Bradford Teaching Hospitals
NHS Foundation Trust

Quality Account 2020/21

CONTENTS

1. Statement of Quality from the Chief Executive 3
   1.1. About Bradford Teaching Hospitals NHS Foundation Trust 4
   1.2. What is a Quality Account? 4
   1.3. Scope and structure of the Quality Account 5
2. Priorities for improvement and statements of assurance from the Board 5
   2.1. Priorities for improvement 5
   2.2. Statement of assurance from the Board 9
      2.2.1. Review of services 9
      2.2.2. Participation in clinical audits and national confidential enquiries 9
      2.2.3. Participation in clinical research activities 10
      2.2.4. Commissioning for quality and innovation (CQUIN) 10
      2.2.5. Care Quality Commission registration 10
      2.2.6. CQC special reviews and investigations 10
      2.2.7. NHS number and general medical practice code validity 10
      2.2.8. Data security and protection toolkit 11
      2.2.9. Payment by results clinical coding audit 11
      2.2.10. Data quality 12
      2.2.11. Learning from deaths 13
      2.2.12. Staff who speak up (including whistleblowing) 15
      2.2.13. Guardian of safe working 16
   2.3. Reporting against core indicators 17
      2.3.1. Summary hospital-level mortality indicator 17
      2.3.2. Patient reported outcome measures (PROMS) 18
      2.3.3. 28-day readmissions 18
      2.3.4. Responsiveness to patient need 20
      2.3.5. Staff friends and family test 21
      2.3.6. Venous thromboembolism event risk assessment (12 month rolling) 21
      2.3.7. C difficile 22
      2.3.8. Patient safety incidents with severe harm or death 24
3. Other information 25
   3.1. Indicators for patient safety 25
      3.1.1. Pressure ulcers 25
      3.1.2. Sepsis screening and time to treatment 26
      3.1.3. Falls 30
      3.1.4. Indicators for clinical effectiveness 30
      3.1.5. Patient experience 32
4. Annexes 34
   4.1. Annex 1: Statements from Commissioners, Local Healthwatch Organisations and Overview and Scrutiny Committees 34
   4.2. Annex 2: Statement of directors' responsibilities in respect of the Quality Account 38

1. STATEMENT OF QUALITY FROM THE CHIEF EXECUTIVE

I am delighted to introduce the 2020/21 Quality Account report as Chief Executive of Bradford Teaching Hospitals NHS Foundation Trust.

We are proud of all that we have achieved over the last 12 months and the continued improvements that we have made despite the challenges presented by the COVID-19 pandemic (hereafter in this report referred to as the pandemic). We have remained committed to the Trust's mission to provide the highest quality of healthcare at all times and our core values; we care, we value people, and we are one team. These values have been bought to life during our response to the unprecedented demands and impact of COVID-19 for our services, staff and patients.

Alongside all health and social care providers across England, we have had to rapidly adapt and adopt different ways of working in a way that we would not have anticipated. Despite the challenges and pressures on our services, and the NHS as a whole, our dedicated and courageous staff have been unrelenting in their response to the crisis and continue to deliver world class services, of which we are immensely proud.

Reviewing the many achievements highlighted in this report, it fills me with immense pride to lead an organisation that is at the forefront of so many innovations. We have continued an extensive programme of clinical research and made significant contributions to the research response to the pandemic. This includes the COVID-19 vaccine trials, as well as developing and testing innovative ways to treat this new disease.

The Trust was also quick to react to the needs of patients and families during the pandemic when visiting restrictions were enforced for safety reasons. A number of new services were promptly set up to enhance patient experience including a relative's telephone line, a dedicated email and a video call service known as 'Family View' to maintain communication between staff, patients, carers, friends and families. This has proved to be an invaluable service and has answered over 43,000 calls from friends and relatives concerned about their loved ones.

As part of our quality improvement programme, we have developed an electronic visual display of real time information to enable us to monitor and manage deteriorating patients. This is part of a suite of tools within our 'command centre wall of analytics' which supports our operational and clinical teams to deliver safe, effective and timely patient care.

As an organisation we realise that providing high quality healthcare is not down to us alone. We have entered into a partnership across Bradford district and Craven with an aim of providing outstanding care to all of our population. 'Act as One' is the way all of us across Bradford district and Craven operate together, supported by governance and shared decision making, to design, develop and deliver integration across care pathways which better meet the needs of our population. Our vision is to help people live 'happy, healthy at home.'

Despite the need for services to respond to the pandemic, our Act as One programme continued to make progress during 2020-2021; we have highlighted one achievement per programme below. Our focus for 2021-2022 will be supporting the recovery of services with a clear mandate to tackle health inequalities that have been further exacerbated by the pandemic.

Quality and safety remain our key priorities as we move into 2021/22. We are looking forward to another year of continued focus on learning from our response to the pandemic and improving the quality of care and experience for our patients.

On behalf of the Board this report provides a true account of quality of care at Bradford Teaching Hospitals NHS Foundation Trust.

Signed by the Chief Executive in which to the best of their knowledge the information in the document is accurate.

Mel Pickup
Chief Executive
July 2021

1.1. ABOUT BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST

Bradford Teaching Hospitals NHS Foundation Trust is responsible for providing hospital services for the people of Bradford and communities across Yorkshire. We serve a core population of around 500,000 people and provide specialist services for some 1.1 million.

Our 5,500 staff work over several sites, including Bradford Royal Infirmary, which provides the majority of inpatient services, and St Luke's Hospital, which predominantly provides outpatient and rehabilitation services. We also manage local community hospitals at Eccleshill, Westwood Park, Westbourne Green, and Shipley.

We are extremely proud of our focus on high quality care and our aspiration to provide outstanding health care to all of our communities. We listen to our communities, work with partners across the city and are innovative and trailblazing in our approach.

We are the first healthcare organisation in Europe to implement a command centre to transform patient flow and safety in our hospitals. This enables a real time view of all of our patients and identifies any changes we need to make to a patient's pathway; we have opened new £3m flagship research centre – the Wolfson Centre for Applied Health Research. This means that Bradford, as a city of research, and our hospitals are in the centre of cutting edge research and development.

1.2. WHAT IS A QUALITY ACCOUNT?

All providers of NHS services in England have a statutory duty to produce an annual report to the public about the quality of services they deliver. This is called the Quality Account and includes the requirements of the appropriate regulations[1]

The Quality Account aims to increase public accountability and drive quality improvement within NHS organisations. This is done by getting organisations to review their performance over the previous year, identify areas for improvement and publish that information, along with a commitment to you about how those improvements will be made and monitored over the next year.

Quality consists of three areas which are essential to the delivery of high-quality services:

- How safe is the care (patient safety)
- How well the care provided works (clinical effectiveness)
- How patients experience the care they receive (patient experience)

[1] NHS (Quality Accounts) Regulations 2010 as amended by the NHS (Quality Accounts) Amendments Regulations 2011; NHS (Quality Accounts) Amendments Regulations 2012.

1.3. SCOPE AND STRUCTURE OF THE QUALITY ACCOUNT

This report summarises our progress on the quality priorities we set for 2020/21. In normal circumstances, we would have engaged with our stakeholders and partner organisations which includes, patients and the public, our staff, Foundation Trust Governors, commissioners and regulators in order to decide our goals and set priorities for the following year. However, this has not been possible this year owing to the on-going pandemic.

Our main focus has been to provide safe, effective - and a positive experience of - care. Therefore, we decided to roll forward the priorities and goals we set ourselves in the previous year. The pandemic has shone a light on existing issues of inequality and provided opportunity to address these both nationally and locally. To reflect this, we have added an additional priority in relation to advancing equality, diversity and inclusion.

This report is divided into three parts:

- Part 1 presents a statement from the Chief Executive about the quality of health services provided during 2020/21.
- Part 2 describes our priorities for improvement for 2021/22, the rationale, our progress in 2020/21 and how we plan to monitor and report progress. It contains statements of assurance relating to the quality of services. This includes a statement about the suspension of our audit programme and a description of our research work
- Part 3 sets out how we identify our own priorities for improvement and gives examples of how we have improved services for patients. It also includes performance against national priorities and our local indicators.

The annex section includes comments from our external stakeholders.

2. PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1. PRIORITIES FOR IMPROVEMENT

Our priorities for improvement are outlined in figure 1, below:

Figure 1 - priorities for improvement 2020/21

Priority 1: improving the management of deteriorating patients			
Target	**Rationale**	**Progress**	**Reporting**
To embed and sustain the use of the patient deterioration tile* to support the early identification and management of patient deterioration across all eligible ward areas by 31 March 2022. To increase sepsis screening and time to treatment (for severe and uncomplicated	This priority has been identified through our incident investigation outcomes and learning from deaths work. This priority is aligned to the NHS Patient Safety Strategy and remains a key focus of work within the national patient safety improvement programmes.	The command centre patient deterioration tile was successfully implemented across all ward areas prior to 31 March 2021. This exceeded our intended target set for 2020/21.	Monitoring and measurement will be achieved via a range of improvement measures. This will include: eligible patients screened for sepsis; time to antibiotic treatment; completion of NEWS2 scores; escalation documentation; and wider learning from incident investigation

sepsis) to 90% for all eligible of patients (emergency department and inpatients) from baseline by 31 March 2022. [*The patient deterioration tile is part of a GE Healthcare co-designed application using Trust criteria to show real-time and actionable information based on NEWS2 scores and other clinical factors to support earlier intervention and escalation].			outcomes. The lead nurse for sepsis and the quality improvement team will provide monthly written and verbal updates to the deteriorating patient group, quarterly written and verbal reports to the patient safety group and bi-annual reports to the Quality Academy.
Priority 2: improving patient experience			
Target	**Rationale**	**Progress**	**Reporting**
The Trust will continue to enhance the patient experience strategy by further development of the e*mbedding kindness* work that has been developed during 2020.	Patient feedback received within the Trust from both staff and patients highlighted the importance of kindness. A clear message received was that one of the most important attributes people required was for people to be kind to them during their stay and during interactions.	An e-learning package has been developed; a nomination for kind acts scheme commenced; and a kindness tree has been erected in the central concourse of the hospital, where patients, staff and the public can make kindness pledges on leaves to add to the tree. The ward accreditation scheme now also includes kindness as part of the ward assessments.	Kindness data will be measured and reported in a number of formats, including the number of pledges, nominations of kind acts and compliments received within the Trust. This information will be reported to patient experience governance meetings and will allow for ongoing learning and improvement into future projects to enhance patient experience. External tools to monitor patient experience will include the CQC national surveying programme.
Priority 3: Continued reduction in stillbirths			
Target	**Rationale**	**Progress**	**Reporting**
The Trust continues to adhere to a significant	The CQC 2019 inspection identified	By May 2021, there was substantial improvement in	The number of stillborn babies is

quality improvement and transformation programme to improve the stillbirth rate.	that Bradford has a higher-than-average rate of stillbirths. 2020/21 saw an annual reduction in the stillbirth rate which has continued into 2021/22. Bradford's overall stillbirth rate remains higher than average for the Yorkshire and Humber region, but is showing substantial improvement. Given the population demographics (ethnicity, socio-economic quintiles) and the presence of a level three neonatal unit, it is likely that we will remain above average in raw figures.	the stillbirth rate, with only 2.5/1000 in the last quarter of 2020/21 (overall 5.6/1000 for the financial year). This represents a fall in actual numbers from 40 to 28 from 2019/20 to 2020/21, a drop of almost a third. The outstanding maternity service programme is now embedded in the culture of the maternity unit with good staff engagement and commitment. A number of transformation projects have been initiated including improved triaging in the ambulatory care areas. 2020/21 has seen a huge improvement with one-to-one care rates which are consistently more than 90%. This position has been sustained for more than six months and is now exception reported if less than 90%. Whilst the service has not achieved the 35% continuity of care trajectory due to COVID-19, progress has continued during 2020/21 with robust plans towards achieving continuity as the default position for all women by 2022. The existing continuity of care pathways includes a high percentage of BAME women and women from the most deprived area of the city. This remains a priority area for 2021/22. The maternity service has worked closely with the Maternity Voices Partnership throughout the pandemic and has co-produced important maternal/foetal well-being information including COVID-specific health messages. Initiatives including improving one-to-one care in labour, increasing the	reported internally to the Board monthly and externally to the CQC. If more than four stillbirths in any month are reported, a table-top review including themes, trends and lessons learned is undertaken and presented to the Board. Progress against the CQC action plan is being reported monthly to the Board committees.

		number of continuity of care pathways particularly for Black, Asian and minority ethnic (BAME) people and vulnerable women, and the saving babies' lives care-bundle version two have been implemented to reduce stillbirths and continue to be key priorities. The board-approved action plan was drawn up from CQC recommendations and staff consultations. By March 2021 the Trust aimed to see reductions in rate of stillbirths for each quarter, down from 8.4/1,000 births in Q3 2019/20. The overall stillbirth rate fell from 8.4/1000 livebirths in 2019 to 6.8/1000 in 2020. The rate for normally formed babies weighing > 500 g ('viable') fell from 5.9/1000 to 5.4/1000 in the same period.	
Priority 4: Advancing equality, diversity and inclusion			
Target	**Rationale**	**Progress**	**Reporting**
With a renewed focus and approach, we are at an early stage of consultation and engagement with our staff and communities in the development and implementation of a Trust-wide three-year strategic equality, diversity and inclusion (ED&I) strategy. This will be developed with the introduction of a refreshed set of strategic equality objectives covering workforce equality and wider population health inequalities.	This priority has been identified through renewed focus and targeted engagement with staff and wider communities. The regional ICS conducted a wider race review and presented its recommendations in January 2021. This was specifically aimed at understanding the impact of COVID-19 on minority ethnic communities and staff. The NHS People Plan 2021/22 places significant emphasis on 'inclusion and belonging'. Local place-based priorities on ED&I.	In January 2021 we developed and launched our strategic Equality and Diversity Council (EDC) chaired by our Chief Executive, who is also the executive sponsor for ED&I across the Trust. The EDC comprises key representation from across our core functions of the Trust, along with individuals who have a pivotal role to play in influencing change both across our organisation and within the wider place and ICS. Targeted engagement with diverse staff around the Trust's priorities for ED&I. Reviewed and refreshed the work of our three staff equality networks, ensuring they have a voice at	The EDC will maintain an overview of our diversity and inclusion agenda/strategic objectives, ensuring these are fit for purpose and aligned with national and regional priorities. People Academy dashboard. Six-monthly ED&I updates to Trust Board. Statutory reporting arrangements (WRES/ WDES/ gender pay gap/ model employer). NHS staff survey and People Pulse Survey

	strategic decision-making meetings and that they are 'thriving' in line with national priorities. Refreshed action plans on the requirements of the NHS Workforce Race Equality Standard (WRES) and NHS Workforce Disability Equality Standard (WDES) with some improved indicators. Introduction of positive action recruitment approaches for senior roles.	NHS patient survey. Patient outcomes (improved data around equality).

