NHS

Calderdale and Huddersfield

NHS Foundation Trust

Quality Account

2019/20

compassionate care

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Part 1: Chief Executive's Statement

Calderdale and Huddersfield NHS Foundation Trust has a strong track record for delivering high quality and good value patient care. It is always our duty to deliver the highest quality services to our patients by ensuring the most effective, safest possible and positive patient experience.

Our Trust Quality Account describes our responsibilities, approach, governance and systems to enable and promote quality across the trust whilst carrying out our business and planned service improvements.

Above everything, the Quality Account is about people. It describes our approach to ensure that we provide everyone with the care and compassion they need and enabling their voice to be heard. Therefore, we would like to welcome the reader to the 2019/20 Calderdale and Huddersfield NHS Foundation Trust (CHFT) Quality Account.

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

The Care Quality Commission concluded their onsite well-led inspection on 5 April 2018 and in June 2018. That rating remains as Good. We know however that works continues behind the scene to ensure that we retain that rating for all our services. Efforts from all teams are working towards maintaining and sustaining our good rating; to our ambitions to be an outstanding NHS Trust.

In early 2020 we commenced our J20 programme - Our Journey to Outstanding and our CQC self-assessment programme. These are just two examples of the developments in the Trust we have designed and started to roll out to services which will in time enable the teams to review, reflect and improve approaches to practice and understand better how we deliver care to all our patients. To complement these ambitious developments, in mid-2020 we will launch our CQC learning portal for staff.

The year has seen colleagues continue to focus on ensuring our patients receive timely and effective care with performance continuing to improve across all domains. Our focus this year has been on understanding complaints and the impact this has on patients, learning lessons from serious incidents and complaints and appointing new clinicians to roles such as Sepsis to ensure that we continually strive for best practice and outcomes.

A focus on learning from incidents and complaints has provided insightful and meaningful change to the outcomes for our patients. We welcomed the participation of one of our Governors to become our critical friend in relation to observations and suggestions as to how we could and will do better in relation to complaints, concerns raised and improvements. We continue to focus on the patient experience with improvements to our 'would recommend' across many wards and departments and using patient stories as a means of learning Board to Ward.

Our delivery of Emergency care services for patients is recognised as being amongst the best nationally. We spent a lot of time learning from last winter and, with clinical colleagues, agreed a very different winter plan for 2019/20 that was successful. We have worked closely with partners across health and social care all year and our partnership working has seen a significant improvement with people being cared for at the right time, in the right place by the right people.

Continues…

Chief Executive's Statement… continued

Our Calderdale Community division has seen increasing numbers of patients, supporting them to remain at home and avoid hospital admission as well as securing a prompt and safe discharge. Patients on cancer pathways are treated within an appropriate timescale.

Our continued focus on quality uses our Work Together Get Results methodology to engage colleagues so the patient is at the centre of care.

We describe in the following Quality Account a detailed appraisal of all the hard work underway to maintain safe, quality care. This is always top of the agenda for our Board of Directors and in this increasingly challenging financial environment, combined with increased demands for our services, it is even more important to ensure that any changes we make are assessed for their impact on quality and how digital technology can improve care before they are able to go ahead.

In drawing this report together, reference should be made to the U.K. Government declaring the COVID-19 pandemic in March 2020, requiring the Trust to initiate a command and control operational model. This meant that the Trust could support the challenges it faced with COVID-19. Utilising a control and command approach has enabled the Trust to oversee both COVID and non-COVID care and to assure the Board that care is and was properly managed and overseen by the relevant clinicians and managers.

The pandemic has required our organisation, in the same way as all other organisations, to work in different ways. However, throughout the pandemic, our core purpose continues to be keeping our patients safe.

There are some excellent examples of high-quality care and services across all our community and hospital services. I hope you will find the following pages informative and helpful in giving you an insight into the vast amount of improvement work we continue to do in the Trust.

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

Owen Williams, Chief Executive, May 2020

Part 2: Priorities for Improvement and Statement of assurances from the Board

2.1 How the Trust performed against the priorities set for 2019/20

Each year the Trust works on several quality priorities.

Last year the Trust identified three projects to be highlighted as key priorities for 2019/20.

This section of the Quality Account shows how the Trust has performed against each of these priorities and the plans going forward.

Improvement Domain	Improvement Priority	Were we successful in 2019/20?
Safety	**Emergency Department –** there are times when we are unable to meet the 4-hour waiting standard for patients in the emergency department, ED. We will continue to work on waits longer than 4 hours in the ED to ensure safe and reliable care	Yes
Effectiveness	**Deteriorating Patients -** ensuring that the new national guidance around observations for deteriorating patients (NEWS2), National Early Warning Scores, is implemented and understood by frontline staff to ensure effective and reliable care is always given	Yes
Experience	**Mental Health –** improving psychological support for mental health patients in the Emergency Department	Yes

Priority One:

Emergency Department – there are times when we are unable to meet the 4-hour waiting standard for patients in the ED. We will continue to work on waits longer than 4 hours in the ED to ensure safe and reliable care

Why we chose this:
As we know there is a considerable evidence base for the harm caused by inefficient and untimely patient flow. Delays lead to poor outcomes for patients, both in terms of safety, experience, and the level of need when they are finally discharged. Unnecessarily prolonged stays in hospital are a poor experience. This is due to the risk of unnecessary waiting, sleep deprivation, increased risk of falls and fracture, low mood, prolonging episodes of acute confusion (delirium) and transmitting healthcare associated infections. All can cause an avoidable loss of muscle strength leading to greater physical dependency (commonly referred to as deconditioning).

Tackling long stays in hospital will reduce risks of patient harm and disability, particularly for those who are intrinsically vulnerable because they have mild or moderate frailty and/or cognitive disorder. For this patient group a different, more positive outcome can be achieved if the right steps are taken very early in their admission.

Hospital-related functional decline in older patients and the subsequent harm has dreadful consequences for many patients, it is something we should not be putting up with and with our system partners we have agreed that this will not be tolerated.

Safe and timely discharge planning for all patients is an essential part of their overall plan of care and treatment and should always start on their admission.

Good patient flow and transfer of care across the health and social care system is now widely recognised as a key indicator of how the system is working in collaboration. The agenda for the system Transfer of Care Group and A&E Delivery Board has a clear focus on safer patient flow and discharge.

Improvement work

SAFER Patient Flow Programme
The work has continued throughout 2019/20 through three work streams
1. bed avoidance
2. bed efficiency
3. bed alternates.

There have been several ongoing successful quality initiatives developed and implemented through the SAFER Programme and in collaboration with partner organisations.

Schemes implemented through the work streams are:
- **Trusted Assessment –** discharge coordinators complete all assessments for patients appropriate for referral into the reablement pathway, with quality control in place, this has enabled a smoother, quicker transfer into reablement services.
- **Trusted Assessor –** A dedicated Trusted Assessor, funded by Local Authority works within CHFT Discharge Team to provide onsite immediate assessments for patients who need to be transferred into a care home facility. This nurse has built strong relationships with care home managers, who trust her to assess the needs of the patients and communicate these to the home in order to prevent the need for the home managers to attend the hospital which was in many cases causing delays of up to a week. This also has improved communication and handover with the nursing home.
- **Home First Team –** working with the discharge team focusing on reducing the number of stranded (patients with a length of stay (LOS) 7 days and over) and long stay patients (patients with a LOS of 21 days and over). The teams ensure discharge planning commences on admission, patients have a clear clinical plan that is reviewed timely and the patients clinical and discharge plan is tracked, to ensure any delays are prevented.

- **Standardised Multi-disciplinary (MDT) meetings –** Elderly Care consultants have developed daily MDTs.
- **Enhanced reablement –** a service that is dedicated to support patients being discharged from hospital.
- **Continuing Healthcare Assessments –** all assessments are now completed following discharge and not prior.
- **Introduction of the Non-weight bearing pathway –** patients with long leg plaster casts or bi-lateral arm plaster casts often struggle to go home as their own accommodation cannot be adapted, in order for them to manage independently. They are provided with alternate accommodation, other than waiting in hospital for the cast to be removed, often up to 6 weeks.
- **Community Care Discharge to Assess Beds –** Enable long term decisions to be made away from an acute setting with an opportunity for further recovery. Enable families and representatives time to visit and select preferred care home settings. Enable ongoing assessments for long term care home provision to be completed in an alternate setting.

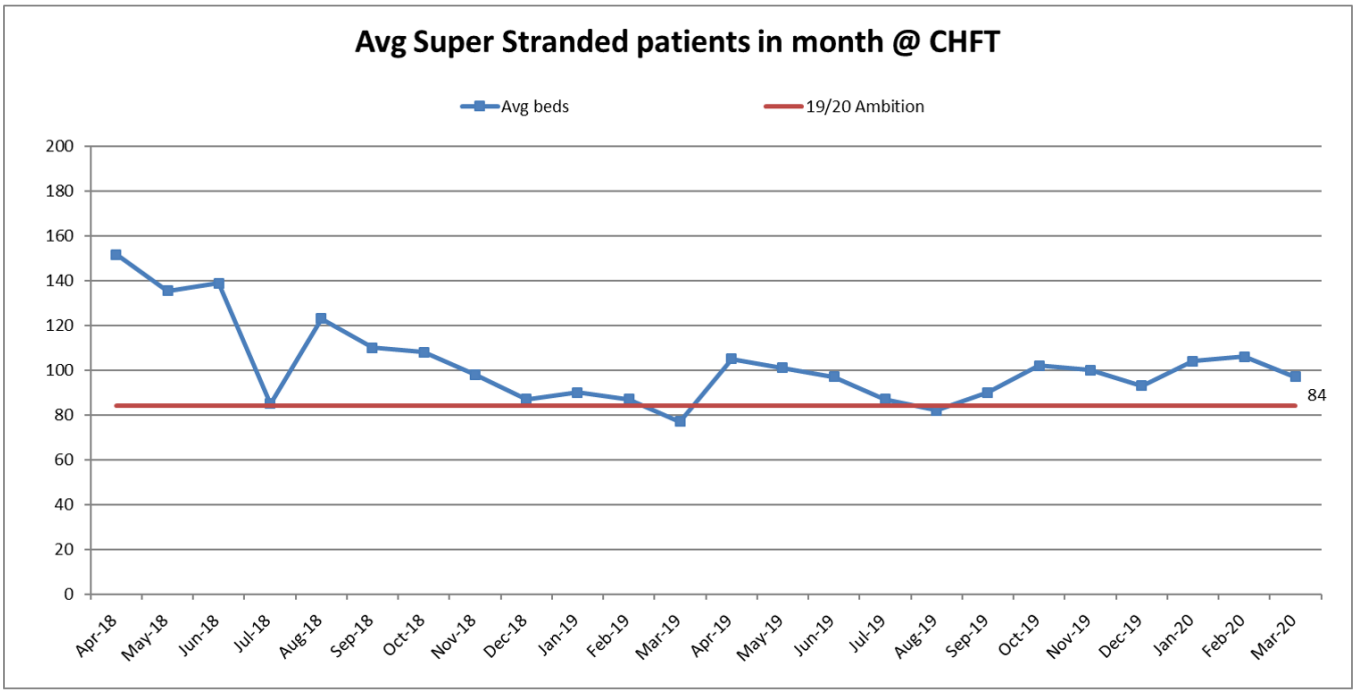
All these schemes have enabled patients to be discharged, safely and in a much timelier way.

Improvement work in this area has also included the introduction of an additional Matron for each of the Emergency Departments where previously a Matron had responsibility for both sites. Streaming now takes place at the front door of the departments ensuring patients are navigated quickly to ensure they are dealt with by a member of staff who has the right skills, at the right time and in the right place. This has included the development of new pathways both within and outside of the hospital including: -

- General Surgery – early referral to senior surgeons
- Ear, Nose and Throat (ENT) pathway to go straight to a clinic appointment for review by a member of the ENT team
- Development of the oncology helpline
- Orthopaedics supporting the minors service
- Options to book appointments with G. P's via phone system
- Options to book appointments with G.P. via the electronic patient record system
- Direct routes to Local Care Direct with improved referral criteria

How have we done?

Below the table demonstrates the gradual improvement in the reduction of beds used for long stay patients since April 2018, it also shows that we have sustained this ambition.



Priority Two:

Deteriorating Patients – ensuring that the new national guidance around observations for deteriorating patients, (National Early Warning Score, NEWS2) is implemented and understood by frontline staff to ensure effective and reliable care is always given.

Why we chose this:
Timely recognition and response to a patient's changing needs can make a difference in their clinical outcomes and their overall experience of care. The Trust has an established Deteriorating Patient Programme which is subdivided into key areas of focus:

- recognition
- response
- prevention of in-patient deterioration

Within each domain there are work streams that are significant enablers for improvement. Since the implementation of several digital systems the Trust can track and retrieve measures that provide a more detailed picture, permitting the identification of further opportunities for improvement.

Improvement work and how we did during 2019/20
The Deteriorating Patient Group focuses on the timely recognition and prompt response to patients who deteriorate in hospital.

National Early Warning Score 2 (NEWS2)
A major priority within the programme has been achieved with the Trust-wide implementation of the National Early Warning Score 2 (NEWS2). NEWS2 looks to standardise the process of recording, scoring and responding to changes in routinely measured physiological parameters in acutely ill patients. These scores are utilised to prompt early medical intervention in the deteriorating patient. Scores range from 0-20 with higher scores reflecting a greater degree of acute illness. A NEWS2 score of 5 or more is a key threshold for an urgent clinical alert and response. Work progresses in monitoring compliance within divisions and the response to a NEWS2 of 5 or more is scrutinised as a key aspect of the Structured Judgement Reviews within the Learning from Deaths programme. These reviews promote learning within divisions and across the organisation.

Following the Trust implementation of NEWS2 additional training was put in place to optimise the new approach including an online e-learning tool. Further evaluation of NEWS2 will be a key measurement in 2020-21.

Sepsis
Throughout the last 12 months the Sepsis Collaborative has continued to focus on quality improvement. We have a sepsis dashboard that pulls data from our Electronic Patient Record (EPR) allowing us to closely monitor changes over time. We regularly review incidents related to sepsis, including diagnosis and management, to ensure shared learning across the organisation. Over the next 12 months the collaborative has agreed to focus on 3 key elements: time to antibiotics in the Emergency Department, completion of the sepsis 6 'Bufalo' (blood cultures, urine output, fluids, antibiotics, lactate, oxygen) for patients with sepsis and review of intravenous antibiotics at 72 hours.

We plan to address these 3 elements through a training programme using quality improvement methodology – Plan Do Study Act (PDSA) cycles within the Emergency Department, with a focus on early identification of possible sepsis, rapid administration of antibiotics and consideration of sepsis trolleys.

To monitor the impact of our programmes, we look to our mortality measures that are nationally benchmarked. The Hospital Standardised Mortality Ratio (HSMR) compares how many patients die within 30 days of admission to hospital, with how many we would have predicted to die given their age, gender, area-level deprivation, diagnoses and comorbidities. The Trust's HSMR position been consistently below the expected target of 100 since April 2017 and below 90 since October 2017. Improving HSMR has been a major drive of quality improvement in recent years. This suggests that compared to other Trusts in England, patients admitted to CHFT are less likely to die than average whilst in hospital.

The Summary Hospital-level Mortality Indicator (SHMI) is for non-specialist acute trusts and is the ratio between the actual number of patients who die and the expected on the basis of average England figures. It includes deaths in hospital and in contrast to the HSMR, deaths which occurred outside hospital within 30 days of discharge. SHMI performance shows that the Trust has been below the expected target of 100 since July 2019.

Recognition
Early recognition of patients who are deteriorating is reliant on timely and accurate patient physiological observations. Following a study during 2019/20 it was noted that many patient observations are carried out by healthcare assistants, HCA's. All HCA's complete competency assessments prior to independently carrying out patient observation tasks.

The review demonstrated the need for ongoing training to ensure that measurements remain accurate. This work was carried out during 2019-20. The recording of observations at the correct time now exceeds 70%.

Response
In line with NEWS2 the escalation policy was revised as part of the overall Adult Physiological Observation policy. In-hours escalation of patients with a NEWS of 5 or more continues through ward-based teams. The Critical Care Outreach Team respond to patients with a NEWS of 7 or more during the period of 08:00 to 20:00, seven days a week. Outside of normal working hours, the Hospital Out-Of-Hours (HOOP) team respond to patients with a NEWS of 3 in one parameter and a NEWS score of 5 or more. Digital prompts within Nervecentre encourage staff to consider and perform sepsis screening tests for these patients.

In order to develop a centrally co-ordinated response to deteriorating patients during daytime hours, the team developed plans to enhance collaboration between Critical Care Outreach and HOOP. We will assess progress through a Work Together Get Results approach within the next 12 months.

Prevention
During 2018/19 safety huddles were promoted to ensure that all team members are aware of those patients who are deemed to be at risk of deterioration. Consistency across huddles can be enhanced by the use of interactive whiteboards displaying information directly from the Electronic Patient Record. Information displayed on the whiteboard comes directly from the patient's electronic record and updates every 30 minutes. Key information displayed includes: length of stay, early warning scores, predicted discharge dates, alerts and allergies as well as prompts to complete important quality measures such as venous thromboembolism assessments, cognitive screening and pressure ulcer assessments. The Trust is working with Cerner (the provider of our electronic patient record system) to customise the information available for huddles, handovers and ward rounds.

Priority Three:

Mental Health – improving psychological support for mental health patients in the Emergency Department

Why we chose this

The number of mental health patients attending the Emergency Departments is increasing. We need to ensure we are providing appropriate support for these patients who present at the Emergency Department.

Improvement work

The department has introduced several strategies in response to this priority including:

- Early intervention from the mental health liaison team which involves the provision of psychological and social support, this will include regular two hourly patient reviews.
- A comprehensive departmental standard operating procedure has been developed which describes strategies to ensure the needs of patients with mental health problems are addressed ensuring their safety is maintained and any risk of harm is minimised
- A designated safe environment for patients with mental health needs has been identified and introduced
- Ongoing risk assessments which provide early recognition of individuals that may require 1:1 support.
- Clear lines of escalation to mental health provider organisations when there are long waits for a mental health assessment and/or identification of a suitable care facility
- Introduction of a rapid investigative tool related to this specific pathway that considers the holistic needs of the patient and how their care needs have been met.

2.2 Looking ahead 2020/21

A 'long list' of potential priorities for 2020/21 was developed from the following sources:

- Regulator reports
- Incidents and complaints
- On-going internal quality improvement priorities
- National reports and areas of concern
- Evaluating the Trust's performance against its priorities for 2019/20
- Membership Council workshop

This long list was discussed with the Trust's Council of Governors; an opportunity to vote was also given via the Trust's internet site, advertised in Foundation Trust News which is circulated to the Trust membership.

Effective: ***Improve staff handovers to ensure they routinely refer to the psychological and emotional needs of patients, as well as their relatives / carers.***

Our mental health influences our physical health and our capability to lead a healthy lifestyle is to manage and recover from physical health conditions, particularly long-term conditions.

Our focus for this quality priority relates to:

- How the Multi-Disciplinary Team will review the handover of patient care between teams of staff, so we can ensure that our patients receive high quality, individualised care throughout their hospital stay
- The focus on handover supports a shared and effective approach to the holistic patient pathway and the identification of risk factors which supports effective signposting and onward referral to specialist services.

Effective: ***Ward Moves – Reduce the number of patients who have multiple ward moves***

Moving patients from one ward to another either for non-clinical reasons or to outlie is shown to have a negative outcome on patients. This includes an increase in their length of stay and increasing the risk of readmission, also the development of medical complications including healthcare acquired infections and blood clots (NHSE & RCP). The purpose of this priority is in the interest of both the hospital and patients that we do not move around in an ad-hoc manner, to solve the bed shortages but to carefully plan this and ensure care is continued.

Our focus for this quality priority, is to develop the patient flow team whereby we will:

- Aim to review the required departments and staff groups in and outside of the hospital that need to attend the bed meetings
- The 12-noon bed meeting will include partners in the Community and Social Care, alongside the Divisional and Department representation
- Each discipline will be able to share their assessments and interventions to deliver effective and responsive patient care. The aim of this is to ensure that if there is a need to outlie patients, that it is undertaken in a measured and safe way.

Safe: ***Falls – Reducing the number of inpatient falls in hospital, will improve the patient experience, reduce their length of stay and improve patient outcomes. The added benefit of this will decrease the cost of caring for our patients, in hospital and in the community.***

'Falls among inpatients are the most frequently reported safety incident in NHS hospitals. 30-50% of falls result in some physical injury and fractures occur in 1-3%. No fall is harmless, with psychological sequelae leading to loss of confidence, delays in functionality, recovery and prolonged hospitalisation'.

The NHS has recognised the importance of falls through its national clinical quality improvement target and has placed the assessment of patients, who may fall as a priority.

There are three objectives to the assessment process that we, as a Trust, need to embed and strengthen; these are lying and standing blood pressure, mobility assessment and a medication review has been undertaken.

- As a Trust the focus for all the teams is to embed and support the NHS clinical improvement agenda as well as our own quality priority.

Safe: ***Learning lessons to improve patient experience.***

Each of us want our care to be safe. As a patient you want to feel safe and have a positive experience when you are under the care of the Trust. One of the ways we can try and ensure that what we do is based upon best practice and safety is to learn from, when things go wrong.

Our focus for this quality priority is to be more innovative in our approach by developing:
- An interactive Learning Portal which will provide staff with useful learning resources, such as powerful real-life patient experiences to understand the emotional and physical impact
- A fully illustrated staff guide, on how to identify learning and more importantly what to do with it, when there has been a problem.

Experience: ***Space for patients/family and staff to care for patients living with dementia. A space such as a reminiscence room with music, art etc to help distract from being in a different environment.***

We know that dementia is a significant challenge and a key priority for the NHS, with an estimated 25% of acute beds occupied by people with dementia. We know that when people with dementia come into acute care, their length of stay is longer than people without dementia.

Our focus for this quality priority, will be to undertake several actions; we aim to scope the requirement for the room, through a review of best practice and go see opportunities; consider whether a separate room is required, or if an existing day room can be refurbished to act as a room for:
- social activities
- a quiet space for calming distressed patients / a therapeutic / a calming place for patients
- Work with service users to co-design the layout, decoration and furnishings
- Identify opportunities for local fund raising

Experience: ***Improved resources for distressed relatives / breaking bad news relating to End of Life Care (EoLC) – e.g. relatives' rooms, relatives camp beds etc.***

Providing compassionate care for our end of life care patients is seen as a high priority for the Trust. When a patient is dying, the care and compassion the relatives receives is critical, to how we wish to work and behave.

Currently when breaking bad news to relatives and patients, it can be a struggle to find an appropriate place to hold these conversations. It is often carried out in the ward sister's office, where interruptions often happen.

When the patient is in their last days and hours of life; relatives may wish to stay at the bedside next to their loved one. We currently have 4 camp beds on each hospital site for this eventuality, but this doesn't always meet the need.

Our focus for this quality priority is to:
- Scope out areas at both Hospitals, for example floors at CRH to find available free rooms that ward areas could use and share.
- Decorate (if needed) and buy comfortable furniture so that they can be used to provide a more comfortable and supportive place to have these discussions.
- Look to purchasing 2 more glide away beds for relatives to sleep on

This work has helped identify the following quality improvement priorities for 2020/21.

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

The three priorities for 2020/21 are:

Domain	Priority
1. Safety	***Learning lessons to improve patient experience.***
2. Effectiveness	***Improve staff handovers to ensure they routinely refer to the psychological and emotional needs of patients, as well as their relatives / carers.***
3. Experience	***Improved resources for distressed relatives / breaking bad news relating to End of Life Care (EoLC) – e.g. relatives' rooms, relatives camp beds etc***

Why our Governors and staff chose these 3 priorities:

Safety – We all want our care to be safe. As a patient you want to feel safe and have a positive experience when you are under the care of the Trust. One of the ways we can try is to and ensure that what we do is based upon best practice and safety and to learn from, when things go wrong.

Effectiveness – Our mental health influences our physical health. It influences our capability to lead a healthy lifestyle and to manage and recover from physical health conditions, particularly long-term conditions.

Experience – Providing compassionate care for our end of life care patients is seen as a high priority for the Trust. When a patient is dying, the care and compassion the relatives receive, is critical to how we wish to work and behave.

2.3 Statements of Assurance from the Board

2.3.1 Review of services

During 2019/20 Calderdale and Huddersfield NHS Foundation Trust provided and/or sub-contracted 36 designated Commissioner Requested Services.

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

The income generated by the relevant health services reviewed in 2019/20 represents 100% of the total income generated from the provision of relevant health services by Calderdale and Huddersfield NHS Foundation Trust for 2019/20.

2.3.2 Participation in clinical audit

The 2019/20 Trust Clinical Audit Programme included a combination of national mandatory audits, non-mandatory audits, local priority audits (e.g. National Institute for Health and Care Excellence Clinical Guideline snapshot audits), and local audit (service evaluations, self-interest). All national mandatory audits presented and delivered by the Trust with any actions underway, should be commenced within 4 months of publication.

During 2019/20, 49 of the national clinical audits and 3 national confidential enquiries covered relevant NHS services provided by Calderdale and Huddersfield NHS Foundation Trust.

During that period Calderdale and Huddersfield NHS Foundation Trust participated in 98% of national clinical audits and 100% confidential enquiries which it was eligible to participate in.

Must do audits the Trust participated in:

- NCAPOP (National Clinical Audit and Patient Outcomes Programme) and other national clinical audits relevant to the services provided, and/or where participation must be reported in Quality Accounts
- Audits demonstrating compliance with regulatory requirements, e.g. audits with the aim of providing evidence of implementation of National Institute for Health and Care Excellence (NICE) guidance,
- National Service Frameworks, and other national guidance such as that generated by the Clinical Outcomes Review Programme and NCEPOD (National Confidential Enquiry into Patient Outcome and Death)
- Audits required by external accreditation schemes, e.g. cancer peer review audits, IR(ME)R (Ionising Radiation (Medical Exposure) Regulations) etc.

Internal must do audits the Trust participated in:

These audits are based upon identified high risk or high-profile matters arising locally. Many of these clinical audits will arise from governance issues or high-profile local initiatives, and may include national initiatives with local relevance, without penalties for non-participation.

- Audits undertaken to meet organisational objectives and service developments
- Clinical risk issues
- Audits undertaken in response to serious untoward incidents/adverse incidents/complaints
- Organisational clinical priorities
- Priorities identified via patient and public involvement initiatives

A key objective for 2019/20 was the development of a comprehensive Clinical Audit Database. All clinical audit projects i.e. National, Trust Priorities, NICE audits, National Patient Safety Alert Audits, Safeguarding Audits etc are included in the database. Project plans, reports, summaries and action plans are embedded with each project. There is a total of 363 audits on the current programme.

