NHS

Calderdale and Huddersfield

NHS Foundation Trust

Quality Account 2017/18

compassionate care

Part 1: Chief Executive's Statement

Welcome to the 2017/18 Calderdale and Huddersfield NHS Foundation Trust (CHFT) 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 Governors, we have identified as priorities for the coming year.

In March 2018 we had unannounced Care Quality Commission visits which were followed by a planned three-day inspection in April 2018 and we await their new rating. We were able to demonstrate trust-wide all the developments since their last visit when 70% of our services were rated as "good", yet overall we received a rating of "requires improvement" which was in line with all other West Yorkshire Trusts.

In April 2018 a High Court judge ruled that our Full Business Case for the health reconfiguration proposals should go to a Judicial Review and this is now due to be heard in June 2018. A decision from the Health Secretary will follow the outcome of that hearing.

As I write, we are emerging from what has been accepted as what has been widely acknowledged as the stand-out winter for the NHS. After a hugely challenging December and January, the "Beast from the East" struck in February. For us it meant extra beds and wards opening to cope with the high numbers of very poorly patients.

It also brought out the very best from colleagues at CHFT who pulled out all the stops to be able to provide compassionate care to our patients.

As a result we were again in the top 10% of best performing Trusts in the country for achieving the targets for emergency care – something we could not have achieved without close working with our partners in social care and in community.

That is the general overview of our performance for this year. In this section you will witness a more detailed appraisal of all the hard work under way to maintaining safe, quality care. This is always top of the agenda for our Board of Directors and in this increasingly challenging financial environment, combined with increased demands for our services, it is even more important to ensure that any changes we make are assessed for their impact on quality 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. 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 2018

Part 2: How the Trust performed against the three priorities set for 2017/18

Each year the Trust works on a number of quality priorities. Last year the Trust identified three projects to be highlighted as key priorities for 2017/18.

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 2016/17?
Safety	Sepsis Screening	Yes
Effectiveness	Discharge Planning	Yes
Experience	Learning from Complaints	Yes

Priority One – Sepsis Screening for in patients

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

It 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 a number of preventable deaths.

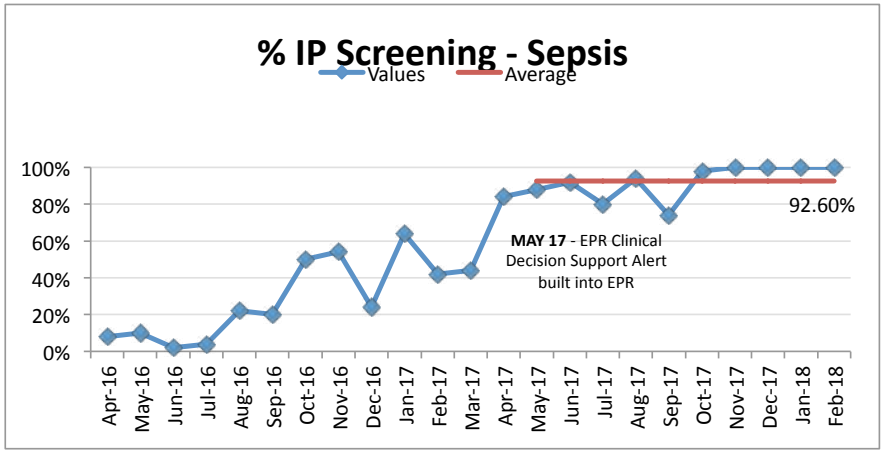
Improvement work
The Trust looked to improve the recognition of potential sepsis through a number of interventions. One key intervention centres on ensuring appropriate screening of patients with suspected sepsis. This screening will enable patients to commence treatments sooner and improve their overall outcomes. This is important for patients both arriving with us with sepsis and those that develop sepsis whilst under our care.

There has been significant process changes with the introduction of the Electronic Patient Record (EPR) in May 2017 with further developments anticipated later this year. Previously CHFT used the clinical criteria of a national early warning score (NEWS) greater than 5 to alert the clinical team to assess for sepsis using the sepsis screening bundle (evidence based interventions for sepsis) in the medical records. A second bundle supported clinicians to recognise and manage severe sepsis.

We have held a number of focus groups with our doctors and nurses to understand what barriers get in the way of recognising and responding to sepsis. This has helped us tailor the right actions to support our doctors and nurses caring for patients with sepsis to ensure our patients are treated in a timely manner.

How did we do?
With the Cerner EPR now in place, CHFT continuously monitors and "screens" inpatients for possible sepsis using a criteria with clinical and laboratory measures. If three clinical parameters, or two clinical parameters and one laboratory measurements are abnormal the system will trigger an alert to the clinical team to consider whether sepsis is present. If severe sepsis is identified the team are prompted to request and complete the adult sepsis 6 care plans which includes further investigations along with prescriptions for fluids and antibiotics.

This has resulted in a significant improvement over the last 12 months in ensuring patients are screened for sepsis. As demonstrated in the chart below, we have exceeded our target of 90% of inpatients being screened.



Priority Two – Discharge Planning

Why we chose this

Safe and timely discharge planning is an important part of the inpatient stay. It is estimated that over 20% of discharges require some complex planning and coordination. In order to ensure that these patients have a safe and appropriate environment to return to after their stay, the Trust developed and further enhanced the role of the discharge co-ordinator, so that these roles continue to be effective and work collaboratively with our partners

Improvement work

Whilst the role of the Discharge Coordinator is pivotal to the continued improvement of safe and timely complex discharges, this is as a part of a wider programme of work that involves forging close and effective partnerships with partners in the local authorities to understand the needs of patients who are medically ready for discharge. We are carried out internal improvement work to make sure our patients can reach their optimum before discharge, primarily through our Frailty Team and by providing more services in the community to keep people fit and able to self-care, often avoiding admission in the first instance.

The work in 2017/18 is a continuation of a transformational piece of work started by the Trust in 2016/17 and will continue into 2018/19.

How did we do?

As shown in the chart below there has been a sustainable reduction in patients with an over 50 day length of stay. This is due to dedicated discharge teams having worked with local authority partners over the last 12 months and focussing on reducing longer stay and medically stable patients.

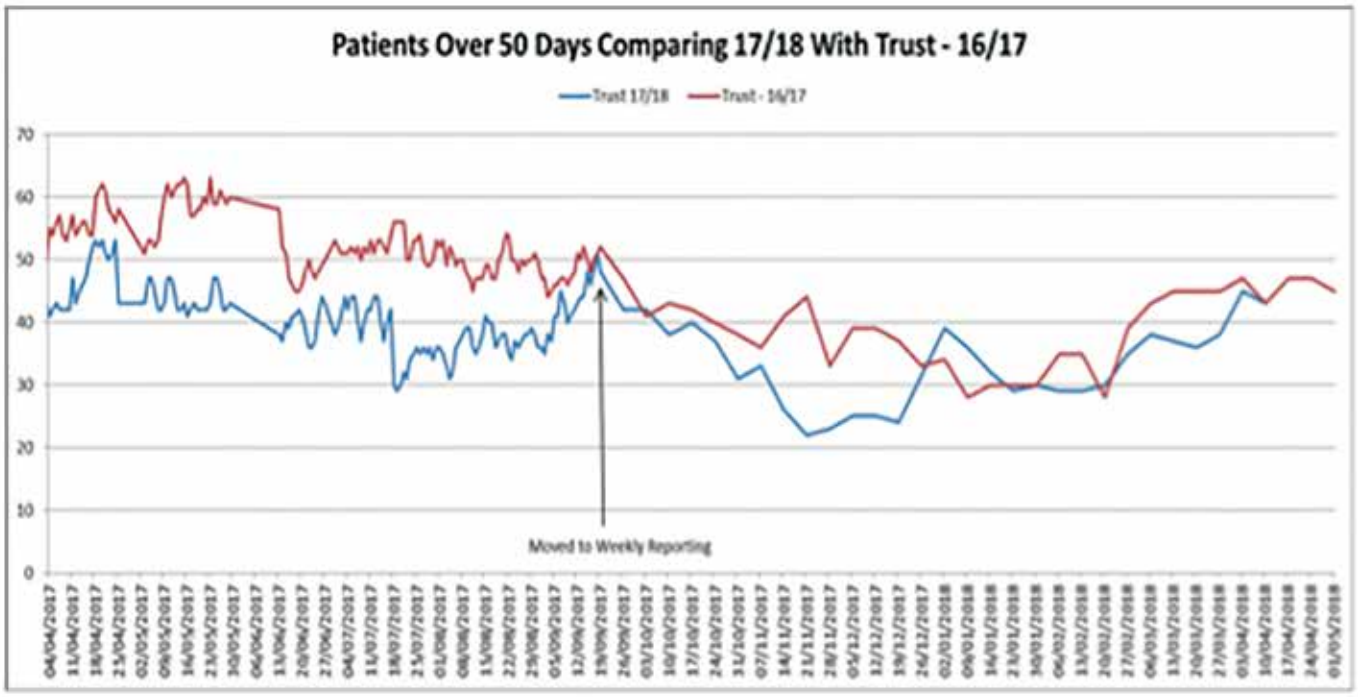


Chart 2: Patients with a Length of Stay greater than 50 days

Discharge Improvements in 2017/18 included the following eight schemes that were initiated to improve discharge as part of the SAFER programme:

- Introduction of a new reablement pathway.
- Tracking and expediting of complex pathways
- Implementation of a new non-weight-bearing discharge pathway
- Introduction of ward based social workers
- Equipment task and finish group
- Implementation of criteria led discharge
- New continuing healthcare assessment process
- Readmission- New cellulitis pathway.

All of these initiatives have been introduced or implemented; some are now well established for example the new reablement pathway was introduced September 2017. Prior to implementation of the new reablement pathway the average time from referral to discharge was 12 days; the new pathway has reduced this to an average of 4 days. A similar improved position is seen with the new continuing care pathway reducing the length of the pathway from over 10 days to 2 days. Other initiative have been more recently implemented and are in the early phase for example criteria led discharge, this has been established on two wards and is about to be rolled out further.

The Integrated Discharge Team, which includes CHFT discharge coordinators, discharge sisters, therapists and matron and the local authority social care team were successful in winning the CHFT Celebrating Success 'Four Pillars Award' and the Gordon Mclean Award for the sustainable improvements they have achieved over the last year in improving discharge planning, reducing the length of stay patients with complex needs and the positive impact this has on those patients and families.

This work to improve discharges will continue through the SAFER programme. Improving hospital flow is a quality account priority for 2018/19 with further details given on page 124.

Priority Three – Learning from Complaints

Why we chose this

We receive a lot of positive feedback on our services throughout the year. However, when our patients are dissatisfied with the service they receive and make a formal complaint, we act on it. It is critical that we learn from patients' experiences of our services and make improvements. We plan to improve the quality of the response to complaints and increase learning from complaints.

Improvement work

The Parliamentary Health Service Ombudsman's report, Learning from Mistakes, July 2016, reiterated that training and accrediting sufficient investigators is crucial to improve learning from investigations. Therefore a new training package has been devised in Q4 of 2016/17 for complaints investigators, with a 2017/18 training programme of dates to support staff in their investigative approach to patient complaints. This training will incorporate the process of how to ensure good quality investigations are undertaken and that the tools for capturing and disseminating learning are known.

Learning from complaints is closely linked to learning from incidents that have caused severe or moderate harm. Having a culture where the expectation is to learn, no matter what happened is key as well as involving patients and families. The work on learning from complaints takes place in the context of the recently developed framework on learning from adverse events, based on a staff survey and focus groups with staff on learning. This identified actions around the methods we use to share learning across the organisation, promoting a safety and learning culture and training.

How did we do?

Complaints Training

A one day complaints training package for staff was developed and introduced in 2017/18 to support staff in undertaking effective complaints investigations. This was a full day course looking at the legislation behind NHS complaints, tools and techniques for investigating a complaint, how to identify and disseminate learning from a complaint.

76 members of staff have been trained in complaints management, attending this course during 2017/18. Positive feedback was received from the evaluation, with attendees feeling more confident in managing complaints, understanding the need to plan and structure the investigation and increased awareness of the requirements for complaints responses and legislative requirements.

On reviewing the course evaluation forms the team has reviewed the complaints training package and is moving from a full day course to a five module training course. This will be introduced in 2018 and will enable more staff to take up the training as the training is split into five modules.

Identifying and Sharing Learning from Complaints

To ensure that learning from complaints is shared with staff in as many ways as possible, learning has been shared in line with the Trust learning framework as detailed further below. This includes:

- Revised Complaints Policy confirming the importance of identifying learning from complaints and governance arrangements / responsibilities for learning from complaints within divisions
- Monthly reports within divisional quality and safety forums
- Quarterly complaints reports
- Shared Learning Improving care - "Focus On…. newsletters
- Team newsletters
- Bite size chunks learning
- Complaints panels with two divisions to ensure all responses capture learning where appropriate

Further detail on a number of these is given below:

Managers from the complaints team undertook a "go see" visit to Morecambe Bay Hospital in September 2017 and during this visit explored how the Trust identifies learning from complaints. The approach taken to identifying learning from complaints at Morecambe Bay was similar to that used within the Trust, through quarterly and an annual complaints report.

Within the Trust, complaints learning is shared within the complaints quarterly report (section 5) which is presented to the Patient Experience Group, with patient experience representatives from each division. This report includes complaints learning from each division and learning from the

Parliamentary and Health Service Ombudsman (PHSO) in the quarter. A new section was added during the year called "featured learning" where learning from a particular complaint is included.

Divisional representatives share learning from complaints within the Divisions, as well as reporting on learning from complaints within the Patient Safety Quality Boards and their reports to the Quality Committee.

In addition to routinely capturing learning from complaints as part of the management of a complaint, as part of the Trust's learning framework, learning from complaints also features in the "Sharing Learning – Improving Care " newsletters, e.g. Focus on Dementia . These newsletters are shared with all ward and outpatient areas and within the Trust staff newsletter.

The Trust has developed and promoted a Shared Learning – Improving Care intranet page during the year. The "Focus on…" newsletters and bite-sized learning from adverse events including complaints are all accessible to staff on this intranet page.

One area that was identified from an internal audit report on complaints and the "go see" visit to Morecambe Bay was the need to seek user feedback on the complaints process. In March 2018 the first electronic surveys of users was commenced, using a pilot survey in Morecambe Bay and the NHS Improvement Complaints Survey Toolkit. The survey gathered views from complainants on their experience of the complaints process via an electronic survey tool. To date response rates have been encouraging and the surveys will be extended during 2018. Information received from the survey will be analysed to identify areas of improvement for handling complaints during 2018.

An internal audit report on complaints handling identified the need for more specific learning to be identified from complaints and for this to be shared across divisions. In response to this the quality assurance process for reviewing complaints has been strengthened, with gaps in identifying learning highlighted as part of the review process. Joint weekly complaints review panels, with managers from the central complaints team and the Surgery and Anaesthetic Division and Medical Division were introduced towards the end of quarter 3. Each complaint is discussed in detail with the lead investigator and as part of this checks are made to ensure that learning is clearly described in the complaint. Where learning has not been identified in the complaints response further work is undertaken to include the learning that has taken place following a complaint.

One theme identified from complaints during 2017/18 was communication within the Emergency Department. A "Go See" visit of the Emergency Department during a nightshift (19:30 – 05:30) by the Complaints Manager took place to identify issues that staff are facing in de-escalating complaints and general customer service techniques. As a result a workshop on customer service has been developed and the first of these sessions was delivered in February 2018, with further sessions planned for 2018.

A sample of learning from complaints during 2017/18 is given later in the report in the complaints section.

A complaints improvement plan for 2018 - 20 has been developed and this will continue the work to improve learning from complaints and improve patient experience and services. Further details of this work is given on page 64 of this report.

Looking ahead to 2018/19

A 'long list' of potential priorities for 2018/19 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 2017/18,
- 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 2018/19.

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

The three priorities for 2018/19 are:

Domain	Priority
Safety	Care of the Acutely Ill Patient: Improving outcomes through recognition, response and prevention of deteriorating patients
Effectiveness	Patient Flow: Managing Complex Discharges
Experience	End of Life Care: Improving the experience of care for those patients who are being managed at the end of life.

Priority One: Care of the Acutely Ill Patient: improving outcomes through recognition, response and prevention of deteriorating patients

Why we chose this

Timely recognition and response to a patient's changing needs can make a difference in their clinical outcomes and their overall experience of care. The Trust has an established Deterioration Programme which is subdivided into key areas of focus namely recognition, response and prevention of deterioration in inpatients.

Within each subheading there are separate work streams that are thought to be significant enablers for improvement. Since the implemented of a number of electronic systems the Trust is able to gain ever more meaningful insights in to the way patients are cared for.

Improvement work

The Deterioration Programme continues to focus on the recognition, response and prevention of deterioration in patients. Quality improvement (QI) continues to focus on timely and quality observations, timely response to patients with an elevated National Early Warning Score (NEWS) and optimisation of both safety huddles and EPR.

To specifically address the response element of the programme, a real time audit of patients who scored a NEWS of 5 or more is being carried out. This is to be performed on both 'in' and 'out' of hour's patients and the learning form this will form part of the 2018/19 improvement plan going forward.

Reporting

Reporting on this priority will be through the Clinical Outcomes Group and the Deteriorating Patient Group.

Priority Two: Patient Flow – Improving Timely & Safe Discharge (right patient, right place, right time)

Why we chose this

On average, every day in CHFT acute hospitals eight people become ready for discharge but need ongoing services to make their discharge safe and appropriate. Management of these patients is an organisational priority, both from a patient safety and experience viewpoint, and also an organisational efficiency perspective. The discharge process is often a complex collaborative plan with multiple agencies.

Any delay in the discharge pathway can mean increased risk of de-compensation of patient condition and an expediential increase in length of stay (LOS), unrelated to original reason for admission. A proportion of these patients may become reportable to NHSE as 'Delayed Transfers of Care', a key metric for Trust performance.

The management of these patients has become

a priority and has been a key focus of the SAFER Patient Transformational Flow Programme led by the Director of Urgent Care.

The key performance and quality indicators are:
1. Number of patients with a LOS over 50 days- target for 2018/19 is <30 patients
2. Number of medically fit for discharge patients- target for 2018/19 is <80 patients
3. Length of stay of patients over 75 years- target for 2018/19 is <7 days

Improvement work
The improvement work that commenced in 2016/17 surrounding the management of the patients with a complex discharge need is established. The evidence shows that this work has been successful and enhancing the capabilities of the discharge coordinators through the trusted assessor route with the aim of reducing the length of the complex discharge pathways is the main focus.
CHFT will also hold a multi –agency discharge event (MADE Event) to improve discharge planning, supported by the Emergency Care Improvement team.

Reporting
Performance against key performance indicators (KPIs) are measured and reported to the monthly SAFER Patient Flow Board. This Board reports into the Transfer of Care Board and A& E Delivery Board.

Priority Three: Improve experience of patients on care of the dying pathway

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

The Trust is looking to sensitively establish that during these times a patients relatives felt that the needs of their loved one were meet in a compassionate and appropriate way.

Improvement work
The Trust will be linking into the Learning from Deaths work (see page 21 to test a short bereavement survey.

Reporting
Reporting on End of Life Care will be to the Clinical Outcomes Group.

Statements of assurance from the Board

Review of services

During 2017/18 Calderdale and Huddersfield NHS Foundation Trust provided and/or sub-contracted 36 designated Commissioner Requested Services.

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

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by Calderdale and Huddersfield NHS Foundation Trust for 2017/18.

Participation in Clinical Audit
During 2017/18, 52 of the national clinical audits and three national confidential enquiries covered relevant NHS services provided by Calderdale and Huddersfield NHS Foundation Trust.

During that period Calderdale and Huddersfield NHS Foundation Trust participated in 91% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. These are detailed in Appendix A.

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

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2017/18 that were recruited into trials during that period to participate in research approved by a research ethics committee was 1491 (as at end of February 2018).

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 improved patient outcomes.

The Trust was involved in conducting 92 clinical research studies all of which were actively recruiting (excludes student and Participant Identification Centre - PIC studies), 33 were closed to recruitment (but participants were still involved) and 19 recruiting studies were commenced. A further 22 studies were undergoing 'capacity and capability assessment'.

During 2017/18 actively recruiting research studies were being conducted across four of the five divisions in twenty six specialties:

- Families and Specialist Services , 16 studies, 8 specialties
- Corporate, study
- Medical Services, 68 studies, 13 specialties
- Surgical and Anaesthetic Services, 7 studies 5 specialties

There were 85 clinical staff (supported by 15 non clinical staff) participating in research approved by a research ethics committee at the Trust during 2017/18, of which 44 were local principal investigators, 1 was a chief investigator on a qualitative study,

Also, in the last three years, six 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.

Learning From Deaths
During 2017/18, 1729 of CHFT adult inpatients died.
This comprised the following number of adult deaths which occurred in each quarter of that reporting period:

384 in the first quarter;
386 in the second quarter;
434 in the third quarter;
525 in the fourth quarter

The current process for learning from adult deaths in the trust includes reviewing cases notes using an initial screening review (ISR) tool to assess the quality of care and structured judgement reviews (SJR) which assesses quality of care and avoidability concerns. Cases that are assessed with either poor or very poor care are escalated for a more in depth SJR. Some case are escalated for a structured judgement review without an ISR and

these cases include deaths in elective patients, patients with learning disabilities, complaints from relatives or carers.

Adult deaths
By April 2018, 478 case record reviews and 20 investigations have been carried out. The investigations are the cases that had been reported on the incident reporting system (Datix) as either a red or orange incident.

All deaths that were subject to an investigation also had case record review at the structured judgement review level. The number of deaths in each quarter for which a case record review was carried out was:
70 in the first quarter;
90 in the second quarter;
154 in the third quarter;
164 in the fourth quarter.

