

Quality Account

2018/19



Together, putting patients first

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PART 1: STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

Thank you for taking the time to read our 2018/19 Quality Account. I hope it reflects how immensely proud we are of our achievements during the year.

Our mission is to provide the highest quality healthcare at all times, supported by our vision to be an outstanding provider of healthcare, research and education and a great place to work.

Despite the challenging financial environment we have focused our resources and actions on delivering safe, effective, caring, responsive and well led services for our patients. This is echoed in our Board Risk Appetite Statement, which underpins our approach to managing risk.

In this Quality Account we describe how we have performed as a Trust, in relation to local and national priorities, including the progress we have made with our Quality Priorities for 2018/19. We also describe our Quality Priorities for 2019/20, and will present our progress against these in next year's Quality Account.

In particular, this year, we have further developed our Electronic Patient Record, which we first implemented in September 2017. We have implemented a range

of tools, alerts and assessments, which support the effective identification and management of sepsis, the effective implementation of the NEWS2 (National Early Warning Score), the effective assessment of risk of Venous-thromboembolism (VTE), and effective medicines management. Our digital strategy, "*From digital to virtual*", launched during 2018/19, describes our ambitions to use digital technology to support continuous improvement in the quality of care we provide.

"*Embracing Kindness*," our patient experience strategy, was also launched during 2018/19. It sets clear expectations for the way that our staff interact with our patients. We listen to those who have had a poor experience of care in our services, to learn how we can make improvements, and we are looking forward to implementing the opportunities for improvement in 2019/20 and beyond.

Between January 2018 and February 2018, the Care Quality Commission (CQC) inspected four of our core services: urgent & emergency, maternity, medical & services for older people, and surgery. They also carried out a "well-led" inspection (CQC have identified a strong link between the quality of overall management of a Trust and the quality of its services).

PART 1

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

Overall, inspectors rated our Trust as “Requires Improvement,” rating us “Good” for being caring and well-led, and “Requires Improvement” for being safe, effective and responsive. We were particularly pleased to receive an overall “Good” rating for the well-led domain, reflecting significant improvements we have made in relation to staff engagement and the core governance of our organisation.

No element of any of our services was “Inadequate” and we did not receive any warning notices. As with our previous inspection, there are examples throughout the CQC’s report where inspectors observed good and outstanding practice and compassionate care by our staff. They heard feedback from patients that staff treated them with kindness and provided emotional support to minimise their distress. Overall, we think that the CQC’s assessment of the services it inspected was accurate, balanced and fair, and we look forward to the opportunity during 2019/20 for a number of our services which have not been inspected since 2016 to be reviewed, and a fresh assessment made to reflect the many improvements since then.

In September 2018 we accepted a fixed penalty fine for a breach in the Duty of Candour in 2016, which we had identified and reported ourselves. We had informed a family that a notifiable incident had been identified, but we did not provide them with a timely written apology, and we regret the additional distress that this caused. When the breach was identified we undertook a review of the systems and processes we had in place to assure our compliance with the regulation, and we have not reported any further breaches in our Duty since then.

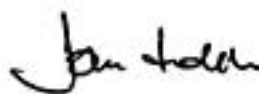
In January 2019 Professor Bill McCarthy, our Chairman, left the Trust to be the North West Regional Director for NHS Improvement. We look forward to

consolidating his legacy with our new Chairman, Dr Maxwell Mclean, who joined us in May 2019.

At the end of March 2019, Professor Clive Kay, our then Chief Executive, left the Trust to begin a new role at Kings College Hospital, London. I am therefore writing this summary as Acting Chief Executive, and on behalf of the leadership team in place during 2018/19. The year was not without its challenges, and I am proud that despite the pressures we faced, we have continued to receive positive feedback from patients and carers, and we continue to fulfil the requirements of NHS Improvement’s Single Oversight Framework.

To the best of my knowledge and belief the Trust has properly discharged its responsibilities for the quality and safety of our care, and the information presented in this Quality Account is accurate.

Signed



John Holden

Acting Chief Executive

24 May 2019

PART 1

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE



PART 1.1 BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST ACHIEVEMENTS IN 2018/19

- **New clinic provides on-the-day results:** Our Urology specialists redesigned the way in which patients with blood in urine are clinically reviewed and investigations undertaken. The new one-stop-shop clinic has sped up the process, saving patients from anxious waits for test results.
- **New CT scanner arrives:** We welcomed the arrival of a brand new £700,000 CT scanner in Radiology. The machine strengthens our scanning capabilities by producing higher quality images and being able to perform more complex scans.
- **Working better together:** We put our Trust's values into action across all our wards and departments with the launch of our first Work As One week – which explored how we could all work better together to improve the flow of patients through, and out of, our hospitals.
- **Royal College recognition:** Our Postgraduate Medical Education Team was presented with a plaque by the Royal College of Physicians London – in recognition of our help in running its prestigious medical exams. It marked a rare double for the team as it is already in possession of a similar award from the Royal College of Physicians Edinburgh.
- **Project SEARCH scoops top prize:** Our terrific team of colleagues involved in Project SEARCH scooped a top accolade in the Healthcare People Management Awards for cross-sector working, helping young people with learning disabilities gain vital on-the-job work experience ahead of finding employment.
- **New clinic brings rapid treatment:** Patients with suspected inflammatory disease were able to access rapid assessment and treatment thanks to a new Early Arthritis Clinic launched at St Luke's. The one-stop clinic brings together a range of different healthcare professionals to offer this unique service.
- **Major step forward in stroke care:** One of our stroke patients, became the first in the country to have been admitted to his local hospital, moved to the regional centre (in Leeds) for a new procedure to remove a clot from the brain called mechanical thrombectomy, and then safely transferred back to our care – all within nine hours. Consultant Stroke Physician Stuart Maguire hailed the new pathway a major step forward.
- **NHS celebrates 70th anniversary:** Our celebrations got into full swing thanks to the wonderful children's choir of Gillingham Primary School. The pupils, all of whom are deaf or hearing impaired, sang and signed renditions of three songs, including taking us back to the 1940s with the classic Run, Rabbit Run.
- **National award for 'trail blazing' project:** Head Orthoptist, Dr Alison Bruce, was awarded the Council for Allied Health Professions Research (CAHPR) Public Health Research Award for her work exploring the effect of reduced vision on literacy. Alison led the largest-ever study of its kind into the effect of children's sight problems on reading skills.

- **New flagship research centre:** Building work started on a new flagship research centre at Bradford Royal Infirmary which will spearhead improvements to the health and wellbeing of children and elderly people. The £3m Wolfson Centre for Applied Health Research is set to open in 2019.
- **Top prize for student:** Desiree Deighton, a third-year student nurse in our neonatal unit, won a top prize from the Royal College of Nursing for her "Safe Baby" booklet. She developed the guide to support parents when their babies are discharged from the unit and give advice on how to promote safe sleeping.
- **Improving care for women with bladder problems:** A new outpatients' clinic has transformed care for women with bladder problems by offering cystoscopy, a procedure in which a thin viewing tube goes into the bladder, as an outpatient appointment instead of an operation under general anaesthetic.
- **From the airwaves to the internet:** Forty years since its launch, radio station St Luke's Sound went digital. Its DJs and presenters – all volunteers – unveiled its first-ever streaming service, opening it up to listeners all over the world on the internet.
- **Building Europe's first AI hospital command centre:** We announced the launch of our very own Command Centre, using unprecedented real-time data from across our hospitals to unblock bottlenecks and improve patient flow – the first Trust in Europe to do so. The Command Centre will transform how care is delivered by reducing unnecessary delays in the patient journey and reducing pressure on staff.
- **National prize for patient safety:** Our Emergency Department team won a national prize for its work on improving the care of deteriorating patients. The King's Fund awarded us its Patient Safety Learning Award, which was received on behalf of the whole department by Consultant in Emergency Medicine, David Robinson.
- **ACE team crowned champions:** Winning in the world's largest healthcare awards was a fitting tribute to the skills of our Children and Young Persons' Ambulatory Care Experience (ACE) Team. It was crowned champion in the Improvement in Emergency and Urgent Care category in the HSI awards. Launched just a year ago, the service brings care to young patients in the comfort of their own home, and prevents unnecessary admissions to our hospitals.
- **EPR system marks its first birthday:** Hailed as the "most complete go-live" switch-on by our technology partners, Cerner UK, our electronic patient records (EPR) system has transformed the way we work forever and helped to develop a sense of togetherness and common purpose.
- **Women's and Newborn Unit gets a makeover:** The £1.8m transformation of our Women's and Newborn Unit was completed. The building has an attractive new look and is more comfortable and welcoming for our staff and patients – with a raft of energy-efficient measures included too.
- **On the road to surgery:** Children undergoing treatment at Bradford Royal Infirmary (BRI) are now able to drive themselves to the operating theatre thanks to the generous donation of a mini electric car by the Tesla Owners Group.
- **Hospital charity has a big impact on patients:** Bradford Hospitals' Charity – the official NHS charity partner of Bradford Teaching Hospitals NHS Foundation Trust – spent £1.2 million on a number of high profile projects. From hospital equipment to items which improved quality of life, toys for our younger patients to events which supported patients and their families – the charity funded extras which had a big impact on patients and were over and above what the NHS provides.

PART 2: PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

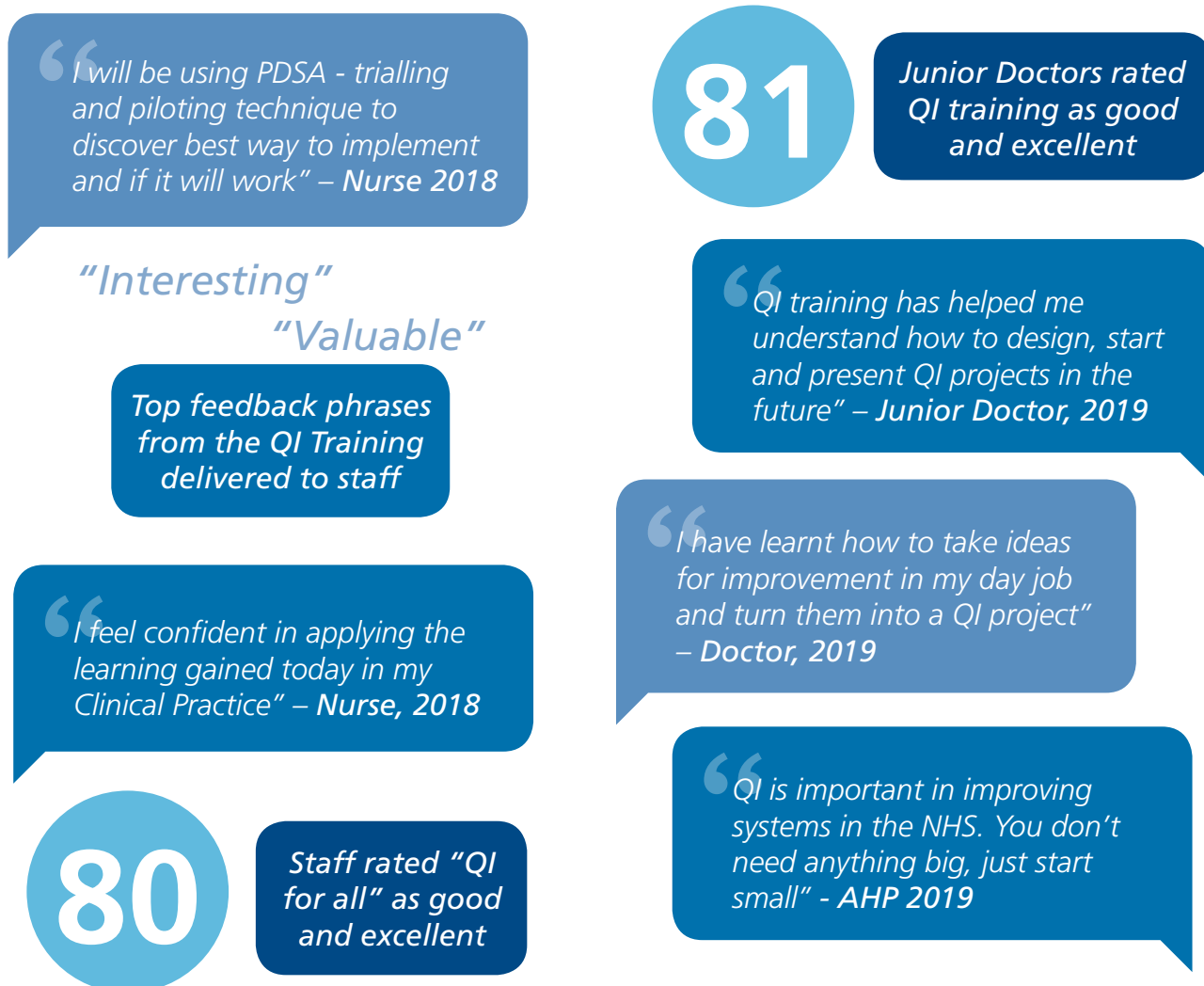
2.1 PRIORITIES FOR IMPROVEMENT

Significant improvement has been made for improving quality over the last year at the Trust. We want to continue to make sure we provide the best possible healthcare

and services to our population which are: Safe, effective, caring, responsive and well-led.

We believe quality improvement (QI) is everyone's business and creating a culture, environment and enthusiasm for ensuring it is part of everyday work is crucial. Staff have embraced Quality Improvement which has been reflected in part 1.1: Trust Achievements 2018/19. Feedback from our staff demonstrates how Quality Improvement is the future for providing the best possible healthcare and services to our population:

Figure 1: Quality Improvement: feedback from staff



Ensuring our staff, services, leadership and culture have Quality Improvement running throughout requires capability and capacity building. We are committed to ensuring we equip our staff with the skills, experience and

resources to carry out Quality Improvement as part of daily practice.

Figure 2 demonstrates some of the achievements made last year that help to ensure we provide the best possible healthcare and services.

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Figure 2: Quality Improvement Achievements 2018-2019



**23%
reduction**

In the time taken to discharge patients as part of the Pharmacy Technician QI project



Patient's Own Medicine lockers secured as part of medication safety



100%

Of learning disability deaths have been reviewed using the Structured Judgement Review (SJR)



287

Back to basics in care pledges have been made by staff



15%

Reduction in inpatient falls as part of the QI Falls Collaborative



3600+

Patients up and dressed/mobilising as part of the End PJ Paralysis campaign

'Keep me safe Keep me warm' campaign launched to ensure babies are kept at the right temperature.



NEW



24-hour Maternity Assessment Unit opened - direct access area for women to contact/ come to if they are experiencing/suspecting reduced foetal movements.



50+

Staff engaged in the QI Falls collaborative



NEW

Recruitment of the Sepsis Nurse Specialist



292

staff members trained in back to basics over 25



450

Red bags have been issued to over 100 nursing homes as part of improving patient's pathways when they come into hospital



30

PRASE volunteers recruited and trained to deliver the PRASE questionnaire to



Award Winning

RCN award winning "safe baby" book – reducing sudden infant death syndrome



Significant

improvement in the number of patients screened for sepsis



First

The neonatal unit is the first in the UK to receive baby friendly accreditation



**50%
reduction**

In 83% of women in the delay during induction of labour



50

Staff members involved in the "Make A Change Heroes" improvement community

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD



88

One of the lowest Hospital
Standardised Mortality
Ratio in our region



Staff members
successful in
completing the
improvement
Science for
Leaders
training
programme



**50%
reduction**

In grade 2 pressure
ulcers on the wards
involved in the pressure
ulcer collaborative



We are part of
NHS Quest
Improving
Theatre Safety
Culture
Clinical
Community



3

Trust wide improvement
collaboratives: Falls,
safer procedures &
Deteriorating patients



59

staff members
engaged in
Improvement
Academy QI Training



**11%
reduction**

In the number of cardiac
arrest calls as part of the
deteriorating patients
programme



80%

of staff rated "QI for all"
training as good &
excellent



Top 3

For participation factors
with NHS Quest



50

improvements
shown at our first
ever "learning
from each other"
celebration event



78

Days was the longest
period Ward 23 ever
achieved without a
pressure ulcer



269

Junior Doctors
trained/engaged
in QI training



Senior Assistant
Pharmacy Technician
made permanent on
Children's ward
following a QI project



12

QI training courses on
offer as part of the new
QI Training plan
launched 2018-19



15

departments signed
up to improving
processes for
invasive procedures
in non-theatre
environments



**Quality, Service
Improvement and
Redesign (QSIR)**

accredited organisation with 5
staff members qualifying at
QSIR Associates



515

Staff members
engaged/trained
in QI training



**99%
& above**

Compliance with
WHO checklist in
theatre areas

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1.1

RETIRED PRIORITIES FROM 2018/19:

The following is a retired priority for improvement that was submitted as a priority for 2018/19.

1. Priority 1 (effectiveness and safety): Mortality review programme

The mortality review programme was a priority for 2018/19. Whilst we will continue to improve how we learn from deaths, extensive improvement work has been carried out to ensure we have a robust and effective framework for doing this.

The Structured Judgement Review (SJR) method is the Trust's standardised template and approach to undertaking mortality reviews. It is a documentation review that constitutes a subjective in-depth capture of the reviewer's assessment of the quality/standard of care received during the hospital stay; and as such, provides invaluable insight into how we provide care in the Trust.

Emergent learning is gleaned through thematic analysis of all mortality reviews submitted centrally. These are captured in the hospital mortality outcomes report, which provides some of the best indications for learning.

Key achievements leading to the retirement of this priority are:

- the Trust continues to have one of the lowest HSMR (Hospital Standardised Mortality Ratio) in our region, 88, (better than expected). This reflects the high level of care delivered by staff in this Trust

- an established framework for capturing, monitoring and ensuring learning is taking place from deaths is in place with strong oversight and governance.
- a mortality screening tool has been implemented to enable screening of all deaths in the hospital
- delivery of SJR training is on-going to all doctors, consultants, senior nurses and allied health professionals in the Trust
- case selection guidance for use by specialties –this guidance recommends a minimum number of reviews to be completed annually by each specialty. It will be expected to include mandated reviews and a selection of cases of interest/alerts identified with a view to eliciting learning
- generation of local mortality outcomes and statistics reports

The excellent work carried out for Mortality Review will continue to be strengthened to ensure it is sustained.

The remaining identified priorities from 2018-19 will remain as priorities for the Trust in 2019/20.

2.1.2

2019/20 PRIORITIES

We are committed to ensuring we continuously improve our healthcare and services for our local population. We will continue to focus on a broad range of topics for the coming year. Figure 3 details our priorities and how they fit in within the organisation's quality objectives:

Figure 3: 2019/20 Priorities

Priority		National Quality Indicator	Local Quality indicator	Trust's values
Priority 1	Management of the Deteriorating Patient	Effectiveness and safety	Safe, effective, caring, responsive, well-led	We care, We value people
Priority 2	Pressure Ulcers	Effectiveness and safety	Safe, caring,	We care, We value people
Priority 3	Safer Procedures	Safety & experience	Safe, effective, caring,	We care, We value people, We are one team
Priority 4	Patient Experience	Experience	Caring, responsive, well-led	We care, We value people
Priority 5	Medication Safety	Effectiveness and safety	Safe, caring	We care, We value people
Priority 6	Learning from each other	Effectiveness	Effective, well-led	We care, We value people, We are one team

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

The improvement priorities for inclusion in the Quality Account have been selected following a review of themes and areas of concern arising from a range of sources including:

- consultation with our Trust members
- a review of complaints and Patient Advice Liaison Service (PALS) reports
- a review of serious incident and other incident reports
- a review of national and local patient surveys; and
- a review of our Quality Dashboard indicators (including patient safety data)

With the recent development and identification of improvement opportunities in medication safety and safer procedures, these are two areas that are identified as a priority for 2019/20. A short summary of each of the areas

is provided below. Work to define the patient experience collaborative for 2019/20 is on-going.

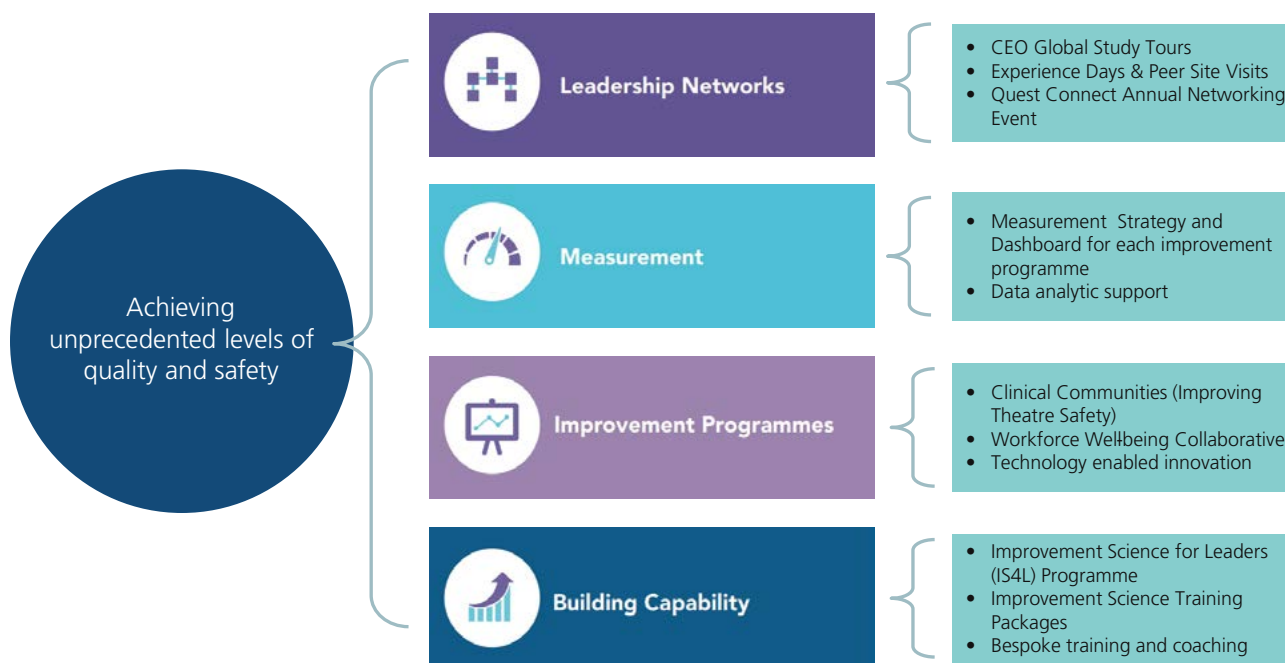
The programmes of work will all report to the Trust's Quality Committee.

2.1.3

NHS QUEST

NHS Quest is a national network that focuses on supporting organisations to improve their quality and safety. They provide a range of resources, development sessions, tools and networking days to assist with learning across organisations. As a member of the NHS Quest network, the Trust utilises these resources to assist with developing an optimistic and compassionate culture for workforce, and reliably deliver our priorities and the best possible care.

Figure 4: The work of the Quest national network



Bradford Teaching Hospitals NHS Foundation Trust is one of sixteen NHS Trusts which is working with member trusts to improve the quality of care for our patients.

The NHS Quest Group of NHS Trusts is committed to the triple aim of:

- improving patient safety and reducing harm in patient care
- striving to be best employers in the NHS
- leading the way in technologically enabled innovation

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

The areas of focus of the NHS Quest network which the Trust is participating in are:

- Improvement Science for Leaders – this learning programme supports leaders within healthcare to develop skills in improvement science and use this to deliver quality improvement projects in their organisation. Our staff are supported by our Quality Improvement team.
- Improving Theatre Safety Culture Clinical Community – This improvement collaborative is enabling member trusts strive to have the safest operating theatres in the country by undertaking an improvement initiative to develop exceptional safety awareness and healthy departmental cultures. Our theatre teams, supported by our Quality Improvement team, are currently actively involved in this initiative and have also hosted a learning workshop on behalf of NHS Quest.

Recent membership participation scores with NHS Quest over the past twelve months highlighted Bradford Teaching Hospitals in the top three for participation factors.

2.1.4

QUALITY IMPROVEMENT CAPABILITY BUILDING

At Bradford Teaching Hospitals NHS Foundation Trust, we aim to provide the highest quality healthcare at all times. We strive for excellence and are committed to learning from and leading best practice to make sure we are delivering quality care.

The aims and objectives for our 2019/20 Quality Improvement Training Plan are:

Figure 5: Objectives for 2019/20 Quality Improvement Plan



Increased patient safety due to QI projects that apply evidence based methodology



Improve culture of celebration, testing and trying new ideas through the promotion of QI projects



Improved capability to address service problems through staff training in QI



Better patient experience through the use of regular continuous improvement



Reduced risk of harm/incidents through the use of a consistent, wide-spread improvement approach

Evidence suggests the potential benefit for applying Quality Improvement (QI) techniques consistently and systematically across organisations is significant. NHSI publications 'Building Capacity and Capability for Improvement, Embedding QI skills in NHS providers' and 'Developing People-Improving Care' give recommended

national best practice in regards to developing QI capability across the workforce. The State of Care report (CQC 2017) found that almost all the Trusts rated as outstanding had a clear model for Quality Improvement across the trust.

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Increasing the capability and knowledge of Quality Improvement for staff is in keeping with the Trust's vision to 'be an outstanding provider of healthcare, research and education' whilst supporting the Trust's strategic objectives

of 'providing outstanding care to patients, delivering our financial plan and key performance indicators.'

The QI Training Plan for 2019/20 will focus on achieving the aim in the Driver Diagram at Figure 6.

Figure 6: Quality Improvement Training Driver Diagram

Aim	Primary Drivers	Secondary Drivers	Change Ideas
To have 10% of the workforce actively engaged/involved in QI projects in their workplace with evidence they are applying QI methodology to them by 31st December 2019 across Bradford Teaching Hospitals NHS Foundation Trust	Leadership & Culture	Roles and responsibilities at all levels	Create an accreditation scheme
		Leadership behaviours	Promote 8 QI leadership behaviours
		Improvement coaching	Connect with Organisational Development
		Empowerment and encouragement	OD: Curious questions cards
	Quality Improvement Training & Education	Accessible QI Training	Varied training dates/times/targeted groups
		Different levels of QI Training	Suite of QI Training packages
		Standard tools and templates	QI Training toolkit
		Upskilling the workforce	Train the trainers: e.g. QSIR
	Communication & Engagement	Learning form each other	Learning form each other quarterly events
		QI training central resources area	QI training intranet page
		Regular QI articles/publications	Global emails, let's talk, flyers, awards
		QI Training walk rounds	Visible engagement - direct communication
	Quality improvement Governance & Monitoring	QI training evaluation	QI training evaluation forms
		Oversight on number of QI projects	QI respository of projects
		QI project registration	Standard QI registration form
		QI training reporting	QI Faculty and QI Programme Board

PART 2

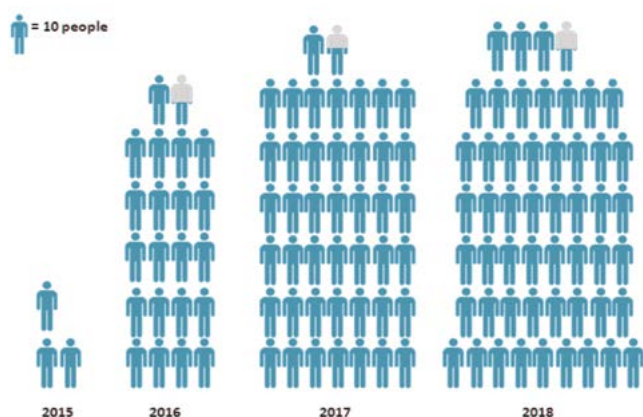
PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD



We believe leadership behaviour is key to ensuring QI is spread, embedded and sustained across the Organisation and therefore, we will continue to deliver a range of QI workshops, training sessions and learning.

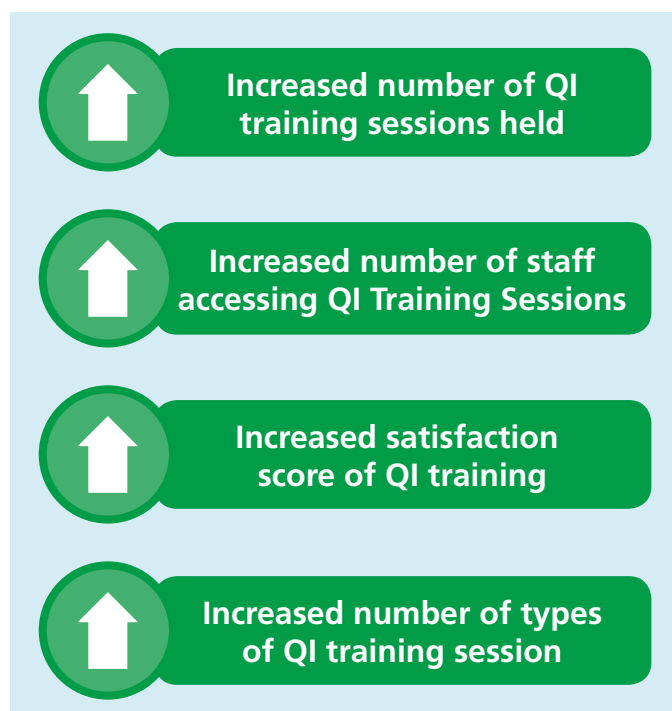
The number of staff accessing QI training in the organisation continues to increase:

Figure 7: Number of staff trained in QI methodology



There is a continuous increase in capability and capacity building indicators which we will continue to strengthen in 2019/20. In comparison with the previous year we have:

Figure 8: increase in QI capability and capacity building indicators



As part of the suite of QI training modules delivered at Bradford Teaching Hospitals, we are now able to offer the nationally recognised Quality, Service Improvement and Redesign (QSIR) programme developed by NHS Improvement. It is aimed at providing staff at all levels a range of tried and tested improvement techniques, tools and skills to design effective and productive services that will lead to sustainable changes that improve the patient experience. We are committed to giving staff the tools they need to carry out their own improvements and we want to empower them to act on their own initiative.

We are also developing our portfolio of targeted QI training for Junior Doctors, New Consultants and Senior Nurses.

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1.5

PROGRAMME DESCRIPTIONS

Management of the Deteriorating Patient



Aim: To reduce avoidable deterioration on the collaborative wards

Operational definition of 'avoidable deterioration' is described as –
'deterioration that could have been prevented if there was timely detection'



How Much:
Reduce by 50%



By When:
March 2019



Outcome: In progress, to date: 11% reduction in the number of crash calls among the collaborative wards

Focus

Improving the care of the deteriorating patient continues to be a key focus for 2019/20. We are committed to ensuring patient safety for deteriorating patients is maintained, sustained and spread across the organisation.

Description

Recognition and timely response to the deteriorating patient is a complex, broad and multi-disciplinary care pathway. Improving the effectiveness and timeliness of how we manage and care for sick patients is influenced by a number of contributing factors. These are actively being explored by collaborative staff members who are trialling different approaches that address identified opportunities for improvement relevant to their clinical areas. A wide range of staff groups are involved in the collaboration which involves those sharing experiences, learning from each other, reflecting on tests of change and measuring their improvement journey.

Key achievements

- 16 wards/departments committed to the collaborative and all areas are actively involved in trying to reduce avoidable deterioration
- Development of a change package consisting of 4 key change ideas which address some of the fundamental issues identified as challenges and barriers to providing safe, timely and effective care to patients.
- Between periods Apr to Dec-17 and Apr to Dec-18 achieved a: 11% reduction in the number of crash calls numbers
- 16% reduction in the number of medical emergency calls

- Introduction of a HCA Co-ordinator role to improve communication of staff concerns relating to patients at risk of deteriorating and workload during shift. Post incident reviews are completed following incidents relating to deteriorating patients by the nurse involved; this includes reflection on what went well, not so well, what happened and then sharing these findings at the clinical governance forums
- Training / education around responding to the sick patient
- Trialling the use of the 'Bones skeleton' template to improve structure and documentation of MDT handovers

Next steps

- Roll out the tried and tested interventions that formed part of the change package that is being tested on the collaborative wards
- Establish robust governance at an operational departmental level (to ensure sustainability)
- Continue to engage with wards/departments to focus on continuous improvement for deteriorating patients
- Create data tiles which will be codesigned with staff and displayed to drive measurement for improvement and local ownership
- Training and education about spotting the signs of a deteriorating patient
- Continue to strengthen safety culture practice, leadership and multiprofessional communication around the recognition of the deteriorating patient
- Develop a "quality" real time analytical tile as part of the Command Centre Programme

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Pressure Ulcers



Aim: To reduce category 2 pressure ulcers by 50% by November 18



How Much:
Reduce by 50%



By When: November
2018 – new aim to be
set for spread phase



Outcome: 50% reduction on 2
wards involved in the collaborative
– now plan to spread the changes
across other wards/departments

Focus

Pressure ulcer prevention remains a key priority for 2019/20 as we work at improving the quality of care we provide by reducing the risk of patients developing a pressure ulcer whilst in hospital. Preventing pressure ulcers is a priority because not only can they cause harm and distress to the patient, they can reduce quality of life, increase the length of stay in hospital and complicate treatment.

Description

Nationally pressure ulcer prevention remains a key priority with working groups examining education, pressure ulcer data collection and audit. We are keen to continue to build on the good work from the national pressure ulcer collaborative and ensure improvement is sustained and consistent across the whole organisation.

The Tissue Viability Nurses, Quality Improvement Team and Wards 23 and 31 participated in the national pressure ulcer collaborative. The ideas that were tested on these 2 wards will be spread to other wards. A positive campaign to help reduce the incidence of pressure ulcers has been spread across the Trust with recognition for wards that have made significant progress.

Key achievements

- Both wards involved in the national collaborative have seen an increase in the days between events. Ward 23 achieved their longest period without a pressure ulcer (78 days)
- A traffic light system has been designed to help reduce pressure damage on the wards
- The wards have reviewed the management of incontinence to ensure a patient-centred approach and the roles and responsibilities of the staff have also been reviewed and expectations are communicated to the team

- A tried and tested “patient repositioning chart” has been created as part of the collaborative
- A 50% reduction in category 2 pressure ulcers has been achieved (comparing pre and post collaborative time periods)
- Delivery of pressure ulcer prevention training by the Tissue Viability Nurses to all newly qualified nurses and midwives, Healthcare Assistants (HCAs), apprentices as well as bespoke sessions as required
- Celebration of good practice and achievement of milestones via monthly pressure ulcer hero nominations and wards
- A robust tried and tested change package ready to be rolled out across the organisation

Next steps

- Spread the learning from the national collaborative project (ended November 2018) to all wards/departments
- Provide other wards/departments with the opportunity to test their own improvement ideas as well as the interventions proven as part of the national collaborative
- Ensure ward level data is shared on a regular basis for pressure ulcers. Ensure this data is used to reflect and learn what improvement is needed and sustained.
- Continue to raise awareness of pressure ulcer prevention through International Stop Pressure Ulcers day, posters and a staff competition.
- Look into testing out new innovative approaches and equipment that reduce the risk of pressure damage skin e.g. softer nasal cannula that reduce the risk of pressure damage to ears and noses.

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Safer Procedures



Aim: To improve the delivery of safe care for patients and reduce the number of incidents for patients who have an invasive procedure in non-theatre areas across the Trust



How Much:
Reduce by 20%



By When: By
September 2019



Outcome: To
be assessed

Focus

This priority will continue for 2019/20. Extensive work has been undertaken in theatres with WHO checklists, working with the Improvement Academy and NHS Quest to embed standards. The focus has now shifted to run a collaborative with wards/departments where invasive procedures happen outside the theatre environment. We will continue to embed the National Safety Standards for Invasive Procedures (NatSSIPs) guidance that set out broad principles of safe practice and advise healthcare professionals on how they can implement best practice, such as a series of standardised safety checks and education and training.

Description

National safety standards for invasive procedures 2015 set out a definition for ensuring invasive procedures have safety checks in place. This includes having key steps in place to harmonise practice across the organisation which is a consistent approach for the care of patients undergoing invasive procedures in any location.

In July 2018 a safer procedures collaborative was formed to reduce the risk of harm from invasive procedures and increase patient safety. In particular, the focus for the collaborative is in non-theatre areas, which builds on the good work that has already taken place for invasive procedures carried out in theatres.

Several departments/wards are currently undergoing testing to explore how to improve safety culture, reduce the risk of harm and maintain a safety standard for patients.