2.2. STATEMENT OF ASSURANCE FROM THE BOARD

2.2.1. REVIEW OF SERVICES

During 2020/21 Bradford Teaching Hospitals NHS Foundation Trust (the Trust) provided and/or sub-contracted 39 relevant health services[2].

We have reviewed all the data available on the quality of care in all of these services.

The income generated by them was reviewed in 2020/21 and represents 100% of the total income generated from the provision of relevant services by the Trust for 2020/21.

2.2.2. PARTICIPATION IN CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

To provide the highest quality patient care at all times, we are committed to supporting a continuous learning and improvement culture. We recognise that clinical audit is part of a range of improvement methodologies designed to make care processes safer and outcomes better for patients.

Our 2020/21 high priority clinical audit programme of planned audit activity was developed prior to the start of the COVID-19 pandemic (the pandemic). Following communication from NHS England (NHSE) in a letter dated 2 April 2020[1] all national clinical audits, confidential enquiries commissioned/funded by NHSE/NHS Improvement (NHSI) and national joint registry data collections were suspended. However, at the discretion of providers, audits could continue if they did not impact front line clinical capacity. This included audits that provided insight on the impact of COVID-19 upon elderly patients (hip fracture, dementia, heart failure), patients presenting for emergency laparotomy and those with cancer and diabetes.[3] The most recent government guidance, contained in letter dated 26 January 2021, said that clinical audits will remain open but local clinical audit teams can prioritise clinical care where necessary and, temporarily, audit data collections will not be mandatory.[1]

[2] Relevant health services are those services published on the Monitor website and as included in the Trust's contracts with commissioners' schedule 2D. The Trust's sub-contracts last year were for two services: endoscopy (Westcliffe) and cardiology (Mediscan).
[3] Impact of COVID-19 on NCAPOP https://www.hqip.org.uk/news/our-response-to-covid-19/#.YKu9WqhKiUk
* In line with NHSE advice with regard to 'reducing burden' for organisations during the pandemic[1]

Therefore, in response to the pandemic, we made a pragmatic decision to prioritise clinical care and, where appropriate, support limited clinical audit work during 2020/21. At the time of this report (May 2021) we are working hard on recovery plans, whilst managing the direct impact of inpatients with COVID-19, and staff wellbeing.

2.2.3. PARTICIPATION IN CLINICAL RESEARCH ACTIVITIES

We have continued with an extensive programme of clinical research and made significant contributions to the research response to the pandemic including vaccine trials and treatment.

In 2020/21, 5667 patients receiving relevant health services provided, or sub-contracted, by the Trust were recruited to participate in research approved by a research ethics committee.

2.2.4. COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

The Trust's income in 2020/21 was not conditional on achieving quality improvement and innovation goals through the commissioning for quality and innovation payment framework because no schemes ran during the pandemic.

2.2.5. CARE QUALITY COMMISSION REGISTRATION

NHS Trusts are required to registered with the CQC. There are no conditions attached to our registration, and the CQC has not taken enforcement action against the Trust during the period 1 April 2020 to 31 March 2021.

2.2.6. CQC SPECIAL REVIEWS AND INVESTIGATIONS

We have not participated in any special reviews or investigations by the CQC during the reporting period.

2.2.7. NHS NUMBER AND GENERAL MEDICAL PRACTICE CODE VALIDITY

During 2020/21 we submitted data to the secondary uses service (SUS) for inclusion in the hospital episode statistics (HES) that it publishes. The percentage of records in the published data that included patients' valid NHS number and general practitioner registration code is displayed in figure 2 below. Percentages for 2020/21 are aligned with peers and national England averages.

Figure 2: percentage of records which included the patient's valid NHS number

Record type	Area	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15	2013/14
		April to November 2020	April to November 2019	April to November 2018	Financial year April to March				
Patients' valid NHS number	Admitted patient care	99.7%	99.8%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%
	Outpatient care	99.9%	99.9%	99.9%	99.9%	99.8%	99.5%	99.4%	99.4%
	Emergency department care	99.2%	99.1%	98.7%	98.8%	98.8%	98.6%	98.5%	98.6%
Patients' valid general medical practice code	Admitted patient care	100.0%	99.7%	100%	99.9%	100%	100%	99.9%	100%
	Outpatient care	100.0%	99.6%	100%	99.9%	100%	100%	100%	100%
	Emergency department care	100.0%	99.6%	100%	99.9%	99.9%	99.9%	99.9%	100%

2.2.8. DATA SECURITY AND PROTECTION TOOLKIT

The data security and protection toolkit[4] (DSPT) contains 10 data security standards (with underlying assertions). These are self-assessed and evidenced to provide overall assurance of the information governance related systems, standards and processes within an organisation.

In 2019/20 the Trust's DSPT achieved 'standards met' which means that all mandatory assertion items have been evidenced by final submission.

In 2020/21, during the pandemic, the national DSPT assessment deadline was changed from 31 March to 30 June 2021 which means that the DSPT assessment is incomplete at the time of this report. We forecast a position of 'standards met' for our final position on 30 June 2021. A sample of the DSPT evidence has been independently assessed by Audit Yorkshire.

Our information governance assessment report overall score for 2020/21 was incomplete at the time of this report. The deadline for all organisations for the DSPT assessment (formerly the IG toolkit) was moved from 31 March 2021 to 30 June 2021. The Trust is forecasting 'standards met' as in 2019/20, to be confirmed on 30 June 2021

2.2.9. PAYMENT BY RESULTS CLINICAL CODING AUDIT

Clinical coding is the process through which the care given to a patient and recorded in their patient notes - usually the diagnostic and procedure information - is translated into coded data.

The Audit Commission did not do a payment by results clinical coding audit on the Trust during 2020/21.

Each year we commission an external audit to assess coding accuracy for continued assurance of data quality and compliance with the NHS Digital DSPT. The DSPT is an online self-assessment tool that allows organisations to measure their performance against the national Data Guardian's 10 data security settings. The accuracy of the coding is an indicator of the accuracy and completeness of documentation patient records. The Trust was subject to an external DSPT clinical coding audit during 2020/21.

The audit sample of 205 finished consultant episodes (FCEs) was selected using random sampling methodology from spells of inpatient discharges between 1 April 2020 and the 31 October 2020. All episodes were audited against National Clinical Coding Standards[5].

The error rates reported in the latest preliminary published audit for that period for diagnoses and treatment coding are shown in figure 3. Primary and secondary diagnosis error rates meet the national standards (>=90% and >+ 80% accuracy, respectively) but have worsened slightly since the previous audit. This is mainly due to inconsistencies or omissions in clinical documentation which will be addressed through monitored improvement plans.

Primary procedure error rates have improved significantly during the period, well above national standards (>=90% accuracy). Secondary procedures have decreased in accuracy, though still above national standards (>=80% accuracy). While root causes of errors can be addressed through monitored improvement plans, a contributing factor to this is the cancellation of elective activity as a response during this period to the pandemic. This had the effect of reducing the overall number of secondary procedures encountered in this audit, with only eight errors producing a 6.8% error rate from 205 audited FCEs.

[4] https://www.dsptoolkit.nhs.uk/
[5] https://digital.nhs.uk/services/terminology-and-classifications/clinical-classifications

Note: Clinical coding results should not be extrapolated further than the actual sample audited; and which services were reviewed within the sample. Additionally, the pandemic has changed case mix such that the randomised sample taken during this period would be incomparable with samples taken in previous years.

Figure 3: clinical coding error rate

Coding field	Percentage incorrect							
	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15	2013/14
Primary diagnoses incorrect	6.30%	5%	5.70%	8.60%	8.17%	5.50%	9%	8%
Secondary diagnoses incorrect	7.80%	3.80%	6.30%	10.20%	9.20%	4.80%	9.47%	5.90%
Primary procedures incorrect	3.80%	8.30%	4.70%	8.10%	9.09%	9.10%	2%	0.70%
Secondary procedures incorrect	6.80%	5.30%	2.10%	7.20%	14.79%	5.60%	8.02%	8.70%

The audit was done by an NHS Digital approved clinical coding auditor, compliant with all requirements of the clinical coding auditor programme (CCAP). The audit was based on the latest version of the Terminology and Classifications Delivery Service's clinical coding audit methodology in adherence to the approved clinical coding auditor code of conduct.

2.2.10. DATA QUALITY

The Trust is in the fortunate position to be one of the most digitally mature trusts in the country. Part of the strategy to digitise is the ambition to become information-led at all levels and areas of operation across the organisation. We have invested in state-of-the-art digital tools for clinicians and operational staff to record patient information and in technology to support the flow, storage and security data through to visualisation to end-users. Our strategy to achieve a high level of maturity in the use of information includes a number of components focussed on people, process and technology. To date this work has seen the Trust progress from an initial stage one: reactive and unorganised maturity state through stage two: developing some coordination and into the third of five stages: defined – standardised. At this stage we are in a stable position regarding governance and controls of data quality, with established standardised reporting, performance monitoring and knowledge sharing and learning in place to drive a "right first time" culture. This progress provides a solid foundation for ensuring good data quality and information provision, including the provision of codified episode data (clinical coding).

Data quality is a vital pre-requisite to effective and efficient operations resulting in improved decision making for improved patient care. We are committed to evidence-based decision making and a data driven approach to quality which applies to all areas - front line patient care, quality improvement, governance and holistic Trust management.

Our data quality strategy, remit and performance have oversight from the Quality Academy via a new digital and data transformation committee. A data governance board ensures controls related to the maintenance of the Trust's business critical and master data are appropriate and effective. These controls ensure subsequent reports, analyses, and decision making are based on high quality, accurate and reliable data. This robust structure advocates a culture whereby data quality is everyone's responsibility, driving ownership from ward to Board.

The nationally reported data quality maturity index (DQMI) also shows that we are in a strong position compared to local and national peers. As at January 2021 our DQMI score was 93.6, which is the third highest score across 12 acute trusts in Yorkshire and the Humber. The data quality position is monitored through the data governance board.

Robust governance mechanisms and controls are in place to continuously evaluate and improve data quality. A data quality framework, policy and roadmap for maturity ensure data quality objectives are fully defined with appropriate improvement plans embedded in the Trust's operations. All data collection and information systems used to record pathway data, clinical activity and/or administrative information across the Trust are within the scope of these controls which assure data across the entire lifecycle, from the point of capture through to disposal. High data quality is enabled through the Trust-wide electronic patient record (EPR) and industry recognised data warehousing, analytical and business intelligence tools. The Trust's EPR is the single source of business-critical patient demographic and activity data which is secured through role-based access.

In the coming year, we will be taking the following actions to further improve data quality and maturity in line with the maturity plans described above. These plans include:

- continuation of the ward dashboard project to implement real-time data in a self-serve manner to the front line, increasing knowledge, value and importance of data quality;
- continuation of a data warehouse optimisation plan - that successfully delivered 14 additional information feeds from non-EPR systems - to create additional automated data flows, driving consistency in Trust-wide analytics and reporting;
- the launch of a new data quality prioritisation group to continuously review/triage ongoing and emerging operational data quality issues;
- targeted operational one-to-one data quality knowledge building workshops, training, guidance and materials for high priority data quality issues;
- continued expansion of our online operational data quality dashboard;
- review and refresh of our data quality policy and framework; and
- re-launch of a data quality audit and review plan, cross cutting information systems, master data and key information.

2.2.11. LEARNING FROM DEATHS

During 2020/21, a total of 1603 patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Figure 4: number of deaths per quarter

Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
444	275	474	410	**1603**

Of these, 649 patients had a positive COVID-19 diagnosis (both primary and secondary diagnosis).

By 31 March 2021, 45 case record reviews – including 11 investigations - had been carried out in relation to 1603 of the Trust's total deaths.

In the 11 cases investigated a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Figure 5: investigated cases by quarter

Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
7	3	11	24	**45**

One (representing 0.06%) of the patient deaths during the reporting period was judged to be more likely than not to have been due to problems in the care provided to the patient. However, it must be noted that only 45 deaths were subject to a case note review during this reporting period which is significantly lower than previous years.

In relation to each quarter, this consisted of:

Figure 6: percentage of deaths investigated

Quarter 1	Quarter 2	Quarter 3	Quarter 4
0 (0%)	0 (0%)	0 (0%)	1 (0.06%)

These numbers have been estimated using the Trust's incident reporting system and serious incident investigation process.

2.2.11.1. Summary of learning from structured judgement reviews

Owing to the response to the pandemic, we decided to suspend structured judgement reviews (SJRs). This was in line with advice from NHSE about prioritising clinical care and reducing the burden upon staff during the pandemic[6].

