Calderdale and Huddersfield NHS
NHS Foundation Trust

Calderdale & Huddersfield Foundation Trust
Q1 Quality Report
2016-17

Subject:	Q1 2016-2017 Quality Report
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Sponsored by:	Brendan Brown - Director of Nursing
Presented by:	Brendan Brown - Director of Nursing
Purpose of paper	Discussion requested by Trust Board Regular Reporting For Information / Awareness
Key points for Trust Board members	The report is structured into the five Care Quality Standards domains, with each section having a summary providing an overview of compliance with each indicator and highlights. During this quarter, all CQUIN, Quality Account and contract requirements were achieved, with the exceptions noted below: <u>Highlights</u>: **SAFETY:** • Falls prevention lead now in place – falls prevention now part of a wider piece of work on reducing harm • Safety huddle work supported by Improvement Academy on wards H19 and CRH ward 6bc • Record keeping – 92% compliance with CRAS audit standards, though variability across wards • Medicines management – self administration medication collaborative established to support patients in managing their medication from home in hospital and supporting poster campaign • Maternity – maternity action plan now in place **EFFECTIVE:** • **Mortality** – The latest SHMI shows the Trust to have a SHMI of 113 which is classified as 'above expected'. key priority areas identified are the reliability of clinical care for respiratory, stroke and elderly patients, recognising and responding to deteriorating patients and timely antibiotics for patients with sepsis.

	• **Care Bundle implementation** – some improvement noted in compliance with asthma bundle and acute kidney infection bundle • **Reducing Hospital Acquired Infection** – 0 cases MRSA bacteraemia since Q2 2015/16 • **Hospital at Night** - achievement of Hospital at Night Programme CQUIN for Q1 • **End of Life** – integrated workplan being developed for end of life care • **Stroke** – improvements in stroke pathway delivery **EXPERIENCE:** • **Improving the Patient Experience** – 4 quality improvement projects in development: - children's voice - effective care on a busy surgical ward - maternity patient experience - developing new measures of feedback for community services • **National Adult In Patient Survey 2015** – some improvement / positive results in relation to availability of hand wash gels and cleanliness of hospital toilets and bathrooms • **Improving Hospital Nutrition** – positive feedback from PLACE inspections of patient food at CRH and HRI **RESPONSIVE:** • **Incidents, complaints, claims** – improvements in sharing of learning from adverse events via Patient Safety Quality Boards and Quality Committee and with divisions for claims • **Appointment Slot Issues** – improvement in the number of referrals awaiting appointment **WELL - LED:** • **Safe Staffing** – Roster efficiency tool introduced to support safe staffing levels and roster efficiency approval for overseas recruitment campaign for nursing staff • **Sickness and absence** – improved position • **7 Day service** – progress in General Surgery towards a more Consultant delivered 7 day service.

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APPENDIX G

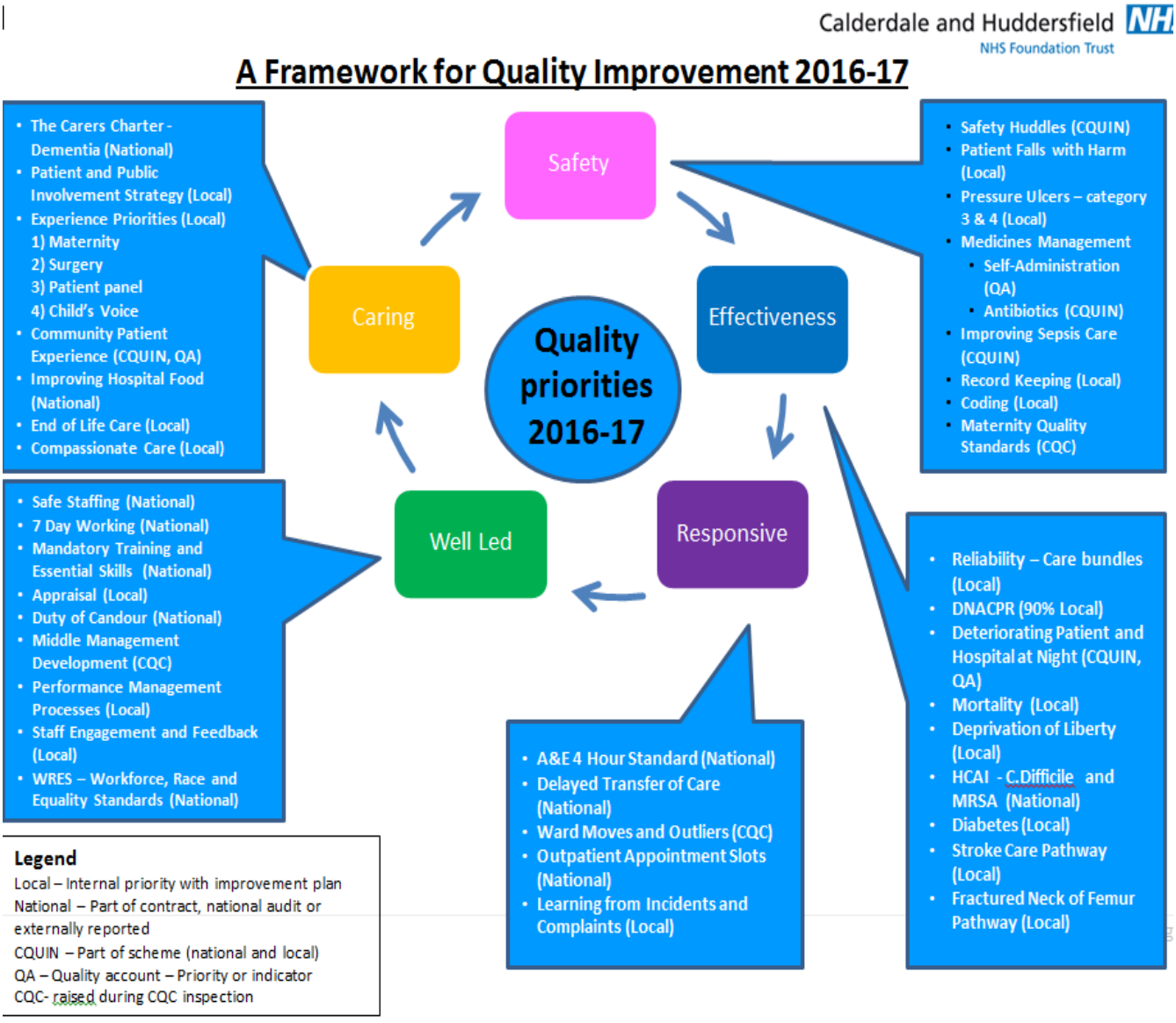
Introduction

This quarterly quality report covers contractual, quality account, national and local quality priority requirements to provide a comprehensive overview of quality performance during each quarter of 2016-2017 within Calderdale and Huddersfield NHS Foundation Trust (the Trust).

Each year the Trust works with the commissioners to agree what should be included in the local contract including CQUIN priorities. These cover key clinical priorities and build upon our strategic aims.

The Care Quality Commission Intelligent Monitoring reports also provide a framework for determining quality priorities.

From all these sources the following diagram shows the Trust key priorities for 2016-17, these have been broken down into the 5 key CQC domains



Summary of Key Performance Frameworks:

2016/17 Quality Account:

There are three Quality Account priorities for 2016/17. These are listed below and further detail regarding progress can be found on the page number indicated

Domain	Focus/Priority	More Details
Safety	Reducing Falls through the implementation of Safety Huddles	Pg 12
Effectiveness	Implementation of Hospital at Night to reduce mortality	Pg 39
Experience	Improving Patient Experience in the Community	Pg 51

2016/17 CQUINS:

There are seven CQUIN areas for 2016/17. These are listed below and further detail regarding progress can be found on the page number indicated. The information contained in the performance box provides a quick overview of target attainment during the most recent quarter, where applicable.

	Indicator Name	Q1 Achievement	Page
1a	Staff Well Being – Services	Y	-
1b	Staff Well Being – HFFSB	Y	-
1c	Staff Well Being – Flu Vaccination	N/A	**N/A**
2a1	Sepsis Screening – Emergency Admissions	Partial - 66%	**Pg. 22**
2a2	Sepsis Antibiotics – Emergency Admissions	Y	**Pg. 22**
2b1	Sepsis Screening – Inpatient Admissions	Y	**Pg. 22**
2b2	Sepsis Antibiotics – Inpatient Admissions	Y	**Pg. 22**
3a	Anti-Microbial Resistance	Y	**Pg. 18**
3b	Antibiotic Review	Y	**Pg. 18**
4	Safety Huddle Implementation	Y	**Pg. 12**
5	Self-Administration of Medicines	Y	**Pg. 18**
6	Hospital at Night	Y	**Pg. 39**
7	Community Patient Experience	Y	**Pg. 51**

Domain One – Patient Safety: People are protected from abusive and avoidable harm.

Patient Safety Compliance Summary

Indicator 2015-16	Compliance
1.1 Reducing patient falls with harm	Reporting only
1.2 Introducing Safety Huddles	Reporting only
1.3 Reducing pressure ulcers	Achieved
1.4 Improving Medicine Management (CQUIN)	Partial
1.5 Improving Sepsis Care (CQUIN)	Reporting only
1.6 Record Keeping	Reporting only
1.7 Maternity Quality Standards	Reporting only
1.8 Coding	Reporting only

1.1 Reducing patient falls with harm

Falls in hospitals are the most common patient safety incidents reported in hospital trusts in England. The National Patient Safety Agency (2011) report 'Essential care after an inpatient fall' states that each year around 282,000 patient falls are reported in hospitals and mental health units. A significant minority result in death, severe or moderate injury. (including approximately 840 neck of femur fractures, 30, head injuries and 550 other fractures). Falls impact on the quality of life through pain, loss of confidence, loss of independence and increased mortality. Falls are estimated to cost the NHS more than £ 2.3 billion per year.

The National Institute for Clinical Excellence (NICE) – Guideline 161 (2013) 'Implementing Fall Safe' provides recommendations for the management and prevention of inpatient falls. CHFT has responded to these recommendations implementing 6 key actions.

- Commencement of a falls lead nurse within the trust to provide traction and drive project work.
- Roll out of safety huddles. Improve engagement with teams
- Review of equipment.
- Review of documentation supporting falls prevention and management that is compliant with guidelines.
- A communication and training strategy including reviews and learning
- Ensure following an in-patient fall patients get the best care to prevent harm and repeat falls.

The target for falls prevention for 2016/17 is to move away from the trajectory of a 10% reduction in falls that cause harm, this is because we know that as patients become more frail and elderly we will see an increase in falls in this group of patients and we know falls will happen.

The focus will continue to be on preventing falls but this will become a larger piece of work focusing on quality of care for patients. Falls will, therefore, become part of a larger project

of reducing harm led by the Deputy Director of Nursing; this project will be a strategic piece of work which will focus on the overarching basic principles of care encompassing, safety, dignity, patient experience and reducing harm.

Current Performance

Since December 2015 up end of March 2016 there were 823 falls in total across the trust. The trust has reported a total of 315 falls throughout the first 2 months of the first quarter for 2016, the table below illustrates a breakdown by Division.

	Quarter 4 2015/16			Quarter 1 2016/17		
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	YTD
Surgery	26	23	30	23	36	138
Medicine	158	133	124	126	121	662
FSS	7	5	2	3	6	23
Total	191	161	156	152	163	823

Falls with harm

Since December 2015 up to the end of March 2016 there were 32 harm falls across the trust, a breakdown by division can be seen in the table below. The Trust has reported 13 harm falls throughout the first 2 months of the first quarter for 2016. This shows that for harm falls the Trust has had a much higher than predicted amount of harms falls.
and is on course for the 10% reduction trajectory.

The first 2 months of quarter 1 in 2016/17 have seen 13 harms falls. This is a steep increase in falls compared to the first 2 months of quarter 1 in 2015/16 where 4 harm falls were reported – this is an increase of 9 harm falls on the previous year and exceeds the planned trajectory.

	Quarter 4 2015/16			Quarter 1 2016/17		
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	YTD
Surgery	1	-	-	-	-	1
Medicine	3	3	2	6	7	21
FSS	-	-	-	-	-	-
Total	4	3	3	6	7	32

The national Audit Falls and fragility Audit of inpatient falls (2015) reported the national average rate of falls per 1000 occupied bed dates (1000 OBDs) as a range of 0.82 -19.20, the mean being 5.6 for acute hospitals. CHFT reports at 8.42 (Per 1000 OBDs). The national reported range for falls resulting in harm was noted as 0.01 –2.00 (Per 1000 OBDs) – CHFT is reported at 0.09 (per 1000 OBDs).

The newly appointed falls lead will continue to drive and work to an action plan to look at the following actions:

- Improving the quality of assessments and intervention for patients at risk of falls
- Improve multidisciplinary working with regard to the assessment and management of patients at risk of falls

- Educate and empower ward staff to make small but effective innovation and change through the implementation of a falls quality improvement collaborative
- Introduce and monitor compliance with a Falls Investigation Prompt sheet to compliment the CHFT RCA investigation tool developed by Effective Investigation Group (to improve quality of RCA).
- Support and monitor actions that were agreed at the CHFT first Harm Summit on 10th November 2015 , such as falls mapping, improving safety huddles, a review of footwear that is available for patients at CHFT and embedding bedside handover.
- Review the Falls Prevention bundle following first National In-patient Falls Audit recommendations.
- Undertake a falls mapping exercise in areas of high incidence (see appendix 3) to further understand what additional measures can be put in place to aid prevention.
- Review the falls prevention strategy, with recommendations to shape the improvement work plan for 16/17.
- Consider high risk patients presenting with a dementia and how environmental factors can support a reduction in falls
- Consider trail of falls bracelets for high risk patients
- Development of a falls policy / protocol to include post fall guidance
- Engage in a multidisciplinary approach to manage falls, including medication reviews, medical reviews.
- Initiation of safety huddle CQUIN to drive a reduction in number of falls

Falls Lead actions to date

- Alterations of existing falls assessment risk tool ongoing as a paper item until it can be merged into EPR.
- Work commenced with EPR to ensure Falls programme and assessment/care plans embedded.
- Formation of Task & Finish group to work on documentation in conjunction with revised documentation group. Falls now a regular agenda item on the fortnightly meetings of this group.
- Commenced work with Improvement Academy and identified that wards H19 and CRH6BC as the first two wards to be supported and monitored on safety huddles.
- Engaged support from senior clinicians on both of the above wards to support safety huddles.
- Receiving all orange and red incidents directly from Datix team and taking lead on identified cases to ensure all learning opportunities are taken forward.
- Taken responsibility for all Trust training on falls in the new starter induction days including medical teams.

Plans for Q2 and Q3

- Risk assessments of all patients presenting with a fall over the age of 65 and those from age 50-64 with an underlying condition as recommended in NICE Guidance 2015 on first 2 wards identified for the Safety Huddle initiative and those areas that are already performing these successfully.
- Review Trust Falls Policy and amend as required.
- Create Post Falls Policy either within or in conjunction of the above.

- Providing access to Knowledge Portal for wards to link directly to Datix on a daily basis to identify trends relating to falls and see what is happening in real time.
- Investigate problems with falls alarms failures due to a reported 21 incidents of green and yellow classification having been identified from January to June 2016, and enquire as to any possible alternatives.
- Review and embed changes to existing Falls Prevention and Risk Management Care Plan on repository as past review date and currently written from a tissue viability perspective.
- Network with other Trust Falls Lead nurses where improvements and innovation has proved helpful in reducing falls and bring back learning.
- Work with Nerve Centre to get Lying and Standing BP within 6 hours of admission to any ward where the patient has met the criteria for high falls risk as recommended in national falls audit.
- Liaise with Improvement Academy around more suitable icons for patient bed PIPA boards to reduce clutter and improve conformity.
- Work with A&E staff to ensure correct falls risk assessment is undertaken and appropriate referral to community services is completed in a timely way. Also to ensure that place of fall is recorded correctly as either patients home; NH/RH or Intermediate Care bed as current data is proving unreliable. (Joint work with Community).
- Community team to liaise with GP's to determine why patients are coming to A&E with falls and what alternative actions there might be for some of these patients to reduce unplanned admissions.
- Embed falls investigation prompt sheet into Datix (adapted format from Improvement Academy Fishbone diagram) to improve learning from incidents such as trends in ward transfers, medications, AHP reports and recommendations around mobility for nursing team; times of day; days of the week; ages of patients; co-morbidities; staffing levels; dependency levels etc.
- Review of available footwear for patients at risk of falling
- Work with Dementia team to ensure all recommendations are complied with at ward level.

1.2 Reducing Harm: Safety Huddles

Background:

Estimates suggest that approximately 5–10% of hospitalised patients in high-income countries experience harm and about one third of these harmful events are preventable.

The local, national and international patient safety initiatives that have been designed over the last decade have almost all failed to demonstrate significant impact. Reducing harm across a hospital requires behavioural change at a ward team level.

National programmes have piloted the use of the patient safety huddles and demonstrated a reduction in the number of falls, an increase in overall staff morale and improved teamwork.

These quality indicators are linked to financial CQUIN to improve care, reduce harm and prevent deterioration on inpatient wards.

Current Performance

NHS Trusts have developed and piloted 'patient safety huddles' to help reduce patient harm. The huddles are led by the most senior clinician and take place at a regular time each day for 10–15 minutes. They provide a non-judgemental, no-fear space in the daily workflow of ward staff. Team members develop confidence to speak up and jointly act on any safety concerns they have. They become a vehicle for ward teams to continually learn and improve.

These are presently happening in around 90 % of medical and surgical wards across both sites at CHFT, however the quality and consistency has been recognised as variable.

In response 14 wards with high numbers of patient harms have been targeted as part of a quality CQUIN to measure the effectiveness of introduction of an effective multidisciplinary safety huddles.

However it has been recognised falls and falls with harm have been identified as a significant risk for the Trust hence the requirement to embed quality safety huddles across all medical and surgical wards with the ongoing support of the national Improvement Academy and the Trust's Falls Quality Improvement Lead.

- Work has started with the Improvement Academy in supporting wards H19 and 6BC at CRH on their daily safety huddles.
- Data is being collated from the previous 12 months to provide a baseline measurement.
- Ward based re-training is booked for the w/c 25th July on Falls Alarms with the company representative and medical devices staff.
- Double sided rubberised strip socks have been requested from Procurement for all wards and training will be provided at ward level.
- BP measurements are to be taken for all patients within 6 hours of admission as per recommendations of the last National Audit of Inpatient Falls.
- Work has started on documentation to ensure that Falls bundles meet the same recommendation

A robust action plan has been developed and remains on track to ensure all medical and surgical wards have effective multidisciplinary safety huddles in place by the end of Quarter 4. Progress and actions against plan will be monitored via the CQUINs performance group.

1.3 Reducing Pressure Ulcers

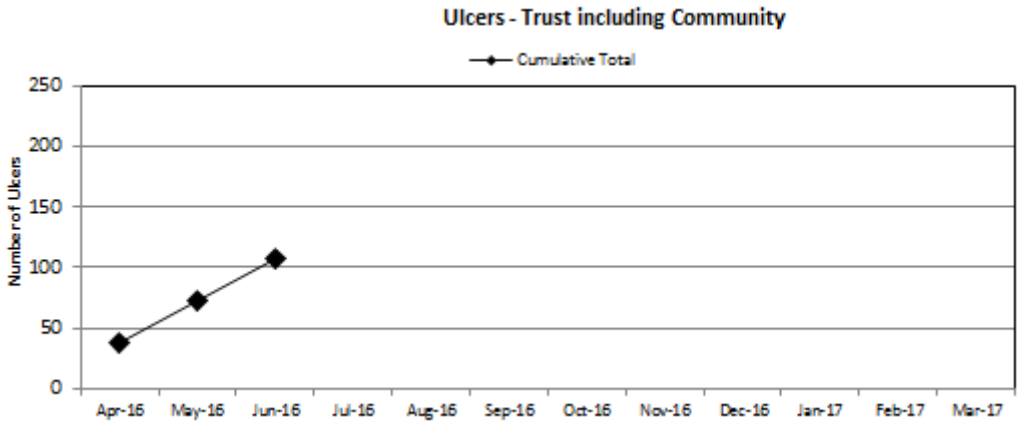
Aims and Objectives of Work

Pressure ulcer prevention is an important measure of the quality of care provided to patients. Pressure ulcers are largely preventable and their prevention is included in domain 5 of the Department of Health's NHS Outcomes Framework 2014/15 (NICE CG, 179). They can have a significant impact on patient's wellbeing and quality of life.

The pressure ulcer prevention and reduction programme is being overseen by the Safeguarding committee and Patient Safety Group which receives regular progress reports

Reduction, correct management and timely referral of other wounds include dehisced surgical wounds, burns, fungating wounds, moisture lesions and leg ulcers.

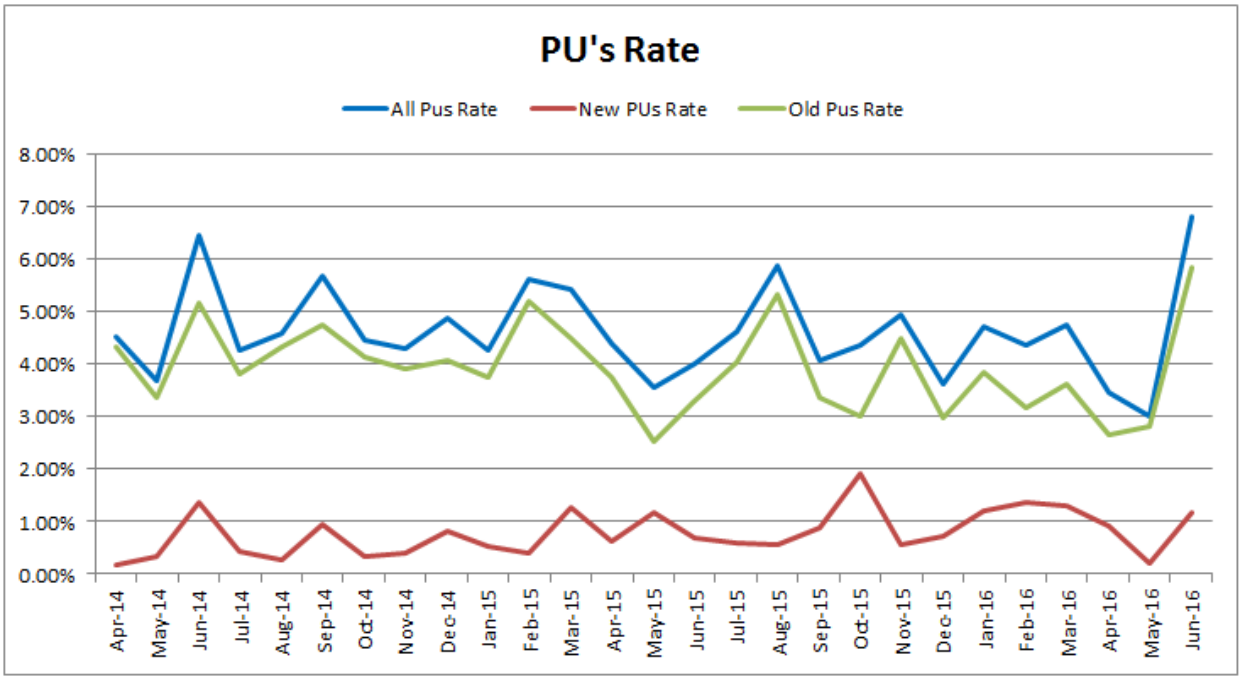
Hospital acquired pressure ulcer trajectory



Safety Thermometer

Pressure ulceration is one of the harms measured as part of the Safety Thermometer. The measure includes old pressure ulcers (pre-existing & occurring within 3 days of admission) and newly developed pressure ulcers.

When benchmarked against national data (obtained from HSCIC) CHFT rate for all pressure ulcers is above the national average of 4.46% for Q1 at 4.60% but below the national rate of 0.95% for new pressure ulcers at 0.86%.



Completed actions in Q1

- Ongoing clinical support and training is being provided by the equipment co-ordinator to wards to ensure appropriate use of pressure relieving equipment, Figures are variable between wards due to however, to date no wards have achieved required training & competency assessment for this equipment.

- All severe (category 3 and 4s) CHFT acquired pressure ulcer investigations now have Senior Nursing approval at the completion stage. The process is being reviewed as the previous process was not robust. Tissue viability, risk and safeguarding teams are developing a process to apply to primary and secondary care, which will ensure clear pathways to CQC notifications, Safeguarding concerns and STEIS. The new approach which will involve a panel review of pressure ulcers to ascertain if harm was avoidable and whether harm was caused, this will be evidenced by a root cause analysis process.
- This will allow better identification of learning from incidents.
- A review of all pressure ulcers in quarters 1, 2 and 3 is being undertaken following identification of reporting of pressure ulcers that are not attributable to CHFT.
- 4 editions of the Pressure Ulcer Newsletter have been published and circulated across CHFT. This will involve partnership working across primary and secondary care settings.
- Tissue Viability team have commenced validation of severe pressure ulcers although the timeliness of this continues to present a challenge due to clinical demand. –the expectation is that all category 3 and 4 pressure ulcers are reviewed by a Tissue Viability nurse within 24 hours. Going forward this will be measured as a key performance indicator for senior specialist clinical review
- The Tissue Viability team are providing training to new RGNs, HCAs and apprentices on pressure ulcer prevention as part of the Trust induction plan and continue to support a commissioned programme of education in community.
- The team are reviewing e training and education modules to support wider access to training and education tools available.

Improvement Plan:

Communication

Smarter ways of working utilising technology to be more efficient. Systm1 referrals to commence supported by IT. Development of wound assessment and management documentation. Electronical referrals commenced to provide audit trail and efficiency.
Database produced to audit and manage caseload

EPR

Progressive work continues in development of tissue viability documentation in EPR in partnership with Bradford.

Equipment

To understand current process and identify improvements for provision of equipment.
Equipment co-ordinator to ensure patients on correct equipment
New equipment to be explored in relation to cost savings.
Investment in equipment to reduce heel pressure ulcers commenced at beginning of 2016, pressure ulcer reporting via Datix will provide assurance for reduction.

Medicine management and formulary
Member of Area Prescribing Committee to influence change regarding wound management dressings, to consider cost effectiveness and evidence based products. To write a wound policy to ensure setting a standard for other wounds.

Link nurse champions
To continue with supporting and educating TV link nurses to empower them to prevent and manage pressure ulcers. To explore a competency framework to ensure a standardised approach.

Partnership working
Network building with North East tissue viability group
Safeguarding links established and work being undertaken to ensure openness and transparency
Infection Control: to discuss merging of TV and Infection control link nurses
Falls Nurse: to ensure partnership working with safety huddles
Workforce and development team: ensure close working partnership and promotion of training days
Medical devices: ensure understanding of roles and working together

Education
To consider different ways of offering education to staff to promote flexible learning e.g. eLearning or webinars to include primary and secondary care settings and care homes.

To ensure TVN are updated to new and current developments in the wound care field partnership working continues with companies and also to develop links with university. Presently due to lack of resources staff are not able to attend university courses for self-development.

Quality and safety
Due to a reactive service, staff capacity is not able to focus on Category 2 pressure ulcer reduction. If more resources were available this would be achieved through the visibility of the TV team on the ward, equipment education and moving and handling education.
Corporate patient leaflet to be developed as presently the one utilised is not CHFT.

Community plan

- Pressure area training should be delivered to all community teams.
    - Monthly training sessions are being delivered to community nursing staff. Non-nursing teams have also been invited to attend. Training includes pressure ulcer prevention and management.
- Concerns with care agencies or care staff should be escalated in a consistent and timely way, process established with safeguarding to attend triangulation meetings
- React to red training pack was sent to care homes by CCG; no implementation was offered to care homes at time. For introduction and embedding of the R”R tool is required
- Equipment co-ordinator to support primary and secondary care
- Pressure ulcer panel streamlined to be consistent with central panel

Supervision

To embed supervision in the TV team to ensure reflective practice

Tissue Viability Service

The Tissue Viability team is a nurse-led service that provides expert advice and support to patients and colleagues across the health economy. The team provides clinical advice, assessment and treatment as well as training on a range of topics, such as pressure ulcer prevention and equipment use and the monitoring of pressure relieving equipment within the hospitals.

The Tissue Viability team has continued to provide training on pressure ulcer prevention & management, wound care and leg ulcer management. However, due to resource issues, half of the planned sessions have not taken place. The team has supported training for apprentices and new nursing recruits and will review the delivery of training to allow wider access via e training modules and tools.

Within the TV team all nurses hold the prescribing qualification; work is progressing with the prescribing lead to ensure this skill is used in primary care

1.4 Medicines management

Aims and Objectives of Work

Effective medicine management ensures that patients receive the correct medicine at the correct time which in turn expedites their return to good health, reduces the time spent in hospital, and prevents unnecessary hospital readmissions. Nationally the transfer of information about patients' medicines continues to be a significant risk to patient safety. Between 30 – 70% of patients can have either an error or an unintentional change to their medication when their care is transferred (Royal Pharmaceutical Society July 2011).

Performance is driven by The Medication Safety Group, established in November 2014, and overseen by the Patient Safety Group.