Corporate Division
- 11 projects on the Corporate 2018/19 clinical audit programme
- 9 Local Priority audits (NICE Guidelines, improvement initiatives)
- 2 National Audits

In addition to the above there was a programme of 11 Infection Control Audits in various stages of the audit process

Surgery & Anaesthetics Division
- 119 projects on the 2019/20 clinical audit programme
- 77 were a mix of local audit and local priority audits
- 42 National Audits

Families and Specialist Services Division
- 91 projects on the 2019/20 clinical audit programme
- 19 National Audits (mandatory and non-mandatory)
- 72 local audit projects including NICE Clinical Guidelines, Trust Priorities etc.

Medicine Division
- 129 projects on the Medicine 2019/20 clinical audit programme
- 62 National / NCEPOD audit projects
- 67 local audit projects including NICE Clinical Guidelines, Trust Priorities etc.

Community Division
- 13 projects on the community 2019/20 clinical audit programme
- 7 National Audit / NCEPOD Projects
- 6 local audit projects including NICE Clinical Guidelines, Trust Priorities etc.

Each programme was broken down into subsections for National Audit (mandatory and non-mandatory) Local Priority Audit (NICE Guidelines, Trust improvement audits) and Local Audit (service evaluation, self-interest etc.)

The National Mandatory Audits (those on the quality account list with subscriptions paid) were mostly continuous data collection year on year. These may appear on the annual audit programme more than once due to a time lag between completion of data collection and publication of the audit results, often up to or beyond 12 months.

Financial implications for the Trust:
Except for NCEPOD studies, all quality accounts audits were paid for on time. Several national audits for 2019/20 were subscription based. The funding arrangements for national audits, that are part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP), have a standard charge of £10,000 + VAT per annum.

These are detailed in Appendix A.

2.3.3 Participation in clinical research

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

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

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2019/20 that were recruited into trials during this period to participate in research approved by NHS Health Research Authority and the National Research Ethics Committee was 1209 (as at end of January 2020).

The Trust is involved in conducting 84 clinical research studies all of which are actively recruiting (excludes student and Participant Identification Centre – PIC studies), 17 have closed to recruitment (but participants are still involved e.g. in follow-up) and 19 new recruiting studies have opened. A further 30 studies are undergoing 'capacity and capability assessment'.

During 2019/20 actively recruiting research studies were being conducted across all 5 Trust Divisions across twenty-five clinical specialties. Specialties such as cancer, stroke, general surgery and reproductive health being the most research active.

There are over 100 clinical staff (supported by 20+ non-clinical staff) participating in research at the Trust during 2019/20, of which 52 were local principal investigators.

In 2019/20 11 publications have resulted from Trust involvement in National Institute for Health Research, which shows Trust commitment to transparency and desire to improve patient outcomes and experience across the NHS.

2.3.4 Proportion of income conditional on CQUIN / Goals agreed with commissioners

A proportion of Calderdale and Huddersfield NHS Foundation Trust's income in 2019/20 was conditional upon achieving quality improvement and innovation goals agreed between Calderdale and Huddersfield NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with, for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. An element of the CQUIN income was guaranteed at a fixed value due to the agreement of an Aligned Incentive Contract with the Trust's main Commissioners, Greater Huddersfield Clinical Commissioning Group and Calderdale Clinical Commissioning Group.

For CCG's and NHS England Public Health and Secondary Care Dental Services the 2019-20 National CQUIN funding is 1.25% across all national schemes and indicators.

For NHS England – Specialised the 2019-20 National CQUIN funding is 0.75% across local CQUIN schemes and indicators.

The contract value for CQUINs in 2019/20 was £3.63m (£3.50m for CCGs and £0.13m for NHS England) compared to 2018/19 when the CQUIN achieved was £6.79m.

The national schemes were as follows.

CQUIN	Community or Acute
1. Antimicrobial Resistance – Lower Urinary Tract Infections in Older People & Antibiotic Prophylaxis in Colorectal Surgery	Acute
2. Staff Flu Vaccinations	Acute
3. Alcohol and Tobacco – Screening and Brief Advice	Acute, Community
4. Three High Impact Actions to Prevent Hospital Falls	Acute
5. Same Day Emergency Care – Pulmonary Embolus/Tachycardia/Community Acquired Pneumonia	Acute, Community

The local NHS England specialised scheme was:

CQUIN	Community or Acute
1. Hospitals Medicines Optimisation	Acute

Further details of the nationally agreed goals for 2019/20 are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

The position provided is reflective of Q3 given consideration to the NHS England/Improvement's publication on 26th March (Revised arrangements for NHS contracting and payment during the COVID-19 pandemic)

The Trust did not fully achieve the following:
- Antimicrobial Resistance – Lower Urinary Tract Infections in Older People – (partially achieved)
- Alcohol and Tobacco – Screening and Brief Advice – (partially achieved)
- Three High Impact Actions to Prevent Hospital Falls
- Same Day Emergency Care – (partially achieved)

2.3.5 CQC registration and conditions/actions

Calderdale and Huddersfield NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and has full registration without conditions.

Following a CQC well-led inspection in April 2018, the CQC published its inspection report in June 2018. The Trust improved its overall CQC rating from 'Requires Improvement' to 'Good'. The report can be found at the following link: http://www.cqc.org.uk/provider/RWY

Our ambition is to achieve an overall rating of 'Outstanding' at the next inspection.

The overall 'Good' rating was aggregated from core service and domain ratings and ratings from the Use of Resources and Well Led inspections. A summary of the domain ratings is given below, comparing this with those of the previous inspection.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement → ← Jun 2018	Good ↑ Jun 2018	Good → ← Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018	Good ↑ Jun 2018

The Trust achieved:
- 'Requires improvement' for the safe question.
- 'Good' for all other core service questions.
- 'Requires improvement' for the Use of Resources inspection.

Following the inspection, action plans remain in situ and we have completed many of those identified actions from 2018/19. Of the outstanding actions from the 2018 CQC inspection, the Trust still has five actions to complete. These have been defined as must do (MD) and should do (SD).

The present position in relation to CQC action plan compliance can be seen below:

CQC Exception Plan – Outstanding Action	Level of Assurance
SD9 – The Trust should ensure they work to meet the Royal College of Emergency Medicine recommendations of 16 hours consultant presence in the department.	Limited Assurance – The Trust remains non-compliant with this standard given our current consultant workforce numbers. We are continuing with attempts to recruit to consultant numbers to deliver this standard
MD1 – The trust must improve its financial performance to ensure services are sustainable in the future	Substantial Assurance – The Trust has submitted a five-year financial plan through the Integrated Care System and onward to regulators in line with the defined challenging Financial Improvement Trajectory. This trajectory sees a projected reduction in the deficit position but continues to require external funding support to achieve breakeven.
MD8 – The Trust must ensure medical staffing at Calderdale is in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards.	Limited Assurance – The Trust requires further work to make the proposal more palatable financially. Consideration is being made within the trusts planning cycle for 20/21. There is still no mitigation and therefore the risk remains red.
SD3 – The trust should develop processes to measure the outcomes of mental health patients in order to identify opportunities to improve care	Substantial Assurance – Work has progressed with the strategy which is now going for Trust approval and through relevant governance processes
SD6 – The trust should continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards.	Substantial Assurance – Discussed at nursing huddles and within Divisional Governance Meeting to strengthen staff knowledge.

The CQC Response Group has continued to meet and is chaired by the Executive Director of Nursing/Deputy Chief Executive. The CQC Response Group reports to the Quality Committee. Calderdale and Huddersfield Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

2.3.6 Data Quality

The Trust submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:
- Admitted Patient Care = 99.9%
- Outpatient care = 100%
- Accident & Emergency Care = 99.4%

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

These figures are based on April 2019 to December 2019, which are the most recent figures in the Data Quality Dashboard.

Several specific data quality KPIs are agreed as priorities and the delivery of progress against these is monitored at the Trust's fortnightly Data Quality Group. This group actively scans for any new issues and responds to these as required, supported by the Cymbio Dashboard.

The Trust has a draft data quality strategy and a Data Quality Board in place. Further detail on the governance structure for data quality and ways of assuring the quality of data is given in the Trust Annual Governance Statement.

The Electronic Patient Record – EPR deployment was a joint deployment between Calderdale and Huddersfield Foundation Trust and Bradford Teaching Hospital Foundation Trust. Certain aspects of the system (specifically the Master Patient Index and system design) require ongoing joint working by both organisations to help address system and data issues. This approach has helped in overcoming some challenges and it is hoped this will continue as we gain more experience and familiarity with the new EPR.

Since June 2019 five notable initiatives at the Trust (all which include data quality elements to greater and lesser degrees) have been commenced;
i. Review of ordering from the wrong encounter
ii. Referral to Treatment (RTT) detailed deep dive,
iii. Outpatient Services Issues work plan
iv. External review by Draper and Dash
v. Programme of review of consistently green Key Performance Indicators (KPIs). Further details of all these are available in detail on request.

An example of one of these initiatives, namely outpatient services, involved the Trust undertaking a significant programme of work to understand outpatients and appointments issues from the perspective of multiple stakeholders. A 'deep dive' was undertaken to ensure all issues related to outpatients and appointments were identified and during the year have developed a comprehensive action plan to drive improvement.

By way of additional assurance, the Trust commissioned an external, independent review of issues raised by the CQC and others about current outpatient provision at the Trust. This focused on identification of current risks and the consequent priorities for the Trust and the experiences of users of the outpatient service (patients and clinicians) and staff engaged in managing the service.

Four issues were identified from the external independent review.
These were;
1. number of patient lists managed across the outpatient system.
2. training of staff managing the outpatient system.
3. the number of cancelled appointments and clinics and communication with patients.

The developed action plan was categorised into the three key issues which were identified from the deep dive:
- Issues related to EPR and digital patient communications
- User issues
- Access issues – capacity / demand

The Trust's ongoing action plan against the key issues listed above provide assurance that the issues arising from the deep dive will in due course have a positive impact on patient experience and outpatient services.

2.3.7 Data Security and Protection Toolkit

The 2018/19 Data Security and Protection Toolkit was submitted in March 2019 with a rating of 'Standards not fully met'. A plan has been agreed to address our compliance and work started immediately after the Trust received the rating and has been on-going throughout 2019 and into 2020 to gather evidence. Our work towards compliance will continue into 2020/21.

There have been online and face-to-face awareness raising events and visits to wards and departments across the Trust to interact with staff and ensure that all information governance standards are being adhered to.

Annually, staff are mandated to complete the Data Security and Protection Training module within the Electronic Staff Record (ESR) , in addition to this, the Information Governance Team have held refresher Data Security and Protection face-to-face training sessions, where a paper-based assessment is always completed at the end of the session.

2.3.8 Clinical Coding Error Rate

Since May 2015 Calderdale and Huddersfield Foundation Trust have not been subject to a Payment by Results clinical coding audit. However, a Data Security and Protection Toolkit (DSPT) compliant audit was carried out in February 2019 by NHS Digital Approved Clinical Coding Auditors.

The Audit looked at 220 Finished Consultant Episodes (FCEs) randomly taken from all hospital spells coded on 25th October 2018. Episodes were audited against national coding standards using Version 12 of the Clinical Coding Audit Methodology.

Overall, both the diagnostic and procedural coding was good. This has led to the Trust achieving the mandatory level for the Data Quality section of Standard 1 of the Data Security & Protection Toolkit. The final percentages are as follows:

Primary diagnosis correct	Secondary diagnoses correct	Primary Procedures correct	Secondary procedures correct
90%	**90.9%**	**91.7%**	**92.9%**

2.3.9 Learning from Deaths – Adult Inpatients

During 2019/20, 1492 CHFT adult inpatients died. This comprised the following number of adult deaths which occurred in each quarter of that reporting period:

- 337 in the first quarter.
- 330 in the second quarter.
- 436 in the third quarter.
- 389 in the fourth quarter

ISRs (Initial Screening Reviews) are a first-line case note review. Monthly mortality is reviewed within each specialty using the generic ISR online tool with or without specialty specific questions. Cases where the quality of care has been assessed as poor or very poor are escalated for a more in depth and independent (of the specialty) SJR (Structured Judgement Review).

The SJR assesses the quality of care in line with the Royal College of Physician's recommendations. Findings from SJRs are collated and are fed back to clinical teams to inform how we improve and review our care pathways. Certain cases are escalated directly for SJR, including deaths of patients admitted for elective procedures, patients with learning disabilities, deaths where there is a Serious Incident and/or complaint from relatives/carers.

As at the end of March 2020, 434 initial screening reviews have been completed which is an overall average of 29.3% of all deaths reviewed

146 Structured Judgement reviews were requested in 2019/20.

The number of Structured Judgement Reviews requested per quarter was:

- 48 in the first quarter.
- 30 in the second quarter.
- 46 in the third quarter.
- 22 in the fourth quarter

During 2019/20 62 Structured Judgement reviews identified problems with care provided to the patient. The reviewers are asked to make a judgement as to if the problem led to patient harm. The breakdown of responses was:

- Yes - 27
- Probably - 15
- No – 22

In 27 cases representing 1.8% of all adult inpatient deaths during 2019/20 a problem with care was judged to have led to patient harm.

Poor or very poor care was identified in 22% of the SJRs
Good or excellent care was identified in 35% of the SJRS

A thematic review of the 2019/20 SJRs identified the top 5 areas of good practice as:

- Early identification of deteriorating/dying patient
- Good clinical decision-making and clear documentation
- Excellent nursing care
- Timely Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) agreed
- Sensitive and frequent communication with families

And the main areas where improvement in care is needed are:

- Timely escalation or decision-making not to escalate – of High NEWS scores to senior colleagues
- Recognition of dying phase
- Failure to consider past medical history leading to delay in diagnosis
- Communication between healthcare professionals, patients and their families and carers
- Documentation especially of communication, diagnoses and cause of death

The next step is to share this learning across the Trust and formulate quality improvement plans.

2.3.10 Seven Day Services

The 7 Day Hospital Services (7DS) Programme was developed to support NHS Trusts to deliver high quality care and improve outcomes on a 7-day basis for patients admitted to hospital in an emergency through ten clinical standards.

Since 2015, acute trusts such as Calderdale and Huddersfield Foundation Trust have been asked to focus on the following four priority standards:

Standard 2 specifies that all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours from the time of hospital admission.

Standard 5 covers the availability of six consultant-directed diagnostic tests for patients either on site or offsite by formal network arrangements: Microbiology, CT, Ultrasound, Echocardiography, MRI, Upper GI endoscopy

Standard 6 covers the 24/7 access to nine consultant-directed interventions, either on site or via formal network arrangements: Critical Care, Interventional Radiology, Interventional Endoscopy, Emergency Surgery, Emergency Renal Replacement Therapy, Urgent Radiotherapy, Stroke Thrombolysis, Percutaneous Coronary Intervention, Cardiac Pacing

Standard 8 relates to on-going consultant-directed of patients admitted acutely once they have had their initial consultant assessment. This means that patients with high dependency needs, usually sited in Acute Medical Unit (AMU), Surgical Assessment Unit (SAU) and Intensive Therapy Unit (ITU), should be reviewed by a consultant twice daily. All other patients admitted in an emergency should be reviewed by a consultant once daily, unless the consultant has delegated this review to another competent member of the multi-disciplinary team, having determined that this would not affect the patient's care pathway.

The Trust has implemented the newly developed national seven-day services board assurance framework and template and submits audit data to NHS England bi-annually using an online survey tool and the compliance target score for each priority standard is 90%.

The Trust continues to review and complete the NHS England Board Assurance Framework for 7 Day hospital Services during the year which is self-assessment of seven-day service performance ***see Figure 1, which provides the CHFT update for 19/20***

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
CHFT continue to progress services in line with a seven day agenda. There has been considerable progress within Medicine since the last submission. Specialities with 7 day cover and on-call now include: Stroke, Acute Medicine, Diabetes (Nurse-led), Cardiology, Haematology, Oncology, Respiratory (from 6.1.20) E-coordinators have worked across seven days for some time and the number of patients discharged on Saturdays and Sundays has held steady after the increase achieved in 2018 and early 2019 S9) . This is evidenced by a maintainence of the reduction in acute length of stay achieved in 2018, indicating that discharge pathways suffer minimal disruption at weekends (S3) and that pathway)management remains active seven days of the week. Acute Mental Health Services are available seven days a week, although work continues to continue to evolve this service to meet what is sometimes an unpredictable demand. Shift handovers are now recorded digitally, giving clarity and a single truth, some work is ongoing to fully standardise these across seven days and variation in practice due to individual custom and practice.

7DS and Urgent Network Clinical Services

A sub set of twenty patients was selected for specific measurement in the areas where CHFT provide network services. In both the organisation was 100% compliant.

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency				Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency				Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency				Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency				Yes, the standard is met for over 90% of patients admitted in an emergency

Figure 1

2.3.11 Ways staff can speak up

The Trust supports a 'speak up' culture where we listen, learn and act on concerns. Colleagues can raise their concerns through a variety of channels:

- via the Freedom to Speak Up Guardian/Freedom to Speak up ambassadors / Freedom to Speak up portal - accessible 24/7, 365 days a year (accessible via the intranet and CHFT website)
- "Ask Owen", colleagues can ask our Chief Executive anything via this channel accessible on the CHFT intranet
- the DATIX incident reporting system
- via their line managers at 1 to 1's and regular team briefings
- via the Union
- via the Equality Networks
- via the Chaplaincy team

Staff can also speak up regarding patient safety issues through the above processes and their divisional governance processes. Bullying and harassment issues are dealt with under the Trust's bullying and harassment policy and staff can also raise issues via the Trust's Grievance Procedure.

The Trust has a Raising Concerns Policy in place and is currently revising this. Work will take place on a process to ensure feedback is given to staff who have raised a concern.

The Trust's Raising Concerns Policy makes it clear that staff who speak up must not suffer a detriment. Where there is evidence that this has occurred action will be taken as appropriate.

The table below states the number and types of cases being dealt with by the Guardian and the Freedom To Speak Up (FTSU) ambassadors/ volunteers since the first concern being raised

Figure 2 – Cases raised since 2018-to date

Date Period	No. of Concerns	No. raised anonymously	No. linked to element of patient safety / quality	No. linked to bullying/ harassment
2018 Total	9	3	4	5

Date Period	No. of Concerns	No. raised anonymously	No. linked to element of patient safety / quality	No. linked to bullying/ harassment
Jan – Mar 2019	9	7	2	0
Apr – Jun 2019	18	5	4	4
July – Sept 2019	22	6	6	1
Oct – Dec 2019	18	10	6	1
2019 Total	67	28	18	6

NB. Albeit a very small sample of data, in 2018, colleagues in roles such as Nurses and Allied Healthcare professionals were more likely to speak up than others.

During 2019/20 there has been:

- A significant increase in colleagues speaking up
- Significant increase in Ambassador activity (26 FTSU Ambassadors and 10 x Talk in Confidence colleagues) wearing their FTSU lanyard with pride and connecting with colleagues across the Trust
- Increased diversity in the type of colleagues raising their concerns i.e. porters, clerical assistants, practice managers, theatre orderlies, nurses, doctors and apprentices.
- The FTSU portal can be accessed via the intranet or via the CHFT website providing round the clock accessibility within and outside of the workplace.
- Improved visibility – Freedom to Speak up stalls, posters, walk arounds, presentations at team meetings

2.3.12 Guardians of Safe Working Hours

The Trust has a Guardian of Safe Working who acts as a champion of safe working hours for doctors in approved training programmes within the Trust and provides assurance that doctors work hours that are safe and in compliance with the terms and conditions of service for NHS Doctors and Dentists in Training 2016.

At the Trust many of our trust grade doctors work side by side with doctors in training. The Trust recognises that the rota gaps can have a noticeable impact on both the training experience and the quality of work life balance. We have a dedicated Medical Human Resources team who can focus directly on recruitment to medical and dental recruitment.

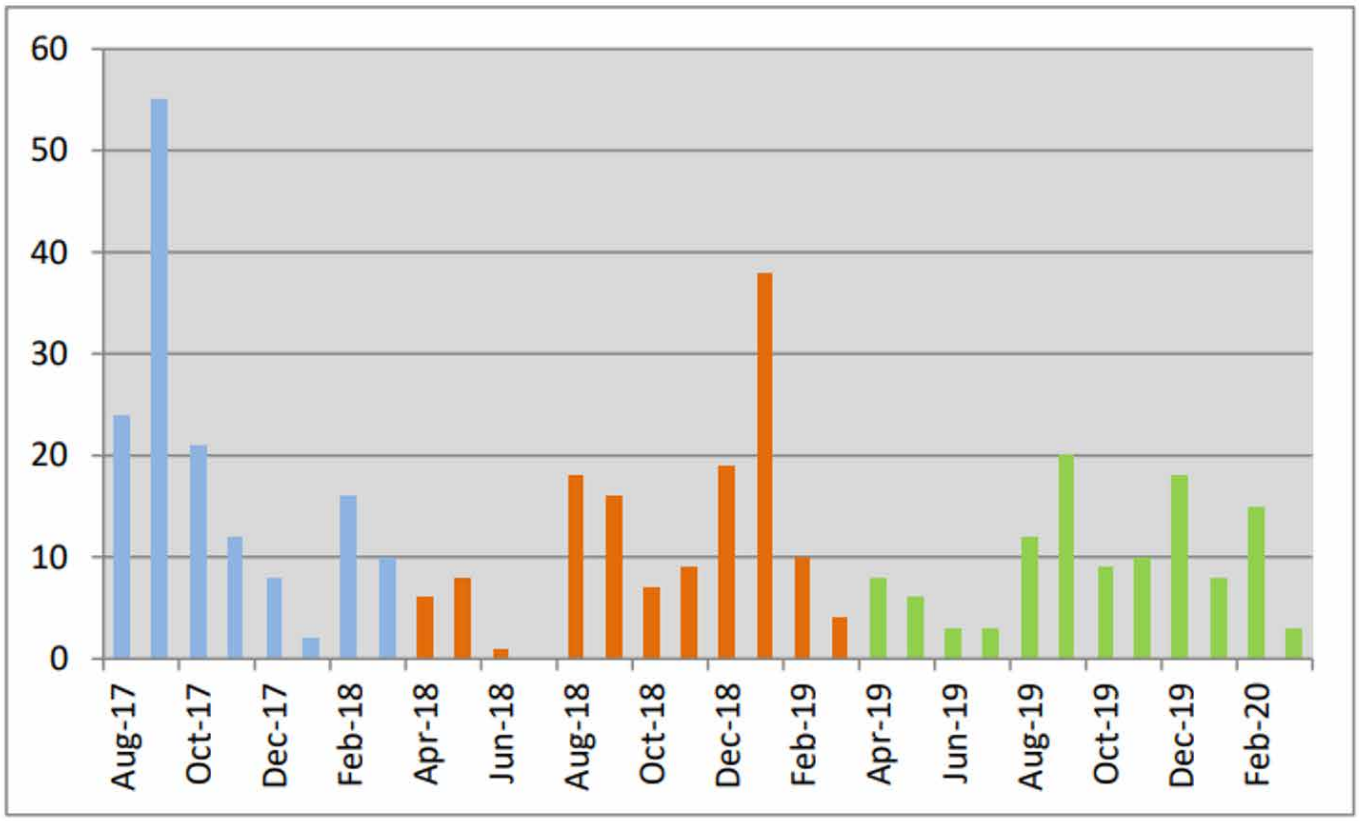
There has been improved engagement of trainees through the junior doctor forum (JDF) which first took place in October 2019. This forum continues to provide better insight into common day-to-day problems faced by them and suggestions on how the organisation could improve their working lives.

The Trust has signed up to the British Medical Association's fatigue and facilities charter led by the Director of Medical Education (DME) with support from the Guardians of Safe Working Hours. The Trust received £30,000, to support the improvement of facilities for junior doctors regarding fatigue issues. Following consultation with junior doctor representatives it was agreed to use these monies to fund refurbishment of existing mess facilities on both hospital sites. This work is now nearing completion.

Implementation of the revised 2016 Terms and Condition Service (TCS) is underway and it is agreed that compliance will be monitored.

Trends in exception reporting
There has been a total of 114 exception reports from junior doctors representing sixteen percent of all doctors in the 2016 TCS. The majority of these (96%) were from junior trainees with five exception reports from ST3-ST6 grades. There is a spike seen with increased exceptions reported soon after the FY1 induction in July and then during the winter months reflecting a busy period in hospital.

Number of monthly exception reports (2017-current)



Reports received by the Board for the period April 2019-March 2020 confirmed the following in relation to rota gaps:

- Within medicine the exception report flagged very busy on-call shifts on weekends. From August 2019 the rota was revised with extra weekend cover arrangements to provide a more equitable distribution of weekend on-call.
- A high number of registrar gaps within the Emergency Department (ED), with a reliance on locums and Advanced Care Practitioners to fill these vacancies. The ED rota was also revised in August 2019 which has improved the position with fewer registrar level gaps.
- Paediatrics had gaps at registrar grade which were covered by a combination of Advanced Clinical Practitioner's and locums, with recruitment of two trust grade doctors in quarter 4 to help bridge gaps
- Two vacancies with anesthetics are being covered by bank staff.
- In trauma and orthopeadics there were three trust grade vacancies (Junior grade) which have been filled, but with a delayed start date due to the COVID-19 pandemic. There is one deanery gap at the registrar level which is covered by bank staff.
- Within general surgery there is a gap at the registrar grade, none at foundation level and the vacancy at the CT grade which has been recruited into. For both urology and Ear, Nose and Throat (ENT) there is a long-term registrar gap which is covered out of hours by locums.

Guardian fines
No fines were levied.

Junior doctor forum (JDF)
As indicated trainee attendance at the JDF in 19/20 improved. The main discussion was around £30,000 allocated to CHFT to be spent in agreement with junior doctors for improving their working conditions at the Trust. This is following the BMA fatigue and facilities charter published in 2018.

Following sign-up to the BMA fatigue and facilities charter CHFT there will be a baseline assessment against the charter and an action plan for 2020/21

A junior doctor poll was requested to ascertain their needs at work to best allocate the above funding and those findings has influenced how the money was allocated.

Results from the junior doctor poll (Oct-Nov 2019, 40 responders)
The survey was around trust facilities, the exception reporting process and improving the working lives of our junior doctors.

Facilities:

- 65% of juniors do not know how to access the mess
- 95% of juniors think the mess facilities are currently unsuitable
- 77.5% said they would use the facilities if they were improved.
- 83% of people would use the mess if it was in a better location
- 60% believe the mess should be functional, 40% think it should be comfortable.