Six (0.35%) of the patient deaths during the reporting period are judged to be more likely than not, to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:
1 case (0.27%) for the first quarter;
2 cases (0.59%) for the second quarter;
2 cases (0.47%) for the third quarter;
1 case (0.19%) for the fourth quarter

These numbers have been estimated from data collected from the ISR and SJR.

A further 62 case record reviews and 4 investigations were completed after 1stApril 2017 which related to deaths which took place before the start of the reporting period (in 2016/17 period).

Two cases representing 3.2% of the patient deaths before the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the ISR and SJR process although the terminology was previously referred to as 1st and 2nd level mortality reviews.

Six representing 0.35% of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient compared to the 5 representing 0.73% of the total patient deaths in 2016/17.

Deaths in 0 to 18 year olds
Deaths of all children from birth to 18 years in the area are notified to the Calderdale and Kirklees Safeguarding Children Boards Joint Child Death Overview Panel (JCDOP).

During 2017/18, 13 of CHFT's paediatric inpatients died

This comprised the following number of child deaths which occurred in each quarter of that reporting period:

7 in the first quarter;
0 in the second quarter;
4 in the third quarter;
2 in the fourth quarter

By April 2018, all 13 cases a case record review and 2 investigations have been carried out.

Deaths that were subject to an investigation are included in the case record review numbers. The number of deaths in each quarter for which a case record review was carried out was:

7 in the first quarter;
0 in the second quarter;
4 in the third quarter;
2 in the fourth quarter

Due to the nature of the child case record review process it is not possible to report the number of deaths which were more likely than not, to have been due to problems in the care provided. Each case is written as a narrative summary as opposed to being given a discrete avoidability score.

Goals agreed with commissioners

A proportion of Calderdale and Huddersfield NHS Foundation Trust's income in 2017/18 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.

For CCG's and NHSE – Direct Services the 2017-19 National CQUIN Guidance split the usual 2.5% CQUIN funding as follows

- 1.5% agreed scheme indicators
- 0.5% to support engagement with service transformation plans (STPs)
- 0.5% linked to risk reserve

For NHSE – Specialised the 2017-19 National CQUIN Guidance split the usual 2.0% CQUIN funding as follows

- 2.0% national indicators

The contract value for CQUINs in 2017/18 was £6.74m (£6.41m for CCG's and £0.33m for NHS England).

The schemes were as follows:

CQUIN		Community or Acute
1.	Improving Staff Health and Wellbeing	Acute
2.	Reducing the impact of serious infections (Antimicrobial resistance and Sepsis)	Acute
3.	Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI)	Acute
4.	Improving services for people with mental health needs who present to A&E	Community
5.	Offering Advice and Guidance	Acute
6.	e-Referrals	Acute
7.	Supporting proactive and safe discharge	Acute
8.	Preventing ill health by risky behaviours – alcohol and tobacco	Acute
9.	Improving the assessment of wounds	Community
10	10.Personalised care and support planning	Community

Further details of the nationally agreed goals for 2017/18 and for the following 12 month period are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

The Trust did not fully achieve the following:

- 1% reduction in antibiotic prescribing
- Risky Behaviours (Alcohol and Tobacco Screening)
- Sepsis antibiotic within an hour

The Trust had a year-end settlement with its main commissioners, NHS Calderdale CCG, NHS Greater Huddersfield CCG and NHS England – Specialised based on full achievement of CQUIN. The actual value of CQUIN achieved in 2017/18 therefore was £6.67m.

Compared to 2016/17 when the CQUIN achievement amount was £6.92 million.

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

As noted in the Chief Executive's statement, Calderdale and Huddersfield Foundation Trust has participated in unannounced CQC visits in March 2018 ahead of a planned inspection in April 2018. This included visits to the following core services: Community inpatients, Emergency Department, Critical Care, Children's and Young Peoples Services, maternity and Community Sexual Health. Following the inspection a rating will be given and actions will be taken to address the conclusions or requirements reported by the CQC.

The CQC carried out an inspection of the Trust between 8th and 11th March 2016 as part of their comprehensive inspection programme. In addition, unannounced inspections were carried out on 16th and 22nd March 2016. The Trust was rated as requires improvement overall.

The reports from the CQC inspection were published on their website in August 2016 and can be found at the following link: http://www.cqc.org.uk/provider/RWY

The judgements made by the CQC following their inspection relating to the Trust overall were:

Overall rating for this Trust:	**Requires Improvement**
Are services at this Trust safe?	Requires improvement
Are services at this Trust effective?	Requires improvement
Are services at this Trust caring?	Good
Are services at this Trust responsive?	Good
Are services at this Trust well-led?	Requires improvement

The CQC is currently carrying out checks on the locations registered by CHFT using their new way of inspecting services, reports will be published when the checks are complete.

Calderdale and Huddersfield Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.
Calderdale and Huddersfield Foundation Trust has made the following progress by 31 March 2018 in taking such action. An end of year report to the Quality Committee and Board of Directors detailed the Trust response to the CQC inspection report and the concerns raised at the time of the inspection. It provided a year-end position against all of the must and should do actions and how the plan has been managed, including the role of the CQC Response Group and ongoing discussions with the CQC management team. The arrangements for the ongoing management of the CQC inspection requirements is monitored through the Risk and Compliance group which reports to Audit and Risk Committee.

Data Quality
The Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

Which included the patient's valid NHS Number was:

Admitted Patient Care = 99.8%
Outpatient care = 100%
Accident & Emergency Care = 99.2%

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

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

These figures are based on April 2017 to December 2017, which are the most recent figures in the Data Quality Dashboard.

The Trust successfully implemented the Cerner Millennium Electronic Patient Record (EPR) in May 2017. As part of this implementation the Trust also implemented the Cymbio Data Quality dashboard, which was recommended by other Cerner Millennium EPR sites. The Dashboard provides a view of operational performance in near real-time, highlighting under-performance, operational inefficiency, issues and bottlenecks. The dashboard indicators have drill-down functionality at Trust, site, division, specialty and department, ultimately down to the detailed patient activity record as required. A RAG status is reported for each indicator based on deviation from levels commonly defined from historical baseline data.

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

The structure for data quality information team has also been reviewed and recommendations made to ensure that adequate resource and oversight is maintained. In the initial months following deployment the Trust employed experts from Cymbio to help advise and train staff, including working closely with the internal data quality team to provide guidance, documentation and support in corrective actions required to ensure data is accurate and fit for purpose.

Information Governance
The Trust Information Governance assessment report overall score in October 2017 was 71% and graded as green, 'satisfactory' with all scores at a level two or three. The Trust achieved 73% compliance in March 2018.

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

Staff are mandated to complete the Information Governance training on a yearly basis through the electronic staff record, ESR, in addition to this from January 2018 face to face overview sessions have been run to raise awareness on the General Data Protection Regulation (GDPR) which comes into force on 25 May 2018.

Clinical Coding Error Rate
Calderdale and Huddersfield Foundation Trust were not subject to the Payment by Results clinical coding audit during 2017/18.

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 2016/17 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	Most recent data	National Average	Best	Worse	last report period	last report period	last report period
Preventing people from dying pre-maturely	SHMI Reporting Period:	Oct16 -Sept17				(Oct 15 – Sept 16)	(Jul 15 – Jun16)	(Apr 15 – Mar 16)
	Summary Hospital-Level Mortality Indicator (SHMI) value and banding	100.81 Band 2 = As expected	100	NA	NA	108 Band2 = As expected	112 Band 1 = higher than expected	113 Band 1 = higher than expected
	The percentage of patient deaths with palliative care coded at either diagnosis or Specialty level for the Trust for the reporting period.	30%	29.6%	NA	NA	27.9%	25.2%	22.2%
Helping people recover from episodes of ill health or following injury	18. PROMS; Patient Reported Outcome Measures Reporting Period:	(2016/17)				(2015/16)	(2014/15)	(2013/14)
	(i) hip replacement surgery,	0.44	0.44	N/A	N/A	0.45	0.45	0.44
	(ii) Groin Hernia	0.07	0.09	N/A	N/A	0.07	0.08	0.07
	(iii) Varicose Veins	0.12	0.09	N/A	N/A	0.12	0.12	0.11
	(iv) knee replacement surgery.	0.32	0.32	N/A	N/A	0.32	0.33	0.34
	19. Patients readmitted to a hospital within 28 days of being discharged. Reporting Period:	Apr17-Feb18				(2016/17)	(2015/16)	(2014/15)
	(i) 0 to 15; and	10.3%	Not released by NHS Digital			10.32%	11.43%	10.64%
	(ii) 16 or over.	11.1%				8.96%%	11.95%	10.80%

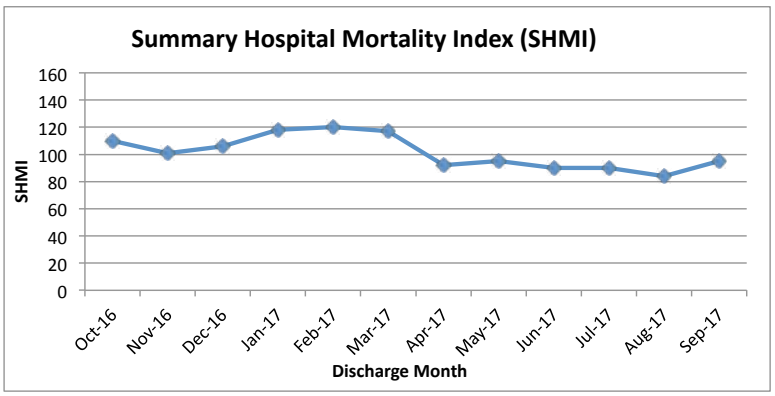
Outcome Domain	Indicator	Most recent data	National Average	Best	Worse	last report period	last report period	last report period
Ensuring that people have a positive experience of care	National Survey Reporting Period:	2016				2015	2014	2013
	20. Responsiveness to the personal needs of patients.	6.8	N/A	N/A	N/A	7.1	7.1	6.9
	Reporting Period:					2016	2015	2014
	21. Staff who would recommend the Trust to their family or friends.	3.63	3.76	NA	NA	3.72	3.67	3.68
Treating and caring for people in a safe environment and protecting them from avoidable harm	Reporting Period:	Apr17–Mar 18				2016/17	2015/16	2014/15
	23. Patients admitted to hospital who were risk assessed for venous thromboembolism.	94.39%	N/A	N/A	N/A	95.11%	95.4%	95.3%
	C.difficile Reporting Period:	Apr 16 – Mar 17				15/16	14/15	13/14
	24. Rate of C.difficile per 100,000 bed days	12.7	13	0	147	10.4	11.4	6.2
	Patient Safety Incidents - Reporting Period:	Oct 16 - Mar 17				April 16 - Sept 16	Oct 15 – Mar 16	Apr 15-Sept 15
	(i) Rate of Patient Safety incidents per 1000 Bed Days	39.6	40.5	N/A	N/A	41.2	40.1	37.5
	(ii) % of Above Patient Safety Incidents = Severe/Death	0.3	0.14	N/A	N/A	0.21	0.1	0.7

Domain: Preventing people from dying prematurely

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

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

Measures of mortality namely Hospital Standardised Mortality Rate, HSMR and SHMI have consistently improved over the past few years. In April 2016 the Trust HSMR was 113.9 and SHMI was 116.8. This improvement is undoubtedly multi-factorial and is a result of a number of Quality Improvement (QI) Initiatives that includes the use of digital technology.



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

EPR was implemented in May 2017 and the Trust had maintained an improving HSMR and SHMI since then. EPR benefits include integration of Nervecentre and EPR, ease of visibility of the medical record especially when a patient deteriorates, improved do not attempt cardio pulmonary resuscitation (DNA-CPR) documentation, universal sepsis screening, e-prescribing and medicines administration. There are ongoing plans to further optimise the use of EPR in QI for example use of ward level dashboards and safety huddles. The Trust has established a monthly Mortality Surveillance Group reporting to the Quality Committee through the Clinical Outcomes Group.

During 2017/18 The Trust continued its work around mortality case note review.
The Trust has performed both initial screening reviews and more in depth structured judgement reviews for a number of years. The revised Learning from Deaths (LfD) policy was published on both the intra and internets in September 2017. Learning from this has highlighted areas for improvement as below:

Theme	QI Response	Result
Delay/lack of medical review	Included in the 7 day working and hospital @ night (HOOP) – Deteriorating Patient work-stream	Fully compliant with 7-day standard 2 HOOP fully imbedded Deterioration Programme continuing to focus on Recognition, Response and Prevention of deterioration in patients
Delayed medications, mainly antibiotics	Included in the Medication Safety Group and Sepsis work-stream	EPR in place for closer surveillance of medication administration Sepsis collaborative QI
Observations not performed as policy	Implementation of Nervecentre for electronic observations and escalation	Marked improvement since Nervecentre was introduced. Ongoing optimisation QI work on accuracy of observations and response to escalations through the Deterioration Programme
Delay or lack of escalation of NEWS		
Incomplete bundles	Review of bundles	Sepsis screening through EPR and ongoing QI with sepsis COPD and pneumonia QI through national audits AKI collaborative reformed
Fluid balance recording	Introduction of EPR	Ongoing optimisation of fluid balance recording

Learning from Death was the subject of the 'Sharing Learning - Improving Care' newsletter and was published in August 2017. This was distributed across the Trust with the intention to share learning from the mortality reviews with frontline staff. The newsletter describes the journey of improvement (see below).

SHARING LEARNING – IMPROVING CARE

ISSUE 2: AUGUST 2017

SHARING LEARNING IMPROVING CARE

SHARING LEARNING IMPROVING CARE

NHS Calderdale and Huddersfield NHS Foundation Trust

ISSUE 2: AUGUST 2017

Mortality: talking points

SHARING LEARNING – IMPROVING CARE

Why do we measure mortality?

Measures of mortality are one of the indicators which could signal concerns with care provided by hospitals. They provide information on expected deaths both in and out of hospital and measure if a hospital trust is seeing on average, higher or lower than average number of deaths than expected among patients. Mortality rates are benchmarked nationally for all trusts using a range of tools such as HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-level Mortality Indicator).

How standardised mortality rates are calculated

- Firstly a benchmark of 100 has been calculated based on mortality rates for all acute hospitals in England and Wales.
- The year is compared on the number of actual deaths against the number of predicted deaths for the patients treated at CHFT.
- A ratio of 100 means expected number of deaths matched actual number of deaths. Above 100 means we had more than expected, less than 100 means we had less than expected.
- SHMI rates include in-patient deaths and deaths that occur within 30 days of discharge.

What have we learnt from our death reviews?

Common factors identified following investigation into deaths. Things that haven't always happened:

- Recording of patients observations and escalation when scores are raised
- Accurate fluid balance charts in sick patients
- Daily senior review, particularly at weekends
- Drugs given on time
- Sepsis screening when raised NEWS score
- Timely discussions with patients, families and carers where death is inevitable

Questions to ask yourself / your team:

- Are we performing patients observations at the recommended times?
- Are we clear about the need to escalate raised NEWS?
- Are we doing sepsis screen on patients with a NEWS 3 or more?
- Are we speaking to patients, families and carers at the earliest opportunity when death is inevitable?
- Are we considering why patients have an imbalanced fluid balance and what action to take?
- Is your documentation specific Complete Accurate Relevant (CCAR)?

How well are we doing?

SHMI - Data for rolling 12 month SHMI until September 2016 – **108.05** (categorised as Band 2 – as expected). This is an improved position from 112.0 from the same period last year.

HSMR - The 12 month rolling data up to March 2017 gives a HSMR score a **100.87** (categorised "as expected"). This is an improved position from 111.01 from the same period last year.

If you think "Someone should do something", remember, you are someone and you can do something!

Focus on Learning from Death

Feedback from colleagues is that we don't always share the outcomes from investigations, including what was learnt and what should be done differently. To learn when something goes wrong we need to know:

- **What happened?**
- **Why it happened?**
- **What can be done to prevent it happening again?**

This document provides facts and learning from our investigations following death, such as information from mortality reviews, complaints investigations, an incident investigation or an inquest.

hello my name is... Carole Hallam

For many patients, death is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision.

The purpose of reviews and investigations of deaths, in which problems in care may have contributed to, is to learn in order prevent recurrence.

Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon (NHS England 2017).

" I am the Senior Nurse for Clinical Governance.

I want to share more information about why having a focus on learning from death is a priority for our Trust "

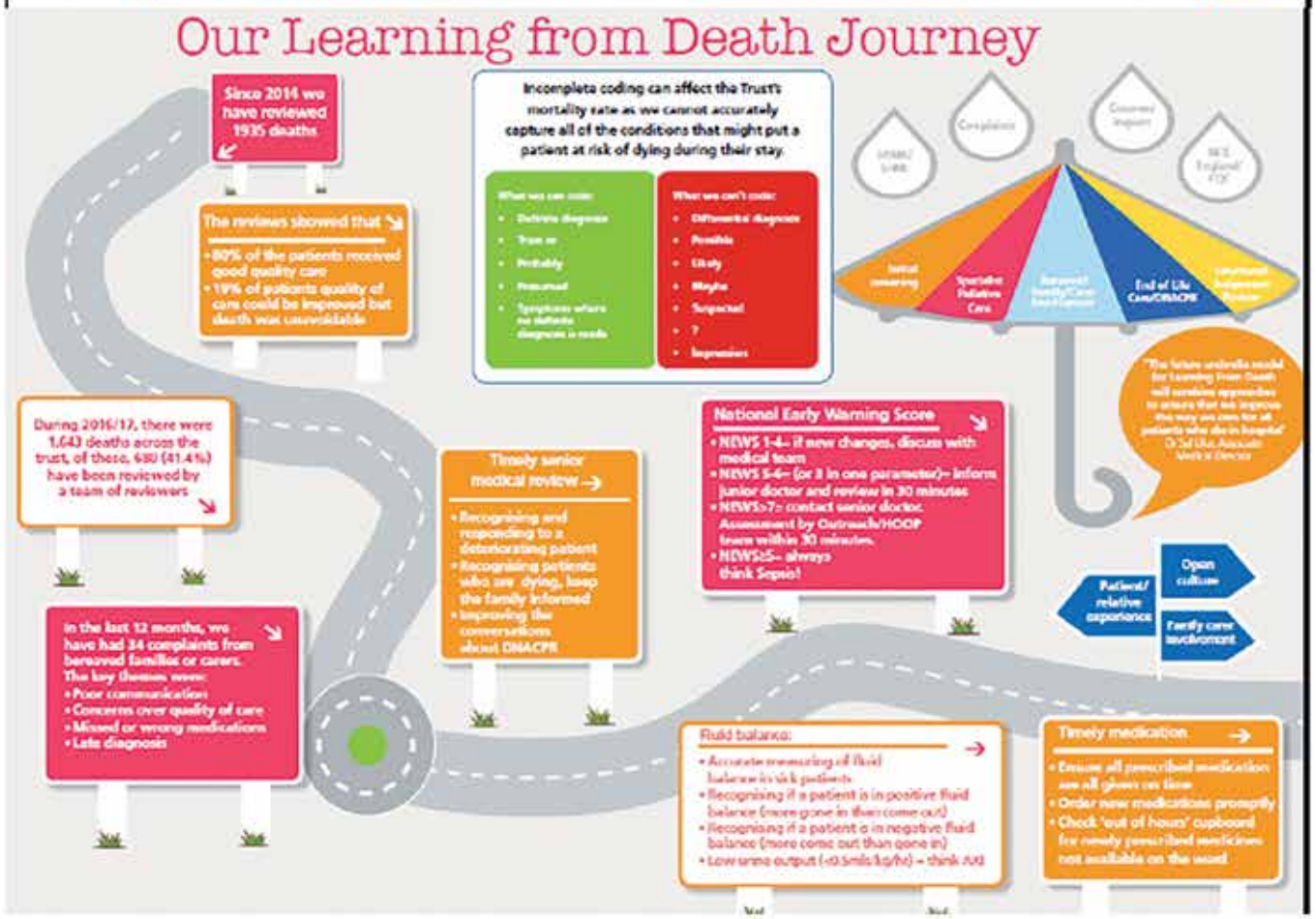
Read on to find out what we know about mortality here at CHFT, including:

1. What we have learnt about Mortality as a Trust
2. What we can do to improve the quality of care for our patients
3. How mortality rates are calculated

The Governance and Risk Team will be publishing regular themed reports to encourage learning from our adverse events. If there is a topic you would like us to feature, please contact Laura Malik (Directorate Secretary) on behalf of the editorial panel.

compassionate care

Our Learning from Death Journey



As a Trust we recognise the significant improvements in HSMR and SHMI as measures of mortality. The emphasis will continue to be learning from deaths through the new LfD structure and process. In addition the new LfD Umbrella will align QI strategies including morality reviews and EOL to promote wider learning to improve patient care. The Deterioration Programme will continue to drive improvements in the recognition and response to patients who become unwell. Safety huddles will remain the chosen method by which safety cultures are driven at a ward level. Finally the Trust is committed to the use of digital technology including the EPR as a significant enabler for QI.

Domain: Helping people recover from episodes of ill health or following injury
Patient reported outcome measures (PROMs)

A patient reported outcome measure is a series of questions that patients are asked in order to gauge their views on their own health. In the examples of 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 a patient sees a 'health gain' following surgery.

The data provided gives the average difference between the first score (pre-surgery) and the second score (post-surgery) that patients give themselves. In November 2017 NHS England discontinued the mandatory varicose vein surgery and groin-hernia surgery, however these are included in the PROMs table above and charts 4a and 4b below.

