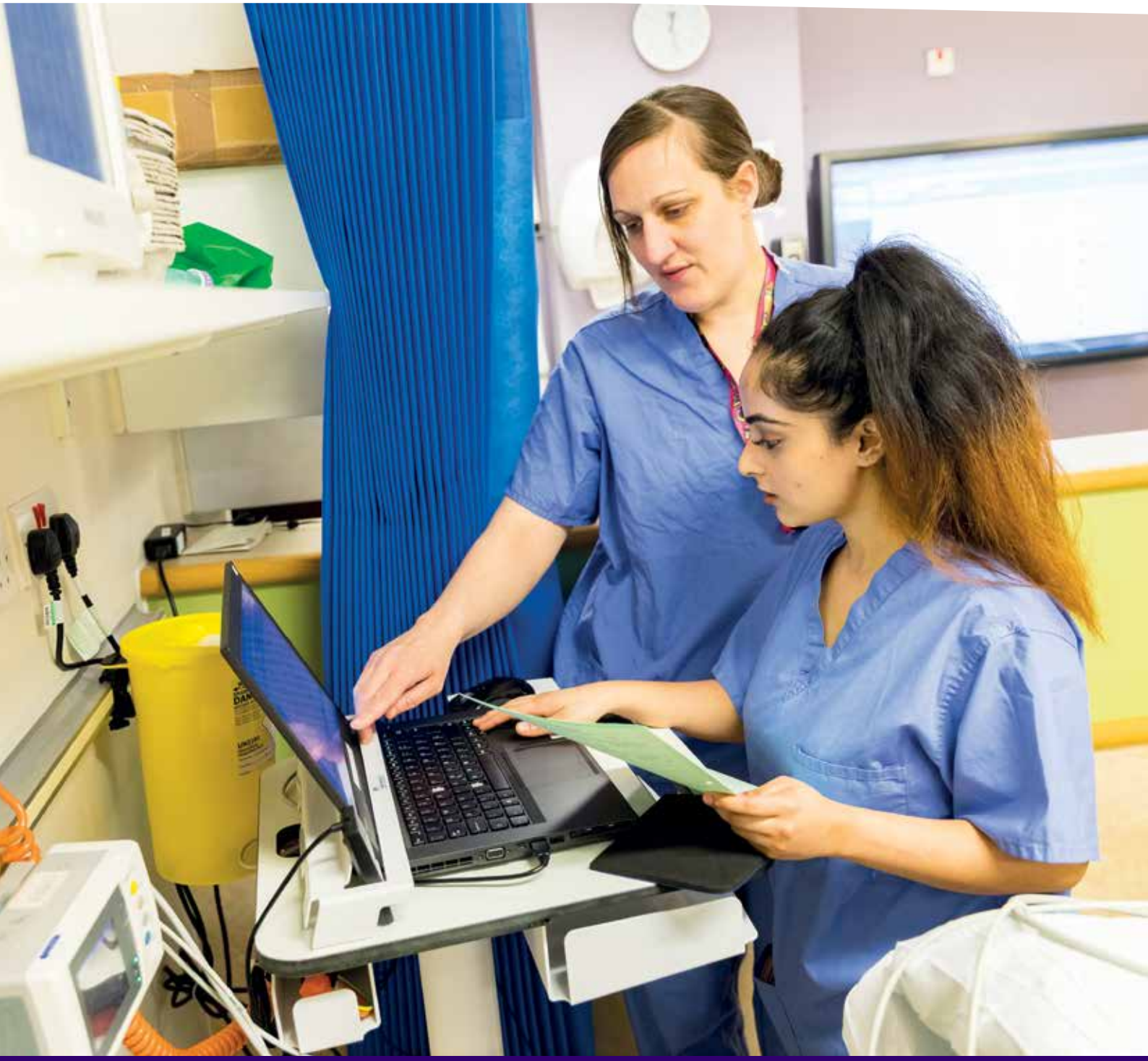
NHS

Calderdale and Huddersfield

NHS Foundation Trust



Quality Account 2018/19

compassionate care

Part 1: Chief Executive's Statement

Welcome to the 2018/19 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 our Governors, we have identified as priorities for the coming year.

The Care Quality Commission concluded their onsite well-led inspection on 5 April 2018 and in June 2018 we were delighted to receive the published report rating the overall quality of care provided by the Trust as "good", an improvement from our previous rating from 2016 of "requires improvement", with some areas of outstanding practice also highlighted.

Following work with partners during the summer of 2018 an enhanced proposal for the future model of care was submitted to the Secretary of State for Health and Social Care in August 2018 and in December 2018 it was announced that capital funding of £197 million had been allocated to support implementation of the enhanced proposal.

The year has seen colleagues continue to focus on ensuring our patients receive timely and effective care with performance continuing to improve across all domains.

A focus on Infection Control has yielded the desired results for our patients. We continue to focus on the patient experience with improvements to our 'would recommend' across many wards and departments.

Our delivery of Emergency care services for patients is recognised as being amongst the best nationally. We spent a lot of time learning from last winter and, with clinical colleagues, agreed a very different winter plan for 2018/19 that was successful. We have worked closely with partners across health and social care all year and our partnership working has seen a significant improvement with people being cared for at the right time, in the right place by the right people.

Our Calderdale Community division has seen increasing numbers of patients, supporting them to remain at home and avoid hospital admission as well as securing a prompt and safe discharge. Patients on cancer pathways are treated within an appropriate timescale and we have seen significant improvements in Stroke care, attaining the highest possible rating in the most recent national audit.

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

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

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 2019

Part 2: How the Trust performed against the three priorities set for 2018/19

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 2018/19.

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 2018/19?
Safety	Improving outcomes through recognition, response and prevention of deteriorating patients	Yes
Effectiveness	Patient Flow – Improving Timely & Safe Discharge	Yes
Experience	Improve experience of patients on care of the dying pathway	Yes

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 implementation 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 and how we did during 2018/19

The Deteriorating Patient Group has met on a monthly basis chaired by the Associate Medical Director for Quality & Safety. The focus has remained on timely recognition and response to patients who deteriorate in hospital and where possible the prevention of further deterioration. The scope of this group is patients with a NEWS, national early warning score of 5 or more excluding patients with suspected sepsis.

Recognition

Early recognition of patients who are deteriorating is reliant on timely and accurate patient physiological observations. Following an observational study during the year it was noted that the majority of patient observations are carried out by healthcare assistants, HCAs. All HCAs complete competency assessments prior to independently carrying out patient observation tasks. The study showed that there is the need for ongoing training to ensure that measurements remain accurate. This work will be carried out during 2019-20. Observations performed on time performance continued to be lower than in previous years for the first six months of this reporting period. However, with a focussed effort especially from within the clinical divisions this has improved once again and remains above 70%. There is scope to improve this further by ensuring that observations are 'skipped' if the patient is for example, off the ward.

The Trust is expected to implement NEWS2, national early warning system, in 2019 and this has been identified as a quality priority for the 2019-20 period. The additional training mentioned above will include focus on the changes seen within NEWS2 including the online e-learning tool. Evaluation of NEWS2 will be a key measurement in 2019-20.

Response

In line with NEWS2 the escalation policy has been revised as part of the overall Adult Physiological Observation policy. In-hours escalation of patients with a NEWS of 5 or more remains through ward based teams. A Critical Care Outreach Nurse responds to patients with a NEWS of 7 or more during the period of 8am to 8pm seven days a week. In the out of hours period the HOOP team will respond to patients with a NEWS of 5 or more. There remains a gap in a centrally coordinated response (not just ward based teams) to patients with a NEWS of 5 to 7 in normal working hours. In order to address this there are plans to review how Critical Care Outreach and HOOP could collaborate to provide a more cohesive approach to all patients who deteriorate. In order to facilitate this there will be a Work Together, Get Results session planned for the summer of 2019.

Previously patients with a NEWS of 5 or more were also screened for Sepsis. However this no longer occurs given that screening for Sepsis is through the EPR algorithm.

Prevention

It was proposed that safety huddles are promoted to ensure that all team members are aware of those patients who are deemed to be at risk of deterioration. Safety huddles are in place across the Trust however the quality and focus of these has been variable. Furthermore it was hoped that a 'ward view' could be projected on flat screen televisions to more easily identify patients with raised NEWS scores. Unfortunately, neither the screens nor the 'ward view' on the electronic patient record, EPR are available. Wards are being encouraged to continue with safety huddles however any further improvement on using EPR will need to be carried into 2019-20.

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

Why we chose this Patient Flow – Improving timely and safe discharge

Why we chose this

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

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

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

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

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

Improvement work

SAFER Patient Flow Programme

The work has continued throughout 2018/19 through three work streams, bed avoidance, bed efficiency and bed alternates.

There have been a number of successful quality initiatives developed and implemented through the SAFER Programme and in collaboration with partner organisations.

Schemes implemented through the work streams are:

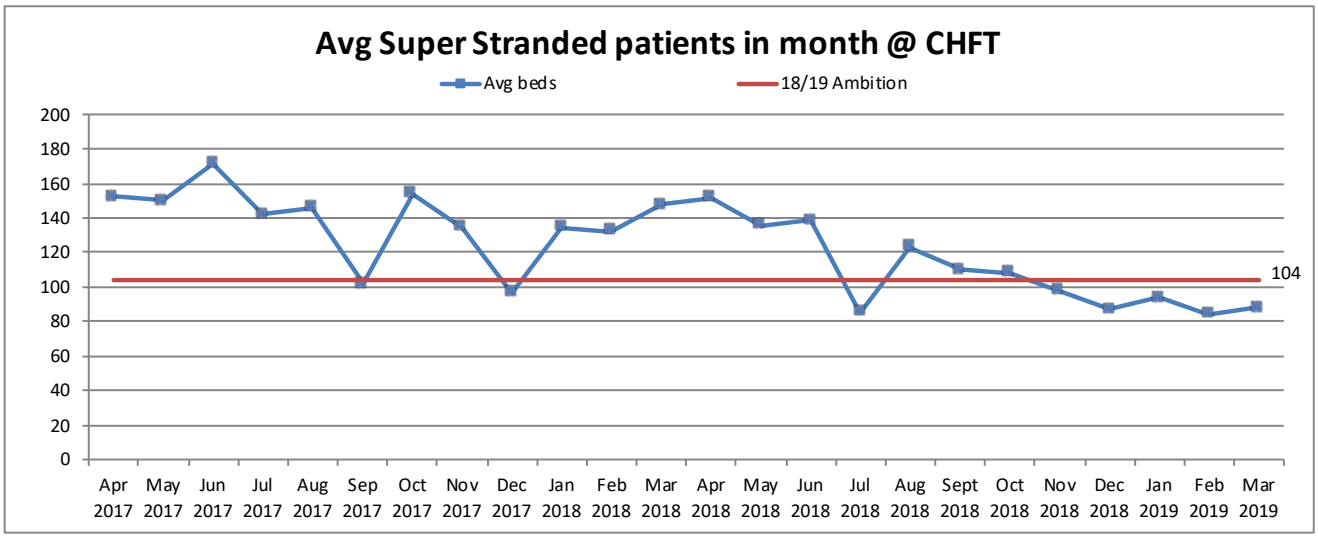
- **Trusted Assessment –** discharge coordinators complete all assessments for patients appropriate for referral into the reablement pathway, with quality control in place, this has enabled a smoother, quicker transfer into reablement services.
- **Trusted Assessor –** A dedicated Trusted Assessor funded by Local Authority works within CHFT Discharge Team to provide onsite immediate assessments for patients who need to be transferred into a care home facility. This nurse has built strong relationships with care home managers who trust her to assess the needs of the patients, communicate these to the home to prevent the need for the home managers to attend the hospital, which was in many cases causing delays of up to a week. She also has improved communication and handover with the nursing home.

- **Home First Team –** working with the discharge team focusing on reducing the number of stranded (patients with a LOS 7 days and over) and long stay patients (patients with a LOS of 21 days and over). The teams ensure discharge planning commences on admission, patients have a clear clinical plan that is reviewed timely, and the patients clinical and discharge plan is tracked to ensure any delays are prevented.
- **Standardised Multi-disciplinary (MDT) meetings –** Elderly Care consultants have developed daily MDTs.
- **Enhanced reablement –** a service that is dedicated to support patients being discharged from hospital.
- **Continuing Healthcare Assessments –** all assessments are now completed following discharge and not prior.
- **Introduction of the Non-weight bearing pathway –** patients with long leg plaster casts or bi-lateral arm plaster casts often struggle to go home as their own accommodation cannot be adapted for them to manage independently. They are provided with alternate accommodation rather than waiting in hospital for the cast to be removed, often 6 weeks.
- **Community Care Discharge to Assess Beds –** Enable long term decisions to be made away from an acute setting with an opportunity for further recovery. Enable families and representatives time to visit and select preferred care home settings. Enable ongoing assessments for long term care home provision to be completed in an alternate setting.

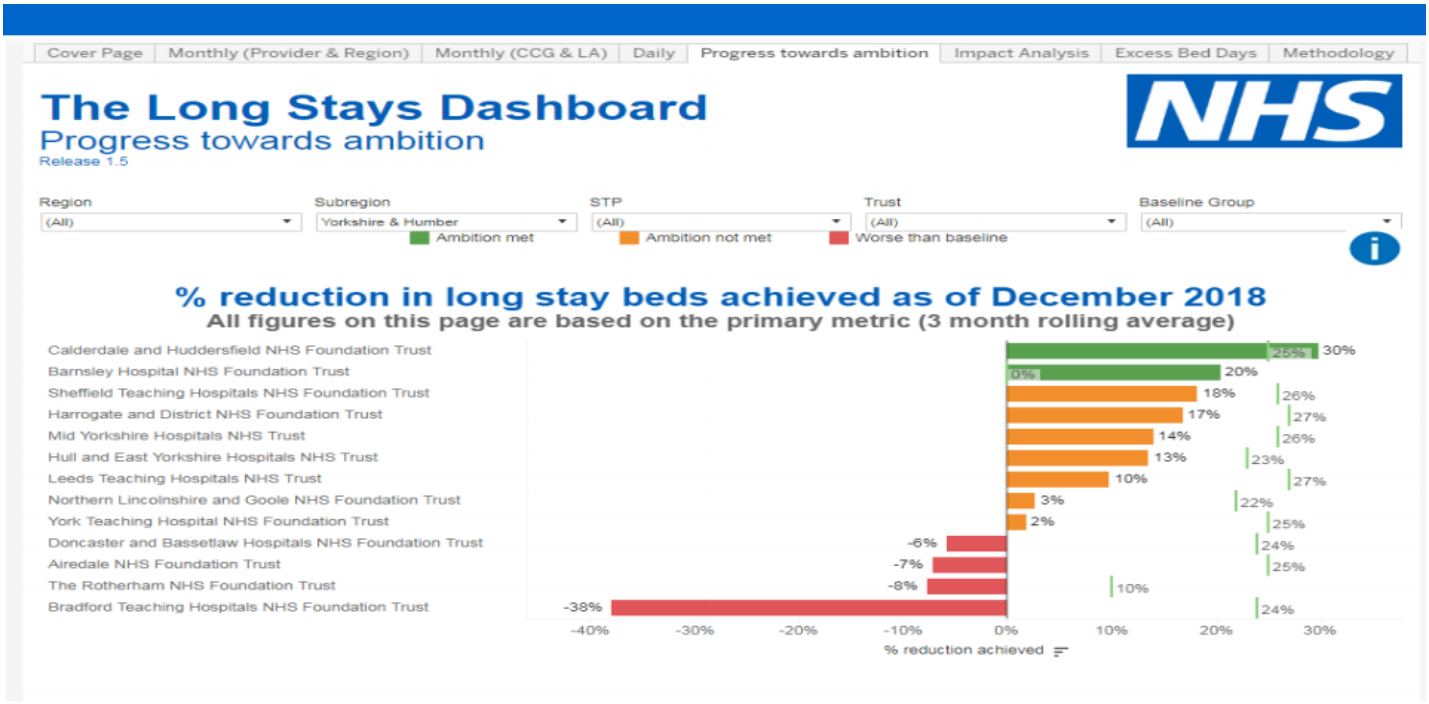
All of these schemes have enabled patients to be discharged, safely and in a much more timely way.

How have we done?

Below the table demonstrates the gradual improvement in the reduction of beds used for long stay patients since August 2018, it also shows that we are now below target and have sustained this ambition since October 2018.



The table below also shows the achievement compared to other Trusts in the Yorkshire and Humber Region.



NHS Calderdale

NHS Greater Huddersfield

The SAFER Patient Flow Programme will continue into 2019/20 with an ambition to continue the discharge improvements and work closer with community colleagues on providing care closer to home.

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

End of Life Care – Why we chose this

Improving end of life care (EOLC) continued to be a priority area for the Trust during 2018/19, as regardless of where patients die, whether their death is expected, it is vital that they receive appropriate end of life care. During the year the Trust has looked to sensitively establish that patient's relatives felt that the needs of their loved one were met in a compassionate and appropriate way.

How Did We Do

End of Life Care Improvement work during 2018/19

Bereavement Survey
The bereavement survey is part of the Trusts Learning from Deaths (LfD) programme. This programme supports a quality improvement plan relating to death and dying primarily for improved patient and family/carer experience and patient outcomes. We undertook an annual bereavement audit with a small number of patients with a response rate of 30%

In order to gather more feedback to both highlight the areas of excellent care and areas that we can improve on, a 6 month pilot audit has been undertaken on our stroke wards at Calderdale Royal Hospital, CRH. Prior to sending the survey, a bereavement card was sent to families to offer support and also inform them of the upcoming survey. The Trust had a 47% response rate which is an increase on the last bereavement survey (30%). The audit has now finished and the results are being shared with the stroke team and an action plan is to be developed.

Bereavement Cards
A bereavement card has been developed and co designed with bereaved relatives. This card will be sent out 1-2 weeks after the death of a loved one offering our condolences as a Trust and also offering a phone number for relatives to ring if they have any question/concerns or compliments. The card is being used initially within the Surgical division and has started to be sent out to our bereaved relatives. The cards will be reviewed after 3 months with the plan to disseminate it Trust wide. The bereavement cards sent from the stroke wards during the pilot are also going to continue.

Bereavement café
The Chaplaincy department alongside the end of life care facilitator have developed the "Marigold café" which is a bereavement café started in September 2018 and is open to anyone who has suffered bereavement. The café is open on both hospital sites on the first Friday of each month. An information leaflet about the Marigold café is given to families when collecting the death certificate. We also plan to advertise the café further within the communities we serve.

End of life Care (EOLC) Education
End of Life Care (EOLC) education is part of the Trust's essential skills training framework for clinical staff including Doctors, Nurses and Health Care Assistants. A DVD about the Individualised Care of the Dying document (ICODD) has been made part of the essential training to help staff support patients and families and also for colleagues to be more confident in using the ICODD and having end of life care conversations.
The Trust continues to provide;

- Communication skills training
- Full EOLC education days for Drs, Nurses, HCAs, AHP and Apprentices.
- Deliver EOLC training on the Trust induction and preceptorship courses.
- We provide and support HCAs to complete EOLC competencies across the Trust.
- Ad hoc teaching and in- reach is provided across areas that ask and also if there have been issues identified in an area we provide support to increase skills.

End of life care champions
Ten community CHFT nursing staff are now EOLC Champions. Our second cohort started in October 2018 with 24 nursing staff from both community and hospital. This six month course helps to increase confidence and skills in EOLC to bridge the gap between specialists and generalists. The Champions take everything they have learnt back to the areas they work and become a resource and a support for other staff. We are also starting healthcare assistant, HCA, Champions in April 2019 and have 14 HCAs signed up for this. The first cohort of Champions still meet regularly to continue the education and training. Since completing the course there has been an increase in the use of an electronic palliative care record known as EPaCCs (a system which stores all palliative care and end of life information about a patient in one place and can be viewed by community colleagues, Trust staff, primary and secondary care colleagues and hospice staff) and Champions having Advance care planning and DNACPR discussions.

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

Horizon group
This is a collaborative group which includes CHFT, Calderdale Council, the Council of Mosques and Overgate Hospice. The group was started to support and develop end of life concerns raised by Muslim patients and families with issues around end of life care – such as feeding and decisions on resuscitation (DNACPR). We feel we have improved the understanding and relationships between healthcare providers and the South Asian Community improving patient and families experiences of dying in CHFT. The group has also developed;

- Faith cards which have cultural and religious basics for each faith in our localities – to all wards and Hospice.
- An audio tape produced locally but distributed nationwide by MacMillan Cancer Support.
- Improvements to education – cultural and religious aspects added to all end of life care training modules
- Changes in hospice practices to enable faith to be celebrated.
- Worked with skills for care nationally to produce a training DVD on being Confident with difference. Two videos have been developed with the Horizon group with skills for care.
- Future EOLC events are planned, including one for May 2019 at the Sikh temple in Huddersfield and one at the Madni Mosque in Halifax for the South Asian community. The group is also developing materials to help support the LGBTQ (lesbian, gay, bisexual, transgender and questioning) community in the last year of life.
- We are also seeking some funding for a two year project for a Cultural Support worker to enhance and develop the work of the Horizon Group.