However, in line with best practice and where cases met the national serious incident framework criteria, SJRs were conducted. This also included SJRs for patients with learning disabilities, severe mental illness and those with definite hospital-onset COVID-19 infections (HOCI). Definite HOCI is defined by NHS England as first positive COVID-19 swab 15 days or more after admission.

The key learning points from the SJR process included:

- evidence of a multi-disciplinary approach to decision-making and care planning;
- best practice had been achieved in terms of end-of-life care;
- communication and support for families followed exemplar practice;
- documentation of the care was good;
- staff identified as delivering exceptional standards of care were celebrated with a personal letter of thanks from the Chief Medical Officer;
- learning from SJRs was shared at the patient safety group meeting.

No case record reviews or investigations which related to deaths that took place before the start of the reporting period were completed after 31 March 2020.

None (representing 0%) of the patient deaths before the reporting period are judged to be more than likely than not to have been due to problems in the care provided to the patient. This number has been estimated using SJR process to review patient deaths.

No patient deaths (representing 0%) during 2019/20 are judged to be more likely than not to have been due to problems in the care provided to the patient.

The Trust's learning from deaths process was suspended during the response to the pandemic to support clinical teams to focus on clinical duties.

2.2.11.2. Implementing the priority clinical standards for seven-day hospital services

[6] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/01/C1064-reducing-burden-and-releasing-capacity-to-manage-the-c19-pandemic-2-feb-2021.pdf

The seven-day service (7DS) programme supports providers of acute services to tackle the variation, across the NHS in England, in outcomes for patients admitted to hospitals in an emergency at the weekend.

The Trust has been a first wave implementer of 7DS, working closely with NHS England's seven-day service improvement programme in implementing and reviewing progress from the initial six-monthly surveys that were undertaken from March 2016 to the more recent board assurance framework that started in 2019.

The board assurance framework supports a review of progress on the implementation of the priority clinical standards. Our last self-assessment in autumn-winter 2019/20 demonstrated continuous improvement and progress in a number of the standards with several new initiatives planned, specifically: the roll out of the deteriorating patient tile in the command centre; work with the clinical teams on the wards and in services to support the SAFER principles; and, further collaboration with our partners as more "act as one" developments were supported. However there are still a number of operational challenges to overcome to complete the transformational change required to achieve all ten seven day service clinical standards[7].

There has been very limited evidence of progress in implementing the standards in 2020 but we have continued to demonstrate throughout the pandemic the principles underpinning the 10 standards.

- **Clinical standard 2**: further improvements have been made in the provision of 7DS with the inclusion in 2020 of a respiratory service 24/7 on-call rota.
- **Clinical standards 5 and 6:** there has been continued work for on- and off-site network arrangements to improve diagnostic and consultant directed interventions.
- **Clinical standard 8:** improvement work is still ongoing with SAFER, and Trust-wide and targeted improvements are being trialed within urgent care. As part of the new 7DS board assurance framework the Trust, as well as reviewing the implementation of the four priority clinical standards, looks at the progress to support the remaining six standards and how much improvement has been completed within the urgent network clinical services.
- **Performance against remaining standards**: with the development of the Trust's Academy structure reporting, assurance, learning and sustained quality improvement are all now directed through the Quality Academy. Using a monthly quality dashboard and a detailed oversight and assurance exception profile, issues are highlighted prompting updates from subject matter experts or clinical and specialty leads. This new forum provides insight and involves clinical and service areas as well as members of the board, ensuring widespread challenge and an opportunity for extensive improvement throughout the Trust.
- **Urgent network clinical services:** there has been ongoing improvement work in stroke services in collaboration with Airedale NHS Foundation Trust and further development work planned in terms of the reconfiguration of vascular services.

2.2.12. STAFF WHO SPEAK UP (INCLUDING WHISTLEBLOWING)

Freedom to Speak Up (FTSU) is embedded at the Trust. Our staff can raise concerns in a number of ways:

- by emailing a secure email – speakup.guardian@bthft.nhs.uk;
- by downloading the Trust's free FTSU app from the App Store (which can be used anonymously); or
- by contacting the FTSU associate guardians directly by telephone, email or in writing.

[7] https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf

The associate guardians support the person raising the concern throughout any period of further investigation. At the initial meeting, the person raising the concern is informed that they will not suffer any detriment as a result of speaking up, and this is monitored throughout the support.

Following any investigation, the FTSU guardian always ensures that the recommendations are shared with the person who spoke up. Once the case is closed, the associate guardians follow up with the person raising the concern at three months to ask if they would speak up again and also the reason for their answer. Our staff can contact the staff advocacy service directly for confidential, impartial advice, helping them to understand their options and make an informed choice about how to address their situation or concern.

Figure 7 - number of concerns raised in 2020/21

Quarter 2020/2021	Number of concerns raised
Q1	6
Q2	6
Q3	11
Q4	14
Total	37

2.2.13. GUARDIAN OF SAFE WORKING

The safety of patients is of paramount concern for the NHS. Significant staff fatigue is a hazard to patients and to the staff themselves; the safeguards around doctors' working hours are designed to ensure that this risk is effectively mitigated, and that this mitigation is assured. The role of the Guardian of Safe Working is to ensure that issues of compliance with safe working hours are addressed by the doctor and employer/host organisation as appropriate. The guardian provides assurance to the Board that doctors' working hours are safe and in line with the relevant terms and conditions[8]. This assurance is provided in a quarterly report detailing information on the working hours of doctors and dentists in training, exception reporting, work schedule reviews, rota gaps and any fines levied. An annual report is also presented to the Board with an overview of the year, recommendations and any improvement work undertaken or planned.

There have been no fines levied during this year.

The annual report for 2020/21 confirms that exception reporting has decreased compared to the previous year. This could be the result of the pandemic as rotas and work significantly changed, and the high locum requirement in emergency and general medicine throughout the pandemic dramatically increased the number of locum doctors working in those areas.

Trainees submit an exception report if they are working beyond contracted hours or educational opportunities are missed. Working through the pandemic, the trainees were very aware they were working during exceptional circumstances so this would also explain the decrease in reporting.

During the pandemic, junior doctors became more involved in the design and implementation of their rotas. To continue this inclusive and collaborative development, and to support more regular feedback on educational issues, the junior doctors' forum now meets every two months instead of quarterly.

There has been an increase in education-related exemption reports this year potentially due to the introduction of self-development time for foundation year (FY) two doctors. This is the first time they have been asked to report if they are not able to get this and it will become mandatory for FY1 doctors from August 2021. This will be closely monitored going forward and will be reviewed jointly by the Guardian of Safe Working and the Director of Education.

[8] https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Junior-Doctors/NHS-Doctors-and-Dentists-in-Training-England-TCS-2016-VERSION-7.pdf

Only one speciality within the Trust has a non-complaint rota which is due to the weekend working pattern. Discussion with the trainees in post shows they are happy with the current work patterns arranged for them while a long-term solution is being sought.

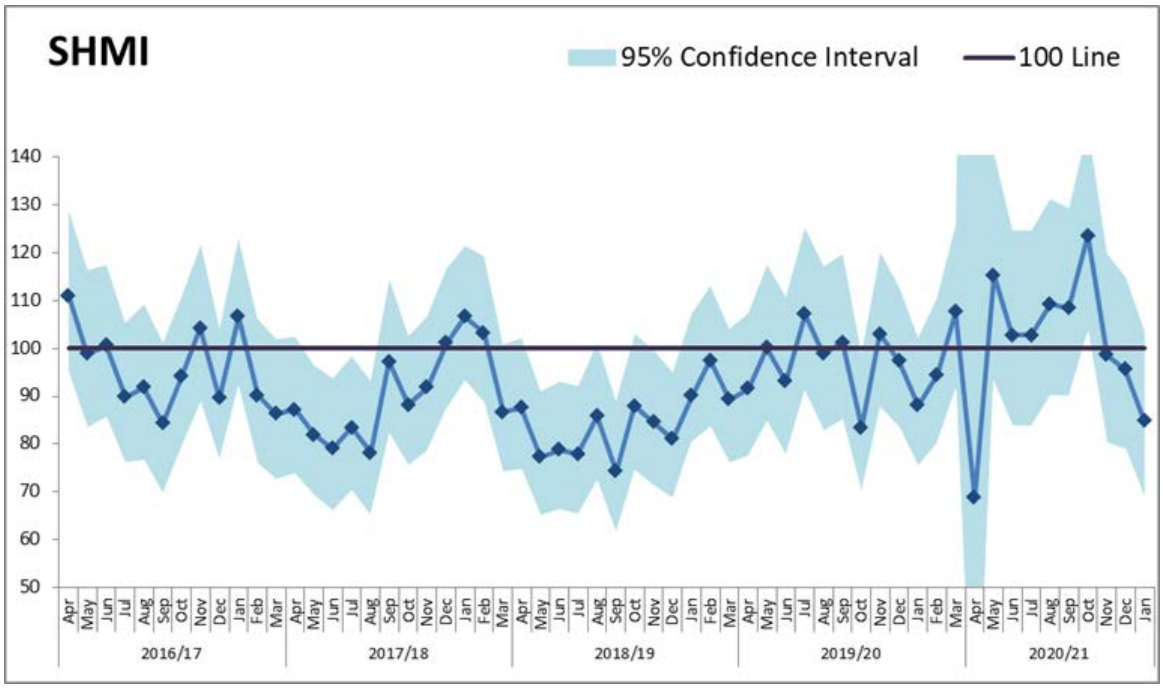
The Guardian of Safe Working and the Director of Education continue to work closely with the junior doctors' forum to review concerns, support development and improvements and provide regular feedback to operational colleagues and assurance to the board. Improvements, new ideas and lessons learnt are also shared across the Trust particularly new workforce initiatives or opportunities to fill rota gaps.

2.3. REPORTING AGAINST CORE INDICATORS

2.3.1. SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR

The summary hospital-level mortality indicator (SHMI) data for 2020/21 has demonstrated wider variation in scores during the pandemic when compared to previous years. Scores have remained within the 95% confidence interval. Work is being done by the quality team and business intelligence to explore possible causes for variations and this will help to inform improvement work for 2021/22.

Figure 8: SHMI scores from 2016/17 to 2020/21



The percentage of patients' deaths with palliative care coded at either diagnosis or whilst under the care of palliative care was 32% of inpatient deaths.

We consider that this data is as described for the following reasons; data is captured, processed and analysed through the Trust-wide EPR, industry-standard data warehousing and analytical and business intelligence tools. An external reporting assurance (ERA) programme actively ensures that robust controls are in place for all mandatory reports. Data is processed by dedicated reporting teams according to standard operating procedures and is signed off by the appropriate sponsors.

The Trust uses healthcare evaluation data (HED) system to understand mortality data to inform areas for improvement as well as learning at clinical speciality level.[9]

We have taken the following actions to improve this indicator, and so the quality of its services, by appointing an Associate Medical Director for Mortality, Patient Safety Manager for Learning from Deaths, a lead Medical Examiner role as well two full-time Medical Examiner Officers. Mortality meetings, which were suspended during the height of the pandemic, will be resumed and work will commence at speciality level to understand their mortality data and identify the relevant learning and improvement priorities.

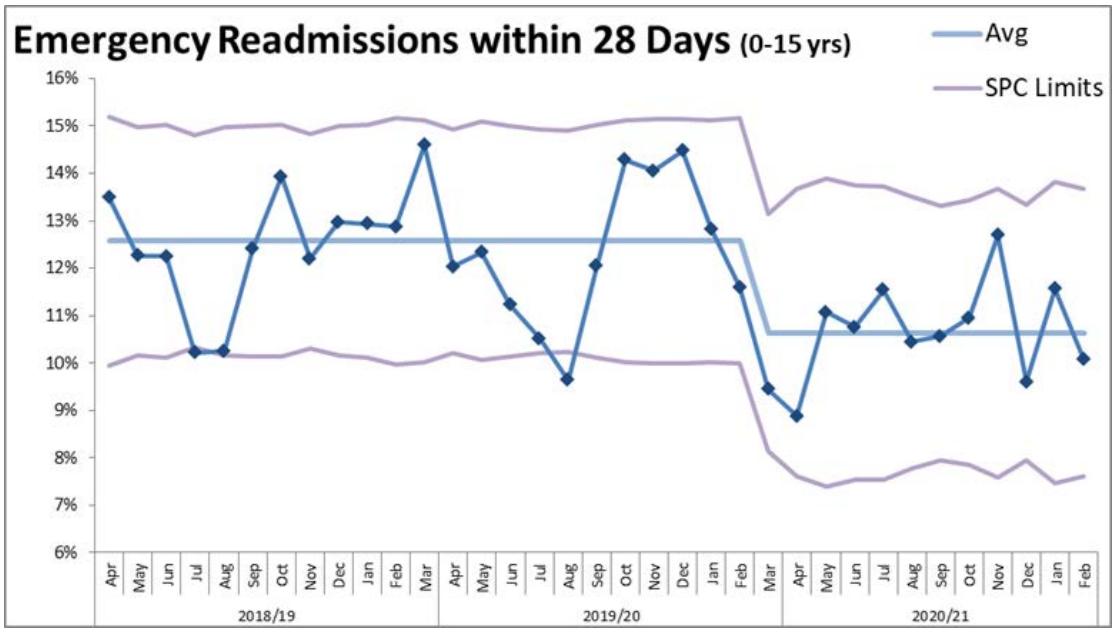
2.3.2. PATIENT REPORTED OUTCOME MEASURES (PROMS)

Because the data has not been updated nationally this year, the Trust is unable to provide any benchmarking data for this core indicator.

2.3.3. 28-DAY READMISSIONS

The percentage of patients aged 0 to 15 years old and 16 years old, or over, readmitted to a hospital (which forms part of the Trust) within 28 days of being discharged, are presented in figures 9 to 12 below.

