Calderdale and Huddersfield NHS

NHS Foundation Trust

Quality Report

2015/16

compassionate care

Part 1: Chief Executive's Statement

Welcome to the 2015/16 Calderdale and Huddersfield NHS Foundation Trust Quality Account.

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

As a further review of the quality and safety of the care we provide, in March we welcomed the Care Quality Commission (CQC) to the Trust. Their team of nearly 60 inspectors came for four days and looked at all areas of the Trust including hospital care and community care. Their visit included talking with my CHFT colleagues – at their work and in specialist forums – and also to our patients and their families to get the full picture of how care is delivered at CHFT. We received some positive verbal feedback and at the time of writing we are awaiting their full written report, their recommendations and their overall rating.

Providing 'Compassionate Care' and putting our patients first continues to be a high priority for all of our staff and the Trust. We are determined to ensure that patients get the care they need, when they need it and from the right person. That is at the very heart of the consultation process (March to June 2016) launched by our clinical commissioning groups (CCG) partners to reconfigure healthcare in hospitals and community setting across Calderdale and Greater Huddersfield with a view to improving quality – and safety - still further into the future.

Consultation and the CQC visit are two exceptional events from the past year yet improving quality is very much an ongoing priority for us. This report by no means covers everything. It is intended to give you a snapshot of where we are doing well and the areas that we continue to focus on.

As an organisation within the NHS we always try to learn from other organisations in the NHS. If there is an issue at another Trust we always take this as an opportunity to reflect on what we are doing locally and look to see where we can make improvements. We also use the feedback we receive through a variety of routes from our patients, their families and carers on what we can do to develop our services further and how we need to change them to meet the needs of our communities in the future.

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

There are some excellent examples of high quality care and services across all of our community and hospital services. There are also areas where we know we need to do better. We will continue to share good practice and make improvements so that all our patients receive high quality compassionate care whenever, and wherever, they access our services. I hope you will find the following pages informative and helpful in giving you an insight into the vast amount of improvement work we continue to do in the Trust.

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

Owen Williams
Chief Executive
May 2016

Part 2: How the Trust performed against the four priorities set for 2015/16

Each year the Trust works on a number of quality priorities. Last year the Trust identified four projects to be highlighted as key priorities for 2015/16.

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 2015/16?
Safety	Improving sepsis care	Partially
Effectiveness	To ensure intravenous antibiotics (IV) are given correctly and on time	Partially
Effectiveness	Improving the discharge process	Yes
Experience	Better Food	Yes

Priority One: Improving sepsis care

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

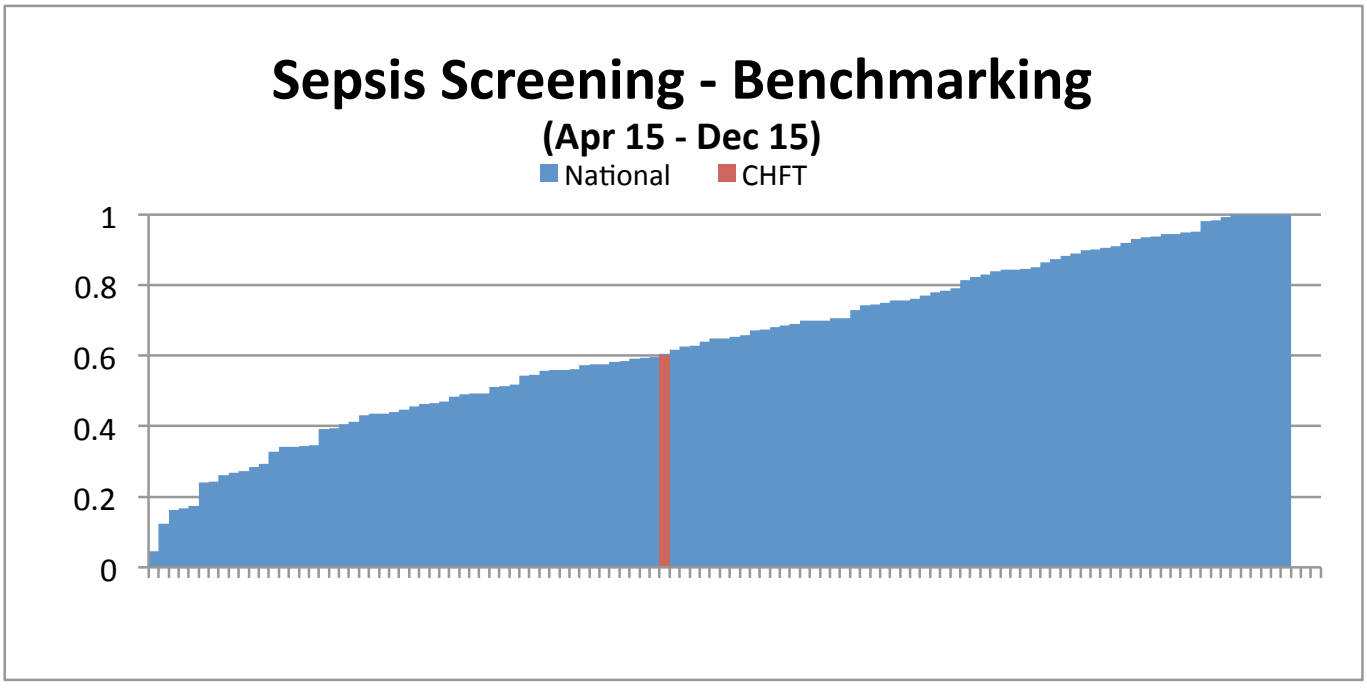
Sepsis is recognised as a significant cause of mortality and morbidity in the NHS. Problems in achieving consistent recognition and rapid treatment of sepsis are thought to contribute to the number of preventable deaths.

As such the Trust has been actively working to reduce mortality and harm from sepsis for a number of years and significant improvements had been made. Last year it was decided that sepsis would be one of the Trusts quality priorities in recognition that more could be done around reliable screening for sepsis and making sure intravenous (IV) antibiotics are given within the one hour recommended timescale, linking in with the new 2015/16 national commissioning for quality improvement indicator (CQUIN).

The Trust worked towards achieving significant improvement in both of the focussed areas below by March 2016:

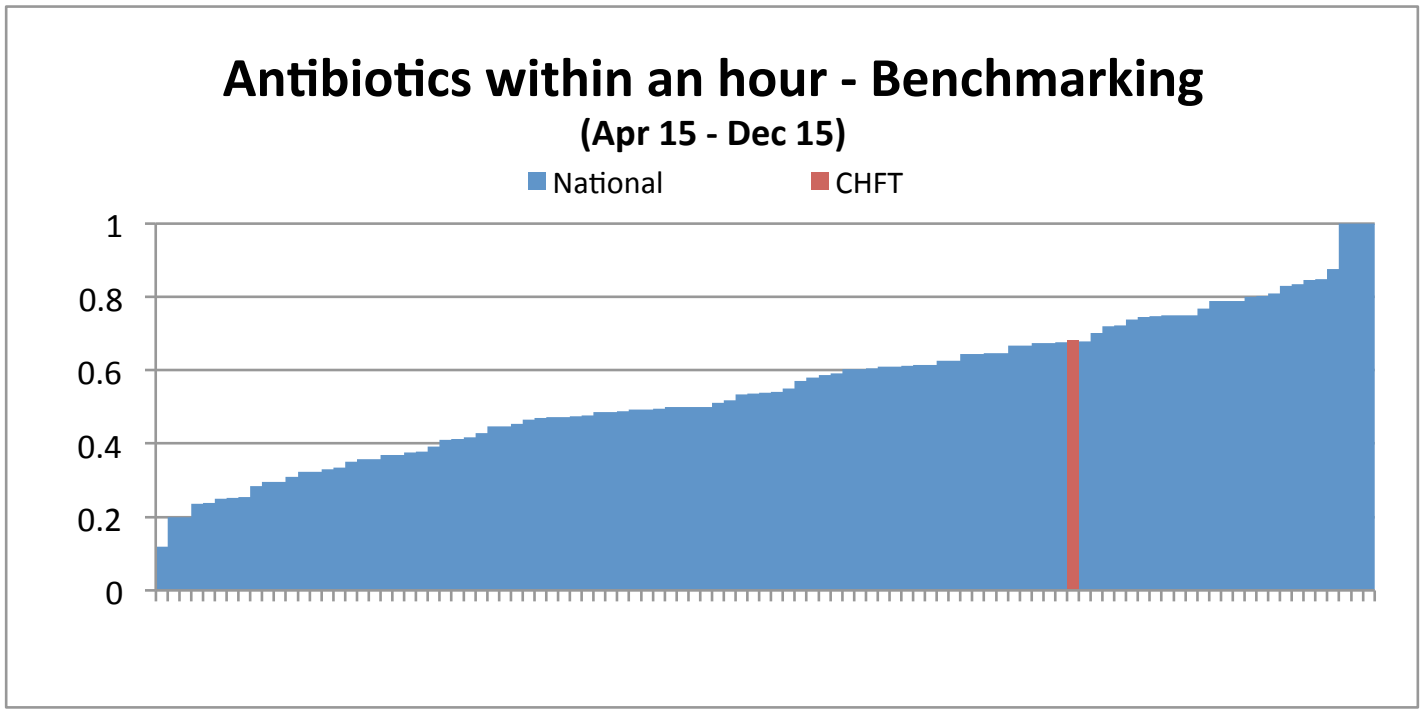
- Introduced reliable screening for sepsis for patients presenting in A&E and other direct emergency admission areas
- Ensure when identified with severe sepsis, red flag sepsis or septic shock patients get the initial IV antibiotic dose within one hour.

Progress to date:
Screening
To date 60% of patients have been routinely screened. The Trust recognises that there is still work to be done in this area and this will be supported through the 2016/17 national CQUIN. Performance is strongest in the A&E units, so work will take place to roll out more reliable screening processing in other direct admission areas. This level of performance benchmarks the trust at just below the national average (66%) for the first three quarters of data.



IV Antibiotics

Over the course of 2015/16 over 68% of patients with severe sepsis have received their antibiotics within the hour, with the majority of the remaining patients getting their antibiotics within 2 hours of admission. Like the screening performance, the Trust recognises that there is more that can be done in this area and this will also be supported through the 2016/17 national CQUIN. This level of performance benchmarks the Trust towards the top 25% of organisations, well above the national average of 53%.



This year has focused on raising further awareness in the Trust through programmes of education and ward based observation. This was assisted by a new clinical facilitator position, which was put in place to support colleagues and lead on the collaborative work. This included building awareness of the need to screen appropriately for sepsis and how best to identify severe sepsis.

Planned Improvements for 16/17

The 16/17 CQUIN will aim to see all trusts aiming towards 90% for both measures. As such there will be targeted improvement work in those areas which directly admit emergency patients, and compliance in these areas will be viewed separately from those admitted to an A&E unit.

The Trust will work with partner organisations, and other trusts, to share learning and built up understanding about how best to support each other in recognition of this as a regional and national challenge.

A working group is in place to examine the new NICE guidance which is expected in early in 2016/17. This will be incorporated into the ongoing education programme.

This hasn't been carried through as one of the three quality account priorities for 16/17, as the national CQUIN and reporting will ensure it continues to have high profile in the organisation. The removal of this enables to Trust to select additional measures for reporting back through the Quality Account (See part 2).

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

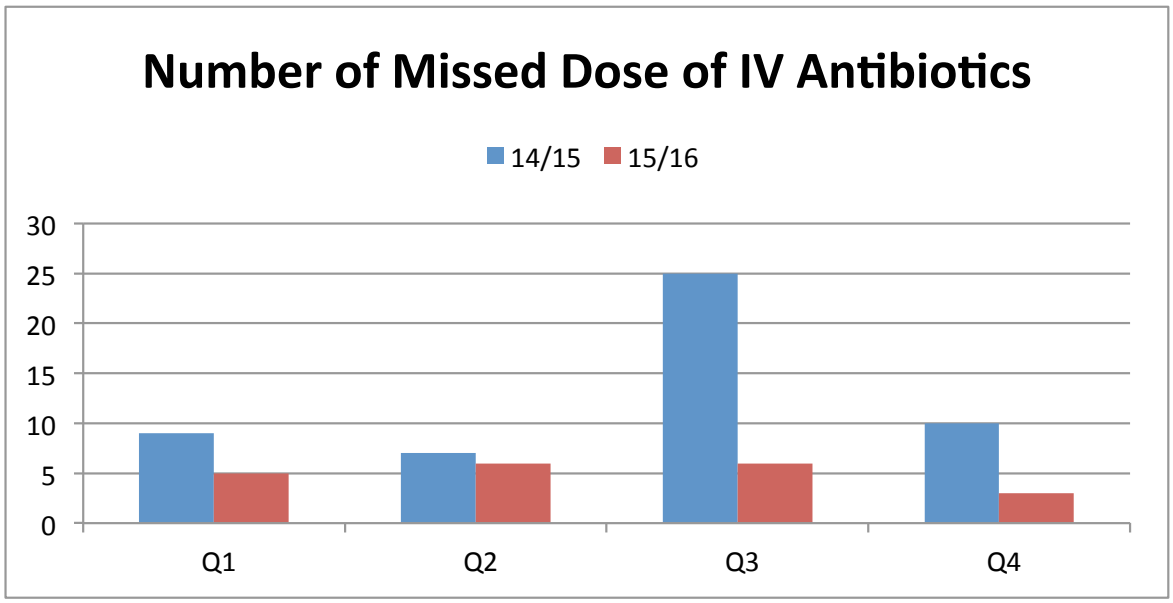
Why we chose this
When infections are diagnosed it is essential antibiotics are given correctly and on time to aid recovery and ensure that the patient's condition does not deteriorate.

This measure was carried over from the previous year in recognition of the need to continuously focus on performance in this area. Data was previously gathered through focused audit carried out by the specialist pharmacy team, alongside the quarterly point prevalence audit focussing on missed doses.

In light of the sepsis CQUIN also concentrating on antibiotic usage, links were made to this work in 2015/16.

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

Progress to date:
Data from the trust wide quarterly missed doses audit contains specific questions around IV antibiotics. Data has been gathered for the first three quarters of 2015/16 so far, and each quarter has seen a reduction against the same time period for the previous year. Improvements are expected to continue.



The specialist antibiotic pharmacy team undertake a six monthly antibiotic audit measuring if antibiotics are given according to Trust guidelines.

Results of the latest audit conducted in February 2016 took place at Calderdale Royal Hospital (CRH) in January – showing 94% compliance with antibiotic guidelines.

The areas of non-compliance are being addressed through the work on the national CQUINs, which includes the aims of reducing antibiotic consumption by encouraging greater focus on antimicrobial stewardship and ensuring any antibiotic prescribed are reviewed within 72 hours. The Trust will continue to work toward improving in this area.

Looking towards 2016/17, the electronic patient record (EPR) will allow staff to see and act immediately when a dose has been missed or delayed. CHFT will also be able to run missed/delayed dose reports at any point so missed/delayed doses, good practice and practice in need of improvement can be identified and acted upon quickly.

This hasn't been carried through as one of the three quality account priorities for 16/17, as the national CQUIN will ensure it continues to have a high profile in the organisation. The removal of this enables to Trust to select additional measures for reporting back through the Quality Account (See part 2).

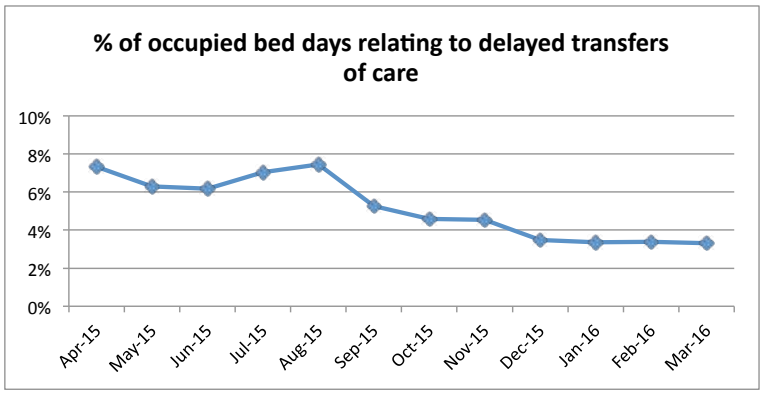
Priority 3 - Improving the discharge process

Why we chose this
Getting patients discharged appropriately means they are likely to have a better recovery, less likely to be readmitted and feel confident in managing their care. In 2015/16 one of the quality priorities focused on ensuring patients felt informed around their discharge planning and that staff would be more proactive in discharge planning.

Progress to date:
It was acknowledged that there was not always proactive discharge planning, leading to some patients potentially staying in hospital longer than necessary, increasing their risks and potentially delaying full recovery. To address this, a roving multi-disciplinary team (MDT) was tested with one of its aims being to coach staff in pathway planning. This has been operational throughout February and March and is currently going through a full design process.

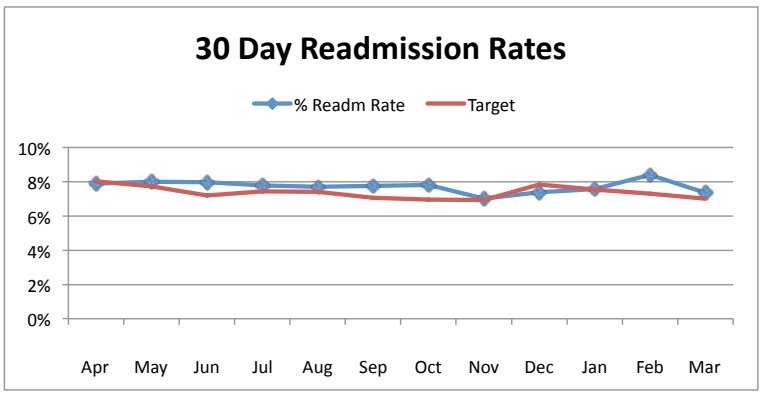
The Trust employed a specialist Matron for Discharge with the aim of providing extra support for people leaving hospital with very complex needs and also helping with the redesign of the process.

There has been a reduction in the number of patients who are delayed in leaving hospital when active treatment has ended.



The reduction in occupied bed days related to reportable delays in transfers of care can be attributed to improved communication and working between the Trust's Discharge Matron and social care colleagues. A new data base has improved visibility of patients awaiting their next destination and regular meetings have brought a more effective degree of operational management.

To ensure patients are not being discharged too early the Trust tracks readmission rates; the target is set by the previous year's performance levels.



In the future, the Trust is implementing a transitional programme in patient flow. This will include significant and improved joint working across health and social care. Taking a more 'case managed' approach to complex discharge planning. This will make systems more responsive and patient focused, with less delays in providing the necessary support and help for patients leaving hospital.

This has not been carried forward as a Quality Account priority for next year. Discharge planning continues to be an important part of improving patient flow and will be monitored accordingly.

Priority 4 - Better Food

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

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

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

Following the local CQUIN in 2014/15, supported by local Healthwatch, NHS Calderdale CCG and both council's public health teams introduced a new CQUIN focusing on improvements to the quality of the food being provided linked into our improvement work in this area in 2015/16.

The targets for this work were built to align with the CQUIN scheme achieving:
- Improvements in the percentage of patient satisfaction with the quality of food provided.
- A reduction in food waste
- Changes to the choices in vending machine healthier

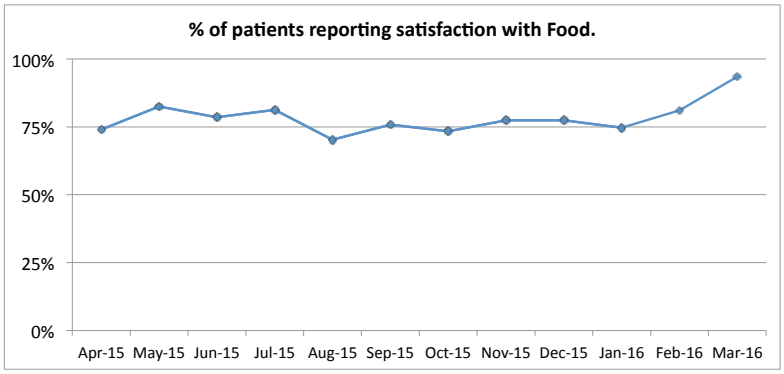
Progress to date:

Patient Satisfaction:
Patient satisfaction has been measured by the distribution of a questionnaire to inpatients. Volunteers on the HRI site and members of ISS on the CRH site have sampled 400 or more patients each quarter.

- As a result of this work, the catering team at CRH have raised the profile of supervisors and team leaders on the ward so they are available to speak to patients and staff around any concern related to food building links between clinical and catering staff and pre-empting potential problems. Feedback from the wards around this has been positive.
- 'Back to the floor' events now happening: walk arounds with matrons and catering staff ongoing to drive improved patient experience
- Concerns had also been raised around the lack of choice for patients who require a soft mashable type diet. Meetings took place in Q2 with staff from one of the CRH rehab wards and now a wider choice of category D and E meals are being tested with patients, staff and the dietetic team to see how this is benefiting patients. Alongside this, Halal meals are also under review to improve both quality and choice.
- Throughout 2015/16 ISS have been working with Burlodge, the heated trolley provider on the CRH site, and Anglican Crown who provide the majority of the meals. The review looked at different ways the food could be plated and reheated in order to prevent some meals becoming overheated and drying out. It is noticeable that complaints from both patients and staff have reduced since this piece of work began.
- A new lighter option menu is in place on one of the complex care wards which is more beneficial for their client group
- The timing for vegetables being cooked has reduced on the HRI site as complaints were raised about over-cooked vegetables
- A snack platter is in place on two complex care wards across CHFT so all patients have an opportunity for a snack between breakfast and lunch time and between evening meal and breakfast the next day
- Paediatric cutlery has been introduced on the Paediatric Ward at CRH
- Patient meal of the day food tasting is undertaken in the main entrance across CHFT three times a year with support from Appetito and Anglian Crown. Feedback is used to review/change menus as required

Positive Comments
So far very good- Happy
Quite good food, I was surprised I enjoyed it
Absolutely
Really satisfied, didn't think that it would taste as good as I imagined- Gammon very nice
Soups and Ham sandwiches very good
Enjoyed salad/Omelettes/
Overall happy with the service, no complaints
Always enjoyed meals, nice choices
Impressed with catering staff who frequently ask if you are happy with the food.
I was in hospital 5 years ago and the food is much improved.
My whole experience of this has been good so far, meals have been the icing on the cake.
The meals and staff have been excellent can you book me in over Xmas please.
Meals are an important part of a long day, something to look forward to, I haven't been disappointed.

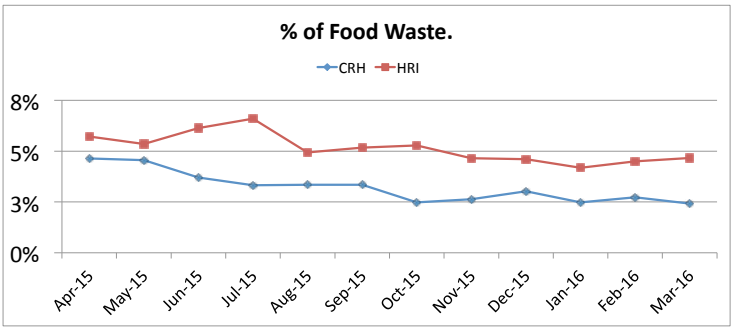
The overall score for patient satisfaction has been between 73% and 81% of those surveyed who have scored good or very good. This means that the Trust has achieved the CQUIN for this year



Food Waste

We have continued to work on reducing the amount of patient food which is wasted; actions have focused on improving communication at ward level which helps to feed back to patients the food choices available to them. This work is also helping to increase accurate ordering at ward level.