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

Participation rate across both procedures, for CHFT was 90.1%, which is in line with the national average of 90.5%

(i) Hip replacement surgery,

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Calderdale	0.45	0.43	0.44	0.49	0.44	0.45	0.45	0.44
National	0.42	0.44	0.44	0.44	0.41	0.43	0.44	0.44

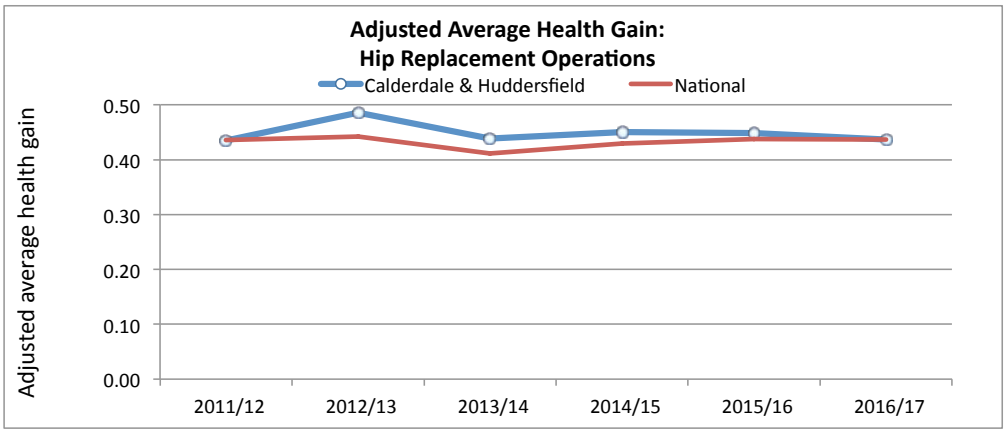


Chart 4: PROMS – Hips

(ii) Groin Hernia

	2012/13	2013/14	2014/15	2015/16	16/17
Calderdale & Huddersfield	0.07	0.09	0.08	0.07	0.07
National	0.09	0.08	0.08	0.09	0.09

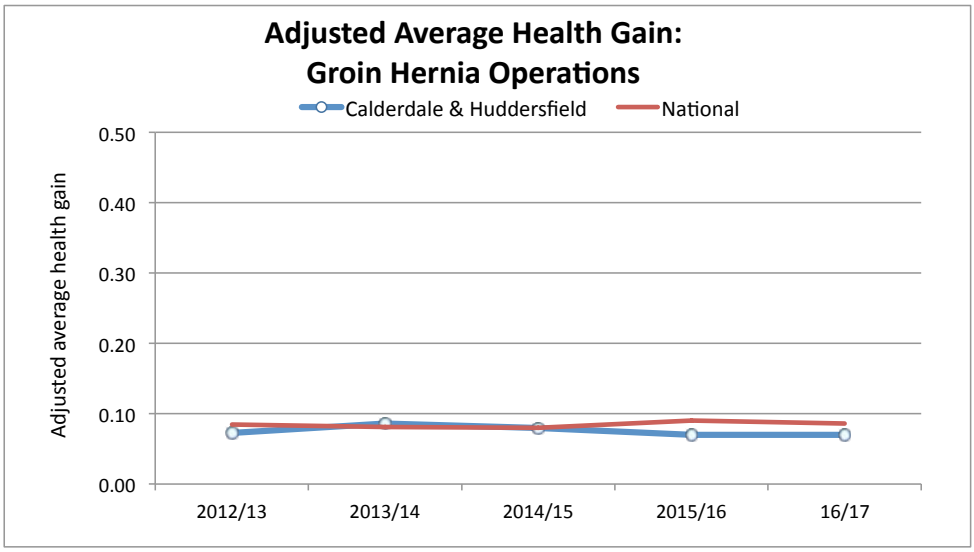


Chart 4a: PROMS – Groin Hernia

(iii) Varicose Vein

	2012/13	2013/14	2014/15	2015/16	16/17
Calderdale & Huddersfield	0.11	0.11	0.12	0.12	0.12
National	0.09	0.10	0.09	0.10	0.09

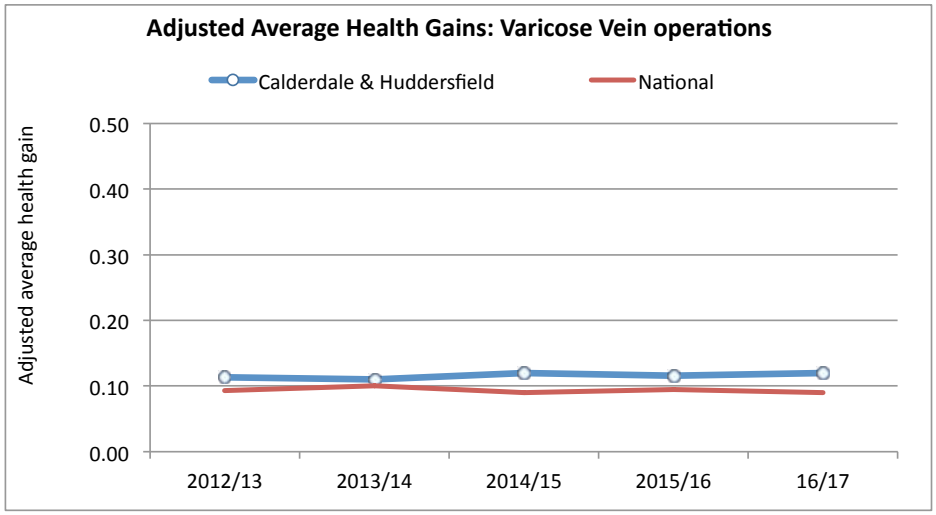


Chart 4b: PROMS – Varicose Veins

EQ-5D

(iv) Knee replacement surgery.

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Calderdale	0.33	0.38	0.32	0.37	0.34	0.33	0.33	0.32
National	0.30	0.30	0.30	0.32	0.32	0.31	0.32	0.32

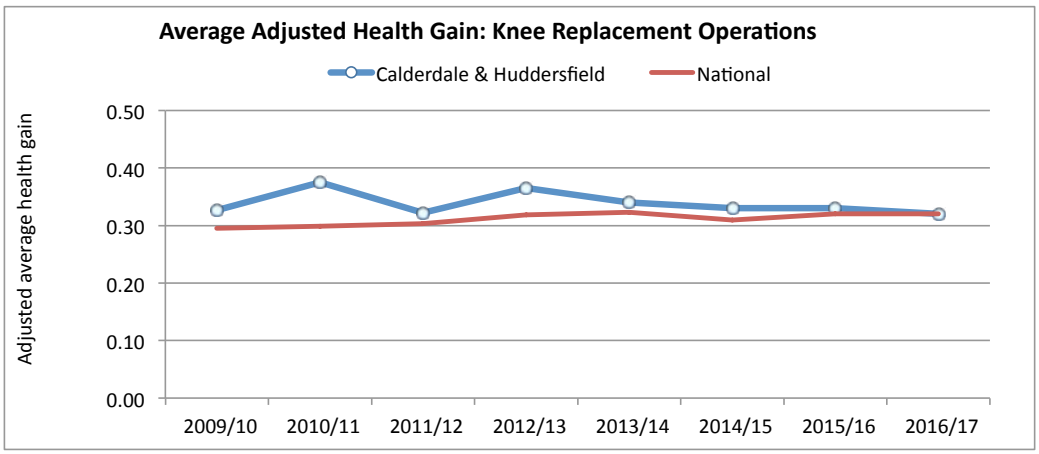


Chart 5: PROMS - Knees

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

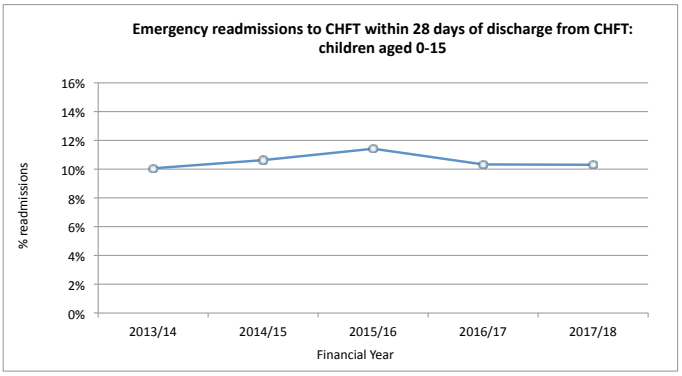
Continuing to ensure this data is accessible at consultant level so it can be used for clinical revalidation and to help drive improvements in practice.

READMISSIONS WITHIN 28 DAYS

The charts show the percentage of patients readmitted within 28 days of discharges, aged:

1. 0 to 15; and
2. 16 and over;

	2013/14	2014/15	2015/16	2016/17	2017/18
0-15	10.06%	10.64%	11.43%	10.32%	10.30%
16+	11.26%	10.80%	11.95%	8.96%	11.10%



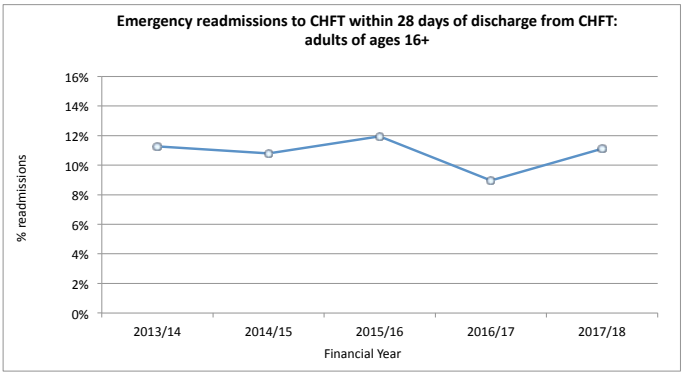


Chart 6: Readmissions within 28 days of discharge

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

- At present there is no national 28 day readmission rate available. The data is not due to be released by NHS Digital until a methodological review takes place.
- Following the implementation of the Electronic Patient Record (EPR) this indicator needed to be reviewed in order to make sense of the new pathways that were available. As such the previous year's performance has also been adapted to reflect the new approach to this measure.
- The data included in these charts differs from the Trust board performance report as the parameters used are slightly different. This variance makes the internal report more meaningful to the Trust.

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

- Through better planned discharges which will lead to fewer readmissions
- Implementation of Safe and Effective Patient Flow Programmes, (see 2018/19 priority two in section two)

Responsiveness to the personal needs of patients (Question 20).
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 2016 survey).

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

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

Calderdale and Huddersfield NHS Foundation Trust consider that this data is as described for the following reason:
The National Inpatient Survey was sent to 1250 patients who had been discharged from inpatient wards at Huddersfield Royal Infirmary (HRI) or Calderdale Royal Hospital (CRH) in July 2016. 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 555 patients who returned completed questionnaires giving a response rate of 47%. This has dropped slightly compared to previous surveys, see the table below:

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

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

Staff Experience

Staff who would recommend the Trust to their family or friends (Question 21)

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

The Trust carried out a census survey in 2017. A total of 2434 colleagues completed and returned the survey to the Picker Institute Europe, our survey co-ordinator. Our response rate was 43% (45% in 2016).

The majority of our scores remained unchanged from 2016. Our best performance areas are:
- Percentage of staff appraised in last 12 months
- Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months
- Percentage of staff able to contribute towards improvements at work
- Percentage of staff experiencing discrimination at work in the last 12 months
- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Our worst performance areas are:
- Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves
- Percentage of staff feeling unwell due to work related stress in the last 12 months
- Organisation and management interest in and action on health and wellbeing
- Quality of appraisals
- Effective use of patient / service user feedback

The staff survey score for indicator KF1 with contributing questions:

Question/ Indicator	CHFT 2017	CHFT 2016	National Average
KF1 - Staff recommendation of the Trust as a place to work or receive treatment	3.63	3.72	3.76
Q21a Care of patients/service user is my organisations top priority	70	77	76
Q21c I would recommend my organisation as a place to work	54	59	61
Q21d If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.	66	68	71

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

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

Question/ Indicator	CHFT 2017	CHFT 2016	National Average
KF25 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White - 28% BAME – 21%	White - 28% BAME – 14%	White - 27% BAME – 28%
KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White – 23% BAME – 25%	White – 24% BAME – 23%	White – 25% BAME - 27%
KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White – 88% BAME – 68%	White – 88% BAME – 76%	White – 87% BAME – 75%
Q17b In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White – 5% BAME – 20%	White – 5% BAME – 14%	White – 7% BAME – 15%

3.3. Summary of all Key Findings for Calderdale and Huddersfield NHS Foundation Trust

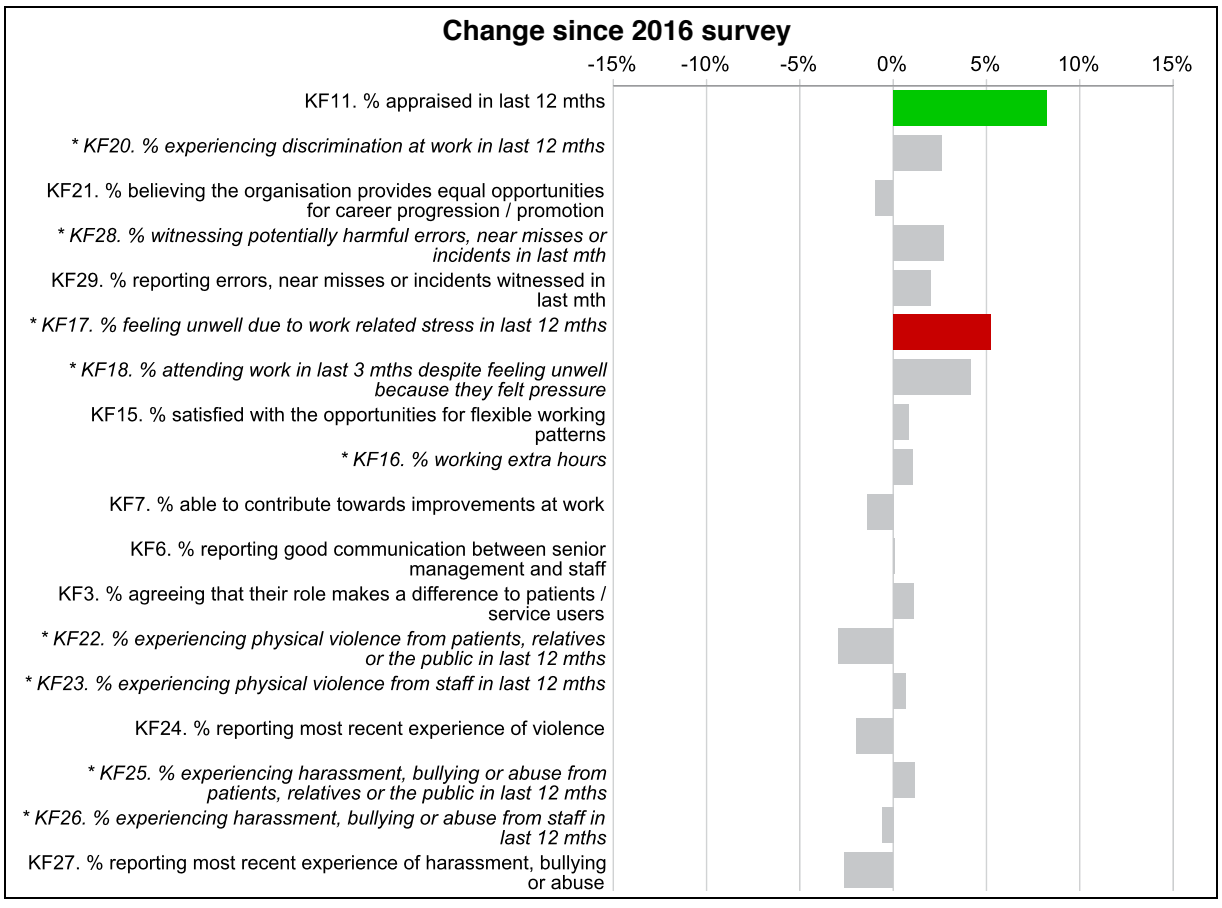
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2016 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2016 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2016 survey.

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 has implemented the Workforce 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

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

Risk assessing inpatients for venous thromboembolism (VTE) is important in reducing hospital acquired VTE. The chart shows the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the report period from April 2017 to February 2018. The target from December 2012 for VTE risk assessment for all patients admitted was set at 95%

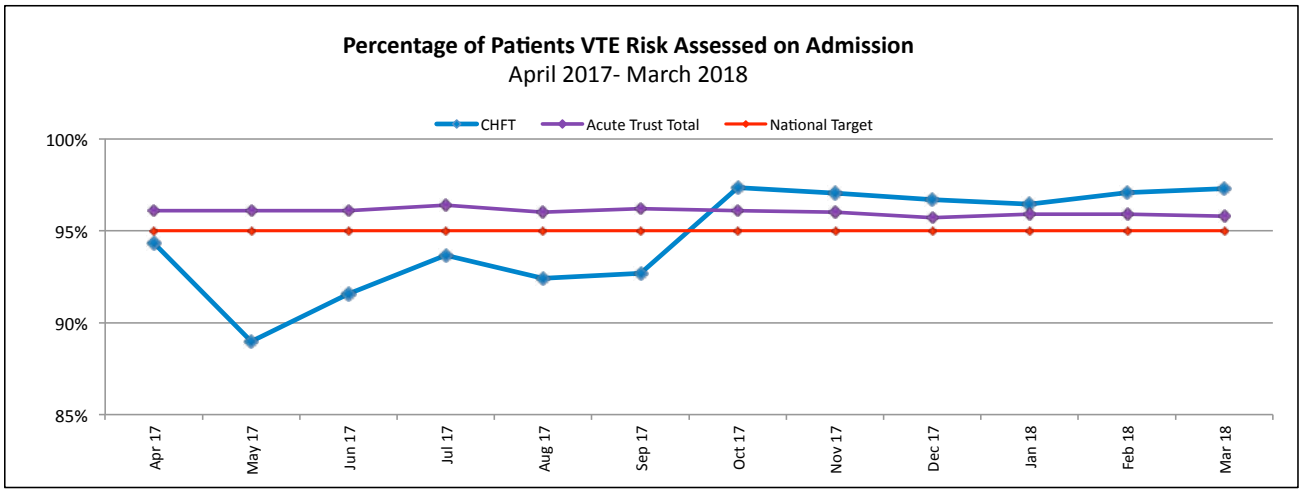


Chart 7: % VTE Risk Assessment Completed

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

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

In the months after the Trust went live with the new EPR system we witnessed a slight drop in performance, which dipped below the 95% target, (as can be seen on the graph above). Following this an extensive deep dive into the areas and patients being cohorted within the data was started, with the help and guidance of the clinical lead for VTE. The cohort arrangements being used had not been reviewed in most cases since 2011, therefore a redesign was required to reflect changes within the Trust in that time.

The new cohorting system that has been designed and signed off for use by the Medical Director now uses a method of looking at the procedure code for the spell, along with taking into account the LOS of the spell.

This involved identifying low risk procedures, and looking at patients with a LOS of less than 24 hours and identifying them as having a low risk of VTE. In doing this it was felt that this was a much more accurate measure of Trust performance around VTE assessments.

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

The benchmarking graph shows the Trust to be in the bottom third of Trusts for Q2 2017/18 data, however as can be seen from the first graph, this position as been improved significantly in Quarter 3 of 2017/18.

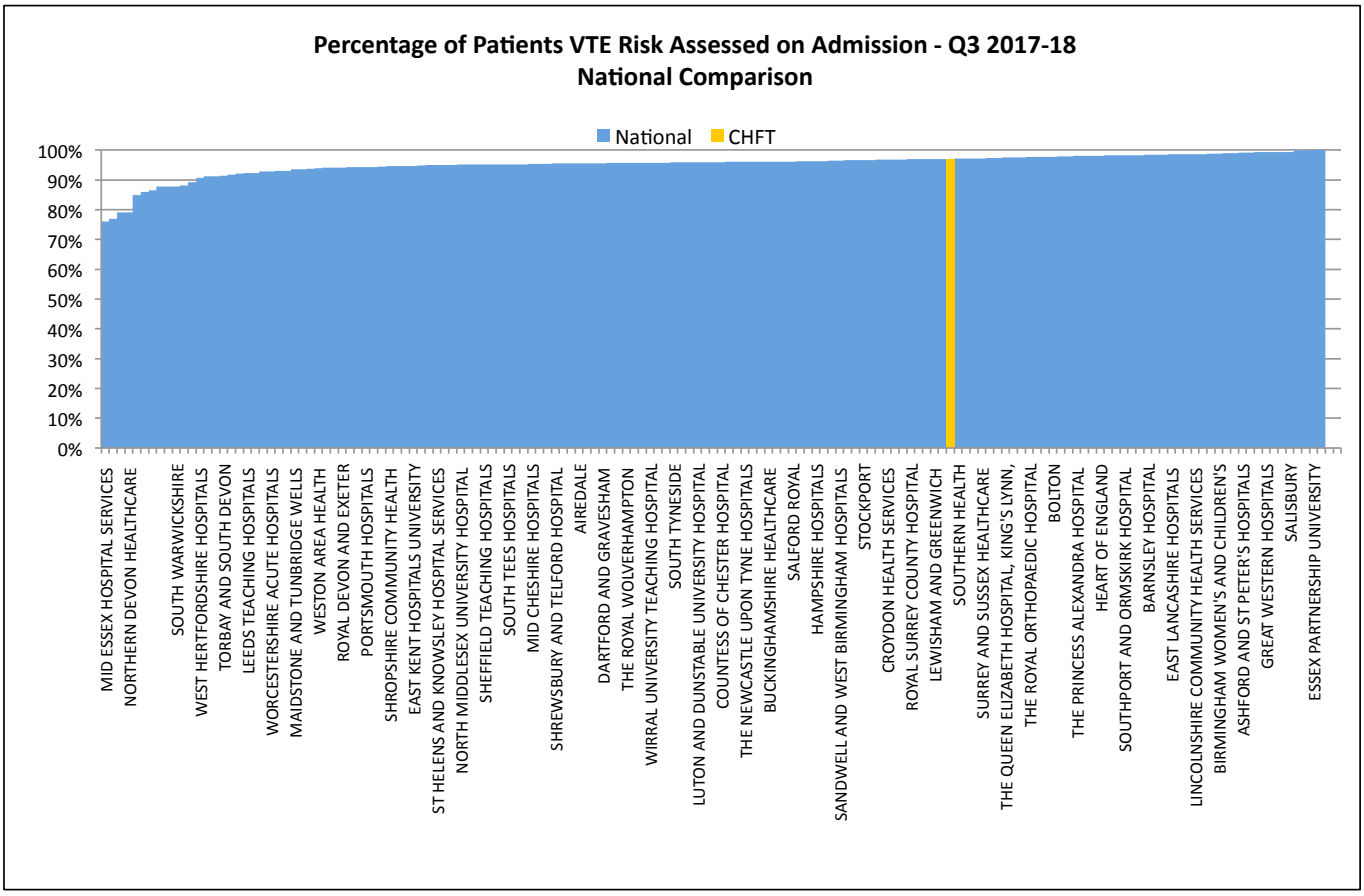


Chart 8: % VTE Risk Assessment Benchmarking

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

- Undertaking work to improve reliability of data and patient care, with work underway to have the VTE assessment incorporated in the new 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.
- Ensuring there is a reliable process so that when hospital associated VTE's are identified they are investigated for any failings of care and actions taken wherever necessary.