Improving junior doctor working life:
Main themes were;

- Increasing availability of computers in wards and offices
- Difficulty in car parking
- Inadequate time given in work schedules to update portfolios and complete mandatory training-Medical education and Human Resources are aware and dedicated time has been allocated.
- Availability of 'doctor's office/space' near clinical areas for administrative work
- Improving catering options and facilities
- The need for a confidential waste bin in the doctor's handover room (Huddersfield Royal Infirmary) was flagged up and resolved

In addition, these themes will form part of the action plan for 2020/21 in relation to outcomes for junior doctors and fatigue.

2.4 Review of quality performance – reporting against core indicators

This section relates to information about the quality of services that the Trust provides by reviewing performance over the last year and how the Trust compared with other Trusts. The NHS Outcomes Framework 2019/20 set out high-level national outcomes which the NHS should be aiming to improve. The framework provides indicators which have been chosen to measure these outcomes.

An overview of the indictors is provided in the table. It is important to note that whilst these indicators must be included in the Quality Accounts the more recent national data available for the reporting period is not always for the most recent financial year.

Where this is the case, the time period used is noted underneath the indicator description. It is also not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.

The information in the table is followed by explanatory narrative for all indicators, ordered by outcome domain in figure 3.

Summary table of performance against mandatory indicators

Outcome Domain	Indicator	Most recent data	National Average	Best	Worse	last report period	last report period	last report period
Preventing people from dying pre-maturely	**SHMI** Reporting Period:	Oct 18-Sept 19				Oct 17-Sept 18	Oct16 -Sept17	(Oct 15 – Sept 16)
	Summary Hospital-Level Mortality Indicator (SHMI) value and banding	98.63	100	NA	NA	100.25 Band 2 – As Expected	100.81 Band 2 = As expected	108 Band2 = As expected
Helping people recover from episodes of ill health or following injury	**18. PROMS; Patient Reported Outcome Measures**							
	Reporting Period:	(2017/18)				2017/18	(2016/17)	(2015/16)
	(i) hip replacement surgery,	0.46	0.45	N/A	N/A	0.47	0.44	0.45
	(ii) knee replacement surgery.	0.32	0.33	N/A	N/A	0.36	0.32	0.32
	19. Patients readmitted to a hospital within 28 days of being discharged.							
	Reporting Period:	Apr19-Mar20				(2018/19)	(2017/18)	(2016/17)
	(i) 0 to 15; and	12.05%	Not released by NHS Digital			10.51%	10.32%	11.43%
	(ii) 16 or over.	10.50%				9.07%	8.96%	11.95%
Ensuring that people have a positive experience of care	National Survey							
	Reporting Period:	2018				2017	2016	2015
	20. Responsiveness to the personal needs of patients.	6.6	NA	NA	NA	6.9	6.8	7.1
Treating and caring for people in a safe environ-ment and protecting them from avoidable harm	Reporting Period:	2019/20				2018/19	2017/18	2016/17
	23. Patients admitted to hospital who were risk assessed for venous	96%	N/A	N/A	N/A	97%	94.39%	95.11%
	C.difficile							
	Reporting Period:	2018/19				17/18	16/17	15/16
	24. Rate of C.difficile per 100,000 bed days	9.9	13.2	NA	NA	16.5	12.7	10.4
	Patient Safety Incidents - Reporting Period:	Oct 18 - March 19				Oct 17 - March 18	April 17 - Sept 17	Oct 16 - Mar 17
	(i) Rate of Patient Safety incidents per 1000 Bed Days	53.17	46.1	NA	NA	42	41.7	39.6

Figure 3 Summary table of performance against mandatory indicators

Domain: Preventing people from dying prematurely

The Summary Hospital Mortality Index (SHMI) is a measure of mortality developed by the Department of Health, which compares our actual number of deaths with the predicted number of deaths. Each hospital is placed into a band based upon their SHMI; the Trust is currently in the 'expected range' category.

There is a six-month time lag in the availability of data for this indicator. SHMI cannot be used to directly compare mortality outcomes between trusts and it is inappropriate to rank trusts according to their SHMI.

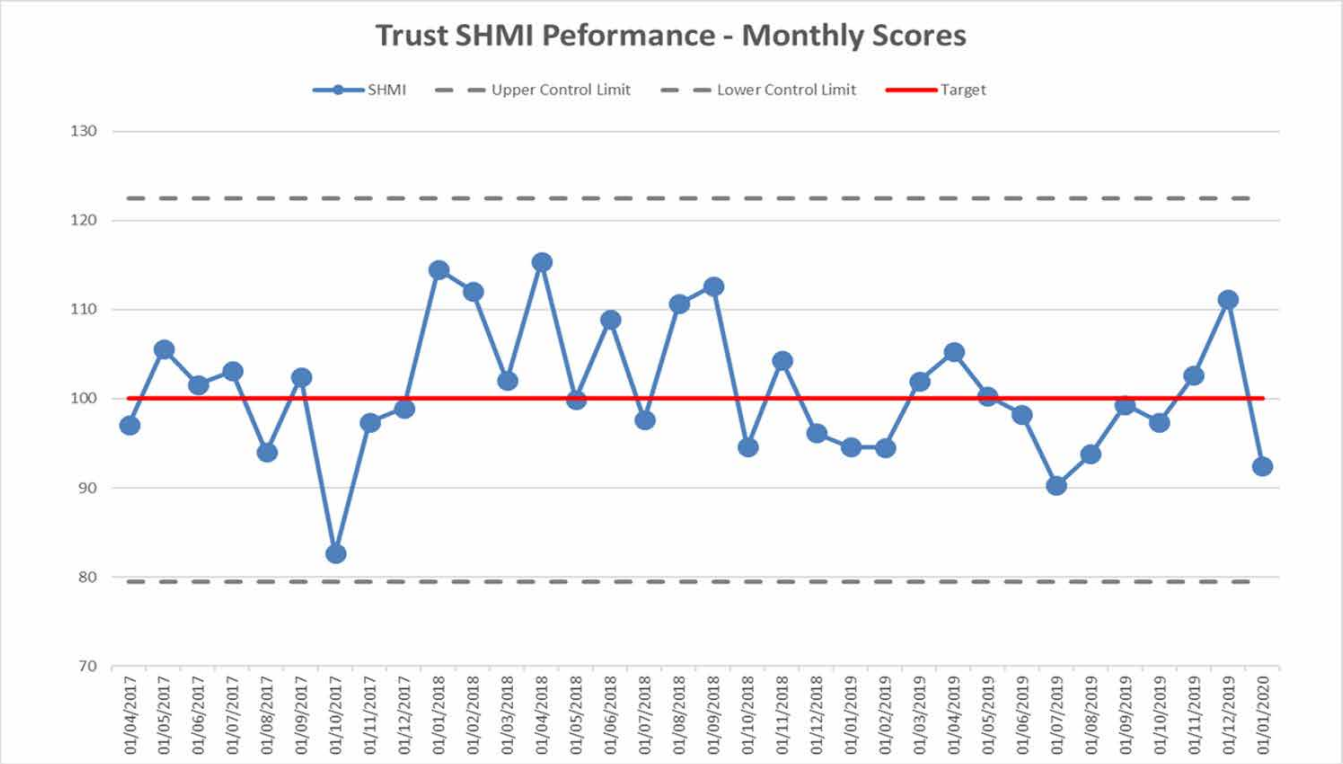


Chart 1: SHMI to date:

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

The Trust has established a monthly Mortality Surveillance Group reporting to the Quality Committee through the Clinical Outcomes Group.

As a Trust we recognise the significant improvements in HSMR and SHMI as measures of mortality. The emphasis will continue to be learning from deaths through the established Learning from Death structure and process. The HSMR figure had risen over the 100 target for the first time in 2 years in December 2019, however this indicator did fall back significantly below the 100 in January 2020 this will continue to be monitored.

During 2019/20 The Trust continued its work around mortality case note review.
The Trust has performed both initial screening reviews and more in-depth structured judgement reviews, information on the learning so far can be seen in the Learning from Deaths section.

Domain: Helping people recover from episodes of ill-health or following injury

Patient reported outcome measures (PROMs)

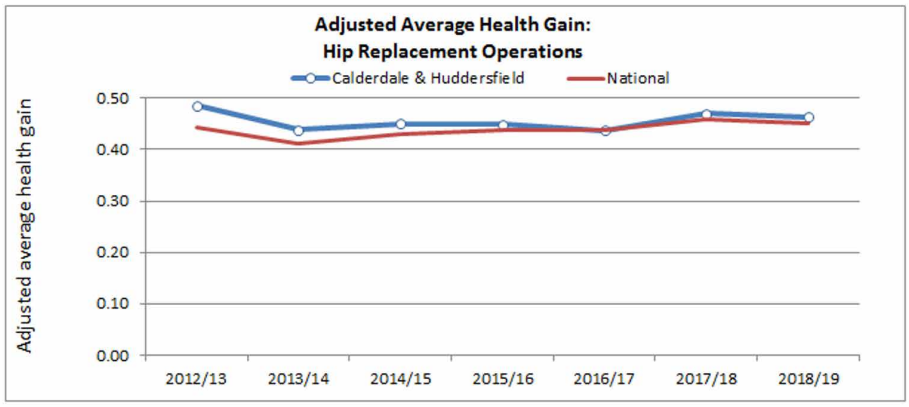
A patient reported outcome measure is a series of questions that patients are asked in order to gauge their views on their own health. In the examples of hip replacement surgery and knee replacement surgery, patients are asked to score their health before and after surgery. We are then able to understand whether a patient sees a 'health gain' following surgery.

The data provided gives the average difference between the first score (pre-surgery) and the second score (post-surgery) that patients give themselves.

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

(i) Hip replacement surgery

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Calderdale & Huddersfield	0.49	0.44	0.45	0.45	0.44	0.47	0.46
National	0.44	0.41	0.43	0.44	0.44	0.46	0.45



(ii) Knee replacement surgery

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Calderdale & Huddersfiel	0.37	0.34	0.33	0.33	0.32	0.36	0.32
National	0.32	0.32	0.31	0.32	0.32	0.33	0.33

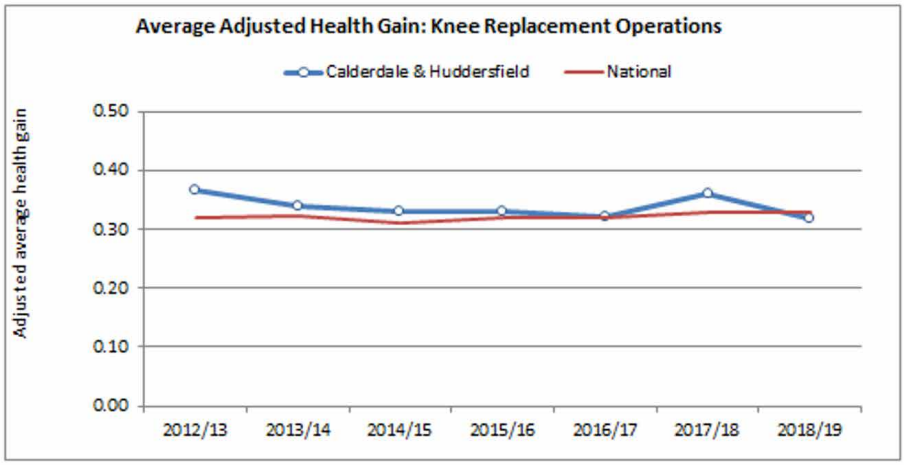


Chart 3: PROMS – Knees

Readmissions within 28 days

The charts show the percentage of patients readmitted within 28 days of discharges, aged:
1. 0 to 15; and
2. 16 and over;

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
0-15	10.64%	11.43%	10.32%	10.30%	10.51%	12.05%
16+	10.80%	11.95%	8.96%	11.10%	9.07%	10.50%

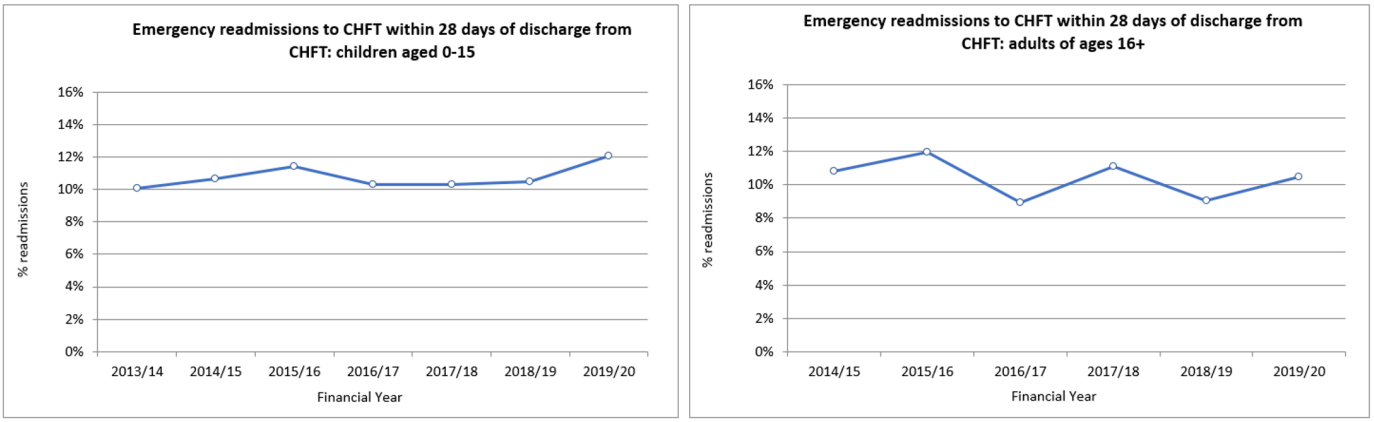


Chart 5: Readmissions within 28 days of discharge

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

- At present there is no national 28-day readmission rate available. NHS Digital has undertaken a methodological review and the metric will be updated in future years to be in line with other standardised readmission figures.
- The data included in these charts differs from the Trust board performance report as the parameters used are slightly different. This variance makes the internal report more meaningful to the Trust.

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

- Through better planned discharges which will lead to fewer readmissions
- By continuation of the SAFER Patient Flow Programmes.

Domain: Ensuring that people have a positive experience of care

Inpatient Survey – Responsiveness to the personal needs of patients (Question 20)

Improving the patient experience is central to the work that the Trust undertakes. This section requires an overview of one of the key questions within the National Inpatient Survey.

The national indicator is a composite of the following questions and calculated as the average of five survey questions from the National Inpatient Survey.

Each question describes a different element of the overarching theme, "responsiveness to patients' personal needs" (based on the 2018 survey).

- Q35: Were you involved as much as you wanted to be in decisions about your care and treatment?
- Q38: Did you find someone on the hospital staff to talk to about your worries and fears?
- Q40: Were you given enough privacy when discussing your condition or treatment?
- Q63: Did a member of staff tell you about medication side effects to watch for when you went home?
- Q69: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

20. Responsiveness to the personal needs of patients.	2012	2013	2014	2015	2016	2017	2018
	7.0	6.9	7.1	7.1	6.8	6.9	6.6

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

The National Inpatient Survey was sent to 1250 patients who had been discharged from inpatient wards at Huddersfield Royal Infirmary (HRI) or Calderdale Royal Hospital (CRH) in July 2018. People were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Overall, we had 499 patients who returned completed questionnaires giving a response rate of 42%. This is a slight increase compared to 2017 survey, see the table below:

% of Responses for National Inpatient Survey	2012	2013	2014	2015	2016	2017	2018
	50%	51%	49%	44%	47%	39%	42%

Calderdale and Huddersfield NHS Foundation Trust intend to take actions to improve this score and the quality of its services by continuing to use patient feedback to create improvement plans for both the overall Trust and individual areas.

Staff Experience

The Trust carried out a staff survey in 2019. A total of 2547 colleagues completed the survey. The survey is anonymous and is conducted by our survey co-ordinator, the Picker Institute Europe.

Our response rate was 46%.

Our best performance areas are:
- Percentage of staff appraised in last 12 months
- Percentage of staff who don't work additional paid hours per week, over and above their contracted hours
- Organisation acts fairly regarding career progression.
- Patient/service user feedback collected within directorate/department.
- Percentage of staff that have not experienced physical violence.

Our key improvements since 2018 are:

- Don't work any additional unpaid hours per week for this organisation, over and above contracted hours
- Last experience of harassment/bullying/abuse reported
- Immediate manager gives clear feedback on my work
- Immediate manager can be counted on to help with difficult tasks
- Satisfied with support from immediate manager

Our worst performance areas are:

- Percentage of staff didn't know who their senior managers are
- Percentage of staff who don't receive regular updates on patient/service user feedback in my directorate/department.
- Percentage of staff that have not had training, learning or development in the last 12 months.
- Percentage of staff who are not involved in deciding changes that affect work.
- Percentages of staff whose training, learning or development need were not reviewed at appraisals.

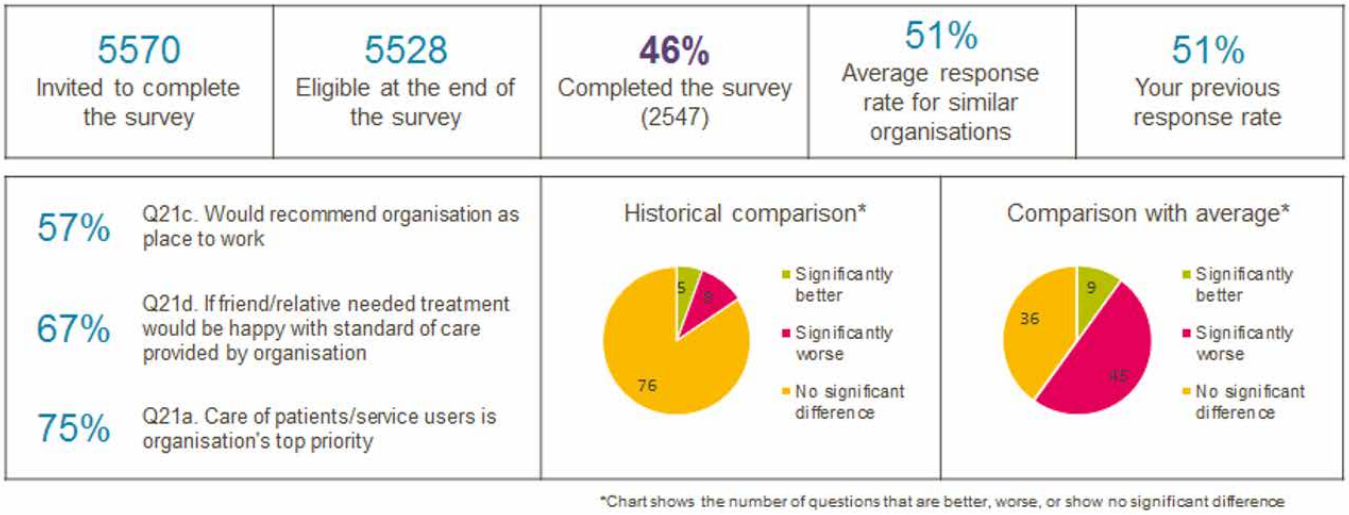


Chart 8- Staff experience

Calderdale and Huddersfield NHS Foundation Trust has an Organisational Development strategy. This aims to support all staff to understand the Trust's business priorities and deliver compassionate care.

The Trust's priorities are underpinned by our four pillars, and demonstrated through our behaviours:

- We Put the Patient First

"I treat patients as people – I listen to their needs and respect their differences."
"I am kind, friendly & compassionate to myself and others."

- We Go See

"I seek out information and use it to make good decisions."
"I seek out opportunities to learn and make things better."

- We Work Together to Get Results

"I recognise and value everyone's contribution."
"I look for solutions and improvement with a can-do, positive approach."

- We Do the Must-Dos

"I take responsibility for my behaviour, actions and learning."
"I champion the rules that deliver compassionate care."

The Trust continues to work to embed these key values and behaviours through its Working Together, Get Results programme, which is available to all staff.

Question/ Indicator	CHFT 2019	CHFT 2018	CHFT 2017	National Average
Q21a Care of patients/service user is my organisations top priority	75% (75.2)	74%	70%	76% (77.4)
Q21c I would recommend my organisation as a place to work	57% (57.3)	58%	54%	62% (62.5)
Q21d If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.	67% (67.5)	70%	66%	71% (70.5)

Question/ Indicator	CHFT 2019	CHFT 2018	CHFT 2017	National Average
Q13a (Indicator 5) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White – 30% BAME – 30%	White – 29% BAME – 30%	White – 28% BAME – 21%	White – 28% BAME – 30%
KF26 (Indicator 6) Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White –23.9% BAME – 27.2%	White – 24% BAME – 27%	White – 23% BAME – 25%	No national
Q14 (Indicator 7) Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White – 87.8% BAME – 79%	White – 86% BAME – 75%	White – 88% BAME – 68%	White – 86% BAME – 70%
Q15b (Indicator 8) In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White – 5.9% BAME – 12.5%	White – 7% BAME – 12%	White – 5% BAME – 20%	White – 6% BAME – 15%

Chart 9 & 10 The responses to KF21, KF25, KF26 and Q17b are reported for the Workforce Race Equality Standard

Domain: Treating and caring for people in a safe environment and protecting them from avoidable harm

Patients admitted to hospitals that were risk assessed for venous thromboembolism.

Venous Thromboembolism (VTE)
Venous Thromboembolism (VTE) is a collective term for deep vein thrombosis (DVT) and pulmonary embolism (PE). VTE is a significant cause of mortality, long-term disability and chronic ill-health problems, many of which are avoidable. It has been estimated that the management of hospital-associated VTE costs the NHS millions per year. This includes the costs of diagnostic testing, treatment, prolonged length of stay in hospital and long-term care. Long term complications that reduce the quality of life add to the human cost and overall burden of VTE. Risk assessing inpatients for venous thromboembolism (VTE) is important in reducing hospital acquired VTE.

The chart shows the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the report period from February 2019 to March 2020. The target for VTE risk assessment for all patients admitted was set at 95% by the NHS.

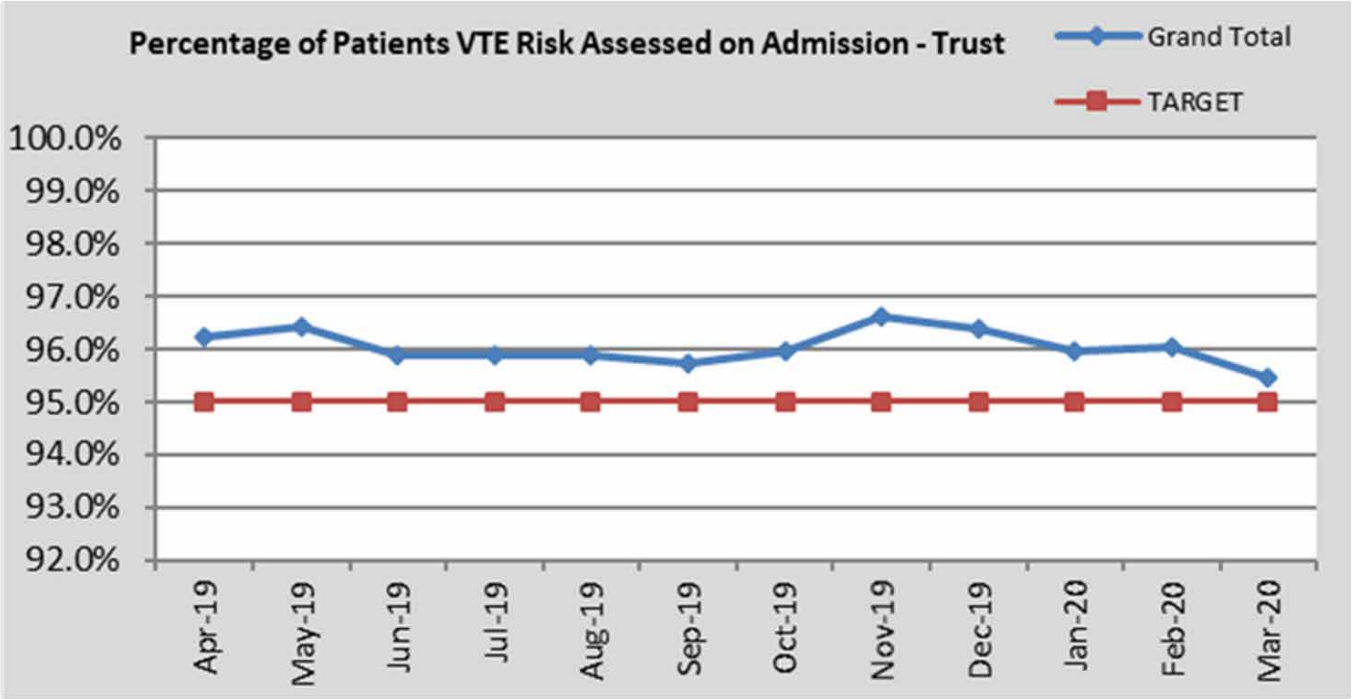


Chart 4: % VTE Risk Assessment Completed

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

Compliance data is now retrieved through our Electronic Patient Record (EPR) when the patient has been discharged from hospital and coded.

The cohort system that has been designed and signed off for use by the Medical Director now uses a method of looking at the procedure code for the spell, along with considering the length of stay (LOS) of the spell. This involved identifying low risk procedures and looking at patients with a LOS of less than 24 hours and identifying them as having a low risk of VTE. In doing this it was felt that this was a much more accurate measure of Trust performance around VTE assessments.

Cohorting is carried out for reporting purposes only and does not mean that a VTE assessment is not required for patients that fall within these cohorts.

Another aspect of the VTE domain is to maintain the level of Hospital-acquired VTE episodes, not more than 20% of all VTE episodes. The Trust achieved well below the 20% trajectory in each quarter, achieving a mean average of 13.5 % for each quarter

The benchmarking graph shows the Trust to be in the second Quartile of Trusts for Q2 2019/20 data, this figure ranks the Trust at 87 of 150 acute trusts nationally.

