Bradford Teaching Hospitals
NHS Foundation Trust

Quality Account 2021/22

CONTENTS

1. STATEMENT OF QUALITY FROM THE CHIEF EXECUTIVE

I am delighted to introduce the 2021/22 Quality Account report as Chief Executive of Bradford Teaching Hospitals NHS Foundation Trust.

2021/22 was one of the toughest years in the history of the Trust. Our staff continued to experience the relentless challenges of the COVID-19 pandemic first-hand, delivering care above and beyond any expectation of our era.

And with the rapid rise in COVID-19 transmissions as a result of the Omicron variant, we can be forgiven for having a sense of déjà vu.

Despite all of this we entered the year with a genuine belief that things were going to get better, vaccines had been developed and rolled out across the country, fewer people were ending up requiring invasive ventilation to manage their illness and we had started to treat patients for elective procedures. Once again, we have witnessed incredible compassion, strength and unity from our colleagues, our partners and our communities.

The pandemic forced rapid change to new ways of working that we all had to adapt to. One of the developments that has accelerated during the pandemic is the way we provide hospital care at home – known as virtual care. We've already won national awards for this in Children's Services and in Care of the Elderly. Our ambition now is to spread the approach right across all our services.

We call it the "Virtual Royal Infirmary", and this programme is helping us improve patient experience and make best use of our resources. By using technology we can look after patients within their own homes, allowing people to both spend precious time with their families and be in the right environment to recover in the comfort of their own home.

The pandemic, sadly, also showed in stark detail the health inequalities throughout the City of Bradford. As a Trust we are now more responsive and mindful of the impact of life outside of the hospital on the many people that we deliver health care for. Inclusive and compassionate leadership has never been so important and I am pleased to say we have started our journey to be more inclusive by formalising greater links into the communities, actively engaging to improve our services in partnership with service users.

The Outstanding Maternity Services programme is a good example of how we have worked closely with women and the Maternity Voices Partnership (MVP) to listen to women's experience of child birth to improve the journey and the maternity outcomes.

We are proud to have played a part in medical and scientific breakthroughs in the race to find a COVID-19 vaccine. This year, once again, we brought a world-first clinical trial to Bradford. We were chosen as one of only a handful of sites to launch the 'Cov-Boost study' – the first in the world to provide vital data on the impact of a third dose of the COVID-19 vaccine. What's more, we were the first study site, across the world, to go live.

Through our work on research and in clinical trials, we – and the many volunteers from our local communities – are very proud to have contributed to the success of the vaccination and booster programme.

The development and use of technology to manage care has played a huge part in being able to deliver care differently and virtually. It has also meant that we can have greater oversight and surveillance of all patients, whether in their own homes or in the hospital.

We know that we cannot deliver the scale and pace of change by acting as a single organisation. 'Act as One' is the way all of us across the Bradford District and Craven Health and Care Partnership operate together. Supported by governance and shared decision making, together we

design, develop and deliver integration across care pathways which better meet the needs of our population. Our shared vision is to help keep people 'happy, healthy at home.'

Despite the ongoing pressures of the pandemic and the huge effort to support the COVID-19 vaccination programme, we have maintained a focus on delivering for our people. Both those living and working in our communities, and our health and care colleagues across the NHS, local authorities, voluntary and community sector organisations and independent care organisations.

Quality and safety remain our key priorities as we move into 2022/23. We are looking forward to another year of continued improvement, building on what we have learned and improving the overall patient experience.

Whilst the focus in 2021/22 has very much been around managing services in response to the pandemic, we have also started to restart suspended services and the latter part of the year has been about the recovery and learning to live with COVID-19. We have now restarted "ultra-green" elective services and our focus for the next year will be ensuring that the total numbers on our waiting lists reduce and that we offer access to surgery that is equitable and fair, tailored to individual needs.

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.

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

I declare that, to the best of my knowledge, the information in the document is accurate.

Professor Mel Pickup
Chief Executive Officer
June 2022

1.1. ABOUT BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST

Bradford Teaching Hospitals NHS Foundation Trust (the Trust) is responsible for providing hospital services for the people of Bradford and communities across Yorkshire. We serve a core population of around 530,000 people and provide specialist services for some 1.1 million.

We employ more than 6,400 staff who 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.

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)

1.3. SCOPE AND STRUCTURE OF THE QUALITY ACCOUNT

This report summarises our progress on the quality priorities we set for 2021/22.
In normal circumstances, we would have engaged with all our stakeholders and partner organisations which include patients and the public, our staff, our Foundation Trust Governors and commissioners in order to decide our goals and set priorities for the following year. This has not been fully possible this year due to the on-going pandemic. We have however engaged with our Foundation Trust Governors and our Commissioners.

Our main focus remains to provide safe, effective and a positive experience of care.

This report is divided into three parts:

- Part 1 presents a statement from the Chief Executive about the quality of health services provided during 2021/22.

- Part 2 describes our priorities for improvement for 2022/23, the rationale, our progress in 2021/22 and how we plan to monitor and report progress. It contains statements of assurance relating to the quality of services. This includes statements on the National Clinical Audits

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

programme which NHS England advises Trusts to prioritise for participation and inclusion in their Quality Accounts for 2021/22 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

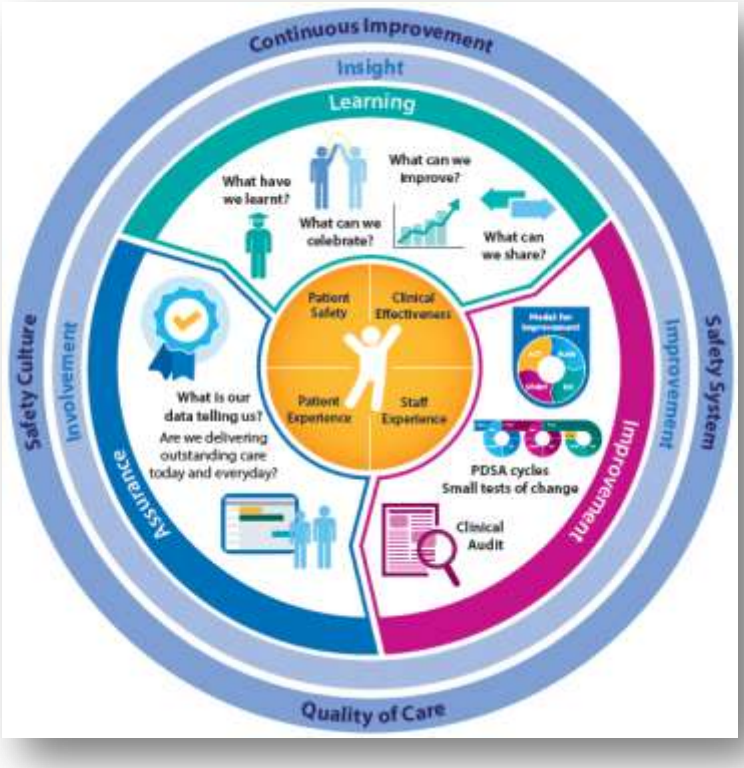
Following the feedback from our engagement event with our Foundation Trust Governors, we decided to roll forward all four priorities and goals we set ourselves in the previous year.

- Priority 1: Improving the management of deteriorating patients
- Priority 2: Improving patient experience
- Priority 3: Continued reduction in stillbirths
- Priority 4: Advancing equality, diversity and inclusion

2.1.1 PROGRESS AGAINST THE 2021/22 Priorities

Figure 1 below shows our approach to Quality, this has been developed and refined over the last year and is becoming embedded in practice.

Figure 1: Trust's approach to Quality



To ensure we deliver the highest quality of care at all times we use our data (insight) to understand our learning. This includes knowing what we do well and what we need to make better (improvement).

Using the Model for Improvement and tools such as clinical audit, we aim to support staff to continuously improve the quality of care for, and with, our local population (involvement).

This will provide the assurance that we are delivering the care we are required to and want to give. This is underpinned by ensuring we have a strong patient Safety culture and a robust patient safety system.

Priority 1: improving and managing deteriorating patients

This improvement priority was informed by learning from safety event investigations, the National Patient Safety Improvement Programme, NICE guidance for Sepsis [NG51]: recognition, diagnosis and early management requirements and as a requirement of the Trust's NHS Standard Contract.

This indicator had two identifiable deliverables: to embed and sustain the deteriorating patient tile as part of the command centre and to improve and sustain sepsis screening and treatment.

a) Improvement in usage of the deteriorating patient tile

In 2019/20, the Trust developed a digital application with GE Healthcare. The Patient Deterioration Tile (PDT) was designed to provide visible real-time NEWS2 scores at an individual patient level. The information is displayed on large ward-based screens and accessible via Trust desktop and laptop computers. This is the first application of its kind to be developed, tested and used in NHS England.

A quality improvement approach was used to safely implement the PDT. Small tests of change were conducted using 'Plan, Do, Study, Act' (PDSA) cycles. Learning from each cycle helped to inform the spread and successful adoption of the tile across 19 wards. This was shared at ward level by the task force team's daily visits. This work was also part of the Trust's response to the COVID-19 pandemic with the tile being rapidly spread to all in-patient areas across Bradford Royal Infirmary in spring and summer of 2020.

Screensavers were used to raise awareness to all Trust users, including how to gain access. Training materials including quick reference cards, training guides and short explanation videos are available to all users on the Trust intranet site. We have shared our experiences with colleagues at Humber River Hospital (Toronto, Canada) who have implemented the same application.

Over all, we have seen an increased number of users of the PDT over the last year (see figure 2). Staff experience feedback demonstrated high acceptability and usability of the PDT. This included a broad range of staff groups from non-clinical support staff e.g. ward clerks, to consultants, to the Patient Flow Team.

The PDT provides us with Trust wide real-time view of patients who may be deteriorating and allow us to be more proactive rather than reactive in treating them.

The quality improvement project was a finalist in the 2021 Health Service Journal awards, showcasing how quality improvement was used to implement digital technology to enhance the quality of care.

b) Sepsis

Overall sepsis screening has been sustained at an average of 70% for eligible patients i.e. Emergency Department and all in-patient wards. However, work continues to drive improvement to achieve the 90% target we set in 2020/21.

Sepsis is covered in more detail in section 3.1.2

Figure 2: Number of unique user logins for the Patient Deterioration Tile (Dec 2020 to May 2022)

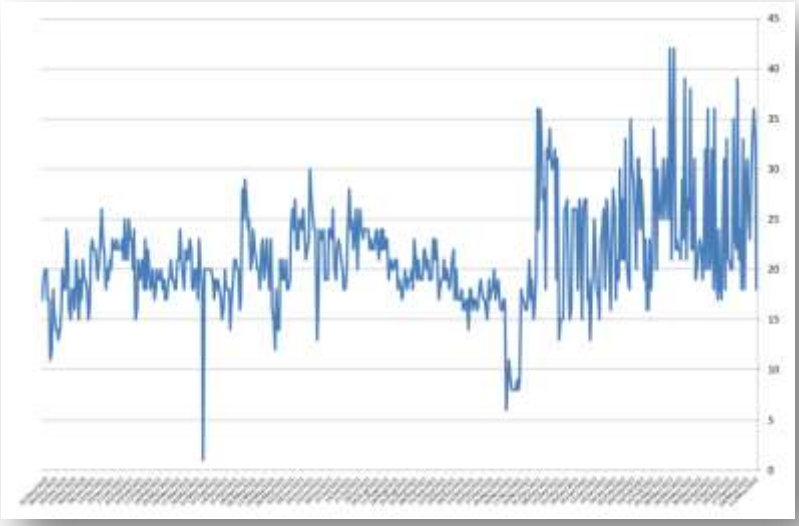


Figure 3: An example of the Patient Deterioration Tile (using mock patient details)

Figure 4: Nursing Staff at BTHFT demonstrating the use of the Patient Deterioration Tile (2021)

Progress against this priority is reported through the Recognition and Response of the Acutely Ill Patient Group (formerly the Patient Deterioration Group), the Patient Safety Group and up to the Quality and Patient Safety Academy as sub-committee of the Trust Board of Directors.

Sepsis dashboard data is shared by the Infection Prevention and Control Team weekly via email to specialities and Clinical Business Units (CBUs). Data is shared monthly at the Patient Safety Group and Quality and Patient Safety Academy. Sepsis data is also presented and discussed at the Trust's Executive to CBU meetings to highlight learning and improvement work.

Priority 2: improving patient experience

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 their interactions.

Our patient experience strategy – 'Embracing Kindness' - was launched in 2018. Moving on from this we have launched the 'Embedding Kindness' initiative. The initiative has received regional and national coverage and we are seeing other Trusts adopting this approach.

Embedding Kindness is as simple as it sounds, an easy way for staff and / or patients to recognise acts of kindness and for those to be rewarded. Throughout the year we have seen up to 60 kindness awards given out for a variety of initiatives. These have ranged from small acts of random kindness by brightening up someone's day through to arranging for pets to visit the hospital or bed side marriages.

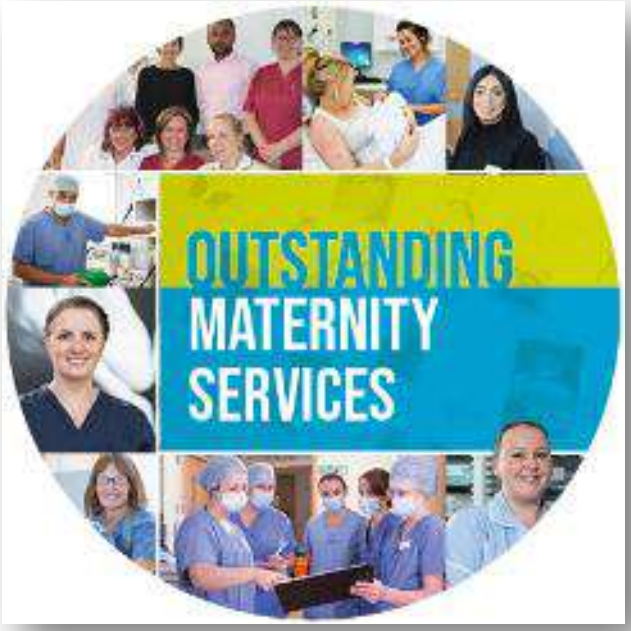
Embedding kindness has been launched Trust wide and across social media with the hash tag #EmbracingKindness the initiative has been launched Trust wide. Staff are invited to complete our on line training and on completion receive a kindness badge and certificate.