Rate of C.difficile per 100,000 bed days (2017/18)

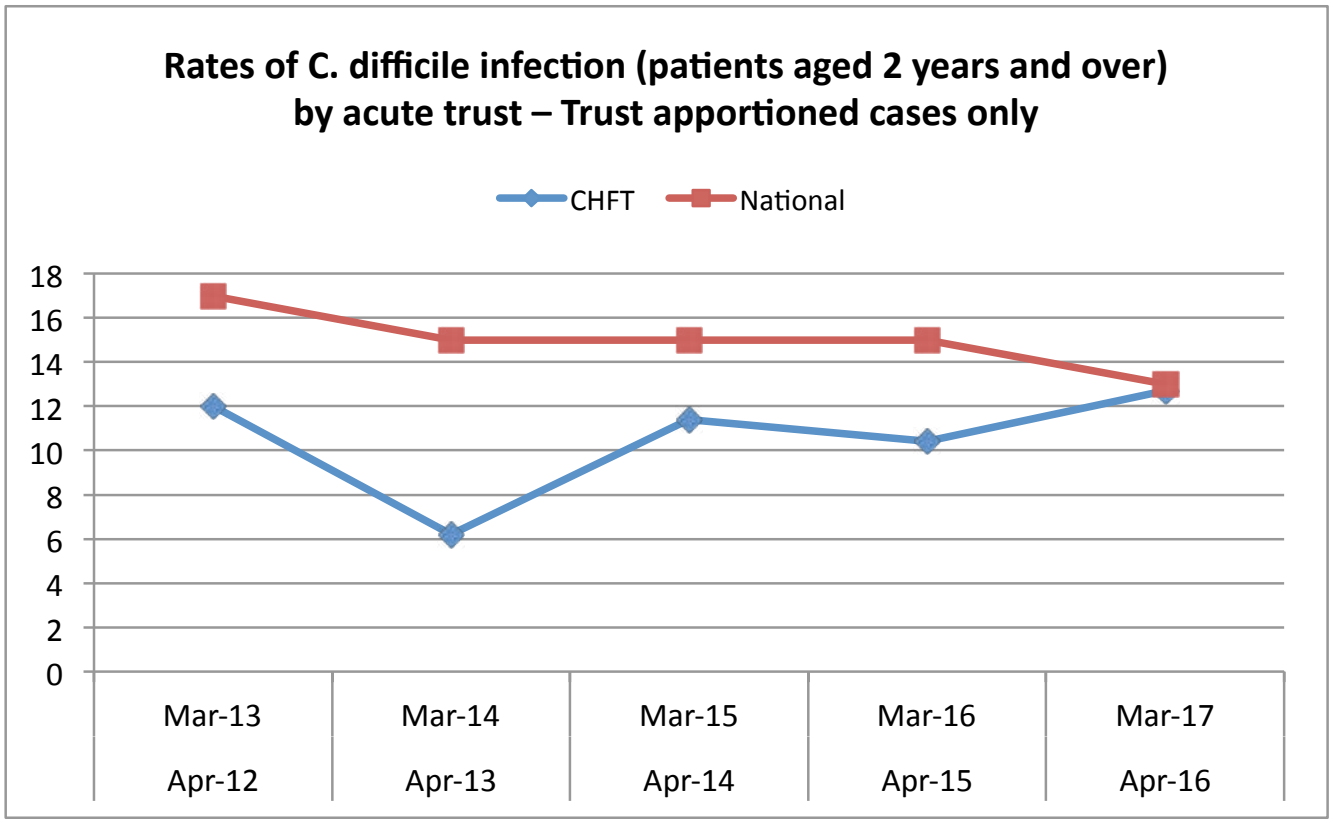


Chart 9: C.Diff Trust apportioned cases

2017/18 has continued to be a challenging year with respect to our absolute numbers of Clostridium difficile infections (CDI), specifically in relation to our performance versus our target.

Whilst we continue to report rates of infection below the national average as indicated in the chart above we have seen a narrowing of the gap.

Of 153 reporting Trusts, Calderdale and Huddersfield NHS Foundation Trust is 61st.

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

At the time of writing the Trust has exceeded our ceiling of cases of CDI by 16 cases (ceiling 21, current position 37 cases). All cases are subject to a root cause analysis which is externally supported, and scrutinised, by our commissioners. In the vast majority of cases, we have been unable to identify specific lapses of care that have directly led to the CDI – the quality of the care provided has been found to be good.

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

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

Serious Incidents

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

Patient safety incidences

The chart above shows the Trust's previous reporting on the National Reporting and Learning Service. Patient safety incidents, reported to the National Reporting and Learning Service, make up 84% of all reported incidents in CHFT. The national levels of reporting continue to rise, but the Trust had seen a reduction in overall reporting. Internal figures indicate that this trend started to reverse, with reported number of incidents increasing in October/ November 2017, and will be reflected in the figures for 2018/19.

The Trust is committed to learning from incidents at all levels, and looks at the prevalence of incidents by theme, producing learning newsletters and "bite-sized" learning to focus attention on identified gaps. The Trust will continue to look at how we can better share and embed learning with all staff to reduce the risk of harm across the organisation.

Serious Incidents

The Trust is committed to improve patient safety by identifying, reporting and investigating serious incidents (SIs), ensuring that actions are taken to reduce incidents reoccurring and that learning is shared across the organisation.

Weekly Executive led panels assess potential serious and severe harm incidents that may meet the reporting criteria. Decisions are collectively made with regard to grading of incidents, duty of candour leads and allocation of investigators.

All serious incidents are reported to commissioners and, as part of the Trust's commitment to openness and honesty, the patient or their relatives receive an apology and are invited to meet to contribute questions to the investigation. A root cause analysis investigation (RCA) is undertaken for each serious incident, producing a report and action plan which is shared with the patient and / or their relatives. Each report is reviewed at the Executive-led serious incident panel to ensure it addresses the root cause of the incident and identifies appropriate actions.

Once approved reports are submitted to the commissioners managers follow up monitoring of the actions arising from the investigation and assurance on this is presented to the Divisional Patient Safety Quality Board.

A Serious Incident Review Group met four times during the year, chaired by the Chief Executive, with membership including senior clinical divisional colleagues. The group provides assurance that the Trust is managing Serious Incidents effectively, identifying themes, and seeks assurance that learning from SIs is shared across the organisation. The group reports to the Quality Committee.

The Quality Committee receives information on new serious incidents, and recommendations and actions being taken to reduce risk. In 2017/18, the Quality Committee also received an assurance report on progress across the Trust with implementation of actions arising from serious incidents.

Themes and trends: The three most frequently reported serious incidents in 2017/18 were:

Incident Type	Number in 2017/18	Comment
Falls with harm	16 incidents	A Falls Collaborative is working on improvements supported by the Improvement Academy.
Pressure Ulcers	5 incidents	There is a new Pressure Ulcer investigation tool to help better understand why pressure ulcers arise.
Infection	5 incidents,	This represents 4 serious incidents, as two incidents were investigated as one due to apparent transmission from one to the other. In 2017/18 there has been a review of the hand hygiene audit process, to strengthen this, a peer review of the weekly environment audits, a revision of the audit and a deep clean of Huddersfield Royal Infirmary undertaken.

Investigations into these incidents enable us to identify and undertake preventative work to improve patient safety.

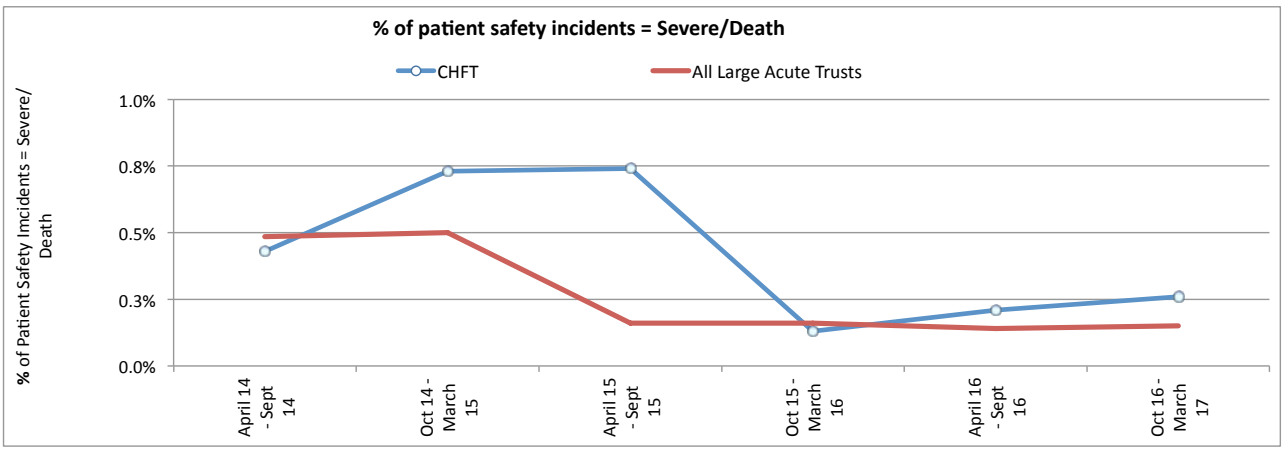
Never Events

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

Over 2017/18 the Trust has reported one never event. This was a wrong site surgery, where the wrong ureter was stented initially, but the error recognised and the correct ureter stented while the patient was still in theatre. No harm was sustained by the patient as a result of this error.

(ii) % of Patient Safety Incidents graded as Severe/Death

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



The chart demonstrates an increase in incidents of severe harm or death in relation to other organisations to March 2017.

There has been an indication in 2017/18 of a reduction in the most severe harm incidents, while an increase in orange, or moderate harm. This reflects the approach to score incidents initially as orange and investigate, reassessing the actual harm following the investigation.

Patient Incidents by Severity

CHFT Incidents	2015/16	2016/17	2017/18	movement
Green	6467	6337	6677	↑ 5%
Yellow	1955	1478	1354	↓ 8%
Orange	130	165	211	↑21%
Red	44	74	59	↓21%
Totals	8596	8054	8297	↑ 3%

Green / Yellow Incidents (No / low harm)
There has been an increase in incident reporting in 2017/18 in comparison to 2016/17, reflecting an improvement in incident reporting from October / November 2017 onwards. High levels of incident reporting are a positive indicator of a safety culture; in Calderdale and Huddersfield NHS Foundation Trust, over 95% of the incidents reported were zero or low harm. Work has started to help staff to explore and understand the range of incidents which should be reported, so we can better address risks to patient safety from low level harm incidents.

Orange incidents (moderate harm)
Throughout the Trust, weekly incident panels for those incidents that have caused moderate harm have continued to take place at a divisional level, ensuring a robust process for assessing incidents, reviewing completed investigation reports and ensuring effective communication with those affected by the incident, known as duty of candour is completed in a timely manner. The increase of orange incidents shows that more divisional investigations are taking place to improve patient safety and support staff in learning from incidents.

Red incidents (serious incidents)
In 2017/18 59 incidents were severity rated as "red – serious" and reported to the Clinical Commissioning Group as per the requirements of the National Serious Incident Framework. Not all of these were incidents resulting in severe harm or death, for example, a 12 hour breach resulted in no physical harm, and the investigation recognised excellent adherence in the Emergency Department to patient dignity and provision of food and fluids throughout. A review of the conclusions in the serious incident reports indicates that serious harm was evident from the incident in approximately half of the cases. A further two cases were rated as orange but investigated at red. The advantage in reporting an incident as red ensures a high level root cause analysis investigation, with an investigator independent to the service where the incident occurred. The investigation is then subject to robust scrutiny.

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

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

The patient or relatives involved in a serious incident are invited to contribute questions to the investigation, and once a report is completed patients and relatives are routinely offered a meeting with staff to discuss the report, unless they have previously indicated that they do not wish to meet.

The Trust is continuing to work towards further improvements in the duty of candour process, to ensure we are supporting patients and families involved in significant events better. Work has commenced to introduce further support to those patients or families who have been distressed by an incident of moderate or greater harm.

Part 3: Performance on selected quality indicators

This section provides an overview of care offered by the Trust based on its performance in 2017/18 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
	Safe and Effective Care (previously LoS 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 NHS Digital looks at patients who had died either in hospital or within 30 days of discharge.
2. The HSMR is a long standing national measure which only looks at those patients who die during their hospital stay.

Our most recent HSMR is shown below (accessed 14/04/18)

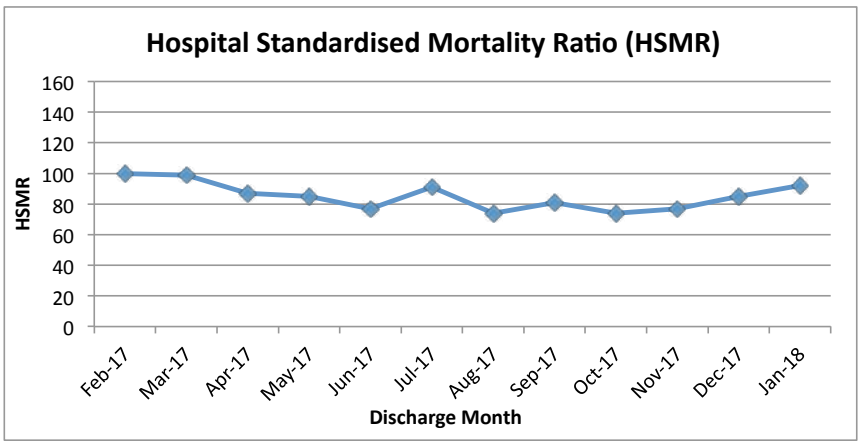


Chart 12: HSMR

See Part 2 for a look into our SHMI performance and work on the Mortality Case Note Review programme. (page 20)

Falls in Hospital

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

The fall improvement collaborative has continued in 2017/18 with a monthly falls dashboard has been introduced to provide an overview of falls incidents and key themes to share learning to heighten awareness on preventative actions to reduce falls. Most wards now have a "days between falls "board to support improvement work and several success stories of 40 days plus between falls. An internal 'falls prevention gets attention' campaign was launched to brand this work and an awareness day in May 2017 resulted in increased awareness across the Trust.

There has been ongoing work to devise safety huddles across medical wards –these are being supported to provide a multidisciplinary focus on falls assessment and preventative intervention. There is evidence from the medical assessment unit (MAU) at Calderdale Royal Hospital (CRH) that three times daily huddles and targeted work on intentional rounding has reduced falls .The leadership and involvement from the clinicians have played a valuable part in this work.

There is ongoing emphasis on falls monitor training monitored monthly via medical device training. Post falls investigations have shown that a falls monitor is not appropriate for some patients and alternative interventions should be utilised. The emphasis remains with the registered nurse's clinical judgement and individualised patient review and evaluation on the ongoing use of the alarms.

Several incidents have identified that the alarms have caused unnecessary levels of agitation for patients so are not an appropriate intervention for continued use.

Patients are encouraged to wear their own clothes and footwear as this encourages an individualised dignified approach. Social mealtimes wherever possible on the ward may also provide an opportunity for routine.

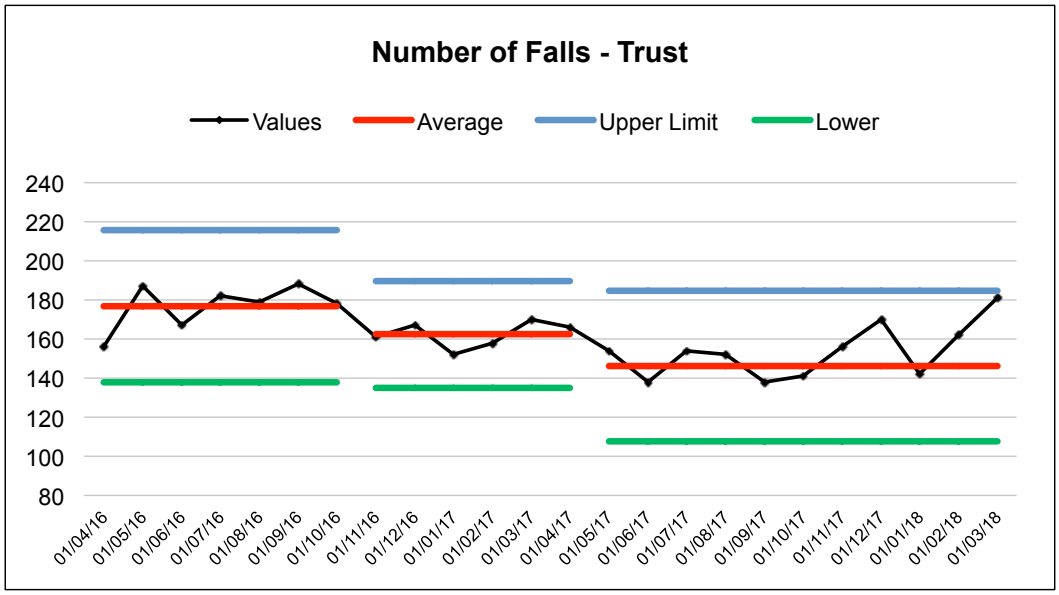


Chart 13: Number of Hospital Falls

The chart above shows the number of falls reduced from an average of 166 in 2016/17 to 147 in 2017/18. There has been some in month increases as operation pressures increase but the total number of falls for 17/18 compared to 16/17 reduced from 2045 to 1854. There has also been no adverse increase in the number of harm falls.

Improvements for 2018/19

- Further focused work is required as a result of the national audit of inpatient falls (November 2017) in the areas of poor compliance.
- EPR includes a risk assessment tool however this needs to be a focus for further work as compliance noted via incident reports shows that initial assessment and individualised care plans are not being undertaken.
- Ongoing emphasis on falls monitor training monitored monthly via medical device training.
- Development of falls awareness training as an essential skill for target clinical audience and included in the nurse induction programme, both linked to ESR introduced November 2017 with latest compliance figures of 74.48 %(Jan 2018).
- Focused work on tag bay nursing as an intervention for high risk patient with individualised organisation of care and interventions to minimise risk of falls.
- Enhanced support workers have been an invaluable care interventions for our most vulnerable patients however further investment in training and recruitment and retention is required

Healthcare Associated Infections (HCAIs)

The Trust monitors and reports infections caused by a number of different organisms or sites of infection. These include:

- Methicillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infections
- Methicillin Sensitive *Staphylococcus aureus* (MSSA) bloodstream infections
- *Clostridium difficile* infections (discussed elsewhere)
- *Escherichia coli* bloodstream infections
- Central venous catheter infections
- Colonisations/infections with Carbapenemase producing Enterobacteriaceae (CPE)

MRSA (Methicillin resistant Staphylococcus aureus) Bacteraemia:

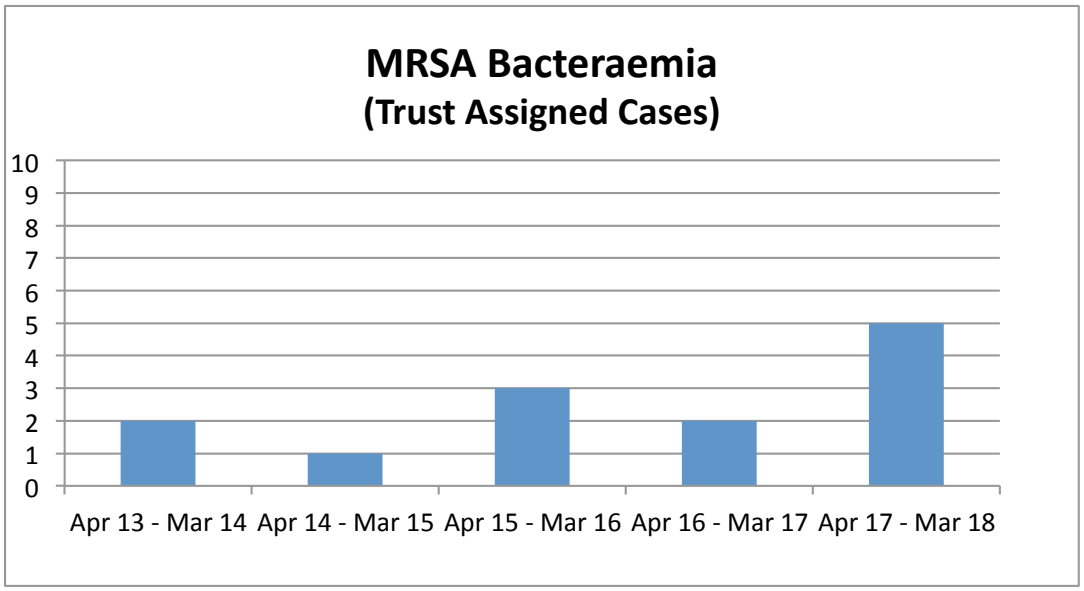


Chart 14: Number of MRSA Cases per year

We have seen an increase in MRSA bacteraemia during the last year, five bacteraemia have been reported since April 2017. All have been subject to a post infection review as per national process. Learning has been incorporated in the Trust Infection Prevention and Control action plan.