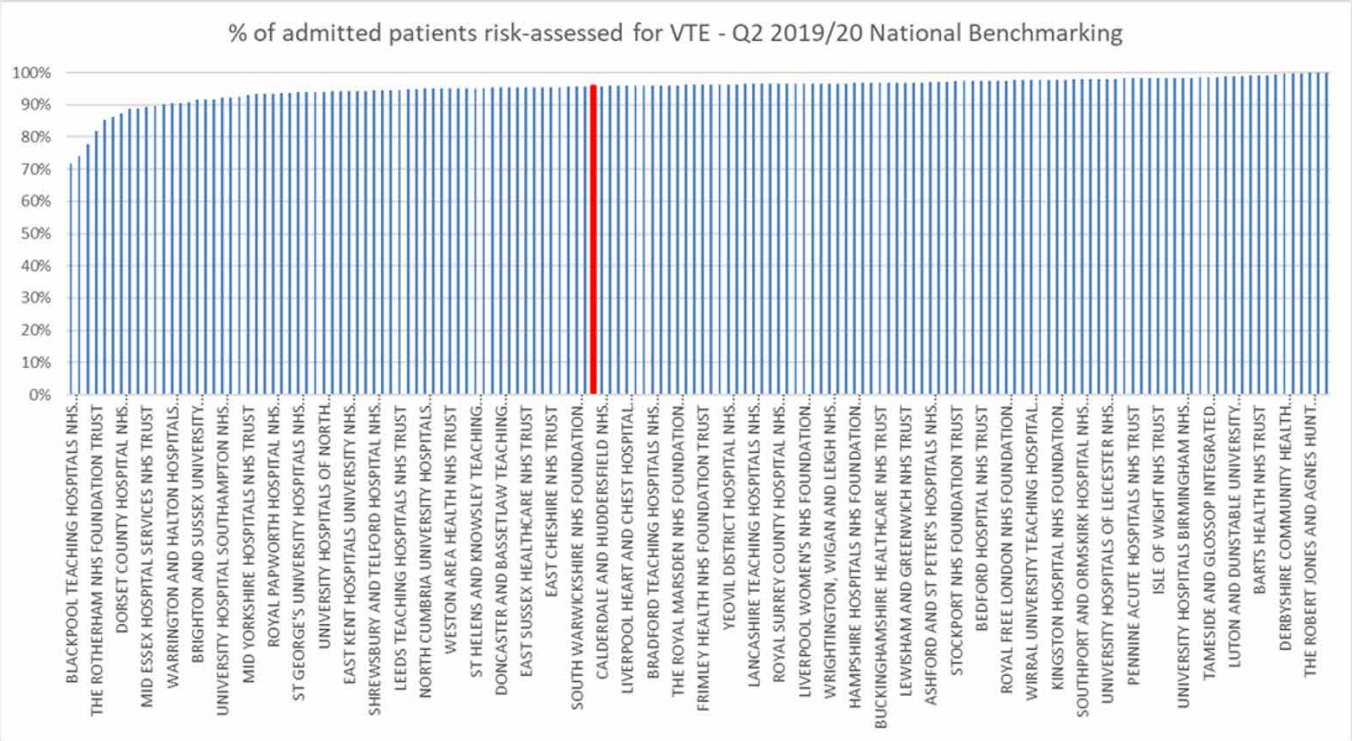


Chart 5: % VTE Risk Assessment Benchmarking

Calderdale and Huddersfield NHS Foundation Trust continues to work and take action to ensure that VTE remains an improving patient safety metric. We can confirm that during 2019/20 there have been no avoidable hospital-acquired VTE deaths

Rate of C.Difficile per 100,000 bed days

Of 132 reporting Trusts, Calderdale and Huddersfield NHS Foundation Trust were 40th.

2019/20 was a challenging year in relation to our absolute numbers of Clostridium difficile infections (CDI), specifically in relation to our performance versus our target.

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

At the time of the reporting period the Trust was within its ceiling of cases of CDI. All cases were subject to a root cause analysis which is externally supported, and scrutinised, by our commissioners. In many cases, we have been unable to identify specific lapses of care that have directly led to the CDI – the quality of the care provided has been found to be good.

However, in some cases, it was possible to identify key areas for improvement. These relate to antimicrobial-use prescribing, environmental cleaning and hand hygiene. All root cause analyses conclude with an action plan to ensure that lessons learnt are acted upon, and that learning is disseminated throughout the organisation to try to prevent similar, avoidable cases. Action plan completion is monitored through the divisions.

The Infection Prevention and Control Team support prevention of C. difficile through the delivery of both mandatory training, and bespoke sessions to clinical areas. An annual hand hygiene roadshow is held which has shown good, rising levels of compliance with bare below the elbows and hand hygiene. Additionally, we continue to work with clinical teams and microbiology to improve antimicrobial prescribing using antimicrobial stewardship ward rounds, and with Estates and Facilities to maintain, and improve where necessary, standards of cleaning. In addition, we undertook a deep clean and of high-risk clinical areas.

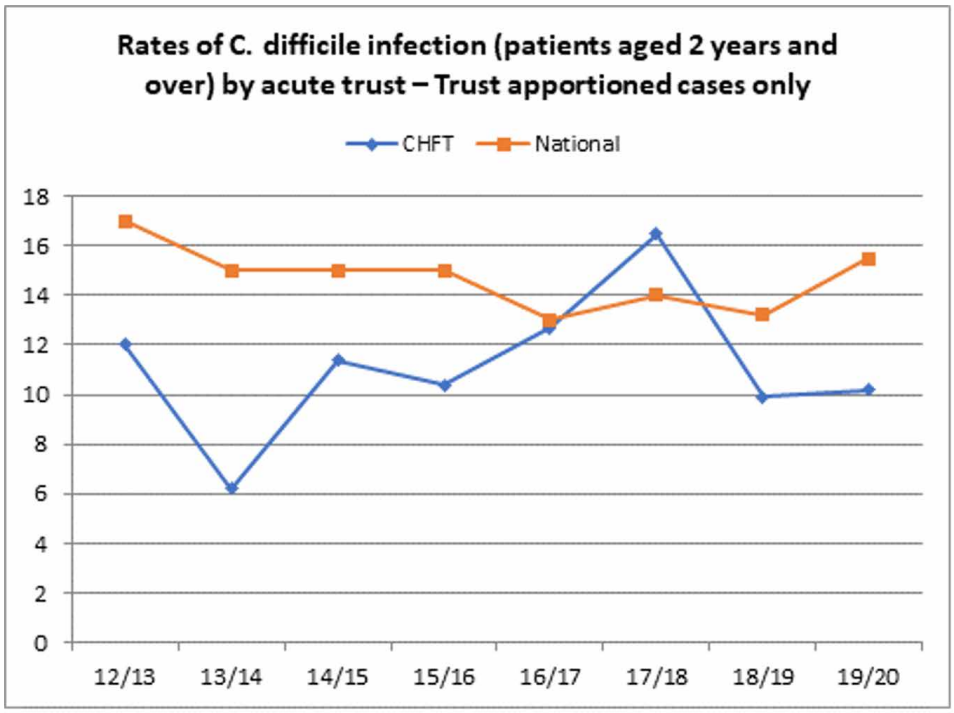


Chart 6: C.Diff. Trust apportioned cases

Performance data for 19/20 shows a declining position with 40 cases compared to 18/19s year-end position of 17.

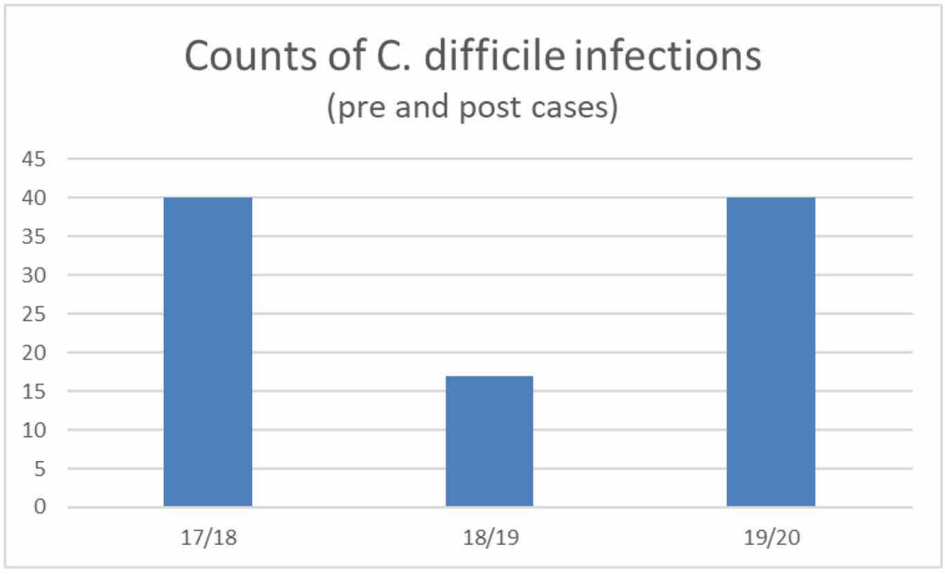


Chart 7 C.Diff. Pre and post cases

Nutrition and Hydration

During 19/20 a mock CQC-style nutrition and hydration peer review took place. The purpose of this review was to test out the Trusts compliance with Nutrition and Hydration standards.

The focus of the review was:
- Parenteral and enteral care of nutritional complex patients, reviewing the co-ordination of service provision.
- Nutrition and hydration standards compliance for all patients of different ages.
- Decision-making and End of Life Care relating to nutrition and hydration.

The Trust invited a team from Leeds Teaching Hospitals NHS Trust to support this review. It has been recommended that the following actions are taken in response to the findings from the External Peer Review:
- The Nutritional Steering Group and Artificial Nutrition Steering group to be accountable for progressing action plans to address issues.
- Response required from the Gastroenterology Team about recommendations for enteral and parental nutrition.
- A review to take place of the current CHFT audit programme in relation to artificial nutrition to ensure this meets the best practice audit standards.
- Updates regarding action plans and progress on improvement work to be presented by the Divisional Associate Directors of Nursing at the CQC Response Group.
- Internal Peer Review to be organised to check progress of actions.

Following the External Review, the Trust has relaunched the Nutrition and Hydration collaborative to support the advancement of best practice around the Trust in relation to recording and compliance of Malnutrition Universal Screening Tool (MUST). This is an ongoing work programme led by the Associate Director of Nursing – Surgery.

Assessment and Dementia Screening

The Assessment and Dementia screening process is an essential part of medical clerking for all patients aged 75 and over. This is a cognitive assessment that measures the following aspects:
- an assessment for delirium; followed by
- a screen for depression; and if the delirium assessment is negative it is followed by
- The dementia screen.

If delirium is diagnosed, the cognitive assessment does not progress to the dementia screen. The dementia screen is a nationally monitored standard requiring 90% compliance. The dementia screen is not intended to be an indicator for investigation whilst the person is in hospital. Its function is to prompt a message for the GP to be aware that a positive screen may lead them to refer the patient to mental health memory services for full investigation. The Trust continues to work towards the 90% compliance required.

Trust Dementia Training Compliance

Community	99.58%
Corporate	98.63%
Families and Specialist Services	99.63%
Health Informatics	97.24%
Medical	99.07%
Pharmacy Manufacturing Unit	100%
Surgical & Anaesthetics	98.51%

Overall compliance for Dementia training across the Trust is 99.06%.

Serious Incidents

The Trust is committed to learning from incidents at all levels, and looks at incidents by theme or type, and has applied the Yorkshire and Humber Contributory Factors Framework tool to support analysis of themes and trends across different types of incidents.

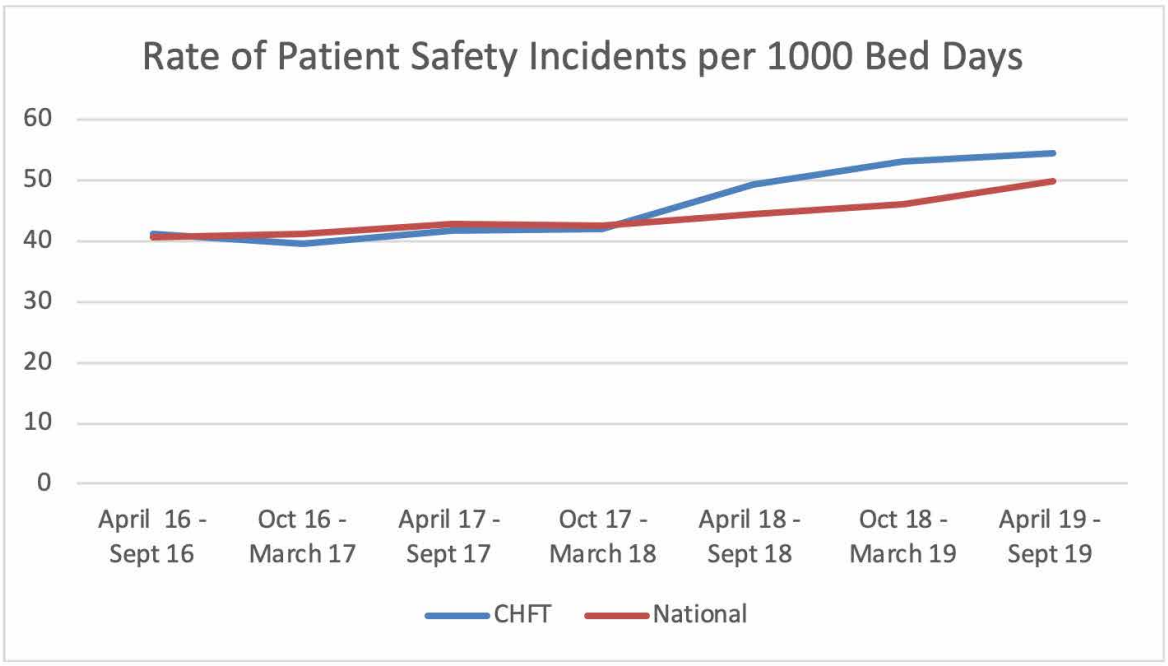
Learning newsletters and learning summaries are distributed to focus attention on lessons to be shared and a Learning Summit was facilitated by the Quality Team in 2019 to share learning and to listen to staff about how best to share learning with them.

Patient Safety Incidents data

The Trust uses the National Reporting and Learning Service (NRLS) data to benchmark incident reporting in respect of number of incidents and rate per bed days, and by level of harm. This data, alongside local data is presented below.

Rate of Patient Safety incidents per 1000 Bed Days
Calderdale and Huddersfield NHS Foundation Trust considers that this data is as described for the following reasons: -

It is derived from the national data collection service



Patient safety incidents
The chart above shows the Trust's previous reporting on the National Reporting and Learning Service.

The Trusts reporting rate for April 2019 to September 2019 was 54.5 incidents per 1000 bed days which is above national average against other Acute (non-specialist Trusts) at 49.8 incidents per 1000 bed days. This data is the most up-to-date available from the National Reporting and Learning Service (NRLS).

Patient Incidents by Level of Harm
Incidents are categorised by level of harm. The Trust governance arrangements are through Divisional and Trust panel processes to scrutinise incidents at the time of reporting to determine the level of investigation which is proportionate to the level of harm and considers the potential for future recurrence and potential for learning.

The number of patient safety incidents by level of harm is presented in chart 11.

	2018/19	2019/20
No Harm	7154	7300
Minor Harm	1835	1701
Moderate harm	130	137
Severe, catastrophic or death	34	43
Total	9153	9181

Chart 11: Patient Safety incidents by level of harm

No harm and minor harm Incidents
There has been a decrease in reporting of minor and no harm patient safety incidents in 2019/20 in comparison to the previous year. Efforts to improve data quality and encourage reporting of no harm and near-miss incidents continues to support analysis of themes and trends and prevent future harm.

The Trust recognises that high levels of incident reporting are a positive indicator of our safety culture in Calderdale and Huddersfield NHS Foundation Trust and for 2019/20, 98% of the incidents reported were Near Miss, No harm or Minor Harm; this has remained steady from the previous year.

Moderate harm incidents
Weekly Divisional incident panels are held to consider incidents that have caused moderate and above harm, ensuring a robust process for assessing incidents. The number of incidents categorised as moderate harm has increased in 2019/20. Divisional investigations continue to take place to improve patient safety, mitigate risk and to support sharing of learning both locally, throughout the Trust and through regional and national networks. Panels also receive and scrutinise completed investigations to approve action plans as proportionate to mitigate identified risks, to enable learning and to ensure that duty of candour is completed in a timely manner with those affected.

Serious incidents
In 2019/20, 32 incidents met the criteria for reporting under the Serious Incident Framework. Not all of these were incidents resulting in severe harm or death, for example an investigation was commenced into a cluster of patients awaiting a mental health bed in the Emergency department, all of which resulted in no harm to patients. This cluster of cases was declared as a serious incident as the potential for harm was identified. The investigation was conducted in conjunction with a partner organisation to ensure risk mitigation was the focus of caring for the patient during the wait. The investigation assessed the impact on patients, staff, evaluated risk assessments and management plans, and whether escalation and communication between organisations was effective. A robust action plan has been agreed between both organisations for managing patients awaiting mental health beds.

In December 2018, the Healthcare Safety Investigation Branch (HSIB) began a national maternity investigation programme to make maternity care safer. Where incidents occurred that met the criteria for such investigations, these were referred to HSIB to undertake an investigation. The Trust also reports all HSIB-reportable incidents as a serious incident. The Families and Specialist Services Division hold the overarching Maternity Quality Improvement Action Plan that collectively captures actions from all maternity incident investigations, in addition to other Quality Improvement (QI) workstreams.

Themes and trends: The three most frequently reported serious incidents in 2019/20 were:

Incident Type	Number in 2019/20	Comment
Diagnostic delay including test results	6 incidents	These incidents relate to cancers diagnoses, radiological examinations, lost to surveillance follow up, and failure of diagnosis
Slips, trips, falls		
	6 incidents	These investigations relate to slips, trips and falls where the specific circumstances of the incident warranted detailed analysis
Treatment delay	7 incidents	Included in this category are delays attributable to waiting for mental health beds, Emergency Department 12-hour trolley waits escalations and sepsis management

Never Events
A never event is a specific serious incident that NHS England has determined is preventable and should not happen if national safety guidelines are followed.

During 2019/20 the Trust reported one Never Event, a wrong site surgery. This was a wrong site regional anaesthetic block prior to shoulder surgery. One anaesthetist delivered general anaesthetic and a second anaesthetist was called in to theatre to perform a regional anaesthetic block. Shoulder surgery was performed on the correct side. The Stop Before You Block procedure was not performed prior to the block being administered. Requirement for a second anaesthetist to attend was a key contributory factor to this incident. The incident is currently under investigation, however immediate actions have been taken to mitigate risk including ensuring surgical cases that require general anaesthetic and regional anaesthesia are scheduled for an anaesthetist who is 'regionalist' trained.

Calderdale and Huddersfield NHS Foundation Trust has taken the following actions to improve this and so the quality of its services by the assurance, scrutiny, training and development described below:

Assurance and Scrutiny
The Serious Investigation Review Group (SIRG) met four times during 2019/20, this forum is chaired by the Chief Executive, with membership including senior clinical divisional colleagues. The Terms of Reference for SIRG were updated mid-year to broaden the scope to include assurance of embedding of learning from serious complaints. The group reviews one investigation per Division at each meeting and offers challenge that investigations are managed effectively, and seeks assurance that actions are sufficiently wide enough to mitigate risk, and learning is shared across the organisation. The group reports into the Quality Committee which is chaired by a Non-Executive Director.

The Risk Team meet with our Commissioners on a quarterly basis to review serious incident reports, to provide evidence of delivery of action plans and assurance of monitoring of embedding of learning.

Training and Development work
In 2019/20 the Risk Team have undertaken a review of serious incidents and Orange action plans to identify commonality between actions across investigations, and across divisions. This allowed a collective response to multiple actions and positively impacting resolution of action plans to mitigate risk.

The Risk Team continued to streamline the incident reporting and investigation processes through review of the Datix reporting forms and analysis of data quality based on feedback of colleagues. The investigation form has been modified to better capture findings and outcome, contributory factors and lessons learned to allow for better analysis of themes and trends from incidents.

The Senior Risk Manager has delivered Root Cause Analysis training to colleagues throughout 2019/20. These colleagues will deliver investigations within their own divisions as well as contributing to serious incident investigations. Duty of Candour training has also been provided to colleagues across all Divisions to support effective delivery of this important role.

Our Commissioners approached the Senior Risk Manager to support colleagues from a local Hospice through a serious incident investigation. Several colleagues from the hospice have subsequently attended the Trust Investigation Training.

Preparation for new national reporting arrangements
There is a planned national-scale transition from recording incidents on the NRLS to a new system; Patient Safety Incident Management System (PSIMS). The Trust is keeping abreast of national developments in respect of feeding into consultation and pilot arrangements to ensure we are prepared for transfer onto the new system.

Duty of Candour

All Trusts are required to comply with the statutory duty of candour after becoming aware of an incident which has caused harm classed as moderate, severe or death on the National Reporting and Learning Systems (NRLS).

Performance is monitored on duty of candour with information reported monthly to the Trust Board on the provision of an initial letter of apology. We also monitor performance on sending a further letter of apology with a copy of the investigation report through the monthly Patient Safety Group.

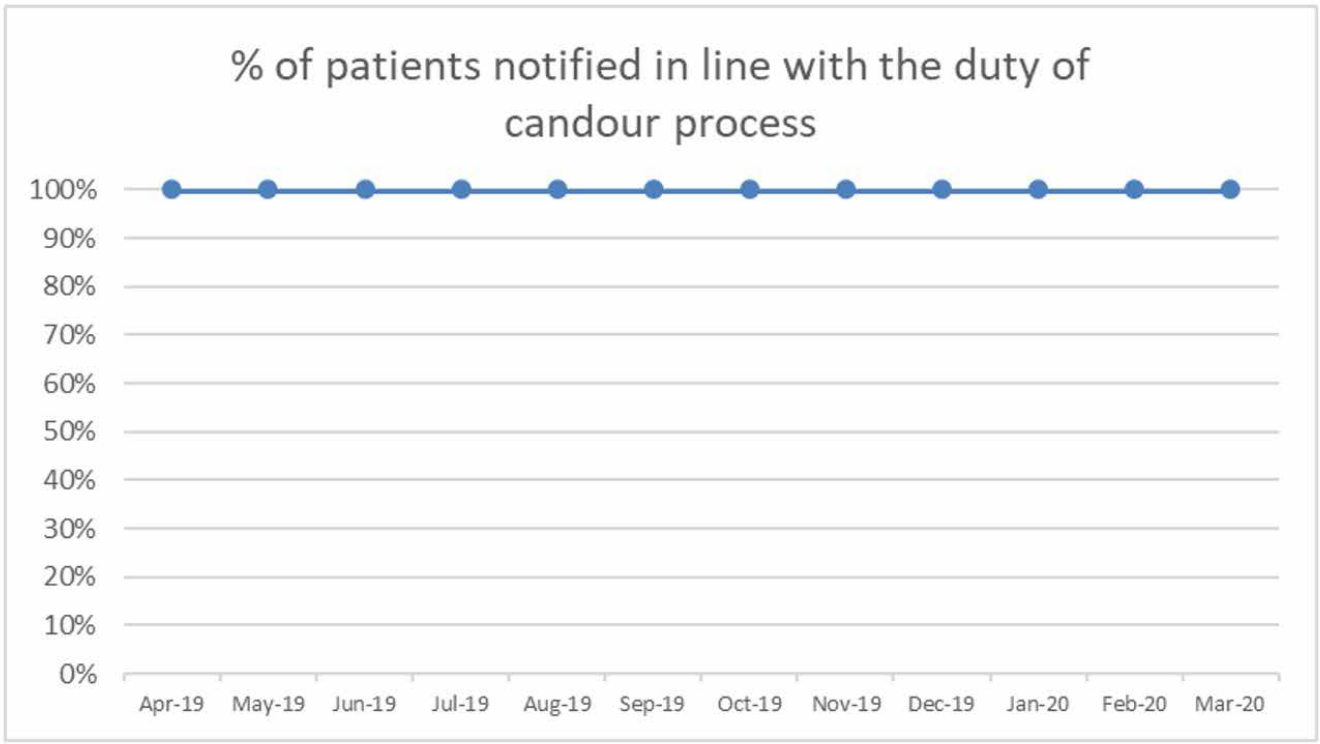


Chart 12 Duty of Candour notification

Part 3

Performance on selected indicators

This section provides an overview of care offered by the Trust based on its performance in 2019/20 against several regularly monitored quality indicators. These are selected by the Trust Board in consultation with stakeholders and reviewed regularly.

The indicators are as follows:

Domains	Indicator
Patient Safety	Mortality Rates (HSMR and SHMI)
	Falls in Hospital
	Healthcare Associated Infections
Clinical Effectiveness	Cancer Waiting Times
	Stroke
	Safe and Effective Care
Patient Experience	End of Life care
	Patient Experience Inc Friends and Family Test
	Complaints
Staff Experience	National Survey
	Friends and Family Test

Hospital Standardised Mortality Rate (HSMR)

Through understanding our hospital mortality, the Trust can gain assurance and learning regarding current care processes and further identify any areas requiring improvements.

There are two main standardised measures. These ratios examine the number of patients who die, either during or, following hospitalisation at the Trust by looking at the expected number of cases in an average English hospital, given the characteristics of the patients treated there.

1. The SHMI calculated by NHS Digital looks at patients who had died either in hospital or within 30 days of discharge.
2. The HSMR is a long-standing national measure which only looks at those patients who die during their hospital stay.

Our most recent HSMR is shown below.

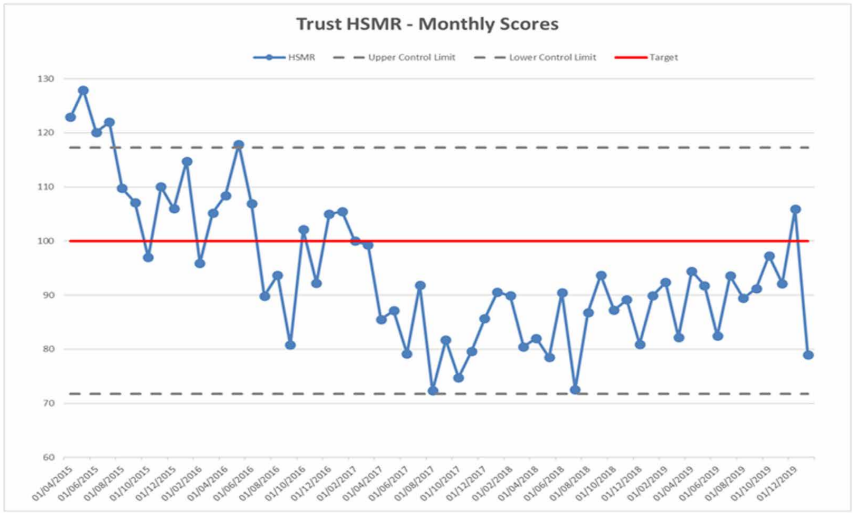


Chart 13: HSMR

See **Part 2** for a look into our SHMI performance and work on the Mortality Case Note Review programme.

Falls in Hospital

Falls in hospitals are the most common patient safety incidents reported in hospitals in England. Falls not only impact on the quality of life through pain, loss of confidence, loss of independence and increased mortality, they are also estimated to cost the NHS more than £ 2.3 billion per year.