The plan for early 2022/23 is to celebrate and showcase the work undertaken whilst continuing to improve services for patients.

Data is collected in a number of formats, including pledges, nominations of kind acts and compliments received. The information is included in the regular reports to the Patient Experience Committee and to the Quality and Patient Safety Academy. External monitoring includes the Care Quality Commission's National In-patient Survey.

Priority 3 – continued reduction in still births

The Trust officially launched its Outstanding Maternity Services (OMS) Programme in 2021. The programme has dedicated resources and uses a multi-disciplinary approach to continuous quality improvement central to this are the women that we care for and their voices are heard and listened to in person and via the Maternity Voices Partnership (MVP).



The Trust has continued to reduce stillbirths year on year and has improved on a number of other metrics in relation to maternity care. More details on the stillbirth data can be found in section 2.3.2 Stillbirths, below.

2021 saw a reduction of 10 stillbirths compared to 2020 resulting in an adjusted rate of 4.2 per 1000 births from 5.6 in 2020. This is extremely positive despite a year filled with the challenges of an ongoing pandemic. It is thought that the rollout of updated guidance for identifying and managing small babies, partnership working with the MVP to disseminate important messages regarding reduced foetal movements, and revisiting and embedding the principles of symphysis fundal height measurement, have contributed to this success. Full compliance with the Saving Babies Lives Care Bundle Version 2, has also contributed to the reduction.

Analysis of the stillbirths occurring during 2021 identified that the majority of cases were to women living in the highest indices of deprivation. This lends itself to a focussed piece of work which will be driven by the OMS programme, aiming to improve outcomes and reduce inequalities amongst women living in the most deprived areas of the city, including targeting maternal health and wellbeing messages and improving access to smoking cessation services.

2021/22 saw a continued improvement with the achievement of one-to-one care rates which are consistently more than 90%. This position has been sustained for more than 18 months and is now exception reported if less than 90%.

Achieving Midwifery Continuity of Carer (MCoC) against the back drop of a national midwifery staffing shortage, has proved challenging. However, whilst the continued rollout of MCoC teams has been paused to focus on safe staffing across maternity service, The Trust has maintained existing pathways of care prioritising women from ethnic minority and vulnerable communities. Moving forward reduction in stillbirths remains a key indicator. However, stillbirths is not the only indicator of wider maternity and neonatal care, therefore moving forward, this priority will be

expanded to include compliance against Ockenden Standards and the expansion of our OMS programme to include neonates.

Our OMS programme reports progress on a quarterly basis to the Quality and Patient Safety Academy and to the Trust Board.

Priority 4: Advancing equality, diversity and inclusion

We continue to embed and mainstream equality diversity and inclusion (EDI) across the Trust. The role of the Equality and Diversity Council (EDC) has been instrumental in raising the profile of EDI but also understanding our role as an acute hospital in reducing population health inequalities. This has provided us with a clear outline of our strategic priorities in further advancing EDI both for our patients, communities and our workforce.

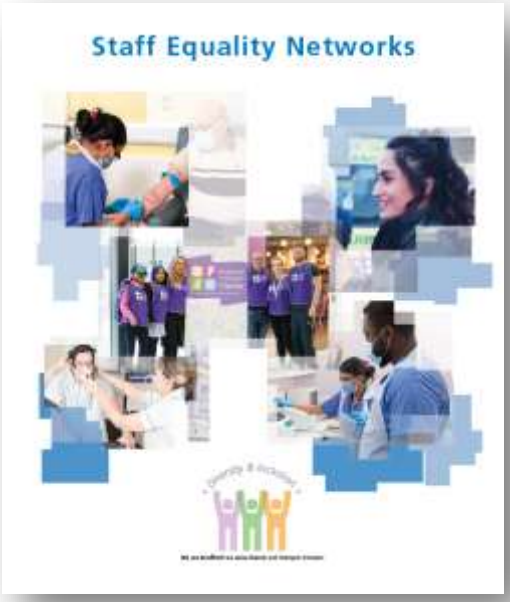
We continue to involve and engage with our staff and the wider community. We are continuously ensuring our EDI priorities are in line with national, regional and local priorities. There are a number of national levers and equality frameworks in which we ensure our EDI activity is aligned including the NHS People Plan with a focus on inclusion and belonging.

The newly developed EDC continues to meet on a regular basis ensuring membership of EDC is fit for purpose and ensuring we have representation from across the core functions of the Trust. This ensures we have individuals who have a pivotal role to play in influencing change both across our organisation and within the wider Place and Integrated Care System (ICS).

There has been considerable focus on targeted engagement on a range of areas with our diverse staff across the Trust. This has been around; refreshing our staff equality networks, encouraging staff to be vaccinated and allowing opportunities for staff to engage in Q&A sessions.

EDI is not limited to staff but also our population that we serve and we are committed to addressing health inequities across Bradford with our partners as part of Act As One. Early successes have been:

- As lead provider for the COVID-19 vaccine we developed a bespoke post to focus on health inequalities in relation to vaccine uptake.
- Work with MVP to develop tools in different languages and pictograms. Recent targeted recruitment for staff with lived experience of some of our wider communities.
- At Place, Act as One is grounded in tackling inequalities; this has now been embedded within the Trust and is one of the key lines of enquiry during performance meetings.
- Revised visiting guidance in line with patient feedback and negative impact on patients with protected characteristics.



The EDC will continue to maintain an overview of our EDI agenda/ strategic objectives, ensuring these are fit for purpose and aligned with national and regional priorities.

Consultation and engagement with staff and communities in the development and implementation of a Trust-wide three-year EDI strategy continues. The EDI strategy and objectives will be launched in October 2022.

2.2. STATEMENT OF ASSURANCE FROM THE BOARD

2.2.1. REVIEW OF SERVICES

During 2021/22 the Trust provided and/or sub-contracted 41 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 2021/22 and represents 100% of the total income generated from the provision of relevant services by the Trust for 2021/22.

2.2.2. PARTICIPATION IN CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

The Trust is committed to supporting learning and improvement to provide assurance that the Trust strives to provide the highest quality patient care at all times. The Trust's clinical audit work provides a way to monitor if care is being delivered in line with national standards, if the service is doing well and where there could be improvements.

The Trust's High Priority Clinical Audit Programme for 2021/22 was informed by the National Clinical Audit and Patient Outcomes Programme (NCAPOP). NCAPOP audits are commissioned and managed on behalf of NHS England by the Healthcare Quality Improvement Partnership (HQIP).

Following guidance from NHS England (letter dated 27-05-21[3]) the NCAPOP programme only recommenced from June 2021. The letter stated that *'NHS organisations should always prioritise*

[2] Relevant health services are those services published on the NHS England website and as included in the Trust's contracts with commissioners' schedule 2D. The Trust also subcontracted four services during 2021/22.

clinical care over data collection if local circumstances dictate that is necessary especially if demand for services changes over the coming months due to COVID-19'.

As a result, the Trust has continued to make pragmatic decisions to prioritise clinical care and where appropriate support clinical audit work during 2021/22. At the time of report writing (May 2022) the Trust is working on recovery plans. This is in order to achieve the ambitions set out in the NHS England delivery plan for tackling the COVID-19 backlog of elective care, whilst managing the impact of in-patients with COVID-19 and staff wellbeing.

The late start of the national programme and ongoing organisational pressures to deliver safe care has meant that submission data for each audit has been difficult to collect centrally on a routine basis. It is anticipated that for the 2022/23 reporting period, the processes for the monitoring and oversight of our clinical outcomes programme (which includes national clinical audits, national confidential enquiries and local clinical audits) will be improved and help to inform our overarching approach to quality: learning, improvement and assurance.

The national confidential enquiries that the Trust has participated in, and for which data collection was completed during 2021/22, are listed below (see figure 5) alongside the number of cases submitted to each enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Figure 5: BTHFT National Confidential Enquiries 2021/22

National Confidential Enquiries	Date commenced	Registered number of cases	Cases submitted to each enquiry as a percentage of the number of registered cases required
Epilepsy	Feb 2021	6	(5/6) 83%
Transition from child to adult health services	July 2021	10	(8/10) 80% This study is still ongoing and open for case submission

During 2021/22, there were 29 national clinical audits and two national confidential enquiries covering relevant health services that the Trust provides.

During that period the Trust participated in 100% of the national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2020/21 are as follows:

- Falls and Fragility Fractures Audit Programme (FFFAP)
  - a. Fracture Liaison Service Database
  - b. National Audit of Inpatient Falls
  - c. National Hip Fracture Database
- National Adult Diabetes Audits
  - a. National Diabetes Core Audit
  - b. National Pregnancy in Diabetes Audit
  - d. National Inpatient Diabetes Audit, including National Diabetes in patient Audit - Harms
- National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme:

[3] https://www.hqip.org.uk/wp-content/uploads/2020/03/COVID19-update-on-NCAPOP-27.05.21.pdf

a. Paediatric Asthma Secondary Care

b. Adult Asthma Secondary Care

c. Chronic Obstructive Pulmonary Disease (COPD) Secondary Care

- National Audit of Breast Cancer in Older People
- National Audit of Care at the End of Life (NACEL)
- National Audit of Dementia (Care in General Hospitals)
- National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)
- National Cardiac Audit Programme:

  a. National Audit of Cardiac Rhythm Management

  b. Myocardial Ischaemia National Audit Programme

  d. National Audit of Percutaneous Coronary interventions (PCI) (Coronary Angioplasty)

  e. National Heart Failure Audit
- National Early Inflammatory Arthritis Audit (NEIAA)
- National Emergency Laparotomy Audit (NELA)
- National Gastro-intestinal Cancer Programme:

  a. National Oesophago-gastric cancer

  b. National Bowel Cancer Audit
- National Lung Cancer Audit (NLCA)
- National Maternity and Perinatal Audit (NMPA)
- National Neonatal Audit Programme (NNAP)
- National Perinatal Mortality Review Tool
- National Paediatric Diabetes Audit (NPDA)
- National Prostate Cancer Audit
- Sentinel Stroke National Audit programme (SSNAP)
- National Vascular Registry

The reports of one national clinical audit were reviewed by the Trust in 2021/22 and the Trust has taken the following actions to improve the quality of healthcare provided described below:

- National Bowel Cancer Audit

  30 September 2021 – Outlier Alert
  Insufficient data submitted for the period 01.04.19 – 31.03.20 to allow for risk adjusted analysis

Improvement:

- Issues identified with insufficient data being submitted for the reporting period.
- This was rectified with the audit provider and amended to reflect accurate data for participation and submission (see figure 6).

Figure 6: Snap shot of data submission for 2019-20 (May 2022)

Data Quality

All Patients:	Trust	Network	National
Number of patients in Audit	157	1455	32641
Case ascertainment (%)	Good	Good	Good
Data completeness of:			
– Pre-treatment TNM (%)	100	88	85
– Performance status (%)	100	83	86

2.2.3. PARTICIPATION IN CLINICAL RESEARCH ACTIVITIES

In 2021/22 the Trust has continued to have an extensive programme of health care research.

The number of patients receiving relevant health services provided or subcontracted by BTHFT in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee is 10,384.

2.2.4. COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

The Trust's income in 2021/22 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 register 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 2021 to 31 March 2022.

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 2021/22 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 7 below. Percentages for 2020/21 are in line with peers and exceed national England averages.

Figure 7: Percentage of records which included the patient's valid NHS number

Record type	Area	2021/22 April to November 2021	2020/21 April to November 2020	2019/20 April to November 2019	2018/19 April to November 2018
Patients' valid NHS number	Admitted patient care	97.3	99.7%	99.8%	99.6%
	Outpatient care	100%	99.9%	99.9%	99.9%
	Emergency department care	99.6%	99.2%	99.1%	98.7%
Patients' valid general medical practice code	Admitted patient care	88%	100.0%	99.7%	100%
	Outpatient care	90.4	100.0%	99.6%	100%
	Emergency department care	98.8%	100.0%	99.6%	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 2020/21 the Trust achieved 'Standards Met' which means that all mandatory assertion items have been evidenced by final submission. The deadline for all organisations for the DSPT assessment (formerly the IG toolkit) for 2021/22 is the same as the previous amended deadline, the 30 June 2022. This national date for annual DSPT assessment submissions for all organisations changed from 31 March to 30 June because of the pandemic.

Our final Information Governance assessment overall position for 2021/22 is therefore incomplete at the time of this report. A sample of the DSPT evidence is also still being independently assessed by Audit Yorkshire at the time of this report.

The Trust is forecasting 'Standards Met' as in 2020/21, to be confirmed on 30 June 2022. NB: the DSPT is no longer scored as a percentage / RAG graded.

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 impose a payment by results clinical coding audit on the Trust during 2020/21 or 2021/22.

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, and the 2021/22 audit took place from 9-20 May 2022, in compliance with the DSPT submission dates in June.

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].

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

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.

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 8: Clinical coding error rate

Coding field	Percentage incorrect								
	2021/22	**2020/21**	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15	2013/14
Primary diagnoses incorrect	TBC	6.30%	5%	5.70%	8.60%	8.17%	5.50%	9%	8%
Secondary diagnoses incorrect	TBC	7.80%	3.80%	6.30%	10.20%	9.20%	4.80%	9.47%	5.90%
Primary procedures incorrect	TBC	3.80%	8.30%	4.70%	8.10%	9.09%	9.10%	2%	0.70%
Secondary procedures incorrect	TBC	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.

2.10 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 and Patient Safety Academy via a new digital and data transformation committee. A data governance board, paused during COVID-19 is being re-established and will reinstate 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. The latest published data (December 2021) gives an overall DQMI score of 90.9 against a national average of 79.9%.

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 where required in a self-serve manner to the front line, increasing knowledge, value and importance of data quality;
- migration of the EPR primary data feed from PIEDW to Nautilus835;
- continuation of a data warehouse optimisation plan to consume additional information feeds from non-EPR systems - to create additional automated data flows, driving consistency in Trust-wide analytics and reporting;
- 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.