Priorities for 2019/2020

- End of Life Care education to be embedded on the essential skills training framework
- Increase in the use of the ICODD to provide consistent evidenced based care to our patients.
- Bereavement cards to be implemented Trust wide
- Promote awareness of the Marigold café
- Increase use of the End of Life Companions

Reporting
Reporting on End of Life Care during 2018/19 has been to the Trust's Clinical Outcomes Group.

Looking ahead to 2019/20

A 'long list' of potential priorities for 2019/20 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 2018/19,
- Council of Governors workshop.

This long list was discussed with the Trust's Council of Governors; an opportunity to vote was also given via the Trust's internet site advertised in Foundation Trust News which is circulated to the Trust membership. This work has helped identify the following quality improvement priorities for 2019/20.

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

The three priorities for 2019/20 are:

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

Priority One: Safe

Clinical outcomes linked to waiting times in the Emergency Department

Why we chose this
The waiting times in the Emergency Department have an impact on clinical outcomes as well as patient experience. The length of time that patients wait in ED can lead to poorer patient outcomes, with some patients leaving without being seen.

We endeavour to see and treat patients as quickly possible, measuring ourselves within the 4 hour emergency care standard, ECS target and monitoring our patients waiting over 8 and 10 hours.

Improvement work
To reduce the number of patients waiting over 8 and 10 hours we will review all the clinical rotas to ensure we have the right number of appropriately trained staff to meet the demand.

As part of this we will have clear escalation protocols for the teams, explaining how to request support when patients are experiencing delays in their pathways.

We will work to embed the Trust action cards, which are Trust agreed rules to ensure patients receive timely specialty reviews, transfer to the ward and are treated in the most appropriate environment for their care, to ensure patients are transferred to the next location in their journey (e.g. the ward) as soon as possible.

Reporting
We will monitor performance against the Emergency Care Standard and patients waiting over 8 and 10 hours in the Emergency Department through the Emergency Department directorate board.

Priority Two: Effective:

Deteriorating Patients – NEWS 2 Implementation

Why we chose this
Implementing NEWS2, the National Early Warning Score will allow us to more accurately recognise and respond to patients who critically unwell or who deteriorate in hospital. NEWS2, in comparison to NEWS, will now alert Trust colleagues to patients who are 'confused' as part of their assessment of consciousness. This is in addition to changes in their physiological parameters such their heart rate, breathing and temperature. NEWS2 is also more accurate for patients with known chronic lung disease, such as Chronic Obstructive Pulmonary Disease, COPD, who at present over alert. As with all patients who deteriorate, early recognition will allow for a more timely response and better outcomes for patients.

Improvement work
In 2019/20 we will:

- embed the changes needed within Nervecentre and the electronic record, EPR, to allow the NEWS2 score to be recorded
- support all clinical colleagues to access the online e-learning training for NEWS2
- revise the escalation policy with respect to raised NEWS
- facilitate additional training of nursing staff to ensure that physiological observations are timely and of high quality
- review and evaluate the use of the Confusion score and support any training required
- analyse outcome data from patients with raised NEWS

Reporting
There will be verbal and data reporting of progress of all of the above to the Deteriorating Patient Group. A quarterly narrative will also be provided.

Priority Three: Experience:

Mental Health in the Emergency Department

Priority Three: Experience: Improving psychological and social support for mental health patients in the Emergency Department

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

Improvement work
We are seeking to improve the environment for high risk patients in the Emergency Department, requiring a ligature free environment, by now having a ligature free room on both sites. We will ensure staff have access to the best guidance on how to appropriately support and manage the patients requiring access to these rooms by using a clear standard operating procedure to guide staff on using these rooms with patients.

We have recently received some funding from our commissioners to have a mental health nurse on site 24/7 to provide 1:1 support to mental health patients in the emergency department and will develop this service during 2019/20.

We continue to work with the mental health liaison team to ensure timely review and care planning for mental health patients

Reporting
We will report regularly on progress in this area within the Emergency Directorate and the Patient Experience Group.

Statements of assurance from the Board

Review of services
During 2018/19 Calderdale and Huddersfield NHS Foundation Trust provided and/or sub-contracted 36 designated Commissioner Requested Services.

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

The income generated by the relevant health services reviewed in 2018/19 represents 90% of the total income generated from the provision of relevant health services by Calderdale and Huddersfield NHS Foundation Trust for 2018/19.

Participation in Clinical Audit
During 2018/19, 48 of the national clinical audits and four 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 92% 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.

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

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2018/19 that were recruited into trials during that period to participate in research approved by NHS Health Research Authority and the National Research Ethics Committee was 1563 (as at end of February 2019).

The Trust was involved in conducting 89 clinical research studies all of which were actively recruiting (excludes student and Participant Identification Centre - PIC studies), 28 were closed to recruitment (but participants were still involved e.g. in follow-up) and 26 new recruiting studies were opened. A further 28 studies were undergoing 'capacity and capability assessment'.

During 2018/19 actively recruiting research studies were being conducted across all 5 Trust Divisions across twenty eight clinical specialties:
- Families and Specialist Services, 18 studies, 9 specialties
- Corporate, 1 study
- Medical Services, 49 studies, 11 specialties
- Surgical and Anaesthetic Services, 9 studies 6 specialties
- Community, 1 Study

There were 110 clinical staff (supported by 18 non clinical staff) participating in research at the Trust during 2018/19, of which 51 were local principal investigators.

Also, in the year nine 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 – Adult Inpatients
During 2018/19, 1464 CHFT adult inpatients died. This comprised the following number of adult deaths which occurred in each quarter of that reporting period:
- 363 in the first quarter;
- 329 in the second quarter;
- 381 in the third quarter;
- 391 in the fourth quarter

The process for learning from adult deaths evolved during 2018-19. ISR's (Initial Screening Reviews) remain first line as a case note review however these are no longer randomly allocated across the consultant body. ISR's are now reviewed within specialty using the generic ISR online tool with or without specialty specific questions. Cases where the quality of care has been assessed as poor or very poor are escalated for a more in depth and independent (of the specialty) SJR (Structured Judgement Review). Similarly the SJR assesses the quality of care in line with the Royal College of Physician's recommendations. Themes from SJRs are collated quarterly and are fed back to clinical teams to inform quality improvement.

Certain cases are escalated directly for a SJR including deaths in patients admitted for elective procedures, patients with learning disabilities, patients with significant mental health disorders, deaths where there is a Serious Incident and/or complaints from relatives/carers.

As at the end of March 2019, 397 initial screening reviews and 91 Structured Judgement reviews have been carried out. It should be noted that the overall number of reviews has declined however should improve with the revised allocation of ISR's within specialties. This improvement should be evident in Q1 of 2019/20.

The number of Structured Judgement Reviews carried out per quarter was:
- 22 in the first quarter;
- 16 in the second quarter;
- 28 in the third quarter;
- 25 in the fourth quarter

During 2018/19 39 Structured Judgement reviews identified problems with care provided to the patient. The reviewers are asked to make a judgement as to if the problem led to patient harm. The breakdown of responses was:
- Yes – 5
- Probably – 20
- No – 13

In one case a judgement regarding harm was not recorded

In 5 cases representing 0.34% of all adult inpatient deaths during 2018/19 a problem with care was judged to have led to patient harm.

From a thematic analysis of cases between August 2017 and end of July 2018 (total number of 101 SJR's) the top 5 areas of good practice are:
- Good quality of care in approximately 85% of cases reviewed
- Excellent junior doctor decision making
- Good pre and post procedural care
- Excellent specialist palliative care in-reach
- Timely and appropriate in-reach into the emergency department,

And the main areas where improvement in care is needed are:
- Communication between healthcare professionals, patients and their families and carers
- Documentation especially of communication, diagnoses and cause of death
- Timely senior review at all levels
- Timely escalation or decision making not to escalate
- Recognition of the dying phase and full implementation of the Individualised Care of the Dying document (ICODD)

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

Child deaths – 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 2018/19, 13 of CHFT's paediatric inpatients died 10

This comprised the following number of child deaths which occurred in each quarter of that reporting period:
- 3 in the first quarter
- 2 in the second quarter
- 3 in the third quarter
- 2 in the fourth quarter

By March 2019, for all 7 cases a case record review.

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:
- 1 in the first quarter
- 1 in the second quarter
- 3 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.

Seven day services

The 7 Day Hospital Services (7DS) Programme was developed to support trusts to deliver high quality care and improve outcomes on a 7 day basis for patients admitted to hospital in an emergency through ten clinical standards. Since 2015, acute trusts such as Calderdale and Huddersfield Foundation Trust have been asked to focus on the following four priority standards:

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

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

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

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

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

The Trust reviewed and completed the draft NHS England Board Assurance Framework for 7 Day hospital Services during the year which is self-assessment of seven day service performance. The Trust is one of two sites in the North of England to pilot the new assurance template for seven day services and in July 2018 a repeat audit was conducted on standards 2 and 8.

	Mar-18	Sep-18
Clinical Standard 2	**91%**	**94%**
Clinical Standard 5	**100%**	**100%**
Clinical Standard 6	**100%**	**100%**
Clinical Standard 8	**98%**	**96%**

The Trust submitted the new methodology and pilot audit results to the Executive Board to confirm that this provides the Board with sufficient assurance. Going forward we look to provide additional assurance through consultant job plans of:

- sufficient daily consultant presence to support the delivery of Standard 2
- twice daily consultant ward rounds for high dependency patients and once daily ward rounds for all other patients in all specialities which cover emergency admissions every day of the week (Standard 8)

The Trust has confirmed continued compliance against the 4 priority standards in September 2018 using the new NHS England methodology.

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

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

- Focussed recruitment meetings with senior clinical leaders and managers
- Foundation Year 3, 'FY3' posts created to attract trust doctors in a number of specialties. Whilst not recognised for training these posts offer junior doctors an opportunity to enhance experience in a number of specialties
- Expanding the number of posts for Medical Training Initiatives (MTI doctors).
- Encouraging the opportunity to appoint doctors at 'middle grade' level in Specialty doctor posts that the trust will support to gain the relevant competencies to gain Specialist registration with the General Medical Council and therefore able to practice at consultant level. These are known as CESR posts (certificate of equivalence for specialist registration). This allows us to 'grow our own' and develop people
- Attending the British Medical Journal Careers Fair in October 2018 to promote the Trust as an attractive place to work
- The board signed up to adopt the SAS Charter (Staff and Associate Specialists)
- Clinical Leadership Programme for our Clinical Directors
- Improving Junior Doctors' Working Lives - focused group looking at a number of measures to enhance the trainees' experience at the Trust

A report from the Guardian of Safe Working presented a report to the Board in March 2019 confirmed the following in relation to rota gaps:

- Within the Medical Division registrar level gaps are an issue with 11 gaps across two sites – these are being covered out of hours by bank / agency staff
- Within Emergency Medicine, from February 2019 the Trust has had a full complement of junior doctor trainees. Registrar level gaps persist, some are covered by long term bank staff and there are five advanced nurse practitioners, some of whom are on the junior trainee rota to help fill gaps
- During quarter 4 there was an improvement in middle grade doctors in the surgery division with a full complement of such doctors for the first time in five years
- Within the Family and Specialist Services division Obstetrics, Gynaecology and Paediatrics have some registrar gaps

Freedom to Speak Up
The Trust encourages all staff to speak up through a variety of means including:

- through the Raising Concerns policy by which staff can access the Trust's Freedom to Speak Up Guardian
- "Ask Owen", an option on the Trust intranet where staff can raise issues directly with the Chief Executive
- the DATIX incident reporting system
- regular team briefings

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

The Trust CQC inspection report, published in June 2018 following an inspection in April 2018, commented on the open culture in the Trust, stating:

"There was strong visible and effective leadership across the majority of the services we inspected. There was an open culture and most staff felt supported by their line managers."

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

The Trust's new Freedom To Speak Up Guardian commenced in late March 2019 and will be supported by a well-established network of Freedom to Speak Up ambassadors who come from a wide cross section of the Trust's workforce.

The Trust's Raising Concerns policy makes it clear that staff who speak up must not suffer a detriment. Where there is evidence that this has occurred action will be taken as appropriate. The Raising Concerns Policy is under review and this work will be completed by the Freedom to Speak Up Guardian with support from workforce and organisational development staff at the earliest opportunity.

Goals agreed with commissioners

A proportion of Calderdale and Huddersfield NHS Foundation Trust's income in 2018/19 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 NHS England – Direct Services the 2017-19 National CQUIN Guidance split the usual 2.5% CQUIN funding as follows:

- 1.5% agreed scheme indicators
- 1% to support engagement with service transformation plans (STPs)

For NHS England – Specialised the 2017-19 National CQUIN Guidance the full 2.0% CQUIN funding was all for national indicators.

The contract value for CQUINs in 2018/19 was £6.85m (£6.56m for CCGs and £0.29m for NHS England compared to 2017/18 when the CQUIN achieved was £6.67m..

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. Preventing ill health by risky behaviours – alcohol and tobacco	Acute
8. Improving the assessment of wounds	Community
9 .Personalised care and support planning	Community

Further details of the nationally agreed goals for 2018/19 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)

The Trust entered into an Aligned Incentive Contract (AIC) in 2018/19 with its main commissioners, NHS Calderdale CCG and NHS Greater Huddersfield CCG. The AIC was a fixed value contract with CQUIN protected at contract levels. The Trust also had a year-end agreement with NHS England – Specialised based on full achievement of CQUIN. The actual value of CQUIN achieved in 2018/19 therefore was £6.85m.

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

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

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

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

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

Following the inspection action plans were developed and a process for monitoring progress via a schedule of core service updates to the CQC Response Group was implemented. The CQC Response Group reports to the Quality Committee.

Most actions are due to be completed and embedded by 31 March 2019 and are on track to deliver. Two actions (Medical Staffing Urgent and Emergency Care and Medical Staffing Critical Care) are not progressing to plan; these actions will not be fully completed until service reconfiguration.

Calderdale and Huddersfield Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Data Quality
The Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

Which included the patient's valid NHS number was:

Admitted Patient Care = 99.9%
Outpatient care = 100%
Accident & Emergency Care = 99.4%

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

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

These figures are based on April 2018 to December 2018, which are the most recent figures in the Data Quality Dashboard.

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

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

The recommendations made following a review of the corporate data quality structure were accepted and additional staff have been recruited. This is a positive step as the introduction of the EPR has raised the profile of data quality within the organisation.

Information Governance
The Trust Information Governance assessment report overall score was 73% compliance in March 2018. Work is continuing with the gathering of evidence for the March submission of the Data Security and Protection Toolkit (Replaced IG Toolkit)

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 the team have been conducting face to face overview sessions to raise awareness on the General Data Protection Regulation (GDPR) which came 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 2018/19.

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:	Oct 17- Sept 18				Oct16 -Sept17	(Oct 15 – Sept 16)	(Oct 14 - Sept 15)
	Summary Hospital-Level Mortality Indicator (SHMI) value and banding	100.25 Band 2 – As Expected	100	NA	NA	100.81 Band 2 = As expected	108 Band 2 = As expected	112 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.	41.6%	33.3%	NA	NA	30.3%	27.9%	18.8%
Helping people recover from episodes of ill health or following injury	18. PROMS; Patient Reported Outcome Measures Reporting Period:	2017/18				(2016/17)	(2015/16)	(2014/15)
	(i) hip replacement surgery,	0.47	0.46	N/A	N/A	0.44	0.45	0.45
	(ii) knee replacement surgery.	0.36	0.33	N/A	N/A	0.32	0.32	0.33
	(iii) Groin Hernia	0.06	0.09	N/A	N/A	0.07	0.07	0.08
	(iv) Varicose Veins	0.08	0.10	N/A	N/A	0.12	0.12	0.12
	19. Patients readmitted to a hospital within 28 days of being discharged. Reporting Period:	Apr18-Mar19				(2017/18)	(2016/17)	(2015/16)
	(i) 0 to 15; and	10.51%	Not released by NHS Digital			10.3%	10.32%	11.43%
	(ii) 16 or over.	9.07%				11.1%	8.96%	11.95%

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
	20. Responsiveness to the personal needs of patients.	6.9	NA	NA	NA	6.8	7.1	7.1
	Reporting Period:						2016	2015
	21. Staff who would recommend the Trust to their family or friends.	3.72 (Significant increase)	NA	4.21	3.27	3.63	3.72	3.67
Treating and caring for people in a safe environment and protecting them from avoidable harm	Reporting Period:	2018/19				2017/18	2016/17	2015/16
	23. Patients admitted to hospital who were risk assessed for venous thromboembolism.	97%	N/A	N/A	N/A	94.39%	95.11%	95.4%
	C.difficile Reporting Period:	2017/18				16/17	15/16	14/15
	24. Rate of C.difficile per 100,000 bed days	16.5	14	NA	NA	12.7	10.4	11.4
	Patient Safety Incidents - Reporting Period: Oct 17 -March 18					April 17-Sept 17	Oct 16 - Mar 17	April 16 - Sept 16
	(i) Rate of Patient Safety incidents per 1000 Bed Days	42	42.1	NA	NA	41.7	39.6	41.2

Domain: Preventing people from dying prematurely

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

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

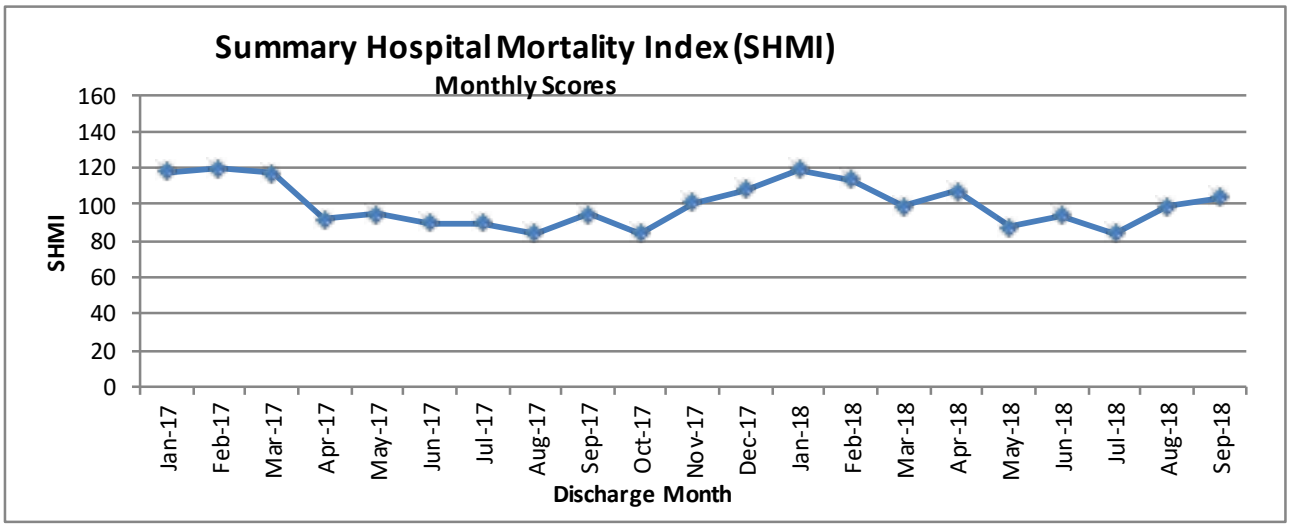


Chart 3: SHMI

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

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

As a Trust we recognise the significant improvements in HSMR and SHMI as measures of mortality. The emphasis will continue to be learning from deaths through the established Learning from Deaths structure and process.

During 2018/19 The Trust continued its work around mortality case note review.
The Trust has performed both initial screening reviews and more in-depth structured judgement reviews, information on the learning so far can be seen in the Learning from Deaths section on page 126.

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

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

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

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

Participation rate across both procedures, for CHFT was 90.4% for Hip procedures and 89.4% for knees, which is above the national average of 86% for hips, 87.3% for knees.

(i) Hip replacement surgery,

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

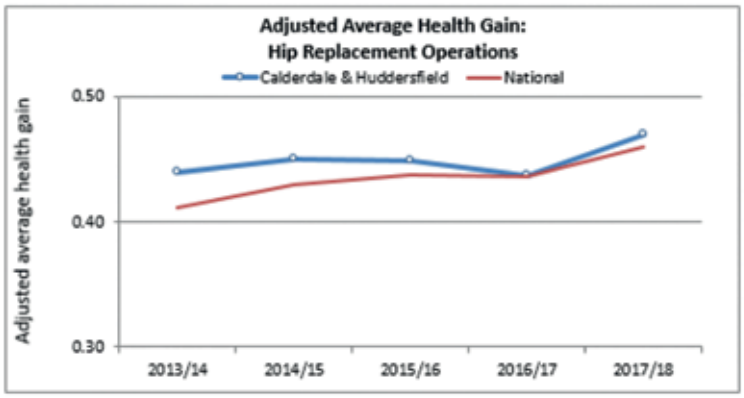


Chart 4: PROMS – Hips

(ii) Knee replacement surgery.