Falls cause distress and harm to patients, families and their carers. The Trust has a Trust-wide Falls Reduction action plan delivery which is overseen by a monthly Falls Collaborative, chaired by a dedicated clinical fall lead who is a consultant within Older People's services.

The action plan is based on some aspects of the previous National Audit which highlighted some areas for improvement including lying and standing blood pressure, medication review and vision.

Since April 2019, the Trust has been working towards achieving the inpatient Falls Reduction CQUIN. The three high-impact actions measured to achieve the CQUIN are:

- Lying and standing blood pressure
- Mobility assessment within 24 hours
- Medication review re anxiolytics rationale for prescribing/administering

The overall impact of this work over the last few years has resulted in a marked and sustained decrease in the number of falls where patients have sustained harm as a result of a fall.

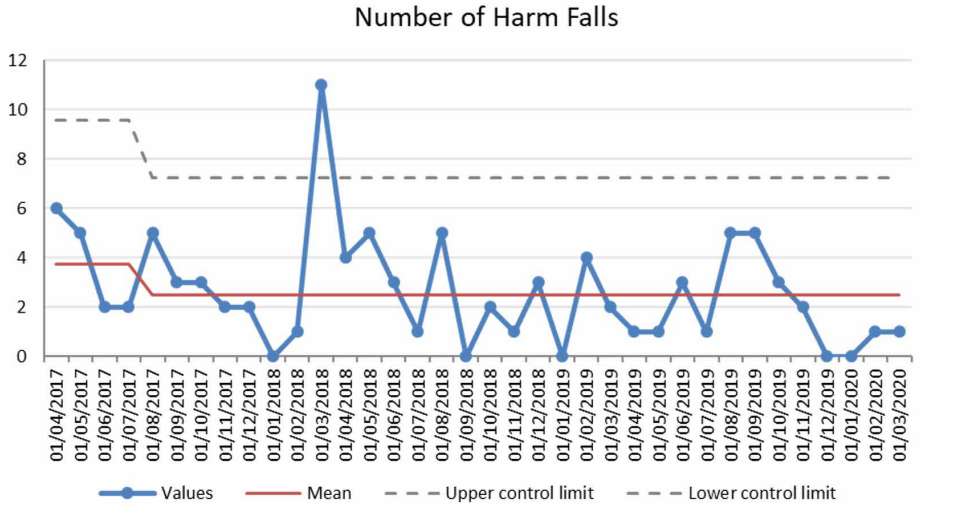


Chart 14: Harm Falls

The Trust peaked against the upper control limit in December 2019, since that peak there has been a concerted effort in month to reduce this concern, and we note that January 2020 has reverted to within the lower control limit.

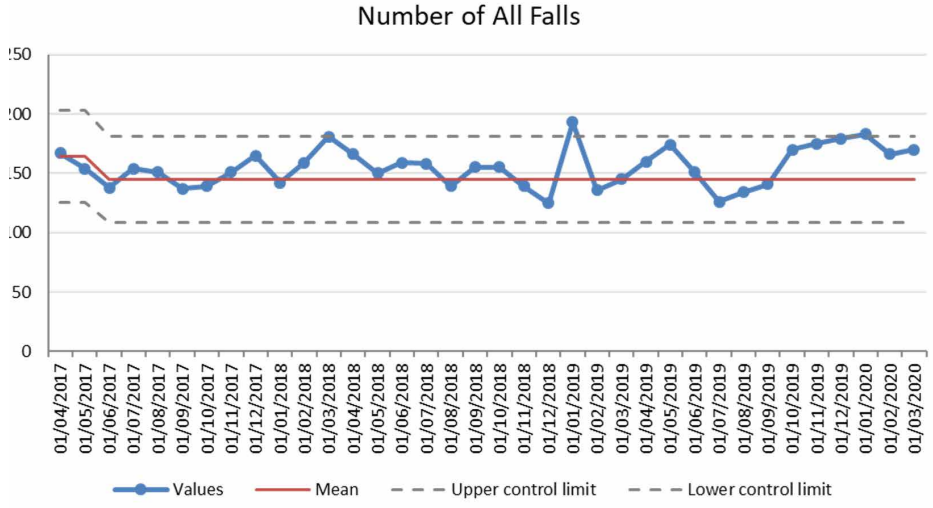


Chart 15: All Falls

The Trust continues to promote falls workshops to help understand the reasons why people fall and importantly what we can do to help prevent these falls and further illustrates the benefits of the FISH (Falls Investigation Safety Huddle) tool. This tool can help prevent numbers of falls and level of harm through greater understanding of why the patient fell.

Falls prevention is also a key element of the Elderly Care Strategy with one of the older people's wards leading on this aspect of the strategy with the support of the Acute Floor Team who made such improvements in their falls last year.

Ongoing work from 2018/19 into 2019/20 has meant that two of our older people's wards are continuing to lead on improving their safety huddles and MDT to ensure key safety information including falls risks are discussed and appropriate interventions put in place and the teams are engaged in the 'PJ Paralysis' work – encouraging patients to get out of bed, dress in day clothes and engage in communal dining and other social activities. This is also a key element of the interventions provided by the Engagement support team and enhanced care team who work with patients with cognitive impairment and those at risk of falling.

The monthly falls dashboard continues to provide an overview of falls incidents and key themes to share learning to heighten awareness on preventative actions to reduce falls.

Plans are in place for the year ahead to build on this long-standing trust priority:
- The Trust is also involved in the National Audit of Inpatient falls causing fractured Neck of femur with focused work based on the findings.
- Strengthen improvement work to align with the national CQUIN requirements.

Healthcare Associated Infections (HCAIs)

The Trust monitors and reports infections caused by several different organisms or sites of infection. These include:
- Methicillin Resistant Staphylococcus aureus (MRSA) bloodstream infections
- Methicillin Sensitive Staphylococcus aureus (MSSA) bloodstream infections
- Clostridium difficile infections (discussed elsewhere)
- Escherichia coli bloodstream infections
- Colonisations/infections with Carbapenemase producing Enterobacteriaceae (CPE)

MRSA (Methicillin resistant Staphylococcus aureus) Bacteraemia:

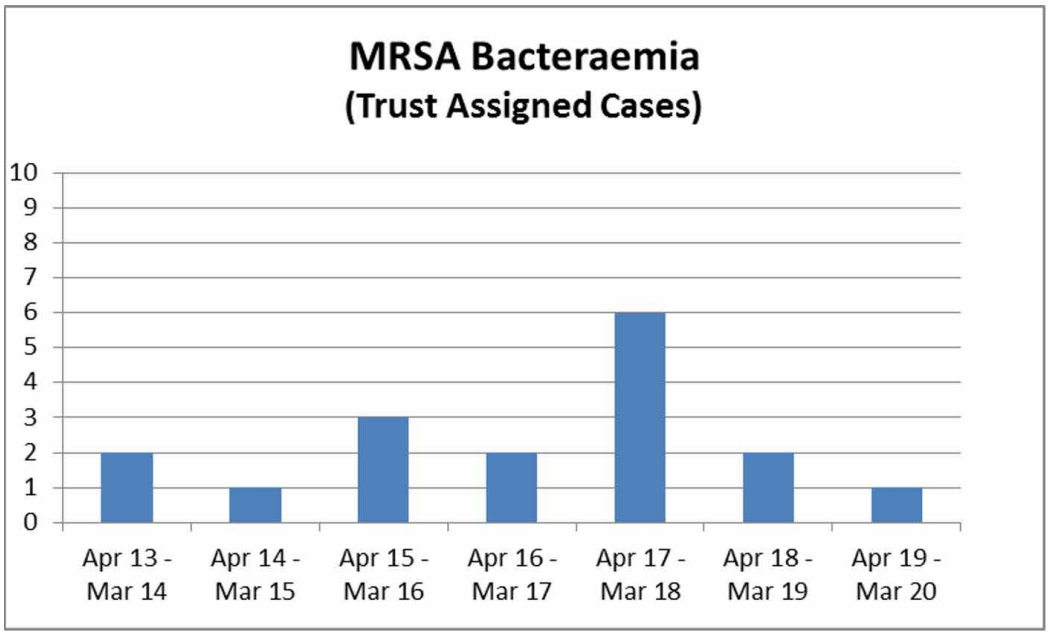


Chart 16: Number of MRSA Cases per year

The Trust has seen a reduction in the number of cases compared to last year. One MRSA bacteraemia was reported in year and this has been subject to a post-infection review as per national process. The learning from this review has been incorporated into the Trust Infection Prevention and Control action plan.

MSSA (Methicillin sensitive Staphylococcus aureus) bacteraemia:
MSSA bacteraemia is not subject to targets in contrast to MRSA bacteraemia. However, mandatory reporting of MSSA bacteraemia is required.

In the year to date 19 cases have been reported, an increase of 4. These are not subject to a formal post-infection review, limited MSSA screening is in place for a select group of patients including patients with central venous catheters.

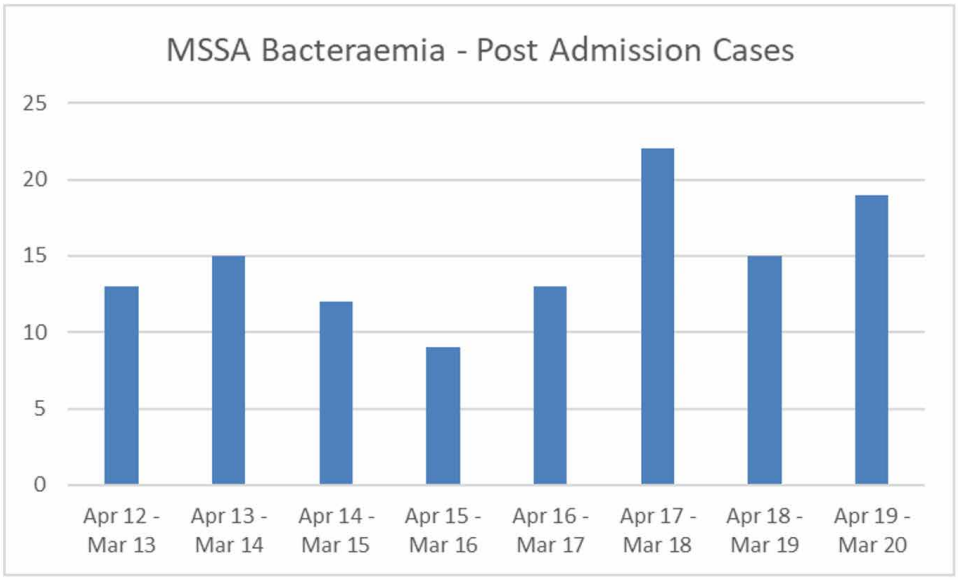


Chart 17: Number of MSSA Cases per year

E.Coli bacteraemia:
E.coli is currently part of a health economy wide plan to reduce rates across the individual Clinical Commissioning Groups – the Trust had an aim to achieve a 10% reduction

The number of cases seen this year have dropped considerably from 51 cases in 18/19 to 29 in 19/20.

Hydration is being promoted via the Nutrition and Hydration Group, with the overall aim to increase drink rounds on the ward from 6 to 7 throughout the day. Other initiatives will be in line with the health economy action plan during 2020/21.

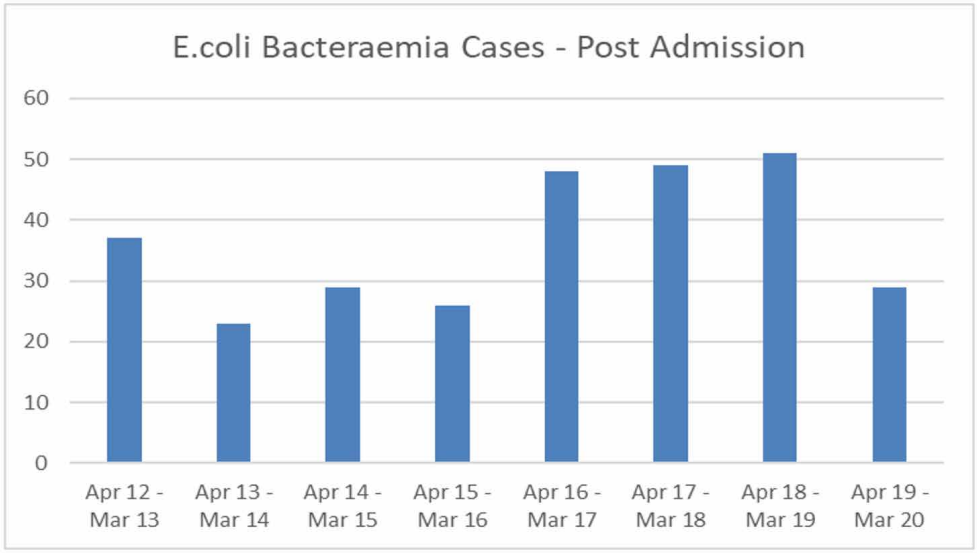


Chart 18: Number of E.coli cases per year

Colonisations/infections with Carbapenemase producing Enterobacteriaceae (CPE):
In line with national guidance from Public Health England, all overnight admissions to the Trust are screened for risk factors for colonisation/infection with CPE. All patients in whom a risk for colonisation or infection is identified are offered microbiological screening.

Key Priority Areas for the Infection Prevention and Control Team:
In addition to working to prevent healthcare associated infections as detailed above, the Infection Prevention and Control Team work to support improvements in the below areas:

- Hand hygiene
- Appropriate use of invasive devices
- Aseptic Non-Touch Technique (ANTT)
- Cleaning standards
- Water and air quality
- Refurbishment of the hospital estate
- Training and education
- Audits and surveillance
- Antimicrobial stewardship

Cancer Waiting Times

The National Cancer Waiting Time Targets is a key quality indicator of performance and CHFT are the only Trust in the Region that has consistently reached the 62 day target for the last 17 months: therefore, providing effective cancer care to our patients. All teams continue to improve and ensure that robust streamline pathways are in place so that care is consistent.

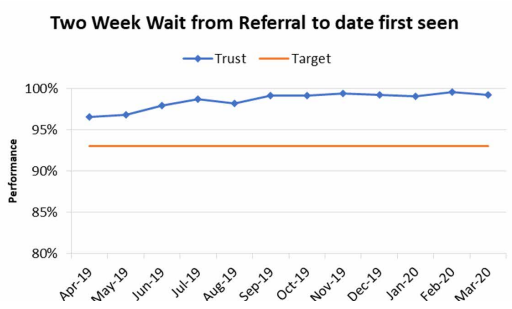
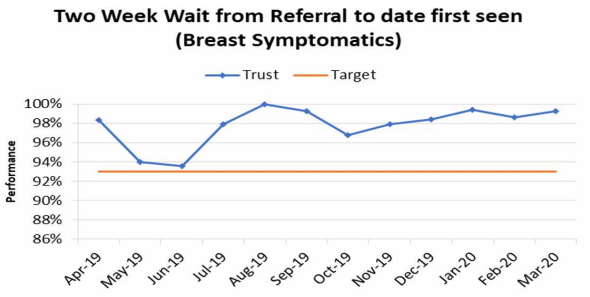
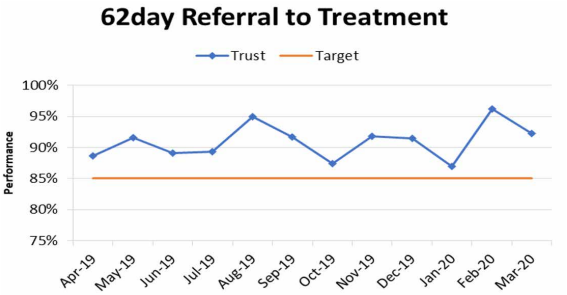
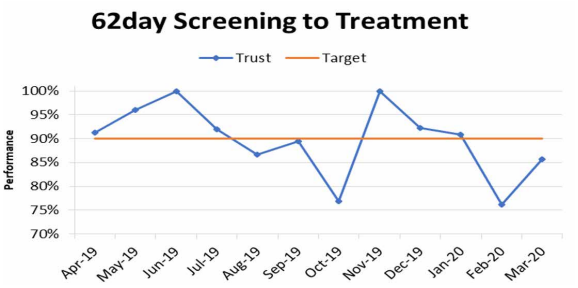
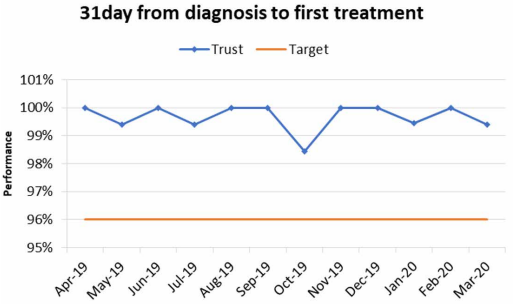
	The performance required for this target is 93%. Over the last year, as can be seen from the chart the Trust has continued to improve. As a Trust, the aim is to reduce the wait time to 7 days rather than the national 14-day target. This will in turn support subsequent targets.
	The performance required for this target is 93% and this continues to be achieved.
	The performance required for this target is 85%. The Trust has achieved this over the last 17 months
	The performance required for this target is 90%. This has not been consistently achieved due to a variety of reasons, e.g. patient compliance in attending for appointments in a timely manner Also, the conversion rate and numbers treated are low therefore the tolerance for breaches is extremely small making 90% often difficult to achieve.
	The performance required for this target is 96%. This is consistently achieved.

Chart 20: Cancer waiting times

A new 28-day target will commence in April 2020, this measures when all patients who are referred in on a cancer pathway are informed whether they have or have not got cancer by day 28 of their pathway. At present CHFT are averaging 70% of all our patients being informed; this will reach the target however, improvement is needed and the cancer team are working with all tumour sites to put consistent changes in place.

Alongside the national standards, the Trust will report on regional targets to ensure patients are transferred to specialist hospitals in a timely fashion. This will aim to:

- See Fast Track patients within 7 days

At present year to date 40.88% of patients are being seen within 7 days of referral which compared to the 28.2% we were achieving 2018/19. However, it is believed to ensure the Trust meets the other targets this should be made a priority by all tumour sites. The Directors are supporting the improvements that need to be made.

- Carry out any Inter Provider Transfers (IPT) by day 38

The year to date Trust position is 53.44%.

This continues to be an issue for the Trust and recruitment issues within Radiology has prevented improvement in the diagnostic parts of the pathways over the last year, though the team do everything possible to ensure patients are treated as soon as possible which can be seen by the 62-day performance. The West Yorkshire Association of Acute Trusts (WYAAT) Alliance have created working groups regarding Radiology and pathology across the region to share good practice and if possible, to create equity across Trusts.

Improvement Plans 2020/21

CHFT commenced hosting the Optimal Pathway project group in December 2019, these are a team of staff that will work across the region with clinicians in all tumour sites to improve the clinical pathways ensuring the Region meets the National optimum pathways.

The West Yorkshire Association of Acute Trusts, and Chief Operating Officers continue to work with the West Yorkshire and Harrogate Alliance to improve a wide variety of issues; they are initially concentrating on the tumour sites that are proving the most difficult in achieving the cancer targets, those being Lung, Colorectal, prostate and Upper GI. The Intensive support Team (IST) has been working with Trusts where needed.

The quality surveillance team (QST) process for 2019/20 was completed and reviewed by the Clinical Commissioning Groups (CCG) and individual plans have been agreed. The CCGs have the power to request an external visit if they feel necessary, this was not requested for any of the tumour sites.

The QST process for 2020/21 has started and each tumour site will develop action plans based on their new self-assessment.

- Vague symptoms pathway (Rapid Diagnostic centres, RDC,)

The commitment to roll out Rapid Diagnostic Centres (RDCs) forms an important part of The National strategy by NHSE and NHSI, to deliver faster and earlier diagnosis and improved patient experience. At present within CHFT we are delivering a non-specific service which we call "vague symptoms" and this deals with patients who are unwell, but the GP is unsure of the next steps. These are referred to CHFT and cared for by a small team consisting of a Consultant, clinical nurse specialist and pathway navigator. The National position is that by 2024, the RDC will provide a single point of access to a diagnostic pathway for all patients with symptoms that could indicate cancer; whilst RDCs will be established for patients with symptoms that could indicate cancer; most patients seen by an RDC will not have cancer. The WY&H Cancer Alliance will be providing money over the next four years to help with this roll out in each Trust across the region.

Prehabilitation of patients
The Prehab project is to support patients who are newly diagnosed with cancer, to engage in exercise, nutritional screening and have improved emotional well-being.

The importance of preparation 'Prehabilitation' and active recovery pathways in cancer are being increasingly recognised by cancer patients and healthcare providers around the world. Patients will be supported before and after cancer treatments (including surgery, chemotherapy and radiotherapy) and where applicable during treatment to have increased physical activity and fitness. Research suggests patients who undergo prehab should have improved clinical outcomes, including improved survival rates, greater tolerance to radical treatments and reduced post-operative complications. This should lead to reduced time spent in hospital or need for readmission to hospital.

At CHFT the Prehabilitation project will be delivered across the acute and community settings by a variety of professionals. The aim is to support patients and their family / carers cope with cancer treatment and feel better, physically and mentally. It is designed to help people take an active role in their cancer care and live as well with and beyond cancer.

Cancer Site Specific Update
The Trust employs specialist staff in roles to support the delivery of cancer care and end of life care in both cancer and non-cancer patients. Below are some of the key strategies and projects that the teams are delivering.

Living with and Beyond Cancer

Personalised Care Support:

Every cancer team is working in line with the recommendations from the World Class Cancer Outcomes Strategy 2015-2020, The NHS Long Term Plan and the National Cancer Patient Experience Survey. The teams are delivering the Living with and Beyond Cancer agenda, in line with the Trust's digital agenda, the Trust has adopted the Macmillan eHNA (electronic Holistic Needs Assessment), this is supporting the delivery of Personalised Care Support at strategic points in the patients' pathways. The cancer team also offer health and well-being events which ultimately support risk stratified follow-up and reduce the burden of hospital appointments, where necessary, for cancer patients.

Health and Wellbeing Provision:

The Health and Wellbeing Provision or Patient Education Programmes are predominantly coordinated by the Macmillan Information Service (as described in the Macmillan Information Service above) but the Clinical Nurse Specialists and Cancer Care Coordinators play an important role ensuring patients can access this provision. Over the last year the Health and Wellbeing Provision that provides patients and their families with the knowledge and skills to feel confident that their jointly developed 'Personalised Care Support' will enable them to access the right care at the right time, whilst also ensuring they can enjoy as good a quality of life as possible away from the hospital. Alongside the Trust's established 'end of treatment' Health and Wellbeing sessions, the Trust has initiated two new services to ensure wider patient coverage and education.

The Trust supports around 3,500 newly diagnosed cancer patients every year, many of whom tell us they feel overwhelmed with information at the point of a cancer diagnosis. At the two Cancer Patient Focus Groups we have held over the last year, patients told us that conversations were better than booklets and that there was a lack of support after they were given an incurable or secondary cancer diagnosis, with many reporting a sense of isolation and not knowing where to turn. Using this patient feedback and targets from the national cancer strategy about personalising our support, we established a new Health and Wellbeing Programme for cancer patients in CHFT in 2019. This was a co-ordinated development lead by our Macmillan Information Service, Lead Cancer Nurse and Macmillan Prehabilitation Project Manager.

Our aims were to introduce more structured information and support on diagnosis as well as after treatment, and to introduce additional support for people with an incurable cancer diagnosis, as well as their families. We were the first Trust in the West Yorkshire and Harrogate Cancer Alliance to introduce an information and support session for newly diagnosed cancer patients and their families. 'First Steps' began in October 2019 and runs as a monthly half-day session at HRI, with a patient sharing their story to begin with. The content includes information to help patients support themselves and manage their own condition and covers areas such as diet, exercise, managing emotions and smoking cessation.

To support the delivery of the Health and Wellbeing offerings described above, we will be utilising the band 4 cancer care coordinators or equivalent that exist in each of the specialist cancer teams. This role has developed significantly over the last two years and supports patient's Personalised Care Support. We are furthering investing in the roles and are providing 'Train the Trainer' training to enable the cancer care coordinators to deliver Patient Education Programmes, which include elements of the Health and Wellbeing provision described above.

Cancer Psychological Services

The Trust's psychology services have grown significantly over the last 18 months. There are now opportunities for psychologists in stroke, bariatric and diabetes as well as increasing the number of psychologists to support cancer from one to two whole time equivalent posts. The psychological and emotional care provided to cancer patients has developed significantly over the last three years. Over this time, all patients with cancer now have access to level 4 psychological support, in line with Supportive and Palliative Care NICE Guidance. Each cancer site specific team now has at least one member, and commonly two, who has completed training to deliver level 2 psychological support to their patients and carers. All individuals who have completed their level 2 training have on-going access to monthly clinical supervision.

The service routinely collects patient feedback, and this has been consistently excellent; similarly, feedback from stakeholders has also been excellent about the impact that the service makes to patient care. The service provides an integral part of the Health and Wellbeing events and this aspect of the event is very well evaluated.

Stroke

There are more than 100,000 strokes in the UK each year, that is around one stroke every five minutes in the UK. Between 1990 and 2010 the incidence of strokes fell by almost a quarter. Around 1 in 6 men will have a stroke in their life and around 1 in 5 women will have a stroke in their life.

The rate of first-time strokes in people aged 45 and over is expected to increase by 59% in the next 20 years (between now and 2035). In the same period, it is estimated that the number of stroke survivors, aged 45 and over, living in the UK is expected to rise by 123%.

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. By focusing on improvement in stroke care, patient outcomes can be vastly improved.