2.2.10. LEARNING FROM DEATHS

During 2021/22, a total of 1482 patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 339 in the first quarter
- 373 in the second quarter
- 379 in the third quarter
- 391 in the fourth quarter

The Learning from Deaths process: scrutiny and structured judgement reviews

The Medical Examiner's Office (MEO) for the Trust was set up in November 2020 and reached full staffing establishment in January 2022. From October 2021 to March 2022 the MEO has scrutinised 100% of in-patient deaths. Following scrutiny, the MEO may recommend a structured judgement review is conducted to identify organisational learning and improvement opportunities.

For reporting purposes the term 'structured judgement review' has been used to refer to case record reviews and investigations.

BTHFT - Structured Judgement Review Process

The Trust uses the structured judgement review (SJR) methodology[1] for the mortality review process. This is a nationally recognised approach with the underpinning principle that trained clinicians use explicit statements to comment on the quality of healthcare in a manner that is reproducible[2].

Following scrutiny by the MEO, patient's deaths that meet the criteria for organisational learning are subjected to an SJR (first stage). The overall care score ranges from 1=very poor care, 2=poor care, 3=adequate care, 4=good care and 5=excellent care. If the review reveals a score of 2 or below a second SJR is conducted. The combined results are then discussed at the weekly Safety Event Group meeting and a multi-disciplinary team decision is made whether the results of the review were more likely than not, to have been due to problems in the care provided to the patient.

References:
Royal College of Physicians. (2016). Using the structured judgment review method–a clinical governance guide to mortality case record reviews. London: RCP.

A total of 980 deaths within the hospital were scrutinised by the ME Office. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 62 in the first quarter
- 210 in the second quarter
- 379 in the third quarter
- 391 in the fourth quarter

During 2021/22, 136 SJR requests were raised, with the numbers by quarter as:

- 20 in the first quarter
- 25 in the second quarter
- 47 in the third quarter
- 44 in the fourth quarter

By March 2022, 62 SJRs had been carried out in relation to 1482 of the deaths during 20221/22.

The number of deaths in each quarter for which a SJR was carried out was:

- 12 in the first quarter
- 20 in the second quarter
- 13 in the third quarter
- 17 in the fourth quarter

There was 1 death representing 0.07% 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. In relation to each quart this consisted of:

- 0 deaths representing 0% for the first quarter
- 0 deaths representing 0% for the second quarter
- 0 deaths representing 0% for the third quarter
- 1 death representing 0.07% for the fourth quarter

There were no SJRs completed after 31st March 2021 which related to deaths which took place before the start of the reporting period.

Summary of learning from structured judgement reviews (SJRs)

The key learning and areas for improvement from the SJR's conducted in 2021/22 are summarised below:

Key Learning points

Celebrating excellence:

- Excellent communication between staff and patients, carers and their families. In the most difficult circumstances there was evidence of excellent support including bereavement support to families.
- Prompt recognition of end of life care for our patients. It was noted that the palliative care the patient received was outstanding.
- Good evidence of multi-disciplinary approaches to decision-making with patients, carers and families
- In cases of patients with severe mental health illnesses, their mental health status and social history were clearly assessed and need addressed.

Areas for improvement:

- Improving documentation during assessments and investigations
- Issues with medicines management including, missed doses of regular medications, a shortfall in pain medication administration and the conversion of epilepsy medications to intravenous therapy.
- Issues with treatment and management plans stemming from systemic delays and pressures owing to the Trust's response to the COVID-19 pandemic.

- Building working relationships with the MEO to support the creation of feedback mechanisms about learning and improvement activities

- Successfully recruited an Associate Medical Director (Learning from Deaths) and a full-time Patient Safety Manager (Learning from Deaths) to support the Learning from Deaths programme of work

- Development of a Learning from Deaths application/database to support learning at an organisational and specialty level. It is anticipated that this will provide assurance on the quality of care being provided to patients that have died whilst in our care.

- Establishing a Multi-Disciplinary Panel to undertake a peer-review SJRs for complex and complicated patient cases.

- Undertaken a cluster serious incident investigation (2021 -8095) for 16 patients that died following a definite Hospital Onset COVID-19 Infection (HOCI). The aim was to review the quality of care delivered in order to identify learning and inform improvement work.

The impact of the above actions has demonstrated the Trust's commitment to learning in line with National Guidance on Learning from Deaths[6] and the NHS Patient Safety Strategy[7]. We anticipate that as our learning approach matures we will be able to provide assurance that we are providing the highest quality of care, as identified in the Trusts' mission statement.

2.2.11. 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.

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 also 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 9: Number of concerns raised in 2021/22

Quarter 2021/2022	Number of concerns raised
Q1	19
Q2	13
Q3	18
Q4	10
Total	60

2.2.12. GUARDIAN OF SAFE WORKING

The safety of patients is the paramount concern for the NHS. Significant staff fatigue is a hazard both 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 Hours 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 this assurance is provided in a quarterly report detailing information on doctors and dentists in training working hours, 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 2021/22 confirms that exception reporting has increased significantly this year compared to the previous year which will be in most part due to the return of the non-COVID-19 rotas, there is also a high locum requirement in Emergency Medicine and General Medicine

[6] National Quality Board. (2017). National Guidance on Learning from Deaths—NHS England
[7] NHS England and NHS Improvement (2019). The NHS patient safety strategy. Safer culture, safer systems, safer patients.

revealing these high pressure specialities has notable rota gaps. The numbers of locums in Medicine dramatically increased during the pandemic and continues to be high.

Trainees submit an exception report if they are working beyond contracted hours or if educational opportunities are missed. Whilst working through the pandemic, trainees were very aware they were working during exceptional circumstances which would explain the decrease in reporting. However, during 2021/22 with the restart of many services alongside continuing COVID-19 care, the complex and demanding working arrangements have been reflected in the number of exceptions reported by trainees largely due to additional hours worked.

There have also been concerns and ongoing issues about allocation of self- development time, annual leave approval, rota gaps and locum rates, all amplified by increasing pressures on the Trust's workforce during the last twelve months and throughout the pandemic. Understandably this has impacted on morale and there is ongoing work to further support the Trust's permanent workforce as well students and trainees to understand and work collaboratively to make improvements and to explore new workforce opportunities.

Only one speciality within the Trust has a non-compliant rota, this is due to the weekend working pattern; discussion with the trainees in-post show they are happy with the current work patterns arranged for them whilst a long term solution is sought.

The Guardian of Safe Working Hours 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 (SHMI)

The Summary Hospital-Level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die during or within 28 days of hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. If the value is greater than 100, this indicates that the patient group being studied has a higher mortality level than the NHS average.

The current available Healthcare Evaluation Data (HED) covers a 12-month period from January 2021 to December 2021 with our current SHMI value being 104.5 which is within the expected range (See figures 10 and 11).

Figure 10: SHMI score (12 month rolling-Feb 2020- Jan 2021): 105.83 – within expected range

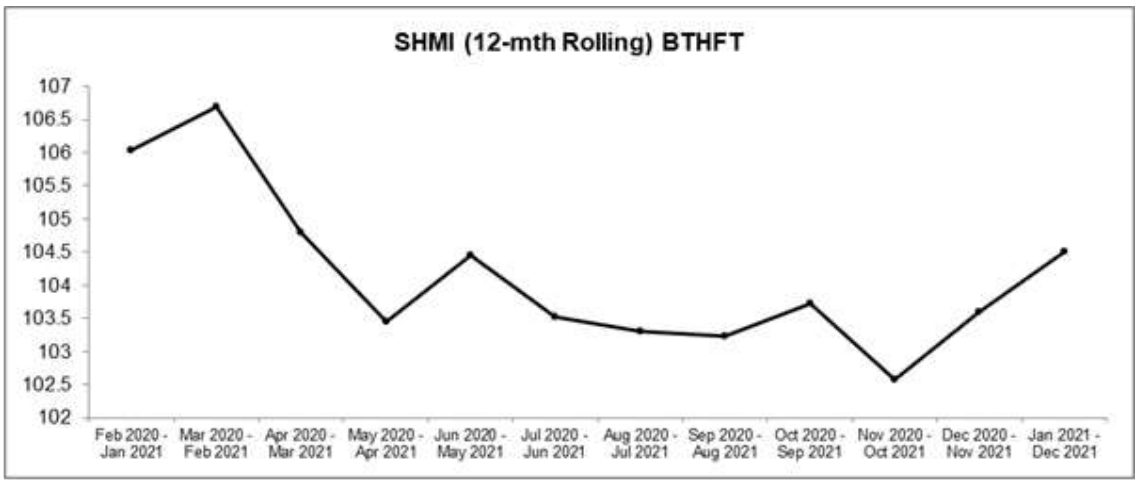
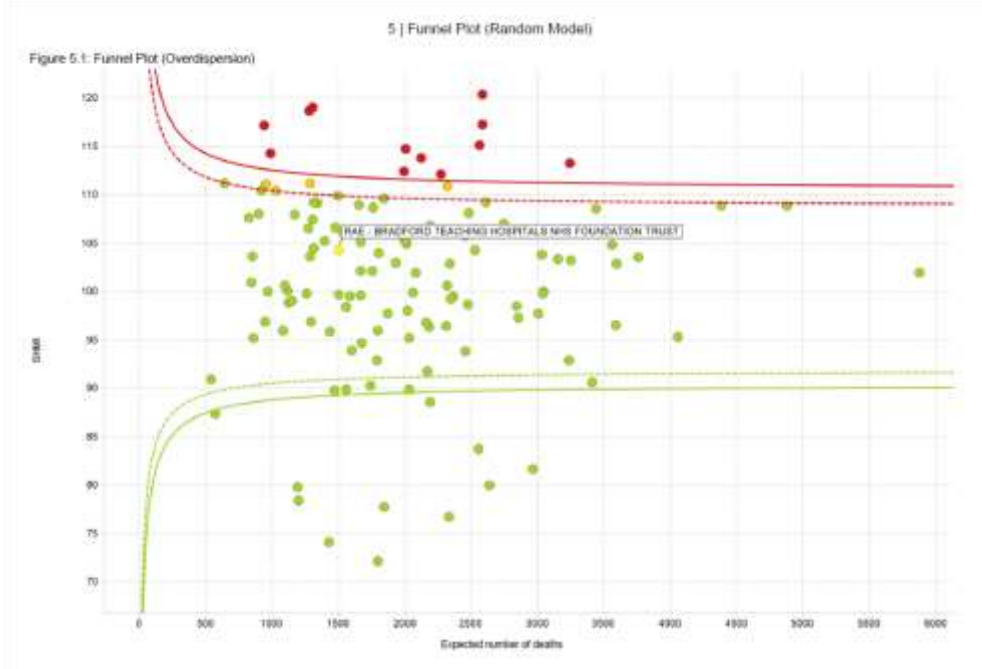


Figure 11: SHMI indicator values, discharges, observed deaths and expected deaths numbers

SHMI 12-month rolling	Indicator Value	Number of Discharges	Number of Observed Deaths	Number of Expected Deaths
Feb 2020 - Jan 2021	106.04	64,167	1,423	1,341.95
Mar 2020 - Feb 2021	106.69	61,727	1,375	1,288.77
Apr 2020 - Mar 2021	104.79	61,555	1,345	1,283.53
May 2020 - Apr 2021	103.46	63,666	1,406	1,358.94
Jun 2020 - May 2021	104.45	65,541	1,468	1,405.39
Jul 2020 - Jun 2021	103.52	66,814	1,469	1,419.07
Aug 2020 - Jul 2021	103.31	67,375	1,480	1,432.59
Sep 2020 - Aug 2021	103.23	67,838	1,489	1,442.38
Oct 2020 - Sep 2021	103.72	68,487	1,497	1,443.27
Nov 2020 - Oct 2021	102.58	69,373	1,483	1,445.75
Dec 2020 - Nov 2021	103.59	70,670	1,524	1,471.22
Jan 2021 - Dec 2021	104.50	71,517	1,565	1,497.58

Figure 12: SHMI Funnel Plot



The funnel plot shows the Trust's SHMI performance in relation to all other acute hospital trusts.[8]

Our current SHMI of 104.5 is marked and shows us as within expected range.

Stillbirths

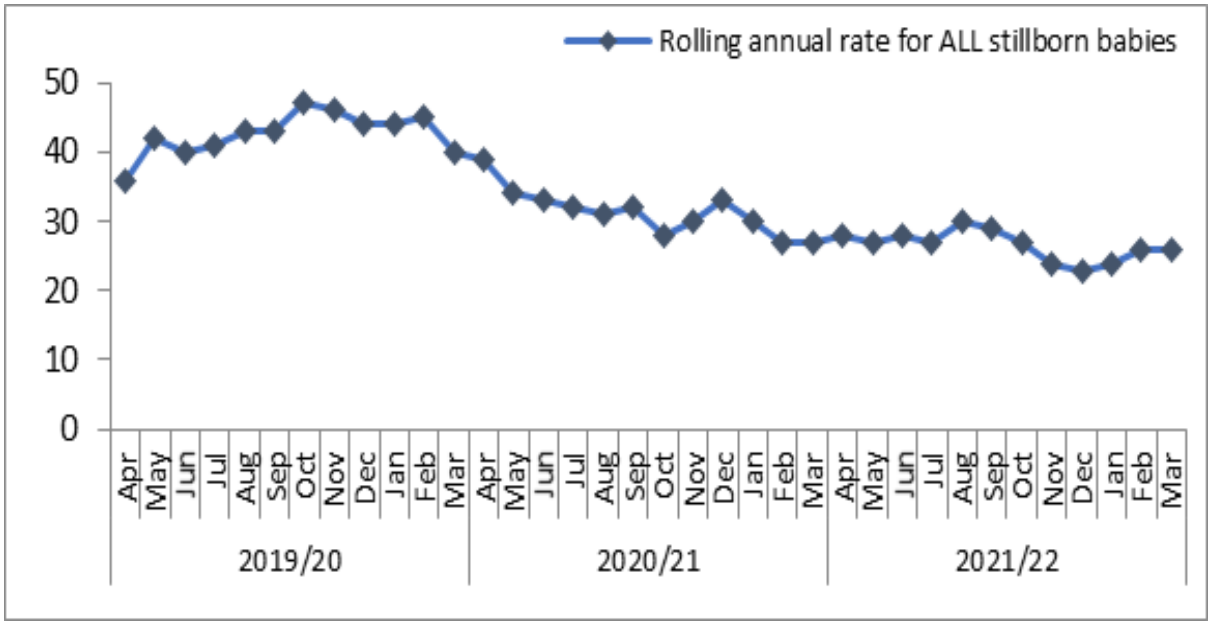
The Maternity service has embarked on a significant quality improvement and transformation project, intended to improve the stillbirth rate and a host of other maternity and neonatal indicators. This is known as the Outstanding Maternity Services programme or OMS. OMS was launched,

[8] A value within expected range is marked in green; a value between 90% upper limit and 95% upper limits is marked in Amber; a value above the 95% upper limit is marked in red.

following a poor CQC inspection and on the back of the emerging findings at other maternity units, including the Ockenden report.

