group

The Trust has identified four key priorities for quality improvement in 2014/15. These have been informed by the discussions and suggestions from the stakeholders identified above, as well as reviews of data and reports relating to the quality of care delivered during 2013/14. We have also considered any recommendations from the small number of serious incidents that have occurred and these have contributed significantly to our choice of quality improvement priorities. The priorities have been approved by the Board of Directors and will include:

1. Reducing morbidity by reducing the numbers of health care acquired pressure ulcers
2. Reducing harm to patients by increased focus on fluid management, pain control and preventing falls
3. Improved responsiveness to patient need including escalation of concerns and handover/ good continuity of care
4. Improved public health particularly reduction of smoking prevalence, misuse of alcohol and obesity

There will be a continued focus on quality improvement in other areas including:

5. End of life care and high quality communications to patient and family
6. Care of patients with dementia across the health community
7. Hospital discharge and especially delays on the day of discharge
8. Transparency of information regarding nursing levels both actual and planned

The Trust's Quality and Governance Group is responsible for ensuring that the detailed work to support delivery of improvements in relation to these areas is defined. There will be identified leads, together with a communication and reporting plan to ensure engagement with staff and effective monitoring of progress.

2.2. Progress against quality priorities identified in 2012/13 Quality Account

2.2.1. <u>High quality and safe discharge</u>

Discharge has been a quality priority identified in our last three Quality Accounts and continues to be an important area for quality improvement in the Trust. There is now a refocused Discharge Improvement Steering Group and whilst there are still delays on the day of discharge, targeted work is progressing. The steering group has developed a more patient-focused set of aims which are:

"Harrogate and District Foundation Trust will ensure that it has plans in place for hospital patients to be transferred back to the care of their GP when it is clinically appropriate. Patients will be able to say:

- I and/or my carers have been involved in planning my discharge.
- I have the correct medication.
- Information sent to me and to others about me is accurate and has been properly communicated to the right people at the right time with my consent.
- Any ongoing support I need is in place.
- I did not stay in hospital longer than I needed to.

In summary, HDFT will protect "the health, welfare and safety of service users in circumstances where responsibility for the care and treatment of service users is shared with, or transferred to, others by means of… the discharge and transfer of service users." (guidelines set by the Care Quality Commission in compliance with Regulation 24, Outcome 6, of The Health and Social Care Act 2008, (Regulated Activities) Regulations 2009").

The quality improvement priority identified last year focuses on:

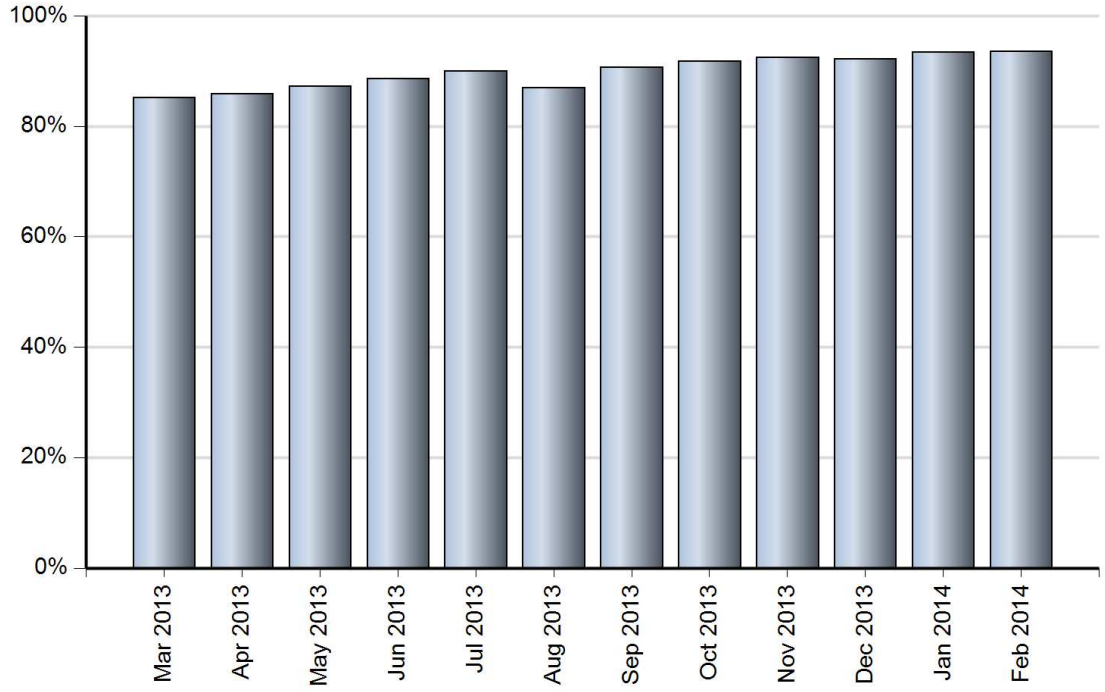
- Attainment of key performance indicators in relation to discharge planning e.g. patients discharged with electronic discharge summary.
- Effective patient flow through hospital wards and departments.
- Improved communication systems across health and social care including:
    - Improvements to discharge letters.
    - Improving safety and efficiency by reviewing patients readmitted following discharge.
- Facilitate appropriate discharge and improve patients' independence and self-care through the provision of a high quality community equipment service.
- Improving the patient experience of discharge.

Electronic discharge summaries

Electronic discharge summaries enable legibility, consistent content, and facilitates earlier and more effective communication with the patient and their GP. The Trust has implemented electronic discharge summaries using software called Integrated Clinical Environment (ICE) in areas which have previously used paper discharge letters.

There has been a gradual rise in numbers of patients discharged with an ICE electronic discharge summary from those areas where this is appropriate. A number of areas are excluded from the electronic discharge figures because they have their own systems in place already. Trinity Ward at Ripon Community Hospital is scheduled to introduce electronic discharge letters and electronic prescribing in July 2014.

Patients discharged with electronic discharge summary



Work has been undertaken to improve written discharge information by standardising our discharge letters. The new letter templates are being implemented and this will improve communication regarding medication changes and further actions for the GP.

Patient flow and patient experience

Achieving a safe and timely discharge can be a complex activity. Successful discharge planning should involve many staff and agencies. We know that both premature and delayed discharge may increase the risk of harm to patients. Progress has been made in relation to both simple and complex discharge. Simple discharge relates to patients who are usually discharged to their home and are independent and complex discharge relates to patients who have health or social needs on discharge; patients with complex discharge needs may or may not return to their own home.

An improvement workshop focused on continuing care has delivered a number of improvements relating to discharge that have clear benefits to patients:

- The Discharge Planning Team is now more visible and accessible, working from ward bases rather than a remote office site.
- Patients requiring continuing health care are now assessed according to a standard process that enables faster and more accurate electronic information sharing between agencies and a better patient/carer understanding of the process.
- Faster and more convenient arrangements are in place to plan meetings that avoid families and staff travelling long distances to poorly attended meetings.
- Stronger communication arrangements with named social services colleagues are now in place.

A further improvement workshop has delivered more timely and better quality communication with the families and carers of people with dementia. It has provided a renewed focus on “fit, ready and safe” discharge criteria, and introduced new daily nurse-led ward rounds to speed up discharge where appropriate.

A third improvement workshop focused on the rapid discharge for patients at the end of life to enable all eligible patients who want this to be discharged home in 48 hours, a reduction from an average of 149 hours (before the workshop) to 39 hours as measured in September 2013. Collaborative working now provides an integrated, quality service for end of life care that respects the wishes of the patients and their families and honours patient choice to die in their preferred location whenever possible.

Community equipment

Community equipment provision was identified as a quality priority in order to provide an equitable and responsive community loan equipment service across North Yorkshire to support an individual's requirements to stay safely at home, enable timely discharge from hospital or improve independence and self-care.

Extensive work has been undertaken within the Trust to redesign the North Yorkshire-wide community equipment service resulting in many positive developments. In order to monitor the effectiveness of the service we required a more robust and consistent process for data collection, reporting on our performance and monitoring quality improvements.

The online equipment ordering system was piloted in February 2014. The fully electronic ordering system will address issues around accessing equipment and provide a more robust system for reporting performance. The new service, which is to be launched in July 2014, will also provide a much quicker turnaround following a request for equipment, with a large proportion of patients benefiting.

The chart below indicates the data for orders for equipment delivered within 7 days, adjusted for those orders where a justifiable reason has been given for delaying delivery, for example to coordinate with a home visit, patient away etc.

	2012-13		2013-14			
Stores	Q3	Q4	Q1	Q2	Q3	Q4
Colburn	95%	96%	97%	97%	95%	96%
Knaresborough	89%	91%	86%	90%	96%	93%
Scarborough	78%	50%	85%	87%	91%	93%
York	90%	81%	85%	93%	92%	93%
Overall Service	90%	79%	87%	92%	93%	94%

Next steps

Information from complaints and other anecdotal sources show that the greatest patient dissatisfaction with discharge arrangements arises from delays occurring from the point that patients are told that they can go home today to the point when everything is actually in place to enable them to leave the hospital.

The next phase of work will focus on:

- Doing more to tackle delays that occur on the day of discharge
- Improving weekend discharge arrangements

2.2.2. Use of technology to drive safe and effective care

Access to mobile technology

The aim of this work was to improve the quality and effectiveness of care delivered to patients in their homes or other community settings by:

- Enabling community staff to access to relevant clinical records
- Improving accuracy in recording interactions with patients
- Improving information sharing with other professionals involved in the patient's care
- Reducing travelling time and costs to enable increased levels of senior review, and improve the effectiveness of the care delivered.

The initial roll out of mobile technology in September 2013 using an electronic "brief case" solution for nursing teams was unsuccessful as it significantly increased the workload for the teams and reduced the time available to them to visit patients.

However the Trust has been working with the manufacturer of "SystmOne", the electronic medical records system used by the majority of our GPs and all of HDFT's community staff, and is one of the pilot sites for a new piece of software that enables "SystmOne" to be used on mobile devices.

Following a successful trial by one of our Adult Community Nursing Teams between December 2013 and January 2014, the Trust is now in the process of implementation to all of the Adult Community Nursing Teams and the Universal Children's Service. We hope to secure funding over the next year for additional mobile devices to allow us to continue to roll out this technology to all of the services that we provide in the community.

Telehealth pilot

Telehealth refers to the use of technology to monitor particular physiological measures that help patients to monitor their health, for example blood pressure, and highlight to the medical team any concerns at an earlier stage. In trials around the country it has been shown to reduce the number of visits to GPs and hospital. Technology and its use in health care is continually developing and is being applied in many different ways. Teleconsultation refers to the use of technology to provide consultations for patients with doctors remotely. This technology is already in use at Harrogate District Hospital and is used to provide expert support for our stroke services outside core working hours.

The use of telehealth monitoring in secondary care was untested, but had been used successfully by our Community Nursing teams for a number of years to support patients with long term conditions to manage their own care at home. In November 2012 we started a pilot project to test the use of telehealth monitoring within secondary care. Harrogate and Rural District Clinical Commissioning Group provided funding for this project.

The project was designed to identify patients attending the Clinical Assessment Team Unit (CAT), or inpatient wards with one of six medical conditions, who might benefit from the use of the telehealth monitoring equipment. The medical conditions included in the pilot were:

- Pulmonary embolism (blood clot in the lungs)
- Atrial fibrillation (a specific irregular heart beat)
- Hypertension (high blood pressure)
- Headaches
- Pneumonia
- Urinary tract infection

The patients included in the pilot were identified to use telehealth monitoring as a means of providing supportive early discharge or to prevent an admission. As well as monitoring the effectiveness of the approach, the patient's experiences were gathered via a survey.

The evidence from the patient survey has strongly indicated that the majority of patients found telehealth monitoring extremely beneficial and that it improved patient confidence post discharge. There were a small number of cases where the use of the equipment was not appropriate.

There is clear evidence from the project that a number of potential hospital admissions were prevented and occupied bed days were saved. There was a reduction in length of stay and follow up attendances. During the 12 month study period:

- 19 admissions were prevented leading to a saving of 29 occupied bed days
- Five inpatients had their length of stay reduced leading to a saving of six occupied bed days
- 45 follow up visits to CAT were prevented.

Whilst this was a small project it has shown benefits from using telehealth monitoring in secondary care for this cohort of patients. Over this coming year we will continue to develop the use of this technology.

Safe prescribing and administration of medicines

The aim of this work was to continue to optimise the way medicines are used at HDFT, especially using technology, to ensure safe and effective treatment of our patients. MedChart Electronic Prescribing and Medicines Administration (ePMA) system, the ICE electronic discharge system and access to the Summary Care Record are used to facilitate this aim.

The specific objectives of this work were to:

- Reduce the number of prescriptions that do not follow trust policy and guidance for accurate completion. The ePMA system ensures the legibility of medicines prescribed. Reported drug prescribing incidents caused by ambiguous or illegible prescriptions have reduced from 15 in 2012/13 to two in 2013/14. Pharmacists intervention reports are undertaken annually and detail interventions that have been required to clarify or amend prescribing to comply with Trust policy. These confirm improvement as there were 21 interventions in 2012/13 and only five in 2013/14. Clarification of brand or generic names account for the majority of these prescriptions, with handwritten outpatient prescriptions being the remainder that have led to incident reports.

- Increase the number of discharge medicines prescribed using the electronic discharge system in order to ensure high quality legible prescribing. The data is from the ICE electronic discharge system and shows that the proportion of discharge medicines prescribed using the electronic discharge system in April 2012 (baseline) was 20.4%, with an average of 34.4% for 2012/13. Results show an improvement to 50.5% in January 2014, with an average of 48.1% for 2013/14.

- Increase the number of antibiotic prescriptions that include the indication for antibiotic use and the duration of therapy. There is a prompt on the ePMA system that encourages the recording of the indication and intended initial duration of antibiotic prescriptions, and this has improved compliance. Data from the baseline Harrogate antibiotic prudent prescribing and intervention (HAPPI) audit showed the indication for antibiotic use and the duration of therapy was documented in 53% of cases in July 2011. The most recent

audit data for January 2014 showed improvement with the indication documented in 73% of prescriptions and the duration documented in 78%. Another resource introduced in June 2013 is a RAPID Live Antimicrobial Prescribing Report available on the Trust intranet homepage, which allows prescribers to review all patients currently prescribed antibiotics. This aims to further encourage compliance with antibiotic prescribing standards and it is currently being accessed approximately 150 times per month by prescribers.

- Reduce the number of prescriptions that include a drug to which the patient has a documented allergy. There were five reported incidents in 2012/13 of prescriptions that included a drug to which the patient had a documented allergy, and this has reduced in 2013/14 to three.

- Reduce the number of patients administered a drug to which they have a documented allergy. There were three reported drug incidents in 2012/13 and one incident in 2013/14.

- Reduce the number of incidents of patients being administered a medicine that was not as intended by the prescriber. There were 77 relevant reported drug incidents in 2012/13, and this has reduced in 2013/14 to 56. This reflects a reduction from an average of 6.4 per month last year to 4.7 in 2013/14.

- Use the Summary Care Record and other means to increase the proportion of patients who have a detailed medication history review within 24 hours of admission. Baseline audit data from Pharmacy audits for 2012 was 75%. 2013/14 audits show improvement with 80% of patients having a level two medication history review within 24 hours of admission. Further improvement is anticipated as access to Summary Care Records is used more often, particularly at weekends.

This work has built on last years quality improvements and all metrics have demonstrated improvement in annual audit or monitoring report data.

Technology to support patient handover

Work has been undertaken during the year to improve the quality, effectiveness and consistency of handover of care of patients on wards and to keep an electronic record of the information that was handed over.

Ward handovers

A trial of a standardised multidisciplinary handover template was commenced in September 2013 on three of the hospital wards. The completed handover document on each of these wards is now saved on a ward handover specific area of a central IT server twice a day to ensure that a formal record is kept. The documents are saved using a standardised naming convention to enable retrieval of information shared at handover, and they are saved in pdf format to prevent retrospective alteration.

This system of saving electronic copies is now being introduced to the rest of the wards.

Medical handovers

The Elective Care directorate have been working with their medical teams to trial an internally developed electronic handover system. The system is accessible through any computer on the hospital site via an electronic link and requires a username and password. The system enables the team to select the relevant ward and patient number then it

automatically populates patient's name, consultant details and specialty with data from the Trust's patient administration system.

Once the patient has been selected the team is able to add a diagnosis and/or procedure for the patient, issues, tasks and/or further patient details. On completion the team save these details and store them for access later by the next team on duty. This enables more effective sharing of information about tasks to be done and patients requiring review. Further information about the patient can be added to the record. The system has offered each team a safe and robust way of reviewing patients at handover especially at weekends.

To support the teams and to enable an audit trail of the clinical record, all amendments are recorded within a database and can be retrieved at any time before or after the patient is discharged.

Next steps

The Trust is in the process of purchasing and implementing an electronic system for observations, escalation and handover. This system will incorporate a combined medical and nursing handover and utilise multiple handheld devices. The system will enable the capture of clinical data in real-time at the point of care. The progression to mobile handover will ensure a constantly updated handover document accessible to all who need the information, whilst ensuring an accurate audit trail. Medical and nursing staff will be able to share information, avoiding duplication and ensuring that everyone is using the same core set of key information.

2.2.3. Improving fundamental care

In our 2012/13 account we stated that we would continue to focus on the delivery of the highest standards of fundamental care to all patients in relation to nutrition and hydration, pressure ulcers, communication, privacy, dignity and compassion, and environmental cleanliness. In addition we would be:

- Working to reduce the prevalence of pressure ulcers reported using the NHS Safety Thermometer
- Responding to the recommendations of the Francis Report II, including:
    - Responding to early warning indicators in order to anticipate challenges to high quality care provision
    - Director inspections and safety visits
    - Acting on Friends and Family Test results including qualitative analysis and reports
    - Improving care and compassion, through recruitment, training and ensuring an appropriate culture in clinical areas at all times by all staff
    - Changes to complaints management and using patient feedback more proactively
    - Using clinical audit to drive higher levels of care delivery, and documentation of fundamental care, with particular emphasis on nutrition.

Nutrition and hydration

Patient assessment on admission

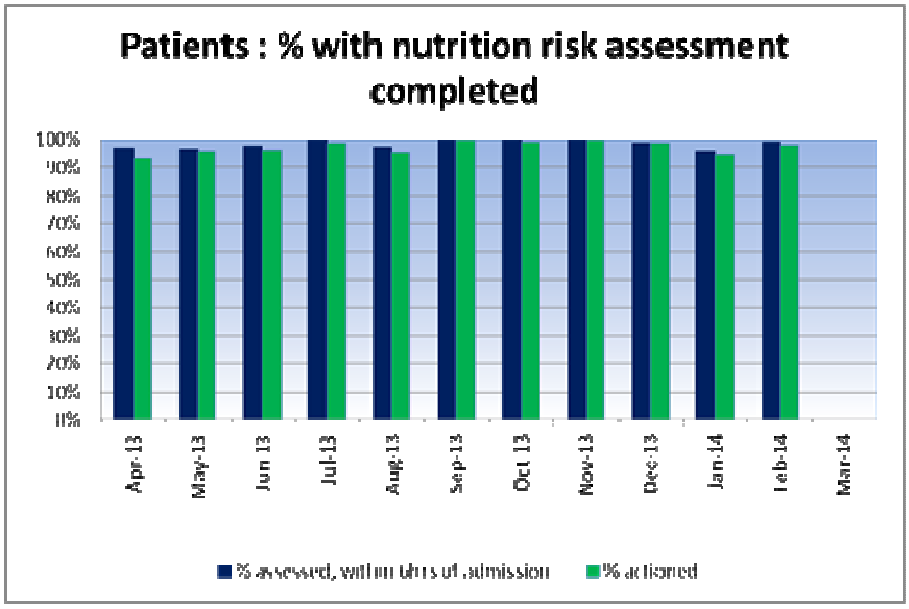
Matrons continue to monitor the recording in the nursing documentation of patients weight, and nutritional risk assessment on admission to the adult inpatient wards as part of their monthly checklist.

The data demonstrates that there are still challenges to ensuring that patients have a weight recorded on admission or a reason why this has not been possible, documented. From a sample of patients reviewed monthly:

	Patients with weight recorded on admission or reason for not weighing documented: % (proportion of sample size)
February 2012	71% (41/58)
February 2013	85% (51/60)
February 2014	69% (45/65)

A review of the adult inpatient nursing documentation highlighted duplication of places to document weight on admission and this has now been amended.

Completion of the nutritional risk assessment and taking appropriate action based on identified risk continues to show good performance.



Previous audits have shown differences between nurse and dietitian nutritional risk assessment scoring, and further work in the form of modification of the assessment tool and teaching aids have sought to strengthen this. In addition targeted education and training is planned for Registered Nurses initially focusing on two pilot wards. These initiatives will be evaluated by an audit in June 2014.

<u>Nutrition and hydration awareness week.</u>

A nutritional focus week took place from 16 - 20 September 2013 and this involved a series of activities to raise awareness amongst staff, patients and visitors of the systems the Trust has in place to ensure good nutritional care for all patients.

Activities were planned throughout the week, with the main focus during afternoon visiting.

- The Trust's ward based Nutrition Assistants manned stands outside the wards to highlight their unique role and the systems utilised at ward level to identify nutritionally at risk patients and to develop a nutritional care plan. Information was provided on protected mealtimes, the 'red tray system', nutrition risk screening, mealtime volunteers, high calorie snacks and oral nutritional supplements.
- The Nutrition and Dietetic Department manned a display in the hospital foyer on the prevalence of under nutrition, its treatment and the role of the dietitian.