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

- Patients are admitted to a stroke bed within four hours
- Patients spend 90% of their hospital stay on the Stroke unit

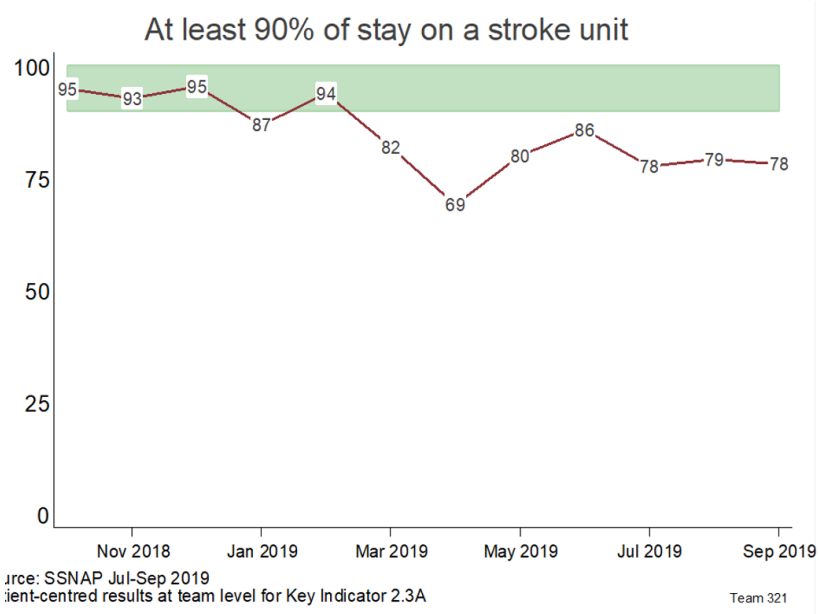
Improvements in 2019/2020

The Trust's approach to the 4-hour target improved following introduction of the stroke assessment bed; however, the Trust did see deterioration in March/April 2019 when the bed base was reduced. To rectify this and to return to a positive target the Trust agreed to undertake during 19/20 some modelling work to address this-

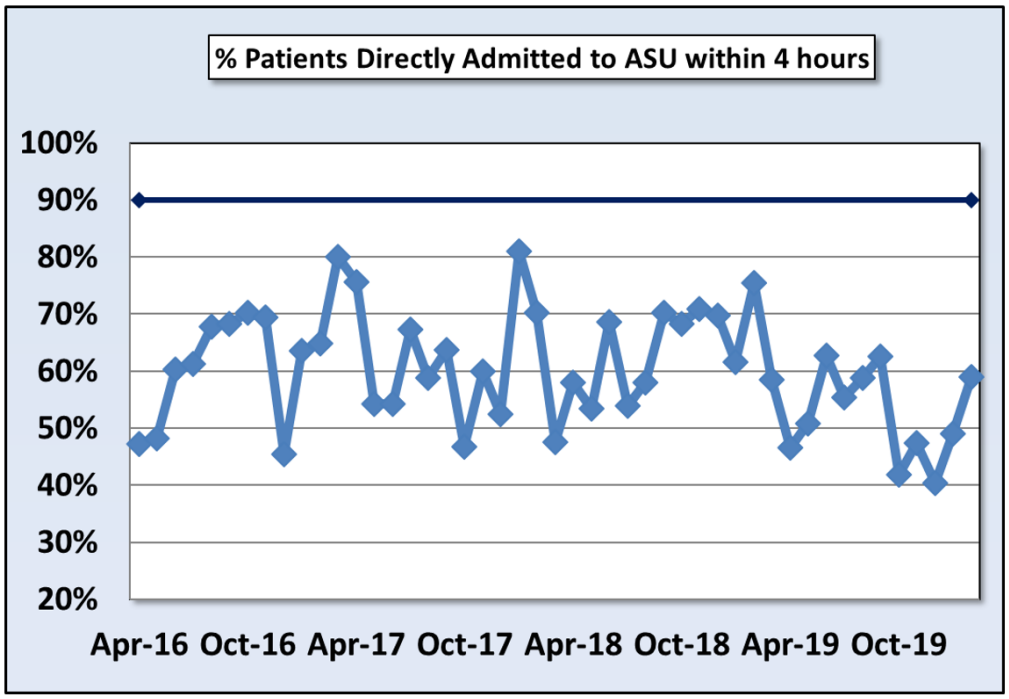
- Trialling a community bed model for patients who do not need hospital-based care
- Introducing a flexible bed model which increases/decreases numbers based on demand
- The Trust has introduced an agreed step-down criterion for patients to be moved to the medical bed base when their Stroke care is completed. We have patients routinely identified and use this when we have no Hyper-Acute Stroke beds available and need to create some for potential admissions.

Recent SSNAP (Sentinel Stroke National Audit Programme) data produced in the third quarter of the year shows we have returned to an overall rating of B from A in 2018/19- we know that this was because in quarter 2 we did not meet our 4-hour target. In all other areas of stroke management and care, we have seen a sustained improvement in scanning within one hour, with all three indicators achieving an A grade and direct admission performance has also sustained its improvement.

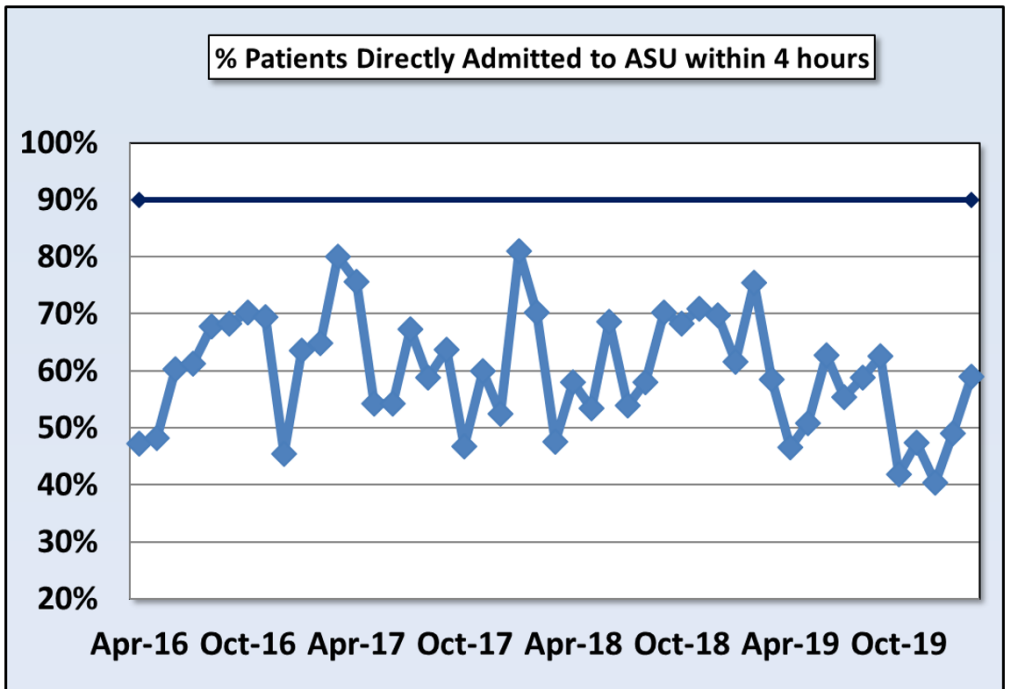
The graph below also shows an upward trend for the percentage of time patients stayed on the stroke unit, evidencing that patients are being cared for in the right environment.



The graph below relating to the four-hour direct admission is variable. Any patients that are brought to CRH for thrombolysis are all admitted. There is still a trend which sees patients who are later diagnosed with stroke or who present at HRI Emergency Department seeing a delay to be directly admitted. However, the introduction of the stroke assessment bed has helped with this and pathways are being strengthened to support referring clinicians at Huddersfield Royal Infirmary.



The second chart shows the percentage of patients diagnosed with a stroke that spent more than 90% of their hospital stay on a specialist stroke ward. Performance has remained variable throughout the year. By improving the above performance this will see an improvement on the below indicator as patients need to be admitted to the Stroke unit immediately so that this can be achieved.



Plans for 2020/21

We have recruited a Stroke Psychologist to develop a structured Clinical Health Psychology service for patients and staff in Stroke services. Approximately 625 people are admitted to CHFT annually with a diagnosis of stroke. Many stroke survivors experience psychological difficulties and cognitive impairment. Psychological mood disturbance is associated with:- higher rates of mortality; hospital readmission, higher utilisation of outpatient services; long-term disability and suicide if untreated. Addressing psychological need in stroke will allow us to meet national guidelines and improves health outcomes for our patients.

Task and finish groups have been developed for further collaborative work to commence to look at standardising pathways and protocols working with colleagues across various specialties. We are also working to develop a service model that delivers good quality stroke rehabilitation in alternate settings or the patients' own home. The effect of the work will have benefits in terms of clinical effectiveness, improving patient experience and generating efficiencies. We will also seek to re-invest within the service to improve patient experience and outcomes. In the preparation for this project, it has been recognised that there is extended scope for further future re-design of stroke services working collaboratively with various service providers, both in and out of the hospital environment.

Following the work completed in 2019/20 we will commence the trial of the community Stroke bed base in 2020/21 (date to be confirmed). Following the introduction of this we will complete a further review of the required flexible bed base in Stroke to develop a proposal for the future bed model.

End of Life Care

Improving end of life care (EOLC) continues to be a priority area for the Trust, and regardless of where patients die or when their death is expected, it is vital that they receive appropriate end of life care.

End of life care can be complex because of the special needs of many at the end of life and because of the need to co-ordinate and integrate a wide range of services across different sectors. However, the rewards for getting it right are huge. Personalised, integrated care at the end of life can transform the experience for the individual, their family, and the staff caring for them.

Linking together the work of the Learning from Deaths (LfD) umbrella, the 2020/2021 EOLC strategy and the EOLC steering group and other initiatives will enable this improvement.

Key issues, achievements, and suggested plans for 2020/2021:

Bereavement Cards
Bereavement cards are being sent out in the surgical division to offer support and a contact number to ring with any concerns, questions or compliments. The plan is for this to be rolled out Trust wide. Bereavement cards have now been ordered for the medical division. There will be communication and training prior to the cards being distributed in the coming weeks.

Bereavement café
The Marigold Café has been set up to support anyone who has had a bereavement. This café runs monthly at both Calderdale Royal Hospital and Huddersfield Royal Infirmary. The café continues to have small numbers attending despite widespread communication across the Acute Trust/ CCGs/Councils/ Hospices etc. When the new Chaplain is appointed, we will look more into the future of the café.

End of life Care Education
End of Life Care education has now become essential training for clinical staff including Doctors, Nurses and Health Care Assistants (HCAs). A DVD about the Individualised Care of the Dying document (ICODD) has been made to be part of the essential training to help staff support patients and families and to be more confident in using the ICODD and having end of life care conversations. A pilot on Advance Care Planning (ACP) has started on Ward 6, looking at recognising patients in the last year of life and offering discussions about their wishes and their future plans.

All qualified staff will be allocated a Smart Card, so they are able to write down conversations on the Electronic Palliative Care Co-ordination System (EPaCCS). This will ensure effective communication about end of life care patients between primary and secondary care and local Hospices. The aim is to improve patients and carers choices and preferences in the last year of life.

The Trust continues to provide:

- Communication skills training
- Full EOLC education days for Drs, Nurses, HCAs, AHP and Apprentices.
- EOLC training on the Trust induction, mentorship, preceptorship courses, FY1, CMT and FY2.
- Support to HCAs to complete EOLC competencies across the Trust.
- Ad-hoc teaching and in-reach are provided across areas that ask and if there have been issues identified in an area, the team provide extra support.

End of Life Care Champions
16 community CHFT nursing staff are now EoLC Champions plus 10 Hospital staff.

We are now on cohort three of Qualified EoLC Champions and our second cohort of HCA Champions will be starting in April 2020. This 6-month course helps to increase confidence and skills in EoLC and to bridge the gap between specialists and generalists.

The Champions take everything they have learnt back to the areas they work and become a resource and support for other staff. There has been an increase in the use of EPaCCs and having Advance Care Planning and DNACPR discussions in place with families and patients since completing the course.

End of Life Care Companions
End of life companions are volunteers who are available to sit with dying patients, so they are not alone and for supporting family who may need a break. The role of the companion is simply that - companionship. They are not there to perform nursing tasks. Companions are not there to 'push' any beliefs or attitudes, they go there to be with the dying patient with compassion. Twenty companions have now been trained to support our dying patients, their families and the ward teams. Some of the new Companions are Trust staff that want to give something back to the Trust in their own time.

Horizon Group
This is a collaborative group which includes CHFT, Calderdale Council, the Council of Mosques and Overgate Hospice. The group was started after concerns were raised by Muslim patients and families with issues around end of life care – such as feeding and DNACPR. As a Trust we believe we have improved the understanding and relationships between healthcare providers and the South Asian Community which includes improving patient and family's experiences of the dying in CHFT.

The Horizon Group has developed Faith Cards for wards, organised events at the Madni Mosque and the Sikh Temple in Huddersfield and influenced teaching practice in the Trust to include different faiths and cultures in the training.

Audit, review and user experience:
New EoLC initiatives and developments are discussed with a cohort of bereaved relatives to ensure users' experiences and feedback are at the heart of EoLC within CHFT. We report on EoLC complaints and incidents at the EoLC steering group. If concerns are raised, we in-reach onto wards to support, educate and upskill staff.

The EOLC facilitator and education lead have been working with a complainant to ensure the Trust has learnt from the complaint, and as a result of this we have made changes to our education and training packages. Trust colleagues have completed a bereavement audit on the stroke wards and have participated in two rounds of the National Care at the End of Life (NACEL) audit which incorporated bereaved relatives' feedback, as well as audit of organisational standards and clinical care given to patients. An action plan has been developed from these audits which will be monitored through the end of life care steering group.

There is a requirement for all deaths that occur in the Trust to be reviewed by Consultants - this also incorporates a number of these cases to undergo a defined critical analysis by the team. This is part of the structured judgement review process which is led by trained structured judgement reviewers. The purpose of this process is to enable teams and the Trust to understand what lessons we can learn and by which we address deficits within care delivery and learning needs.

Better identification/recognition of patient in the last year:
The feedback from the Macmillan Medical Assessment Unit and Emergency Department Project at Huddersfield Royal Infirmary has identified high numbers of patients presenting acutely who are likely to be in the last year of their life.

Suggested improvements include the use of prognostic tools, like the Supportive and Palliative Care indicators Tool (SPICT), a tool being used by clinical teams. Earlier recognition of these patients is needed across primary and secondary care and equally as important is the communication of this between all care settings, to enable patient's wishes to be met and to enable patients to be cared for and die in their preferred place.

The SPICT tool is also being used on Ward 6 to recognise patients in the last year of life to support advance care planning discussions.

Coordinated, timely and equitable access to good care:
The co-ordination and equitable access to EoLC care is another key priority. There is a need to improve communication and connectivity between primary and secondary care. We are currently working on optimising the trusts digital systems by improving access to SystmOne and the Electronic Palliative Care Co–ordination Systems (EPaCCs) across both primary and secondary care to enable patient's preference to be communicated between settings in a timely manner. There are ongoing discussions around the Specialist Palliative Care Team (SPCT) working 7 days a week to enable timely access to SPCT support.

Better management of the last days of life:
The use of the Individualised Care of the Dying Document (ICODD) has fallen since the advent of electronic records in May 2018. The National Care at the End of Life (NACEL) audit from May 2018 shows the Trust now has a 40% rate of people being supported by the ICODD, compared to a national average of 62%. Improvements for this include a joint build between CHFT and Bradford Hospital Foundation Trust (BHFT) to add the ICODD onto the electronic patient record (EPR) which we believe will improve the completion of the ICODD document.
The new build is being trialled at BHFT. A dedicated ICODD learning DVD resource has been created (See EoLC education for details). We now have the Marigold Bag for relatives to take home their loved one's belongings in, instead of the plastic bags we used to use. This is to show respect, kindness and care when giving the belongings back to the relative but also so that bereaved relatives are recognised while in the Trust, so staff are aware that they may need extra support.

End of Life Care Priorities for 2020/2021
- End of Life Care education to be embedded on the essential skills training framework
- ICODD onto EPR – The individual care of the dying document (ICODD) is not currently on EPR but the build has commenced.
- Increase in the use of the ICODD to provide consistent evidenced based care to our patients.
- Bereavement cards to be implemented Trust wide.
- Increased collaborative working with frailty and other specialists to promote an increase in Advance Care Plans.
- Promote awareness of the Marigold café.
- Increase use of the End of Life Companions.
- New Faith card for End of Life Care.

Patient Experience

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 were treated with respect and dignity and how their interactions with staff made them feel.

It is important that the feedback is used to influence changes in practice; this may be about the little things as well as any large system changes. Staff from across the Trust recognise the importance of listening and responding to patient and carers views, this is championed through the representatives on the Trust Patient Experience and Caring Group.

Feedback methods

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

When carrying out the FFT, the Trust takes the opportunity to ask supplementary questions, to identify what patients report as working well and what could be done better. These comments are accessible for individual teams about their own area and at a Trust level to identify any system-wide issues.

More innovative approaches continue to be introduced to gather feedback and create opportunities to 'listen', through a range of feedback options that sit alongside the more formal methods of FFT, complaints, patient advice service and surveys. These include direct patient contact through rounding by the ward managers and matrons, debriefs, surveys carried out by volunteers, social media, guest books and graffiti boards. Opportunistic engagement is also carried out to gather service-user opinions to support improvements the teams are taking forwards, as well as more formal enquiries to support service evaluations.

Friends and Family Test

The FFT question asks, "How likely are you to recommend our ward / department to friends & family if they needed similar care or treatment?" Performance is monitored internally against national performance baselines.

Annual figures for percentage response rate and the percentage who would recommend the service is given below.

Chart 21: 2019/20 % Response Rate & Would Recommend as of February 2020

	2019/20 Response Rate (%)	Target (%)	2019/20 Would Recommend (%)	Target (%)
Inpatient	31.63	24.5	97.06	96.7
A&E	11.13	11.7	84.16	87.2
Maternity	33.18	20.8	99.15	97.3
Community	4.53	3.2	96.24	96.7
Outpatients	7.31	4.7	91.87	96.2

Following the NHS England review of the way the Friends and Family Test works across the country, guidance has been published which aims to make the FFT a more effective tool in gathering patient feedback and driving local improvements in healthcare services.

The Trust has taken forward the national guidance ahead of the April 2020 deadline, including:

- Revised mandatory question and standard response scale
- No limit on how often a patient or service user can give feedback
- Greater emphasis on use of the FFT feedback to drive improvement

Local Quality Improvement Work

The Trust Patient Experience and Caring Group has taken forward several initiatives over the last 12 months. These demonstrate the Trust's ambition to:

- Encourage feedback, and respond to emerging themes
- Engage with service users and carers as active partners in their care and provide opportunities for involvement in service development and improvement
- Further develop services that have a direct impact on patient experience

PRASE (Patient Reporting and Action for a Safe Environment:
The Trust has worked with the Yorkshire & Humber Improvement Academy using the PRASE survey, which are conducted by trained volunteers at ward level. This approach enables patients to provide anonymised feedback (positive and negative) on the safety and quality of care experienced during their ward stay.

The questions are linked to 8 safety domains:

- communication and teamwork
- organisation and care planning
- access to resources
- the ward environment
- information flow
- staff roles and responsibilities
- staff training
- delays

In the main, the surveys have shown positive results, however, there have also been improvement opportunities identified regarding patient understanding of staff roles and responsibilities and the ward environment

Experienced based co-design (EBCD)
The Trust's Patient Experience and Caring Group has championed the use of EBCD as an opportunity for service users and staff to come together to design, monitor and improve the care provided. The Trust held an event with women who had used the maternity service to understand what information they would like to be available on the CHFT website. Colleagues have continued to work with the local Maternity Voices Partnership representatives to develop the required web pages.

NHS England Always Events
The ambulatory area of the Surgical Assessment Unit has used the 'always event' framework to develop and improve the experience for patients. A vision statement has been agreed based on patient feedback – 'I will always feel up to date with the progress of my care', a new working model has been implemented to help achieve this. Data is now being collected to determine if a sustained improvement has been achieved.

Research
The Trust is working with the University of Huddersfield in a study with the aim of promoting sleep and reducing noise for hospitalised patients at night.

Outpatient transformational work
This programme is focused on improvements and efficiencies that will lead to a better experience for patients. The programme known as Project 20-20 has an objective of delivering 20 improvement projects by 2020. The projects are governed by a multi-organisational Board, including Healthwatch, patients' representatives and GP's.

The number of improvement projects has been achieved, using a variety of delivery methods including virtual, video and telephone clinics along with remote monitoring. For the year 2020 / 2021 over 50 projects are planned.

During the year, a survey was conducted with local outpatient service users to hear their views about alternative methods for accessing outpatient consultations, this was followed up with a targeted survey of patients with a protected characteristic (English not the patient's first language, sight or hearing loss, patients with a Learning Disability)

Learning Disabilities – the Trust is currently part of 2 national initiatives:
Royal Mencap Treat me well campaign, which is a campaign to transform how the NHS treats people with learning disability in hospital. "Simple changes in hospital care can make a big difference, better communication, more time, and clearer information." A local Treat me well group has been established and following a successful response to a survey the group are taking forward some improvements:

- Walked the wards of the hospital during learning disability week in June raising awareness of VIP passport and reasonable adjustments.
- Hosted a stand in the main entrance at HRI and in the staff canteen at CRH with information and leaflets.
- Prepared packs with questions for staff and resources to educate them during the interaction.

Further work over the next 12 months, includes:

- making a film for learning disability awareness which will be shown at Trust induction
- Incorporating 'changing places' and quiet areas across the Trust as part of any reconfiguration plans

CHFT worked with NHS Improvement as a pilot site to test an improvement toolkit based on standards for improving learning disability care in NHS Trusts. This has now been rolled out nationally through NHS Benchmarking which included 129 acute providers. Overall CHFT was in keeping with the National picture and other NHS acute Trusts.

Further audit data has been collected between November 2019 and February 2020 which has three components covering: organisational level data collection, a staff survey and and service user survey,

Dementia
Work has continued to deliver the Trust's Dementia strategy, this includes:

- A relaunch of the Butterfly scheme, a national initiative that uses a discreet butterfly symbol as a prompt for staff that the patient requires memory support and to follow a special response plan
- The introduction of a Memory Café (Butterfly Lounge) with themed activity sessions supported by the prevention of delirium team (POD) and engagement support workers.

Interpreting service – in response to a report received from the local Healthwatch and CQC recommendations, a review of the interpreting policy has been undertaken, resulting in clarity of best practice and a standard operating procedure detailing roles, responsibilities and processes.

End of life care
Work has continued to deliver the Trust's End of Life care strategy:

- Colleagues from the Trust (chaplaincy and end of life care) are part of a local group (Horizon Group) which was set up to support patient / relatives end of life care experience. The group organised a seminar on End of Life Care with members of the local Sikh community along with colleagues from Locala and both Hospices to offer information and advice on the nature of palliative care and support services available.
- Increased use of Bereavement cards;
- Greater uptake in the use of the Marigold (Bereavement) Cafe
- 'Marigold' bags available on wards for relatives to take home belongings of the deceased.

Divisional improvement work:
Clinical Divisions have delivered several improvements that demonstrate a real focus on delivering patient-centred care, including in response to feedback

Meeting needs of local people:
- Introduction of a virtual patient clinic for young people transitioning to adult epilepsy services enabling a consultation from a setting of their choice.
- Brand new play area at ENT outpatient department at Calderdale Royal Hospital –keeping young children happy whilst they wait.
- CHFT Youth Forum launched giving an opportunity for young people to have a voice about services
- As part of the Avoiding Term Admissions into Neonatal units' programme (ATTAIN) staff are using different coloured hats (red, amber, green) as an early warning risk assessment to monitor babies
- Public involvement in the interview process for the new Orthotics tender
- Introduction of a maternity advice line (non-urgent)

Meeting individual needs:
- The Trust is part of a NHSI Transition Collaborative with focused improvement work for young people with a neuro-disability – to be supported through transition to adult epilepsy services, enabling a consultation from a setting of their choice.
- As part of a 'Think LD' campaign, the Matron for complex care is attending 'board rounds' on the Acute Floor.
- The Frailty Team are working with the Regional Improvement Academy to increase knowledge and practice in advanced care planning
- A bid has been made to the Roald Dahl Foundation for transition nurses.
- To support the care of young people with mental health issues a review of risk assessments, guidance and staff training has taken place
- Colouring packs have been introduced by Radiology to make their environment more child-friendly.
- Creating easy read guidance regarding radiation dose consent.

Supporting emotional needs:
- Introduction of Pets as Therapy on the Children's ward and surgical rehab wards
- The Surgical Admissions Unit (SAU) have updated their pledges in line with the "Disney" and #if not me who campaign, these are on display in the unit
- Frequent visits by Tilly the therapy dog to CHFT critical care patients is having a positive impact upon patient experience

Involvement / feedback opportunities:
- New innovations in Children's Outpatients 'feedback fish' – comments can be written on the fishes' abdomen, any responses are added to the oxygen bubbles
- BFI (baby-friendly initiative) Gold Award Assessment: achieved in May 2019 – CHFT are the 9th maternity service in the UK to gain this award
- Evaluation of the 'surgery school', attended by patients on the enhanced recovery programme for bowel surgery, has demonstrated positive feedback about preparing for surgery and recovery.

Promoting compassion and kindness:
- Workshop focused on attitude and behaviours held for radiology staff recruited within the last year
- Surgical patient experience lead promoted 'Patient Experience the Disney Way' with a focus on #ifnotmewho across the division and other clinical teams
- Praise for going above and beyond - helping to celebrate a patient's 90th birthday and arranging a wedding on one of the wards
- Fundraising during pregnancy-loss week to improve the patient environment on the gynaecology ward

Improved access to services:
- Increased availability of phlebotomy in the community - new service at Broad Street Plaza (4 mornings a week)
- MAST primary care network (Kirkburton, Kirkheaton, Skelmanthorpe, Lepton and Dene Valley surgeries) redesigned the service to increase available phlebotomy time and offer patient choice regarding which practice within the MAST group they attend
- CRH Phlebotomy team trained a cohort of Surgical outpatient HCAs to improve patient flow / experience. The scheme will particularly focus on patients with mobility problems / dependent on patient transport / attending clinics which are running late after Phlebotomy has closed.

Timely access:

- Focused work with patients waiting in ED - screening nurse to prevent inappropriate waits and undertake regular re-assessment of pain scores
- Scheme of volunteers supporting the delivery of medicines to wards and bringing requests back to pharmacy – aim to save nursing time / get medicines to the patient quicker facilitating a faster discharge / enable nurses to remain with their patient helping patient experience / quality.
- Dedicated Pharmacy support in the newly opened discharge lounge
- District Nurses, Lymphoedema Nurses, Tissue Viability Nurses and Podiatry working together to develop a lower limb pathway to improve treatments and communication, and prevent duplication of visits between services leading to a better experience and outcomes for patients

Nutrition:

- Ingleton Falls restaurant participated in the Government 'Vegpower' campaign, each week the restaurant focussed on a vegetable highlighting the benefits
- An additional blast chiller installed at CRH allowing the provision of 'home-made' soup (a patient favourite) at lunchtime as well as teatime.

Learning from feedback:

- Community Matrons using the '15 Steps Challenge' which is providing a broad depth of insight and information
- Chaplaincy's 'Faith Card' developed which includes guidance re dietary requirements.
- The 15 steps challenge completed in maternity services with the help of the Maternity Voices Partnership (MVP).

National surveys

CHFT participates in all the national patient experience surveys. For all the national surveys each question is scored out of 10, a higher score is better. Trust scores for each question 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.
The following are the high-level results for surveys published this year:

Inpatient: published June 2019, CHFT results:
- The Trust was reported as scoring about the same for all but one of the questions.
- The Trust was reported as scoring better than the majority of other Trusts for the question: After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?