The Trust was a regional and national outlier for stillbirths. The service reported an annual reduction in stillbirths during 2020, with a further reduction in 2021. However, stillbirth reduction remains a key priority for the service as we continue to work towards the national ambition and 'halve it' trajectory. The service reported an annual reduction in stillbirths during 2020, with a further reduction in 2021.

Figure 13: Stillbirths 2021/22



The data in the graph is defined as follows: Rolling Annual Total Number of Stillbirths; Rolling annual rate for ALL stillborn babies

2.3.2. PATIENT REPORTED OUTCOME MEASURES (PROMS)

PROMS assess the quality of care delivered to NHS patients from the patient perspective and currently cover two clinical procedures. The two procedures are:

- hip replacements
- knee replacements

The Trust is not able to provide any benchmarking data for PROMs. As a consequence of the pandemic no data has been submitted to NHS Digital.

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 14 to 15 below showing the percentage of patients within those age groups..

Figure 14: 0 to 14 readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

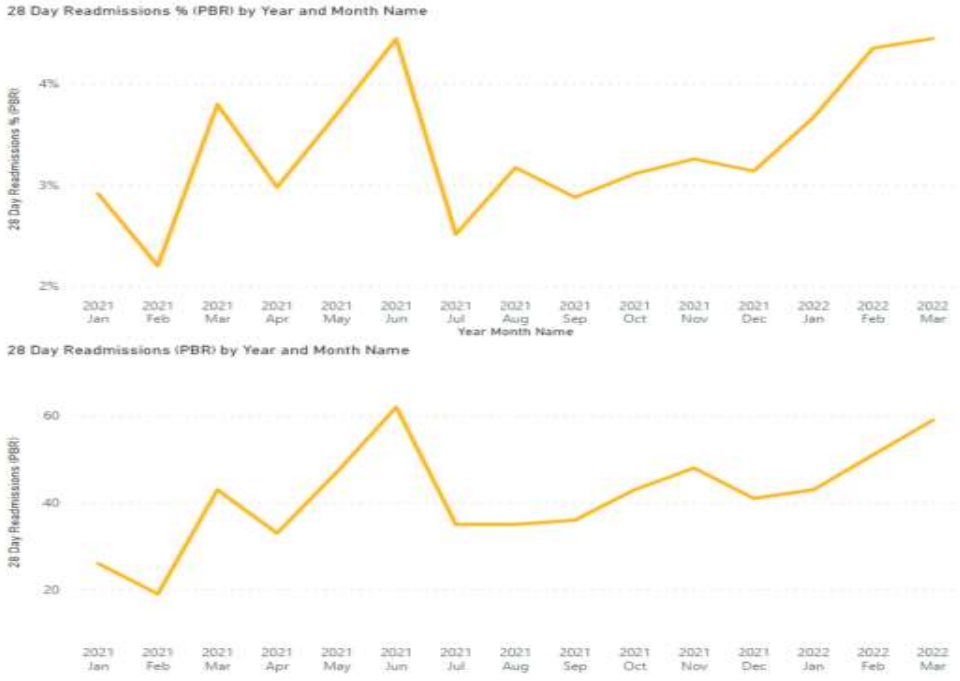
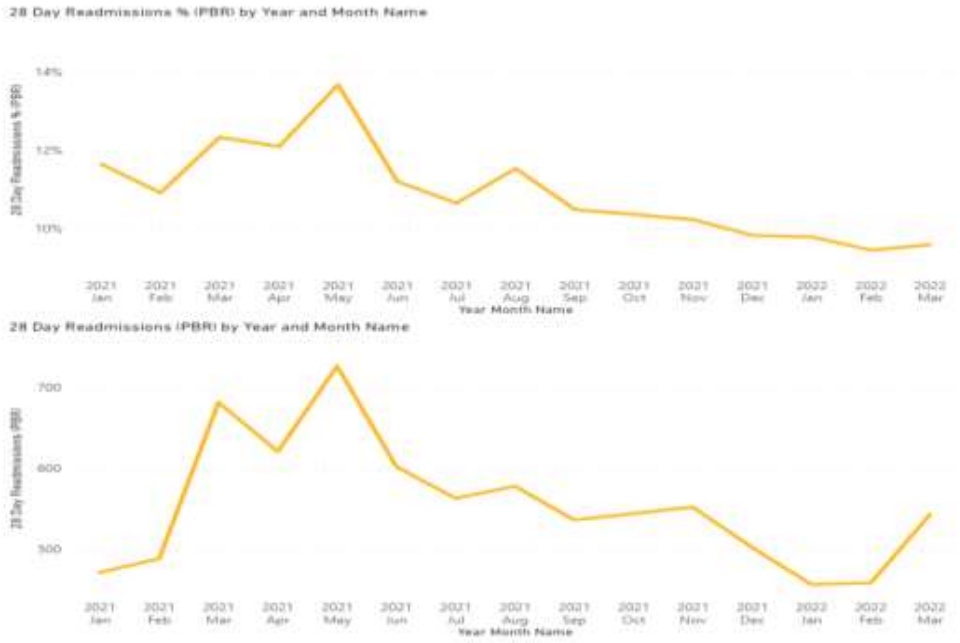


Figure 15: 15 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period



Our baseline re-admission rates are between 8-10% and there is usually seasonal variation. However, recently the pandemic has skewed this normal variation and the high percentage figures reported between March to May 2021 is likely to be related to the 2nd and 3rd COVID-19 waves during the late winter 2020/21.

We have had better treatment and drugs available to treat COVID-19 and have been in a position to be able to manage patients as the pandemic progressed, resulting in reduced rates of re-admission after each wave. There now appears to be a sustained continued reduction in re-

admission rates since May 2021. This provides some encouragement that COVID-19 is having less of an impact on re-admission rates within 30 days.

2.3.4. RESPONSIVENESS TO PATIENT NEED

Friends and Family Test (FFT)

The overall Trust position score from FFT at time of reporting is a score of 84% of patients scoring the Trust as 'very good' or 'good'.

Overall the Trust has received 30,409 FFT results, with SMS text messaging making up the majority of this. The table below (figure 16) shows the breakdown of responses.

Figure 16: Friends and Family Test Responses 2021/22

Response	Percentage	Number of times response selected
Very good	68.24%	20,751
Good	14.77%	4,491
Neither good nor poor	4.85%	1,476
Poor	4.84%	1,471
Very poor	3.93%	1,195
Don't know	3.37%	1,025

In previous years annual reporting scores used a different metric of 'would recommend' and 'would not recommend', it is therefore not possible to make direct comparison.

CQC surveys

During 2021/22 the Trust has taken part in the mandated CQC surveys (Urgent and Emergency Care, Inpatient survey, Children's and Young People and Maternity surveys).

The Trust has much to celebrate with the success of the 2020 Urgent and Emergency Care CQC survey results. The Health Service Journal (September 2021) reported that the Trust was the most improved hospital from 2018-2020 in their results. This is a credit to all the hard quality improvement work that has taken place to improve Patient Experience.
Improvements noted in 2020 relate to:

- Privacy at reception.
- Reduced wait time to see a clinician.
- Overall length of visit.
- Confidence in clinicians.
- Cleanliness of the department.
- Dignity and respect.

2.3.5. PEOPLE PULSE AND NHS STAFF SURVEY

The National Quarterly Pulse Survey (People Pulse) has been implemented from April 2021, replacing the Staff Friends and Family Test (Staff FFT) which had previously been carried out since April 2014.

The primary purpose of the People Pulse is to provide an additional and more frequent opportunity to hear from staff to help understand employee experience and to support decision making and actions for improvement with the ambition of making the NHS the best place to work.

The survey consists of the nine questions which make up the existing Engagement theme of the NHS Staff Survey, measuring motivation, advocacy, and involvement. It runs in quarter one, two and four. There is not 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.

The results of the People Pulse survey are used to inform local actions to improve the experiences of our people and patients.

In 2021/22 our NHS Staff Survey received the biggest response to date with over 47% of staff completing it; providing a wide range of feedback and insight into Trust employee experience.

The priority areas highlighted for particular focus over the next year are:

- Improving staff engagement levels and morale – a focus on supporting each other, ensuring the organisation is a compassionate place to work;
- Increasing awareness of the Trust 'Thrive' offer;
- Reward and recognition – a focus on staff feeling that they are valued for what they do;
- Teamwork - a focus on team effectiveness and the role of line managers; *and*
- Ensuring that staff feel confident and safe to speak out if there is something that needs to change.

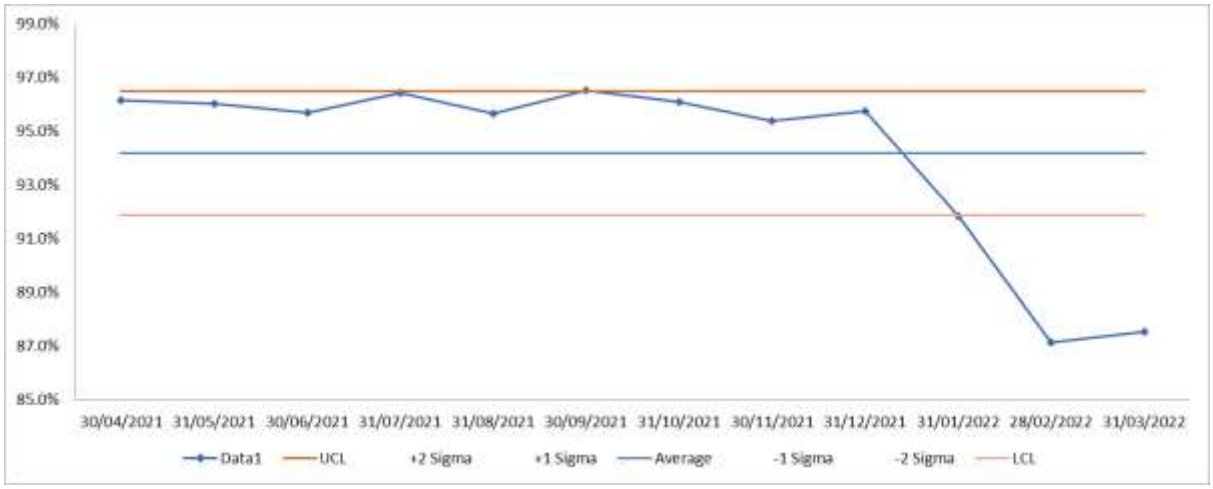
2.3.6. VENOUS THROMBOEMBOLISM EVENT RISK ASSESSMENT (12 MONTH ROLLING)

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 (NG158)[9].

This indicator shows the percentage of spells where the patient has been risk-assessed for a venous thromboembolism event (VTE). A higher percentage would mean that the trust has a higher compliance rate with the NICE guidelines, which state that all patients who are admitted to hospital should be risk-assessed for VTE.

The data in Figure demonstrates that during 2021/22 on average over 94% of patients were risk assessed for VTEs.

Figure 17: Percentage of eligible patients that have had a VTE risk assessment



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

[9] Venous thromboembolic diseases: diagnosis, management and thrombophilia testing https://www.nice.org.uk/guidance/ng158

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 January 2022 and was below the Trust's lower confidence limit in February and March 2022. We believe this is partly owing to the Trust's ongoing response to the COVID-19 pandemic. This included rapid ward re-configurations and resetting speciality bed bases and staff re-deployment to support the safe delivery of care flexibly across the organisation.

We intend to continue to improve VTE risk assessment rates as part of and so the quality of care at service level. We will achieve this by:

- Working with the clinical nurse specialist to support with training and real time data collection;
- Working with areas that are not fully compliant with the standard;
- Ensuring that all inpatient areas exempt from the standard are recoded appropriately within the system.

This will be monitored monthly basis by the Quality and Patient Safety Academy.

2.3.7. C DIFFICILE

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

The objectives for reduction for CDI for 2021/22 were set as 37 cases. The Trust reported 44 hospital attributable cases during 2021/22.

We consider that this data is accurate because it is captured, processed and analysed through the Trust-wide Laboratory Management Systems (LMS), 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 has seen an increase in C. *difficile* cases during 2021/22 which has been reflected nationally during the COVID-19 pandemic. Each C. *difficile* case is sent to a UK Health Security Agency (UKHSA) (previously Public Health England) reference laboratory for typing; 25 subtypes of Clostridioides *difficile* have been reported during 2021/22 at BTHFT. A search is undertaken to identify any potential risks for cross transmission (for example, the same ward either at the same time or at different times) and no evidence of cross transmission has been identified. Each room occupied by a patient with C. *difficile* receives a full decontamination utilising hydrogen peroxide vapour.

Antibiotic usage is the most common risk factor associated with Clostridioides *difficile* infection; the antibiotics most commonly reported nationally as being associated with Clostridioides *difficile* infection were cephalosporins and quinolones.

The role of antibiotic stewardship is a primary preventative strategy in the prevention of Clostridioides *difficile* infection and will be a focus during 2022/23 to reduce the usage of the high risk antibiotics. The Trust is aware that the use of piperacillin-tazobactam requires evaluation and therefore there will be a review of the Trust antibiotic guidelines to ensure that high risk antibiotics are only recommended in line with national evidence.

Figure 18: Healthcare Evaluation Data (HED) for C. *difficile*

Standard Indicator Set: Clinical Quality	Trust Performance			Benchmarking			
Indicator	Current	Previous	Change	Peer	National	Position	Module Link
Infection rate - C. diff (12 mth rolling) PHE C. Diff Infection Rates, HES Inpatients (May 2022)	18.45 (Apr 2021 - Mar 2022)	17.58 (Mar 2021 - Feb 2022)	0.87	-	17.40		

Figure 19: Healthcare Evaluation Data (HED) for C. *difficile*: Benchmarking data for both Yorkshire Region and National Acute NHS Trusts *(the black line represents our Trust)*

2.3.8. PATIENT SAFETY INCIDENTS WITH SEVERE HARM OR DEATH

The Trust uses an electronic reporting system (Datix) to monitor and manage patient safety events and concerns. The Trust is currently reviewing and adapting the reporting system to ensure it meets the new requirements of the Patient Safety Incident Response Framework (PSIRF) due to come into effect from April 2023. This includes reporting to the 'learn from patient safety events' (LFPSE) service by the end of March 2023 as required by NHS England and NHS Improvement. The Trust has a robust governance and quality oversight system in place with weekly meetings to identify learning and improvement.