Key achievements

- "BRADSIPPS" Local standards have been developed in line with the national safety standards for invasive procedures.
- Extensive work in theatres on checklists, briefing and debriefing
- On-going monthly audits show consistent 99% and above compliance with WHO checklist in theatre areas

- New World Health Organisation (WHO) checklists produced in areas outside theatres
- Safer procedure group recently revitalised to review checklists, identify any gaps and provide audit and assurance in all areas
- Quality improvement collaborative using agreed Institute of Healthcare Improvement (IHI) breakthrough collaborative methodology with 15 different departments
- Improvement ideas booklet created with over 16 improvement interventions for non-theatre environments to test
- Learning from incidents and reflecting on culture taking place as part of the collaborative sessions
- Some WHO checklists are been re-designed in collaboration with non-theatre teams and successful PDSA testing taking place

Next steps

- Continue with the monitoring and sustainability of The National Safety Standards for Invasive Procedures (NatSSIPs).
- Continue with the Breakthrough series collaborative (across 15 departments/ward areas) aimed at reducing incidents and harm relating to invasive procedures
- Work closely with our external colleagues through the NHS Quest Theatre Clinical Community to share good practice and aid widespread, sustainable improvements.
- Continue to work on our primary drivers: 1. Culture and teamwork 2. Standardisation of the 5 steps to safer surgery 3. Education and awareness
- Create a best practice change package to share across all areas (following testing within the collaborative)
- Ensure there is a robust governance and framework to continue to ensure WHO checklists are in place for all invasive procedures

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD



Patient Experience



Aim: In line with the new Patient Experience Strategy, aim to promote kindness across the Organisation



How Much: To be determined



By When: Date to be agreed but will be approximately March 2020



Outcome: To be determined

Focus

Patient experience will be a key priority area for 2019/20. Patient experience is core to everything we do in the NHS. We want to provide the best possible experience for patients, their relatives and carers. Patient experience encompasses a wide range of both clinical and non-clinical aspects of a patient's journey; this means that improving patient experience requires the involvement of every member of staff.

Description

Measuring patient experience is fundamentally about ensuring our patients and the community we serve has a voice. We can listen to that voice directly through complaints, compliments, engagement work and surveys or more indirectly by working in partnership with patient bodies such as Healthwatch and on specific Campaign like the very successful #Hellomynameis.

Bradford Teaching Hospitals NHS Foundation Trust's mission is to provide the highest quality healthcare at all times. We will do this by working together, putting patients first. We believe listening, talking and responding to patients, carers, relatives and local people should be part of our everyday work and that the way we do this should match what we say we believe in – our values.

With the recent publication of the new Patient Experience Strategy (2018-2023) plans are under development to create a Patient Experience Collaborative that will help achieve some of the aims and ambitions outlined in the strategy.

Next steps

- Strengthen leadership and partnership for improving patient experience
- Work collaboratively with external organisations to ensure we have an active voice in the shaping and delivery of healthcare services, such as Healthwatch, national and local organisations and community representatives
- Create a culture of improving experience
- Improve how we ask and capture experiences
- Improve how we listen, understand and act to improve on experiences shared
- Set up a collaborative programme to embed the new patient strategy across the organisation

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD



Medication Safety



Aim: Introduction of a Senior Pharmacy Assistant working as part of the paediatric team to facilitate good management of medicines



How Much: 1. Reduce the cost associated with medication waste by 20%

2. To decrease the time taken to produce discharge prescriptions for patients on the paediatric ward by 10%



By When:
March 2019 then
spread phase
until March 2020



Outcome: To
be assessed

Focus

There are an estimated 237 million 'medication errors' per year in the NHS in England, with 66 million of these potentially clinically significant (NHS England 2018). Medication safety is about preventing errors in the process of prescribing, preparing, dispensing, and administering, monitoring or providing advice on medicines. There are 3 key projects that will be a priority for medication safety during 2019/20.

Description

It is anticipated that the implementation of a medicines optimisation assistant (known as a SATO) on ward 30 will enhance medication safety. The SATO role, previously undertaken by the nurses, will involve ordering of medicines, stock rotation and clinic room management. They will also encourage patients to bring their own drugs into hospital. By introducing a Senior Pharmacy Assistant to undertake medicines specific tasks, it is hoped that nursing time will be freed up to spend more time with patients and thus reduce patient harm

The project also focuses on achieving a more fluid approach to patient flow by identifying patients for discharge in advance and ensuring the medicines are ready in a timely manner.

Key achievements

- Funding Senior Pharmacy Assistants (2x job share) in position and role extended for a further 3 months
- Extremely positive feedback from ward staff who have found this role meant nursing staff had more time to engage in patient related matters
- Data collection in progress. Initial data shows a reduction in time taken to discharge patients by 23%.
- Stock lists have been reviewed and amended, meaning wastage is reduced
- Patient's Own Medicine lockers in situ and discussions starting around this

Next steps

- Assess outcome measures to show if the introduction of a Pharmacy Technician leads to improved medication safety
- Continue with the trial of a Senior Pharmacy Assistant on the children's ward – aim to enable nurses and healthcare workers to focus more of their time on direct patient care.

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Medication Safety



Aim: To reduce the number of avoidable omissions of critical medications on SAU and AMU wards



How Much:
By 10%



By When: By
March 2020



Outcome: To
be assessed

Focus

There are an estimated 237 million 'medication errors' per year in the NHS in England, with 66 million of these potentially clinically significant (NHS England 2018). Medicines should be administered at the prescribed time and for most this can be considered as plus or minus two hours from the time prescribed on the inpatient prescription. An omitted dose is a failure to administer a dose before the next scheduled dose is due or a failure to prescribe a drug in a timely manner. Omitted medicine remains the highest category of medication errors reported to the NRLS. The UK National Patient Safety Agency has reported that up to 20% of medication errors were omitted doses.

Description

Medication omissions at prescribing, dispensing or administration stages have been identified as a potential for patient harm. Omissions at the dispensing or administration stages may persist, leading to suboptimal treatment, which is why this is a priority area for Bradford Teaching Hospitals NHS Foundation Trust. This project is currently under development with a plan to carry out the Quality Improvement on Surgical Assessment Unit and Acute Medical Unit.

Key achievements

- Project not commenced yet.

Next steps

- Review the culture within the organisation in relation to medicines-related incidents and act on the information received.
- Review processes and procedures to reduce avoidable drug omissions
- Improve the reporting of medicines-related incidents and learning from any incidents that occur in order to increase prevention.
- Understand the reasons behind the omission of medicines, with a view to further work on other wards.

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD



Learning from Each Other



Aim: To increase showcasing, sharing and learning from improvements/good changes



How Much:
By 50%



By When:
December 2019



Outcome:
To be assessed

Focus

This is a new priority for 2019/20. As part of being a continuously learning organisation, we recognise the importance behaviours, culture and values have on Quality Improvement. The concept of “learning from each other” is to help celebrate, recognise and share improvements that are successful.

Learning from what has gone well is crucial to help ensure they spread and are sustained. Recognition of achievements carried out helps improve staff morale and boosts confidence in carrying out improvement.

We want to focus on the best in people, our organization, and the opportunity-rich environment around us. This requires a fundamental shift in the overall perspective to focus on system's strengths, possibilities, and successes.

Description

At Bradford Teaching Hospitals NHS Foundation Trust, the Quality Improvement agenda has a key focus on “learning from each other” which focuses on showcasing, sharing and learning from improvements/good changes carried out throughout the organisation. This links closely to the Appreciative Inquiry model (Cooperrider 1986) which focuses on facilitating positive change in human systems by promoting what is already working rather than promoting problems. It also links to the IHI Joy in Work whitepaper (2018) which highlights how to bring joy, purpose and meaning to the good work that is carried out on a daily basis.

In November 2018 we held our first “learning from each other” event in the main concourse at Bradford Teaching Hospitals NHS Foundation Trust. It was organised in less than 5 weeks and we had over 50 improvement projects, ways of working and innovation showcased from a

wide range of staff. It helped shine a spotlight on the great Quality Improvement work that is taking place on a regular basis. It was a forum to share successes and learning – no matter how small or big.

Key achievements

- Over 50 improvement projects showcased at the first learning from each other event
- Highlighted and celebrated improvement work
- Sharing and learning from successes
- Created networks between staff to learn/adapt improvement initiatives

Next steps

- Hold “learning from each other” showcasing events
- Have a “learning from each other” celebration awards event & Increase recognition of achievements through publications, articles and awards
- Create an annual “learning from each other” yearbook
- Increase networking opportunities to learn from things that have gone well and spread them to other areas
- Create a positive culture through acknowledgement of all successes taking place in the organisation
- Capture all the “learning from each other” into a central QI repository to ensure they are shared at a senior level
- Link “learning from each other” into all the QI training we deliver

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.2 STATEMENTS OF ASSURANCE FROM THE BOARD OF DIRECTORS

2.2.1

REVIEW OF SERVICES

During 2018/19 Bradford Teaching Hospitals NHS Foundation Trust provided and/or subcontracted 41 relevant health services.

The Trust has reviewed all the data available to them on the quality of care in all 41 of these relevant health services.

The income generated by the relevant health NHS services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant services by the Foundation Trust for 2018/19.

2.2.2

PARTICIPATION IN CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

Bradford Teaching Hospitals NHS Foundation Trust is committed to a programme of continuous improvement supporting its provision of safe, high quality patient care. It understands clinical audit as a professionally led, multi-disciplinary exercise, which should be integral to the practice of all clinical teams. The Foundation Trust also

believes that clinical audit should not occur in isolation and supports the view that it should be considered both within the context of organisational learning and as a mechanism to provide assurance about the quality of services.

The Foundation Trust has a High Priority Clinical Audit Programme that describes both its involvement in the National Clinical Audit Programme and its management of audits that are prioritised at a local level.

During 2018/19 the following covered NHS services that the Foundation Trust provides:

- 60 National Clinical Audits / Registries
- 3 Mothers and Babies: Reducing Risk through Audits and Confidential

Enquiries across the UK (MBRRACE - UK) studies

- 5 National Confidential Enquiries (NCEPOD) and
- 1 Learning Disability Mortality Review Programme (LeDeR)

During that period, the Foundation Trust participated in 97% of the national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate. The national clinical audits and national confidential enquiries that the Foundation Trust was eligible to participate in during 2018/19 are described as follows:

Figure 9: Participation in the National Clinical Audit Programme 2018/2019.

National Clinical Audit and Clinical Outcome Review Programmes	Eligible to participate	Participating	% case ascertainment
Adult Cardiac Surgery	No	No	Not Applicable
Adult Community Acquired Pneumonia	Yes	Yes	100% (est)
BAUS Urology Audit - Cystectomy	Yes	Yes	On-going
BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	Yes	Yes	On-going
BAUS Urology Audit - Nephrectomy	Yes	Yes	On-going
BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	On-going
BAUS Urology Audit – Radical Prostatectomy	Yes	Yes	On-going
Cardiac Rhythm Management (CRM)	Yes	Yes	100%
Case Mix Programme (CMP)	Yes	Yes	50%
Child Health Clinical Outcome Programme: Long-term ventilation in children, young people and young adults (NCEPOD)	Yes	Yes	Not Applicable

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PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

National Clinical Audit and Clinical Outcome Review Programmes	Eligible to participate	Participating	% case ascertainment
Elective Surgery (National PROMs Programme) <ul style="list-style-type: none"> • Hernia • Hip • Knee • Vein 	Yes Yes Yes Yes	Not Required Yes Yes Not Required	Not Applicable On-going On-going Not Applicable
Falls and Fragility Fractures Audit Programme (FFFAP) <ul style="list-style-type: none"> • National Hip Fracture Database • National Audit of Inpatient Falls • Fracture Liaison Service Database 	Yes Yes Yes	Yes Yes Yes	100% (est) 100% (est) 67% (est)
Feverish Children (care in emergency departments)	Yes	Yes	100%
Inflammatory Bowel Disease programme / IBD Registry	Yes	Yes	Not Applicable
Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	84%
Major Trauma Audit (TARN)	Yes	Yes	41%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	Yes	Not Applicable
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK): <ul style="list-style-type: none"> • Perinatal Mortality Surveillance • Perinatal morbidity and mortality confidential enquiries • Maternal Morbidity Surveillance and Mortality Confidential Enquiries 	Yes Yes Yes	Yes Yes Yes	On-going On-going On-going
Medical and Surgical Clinical Outcome Review Programme: Pulmonary Embolism (NCEPOD)	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: Perioperative Diabetes (NCEPOD)	Yes	Yes	58%
Medical and Surgical Clinical Outcome Review Programme: Cancer Care in Children, Teens and Young Adults (NCEPOD)	Yes	Yes	100%
Medical and Surgical Clinical Outcome Review Programme: Acute Bowel Obstruction (NCEPOD)	Yes	Yes	38% ¹
Mental Health Clinical Outcome Review Programme	No	No	
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	On-going
National Asthma and COPD Audit Programme (NACAP) <ul style="list-style-type: none"> • Chronic Obstructive Pulmonary Disease • Adult Asthma 	Yes Yes	Yes Yes	On-going On-going
National Audit of Anxiety and Depression	No	No	

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PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

National Clinical Audit and Clinical Outcome Review Programmes	Eligible to participate	Participating	% case ascertainment
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	Not Applicable
National Audit of Cardiac Rehabilitation	Yes	Yes	On-going
National Audit of Care at the End of Life (NACEL)	Yes	Yes	Not Applicable
National Audit of Dementia (NAD)	Yes	Yes	100% (est)
National Audit of Intermediate Care (NAIC) • Bed based service user questionnaire • Bed based patient reported experience measure • Home based service user Questionnaire • Home based patient reported experience measure	Yes	Yes	6v5% 86% 14% 91% 56%
National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	100%
National Audit of Pulmonary Hypertension	Yes	No	
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	Yes	On-going
National Bariatric Surgery Registry (NBSR)	Yes	Yes	On-going
National Bowel Cancer Audit (NBOCA)	Yes	Yes	85%
National Cardiac Arrest Audit (NCAA)	Yes	Yes	84%
National Clinical Audit of Psychosis	No	No	
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	No	No	
National Comparative Audit of Blood Transfusion Programme: • National Comparative Audit of The Use of Fresh Frozen Plasma, Cryoprecipitate and other Blood Components in Neonates and Children • National Comparative Audit of the Management of Major Haemorrhage • Audit of The Management of Maternal Anaemia	Yes Yes Yes	Not Required ² Yes No	Not Applicable 100% Not Applicable
National Congenital Heart Disease (CHD)	No	No	
National Diabetes Audit - Adults • Care Processes and Treatment • Insulin Pump • Foot care audit	Yes Yes Yes	No No No	Not Applicable Not Applicable Not Applicable
National Diabetes Audit – Inpatient (NaDIA)	Yes	No	Not Applicable
National Diabetes In-patient Audit (NaDIA) Harms	Yes	Yes	100% (est)
National Pregnancy in Diabetes Audit	Yes	Yes	100% (est)

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PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

National Clinical Audit and Clinical Outcome Review Programmes	Eligible to participate	Participating	% case ascertainment
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	On-going
National Emergency Laparotomy Audit (NELA)	Yes	Yes	100% (est)
National Heart Failure Audit	Yes	Yes	On-going
National Joint Registry (NJR)	Yes	Yes	On-going
National Lung Cancer Audit (NLCA)	Yes	Yes	100% (est)
National Maternity and Perinatal Audit (NMPA)	Yes	Not Required	Not Applicable
National Mortality Case Record Review Programme	Yes	Yes	Not Applicable
National Neonatal Audit Programme (NNAP)	Yes	Yes	100%
National Oesophago-gastric Cancer (NAOGC)	Yes	Yes	80%
National Ophthalmology Database	Yes	Yes	98.5%
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100% (est)
National Prostate Cancer Audit	Yes	Yes	On-going
National Vascular Registry	Yes	Yes	On-going
Neurosurgical National Audit Programme	No	No	
Non-Invasive Ventilation - Adults	Yes	Yes	On-going
Paediatric Intensive Care (PICANet)	No	No	
Prescribing Observatory for Mental Health (POMH-UK)	No	No	
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Yes	Yes	55% (est)
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	97% (est)
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	Yes	100%
Seven Day Hospital Services	Yes	Yes	100%
Surgical Site Infection Surveillance Service	Yes	Yes	100% (est)
UK Cystic Fibrosis Registry	Yes	Yes	On-going
Vital Signs in Adults (care in emergency departments)	Yes	Yes	100%
VTE risk in lower limb immobilisation (care in emergency departments)	Yes	Yes	98%

¹ Submission on-going

² No cases eligible for submission

The reports of 53 national clinical audits that were reviewed by the Foundation Trust during 2018/19, and any actions that the Foundation Trust intends to take to improve the quality of healthcare provided, are described in the Figure 10.

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD



Figure 10: Actions taken to improve the Quality of healthcare

Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
BAUS Urology Audit - Cystectomy	October 2018	The 2018 data covered the published results of cystectomy for surgery performed between 2015 and 2017. Mortality is higher than the national average for both 30-day mortality rate (2.8% against 1.31%) and 90-day mortality rate (2.8% against 2.21%), assurance has been received from the audit lead that this does not represent a concern, as the patient risk profiles are higher than the national average. As a result further action was not assessed as being necessary.
BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	June 2018	The data published covered the period between 1st January 2015 and 31st December 2017. The published findings consider the outcomes for patients considering the type and volume of surgery undertaken. All outcomes were reported as being within range or better than the national average. The Foundation Trust identified some potential concerns regarding data completeness for this audit, specifically relating to Patient Reported Outcome Measures (Pre-op, post-op and follow-up questionnaires).
BAUS Urology Audit - Nephrectomy	August 2018	The audit published covered the period between January 2015 and December 2017. The audit data indicates that the complication rate experienced by patients is slightly above the national average. This finding has been assessed by the Foundation Trust and it was concluded that this outcome reflects the morbidity of patients being managed by the service (24.2% of patients have a recorded WHO performance status of 2, 3 and 4, compared to the national average of 10.4%). Performance in relation to case ascertainment and the audit findings were discussed with the speciality lead. An investigation in to case ascertainment is planned to be undertaken by the audit lead with support from the central Clinical Effectiveness Team.
BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)	May 2018	The Foundation Trust reviewed the findings and recommendations from the published report The transfusion rate was 0%; this is below the national average of 2.09%. The median length of stay (LOS) was 3 days which is similar to the national average. Mortality rate is reported as being below the national average (0% against 0.4%).

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PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
BAUS Urology Audit – Radical Prostatectomy	September 2018	The Foundation Trust reviewed the findings from the data published which covered the reporting period 1st January 2015 and 31st December 2017. The complication rate (graded Clavien Dindo III and above) was slightly higher than the national average, this has been considered within specialty discussions.
Case Mix Programme (CMP)	October 2018	The Foundation Trust reviewed the Annual Quality Report. Case ascertainment reported was 50%, this is due to a vacancy within the post of ICNARC Audit Clerk. Whilst the Trust is not an outlier for any outcomes reported in the audit, the findings suggested that the number of high-risk admissions from medical wards and the number of unplanned readmissions within 48 hours were above comparator units. The ICU Unit reviewed all the records where it was identified that patients had been re-admitted and assurance was gained that all patients were appropriately discharged by the unit however later required ICU care again due to their medical condition. High-risk sepsis admissions from wards were one of the highest rates within the region. The Foundation Trust has developed a local service action plan to mitigate the risks identified; in addition the Trust is implementing a Trust-wide Sepsis improvement plan which is being led by the newly appointed Sepsis Specialist Nurse.
Child Health Clinical Outcome Programme: Chronic Neurodisability (NCEPOD)	March 2018	The Foundation Trust has initiated the process of reviewing the report recommendations with the speciality.
Elective Surgery (National PROMs Programme) - Hip	August 18	The provisional report data was published in August 2018. Total hip replacement average health gain is below the national average. The report was discussed within the speciality clinical governance and weekly Arthroplasty meetings by the clinical lead for the service. Reported performance is due to low response rates, this is being addressed by discussion with patients as part of the Enhanced Recovery programme in the Arthroplasty service, with the aim to improve response rates and data quality.
Elective Surgery (National PROMs Programme) - Knee	August 18	The provisional report was data published in August 2018. The knee replacement health gains are generally above the national average. The report has been discussed within the speciality clinical governance and weekly Arthroplasty meetings by the clinical lead for the service. Reported performance is due to low response rates, this is being addressed by discussion with patients as part of the Enhanced Recovery programme in the Arthroplasty service, with the aim to improve response rates and data quality.

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PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
National Hip Fracture Database (Falls and Fragility Fractures Audit Programme (FFFAP))	September 2018	The Foundation Trust is in the top quartile of the national outcome for 13 standards, the second quartile for 7 standards and the 3rd quartile for 4 standards. Standards that are lower are delirium assessment, this has been discussed at the monthly Hip Fracture Meeting and the audits leads plan to discuss this with junior doctors for improving completion timely. Recording has been amended on the electronic patient record in relation to recording mobilisation the day after surgery, this should improve compliance with this standard.
Fracture Liaison Service Database Falls and Fragility Fractures Audit Programme (FFFAP)	September 2018	The Foundation Trust reviewed the findings from the FFFAP audit. The Trust has made improvements since the Bradford Falls Liaison Service was established during 2017/18. Performance associated with major key performance indicators are being supported by this service.
Fractured Neck of Femur (care in emergency departments)	May 2018	Patients in severe pain receiving analgesia for developmental targets is 0%, although this is on par with the national average, 100% of these patients received analgesia within 60 minutes of arrival which is above the national median of 30%. The audit was discussed in the Trust's Quality and Safety meeting. A local re-audit is planned to take place.
Inflammatory Bowel Disease programme / IBD Registry	September 2018	The findings of this report were based on cumulative data submitted up to September 2018 (91 patients registered with a recorded diagnosis). The Foundation Trust reviewed the recommendations from this report and as a result the Foundation Trust is considering a new method of recruitment to the Registry via invitation letters being sent to eligible patients.
Learning Disability Mortality Review Programme (LeDeR)	March 2018 - Ongoing	The Foundation Trust now participates fully in the local LeDeR programme, following the establishment of an appropriate governance framework. The Foundation Trust has trained members of the risk team to undertake reviews which will commence in May 2019.
Major Trauma Audit (TARN)	August 2018 and November 2018	The audit findings and outcome measures from the validated live dashboard system is reviewed on a regular basis. The case ascertainment and data completeness were variable during 2018/19. Process mapping and gap analysis sessions were carried out in November 2018. Following the gap analysis session, a service level action plan was completed. The compliance around criteria relating to Consultant/STR-3 led trauma teams has since improved. The Foundation Trust continues to network with other Trusts and take part in the regional TARN meetings. The Foundation Trust's Informatics and Business Intelligence Team developed an SQL script to run the data sample which should improve data quality, data completeness and case ascertainment in the future.
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK): Perinatal Mortality Surveillance	June 2018	The Perinatal Surveillance Report (2017 data) from MBRRACE was published in June 2018. The Foundation Trust reviewed the findings and recommendations from this report. The report was discussed with the speciality lead for obstetrics. There is on-going quality improvement work within Maternity Services that will address the findings and recommendations within the report.

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PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK): Maternal Morbidity Surveillance and Mortality Confidential Enquiries	November 2018	The Foundation Trust reviewed the report findings and recommendations. Legitimate concern was raised during this process of review about test tracking of investigations which are managed externally to the Electronic Patient Record. Discussions have been held in the core speciality and divisional governance meetings to ensure these concerns were escalated. In addition, a Training Needs Analysis has been undertaken in response to the findings of the report and the relevant guideline updated. The specialty is assured that more proactive use of risk assessments has improved the overall outcome with regards to this audit.
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) - Acute Heart Failure: Failure to Function	November 2018	The Foundation Trust has reviewed the recommendations from this National Confidential Enquiry. The overarching purpose of these recommendations is to improve the quality of care provided to people with acute heart failure. The specialty have considered the recommendations and included any identified actions to optimise patient care in their routine governance.
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) - Peri-operative management of surgical patients with diabetes: Highs and Lows	December 2018	The Foundation Trust has reviewed the recommendations from this National Confidential Enquiry. The overarching purpose of these recommendations is to improve the quality of care provided to patients over the age of 16 who were diabetic and were undergoing a surgical procedure. An action plan has been developed by the division to address the concerns, and any opportunities for change and improvement identified within the service. There is an established whole Trust governance forum to promote and ensure safety of children and young people, the 'Children's and Young People's Board' where improvements have been driven in relation to the surgical care of all children, including those with complex co-morbidities.
Myocardial Ischaemia National Audit Project (MINAP)	November 2018	The MINAP report made six recommendations for Acute Trusts and these relate to the dissemination of findings, exploration and action in relation to variations, maintenance of the quality of care, timely angiography, resource allocation for audit and quality improvement and presentation of findings at board level; these have been fully considered by the relevant speciality. The findings were presented within the Cardiology Speciality Quality and Safety Meeting. A locally developed action plan is being implemented to address areas for improvement, in relation to the number of patients admitted to a specialist ward. In addition the NSTEMI pathway in A&E is being reviewed to ensure that there is earlier recognition of NSTEMI cases; the implementation of a daily handheld echo ward round and a confirmatory local audit is planned during 2019/20.

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Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
NACAP - COPD Audit Programme	November 2018	The Foundation Trust reviewed the findings and recommendations from the COPD audit. The audit findings were discussed and presented in the Speciality Respiratory Clinical Governance Meeting. The Foundation Trust was not compliant with the Best Practice Tariff for the second consecutive year. The audit found that the respiratory team reviewed a lower proportion of patients during admission and there was a longer mean time from admission to respiratory review. Spirometry results were not available in a higher proportion of cases than the national average. BTS discharge bundle completion rates were also lower than the national average. There were lower levels of clarity regarding follow-up arrangements, with 48.8% of cases where arrangements were not apparent. In order to address the findings of the audit a business case to increase capacity within the Respiratory service for additional Clinical Nurse Specialist and Consultant time in order to achieve compliance with best practice standards has been developed and subsequently approved. A local service action plan has been developed by the respiratory core group to address all the opportunities for change and improvement identified.
National Audit of Breast Cancer in Older People (NABCOP)	June 2018	The Foundation Trust reviewed the recommendations relating to carer and patient involvement; monitoring length of stay, reviewing the accuracy of audit data and the use of protocols for assessment and treatment. The report was discussed at the Breast Clinical Governance Meeting and it was reported that some of the outcomes of the audit were not reflective of practice, including the proportion of women that have contact with the Breast Care Nurses and the proportion of women receiving triple diagnostic assessment in a single visit. There is on-going work to ensure clinical validation can be completed prior to data submission. Developments with recording for Cancer Services have improved the quality of data that is submitted to the Cancer datasets.
National Audit of Cardiac Rehabilitation	November 2018	The Foundation Trust have achieved the NACR certification for 2018/19, meeting all seven standards, including having evidence of prompt identification of eligible patients, early assessment and demonstration of sustainable health outcomes.
National Audit of Dementia (NAD): Care in General Hospitals 3rd Round (NAD) - Assessment of delirium in hospital spotlight report	August 2018	The Foundation Trust reviewed the audit findings and recommendations of this report. A "Plan on a Page" has been completed, which supports the assessment of risk in relation to the audit outcomes and an action plan has been implemented to ensure that care for patients with dementia is optimised across the Trust. The Trust has recruited a new Dementia Specialist Nurse. Areas of concern identified within the report relating to obtaining a corroborative history from someone who knows the patients well, undertaking a standardised confusion assessment and a standardised cognitive test. Lower compliance than nationally with physical investigations (FBC, LFT, blood cultures, urinalysis / MSU, chest x-ray). Delirium or acute confusion during initial presentation or within 24 hours of admission recorded on the discharge summary. A spot check of electronic records was undertaken by the Dementia Lead in April 2019 of all patients with a diagnosis of Delirium (n=18). The results from this spot check confirmed that 94% of patients had a corroborative history completed and had all routine investigations completed. 90% of patients discharged in March 2019 had a recorded diagnosis of delirium or dementia (or both) on the GP discharge summary.

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Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
National Audit of Intermediate Care	November 2018	The Foundation Trust reviewed the audit findings and found that the registered nursing staff vacancy rate (26%) for home based rehabilitation is higher than the England mean (10%). The Trust is engaging in recruitment of nursing staff in order to address this concern.
National Audit of Percutaneous Coronary Interventions (PCI)	November 2018	The audit findings and recommendations of this report have been considered and discussed in the specialty meeting. The report identifies that there were no areas of sub-optimal care identified, and the results demonstrate that in spite of the local population having higher prevalence rates of diabetes and acute work (previous MI & previous CVA) outcomes are comparable to the national average.
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	January 2019	This organisational audit report made 12 recommendations including a recommendation relating to workforce. A plan on a page and a recommendations checklist are underway to support with reviewing the findings and recommendations. The percentage of general paediatric workforce with 'expertise in epilepsy' is 5.4%, this is lower than in England & Wales (14.8%). A business case has been approved which will increase the number of Paediatricians with a specialist expertise in epilepsy. In addition adjustments have been made to clinical appointment timings to enable a longer paediatric consultation.
National Bariatric Surgery Registry (NBSR)	July 2018	The Foundation Trust reviewed the findings and recommendations from this report. There are significant concerns relating to data completeness, data quality and case ascertainment with this audit which have been escalated to the Chief Medical Officer. A process mapping exercise and gap analysis is being undertaken to identify areas where these issues can be effectively mitigated. These issues are being directly considered by the Foundation Trust's Clinical Audit and Effectiveness Committee.
National Bowel Cancer Audit (NBOCA)	December 2018	The NBOCA 2018 Report presents data from patients diagnosed with Colorectal Cancer between 1st April 2016 and 31 March 2017 (the 2017/18 reporting period), alongside an organisational report detailing services that the Foundation Trust provides. The Trust is reported as being excluded from the risk-adjusted analysis for 90-day mortality and 30-day emergency re-admission rates due to data completeness/data quality issues. A process mapping exercise and gap analysis have been undertaken to identify reasons for this poor case ascertainment and data quality. The outcome of this work is currently under review.
National Cardiac Arrest Audit (NCAA)	May 2018	The Foundation Trust considered and discussed the findings and recommendations of this report in the Divisional Quality Governance meeting, Deteriorating Patient Group and Patient Safety Committee. Data completeness is 100% for all values. Favourable neurological outcomes and survival to discharge are lower than national average, but are within the acceptable limits. Actions being taken to respond to the findings are monitored by the Patient Safety Committee.

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Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
National Comparative Audit of Blood Transfusion: Audit of Transfusion Associated Circulatory Overload The (TACO)	2018	The Foundation Trust developed a Local Service Action Plan in response to the audit results and recommendations made by the audit provider. The audit results indicate that not all patients for TACO had documentation for risk assessment in their clinical notes. To ensure that a formal pre-transfusion risk assessment for TACO a checklist has been developed by the Transfusion Nurse Specialist and added to the Hospital Transfusion policy. The TACO checklist has been added to the blood component record / prescription record.. There is a plan to implement an appropriate transfusion campaign to re-inforce what is discussed in medical mandatory training.
National Comparative Audit of Blood Transfusion: Re-Audit of Red Cell & Platelet Transfusion in Adult Haematology Patients	2018	The Trust development and implemented an action plan in response to the audit results and recommendations. The results of audit were presented at the Haematology Journal Club and the audit results were discussed by the Consultant Haematologist audit lead and Transfusion Lead. Where appropriate the Trust guidelines have been re-iterated to support improved patient care and compliance with best practice.
National Diabetes Audit – Core Audit	March 2018	The Foundation Trust was not able to participate in the 2017/18 audit due data transfer and compatibility problems following a change in pathology provide. . A work stream has been established, involving Informatics, Specialty and Clinical Effectiveness Teams to lead and task the effective collection and input of audit data to enable a more meaningful participation with the national audit.
National Diabetes Audit – Insulin Pump	June 2018	The Insulin Pump audit is part of the National Diabetes Core Audit, is as described above, the Foundation Trust could not participate in this audit due to data transfer issues. The issue is now resolved and the data has been collected for the 2018/19 National Diabetes – Insulin Pump Audit.
National Diabetes Transition Audit	January 2019	The National Diabetes Transition Audit covers the care of children / young people transitioning to adult services and included recommendations that support the transition processes.
National Emergency Laparotomy Audit (NELA)	September 2018	The Foundation Trust reviewed and considered the audit findings and recommendations. The recommendations were discussed at the Clinical Audit and Effectiveness Committee. Key areas considered relate to the assessment by elderly medicine specialist patients >70 years decreased in compliance compared to the previous year but was higher than the national average (28.3% verses national mean of 22.9%). A “Plan on a Page” and local service action plan have been developed and implemented to ensure that any areas of potential sub-optimal care provision have been identified, risk assessed and that there is a plan for improvement in place.

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Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
National Heart Failure Audit	November 2018	The National Audit of Heart Failure 2017/18 is a continuous, prospective audit that looks at the treatment and management of heart failure patients who have an unscheduled admission to hospital. The audit looks at inpatient care, investigations and treatment and also referral to outpatient services. The Foundation Trust is lower than the national average in a number of standards, including rates of echocardiogram, input from a consultant cardiologist and referral to cardiology and/or cardiac rehabilitation. An action plan is in place to address all these issues and it is anticipated that the results for 2018/19 will be significantly improved. Indeed early informal feedback from the 2018/19 audit results is that Bradford has performed significantly better in a number of audit standards and has been approached by the audit provider to share its improvement story.
National Joint Registry (NJR)	September 2018	The Foundation Trust reviewed the audit findings and recommendations. The Foundation Trust was historically reported an outlier for knee revision rates (2003-2017 data). All key performance indicators are currently within the expected range. During 2018/19 the Foundation Trust was awarded as an NJR Quality Data Provider Certification for commitment to patient safety through National Joint Registry. This was discussed at the Clinical Audit and Effectiveness Committee and congratulated the staff who collect and input the data for NJR.
National Mesothelioma Audit (Spotlight Audit of National Lung Cancer Audit)	June 2018	The results from the spotlight audit were reviewed by the audit lead, data quality issues found are being addressed by the Cancer Services Team. A lower proportion of patients are seen by a clinical nurse specialist. The Trust has completed a local audit and results suggest that a higher percentage of patients are now seen by nurse specialist.
National Mortality Case Record Review Programme	October 2018	The Mortality Review Outcomes Report and Mortality Dashboard provides an overview of the mortality case note reviews completed by doctors and senior nurses in the Foundation Trust on deaths occurring between January 2019 and March 2019. It presents a summary of emerging themes and identifies key learning and areas for improvement such as timeliness of care and delayed treatments monitoring of medications, care of the deteriorating patient. The Foundation Trust holds a bi-monthly Mortality Committee to monitor the SJR reviews outcomes and to assure the lessons are learned across the Trust, these feed into the Quality oversight system and the Quality Improvement programme. The Quality Committee receives a quarterly Learning from Deaths report.

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Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
National Neonatal Audit Programme (NNAP)	September 2018	The National Neonatal Audit presents results relating to 15 neonatal care indicators for neonates with a final discharge from neonatal care between 1st January 2017 and 31st December 2017. The Foundation Trust reviewed the findings and recommendations from this report. Compliance with many standards was above national average and the Trust received a positive outlier notice (this relates to care that is excellent) for admitted babies born at less than 32 weeks having a first measured temperature 36.5°C to 37.5°C within one hour of birth. Actions identified for improvement relate to the measures of parental involvement and performance associated with follow up and improved communication with the staff team is in place to address this. The Foundation Trust is also improving information to improve the usage of breastmilk to address the higher than national rate of necrotising enterocolitis.
National Oesophago-gastric Cancer (NAOGC)	September 2018	The Foundation Trust reviewed and discussed the findings of this audit and at the Clinical Audit and Effectiveness Committee.
National Ophthalmology Database	August 2018	This is the second prospective report from the National Ophthalmology Database Audit. A total of 2,344 eligible cases were submitted (e 94.5% case ascertainment) from 30 surgeons. Data collected include visual accuracy pre and post operation and change. The report makes several recommendations including supporting improved data collection, use of audit information in revalidation and appraisal, reviewing care pathways to ensure that data is recorded for every operation, and individual surgeons comparing their results against their peers. The Foundation Trust reviewed the recommendations A Plan on a Page has been completed with the audit lead to assess any emergent risk and ensure an improvement plan is in place. A business case been developed to address purchase of new instrumentation. A local audit of cataract surgery is on-going to compare the latest data with the given national findings. A new service will be provided at Westwood park, which will use improved instrumentation.
National Paediatric Diabetes Audit (NPDA)	July 2018	The Foundation Trust disseminated and discussed the audit findings with speciality core groups and divisional quality meetings. The Trust had negative outlier status for two audit measures; HbA1c (measure of diabetes control) and the healthcare check completion rate. Collection of this data was affected by children having separate notes for dietetics, nursing and medical, and the service did not used a shared electronic record. The Trust has now developed a system to improve the capture of information related to procedure performed elsewhere. An action plan has been put in place to address the outlier notifications and the Foundation Trust is no longer an outlier for the health care check – now at 98%, for the high HbA1c measurement there is quality improvement work commencing on the introduction of education to patients and new technology that aim to demonstrate improvements going forward.