At the end of Q3 an initiative was in place at HRI to offer surplus meals to relatives who may be visiting patients for long periods of time due to the nature of the patient condition, thus ensuring that less food was wasted and returned to the kitchen.



Vending:

A proposal for improvements in vending paper was developed in partnership with Food for Life (FFL) and the Trust in view of NHS 5 year forward view & user comments in Nov/Dec 2015. The proposal has been updated in line with feedback from board members to ensure there is still a choice for all users. In line with the National CQUIN for 2016/17 healthy food for NHS staff, visitors and patients based on the Public Health report "Sugar Reduction", further work is required in the tendering specification. The tender document is planned to be completed by April 2016

The team has seen many improvements over the past year and have achieved their goals. As such this no longer features as a Quality Account priority. Work will however continue on this very important agenda.

Looking ahead to 2016/17

Looking ahead to 2016/17

A 'long list' of potential priorities for 2016/17 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 2015/16,
- Membership Council workshop.

This long list was discussed with the Trust's Membership Council; an opportunity to vote was also given via the Trust's internet site advertised in Foundation Trust News which is circulated to the Trust membership. This work has helped identify the following quality improvement priorities for 2016/17.

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

The three priorities for 2016/17 are:

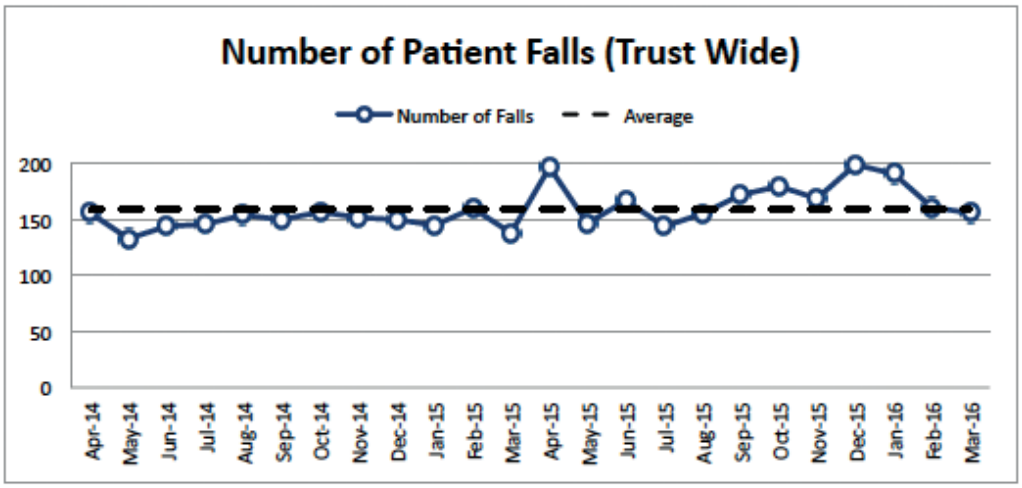
Domain	Priority
Safety	Falls
Effectiveness	Mortality
Experience	Community Experience

Priority One – Falls

Why we chose this

Falls are the most commonly reported type of patient safety incident in healthcare. Around 250,000 patients fall in acute and community hospitals each year (NHS England, National Reporting and Learning System, 2013, 2014). Although most falls do not result in injury, patients can have psychological and mobility problems as a result of falling.

The Trust has been monitoring the number of falls each year through a number of audits but has not seen any reduction in the reported numbers each month.



In recognition of this, the Trust has engaged with the local Improvement Academy and is looking to establish Safety Huddles. The Improvement Academy is supporting frontline teams to integrate multi professional safety huddles into their routine clinical care as part of a systematic approach to reducing harm. Team huddles, led by senior consultants, involve all levels of staff and provide important space for discussion of patient safety issues.

Improvement work
Patient safety huddles are clinically led and locally owned. Key content for discussions are tested and adapted by the team to fit their local context. Examples include identifying which patients most are most at risk from falls and pressure ulcers. The huddles:

- Are clinically led by the most senior clinician
- Involve the multi-professional team of all levels
- Happen every day in a timely efficient manner
- Focus on safety issues "what might stop us keeping our patients safe?"

Teams who have successfully embedded huddles into their ward routine have reduced harm in their areas e.g. reduced numbers of falls.

The Trust has been trialling the safety huddle approach to creating a safe ward area and from April 2016 will be devising a spread plan to ensure this good practice can be rolled out into a number of areas over the coming year.

Target
By the end of 16/17, at least 7 inpatient ward areas will have established regular safety huddles and seen reductions in their rate of falls.

Reporting
The Trust will continue to monitor the number of falls through its monthly Integrated Performance Report. The progress of the safety huddle plan will be reported in our regular Quarterly Quality Reports and progress against the aim of reducing falls monitored. The spread of the safety huddles is to be linked to a local CQUIN.

Priority Two – Improving Response to Deterioration (Mortality Reduction)

Why we chose this
Understanding hospital mortality is a key area for any acute trust. The Trust has been undertaking retrospective case note reviews on inpatient deaths since 2013. Some of the learning has highlighted the need to be more responsive to those patients who may experience a deterioration in their condition during the evening and early morning hours.

Improvement work
This is a new area of work for the Trust building on the successful implementation of an electronic observation system (Nerve Centre) through 2015/16. This has resulted in improvements regarding the early recognition of patients who are showing signs of deterioration, their need for closer monitoring can then be escalated appropriately. The Trust now wishes to roll out this good practice by implementing an additional module known as 'the Hospital at Night' model. It is anticipated that through improved standards in care there will be a reduction in hospital mortality rates.

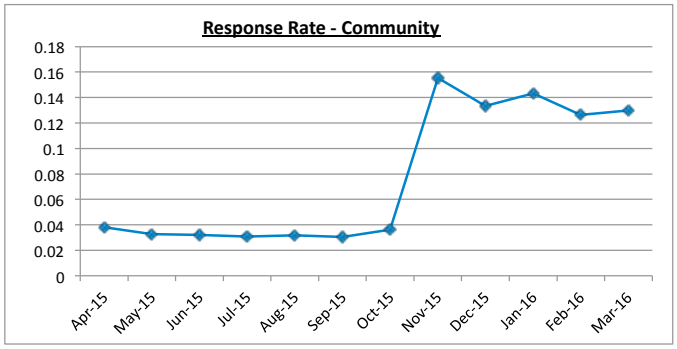
Target
The Trust aims to see improvement in the time taken to responses to patients who may deteriorate during the evening and early morning hours. Once the system is in place, baselines will be gathered and ongoing performance monitored. Initially the aims of the project are to have a fully implemented Hospital at Night module during evening hours. This will involve the recruitment of additional staff to support the project.

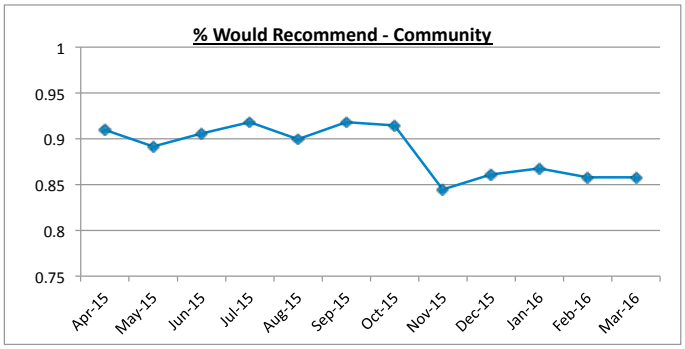
Reporting
A number of key metrics from the Nerve Centre software will be monitored on an ongoing basis, such as time between observations and response to escalation. At a higher level the Trust's mortality rate will continue to be monitored through the monthly Integrated Performance Report. The progress of the implementation plan will be reported in the Quarterly Quality Reports

Priority Three – Improving Community Services

Why we chose this

Community services by their very nature are complex and diverse, with many patients accessing a number of different services multiple times. The Trust has engaged with the Community Friends and Family Test (FFT) since April 2014. Over recent months improvements have been seen in the response rate however only only 10% of patients engage in this process. Alongside





this limitation, the feedback mechanisms do not allow for gaining insight into the views of those patients who may be less satisfied with our services than we would like.

Improvement work

In order to gain insight into these diverse services, additional feedback mechanisms are required to show where improvement can be made and how we can best support this client group.

Over the course of 2015/16, work will begin to develop new methods to gain insights into the experiences of patients who use our community services.

Target

The Trust will aim to get feedback regarding a number of different community setting and each quarter will target a new area. This area will be chosen through the use of local intelligence from any complaints, FFT comments and/or any concerns raised by staff to ensure we are looking at the areas that we can most learn from.

Reporting

Each quarter the feedback will be counted and the learning and subsequent action plans will be reported in the Trust's Quarterly Quality Report. Measures for ongoing monitoring will be selected as appropriate.

Statements of assurance from the Board

Review of services
During 2015/16 Calderdale and Huddersfield NHS Foundation Trust provided and/or sub-contracted 41 relevant health services.

Calderdale and Huddersfield NHS Foundation Trust have reviewed all the data available to it on the quality of care in 38 of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents 98.9% of the total income generated from the provision of relevant health services by the Calderdale and Huddersfield NHS Foundation Trust for 2015/16.

Participation in Clinical Audits
During 2015/16, 45 of the national clinical audits and 7 national confidential enquiries covered relevant NHS services that Calderdale and Huddersfield NHS Foundation Trust provide.

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

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

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2015/16 that were recruited into trials during that period to participate in research approved by a research ethics committee was 1,142.

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

The Trust was involved in conducting 168 clinical research studies of which 67 were actively recruiting, 102 were closed to recruitment (but participants were still involved) and 9 studies were 'in set up' (either waiting for initiation or local approval).

During 2015/16 actively recruiting research studies were being conducted across four of the five divisions in fourteen specialties:

Families and Specialist Services	(6 studies, 4 specialties);
Corporate	(1 study);
Medical Services	(54 studies, 13 specialties);
Surgical and Anaesthetic Services	(6 ophthalmology studies).

There were 50 clinical staff participating in research approved by a research ethics committee at the Trust during 2015/16, of which 35 were local principal investigators, one was a chief investigator on a qualitative study and one was chief investigator on an collaborative laboratory study. There were 2 clinicians commencing, and a further 6 continuing their studies at doctoral level.

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

Goals agreed with commissioners
A proportion of Calderdale and Huddersfield NHS Foundation Trust's income in 2015/16 was conditional upon achieving quality improvement and innovation goals agreed between Calderdale and Huddersfield NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with, for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. The figure for CQUINs allocated for 2015/16 was £6.7 million and for **2016/17** is **£6.8 million**.

The CQUIN areas identified for 2015/16 covered a broad range of areas and reflected priorities specified at a national level supported by local priorities identified in partnership between commissioners and the Trust.

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

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

The Trust did not achieve the full target for the Sepsis CQUIN 2015/16 or the AKI CQUIN. However partial achievement was noted.

In planning for 2016/17 the Trust has continued to work closely with local commissioners to develop a programme of CQUIN quality indicators which are consistent with the key challenges faced locally. The development of these areas of focus has had strong clinical involvement in identifying areas for possible inclusion.
A number of 2015/16 CQUIN indicators have been retained and will enter a further year of targeted improvement work during 2016/167:

Three national CQUIN areas were identified for acute trusts in 2016/17:
- NHS Staff health and wellbeing
- Timely identification and treatment of sepsis
- Antimicrobial Resistance and Antimicrobial Stewardship

These national areas will be complemented by further locally agreed CQUIN indicators in the following areas:
- Improving Safety – Implementation of the Safety Huddles.
- Experience of Community Services
- Self-Management of Medications

Further details of the nationally agreed goals for 2015-16 and for the following 12 month period are available electronically at: http://www.england.nhs.uk/nhs-standard-contract/

Care Quality Commission registration
The Trust is required to register with the Care Quality Commission (CQC) and has full registration without conditions. The CQC has not taken enforcement action the Trust during 2015/16.

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

CQC Intelligent Monitoring Report
In 2015/16 one report was published for the Trust.

Each report contains a priority band for inspection of the Trust, 1 being the highest priority for inspection (i.e. where the data indicates greatest concern for care quality) and 6 being the lowest priority.

The indicators cover:

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

In the May 2015 report the Trust was assessed as being in band 5 for the third consecutive time, with four areas of risk: two in the effective domain and two in the well-led domain.

The risks are described in two ways either a "risk" or an "elevated risk".

The effective domain risks relate to:
- A risk in SSNAP (sentinel stroke national audit programme) domain 2: overall team centred rating for key stroke unit indicator, this specifically relates to a lack of clinical psychology support, senior nurse or therapist cover and patients staying in bed until assessed by a physiotherapist. This indicator has been a risk since July 2014 when it was introduced. The data has been updated since the October report and includes the period from 1st July 2014 to 30th September 2014.
- An elevated risk in the proportion of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database, this has featured in all five reports but the data used for this report is from 2013 and has not been updated in this report.

The well-led risks relate to:
- A risk in the Trust's Monitor governance risk rating, this relates to a "material risk" being in place in March 2015. The Governance rating is a combination of all factors and it is the financial element that is causing the governance rating and enforcement action. At Q1 we declared compliance with all other elements of the governance rating.
- An elevated risk in Monitor-Continuity of service risk rating, this relates to enforcement action being in place in March 2015.

Both the risks in the effective domain have action plans monitored through the Divisional management structure and are reported through to the Quality Committee at regular points. In both areas performance against the quality indicators is improving with more improvement expected. However the specific risks from the stroke services may not be removed..

On review of our recent Q1 return and the Monitor Risk Assessment framework it shows that the Monitor Governance rating remains as subject to "enforcement action" but the continuity of service risk rating has deteriorated to level 1, "significant risk".

Data quality
The Trust is in the process of implementing the 'Cerner' Millennium EPR system, with a go-live date of October 2016. This provides an opportunity to review and update the Trusts data quality protocols and standard operating procedures.

It has been agreed by the Trust's Information Governance and Records Management Group that the data quality team should concentrate its efforts on assuring future state processes for the EPR and ensuring the quality and integrity of patient data being migrated from the legacy systems into the EPR. This includes

- Cleaning of data to be migrated e.g. maximum tracing and validation of NHS numbers and resolution duplicate patient registrations
- Ensuring that no patient and no future scheduled patient activity is lost during the data migration process
- Agreeing validation standards for patient data which will be entered directly into the new EPR
- Quality ensuring processes for the electronic harmonisation of patient data between the EPR and other clinical systems holding patient data
- Work with the EPR business change and training teams to incorporate data quality awareness

As the current PAS system now has a limited lifespan, no further development will be undertaken unless one of the following criteria can be demonstrated

- A patient safety issue needs to be resolved
- There is a national mandate to be implemented before the EPR go-live
- There is a significant impact on the Trusts financial standing or reputation

NHS Number and general medical practice code validity
The Trust submitted records during 2015/16 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 = 99.9%
Accident & Emergency Care = 99.0%

– Which included the patient's valid General Practitioner's Registration Code was:

Admitted Patient Care = 100%
Outpatient Care = 100%
Accident & Emergency Care = 100.0%

These figures are based on April 2015 to January 2016, which are the most recent figures in the Data Quality Dashboard.

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

A substantial programme of work has been undertaken for the March 31st 2016 submission to promote the continued use of technology within the Trust this includes the electronic patient record. There have been leaflets, awareness raising events and visits to wards and departments across the Trust to interact with staff and ensure that all information governance standards are being adhered to.

We expect to achieve 78% compliance in March 2016.

Clinical Coding Error Rate
The Trust was subject to the Payment by Results clinical coding audit in May 2015 by CHKS (Capita plc) and 200 FCE's were audited covering 2 HRG's - HB (Orthopaedic Non-trauma Procedures) and BZ (Eyes and Periorbital Procedures and Disorders). There were no price changes for the BZ HRG and only 2 price changes in the HB area producing a 1% error rate.

Review of quality performance – how we compare with others

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

The NHS Outcomes Framework 2014/15 sets 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.

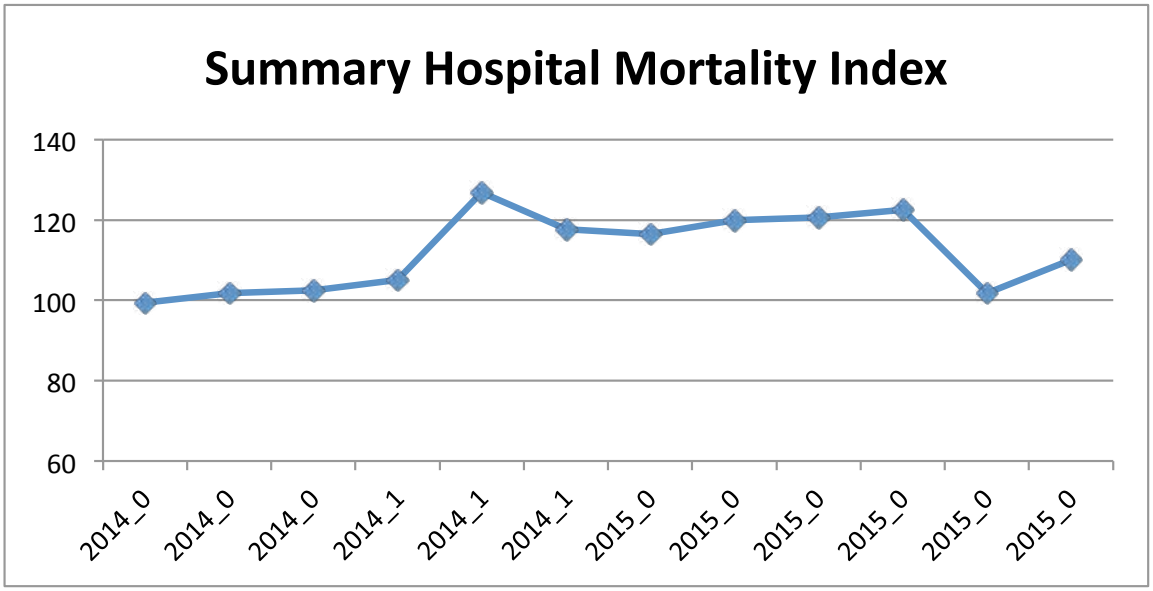
The information in the table is followed by explanatory narrative for all indicators, ordered by outcome domain.

Summary table of performance against mandatory indicators:

Outcome Domain	Indicator	2015/16 (or most recent data)	National Average	Best	Worse	2014-15	2013 - 14	2012 - 13
Preventing people from dying prematurely	Summary Hospital-Level Mortality Indicator (SHMI) value and banding	SHMI Value = 111 Band 1 = higher than expected (July 14 – June15)	100	66.5	120	109 Band 2 = as expected	111 Band 2 = as expected	102 Band 2 = bas expected
	The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.	18.1% (July 14 – June15)	25.9%	NA	NA	19.3%	19.2%	No data
	18. PROMS; patient reported outcome measures (latest reported 14/15)							
Helping people recover from episodes of ill health or following injury	(i) groin hernia surgery,*	0.08 (2014/15)	0.08	N/A	N/A	0.07	0.07	0.10
	(ii) varicose vein surgery,*	0.12 (2014/15)	0.09	N/A	N/A	0.11	0.10	0.09
	(iii) hip replacement surgery, and *	0.45 (2014/15)	0.43	N/A	N/A	0.44	0.43	0.45
	(iv) knee replacement surgery.*	0.33 (2014/15)	0.31	N/A	N/A	0.34	0.37	0.32
	19. Patients readmitted to a hospital within 28 days of being discharged.							
	(i) 0 to 15; and	11.43%	N/A	N/A	N/A	10.64%	10.06%	10.18%
	(ii) 16 or over.	11.95%	N/A	N/A	N/A	10.80%	11.26%	11.42%
Ensuring that people have a positive experience of care	20. Responsiveness to the personal needs of patients.	71.0% (14/15)	N/A	N/A	N/A	69.4%	69.9%	No data
	21. Staff who would recommend the Trust to their family or friends.	3.67	3.74	4.10	3.30	3.67 (2014)	3.68 (2013)	3.57 (2012)
Treating and caring for people in a safe environment and protecting them from avoidable harm	23. Patients admitted to hospital who were risk assessed for venous thromboembolism.	95.4% (Apr 15 – Dec)	95.7%	100%	80.6%	95.3%	96.2%	91.4%
	24. Rate of C.difficile per 100 000 bed days (2014/15)	11.5	15.1	0	62	6.2 (2013/14)	12.0 (2012/13)	14.3 (2011/12)
	25. Patient safety incidents and the percentage that resulted in severe harm or death.							
	(i) Rate of Patient Safety incidents per 1000 Bed Days	37.88 (Oct 14 - March 15)	35.34	N/A	N/A	36.22 April 14 - Sept 14	5.24 Oct 13 – Mar 14	5.51 April 13 - Sept 13
	(ii) % of Above Patient Safety Incidents = Severe/ Death	0.0%	0.1%	N/A	N/A	0.1%	0.0%	0.0%

Domain: Preventing people from dying prematurely
The Summary Hospital Mortality Index (SHMI) is a measure of mortality used 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 has been recently banded in the 'higher than expected' category.

There is a 6 month time lag in the availability of data for this indicator. The past 12 months performance is reflected below. SHMI cannot be used to directly compare mortality outcomes between trusts and it is inappropriate to rank trusts according to their SHMI.



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

The Trust has done a lot of work on understanding what this ratio is telling us about our hospital. As explained by the Health and Social Care Information Centre (HSCIC), SHMI is not a measure of quality of care and that a higher/lower than expected number of deaths should not immediately be interpreted as indicating poor/good performance and instead should be viewed as a 'smoke alarm' which requires further investigation.

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

The Trust has invested considerably in additional work streams to ensure that the quality of care delivered is of a standard we can be proud of. Through the implementation of a Mortality Case Note Review programme, the trust is on track to have reviewed a large proportion of in hospital deaths on a case by case basis resulting with learning fed into appropriate work streams in the Care of the Acutely Ill Patient (CAIP) programme.

This method doesn't adjust for those patients who are receiving specialist End of Life care, and as such the Department of Health also publishes an additional indicator which shows the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. The Trust is currently reporting 18% of deaths receiving palliative care, as opposed to 25% nationally. Please see the section on End of Life care (p53) for the Trust's work in this area.

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

Domain: Helping people recover from episodes of ill health or following injury
Patient reported outcome measure (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 groin hernia surgery, varicose vein surgery, 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 patient sees a 'health gain' following surgery.

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

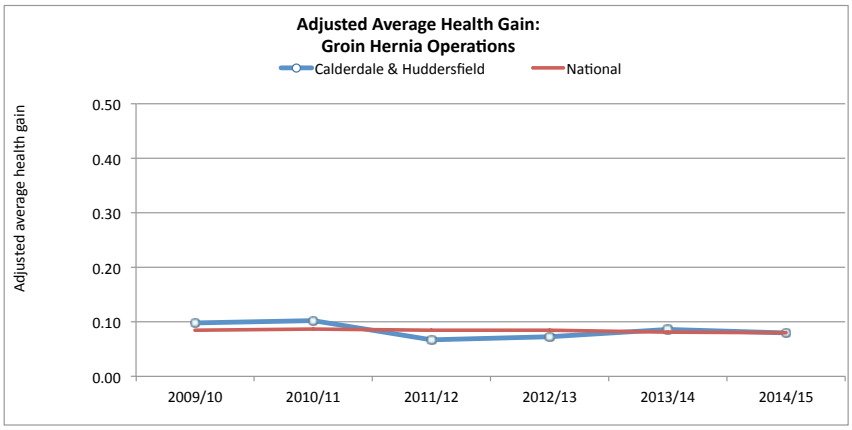
Calderdale and Huddersfield NHS Foundation Trust consider that this data is as described for the following reason:

Participation rate across all 4 procedures, for CHFT was 74.1%, which was above the national average of 69.4%.