MSSA (Methicillin sensitive Staphylococcus aureus) bacteraemia:
MSSA bacteraemia is not subject to targets in contrast to MRSA bacteraemia. However, mandatory reporting of MSSA bacteraemia is required. In the year to date 20 cases have been reported. These are not subject to a formal post infection review, limited MSSA screening is in place for a select group of patients including patients with central venous catheters.

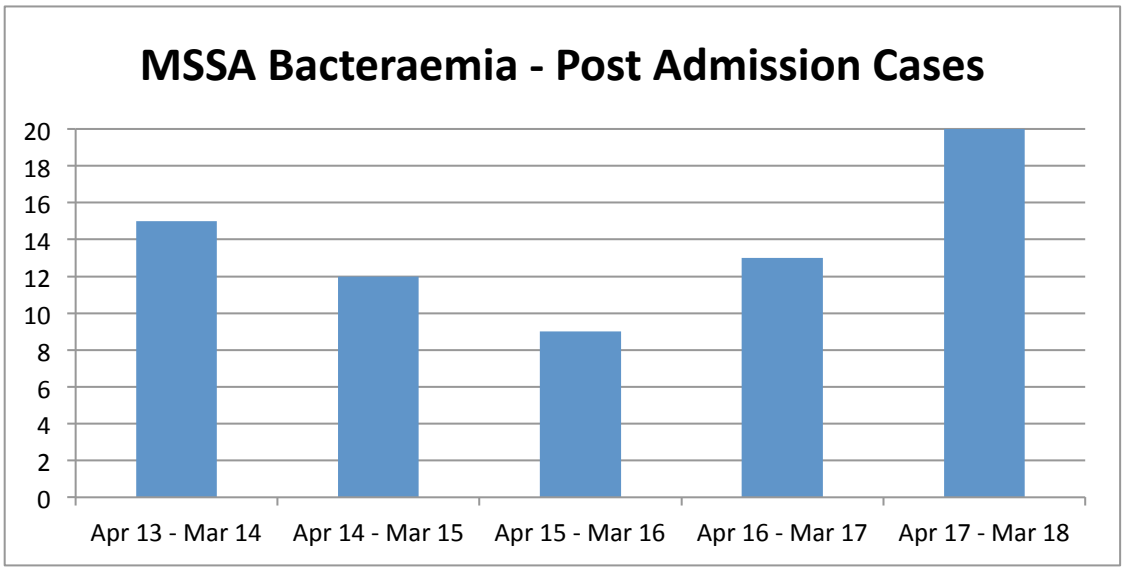


Chart 15: Number of MSSA Cases per year

E.coli bacteraemias:
There is currently no national reduction targets for E. coli bacteraemia, however mandatory reporting of E-coli's is required, and in the last year 45 cases have been reported to date. A review of cases indicates the majority of these are sporadic, although a small number are associated with the use of urinary catheters. Measures to tackle E. coli bacteraemia are ongoing within the organisation.

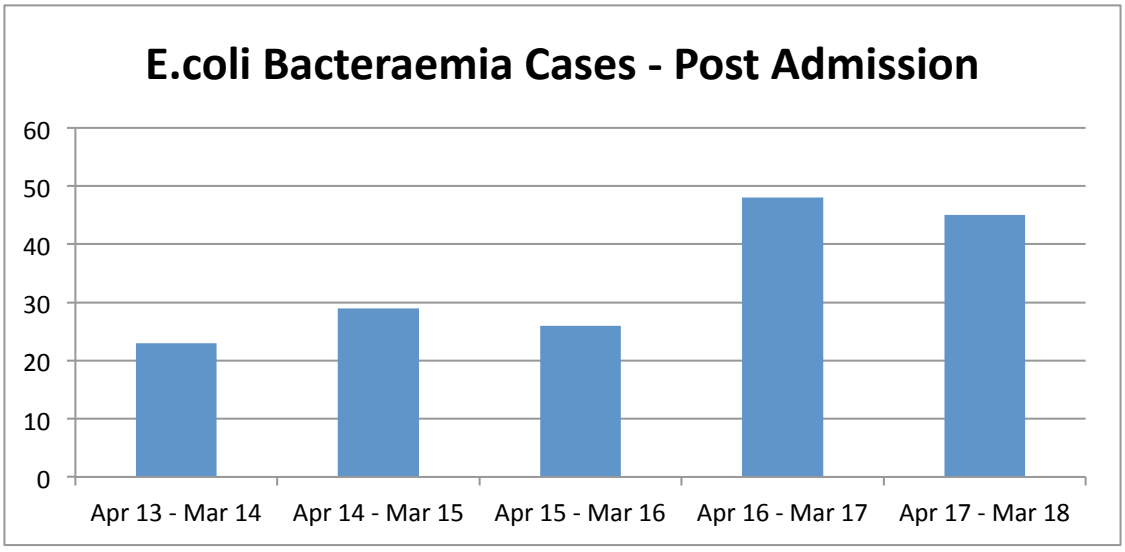


Chart 16: Number of E.coli cases per year

Central Venous Catheter Infections:
The Trust continues to report low levels of central venous catheter infections. For the 12 month period ending in February 2018, we reported a cumulative infection rate per 1000 CVC days of 0.48. This is well below our internal target of 1.0 per 1000.

Colonisations/infections with Carbapenemase producing Enterobacteriaceae (CPE):
In line with national guidance from Public Health England, all overnight admissions to the Trust are screened for risk factors for colonisation/infection with CPE. All patients in whom a risk for colonisation or infection is identified are offered microbiological screening. Over the past three years, 11 patients have been identified who are colonised with CPE. The Infection Prevention and Control Team support clinical areas with enhanced infection control precautions when these patients are identified.

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

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

Cancer Waiting Times

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

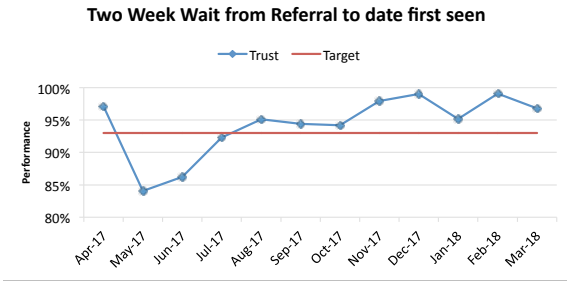
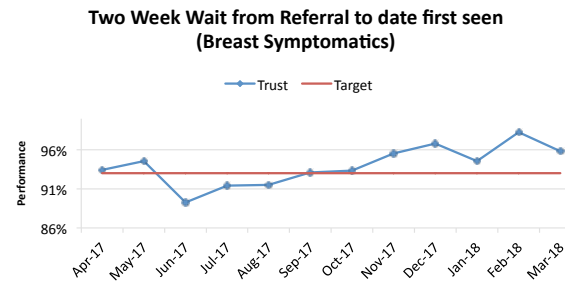
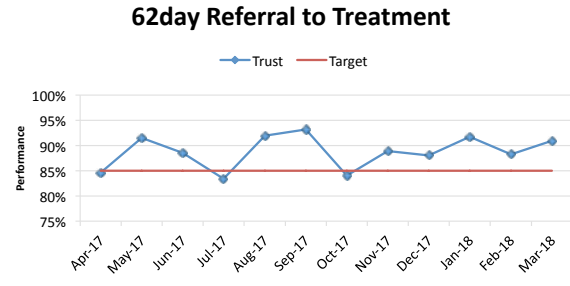
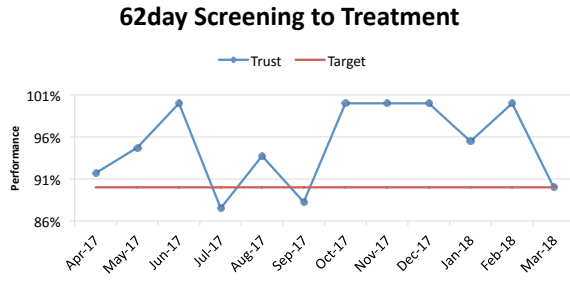
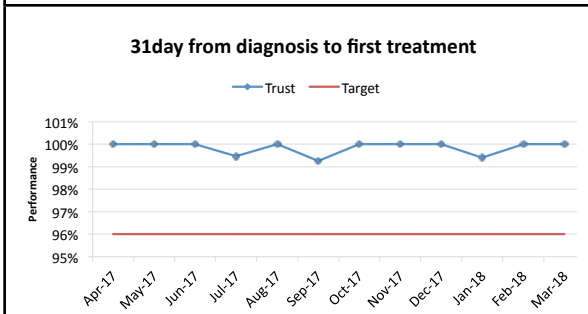
	The performance required for this target is 93% and Over the last year as can be seen from the chart the Trust had a large dip in performance. This unfortunately was due to the introduction of the new electronic system in the Trust. This has now been rectified and changes have been made with the team so that they are working very closely with the patient pathway coordinators. Performance is now on track.
	The performance required for this target is 93% and Since September 2017 this has been achieved. The Trust had a dip in performance from June to September again this was due to introduction of the electronic system as for the 2 week waits above.
	The performance required for this target is 85%. Unfortunately there have been a couple of months that the Trust has not achieved this target. There has been an action plan produced which has gone to the Directors and work is taking place with the teams to review pathways.
	The performance required for this target is 90% and the main issue has been bowel screening that has not achieved the target due to a variety of reasons, e.g. the patient feels well so there are many delays to diagnosis due to patient choice (holidays etc.) Also the conversion rate and numbers treated are low therefore the tolerance for breaches is extremely small making 90% often difficult to achieve.
	The performance required for this target is 96%. This is consistently achieved. The last recorded month failure of this target was June 2008.

Chart 17: Cancer Waiting

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 year to date 30% of patients are being seen within 7 days of referral which compared to the 46.8% we were achieving 2017. However it is felt to ensure the Trust meets the other targets this should be made a priority by all tumour sites. The Directors are supporting the improvements that need to be made.

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

The Trust has issues meeting the target of referring 85% of patients to tertiary centres by day 38 of their pathway. The year to date Trust position is 44.14%. Unfortunately this is little improvement from last year. The work on going with the teams and the improvements mentioned in the document will hopefully improve this performance. This is being closely monitored.

Improvement Plans 2018/19

Over the last year and continuing into 2018/19 the West Yorkshire and Harrogate Cancer Alliance have been reviewing all tumour site pathways and gaining agreement from Clinicians to follow these pathways. This gives the District General Hospitals a minimum data set that must be completed prior to referral on to the Tertiary centres and aids consistency across the region. Ultimately this will aid the inter provider transfer date which is referral by day 38.

The Trust has an action plan which is reviewed by the Weekly Executive Board (WEB); the next review is due at the end of April. This encompasses actions such as to ensure patients are seen within seven days of referral, patients are sent to tertiary centres by day 38, reviewing the length of time it takes for patients with a benign disease to be informed of their diagnosis.

Tumour site specific self-assessments for 2017/18 have been completed and reviewed by WEB; individual plans have been developed and considered against the quality surveillance team (QST) measures. The Clinical Commissioning Groups have reviewed and agreed the individual plans and have the power to request an external visit if necessary. The QST process for 2018/19 is dues to start in April and each tumour site will develop action plans based on their new self-assessment.

The Trust has achieved some funding from the Cancer Alliance to pilot four schemes, see below:
Vague symptoms pathway

- FIT Testing (Faecal Immunochemical Test)
- Workforce redesign , including advanced Practitioners in cellular pathology and workforce role redesign in endoscopy

These will commence in April 2018 and will run for 12 months, the teams will report to the Cancer Alliance and the Trust. The main aim of all the schemes is to try to improve earlier cancer diagnosis.

Cancer Site Specific and Specialist Palliative Care teams update

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

Acute Palliative Care

A pilot commenced in October 2017 at Huddersfield Royal Infirmary. The aim of the pilot was to provide acute palliative care In the Emergency Department and Medical assessment unit, to reduce admissions by appropriate nurse led triage and management of palliative and end of life patients and where possible to facilitate rapid discharge.

Across the board, the aim is to identify patients in the last 12 months of life, and to offer an holistic assessment to them including advanced care planning which will facilitate admissions avoidance (where appropriate).Increase palliative care and end of life care knowledge for ward/departmental staff in the delivery care in the last days/hours of life.

Palliative Care in Stroke
A pilot commenced on the Stroke unit in October 2017, this has funded a specialist palliative care nurse to work 2 days a week solely on the stroke unit. The nurse is working with whole multidisciplinary team to encourage thought around decisions about end of life care and nutritional issues. The nurse is joining the family meetings to aid discussions around advanced care planning to ensure that quality of care improves.

Lung Cancer Follow-up
A recent pilot of nurse led follow-up for patients with lung cancer has shown increased compliance with the cancer pathway due to increased consultant capacity for new patients. With recently agreed extra funding this will be formalised during 2018, where further nurse led follow-up can be optimised.
Cancer Psychological Services

Psychology services for cancer patients have developed significantly during the last year. Since March 2017 all patients with cancer have some access to level 4 psychological support, this is in line with Supportive and Palliative Care NICE Guidance. For the first time each cancer site specific team now has at least one member who has completed training to deliver level 2 psychological support to their patients and carers. The individuals who have completed their level 2 training have on-going access to clinical supervision. In recognising that the cancer care coordinators deliver a large element of face-to-face care with cancer patients, the clinical psychologist also offers the individuals in this role an appropriate level of supervision and was presented with the 'Going the Extra Mile' award at this year's Celebrating Success awards.

Living With and Beyond Cancer
Cancer patients now access to regular health and wellbeing sessions, the aim of these sessions is to empower patients to self-manage following completion of their cancer treatment. The sessions support physical and emotional wellbeing whilst also promoting a healthy lifestyle. Empowering the patients enables individual teams to further stratify follow-up for low-risk (of recurrence) patients.

To meet the changing landscape of cancer treatment and a 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 are changes 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 role is the 'Cancer Care Co-ordinators'.

These are non-registered roles, but provide support to patients and co-ordinate all the other referrals to 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.

Throughout 2017 CHFT cancer teams will be working in line with the recommendations from the World Class Cancer Outcomes Strategy 2015-2020 and the National Cancer Patient Experience Survey, we will deliver the living with and beyond cancer agenda, offering health needs assessments at strategic point in the patients pathways, care plans with long term side effects and how to access specialist services at a time when patients need them as well has health and well-being events being offered.

Stroke

There are more than 100,000* strokes in the UK each year, that is around one stroke every five minutes in the UK.

- Between 1990 and 2010 the incidence of strokes fell by almost a quarter. Around 1 in 6 men will have a stroke in their life and around 1 in 5 women will have a stroke in their life.

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

It is accepted that 85% of strokes are due to cerebral infarction, 10% due to primary haemorrhage and 5% due to subarachnoid haemorrhage. The risk of recurrent stroke is 26% within 5 years of a first stroke and 39% by 10 years. By focusing on improvement in stroke care, patient outcomes can be vastly improved.

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

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

Improvements in 2017/18:

The whole of the Stroke unit is now on one floor which aids seamless flow for the patients, relatives, Nursing, allied healthcare professionals and doctors. As patients progress from being acutely ill to their next stage of rehabilitation the staff seeing them can discuss goals with the staff caring for them and ensure their care is not disrupted in any way.

A pilot commenced on the Stroke unit in October 2017, this has funded a specialist palliative care nurse to work two days a week solely on the stroke unit. The nurse is working with whole multidisciplinary team to encourage thought around decisions about end of life care and nutritional issues. The nurse is joining the family meetings to aid discussions around advanced care planning to ensure that quality of care improves and all parties are happy with the pathway.

The monthly Clinical Governance meeting for the whole multi-disciplinary team has been reviewed so that it is more inclusive of all staff. The first part of the meeting is around the departmental business i.e. Risks, Governance, mortality, targets etc. and
the second half is around learning e.g. learning from complaints, incidents mini audits undertaken by staff all grades of staff are encouraged to attend.

Following the pilot held on one of the rehabilitation wards, the team has implemented a change to working patterns for doctors, therapists, nurses and social services. The team has secured a new consultant who will hopefully start in the summer of 2018. Each morning there is a multi-disciplinary team meeting to discuss every patient and what is happening to the patient, their needs any risks that need to be addressed and the goals that day and the next week. This has led to increased patient and family satisfaction and also staff satisfaction as they feel they are working as a team.

Recruitment has been difficult and to try to improve this, development band 6 posts have been put in place. Also to aid succession planning to the small team of thrombolysis nurses two development posts have been appointed to; initially these will work partially on the ward and as a thrombolysis nurse. This has been a successful way forward for recruitment

The first chart relating to the four hour direct admission is variable. Any patients that are brought to CRH for thrombolysis are all admitted. The trend is that the patients that are not achieving this target are the patients that are not initially diagnosed as a stroke or attend the HRI Emergency Department (ED). It is felt with the plan for the assessment beds in the ED will reduce number of stroke that are miss diagnosed and will ensure patients are seen by the right clinician initially.

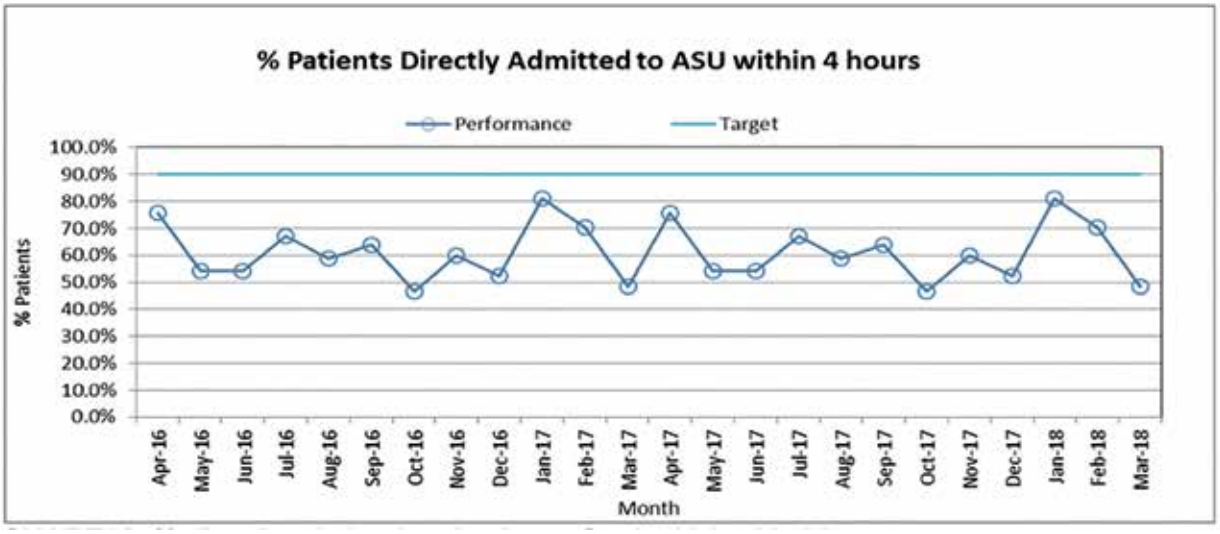


Chart19: % directly admitted to the Acute Stroke Unit with 4 hours

The second chart shows the percentage of patients diagnosed with a stroke that spent more than 90% of their hospital stay on a specialist stroke ward. Performance has remained variable throughout the year; though there has been a step change over the last 18 months. Again patients need to be admitted to the Stroke unit immediately so that this can be achieved.

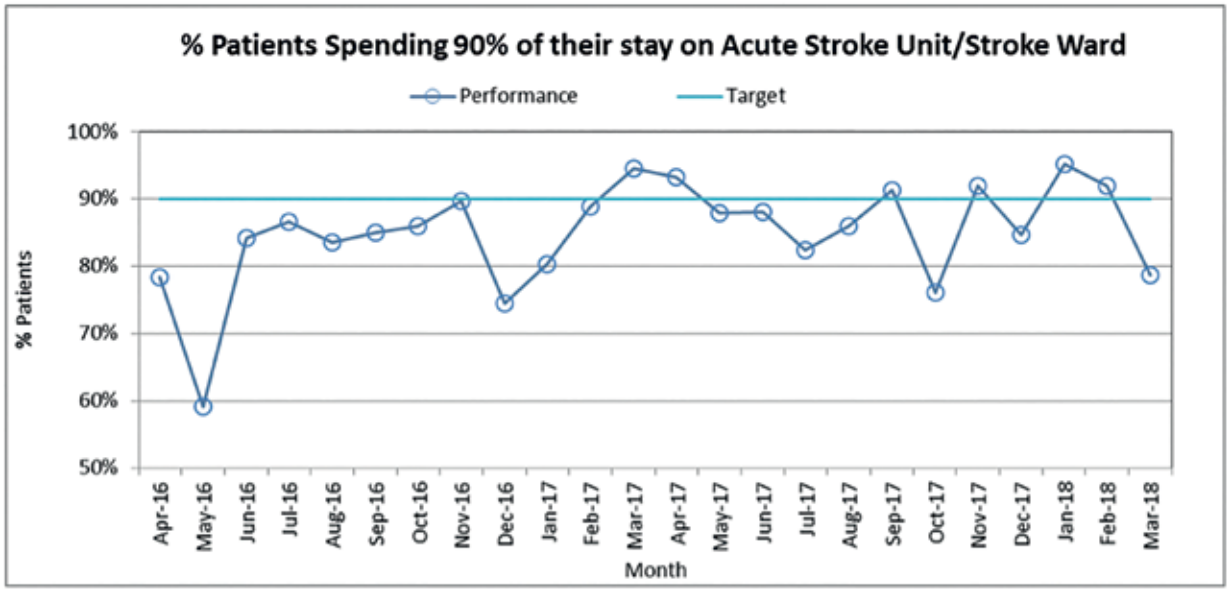


CHART 20: % of patients spending 90% of their stay on the ASU

Plans for 2018/19

The main area that the team wish to improve is the commencement of a stroke assessment area in the Emergency Department. The consultant and thrombolysis nurse will see patients with neurological conditions and determine whether they are a stroke or not. This will ensure that the patients are directed to the correct care area immediately; which in turn should result in better outcomes for patients as they will be cared for by clinicians with the specialist knowledge.