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Name of audit / Clinical Outcome Review Programme	Date of publication	Actions taken
National Prostate Cancer Audit	February 2019	The National Prostate Cancer annual report covers the complete care pathway for men diagnosed between 01/04/2016 to 31/03/2017. The Foundation Trust reviewed and discussed the findings and recommendations both within the core specialty and at the Clinical Audit and Effectiveness Committee. The data completeness and data quality were identified as the key issues, overall the standards were better than the national average and the service is recruiting another clinical nurse specialist to further improve the service.
National Vascular Registry	November 2018	The Registry is commissioned by the Healthcare Quality Improvement Partnership and is designed to support quality improvement within NHS hospitals performing vascular surgery by providing information on their performance. This registry collects data for surgery for aortic aneurism, carotid endarterectomy, lower limb angioplasty or stent and lower limb amputation. The review of the audit outcome with the Audit Lead identified some areas for improvement in relation to data quality and data completeness. The Trust is working with the West Yorkshire Association of Acute Trusts (WYAAT) to review and enhance pathways of all relevant conditions to ensure optimal care for our patients and compliance with audit standards.
Pain in Children (care in emergency departments)	June 2018	The foundation Trust reviewed the report and found that there was a lower number of children that had pain assessed and offered analgesia within the recommended timeframes. 50% of children had received analgesia within 60 minutes of arrival / triage compared with nationally. The Trust is in the process of reauditing these measures.
Procedural Sedation in Adults (care in emergency departments)	May 2018	Performance for standards relating to location of procedural sedation and presence of staff are 100% compliant. Areas of where improvements have been made are the implementation of a LocSSIP checklist and also information leaflets regarding procedural sedation will be provided to patients.
Sentinel Stroke National Audit programme (SSNAP)	December 2018	The Sentinel Stroke National Audit Programme published the annual portfolio based on stroke patients admitted to and/or discharged from hospital between April 2017 and March 2018. The Foundation Trust has shown an improvement in the overall SSNAP indicator, which has now moved to a 'B banding' and SSNAP score is 71. The case ascertainment and audit compliance has remained at the highest performance indicator level, A. The findings and a proposed action plan to improve the thrombolysis indicator and stroke unit (patient-centred KI level) are routinely discussed at the Clinical Audit and Effectiveness Committee and the Quality Committee.
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	July 2018	The Serious Hazards of Transfusion annual report covers all reportable transfusion related events and near misses. The root cause analysis from each transfusion incident is reported at the Hospital Transfusion Committee. The findings suggested that the near misses are above the average by area and cluster use. The implementation of the 'Group and Save Two-sample Rule' has demonstrated positive results in reducing incidents. Incidents relating to Transfusion are routinely reported to the Quality Committee.

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The reports for 25 local audits and audit programmes were reviewed by the Trust in 2018/19; the key actions that it intends to take to improve the quality of healthcare provided are described in Figure 11, which includes examples of local audits reported in 2018/19.

A more detailed review of the outcomes of the Trust's local audit programme will be published in its Annual Clinical Audit Report later in 2019/20.

Figure 11: Intended actions following review of the recommendations from local audits completed during 2018/19

Title of Audit	Report Produced	Actions
Sepsis CQUIN	Quarterly	The Deteriorating Patient Group continues to work to improve sepsis care within the Foundation Trust and sepsis screening continues to improve. The Nurse Consultant Infection Control and Sepsis Nurse Specialist review reporting weekly, this is disseminated to Head of Departments and Clinical Leads. Sepsis improvement events have been held, including ward visits. Data collection against the CQUIN is continuous and reported to the Deteriorating Patient Group regularly. Appointment of a Sepsis Nurse Specialist has occurred. The Quarterly Sepsis report is presented to Quality Committee.
Seven Day Self-Assessment Toolkit (7DSAT)	March and September	The Seven Day Self-Assessment Tool audit has been discontinued. The last audit was done in March 18 and reported on in June 2018. There will be no further seven day services self-assessments that are commissioned; this will be done via Board Assurance Framework.
Nutrition	Ongoing	Dieticians have worked with the Chief Nurse's Office to rewrite the audit tool to reduce overlap with Ward Accreditation audit. The data collection is ongoing and the audit outcomes are reported to the Improving Nutrition Group where Trust wide actions are agreed and assured,
Fundamental Standards of Quality and Safety (ProgRESS)	Various	The Foundation Trust has an established programme of reviews, ProgRESS (Programmed Review of Effectiveness, Safety and Sensitivity). ProgRESS enables the Trust to identify difficulties, risks, opportunities for improvements and areas of best practice against the CQC Fundamental Standards. Review outcomes are reported to the Patient Safety Sub-Committee. The reviews resulting in no confidence or limited confidence are escalated to the Executive Lead for action through the designated oversight committee. In 2018/19 ProgRESS has been adapted to focus on the moving to good, becoming outstanding and has supported a series of Mock Inspections of the CQC core services.

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Title of Audit	Report Produced	Actions
Medicines Safety	Various	<p>Four medicines safety audits were reported on in 18/19.</p> <ul style="list-style-type: none"> Medicines practice audit: wards and departments (April 2018) audited forty-five wards and three departments. It was found that in one area the medicine return to pharmacy box was overflowing, it has been re-iterated that these can be reported to the Pharmacy Department. Medicines practice audit: theatres (April 2018) audited eleven theatres. In general a high level of compliance was shown with audit standards, however there was found to be out-of-date posters within some theatres and in one theatre food items were stored within the medicine cupboard. Actions have been taken to reinforce the importance of storing medications safely and reiterating that no items other than medications should be stored within the medicines cupboards or refrigerator. A medicines management checklist for theatres will be used to audit areas regularly and it has been assurance that all posters / guidelines are up to date. Storage and Handling of Control Drugs was audited twice (June 2018 and November 2018). 13 actions were recommended from the first audit and 11 recommendations from the second audit. In areas where wards are not manned 24 hours a day and there is no alarm system in place there have been a risk assessment completed and this will be checked in May / June. The audits were presented at the Medicines and Nursing Midwifery Forum.
NHS Safety Thermometer	Ongoing	The Patient Safety Thermometer results are reported at the monthly Patient Safety Sub Committee. Any actions that are required are completed within Care Groups.
Endoscopy Global rating scale (JAG)	Ongoing	GRS data is submitted twice a year. There was a break in submission because of software problems which are now resolved. Data was submitted as required on April 2019.
Physiological and Operative Severity Score for Enumeration of Mortality and Morbidity (POSSUM)	N/A	Data extract from the POSSUM database has been severely limited due to technical problems. In light of this the Trust has downgraded the audit and closed work on this at present.
VTE prophylaxis on the Gynaecology Ward	2018	This audit identified that 65% of patients were up-to-date with their VTE forms however 35% were not, however all patients audited were on the correct VTE. Several recommendations were made in relation to the audit including suggestions to amend the VTE 'pop' up window to appear upon opening a record as well as when a patient record is closed and if the electronic patient record system would be able to alert the ward charge nurse if the VTE form is over 12 hours overdue. A re-audit has also been proposed.
Renal Registry 20th Annual Report	01/07/2018	The Trust plans to review the report findings and will take appropriate action where necessary.

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Title of Audit	Report Produced	Actions
Induction of Labour and Monitoring	April 2018	The results of this audit indicate that there is assurance in 70% of cases that the decision to induce was based on clinical guidelines however in the remaining 30% of cases forms were not completed. There was a documented risk discussion in 30% of cases, in the remaining 70% of cases there was not a form completed.
Audit of discharge of 15-17 year olds from adult wards	April 2018	In all cases audited a safeguarding concern was identified however Trust procedure was not followed with a notification to the Children's Safeguarding Team. In only 28% of cases was the documentation felt to be clear about the concern. An action plan has been developed to ensure that Level 2 training is continued to be offered for all adult staff, there is an on-going audit of training figures. There will also be liaison with ward managers and divisional manager to ensure that staff have access to training date and ward staff on adult wards will be targeted to ensure that they are aware of Safeguarding training.
Audit of Management of Bruises, Burns and Scalds in non-mobile infants	August 2018	It was found that 21 children had no LCS ID reference and an additional 6 children did have a reference however no contact was recorded following the Emergency Department Visit. Recommendations have been made by the audit authors including improving referral to Paediatric Liaison Nurses and to ensure that all cases are discussed with social care. Improvements have been made and now there is screening of all paediatric attendances to the Emergency Department. The audit findings have also been presented.
Patient involved audit of Inflammatory Bowel Disease (IBD) Transition Service	May 2018	This was a joint Paediatric and Gastroenterology Audit. The audit was presented at the Speciality Governance meeting. Recommendations have been made and there is a plan for ongoing review.
Management of anaemia in children and young people with inflammatory bowel disease	July 2018	The audit findings were presented at the Yorkshire Paediatric Gastroenterology Network in September 2017. The audit found that whilst patients undergo regular blood tests for anaemia treatment is not always initiated in those with milder anaemia, this has resulted in a change of practice from the audit report author. It is suggested that a short cut could be created for the electronic patient record as well.
Palliative Care Team Prescribing Audit 2018	June 2018	The palliative care team saw a total of 20 patients during the audit period and made 81 medication recommendations, slightly lower than in previous years, but they directly prescribed a higher proportion of medications than in previous years. The audit found that syringe drivers were mainly initiated by the team, but delays were noted in the administration. There is a plan for increased education to improve this standard. An action plan has been completed to address all the issues raised in the audit.

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Title of Audit	Report Produced	Actions
Paediatric Stabilisation Audit	May 2018	The Paediatric Stabilisation audit recommendations were discussed at the core speciality group and an action plan has been developed and implemented. Following the audit the PAWS (Paediatric Advanced Warning Score) track and trigger tool was modified. Escalation was changed with an ordered response strategy with an emphasis on continuous monitoring until the doctor review and timings set for clinician to attend. Regular scenario on training real time is provided to ward staff, all nurses were also assessed on recognising and responding to the sick child in response to the audit.
Unexplained Extubations in the Neonatal ICU	February 2019	This audit was undertaken to identify potential themes contributing to the incidence of unplanned extubations, identify potential changes that could be made to practice to reduce the risk of unplanned extubations and to put changes into place and re-audit to assess whether changes made have improved the rate of unplanned extubations. A local service action plan was been developed to implement the audit recommendations.
Adult Head Injury re-audit	May 2018	It was found that whilst clinicians do not use the specified EPT Head Injury template for documentation for the majority of cases patients are received promptly and there is through assessment in line with NICE guidance. Areas of lower compliance are in documenting any amnesia post injury and also of any anticoagulant medication taken by the patient. Recommendations made in the report are that clinicians consider using the EPR template and that this would be able to support improvement in formal documentation of GCS, post-injury amnesia and anticoagulation status.
Hepatitis B screening pre-chemotherapy	January 2019	This audit reviewed new haematology regimes on ChemoCare undertaken between May 2017 and July 2017. The Pathology records were examined for HBcAg screening in 3 months prior to regime initiation. The audit recommendations are to increase the awareness of staff and to develop prompts on ChemoCare to improve compliance.
Autism Spectrum Disorders (ASD): Diagnosis – Inconclusive or Uncertainty	July 2018	This local audit was aimed to review the current practice of pre-5 ASD diagnostic assessment in case of uncertainty following initial assessment. The audit reviewed cases within 6 months (unless complex cases), and considered social communication, and neurocognitive or disinhibited social engagement. It was recommended that the children should be referred to Joint Assessment Clinic for Communication after 6 months attendance in a nursery settings. A local service action plan has been developed to address this recommendation.
Anaemia in Pregnancy	May 2018	This retrospective audit looked at the management of anaemia in pregnancy. 10% of patients had prophylactic iron and 9% of patients had prophylactic folic acid. Iron and folic acid documentation is an area of low compliance. Recommendations included of improving documentation and to aim for all patients to have a FBC check at 28 and 36 weeks gestation. The audit was presented in Speciality Governance.

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Title of Audit	Report Produced	Actions
Small for Gestational Age (SGA) Audit	October 2018	This local audit covered two criteria; babies born as SGA should have risk assessments correctly documented and filled in both at booking and throughout pregnancy and babies born as SGA who were scanned should have had their SGA status identified. Out of 9 missed cases, 3 (33%) were missed due to incorrect antenatal risk assessment. There were 5 risks missed from these cases, these included a previous SGA baby x2, heavy smoker x2 and static growth on SFH. The Trust has made the following recommendations for practice including All women at booking should receive adequate screening for risk factors for the possibility of SGA and for those who are identified as being high risk should be appropriately referred according to the Trust Fetal Growth and Doppler guideline for follow-up. The audit was also presented at the Speciality Group meeting.
Fetal Monitoring Audit	March 2019	This local audit reviewed 28 sets of notes between January – March 2019. There were four standards that were reviewed. The audit found concern with clear documentation of hourly review of the CTG, clear documentation of fresh eyes hourly review on CTG assessment sticker and a maternal pulse oximeter used for a minimum of 20 minutes if a CTG is required or recommended. Two recommendations were made regarding 1) educational standards for CTG's via posters on the Labour Ward and a plan to include these in the next Lessons Learned e-mail and 2) Disseminate the audit results at the Labour Ward handover. The audit was presented at the Speciality Group meeting. There is a plan for a repeat audit.
Management of Preterm Birth	July 2018	The audit found that 2 patients had no booking MSU sent and no patients audited had a MSU in every trimester. Only 2 out of 9 patients received cervical length scanning. Not all patients received Steroids and Magnesium Sulphate. The audit concluded that management of preterm labour is generally well performed however there is variation of management. Recommendations proposed are to improve the standard of care for managing women at risk of preterm births in Antenatal Clinic, consider introducing a preterm clinic or guidance tick box sheet to aim for consistency in management, ensure that all patients identified at risk are offered cervical length scanning and clarify local guidance regarding investigation required and when. The audit was presented at the Speciality Group meeting.

2.2.3

PARTICIPATION IN CLINICAL RESEARCH ACTIVITIES

In 2018/19 Bradford Teaching Hospitals NHS Foundation Trust recruited patients to 189 National Institute for Health Research (NIHR) portfolio projects.

There were 11825 patients who received relevant health services, provided or sub-contracted by the Foundation Trust in 2018/19 that were recruited during that period to participate in NIHR portfolio research.

Participation in clinical research demonstrates the Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff are aware of the latest treatment possibilities and active participation in research can improve the prospect of successful patient outcomes.

Further information is detailed in this report under section 3.6 Research Activity.

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2.2.4

COMMISSIONING FOR QUALITY INNOVATION FRAMEWORK (CQUIN)

The Commissioning for Quality and Innovation payment framework is an incentive scheme which rewards the achievement of quality goals to support improvements in the quality of care for patients. The inclusion of the CQUIN goals within the Quality Account indicates that Bradford Teaching Hospitals NHS Foundation Trust is actively engaged in discussing, agreeing and reviewing local quality improvement priorities with our local Clinical Commissioning Groups (CCGs).

In 2018 the CQUIN scheme announced encompassed a 2-year period between 2017 and 2019. A proportion of the Foundation Trust income in 2017-19 was conditional upon achieving quality improvement and innovation goals agreed between the Foundation Trust and any of its commissioning partners who entered into a contract, agreement or arrangement for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the CQUIN goals for 2017-19 are available online at:

<https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/>

The Trust's performance against the second year of CQUIN standards can be found in 3.4.2 Local Performance Measures section of this report.

The monetary total for the amount of income in 2018/19 conditional upon achieving quality improvement and innovation goals is estimated as £7.5m and the monetary total for the associated payment in 2017/18 was £6.7m.

2.2.5

CARE QUALITY COMMISSION (CQC) REGISTRATION

Bradford Teaching Hospitals NHS Foundation Trust is required to register with the CQC and its current registration status is 'registered' with no compliance conditions on registration.

The CQC served a fixed penalty notice on the Foundation Trust for failing to meet fundamental standards on the 18 September 2018. A fine of £1250 was paid as an

alternative to prosecution. This related to a breach in Duty of Candour which occurred in 2016.

2.2.6

CQC INSPECTION

In 2018 the Foundation Trust's overall rating, following an unannounced inspection of four core services and a Well Led Inspection, was 'Requires Improvement'. The Trust received a "Good" overall rating for the Well Led Domain. The Trust developed and implemented a detailed action plan to address the compliance actions identified in the report, including actions to address the "should" and "could" dos identified by the CQC during the inspections.

We provide regular evidence to the CQC in relation to progress with, and outcomes of, action plans, and have our own internal challenge and assurance process through ProgRESS (Programmed Review of Effectiveness, Safety and Sensitivity), a programme of work within the Foundation Trust in relation to understanding and ensuring compliance with the CQC's Fundamental Standards. This is discussed in more detail in section 3.4.4 The Quality Management System, on the Assurance, Testing and Inspecting Process.

The Foundation Trust participated in an Area Review undertaken by the CQC in February 2018 relating to partnership arrangements in relation to the care and management of people over 65 living in Bradford and Airedale. The report identified areas of good practices and also areas where there were opportunities for change and improvement. The Foundation Trust has participated in the development of system-wide action plan which is currently being implemented.

The Foundation Trust was included in a short notice local health system CQC inspection which focused on safeguarding children and young people. The inspection took place in February 2019, and the report has not yet been published.

2.2.7

NHS NUMBER AND GENERAL MEDICAL PRACTICE CODE VALIDITY

Bradford Teaching Hospitals NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode

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Statistics (HES) that are included in the latest published data by the Service. The percentage of records in the published data that included patients' valid

NHS Number and General Practitioner Registration Code is displayed in Figure 12. These percentages are equal to or above the national averages.

Figure 12: Percentage of records which included the patient's valid NHS number

Record type	Area	2018/19	2017/18	2016/17	2015/16	2014/15	2013/14	2012/13	2011/12
		(April 2018 to December 2018)	(April 2017 to December 2017)	(April 2016 to January 2017)	(April 2015 to January 2016)	(April 2014 to January 2015)			
Patients Valid NHS number	Admitted Patient Care	99.6%	99.6%	99.59%	99.00%	99.60%	99.60%	99.60%	99.50%
	Outpatient Care	99.9%	99.9%	99.83%	99.00%	99.40%	99.40%	99.40%	99.80%
	A&E Care	99.8%	98.8%	98.71%	98.00%	98.50%	98.60%	98.40%	98.30%
Patients Valid General Medical Practice Code	Admitted Patient Care	100%	99.0%	99.26%	100%	99.90%	100%	100%	100%
	Outpatient Care	100%	99.2%	99.89%	100%	100%	100%	100%	100%
	A&E Care	100%	98.9%	99.06%	100%	99.09%	100%	100%	100%

2.2.8

DATA SECURITY AND PROTECTION TOOLKIT ASSESSMENT

For 2018/19, the Information Governance Toolkit was replaced by the Data Security and Protection Toolkit.

The data security standards (known as Assertions) which are assessed within the Data Security and Protection Toolkit (DSPT) provide an overall measure of the quality of information governance related systems, standards and processes within an organisation. Bradford Teaching Hospitals NHS Foundation Trust's Data Security and Protection Assessment outcome for 2018/19 is 'Standards Met'. This is confirmed when an organisation evidences all mandatory Assertion items by final submission on 31 March 2019. A sample of the Assessment Evidence is independently assessed by Audit Yorkshire.

2.2.9

PAYMENT BY RESULTS CLINICAL CODING AUDIT

Clinical coding is the process through which the care given to a patient (usually the diagnostic and procedure information) that is recorded in the patient notes is translated into coded data. The accuracy of the coding is an indicator of the accuracy of patient records.

Bradford Teaching Hospitals NHS Foundation Trust was subject to an Information Governance clinical coding audit during 2018/19. The audit consisted of a sample of all specialties selected at random from activity between January and June 2018. The error rates reported in the latest preliminary published audit for that period for diagnoses and treatment clinical coding are shown in Figure 13. These rates have improved significantly in 2018/19.

Note: Clinical Coding results should not be extrapolated further than the actual sample audited; and which services were reviewed within the sample

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Figure 13: Clinical Coding Error Rate

Coding Field	% Incorrect 2018/19	% incorrect 2017/18	% incorrect 2016/17	% incorrect 2015/16	% incorrect 2014/15	% incorrect 2013/14	% incorrect 2012/13
Primary Diagnoses Incorrect	5.7%	8.6%	8.17%	5.50%	9.00%	8.00%	10.45%
Secondary Diagnoses Incorrect	6.3%	10.2%	9.2%	4.80%	9.47%	5.90%	11.82%
Primary Procedures Incorrect	4.7%	8.1%	9.09%	9.10%	2.00%	0.70%	6.45%
Secondary Procedures Incorrect	2.1%	7.2%	14.79%	5.60%	8.02%	8.70%	10.50%

The audit was based on the methodology detailed in the current Version 11.0 of the Clinical Coding Audit Methodology set out by NHS Digital Classifications Service undertaken by an approved Clinical Coding Auditor.

2.2.10

DATA QUALITY

The maturity of data and information, its use, processes and supporting technology is key to the Trust using information to make decisions; an information-led Trust. High quality data and information is vital to the effective and efficient running of the Trust and leads to improved decision making which in turn results in improved patient care, wellbeing and safety.

Poor data quality can put the Trust at significant risk of losing stakeholder trust, negatively impacting service delivery, incurring financial penalties or inappropriate utilisation of resources amongst others. The Trust has clear processes, controls, and governance in place to manage the quality of data, using best practice and including a master list of key data and information and how it is identified and kept current. In any organisation there are a number of data sets that are important to the successful operation of the business. Should the quality of this data be sub-optimal the business will not properly execute its role. The Trust uses a standard classification system to assist in the process of managing data quality. There are a number of systems and controls in place for each of the data types at various stages in the lifecycle of data and its conversion to information. The responsibility for overarching data quality lies with the Information Governance Sub-Committee. The Information Governance Sub-Committee provides assurance to the Quality

Committee of the Board of Directors. The data quality position is presented through a scorecard-type approach using a number of indicators.

With high quality data and information the Trust can support decision-making for patient care, day-to-day and tactical management and strategic planning and decisions. The Trust enables this requirement through a suite of industry-standard tools, including the highly-ranked Cerner Millennium Electronic Patient Record, a CACI data warehouse, SAP's Business Objectives business intelligence tools, and a variety of presentation tools. The tools allow the Trust to present data and information pertinent to and in a way (visual intelligence) which supports the nature of the decision.

The need of clinicians and administrative teams for data and information in the delivery of front line care is provided mainly directly through the Electronic Patient Record. Day-to-day and tactical management of the Trust's operations are supported by data and information specific to those functions being executed. This could be done through daily reports, dashboards, and through real time software. The Trust utilises 'ward to board' dashboards for key indicators aligned to the Trust's Strategic Objectives. These indicators, reviewed ultimately by Board of Director's Committees, aggregate into a Board of Directors Dashboard that provides a holistic, rounded view of the Trust's position against its plans.

2.2.11

REPORTING AGAINST CORE INDICATORS

The indicators that are relevant to Bradford Teaching Hospitals NHS Foundation Trust for 2018/19 are reported in Appendix A.

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In order to provide assurance on the quality of the data the Trust has governance arrangements to review and improve data quality, and has acted upon recommendations of internal and external data quality audits.

All of our data-reporting processes have standard operating procedures which ensure that correct processes are followed. The data is then checked for validity and data quality errors, sometimes using the previous period to ensure it is in line with what is expected, and where this does not occur, is checked by another member of the team to ensure there are no data anomalies.

2.2.12

DUTY OF CANDOUR

The statutory Duty of Candour for the NHS is designed to ensure that providers are open and transparent with people in relation to care and treatment, specifically when things go wrong, and that they provide people with reasonable support, truthful information and an apology.

Healthcare treatment is not risk-free. Patients, families and carers want to know that every effort has been made to put things right, and prevent similar incidents happening again to somebody else. We know that trust in our organisation is directly related to how we respond when things go wrong. Being open is comparatively easy when all is well, but can be far more challenging in cases of actual or possible harm, whether caused by error or when a known and accepted complication occurs during treatment.

The Trust is committed to making this duty a reality for the people who use our services. We want to ensure there is clear, strong organisational support for staff to supplement their professional and ethical responsibility in being open and honest with patients. We understand that the impact and consequences of mistakes or errors made during the course of care or treatment can affect everyone involved and be devastating for individual staff or teams. We aim to ensure there is sustained support for staff in reporting incidents and in being open with their patients. Clinicians already have an ethical Duty of Candour under their professional registration to inform patients about any errors and mistakes related to their care.

The Trust has therefore built on that individual professional duty and has implemented a policy which places an obligation on the organisation, not just individual healthcare professionals, to be open with patients when

harm has been caused. The policy describes how the Foundation Trust will meet its statutory and contractual Duty of Candour. The intention is to support a culture of openness, transparency and candour between healthcare professionals and patients and/or their carers when an incident or a prevented incident has occurred and to learn from the error, whatever the level of harm caused.

We routinely monitor our compliance with the statutory and contractual requirements relating to our Duty of Candour using our incident reporting system. We report details of any breaches, their impact and opportunities for change and improvement through our Quality Committee and Finance and Performance Committee, to the Care Quality Commission and our Commissioners. During 2018/19 there have been no reported breaches in Duty of Candour.

In the 2016/17 Quality Report the Trust reported a breach of its Duty of Candour which related to a serious incident. The CQC commenced an investigation into this breach during Quarter three in 2017/18. This investigation was concluded during 2018/19 and the CQC served a fixed penalty notice on the Trust. A fine of £1250 was paid as an alternative to prosecution.

2.2.13

LEARNING FROM DEATHS

The Trust routinely reviews the care of patients that have died whilst in hospital and uses various methodologies and uses various data sources to do this. These processes include:

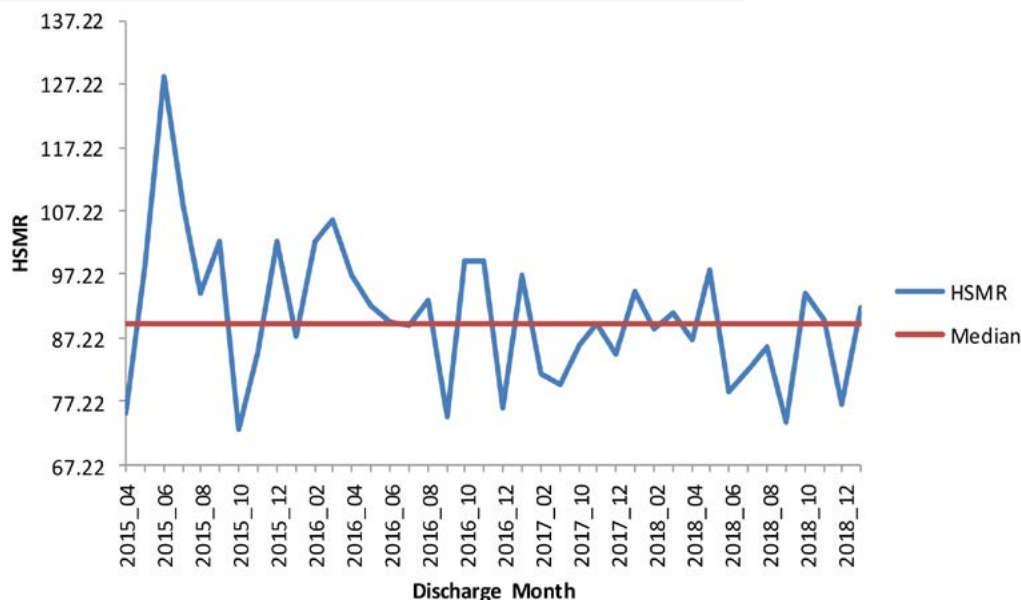
- Mortality statistics which includes Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). These are nationally benchmarked and reviewed on a monthly basis
- Reports from National audits when published
- Learning from internal investigations, serious incidents and coroners investigations.
- Screening tool used to identify patients requiring case note reviews
- Use of the Structured Judgement Review (SJR) methodology as a standard template for undertaking case note reviews

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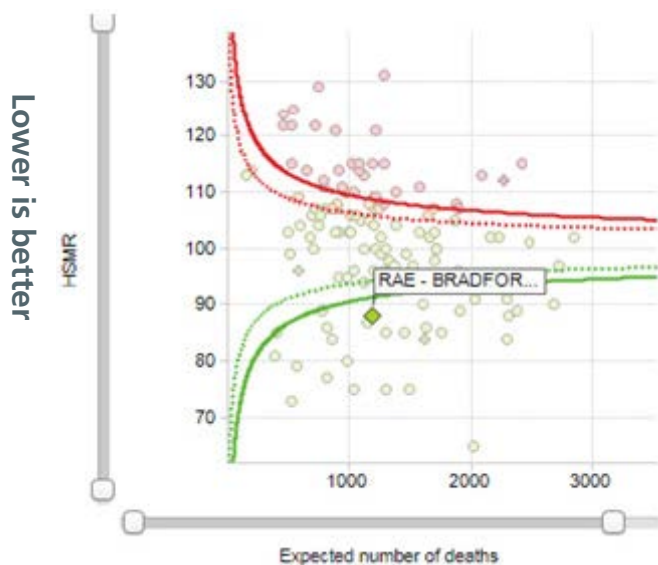
Mortality Statistics

Figure 14: Graph showing monthly HSMR at BTHFT



The Trust continues to have one of the lowest HSMR (Hospital Standardised Mortality Ratio) in our region, 88, which is better than expected. This represents 142 fewer deaths than expected over the 12 month period (February 2018—March 2019). This reflects the high level of care delivered by staff in this Trust.

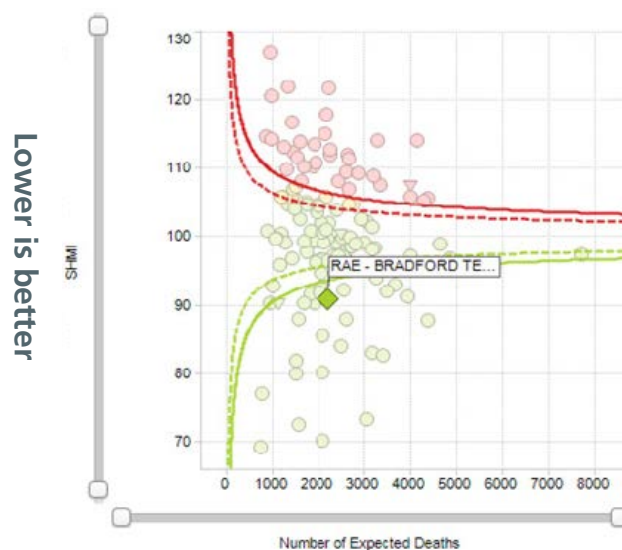
Figure 15: HSMR –National Funnel Pot



HSMR for most recent 12 months is 88 (better than expected)

The Trust's most recent data for the Summary Hospital-level Mortality Indicator (SHMI) places the Trust in the "as expected" category with an outcome of 93.

Figure 16: SHMI –National Funnel Pot



SHMI for most recent 22 months is 91 (better than expected)

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As part of the national guidance on learning from deaths, a quarterly report outlining the mortality statistics and learning identified from mortality case note reviews is compiled by the central mortality team and reported quarterly at the Quality Committee. This includes

information on reviews of the care provided to those with learning disabilities and severe mental health needs.

Statements of assurance in line with Learning from death reporting

Figure 17: The number of patients who have died during April 2018 to March 2019, including a quarterly breakdown of the annual figure.

Period	Quarter	Number of deaths
April – June 18	Q1	325
July - September 18	Q2	268
October - December 18	Q3	323
January - March 19	Q4	405
Total		1321

Figure 18: The number of deaths included in Figure 17 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.

Period	Apr - Jun 18	July - Sept 18	Oct - Dec 18	Jan - Mar 19	Total
Quarter	Q1	Q2	Q3	Q4	
Number of deaths	325	268	323	405	1321
No. of SJR reviews	48	37	21	37	143
No. of SJR second reviews	1	4	3	1	10
Number of deaths with potential problems in care identified requiring further investigation	1	2	2	1	6

There were 6 deaths representing 0.5% of the patient deaths during the reporting period that are judged to be more likely than not to have been due to problems in the care provided to the patient.

Figure 19: Is an estimate of the number of deaths during April 2018 to March 2019, included in Figure 18 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

In relation to each quarter, this consisted of 1 representing 0.3% for the first quarter; 2 representing 0.7% for the second quarter; 2 representing 0.6% for the third quarter; 1 representing 0.2% for the fourth quarter. These numbers have been estimated using the methodology described below:

Methodology used to assess problems in care provided to patients

The SJR method is the Trust's standardised template and approach to undertaking mortality reviews. It is a documentation review which constitutes a subjective in-depth capture of the clinical reviewer's assessment of the quality/standard of care received during their stay in

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hospital, providing invaluable insight into how we provide care across the organisation.

Where care has been viewed as excellent and of an exemplary nature relevant staff or team efforts are acknowledged and showcased within the internal mortality reports as part of evidence of exemplary care provided in the organisation. Where overall care has been judged to be inadequate or poor, a second review is initiated. This assesses whether problems in care identified contributed to death. These cases which are very few may lead to an internal investigation. The learning from these reviews are collated centrally at an organisational level to generate themes which are shared with appropriate specialties.

The SJR reviews provide some of the best indications to where overall care has been very good and areas where we could do better.

Problems in care identified are dealt with through our internal investigation systems which include serious incident investigations or referral to the Coronial services. For cases that go on for further trust wide investigations, the learning is managed through risk management governance processes in place. Following a reported patient death on datix where there is an assessment completed (via the daily risk safety huddle) that describes suspected omissions in care, a SJR or Clinical review is requested to ascertain level of harm and outcomes for the patient.

This information is subsequently discussed at the incident performance management group and either an internal investigation will be reported or a referral to the Quality of Care panel for consideration to declare a serious incident investigation. Learning from these investigations are subsequently fed back to the hospital staff using the established processes.

Figure 20: A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in Figure 19.

- *Timeliness of care - Delays in healthcare make outcomes poorer*
- *Communication - Poor communication leads to delays and poor care*
- *Infections – It is easy to spread infection. All staff are to be vigilant*
- *Reports - A requested investigation must be read and acted upon*
- *Diagnostic bias - Just because a patient has one diagnosis does not mean they cannot have 2 or more problems.*
- *Make sure NEWS observations are done and appropriately acted on at all times.*
- *When transferring or receiving patients to new areas, make sure a risk assessment of the transfer has been considered, a quality handover is completed and that this is documented.*
- *Ensure appropriate communication with bereaved relatives including outcomes of discussions are documented.*
- *Investigation requests must be followed up and acted on in a timely way*
- *It is important to identify early on that the patient has a learning disability and establish what their typical level of functioning is - Remember 'Walk, Talk, Feed, Read'.*
- *Routine consideration of the involvement of relevant learning disability & mental health services is beneficial so that they are aware of the patient's current condition and also for the ward team to gain an understanding of the patient's usual capacity e.g. Waddiloves (Bradford learning disability health support team) are an excellent resource and can be contacted for support and background information.*

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Figure 21: A description of the actions which the provider has taken in April 2018 to March 2019, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see Figure 20).

- Delivery of the deteriorating patient collaborative improvement programme
- Ongoing improvement work around early detection, screening and treatment of patients with suspicion of sepsis, medicines safety, falls and pressure sores, 7 day working
- Junior doctor induction and training regards communication, handovers and treatment of deteriorating patients
- Simulation Training
- Improvement of facilities for stroke patients
- Improvement of facilities for fractured neck of femur patients
- Publication of internal rapid response alerts covering topics such as safe patient transfers, restraining patients and monitoring vital signs
- Timely response and actions to NPSA alerts
- Learning Disability training and awareness events

Figure 22: The number of case record reviews or investigations finished in April 2018 to March 2019 which related to deaths during the previous reporting period but were not included in Figure 18 in the relevant document for that previous reporting period.

There were 62 case record reviews and 2 investigations completed after March 2018 which related to deaths which took place before the start of the reporting period.

Figure 23: An estimate of the number of deaths included in Figure 22 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.

There were 2 deaths representing 0.14% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the methodology described in Figure 19.

Figure 24: A revised estimate of the number of deaths during the previous reporting period stated in Figure 19 of the relevant document for that previous reporting period, taking account of the deaths referred to in Figure 23.

There were 2 deaths representing 0.14% of the patient deaths during 2017-2018 that are judged to be more likely than not to have been due to problems in the care provided to the patient.

Figure 23 is reporting the same number and percentage as Figure 24 because numbers due to problems in care have only been reflected in reports for the 2018-2019 reporting period onwards.



PART 3: INFORMATION ON THE QUALITY OF HEALTH SERVICES

3.1 KEEPING PATIENTS SAFE

3.1.1

PATIENT SAFETY PROGRAMMES

In addition to the Quality Improvement initiatives that will take place over the coming year, the Trust is committed to delivering key patient safety programmes that focus on

the safety of our patients and staff. These programmes are described in Figure 32 – 42.

Quality and Safety Leadership Walk-round Programme



Aim: To increase the visibility of the senior executive team with frontline staff and patients



How Much:
By 100%



By When:
March 2020



Outcome: To be assessed

Focus

Leadership Walk rounds were initially developed by the Institute for Healthcare Improvement (IHI) as an improvement tool to connect senior leaders with their frontline staff, to help build a culture of safety within the organisation. The walk rounds increase Executive visibility and oversight of the operations of the hospital at different times in the day.

Description

The current format of the walk rounds enables an informal reflective engagement meeting intended to allow more meaningful conversations between the Executive Team, staff and patients. Leadership walk rounds routinely take place throughout the organisation across the Bradford Royal Infirmary, St Luke's Hospital and the Community Hospitals. This approach has allowed for in-depth, rich conversations between the leadership team and frontline teams.

Clinical teams share their stories and experiences of the innovative work practices developed as well passion and pride in their areas of work. This has increased staff engagement and developed a culture of open communication where the safety of patients is seen as a priority of the organisation.