Improvements have been seen in the health gain scores for three of the indicators. Knee replacement showed a small decrease but remains above national average performance.

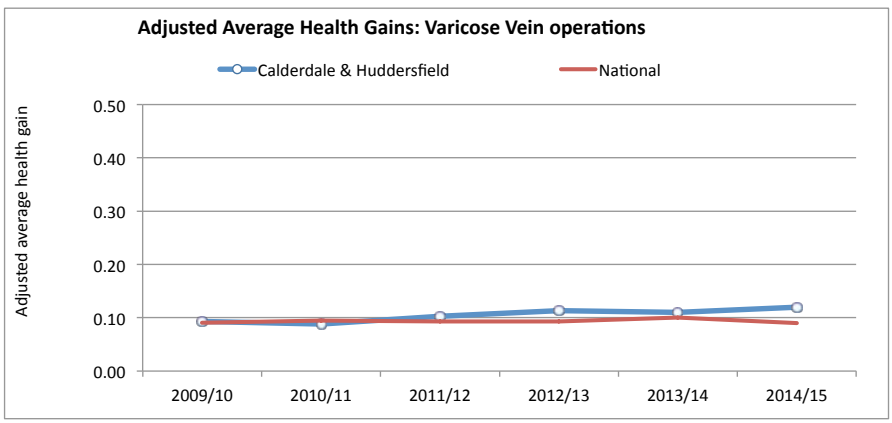
*(i) groin hernia surgery,**

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Calderdale & Huddersfield	0.10	0.10	0.07	0.07	0.09	0.08
National	0.09	0.09	0.09	0.09	0.08	0.08



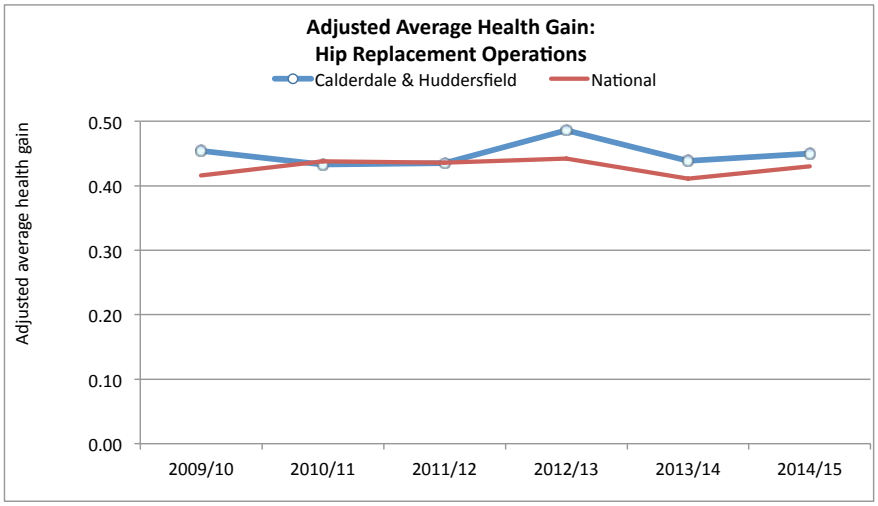
*varicose vein surgery,**

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Calderdale & Huddersfield	0.09	0.09	0.10	0.11	0.11	0.12
National	0.09	0.10	0.09	0.09	0.10	0.09



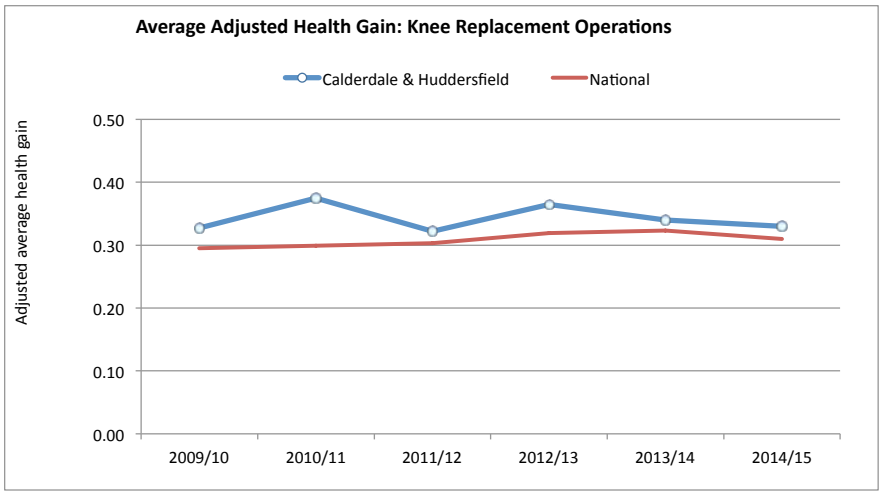
*hip replacement surgery, and **

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Calderdale & Huddersfield	0.45	0.43	0.44	0.49	0.44	0.45
National	0.42	0.44	0.44	0.44	0.41	0.43



*knee replacement surgery.**

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Calderdale & Huddersfield	0.33	0.38	0.32	0.37	0.34	0.33
National	0.30	0.30	0.30	0.32	0.32	0.31



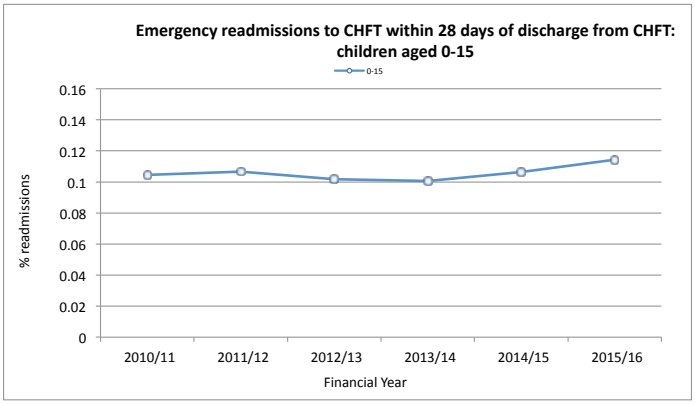
Calderdale and Huddersfield NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

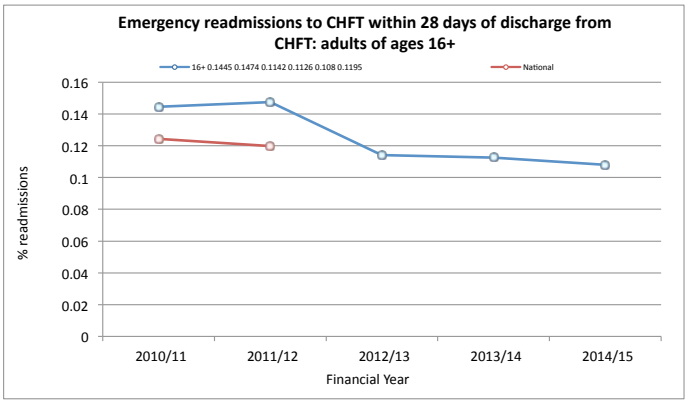
Continuing to ensure this data is accessible at consultant level so it can be used for clinical revalidation and to help drive improvements in practice.

READMISSIONS WITHIN 28 DAYS

The charts show the percentage of patients aged:
1. 0 to 15; and

	2010/11	2011/12	2012/13	2013/14	2011/15	2015/16
0-15	10.45%	10.66%	10.18%	10.06%	10.64%	11.43%
16+	14.45%	14.74%	11.42%	11.26%	10.80%	11.95%





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

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

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

- Through better planned discharges which will lead to less readmissions.
- Implementation of Safe and Effective Patient Flow Programmes

Domain: Ensuring that people have a positive experience of care

20: Responsiveness to the personal needs of patients.

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 2015 survey).

- Q32: Were you involved as much as you wanted to be in decisions about your care and treatment?
- Q35: Did you find someone on the hospital staff to talk to about your worries and fears?
- Q37: Were you given enough privacy when discussing your condition or treatment?
- Q57: Did a member of staff tell you about medication side effects to watch for when you went home?
- Q63: 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
	70%	69%	71%

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

The National Inpatient Survey was sent out to 850 patients who had been discharged from inpatient wards at Huddersfield Royal Infirmary (HRI) or Calderdale Royal Hospital (CRH) in July 2014. 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 420 patients who returned completed questionnaires giving a response rate of 49%. This is similar to the last two years, 2013 at 51% and 2012 at 50%.

Calderdale and Huddersfield NHS Foundation Trust intend to take the following actions to improve this score and so the quality of its services by continuing the initiatives described in part 3.

Staff Experience

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

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

A total of 850 colleagues were randomly selected in our sample by Picker Institute Europe, our survey administrator. Our Picker response rate was 40.5% (45% in 2014). The Trust has incorporated local questions in the survey in the same way as it did in 2014 focusing on patient experience, raising concerns, Trust values and its financial position.

Our actual scores remained unchanged from 2014. Our top five ranking scores are:
- Percentage of staff reporting errors, near misses or incidents witnessed in the last month
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month
- Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months
- Staff confidence and security in reporting unsafe clinical practice
- Percentage of staff appraised in last 12 months

Our bottom five ranking scores are:
- Percentage of staff satisfied with the opportunities for flexible working patterns
- Percentage of staff suffering work related stress in last 12 months
- Percentage of staff suffering work related stress in last 12 months
- Organisation and management interest in and action on health and wellbeing
- Recognition and value of staff by managers and the organisation

The staff survey score for indicator KF1 with contributing questions:

Question/ Indicator	CHFT 2014	CHFT 2015	National 2015
Q21a Care of patients/service user is my organisations top priority	70	75	75
Q12b My organisation acts on concerns raised by patients /service users	70	68	73
Q12c I would recommend my organisation as a place to work	57	54	61
Q12d If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.	65	67	70
KF24 (Overall Indicator) Staff recommendation of the Trust as a place to work or receive treatment	3.67	3.67	3.76

Staff recommendation of the Trust as a place to work or receive treatment is 3.67 out of 5; this is the same score as the previous survey.

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

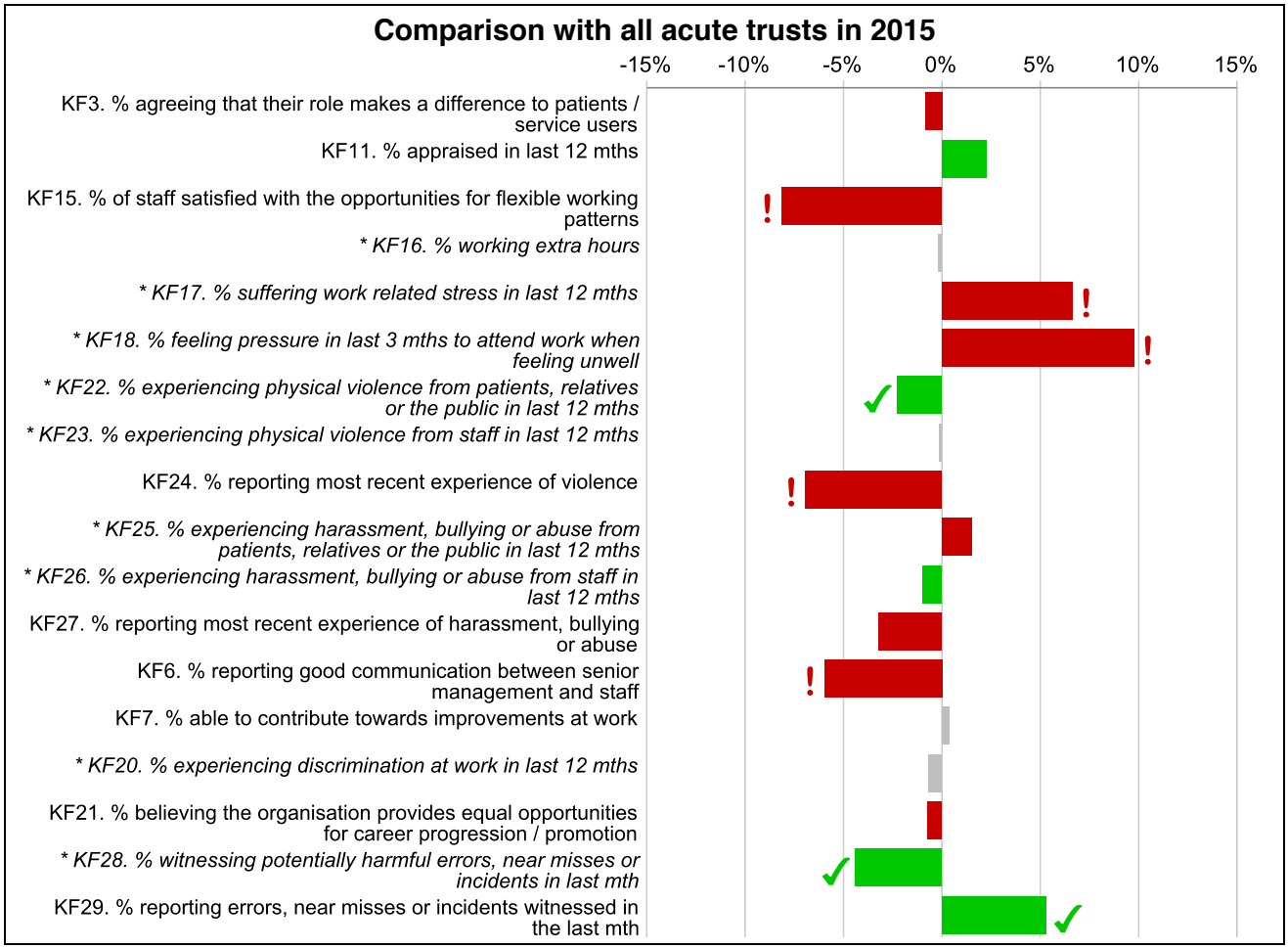
KEY

Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, e.g. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



Calderdale and Huddersfield NHS Foundation Trust intend to take the following actions to improve this score and so the quality of its services by implementing the colleague engagement strategy which has at its core four behaviours that the Trust expects to see across the organisation. The Trust continues to work to embed these key values through its Working Together, Get Results programme.

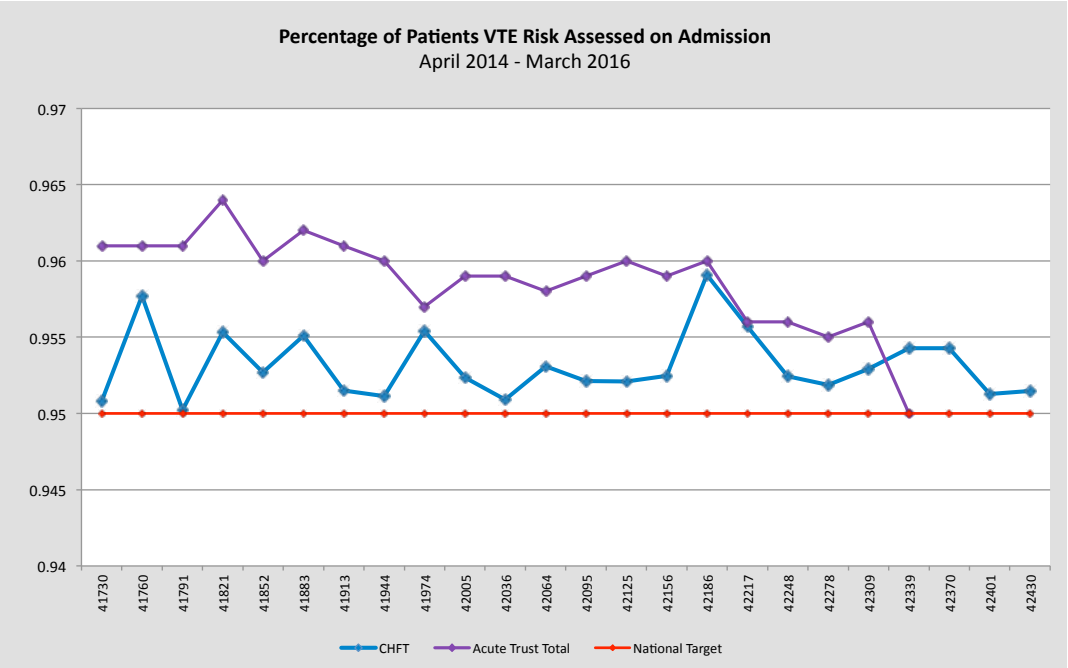
The behaviours are:-

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

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

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

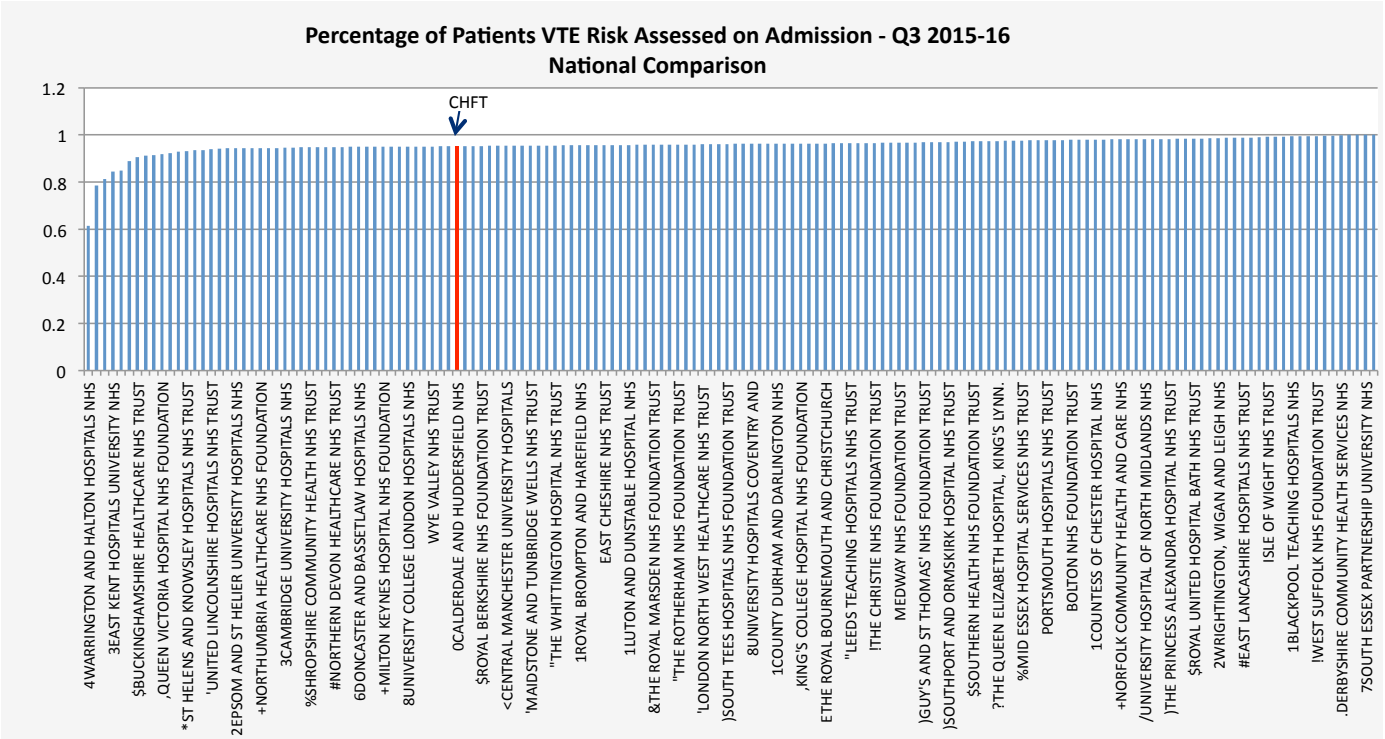
Risk assessing inpatients for venous thromboembolism (VTE) is important in reducing hospital acquired VTE. The chart show the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the report period from April 2014 to February 2016. The target from December 2012 for VTE risk assessment for all patients admitted was set at 95% and this has been consistently met.



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

Compliance data is currently retrieved manually after the patient has been discharged from hospital.

The benchmarking graph shows the Trust to be in the bottom third of Trusts, however issues with data capture make it difficult to evidence performance above the 95% target.



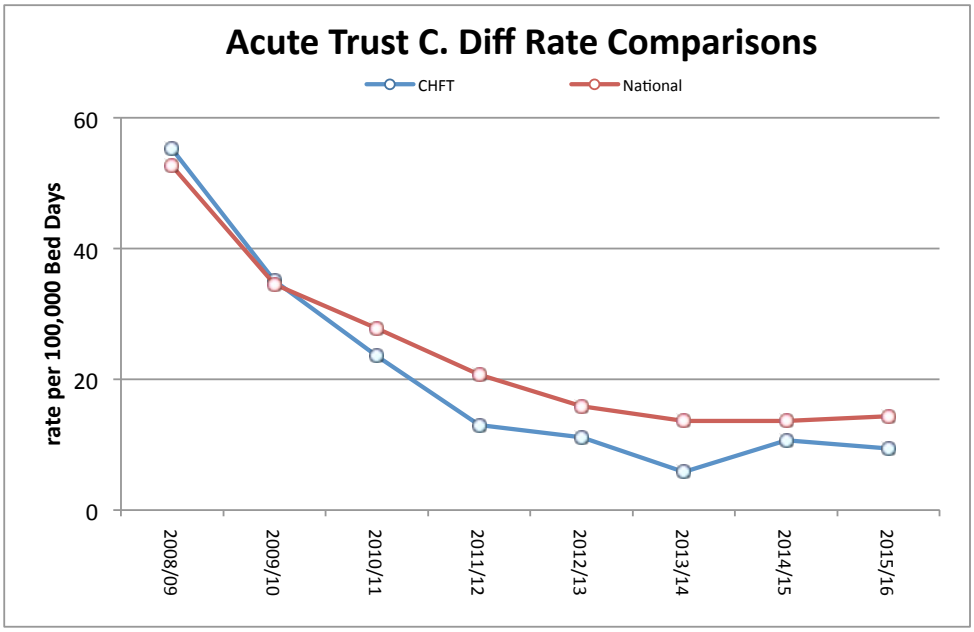
Calderdale and Huddersfield NHS Foundation Trust have taken the following actions to improve this and so the quality of its services by:

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

24. Rate of C.difficile per 100 000 bed days (2015/16)

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

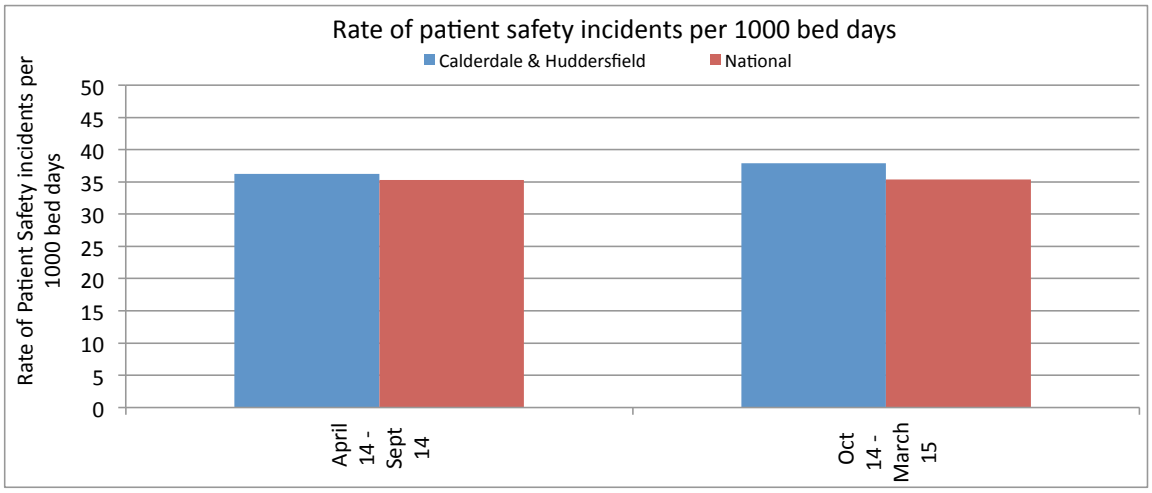
The chart shows the rate per 100,000 bed days of cases of Clostridium-difficile infection reported within the Trust amongst patients aged two or over during the reporting periods from April 2008 to November 2015.