Discussions are underway with the CCG's regarding rehabilitation and what environment is the best area for the patients to be cared in; i.e. in the community rather than in a hospital.

The team wish to improve their SSNAP score (Sentinel Stroke National Audit Programme) to an A from a B which is another indicator that the Trust is proving excellent care to their patients.

End of Life Care

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

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

Many of the actions from 2016/17, and our achievements linked to these, remain valid, and significant progress has been made during 2017/18 in many areas. However, it is clear that continued work is needed to improve both the recognition of patients in the last year and last days of life, and communication with them and their families. Linking together the work of the Learning from Deaths (LfD) umbrella, the EOLC strategy, which is to be reviewed and updated this year, the EOLC steering group and other initiatives will enable this improvement.

Key issues, achievements and suggested plans for 2018/19:

Better identification/recognition of patient in the last year: the preliminary feedback from the Macmillan MAU/ED project at HRI has identified high numbers of patients presenting acutely who are likely in the last year of life. Suggested improvements include the use of prognostic tools by clinical teams. Earlier recognition of these patients in community will also be needed.

Better management of the last days of life: the use of the ICODD (Individualised Care of the Dying Document) has fallen since the advent of electronic records in May 2018. Work has begun to create a version of the ICODD within EPR. A dedicated learning DVD resource has been created and will be added to the learning platform for clinical staff, and other resources also developed.

Specialist Palliative Care Team (SPCT) activity: we have been recording patients' phase of illness and Karnofsky performance score for almost three years now, and the proportion of patients referred to the SPCT who are either deteriorating or actively dying on first assessment has increased threefold and fourfold respectively in the last two years, reflecting a much sicker and needier hospital population. A broader skill mix within the team and collaboration with the frailty team and discharge team may be one way to address these pressures.

Education for clinical staff: communication skills training will be delivered to 15% of staff in targeted areas, and all new nurses joining the Trust receive essential skills training in EOLC. Hundreds of staff have been educated by members of the training team, in a variety of settings. New resources are being added to ESR, where appropriate levels of EOLC training will be delivered to all staff, dependent on their roles. Linking learning on EOLC more formally to the appraisal and revalidation process would also be a helpful process.

Audit, review and user experience: plans are in place to obtain more robust feedback from bereaved relatives by way of an initial pilot within the stroke wards, and later in the year, our participation in the national Care at the End of Life (NACEL) audit will incorporate bereaved relatives' feedback, as well as audit of organisational standards and clinical care given to patients dying in May 2018. The requirement for all deaths to be reviewed by consultants, and for a selection to undergo more critical analysis by the team of structured judgement reviewers, will also inform the process by which we address deficits within care delivery and learning needs.

Seven Day Services

A series of clinical standards for seven day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh. Ten standards were agreed and have been rolled out across the NHS England in acute hospitals. Four of these standards were identified as priority clinical standards on the basis of their potential to positively affect patient outcomes. These are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

The purpose of the standards are to deliver safer patient care, to improve patient flow through the acute system, to enhance patient experience of acute care, to reduce the variation in appropriate clinical supervision at weekends and potentially, to mitigate the excess mortality that has been shown in large studies to be associated with weekend admission to hospital.

The Trust participates in regular surveys to gauge progress and compliance against these four priority standards. In March 2017, all four priority standards were audited, in September 2017 only standard 2 was audited. CHFTs most recent results are below;

Survey Results			
Standard	**Overall Result**	**Target**	**Survey**
Standard Two- Time to first review	93%	90%	September 2017
Standard Five- Access to Diagnostics	80%	90%	March 2017
Standard Six- Access to Interventions	100%	90%	March 2017
Standard Eight- Ongoing review	90%	90%	March 2017

CHFT was one of only four acute Trusts in the north of England to achieve the target on standard 2 in the September 2017 survey. These results have been formally fed back to the Trust Board and some areas of focus identified, particularly regarding access to diagnostics.

The next survey will be in April 2018. In this survey all four priority standards will be measured. In preparation for this the Trust lead of seven day services is working with clinicians and managers to keep delivery of seven day services as a priority for the organisation, asking for progress against not only the four priority standards but also evidence that the further six are being considered in service planning.

Patient Experience

1. Aims and Objectives of Work

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

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

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

2. Feedback methods

The primary method of measuring the patient experience in the Trust remains through the Friends and Family Test (FFT) which is now well established across all inpatient and day case areas, as well as in the A&E and outpatient departments, maternity services and across community services. More innovative approaches continue to be introduced to gather feedback and create opportunities to 'listen', through a range of feedback options that sit alongside the more formal methods of FFT, complaints, patient advice service and surveys.

Over the last 12 months wards and departments have used a variety of other methods to encourage patient feedback, examples include direct contact through rounding by the ward managers and matrons, debriefs, guest books and graffiti boards. Opportunistic engagement is also carried out to gather service user opinions to support improvements the teams are taking forwards, as well as more formal enquiries to support service evaluations.

3. Friends and Family Test

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

Top 20%	Super Green
50%-79%	Green
21%-49%	Amber
Bottom 20%	Red

Information for the year for the FFT response rate as well as the percentage who would recommend the service is given below.

2017/8 % Response Rate & Would Recommend

	2017/18 Response Rate	2017/18 Would Recommend
Inpatient	31.4%	96.9%
A&E	10.2%	85.0%
Maternity	41.0%	97.6%
Community	6.5%	90.0%
Outpatients	10.1%	89.7%

4. Local Quality Improvement Work

The Trust Patient Experience and Caring Group has taken forward a number of priorities over the last 12 months, below are some examples of these.

4.1 PRASE (Patient Reporting and Action for a Safe Environment:

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

The questions are linked to 8 safety domains:

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

Results for surgical wards have shown some excellent results, with feedback around 'communication and team work' and the responsiveness of staff to answering buzzers being particularly positive. Some opportunities for improvement were to improve 'organisation and care planning', with one ward conducting improvement work to help ensure staff and patients are aware of the plan of care and another ward making better use of ward space. The initial surveys were undertaken on some of the surgical wards, they have now been rolled out to other areas - medical and paediatric wards.

4.2 Experience Based Co-design (EBCD):
The Trust's Patient Experience and Caring Group have championed the use of EBCD as an opportunity for service users and staff to come together to design, monitor and improve the care provided. The Trust held two events during 2017 related to the reconfiguration of medical services - Respiratory and Frailty.

Outputs from the frailty event included working with patients to:
- Develop a patient/carer leaflet (draft shared with those present)
- Include information about tests, results and follow ups on the leaflet – discuss with patients/carers to assess whether this would provide the information they need (draft has been sent to EBCD participants)

Other ideas for improvement have been taken forward via the Frailty Operational Group:
- Development of staff competencies, including implementing advanced care plans
- Training staff to advanced practitioner level

An event relating to End of Life care has also been held, dignity symbols, a bereavement card and a 'coffee mourning' were examples of ideas discussed and agreed and are being taken forward through the end of life care group.

A final event relating to high risk antenatal services is scheduled for May 2018.

4.3 Divisional reporting:
The reports received quarterly from divisions have been redesigned in order to increase the opportunities to share:
- how teams have responded to patient feedback along with examples of innovation
- examples of improvement work related to the experience of service users with one of the 9 protected characteristics and any improvements made to make the physical environment accessible to all
- any opportunities taken to involve our patients / public in service improvements
- public consultation on planned projects or user reference groups feeding back their views

Examples from reports include:
- new chairs have been purchased following a trial by parents to help promote skin to skin with babies on the neonatal unit
- paediatric diabetes team introduced a new program of diabetes education sessions for our young patients with type 1 diabetes and wellbeing days held at a local climbing centre.
- a roadshow was held on the new food provision contract which included a food tasting session and a competition to design a regional dish. Excellent feedback was received regarding the quality of the food and a new finger food menu introduced as a result of the feedback.
- dementia and delirium and visually impaired: Coloured plates, cups, bowls and side plates now available for patients on a number of wards at HRI. When trialled positive feedback was also received relating to the yellow crockery as being suitable for the visually impaired too
- responded to feedback from young people that there was a lack of facilities for older children on the children's ward. Staff gathered opinions from young people through the use of a mood board and have developed a teenage room.
- the surgical assessment unit (SAU) placed posters behind the bed with information about visiting hours, mobiles on silent, use of dayroom, promoting graffiti boards; also developed an ambulatory area to create a more comfortable environment
- Critical Care: using feedback from patients attending the follow-up clinic to better prepare patients with coping strategies to manage their future mental well-being; staff attended a regional afternoon tea event with staff and service users and plan to establish these locally as an opportunity to share experience and feedback
- a room on the neonatal unit has been refurnished to be used by parents as part of their preparation for discharge home. All clinical equipment has been removed and it has new family friendly furnishings. Feedback has been excellent.

5. National surveys

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

Inpatient: published May 2017, CHFT were reported as scoring **about the same** for all but one of the questions. The Trust was reported as scoring **better** than the majority of other Trusts for the question - 'If you brought your own medication into hospital, were you able to take it when you needed to?'

Emergency Department: published October 17, CHFT scored 'about the same' for all but one question –'Did a member of staff tell you about medication side effects to watch for? The Trust scored worse for this question.

Children and Young People: published November 2017, CHFT scored 'about the same' for all but one question: Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs? The Trust scored worse for this question.

Maternity: published January 2018, CHFT scored about the same for the majority of questions.

There were two questions where the Trust scored 'better':

- Did you feel that midwives and other health professionals gave you consistent advice about feeding your baby?
- Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?

There was one question where the Trust scored' worse':

- Did a midwife tell you that you would need to arrange a postnatal check-up of your own health with your GP?

For the questions where the Trust scored 'worse' the services are taking forward actions. Progress with these will be monitored through their internal governance arrangements and reported through Divisional reports to the patient experience and caring group.

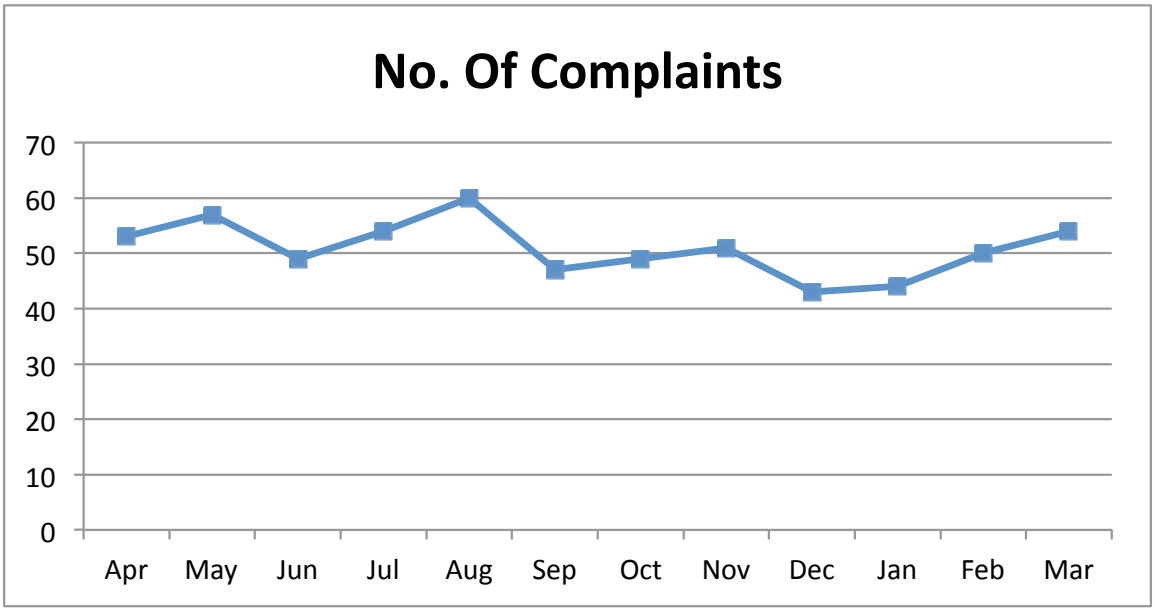
Staff posters have been produced to highlight some of the key messages from the surveys as an opportunity to share what patients say we do well, recent service improvements and any further actions to be taken.

			2016 Case-mix Adjusted			
Question		Number of respondents for this Trust	2016 Percentage for this Trust	Lower limit of expected range	Upper limit of expected range	National Average Score
Clinical Nurse Specialist						
Q17	Patient given the name of the CNS who would support them through their treatment	446	86%	87%	93%	90%
Q19	Get understandable answers to important questions all or most of the time	329	85%	85%	92%	88%
Support for people with cancer						
Q20	Hospital staff gave information about support groups	324	75%	79%	89%	84%
Q22	Hospital staff gave information on getting financial help	233	48%	49%	64%	56%
Your overall NHS care						
Q56	Overall the administration of the care was very good / good	462	93%	86%	93%	89%

The Trust's lead cancer nurse is working with each cancer team to deliver individual plans based on their results. The main focus for the teams is clinical nurse specialist interaction and the continued development of the cancer information service.

Complaints (Type and Severity)
In 2017/18 the Trust received a total of 615 complaints, a 0.3% decrease in complaints received from 2016/17 to 2017/18.

The profile of the spread of the complaints received by month is given below.



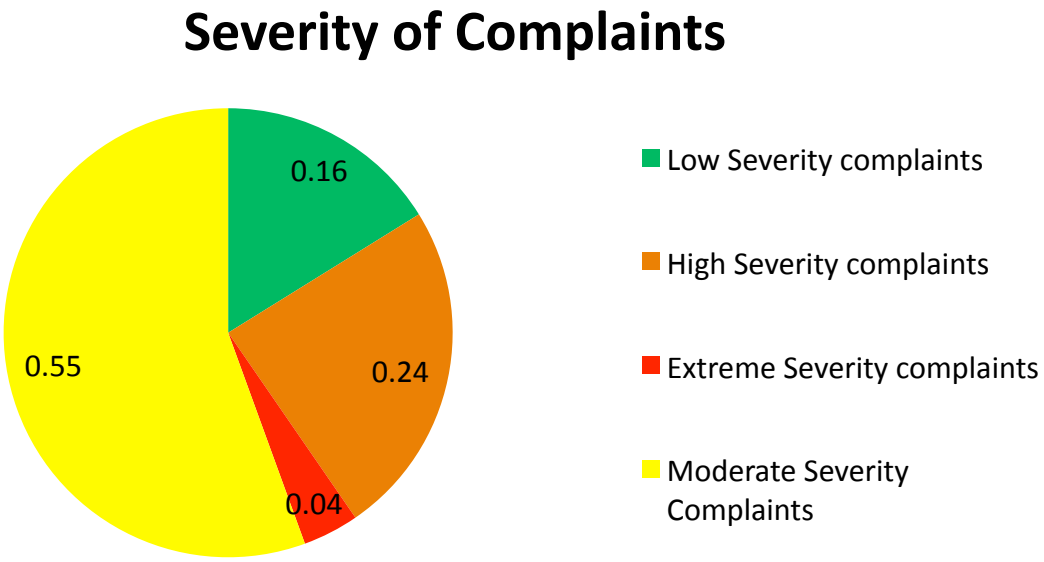
Number of complaints per month 2017 /18

The average number of complaints received each month by the Trust in 2017/18 was 51. The Trust received the highest number of complaints in May, the period during which the electronic patient record (EPR) was implemented...

Severity of Complaints Received
Complaints are triaged and graded on receipt for severity. In 2017/18 the Trust moved from a four tiered rating (green, yellow, amber, red) for complaints to a three tiered rating (green, amber, red). The initial grading is determined by the Patient Advice and Complaints Department based on the patient experience described in the complaint.

CONSEQUENCE	LIKELIHOOD OF RECURRENCE				
	Frequent	Probable	Occasional	Uncommon	Remote
Serious	HIGH	HIGH	HIGH	MEDIUM	MEDIUM
Major	HIGH	HIGH	MEDIUM	MEDIUM	MEDIUM
Moderate	HIGH	MEDIUM	MEDIUM	MEDIUM	LOW
Minor	MEDIUM	MEDIUM	LOW	LOW	LOW
Minimum	LOW	LOW	LOW	LOW	LOW

In 2017/18 the majority of complaints (50%) were graded as orange, 5% (31) complaints were graded as red (extreme severity) as shown in the pie chart below.

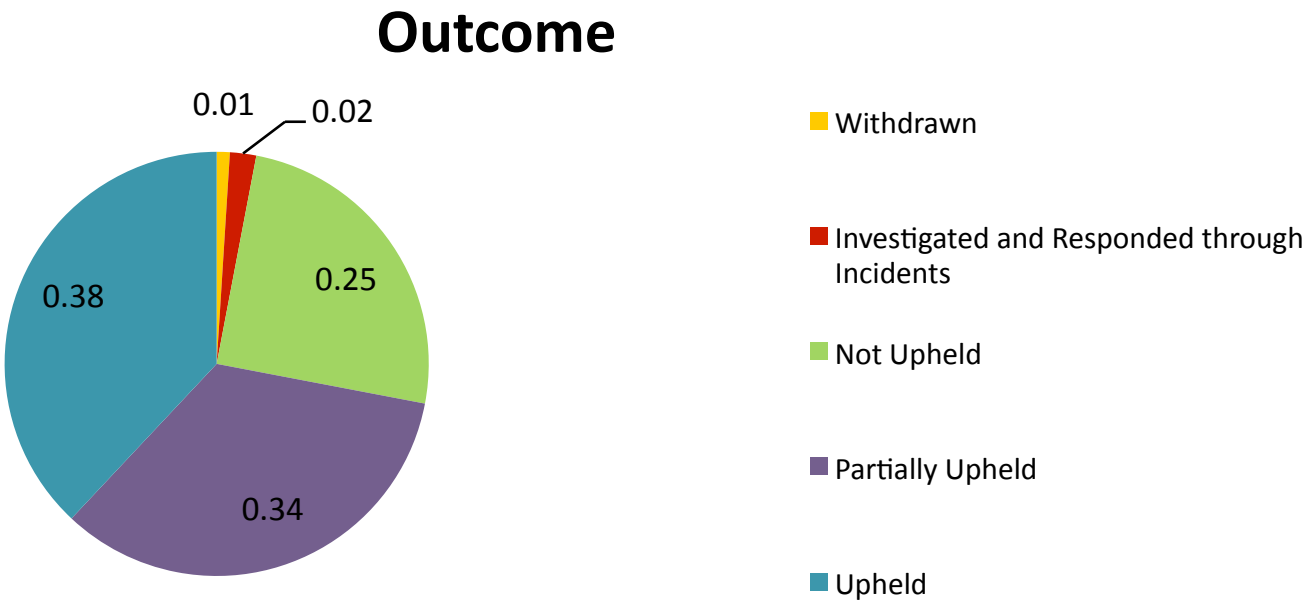


Red Complaints Data
Complaints that are triaged as red are reviewed at a red panel meeting and are linked to an incident where appropriate.

In 2017/18 the Trust received a total of 31 red complaints.

Acknowledgement Time
99% of the complaints received in 2018/19 were acknowledged within three working days.

Complaints Closed
The Trust closed a total of 559 complaints in 2017/18; this is a decrease of 17% from 2016/17. Of the 559 complaints closed, 46% were upheld, 36% were partially upheld (NHS Digital counts partially upheld complaints as upheld complaints so if looked at in this way the figure is 77%), 16% were not upheld, 1% related to an incident and 1% were withdrawn.



The Trust will re-open a complaint for one of the following three reasons.
I. response failed to address all issues and concerns
II. new issue and concern
III. Parliamentary and Health Service Ombudsman Investigation

The Trust re-opened a total of 71 complaints in 2017/18. This is a 1% decrease from 2016/17.

3.7 Timeliness of Complaints Responses
There has been significant work undertaken by the Trust in 2017/18 to improve the timeliness of responses to complainants. During the month of December 2017 the Trust closed a total of 70 complaints reducing the backlog of breaching complaints from 66 to 40, a reduction of 39%.

Processes have been put in place to closely monitor timescales and escalate any delays in response to ensure that all complainants receive a timely response. The total number of overdue complaints at the end of 2017/18 was 31.

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

Subject	Percentage	Increase /decrease from 2016/17
Communications	↓ 22%	8%
Patient Care (including nutrition and hydration)	↓ 19%	8%
Clinical Treatment	↓ 19%	8%

Communications, patient care (including nutrition and hydration) and clinical treatment remain the top three subjects of complaint in 2017/18.

Parliamentary and Health Service Ombudsman Complaints
The Parliamentary and Health Service Ombudsman (PHSO) investigate complaints where an organisation has not been able to resolve the complaint at a local level. The PHSO have broadened their review process and have considerably increased the numbers of cases that they consider.

The table below shows figures relating to the Trust is a time with the figures relating to the Trust;

	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Number of Complaints Received by PHSO	1	2	3	1
Number of Complaints accepted for investigation by the PHSO	1	2	3	1
Number of Complaints the PHSO Upheld or Partly Upheld	1	3	0	2
Number of Complaints not upheld	3	0	1	0

Seven cases were accepted for PHSO investigation between April 2017 and March 2018. During this period the PHSO also concluded seven complaints against the Trust Of these eleven, three complaints were not upheld and four were upheld /partially upheld.

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

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

Some examples of learning from complaints for each division is given below.