Urgent & Emergency Care (UEC) Survey 2018: published October 2019.
- The Trust's results were better than most trusts for one question: Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home? Scoring 7.2
- The Trust's results were about the same as other trusts for 35 questions.

Children and Young People's Survey 2018: published November 2019.
- The Trust's results were better than most trusts for one question: Did the hospital staff answer your questions? (answered by C&YP aged 8 – 15) Scoring 9.8
- The Trust's results were worse than most trusts for one question: Did staff play with your child at all while they were in hospital? (answered by parents / carers of 0-7-year olds) Scoring 5.7
- The Trust's results were about the same as other trusts for all other questions.

Maternity survey 2019: results were published on the CQC website January 2020.
- The Trust's results were better than most trusts for one question: Thinking about your stay in hospital, how clean was the hospital room or ward you were in? Scoring 9.5
- The Trust's results were about the same as other trusts for the other 46 questions.

Cancer Patient Experience Survey 2018: published October 2019.
The Trust's results were better than the expected range for three questions:
- Patient given enough support from health or social services during treatment 61%
- Practice staff did everything they could to support patient 67%
- Patient given a care plan 42%
- The Trust's results were lower than the expected range for two questions.
- Patient completely understood the explanation of what was wrong 69%
- Staff explained how the operation had gone in an understandable way 73%

All surveys are reviewed through Trust governance structures, with key messages and improvement work shared with teams.

Complaints

Divisional Senior Management Teams and Corporate Complaints Team colleagues continue to work together to improve the quality and timeliness of complaint responses, and training and supervision of colleagues responding to complaints.

At the end of 2019/20 the Trust received 505 complaints, this is a decrease of 11% from 2018/19.

The profile of the spread of the complaints received in 2019/2020 is given below.

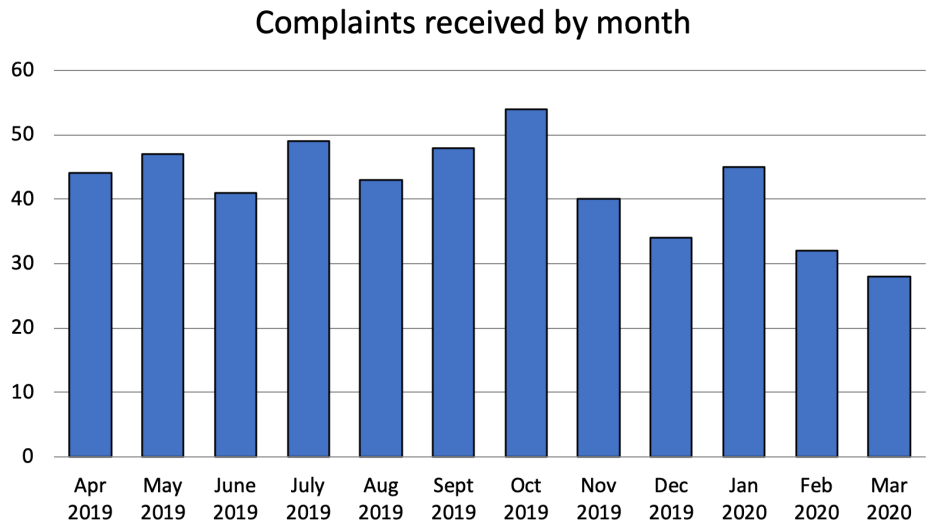


Chart 22 Complaints

The average number of complaints received by the Trust in 2019/20 was 42. The Trust received the highest number of complaints in October 2019.

Severity of Complaints Received

Complaints are triaged based on the patient experience described in the complaint using a three-tiered rating given below:

- Green – no / minimal impact on care
- Amber – quality care issues/ harm
- Red – long-term harm, death, sub-standard care

In 2019/20 60% of complaints were graded as amber, medium severity, 22% were graded as low severity and 18% of complaints were graded as red, extreme severity.

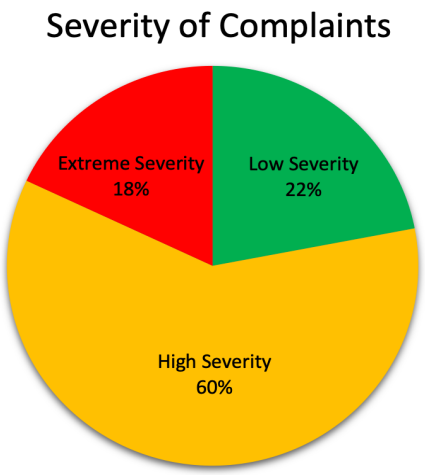


Chart 23: Severity of complaints

Acknowledgement Time
100% of the complaints received in 2019/20 were acknowledged within three working days.

Complaints Closed
The Trust closed a total of 525 complaints in 2019/20; this is a decrease of 13% from 2018/19.

Of the 525 complaints closed, 35% were upheld, 43% were partially upheld, 15% were not upheld, 4% were withdrawn, and 3% were investigated as an incident.

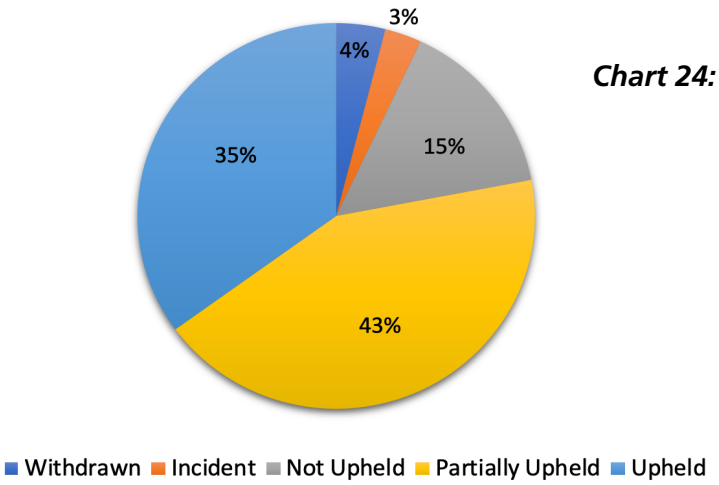


Chart 24: Complaints Closed

Re-Opened Complaints
The Trust re-opened a total of 64 complaints in 2019/20. This is a 22% decrease from 2018/19 (82).

Timeliness of Complaints Responses
The total number of overdue complaints at the end of 2019/20 was 35.

There has been significant work undertaken by the Trust in 2019/20 to improve the timeliness of responses to complainants. During January 2020, the Trust reduced the breaching complaints to 9, to compare, there were 23 breaching complaints in January 2019; this is a remarkable decrease of 61%.

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

Subject	Percentage	Increase / decrease from 2018/19
Clinical Treatment	51%	↑30% (21%)
Communications	12%	↓10% (22%)
Appointments	10%	↓ 2% (12%)

At the end of 2019/20 there has been a significant increase of 30% in receiving complaints that are relating to a patient's clinical treatment. This subject remains one of the top 3 subjects each month. Communications and Appointments consistently figure in the top subjects however, on occasion can be replaced with Patient Care and Hydration. The decrease in communications and appointments could be that as we are into the third year of EPR that initial problems with the booking of appointments and communications in this regard are being identified and starting to resolve.

Parliamentary and Health Service Ombudsman Complaints

The Parliamentary and Health Service Ombudsman (PHSO) investigate complaints where an organisation has not been able to resolve the complaint at a local level. The PHSO have broadened their review process and have considerably increased the numbers of cases that they consider. At the time of writing 2019/20 final figures had not been released; however, in 2018/19 the PHSO handled 112,262 enquires of which 27% were considered for investigation.

The table below shows PHSO cases relating to the Trust.

	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Number of Complaints Received by PHSO	**1**	**1**	**0**	**0**
Number of Complaints accepted for investigation by the PHSO	**1**	**1**	**0**	**0**
Number of Complaints the PHSO Upheld or Partly Upheld	**4**	**1**	**1**	**0**
Number of Complaints not upheld	**1**	**2**	**0**	**0**

Two cases were accepted for PHSO investigation between April 2019 and the end of March 2020. During this period the PHSO also concluded nine complaints against the Trust, of these three complaints were not upheld and six were upheld or partially upheld.

Learning from Complaints

The feedback we receive from complaints is extremely valued and helps us to improve our services and prevent poor experiences from reoccurring.

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's experience
- Reduce the number of complaints

Our complaints process includes identifying learning from each complaint and sharing this. Each service and division are required to demonstrate:
- How the service 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

Complaints data and learning from complaints is reported within divisional Patient Safety Quality Boards and quarterly to the Trust's Patient Experience Group to ensure that learning is shared across the Trust.

Some examples of learning from complaints for each division and one from the PHSO's are given below.

Learning:

Case One – A complaint was received from a son who was unhappy with the care and treatment that was provided to his father. Whilst the patient was at home, he complained of symptoms that the family thought to be a heart attack, with severe back pain, chest pain and shortness of breath. Emergency services were called, and the ambulance crew carried out observations which diagnosed that the heart was working normally. However, although there was a pulse on the patient's left-hand side, there was no pulse on his right.

Arriving at Calderdale Royal Hospital, repeat tests were carried out several times which again showed that the heart appeared normal. There was still no pulse on his right-hand side.

The complainant describes how there appeared to be much confusion as the same test was repeated 6 or 7 times, staff allegedly concluded that it was due to faulty equipment and they were transferred to a side room. The complainant and patient had been at the hospital at this point for over two hours and the patient was constantly complaining of severe pain. A decision was finally made to administer morphine however was provided without anti-sickness medication and the patient became violently ill.

A senior doctor attended, and the patient was moved to resus, the patient is described to have been quickly deteriorating. The doctor realised that no anti-sickness medication had been prescribed and the doctor stated he believed the patient was suffering from an aortic aneurysm. This was now almost six hours from the original incident and the complainant states the senior doctor diagnosed the problem within 30 minutes of seeing the patient. Further tests were carried out and it was confirmed that it was an aortic aneurysm/ dissection and the patient was transferred to Leeds Trust.

In addition, due to technology problems, CHFT were unable to send the x-rays electronically and had to resort to sending them to Leeds in a taxi.

The patient did survive however, his son feels that on that day there were lots of missed opportunities of spotting the warning signs earlier. It took several hours before a senior doctor was called who diagnosed the problem very quickly, however the patient had been at the hospital for many hours and had to undergo many repeated tests. Why weren't the warning signs picked up earlier?

Actions taken:
On investigation it was found that the patient was triaged as category 2 which is to be seen in 10 minutes, however the patient was not seen until 34 minutes following arrival, this was due to the department experiencing a high number of attendances in that hour. Nursing staff struggled to obtain a blood pressure reading in his right arm and documented that during an ECG his blood pressure was low, and a doctor was notified immediately. The doctor advised to repeat the ECG in half an hour, to order blood tests, pain relief and a fast scan of the patient's heart. The doctor discussed the case with a registrar and a consultant. One hour from arrival it was acknowledged that the patient was in severe pain and morphine was prescribed. The patient was with clinical staff throughout his time in the department and he was being monitored closely. Staff were aware that the patient was extremely unwell, and staff wanted to ensure that the patient was stable enough to be able to send him for a scan of his heart. The patient upon attended for a CT scan became unwell and the Critical Care Team were called to review him. The CT scan which was reported 4 hours from arrival diagnosed the patient with an aortic dissection. Leeds Trust were then contacted but called back to say they were unable to see the images. It was requested that radiology resend them immediately. Leeds Trust called again to say they were still unable to view the images, so the decision was made to send them straight away via taxi.

The patient was not provided with anti-sickness medication at that time as guidelines state that if a patient is not actively vomiting or feeling nauseous then an anti-sickness is not indicated.

The investigation identified that the appropriate clinical care and treatment was provided to the patient. However, it was unfortunate that at that time the department were experiencing a very high attendance of patients which subsequently caused a delay and meant that the patient was not seen within 10 minutes of arrival.

No actions were identified; however, apologies were provided to the patient and his son for the delay upon arrival.

Case Two – A patient was admitted to HRI following a fall sustaining a fractured left hip. He was admitted onto a ward where he had a primary cemented hemiarthroplasty of hip. Following a five-week length of stay he had two falls, one resulting in a fracture of the right zygoma with maxillary sinus fracture, developed a category 3 pressure sore to his sacral/coccyx area and was discharged with undiagnosed shingles. The patient had a period of becoming generally unwell whilst in hospital, complaining of overall tenderness and body pain, especially in the right upper quadrant of his back and under his right breast and he became very weak. It was thought he may have had a urine infection or possibly caused by a result of new medication prescribed which one of the side effects being weak and tiredness. The urine sample came back negative. He developed a discoloured rash to his back which tracked under his right breast, which he was told had resulted from a fall.

The patient was discharged from hospital and on discharge his daughter was concerned of the deterioration of the rash. The District Nurses visited and contacted the GP who diagnosed shingles. His daughter contacted the ward following his discharge and asked if his rash had been seen and reviewed by the doctors prior to discharge. She was informed that they were in the process of investigating the development of a category 3 pressure sore.

The patient's daughter wanted to know how the patient sustained two falls, how he developed a category 3 pressure ulcer and why he was discharged home before a shingles diagnosis was made.

Actions taken:
An initial falls risk assessment was made on admission and the falls prevention care plan initiated. He was nursed with a falls alarm and the bed was put into its lowest position and regular visual checks were made, he had appropriate footwear and mobility aids. The patient was reviewed following both falls and investigations were carried out, in addition Datix incidents were raised on both occasions. Both falls were unwitnessed.

Nursing staff failed to ensure that the patient had his position changed every two hours which resulted in pressure damage to his skin. The complaint was shared with staff at the ward meeting and safety huddle and staff were reminded to ensure that patients are moved in accordance with their plan of care and to ensure that accurate documentation is in the skin bundle.

The patient's rash was not documented on the EPR and a doctor was not called to examine this therefore no treatment was provided. Staff were reminded of the importance of ensuring that everything is documented on EPR accurately.

Case Three – A daughter submitted a formal complaint as she had concerns about the way nursing staff spoke to her mother who was an inpatient at Calderdale Royal Hospital. The complainant felt that two nurses were rude with her mother and were asking her to stand and walk to the bed and the toilet despite knowing that she cannot feel her left side and needs assistance. He mother was also asked to stand up and walk to the bed. She said that her mother felt humiliated, bullied and very upset by their behaviour which seemed intentional and thought out. She understandably finds it's hard to accept that someone needs to go to the toilet with her and had been crying all night and day because of this and requested that these nurses do not provide care for her, but they continued to do so. The patient was left feeling humiliated and bullied by the staff.

Actions taken:
It was found that the reasoning behind asking her mother to walk to the bed from the toilet was because they were unable to lift her from the toilet. This was not communicated to the patient and left the patient feeling humiliated. The nursing staff were asked for reflective statements to ensure that they understood the importance of treating people with dignity and respect.

Case Four – A patient had a routine follow up appointment and at the appointment the doctor stated that his cancer had spread to the bone. This came as a huge shock as he had received a letter 3 months earlier which contradicted this statement stating the recent bone scan showed no significant abnormality and there were no signs of the prostate cancer spreading into your bones which subsequently meant that the patient and his family were under the impression that his prostate cancer was under control. It was noted that although it was likely that a 3 month delay would not make a difference to his treatment plan the family have concerns that should this happen to a different patient; it could have a different outcome.

Actions taken:
It was found that although the delay had not adversely impacted the patient's treatment the error was a result of human error. The letter had been typed incorrectly and had not been proofread prior to sending. Once the mistake had been identified the letter had already been sent out. This complaint was shared with staff and highlighted the importance of proof-reading letters to ensure that they contain accurate information.

Case Five (PHSO) – A patient consented to a partial removal of her little toe. However, felt she was misled as to what this would mean. The patient's foot has the appearance that the full toe has been removed. Had the little toe not been strapped beneath the fourth toe following some previous surgery; the patient would not have needed this operation at all. The patient was left highly distressed at an outcome for which she was not prepared.

PHSO Recommendations/Actions:

Partly Upheld – The Parliamentary and Health Service Ombudsman made the decision to partly uphold their investigation. They found that after reviewing the consent form it did state partial amputation, however they felt that the photographs that were provided by the patient showed the entire toe was removed. It was stated by their clinical adviser however that there are no specific guidelines in relation to the level of amputation and what constitutes a partial toe amputation. The operation note referred to a piece of bone that was left and that strictly speaking this would be a partial amputation. They found that there was no documentation in relation to the level of detail that was discussed with the patient and no specific details regarding the extent of the amputation.

The Trust acknowledged that a more detailed discussion should have taken place which would have ensured the patient was more aware of what the toe would look like post operatively.

The Ombudsman's recommendations were to provide the patient with a financial remedy of £450 as recognition of the distress caused and that a letter of apology be sent along with an action plan detailing the steps that had been implemented to avoid reoccurrence of this.

The action plan detailed the sharing of this complaint with the Orthopaedic Team by way of a 'learning page' to ensure that lessons were learnt. To improve and be aware of communications when consenting a patient for treatment and to provide them with clear, accurate and realistic expectations of the outcome of surgery prior to obtaining consent. There are 8 active cases under investigation by the Ombudsman at the end of January 2020.

Improvement priorities for 2020-2021

During 2020 - 2021 we will:

1. Continue to work with the Divisions to improve the timeliness of responses.
2. Work with wards and departments to help them understand their complaints, and the learning from these.
3. Audit of learning from complaints to see how learning has been embedded.
4. Focused piece to work on re-opened complaints, to understand the reason for the increase in re-opened complaints.
5. Educate Trust staff on how and when to signpost to the Complaints Team or whether they can escalate within their own division for resolution.
6. Identify any training and support need with complaint investigators and put actions in place to resolve these. To be identified by way of anonymised questionnaire to past and present investigators.
7. To create a mandatory complaints/patient experience training module on ESR and a specified complaints investigator training module.
8. Discuss with the Division's Associate Director's whether a 'buddy' system of two investigators could assist in the timeliness of complaint responses.
9. Revisit the Trust induction slides and staff induction handbook to review the complaints process content and to add patient stories.

Performance against relevant indicators and performance thresholds from the Standard Operating Framework

Indicator	Threshold	2019/2020 Year End Performance	Achieved
Maximum time of 18 weeks from point of referral to treatment in aggregate-admitted	NA	NA	NA
Maximum time of 18 weeks from point of referral to treatment in aggregate- non admitted	NA	NA	NA
Maximum time of 18 weeks from point of referral to treatment in aggregate- patients on an incomplete pathway	NA	NA	NA
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	87.44%	No
All cancers: 62-day wait for first treatment from: • Urgent GP referral for suspected cancer • NHS Cancer Screening Service referral	 85% 90%	 90.81% 90.80%	 Yes Yes
All cancers: 31-day wait for second or subsequent treatment, comprising: • Surgery • Anti-cancer drug treatments • Radiotherapy	 94% 98% n/a	 98.96% 100.00%	 Yes Yes
All cancers: 31 day wait from diagnosis to first treatment	96%	99.64%	Yes
Cancer: two week wait from referral to date first seen, comprising: • all urgent referrals (cancer suspected) • for symptomatic breast patients (cancer not initially suspected)	 93% 93%	 98.59% 97.66%	 Yes Yes
Clostridium difficile – meeting the C. difficile objective	40	26 (5 Preventable)	Yes
Maximum 6-week wait for diagnostic procedures	99%	99.7%	No

Feedback from commissioners, overview and scrutiny committees and Local Health Watch

Response from Greater Huddersfield and Calderdale Clinical Commissioning Group
NHS Calderdale CCG and NHS Greater Huddersfield CCG welcome the opportunity to review and comment on the Quality Account prepared by Calderdale and Huddersfield NHS Foundation Trust (CHFT) 2019/20. The report illustrates the organisation's commitment and focus on the quality of patient care, safety and experience as well as highlighting achievements and successes.

The Quality Account acknowledges the areas requiring improvement and progress in the future whilst providing a comprehensive transparent assessment of existing levels of quality which are consistent with the Commissioners understanding of quality within CHFT.

Feedback on the 2019/20 priorities is noted. The reported benefits of the SAFER Patient Flow Program are demonstrated through the collaborative working arrangements and are illustrated by the sustained improvement in the reduction of beds occupied by long stay patients. This progress is welcomed by commissioners and demonstrates the Trusts dedication and commitment to improve the safety and experience of the people and their relatives throughout their journey.

The commitment of CHFT to local and national audits is demonstrated by the participation in 98% of national clinical audits and 100% of confidential enquires. We welcomed the detail on the NICE guidance and how this has been progressed, particularly in relation to the development of the Clinical Audit Database which has led to improvement for patients with cancer that can now access to level 4 psychological support.

Commissioners note the findings around National and local audits in regard to outcomes of the National RCEM Feverish Illness in Children's Audit, Naloxone use in CHFT and Reasonable Adjustments in patients with Learning Disabilities. It is also encouraging that the Trust continues to partake in a large number of research activities with plans for this to continue throughout the coming year/s.

The Commissioners note that CHFT are dedicated to learning from the patients' journey and this is reflected throughout the account. It is pleasing to note that CHFT is experiencing a reduction in complaints received and complaints reopened in the last year. The willingness to learn from service user feedback is acknowledged, this is clearly evidence by including helpful real examples of how CHFT act on feedback and implement change to improve things. We would like to thank CHFT for their contribution to assist colleagues from a local hospice to support them through a serious investigation process and appreciate that CHFT have welcomed staff from the hospice to attend their Trust Investigation Training which shows a strong commitment to collaborative system working and patient safety.

The improvement work detailed regarding reducing the incidence of inpatient falls is encouraging. Commissioners welcome the opportunity to work in partnership with the Trust on this and the other priorities identified over the coming year such as the priority identified to improve safety and effectiveness within the organisation.

The CCGs wish to acknowledge the successful implementation, embedding and reported increase in numbers of staff speaking up. This is a marked increase in the data captured for 2018. The introduction of the Freedom to Speak up ambassadors/volunteers, portal and the "ask Owen" channel on the Trust Intranet is positive and demonstrates the Trusts willingness to value staff and want to improve their experiences.

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Commissioners would have welcomed more detailed information in relation to challenges faced by the Trust regarding Medical, Nursing and Allied Health Professionals recruitment and would welcome more information regarding the successes and challenges healthcare recruitment brings through our combined forums. The engagement work carried out with Junior Dr's shows the Trusts commitment to staff wellbeing and a willingness to adapt to feedback received from their workforce.

We can confirm the accuracy of the Quality Account, to the best of our knowledge, based on the information shared through Quality and Contract Management arrangements in 2019-20 and we look forward to working in partnership in 2020-21 to continue to improve outcomes for our patients.

Penny Woodhead
Chief Quality and Nursing Officer
On behalf of Calderdale CCG and Greater Huddersfield CCG
24 September 2020

Response from the Governors to CHFT Quality Accounts 2019-2020
I am responding on behalf of the Council of Governors to a request to review the Trust's Quality Account for 2019/20

The Governors have met throughout the year to consider detailed reports on the performance of the Trust and challenge Board Members to ensure that higher quality care is provided as detailed in the Quality Account. We do this by ensuring a high attendance by Governors at Divisional Reference Groups where we meet with all levels of staff at the Trust usually in their working environment to question and often witness the quality of service provided. The Council of Governors are also represented at the Trusts Board Meetings where Quality issues are considered, a Governor is appointed to the Trusts sub committees and Boards and have regular meetings with Executive and Non-Executive Directors. As Lead Governor I also have regular meetings with the Chair of the Trust who keeps me informed of any major issues affecting the Trust.

This work gives us knowledge of all the challenges involved in maintaining a high level of quality across the Trust and the opportunity to ask challenging questions to ensure our staff and patients receive the best possible standards of care.

I am pleased that the Trust have delivered improvements on the three quality priorities chosen by members during the year and on behalf of the Council of Governors I am happy to confirm that the Quality Account is a true and accurate statement of the Trust's activities in 2019-20.

Stephen Baines
Lead Governor
Calderdale & Huddersfield NHS FT
27 August 2020

Response from Locala Community Partnerships

As a partner of the Trust Locala, we are pleased to receive and provide comment on the Quality Account prepared by Calderdale and Huddersfield NHS Foundation Trust (CHFT) for 2019/20.

The Quality Account provides a comprehensive assessment of the levels of quality provided by the Trust. It details the progress made in a broad range of quality improvement areas which the Trust has undertaken during 2019/20 together with benchmarking data against other organisations.

It is pleasing to read of the commencement of the J20 programme which aims to build upon the 2018 CQC rating of Good and support the organisations Journey to Outstanding. Further the positive progress made towards achieving your top three improvement priorities for 2019/20; meeting the 4-hour waiting standard for patients in the emergency department, implementation of NEWS2 and enhancing mental health care in the emergency department is to be commended

Locala works closely with CHFT on a number of work streams discussed in this Quality Account including the SAFER Patient Flow Programmes, the Multi Agency Discharge planning meetings, supporting CHFT to meet the 4-hour target and ensuring the prevention of unnecessary hospital readmissions. The enhanced partnership working built upon throughout the pandemic period has realised several benefits for people who access our services and we look forward to building upon these collaborative work programmes in 2020/21.

We are pleased to see that the priorities for 2020/21 will have a positive impact on the experience of people accessing CHFTs services and the wider system:

- Learning lessons to improve patient experience
- Improving staff handovers
- Improving resources for distressed relatives relating to End of Life Care

Locala is committed to working with the Trust to realise these priorities where appropriate to do so.

As a community service provider and key system partner Locala welcomes CHFTs commitment to collaborative working and development of care pathways that benefit our local communities. We look forward to working with you in the year ahead.

Julie Clennell
Director of Nursing, Allied Health Professionals & Quality
Caldicott Guardian
Locala Community Partnerships CIC
21 September 2020

Response from the Kirklees Health and Social Care Scrutiny Panel
Thank you for inviting comment from the Kirklees Health and Adult Social Care Scrutiny Panel on the draft 2019/20 Quality Account for Calderdale and Huddersfield NHS Foundation Trust.

The Panel's comments are summarised below:

"The Panel notes the reference in the Chief Executives Statement to the COVID-19 pandemic and was surprised that the reference was relatively brief. The Panel accepts that it was not until towards the end of your Quality Account reporting year that the true implications of the pandemic materialised. However, the impact on the health and social care system has been so great that the panel believes that much greater emphasis should have been put on its importance to the Trust's quality assurance and quality enhancement and the impact it will have on future planning and service provision.

The Panel is pleased that the Trust has successfully met its three priorities for 2019/20. As mentioned in the 2018/19 response the Panel did not feel that the focus on the Emergency Department would present a significant challenge given that the Trust has previously highlighted its delivery of emergency care services as being amongst the best nationally.