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

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

(i) Rate of Patient Safety incidents per 1000 Bed Days



The chart above shows the Trust's previous reporting on the National Reporting and Learning System. Calderdale and Huddersfield NHS Foundation Trust consider that this data is as described for the following reason:

It illustrates the improvement with the Trust now reporting above the national average.

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

- **Policy** – An Incident Reporting, Management and Investigation Policy was approved at the end of December 2015, replacing the Learning from Experience Policy which covered incident reporting. The SI policy was updated to incorporate the changes from the revised 2015/16 Serious Incident Framework which came into effect in April 2015 and also provided clarity on duty of candour arrangements and revised template reports for orange and red incidents.

- **Serious Incident Panels** – The process for assessing potential serious and severe harm incidents has been revised during the year to make it more robust and efficient. The panels are chaired by the Medical Director and Director of Nursing and held weekly. The Divisional leads doctors and senior nurses with knowledge of the incident subject area also attend the panels to provide expert evidence. For efficiency and time management, the meeting rooms are pre-booked in advance with arrangements for video link for staff at the different site to ensure time is not wasted travelling between sites for the panels.

- **Investigation Report sign off** – The Director review panel above is used to quality assure serious incident reports and action plans and has led to an improvement in the quality of the reports

- **Serious Incident Review Group** – In December 2015 a Serious Incident Review Group, chaired by the Chief Executive met for the first time. The group's membership includes senior clinical division colleagues and its aim to provide assurance that the Trust is learning from Serious Incidents. The terms of reference for the group were approved by the Quality Committee.

- **Moderate Harm Incident Panels** – A new process for assessing Moderate Harm incidents was introduced during quarter 4, and potential moderate harm incidents are now reviewed weekly at divisional meetings. The investigation team and staff providing the Duty of Candour is identified at the divisional meeting where the final investigation report is also reviewed and signed off.

- **Pressure Ulcer** – the reporting and investigation process for pressure ulcers has been revised in year in line with the Serious Incident Framework 2015/16 and NRLS regarding the assessment of degree of harm for grade 3 and 4 pressure ulcers. The revised approach is providing a more thorough process which has re-focused the management of Pressure ulcers. The pressure ulcers that had been reported as serious incidents during this financial year were re-assessed in light of the guidance. Pressure ulcer incidents which had been wrongly graded and reported to StEIS were de-logged. Going forward a cluster approach to pressure ulcer investigations will be taken.

- **Data quality** – issues pertaining to the grading of patient safety incidents (degree of harm) were highlighted by the national reporting and learning system, NRLS. The Trust provides information to the NRLS regularly to enable national comparisons of incident activity. A review and re-upload of incorrectly graded incidents submitted in the previous two years has been requested and is due for completion in April 2016. The data includes pressure ulcer incidents which have now been reviewed and downgraded. This review has significantly reduced the number of incident reported as Serious Harm (red)

- **DatixWeb** – An Interim Datix manager has been appointed to support changes on DatixWeb and provide training to staff. Some of the Data Quality Issues reported above are due to the way Datix was originally set up and used in the Trust. A Datix Manager and a Datix Task and Finish Group are working on resolving the issues

- **Learning from Incidents** – the Trust has introduced a newsletter for staff, "So What Happened Next" to provide feedback to staff on incidents

Type and Severity of Incidents

Incidents by severity:

- The number total number of incidents reported has increased by 35% from the previous year. However, despite the increase in green, yellow and orange categories, there is a 58% decrease in severe and serious harm incidents (red incidents) which is due to changes in the reporting of pressure ulcers. There has been annual reviews and changes regarding the reporting of pressure ulcers from 2013/14 to 2014/15 and 2015/16. The current position is on severity of harm as opposed to the grade of the pressure ulcer.

- In 2013/14 - 54 incidents were severity rated as "red – serious" and reported to the Clinical Commissioning Group as per the requirements of the National Serious Incident Framework.

- The Serious Incident Framework 2015/16 again reviewed the way pressure ulcer incidents were graded. The changes to the grading and recording of pressure ulcer incidents resulted in a decline in the number of red incident which have caused significant harm.

- This was attributable to the type of incidents the Trust previously categorised as severe harm patient safety incidents. All category 3 and 4 pressure ulcers were categorised as severe harm reportable to StEIS and all fractured neck of femur whilst in the care of the Trust were also reported as severe harm incidents. The current position is that there is no "blanket " approach as the severity of harm is case specific and is assessed according to impact it has on the patient.

Table 8: Patient Incidents by Severity

CHFT Incidents	2014/15	2015/16	Movement
GREEN	4973	6467	↑ 23.1%
YELLOW	1651	1955	↑ 15.5%
ORANGE	101	130	↑ 22.3%
RED	136	44	↓ -209%
TOTALS	6861	8596	↑ 20.1%

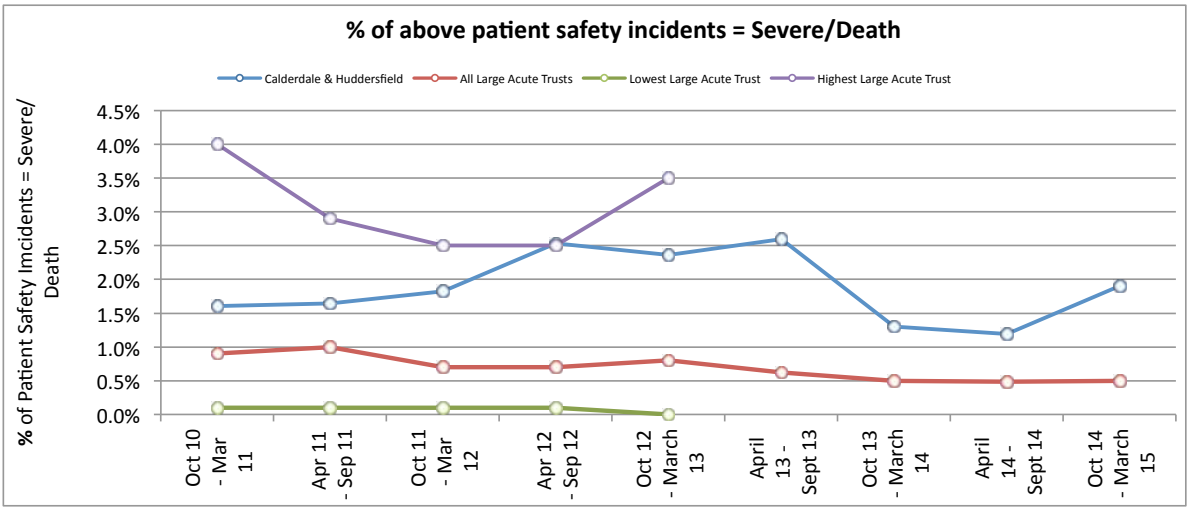
- There has been a serious incident that was reportable to the Information Commissioner's office, in line with the national HSCIC checklist for reporting information governance serious incidents.
-
- *Duty of Candour* - The Duty of Candour introduced in November 2014 has not always been in that the Trust has not complied with timeframes set for communicating with the patients/families that have come to harm. The current position good progress at demonstrating compliance with the duty. Further work is needed in 2016/17 in the recording of duty of candour on the incident reporting system to evidence when it has taken place.
-
- A systematic thematic review of the serious incidents reported in the past two years (excluding pressure ulcer incidents) was conducted on all serious incidents which had been concluded by December 2015. A score was attributed for the presence of each contributory factor appearing in an SI report. The findings of the thematic review as below;

Never Events

Two Never Events incidents were reported in obstetrics and maternity. There was a short timeframe between the two last reported Never Events which are currently being investigated as a multi-incident investigation. Immediate actions were put in place to prevent recurrence whilst the investigation is on-going.

(ii) % of Above Patient Safety Incidents = Severe/Death

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



The above table shows that the Trust reports a higher rate of severe/death patient safety incidents than other large acute trusts. This is attributable to the type of incidents the Trust views as severe patient safety incidents compared with other large acute trusts, for example, all category 3 and 4 pressure ulcers are viewed by the Trust as severe harm.

At the end of March 2015 a revised Serious Incident Framework was issued that advised against categorising all category 3 and 4 pressure ulcer incidents as serious incidents as the grading of a pressure ulcer alone does not determine severity. The guidance advised that any pressure ulcer that meets the threshold of a serious incident, i.e. unexpected or avoidable injury resulting in serious harm or death, should be reported as a serious incident.

The Trust adopted this approach from January 2016 onwards and this is not reflected in the above NRLS data which pre-dates this.

Part 3: Performance on selected quality indicators

This section provides an overview of care offered by the Trust based on its performance in 2015/16 against a number of regularly monitored quality indicators. These are selected by the Trust Board in consultation with stakeholders and reviewed regularly.

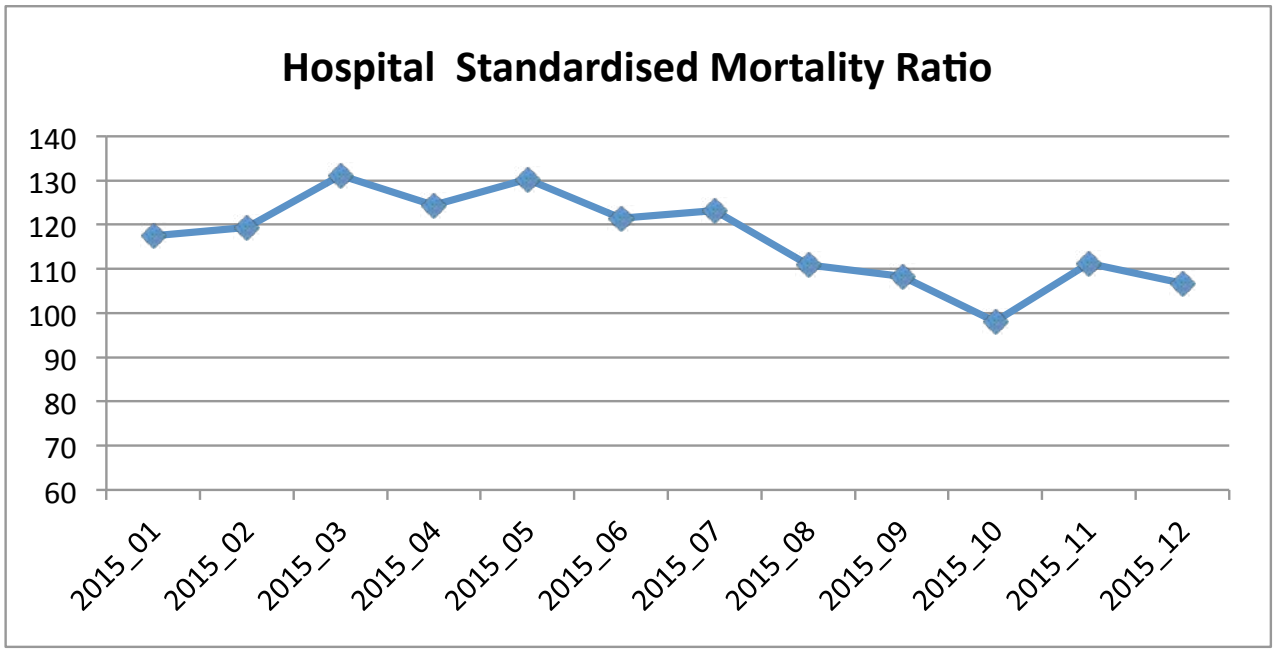
The indicators are as follows:

Domains	Indicator
Patient Safety	Mortality Rates (HSMR and SHMI)
	Falls in Hospital
	Healthcare Associated Infections
Clinical Effectiveness	Cancer Waiting Times
	Stroke
	Length of Stay in Medicine
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 is able to both 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 the HSCIC. This 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.



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

Falls in Hospital

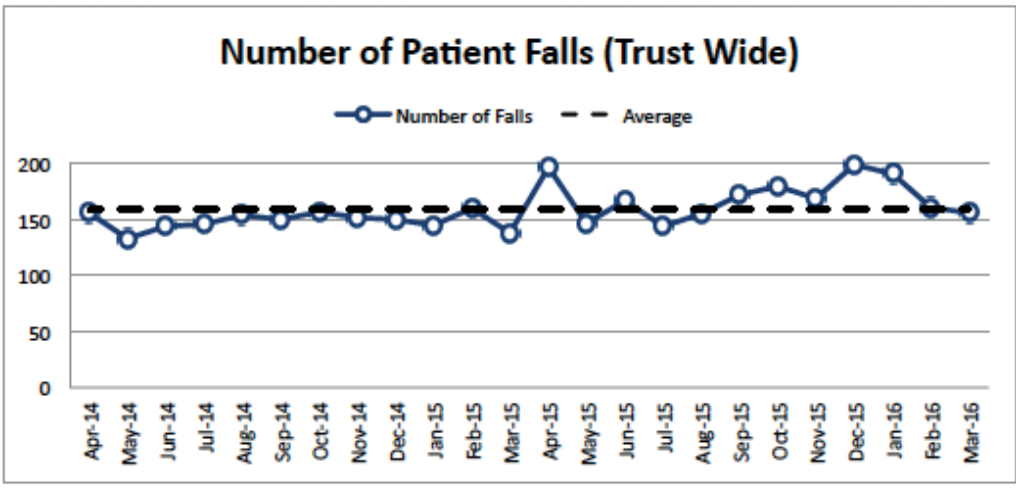
Falls in hospitals are the most common patient safety incidents reported in hospital trusts in England. Falls do not only impact on the quality of life through pain, loss of confidence, loss of independence and increased mortality. Falls are estimated to cost the NHS more than £ 2.3 billion per year.

The Trust participated in the National Audit Falls and Fragility Audit of inpatient falls in summer 2015. The NPSA reported that the national average rate of falls per 1000 occupied bed dates was 5.6 for acute hospitals, with a range of 0.82 -19.20. CHFT reports at 8.42 (Per 1000 OBDs).

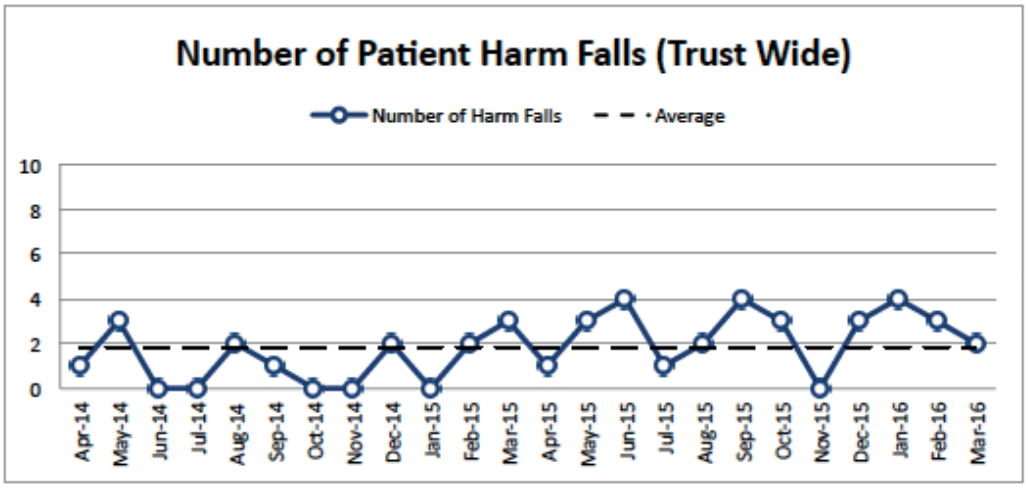
The National reported range for falls resulting in harm was noted as 0.01 –2.00 (Per 1000 OBDs) CHFT is reported at 0.09 (per 1000 OBDs).

Throughout 2015-16 the work of the falls collaborative has been focussed around:

1. Implementation of documentation supporting falls prevention and management that is compliant with guidelines.
2. Provide risk assessment on admission for falls and implement preventative actions.
3. Ensure following an in-patient fall patients get the best care to prevent harm and repeat falls.
4. Ensure falls data is robust by understanding where gaps in reporting are currently.
5. Undertake thematic review of inpatient falls causing harm rated as amber/red to capture learning.
6. Improve engagement with staff around falls prevention work to ensure impact of fall on the patient is understood by use of patient stories and training.



The chart shows the number of falls patients have had whilst in hospital, on average this was 171 per month. In addition to the total number of falls reported the Trust also measures falls that result in harm.



Improvements for 16/17
Recognising that there is still work to be done in this area, one of the quality priorities for the trust (see part 1) is the implementation of safety huddles which will aim to reduce the number of falls experienced in hospital.

There will also be the appointment of a specialist fall's lead to drive the Fall Safe Project with key objectives to reduce the number of in-patient falls by:

- Improving the quality of assessments and intervention for patients at risk of falls
- Improve multidisciplinary working with regard to the assessment and management of patients at risk of falls
- Educate and empower ward staff to make small but effective innovation and change through the implementation of a falls quality improvement collaborative
- Introduce and monitor compliance with a Falls Investigation Prompt sheet to compliment the CHFT RCA investigation tool developed by Effective Investigation Group (to improve quality of RCA).
- Support and monitor actions that were agreed at The CHFT first harm summit on the 10th November 2015 , such as falls mapping, improving safety huddles, a review of footwear that is available for patients at CHFT and embedding bedside handover.
- Maintain links with the Improvement Academy, with an aim to achieve 95% compliance in actions identified from the safety briefings.
- Review the Falls Prevention bundle following first National In-patient Falls Audit recommendations.
- Undertake a falls mapping exercise in areas of high incidence (see appendix 3); to further understand what additional measures can be put in place to aid prevention.
- Review the falls prevention strategy, with recommendations to shape the improvement work plan for 16/17.
- Consider high risk patients presenting with a dementia and how environmental factors can support a reduction in falls
- Consider trail of falls bracelets for high risk patients
- Development of a falls policy / protocol to include post fall guidance
- Engage in a multidisciplinary approach to manage falls, including medication reviews, medical reviews.

Healthcare associated infections (HCAIs)
In additional to the mandatory indicators around C.Diff performance, the Trust regularly monitors activity around a number of other infections.

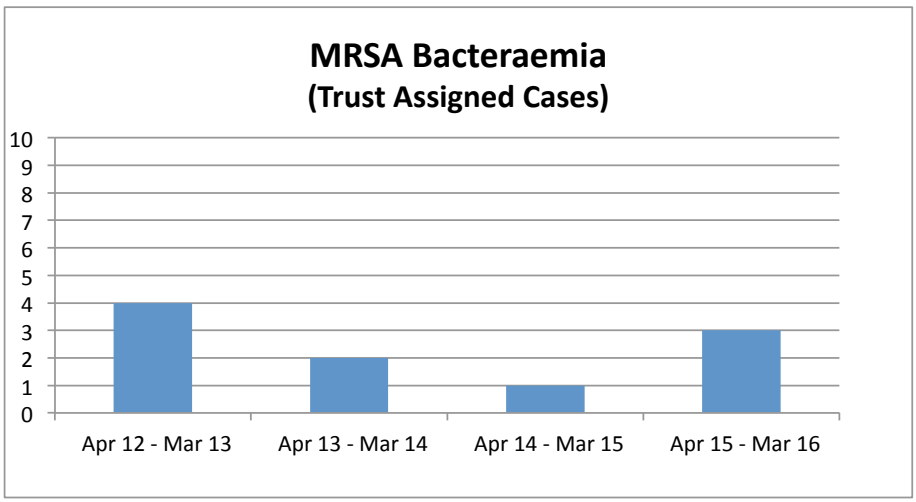
MRSA (Meticillin resistant Staphylococcus aureus) Bacteraemia:

The clinical teams have worked hard over the last 4 years to improve

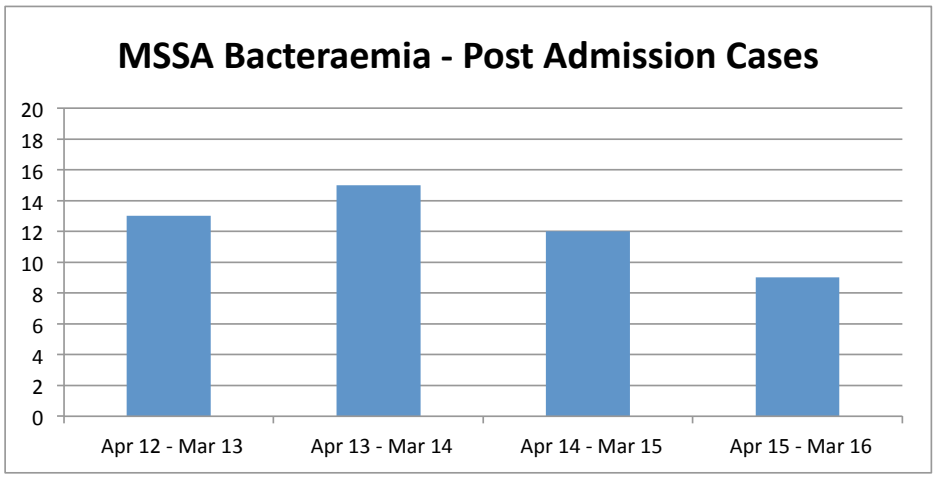
- hand hygiene,
- care of invasive devices with earliest removal,
- improved communication
- MRSA screening of patients.

Continued work has seen improvements in cleanliness across all ward areas with frontline ownership from ward managers and charge nurses to keep their areas tidy and organised. The main action identified from the last case was improvement work with ANTT (aseptic non-touch technique). The Infection Prevention and Control Team have provided training sessions for key trainers and junior doctors.

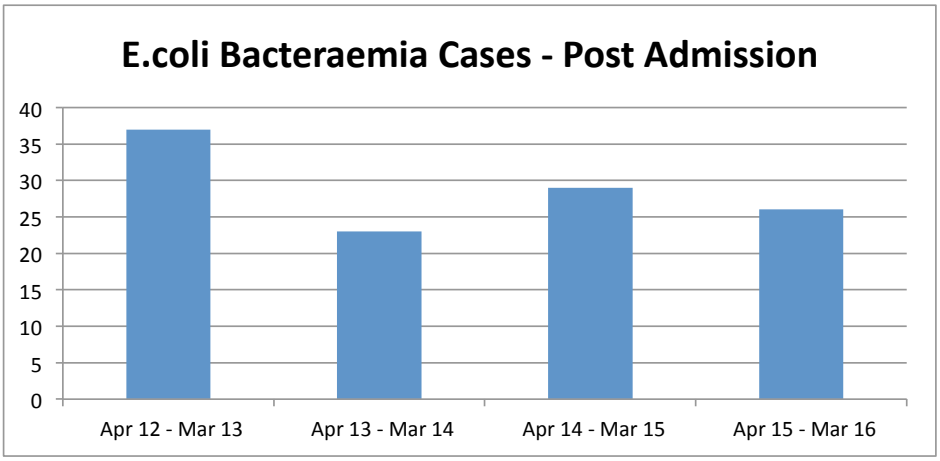
There have been three cases this year, Root Causes Analysis has been done on all three, and whilst no lapses in care had been noted, the Trust has suggested refreshing the ANTT training package.