- A training 'road show' toured the wards to provide training on enteral feeding for nursing staff.
- The Catering Department produced a 'photo story board' detailing the many steps involved in the production and delivery of patient meals, which was displayed in Herriots Restaurant throughout the week.
- A chef, a Matron and a member of the Patient Voice Group toured the wards one afternoon to speak to patients and relatives. The aim was to highlight that HDFT food is produced on the premises and to gain feedback on the food from patients.
- The Speech and Language Therapy Department offered the opportunity for staff and visitors in Herriots Restaurant to try the altered consistency meals and thickened fluids often recommended for patients with dysphagia (difficulty swallowing).
- The availability of food throughout the 24 hour period was promoted. A patient information leaflet promotes the availability of food outside of the standard mealtimes.
- Nutrition related "facts of the day" were sent out to staff with the Daily Bulletin email.

The event received coverage in the local press.

Hydration and fluid balance

An audit of fluid balance charts was undertaken in August 2013 across the adult inpatient wards excluding the Intensive Care Unit. This demonstrated that further work was required including changes to the fluid balance chart and the production of guidelines for fluid management based on best practice. The audit was presented to senior nurses at a "What's New" event in January 2014. This piece of work has been led by the Critical Care Outreach Team, and the Patient Safety Group will monitor progress on actions identified. We recognise that further work is required in this area and consequently this is included within the quality improvement priorities for 2014/15.

Pressure ulcers

In our 2012/13 account we stated that we would continue to focus on the delivery of the highest standards of fundamental care to all patients in relation to pressure ulcers, and we would be working to reduce the prevalence of pressure ulcers reported using the NHS Safety Thermometer. This is a tool for measuring, monitoring and analysing patient harms and 'harm free' care.

We now have two Tissue Viability Specialist Nurses to provide an integrated service across community and acute care settings. Patient contact rounds, regular reviews of patients by nurses every two hours on inpatient wards have been implemented and are monitored through the adult inpatient Matrons' monthly ward checks. The pressure ulcer guidelines were revised and re-launched in 2013. In addition the Trust has invested in more pressure relieving equipment, including the purchase of some new inpatient bedside chairs that have inbuilt pressure relieving cushions.

A trial of gel heel support cushions has been completed and we are progressing purchase of these for inpatient wards. In March 2014 we have started a trial of a new pressure relieving heel lift boot on two adult inpatient wards.

We have continued to provide education and training programmes around prevention of pressure ulcers for Registered and Unregistered Nurses (also known as Care Support Workers). An education event for Registered Nurses focusing on the assessment, prevention, grading and treatment of pressure ulcers commenced in September 2013 with a series of workshops. Ward Sisters and Senior Nurses received a pressure ulcer update from the Tissue Viability Nurses at the "What's New" event in January 2014. Specific pressure

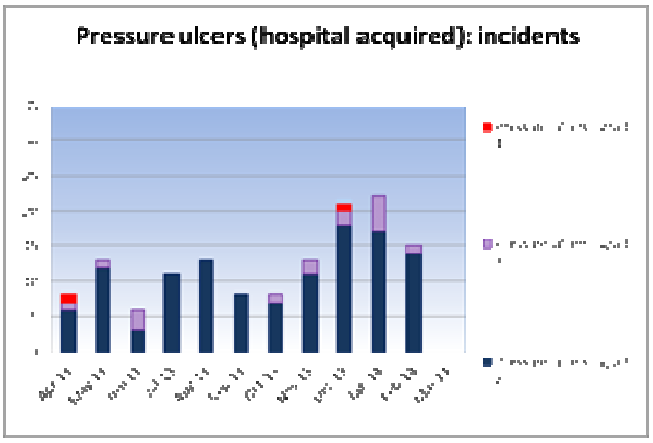
ulcer root cause analysis training and discussion for Ward Managers, Team Leaders and Matrons will commence in April 2014.

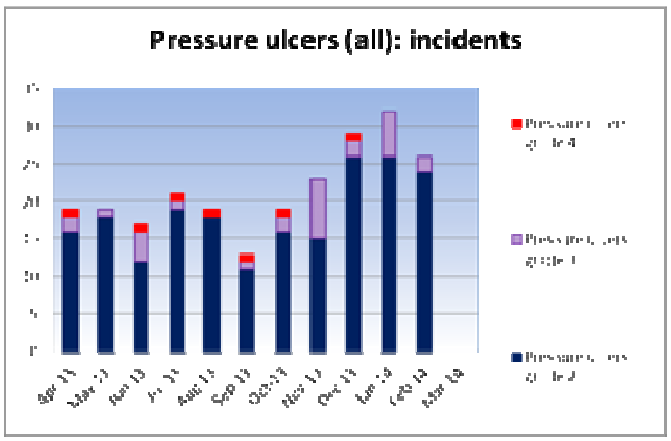
Previously staff have reported any grade three or four pressure ulcers as clinical incidents, but from April 2013, staff have also been required to report grade two pressure ulcers that have developed whilst a patient has been receiving HDFT hospital or community care. The data is included on the Quality and Safety Dashboard which is produced each month and reviewed within the Trust, including by the Board of Directors.

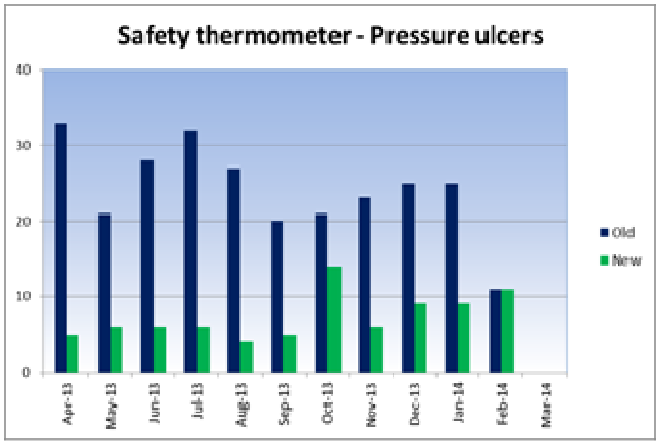
The data from the NHS Safety Thermometer in relation to pressure ulcers is reviewed and the results for HDFT compared with the national results. The Pressure Ulcer Steering Group reviews the pressure ulcer incidence data to identify areas to target for further work. Currently root cause analysis (RCA) is undertaken for all grade three and above pressure ulcers and learning identified. Learning from the successful infection control methodology it is proposed that a post RCA review meeting is undertaken which will allow a more detailed review of each case. From June 2014 grade three and four pressure ulcers that are HDFT acquired will be reported as serious untoward incidents. This was a recommendation from the CQC following its inspection in November 2013.

As seen on the charts below, since December 2013 there has been an increase in grade two pressure ulcers reported on the Quality and Safety Dashboard. This could be representative of further active encouragement to report grade two pressure ulcers.

Between July-September 2013 there were no hospital acquired grade three or four pressure ulcers reported, however since October 2013 there has been an increase. A large proportion of these have been located on patient heels.



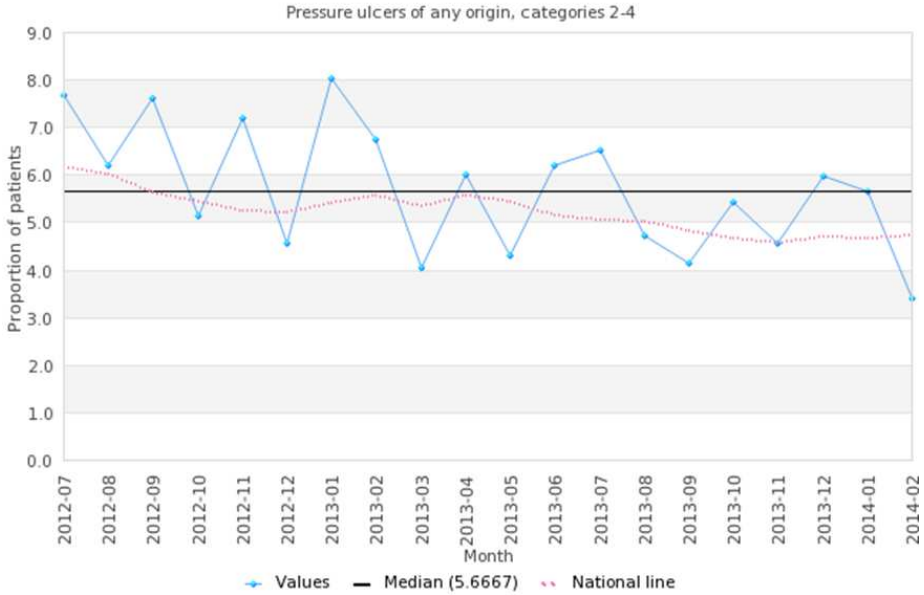




Source: HDFT Quality and Safety Dashboard February 2014

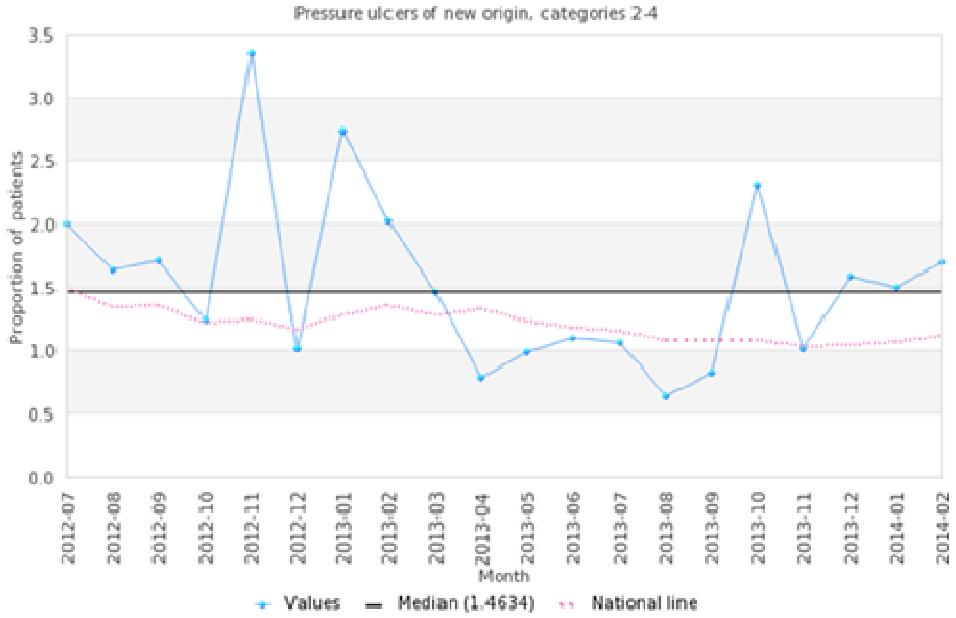
Regarding pressure ulcers reported via the NHS safety thermometer methodology, there has been a downward trend nationally for all and new pressure ulcers, but HDFT has a incidence of new pressure ulcers which is slightly higher than the national line, as described below.

The chart below shows data for old and new pressure ulcers for the reporting period March 2013 - Feb 2014



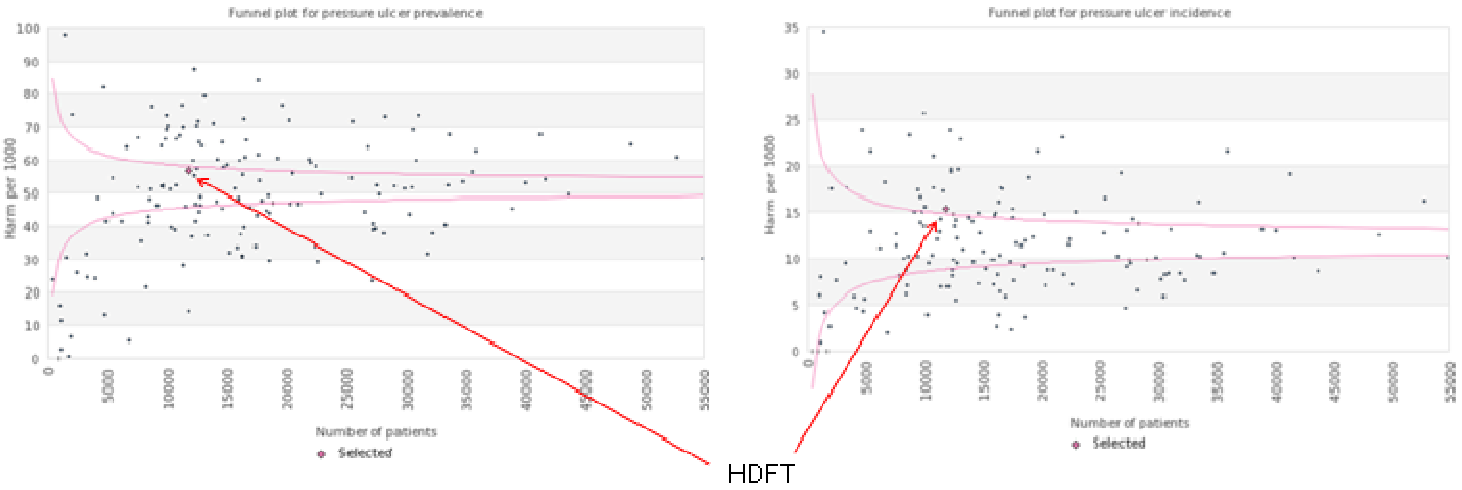
Data from NHS Safety Thermometer funnel plots: March 2014

The chart below shows data for new pressure ulcers for the reporting period March 2013 - Feb 2014



Data from NHS Safety Thermometer funnel plots: March 2014

The data below shows that pressure ulcer prevalence for new and old pressure ulcers is within the expected range however for new pressure ulcers the incidence funnel plot shows HDFT to be slightly worse than average. This is for the period March 2013 - Feb 2014.



The Trust has identified pressure ulcers as a specific priority for quality improvement in 2014/15. Whilst it is worth noting that the Trust is seeing increasing patient frailty and increasing numbers of very elderly patients with co-morbidities (more than one condition), further work will focus on targeting the areas of greatest incidence of pressure ulcers to achieve reduction. We will more explicitly adopt a "zero tolerance" approach to pressure ulcer development for those patients in receipt of HDFT nursing care and that our training programmes and investigation processes support this principle.

Communication

Data relating to complaints and concerns about communication and attitude of staff continue to be monitored. The tables show complaints by sub-subject and date consent received.

	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4	Total
Total Concerns and Complaints	113	155	150	161	579
Total Relating to Communication and Attitude	75	78	80	93	326
Admin Attitude	1	6	7	5	19
Medical Attitude	16	14	14	12	56
Nursing Attitude	11	13	12	18	54
Other Attitude	3	1	1	3	8
Allied Health Professional Attitude	1	1	1	2	5
Admin Communication	1	0	4	3	8
Medical Communication	22	28	28	24	102
Nursing Communication	15	12	11	14	52
Other Communication	3	0	2	10	15
Allied Health Professional Communication	2	3	0	2	7

Table: Complaints and concerns received 2012/13

	2013/14 Q1	2013/14 Q2	2013/14 Q3	Total
Total Concerns and Complaints	158	164	146	468
Total Relating to Communication and Attitude	91	99	78	268
Admin Attitude	4	8	3	15
Medical Attitude	14	19	18	51
Nursing Attitude	15	17	11	43
Other Attitude	1	3	2	6
Allied Health Professional Attitude	2	2	1	5
Admin Communication	5	10	9	24
Medical communication	28	21	16	65
Nursing communication	19	14	11	44
Other communication	0	2	4	6
Allied Health Professional Communication	3	3	3	9

Table Complaints and concerns received 2013/14 (year to date).

Disappointingly the numbers of complaints citing poor attitude and communications by clinical staff has not reduced this year in comparison with the previous year. More positively however there has been a marked increase in the number of such complaints which have been upheld by the Trust which demonstrates a more open approach to acknowledging poor communications and attitudes between staff, patients and families. In addition the new complaint process implemented during the year allows for earlier personal contact by an experienced member of staff with the complainant. We also take the opportunity for members of the senior management team including the Chief Executive, Chief Nurse and Medical Director to meet with patients and relatives where this would be helpful, as part of this process. Positive feedback has been given by both staff and complainants about the helpfulness of this approach. Finally the scrutiny given to such complaints by the Quality of Experience Group has increased, to allow more in depth review of issues raised and therefore to generate more local actions within Directorates, including specific feedback to individual members of staff cited in the complaints.

Privacy, dignity and compassion

We aim to improve care and compassion through recruitment, training and ensuring an appropriate culture in clinical areas at all times by all staff.

The ‘15 step challenge’ is an initiative that encourages patients and staff to work together to identify improvements which may enhance the patient experience. This is being implemented with reinforcement of positive meeting and greeting by all members of staff, patient contact rounds and “Every Patient Every Time” training.

Patient contact rounds have been implemented across the wards and an initial evaluation of the project implementation was positive. It did however demonstrate areas that could be improved upon, relating mainly to compliance with the two hour review standard and further work is being undertaken to improve compliance with this. Patient contact round monitoring has been included in the Matrons’ monthly checks since February 2014. This will focus on compliance with the two hour standard and increased observation for patients at risk of falls. An audit of the contact rounds will be undertaken in April 2014.

The Trust engaged the Royal College of Nursing to provide three workshops on dignity and respect for Registered Nurses and Care Support Workers, to enable attendees to share learning and take forward actions related to dignity in their own areas. The initial workshops

were delivered between September and November 2013 and follow up workshops will commence in June 2014 to review, monitor and share good practice.

Nursing staff now ask each inpatient on admission what their preference is regarding showers and baths and the nursing documentation has been modified to enable this to be recorded. In February 2014, monitoring of a sample of patients across nine adult inpatient wards showed that 60% patients (27/45) had their preference for this aspect of personal care documented on admission. Progress with improving this indicator will be monitored by the Matrons through their monthly ward checks.

Environmental cleanliness

April 2013 saw the introduction of Patient-led Assessments of the Care Environment (PLACE). The PLACE programme applies to all providers of NHS-funded care in the NHS. Participation is voluntary, but the Care Quality Commission have indicated that if PLACE information is not available, providers will need to offer an alternative form of evidence around the areas to which the PLACE programme applies. The Trust participated in the programme.

HDFT has always had patient representatives on assessment teams. However to ensure nationally that the patient voice is heard, a key change from the former Patient Environment Action Team (PEAT) process is that the assessment is now patient led, with an increased number of 'patient assessors'. These are individuals who represent users of healthcare services. All assessing teams must now include at least two patient assessors, who must also comprise at least 50% of the overall team. The Trust met this requirement by using volunteers from Health Watch, the Patient Voice Group and Trust Governors. External verifiers from York Teaching Hospitals NHS Foundation Trust were present at all assessments which were undertaken over the period 18 April to 14 June 2013.

The assessment process focused on the environment in which care is provided with particular emphasis on cleanliness, general condition, appearance and maintenance, privacy and dignity and the provision of food and drinks. It did not cover clinical care provision or how well staff were doing their job. All assessments were undertaken to a standard assessment format issued by the NHS Commissioning Board.

Results of the first PLACE assessment programme have been published by the Health and Social Care Information Centre along with national comparative data for other hospitals. The table below shows the scores achieved for Harrogate District Hospital (HDH), Ripon Community Hospital (RCH) & the Lascelles Unit. Higher scores are better.

Location	CLEANLINESS		FOOD		PRIVACY, DIGNITY AND WELLBEING		CONDITION, APPEARANCE AND MAINTENANCE	
	Trust Score	National Score	Trust Score	National Score	Trust Score	National Score	Trust Score	National Score
Lascelles	99.52	96.74	94.09	84.98	91.3	88.87	88.39	88.75
HDH	98.26	95.74	90.83	84.98	85.08	88.87	94.65	88.75
RCH	96.43	95.74	94.88	84.98	82.70	88.87	84.48	88.75

Regarding privacy, dignity and related patient wellbeing, the reasons for lower scores relate in part to the physical environment and the impact of this on ensuring ideal conditions for privacy, for example the physical layout and the possibility for discussions to be overheard. Action plans for each location were issued to directorate leads to progress for their areas of

responsibility. Unfortunately, some of these elements will continue to score low in future assessments until such times as the physical layout of areas can be altered.

Regarding the condition, appearance and maintenance assessments, no allowance is made for the age of the premises. Ripon Hospital is owned by NHS Property Services Ltd and the Trust is in ongoing consultation regarding the fabric of the building.

It is pleasing to note the Trust's high standards in relation to cleanliness and food across all locations, and the condition, appearance and maintenance at Harrogate District Hospital. The PLACE inspection will be repeated annually and it is anticipated that some of the assessment questions will be amended as the assessment process is evolving.