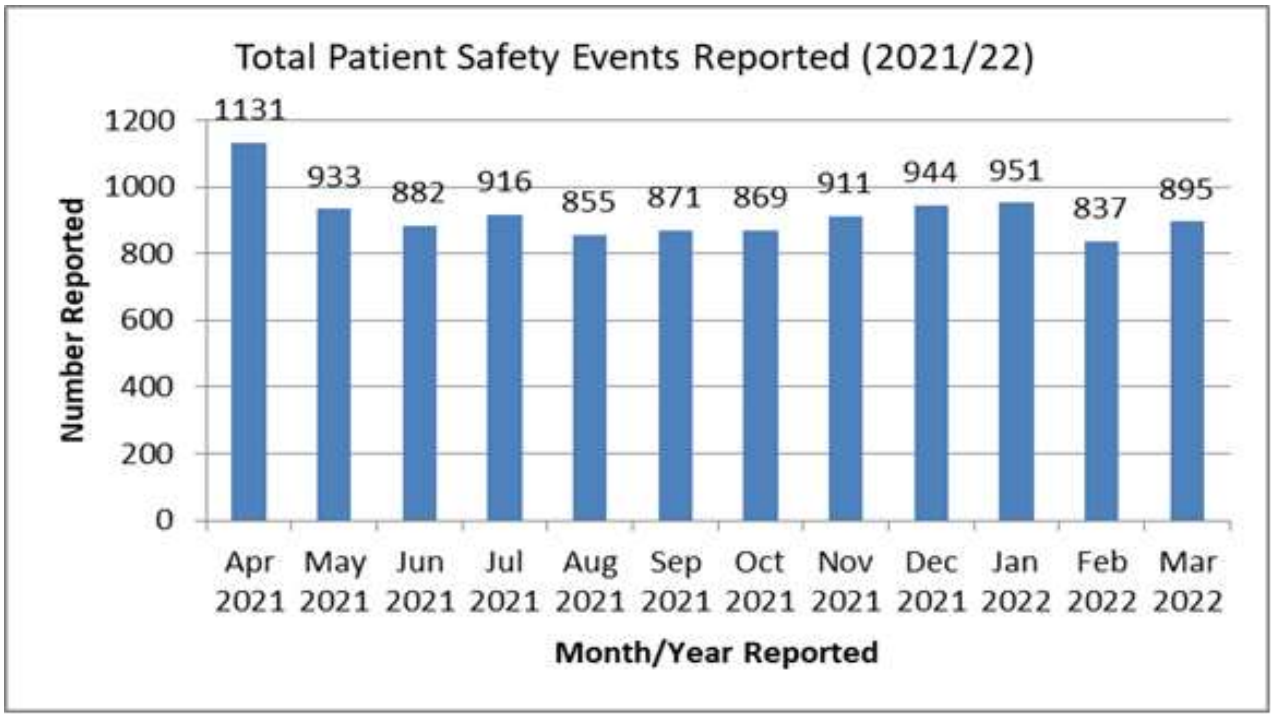
During 2021/22 the Complaints, Litigation, Incidents (safety events) and PALs Report (CLIP) has been re-introduced to ensure triangulation of safety events, learning and improvement across the Trust. The Trust also engages in a West Yorkshire learning forum to ensure learning is shared more widely.

In addition, engagement work is ongoing with one of our partner Trusts, Airedale NHS Foundation Trust, and RLDatix (the supplier), to ensure that Datix is fit for purpose for both Trusts to use for the reporting and learning from safety events.

There were a total of 10,995 patient safety events reported within the Trust during 2021/22, an increase of 989 (9.9%) when compared with the previous year (see figure 20).

There were 23 patient safety events that resulted in severe harm or death. The percentage of patient safety events resulting in severe harm or death was 0.21%.

Figure 20: Total number of patient safety events reported (2021/22)



A five year view of the number of patient safety events resulting in severe harm (figure 21) or death (figure 22) has been provided in the tables below. This is to demonstrate our pre and post COVID-19 patient safety event reporting resulting in severe harm or death which is comparable.

Figure 21: Number of patient safety events resulting in severe harm (2017/22)

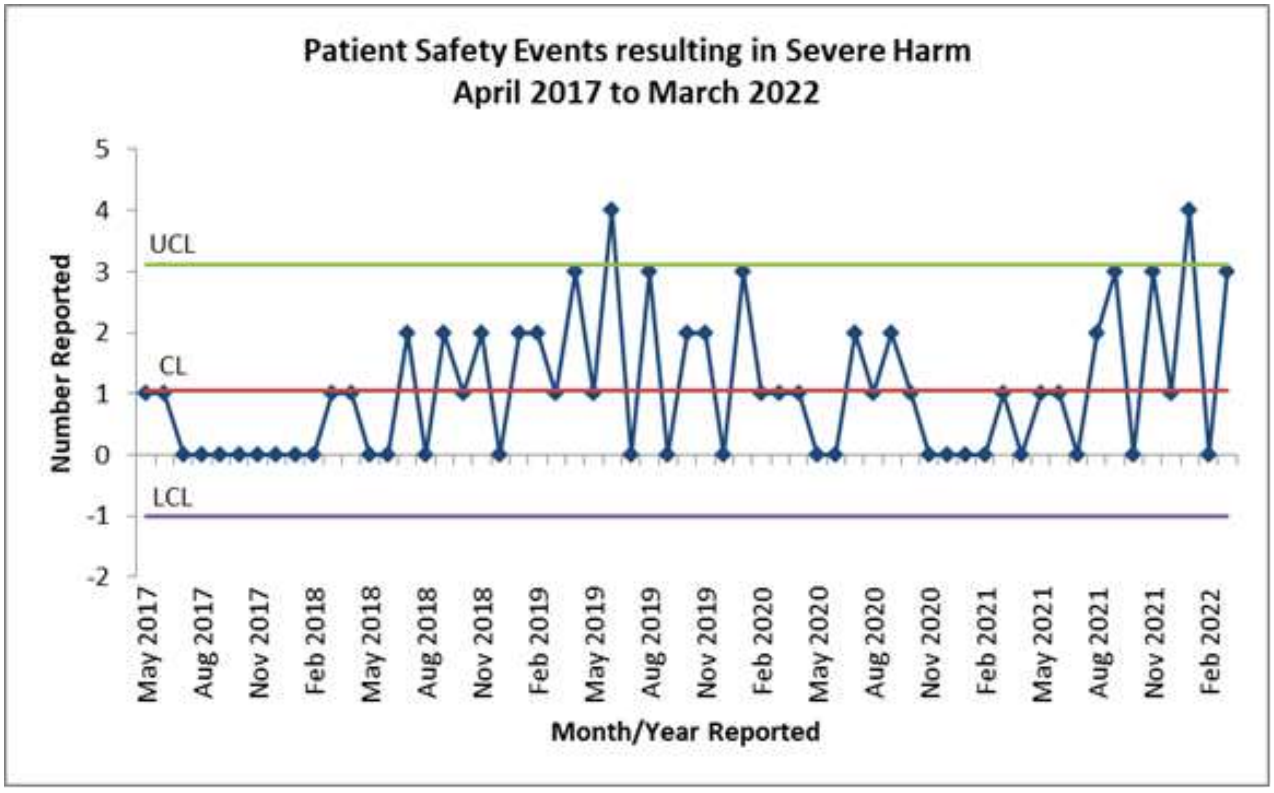
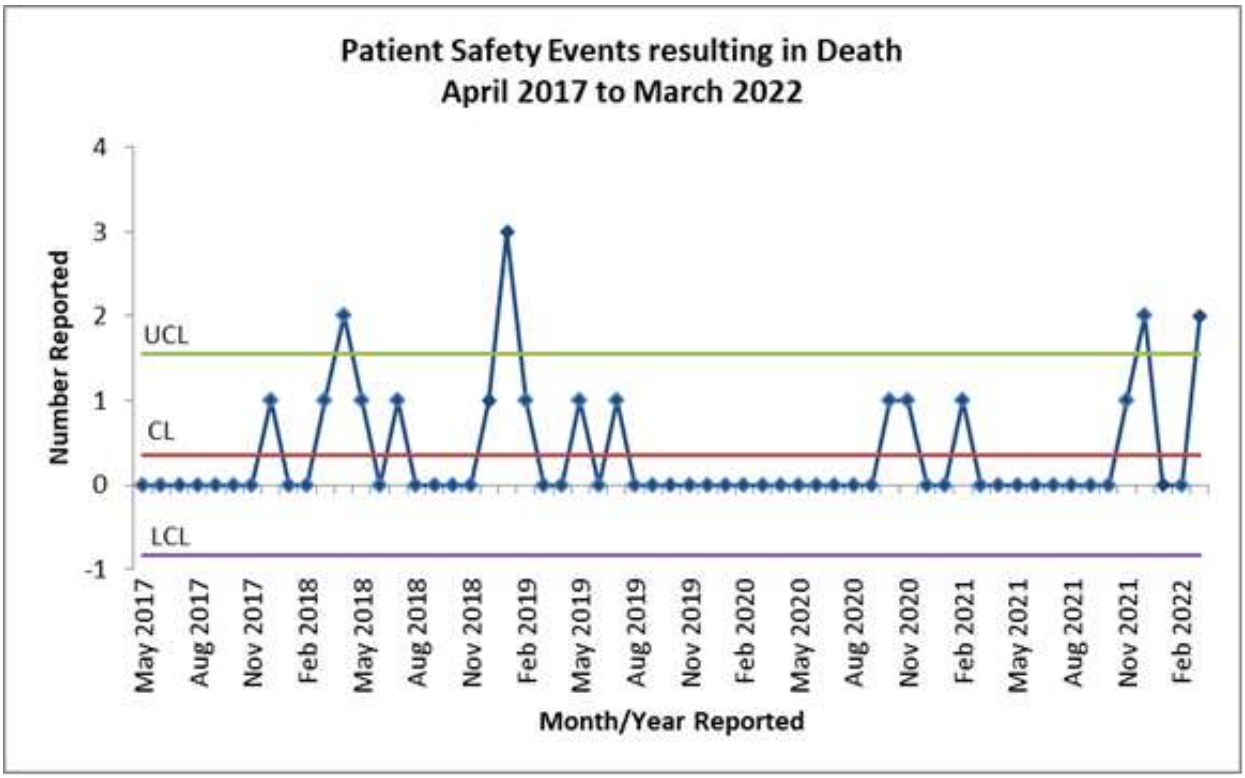


Figure 22: Number of patient safety events resulting in death (2017/22)



Patient safety events resulting in severe harm

There were 18 patient safety events resulting in severe harm (see figure 23 for details).
Nine of the patient safety events relate to falls (this includes patient fall, slip or trip from the same level and fall from height). The Trust has commenced an improvement programme to carry out falls prevention work trust wide (see section 3.1.3).The remaining nine events resulting in severe harm were owing to, delay in diagnosis, Hospital Onset COVID-19 Infection, inappropriate discharge from ED, alleged sexual assault (patient on patient), care and treatment and medication management (see figure 24 for details).

Figure 23: Number of Patient Safety Events by category during 2021/22

Category of patient safety incident	n= number of patients
Delay in diagnosis	n=2
Falls (patient fall, slip or trip from the same level and fall from height)	n=9 Sustained a fracture n=8/9 Sustained a head injury n=1/9
Hospital Onset COVID-19 Infection	n= 1
Inappropriate discharge from ED	n=1 (relates to SI investigation for case x in Table X)
Alleged sexual assault (patient on patient)	n= 1
Care and treatment in total	n=3 in total (n=1 joint investigation with Yorkshire Ambulance Service and n=1 external safeguarding issue)
Medication management	n=1

Patient safety events resulting in death

The total number of reported patient safety events resulting in death was five. Three were declared as serious incidents (SI), with one also meeting the Never Event criteria. One SI investigation has been completed and closed on STEIS (the national reporting system). There are two ongoing SI investigations and two internal investigations at the time of report writing (May 2022).

Figure 24: Reported patient safety events resulting in death

Description of safety incident	Scrutinised by Medical Examiner's Office (ME0)?	Structured Judgement Review requested by MEO?	Serious Incident declared (Yes/No)
1. Sub-optimal care of the deteriorating patient meeting SI criteria.	Yes	Under review by Mental Health Lead	Yes – Investigation ongoing
2. Failure to recognise and respond to a deteriorating patient	Yes	No (Medical Examiner not requested SJR for this patient)	No - This is an internal investigation
3. Medication incident meeting SI criteria	Yes	No	Yes - Investigation completed and closed with commissioner (BDC CCG) 12/04/22
4. Surgical/invasive procedure incident meeting SI criteria and Never Event	Yes	Under review by Consultant Anaesthetist	Yes - Investigation ongoing
5. Unsafe Environment	Yes	Under review by Consultant Nephrologist	No - This is an internal investigation -investigation ongoing

The Trust considers that this data is as described for the following reason; the Trust's internal incident reporting system is available for all employees to access, is checked and verified by the system administrator.

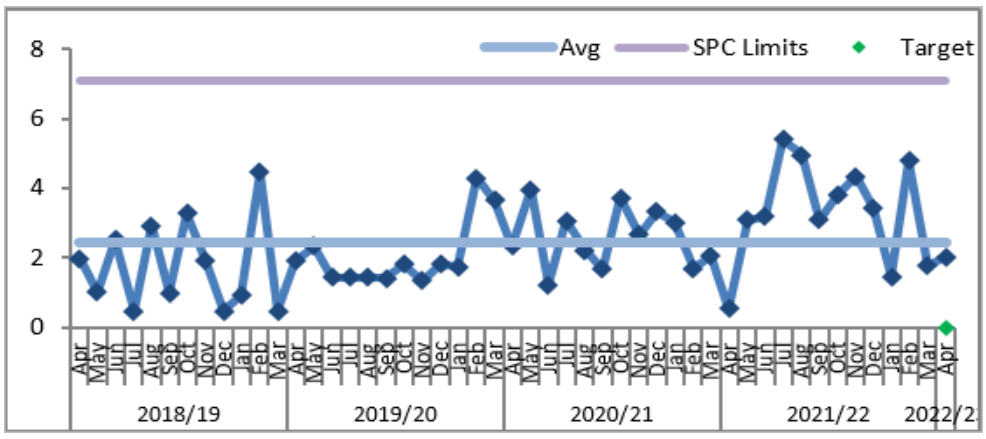
3. OTHER INFORMATION

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, buttocks, 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 25: Pressure ulcer incidence (category 3 and above) during 2021/22



In 2018 NHS Improvement issued new guidance 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, four and unstageable pressure ulcers and deep tissue injuries.