Figure 9: percentage of patients (0-15 years old) readmitted to hospital within 28 days of discharge



[9] Healthcare evaluation data (HED) system is an online benchmarking solution designed for healthcare organisations. HED has been developed to be a flexible and interactive tool with numerous dashboards and in-depth modules. The HED suite allows healthcare organisations to utilise analytics which harness HES (Hospital Episode Statistics), national inpatient and outpatient and ONS (Office of National Statistics) Mortality data sets.

Figure 10: percentage of patients (16 years old and over) readmitted to hospital within 28 days of discharge

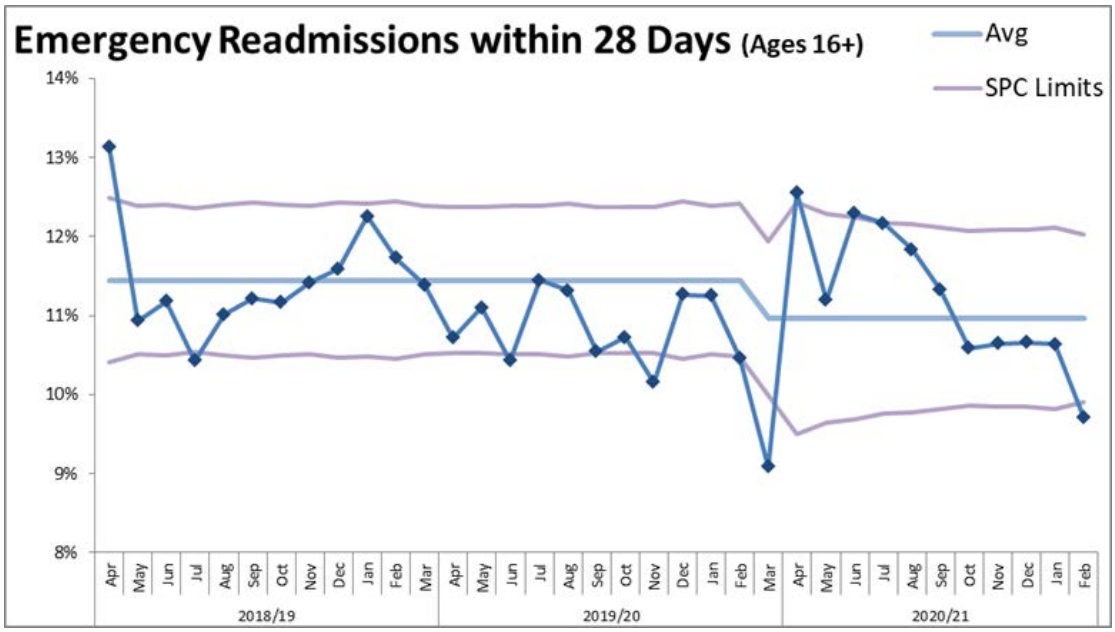


Figure 11: readmission rate for patients (0-15 years old) February 2021

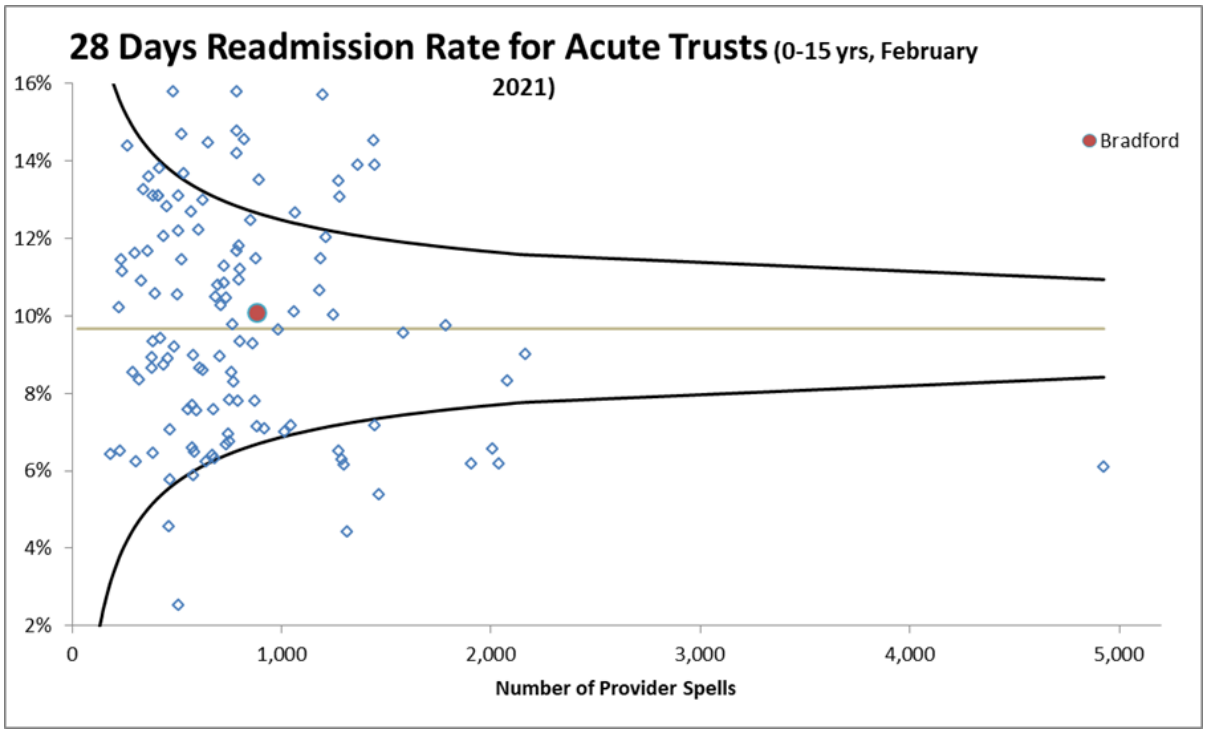
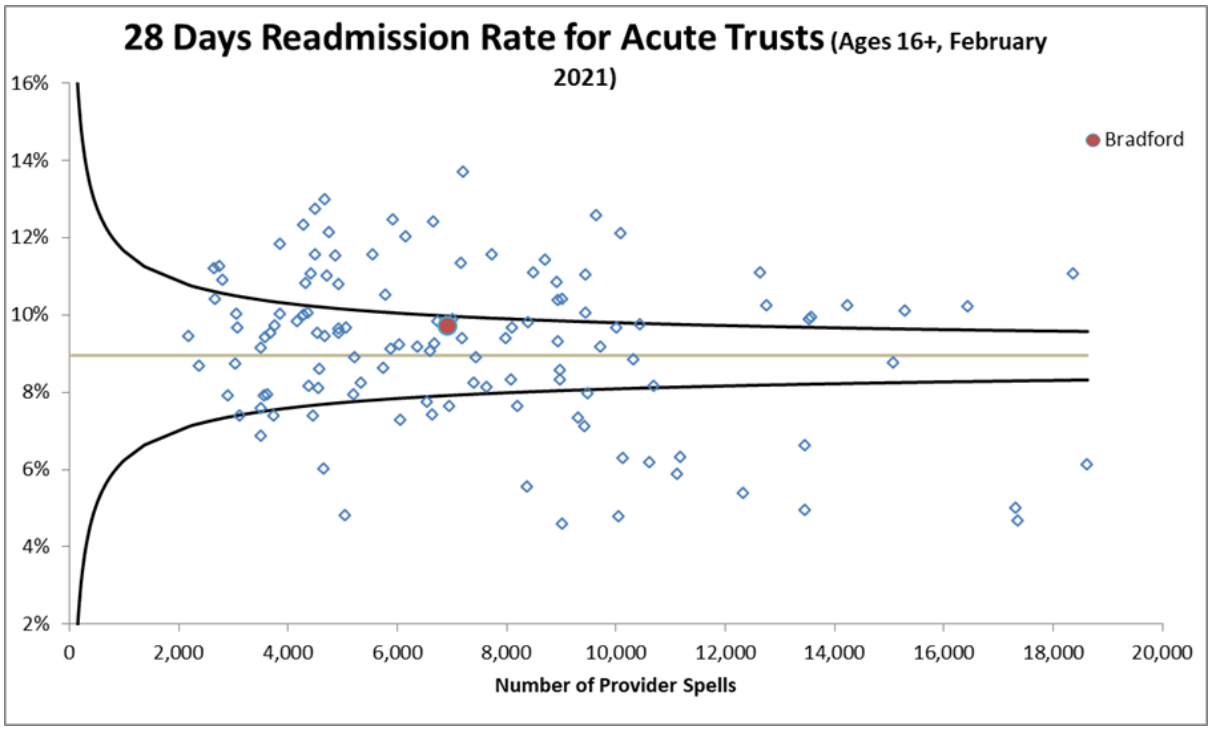


Figure 12: readmission rate for patients (16 years old and over) February 2021



We consider that this data is as described for the following reasons; data is captured, processed and analysed through the Trust-wide EPR, industry-standard data warehousing and analytical and business intelligence tools. An ERA programme actively ensures that robust controls are in place for all mandatory reports. Data is processed by dedicated reporting teams according to standard operating procedures and is signed off by the appropriate sponsors.

As a consequence of COVID-19, the improvement programme associated with readmissions was paused. We intend to improve this indicator and so the quality of its services by re-starting the improvement programme once the impact of the pandemic and the resumption of normal NHS activities are fully in place.

2.3.4. RESPONSIVENESS TO PATIENT NEED

Friends and family test

The Friends and Family Test (FFT)[10] provides patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely - on a scale ranging from extremely unlikely to extremely likely - they are to recommend the service to their friends and family if they needed similar care or treatment. Data on all these services is usually published on a monthly basis.

As a consequence of the pandemic, FFT collation was put on hold nationally from April 2020. The formal submission was recommenced in December 2020. Despite this national direction, some FFT data was collected in small pockets throughout the organisation internally during Q1-Q3. Figure 13 below summarises the returns received.

[10] https://www.nhs.uk/using-the-nhs/about-the-nhs/friends-and-family-test-fft/

Figure 13: Friends and Family Test returns 2020/21

	Q1		Q2		Q3		Q4		2020/21	
Area	**Recommend %**	**Not recommend %**	**Recommend %**	**Not recommend %**	**Recommend %**	**Not recommend %**	**Recommend %**	**Not recommend %**	**Recommend %**	**Not recommend %**
Wards	95%	4%	95%	4%	85%	14%	96%	2%	92%	7%
Emergency department	0%	0%	90%	0%	66%	5%	67%	14%	81%	3%
Maternity	75%	25%	0%	0%	90%	10%	94%	6%	93%	7%
Day case	0%	0%	93%	7%	96%	4%	99%	1%	99%	1%
Outpatients	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Trust total	**95%**	**4%**	**95%**	**4%**	**86%**	**13%**	**97%**	**2%**	**93%**	**6%**

We consider that this data is as described for the following reasons: the Trust's internal data collection shows the percentage of people recommending the service remained high throughout the year despite the challenges of the pandemic, except for quarter three which saw the number dip slightly to 86%. The annual recommended percentage rate was overall 93%. To improve this response, and so the quality of services, we have fully recommenced the FFT programme and a number of real-time feedback mechanisms for departments including outpatients and emergency department which include a text messaging (SMS) service and the use of iPads to collect feedback.

2.3.5. STAFF FRIENDS AND FAMILY TEST

The staff FFT was suspended at a national level in 2020 without the requirement to complete this during quarter one of 2021/22.

The two mandated questions from the staff FFT have been replaced by nine engagement theme questions from the national staff survey focusing on three dimensions of engagement: motivation, involvement and advocacy.

We will use the people pulse survey as a vehicle to ask our staff these nine questions on a quarterly basis which will support longitudinal analysis[11]. This is in response to a Prime Minister's request for more regular reporting of our NHS people's working experience.

The quarterly staff survey will run in quarter one, two and four. There will not be a requirement to participate in the survey in quarter three to account for the annual staff survey fieldwork which already captures answers to the nine engagement theme questions.

2.3.6. VENOUS THROMBOEMBOLISM EVENT RISK ASSESSMENT (12 MONTH ROLLING)

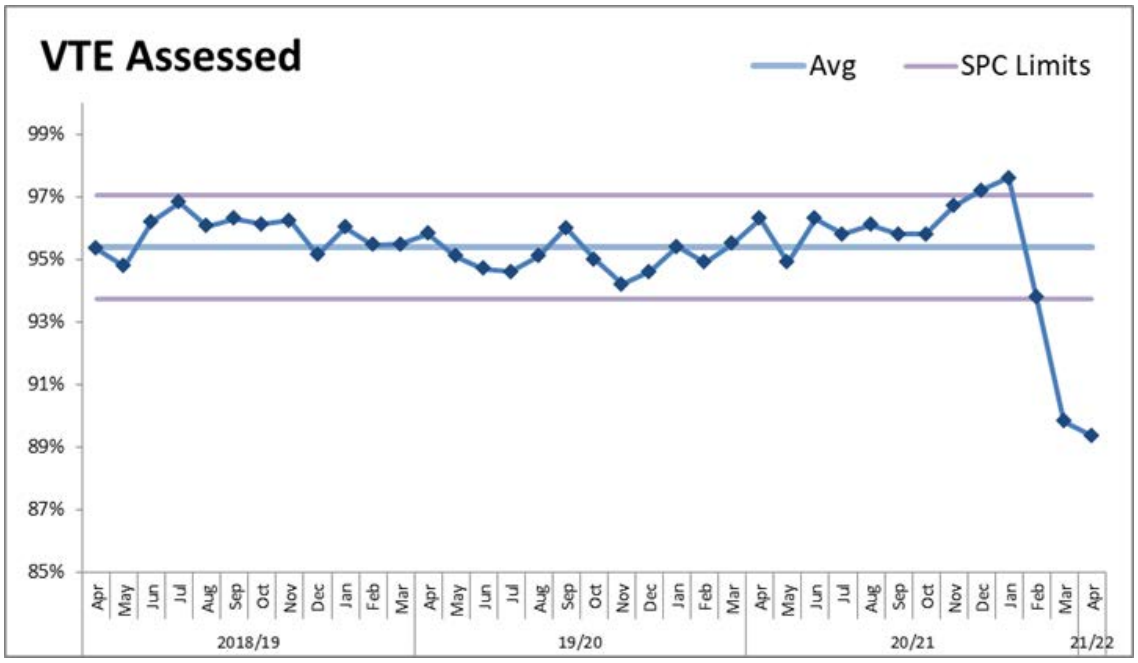
The Trust is required to collect the numbers and proportion of inpatient hospital admissions, aged 16 and over, who are being risk assessed for a venous thromboembolism event (VTE) to allow for appropriate prophylaxis to be given based on national guidance from NICE[12].