Q1 Performance: Missed Doses:

The Trust wide missed doses audit monitors intentional and unintentional missed doses (see table below for overview of the differences) with a focus on blanks, ticks and crosses which are in breach of policy as outlined in section 12 of the Medicine Code (Preparation & Administration of Medicines) and documentation on Prescription Chart & Administration Records.

Intentional missed doses	Unintentional missed doses
✓ Omitted at nurses discretion ✓ Prescriber requested omission ✓ Pharmacist/ Healthcare professional requested omission ✓ Patient refused	✓ Patient away from ward ✓ Patient could not take/ receive dose ✓ Dose not available ✓ Nil by mouth ✓ Blanks, Ticks, Crosses

The last missed doses audits were undertaken week commencing 11th January and 25th April 2016. These were one month later than usual for Q3 and Q4. This was because Q1 and Q2 data collection had to be delayed because the Pre-Registration Pharmacists who collect the data had only come into post and had to receive training to enable them to collect the data.

	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
For all missed doses	13.37%	17.26%	15.29%	16.54%
Intentional missed doses	5.57%	8.50%	7.58%	7.01%
Unintentional missed doses	7.80%	8.68%	7.71%	9.54%
Blanks	216	268	223	246
Ticks/crosses etc	32	45	36	125

Performance increased in Q3 but slipped in Q4 with unintentional missed doses at 9.54%. The next Trust wide missed doses audit will take place July/August 2016 when the new Pre-registration Pharmacists are in post. Data will be collected for one 24 hour period in order to establish the number of intentionally missed and unintentionally missed doses.

In order to endeavour to get back on track and improve performance results continue to be fed back to all Ward Managers/Matrons, the Nursing and Midwifery Practice Group and to the Nursing and Midwifery Committee.

There is an ongoing campaign to encourage patients to bring all their medicines and diabetes related equipment into hospital with them so they can manage their medicines if they are able and reduce the number of missed/delayed doses. Work continues with the Yorkshire Ambulance Service and other regional NHS Trusts. The plan is for a targeted approach to encouraging this practice. This would include the use of a 'sealable green medication bag' (that is currently being used for medicines when a patient is transferred or discharged) that would be used by ambulance staff when they bring patients form home to a Medical Assessment Unit, Surgical Assessment Unit, Accident and Emergency, Coronary Care.

Wards continue to be encouraged to check prescription chart and administration records on each shift change/handover to check documentation and ensure doses have not been missed. It also gives the opportunity to 'challenge' colleagues. Identifying missed doses and raising any concerns with the nurse in charge is also part of the mock CQC medicines management audits. These audits are used to populate individual ward/departmental action plans for improvement.

There is now a Self-administration Collaborative and self-administration will be spread. It is anticipated that delays and missed doses will reduce in areas offering and encouraging self-administration. Currently staff on Ward 17 and 12 HRI and 8AB CRH have been re-trained in the self-administration of medicines.

In the future, EPR will allow CHFT to run missed/delayed dose reports at any point so missed/delayed doses, good practice and practice in need of improvement can be identified and acted upon quickly.

Self-administration Collaborative

It is important that patients who successfully manage their medication in community are also supported to manage this whilst in hospital. This reduces the risk of issues such as missed and can reduce the length of patients alongside encouraging their independence.
In Quarter 1 Ward 17 at HRI has been the ward used for the CQUIN. Baseline collections and improvement work has also taken place on the following wards.

HRI: Wards – 22, 12, 10, 6, 3, 15
CRH: Wards – 5C, 6BC, 9, 8AB, 8D, CCU

The work stream is led by clinical lead Rob Moisey who continues to be supported by other clinical, nursing and pharmacy colleagues. Project support is provided by the Clinical Governance Support Unit and the Health Informatics Service.

Self Admin CQUIN % Compliance							
Month/Week	Patients Audited	Is the level written on the drug chart %	Is there a self-administering form in the notes %	Is a 7 stated in the prescription sheet %	No of patients willing and able to self care %	No achieved	% Achieved
Apr-16	**23**	**100%**	**96%**	**13%**	**17%**	**3**	**75%**
08/04/2016	22	100%	32%	18%	18%	4	100%
15/04/2016	24	100%	96%	8%	8%	2	100%
28/04/2016	23	100%	96%	13%	17%	3	75%
May-16	**24**	**83%**	**88%**	**8%**	**8%**	**2**	**100%**
05-May-16	24	100%	96%	8%	8%	2	100%
19-May-16	24	96%	88%	13%	13%	3	100%
26-May-16	24	83%	88%	8%	8%	2	100%
Jun-16	**23**	**96%**	**91%**	**9%**	**9%**	**2**	**100%**
16-Jun-16	23	78%	87%	9%	9%	2	100%
30-Jun-16	23	96%	91%	9%	9%	2	100%

Training ward staff

As each new ward become involved in the collaborative, nursing staff undertake a program of training in the elements of self-administration and self-management and the use of associated documentation. Training sessions are arranged on all the wards for Nursing/Midwifery staff and the sessions are delivered in the main by the Specialist Nurse Medicines Management, remaining staff are trained by the Ward Manager. The Specialist Nurse Medicines Management maintains contact with wards after self-care has been launched and ward staff are made aware to contact her should any problems arise of if any clarification is required.

It has been acknowledged by the Collaborative and the Nursing and Midwifery Committee that the training of ward staff in self-management self-administration of medicines can no longer be sustained using this approach due to the workload of the Specialist Nurse, Medicines Management and capacity to release ward staff for training. Due to the latter training has been delayed on 4C CRH and Ward 11 HRI. 4C CRH will offer and encourage the self-management of diabetes and self-administration of medicines from December 30th in line with meeting the end of Q3 deadline but Ward 11 HRI will miss this slightly offering the self-management of diabetes and self-administration of medicines from January 18th.

Campaign

There is an ongoing campaign to encourage patients to bring all their medicines and equipment into hospital with them so they can manage their medicines if they are able and reduce the number of missed/delayed doses. Work has now spread to the Yorkshire Ambulance Service and other regional NHS Trusts. The plan is for a targeted approach to encouraging this practice. This would include the use of a 'sealable green medication bag' (that is currently being used for medicines when a patient is transferred or discharged) that would be used by ambulance staff when they bring patients form home to a Medical Assessment Unit, Surgical Assessment Unit, Accident and Emergency, Coronary Care.

Patient information

Work is being done on the collaborative wards to ensure that patients receive a self-administration leaflet.

Patient questionnaire

A questionnaire has been developed and introduced in Q1 in order to obtain feedback from patients about their experiences managing their medication and/or self-administering their medicines (see below).

Q2 Improvement Plan:

- Two more wards have been identifed as the next to be brought into the CQUIN in Q2 and a training programme is now in place for these wards.
- Continue to complete the questionnaire with patients managing their medication and/or self-administering their medicines.
- Continue to share progress at the Joint Sisters meeting, nursing and midwifery practice group and Nursing and Midwifery Committee

CQUINS – Antimicrobial

Reduction in antibiotic consumption/1000 admissions

Baseline data has been submitted to Public Health England. The CQUINS looks for a 1% reduction in a number of antibiotics against consumption in 13/14. Internal monitoring indicates this will be challenging.

Empiric review of antibiotic prescriptions

As part of good antimicrobial stewardship it would be expected that a review of an antibiotic should take place within 72 hours (by day 4) of starting (day 1). This review would include documented evidence of either:

- Stop
- IV to PO switch
- Change antibiotic
- Continue
- OPAT

This information can be documented within the medical notes, on the medication chart or electronically

Monthly audit to be undertaken by pharmacists:

- Minimum 50 antibiotic prescriptions from a representative sample across wards and sites in the Trust
- Sampling criteria:
  - 12 wards – up to 6 antibiotic prescriptions
  - CRH – children's ward (3bcd), 2a, 4c, 5a, 6c, 8a
  - HRI – 10, 11, 15, 17, 21, ITU
  - Random sampling by bed numbers (start at bed 1, bed 2 etc until reached 6 antibiotic prescriptions per ward) on one day per month

	Apr 16	May 16	Jun 16	Q1 total
Total number prescriptions	50	56	49	155
Number reviews documented within 72 hours	36	54	46	136
%	72%	96%	94%	88%

The CQUIN Q1 target was 25% which was exceeded. The Q2 target is 50% and the Trust is not envisaging any risk in meeting the target.

1.5 Improving Sepsis Care

Aims and Objectives of Work:

Sepsis is a complex disease process associated with multiple pathologies, and high mortality rates. Sepsis causes about 37,000 deaths per year in the United Kingdom alone, as such accounting for more deaths than lung cancer alone, or breast and bowel cancer combined (Survive Sepsis, 2010).

Early identification and intervention improves both morbidity and mortality from sepsis. The UK Sepsis Trust, working with Health Education England (HEE) has produced a number of clinical tools to support consistent recognition and response across primary and secondary care.

In 2016/17 a national CQUIN continues and now aims to have:

- 90% of emergency admissions, and inpatients, being screen for sepsis where appropriate.

- 90% by Quarter 4 those patients who have been identified as Septic having received antibiotics within an hour of admission.

Q1 Performance:

- Sepsis Screening has been incorporated into the triage processes in both the Emergency Department, which will have a significant impact on the % of patient undergoing a screening for sepsis.

- The Sepsis Improvement group continues the work of the previous year and now includes representation from children directorate

- Regional wide network group have been coordinated to share learning and best practice.

APPENDIX G

Performance:

2A Timely identification and treatment of sepsis in emergency departments
A1 Screening

	Quarter 1									Q1		
	Apr-16			May-16			Jun-16					
	Adult	Paed	Total	Adult	Paed	Total	Adult	Paed	Total	Adult	Paed	Total
Number of patients who met the criteria for sepsis screening and were screened for sepsis	24	0	24	13	7	20	39	11	50	76	18	94
The total number of patients who met the criteria for sepsis screening according to the agreed local protocol	50	0	50	35	15	50	39	11	50	124	26	150
% Eligible patients screened for Sepsis	48%	-	48%	37%	47%	40%	100%	100%	100%	61%	69%	63%
Target	90.0%											

A2 - Initiation of treatment and 3 day review

	Quarter 1									Q1		
	Apr-16			May-16			Jun-16					
	Adult	Paed	Total	Adult	Paed	Total	Adult	Paed	Total	Adult	Paed	Total
Number of patients (in sample) with severe red flag or septic shock who received IV antibiotics < 1 hour	13	0	13	6	0	6	2	0	2	21	0	21
Number of patients (in sample) with severe red flag or septic shock who received a review after 3 days	10	0	10	7	0	7	2	1	3	19	1	20
Number of patients (in sample) with severe red flag or septic shock who received IV antibiotics < 1 hour and a review after 3 days	10	0	10	6	0	6	2	0	2	18	0	18
Patients who had recorded evidence of severe, Red Flag or Septic Shock on emergency presentation who should have IV antibiotics < 1 hr	14	0	14	11	0	11	2	1	3	27	1	28
% Patients with severe red flag or septic shock that received Iv antibiotics < 1 hour.	71%	-	71%	55%	-	55%	100%	0%	67%	67%	0%	64%
Target	Baseline											

2A Timely identification and treatment of sepsis in acute in-patient settings
B1 - Screening

	Quarter 1									Q1		
	Apr-16			May-16			Jun-16					
	Adult	Paed	Total	Adult	Paed	Total	Adult	Paed	Total	Adult	Paed	Total
Number of patients who met the criteria for sepsis screening and were screened for sepsis	4	0	4	4	0	4				8	0	8
The total number of patients who met the criteria for sepsis screening according to the agreed local protocol	43	4	47	36	4	40				79	8	87
% Eligible patients screened for Sepsis	9%	0%	9%	11%	0%	10%	-	-	-	10%	0%	9%
Target	Baseline											

B2 - Initiation of treatment and 3 day review

	Quarter 1									Q1		
	Apr-16			May-16			Jun-16					
	Adult	Paed	Total	Adult	Paed	Total	Adult	Paed	Total	Adult	Paed	Total
Number of patients (in sample) with severe red flag or septic shock who received IV antibiotics < 90 mins	0	1	1	2	2	4				2	3	5
Number of patients (in sample) with severe red flag or septic shock who received a review after 3 days	1	2	3	3	5	8				4	7	11
Number of patients (in sample) with severe red flag or septic shock who received IV antibiotics < 90 mins and a review after 3 days	0	1	1	2	3	5		1	1	2	5	7
Patients who had recorded evidence of severe, Red Flag or Septic Shock on emergency presentation who should have IV antibiotics < 90	2	2	4	3	5	8		3	3	5	10	15
% Patients with severe red flag or septic shock that received Iv antibiotics < 90 mins	0%	50%	25%	67%	60%	63%	-	33%	33%	40%	50%	47%
Target	Baseline											

Improvement plans for 16/17:

- Introduction of a new Matron for Sepsis to support improvement work throughout he Trust. Due to start end of July.
- Develop clarity around processes to evidence that a sepsis screen has taken place when an inpatient scores high NEWS. At present clinical judgements are being made in this patient cohort, however there is not a robust mechanisms to enable this decision making to be noted
- To review the recommendations in the recent release of NICE guidance on sepsis and assess impact and application of guidelines.
- Roll out Paediatrics screening tool as appropriate.

1.6 Improving Record Keeping

In 2013 the Trust prioritised improvement to our clinical records and documentation. A clinical lead for records was appointed and an in-depth review of governance took place, along with a complete revision and review of clinical documentation and awareness raising of professional standards. The intended result was to ensure a high quality record that is patient centred, involves the multidisciplinary team, involves the patient and tells the patient story.

The Clinical Records Management Board was established and remains in place to ensure improvement in the quality of clinical records is maintained. The group governs the process for agreeing new documentation, overseas performance, enables the transition to digital records and has oversight of information governance issues.

Quality of the record and record keeping is monitored through data collected using the Clinical Record Audit Standard (CRAS) tool. Monthly audits have been carried out since April 2013, covering 12 standards with 23 individual elements assessed. A RAG rated system is used to highlight those teams achieving the 95% target required to be compliant with the documentation against the 107 individual questions. Further audit has been developed to provide assurance regarding patient involvement, MDT working and effective communication and handover and where necessary this is actioned to assist in behavioural and cultural change.

The audits are primarily performed by Matrons, Sisters and colleagues from the audit department; although, a therapy and medical audit are in place and can be utilised by teams. All of the results are performance managed through the Divisional Patient Safety and Quality Boards with areas identified that require further focused work and action/ improvement plans implemented and managed.

Current Performance

Current performance demonstrates an overall Trust compliance of the CRAS audit at 91.9% against the 107 questions within the 12 standards. However, there are areas that are consistently problematic across a high number of wards and departments, measuring less than 80% compliance consistently in the following areas-:

- Discharge/ Transfer
- Falls
- Fluid Balance
- Medication Charts
- Accessibility and Quality of the Notes

The best performing wards in May were 17, 12 and CDU at HRI and 2CD and 8D at CRH. The worst performing wards were 11, 22 and 15 at HRI and 6BC and 7BC at CRH.

Improvement Plans for 2016/17

Transformational change is underway with the vision that the Electronic Patient Record (EPR) will enable the safest, most efficient and patient-centred organisation in the NHS. CHFT jointly procured with Bradford Teaching Hospitals NHS Foundation Trust (BHTFT) the Cerner Millennium EPR to empower the Trust to work more effectively, so patients benefit

from improved quality and experience specifically through having an accurate, timely, high quality patient record. It will be implemented fully in A&E and all inpatient wards including paediatrics, outpatients, community, and virtual wards.

In the meantime wards and departments continue to develop specific action plans tailored to their results that are monitored through Divisional Patient Safety Quality Boards.

However, it is recognised that sustaining improvement has proven difficult in some elements; therefore, a focus on specific areas for improvement has been re- energised. With the support of the Deputy Director of Nursing (DDON), the, matrons and sisters in Band 6 development roles across the Trust are reinstating the Documentation Improvement Group. This group will lead on a number of improvements that have proved difficult to change and will be supported through action learning and coaching circles facilitated by DDON and the Professor of Nursing. Best evidence demonstrating peer review has been implemented and best and worst performing wards are buddying in order to learn from each other.

The evidence base for falls documentation and recording of fluid balance has been reviewed. A lead nurse for falls has recently been appointed and identified documentation as a priority for improvement. The Discharge Matron and Discharge Team are also reviewing the discharge documentation along with the Multi-Disciplinary Team ensure it is appropriate without being onerous.

All work is linking with the EPR work streams to ensure there is a consistent approach.

1.7 Maternity

Background

The CQC pre report action plan for maternity, an update was presented to the CQC response group on the 22nd June which identified the following aims:

- Improved Outcomes for women

- Reduction in PPH
- Reduction in third degree tears
- No never events
- Delays in Induction Occur only for Clinical reasons

- Positive Patient Experience feedback from women
- Positive staff feedback(engagement events, staff survey)

Q1 Developments

- Maternity Patient Experience group has met and agreed terms of reference and a work plan is being developed. Assistance from a member of the Maternity Services Liaison Committee has been agreed to support maternity patient experience actions. Reviewing the feedback from Meet the Midwife and weekly roundings

- A Maternity dashboard has been signed off. The draft was reviewed at maternity forum with good feedback from the forum members.

  The Trust has commissioned the Royal College of Obstetricians and Gynaecologists (RCOG) to undertake an invited service review of maternity services. The review will take place 26 to 28 July.

- Training reviewed and agreed for third and fourth degree tears, flyer going out to staff with all dates.

- A Maternity action plan is place following the CQC visit and focuses on the following:

  - Ensure compliance with CHFT guidance on monitoring fetal growth
  - Reduce the rates of PPH
  - Ensure learning from themes and trends in lower harm Incidents
  - Improve the experience of patients using the service
  - Reduce the numbers of third & fourth degree tears
  - Provide assurance of safe management of shoulder dystocia
  - Review service to ensure adequate service provision to avoid delays in induction of labour, augmentation or acceleration
  - Set key outcome measures to monitor performance and identify risk to performance delivery
  - Review the access to theatres in and out of hours to ensure that we are compliant with the Royal College of Anaesthetists Standards for Obstetric Units and NICE guidelines for Caesarean Section
  - Effective governance and risk management arrangements for the division
  - Workforce engagement plan

Improvements for 16/17

- RCOG invited service review which is due to take place in Q2.

- Further staff engagement events planned

- Compliance with training for third and fourth degree tears to be reported

1.8 Improving Clinical Coding

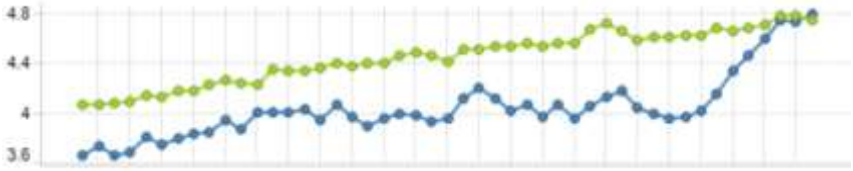
Background

Clinical Coding is used to classify the diagnosis and treatment of every admitted patient. The system relies on the expertise of clinical coders, who extract data from documentation used to record clinical information. The quality (accuracy and completeness) of the documentation is also crucial to the quality of the coded data. CHFT performance against clinical coding KPI's (% Sign & Symptom, Depth of Coding and Average Charlson Score) were below the national average for the Trust and at specialty level. By improving the performance for each KPI's it would result in a positive impact on HSMR/SHMI. CHFT's aim is to be in the national upper quartile for the 3 coding KPI's and this is reliant on the documentation and the quantity and quality of the coders extracting the data.

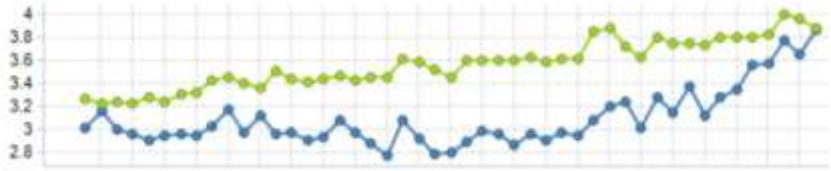
Current Performance

There has been significant improvement in all coding KPI's within the last quarter and 12 months as a result of increased clinical engagement, improvements to clinical documentation to aid the clinical coding process, vacancies filled within the coding team and improved use of data to identify areas for improvement. All 3 of the clinical coding KPI's show a positive improvement as demonstrated in the graphs below.

Depth of Coding Apr 2012 – Feb 2016



Average Charlson Score Apr 2012 – Feb 2016



% Sign & Symptom Apr 2012 – Feb 2016

Source: HED. CHFT – Blue Line; National Average – Green Line

However there is considerable variation at a specialty level as shown in table below.

Coding KPI's by Specialty – June 2016

Treatment function	Episodes	Average co-morbidity score	Average diagnoses	% signs and symptoms
100 - General Surgery	1,676	2.72	4.70	9.37%
101 - Urology	433	2.98	4.96	9.70%
107 - Vascular Surgery	46	11.78	9.96	0.00%
110 - Trauma & Orthopaedics	631	2.24	4.51	0.32%
120 - ENT	247	1.28	3.20	9.31%
130 - Ophthalmology	800	1.41	3.47	0.00%
140 - Oral Surgery	139	1.00	2.26	0.00%
160 - Plastic Surgery	114	1.07	2.19	0.00%
191 - Pain Management	216	1.91	3.24	9.26%
Surgical Division Total	**4,302**	**2.30**	**4.22**	**5.67%**
180 - Accident & Emergency	341	5.01	6.60	28.15%
300 - General Medicine	2,368	7.08	7.28	19.89%
301 - Gastroenterology	569	4.00	4.71	8.08%
303 - Clinical haematology	350	3.16	3.85	0.57%
306 - Hepatology	37	13.97	9.57	5.41%
314 - Rehabilitation service	67	9.00	11.15	0.00%
320 - Cardiology	412	6.18	7.67	17.72%
328 - Stroke Medicine	89	7.66	9.28	11.24%
340 - Respiratory medicine	141	7.48	7.89	7.80%
370 - Medical Oncology	568	9.27	4.98	0.18%
400 - Neurology	9	0.00	1.22	0.00%
410 - Rheumatology	85	1.20	3.00	0.00%
430 - Geriatric Medicine	228	13.50	11.28	10.09%
Medical Division Total	**5,264**	**6.78**	**6.72**	**13.97%**
420 - Paediatrics	1,133	0.13	2.11	10.77%
501 - Obstetrics	576	0.31	4.09	0.00%
502 - Gynaecology	296	0.84	3.84	6.42%
560 - Midwifery service	173	0.28	2.84	0.00%
811 - Interventional Radiology	60	5.75	5.02	13.33%
FSS Division Total	**2,238**	**0.43**	**2.99**	**6.65%**
CHFT TOTAL	**11,804**	**3.95**	**5.10**	**9.6%**

Source: Standard Activity, Knowledge Portal. Red = Lower Quartile, Amber = Interquartile and Green = Upper Quartile

Improvement plans for 2016/17

- 4 out of 5 clinicians with PA for coding identified which will assist with specific coding improvements particularly 'lost' co-morbidities, further improvement in documentation used for coding and education/engagement sessions for clinical staff.
- 6 trainees recruited and will commence training leaving 2.5wte vacancies that will continue to be advertised as a rolling advert with the plan that if no suitable applicants by autumn/winter 2 additional trainees will be recruited. Additional capacity will allow more time for coding and for clinical engagement to improve documentation.
- Roll out of 3M Encoder which will assist with the coding process especially for coding trainees.
- Roll out of Cerner Millennium - Cerner Millennium will 'pull-through' conditions documented in the LTC/Problem section of Millennium into clerking in section. Emphasis to be given in clinical training for this section of Millennium to be completed ASAP after go-live with all important co-morbidities (that impact on patient care, HSMR or SHMI).
- Continue to work with wards and Specialist Palliative Care (SPC) teams regards importance of documenting SPC input and continue with the check process to ensure SPC involvement in care is not missed.

- Develop specialty specific coding awareness presentations for clinical teams
- Continue to identify and work with areas/specialties where coding quality improvements are required.

Domain Two – Effective: Peoples care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

Effectiveness compliance summary

Indicator	Compliance
2.1 Reducing Mortality	Partial Compliance
2.2 Improving Reliability – Implementing Care Bundles	Reporting Only
2.3 Improving the Management of Fracture Neck of Femur	Reporting Only
2.4 Improving Diabetic Care	Reporting Only
2.5 Reducing Hospital Acquired Infections (Contract)	Achieved
2.6 Hospital at Night (CQUIN)	Achieved
2.7 Deteriorating Patient	Reporting Only
2.8 Improving End of Life Care	Achieved
2.9 Deprivation of Liberty (DOLs)	Reporting Only
2.10 Conditions of Interest – Stroke	Reporting Only

Highlights:

Mortality – key priority areas identified are the reliability of clinical care for respiratory, stroke and elderly patients, recognising and responding to deteriorating patients and timely antibiotics for patients with sepsis.

Care Bundle implementation – some improvement noted in compliance with asthma bundle and acute kidney infection bundle

Reducing Hospital Acquired Infection – 0 cases MRSA bacteraemia since Q2 2015/16

Hospital at Night - achievement of Hospital at Night Programme CQUIN for Q1

End of Life – integrated workplan being developed for end of life care

Stroke – improvements in stroke pathway delivery

2.1 Learning from Mortality

The main outcome measure is the Summary Hospital Mortality Index (SHMI) calculated by the Health and Social Care Information Centre (HSCIC). The SHMI is the ratio between the actual number of patients who die within 30 days of discharge from the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the local patients.

The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100).

The Trust aims to:

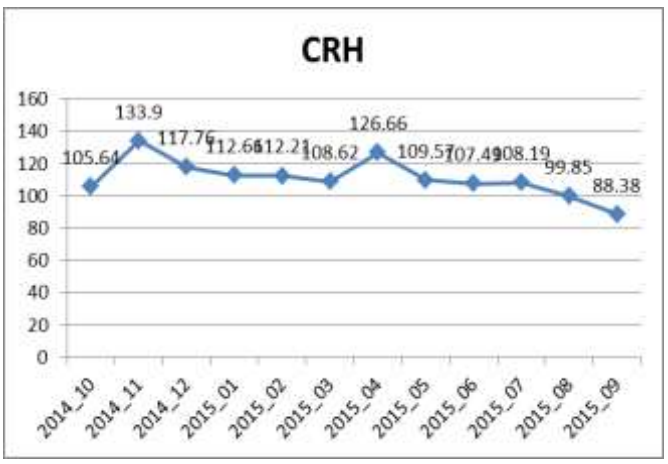
- Reduce the SHMI to 100
- To review 100% of all in hospital deaths each month

SHMI update

Data has been released in May for SHMI incorporating performance data up to **September 15**

- Looking at the rolling 12 month SHMI (October 14 – September 15), the score is **113.88**. This is a declining position from 111.00 (from the previous rolling 12 month period of (July 14 – June 15)

- The site breakdown shows HRI at 116.19 and CRH 111.21. The graphs below show the month on month SHMI for HRI and CRH.

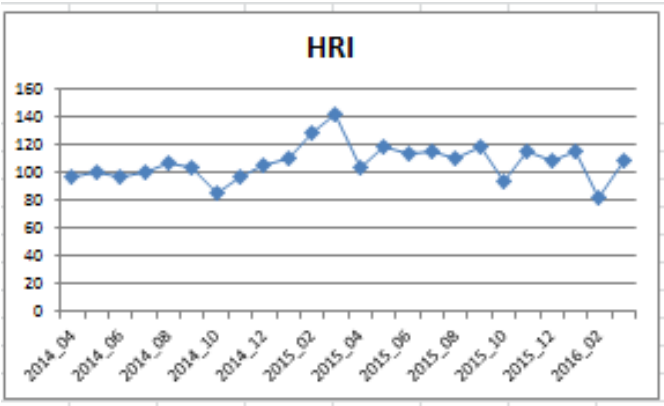


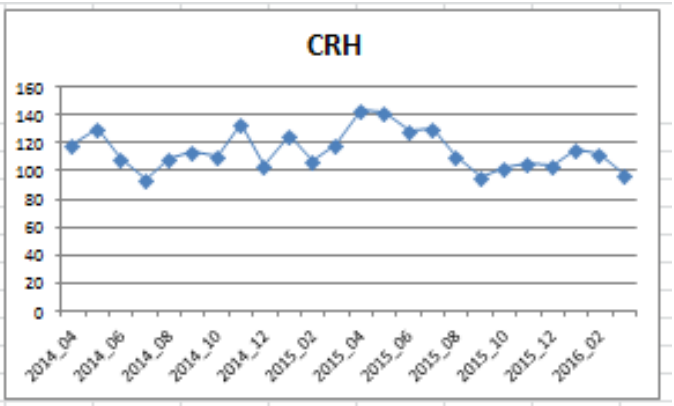
HMSR update

Data has been released in **June** for HSMR incorporating performance data up to **March 2016.**

- Looking at the rolling 12 month HSMR (April 15 – March 16), the score is **111.62**. This is a notable improvement from 114 (from the previous rolling 12 month period of March 15 – Feb 16)

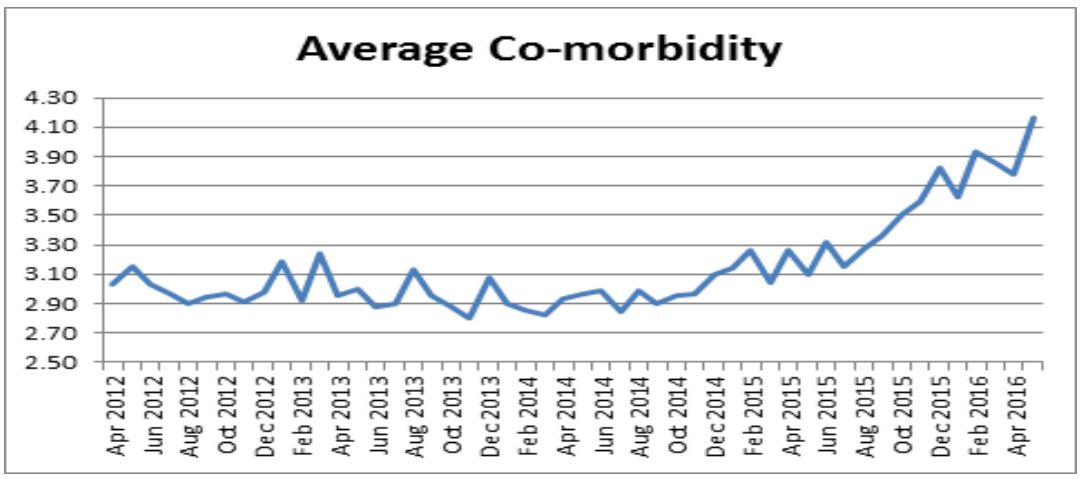
- The site breakdown for the same period shows HRI at 108.00 and CRH at 115.00. The graphs below show the month on month HSMR for HRI and CRH.