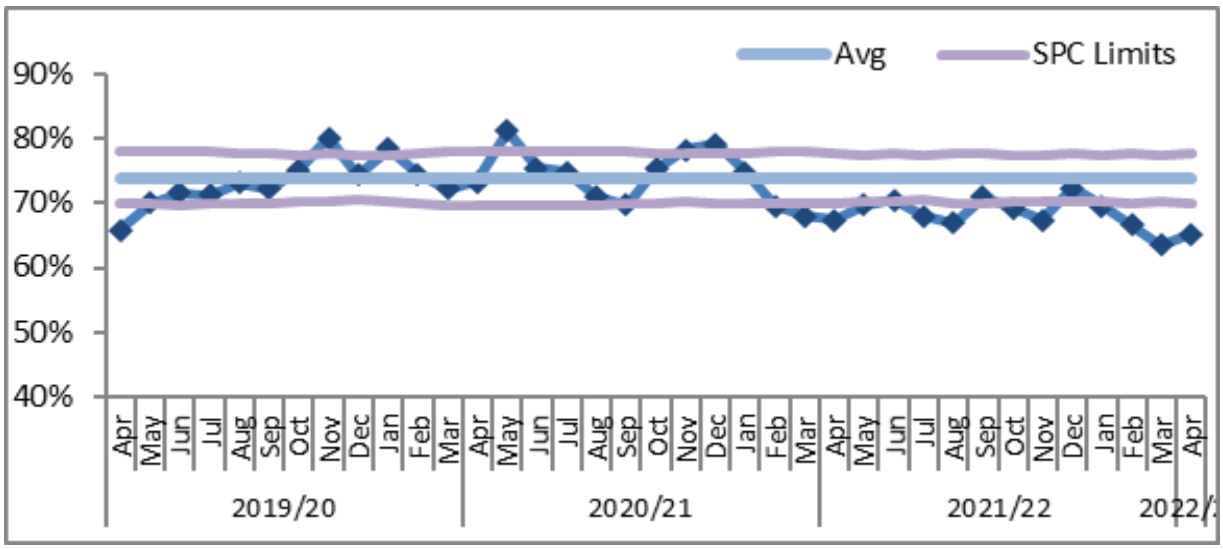
The pandemic has had a negative impact on pressure ulcer incidents. This was in part due to the increased use of medical devices such as tightly fitting face masks used to treat patients with COVID-19 and the severity of the patients' conditions. We continue to focus on improving pressure ulcer prevention 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 2020/2115 and NICE guideline [NG51] Sepsis: recognition, diagnosis and early management. NICE guidance states that treatment should commence within one hour for severe sepsis.

Overall sepsis screening has been sustained at an average of 70% for eligible patients i.e. Emergency Department and all in-patient wards (see figure 26). However, work continues to drive improvement to achieve the 90% target we set in 2020/21.

Figure 26: Patients screened for sepsis from April 2019 to April 2022



The Trust-wide deteriorating patient and sepsis improvement programme remains a priority and is overseen by the Recognition and Response to the Acutely Unwell Patient Group, which in turn reports to the Patient Safety Group.

A number of approaches have been used to drive improvement in the areas identified as requiring more focus and support, for example - education, audit and feedback, clinical ward rounds, weekly data reviews with clinical teams, and small scale quality improvement projects led by some junior doctors.

The Deteriorating Patient Tile which forms part of our suite of electronic tiles in our command centre enables us to use real time NEWS2 scores along with other parameters to help identify early signs of sepsis.

Smaller change ideas that have been tested include:

- a sepsis response trolley in the emergency department (ED)
- introducing more second checkers for intravenous antibiotics in ED
- the development of a screening tool within the electronic patient record (EPR) system
- changing when the screening tool appears on EPR so it pops up when you first enter the patient record and also just before you exit the patient record
- using a behaviour change questionnaire to understand the barriers to completing the screening tool

Our sepsis dashboard was launched in 2020/21 which pulls data form EPR and enables wards and specialties to monitor key outcome and process measures.

Sepsis screening in ED has seen a small reduction through 2021/22 owing to operational pressures on the Urgent and Emergency Care pathway throughout this year. However, sepsis screening across in-patient wards has improved.

Figure 27: Percentage of patients screened for sepsis in the emergency department May 2021 to April 2022

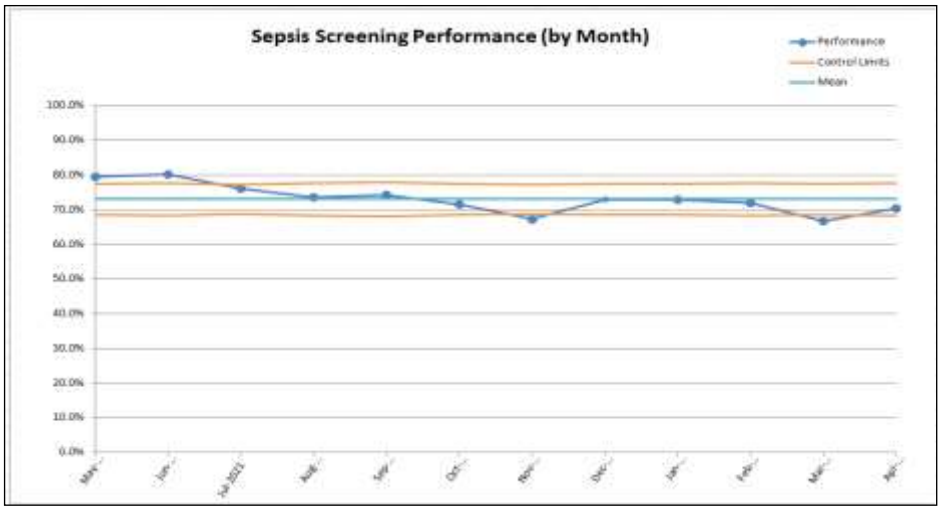


Figure 28: Sepsis screening completed on in-patient wards June 2020 to March 2021

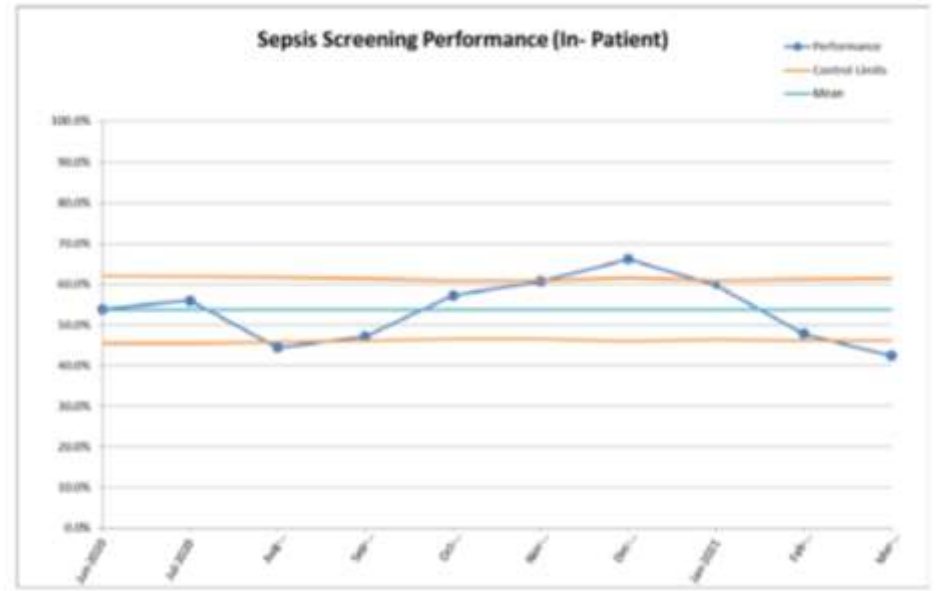
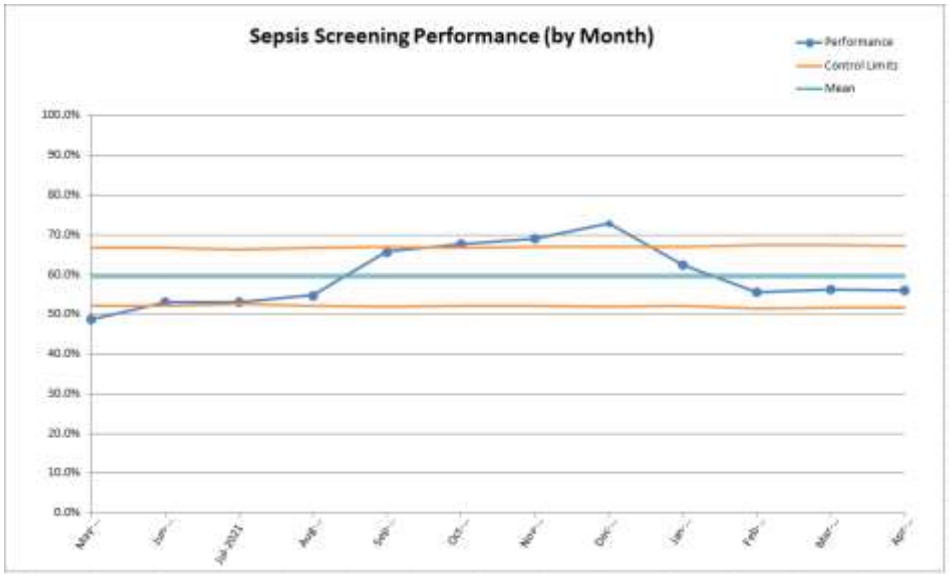


Figure 29: Percentage of patients screened on in-patient wards May 2021 to April 2022



The time to treatment for patients with suspected severe sepsis (antibiotics within a maximum of 1 hour) within the ED and for in-patient areas across the Trust has been consistently achieved for over 85% of patients (see figure 30). This demonstrates an improvement on results from the previous reporting year 2020/21, in terms of an approximate 5% increase and reduced variation in the length of time to antibiotics (see figure 31).

Figure 30: Time to treatment in severe sepsis ED and in patient ward

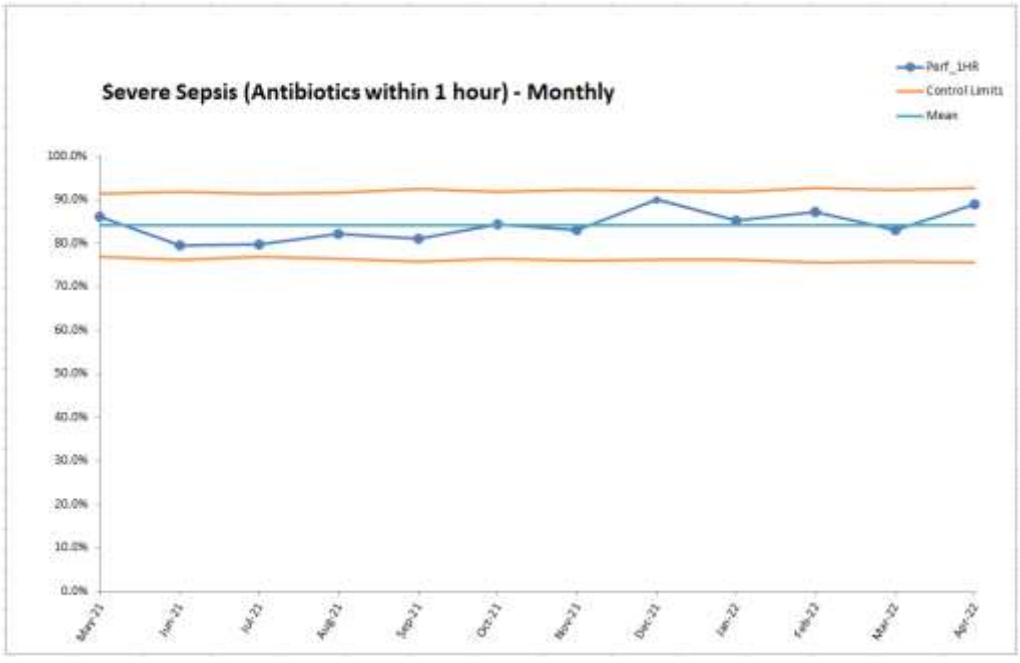
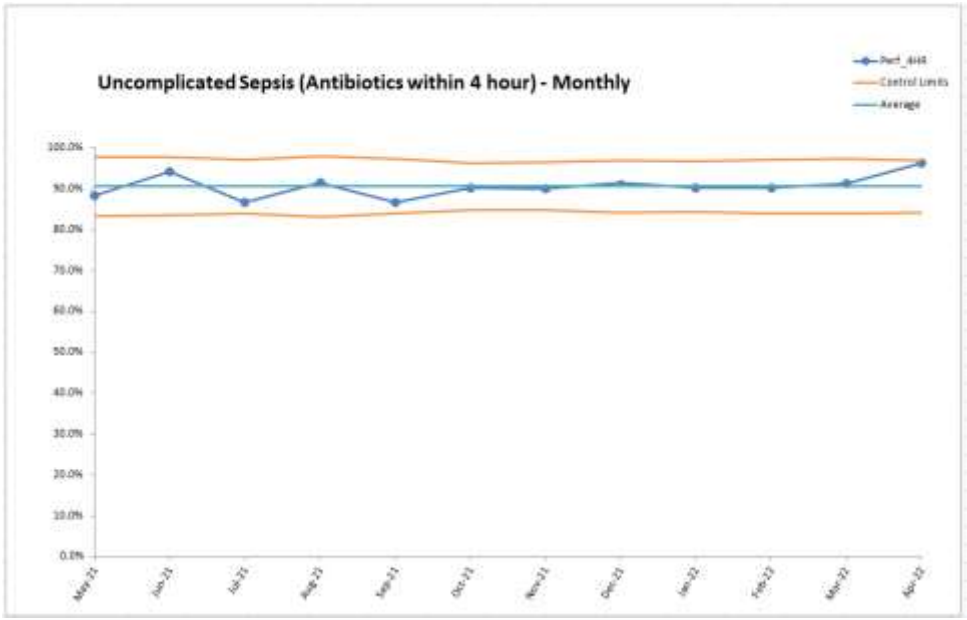


Figure 31: Time to treatment in uncomplicated sepsis ED and in patient wards



Over 90% of patients with suspected uncomplicated sepsis have received antibiotic treatment within the recommended four hour period.

