Calderdale and Huddersfield NHS

NHS Foundation Trust

Quality Report 2014/15

compassionate care

Quality Report 2014/15

Part 1

Chief Executives' Statement

Welcome to the 2014/15 Calderdale and Huddersfield NHS Foundation Trust Quality Report.

This report gives us the opportunity to let you know about the quality of services we deliver to our patients. It includes information on how we have performed against key priorities that were identified for further work last year and those areas that, together with our members and the Membership Council, we have identified as priorities for the coming year.

Providing 'Compassionate Care' and putting our patients first continues to be a high priority for all of our staff and the Trust. We are determined to ensure that patients get the care they need, when they need it and from the right person.

By no means does the report cover everything we are doing to constantly improve the quality of our services for our patients and their families. It is intended to give you a snapshot of where we are doing well and the areas that we continue to focus on.

The quality of care people receive across the NHS remains high on the national agenda and there have been a number of high profile reports over the last year setting out what organisations like ours can learn from these incidents. We always take this as an opportunity to reflect on what we are doing locally and look to see where we can make improvements. We also use the feedback we receive through a variety of routes from our patients, their families and carers on what we can do to develop our services further and how we need to change them to meet the needs of our communities in the future.

Quality of care is top of the agenda for our Board of Directors and in this challenging financial environment it is even more important to ensure that any changes we make are assessed for their impact on quality before they are able to go ahead.

There are some excellent examples of high quality care and services across all of our community and hospital services. There are also areas where we know we need to do better. We will continue to share good practice and make improvements so that all our patients receive high quality compassionate care whenever, and wherever, they access our services

I hope you will find the following pages informative and helpful in giving you an insight into the vast amount of improvement work we continue to do in the Trust.

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

Owen Williams
Chief Executive
28 May 2015

Part 2

How the Trust performed against the four priorities set for 2014/15

Last year the Trust identified five quality improvement priorities for 2014/15. This section of the Quality Report shows how the Trust has performed against each of these priorities.

Improvement priority	Were we successful in 2014/15?
To improve the quality of the care we provide as measured by the Hospital Standardised Mortality Rate (HSMR)	Yes
To ensure intravenous antibiotics (IV) are given correctly and on time	Partially
Improving the care of patients with diabetes so they do not develop complications and have to spend longer in hospital	Yes
To help patients with long term pain develop the skills needed to manage their condition through supported self-management courses	Yes

Priority one: To improve the quality of the care we provide as measured by the Hospital Standardised Mortality Rate (HSMR)

HSMR is a high level outcome measure that can be used for tracking the quality of care provided. For this reason the Trust's Care of the Acutely Ill Patient (CAIP) Programme uses this as one of its measures to track progress.

HSMR - What is it?
Hospital Standardised Mortality Rate (HSMR) is a standardised measure of mortality produced by Dr Foster Intelligence (DFI).The rate is the number of actual deaths divided by the number of predicted deaths for the Trust's patients treated.
A rate of 100 means expected number of deaths matched actual number of deaths. Above 100 means we had more than expected, less than 100 means we had less than expected. The 100 benchmark is calculated based on mortality rates for all acute hospitals in England and Wales.

The CAIP programme was revised in August 2014; this resulted from the need to re-focus to areas which will lead to the biggest benefits.
This programme now consists of eight domains:

1. Reducing mortality (overall outcome measures)
2. Ensuring the recognition and prompt treatment of our deteriorating patients.
3. Delivering high standards of care through reliable delivery of care bundles.
4. Improving the care delivered to frail and elderly people.
5. Effective (focus on the courage to put patient first programme).
6. Focus on summary hospital-level mortality indicator (SHMI) conditions of interest. This is a similar measure to HSMR but focuses on specific conditions such as stroke.
7. The well led organisation.
8. Improving depth of coding.

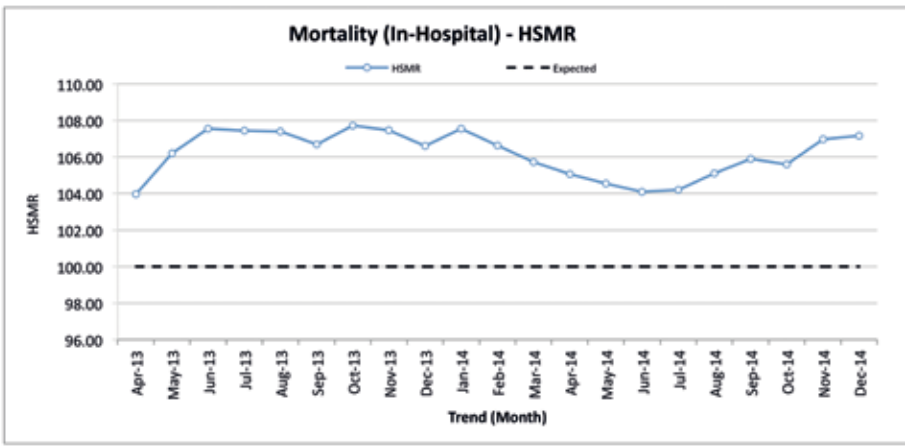
a. Target

The priority aimed to see a 10 point drop in HSMR from the 12/13 position of 104 to 94 by September 2014.

b. Achieved year to date

Data released for the period of July 2013 – June 2014 indicated that our HSMR was 92.08 against our own baseline of 104 (relating to April 12 to March 13). However the national HSMR at this time was 87.25. Therefore the national rate was showing greater improvement than that of the Trust.

If the Trust data is plotted against the national rate (the median always remains as 100), the pattern in the data can be seen in the chart below. There was an initial fall in line with the original target date of September 14 however the data has now started to rise again.



In line with national drivers the Trust is focusing on learning from deaths through its mortality review process and relying less on these complex statistical measures.

Although the original aim has not been achieved the key work plan that will lead to improvement namely the Care of the Acutely Ill Patient programme is continuing. The programme tracks progress in each of the 8 themes with clear targets and areas of work. Progress is overseen by the Clinical Outcomes Group on a monthly basis reporting through the Trust's Quality Committee to the Board of Directors. The programme is scheduled to continue in its current form to September 15 and will then be reviewed again against its outcome aims.

Specifically two of the priorities for this year – sepsis and administration of IV antibiotics will have a positive impact on this outcome.

Priority two: To ensure intravenous antibiotics (IV) are given correctly and on time

When infections are diagnosed it is essential antibiotics are given correctly and on time to aid recovery and ensure that the patient's condition does not deteriorate.

Although work has continued and improvements made the Trust did not meet the initial aims for improvement in this area, it has been agreed that this priority will continue in the Quality Account for the next year. Work will be linked to the interventions needed to meet the national sepsis commissioning for quality and innovation (CQUIN) target.

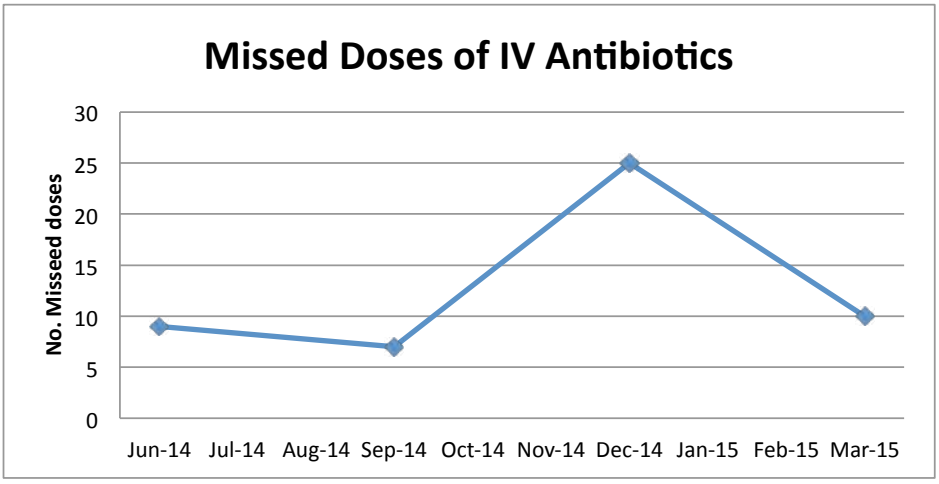
a. Target

- The Trust aimed to reduce by 50% unintentional missed doses of IV antibiotics.
- To ensure that antibiotics are prescribed according to Trust guidelines.

b. Achieved year to date

Measurement of this priority remained a challenge; data is currently gathered through focused audit carried out by the specialist pharmacy team and also the quarterly point prevalence audit focussing on missed doses

Data from the trust-wide quarterly missed doses audit contains specific questions around IV antibiotics.



The specialist antibiotic pharmacy team undertake a six monthly antibiotic audit measuring if antibiotics are given according to Trust guidelines. Results of the latest audit conducted in November 2014 (split by the two main hospital sites) were as follows:

Calderdale Royal Hospital - 100% compliance all wards apart from one surgical ward at 70%.

Huddersfield Royal Infirmary - 100% on Medical and Rehabilitation wards. Surgical wards overall had 91.4% compliance.

It is worth noting that a figure of 100% compliance was achieved for the prescribing of antibiotics according to Trust guidelines.

Because of the way administration of antibiotics is recorded on the prescription chart it is difficult to calculate if the IV antibiotic was given within the accepted 1 hour time period. In addition there is a lot more understanding of the reasons why doses are missed and delayed. This has led to a detailed action plan. Unfortunately as these are large scale actions they need to be fully implemented before the impact is seen.

Antibiotic ward rounds have continued on a twice weekly basis. This is a ward round involving a consultant Microbiologist, specialist antibiotic pharmacist and infection control nurse. The focus of these is education, challenge, advice and monitoring of antibiotic use. These ward rounds have also helped the specialist staff gain further understanding of the issues in administering and prescribing antibiotics in clinical areas.

The specialist pharmacists continued to work with junior front line staff in implementing changes in their ward/departmental areas.

One key piece of work being carried forward was the identification of the time taken to reconstitute and administer Piperacillin-tazobactam (one of the Trust's most widely used antibiotics) leading to a trial of a "docked-vial" version of this antibiotic commencing after Easter 2015 at HRI.

Priority three: Improving the care of patients with diabetes so they do not develop complications and have to spend longer in hospital

At any one time 20% of all adult patients in hospital have diabetes. Patients with diabetes stay on average two days longer than patients without diabetes. The Trust wants to improve the care of patients with diabetes and encourage more patients to manage their own diabetes whilst on the ward. Often patients with diabetes are experts in their condition, therefore encouraging them to continue to manage their diabetes whilst in hospital reduces error, maintains independence and shortens length of stay.

a. Improvement work carried out

The focus of this work was around supporting patients to self-care with their medications, which included patients with diabetes who self-administer their insulin.

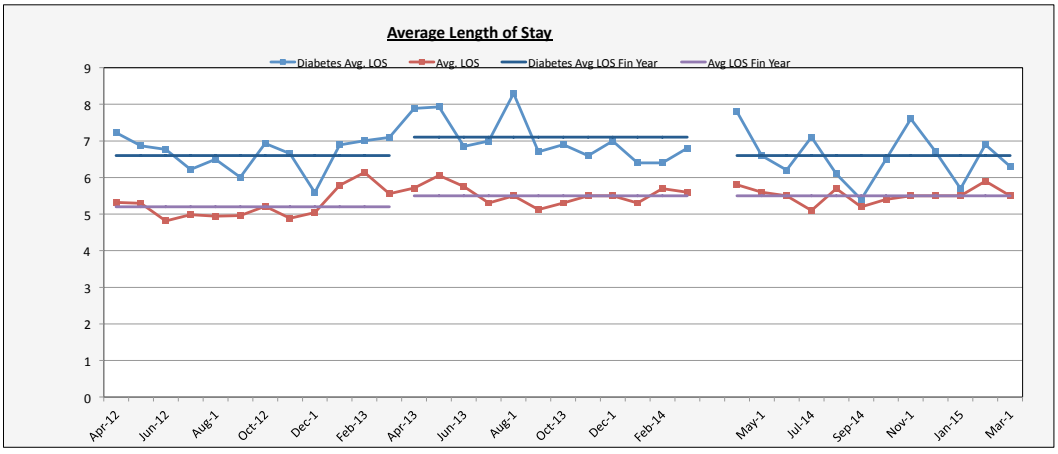
This was achieved through the introducing of a process for medication self-administration, robust testing of this process had already taken place.

This improvement work meant that more patients (if they are assessed as able), were encouraged to test their own blood sugars, adjust the dose, administer their own insulin, and had full access to snacks should they need them to manage their blood sugars. Over the year further wards were included in the work (a maternity and a short stay ward) making a total of eight wards using the new process.

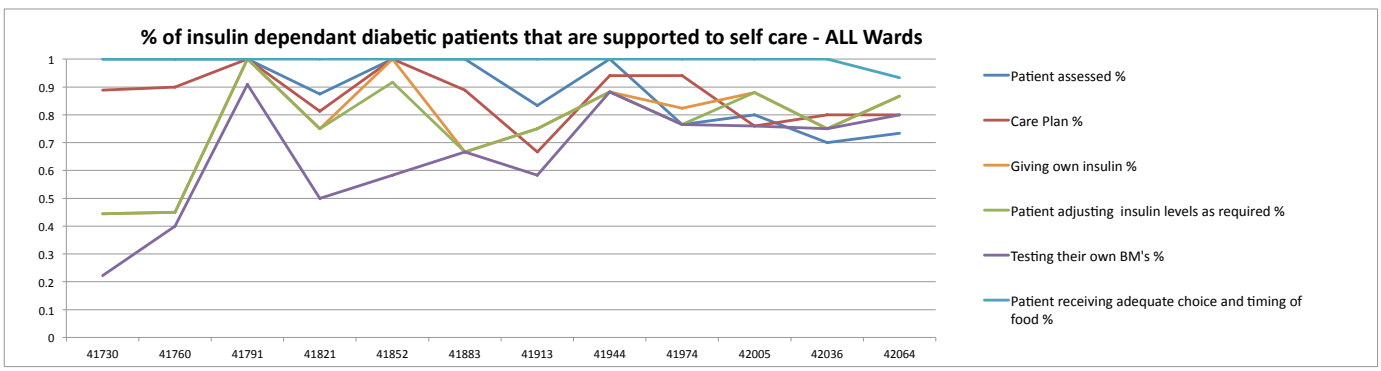
b. Target

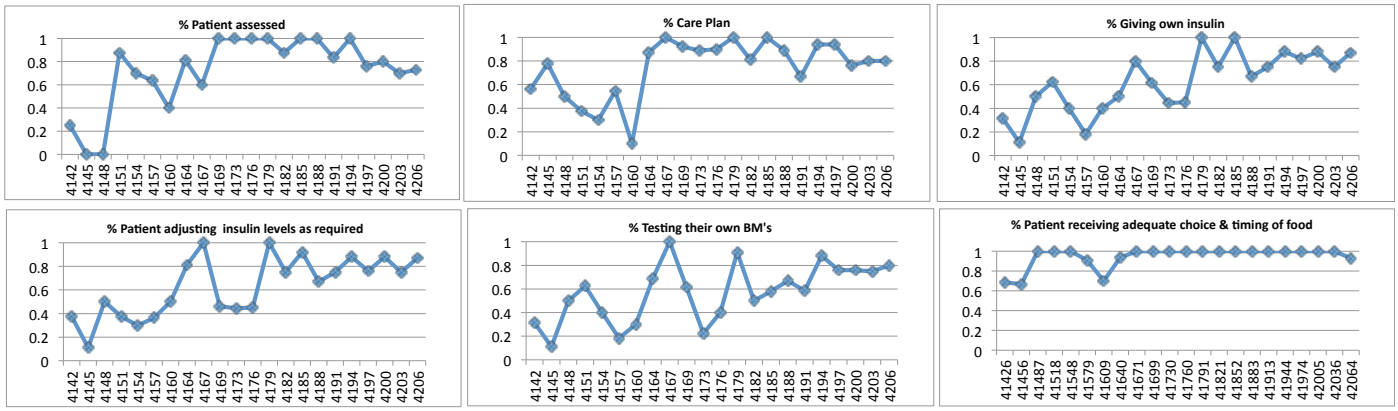
The overall outcome and aim of the work was to reduce harm and length of stay for diabetic patients through encouragement to self-manage.

The chart below shows an improvement in length of stay for patients with Diabetes from May 14 that has been sustained throughout the year.



The following charts show overall compliance and improvement with using the care bundle for patients self-administering their Insulin. It also includes compliance with each of the 6 individual elements.





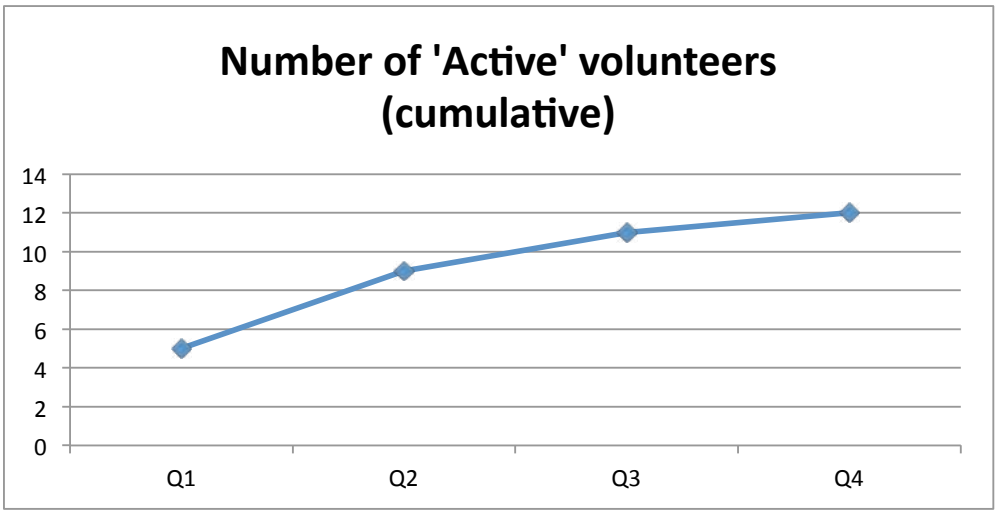
c. Further work
A further two wards (an Orthopaedic ward and an Oncology ward) will be included during the next quarter; training is underway on these wards. The CQUIN requirements for 2015-16 means that a further two wards will be included in this work each quarter.

To support the work a campaign is to be held in June 2015 to encourage patients to bring their own medication into hospital and self-medicate, this will include diabetic patients.

Priority four: To help patients with long term pain develop the skills needed to manage their conditions through supported self-management courses

This course is one part of an overall programme that aims to further embed self- management into the care given to patients. By developing self-management skills, patients become more confident to manage their condition better and to work in a more collaborative way with health professionals. The outcome is more activated patients who want to maintain more control of the management of their lives and their health.

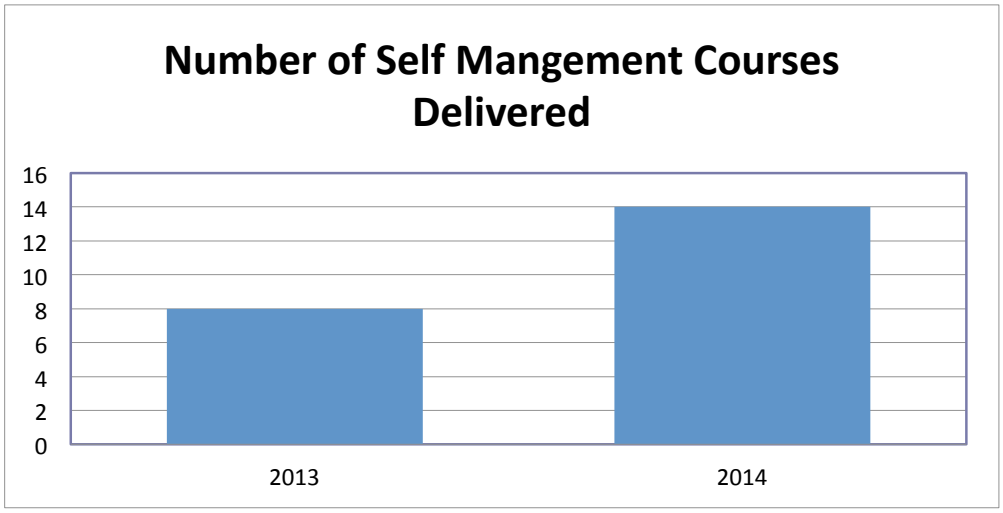
a. Improvement work carried out
So far this year 12 new tutors have been trained – this includes 7 staff and 5 volunteers. The Trust is in the process of recruiting further volunteers following keen interest from course participants. There are now 12 active volunteers delivering this programme.



14 programmes were delivered in 2014 and new patient information leaflets were launched in June 2014. Demand for courses has increased, with more calls to the programme office received since the new leaflets were used. The first course ever has now been delivered in Todmorden with 15 people completing the course.

The number of courses being provided has increased and there is no waiting list currently. Due to work carried out by community rehabilitation teams there was a further train the trainer course in 2014. This focussed on training clinical tutors so that courses can be carried out for new groups of patients.

All the volunteers have now delivered a course to patients. They have been supported by experienced volunteers who helped build their confidence.



From simple feedback measures post course all responses for this year to date have been in the positive range. Mean confidence scores changed from 3.5/10 at the beginning of the course to over 8/10 at the end of the courses from a cohort of 40 participants.

Participants reported numerous achievements against the goals they set on courses stating they felt more in control. Participant feedback about tutors has been complimentary and indicates how valued the input of our volunteers is alongside clinical tutors.

The volunteers won the CHFT Volunteer of the Year award at this year's Celebrating Success Awards. They are very grateful and proud of this recognition. The work they do is invaluable in supporting other people with long term conditions.

b. Target

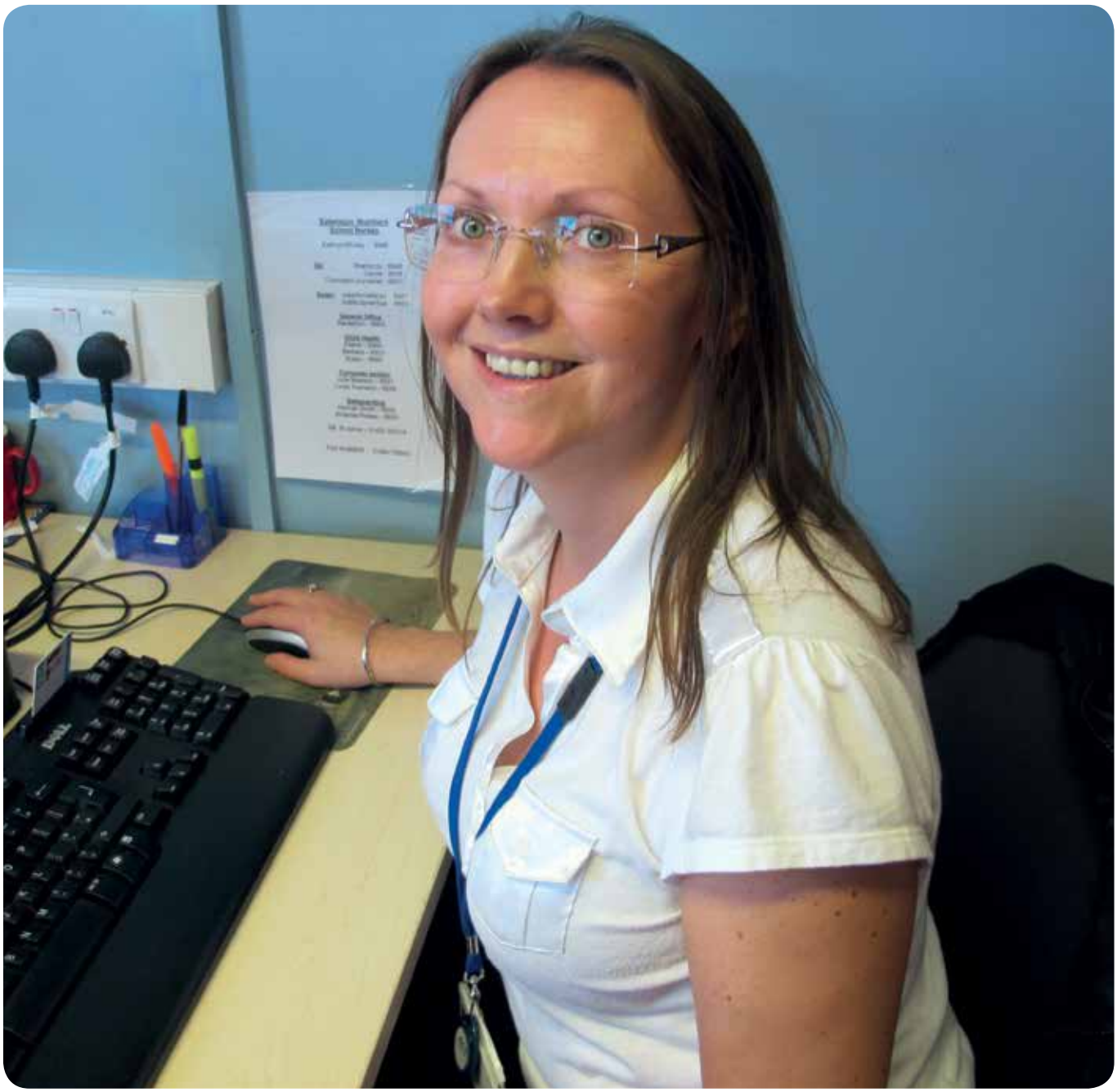
- Continue to deliver supported self-management courses and improve the quality of these courses and patient number attending.
- Improve the quality and usefulness of materials provided to patients.
- Continue to utilise the experience of the advocates for self-management (patients who have attended the course before).
- Increase the mean improvement score in the confidence of attendees to 'take control' of their conditions. A range of measures were used to ascertain if the courses have linked to improved outcomes.

c. Further work

Work has progressed on a new participant handbook to complement the self-management programme. This is currently being drafted and will be tested on a course before being signed off for printing.