Complaints Learning:

Medical Division		
Issue:	**Findings:**	**Learning:**
Clinical Treatment:		
Care and treatment of patient whilst using emergency services. Different information about diagnosis given to family. Patient discharged, then re-admitted a few days later with pneumonia and subsequently died.	Difficulties reaching a firm diagnosis due to clinical symptoms, once diagnosis made patient appropriately commenced on antibiotics. Error on discharge summary - wrong diagnosis listed. Antibiotics should have been commenced within the first 24 hours to give the patient the best possible chance of recovery.	To share the patient's experience in the Junior Doctor Forum regarding the importance of commencing antibiotics in a timely manner To share patient's experience in the next departmental governance meeting - Junior Doctors will use the learning to ensure they start patients with similar issues on antibiotics sooner. Further training in the use of EPR for junior doctors - Junior doctors will be competent in the use of EPR.

Family and Specialist Services Division		
Issue:	**Findings:**	**Learning:**
Attitude of Staff:		
Poor attitude and communication of a Sonographer with patient's relative during an appointment. The Sonographer would not allow the relative to go in with mother for the scan even though daughter tried explaining that the carer was going to leave the room allowing space for the daughter to stay.	The Sonographer offered her sincere apologies for the distress caused and appreciated she should have offered the opportunity of the daughter swapping places with the carer.	The Sonographer has reflected on her behaviour and attitude, and in future will ensure that she gives the opportunity to ensure that the appropriate person remains in the room to support the patient. The standard letter template will be revised to inform patients that only one escort can stay in the room with the patient during the procedure and signs erected in the room informing patients of the one escort policy.

Surgical and Anaesthetics Division		
Issue:	**Findings:**	**Learning:**
Clinical Treatment:		
Complaint regarding the care and treatment of a child who underwent an adenoidectomy at HRI. The patient was discharged, still vomiting and had not been seen by a Doctor since starting to vomit, neither kept fluid down or eaten. Parents were informed this was normal and left. 24 hours later the child was very weak/ dehydrated and still vomiting. Parents contacted the assessment unit and were told to attend. Parents were not informed on the telephone that they meant attend at CRH not HRI where the surgery had taken place. Consequently they had to take their child to emergency services at HRI as the child was so poorly.	Morphine was given for pain relief but anti-emetics were not prescribed for vomiting. Vomiting was not escalated to the anaesthetist. Nurse 'assumed' patient had eaten toast. Leaflet given and was not clear at which hospital the assessment unit was.	Future episodes of vomiting to be escalated to anaesthetics for prescription of anti-emetics. If vomiting occurs nursing staff must check with anaesthetist they are happy for the patient to be discharged. Nursing staff now documenting exact fluid and food intake. Nursing staff will now ensure that patients are fully aware of where the assessment unit is. Clarity on communication - shared with the ward team so they are able to reflect on their approach.

Parliamentary Health Service Ombudsman (Medicine)		
Issue:	**Findings:**	**Learning:**
Delay in Diagnosis :		
The complainant felt her father's care and treatment was unsatisfactory and she is unhappy that his diagnosis was delayed	The PHSO decided to partly uphold the complaint. They found that the Trust failed to identify promptly that the patient had metastatic spinal cord compression (MSCC) and are confident that there were sufficient clinical pointers to suggest a suspicion of MSCC, a whole spine MRI should have been done within 24 hours.	Flowchart for diagnosis of MSCC implemented which is rolled out in Doctor training.

Areas for Improvement

An update against the key priorities for 2018/19 for the complaints and patient advice service are:

- Sustain timely responses to complainants;
- Update the complaints training to modular based training, containing an online modular that complaints investigators can complete.
- Continue to focus on quality responses that address all aspects of complaints and introduce the Trust new response template.
- Analyse responses from satisfaction survey, to identify further areas for improvement.
- Improve identification of sharing and learning from complaints within the Trust learning from adverse events framework

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

Indicator	Threshold	Performance	Achieved
Maximum time of 18 weeks from point of referral to treatment in aggregate-admitted	90%	83.21%	No
Maximum time of 18 weeks from point of referral to treatment in aggregate- non admitted	95%	93.03%	No
Maximum time of 18 weeks from point of referral to treatment in aggregate- patients on an incomplete pathway	92%	93.75%	Yes
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	90.61%	No
All cancers: 62-day wait for first treatment from: • Urgent GP referral for suspected cancer • NHS Cancer Screening Service referral	 85% 90%	 88.71% 94.87%	 Yes Yes
All cancers: 31-day wait for second or subsequent treatment , comprising: • Surgery • Anti-cancer drug treatments • Radiotherapy	 94% 98% n/a	 99.26% 100%	 Yes Yes
All cancers: 31 day wait from diagnosis to first treatment	96%	99.83%	Yes
Cancer: two week wait from referral to date first seen, comprising: • all urgent referrals (cancer suspected) • for symptomatic breast patients (cancer not initially suspected)	 93% 93%	 94.10% 93.88%	 Yes Yes
Clostridium difficile – meeting the C. difficile objective	21	8	Yes
Maximum 6-week wait for diagnostic procedures	99%	99.59%	Yes
Data completeness: community services, comprising: • Referral to treatment information • Referral information • Treatment activity information	 50% 50% 50%	 100% 99.73% 100%	 Yes Yes Yes

Feedback from commissioners, overview and scrutiny committees and Local Healthwatch, Governors and local providers

Response from Greater Huddersfield and Calderdale Clinical Commissioning Group

RE CHFT Quality Accounts Feedback 2017/18
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 again a comprehensive assessment of the levels of quality and is consistent with the Commissioners understanding of quality within CHFT; we note the continued commitment to quality despite the increasing demand and financial challenges. The account describes progress in many areas against national targets and local ambitions 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 the improvement work the Trust has undertaken in the past year, particularly in relation to the implementation of the Electronic Patient Record (EPR) and the number of benefits this has brought about, however, in the interest of transparency the CCGs feel it would be beneficial to note some of the initial issues that the implementation raised; particularly in relation to access to patient appointments and correspondence with external agencies.

We welcome the progress made in relation to the identified priority areas for 2017/18, and are reassured to see the improvement in sepsis screening as a result of ERP, the improved partnership working resulting in better discharge planning and reduced length of stay, and the Trusts commitment to learning from complaints. However it may also be pertinent to include information on the challenges of responding to complainants in a timely manner.

We recognise the improvement work and reduction in the number of falls in hospital and welcome the plans to continue this work into 2018/19. We note that you continue to perform well against the National Cancer Waiting Times targets and are pleased to see your continued commitment to the West Yorkshire and Harrogate Cancer Alliance.

The CCGs commend the hard work undertaken to improve mortality rates, HSMR and SHMI, and are pleased to have had CCG representation working with you to support this achievement.
We note your open account of the Care Quality Commission (CQC) inspection and the improvements made against the action plan. We were pleased to support you with the mock inspections and open conversations with the inspectors prior to the visits. Like you we await the outcome of the recent unannounced and planned visits.

The CCGs are pleased to see that the priorities for 2018/19 will continue support system wide improvement and will build on last year's priorities:
- Care of the Acutely Ill Patient
- Patient Flow
- End of Life Care

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 improvement work and we welcome the plan for commissioners to work closely with the Trust, we will continue to visit the hospitals and participate in the "go see" reviews of the work you are undertaking. This

is a welcome demonstration of your willingness to be transparent.

As last year the account could be further strengthened by the inclusion of narrative around the difficulties the Trust continues to experience in recruitment and retention of both medical and nursing staff.
The CCGs will of course continue to support you over the coming year in achieving the quality improvement priorities set out in the account.

Response from HealthWatch in Kirklees and Calderdale

HealthWatch in Kirklees and Calderdale continues to have an open, constructive relationship with CHFT. From working to understand the impact of Electronic Patient Records, to supporting people wanting to make complaints against the hospital, our relationship is always based on transparency and mutual trust. We look forward to continuing this relationship in 2018/19".

Rory Deighton Director HealthWatch Kirklees
Helen Wright, HealthWatch Calderdale

Response from the Governors to CHFT Quality Accounts 2017-2018:

The Council of Governors is pleased that the Trust continues to strive to provide high quality care, as detailed in its Quality Account. The Governors were given the opportunity to develop and select the key quality indicators for 2018/19 which were then put out to the wider membership for final selection. During 2017/18 Governors have been informed of the progress being made against the quality priorities for the year through formal reports to the Council of Governors meetings and discussions at Governors workshops and development sessions.. Governors sit on Divisional Reference Groups where they discuss patient safety and quality with the divisional management teams and undertake walkarounds in clinical areas. Governors have representation on the Patient Experience and Caring Group which looks at patient experience, engagement and equality and Governors have also taken part in PLACE inspections of both hospital sites.

All of this enables us to see at first hand the challenges of maintaining quality at a high level on an enduring basis. In addition, Governors have regular meetings with both Executive and Non-Executive Directors formally at Council of Governor meetings and more informally. Governors also attend, in an observer role, Board of Directors meetings and committee meetings, particularly the Quality Committee which has delegated responsibility and oversight of the Trust's progress towards achieving the quality priorities.

The Council of Governors supports and endorses the Quality Account and the priorities selected for particular focus over the coming year.

Brian Moore
Lead Governor

Response from Calderdale Overview and Scrutiny Committee

Comments requested but none received as at 20 April 2018.

Response from the Kirklees Health and Social Care Scrutiny Panel
Re: Calderdale and Huddersfield NHS Foundation Trust Draft Quality Account 2017/18

Thank you for your email dated 4 April 2018 inviting comment from the Kirklees Health and Adult Social Care Panel on the draft 2017/18 Quality Account for Calderdale and Huddersfield NHS Foundation Trust.

Please note that due to the timing of the submission the Panel hasn't had the opportunity to have a full discussion at a panel meeting and this is reflected in the level of comments received which is summarised below:

"The Panel welcome the opportunity to comment but wish to highlight that due to the timing of the submission the Panel did not have an opportunity to include a discussion at a full panel meeting and unfortunately this has resulted in restrictions in the level of feedback and comments.

The Panel is pleased to see that the Trust remains in the top 10% of best performing Trusts for achieving the targets for emergency care despite the extreme pressures that the Trust has faced during the winter period.

The Panel note that the three priorities set for 2017/18 have all met with measurable indices of success. Achieving a 90% screening for pathogens is a notable achievement and when taken with the improvements in the process for the recognition and rapid treatment of sepsis the Panel believe this will help make the Trust a safer place to be treated than previously.

The Panel do however have a concern that the targets set through the Commissioning for Quality and Innovation payment framework were not all fully achieved and in particular the administering of antibiotic within an hour for sepsis.

The Panel welcome the strategies to improve and develop effective discharge planning although the Panel would have liked to have seen more detail on readmission rates within 28 days.

The Panel support the work being done by the Trust to learn from complaints and believe that this should be a continued area of focus. The Panel would also wish to see the Trust continue to develop an open and transparent approach to sharing with the public details of common areas of complaints and the measures being taken to address them.

The Panel note the three priorities for 2018/19 and are generally supportive of the areas that will be covered although it was felt that for both priority one (Care of the Acutely Ill Patient) and priority three (End of Life Care) it was not entirely clear what the outcomes are to be and how they will be measured.

The Panel note that the overall ratings for the Trust's responsiveness to the personal needs of patients as reported from the National Inpatient Survey were lower than previous years. The Panel is supportive of the Trust's intention to improve the rating although it's unclear what steps will be taken to do this.

The Panel is pleased that the Trust has introduced an Electronic Patient Record and recognise the considerable benefits that this can bring with the potential to improve all aspects of patient care.

The Panel do however note that the introduction of the new system did have an impact on some areas of the Trust's performance and hope that the Trust will take forward the learning from this project when managing the introduction of other types of new systems in the future.

The Panel note that as in previous years the Quality Account includes minimal information on the local plans to reconfigure healthcare in the hospital and community settings which continues to be of significant interest to the Panel and local residents.

The performance of the Trust remains a high priority area for the Panel and is committed to continue to work closely with the Trust with the aim of ensuring that patients are receiving safe and effective services.

The Panel is also mindful of the significant financial challenges that the Trust faces in the coming years. The Panel intend to maintain a focus during 2018/19 on the work being developed locally by the Trust and the wider health and social care sector to increase efficiencies with the aim of ensuring that there is no adverse impact on the accessibility, quality and safety of patient services for the residents of Kirklees.

Yours sincerely,
Richard Dunne
Principal Governance and Democratic Engagement Officer
On behalf of the Kirklees Health and Adult Social Care Scrutiny Panel

Response from South West Yorkshire Partnership NHS Foundation Trust

As a partner of the Trust, we were pleased to receive and be asked to comment on the Calderdale and Huddersfield NHS Foundation Trust (CHFT) draft Quality Account for 2017/18.

The Quality Account provides an assessment of the levels of quality provided by the Trust, describing the progress made in many areas together with comparisons against other organisations. It was good to note the positive progress in achieving the three improvement priorities for 2017/18; sepsis screening, discharge planning and learning from complaints.

We welcomed the priorities for 2018/19 which focus on care of the acutely ill patient and improving outcomes through recognition, response and prevention of deteriorating patients; managing complex discharges and improving the experience of those patients who are being managed at the end of life.

We recognise the efforts by the Trust to address the areas in the CQC inspection, where CHFT was rated as good for caring and responsive but rated as "requires improvement" overall. The most recent CQC inspection has just taken place and we note that CHFT are awaiting the results of this.

We acknowledge the efforts of CHFT in response to a particularly challenging winter period. Despite the challenges and demands placed on services, we note the resilience and the professionalism shown by all staff resulting in CHFT being in the top performing 10% of NHS Trusts for emergency care.

We continue to work closely with CHFT on shared sites and in response to issues and challenges that arise where close collaboration provides mutual benefits for the users of our respective services, carers and staff.

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

Yours sincerely
Tim Breedon
Director of Nursing & Quality
South West Yorkshire Partnership NHS Foundation Trust.

Statement of directors' responsibilities in respect of the quality report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 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 2017 to May 2017
  - papers relating to Quality reported to the board over the period April 2017 to May 2018
  - CQC inspection report dated August 2016
  - feedback from commissioners dated 20 April 2018
  - feedback from governors dated 20 April 2018
  - feedback from local HealthWatch organisations dated 5 April 2018
  - feedback from Kirklees Overview and Scrutiny Committee dated 18 April 2018
  - feedback from South West Yorkshire Partnership Foundation Trust date 10 May 2018
  - the Trust's complaints report for 2017/18 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - the 2016 Adult inpatient survey May 2017
  - the 2017 national staff survey March 2018
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated 23 May 2018.

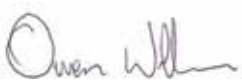
Feedback was requested from Calderdale Overview and Scrutiny Committee, Trust and Locala on 4 April 2018 but had not been received by 23 May 2018.

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

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

By order of the board

.....Chairman



..... Chief Executive

Independent Auditor's Report to the Membership Council of Governors of Calderdale and Huddersfield NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Calderdale & Huddersfield NHS Foundation Trust to perform an independent assurance engagement in respect of Calderdale & Huddersfield NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 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 or discharge;

We refer to these national priority indicators collectively as the 'indicators'.

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 NHS Improvement.

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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed requirements for quality reports for foundation trusts 2017/18 ('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 Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18.

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 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from commissioners, dated 20 April 2018;
- feedback from governors, dated 20 April 2018;
- feedback from local Healthwatch organisations, dated 5 April 2018;
- feedback from Kirklees Overview and Scrutiny Committee, dated 18 April 2018;
- feedback from South West Yorkshire Partnership Foundation Trust date 10 May 2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2016 national adult patient survey, dated May 2018;
- the 2017 national staff survey, dated March 2018;
- Care Quality Commission Inspection, dated August 2018;
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated 23 May 2018; and
- any other information included in our review.

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 & 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 2018, 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 & 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.

Limitations

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 and supporting guidance.

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

Basis for qualified conclusion

The Trust has included a statement in the Quality Report that it does not report the number of deaths of patients aged 0-18 which were more likely than not, to have been due to problems in the care provided. This information is only reported for deaths of adult patients. The reported information is therefore not in compliance with the requirements of the Detailed Requirements for Quality Reports 2017/18 issued by NHS Improvement.

With regard to the 'A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge' indicator, our testing identified that there was a discrepancy between the number of arrivals at A&E included in the report derived from the Trust system and those reported through the year by the Trust. The total discrepancy of case numbers was 768.

With regard to the 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' indicator our testing identified that the Trust's processes were not accurately identifying the correct pathways. We identified cases which had been included in the calculation of the indicator which were not pathways. In addition the Trust undertakes a validation process for this data, this is a targeted methodology to ensure the Trust achieves the required performance and may not cover the total population in any one month.

As a result we are not able to conclude that nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018, the 'A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge', and 'the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' indicators have 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.

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 has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- 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 indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
1 Sovereign Square
Leeds
LS1 4DA
24 May 2018

Appendix A: 2017/18 Clinical Audit

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust were eligible to participate in/participated in for which data collection was completed during 2017/18, 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 2017	Yes	Yes	100%	100%
Maternal, infant and newborn programme (MBRRACE-UK)	Yes	Yes	100%	100%
Neonatal intensive and special care (NNAP)	Yes	Yes	417	100%
Paediatric intensive care (PICANet)	No	NA	NA	NA
RCEM Pain in children 2017	Yes	Yes	All cases in time period	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	1087	100%
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Yes	All	100%
National emergency laparotomy audit (NELA)	Yes	Yes	143	100%
RCEM Procedural sedation 2017	Yes	Yes	All cases in time period	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:				
2017 Re- Audit of Red Cell & Platelet transfusion in adult haematology patients	Yes	Yes	30	100%

Cancer

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Bowel cancer (NBOCAP)	Yes	Yes	235	100%
Lung cancer (NLCA)	Yes	Yes	303	100%
Oesophago-gastric cancer (NAOGC)	Yes	Yes	All cases in time period	100%
National Prostate Cancer Audit	Yes	Yes	283	100%

Heart

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes	901	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	151YTD	on-going
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Yes	Yes	324	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	105	On-going
Diabetes (Paediatric) (NPDA)	Yes	Yes	100%	100%
Inflammatory bowel disease (IBD) Registry**	Yes	No	On-going	None
Renal replacement therapy (Renal Registry)	No	N/A	N/A	N/A
National Complicated Diverticulitis Audit (CAD)	Yes	Yes	On-going	All cases
National Ophthalmology Audit	Yes	Yes	2864	100%
RCP National COPD secondary care audit 2017	Yes	Yes	On–going	All cases

Mental Health

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Prescribing observatory for Mental Health(POMH-UK)	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
National audit of Dementia 2016-17 (round 3)	Yes	Yes	94	100%
RCEM Fracture Neck of Femur 2017	Yes	Yes		

Other

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Specialist Rehab for patients with complex needs	No	N/A	-	-
UK Cystic Fibrosis Registry	No	N/A	-	-
Learning Disability Mortality Review (LeDeR)	Yes	Yes	10	100%
Elective surgery (National PROMs Programme)				
Groin hernia	Yes	Yes	All	On-going
Hip replacements	Yes	Yes	All	On-going
Knee replacements	Yes	Yes	All	On-going
Varicose veins	Yes	Yes	All	On-going

National Confidential Enquiries (NCEPOD)

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Deaths:				
Young Peoples Mental Health	Yes	Yes	3	75%
Chronic Neurodisability	Yes	Yes	2	100%
Cancer in Children, teens and young adult study (0-25 years)	Yes	No patients met the audit criteria		
Heart Failure Study	Yes	Yes	5	50%
Peri-operative Diabetes Study	Yes	Yes	Ongoing	Data collecting

The Trust did not take part in three national audits as detailed below.

Name of audit	Reason
Inflammatory bowel disease (IBD) Registry	Lack of resources
National audit information about the content of the delirium screen and delirium assessment – part of NAD audit	Not able to take part due to pressures of reconfiguration.
National Bariatric Surgery Registry	Awaiting response from lead, regarding subscriptions
BAUS Nephrectomy Surgery	Lack of resources
BAUS PCNL	Lack of resources

The reports of 39 national clinical audits were reviewed by the provider in 2017/18 and the following are examples where Calderdale and Huddersfield NHS Foundation Trust intend to take actions to improve the quality of healthcare provided.

National audit of Rheumatoid arthritis & early inflammatory arthritis (final / 2nd year results) 2015- 2016

The National Clinical Audit of Rheumatoid and Early Inflammatory Arthritis is part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP), overseen by the Healthcare Quality Improvement Partnership (HQIP). NCAPOP is a closely linked set of centrally-funded national clinical audit projects that collect data on compliance with evidence based standards and provide local Trusts with benchmarked reports on compliance and performance.

The HQIP funded project will provide a national comparative audit of the assessment, management and outcomes of adults presenting with rheumatoid and early inflammatory arthritis in all NHS secondary care settings in England and Wales where the service is provided. The audit is being designed so that results help clinicians improve the quality of care for patients and control their joint inflammation.

The National Institute for Health and Clinical Excellence (NICE) has drawn up seven key quality standards (Quality Standard 33) that are evidence-based and identify the most important goals for us to meet in delivering high quality care to our patients.

Patients aged 16 and over who presented for the first time in rheumatology departments were recruited where early inflammatory arthritis was suspected, following an assessment within the clinic. This included patients with:

- Rheumatoid arthritis
- Psoriatic arthritis
- Spondyloarthropathy with peripheral arthritis
- Undifferentiated arthritis

Data were collected at presentation to NHS rheumatology services and for the first 3 months of subsequent follow up appointments. Care received by these patients was assessed against the NICE Quality Standards for Rheumatoid Arthritis (QS33)1 and patient reported measures of experience and outcome, including data on ability to work. Data were also collected on the staffing and service models of each rheumatology service to explore the relationships between performance and organisational factors.

Data presented in this report are for patients recruited from 1 February 2015 to 30 October 2015. Recruitment was shortened to a 9-month period to ensure the analysis could be completed before the end of the contract. 97% of NHS rheumatology providers in England and Wales were registered to participate in the 2nd year of the audit and data from 5,002 patients were available. Over a 12 month period, this shows a 5% increase in patient recruitment. Overall, 11,356 patients were recruited in the two year data collection period, amounting to 38,311 records in total.