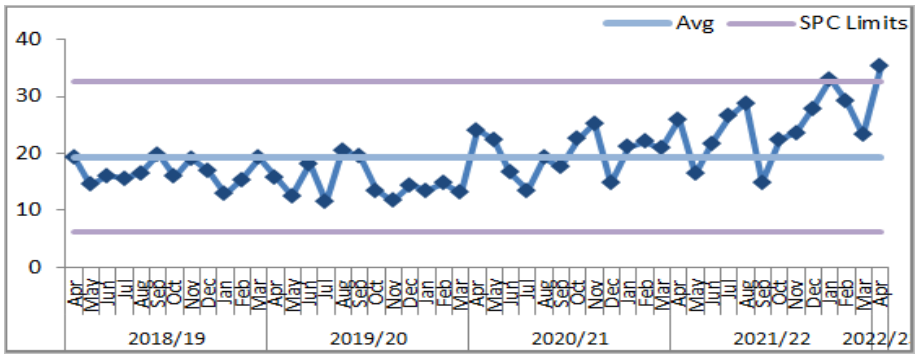
The screening time to antibiotic compliance rate is good and demonstrates that patients are being treated in a timely manner despite the screening assessment tool in EPR not being completed as required. This will be addressed through our improvement programme in 2022/23.

3.1.3. FALLS

This data is collected via EPR and our incident monitoring system (Datix) and is validated by clinical staff. The Trust routinely monitors all 'Falls' incidents that take place within Trust premises. The Lead Nurse for falls routinely reviews all falls that are graded as moderate harm or above.

We have seen an increase in our total numbers of falls over the last twelve months (see figure 32). This is multi-factorial and is partly owing to an increased reporting culture of no and low harms falls. The COVID-19 pandemic has also impacted upon the health and wellbeing population nationally and locally[10]. Patients are presenting with increased frailty as a result of effects of self-isolation, shielding and social distancing.

Figure 32: Total number of in-patient falls over 2021/22



[10] De Biase, S., Cook, L., Skelton, D. A., Witham, M., & Ten Hove, R. (2020). The COVID-19 rehabilitation pandemic. Age and ageing, 49(5), 696-700.

Learning and improvement

Learning from the monitoring and management of falls revealed that we completed risk assessments, care plans initiated and put interventions into place, such as, non-slip red socks and the use of falls alarms. However, 27.5% of falls with moderate harm and above required further investigation following a review by the Falls Panel team (this includes the Deputy Associate Director of Nursing and Nursing and Midwifery Quality Lead). This process for moderate and above harm that was implemented in 2020 is being reviewed and adapted for use with the new safety incident framework (PSIRF) due to implemented nationally in 2022.

Quality improvement (QI) work about falls prevention is being reinvigorated by the Falls Panel team and Quality team. A new QI programme of work is to be launched on the 1 June 2022 trust wide with the aim of reducing all in-patient falls by March 2023.

3.1.4. INDICATORS FOR CLINICAL EFFECTIVENESS

Hospital standardised mortality ratio (HSMR)

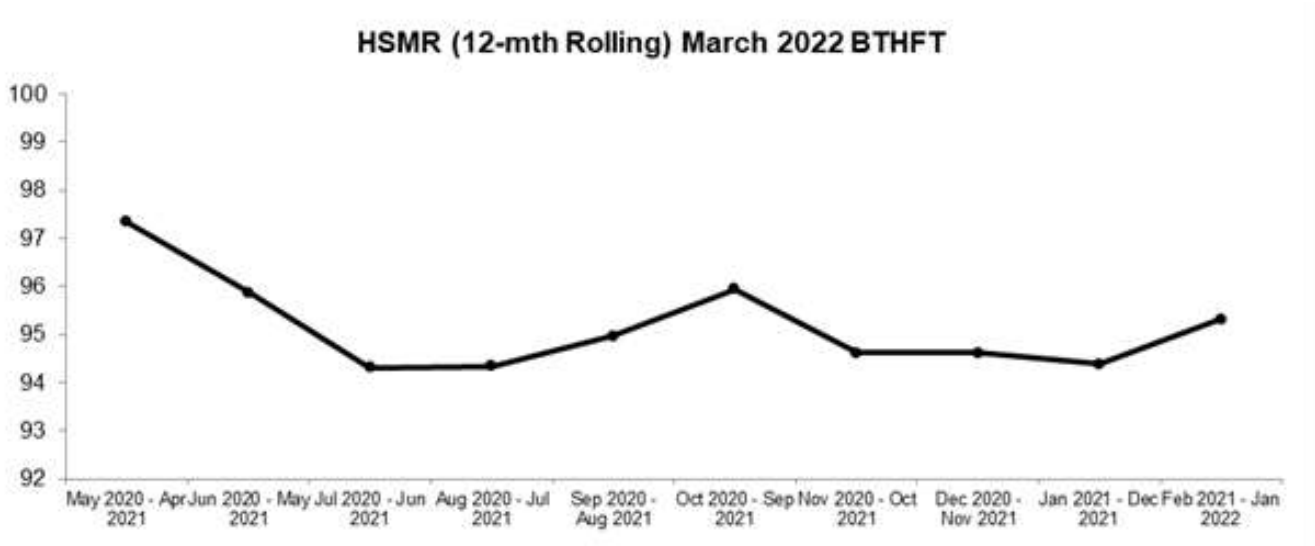
The Hospital Standardised Mortality Ratio (HSMR) is the ratio of observed deaths to the expected number of in-hospital deaths at the end of a continuous inpatient (CIP) spell. A value greater than 100 means that the patient group being studied has a higher mortality level than the NHS average. Unlike the SHMI which is capped at 28 days, the HSMR considers the entire period a patient had continuous inpatient care.

The Trusts HSMR demonstrates that the Trust has remained within expected limits during the reporting period

Figure 33: Hospital Standardised Mortality Ratio data

HSMR 12-month rolling	Indicator Value	Number of Discharges	Number of Observed Deaths	Number of Expected Deaths
May 2020 - Apr 2021	97.34	27,921	838	860.91
Jun 2020 - May 2021	95.87	29,115	846	882.42
Jul 2020 - Jun 2021	94.31	29,994	834	884.31
Aug 2020 - Jul 2021	94.34	30,650	846	896.71
Sep 2020 - Aug 2021	94.97	31,158	855	900.24
Oct 2020 - Sep 2021	95.94	31,485	868	904.78
Nov 2020 - Oct 2021	94.62	31,910	853	901.52
Dec 2020 - Nov 2021	94.62	32,626	860	908.94
Jan 2021 - Dec 2021	94.38	32,987	865	916.47
Feb 2021 - Jan 2022	95.32	33,174	869	911.7

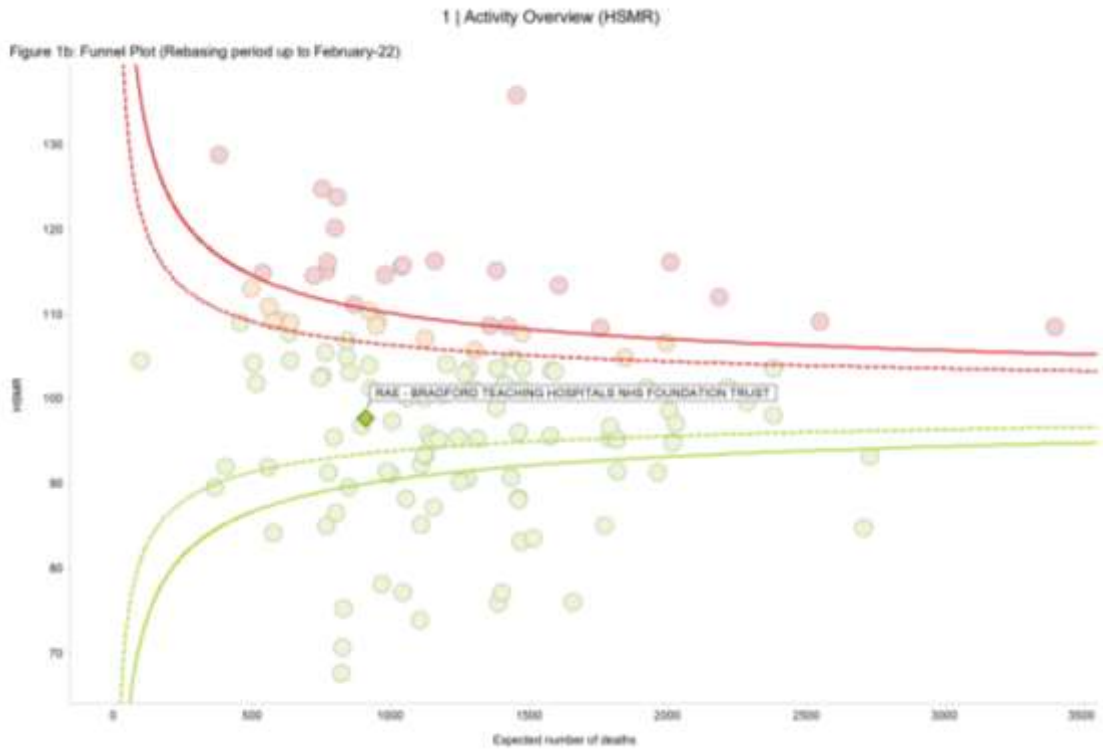
Figure 34: Hospital Standardised Mortality Ratio data



The current available HED data covers a 10-month period from April 2021 to January 2022 with our current HSMR value being 95.32 with our average value across the period being 95.17.

Throughout the period reported our HSMR values show we have been consistently below the national NHS mortality average for patients during their continuous inpatient care. This implies that we have fewer patient deaths than the national average when we consider continuous inpatient care.

Figure 35: HSMR Funnel Plot



The funnel plot shows the Trust's HSMR performance in relation to all other acute hospital trusts.[11]

[11] A value within expected range is marked in green; a value between 90% upper limit and 95% upper limits is marked in Amber; a value above the 95% upper limit is marked in red.

3.1.5. PATIENT EXPERIENCE

Work in relation to Patient Experience has gone from strength to strength over the past year. Some of the highlights are as follows:

- The Embedding Kindness project which evolved from the Patient Experience Strategy has been shared with NHS England receiving National and local interest #embeddingkindness.

- Strong links with our new Organisational Development Team has enabled us to develop our thinking around civility in the workplace and wellbeing in relation to kindness. Patient Experience have representation at the Workplace Civility Board to ensure that key messages and work streams work alongside and complement each other.

- Work with the national group Ageing Without Children (AWOC) has resulted in a 'Kindness Conference' being planned later this year.

- The SPaRC service (formerly 'Chaplaincy') has received national recognition and awards for their pioneering new model of working.

- The public engagement forum set up with individuals across Bradford District and Craven. A safe space to have honest conversations about the experiences of care and how these can be improved.

- The Trust has been working towards obtaining Veteran Accreditation status, planned for summer 2022.

This rewarding and exciting work has led to national nominations for Leadership awards for members of the Patient Experience team.

During the past year the Trust's approach to spiritual support has also been reviewed. This has enabled us to consider how we care for all. The new Bradford model SPaRC (Spiritual, Pastoral, and Religious Care) focuses on collaborative working with patients and their families and becoming part of the wider hospital team. The model is underpinned by 7 anchors:

- Equality
- Person Centred care
- Belief Based care
- Spiritual and reflected Spaces
- Collaborative practice
- Professional Practice and Data
- Data and Organising

The model has been well received by staff and patients and has received regional awards, generated national interest including the NHS England Review Committee who consider our model as an example of inclusivity. The SPaRC team, in collaboration with the University of Bradford, have also developed an IT Application for staff and patients. This provides a plethora of resources and information and is due to be launched in spring 2022.

The patient and public involvement team continue to work on a number of projects to enable positive engagement to take place and changes to be made as a direct result of feedback. For example, working with partner agencies to gain feedback from service users with Special Educational Needs (SEN) in our community paediatric department. We are also working with our local Healthwatch team regarding service users' experience of virtual appointments and contributing to Bradford Councils stakeholder group for people with visual and hearing impairment visiting our sites to enable future improvements to be made.

By far the most complex and impactful area of patient experience has been the restriction of visitors. The Patient Experience Team has worked in partnership with communities and the infection prevention and control team to enable the least restrictive visiting measures. Although visiting has still been restricted for the majority of patients, we have maintained visiting for patients with additional need, children, maternity services and end of life patients.

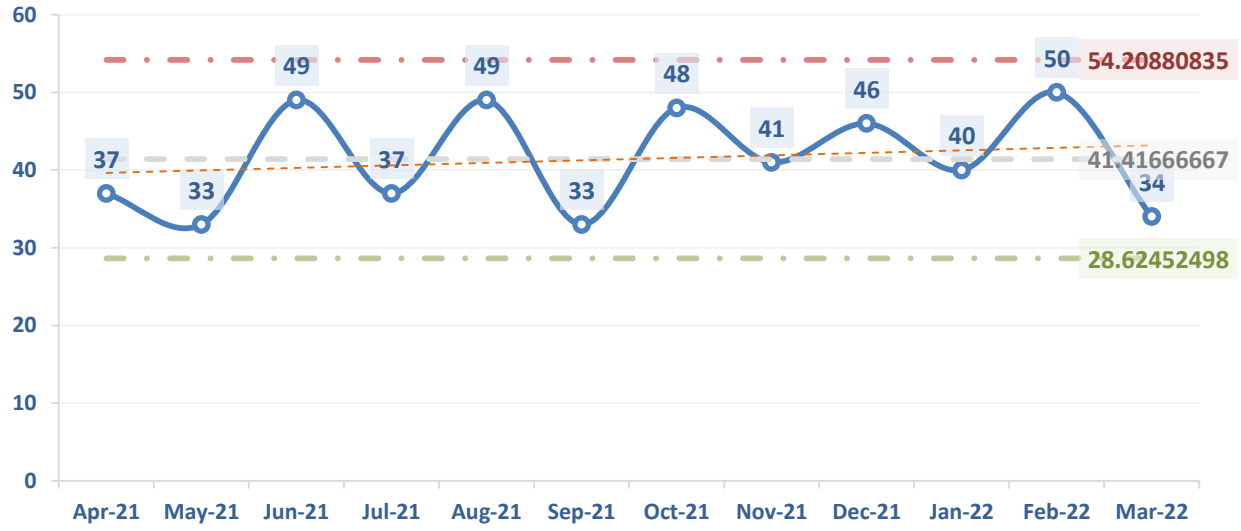
By listening to our communities we also brought in further measures to help and assist members of our community who did not speak or understand English, by allowing a family member to be present with them whilst in hospital.

We have further reviewed visiting restrictions anticipating that all patients will have at least one visitor per day in early 2022/23.

Complaints

The Trust has seen an overall 19% increase in complaints received from the previous financial year, from 404 up to 497 annually. See figure 36 below

Figure 36: Complaints received during 2021/22 compared with the national data

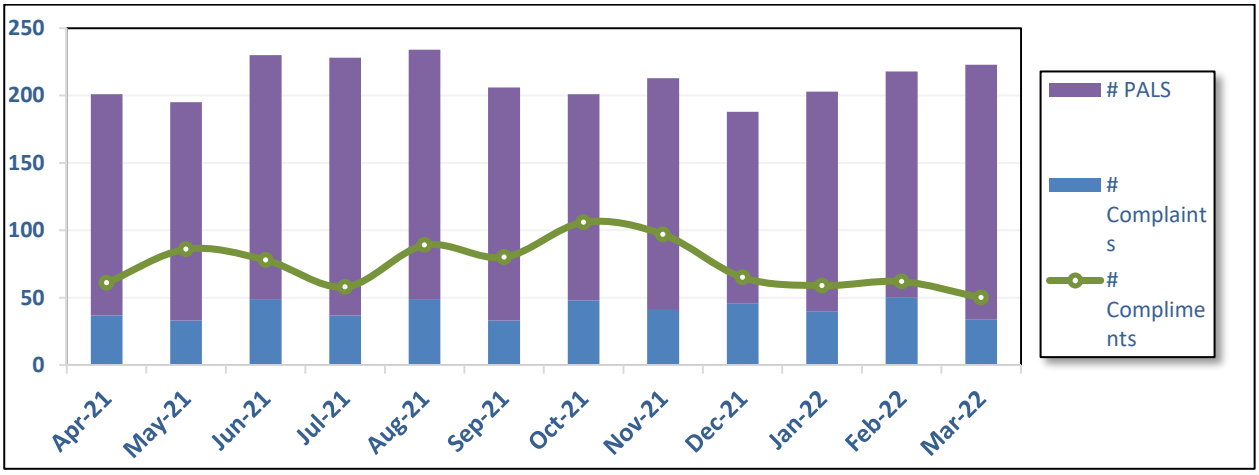


The themes and trends of complaints received within the Trust sadly reflect the same themes received nationally which include communication, patient care, specifically nutrition and hydration and values and behaviour.

The Trust has also received more than a 25% increase in the number of PALs contacts during 2021/22, to a total of 2,044. At the time of writing, all have been resolved with the exception of a few.

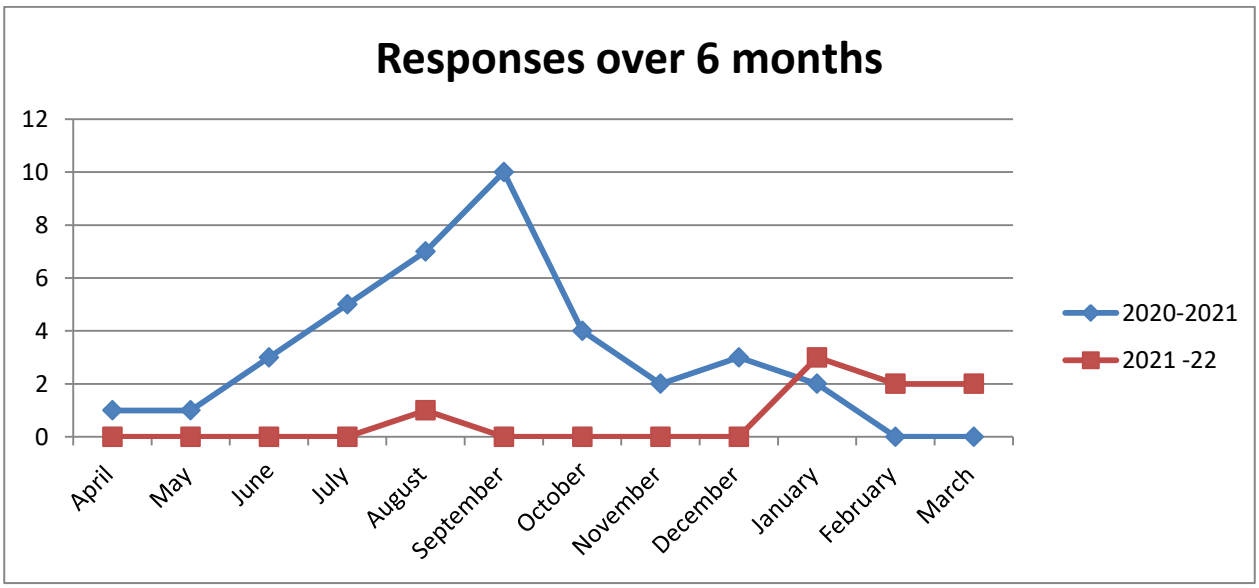
Figure 37 below provides the Trust overall figures of Complaints, PALs and Compliments received within the Trust.

Figure 37: Overall view of Complaints, PALs and Compliments received in 2021/22



One of the key objectives of the central complaints team was to track and ensure that the Trust minimised the number of complaints that were responded to beyond 6 months from receipt, to align with national recommendations and Trust policy. Figure 38 highlights a steady position of maintaining near to zero complaints over 6 months up until January where clinical demands and challenges relating to COVID-19 led to delays. This equates to less than 2% of the overall total number of complaints processed. Figure 2 represents the number of responses over 6 month time frame for complaints to be completed.

Figure 38: View of responses made beyond 6 months of receipt of complaint 2021/22



Complainants are entitled to take any unresolved concerns they may have to the Parliamentary and Health Service Ombudsman (PHSO) for further independent review once they have exhausted local resolution and received two written responses from the Trust in relation to their complaint. During 2021/22 the Trust received 10 cases with the following outcome:

- 6 PHSO decided not to investigate.
- 1 PHSO partly upheld.
- 3 still awaiting outcome from the PHSO.

4. ANNEXES

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

4.1.1. STATEMENT FROM NHS BRADFORD DISTRICT AND CRAVEN CCG

June 2022

NHS
Bradford District
and Craven
Clinical Commissioning Group

Scorex House
1 Bolton Road
Bradford
BD1 4AS

Tel: 01274 237290

The Bradford Teaching Hospitals Quality Report Accounts 2021/2022

On behalf of NHS Bradford District and Craven CCG, I welcome the opportunity to feedback to Bradford Teaching Hospitals on its 2021/22 Quality Report.

The Quality Account has been shared with key members across the CCG and this response is on behalf of the organisation.

In March 2020, the Covid-19 pandemic caused extraordinary challenges for global health and care systems. Bradford Teaching Hospitals found innovative ways to work in partnership to address these challenges. Evidenced through the ability to adapt proactively to rapid changes and new ways of working, the highly successful “Virtual Royal Infirmary” programme was established, this led to virtual care national awards for Children’s and Care of the Elderly services.

Despite the significant challenges the Trust has experienced with the Covid-19 pandemic, there has been progress with improvements in 2021/22, there is continued commitment to;

- Tackling health inequalities across Bradford through strengthened links with communities and active service user engagement.
- The Maternity Voices Partnership listening to women’s experience of childbirth to improve maternity outcomes.
- Scientific breakthrough ‘Cov-Boost study’, the first to provide vital data on the impact of a third dose of Covid-19 vaccine.
- Support urgent and emergency care, leading to the Health Service Journal citing the Trust as the most improved hospital from 2018 to 2020.
- Receive national recognition and nominations for the patient experience team projects.

Review of achievements 2021/22

There is continued commitment to drive improvements in the following four priority areas during 2021/22:

- Priority 1:
  - Applied Learning and quality improvement initiatives to help inform the spread and successful adoption of the Patient Deterioration Tile across 19 wards.

- Priority 2:
  - 'Embracing Kindness' 60 kindness awards given out for a variety of initiatives.

- Priority 3:
  - Full compliance with Saving Babies Lives Care Bundle Version 2
  - Reduction in stillbirths, with an adjusted rate of 5.6 per 1000 births 2020, to an adjusted rate of 4.2 per 1000 births 2021.
  - One-to-one care in labour rates consistently above 90%.
  - Achieving the Midwifery Continuity of Carer (MCoC), despite challenges with national midwifery staffing shortages

- Priority 4:
  - Early successes in reducing health inequalities in relation to Covid-19 vaccine uptake and the development of tools in different languages and pictograms.
  - A bespoke post to focus on health inequalities in relation to vaccine uptake.
  - Commitment at place to the 'Act as One' programme, focusing on tackling inequalities across the wider system.

Additional improvements have included:
- Commitment to achieve a high level of Digital Maturity, with the ambition to progress towards level 4 during 2022/23.
- 100% compliance with the national clinical audits and national confidential enquiries with a continued commitment to the quality and oversight for 2022/23

Areas to consider in future quality accounts:
- Healthcare associated infections (HCAI), information pertaining to MRSA, MSSA & E.Coli data together with a clear strategy for HCAI in 2022/23.
- Safeguarding both adults and children

Priorities for 2022/23 have been rolled forward to ensure continued improvement and include:
- Adoption of Patient Deterioration Tile, widely across the Trust for 2022/23.
- Increase the sepsis screening tool compliance to 90% for 2022/23.
- Maternity priorities expanded to include compliance against Ockenden Standards for 2022/23
- Expansion of the Outstanding Maternity Services programme to include neonates for 2022/23.
- Continued commitment to the implementation of the 3-year Equality Diversity and Inclusion strategy.
- Learning and improvement from the structured judgement reviews (SJRs) to continue into 2022/23
- New Quality Improvement programme of work to be launched on the 1 June 2022, aiming at reducing in-patient falls by March 2023.
- Adapting the current incident reporting system to meet the new requirements of the Patient Safety Incident Response Framework (PSIRF) from April 2023.
- Continued focus on improving pressure ulcer prevention through quality improvement methodology in 2022/23.
- Continued focus on still birth reductions, working towards the national ambition and 'halve it' trajectory
- Focus on reducing falls for 2023

- Minimise the number of complaints that are responded to beyond 6 months.

Together with significant ambitions for quality improvement the Trust is formulating recovery plans to achieve the ambitions for tackling the Covid-19 backlog of elective care whilst managing the impact of Covid-19 on in-patient services and staff wellbeing.

I confirm that the statements of assurance have been completed demonstrating achievements against the essential standards.

Finally, I am required to confirm that NHS Bradford Districts and Craven CCG has reviewed the Quality Account and believe that the information published provides a fair and accurate representation of Bradford Teaching Hospitals quality initiatives and activities over the last year.

I can also confirm that the NHS Bradford Districts and Craven CCG has taken reasonable steps to validate the accuracy of information provided within this Quality Account and can confirm that the information presented appears to be accurate and fairly interpreted; the Quality Account demonstrates a high level of commitment to quality in the broadest sense and we support the positive approach taken by the Trust.

Yours sincerely

Helen Hirst
Chief Officer
Bradford District and Craven CCG

4.1.2. STATEMENT FROM HEALTHWATCH BRADFORD AND DISTRICT

June 2022

Healthwatch Bradford and District welcomes this opportunity to comment on the Bradford Teaching Hospitals NHS Foundation Trust Quality Report for 2021/2022.

As the independent champion for people using health and care services, we welcome the work to ensure the voices of patients and service users are heard, despite the ongoing difficult circumstances imposed by the COVID-19 pandemic and its legacy. Once again we recognise the commitment to the continued delivery of excellent services for the citizens of Bradford.
We're especially pleased to see the continuation of 'Improved Patient Experience' as a Trust priority.

The ongoing commitment to listening to patients' and service users' experiences is welcomed, because we know that high-quality feedback is the key to understanding the crucial details of the issues faced by those accessing services. We look forward to ensuring that the voices of those who share their views and experiences with Healthwatch are heard and that their feedback leads to meaningful improvements.

We welcome Healthwatch Bradford and District's membership of the Trust Community Engagement Group alongside our regular meetings with the quality and patient engagement leads. This is representative of our respectful and positive relationship with the Trust. We are able to have open and honest conversations around people's experiences of services – both directly and through robust challenge on both Bradford Council's Health and Wellbeing Board and the Health and Social Care Overview and Scrutiny Committee.

The improvements made to neonatal and maternity services are recognised, as is the commitment to their continued improvement via the design and implementation of the Outstanding Maternity Services initiative and the continued reduction in stillbirths as a recurring Trust priority.

We are interested in the development of the Virtual Infirmary and are working with the Trust to involve people in its design, to ensure the service meets the needs of all stakeholders.

We are grateful to Bradford Teaching Hospitals NHS Foundation Trust staff for their hard work amid unprecedented demand for services, and welcome the Trust's focus on their health and wellbeing. We know that it's vital for patients and service users that staff feel well and able to do their jobs to the best of their ability.

Healthwatch Bradford and District commends the leadership of the Trust for their commitment to continued improvement and looks forward to a continued relationship of trust and challenge.

Helen Rushworth, Lead Officer
Healthwatch Bradford and District

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

June 2022

Bradford Metropolitan District Council (BMDC) Health and Social Care Overview and Scrutiny Committee (HSCOSC)has advised the Trust that it has opted not to provide comments on the 2021/22 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 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 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
June 2022

Professor Mel Pickup
Chief Executive Officer
June 2022