MSSA (Meticillin-sensitive Staphylococcus aureus) bacteraemias:
There has been a drop in the number of MSSA cases. Further improvements include MSSA screening or patients with central venous access devices and for patient undergoing selected high risk elective surgery.

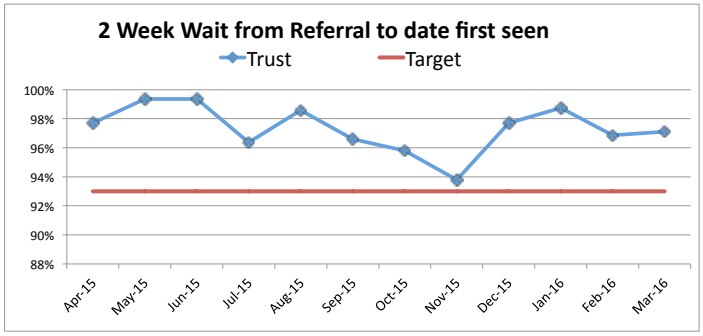


E.coli bacteraemias:
Whereas there is no national reduction target set for E. coli bacteraemia the trust recognises the need to set the internal target and this was set at not exceeding the out-turn of cases in the previous year. The Trust is on track to meet this target.

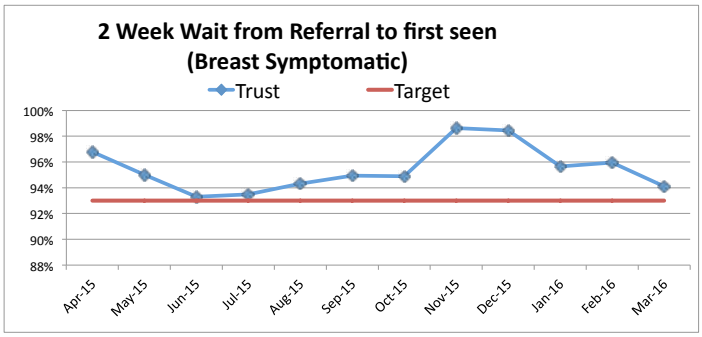


Cancer Waiting Times

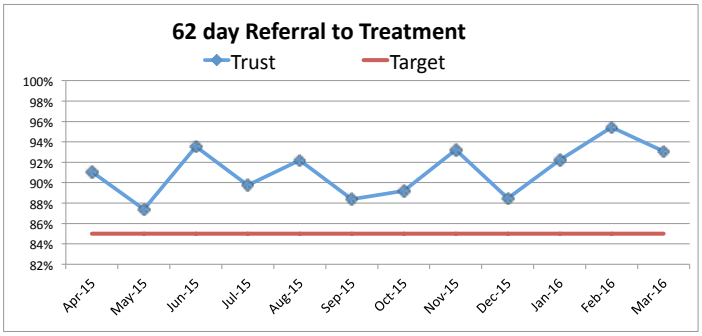
Delivery of the National Cancer Targets is a key part of cancer care and the Trust's performance around these key targets is a significant indicator of the quality of cancer services delivery. The Trust continues to consistently achieve the cancer waiting times standards.



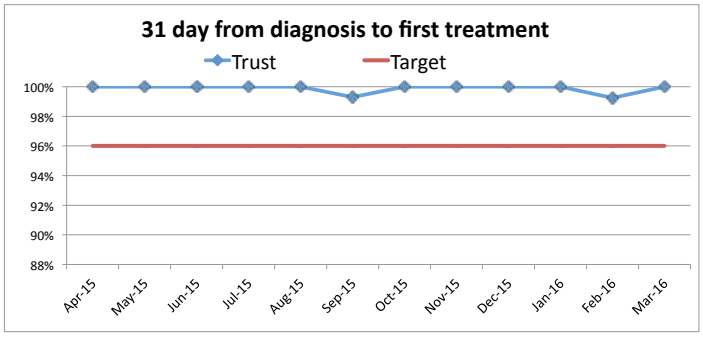
The performance required for this target is 93% and this has been exceeded for the whole of the year.



The performance required for this target is 93% and this has been exceeded for the whole of the year.



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



The performance required for this target is 96%. Performance has largely been maintained at 100%

Alongside the national standards the Trust is looking to 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, 71% of patients are being seen within 7 days of referral which is excellent compared to the 30% we were achieving in April 2014.

- Provide diagnostics tests within 7 days

  Unfortunately the 7 days to Diagnostics target which was an aspiration of WEB has not been successful and needs continued action to ensure this is achieved so that the measures become sustainable.

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

  The Trust has issues meeting the target of referring 85% of patients to tertiary centres by day 38 of their pathway. For August, the Trust only managed to send 59.3% of patients by this target which is much lower than we would wish to have achieved at this point in the year. Discussions are on-going within the divisions and with the cancer teams. Also discussions are being held with our tertiary centres to agree some fundamental issues around transfer dates as at present there is no agreed criteria..

Improvement Plans 2016/17

A further review of all tumour sites has taken place to address how the teams can operate differently to meet the 38 day referral to Tertiary centre. An action plan has been put in place by each division as to how they are going to rectify the poor performance and this will have to be closely monitored throughout the year. This has improved performance in certain areas, however due to demand and capacity areas such as diagnostics are struggling to improve their performance.

In line with the 96 recommendations from the *"Achieving World Class Cancer outcomes - A Cancer Strategy 2015-2020"* The cancer teams alongside commissioners and patients will be work to achieve these.

From the Improvement plan set out by NHS England, NHS Trust Development Authority and Monitor, the Trust has completed their self-assessment and put together an action plan to achieve all the eight key priorities for the Cancer Waiting Time Standards within this financial year. This will be achieved by 1st April 2016.

Cancer Site Specific and Specialist Palliative Care teams update:

The Trust employs a number of specialist roles to support the delivery of cancer care, and end of life care in both cancer and non-cancer patients.

Specialist nurse roles have evolved due to the changing needs of patients, a much younger population, changes in treatment choices- more intensive and complex treatments and NHS service demand with an increase in newly diagnosed cancers every year as well as people 'surviving' their cancer and treatment , but living with the side effects of that treatment. Living with the consequences of successful cancer treatment is the great challenge of modern life.

To meet the changing landscape of cancer treatment and patient's needs, specialist nurses (working closely with the designated named cancer site specific consultant) have and are developing nurse led clinics: assessing appropriate new cancer fast track patients, undertaking biopsies and ordering investigations, breaking the news of a new cancer to patients as well relevant cancer follow up (appropriate to the training level and competencies of the Specialist Nurse.). A crucial part of Specialist Nurses role is also in the assessment and interventions/care of patients during the patient's treatment, recovery and living with the consequences of the treatment.

The advanced roles that specialist nurses are undertaking in the patient's pathway means that there is a changing landscape in professional roles and service provision for patients. As well as piloting nurse consultant posts in cancer teams and how they help improve the patients experience and pathway to treatment, new roles are being considered. One such is the 'Cancer Care Co-ordinators'.

These are non-registered roles, but provide low level support to patients and co-ordinate all the other referrals services. They include traditional non specialist parts of Cancer Nurse Specialist (CNS) roles. Cancer Care Co-ordinator posts are a valuable resource in the patient's management for low level specialist intervention once training and experience has been gained. They

are a first port of call for patient's questions and queries, emails and phone calls. Baseline assessments and continuity for patients having access to the service can be through these posts.

In support of these roles, a number of Macmillan funded projects are ongoing in CHFT currently:
Macmillan Head and Neck Specialist Nurses and Allied Health Professionals (Part of a Regional Head and Neck redesign project to inform national services for Macmillan)

- Continued Macmillan funding - to be trained in cancer follow up. (Extend a project that has been successful at Mid-Yorkshire Hospital) Sept 2015 -March 2018

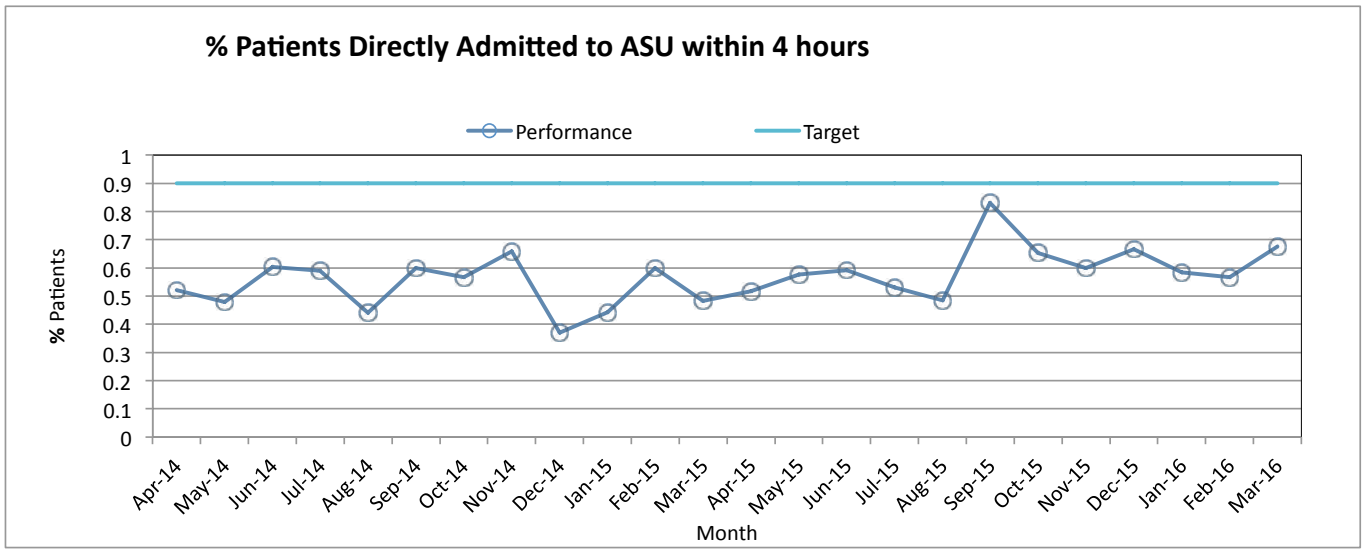
- The team have just completed successful specialist nurse and allied health professional management post treatment assessment and follow up , with funding for posts from Macmillan (up to march 2016). This replaces traditional consultant only follow up, with amazing outcomes for increased rehabilitation and recovery with intense intervention in first 6 weeks from head and neck team

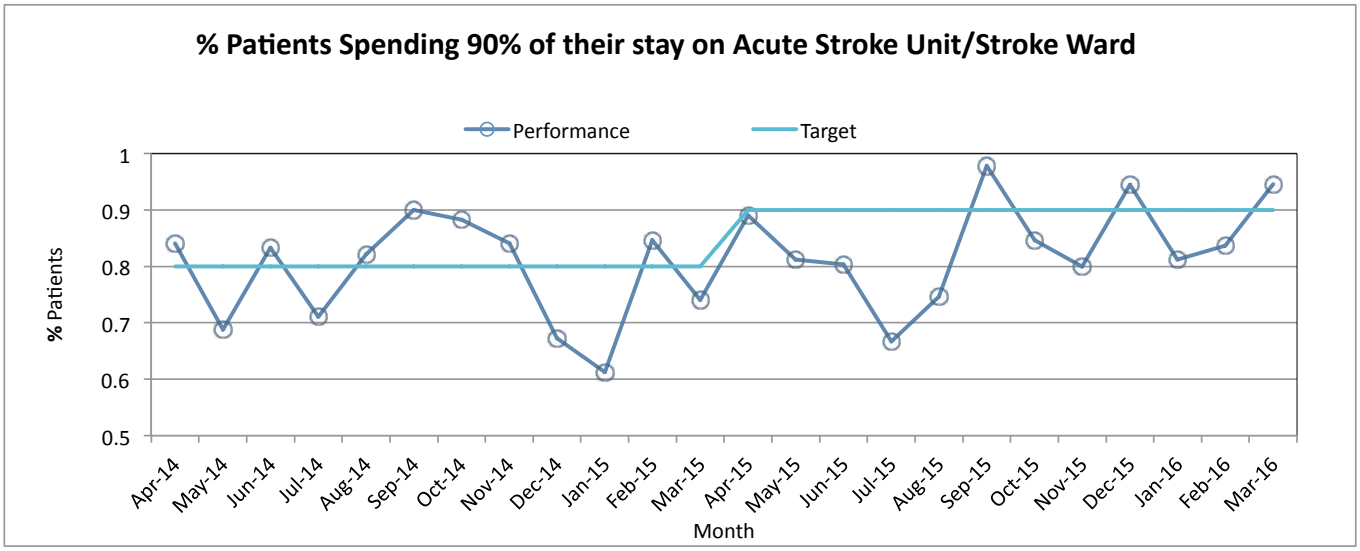
Stroke
Strokes affects between 174 and 216 people per 100,000 population in the UK each year (Mant et al 2004), and accounts for 11% of all deaths in England and Wales. It is accepted that 85% of strokes are due to cerebral infarction, 10% due to primary haemorrhage and 5% due to subarachnoid haemorrhage.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

The Trust has the following aims to strengthen and improve stroke services:
– Admission to a stroke bed within 4 hours.
– Spend 90% of their Hospital Stay on the Stroke Unit

Improvements in 2015/16:
The stroke team routinely review breaches in the 4hr and 90% stay measures.

Previously a number of breeches were due to availability of beds on the ASU. We have introduced a number of measures to improve this: including a weekly ASU report which indicates the number of empty beds, beds occupied by stroke patients and beds occupied by non-stroke patients. This method has meant the teams have been able to actively intervene and reduce the number of non-stroke patients on the ASU, ensuring that those patients are places in more appropriate areas for their needs and increase the availability of ASU beds for those stroke patients who require specialist care. We have also increased the bed base for the stroke team with an additional 6 stroke rehab beds.





The above chart shows the percentage of patients diagnosed with a stroke that spent more than 90% of their hospital stay on a specialist stroke ward. Performance has remained variable throughout the year. Winter pressures in December and January explain the dip in compliance that occurred during these months, however performance in this pressured months is better than in the previous year.

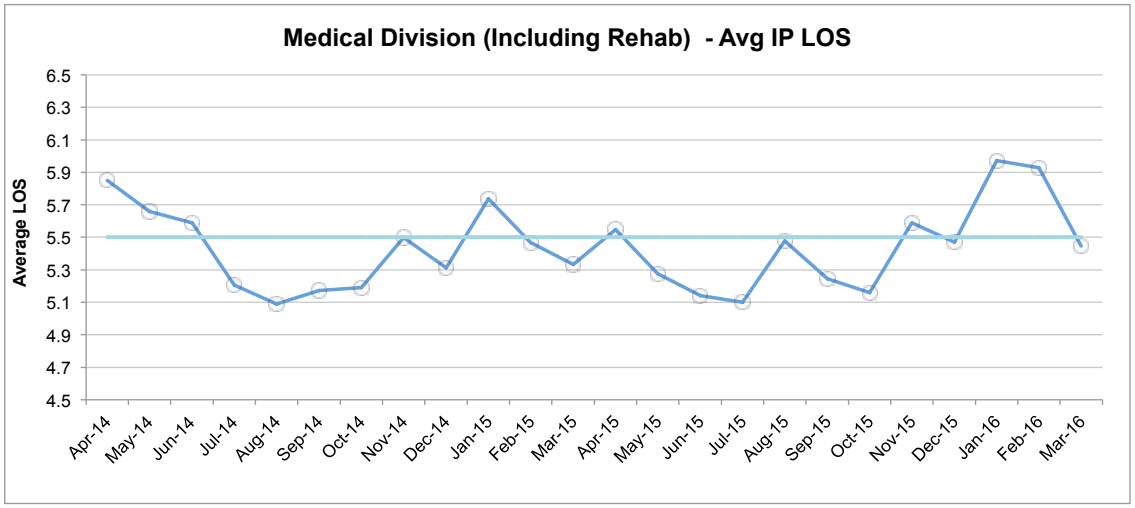
On 7 December 2015 the Acute Stroke Unit (ASU) was visited by Healthwatch Calderdale. This visit was organised following feedback from members of the public. The report highlights areas of good practice with relatives and patients being positive about the care and treatment on the ward, the environment provided privacy for individuals and a dedicated quiet area and visitor room, as well as areas for improvement such as lack of clarity as to which consultant was in charge of their relative. The ward has developed an action plan to address the issues raised. In addition the consultant input on the ward has changed; rather than each consultant doing a ward round on the ASU one day each week they have a consultant of the week. This is expected to improve continuity of care, communication and patient experience.

Plans for 2016/17

At present the most significant factor now affecting both measures is the early recognition of stroke as the diagnosis for those patients who may present with atypical symptoms e.g. dizziness or a collapse. The stroke team is working with regional partners such as the Yorkshire Ambulance Service (YAS), the Emergency Department staff and acute medical teams to ensure a higher degree of suspicion for those patients presenting with atypical features.

Length of stay in medicine

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



The chart above shows that the length of stay in medicine highlights the recent winter pressures.

The primary reasons for the usually pattern of variation are seasonal pressures and an increased number of admissions. Analysis tells us that when patients are placed in beds in other specialities (because no beds are available in on the most appropriate ward) this increases length of stay.

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

In 2016/17 Safe and Effective Patient Flow Programmes will continue to focus on how best to maximise flow through the organisation and it is likely that this measure will be replaced with more additional and more integrated flow measures in future.

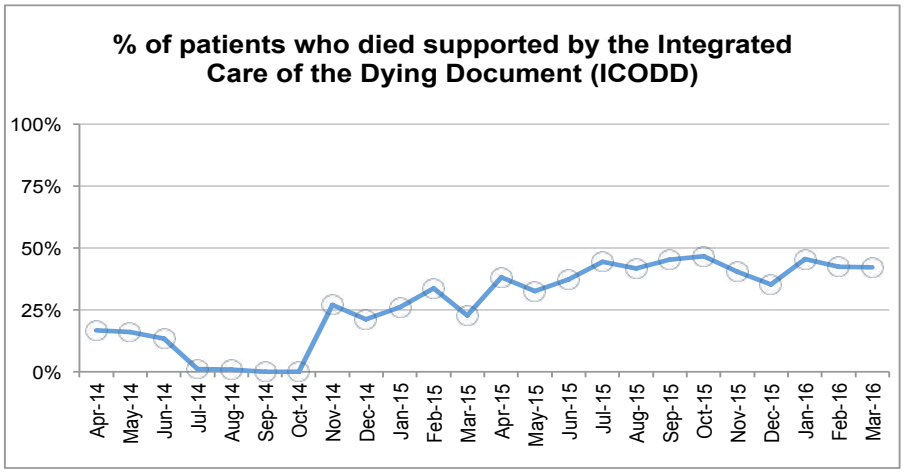
End of Life Care

End of life care provides particular challenges, not only because of the special needs of many at the end of life but also because of the need to coordinate 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 that experience for the individual, their family, and the staff caring for them (source: NHSIQ)

Improving end of life care remains a priority area for the Trust and it continues to work to ensure that when patients die in hospital, and their death is expected, that they receive appropriate end of life care.

Key achievements in 2015/16

Since the introduction of a dedicated end of life care plan (the ICODD), there has been a steady increase in the number of patients who die supported by this, and this now stands at over 40%.



The hospital Specialist Palliative Care Team (SPCT) has continued to deliver 'in-reach' activity to medical and nursing staff within gastroenterology and respiratory teams, with the result that since April 2015, over 500 patients discussed at 'board rounds' have had expert advice given on symptoms, goals of care, and the suitability of initiation of advance care planning, etc.

The hospital SPCT has also been active all year in delivering a range of educational events to staff working within CHFT. Some of these activities have been delivered in conjunction with colleagues from Kirkwood Hospice, in particular the delivery of full day educational sessions, and with in-house ward based training on a range of end of life care issues. Education is delivered to a variety of professional groups, and this year has seen the delivery of the second successful training day for 40 FY2 doctors working across the Yorkshire Deanery. Targeted education to nurses on the Verification of Expected Death (VOED) should greatly reduce the delay and distress caused to families who currently are required to wait for medical staff to verify death, in hospital and in community. This teaching programme was awarded 2nd place in the International Journal of Palliative Nursing awards.

Significant improvements have been made within the mortuary facilities on both sites, with refurbishments undertaken to improve the experience of bereaved relatives. New trolleys for the transfer of deceased patients from wards have been purchased, and there is also improved lifting machinery to accommodate the increasing number of obese and morbidly obese patients. This benefits both the health and safety of staff, and the dignity and respect afforded to the deceased.

Proposed improvements for 2016/17

Continued effort is required to ensure that the improvements seen in supporting dying patients with the ICODD are maintained and enhanced (there has been a slowing in the increased adoption and use of the care plan in recent months). We must ensure that all staff are aware of their responsibilities in caring for these patients, and that they have the appropriate skills and resources to do so. This will include the necessary communication skills and knowledge base, and easy access to vital equipment such as syringe drivers for the administration of essential subcutaneous medications. We have been assured that centralised access will be available from mid-March.

The ICODD itself will be reviewed and amended to ensure that it remains a robust document. These amendments will take the form of enhanced clinical guidance on the use of medications at the end of life, and incorporation of guidance relating to the Deprivation of Liberty Safeguards (DoLS) legislation. Continued and updated educational sessions delivered by the SPCT will accompany this piece of work.

Feedback from the bereaved relatives' questionnaire as part of the National Care of the Dying in Hospitals audit confirms that the vast majority of patients' relatives had confidence and trust in staff caring for their loved ones. Although significant proportions of patients were reported to have symptoms of pain, restlessness and noisy breathing at the end of life, it was also felt that doctors and nurses did all that they could to attempt to relieve these distressing symptoms. Generally, relatives felt that the overall level of emotional support given to them by ward staff was excellent or good. However there were some concerns expressed regarding the quality of communication which some relatives received, and in particular inconsistent clarity relating to some end of life care decisions. It is clear that communication skills and the quality of discussions can be improved. It may be advantageous to create an educational DVD resource which addresses some of these issues and which can be used as part of mandatory or essential skills training.

Patient Experience

Friends and Family Test

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

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

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

The primary method of measuring the patient experience in the trust is through the Friends and Family test (FFT) which is now well established across all inpatient areas and embedded as a performance measure and indicator for improvement at ward level. The reporting of the FFT results enables staff at ward level to track and benchmark their performance and they are also encouraged to review the comments provided by patients about what they think went well and what they would like to see improved.

FFT was no longer a CQUIN during 2015/16, but was incorporated into the trust contract with the requirement that the Trust continues to comply with the FFT data submissions.

In September 2014, the Patient Experience and Caring Group worked with staff, patients and staff who have patients to identify a small number of corporate projects which would form the improvement programme for the next 12 – 18 months.

Comments received through the various feedback systems in the Trust, along with some comments from staff submitted as part of the staff friends & family initiative, were used to describe what patients / staff see as a good experience and also what they would like us to improve

The Friends and Family Test was originally a question that was been asked in all inpatient areas in NHS hospital trusts since April 2013. The question asks "How likely are you to recommend our ward to friends & family if they needed similar care or treatment?" Throughout 2015/16 this has been rolled out wider to the following areas:

- Inpatients
- Maternity
- Accident and Emergency
- Outpatients
- Community

Performance is monitored internally against the national performance baselines during summer 2015.