However, the Panel does acknowledge that the operational changes cited appear to have enhanced the functioning of the Emergency Department and improved patient flow. The Panel also welcomes the successful work that has taken place in collaboration with partners which has enabled patients to be discharged safely and in a timelier way.

The Panel welcomes the various initiatives that the Trust has put in place to improve the clinical outcomes and experiences of patients. The Panel is pleased that the Trust's focus on the priority "deteriorating patients" has resulted in some positive structural development to improve the detection of deteriorating patients in general and those with sepsis in particular. The Panel however feels that the good work reported by the Trust could have been validated by publishing the outcomes data (NEWS2).

The Panel welcomes initiatives that help to improve the support and experiences of mental health patients. The Panel notes the strategies that have been introduced to address the Trust's mental health priority but are disappointed in the lack of detail and the absence of information identifying any measurable improvements.
The Panel notes the priorities for 2020/21 and agree that the issues that fall under these priority areas are important. However, the Panel believe that many of the areas highlighted should already be clear areas of focus and being addressed as a matter of clinical routine performance and respect for the dignity of patients.

There are a number of pleasing and positive examples in the document that demonstrate the trust's commitment to measuring patient experience and to enable their voice. The panel supports this focus and welcomes the innovative approaches that have been introduced to gather feedback and the various initiatives that are aimed at meeting the needs of local people.

The Panel agrees with the trust that learning from complaints is an extremely valuable tool that will help to improve services, quality of care and limit the reoccurrence of poor patient experiences. The Panel supports the Trust's commitment to share across the organisation the lessons learned from complaints and would wish to see further work being done to identify common areas of complaint to ensure that the measures required to address them can, if needed, be strengthened.

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The Panel supports the Trust's approach to encouraging a culture in the workforce where staff are supported to speak up if they have concerns knowing that the organisation will listen, learn and act upon these concerns. The Panel however notes that there has been a significant increase in the numbers of staff who have reported concerns and feel that it would be helpful if the Trust could provide anonymised information that provides the public with details of concerns that relate to patient safety and quality.

The Panel acknowledge that once again the Trust is able to report some impressive results from performance indicators and nationally comparable metrics and from this perspective the Quality Account is a soundly produced and technically competent report. However, as highlighted last year the Panel still feels that the document contains confusing terminology and a series of acronyms that many members of the public will struggle to understand. The Panel would therefore reiterate its request for the Trust to consider how the information can be presented in a manner that can be more easily understood by the public.

Richard Dunne
Principal Governance and Democratic Engagement Officer
On behalf of the Kirklees Health and Adult Social Care Scrutiny Panel
25 September 2020

Response from South West Yorkshire Partnership NHS Foundation Trust
As a partner of the Trust, we were pleased to receive and be asked to comment on the Calderdale and Huddersfield NHS Foundation Trust (CHFT) draft Quality Account for 2020/21.

The Quality Account provides an assessment of the levels of quality provided by the Trust, describing the progress made in many areas together with comparisons against other organisations.

The Trust has maintained its CQC good rating. Similar to SWYPFT, we are aware that CHFT is committed to improving their rating and their 'journey to outstanding' J2O work is very impressive and something we hope to learn from.

Given the CHFT focus on quality, it is unsurprising that they have achieved their objectives against the three key priorities related to safe and reliable care in the emergency department, intervening quickly in response to patient deterioration and psychological support for those with mental health problems who attend the emergency department.

In terms of the support for those with mental health problems, I can say that we have maintained a close and productive working relationship with CHFT to work in partnership to meet the challenges experienced. We always find CHFT easy to work with as we share the same values with a similar focus on quality and safety.

In SWYPT, we welcome the CHFT choice of priorities for 2020/21 aimed at learning lessons to improve patient experience, improving staff handovers to ensure they refer to psychological and emotional needs of patients and carers, and improving resources for distressed relatives, especially when breaking bad news. As always, SWYPT will be ready and willing to support CHFT with their efforts.

Our experience of CHFT as a partner has always been very positive and we continue to be impressed by the resilience and the professionalism shown by all your staff in the face of ongoing challenges, not least in your response to the COVID-19 pandemic. It has been an extraordinary effort by you and your staff in managing the pandemic while marinating high quality services throughout.

We continue to work closely with CHFT on shared sites and in response to issues and challenges that arise where close collaboration provides mutual benefits for the users of our respective services, carers and staff. The support and advice offered by CHFT is always greatly appreciated.

As a provider organisation we welcome CHFT's commitment to working to ensure joined up services with partners and we look forward to working with CHFT in the future for the benefit of our local communities.

Tim Breedon
Director of Nursing & Quality
Deputy CEO
South West Yorkshire Partnership NHS Foundation Trust
12 August 2020

Comments were requested from HealthWatch in Kirklees and Calderdale, and Calderdale Overview and Scrutiny Committee, however no responses were received as at 14 October 2020

Statement of directors' responsibilities in respect of the quality report

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

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

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

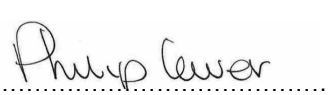
- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20 and supporting guidance Detailed reporting for Quality Reports 2019/20
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2019 to June 2020
  - papers relating to Quality reported to the board over the period April 2019 to June 2020
  - feedback from commissioners dated 24 September 2020
  - feedback from governors dated 27 August 2020
  - feedback from local HealthWatch organisations
  - feedback from Kirklees Overview and Scrutiny Committee
  - feedback from South West Yorkshire Partnership Foundation Trust dated 12 August 2020
  - the Trust's complaints report for 2019/20 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - the 2018 Adult inpatient survey May 2019
  - the 2019 national staff survey March 2020
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2020.

  Feedback was requested from Calderdale Overview and Scrutiny Committee, Trust and Locala in August 2020.

- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board



.....Chairman

..... Chief Executive

Appendix A: 2019/20 Clinical Audit

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust were eligible to participate in/participated in for which data collection was completed during 2019/20, are listed below. The numbers of cases submitted to each audit or enquiry as a percentage of the number of registered cases required (by the terms of that audit or enquiry) are also listed.

During 2019/20, 48 of the national clinical audits and 3 national confidential enquiries covered relevant NHS services provided by Calderdale and Huddersfield NHS Foundation Trust.

During that period Calderdale and Huddersfield NHS Foundation Trust participated in 98% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

Women's and Children's Health

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Maternal, infant and new-born programme (MBRRACE-UK)	Yes	Yes	100%	100%
Neonatal intensive and special care (NNAP)	Yes	Yes	470	100%
Paediatric intensive care (PICANet)	No	NA	NA	NA
Audit of seizures & epilepsies in children & young people	Yes	Yes	All cases in time period	100%
National Maternity & Perinatal Audit (NMPA)	Yes	Yes	4455	82.5%

Cancer

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
National Bowel cancer (NBOCA)	Yes	Yes	262	93%
Lung cancer (NLCA)	Yes	Yes	308	100%
Oesophago-gastric cancer (NAOGC)	Yes	Yes	All cases in time period	100%
National Prostate Cancer Audit	Yes	Yes	320	100%
Endocrine & Thyroid National Audit (BAETS)	Yes	Yes	All cases in time period	100%
Head & Neck HANA	No	NA	NA	NA
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	136	100%

Acute

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases Submitted
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	Yes	621	100%
National Joint Registry (NJR)	Yes	Yes	1054	100%
Major trauma audit (Trauma Audit & Research Network, TARN)	Yes	Yes	All	100%
National emergency laparotomy audit (NELA)	Yes	Yes	171	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Yes	85	100%
RCEM Care of Children in Emergency Departments	Yes	Yes	All cases in time period	100%
RCEM Assessing Cognitive Impairment in Older People/Care in Emergency Departments	Yes	Yes	All cases in time period	100%

Heart

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes	944	100%
Adult cardiac surgery audit (ACS)	No	N/A	N/A	N/A
Cardiac arrhythmia (HRM)	Yes	Yes	100%	On-going
Congenital heart disease (Paediatric cardiac surgery) (CHD)	No	N/A	N/A	N/A
Coronary angioplasty/PCI (NICOR)	Yes	Yes	100%	On-going
Heart failure (HF)	Yes	Yes	100%	On-going
National Cardiac Arrest Audit (NCAA)	Yes	Yes	110 YTD	on-going
National Audit of Cardiac Rehabilitation	Yes	Yes	100%	On-going
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Yes	Yes	292	100%

Mental health

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Prescribing observatory for Mental Health (POMH-UK)	No	N/A	-	-
RCEM Mental Health Care in Emergency Departments	Yes	Yes	All cases in time period	100%

Long term conditions

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	Yes	79 YTD	On-going
Diabetes (Paediatric) (NPDA)	Yes	Yes	100%	100%
Inflammatory bowel disease (IBD) Registry**	Yes	No	None	None
National Ophthalmology Audit	Yes	Yes	2148	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	35	1.6%
Audit of Pulmonary Hypertension 2019	NA	NA		
National Audit of Care at the End of Life (NACEL)	Yes	Yes	80	100%
National RCP Asthma Audit Programme (NACAP)	Yes	Yes	48	100%
National RCP COPD Secondary Care Audit Programme 2019 (NACAP)	Yes	Yes	312	100%
National Audit of Seizures Management in Hospitals (NASH 3)	Yes	Yes	60	100%
Neurosurgical National Audit Programme	No	NA		

Blood

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Re-audit of the Medical use of Blood	Yes	Yes	All cases in time period	100%

Older People

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Sentinel Stroke (SSNAP)	Yes	Yes	All	On-going
National audit of Dementia 2018 (round 4)	Yes	Yes	100	100%
Falls & Fragility fractures – inpatients falls	Yes	Yes	All cases in time period	100%
National Audit of Intermediate Care	Yes	Yes	ongoing	100%
UK Parkinson's Audit 2019	Yes	Yes	40	100%

National Confidential Enquiries into Patient Outcomes & Death (NCEPOD)

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
On hospital Management of out of Hospital Cardiac Arrests.	Yes	Yes	11	100%
Dysphagia in people with Parkinson's Disease study	Yes	Yes	6	50%
Pulmonary Embolism Study	Yes	Yes	15	53%

Other

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
UK Cystic Fibrosis Registry	No	N/A	-	-
BAUS Nephrectomy Surgery	Yes	Yes	47	35%
BAUS PCNL	Yes	Yes	11	Not known
National Bariatric Surgery Registry	Yes	Yes	139	Not known
National Smoking Cessation	No	NA		
Surgical Site Infections Surveillance Service (GIRFT)	Yes	Yes	All cases in time period	100%
Reducing the impact of serious infections (antimicrobial resistance & sepsis)	Yes	Yes	All cases	Ongoing
Elective surgery (National PROMs Programme) Hip replacements/Knee replacements	Yes	Yes	Pre-op 838 Post-op 494	90.2% (929) 69.9.% (707)

The Trust did not take part in the national audits (that it was eligible for) as detailed below.

Name of audit	Reason
Inflammatory bowel disease (IBD) Registry	Lack of resources. Medical division aware. Data submission to begin April 2020

The reports of 33 national clinical audits were reviewed by the provider in 2019/20 and the following are examples where Calderdale and Huddersfield NHS Foundation Trust intend to take actions to improve the quality of healthcare provided.

Families and Specialist Services (FSS) – National Cardiac Rehabilitation 2019

introduction
Cardiac rehabilitation is a cost-effective programme that reduces cardiac mortality, as well as promoting self-management and improving quality of life. There is increasing evidence that cardiac rehabilitation also reduces unplanned hospital admissions, which not only improves the patient experience but has the potential to achieve substantial cost savings for the NHS.

Aims
- To reduce cardiac mortality, as well as promoting self-management and improving quality of life.
- To assess current practice and management of cardiac rehab patients within the trust
- To review practice against guidelines and recommendations set out by NACR
- To identify areas of good practice.
- To identify areas for future service development.

Cardiac rehabilitation (CR) quality has increased across the UK this year. Sixty-six programmes have now achieved Green status, an increase of 20 programmes compared with last year. Green status means programmes are meeting all seven key performance indicators (KPIs) required for certification by the National Certification Programme for CR (NCP_CR). **CHFT did not achieve accreditation status last year, however, due to the hard work of the professional healthcare team and the implementation of the actions described below, CHFT are now one of the sixty-six programmes to have achieved accreditation and Green status.**

CHFT response to lack of accreditation/green status
The Community Core Rehabilitation areas needed to be reviewed. Staff were not fully completing the two questionnaires required to achieve accreditation. Since the previous year's report, training has been given to the cardiac rehabilitation team by the Programme Manager at the National Audit of Cardiac Rehabilitation, York. Staff are all now fully aware of how to complete both questionnaires. Data quality checks are undertaken each month by the Team Leader and Data Information Analyst to validate the data and ensure it is submitted correctly.

Cardiac Rehabilitation programmes are being run at Brighouse, North Bridge Leisure Centre and Todmorden. Each programme provides gym-based exercise and circuit. Every patient is offered the same service no matter where they live.

As described above, CHFT have recruited an Exercise Physiologist to develop a homebased programme. The Physiologist visits the patient's home providing homebased exercise, care and follow up.

Action Plan

Recommendation	Actions required (specify 'None', if none required)	Action by date	Person responsible	Change stage
Optimise recruitment of post-MI patients to CR.	**Everyone who has an MI is referred to the CR team – All wards refer to CR**	**Actioned - Ongoing**	**Clair Jones**	Fully Implemented
Ensure patient comorbidity is considered as part of CR recruitment, assessment and tailoring of interventions.	**Every patient has an individualised exercise programme tailored to their needs**	**Actioned - Ongoing**	**Clair Jones**	Fully Implemented
Offer greater innovation in recruiting and managing patients with HF.	**CHFT have recruited an Exercise Physiologist to develop a homebased programme. The Physiologist visits the patient's home providing homebased exercise, care and follow up**	**Actioned - Ongoing**	**Clair Jones**	Fully Implemented
Recruit more female patients across all condition/treatment groups.	**Always ongoing. Homebased rehab can access female patients not attending**	**Actioned - Ongoing**	**Clair Jones**	Fully Implemented
Pursue quality CR delivery evidenced by achieving 'certified' programme status.	**CHFT have achieved 'certified' programme status**	**Actioned**	**Clair Jones**	Fully Implemented
Review recruitment protocols and management of post-MI patients to increase uptake. NACR will report more extensively on this next year.	**Ongoing review. Constantly looking at the cohort of patients coming through. Data quality checked every month by Team Leader and Information Analyst**	**Actioned - Ongoing**	**Clair Jones**	Fully Implemented
Tailor the CR intervention (mode of delivery, content and staff type) to accommodate comorbidity.	**All exercise is tailored to the individual person by fitness instructors and the exercise physiologist**	**Actioned - Ongoing**	**Clair Jones**	Fully Implemented
Ensure NACR captures innovations in HF rehabilitation via new modes of delivery, e.g. REACH–HF.	**Pick this up from ward referrals and community referrals. Inpatient and Outpatient referral teams refer patients.**	**Actioned - Ongoing**	**Clair Jones**	Fully Implemented
Ensure that CR is tailored to the needs of female patients, particularly interventions aimed at managing CVD risk factors and encouraging more physical activity.	**All exercise is tailored to the individual person by fitness instructors and the Exercise Physiologist**	**Actioned - Ongoing**	**Clair Jones**	Fully Implemented

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Recommendation	Actions required (specify 'None', if none required)	Action by date	Person responsible	Change stage
Liaise with the NACR team about acquiring or maintaining 'certification' of CR delivery against clinical standards.	**Liaising on a monthly basis to ensure this is happening**	**Actioned - Ongoing**	**Clair Jones**	Fully Implemented
To share with the team to show outcomes of hard work	**Clair Jones to present at the Cardiac Rehab Team Meeting**	**Ongoing**	**Clair Jones**	ongoing

Division of Medicine – National RCEM Feverish Illness in Children Audit

Introduction: Nationally driven audit into compliance with the NICE guidelines for fever is the under 5s: assessment and initial management. Fundamental standards audits were a full set of observations within 15 mins and the use of a stratified sepsis risk assessment. Developmental standards included use of the NICE traffic light sigs in a fever of unknown origin; timely review by a senior ED/Paediatrician in high risk groups such as the under 1s and provision of training in the recognition of sepsis in children. On aspirational standard was providing education leaflets for patients and their families on discharge

Summary of findings for CHFT
Generally, the Trust is achieving standards above the national average with the exception of some high-pressure periods. At these times, the ability to achieve observations within 15 mins was affected.
Use of a risk stratification for sepsis was achieved 100% of the time as this is integrated with EPR and the observations entered.

Use of NICE traffic light system is unclear and there is not certain way of recording this on the electronic record. Timely senior review is variable but consistently is above the national average. Issues may be the recognition of high-risk patients as well as the availability of the senior doctor.

With regards to providing leaflet- they are available, but it is not clear whether they have been provided depending on documentation by the doctor.

Teaching on the recognition of paediatric sepsis forms part of standard induction training of junior doctor 4 month and 6 months rotations, including recognition of high-risk groups. There is also further paediatric teaching as part of the weekly junior doctor teaching programme.

Conclusions
Use of EPR allows for accurate recording of observations and to allow sepsis risk assessment based on initial observations. Increased demand on the system and availability of staff are likely the causes of delay in achieving timely observation and senior review.

The induction and education programme do cover Paediatric sepsis.
Use of the NICE traffic light system is less easy to record but the use of posters may allow a reference point of doctors assessing children.

RCEM recognised that national/generic sepsis protocols and triage based on initial observations are likely to over-triage children more often into sepsis categories and therefore there is a risk of over investigating and over-treating a sensitive population. Because of this there is an allowance for trust to use the NICE traffic light system and to individually develop safe local protocols to minimise this.

Recommendation	Actions required	Action by date	Person responsible	Comments/ action status	Change stage
New NICE traffic light posters	Generating and placing posters	31/12/2019	Sachini Dharmaratne	N/A	In progress
Increase existing trust Paediatric sepsis posters visibility.	Generating and placing posters	31/12/2019	Sachini Dharmaratne	N/A	In progress
Ongoing inclusion of Paediatric sepsis in the Induction and ED education programme.	None	Continuous	Chamika Mapatuna	No issues, continues to be a part of the teaching programme and given by Paediatric seniors.	N/A
Encourage early discussion with senior in high risk Paediatric groups.	None	31/12/2019	Chamika Mapatuna	Inclusion in handover and memo	Complete
Giving written advice on discharge.	Inclusion in daily huddle/ handover.	31/12/2019	Chamika Mapatuna		In progress

Other National Clinical Audits the Trust has participated in during 2019/20:

- Breast & Cosmetic Implant Registry
- National Audit of Hip Fractures
- Diabetic Retinopathy Screening (KPI)
- Potential Donor Audit
- Management of Urinary Retention (Collaborative Regional Audit)
- National Audit of inpatient complex and chronic pain (CHIPS)
- The Efficacy and Safety of Sleep Deprivation for EEG examination
- FAMCARE
- BTS Adult Community Acquired Pneumonia
- BTS non – invasive ventilation
- Learning Disability Mortality Review (LeDeR)
- DAMASCUS Study: Diverticular Abscess Management: A Snapshot Collaborative Audit Study
- IMPACT: Improving Management of Patients with Advanced Colorectal Tumours
- National Evaluation of Accuracy of Stillbirth Certificates (NESTT study)
- National Audit of Seizure Management in hospitals (NASH3)

The reports of 108 local clinical audits were reviewed by the provider in 2019/20 and the Trust intends to take the following actions to improve the quality of healthcare provided:

National Patient Safety Alert – Audit of Naloxone use in Calderdale & Huddersfield Foundation Trust

Introduction
The patient safety alert on naloxone was published in October 2015. This highlighted that the inappropriate use of naloxone (either use when it is not indicated or in larger than recommended doses) can lead to significant pain and distress in the form of rapid and inappropriate reversal of the analgesic effects of opioids. It also leads to an increase in sympathetic nervous stimulation and cytokine release which can lead to acute withdrawal and severe consequences (hypertension, cardiac arrhythmias, pulmonary oedema or cardiac arrest).

Method:
Using EPR explorer menu we searched for every "complete" occurrence for naloxone over three months from 1st November 2018 - 31st January 2019 inclusive.
This generated a list of 31 MRN numbers. Each case record was then reviewed electronically, and data collected in an excel spread sheet. Following this the data was collated and analysed. One patient was excluded as although he was prescribed naloxone it was never administered. The remaining 30 patients were included in the audit.

The standard for all criteria was set at 100%. This is because there are easily accessible trust guidelines with the recommendations followed in this audit.

These results show us that we are comfortable with using naloxone in emergency situations and the correct dose was used for 96% prescriptions. However further education is required to raise awareness about using lower naloxone doses in patients with respiratory depression where full reversal is not desirable, or the patient is palliative. It is also important to consider the cause for opiate toxicity and act to pre-empt whether further doses or an infusion may be needed and to reduce/stop the offending opiate. This would be aided by ensuring that the correct observations were taken and documented to allow early detection of symptoms of opiate toxicity that may require more treatment.

Recommendation	Actions required (specify 'None', if none required)	Action by date	Person responsible	Comments/action status (Provide examples of action in progress, changes in practices, problems facilitating change, reasons why recommendation is not actioned etc.)	Change stage
Raise awareness of naloxone doses used for "patients with respiratory depression where full reversal is not required" and "patients with respiratory depression and the patient is palliative" Investigate possibility of presenting at acute medicine meeting	Teaching session at GIM lunchtime teaching Email reminder to junior doctors **Include in Junior doctors' newsletter**	**July 2019**	K Astbury **M Atkinson**	21st June 2019 (GIM teaching slot)	Complete

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Recommendation	Actions required (specify 'None', if none required)	Action by date	Person responsible	Comments/action status (Provide examples of action in progress, changes in practices, problems facilitating change, reasons why recommendation is not actioned etc.)	Change stage
Consider the cause of opiate toxicity and review the patient's prescription to reduce /stop any opiates	Teaching session at GIM lunchtime teaching Email reminder to junior doctors **Include in Junior doctors' newsletter**	**July 2019**	K Astbury **M Atkinson**	**21st June 2019 (GIM teaching slot)**	Complete
Consider whether PRN doses of naloxone or a naloxone infusion is needed	Teaching session at GIM lunchtime teaching Email reminder to junior doctors **Include in Junior doctors' newsletter** **Email to NS and HCA**	**July 2019**	K Astbury **M Atkinson**	21st June 2019 (GIM teaching slot)	Complete
Results to be fed back to MMC	Awareness	**August 2019**	K Astbury M Atkinson Anita Hill	Date to be confirmed	Complete

Local Audit – Reasonable Adjustments Audit in patients with Learning Disabilities

Introduction

Nationally there is significant research and papers highlighting that when the health needs of people with learning disabilities are not met, they have a higher incident of poorer health outcomes. The annual report for Learning disability mortality review (LeDeR) highlighted a 20-year gap in mortality compared to the general population

Summary of results

Questions from the audit reviewed in EPR.	Q3 unplanned	Q3 planned	Q4 unplanned	Q4 planned
1) Learning disability flag on EPR	5/5 100%	5/5 100%	5/5 100%	5/5 100%
2) LD mentioned in records	4/5 80%	4/5 80%	4/5 80%	1/5 20%
3) VIP passport mentioned in notes	2/5 40%	0/5 0%	1/5 20%	1/5 20%
4) Referral to LD matron (Please note this does not take account on weekend and BH and this is a 9-5 service M-F)	3/5 60%	2/5 40%	2/5 - yes 2/5 – well known did not need support 1/5 – no 80%	4/5 80%
5) Capacity considered and assessed	3/5 60%	5/5 100%	5/5 100%	3/5 60%
6) Evidence of reasonable adjustments	4/5 80%	5/5 100%	2/5 3/5 not required 100%	5/5 100%
7) Areas of concern	I patient attended ED and despite concerns raised by nursing home was discharged. Was readmitted that afternoon direct referral to AMU via GP	Special needs dental team Locala documented on consent form 4 LPA involved. No copy of LPA on our system.		Communication with care home manager was via 1:1 provided by care home rather than staff team. Therefore, it contributed to mixed messages and element of discrepancy

Questions from the audit reviewed in EPR.	Q3 unplanned	Q3 planned	Q4 unplanned	Q4 planned
8) Good practice	Ensured follow up appointment in epilepsy clinic CD player and headphones for distraction Keeping family fully informed Meeting with family regarding end of life in a timely manner Good involvement of care staff at bed side during ward rounds. Liaised with home manager prior to discharge	Timely discharge from DSU to meet patients' needs Care team went into theatre and kept well informed of what to expect First on theatre list	Well known to medical day case team and due to good relationships does not need LD matron support or reasonable adjustments Reasonable adjustments seen by podiatry and had bloods whilst under GA for dental	Good communication with family from all MDT Using side rooms and glide away beds Use of Ametop before bloods taken by FYI 1:1 provided by enhanced care team

Action Plan

Recommendation	Actions required	Action by date	Person	Comments/ action status	Change stage
Raise awareness of VIP passports on wards and departments ensuring a supply is available to the wards – this is the priority work of the Treat me well campaign group with a planned piece of work taking place during Mencap week in June 2019.	Email to ward managers and matrons to raise awareness of VIP passports for patients with learning disabilities and for cascade within the teams to download from the clinical repository Hard copies of VIP passports to be made available on admission units During learning disability week 17th June 2019, the local treat, me well campaign group plan to walk the wards to raise awareness and have stalls in the main entrance. Bite size learning or screen saver to be produced during learning disability week.	June 2019	Amanda Mckie	Email sent to ward managers 05/08/19 VIP passports on all admission units Completed on both sites. Pictures on screen savers and in CHFT news Screen saver and in CHFT newsletter	Complete

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Ensure teams are aware to refer patients to Matron Lead for learning disabilities for support as needed	Email to all ward managers and matrons to ensure they are aware to refer via email or telephone when a patient is admitted To attend ward clerks meeting to reinforce the need to refer when patients with EPR special needs flag (learning disabilities is admitted) During learning disability week for screen saver regarding VIP passport and referral to matron when patients admitted.	June 2019	Amanda McKie	Completed 05/08/19 Need to book September 2019 CHFT newsletter and screen saver and awareness session when walking wards and on display board.	Complete
Raise awareness within medical teams need to document learning disabilities as well as primary diagnosis such as cerebral palsy and Down syndrome.	Email to be sent to Divisional directors of what to record and the clinical coding requirements for dissemination to the teams To review teaching sessions offered to junior medical staff and ensure they have awareness session on learning disabilities and recording in clinical records	June 2019	Amanda McKie	Ongoing September 2019 Ongoing September 2019	In progress
Audit in 19/20 to review free text box linked to EPR flag to review if used to document reasonable adjustments	Audit to take place during quarter three alongside MCA / consent form 4 audit with safeguarding adults' team	March 2020	Amanda McKie		In progress

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