Courses for people with Multiple Sclerosis and Parkinson's disease are being developed to start in April 2015 and work is on-going to integrate the approach into the existing falls prevention programme.

From the organising of the Todmorden course the team have learnt that working closely with the GP practice to recruit participants was helpful – this is a more proactive way of working than waiting for participants to apply themselves. The idea is to try this approach against when recruiting for the 16 courses planned for next year.



Looking ahead to 2015/16

A 'long list' of potential priorities for 2015/16 was developed from the following sources:
- regulator reports,
- incidents and complaints,
- on-going internal quality improvement priorities,
- national reports and areas of concern,
- evaluating the Trust's performance against its priorities for 2014/15,
- at a membership council workshop meeting.

This long list was discussed with the Trust's Membership Council; an opportunity to vote was also given via the Trust's internet site, advertised in the local press and through a tear off slip in Foundation News sent out by post to all Trust members.

This work has helped identify the following quality improvement priorities for 2015/16 because they are important to the Trust's stakeholders.

One priority has been carried over into this year's account as this was only partially achieved. It was agreed that three new projects should be selected this year that better reflected the current quality priorities for the Trust.

All previous priorities will continue to be monitored as part of the Trust's on-going improvement programmes.

The four priorities for 2015/16 are:

Domain	Priority
Safety	Improving Sepsis Care
Effectiveness	To ensure Intravenous antibiotics are given correctly and on time (continued from last year)
Effectiveness	Improving the discharge process
Experience	Better Food

Priority One - Improving Sepsis Care

Why we chose this
Sepsis is an infection which starts in one part of the body but spreads via the blood to others and can prove fatal for some patients.

Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths attributed to sepsis annually. Of these some estimates suggest 12,500 could have been preventable. Problems in achieving consistent recognition and rapid treatment of sepsis are currently thought to contribute to the number of preventable deaths.

The Trust has been actively working to reduce mortality and harm from sepsis for three years, significant improvements have been made around mortality rates but it is recognised that more can be done specifically around reliable screening for sepsis and making sure IV antibiotics are given within theone hour recommended timescale.

Improvement work
- Introduce reliable screening for sepsis for patients presenting in A&E's and other direct admission areas.
- Ensure when identified with severe sepsis, red flag sepsis or septic shock patients get the initial IV antibiotic dose within one hour.

Target
To achieve significant improvement in both of the above focussed areas for improvement by March 2016. We will measure our baseline performance in quarter one of the year and set a target for improvement based upon that measurement.

Reporting
The progress of improvement work around sepsis is monitored by the deteriorating patient collaborative (part of the care of the acutely ill patient programme), overseen by the Clinical Outcomes Group, Quality Committee and by exception Trust Board. In addition there will also be monthly reporting as part of CQUIN's requirement into the Trust Integrated Board Report.

Priority 2 - to ensure Intravenous (IV) antibiotics are given correctly and on time

Why we chose this
When infections are diagnosed it is essential antibiotics are given correctly and on time to aid recovery and ensure that the patient's condition does not deteriorate.

Work has been on-going in the Trust for a number of years and changes have occurred but this priority was chosen as it is recognised that further improvements need to be made.

Improvement work
The focus of the improvement work this year will continue to be around ensuing the Trust is ready for the new electronic prescribing system.
On-going audit work will continue so improvements can be targeted where they are most needed, point prevalence audits of antibiotic use in the Trust will happen quarterly through 2015-16 as part of the missed doses work. In addition the Trust's specialist antibiotic pharmacists will continue to audit trust wide every six months that antibiotics are given according to Trust policy. Results will be directly fed back to wards that are non-compliant.

Antibiotic ward rounds will continue on a twice weekly basis. The focus of these is education, challenge, advice and monitoring of antibiotic use. Different themes as they emerge will be targeted for improvement, for example the Trust is currently looking at intravenous Meropenem use.

The specialist antibiotic pharmacists will continue to work with junior front line staff in implementing change in their own ward/departmental areas, a number of junior doctors are currently working on their ideas for improvement.

The Trust has identified that the time taken to reconstitute and administer Piperacillin-tazobactam (one of the most widely used antibiotics) is significant – a trial of a "docked-vial" version of this antibiotic begins after Easter 2015 at HRI which will make the process quicker and simpler.

Target
- The Trust aim is to reduce by 50% unintentional missed doses of IV antibiotics.
- To ensure that antibiotics are prescribed according to Trust Guidelines.

Reporting
Reporting of progress is through missed doses audits via the Medication Safety Group, reporting in to Patient Safety Group and by exception to quality committee and Trust Board. In addition this measure is linked to the Sepsis CQUIN (IV Antibiotics) so will also report in via this route.

Priority 3 - Improving the discharge process

Why we chose this
We aim to make leaving the Trust and returning home for continuing recovery as smooth as possible by working closely within the Trust and with partner organisations.

Improvement work
The Trust will do this using a number of key improvement ideas.

One area the Trust is keen to target is to make sure patients are kept better informed around their discharge planning. On admission to hospital the clinical team decide on an estimated date of discharge when the patients care and treatment will have been completed. The Trust acknowledges that this has not always been consistently communicated. The idea is to use a welcome letter for all patients when they are admitted, this letter will contain discharge information around the process, an initial expected date of discharge so plans can be made and if concerns are raised who to talk to.

To supplement this the 'ticket home' conveys discharge information at the bedside to ensure family and carers are sufficiently informed of plans and ways in which they can support a smooth discharge.

It has also been acknowledged that staff have not always been proactive in discharge planning leading to patients staying in hospital longer than necessary, increasing their risks and potentially delaying full recovery. To address this a training programme for staff is being developed.

Closer ties are being forged with our local authority partners and other care providers to better understand and tackle the causes of delay for example equipment and transport issues. The aim is to ensure better cooperation around discharges to enable better planning and greater efficiency.

Target
A reduction in the number of patients who are delayed in leaving hospital when active treatment has ended.

To ensure patients are not being discharged too early the Trust tracks readmission rates; the aim is to stay below the national average rate of 7.30%.

Improvement in patient involvement in discharge planning scores (from patient surveys).

Reporting
The overall responsibility for efficiency of bed use (encompassing timely and appropriate bed use) reports into the bed efficiency group, reporting to the Executive Director of Nursing and Operations and through this to Executive Board and Board of Directors.

Priority 4 - Better Food

Why we chose this
The Trust has a responsibility to provide the highest level of care possible and this includes the quality of the food that is provided for patients.

Nutrition designed to meet patients' individual needs is central to a good recovery. The Trust aims to provide patient choice which is both hot and appetising and nutritionally balanced.

Improvement work
Good nutrition has been a priority for the Trust for the past few years, through the past year working nationally with the 'food for life' initiative along with two other Trusts. This project has received funding for another two years from Calderdale Clinical Commissioning Group (CCG) . As an organisation 'food for life' are known for their certificate scheme, the Catering Mark, which supports organisations to meet sustainability and nutrition standards in catering. Through the Big Lottery Fund the work is focussing on developing a new health promoting hospital model that focuses on food.

There has been a local CQUIN in place for the past year supported by local Healthwatch, Calderdale Care CCG and both council's public health teams focussing on improvements to the quality of the food being provided. Some changes resulting from the work have included bespoke menus for paediatrics and the introduction of homemade soups. A key part of the success of this work has resulted from improved partnership working between nursing, dietetics and catering in the Trust.

The CQUIN for next year will continue to focus on further improving the quality of food. In addition the work commenced as part of the 'food for life' initiative will continue to be developed and changes made. The continued engagement of key staff members will enable further sustained improvements.

Another piece of work is around vending machine food choices, the aim is to improve patient, visitor and staff choice whilst providing healthier options.

Target
The targets for this work will be in line with CQUIN requirements measured by:

- Improvements in the percentage of patient satisfaction with the quality of food provided.
- Reduction in food waste
- Changes that make the choices in vending machine healthier

Reporting
There will be quarterly reporting of progress against the CQUIN targets.

Operationally there is a multi-agency food steering group in place that reports to the Patient Experience Group and to the Trust's Quality Committee.

Award-winning: Acre Mills

Statements of assurance from the Board

Review of services

During 2014/15 the Calderdale and Huddersfield NHS Foundation Trust provided and/or sub-contracted 41 relevant health services.

The Calderdale and Huddersfield NHS Foundation Trust has reviewed all the data available to it on the quality of care in 34 of these relevant health services.

The income generated by the relevant health services reviewed in 2014/15 represents 62.55% of the total income generated from the provision of relevant health services by the Calderdale and Huddersfield NHS Foundation Trust for 2014/15.

Participation in Clinical Audits

During 2013/14, 32 of the national clinical audits and four national confidential enquiries covered relevant NHS services that the Calderdale and Huddersfield NHS Foundation Trust provide.

During that period Calderdale and Huddersfield NHS Foundation Trust participated in 100% of national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust was eligible to participate in during 2014/15 are contained in Appendix A

Participation in clinical research

The Calderdale and Huddersfield NHS Foundation Trust is committed to research as a driver for improving the quality of care and patient experience.

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2014/15 that were recruited into trials during that period to participate in research approved by a research ethics committee was 1, 056.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Trust clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

The Trust was involved in conducting 154 clinical research studies of which 55 were actively recruiting, 87 were closed to recruitment (but participants were still involved) and 13 studies were 'in set up' (either waiting for initiation or local approval).

During 2014/15 actively recruiting research studies were being conducted across four of the five divisions in fourteen specialties:

- Women, Children and Family Services (5 studies, 3 specialties);
- Diagnostic and Therapeutic Services (5 infection studies);
- Medical Services (42 studies, 9 specialties);
- Surgical and Anaesthetic Services (3 ophthalmology studies).

There were 67 clinical staff participating in research approved by a research ethics committee at the Trust during 2014/15, of which 54 were local principal investigators and one was chief investigator on an international multicentre clinical trial. There was one clinician commencing, and a further 5 continuing their studies at doctoral level.

Also, in the last three years, five publications have resulted from Trust involvement in National Institute for Health Research, which shows Trust commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Goals agreed with commissioners

A proportion of Calderdale and Huddersfield NHS Foundation Trust's income in 2014/15 was conditional upon achieving quality improvement and innovation goals agreed between Calderdale and Huddersfield NHS Foundation Trust 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 (CQUIN) payment framework. The figure for CQUINs allocated for 2014/15 was £6.8 million and for 2015/16 is £6.7 million. The Trust did not achieve the target for the Asthma CQUIN 2014/15 CQUIN programme. However, the 2014/15 CCG contract was under a fixed value agreement, inclusive of CQUINS, so no loss of CQUIN funding was incurred due to the failure of this target.

The CQUIN areas identified for 2014/15 covered a broad range of areas and reflected priorities specified at a national level supported by local priorities identified in partnership between commissioners and the Trust.

Four National CQUIN areas were identified for 2014/15:
- Friends and family test
- NHS Safety Thermometer Harm Measurement Indicator
- NHS Safety Thermometer - Reduction in the prevalence of pressure ulcers
- Dementia screening and referral; Clinical leadership and carer support

These national areas were complemented by further locally agreed CQUIN indicators in the following areas:
- Respiratory care bundles – asthma and community acquired pneumonia
- Diabetes: supporting the treatment of patients presenting acutely with hypoglycaemia and the promotion of self-care
- Improving medicines safety (transfer of care and discharge accuracy checks)
- End of life care
- Improving hospital food

In planning for 2015/16 the Trust has continued to work closely with local commissioners to develop a programme of CQUIN quality indicators which are consistent with the key challenges faced locally. The development of these areas of focus has had strong clinical involvement in identifying areas for possible inclusion.

A number of 2014/15 CQUIN indicators have been retained and will enter a further year of targeted improvement work during 2015/16:

Four national CQUIN areas were identified for 2015/16:
- Acute Kidney Injury
- Sepsis – screening and antibiotic administration
- Urgent care
- Dementia screening and referral; Clinical leadership and carer support

These national areas will be complemented by further locally agreed CQUIN indicators in the following areas:
- Respiratory care bundles – asthma and community acquired pneumonia
- Diabetes – promotion of self-care
- Improving medicines safety (transfer of care and discharge accuracy checks)
- End of life care
- Hospital food – patient satisfaction, reduction of waste and vending

Further details of the nationally agreed goals for 2014-15 and for the following 12 month period are available electronically at: http://www.england.nhs.uk/nhs-standard-contract/

Care Quality Commission registration

The Trust is required to register with the Care Quality Commission (CQC) and has full registration without conditions. The CQC has not taken enforcement action the Trust during 2014/15.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

CQC Intelligent Monitoring Report

To date in 2014-15 two reports have been published for the Trust.
Each report contains a priority band for inspection of the Trust, 1 being the highest priority for inspection (i.e. where the data indicates greatest concern for care quality) and 6 being the lowest priority.

The indicators cover:

- Incidents
- Infections
- Mortality
- Maternity and women's health
- Readmissions
- Patient Reported Outcome Measures (PROMs)
- Audit
- Compassionate care
- Meeting physical needs
- Overall experience
- Treatment with dignity and respect
- Trusting relationships
- Maternity survey
- Access to treatment measures
- Discharge and integration
- Patient-led assessments of the care environment
- Reporting culture
- Partners
- Staff survey
- Staffing levels
- Qualitative intelligence

In the July 2014 report the Trust was banded as a 4. The reasons for this rating are graded as elevated risks and risks.
Elevated risks were reported for the following:

- The proportion of patients assessed as achieving compliance with all 9 standards of care as measured through the hip fracture database (April 12 to March 13).

Risks were reported for the following:

- Composite of Central Alerting System (CAS) indicators (Feb 13 to Jan 14)
- Sentinel stroke national audit programme (SSNAP) – overall team-centred rating score for key stoke indicator) Oct 13 to Dec 13).
- Maternity survey – 'did staff treating and examining you introduce themselves' (Feb 14)
- Monitor – continuity of service rating (May 14)
- Electronic Staff Record items relating to staff support/supervision (March 14).

In the October 2014 report the Trust was banded as a five (an improvement of one band from July 14). Elevated risks were reported for the following:

- The proportion of patients assessed as achieving compliance with all nine standards of care as measured through the hip fracture database (Oct 13 to March 14).
- Consistency of reporting to the National Reporting and Learning System (NRLS) (Oct 13 to Mar 14).

Risks were reported for the following:

- SSNAP – overall team-centred rating score for key stoke indicator (Oct 13 to Dec 13).
- Composite risk rating of ESR items relating to staff support/supervision (Aug 13 – July 14).

It is of concern that standards of care as measured through the hip fracture database have remained an elevated risk through this year – this encompasses data between April 12 to March 14.

There is a detailed action plan in place in the surgical division to address this. Over the year so far the Trust has seen improvement and delivered all nine elements to over 30% of patients (based on a trajectory where the Trust was below 30% at the beginning of the year).

In the five months from November 2014, 77% of patients had their operation within 36 hours.

The trauma co-ordinator has taken responsibility for addressing the gaps in the national hip fracture database that were due to administration or task management.

A key challenge is to fill medical posts; the Trust continues to advertise but has had little success to date. In the meantime to address any risk some of the junior doctor vacancies are covered by locums.

The elevated risk around the NRLS had already been noted by the risk team at the Trust, due to staff changes some inconsistencies had developed. These have now been corrected and a system of a weekly upload put into place and is being performance managed. This new system has been discussed with the Trust's CQC compliance inspector who is satisfied with the changes.

The Trust is aware of on-going risk around the SSNAP – (overall team-centred rating score for key stoke indicator Oct 13 to Dec 13). There is a detailed action plan in place and being delivered around Stroke Care (see local indicator for more detail). Composite risk rating of electronic staff record (ESR) items relating to staff support/supervision (Aug 13 – July 14). This risk specifically relates to the ratio of band 7 nurses to band 5/6 nurses and proportion of all ward staff who are registered nurses. This data set has now been added to the well led domain dashboard using the same calculations as the CQC so it can be monitored internally. There has been some improvement in both data sets; however both indicators are still below the expected rate. In addition through the 'Hard Truths' work safe staffing levels are being monitored monthly. Band 7 nurses are also being introduced in the Trust's community team which will improve ratios. Band 8A nurses are supervising and supporting band 5 and 6 nurses.

Data quality

The Trust has signed a contract with 'Cerner' for the implementation of their Millennium electronic patient record (EPR) system during 2016. This not only provides an opportunity to modernise the Trust's operating procedures to support and improve patient care, but also acts as a driver to improve data quality. During the next 18 months, the Trust will:

- Agree an approach to data migration from legacy systems
- Undertake cleaning of the data to be migrated
- Develop operating procedures for data collection within the EPR
- Work with the EPR business change and training teams to incorporate data quality awareness
- Identify future integration solutions between the EPR and bespoke systems, including the tactical deployments for theatres, vital signs, scanned case notes and maternity deployed in 2014/15 and early 2015/16

As the current PAS system now has a limited lifespan, data quality management will focus on continuing to address data quality issues identified through audit or through operational experience and addressing any new data quality standards mandated nationally or through commissioning requirements.

NHS Number and general medical practice code validity

The Trust submitted records during 2014/15 to the Secondary Uses Service 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:
  Admitted Patient Care = 99.8%
  Outpatient care = 99.9%
  Accident & Emergency Care = 98.8%

- Which included the patient's valid General Practitioner's Registration Code was:
  Admitted Patient Care = 100%
  Outpatient Care = 100%
  Accident & Emergency Care = 99.9%

These figures are based on April 2014 to January 2015, which are the most recent figures in the Data Quality Dashboard.

Information Governance

The Trust Information Governance Assessment Report overall score in March 2015 is 78% and graded as 'satisfactory' with all scores at a level two or three.

In the submission of the information governance toolkit for March 2015 the Trust scored 78% and was marked as 'satisfactory'. All scores were either at a level two or a level three. A substantial programme of work is under way for 2015/16 to promote the continued use of technology within the Trust this includes the electronic patient record. There will be leaflets, awareness raising events and visits to wards and departments across the Trust to interact with staff and ensure that all information governance standards are being adhered to.

Clinical Coding Error Rate

The Trust was not subject to the Payment by Results clinical coding audit 2014/15 by the Audit Commission.

Review of quality performance – how we compare with others

In this section you will find more information about the quality of services that the Trust provides by looking at performance over the last year and how the Trust compares with other Trusts.

This year the Department of Health (DH) has published a core set of indicators to be included in the Quality Accounts of all NHS Foundation Trusts. These changes support the Mandate commitment that the NHS should measure and publish outcome data for all major services by 2015.

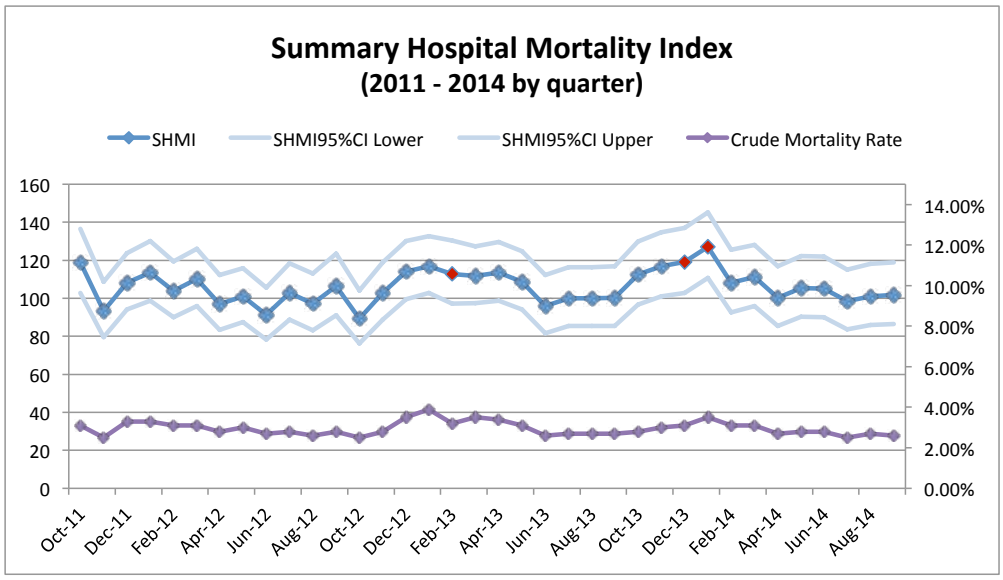
Summary table of performance against mandatory indicators

Indicators	Previous 2 Periods		Most Recent Period
12. Summary Hospital-Level Mortality Indicator (SHMI).	**Jul 2011 – Jun 2012**	**Jul 2012 – Jun 2013**	**Oct 2013 – Sept 2014**
(i) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period: National Average: 100 Lowest: 54.1 Highest: 119.8	102	105.7	109
(ii) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. National Average: 24.6 Lowest: 0 Highest: 49	19.1%	19.7%	20.3%
18. PROMS; patient reported outcome measures.	**2011/12**	**2012/13**	**2013/14**
(i) groin hernia surgery,*	0.10	0.07	0.07
(ii) varicose vein surgery,*	0.09	0.10	0.11
(iii) hip replacement surgery, and *	0.45	0.43	0.44
(iv) knee replacement surgery.*	0.32	0.37	0.34
19. Patients readmitted to a hospital within 28 days of being discharged.	**2012/13**	**2013/14**	**2014/15**
(i) 0 to 15; and	8.9 %	8.7 %	9.0 %
(ii) 16 or over.	7.3 %	6.8 %	6.5 %
20. Responsiveness to the personal needs of patients. (this data is yet to be released for 2014)	**2012**	**2013**	**2014**
	69%	68%	TBC
21. Staff who would recommend the Trust to their family or friends.	**2012**	**2013**	**2014**
	69%	68%	65%
New Indicator - Patients who would recommend the Trust to family or friends.	Jan 2015	Feb 2015	Mar 2015
	96.5	95.6	96.4
23. Patients admitted to hospital who were risk assessed for venous thromboembolism.	**2014/15 Q1**	**2014/15 Q2**	**2014/15 Q3**
	95.3%	95.4%	95.3%
24. Rate of C.difficile per 100 000 bed days	**2012/13**	**2013/14**	**2014/15**
	14.3	12.0	6.2
25. Patient safety incidents and the percentage that resulted in severe harm or death.	April 13 - Sept 13	Oct 13 - March 14	April 14 - Sept 14
(i) Rate of Patient Safety incidents per 1000 Bed Days	5.51 (per 100 Admissions)	5.24 (per 100 Admissions)	36.22
(ii) % of Above Patient Safety Incidents = Severe/Death	2.6%	1.3%	1.2%

12 Preventing People from dying prematurely
(i) Summary Hospital-Level Mortality Indicator (SHMI).

The summary hospital-level mortality indicator (SHMI) measures deaths that happen both in an NHS hospital and within 30 days of discharge from a hospital stay. It is the ratio between the actual number of patients who die following a treatment at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

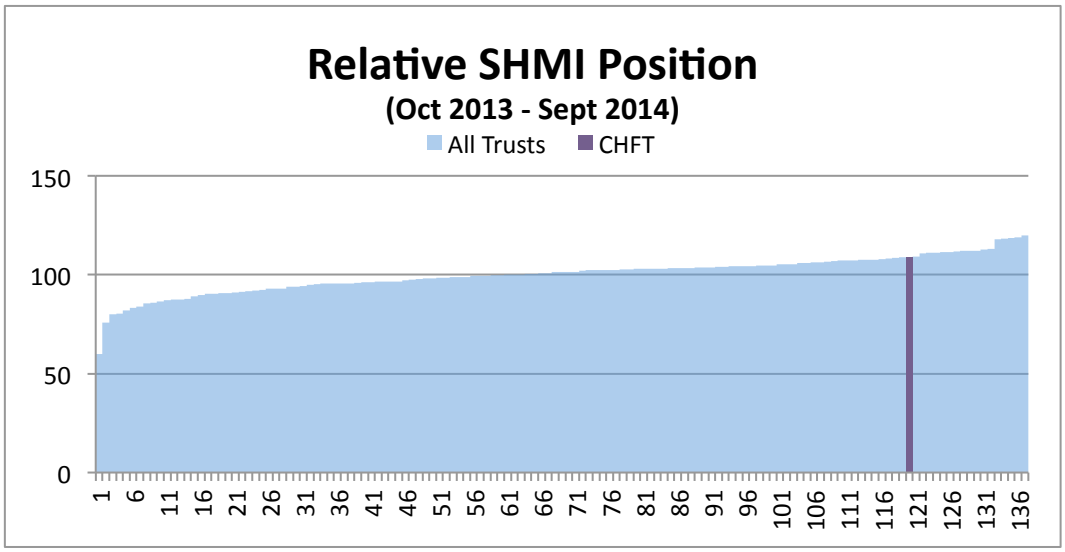
The chart below shows the value and banding of the SHMI for the Trust for the reporting period from October 2011 to September 2014.



100 is the expected score based on data submitted from all NHS trusts.

The blue diamond's represent the Trust's position for the quarter.
Where the diamonds are red this means the quarter they represent had a statistically significant relative risk (i.e. the lower 95% confidence limit and the upper 95% confidence limit are both above 100) that was higher than predicted.

This chart shows the Trust's relative positions when compared against other acute NHS providers in England.



The Calderdale and Huddersfield NHS Trust considers that this data is as described for the following reason:

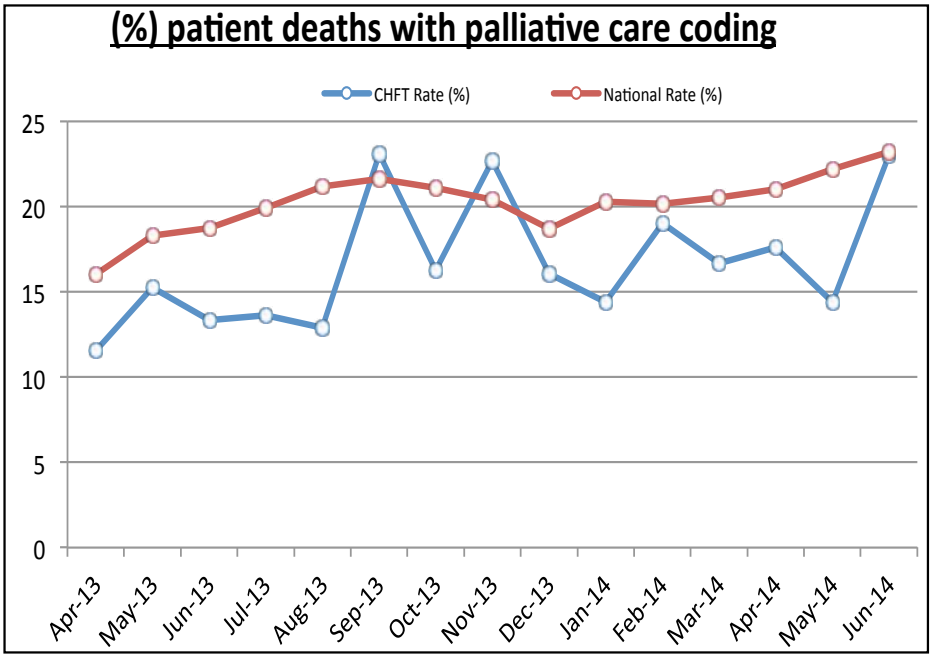
- The SHMI data shows the Trust's performance against the expected mortality rate of 100. Data available for the past three years is relatively stable against expected with two periods (red diamonds) of concern.

The Calderdale and Huddersfield NHS Trust has taken the following actions to improve this score and so the quality of its services, by:

- The impact on SHMI is linked to the Trust's strategy for improving the quality of care overall. The largest programme designed to impact on SHMI is the care of the acutely ill patient programme. This has been running since October 2013; reviewed in October 2014.
- In addition the SHMI data can be tracked to specific conditions where the actual number of deaths exceeds expected, where this occurs cases are investigated and reports presented to clinical outcomes group with actions where necessary.

12 (ii) Percentage of patient deaths with palliative care coded

The chart shows the percentage of Calderdale and Huddersfield NHS Foundation Trust hospital deaths that have a palliative care code against the national rate.



The Calderdale and Huddersfield NHS Foundation Trust considers that this data is as described for the following reason:

- The Trust data has been variable when compared to the national rate however the latest data point available shows it to be the same illustrating an improvement.

The Calderdale and Huddersfield NHS Trust has taken the following actions to improve this score and so the quality of its services, by:

- Use of palliative care coding is monitored closely, it is reported monthly in the coding dashboard which is discussed at divisional and Trust level, and any issues with performance are identified and discussed. The coding team have carried out work to ensure the national rules are being correctly applied to the Trust's data.

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

Patient reported Outcome Measures (PROMS) are a way of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves.

Data on PROMS has been collected since April 2009 (six years) on four different procedures:

- Groin Hernia;
- Hip replacements;
- Knee replacements;
- Varicose Veins.

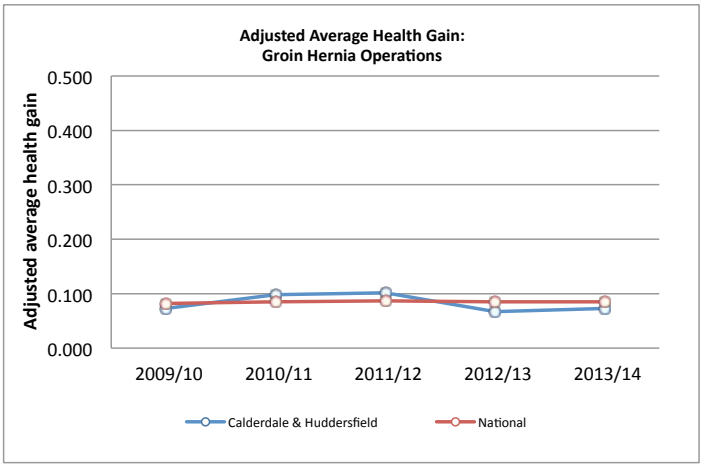
Questionnaires are completed by patients before and after the surgery to evaluate how effective the procedure has been. From the findings of these questionnaires, pre and post-operative scores and health gains are calculated. (Example of pre questions – answering questions on five different areas of the individuals own health state, Mobility, Self Care, Usual Activities, Pain/Discomfort and Anxiety/Depression).

Please note: there is no data available showing the Trust compared to best and worst performers

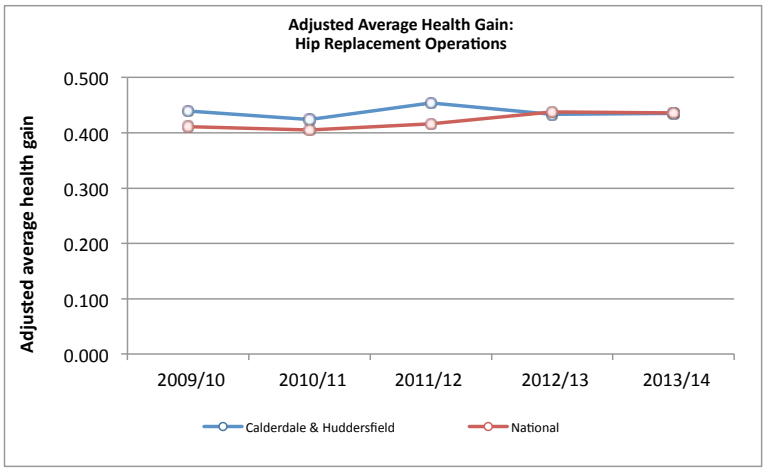
The Calderdale and Huddersfield NHS Foundation Trust considers that this data is as described for the following reasons:

- Participation: Nationally there were 251,843 eligible hospital episodes and 194,643 pre-operative questionnaires returned – this equates to a headline participation rate of 77.3% across all 4 procedures, for CHFT the rate was 77.7% (slightly above). For the post procedure questionnaires the national response rate was 67.8%, for CHFT it was 72.1% (significantly better).

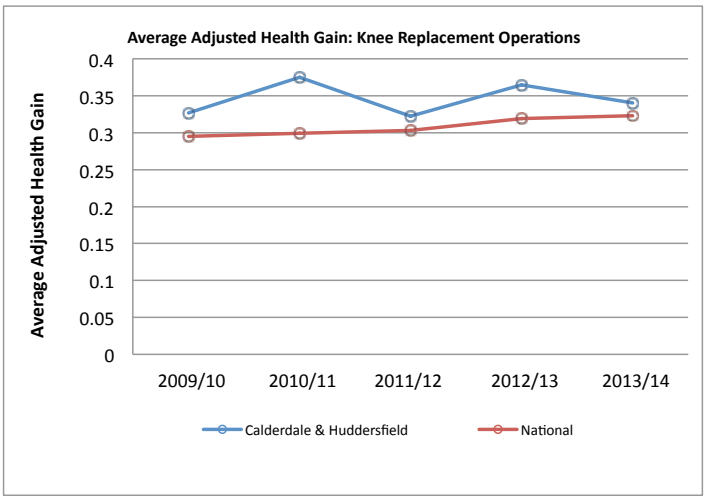
- Health Gain compared to national data: Note the graphs show the increase or decrease in health gain each year, the data below is the percentage of patients reporting a health gain in 2013/14 (the latest data available).



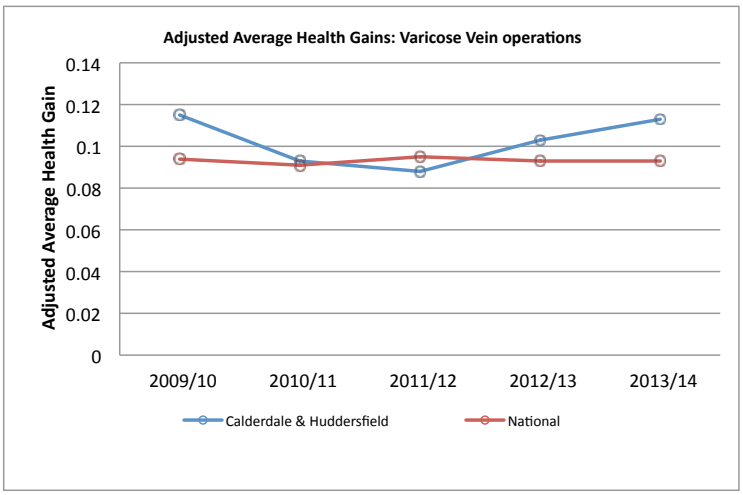
Groin Hernia – Calderdale and Huddersfield NHS Foundation Trust, 46.1% have improved, England 50.6%. This data is taken from 152 responses.



Hip Replacement – Calderdale and Huddersfield NHS Foundation Trust, 90.2% have improved, England 89.3%. This data is taken from 255 responses.



Knee Replacement – Calderdale and Huddersfield NHS Foundation Trust, 82.4% have improved, England 81.4%. This data is taken from 295 responses.

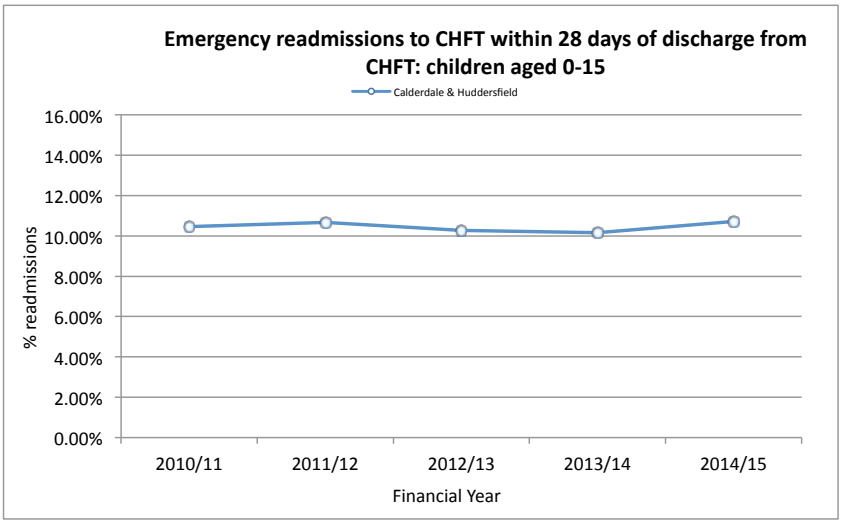


Varicose Veins – Calderdale and Huddersfield NHS Foundation Trust, 51.7% improved, England 51.8%. This data is taken from 87 responses.

The reported health gains for Groin Hernia and Varicose Veins are lower than for Hip and Knee replacements; this could be due to patients' not actually experiencing problems such as pain or reduced mobility prior to the procedure.

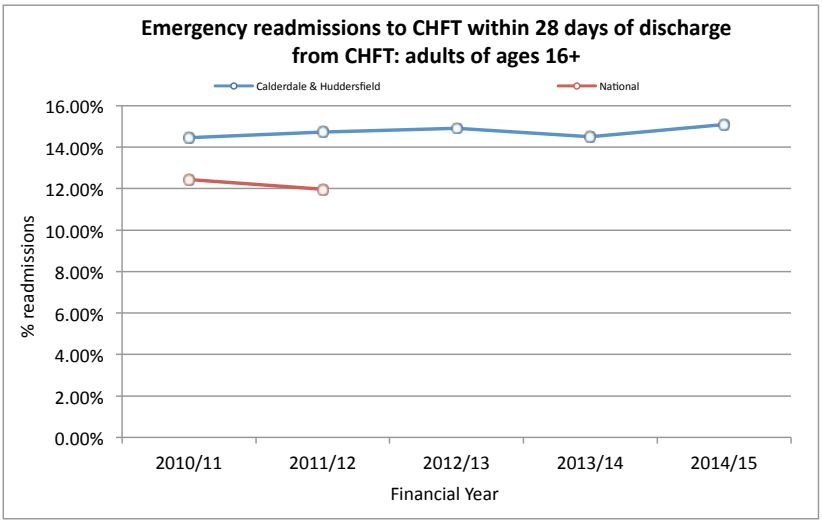
The Calderdale and Huddersfield NHS Trust has taken the following actions to improve this score and so the quality of its services, by:

- continuing to ensure this data is accessible at consultant level so it can be used for clinical revalidation and to help drive improvements in practice.



0-15	2010/11	2011/12	2012/13	2013/14	2014/15
Calderdale & Huddersfield	10.45%	10.66%	10.27%	10.16%	10.72%

Age 16 and over



16+	2010/11	2011/12	2012/13	2013/14	2014/15
Calderdale & Huddersfield	14.45%	14.74%	14.90%	14.50%	15.09%

The Calderdale and Huddersfield NHS Trust considers that this data is as described for the following reason:

- At present there is no national 28 day readmission rate available. The data is not due to be released by the Health and Social Care Information Centre until 2016
- The data included in these charts differs from the Trust board performance report as the parameters used are slightly different. This variance makes the internal report more meaningful to the Trust.

The Calderdale and Huddersfield NHS Trust intend to take the following actions to improve this score and so the quality of its services, by:

- Better planned discharges lead to less readmission; discharge planning is one of the Trust priorities for the next year, and there are a range of interventions outlined in part 2 of this account.

20. Responsiveness to the personal needs of patients. (please note this section reflects the national patient survey,)

This is the Trust's Commissioning for Quality and Innovation indicator (CQUIN) score with regard to its responsiveness to the personal needs of its patients during the reporting period.

The Calderdale and Huddersfield NHS Trust consider that this data is as described for the following reason:

Question		2013		2014	
		CHFT Score	National Score	CHFT Score	National Score
Q32	Were you involved as much as you wanted to be in decisions about your care and treatment?	7.3	7.3	7.6	7.7
Q34	Did you find someone on the hospital staff to talk about your worries and fears?	6.3	6.0	6.3	6.3
Q36	Were you given enough privacy when discussing your condition or treatment?	8.5	8.4	8.6	8.5
Q56	Did a member of staff tell you about medication side effects to watch for when you went home?	4.4	5.5	4.6	5.7
Q62	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	8.2	8.0	8.4	8.1
OVERALL EXPERIENCE		**7.8**	**8.1**	**8.1**	**8.2**

The Calderdale and Huddersfield NHS Trust intends to take the following actions to improve this score and so the quality of its services by: implementing the Patient Experience Improvement plan.

Patient Surveys

NATIONAL INPATIENT SURVEY 2014

	2012 Results	2013 Results	2014 Results	Change from 2013 to 2014
The emergency/A&E department (answered by emergency patients only)	8.5	8.7	8.6	↓
Waiting lists and planned admissions (answered by those referred to hospital)	8.9	9.0	9.0	-
Waiting to get to a bed on a ward	7.4	7.2	7.6	↑
The hospital and ward	8.3	8.3	8.2	↓
Doctors	8.4	8.5	8.6	↑
Nurses	8.4	8.4	8.5	↑
Care and treatment	7.6	7.8	7.9	↑
Operations and procedures (answered by patients who had an operation or procedure)	8.1	8.3	8.6	↑
Leaving hospital	7.2	7.3	7.3	↑
Overall views of care and services	5.0	5.2	5.8	↑
OVERALL EXPERIENCE	7.7	7.8	8.1	↑

SUMMARY

Overall, the trust has performed slightly better in the 2014 survey compared to previous surveys going from 7.8 to 8.1. In the 2014 Inpatient Survey, the trust has scored the same for Waiting List and Planned Admissions and has improved for most areas except for A&E departments and Hospital and Ward. This is shown in the table below with a comparison of previous years and also showing an increase or decrease from last year's survey.

Trust Comparisons by Question

- In the 2014 survey, overall the trust has performed at a similar level to the 2013 survey and has continued to score highly in the patients experience on the Hospital and Ward section regarding feeling threatened by other patients or visitors and the availability of hand gels and also in Care and Treatment section regarding privacy when being examined or treated.

- This year, the trust has improved significantly on planning for a patients discharge and giving families information needed for care when patients leave the hospital going from 7.1 to 7.8. The trust has also scored better in this year's survey for patients being given full information when having an operation or procedure going from 8.9 to 9.1 and also for patients being treated with respect and dignity from 8.7 to 9.1.

- Even though the trust has stayed at a similar level for the last 3 years; some areas have not performed as well as previous years. These include patients not being given enough privacy when being treated in A&E going from 9.0 to 8.6, noise at night by other patients from 7.0 to 6.4 and patients being delayed on discharge and not given enough information regarding what they should and shouldn't do when leaving the hospital going from 7.2 to 7.0 and Q55 from 7.2 to 6.7.

	Patient responseFor each question in the survey, people's responses are converted into scores, where the best possible score is 10/10	Compared with other trusts Each trust received a rating of Better, About the same or Worse on how it performs for each question, compared with most other trusts.
The emergency/A&E department (answered by emergency patients only)	**8.6/10**	**About the same**
Information - for being given enough information on their condition and treatment in A&E	8.6/10	About the same
Privacy - for being given enough privacy when being examined or treated in A&E	8.7/10	About the same
Waiting lists and planned admissions (answered by those referred to hospital)	**9.0/10**	**About the same**
Waiting to be admitted - for feeling that they waited the right amount of time on the waiting list to be admitted	8.6/10	About the same
Changes to admission dates - for not having their admission date changed by the hospital	9.2/10	About the same
Transitions between services - that the specialist they saw in hospital had been given all the necessary information about their condition or illness from the person who referred them	9.2/10	About the same
Waiting to get to a bed on a ward	**7.6/10**	**About the same**
Waiting to get to a bed on a ward - for feeling they did not have to wait a long time to get to a bed on a ward, following their arrival at the hospital	7.6/10	About the same
The hospital and ward	**8.2/10**	**About the same**
Single sex accommodation - for not having to share a sleeping area, such as a room or bay, with patients of the opposite sex	8.7/10	About the same
Single sex bathrooms -for not having to share a bathroom or shower area with patients of the opposite sex	8.3/10	About the same
Noise from other patients - for not being bothered by noise at night from other patients	6.4/10	About the same
Noise from staff - for not being bothered by noise at night from hospital staff	8.2/10	About the same
Cleanliness of rooms or wards - for describing the hospital room or wards as clean	9.1/10	About the same
Cleanliness of toilets and bathrooms - for describing the toilets and bathrooms as clean	8.7/10	About the same
Safety - for not feeling threatened by other patients or visitors during their hospital stay	9.8/10	About the same
Availability of hand-wash gels - for hand-wash gels being available for patients and visitors to use	9.8/10	About the same
Quality of food - for describing the hospital food as good	5.1/10	About the same
Choice of food - for having been offered a choice of food	8.8/10	About the same
Help with eating - for being given enough help from staff to eat their meals, if they needed this	7.8/10	About the same
Doctors	**8.6/10**	**About the same**
Answers to questions - for doctors answering questions in a way they could understand	8.4/10	About the same
Confidence and trust - for having confidence and trust in the doctors treating them	9.0/10	About the same
Acknowledging patients - for doctors not talking in front of them, as if they weren't there	8.5/10	About the same
Nurses	**8.5/10**	**About the same**
Answers to questions - for nurses answering questions in a way they could understand	8.5/10	About the same
Confidence and trust - for having confidence and trust in the nurses treating them	9.0/10	About the same
Acknowledging patients - for nurses not talking in front of them, as if they weren't there	8.8/10	About the same
Enough nurses - for feeling that there were enough nurses on duty to care for them	7.5/10	About the same
Care and treatment	**7.9/10**	**About the same**
Avoiding confusion - For not being told one thing by a member of staff and something quite different by another	8.1/10	About the same
Involvement in decisions - for being involved as much as they wanted to be in decisions about their care and treatment	7.6/10	About the same
Confidence in decisions - for having confidence in decisions made about their condition or treatment	8.4/10	About the same
Information - for being given enough information on their condition and treatment	8.4/10	About the same
Talking about worries and fears - for finding someone on the hospital staff **to talk to about any worries and fears**, if needed	6.3/10	About the same
Emotional Support - for receiving enough emotional support, from hospital staff, if needed	7.7/10	About the same
Privacy for discussions - for being given enough privacy when discussing their condition or treatment	8.6/10	About the same
Privacy for examinations - for being given enough privacy when being examined or treated	9.5/10	About the same
Pain control - that hospital staff did all they could to help control their pain, if they were ever in pain	8.5/10	About the same
Getting help - for the call button being responded to quickly, when used	6.4/10	About the same

	Patient responseFor each question in the survey, people's responses are converted into scores, where the best possible score is 10/10	Compared with other trusts Each trust received a rating of Better, About the same or Worse on how it performs for each question, compared with most other trusts.
Operations and procedures (answered by patients who had an operation or procedure)	**8.6/10**	**About the same**
Explanation of risks and benefits - before the operation or procedure, being given an explanation that they could understand about the risks and benefits	9.1/10	About the same
Explanation of operation - before the operation or procedure, being given an explanation of what would happen	8.9/10	About the same
Answers to questions - he operation or procedure, having any questions answered in a way they could understand	9.0/10	About the same
Expectation after the operation - for being told how they could expect to feel after the operation or procedure	7.1/10	About the same
Information - for receiving an explanation they could understand from the anaesthetist or another member of staff about how they would be put to sleep or their pain controlled	9.4/10	About the same
After the operation - for being told how the operation or procedure had gone in a way they could understand	8.0/10	About the same
Leaving hospital	**7.3/10**	**About the same**
Involvement in decisions - for being involved in decisions about their discharge from hospital, if they wanted to be	6.9/10	About the same
Notice of discharge - for being given enough notice about when they were going to be discharged	7.5/10	About the same
Delays to discharge - for not being delayed on the day they were discharged from hospital	7.0/10	About the same
Length of Delay to discharge - for not being delayed for a long time	8.1/10	About the same
Advice after discharge- for being given written or printed information about what they should or should not do after leaving hospital	6.7/10	About the same
Purpose of medicines - for having the purpose of medicines explained to them in a way they could understand (those given medicines to take home)	8.2/10	About the same
Medication side effects - for being told about medication side effects to watch out for (those given medicines to take home)	4.6/10	About the same
Taking medication - for being told how to take medication in a way they could understand (those given medicines to take home)	8.3/10	About the same
Information about medicines - for being given clear written or printed information about medicines (those given medicines to take home)	7.8/10	About the same
Danger signals - for being told about any danger signals to watch for after going home	5.4/10	About the same
Home and family situation - for feeling staff considered their family and home situation when planning their discharge	7.7/10	About the same
Information for family or friends - for information being given to family or friends, about how to help care for them if needed	6.3/10	About the same
Contact - for being told who to contact if worried about their condition or treatment after leaving hospital	8.4/10	About the same
Equipment and adaptions in the home - for hospital staff discussing if any equipment, or home adaptions were needed when leaving hospital, if this was necessary	7.8/10	About the same
Health and social care services - for hospital staff discussing if any further health or social care services were needed when leaving hospital, if this was necessary	8.4/10	About the same
Overall views of care and services	**5.8/10**	**About the same**
Respect and dignity - for being treated with respect and dignity	9.1/10	About the same
Care from staff - for feeling that they were well looked after by hospital staff	8.9/10	About the same
Patients' views - during their hospital stay, being asked to give their views about the quality of care	2.4/10	About the same
Information about complaints - for seeing, or being given, any information explaining how to complain to the hospital about care received	2.8/10	About the same
Overall experience	**8.1/10**	**About the same**
Overall view of inpatient services - for feeling that overall they had a good experience	8.1/10	About the same

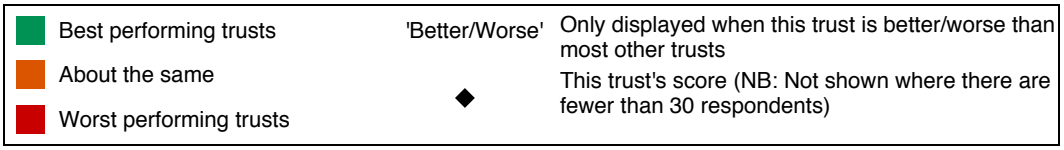
A&E Patient Surveys 2014

NATIONAL A&E SURVEY

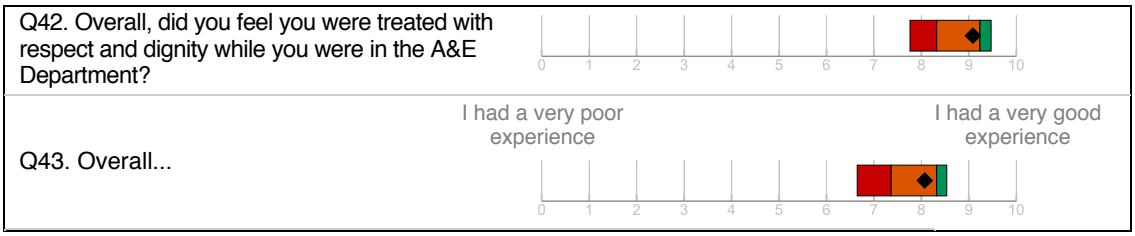
This national survey focused on people who recently used a hospital accident and emergency department (A&E). Patients were eligible to take part in the survey if they:

- were aged 16 years or older,
- were not staying in hospital at the time patients were sampled,
- had attended A&E in March 2014.