Early warning indicators to anticipate challenges to high quality care provision

The Francis Report II, published February 2013, contained the findings of the public inquiry into Mid Staffordshire Foundation Trust. The report clarified the importance of organisations seeking accurate information about their performance in as near real time as possible, taking advantage of all safety related information. The Trust uses a variety of mechanisms to monitor and anticipate challenges to high quality care provision. These include:

- Monitoring information in order to actively manage the pressures on services which can have a direct impact on the quality of patient care delivered. This includes staffing levels, activity such as call volume to the GP out of hours service, delayed transfers of care and discharges, admission of patients with a stroke to the Stroke Unit and acute bed occupancy. There are daily meetings to review the information relating to inpatient activity and plan appropriate management. During the autumn 2013, the bed occupancy was sustained at a higher level than ideal and as a direct result, an escalation ward was prepared, staffed and opened for a three month period to provide additional capacity.
- Entering patient feedback from the Friends and Family Test onto a database which is available to staff to review in real time, and which enables specific concerns to be actioned rapidly and themes and trends to be identified.
- Staff reporting incidents onto an online tool which enables real time review of actual incidents being reported. The Complaints and Risk Management Group chaired by the Medical Director meets weekly and reviews incidents and complaints to identify and action any significant concerns, themes, trends or clusters.
- Updating the Quality and Safety Dashboard each month with information detailed to ward and department level, and then reporting to and discussing at every Board of Directors meeting. The dashboard enables triangulation of information from different sources, including:
    - Matrons monthly audits on their wards
    - Incident reports from staff including reporting rate, top incidents types, and specific detail of areas of particular concern e.g. pressure ulcers, falls, medication incidents
    - Results of the Friends and Family Test
    - Results of audits and checks of hygiene standards
    - Complaints received
- Utilising the Healthcare Evaluation Data (HED) tool to monitor and compare data on a variety of measures, which then enables focused further investigation. For example HDFT identified a period of increased mortality for stroke patients in November 2013 using this tool. With the small number of patients involved, this could simply be chance, but a clinical review was commissioned and the Deputy Medical Director reviewed the case notes of nine patients. The review found no serious concerns and one minor issue around intravenous fluid management which was followed up. The review also found many examples of good practice, particularly around the quality of

clinical note taking, frequent senior clinical involvement and involvement of families in making best interest decisions.

- The Performance Report which is reported to and discussed at every Board of Directors meeting and includes information about service activity and performance against targets, mortality, and the Care Quality Commission's Quality & Risk Profiles which were then replaced by "Intelligent Monitoring Reports" in Autumn 2013. See part three of this report for further information. Some of this information is based on data which by necessity relates to patient care in previous months. However the most up to date information available is included.
- Planned visits and inspections to gain feedback from staff and patients. See further detail below. Patient Safety visits are specifically undertaken to seek any concerns of staff relating to patient safety. Director inspections are unannounced opportunities to check wards and departments against various standards, and include seeking the views of staff and patients.
- Audits of service delivery undertaken to review specific issues and provide information about quality of care. An audit of the time to assess admitted patients was undertaken during 2013 which revealed delays affecting the quality of care provision. As a direct result, the availability of junior medical staff in the evenings was increased.

Director inspections

Unannounced Director inspections of all inpatient ward areas continue to be prioritised. A total of 29 inspections have been carried out during 2013/14. The area being inspected is assessed using set criteria related to standards that include cleanliness of areas and equipment, areas being free of clutter, correct management of IV cannulas, ward leadership, medication safety, staff and patient feedback. There are strict scoring criteria that result in a risk rating red, amber or green.

Of the 29 areas inspected, the initial results were that 17 were found to be risk rated green, one amber and 11 red. Those found to be red are all revisited and reassessed within two weeks to ensure remedial actions have been taken. In all cases, subsequent inspections resulted in a lower risk rating, with most scoring green.

Patient Safety Visits

An annual programme of safety visits and revisits to hospital departments, wards and community based settings is developed with the directorates. Since September 2009, 99 visits have been carried out with 20 visits between April 2013 and March 2014.

All staff are encouraged to participate and to identify any patient safety concerns that they might have. Any significant issues raised are immediately actioned if necessary and all the findings reported to the relevant directorate and the Executive Director Team. Resolution or appropriate management of risk is achieved in the majority of cases. Examples of good practice arising from the visits include good and effective teamwork, learning from regional and national events and implementation of local protocols to encourage good practice, implementation of patient contact rounds and staff reporting improved patient care as a result. Examples of improvements reported following patient safety visits include moving and handling training introduced as part of the Care Support Workers induction, increase in consultant cover on medical and elderly wards over the weekend, improvements to the hardware for electronic prescribing on wards, and customised local moving and handling training now available to ward staff.

The patient safety visiting team usually includes a Director and a Non-Executive Director, together with members of the Patient Safety Group. During 2013 Public and Staff Governors have participated in some of the patient safety visits. We are currently reviewing the process

to ensure appropriate follow up of issues raised to enable effective assurance to the Council of Governors.

Summary and further work

We have made good progress in some areas, for example the implementation of patient contact rounds has been achieved across all in patient wards, and we have had a successful nutritional focus week. Patient safety visits are giving valuable feedback about local safety issues and concerns.

There are some areas that require further work especially in relation to pressure ulcer prevention, and staff attitudes and communication. It is envisaged that the role of the Patient Safety Group within the governance framework of the Trust will be strengthened to enable stronger monitoring of key quality priorities such as falls reduction, pressure ulcer incidence and further embedding of a strong patient safety culture across the Trust.

Much of this work will be further developed in the coming year, but pressure ulcers have been specifically identified for further quality improvement across the Trust in 2014/15.

2.3. Statements of Assurance from The Board

1. Provision of relevant health services and income

During 2013/14 HDFT provided and/or sub-contracted 60 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 2013/14 represents 100 per cent of the total income generated from the provision of relevant health services by HDFT for 2013/14.

2. National and local audits

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Put more simply, clinical audit is all about measuring the quality of care and services against agreed standards and making improvements where necessary (NICE, 2011).

This means that clinical audit identifies the gaps in current practice and identifies areas for improvement. One of the most important aspects of the audit cycle is to re-audit to ensure that clinical care has improved.

National audits

During 2013/14 33 national clinical audits and four national confidential enquiry covered NHS services that HDFT provides. 19 audits are from the National Clinical Audit and Patient Outcome Programme and 14 are run by other organisations. During that period HDFT participated in 91% of the 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.

The national clinical audits and national confidential enquiries that HDFT was eligible to participate in during 2013/14 are shown in the list at Annex Three. The national clinical audits and national confidential enquiries that HDFT participated in during 2013/14 are in the

list at Annex Three. The national clinical audits and national confidential enquiries that HDFT participated in, and for which data collection was completed during 2013/14 are listed in 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 clinical teams review reports published following national clinical audits and national confidential enquiries and undertake a gap analysis prior to reporting action plans to the Trust's Standards Group. The reports of 22 national clinical audits were reviewed by HDFT in 2013/14 and HDFT intends to take the following actions to improve the quality of healthcare provided.

Adult Critical Care

As a result of the Intensive Care National Audit and Research Centre (ICNARC) report there are many interventions being undertaken to increase awareness of and improve management of sepsis within the wards. This will include training for medical staff which will be included as part of a package of essential training, based on NICE guidance on fluid management.

Emergency Medicine: Consultant sign off

An action plan has been developed as a result of the audit. Junior doctors are being informed at induction and teaching sessions of the importance of senior review prior to patient discharge. In order to allow junior staff to have patients reviewed by senior medical staff and/or Consultants, the job plans of Consultants and their hours has been reviewed. A review of the functionality of relevant information systems within HDFT is being undertaken in order to capture data on consultant "sign off".

Emergency Medicine: Severe sepsis and septic shock

Improvement in timeliness of physiological observations is expected by including the requirements in a training programme for nursing staff and the management of sepsis is to be included in the regular staff training programme for junior doctors. Individual case reviews will be undertaken to ensure appropriate administration of fluid management and antibiotic use.

Emergency Medicine: Fractured neck of femur

To improve the management of patients' pain, there is a focus on routine assessment of pain and the administration of appropriate analgesia including intravenous paracetamol. Monthly audits of pain management are to be undertaken over the next six months and the results reported back to the Emergency Department senior management.

Emergency Medicine: Renal colic

This audit demonstrated a need for a review of the current pathway for urological patients by the clinical teams within the Emergency Department and the Urology Department. Following the pathway review a re-audit will be undertaken.

Epilepsy management in the Emergency Department

Areas identified for improvement are the documentation of neurological assessments and observations on admission to the Emergency Department, and the documentation of a discussion regarding driving and alcohol intake. These areas are to be addressed through teaching within the department and reminders to all staff that assessments should be

completed. The introduction of the NICE pathway for epilepsy is to be included in the Emergency Department's clinical guidance folder on the Trust intranet for staff to access.

Parkinson's disease

The Trust participated in all elements of the National Parkinson's audit, which included patient management, physiotherapy, occupational therapy, and speech and language therapy. The multi-disciplinary team have highlighted several areas for improvement:

- The inclusion of leaflets on falls and bone health in the information pack given to patients.
- The development of a pathway with the Specialist Palliative Care Team for patients in the palliative stage of Parkinson's disease.
- Improve the timeliness of referral to physiotherapy.

Bowel Cancer

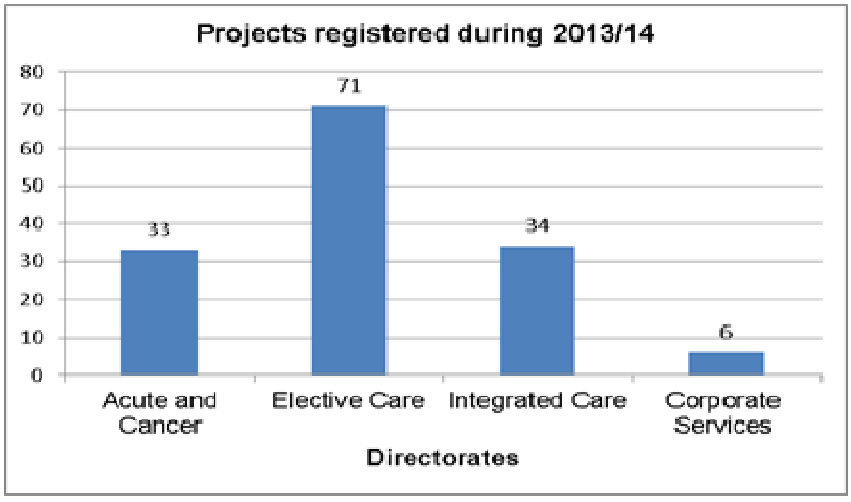
The results from the audit are used to benchmark practice and are used as part of the Cancer Peer review. The following areas all demonstrated good practice:

- Patients discussed at Multi Disciplinary Team meetings
- Patients seen by Clinical Nurse Specialist
- CT scans reported
- MRI scan reported

Local audits

154 projects (excluding national) audits were registered with the Clinical Effectiveness Department during 2013/14. This includes 29 projects aimed at improving quality by using service evaluation and patient experience surveys.

The results of local audits are presented at the directorate or specialty audit or governance meetings where the results and recommendations are discussed. Audits are defined as complete when a summary 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. During 2013/14 31 re-audits were undertaken.



The chart above shows clinical audit, service evaluation and patient surveys registered during 2013/14 by directorate.

The reports of 76 local clinical audits were reviewed by the provider in 2013/14 and HDFT intends to take the following actions to improve the quality of healthcare provided.

Management of diarrhoea in children under 5 years of age

In 2009 NICE published guidance on the assessment, diagnosis and management of gastroenteritis in children less than five years of age in order to promote best practice and continuity of care. Over the past three years departmental audits were undertaken at a local level to determine the compliance of Harrogate District Hospital's paediatric ward in treating children with gastroenteritis. The assessment of signs of dehydration, rehydration regime, discharge information and documentation were consistently reported as poor. The re-audit has shown some improvement:

- Better assessment and documentation of signs and symptoms of dehydration.
- Better fluid management both intravenously and using oral rehydration solution.
- Improved requesting of microbiology samples.

Further actions have been implemented to improve documentation by redesigning the clinical assessment document to include signs and symptoms identified as "red flags" for dehydration by NICE. A parent information leaflet has been developed and piloted with families.

Accuracy of completion of venous thromboembolism risk assessment

This audit followed on from an audit report in September 2012 on the accuracy of risk assessment forms for venous thromboembolism (VTE). The suggestions from that audit included completing the audit cycle, increasing the sample size to incorporate patients from other specialties and identifying whether the inaccuracies in the completion of the form affected the management of the patient.

In the re-audit, 90% of patients had a completed VTE risk assessment form in their notes, and although some patient risk factors were found to be omitted on the form this did not affect the management of the patients and the use of appropriate thromboprophylaxis. The table below shows the results of the audit.

Criteria	**Expected performance**	**Actual performance**
All patients have a completed VTE risk assessment form.	100%	90%
All clinical risk factors for thrombosis are recorded on the risk assessment form	100%	45%
All risk factors for bleeding are recorded on the risk assessment form	100%	94%
All patients are appropriately managed according to risk factors	100%	94%

The following actions have been implemented:

- All health professionals undertaking VTE risk assessment have been reminded of the importance of completing the form accurately.
- The risk assessment form has been amended to include a box to indicate that the patient has no thrombotic or bleeding risk factors.
- An emergency admissions proforma has been introduced for gynaecology which contains the VTE risk assessment form, acting as a prompt that risk assessment should be undertaken.
- All health professionals are reminded of the importance of checking the VTE risk assessment on the ward round following admission.

Regular audit of risk assessments and appropriate use of thromboprophylaxis are undertaken across the Trust and reviewed by the Thrombosis Committee.

Heavy menstrual bleeding

In 2010 the gynaecologists reviewed practice of the management of heavy menstrual bleeding as part of their local clinical audit programme, as opposed to participating in the national audit. The decision not to take part in the original national audit was because the Trust could not be confident that appropriate clinical audit standards would apply when initial details were supplied. The Trust's Standards Group approved the decision not to partake in the audit. In 2013/14 practice was reviewed again. Although some improvements were identified there remain some areas where more focus is required. The table below indicates the initial audit results and the re-audit.

Criteria	2010 Audit	2013 Audit
Clinical history documented	100%	100%
Physical examination	92%	79%
Full blood count	58%	34%
Ultrasound performed when indicated	48%	94%
Biopsy taken when appropriate	100%	100%
Surgical treatment offered appropriately	88%	89%

Assessment of patient pain

The purpose of this audit was to observe the frequency of pain assessment undertaken by nursing staff and to highlight areas for improvement. The Acute Pain Team have been aware that the assessment of pain and subsequent record of pain scores required improvement. Without assessment of a patient's experience of pain, their management may not be appropriate.

The initial audit focussed on the surgical wards and reviewed patients that had undergone surgery and were at least 48 hours post-operation. The results of the audit identified that pain scores were not routinely recorded in conjunction with other physiological observations, for example temperature and heart rate. In addition, where patients reported a high level of pain, it was not re-assessed in a timely manner. Results of the audit were fed back to the teams and a re-audit of surgical wards was undertaken after three months, which showed some improvement. Results of the surgical audit and re-audit are shown below.

Criteria	Expected performance	Surgical audit 1	Surgical audit 2
Pain scores are recorded on admission to ward	100%	47%	46.4%
Pain scores are recorded on return to ward following surgery and recorded with first set of observations	100%	53%	61%
Pain scores recorded with all observations	100%	3%	41%
Pain identified as a score of 7 or above is reassessed within 30 minutes (NB. small numbers in the audit samples)	100%	0%	50%

Following circulation of the audit results to the nursing teams the Acute Pain Team supported by the Matron for the area are delivering short training sessions on the wards. A pain assessment policy has been developed and an appropriate information cascade to all relevant staff. A pain assessment tool for patients with cognitive impairment has also been introduced.

Pain management has been identified as an area for the Trust to focus on for quality improvement in 2014/15. A bi-annual audit will take place across the Trust and include a review of the assessment and management of patients' pain.

The four audits listed below were led by Junior Doctors and were accepted for poster presentations at the regional Yorkshire Clinical Effectiveness and Audit Conference.

Antibiotic prophylaxis for urological procedures at Harrogate District Hospital

The Microbiology Department has produced clear guidelines on the use of prophylactic antibiotics for patients undergoing urological surgery. The aim of this audit was to determine if these guidelines were being adhered to. The audit consisted of patients that had undergone transurethral resection of the prostate (TURP), resection of bladder tumours (TURBT) and cystoscopy.

The results showed that 80-87% of patients undergoing TURP and TURBT received appropriate antibiotic prophylaxis, however the timeliness of the administration did not comply with the guidelines. Recommendations and actions from the audit were as follows:

- The current guidelines were updated to reflect that gentamicin dosing is to be done according to ideal body weight, and cystoscopy with ureteroscopy should always receive antibiotic prophylaxis, even when the urine is sterile.
- The timeliness of antibiotic administration is to be resolved through discussion with the surgeons and anaesthetists.
- A handbook including local guidelines and flowcharts will be provided to the junior staff. The outgoing junior doctor provided peer-to-peer induction to educate the incoming junior staff.

Management of patients with an acute upper gastrointestinal bleed

The initial audit of the presentation, initial management, endoscopy findings and post-endoscopy management of patients presenting with acute upper gastrointestinal bleeding (AUGIB) consisted of 30 patients. Practice was assessed against NICE guidance.

The risk assessment of patients using a specific (Rockall) scoring tool had improved from a previous audit but did not demonstrate good practice, and there were other areas of concern. Recommendations following discussion with gastroenterologists and surgeons were:

- A daily designated appointment space to be implemented in Endoscopy for AUGIB.
- A named endoscopist to be available for AUGIB in normal working hours
- Clarification of out-of-hours cover to be established
- Pre-endoscopic Rockall score to be added to the endoscopy request card
- Post-endoscopy Rockall score to be added to endoscopy reports
- Education of doctors on indications for proton pump inhibitor medication.

Some of the above recommendations were initiated prior to a re-audit of 11 patients.

Criteria	**Expected performance**	**Audit 1**	**Re-audit**
Risk assessment score recorded on admission (Rockall)	100%	61%	92%
Proton pump inhibitor given pre-endoscopy	Not recommended	79%	67%
Risk assessment score recorded post endoscopy (Rockall)	100%	5%	17%
Endoscopy performed within 24 hours	100%	45%	27%

A review of the timeliness of endoscopy has been repeated following the introduction of an operational policy within the Endoscopy Unit and practice will be reviewed as part of the Scope for Improvement project.

Tilt table audit 2013

Syncope is defined as transient loss of consciousness due to a transient global hypo-perfusion characterised by rapid onset, short duration and spontaneous complete recovery. It accounts for 1% of all Emergency Department referrals and out of these, 40% of patients are admitted to hospital. In the absence of a gold standard test to diagnose some types of syncope, it becomes extremely important that guidelines are followed appropriately. This in turn ensures that patients get the best level of care and that the organisation makes the best use of resources.

The audit sample consisted of 100 patients that were investigated using the tilt table test. This is a diagnostic procedure that creates changes in posture from lying to standing and can be used to assess syncope.

Criteria	Standard	Result
All patients should have the indication documented for having the tilt table procedure.	100%	97%
Only patients with a valid indication should have the tilt table procedure undertaken.	100%	75%
All patients should have a lying and standing blood pressure reading taken.	100%	80%
All patients should have an ECG as part of basic investigations.	100%	95%

Following the audit and presentation of results the recommendations and actions are listed below:

- Production of a proforma to be available on the medical wards and the Outpatient Department to decide if investigations and the tilt table procedure is appropriate
- Proforma and guidelines to be available on the intranet for diagnosing and managing syncope
- Re-audit once the proforma has been in place for one year
- Electrocardiogram (ECG) and lying and standing blood pressure to be recorded for all patients prior to attending clinic appointments.

Management of patients with unstable angina

The rationale for conducting this audit is to ensure that we are compliant with NICE guidelines for unstable angina (a type of recurring chest pain) and NSTEMI (non-ST-segment-elevation myocardial infarction, a type of heart attack). These are disorders in which patients have widely varying risks. Risk is an important “driver” of clinical management decisions, and accurate yet simple methods of risk assessment are important for patient care.

A sample of 52 patients were reviewed, and the recording of comorbidities (other illnesses), the appropriate use of physiological, haematological and biochemical tests was recorded. The main finding which required a change to practice was the assessment and documentation of a risk score (GRACE score) which is used to determine the need for angiography. This has been discussed in the clinical teams and a prompt for the risk to be assessed when the patient is admitted is to be implemented.

3. Participation in Clinical Research

Research remains a high priority for the trust as there is increasing evidence that active participation in research improves patient outcomes.

The number of patients receiving relevant health services provided or sub-contracted by HDFT in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 7,965.

A large proportion of this recruitment, 6,424 patients, can be attributed to a Harrogate based, internationally recruiting observational study affiliated to the James Lind Alliance Priority Setting Partnership (JLA PSP).

The Trust achieved the regional research target set in 2013/14. The continuing expansion of research into different clinical areas reflects investment in infrastructure, excellent collaboration between the Trust and the North East Yorkshire and Northern Lincolnshire Comprehensive Research Network (NEYNL CLRN) and a clear commitment by the Trust to support and participate in research.

Recruitment compares very favourably against the national average for small acute Trusts and has more than doubled over the past year. In addition Harrogate was recognised nationally as undertaking the highest number of studies within a small NHS Acute Trust in 2012/13. Recruitment locally has contributed to NEYNL CLRN achieving hatched green and green national ratings for recruitment to time and target for life sciences research.

The number of National Institute for Health Research (NIHR) research studies open as one of the treatment options for Trust patients is currently 69. Of these, 39% are randomised controlled trials, 12% are sponsored and/or funded by life science partners. The Trust Research Department has the goal of ensuring taking part in research is a choice for as many patients treated within the Trust as possible. With this goal in mind there is on-going work to track the treatment pathways of HDFT patients being treated in other centres to ensure that they also have access to research.

During the period April 2013 and March 2014 the number of dedicated staff participating in clinical research approved by a research ethics committee at HDFT increased from 40 to 92. The research conducted at HDFT now embraces 19 different clinical specialties. The Trust, in collaboration with NEYNL CLRN has continued to support training and education of clinical teams in 2013/14. Maintenance of a responsive workforce, with a mix of specialist and generic research staff enables the team to manage fluctuating workloads and reduces delays in study start up.