Conversations are noted and organised into themes. Responsibility for any immediate actions identified is confirmed at the visit which may be led by the Executive Director, ward level management or appropriate divisional lead.

Key achievements

- Collaborative working between Multi-professional teams (internal and external) is now common practice
- There are some great examples of a positive safety culture, with safety huddles taking place across more clinical areas
- Key themes from the walk rounds are about excellent patient care, collaborative working, patient safety and positive patient/staff feedback
- Patients are approached as part of walk rounds to gain feedback on their experiences
- Continued positive feedback from staff relating to the style walk-round visit format which is more informal, reflective and conversational

PART 3

INFORMATION ON THE QUALITY OF HEALTH SERVICES



The Learning Hub



Aim: To develop and facilitate a multi-disciplinary forum that translates data from our surveillance mechanisms into opportunities to learn



By When: Established
– meeting monthly



Outcome: To
be assessed

Focus

The Learning Hub (was the learning and Surveillance Hub) is a key part of our quality oversight system. We have developed a virtual network of partners who work across the Foundation Trust. The Hub brings together all Divisions and Corporate Departments and their respective information and intelligence, gathered through performance monitoring and regulatory activities and our day to day work. The group works to collectively consider and review this information, with members working together to safeguard the quality of care that people receive through identifying learning and ensuring translation into practice.

Description

In 2017/18 the Hub developed the use of 'Learning Matters' which identifies learning from incidents and produces a regular publication that describes high impact learning from incidents that have taken place in the Foundation Trust. In 2018/19 the Hub tailored and expanded the use of alerts to ensure the learning from incidents is easily recognisable and themed based on the cause or impact of the incident(s). The Hub now produces Learning Matters, EPR matters, Caring Matters, People Matters, Medicine Matters and Checking Matters.

The Hub has also embedded a quarterly learning newsletter 'Responding and Improving', which describes how the Foundation Trust has responded to serious incidents, and how we know that the actions undertaken

have been effective, thus reducing the likelihood of similar incidents.

Key achievements

- Identification and agreement of learning strategies and information sharing mechanisms across the Foundation Trust
- Development of testing methodologies ensuring learning and information is received and utilised by the intended audience
- Tailored and expanded the use of the Learning Matters alerts to ensure the learning from incidents are easily recognisable and themed based on the cause or impact of the incident(s)
- Embedded Responding and Improving, a quarterly publication which describes the response and its effectiveness to serious incidents in the Foundation Trust
- Held a second victim workshop focused on being involved in a patient safety incident as either a witness or a reviewer
- Developed a learning strategy to ensure the Trust is learning from external organisations and considering 'could it happen here?'
- Annual work plan established with theme based learning each month

PART 3

INFORMATION ON THE QUALITY OF HEALTH SERVICES

National maternity and neonatal health safety collaborative



Aim: 1. Reduce the number of women experiencing delays during the induction of labour care pathway in our antenatal ward
2. Reduce the number of babies admitted to the neonatal unit due to avoidable hypoglycaemia and hypothermia
3. Work with expectant mothers to understand the reasons why there is a delay in accessing the maternity services when they experience decreased foetal movements



How Much: 1. Reduce by 50%
2. Reduce by 5%
3. 95% contact within 12 hours



By When: 1. March 2020
2. March 2020
3. March 2020



Outcome: 1. On target
2. On target
3. On target

Focus

The Maternal and Neonatal Health Safety Collaborative is a three-year programme, launched in February 2017. The collaborative is led by NHS Improvement and covers all maternity and neonatal services across England

Description

The aims of this programme are to:

- Support maternal and neonatal care services to provide a safe, reliable and quality healthcare experience to all women, babies and families across maternity care settings in England
- Create the conditions for continuous improvement, a safety culture and a national maternal and neonatal learning system.
- Contribute to the national ambition of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020.

Each Trust involved in the collaborative is responsible for developing a set of local improvement objectives based around: human dimensions; systems and processes; clinical excellence and person centeredness.

Key achievements

- Analysed data from 80 sets of case notes to ensure the change has been sustained showed 83% of women experienced a 50% reduction in the delay during induction of labour pathway; and 39% of women are experiencing a 50% reduction today compared to the baseline. The original target is achieved when excluding the times Labour Ward was in escalation. Next steps are to create a separate induction suite / 2-person staff team in May 2019 and measure progress using the same methodology

- Now cohort women in a 4 bedded bay, previously they had next available bed anywhere in a large ward area
- Assessing continuity of carer as a factor in enhancing timeliness of assessments and Prostin dose intervals
- Started a weekly case discussion for all babies admitted to Neonatal Unit at term to learn from the reasons for admission to understand what processes can be put in place to reduce avoidable admissions
- 'Keep me safe Keep me warm' campaign launched to ensure babies are kept at the right temperature
- Secured 1 year supply of MAMA wallets (a plastic wallet for carry notes and maternity information in) that are aimed to help women detect the signs of reduced foetal movement
- A new 24-hour Maternity Assessment Unit opened which will be the direct access area for women to contact/come to if they are experiencing/suspecting reduced foetal movements
- A patient focus group is being set up with vulnerable women in the community to understand how we can increase the recognition and timely response to reduce foetal movement
- Bespoke Quality Improvement training was provided to Maternity staff to help develop their knowledge and skills for carrying out improvements as part of this collaborative
- Implemented a daily MDT safety huddle based on Labour Ward

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INFORMATION ON THE QUALITY OF HEALTH SERVICES



Reducing Inpatient Falls Collaborative



Aim: To reduce the number of inpatient falls



How Much:
By 15%



By When: September 2018 (then to reassess for the spread phase)



Outcome: 15% achieved

Focus

We wanted to try to reduce the number of inpatient falls happening at Bradford Hospitals. A fall can be devastating, the human cost of falling includes, distress, pain, injury, loss of confidence, loss of independence and increased morbidity and mortality.

Falling also affects the family members and carers of people who fall and has an impact on quality of life, health and social care costs. Using the estimated falls rate per 100 bed days, a provider with 800 beds will have approximately 1,500 falls at a cost of £3.9 million. (The estimate in 2007 was £92,000).

Description

Our aim was to reduce inpatient falls by 15% by September 2018. Our approach was to use a collaborative method with 12 of our wards. We empowered, educated and gave them space to work together to think of ways to reduce falls. We held a series of collaborative working sessions where the wards came together to work on achieving the aim.

All the wards involved tried and tested different improvement ideas and along the way, they tweaked them if they didn't work. They carried out PDSA (plan do study act) cycles until eventually, we had the best possible versions of the things that were tested. We then created a change package with all the great interventions gathered, with some credit to East Lancashire Hospitals who shared some of their improvement ideas with us.

One of the key changes was the falling leaves system – an amber leaf is placed on the patient's bed board if they are at risk of a fall, and a red leaf is placed if they have had a fall. This is a great simple visual reminder. The focus is to now roll out the change package across the Hospital to spread and sustain the improvements across the whole organisation.

Key achievements

- 15% reduction in inpatient falls across the pilot wards (12 wards)
- A robust tried and tested change package with interventions proven to reduce falls
- A buddy system set up to help wards learn from each other and implement falls interventions
- A successful 12 month falls collaborative
- Improved staff skills and knowledge for reducing falls and using improvement methodology
- Improved patient safety, care and experience for patients
- Better identification of patients who are at risk of a fall

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Red Bag Pathway



Aim: To improve the experience and pathway for care home residents when they need to go in to hospital



By When:
June 2019



Outcome:
To be assessed

Focus

The aim of the Red Bag Pathway is to improve the experience for care home residents when they need to go into hospital by helping to streamline and speed up transfers between hospital, ambulance and care home settings.

The distinctive red bag contains all the patient information staff require to understand their health and social care needs, why they have been sent to the hospital and details of their current medication. In addition to this, the red bag will contain personal items to make their stay more comfortable, such as day/ night clothes, dentures, spectacles and hearing aids. Each year we have approximately 2300 A&E presentations and 1800 Emergency hospital admissions of care home residents.

Nationally one in seven people aged 85 or over are living permanently in a care home. The evidence suggests that many of these people often experience unnecessary, unplanned and avoidable admissions to hospital.

Description

We worked with our clinical commissioning group (CCG) colleagues, who had discussions with our colleagues from care homes, Yorkshire Ambulance Service, hospitals and communities to find out if the Red Bag Transfer Pathway could work for us.

We helped scope out best practice from other organisations and had workshops where a wide range of staff came together to design what key documentation

will go in the red bags. We then tested this for 2 months with 6 care homes to see if it worked in practice. We analysed the findings, made some final changes and launched the red bag pathway through several launch events, roadshows and promotions at the local Hospitals.

Key achievements

- Over 100 residential and nursing homes have joined the Pathway and over 450 Red Bags have been issued.
- At Bradford NHS, we have seen an increase in the red bag through our A&E.
- Staff have also fed back how it has improved communication with care homes
- Care homes have reported how the use has improved patient experience
- Reduced delays for some patients as the Hospital staff knew what to expect when the patient first arrived- this was through the 6 key standard documents in the red bag

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Enhanced Care



Aim: To achieve a statistically significant reduction in the total hours for enhanced care without increased recorded incidents and calls for security



By When:
June 2019



Outcome: To be assessed

Focus

There are many reasons for wanting improving the quality, experience and cost of for patients who receive enhanced care. Enhanced care is for vulnerable patients who might be at risk of harm or due to psychological needs; so they need someone to stay with them at specified times.

Description

We want to:

- Engage more with those who receive enhanced care to improve their experience and keep them stimulated
- Engage more with family and carers to build a partnership with them and recognise their rights as care givers
- Create a standard process for determining which patients need enhanced care and assessing this requirement every 24 hours. Currently, practice varies across the organisation.
- Strengthen how we communicate to family and carers especially in terms of understanding how the patient is in their home setting, what they likes/dislikes are and what information might be useful to us.

- Over recent months, the cost of bank and agency staff for enhanced care has rapidly increased across many organisations. By focusing on providing high quality services and improving experience, this should naturally have a positive effect on cost saving.

Key achievements

- 3 pilot ward testing how to improve enhanced care processes, procedures and experiences
- A bespoke training course set up for staff to help improve skills/knowledge of enhanced care
- Involvement of the new Dementia Nurse on how to deliver enhanced care for dementia patients
- Promoting and signing up for John's Campaign
- Reviewing visiting times for families/carers/visitors
- Approval to set up central enhanced care team to review requests for extra staff to provide enhanced care

PART 3

INFORMATION ON THE QUALITY OF HEALTH SERVICES

Quality Improvement for Surgical Teams (QIST)



Aim: To improve patient outcomes after hip and knee replacement surgery in Bradford Teaching Hospitals NHS Foundation Trust



By When: By September 2020



Outcome: On target – to date since starting project, 0 infections.

Focus

QIST provides orthopaedic teams the opportunity to share best practice as part of a national collaborative project. The project aims to reduce infections from MSSA for patients having hip and knee replacement surgery.

Description

The purpose of the Quality Improvement in Surgical Teams Collaborative is to improve the quality of care delivered to patients requiring joint replacement surgery. This is by introducing two complimentary care-bundles, for mild anaemia and MSSA into routine clinical practice. It will focus on the 'scale up' of these two surgical care bundles which have already been tested by Northumbria Healthcare NHS Foundation Trust. They have shown to improve care and outcomes for patients with mild anaemia and to reduce MSSA infection rates. Our Trust

is currently participating in this national collaborative and has recently been commended for its contributions to this ambitious improvement initiative to date.

Key achievements

- HSJ Awards 2018 –Acute Sector Innovation category- Highly commended
- Deliver of pre-operative assessment clinical (POAC) training around the Meticillin sensitive Staphylococcus aureus (MSSA) screening protocol
- Redesign relevant patient information document leaflets
- Development of a database to collect measurement for improvement data
- Creation of MSSA and Anaemia screening protocols

PART 3

INFORMATION ON THE QUALITY OF HEALTH SERVICES



Improving outcomes of patients undergoing Emergency Laparotomy surgery



Aim: Improve outcomes in patients undergoing Emergency Laparotomy surgery in Bradford Teaching Hospitals NHS Foundation Trust



By When: By September 2019



Outcome: Reduction in mortality rate to 11.8%

Focus

The Trust is currently participating in the Emergency Laparotomy Collaborative (ELC) which is a two-year quality improvement project aimed at improving standards of care and outcomes for patients undergoing emergency laparotomy. The hospital also participates and contributes data to the National Emergency Laparotomy Audit (NELA).

Description

The ELC has grown from the successful Emergency Laparotomy Pathway Quality Improvement Care bundle project (ELPQuIC) which was carried out three years ago in four hospitals in the South of England. It is anticipated that we 'hold the gains' gathered through collaborative learning among our peers in the region.

Being part of the collaborative has provided the team the opportunity to share some of the work they have done and also explore and trial different mechanisms for enabling care standards to become part of daily routine. The team are focussing on learning from structured

judgement mortality reviews, improving consultant-led input, and improving quality of care which is reflected in the 9 care standards captured as part of the NELA database.

Key achievements

- Reduced mortality rates across the emergency laparotomy patient cohort
- Improved consultant-led care
- Implementation of an emergency laparotomy pathway care bundle
- Engagement of multiple specialties involved in care of this patient group – Emergency Medicine, Radiology, Anaesthesia, Critical care, General Surgery.
- Achieved consistently 100% case ascertainment on the NELA National database
- Improved preoperative risk scoring to guide perioperative Care

SEPSIS

Awareness Week

Sepsis



Aim: To achieve a 50 % increase in the recognition and screening of patients with suspicion of sepsis in Bradford Teaching Hospitals.



By When:
March 2019



Outcome: In progress, however to date a 57% increase has been achieved

Focus

Sepsis is the body's overwhelming and life-threatening response to infection. Sepsis can lead to tissue damage, organ failure and death. It is extremely important for health care providers to be well-versed in the signs and symptoms of sepsis in order to treat patients as early and effectively as possible.

Description

We have developed a number of initiatives to improve performance in the recognition and treatment of sepsis. Following EPR implementation and 'switch-on' of the sepsis alert, the Trust is now in a position to extract sepsis data directly from EPR. As a result a reporting suite has been developed to initiate conversations with clinicians in their areas around improving the recognition and response to patients suspected or diagnosed to have sepsis.

The trust has also recently successfully recruited to its first ever Sepsis Nurse Specialist role who is integral to raising the profile of sepsis in the organisation and supporting clinical teams.

Key achievements

- Increased awareness in all departments on the need for early recognition for sepsis
- Education being delivered to individual wards and departments to ensure increased awareness
- Discussions with each division to understand the barriers to completing screening tool aiming for changes and updates to EPR as appropriate
- Sepsis reports indicate a significant improvement in the number of patients screened for sepsis when compared against data submitted in Q3 and Q4 2017/18.
- There has also been a significant improvement in the giving of intravenous (IV) antibiotics within 1 hour of diagnosis.
- Recruitment of the Sepsis Nurse Specialist Collaborative project with Performance team to identify reporting systems and processes from EPR data extract to support CQUIN reporting.
- The new performance report which captures sepsis screening compliance from EPR

PART 3

INFORMATION ON THE QUALITY OF HEALTH SERVICES



Back to Basics



Aim: To raise the awareness and use of the basic principles of care given to patients



By When: March 2020



Outcome: To be assessed

Focus

The back to basics campaign was launched in 2017 and the purpose was to promote the basics in care.

The Back to Basics campaign is about:

- Putting our patients first
- Sharing the learning
- Making things more relevant
- Real patient stories
- Doing things differently
- Recognising everyone has a contribution
- Remembering what everyone is here for

Description

Monthly back to basic sessions are held with a focus on a particular topic. It is open to all staff to come along and learn more about that topic area. There is a mixture of interactive activities, role play, quizzes and scenarios.

Staffs are given the space to reflect on the basics in care they deliver/their department deliver and think of ways it could be improved or simply take a learning message away to share back in their department.

Providing care to patients with multiple conditions, requirements and treatment management is complex.

There are lots of national and local guidelines to follow, many procedures to adhere to and every patient is different.

Creating a foundation and basic principles can ensure we have a consistent approach to the care given to our patients as well as explore ways to enhance it.

Key achievements

- Over a 12 month period we assessed the evaluation feedback given from staff who attended the back to basics sessions. The top 3 feedback comments were:
 - It is interesting
 - Valuable
 - Thought provoking
- Well structured, engaging and relevant information is shared at the sessions that can practically be taken back to our wards/departments to use
- Over 292 staff trained through the back to basics sessions



End PJ Paralysis

Focus

#EndPJParalysis is a global social movement embraced by nurses, therapists and medical colleagues, to get patients up, dressed and moving.

Having patients in their day clothes while in hospital, rather than in pyjamas (PJs) or gowns, enhances dignity, autonomy and, in many instances, shortens their length of stay. For patients over the age of 80, a week in bed can lead to 10 years of muscle ageing, 1.5 kg of muscle loss, and may lead to increased dependency and demotivation. Getting patients up and moving has been shown to reduce the risk of falls, improve patient experience and reduce length of stay by up to 1.5 days.

Description

Since the start of 2018 we have been working across wards, departments and services to promote encouraging patients to get up, dressed and moving about. This could be through simple things like going to the dining area on the ward to have their lunch.

We also encourage patients to bring their day clothes into Hospital rather than be in their PJs because psychologically, this helps them on their path to recovery. We have been raising the awareness by getting staff to pledge to encourage patients to get up, dressed and moving.

Making the most of valuable patient time is particularly important – as figures show nearly half of people aged over 85 die within one year of a hospital admission.

A patient wearing their own clothes in hospital enhances their dignity, safety and retains their sense of identity. Encouraging patients to get dressed everyday boosts recovery and makes the most of precious time so it can be better spent with loved ones.

Key achievements

- Over 2000 patients up and dressed
- Over 1600 patients encouraged to mobilise
- “Stop gowning around” campaign which aims to encourage staff to assess if patients need to still be in a hospital gown
- We created our own End PJ Paralysis song and movement with lots of different staff coming together to promote the message
- We also found that going back to the basics and promoting independence can have a positive impact on our patients

3.1.2

LEARNING FROM INCIDENTS AND NEVER
EVENTS**Learning from incidents**

The Trust recognises that many incidents occur because organisations have ignored the warning signs of precursor incidents or have failed to learn from the lessons of the past. We recognise that most learning in any organisation

is incidental rather than formal and any system should not replace that, but serve to strengthen it. As a result we have embedded our approach to this 'formal' learning within our Quality Oversight System.

Our Quality Oversight System is designed to ensure that we adopt a systematic approach to learning from incidents. The approach is applied across the Trust to ensure that the key elements of the system are embedded in our governance and assurance structures.

Figure 25: The Quality Oversight System



Surveillance: Information is drawn from safety huddles occurring throughout the Trust and a daily review of all the incidents, coronial referrals and complaints from the previous day into a daily 'risk huddle' where specific incidents and contemporaneous themes and trends are identified and associated action or escalation planned.

Understanding: Every week the Quality of Care Panel (chaired by an Executive Director) meets to discuss and agree the actions associated with any outputs from the Quality Oversight System that are significant. These include incidents that meet the criteria for the declaration of a serious incident, significant themes and trends, or,

where concerns are identified that learning following a serious incident is not as effective as it should be. In addition, the Incident Performance Management Group, with representation from all clinical divisions, met weekly during 2018/19 to support the understanding of less serious incidents, themes, or trends, and support appropriate action or escalation.

Managing: The management of incidents, ensuring high quality and timely investigations to maximise the opportunities for high impact learning happens predominantly through the Incident Performance Management Group, the Complaints Management

Group, the Inquest and Claims Management Group and Divisional Quality meetings. These groups are all responsible for supporting the Quality Oversight System and ensuring that issues requiring escalation are managed appropriately and opportunities for learning, change and improvement are provided to the Learning Hub.

Learning: the Learning Hub, members have a key role in relation to the identification of learning and testing of dissemination of learning methodology. Learning Huddles occur in specialties and this learning is shared for Trust-wide contextualisation at the Learning and Surveillance Hub. In addition all Serious Incident reports are distributed for consideration of the actual and potential learning for operational divisions, through the divisional quality systems.

The Quality Committee receives a quarterly report that describes a range of 'precursor incidents' (generated from national audit outcomes, incidents, complaints, ProgRESS reviews etc.), the associated learning and how that learning has been managed and assured across the Trust.

Never Events

Some incidents that occur are serious, largely preventable patient safety incidents that should not occur if the preventative measures have been implemented by healthcare providers. These are defined nationally and called Never Events. It is important to recognise that Never Events hold a high potential for severe harm or death.

The Trust has reported three Never Events in the period 1 April 2018 - 31 March 2019. Two incidents occurred within the Maternity service and related to retained vaginal swabs following perineal repair.

The Trust is committed to learning lessons from all incidents and we take the learning from Never Events extremely seriously. The key lessons learned from the Never Events described above, where there was a failure of the processes designed to ensure the safe management of interventional procedures were as follows:

- the adoption of Local Safety Standards for Invasive Procedures (LocSSIPs) throughout the department / including a review of current procedures
- the participation of the service in the Trust wide safer procedures collaborative

- the introduction of a period of preceptorship midwives (practical training for a student or novice under the supervision of a preceptor) during rotation throughout the departments
- the procurement and introduction of delivery packs to commensurate with requirements
- the development of new swab, needle and instrument check list in maternal notes
- a review of compliance with the procedure checklist on transfer of patients onto wards
- the implementation of a training plan and competency process for midwives inducted / rotating back into the labour ward in perineal repair
- the introduction of visual aids to be used as aide memoirs (i.e. white boards)
- the assurance that all staff are able to identify and articulate the risk associated with the use of non-radio opaque swabs, and can identify when it is not appropriate to use them

One further incident occurred when the wrong tooth was extracted in a patient undergoing multiple extractions. The key lessons learned from this Never Event, where there was again a failure of the processes designed to ensure the safe management of interventional procedures were as follows:

- LocSIPPs are included in the training package for all dental surgical staff, and reinforced with all staff as a reminder
- if at any time there is an interruption in the procedure, the LocSIPPs individual patient pathway incorporating the three R's: Reposition, Recheck, Reaffirm with the assistant is followed
- ensure all members of the team have the confidence to speak up and challenge if they feel there is potential for error

A clear theme across all the Never Events reported during 2018/19 was identified in relation to the handover between clinicians mid-procedure (for appropriate reasons) but without a pause and a recheck of safety processes. This learning has been used to enhance the safety of all interventional procedures in the work of our safer procedures collaborative.

3.1.3**SAFEGUARDING CHILDREN**

The Trust's framework for safeguarding children is based on the Working Together to Safeguard Children (2018) national guidance, which promotes interagency working to safeguard children. The Trust executive lead for safeguarding is the Chief Nurse, and the Deputy Chief Nurse represents the Trust on the Bradford Safeguarding Children Board (BSCB). The BSCB has a number of subgroups, which are attended by the Named Nurses and Named Doctor, as well as the Safeguarding Children's Specialist Nurse Practitioners, ensuring that Trust staff work closely with other relevant agencies across Bradford to safeguard children.

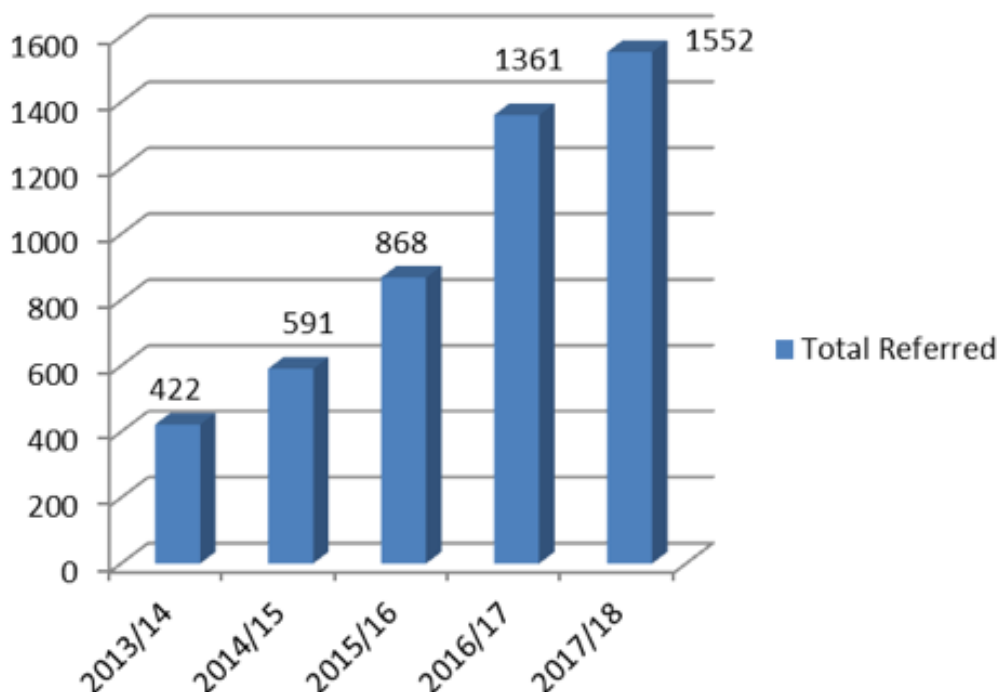
As detailed in Section 11 of the Children Act, the BSCB and the Clinical Commissioning Groups (CCG) require assurance from the Trust that all service users (patients) are safeguarded and their wellbeing is promoted. The

Trust provides evidence of this on a regular basis via an online portal, which holds information that shows how we comply with the requirements of Section 11 (known locally as the Section 11 audit).

Safeguarding children remains a high priority in the Trust. There is a robust policy in place that provides a framework that should be followed by all Trust staff, encouraging professional challenge of practice where appropriate. Best practice is reinforced in training, and through staff support and supervision. There is clear guidance with agreed processes for staff to follow to ensure that they recognise, respond to and report vulnerability of children at risk of abuse or harm.

The activity related to safeguarding is collated on an ongoing basis and the number of referrals to the safeguarding children team is increasing year on year. Figure 26 shows the number of referrals by year from 2013-14 up to 2018-19.

Figure 26: Total number of notifications/referrals to the safeguarding children team



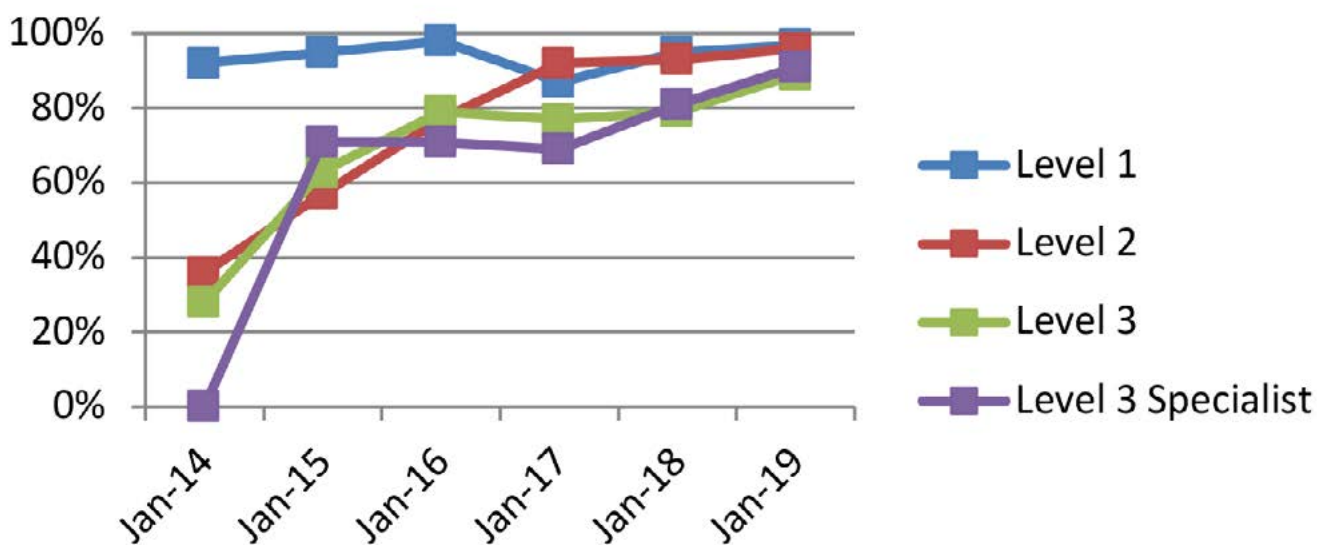
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Training for all staff in relation to the Safeguarding of Children is mandatory, based on their roles and responsibilities, in line with national guidance. Compliance with training is closely monitored.

Figure 27 demonstrates the increase in training compliance highlighting that this is currently at the highest level since safeguarding children training became mandatory in the Trust.

Figure 27: Safeguarding Children Mandatory Training Compliance 1st January 2014 – 2019



The Trust has been working closely with NHS Digital to introduce CP- IS (Child Protection - Information System), an additional system to protect children attending for unplanned (emergency or urgent) care. CP- IS is a national system that connects Children's Social Care IT systems with those used by the NHS. CP- IS gives health professionals the ability to see whether a child is subject to a child protection plan (CPP), where a pregnant mother's unborn child is subject to a CPP or whether the child is a Looked After Child. CP- IS has been successfully implemented into the Emergency Department, Children's Clinical Decisions Area and Maternity services. This is particularly helpful for children attending the Trust from outside Bradford, to ensure that staff are aware of any protection measures that are already in place.

The Trust is committed to listening to the voice of the child and is working with multiagency partners on how to ensure that staff can identify and record the child's views. The Trust recognises how important involving children in decisions that affect them is and how this can have a positive impact on the child's care whilst attending the Trust and enable effective safeguarding.

A key emerging theme within child safeguarding nationally is contextual safeguarding, which predominantly affects adolescent children. Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighborhoods, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts and young people's experiences of extra-familial abuse can undermine parent-child relationships.

The Trust is dedicated to safeguarding this group of young people by raising staff awareness of the complex issues that may affect them and how this may present in the Trust. Due to this, the theme for all training for 2019 is focusing on this issue, and additional activity with this age group is taking place by monitoring daily attendance or admissions and taking action where required to ensure they are safeguarded and their wellbeing is considered.

3.1.4**SAFEGUARDING ADULTS**

The Trust has continued to undertake work to improve the services it provides with respect to safeguarding adults. This has been both internally within the Trust and externally by working with partner agencies across the District.

There has been a continuous programme of training relating to safeguarding adults. All staff have now been assigned their appropriate level of training on the electronic staff record (ESR) and the Safeguarding team work closely with the Education Department to ensure all staff understand their training requirements and that there are sufficient training sessions provided to meet demand.

The Safeguarding Adults team works closely with the Safeguarding Children team. Each attends the others' safeguarding meetings as well as the Integrated Safeguarding Committee meeting, which is chaired by the Deputy Chief Nurse, and has a role in overseeing the standard of safeguarding across the Trust. The teams work closely together to identify and support adults and children who are experiencing domestic abuse, with targeted work in the Accident and Emergency Department in particular. The Prevent agenda (the Government's Counter Terrorism Strategy) has also required close working to ensure all staff across the Trust have received training appropriate to their role to ensure compliance with NHS England requirements.

Responsibility for raising awareness of the needs of patients with Learning Disabilities now sits with the Safeguarding Adults team. Work has been undertaken with the learning disabilities team from Bradford District Care NHS Foundation Trust (BDCFT) to raise awareness amongst staff and ensure information and support is available to staff and patients. Honorary contracts have been given to the Learning Disability Matrons from BDCFT to ensure expert support and information is received in a timely manner to ensure appropriate care delivery.

The Chief Nurse is the Vice Chair of the Bradford Safeguarding Adults Board and Chair of the city-wide Safeguarding Delivery Group.

Work with Partners

The Safeguarding Adults team has continued to attend the district-wide Safeguarding Adults Board and its sub groups; the Domestic and Sexual Violence Strategy Board and the Multi Agency Risk Assessment Conference (MARAC). Other district-wide meetings are attended as necessary such as those on the West Yorkshire Human Trafficking and Anti-Slavery Network (WYHTASN) and Prevent, with established links for receiving information and updates.

The Team participates in Domestic Homicide Reviews (DHRs), not only within the Bradford District, but from any area which requests information about victims or perpetrators who have been treated at the Trust. The Trust is legally obliged to participate in any DHR where the Trust has been involved in the care of either the victim or the perpetrator, within a relevant period of time. The Safeguarding Adults team receives the notification when a DHR is required, and is responsible for coordinating the response, monitoring progress and collating information as required. The Trust provides a panel member to sit on the DHR panel, and an author to conduct an Independent Management Report (IMR). The IMR identifies the Trust's involvement and makes an assessment of whether there were indications of domestic abuse apparent, whether support or advice was provided accordingly, or whether there were any actions that could have been taken that might have prevented it from occurring. During 2018/19 the Trust has provided information as requested for DHRs, and worked with partners to review previous action plans related to previous DHRs.

The Named Nurse for safeguarding adults is the chair of the Safeguarding Adults Review (SAR) subgroup of the district wide Safeguarding Adults Board (SAB). This process is similar to the DHR process and requires the Trust to provide information as requested to identify learning.

The Team works closely with the hospital social work team to make enquiries on behalf of the Local Authority (Bradford Metropolitan District Council) when there is a concern that abuse has occurred. This often involves joint visits and ensures that care needs are identified and safety plans are considered, both for whilst the person is in hospital, and also on discharge.

Training is delivered externally by members of the Safeguarding Adults team, in collaboration with partners across Bradford, to assist in the awareness raising and understanding of the West Yorkshire, North Yorkshire and York's multi-agency Safeguarding Adults procedures. This allows for greater understanding of the various agencies' roles within the safeguarding process. It facilitates effective links being made across agencies.

The Safeguarding Adults team participated in Bradford's Safeguarding Week, which took place in June 2018. Training was provided for staff in the Trust as well as those across the Bradford health economy.

Progress and Outcomes

There has been a continued increase in the number of referrals to the Safeguarding Adults team from staff across the Trust, seeking advice and support on a range of safeguarding issues, with noticeable increases in contacts in relation to Mental Health concerns and Human Trafficking. Referrals to the Local Authority relating to concerns of abuse are relatively low in comparison to the total number of contacts. This is due to the implementation of the Making Safeguarding Personal agenda and the involvement of the patient from the outset.

There has been on-going work to embed the routine questioning of staff about domestic abuse, as part of the return to work interview following sickness, following changes made to the Trust's attendance management policy. The policy aims to support staff to disclose domestic violence following periods of sickness, not only to enable them to be signposted to sources of support, but also to make the question routine so that staff in turn feel able to ask patients. The Safeguarding Adults team have supported managers who may have had a disclosure and will support staff experiencing domestic abuse as requested.

The Safeguarding Adults team worked closely with the EPR team and their counterparts in Calderdale to develop

further some of the processes in EPR to ensure information that is not currently compatible with EPR, such as national documentation in relation to the Deprivation of Liberty Safeguards (DoLS) and the Mental Health Act (MHA), is accurately reflected in the patient's record. The team ensure accuracy and compliance with legislation.

Future Work

Over the coming year we will see:

- on-going participation and involvement with district-wide work across all networks to ensure staff have access to consistent advice and current practice guidance
- staff continuing to attend multi-agency meetings and assist with the delivery of multi-agency training
- a programme of clinical audits. Any areas of need identified from these will be used to adapt training as necessary
- further development of the processes within the Trust to support people with a learning disability, in conjunction with Bradford District Care Foundation Trust, with specific focus on reviewing the current policies to ensure they achieve a smooth transition for patients with a learning disability from community to hospital and back to community
- development of pathways for accessing support in relation to Mental Health services for patients and the implementation of the NCEPOD guidance 'Treat as One', to ensure a patient's mental illness is recognised and treated concurrently with any physical condition
- review of domestic abuse work within the Trust, with focus on ensuring staff knowledge of recognising signs, responding to disclosures, the child behind the adult and referral to support services
- we are planning to hold a multi-agency event in early summer to look at the 'Treat as One' agenda and how we can take this forward.



3.1.5

SAFE NURSE STAFFING LEVELS

Nurse Staffing Levels

National guidance from the Chief Nursing Officer for England, the National Quality Board and the Care Quality Commission requires all hospitals to agree safe staffing levels for each ward and department, and to publish, on a monthly basis, details of the actual number of nursing and midwifery staff who worked compared to the number of staff planned. This information is uploaded to a central data base (Unify) and is reported to the Board of Directors by ward, following which it is made available on the Trust's website. As part of the information collected, Trusts are also required to provide information about the number of patients occupying beds at midnight, collated over a month. This information along with the actual number of staff available enables the calculation of the total number care hours per patient day.

We take the care of our patients very seriously and have established a number of robust mechanisms to ensure that our wards are safely staffed. This includes taking a census of the number of staff present along with the acuity and dependency of patients on the ward at the time of the census. This information is collected using Safecare a module that forms part of our electronic rostering system. Staffing figures are displayed in each area for each shift, to ensure transparency for our patients and visitors.

Daily meetings of matrons and heads of nursing take place to review the staffing levels (known as staffing huddles), against the information collected in SafeCare about the acuity and dependency of patients, so that decisions about

how best to maintain safe staffing levels can be made with all the relevant information required.