Aim:
- For patients the aim is that they will be more aware of their care and more able to take control of their personal health.

Objectives:
- To help transform the way that rheumatology is viewed and commissioned.
- To drive better access for patients and better care.

Summary of Findings:
The British Society for Rheumatology (BSR) 2nd and final report on the findings of the national audit for Rheumatoid & early inflammatory arthritis was published in July 2016.
The report covered data from Feb 2015 – Jan 2016.
They have stated that CHFT data submitted (i.e. case ascertainment) was not sufficient to provide robust benchmarking at trust level for this report.

What changes in practice have been agreed?
Actions from previous round are complete & embedded

Recommendation	Action	Lead Person	Timescale
Patients seen within 3 wks of referral	Triaging patients with inflammation into earlier clinics	Cheryl Fernandes	6 months to complete backlog of patients waiting to be seen, once we have substantive medical staff on board. - Sept 2016. **Now complete Sept 2017**
Achieving treatment target at follow up	Nurse training to document and act on disease activity	Julie Madden	6 months completing back log, nurse training. – Sept 2016. Now complete Sept 2017

National Paediatric Diabetes Audit 2015-16
The National Paediatric Diabetes Audit (NPDA) report highlights the main findings on the quality of care for children and young people with diabetes mellitus in England and Wales. Children and young people with diabetes have complex needs as they develop and grow, with a risk of complications or serious disease in later life. NPDA reports on markers that identify the risk of kidney, eye and cardiovascular disease, revealing hypertension in young people with Type 1 diabetes and an increase in obesity. An expanding partnership with the National Diabetes Audit (NDA) for adults is another way in which the NPDA is working to ensure that young diabetes patients receive more seamless diabetes care as they make the transition into adulthood. Diabetes is just one of many long-term conditions suffered by children and young people today, but with more cases of paediatric diabetes being reported year on year, the NPDA has never been more relevant.

The NPDA is a powerful tool for measuring performance, and reports on the delivery of a high quality system of care based on standards set by the National Institute for Health and Care Excellence (NICE). The audit specifically refers to the NICE clinical guideline CG15, Type 1 diabetes: Diagnosis and management of Type 1 diabetes in children, young people and adults, and enables commissioners to monitor progress against the national standards and identify gaps in care; helps families to benchmark local service quality and provides data to support PDUs and regional networks in the improvement of care across the UK.

The NICE CG15, states that all children and young people with diabetes over 12 years of age should receive seven key care processes in order to achieve optimum control over their disease and reduce the potential for serious health complications. The seven care processes include:

- HbA1c (all ages to receive this process)
- Height and weight
- Blood pressure
- Urinary albumin
- Cholesterol
- Eye screening
- Foot examination

The responsibility for addressing any inconsistencies and gaps in care which are failing many children, lies primarily with the PDUs, but also requires a coordinated effort from regional networks, commissioners, local authorities, families and other stakeholders to ensure the high standards are reached and variability in outcomes is reduced. Where PDUs show under-performance by these measures, Trusts/Health Boards and Commissioners are urged to work with regional networks to ensure that clinical data are captured in their entirety, and to facilitate the submission of the most complete and accurate dataset to better ensure appropriate representation of PDU outcomes.

Objectives:
The main objective of NPDA is to examine the quality of care for children and young people with diabetes mellitus in England and Wales.

Summary of findings for CHFT
A total of 229 children and young people were included in this audit.

Compared to audit 2014-15 our HbA1c has improved more than Y&H and E&W but is still an outlier and is an outlier in the percentage of patients with HbA1c <58mmol/mol.

Median

Year	CHFT	E&W
2014-15	74	66.5
2015-16	69.5	65

Proportionally greater reduction.

Adjusted mean

Year	CHFT	E&W
2014-15	78	70.6
2015-16	75.1	68.3

In 2014 our current Consultant for diabetes at CRH started as a locum, being the 4th Consultant covering the service at CRH in two years. This is unsettling for patients, parents and the Team. Since July 2015 Dr How Yaw has been appointed to the substantive post which has provided continuity and stability to the Team from a medical point of view. During 2015-16, Nancy one of our experienced PDSNs retired in the January and was not replaced until the July, Maria, another experienced PDSN, retired in the August and was not replaced until March 16. Both new PDSNs were new to the post and required a period of learning and development. Another experienced PDSN had a period of prolonged sick leave during the year as well, following surgery. The Team have been back up to full numbers since March 16 and hopefully this will be reflected in the next audit. Despite being at least one PDSN down for the year, the team did make improvements in the mean and median HbA1c during 2015-16.

The age distribution of patients in the CHFT children's diabetes service are similar to Y&H and E&W, except for the 5-9 age group where CHFT have more. The ethnicity of patients and the type of diabetes are the same across Y&H and E&W.

Care Processes
Percentage of patients with the care processes HbA1c, BP and albuminuria screening is the same across the 3 groups. Thyroid screening and BMI documentation is slightly reduced in CHFT compared to the other groups but eye screening and foot examination were significantly better in CHFT compared to Y&H and E&W.

The percentage of patients that have completed all 7 care processes, CHFT was in the middle of the funnel plot but no actual figure was given.

The percentage of patients screened for thyroid disease and coeliac disease within 90 days of diagnosis was much better at CHFT than Y&H and E&W.

Outcomes of care
Fewer patients at CHFT had HbA1cs <48, 53 and 58 mmol/mol than Y&H and E&W.
More patients at CHFT had HbA1cs >69, 75 and 80 mmol/mol than Y&H and E&W.
This is related to our higher adjusted mean and median HbA1cs.

The percentage of patients with an HbA1c >80mmol/mol has come down from 37.9% to 28.8% (and reduced in E&W down from 21.5% to 17.9%). CHFT was an outlier on this funnel plot but has now moved to the edge of the plot.

CHFT has significantly fewer patients with abnormal eye screening compared to Y&H and E&W and fewer patients with missing eye screening data, suggesting that this a real difference.

The percentage of patients with microalbuminuria is higher in CHFT than the other 2 groups and is higher than CHFT in 2014-15. This is not a difference that has been noted clinically and is therefore likely to be due to data entry.

Patient's BP, patients with hypertension, with high cholesterol and weights (underweight, overweight and Obese) are similar across the 3 groups.

Access to education is better in CHFT than Y&H and E&W. 'No psychology referral required' is significantly lower in CHFT and those referred to and seen by psychology are significantly higher in CHFT than the other groups and again this is likely to be a data entry error.

CHFT continues to have a higher percentage of patients with coeliac disease and diabetes than the rest of the country.

What changes in practice have been agreed?
KEY (Change status)
1 Recommendation agreed but not yet actioned
2 Action in progress
3 Recommendation fully implemented
4 Recommendation never actioned (please state reasons)
5 Other (please provide supporting information)

Action plan lead	Name: Lynne Terrett	Title: Consultant	Contact: 2465 HRI

The 'Actions required' should specifically state what needs to be done to achieve the recommendation. All updates to the action plan should be included in the 'Comments' section.

Recommendation	**Actions required** (specify 'None', if none required)	**Action by date**	**Person responsible**	**Comments/action status** (Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc.)	**Change stage** (see Key)
Planned Time-Out for the whole team	To take place 21/07/17	21/07/17	Dr Lynne Terrett, Cons		2
To start high HbA1c clinic	Already discussed and arranged with clinic	December 2017	Dr Lynne Terrett, Cons; Jean Hayman, Lead Nurse	Already discussed and arranged with clinic, awaiting EPR to settle	2
Longer clinic appointments to 30 minutes, to provide more education and support.	Have 30 minute appointments to comply with peer review	October 17	Dr Lynne Terrett, Cons; Dr Steph How-Yaw, Cons; Gill Harris, General Manager	Spoken to Gill Harris	3
To present 6 monthly data to network and paeds forum	Ongoing	Ongoing throughout the year every 6 months	Alison Oversby, Paeds Dietitian	Embedded - Complete	3
To make IT data collection more accurate.	Team to meet monthly for a half day with Mandy, secretary, to support and improve accuracy of data entry. Continue to discuss with IT re: data collection from EPR and SystmOne to make it easier	Underway every month	Alison Oversby, Paeds Dietitian and Amanda Watson, Secretary	Underway	2
Psychology-facilitated clinics for patients with recurrent admissions	Trial of psychology facilitated clinics	November 2017	Amanda Gill, Paeds Psychologist		2
More education and activity days to support and educate young patients	Ongoing	March 2018	Jean Hayman, Lead Nurse		2
Focus on management in first 12 months after diagnosis, aiming for early normoglycaemia. Review of initial targets, meter settings etc.	Review at the Time-Out meeting to aim to set up good habits	21/11/17	All		2

Other National Clinical Audits the Trust has participated in during 2017/18:
- Breast & Cosmetic Implant Registry
- National Audit of Hip Fractures
- Diabetic Retinopathy Screening (KPI)
- Invasive cytology
- National Cardiac Rehab audit
- SAMBA 2017 (Against the Clock)
- BTS Bronchoscopy
- BSUG Stress Incontinence database
- National Completed Acute Diverticulitis Audit (CADS)
- OAKS (Outcomes after Kidney Injury)
- National Audit of Small Bowel Obstruction (NASBO)
- Potential Donor Audit
- Epistaxis Audit

The reports of 89 local clinical audits were reviewed by the provider in 2017/18 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Missed Small for Gestational Age audit
Babies who weigh <10th centile at birth are described as Small for Gestational Age (SGA) and have an increased risk of stillbirth or poor neonatal outcome. Risk assessment and surveillance for fetal growth restriction are part of the NHS Saving Babies' Lives Care Bundle.

Objectives:
- The number of babies <10th centile on the customised growth chart at birth
- The number of undetected small for gestation age babies <10th centile at birth
- Compliance with the CHFT guideline for the routine assessment of fetal growth

Summary of Findings:
To ensure all babies < 10th centile were included in this audit babies weighing ≤ 3000gms n = 321 were reviewed to capture babies not recorded as < 10th centile on Athena
- Number of babies < 10th centile n = 143
- Total births CHFT May – July 2017 n = 1399
- Incidence of babies < 10th centile 10.2%
- Number babies known to be SGA on scan n = 88
- Missed SGA n = 55
- Detection rate SGA 61%

Reasons for missed SGA
- Fundal height measurement/ centiles were higher than birth weight centiles, 20th – 95th centile. The fundal height measurement predicted a baby ≥ 50th centile 82% (14/17) women who had no scans.
- 69% (38/55) women with a missed SGA baby had growth scans in pregnancy. Staff were reassured by the estimated fetal weight centiles on scan 12th, to 95th centiles (≥ 50th centile n = 10 nearest to birth).
- One woman had five different sonographers performing the growth scans, the centiles from EFW were 95th, 30th, 30th, 10th and 40th.
- 4 Bradford women did not have a customised growth chart completed by their midwife

Summary
- Clinical documentation in Athena regarding birthweight centile < 10th centile is not accurate.
- The detection rate for known SGA < 10th centile May – July 2017 was 61%
- Women with a previous SGA baby 12/12, women who conceived following IVF 3/3, women who reported reduced fetal movements (RFM) 9/9 and women with a BMI ≥ 37 4/4 were offered growth scans following trust guidance

What changes in practice have been agreed?

Recommendations	Actions	Lead Person	Timescale
A business case to plot the Resistance Index with the scan instead of manually writing this on a paper form	A business case is being prepared	Kathy Kershaw, Midwife	January 2018

Audit of Senior Review of under 1yr olds (Infants) in the emergency department

Ideally those patients under 1 year of age (infants) should be seen by a senior member of the A&E team prior to discharge. This is a high risk group – particularly when presenting with bruise or injury in infants<6 months or in a non-mobile child.
Guidance should be followed regarding adequate care received by paediatric cases in the ED: Specific guidance regarding safeguarding children potentially at risk – often outlined in Local trust policy

Infants (Under 1yr Olds) are recognized as a group of patients who are at a higher risk level due to various reasons. Hence it is recommended that they be reviewed by a Senior Clinician. Last year's audit of practice showed that 25% of Infants were not offered this service. This group included Infants who were known to Social Services as well.
Senior Clinicians = ED Consultants, ED Registrars/MGs, Paediatric Consultants, Paediatric Registrars, Paediatric Advanced Nurse Practitioners.

Aim:
To review all children under 1 presenting to the A&E department from Sept 2015 – Aug 2016
Children discharged from A&E
Seen by senior (ENP, middle grade or above)
Presenting with burns, contusions, #
Discussed with paediatrics, Social Services/already known to services

Summary of Findings
EDIS notes reviewed for the following information:-
1) Documented ED senior as reviewing the patient in the department.
2) Children presenting with burns, contusions (inc head injury), #
3) Children d/w paediatrics
4) Children known to or referred to SS prior to d/c

Results
- Total included = 1373
- Number seen by Senior in A&E = 984 (72%)
- Burns/contusion (inc MHI), # = 208 (15%)
  ==> Of these 199 (96%) were seen by a senior
- D/W paeds rather than A&E senior = 106 (8%)
- Known to or d/w SS or support workers = 12 (0.9%)
  ==> 3(0.2%) infants known to SS were not seen by a senior
- 283(21%) neither seen by A&E senior nor d/w paeds

Conclusion
- 21% of children <1 discharged from ED were not seen by an A&E senior
- Of those infants presenting with burns, contusion or # 4% were not seen by a senior in the emergency department
- 25% of those infants either referred to or already known to SS were not seen by a senior in the department
- Noted from EDIS retrieval that some of these patients may have been seen but nothing was documented!

All infants presenting to our EDs are reviewed by a Senior Clinician before they are discharged. Junior colleagues are advised to discuss all infants with a senior.

It is highly recommended for seniors to review patients themselves in following presentations:
1. All with fever
2. All with PAWS score >4
3. All neonates (less than 28days old)
4. All known to social services (including any family member known to services)
5. All with burns
6. All with suspected skull fractures
7. All with long bone fractures (excluding elbow, wrist, knee & ankle fractures)
8. All non-mobile infants with injuries
9. Returning with same problem within 72hrs
10. Any concerning presentations

After review/ discussion, the encounter should be documented in EPR notes as a separate entry titled as "Senior Review". It's recommended to use "ED Senior Review Notes" for this purpose. This should be ideally done by the Senior Clinician; however, the Junior Clinician could do it on behalf of them. Senior should check that note and endorse it in an addendum with any corrections/ additions if needed.

What changes in practice have been agreed?

Recommendation	Action	Responsible Person	Target Date	Date Completion & Evidence
Ensure infants would not be streamed in to "Minors"	All current Triage trained nurses should be informed about this & add on to ongoing Triage Training	Ms Louise Croxall	15/08/2017	15/09/2017
Ensure all Junior Doctors & ANPs are informed that infants should be discussed with a Senior & document the encounter on EPR	Include in Junior Doctors & ANPs Induction. Expand 1 of 4 "Consultant sign-off" indications "Under 1yrs old with Fever" to "All Under 1Yr old" Reinforce through "Paediatric" talk at Induction	Dr Mark Davies Dr Chamika Mapatuna	03/08/2017	03/08/2017 Induction PP presentations
	Reinforce same information at Junior Doctors teaching session on "Safeguarding"	Dr Chamika Mapatuna Ms Janet Youd	28/09/2017	28/09/2017 Teaching PP presentation
	Reinforce same information at ANP teaching	Dr Huw Masson	15/08/2017	15/09/2018
Ensure all ED Senior Clinicians are informed that they should give a "Senior Sign-Off" to all infants by direct review or through case discussion with documented evidence on EPR	Memo to all ED Consultants, Registrars/ MG Trust Doctors, regular MG Locums & Senior Paediatric Doctors and PNPs (via Dr Cath Rouke ED Link Paediatric Consultant)	Dr Chamika Mapatuna	15/08/2017	15/09/2017 Memo
Re-audit the process	Audit in April 2018 – Review randomly selected 100 (50 from each site) case notes of Infants presented between Oct 2017 to March 2018	Dr Chamika Mapatuna	15/04/2018	01/06/2018 Present at June QI Forum

Use of opioids in palliative care – NICE CG140 snapshot

Pain is common in advanced and progressive disease. Up to two-thirds of people with cancer experience pain that needs a strong opioid. This proportion is similar or higher in many other advanced and progressive conditions.

Despite the increased availability of strong opioids, published evidence suggests that pain which results from advanced disease, especially cancer, remains under-treated.

Each year 300,000 people are diagnosed with cancer in the UK and it is estimated that there are 900,000 people living with heart failure. Others live with chronic illness such as kidney, liver and respiratory disease, and with neurodegenerative conditions. Many people with these conditions will develop pain for which a strong opioid may be needed.

Strong opioids, especially morphine, are the principal treatments for pain related to advanced and progressive disease, and their use has increased significantly in the primary care setting. However, the pharmacokinetics of the various opioids are very different and there are marked differences in bioavailability, metabolism and response among patients.

A suitable opioid must be selected for each patient and, because drug doses cannot be estimated or calculated in advance, the dose must be individually titrated. Effective and safe titration of opioids has a major impact on patient comfort.

Objectives:

- To ascertain if prescriptions are appropriate
- Do patients understand what they are prescribed & the side effects →Communication
- To review compliance (should hit 100%)

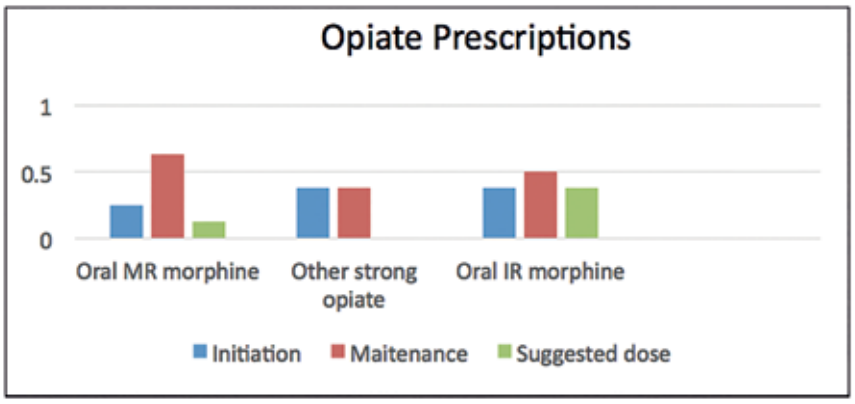
Summary of findings for CHFT

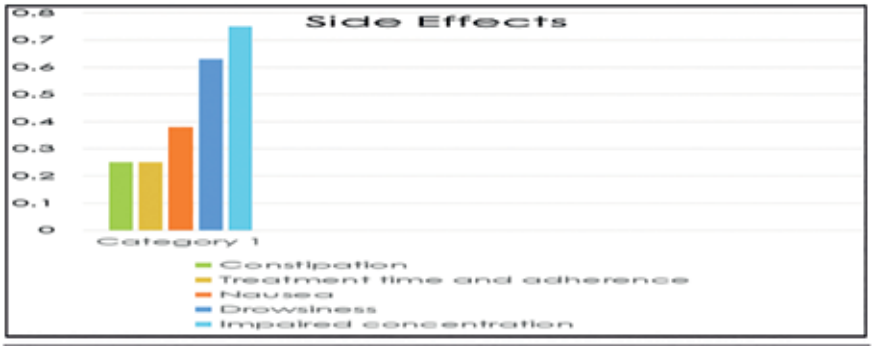
The ward 12 book was used to review current inpatients with admissions over the last four months.

Discharge summaries were also reviewed.

8 patients only – difficult to find on EPR.

Difficult to go back more than 4 months as some patients had died, some at end of life or didn't meet criteria so were not included. Some patients were started on opiates by GP.





Conclusions

- Limitations included:
- Sample number small
- Finding the information challenging
- Patient life span reduced
- Refusal or inappropriate to fill questionnaire
- Opiates prescribed in other settings
- Anticipatory prescribing
- Failing to prescribed laxatives
- Not reaching NICE standards

Discussion

- A leaflet re morphine is already available on the repository. Beware of information overload for patients and also of morphine addiction /overload / side effects.
- A significant number (almost 40%, of a small number) were prescribed other strong opioids, ?oxycodone. The guidance is clear that the first line opioid should be morphine, so when a re-audit is undertaken, we need to look at much bigger numbers, and also look for evidence as to why morphine wasn't prescribed, or why oxycodone was.
- It would also be good to look at prescribing in renal impairment (which isn't mentioned in NICE guidance, but is hugely important).
- Look and see if the guidance on the Trust intranet (and which echoes regional guidance in Y&H) is being adhered to.
- Also review anticipatory medicine prescribing, which can easily be accessed through EPR. There is a suspicion that the PRN doses are often incorrect for patients already prescribed strong opioids.

Recommendations

- Leaflets, TTOS →patients. Encourage patients to ask questions in consultations
- Re-audit with larger number. Re-audit to include:
  o evidence as to why morphine wasn't prescribed, or why oxycodone was.
  o prescribing in renal impairment
  o if the guidance on the Trust intranet (and which echoes regional guidance in Y&H) is being adhered to.
  o review of anticipatory medicine prescribing to ascertain if the PRN doses are correct for patients already prescribed strong opioids.

What changes in practice have been agreed?

KEY (Change status)
1 Recommendation agreed but not yet actioned
2 Action in progress
3 Recommendation fully implemented
4 Recommendation never actioned (please state reasons)
5 Other (please provide supporting information)

Action plan lead	Name: Mary Kiely	Title: Palliative Care Consultant	Contact: x2965 HRI

Recommendation	**Actions required** (specify 'None', if none required)	**Action by date**	**Lead Person**	**Comments/action status** (i.e. action in progress, changes in practices, problems facilitating change, reasons why recs have not been actioned etc.)	**Change stage** (see Key)
Improve communication with patients : i.e. leaflets &, TTOS	Encourage patients to ask questions in consultations	Ongoing	All medical staff		2
Re-audit with larger numbers & points listed above for more robust results	Add to 2018/19 OHPC audit programme	April 2018	Junior doctors to be nominated by MK		1