[11] A longitudinal study is a type of correlation research study that involves looking at variables over an extended period of time.
[12] Guidance notes to accompany VTE risk assessment data collection March 2019 update

The VTE risk assessment is a former national CQUIN indicator and is a national quality requirement in the NHS standard contract for 2019/20. It sets an operational standard of 95% of inpatients aged 16 and over being risk assessed for VTE on admission each month. Prior to April 2019 the operational standard related to adult inpatients aged 18 and over.

The data below demonstrates that during 2020/21 over 95% of patients were risk assessed for VTEs.

Figure 14: percentage of inpatient hospital admissions aged 16 and over who are being risk assessed for VTE.



We consider that this data is as described for the following reasons; data is captured, processed and analysed through the Trust-wide EPR, industry-standard data warehousing and analytical and business intelligence tools. An ERA programme actively ensures that robust controls are in place for all mandatory reports. Data is processed by dedicated reporting teams according to standard operating procedures and is signed off by the appropriate sponsors.

It is acknowledged that the data shows a fall in the percentage of VTE risk assessments being recorded as complete in February and March 2021 to below the Trust's lower confidence limit. We believe this is due to the fluid nature of bed re-configuration in response to the pandemic and re-setting speciality bed bases to support restoration of services.

We intend to improve this percentage, and so the quality of its services, by: identifying inpatient areas that are not fully compliant with the standard; working with the clinical nurse specialist to support with training and real time data collection; and, ensuring that all inpatient areas exempt from the standard are recoded appropriately within the system. This will be monitored monthly by the Quality Academy.

2.3.7. C DIFFICILE

Clostridium Difficile infection (CDI) (now renamed Clostridioides difficile) is a type of bacteria which causes diarrhoea and abdominal pain and can be more serious in some patients.

Healthcare associated infections (HCAI) remain one of the major causes of patient harm and although nationally there continues to be a reduction in the number of patients developing serious infections such as Clostridium difficile (C difficile) in health care settings, the rates of other HCAI

have risen due to an emergence of resistant organisms. It is therefore vital that the reduction of HCAI remains a high priority on the patient safety agenda within the Trust.

For 2019/20, Public Health England changed the surveillance definitions for C difficile. From April 2019, any cases of C difficile within 48 hours of admission have been classed as hospital acquired (previously this was 72 hours).

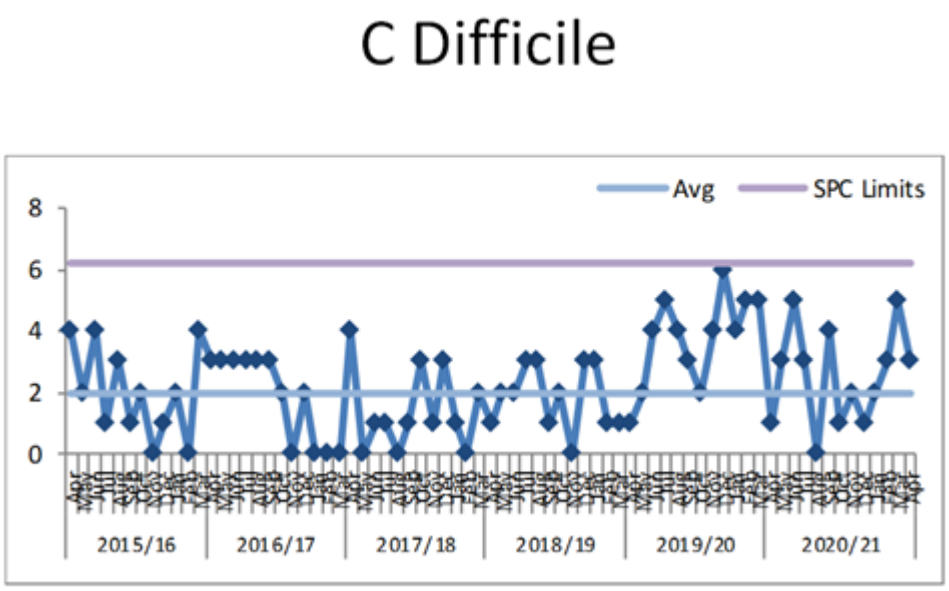
The objectives for reduction for CDI for 2020/21 were set in 2019/20 as 30 cases. The Trust reported 30 hospital attributable cases during 2020/21.

Figure 15: Healthcare Evaluation Data (HED) for C difficile

Standard Indicator Set: Clinical Quality	Trust Performance			Benchmarking		
Indicator	Current	Previous	Change	Peer	National	Position
Infection rate - C. diff (12 mth rolling) PHE C. Diff Infection Rates, HES Inpatients (May 2021)	10.43 (Apr 2020 - Mar 2021)	10.91 (Mar 2020 - Feb 2021)	-0.48	18.07	16.51	

The statistical process control chart is a graph used to study how a process changes over time. A control chart always has a central line for the average, an upper line for the upper control limit, and a lower line for the lower control limit. These lines are determined from historical data. By comparing current data to these lines, you can draw conclusions about whether the performance is consistent (in control) or is unpredictable.

Figure 16: Trust statistical process chart for C difficile



We consider that this data is accurate because it is captured, processed and analysed through the Trust-wide EPR, industry-standard data warehousing and analytical and business intelligence tools. Data is processed by dedicated reporting teams according to standard operating procedures, is validated by clinical staff, and is signed off by an appropriate executive.

To improve this performance, and so the quality of services, we are continually monitoring quality of care through our quality oversight system. In addition, any case of confirmed infection is subject to a comprehensive review process to identify any lessons to learn. The Trust remains in the top quartile for all acute trusts for performance in reduction of healthcare acquired C difficile and this has been achieved through a robust focus on hand hygiene, environmental decontamination, and supportive programmes of antimicrobial stewardship by the antimicrobial management team.

2.3.8. PATIENT SAFETY INCIDENTS WITH SEVERE HARM OR DEATH

There was a total of 10,006 patient safety incidents, including 12 that resulted in severe harm or death. The percentage of patient incidents resulting in severe harm or death was 0.12%.

Figure 17: total patient incidents reported (2020/21)

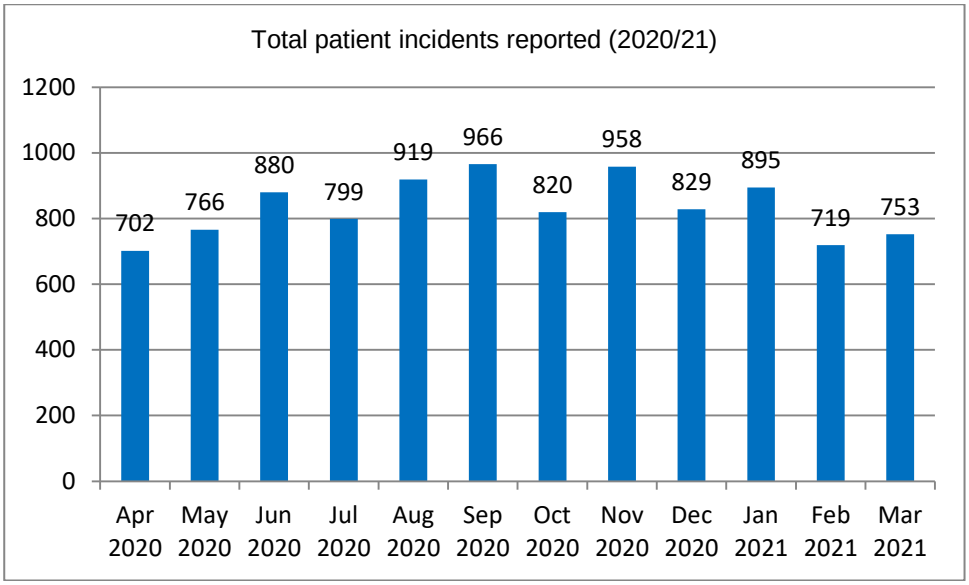
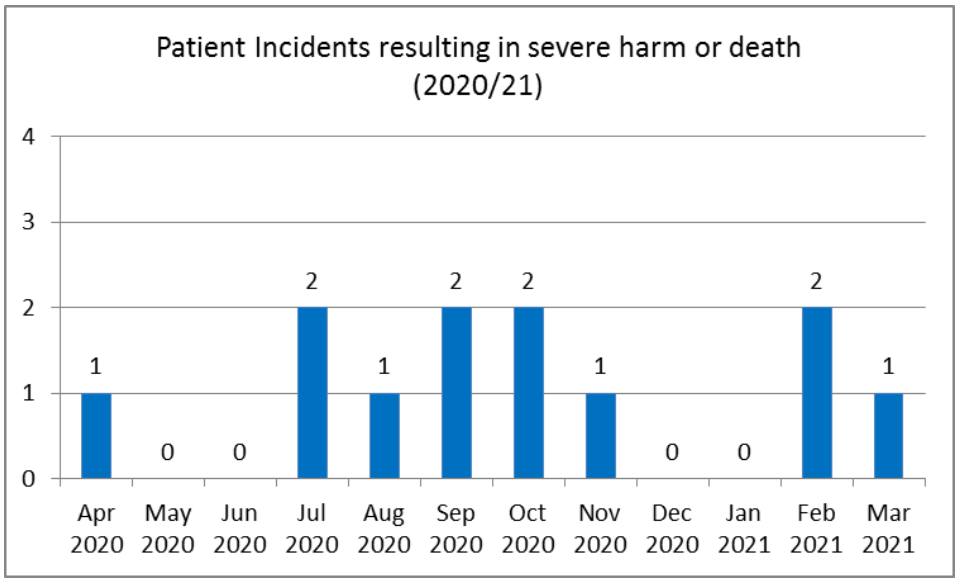


Figure 18: patient incidents resulting in severe harm or death (2020/21)



We are listening

The Trust uses an electronic reporting system called Datix to monitor and manage patient safety incidents and concerns. As the new NHS England patient safety incident response framework[13] comes into effect (from 2022) we are testing new ideas to improve the way we facilitate more reflection and learning. It is anticipated that, if we have user-friendly ways of capturing patient safety concerns or no harm/low harm incidents, we will increase our capacity to identify free

[13] https://www.england.nhs.uk/patient-safety/incident-response-framework/

learning and themes or trends within specialities and across the organisation and with our wider system partners.

We tested a dedicated email account 'we are listening' to provide staff an opportunity to report no and low harm patient safety concerns and issues. A process was set up to ensure concerns were monitored and allow appropriate action to be taken. Our findings revealed:

- staff that infrequently report incidents via the Datix system (for example, doctors and agency staff) used the email to report patient safety concerns; and
- staff identified low and no harm patient safety concerns that have not previously been reported via Datix system.

The 'we are listening' test of change continues with learning to be shared via the patient safety group.

We consider that this data is as described because data is captured through our internal incident reporting system is available for all employees to access, is checked and verified by the system administrator. Additionally, we have a robust governance and quality oversight system in place with weekly meetings to identify learning and improvement.

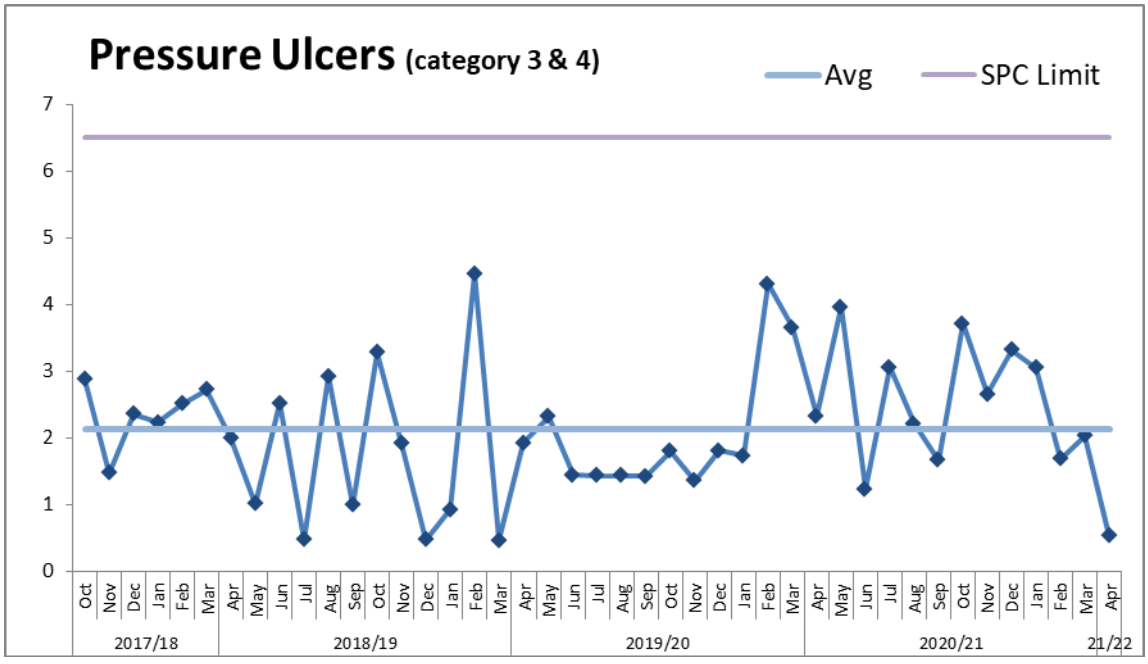
3. OTHER INFORMATION

3.1. INDICATORS FOR PATIENT SAFETY

3.1.1. PRESSURE ULCERS

Pressure ulcers are injuries to the skin and underlying tissue, usually caused by prolonged pressure. They can affect any part of the body that is put under pressure, for example, commonly affected areas are heels, elbows, hips and the base of the spine. They can happen to anyone but may affect people confined to a bed or who sit in a chair or wheelchair for long periods of time. They develop gradually but can sometimes occur in a few hours. The occurrence of pressure ulcers is considered a measure of the quality of care being provided.