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the Trust is performing. The following table represents the Trust's performance from the summary of all sections of the report:



The results were positive; there were no scores on the worst performing Trusts range, of note the care and treatment section scored in the best performing Trusts range. The overall experience questions were also positive, both towards the upper end of the amber score.

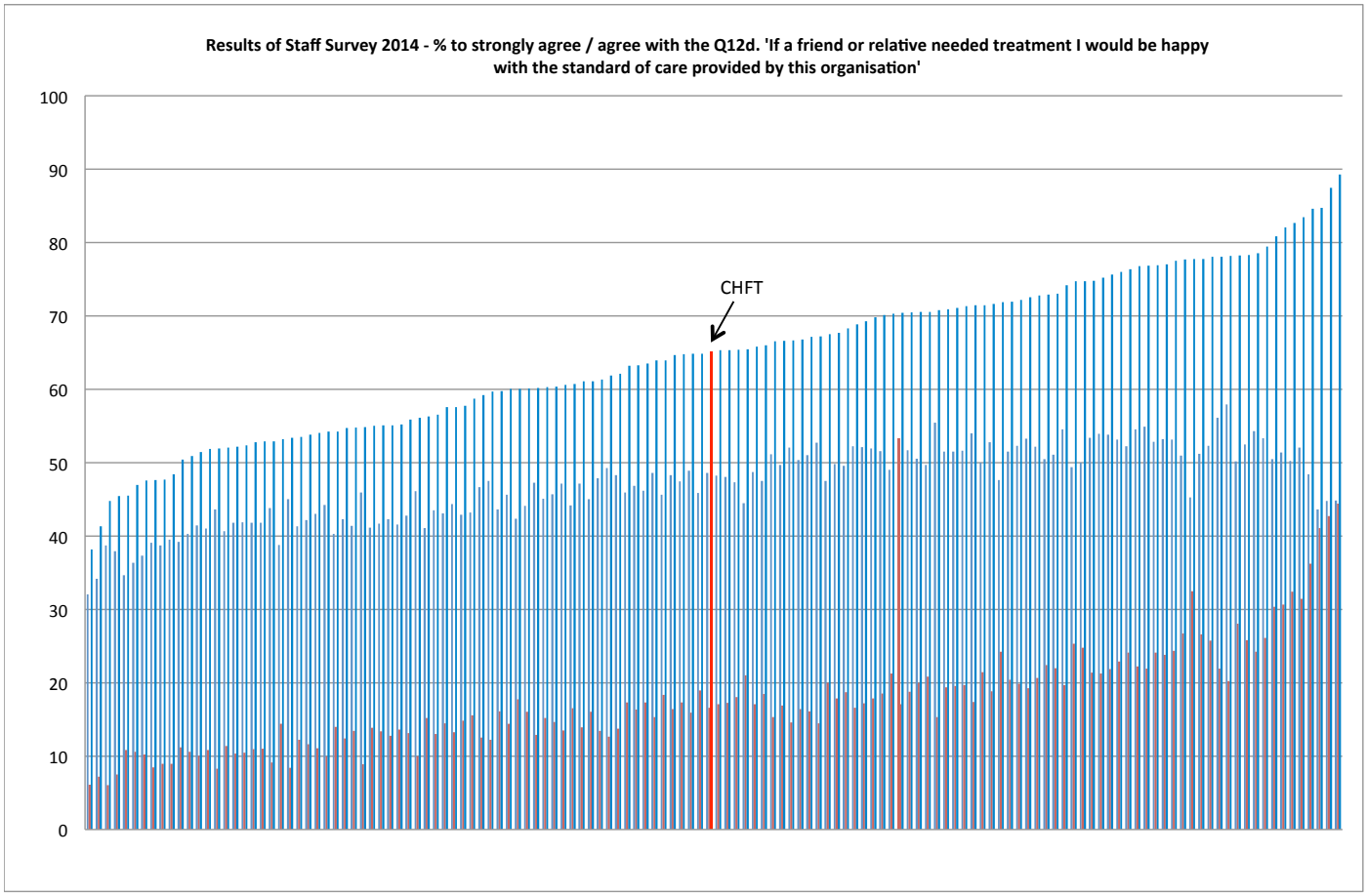


Actions being taken to improve scores:

- It is recognised that communication about waiting times on arrival to the unit need to be improved. There is work underway with reception and triage staff about how to ensure patients are kept as up to date as possible.
- Discharge is also an area of focus for the Trust. Leaflets are being updated as part of the emergency department's quality improvement programme. The aim is to ensure there is adequate discharge information for all conditions that patients present with that is relevant to all age groups. These leaflets focus on what to do and who to contact if symptoms persist or if further help is required.

21. Staff who would recommend the Trust to their family or friends

The charts shows the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family and friends.



The Calderdale and Huddersfield NHS Trust consider that this data is as described for the following reason:

- The Trust's staff survey is based on a sample of 850 staff of which 822 were eligible to complete the survey. The response rate was 45% - making a total of 370 staff who participated in the survey.

The staff survey score for indicator KF24 with contributing questions:

Question/ Indicator	CHFT 2013-14	CHFT (compared to national) 2014-15	National 2014-15
Q12a Care of patients/service user is my organisations top priority	**72**	**70**	**70**
Q12b My organisation acts on concerns raised by patients /service users	**71**	**70**	**71**
Q12c I would recommend my organisation as a place to work	**62**	**57**	**58**
Q12d If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.	**68**	**65**	**65**
KF24 (Overall Indicator) Staff recommendation of the Trust as a place to work or receive treatment	**3.74**	**3.67**	**3.67**

Staff recommendation of the Trust as a place to work or receive treatment is 3.67; the score in the 2013 survey was 3.74 out of 5. This is a small reduction in performance against the previous years' survey.

Looking at the survey as a whole the following table shows where the Trust performed in the best 20% or worst 20% than the national average.

Indicator	CHFT	National	Top or Bottom 20% of Trusts
KF7 staff appraised in last 12 months	91%	85%	Top
KF13 reporting errors, near misses or incidents witnessed in the last month	94%	90%	Top
KF22 able to contribute towards improvements at work	72%	68%	Top
KF27 belief that the trust provides equal opportunities for career progression or promotion	91%	87%	Top
KF28 experiencing discrimination at work in last 12 months	9%	11%	Top
KF17 experiencing physical violence from staff in last 12 months	4%	3%	Bottom
KF26 having equality and diversity training in last 12 months	45%	63%	Bottom

Of the 29 key findings, 11 have shown improvement since 2013, one has remained the same, 15 have deteriorated and two cannot be compared due to changes in the questions.

The Trust scored well in each of the sub-dimensions for staff engagement and above average for the overall staff engagement indictors. It was ranked in the top 20% of Trusts for K22 'staff ability to contribute towards improvements at work (the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work'.

There are some positive improvements in the perception of quality of care. For example, 67% of staff said they thought patient care was the top priority for their organisation compared to 66% in 2013. More than three quarters of staff reported that patient experience measures are collected in their organisation and 50% said such feedback is used to improve patient care.

A new question on raising concerns shows that 68% of staff would feel safe to raise a concern about unsafe clinical practice and 93% would know how to do so.

The Trust has a colleague engagement strategy which has at its core four behaviours that the Trust expects to see across the organisation. The Trust continues to work to embed these key values through its Working Together, Get Results programme.

The behaviours are:-

- We put the patient first – we stand in the patient's shoes and design services which eliminate unproductive time for the patient.
- We 'go see' - we test and challenge assumptions and make decisions based on real time data.
- We work together to get results - we co-create change with colleagues creating solutions which work across the full patient journey
- We do the must-do's - we consistently comply with a few rules that allow us to thrive.

The programme is aimed at achieving a consistent approach to how change is managed, in particular to ensure it fully engages the potential and creativity of staff and allows colleagues to work across divisional and organisational boundaries. There are simple and practical tools that help leaders engage colleagues in a way that allows breakthroughs in their ability to lead transformational change in the organisation. Properly applied the tools secure the commitment of colleagues to the organisation's vision and values and ensures colleagues are motivated and contribute to delivering the Trust vision:

In respect of the staff survey feedback the Trust plans to develop and agree actions for sign off by the Well Led Group in May and for that to progress to Quality Committee, Executive Board and the Board of Directors in the same month. The intention is to test the response with a range of colleagues between these meetings including those who participated in the Picker 2013 survey focus groups. The Trust also intends to use Picker to independently share the key messages from the survey in the organisation. In the meantime, colleagues will be updated Trust-wide about plans to progress action planning.

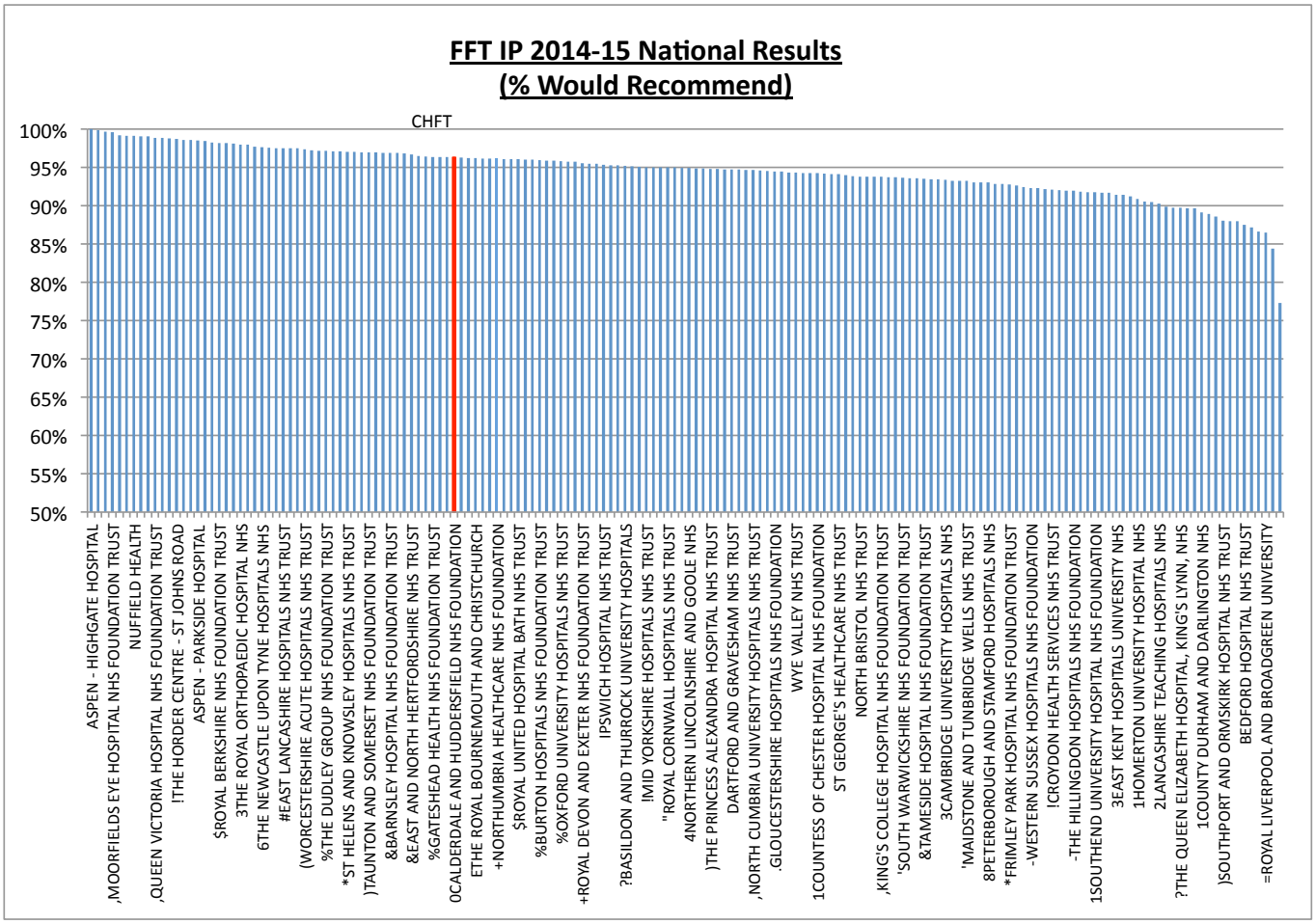
In addition there are some more immediate actions that the Trust plans to take/has taken:

- Building on significant risk/health and safety and equality and diversity training developments in 2014 a refresh of the approach to mandatory and essential skills training to improve access has been undertaken and will be considered for approval by the Trust's Executive Board in May.
- A mental health well-being and stress management policy was approved in March 2015.
- A health and well-being strategy with a supporting calendar of activities to promote colleague well-being is under development.
- Through the Trust's raising concerns/whistleblowing activity improving the feedback to colleagues on changes made when issues/ concerns are raised is being improved.
- The Trust is exploring the opportunities to influence behaviour of patients towards employees and to the provision of a safe and secure work environment for colleagues.
- In addition to the annual staff survey, where the friends and family questions are asked, the Trust also provides an opportunity for all staff to access the Staff Family and Friends Test on a quarterly basis.

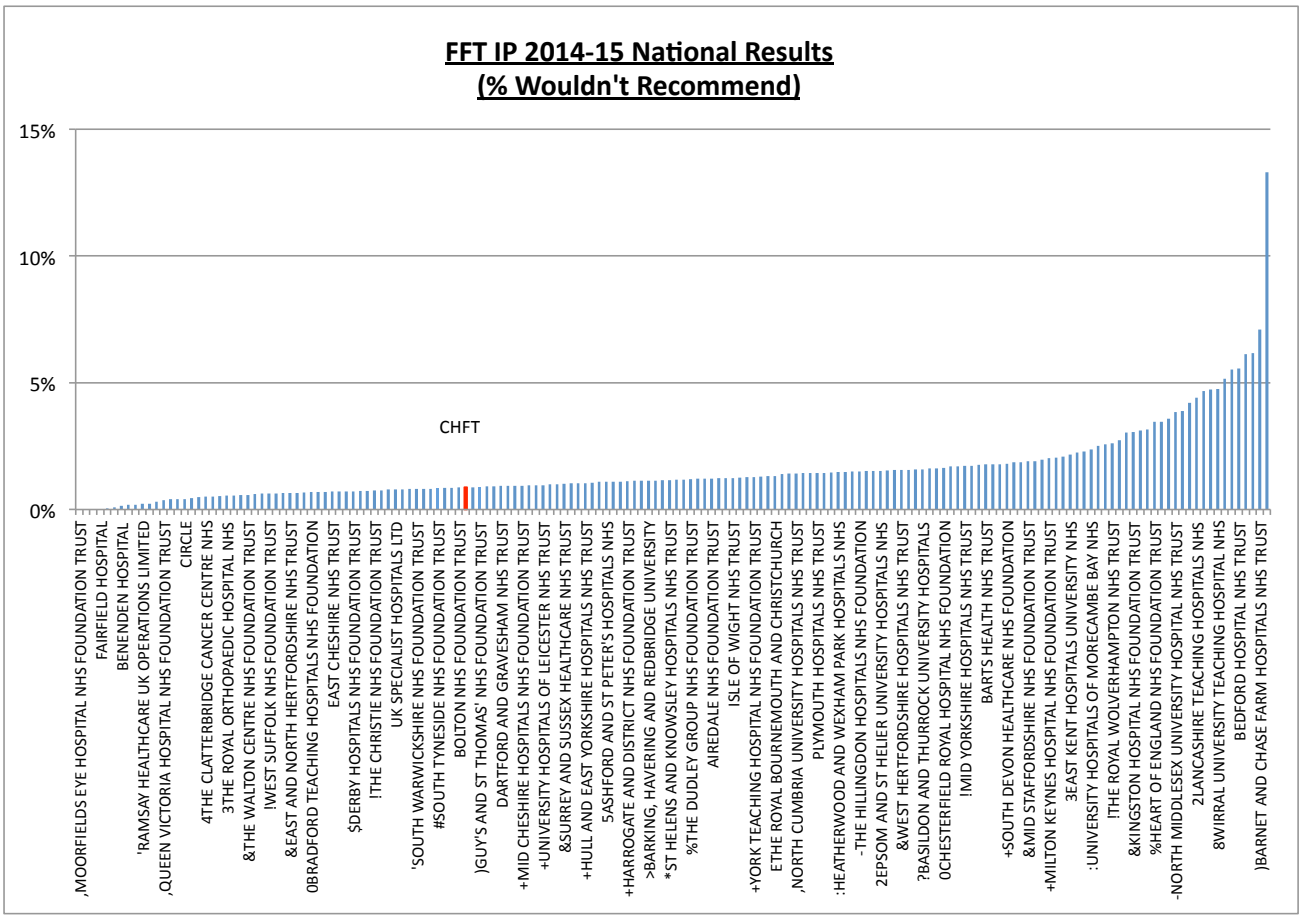
Patient element of friends and family test (FFT)

The Friends and Family Test is a question that has been asked to all inpatients over 16 in NHS hospital trusts since April 2013. The question asks "How likely are you to recommend our ward to friends & family if they needed similar care or treatment?" Up until October 2014 this was a Net Promoter Score (NPS) which is calculated on a scale of -100 to 100; following a review by NHS England a decision was made to introduce a more transparent presentation of the data which the patents and staff would find easer to understand and use. The outcome is that results are now presented as a % of patients who would recommend the service and the % of patients who would not.

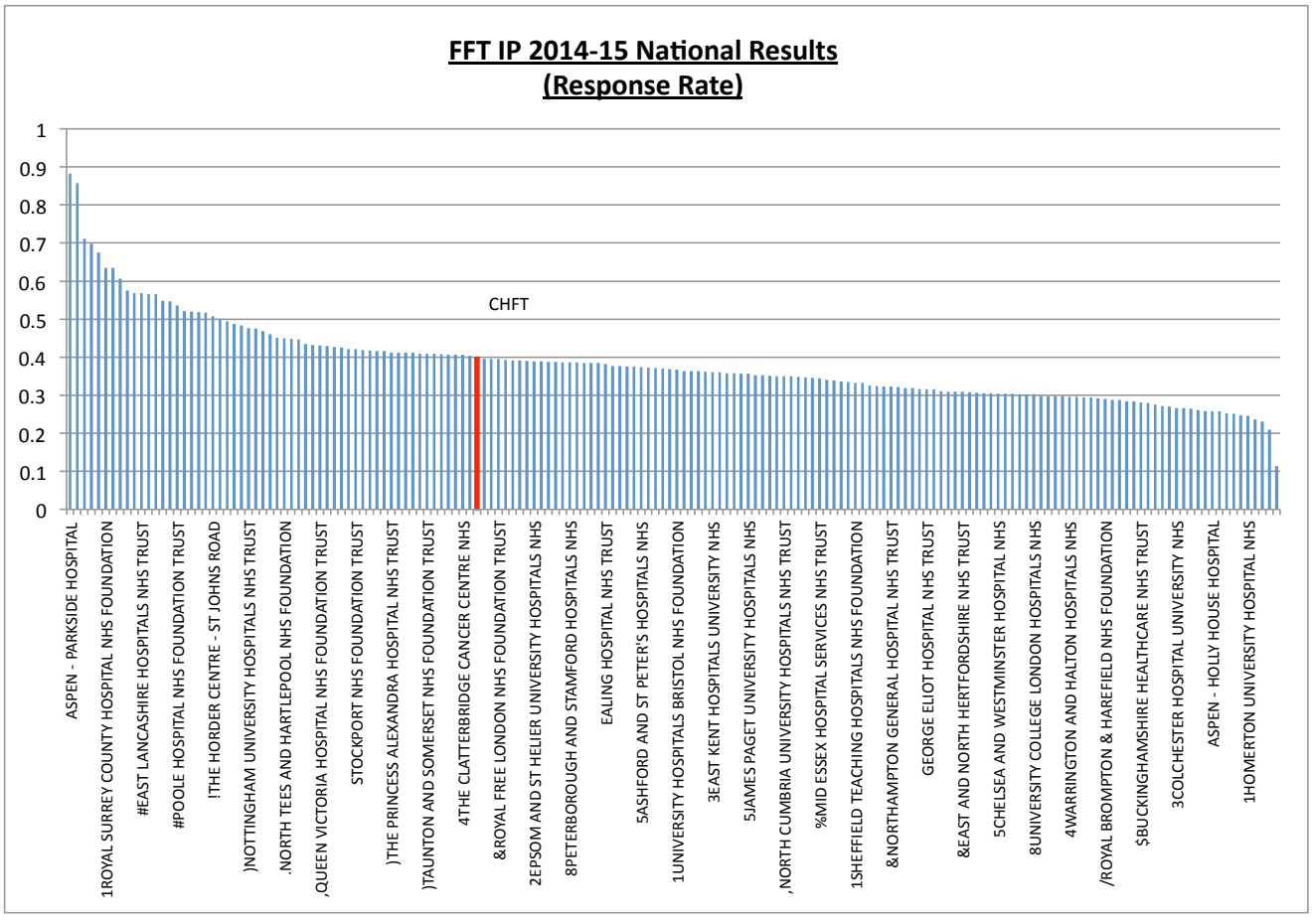
The chart below shows the % of patients who would recommend care or treatment by individual Trusts between April 2014 and February 2015 – CHFT is highlighted in red. The data shows that the Trust is in the top 1/3 of Trusts.



- The chart below shows the % of patients who would NOT recommend care or treatment by individual Trust between April 2014 and February 2015 - CHFT is highlighted in red.



- The Trust is ranked 58th out of 170 trusts in response rate, an improvement on last year's position.

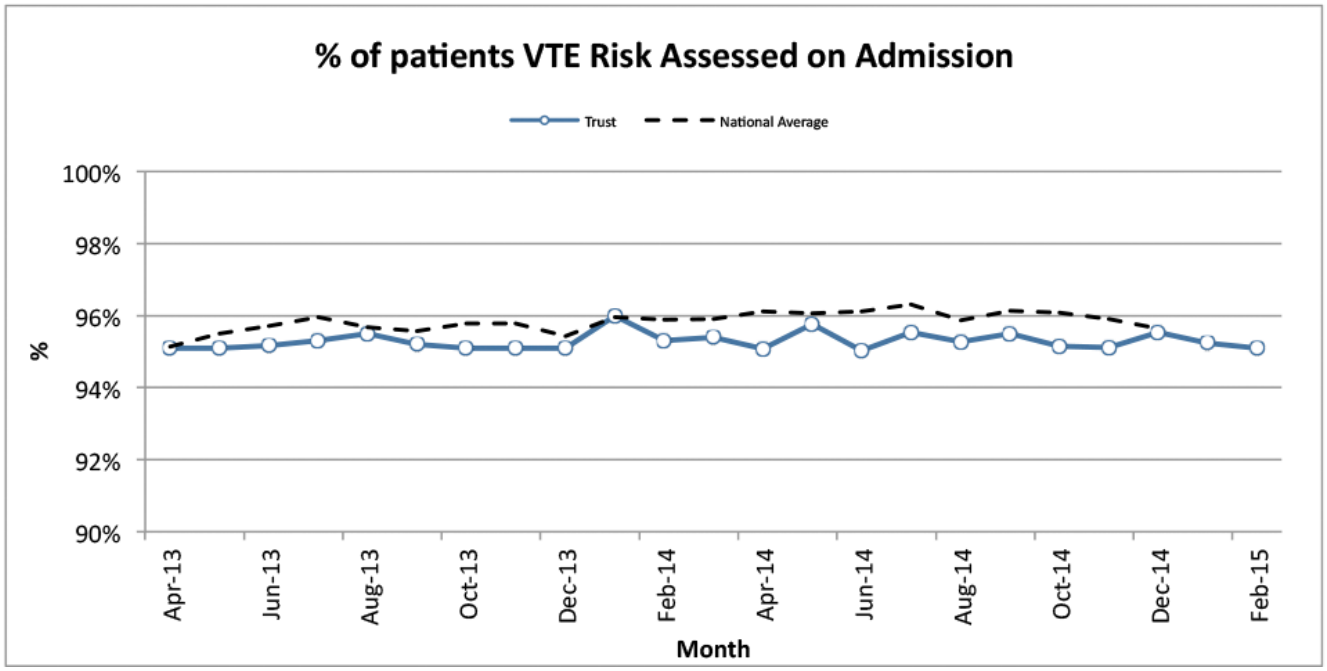


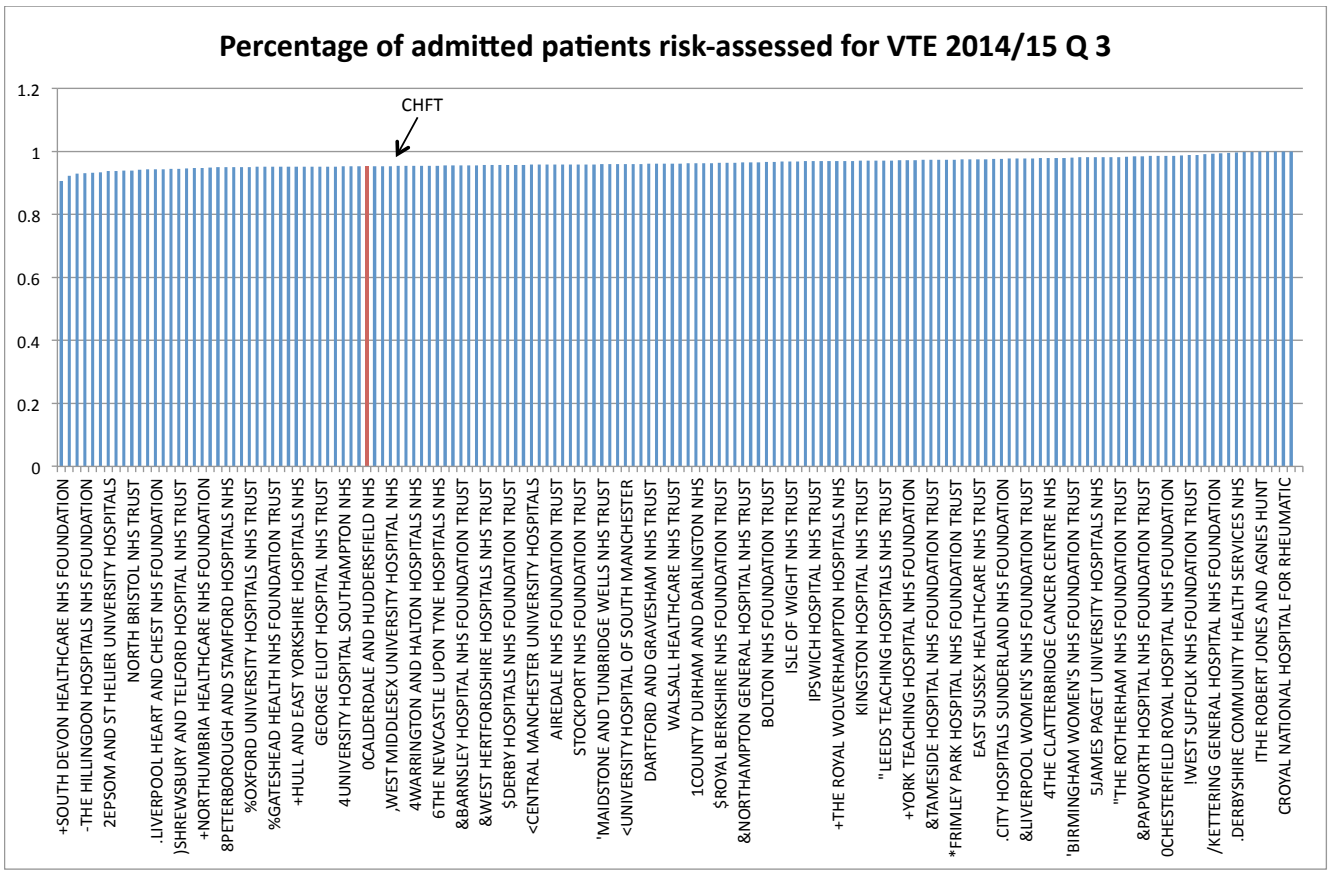
The Calderdale and Huddersfield NHS Trust has taken the following actions to improve this percentage and also the quality of its services:

- In order to promote improvement, scores are provided monthly at ward level. The comments collected through the friends and family test process are also made available to allow the Trust to gain a better understanding of patient perception and to plan interventions when necessary.
- A walk round on all medical wards was carried out asking staff to explain their processes for getting FFT responses and how the information was being used to make improvement in the clinical areas. The results were fed back to teams and to continue this work, six-weekly meetings are in place to discuss responses and share good practice.

23. Patients admitted to hospital who were risk assessed for venous thromboembolism.

The charts show the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the report period from April 2013 to February 2015.





The Calderdale and Huddersfield NHS Trust considers that this data is as described for the following reason:

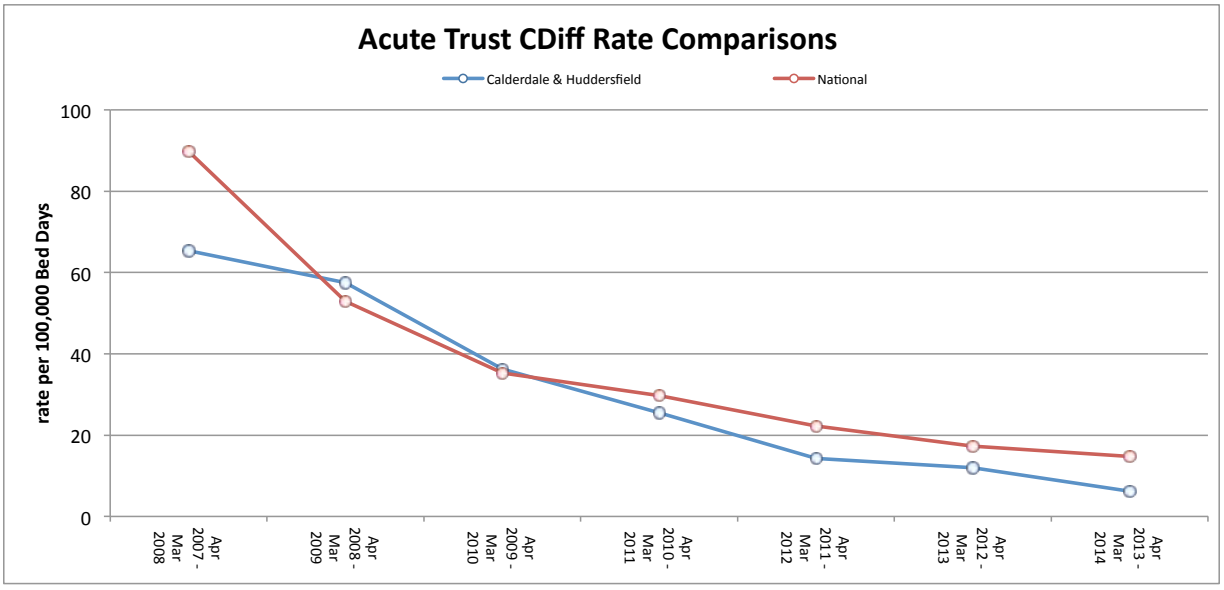
The target from December 2012 for VTE risk assessment for all patients admitted was set at 95% and this has been consistently met. The benchmarking graph shows the Trust to be in the bottom third of Trusts, however issues with data capture make it difficult to evidence performance above the 95% target.

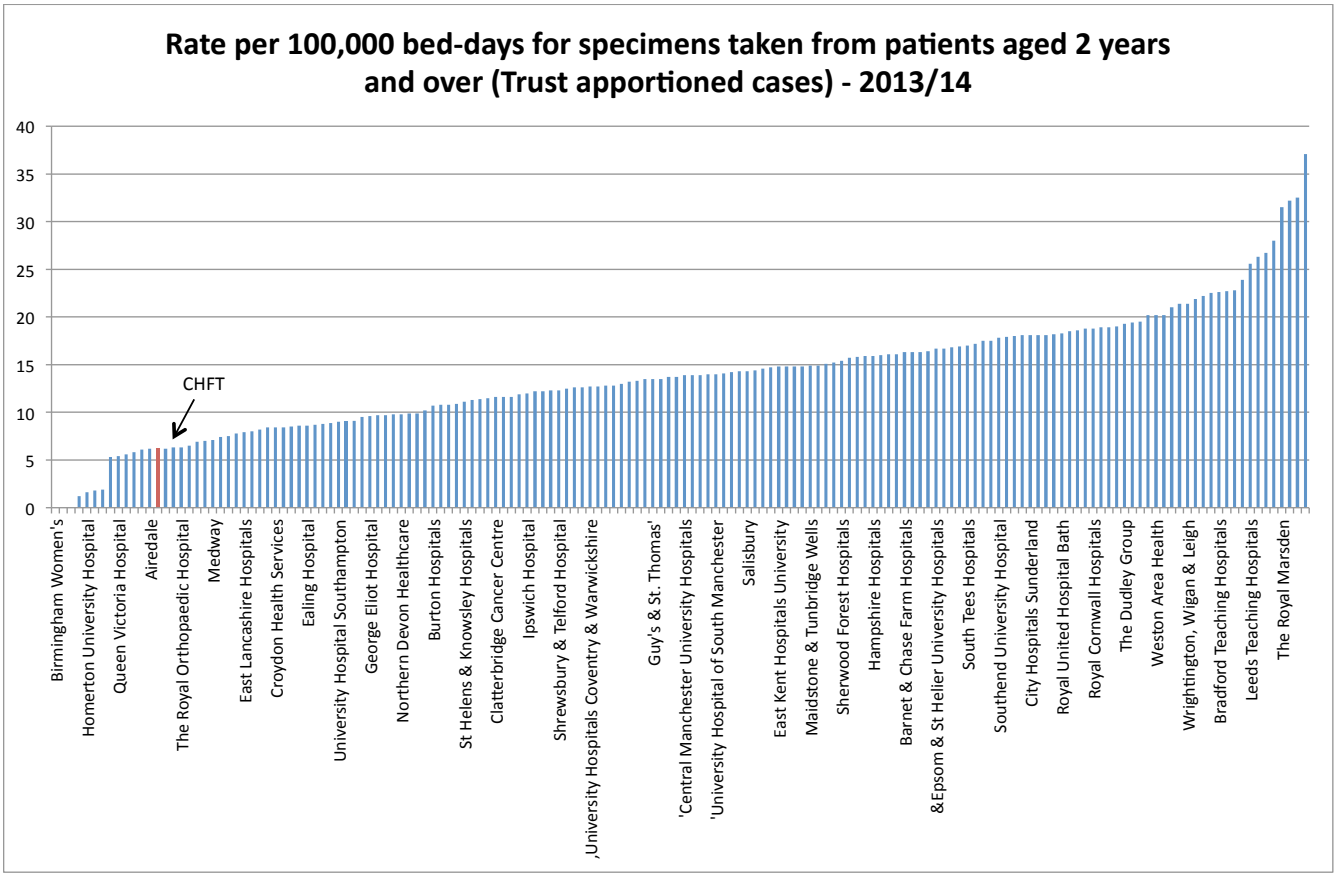
The Calderdale and Huddersfield Foundation Trust have taken the following actions to improve this and so the quality of its services:

- Compliance data is currently retreived manually after the patient has been discharged from hospital. To improve reliability of data and patient care, work is underway to have the VTE assessment incorporated on the nerve centre (electronic assessment system) for doctors to complete. This will allow data on compliance with the process to be reviewed live so any issues can be addressed immediately. In addition to this the system will include a prompt the doctors to review the VTE assessment after 24 hours.
- There is a reliable process in place to ensure that when hospital associated VTE's are identified they are investigated for any failings of care and actions taken wherever necessary.

24. Rate of Clostridium-difficile infection

The chart shows the rate per 100,000 bed days of cases of Clostridium-difficile infection reported within the Trust amongst patients aged two or over during the reporting periods from April 2007 to March 2014.





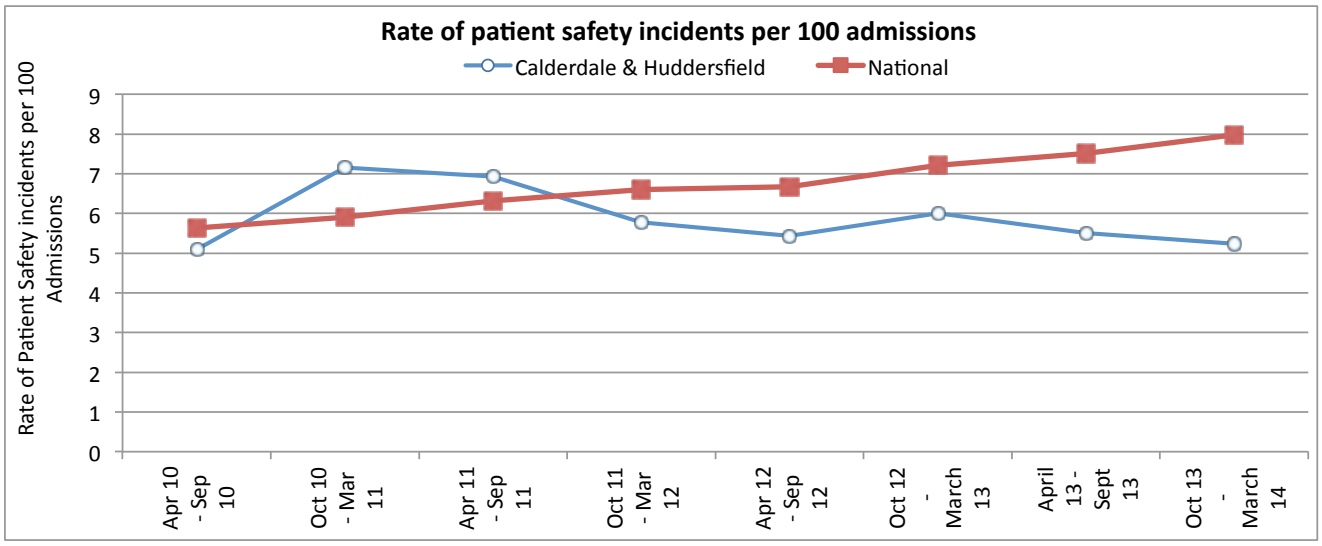
The Calderdale and Huddersfield NHS Trust considers that this data is as described for the following reason:

- The Trust continues to report all data externally via the Public Health England data capture system and internally to the Executive Board and Board of Directors monthly.
- The charts show a reduction in Clostridium cases and have remained below the national average throughout 2010 and 2014.
- The second chart shows that in 2013/14 the Trust performed very well when compared to other similar NHS organisations

The Calderdale and Huddersfield NHS Trust intends to take the following actions to improve this rate and so the quality of its services, by:

- Strict adherence to personal protective equipment policies and protocols, additional signage and use of hand hygiene with soap and water
- Mandatory training for all clinical staff and new starters
- Continuing to manage patients with C-difficile on an evidenced based specific pathway
- Continue to review all patients with C-difficile by a specialist infection prevention and control nurse using a daily checklist and escalating any issues immediately
- Routine use of Hydrogen Peroxide Vapour (HPV) decontamination of all rooms where patients with C-difficile have been treated after they are discharged
- Regular infection control and antibiotic ward rounds with a microbiologist
- Continued collaborative working with Matrons
- Root Cause Analyses of every single case of hospital acquired C.difficile to ensure that lessons are learned to prevent future infections

25. Patient safety incidents and the percentage that resulted in severe harm or death.
The charts show the rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.



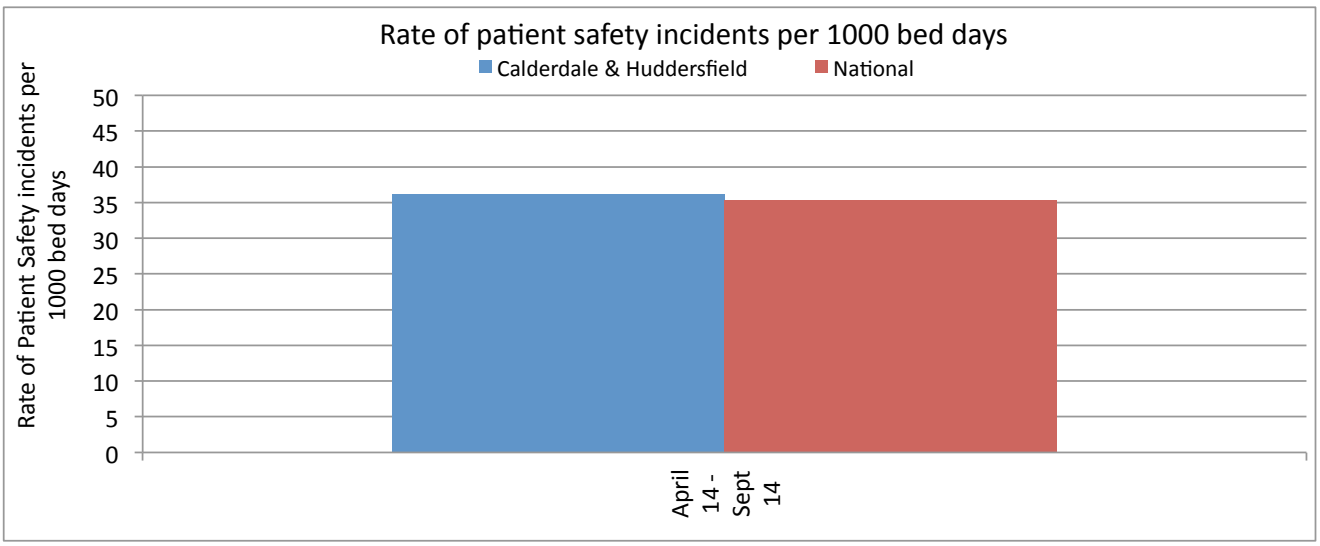
The Calderdale and Huddersfield NHS Trust considers that this data is as described for the following reason:

The chart above shows the Trust's previous reporting on the National Reporting and Learning System. This shows that the Trust was slipping down the table in terms of the number of patient safety incidents reported. Over the last 12 months two important changes have been made to reporting processes: 1) the number of patient incidents uploaded to NRLS has been increased as there has been an increased focus on the importance of reporting incidents and 2) the severity scoring rating has been changed to reflect actual harm caused.

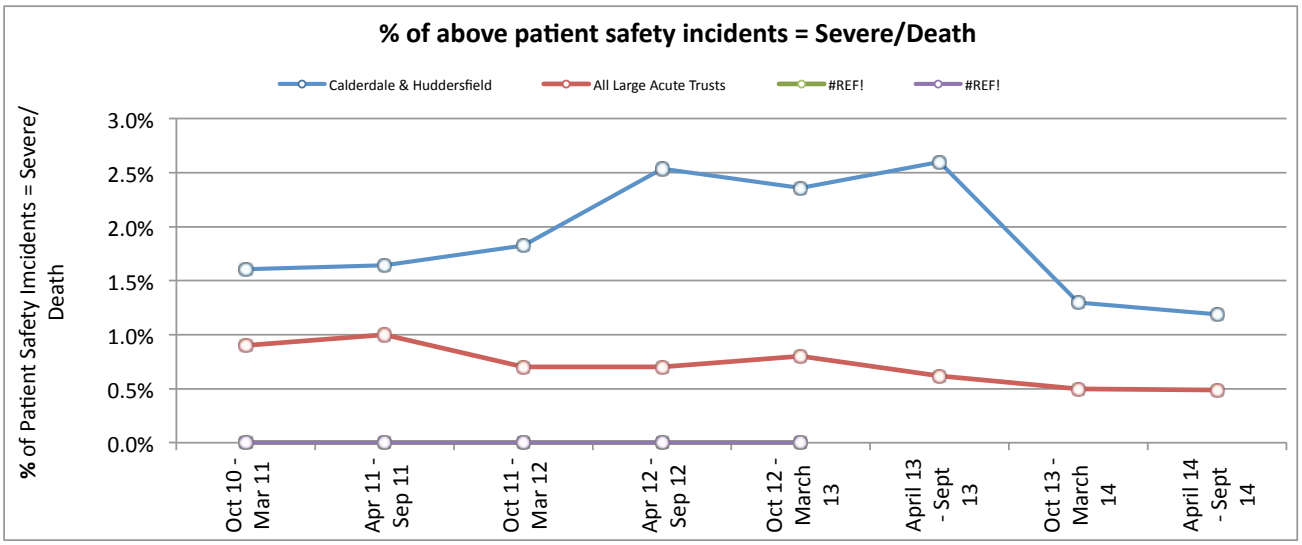
The above have resulted in an improved position in the recently published NRLS reports yet to be reflected in the national dataset.

It should be noted that NHS England has changed the way that they have reported in the latest report: the first change is that there is now an "Acute" hospital type (it used to be acute large/Acute teaching/other). This has resulted in the Trust being benchmarked within 140 Trusts as opposed to 38. The second change is that incidence rate is now calculated by 1000 bed days as opposed to 100 admissions. This has changed the ratio from 5 to 36. As a result of this change we are unable to provide graphs to demonstrate the improvement based on previously published reports.

The chart below shows the data set from April to September 2014 based on the new way of calculating the rate. It illustrates the improvement with the Trust now reporting above the national average.



The following chart shows the % of incidents graded as severe harm or death.



The Trust reports a higher rate of severe/death patient safety incidents than other large acute trusts. This is attributable to the type of incidents the Trust views as severe patient safety incidents compared with other large acute trusts, for example, all category 3 and 4 pressure ulcers are viewed by the Trust as severe harm and any patient who sustains a fractured neck of femur whilst in the care of the Trust is also reported as severe harm. This reflects the seriousness with which the Trust views these incidents and grading and in this way ensures the correct level of investigation is carried out and appropriate actions taken to reduce their incidence in future. In addition the Trust had been grading the severity of incidents on the impact "risk" to the patient rather than the actual harm caused. This has now been altered in line with national guidance and the severity rates have fallen. This is not yet reflected in the national datasets.

The Calderdale and Huddersfield NHS Trust has taken the following actions to improve this percentage and so the quality of its services:

- In January 2014, the Trust introduced DatixWeb, an on-line incident reporting tool. The aim of this was to provide an accessible system which could provide instant reporting and up to date data. This also enables the service manager to review and undertake an initial investigation into the incident to establish whether this has been managed satisfactorily or needs to be escalated.
- The Trust has introduced a 48hr serious incident panel (chaired by Director of Nursing/Medical Director) where potentially serious incidents are discussed and agreed within a short period of time following the event. This panel also considers what immediate actions may be needed to prevent a recurrence.
- Introduction of timescales for completion of incident investigations (45/60 days in line with the national serious incident framework).
- Introduction of sign off of serious incident investigation reports at a panel (again chaired by Director of Nursing/Medical Director).
- Improved reporting to the national learning and reporting system (NRLS).
- Continued patient safety improvement work on areas of concern (i.e. falls and pressure ulcer collaborative).
- One of the largest areas where improvement can be made is around ensuring that events are properly investigated to ascertain the root cause and any actions agreed and delivered will reduce the chance of the event re-occurring. The current investigations process is being reviewed including designing a toolkit to aid effective investigations from simple incidents through to complex serious harm events. To support this training for investigators is being designed to ensure there is clarity of aims and investigators have the skills and knowledge to get to the root cause. In addition the Trust's current risk management system DatixWeb is being revised so it is better able to pull out causes of harm and analyse at this level to promote and inform change.

There have been no Never Events in the Trust this year.

- **Type and Severity of Incidents**

6,771 patient safety incidents were reported in 2014/15 (8,924 if you include those incidents reported but allocated to another organisation). Of the 6,771 incidents, 1,641 resulted in harm, mostly minor harm (87%).

In 2014/15, Calderdale & Huddersfield NHS Foundation Trust changed the criteria of severity rating harm incidents from the risk of harm which may be caused to the actual level of harm caused to the patient. This brought us in line with the reporting requirements for the NRLS. This has resulted in a decrease in the number of severe harm (classed as red) incidents reported and an increase in the number of moderate harm (classed as orange) incidents. An investigation is undertaken for all orange and red incidents.

All red severity incidents are reported to the Clinical Commissioning Group (CCG) under the National Serious Incident Framework. Of the 106 incidents reported to the CCG in 2014/15, 95% related to category 3 (87) and 4 (14) pressure ulcers. Overall when analysing categories by level of harm, the top three issues for the year are: Falls, Pressure Ulcers and 3rd degree/4th degree tears. All of which have dedicated improvement work looking at cause and reducing the risk of occurrence.

Type and Severity of Complaints
The total number of concerns and complaints received has increased by 6% 2014/15. Within this total there is a 7% increase in complaints and an 8% decrease in concerns.

The key areas of issues raised across concerns and complaint remain access; communication and treatment, however the ranking is different between concerns and complaints.

In concerns the top issues raised relate to access to services, then communication followed by treatment.

In complaints the top issues raised relate to treatment, then communication and access to services.

All complaints are assessed, upon receipt, in terms of severity. This year there has been a slight reduction in the number of red (extreme) severity complaints 22 compared to 27 last year, and a significant increase in the number of orange (high) severity complaints from 57 last year to 142 this year.

A new process has been introduced for complaints assessed as red (extreme) severity. The Division are given approximately two weeks to undertake a preliminary investigation which is then discussed at a Complaints Panel (chaired by the Deputy Director of Nursing or the Assistant Director for Quality). The panel considers the findings, any additional action that needs to be taken and how the complaint will be resolved.

Over the year we have been introducing improvements to the way we handle complaints as we strive to ensure:
- Everyone feels confident to speak up if they are worried about any aspect of their care
- It is simple and straightforward to raise concerns and complaints
- We listen and understand the issues raised and make sure we agree how we will address these
- We respond in the way we agreed and the timescale we agreed
- We show the changes that are made as a result of the issues raised.

Parliamentary Health Services Ombudsman (PHSO) Complaints
In the past 12 months, we are aware of 21 cases being raised that have led to an investigation with the PHSO, compared to 11 the previous year. This reflects a change of approach by the PHSO to investigate more cases.
Of these 21:
- 7 were not upheld or discontinued;
- 3 were resolved following further action;
- 9 are currently under review by the PHSO (who are currently experiencing a backlog)
- 2 were partly upheld and recommendations completed.

Information Commissioner
We have not had any complaints investigated by the Information Commissioner.

Outcomes of Complaints received
Of the complaints closed to date, 33% have been upheld; 37% partially upheld and 30% not upheld. Over the year 32% of complaint responses have been made within the agreed timescale.

The Trust has changed its internal processes to provide close monitoring of the investigations being carried out and introduced improved key performance indicators. Performance against these are reported monthly to the Patient Experience and Caring Group and through a monthly performance report to the Trust Board.

A quarterly quality report to the Trust Board provides detailed analysis of the issues being raised through complaints and concerns.

Key themes and learning from Complaints
Communication is a large issue in complaints, and is raised as a specific issue of complaint in 50% of all complaints received. Themes raised in complaints regarding communication relate to patients feeling that they are not being treated as individuals; not being listened to and staff not being aware of their individual situations.

The introduction of courtesy rounds in all areas is expected to improve communication with patients and families.

The following are examples where learning from complaints has helped lead to changes:

- New leaflet used by the Leeds cancer service included in patient information pack.
- Flexible visiting time introduced for relatives of patients with advanced cancer but not yet on end of life care plan but would find comfort for family members to be close.
- "Scheduling" of appointments introduced in 'Systm 1' to prevent missed visits by community staff.
- Improving provision of palliative support during weekends to enable regular discussion with family.
- Letter being sent to women following colposcopy revised to provide better explanations of what happens next.
- Additional staff recruited to enable increased therapy provision on Stroke Rehabilitation.
- Frenulotomy service reviewed and business case completed for training of additional frenulotomy skills.
- A quiet room was created to have discussions with families and new boards introduced behind each bed soon to highlight what is important to the patient and relatives.
- New leaflet completed to help ensure women understand the induction of labour process.
- Patient helping to develop angiography service leaflet from patient perspective.
- Pressure Ulcer Prevention and Management Plan developed for the children's ward. (Glamorgan Scale)
- Stone Management System and Stent Register established to enable monitoring of all patients with a stent.

Common issues raised in complaints were also used to inform the patient experience work streams for example the 'Hello My Name Is' campaign.

Part 3

Performance on selected quality indicators

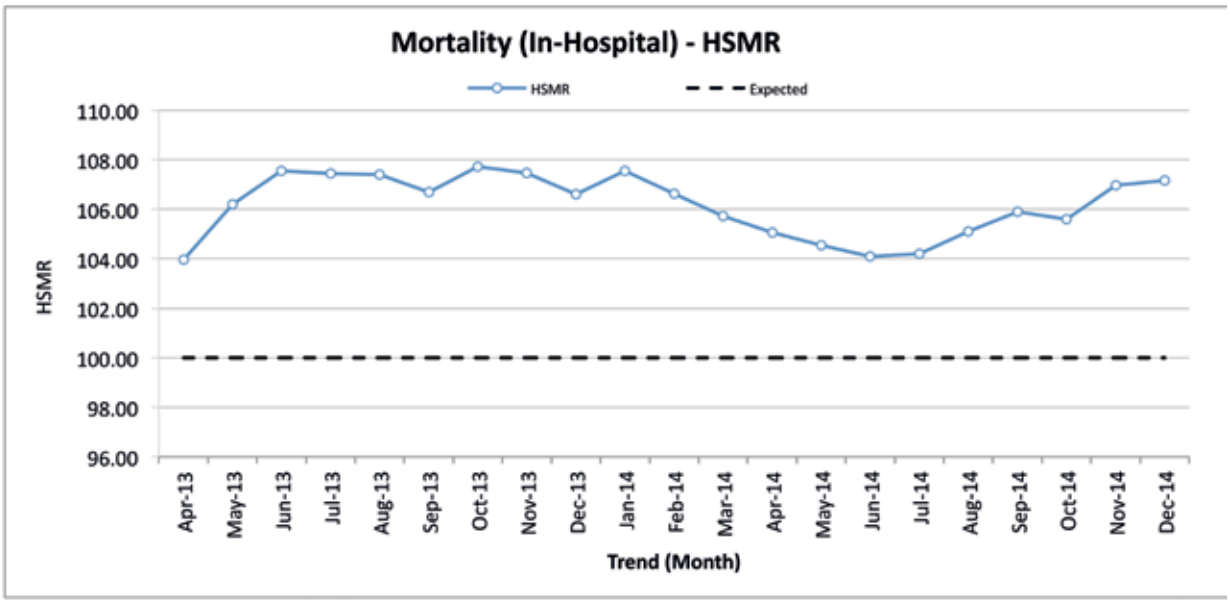
This section provides an overview of care offered by the Trust based on its performance in 2014/15 against indicators selected by the Trust Board in consultation with stakeholders, with an explanation of the underlying reason for selection.

The indicators are as follows:

Patient Safety	Clinical Effectiveness	Patient Experience
Hospital Standardised Mortality Rates (HSMR)	Cancer Waiting Times	Real Time Patient Monitoring
Falls in Hospital	Stroke	End of Life care
Healthcare Associated Infections	Length of Stay in Medicine	Patient Experience in accident & emergency

Hospital Standardised Mortality Rate (HSMR)

HSMR is a national measure that the Trust uses to compare its mortality rate with that of other English trusts.

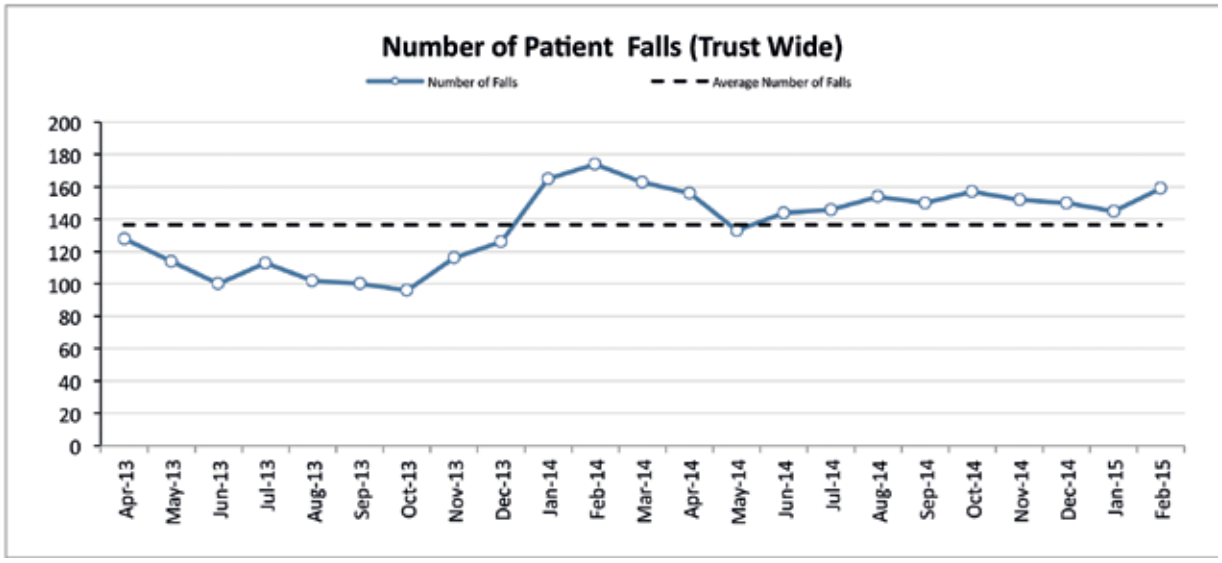


HSMR is a national measure that the Trust uses to compare its mortality rate with that of other English trusts.
On the chart the dotted 100 line indicates the expected rate of overall deaths for the Trust (the relative risk). The Trust aims to maintain its score below this line as this tells us there is a lower than expected mortality rate for our population.

It has been recognised that HSMR is only one indicator of mortality and this measure must be used in conjunction with SHMI, crude mortality as well as a robust system for mortality review. This is to ensure a true picture around care quality and preventability is seen and can be acted upon. The Care of the Acutely Ill Patient programme uses all these metrics as its key outcomes.

Falls in Hospital

Hospital falls continue to be the highest reported safety incident in the Trust and therefore remain a priority for improvement.



The chart shows the number of falls patients have had whilst in hospital, on average this was 137 per month. In addition to the total number of falls reported the Trust also measures falls that result in harm.

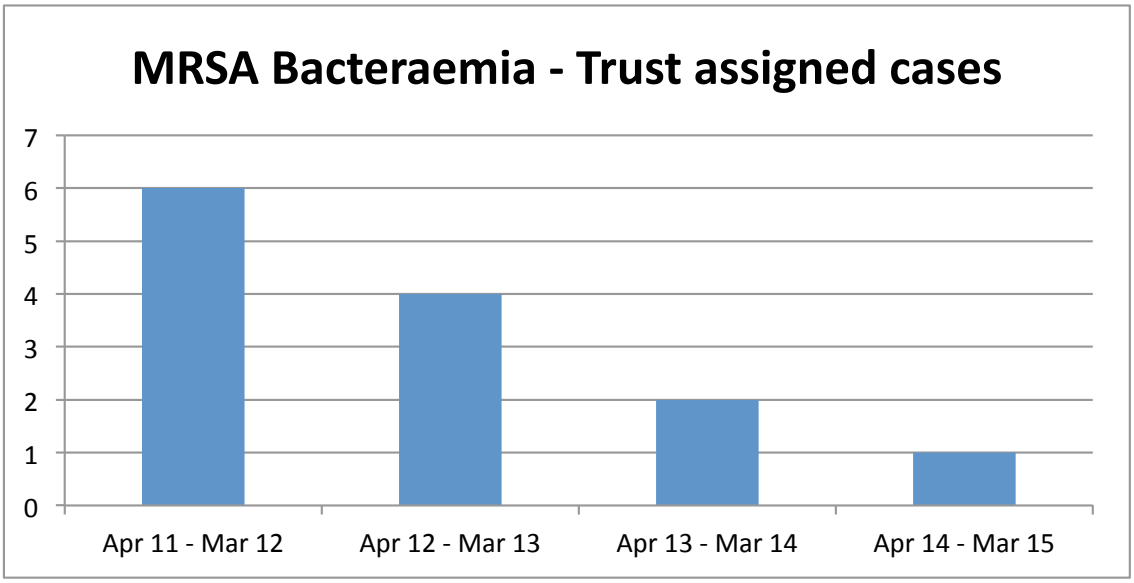
As the chart shows there was initial improvement in the number of harm falls through 2013 although this has now stabilised.

Throughout 2014-15 the work of the falls collaborative has been focussed around designing new documentation to better reflect the national evidence base for falls prevention, these tools have been available in all clinical areas since January 2015.

- The first thematic review of red and orange incidents for falls took place on the 25 November 2014. This highlighted poor compliance with care bundles and lack of person centred care planning. This review will be repeated in April 2015 and the information cross referenced to the interventions and new documentation the Trust has in place to ensure these will address all the root causes of falls.
- On two wards a safety briefings process has been tested and is now in place, this is led by senior clinicians. On one ward this has had a dramatic effect on reducing falls. The immediate plan is to recruit another two clinicians willing to test and implement this on their wards.
- The first national falls audit is taking place on May 12 and 13 2015. The audit looks at assessment and documentation. Results will be used to inform the work.

Healthcare associated infections (HCAIs)
Mandatory indicator 24 sets out the Trust's on-going plans for further reduction of Clostridium-difficile.

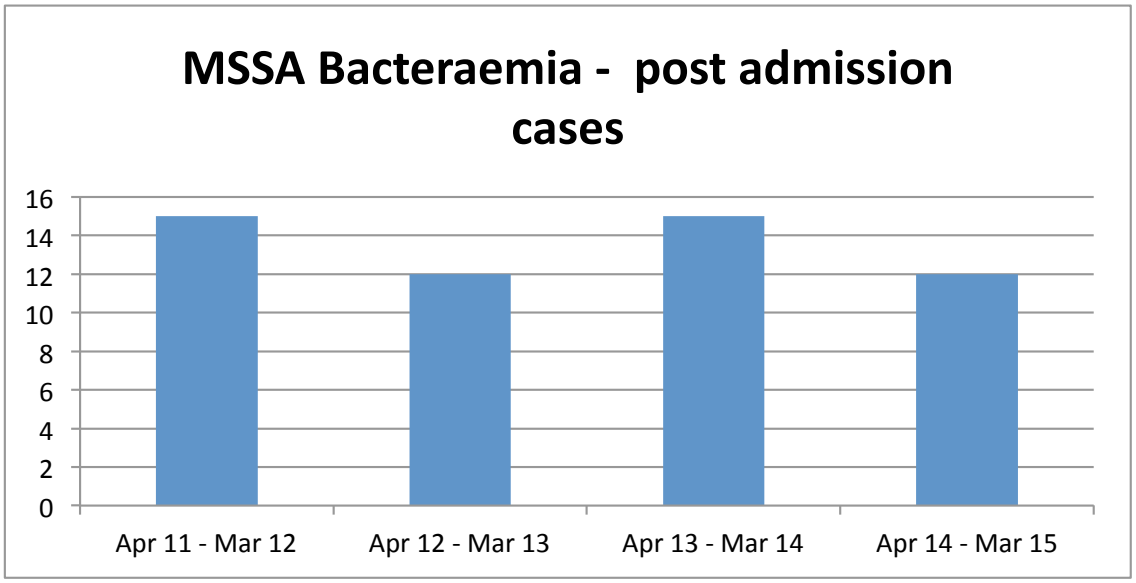
The following is an explanation around other key infections the Trust has targeted improvement work in place to address.



The Trust has seen a year on year reduction of MRSA (Meticillin resistant Staphylococcus aureus) bacteraemia cases over the last four years. This has been due to the hard work of all the clinical teams to improve hand hygiene, care of invasive devices with earliest removal, improved communication and MRSA screening of patients. Continued work has seen improvements in cleanliness across all ward areas with frontline ownership from ward managers and charge nurses to keep their areas tidy and organised.

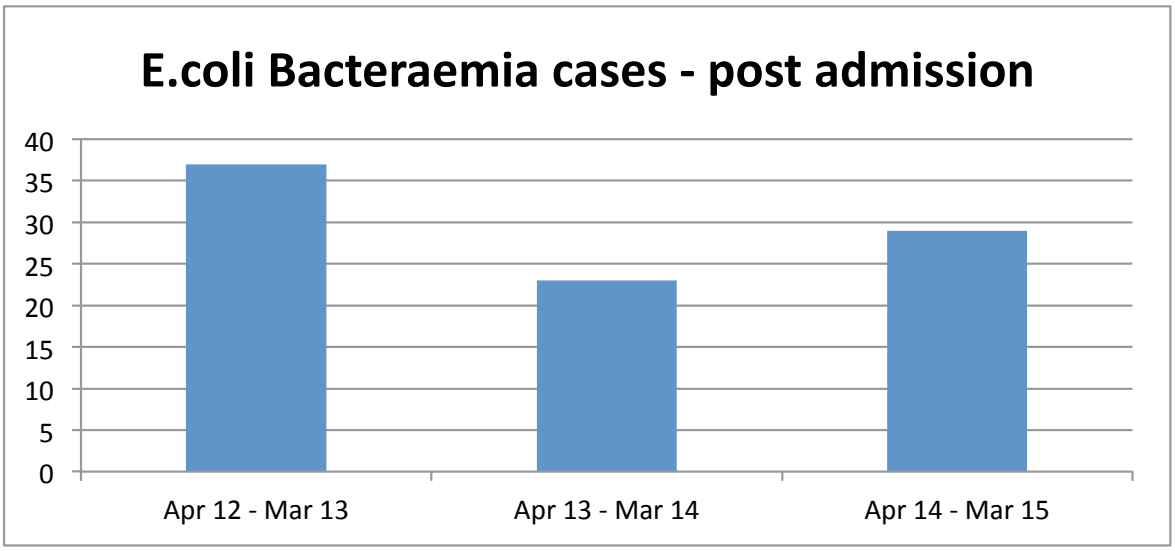
The infection prevention and control team visit the wards to review patients and promote high standards of infection prevention and control practice. In addition the Microbiology Consultants carry out regular antibiotic ward rounds to optimise antibiotic prescribing.

Infection prevention and control training is provided to clinical staff on a face to face basis allowing it to be interactive and ensure a good level of understanding.



MSSA (Meticillin sensitive Staphylococcus aureus) bacteraemia cases have remained static over the last four years although of note is the relatively low numbers. An internal target has been set to provide focus and to manage a reduction in MSSA cases in the Trust.

Initiatives will include screening of patients going for high risk surgery to ensure the MSSA is treated prior to surgery. All devices related MSSA bacteraemia cases are investigated and lessons learn to prevent further cases. This has prompted improvements in central line management.



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E.coli (Escherichia coli) bacteraemia cases are a great concern nationally and often associated with urinary tract infections. An internal target has been set to provide focus and manage a reduction in E.coli cases in the Trust.
The Trust recognises that long term urinary catheters increase the risk of E.coli and has embarked on a project to reduce the number of long term catheters by providing alternatives where appropriate and improving the care of catheters that are required.

One of the initiatives has included a patient held record for patients discharged into community with catheters so they know how to look after their catheter and know when to seek help. This also provides a record for the nursing team to document when the next catheter change is due.

Cancer Waiting Times

Significant progress has been made in delivering important aspects of cancer services leading to falling mortality rates and consistent achievement of the cancer waiting times standards.

High quality and accurate data is key to improving services and therefore outcomes for patients, the Trust continues to be committed to supporting the Cancer Outcomes and Services Dataset (COSD).

Delivery of the National Cancer Targets is a key part of cancer care and the Trust's performance around these key targets is a significant indicator of the quality of the delivery of cancer services.

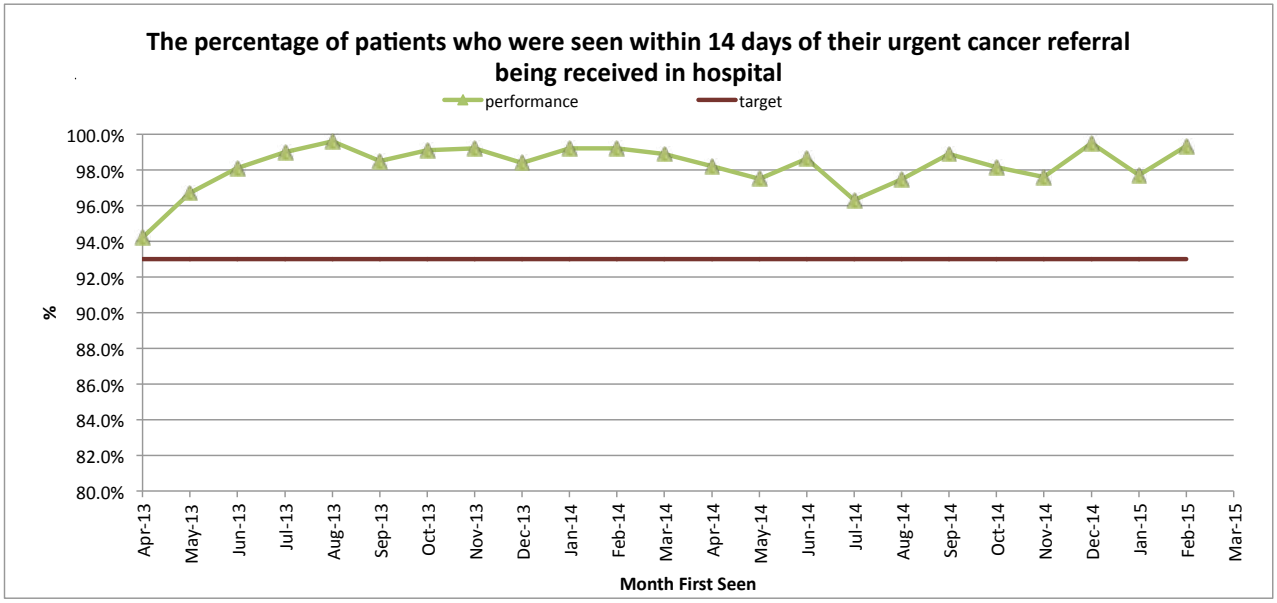


Chart 1 shows the Trust's reporting period April 2013 – March 2015 for patients seen within 14 days for urgent referral. The performance required for this target is 93% and this has been exceeded for the whole of the year.

The Trust intends to take the following actions to improve this percentage further and so the quality of its service by continued monitoring of the target:

- Patient choice of appointment date and time as a key driver for performance.
- The Trust has worked hard to review pathways so that patients can be seen within 7 days rather than 14.
- Within the network the Trust has made a significant achievement with this work.

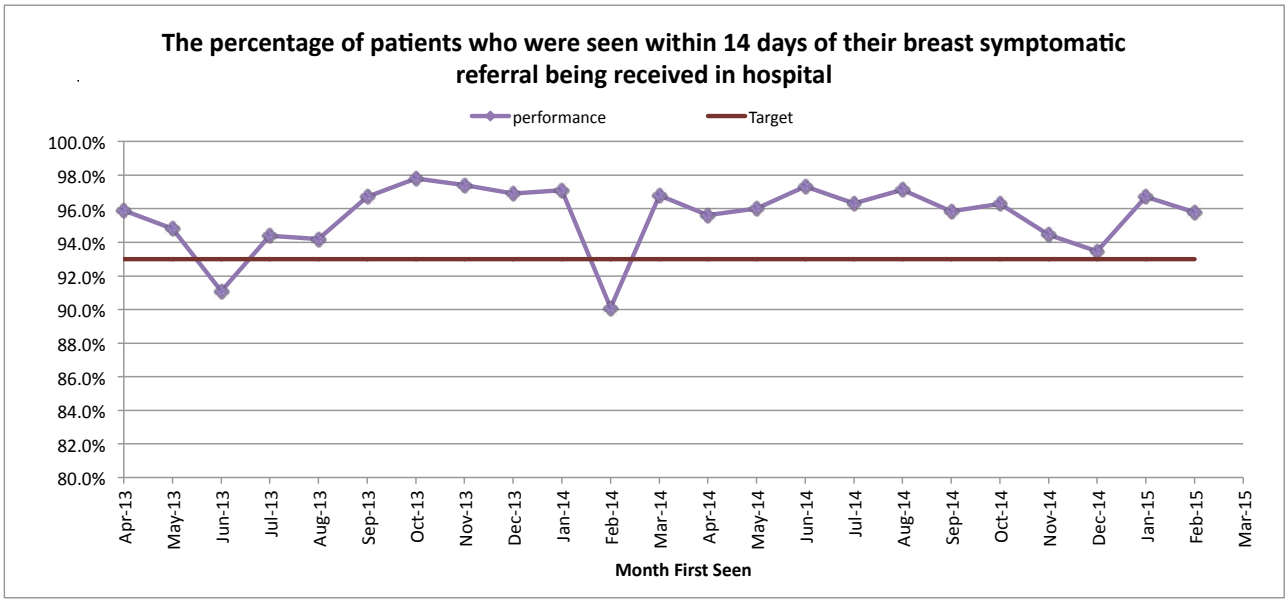


Chart 2 shows the percentage of patients who were seen within 14 days of their breast symptomatic referral being received in hospital for the reporting period April 2013 – March 2015.

The performance required for this target is 93%. Performance has been variable largely due to patients exercising choice about time and date of appointment.

The Trust has an action plan in place to further improve performance which includes:

- Monitoring and intervention for appointments booked outside of 14 days.
- In conjunction with primary care provide more robust information for patients on the need to attend an appointment within 14 days.
- Sharing of data and information on cancellations with GP colleagues.

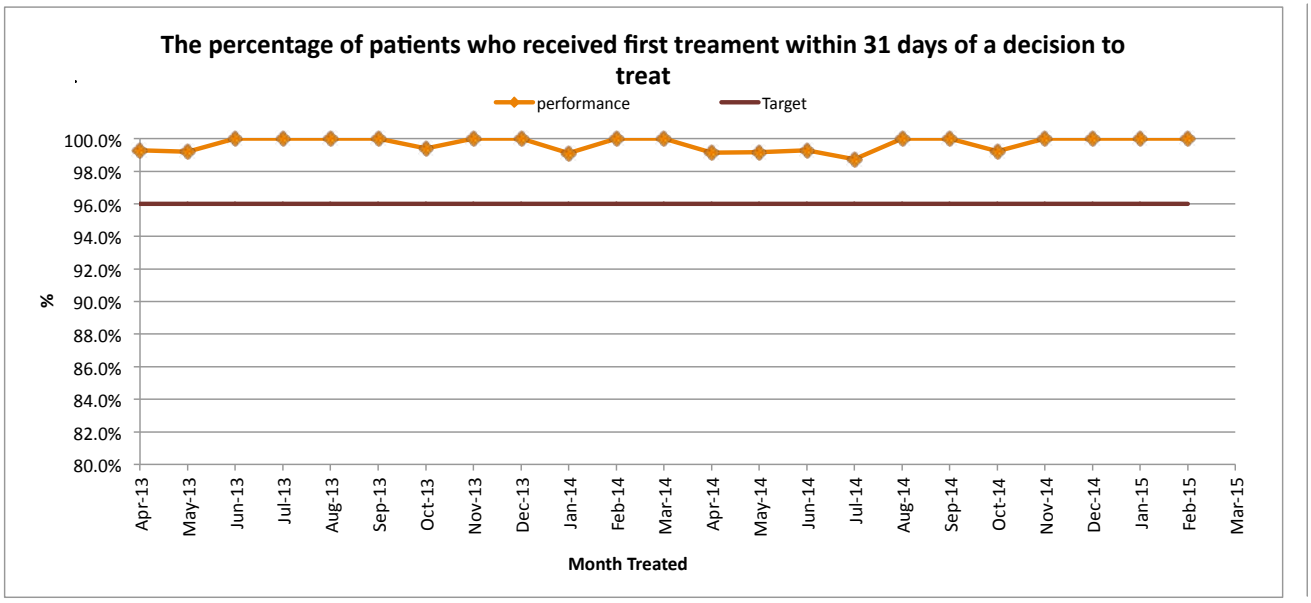


Chart 3 shows the percentage of patients who received first treatment within 31 days of a decision to treat for the reporting period April 2013 – March 2015.

The performance required for this target is 96%. Performance has largely been maintained at 100% with slight variations on four occasions; however this has not fallen below 99%.

The Trust intends to continue close monitoring of this target to maintain and improve performance.

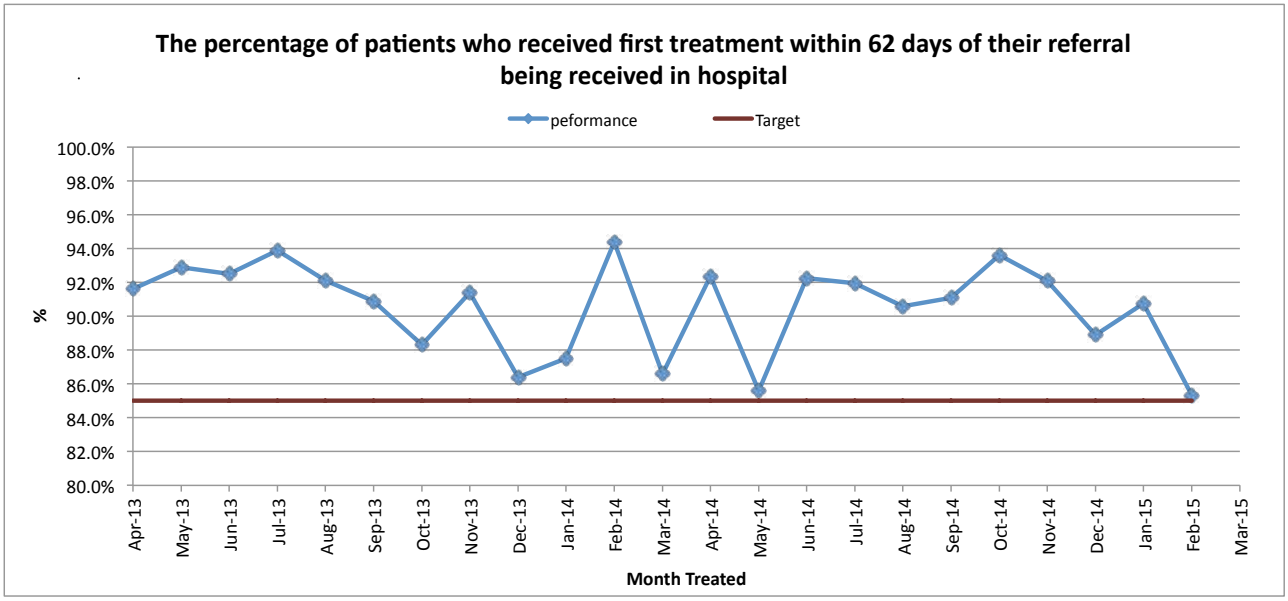


Chart 4 shows the percentage of patients who received first treatment within 62 days of their referral being received in hospital for the reporting period April 2013 – March 2015.

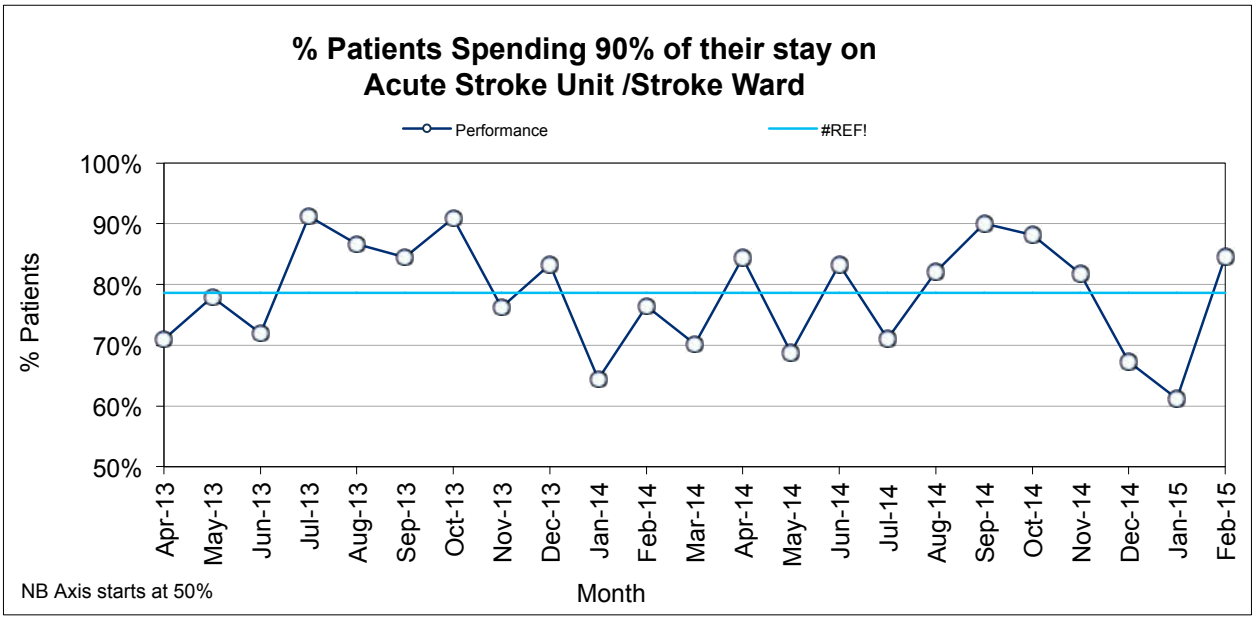
The performance required for this target is 85%. Performance has been above the required 85% for all of the year.

The Trust intends to take the following actions to improve performance and so the quality of its service by continuing to undertake pathway work in a number of areas to improve the timeliness of the patient's pathway. This will include:

- Meet with all Clinicians to review pathways.
- Review of CT scan availability; reduce the diagnostic wait to 7 days.
- Working with primary care colleagues to review the diagnostic pathway.
- Continue to work with tertiary centres to improve handovers.
- Continue robust tracking of patients.

Stroke

As stroke patients occupy around 20% of all hospital beds, it is very important they receive specialist care proven to aid recovery and reduce mortality.



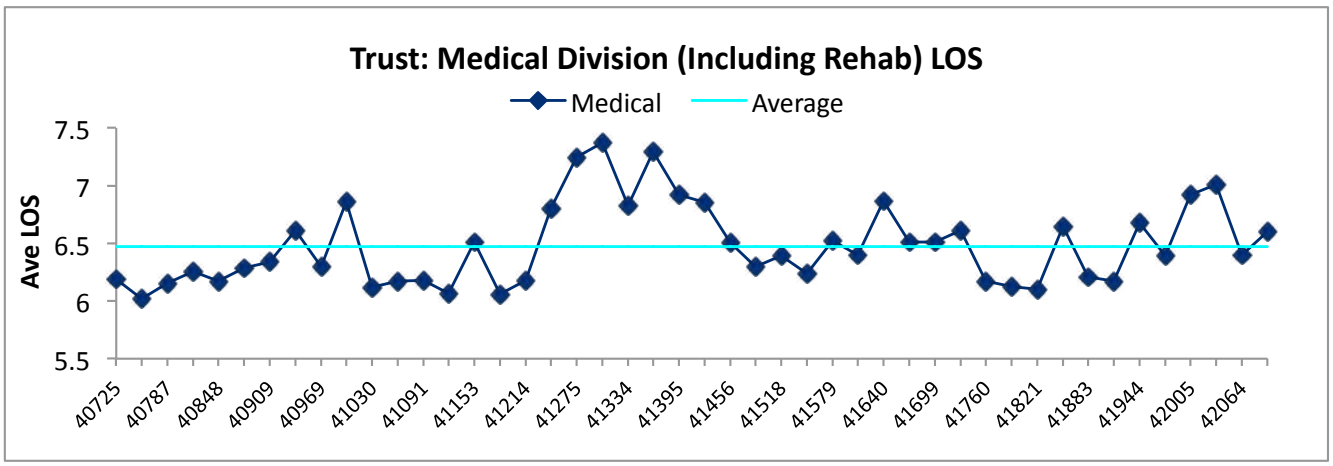
The above chart shows the percentage of patients diagnosed with a stroke that spent more than 90% of their hospital stay on a specialist stroke ward.

Performance has remained variable throughout the year. Winter pressures in December and January explain the dip in compliance that occurred during these months.

There is a quality improvement work stream on Stroke. One of its key interventions is around improving this the time that patients stay on the specialised stroke ward along with other indicators from the sentinel stroke national audit programme such as therapy support, time to thrombosis etc. All these indicators are closely monitored and compliance is reported in the Trust.

Length of stay in medicine

Ensuring that patients have the correct length of stay (LOS) in hospital reduces the risk of avoidable harm, improves patient experience and also helps ensure the Trust is able to reduce financial pressures and give good value care.



The chart above shows that the length of stay in medicine was relatively stable following the rise in early 2013; however since November 2014 it has started to rise again.

The primary reasons for the variation are seasonal pressures and an increased number of admissions.
Analysis tells us that when patients are placed in beds in other specialities (because no beds are available in on the most appropriate ward) this increases length of stay. Seasonal pressure led to a rise in this practice and therefore a corresponding rise in length of stay.

Increased seasonal activity also increased pressure over the whole health economy, this increased delayed discharges due to lack of services in the community and further increased length of stay.

Work to address this is through the bed efficiency and length of stay programmes which are linked to the improving discharge planning priority in the quality account this year.

The length of stay and efficiency programmes are central work streams around planning bed stock for next winter to mitigate the need to place patients in other speciality beds and therefore reduce any seasonal variations.

Real time patient monitoring

The Trust has continued to operate a real time patient monitoring system, using volunteers to ask patients a set of pre-determined questions when they are ready for discharge. This allows the Trust to relate feedback to specific wards to drive improvement.

In previous years there has been a focus on improving doctors' communication, the data for 2014/15 demonstrates a continued high score for this indicator.

	2010/11	2011/12	2012/13	2013/14	2014/15*
When you have important questions to ask a doctor, do you get answers that you can understand?	8.0	8.3	8.9	9.3	9.3

- 11 months data only (April – February)

A series of questions assess whether patients know what is happening to them and whether they feel involved in decision making about their care and treatment. These have continued to score positively over the last 12 months.

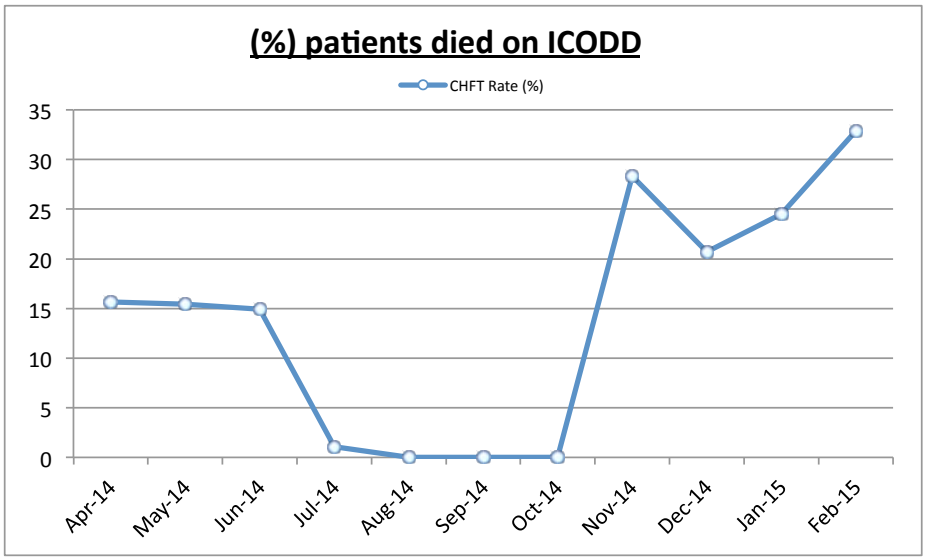
	2010/11	2011/12	2012/13	2013/14	2014/15*
Are you involved as much as you want to be in decisions about your care and treatment?	7.7	8.0	8.5	9.0	9.1
How much information about your condition or treatment has been given to you?	8.2	8.2	8.8	8.8	8.9
Before your operation or procedure, did a member of staff explain what would be done?	8.8	8.8	9.2	9.4	9.5
After the operation or procedure, did a member of staff explain how it had gone in a way you could understand?	7.9	8.2	8.6	8.8	8.7
Do you feel involved in decisions about your discharge from hospital?	7.3	8.5	8.8	9.2	9.4
Has a member of staff explained the purpose of the medicines you are to take at home in a way you could understand?	7.9	8.7	9.1	9.5	9.4
Have the doctors or nurses given your family or someone close to you all the information they need to help care for you?	6.6	7.5	8.2	9.0	9.1

Whilst the Trust has received high scores for all of the above questions, a number of the comments we receive through real time patient monitoring and the Friends and Family Test suggests that there is still room for improvement. A project has therefore been designed with a focus on ensuring that patients / their family receive regular updates on their condition and treatment, based on 3 W's:

- What is the working diagnosis and plan for my patient?
- What do I need to communicate to other members of my clinical team (nursing staff, junior doctors, and staff in community)?
- What do I need to communicate to my patients and/or their families?

End of Life Care

The Trust continues to work to ensure that when patients die in hospital and their death is expected that they receive appropriate end of life care.



The above graph shows the percentage of patients dying who were supported by the individualised care of the dying document (ICODD). This document was implemented in the Trust at the beginning of November 2014 following consultation with staff from community and the hospices. It has received warm feedback from both families and clinicians.

The ICODD offers advice and guidance to staff and is focussed on the patient's individual needs at the end of life... Improving end of life care remains a priority area for the Trust, as well as the ICODD there are other interventions being introduced, for example comfort bags. These bags contain little essentials, such as bed socks, tissues, a dental kit, and a notebook and pen all aimed to ease time spent at a bedside if a relative needs to stay overnight.

Patient experience in accident & emergency

For the majority of unplanned patient attendances at hospital A&E is the first experience of care. As this is often a very stressful time it is important that the Trust understands and can improve on the service they receive.

Figure 1 - A&E RTM Comparison of Quarterly Results after Offset	National Survey 2012	2010/11 (Baseline)	2011/12	2012/13 (Only Q1 & Q2)	2013/14	2014/15
Sample Size	338	583	549	239	428	446
Q1 Were you told how long you would have to wait to be examined?	3.2	4.3	8.2	6.5	#REF!	#REF!
Q2 Did the member of staff treating and assessing you introduce themselves?	N/A	N/A	N/A	7.9	#REF!	#REF!
Q3 Did you have enough time to discuss your health or medical problem with the doctor or nurse?	8.1	N/A	N/A	8.6	#REF!	#REF!
Q4 Did a doctor or nurse explain your condition and treatment in a way you could understand?	7.7	8.2	8.9	8.1	#REF!	#REF!
Q5 If you have an anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	7.1	N/A	N/A	N/A	#REF!	#REF!
Q6 How much information about your condition or treatment was given to you?	8.4	N/A	N/A	N/A	#REF!	#REF!
Q8 Do you think the hospital staff did everything they could to help control the pain?	6.9	8.3	8.8	7.6	#REF!	#REF!
Q9 If you needed attention, were you able to get a member of medical or nursing staff to help you?	8.0	N/A	N/A	8.6	#REF!	#REF!
Q11 Did a member of staff explain the results of your tests in a way you could understand?	8.1	N/A	N/A	7.6	#REF!	#REF!
Q12 In your opinion, how clean was the A&E Department?	8.4	8.5	9.0	8.3	#REF!	#REF!
Q13 Were you able to get suitable food or drinks when you were in the A&E Department?	5.7	N/A	N/A	8.9	#REF!	#REF!
Q14 Overall, did you feel you were treated with respect and dignity while you were in the A&E Department?	8.8	9.5	9.7	9.2	#REF!	#REF!
Average Score	7.3	7.8	8.9	8.1	#REF!	#REF!
If the need arose, would you recommend this hospital to your family and friends? (Yes, definitly)	N/A	NA	NA	NA	85%	89%

The RTPM data is collected and reported quarterly in both A&E departments. It is mainly collected by volunteers as it is felt that A&E patients may feel more able to give an open response to a non staff member. However at the Calderdale site difficulty recruiting volunteers has meant that staff do supplement the data sets (although they do not work in the A&E department).

There has been a marked difference in patient experience scores across the two sites, both with questionnaire data and in friends and family feedback. As a result a specific action plan has been implemented at Huddersfield Royal Infirmary with many of the actions now complete. Patient experience groups are also meeting on both sites and include patient participation, to discuss areas of concern and to champion change.

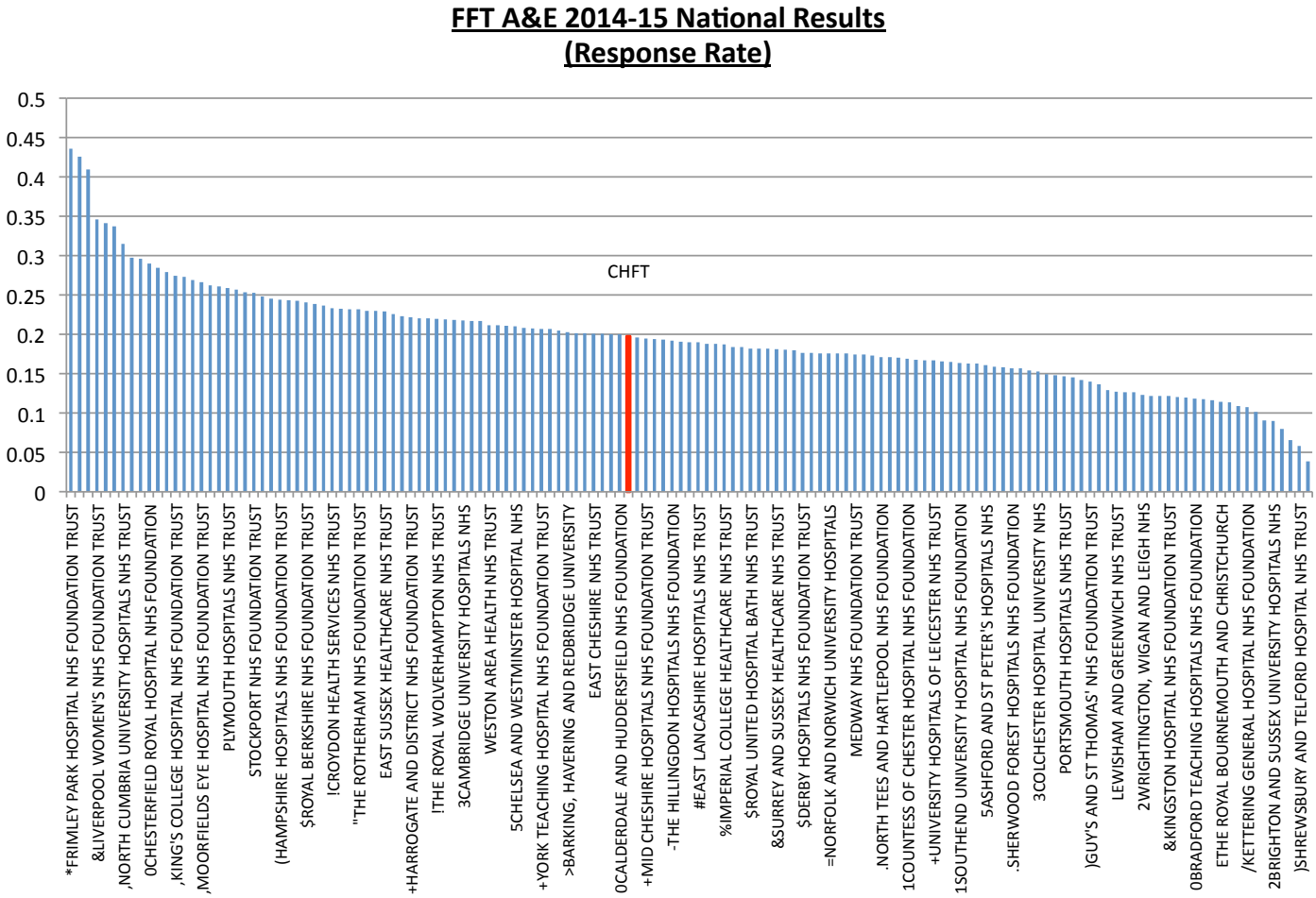
To supplement the information further monthly data is also collected around 6 questions based on patient and staff experiences as part of the A&E quality improvement programme. The information is discussed monthly at the quality forum and in directorate management group so action can be taken where failings have been identified.

Friends and family in A&E

Another source of information is the friends and family test. The results are within the normal range but the response rate is however a challenge despite continual efforts to improve.

A lower target of 20% was set for the Accident & Emergency F&F response rate. This was achieved for the first 7 months of 2014/15; however this dropped to below 20% for subsequent months and can be directly attributed to a change in the method for capturing feedback. There was a shift from using tokens to using postcards based on national guidance that token collection systems (patients indicating their score by dropping a token into a box) were no longer permitted.

Over the 11 months a total of 88.7% of patients who responded said that they would recommend our care and 6.0% said they would not.



Performance against relevant indicators and performance thresholds from the Risk Assessment Framework

Area	Indicator	Threshold	Performance	Achieved?
Access 1	Maximum time of 18 weeks from point of referral to treatment in aggregate-admitted	90%	91.4%	Yes
Access 2	Maximum time of 18 weeks from point of referral to treatment in aggregate- non admitted	95%	98.6%	Yes
Access 3	Maximum time of 18 weeks from point of referral to treatment in aggregate- patients on an incomplete pathway	92%	94.5%	Yes
Access 4	A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	94.6%	No
Access 5	All cancers: 62-day wait for first treatment from:			
	● Urgent GP referral for suspected cancer	85%	91.0%	Yes
	● NHS Cancer Screening Service referral	90%	92.1%	Yes
Access 6	All cancers: 31-day wait for second or subsequent treatment , comprising:			
	● Surgery	94%	98.5%	Yes
	● Anti-cancer drug treatments	98%	100.0%	Yes
Access 7	All cancers: 31 day wait from diagnosis to first treatment	96%	99.6%	Yes
Access 8	Cancer: two week wait from referral to date first seen, comprising:			
	● all urgent referrals (cancer suspected)	93%	98.2%	Yes
	● for symptomatic breast patients (cancer not initially suspected)	93%	95.6%	Yes
Outcomes 16	Clostridium difficile – meeting the C. difficile objective	18	22	No
Outcome 20	Certification against compliance with requirements regarding access to health care for people with a learning disability	N/A	Yes	Yes
Outcome 21	Data completeness: community services, comprising:			
	● Referral to treatment information	50%	91.41%	Yes
	● Referral information	50%	98.32%	Yes
	● Treatment activity information	50%	98.57%	Yes

Feedback from commissioners, overview and scrutiny committees and Local Healthwatch

Response from Greater Huddersfield and Calderdale Clinical Commissioning Group

We were pleased to receive and comment on the Quality Account prepared by Calderdale and Huddersfield NHS Foundation Trust (CHFT). The following statement is presented on behalf of NHS Greater Huddersfield CCG and NHS Calderdale CCG. The Quality Account is a comprehensive assessment of the levels of quality and is consistent with the Commissioners understanding of quality in CHFT. It describes progress in many areas with comparisons against other hospitals and national targets which is helpful and demonstrates transparency. This statement will reference areas as CCGs we are pleased to see the progress made, and others where we feel the account could be strengthened.

We recognise a range of improvement work in relation to the identified priority areas for 2014/15, and welcome the improvement in incident reporting and complaints handling, which shows an open, transparent and listening culture. Your achievements in relation to reducing length of stay for patients with Diabetes, in particular, is to be commended, as is the evidence of greater autonomy for this group of patients. The account would be strengthened with inclusion of some narrative around sustainability of the improvement work, particularly in relation to the work to help patients with long term conditions to self-manage and how this will be rolled out to other areas.

We note that the information provided on readmissions is good, particularly for adults, and shows a significantly higher performance than average. However, we would have expected reference in the publication of nurse staffing levels, the work you are undertaking towards seven day working, and reference to safeguarding information in relation to adults or children. There are inconsistences in the narrative on mortality indicators and sections on definitions are not clear for a lay person to understand.

The inclusion of the Care Quality Commission intelligence monitoring is good, along with the associated areas for improvement.

The identified priorities for 2015/16 of
l Improving Sepsis Care
- To ensure Intravenous antibiotics are given correctly and on time
- Improving the discharge process, and
- Better food

The rationale for why these have been chosen, the work to be carried out and what you are trying to achieve is clearly articulated and are recognised by commissioners.

We look forward to continuing to work closely with the Trust over the coming year in order support the Trust in achieving the quality improvement priorities set out in the account.

Dr Majid Azeb
Chair Calderdale CCG Quality Committee

Dr Judith Parker
Chair Greater Huddersfield CCG Quality and Safety Committee

Response from Healthwatch Kirklees

We have received no response from Healthwatch Kirklees, there is no requirement for them to comment.

Response from the Governors

We have received no responses from the Governors.

Response from Healthwatch Calderdale

Healthwatch Calderdale (HWC) notes that the Quality Accounts Report has been subject to audit. HWC has no significant anecdotal or soft evidence that would prompt doubt. We recognise the report as being an accurate reflection of CHFT performance.

HWC welcomes attempts to involve a wider public in the selection of action priorities. As the Members Council had participated in the process we would like to see their assessment of the outcomes included.

Although the priority of reducing the mortality rate has been partly met, HWC would like to see prominence given to the comparison with other similar hospitals. As "the SHMI data can be tracked to specific conditions where the actual number of deaths exceeds expected" we would urge highlighting of those areas and the actions taken to improve them.

The friends and family test is welcomed as is the Real Time monitoring by public & patient engagement - we note the high levels of satisfaction expressed.

The CQUINS achievements are not available in the draft versions, but we look forward to seeing them. If expressed as a % of the available amount, it would provide a useful indicator of the quality perceived by the commissioners.

Calderdale public have been extremely engaged about hospital reconfiguration especially around A&E services. The Quality Accounts Report does not clearly add to public knowledge by giving prominence to the relationship between the financial sustainability of the Trust, the quality of care it can provide, the safety of activity within the A&E departments and the pressures these make on a need for change.

The report is complex and is not a friendly document for general public use. HWC recognise that the report has been prepared for widely different readerships and has to conform to some specifications, but we would like to see a consistent display of how the measured parameters compare with other Trusts and have an easy read summary incorporated. Presentation of the facts in a more easily comprehendible manner would be a clear expression of recognition regarding the publics' needs and would display a culture of openness.

Mr Tony Wilkinson
Chair of Healthwatch Calderdale

Response from Calderdale Overview and scrutiny Committee

Much of our time in Adults Health and Social Care Scrutiny Panel meetings this month has been spent on the implications of any hospital reconfiguration for Calderdale residents. This has meant that the Scrutiny Panel (as well as the Council's People's Commission and the Calderdale and Huddersfield Joint Health Scrutiny Committee) has paid considerable attention to the medium and long term strategic plans for hospital care and less on some of the detail contained in your Quality Plan. I hope that next year we can include some time at the Scrutiny Panel on more of the detail of the services provided by your Trust, as well as the long term future for the Trust which will inevitably take much of our attention. I think there would be merit in the Scrutiny Panel devoting one meeting to discussing quality of service issues with you (perhaps holding the meeting at Calderdale Royal Hospital if that is possible) and I will ask Mike Lodge to contact Catherine Riley to arrange that.

It is pleasing to see some progress against your priorities for 2014/5. However, mortality rates remain above national averages and I would welcome some discussion of this at a Panel meeting over the coming year. One of Sir Robert Francis' comments about overview and scrutiny in Staffordshire was,"[they] showed a remarkable lack of concern or even interest in the [mortality] data. Difficult though statistics can be to understand, it should have been possible to grasp that they could have meant there was an excess mortality that required at least monitoring by the committee". I feel that we have not given this issue sufficient attention despite the clear message from Sir Robert and I think this should be rectified in the coming year.

It is perhaps inevitable that the Quality Account should focus on hospital services. However, it is difficult to identify which of your Priorities for last year or the coming year have some application to those community health services that you provide. Improvements in community health services have been presented to the Scrutiny Panel as a key way of supressing demand for acute hospital care and hence influencing any reconfiguration of hospital services. I am sure the Panel will be interested in your assessment of progress in changes to community health services that you provide and we will build that into our schedule for 2015/16.

I would like to comment particularly on your new priority of improving the discharge process. Delayed discharge continues to be reported above target levels and, as you indicate in the Quality Account the local authorities and other care providers have a part to play in helping improve this situation. I hope that the Better Care Fund will contribute to achieving improvements in this area. I am sure that the Scrutiny Panel will want to ensure that all partners are playing their part to ensure that patients get the right outcomes and the best experience when they are discharged from hospital.

It is understood that there is frequently a difference of view between CHFT and AHSC regarding the responsibility for the delay in patients leaving hospital. This is regarded as a major cost point to CHFT and several approaches are proposed to improve the position. The Scrutiny Panel will wish to explore this in considerable detail next year with a view to establishing the causes and results of the so called "bed blocking".

Our Scrutiny Panel and the Calderdale and Kirklees Joint Health Scrutiny Panel will inevitably be heavily involved in assessing the impact of any proposals that Calderdale Clinical Commissioning Group and Greater Huddersfield Clinical Commissioning Group make about the provision of acute hospital care. Our priority next year will be to ensure that high quality easily accessible hospital care is available for all Calderdale residents and I look forward to working with you on that over the coming year.

Councillor Malcolm James
Chair, Adults Health and Social Care Scrutiny Panel

Response from the Well-Being and Communities Scrutiny Panel in Kirklees Council

Thank you for the letter dated 17 April 2015 inviting comment from the Well-Being & Communities Scrutiny Panel in Kirklees Council on the draft 2014/15 Quality Account for Calderdale and Huddersfield NHS Foundation Trust.

The comment from the Panel for publication is detailed below:

The Kirklees Council Well-Being & Communities Scrutiny Panel, as the local health overview and scrutiny committee, has reviewed the Draft Quality Account which included reference to the Department of Health's guidance for Overview and Scrutiny Committees.

The Panel has noted your priorities for 2015/16 and is generally supportive of the range of areas that they will cover although there were a number of areas that it felt warranted further comment.

The Panel welcomed the priority for improving sepsis care and noted that the Yorkshire Ambulance Service had also highlighted this issue and included it as a priority for 2015/16. The Panel did however feel that the domain for this priority should have been classed as an effectiveness criterion and that it would be helpful to include an explanation of the differences in the domains that are used by the Trust to categorise the priorities.

The Panel also welcomed the continued focus on intravenous antibiotics and look forward to seeing further progress during 2015/16. However the Panel did note the rise in missed doses during the winter months 2013/14 and felt that it would have been prudent to include an additional objective for 2015/16 designed to improve performance during the next winter period.

The Panel was pleased that work will be done to improve the discharge process and keep patients better informed about their care arrangements. During 2014/15 the Panel has maintained a close focus on the work that is being done to enhance and strengthen community based healthcare services across Calderdale and Kirklees. The integration of health and social services is a key element of these changes and will have a significant impact on the Trust's objective of reducing delays in discharge from hospital. For this reason the Panel felt that it would have been sensible to reference this work and outline the approach the Trust is taking to support these developments.

The Panel acknowledged the importance of patients receiving appetising and nutritionally balanced food and the contribution it can make to the wellbeing of a patient. However the Panel felt that the target of improvements in patient satisfaction was unambitious and believed that the target could have been strengthened by including specific objectives in terms of the food offering in order to demonstrate progress in the provision of a wider range of nutritious and healthier food options and in the choice of food selected by the patient.

The Panel noted that the Trust's Hospital Standardised Mortality Rates are still above the national average and although the Panel acknowledged that the 2015/16 focus on sepsis and the administration of IV antibiotics will have an impact on this issue the Panel felt that it would have been sensible to continue to include this is a priority for 2015/16.

The Panel also noted that the number of patient falls in the hospital continued to be the highest reported safety incident in the Trust and although the Panel acknowledged that work was taking place to address this issue the Panel was surprised that hospital falls wasn't included as one of the priorities for 2015/16.

During 2014/15 the Panel considered and reviewed a number of areas that it felt were of local importance. This included: looking at the Trust's plans to achieve financial savings through its balanced plan; reviewing the work being done to improve the quality of care provided to patients through the Care of the Acutely Ill Patient Programme; challenges related to staff shortages in key areas such as nursing and A&E; the impact that the increased demand during the winter period had on A&E; and the work that is taking place to develop proposals for changes to hospital services.

Given the local interest in these matters and the potential impact on health services in the district the Panel felt that it would have been appropriate for the Trust to have made reference to these issues in the document.

The Panel felt that the report did highlight the work of the trust to engage with staff, patients and the public and noted the importance that the Trust placed on using information from a variety of sources such as clinical data and patient feedback to help improve the quality and safety of care provided to patients.

In addition to the above statement for inclusion in the report, the Panel would also like to make the additional comments regarding the content and format of the report:

- General – The Panel accept the need to use medical terminology and acronyms but believe that most people reading the account would find it difficult to fully comprehend the information and for this reason the Panel would recommend that you refer to and include a glossary of terms in the document.
- General – Although the Panel noted that a statement from the Chief Executive will be added the Panel felt that it would have been helpful to have included an executive summary that would provide an explanation of what the document is intended to convey. The Panel also believed that a contents page would be useful.

- General – The Panel accept that the use of graphs can be a useful way to present data/information however the Panel found a number of the charts difficult to interpret (Particularly those graphs that showed a number of different fields/data) and some of the charts/graphs were too small and difficult to read.
- Final data relating to the CQUIN payment framework is missing which means that the Panel is unable to fully comment on this aspect of the Quality Account.
- SHMI Trend – The Panel felt that it would be helpful to provide an explanation for those periods that show a higher risk (concern); and the Trust's position when compared against other acute NHS providers.
- The Panel noted that the numbers of patient's deaths with palliative coding has varied considerably from the national rate. The Panel support the approach to monitor closely the use of palliative care coding but felt that taking account of the information the trust has collated it would be helpful to include an explanation on why there is such a variance in the data.

Richard Dunne
Principal Governance and Democratic Engagement Officer
On behalf of the Well-Being & Communities Scrutiny Panel

Statement of directors' responsibilities for the quality report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2014 to 28 May 2015
    - papers relating to Quality reported to the board over the period April 2014 to 28 May 2015
    - feedback from commissioners dated 08/05/2015
    - feedback from governors dated – not received
    - feedback from local Healthwatch organisations dated 28/04/2015
    - feedback from Overview and Scrutiny Committee dated 05/05/2015 and 08/05/2015
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX
    - the latest national patient survey 21/05/2015
    - the latest national staff survey February 2015
    - the Head of Internal Audit's annual opinion over the trust's control environment dated 28 May 2015
    - CQC Intelligent Monitoring Report dated May 2015
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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 of Directors

Owen Williams
Chief Executive
28 May 2015

Andrew Haigh
Chief Executive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Independent Auditor's Report to the Membership Council of Calderdale and Huddersfield NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Calderdale and Huddersfield NHS Foundation Trust to perform an independent assurance engagement in respect of Calderdale and Huddersfield NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicator for the year ended 31 March 2015 subject to limited assurance is:

- emergency re-admissions within 28 days of discharge from hospital

We refer to this national priority indicator as "the indicator"..

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2014/15 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- board minutes for the period April 2014 to the date of signing of the limited assurance opinion
- papers relating to quality reported to the board over the period April 2014 to the date of signing of the limited assurance opinion
- feedback from Commissioners, dated 08/05/2015
- feedback from local Healthwatch organisations, dated 28/04/2015
- feedback from Overview and Scrutiny Committee dated 05/05/2015
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/05/2015,
- the [latest] national patient survey, dated 21/05/2015.
- the 2014 national staff survey
- Care Quality Commission Intelligent Monitoring Reports, dated July 2014 and October 2014; and
- the Head of Internal Audit's annual opinion over the trust's control environment, dated April 2015.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Calderdale and Huddersfield NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Calderdale and Huddersfield NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- testing key management controls
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Calderdale and Huddersfield NHS Foundation Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
1 St Peter Square
Manchester
M2 3AE

The independent auditors reviewed three indicators this year, 18 weeks, 28 day readmissions and average length of stay. One was selected by Monitor and the other two by the Trust. The mandatory indicator selected by monitor was the 18 week indicator. We haven't received the final report from the auditors but we are aware that they will be unable to provide us with assurance against this indicator. This is due to there being six patients of the 23 that were audited where there were errors in the way the individual patients had been coded. We had coded them as breaches but the auditors have confirmed that they weren't likely to have been breaches. Action is being taken to look at the causes of this and changes will be made to resolve the issue. The other two indicators we believe will be assessed as compliant with the reporting rules for those indicators.

Appendix A

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust were eligible to participate in/participated in for which data collection was completed during 2014/15, are listed below. The numbers 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) are also listed.

Women's and Children's Health

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases Submitted
Child health programme (CHR-UK)	No	NA	-	-
Epilepsy 12 audit (Childhood Epilepsy)	Yes	Yes	All	Continuous – all cases ongoing
Maternal, infant and newborn programme (MBRRACE-UK)	Yes	Yes	100%	100%
Neonatal intensive and special care (NNAP)	Yes	Yes	484	100%
Paediatric intensive care (PICANet)	No	NA	-	-
CEM Audit – fitting child	Yes	Yes	On-going	On-going

Acute

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases Submitted
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	Yes	100%	On-going
National Joint Registry (NJR)	Yes	Yes	967	On-going
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Yes	All	100%
National emergency laparotomy audit (NELA)	Yes	Yes	130	100%
CEM Audit Older People	Yes	Yes	On-going	On-going
CEM Audit Mental Health	NA	NA	-	-
BTS Adult Community Acquired Pneumonia	Yes	Yes	On-going	On-going
BTS National Plural Procedures	Yes	Yes	16	100%
BTS Adult NIV Audit	Yes	Yes	On-going	On-going

Blood and transplant

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Medical Use of Blood (National Comparative Audit of Blood Transfusion) National Comparative Audit of Blood Transfusion - programme includes the following audits, which were previously listed separately in QA: 2014 Audit of transfusion in children and adults with Sickle Cell Disease	Yes	Yes	On-going	All cases to be submitted

Cancer

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Bowel cancer (NBOCAP)	Yes	Yes	249	100%
Head and neck oncology (DAHNO)	No	N/A	-	-
Lung cancer (NLCA)	Yes	Yes	100%	All cases in time period
Oesophago-gastric cancer (NAOGC)	Yes	Yes	100%	On-going
National Prostate Cancer Audit	Yes	No	-	-

Heart

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes	100%	100%
Adult cardiac surgery audit (ACS)	No	N/A	-	-
Cardiac arrhythmia (HRM)	Yes	Yes	100%	On-going
Congenital heart disease (Paediatric cardiac surgery) (CHD)	No	N/A	-	-
Coronary angioplasty	Yes	Yes	475	100%
Heart failure (HF)	Yes	Yes	100%	On-going
National Cardiac Arrest Audit (NCAA)	Yes	Yes	196	31%
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Yes	Yes	53	On-going

Long term conditions

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	Yes	On-going	On-going
Diabetes (Paediatric) (NPDA)	Yes	Yes	100%	100%
Inflammatory bowel disease (IBD)	Yes	Yes	31	All cases in time period
Renal replacement therapy (Renal Registry)	No	N/A	-	-
National COPD Audit BTS	Yes	Yes	257	100%
National Diabetes Foot Care Audit	Yes	Yes	On-going	On-going
National Audit of Standards for Ulnar Neuropathy at the Elbow (UNE) testing	Yes	Yes	20	100%

Mental Health

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Prescribing for substance misuse: Alcohol detoxification	No	N/A	-	-
Prescribing for bipolar disorder (use of sodium valproate)	No	N/A	-	--
Prescribing for ADHD in children, adults and adolescents	No	N/A	-	-

Older People

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Falls and fragility fractures audit programme	Yes	N/A	-	-
Sentinel Stroke (SSNAP)	Yes	Yes	All	On-going
Rheumatoid and early inflammatory arthritis (NCAPOP)	Yes	Yes	All	On-going
National Audit of Intermediate Care	Yes	Yes	All	All cases in time period

Other

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Elective surgery (National PROMs Programme)				
Groin hernia	Yes	Yes	173	On-going
Hip replacements	Yes	Yes	252	On-going
Knee replacements	Yes	Yes	202	On-going
Varicose veins	Yes	Yes	131	On-going

National Confidential Enquiries

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Deaths:				
Gastrointestinal Haemorrhage	Yes	Yes	9	88%
Lower limb amputation study	Yes	Yes	7	86%
Tracheostomy study	Yes	Yes	2	100%
Sepsis Study	Yes	Yes	10	90%

The national clinical audits and national confidential enquiries that the Trust did not participate in and reasons during 2014/15 are as follows:

- The Trust didn't participate in the National Prostate Cancer Audit due to unsupported IT systems.

The reports of 25 national clinical audits were reviewed by the provider in 2014/15 and the following are examples where Calderdale and Huddersfield NHS Foundation Trust intend to take actions to improve the quality of healthcare provided.

National audit of inflammatory bowel disease (IBD) service provision
The UK National IBD Audit aims to improve the quality and safety of care for IBD patients throughout the UK, by involving professional groups and patients in a national audit of individual patient care and of service resources and organisation in all hospitals

The project is based on a collaborative working partnership between the British Society of Gastroenterology, the Association of Coloproctology of Great Britain and Ireland, the National Association of Colitis and Crohn's Disease and the Royal College of Physicians' Clinical Effectiveness and Evaluation Unit.

Objectives:
The aim of the national IBD audit (round 4) (2012–14) has seen substantial changes to methodology, with the prospective collection of data for up to 50 patients with ulcerative colitis per site and the adoption of the IBD quality improvement project (IBDQIP) tool for the assessment of organisation of services and to drive quality improvement. The audit has assessed patient outcomes more thoroughly in terms of disease activity, quality of life, patient-reported outcome measures and patient experience.

The report examines the quality of adult IBD services throughout the UK. Participating services were asked to report the status of their own service as at 31 December 2013. The quality of a service is assessed against the Standards for the healthcare of people who have inflammatory bowel disease:

- Standard A – High Quality Clinical Care
- Standard B – Local Delivery of Care
- Standard C – Maintaining a Patient- Centred Service
- Standard D – Patient Education and Support
- Standard E – Data, Information Technology and Audit
- Standard F – Evidence-Based Practice and Research

What changes in practice have been agreed?

- Setting up of IBD MDT to meet on a monthly basis
- To establish a monitoring tool
- Recruitment of an additional Gastroenterologist Consultant

CEM – Severe sepsis and septic shock (adults)
The College clinical standards for severe sepsis and septic shock were first published in May 2009. The standards are based on the 'Sepsis Six' published by the Surviving Sepsis Campaign. A national audit of the standards was undertaken for the first time in 2011/12. Following the audit the College standards were revised in August 2012.

The purpose of the audit is to identify current performance in Emergency Department (EDs) against CEM clinical standards on the recognition and management of adults with severe sepsis or septic shock and show the results in comparison with other departments.

The standards are as follows:
1. Temperature, pulse rate, respiratory rate, blood pressure, oxygen saturation, mental status (AVPU or GCS) and capillary blood glucose within 15 minutes of arrival
2. Senior EM assessment of patient within 60mins of arrival
3. High flow O2 via non-re-breathe mask was initiated (unless there is a documented reason to the contrary) before leaving the ED
4. Serum lactate measured before leaving the ED
5. Blood cultures obtained before leaving the ED
6. Fluids - first intravenous crystalloid fluid bolus (up to 20mls/kg) given:
- 75% within 1 hour of arrival
- 100% before leaving the ED

7. Antibiotics administered
- 50% within 1 hour of arrival
- 100% before leaving the ED

8. Urine output measurements instituted before leaving the ED.

A departmental drive to improve practice and meet the 1 hour target was put into effect immediately. A repeat audit of 50 patients was undertaken April/May 2014.The results showed an improvement. 36% of patients received antibiotics within an hour.

Other National Clinical Audits the Trust has participated in during 2014/15:
- Breast cancer clinical outcome measures project - National Audit Symptomatic Breast Cancer
- National Breast Screening Programme
- UK National Bariatric Surgery Registry
- National Audit of Hip Fractures
- Diabetic Retinopathy Screening (KPI)
- Mid-Urethral Tapes (BAUS)
- Nephrectomy Surgery (BAUS)
- PCNL (BAUS)
- Invasive cytology
- British Association for Sexual Health and HIV and British HIV Association
- National Cardiac Rehab audit
- National review of adult asthma deaths – year 3
- National care of the dying – round 4
- British Society of Urogynaecology National Audit on Stress Incontinence
- Audit on Preventing early onset neonatal group B streptococcal disease
- Autoimmune Hepatitis
- SAMBA (Day in the life of an AMU)
- National Transition and DKA Audit
- NAP 5: Accidental Awareness during General Anaesthesia (AAGA)
- Sprint National Anaesthesia Project SNAP 1
- APRICOT (Anaesthesia Practice in Children Observational Trial)
- National Completed Acute Diverticulitis Audit (CADS)
- RCR National Emergency CT reporting audit

The reports of 80 local clinical audits were reviewed by the provider in 2014/15 and the Trust intends to take the following actions to improve the quality of healthcare provided:

New onset angina clinic (rapid access chest pain clinics)
The new onset angina clinic (rapid access chest pain clinics) is new service for CRH. It provides a quick and early specialist cardiology assessment for patients with new onset of exertion chest pain thought likely to be angina, and for patients not currently under a cardiologist who have known ischaemic heart disease and worsening symptoms and who need urgent assessment. This is a consultant-led, one-stop clinic, which enables a rapid and definitive assessment of symptoms and investigations and results in either the initiation of treatment or the swift reassurance of patients without pathology and at the moment are run 3 times a week

All patients are seen within two weeks of a referral, with results sent by fax within 24hrs. The clinic is a fast route of entry for patients into cardiology services. It allows quick access to appropriate treatment, either medication or invasive procedures and to all-important risk factor modification, prevention and rehabilitation services. It accepts referrals of patients with new onset chest pain suspected to be cardiac in origin. Patients with known ischaemic heart disease are referred to the general cardiology clinic unless they have worsening symptoms.

The audit was undertaken to review referrals to the new onset angina clinic in CRH in the first 12 months of the service using NICE CG95: Managing new onset angina.

Of the total number of 810 patients who were referred, only 133 were inappropriate (16%). The majority of patients (82%) were referred from primary care. 11% of patients had no chest pain and 30% were followed up in the cardiology clinic. The majority of patients had low probability of IHD (71% are < 30%).

The new onset angina clinic is working well. New standards for the new onset angina clinic acceptance forms have been set thereby working towards more efficient clinics.
Consultants will refer to the Heart Failure Nurse, and the Acute Coronary Syndrome nurse aids the cardiology non-invasive team lead with clinical decisions.

Re-audit of Gentamicin levels following change of dosing regime to comply with NICE CG149: Antibiotics and Early Onset of Neonatal Infection
Gentamicin is a broad spectrum aminoglycoside antibiotic that is widely used as the first choice antibiotic for the treatment of neonatal infection.
NHS organisations, clinical directors and those responsible for the provision of neonatal services have to ensure that compliance with the care bundle is measured daily for each patient in the sample group until full compliance for all patients receiving gentamicin is achieved.

As recommended in the March 2014 audit, a new prescription chart was introduced in August 2014, following approval from the Medicines Management Committee. This was to ensure compliance with NICE guidelines in the prescribing and administration of gentamicin.

The audit was undertaken to ensure improvement of compliance of gentamicin levels in accordance with the NICE guidance and to check that levels of gentamicin have improved since introduction of new prescription chart
71 samples (10 post dose & 61 pre-dose) of gentamicin levels were checked in the period August to October 2014. Samples were taken from NNU and postnatal wards at CRH.
Findings were:

- The number of post dose levels has reduced significantly. Only 10 post dose levels were done in this period, according to previous criteria about 60 post dose levels would have been done in the same period of time.
- The post dose levels done have a higher mean level now suggesting that a better therapeutic range is being achieved overall.
- Pre dose gentamicin levels have improved, previously up to 20% of levels in the smallest babies had been too high, increasing the risk of toxicity, and this proportion overall has dropped to 4.7%.
- The proportion of levels below the lower cut off range has decreased and the proportion of levels above the upper cut off range of 12 has increased but none of the levels done were significantly too high.

The new Gentamicin dosing regime seems to be working well apart from occasional problems with inappropriate post gentamicin levels being taken.

Actions:
- The aim is to set up a real time monitoring system of Gentamicin levels to ensure these are now within the satisfactory range following the recent changes made. An alert box will be added to PAS to remind requesters of the criteria for checking post dose levels. Microbiology / IT have agreed to put an alert on the system.
- Need to promote the indications for post gentamicin levels being taken, including on the postnatal wards
- Re-audit in 2015-16.


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