During December 2018, we reviewed the nurse and midwifery staffing establishments on all our wards and departments and a report of the results was presented to the Board of Directors in March 2019. This strategic nursing and midwifery staffing review was conducted in accordance with the National Quality Board Safe, Sustainable and Productive Staffing Summary (SSPS). The SSPS document describes that the key to high quality care for all is our ability to deliver services that are sustainable and well led. For nurse staffing, this means continuing our focus on planning and delivering services in ways that both improve quality and reduce avoidable costs, underpinned by the following three principles set out in the SSPS document:

- right care
- minimising avoidable harm
- maximising the value of available resource

The review also ensured that there is effective management and mitigation of current and future nursing/midwifery care delivery risks.

The review utilised the data from the SafeCare system, to look back at the extent to which the planned and actual staffing levels were in line with actual acuity and dependency of patients in a given area over a period in the preceding months. This was compared with other information about nursing indicators such as falls, pressure ulcers and other harms, and took account of the professional judgement of the relevant Senior Sister or Charge Nurse, Matron, and Head of Nursing, together with the Chief Nurse and Deputy Chief Nurse.

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An example of the template used to collate this information for each ward and department is shown in Figure 28.

Figure 28: Strategic staffing review template

Actions taken by the Foundation Trust to improve nurse recruitment and retention

The Trust has a comprehensive recruitment and retention plan that is implemented and overseen by the Recruitment and Retention Steering Group. This group is chaired by the Deputy Chief Nurse. The overarching objectives are identified in Figure 29.

Figure 29: Recruitment and Retention Plan objectives

Aim	Objective Ref	Expected Outcome	Assurance Mechanism	Review date
Ensuring continued safe and effective delivery of care and quality within the current constraints of nursing vacancy, national recruitment and retention difficulties and developing a junior workforce.	1	To improve/maintain retention rates	Retention rates remain within the national average and improve to the 25th percentile of all Trusts.	Monthly Workforce and staffing papers with analysis of data Model Hospital comparative data
	2	To recruit vacancies	Aim for 95% of all vacancies filled	Monthly Workforce and staffing papers with analysis of data Model Hospital comparative data

There are a number of detailed actions supporting the delivery of these overarching objectives; an update on

areas of achievement in 2018-19 toward delivering this plan are detailed in the retention section on page 212.

Recruitment

Nursing Associates

The Trust is one of the six regional partnership sites participating in the Health Education England (HEE) Pilot to recruit and train Band 4 Nursing Associate posts to bridge the gap between Health Care Assistants holding the Care Certificate and Registered Nurses. The roles are supported by a two year foundation degree programme, with the aim of introducing an improved career pathway within the nursing workforce and allowing registered nursing staff to focus on the more advanced elements of their roles.

The Trust appointed fifteen Trainee Nursing Associates, who started their employment with us at the end of January 2017. These trainees are based within our Elderly Care, Stroke, Vascular, and Paediatric wards, as well as our Maternity Theatres. A clinical tutor was appointed to support both the trainees in getting to grips with their role within the Trust, as well as our ward teams in understanding how the new role fits into the workforce.

The first cohort of Trainee Nursing Associates has just completed the second year of the foundation degree at the University of Bradford. The successful Trainees are currently in the process of completing their registration with the Nursing and Midwifery Council (NMC), after which they become registered Nursing Associates. Celebration events have been held in conjunction with other partners in the pilot. As part of the programme, the Trust has participated in an annual seminar designed specifically for our Trainee Nursing Associates, which was an opportunity to network with other Trainees from across the partnership as well as hear from local and national speakers on topics relevant to them, as a key part of our workforce.

Figure 30: Certificate of attendance showing all the partner organisation logos involved with the Trust in the West Yorkshire Nursing Associate Pilot programme.



The Trust has established a twice yearly recruitment of Trainee Nursing Associates, which from the second year of the pilot became an apprenticeship route. The University of Bradford continues to be a key partner with the Trust, as the education provider for our January cohort. We are delighted to have been joined in 2018, by the University of Bolton who are supporting our April cohort. This has strengthened the growth of the workforce on the in-patient ward areas.

The introduction of Nursing Associates into several of our ward establishments was a recommendation in the strategic nursing and midwifery staffing review submitted to the Board of Directors in March 2018, and takes account of the National Quality Board improvement resource for the deployment of nursing associates in secondary care.

Return to Practice Course

The Trust continues to support nurses wanting to return to practice, and working in conjunction with the University of Bradford, offers training posts to support nurses who have lapsed NMC registration. This gives them the opportunity to refresh their skills in a clinical area whilst undertaking their required Return to Practice Module, and being paid as a trainee. Previously these staff had to self-fund this process. Numbers are small, but never the less, this is considered an important element of our recruitment strategy.

Overseas Nurse Update

Small numbers of overseas nurses arrived during 2018, as the last of our overseas recruits from our previous recruitment campaign have completed the necessary language and knowledge testing process prior to arrival in the UK. On arrival in the UK, they were supported to work as a Health Care Assistant whilst undertaking the necessary Objective Structured Clinical Examination (OSCE) as required by the NMC. We are proud to report that all of the 2018 recruits passed their OSCE examination first time, following an intensive learning and support programme provided by our Education Department.

Newly Qualified Nurses

Plans are in place for attracting nurses to the Trust who are due to qualify in 2019 with the Trust attending the University of Bradford Careers event in November 2018. Between September 2018 and January 2019 the Trust was delighted to employ a total of hundred newly qualified adult and paediatric nurses and newly qualified midwives.

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The Facebook campaign that ran for 2018 has proved extremely successful in advertising and promoting vacancies across the Trust, signposting people to open days that have been held in each of the departments. The Trust continues to use this methodology, with a number of open days to support recruitment in a range of specialty areas, as well as Trust wide open days, the next of which is planned for June 2019.

Figure 31: Facebook campaign supported the new branding and imagery of the Trust



The new initiative that newly qualified nurses should be paid at band 4 pending receipt of their PIN and have their first year's NMC membership funded by the Trust, has made a positive difference in the number of new nurses and midwives attracted and retained.

The Education Department has worked closely with the University of Bradford to offer final placements to student nurses in the area of their choosing, to given them the chance to experience a placement in a ward or department they would like to work in when they qualify. Students will also be interviewed for a post in this last placement to give them an opportunity to secure their chosen area.

The paediatric wards were successful in recruiting a number of newly qualified child nurses in 2018, and in order to ensure they all received the level of support and guidance they would need to make the transition to registered nurse, Practice Educator, Laura Deery produced a bespoke education and competency package for them.

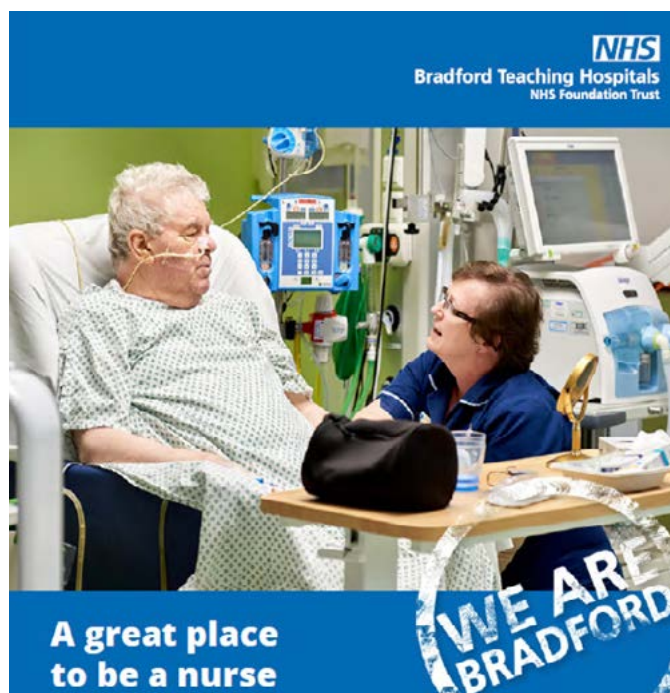
Figure 32: Shows a newly qualified paediatric nurse with the practice educator holding her support profile that has been used to develop her competencies during preceptorship.



New Recruitment Brochure

During 2018, the Trust has produced a recruitment brochure for all areas of employment across the Trust, and the Chief Nurse Team have worked closely with HR colleagues to produce a specific pull-out for nurses and midwives, to supplement this. The supplement sets out the range of opportunities available within the trust and includes a large number of staff profiles, to help bring to life the positive messages about working in the Trust.

Figure 33: The nurse recruitment brochure pull out.



PART 3

INFORMATION ON THE QUALITY OF HEALTH SERVICES

Mitigation

The number of nurse vacancies continues to be managed through use of existing rota cover, agreed over-establishment recruitment in some areas, the use of the Nurse Bank, additional hours and agency usage where required. Matrons review staffing on a daily basis to ensure that ward areas are safe. The strategic staffing reviews have focused on all members of the ward team in order to support patient care, with new roles such as the Nursing Associate, Senior Support Worker and Advanced Clinical Practitioners all being utilised to ensure that teams are able to provide a range of skills to meet the needs of our patients.

The Chief Nurse report provides further detail on nurse staffing levels in line with national requirements.

Retention

There has been significant progress in the retention work plan throughout 2018-19, with many of the actions, such as the development of leadership programmes for particular bands of nurses, (staff nurse, sister / charge nurse and senior sister / charge nurse) fully established and now business as usual. The transfer register for Band 5 nurses remains in place, and this has recently been opened up to Band 2 Health Care Assistants.

Strong links have been made with health education providers (universities and colleges), Health Education England, and Airedale NHS Foundation Trust to progress the development of new roles.

Any emerging national guidance / innovation in relation to recruitment and retention are reviewed in the Nursing and Midwifery Recruitment Steering Group and any new actions added to the action plan as appropriate.

During 2018 there has been a reduction in all areas of band 5 vacancy across the trust for nurse and midwives and review of the data from the Model Hospital Portal (a national benchmarking tool created by NHS Improvement) for retention rates and vacancy position for nursing and midwifery staff shows Bradford Teaching Hospitals NHS Foundation Trust are almost 2% above the national median in the latest data (taken from August 2018), with a Trust Value: 89.3% and a National Median: 87.6%

Figure 34: Senior Sister who has completed the Band 7 leadership programme



Significant work has taken place to develop more opportunities for new roles, e.g. Advanced Clinical Practitioners, to support the wards and departments. The Advancing Practice group continues to review and support applications for advancing practice in all areas of the Trust to support the development of new ways of working, thus creating the opportunity for career development and enhancing skills of the existing workforce to support the quality of care received for patients.

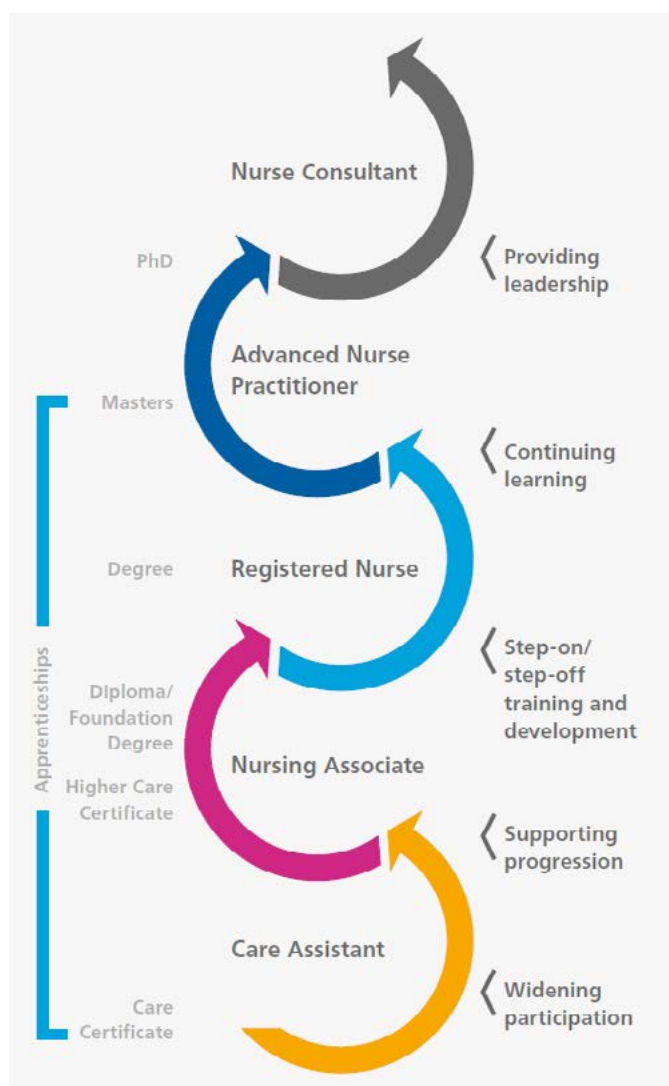
The Trust continues to work closely with education providers to enable training development to support the development of the existing workforce in Bradford in line with the approach shown in Figure 35. Plans involve pre-nursing associate training, post-nursing associate and pre-registered nurse training and development, including support throughout apprenticeship to progress. Furthermore, the Trust is working with the University of Bolton, to establish a new intake of pre-registration nursing students, which will result in Bradford having an outturn of registered nurses twice a year, rather than the current once a year in September.

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Figure 35: Nursing workforce development, Health Education England.



3.1.6

MEDICAL STAFFING

Post-Foundation Fellows

A 2016 review of recruitment to trainee rotation gaps (with the emphasis on moving to generic-type appointments rather than individual specialty-specific posts) led to the first cohort of Post-Foundation Fellows joining the Trust in August 2016. These junior doctors had just completed their foundation training, and many were unsure of their future career path in light of the new junior doctor contract negotiations. Whilst they were utilised across specialties to cover gaps in training rotations and long-standing non-training posts, the Fellows were also offered the opportunity to 'try out' other specialties of their choosing during the daytime (they cover rota gaps out of hours), granted up to three months unpaid leave (in agreed blocks), and given study leave time to complete post graduate certificates in education.

The second cohort of Fellows commenced August 2017 with a number assisting the clinical education team as part of their personalised rotations. The third cohort in August 2018 included three Post Core Fellows. These individuals had completed two years Core Medical Training and were seeking additional support to complete exams or to bridge the gap between core training and higher specialty training.

A review of the programme has shown that undertaking such a scheme allows junior doctors to confirm their future specialty choices. There have been a number of Fellows who have gone on to secure places on HEE training rotations having 'tried out' the specialty beforehand.

Medical Training Initiative

The Medical Training Initiative (MTI) is a national scheme designed to allow a small number of doctors to enter the UK from overseas for a maximum of twenty four months, so that they can benefit from training and development in NHS services before returning to their home countries. It has been in place with the Academy of Royal Colleges for a number of years. However over the past two years the number of MTI doctors recruited to the Trust has increased considerably. MTI doctors work for a period of six months on core trainee rotas, at which point they join registrar level rotas (subject to competence assessment). There are currently several MTI doctors in the Trust working in Anaesthetics.

Physician associates

Nationally, the development of Physician Associates forms part of the NHS transformation agenda and is aimed at supporting the need for the NHS to work differently in order to continue providing outstanding care to patients. The role of the Physician Associate is an innovative new health care professional who works to the medical model with the attitudes, skills and knowledge base to deliver holistic care under defined levels of supervision.

Seven posts were recruited to for surgical specialties and commenced August / September 2018. A further five posts are being appointed to for acute medicine at present.

The roles will be mentored by a designated Consultant and will work alongside a highly trained team of junior doctors and nurses. They will work collaboratively with all members of the multidisciplinary team contributing to the delivery of care in a range of settings including inpatient wards, outpatient clinics and community clinics.

3.1.7

2018/19 ANNUAL REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

The 2016 junior doctor contract includes a requirement for there to be a Guardian of Safe Working Hours who will submit an annual report to the Board to provide assurance that doctors and dentists in training are working safe rotas and that working hours are compliant with terms and conditions.

High level data

Number of doctors/dentists in training:	358
Number of doctors/dentists in training on 2016 contract:	357
Number of GP trainees (BTHFT lead employer arrangement)	41

Exception reports

Trainees submit exception reports if working beyond contracted hours or educational opportunities are missed. The Guardian monitors hours-related reports, while the Director of Education monitors training-related reports. The exception reporting process is a crucial part of the junior doctors' 2016 contract as it allows contemporaneous reporting of issues, feeding in to the trust and HEE's quality processes, with potential to drive improvement.

There were three hundred and nineteen exception reports submitted for the period 1 April 18 – 31 March 19. The majority related to additional hours worked. Fifteen highlighted educational concerns, submitted by junior doctors in ophthalmology, obstetrics and gynaecology, general medicine, elderly medicine, general surgery and paediatrics.

In total, eight hundred and fourteen additional hours were worked by junior doctors. Additional hours may be recognized with a supplementary payment, time-off-in-lieu or no action.

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Figure 36 shows the hours-related exception reports.

Figure 36: Exception reports (hours/rest) by speciality and training grade 1 April 18 – 31 March 19.

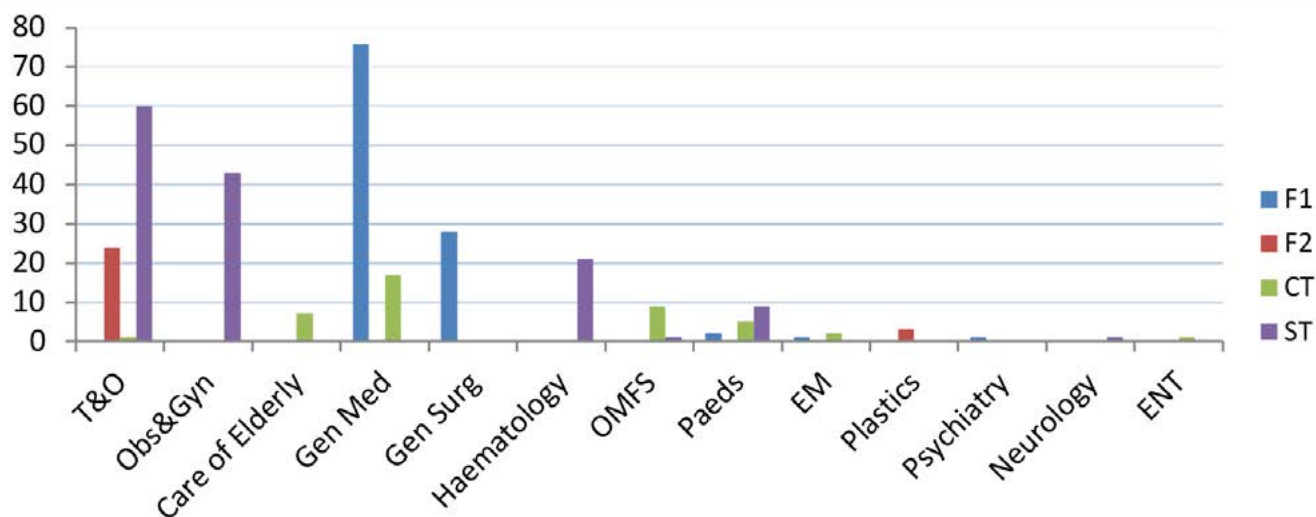


Figure 37 shows the top 5 reporting specialties and the trend in reporting rates.

Figure 37: Number of exception reports by top 5 specialties 1 April 18 – 31 March 19.

April 18 – March 19	
General medicine	94
Trauma & Orthopaedics	85
Obstetrics & Gynaecology	44
General surgery	28
Haematology	21

Vacancies

A gap on a rota results from the post not being filled or from long term sickness. This puts additional pressure on those junior doctors working the rotas. The number of gaps varied over the year between twenty one and twenty four across several specialties. Many were filled by the trust with doctors not in training.

Fines

The Guardian of Safe Working Hours can apply fines if breaches of working hours and rest periods occur. Examples of potential breaches are exceeding the 48-hour average working week, exceeding seventy two hours of work in seven consecutive days, lack of eleven hours rest between shifts, or missed breaks. Fine monies, via the Junior Doctor Forum, are spent on initiatives to enhance the working lives of trainees, in addition to paying locum rates to the affected junior doctors. No fines were levied in 2018-19.

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INFORMATION ON THE QUALITY OF HEALTH SERVICES



Qualitative Information

The Junior Doctor Forum meets quarterly and provides an opportunity for junior doctor representatives to bring concerns from their colleagues for discussion. Of note, positive feedback has been received about quality of training and supervision in paediatrics and plastic surgery. A working group has been set up to look at Trust implementation of the BMA's Fatigue & Facilities Charter, in an effort to enhance junior doctor's working lives.

The Trust is actively embracing alternative workforce options, with the appointment of physician associates. This has potential for easing pressure on the junior doctor workforce.

The trust is now lead employer for GP trainees with exception reporting from primary care now falling within the remit of our Guardian of Safe Working Hours.

Summary

The nature of exception reports was similar this year to 2017-18, although numbers were down slightly. The majority of consultant supervisors respond to exception reports appropriately and in a timely manner. Significant efforts have been made by the medical HR department that has led to closure of longstanding overdue reports.

Obstetrics and gynaecology began the year as a high exception reporting specialty. However, due to altered shift times and changes to service delivery, the reporting rate has fallen significantly over the year. Working closely with the education department, new initiatives continue to drive improvement in this high-pressured specialty.

Areas identified in this year's exception reports have an active work programme to reduce the hours of work.



3.2 FOCUS ON THE EXPERIENCE OF PATIENTS AND THE PUBLIC

Patient Experience remains at the heart of our core values within the Trust. Putting patients at the forefront of everything we do remains a high priority and we recognise that this can only be achieved by continuing to engage with patients and develop new ways of working to improve how they, their friends and family experience our care.

Work carried out within the Trust in relation to Patient Experience is over-seen by our Patients First Sub-Committee. This group meets monthly and provides assurance to our Board of Directors via the Quality Committee that we are striving to provide the highest quality of healthcare at all times. As well as providing assurance to the Board, we recognise the need for dissemination throughout the organisation to all areas to ensure patients, friends and family are at the forefront of what we do. During 2018, we have benefited from two excellent Patient and Public Voice Representatives, who are members of the Patient First Committee, increasing our accountability and transparency and furthering our ethos of co-working.

Patient Experience Strategy



Our mission is to provide the highest quality healthcare at all times and over the last year we have been looking closely at what makes a good patient experience. We have spoken to staff, patients and their families and carers and have used a blended approach to gather as much information as possible from a range of resources.

We set out with no pre-conceived ideas other than a willingness to listen, engage and put what we were told into practice. Our findings were simple and can be summarised into one word- kindness.

People told us what mattered most to them was that they were treated kindly, and this has led to the development of the Patient Experience Strategy: Embracing Kindness.

People told us what mattered most to them was that they were treated kindly, and this has led to the development of the Patient Experience Strategy: Embracing Kindness.

The Patient Experience five year Strategy was launched within the Trust during 2018, and extensive work has been carried out to embed this work and promote the five core principles that underpin the strategy. These are:

- Be kind and treat others as we would want our loved ones to be treated
- Introduce ourselves by our first name and explain what we do #hellomynamesis
- Make eye contact, use open body language and smile
- Value patients time, if something is delayed we will explain and give realistic timescales
- Ensure that we will always communicate with patients in an honest way, easy to understand and kind

3.2.1

PATIENT STORIES



Patient stories bring the experience of patients, and sometimes of their families or others who care for them, into the spotlight and are a rich and valuable source of learning for improvement. These continue to be of high importance to the Trust and our Board of Directors meetings commence with a Patient Story presentation.

A variety of clinical and non-clinical areas have been the focus of the Patient Stories at Board. We continue

to seek out stories from a wide range of patients to maximise our exposure and learning. These stories both celebrate excellent care and highlight areas for improvement.

Patient Stories can:

- identify problems, issues, risks, causes and potential solutions as well as highlight good practice.
- actively provoke debate about change and improvement; hence they can have transformative power.
- enrich and extend our knowledge, understanding, and empathy and open up a different way of knowing and understanding patient experience.
- connect organisational processes, systems and protocols with humanity, values and ethical practice and have a potential positive impact on thinking/decisions.

Patient stories come from a variety of sources including patient feedback mechanisms, personal contact with people in community organisations and events, in addition to staff suggestions. During 2018, we have proactively sought out stories and experiences from some seldom-heard groups including physically and cognitively disabled patients, profoundly deaf and BAME patients. This has enriched the diversity of our learning.

Staff members working in areas related to the patient story are invited to our Board meetings; this enables an active discussion regarding learning and feedback for the area concerned. When it is appropriate, a formal action plan can be requested by the Board of Directors to take forward any necessary learning and improvements which may be identified from a story. On other occasions more informal discussions to share good practice or embed positive changes are more appropriate. Participants have told us that taking part in patient stories has been important for them, both as an opportunity to share the good care they have received and to help us to improve.

During 2018/19 we have worked with the University of Bradford's Working Academy to produce films for our suite of Patient Stories. These are a valuable learning resource for individual staff and teams and they enable stories to reach a wider audience and provide continuous learning.

3.2.2

PATIENT AND PUBLIC INVOLVEMENT (PPI)

We aim to continually develop a range of effective way of involving patients, patient representatives and the wider community at all levels and in all aspects of our work. At this time of change and challenge for the NHS, enabling dialogue with the communities we serve and harnessing their expertise by experience is paramount.

All departments and services within the organisation are responsible for making sure that they think about and plan adequately for patient and public involvement in their services. Support and advice to



do this has been provided as required by the patient and public involvement lead. Examples of work carried out within the Trust during 2018/19 are presented in Figure 38.

Figure 38: Examples of collaborative work with patient and public representation involvement during 2018/19.

Department/Service	Action
Estates/Chief Nurse Office	Implementation of AccessAble. Full survey of site taken place and website now live to provide our service users with very specific details about our buildings and access points. This is available to view at: https://www.accessable.co.uk/
Maternity	Participation in the Maternity Voice Partnership. Antenatal project around “flow” through their services. Involving the Trust Transformation Team and service users to improve quality of service.
Estates	On-going development with Patient-Led Assessments of the Care Environment (PLACE). New monetary powers have enabled patients to be consulted about new equipment e.g. handrails.
Informatics	A listening event was held in June 2018, involving a patient representative group to consult on the new informatics strategy. In particular this demonstrated support for the patient portal (Your EPR), which is now an integral part of our strategy.
Cancer Services	Co-production with cancer patients of enhanced communication standards and bespoke training for staff to improve the experience for patients with cancer.
End of Life Care	Facilitating patient input and providing advice on content and design of the Bereavement Survey.
Paediatric	Survey work carried out with children who have been cared for on adult wards has been carried out to capture their experience and collate suggested improvements.
Estates	Innovation for signage for disabled parking has been improved and the number and proximity of disabled parking spaces providing access to the site has seen development.
Stroke services	Patient feedback regarding service reconfiguration

New standards and frameworks for patient and public involvement have recently been published which will be reviewed and applied appropriately to our approach to involvement.

Initial pilot efforts this year to improve the diversity of people involved with us, sometimes in partnership with other local organisations, have been fruitful, particularly in relation to young adults, disabled people and people from BAME communities. We plan to build on this through increased community outreach. Examples during 2018/19 include inviting local community members via a local Housing Association who support refugees to be part of our work stream and act as ambassadors from their own communities.

We have continued to develop productive collaborative work with other local organisations including, Bradford Metropolitan District Council, Healthwatch, Bradford University, the Alzheimer's Society, and the Stroke Association. This is in addition to working with local schools and colleges.

Membership and diversity of the Involvement Register has continued to grow, enabling us to meet the needs of services who want to be involved and fostering people with specific experience and expertise. Sustained involvement of patient representatives in strategic work has increased this year and relationships with community groups and organisations continue to underpin the development of involvement, an example of this is Public Voice Representation which is now part of our Patients First Sub-Committee.

Social media use and engagement has increased, raising the profile of patient and public involvement at the Trust and creating new connections. We have actively embraced and grown our social media presence with a considerable number of patients, staff and departments throughout the Trust choosing this platform of communication. The established @bthftpatientexperience and @bthft_yourvoice will continue to value feedback via this medium to further develop patient experience.



3.2.3

FRIENDS AND FAMILY TEST (FFT)

We want to continually use near real-time patient feedback to improve patient experience. The Friends and Family Test (FFT) provides an opportunity for people who use NHS services to provide feedback on their experience in real or near real-time. It asks people if they would recommend the services they have used to friends and family if they needed similar care or treatment and offers a range of responses. The Trust combines the core question with brief follow-up questions to provide more detailed insight, sometimes on areas specifically targeted for improvement, for example, linking to the results of the National Patient Surveys or quality initiatives.

Different methodologies are used depending on the context and type of care. The Foundation Trust offers two main routes for patients to provide their views: postcard type forms and using a tablet device whilst in the ward. The option to use a link in a text message to access an online version is also available for patients attending the Emergency Department who have given us permission to use their mobile phone numbers.

Work continues to promote the use of electronic collection, as the main route for inpatient environments, as this has greater potential to support a swift response to any reported issue and track participation levels on a regular basis, so that the level of feedback remains at a useful level.

Figure 39: Friends and Family Test 2018/19 results

	Q1			Q2			Q3			Q4		
Area	Recommend %	Not Recommend %	Response Rate %	Recommend %	Not Recommend %	Response Rate %	Recommend %	Not Recommend %	Response Rate %	Recommend %	Not Recommend %	Response Rate %
Wards	96%	1%	33%	95%	1%	37%	95%	1%	34%	96%	1%	37%
A&E	100%	0%	0%	89%	3%	0%	90%	2%	0%	83%	17%	0%
Maternity	98%	1%	17%	98%	1%	20%	96%	1%	27%	97%	1%	24%
Day Case	98%	1%	14%	98%	0%	11%	96%	1%	11%	98%	1%	19%
Outpatients	97%	2%	-	96%	2%	-	96%	2%	-	96%	2%	-
Trust Total	97%	1%	11%	95%	1%	10%	95%	1%	10%	96%	1%	13%

Friends & Family Response

The Friends and Family Test is now part of the NHS contract for most NHS-funded services in England, including inpatient, day-case, outpatient, community, maternity and paediatric services. The Trust has implemented the Friends and Family Test across all divisions and services in accordance with NHS England requirements.

Please note some patients did not express an opinion which could be categorised as Recommend or Not Recommend.

% Recommend based on number of responses Extremely Likely and Likely

% Not Recommended based on number of responses Unlikely and Extremely Unlikely

Response rate % based on the above categories including: Neither Likely nor Unlikely and Don't Know

Figure 39: Friends and Family Test 2018/19 results (continued)

2018/19 results			
Area	Recommend %	Not Recommend %	Response Rate %
Wards	95%	1%	37%
A&E	87%	2%	0%
Maternity	97%	1%	21%
Day Case	98%	1%	13%
Outpatients	96%	2%	-
Trust Total	96%	1%	12%

The overall percentage of patients who would recommend us to family and friends through each quarter (Q1-Q3) remains fairly consistent with around 95% who would recommend. Whilst this is a figure to be proud of, we always look at what we could be doing better.

We recognise that an area for improvement is within the Emergency Department in relation to patient satisfaction and whilst we acknowledge this is an area of great pressure, we need to look at ways to improve during 2019/20. There is currently a strong focus for development within this area of work.

We are proud to report that our maternity results are excellent from the feedback we have received, demonstrating a consistent trend of patient satisfaction.

The Trust is working on ensuring that each ward is displaying up to date FFT data, including "You Said, We Did" information that shows how we are acting on the issues raised. This is valuable for staff, patients and visitors to visualise how we have acted on the feedback provided and should act as further encouragement to participation in future feedback.

3.2.4

CHAPLAINCY AND BEREAVEMENT

The Trust has a strong multi-faith Chaplaincy Team, which consists of two full time and five part time Chaplains, covering Muslim, Free Church/Church

of England, Roman Catholic, Hindu and Sikh faiths alongside Jewish and Jehovah's Witnesses. The Chaplaincy team is there to support patient, carers and staff within the organisation. Referrals to Chaplains can be made directly by patients, carers or by the ward staff, via the Chaplaincy office. An on-call service is also provided by the Chaplains on a rotational basis and the department is contactable seven days a week.

The department is also responsible for prayer facilities and has a Chapel and Prayer Room with ablution facilities and a quiet room for all to use, at our two main sites at Bradford Royal Infirmary and St Luke's Hospital. Our Community Hospital sites also provide prayer facilities. A multi-faith room is provided for all, with ablution facilities, at Westbourne Green and a similar dedicated space is available at Westwood Park.

The Chaplaincy department also has approximately 75 volunteers of different faiths and denominations and of no faith, who visit patients on the wards on a daily basis. The department's volunteers make an average of 32,000 contacts every year providing spiritual and religious support to patients and their carers on the wards.

Bereavement services sit within the Patient Experience Team. In March 2017, the Trust introduced a Bereaved Carer Survey. This is given to a family member when a patient dies in any of the hospital wards and provides us with useful feedback on how the Trust supports families at this difficult time. The Trust recognises that this is a difficult time for any family member and families are under no obligation to complete this. To date there has been a steady flow of responses that are reviewed regularly and fed into the End of Life steering group to inform us about any areas for improvement.



3.2.5

NATIONAL PATIENT SURVEYS

We continue to work on strategies to make sure we make best possible use of the data the surveys provide alongside other patient feedback.

Participating in the Care Quality Commission's National Patient Survey programme is a mandatory activity. This year has seen a number of changes in the CQC programme and methodology, such as increasing the minimum sample size for all surveys, increasing the frequency of some surveys, and new publicity requirements to make sure patients are aware they may receive a survey and offer them the opportunity to opt out of this.

These surveys provide an opportunity for patients and, in the case of children, their parents, to provide us with more detailed and comprehensive feedback on their experience with us. The results contribute to assessments of NHS performance and are also used for regulatory activities such as registration, monitoring and on-going compliance.

Each survey page shows England level results and provides access to Foundation Trust-level results, including results of earlier surveys. Because of the methodology CQC uses, care must be taken when

interpreting the results, as it does not allow direct comparison between Trusts, although it does provide a sense of how an organisation is performing compared to all other participating organisations.

All National Patient surveys are provided for the Foundation Trust by Patient Perspective, working closely with our staff. Provision is made, at the point when a postal survey questionnaire is received, for patients who do not read English, or need other support to take part. However, it is the patient's choice to access this or not. Achieving a good response rate continues to be a challenge for the Trust.

There are strict limitations on what we are allowed to do to publicise and promote the survey, so as to ensure methodologies remain as standardised as possible across all participating organisations.

An in-depth analysis is provided by Patient Perspective, which is used alongside the CQC analysis to help staff understand the experience of patients and identify areas where improvement or change is needed.

The Trust holds workshops led by Patient Perspective to enable key staff to gain a more in-depth understanding of the findings and identify priority areas for improvement work, to develop and work through action plans.



Inpatient Survey data July 2018

At the time of writing this report, data is not available (expected publication June 2019).

National Maternity Survey 2018 (reported in 2019)

The National Maternity Survey is now an annual survey and was sent to all women who gave birth in February 2018. In Bradford, 414 surveys were posted and there was a 29% response rate which is slightly higher than the 2017 survey. The average Mean rating score, across all questions was 78.7%, which again was slightly higher than in 2017. On 8 of the questions Bradford scored in the top 20% of Trusts nationally. Ten questions showed at least 5% improvement on the 2017 score and the remaining questions showed either less than 5% change in score or a worse score.

In response to the survey results, we have had very good staff engagement and we have identified a number of areas of care for improvement. This includes

- information around postnatal care and how to access follow up and advice regarding contraception following birth
- advice given around the early stages in labour both at the time and in preparation for birth antenatally
- improving support and 1:1 care in labour

Since the 2018 survey, improvements have been put in place to the overall condition and appearance of the building. A fresh new look and 'face lift' with new cladding and windows for the main maternity building have been completed. We have opened the Maternity Assessment Centre (MAC) twenty four hours a day, where women and their partners can not only ring for advice, but attend for assessment, which enhances the maternity care and experience patients receive.

3.2.6**PATIENT-LED ASSESSMENTS OF THE CARE ENVIRONMENT (PLACE)**

Patient-Led Assessments of the Care Environment (PLACE) is a voluntary programme of assessments, run by the Department of Health and Social Care, via NHS Digital, which the Trust participates in every year. All

providers of NHS funded care are encouraged to be involved in these unannounced assessments which aim to:

- assess what matters to patients/the public
- report what matters to patients/the public
- ensure that the patient/public voice plays a significant role in determining the outcome

Assessments focus on the environment, in which care is provided, with particular emphasis on:

- cleanliness (including hand hygiene)
- general condition, appearance and maintenance of buildings, fixtures and fittings including safety
- access (for disabled patients and other people who use the Trust premises).
- dementia friendly environments
- privacy, dignity and wellbeing
- nutrition and hydration (including choice of food and drink and other elements of the food service assessed at the point of service on wards)

Assessments are undertaken over several months by teams of 'patient assessors' – in effect volunteers representing the perspective of patients and the public - supported by staff facilitators. The Trust asks all potential patient assessors and staff facilitators to attend training together, before taking part in an assessment. Additional staff from a wider range of services represented the team this year, which has brought useful additional experience and perspectives to the process, and eased the workload and logistical challenges for those carrying out the assessments.