Improvement in Key Coding Indicators

There has been significant improvement in documentation and coding of the co-morbidities that affect HSMR/SHMI as seen in the chart below however there is further work is required to achieve national upper quartile performance in all specialities.



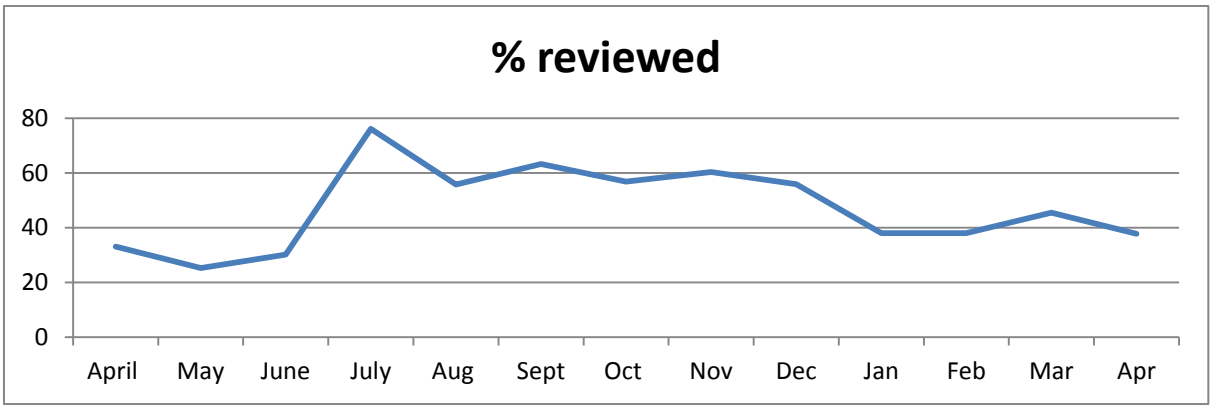
Internal Mortality Review Process

Mortality cases are reviewed internally using a two level process with the aim to review 100% cases at first level. These reviews are performed by a team of 'mortality reviewers' using a standard tool with a number of 'screening' questions to assess whether there were any preventability factors. The preventability is scored using the Hogan score of preventability on a scale of 1 to 6 as described below.

1. Definitely not preventable.
2. Slight evidence for preventability.
3. Possibly preventable but not very likely, less than 50–50 but close call.
4. Probably preventable, more than 50-50 but close call.
5. Strong evidence for preventability.
6. Definitely preventable.

In addition, the 1st level reviewers can provide some free text that captures useful information on preventability and provide a score of the care provided. All cases assessed as Hogan 3 or above are sent for a second level review with the purpose to provide a more in-depth review of the patients care and management to understand where the gaps have occurred. Performance of the first level reviews had improved in the last 6 months of 2015 but has now declined. The chart below shows the % of mortality cases reviewed each month. The decline has been due to many

of the senior nurses who perform the mortality reviews being required to manage other priorities in the Trust including maintaining safe staffing levels and patient flow.

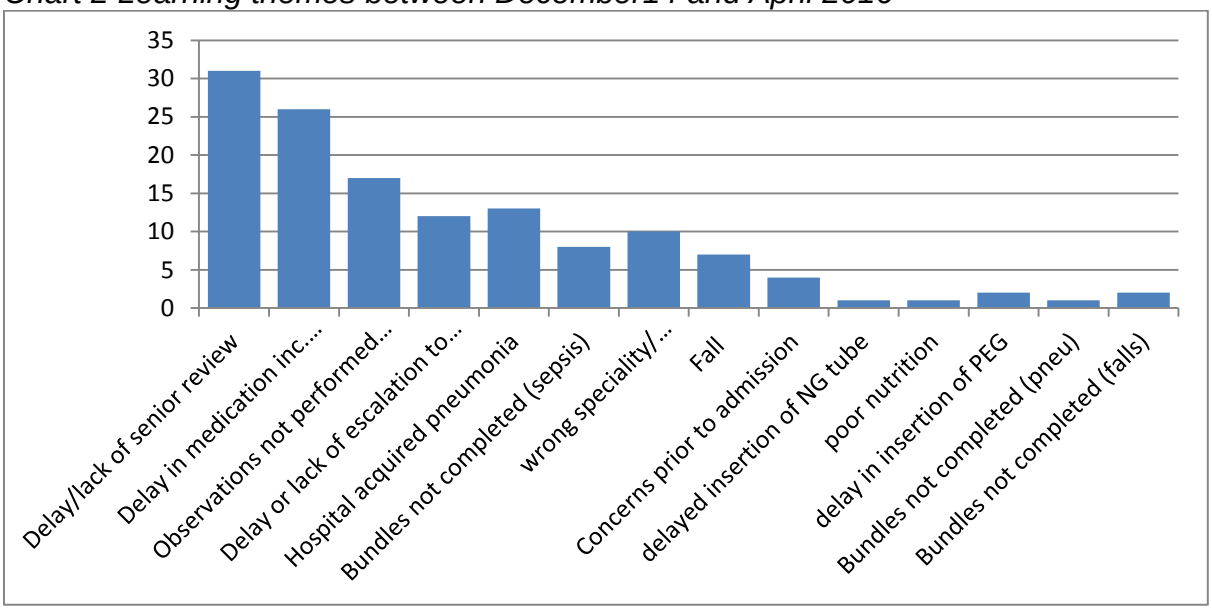


The second level reviews are currently performed by 3 senior doctors who were appointed in January using a standardised tool. Of the cases identified for second level review since April 2015, 40 second level reviews have been performed, prioritising on the more recent cases and the Hogan 4 and 5 cases. Of these, 23 cases were reassessed as a lower preventability score including both Hogan 5 cases. 13 remained the same score and 4 were scored higher on second level review.

Learning from mortality reviews

Once the reviews have been performed, the data is added to the Knowledge Portal. In addition, data is being analysed on a monthly basis using the key learning themes from cases assessed as Hogan 2 and the more in-depth details gathered from the Hogan 3-5 cases. The 'Learning from Mortality Reviews' reports is shared with the reviewers, members of the Clinical Effectiveness and Mortality Group, Clinical Outcomes Group and Divisional Patient Safety and Quality Boards.

Chart 2 Learning themes between December14 and April 2016



The top themes from the reviews are aligned to various improvement work streams as identified below.

Top themes	Improvement work
1. Delay/lack of medical review	Included in the 7 day working and hospital @ night – Deteriorating Patient work stream
2. Delayed medications, mainly antibiotics	Included in the Medication Safety Group and highlighted at the Nursing and Midwifery Committee
3. Observations not performed as policy	Included in the deteriorating patient work stream and since the implementation of Nerve Centre last year there has been a marked improvement
4. Delay or lack of escalation of NEWS	
5. Incomplete bundles	Included in the Reliability theme of the CAIP
6. Fluid balance recording	Included in the CRAS audit action plan with matron led improvement work on documentation
7. Hospital acquired pneumonia (including aspiration pneumonia)	Include in the HCAI action plan

Mortality Alerting Conditions

The Trust is showing as an outlier in mortality for two diagnostic groups; Acute Cerebrovascular Disease (ACD) and Pneumonia. An in depth review of 15 ACD has been carried out with the main learning themes being poor documentation at clerking, co-morbidity capture, Stroke Pathway, DNA CPR and Care of Dying Pathway. Also, issues with NG feeding, including aspiration pneumonia and delays in PEG insertion.

An in depth review of 30 Pneumonia cases have been commissioned from the inaugural meeting of the Mortality Surveillance Group and is currently underway.

Improvement work

From the various information sources it would suggest that there are a number of complexities that effect the currently Trust's mortality position. However from the information, key priorities can be identified that would lead us to improve patient outcomes and thus improve the mortality position.

The key priority areas are identified below and are aligned with the work streams within the 'Care of the Acutely Ill Patient', divisional action plans and sepsis improvement programmes.

1. Reliability of clinical care, particularly with respiratory patients and stroke patients ensuring that all elements of the evidence based pathways and bundles are met
2. Reliability of clinical care with the elderly, particularly frail patients, ensuring these patients are provided regular senior review on a daily basis
3. Recognising and responding to deteriorating patients
4. Timely antibiotics for treating patients with sepsis

2.2 Improving Reliability – Implementing Care Bundles

Aims and Objectives of Work

Improvement theory suggests that care bundles allow clinical teams to focus their efforts on a small number of measurable strategies aimed at improving specified outcomes (BTS/NHSI; 2012). Protocol-based care also enables staff to quickly see what action should be taken, when and by whom. They allow practice to be standardised and reduce variation in the treatment of patients. They are also an important tool in improving the quality of care, as variance from the agreed care pathway can be measured easily, allowing systemic factors that inhibit provision of best care to be identified

There are five conditions identified within the Care of the Acutely Ill (CAIP) work stream where evidence-based care bundles have been developed to improve patient outcomes. These are;

- Asthma
- Acute Kidney Injury (AKI)
- Sepsis
- Chronic Obstructive Pulmonary Disease (COPD)
- Community Acquired Pneumonia (CAP)

These care bundles have been included in the medical clerking documentation and compliance is measured monthly by members of the audit team with a target compliance of 95%.

Indicator	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
Asthma - Bundle Started	95%	87%	100%	100%										95%
Asthma - Bundle Completed	95%	46%	50%	42%										43%
AKI - Bundle Started	95%	58%	62%	79%										68%
AKI - Bundle Completed	95%	39%	38%	48%										43%
Sepsis - Bundle Started	95%	88%	91%	86%										88%
Sepsis - Bundle Completed	95%	41%	45%	39%										42%
COPD - Bundle Started	95%	43%	65%	77%										61%
COPD - Bundle Completed	95%	85%	33%	48%										53%
Pneumonia - Bundle Started	95%	40%	23%	43%										36%
Pneumonia - Bundle Completed	95%	67%	20%	77%										75%

Asthma

There has been very good compliance with commencing the Asthma care bundle with overall compliance to the end of Q1 being 95%. However, compliance with completing all the elements was only 43%

Acute Kidney Injury

There has been month on month improvement during the last quarter for both commencing the AKI bundle and completing all the elements but overall compliance is still a long way from the target at 68% and 46% (year to date) respectively.

Sepsis

The monthly compliance of commencing the sepsis bundle remains fairly static at 88% overall compliance to date but the ongoing completion remains at 42% overall compliance

Chronic Obstructive Pulmonary Disease

Improved compliance on commencing the COPD bundle has been achieved each month but has deteriorated for the completion of all the elements since April. Overall compliance year to date is 61% and 53% respectively.

Community acquired Pneumonia (CAP)

There has been a variable compliance with both the commencing of the CAP and completing all the elements with a noted better compliance for completing all the elements. Overall compliance from April is 36% for commencing the bundle and 75% for completing all the elements.

Improvement work

Each of the care bundles have now been incorporated in the medical clerking documentation to prompt the commencement of the appropriate bundle. This has probably contributed the improvement noted in some of the bundles and has allowed retrospective audit to take place. The sepsis and AKI bundles are also incorporated into the surgical clerking documentation from July 2016.

Future Plans

1. To gain a better understanding of why there is better compliance with some elements of each bundle and why we fail to comply or document other elements of the bundles.
2. Identify a clinical lead for each of the bundles and to see how this work may fit with existing workstreams such as the ‘care of the frail patient’ and ‘plan for every patient’ workstreams.
3. Meet with the EPR team to understand how the elements of each of the bundles will fit within the new EPR

2.3 Improving Management of Fracture Neck of Femur

Introduction:
The Best Practice Tariff (BPT) was introduced in 2010. It aims to act as a financial incentive for hospitals to optimize management of patients with neck of femur (NOF) fractures.
Where all the factors associated with best practice have been delivered a supplement of just over £1300 is added to the tariff.

We expect to receive between 450 and 500 patients who have sustained a fractured NOF each year.

Aims and Objectives of Work:

Seven factors were identified by NICE and require inputting into the National Hip Fracture Database (NHFD). Each of these factors relates to either patient experience or outcome.
The first of the factors relates to getting patients to theatre within 36 hours of admission, this target was set to ensure no patient ever spent more than one night in a hospital bed with a broken hip.

We set the ambition to get to 85% for all components in October last year. For all aspects of the BPT standards we have achieved this ambition with the exception of time to theatre. The reasons for this are:

- A high percentage of patients who are clinically not fit
- There is not always a hip surgeon available within 36 hours for patients who require total hip replacement
- Theatre capacity, there are sometimes patients with conditions other that #NOF who need to be operating on first.

Q1:

Performance for individual components Q1

		(Last year)
• Time to theatre	69%	(70%)
• Admitted under joint care	99%	(96%)
• Admitted using appropriate assessment protocol	100%	(99%)
• Assessed by a geriatrician within 72 hours	98%	(90%)
• Post-op geriatric MDT	96%	(88%)
• Falls assessment	99%	(84%)
• Bone health assessment	99%	(99%)
• Pre and post op AMT	95%	(86%)

66% of patients got all components of BPT (best practice tariff).

The service continues to utilise elective theatre space where necessary to carry out procedures in the necessary timescales and is now successfully carrying out total hip replacements at HRI when patients need them.

Fallow lists are being identified further in advance; we are currently booking vacant lists to the end of August in order to inject extra capacity.

The Directorate monitors the mean wait times on a monthly basis for patients who were delayed due to organisational reasons; this has not exceeded 48 hours.

The nursing teams on the wards continue to focus on every single component of best practice guidance, taking responsibility for making sure each patient gets each component where possible.

In June the Orthogeriatric service suffered some unexpected sickness, but the team were supported by the medical Division to be able to deliver the necessary components of care.
The Directorate has updated the RCA form to compare outcomes and quality of experience between patients receiving their operations before and after the 36-hour target.

Improvement Plans:

The team is shadow reporting all patients so they can be audited and practice changed to ensure all patients receive the 2 new components that we expect to be included in BPT.
Ongoing participation in the PERFECTED research study (Peri-operative Enhanced Recovery hip Fracture Care of patients with Dementia). This is a National Institute for Health Research (NIHR) funded Applied Research Programme aiming to improve hospital care for patients with Dementia who break their hip. The Directorate is getting positive feedback from the research team that

changes and recommendations are being embraced. The research project has been a very positive experience for all involved.

The directorate has been supported by THIS to develop a tool which provides information on the historic patterns of trauma and the activity over the year, to allow the service to calculate the amount of trauma operating capacity it needs to be able to provide a consistent service, which delivers patients to theatre in a class leading timescale. The capacity needed will be available from autumn when the theatre refurbishment at HRI is complete and theatre 6 is available.

2.4 Improving Diabetic Care

Aims and Objectives of Work

People with diabetes admitted to hospital benefit most when they are cared for by appropriately trained staff, provided with access to a specialist diabetes team, and given the choice of self-monitoring and managing their own insulin (NICE quality standard).

A programme of work is underway to improve care of the diabetic patient and aligns with the self-administration of medicines CQUIN as discussed in the Medicine Management section.

2.5 Reducing Hospital Acquired Infections

Aims and Objectives of Work

The Trust is committed to providing a safe environment for patients including preventing healthcare associated infections (HCAI). Although significant reductions in HCAI have been made over the past few years, it is recognised that continued focus and effort is required to sustain the changes that have been successful in reducing our HCAI rate and ensure that we do not exceed the targets set for HCAI as detailed below.

In 2016/17 the Trust aims are to:

- Have 0 Trust assigned MRSA bacteraemias
- Have no more than 21 Clostridium difficile (Post 48-hour admission) infections
- Improve on the previous year's outturn of MSSA Bacteraemias, i.e. 9
- Improve on the previous year's outturn of E.Coli infections, i.e. 25
- Screen more than 95% of all elective in-patients for MRSA

Current Performance
Performance at the end of Q1:

Indicator	Q1 Performance	On Track?
Meeting the MRSA bacteraemia (Trust assigned)	0	On Track
Meeting the C-diff target (Post 48 hours)	6	Over Trajectory
MSSA Bacteraemias	2	On Track
E-coli rates	5	On Track

MRSA (Meticillin-resistant *Staphylococcus aureus*) bacteraemia:
There have been no further cases of MRSA bacteraemia since Q2 of 2015/16. The main action identified from the last case was improvement work with ANTT (aseptic non-touch technique). The Infection Prevention and Control Team have trained an additional 80 ANTT assessors, and will implement a new e-learning package for junior medical staff from August 2016.

MSSA (Meticillin-sensitive *Staphylococcus aureus*) bacteraemia:
There have been 2 reported cases in Q1. These cases have not been linked. MSSA screening has commenced for patients with central venous access devices and patients undergoing vascular fistula formation. These are subject to case note review and any lessons fed into the Trust HCAI Action Plan.

E.coli bacteraemia:
There have been 5 post admission cases in Q1. These are subject to case note review and any lessons fed into the Trust HCAI Action Plan.

There is no national reduction target set for E. coli bacteraemia, however the Trust has set an internal target to not exceed the out-turn of cases (25) in 2015/16. This may be challenging to achieve as a review of all of last year's cases did not reveal many common areas for action. 4 were related to long term urinary catheters. Lessons from a former catheter project nurse are incorporated in the trust HCAI action plan to support the reduction in the use of urinary catheters.

***Clostridium difficile* (*C. difficile*):**
There have been 6 post admission C. difficile cases in Q1.
3 of the 6 cases have been agreed as avoidable following the RCA meetings. Of the 3 cases agreed as avoidable the following key learning opportunities were identified: appropriate timeliness of stool specimens, clear documentation on normal bowel habits and when specimens have been taken and prompt isolation of patients with loose stools.

Improvement Plans for 2016/17

The Trust recognises the challenge to meet the target for *C.difficile* cases (external target). There is a comprehensive programme and action plan to reduce healthcare associated infections, the following actions are included within the action plan:

- The PIIP (Preventing Infection, Improving Prescribing) Group has been established, but attendance has been poor with 2 meetings being cancelled in quarter 1. This will report to the Infection Control Committee (ICC). In addition, the Divisions will be requested to provide information on their performance on reducing HCAI, particularly on the progress of their action plans with quarterly reporting to the ICC.
- The IPCT are leading an audit of Aseptic Non-touch Technique (ANTT) practice across the Trust.
- Work has been done to improve the timeliness of isolation of patients with suspected infective diarrhoea with support from the ADNs and matrons. MAU have been given 'read only' access to ICNet to give them access to the information required to make appropriate isolation decisions.
- Enhanced surveillance of surgical site infection is currently underway in orthopaedics
- Surveillance of cases of Hospital Acquired Pneumonia is currently underway to try to establish a benchmark for some improvement work

2.6 Hospital at Night

Background

Patient care is generally described as delivered 'in-hours' - Monday-Friday 8am-5pm - or 'out-of-hours', evening, nights and weekends, including public holidays. This out-of-hours proportion accounts for over 70% of care time, with significantly reduced staffing across all healthcare professional groups. Increasing patient acuity and dependency means there are multiple demands on senior nurses and medical staff working out of hours.

Hospital at Night (H@N) is a set of national standards for how clinical care is delivered out-of-hours, with medical staff working together across specialty or division to share workload that is coordinated, usually by a senior nurse, to ensure prioritization and patient safety.

Current Performance

At CHFT, medical and senior nursing staff are available variably across the out-of-hours period to support wards and clinical areas. There is currently no tracking system to identify tasks required or prioritisation, clinical night staff are dependent of ward staff bleeping them with individual tasks. Current staffing only accounts for clinical support/coordination overnight, leaving weekend/bank holiday days and evenings uncovered.

Improvement plans for 2016/17

As part of the Nervecentre system purchased through the Nursing Technology fund, H@N Task management has been scoped and is currently undergoing testing and debugging. This system uses the mobile/web application for Nervecentre to request tasks for clinical care outside the competencies of ward based staff, which will then be co-ordinated using mobile technology across all available clinical staff. The technology will allow the coordinator to see individual workloads and allocate as patients require.

The system requires clinical coordination for the full out-of-hours period. A group of band 6 nurses have been recruited and with the current night sister team will form the new Clinical Coordinator Team. All of these staff will be trained to co-ordinate this workflow. In addition a new team of band 3 clinical support workers have been recruited who have extended clinical skills and will be able to act as a supplement to the current night team.

A proposal has been submitted to go-live with the Hospital@Night system in September at Calderdale and in October in Huddersfield. However, the scope of the current hospital at night project is limited to the introduction of this electronic task management system and clinical

coordination. There will be a WTGR breakthrough event on the 5 August to look at a broader vision of all out of hours hospital care namely the HOOP – Hospital Out Of hours Programme. The aim is to transform both clinical and operational responses out of hours to deliver better patient experience by reducing delays in moving patients from our EDs and responding to tasks in a more timely manner, improve patient outcomes by recognising and responding to our sickest patients, contribute to achieving our ED performance and improving the experience of our staff out of hours. The break through event will lead to a project plan for improvement reporting to the Safer Programme Board.

2.7 Deteriorating Patients

Background
It is clear that whilst in hospital there is a risk of patients deteriorating which will undoubtedly affect their outcome. A recent (12 July 2016) patient safety alert from NHSI describes that 26% of preventable deaths arises from 'inadequate monitoring' for both adults and children. It advocates the use of EWS (Early Warning Scores) to identify deteriorating patients.

Current Performance
At CHFT EWS are in place throughout the organisation. With the introduction of Nervecentre all observations are electronic using hand-held devices in all inpatient areas. If a patient's EWS is abnormal then the system prompts the nurse to either repeat observations sooner and/or manually escalate the patient to a doctor. For adult patients who score a NEWS of 7 or more are automatically escalated to outreach during the hours of 8am and 8pm every day. Hospital at night will respond to these escalations as described above.

DPG (Deteriorating Patient Group) has re-formed after the initial implementation of Nervecentre.

At present the plan is to consolidate and review the data available through Nervecentre but also look at themes identified from mortality reviews, cardiac arrests and clinical incidents to inform a specific action plan for improvement. There is also a plan to audit responses to patients who score a NEWS of 7 or more both in and out of hours to better understand where improvement(s) can be made.

Improvement plans for 2016/17
The plan for improvement is yet to be confirmed. However, it is anticipated that learning from mortality reviews, cardiac arrests, clinical incidents and the planned audit of patients with a NEWS score of 7 or more will provide the areas that are in need for improvement. One area that has already been highlighted is the timeliness of observations. Discussions are already in place with senior nursing colleagues to develop an improvement plan. Thus the actions to NHSI's alert are already underway and the action plan will be shared with NHSI by January 2017. The DPG action plan is expected to be confirmed by Q3.

2.8 End of Life Care inc DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation)

The quality of end of life care delivered within CHFT remains an important priority. The recent CQC visit identified the fact that while there are elements of excellent practice, there is a need to fully embed its position within the organisation. There has also been a downturn in performance results in the National Care of the Dying Audit for hospitals.

There is now a plan to re-establish the End of Life Care Collaborative with a much broader base of input from senior medical and nursing staff. This coincides with the creation of a year long secondment post to scope end of life care provision and education across CHFT.

Three main documents are being pulled together to create a workplan to improve end of life care, with primary goals, secondary drivers and measureable outcomes. It is imperative that there are better mechanisms in place to report progress, failings and potential developments.

The main goals are:

- Identification of people in the last 12 months of life and communication with these patients and those important to them.
- Co-ordination of care particularly for people with complex needs and vulnerabilities.
- Timely and equitable access to high quality care including 24/7 support.
- Care in the last hours and days of life which delivers the 5 priorities of care for the dying patient.

Identification of the last year of life:
It is recognised that there is a need for better training in advanced communication skills and in the recognition of the last 12 months of life. Three further study days founded by Health Education for Yorkshire and the Humber (One Chance to Get it Right) remain, with education delivered by a joint team of professionals from Kirkwood Hospice and CHFT.

It is imperative that more senior doctors attend these study days. It is clear that there continues to be reluctance to make appropriate and timely decisions regarding cardiopulmonary resuscitation and enhanced levels of mandatory training may address this problem. Making part of the region-wide DNACPR video mandatory as part of basic life support training would be helpful. Roll-out of and training in tools such as the SPICT (Supportive and Palliative Care Indicators Tool) should also be encouraged.

Co-ordination of care:
It is recognised that there is a need for clearer decision-making regarding treatment plans by senior clinicians with better communication within and between teams. The use of safety huddles should be explored with respect to end of life care decisions and all efforts made to enhance the quality of clinical handover. It is identified that there is a need for a robust supported discharge pathway for those patients approaching the end of life and better monitoring of Fast Track applications is needed. The Electronic Palliative Care Co-ordination System (EPaCCS) has been proven in other areas of the country to increase the likelihood of patients dying in their place of preference and in avoiding unnecessary hospital admissions for patients at the end of life. Implementation of EPaCCS should be considered following introduction of the Electronic Patient Record.

Timely access to high quality care:
There has been a temporary cessation of clear categorisation of complaints at the end of life, but if we are to respond to these issues, continued surveillance will be required.
The creation of a central syringe driver pool should go some way towards alleviating the lengthy delays in accessing this important piece of equipment for patients at the end of life. Negotiations and planning continues to implement a 9-5, 7 day-a-week service for the specialist palliative care nursing service within CHFT. Further workforce planning and investment in the service will be required if high quality care is to be delivered at weekends without compromising the existing service through the week. There is now a well-established process for recording Level 1 advice given by the Specialist Palliative Care Team to patients on wards across the Trust, which has gone some way to correcting inaccuracies in the appropriate coding of patients' multiple co-morbidities at the end of life. This will continue along with continued support from the coding

team. Following full implementation of the Electronic Patient Record, it is hoped that a more accurate picture of specialist palliative care involvement will be possible.

Care in the last hours and days of life:
Training in the use of the Individualised Care of the Dying Document (ICODD) continues, but it is evident that there continues to be some reluctance or reticence on the part of some clinicians to use this document to support people in the last days of life. Currently the use of the ICODD across hospital wards is falling slightly to approximately 35% usage in the month of May 2016; reasons for this are unknown. There is a need to understand the number of anticipated deaths in our hospital wards of which 100% should be supported by the ICODD. An audit of all deaths in a 4 week period will allow us to identify the magnitude of this task. This measure will remain critical for review and improvement and undoubtedly further education will be required.

Regular audit of practice will be required and this Trust is committed to taking part in the National Care of the Dying Audit for Hospitals including accessing feedback from bereaved relatives. Following the publication of this year's results, which showed a reduction in performance across many parameters, it is clear that we will continue to need to improve the services that we deliver to patients and their families and that this will require to be done in co-operation with our partner organisations. Other audits planned for the forthcoming year include a specific audit of bereaved relatives of patients who were seen by the Hospital Specialist Palliative Care Team, along with a wider audit of clinical nurse specialist activity within the Trust. There will also be continued audit of compliance of DNACPR decisions.

2.9 Safeguarding Patients/ Mental Capacity Act and Deprivation of Liberty Safeguards

Aims and Objectives of Work

CHFT is committed to ensuring that all staff follow the principles and practice of the Mental Capacity Act (MCA, 2005), and Deprivation of Liberty Safeguards (DoLS, 2009).The legal framework provided by the MCA 2005 is supported by the MCA Code of Practice, which provides guidance and information about how the Act works in practice. The Code has statutory force which means staff who work with and/or care for adults who may lack capacity to make particular decisions have a legal duty to have regard to relevant guidance in the Code.

The DoLS provides legal protection for those vulnerable people who are, or may become, deprived of their liberty within the meaning of Article 5 or the European Convention on Human Rights (ECHR) in a hospital or care home. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where Deprivation of Liberty appears to be unavoidable, in a person's own best interests.

The specific aims for the work are to:

(i) To ensure all patients who are deprived of their liberty have in place a legal Safeguard that authorises CHFT to detain the patient, whether it be under the DoLS, the Mental Health Act 1983 (amended 2007), or the Mental Capacity Act 2005.
(ii) Provide assurance that CHFT are compliant with all aspects of the MCA 2005 and DoLS 2009.