Figure 19: pressure ulcers (category three and four)



In 2018 NHS Improvement issued new guidance[14] on the definition and measurement of pressure ulcers to standardise practice. This was adopted by the Trust in April 2019.

Safety thermometer data had previously been used to benchmark pressure ulcer data but due to the pandemic this was suspended.

We monitor routinely all pressure ulcer incidents that are category two and above (this includes hospital acquired and patients admitted with pressure ulcers). This data is collected via EPR and Datix, our incident monitoring system, and is validated by clinical staff. The data presented in this report includes hospital acquired category three and four pressure ulcers.

The pandemic has had a negative impact on pressure ulcer incidents particularly late winter/spring (2020) and autumn/winter (2020/21). This was in part due to the increased use of medical devices used to treat patients with COVID-19 and the severity of the patients' conditions. Pressure ulcer incidents have now started to reduce. We continue to focus on improving pressure ulcer prevention through quality improvement methodology, training and education and implementation of evidence-based patient care.

3.1.2. SEPSIS SCREENING AND TIME TO TREATMENT

The Trust monitors patient screening and antibiotic treatment times for patients with suspected sepsis. Our guidelines have been informed by the national quality requirements as set out in the NHS Standard Contract 2020/21[15] and NICE guideline [NG51] Sepsis: recognition, diagnosis and early management[16].

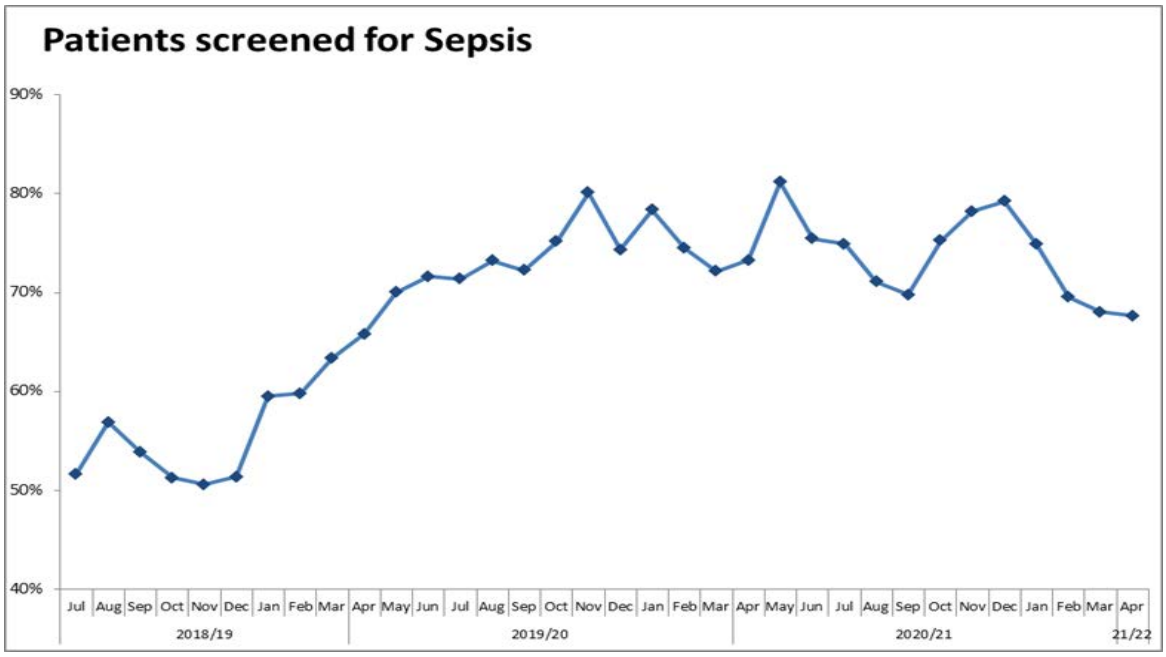
NICE guidance states that treatment should commence within one hour for severe sepsis.

Performance in relation to patients being screened for sepsis has shown improvement over the past three years (see figure 20). This has been the result of the Trust-wide sepsis improvement programme.

We use education, audit results, clinical ward rounds and weekly data reviews with clinical teams to monitor improvement and identify areas requiring more focus and support.

[14] NHS Improvement (2018) Pressure ulcers: revised definition and measurement; Fletcher, J, and Hall, J (2018) New guidance on how to define and measure pressure ulcers. Nursing Times, 114(10), 40-44.
[15] Proportion of service users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis: operating standard of 90% (based on a sample of 50 service users each quarter)
[16] NICE guideline [NG51] Available online from https://www.nice.org.uk/guidance/NG51/chapter/Recommendations#stratifying-risk-of-severe-illness-or-death-from-sepsis

Figure 20: percentage of patients screened for sepsis from 2018/19 to 2020/21



As part of the programme we have developed a ward-based electronic dashboard using patient real time NEWS2 scores to identify early signs of sepsis. This innovative electronic tool will support our clinical teams to ensure timely and effective treatment is given. Smaller change ideas that have been tested also include a sepsis response trolley in the emergency department (ED) and the development of a screening tool within the electronic patient record (EPR) system.

We have also developed a sepsis dashboard, it is anticipated this will provide live data to wards and specialties to monitor key outcome and process measures.

Figures 21 and 22 below present screening performance within the ED and for in patient areas across the Trust. The figures differ from data presented in previous years owing to changes made to the way data is captured, processed and analysed through the new sepsis dashboard.

Sepsis screening has been sustained at an average of 80% for eligible patients in ED over 2021. Improvement work involving junior doctors continues to drive improvement work to meet the 90% target.

Figure 21: sepsis screening completed in the emergency department, June 2020 - March 2021

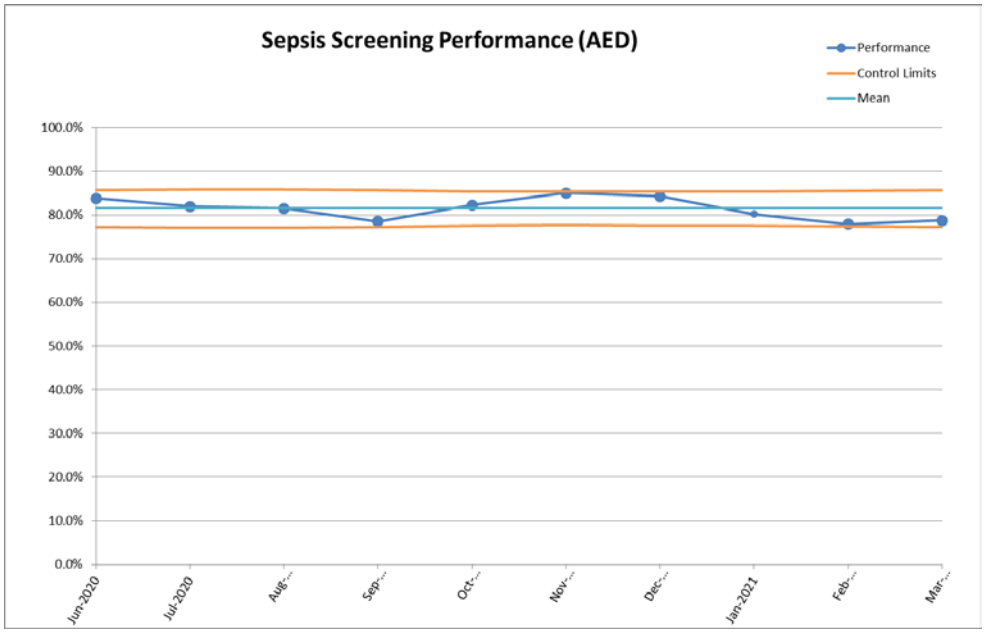
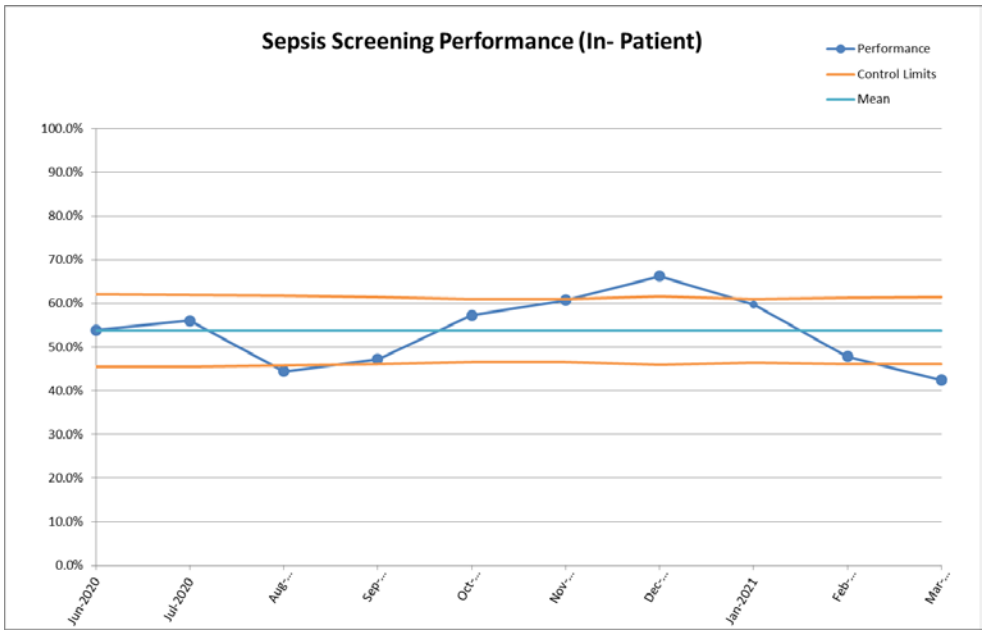


Figure 22: sepsis screening completed on inpatient wards, June 2020 - March 2021



Figures 23 and 24 below present time to antibiotic treatment for patients with suspected severe sepsis within the ED and for inpatient areas across the Trust.

Improvement work continues to drive the early detection and management of the deteriorating patient and sepsis.

Figure 23: patients receiving antibiotics within one hour for severe sepsis within the emergency department, June 2020 - March 2021

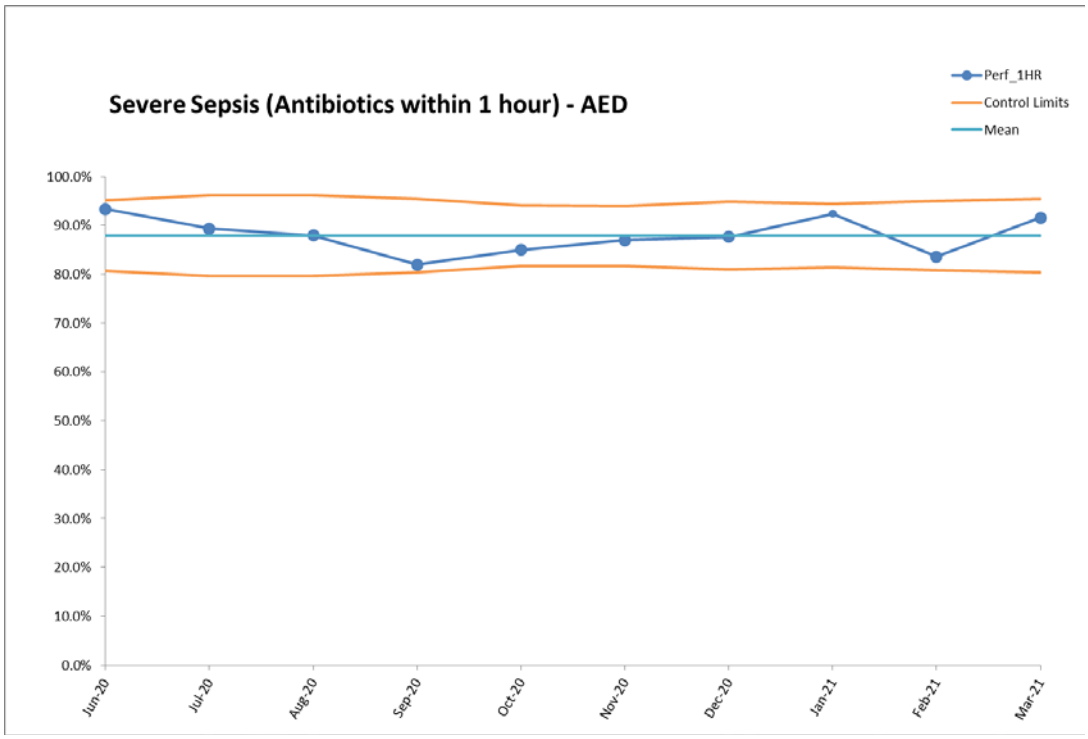
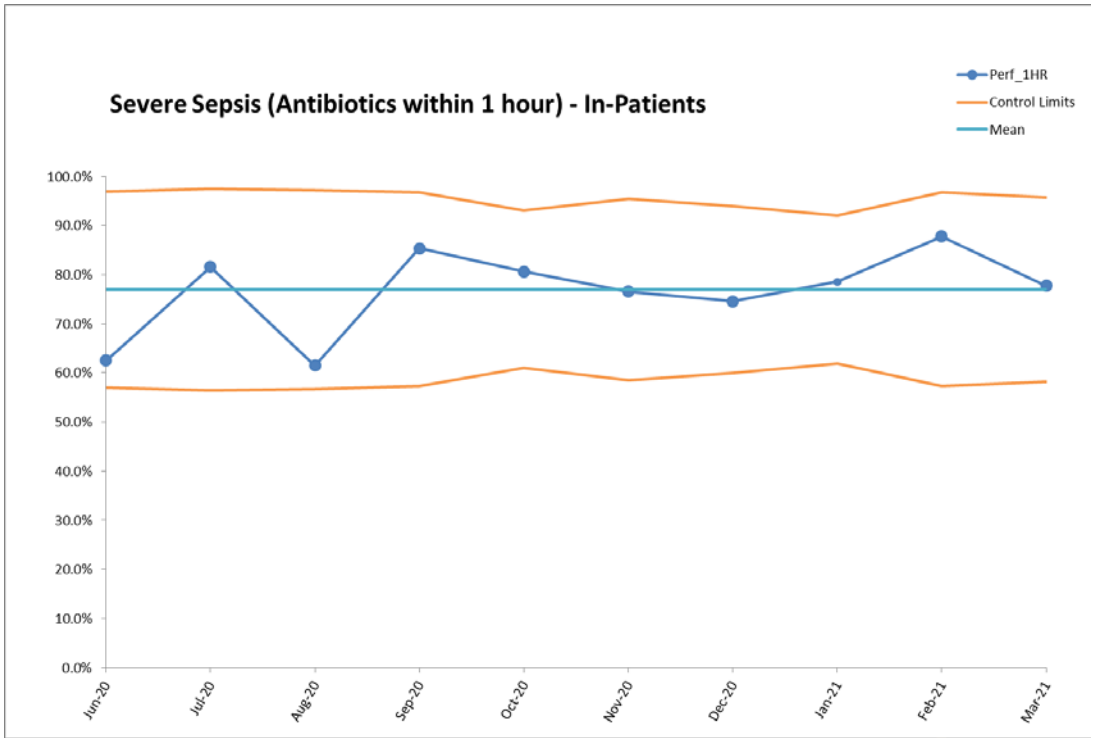


Figure 24: patients receiving antibiotics within one hour for severe sepsis on inpatient wards, June 2020 - March 2021



3.1.3. FALLS

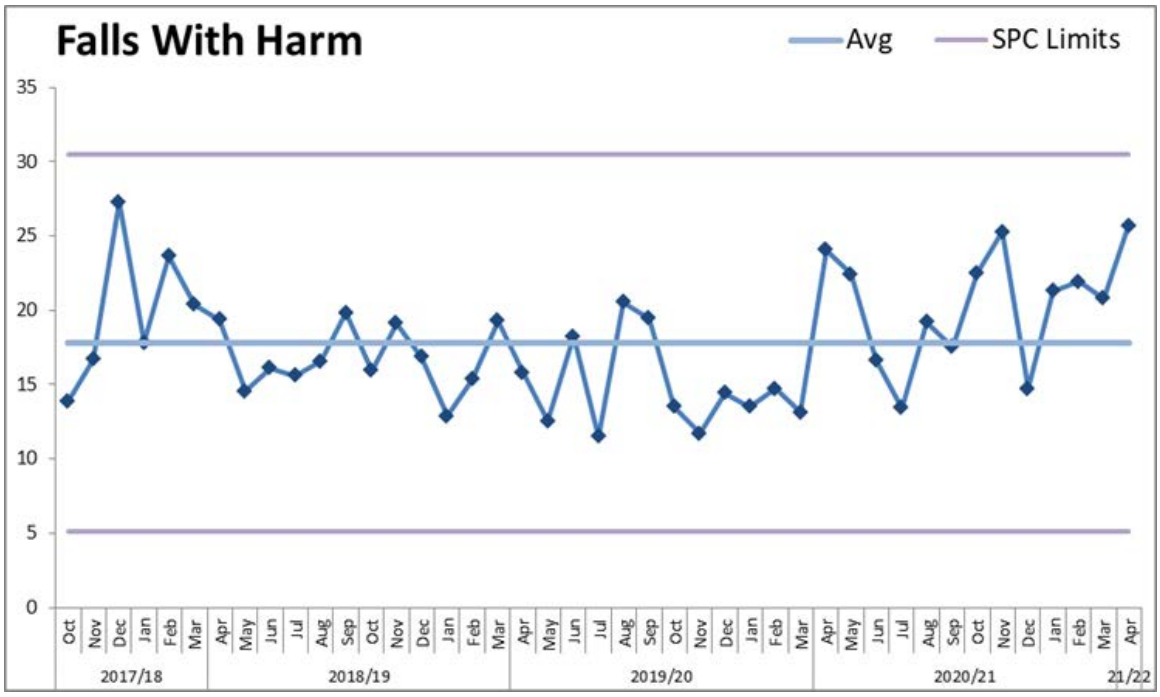
Routinely, we monitor falls with harm[17] per 10,000 bed days. The number of falls has remained with normal limits for the Trust (see figure 25). However, it is noted that there is an increasing trend.

During 2020/21 the process to review falls with harm was re-designed to support organisational learning and improvement. This was in response to reducing the burden for clinical staff during the pandemic.[18] The multi-disciplinary falls panel identified key learning points using the new approach including:

- environmental issues for the care of the elderly ward after relocating to a new space to accommodate the creation of new COVID wards (that is, unfamiliar ward layouts/equipment availability);
- changes to nursing team (staff redeployed to the wards from different specialities); and
- increased patient acuity.

Improvement work is in place to support ward and clinical areas to reduce falls with harm. Our local falls guidelines have been updated and have been made widely accessible for staff on the intranet.

Figure 25: number of falls with harm per 10,000 bed days over time



3.1.4. INDICATORS FOR CLINICAL EFFECTIVENESS

3.1.4.1. Hospital standardised mortality ratio

Our hospital standardised mortality ratio (HSMR) demonstrates that the Trust has remained within expected limits.

[17] The definition of 'falls with harm', using the criteria set out in NHS England Serious Incident Framework (2015)

[18] *This was in response to increased clinical activity owing to the Trust's response to the pandemic and the need to reduce burden for frontline staff (See Section 2.2).

Figure 26: HSMR score over time

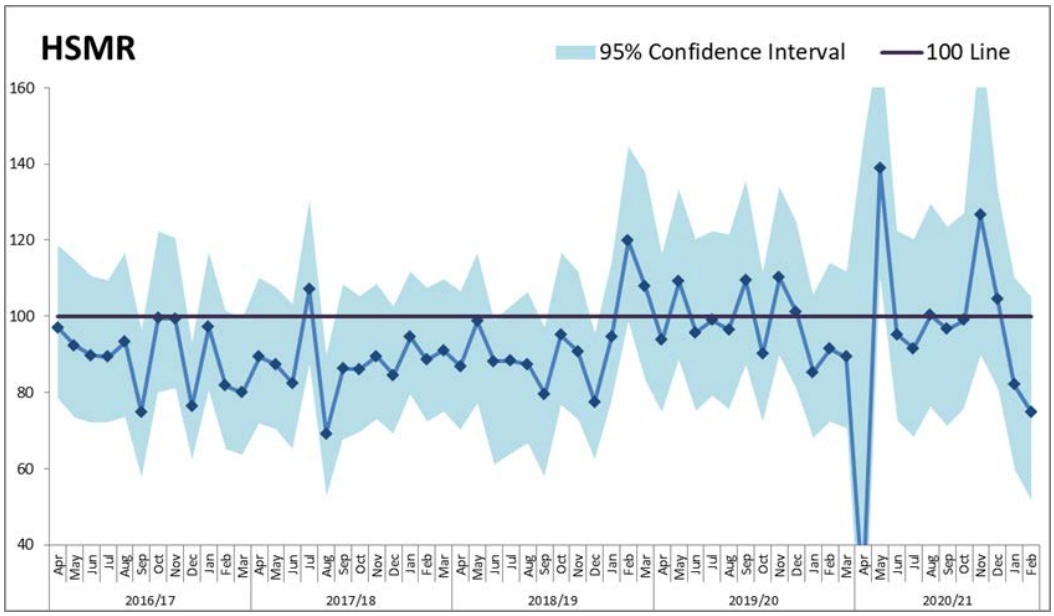


Figure 27: HSMR score and other NHS acute care trusts in England

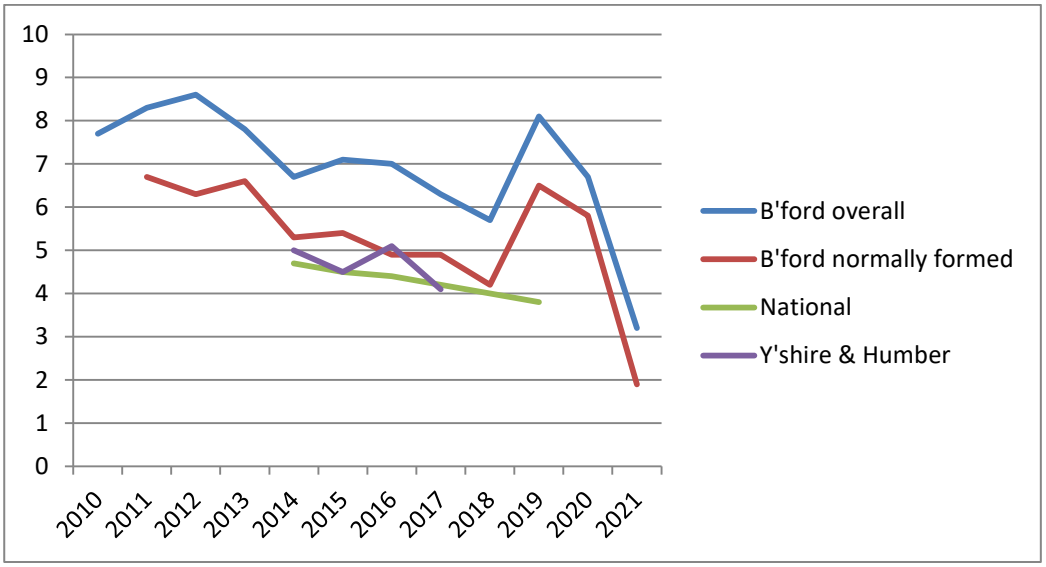
3.1.4.2. Stillbirths

In 2019/20 at 8.4 stillbirths per 100.000 births, the Trust was higher than the average rate and was above the threshold of less than 4.7. The data for 2020/21 shows an improvement in the rate to 6.8 per 100,000 in 2020. The rate for normally formed babies weighing more than 500g ('viable') fell from 5.9 per 100.000 to 5.4 per 100,000 in the same period.

The outstanding maternity services programme has a number of work streams to ensure that there is a continued reduction in stillbirths. 2020/21 has seen a huge improvement with one-to-one care

rates consistently more than 90%. This position has been sustained for more than six months and is now exception reported if less than 90%.

Figure 28: stillbirth trend (source: Office for National Statistics)



3.1.5. PATIENT EXPERIENCE

3.1.5.1. National CQC surveys

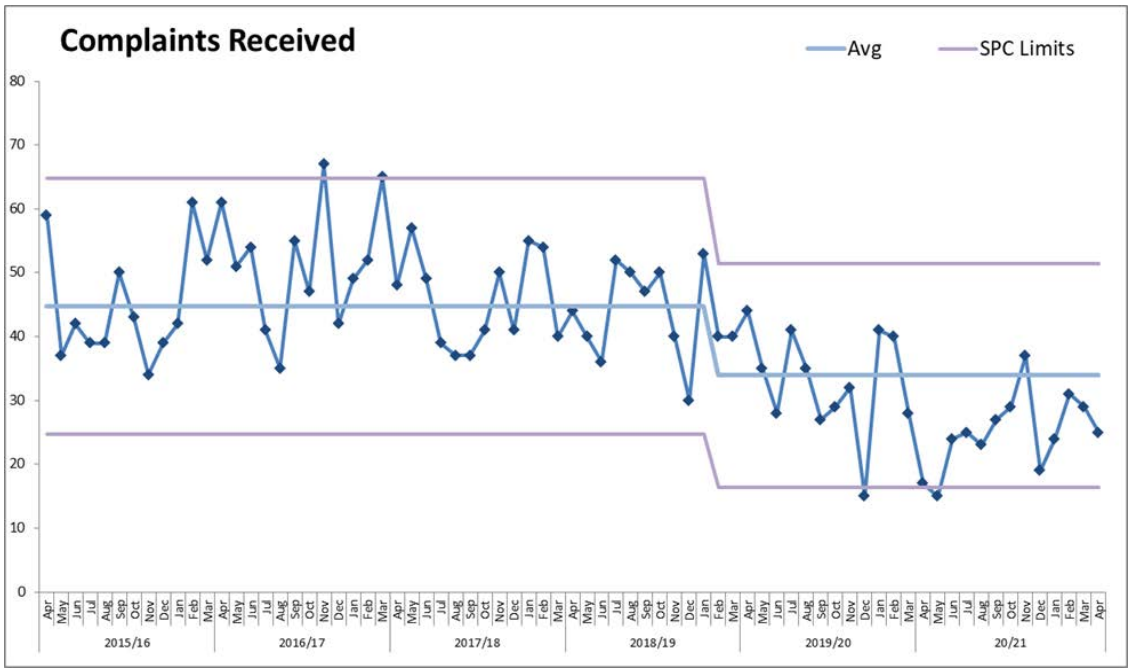
The NHS national CQC survey programme, which allows patients and the public to have a real say about the quality of care they received in a number of specific areas, was put on hold in 2020 due to the pandemic. The delayed programme restarted in autumn 2020 and results of these are expected from summer 2021 onwards.

Despite this national hold, the CQC carried out an extraordinary survey on inpatient experience during the pandemic. Despite nationwide lockdown, the national report highlighted that generally inpatient experience during this period was positive, but it did highlight that those patients with a COVID-19 diagnosis reported consistently poorer experiences than those who did not have the virus. People with dementia, mental health and learning disability reported more negative experiences. We did a number of pieces of work to support this, including: the appointment of additional needs health care assistant; a VIP passport scheme; the appointment of mental health practitioners; and, additional resources for patients with learning disabilities including communication boards, books and sensory equipment.

3.1.5.2. Complaints

During the early phase of the pandemic all complaint responses went on hold nationally at the recommendation of NHS England. This is no longer the case and complaints work resumed from September 2020 onwards. The Trust received an increased number of complaints during quarter three and particularly during the month of November, when the country was in the middle of the second national lockdown. A total of 404 complaints were received during 2020/21 which saw a 9% reduction on the previous financial year.

Figure 29: complaints data compared to national average



3.1.5.3. New ways of working during COVID-19

The Trust was quick to react to the needs of patients and families during the pandemic when visiting restrictions were enforced for safety reasons. A number of new services were set up to enhance patient experience and these included:

- Relative's line: a telephone service run by qualified staff who could access patient electronic records and take calls from worried family members and provide updates. This service runs seven days per week and during 2020/21 answered over 43,000 calls from family and friends who were concerned about their loved one.
- Patient property management service: a team has been formed to receive and deliver items to patient sent in from family members in the absence of visiting. On average the team managed over a 1,000 bags of property per month.
- 'Thinking of you' service: this is an email service which can receive messages, videos and photographs from loved ones direct to a dedicated email box. These messages are then delivered to patients on the ward in the absence of visitors being allowed on site to ensure the patient and relatives can receive those important messages and good wishes.
- Family View: this is an NHSE approved mechanism for relatives to video call patients in hospital. Each ward was allocated a dedicated tablet devise to enable them to receive a video call from a relative. This service was utilised with other services when requested which included chaplaincy to enable families to witness and join in prayers and pastoral support.

4. ANNEXES

4.1. ANNEX 1: STATEMENTS FROM COMMISSIONERS, LOCAL HEALTHWATCH ORGANISATIONS AND OVERVIEW AND SCRUTINY COMMITTEES

4.1.1. STATEMENT FROM BRADFORD DISTRICT AND CRAVEN CCG

NHS
Bradford District
and Craven
Clinical Commissioning Group

Scorex House
1 Bolton Road
Bradford
BD1 4AS

Tel: 01274 237290

19th. July 2021

Dear Mel,

The Bradford Teaching Hospitals (BTHFT) Quality Report Accounts 2020/2021

On behalf of NHS Bradford District and Craven CCG, I welcome the opportunity to feed back to Bradford Teaching Hospitals (BTHFT) on its Quality account for 2020/21.

March 2020, we saw the increasing prevalence of the SARS-CoC2 virus and the associated disease Covid-19 which has caused extraordinary challenges for global health and care systems. The Trust has found innovative ways to continue to meet the most essential needs of the population, including through partnerships, to address these challenges.

I would like to take this opportunity to say a heartfelt thank you to your staff for their hard work and admirable dedication. The difficulties of ensuring that services are agile and responsive to changing needs of patients through the pandemic cannot be underestimated.

Specific key achievements during the year include:

- National Institute of Health Research singled out the Research Team for its recruitment to a series of vital COVID-19 studies – the RECOVERY trial was referenced in the prestigious New England Journal of Medicine. Trust continues to contribute and lead on extensive research locally, regionally and nationally. I would particularly like to thank you for your significant contributions to the research of the COVID-19 vaccine trials, alongside the development and testing of innovative COVID-19 treatments, which have benefitted patients nationally.
- The newly created Equality and Diversity Council further supports the Trusts commitment to valuing diversity and champion inclusion. This will be fundamental to understanding the Trust's collective role and responsibilities in reducing population health inequalities across the district. I recently saw a video that your staff have produced which demonstrates this commitment. The stories shared by staff demonstrated a strong sense of belonging and inclusion and where diversity, difference and uniqueness matters.
- Appointment of a joint Chief Digital and Information Officer for Airedale and Bradford Teaching Hospitals to support the improved patient care and inclusive digital transformation as well as great signs of collaboration.
- The establishment of a Trust Quality Improvement Academy that changes the focus of assurance, improvement and learning from each other and with a wider membership.

- The Trust was quick to react to the needs of patients and families during the pandemic when visiting restrictions were enforced for safety reasons. The Trust rapidly establishedthe Family View service to maintain communication between teams, patients, carers, friends and families (responding to over 43,000 calls).
- The Trust ran a very successful hospital vaccination hub at the start of the programme which vaccinated health and care staff and vulnerable patients.
- The Trust actively contributed, with other health and care partners, to the development of a new clinical model for the 'care of looked after 'children. Our performance as a system prior to the new clinical model was poor but the new model has enabled significantly more children to access care in a timely manner.
- The Trust continues to focus on providing high quality healthcare for all of its communities. The Trust actively listens to its communities, working with partners across the city.
- As part of the quality improvement programme the Trust developed an electronic visual display of real time information to enable the Trust to monitor and manage deteriorating patients. This is part of a suite of tools within the Trusts command centre which supports operational and clinical teams to deliver safe, effective and timely patient care.
- The Trust has demonstrated a commitment to continuous quality improvement following a previous Care Quality Committee (CQC) inspection in 2018 (where the Trust received an improved rating to an overall 'good'.) Since its launch in August 2020, the outstanding maternity services programme (which is an extensive transformation programme) continues to drive a reduction in unwanted variation, continuity of career targets and improve the experience of our women and families. This programme is further improved though Maternity Voice Partnerships who support the co-design of maternity and neonatal services by adding the voice of our communities. Progression on the Moving to Digital programme continues support the Trusts drive towards clinical excellence.

In common with many areas of health and social care, the unparalleled challenges over the past 12 months have meant that the Trust has been unable to consistently deliver national standards, with particular pressures around maximum waiting times for the Emergency Department, referral to treatment, diagnostics and some cancer standards. It is clear that there are considerable ongoing actions being undertaken to improve patient flow and system recovery both internally and with partners.

In normal circumstances you would have engaged with all stakeholders to review 2020/21 achievements and set 2021/22 goals. The Trust's main focus has been to provide safe, effective - and a positive experience of care during a pandemic. Consequently, the Trust will roll forward the 2020/21 priorities with a summary review and refocus these goals for 2021/22 priorities; with the additional welcomed focus on advancing equality, diversity and inclusion.

This report includes a review of last years' priorities and the improvements the Trust has achieved which include:

- Advanced data quality strategy, and performance with oversight from the Quality Academy – the data quality maturity index (DQMI), as of January 2021 BTHFT achieved a score of 93.6 is the third highest across 12 acute Trust's in Yorkshire & Humber.
- The Trust has been part of the first wave implementer of a seven-day service, a step toward reducing unwanted variation.
- The Trust continues to improve Venous Thromboembolism treatment confidence levels, though training and improved data collection. 95% of patients aged 16 and over were risk assessed for Venous Thromboembolism
- Although the Trust Intentions to respond to healthcare acquired infections (which have risen due to an emergence of resistant organism) are not referenced within the account, the Trust remains in the top quartile for all acute Trust's for performance in reduction of healthcare acquired C difficile.
- The standardised mortality ratio (HSMR) demonstrates that the Trust has remained within expected limits during 2020/21.
- One to one maternity care rates during 2020/21 were maintained above 90%.

- The implementation of a command centre to transform patient flow, to support operational and clinical teams to deliver safe, effective and timely patient care
- A further step towards system working through the 'Act as One' model with a clear vision to help our residents live happy, healthy at home
- Further strengthening of how we learn from deaths as system, through the recruitment of the Medical Examiner roles and supporting officers
- Further revision of the staff friends and family test (FFT) in response to national staff survey outcomes themes

I would welcome reference to the continual improvements in safeguarding, as appropriate, in next year's report.

Quality and Safety will remain key priorities for the Trust in 2021/22. The Trust will continue to focus on learning from the Trusts response to the pandemic and improving the quality of care and experience of its patients. The Trust has identified a number of quality improvement priorities for 2021/22, acknowledging that some of the work was paused during the pandemic. The key areas of focus for the Trust are the restoration of services and a programme to reduce health inequalities.

The priority areas identified for 2021/22 are:

Priority 1: Improving the management of deteriorating patients:

- To embed and sustain the use of the patient deterioration tile by 31 March 2022
- To improve sepsis screening time to treatment to 90% for all eligible of patients

Priority 2: Improving patient experience:

- The Trust will continue to enhance the patient experience strategy by further development of the embedding kindness work that has been developed during 2020/1

Priority 3: Continued reduction in stillbirths:

- The Trust continues to adhere to a significant quality improvement and transformation programme to improve the stillbirth rate

Priority 4: Advancing equality, diversity and inclusion:

- Consultation and engagement with staff and communities in the development and implementation of a Trust-wide three-year strategic equality, diversity and inclusion (ED&I) strategy. Developed with the introduction of a refreshed set of strategic equality objectives covering workforce equality and wider population health inequalities

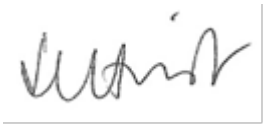
I confirm that the statements of assurance have been completed demonstrating achievements against the essential standards. These included audits that provided insight on the impact of COVID-19 upon elderly patients, patients presenting for emergency laparotomy and those with cancer and diabetes.

The Trust is an active, influential and often a driving force in the system wide Act as One partnership, which brings together the contributions of PCNs, district nurses, social workers, mental health providers, care homes, voluntary organisations and local hospitals into a single integrated care partnership for Bradford District and Craven

The impact of your personal leadership within Bradford Health and Care Partnership, as well as the wider district, has been significant in both the way we managed the approach to the pandemic as a system and also in the recovery and restart work, I look forward to further strengthening the Bradford District and Craven partnership as we develop our transformational plans as part of the West Yorkshire Integrated Care System

Finally, I confirm that I believe this report to be a fair and accurate representation of the Trust's achievements and commitments to improve the safety and quality of care if their services.

Kind regards



Helen Hirst Chief Officer
NHS Bradford District and Craven CCG

4.1.2. STATEMENT FROM HEALTHWATCH BRADFORD

16/07/2021

Healthwatch Bradford and District welcomes this opportunity to comment on the Bradford Teaching Hospital Foundation Trust Quality Account for 2020/2021.

The report provides a comprehensive view of positive actions taken to improve the quality of care and also the patient and carer experience; particularly during the unprecedented demands on services linked to the Covid-19 pandemic.

Healthwatch Bradford & District congratulates the Trust on its flexible response to the challenges posed by the pandemic and its continuous support in delivering Covid-19 related services across the district. We thank the staff for their hard work and dedication in continuing to prioritise patient care throughout. This is exemplified by the innovative and flexible response to patient experience such as establishing 'Family View' to support communication with loved ones during the exceptional circumstances of prohibited visiting. We recognise the impact on staff to support patients in such circumstances and the efforts of the Trust to support the workforce.

Healthwatch Bradford & District are pleased to see the breadth of priorities for improvement, and particularly welcome the recognition of the importance of patient well-being. 'Embedding Kindness' as an improvement priority with measurable targets reflects this recognition and we will support the Trust, as appropriate, by sharing our intelligence and data to assist with measuring this and all improvement priorities.

Healthwatch Bradford & District recognise and share the concerns relating to maternity services. We commend the Trust on the improvements made in this area and acknowledge the positive impact of the 'Outstanding Maternity Services Programme'.

We remain confident of the commitment to service improvement and look forward to reviewing the same throughout the year.

Due to the pandemic restrictions we have not been able to collect feedback on Trust services in the same numbers as previous years. This is likely due to the lack of face to face engagement by Healthwatch Bradford & District as well as the reduction of non-urgent care delivered by the Trust.

As a service we have participated in the Trust Wide Involvement Group meetings, Carers In Action Group meetings and many Covid-19 specific groups. Any views of BTHFT services gathered from these or other engagement activities has been collated as feedback through the usual channels.

We are pleased to report that patient feedback for the reporting year 2020-21 shows an 11% increase in positive sentiment on the previous year with positive and negative sentiment now equal. This appears to be supported by the Family and Friends Test data recorded by the Trust.

The feedback gathered covered a wide range of services; 16 in total with maternity services by far the largest.

The specific nature of sentiment varied considerably. Of those patients who provided specific details as to what they classed as a "negative experience", a small majority felt this was due to them having a protective characteristic. We are pleased to see equality and diversity mentioned throughout the improvement plan and feel encouraged this will help to address such issues going forward.

Positive comments related to digital access to services, and gratitude at the level of service continuing to be offered despite the obvious challenges posed by 'lockdown'.

Whilst we recognise the need for improvement and would like to see positive sentiment as the majority figure, we applaud the Trust for this significant increase in positive patient feedback; particularly when faced with the challenges of providing healthcare during a pandemic.

Healthwatch Bradford and District will continue to listen to people's views and share these with the Trust, which will hopefully contribute to, as well as support the Trust with their 2021/22 quality improvement plan.

Helen Rushworth
Manager

Healthwatch Bradford & District

4.1.3. STATEMENT FROM BMDC HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

BMDC Health and Social Care Overview and Scrutiny Committee has advised the Trust that it has opted not to provide comments on the 2020/21 Quality Account on this occasion.

4.2. ANNEX 2: STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and Social Care issued guidance on the form and content of annual Quality Accounts, which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010. The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017. These added

new mandatory disclosure requirements relating to ‘Learning From Deaths’ to quality accounts from 2017/18 onwards.

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

- the Quality Accounts 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 confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Dr Maxwell Mclean
Chairman

Ms Mel Pickup
Chief Executive