Assessments were carried out over a wider range of days and times than ever before, to sample the standards on areas assessed across the week, and to enable people to take part who are not available during normal working hours. All assessing teams include at least two patient assessors and teams must have a minimum ratio of 50% patient assessor representation in each team.

Assessors are recruited from a variety of sources, including Healthwatch, voluntary and community groups, the Foundation Trust membership and Council of Governors, the Foundation Trust Involvement Register, local colleges and university, and through communications with the local press, media and Foundation Trust social media. We have trained a pool of over 50 volunteers to carry out PLACE assessments; this includes an increased proportion of assessors from BAME backgrounds, students, young adults and disabled persons.

The 2018 PLACE results have been analysed nationally, locally and compared to our local cohort of Acute Trusts.

It is pleasing to note that across all of the assessed domains, the Trust has seen a positive trend against the 2017 scores. The most significant improvements have been seen in Dementia, Disability, Privacy, Dignity and Wellbeing and; Condition and Appearance.

In order to ensure that we continue to improve, a robust Action Plan is generated to ensure any areas where low performance scores have been obtained, actions to improve are identified.

Figure 40 shows, at a glance; the scores obtained for each domain in both 2017 and 2018. This notes the percentage difference column shows an improvement in all domains in 2018.

This demonstrates a fantastic result in terms of the enhancement work completed in our care environments and the ownership shown by wards and departments in maintaining our sites in good order.

3.2.7

COMPLAINTS

This Trust takes all complaints seriously, and through a rigorous process of investigation, we always strive to be open and honest, providing a thorough explanation to complainants, including offering an apology and taking actions to identify a remedy where services do not meet the expected standard.

We have worked hard this year to ensure better alignment of our complaints and risk management processes, to ensure risks to patient safety and incidents of poor patient experience are addressed in a uniform and robust manner. This will also ensure that we continue to learn valuable lessons from patient feedback and those lessons are shared and actioned across all staff and departments. Further information is detailed in section 3.1.2 Learning from Incidents.

Figure 40: Scores obtained for each domain in both 2017 and 2018

Domain	2017 score	2018 score	% improvement
Cleanliness Score %	96%	97%	↑ 0.9%
Food and Hydration Score %	85%	85%	↑ 0.4%
Organisational Food Score %	89%	89%	↑ 0.4%
Ward Food Score %	84%	84%	↑ 0.1%
Privacy, Dignity and Wellbeing Score %	71%	76%	↑ 5.0%
Condition, Appearance and Maintenance Score %	85%	90%	↑ 4.7%
Dementia Score %	63%	76%	↑ 13.0%
Disability Score %	67%	76%	↑ 8.7%

3.2.8

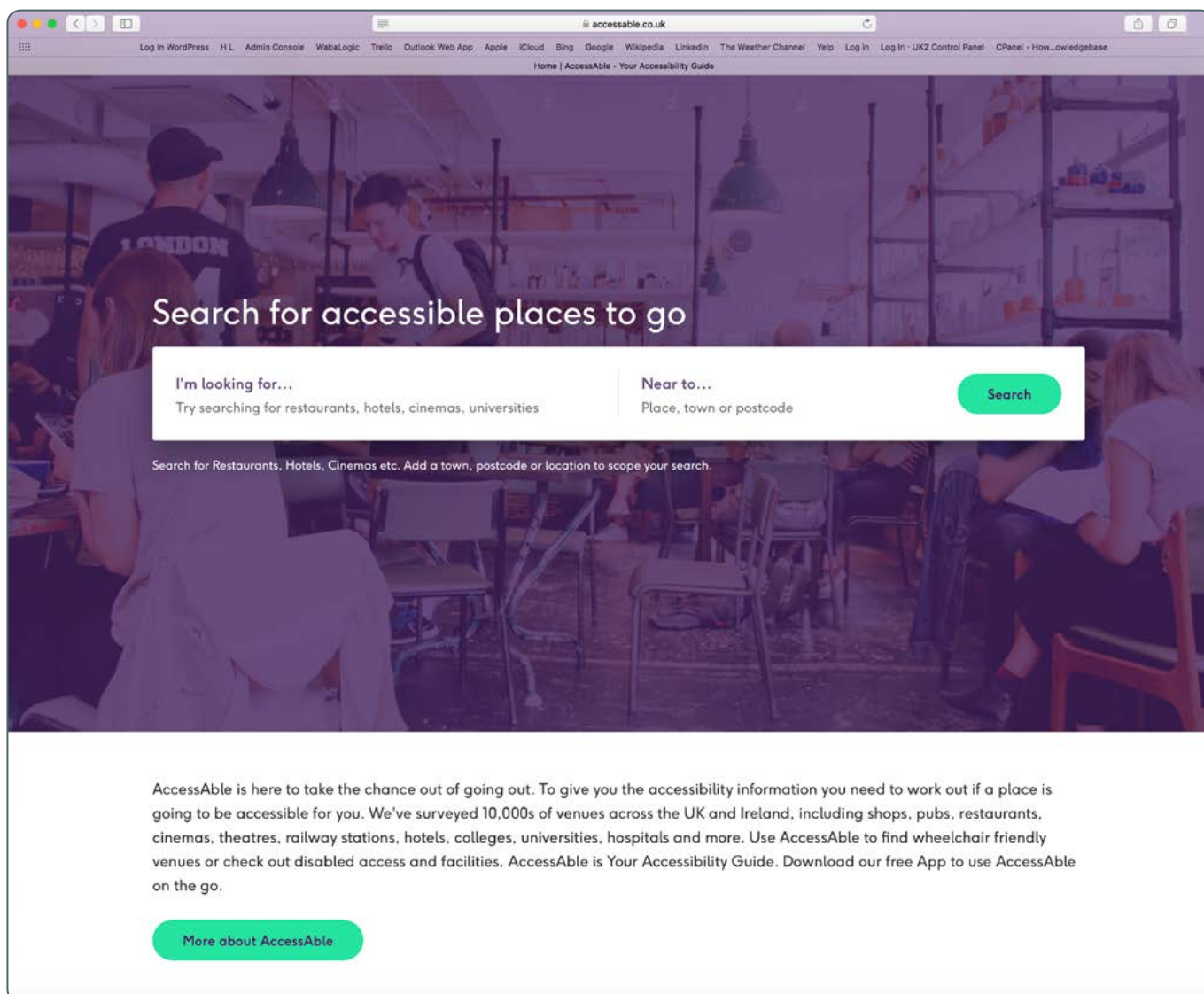
DEVELOPMENTS

AccessAble

In 2017, the Trust was approached by Disabled Go, a charity set up to provide free information to the public (via a website) about the accessibility of a range of public venues, such as restaurants, shops, cinemas, universities and more recently hospitals. The website provides information describing the accessibility features of these venues including parking, ramps, toilet/changing facilities etc. and includes dimensions/pictures/maps as appropriate.

During 2018 the Trust has been working with this organisation to develop the information for all Trust sites, developing guidance pages. It was originally due to be completed in 2018, but the company itself has gone through a rebranding process which meant the original planned launch was deferred. The company is now called AccessAble, and the information relating to the Trust's facilities is now live, and can be accessed via www.AccessAble.co.uk.

This site is useful to any patient or visitor to the Trust as this provides a comprehensive up to date guide of all areas. An official launch date is currently being arranged for 2019.





3.3 STAFF EXPERIENCE

3.3.1

WE ARE BRADFORD

We are Bradford is about who we are, why we are here and what we're about. It helps staff to make the link between what they do, whatever the role they are in, and our patients. Part of this, bringing our values to life, is really important in shaping our culture and has been the focus for our work during 2018/19. In May 2018 our first 'Work as One' week took place, to bring our values to life as a Trust. The aim was to empower and engage staff through focusing on an operational priority. It encouraged staff to think differently, to be innovative and make changes that will improve the quality of patient care and patient experience. It was a great success and we held five further events throughout the year, including a system-wide week in January 2019.

We are Bradford encompasses all our work around staff engagement, developing our culture and developing our leaders to make sure we deliver the highest quality care for our patients and service users:

We are Bradford

- bringing values to life as teams - workshops launched in May and delivered to teams across the Trust
- embedding our values in our recruitment process (can include link to Nurse recruitment and recruitment materials and/or Trust website)

Work as One

- bringing values to life as a Trust
- working as one big team to develop and embed improvements
- success of first week in May, everyone behind patient flow, with improved patient experience, improved staff experience, improved process and improved collaboration



**BRILLIANT
BRADFORD**
STAFF AWARDS

Brilliant Bradford

- team and employee of the month awards
- Brilliant Bradford annual staff awards
- staff voted online to shortlist for the annual Team and Employee of the year
- We are Bradford page on external website shares staff stories
- newsletter special editions to celebrate 'Work as One' weeks and NHS 70
- nurse Facebook page celebrating winners and sharing staff stories
- 'Let's Talk' Live events shared

Happy, healthy and here

- health and wellbeing initiatives throughout the year
- 12 days of Christmas campaign covering key areas such as mental health, diet, exercise, smoking and flu
- initiatives to improve the health and wellbeing of our staff and reduce sickness absence

Let's Talk

- 'Let's Talk' newsletter, sharing staff stories
- Core briefs to cascade key messages about the Trust to staff
- 'Let's Talk' Live listening events with the Chief Executive
- 'Let's Talk' Together events for Senior Leaders to help shape the direction of our Trust
- increasing our use of social media using Podcasts; Blogs; Facebook and Twitter
- 'Time2talk' campaign to make sure everyone has effective one to one conversations and appraisals
- Annual Staff Survey and regular Staff Friends and Family Test

Our Leaders

- launched Trust Leadership Development programme
- launched Senior Leadership Development programme
- delivered Management Essentials workshops increasing the confidence and capability of our managers
- reviewed and refreshed our Leadership and Management Development framework and intranet hub
- delivered Leadership workshops, accessible to all staff

3.3.2

STAFF SURVEY

Outcomes

Overall the results of the annual NHS Staff Survey

are positive and show that we are listening to our staff, working with them to make improvements and making a difference to their experience and how they feel about working here.

Staff feel satisfied with the quality of care they give, feel their role makes a difference, and they are able to do the job to a standard they are pleased with. They feel supported by managers and colleagues; they're clear on responsibilities and feel trusted to do their job. This is the very essence of We are Bradford and shows how important it is to make sure we continue our work to bring our values to life.

More staff are saying they have opportunities to;

- show initiative in their role
- feel able to make suggestions for improvements
- be involved in decisions about changes that affect their work

More are saying their team has;

- a shared set of objectives and meet regularly to discuss how they are doing – things which are demonstrated by effective teams
- a significant positive shift in the number of staff satisfied with recognition of good work and feeling that the organisation values their work

There are improvements across the majority of the areas in last year's Staff Survey action plan. Staff engagement, our priority in 2018, significantly increased again, showing an upwards trend over the last three years from 6.9 in 2016 to 7.2 in 2018. Staff motivation and recommending us as a place to work and receive treatment both show a significant increase in scores. There were positive shifts in the scores for communications between senior management and staff, up from 37.8% to 42.1%; reporting of errors and incidents from 92.9% to 96.0% and a decrease in the percentage of staff experiencing physical violence from staff in the last 12 months.

Overall our scores are above average in nine of the new themed areas; our score for 'Safe environment – Violence' matches the 'best' score of 9.6 benchmarked against other Acute Trusts and we have made significant increases in scores for Quality of Appraisals, Safety Culture, Engagement, Immediate Managers and Safe environment – violence.

Workforce Race Equality Standard (WRES)

NHS England has agreed a set of Standards against which we have to submit our data in order to comply with the NHS standard contract. The WRES forms the first stage in a process of addressing workforce equality issues. Our WRES data helps form part of the data we scrutinise as part of our Corporate Objective to be in the top 20% of NHS employers.

The nine WRES indicators are:

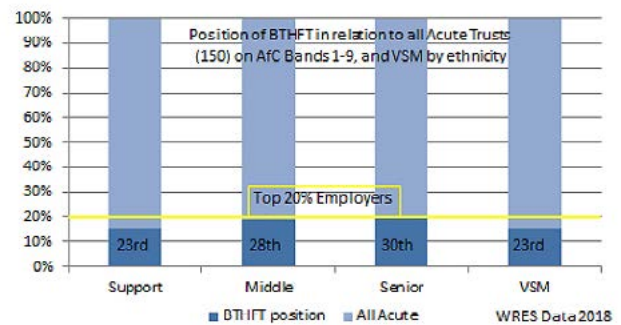
1. percentage of staff in each of the aggregate AfC Bands 1-9, and VSM by ethnicity (broken down Non Clinical and Clinical)
2. relative likelihood of staff being appointed from shortlisting across all posts
3. relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
4. relative likelihood of staff accessing non-mandatory training and CPD
5. percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6. percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7. percentage believing that trust provides equal opportunities for career progression or promotion
8. in the last 12 months have you personally experienced discrimination at work from any of the following? a) Manager/team leader or other colleagues
9. percentage of Board representation by ethnicity and Executive/Non Executive membership

Four indicators from the 2017 Staff Survey contribute to our WRES data, which we submit annually in July. Our overall WRES response is set out in Figure 41.

Figure 41: Overall WRES response by the Trust

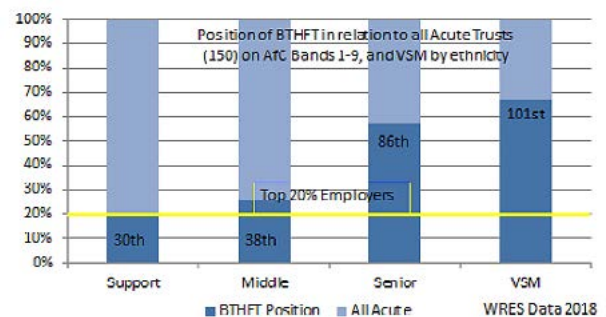
Indicator 1: Non Clinical % BAME Staff

NHS
Bradford Teaching Hospitals
NHS Foundation Trust



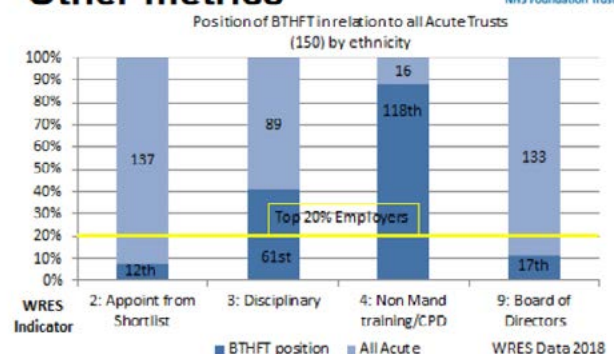
Indicator 1: Clinical % BAME Staff

NHS
Bradford Teaching Hospitals
NHS Foundation Trust



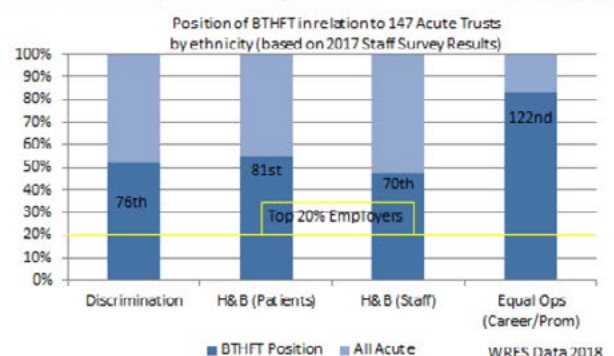
Other metrics

NHS
Bradford Teaching Hospitals
NHS Foundation Trust



Staff Survey 2017 responses

NHS
Bradford Teaching Hospitals
NHS Foundation Trust



2018/19 and beyond

It is important that we continue to build on the progress we have made during 2018/19 and increasing staff engagement remains our top priority – getting this right should have a positive impact on other areas including patient experience and outcomes; staff motivation; morale and wellbeing.

Although we have made significant improvements in many of the themed areas compared to last year, there is more work to do to improve Equality, diversity and inclusion, Quality of care, Quality of appraisals, Safe Environment – Bullying and harassment and Health and wellbeing and Safety culture. We will be focusing on these areas during 2019/20. We will also be addressing the areas where we are either below average or our scores have decreased since last year. This includes reporting of physical violence and areas around use of patient and service user feedback.

These priorities will be addressed through our Trust Staff Survey action plan and our People Strategy annual plans, with progress monitored throughout the year by the Workforce Committee, Executive Management Team and Board of Directors.

3.3.3

STAFF WHO SPEAK UP (INCLUDING WHISTLEBLOWING)

Freedom to Speak Up (FTSU) is embedded at BTHFT. Staff can raise concerns in a number of ways:

- by emailing a secure email – Speakup.guardian@bthft.nhs.uk
- by down loading BTHFT FTSU free App from the App store (this can be used anonymously)
- 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 Associate 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.

Figure 42: Details the number of concerns raised in 2018/19

Quarter 18/19	No. Of concerns raised
Q1	3
Q2	6
Q3	13
Q4	22

The Trust has also implemented a staff advocacy service which staff can contact directly for confidential, impartial advice, helping them to understand their options and make an informed choice about how to address their situation or concern.

Staff Advocacy Service

Bradford Teaching Hospitals NHS Foundation Trust

Staff Advocates ... Have your voice heard!

You can contact a Staff Advocate directly for confidential, impartial advice, helping you to understand your options and make an informed choice about how to address your situation or concern.

You can read more about the role of the staff advocate on the Trust Intranet. Click on the quick link to "Staff Advocates" on the home page.

If you have any queries or concerns with this process please contact Ruth Haigh, Staff Experience Manager (Ext: 4048 or e-mail: ruth.haigh@bthft.nhs.uk).

MID No: 18082/306

3.4 PERFORMANCE AGAINST NATIONAL AND LOCAL INDICATORS, AND MANAGEMENT OF PERFORMANCE

3.4.1

NATIONAL PERFORMANCE MEASURES

The Trust's performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS Improvement is reported in Figure 43. For 2018/19 these are the indicators that are measured by the Single Oversight Framework.

Figure 43: 2018/19 indicators measured by the Single Oversight framework.

Area	Indicator	Current Target	2018/19	2017/18	2016/17	2015/16	2014/15	2013/14	2012/13	2011/12
Access	Total time in A&E: maximum wait time of 4 hours	>=95%	80.07%	83.17%	88.50%	93.50%	95.10%	96.20%	95.70%	95.90%
The foundation Trust has not achieved the 95% threshold for the Emergency Care Standard throughout the financial year which is a position reflected nationally, with the majority of NHS organisations experiencing pressures in achieving this standard. The A&E department saw a high number of attendances in the financial year 2017/2018 with the 3rd highest volumes of the last 8 years. A number of remedial actions have been undertaken with the focus on improving patient flow throughout the hospital. Early planning guidance for 2018/2019 indicates the threshold has been reduced to 90% until September 2018.										
Access	Cancer 2 week wait standard	>=93%	72.73%	80.52%	95.30%	94.80%	95.50%	95.50%	95.10%	94.00%
	Cancer 62 day standard - First Treatment	>=85%	67.06%	76.27%	84.40%	88.70%	86.30%	88.80%	93.30%	83.70%
	Cancer 62 day standard - Screening	>=90%	89.64%	91.83%	92.50%	97.10%	97.00%	97.20%	98.80%	96.20%
In 2017/18 the foundation Trust continued to underachieve against the Cancer 62 day standard. In addition in the second half of the year service demand coupled with clinical capacity gaps have resulted in the Cancer 2 week standard failing the threshold for a number of months and for the financial year as a whole. For the second consecutive year the Foundation Trust has increased the number of patients treated for both indicators but has struggled to accommodate all patients within the threshold.										
Access	Referral to Treatment Waiting Times <18 weeks - Incomplete pathway	>=92%	77.14	82.30%	90.29%	92.60%	96.50%	97.20%	n/a	n/a
The foundation Trust did not achieved the RTT Incomplete threshold in 2017/18. The implementation of the Electronic Patient Record has meant there has been a transition period in reporting performance. The full year position presented represents a combination of performance from the tow systems used. The Foundation Trust has a recovery plan in place to increase access to elective services thereby reducing waiting times for patients and ensuring a better overall patient experience.										
Outcomes	Incidence of <i>Clostridium Difficile</i>	<=51	22	17	24	24	32	43	58	88
The foundation Trust has continued to perform well against the threshold set for Clostridium Difficile cases and will report a maximum of 17 cases currently still pending attribution. This reflects the efforts of all staff to incorporate infection control procedures into their normal working practice.										

Key



Green rating indicates that the target was achieved

Red rating indicates that the Foundation Trust failed to meet the target

Reporting against two mandated performance indicators and one locally selected indicator

NHSI Guidance stipulates that the External Auditor should undertake substantive sample testing on two mandated performance indicators and one locally selected indicator. The mandated indicators tested for 2018/19 are:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer

The locally selected indicator is that chosen by the Council of Governors. At their meeting held 11 January 2019 the Council of Governors confirmed that the locally selected indicator would be the 'Summary Hospital-level Mortality Indicator' (SHMI). The Governors noted that this was a nationally defined indicator produced and published quarterly as a National Statistic by NHS Digital.

The SHMI values and bandings for the Trust since July 2014 are presented in Figure 44.

The indicator definition is available in Appendix B.

3.4.2

LOCAL PERFORMANCE MEASURES

In determining the quality indicators for inclusion in the 2018/19 Quality Report we have incorporated Commissioning for Quality and Innovation scheme indicators (CQUIN) to ensure coverage of locally agreed quality and innovation goals as well as nationally defined quality assurance indicators.

The inclusion of the CQUIN goals within the Quality Report indicates that the Trust is actively engaged in discussing, agreeing and reviewing local quality improvement priorities with Bradford City and Bradford Districts Clinical Commissioning Groups.

National CQUIN goals reflect areas where there is widespread need for improvement across the NHS. They aim to encourage local engagement and capability building, but also to share good practice, encourage benchmarking and avoid duplication of effort across the country.

A summary of the goals selected by the Board of Directors in consultation with the lead commissioners and an explanation of their importance is presented in Figure 45.

Figure 44: Summary Hospital-level Mortality Indicator (SHMI) Latest available data (Oct17-Sep18).

Date	SHMI Value	SHMI Banding
Oct17-Sep18	0.909	2 – As Expected
Jul17-Jun18	0.926	2 – As Expected
Jul16-Jun17	0.926	2 – As Expected
Jul15-Jun16	0.978	2 – As Expected
Jul14-Jun15	0.971	2 – As Expected

Figure 45: Goals selected by the Board of Directors in consultation with the lead commissioners

Goal Name	Description of Goal	Quality Domain			
		Safety	Effectiveness	Patient Experience	Innovation
Staff Health & Wellbeing	Trusts should develop and implement plans to introducing a range of physical activity schemes, improve access to physiotherapy services and introduce a range of mental health initiatives for staff. Trusts are also expected to achieve a step-change in the health of the food offered on their premises in 2018/19 and ensure at least 75% of clinical staff receive influenza immunisation vaccinations.		Yes	Yes	Yes
Reducing impact of serious infections	This CQUIN seeks to incentivise providers to screen for sepsis all those patients for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics, within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock. It also requires that all antibiotic prescriptions for patients diagnosed with sepsis are reviewed after 72 hours if the patient is still in the hospital. Finally, it requires the Trust to reduce antibiotic consumption.	Yes			
A&E Mental Health	This CQUIN aims to reduce A&E attendances for patients attending A&E frequently with mental health needs by working with partners to redirect these patients to more appropriate services in the community.		Yes	Yes	Yes
Advice & guidance	This CQUIN seeks to improve GP access to consultant advice prior to referring patients in to secondary care.		Yes	Yes	Yes
Preventing Ill Health - Tobacco & Alcohol	This CQUIN aims to prevent ill-health related to alcohol and tobacco consumption by asking Trusts to screen every patient admitted to hospital in order to identifying patients at risk and providing them with advice and onward referral to the relevant cessation service if necessary.	Yes	Yes		
Patient Activation	Aims to encourage use of the "patient activation measurement" (PAM) survey instrument, firstly to assess levels of patient skills, knowledge, confidence and competence in self-management for different groups of patients meeting the criteria			Yes	Yes
Haemoglobinopathy ODNs	This CQUIN incentivises removal of the remaining barriers to achieving an appropriate network of care by enabling lead / specialist centres to provide MDT led annual review of all patients and the associated communications, clinical support, staff training and data entry to demonstrate the clinical outcome benefits of such a model.			Yes	Yes
QIPP	The Quality, Innovation, Productivity and Prevention (QIPP) programme is a large-scale programme developed by the Department of Health to drive forward quality improvements in NHS care, at the same time as making efficiency savings.				Yes
Dental coding	This CQUIN aims to ensure consistent coding for Oral Surgery and Maxillo-Facial Surgery procedures carried out in an outpatient setting.		Yes		

A summary of our 2018/19 performance against the indicators within both the locally-selected and national goals is outlined in Figure 46. Quarter 4 results are currently projected while awaiting feedback from the Commissioners.

Figure 46: 2018/19 CQUIN Achievement

CQUIN	Indicator name	2018/19			
		Q1	Q2	Q3	Q4
Staff Health & Wellbeing	Improvement of health and wellbeing of NHS staff				
	Healthy food for NHS staff, visitors and patients				
	Improving the update of flu vaccinations for frontline clinical staff				
Reducing impact of serious infections	Timely identification of patients with sepsis in the emergency departments and acute inpatient settings				
	Timely treatment of sepsis in the emergency departments and acute inpatient settings				
	Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours				
	Reduction in antibiotics consumption per 1,000 admissions				
A&E Mental Health	Improving services for people with mental health needs who present to A&E				
Offering Advice & guidance	Advice & guidance				
Preventing ill health by risky behaviours	Tobacco screening				
	Tobacco brief advice				
	Tobacco referral and medication offer				
	Alcohol screening				
	Alcohol brief advice or referral				
Patient Activation	Ongoing implementation for renal patients				
	Implementation for HIV patients				
Improving Haemoglobinopath Pathways through ODN Network	Participation in ODN				
QIPP	Delivery of a range of QIPP schemes				
Dental coding	Improving inpatient coding for oral and max facial surgery				
Staff Health & Wellbeing	Healthy food for NHS staff, visitors and patients				
	Improving the update of flu vaccinations for frontline clinical staff (Bowel and Breast screening)				

	Achieved
	Partially achieved/Undecided
	Not achieved
	Projected

3.4.3

IMPLEMENTING THE PRIORITY CLINICAL STANDARDS FOR SEVEN DAY HOSPITAL SERVICES

The Trust's Clinical Service Strategy 2017- 2022 describes how we will develop our clinical services consistent with the vision "to be an outstanding provider of healthcare, research and education and a great place to work" in order to meet the health needs of the people of Bradford and West Yorkshire.

The Clinical Services Strategy is set in the context of the NHS Five Year Forward View and its 2017 update, and the West Yorkshire & Harrogate Sustainability & Transformation Plan.

It outlines how we will work with partners to provide new, flexible models of care, tailored to the needs of patients. The vision statement in the Clinical Services Strategy makes a commitment to our patients to meet their needs now and in the future.

That we will "provide high quality healthcare, 24 hours a day, 7 days a week" – in particular we will focus on seven day services, mortality, the deteriorating patient, surgical safety and the use of digital technology to improve care."

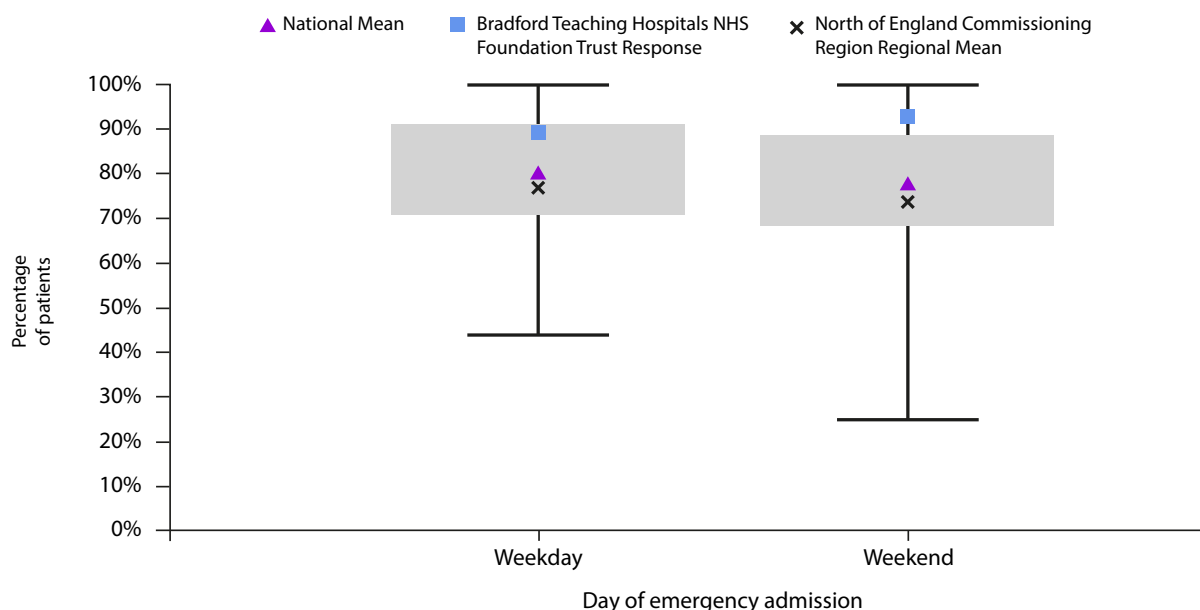
The Seven Day Hospital Services [7DS] Programme supports providers of acute services to tackle the variation in outcomes for patients admitted to hospitals in an

emergency, at the weekend across the NHS in England. The Trust has been a first wave implementer of 7DS, working closely with NHS England, Seven Day Service Improvement Programme [SDSIP] in implementing and reviewing progress from the six monthly surveys undertaken since March 2016. The Trust has also worked with regional and national colleagues to look at new ways of working to improve compliance to the four priority clinical standards. The Trust survey results have shown a continual improvement in compliance with the priority clinical standards, and in the April 2018 the Trust achieved the required 90% compliance for Standard 2 which benchmarked well in terms of National and Regional mean, see Figure 47; however there are still operational challenges to overcome to complete the sustainable transformational changes required to meet all ten agreed 7DS Standards.

From 2018 the six monthly surveys have been replaced by a Board Assurance Framework, NHS England and NHS Improvement have developed a robust board assurance process and single template which enables Trusts to record their assessments of 7DS delivery in each of the four priority standards for both weekdays and weekends as well as allowing a record of progress against the remaining six standards and the network specialised services.

The first formal board assurance submission will be due on the 28/06/2019.

Figure 47: Proportion of patients who received a first consultant review within 14 hours of admission to hospital



As of June 2019 the Trust will be submitting formal bi-annual self- assessments with local evidence that has been Board assured to NHS Improvement, to demonstrate compliance and improvement towards delivery of the ten 7DS standards.

The results from the board-assured assessments will form a 7DS metric in the clinical commissioning group improvements and assessment framework to allow CCGs to assess local delivery of 7DS. The CQC inspection regime will also assess 7DS as part of its judgement on a Trust's effectiveness.

3.4.4

THE QUALITY MANAGEMENT SYSTEM

During 2018/19 the Trust continued the implementation of its Clinical Service Strategy for the next five years. The Clinical Service Strategy was developed to support the development of the Foundation Trust's vision and mission, and was underpinned by its values.

The Clinical Service Strategy directly influenced the identification of the Trust's strategic objectives and as such the design, development, improvement, provision and delivery of its core services. As a result the Trust has worked to ensure that its Quality Management System is aligned to the Clinical Service Strategy, this for instance has led to the implementation of a one year Quality Plan and the Trust's Risk Management Strategy.

The progress of the Foundation Trust in relation to the achievement of the objectives set within the Clinical Service Strategy (and related strategies and plans that support it) is monitored by the Board of Directors, with the oversight of risk and assurance associated with the achievement of key performance indicators being delivered through the Board Assurance Framework.

The Quality Management System ensures, ultimately, that we have a comprehensive approach to identifying, measuring, and controlling and improving our core processes which are designed to support the delivery of our Clinical Service Strategy. This system includes our operational processes, management and review processes and support and assurance processes.

Management and review processes

- a Trust-wide approach to the governance of external data quality submissions has been implemented
- the Quality Oversight System (see section 3.1.2) was reviewed and strengthened
- a full self-assessment of the Board and Board Committees was undertaken and used to strengthen the use of assurance and the Board Assurance Framework throughout the governance infrastructure
- the Trust continues to implement a standardised approach to risk assessment and risk register management and risk escalation
- the Trust continues to implemented a standardised approach to action planning
- the Trust has implemented a consistent programme of Quality Improvement.

Assurance, testing and inspecting

- the Trust's ProgRESS Programme continued to assure and test the compliance with the CQC's Fundamental Standards of Quality and safety.
- the Trust received a rating of 'Good' for the Well Led Domain during 2018/19 following the CQC inspection undertaken during Quarter 4 2017/18
- the Trust received an overall rating of 'requires improvement' following the CQC inspections during Quarter 4 2017/18.
- the Trust participated in a CQC-led area review during 2017/18, the results of which was published during 2018/19
- the Trust commissioned Internal Audit to assure the effective implementation of its Risk Management Strategy and its Board Assurance Framework during 2018/19, resulting in a conclusion that there was significant assurance in relation to the use of both within the Trust's Quality Management System
- the Trust participated in all other statutorily required inspections related to the services which it provides

PART 3

QUALITY REPORT



3.5 EHEALTH ADVANCEMENTS

The Trust is in a privileged position in England with the success of our Electronic Patient Record and state-of-the-art supporting tools. Using the HIMSS EMRAM model, on a scale of 0 to 7, where 7 is everything everywhere is digital, the Trust is currently at a maturity level of 5.036 against an average of 1.5 for other hospitals. The high degree of digitisation, technologically-literate staff, and strong working relationships in our Bradford District and Craven Place provide an enviable position. This position allows us to use our data, tools, and skills for even safer care to our patients, learn and teach, conduct research, and drive innovation for our populations of citizens.

Continuing to develop our digital tools

In particular this past year the Trust has embedded the Electronic Patient Record into clinical use and has seen a number safety benefits. For example VTE Assessments are now consistently over 95%, 89% of discharge summaries are completed online, a decrease has been reported in medication errors and in Grade 3 pressure ulcers. We are now delivering 81% of antibiotics for Sepsis within a fast delivery time. For every patient bed-day the Electronic Patient Record is providing eighteen alerts to clinicians that could potentially avoid harm. The Electronic Patient Record

is also contributing to consistent care with 71% of all orders using the standardised protocol.

Further Electronic Patient Record advancements have been made this year with the addition of a direct link into patient images, a Sepsis Alert, updating the early warning score algorithm for deteriorating patients alert, and the new Emergency Care Dataset. Of particular importance in the district is the Health Information Exchange, which came online this year and provides all our GPs and Airedale Hospital clinicians with the ability to see into the Trust's and Calderdale & Huddersfield Hospital's Electronic Patient Record. Going beyond the area, the Trust is home to the Yorkshire Imaging Collaborative whereby the ability for Radiologists to see images from all nine Trusts has been tested and is coming online shortly. This will complement the Trust's active participation in the Yorkshire and Humber Care Record.

With the Electronic Patient Record in place and upgrades to our supporting tools the Trust has been able to advance our digital maturity. This has included growing the Business Intelligence team with the addition of apprentices and skilled people, providing increased opportunity and development for our staff.

The Clinical Coding service has defined a new service development plan which will see their skills and expertise align with the business intelligence aims. The teams have continued to develop the Data Warehouse with automations added for financial processing, and a Neonatal Intensive Care information system feed added in 2018/19. Work is progressing on providing near real time reporting using clinical data with the addition of a facilitating tool.

Keeping our technology current and safe

The Trust completed a number of upgrades this year, ending the year with only a minor number of technology systems that are behind their optimal version. This strong position is complemented by the introduction of a Cyber Security Strategy. The Trust is active in protecting our patients' data and our information systems. The strategy outlines four objectives, whereby the Trust will:

- use a range of technologies to ensure any potential cyber security issues are identified and blocked before any adverse effect on the Trust
- manage cyber security risks by using controls and IT technical user policies to mitigate risk, to ensure the routes to any potential cyber-attacks are mitigated
- continually develop processes and staff to keep the Trust safe
- ensure robust plans to respond to any cyber risks or cyber-attacks

This year the Trust is expected to become one of twelve Trusts in the country to achieve ISO27001 accreditation. This will provide the Trust with assurance that all emails sent to all government bodies are encrypted by default. The accreditation is expected to be in place by the end of May 2019.