The Trust achieved the required 30 day target for study submission to NHS Permissions to be granted.

The Trust Research and Development (R&D) Group, chaired by the Medical Director of HDFT, ensures research strategy and developments are embedded in Trust governance structures and provides assurance regarding quality and safety.

The Research and Development Team provide a comprehensive support system for research teams and regularly monitor studies and report back to the R&D Group to ensure quality of study delivery. This year has seen the introduction of EDGE, a research management system which supports and improves the quality of research delivery in the NHS.

Raising awareness of research activity is vital for increasing participation in research. At HDFT research staff have worked with patient and public involvement representatives on a number of projects with this goal. This has been achieved through promotional materials on electronic screens in patient waiting areas, handing out information about research on International Clinical Trials Day including the “OK to ask” campaign, ensuring that front of house staff know how to refer on queries about research and displaying details of clinical research teams and on-going studies on a notice board located in main reception and in the

appropriate clinical area. In addition a number of patient/public groups have been involved in consultations with local academic researchers, for example a group of mothers of children with eczema contributed to the redesign of outcome measures for a project looking at the effectiveness of an educational intervention for eczema management. Two Foundation Trust Members have agreed to act as ambassadors for research within the Trust and the wider public.

The dermatology research team have led a successful James Lind Alliance Priority Setting Partnership for acne. A mixed group of clinicians and patients identified their top ten research questions after 6,400 submissions to the international survey.

A number of NIHR studies which recruited patients at HDFT have reported in the last year. An example is the venUS lV clinical trial, for which patients were recruited from primary and secondary care. The study compared four-layer bandage systems with two layer stocking systems in the treatment of venous leg ulcers. The results showed that there was no significant difference in healing times, but potential huge cost savings for the NHS. The overall cost of stockings is less than the bandage systems. Using stockings meant less nursing time to do dressings. Once the ulcer was healed and all patients were given stockings as a preventative measure those who had the stockings from the beginning kept using them and so the ulcer was less likely to come back in this group. The study concluded "increased use of hosiery as a treatment is likely to result in substantial savings for the NHS and improved quality of life for people with venous leg ulcers."

Trust staff remain abreast of the latest treatment possibilities and active participation in research has been shown to improve patient outcomes. Increasingly clinical staff involvement in research prompts changes to everyday practice. As an example, the use of income from research in pathology has enabled several staff to attend project management training. As part of their training they conduct various internal projects improving pathology services. Internally there has been less paper use and wastage, better stores management, reduction in waste and improved samples handling and processing.

Participation in clinical research demonstrates HDFT's commitment to improving the quality of the care it offers, testing and offering the latest medical treatments and techniques and to making a contribution to wider health improvement.

4. Use of the Commissioning for Quality and Innovation Framework

A proportion of HDFT income in 2013/14 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 2013/14 and for the following 12 month period are available electronically at:
http://www.hdft.nhs.uk/about-us/commissioning-for-quality-and-innovation-cqin/

The monetary total for the amount of income in 2013/14 conditional upon achieving quality improvement and innovation goals was £2,984,000.

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 2013/14:

- Harrogate District Hospital
- Lascelles Unit
- Ripon Community Hospital
- HMP Askham Grange
- HMP Northallerton.

The Care Quality Commission has not taken enforcement action against Harrogate and District NHS Foundation Trust during 2013/14.

HDFT has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

6. Information on the Quality of Data

HDFT submitted records during 2013/14 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:

- 99.5% for admitted patient care
- 99.7% for outpatient care
- 96.0% for accident and emergency care

Patient's valid General Practitioner Registration Code was:

- 99.8% for admitted patient care
- 99.8% for outpatient care
- 99.7% for accident and emergency care.

7. Information Governance

HDFT's Information Governance Assessment Report overall score for 2013/14 was 84% and was graded satisfactory/green. The Trust reported 111 out of 132 standards at level two or above (there are three levels with level three being the highest), compared to 104 out of 132 in 2012/13.

8. Payment by results

HDFT was not subject to a Payment by Results clinical coding audit in 2013/14 by the Audit Commission. However the Trust commissioned an external clinical coding audit to meet Information Governance requirements. The audit was carried out in January 2014 by nationally registered clinical coding auditors from D & A Clinical Coding Consultancy Limited. An audit sample of 200 episodes was reviewed, 75 randomly selected Elderly Care episodes, 75 randomly selected Urology episodes and 50 randomly selected Gynaecology episodes, from across the whole range of activity for the period July – September 2013. The results showed an overall error rate (coding errors affecting the Healthcare Resource Group (HRG)) of just 3% compared to the latest published national average error rate of around 9%. 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 4.5%
- Secondary procedures 7%
- Primary diagnoses 5.5%

- Secondary diagnoses 5.1%
- An overall combined diagnostic and procedural error rate 5.5% (2.5% of the error rate did not affect the HRG as described above)

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 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 table 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 (H+SCIC).

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 1.0000 – a Trust score significantly above 1.0000 indicates higher than expected death rates, whereas a score significantly below 1.0000 indicates lower than expected death rates.

SHMI (Summary Hospital Level Mortality Indicator)		
	Data period	
	Jul 12 to Jun 13	Oct 12 to Sep 13
HDFT value	0.9848	
HDFT banding	2 (as expected)	
National average	1.0000	
Highest value for any acute Trust	1.1563	
Lowest value for any acute Trust	0.6259	

Oct 12 to Sep 13 data due for publication late April 2014

Note - highest and lowest trust scores include all providers with data published by H +SCIC

HDFT's latest published score of 0.9848 is within the expected 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 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:

- 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 is participating in an Academic Health Service Network (AHSN) project and regional mortality review group evaluating methods of clinical review with a view to sharing learning.

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.

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

	Data period	
	Jul 12 to Jun 13	Oct 12 to Sep 13
HDFT value	14.8	
National average	20.3	
Highest value for any acute Trust	44.1	
Lowest value for any acute Trust	0.0	

Oct 12 to Sep 13 data due for publication late April 2014

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

HDFT's latest published score of 14.8% 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 palliative care coding 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:

- Investing in specialist palliative care provision by increasing the hours and resource available to provide the service to patients in hospital.

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.

PROMs - Patient Reported Outcome Measures

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

	Data period		
	2011/12 (final)	2012/13 (provisional)	Apr-13 to Sep-13 (provisional)
HDFT value	0.083	0.088	0.076
National average	0.087	0.085	0.086
Highest value for any acute Trust	0.143	0.119	0.138
Lowest value for any acute Trust	0.030	0.021	0.019

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

	Data period		
	2011/12 (final)	2012/13 (provisional)	Apr-13 to Sep-13 (provisional)
HDFT value	Data suppressed due to small numbers	Data suppressed due to small numbers	Data suppressed due to small numbers
National average	0.095	0.093	0.102
Highest value for any acute Trust	0.167	0.023	0.094
Lowest value for any acute Trust	0.049	0.175	0.058

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

	Data period		
	2011/12 (final)	2012/13 (provisional)	Apr-13 to Sep-13 (provisional)
HDFT value	0.426	0.427	0.397
National average	0.416	0.438	0.447
Highest value for any acute Trust	0.470	0.538	0.492
Lowest value for any acute Trust	0.318	0.319	0.373

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

	Data period		
	2011/12 (final)	2012/13 (provisional)	Apr-13 to Sep-13 (provisional)
HDFT value	0.336	0.327	0.355
National average	0.302	0.319	0.339
Highest value for any acute Trust	0.371	0.376	0.429
Lowest value for any acute Trust	0.181	0.195	0.264

Note - highest and lowest Trust scores exclude independent sector providers and PCT providers

2012/13 and 2013/14 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 national average for groin hernia surgery and hip replacement surgery, and above national average for knee replacement surgery.

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 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.

Emergency readmissions to hospital within 28 days

This data looks at the percentage of patients who are readmitted to hospital as an emergency within 28 days of being discharged. The data is standardised by the Health & 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.

Emergency readmissions to hospital within 28 days
Age 0-15

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

Age 16+

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

2011/12 data published Dec-13
2012/13 data due Dec-14

Note - the data for 2009/10 and 2010/11 has been re-standardised by HSCIC and so will not correlate with the data in last year's Quality Account

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 actions 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.

3. Ensuring that people have a positive experience of care

Inpatient survey

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 presented out of 100 with a high score indicating good performance.

Inpatient survey - responsiveness to inpatients' personal needs

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

	Data period		
	2011	**2012**	**2013**
HDFT value	69.2	72.3	
National average	67.3	67.4	
Highest value for any acute Trust	73.2	72.3	
Lowest value for any acute Trust	56.7	56.5	

Composite score for 2013 awaited from H+SCIC

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 quality improvement 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 nutrition and communication
- These standards are monitored through a governance system which includes Matrons' audits and meetings, unannounced Director led inspections, Patient Safety Visits, local Quality of Care Teams and the Trust's Standards Group
- 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:

- The implementation and review of a detailed action plan relating to both the most recent 2013/14 survey and 2012/13 survey will continue through the Trust's Standards Group with accountability for the delivery of the plan sitting with the Trust's Clinical Directorates
- The use of patient feedback through the full implementation of the national Friends and Family Test from April 2013 will enable further improvements to be made
- The introduction of quality initiatives for cascading information on performance improvements and areas for focus, delayed discharge, infection control will be implemented through a group leading work to develop inpatient quality and performance notice boards.

National Staff Survey – Standard of Care Provided

The data (shown in the table below) 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 2013. The Trust achieved a ranking of the highest (best) 20% when compared with all acute Trusts for this Key Finding.

	Data period		
	2011	**2012**	**2013**
HDFT value	76	73	77
National average	60	63	65
Highest value for any acute Trust	89	86	94
Lowest value for any acute Trust	33	35	40

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

- The Trust was the subject of a Care Quality Commission Inspection using their new inspection model to look at acute services. Overall, it found that Harrogate District Hospital provided care that was safe, effective, caring, responsive and well-led. The hospital was clean and it had systems in place for infection control.
- The Trust has gained accreditation in the key service areas of Stroke and Endoscopy, as well as receiving Investors in People accreditation which all endorse the service we deliver increasing staff confidence in their own departments and the Trust generally.
- The Trust's ethos places patients and staff and the delivery of the highest standards of care at the centre of its work, demonstrated through the Trust's vision and objectives, embedded in the Trusts values and behaviours. These run throughout the Annual and Business Plan as well as the Quality objectives.
- The Trust has increased the two way channels of communication between its senior managers and patients and staff. There are more Director Walkabouts; staff have regular access to senior managers both throughout acute and community settings. There are regular Team Briefs, Listening Events, Patient Safety Visits, Director Inspections where patients are specifically spoken to about their experience of the Trust and an Ask the Directors' email facility, all which focus on a culture of sharing and learning with an emphasis on improving patient safety, incident reporting and promoting a culture of openness.
- Overall, the Trust has received positive results in the national in-patient and other patient related surveys.

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

- Reaccreditation of Investors in People. Identifying areas of continuous improvement and demonstrating the link between training and development and patient outcomes and safety. This develops staff confidence in our services.

- Rapid Improvement Programmes where service improvement and innovation projects take ideas from members of the workforce and then apply lean methodology to improve services for staff and patients and heighten confidence.
- Encouraging all our Governors to have a greater role within the Trust through attendance at various patient safety/experience related events.
- Visits by Directors to a number of locations across North Yorkshire where we provide services, with the aim to specifically listen to staff.
- Participated in a Dementia Collaborative with other local service providers to improve services for people with dementia.
- Provided more services closer to people's homes to improve access for patients and people that use our services.

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

VTE (venous thromboembolism) risk assessment

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

VTE risk assessment - % eligible admitted patients risk assessed for VTE

	Data period		
	Q1 2013/14	**Q2 2013/14**	**Q3 2013/14**
HDFT value	96.5	97.4	97.8
National average	95.4	95.7	95.8
Highest value for any acute Trust	100.0	100.0	100.0
Lowest value for any acute Trust	78.8	81.7	77.7

http://www.england.nhs.uk/statistics/statistical-work-areas/vte/

HDFT's published scores have been above the national average for the whole year.

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 Information and Clinical 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:

- Identifying wards with poorer performance and examining whether there are issues with completion of the risk assessment or inputting of information onto ICS
- Continued scrutiny of results at Director level via the Trust's Performance Group

Clostridium difficile (C.diff) rates

The data shows the rate per 100,000 bed days of cases of C.diff infection (CDI) reported amongst patients in hospital who are aged two years or over. A low rate is good.

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

	Data period		
	2010/11	**2011/12**	**2012/13**
HDFT value	14.6	10.3	20.8
National average	29.7	22.2	17.3
Highest value for any acute Trust	71.2	58.2	30.8
Lowest value for any acute Trust	0	0	0

Data source:

http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/ClostridiumDifficile/EpidemiologicalData/

Note - the data for 2010/11 and 2011/12 has been re-calculated by Health Protection Agency and so will not correlate with the data in last year's Quality Account

HDFT's latest published score is above the national average.

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

- The Trust has an extremely robust diagnostic testing protocol which uses four stages to identify cases. Data is to be presented at an international scientific meeting later in 2014 to show that this approach identifies 30% more cases than would be diagnosed if the Trust were to follow Public Health England nationally mandated protocol which proscribes a two-stage protocol.
- All cases of CDI and most cases of *C. difficile* colonisation are subject to genetic fingerprinting using ribotyping and, if indicated, more detailed genetic analysis.
- All confirmed cases are closely scrutinised through the Trust's internal reporting mechanisms and subject to root cause analysis including, as appropriate, input from primary care and then reported to Public Health England, Monitor and commissioning organisations
- The Trust's commitment to preventing C. diff through the key strategies of high levels of environmental cleanliness, high standards of staff and patient hand hygiene, an effective antibiotic stewardship programme and education and awareness for staff and to the public remains unchanged. A comprehensive *C.difficile* strategy has been strengthened by, for example, extension of the working hours of the Deep Clean Team, the purchase of mobile handwash stations and introduction of PCR-based testing (polymerase chain reaction).

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

- Future scrutiny of potential cases by the internal *C. difficile* Case Attribution Panel to ensure that cases reported by the Trust satisfy, in full, the national criteria for the diagnosis of *C. difficile* infection

- Ensuring the prompt isolation of any patient with unexplained loose stools within specific Trust standards
- Further developing the Trust's antibiotic stewardship programme through further exploitation of the capabilities of the electronic prescribing system.

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

Patient safety incidents

	Apr 12 - Sep 12			Oct 12 - Mar 13		
	Rate of incidents reported (per 100 admissions)	Incidents that resulted in severe harm or death		Rate of incidents reported (per 100 admissions)	Incidents that resulted in severe harm or death	
		Number	Rate (per 100 admissions)		Number	Rate (per 100 admissions)
HDFT value	6.42	4*	0.20	7.28	3	0.20
National position (all acute trusts)	7.01	3390	0.72	7.76	3239	0.68
Highest value for any acute Trust	24.88	98	3.60	30.95	114	4.75
Lowest value for any acute Trust	1.37	0	0.00	1.68	0	0.00

***** Please note this figure is inaccurate and should be 5. This case has been reported through NRLS but central data not updated to reflect.

Data source:

http://www.nrls.npsa.nhs.uk/resources/

HDFT's latest published scores are below the national average for all three measures.

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.

In addition the Trust can report an updated position up to September 2013. Incidents reported by degree of harm in this period were two graded as severe, and one that resulted in death. All three have been investigated as serious untoward incidents, and actions to address the findings put in place.

Please note that the time period described here is different to that in part one of this Quality Account.

3. OTHER INFORMATION

3.1. Review of Quality Performance

This section provides an overview of the quality of care offered by HDFT based on performance in 2013/14 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
- Clinical effectiveness
- Patient experience

We have included some of the same indicators that were included in the 2012/13 Quality Account in order to report ongoing work and progress. Some of the indicators previously reported in this section in 2012/13 have been part of the key priorities for 2013/14 and are reported in part 2. We have also introduced a few new indicators.

3.1.1. Patient Safety

1. Care of the deteriorating patient

It is essential that the severity of a patient's condition is identified early, and that there is a timely and competent clinical response to their needs. This would include review by more senior staff if required.

In January 2013, the new National Early Warning Score (NEWS) was rolled out across the Trust. One of the main aims of this project was to ensure a uniform approach across the whole of the NHS in England, so that healthcare professionals in a variety of settings would use the same assessment and scoring system for their patients, ensuring better communication and a common language amongst teams. In addition to the NEWS score, a standardised nursing observation chart was developed so that staff moving between different trusts are familiar with this essential documentation.

Although the NEWS system is standardised across England, the responses to the scores obtained are decided locally to fit the resources available. Therefore as NEWS was rolled out across the Trust, each clinical area designed their own appropriate response levels. For example, a patient with a certain score in Harrogate District Hospital may require a review by a doctor within fifteen minutes, whereas a similar patient in a community setting would require a "999" ambulance call.

Prior to its introduction, a significant educational program was put in place to ensure that all staff were aware of the significant change in practice. Six months after its introduction, a scoping exercise was performed to explore any problems which had emerged since its launch. As a result of this exercise, a few minor modifications of the chart were made to improve the ease of use.

In January 2014, an in-depth audit of the escalation pathways for adults, paediatrics and maternity was undertaken by Internal Audit, who gave an opinion of significant assurance. It was noted that significant improvement had been achieved regarding improved compliance with the documentation of patient escalation since the introduction of the new policy, although further work is still required.

The results show:

Audits of escalation of deteriorating patients	July 2011	April 2014
Episodes with an Early Warning Score of 3 or 4, or NEWS of 3 or above had observations repeated in line with policy	24% (26/107)	41% (21/51)
Observations and NEWS score recorded accurately	No data available	84% (43/51)
Escalation documented	24% (30/123)	61% (31/51)
Episodes reviewed by medical staff	72% (89/123)	98% (50/51)
Timeliness of review	29% (26/89) within 30 minutes	74% (23/31) within 1 hour

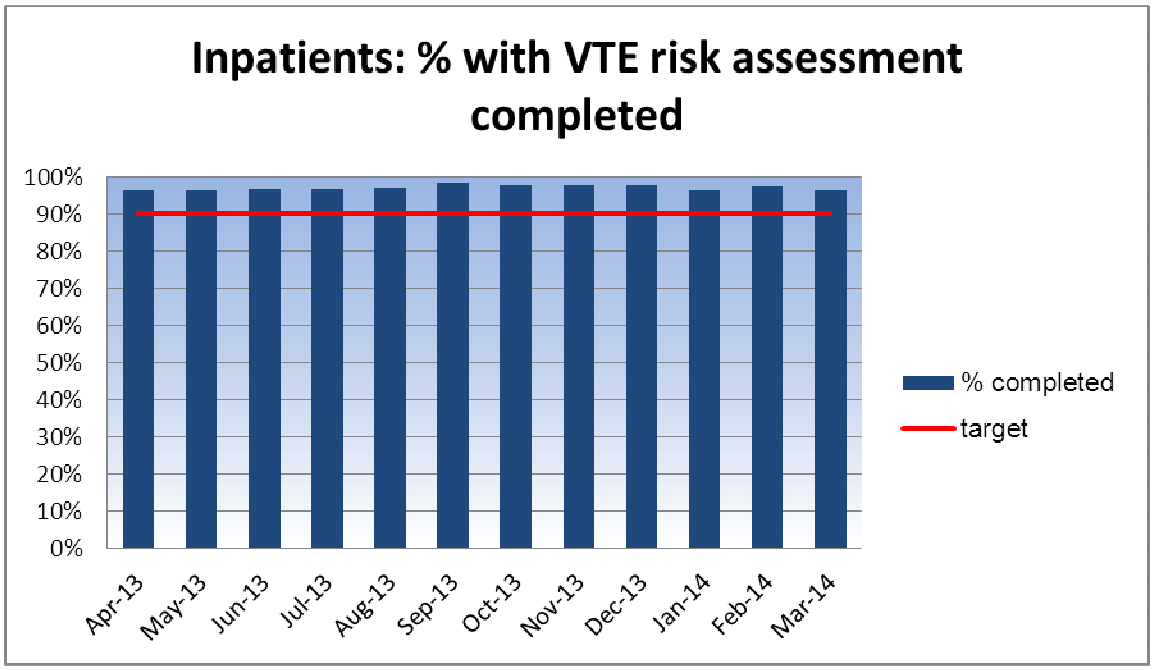
Data source: HDFT

Whilst this demonstrates a significant improvement from the last audit (especially confirmation that 98% of triggers were reviewed by a doctor) there is still room for improvement, in particular relating to the timeliness of both review and repeated observations and the documentation of all escalations performed.

To ensure improvement, we are currently planning to move away from paper recording of patient observations to an electronic system which will automatically trigger an appropriate response. This should represent another significant advance in ensuring that prompt and effective care is delivered to all our patients.

2. Venous thromboembolism (VTE) risk assessment and root cause analysis

VTE includes deep vein thrombosis (DVT) and pulmonary embolism (PE), types of blood clots that are important causes of morbidity and mortality in hospitalised patients. Our aim this year has been to maintain compliance with the target of at least 95% of all adult admissions having a risk assessment, and to introduce a process to review and undertake a root cause analysis of possible cases of hospital associated thrombosis (HAT).



Data source: HDFT

HAT is defined as any new episode of VTE diagnosed during hospitalisation or within 90 days of discharge following an inpatient stay of at least two days, or following a surgical procedure.

Undertaking root cause analysis (RCA) of every case of HAT is a major challenge which requires data capture, engaging with stakeholders to undertake a structured analysis of why the thromboembolic event happened and then feeding lessons learned back into the Trust quality management framework.

The Trust introduced such a process in 2013 and the results are below:

Results of VTE RCA 2013/14	**Q1**	**Q2**	**Q3**	**Q4**
Total number. of VTE cases diagnosed	41	47	49	
Number. of potential HAT identified	14	13	20	
Number of RCA completed on potential HAT	13	13	15	
Number confirmed as HAT	9	7	12	
Root causes identified				
Inadequate thromboprophylaxis	1	2	0	
Thromboprophylaxis failure	6	3	11	
Contraindication to all thromboprophylaxis	0	1	0	
Contraindication to chemical thromboprophylaxis	0	1	0	
Line associated	0	0	0	
Unexpected	2	0	1	
HAT cases potentially preventable	1	2	0	
% HAT cases potentially preventable	11.1%	28.6%	0.0%	

Data source: HDFT (Quarter 4 data awaited)

The root cause definitions are taken from the National VTE Registry:

- Inadequate thromboprophylaxis: patient with high risk of VTE and any unexplained omission in chemical thromboprophylaxis e.g. missed doses, wrong dose, delay in starting thromboprophylaxis, failure to prescribe thromboprophylaxis, inadequate duration of thromboprophylaxis.
- Thromboprophylaxis failure**:** patient with high risk of VTE who was prescribed and administered chemical thromboprophylaxis as indicated.
- Contraindication to all thromboprophylaxis**:** patient with both VTE and bleeding risk who also have contraindications to mechanical thromboprophylaxis e.g. stroke patients.
- Contraindication to chemical thromboprophylaxis**:** patient with both VTE and bleeding risks (without contraindication to mechanical thromboprophylaxis) e.g. thrombocytopenia (low platelets).
- Line-associated**:** DVT associated with any central indwelling catheter irrespective of VTE or bleeding risk.
- Unexpected: patient with low risk of VTE

The learning identified from this process has been shared with clinical staff and includes:

- Reminding staff that risk assessment must be completed accurately on all relevant cases
- Ensuring timely prescription of thromboprophylaxis following risk assessment for patients at risk. This is a multidisciplinary responsibility and should be checked on ward rounds

- Reviewing orthopaedic thromboprophylaxis guidelines
- Reviewing evidence for weight-based dosing for dalteparin thromboprophylaxis.

3. Falls prevention

In 2012/13 we reported an improvement in the availability, delivery and uptake of falls prevention training, and a significant improvement in risk assessment and documentation. However the impact of this on preventing falls was not as successful as we had hoped. Falls prevention has therefore continued to be a safety priority during the past year that is being monitored carefully.

Unfortunately we have more reported falls in 2013/14 than last year. It is difficult to ascertain if this is due to more falls, better reporting or elements of both.

However, when we look at falls causing harm, the numbers are more positive.

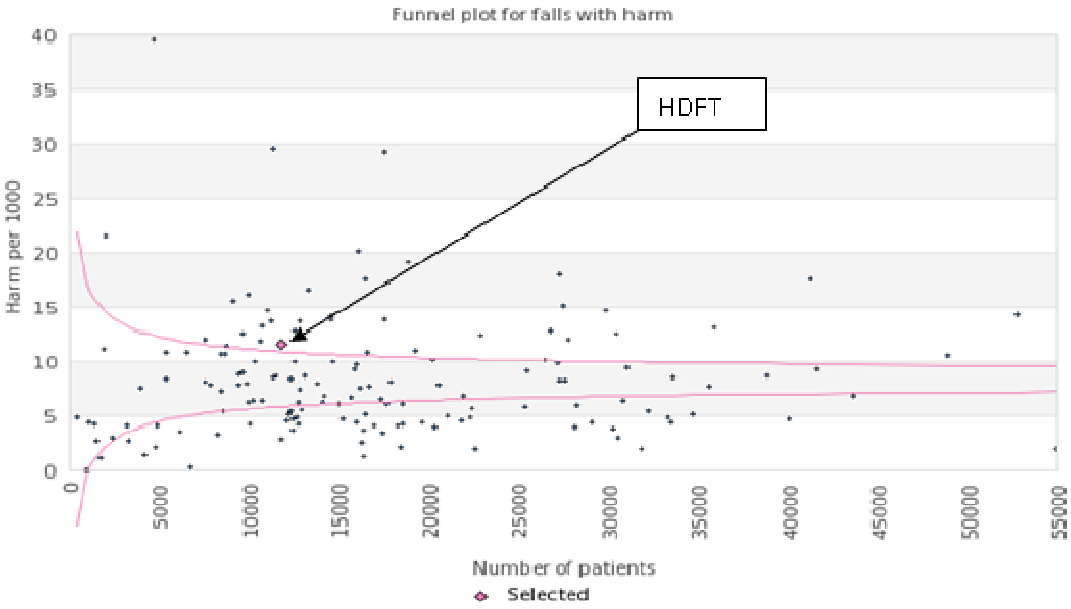
	2011/12 (Apr – Feb)	2012/13 (Apr – Feb)	2013/14 (Apr – Feb)
All Reported (inpatient) Falls	783	891	904
Harmful Falls	273	280	234
Fractures	13	16	12

Data source: HDFT local incident reports

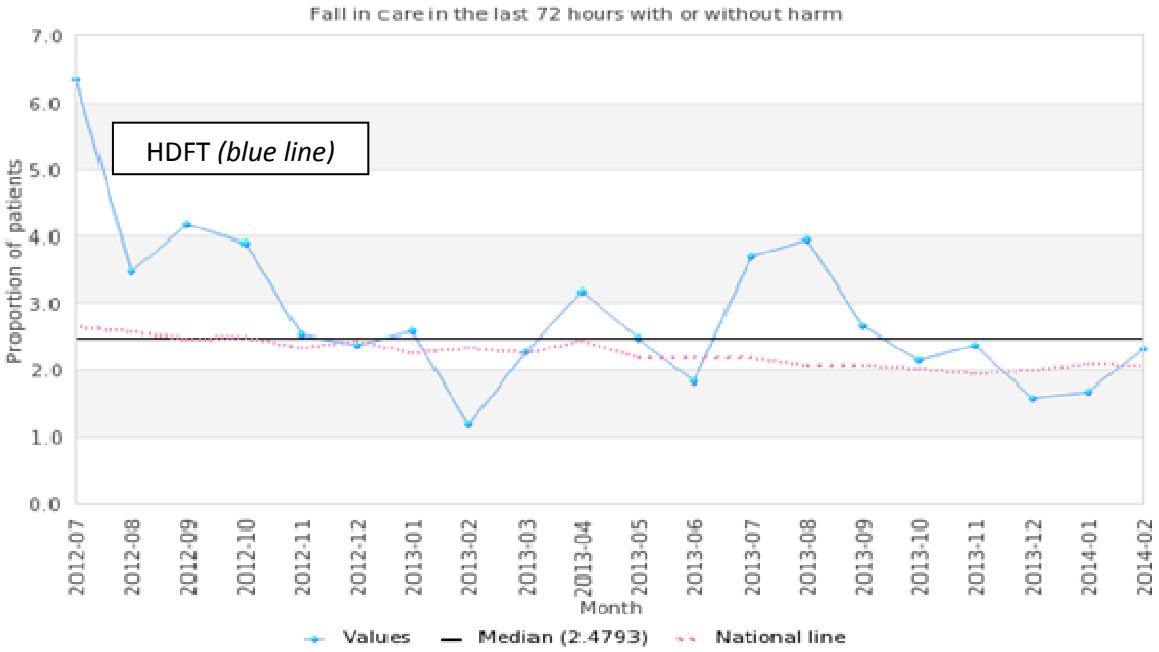
When this is converted to demonstrate the rate of falls per 1000 occupied bed days (OBD) it reflects the same picture of higher reported falls with less harmful outcomes:

	2012/13 (Apr – Feb)	2013/14 (Apr – Feb)
Falls Rate *(per 1000 OBD)*	9.49	10.22
Harm Rate *(per 1000 OBD)*	2.98	2.64

The NHS Safety Thermometer data which is a snapshot of falls over a period of time each month shows the organisation as slightly outside the expected level of harmful falls as at the end of February.



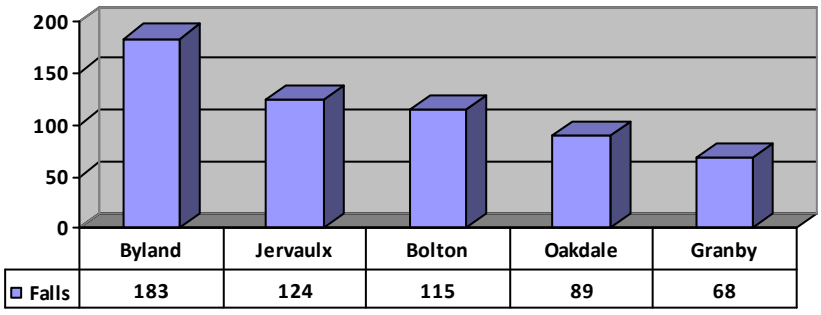
Data Source: NHS Safety Thermometer



Data Source: NHS Safety Thermometer

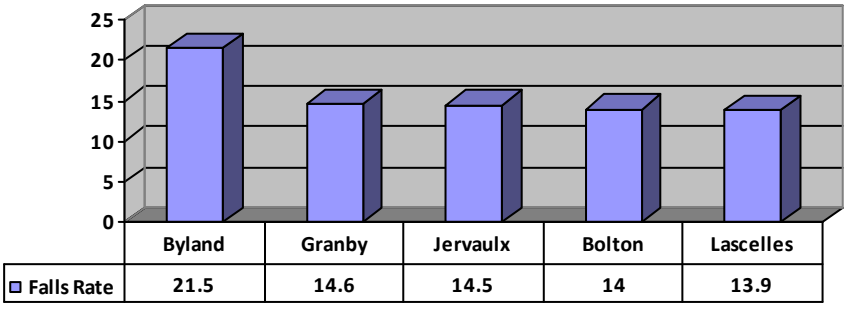
It is important to note that the NHS Safety Thermometer data only represents the previous 72 hours of care on the audit day each month and is not representative of actual numbers of falls and harm. It also includes data from community teams and therefore is not exclusively relating to inpatients.

Monitoring the breakdown of falls numbers and rates by location is an ongoing process and the following areas have been identified as the five areas with highest levels of falls during 2013/14:



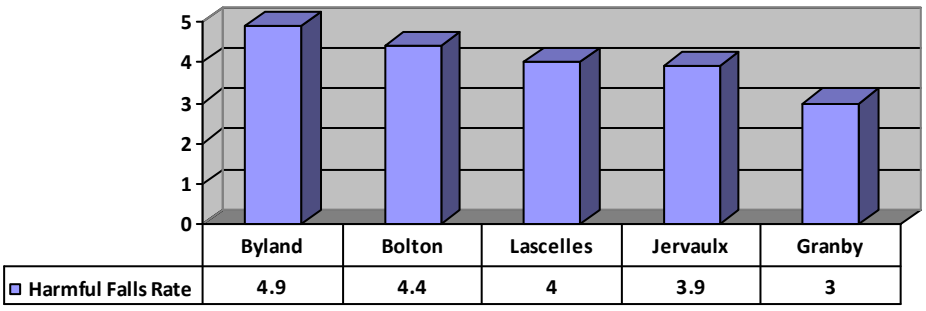
Data from 1st April 2013 – 28th Feb 2014

However, when the number of falls is calculated against the number of occupied bed days to obtain a falls rate (number of falls per 1000 OBD) the order changes slightly:



Data from 1st April 2013 – 28th Feb 2014

When the number of falls resulting in harm is calculated against the number of occupied bed days to obtain a harmful falls rate (number of falls causing harm per 1000 OBD) there is another change:



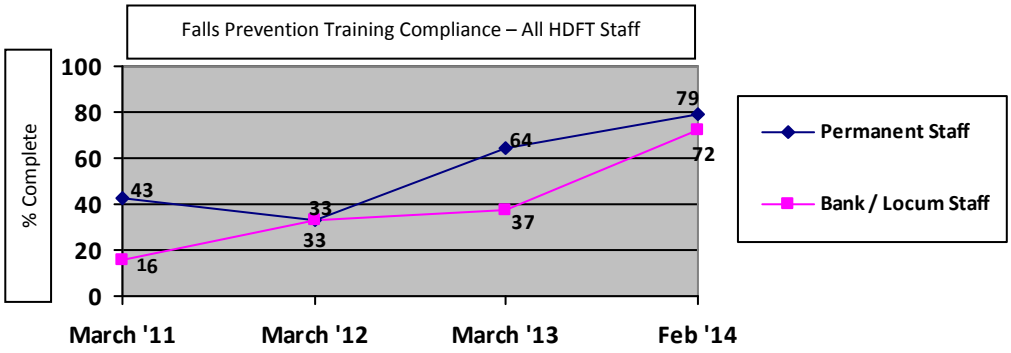
Data from 1st April 2013 – 28th Feb 2014

Data Source: HDFT

Although all the ward areas that appear with the worst numbers for falls, rate and harm it is important to note that this would be expected as all are wards with the highest population of patients with multiple risk factors for falls, for example elderly and frail patients.

Two other priorities identified by the Trust are to improve falls prevention training compliance and documentation compliance.

Training compliance is steadily improving overall with the Trust overall now at 79% compliance for substantive staff.



Data Source: HDFT

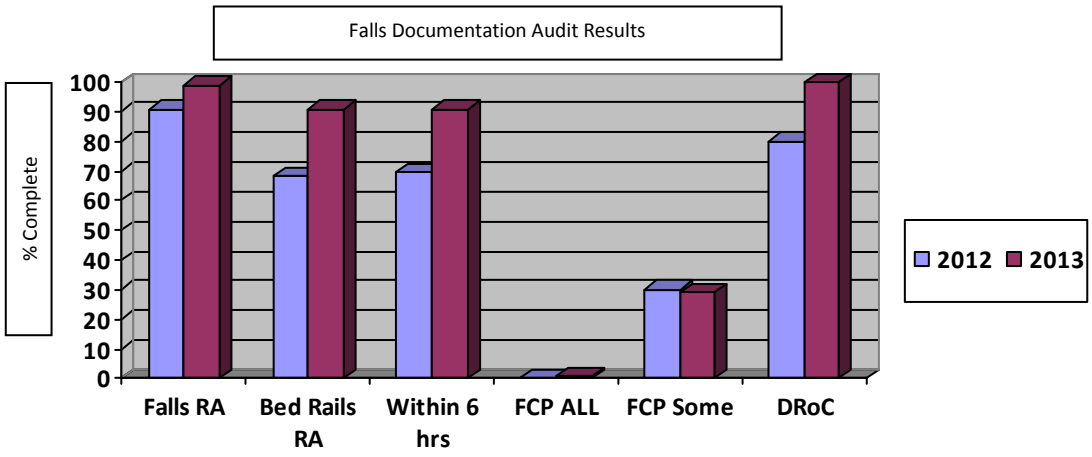
Training is now available via e-learning, face to face sessions, quarterly drop in sessions or can be directly arranged with the Falls Co-ordinator. Community based sessions are also provided and can be delivered jointly with clinical handling training where required. Falls prevention is now also included in the Care Support Worker induction training.

Documentation compliance is also improving in parts. The annual falls documentation audit in November 2013 demonstrated the following improvements from the previous audit:

Audit area	Total Compliance	Improvement
Falls Risk Assessment	98.7%	8% increase
Bed Rails Risk Assessment	90.8%	22% increase
Risk Assessment complete within 6 hours of admission	90.6%	21% increase

Data Source: HDFT

There has also been an improvement in the daily record of care (DRoC), however, the documentation of care planning continues to be poor despite changes being made to the fundamental care plan (FCP).



Data Source: HDFT

This clearly demonstrates that although there have been improvements in compliance of documentation completion relating to risk assessment and an appropriate daily record of care, there remains a significant issue with the documentation of planning care for falls prevention.

This has already been highlighted with Matrons and Ward Sisters and a radical change to the falls section of the fundamental care plan has been approved by the Trust's Documentation Group.

Recent and ongoing activities and developments include:

- Harrogate District Hospital is a pilot site for the national Royal College of Physicians Falls and Fragility Fracture Audit Programme Inpatient Falls Audit. The audit was completed in February 2014, and results demonstrate areas already acknowledged as requiring significant improvement, including medication reviews, postural blood pressure monitoring and care planning.
- Movement alarms for all inpatient ward areas are to be purchased in April 2014 following a successful pilot in 2013.
- A pilot scheme to review medication has commenced on Jervaulx and Byland Wards, and has included a baseline audit of medication review completion. The audit has demonstrated low levels of medication reviews conducted and/or documented. Ways to improve referral to the pharmacist for review are currently being discussed.
- Integrated working with voluntary organisations within the Trust has begun to provide exercise and stability classes for the high risk patient group. An initial trial in Ripon has been successful but there are some issues to resolve with transport and ensuring the facility is used to capacity. A location is now being sought for an additional class in the Harrogate area and then patients will be recruited into the scheme.
- The community falls assessment tool has been redesigned and a pilot of the new document commenced.
- Changes to documentation have been made to reflect NICE guidance on risk assessment and to reflect the issues established from previous audits.

- Improvements have been made to reflect the reclassification of falls resulting in fracture to a serious untoward incident from June 2014, including updating the root cause analysis template and the provision of training.
- A business case is in development for a falls prevention programme based on the national FallSafe project with support from the Royal College of Physicians Clinical Effectiveness and Evaluation Unit. This is a large quality improvement project and requires commitment and financial support from the Trust. The project plan is being drawn up and some initial streams of work have commenced:
    - Audit work to review any potential under reporting of falls for establishing a baseline.
    - Work to enable the immediate provision of walking aids.
    - Documentation review to reflect the FallSafe care bundles.
    - New data analysis to assist ward areas to focus on significant themes, including the most common time and location of falls.

Future work

Further work is already being progressed to further improve the assessment of risk in relation to slips, trip and falls and to improve the information available to investigate incidents of falls more thoroughly. The falls pathway is to be redesigned and a multidisciplinary falls prevention passport developed. Falls prevention training is to be introduced into induction training for clinical staff, and collaborative training is planned with care homes to improve falls prevention and reduce hospital admissions. In addition a new service is being developed in conjunction with Yorkshire Ambulance Service to reduce hospital admissions.

3.1.2. Clinical Effectiveness

1. Stroke care

The care of patients who have had a stroke has been a priority for the Trust for some time. The stroke data reported in 2012/13 showed a marked improvement and the Trust aimed to remain at or above the national average for the relevant indicators. In addition the Community Stroke Team was introduced in 2012 and a review was planned to enable progress to be evaluated and further improvements to be prioritised.

In our 2012/13 account we reported that the Stroke Improvement National Audit Programme (SINAP) data was not to continue in the future, and further information would be recorded in the Sentinel Stroke National Audit Programme (SSNAP), a larger data collection covering not just the first 72 hours of care for stroke patients but the full care pathway. This was initially looking at the acute hospital phase but it will subsequently be expanded to also include information on the post discharge period.

The Trust has fully participated in collecting and submitting the data for SSNAP. The third pilot SSNAP report was issued to participating Trusts in January 2014 prior to wider publication of the national results. The pilot report looks at data for the period July to September 2013.

Results are presented in 10 domains covering 45 key indicators and looking at all aspects of stroke patients' care in hospital including arrival and diagnosis, treatment and rehabilitation.

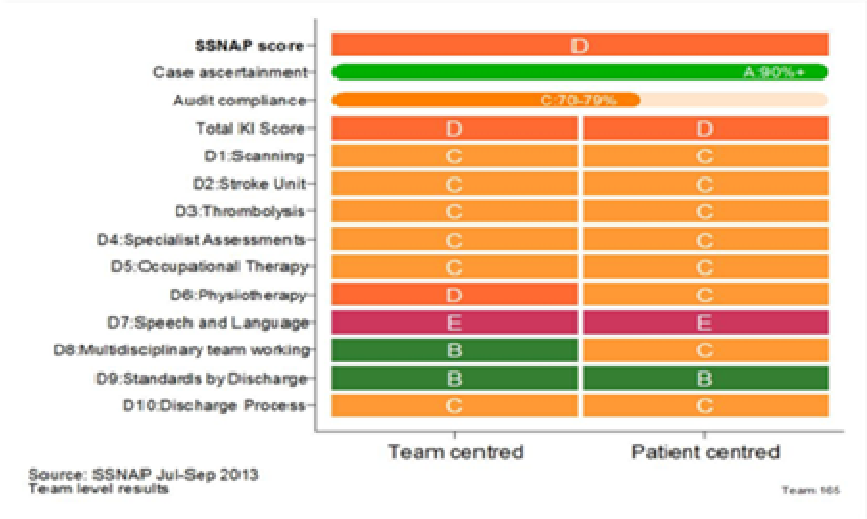
Each participating Trust is given an overall SSNAP score (a banding from A to E). HDFT has been assigned an overall rating of D this quarter, compared to E last quarter. As can be seen in the chart below, only 15% of participating Trusts scored a rating of A to C. Out of 178 trusts who submitted data this quarter, none scored in the highest band of A, eight scored B, 19 scored C, 74 scored D and 77 scored E. All trusts in the Yorkshire & Humber region scored either D or E.

100% of eligible patients were thrombolysed during the period and the number of patients scanned within 1 hour continues to improve (from 41% for the previous two quarters) and was 45% for the most recently published SSNAP data which related to July – September 2013, compared to a national average of 41%.

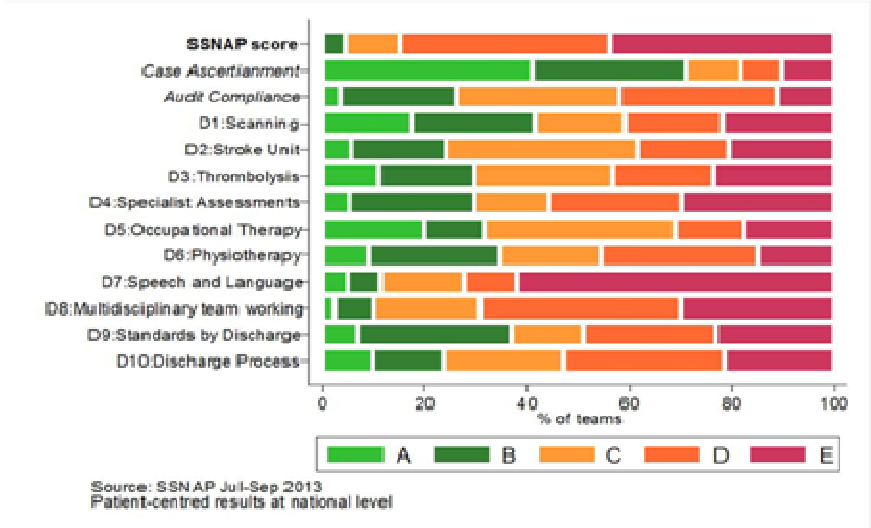
We continue to perform better than average on the number of patients spending >90% of their time on an appropriate stroke ward. We also score significantly better than average for the "discharge processes" indicator section.

However despite significant improvements in thrombolysis rates, the Trust still performed worse than average on the number of patients thrombolysed within 1 hour. It is anticipated that the introduction from September 2013 of the stroke specialist nurse attending the Emergency Department for every stroke patient will contribute to improving this position going forwards.

HDFT performs particularly well on the two domains (D9 and D10) related to discharge. The lowest scoring domain for HDFT is D7 – Speech and Language, which relates to speech and language therapy input during the inpatient stay. In response to this, the Speech and Language Therapy (SALT) input into stroke care will be reviewed over the next 3 months and on an ongoing basis as part of the Stroke Peer Review process with a view to improving care for patients and performance against the SALT related metrics in the SSNAP dataset. This is also the worst scoring domain nationally with 62% of teams scoring the lowest rating of E.



Scores for HDFT



National distribution of scores

The Stroke Steering Group have agreed on key indicators to focus on in their work programme, based on the SSNAP indicators where HDFT performed worse than the national average. These include time to thrombolysis, time to scan and improving Multi Disciplinary Team involvement and approach to Early Supported Discharge. Improvement will be monitored via the stroke steering group and performance on the key indicators will also form part of the performance framework reported to Trust Board on a monthly basis in 2014/15.

2. End of life care

End of life care provision

Over the last year we have made a number of changes to improve the care provided to patients in hospital at the end of their life. Working in partnership with Saint Michael's Hospice we have invested in our specialist Palliative Care Consultants team to increase their availability to provide support within the hospital. We have also expanded the role of the End of Life Care Facilitator. This is a dedicated Specialist Nurse Role designed to provide support for the ward clinical teams, patients and their families as they make choices about how they are cared for at the end of their lives.

In addition to supporting patients the End of Life Care Facilitator is also available on the wards to assist nursing, medical & caring staff with advice & guidance around having difficult conversations, supporting decision making, symptom control, supporting staff advocacy and ensuring accurate documentation is completed. They are part of the Saint Michael's Hospice Team and can help to signpost patients, carers and staff to seek expert specialist advice from other clinicians.

These changes were introduced in Autumn last year and are already producing positive results for patient care. Wards are working closely with the End of Life Facilitator and valuing the input and support that they receive. The increased presence on the wards is also providing the Trust's End of Life Steering Group with valuable qualitative information about opportunities for further improvement. Whilst progress has been good, there are still some improvements to be made which the steering group is addressing.

We continue to develop our systems and processes to support effective end of life care across all of the services we provide. This year we have updated our End of Life Care Pathway for patients cared for by our Community Nursing Team and completed a comprehensive training programme to support the use of the pathway. Our Community Nursing teams are often involving in supporting patients in their own homes at the end of their life and the introduction of this improved pathway will further strengthen the quality of care this team provides.

We are continually looking for ways to improve the care we provide and learn more about areas our patients and their carers believe we can improve. This year we completed our first bereavement survey and were extremely appreciative of the valuable information we received from families who had lost a loved one but were willing to give us feedback on their experiences. Overall the families told us that the care and support provided at the end of their relatives life was good, however they did highlight some areas where they believed that the care could be improved. These areas included communication about services available to the families and communications about what to expect of the dying process and providing a consistent approach to symptom control. We have developed an information sheet summarising the services available to families and we believe that the additional training and support we have invested into our ward teams will start to address the other issues.

We have also participated in the Royal College of Physicians National Care of the Dying Survey, which is due to report in April 2014. This involved an organisational audit of staffing

and facilities, a case note audit to review decision making and quality of care provided, and a bereavement survey. We expect that this will provide us with valuable benchmarking information about the services we provide and help us to identify further areas to develop and improve. Following a review of the results of this survey we will then plan our next bereavement survey to help us to understand if the changes that we have introduced over the past year have made the positive impact we believe that they have.

Our work on this quality priority will continue in 2014/15. We have already planned training programmes for our medical teams, and are developing the Advance Care Plan and looking at how we can effectively use national frameworks to support our patients and staff. Both HDFT and St Michael's Hospice have recently made further investments into the Specialist Palliative Care team and we will be working closely with all our partner agencies over the coming year to continue to improve the care that we provide to patients at the end of their life.

Promoting good resuscitation decision making

Cardio pulmonary resuscitation (CPR) could be attempted on any individual in whom cardiac or respiratory function ceases. Such events are inevitable as part of dying and thus, theoretically, CPR could be used on every person prior to death. It is therefore essential to identify patients for whom CPR is inappropriate, or who have requested that CPR is not attempted at the end of their life, in order to ensure dignity, quality of care and patient choice. This involves sensitive and skilled communication with patients and their families. The decision making is documented on a "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) form. The regional DNACPR form was implemented in 2011, supported by a local DNACPR policy.

Initially completion of this form was poor, and a considerable amount of education and support has been invested in ensuring adherence to the policy. The results below demonstrate that considerable headway has been made in improving standards, yet there is still some progress to be made to ensure we provide the best quality care in respect of resuscitation decision making to all patients.

The data below presents the results of quarterly audits undertaken on all adult wards on the Harrogate District Hospital site, Lascelles Unit and Ripon Community Hospital on a single day in the month specified to determine if patient case notes contained a DNACPR form. Each form is reviewed against specified standards. All forms are reviewed three weeks later following the first stage of the audit to record any changes made to the form. The audit is conducted quarterly and yields a sample size of between 37-56 forms.

	Objectives	Standards	2013 (Dec)	2013 (Sep)	2013 (July)	2013 (March)
1.	DNACPR orders are filed correctly at the front of the notes.	100%	**96%**	100%	90%	100%
2.	DNACPR orders completed by a Non-Consultant grade should be endorsed by a Consultant within 24 hours	100%	**68%**	64%	43%	47%
3.	DNACPR orders contained adequate patients demographics identified as three unique identifiers	100%	**100%**	100%	98%	100%
4.	DNACPR order contains relatives details in full.	100%	**71%**	38%	43%	35%

5.	All DNACPR forms must have at least one of the boxes ticked in Section one (Reason for DNACPR).	100%	**100%**	100%	100%	100%
6	Indication on the DNACPR form that this has been discussed with patient/ and/or relevant others.	100%	**90%**	56%	77%	52%
7.	Documentation in the notes regarding DNACPR order	100%	**86%**	90%	86%	62%
8.	Review section on DNACPR form must be completed	100%	**77%**	33%	25%	10%
9.	Discharged patients had the DNACPR form correctly sent home.	100%	**90%**	93%	81%	81%
10	Section must be complete. (Print, Sign, Designation, Date, Organisation)	100%	**83%**	50%	75%	56%
11	The form must be completed in full. * Includes review section (new addition to audit)	100%	**48%**	18%	12%	* 0%

Data Source: HDFT

The areas currently being focussed upon are:

- Ensuring forms are endorsed by a consultant within 24 hours
- Ensuring communication regarding the DNACPR process is shared with the patient and/or their relatives
- Ensuring review dates are recorded.

An action plan detailing a number of initiatives to improve standards has been produced. These actions include:

- Notification to the consultant in charge of the patients care if any gaps in DNACPR form completion are identified at audit with a request for the case to be reviewed and a rationale provided for incomplete form completion. This notification is copied to the Medical Director
- Widespread publication of audit results and education at nursing and medial forums
- Ensuring time allocation on junior doctors induction to discuss DNACPR
- Placing of folders on all wards that contain helpful information on how to complete DNACPR forms and a frequently asked questions sheet
- Addition of DNACPR as a topic on all Resuscitation Council (UK) Immediate Life Support courses (Intermediate level).

It is hoped that with these actions the standards relating to DNACPR decision making will continue to rise, giving patients and their families confidence that this is a transparent process that will play an important part in facilitating a peaceful and natural death.

3. <u>Endoscopy – Histopathology Specimen Pathway</u>

The Trust has a developing programme of rapid process improvement workshops which can potentially cover any aspect of the Trust's services. A recent workshop relating to the processing of tissue samples from the Endoscopy Unit has taken place. This workshop was also held on 10-14 March 2014. The purpose of this workshop was to:

- Improve the flow of samples from Endoscopy through to the Histopathology Department.
- To reduce duplication between manual and IT-based reporting systems.
- Reduce the other repetition in the work processes.

Before the workshop, samples from Endoscopy were sent in batches at the end of clinics. This meant that there were issues with the timeliness of transportation of samples, and some samples missed overnight processing in the laboratory causing 24 hour delays. 16% of samples contained errors.

The laboratory had lean processes already in place but there were lots of ideas from colleagues during the workshop on how to improve further.

An efficient process was sought to ensure samples got to Histopathology in smaller batches (4-5 patients) throughout the day, for same day processing, and therefore earlier availability of results. A trial of a webcam at the front desk was put in place. The webcam was placed above the collection tray and once small batches of samples were ready, a “ready to go” sign was placed over them. Porters regularly checked the webcam and arranged collection when the sign was in place. The webcam alert for rapid transportation of samples cut delays by 60%.

In Endoscopy, multiple checks have been replaced with one effective check; this has not only saved time but reduced the error rate to 0%.

Future rapid process improvement work will be delivered according to priorities agreed in the Trust’s first Improvement Strategy, due for authorisation early in 2014/15.

3.1.3. Patient Experience

1. Outpatient waiting times

An improvement event was held on the 11-13 December 2013. Members of the team were tasked with looking at improving outpatient flow throughout the hospital. The aims were to:

- Improve the quality of contact with patients before their outpatient appointments.
- Improve the patient experience in the department by improving the quality of information for patients using visual controls and reducing waiting times at the main outpatient reception desks.
- Improve follow-up of patients after the appointment.

Before the event it was observed that patients would often queue at the wrong reception desk before being directed to the right place where they would have join another queue. The signage in the main reception was cluttered and confusing, leading to some patients becoming lost in the hospital. This negative experience was the result of unclear signage and instructions. The appointment letters to patients were found to be complicated with too much information. Vital clinic information was often missed by patients, resulting in them not preparing correctly for their appointment.

Since the event, key departments along the main corridor have been given colour coded boxes outside their entrances. This enables staff to give clear instructions to patients to enable them to easily locate departments. Volunteers at the front of the hospital are now wearing red polo tops that make them more visible to patients.

Around 40 signs have been removed from the reception area and this has opened up the space. Direction enquiries were monitored by General Office staff and volunteers before and after the signs were

removed. The reduction in signage did not increase the level of enquiries from patients and visitors but did improve patient speed through departments. It has been identified that all departments in the main corridor would benefit from this system, so work is on-going to colour code a number of other areas. New maps to support the colour coding system are being planned. Clearer, more concise appointment letters with essential self-preparation and self-care information at the top of the letter have been introduced. Smaller appointment cards are also to be introduced.

The information packs being sent to patients attending outpatient clinics have been streamlined:

- MRSA infection information sheets will no longer be sent and patients with MRSA will be communicated with directly.
- The blue patient information leaflet will no longer be included as it was felt the majority of the information is not relevant.
- Large coloured maps of the hospital site will no longer be included with the outpatient letter.

Specific work undertaken in one urology clinic has led to a reduction of 90 minutes waiting time for each of the 24 patients seen in the clinic. The reduction in waiting time has freed up one clinical room session per week and one member of the nursing staff per week.

Next Steps

To take the learning from the event and the improvements made within the urology clinic, and look for opportunities in other clinics to improve patient flow and patient experience.

2. Dementia care

The Trust's strategic approach to the care of confused patients, including people with dementia, has been recently reviewed and revised.

The Dementia Steering Group has been replaced by a smaller steering group that meets monthly and a wider reference group that will meet around four times per year. The steering group is now called the Care of Confused Patients and Dementia Steering Group. The aim of the steering group is to provide leadership and direction for the care of people with acute confusion, including dementia and delirium, and their families and/or carers to ensure they have a positive experience of high-quality, personalised care. This aim has been developed from a recognition that good quality care will be very similar for confused patients, regardless of their specific diagnosis.

A review of the existing dementia action plan has been undertaken and an approach proposed to simplify the planning process by maintaining a single corporate action plan with fewer priorities.

As well as delivering work to address local concerns and support national standards in this area, the group will also help the Trust to engage with the public to help educate people about the role HDFT has in treating confused patients who may be anxious and whose behaviour may be unpredictable.

National CQUIN for dementia
Elements of the identification and management of people with dementia are defined by national CQUIN (commissioning for quality and innovation) indicators.

a) Find, assess, investigate and refer

The table below shows performance during 2013/4. All domains show performance above the target of 90%. Encouragingly, the figures show that everyone who is found to have dementia and is eligible for a full diagnostic assessment and subsequent specialist referral receives this assessment and referral.

Performance Indicator Description	Q1	Q2	Q3
Dementia screening - % eligible patients screened within 72 hours of admission (FIND)	93.5%	92.2%	93.1%
Dementia screening - % eligible patients having a full diagnostic assessment for dementia (ASSESS/INVESTIGATE)	100%	100%	100%
Dementia screening - % eligible patients referred on for specialist assessment (REFER)	100%	100%	100%

Data Source: HDFT

b) Clinical leadership and training for staff

We have an established and experienced Consultant in Elderly Medicine providing clinical leadership for older people and dementia. An initial training plan for dementia identified types and frequency of training that is suitable for different clinical and non-clinical staff. The aims of our approach to training were:

- To employ an Older Persons' Champion to work with the Clinical Lead for Older People to co-ordinate and deliver training;
- To assess opportunities for participation in regional training;
- To promote the use of the Butterfly Scheme, which aims to improve the safety and well-being of people with dementia (or any kind of memory problems) during their hospital stay with a focus on engagement with nursing colleagues;
- To promote an e-learning module and invest time in the development of an improved package that better meets the identified training needs of our workforce;
- To revise and re-launch an up-to-date day-long training course about the care of patients with dementia and confused behaviour;
- To encourage and support participation in rapid process improvement workshops.

Training of staff regarding caring for patients with dementia during 2013/14 has included:

- 107 people during the year-to-date received training relating to the use of the dementia Butterfly Scheme.
- 11 people during the year-to-date completed the dementia e-learning package to raise their awareness of issues surrounding dementia.
- 12 people during the year-to-date participated in a day-long course about the care of patients with dementia and confused behaviour. The course covered legal issues, safeguarding, the effects of dementia and how the condition affects the patient and others, as well as a range of case studies covering hospital abscondence, nutrition, hydration and other key factors.

- The Older Persons' Champion has worked with the Mental Health Liaison Nurse to make a number of personalised advice/informal training interventions which have provided bespoke learning opportunities.
- Colleagues from Byland and Jervaulx Wards have been trained in the delivery of rapid process improvements through their participation in the Harrogate Dementia Collaborative.

Intelligence and insight gained from the Older Persons' Champion's work with colleagues in acute settings has led to the preparation of a more detailed training plan for 2014/15.

c) Supporting carers of people with dementia

Interviews of carers of people with dementia have been carried out during the year. It has been a significant challenge for those undertaking the interviews to access carers or relatives at the right time when they are visiting the hospital.

There have been mixed responses to a question about whether carers feel that they were involved in planning the care that the person with dementia received while in hospital. Interviewees have said that they did not receive written information about the Butterfly Scheme, available support or key contact organisations. This is an area for future improvement that work in the rapid process improvement work relating to "the discharge of a patient with dementia and complex needs from hospital" has already begun to address.

One of the carers reported that whilst they were not offered the Butterfly Scheme, the symbol was automatically put at the bedside and the carer was reassured about the patient's care in hospital because of the Butterfly Scheme. Although planned dates for discharge were not consistently given for all patients, carers felt that they were up-to-date with current thinking when plans for discharge were progressing. Overall interviewees did feel supported on the wards.

The methodology used to seek feedback from carers of patients with dementia needs to change and a mixed approach is being considered with face-to-face interviews supplemented by asking carers for feedback by questionnaire, using paper forms or telephone follow-up following discharge. The possibility of involving experienced volunteers in this audit work in order to generate more responses and therefore more meaningful results is also being explored.

d) Participation in rapid process improvement work

HDFT is a founding member of the Dementia Collaborative within Harrogate. The collaborative was established with the aim of improving service quality and experience for people living with dementia by:

- Establishing user-focused services able to meet the needs of an ageing population
- Facilitating large-scale, cross-organisational change
- Removing wasted time and adding value
- Developing a sustainable platform for improvement.

As planned, HDFT has participated in and/or advised on ten rapid process improvement workshops benefiting people with dementia since July 2012:

1. Byland Ward: patient flow and experience
2. Referral to mental health community services
3. Movement of patients with dementia through the Emergency Department
4. Standard assessments across health and social care community teams
5. Reducing avoidable attendance at the Emergency Department from care homes

6. Primary care dementia screening
7. Domiciliary care referral
8. Mental health hospital liaison
9. The discharge of patients with dementia and complex needs from hospital
10. Respite and support for carers of people with dementia

Many and varied outputs have included:

- Development of a multi-agency community assessment to reduce duplication between community, mental health and social care assessments.
- Development of a minor injury process, designed to improve the flow of patients through the Emergency Department, with results showing the new approach shortens the visit by 47%.
- Development of a standard approach to managing residents' personal files in care homes (being implemented in five care homes in the Harrogate area) and improving communication and raising alerts. The expectation is to reduce the number of residents with dementia who visit the Emergency Department.
- Introduction of continuous flow to the process of managing referrals in mental health services for older people.
- Daily nurse ward rounds on some wards at visiting times to support patients and carers, combined with clearer and more visible patient and carer information.
- Jervaulx Ward colleagues have improved their multi-disciplinary team meetings to re-focus on "fit, ready and safe" discharge criteria to hasten discharge and reduce likelihood of readmission, which will bring particular benefits to patients with dementia.
- Improved patient experience, and carers and relatives who feel better informed
- Hospital admissions avoided and shorter stays for people who are admitted.

The Harrogate Dementia Collaborative ends in its current format at the end of March 2014. The Collaborative Project Board is currently examining options for future delivery.

Next Steps

The rationalisation and prioritisation of the dementia action plan will mean that HDFT will concentrate on making progress against fewer priorities next year, with particular emphasis on embedding the Butterfly scheme, developing the work of the Dementia Collaborative into a second phase, educating members of the public about the needs and rights of people with dementia, to help tackle the stigma surrounding the condition.

3. Patient feedback and friends and family test

The Friends and Family Test (FFT) was implemented across the NHS during 2013. The FFT aims to ask a simple question which, when combined with follow up questions, provides a standardised mechanism to identify both good and bad performance and can be used to drive improvements in quality of care. This Trust implemented the FFT for inpatient wards and the Emergency Department in April 2013, building on an existing patient questionnaire that had been in use across our inpatient wards for some years.

A baseline combined response rate of 15% was expected by NHS England at the end of Q1 increasing to 20% by the end of Q4 2013/14 as part of the national CQUIN. In October 2013 the Maternity FFT was also fully implemented which asked patients their views on the maternity services at the following stages:

1. Antenatal care – to be surveyed at the 36 week antenatal appointment;
2. Birth – to be surveyed at discharge from the ward/birth unit/following a home birth;

3. Care on the postnatal ward – to be surveyed at discharge from the ward/birth unit/following a home birth;
4. Postnatal community care – to be surveyed at discharge from the care of the community midwifery team to the care of the health visitor/GP (usually at 10 days postnatal).

The FFT asks a standardised question "How likely are you to recommend our ward/A&E (Emergency Department) department/maternity service to friends and family if they needed similar care or treatment?" The possible answers are: Extremely likely: Likely: Neither likely nor unlikely: Unlikely: Extremely unlikely: Don't know.

There are currently three methodologies the Trust is using to meet the target response rate for FFT feedback: Paper feedback forms; a token system used in the Emergency Department; and telephone interviews to patients at home within 48 hours of discharge.

A net promoter score is used to enable consistent comparison across the NHS. It is calculated as follows:

Proportion of respondents who would be extremely likely to recommend (response category: "extremely likely")	minus	Proportion of respondents who would not recommend (response categories: "neither likely nor unlikely", "unlikely" and "extremely likely")

FFT results from the Emergency Department, Inpatient wards and Maternity are included on the Quality and Safety Dashboard and these and comments received are shared widely throughout the organisation. The results are reviewed regularly by the Trust's Performance Management Group. Individual areas are expected to use the results and comments to drive improvements, and the wards provide "you said – we did" updates on their noticeboards to highlight comments received and what actions are being taken.

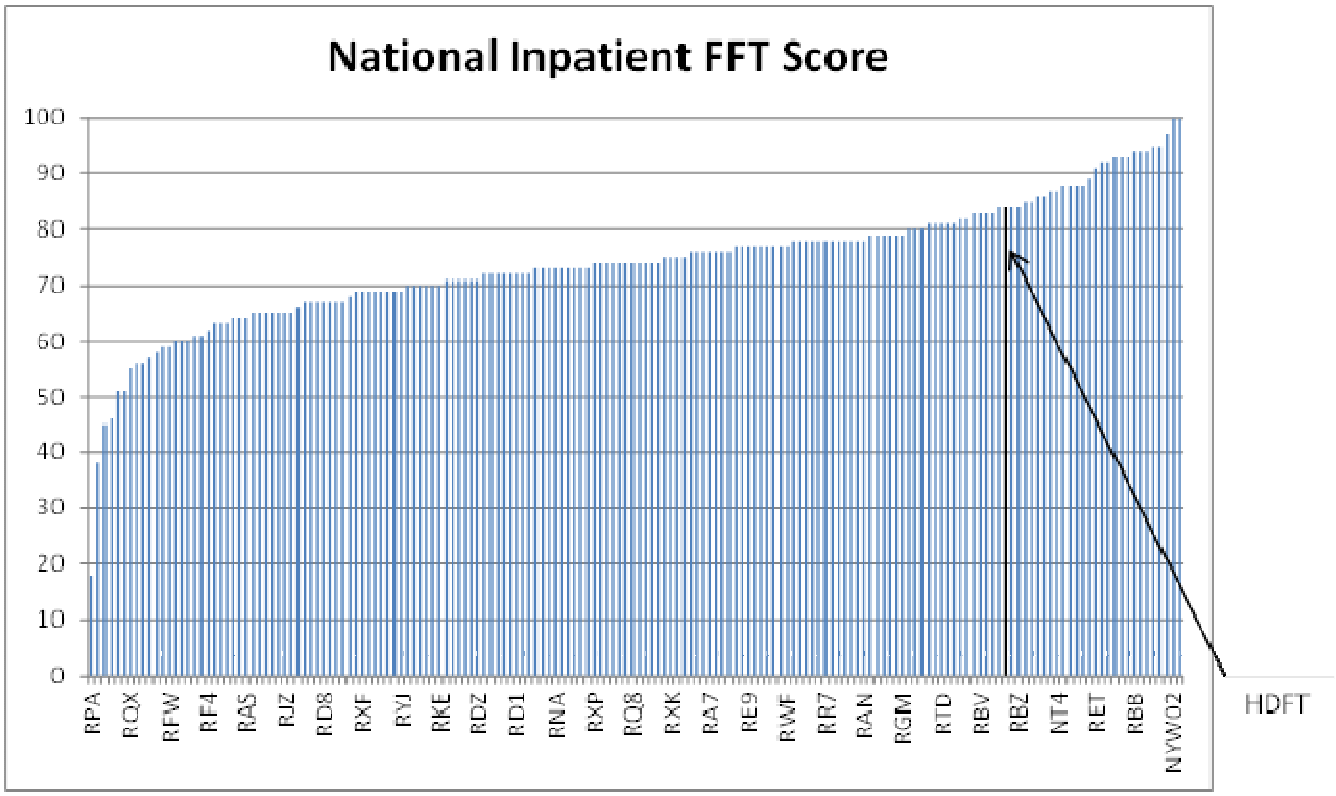
Results

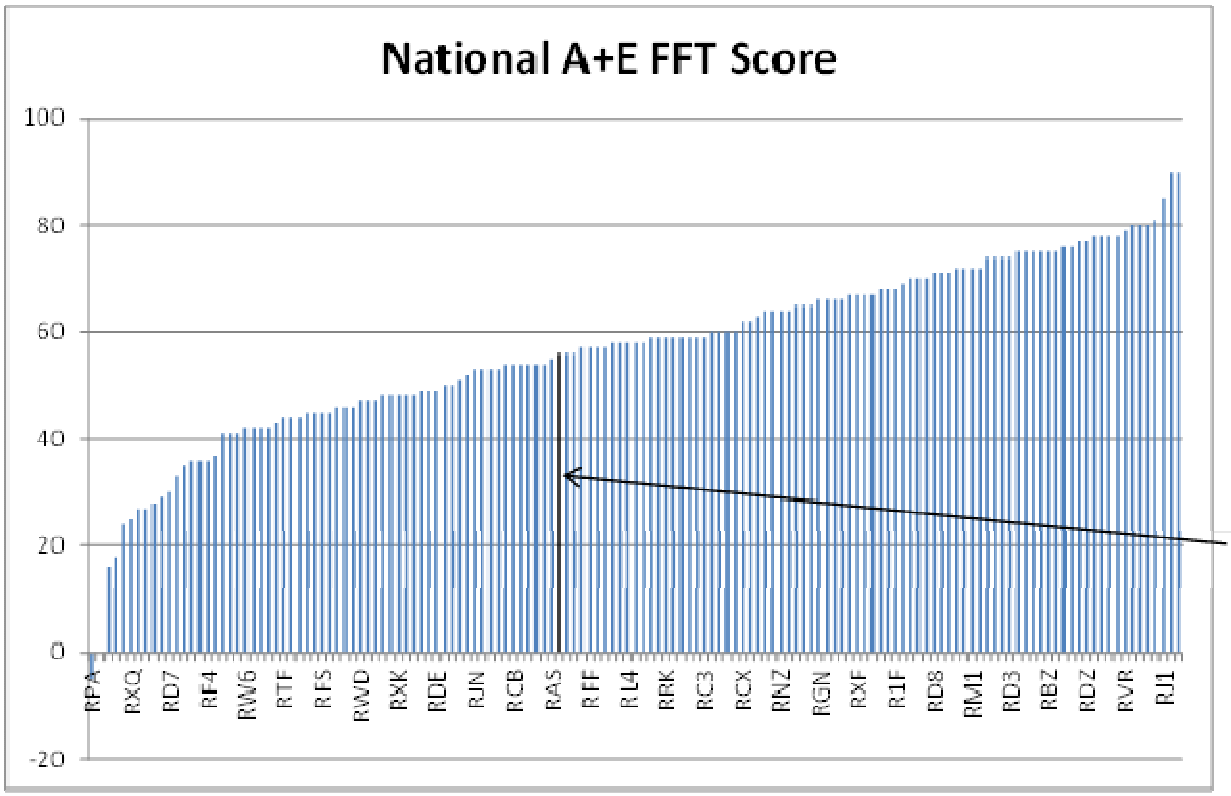
The table below shows the results for each quarter during 2013/14 for inpatient wards, A&E, combined inpatient wards and A&E, and the overall results for maternity as well as antenatal care, Birth, care on postnatal ward and postnatal community provision

Family and Friends Test Summary 2013/14		**Q1**	**Q2**	**Q3**	**Q4**
Inpatient Wards	FFT Score	73	68	73	80
	Response Rate %	21.89%	36.23%	34.78%	36.25%
	No of Responses	705	1227	1156	1211
A&E	FFT Score	69	56	59	60
	Response Rate %	15.32%	20.72%	16.85%	22.51%
	No of Responses	1078	1548	1140	1505
Combined Wards and A&E	FFT Score	71	61	73	69
	Response Rate %	17.39%	25.55%	34.78%	27.09%
	No of Responses	1783	2775	2296	2716

Maternity (overall)	FFT Score			85	88
	Response Rate %			16.90%	21.90%
	No of Responses			312	381
Antenatal care	FFT Score			73	78
	Response Rate %			17.50%	24.00%
	No of Responses			97	119
Birth	FFT Score			94	94
	Response Rate %			20.80%	20.50%
	No of Responses			101	95
Care on postnatal ward	FFT Score			91	88
	Response Rate %			15.60%	21.30%
	No of Responses			76	99
Postnatal community provision	FFT Score			79	94
	Response Rate %			12.00%	21.40%
	No of Responses			38	68

The following graphs show the FFT score for eligible NHS Trusts for inpatients and A&E in February 2014 (latest data) and the position of HDFT. The codes along the bottom axis are organisational codes for each trust providing acute services.





Data source: NHS England

Friends & Family Test - Patient

Response rate

	Dec-13			Jan-14		
Month	**Inpatient wards**	**A&E**	**Combined**	**Inpatient wards**	**A&E**	**Combined**
HDFT value	27.3%	13.6%	17.9%	30.3%	13.4%	19.3%
National average	28.5%	15.3%	19.7%	31.0%	17.4%	22.0%
Highest value for any acute Trust	77.3%	63.4%	77.3%	76.3%	52.4%	71.0%
Lowest value for any acute Trust	8.0%	0.2%	3.0%	10.9%	1.7%	6.1%

FFT score

	Dec-13			Jan-14		
Month	**Inpatient wards**	**A&E**	**Combined**	**Inpatient wards**	**A&E**	**Combined**
HDFT value	76	71	73	79	61	71
National average	71	56	64	72	57	64
Highest value for any acute Trust	100	96	100	97	92	97
Lowest value for any acute Trust	37	-11	2	27	0	10

England figures exclude independent providers

Note - data updates are published monthly.
Feb-14 data due to be published in Apr-14

http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/

In 2014/15 there is a target response rate for inpatients of 30% and ED of 20% by Q4. In addition, the FFT is to be extended to other services which will require the implementation of different methodologies within HDFT. The Quality of Experience Group is to start reviewing all feedback from the FFT to identify any trends and opportunities for additional learning and improvement.

3.2. Performance against key national priorities including indicators and performance thresholds in the framework

The following table demonstrates HDFT's performance against the indicators in Monitor's Compliance and Risk Assessment Frameworks for each quarter in 2013/14.

Indicator description	Target	Q1	Q2	Q3	Q4 (provisional)
RTT admitted pathways (% within 18 weeks)	>=90%	93.6%	95.2%	94.8%	93.8%
RTT non-admitted pathways (% within 18 weeks)	>=95%	97.8%	98.0%	97.8%	97.4%
RTT incomplete pathways (% within 18 weeks)	>=92%	97.0%	97.6%	97.8%	97.4%
A&E: Total time spent in A&E	>=95%	97.9%	97.5%	96.8%	96.5%
Cancer - Maximum waiting time or 14 days from urgent GP ref to date first seen for all urgent suspect cancer referrals (%)*	>=93%	98.9%	99.2%	99.4%	99.8%
Cancer - maximum waiting time of 14-days for symptomatic breast patients (cancer not initially suspected)*	>=93%	97.0%	98.6%	96.8%	95.4%
Cancer - 31 day wait for second or subsequent treatment: Surgery*	>=94%	100.0%	96.6%	100.0%	100.0%
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug*	>=98%	100.0%	100.0%	100.0%	100.0%
Cancer - 31 day wait for second or subsequent treatment: Radiotherapy*	>=94%	NA	NA	NA	NA
Cancer - Maximum waiting time of 31 days from diagnosis to treatment for all cancers (%)*	>=96%	100.0%	99.6%	100.0%	100.0%
Cancer - 62 day wait for first treatment from urgent GP ref to treatment: all cancers*	>=85%	93.4%	91.2%	91.0%	91.4%
Cancer - 62 day wait for first treatment from consultant screening service referral: all cancers*	>=90%	92.9%	92.6%	91.2%	100.0%
C-Difficile	<= 11 cases in year	3	2	6	3
Community services data completeness - RTT information	>=50%	79.8%	80.7%	82.3%	
Community services data completeness - Referral information	>=50%	70.0%	70.8%	73.7%	
Community services data completeness - Treatment activity information	>=50%	78.5%	82.1%	85.5%	

Performance summary of 2013/14

- All access and waiting times standards were achieved in each quarter of 2013/14 including cancer waiting times and 18 weeks referral to treatment times (RTT).
- The Trust reported 2 mixed sex accommodation breaches in 2013/14. Though these occurred at a time of significant pressure, systems have been reviewed to prevent any future breach of this standard.
- The Trust reported 14 cases of hospital acquired *C difficile* and one case of hospital-acquired MRSA during 2013/14.
- Overall, the Trust's 4 hour performance was above the 95% standard for every month of 2013/14 - this includes attendances at Harrogate Emergency Department, Ripon Minor Injuries Unit (MIU) and Selby MIU. However performance at Harrogate Emergency Department was below the 95% standard for 3 out of 12 months in 2013/14.
- The Trust continues to consistently achieve all three dementia screening performance indicators. All eligible patients received a full diagnostic assessment and onward referral for specialist advice / follow-up during 2013/14.
- Delivery of the Transient Ischaemic Attack (TIA) standard in February was at 81% during 2013/14, against the 60% national standard. The stroke performance standard (the percentage of stroke patients who spend over 90% of their stay on the stroke unit) was at 87% and has been above the national standard of 80% throughout 2013/14. HDFT's Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Mortality Index (SHMI) for the most recently available 12 months both remain within expected levels.
- The five key Emergency Department clinical quality indicators were delivered in all four quarters of 2013/14.
- Recruitment of health visitors to support the national "Call to Action" strategy was at 96.8 whole time equivalents (WTEs), which is above, at the time of writing in February, the end year trajectory.

3.3. Other quality information

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

3.3.1. Quality inspections and accreditation

In 2013 HDFT was identified in the first wave of inspections announced by the Care Quality Commission using its new inspection regime. The Trust was identified as a low risk organisation prior to the inspection.

The inspection took place within the hospital only, not within the community services and consisted of a two day announced inspection and an unannounced inspection ten days later that took place at night.

There were 32 inspectors involved in the process and it was a detailed inspection which included many staff members, Governors and a public consultation.

The outcome of the inspection was positive, and the resulting report identified that the hospital was safe, effective, caring, responsive and well led. There were some areas for improvement identified. The conclusion of the inspection report stated:

> "Harrogate District Hospital is the main acute hospital managed by Harrogate and District NHS Foundation Trust. It has 396 beds, a 24-hour A&E, maternity and children's departments, and a range of other services. It serves the population of Harrogate, parts of North Yorkshire, York and North and West Leeds. The trust employs more than 3,500 staff and has a budget of £175 million.
>
> Overall, Harrogate District Hospital provided care that was safe, effective, caring, responsive and well-led. The hospital was clean and it had systems in place for infection control.
>
> However, there were some areas, in terms of being safe, effective and responsive, that the trust could improve. Staffing levels in some areas, particularly in the care of older people, meant that although staff were keeping patients safe and meeting their needs, they were not at times able to do so promptly. Pain control on some surgical wards was not always effective. Some patients we talked to did not feel that their pain was effectively controlled. The completion of 'do not attempt cardio pulmonary resuscitation' (DNACPR) records in end of life care was not consistent. The trust's thresholds for reporting serious incidents were not comparable with most trusts.
>
> There were some areas of good practice. These included the way in which the trust valued and used volunteers, and the use of telemedicine in patient care".

In response to the report, the Trust has implemented actions to address the areas for improvement and is regularly reporting on progress against the actions to the Care Quality Commission.

The Trust was successful in achieving Level 2 of the NHS Litigation Authority (NHSLA) Risk Management Standards for Maternity Services in September 2013 with a score of 48/50 standards. This is a significant achievement.

3.3.2. Key staff survey results 2013 and comparison with 2012

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

In 2012 HDFT was in the best 20% of Acute Trusts in the country for 11 key findings. This represented 39.3% of the total key findings. In 2013 HDFT improved upon this record achieving 13 key findings in the best 20% of Acute Trusts, which represented 46% of the total key findings.

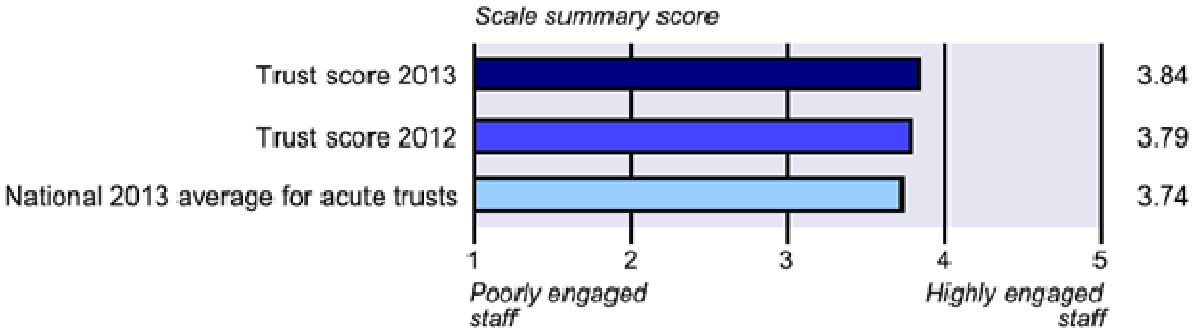
The Trust had one key finding that fell into the bottom 20% of Acute Trusts. This related to staff receiving job relevant training, learning or development in the last 12 months and equated to 3.6% of the staff survey's key findings.

The following 9 key findings have placed the Trust in the 'best 20%' for the past two consecutive years:

- Staff suffering work-related stress in last 12 months (low score);
- Staff witnessing potentially harmful errors, near misses or incidents in last 12 months (low score);
- Staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (low score);
- Staff experiencing harassment, bullying or abuse from staff in last 12 months (low score);
- Staff believing the Trust provides equal opportunities for career progression or promotion;
- Staff experiencing discrimination at work in last 12 months (low score);
- Staff job satisfaction;
- Staff recommendation of the Trust as a place to work or receive treatment;
- Staff motivation at work.

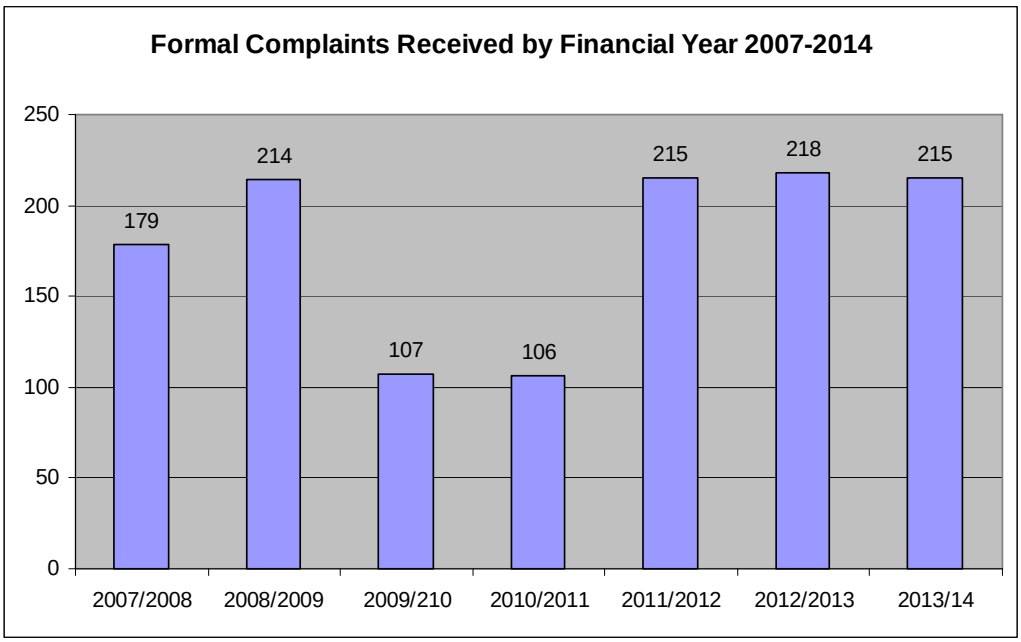
Overall Staff Engagement

For comparative purposes the table below demonstrates the Trust performance in relation to overall staff engagement. Overall staff engagement comprises three key findings: 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.



3.3.3. Formal and informal complaints and compliments

Formal complaints and informal "(Patient Advice and Liaison Service) PALS" type contacts



Data source is local patient feedback data

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 2013/14 is presented below by grade and quarter in which it was received.

	2013/14					2012/13
	Q1	**Q2**	**Q3**	**Q4**	**Total**	Total
Complaints Total	**57**	**47**	**54**	**57**	**215**	218
Complaint Green	40	29	23	37	129	127
Complaint Yellow	17	17	29	19	82	83
Complaint Amber	0	1	2	1	4	8
Complaint Red	0	0	0	0	0	0

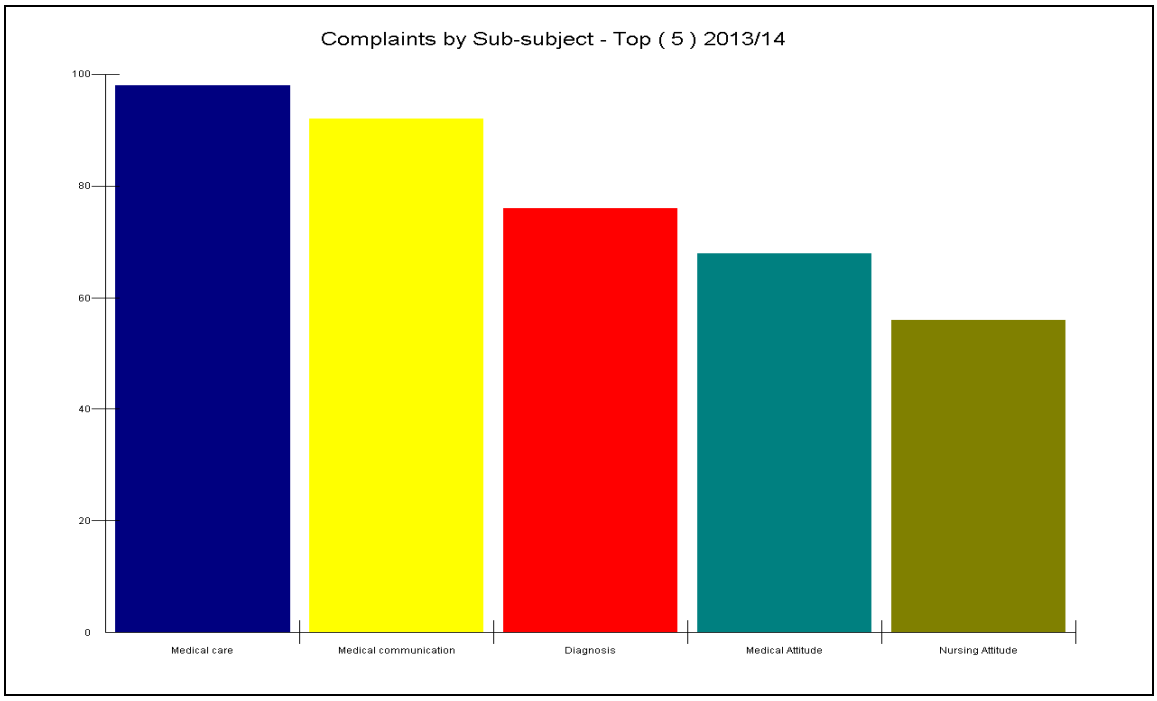
Data source is local patient feedback data

The number of complaints received is similar to the previous year and the number of cases graded as low level (green) and moderate (yellow) are similar. The number of high level (amber) cases has reduced in comparison with last year. The numbers of cases received has been consistent across three quarters but there was a reduction in complaints in Quarter 2. During Quarter 2 slightly more contacts were made informally.

In addition, the Trust handles informal PALS type contacts, which includes concerns, information requests and comments. In total in 2013/14, 736 were received compared to 762 in last year's report for 2012/13. Of these 736, 398 were concerns, 107 were requests for information and 231 were comments. Although less in overall number this year

compared with 2012/13, the data demonstrates a fall in the number of comments compared with 2012/13 and an increase in the number of concerns.

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, including diagnosis and medical communication and attitude of medical and nursing staff. Nursing care was highlighted as a theme in the top five for 2012/13 and although it does not feature in the top five issues for 2013/14, nursing attitude is now in the top five.



Action plans are developed to improve patient care as a result of feedback and these are monitored regularly.

Nine cases were referred to the Health Service Ombudsman in 2013/14 (compared with seven last year). Out of the nine cases:-

- two have been closed with no further investigation or action
- four have been investigated of which three have been found to be upheld and actions requested, one was not upheld
- one is currently being investigated
- two are awaiting consideration for investigation

Of the three that were found to be upheld, in two cases compensation has been paid to the complainant following the Ombudsman's recommendation, and in one case we have written to the complainant with an update on the actions taken as a result of their complaint.

Compliments

Compliments Received by the Patient Experience team	2009/10	2010/11	2011/12	2012/13	2013/14
Compliments excluding to the media	233	354	354	291	330*

Data source is local patient feedback data. This data excludes all records of thanks received directly at ward and team level.

* for 2013/14 289 records of thanks were reported via the local media compared to 331 in 2012/13.

3.3.4. Care Quality Commission (CQC) Intelligent Monitoring Reports

As part of the CQC's new operating model, the Quality & Risk Profiles (QRPs) were replaced by "Intelligent Monitoring Reports" in Autumn 2013. CQC initially published a report for each trust in October, followed by an update in March 2014.

The reports include around 150 indicators and are used by CQC as part of the new inspection process to raise questions about the quality of care at acute trusts and were chosen by CQC to reflect the five key questions that they will ask of all services – are they safe, effective, caring, responsive and well led? For each indicator, Trusts are assessed as "no evidence of risk", "at risk" or "elevated risk". In addition, each Trust is given a banding from 1-6, where 1 indicates highest risk and 6 indicates lowest risk.

For the latest publication in March 2014, HDFT has no indicators assessed as either "elevated risk" or "at risk", out of 93 applicable indicators. This makes HDFT one of only 6 trusts nationally (two acute and 4 specialist trusts) with a zero risk score.

This is an improvement on HDFT's score in first reports published in October 2013 when HDFT had 1 indicator assessed as "elevated risk" and 1 indicator assessed as "risk" and the remaining applicable indicators assessed as "no evidence of risk".

3.3.5. The Patient Voice Group (PVG)

The PVG comprises 14 lay members and one HDFT Governor, all of whom give their considerable time voluntarily. The PVG looks at the quality of the patient care at the hospital with a view to both endorsing good practice and suggesting ways of enhancing the services. It performs the role of "critical friend". It responds to issues raised by the public and by PVG members, and will also undertake visits to a service at the request of the Trust. The PVG reports to the Chief Nurse as Patient and Public Involvement lead, and its reports and work programme are presented to the Quality of Experience Group (QEG). The group meets monthly except for January and August to work through the set 'Work Programme'.

The PVG is *an independent group of volunteers* which focuses on issues, not individual complaints which are dealt with by the Trust's Patient Experience Team (PET). Information about the work of the PVG and its written reports together with the Trust responses to its recommendations can be found on the Trust website for all to read.

The group has more recently also undertaken new developments including *visits to community services*. When making visits, members look at quality issues including patient care; communications, privacy and dignity and safety for patients. The PVG written report format is guided by the Care Quality Commission's new domains for assessing the quality of patient care: effective care, responsive to patients needs, being safe, being well-led.

1. Our monitoring of the care of inpatients in 2013

During this year, the PVG members focussed their work on the inpatient wards and undertook to visit and monitor developments and good practice in all the HDFT hospital wards as a priority. This involved two members of the group researching the ward to be visited, talking to the ward manager, staff and especially the patients and having a ward 'look around'. Following this, the members compiled a detailed report which included some recommendations and suggestions.

More recently, views from patients by telephone once they are at home have been sought as this is felt to give patients the opportunity to provide more reflective feedback for the Trust. The PVG ward reports were then sent to the Operational Director of the relevant Directorate, the appropriate Ward Manager, the Chief Nurse and the Chair of the Trust. Responses to the report and the recommendations from the Trust was sought and received using a template set up by the group for each report.

2. PVG involvement in other Trust matters

During 2013, the Trust asked PVG members to be involved in: the Protected Mealtime survey; the Diabetics audit; the Discharge telephone survey, and the Chronic Pain Relief Clinic patient satisfaction telephone survey. Several workshops organised by the Trust had PVG representation including: end of life; outpatient appointments/reception; CQC Consultation; dementia collaborative and meeting with matrons, and the development of the 'end of life leaflet'.

The group provided posters for the Trust Open Event. Training for the new annual PLACE inspections also took place, and a PVG member attends the monthly internal PEAT, now called PLACE, which inspects wards and hospital environments.

In line with HDFT's priority for enhancing the care of the elderly and the confused patient, the PVG focused in 2013 on ensuring that care for older people and those with confusion is continually improving. A large project is to be developed during 2014 and pre - work for the PVG has included meetings with relevant Trust staff. This is in preparation for developing a PVG project to ensure that the voices of elderly and confused patients are heard when strategies and action plans are drawn up to enhance their care.

3. Key achievements for the quality of patient care in 2013

In addition to the implementation of a number of the PVG ward recommendations in their reports, there were two significant developments in 2013 resulting from PVG recommendations:

- An improvement in the quality of the Orthotics Service for patients as the result of persistent PVG reports commenting on the need for more space for patients.
- The Phlebotomy service is looking at providing additional external space for patients thus reducing the long queues in Phlebotomy within the hospital.

During 2013 members have endeavoured to speak to more patients at home via telephone calls and home visits to ensure patients provide honest and reflective views of services they received from HDFT services. It is generally felt that the patient experience of patients accessing HDFT services is very good. Those who did have concerns usually provided positive and helpful comments which were recorded in the reports. The work of the PVG overall endorses the Trust's emphasis on providing well-led and compassionate care of patients and on listening to the needs of its customers.

4. Future work programme, 2014

The PVG will continue to monitor areas already looked at in 2013, such as discharge, protected mealtimes, bed management, communication, care of the elderly. Several ward reports are due to be followed up to see whether the recommendations made in the reports have been implemented, e.g. reports on Children's ward, Byland ward, Oakdale, Farndale, Littondale, etc. The group will also be looking at some of the Community Services, including a follow up to their Community Nursing Report in 2012, and will make a contribution of the patient perspective to the CCG/HDFT Review of Community Services.

The PVG is committed to working with the Trust in developing new ways of communicating with patients to ensure that a wide range of views from as many patients and relatives, where appropriate and possible, is achieved and reported on.

Rosemary Marsh
PVG Chair – April 2014

3.3.6. Innovation work

As well as improvement work carried out as part of the Harrogate Dementia Collaborative and separately to improve outpatient flow, further rapid process improvement work has been carried out in antenatal care.

Antenatal Care Workshop

This improvement workshop was held on 10-14 March 2014, for members of the team to seek improvements in the delivery of care to patients through an evaluation of the current booking of patients and clinic model. Before the workshop there was an identified need for improvements in the quality of the service to improve safety, outcomes and people's personal experiences of the services. There was too much waiting time in antenatal care, some people were making too many visits to the service and there was no standard room layout in the clinics. The aims were to:

- Reduce the overall lead time by reducing waits.
- Increase the number of patients attending antenatal care who can attend a "one stop" service to avoid multiple visits.
- Develop standard work for staff.
- Standardise the layout of rooms.
- Improve patient confidentiality.

Following implementation of identified changes, there has been a significant reduction in the time patients spend at the clinic. Patients are now in the clinic for under an hour compared to 1 hour 41 minutes before the improvement work started. There have been some changes to the clinic timings, enabling the sonographer to start earlier, which both improves patient flow and minimises delays for clinicians. There has also been an improvement in clinical appointment letters to make them easier for patients to understand. This is part of a corporate approach to improving outpatients letters.

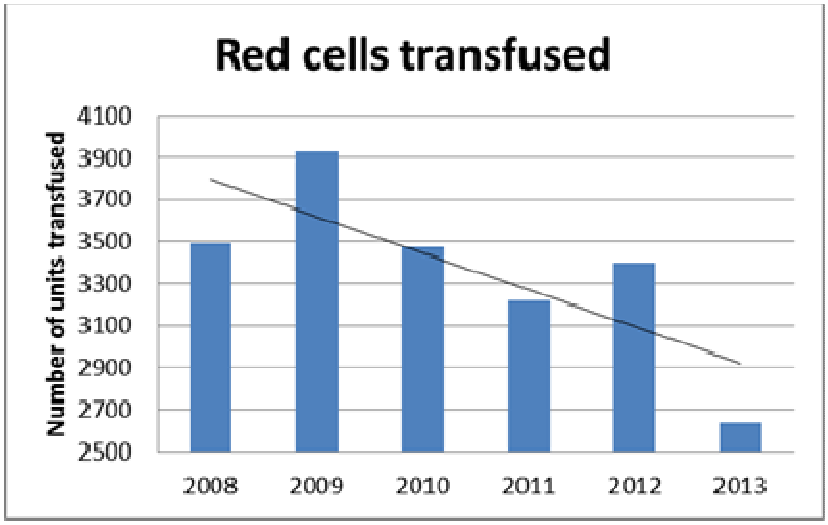
De-cluttering has improved waiting areas and clinic layouts. A standard layout for the clinic rooms has been implemented, with everything removed that is not required. The store room has been de-cluttered and labelled making it easier to find equipment. Tighter stock control has saved £2,500 in stationery costs.

Before

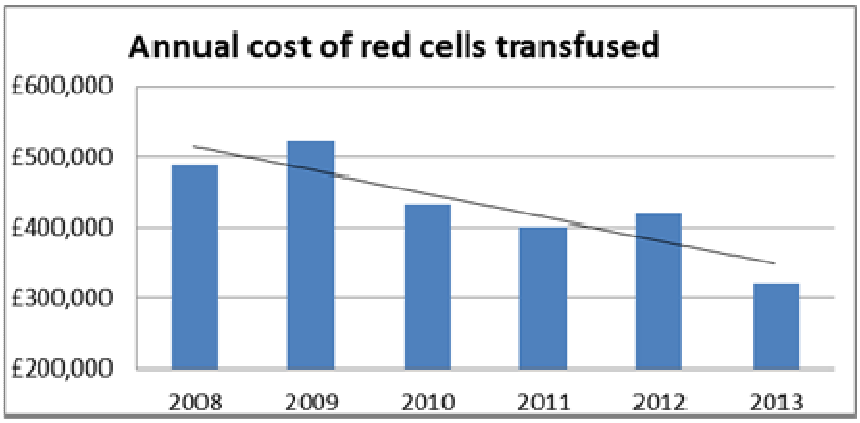
After

3.3.7. Review of annual red cell (blood transfusion) use 2008 – 2013

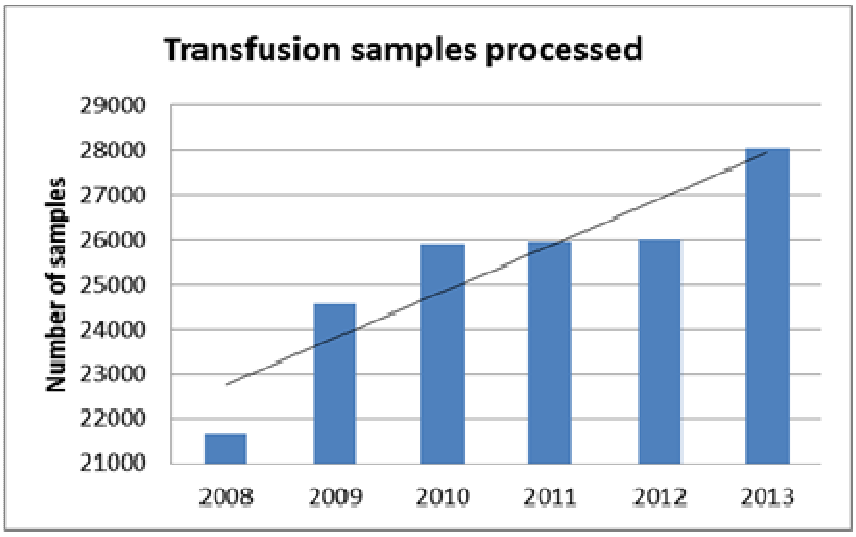
There has been a steady reduction of red cell use over the past 6 years (see chart below). This has been achieved by a number of strategies implemented in line with the Department of Health (DH) publications 'Better Blood Transfusion' in 2002, 2007 and 2009. Together with national guidelines produced by the British Committee for Standards in Haematology (BSCH) and Serious Hazards of Transfusion (SHOT), changes have enabled the reduction of blood transfused by implementing blood conservation strategies at a local level using accurate and informative data and guidelines to influence practice.



There have been considerable cost savings for Harrogate & District NHS Foundation Trust (see chart below). This has led to a cumulative cost saving of £166,231 over the past 6 years, with a cost reduction of over £97,000 in the year 2013 compared with 2012.



These reductions in blood use have occurred despite the growth in activity in the transfusion department with a consistent increase in samples processed over the same period. (See below). The increase in samples relates partially to increased activity in the trust but mostly because national guidelines now require two samples to be on the laboratory database before non emergency blood products can be issued.



This achievement is only possible through the hard work and assistance of all staff involved in the transfusion process. This includes the Hospital Transfusion Team, the transfusion department staff and all the clinical staff either involved in making the decision to transfuse or administering the transfusion appropriately and safely.

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 2014

HEALTHWATCH NORTH YORKSHIRE QUALITY ACCOUNT STATEMENT 2014

NORTH YORKSHIRE COUNTY COUNCIL SCRUTINY OF HEALTH COMMITTEE QUALITY ACCOUNT STATEMENT 2014

COUNCIL OF GOVERNORS QUALITY ACCOUNT STATEMENT 2014

HEALTH AND WELLBEING BOARD QUALITY ACCOUNT STATEMENT 2013/14

NOTE – ALL STATEMENTS AWAITED

ANNEX TWO: STATEMENT OF DIRECTORS' RESPONSIBILITIES

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended 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 2013/14;
- 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 2013 to June 2014
    - Papers relating to Quality reported to the Board over the period April 2013 to June 2014
    - Feedback from the commissioners dated xx/xx/xx
    - Feedback from governors dated xx/xx/xx
    - Feedback from local Healthwatch organisations dated xx/xx/xx
    - Feedback from Health and Wellbeing Board dated xx/xx/xx
    - Feedback from North Yorkshire County Council Scrutiny of Health Committee dated xx/xx/xx
    - The trust's draft complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xx/xx/xx
    - The 2013 national patient survey 08/04/2014
    - The 2013 national staff survey 25/02/2014
    - The Head of Internal Audit's annual opinion over the trust's control environment dated April 2014
    - CQC quality and risk profiles dated xx/xx/xx
- 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
.....Date.....Chairman
.....Date.....Chief Executive

ANNEX THREE: NATIONAL CLINICAL AUDITS 2013/14

This table contains a list of the national clinical audits that HDFT was eligible to participate in during 2013/14.

National Clinical Audit and Patient Outcome Programme (NCAPOP)	Number of patients data submitted for 2013-14	Data submitted as a percentage of the number of registered cases required for that audit
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)		
Medical and surgical clinical outcome review. Subarachnoid Haemorrhage (Managing the Flow) NCEPOD	**1 organisational questionnaire only**	**None required**
Tracheostomy Care	**2**	**100%**
Alcohol Related Liver Disease	**2**	**66%**
Lower limb amputation	**1 organisational questionnaire**	**Audit remains open**
Trauma and Orthopaedics		
National Joint Registry (NJR)	**954**	**89%**
Hip fracture database (NHFD)	**277**	**100%**
Cancer Services		
Bowel cancer (NBOCAP)	**69**	**100%**
Lung cancer (NLCA)	**119**	**100%**
Oesophago-gastric cancer (NAOGC)	**41**	**100%**
Respiratory		
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme*	**24**	**Data collection ongoing data collection started in February 2014**
Cardiology		
Acute coronary syndrome or Acute myocardial infarction (MINAP)	**311**	**100%**
National Heart Failure Audit	**218**	**100%**
Cardiac Rhythm Management	**600**	**100%**
Long term Conditions		
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)*	**26**	**100%**
Inflammatory bowel disease (IBD) and Biological Therapies	**22** **10**	**96%**
Rheumatoid and early inflammatory arthritis	**8**	**Data collection ongoing**

National Audit Clinical Outcome Review Programme (NCAPOP)	Number of patients Data submitted for 2013-14	Data submitted as a percentage of the number of registered cases required for that audit
Paediatrics		
Diabetes (Paediatric) (NPDA)	**94**	**100%**
Epilepsy 12 audit (Childhood Epilepsy)	**9**	**Study still open**
Neonatal intensive and special care (NNAP)	**177**	**100%**
Maternal, New-born and Infant Clinical Outcome review Programme	**6**	**100%**
Child health clinical outcome review programme (CHR-UK)	**1**	**100%**
Acute medicine		
Sentinel Stroke National Audit Programme (SSNAP)	**299**	**100%**
General Surgery		
National emergency laparotomy audit (NELA)	**9**	**Data collection ongoing started in December 2013**

Data submitted to National Audit not part of NCAPOP	Number of patients Data submitted for 2013-14	Data submitted as a percentage of the number of registered cases required for that audit
Audits not part of National Clinical Audit Outcome Programme		
Case Mix Intensive Care National Audit Research Centre	**390**	**100%**
National Cardiac Arrest (Part of ICNARC)	**HDFT did not participate in 2013/14**	**Joined and Started data collection 01/04/2014**
Emergency Medicine		
National Audit of Seizures in Hospitals (NASH)	**31**	**100%**
Severe sepsis & septic shock	**50**	**100%**
Paracetamol overdose (care provided in emergency departments)	**50**	**100%**
Moderate or severe asthma in children (care provided in emergency departments)	**50**	**100%**
Trauma		
Severe trauma (Trauma Audit & Research Network, TARN)	**60**	**42%**
Anaesthetic Sprint Audit (Anaesthetics in Hip fracture patients)	**58**	**89%**

Data submitted to National Audit not part of NCAPOP	Number of patients Data submitted for 2013-14	Data submitted as a percentage of the number of registered cases required for that audit
Transfusion		
National Comparative Audit of Blood Transfusion programme: Consent for transfusion Appropriate use of red cells	**24** **23**	**100%** **100%**
Elderly Medicine		
Falls and Fragility Fractures Audit Programme (FFFAP)	**24**	**96%** **Pilot audit of In-patient at risk of falls**
Paediatrics		
Paediatric Bronchiectasis	**HDFT did not participate in 2013/14**	
Paediatric asthma	**25**	**100%**
Surgery		
Elective surgery (National PROMs Programme)	**447 (Pre-op)** **224 (post-op)**	**82.6% Pre-op** **42.9 Post-op**
Respiratory		
Emergency use of oxygen	**HDFT did not participate in 2013/14**	

For information, the Trust also participated in the following three audits.

Data submitted to National Audit not part of NCAPOP	Number of patients Data submitted for 2013-14	Data submitted as a percentage of the number of registered cases required for that audit
Care of dying in hospital (NCDAH)	**52**	**>100%**
Prostate Cancer	**Organisational audit submitted**	**Clinical data collection commencing April 2014**
Diabetes in pregnancy	**1**	**14%**