Historical Data and Analysis
Historically there have been in totality:

In 2014

Number of DoLS Applications 11/ Number of DoLS authorisations 5
(Reasons for non-authorisations 2 discharged, 1 regained capacity, 2 under MHA, 1 best interest decision)

In 2015

Number of DoLS Applications 113 / Number of DoLS authorisations 38 (Reasons for non-authorisations 46 discharged, 7 regained capacity, 9 under MHA

In 2016 (up to 31.3.16)

Number of DoLS applications 94
Data is now captured quarterly and reports are shared at the Safeguarding Committee meeting.

The MCA came into effect in 2007 followed by the DOLS on the 1st April 2009. The DoLS apply to vulnerable people aged 18 or over who have a mental health disorder including dementia, who are in hospital or a care home and who do not have the mental capacity to make decisions about their care or treatment. Those providing the care should consider all options, which may involve restricting the person's freedom, and should provide care in the least restrictive way possible. However, if all alternatives have been explored and the hospital believes it is necessary to deprive a person of their liberty in order to care for them safely, they must get permission to do this by following processes known as the Deprivation of Liberty Safeguards; and they have been designed to ensure that a person's loss of their liberty is lawful and that they are protected. A ruling from the UK Supreme Court in March 2014 has given a new 'acid test' for deprivation of liberty:

- being under continuous supervision and control; and
- not being free to leave; and
- lacking the mental capacity to consent to these arrangements.

The legislation includes a statutory requirement to keep clear and comprehensive records for every person deprived of their liberty. This includes records of applications for authorisations, details of the assessment process, information about the relevant person's representative and the documentation related to termination of authorisation.

There have been two MCA/DoLS audits last year (2015-2016) and improvement plans were developed to address issues identified and we continue to raise awareness in this area. Increased staff awareness has resulted in increased authorisations.

(i) Q1 Progress.

From April to June 2016 there have been 93 urgent authorisations in total made to both Kirklees and Calderdale Metropolitan Councils regarding patients who are deprived of their liberty whilst being cared for as inpatients. CHFT can grant itself an urgent authorisation for up to a period of 14 days whilst the Local Authority determines whether or not to authorise the deprivation of liberty.

From these urgent authorisations made 17 urgent authorisations progressed and the standard authorisation was authorised under the DoLS. Whilst this may appear to be small numbers, 49 of the authorisations were cancelled by the Trust; because the patient was discharged, they had died, it was more appropriate for the Mental Health Act to be used as the legal authorisation, or they regained capacity and therefore it was not lawful to continue with the deprivation of liberty. So for the time the authorisation was in place it was appropriate under the legislation. A small number of the urgent authorisations have lapsed. This occurs when the Local Authority do not complete all their assessments within 14 days of the urgent authorisation being applied. Unfortunately CHFT do not have any influence over the assessment timescales and Local Authority processes for managing this. In these cases the Safeguarding Team continues to

monitor the patient to ensure that the deprivation is still valid, the patient still lacks capacity, all restrictions in place remain least restrictive whilst ensuring the patient remains safe on the wards, and that there are no objections to the DoL. These numbers have not yet been captured and further work is progressing to build this into the database.

All DoL applications are recorded and kept centrally within the Safeguarding Team records. A comprehensive database captures all contacts and records the outcomes of applications made. The CQC are notified of all DoLS authorisations and outcomes. This is in line with the requirements of the legislation. All patients who are subject to an urgent or standard authorisation are monitored by the team.

ii) Assurance and Audit

Since CHFT was inspected in March 2016 there is still some uncertainty with staff regarding the Interaction between DoLS and MCA Legislation leading to delays in obtaining a timely Deprivation of Liberty and notification to the Safeguarding Team for advice and support. To ensure that CHFT are acting in accordance with MCA and DoLS Act legislation and compliant with statutory responsibilities further advice and support is being considered from a legal perspective in utilising the standard authorisation process without applying for an urgent authorisation. Legal clarity will be sought before further discussion.

Twice yearly audits to identify any gaps and good practice in relation to MCA DoLS are planned for July and December this year. In 2015 two audits were undertaken within CHFT which comparatively identified areas where patients were more likely to be who met the 'acid test' criteria for a DoL, and showed an increase in knowledge and awareness at the 2nd audit by a significant increase in the number of authorisations granted.

iii) Training

A significant piece of work has taken place to review all staff groups within CHFT and the level of safeguarding training that they are required to complete in line with the Intercollegiate document for Safeguarding Children and the draft intercollegiate document for Safeguarding Adults. These new figures and compliance reflect the increased numbers of staff that are required to complete a higher level of training. MCA and DoLS is delivered as part of levels 2 and 3 Safeguarding Adults training.

Level 1 training figures have remained static at 81% compliance and have increased since quarter 3 2015-16 (72.6%). This is delivered by an eLearning package.

Level 2 has increased from 61% to 64% (adults) and from 63 to 65 % (children). This is now delivered by a new eLearning package launched in February 2016.

Level 3 Adults – is a new data capture since the allocation of Level 3 to particular staff groups, and has increased from 13% to 22%. A training strategy to target this group of staff is required. This training is delivered face to face

Level 3 Children has increased from 33% to 53% during this quarter. This training is delivered face to face.

Other work has included;

- Continued work and updating the Trusts Intranet Safeguarding pages which include MCA and DoLS to facilitate easier and up to date information.

- Further governance work is ongoing in attending and sharing safeguarding data and information at Patient Quality and Safety Divisional Meetings ensuring safeguarding continues to be a priority.

- The safeguarding team have worked with the Risk Department to ensure that the CQC are aware and notified of all DoLS authorisations which includes outcomes.

- Improved information capturing by collaborative working with the health informatics team in developing a safeguarding dashboard to include DoLS and Mental Health Act statistics.

Improvement Plans for 2016/17

- The Safeguarding Policies and Procedures for Children and Adults are currently being reviewed and updated in line with The Care Act 2014, Working Together 2015, and the Intercollegiate Document for Children 2014. The new Mental Capacity and Deprivation of Liberty Policy will be introduced with updated referral processes and pathways.
- The Safeguarding Team are now co-located within the same offices as Calderdale Local Authority Adult Health and Social Care Team. This is in line with the true spirit of the Care Act 2014.

- Priorities for 2016 will include compliance with The Mental Health Act (1983). This includes: securing honorary contracts to enable Mental Health Liaison Psychiatrists to act as Responsible Clinicians for CHFT detained patients, writing a Mental Health Act policy for CHFT to include roles and responsibilities processes and training strategies, finalising a service level agreement for the Mental Health Liaison Team service and servicing of Mental Health Act papers by SWYPT, training for Duty Matrons and Site Commanders on the receipt and scrutiny of mental health act papers, and understanding the role of security and use of restrictive interventions to enable appropriate detention of patients under the Act.

- To Develop MCA DoLS as part of essential skills training; MCA DoLS training is ongoing within level 2 and level 3 safeguarding adults. Separate MCA/DoLS training can be facilitated and delivered to staff in more detail that requires enhanced skills in MCA and DoLS.

- Develop a strategy to ensure all Matrons attend multiagency MCA DoLS training and Safeguarding children and adults training; External MCA/DOLS training dates circulated to all matrons.

2.10 Conditions of Interest – Stroke

Aims and Objectives of Work

Strokes affects between 174 and 216 people per 100,000 population in the UK each year (Mant et al 2004), and accounts for 11% of all deaths in England and Wales. It is accepted that 85% of strokes are due to cerebral infarction, 10% due to primary haemorrhage and 5% due to subarachnoid haemorrhage. The risk of recurrent stroke is 26% within 5 years of a first stroke and 39% by 10 years (Mohan et al 2011). By focusing in improvement in stroke care, patient outcomes can be vastly improved,

The Trust has the following aims to strengthen and improve stroke services

- Reduce stroke mortality to a SHMI of less than 100,
- Improve functional outcomes for patients
- Reduce the length of stay by 20%
- Improve overall SSNAP score to “A”

To do this we will:

- Ensure all stroke patients are admitted directly to a stroke bed
- Ensure all patients received 45 minutes of therapy 5 times a week
- Ensure all appropriate patients receive thrombolysis within 60 minutes of arriving at hospital

Current Performance

The end of Q1 has seen significant improvement in key areas:

- SNAPP data showed that the service had moved from a D to a B rating.
- Improvements noted in all indicators although ongoing work to achieve full compliance still continues.
- 90% stay on stroke ward now at 87.50%
- This is the an improvement in month
- 68.75% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival. An improvement of 18.75% in month.

Future actions for 16/17:

A full report will be presented in the Q2 report.

Domain Three – Experience (Caring): Staff involve and treat people with compassion, kindness, dignity and respect

Patient experience compliance summary

Indicator	Compliance
3.1 Dementia	Reporting only
3.2 Improving the Inpatient Experience	Reporting only
3.3 Improving the Community Experience (CQUIN)	Achieved
3.4 Improving Hospital Nutrition	Reporting only
3.5 Improving End of Life Care	Reporting only

Highlights:

Improving the Patient Experience – 4 quality improvement projects in development:

- children's voice
- effective care on a busy surgical ward
- maternity patient experience
- developing new measures of feedback for community services

National Adult In Patient Survey 2015 – some improvement / positive results in relation to availability of hand wash gels and cleanliness of hospital toilets and bathrooms

Improving Hospital Nutrition – positive feedback from PLACE inspections of patient food at CRH and HRI

3.1 Dementia

The Trust is currently redeveloping its dementia strategy and fuller report on this will be received in the Q2 report.

3.2 Improving the Inpatient Experience

1. Aims and Objectives of Work

Measuring patient experience is essential in order to assess the delivery of the Trust's vision**:** ***Together we will deliver outstanding compassionate care to the communities we serve*** along with the strategic goal of: ***Transforming and improving patient care.***

Analysis of patient feedback helps us to better understand our patients' expectations, their experience and their satisfaction. For example their views of the environment in which their care and treatment was delivered, whether they were kept informed, whether they treated with respect and dignity and how their interactions with staff made them feel.

It is important when we measure patient experience, that patients are also given the opportunity to tell us how we can make it better. This may often be about the small things as well as any large system changes.

The primary method of measuring the patient experience in the trust is through the Friends and Family test (FFT) which is now well established across all inpatient and day case, as well as in the A&E and outpatient departments areas, maternity services and across community services.

2. Local Quality Improvement Projects

This year four quality improvement projects have been identified, which will use FFT and other feedback data to direct the aspects of improvement. For each of these improvement priorities, there will be an objective to build into the project plan an element of service user involvement.

All projects are currently in their infancy and will be scoped to run over the next 12 months, an initial outline for each is detailed below.

2.1 Children's voice

Staff working with children and young people are looking for innovative ways of increasing the opportunities to involve children and young people in their healthcare and also in how services are designed and delivered.

Methods have been used previously, e.g. young people included on recruitment panels, the 15 step challenge; however these tended to be a one off initiatives. The aim of this approach will be to establish a more robust arrangement, enabling more sustainable activities to be put in place.

The first step will be 'a go see' exercise to find out what other Trusts have achieved, examples identified are:

- Wye Valley NHS Trust's 'Voice of the Child' with 12 young people known as CHIPS (Children in Hospital Improvement Partner Service) working as you ambassadors to help improve hospital services
- Blackpool Teaching Hospital NHS Trust 'Victoria's Voice' which aims to make it easier for children and young people to get involved in the trusts services and have a say in how things work for children and young people
- Addenbrooke's Hospital's 'ACTIVE' project which is a children and young people's board made up of children and young people who have been patients, some who are thinking about working in a medical career and others who are just interested and want to make a difference.

2.2 Effective communication on a busy surgical ward.

Surveys of patients' views have revealed that patients are not always aware of their plan of care, with communication not always being as good as it could be. This project will further explore how communication takes place between the multidisciplinary team and how key information such as a patient's clinical condition, the treatment plan, and expected outcomes is shared with patients / relatives.

This work will commence on a general surgical ward which receives post-surgery patients, where there can be as many as 11 ward rounds taking place each day. It is not possible for the nursing staff to chaperone each of these rounds and this can have a detrimental impact on communication with nursing staff relying on the medical records to get updates regarding plans of care. Support from the Yorkshire & Humber Improvement Academy has been secured to help take this project forward. A culture survey will be the first step to explore potential barriers, followed by a focus group to identify interventions. Testing these with both staff and patients will be an important element of this project.

2.3 Maternity patient experience work

The Maternity Patient Experience Group has revised its terms of reference and membership and has a new workplan in place. A key element of the plan is a workshop - Putting the

Patient First: Customer Care and Communication Skills in the NHS. This is delivered by the NHS National Performance and Advisory Group.

Four half day sessions will be run during August and September that will include a focus on:

- Understanding the impact of your own behaviour on others
- How to handle challenging situations and people
- Effective communication techniques
- Understanding and managing patient expectations
- Identifying how and why perceptions are formed
- Proactive versus reactive behaviour
- Demonstrating a positive attitude
- Taking ownership

The workshop is designed to look at an individual's attitudes and behaviours and how they impact on the provision of service to both service users and colleagues.

2.4 Community CQUIN - Introducing new measures of feedback.

Patient feedback in the Community only has one formal mechanism, the Friends and Family Test, which doesn't always provide the detail required to really understand the issues of those areas which may be in need of improvement. A number of informal methods are used but the information is not easy to triangulate with our quality improvement process. As part of this CQUIN the Trust aims to develop some specific feedback tools / questionnaires to enable assurance / measurement of the services.

3. Other patient experience feedback

National surveys are another key source of patient feedback. During quarter 1 2016, there have been 2 surveys published with the following high-level messages:

3.1 National survey of adult inpatients 2015

Each year all acute and specialist NHS Trusts participate in a survey of adult inpatients. This year the survey was sent to 1220 patients discharged from a CRH or HRI inpatient ward in July 2015, of these 552 responded, giving a response rate of 45%

Patients were asked about their experience of:

- The Emergency /A&E department
- Waiting list and planned admissions
- Waiting to get a bed on a ward
- Doctors and nurses
- Care and treatment
- Operations and procedures
- Leaving hospital

Results of the survey were published on Wednesday 8th June 2016 . Scores for each question are out of 10, a higher score is better. Trust scores of each question in the survey are also compared with the range of results from all other Trusts that took part. An analysis technique called the 'expected range' is used to determine whether a Trust performs 'about the same', 'better' or 'worse' than other Trusts. This analysis is based on a rigorous statistical analysis and therefore any scores outside the expected range means it performs significantly better / worse than what would be expected and unlikely to have occurred by chance.

CHFT were reported as scoring about the same for all but 2 of the questions. The Trust was reported as scoring better than the majority of other Trusts for the questions:

- Were hand-wash gels available for patients and visitors to use? Scoring 9.8
- Were you given enough privacy when being examined or treated on the ward? Scoring 9.7

The Trust was also noted to have made a statistically significant increase since last year in the scores for 2 of the questions:

- Were you given enough privacy when being examined or treated in the A&E department? Scoring 9.1
- How clean were the toilets and bathrooms that you used in hospital? Scoring 9.0

The results will be further analysed by the Trust's Health Informatics team, including a review of any comments supplied by patients. This will be reviewed by the Patient Experience and Caring Group who will be responsible for identifying any improvement work required.

3.2 National Cancer Patient Experience Survey - 2015 Results

A survey of cancer patients is carried out each year with results published at both a overarching level as well as for each tumour site. These results are analysed to assess comparative performance, based on a calculation of "expected ranges". This means that Trusts are flagged as outliers only if there is statistical evidence that their scores deviate (positively or negatively) from the range of scores that would be expected for Trusts of the same size.
At the overarching level the Trust scored outside the expected range in 3 questions.

- *Negatively for 2 questions:*
  - Q17 Patient given the name of the CNS who would support them through their treatment. Trust score = 84%. Expected range = 86% to 94%
  - Q22 Hospital staff gave information on getting financial help. Trust score = 47%. Expected range = 47% to 63%
- *Positively for 1 question:*
  - Overall the administration of the care was very good / good. Trust score = 93%. Expected range = 85% to 92%

The Trust's lead cancer nurse is now working with each cancer team to develop individual plans based on their results.

3.3 National surveys being carried out during 2016

Three further surveys will be conducted this year:

- National inpatient survey
- Children and young people's survey
- Accident and emergency survey

3.3 Improving the Community Experience

This work is being progressed as part of the CQUIN program and a full report in to the design and development of the community patient survey tool will be received in Q2.

3.4 Improving Hospital Nutrition

Aims and Objectives of Work

Nutrition for patient's staff and the public is still classed as a priority for CHFT, following on from the ground work done in 15/16 as part of the CQUIN scheme.

With support from Food for Life who are funded by Calderdale CCG we will continue to:

- Develop and progress a Whole Hospital Food For Life Approach in six key areas: leadership for a health promoting setting, catering quality, patient experience, staff health and wellbeing, retail and vending and community and partners. This is highlighted in the Trust Food and Drink Strategy
- Integrate CQUIN objectives into a wider Whole Hospital approach to food through the introduction of the National Health and Wellbeing CQUIN .
- Increase level of integration and partnership working with other local services and stakeholders through our contacts with food for Life .
- Create opportunities to share learning and best practice between CHFT, partners and other NHS Trusts.

Nutrition including the Health and Wellbeing CQUIN will continue to be monitored and reported each quarter at the Food for life Hospital Leaders steering group with representation from the CCG, Public health, CHFT and Food for Life

Patient Satisfaction:
Patient satisfaction is currently measured by the distribution of a questionnaire to inpatients. This has been reviewed and due to the length of the questionnaire will be discontinued over the next few months but will be replaced with 3 key questions taken from the national PLACE inspection and will be integrated within an Estates and Facilities questionnaire. This is currently with the Membership Council to review.

On 27th June at HRI in partnership with Appetito a food tasting event was held in the main entrance. Some of the feedback is highlighted below

- You should be very proud of the food you serve.
- All the soups are delicious.
- All the items are very fresh and nice I enjoyed the food thanks for the lunch.
- A lovely menu.
- Hospital food this is brilliant.

Although a lot of partnership work has been undertaken with CHF and its partners (ISS/ Engie/Anglia Crown/Burlodge) the meal delivery system in place at CRH continues at times to be problematic.

ISS are working with CHFT around delivering an improved meal delivery service in line with CHFT maintaining the current contract we have with ISS. A Go See event is scheduled on the 17th August to Derby where the system is in place including senior Estates and Facilities staff ,matrons and dietetic staff.

PLACE 2016
The PLACE inspections took place at HRI on 27th and 28th April 2016 and for CRH on 10th May 2016 and Friday the 20th May 2016 .

HRI
The inspection teams undertook food tasting on ward 17, 19 and 20 the service was observed and showed full interaction between nursing and catering teams. Patients were complimentary about the food received and were in happy in general with the menu content. At the end of the service, the food was tasted by the inspection team and this was approximately 20 minutes after

the meal trolley had arrived on each ward. On ward 19 it was noted the day room being used for meal times and there was excellent interaction between the staff and patients. It was noted by the inspection team the quality/taste and temperature of food was of a very good/good standard along with the service. The only food tasted which raised a concern was jelly which was sugar free and a pasta dish. Both were marked as poor as both lacked flavour.

CRH

The inspection teams undertook food tasting and service delivery on wards 1d /4c which is the standard plated service and ward 3abcd paediatrics which offers a bulk service.
Patients on these wards were complimentary about the food received and were happy in general about the menu content. At the end of the service to patients, the food was tasted by the inspection team.

The inspection team were complimentary with the menu options for the children's ward. They could choose off a normal children's menu offering fish fingers/chicken nuggets or from the standard menu offering more traditional pasta dishes/vegetables/fish etc.

The only food tasted which raised concerns were:

- Cheese and tomatoes quiche which scored acceptable for texture. Taste was very good
- Roast potatoes on one ward scored acceptable on taste and acceptable on texture
- Cheese pasty acceptable on taste and acceptable on texture. Was a little dry
- Sausages score acceptable on texture as the skin appeared a little tough
- Carrots scored poor on taste on one ward by one half of inspection team but on the other ward scored very good

All food scored high on temperature

Food Waste

CHFT achieved our CQUIN for 2015/2016 by reducing food waste overall by 1%

On May 24th a workshop was held at CHFT looking at reducing waste . This was organised by Food for Life

Vending Facilities

The tender specification for Vending is nearing completion and it is in line with the National CQUIN for 206/2017 which is "healthy food for NHS staff, visitors and patient based on the Public Health report "Sugar Reduction"

Partnership working with Food for Life:

Calderdale CCG have funded the Soil Association Food for Life (FFL) for the next 2 years .FFL are continuing to use their expertise in supporting CHFT in improving the food experience for staff, visitors and patients. As FFL link into other NHS organisations CHFT have attended and also hosted a workshop at CRH . The workshop attend at South Warwickshire NHS Foundation Trust was called "Making the most of Volunteers to Support Food Activities". The event was attended by Matron Chris Bentley and Renee Comerford, Practice Learning Facilitator who presented the work on Prevention of Delirium and the role of the student volunteers in Nutrition . The workshop hosted by CHFT "Engaging ward level staff around Food" was well attended by CHFT staff and other Trusts

Nutrition and Hydration Strategy:
The strategy will be reviewed by CHFT Communication team to ensure the strategy is written in line with our branding
It has been shared at the Nursing and Midwifery Committee/Nutritional Steering Group and Patient Experience Group

Fruit and Veg stall:
The fruit and Veg stall at HRI continues to be a success. It is now available for 3 days a week. Due to partnership working with Calderdale Public Health/CHFT Catalyst (SPC) and the local markets the CRH Food and Veg stall has been agreed initially as a Pilot for one day a week. The Trust is awaiting confirmation of a start day but planned for the end of July 2016

Food for Life Catering Mark:
In December last year ISS achieved their Bronze Catering mark in retail this was re accredited in February 2016 and have retained the Bronze standard. ISS continuing to work towards achieving the silver standard over 2016 /2017

Incredible Edible/Rooting and Fruiting :

Trees for Wellbeing is a project run by Rooting and Fruiting, a Social Enterprise. Their vision is to create abundance in our local area; green spaces that are great for residents and local habitats, and that can support happy, healthy and connected communities.

They aim to help fulfil this vision by working with people from all walks of life to establish permanent food landscapes. They are interested in how green spaces, particularly trees, reduce preventable illnesses and help people to get well quickly.

Trees for wellbeing have been funded to create a series of small food forests within Calderdale Royal hospital. These are edible gardens, which model natural woodlands. They include a range of trees, shrubs, creeping and climbing plants, and even mushrooms. These plants work together to provide a flourishing environment for everyone to enjoy.

They are working with the hospital staff especially OT, patients, visitors and neighbours of the hospital to have a say in how these are designed and developed. As well as providing advice and hands-on workshops on planting techniques and maintenance to those involved, and will be working with people to care for, develop and benefit from these beautiful and abundant gardens. The launch event is planned for the 28th July

MUST (Malnutrition Universal Screening Tool) Compliance:

From April 2016 the Trust is taking part in the BAPEN (British Association Of Parenteral and Enteral Nutrition) national audit on a quarterly basis which includes the monitoring of the MUST tool. This is so CHFT can benchmark themselves against other organisations. The latest audit was completed in June of this year and we are still awaiting the results. The results and relevant action plans from the divisions will be managed through the Nutritional Steering Committee which was re-established in June 2016 chaired by Joanne Middleton ADN for surgery

Domain Four – Responsive: Services are organised so that they meet people's needs

Indicator	Compliance
4.1 Learning from Incidents, Claims and Complaints	Reporting only
4.2 Appointment Slot Issues	Reporting only
4.3 Patient Flow and the SAFER programme	Reporting only

Highlights:

Incidents, complaints, claims – improvements in sharing of learning from adverse events via Patient Safety Quality Boards and Quality Committee and with divisions for claims

Appointment Slot Issues – improvement in the number of referrals awaiting appointment

4.1 Incidents, Complaints and Claims

Incidents

Key messages:

- 1.9% reduction in CHFT incidents recorded in Q12016/17 compared to Q1 2015/16
- Suspected falls is the top reported incident in Q1, as in the last quarter
- Medical Division is the highest reporter of incidents in Q1 (43.1% all incidents) by division
- Labour Delivery recovery Post Natal Unit is the highest reporting department (215 incidents)
- 13 Serious Incidents (Sis) Q1, 1 of which is a pressure ulcer
- 1 never event in Q1

1.1 Numbers of Incidents

For the period 1 April 2016 to 30 June 2016 a total of 2,593 incidents were reported by CHFT members of staff. Of these, 1120 43.1% were reported by the Medical Division.
The table below shows that the number of incidents report has decreased by 49 incidents (1.8%)

1.2 Incidents by Divisions:

The tables below show that the number of incidents reported in Quarter 1 per Division, with the Medical Division reporting 43.1% of total incidents

Incidents Reported by Division	Q4 2015-2016	Q1 2016-2017
Community Division	125	78
Corporate Division	8	5
Estates and Facilities	29	37
Families and Specialist Services	677	798
Huddersfield Pharmacy Specials	1	1

Medical Division	1203	1120
Surgical & Anaesthetics Services Division	599	554
Totals:	**2642**	**2593**

In Community the likely reason for a fall in the number of incidents reported is the transfer of a number of community services on the Huddersfield site being transferred , under contract transfer, to Locala Provider services . this will need to be monitored in future quarters to test this

A positive reporting culture remains in the Trust despite the reduction in the number of incidents reported. The incidents reported by the community division have reduced by 47 (37%). This is as a result of a change in the coding of incidents that occur in nursing homes which have previously been reported as CHT incidents and now are more accurately reported as non CHT incidents.

2 . CHFT Incidents

2.1Top Incident Categories

The top 20 reported incidents for Quarter 1 are given below with suspected fall being the top incident category reported, accounting for just under a third of incidents. This is consistent with quarter 4 of 20151/6.

There has been a change in the approach to coding during Q1, with staff coding incidents from mid May 2016. The incident team is currently reviewing what impact this is having on the reporting of incident categories.

Top 20 Incident categories Q1 2016/17

Top 20 Q4 15-16		Top 20 Q1 16-17	
Slips, trips, falls and collisions	547	**Slips, trips, falls and collisions**	523
Administration or supply of a medicine from a clinical area	193	**Administration or supply of a medicine from a clinical area**	161
Patient's case notes or records	140	**Pressure sore / decubitus ulcer**	132
Lack of/delayed availability of facilities/equipment/supplies	128	**Connected with the management of operations / treatment**	103
Connected with the management of operations / treatment	125	**Adverse events that affect staffing levels**	96
Adverse events that affect staffing levels	123	**Transfer**	81
Transfer	102	**Accident caused by some other means**	76
Pressure sore / decubitus ulcer	98	**Lack of/delayed availability of facilities/equipment/supplies**	75
Discharge	96	**Discharge**	72
Accident caused by some other means	73	**Patient's case notes or records**	71
Abuse etc of Staff by patients	69	**Other**	66
Infection control	67	**Communication between staff, teams or departments**	61
Communication between staff, teams or departments	64	**Abuse etc of Staff by patients**	58
Medical device/equipment	61	**Transfusion of Blood related problem**	49
Administration of assessment	53	**Appointment**	48
Appointment	44	**Medical device/equipment**	45
Labour or delivery – other	43	**Labour or delivery – other**	44
Preparation of medicines / dispensing in pharmacy	37	**Security incident related to Personal property**	44

Admission	34		**Admission**	42
Possible delay or failure to Monitor	34		**Medication error during the prescription process**	41
Totals:	2131		**Totals:**	1888

FALLS

Falls remains the highest incident category reported, with 523 incidents reported in Q1 2016/17, a slight reduction from 541 falls in Q4 2015/16.

The above data shows an increase in the number of falls from height during the quarter, up from 23 in Q4 2015/16 to 67 in Q1 2016/17.

There have been 4 serious incidents relating to falls with harm and root cause analysis investigations are underway for each of these falls to identify learning and actions to prevent recurrence. Further details on falls is given in the Safe section of this report.

2.2 Incidents by Department:

The table below identifies the highest reporting ward/department (Top 10), with labour delivery recovery post-natal unit now being the highest department reporting incidents in Q1 2015/16. This is suggestive of an improved reporting culture in this area.

Q4 15-16 **Top 10 by dept/ward**	
Operating Theatre	163
Labour Delivery Recovery Post-natal Unit	146
Accident and Emergency	129
Intensive Care Unit/High Dependency Unit	91
Outpatient Department	81
HWD5	68
HWD19 Trauma	60
HWD8	60
HRI MAU	59
Health Centre/Clinic	56
Totals:	913

Q 1 16-17 Top 10 by dept/ward	
Labour Delivery Recovery Post-natal Unit	215
Accident and Emergency	137
Calderdale birth Centre WD1A	96
Operating Theatre	96
HWD19 Trauma	86
Outpatient Department	77
HRI MAU	76
HWD5	73
HWD8	64
Intensive Care Unit/High Dependency Unit	62
Total	982

Incidents by Severity:

The numbers of incidents by severity are:

by severity	**Q4** 2015/16	**Q1** 2016/17
GREEN	**2065** (78.1%)	**1966** (75.8%)
YELLOW	**530** (20.1%)	**551** (21%)
ORANGE	**39** (1.5%)	**60** (2.3%)
RED	**8** (0.3%)	**16** (0.6%)
Totals:	2643	2593

There is a 2.3% decrease in the number of incidents reported. However, the incidents with harm have increased for all *harm* incidents. It is worth noting that incidents are now coded and categorised by the reporters and incident managers/handlers.

In Quarter 1, 13 incidents were identified as being “serious” and required reporting to the CCG/NHS England via STEIS. The types of incidents were:

Serious Incidents reported to CCG/NHS England via STEIS.	**2016/17 Q1**
HCAI/Infection control incident meeting SI criteria	1
Screening issues meeting SI criteria	1
Sub-optimal care of the deteriorating patient meeting SI criteria	1
Surgical invasive procedure incident meeting SI criteria	1
Treatment delay meeting SI criteria	1
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	1
Maternity/Obstetric incident meeting SI criteria: (mother and baby)	1
Slips/tips/falls meeting SI criteria	4
Medication incident meeting SI criteria	1
Diagnostic Incident meeting SI criteria (including failure to act on test results)	1
Grade 3 Pressure Ulcer	1
Totals:	14

All incidents were reported on STEIS within the 48hr timescale.

Learning from Incidents
Information on learning from incidents is shared within divisional Patient Safety Groups and for serious incidents via the Quality Committee.

Learning from Incidents

Information on learning from incidents is shared within divisional Patient Safety Groups and for serious incidents via the Quality Committee. Learning identified from incidents during the quarter is given below.

Learning the Lessons - Medicine	
Issue:	Learning:
Pressure Ulcer On washing patient discovered category 3/4 in sacral cleft. looks deep approximately 1cm possibly secondary to moisture. Surrounding tissue looks macerated. Barrier spray applied. Observed pressure ulcer prevention care plan and no evidence of the sore on admission. Sister informed. Pressure mattress ordered but patient may not be stable enough to transferred onto it.	Found to be moisture linear skin damage secondary to faecal and urinary incontinence. Waterlow calculated wrong (too low) on 3 occasions. Skin inspections carried out x 2 daily no detection of pressure damage to natal cleft until March 27. but moisture damage found. Intentional rounding should have been 2 hourly and not 4 hourly as completed. Moving and handling careplan should have been in situ. Urine incontinence careplan should have been in use also. Closer inspection of all patient pressure areas should be
Observation Called to bed 8 a side by nurse call bell from bed 7 to tell us that the patient was out of bed and disorientated when we then realised she had dislodged her chest drain. on further questioning the lady in bed 7 Thought she had seen patient take a pair of scissors to her actual chest drain, on inspection this looked the case. The drain was found on floor in two parts with a piece of suture connected to one part of it with the possibility of the tip being embedded into the tissue. This was not visible on inspection. EWS 2 O2 in place.	Patients with chest drains need very close observations during the day and night. This patient was in a three bedded room off the main ward area. In the future we should be considering these patient being in a high visibility bed for safety. To discuss in the ward meeting.
Blood Products Member of clinical team brought 3 bottles of 20%HAS that had been sitting on the ward (in sunlight) for 3 weeks. The Blood Transfusion Department had followed the traceability protocol and a letter regarding the fate of these units had been used to the ward. The ward had returned this legal document and had stated that the returned units were transfused to the named patient.	To ensure that all qualified nursing staff sign for all blood products when they have administered them and ensure that unused blood products are returned immediately to the transfusion department. Stress to nursing staff the cost of wasted units.
Equipment training HCA informed me that on transferring patient with samhall turner, she was unable to take her own weight on her legs and hca lowered her to the floor and came for assistance.	Member of staff tried to transfer patient using equipment. This type of equipment needs X 2 members of staff. Training need identified. Staff member in question has been spoken to. The moving and handling co-ordinator on the ward is ensuring that all relevant competencies are up to

	date.
Discharge Medication Discharged home with buprenorphine patches. one 20mcg box with one patch in and one 5mcg box with one patch in. Neither box had a patients name on but specified the ward. Date on 20mcg box was 5.5.16 and date on 5mcg box was 12.5.16 Patient normally takes fentanyl patches 25mcg every 72 hours.	Adherence to the CHFT Medicine Code and RGN accountability for their actions. Discharge medications to be prepared in advance to promote a smooth discharge for the patient. Clear communication between departments post angio procedure to ensure ward is fully aware of discharge plans.
Lack of handover The patient was brought up to the ward post having a peg put in place without a handover from Medical Assessment Unit (MAU). The patient had been on MAU that day but was transferred to ward 6 without a handover. Only a name was given. Endoscopy also phoned us asking to collect the patient who had been sedated however we did not as we knew nothing about the patient. She was eventually brought to the ward unexpectedy where the nurses from endoscopy gave a handover from their point of view.	It is imperative that we communicate effectively when transferring patients to other specialist areas. To ensure a safe patient experience.

Learning the Lessons - Surgical Division

Issue:	Learning:
Underlying condition - An orthopaedic inpatient had an undiagnosed heart block - The fall the patient suffered could have been as a result of this	- The need for a holistic approach to all patients who have underlying and known conditions - Information must be followed up at the time of test result so as not to 'get lost in the system' - The need to complete documentation fully in particular in this case the falls bundle
Pressure Ulcer - Patient had a hospital acquired grade 3 pressure ulcer - Poor documentation led to not being able to evidence where this pressure damage occurred	- Documentation has to be completed at time of admission and transfer - Collaborative working between Divisions where there is discrepancy as to where incident occurred - All staff should be able to assess pressure damage categories and arrange for suitable equipment where necessary. Need for more staff training - Share learning regarding incident with all ward staff (Surgical and Medical Divisions)
- Failure to escalate a deteriorating patient with NEWS between 12 and 14. Patient died - Delay in certifying the death	• instances where escalation should have occurred but did not – Nerve Centre now in place to highlight elevated NEWS and to reduce risk of occurrence.

	• Death certificate training is now included in the Junior Doctor's training pack • Need for holistic approach to all patients
Insulin / handover - Insufficient insulin checks - Empty fluid bag - Poor handover of diabetic patient	- All staff on ward received up to date training on managing patients who are insulin dependent - Staff training regarding handover of all patients and in particular those who are insulin dependent - Continuous monitoring of record keeping standards - All staff have received training and have signed off competencies in new blood sugar monitoring
Learning the Lessons - FSS	
Issue:	Learning:
Labour / Delivery - Emergency caesarian section for failure to progress at 5cm. Epidural top up ineffective, Remifent given. - Unable to deliver baby - delivered as breech in poor condition, no respiratory effort, full resuscitation given and transferred to Special Care Baby Unit.	- Escalation to Consultant where necessary for all surgical procedures in a timely manner. - Importance of keeping the anesthetist informed of progress and complications - Learning from experience newsletter to remind staff about timely summoning of consultant paediatrician in a timely manner. - Findings to be presented at Perinatal Mortality Meeting
Labour Delivery - Delay in admission for undiagnosed breech presentation. - Baby born in poor condition.	- It is crucially important to listen to what the woman is telling us - Health care staff should keep the woman the focus of care - If a woman is unhappy with the clinical advice she is given this should be escalated and dealt with immediately. -
Stillbirth Unexpected stillbirth at Emergency Caesarean Section in maternity theatre	- CTG interpretation was incorrect in the last hour - The category of Caesarean section declared and documented was incorrect reflecting the lack of urgency - Misinterpretation of the fetal growth based on the last scan as well as incorrect SFH - Measurement after the scan which would contribute to the compromise in reserves - This was an IVF pregnancy which has an increasing risk of small babies and a two to four fold risk of stillbirth
Intra Uterine Death (IUD)	- This woman had a large uterine fibroid but

- high risk pregnancy, uterine fibroids. - Attended for augmentation in view of spontaneous rupture of membranes (SROM). Prostin administered at 01 50, CTG following classified as reassuring, therefore discontinued at 02:59. - Reports to have been contracting frequently. Care taken over on day shift, history noted, planned for CTG monitoring, unable to locate fetal heart rate, escalated this to shift coordinator and registrar. Portable scanner used by registrar, still unable to locate fetal heart. Transferred to main scan room to be scanned by sonographer. IUD confirmed on scan.	growth scans were discontinued at 36 weeks. - Fundal height palpation (which plotted on the 90th centile) was inappropriate in this case. i. Fetal growth scan should have been continued until delivery. ii. Offer immediate augmentation for term SROM as per NICE and our guidelines.

Improvements:

An update against improvement areas for 2016/17 is given below:

- Changes have been made to the incident reporting and investigation process. Incidents are now categorised (coded) by the reporter and quality checked by the investigating managers. This process gives the incident administrators the opportunity to check and assure the quality of the information provided as well as to follow up on actions. The change was introduced mid May 2016. It is proving a challenge to ensure that coding, and therefore incident analysis , information is accurate and important that incident reporters and investigating managers check coding accuracy. Individual feedback is being given to reporters and Datix drop in sessions are in place to support staff. The incident team and system super users have held sessions and been out to wards to train staff in the coding process.

- Ensuring that duty of candour is undertaken in a timely way for incidents with harm and evidencing this within the incident reporting system is also proving a challenge. This is being monitored closely and a toolit is to be developed for staff, as well as a more prominent area within the recording system to record duty of candour discussion dates.

Complaints

Complaints are a vital source of information for the Trust, helping to identify where the quality and safety of services and care require improvement for service users.

This section provides a quarterly summary of Patient Advice and Complaints contacts using information collected from the data held on the Trust's Patient Advice and Complaints database. This section includes information on:

- Performance re: complaints management in 2016/17
- Information on complaints by Division
- Learning from complaints
- Improving complaints management in 2016/17
- Areas for improvement

Key points detailed in the section below are:

- A small decrease of 6% in the number of complaints received in this quarter, compared to the same quarter in 2015/16; however, there has been an increase 15% from the last

quarter of 2015/16.

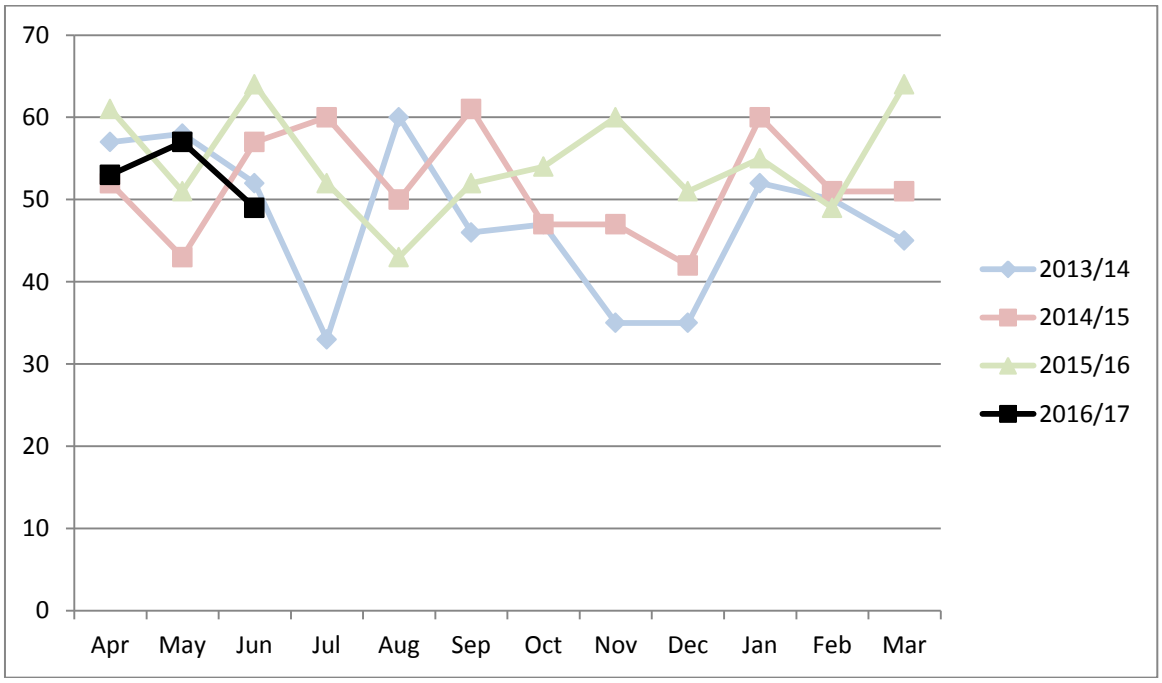
- The majority of complaints (70%) were graded as yellow or green, ie no lasting harm / minimal impact on care
- Clinical treatment and communications are the main subjects of complaints; this was the same as the financial year.
- Appointments and access to appointments are the main areas of concern
- Medicine is the Division with the highest number of complaints; however, it is also the largest Division and the number of complaints reflects its size.

Key Performance Indicators

Complaints 2016/17	**2016/17 Q1**
Number of new complaints received	159
% increase / decrease on 2015/16	↓ 6% (169)
Number of complaints closed	177
% complaints upheld	45%
% complaints partially upheld	34%
% complaints not upheld	18%
Number of complaints re-opened following final response	19
Number of complaints received from Ombudsman for investigation	10
Number of complaints upheld by Ombudsman (includes partially upheld)	2
Number of complaints not upheld by Ombudsman in quarter	0

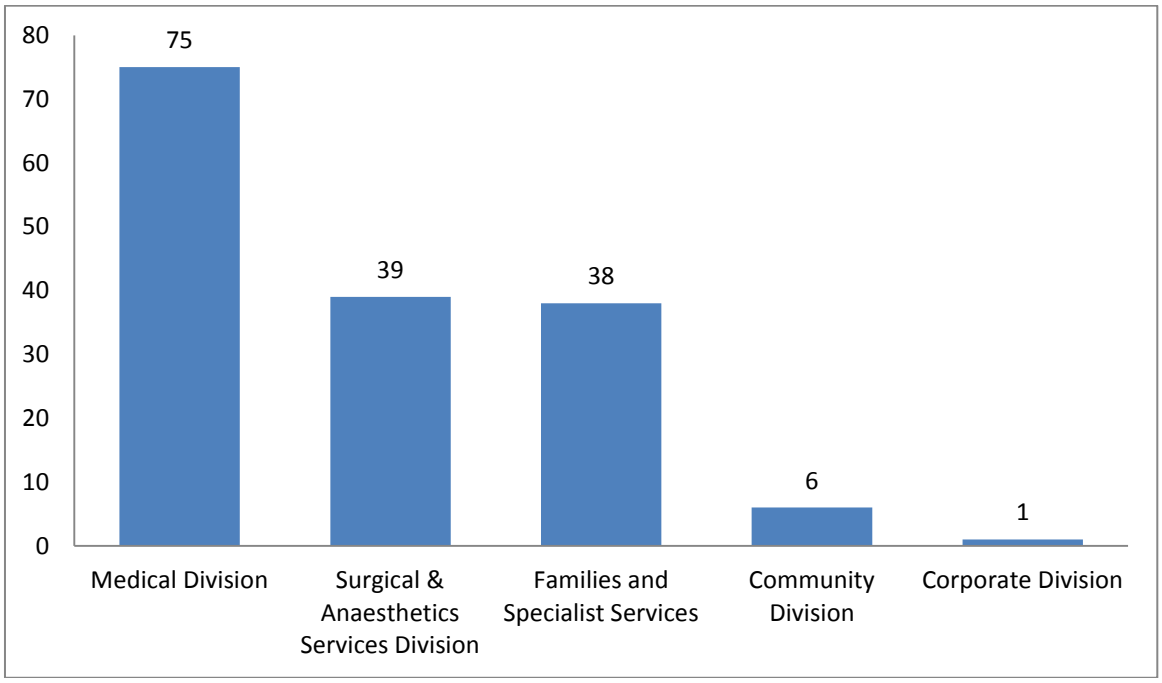
Complaints Performance 2016/17

Comparison of complaints from 2013/14 to present:
Complaints data reflecting the trends in the number of complaints for the past three years – including numbers for this quarter



Complaints Received:
At the end of quarter 1 of 2016/17 the Trust received a total number 159. This is an decrease of 10% from the same quarter last year and a decrease of 5% from the same quarter in 2013/14. National complaints data for quarter 1 of 2016/17 has not yet been released from the HSCIC.

Quarterly Complaint Numbers by Directorate:



Of the 159 Complaints received in 2015/16:

- 47% of complaints received related to the Division of Medicine, which is the largest

division with Accident and Emergency Services. The Emergency Network was the Directorate within Medicine with the highest number of complaints, a total of 39. Acute Medical received a total of 19 complaints and Integrated Medical received a total of 17.

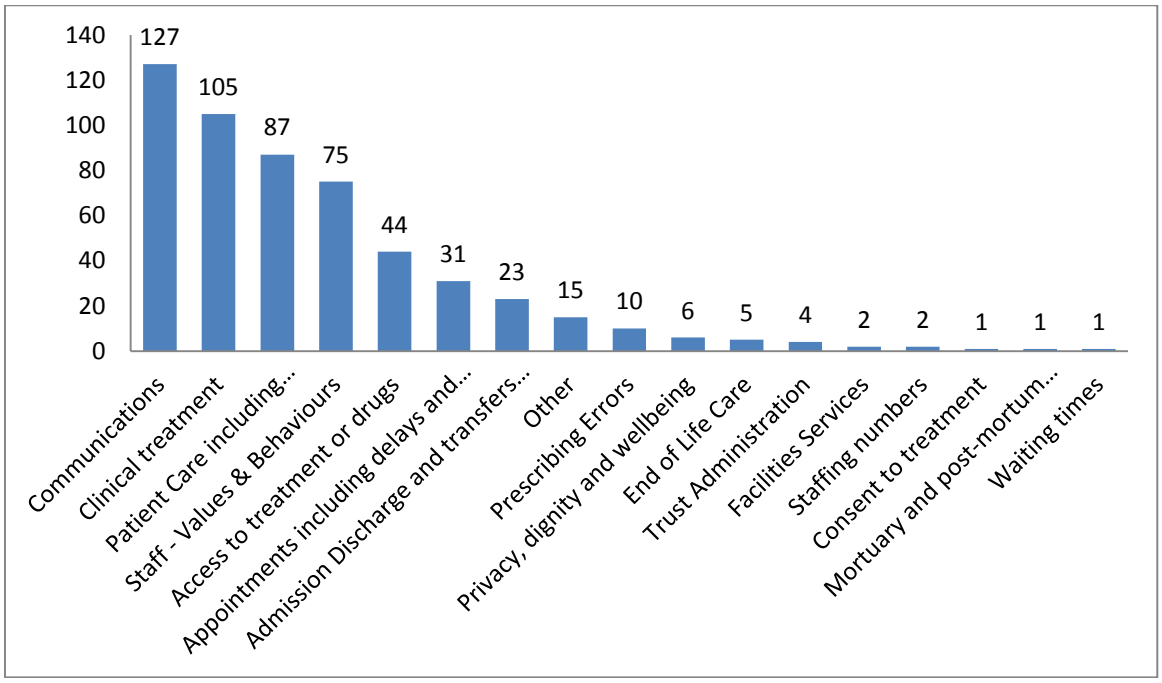
- 25% complaints received related to the Division of Surgery and Anaesthetic Services (SAS). General and Specialist Surgery was Directorate within SAS with the highest number of complaints, a total of 22. Head & Neck received a total of 12 complaints, Orthopaedic a total of 12, and Critical Care received a total of 2.

- 24% complaints received related to the Division of Family and Support Services (FSS). Woman's Services was the Directorate within FSS with the highest number of complaints, a total of 20. Radiology received a total of 7 complaints, Outpatient and Records a total of 5, Children's Services a total of 4, and Pathology and Pharmacy both received a total of 1.

- 3% complaints received related to the Division of Community. Intermediate and Community was the Directorate within Community with the highest number of complaints, a total of 5. Families Directorate received 1 complaint.

Analysis of Complaints by Theme

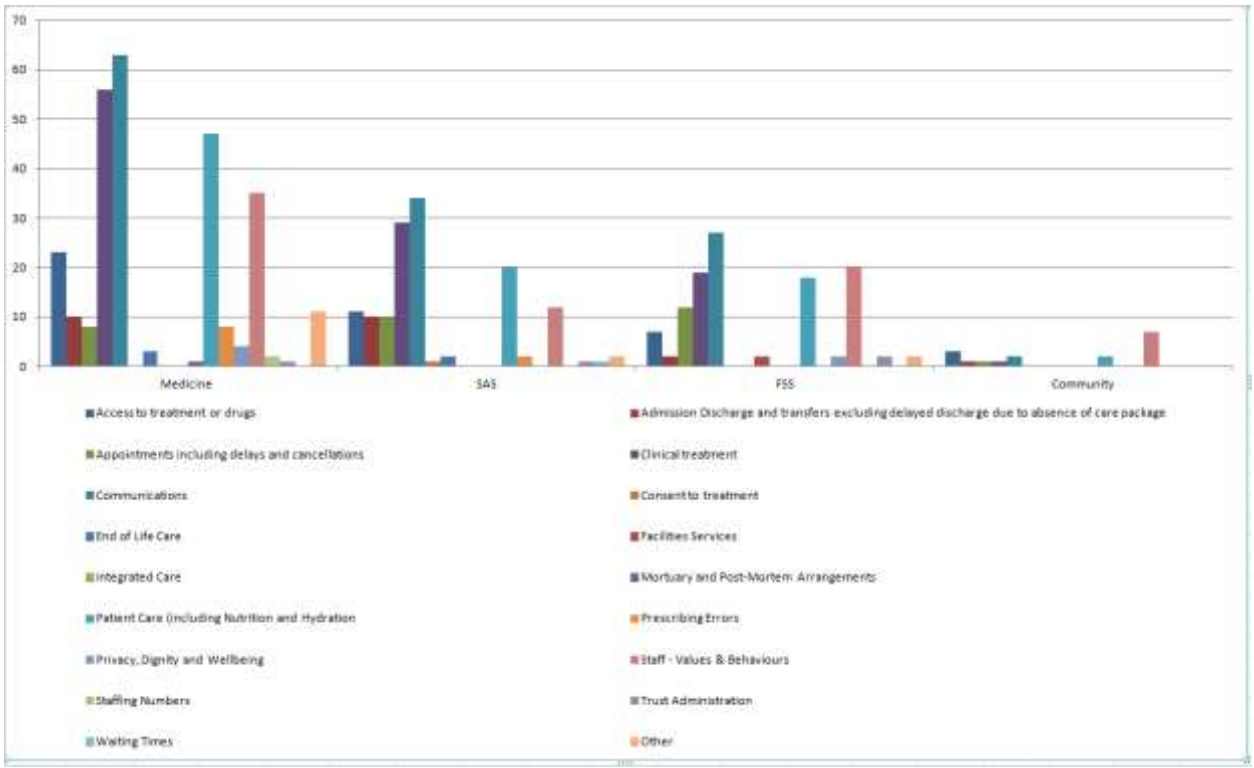
Complaints are analysed below by Primary Subjects, within each complaint subject there will be a number of different sub categories with more detail relating to the complaint. There are often a number of issues logged for a single complaint, which is way the number of Primary Subjects differs from the total number of complaints received.



The top three subjects of Complaints for the Trust are as follows:

Subject	Percentage
Communication	24%
Clinical Treatment	19%
Patient Care (including Nutrition and Hydration)	16%

Quarter 1 Complaints received by Division and Primary Subject



- The top subject of complaint for Medicine was Communication, representing 23% of all complaint subjects received for Medicine within Quarter 1. Clinical Treatment represented 21% and Patient Care (including Nutrition and Hydration) 17%.

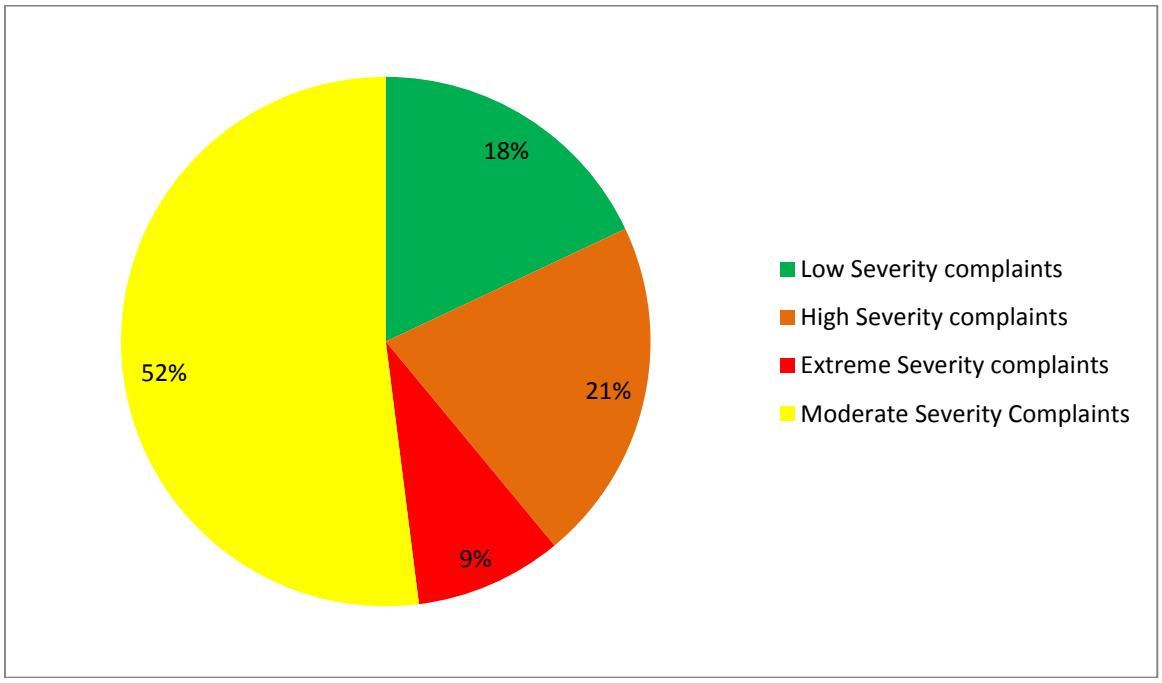
- The top subject of complaint for SAS was Communication, representing 25% of all complaint subjects received for SAS within Quarter 1. Clinical Treatment represented 21% and Patient Care (including Nutrition and Hydration) 15%.

- The top subject of complaint for FSS was Communication, representing 24% of all complaint subjects received for FFS within Quarter 1. Staff – Values & Behaviours represented 18% and Clinical Treatment 17%.

- The top subject of complaint for Community was Staff - Values & Behaviours representing 41% of all complaint subjects received for Community with Quarter 1. Access to Treatment or Drugs represented 18% and Communication 12%.

Severity of Complaints Received

The majority of complaints received in are graded as yellow severity; no lasting harm (52%) in Quarter 1. 9% complaint received were graded Red.



Key: Green – no / minimal impact on care, Yellow – no lasting harm,
Amber – quality care issues/ harm, Red – long term harm, death, substandard care

Red Complaints Data

A red complaint is a case where the patient, or their family, feels the action or inaction of the Trust have caused the death or significant and non-reversible harm to the patient. A complaint may also be graded Red, although the Trust has not caused the death or significant and non-reversible harm to the patient, if the complaint has had a significant impact on patient experience or Trust reputation.

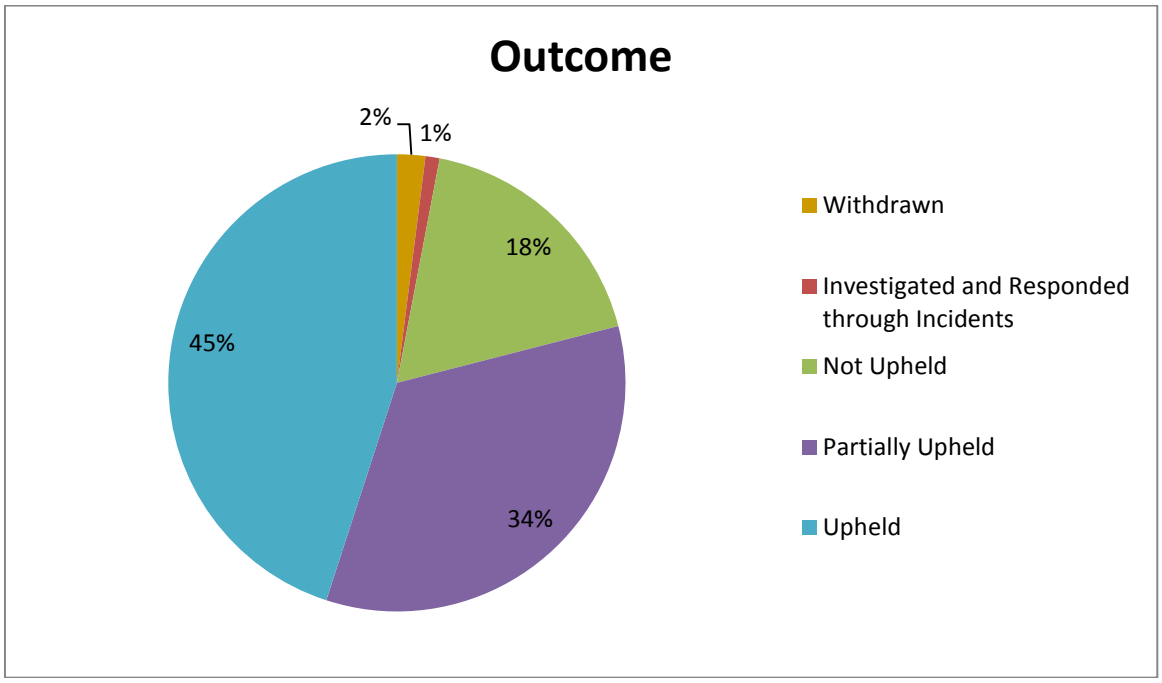
For Quarter 1 of 2016/2017 the Trust received a total of 14 Red complaints, this is a 50% increase from the same quarter last year. Of these 14 complaints 3 are linked to an incident and 1 is linked to a claim.

Acknowledgement Time

1 out the 159 complaints received within Quarter 1 of 2016/17 was not acknowledge within three working days, this represents less than 1% of all complaints received. The complaint was not acknowledge within time as complaints staff needed to find the details for the Next of Kin, to complete the complete the consent form that would that accompanies the acknowledgment.

Complaints Closed

The Trust closed a total of 177 within Quarter 1 of 2016/17. This is a decrease of 12% from the same quarter last year. Of these 177 complaints closed 45% were upheld, 34% were partially upheld (The HSCIC counts partially upheld complaints as upheld complaints so if looked at in this way the figure is 80%), 18% were not upheld, 2% were withdrawn, and 1% of complaints were closed, investigated and responded to through incidents.



Re-Opened Complaints

The Trust re-opened a total of 19 complaints in Quarter 1 of 2016/17. This is 24% decrease from the same quarter last year. The Trust will re-open a complaint for 1 of the following three reasons.

i. Response failed to address all issues and concerns
ii. New issue and concern
iii. Parliamentary and Health Service Ombudsman Investigation

In 2015/16 the Trust undertook a piece of work to improve the overall quality of its responses to complaints so that people received a full and detailed response to the issues they had raised. We introduced a robust quality checking process; the decrease in re-opened complaints would suggest an increase in the quality of complaints responses.
The Trust has developed a Patient Satisfaction questionnaire which will be sent out to complaints responded to in 2016/17. Responses from these will be used in conjunction with the continued monitoring of the re-opened complains to assess the quality of the responses provided by the Trust.

Overdue Complaints

Closing overdue complaints remains a primary focus for the Trust in 2016/17. The total number of overdue complaints at the end of Quarter 1 2016/17 was 44. The number of overdue complaints for the same quarter last year has not been recorded; however, at the end of Quarter 1 2016/17 there has been an increase of 52% from the number overdue from the end of the last financial year.

The breakdown of overdue complaints at year end is as follows:

0 – 1 month overdue: 21 complaints
1 – 2 months overdue: 15 complaints
2-3 months overdue: 7 complaints

3-4 months overdue: 1 complaint

Weekly monitoring reports continue to be provided to divisions to ensure that all cases overdue are clearly identified and timescales for completion of complaints that are due are clear.

Parliamentary and Health Service Ombudsman Complaints (PHSO)

The Trust received a total of 9 complaints in Quarter 1 of 2016/17 for investigation from the PHSO.

By the end of Quarter 1 of 2016/17 the Trust had 17 active cases which the Ombudsman is investigating.

The breakdown of these are as follows:

Division	Directorate	Received	Description
Community	Intermediate and Community	01/04/2016	Failure to provide a Lymphoedema Clinic
SAS	Head and Neck	14/04/2016	Complaint regarding lack of treatment/diagnosis dating back to December 2007
Medicine	Integrated Medical	20/04/2016	Delay in diagnosing brain tumour and communication regarding Lymohoma.
Medicine	Emergency Network	20/04/2016	Care and treatment of patient leading up to their death
Medicine	Acute Medical	16/05/2016	Complainant claimed incorrect medication prescribed which caused Atrial Fibrillation. Inappropriate discharge.
Medicine	Acute Medical	16/05/2016	Dates back to 2013; ambulance failed to arrive to transport patient to x-ray appointment. Patient admitted and died a few days later.
Medicine	Acute Medical	19/05/2016	Daughter concerned her late mother was put on care of dying pathway. Daughter does not feel it was the correct decision and is concerned this was not communicated with her in detail.
Medicine	Acute Medical	24/05/2016	Soup given when nil by mouth so procedure couldn't go ahead. Daughter complains that this affected her mother's medical care
Medicine	Emergency network	14/06/2016	Sub standard care in A&E. Errors in documentation and treatment provided and in discharge information

The red line indicates a complaint graded and managed as a red complaint, i.e. where Trust actions / inactions caused death or significant and non-reversible harm.

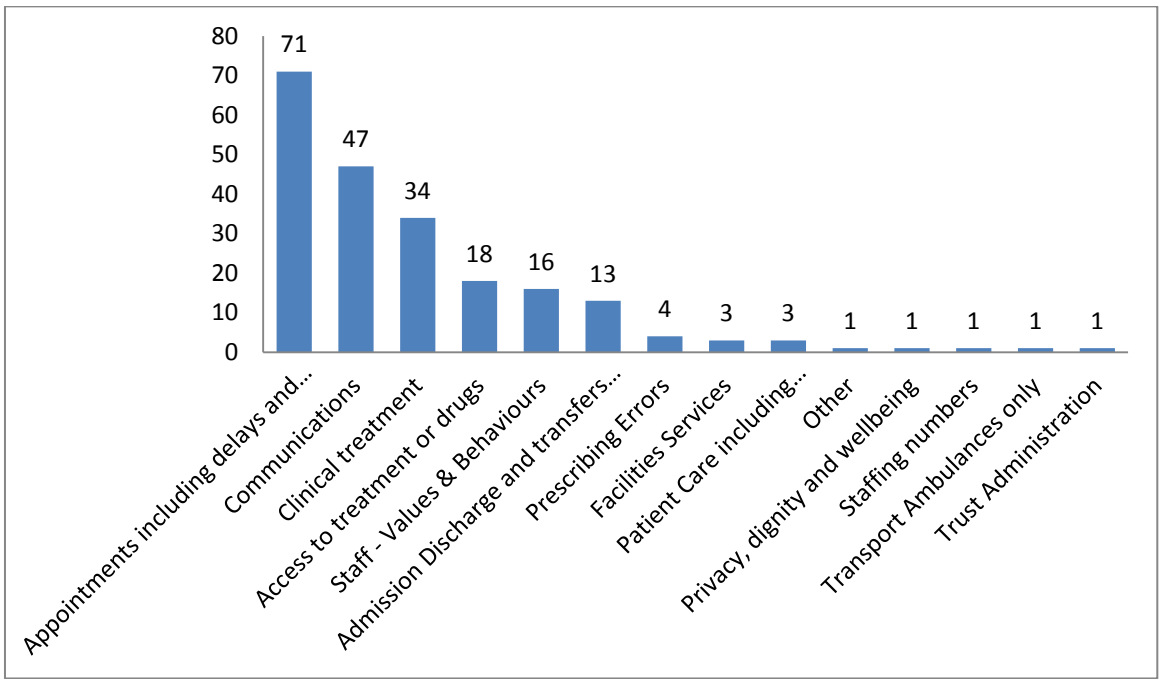
3 PHSO complaints were closed in Quarter 1 of 2016/17; of these 2 were part upheld and 1 was withdrawn. Learning from PHSO cases is given at the end of this section.

Patient Feedback from Other Sources: Concerns, Patient Opinion and Compliments

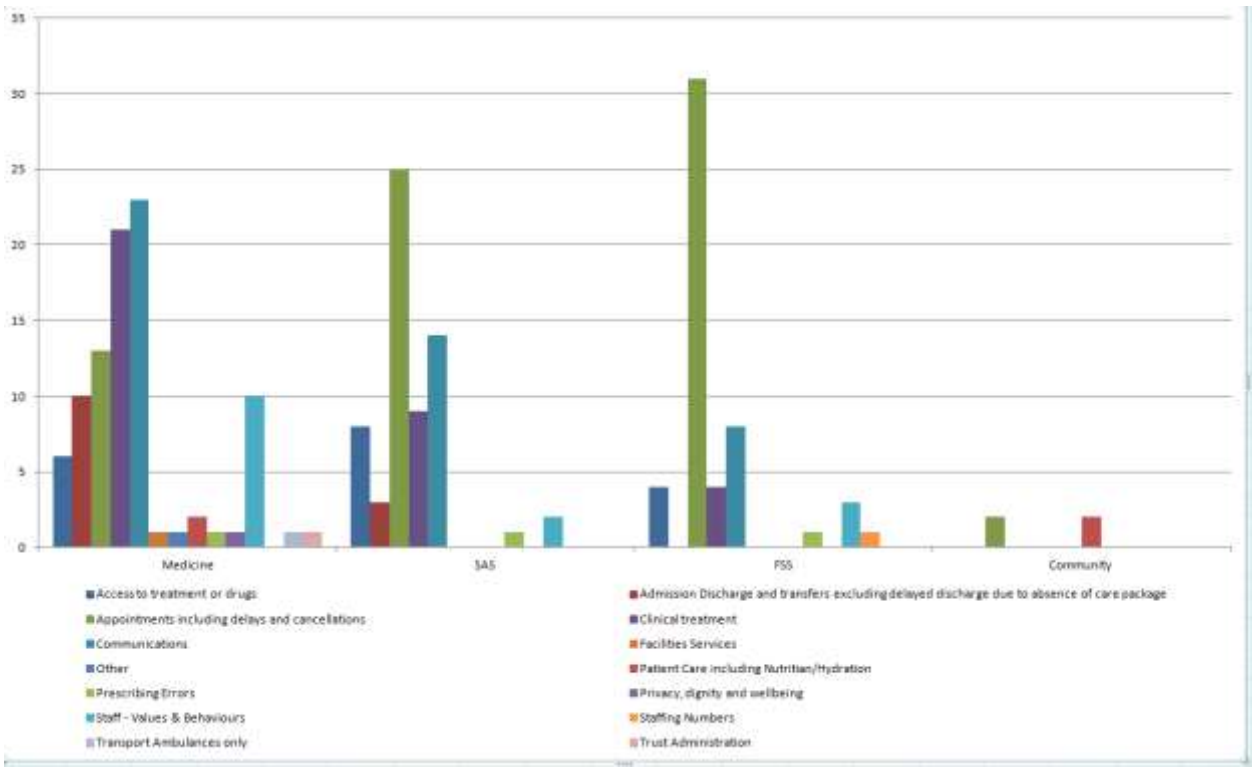
Concerns

The Trust received a total number of 210 concerns in Quarter 1 of 2016/17. Concerns are issues raised by patients or relatives via the Patient Advice Team. There has been a 29% increase in the number of concerns received in Quarter 1 of 2016/17 compared to the same quarter last year.

Analysis of Concerns by Theme



Appointments and Appointments including Delays and Cancellations has dominated the concerns received in Quarter 1 of 2016/17 representing 33% of all subjects. Communication represented 21% and clinical treatment represented 16%.



- The top subject of concern for Medicine was Communication, representing 25% of all

concern subjects received for Medicine within Quarter 1; this was also the top complaint subject received for Medicine within Quarter 1. Clinical Treatment represented 22%, again similar to the second largest complaint subject for Medicine with Quarter 1, and Appointments including Delays and Cancellations 17%.

- The top subject of concern for SAS was Appointments including Delays and Cancellations, representing 40% of all concerns subjects received for SAS within Quarter 1, unlike complaints subjects where Communication was the largest complaint subject received for SAS within Quarter 1. Communication represented 23% and Clinical Treatment) 15%.

- The top subject of concern for FSS Appointments including Delays and Cancellations, representing 61% of all concerns subjects received for FSS within Quarter 1, unlike complaints subjects where Communication was the largest complaint subject received for FSS within Quarter 1. Communication represented 13% and Access to Treatment or Drugs 8%.

- The top subject of concern for Community was Appointments including Delays and Cancellations, representing 66% of all concerns subjects received for FSS within Quarter 1, unlike complaints subjects where Staff - Values & Behaviours was the largest complaint subject received for Community within Quarter 1. Patient Care (including Nutrition and Hydration) 33%.

Whilst Appointments including Delays and Cancellations was top subject of concern in Quarter 1 and the top subject for SAS, FSS and Community, it was not in the top three subjects of complaint, nor was it with the top three for any Division. This would suggest that the majority of these issues are resolved through Patient Advice.

Patient Opinion Feedback 2015/16

Patient Opinion is an independent website about patient's experiences of health services, good and bad. The Patient Advice Team review comments receive and advise people leaving negative feedback to contact the service if they wish to take their concerns further.

Compliments 2015/16
12 compliments were recorded on the Datix risk management system by staff. The numbers below under estimate the number of compliments received by staff, as many compliments are made direct to teams and wards and are not captured in a central system.

The Trust is currently developing a user manual, which will guide ward staff through upload a compliment onto Datix step by step. Once this has been developed and roll out we hope to have a truer reflection of compliments received by the Trust, and use these to prompt learning from good practices.

Division	Number of Compliments recorded on Datix Q3 2015/16 by directorate
Medicine	4
Surgical and Anaesthetics	1
Family and Specialist Services	7

Learning from Complaints
The feedback we receive from complaints gives the Trust a wealth of information that can be used to improve services as an individual complaint provides detailed insight into a patient's experience.

As an organisation we aim to ensure that we learn from complaints so that we can:

- Share good practice
- Increase patient safety
- Improve the patient experience
- Reduce the number of complaints

Our complaints process includes identifying learning from each complaint and sharing this and each service and division is required to be clear:

- How the services records learning from complaints
- How this learning is disseminated within the service / directorate / division
- How it can point to changes arising from learning from complaints

Information on learning from complaints for each division is given below.

Learning:

Medicine	
- Giving the patient incorrect technical information.	- Small errors in wording can lead to confusion and stress for the patient. - Response letters to be over read by specialist in that area to ensure technical information is correct and to review how it will sound to the patient.
- Inadequate level of support and follow-up instructions given in Emergency department	- Staff are ill prepared/trained to do adequate discharges in an area where they usually do not discharge patients. - Training regarding the discharge process for all staff in the area.
- Family felt that the wrong information/ diagnosis was given about their loved one. Doctor stated stroke, nurse stated TIA.	- Patients and their families can be confused by different definitions given for one condition. - Explained both definitions, which without correct assessment, present in exactly the same way in the majority of cases and assured that both definitions were correct.
- Investigations were not performed and a diagnosis was missed as a result.	- Patient stated that they had already had an investigation however this was not followed up. - To repeat investigations if results cannot be verified.
- Lack of perceived input from the clinical team with regards to changes in patient's skin condition	- Improved communication between clinical staff and families following examinations and reviews to ensure the family and patient are aware that that their concerns have been acknowledged and addressed. Comprehensive clinical documentation in patient's clinical records regarding changes in patient's skin condition's needed.
- Delay in prescribing medications	- This would have ensured that the patient received the appropriate treatment for recent eye surgery. - Medical staff need to be more vigilant when taking drug history and nursing staff need to be more proactive in ensuring medications are transcribed once alerted that they have been omitted.
- Patient did not have a bath or shower while on ward	- In this instance the patient had the capacity to be able to make this decision however documenting clearly will evidence the offers made to patients and also include alterative

	options for hygiene needs to be met. - To ensure that staff are aware to inform family if needed they can support with this.
- No follow up appointment made with the appropriate consultant	- This would have ensured that the patient received the follow up care that was required. All staff are having clear training on leaving the correct information to the ward clerks to ensure they can send copies of discharge letters on that are needed
- Patient was found off the ward causing distress for patient and family	- Staff to be more vigilant with checking on patients if needed. - If the patient is confused may need to consider DOLs. Will help support staff to ensure patient who are confused and lack capacity may require 1:1 care or increased visual checks
- Confidentiality policy not adhered to as patient diagnosis was discussed at a handover within the hearing of patients and visitors to the department	- To ensure that all handovers are completed using nervecentre technology and that diagnoses are not verbally referred to at patient's bedside.
FSS	
Emergency LSCS for failure to progress at 5cm. Epidural top up ineffective, Remifent given. - Unable to deliver baby - delivered as breech in poor condition, no respiratory effort, full resuscitation given and transferred to SCBU.	- Escalation to Consultant where necessary for all surgical procedures in a timely manner. - Importance of keeping the anesthetist informed of progress and complications - Learning from experience newsletter to remind staff about timely summoning of consultant paediatrician in a timely manner. - Findings to be presented at Perinatal Mortality Meeting
- Delay in admission for undiagnosed breech presentation. - Baby born in poor condition.	- It is crucially important to listen to what the woman is telling us - Health care staff should keep the woman the focus of care - If a woman is unhappy with the clinical advice she is given this should be escalated and dealt with immediately
Following up an anomaly with final rinse water results from the Nasendoscope washer disinfector; it was discovered that there was a series of process failures associated with the decontamination of the scopes	Prior to implementation of new equipment that require decontamination: a. An operational policy should have been in place b. Clear, user friendly Standard Operating Procedures for the various elements of the task should be in place c. Staff should be trained to follow these SOP's and have documentary evidence of training and competence in them d. Documentation to support traceability at each critical point of the process should be in place with a planned audit schedule prior to implementation of the new equipment.
- high risk pregnancy, uterine fibroids.	- This woman had a large uterine fibroid but

- Attended for augmentation in view of spontaneous rupture of membranes Prostin administered at 01 50, CTG following classified as reassuring, therefore discontinued at 02:59. - Reports to have been contracting frequently. Care taken over on day shift, history noted, planned for CTG monitoring, unable to locate fetal heart rate, escalated this to shift coordinator and registrar. Portable scanner used by registrar, still unable to locate fetal heart. Transferred to main scan room to be scanned by sonographer. IUD confirmed on scan.	growth scans were discontinued at 36 weeks. - Fundal height palpation (which plotted on the 90th centile) was inappropriate in this case. i. Fetal growth scan should have been continued until delivery. ii. Offer immediate augmentation for term SROM as per NICE and our guidelines.
Unexpected stillbirth at Emergency Caesarean Section in maternity theatre	- CTG interpretation was incorrect in the last hour - The category of Caesarean section declared and documented was incorrect reflecting - the lack of urgency - Misinterpretation of the fetal growth based on the last scan as well as incorrect SFH - Measurement after the scan which would contribute to the compromise in reserves - This was an IVF pregnancy which has an increasing risk of Small babies and a two to four fold risk of stillbirth

Key National Publications

Parliamentary and Health Service Ombudsman - A Report of Investigations into Unsafe Discharge from Hospital, May 2016

The report focuses on nine experiences drawn from recent complaints the Parliamentary and Health Service Ombudsman investigated, which best illustrate the problems they are seeing.

People told the Parliamentary and Health Service Ombudsman how their loved one's traumatic experience of leaving hospital, including repeated emergency readmissions, added to their pain and grief. One woman captured the sentiment of many, saying she would be 'haunted for the rest of her life' by her mother's avoidable suffering before her death.

The Parliamentary and Health Service Ombudsman identified four areas of concerns which were:

1. Patients being discharged before they are clinically ready to leave hospital
2. Patients not being assessed or consulted properly before their discharge
3. Relatives and carers not being told that their loved one has been discharged
4. Patients being discharged with no home-care plan in place or being kept in hospital due to poor co-ordination across services

The Trust is doing a piece of work to look into these issues, which will be present at the Patient experience group.

Claims

CLINICAL CLAIMS

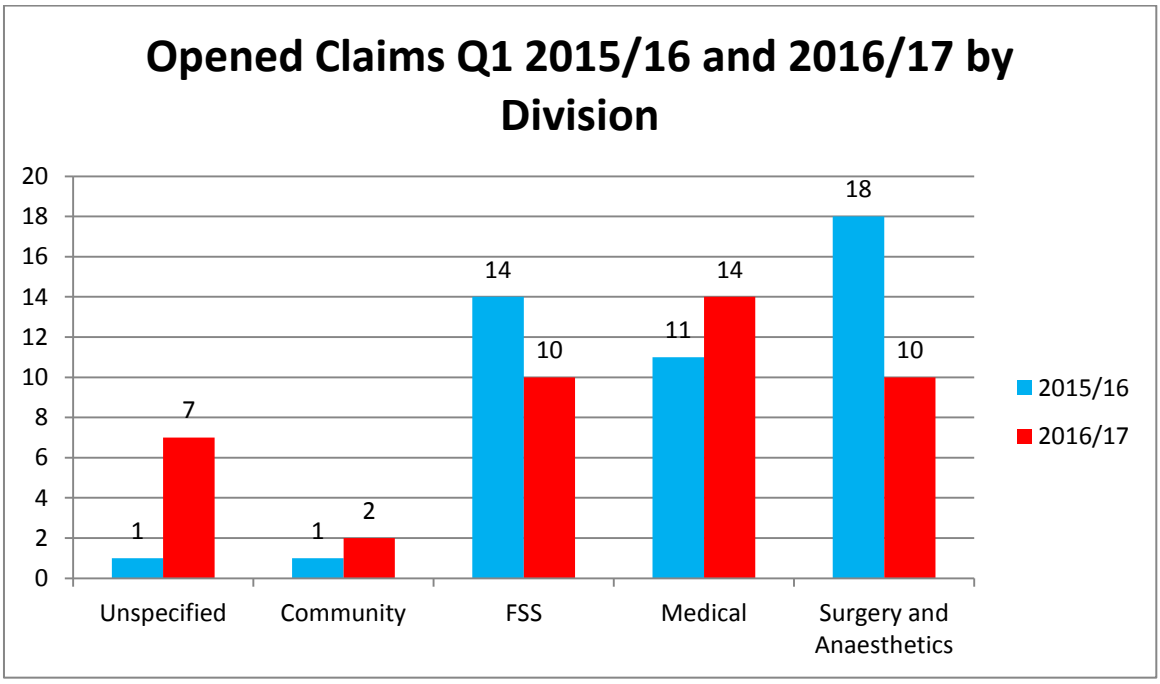
During the last 5 financial years up to 30 June 2016, CHFT has opened 874 new clinical negligence claims. Nationally NHS Trusts have seen a sharp increase in the number of clinical negligence claims brought.

Opened Claims

In Q1 2016/17 43 new clinical claims were opened. In the same quarter of 2015/16 45 new claims were opened. This represents a small decrease of 4.4%.

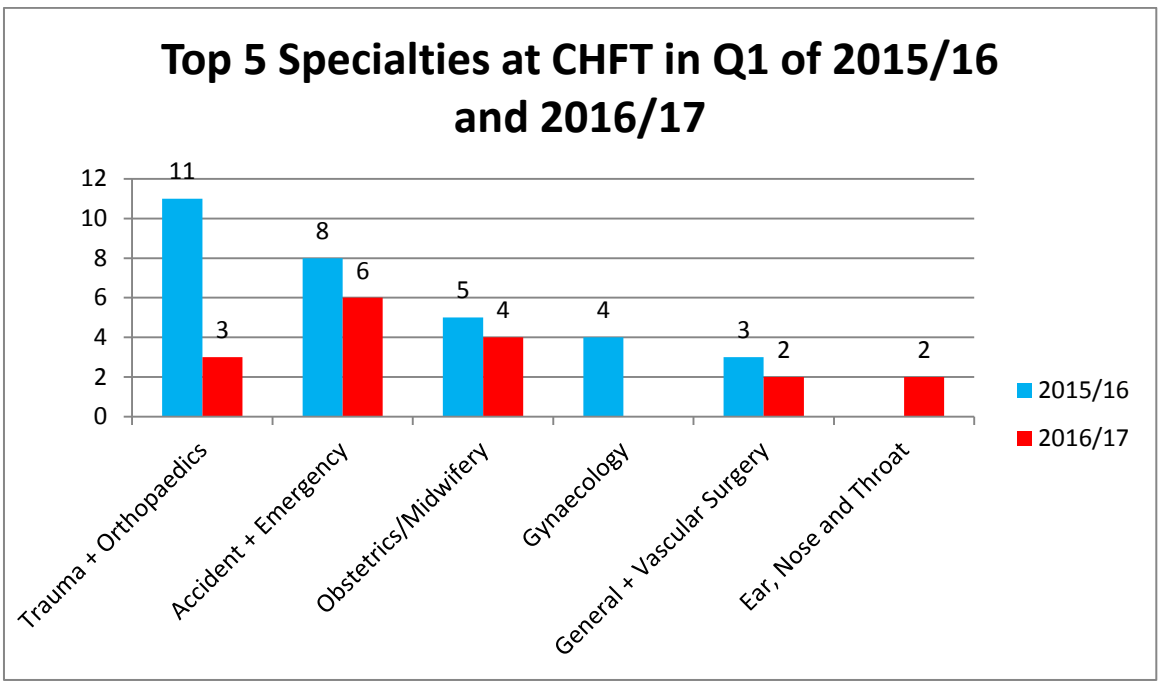
Opened Claims by Division

The graph below shows the number of opened claims over the comparable quarters by Division during Q1 of 15/16 and 16/17. Notable trends show a decrease in FSS from 14 to 10 claims (28.5%) and a large decrease in Surgery and Anaesthetics from 18 to 10 claims (44.4%).
Of note is the large number of claims in Q1 of 2016/17 which are unallocated to a division. It is not uncommon for claimant solicitors not to specify the nature of the claim despite the Legal Services Team asking them to specify the nature of the intended claim in line with the Clinical Negligence Protocol.



Claims Opened by Specialty

The Top 5 specialties at CHFT for Q1 of 2016/17 and 2015/16 are detailed below.



Trauma and Orthopaedics have seen a marked decrease from 11 to 3 claims (266%) in the last year. A+E, Obstetrics and Midwifery and General and Vascular Surgery have seen small decreases in the number of claims whilst still remaining in the top 5 specialty claim types for both quarters.

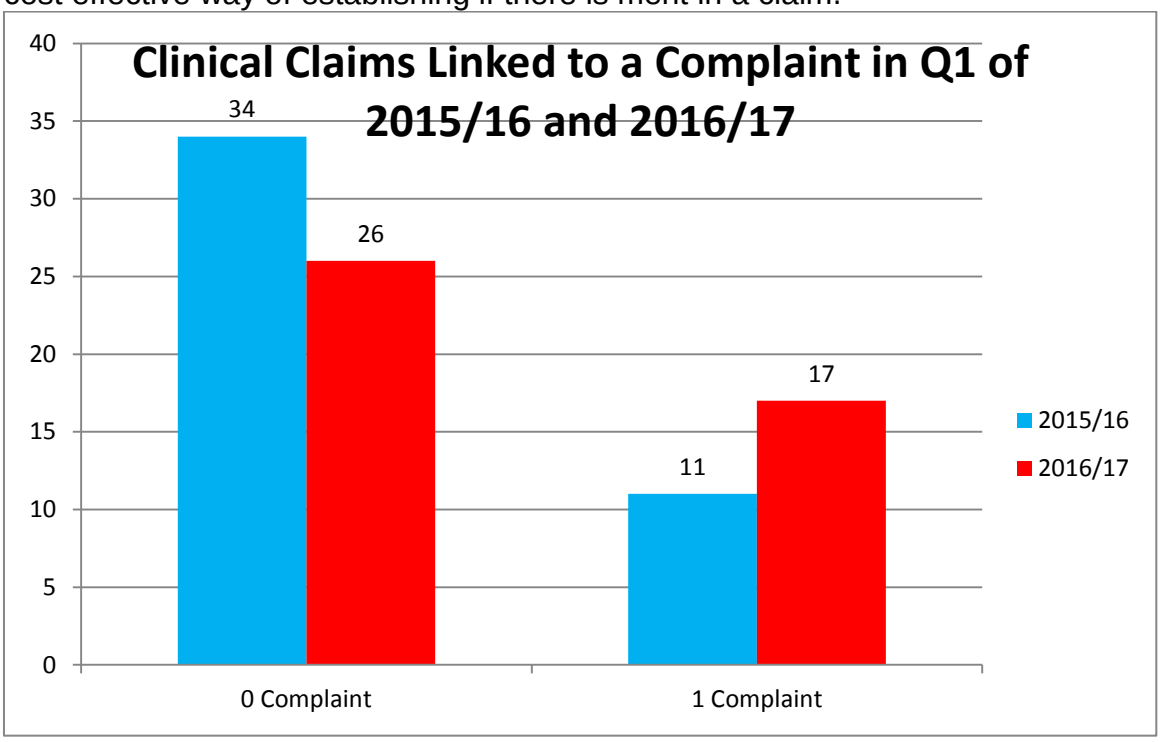
Ear, Nose and Throat have newly entered in to the top 5 of claim specialty in 2016/17 with 2 claims. Looking at these claims in more detail they relate to:

a) One claim relates to an alleged delay in diagnosis of throat cancer. The case is at the disclosure of medical records stage and comments will be obtained by our staff;

b) One claim relates to the alleged negligent fitting of a hearing aid. The medical records have been disclosed on this matter.

Claims Linked to Complaints

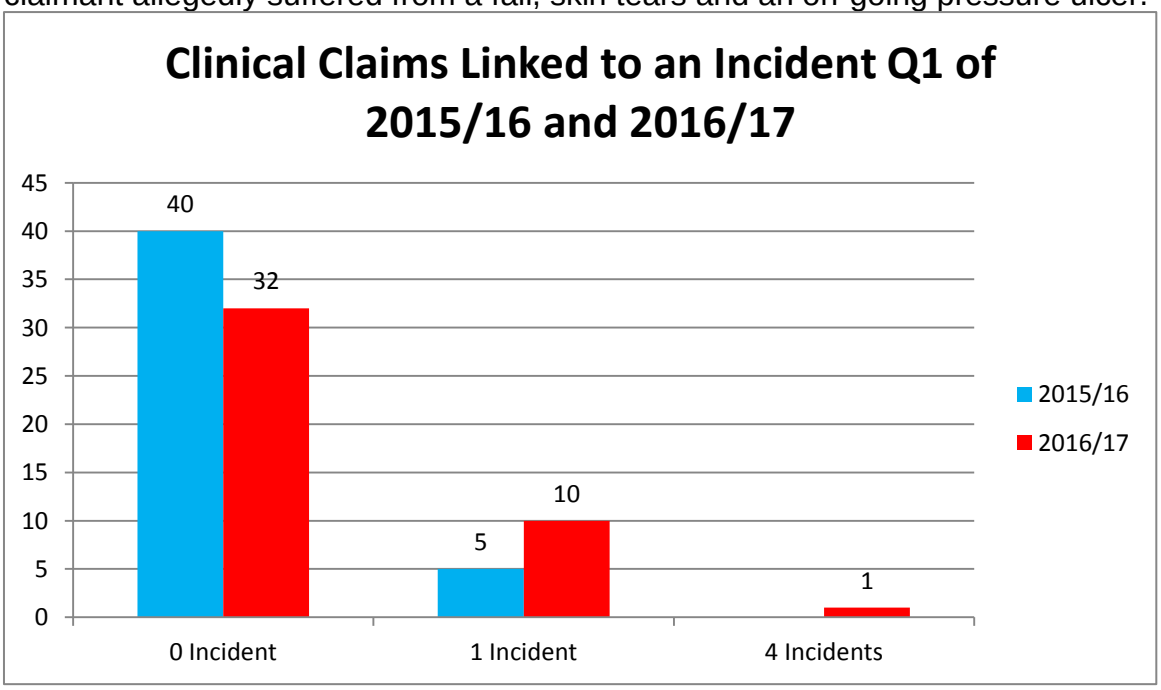
The bar graph below shows that in2016/17 17/43 (39.5%) claims were linked to a complaint. In the same quarter of 2015/16 11/45 (24.4%) claims were linked to a complaint. This shows a marked increase over the last two quarters. One reason for this is that pursuing a complaint is a cost effective way of establishing if there is merit in a claim.



Claims Linked to Incidents

The bar graph below shows the number of claims linked to an incident. In Q1 of 2016/17 11/43 (25.5%) of claims were linked to at least 1 incident. In Q1 of 2015/16 5/45 (11.1%) of claims were linked to an incident.

The claim linked to 4 incidents relates to treatment from 2 June to October 2015 during which the claimant allegedly suffered from a fall, skin tears and an on-going pressure ulcer.



Closed Claims

In Q1 of 2016/17, 14 claims were closed. Of the 14 claims that were closed 7 claims (50%) closed without any payments being made. Of the 7 claims that closed with payments, the highest payment was from Medicine Division for £148,380 (comprising of £40,000 damages, £95,000 claimant costs and £13,380 of defence costs) for a failure to diagnose a left hand scaphoid fracture.

In Q1 of 2015/16, 20 claims were closed. 10/20 (50%) closed without any payments being made. The remaining 10 closed with a payment being incurred.

Learning from Claims

Claims that closed between 1 January 2016 and 1 June 2016 resulting in a payment of damages to patients and staff have been circulated to the divisions for them to action and evidence what has and will be done to prevent or minimise a recurrence. A summary is provided below.

CWS	Management of breech delivery
CWS	Alleged failure of adequate obstetric care resulting in a still birth
DATS	Failure to diagnose Quadriceps muscle damage
DATS	Failure to diagnose fracture of Ankle
Medical	Failure to diagnose severed tendon in hand
Surgical & Anaesthetics	Failure to implement gall bladder pathway resulting in death
Medical	Slip on floor in hydrotherapy pool area
Medical	Patient assault injury to hand

EMPLOYEE AND PUBLIC LIABILITY CLAMS

During the last 5 financial years up to 30 June 2016, CHFT has opened 110 new employee and public liability claims.

Opened Claims

In Q1 of 2016/17 7 new claims were instigated against CHFT. In Q1 of 2015/16 6 claims were brought.

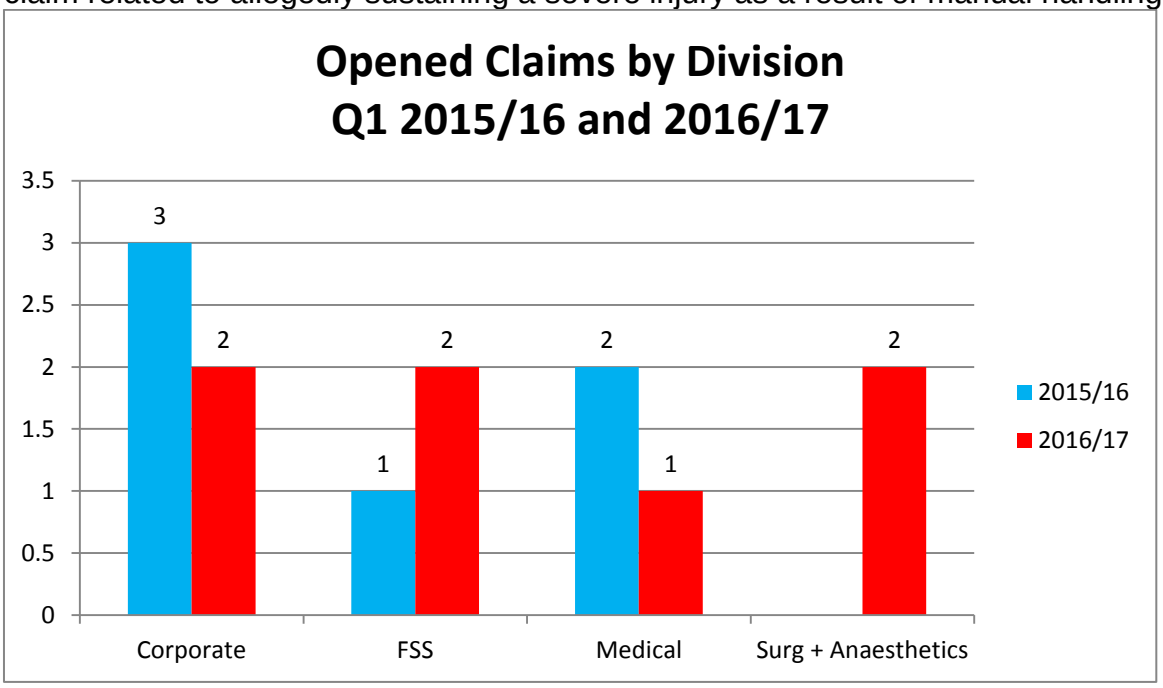
An extract of the claims descriptions brought in Q1 of 2016/17 is provided below.

Ref	Description (Policies)
PL CLAIM	Incident occurred on 1st floor of Acre Mill of Female Public Toilet in disabled toilet cubicle Patient used it between 16.10-16.15 hrs Apparently no witnesses she was using toilet and wanted to exit and pulled the door open and door fell off its hinges and hit her left Arm ? also shoulder as she tried to push it off herself and pushed the door back and lent it against wall so that she could exit Toilet. She then went to Nurse in ENT who she first met to tell her also what had happened.
PL1	Claimant's fingers trapped by an electrical recliner chair in the WEEE compound CRH
2989	Claimant walked into theatre 2 and she went to get a phone base and the boom that the gases come down through had been left down and not pushed back up to the ceiling and the Claimant walked into the boom and banged her head and was knocked to the floor as a result of this incident.
2946	The Claimant is a driver. He was making a delivery on behalf of his Employer, Polar Speed Distribution Ltd, when he slipped on pieces of broken black plastic that were littered on the floor of the parking area to the loading bay. He fell heavily to the ground.

2967	Slipped on wet floor in scrub room. Tried to prevent myself from falling but went down on my left knee and on my right hand.
2948	Claimant's statement verbatim on EL1 Form: "Due to the way the ward was on the day i had no choice but to move a demanding patient onto a slipper pan by myself...as i turned the patient i felt my left elbow give way.... thinking that it was a pulled muscle i continued to work after reporting the incident to the qualified member of staff that was on duty with me....i know i shouldn't off moved him but the patient declared that he would defecate the bed if i didn't.....and that would of taken three members off staff to deal with said patient... And at the time off the incident they were not available...."
2999	Whilst getting trolley cleaned down in wash up area near waste food bin slipped on the floor and fell down on left hand side of body left buttock, Shoulder, arm and elbow. Slipped on custard that had been spilt on the floor. Area had been signed with a slippery floor sign.

Claims by Division

The graph below shows the number of opened claims over the comparable quarters by Division during Q1 of 16/17 and 2015/16. The claims relating to Corporate Division come from the Estates and Facilities specialty. In 2016/17 3/7 (42.8%) of these claims related to a slip and 1/7 (14.2%) claim related to allegedly sustaining a severe injury as a result of manual handling.



Claims Linked to Incidents

In Q1 of 2016/17, 5/7 (71.4%) claims were linked to an incident. In Q1 of 2015/16, 4/6 claims were linked to an incident. If a claim is not linked to an incident the Trust has the possibility of a reasonable defence.

Closed Claims

In Q1 of 2016/17 4 claims were closed. ¼ claims closed with a payment of damages to the claimant (a staff member). The claim relates to a failure to provide extra staff for a known aggressive patient who subsequently assaulted the staff member. The damages payment was £7,500, defence costs £9,300 and defence costs were £480. The remaining 3 closed without any payment of damages or costs.

In Q1 of 2015/16, 3 claims were closed. 1/3 claims closed with a payment of damages to a staff member which was lodged against Surgery and Anaesthetics. This was for a needlestick injury. The damages were £1,500, claimant's costs were £1,080 and defence costs were nil. 1 claim closed without any payments and 1 claim closed with defence costs only.

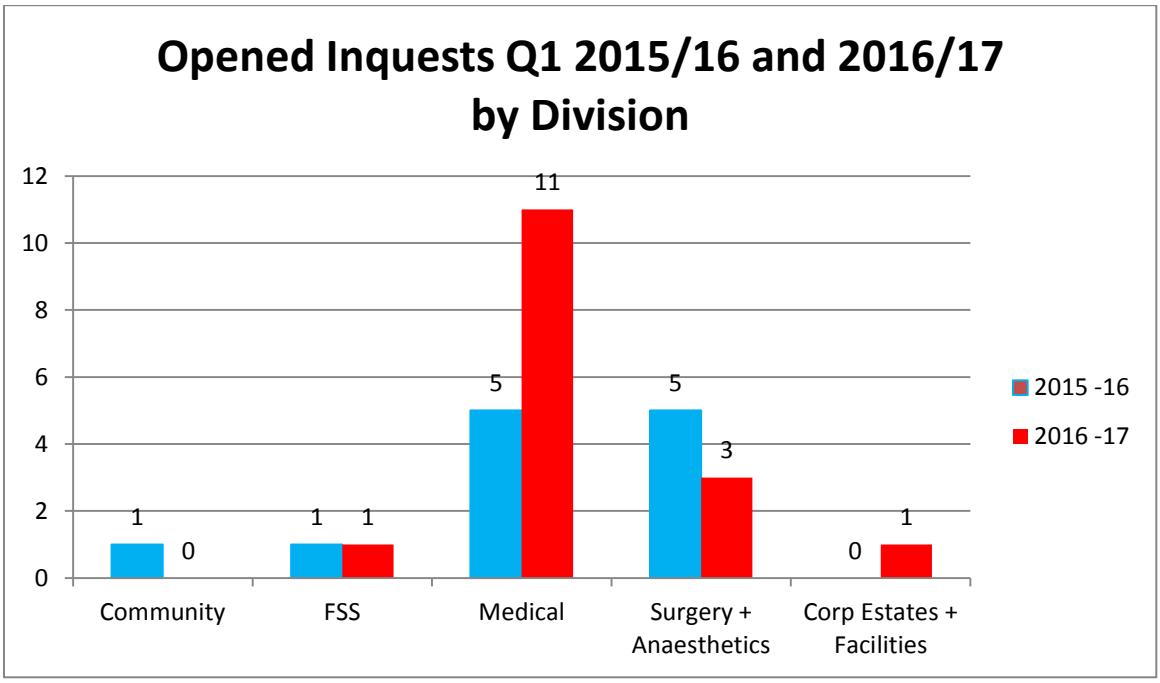
INQUESTS
As at 30 June 2016 the Trust opened 54 inquest cases. An inquest by HM Coroner is held where here is a concern that the patient suffered a violent or unnatural death, or if the cause of death cannot be ascertained, and by a post mortem.

Opened Inquests

In Q1 of 2015/16 12 new inquests were opened. In Q1 of 2016/17 16 new inquests were opened. This represents an increase of 33.3% in the corresponding quarters.

Opened Inquests by Division

The graph below shows the number of inquests opened by each division in Q1 over the last two financial years. Notable trends are that Medicine has seen a 120% increase in the number of inquests from 5 to 11 inquests over the corresponding quarters.



Looking at the 11 opened inquests for Q1 of 2016/17:
4/11 (36.3%) relates to A&E but of note is that 2 of these 3 relates to fatalities pre-dating admission to CHFT.
3/11 (27.2%) inquests relate to Acute Medicine.
1/11 (9%) relate to Cardiology; 1/11 relate to elderly care; 1/11 relate to Rheumatology; 1/11 relate to Short Stay.
Of particular note is that 5/11 (45.4%) of the above inquests are related to a fall sustained whilst being treated at CHFT hospitals.

Closed Inquests and Learning

In Q1 of 2015/16 7 inquests were closed. In the same quarter of 2016/17 5 inquests were closed. They are detailed below.

Where there is a robust investigation with evidenced actions on how the incident (giving rise to the death) can be prevented HM Coroner is less minded to issue a Regulation 28 report.

ID	Description	Determination (at Inquest) and Learning
2740	Died on Ward 5d CRH following admission. Patient admitted due to self-neglect and burns. DoL in place and Safeguarding Alert raised at time of death.	INQUEST OUTCOME: NATURAL CAUSES Actions from investigation on-going. HM Coroner applauded CHFT for thorough incident investigation.
2772	Died following reaction to cement inserted to repair hip fracture. Reported to HMC as died within 24 hours of procedure. Statements obtained from 2 x staff plus investigation report sent to HM Coroner.	Narrative verdict reached. Paper Inquest held on 26/2/16. No witnesses called as there were no issues to resolve.
2690	Male was admitted to Calderdale Royal Hospital on the 3rd June following a collapse at home. He remained overnight. Examination showed air under the diaphragm in keeping with spontaneous bowel perforation. High mortality rate discussed and agreed with the patient prior to consent. He was transferred to Huddersfield Royal Infirmary on 06/06/15 and taken to theatre on 07.06.15. At operation, two perforations in the small bowel were identified and a 20cm segment of bowel was removed. There was no evidence of necrosis. The operation was successful and he was taken to the ICU for the following two days. On the 12th June he developed diarrhoea possibly thought to be due to antibiotics but then rapidly deteriorated. It is unclear whether there was an anastomotic leak or bowel ischaemia. He died on 13.06.15.	Misadventure. No further learning for CHFT. CHFT staff commended by HM Coroner and the family.
2667	Safeguarding concern raised by Nursing Home re decision to discharge in early hours of morning readmitted	INQUEST OUTCOME: The verdict was a narrative verdict which essentially sets out the

	same day 3.5.15 with chest symptoms, subsequently died 11.5.15. A Safeguarding and incident investigation took place. Issues regarding loss of IV access and aggressive behaviour were investigated.	circumstances. The Trust is required to write to the Coroner to set out the lessons learned regarding their involvement with the patient arrangements to make to avoid future miscommunications with the home and other similar care homes Response provided to HM Coroner on 16 June 2016 setting out the integration process Pose a Risk Documentation that is to be incorporated before December 2016.
2784	Preliminary cause of death is sepsis. Safeguarding Referral to Police led to Forensic PM. Inquest is not listed and case is closed. Awaiting formal notification from HM Coroner as at 16/3/16 and 29/03/16.	No inquest hearing.

One inquest that was concluded in the Quarter 4 of 2015/16 but from which the actions were ongoing in to Q1 of 2016/17 and concluded was the inquest of a patient who had had a GI bleed and died after transfer from CRH to HRI, following which CHFT received a Prevention of Future Death (PFD) letter from HM Coroner.

A PFD letter is issued by HM Coroner who is now under a duty (no longer discretion) to issue the same where they consider that a future death can be prevented.

The detail is provided below:

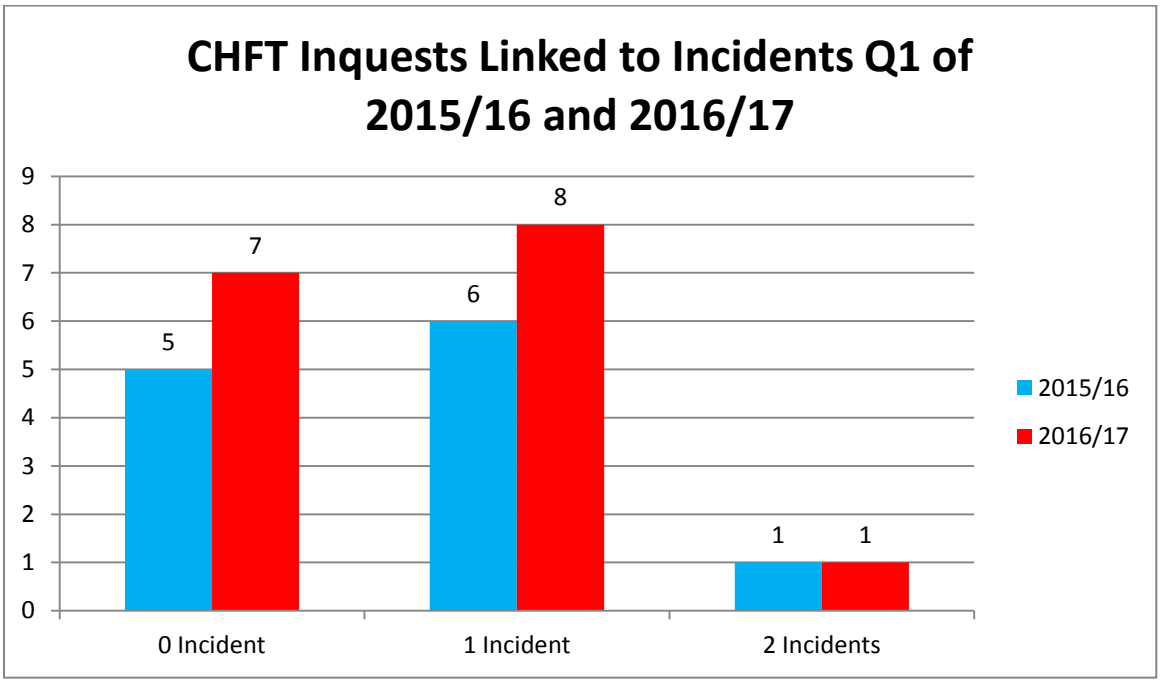
ID	**Description**	**Determination (at Inquest) and Learning**
2542	Patient under GI bleed protocol bled prior to transfer to CRH and was unstable - patient deteriorated and died on arrival. The Trust was criticised for its management of the suspected GI bleed that she presented with and the transfer arrangements. Had the patient been transferred before the afternoon of 16 December 2014, she would in all probability have survived the GI bleed she suffered from.	PFD response received with 7 specific points for CHFT to address. Detailed action plan (with evidence) including the roll out of the new GI Bleed Protocol Trust wide and documentation process for all staff submitted to HM Coroner.

Inquests Linked to Incidents and Complaints

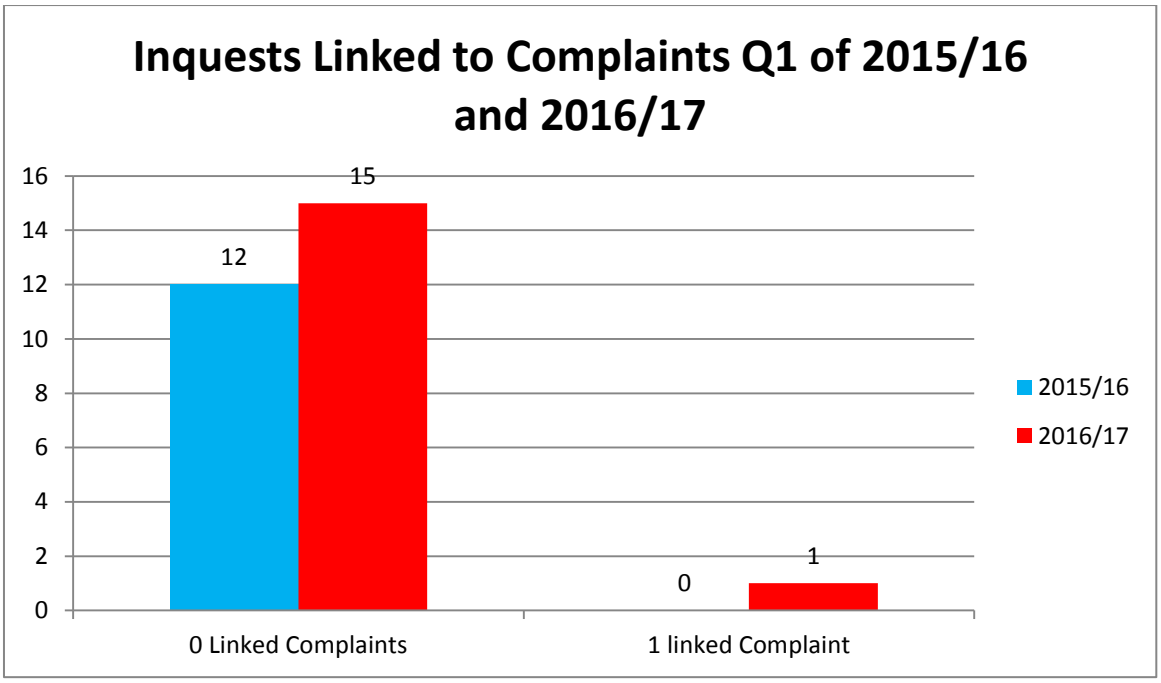
The Legal, Complaints and Investigations teams are triangulating data from their respective areas to highlight and action where inquests are related to incidents and complaints so that better family, Trust and coronial engagement can take place.

Often families will use the inquest process as a vehicle to air their concerns where a complaint could have resolved the issues that they have. Relationships are being forged to assist HM Coroner where our Trust can dispense with issues that relate to a complaint.

The graph below shows that in Q1 of 2015/16 7/12 (58.3%) inquests were linked to at least 1 incident. In the same quarter of 2016/17 9/16 (56.25) of inquests were linked to an incident.



In Q1 of 2015/16 no inquests were linked to a complaint.
In Q1 of 2016/17 1/16 (6.25%) inquests were linked to a complaint.



4.2 Appointment Slot Issues (ASI)

Background

E-Referral

In order to understand the difference between national e-referral data and the CHFT reported position, a review of the April 2016 ASI position has been undertaken (the available data is 2 months in arrears).

In the month of April,1159 patients were unable to book an appointment at the first attempt and were “deferred to provider” for booking. The data confirms that 531 (46%) of these patients were allocated appointments on the same or next working day. Excluding these patients who were given an appointment within 24 hours reduces the Trust’s ASI position for April to just 8%. This is a month on month improvement (February 39% and March 40%)

April 2016 data

1159	Total ASI's
531	Total booked next working day
46%	**% resolved next working day**

The elements supporting next day resolution are predominantly additional capacity becoming available through the nightly harvesting of slots (booked via the national telephone line or e-booking system), or lifting of the waiting time bar by the Appointment Centre where the numbers of ASIs are small and will not impact on the referral to treatment pathway.

Trust Current Position

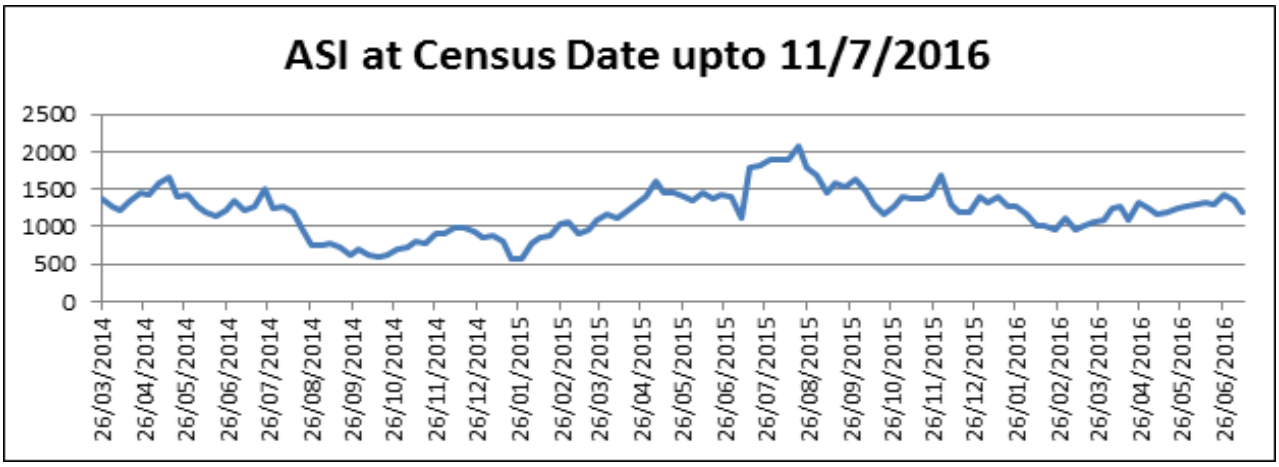
As at the 15 July there were 1050 referrals awaiting appointment of which 343 are e-referrals. This is a reduction of 774 referrals from the 22nd July 2015 position of 1824.

By way of illustration the average number of daily bookings via the e-referral service is 200. Assuming a current Trust ASI rate of 16%, this 200 can be summarised as follows:

- 168 patients get an appointment at the first time of asking (84%).
- Of the 32 patients who do not get an appointment at first time of asking 15 of these are successful within 24 hours
- The remaining 17 patients see a delay in getting an appointment with the Trust >1 day and would be placed onto the Trust’s ASI list and managed in line with the process set out.

- It should be noted that of the 8% of patients who do not get an appointment within 24 hours, more than half of these referrals will be ERS and therefore the referral cannot be seen until an appointment is given.

- The longest wait for an e-referral appointment being from March 2016 (4 months), in the specialties of Colorectal Surgery, Respiratory. The average wait for those unable to get an appointment and still on the waiting list is 30 days. A minimal number of ERS ASIs relate to the system being unavailable (16 in April), but the majority relate to a lack of immediate capacity.



The inability to place a patient into a clinic appointment at the first attempt results in a disruption to the patient's pathway and can also result in a significant amount of rework within the system in attempting to create additional clinical capacity within a necessary short period of time.

No patients should wait beyond the maximum waiting time to be seen by specialty. However the current ASI position regularly results in patients waiting beyond the recommended 6 (urgent) and 11 (routine) days for an appointment to be offered.

All paper referrals are triaged by Consultants as part of the registering process, however, triage of referrals received via ERS cannot be undertaken until an appointment has been allocated. This means that any reclassification of priority cannot be determined until an appointment is allocated

Capacity Requirements (as at 15th July 2016)

The table below shows the number of patients waiting for appointment by time band :

	Ophthalmology		Total	Colorectal Surgery		Total	Cardiology		Total
Row Labels	ERS	Paper		ERS	Paper		ERS	Paper	
0 Weeks	15	2	17	12		12		1	1
1 Week	17	4	21	6	5	11		5	5
2 Weeks	6	25	31	10	7	17		22	22
3 Weeks	9	16	25	12	8	20	2	31	33
4 Weeks	1	25	26	11	12	23	9	19	28
5 Weeks	1	3	4	16	6	22	2	14	16
6 Weeks	2	8	10	17	17	34		21	21
7 Weeks	2	22	24	11	7	18		20	20
8 Weeks	8	23	31	14	7	21		5	5
3 Months	16	60	76	17	23	40	4	34	38
4 Months		10	10	2	12	14		1	1
5 Months		2	2	1	5	6		1	1
6 Months		1	1		1	1			
Grand Total	**77**	**201**	**278**	**129**	**110**	**239**	**17**	**174**	**191**

ASI Reporting and Validation

The Waiting List is managed centrally by the Appointment Centre; Appointment Slot Issues are added daily from the E-Referral Service (ERS) report of patients unable to book an appointment, and the list of paper referrals unable to book.

The daily report is filtered by specialty by the Appointment Centre, in non-problem specialties, and for small numbers of ASIs, the waiting time bar is lifted (on the day of receiving the ASI) in order to allocate an appointment. The remaining ASIs are forwarded to the specialty leads in the clinical divisions for action. On receipt of additional capacity (which can take days/weeks), contact is made with each patient in chronological order, and appointments booked.

Currently the ASI list is contained in a spreadsheet, which is both labour intensive and not designed for the current volumes of ASIs. A database is under production, to enable real time management and reporting.

Action Plan

The clinical divisions (at divisional Access meeting) regularly review current clinic capacity v demand in order to evaluate where there are / will be any capacity pressures. A gap analysis is undertaken at specialty level and shared with the operational managers for action.

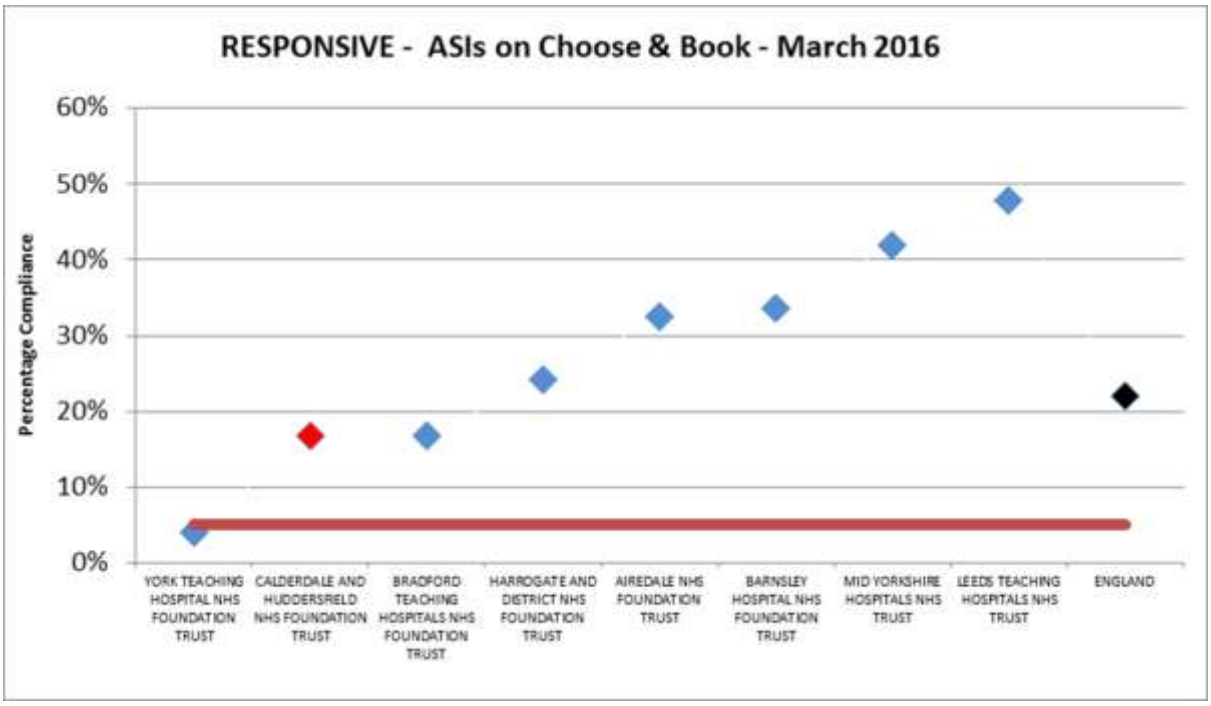
Capacity and demand modelling is an integral part of the Access meeting and the Information Team regularly discuss with service leads in order to ascertain any pressures. Additionally they report on referral demand monthly by specialty, as any growth over contract will also cause a pressure on the ASI.

Current ASI Action Plan (appendix 1) which has been developed to reduce the current ASIs and maximise slot availability, and provides a timeline to improve the ASI position in those specialities which are currently most challenged.

Monitoring of the Action Plan takes place via the weekly Performance Meetings and progress reported to the monthly Divisional Business Meetings.

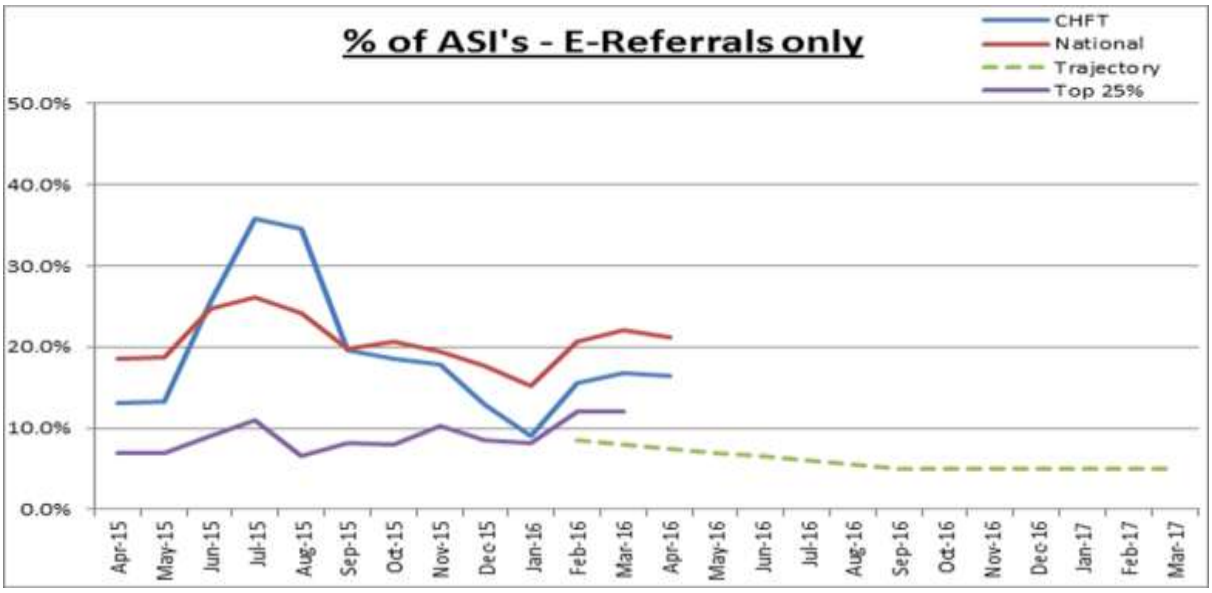
Benchmarking

The graph below shows the E-referral ASI position in comparison to other local Trusts. Contact has been made with York Trust to understand the excellent ASI position (4%), which we now appreciate is achieved through extending the polling range for appointments beyond the 18 weeks ceiling. Incidentally, York's 18 weeks non admitted RTT performance is 95% and admitted 70%, in comparison to 86% and 98% at CHFT.



Trajectory

The graph below shows the proposed trajectory to recover the ASI position based on the actions described above. It is anticipated that the ASI position of <5% will be achieved by September and will be monitored thereafter via the Performance and Outpatient Productivity Divisional Challenge meetings.



Recommendations

The following actions are proposed in order to reduce ASIs to the 5% threshold and ensure patients are seen in a timely manner, and any delays to treatment are within a clinically acceptable timeframe:

- Clinical Divisions to concentrate efforts on reducing ASIs in the on top 4 specialties of Colorectal, Respiratory Medicine, Ophthalmology and Cardiology as the combined specialties represent 80% of the total waiting list.
- Clinical Divisions to review capacity and demand plans to minimise future ASIs.
- Clinical Divisions to support delivery of a Trust maximum standard of 11 working days from appointment identification to allocation to minimise impact on patient experience.

4.3 Patient Flow

A number of patient flow indicators are reported through the Trust's IPR and Divisional Performance Review.

A full report into Patient Flow, inclusive of A&E quality performance, is in development and will be available from Q2.

Domain Five – Well Led: The Leadership, management and governance of the organisation assure the delivery of high quality person centred care, supports learning and innovation and promotes an open and fair culture.

Well Led Compliance summary:

Indicator	Compliance
5.1 Safe Staffing	Reporting Only
5.2 Mandatory Training	Partial Compliance
5.3 Appraisal	Partial Compliance
5.4 Patient and Public Involvement	Reporting Only
5.5 Operational Management and Succession Planning	Reporting Only
5.5 Sickness and Absence	Reporting Only
5.6 Staff Experience and Engagement	Reporting Only
5.7 WRES	Reporting Only
5.8 Duty of Candour (DOC)	Reporting Only

Highlights:

- Safe Staffing – Roster efficiency tool introduced to support safe staffing levels and roster efficiency approval for overseas recruitment campaign for nursing staff

- Sickness and absence – improved position

- 7 Day service – progress in General Surgery towards a more Consultant delivered 7 day service.

5.1 Safe staffing

Aim and Objectives of Work

The Nursing Workforce Strategy Group implements and lead the Nursing and Midwifery Workforce Strategy, providing monitoring and assurance of the Nursing and Midwifery Workforce across the Trust.

Objectives include:

- To set direction of the Nursing and Midwifery Workforce including defining, monitoring and continually updating the Trusts policies and procedures to ensure that the workforce is safe, effective and able to deliver high quality compassionate care consistently;
- To monitor and manage the Hard Truths requirements ensuring data is accurate, utilised to provide assurance and incorporated into workforce planning;
- To define standards for the workforce;
- To oversee nursing establishments which are linked to acuity and dependency studies, evidence based tools and professional judgement.

1.0 Safe Staffing Levels

Average fill rates are monitored and reported to the Board each month. The report has been developed within the last quarter to include Care Hours Per Patient Day (CHPPD) data. Areas of concern are noted within the monthly report alongside mitigating action taken and any resulting impact from reduced staffing levels.

Areas with average fill rates of less than 75% for Registered Nurses (RN) have remained a challenge throughout the last quarter.

Table 1: Average Fill Rates Registered Nurses and Care Staff

Average Fill Rates				
	Registered Nurses		Care Staff	
	Day	Night	Day	Night
June 2016 HRI	87.1%	94.0%	104.9%	128.6%
June 2016 CRH	83.7%	92.0%	96.3%	110.1%
May 2016 HRI	91.94%	94.24%	107.48%	125.10%
May 2016 CRH	89.60%	94.55%	104.84%	113.97%
April 2016 HRI	90.64%	97.30%	107.82%	123.86%
April 2016 CRH	89.46%	95.51%	105.79%	118.69%

Fill rates in excess of 100% have been reported for care staff within the last quarter. This has been attributed to supporting reduced fill rate for RN and providing 1-1 care requirements.

Average fill rates of less than 75% within the last quarter have been attributed to: increased bed capacity; sickness levels; vacancies and increased long days (resulting in the right number of nurses on shift, but reduced total nursing hours against planned per day.)

Average fill rates are reviewed by the senior nursing team at any point utilising the daily staffing tool, but as a minimum weekly reports are circulated to the senior nursing team.

During the last quarter the nursing workforce team have developed a roster efficiency tool which has been launched within divisions to aid weekly confirm and challenge sessions focussing on ensuring safe staffing levels and roster efficiency.

2.0 Staffing Data

The nursing workforce team have worked with health informatics and have begun to develop a dynamic dashboard to enable real time and accurate data to be available to assist in supporting safe staffing levels.

Quality dashboards developed by the nursing workforce team in 2015 are utilised and a task and finish group reviewing the content in light of recommended indicators to include following the recently published National Quality Board Guidance (2016).

CHPPD have been reported for the last two months externally and the nursing workforce team are reviewing planned against actual CHPPD each month for clinical areas.

As the efficiency portal is developed the nursing workforce team will review CHPPD against peers utilising the portal.

3.0 Recruitment and Retention

Best practice guidance published by Health Education England (2016) to inform retention of the nursing workforce has been reviewed by the nursing workforce strategy group and current practice mapped against this. A “Band 5” competency document based on the NMC’s standards for competency for registered nurses was launched to the nursing workforce in October 2015. Clinical teams are now utilising the document & records of compliance are held on ESR.

Following review of national frameworks & guidance in relation to preceptorship, CHFT have developed a new robust preceptorship document & support package for new registrants within the organisation

Recommendations for action have been taken forward to the nursing workforce strategy group and form part of the retention strategy currently being reviewed by the senior nursing team.

Recruitment both local and international has continued.

Robust keep in touch events for soon to be qualified nurses and midwives has been completed to maintain engagement with nurses / midwives recruited well in advance of their planned arrival at CHFT in September 2016.

International recruitment has continued via skype interviews resulting in 31 nurses arriving in 2016 to join CHFT. The available pool of nurses from the EEA has been impacted upon by the introduction of the IELTs requirement by the Nursing and Midwifery Council (NMC).

The nursing workforce team have worked with colleagues at CHFT and the NMC to assist nurses through the NMC registration process and will continue to support nurses through their IELTs requirements as this becomes necessary from Eighteenth July 2016.

Recent approval has been received by the team to undertake an overseas recruitment campaign for 75 nurses which is being developed at pace.

Further work with the communications team has been started to improve the recruitment and branding of the nursing workforce at CHFT

4.0 Additional roles within the Nursing Workforce

A task group has been reviewing additional roles and the potential benefits of introducing these at CHFT. Advance Clinical Practitioner roles; Associate Nurse roles and Assistant practitioner roles have been considered.

Scoping of areas which would benefit from additional roles within the workforce has been completed and the nursing workforce team are currently working with partners to develop next steps.

5.0 Conclusion

The Nursing Workforce Strategy Group continue to implement and lead the nursing workforce to ensure safe staffing levels are reviewed, monitored and reported.

5.2 Mandatory Training

Aims and objectives of the work

The aim of mandatory training is to help enable employees achieve safety and efficiency in a timely manner. The mandatory training programme enables the Trust to demonstrate that employees regularly have mandatory training designed to ensure they can undertake their job roles safely and maintain a safe and healthy work environment. The approach describes what training employees are required to complete, how often they are required to complete the training and how to access the training.

Current performance

Mandatory training compliance as at 30 June 2016 is detailed below:-

Compliance As Of: 30/06/2016	Information Governance	Equality and Diversity	Infection control	Moving and Handling	Health, Safety and Welfare	Safeguarding	PREVENT	Fire Safety	Dementia Awareness	Conflict Resolution
Medical	13.88%	81.56%	14.17%	84.60%	81.56%	74.62%	52.06%	10.05%	79.98%	75.63%
Corporate	13.04%	90.68%	13.04%	88.20%	88.82%	81.06%	80.12%	14.60%	84.16%	84.78%
Families & Specialist Services	11.74%	93.42%	11.26%	93.69%	92.88%	87.11%	72.86%	13.57%	91.11%	89.28%
Surgery & Anaesthetics	10.60%	88.01%	10.60%	88.88%	87.49%	82.88%	60.12%	17.29%	86.10%	82.54%
Health Informatics	6.57%	99.49%	9.09%	98.99%	99.49%	92.93%	87.37%	11.62%	96.97%	96.46%
Community	13.94%	93.35%	14.42%	92.38%	93.03%	87.36%	84.12%	13.94%	91.73%	88.49%
Estates & Facilities	12.10%	77.15%	13.44%	75.81%	76.61%	71.51%	46.77%	7.80%	75.81%	75.54%
Trust	**12.18%**	**88.24%**	**12.38%**	**88.88%**	**87.81%**	**81.90%**	**65.48%**	**11.10%**	**86.07%**	**83.40%**

Improvement plans for 2016/2017

Issues:-

The functionality of the Oracle Learning Management (OLM) system in the national Electronic Staff Record (ESR) is limited and is not user friendly which has deterred some colleagues from using the tool enabling them to be fully compliant.

A specific functionality limitation has been highlighted regarding refresher training and the length of 'window' prior to renewal. This is currently set at 3/12 months before compliance expires.

There is an absence of a sanction for non-compliance.

The PREVENT element of mandatory training is delivered on a classroom basis through the Safeguarding team and capacity to deliver sufficient sessions to facilitate full compliance is limited. The requirement to deliver this training in a classroom environment is a DH requirement placed on all public sector bodies.

Response:-

Business case for replacement learning management system considered and approved by the July Commercial Investment and Strategy Committee meeting.

Design a proposal for a link to incremental pay progression and mandatory training and appraisal compliance – 31 July 2016.

Prevent paper to be submitted to Executive Board in July 2016 by Head of Safeguarding.

A paper describing the options to manage mandatory training compliance, as a consequence of EPR implementation in 2016, to be considered by Executive Board on 21 July 2016.

5.3 Appraisal

Aims and objectives of the work

A formal annual appraisal process provides employees with information around how they may be perceived within their team and organisation and offers constructive feedback about their performance at work. A good appraisal also helps colleagues understand the strengths they should capitalise on and the weaknesses where improvement may be required. This helps to ensure that each individual in the team understands how their input contributes to the whole and how achieving their goals will ensure the organisations vision of compassionate care is delivered.

The aims of the work are:-

- To ensure all colleagues have access to a simple and effective appraisal structure
- To maximise progress using that simplified structure towards the 100% annual target (90% by 31 December)
- To facilitate effective and timely reporting for the organisation to ensure compliance
- To provide access to a high quality appraisal interaction

Current performance

April	May	June	Target	Trajectory
4.28%	6.77%	6.77%	100.00%	24% (100% at 31 March 17)

Improvement plans for 2016/2017

Issues:-

There is an absence of a sanction for non-compliance.

The appraisal scheduler tool which captures planned activity has not in previous years been fully or consistently utilised.

Limited opportunity for appraiser training.

The quality of appraisal is reported through the staff survey as requiring improvement.

Response:-

Appraisal compliance to be monitored monthly through the divisional performance meetings

Design a proposal for a link to incremental pay progression and mandatory training and appraisal compliance – 31 July 2016.

Audit the use of the appraisal scheduler in Division/ corporate directorates to ensure a robust plan exists for all service areas - 15 August 2016.

A proposal for a pilot three-step appraisal training programme is being costed as part of a business case for resource for the Education and Learning Group.

An approach has been made to NHS Employers to commission an audit study of the quality aspect of appraisal.

5.4 Patient and Public Involvement

To be received in Q2 – reported to Quality Committee every 6 months.

5.5 Operational Management & Succession planning

Aims and Objectives

- New Operational management structure with increased opportunities for management progression within CHFT
- Introduction of clear Clinical Leadership structure
- Development and Implementation of a Talent Management Strategy

- Development and implementation of management & leadership development programme

Action plans are in place as part of the CQC response group. Currently on track to meet interim objective which include:

- Operational structures for Clinical Divisions agreed including opportunity for development at General Manager, Matron and ADD level

- Operational Management numbers increased and new Divisional support posts introduced to give opportunities for junior staff to become involved in management roles and ADDs to develop formal deputy functions to the COO

- Within nursing some developmental Matron roles in place and renewed; additionally band 6 posts increased and formal band 6 development posts in place and supported through all

- New Director of Nursing designing a ward manager development programme including awareness of management issues

- Clinical Management Proposals developed and agreed at Commercial Investment Committee; recruitment process and development plan yet to be confirmed

- Standards for managers being developed using a WTGR process

- Local management training programme in conjunction with University of Huddersfield

5.6 Sickness and Absence

Aims and Objectives

The Trust aims to ensure that employees are able to make the most effective contribution, individually and collectively, to improving the services that that Trust provides. Managing sickness absence and improving sickness rates is an indicator of creating both a healthier and more efficient workplace.

Current Performance

1) The table below shows the Trust's performance against the 4% threshold for Q1.

Quarter	CHFT (%)	2016/17 Q1	RAG
2016/17 Q1	4.41%	4.00%	□

2) The table below shows the long term and short term sickness absence split for Q1.

Month	Avail FTE	ST FTE	LT FTE	ST FTE %	LT FTE %	Total Sickness %
2016 / 04	152,071.10	2,379.93	4,288.97	1.57%	2.82%	4.39%
2016 / 05	157,459.34	2,146.58	4,469.70	1.36%	2.84%	4.20%
2016 / 06	152,818.10	2,201.78	4,895.78	1.44%	3.20%	4.64%
	462,348.54	**6,728.29**	**13,654.44**	**1.46%**	**2.95%**	**4.41%**

3) The table below shows the sickness absence rate for Q1 2016/2017 in comparison to Q4 2015/2016 broken down by Division:-

Division	2015/16 Q4	2016/17 Q1	Change	Movement	Trust Threshold	RAG 2015/16 Q4	RAG 2016/17 Q1
Surgery	5.58%	5.05%	-0.53%	↓	4.00%	□	□
Medical	5.21%	5.51%	0.30%	↑	4.00%	□	□
Community	4.55%	4.41%	-0.14%	↓	4.00%	□	□
FSS	4.15%	3.62%	-0.53%	↓	4.00%	□	□
Estates	5.05%	4.44%	-0.61%	↓	4.00%	□	□
Corporate	2.80%	2.72%	-0.08%	↓	4.00%	□	□
THIS	2.13%	1.17%	-0.96%	↓	4.00%	□	□

Work undertaken in 2016/2017

100% of long term sickness absences have a 'wrap round' management plan. This is monitored on a routine basis and reported to the Board monthly.

Cases moving from short term to long term are monitored and reviewed by the end of 2nd week each month.
Return to work forms analysed to ensure short term absence is managed in accordance with policy triggers.

Return to work interview dates to be automatically transferred from e-roster to ESR - 31 August 2016.

On a monthly basis contact non-compliance areas to obtain an understanding of the reasons why return to work interviews are not undertaken or recorded - 31 July 2016.

Drop in open surgery sessions for line managers organised - up to 31 August 2016.

5 worst performing areas identified in each Division and meetings to be held with Directorate Managers to discuss action required - 31 August 2016.

5.7 Staff Experience and Engagement

Staff Friends and Family Test

The Staff Friends and Family test aims to provide a simple, headline metric which can be used to drive cultural change and continuous improvements in the quality of the care received by NHS patients and the working conditions of its staff. The survey questions are:

A – Would you recommend your Trust as a place to receive treatment?
B – Would you recommend your Trust as a place to work?

The survey runs on a quarterly basis with the exception of Q3 (October to December) when the National Staff Survey takes place.

The 2016/17 Q1 survey was an on-line survey only and focused on Families and Specialist Services and THIS. The results are as follows:

Staff would recommend the Trust as a place to receive treatment:
FSS – 81%, THIS – 70%
Staff would recommend the Trust as a place to work:
FSS – 58%, THIS – 70%

Analysis of the qualitative feedback received through the surveys and actions plans are produced within the respective divisions in order to identify themes and the necessary responses to improve colleague experience in the Trust. These actions are monitored by the Colleague Engagement, Health and Wellbeing Group and learning shared between divisions.

NHS Staff Survey

The Trust participated in the 13th national annual NHS Staff Survey in 2015. A total of 850 colleagues were randomly selected in our sample by Picker Institute Europe, our survey administrator. The formal benchmarking results were released by NHS England on 23 February 2016. The Trust incorporated local questions in the survey in the same way as it did in 2014 focusing on patient experience, raising concerns, Trust values and its financial position.

The following initiatives have been introduced in 2015/16:

- Colleague engagement and communication plan supported by divisional specific plans
- "Star Award" – we made our first nomination in January – a Wall of Fame has been introduced on each of the hospital sites
- Appraisal planning tool
- New approach to mandatory training – online access (compliance to be monitored by the Colleague Engagement, Health and Wellbeing Group)
- Back to the floor/leadership walk round activity
- Monthly 'Big Brief' events led by Executive Directors
- 'Ask Owen' facility on the intranet
- Work Together Get Results (WTGR) workshops with senior teams to support the sustainability of the consistent approach to change management that has colleague engagement at its core
- Enhanced resources for line managers to assist in the management of colleague health and well being

- Board of Directors Workforce Committee with a sub group structure that includes colleague feedback, which will support the design of a more effective feedback capture model and robust response to feedback to ensure continuous improvement
- Attendance Management Team with dedicated resource into divisions
- Focus group activity as part of the CQC Inspection preparations and Investors in People assessment*
- Redesign of the Trust's website
- Focus groups for staff to improve engagement on the staff survey results
- Focus groups for BME staff to improve opportunities for career progression, training and development led by the Chief Executive

* The Trust had a successful outcome to a recent Investors in People (IIP) assessment against the national IIP Standard. The Trust achieved a Bronze Award – one step up from the core standard recognition in previous years.

Further Developments for 2016/17

- A colleague health and wellbeing strategy, developed through involvement of key stakeholders
- A recruitment and retention strategy, developed through involvement of key stakeholders
- Extend the Trust's values-based recruitment approach to all staff groups (already operational for therapies and diagnostic staff)
- BME Staff Network commencing in September 2016
- Colleague Engagement Network commencing in September 2016
- Develop a social media engagement plan
- Create a network of "raising concerns" champions to signpost colleagues to appropriate resources and processes
- Design a communication strategy to support the "raising concerns" process

The Trust will be participating in the 14th national annual survey from September 2016 using the basic sample, which has been increased in 2016 to 1,250.

5.8 Duty of Candour

The Trust Being Open/Duty of Candour Policy and Incident Reporting Policy sets out that the Trust has a duty to limit the potential impact of clinical and non-clinical risks and put in place robust and transparent systems to make sure that all incidents which might cause actual or potential harm to patients, visitors and staff are identified, investigated and rectified.

In particular, it involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment or when in-patients or outpatients of the Trust. Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 sets out the legal obligation under-pinning the Duty of Candour.

During Quarter 1 there were 4 duty of candour breaches across red and orange incidents.

Improvement Plans:

Revised performance management framework will increase accountability within divisions for monitoring and delivery of duty of candour.

Meeting with CCG in quarter 2 to re-affirm Trust position regarding duty of candour at both the start and end of an incident and the investigation.

The Trust will continue to implementation of duty of candour internal audit report recommendations.

5.9 7 Day Services

Background

7DS (7-day services) is a nationally driven Quality Improvement initiative and is a key area of focus on the trust's QI plan. It stems from an initial perspective that patients admitted over the weekend were at a greater risk of dying than patients admitted during the week. This has been subject to some controversy and the evidence to support is somewhat contradictory. Never the less the emphasis is now more about reducing variation in care over the seven days for better patient experience, reduced LOS (length of stay) and readmissions, and possibly improved patient outcomes such as mortality. The vehicle driving this improvement are the 7DS ten clinical standards described by Sir Bruce Keogh. Whilst these standards refer to unplanned admissions to hospital there is an emphasis on a multi-agency response to 7DS especially with respect to standard 9. For further information regarding the ten clinical standards: http://www.nhsiq.nhs.uk/media/2638611/clinical_standards.pdf

NHSE have stipulated that standards 2 (time to first consultant review), 5 (diagnostics), 6 (consultant led interventions) and 8 (on-going review) are priority standards for implementation. CHFT, as part of West Yorkshire, is an early implementer of these priority standards aiming to achieve compliance by March 2017.

Current Performance

To date the focus has been on understanding the trust's current position (Reality) against the clinical standards. In September 2015 the trust submitted data towards the first national 7DS survey. The results from the 2015 survey demonstrated significant gaps against all four priority standards with the exception of General Surgery. Following this there was an initial high level review of the potential cost of implementing the four priority standards across all specialties. This cost highlighted the extreme challenge in achieving compliance with the priority standards and therefore further work was undertaken looking specifically at Medicine.

Early in 2016 CHFT collaborated with colleagues from NHSI to develop a high level action plan submitted to NHSE. The action plan detailed the challenges faced by CHFT with particular reference to the 5-year plan for the future of hospital services.

In April 2016 the trust submitted data once again towards the second 7DS national survey. The methodology differed to the first survey and involved a review of 40 unplanned admissions for 7 consecutive days. The results published in June 2016 showed that just under 50% of all unplanned admissions are to acute medicine with 15% to general surgery and paediatrics equally. The survey data showed variable performance against each standard but overall still below expected to be deemed to be compliant. A full analysis of the 2016 survey is attached.

The current position is that the 2015 and 2016 surveys have been shared with Clinical Directors with a request for each directorate to develop their own action plan for improvement. Directorate action plans will be collated to form a trust-wide action plan with the aim of further

reviewing the high level cost for implementing 7DS balanced with qualitative and financial benefits to the organisation.

Finally, there has been a significant improvement in General Surgery towards a more consultant delivered 7-day service. Early indicators are that these changes have seen significant improvements in surgical outcomes and possibly mortality too but not LOS. Further work is needed to evaluate the impact on patient experience and outcomes whilst optimising the consultant delivered service. It should however be noted that these changes in general surgery did incur an additional financial burden on the trust and for a period a reduction in planned activity.

Improvement plans for 2016/17
Much of the plan for improvement for 2016/17 is detailed above. As stated Directorate action plans are being formed to support a trust-wide action plan for 7DS. It is anticipated that this trust-wide plan leads to a further more detailed analysis of the cost of implementing 7DS versus the qualitative and financial benefits from improved LOS.

Finally we are actively engaged in dialogue with CCGs and partners in both health and social care on a system response to 7DS. A multi-agency event was held on 13 July 2016 with good representation from commissioners, other acute and community providers, and social care from both Kirklees and Calderdale. A proposal lead by CHFT and Calderdale CCG is being developed and will be proposed to the System Resilience Group later this year.

5.10 Workforce Race Equality Standards (WRES)

Background

The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

Simon Stevens, Chief Executive of NHS England, said: "The Five Year Forward View sets out a direction of travel for the NHS – much of which depends on the health service embracing innovation, engaging and respecting staff, and drawing on the immense talent in our workforce.

"We know that care is far more likely to meet the needs of all the patients we're here to serve when NHS leadership is drawn from diverse communities across the country, and when all our frontline staff are themselves free from discrimination. These new mandatory standards will help NHS organisations to achieve these important goals.

A number of key pieces of work have been commenced and a full report will be available from Q2.