	2013/14	2014/15	2015/16	2016/17	2017/18
Calderdale & Huddersfield	0.34	0.33	0.33	0.32	0.36
National	0.32	0.31	0.32	0.32	0.33

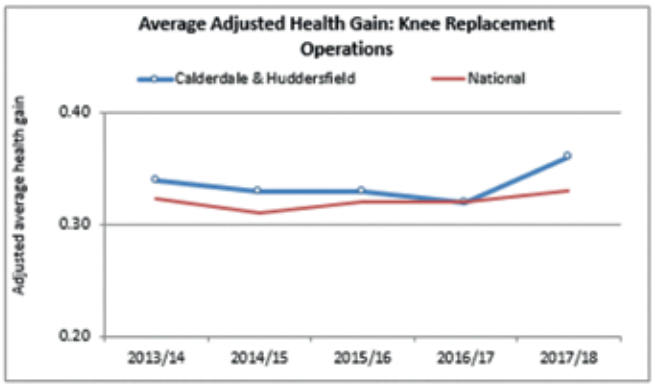


Chart 5: PROMS - Knees

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.

(iii) Groin Hernia

	2013/14	2014/15	2015/16	16/17	17/18
Calderdale & Huddersfield	0.09	0.08	0.07	0.07	0.06
National	0.08	0.08	0.09	0.09	0.09

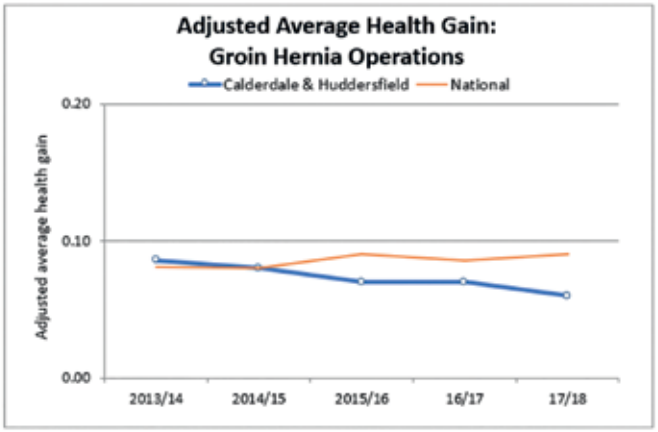


Chart 6: Groin Hernia

(iv) Varicose Veins

	2013/14	2014/15	2015/16	16/17	17/18
Calderdale & Huddersfield	0.11	0.12	0.12	0.12	0.08
National	0.10	0.09	0.10	0.09	0.10

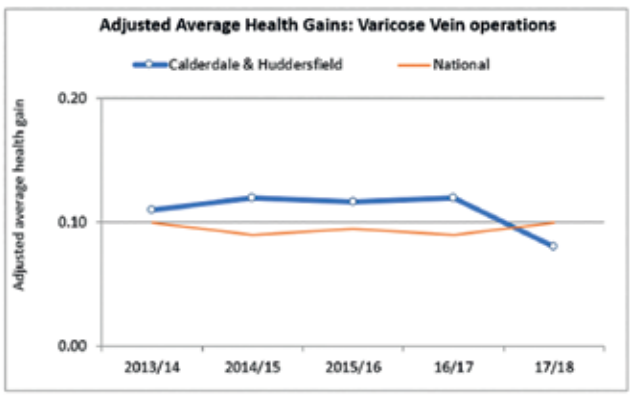


Chart 7: Varicose Veins

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

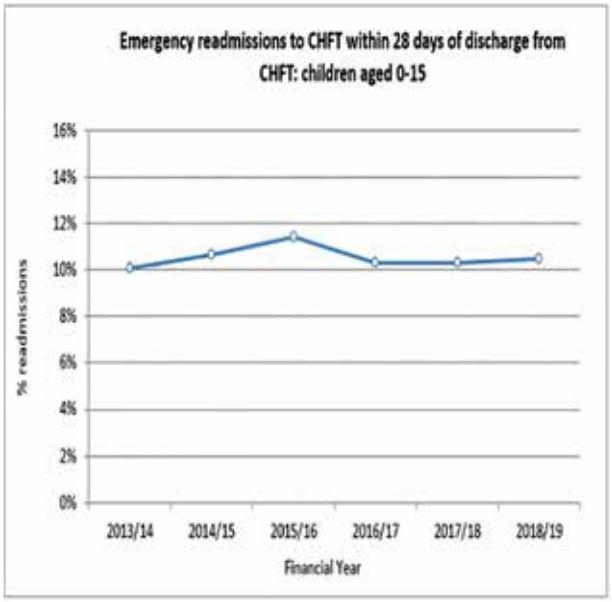
Continuing to ensure this data is accessible at consultant level so it can be used for clinical revalidation and to help drive improvements in practice. It should be noted that Groin Hernia and Varicose Vein PROMs ceased to be part of the national reporting framework in October 2017.

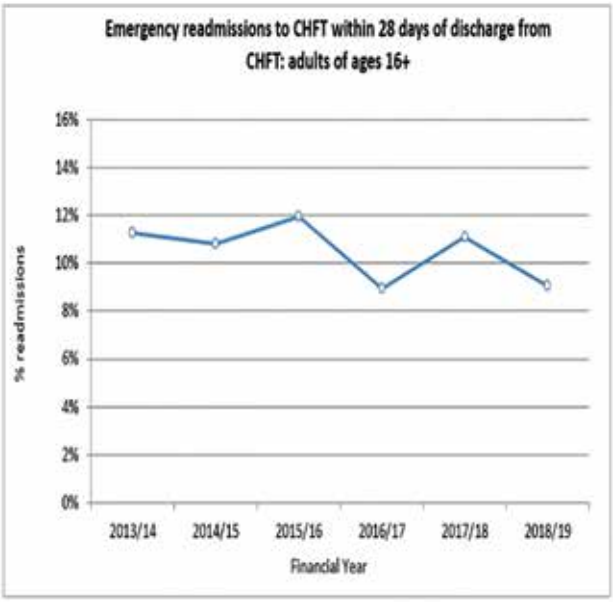
READMISSIONS WITHIN 28 DAYS
The charts show the percentage of patients readmitted within 28 days of discharges, aged:

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

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
0-15	10.06%	10.64%	11.43%	10.32%	10.30%	10.51%
16+	11.26%	10.80%	11.95%	8.96%	11.10%	9.07%

Chart 8: Readmissions within 28 days of discharge





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

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

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

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

In Patient Survey - Responsiveness to the personal needs of patients (Question 20).
Improving the patient experience is central to the work that the trust undertakes, Patient Experience section at page 164 for a full review. This section requires an overview of one of the key questions within the National Inpatient Survey.

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

Each question describes a different element of the overarching theme, "responsiveness to patients' personal needs" (based on the 2017 survey).

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

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

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 2017. 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 487 patients who returned completed questionnaires giving a response rate of 39%. This has dropped slightly compared to previous surveys, see the table below:

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

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

Staff Experience

The Trust carried out a census survey in 2108. A total of 2779 colleagues completed the survey. The survey is anonymous and is conducted by our survey co-ordinator, the Picker Institute Europe.

Our response rate increased from 43% to 51% - 4% above average. This is the highest response rate for CHFT in six years and is a positive indicator of improved colleague engagement.

Our best performance areas are:

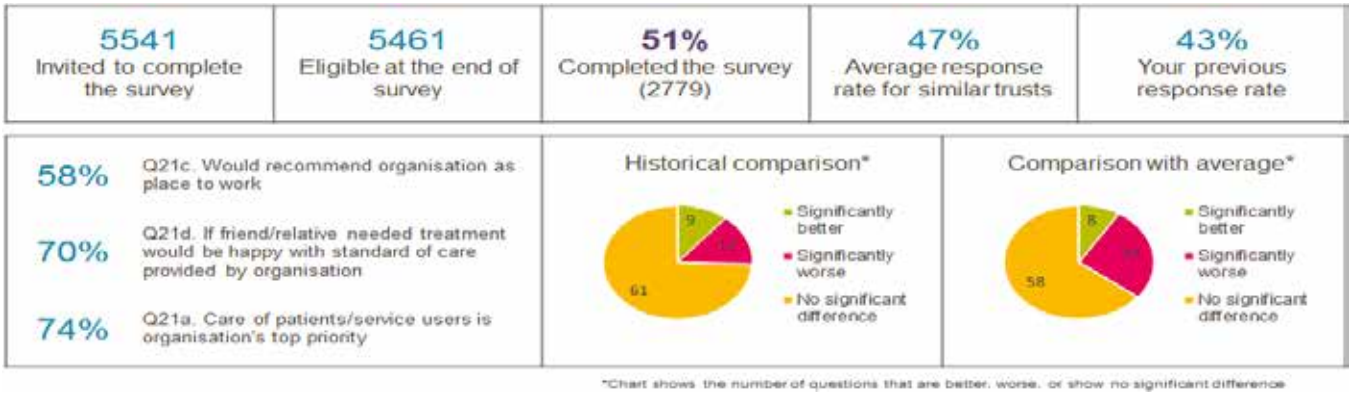
- Percentage of staff appraised in last 12 months
- Percentage of staff who don't work additional paid hours per week, over and above their contracted hours
- Percentage of directorate/departments which collect patient/service user feedback
- Percentage of staff not experiencing harassment, bullying or abuse from managers
- Percentage of staff who feel the organisation acts fairly regarding career progression

Our key improvements since 2017 are:

- Disability: The organisation made adequate adjustment(s) to enable me to carry out work
- The organisation treats staff involved in errors fairly
- Staff are given feedback about changes made in response to reported errors
- Percentage of staff who are satisfied with level of pay
- Percentage of staff who are would recommend the organisation as place to work

Our worst performance areas are:

- Percentage of staff who feel the organisation takes positive action on health and well-being
- Percentage of staff who don't work additional unpaid hours per week, over and above their contracted hours



- Percentage of staff who receive regular updates on patient/service user feedback
- Percentage of staff who feel that feedback from patients/service users is make informed decisions within the directorate/department
- Percentage of staff whose appraisal/performance review identified learning or development needs

Calderdale and Huddersfield NHS Foundation Trust has an Organisational Development strategy. This aims to support all staff to understand the Trust's business priorities and deliver compassionate care. The Trust's priorities are underpinned by our four pillars, and demonstrated through our behaviours:

- **We Put The Patient First**
  "I treat patients as people – I listen to their needs and respect their differences."
  "I am kind, friendly & compassionate to myself and others."
- **We Go See**
  "I seek out information and use it to make good decisions."
  "I seek out opportunities to learn and make things better."
- **We Work Together to Get Results**
  "I recognise and value everyone's contribution."
  "I look for solutions and improvement with a can-do, positive approach."
- **We Do the Must-Dos**
  "I take responsibility for my behaviour, actions and learning."
  "I champion the rules that deliver compassionate care."

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

Question/ Indicator	CHFT 2018	CHFT 2017	National
KF1 - Staff recommendation of the Trust as a place to work or receive treatment	3.72	3.63	3.76
Q21a Care of patients/service user is my organisations top priority	74	70	76
Q21c I would recommend my organisation as a place to work	58	54	62
Q21d If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.	70	66	71

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

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

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 2018 to March 2019. The target for VTE risk assessment for all patients admitted was set at 95%

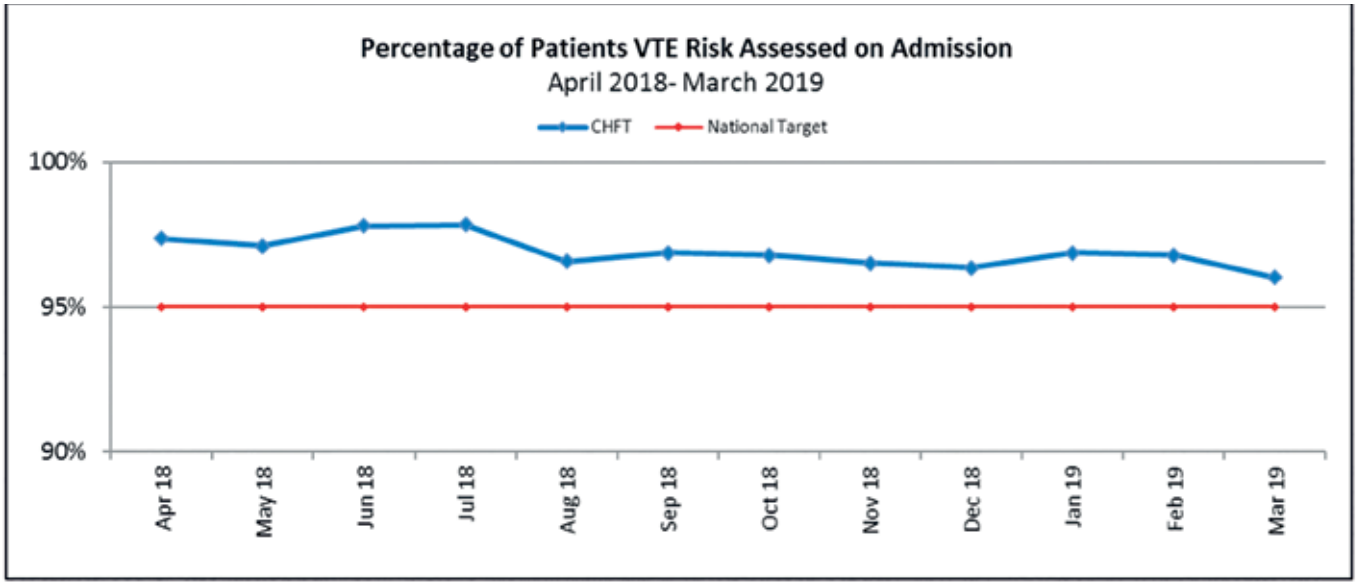


Chart 9: % VTE Risk Assessment Completed

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

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

The 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 top third of Trusts for Q2 2018/19 data, this figure ranks the trust at 41 of 150 acute trusts nationally.

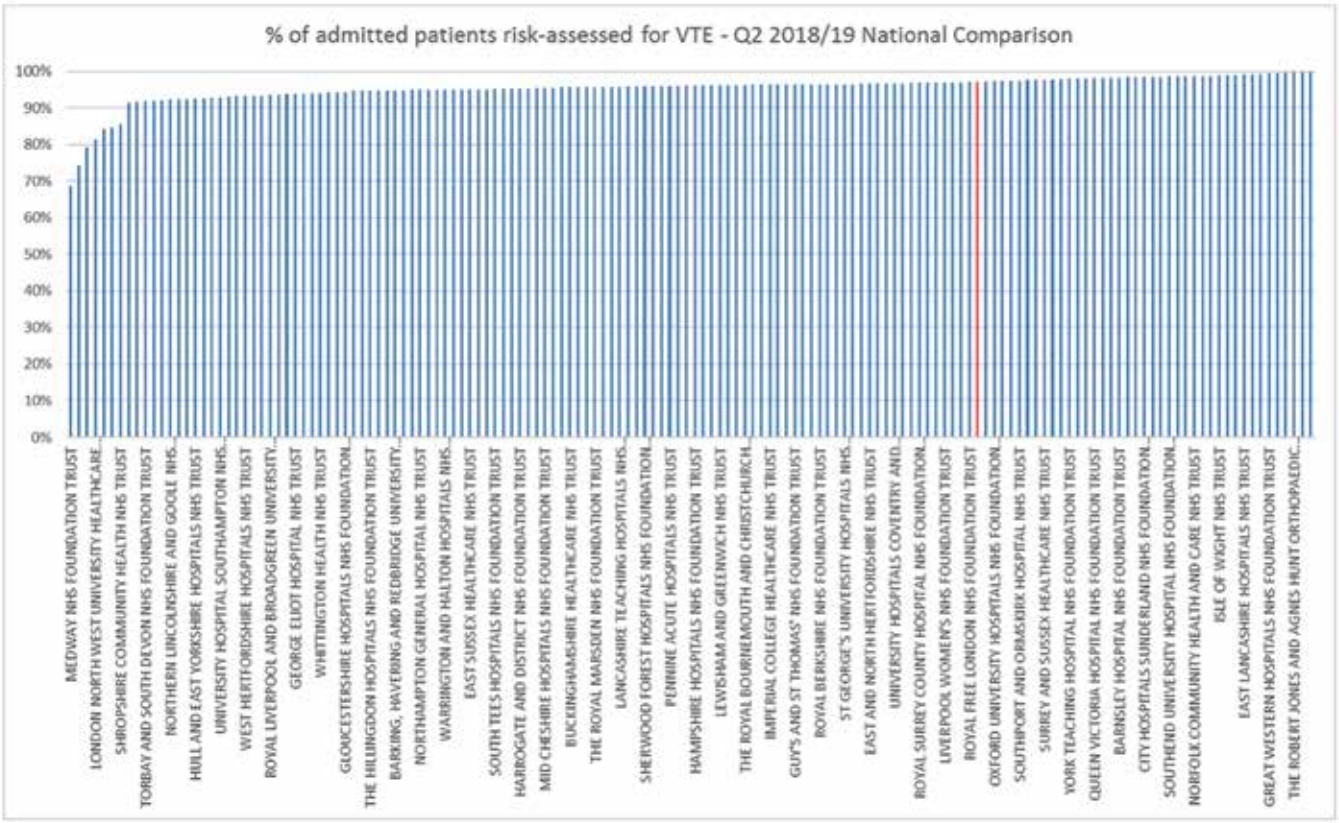


Chart 10: % VTE Risk Assessment Benchmarking

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 to 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

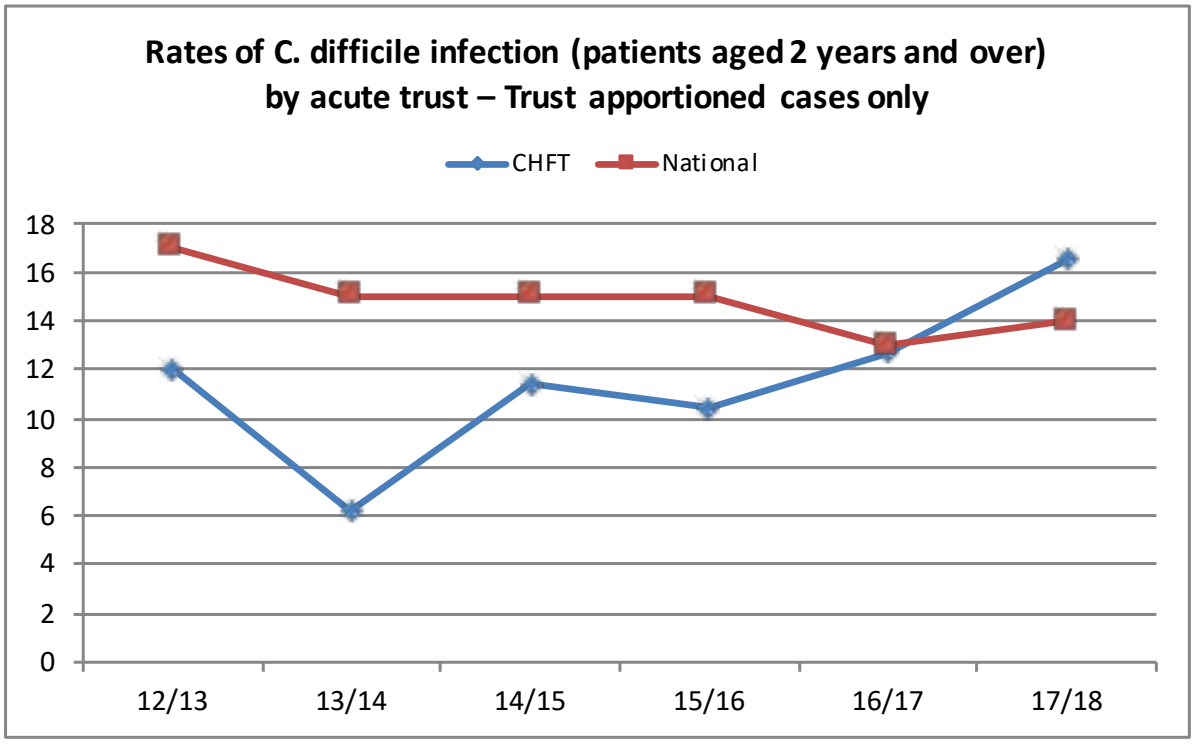


Chart 11: C.Diff Trust apportioned cases

2017/18 was a challenging year in relation to our absolute numbers of *Clostridium difficile infections (CDI)*, specifically in relation to our performance versus our target.

Of 153 reporting Trusts, Calderdale and Huddersfield NHS Foundation Trust were 116th.

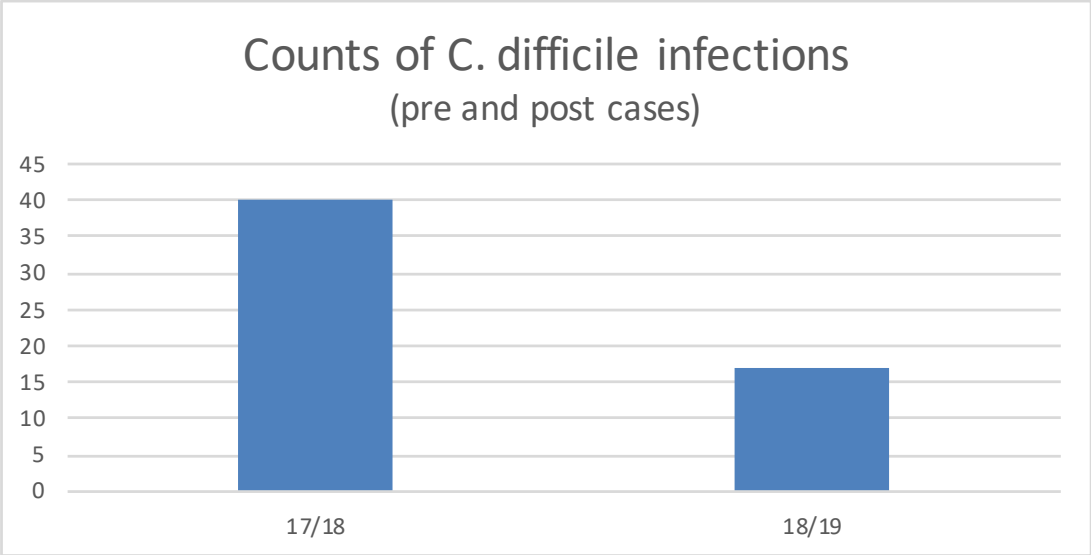
Calderdale and Huddersfield NHS Foundation Trust consider that this data is as described for the following reason:

At the time of the reporting period the Trust had exceeded it's ceiling of cases of CDI . All cases were 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 some cases, it was possible to identify key areas for improvement. These relate to antimicrobial use prescribing, environmental cleaning and hand hygiene. All root cause analyses conclude with an action plan to ensure that lessons learnt are acted upon, and that learning is disseminated throughout the organisation to try to prevent similar, avoidable cases. Action plan completion is monitored through the divisions.

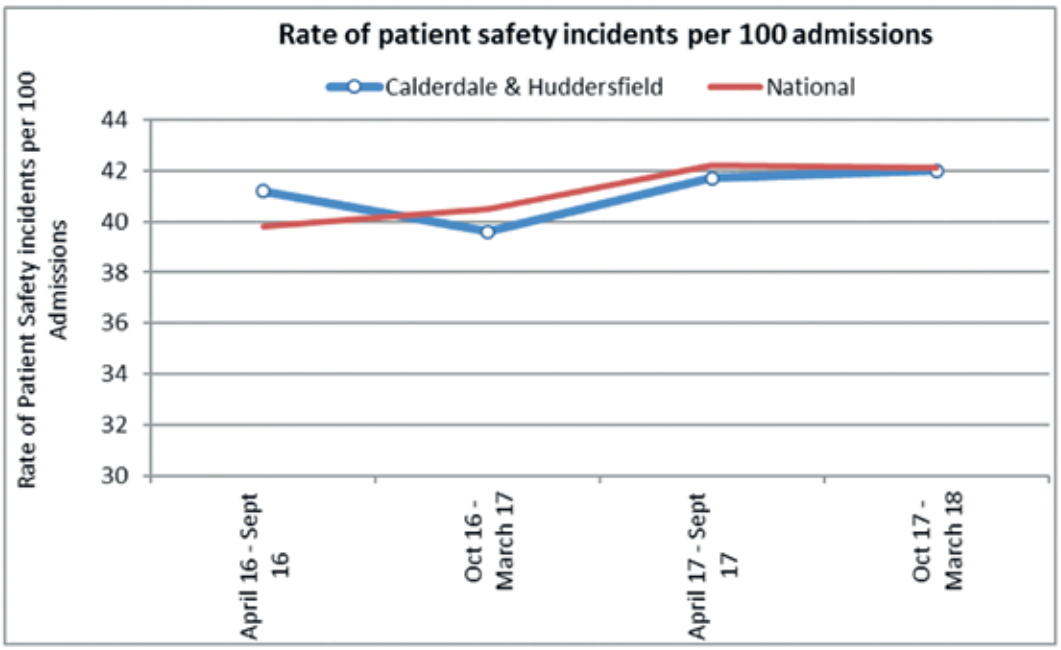
The Infection Prevention and Control Team support prevention of C. difficile through the delivery of both mandatory training, and bespoke sessions to clinical areas. An annual hand hygiene roadshow is held which has shown good, rising levels of compliance with bare below the elbows and hand hygiene.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

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



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

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, made up 95% of all reported incidents in CHFT in 2018/19. The Trust has seen an increase in reporting of 9% over the year, reflecting an increased understanding of the benefit of reporting.

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 on 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 ensures appropriate actions are in place to reduce the risk of future events.

Once approved reports are submitted to our commissioners. Follow up monitoring of the actions arising from the investigation and assurance on this is presented to the Divisional Patient Safety Quality Board. A report on progress of delivery of actions from Serious Incidents is taken to the Quality Committee on a quarterly basis. The Quality Committee also receives information on new serious incidents, and on concluded investigations, with the learning documents for each.

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 reviews four incidents per meeting, and provides assurance that the Trust is managing Serious Incidents effectively, identifying themes, and seeks assurance that actions are sufficiently wide enough to reduce the risk, and learning from Serious Incidents is shared across the organisation. The group reports to the Quality Committee.

Themes and trends: The three most frequently reported serious incidents in 2018/19 were:

Incident Type	Number in 2018/19	Comment
Implementation of ongoing care	6 incidents	These relate to hospital acquired infections, category 4 pressure ulcers and delay in medical review on ward admission. Robust actions plans are in place.
Neonatal death	5 incidents	A working group has been commissioned to review the neonatal deaths. Since 3 December 2018, all neonatal deaths meeting specific criteria were referred to the HSIB (Healthcare Safety Investigation Branch) for investigation.
Inadvertent connection of Oxygen to air Never Event	4 incidents,	There were four cases where patients who had been in receipt of oxygen were inadvertently connected to air flowmeters. To address this risk, air outlets have been capped, and nebulising machines introduced to eliminate the need for air outlets in most areas.

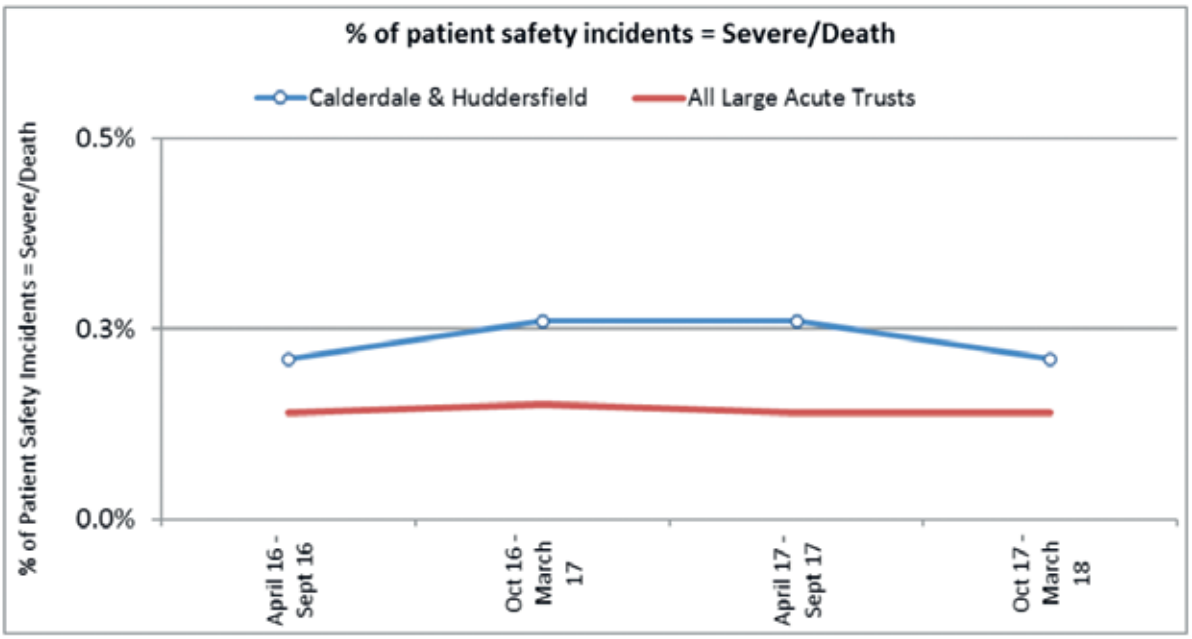
Investigations into these incidents enable us to identify and undertake preventative work to improve patient safety.

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 2018/19 the Trust has reported five never events. There was a retained surgical item (gauze roll in an abdomen), and four cases where oxygen was inadvertently connected to the air flowmeter in the air outlet. This type of never event was added to the national never events list in January 2018. Action has been taken to significantly reduce this risk; air is needed on wards for nebulisers. The Trust has purchased nebulising machines to remove this need and enable the air outlets to be capped. In response to these four never events the Trust invited the Royal College of Physicians to review the Trust's response to a national alert on reducing the risk of oxygen tubing being connected to air flowmeters. The reviewers commended the Trust on its incident reporting culture which had identified these never events. The report is expected during late Spring 2019.

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

Of those patient safety incidents reported, 0.34% of incidents, 29 incidents were graded as severe harm or death, a reduction compared to 2017/18.



Patient Incidents by Severity

CHFT Incidents	2015/16	2016/17	2017/18	2018/19	movement
Green	6503	6529	6739	7097	↑
Yellow	1957	1376	1313	1718	↑
Orange	122	151	185	182	↓
Red	39	65	60	28	↓
Totals	8621	8121	8297	9025	↑

Green / Yellow Incidents (No / low harm)

There has been an increase in incident reporting in 2018/19 in comparison to 2017/18, reflecting an improvement in incident reporting. High levels of incident reporting are a positive indicator of a safety culture; in Calderdale and Huddersfield NHS Foundation Trust, over 97% of the incidents reported were zero or low harm.

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. There has been a very small reduction in orange incidents (3 incidents, 1.6%) and divisional investigations continue to take place to improve patient safety and support staff in learning from incidents.

Red incidents (serious incidents)
In 2018/19 28 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, the four never events re: oxygen did not result in severe harm or death. Information on the three most frequent types of serious incidents during the year is given above which related to ongoing care, e.g. pressure ulcers, infection, neonatal deaths and where oxygen was inadvertently connected to the air flowmeter in the air outlet, see the Never Events section above.

In December 2018 the Healthcare Safety Investigation Branch (HSIB) began a national maternity investigation programme to make maternity care safer. Where incidents occurred that met the criteria for such investigations these were referred to HSIB to undertake an investigation. Where the Trust determined a maternity incident constituted a serious incident this was reported to commissioners and as noted above is being investigated by HSIB rather than the Trust.

There has been a 47% reduction in serious incidents reported in 2018/19 compared to serious incidents reported in 2017/18. During the latter part of the year, following discussions with commissioners the Trust compared its approach to declaring serious incidents with other Trusts. Following this for those incidents where improvement work was already underway to address the issues identified in the incident, then a moderate harm investigation was undertaken rather than a further serious incident investigation.

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.

Part 3: Performance on selected quality indicators

This section provides an overview of care offered by the Trust based on its performance in 2018/19 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
Patient Experience	End of Life care Patient Experience, including 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.

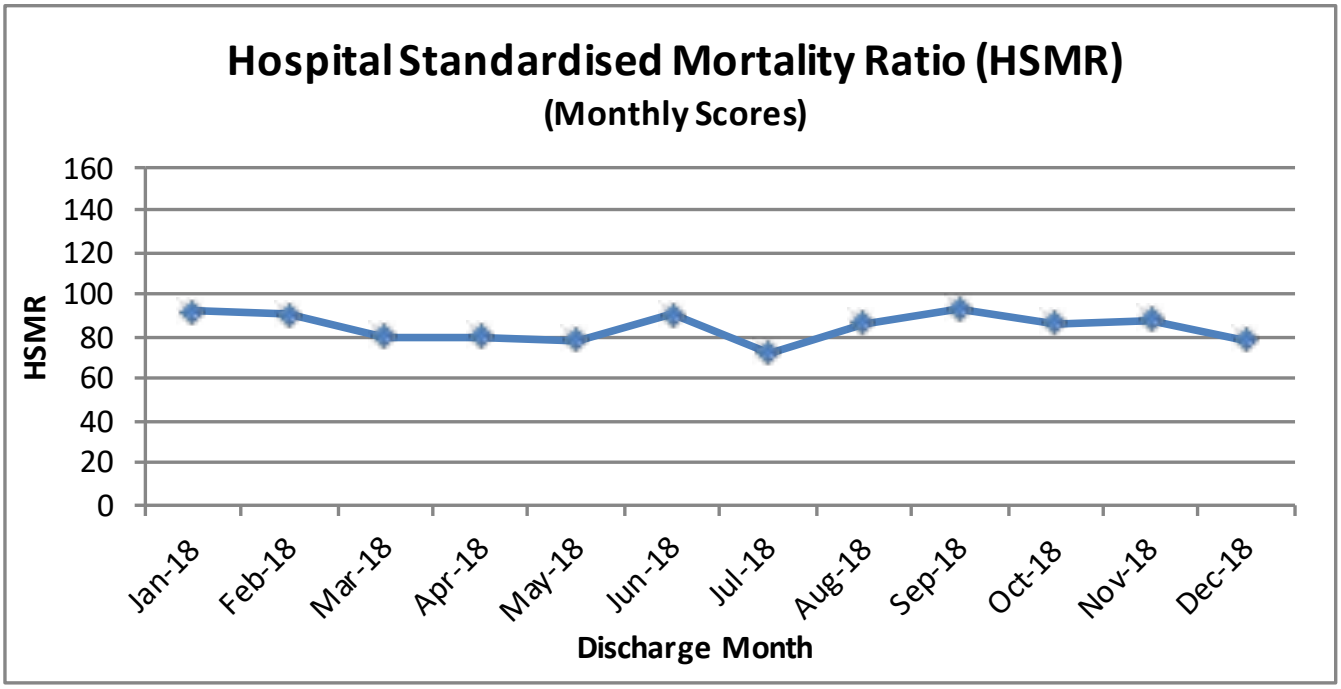


Chart 12: HSMR

See Part 2 for a look into our SHMI performance and work on the Mortality Case Note Review programme. (page 134)

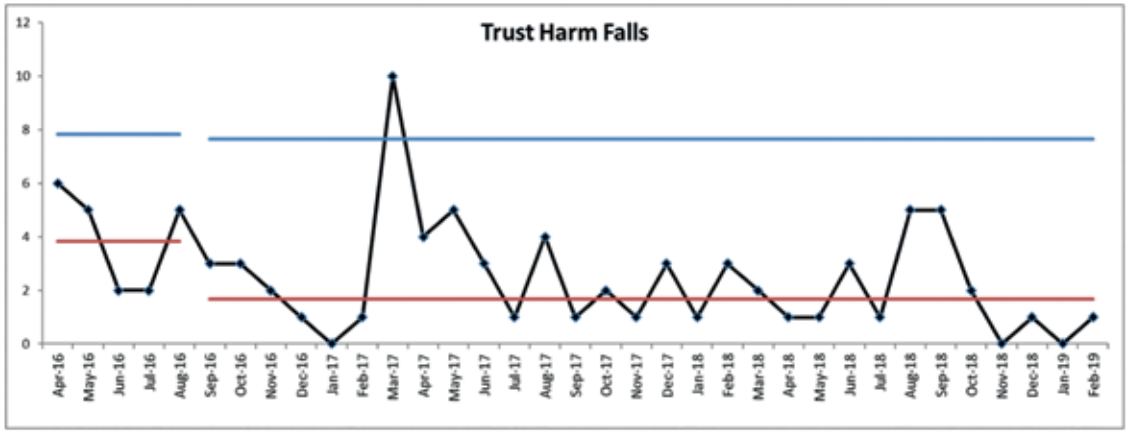
Falls in Hospital

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

The Falls Improvement work has continued over the last 12 months, working through the key priorities identified in the Trust Wide Falls Prevention Action Plan established in the previous year. This work is led by a multidisciplinary Falls Collaborative team headed by our falls Lead Clinician.

The action plan is based on aspects of the National Audit which highlighted some areas for improvement including lying and standing Blood Pressure, medication reviews, safety huddles and vision assessments, some of which will now form part of the national CQUINs into 19/20.

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



In addition since November 2016 we have seen a reduction on average of 17 falls per month moving from an average of 177 falls a month to 160 over the last 18 months.

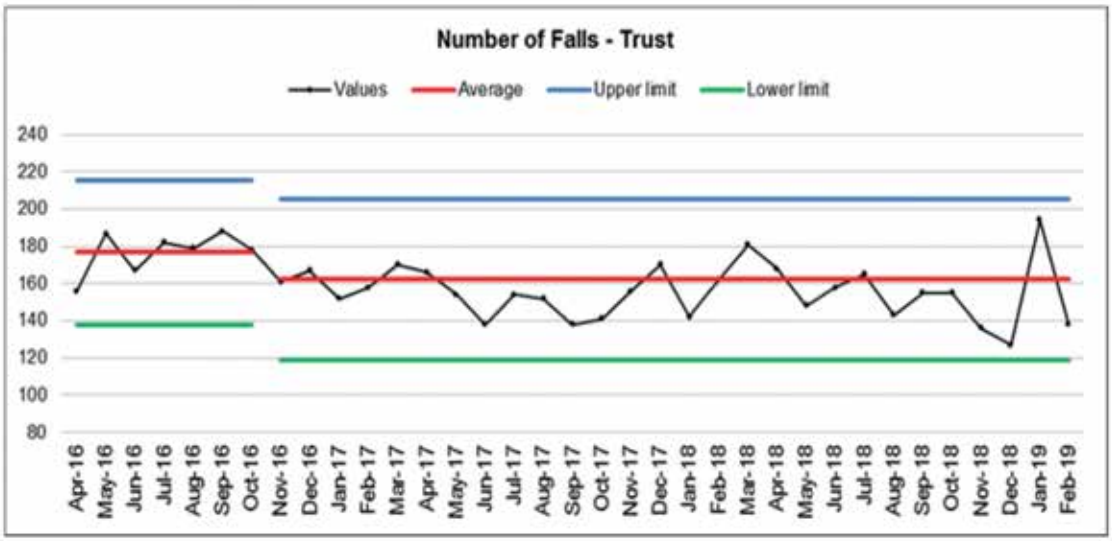


Chart 13: Falls

Throughout this year, there have been falls workshops to help understand the reasons why people fall and importantly what we can do to help prevent these falls and futher illustrates the benefits of the FISH (Falls Investigation Safety Huddle) tool. This tool can help prevent numbers of falls and level of harm through greater understanding of why the patient fell.

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

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

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

Plans are in place for the year ahead to build on this long standing trust priority:

- Falls Champions – these are members of staff who have an interest in advocating the benefits of Falls prevention work in their clinical area, meetings held monthly on either site and run by the MDT with a training plan for Falls champions to cascade their learning to their ward areas.
- The Trust is also involved in the National Audit of Inpatient falls causing fractured Neck of femur (January 2019) with focused work based on the findings.
- Strengthen improvement work to align with the national CQUIN requirements.
- Falls prevention themed week planned for October to work in conjunction with the Kirklees Falls Prevention Group. These weeks give an opportunity to spread the work of the falls collaborative and raise awareness.

Healthcare Associated Infections (HCAIs)
The Trust monitors and reports infections caused by several different organisms or sites of infection. These include:

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

MRSA (Methicillin resistant Staphylococcus aureus) Bacteraemia:

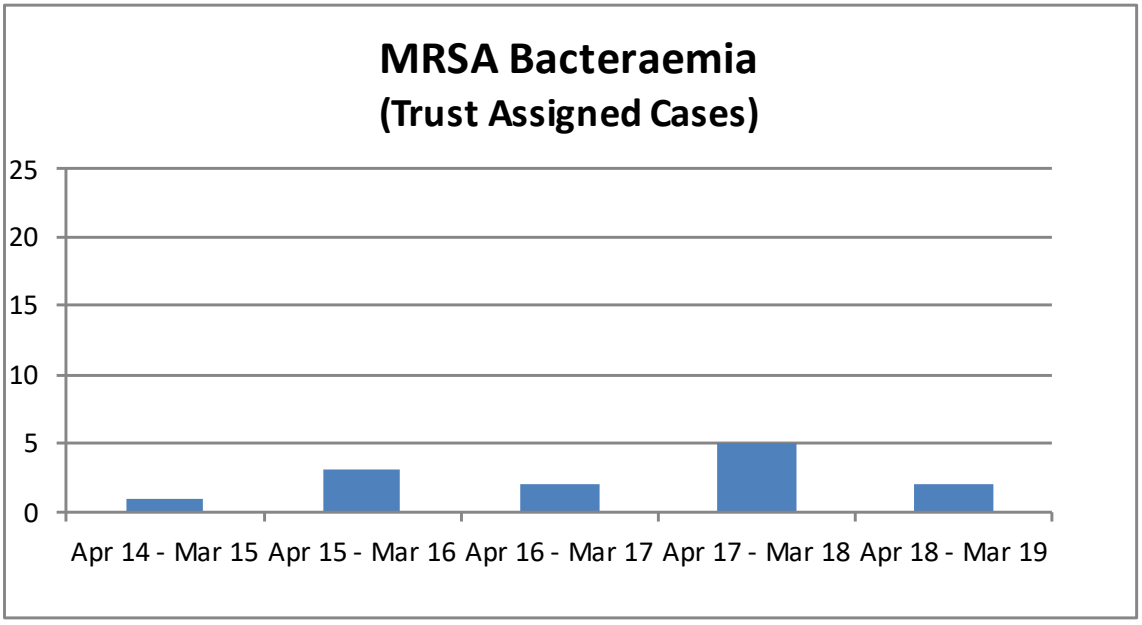


Chart 14: Number of MRSA Cases per year

The Trust has seen a reduction in the number of cases compared to last year. Two MRSA bacteraemias were reported in year and both have been subject to a post infection review as per national process. The learning from these reviews has been incorporated into the Trust Infection Prevention and Control action plan.

MSSA (Methicillin sensitive Staphylococcus aureus) bacteraemia:
MSSA bacteraemia is not subject to targets in contrast to MRSA bacteraemia. However, mandatory reporting of MSSA bacteraemia is required. In the year to date 15 cases have been reported, a reduction on the previous years position of 22. 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.

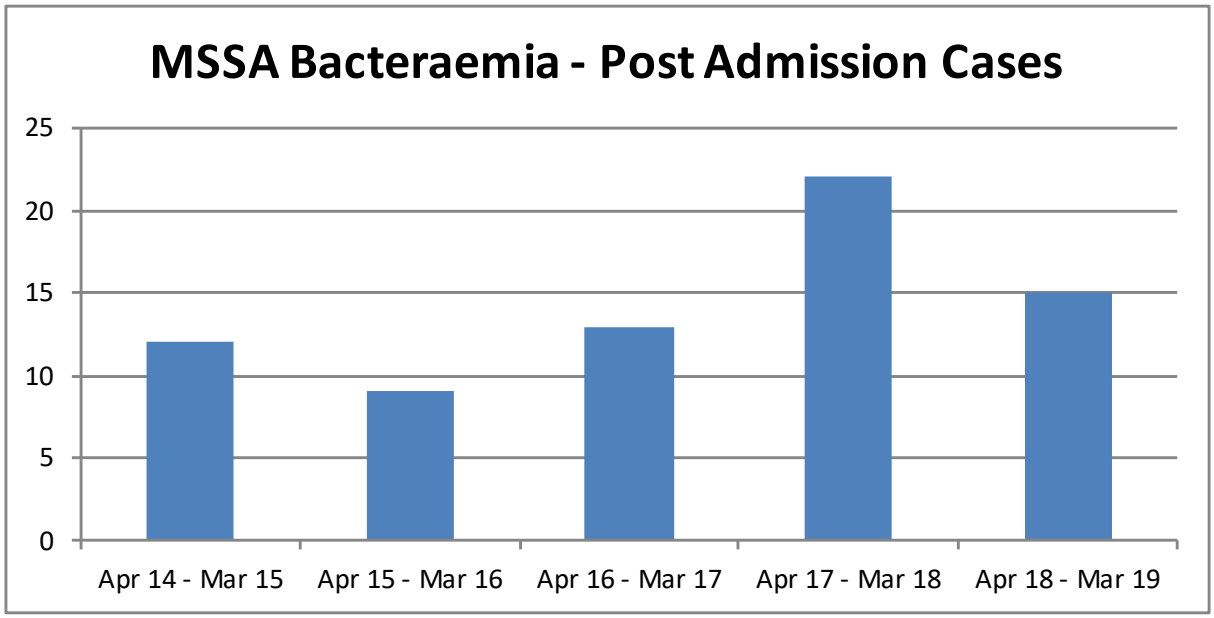


Chart 15: Number of MSSA Cases per year

E.coli bacteraemias:
E.coli is currently part of a health economy wide plan to reduce rates across the individual CCGs – the trust had an aim to achieve a 10% reduction

The number of cases seen this year have been in line with the two previous years remaining static.
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.

Hydration is being promoted via the Nutrition and Hydration Group, with the overall aim to increase drink rounds on the ward from 6 to 7 throughout the day. Other initiatives will be in line with the health economy action plan during 2019/20.

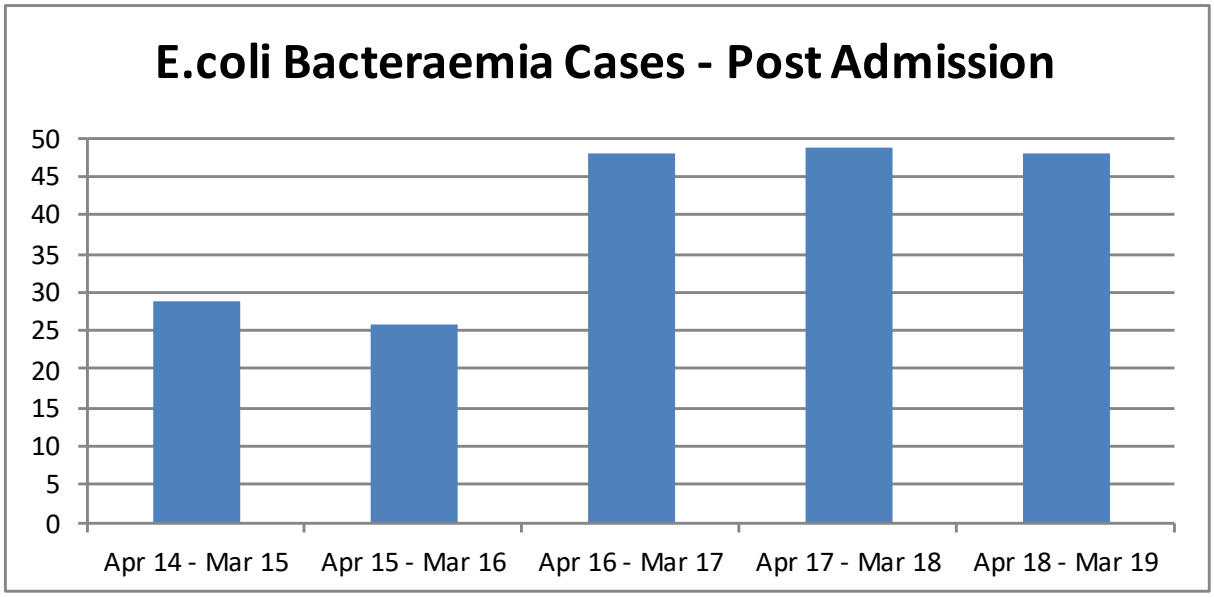


Chart 16: Number of E.coli cases per year

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

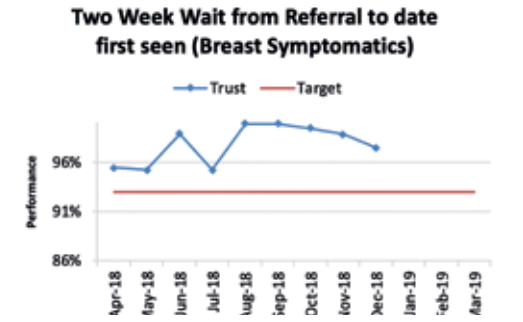
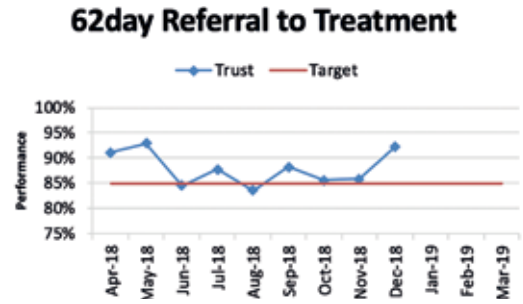
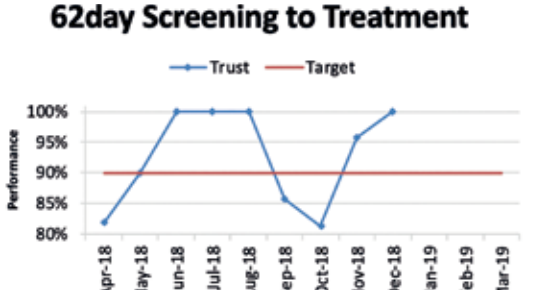
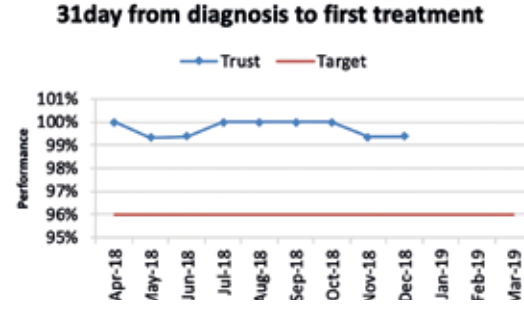
Key Priority Areas for the Infection Prevention and Control Team:

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
- Antimicrobial stewardship

Cancer Waiting Times

The National Cancer Waiting Time 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. All teams are working extremely hard to streamline pathways so that the Trust continues to consistently achieve the cancer waiting times standards.

	The performance required for this target is 93%. Over the last year as can be seen from the chart the Trust has maintained performance. As a Trust the aim is to reduce the wait time to 7 days rather than the national 14 day target this will then aid the other targets.
	The performance required for this target is 93% and this has been achieved.
	The performance required for this target is 85%. Unfortunately there has been one month (August) that the Trust has not achieved this target. This was mainly due to the urology, prostate pathway; however a significant amount of work has taken place to rectify the issues and the target has been achieved since then.
	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.

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 23.43% of patients are being seen within 7 days of referral which compared to the 30% we were achieving 2018. 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 51.84%. The Divisions and cancer team are working with Clinicians around the tumour sites to try to improve this position, significant changes in pathways are needed e.g. around diagnostic tests and results/ reports being available to progress the patient along their pathway. This is monitored closely.

Improvement Plans 2019/20

Over the last year and continuing into 2019/20 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. National changes will commence in April 2019; this has been delayed initially as it was due to start October 2018.

Work has been completed with the three main tumour sites that have difficulty in achieving a diagnosis by day 38, those being Lung, Colorectal and Prostate; this work has been completed alongside the intensive support team, IST, across the region. It has reviewed the pathways and helped each Trust to identify areas of deficit and where action needs to be undertaken. The West Yorkshire Association of Acute Trusts, WYATT, Chief Operating Officers are reviewing this work and have made money available from the West Yorkshire and Harrogate Alliance to Bradford, Mid Yorkshire and Leeds Trusts to rectify areas of deficiency.

The quality surveillance team, QST, process for 2018/19 was completed and reviewed by the Clinical Commissioning Groups and the individual plans agreed. The CCGs have the power to request an external visit if they feel necessary, this was not requested for any of the tumour sites.. The QST process for 2019/20 has started 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*
  This commenced December 2019, the aim is to aid GP's in diagnosing patients and picking any cancers up early. A matrix has been set to monitor it's performance and this is reviewed monthly at the CANCER Network meeting with the CCG's
- *FIT Testing (Faecal Immunochemical Test).*
  This commenced on the 1st October 2019, a dashboard has been developed to review how this is working, it is for low symptomatic patients and replaces the FOB test. It is on the list of commissioning intentions for 2019/20.
- *Workforce redesign*
  Nurses are being trained in cystoscopy so that they can perform the test, which in turn will free up consultants to do other parts of the urology pathway. Training commenced January and is aimed to be completed July 2019.

- Extra support for Advanced Practitioners in cellular pathology is supporting enhanced training; this enables the Advanced Practitioners to complete more complex work in pathology freeing up consultant time to support cancer pathology analysis.

Cancer Site Specific and Specialist Palliative Care teams update

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

Living With and Beyond Cancer
Every cancer team is working in line with the recommendations from the World Class Cancer Outcomes Strategy 2015-2020 and the National Cancer Patient Experience Survey. The teams are delivering the Living with and Beyond Cancer agenda, they are offering holistic 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. They also offer health and well-being events which ultimately support risk stratified follow-up and reduce the burden of hospital appointments, where necessary, for cancer patients.

To deliver the elements above new roles have been developed within teams and others have been advanced. Nurse consultants are now established in several key specialities, these significantly improve patient pathway and experience. The relatively new Cancer Coordinator roles have also been established in nearly all cancer specialist teams; these band 4 roles support management of high volume low level specialist intervention (once training and experience has been gained). They are a first port of call for patient's questions, emails and phone calls and provide appropriate triage to services often outside of the team such as the Macmillan Cancer Information Service with little or no input from the team's nurse specialists.

The Clinical Nurse Specialists and Cancer Care Coordinators play an important role in the delivery and coordination of the Health and Wellbeing provision. This provides patients and their families with the knowledge and skills to feel confident that their jointly developed 'Personalised Support' will enable them to access the right care at the right time, whilst also ensuring they can enjoy as good a quality of life as possible away from the hospital.

Acute Palliative Care
This Macmillan funded 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.

The project has shown hugely encouraging results. As per one of the project's key goals, quality of care is improved for patients in the last year of life. This has been seen through achievement in preferred place of death, better symptom control and speedier access to the service. The project has also shown that early intervention has had a positive impact on admission avoidance, reduced 30-day readmission rates and reduced length of stay. This is evidenced in the project's annual report.

These outcomes have highlighted a need for a more responsive palliative care service. Macmillan have extended the funding for a further year, this will enable the project team to assess if a transition from the current way of working to a more responsive model is feasible with current staffing levels. This work was recognised nationally when the team won the Nursing Times Managing Long Term Conditions award in 2018.

Prehabilitation
This is a new project to look at the feasibility of developing and delivering a model of prehabilitation across all cancer sites in the Trust. The early phase of the project will look to test developed models in targeted groups of patients. It aims to use or adapt existing services delivered in the acute trust and the community to support the psychological wellbeing, dietary and physical activity needs of newly diagnosed cancer patients. These services are usually accessed by patients during and after treatment. The ultimate aim is to optimise patients' health and wellbeing primarily before but continue this both during and after primary cancer treatment. There is increasing evidence that delivering a fitter patient, both physically and mentally, can significantly improve outcomes.

This project's progress will feed in to and learn from national activities around prehabilitation where emerging evidence is constantly informing practice.

Macmillan Cancer Information Service
The Cancer Information Service provides high quality information and support in conjunction with clinical staff to give patients the best possible experience. The service currently employs two full time paid staff supported by a growing number of trained volunteers. The team aims to help every patients live their lives as fully as they can by providing practical, financial and emotional support. Specifically this is a listening ear, help with benefits advice and grants referral for home adaptations or equipment and counselling.

The team see on average 200 patients a month. Age UK is one of the agencies that the team refer on to for support in completing benefits applications. Age UK recorded 386 referrals from the Cancer Information Team at the trust in 2018 which resulted in £1,498,992 in confirmed benefits awarded to patients living with and beyond cancer.

Cancer Psychological Services
The psychological and emotional care provided to cancer patients has developed significantly since March 2017. Since this time all patients with cancer now have access to level 4 psychological support, in line with Supportive and Palliative Care NICE Guidance. For the first time each cancer site specific team now has at least one member, and commonly two, who has completed training to deliver level 2 psychological support to their patients and carers. All individuals who have completed their level 2 training have on-going access to monthly clinical supervision. The service routinely collects patient feedback and this has been consistently excellent; similarly feedback from stakeholders has also been excellent about the impact that the service makes to patient care. The service provides an integral part of the Health and Wellbeing events and this aspect of the event is very well evaluated. The Clinical Psychologist leading the development of psychological care was presented with the 'Going the Extra Mile' award at the 2017 Celebrating Success awards.
The service has continued to grow and receive an increasing number of referrals. As the existing clinical psychologist is due to go on maternity leave in May 2019 the service is in the process of recruiting to a full time permanent replacement which on the existing clinical psychologist's return, will increase the capacity of the service; this means that the service will be able to review their capacity to provide support to families and caregivers as per NICE guidance along with inpatient care as required.

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.

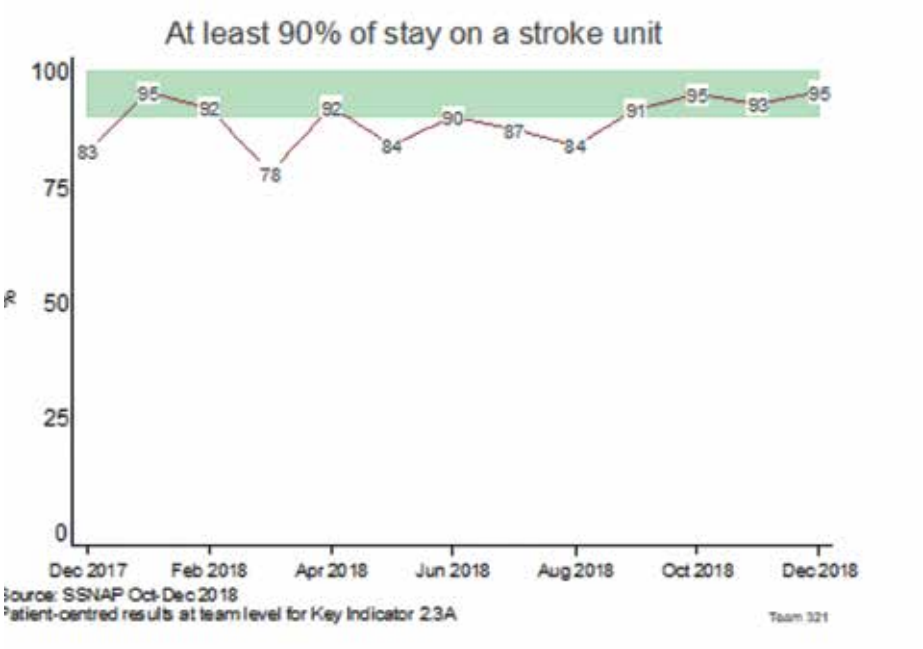
The rate of first time strokes in people aged 45 and over is expected to increase by 59% in the next 20 years (between now and 2035). In the same period, it's estimated that the number of stroke survivors, aged 45 and over, living in the UK is expected to rise by 123%.

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

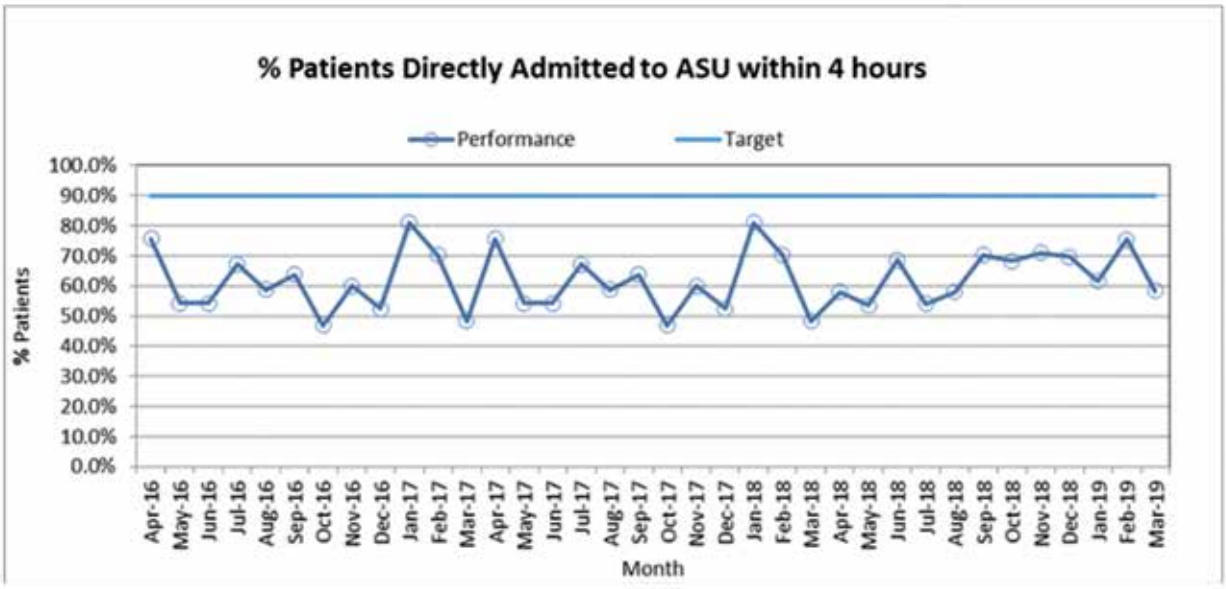
The Trust has the following aims to strengthen and improve stroke services:
- Patients are admitted to a stroke bed within four hours
- Patients spend 90% of their hospital stay on the Stroke unit

Improvement in 2018/2019
2018/2019 saw the successful implementation of a pilot scheme to have a Stroke Assessment Bed within our emergency department at Calderdale Royal Hospital. A recent audit has shown an improvement in the arrival to CT scan time as well as a reduction in the time taken for a patient to receive an assessment from a member of the stroke team.

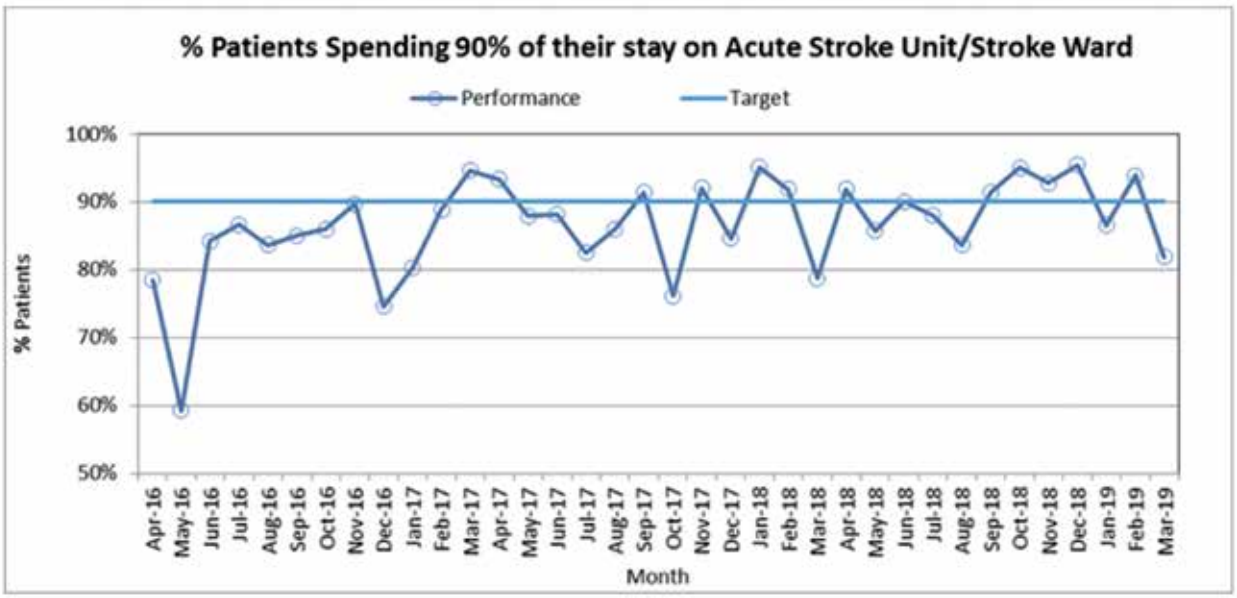
Recent SSNAP (Sentinel Stroke National Audit Programme) data produced in the third quarter of the year shows we have moved from a B to an A score which is another indicator that the Trust is providing excellent care to their patients and evidences the success of the improvement work that was undertaken in 2018/2019. We have seen a sustained improvement in scanning within an hour, with all three indicators achieving an A grade and direct admission performance has also sustained its improvement. The graph below also shows an upward trend for the percentage of time patients stayed on the stroke unit, evidencing that patients are being cared for in the right environment.



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



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



Plans for 2019/20

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

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

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 our 2016/17 EOLC strategy, 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 2019/2020 EOLC strategy and the EOLC steering group and other initiatives will enable this improvement.

Key issues, achievements and suggested plans for 2019/2020:

Better identification/recognition of patient in the last year:
The feedback from the Macmillan Medical Assessment Unit and Emergency Department Project at Huddersfield Royal Infirmary has identified high numbers of patients presenting acutely who are likely in the last year of life. Suggested improvements include the use of prognostic tools, like the Supportive and Palliative Care indicators Tool (SPICT) tool, by clinical teams. Earlier recognition of these patients is needed across primary and secondary care and equally as important is the communication of this between all care settings to enable patient's wishes to be met and to enable patients to be cared for and die in their preferred place.

Coordinated, timely and equitable access to good care
The coordination and equitable access to EOLC care is another key priority. There is a need to improve communication and connectivity between primary and secondary care. We are currently working on optimising the trusts digital systems by improving access to Systmone and the Electronic Palliative Care Co–ordination Systems (EPaCCs) across both primary and secondary care to enable patient's preference to be communicated between settings in a timely manner.

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. The National Care at the End of Life (NACEL) audit from May 2018 showing the Trust now has a 40% rate of people being supported by the ICODD compared to a national average of 62%. Improvements for this include; A joint build between CHFT and BHFT to add the ICODD onto EPR which will improve the completion of the ICODD document. Also a dedicated ICODD learning DVD resource has been created (See EOLC education for details)

Specialist Palliative Care Team (SPCT) activity:
The team has been recording patients' phase of illness and Karnofsky performance score for over 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 may be one way to address these pressures. The team has just employed a Band 4 member of the team to actively support wards with low level EOLC and also discharge planning – this is a 6 month secondment which aims to help support wards with our EOLC patients.

Education for clinical staff:
End of Life Care (EOLC) education is now part of the trusts essential skills training framework for clinical staff including Doctors, Nurses and Health Care Assistants. A DVD about the Individualised Care of the Dying document (ICODD) has been made to be part of the essential skills training to help staff support patients and families and also to support colleagues to be more confident in using the ICODD and having end of life care conversations.

The Trust continues to provide:
- Communication skills training
- Full EOLC education days for Doctors, Nurses, Health Care Assistants (HCAs), Allied Health Professions and Apprentices.
- Deliver EOLC training on the Trust induction and preceptorship courses.
- We provide and support HCAs to complete EOLC competencies across the Trust.
- Ad hoc teaching and in- reach is provided across areas that ask and also if there have been issues identified in an area we provide support to increase skills.

End of life care champions
Ten community CHFT nursing staff are now EOLC Champions. Our second cohort started in October 2018 with 24 nursing staff from both community and hospital. This six month course helps to increase confidence and skills in EOLC to bridge the gap between specialists and generalists.

The Champions take everything they have learnt back to the areas they work and become a resource and support for staff, patients and families. We are also starting Health Care Assistants (HCAs) Champions in April 2019 – we have 14 HCAs signed up for this.

The first cohort of Champions still meets regularly to continue the education and training. There has been an increase in the use of EPaCCs and Champions having advance care planning and Do Not Attempt Cardio Pulmonary Resuscitation discussions since finishing the course.

Linking learning on EOLC more formally to the appraisal and revalidation process may also be a helpful process

Audit, review and user experience:
New EOLC initiatives and developments are discussed with a cohort of bereaved relatives to ensure users experiences and feedback are at the heart of EOLC within CHFT. We report on EOLC complaints and incidents at the EOLC steering group. If concerns are raised we in-reach onto wards to support, educate and upskill staff. The EOLC facilitator and education lead have been working with a complainant to ensure the Trust learnt from the complaint, and as a result of this have made changes to our education and training. Trust colleagues have completed a bereavement audit on the stroke wards, and have participated in National Care at the End of Life (NACEL) audit which incorporated bereaved relatives' feedback, as well as audit of organisational standards and clinical care given to patients. The preliminary results of the NACEL audit are coming through and an action plan will be developed from these. 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.

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.

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

More innovative approaches continue to be introduced to gather feedback and create opportunities to 'listen', through a range of feedback options that sit alongside the more formal methods of FFT, complaints, patient advice service and surveys.

These include direct patient contact through rounding by the ward managers and matrons, debriefs, 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.

2018/9 % Response Rate & Would Recommend

	2018/19 Response Rate	2018/19 Would Recommend
Inpatient	36.39%	97.46%
A&E	13.03%	83.80%
Maternity	36.51%	98.64%
Community	4.91%	94.64%
Outpatients	10.75%	90.92%

4. Local Quality Improvement Work
The Trust Patient Experience and Caring Group has taken forward a number of priorities over the last 12 months, including work with external partners, 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

This year the Trust participated in some research with the University of Leeds, which used clinical students to carry out the patient surveys, analyse the results and feedback to the wards. In the main the surveys show positive results, however there have also been improvement opportunities identified regarding patient understanding of staff roles and responsibilities and staff knowledge when a doctor changes the plan of care

4.2 Co-design:
- The Trust's Patient Experience and Caring Group have championed the use of EBCD (Experience-based co-design) as an opportunity for service users and staff to come together to design, monitor and improve the care provided. The Trust held an event with women attending the antenatal Diabetic Clinic and staff who provide the service. Outputs include creating a greater awareness of the Specialist Midwife and improved access to the Dietician during clinic hours. Opportunities to utilise technology for the remote review of results is also being progressed.
- Staff, former patients and members of the Stroke Association have reviewed and resigned the way rehab related activities in stroke units is provided in the early days and weeks after a stroke. This was part of the CREATE (Collaborative Rehabilitation in Acute Stroke Project) trial as one of the four stroke centres involved.

4.3 NHS England Always Events – the ambulatory area of the Surgical Assessment Unit is working with patients to identify an always event priority that can be embedded into practice and monitored for impact

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

4.5 Outpatient transformational work – this programme is focused on improvements and efficiencies that will lead to a better experience for patients. The programme known as Project 20-20 has an objective of delivering 20 improvement projects by 2020. The projects are governed by a multi-organisational Board, including Healthwatch, patients representatives and GP's., The focus is on how to deliver outpatient activity differently – including how and where patients have their consultation, how results are received. New pathways are being co-designed with the engagement of patients.

4.6 Learning Disabilities – the Trust is currently part of 2 national initiatives:

- CHFT are in the first phase of Royal Mencap Treat me well campaign, which is a campaign to transform how the NHS treats people with learning disability in hospital. "Simple changes in hospital care can make a big difference, better communication, more time, and clearer information." A local Treat me well group has been established and following a successful response to a survey the group are taking forward some improvements which relate to improved communication and raising awareness of VIP passports and the matron role.
- CHFT is one of the pilot sites working with NHS Improvement (NHSI) to test an improvement toolkit based on standards for improving learning disability care in NHS Trusts. There are 4 standards in total with 3 that relate to secondary care: Respecting and protecting Rights; Inclusion and engagement; Workforce. In October 2018 the Trust was the first Trust to pilot NHSI improvement took kit. This allowed the Trust to benchmark itself against the standards and develop a local action.

4.7 Dementia – a revised strategy has been developed following consultation with local stakeholders and carers. The strategy focuses on 6 main themes:
Early Identification, Promoting health and well-being; Developing dementia friendly communities; Supporting carers of people with Dementia; Preventing and responding to crisis; Evidence based care.

4.8 Divisional reporting:
The reports received quarterly from divisions provide an opportunity to share good practice about how patient experience has been improved through:

- Feedback: encouraging feedback, receiving positive feedback and responding to feedback
- Involvement :approaching service users as active partners in their care and engaging on service development and improvement
- Delivering a patient centred culture recognising emotional and social needs

Examples from the reports include:

- Introducing an interactive app to help reduce anxieties for children coming into hospital using a story telling approach about what to expect
- Use of a Board in Emergency Department to explain the journey through the department
- Involvement of a relative to inform end of life care training events
- Changes to community transport to avoid lengthy journeys for patients
- Development of a you and your medicines leaflet for use at the point of discharge
- Work with Healthwatch to gain an understanding of booking appointments and attending outpatients following the implementation of an electronic patient record
- Early work regarding changes to the traditional outpatient clinics – virtual clinics and receiving results by telephone
- Improvements to the food provision in response to feedback– homemade soups at both lunch and evening meals; installation of a blast chiller to prevent dried up food

- Commencement of a Dementia pop-up cafe
- Running a surgery school for patients prior to colorectal surgery
- Introduction of bereavement cards, offering condolence and the opportunity to discuss any questions
- Use of secret shoppers (2 with physical disabilities) to test out facilities and the environment in the Endoscopy units.

5. National surveys
CHFT participate in all the national patient experience surveys, results from these surveys inform a number of national indicators and are used by the CQC as part of the 'Insight' reporting.

For all of the national surveys each question is scored out of 10, a higher score is better. Trust scores for each question are also compared with the range of results from all other Trusts that took part. An analysis technique called the 'expected range' is used to determine whether a Trust performs 'about the same', 'better' or 'worse' than other trusts. 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 June 2018, 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: After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition? ***Scoring 7.6***

The Trust was also noted to have made a statistically **significant increase** since last year in the score for one of the questions: During your hospital stay, were you ever asked to give your views on the quality of your care? ***Improving from a score of 1.7 to 2.5***

Emergency Department: no survey results published during 2018 / 19, next set of results anticipated October 19.

Children and Young People: no survey results published during 2018 / 19, next set of results anticipated November 2019.

Maternity: published January 2019. CHFT results were **about the same** as other Trusts for 46 questions, **better than** the majority of other Trusts for 1 question:
- Did the staff treating and examining you introduce themselves? ***Scoring 9.6***

The Trust's results were worse than most trusts for 4 questions:
- Did you have skin to skin contact (baby naked, delivered directly on your chest or tummy) with your baby shortly after the birth? ***Scoring 8.4***
- Were you given a choice about where your postnatal care would take place? ***Scoring 2.4***
- Did you feel the midwife or midwives that you saw always listened to you? ***Scoring 8.1***
- Did a midwife tell you that you would need to arrange a postnatal check-up of your own health with your GP? (Around 6-8 weeks after the birth) ***Scoring 7.3***

Cancer Patient Experience Survey: published October 2018, CHFT scored outside the expected range on five questions (three better than and two lower than)

Questions which scored outside expected range

Question		Number of respondents for this Trust	2017 Case-mix Adjusted: 2017 Score for this Trust	2017 Case-mix Adjusted: Lower limit of expected range	2017 Case-mix Adjusted: Upper limit of expected range	2017 Case-mix Adjusted: National Average Score
Support for people with cancer						
Q23	Hospital staff told patient they could get free prescriptions	171	88%	76%	87%	81%
Hospital care as an inpatient						
Q29	Patient had confidence and trust in all doctors treating them	211	79%	80%	90%	85%
Q35	Patient was able to discuss worries or fears with staff during visit	153	42%	45%	60%	53%
Care from your general practice						
Q53	Practice staff definitely did everything they could to support patient	234	68%	54%	67%	60%
Your overall NHS care						
Q55	Patient given a care plan	270	42%	29%	41%	35%

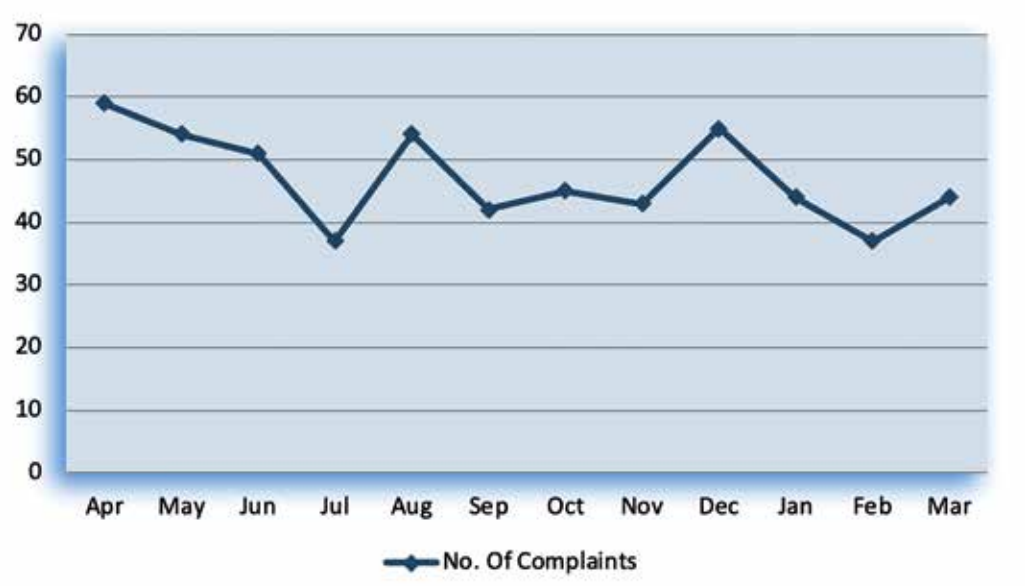
The Trust's lead cancer nurse is working with each cancer team to deliver individual plans based on their results. The main focus for the teams is clinical nurse specialist interaction and the continued development of the cancer information service.

Across all surveys, for the questions where the Trust scored 'worse' the services are taking forward action as required. Progress with these will be monitored through their internal governance arrangements and reported through Divisional reports to the patient experience and caring group.

Complaints

At the end of 2018/19 the Trust received 565 complaints, this is a decrease of 8% from 2017/18.

The profile of the spread of the complaints received in 2018/19 is given below.

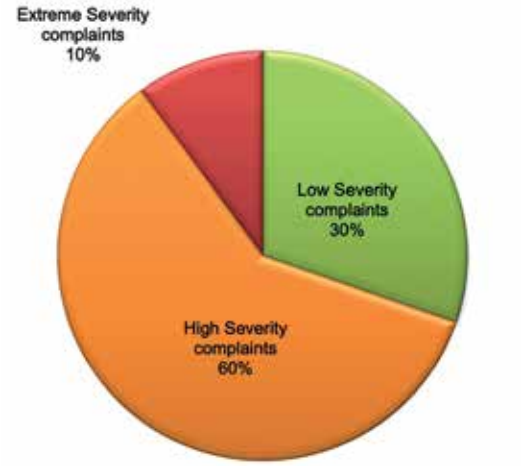


The average number of complaints received in a month by the Trust in 2018/19 was 47. The Trust received the highest number of complaints in April 2018.

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

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

In 2018/19 the majority of complaints (65%) were graded as amber, medium severity. 30% were graded as low severity 11%, 60 complaints were graded as red (extreme severity).

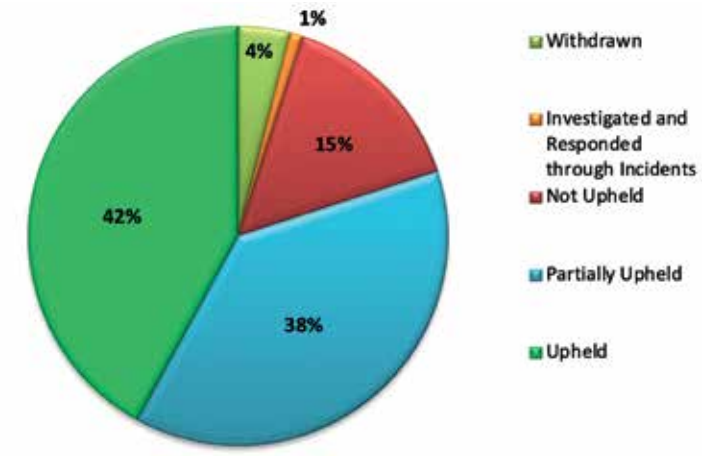


Red Complaints Data
Complaints triaged as red are reviewed at a red panel meeting and linked to an incident where appropriate.

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

Complaints Closed
The Trust closed a total of 614 complaints in 2018/19; this is an increase of 19% from 2017/18.

Of the 614 complaints closed, 42% were upheld, 38% were partially upheld, 15% were not upheld, 4% were withdrawn, and 1% were investigated as an incident.



Re-Opened Complaints
The Trust re-opened a total of 86 complaints in 2018/19. This is a 30% increase from 2017/18 (66).

Timeliness of Complaints Responses
The total number of overdue complaints at the end of 2018/19 was 21.

There has been significant work undertaken by the Trust in 2018/19 to improve the timeliness of responses to complainants. During December 2018 the Trust reduced the breaching complaints to 5, to compare, there were 66 breaching complaints in December 2017; this is a remarkable decrease of 92%.

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

Subject	Percentage	Increase / decrease from 2017/18
Communications	22%	↓ 8% decrease
Clinical Treatment	21%	↑ 2% increase
Patient Care (including nutrition/ hydration)	19%	↓ 8% decrease

At the end of 2018/19 there has been a significant decrease in complaints about appointments (including delays and cancellations), this subject was one of the top 3 subjects in 2017/18 and has seen a decrease of 31% which has taken it from the top 3 this year. This fall could be following the large rise in complaints we experienced as a result of migrating to EPR (electronic patient records) in May 2017, this would suggest that any problems that occurred during this time have resolved.

Parliamentary and Health Service Ombudsman Complaints
The Parliamentary and Health Service Ombudsman (PHSO) investigate complaints where an organisation has not been able to resolve the complaint at a local level. The PHSO have broadened their review process and have considerably increased the numbers of cases that they consider. At the time of writing 2018/19 final figures had not been released; however, in 2017/18 the PHSO handled 114,278 enquires of which 28% were investigated.

The table below shows PHSO cases relating to the Trust;

.	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
Number of Complaints Received by PHSO	1	3	4	5
Number of Complaints accepted for investigation by the PHSO	1	3	4	5
Number of Complaints the PHSO Upheld or Partly Upheld	0	2	1	2
Number of Complaints not upheld	2	0	1	0

13 cases were accepted for PHSO investigation between April 2018 and the end of March 2019. During this period the PHSO also concluded 8 complaints against the Trust, of these 8, 3 complaints were not upheld and 5 were upheld or partially upheld.

Learning from Complaints
The feedback we receive from complaints is valued and helps us to improve services.

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. Each service and division is required to demonstrate:
- 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 within divisional Patient Safety Quality Boards and quarterly to the Trust's Patient Experience Group to ensure that learning is shared across the Trust.

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

Learning:

Case One – A complaint was received from a patient's mother, who had some concerns regarding the treatment of her daughter, who had talipes which is a deformity of the foot whereby it is twisted out of the normal position.

The complainant explained that when her daughter came for a procedure known as tenotomy (cutting of a tendon, also called tendon release), no anaesthetic was administrated prior to the cutting of the baby's tendons. This caused great distress for both the baby and the complainant; the complainant explained that hearing her baby scream when the tendons were cut, haunted her and she felt guilty for letting this happen as she knew that anaesthetic cream had not been administrated.

Actions taken:

On investigation it was found that the practice of applying anaesthetic varies between consultants, some believe it helps others don't, and there is no established best practice. Although there is no established best practice in relation to this procedure, as a Trust we recognised the distress that this cause the patient, and it was felt that this distress was added to by knowing that hospital staff did nothing to try and ease the baby's pain. We have created a standing operating procedure (SOP) for tenotomy, this includes the application of anaesthetic cream prior to the cutting of the tendons. This case study was also promoted as a screen saver across the Trust to promote awareness.

Case Two – Concerns at communication regarding appointments. Letters are not being received in a timely manner resulting in missed appointments. On one occasion an appointment was cancelled without notice

Urology secretaries were unaware of the process for generating letters and contacting patients by phone when short notice changes are made to appointments. Additionally, training issue identified for clinicians on discharging patient through EPR. The patient was inadvertently discharged from the wrong service

Actions taken:

- The Urology secretary team leader has introduced a new system from February 2019 whereby the Urology Secretaries will follow the same process as the Appointment Centre staff, i.e. to print a letter locally and to ensure that they telephone the patient to inform them of the appointment date and time.
- Further training is needed for clinicians. EPR trainers are currently working with all Outpatient areas and targeting clinicians, particularly in relation to regarding hospital attendances (encounters).
- Trainers to train clinicians about encounters

Case Three – Patient attended the Accident and Emergency Department at Calderdale Royal Hospital with a post-operative issue (congestion and breathing difficulties) following a Submucous Resection of Nasal Septum and was discharged without treatment for a throat infection.

Observations were taken but no examination of the throat took place, the ENT Registrar on call advised A&E to reassure the patient and that no further management was required as it can take up to six weeks before any benefit from the procedure could be felt. ENT Registrar also advised to continue with the listed methods advised in the discharge leaflet and offered to arrange an urgent appointment in ENT. This appointment was arranged via the Accident and Emergency reception for 24 May 2018, 15 days after presentation.

Patient attended his GP the following day and his throat was examined. As a result the patient was diagnosed with an infection of the throat and was prescribed antibiotics.

Action taken:

As a result of this complaint the Head and Neck directorate are in the process of implementing a robust questioning process for patients who present with any head and neck post-operative issues, to ensure that patients are assessed and their condition communicated to the appropriate colleagues in a timely manner.

The lead investigator has also implemented discussion of post-operative patients who attend the Accident and Emergency Department at the Ear, Nose and Throat Consultant meetings to ensure that patients receive the best possible follow up care.

Case Four – Diabetic patient who presented with symptoms of DKA (acute condition caused by high blood sugars) was not seen for over three hours after arrival at triage, and only then when he started vomiting. This could have had serious consequences for the patient. This delay was against the protocols for treating DKA. The patient should have been seen by a clinician within 10 minutes.

The patient had his own urine ketone testing strips at triage, and these indicated he had ketones in his urine, should have alerted the triage nurse to the fact the patient was a diabetic with high blood sugars and possibly in DKA.

Additional tests should have been requested at triage to confirm the presence of ketones in the urine; either point of care urine testing or if unattainable then blood ketones should have been tested using a blood ketone meter. A venous blood gas sample should also have been taken (processed within a few minutes) to establish the acidity of his blood. This would have enabled the ED staff to confirm the patient was in DKA and appropriate treatment could have been instigated earlier.

Actions taken:

Notices have been placed in the triage/assessment areas reminding staff of the need to obtain a venous blood gas to establish the PH of the patient's blood and either urine or blood ketone reading should be obtained to establish if the patient is in ketosis.

A blood ketone meter has been bought for both sites and the required software is being installed onto the computers to enable them to be used. Whilst we are awaiting completion of this, staff have been made aware that there is a ketone meter on the medical assessment unit that can be used if needed.

Case Five – Patient did not receive endocrine therapy at the end of their treatment at the MacMillan Unit, and staff did not pick up on the fact that the patient did not receive her endocrine therapy despite the patient attending two further appointments following the completion of her treatment

The nurse had not printed off the endocrine prescription at the end of the patient's treatment therefore the endocrine therapy was not dispensed.

Actions taken:

The nurse has reflected upon this incident and will undergo retraining on the use of Varian to reinforce her knowledge around the system to ensure that this error does not occur again.

Every patient commencing adjuvant/neo-adjuvant chemotherapy will be scheduled for an endocrine therapy check on the last cycle of treatment.

A holistic needs assessment clinic is to take place at the end of the treatment, which will potentially capture any problems following treatment.

Case Six – Why was the mother mistakenly informed that the wrong dose of potassium had been given to her child?

The ward manager confirms that, in relation to the fluids commenced in ED, the staff nurse correctly identified that the incorrect infusion had been commenced and was correct to stop this. She also confirms that the Staff Nurse, in line with Trust Policy, reported this error as an incident via our Trust's incident reporting system.

The ward manager also confirms that a check of the label confirmed that the glass bottle stated 0.9% Sodium Chloride with 20% Potassium Chloride but the glass bottle only contained 500mls. This led to the Staff Nurse to think that there was not enough potassium chloride in the bottle. She therefore mistakenly informed the mum that the fluid was wrong which caused unnecessary upset and distress.

Actions taken:

The Paediatric Pharmacist has been asked to develop a document which shows all the different fluids used and how their size and subsequent concentrations can differ from supplier to supplier. This will be available in the diabetes folders on the Children's Wards for all staff to access.

Case Seven – Child's temperature was recorded inaccurately due to inaccurate thermometer.

From review of the child's records the ward manager concludes that it was not known at the time of the child's first and second attendance that the thermometer used was inaccurate. Once the parent was able to demonstrate with their own thermometer the discrepancy in readings the ward manager requested an under arm temperature to be obtained. This confirmed that there was an error with the ward thermometer.

Actions taken:

The ward manager advises that the thermometer identified to be inaccurate has been removed from use and that any other thermometers in use on the ward have been calibrated to ensure they are recording correctly.

correctly. She also confirms that new thermometers have been identified and will be ordered when approved through paediatric forum and we await delivery. This has had a knock on effect for the use of thermometers on children elsewhere in the organisation.

Case Eight (PHSO) – The complainant felt that when the patient (her mother) attended the Trust's Accident and Emergency Department for treatment following a fall in her home, the clinicians did not perform sufficient tests to diagnose her symptoms of confusion and pain in her head and thigh. As a result, it is claimed that the Trust delayed diagnosing her thigh fracture until later when she returned to A&E after being in private respite care for her pain and mobility issues. She also states that there was a delay in referring her for a dementia assessment, as she felt the Trust dismissed her concerns as 'confusion'.

The PHSO found that the assessment the Trust provided to the patient in relation to her symptoms and her confusion was appropriate. However, they found a failing in the lack of consultant review, which led to a missed opportunity to diagnose her fracture. The junior doctor who reviewed the patient should have performed an x-ray, which would have shown that the patient had a fracture, the junior doctor should have sought a senior review. If the fracture had have been diagnosed at that time, the appropriate treatment and physiotherapy would have been provided.

PHSO Recommendations/Actions:

Partly Upheld – the Trust apologised and said that although the outcome would have more than likely been the same, there would not have been a period of uncertainty. The Trust will share the learning from this complaint in the junior doctors' training sessions.

Improvement priorities for 2019-2020

During 2019/2020 we will:

- Continue to work with the Divisions to improve the timeliness of responses.
- Work with wards and departments to help them understand their complaints, and the learning from these.
- Explore the use of voluntary worker with the PALS team.
- Audit of learning from complaints to see how learning has been embedded.
- Focused piece of work on re-opened complaints, to understand the reason for the increase in re-opened complaints.
- Review the complaints module on Datix with the Trust Datix Manager

Performance against relevant indicators and performance thresholds from the Standard Operating Framework			
Indicator	**Threshold**	**2018/19 Year End Performance**	**Achieved**
Maximum time of 18 weeks from point of referral to treatment in aggregate-admitted	90%	80.93%	No
Maximum time of 18 weeks from point of referral to treatment in aggregate- non admitted	95%	92.46%	No
Maximum time of 18 weeks from point of referral to treatment in aggregate-patients on an incomplete pathway	92%	92.05%	Yes
A&E: maximum waiting time of four hours from arrival to natioadmission/ transfer/discharge	95%	91.29%	No
All cancers: 62-day wait for first treatment from: • Urgent GP referral for suspected cancer • NHS Cancer Screening Service referral	 85% 90%	 88.37% 94.42%	 Yes Yes
All cancers: 31-day wait for second or subsequent treatment , comprising: • Surgery • Anti-cancer drug treatments • Radiotherapy	 94% 98% n/a	 99.04% 100.00%	 Yes Yes
All cancers: 31 day wait from diagnosis to first treatment	96%	99.63%	Yes
Cancer: two week wait from referral to date first seen, comprising: • all urgent referrals (cancer suspected) • for symptomatic breast patients (cancer not initially suspected)	 93% 93%	 98.46% 97.56%	 Yes Yes
Clostridium difficile – meeting the C. difficile objective	21	18 (5 Preventable)	Yes
Maximum 6-week wait for diagnostic procedures	99%	87.89%	Yes
Data completeness: community services, comprising: • Referral to treatment information • Referral information • Treatment activity information	 50% 50% 50%	 79.7% 97.87% 100%	 Yes Yes Yes

Feedback from commissioners, overview and scrutiny committees and Local HealthWatch

Response from Greater Huddersfield and Calderdale Clinical Commissioning Group

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

The Quality Account is once again a comprehensive assessment of the levels of quality and is consistent with the Commissioners understanding of quality within CHFT. The account describes the vast amount of improvement work which the Trust has undertaken during 2018/19. The CCGs would like to congratulate CHFT on their improved CQC rating.

Like CHFT, commissioners welcomed the outcome of the enhanced proposal for the future model of care submitted to the Secretary of State for Health and Social Care and the subsequent allocation of capital funding, and we look forward to working with you on the proposals in the future.

We welcome the progress made in relation to the identified priority areas for 2018/19, and note that the work by the Deteriorating Patient Group will continue into the coming year in relation the introduction of NEWS2, this is welcomed by commissioners in the continued partnership drive to improve early recognition and management of sepsis.

Partnership working is also to be commended on the results of the SAFER Patient Flow Programme which has had a positive impact on delayed transfer of care and reduction of long stay beds, the CCGs recognise and commend this performance.

We also note the amount of work that has been undertaken on improving the experience of patients at the end of their life; however the CCGs would like to continue to work with the Trust to improve the numbers of those who die in their preferred place of death, which is not necessarily the acute hospital.

We are pleased to see that you are committed to improving the timeliness of complaint responses and note the work undertaken to reduce the backlog of responses.

The CCGs are also pleased to see that the priorities for 2019/20 will have a positive impact of the experience of people using CHFTs services and the wider sector.

- Emergency Department
- Deteriorating patient
- Mental health

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 "Quality Friday" visits to ward areas. This is a welcome demonstration of your continued 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.

Yours Sincerely

Penny Woodhead.

Chief Nurse and Quality Officer
23 April 2019

Response from HealthWatch in Kirklees and Calderdale

Comments requested however advised unable to comment.

Response from the Governors to CHFT Quality Accounts 2018-2019:

The Council of Governors has been working hard during the past year to enable the trust to strive towards providing higher quality care as detailed in this report. Governors were asked for their feedback in regards to this report and this has been taken into account. During 2018/2019 governors have been working hard throughout the trust sitting on divisional reference groups to improve quality for each section of the hospital. Patient safety and quality assurance has been discussed throughout the year, with governors holding to account and joining in discussions to strive for better results.

As governors this helps us to understand all the challenges of maintaining high level of quality across the trust throughout the year. Governors have also attended regular meetings with executives and non-executive directors, where they have asked challenging questions and been supportive critical friends to the trust.

The quality priorities for 2018/2019 are excellent and governors are pleased that they remain at such a reassuring level, however governors have indicated that they would like more focus to be placed on improving the quality of the complaints procedure and outcomes during the next year.

The Council of Governors supports and endorses the quality account for 2018/2019.

Alison Schofield
Lead Governor

24 April 2019

Response from Calderdale Overview and Scrutiny Committee

Comments requested but none received as at 2 May 2019.

Response from the Kirklees Health and Social Care Scrutiny Panel

Thank you for your email dated 4 April 2019 inviting comment from the Kirklees Health and Adult Social Care Scrutiny Panel on the draft 2018/19 Quality Account for Calderdale and Huddersfield NHS Foundation Trust.

Please note that as has been the case in previous years the timing of the submission has meant that 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 the timing of the submission has meant the Panel has not been able to have a discussion at a full panel meeting and unfortunately this has resulted in limiting the level of feedback and comments.

The Panel is pleased to see that the Care Quality Commission report published in June 2018 rated the overall quality of care provided by the Trust as good. The Panel's work programme will continue to include a focus on the performance of the Trust and the quality and safety of services it delivers.

The Panel was also pleased that the three priorities set for 2018/19 all met with measurable indices of success. It was however noted that the improvement priority that focused on deteriorating patients did highlight issues regarding the quality and focus of the safety huddles and problems with obtaining a 'ward view' to help more easily identify patients at risk of deterioration.

The Panel acknowledge that the Trust will continue to encourage the use of safety huddles and noted that further improvement on using the electronic patient record to obtain a 'ward view' had been identified and look forward to these issues being resolved during 2019/20.

It is encouraging to see that patient flow has improved overall although an explanation for the spike in the numbers of long stay patients in July and August 2018 would have been helpful. The achievements of the work that has been done by the Trust on improving the experience of patients on end of life care is laudable and the Panel was encouraged by the initiatives in this area.

The Panel noted the priorities for 2019/20 and were broadly supportive of the areas the Trust will focus on. However it was felt that the priority that will focus on the Emergency Department would not present a significant challenge given that the Trust already highlights that its delivery of emergency care services as being amongst the best nationally and the latest 2019 data ranks the Trust as one of the top trusts for meeting the 4 hour waiting standard.

The Panel noted that in some areas the Trust had demonstrated the involvement of patients and the public to help inform its practices and delivery of services. The Panel welcomed the initiatives used to help capture patient's feedback and experiences such as the bereavement survey; and the commitment to continue to review and develop more innovative feedback methods.

There were however some areas where the Panel felt more focus could have been given to involving patients, carers and family members in helping to shape practice. For example the Panel noted that the observational study on the early recognition of patients who are deteriorating highlighted the need to provide ongoing training for health care assistants. The Panel felt that more involvement with carers and family members may have helped to identify additional initiatives that would have contributed to improved patient outcomes.

The Panel welcomed the work that is being done by the Trust to improve the timeliness of responses to a complaint and support the focus on learning from complaints in order to help improve services.

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.

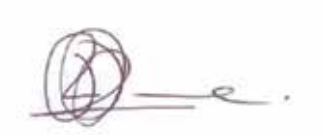
The Panel did note that no mention has been made on how the Trust communicates with the public on its complaints procedures and believe that it would be helpful to understand the approach that the Trust takes to seeking the views of the public so it can refine and improve its procedures.

As in previous years with the exception of a comment in the Chief Executive's statement the document does not include any significant details on the plans to reconfigure healthcare in the hospital and community. This is of significant interest to the Panel and local residents and the Panel feel this should be given far more prominence in the Quality Account.

The Panel acknowledge that there are some impressive results from performance indicators and nationally comparable metrics and the Quality Account is a thorough and technically competent report. However from a public perspective the Panel feel that there is a lack of clarity in how the information and detail is explained and the document includes confusing jargon and acronyms. The Panel would welcome further work from the Trust in considering how the information can be more easily presented to the public.

The Panel is also mindful of the continued financial challenges that the Trust and the wider health and social care economy faces. The Panel intend to continue its focus during 2019/20 on the work being developed locally to increase efficiencies and work in a more integrated way without adversely affecting the quality and safety of patient's services."

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 2019/20.

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 great to see the CHFT overall CQC rating improve from requires improvement to good. From a SWYPFT perspective we know this is very well deserved based on all the hard work of the staff and stakeholders of CHFT.

I noted the positive progress in achieving your top three improvement priorities for 2018/19; improving outcomes through recognition, response and prevention of deteriorating patients; patient flow and improving timely & safe discharge, and improving the experience of patients on the care of the dying pathway.

We welcome the priorities for 2019/20, which focus on emergency department waiting times to ensure safe and reliable care, implementing new national early warning signs guidance and improving psychological support for mental health patients in the Emergency Department. We look forward to working with you on these top priorities and others and I know we are already working closely with you on improving psychological support in the ED.

Our experience of CHFT as a partner has always been very positive and we continue to be impressed by the resilience and the professionalism shown by all your staff in the face of ongoing challenges.

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

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

Yours sincerely

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

15 April 2019

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:

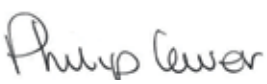
- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2018 to May 2019
  - papers relating to Quality reported to the board over the period April 2018 to May 2019
  - CQC inspection report dated June 2018
  - feedback from commissioners dated 23 April 2019
  - feedback from governors dated 24 April 2019
  - feedback from local HealthWatch organisations dated 16 April 2019
  - feedback from Kirklees Overview and Scrutiny Committee dated 17 April 2019
  - feedback from South West Yorkshire Partnership Foundation Trust date 15 April 2019
  - the Trust's complaints report for 2018/19 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - the 2017 Adult inpatient survey May 2018
  - the 2018 national staff survey March 2019
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated 21 May 2019.

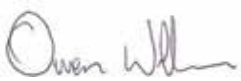
Feedback was requested from Calderdale Overview and Scrutiny Committee, Trust and Locala on 3 April 2019.

- 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 AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF CALDERDALE AND HUDDERSFIELD NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of Calderdale and Huddersfield NHS Trust's Quality Account for the year ended 31 March 2019 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following indicators:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge
- Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the Directors and the auditor

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

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 Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2018 to May 2019;
- papers relating to quality reported to the Board over the period April 2018 to May 2019;
- feedback from the Commissioners dated 23/04/2019;
- feedback from Local Healthwatch dated 16/04/2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national impatient survey (June 2018), Maternity survey (January 2019) and Cancer Patient Experience Survey (October 2018)
- the latest national staff survey dated March 2019
- the Head of Internal Audit's annual opinion over the trust's control environment dated 21/05/2019; and
- the annual governance statement dated 24/05/2019.

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

This report, including the conclusion, is made solely to the Board of Directors of Calderdale and Huddersfield NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Calderdale and Huddersfield NHS FT for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower 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 impact 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 thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

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

Basis for qualified conclusion on the A&E indicator

With regard to the 'A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge' indicator, our testing identified three incidents where there was a discrepancy between the clock 'stop' time on the EPR system and the time noted in the patients records. Based on the 'stop' times per the patient notes these 3 incidents would have been reported as breaches of the 4 hour maximum waiting time.

The Trust has investigated these instances and it appears that where the 'stop' time is backtimed the staff had made notes to explain this on the system however these notes were not retained by the system. The Trust has carried out additional sampling and put in place appropriate controls to address this.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion on the A&E indicator' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- 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

KPMG LLP
Chartered Accountants
Leeds

24 May 2019


The Human Skeleton

Appendix A: 2018/19 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 2018/19, are listed below. The numbers of cases submitted to each audit or enquiry as a percentage of the number of registered cases required (by the terms of that audit or enquiry) are also listed.

During 2018/19, 48 of the national clinical audits and 4 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 92% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. These are detailed in Appendix A.

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 2018	Yes	Yes	100%	100%
Maternal, infant and new born programme (MBRRACE-UK)	Yes	Yes	100%	100%
Neonatal intensive and special care (NNAP)	Yes	Yes	451	100%
Paediatric intensive care (PICANet)	No	NA	NA	NA
RCEM Feverish Children 2018 (care in emergency depts)	Yes	Yes	All cases in time period	100%
Audit of seizures & epilepsies in children & young people	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	1182	100%
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Yes	All	100%
National emergency laparotomy audit (NELA)	Yes	Yes	187	100%
RCEM Vital signs in adults 2018	Yes	Yes	All cases in time period	100%
RCEM VTE risk in lower limb amputation 2018 (care in emergency dept)	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:				
Audit of the use of FFP and Cryoprecipitate in neonates and children	Yes	NA (none eligible)		
National Audit of the management of massive haemorrhage	Yes	Yes	7	100%
Use of O neg red cells (lab manager audit only)	Yes	Yes	30 units	100%

Cancer

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Bowel cancer (NBOCAP)	Yes	Yes	474	100%
Lung cancer (NLCA)	Yes	Yes	331	100%
Oesophago-gastric cancer (NAOGC)	Yes	Yes	All cases in time period	100%
National Prostate Cancer Audit	Yes	Yes	320	100%
Endocrine & Thyroid National Audit (BAETS)	Yes	Yes	All cases in time period	100%
Head & Neck Cancer Audit (HANA)	Yes	Yes	All cases in time period	100%
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	475	

Heart

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes	927	100%
Adult cardiac surgery audit (ACS)	No	N/A	N/A	N/A
Cardiac arrhythmia (HRM)	Yes	Yes	100%	On-going
Congenital heart disease (Paediatric cardiac surgery) (CHD)	No	N/A	N/A	N/A
Coronary angioplasty/PCI (NICOR)	Yes	Yes	100%	On-going
Heart failure (HF)	Yes	Yes	100%	On-going
National Cardiac Arrest Audit (NCAA)	Yes	Yes	125 YTD	on-going
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Yes	Yes	305	100%

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	Yes	53 YTD	On-going
Diabetes (Paediatric) (NPDA)	Yes	Yes	100%	100%
Inflammatory bowel disease (IBD) Registry**	Yes	No	On-going	
	None			
National Ophthalmology Audit	Yes	Yes	2864	100%
RCP National COPD secondary care audit 2018	Yes	Yes	On–going	All cases
National audit for rheumatoid & early inflammatory arthritis	Yes	Yes	On-going	On-going
Audit of Pulmonary Hypertension 2018	Yes	Yes	On–going	All cases
National Audit of Care at the End of Life (NACEL)	Yes	Yes	80	100%

Long term conditions

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 2018 (round 4)	Yes	Yes	100	100%
Falls & Fragility fractures – inpatients falls	Yes	Yes	30	100%
National Audit of Intermediate Care	Yes	Yes	50	100%

Other

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Specialist Rehab for patients with complex needs	No	N/A	-	-
BTS adult community acquired pneumonia	Yes	Yes	200	On-going
BTS non-invasive ventilation - adults	Yes	Yes	All cases in time period	On-going
UK Cystic Fibrosis Registry	No	N/A	-	-
Seven Day Hospital Services	Yes	Yes	70	100%
Learning Disability Mortality Review (LeDeR)	Yes	Yes	11	100%
BAUS Nephrectomy Surgery	Yes	No	-	-
BAUS PCNL	Yes	No	-	-
National Bariatric Surgery Registry	Yes	No	-	-
Elective surgery (National PROMs Programme) Hip replacements/Knee replacements	Yes	Yes	Pre-op 1042 Post-op 922	90.1%(939) 81.6% (752)

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:				
NCEPOD Pulmonary Embolism Study	Yes	Yes	9	88% (8)
NCEPOD Acute Bowel Obstruction	Yes	Yes	8	Ongoing
Long Term Ventilation (NCEPOD Child Health Programme)	Yes	NA (none eligible)		
NCEPOD Peri-operative Diabetes Study	Yes	Yes	3	100% (3)

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

Name of audit	Reason
Inflammatory bowel disease (IBD) Registry	Lack of resources
National Bariatric Surgery Registry	Breakdown in data submission systems
BAUS Nephrectomy Surgery	Lack of resources
BAUS PCNL	Lack of resources
Long Term Ventilation (NCEPOD Child Health Programme)	The Trust had no patients eligible for this study
Audit of the use of FFP and Cryoprecipitate in neonates and children	The Trust had no patients eligible for this study

The reports of 38 national clinical audits were reviewed by the provider in 2018/19 and the following are examples where Calderdale and Huddersfield NHS Foundation Trust intend to take actions to improve the quality of healthcare provided.

National Ophthalmology Audit

The Health Quality Improvement Partnership (HQIP) has commissioned the National Ophthalmology Database (NOD) Cataract Audit to report on all NHS funded cataract surgery in England and Wales. The quality of delivery of this high volume surgical activity nationally is unknown, previous reports have been based on data from self-selected centres and thus may not provide a comprehensive picture representative of NHS cataract surgery as a whole. The current report documents prospectively collected cataract surgery data and reports results for named NHS centres. These include operations performed and recorded by all surgeons of all grades within centres.

Objectives

- To compare CHFT cataract surgery complication in 2017-18 (PCR –Posterior Capsule Rupture Rate) with national published database in ophthalmology NOD
- To recommend further action plan to improve the PCR rate if needed

Summary of findings for CHFT

- CHFT overall PCR rate is 1.1% same as seen in NOD outcome.
- CHFT risk adjusted visual loss is 0.9% comparable to NOD outcome of 0.81%
- There is variation in PCR rate at CRH (1.5%) and HRI (0.9%) as well as risk adjusted visual loss (CRH 1.2% and HRI 0.8%). These findings are consistent with most of the complex cases including GA are done at CRH and only LA cases are operated at HRI
- Post op visual outcome data was available in 71.77% of cases. These numbers at NOD are 67.4%

Actions

Recommendation	Actions required (specify 'None', if none required)	Action by date	Person responsible	Comments/action status (Provide examples of action in progress, changes in practices, problems facilitating change, reasons why recommendation has not been actioned etc.)	Change stage (see Key)
To record PCR risk factors on Medisoft while listing patient for cataract surgery	Every clinician who lists patient for cataract surgery should complete the Medisoft records	Jan 2020	Ms Gogi / Clinical Lead		**Action in progress**
To improve pre op VA data capture from 72.73% to >95%	All HCAs who does the vision in eye clinic at either side should record on medisoft	Jan 2020	Eye clinic Sisters at both sites CRH and HRI	Medisoft /electronic patient record system specific to ophthalmology is been in use exclusively since year 2017	**Complete**
To improve post op VA data collection from 71.77% to 90%	Local optometrists should be encouraged to send post op VA data	Jan 2020, repeat audit to show change	Clinical Lead/ Ophthalmology Manager to liaise with local optometrist group	Commissioners can influence local optometrist group to send post op VA outcome, enhancement of community services	**Action in progress**

Recommendation	Actions required (specify 'None', if none required)	Action by date	Person responsible	Comments/action status (Provide examples of action in progress, changes in practices, problems facilitating change, reasons why recommendation has not been actioned etc.)	Change stage (see Key)
Quality assurance for acceptable rate of adverse events	Clinicians in the dept should update the referrals taken for adverse events after the cataract surgery done outside CHFT to audit lead	Jan 2020	Dr Shevade/ Ms Gogi	Centrally accessible database will be created so all adverse post cataract surgery events can be collected where patients had surgery in private sector	**Action in progress**

SSNAP Annual Report April 2017- 2018

Introduction:

This Annual report is based on patients arriving at hospital (or having stroke onset as an inpatient) between 1 April 2017 – 31 March 2018 and patients who were discharged from inpatient care during the same period. The Clinical Effectiveness and Evaluation Unit in the Clinical Standards Department of the Royal College of Physicians first conducted the National Sentinel Stroke Audit (NSSA) in 1998 and subsequently a total of 7 rounds have been undertaken with 100% participation achieved since 2006. SSNAP combines the NSSA and the Stroke Improvement National Audit Programme (SINAP) which audited care in the first 72 hours after stroke. SSNAP is aiming to be the single source of stroke data for local teams, regional authorities and at a national level.

Aim:

- benchmark services regionally and nationally
- monitor progress against a background of organisational change to stroke services.
- support clinicians in identifying where improvements are needed, planning for and lobbying for change and celebrating success
- empower patients to ask searching questions

Summary of Findings

SSNAP KI		NO.	METRIC	CURRENT MONTH			TARGET	SSNAP LEVEL
SCANNING	1 Hour scanning	1	% of stroke patients scanned within 1 hour of hospital arrival	March			TARGET	LEVEL
				Numerator	26	41.3%	48%	C
				Denominator	63			
	12 Hour Scanning	2	% of stroke patients scanned within 12 hours of hospital arrival	March			TARGET	LEVEL
				Numerator	55	87.3%	95%	C
				Denominator	63			
	Median time to scan	3	Median arrival to scan time (minutes)	March			TARGET	LEVEL
				100 minutes			<60	D
STROKE UNIT	Direct Admission	4	% of stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	March			TARGET	LEVEL
				Numerator	30	47.6%	90%	E
				Denominator	63			
	90% Stay	5	% of stroke patients spending 90% of their stay on a stroke unit	March			TARGET	LEVEL
				Numerator	48	77.4%	90%	D
				Denominator	62			
THROMBOLYSIS	No. Thrombolysed	6	% of all stroke patients thrombolysed	March			TARGET	LEVEL
				Numerator	7	11.1%	20%	D
				Denominator	63			
	Thrombolysis within 1 hour	7	% of stroke patients thrombolysed within 1 hour	March			TARGET	LEVEL
				Numerator	7	100.0%	55%	A
				Denominator	7			
	Median time to scan	8	Median clock start to thrombolysis time (minutes)	March			TARGET	LEVEL
				31 minutes			<40	A

SNNAP Key indicators -Area of improvement

SSNAP KPI		Metric	SSNAP Level Target	YTO March 18 CRH
Thrombolysis	Thrombolysis within 1 hour	% of stroke patients thrombolysed within 1 hour	55%	81.8%
	Median	Median clock start to thrombolysis time (minutes)	<40	36
Discharge Process	Joint care	% of stroke patients with joint care plans on discharge from hospital	90%	99.2%
	ESD	% of stroke patients supported by an Early Supported Discharge Team	40%	63%
	Atrial Fibrillation	% of stroke patients , presenting with AF, anticoagulation on discharge	95%	95.5%

THERAPY	INITIAL ASSESSMENT COMPLETED WITHIN 72 HOURS OF ARRIVAL/ONSET	March		Level
		OT	83.0%	C
		PHYSIO	81.6%	D
		SALT COMM	96.0%	A
		SALT SWALLOW	82.6%	B

MEDIAN NUMBER OF MINUTES PER DAY ON WHICH THERAPY IS RECEIVED	March		Level
	OT	36.8	A
	PHYSIO	31.0	B
	SALT	27.2	C

MEDIAN % OF DAYS IN HOSPITAL WHICH THERAPY IS RECEIVED	March		Level
	OT	62.5%	C
	PHYSIO	63.2%	B
	SALT	58.8%	C

Recommendation	Actions required (specify 'None', if none required)	Action by date	Person responsible	Comments/action status (Provide examples of action in progress, changes in practices, problems facilitating change, reasons why recs not actioned etc.)	Change stage (see Key)
D1: Scanning – Currently achieving a C Forecast next quarter SSNAP rating to be A/B	Radiology depart do the scans for suspected stroke but not after 2 hours – this will link in with the new assessment beds – signed up to see the patients within 10 minutes after admission to order a scan & therefore be scanned with an hour. Assessment beds to open in A&E – 28th Sept 2018. (Cubicle 6 and not a 24 hour service).		Anand Nair	The problem is due to not delivering patients to the scanner in the appropriate time after arrival and due to there not being a 1 hour scanning policy for all stroke patients	2
D2: Stroke Unit - Currently achieving a C Forecast next quarter SSNAP rating to be A/B.	Review breaches to see if patients have self-presented or YAS presented & review discrepancy between A&Es. To work with YAS and pull all audit information together to see what the impact is		Anand Nair Oliver Hutchinson	If patients self-present then need to do some work as a Trust to encourage people with Stroke symptoms to attend CRH and if YAS presented to HRI then training /education needs to be conducted with the ambulance service.	2
D3: Thrombolysis - Currently achieving a B Forecast next quarter SSNAP rating to be A.	To circulate response from SSNAP on clarity around the meaning of 'Stroke unit within 4 hours and thrombolysis if required' 1 - Open twist trial for wake up stroke-opening next week - (AN accountable) starting this week 2 - Devise protocol for minor stroke thrombolysis with CHFT registry-by next CGM (AN accountable) starting 1st Dec – should increase score by up to 20%. Review after a month of introduction – look at Dec figures 3 - Locally agreed guideline for thrombolysis for patients on anticoagulants (PR accountable) by next CGM. – postpone for next SSNAP A meeting			Number of patient we offer Thrombolysis to will decrease due to the new national thrombectomy agreement – will make figures look worse as numbers and performance going to Leeds. Add shadow number so we have previous/ corrected number so can compare with previous performance.	2

Recommendation	Actions required (specify 'None', if none required)	Action by date	Person responsible	Comments/action status (Provide examples of action in progress, changes in practices, problems facilitating change, reasons why recs not actioned etc.)	Change stage (see Key)
D4: Specialist Assessment – Currently achieving a D Forecast next quarter SSNAP rating to be B/C	To audit and review breaches for one single month.			Update: 3 patients sent across. 1 was not a breach, 1 was due to delayed admission from a/e over the weekend after consultant ward round. The last one was a patient transferred from MAU after 12 hours - unavoidable based on current setup. Our trust process has changed in Sept 2018 to introduce a Telemedicine assessment/ward round for all admissions – change in practice.	2

What potential clinical benefits will result from this audit?
Benchmarking of performance, review significant changes over time, and regional comparisons resulting in a better service for stroke patients

What other uses will result from this audit? (e.g. publication, awards, accreditation)
- Local data collection in addition to national SSNAP audit.
- Additional value needs to be discussed further in the Trust.
- It will be useful to discuss the measures that are needed to make improvements in some areas.

Other National Clinical Audits the Trust has participated in during 2018/19:
- Breast & Cosmetic Implant Registry
- National Audit of Hip Fractures
- Diabetic Retinopathy Screening (KPI)
- SAMBA 18
- BSUG Stress Incontinence database
- Potential Donor Audit
- Management of Urinary Retention (Collaborative Regional Audit)
- IMAGINE: Ileus Management International (STARsurg)
- RICOCHET Study (National Pathways for patients with HPB malignancies)
- Respiratory complications after abdominal surgery (RECON)
- National Audit of inpatient complex and chronic pain (CHIPS)
- National Audit of Seizure Management (NASH) 3
- The Efficacy and Safety of Sleep Deprivation for EEG examination
- National exploration of neuro-diagnostic practices for the diagnosis of Motor Neuron Disease (MND).
- Standardising Visual, Somatosensory and Brainstem Auditory Evoked Potential (EP) recordings
- FAMCARE2 (end of life care)
- National Audit of Cardiac Rehabilitation

The reports of 89 local clinical audits were reviewed by the provider in 2018/19 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Trust Chaperone Audit

This project will be focussing on whether the patients are protected from any inappropriate occurrences when a chaperone is present and the organisation Calderdale and Huddersfield Foundation Trust is protected from false allegations whilst a patient is having an intimate examination or procedure. A chaperone is an independent person, appropriately trained, whose role is to independently observe the intimate examination/procedure undertaken by the doctor/health professional to assist the appropriate doctor-patient relationship. A chaperone is required to add a layer of protection for both the doctor as well as for the patient.

Objectives

- To review the current chaperone policy and ensure that is being followed and fully adhered to
- Conduct interviews with clinicians that will be fully anonymised to identify if they understand and are complying with the organisations chaperone policy
- Perform a case study within the areas of breast, general surgery, urology and gynaecology specialities

The analysis of the findings from the qualitative piece of research focussed on five areas of speciality; Gastroenterology (Gastro), gynaecology (gynae), urology, breast surgery and colorectal. The patient information was fully anonymised and no information was patient identifiable.

Initially the data was obtained from three separate clinic sessions for each of the five specialities. Within this research data, the information was further broken down to identify how many patients within the clinic had had an intimate examination on clinic days. The patients who did have an intimate examination or procedure defined as examination of the genitalia, per rectum, per vagina, breast or abdomen examination were included in this data set. These patients were a mix of new and follow up patients, which highlights why some of the follow up patients did not require an examination.

Intimate examination performed

	Urology		Breast		Colorectal		Gastro		Gynae	
Had intimate examination?	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes
Clinic 1	14 (47%)	16 (53%)	2 (14%)	12 (86%)	4 (29%)	10 (71%)	18 (69%)	8 (31%)	4 (29%)	10 (71%)
Clinic 2	15 (94%)	1 (6%)	4 (40%)	6 (60%)	1 (8%)	12 (92%)	13 (87%)	2 (13%)	18 (95%)	1 (5%)
Clinic 3	2 (13%)	14 (88%)	0	29 (100%)	0	7 (100%)	7 (47%)	8 (53%)	0	10 (100%)
Total:	**31 (50%)**	**31 (50%)**	**6 (11%)**	**47 (89%)**	**5 (15%)**	**29 (85%)**	**38 (68%)**	**18 (31%)**	**22 (51%)**	**21 (49%)**

**percentage is rounded up or down to nearest number*

From the patients who had received an intimate examination, a random sample was selected of twenty (where possible) from each of the specialities. Gynaecology had 21, and Gastroenterology had 18. There were 99 anonymised patients included in the research data sample of which 65 were female and 34 were male. For Urology we are estimating 50% of clinic attendances have intimate examinations, 89% for breast, 85% for colorectal, 31% for gastroenterology and 49% for gynaecology.

The majority of intimate examinations were undertaken in the Calderdale hospital as five of the outpatient clinics are held at the Calderdale hospital, and two outpatient clinics are held at the Huddersfield hospital. Intimate examinations take place within the hospital on a daily basis across both sites.

It shows from the research evidence that when a female is having an intimate examination, this has been performed by a male consultant 78% of the time and by a female consultant 22% of the time. The gender of the clinicians was confirmed by a list provided by Human Resources at Calderdale and Huddersfield

Foundation Trust and personal knowledge. However for a male patient, they have been seen by a male consultant 100% of the time. This is because there are a larger number of male consultants (65%) than female consultants (35%).

Interviews with clinicians

Knowledge of policy

Question	Yes	No
Do you know we have a chaperone policy?	4	1
Do you know how to access the chaperone policy?	5	-
Have you accessed the chaperone policy?	3	2

Question	Yes	No
Do you document whether you had a chaperone and whether the patient declined?	2	3
Do you document the name of the chaperone?	2	3
Does the chaperone document anything?	-	5

Conclusions

The findings have shown and evidenced that staff do not fully understand or comply fully with the current chaperone policy. In some areas clinicians will say that they do comply, but that they do not evidence any of this within the patient record.

Recommendation	Actions required (specify 'None', if none required)	Action by date	Person responsible	Comments/ action status (Provide examples of action in progress, changes in practices, problems facilitating change, reasons why recs not actioned etc.)	Change stage (see Key)
Amend posters and leaflets		April 2019	Neeraj Bhasin		2
Amend current policy		April 2019	Neeraj Bhasin		2

Re-audit of Neonatal Jaundice admissions to wd 3 (paeds) CRH

Babies who come to hospital with jaundice are treated with phototherapy lights until their bilirubins are 50 or more below the treatment line on an age specific graph. Babies can often stay in hospital for up to 24hrs waiting for the 'rebound' blood test to be taken, collected and acted on / discharge arranged.
NICE guidelines suggest that for jaundice babies who are otherwise well, with no other concerning factors (eg weight loss, poor feeding, maternal concerns), they can go home as soon as the lights are turned off and have their rebound blood test done 12-18hrs later at home or as a ward attender.
This was not routinely carried out on paediatric wards but could save beds being used, particularly in busy periods, and also prevent newborn babies being around ill children for longer than necessary. It also helps promote bonding with the family and improve general health of the mother by allowing them to go home sooner and be with family support.

A trial was undertaken from 1st Feb 2018 – 31st July 2018 to see if this method worked or if there was still a significant number of readmissions as a result.

Objectives:

- To assess the effectiveness of recent changes made to local jaundice guidelines with a view to updating the guideline

Summary of findings for CHFT

- 133 babies in audit (104 above treatment line)
- Results compared to 2017 (pre guideline) results

Audit results	2017 Pre guidelines	2018 Post guidelines
Babies stayed in hospital for rebound SBR	97%	45%
Lights off: SBR <50 below SBR >50 below	 11% 89%	 1% 99%
Time from lights off to discharge	3% stayed <6 hrs 37% stayed 7-12hrs 46% stayed 13-18hrs 14% stayed over 18hrs	
Went home before having rebound blood tests as there were no other concerns	NA – not offered pre guidelines	55%
Re-attended on ward	NA	12.5% 6 = pre rebound 6 = post rebound

Conclusions
Continue good practice

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)
Adopt new local jaundice guidelines and continue current good practice	None	Complete	V Stead		3