Our new Digital Strategy

In recognition of the completion of the previous strategy, in 2018/19 the Digital Strategy was updated. Our new digital strategy aims to see technology and information used intelligently, and along with our partners, to keep our communities well and out of hospital – for example:

- by analysing community-based data from all the providers in near real-time we can coordinate care better and target interventions
- by using artificial intelligence to analyse our data we can assist in determining when patients would do better with other interventions then coming into the hospital
- by using tele-medicine and technology to 'see' patients where they are and help them manage their conditions better outside of hospital with and without our virtual help
- by using home monitoring instead of in-hospital monitoring to keep people at home

This strategy also has the complementary aims of improving the staff working experience through continued development and upgrading of our tools. In 2019/20, the Trust will see the AI-driven Command Centre come on line that will analyse our data, simulate scenarios, and provide prompts for targeted actions. This coming year we are also working to use our Patient Portal to enable patients to fill in assessments prior to coming into hospital and to provide an alternative to in-person visits.



Artist impression of the Wolfson Centre for Applied Health Research

3.6 RESEARCH ACTIVITY

The Trust continues to be the third highest recruiter in the region to National Institute for Health Research (NIHR) portfolio studies ensuring that our patients are able to receive innovative treatments. Up to mid-February 2019, 11825 patients were recruited into NIHR Portfolio adopted studies exceeding the previous year's recruitment levels as well as the Trust target for 2018/19 (6750 patients).

Work on developing the research infrastructure at the Trust continues with the progression of the Wolfson Centre for Applied Health Research. This is a major research venture and collaboration between the Trust and the Universities of Leeds and Bradford. As well as the physical build and its associated design much work is also being undertaken in to the development of the research agenda which builds on and extends the applied health research work undertaken within our Bradford Institute for Health Research. The construction of the Centre is due for completion in May 2019 with occupancy soon after.

The Wolfson Centre for Applied Health Research will focus on two crucial periods of life – healthy childhood and healthy ageing – with an underpinning theme of enhancing quality and safety across the care pathway during those periods.

The Trust continues to conduct a wide range of both clinical and applied health research with most specialties within the Trust being research active. Listed below are some of those areas of work.

Leading centre in Applied Health Research

The three main applied health research teams (Academic Unit of Elderly Care and Rehabilitation, Born in Bradford and Quality and Safety) continue to thrive:

Academic Unit of Elderly Care and Rehabilitation

The Academic Unit of Elderly Care and Rehabilitation research group has developed a programme of multidisciplinary health services research, with current funding over £12million, facilitated by a strong and supportive network of local and national colleague researchers, NHS clinical staff, patients and their families. This includes four large programme grants:

- Developing and evaluating strategies to provide longer term health and social care for stroke survivors and their carers (£1.6m);
- Strategies to reduce sedentary behaviour in patients after stroke and improve outcomes (£3m);
- Personalised care planning to improve quality of life for older people with frailty (£2.7m)
- A NIHR HTA randomised controlled trial to determine the clinical and cost effectiveness of a home-based exercise intervention for older people with frailty (£2m).

Continuing the department's highly successful grants record, we have recently been awarded a new NIHR Programme Development Grant to develop a novel system of care targeting risk factors for five manifestations of frailty to maintain the independence of older people in hospital and post-discharge. The project is scheduled to commence in spring 2019.

Striving to improve outcomes for patients and enhance the health and care system, our research outputs have had an influential impact at both national and international levels. For example, our NIHR funded study exploring the provision of post-stroke therapy led by David Clarke has been used as a case-study by the Royal College of Physicians.

Also cited in the Sentinel Stroke National Audit Programme (SSNAP) report in 2018, the team have showcased the research findings at several national and international conferences, including presentations at the Greater Manchester Stroke Operational Delivery Network and dissemination in Ireland and Australia.

We have also had international success with our Longer-term Unmet Needs after Stroke Questionnaire (LUNS). This has been translated into Dutch and French and is being used widely in service provision and research internationally. The 22 item questionnaire measures the longer-term problems affecting physical, social and mental well-being in the special context of longer-term stroke care. The Dutch team validated LUNS against the Dutch stroke population and concluded that it was feasible, reliable and valid. [https://www.strokejournal.org/article/S1052-3057\(17\)30464-0/pdf](https://www.strokejournal.org/article/S1052-3057(17)30464-0/pdf)

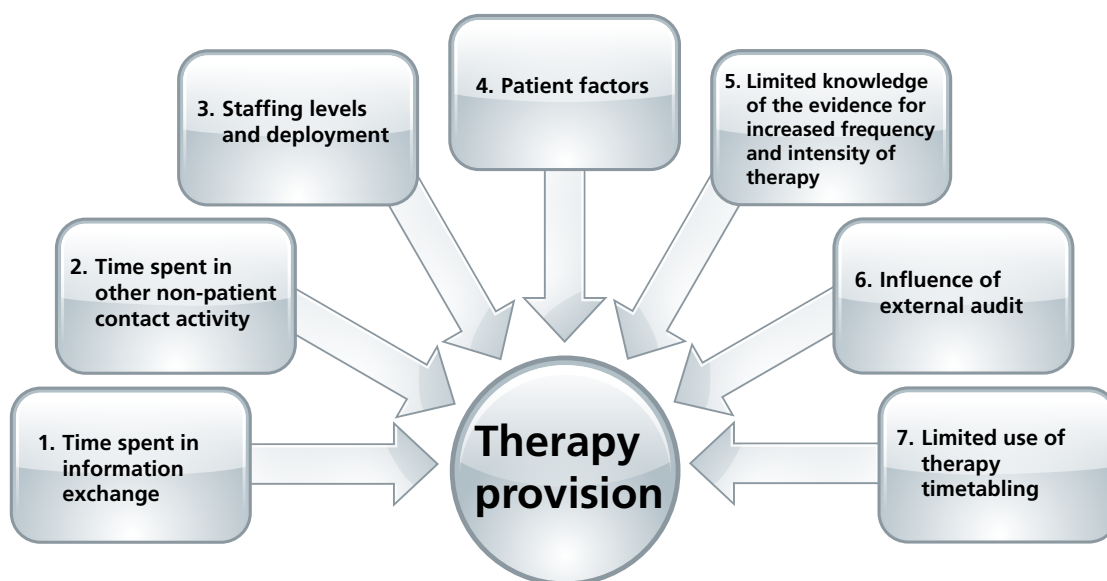


Our Community Ageing Research Study 75+ (CARE75+) longitudinal cohort study is also progressing at a strong pace with an impressive recruitment figure of over 1200 participants. Recruitment is still on-going in various sites across the nation. The large CARE75+ cohort is collecting an extensive range of health, social and economic outcome data, including on the wider determinants of health, with a particular focus on frailty status and frailty trajectories. CARE75+ uses the 'trial within cohort' design which provides a valuable recruitment platform for other studies to conduct research with older people in varied topics.

December 2018 also saw the retirement of the founder of our Unit, Professor John Young. John's substantial contribution to the local, national and international improvement in care for older people was reflected in the testimonials received from colleagues world-wide.



Figure 48: Factors influencing therapy provision²



² Clarke DJ, Burton L, Tyson SF, Rodgers H, Drummond A, Palmer R, Hoffman A, Prescott M, Tyrrell P, Brkic L, Grenfell K, Forster A. Why do stroke survivors not receive recommended amounts of active therapy? Findings from the ReAcT study, a mixed-methods case-study evaluation in eight stroke units. Clinical Rehabilitation 2018; 1-14. DOI: 10.1177/0269215518765329

Born in Bradford [BiB]

Established in 2007, the Born in Bradford research programme is one of the largest health research projects in the UK involving over 30,000 Bradfordians. By focusing on key public health priorities for families and conducting cutting edge research it is exploring the reasons why some people fall ill and others stay healthy. This information is being used to develop and evaluate interventions to improve the lives of families.

Over the past five years we have attracted over £20 million in research grants from national and international funders. We host two internationally recognised birth cohort studies - Born in Bradford and Born in Bradford's Better Start, an established programme of applied health research, Connected Yorkshire, and the Better Start Bradford Innovation Hub. Our funders include the National Institute for Health Research, Wellcome Trust, Economic and Social Research Council, Medical Research Council, National Lottery, British Heart Foundation, Kidney Research UK, and Horizon 2020.

We have had a very busy year recruiting thousands of families to our projects. As part of the BiB Growing Up study we have visited over 2500 families, and assessed over 6500 BiB children aged 7-10. We have assessed the cognitive development and wellbeing of over 15,000 Bradford school children in Years 3-5. Our 'Born in Bradford's Better Start' birth cohort has

recruited over 2000 pregnant mums living in Little Horton, Bowling and Barkerend and Bradford Moor wards within the city. The results from all of these projects will be used to help shape services within the city to help improve health and wellbeing of Bradford families.

We continue to work closely with our key health, local authority and education partners across the city. Our Sport England Funded Local Delivery Pilot is now in full swing, we are working with local communities to develop and evaluate new and innovative approaches to increasing physical activity amongst children. With support from the Bradford Opportunity area, we have established the new Centre for Applied Education Research (CAER) (www.caerbradford.org) involving partnerships between researchers from Born in Bradford, the Department for Education, Bradford Council, the Educational Endowment Fund (EEF) and the new EEF Research School in Bradford. CAER is currently running two large Randomised Controlled Trials (RCTs) funded by the EEF – Helping Handwriting SHINE <https://educationendowmentfoundation.org.uk/projects-and-evaluation/projects/helping-handwriting-shine/>

and Glasses in Classes

https://www.leeds.ac.uk/news/article/4370/glasses_trial_sets_sights_on_primary_pupils.



We have also started to work with mosques and madrassas to develop new approaches to tackling obesity based within Islamic Religious Settings, and were delighted to partner with Bradford Council to be one of 13 local authority obesity trailblazer sites which will see us working closely with Public Health England to develop a scalable approach to tackling the obesity crisis.

Based on our learning of working across services in the early years, we have produced toolkits to enable organisations to successfully monitor and evaluate their own services. These have been used widely in Bradford and BiB are now working in partnership with the Early Intervention Foundation in a flagship programme to transform early years services across England.

The Connected Health Cities project (<https://www.connectedhealthcities.org/>) continues to go from strength to strength on their work with connecting different data sets and identifying pathways through health services. For example, a smaller study within Connected Yorkshire has identified disparate systems used by schools and clinicians which will need improvement to provide better support to local children. Furthermore, working with school nurses has been important in gaining support to use the Unique Pupil Number in child health records, providing an important link to different databases.

Over the past year we have appeared in over 20 local and national television and radio news features including our highly acclaimed yearly Radio 4 broadcast. We have attended over 45 local community events, including taking to the streets in July 2018 for the Bradford Science Festival and we have started planning our 9th Annual Conference which will take place in September. You can find out more about our research, findings and events on our website: www.borninbradford.nhs.uk, Facebook page (BorninBradford) or by following @bibresearch on twitter.

Quality and Safety Research Team

The National Patient Safety Translational Research centre, a collaboration between Bradford Teaching Hospital Foundation Trust and the University of Leeds is now fully established. In 2018 we completed a priority setting exercise, supported by BTHFT. The findings generated from this work were used as

the basis of a competitive fund called the Safety Innovation Challenge Fund. In November we hosted an event to introduce this fund to clinical and academic teams around the region. Thirteen applications were submitted in December 2018 and we are planning to shortlist three of these for funding in 2019.

In 2018 the Quality and Safety research group were successful in attracting funding from the Medical Research Council (MRC) of just over £1million to develop and evaluate a technological solution to the problem of misplaced nasogastric tubes. This programme of work, led by Angela Grange, Head of Nursing (Research and Innovation), BTHFT, started on 1st January 2019.

In 2018, the Quality and Safety research group were successful in a bid to THIS Institute, a new Institute set up by the Health Foundation to develop their portfolio of work in Improvement Studies. Our bid, for a PhD student, will focus on identifying and eliminating those practices that are carried out 'In the Name of Safety' but are perceived by healthcare staff to have very little value for safety. For more information please see <http://yhpstrc.org/2018/03/02/in-the-name-of-safety/>

In 2018, we also completed our NIHR HS&DR project 'Understanding and enhancing the usefulness of patient experience data'. We have written and edited the monograph reporting on this work and have received extremely positive feedback. The toolkit, developed during this project, to support Trusts to engage in patient experience based improvement projects is now available via the Improvement Academy <https://improvementacademy.org/tools-and-resources/the-yorkshire-patient-experience-toolkit.html>

Clinical Research

Most clinical specialities in the Trust are research active and are taking part in a large number of research projects. The research teams within the clinical areas are extremely motivated to ensure that their patients have the opportunity to take part in research projects thereby being able to receive innovative treatments and the latest advancements in healthcare. Some of their achievements this year include:

Maternal Health Research

The Bradford Reproductive Health and Childbirth Clinical Research team are amongst the most successful; they consistently achieve or surpass performance targets, strengthening their excellent national and international reputation for research delivery.

Since being awarded an NIHR fellowship in 2014 to investigate hypertensive disorders and blood pressure across pregnancy, Dr Diane Farrar has since published papers in several important journals. This includes the Lancet Diabetes and Endocrinology, BMJ and Diabetologia and was recently awarded the title of Visiting Associate Professor at the University of Leeds. Professor Derek Tuffnell is a co-applicant on a NIHR HTA grant to investigate treatments for hyperemesis, has co-authored the recent maternal mortality report and is data monitoring chair for a trial investigating the use of high dose oxytocin to augment labour.

Children's research

We have had another great year full of rewards and challenges. We have continued to increase and diversify our portfolio and recruit more children and families to studies.

We have been able to open two commercial studies this year, one in Paediatrics and one in Neonates, each with a different commercial sponsor. We have opened the Petechiae in Children study on the paediatric wards engaging staff in research and working with a new, enthusiastic Principal Investigator. We have reached and gone beyond our target of 24 for the Neonatal study Baby Oscar, with the study being extended into 2020 we will continue to recruit to this.

We have attended several end of study meetings this year to find out results of the studies we contributed to, several of the trials have now published their work in various journals including ELFIN (Lancet), PREVAIL and SIFT (conference abstracts only to date), and PLANET-2 (NEJM).

We have investigator status in a further two funded neonatal trials, and anticipate shortly opening as a pilot site in a further large multicentre randomised controlled trials with more trial activity in the pipeline.

For the SIFT study – Speed of InFanT feeding trial we were also given an award for being one of the top recruiters to the trial.

Bradford Ophthalmology Research Network (BORN)

The ophthalmology research portfolio has continued to grow in 2018/19 with the opening of two phase two studies, a first for our team. One of these studies – PanOptica, if successful, could revolutionise the way patients are treated for Wet Macular degeneration. Currently patients are injected with drugs into the eye itself within a hospital setting. The PanOptica trial is looking at the possibility of an eye drop which delivers the same treatment, but is self-administered in the comfort of the patient's home. Additionally, BORN have recruited the first European patient to RHINE study. As a result of diabetic eye disease, there is a trial looking at a new treatment for patients with Diabetic Macular Oedema. We continue to lead recruitment in the UK for this trial, and as such have been offered a second trial for the same treatment but in patients with Wet Macular Degeneration which opened in the UK in April 2019.

Digestive Diseases Research

The Gastroenterology and Hepatology Research Department, collectively known as Digestive Diseases, are based at Bradford Royal Infirmary but also work at St. Luke's Hospital. We have a dedicated research team of clinicians, nurses, and our own clinical trials administrator. The main areas we deal with are Inflammatory Bowel Disease, upper and lower gastrointestinal cancers and liver disease such as viral hepatitis, autoimmune liver diseases, alcohol and non-alcoholic liver conditions and pancreatic and biliary disorders.

As a speciality, we work very closely with all the Medical team, Specialist nurses, ward and other health professionals to promote, recruit and deliver the Research Studies.

Our Consultants are Dr Cathryn Preston for Gastroenterology & Dr Sulleman Moreea for Hepatology.



Our aim is to demonstrate how engagement in clinical research leads to improvement in health outcomes and management of patients care and quality of life.

Gastroenterology

2018/19 has been a busy year with the opening of four new studies plus a new commercial study. The purpose of this study is to assess the long-term safety of vedolizumab versus other biologic agents in participants with Ulcerative Colitis (UC) or Crohn's Disease (CD).

Recruitment has been very successful and we are able to follow up our patients working alongside the study protocol offering them extra support. This study will look at the long-term safety of vedolizumab versus other biologic agents in participants with UC or CD. This multi-centre trial will be conducted worldwide. The overall time to participate in this study is seven years. Participants will make visits at every six months to their treating physician.

We continue to recruit all of our willing Inflammatory Bowel Disease (IBD) patients into the IBD bioresource. The IBD Bioresource is a national platform designed to expedite research into Crohn's disease and ulcerative colitis and help develop new and better therapies.



The IBD BioResource is funded and supported by these partners



We have also been busy with our colleagues in the colorectal department and this year we opened the FIT study. FIT (Faecal Immunochemical Test) is a stool test designed to identify possible signs of bowel disease. It detects minute amounts of blood in faeces (faecal occult blood). Many bowel abnormalities which may develop into cancer over time are more likely to bleed than normal tissue. So, if there is blood in the stool this can indicate the presence of abnormalities in the bowel. Patients with a positive FIT result are referred for further investigation by colonoscopy. If cancer is found early, treatments are more effective. The FIT test is currently only available to research participants referred into the colorectal fast track clinic, as it is still under investigation as a screening tool for high risk symptomatic patients, however the Trust launched FIT for low risk symptomatic patients, with the test being available to GPs from the 7 May.



We also opened up recruitment to the Yorkshire Cancer Research Bowel Cancer improvement Programme (YCR BCIP). There is evidence of variation in the management of bowel cancer and outcomes for patients across Yorkshire and the Humber. This five year study funded by Yorkshire Cancer Research aims to understand the variation and then improve outcomes by addressing these issues. Patients with bowel cancer being treated at Bradford Teaching Hospitals NHS Foundation Trust will be asked to consent to participate in the collection of patient reported outcome measures (PROMS) via patient questionnaires. Patients will also be consented for the use of some of their tissue, which is excess to that required for diagnosis and treatment, to be sent to the research team in Leeds for additional novel biomarker testing.



Saving Yorkshire Lives

Hepatology

The Hepatology research team recruited three patients to the AbbVie study, a study to ascertain the safety of a combination treatment for Hepatitis C and whether the medication is able to clear HCV from the body. We completed this study in July 2018.

In early 2018 we opened the Nuc-B study with sponsor Imperial College London, this study examines whether if nucleos(t)ide treatment for Hepatitis B is stopped after a few years of treatment/viral suppression some patients may be able to eliminate the virus representing a cure of infection. Participants are followed up by the research team for three years following recruitment. We currently have three participants enrolled in the study and will be continuing to recruit until 31st May 2019.

We are also involved in commercial studies, continuing to recruit to Regenerate, a study regarding non-alcoholic steatohepatitis.

We are recruiting to a study investigating treatment for hereditary haemochromatosis, which opened here in Bradford in May 2018. Sponsored by La Jolla, this a single-blind study assessing the efficacy and safety of a synthetic protein to reduce iron overload in patients with hereditary haemochromatosis.

We successfully recruited 2 patients into the study and recruitment at Bradford Teaching Hospitals NHS Foundation Trust ends May 2019.



The Team - Sarah Tinker, Janet Johnson, Carol Firth, Wendy Cardozo & Sophie Stephenson

Renal Research

Renal patients in Bradford have the opportunity to take part in clinical trials to find new and improved ways to treat, manage and diagnose conditions. The renal research team contribute to a portfolio of

commercial and non-commercial projects. The team are proud to have contributed to the PIVOTAL study, which is one of the largest randomised controlled trials to have taken part in the UK dialysis population, exceeding the set recruitment target in this and many other studies.

Rheumatology

Based at St Luke's Hospital the rheumatology research team continues to grow and now has seven members working across a range of commercial and non-commercial studies. 2018 saw us consolidate our work for the NIHR programme grant into the early detection of psoriatic arthritis and the value of such in terms of outcome. We are one of four centres recruiting nationally. In addition to this we are starting to work more collaboratively with Leeds and so we are now beginning to extend the scope of our research into connective tissue diseases which are particularly prevalent in the Bradford area.

Stroke Research

Research is an integrated part of stroke care. At the recent internal Acute Stroke day a teaching session was delivered by the research team. The overall aim of the session was for staff to understand how they are involved with research by 'delivering evidence based care for stroke survivors at Bradford'.



This session covered an overview of the National (NHS England), Regional (NIHR CRN) and Local (Bradford Teaching Hospitals NHS Foundation Trust) drivers, the plans and strategies, followed by how results are disseminated and how this is transferred to practice.

At the end of the session the care staff could say why research is important and how it is part of their job. Positive reviews and staff discussion about the training day was on face book and twitter.



3.7 SERVICE IMPROVEMENT PROGRAMME

The Bradford Improvement Programme is designed to empower colleagues and engender behaviours that lead to irreversible improvements to patients' experience and outcomes.

The Programme represents a balanced portfolio of actions to address value and efficiency; team performance and colleague wellbeing; safety and reliability of care.

During 2018/19 the Bradford Improvement Programme focused on three key areas:-

- Urgent & Emergency Care Improvement
- Elective Care Improvement
- Better Notes, Better Care

3.7.1

URGENT AND EMERGENCY CARE IMPROVEMENT

The Urgent and Emergency Care Improvement Programme is aimed at better understanding and managing patient flow, predominantly in support of patients attending our Emergency Department and those subsequently admitted on a non-elective basis.

Ambulance Handover Performance

Over winter the ambulance handover process has been supported by a Yorkshire Ambulance Service (YAS) (Hospital Ambulance Liaison Officer (HALO) to help improve the handover of all ambulance conveyed

patients. The HALO has ensured that ambulance crews follow the correct process for handover and has ensured that crews are back 'on the road' as soon as practically possible. This has been a great asset to the department.

Work has also been undertaken to look at how the Emergency Department manages the assessment and placement of this group of patients to the most appropriate area within the Emergency Department. Increased staffing in the area and a dedicated porter has meant that a rapid handover can be undertaken, appropriate clinical stabilisation and the patient taken directly to the correct area by the porter. Staff have been involved in embedding the "fit to sit" principle, moving appropriate patients from the trolley into a seating area and encouraging "self-handover" of the patient in main reception.

These activities have contributed towards a reduction of ambulance crews queuing in the assessment area and an improvement in the handover turnaround performance. Year to date the 'ambulance turnaround in less than 15 minutes' is running at 85.25% and breaches over 60 minutes have fallen by 50%.

Streaming

The streaming project aims to ensure that patients are referred to the correct area for assessment and treatment. This project is focused on 3 key areas: initial navigation & streaming, use of same day emergency care and admission avoidance.

A number of pilots have been undertaken to agree the most effective method of streaming patients to the right service within ED or elsewhere within the hospital. The navigation and streaming involves a senior nurse being based in the main access area in the ED department and before registration speaking with the patient to determine the most appropriate setting for their care. Patients arriving with GP letters are directed to the appropriate specialty without having to wait for 'triage'; and patients with minor illnesses or injuries are directed to Green Zone to be seen by a GP or Emergency Department Practitioner. Feedback from patients, nursing staff, and reception staff has been extremely positive and as a result the navigation nurse is now a protected role with effect from the 1 April 2019 between the hours of 10:00 – 22:00 hours.

Work has been undertaken with the Yorkshire Ambulance Service (YAS) around admission avoidance and assurance has been gained that the patients being conveyed are those who will require emergency care. Further work will continue with the support of the Department of Health, Emergency Care Intensive Support Team (ECIST), to look at other primary care service areas and how they can be improved to support admission avoidance.

Green Zone - GP & Minors Unit

The Green Zone has been established to bring together the minor injuries service of the Emergency Department and the Primary Care streaming service which is provided by Bradford Care Alliance, Kensington Street Surgery and Clarendon Medical Centre. The Primary Care Streaming service was launched in November 2017 and its aim is to move suitable patients from the Emergency Department into primary care, where their needs will be best addressed. This is an alternative route for patients with conditions suitable for management by a GP. An area within the Emergency Department footprint has been refurbished to allow the co-location of these two services.

Ten flexible clinical rooms have been developed; a designated reception area and two waiting areas have also been refurbished. Green Zone accommodates approximately 130-140 patients per day including an average of 40 patients being treated through the Primary care Streaming service between the hours of 12.00-00.00, thereby supporting patient flow and waiting times in the Emergency Department.

Blue Zone – Same Day Ambulatory Emergency Care

Work on increasing the use of same day emergency care commenced with a multi-disciplinary workshop in

December 2018 where it was agreed that the following pathways were a priority:

- low risk pulmonary embolism
- cellulitis
- low risk Chest Pain
- headaches and acute neurology

All the pathway redesign work has been clinically led with the full involvement of the services.

There are several additional streams being worked on by the senior leadership team to address medical admission avoidance and reduction in the length of stay. These include:

- the development of Consultant Led hot clinics which will enable patients requiring medical assessment to be given an urgent clinic appointment rather than be admitted to hospital.
- nurse led returners' clinics which will enable patients to be discharged from hospital but to return to follow up clinics to continue treatment or follow up care.

Further improvement work is underway to increase the proportion of patients who are referred by their GP or who attend the Emergency Department and require surgical assessment to be assessed and treated on a Surgical Emergency Ambulatory Care pathway, avoiding the need for overnight admission to hospital.

Long Length of Stay (LLOS) Patients

The Trust faces a continuing challenge with ensuring sufficient bed capacity is available to manage acute demand, particularly during the winter months.

In line with the national priority set out by NHS England to reduce the number of patients in hospital with a length of stay greater than 21 days by 24% in 2018/19; the Trust was allocated an improvement target of no more than 55 patients with a length of stay over 21 days by 31 March 2019.

The Trust has increased the focus and monitoring of 'Long Length of Stay' (LLOS) patients which has resulted in improvement to a number of processes including:

- implementing a twice weekly multi-agency ward round to review each patient's plan of care to ensure robust pathway management and effective discharge planning

- increased focus in the multi- agency complex discharge meeting to promote early identification of patients with complex needs or who may require post discharge health or social care support. This is to ensure early planning and effective discharge co-ordination
- implementing a daily long length of stay report identifying patients who are still in hospital at seven, fourteen and twenty one days to enable matrons to maintain oversight of pathway management and take targeted action to prevent unnecessary discharge delay
- a system wide 'Work as One' week was held during the week of 25-29 Jan 2019 to work together with health and social care system partners to identify blockages that prevent us managing patient flow effectively across the whole system and to identify opportunities for new and improved ways of working. This was a real success and demonstrated the positive outcomes which could be achieved through whole system partnership together
- education and training sessions on best practice in the management of LOS commenced for all Clinical staff.

As at 31 March 2019 the number of patients within the Trust with a length of stay greater than 21 days was 70.

Emergency Care Intensive Support Team (ECIST) Whole System Enquiry Visit

The Emergency Care Intensive Support Team was invited by the Trust to undertake a whole system enquiry with system partners to identify areas of opportunity and development to support delivery of the Emergency Care Standard.

The review took place over three days in December 2018 following which a report was received that outlined a number of recommendations of areas for improvement.

ECIST have also supported the Trust in our Emergency Care Improvement Programme including ambulance handover processes, streaming within the emergency department and implementation of the ECIST model for review of stranded patients (patients with a length of stay in excess of twenty one days).

Command Centre

The Command Centre Transformation Programme was established in 2018 to deliver sustainable improvements in how the Trust manages patient flow and makes best use of Trust capacity, infrastructure and staff resources.

The Command Centre will help Bradford transform the delivery and organisation of care in the face of ever-increasing patient numbers. It will help the Trust reduce waiting times, treat more patients, improve their experience, reduce pressure on staff and help identify and mitigate clinical risk.

It will also help to reduce unnecessary time spent in hospital after a patient is medically ready to leave, increase the proportion of patients who arrive and are admitted, transferred or discharged from Accident and Emergency (A&E) within four hours, and help ensure that patients are always treated in the wards best suited to manage their care.

The Command Centre will draw information in real time from a range of source systems including EPR; process that data using advanced algorithms and display new intelligence on custom-built analytic Tiles. These analytic tiles will be displayed across a mosaic of fifty five inch video monitors to form the Command Centre's Wall of Analytics. Analytic Tiles allow more timely and relevant information on patients, beds, diagnostics, and other factors that impact care and throughput, providing a much better understanding of current and predicted operational pressures than is currently available from any one system.

The Tiles are currently under development and will be introduced in a phased way between April and September 2019. The first seven of eight Tiles have now been designed with the first Tile becoming operational in June 2019. An additional Tile will be implemented each month after that until all eight Tiles are operational by March 2020. Each tile has been designed by the staff who will use the data and will be supported by detailed operating procedures and escalation processes. As each tile 'goes live' there will be robust testing of the tile data, procedures and staff training to ensure the whole system is implemented smoothly.

The Command Centre physical space is now open and the clinical site team have relocated to the new working area. It enables appropriate staff to be co-located to work together to manage patient flow across the hospital.

This is an exciting development for the Trust and allows us to be the first healthcare organisation in Europe to develop an AI-powered Command Centre and to use this capability to achieve new levels of operational excellence - meeting the needs of our patients and supporting our staff. Through this programme we will apply the latest digital innovation and proven best practices to optimise patient flow and enable real-time co-ordination of care for each and every patient. This programme is complementary to the EPR implementation (Cerner) and to BTHFT's developments in business intelligence.

3.7.2

ELECTIVE CARE IMPROVEMENT

The objective of this programme is to improve timely access for patients requiring elective treatment by ensuring our operating theatres are safe, effective and efficient.

- **Orthopaedics**

A key focus of the orthopaedic work stream has been to ensure that patients have optimal, timely access to treatments and in doing so reduce overall waiting times for patients.

Ward 28 is the elective inpatient ward for Orthopaedics. In previous years attempts to mitigate the effects of 'Winter Pressures' have resulted in the temporary cessation of elective orthopaedic surgery with Ward 28 being used to cope with demand for increased emergency admissions. A decision was taken to 'ring-fence' these beds from April 2018 with no reduction in planned elective surgery.

Drawing on work initiated as part of the Orthopaedic West Yorkshire Association Acute Trust collaborative, clinicians operate morning and afternoon back-to-back seamless sessions. This entails flexible scheduling of staff around lunch-breaks and prevents the middle of the day down-time as one list finishes and a new list starts, creating additional capacity for an additional arthroplasty case (four cases per list in total).

Similarly, seamless arthroscopy lists have resulted in there being insufficient patients waiting to continue running the high volume lists. Plans are in place to further communicate the minimal waiting times and improved access for these procedures.

A Hand Unit model was also trialled successfully with two Consultants sharing capacity across parallel theatres. This team approach resulted in

an increase in two patients treated per parallel session and a business case is in development to further develop and sustain this model.

The above initiatives are expected to deliver an additional 200 surgical cases in orthopaedics by the end of March 2019.

- **Forward Wait Area - Nucleus Theatre**

Bradford Royal Infirmary has several blocks of operating theatres. The layout of multiple theatre blocks creates inefficiencies in theatre utilisation due to delays in patient transfer between wards and theatres. To address this, the Trust is implementing a new 'forward-wait' area for Urology and Gynaecology patients to reduce delays between theatre cases.

- **Operating Department Practitioner (ODP) Apprenticeships**

ODPs are key members of the theatre team. There is a recognised national shortage of ODPs. In an attempt to recruit into the persistent vacancies for ODPs ten apprenticeship posts have been created from existing vacancies. All posts have been recruited into and staff commenced work at the Trust in January 2019.

- **Outpatient Improvement Programme**

The aim of the Outpatient Improvement Programme is to improve the utilisation of our outpatient clinics and to reduce the number of unnecessary outpatient attendances at hospital. Examples of some of the improvement work streams include:

- **SMS 2-Way Text Messaging, Booking and Clinic Utilisation Tool**

A new two-way SMS Text confirmation service was introduced in September 2018. This allows patients to let us know they will or will not be attending their outpatient clinic appointment; it also acts as a reminder to attend.

- **Virtual Clinics**

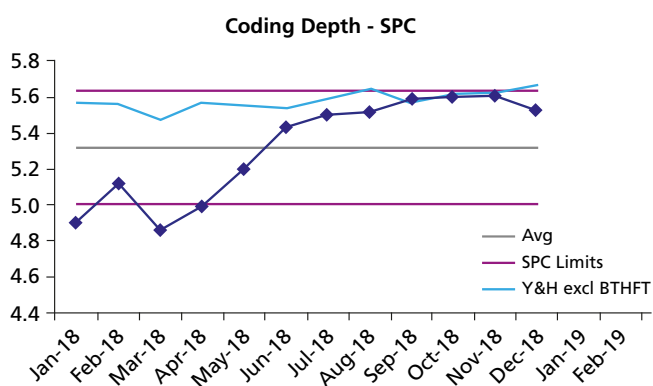
In December 2018 a trial of virtual clinics was implemented. This involved converting the traditional four hour face to face clinic to a combined 3hr face-to-face Clinic plus a 1hr telephone assessment Clinic. Analysis has shown an aggregate increase of two follow-up appointments per session

BETTER NOTES BETTER CARE

In September 2017 the Trust went live with its new Electronic Patient Record system. Lessons learnt from previous implementations of the same system highlighted a risk to the detail and depth of the clinical coding of patients notes during the immediate post-implementation of such a system. By working as a multidisciplinary team to complete Problems and Diagnoses within Powerchart we are starting to see EPR as an effective tool for communication during handover, on ward rounds and between inpatient and outpatient encounters. As a result since September 2017 we have achieved a progressive increase in the number of diagnoses recorded. This is despite regional and national trends that have seen a decline in the same period.

Thanks to this global effort to improve documentation, by March 2019 the number of secondary diagnoses (sub-diagnoses) recorded per admission had risen by 30% from the 2017 baseline. This improvement has elevated Bradford Teaching Hospitals ranking from 114 of 135 to 61 of 132 acute trusts with respect to depth of coding since 2017.

Figure 49: Coding Depth - SPC



We are now beginning to truly demonstrate the complexity of the patients we are treating. Having a complete picture allows us to channel resources to areas where they are most needed; invest effectively where demands are greatest; and gain credit locally and nationally for the safe, effective and compassionate care we provide.

3.7.3

WORKFORCE IMPROVEMENT

Apprenticeships

In 2018/19 we have recruited 141 apprentices across 17 different apprentice standards at various qualification levels up to degree level. We have recruited an apprenticeship coordinator who has focussed on engagement with staff and managers within the organisation to utilise apprenticeship to meet the learning needs of their existing staff and to recruit new staff in to post.

A review by the Education and Skills Funding Agency (ESFA) has highlighted that of the apprentices we recruited

- 42 apprentices were from a BAME background
- 94 apprentices were from a disadvantaged area
- 19 apprentices had a learning disability or a learning difficulty

This has been highlighted as excellent by the ESFA and we have been invited to be part of a national and local ambassador network for employer diversity champions and we have been asked to share our story.

Agency Staff

As part of improving workforce and reducing reliance on external agency staff, we have an internal nursing and medical bank. This helps with the quality of care as internal staff are more familiar with procedures, processes, culture and care delivery requirements. Review meetings take place with agencies to help ensure where agency staff are used, they are providing the care and services needed. The Trust only uses NHS framework approved agencies that ensure all mandatory training is completed and their agency workers are fully compliant before working shifts.

Attendance Management

Staff health and wellbeing is an important factor in being able to provide high quality care to patients. Development of attendance management training as part of the management development programme was initially launched in 2018 in collaboration with our Organisational Development Team. This training will be revisited in quarter two of 2019/20 following the review of the attendance policy to focus more explicitly on health and well-being support. This fits in with “Our People Strategy” launched in 2017. This focuses on creating a supportive, diverse and engaging environment for our staff.

Attendance officers continue to provide direct support to help manage sickness absence and the Occupational Health Manager appointed in 2018 is working closely with HR and Organisational Development to support a calendar of health and well-being events for 2019.

3.7.4

INTEGRATED EDUCATION SERVICE

The Trust’s vision is to be “an outstanding provider of healthcare, research and education.” The Clinical Services Strategy describes how we will develop our clinical services consistent with this vision, to meet the health needs of the people of Bradford and West Yorkshire. Improved organisational performance, clinical outcomes and patient experience can only be delivered through people. The Board is committed to develop its staff and the next generation of healthcare professionals to deliver the high quality patient care that is the cornerstone of its ambitions and strategic goals.

BTHFT is proud of its Teaching Hospital status and reputation of excellence in provision of clinical placement activity for a whole range of students and trainees from across the healthcare professional groups.

The Education Plan 2019 – 2024, launched in January 2019, sets out how BTHFT will ensure the workforce has the right skills and knowledge to meet the current and future challenges whilst delivering high quality care. It will ensure that the Trust is focussed on developing a flexible workforce that can meet the challenges of the next 5 years, be able to adapt to change and transfer skills into new and different roles as required. The plan targets 2 key groups of staff;

- 1) BTHFT employees
- 2) Staff and students undertaking health care professional training.

The objectives within the Education Plan are closely aligned to the HEE Quality Framework to ensure that we are implementing, monitoring and meeting all the quality standards for all learner groups within the healthcare system. The key objectives are:

- to develop a competent, capable, caring and sustainable workforce
- to provide high quality multi-professional training
- to develop excellence in the provision of patient safety training
- to provide high quality learning environments with a culture of lifelong learning
- to support and empower educators, trainers, mentors, supervisors
- to ensure effective governance for all education and maximize the use of resources and funding to support delivery of the plan

An annual implementation plan is being developed and oversight of the implementation will be monitored via the Education and Workforce subcommittee.