Green = top 50% (i.e. above the England ranked average)
Amber = above the bottom 20% and up to 50%
Red = bottom 20%

		Percentage response rate											
	Target (green)	Apr 15	May 15	June 15	July 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Inpatient	28.0%	25.8%	21.4%	21.9%	26.5%	28.1%	24.4%	31.1%	32.9%	34.3%	32.1%	33.5%	30.7%
Maternity	22.0%	18.2%	23.8%	26.3%	27.5%	29.6%	42.6%	30.9%	40.8%	33.6%	30.3%	30.7%	34.5%
A&E	14.0%	6.8%	10.0%	8.6%	5.7%	2.7%	9.6%	12.1%	9.2%	9.1%	10.2%	9.7%	8.4%
Community	3.4%	3.8%	3.3%	3.2%	3.1%	3.2%	3.0%	3.6%	15.6%	10.0%	14.3%	12.6%	13.0%
Outpatient	5.0%	14.4%	13.9%	13.6%	13.8%	13.5%	13.3%	13.2%	13.1%	12.9%	13.6	13.7%	13.2%

		Percentage would recommend											
	Target (green)	Apr 15	May 15	June 15	July 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Inpatient	96.0%	97.3%	96.4%	97.4%	96.6%	97.1%	96.5%	96.7%	96.7%	96.4%	97.1%	97.0%	96.9%
Maternity	96.9%	94.0%	91.1%	94.8%	97.8%	95.2%	98.8%	95.0%	97.0%	96.5%	97.8%	96.8%	97.8%
A&E	90.0%	90.7%	90.5%	91.1%	91.1%	84.8%	86.2%	86.8%	81.6%	85.4%	86.5%	84.4%	84.6%
Community	96.2%	90.9%	89.1%	90.6%	92.4%	89.7%	91.6%	91.3%	84.4%	86.1%	86.7%	85.8%	85.8%
Outpatient	95.0%	88.0%	87.9%	88.4%	89.5%	89.2%	89.2%	90.2%	90.5%	91.6%	90.5%	89.7%	90.7%

The Trust has a well-established patient experience programme; feedback from the FFT comments has been used to influence the improvement programme, with five key projects being carried over from the end of 2014/15.

A summary of each project is detailed below:

1) Hello my name is … is aimed at reminding staff of the importance of introducing themselves to patients, carers and visitors and to always include their role in any proposed care or treatment.

Progress during 2015/16

Following the successful launch of the campaign in May 14, which included a visit from Dr Kate Granger, there have been a number of activities aimed at embedding this approach. This included:

- Articles in Trust News and CHFT weekly of this simple intervention and the impact it can have on delivering compassionate care
- Stands at the front entrance of both hospitals to raise awareness and encourage staff to make a pledge to support the campaign
- Divisional patient experience leads conducting a roadshow around the wards
- Renaming the Trust News 'face facts' section to # hello my name is… to show support for the campaign
- New uniforms for the facilities team have # hello my name is… embroidered on their shirts
- The national maternity survey published December 15 placed CHFT in the 'better' category for the question 'did the staff treating and examining you introduce themselves?', the service was in the 'worse' category for this question in the survey 2 years ago

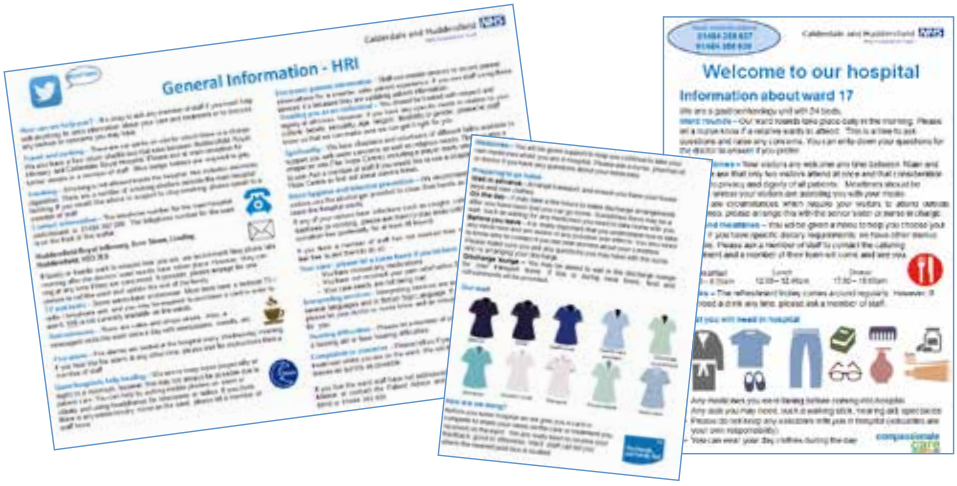
2) Ward orientation. The focus of this project was about reducing patient anxiety when being cared for on a ward. The project has three components:

- Orientation of patients to the ward supported by a welcome to the ward leaflet. Our patient feedback has told us that patients do not always feel welcomed onto the wards and that once they are there, they would like more information about the ward routines.
- Availability of individual 'about me' boards for all patients. These aim to provide an 'at a glance' source of information for staff about individual patient care needs and a personal 'what is important for me' statement
- Provision of a public facing information board for patients / visitors about the ward. The public facing boards provide consistent information for patients and visitors across all wards.

Progress during 2015/16

Ward leaflets:

- The first draft of the leaflet was designed with input from patients, a hospital volunteer and staff, they used examples from other hospitals to help inform what should be included in the generic information on all leaflets
- Each ward was given the opportunity to localise the leaflets in terms of their ward specific information, whilst undertaking this work it became apparent that there was variation in visiting times and a decision made that the majority of wards should introduce an open visiting policy from 10am – 8pm
- The first draft of the leaflet was tested on 2 wards and an evaluation carried out by hospital volunteers – some slight amendments were introduced including changing the leaflets from an A3 double sided laminated document to a folded A4 booklet. In general the leaflets evaluated well and feedback from patients included: I found it all useful, it is very interesting and well put together
- Leaflets are now available on all the wards, with adapted versions for maternity and paediatrics
- Each ward also has 2 copies printed on yellow paper for patients who have a visual impairment
- The generic content of the leaflets is being made available in the 3 languages most commonly used for translation services. This will be made available on the patient information repository.



Behind the bed boards:

- Ward based staff were involved in the design of the boards and in agreeing a list of generic magnets, that each ward could then select from
- Training was provided to ward representatives based on a job breakdown sheet – how to update the boards with up to date relevant information
- Boards are now located on all inpatient wards, with the exception of NICU, where a decision was made that the boards were not applicable for the area
- A walk around across all wards was carried out to confirm that all boards are in place, check for any additional tidy boards required and remind staff how to order additional magnets if required

Public facing boards

- Ward based staff were involved in the design of the boards, with adapted designs for Maternity, paediatrics and NICU. They have been designed in line with the Trust corporate branding using simple icons to help create a visual impact.
- The boards are now located at the front entrance to the wads and provide information on some key performance indicators along with an opportunity to share changes introduced in response to feedback via a 'you said, we did' approach.
- A standard operating procedure has been shared with the wards to ensure updating of the boards is co-ordinated

4. Reducing Noise at night. Noise at night is something patients continue to raise with us through our patient feedback. Research tells us that quiet hospitals help healing – we have therefore made this our message in a campaign to reduce avoidable noise.

Progress during 2015/16

- One of the first actions undertaken was to develop a night time routine checklist designed along with a 3 step challenge which was used when carrying out ward based assessments with staff – this was publicised through Trust News


NIGHT TIME ROUTINE

– Step 1. Take a minute to just listen – imagine you are trying to rest or sleep, what do you hear? Think how you can help to make changes to create a quieter ward or department.
– Step 2. Take five minutes to ask patients or families on your ward or department what disturbs their rest.
– Step 3. Make it happen – We regularly challenge colleagues about being naked below the elbow when entering our clinical areas – so please make it normal practice to help reduce unnecessary noise too –Together we can – "Shhh" and create a calm healing environment

– Lead for wards undergoing assessment were identified and given responsibility of:
  – Walking the ward and identifying the quick fixes and longer term actions
  – Promoting the campaign and the 3 step challenge with their team
  – Introducing the night time routine
– Ward based assessments continued to identify that the core concerns identified relate mainly to noisy bins, noisy staff and noisy equipment.
– There has been joint working with Estates on this project, which has supported the wards by addressing squeaky trolleys and placing sponges on door frames to prevent banging.
– Bin lids are an issue that patients have mentioned as contributing to noise on the wards; some of these wards have purchased soft closing bins and located these close to the nurses' station (most frequently used); however this has not been done consistently across all wards. An alternative initiative to address noisy bins is the bag to bed system which after a successful trial period is being rolled out. This reduces the need for bins on the wards, therefore supporting the reduction in noise
– A night matron is supporting the project group, creating awareness amongst the night staff and influencing practice. An issue picked up this quarter was the use high wattage light bulbs on 2 of the wards. This has been resolved and whist this wasn't a noise issue, it was impacting on ability to sleep.
– A learning event was held January 16, with an invite to all wards, to come together and share good practice and remaining concerns.
– The welcome to the ward signs at the entrance to all ward areas has a reminder for visitors of the quiet hospitals help healing ethos.

4. How can I help?

Patients have expressed a view that staff are not always empowered or enabled to respond to solve problems for them. Another view from patients is that they don't always want to bother staff with their issues as they can see how busy they are. This project recognised the following as being key to achieving a culture of 'How can I help you?' within a team:

– Sharing experiences of helping
– Troubleshooting on behalf of patients and colleagues
– Taking actions to solve problems, no matter how large or small

Progress during 2015/16:

– The project has been linked to some improvement work for complaints; this includes achieving a change in staffs approach to complaints, via a co-ordinated campaign. Key actions in this project are to promote a culture where staff feel empowered to sort out concerns on the spot and to encourage staff to recognise that dealing with situations / capturing a complaint on behalf of a patient is their responsibility, not that of the corporate team.
– The result we are aiming to achieve is an improved handling of concerns by staff and that these do

not therefore develop into a complaint. Having a 'How can I help?' attitude will be key to achieving the result.
– The message behind How can I help? has been promoted through the patient information leaflet (see section 2 ward orientation). A specific section was added to encourage patients to raise any issues as they occur:

It is also promoted on the recently updated 'Talk to us…' poster, encouraging patients with a concern to speak to the person in charge as the first step.

5. Regular information round. Surveys of patients' views have revealed that doctor / patient communication is not always as good as it could be and in some cases it is judged by patients to be extremely poor. The areas where we seem to consistently fail relate to communication between doctors and patients about a patient's clinical condition, the treatment plan, and expected outcomes.

Progress during 2015/16:
The aims of this project have benefited from the introduction of ward based safety huddles and an increase in bedside handovers. Further work is planned for 2016/17 with the Yorkshire and Humber Improvement Academy.

Patient Surveys

NATIONAL INPATIENT SURVEY 2015
SUMMARY

Overall, the trust has performed slightly better in the 2014 survey compared to previous surveys going from 7.8 to 8.1.

In the 2014 Inpatient Survey, the trust has scored the same for waiting list and planned admissions and has improved for most areas except for A&E departments and hospital and ward. This is shown in the table below with a comparison of previous years and also showing an increase or decrease from last year's survey.

- In the 2014 survey, overall the Trust has performed at a similar level to the 2013 survey and has continued to score highly in the patients experience on the Hospital and Ward section regarding feeling threatened by other patients or visitors and the availability of hand gels and also in care and treatment section regarding privacy when being examined or treated.
- This year, the Trust has improved significantly on planning for a patients discharge and giving families information needed for care when patients leave the hospital going from 7.1 to 7.8. The Trust has also scored better in this year's survey for patients being given full information when having an operation or procedure going from 8.9 to 9.1 and also for patients being treated with respect and dignity from 8.7 to 9.1.
- Even though the Trust has stayed at a similar level for the last 3 years; some areas have not performed as well as previous years. These include patients not being given enough privacy when being treated in A&E going from 9.0 to 8.6, noise at night by other patients from 7.0 to 6.4 and patients being delayed on discharge and not given enough information regarding what they should and shouldn't do when leaving the hospital going from 7.2 to 7.0 and Q55 from 7.2 to 6.7.

Trust Comparisons by Question

	2012	2013	2014	Change from 2013 to 2014
The A&E Department	8.5	8.7	8.6	↓
Waiting list and Planned Admission	8.9	9.0	9.0	-
Wait for bed	7.4	7.2	7.6	↑
The Hospital And Ward	8.3	8.3	8.2	↓
Doctors	8.4	8.5	8.6	↑
Nurses	8.4	8.4	8.5	↑
Your Care and Treatment	7.6	7.8	7.9	↑
Operations & procedures	8.1	8.3	8.6	↑
Leaving Hospital	7.2	7.3	7.3	-
Overall	5.0	5.2	5.8	↑
OVERALL AVERAGE	0.0	0.0	0.0	

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

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

Other National Surveys:

NATIONAL MATERNITY SURVEY

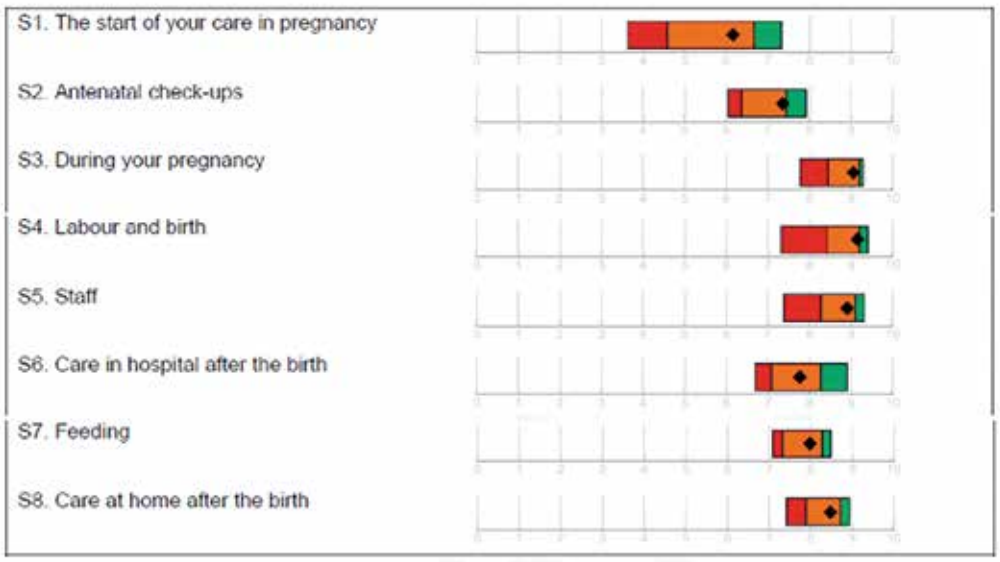
This national survey focused on people who recently used the maternity services in hospital. Patients were eligible to take part in the survey if they:

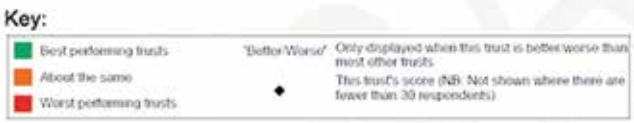
- Were aged 16 years or older,
- Gave birth in February 2015 (and January 2015 at smaller trusts)
- Who had a live birth in a hospital, birth centre, maternity unit or at home

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the Trust is performing. The following table represents the Trust's performance from the summary of all sections of the survey compared to the 2013 survey:

	National Maternity Survey 2013	National Maternity Survey 2015	Change from 2013 to 2015
The start of your care in pregnancy	6.2	6.2	-
Antenatal Check-ups	6.9	7.4	↑
During Your Pregnancy	8.9	9.1	↑
Labour and Birth	9.3	9.1	↓
Staff	8.6	8.9	↑
Care in hospital after the birth	8.4	7.8	↓
Feeding	8.1	8.0	↓
Care at home after the birth	8.8	8.5	↓
OVERALL	**8.4**	**8.3**	↓

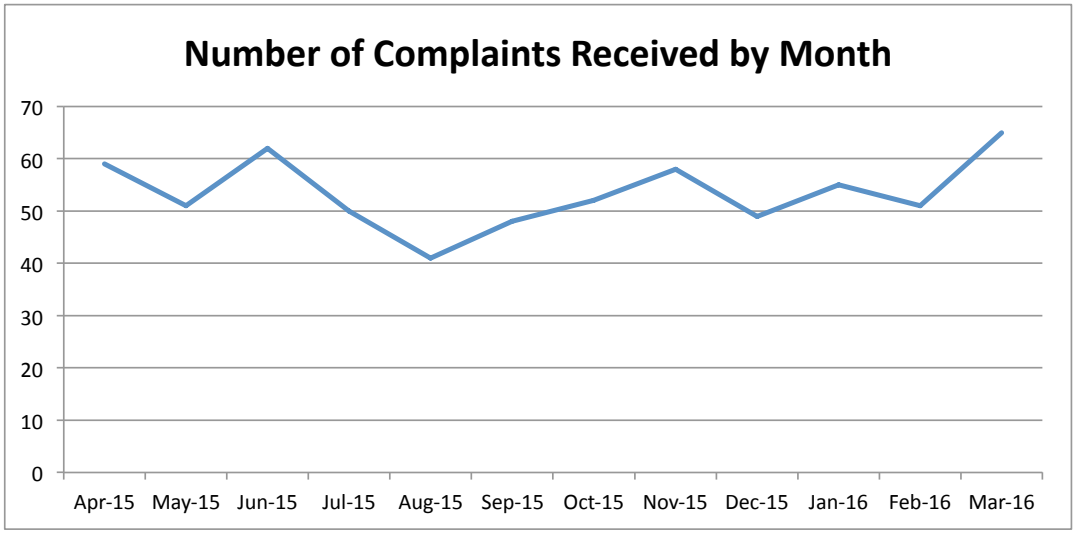
Below is a breakdown of how the Trust scored against other trusts, overall for each area, the Trust sits 'About the same', however, 'Labour and Birth' falls closest into being the one of the best performing trusts.





Complaints (Type and Severity)

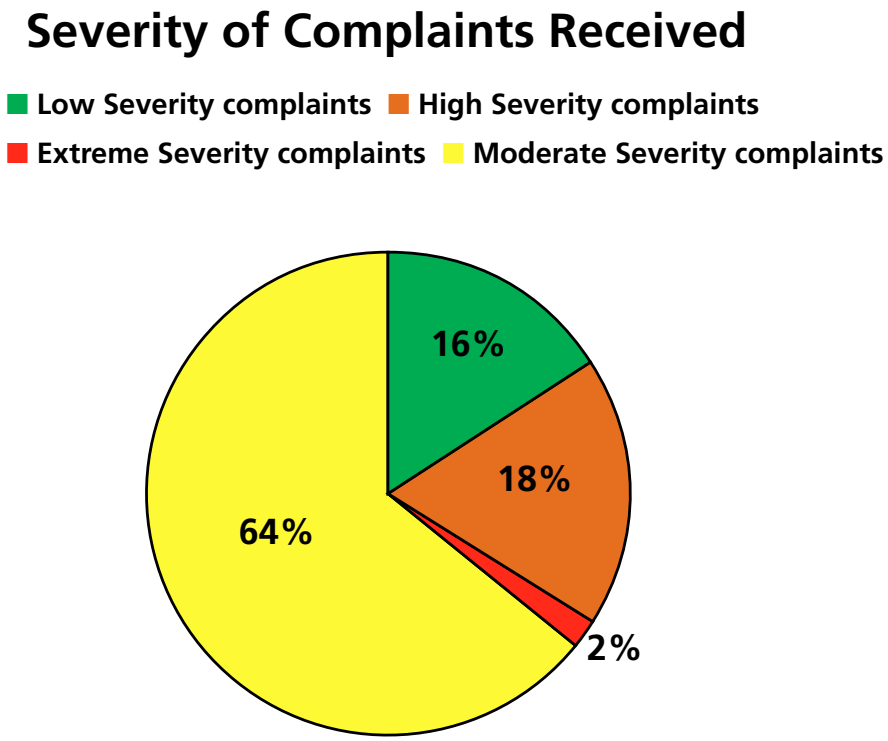
In 2015/16 the Trust received a total of 657 complaints, a 6% increase in complaints received from 2014/15 to 2015/16. This is in line with a national increase of complaints for hospital and community health service complaints in 2014/15 of 6% (Source: HSCIC). It continues the upward trend in complaints which increased for the Trust by 8% in 2014/15 compared to 2013/14.



The profile of the spread of complaints received by month shows a slight dip in the months of August and December, which is in line with previous year and normal patterns of complaints activity. There were between 40 and 65 complaints received a month during the year.

Severity of Complaints Received

The majority of complaints received in are graded as yellow severity; no lasting harm (64%) in 2015/16 with only 2% being graded as red.



Red complaints data
A red complaint is a case where the patient or their family feel the action or inaction of the Trust have caused the death or significant and non-reversible harm to the patient.

During 2015/16 the Trust received a total of 16 red complaints and closed 16 red complaints. Of the 16 red complaints closed 50% were upheld.

At the end of the year the Trust had 10 red complaints under investigation. Learning from red complaints is given at the end of this section.

Acknowledgement time
The Trust has performed consistently well at acknowledging all complaints within the 3 working days. The Trust target of this is 100% and by year end this target was met.

Complaints closed
The Trust closed a total of 683 complaints in 2015/16 with is a 10% increase from 2014/15. Of these 683 complaints closed 48% were upheld, 32% were partially upheld (The HSCIC counts partially upheld complaints as upheld complaints so if looked at in this way the figure is 80%) and 20% were not upheld.

The top two subjects of complaints remain clinical treatment, and communication in both 2014/15 and 2015/16:

Subject	2014/15	2015/16
Treatment, procedure (& clinical treatment)	30%	30%
Consent, confidentiality, communication	25%	20%

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

Overdue Complaints
Throughout 15/16, 48.45% of complaints were closed within target time. Closing overdue complaints has been a primary focus for the Trust in 2015/16. The number of overdue complaints has decreased from 50 in Q2 to 38 in Q3 to 29 in Q4, showing a steady decrease throughout the year. This has been achieved by focus within the divisions to close overdue complaints and a targeted approach by the central complaints team to support the divisions with closure. Closing these overdue complaints has had an adverse effect on those closed with in target time, however performance in this area will improve now that the number of overdue complaints is significantly reduced.

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

0-1 month overdue:	20 complaints
1-2 months overdue:	9 complaints
2-3 months overdue:	0 complaints
3-4 months overdue:	0 complaints
4-5 months overdue:	0 complaints
5 months Plus overdue:	0 complaint

Weekly monitoring reports continue to be provided to divisions to ensure that all cases overdue are clearly identified and timescales for completion of complaints that are due are clear. During the latter part of the year we introduced weekly meeting with the divisions and complaints department to maintain the focus on managing complaints within timescales. At these meetings action plans are put in place for difficult complaints to prevent further cases becoming overdue.

Parliamentary and Health Service Ombudsman Complaints (PHSO)
The PHSO published records for complaints they received regarding Calderdale and Huddersfield NHS Foundation Trust are as follows:

	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 2015/16
Number of Complaints Received by PHSO	23	27	21	5	9
Number of Complaints accepted for investigation by the PHSO	3	9	12	0	2
Number of Complaints the PHSO Upheld or Partly Upheld	1	1	1	0	2
Number of Complaints not upheld	1	4	2	1	5

Quarter 4 data has not yet been published.

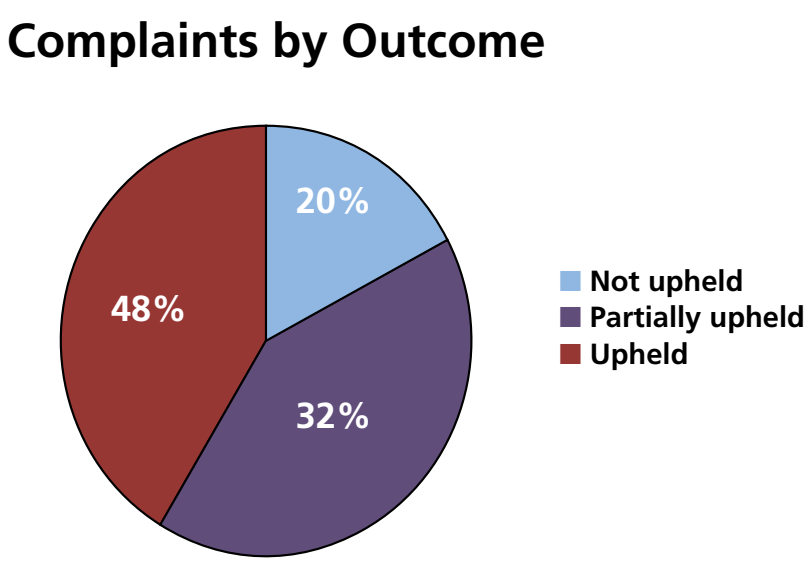
Despite the PHSO now investigating significantly more complaints referred to them following local resolution of complaints by Trusts, there has been a marked decreased (87%) in the number of complaints being referred by complainants to the PHSO from Q3 2014/15 to Q3 2015/16. There has also been a 20% increase in the number of complaints investigated by the PHSO that they have not upheld. This would suggest that the quality of the Trust's responses have improved throughout 2015/16, and that we are now resolving more complaints at Trust level.

The Trust received a total of 18 complaints in 2015/16 for investigation from the PHSO.

By the end of the year the Trust had 11 active cases which the Ombudsman is investigating.

Information Commissioner
We have had one complaint investigated by the Information Commissioner. This was not upheld.

Complaints Closed
The Trust closed a total of 683 complaints in 2015/16 with is a 10% increase from 2014/15. Of these 683 complaints closed 48% were upheld, 32% were partially upheld (The HSCIC counts partially upheld complaints as upheld complaints so if looked at in this way the figure is 80%) and 20% were not upheld.



Key themes and learning from Complaints

Complaints - Areas for Improvement

An update against the key priorities for 2016 -17 for the complaints and patient advice service are:

- Access to the complaints system- develop an "easy read" complaints leaflet
- Analyse user satisfaction with complaints process
- Continue to closely monitor responsiveness to complaints and ensure timely response to complainants – reinforce key performance indicators for complaints
- Focus on quality responses that address all aspects of complaints
- Revise action planning and learning form, monitoring of action plan completion
- Improve identification of sharing and learning from complaints
- Analyse reasons for re-opened complaints
- Ensure clear recording of PALS concerns that become complaints
- Introduce formal monitoring of PALS key performance indicators.
- Develop and deliver complaints training programme to support staff in the effective management of complaints

Learning From Complaints

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

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

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

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

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

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

Learning from the Divisions

Medicine

The Division has introduced a 'Learning the Lessons' Bulletin which is disseminated and discussed at the Medical Patient Safety and Quality Board and disseminated to the whole of the division to ensure there is evidence of shared learning. The Division also uses patient stories to learn from experience and these are disseminated widely across the division as relevant. Lessons learnt are also included in the Trust wide 'So What Happened Next..? Newsletter.

Issue: Delay in pain relief due to lack of escalation by ward team to on call consultant **Finding**: The investigation showed that there were unacceptable delays to the patient receiving her pain relief, due to stretched medical resources over a weekend and delays in escalation from the ward staff.	**Learning:** There is a need to review the staffing model and the way it provides services over 7 days and this review has commenced. The incident has been discussed in depth by the ward team and a clear escalation plan has been drawn up and all staff made aware.
Issue: Management of GI Bleed **Finding**: Delay in endoscopy at CRH and delay in transfer to HRI for emergency endoscopy	**Learning:** Full review of upper GI bleeding management protocol and review of emergency endoscopy protocol for managing acute GI bleeds in hospital within hours

Surgery and Anaesthetic Services

A lot of work has taken place in the surgical division to close down a number of outstanding complaints. Going forward the division intends to implement a robust process of thematic review which will inform service improvement plans.

Issue: Concerns raised about long waits in Endoscopy and Clinics **Finding**: Unavoidable delays were not communicated in a timely manner. Avoidable delays were not communicated in advance	**Learning:** Appointment letters advice potential for long visits (one stop clinics), white boards in clinics with any delays displayed. Pager system introduced. Patient information and notices in Endoscopy advise of procedure times and will call relatives to return to collect when patient ready
Issue: Concerns raised about difficulty for family members to discuss patient care with senior medical team **Finding**: relatives attend during visiting times when medical team busy unless appointments made to see Doctor	**Learning:** Open visiting now in place. Twice daily Consultant review of all acute admissions, ill and deteriorating patients improved access for relatives. Introduction of 'cards' to enable family to write questions for doctors if they are unable to be present during the day. Phone call to relatives after MDT for complex patients on ward 19 & 20

Family and Specialist Services

Complaints relating to Sign Language Interpreters

During the period January to April 2015 relating to the services provided by the Big Word, with 8 complaints in total received and a petition from the Calderdale Deaf Community. The complaints relate to the skill level and availability of British Sign Language (BSL) Interpreters employed by the Big Word.

- As a result of the complaints an engagement event, attended by over 40 members of the deaf communities of Calderdale and Kirklees, was held on 21 August 2015 which included patients, carers, parents and local BSL interpreters, with BSL interpretation. Additionally the agreement to transfer services over to the preferred new provider, Pearl Linguistics, was paused to enable the Trust to consider the feedback from the engagement event and commission the most appropriate service for this client group.
- Key messages from the audience included the importance of local knowledge/accents; feeling assured that the BSL interpreter had been booked and for a long enough duration; having suitably qualified BSL interpreters.
- Notes and feedback from the event have been analysed and is being used to help draw up a list of requirements that the Trust will want to see from its BSL provider. Work with our deaf communities continued during the process to help the Trust make the best decision about BSL interpretation services.

Patient Leaflet

A new patient information leaflet for care of children with abdominal pain has been developed following investigation of a complaint. The child's journey and experience has been captured as a patient story and will be used upon completion.

Patient Experience

The importance of compassionate care and understanding of how the woman was actually feeling was stressed to midwives through a presentation by Consultant Midwife consultant following review of care of a lady who developed sepsis following a difficult C- Section. The lady reported she did not feel listened to. The treatment and management plan was appropriate but from the investigation it was felt that some elements of human compassion were not addressed.

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

Area	Indicator	Threshold	Performance	Achieved?
Access 1	Maximum time of 18 weeks from point of referral to treatment in aggregate-admitted	90%	91.92%	Yes
Access 2	Maximum time of 18 weeks from point of referral to treatment in aggregate-non admitted	95%	98.48%	Yes
Access 3	Maximum time of 18 weeks from point of referral to treatment in aggregate-patients on an incomplete pathway	92%	95.67%	Yes
Access 4	A&E: maximum waiting time of four hours from arrival to admission/ transfer/discharge	95%	93.88%	No
Access 5	All cancers: 62-day wait for first treatment from:			
	Urgent GP referral for suspected cancer	85%	91.19%	Yes
	NHS Cancer Screening Service referral	90%	95.74%	Yes
Access 6	All cancers: 31-day wait for second or subsequent treatment , comprising:			
	Surgery	94%	99.15%	Yes
	Anti-cancer drug treatments	98%	100.00%	Yes
Access 7	All cancers: 31 day wait from diagnosis to first treatment	96%	99.81%	Yes
Access 8	Cancer: two week wait from referral to date first seen, comprising:			
	all urgent referrals (cancer suspected)	93%	97.34%	Yes
	for symptomatic breast patients (cancer not initially suspected)	93%	95.82%	Yes
Outcomes 16	Clostridium difficile – meeting the C. difficile objective	21	25	No
Outcome 20	Certification against compliance with requirements regarding access to health care for people with a learning disability	N/A		
Outcome 21	Data completeness: community services, comprising:			
	Referral to treatment information	50%	100%	Yes
	Referral information	50%	98.06%	Yes
	Treatment activity information	50%	100%	Yes

Feedback from commissioners, overview and scrutiny committees and Local Healthwatch

Feedback from commissioners, overview and scrutiny committees and Local Healthwatch

Response from Greater Huddersfield and Calderdale Clinical Commissioning Group

We were pleased to receive and comment on the Quality Account prepared by Calderdale and Huddersfield NHS Foundation Trust (CHFT). The following statement is presented on behalf of NHS Greater Huddersfield CCG and NHS Calderdale CCG.

The Quality Account is a comprehensive assessment of the levels of quality and is consistent with the Commissioners understanding of quality in CHFT, and reflects the areas discussed through our governance arrangements. It describes progress in many areas against national targets which is helpful and demonstrates transparency. This statement will reference areas as CCGs we are pleased to see the progress made, and others where we feel the account could be strengthened.

We recognise a range of improvement work in relation to the identified priority areas for 2015/16, and welcome the improvement in particular around incident reporting, investigation and shared learning which is evidence of the open culture within the organisation.

Your achievement in relation to maintaining the cancer waiting times which remain above national average is commendable, as is the reduction of the number of missed doses of IV antibiotics and the number of patients who die supported by the end of life care plan. The CCGs acknowledge the focussed work that has taken place around the Care of Acutely Ill Patient and recognise the need for further work, although there is reference to the Nervecentre technology within the report it would be strengthened by including further narrative on the ongoing improvement work in this area.

The work around improving patient experience is also a welcome inclusion and again is evidence that the organisation is one of listening and learning. We note the improvement in Friends and Family Test response rates in quarter 3, set against the agreed local targets. As Commissioners we look forward to working together to strengthen patient experience in 2016/17.

The Care Quality Commission (CQC) intelligence monitoring is confusing in terms of the Trust being in "band 5" without any definition of what this means. It is notable that the SSNAP risk has been a risk since 2014 but the report does not explain what actions are being taken to reduce the risk.
The CCGs recognise the identified priorities for 2016/17:

- *Reduction in Falls*
- *Mortality, and*
- *Improving Community Experience*

The rationale for why these have been chosen, the work to be carried out and what the Trust is trying to achieve is clearly articulated and supported by the commissioners. The priorities are aligned with the local CQuINs and we welcome the plan for commissioners to work closely with the Trust, we have started to visit the hospitals in "Go See" reviews of the work you are undertaking. This is a welcome demonstration of your willingness to be transparent.
The account could be further strengthened by the inclusion of some narrative around the difficulties the Trust is experiencing in recruitment and retention of both medical and nursing staff, and A&E performance.

We note your reference to the recent CQC visit and look forward to working with the Trust in response to the inspection report in due course, we will of course continue to support you over the coming year in achieving the quality improvement priorities set out in the account.

Yours Sincerely

Dr Majid Azeb
Chair Calderdale CCG Quality Committee

Dr Jane Ford
Chair Greater Huddersfield CCG Quality and Safety Committee

Response from Healthwatch Kirklees and Healthwatch Calderdale

Healthwatch have a constructive and positive relationship with CHFT. We have worked in the last 12 months on improving the quality of food served to patients, parking, outpatient appointments, patients who have learning disabilities, patients with HIV and patients who are Deaf or hard of hearing.

We have found the trust to be responsive to the issues that patients have raised with us, and look forward to working together in the same way next year.

Rory Deighton Director Healthwatch Kirklees
Helen Wright Director Healthwatch Calderdale

Response from the Governors

The Membership Council is actively involved in the development and quality of patient services at the Trust. The Membership Council comprises elected representatives of the patient and staff bodies, together with councillors nominated from the Trust's partner organisations. As such, it is well placed to offer an objective and rounded view of the Trust's services to patients.

Membership Councillors are afforded a range of opportunities to become familiar with the workings of the Trust. These opportunities allow us to monitor the quality of patient services and to offer our views about any quality issues or areas for development.

Membership Councillors chair a series of divisional reference group meetings where Trust colleagues present progress on quality indicators. Discussions take place concerning patient outcomes, achievement against agreed targets and any areas that require additional support. A 'Learning from Experience' discussion is a standing item on the agenda of each of these divisional reference group meetings. This helps Membership Councillors to understand and comment on the range and themes of any complaints (and compliments) received in each division.

Discussions at divisional reference group meetings are complemented by a series of Trust 'walkabouts'. Membership Councillors visit clinical and non-clinical areas and use these opportunities to talk to patients and staff about the quality of services.

Membership Councillors play an important part in the governance arrangements of the Trust, and through this, help to provide oversight of the quality of patient services. Each of the formal sub-committees of the Trust's board has Membership Councillors as part of their make-up, and both the Quality Committee, and the Audit & Risk Committee routinely consider the quality of patient services. In addition, joint workshops are held between the Membership Council and the Trust board where Membership Councillors are able to hold to account the non-executive directors for the performance of the board.

In addition to this scrutiny, Membership Councillors were able to contribute to findings on the quality of Trust services by participating in a focus group discussion with the Care Quality Commission on their recent inspection visit to the Trust.

The views and opinions of Membership Councillors are an intrinsic part of the selection process to choose the quality indicators and priorities for the Trust. Comprehensive evidence is presented to us throughout the year as to progress against the existing priorities, and then we, and the Trust's membership, are canvassed for our views on what should be the quality priorities for the forthcoming year.

Membership Councillors are supportive of the efforts of Trust staff to improve the quality of services for patients, and we endorse these Quality Accounts.

Rev Wayne Clarke
Deputy Chair and Lead Governor
CHFT Membership Council

Response from Calderdale Overview and Scrutiny Committee

The Kirklees Council Overview and Scrutiny Panel for Health and Social Care, as the local Health Overview and Scrutiny Committee has reviewed the Draft Quality Account which included reference to the Department of Health's guidance for Overview and Scrutiny Committees.

The Panel has noted your priorities for 2016/17 and was generally supportive of the range of areas they will cover, although there were a number of areas that it felt warranted further comment.

The Panel was disappointed that the 2015/16 improvement priority on intravenous antibiotics and improving Sepsis care had only been partially met and felt that the trust should continue to prioritise this work.

According to the report, the reason for not continuing with Sepsis as a quality account priority is that the national CQUIN and reporting will ensure that it continues to have a high profile in the Trust. However as this work was not fully met during 2015/16 the Panel believe that despite the national focus on this issue that the Trust should continue to include Sepsis as a 2016/17 improvement priority.

Last year the Panel commented that it was surprised that falls were not included as a priority and therefore welcome the inclusion of falls as one of the three priorities for 2016/17. The Panel also welcome the focus on including more statistical data and believe that it is important that the Trust can demonstrate that it has used this data to understand what additional measures can be taken to aid prevention.

The Panel noted the introduction of Safety Huddles as one method of focusing on safety issues such as patient falls but felt that it would have helped to include a more detailed explanation on how this initiative had helped to reduce falls. The Panel also felt that it would have been useful to explain why the Trust appears to be introducing a modest target of establishing regular huddles in only 7 inpatient wards.

The Panel noted that Community Experience would be a priority for 2016/17 and felt that it would be helpful to include a further explanation on why this has been chosen as a priority and how the Trusts community services linked with other domiciliary agencies.

During 2016/17 the Panel will be continuing with its review of the changes to community services through the Care Closer to Home Programme which will include assessing the impact of these changes on the timeliness of patient discharge and readmission rates. The Panel will therefore maintain an interest in the work that is being undertaken by the Trust to improve the discharge process and believe that this should continue to be a Trust priority.

The Panel is pleased with the progress that has been made in the quality of food provided to patients however the Panel would also wish to see more information on parenteral nutrition that would demonstrate the support that is being provided to those patients that are unable to eat.

The Panel noted that the reduction of noise on wards is an important issue for patients and is pleased that steps have been taken to help reduce avoidable noise through a Trust campaign and the introduction of initiatives such as the night time routine. The Panel would welcome a continued focus on this issue and feel it would be helpful for the Trust to continue to capture evidence through patient feedback to demonstrate that these initiatives are having a positive impact on patient experience.

The Panel has continued to maintain a close overview on the work that has taken place by the Trust to improve hospital mortality and is concerned that this is still an area that requires much improvement. The Panel therefore agree that Mortality Reduction should be a major priority for the Trust in 2016/17 and believe that work on understanding the reasons for the levels of incidents in the Trust should also be undertaken.

The Panel noted the severity and number of complaints received and agreed that this needed to be carefully monitored. The examples quoted on pages 72 and 73 should not have occurred and the learning from the complaints will need to be embedded in the organisation so that actions to address these issues become normal practice.

The Panel has noted the statements of assurances from the Board and believed that this has demonstrated a commitment to innovation and development. However the Panel felt that these assurances could have been further strengthened by including greater evidence of achievement.

The Panel was concerned that the accounts did not mention in any detail the planned changes to hospital reconfiguration and community health services and felt that greater reference should have been made to these two important areas of work which are currently a priority for Scrutiny.

Helen Kilroy
Principal Governance and Democratic Engagement Officer
On behalf of the Overview and Scrutiny Panel for Health and Social Care

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

Feedback requested but not received in timescale.


Hand Hygiene Point
NHS
NHS

Statement of directors' responsibilities in respect of the quality report

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.

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance

- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2015 to 26 May 2016
  - papers relating to Quality reported to the board over the period April 2015 to 26 May 2016
  - feedback from commissioners dated 06/05/2016
  - feedback from governors dated 06/05/2016
  - feedback from local Healthwatch organisations dated 14/04/2016
  - feedback from Overview and Scrutiny Committee dated 06/05/2016
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/05/2016 (planned date)
  - the 2014 national patient survey 21/05/2015
  - the 2015 national staff survey 22/03/2016
  - the Head of Internal Audit's annual opinion over the trust's control environment dated April 2016
  - CQC Intelligent Monitoring Report dated 01/05/2015

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered

- the performance information reported in the Quality Report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

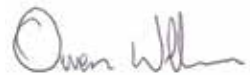
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- the Quality Report has been prepared in accordance with Monitor's annual reporting 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

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 2015/16, 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.

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Calderdale and Huddersfield NHS Foundation Trust to perform an independent assurance engagement in respect of Calderdale and Huddersfield NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;
- A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge.

Respective responsibilities of the directors and auditors

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

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2015/16 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

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

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

- board minutes and papers for the period April 2015 to May 2016;
- papers relating to quality reported to the board over the period April 2015 to May 2016;
- feedback from commissioners dated 6 May 2016;
- feedback from governors dated 6 May 2016;
- feedback from local Healthwatch organisations dates 14 April 2016;
- feedback from Kirklees Overview and Scrutiny Committee dated 6 May 2016;
- the trust's latest complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the national patient survey published on 22 May 2015;
- the 2015 national staff survey published on 23 February 2016;

- the 2015/16 Head of Internal Audit's annual opinion over the trust's control environment; and
- the May 2015 CQC Intelligent Monitoring Report.

We have not been able to review consistency with feedback from Calderdale BC Overview and Scrutiny Committee. This was requested on 14 April 2016 but not received.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Calderdale and Huddersfield NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Calderdale and Huddersfield NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may

change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

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

Basis for qualified conclusion

As set out on page 79 of the Trust's Quality Report, we are unable to obtain assurance on the accuracy of the data supporting the incomplete pathways indicator. Whilst the Trust undertakes a validation process for this data, this is a targeted methodology to ensure the Trust achieves required performance and may not cover the total population in any one month. As a consequence the actual performance may be better than that reported.

As a result of the issues described above we are unable to conclude that nothing has come to our attention that causes us to believe that the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways indicator for the year ended 31 March 2016 has been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing have come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the remaining indicator in the Quality Report subject to limited assurance (the 4 hour A&E indicator) has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
Leeds

26 May 2016

Appendix

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 2015/16, are listed below. The numbers of cases submitted to each audit or enquiry as a percentage of the number of registered cases required (by the terms of that audit or enquiry) are also listed.

Women's and Children's Health

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Child health programme (CHR-UK)	No	NA	NA	NA
Diabetes in pregnancy audit 2015	Yes	Yes	100%	100%
Maternal, infant and newborn programme (MBRRACE-UK)	Yes	Yes	100%	100%
Neonatal intensive and special care (NNAP)	Yes	Yes	429	100%
Paediatric intensive care (PICANet)	No	NA	NA	NA
RCEM Audit – paeds vital signs 2015	Yes	Yes	110	All cases in period
BTS Paediatric Asthma	Yes	Yes	40	100%

Acute

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases Submitted
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	Yes	100%	On-going
National Joint Registry (NJR)	Yes	Yes	998	On-going
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Yes	All	100%
National emergency laparotomy audit (NELA)	Yes	Yes	140	100%
RCEM lower limb VTE risk assessment 2015	Yes	Yes	50	100%
RCEM sedation audit 2015	Yes	Yes	50	100%
BTS Emergency Oxygen Audit 2015	Yes	Yes	100%	100%
BTS National Pleural Procedures	Yes	Yes	20	100%

Blood and transplant

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Medical Use of Blood (National Comparative Audit of Blood Transfusion) National Comparative Audit of Blood Transfusion - programme includes the following audits, which were previously listed separately in QA:				
2014 Audit of transfusion in children and adults with Sickle Cell Disease	Yes	Yes	On-going	All cases submitted
2015 Audit of Patient Blood Management in adults undergoing elective, scheduled surgery	Yes	Yes	27	All cases
2015 Audit of lower gastrointestinal bleeding and the use of blood - Data collection closes in December.	Yes	Yes	On-going	All cases
2016 Audit of Red Cell & Platelet transfusion in adult haematology patients	Yes	Yes	31	100%

Cancer

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Bowel cancer (NBOCAP)	Yes	Yes	249	100%
Lung cancer (NLCA)	Yes	Yes	100%	All cases in time period
Oesophago-gastric cancer (NAOGC)	Yes	Yes	100%	All cases in time period
National Prostate Cancer Audit	Yes	Yes	100%	All cases

Heart

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes	100%	100%
Adult cardiac surgery audit (ACS)	No	N/A	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 (NICOR)	Yes	Yes	100%	On-going
Heart failure (HF)	Yes	Yes	100%	On-going
National Cardiac Arrest Audit (NCAA)	Yes	Yes	155 YTD	50%
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Yes	Yes	244	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	On-going	On-going
Diabetes (Paediatric) (NPDA)	Yes	Yes	100%	100%
Inflammatory bowel disease (IBD)	Yes	Yes	31	
	All cases in time period			
Renal replacement therapy (Renal Registry)	No	N/A	N/A	N/A
National Diabetes Foot Care Audit	Yes	Yes	On-going	On-going
National Complicated Diverticulitis Audit (CAD)	Yes	Yes	33	All cases
National Ophthalmology Audit	Yes	Yes	2717	100%
National Parkinson's Disease Audit 2015	Yes	Yes	40	100%

Mental Health

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

Older People

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Sentinel Stroke (SSNAP)	Yes	Yes	All	On-going
Rheumatoid and early inflammatory arthritis (NCAPOP)	Yes	Yes	72	All cases in time period
National Audit of Intermediate Care (Hudds – service now moved to Locala)	Yes	Yes	27	All cases in time period
National Inpatient Falls audit (ffap)	Yes	Yes	30	100%

Other

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Elective surgery (National PROMs Programme)				
Groin hernia	Yes	Yes	151	On-going
Hip replacements	Yes	Yes	267	On-going
Knee replacements	Yes	Yes	209	On-going
Varicose veins	Yes	Yes	100	On-going

National Confidential Enquiries

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Deaths:				
Gastrointestinal Haemorrhage	Yes	Yes	8	80%
Acute Pancreatitis	Yes	Yes	6	60%
Sepsis Study	Yes	Yes	10	100%
Mental Health in Adults	Yes	Yes	10	100%
Chronic neuro-disability (cerebral palsy)	Yes	Yes	Ongoing	Ongoing
Non-Invasive Ventilation Study	Yes	Yes	Ongoing	Ongoing
Child Health Review -a study into the care of mental Health conditions in young people	Yes	Yes	Ongoing	Ongoing

The reports of 40 national clinical audits were reviewed by the provider in 2015/16 and the following are examples where Calderdale and Huddersfield NHS Foundation Trust intend to take actions to improve the quality of healthcare provided.

2015 Audit of Patient Blood Management (PBM) in Adults undergoing elective, scheduled Surgery
Patient Blood Management (PBM) is an emerging concept whereby factors that may predispose patients to needing allogeneic transfusions are addressed before transfusion is considered. PBM has been described as a "three-pillar" approach: Optimise red cell mass, reduce surgical blood loss and harness the patient's reserve whilst using restrictive transfusion triggers.

Objectives:
The audit documented blood management practice and transfusion decisions in a sample of scheduled surgical cases who have received transfusion. This provided a baseline of practice prior to full implementation of the national PBM recommendations. It will serve to highlight areas of good practice as well as variability in practice and enable hospitals to prioritise implementation of PBM initiatives.

National Patient Blood Management Recommendations for hospitals in England published in 2014 formed the basis for the audit.

Standard 1: Clinical staff must ensure that patients listed for elective major blood loss surgery have an Hb measured at least 14 days pre-operatively and act upon results*
Standard 2: Clinical staff should only prescribe a pre-operative transfusion in patients undergoing elected major blood loss surgery if the Hb is less than the defined Hb threshold for transfusion (70g/L in patients without acute coronary ischaemia or 80g/L in patients with acute coronary ischaemia)
Standard 3: Clinical staff should only prescribe a pre-operative transfusion in patients undergoing elective major blood loss surgery if the Hb is less than the defined Hb threshold for transfusion and pre-operative anaemia optimisation has been attempted

Standard 4: For patients receiving a pre-operative transfusion, clinical staff should prescribe one unit of red cells at a time and re-check Hb before prescribing a further unit
Standard 5: For patients undergoing elective major blood loss surgery who are taking oral anticoagulants and/or antiplatelet agents, clinical staff must stop the oral anticoagulant and/or antiplatelet agent(s) at least 5 days pre-operatively (unless there are good reasons to continue) and document the management plan in the case notes – For patients with fractured neck of femur taking warfarin, clinical staff should aim for an INR of less than 1.5 on the day before or the day of surgery
Standard 6 & 7: Clinical staff should attempt at least one (PBM standard 6) or all (PBM standard 7) appropriate patient blood management measures in patients who receive a transfusion during major blood loss surgery
Standard 8: In patients who do not have active post-operative bleeding, clinical staff should only prescribe a transfusion if the Hb is less than the defined Hb threshold or for transfusion (70g/L in patients without acute coronary ischaemia 80g/L in patients with acute coronary ischaemia)
Standard 9: For patients receiving a post-operative transfusion, clinical staff should prescribe one unit of red cells at a time and re-check Hb before prescribing a further unit (unless the patient has active bleeding).
Standard 10: Clinical staff should attempt at least one (PBM standard 10) or all (PBM standard 11) appropriate patient blood management measures in patients who receive a transfusion during major blood loss surgery

What changes in practice have been agreed?

Recommendation	Action	By Whom	When By
Mid-range performance for standard 1: Clinical staff must ensure that patients listed for elective major blood loss surgery have an Hb measured at least 14 days pre-operatively and act upon results. Room for improvement on the 11 patients audited.	A full case note review of the 11 elective patients (note: of the total of 27 patients, fourteen had fractured femurs and two underwent index operations as urgent cases, hence 11 to evaluate) will take place before the end of March 2016. Any actions for implementation will be then be discussed. There is a National Re-audit of Patient Blood Management in Adults undergoing Elective & Scheduled Surgery in late 2016.	Dr Pnt Laloë	31.03.16

National Pregnancy in Diabetes Audit Report, 2014 (second year)

The National Pregnancy in Diabetes (NPID) Audit is part of the National Diabetes Audit (NDA) programme. This report from the second year of the NPID audit presents key findings on the care and outcomes for women and diabetes in the Yorkshire and Humber region who had pregnancies in 2014.

Objectives:
This audit is a measurement system to support improvement in the quality of care for women with diabetes who are pregnant or planning pregnancy and seeks to address the three key questions:

- Were women adequately prepared for pregnancy?
- Were adverse maternal outcomes minimised?
- Were adverse fetal/infant outcomes minimised?

The NPID audit measures the quality of care received by women with diabetes who become pregnant using national standards set in our National Institute for Health and Clinical Excellence (NICE) guidelines.

Summary of Findings:
As the number of women with diabetes receiving pregnancy care at each hospital/Trust is relatively small, the report provided local information at ONS Region level rather than provider level.
The report included data on women with diabetes whose pregnancy was completed between 1 January 2014 and 31 December 2014 and where the date was submitted to the audit by 12 February 2015.

- 210 pregnancies in Yorkshire & Humber in audit period, 53% had type 1 diabetes, 37% had type 2 diabetes and 10% in other women with diabetes
- Average age 30.5 yrs (31.7 yrs nationally)

First trimester HbA1c measurement in the audit for 2014 in the Yorkshire and The Humber region and in England and Wales

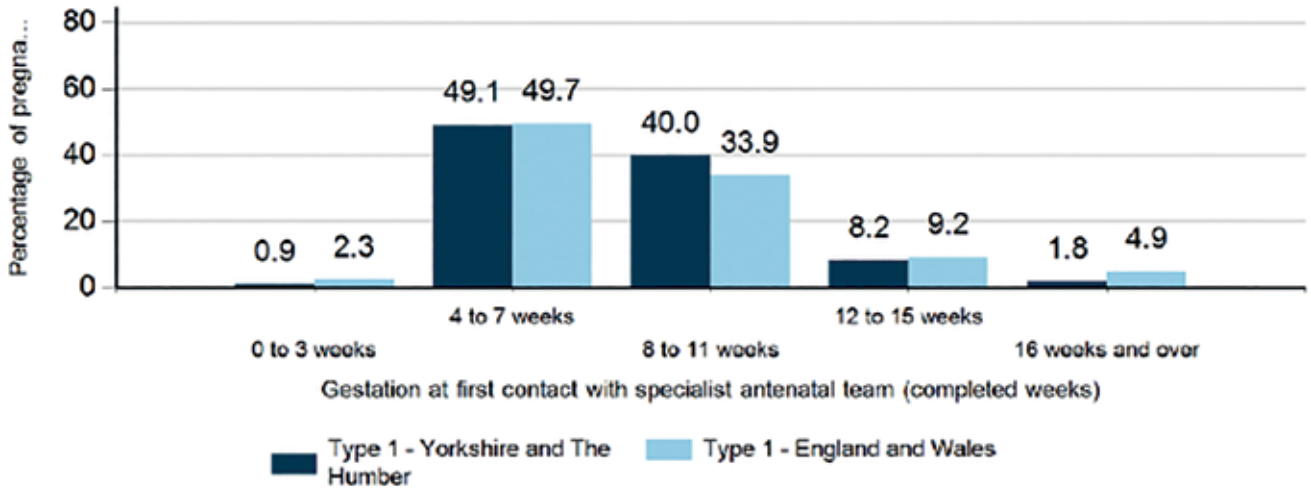
	All pregnancies		Pregnancies in women with Type 1 diabetes		Pregnancies in women with Type 2 diabetes	
	Yorkshire and The Humber	England and Wales	Yorkshire and The Humber	England and Wales	Yorkshire and The Humber	England and Wales
	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage
Result < 43 mmol/mol (6.1%)	15.5	14.6	9.2	7.9	24.2	21.7
Result < 48 mmol/mol (6.5%)	26.4	25.9	18.4	15.4	38.7	35.8
Result < 58 mmol/mol (7.5%)	42.0	51.6	29.6	40.1	61.3	62.9
Result ≥ 86 mmol/mol (10.0%)	14.9	9.7	17.3	11.6	9.7	8.1

Folic acid use and first trimester HbA1c measurement in the audit for 2014 in the Yorkshire and The Humber region and in England and Wales

	All pregnancies		Pregnancies in women with Type 1 diabetes		Pregnancies in women with Type 2 diabetes	
	Yorkshire and The Humber	England and Wales	Yorkshire and The Humber	England and Wales	Yorkshire and The Humber	England and Wales
	Percentage	Percentage	Percentage	Percentage	Percentage	Percentage
Taking 5mg folic acid and HbA1c <43 mmol/mol (6.1%)	11.0	7.2	9.2	6.4	12.7	7.7
Taking 5mg folic acid and HbA1c <48 mmol/mol (6.5%)	20.1	12.8	17.2	11.8	25.5	13.1

Care in Pregnancy

Gestation (completed weeks) at first contact with the specialist antenatal team for women with Type 1 diabetes in the audit for 2014 in the Yorkshire and The Humber region and in England and Wales



- 39% of all singleton babies were large for gestational age (34% nationally)
- 41% babies delivered before 37 weeks received normal neonatal 84% after 37 weeks (37% & 81% nationally)

Recommendations	Actions	Lead Person	Timescale
To be successful in reducing pregnancy risk in women with diabetes, collaboration across current healthcare boundaries will be needed, with an integrated approach involving strategic networks, policy makers, commissioners, acute Trusts/Local Health Boards, clinical teams, local general practices and professional bodies.	For primary care the following ***guidelines have been created and recently updated (based on NICE).*** 'Diabetes and pregnancy preconception management and referral pathway for primary care' (Guidance compliant with NICE NG3) ***This has been presented to the Diabetes Network Group at the CCG.*** Women who are already under the secondary diabetes care team will get preconception counselling, as specialists are more aware of doing so. The guidelines are there to make GPs more aware to counsel and/or refer women if they are normally under GP care only. Mass joint focused education is challenging due to resources, ***however, the diabetes team started formal education on general diabetes to Calderdale practices. Preconception care will definitely be covered.***	Dr Julie Kyaw-Tun, Consultant	Implemented
Because women need to be aware of pregnancy risks and have access to information about how to minimise these risks in advance of pregnancy, diabetes and maternity services (and networks) need to develop a focus on pregnancy preparation. Services and networks will be a key element of an integrated approach to engaging with and informing women, and should work with primary care teams to identify and inform all women with diabetes who might become pregnant about the importance of, and options for, safe effective contraception and pregnancy planning.			
Particular focus is needed on engagement with women with Type 2 diabetes, who are likely to receive their diabetes care wholly in a primary care setting and may have less contact with specialist teams, and women from ethnic minority groups or living in areas of high deprivation, fewer of whom have HbA1c measurements within the recommended level.			

National Lung Cancer Audit 2015 (for the audit period 2014)
In December 2014, the Royal College of Physicians (RCP) was awarded the new contract to deliver the National Lung Cancer Audit (NLCA) in England and Wales for the next 3–5 years and are determined to work together with lung cancer teams to maintain excellent levels of engagement and to go even further to improve outcomes for patients

This will be the 11th annual National Lung Cancer Audit (NLCA) for patients diagnosed with lung cancer in England, Wales, Guernsey and Scotland in 2014. Lung cancer is the second most common cancer in the UK after breast cancer. In 2012, there were over 40,000 new cases of lung cancer in the UK and more than 35,000 people died from the condition.
Current survival rates for lung cancer are the second lowest out of 20 common cancers in England and Wales.

Data was submitted by CHFT to LUCADA for 2014. The data was collected on all patients first presenting in 2014, and was uploaded to the LUCADA database via the Open Exeter portal.

Objectives:
To summarise the key findings of the audit for patients diagnosed with lung cancer or mesothelioma who were first seen in 2014.
- To review the quality of lung cancer care,
- To highlight areas for improvement
- To reduce variation in practice.

Summary of findings:
2014 recommendation: Data completeness for key fields to exceed 85%.
2015 result: Overall recordings of key data items continue to be of a high standard: 89% of submitted records included performance status and 92% included disease stage; 84% included both items.

2014 recommendation: Maintain the level of 95% of patients submitted to the audit discussed at a multidisciplinary team (MDT) meeting.
2015 result: 94% of cases submitted were recorded to have been discussed in an MDT meeting.

2014 recommendation: Pathological confirmation rates below 75% should be reviewed to determine whether best practice is being followed.
2015 result: 69% of cases submitted were recorded to have a pathological confirmation of their cancer.

2014 recommendation: At least 80% of patients are seen by a lung cancer nurse specialist (LCNS).
2015 result: 78% of patients were recorded to have seen a specialist nurse (although 13% of cases were missing this information).

2014 recommendation: Active anticancer treatment rates below the England and Wales average of 60% should be reviewed.
2015 result: 58% of patients were recorded to have had anticancer treatment.

2014 recommendation: Chemotherapy rates for small-cell lung cancer (SCLC) below the England and Wales average of 70% should be reviewed.
2015 result: 68% of patients with SCLC were recorded to have had chemotherapy.

2014 recommendation: Chemotherapy rates for good performance status (PS 0–1) stage IIIB/IV non-small-cell lung cancer (NSCLC) below the England and Wales average of 60% should be reviewed.
2015 result: 58% of patients with good PS and stage IIIB/IV NSCLC were recorded to have had Chemotherapy.

What changes in practice have been agreed?

Improvement of the lung cancer pathway, along with more accurate data keeping.

Recommendations	Action	Lead	Target timescale
Fast track vetting	To ensure fast track vetting is started.	Dr R Naseer	Started
Database of active Lung Cancer patients	To develop a database of active Lung Cancer patients. Supported by the lung cancer nurses and PPM trackers.	Dr R Naseer	Started
Regular check of data accuracy	For Lung Cancer lead to meet with PPM lung pathway co-ordinator regularly	Dr R Nasser	To start April 2016

Other National Clinical Audits the Trust has participated in during 2015/16:

- UK National Bariatric Surgery Registry
- National Audit of Hip Fractures
- Diabetic Retinopathy Screening (KPI)
- Mid-Urethral Tapes (BAUS)
- Nephrectomy Surgery (BAUS)
- PCNL (BAUS)
- Invasive cytology
- National End of Life 2015 audit
- National Cardiac Rehab audit
- National review of adult asthma deaths – year 5
- Autoimmune Hepatitis (2 yr audit)
- SAMBA 2015 (Day in the life of an AMU)
- BSUG Stress Incontinence database
- APRICOT (Anaesthesia Practice in Children Observational Trial)
- National Completed Acute Diverticulitis Audit (CADS)
- National FAMCARE2 audit 2015
- BAD National re-audit of non-melanomas in cancer excision & completeness of histopathological reporting
- Audit of primary pPCI referrals
- Audit of patient characteristics assessed by community specialist palliative care teams (PCFR national indicators)
- OAKS (Outcomes after Kidney Injury)

NICE CG 74 Surgical Site Infection

A surgical site infection is an infection that occurs after surgery in the part of the body where the surgery took place. Surgical site infections can sometimes be superficial infections involving the skin

Objective:
To measure current practice in the prevention and treatment of SSI against NICE clinical guideline 74

Criteria 1: All patients should be offered information & advice on SSI including risks, what is being done to reduce them and how they are managed
All patients should be offered 'Understanding NICE guidance' booklet.

Criteria 2: All carers should be offered information & advice on SSI including risks, what is being done to reduce them and how they are managed

All carers should be offered 'Understanding NICE guidance' booklet.

What changes in practice have been agreed?

Recommendation	Action	When By	Lead
Understanding NICE guidance booklet to be given to every patient/carer	To be ordered as there are none available in the Trust	April 2016	Mr Graham Walsh

Tongue Tie Audit - NICE CG37

Ankyloglossia, also known as tongue-tie, is a congenital anomaly characterised by an abnormally short lingual frenulum, which may restrict mobility of the tongue. It varies from a mild form in which the tongue is bound only by a thin mucous membrane, to a severe form in which the tongue is completely fused to the floor of the mouth. Breastfeeding difficulties may arise, such as problems with latching, sore nipples and poor infant weight gain.

Many tongue-ties are asymptomatic and cause no problems. Some babies with tongue-tie have breastfeeding difficulties. Conservative management includes breastfeeding advice, and careful assessment is important to determine whether the frenulum is interfering with feeding and whether its division is appropriate. Some practitioners believe that if division is required, this should be undertaken as early as possible. This may enable the mother to continue to breastfeed, rather than having to feed artificially.

Current evidence suggests that there are no major safety concerns about division of ankyloglossia (tongue-tie) and evidence suggests that the procedure can improve breastfeeding. NICE concludes that the evidence is adequate to support the use of the procedure provided that normal arrangements are in place for consent, audit and clinical governance (NICE, 2005).
Objectives:

- To review the first 12 months of assessment and release of lingual frenulum (frenulotomy) at a CHFT Lactation Consultant led Tongue-Tie Clinic. The clinic commenced on the 2nd September 2014 and is staffed by the Infant Feeding Advisor and a Maternity Support Worker. The Clinic opens weekly from 09.00 to 13.00 hrs.
- Clinic audited against standards in NICE CG37 (2005) Division of ankyloglossia (tongue-tie) for breastfeeding ; –clauses 1.3.39 & 1.3.40 and also against NICE IPG149

Summary of Findings:
Activity data was collected by the Trust Health Informatics Department for the first 12 months of operation (2.9.14 to 31.8.15). Data were collected regarding the presenting problem and the effect of the release of the tongue-tie.

- **43** Frenulotomy Clinic sessions were held in first 12 months of operation
- A total of 305 Babies attended for Frenulotomy as Out-Patients, in addition 29 babies had tongue-tie release on the post-natal wards.
- Resulting in 334 frenulotomy procedures in total: female 124; male 21. Infants ranged in age from 1 day – 129 days old (mean 24 days).

Mothers were also asked about their satisfaction with the amount of information received prior to the procedure; the service received when attending the clinic and any problems encountered following the release.
The majority of the mothers of babies assessed for tongue-tie reported difficulties breastfeeding their infants. 38% of babies had an existing family history of tongue tie.

The average waiting time for all attendances throughout the year was 6 days.

Presenting problem	Number of infants	Percentage	Resolved Following division	Resolved Immediately or within first week
Frequent Feeds	21	45 %	81%	94%
Prolonged Feeds	17	36%	88%	86%
Excessive weight loss/ slow gain	12	32%	75%	66%
Attachment difficulties	34	72%	79%	92%
Clicking when feeding	17	36%	82%	86%
Fussiness at the breast	22	47%	68%	100%
Prolonged Jaundice	3	6%	100%	66%
Requiring Supplementary feeds	20	42%	60%	100%
Sore/damaged nipples	19	47%	84%	75%
Engorgement/Mastitis	9	23%	89%	87%
Low milk supply	8	20%	62%	100%

Additional Problems
87% of mothers reported that their baby did not experience any problems following the procedure.

Mothers were asked if they felt they had been given enough information about the condition and procedure. The evaluation forms indicated 100% of respondents had received enough information.
Additionally, women were asked if they were satisfied with the service they received when attending the tongue tie clinic. 100% of respondents replied that they were satisfied.

Conclusions:
This review indicates that satisfaction levels with the service were high.
Mothers appreciated the professional and caring support provided and the explanations they were given by the clinician.
Between 60%-100% of mothers reported an improvement of breastfeeding problems following frenulotomy with problems resolved quickly (either immediately or within the first week) following the procedure.
Complaints relating to tongue tie division have been eliminated. According to Datix between May 2012 and August 2014 there were 7 complaints and 1 concern (resolved informally).
Since Sept 2014 there have been no complaints relating to new-born infants.

What changes in practice have been agreed?

Recommendations	Actions	Lead Person	Timescale
Continue to provide a high standard tongue tie practice through the professional and caring support of all the staff involved	No actions required	Marilyn Rogers, Infant Feeding Advisor	Clinic service ongoing

Audit of new onset angina clinic

The new onset angina clinic allows specialist assessment of patients with new onset of chest pain suspected to be angina. They should be seen within 2 weeks of the referral as per the National Service Framework for coronary heart disease target. The clinic provides one stop service involving clinical assessment and investigations to confirm or exclude IHD.

Aim:

- To re-evaluate the appropriateness of referrals to the new onset angina clinic following the application of the previous recommendations.
- Audited against NSF coronary Heart disease (2000)

Summary of Findings

- Prospective audit of referrals to new onset angina clinic between Apr 2014 and April 2015.
- Data collected using a standardised audit proforma.
- Proforma is filled in by the attending clinician at the end of each clinic.

Source of referral	Audit	Re Audit
Primary Care	108 (82%)	100(87%)
Secondary Care	25 (18%)	14 (12%)

Source of referral	Audit	Re Audit
Primary Care	108 (82%)	100(87%)
Secondary Care	25 (18%)	14 (12%)

NICE probability of IHD

	Audit	Re Audit
<30%	95 (71%)	56 (54%)
31-60%	28 (21%)	41 (40%)
63-90%	10 (<1%)	5 (<1%)

Investigations	Audit	Re Audit
ETT	5 (all-ve)	3(all-ve)
Echo	15 (all normal)	10 (7 normal)
Stress Echo	1 (normal)	0
MPS	2 (normal)	0
24h ECG	9	8
Angiogram	0	2

The 2 patients who underwent angiogram had typical symptoms of angina and one of them had PCI

Reasons for inappropriate referrals

- No reason given 31%
- No cardiac pain 62%
- No chest pain 7%

Outcome	Audit	Re Audit
Discharged	93 (70%)	99 (87%)
Cardiology Follow Up	40 (30%)	15 (13%)

Conclusion

- Overall no improvement in the percentage of patients who considered to be inappropriate referrals.
- Reduced number of inappropriate female referrals by 27%.
- Reduced number of inappropriate referrals from secondary care (A&E) from 18% 12%.
- Decreased number of referrals with IHD probability of less than 30% from 71% to 54%.
- Doubled the percentage of referrals with IHD probability of 31-60% (21% to 40%)
- Reduced numbers of patients referred for cardiology F/U from 30% to 13 %.

What changes in practice have been agreed?

Recommendations	Actions	Lead Person	Timescale
Clinicians who run the NOAC should give the reason when deciding the referral was inappropriate	Prompt the clinicians running the NOAC clinics to fill in the audit form appropriately especially the reason for finding the referral inappropriate **Outcome Measure** Target of 80% of audit forms to be filled in appropriately especially the reason for finding the referral inappropriate	Michelle Foster Lead / nurses in NOAC clinic	6-12 Months
The referral letter for new onset angina clinic should include a brief summary of the patients symptoms especially when low risk	A new from for the NOAC to be created to include a summary box for the GP to add clinic details **Outcome Measure** Target of 80% of the referrals where the brief summary box (to be added to the new forms) are completed by the GP's	Michelle Foster	3 months
Continuous measurement of the inappropriate referrals to the new onset angina clinic	Re audit 2016 **Outcome Measure** To reduce the overall percentage of inappropriate referrals to the new onset clinic to less than 15%	Talal Ezzo	November 2016


Coming to
see the doctor ?