The structure of the Education Service is that of an integrated service with a Director of Education and Head of Education providing leadership, oversight, quality improvement and quality assurance across postgraduate and undergraduate medical, pre-registration and post-registration non-medical, as well as apprenticeships and staff in bands 1 – 4. A named executive and board member has overall responsibility for the Education Service with additional professional leadership from another board member.

The educational governance arrangements are robust, focused on improving the quality of education and training and are integrated within the overall corporate and clinical governance structures.

We have very good engagement with clinical colleagues, educators and mentors and work closely with them to ensure high quality learning environments for all our students/ trainees. Where we have evidence or feedback to suggest improvement is required action plans are developed in collaboration with the clinical teams to address the issues, with appropriate escalation through the governance structure.

There is a focus on creating a learning culture within the organisation which is clear from the Trust vision and strategy. To support this, appropriately qualified educators are recruited, developed and appraised to reflect their education, training and scholarship responsibilities.

Educators receive the support, resources and time to meet their education, training and research responsibilities.

Our top 3 successes as a service are;

- integrated education service with a named executive lead and a clearly defined education plan provides strategic oversight and management of the education service
- excellent student and trainee feedback with high levels of satisfaction reported across all professional groups
- increasing placement capacity and student numbers across the board alongside provision of placements and support to students in new roles such as physicians associates, nursing associate and advanced clinical practitioners

Our 3 Key Challenges

- supporting and managing the totality of the demands on clinical supervisors, mentors and placement areas whilst maintaining the quality of education provision. This includes the additional demands of supporting staff in new roles
- financial constraints and staffing levels within the clinical areas is beginning to impact on trainer/mentor engagement
- clarification required for new roles and where they will be aligned to within HEE in terms of professional oversight and educational governance

Figure 50: 2018 – Year of Achievement





3.8 KEEPING EVERYONE INFORMED

Our Trust is a special place to work. While we're a large regional centre recognised for clinical excellence, we're also known for our friendly and inclusive culture. People come to work here to care for our patients and progress their careers – and stay because they become part of our 'Brilliant Bradford' family.

We are proud of our people and our culture – which is built on our shared values – we care, we value people, we are one team. Our workforce is the most important asset we have. We understand the importance of communicating with our staff, because an engaged workforce delivers better patient outcomes.

We are significantly improving communications to our people, our patients and the wider public in many different ways, to increase knowledge and awareness of the work of the Trust.

Last year we carried out extensive engagement with our staff, Foundation Trust members, Governors and other stakeholders including local GPs about how we communicate with them – what works well and how we could improve.

This year, as a direct result of their feedback, we have been implementing a new communications strategy which focuses on the way we communicate – how we get the right messages out, at the right time, to the right audience in a format that suits them.

Our staff value our weekly bulletin 'Let's Talk' from the Chief Executive. It keeps them up-to-date with news, views and latest developments across the Trust.

We also use email, the intranet, screensavers, as well as regular walkarounds and Let's Talk Live face-to-face sessions with the Chief Executive and individual directorate briefings.

As a result of staff feedback, we have implemented screen-based information channels across our sites. Displaying key messages and celebrating our monthly staff awards, the screens keep staff and members of the public up to date with our latest achievements.

By engaging effectively with our staff, we believe people will be proud to say they work for Bradford Teaching Hospitals, and recommend it to others as a place to develop their career and to be treated here. We have used our brand new-look website to showcase our world-leading achievements, our excellent reputation for research performance, and the services we provide and the staff who deliver them.

ANNEX 1:**STATEMENTS FROM COMMISSIONERS,
LOCAL HEALTHWATCH ORGANISATIONS
AND OVERVIEW AND SCRUTINY
COMMITTEES****Healthwatch Bradford and District**

16 April 2019

Healthwatch Bradford and District welcome the opportunity to comment on Bradford Teaching Hospitals NHS Foundation Trust's Draft Quality report. Healthwatch has an established and positive relationship with the Trust which we will continue to build on in the coming year.

The report sets out a lot of positive action taken in 2018/19 to improve quality at the Trust, and we congratulate staff on these achievements and their on-going commitment to excellent patient care, particularly given the challenging environment facing the NHS locally and nationally.

Healthwatch is supportive of the Trusts priority areas for the coming year and that these are commensurate with the Care Quality Commission recommendations detailed in the 2018 inspection report. Healthwatch additionally believes that the priorities are challenging enough to drive improvement in the future.

Over the past year, Healthwatch Bradford and District has gathered views and experiences of care at the Trust from service users, and their families and carers. People share their experiences both good and bad with Healthwatch Bradford and District and feedback was collected through: outreach sessions at both the Bradford Royal Infirmary and St Luke's Hospital; outreach sessions held with community groups and members of the wider public; patients and carers contacting us directly.

An analysis of the feedback Healthwatch Bradford and District has received over the past year has highlighted:

- Reduction in negative sentiment and more positive sentiment from feedback in 2018 than in 2017.
- Negative feedback was more prevalent amongst the younger and older end of the age spectrum.
- Male and female genders had similar levels of positive sentiment. However females had

significantly higher negative sentiment than males.

- Pakistani and White British groups have very similar profiles on sentiment. Other ethnic groupings (treated as a single group in our analysis) exhibited greater negative sentiment.
- St Lukes had slightly higher positive feedback and Bradford Royal Infirmary had the most negative feedback in 2018

In respect to the themes of feedback received by Healthwatch Bradford and District:

- Quality of treatment, Quality of care and Staff attitudes were the three most common and consistent key themes, Quality of care receiving the greatest number of comments in 2018.
- The least well performing theme was that of communication between staff and patients.
- We saw the highest positive sentiment for Service delivery. Quality of care and Quality of treatment scored frequently and well.

Referring to the above reported patient experience of staff to patient communication we recommend that the stated on-going work to define the patient experience collaborative for 2019/20 considers this feedback in its developments.

We are encouraged by the Trusts continued commitment to patient involvement and engagement and welcome the five year Patient Involvement Strategy that will underpin this area of work. We note the statement (page 70) regarding new standards and frameworks for patient and public involvement have recently been published which will be reviewed and applied appropriately to our approach to involvement and we recommend it would be beneficial to state what these are with the inclusion of a timeline for inclusion.

At Healthwatch Bradford and District we believe that demonstrating to patients how their feedback is used to make changes or improvements shows service users and the public that they are valued in the decision-making process. Consequently, this has the potential to increase feedback. We note that the Trust is using various ways to communicate with staff and service users regarding how their feedback is used to make changes and improvements. We therefore welcome the Trusts commitment to ensuring the “you said we did” initiative is embedded across all wards and departments. We particularly welcome the Trusts commitment to the Quality Improvement Capability Building initiative and the Walk-round Leadership programme and look forward to seeing the impact of these in the 2020 quality report.

The Trusts commitment to patient involvement is further evidenced by the PLACE programme and Healthwatch Bradford and District acknowledges the work that has contributed to improvement in PLACE results across all domains.

Healthwatch Bradford and District Bradford and District will continue to listen to people’s experiences of care and feeding these back to the Trust. We look forward to working with the Trust to ensure that these experiences remain central to its approach to quality improvement.

Neil Bolton-Heaton

Manager

Healthwatch Bradford and District
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Bradford Teaching Hospitals NHS Foundation Trust Quality Report 2018/19

On behalf of NHS Bradford District and Craven CCGs, I welcome the opportunity to feedback to Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) on its Quality Report for 2018/19.

The NHS recently marked its 70th Anniversary; this is a key time to reflect upon achievements across partnerships and look forward to new ways of working, which crucially harnesses the power of people and communities. The Trust has been a key partner in delivering ongoing care and improvements to the population of Bradford District and Craven and has demonstrated a year of progress, driven by a continued commitment to place quality improvement at the very heart of the organisation, from floor to board.

First congratulations on some of the Trust's key achievements during 2018/2019. These include:

- Innovation for Improvement - the Trust launched Europe's first AI command centre, to collect 'real time' data to improve patient flow which will be pivotal in meeting increasing demand for care
- The Project SEARCH team won the top prize in the Healthcare People Management Awards for cross-sector working in recognition of their work helping young people with learning disabilities gain vital on-the-job work experience ahead of finding employment
- The Emergency Department won the King's Fund prize (*Patient Safety Learning award*) for its work on improving the care of deteriorating patients
- The emergence of new clinics to improve the experience of urology and early arthritis patients has been a great success
- The Royal College appreciation of the Postgraduate Medical Education Team in recognition of assistance in running its prestigious medical exams
- The Children and Young Persons' Ambulatory Care Experience won the Improvement in Emergency and Urgent Care category in the HSJ awards for bringing care to young patients in the comfort of their own home preventing unnecessary admissions

I also welcome the news of initiatives which strengthen the way we work as a broader system. These include:

- The system has been working together to improve the way stroke services are delivered across BTHFT and ANHSFT delivering a real improvement in stroke care to our patients (The latest report showed that BTHFT had improved to a grade 'B' for both patient and team centred results). The appointment of system wide posts and single governance and reporting arrangements is positive.
- The first 'Work as One' week was held involving commissioners, Trust colleagues and Local Authority partners to understand how partners can work together better to improve the way our patients move between the hospital and communities.

CCGs working together

NHS Airedale, Wharfedale and Craven CCG
Bradford City CCG
Bradford Districts CCG

- The embedding of the Electronic Patient Record (EPR) continues to improve the ways of working and care delivery and access to real time data across the Trust and I note the arrival of a new CT scanner will strengthen the Trust's ability to perform more complex scans and improve care management.
- The pending opening of the Wolfson Centre for Applied Research, to drive improvements in the health and wellbeing of adults and children will further embed Bradford reputation as a City of Research.

However, the pressures and challenges continue around the achievement of the Emergency Care Standard, urgent care services, recruitment and retention of a skilled workforce, delivery of the 18 week targets and emergency readmissions. This picture is mirrored nationally.

Disappointingly the Trust reported three Never Events during 2018/19 and a CQC fixed penalty notice was also enforced in response to a breach in the Duty of Candour Regulation.

I note that following a CQC inspection earlier in 2018, BTFHT has an overall rating of '*Requires Improvement*' for the services inspected and the Trust was rated as 'Good' in the well-led domain. I understand that the Trust is reporting progress against their CQC improvement action plan and has started planned bi-monthly engagement visits with the CQC to review areas for improvement. The Trust has also implemented an executive committee that reviews CQC actions and highlights areas of good practice and/or areas for improvement.

Bradford is a young city with high levels of deprivation and the Trust's maternity services continue to face a high demand. The Trust continues to make progress against the CQC maternity services improvement action plan and I note the significant amount of work which has already been undertaken by your staff to date. I welcome your proactive approach with the commissioners and regulators to agree a joint approach to quality improvement and surveillance within the service.

The Trust achieved its ambition to implement an effective system mortality review during 2018/19, leading nationally on the Structured Mortality Review process and have plans in place to progress this further.

BTHFT has identified six priority areas for 2019/2020; five of the priority areas are a continuation of the previous year in recognition that there are still more improvements required. These are:

- Management of the deteriorating patient
- Reducing pressure ulcers
- Safer procedures
- Patient experience
- Medication safety

A new priority area for 2019/20 includes:

- Learning from each other by increasing showcasing, sharing and learning from improvements and good changes.

The report includes a review of last year's priorities and I note the improvements the Trust has achieved against these which include:

- The deteriorating patient: a 11% reduction in crash calls and 16% reduction in medical emergency calls
- Pressure ulcers: a 50% reduction of category 2 pressure ulcers on the two focussed wards
- Safer procedures: an improvement in compliance with theatre checklists
- Patient experience: the creation of a patient collaborative in line with the 2018-23 patient experience strategy
- Medication safety: the introduction of pharmacy assistants to facilitate improved medicines management.

Other initiatives include:

- Introduction of a learning hub to promote lessons learned from incidents
- A collaborative for falls prevention resulting in a 15% reduction in the twelve pilot wards.
- Inclusion in the Red Bag Hospital Transfer Pathway to improve the experience for older people in care homes

I would welcome reference to the Trust's community intermediate care services provision in future quality reports as we recognise the importance of the Trust's crucial role in care out of hospital.

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

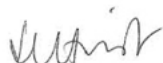
BTHFT has committed to working as one system to integrate care locally and is a key member of the Bradford Health Care Partnership Board and actively supports local community partnerships. Demonstrable progress has been made towards utilising the opportunities a shared system will bring involving other partners which includes the work of the acute provider collaboration.

I look forward to continuing to work with you and other partners across the health and social system to ensure that local people will be healthier, happier, and have access to high quality care that are clinically, operationally and financially stable.

I recognise that the workforce remains hugely committed to meeting the needs of the local population in a year of both progress and pressures. I commend the Trust's ongoing commitment to improve the quality and safety of the care that our communities receive.

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

Helen Hirst



**Chief Officer
NHS Airedale, Wharfedale & Craven,
Bradford City & Bradford Districts CCGs**

OVERVIEW AND SCRUTINY COMMITTEE

Due to the timing of the local elections this year, the Overview and Scrutiny Committee have opted not to provide comments on the 2018/19 Quality Report.

ANNEX 2:**STATEMENT OF DIRECTORS' RESPONSIBILITIES FOR THE QUALITY REPORT**

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

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

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19.
- the content of the quality report is not inconsistent with internal and external sources of information including:
 - board minutes and papers for the period April 2018 to May 2019
 - papers relating to quality reported to the board over the period April 2018 to May 2019
 - feedback from Commissioners dated 23 April 2019
 - feedback from Council of Governors. The draft Quality Report was circulated to Governors but no comments were received
 - feedback from local Healthwatch organisations dated 16 April 2019
 - feedback from Overview and Scrutiny Committee, Bradford Metropolitan District Council dated 23 April 2019 confirming they would not be providing comments
 - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated August 2018 (Q1), November 2018 (Q2) and February 2019 (Q3)

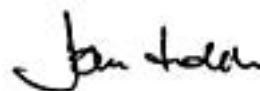
- the latest national patient survey
- the latest national staff survey
- the Head of Internal Audit's annual opinion of the Trust's control environment dated 21 May 2019
- CQC inspection report dated 15 June 2018
- the quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board



Dr Maxwell Mclean,
Chairman
Date: 24 May 2019



John Holden,
Acting Chief Executive
Date: 24 May 2019

Annex 3: Independent Auditor's Report to the Council of Governors of Bradford Teaching Hospitals NHS Foundation Trust on the Quality Report

Independent auditor's report to the council of governors of Bradford Teaching Hospitals NHS Foundation Trust on the quality report

We have been engaged by the council of governors of Bradford Teaching Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Bradford Teaching Hospitals NHS Foundation Trust's quality report for the year ended 31 March 2019 (the 'quality report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Bradford Teaching Hospitals NHS Foundation Trust as a body, to assist the council of governors in reporting Bradford Teaching Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and Bradford Teaching Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers, reported in accordance with official performance statistics based on 50:50 breach allocation rules.

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

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Improvement.

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

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in Statement of Directors' Responsibilities for the Quality Account; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from Commissioners, dated 23 April 2019;
- feedback from local Healthwatch organisations, dated 16 April 2019;
- feedback from Overview and Scrutiny Committee, dated 23 April 2019;
- the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated August 2018 (Q1), November 2018 (Q2) and February 2019 (Q3);
- the latest national patient survey;
- the latest national staff survey;

Independent auditor's report to the council of governors of Bradford Teaching Hospitals NHS Foundation Trust on the quality report (continued)

- Care Quality Commission inspection report, dated 15 June 2018; and
- the Head of Internal Audit's annual opinion over the trust's control environment, dated 21 May 2019.

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

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

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Bradford Teaching Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in Statement of Directors' Responsibilities for the Quality Account; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.

Deloitte LLP

Deloitte LLP
Newcastle
24 May 2019

APPENDIX A: NATIONAL QUALITY INDICATORS

Domain			Preventing people from dying prematurely
Indicator			SHMI value and banding (Oct 2017 - Sep 2018)
Latest available reported position			SHMI value = 0.9086 Band 2 As expected
National Average			1 Band 2 As expected
Where Applicable – Best Performer			
South Tyneside NHS Foundation Trust		SHMI Value = 1.2681	Band 1 - Higher than expected
Where Applicable – Worst Performer			
Homerton University Hospital NHS Foundation Trust		SHMI Value = 0.6917	Band 3 - Lower than expected
Trust Statement			
<p>Bradford Teaching NHS Foundation Trust is proud of the high quality care all the staff give to all our patients which is reflected in our low mortality rate. The Foundation Trust has the second lowest mortality rate in the West Yorkshire region and ranks around 20th in having one of the lowest mortality rates nationally.</p> <p>In line with National Guidance on learning from Deaths, the Foundation Trust has actioned in depth case note reviews using Structured Judgement review methodology. The learning from these reviews including serious incident investigations are used to drive our quality improvement programmes and the training we deliver. Some of the Quality improvement programmes include; recognition of the deteriorating patient, sepsis care, safer invasive procedures and pressure ulcer prevention. We carry out mortality surveillance which involves a complete analysis of our mortality data and also involve the bereaved in the review of care.</p>			
Currently reported position for 2017/2018			0.926 Band 2 As expected
Currently reported position for 2016/2017			0.926 Band 2 As expected
Currently reported position for 2015/2016			0.978 Band 2 As expected
Currently reported position for 2014/2015			0.971 Band 2 As expected
Currently reported position for 2013/2014			0.963 Band 2 As expected
Currently reported position for 2012/2013			0.999 Band 2 As expected
Currently reported position for 2011/1012			0.953 Band 2 As expected

Domain	Enhancing quality of life for people with long-term conditions
Indicator	% patients deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period (Oct 2017 - Sep 2018)
Latest available reported position	Combined Rate - 25.1
National Average	33.6
Where Applicable – Best Performer	
Royal Surrey County Hospital NHS Foundation Trust	59.5
Where Applicable – Worst Performer	
The Queen Elizabeth Hospital, Kings' Lynn, NHS Foundation Trust	14.3
Trust Statement	
<p><i>The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons; the Trust has an advisory palliative care team available to the wards which sees approximately 60 patients per month.</i></p> <p><i>The Bradford Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by taking steps to improve the recognition of patients that are in the last years of life, improving the sharing of information between primary and secondary care relating to palliative care patients and implementing the five priorities for the care of the dying.</i></p>	
Currently reported position for 2017/2018	Combined Rate - 26.6
Currently reported position for 2016/2017	Combined Rate - 31.6
Currently reported position for 2015/2016	Combined Rate - 22.37
Currently reported position for 2014/2015	Combined Rate - 18.7
Currently reported position for 2013/2014	Combined Rate - 18.7

Domain	Helping people recover from episodes of ill health or following injury
Indicator	Patient reported outcome scores for groin hernia surgery
Latest available reported position	No provisional data available for 2017/18
National Average	N/A
Where Applicable – Best Performer	
N/A	
Where Applicable – Worst Performer	
N/A	
Trust Statement	
<i>The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust no longer participates in this therefore no information is available.</i>	
Currently reported position for 2017/2018	
Currently reported position for 2016/2017	0.093 (Not an outlier)
Currently reported position for 2015/2016	0.082 (Not an outlier)
Currently reported position for 2014/2015	0.103 (Not an outlier)
Currently reported position for 2013/2014	0.091 (Not an outlier)
Currently reported position for 2012/2013	0.086 (Not an outlier)
Currently reported position for 2011/1012	0.114 (Not an outlier)

Indicator	Patient reported outcome scores for varicose vein surgery
Latest available reported position	No provisional data available for 2017/18
National Average	N/A
Where Applicable – Best Performer	
N/A	
Where Applicable – Worst Performer	
N/A	
Trust Statement	
<i>The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust no longer participates in this therefore no information is available.</i>	
Currently reported position for 2017/2018	
Currently reported position for 2016/2017	0.089 (Not an outlier)
Currently reported position for 2015/2016	0.118 (Not an outlier)
Currently reported position for 2014/2015	0.053 (Not an outlier)
Currently reported position for 2013/2014	0.104 (Not an outlier)
Currently reported position for 2012/2013	0.098 (Not an outlier)
Currently reported position for 2011/1012	0.085 (Not an outlier)

Indicator	Patient reported outcome scores for hip replacement surgery (2017/18 data)
Latest available reported position	0.444 (Not an outlier)
National Average	N/A
Where Applicable – Best Performer	
N/A	
Where Applicable – Worst Performer	
N/A	
Trust Statement	
<p>The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has undertaken a programme of work relating to safer procedures.</p> <p>The performance is due to a low response rate, the actions agreed to improve this are that we are now picking this up with patients as part of the Enhanced Recovery programme which is underway in the Arthroplasty service. The aim of which is to improve both response rates and data quality going forward.</p>	
Currently reported position for 2017/2018	0.444 (Not an outlier)
Currently reported position for 2016/2017	0.442 (Not an outlier)
Currently reported position for 2015/2016	0.445 (Not an outlier)
Currently reported position for 2014/2015	0.439 (Not an outlier)
Currently reported position for 2013/2014	0.416 (Not an outlier)
Currently reported position for 2012/2013	0.39 (Negative)
Currently reported position for 2011/1012	0.371 (Negative)

Indicator	Patient reported outcome scores for Knee replacement surgery (2017/18 data)
Latest available reported position	0.305 (Not an outlier)
National Average	N/A
Where Applicable – Best Performer	
N/A	
Where Applicable – Worst Performer	
N/A	
Trust Statement	
<p>The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has undertaken a programme of work relating to safer procedures.</p> <p>The performance is due to a low response rate, the actions agreed to improve this are that we are now picking this up with patients as part of the Enhanced Recovery programme which is underway in the Arthroplasty service. The aim of which is to improve both response rates and data quality going forward.</p>	
Currently reported position for 2017/2018	0.305 (Not an outlier)
Currently reported position for 2016/2017	0.326 (Not an outlier)
Currently reported position for 2015/2016	0.304 (Not an outlier)
Currently reported position for 2014/2015	0.341 (Not an outlier)
Currently reported position for 2013/2014	0.321 (Not an outlier)
Currently reported position for 2012/2013	0.297 (Not an outlier)
Currently reported position for 2011/1012	0.289 (Not an outlier)

Domain	Helping people to recover from episodes of ill health or following injury	
Indicator	28 day readmission rate for patients aged 0 – 15	
The data made available to Trusts for reporting has not been updated since last year's Quality Account.		
Currently reported position for 2017/2018		
Currently reported position for 2016/2017		
Currently reported position for 2015/2016		
Currently reported position for 2014/2015		
Currently reported position for 2013/2014	(2011/12) 8.04%	
Currently reported position for 2012/2013	(2010/11) 7.23%	
Currently reported position for 2011/1012	(2009/10) 6.94%	
Indicator	28 day readmission rate for patients aged 16 or over	
The data made available to Trusts for reporting has not been updated since last year's Quality Account.		
Currently reported position for 2017/2018		
Currently reported position for 2016/2017		
Currently reported position for 2015/2016		
Currently reported position for 2014/2015		
Currently reported position for 2013/2014	(2011/12) 12.38%	
Currently reported position for 2012/2013	(2010/11) 11.93%	
Currently reported position for 2011/1012	(2009/10) 11.16%	

Domain	Ensuring that people have a positive experience of care
Indicator	Responsiveness to inpatients' personal needs: CQC national inpatient survey score (2017/18 data)
Latest available reported position	74.5%
National Average	78.4%
Where Applicable – Best Performer	
The Clatterbridge Cancer Centre NHS Foundation Trust	(88.9%)
Where Applicable – Worst Performer	
Barts Health NHS Trust (71.8%)	(71.8%)
Trust Statement	
<p><i>The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has continued to focus on a programme of work to improve the patient experience through the Patient First Committee. In November 2018, Bradford Teaching Hospitals NHS Foundation Trust launched a Patient Experience Strategy: Embracing Kindness, which sets out our approach to enable all our staff to improve the care we provide, and help us to deliver our ambition of providing outstanding care for all our patients.</i></p>	
Currently reported position for 2017/2018	74.5%
Currently reported position for 2016/2017	75.6%
Currently reported position for 2015/2016	73.8%
Currently reported position for 2014/2015	74.5%
Currently reported position for 2013/2014	75.2%
Currently reported position for 2012/2013	71.5%
Currently reported position for 2011/2012	74.2%

Indicator	Percentage of staff who would recommend the provider to friends or family needing care (2018 Staff Survey)
Latest available reported position	67.7%
National Average	70.0%
Where Applicable – Best Performer	
Liverpool Heart and Chest Hospital NHS Foundation Trust	92.4%
Where Applicable – Worst Performer	
Norfolk and Suffolk NHS Foundation Trust	43.2%
Trust Statement	
<p><i>The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has continued to focus on a programme of work to improve the patient experience through the Patient First Committee. In November 2018, Bradford Teaching Hospitals NHS Foundation Trust launched a Patient Experience Strategy: Embracing Kindness, which sets out our approach to enable all our staff to improve the care we provide, and help us to deliver our ambition of providing outstanding care for all our patients.</i></p>	
Currently reported position for 2017/2018	67.47%
Currently reported position for 2016/2017	67.5%
Currently reported position for 2015/2016	63.8%
Currently reported position for 2014/2015	66.3%
Currently reported position for 2013/2014	68.0%
Currently reported position for 2012/2013	71.0%
Currently reported position for 2011/2012	67.0%

Domain	Treating and caring for people in a safe environment and protecting them from avoidable harm
Indicator	Rate of patient safety incidents per 1,000 Bed days (Oct 2017 – Mar 2018) *High Reporters Should be shown as better
Latest available reported position	31.34 (Number of incidents occurring 3903)
National Average	Not Given
Where Applicable – Best Performer	
South Tyneside NHS Foundation Trust	(24.19)
Where Applicable – Worst Performer	
Croydon Health Services NHS Trust	(124)
Trust Statement	
<p><i>Bradford Teaching Hospitals NHS Foundation Trust considers that this data demonstrates that the Trust continues to promote a culture of open and honest reporting and endorses a just culture so that all opportunities for learning are identified. Bradford Teaching Hospitals NHS Foundation Trust has taken actions to improve this outcome, and to improve the experiences of care and quality of its services. A quality oversight system is in place to ensure there are effective processes for managing risks and learning.</i></p>	
Currently reported position for 2017/2018	
Currently reported position for 2016/2017	52.42 (Apr17_Sep17 Number of incidents occurring 3963)
Currently reported position for 2015/2016	52.82 (Oct15_Mar16 Number of incidents occurring 4732)
Currently reported position for 2014/2015	57.83 (Apr15_Sep15 Number of incidents occurring 4989)
Currently reported position for 2013/2014	52.34 (Oct14_Mar15 Number of incidents occurring 4924)
Currently reported position for 2012/2013	40.36 (Apr14_Sep14 Number of incidents occurring 3745)
Currently reported position for 2011/2012	No data for rate per 1,000 bed days (Oct13_Mar14 Number of incidents occurring 3598)

Indicator	Rate of patient safety incidents per 1,000 Bed days that resulted in severe harm or death* (Oct 2017 – Mar 2018)* High Reporters Should be shown as better
Latest available reported position	0.1% (count of incidents = 3)
National Average	Not Given
Where Applicable – Best Performer	
Multiple Trusts	(0%)
Where Applicable – Worst Performer	
United Lincolnshire Hospitals NHS Trust	(1.5%)
Trust Statement	
Bradford Teaching Hospitals NHS Foundation Trust considers that this data demonstrates that the Trust continues to promote a culture of open and honest reporting and endorses a just culture so that all opportunities for learning are identified. Bradford Teaching Hospitals NHS Foundation Trust has taken actions to improve this outcome, and to improve the experiences of care and quality of its services. A quality oversight system is in place to ensure there are effective processes for managing risks and learning. All serious incidents are shared within and outside of specialities to ensure wide spread learning. There is also an established Trustwide Learning HUB with monthly presentations and dissemination of alerts, learning and current articles.	
Currently reported position for 2017/2018	
Currently reported position for 2016/2017	0.00 (count of incidents = 2) (Apr17 - Sep17)
Currently reported position for 2015/2016	0.08 (count of incidents = 4) (Oct15 - Mar16)
Currently reported position for 2014/2015	0.08 (count of incidents = 4) (Apr15-Sep15)
Currently reported position for 2013/2014	0.20 (count of incidents = 10) (Oct14-Mar15)
Currently reported position for 2012/2013	0.21 (count of incidents = 8) (Apr14-Sep14)
Currently reported position for 2011/2012	0.25 (count of incidents = 9) (Oct13-Mar14)

*** A note from the guidance**

The SHMI cannot be used to directly compare mortality outcomes between trusts and, in particular, it is inappropriate to rank trusts according to their SHMI. Instead, the SHMI banding can be used to compare mortality outcomes to the national baseline. If two trusts have the same SHMI banding, it cannot be concluded that the trust with the lower SHMI value has better mortality outcomes

APPENDIX B: GLOSSARY OF AUDITED INDICATORS

Indicator	Description	Criteria	Source
Cancer – 62-day wait from GP referral to treatment	This indicator is required to be reported by the Single Oversight Framework: Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	Operating standard of 85%.	Data is submitted monthly to NHS England by all providers of NHS-funded, consultant led services, through the Strategic Data Collection Service (SDCS). SDCS is the online tool used by NHS England for the collection and sharing of NHS performance data. NHS commissioners review and sign off the data and NHS England performs central validation checks to ensure good data quality.
Emergency care standard	This indicator is required to be reported by the Single Oversight Framework: Percentage of A&E attendances where the service user was admitted, transferred or discharged within 4 hours of their arrival at an A&E department.	Operating standard of 95%. Reduced to 90% in January 2018 with a trajectory for recovery to 95% in 2018/2019.	The definition of the indicators are provided by the NHS Standard Contract 2018/19
Summary Hospital-level Mortality Indicator' (SHMI)	The SHMI is the ratio between the actual number of patients who die following 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 there.	A 'higher than expected' SHMI should not immediately be interpreted as indicating bad performance and instead should be viewed as a 'smoke alarm' which requires further investigation by the trust.	

APPENDIX C: GLOSSARY OF ABBREVIATIONS AND MEDICAL TERMS**List of Abbreviations**

AAWG	Audit Appointment Working Group	DNACPR	Do Not Attempt Resuscitation
A&E	Accident and Emergency	DoLS	Deprivation of Liberty Standards
ACE	Ambulatory Care Experience	ECDS	Emergency Care Data Set
AED	Accident and Emergency Department	ECS	Emergency Care Standard
AIS	Accessible Information Standard	eFI	Electronic Frailty Index
AKI	Acute Kidney Injury	ELC	End of Life Companions
AUKUH	Association of UK University Hospitals	ENT	Ear, Nose and Throat
BAC	Business Advisory Committee	EPR	Electronic Patient Record
BAF	Board Assurance Framework	ERIC	Estates Returns Information Collection
BAME	Black, Asian and Minority Ethnic	ESR	Electronic Staff Record
BAPM	British Association of Perinatal Medicine	FFFAP	Falls and Fragility Fractures Audit Programme
BAT nurses	Brain Attack nurses	FFT	Friends and Family Test
BDCFT	Bradford District Care NHS Foundation Trust	FREDA	Human Rights principles - Freedom, Respect, Equality, Dignity, Autonomy
BIG	Bradford Innovation Group	FRF	Financial Recovery Fund
BIHR	Bradford Institute for Health Research	GP	General Practitioner
BMDC	Bradford Metropolitan District Council	HCA	Healthcare Assistant
BPA	Bradford Provider Alliance	HPMA	Healthcare People Management Association
BRI	Bradford Royal Infirmary	HQIP	The Healthcare Quality Improvement Partnership
BSCB	Bradford Safeguarding Children's Board	HSE	Health and Safety Executive
BTHFT	Bradford Teaching Hospitals NHS Foundation Trust	HSMR	Hospital Standardised Mortality Ratio
CCG	Clinical Commissioning Group	HUB	Health User Bank
CIP	Cost Improvement Programme	IBD	Inflammatory Bowel Disease
COPD	Chronic Obstructive Pulmonary Disease	ICNARC	Intensive Care National Audit
CPAP	Continuous Positive Airway Pressure	ICO	Information Commissioner's Office
CQC	Care Quality Commission	IHI	Institute for Healthcare Innovation
CQUIN	Commissioning for Quality and Innovation	IMR	Independent Management Report
CRIS	Clinical Record Interactive Search	ITFF	Independent Trust Finance Facility
DCE	Deputy Chief Executive	KPI	Key Performance Indicator
DEC	Display Energy Certificate	LeDeR	National Learning Disabilities Mortality Review
DHR	Domestic Homicide Review	LGBT	Lesbian, Gay, Bi-Sexual and Transgender
DHSC	Department of Health and Social Care	LLP	Limited Liability Partnerships
DNA	Did Not Attend appointment		

List of Abbreviations

MARAC	Multi-Agency Risk Assessment Conference	PMO	Programme Management Office
MARS	Mutually Agreed Resignation Scheme	POMH	Prescribing Observatory for Mental Health
MBRRACE - UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK	PPI	Patient and Public Involvement
MEWS	Maternal Early Warning System	PRASE	Patient Reporting and Action for a Safe Environment
MINAP	Myocardial Ischaemia National Audit Project	ProgRESS	Programmed Review of Effectiveness, Safety and Sensitivity
MHA	Mental Health Act	PSF	Provider Sustainability Funding
MRSA	Methicillin Resistant Staphylococcus Aureus	QIA	Quality Impact Assessment
MTI	Medical Training Initiative	QIPP	Quality, innovation, Productivity and Prevention
NatSSIPs	National Safety Standards for Invasive Procedures	PROMS	Patient Reported Outcome Measures
NCEPOD	National Confidential Enquiry into Patient Outcome and Death	RAG	Red, Amber, Green
NHS	National Health Service	RIDDOR	Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013
NHSCFA	NHS Counter Fraud Authority	RTT	Referral To Treatment
NHSI	NHS Improvement	SDSIP	Seven Day Service Improvement Plan
NICE	National Institute for Health and Care Excellence	SFI	Standing Financial Instructions
NIHR	National Institute for Health Research	SHMI	Summary Hospital-level Mortality Indicator
NIPE	Newborn and Infant Physical Examination	SID	Senior Independent Director
NIV	Non-Invasive Ventilation	SIP	Safety Improvement Plans
NLCA	National Lung Cancer Audit	SIRO	Senior Information Risk Owner
NNAP	National Neonatal Audit Programme	SJR	Structured Judgement Review
NPCA	National Prostate Cancer Audit	SSNAP	Sentinel Stroke National Audit Programme
NPDA	National Paediatric Diabetes Audit	STF	Sustainability and Transformation Funding
NRC	Nominations and Remuneration Committee	VTE	Venous Thromboembolism
ODN	Operational Delivery Network	WHO	World Health Organisation
PALS	Patient Advice and Liaison Service	WRAP	Workshops to raise Awareness of Prevent
PCI	Percutaneous Coronary Interventions	WRES	Workforce Race Equality Standard
PCSO	Police Community Support Officers	WTE	Whole Time Equivalent
PCT	Primary Care Trust	WYAAT	West Yorkshire Association of Acute Trusts
PLACE	Patient-Led Assessment of the Care Environment	WYHTASN	West Yorkshire Human Trafficking and Anti-Slavery Network

List of Terms

Anticoagulation	Medicines that reduce the ability of the blood to clot
Cochrane Review	Cochrane Reviews are systematic reviews of primary research in human healthcare and health policy
Computerised tomography (CT) scan	Uses X-rays and a computer to create detailed images of the inside of the body
Deep vein thrombosis (DVT)	A blood clot that develops within a deep vein in the body, usually in the leg
Endoscopy	A procedure where the inside of your body is examined using an instrument called an endoscope
Ischaemic stroke	The most common type of stroke. They occur when a blood clot blocks the flow of blood and oxygen to the brain
Laparotomy	A surgical procedure done by making an incision in the abdomen (tummy) to gain access into the abdominal cavity
Luer connection systems	The standard way of attaching syringes, catheters, needles, IV tubes etc to each other
Nephrectomy	Surgery to remove all or part of the kidney
Operational Delivery Network	Clinical networks which coordinate patient pathways between providers over a wide area to ensure access to specialist resources and expertise.
Parenteral Nutrition	The feeding of a person directly into the blood through an intravenous (IV) catheter (needle in the vein)
Percutaneous Coronary Interventions	A procedure used to widen blocked or narrowed coronary arteries (the main blood vessels supplying the heart)
Percutaneous nephrolithotomy	A minimally-invasive procedure to remove kidney stones via a small incision in the skin
Prostatectomy	Surgery to remove the prostate gland
Pulmonary embolism	A blockage in the pulmonary artery, the blood vessel that carries blood from the heart to the lungs
Subarachnoid haemorrhage	An uncommon type of stroke caused by bleeding on the surface of the brain. It's a very serious condition and can be fatal
Thalassaemia	The name for a group of inherited conditions that affect a substance in the blood called haemoglobin. People with the condition produce either no or too little haemoglobin, which is used by red blood cells to carry oxygen around the body
Venous thromboembolism (VTE)	A condition where a blood clot forms in a vein. This is most common in a leg vein, where it's known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE)