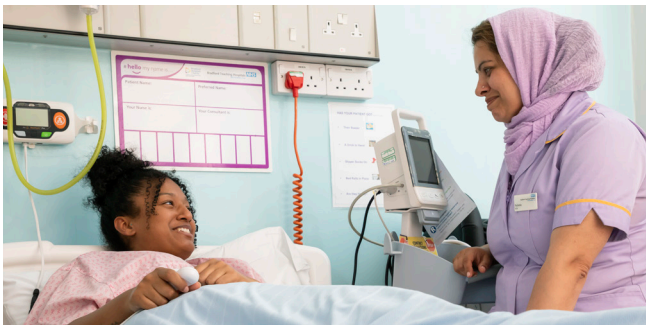
NHS

Bradford Teaching Hospitals

NHS Foundation Trust

Quality Account

2022/23



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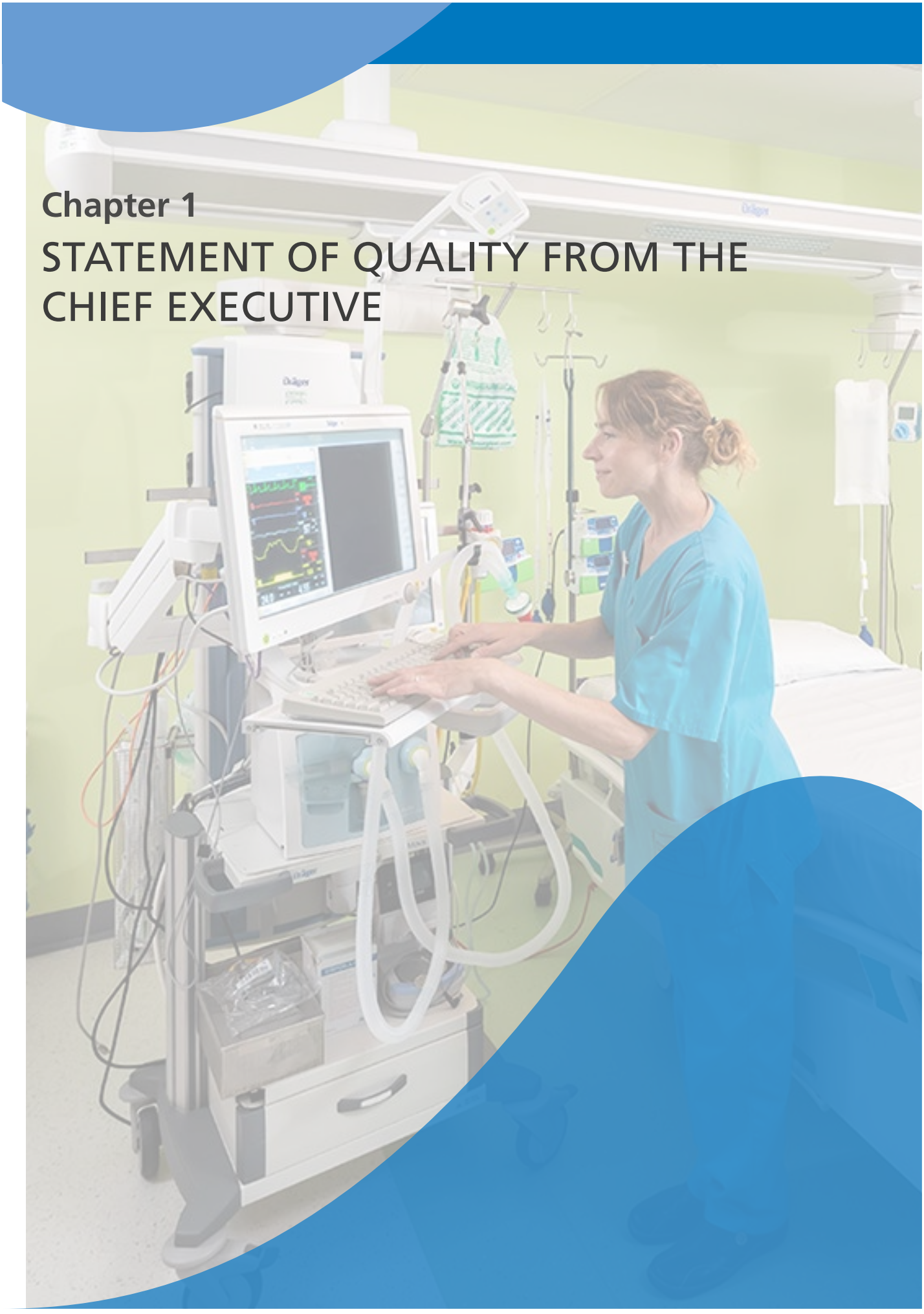


Chapter 1

STATEMENT OF QUALITY FROM THE CHIEF EXECUTIVE

I am delighted to introduce the 2022/23 Quality Account report as Chief Executive of Bradford Teaching Hospitals NHS Foundation Trust.

We are immensely proud of all that we have achieved over the last 12 months recognising that our staff have worked tirelessly to ensure that our elective recovery programme is on track. We have seen departments innovate and collaborate in ways never seen before to ensure that our patients have been treated quickly and safely, despite continuing to feel the effects of the global COVID -19 pandemic impacting on what we do and how we do it.

During the last 12 months we have worked within the Trust and with our system partners to maintain 'business as usual', whilst dealing with the challenge of unprecedented levels of demand, with record numbers of patients attending our Emergency Department. We have faced this challenge head on and continued to find new and innovative ways to manage patient flow, enhance the way we work and create new rolls to support new ways of working.

The Care Quality Commission (CQC) inspected two of our services in the last 12 months. The Emergency Department was inspected in April 2022 as part of a wider programme of inspections in West Yorkshire. Whilst the service was not rated the CQC found that despite the high demand staff provided good care and treatment with compassion and kindness.

Maternity Services were inspected at the beginning of January 2023. The report[1] was published on 26 May 2023 and highlights the many improvements we have made since the last inspection in 2019.

For large scale improvement we have developed an 'Outstanding' improvement approach. Initially tested and evaluated in maternity services we have now commissioned two further programmes, 'Outstanding Theatres' and 'Outstanding Pharmacy'. We use this approach where there is a requirement for longer term support to facilitate a positive impact on the team and overall quality and performance. These programmes are sponsored and championed by an Executive and the Trust Board and supported with project management. They have oversight of progress but also act as enablers or brokers where there may be competing agenda's that require decisions to support success.

Despite the high levels of activity and continuous demands on our staff and services, we remain committed to our mission 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. This is why the essence of our quality priorities for the next year remains largely unchanged with the

1 https://api.cqc.org.uk/public/v1/reports/d7a4bd50-0442-4973-b45c-7fb6ba2463a2?20230526070057

exception of implementing the national Patient Safety Incident Response Framework. We see this new priority as an opportunity to build on our safety culture, bringing our Organisation Development and Quality Teams together to embed a just culture recognising civility as a key component of a safe healthcare provider.

Our priorities for 2023/24 are:

- Improving the management of deteriorating patients (rolled over from 2022/23).
- New: Implementing Saving Babies Lives Care Bundle[2] (version3).
- New: Improving patient experience by advancing equality, diversity and inclusion.
- New: Implementation of the Patient Safety Incident Response Framework[3] including the transition from the National Reporting and Learning System to Learning from Patient Safety Events platform.

The tenacity, dedication, creativity and compassion shown by all our staff and volunteers over the past year has been exemplary and the learning, knowledge and skills will enable us to deliver even more dynamic, outstanding and safe healthcare services in the future.

Achievements in Quality

- National award for the Spiritual, Pastoral and Religious Care team (SPaRC).
- Veteran Accreditation awarded Silver.
- Introduction of VIP pathway for patients with additional needs.
- Relaunch of Friends and Family Test (FFT).
- Chosen to represent the region for the NHS England 'Worry and Concerns ' programme.
- Received Health Business Award for Patient Safety for the Learn Together research programme. In conjunction with Bradford Institute for Health Research.
- National award for the End of Life Care Team.

Professor Mel Pickup
Chief Executive Officer

June 2023

2 https://www.england.nhs.uk/mat-transformation/saving-babies/

3 https://www.england.nhs.uk/patient-safety/incident-response-framework/

1.1. ABOUT BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST

Bradford Teaching Hospitals NHS Foundation Trust[4] (our Trust) is responsible for providing hospital services for the people of Bradford and communities across Yorkshire. We serve a core population of around 550,000 people and provide specialist services for some 1.1 million.

Our Trust is an integrated Trust that provides acute, community, inpatient and children's health services. Acute services are provided from the Bradford Royal Infirmary site.

In addition to Bradford Royal Infirmary and St Luke's Hospital, our Trust provides a range of services from community sites at Westbourne Green, Westwood Park, Shipley, Eccleshill, Skipton and the Bradford Macula Centre[5]. We have approximately 630 acute beds, employ over 6,750 members of staff. In 2022/23 our Trust delivered 5,068 babies, performed 16,872 operations in theatre and handled 446,204 outpatient appointments. We had 141,064 attendances at our Emergency Department.

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

1.2. WHAT IS A QUALITY ACCOUNT?

All providers of NHS services in England have a statutory duty to produce an annual report to the public about the quality of services they deliver. This is called the Quality Account and includes the requirements of the appropriate regulations[6].

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

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

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

4 https://www.bradfordhospitals.nhs.uk

5 https://www.bradfordhospitals.nhs.uk/bradford-macula-centre/

6 *NHS (Quality Accounts) Regulations 2010 as amended by the NHS (Quality Accounts) Amendments Regulations 2011; NHS (Quality Accounts) Amendments Regulations 2012.*

1.3. SCOPE AND STRUCTURE OF THE QUALITY ACCOUNT

This report summarises our progress on the quality priorities we set for 2022/23.

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

This report is divided into three parts:

- **Part 1** presents a statement from the Chief Executive about the quality of health services provided during 2022/23.
- **Part 2** describes our priorities for improvement for 2023/24, the rationale, our progress in 2022/23 and how we plan to monitor and report progress. It contains statements of assurance relating to the quality of services. This includes statements on the National Clinical Audits programme which NHS England advises Trusts to prioritise for participation and inclusion in their Quality Accounts for 2022/23 and, a description of our research work.
- **Part 3** includes performance against national priorities and our local indicators.
- The annex section includes comments from our external stakeholders.

Chapter 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1. PRIORITIES FOR IMPROVEMENT

Following the feedback from engagement events with our Foundation Trust Governors and our people, we have reviewed and revised our priorities and goals we set ourselves in the previous year. Our Quality Priorities for 2023/24 are:

1. **Improving** the management of deteriorating patients
2. **New:** Implementing Saving babies Lives Care Bundle version 3
3. **New**: Improving patient experience by advancing equality, diversity and inclusion
4. **New:** Implementation of the Patient Safety Response Framework including transition from the National Reporting and Learning System to the new Learning from Patient Safety Events platform.

Progress against key metrics will be monitored at the Quality and Patient Safety Academy.

2.1.1
PROGRESS AGAINST THE 2022/23 PRIORITIES

Priority 1:

Improving the management of deteriorating patients

We continue to build on this improvement priority over the past few years. This has included work to embed the use of the Patient Deterioration Tile (PDT), piloting the 'Hospital at Night' initiative and a roadshow to learn about detecting signs of sepsis early.

Patient Deterioration Tile

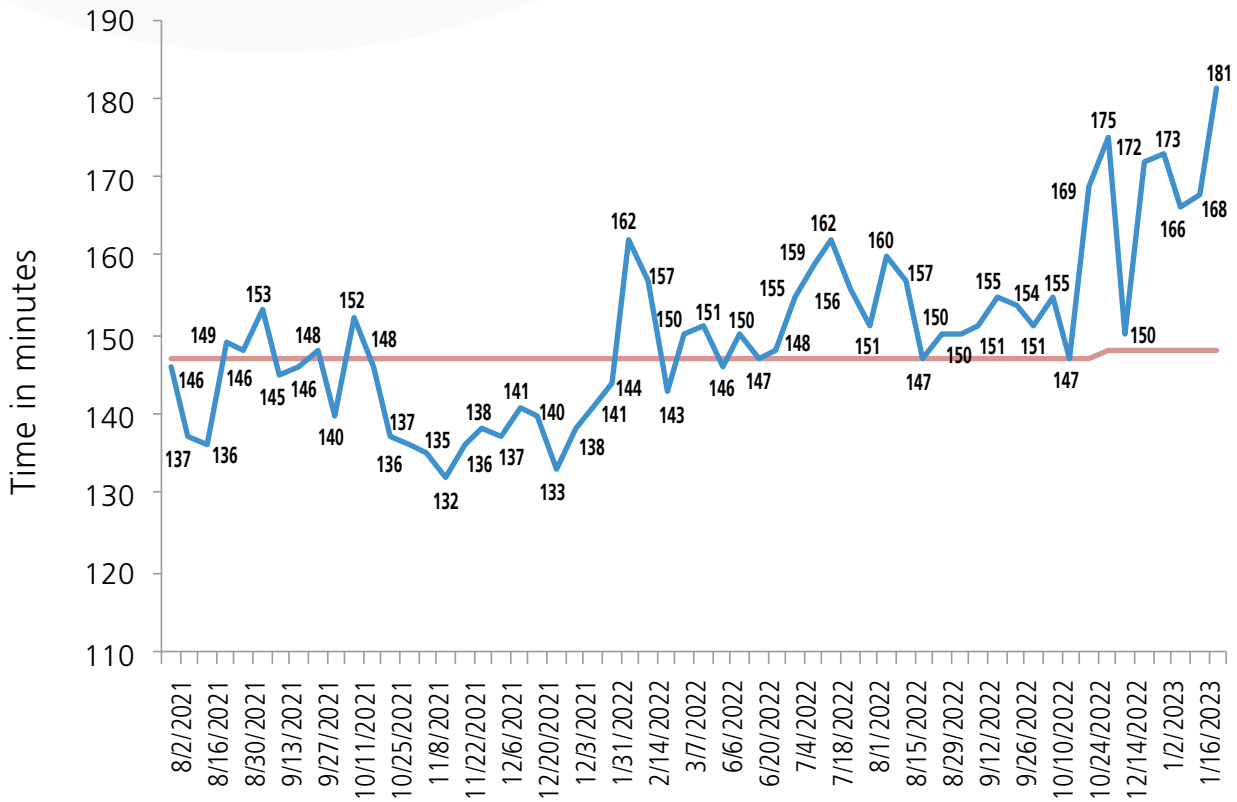
This application was designed with GE Healthcare in 2019/20 and is the first digital innovation to support early deterioration in patient wellness to be developed, tested and used in an acute care setting across NHS England.

Information about the condition of the patient is displayed on large ward-based screens and is also accessible via Trust desktop and laptop computers. This provides a visual prompt to ensure observations are carried out as per clinical need and encourage earlier escalation to appropriate clinicians. The monitoring section captures any patient that has a National Early Warning Score (NEWS) 2 due according to the Royal College of Physicians (RCP) minimum frequency of monitoring nationally mandated guidelines. The severity section captures any patient that has a NEWS2 score of 5 and above or 3 in a single parameter. Having the tile visible within all ward areas enables observations to be completed in line with the RCP minimum frequency of monitoring guidelines, which ensures earlier detection of deterioration.

The aim of the PDT is to support timely monitoring of clinical observations for Ward based adult in-patients and to help identify early signs of sepsis or deterioration. We have been monitoring the use of the tile over 2022/23 and the measures for improvement include:

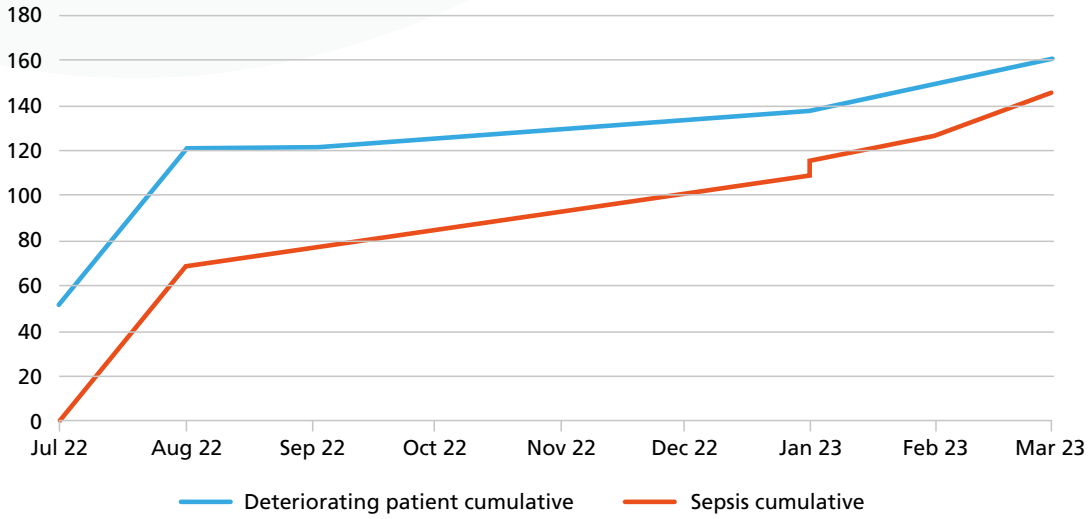
- Outcome Measure: Average time in monitoring section (April 22 – March 23)
- Process Measure: Number of staff that received education session on sepsis
- Balancing Measure: Number of critical care out-reach referrals

Figure 1: Average time spent in the monitoring section of PDT for all wards at BTFHT



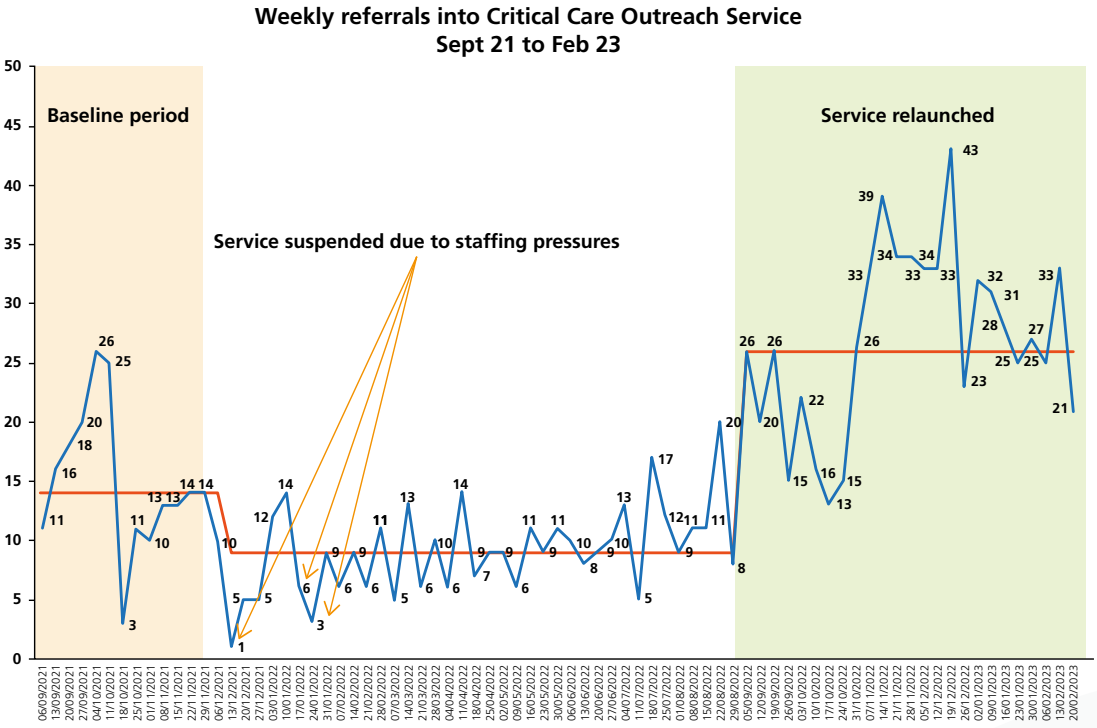
The average time patients spend in the monitoring section has increased, however this shows that observations are being recorded as the patient requires them according to the RCP guidelines. Work has been undertaken within specific ward areas regarding the frequency of monitoring, this has enabled time to be allocated to other carers and providing more patient centred care.

Figure 2: Number of staff that received education session on sepsis and deterioration



Education sessions are ongoing across all clinical areas and staff groups regularly, with leaders from the clinical areas are providing support for staff to be released to attend the training

Figure 3: Number of critical care out-reach referrals



Hospital at night pilot – Led by Chief Specialist Registrar

Following COVID-19, the Critical Care Outreach Team was relaunched in August 2022 with new leadership. The outreach team have made it simpler to make referrals, re-engaged with wards to promote the service and now provide 24/7 support. We have seen the number of referrals increase month on month from this date and we anticipate that this will improve patient outcomes and support earlier detection of deterioration of care.

During the pilot the tile demonstrated to have a positive impact on early recognition and response to a deteriorating patient. This led to improved outcomes and experience for patients.

In 2023/24, we will continue to embed the use of the PDT and increase our understanding about how, why and when staff use this tool to improvement patient outcomes and quality of care.

How do we make changes?

Model for Improvement.

There are 4 steps:

1. Identify the problem and create a SMART aim
2. Identify measures to show changes
3. Think about ideas you want to try
4. Test out ideas using PLAN-DO-STUDY-ACT cycles

QI Case Study: 'Hospital at night'

The problem: A perceived lack of support for Junior Doctor's (JDs) when working at night. We used national survey data and spoke to many nurses and doctors to understand the issues. An extract from a conversation from a JD summarises some of the key issues they face:

> *'Someone to help do an ECG, deliver bloods to the lab and run samples to ABG [blood gas] machine…can be challenging when I am left with a sick patient on my own. I sometimes have to go around wards to find equipment (catheters on SAU, ECG machine, butterflies) at the start of night shift.' (Junior Doctor at BTHFT, 2022)*

What are we trying to accomplish?

The aim of this project is to increase joy in work and the wellbeing of junior doctors by reducing the amount of clinical tasks they have to carry out overnight.

How will we know that a change is an improvement?

Outcome Measure:

Qualitative Feedback from staff about experience of working at night.

Process Measures:

- Numbers of times a set of bloods are taken overnight.
- Number of cannulas.

Balancing measure:

- Step Count over night for JD's.

Change ideas:

1) Care Support Worker (CSW) to support the JD's to deliver care overnight.
2) Clinical Nurse Co-ordinator to provide oversight of clinical tasks and patients who are unwell.

Plan-Do-Study-Act Cycle #1

09/01/23: First cycle tested for one week using CSW to support the JD's at night. Feedback from JD's was that they Doctors felt less stressed, better able to prioritise and focus on care of unwell patients. For example, doctors felt that they delivered care more rapidly with potential improvements administering intravenous medications and fluids and patient flow. The process measures demonstrated a sustained reduction for JDs inserting cannulas and reduction in the number of blood tests taken. There was a reduction in the number of steps taken by JD's (See Figures 4, 5 and 6). The feedback from the CSW indicated that this was a rewarding role with clear benefits for patients and the JD's. However, the nights were very busy and this had an impact on the number of consecutive nights that were deemed as practical.

The result of the test suggested introducing the CSW role for a longer test period but limiting the run of nights for CSW to three/four nights in a row owing to the nature of the work. A second PDSA cycle is underway to test the clinical nurse co-ordinator role to underhand the effect of this role for patient outcomes and staff experience.

Figure 4: Number of cannulas placed over night

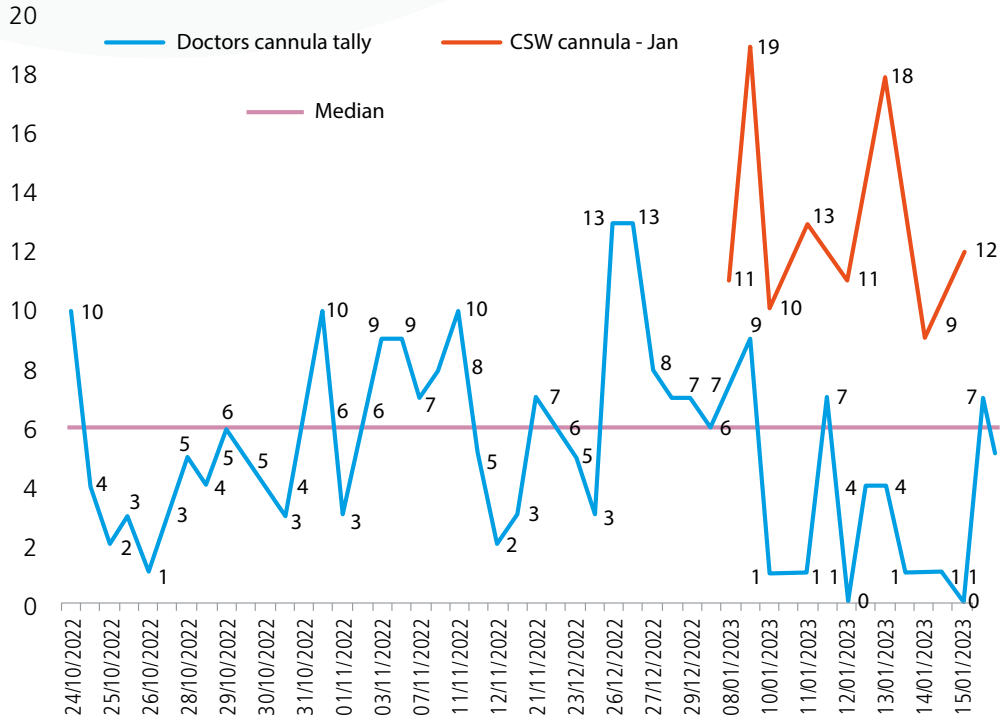


Figure 5: Number of blood tests taken overnight

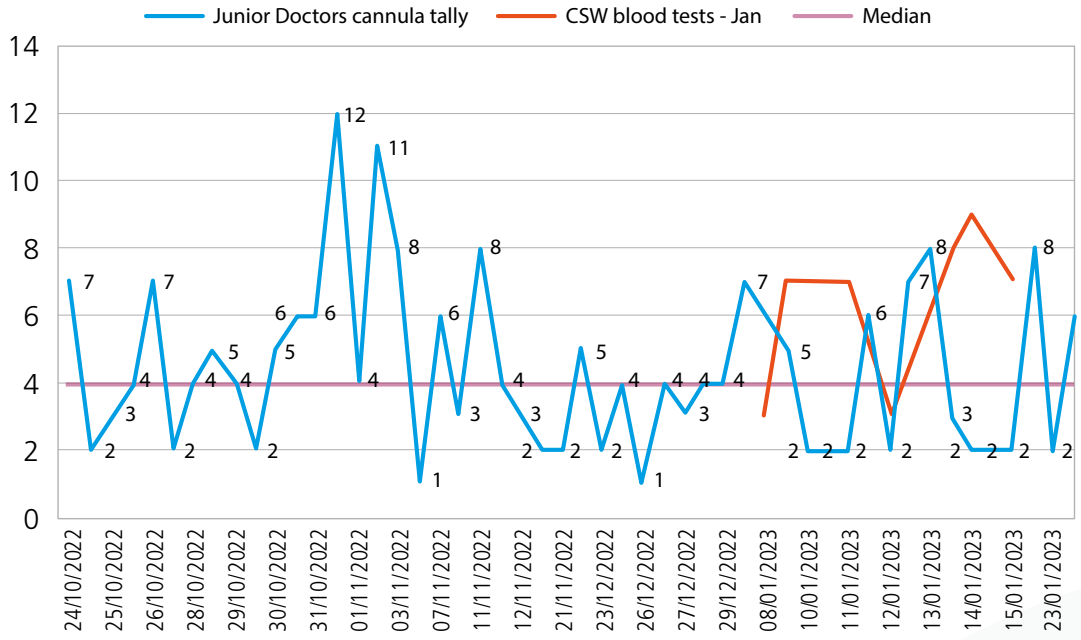
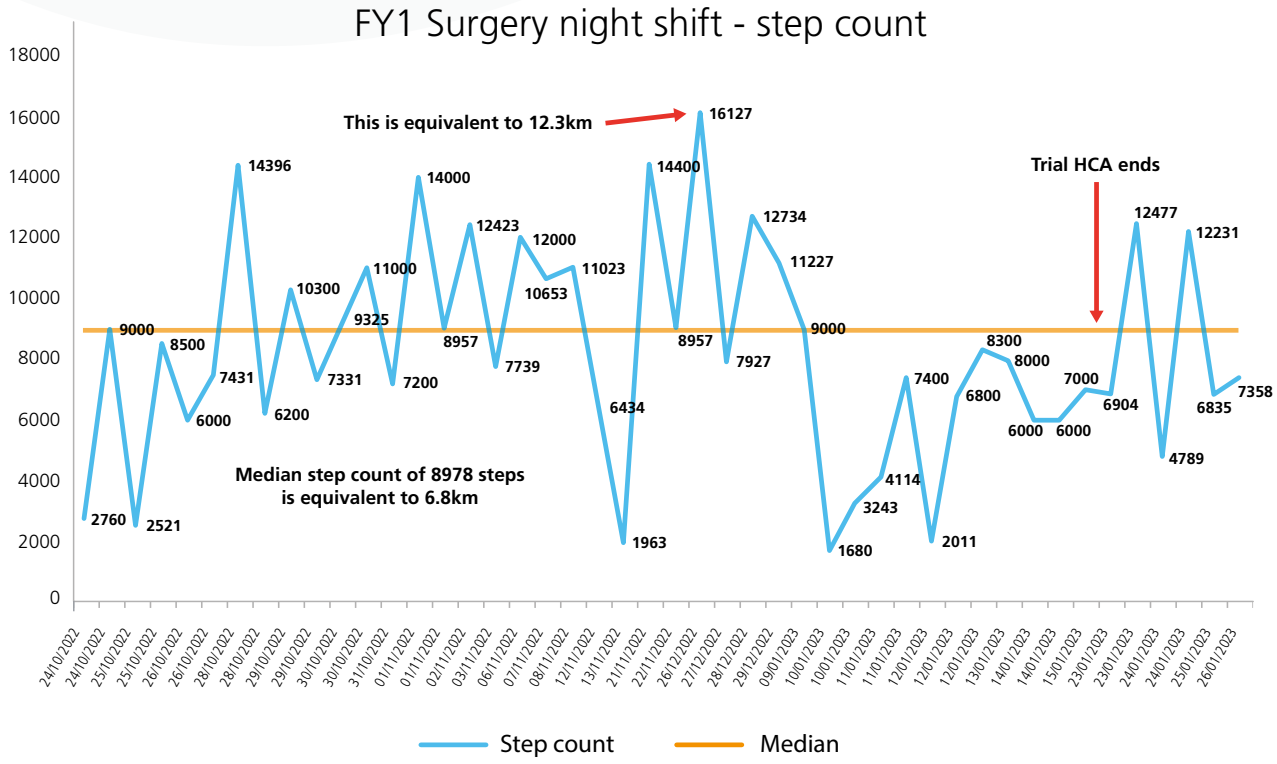


Figure 6: Step count for Foundation Year (FY)1's night shift



Recognition and Response Roadshow

From October 2022 the Clinical Nurse Specialist for Sepsis and Quality Improvement team have been visiting wards to talk about how they use the tile and share insights from data looking at time spent in frequency of monitoring.

Continued improvement work for 2023/24 will focus on recording of respiratory rates and ensuring escalation has been documented within the electronic health care record and exploring high NEWS2 scores on admission to understand the needs of acutely unwell patients.

We will also be launching 'patient deterioration champions' on wards with planned training and education to support early recognition and response of the deteriorating patient.

Junior Doctors quality improvement projects

Junior Doctors leading on quality improvement projects within specific ward areas, with the use of questionnaires to engage staff and change daily practice has been shown to improve staff knowledge and skills as well as screening and administration of antibiotics for patients.

Sepsis Dashboard

Our sepsis dashboard was launched in 2020/21 which pulls data from EPR and enables wards and specialties to monitor

key outcome and process measures. During 2022/23 we have included the use of the sepsis bundle in EPR to the dashboard and this year plan to report on all elements of the Sepsis 6 being completed.

NHS England Pilot - Worries and Concerns

Our Trust has been successful in an application to NHS England to participate in a national improvement collaborative to develop, test and implement ways to involve patients, carers and families to raise worries and concerns about acute illness and deterioration. We have proposed testing the Patient Wellness Questionnaire (PWQ) as a way to capture patients' ratings of their wellness to detect early changes to their condition.

Priority 2:

Improving patient experience

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

- The embedding kindness project which evolved from the Patient Experience Strategy has been shared with NHS England receiving National and local interest #embeddingkindness.
- Strong links with our new Organisational Development Team has enabled us to develop our thinking around civility in the workplace and wellbeing in relation to kindness. The Patient Experience team has representation at the Workplace Civility Board to ensure that key messages and work streams work alongside and complement each other.
- Work with the national group 'Ageing without Children' (AWOC) has resulted in a 'Kindness Conference' being held. This was very well received when it took place in the autumn of 2022 with a plan for a further conference in 2023.
- The Spiritual, Pastoral and Religious Care (SPaRC) service (formally chaplaincy) has received national recognition and awards for their pioneering new model of working.
- The SPaRC team have launched an interactive platform accessible by smartphone to increase their reach to patients and staff. This has gained a lot of interest from other organisations and is supported by religious leaders from the community.
- Our Trust has been working towards obtaining Veteran Accreditation status. It has been recommended that our Trust is in a position to apply for silver accreditation status. A veteran lead has been identified with plans to engage with our volunteer service in recruiting ex-service personnel. Their role would be to support veterans and serving personnel alongside the veteran lead. This is to ensure that service persons and their families are not disadvantaged due to them moving areas frequently.

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

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

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

The model has been well received by staff and patients and has received regional awards, generated national interest including the NHS England Review Committee who consider our model as an exemplar of inclusivity. The SPaRC team, in collaboration with the University of Bradford, have also developed an IT Application for staff and patients. This provides a plethora of resources and information and was launched in spring 2022. They have recently been shortlisted for a HSJ Award for this work.

The SPaRC team have also had external recognition and enquiries about their Fast packs first developed in 2022. These include pop up prayer facility packs that have helped managers support their colleagues during the Ramadan period. A bigger and more organised campaign has been commenced for this year's Holy month of Ramadan that started mid-March.

The Carers Passport and care plan were launched towards the end of 2021 alongside a Carer's Charter. The Carers Passport is designed to support Carers and ensure they are supported throughout a patient's hospital admission. The passport is supported by the Lead Nurses for Dementia and the Lead Nurse for learning disabilities. Feedback has been positive so far. An audit of compliance and usage will be conducted in 2023.

The implementation of a VIP pathway and red backpacks was successfully launched in the early part of 2023 enabling patients with additional needs to be identified and additional support to be provided. The pathway allows for a more streamlined transition between home, community settings and hospital so that it is less overwhelming for patients and their carer's. This was initiated following discussions with people with additional needs and after reviewing our complaints and incidents.

The Patient and Public Involvement team continue to work on a number of projects to enable public engagement to take place and changes to be made as a direct result of feedback. For example; working with partner agencies to gain feedback from service users with Special Educational Needs and Disability (SEND) in our community paediatric department; working with our local Healthwatch team regarding service user experience of virtual appointments, and contributing to the City of Bradford Metropolitan District Council's stakeholder group for people with visual and hearing impairment visiting our sites to enable future improvements to be made.

Our Maternity Unit has worked in partnership with the Maternity Voices Partnership (MVP) to modernise our facilities based on the experience of women, all clinical areas in Maternity have now had a "15 step review" and the findings of these have been included in our plans to refashion the unit.

Further work has been commenced with the paediatric inpatient team and the VRI (Virtual Royal Infirmary) to produce a virtual tour of the hospital to alleviate anxiety in children with additional needs.

The Relatives Line was implemented during Covid-19 however it has been so successful it has been made a permanent service. It is staffed by 3 registered nurses and reduces the number of calls from families to the wards allowing staff time to deliver care. Users of the service value the nursing expertise and the time they are able to give to their enquiries.

Figure 7: Relatives Line Activity 2022/23

Month	Calls Presented	Calls handled	% HANDLED
Apr-22	1,331	1,157	87%
May-22	830	793	96%
Jun-22	754	676	90%
Jul-22	1,387	1,259	91%
Aug-22	1,346	1,231	91%
Sep-22	1,221	1,140	93%
Oct-22	1,214	998	82%
Nov-22	1,198	1,045	87%
Dec-22	1,376	1,198	87%
Jan-23	1,178	1,063	90%
Feb-23	1,297	1,080	83%
Mar-23	1,161	876	75%

Friends and Family Test

Our Trust has recently appointed a new contractor for the friends and family test (FFT). The aim is to significantly improve the volume of FFT responses. There will a reduced reliance on paper feedback forms, although these will still be available, and an increased volume of SMS responses. QR codes will be added to posters in all patient areas to encourage FFT feedback through the electronic route. It is hoped that the anonymity offered by the use of QR codes will improve response rates and the quality of data. The new system has yet to be launched but the data for Jan-April 2023 will be uploaded retrospectively from feedback forms. The results from the friends and family test for 2022/23 are included under section 2.3.4

CQC surveys

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

The Outstanding Maternity Service has been working with patients and staff to improve the outcomes for service users and their babies. They have had national recognition with their television documentary following the home birth team.

The Children and Young People's survey was carried out with reduced scoring in some areas however the report acknowledges that the survey was conducted during the pandemic and therefore access to play facilities, access to heat and store own food were limited and this was reflected in the scoring. It has generated a number of work streams with improvements being made particularly in the areas of:

- A review of the child specific menu. A trial has been undertaken in conjunction with the catering department, dietetics and children to revise the menu to a more child friendly version. To be audited in 2023/24;
- Work has been undertaken in collaboration with the theatre team to improve the experience of children attending theatres for surgical procedures. Baggins the bear is now a familiar sight around the organisation;
- Posters with QR codes for reporting on patient experience;

- Play (new toys, crafts for adolescents) ordered and the playroom has now been re-opened;
- Communication bedside folders completed;
- To increase the number of responses to the next survey by actively promoting the survey to families.

Complaints

Our Trust performance regarding complaints is included under section 3.1.5 Patient Experience.

Bereavement Services

The Bereavement team continue to support families after the death of their loved ones with high volumes of calls and face to face meetings being responded to. The team work closely alongside the mortuary team and the medical examiner's office to provide holistic care to the deceased person and their family/carers.

Improvements to Bereavement Services:

- Electronic records. Both Bereavement records and cremation forms are logged onto an electronic database.
- Change of Evolve. GP death notifications/ final GP notifications have changed from Evolve to EPR standardising the documentation used.
- Bereavement waiting area improvements. Newly decorated Bereavement area for relatives providing a quiet reflective space.
- Revised internal property process. Electronic internal database to log all property that comes to Bereavement. All property logged and signed into the Bereavement office. Reiterated Bereavement will not take property without a property list.

Ongoing projects for bereavement team in the year ahead:

- Review publications for next of kin.
- Continue to work closely with funeral directors to ensure that services can take place in a timely manner.
- Review full hospital funeral process including financial impact to the Trust.
- Working with Safeguarding team with an emphasis on safeguarding deceased and their property.
- Website content internal/external.

Projects for the Patient Experience team for the year ahead

- Launch of our revised engagement strategy.
- In partnership with the University of Bradford launch our 'Clinical Customer Care' training.
- Increase the number of Patient Led Assessments of the Care Environment (PLACE) visits.

Priority 3:

Continued reduction in stillbirths

Our Trust officially launched its Outstanding Maternity Services (OMS) Programme in August 2021 and continued during 2022/23. The programme has dedicated resources and uses a multi-disciplinary approach to continuous quality improvement central to this are the women that we care for and their voices are heard and listened to in person and via the Maternity Voices Partnership (MVP).

We have continued our focused work and commitment to reduce stillbirths during 2022/23, which will remain a key focus and priority during the next financial year. More details on the stillbirth data can be found in this Quality Account under section 2.3.1 Stillbirths.

2022 ended with a total of 32 stillbirths including 8 babies who were not expected to survive. This resulted in an adjusted rate of 4.8 per 1000 births, a slight increase on the 4.2 per 1000 births in 2021, but a reduction from the 5.6 per 1000 in 2020.

The sustained reduction is reflective of our full compliance with the implementation of the Saving Babies Lives Care Bundle Version 2[7] and embedded messaging regarding the importance of early presentation with reduced fetal movements.

Our maternity service is awaiting the imminent publication of version 3 of the care bundle and is committed to reviewing any new recommendations and implementing changes.

There was an increase in the number of stillborn babies cared for on the 'Butterfly Pathway' during 2022. Our maternity and neonatal services are extremely proud of this pathway, which supports women, pregnant people and families to continue a pregnancy where there is an antenatal diagnosis of a lethal abnormality, making memories and providing choice and a positive experience under very sad circumstances.

Analysis of the stillbirths occurring during 2022 again identified that the majority of cases were to women living in the highest indices of deprivation. However, it also highlighted that the cost of living crisis experienced by many during 2022/23 is having a direct impact on the ability of women and pregnant people to access maternity care.

In response to this, our maternity service implemented a number of interventions aimed at tackling deprivation and reducing inequalities. This includes partnering with Bradford Metropolitan Food Bank to become a mini distribution site and the launch of the 'Ask for Betty' campaign. Around 20 women and families per month are now able to access food at the same time as attending for maternity care. This initiative will continue during 2023/24.

The national target for achieving Midwifery Continuity of Carer (MCoC) was officially paused during 2022/23, due to the ongoing national midwifery staffing shortage. The national message is for maternity services to prioritise safe staffing levels in the first instance, developing MCoC teams when this is achieved and sustained.

Bradford has followed this directive and robust recruitment and retention plans are in place, including the recruitment of International Midwives and Apprentice Midwifery opportunities. No new MCoC teams were rolled out during 2022/23 and the intrapartum element was paused in the 2 established teams which provide MCoC to some of Bradford's most vulnerable women and other pregnant people. However, intrapartum continuity is expected to resume in early 2023/24 for the existing pathways of care prioritising women from ethnic minority and vulnerable communities.

Moving forward reduction in stillbirths remains a key indicator. However, stillbirths is not the only indicator of wider maternity and neonatal care, therefore moving forward, this priority will be expanded to include compliance with the recently published single delivery plan, which incorporates recommendations from the high profile Ockenden and Kirkup reports into maternity services.

7 *https://www.england.nhs.uk/mat-transformation/saving-babies/*

Priority 4:

Advancing equality, diversity and inclusion

Our Equality and Diversity Council (EDC) continues to meet regularly and is chaired by our Chief Executive Officer who is also our Executive Sponsor for equality, diversity and inclusion. EDC has continued to focus on advancing our progress on workforce equality and diversity related matters, including the Trust's approach to tackling health inequalities. Membership of EDC is reviewed regularly with focus on ensuring its' role and remit is fit for purpose and the terms of reference are reviewed annually. Having EDC in place demonstrates our Trust's commitment and collective responsibilities in advancing EDI and our focus on tackling health inequalities, this has led to the development of a three year EDI Strategy which was approved by our Trust Board in March 2023.

This new EDI strategy sets out our ambitions and plan of actions to promote and advance equality of opportunity, with sharp focus on belonging and inclusion. It has been shaped from our willingness to listen and involve our staff and key stakeholders through extensive consultation; from partnerships with our staff equality networks, understanding their 'lived experiences' of working and being service users and patients, and from the learning we have gained from external benchmarking, peers and partners. The strategy aims to drive a step change in the culture of our organisation, helping us to embed and advance equality, diversity and inclusion, for the benefit of our staff, patients and the wider community.

As part of the strategy the following five refreshed strategic objectives have been identified to develop and action over the next three years (2023 to 2025). These are:

- Education, Empowerment and Support
- Effective Staff and Community Engagement and Involvement
- Population Health Inequalities
- Promoting Inclusive Behaviours
- Reflective and Diverse Workforce

The strategy will be accompanied by a year on year implementation plan which will also show the progress we are making.

Our reviewed and refreshed staff equality networks were re-launched in May 2022. We strongly believe they are the key building block to our Trusts diversity and inclusion agenda where staff can share their 'lived experiences' and effectively influence change. Our network representatives are able to influence strategic decision making in the Trust through their active membership of both the People Academy and the Equality and Diversity Council.

We submitted our Gender Pay Gap data in March 2023 and are working with our Gender Equality Reference Group to develop a refreshed Gender Equality action plan around the following key areas of focus:

- Development of Women in Leadership (including Talent Management and exploring blockers for Women progressing).
- Further developing a culture of flexible working (focusing on frontline staff).
- Under-representation of men in traditionally female roles.

In addition to the work around gender equality, there has been considerable focus at our Trust in raising awareness around menopause for our staff. There has been lots of activity in working with managers across our Trust in terms of education and raising awareness, so that managers have a good understanding of menopause and how this can affect staff, so that they can recognise symptoms and access and signpost to the necessary support to improve their quality of life and work experiences.

We have demonstrable executive support to continue and develop this work, and our menopause network meets fortnightly to discuss wider plans and next steps. We are working towards the menopause friendly employer accreditation, and are well on the way to achieving this. We have teamed up with app 'Balance' to provide licences for our staff to access content and resources to help and support and educate further. We send out fortnightly mailshots with snippets of useful information and have converted our menopause guide into a standalone menopause policy.

We have a calendar of events which covers a range of areas to take us across the year and we are always on the lookout for new ideas.

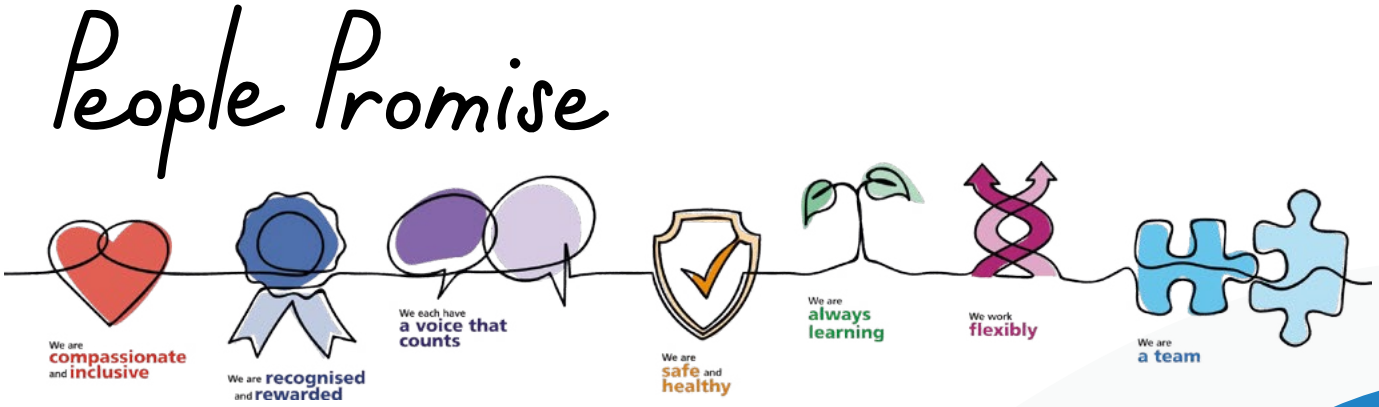
Our refreshed Workforce Disability/ Race Equality standard action plans were co-produced with our staff equality networks in response to our 2022 workforce/ staff survey data. The action plans were grouped into three key themes "Workforce Representation, Recruitment & Retention", "Leadership, Learning & Development" and "Staff Experience (Inclusion & Belonging)". A range of targeted activity has taken place to improve our data and ultimately the experiences of our diverse staff. Some of these key actions include;

- Development of a disability equality video[8] and travelling photography exhibition (using funding from the WDES innovation fund) showcasing the experiences of 6 members of staff who share their positive experiences of being supported in the workplace in terms of managing their long-term health condition or disability, including supporting staff with caring responsibilities.
- Continued support and hosting of Project Search; an initiative aimed at young people with learning difficulties to support them into paid employment, this has a positive impact on all graduates and their families and we continue to see positive results for young people.

8 https://www.youtube.com/watch?v=FyuxFAYIrA8

- The successful launch of a Reciprocal Mentoring Scheme pairing aspiring Ethnic Minority/ Disabled staff with members of the Trust Board and plans to roll out the second cohort in May 2023. The focus of this scheme has arisen from our WRES and WDES action plans and the need to ensure we are supporting those staff that are aspiring to move into senior leadership roles.

- We have continued our efforts to further engage with diverse staff across our Trust, with the aim of providing safe space, responding to risks, concerns and issues and with a view to understanding their lived experience, celebrate diversity, and using this to bring about a change in the culture of the organisation. Recent examples include; a Filipino nurse appreciation event, celebrations for Black History Month, LBGT+ History month and week-long disability equality festival in partnership at place level. In celebration of International Women's Day in March we held a live streaming of the NHS Confederation Health and Care Women Leaders and held an engagement event to explore flexible working opportunities for front line staff, aligning this work to the NHS People Promise.



2.2. STATEMENT OF ASSURANCE FROM THE BOARD

2.2.1. REVIEW OF SERVICES

During 2022/23 our Trust has provided and / or sub-contracted 41 designated Commissioner Requested Services.

Our Trust has reviewed the data available to it on the quality of care in all of these relevant services.

The income generated by the relevant health services reviewed in 2022/23 and represents 100% of the total income generated from the provision of relevant services by our Trust for 2022/23.

2.2.2. PARTICIPATION IN CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

The ethos of learning and improvement underpins our approach to quality as our Trust strives towards the delivery of the highest quality healthcare at all times.

Our Trust's clinical audit work provides one way to monitor if care is being delivered in line with national standards and best available evidence. Clinical audit allows services to identify good practice and positive patient outcomes, as well as, areas for improvement.

The High Priority Clinical Audit Programme for 2022/23 was informed by our Trust's NHS Standard contract requirements which includes by the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and any other relevant national programme included within the NHS England Quality Accounts List.

During 1 April 2022 to 31 March 2023, our Trust was eligible to participate in 34 out of 42 national clinical audits and three national confidential enquiries that covered relevant health services that our Trust provides.

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

The national clinical audits that our Trust was eligible to participate in during 1 April 2022 to 31 March 2023 are as follows:

- Child Health Clinical Outcome Review Programme
- Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People
- Falls and Fragility Fracture Audit Programme:
  a. Fracture Liaison Service Database
  b. National Audit of Inpatient Falls
  c. National Hip Fracture Database
- Gastro-intestinal Cancer Audit Programme:
  a. National Bowel Cancer Audit
  b. National Oesophago-gastric Cancer
- Maternal and Newborn Infant Clinical Outcome Review Programme
- Medical and Surgical Clinical Outcome Review Programme
- National Adult Diabetes Audit
  a. National Diabetes Core Audit
  b. National Diabetes Inpatient Safety Audit
  c. National Pregnancy in Diabetes Audit

- National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme
  a. Adult Asthma Secondary Care
  b. Chronic Obstructive Pulmonary Disease Secondary Care
  c. Paediatric Asthma Secondary Care
- National Audit of Breast Cancer in Older Patients
- National Audit of Care at the End of Life
- National Audit of Dementia
- National Cardiac Audit Programme
  a. Myocardial Ischaemia National Audit Project
  b. National Audit of Cardiac Rhythm Management
  c. National Audit of Percutaneous Coronary Interventions
  d. National Heart Failure Audit
- National Child Mortality Database
- National Early Inflammatory Arthritis Audit
- National Emergency Laparotomy Audit
- National Lung Cancer Audit
- National Maternity and Perinatal Audit
- National Neonatal Audit Programme
- National Obesity Audit
- National Paediatric Diabetes Audit
- National Perinatal Mortality Review Tool
- National Prostate Cancer Audit
- National Vascular Registry
- Sentinel Stroke National Audit Programme

The national confidential enquiries that our Trust was eligible to in during 1 April 2022 to 31 March 2023 are as follows, Community Acquired Pneumonia, Testicular Torsion and Endometriosis.

The national confidential enquiries that our Trust participated in, and for which data collection was completed during 1 April 2022 to 31 March 2023 are presented below alongside the number of cases submitted to each enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (See figure 8).

Figure 8: BTHFT National Confidential Enquiries 2022/23

National Confidential Enquiries	Date commenced	Registered number of cases	Cases submitted to each enquiry as a percentage of the number of registered cases required
Community Acquired Pneumonia	April 2022	7	(7/7) 100%
Testicular Torsion	August 2022	6	(6/6) 100%
Endometriosis	November 2022	N/A	Data has been submitted to NCEPOD 17/11/22- awaiting clinical questionnaires to complete

The annual reports that were published in 2022/23 for national clinical audits were reviewed by the clinical audit leads. The following clinical audits and programmes presented at the monthly Clinical Outcomes Group meeting, which aims to share best practice, learning and improvement work:

- National Audit of Inpatient Falls
- LeDeR – learning from lives and deaths of people with a learning disability and autistic people
- National Pregnancy in Diabetes Audit
- National Audit of Percutaneous Coronary Interventions
- National Neonatal Audit Programme
- National Perinatal Mortality Review Tool
- National Vascular Registry
- Sentinel Stroke National Audit Programme

During 2022/23 the Trust received outlier notices for two national clinical audits which were for the National Emergency Laparotomy Audit and the National Audit of Care at the End of Life. The following actions taken for each are described below:

National Emergency Laparotomy Audit

In June 2022 the Trust received a NELA statistical alert regarding the mortality rate for hospital admissions within 30 days. The NELA clinical lead and Learning from Deaths team agreed to investigate the last 10 deaths within the audit through Structured Judgement Reviews in order to assess the quality of care received by these patients. Learning from the reviews included:

- The overall quality of care received by the patients was scored as either 'Good' or 'Excellent'.
- There appeared to be discrepancies between NELA scores calculated by surgical clinicians and anaesthetic clinicians.

In order to mitigate these discrepancies, the Anaesthetics and Surgical teams held joint learning sessions that involved training scenarios and facilitated discussions about using the NELA scoring system. Since these sessions, there has been little to no discrepancy found in NELA scores within the audit.

In December 2022, the NELA clinical lead confirmed that the Trust's NELA mortality rate for hospital admissions within 30 days had returned to within expected limits.

National Audit of Care at the End of Life

On 2 December 2022, a 'Cause for Concern Notification' was received by the Trust. This notification had been triggered by a response from the quality survey. We investigated the concern that had been raised and responded to the audit provider within the required time frame. The final decision received from the audit provider on the 31st January 2023 declared that there was no further case to answer. As an organisation we identified areas of good practice and areas for improvement which included:

- Reviewing the national guidance of 'The Care of the Older or Frail Orthopaedic Trauma Patient' to ensure we consistently met the standards.
- Reviewing with multidisciplinary team input the way acute pain is managed for in-patients trust wide who may have fluctuating and /or impaired cognition.
- To raise awareness of the referral process to the palliative care team.

2.2.3. PARTICIPATION IN CLINICAL RESEARCH ACTIVITIES

In 2022/23 our Trust continued to have an extensive programme of health care research.

The number of patients receiving relevant health services provided or subcontracted by our Trust in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee is 12,008.

Research engagement

- In year we have continued to embed research as part of routine clinical care throughout the Trust
- Information on research and how to take part is now being included on all outpatient and inpatient letters including electronic letters
- An EPR (electronic patient record) reminder card on research has now been provided for clinical staff
- Photographs taken of all research teams for our ward research boards and research promotional artwork/information
- Developing new research leaflets and posters for patients to highlight research and the 'City of Research – Research as One' register

Research training and induction

- Trust Research Induction package in the pilot phase
- Research Informed consent training launched – Research matron and Education team have created a bespoke research informed consent training session and competency package
- Research training now added to ESR – Training team have created the option to add Informed consent and GCP training to staff training matrix.

National Institute of Health Research (NIHR) Patient Recruitment Centre (PRC): Bradford

Our Patient Recruitment Centre is very busy and currently is running 30 commercial clinical trials, has recruited 227 patients and has recently met the recruitment target for the Tide study after being the site to recruit the first patient in Europe in November 2022. Our ambition is to expand the PRC research (and commercial research) into more clinical areas to meet the research needs of our population and to provide a wider and more comprehensive commercial research portfolio thereby enabling an increase in research income, reputation and sustainability. To enable this expansion we will be investing in Consultant PAs in a number of areas (where an expanding commercial pipeline is envisaged) which will free up consultant time to work with the PRC team to develop the PRC and their speciality's commercial research portfolio.

Finding out more

More detail on our clinical research activities and the full work of the Bradford Institute for Health Research can be found here.[9]

9 https://www.bradfordresearch.nhs.uk

2.2.4 COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

The Commissioning for Quality and Innovation (CQUIN) scheme was set up in 2009 with the intention of driving transformational change by supporting clinical quality improvements to address health inequalities in access to services, patient experiences and health outcomes.

However, the COVID-19 pandemic presented the NHS with a unique set of challenges and as result the CQUIN scheme was paused from 2020 to 2022. In order to support the NHS recovery priorities CQUINs were re-introduced for 2022/23. NHS England and NHS Improvement identified a number of core clinical priority areas which were selected owing to their importance in the context of COVID-19 recovery and to reduce clinical variation between providers.

A CQUIN scheme must be offered to each Provider which provides healthcare services under the NHS Standard Contract, where indicated in the API (Aligned Payment and Incentive) rules within the National Tariff Payment System. The CQUIN schemes contain goals for quality and innovation that have been agreed between the Trust and its Commissioners (NHSE and ICB's). The CQUIN financial incentive (1.25% as a proportion of the fixed element of payment as set out in the Trust's NHS Standard Contract) is only be 'earnable' on the five most important indicators for each contract, as agreed by commissioners. Listed below are the five core indicators which were agreed by our Trust with the Commissioners for 2022/23:

1. **CCG3:** Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions
2. **CCG4:** Compliance with timed diagnostic pathways for cancer services
3. **CCG9:** Cirrhosis and fibrosis tests for alcohol dependent patients
4. **PSS1:** Achievement of revascularisation standards for lower limb Ischaemia
5. **PSS5:** Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines

The basis for payment for all indicators is based on a performance assessment conducted at the end of the scheme. At the time of writing, the final assessments are expected to be completed by mid-summer 2023.

2.2.5 CARE QUALITY COMMISSION REGISTRATION

Our Trust is required to register with the CQC and its current registration status is registered with the CQC without conditions. The CQC has not taken enforcement action against our Trust during the period 1 April 2022 to 31 March 2023.

2.2.6 CQC SPECIAL REVIEWS AND INVESTIGATIONS

Our Trust has not participated in any special reviews during the reporting period but has participated in investigations by the Care Quality Commission relating to the following areas during 1 April 2022 to 31 March 2023:

20 April 2022

Unannounced focused inspection of the Urgent and Emergency Care (UEC) department at Bradford Royal Infirmary in April 2022 as part of the Integrated Care System (ICS) review for West Yorkshire.

Our Trust intended to take the following actions to address the CQC 'should do' actions identified as a result of the inspection in order to make improvements:

CQC Action 1: The trust should ensure that there is a dedicated, fully risk-assessed room available for patients presenting to the department experiencing mental health crisis.

Trust action: Dedicated mental health suite to be designed and built/adapted into the current ED footprint.

CQC Action 2: The trust should ensure that there is a sustained improvement in the oversight and treatment of sepsis.

Trust action:

1. RCEM severe sepsis and septic shock audit
2. Sepsis Dashboard monitored monthly
3. QI project to be initiated with identified outcomes to ensure sustainability in conjunction with Lead Sepsis Nurse.

CQC Action 3: The trust should ensure there is a sustained improvement in the quality of patient records to ensure that they are fully documented and up-to-date with all observations.

Trust action:

1. Documentation audits to be completed from EPR on a weekly basis
2. Audit results to monitored a monthly Quality and Safety meetings

CQC Action 4: The trust should continue to work with system partners to improve patient flow throughout the emergency care pathway.

Trust action: Emergency care has been identified as a priority work stream as part of Integrated Care System (ICS) linking into to wider West Yorkshire system.

Our Trust has made the following progress by 31 March 2023 in taking such action:

CQC Action1: A dedicated mental health cubicle adapted into the current emergency department footprint is now in use.

CQC Action 2: Leads for sepsis at both junior doctor and consultant level are in place. Pathways have been redesigned to facilitate improvement and the Trust sepsis lead nurse is meeting regularly with the accident and emergency department team to monitor and track progress.

CQC Action 3: Initial audits have taken place and are monitored at the departments Quality and Safety meetings to track progress.

CQC Action 4: An Urgent Care Centre adjacent to the current emergency department footprint has gone live from 03 April 2023 to help reduce pressure within the emergency department and the work with system partners continues.

4 January 2023: Announced Maternity inspection of Safe and Well-led domains.

The Care Quality Commission (CQC) carried out an announced focused inspection of the maternity service, looking at the safe and well-led key questions in early January 2023, this was part of the national maternity inspection programme. The report[10] was received on the 26 May 2023 (following the review of this Quality Account by our external stakeholders) and showed an improvement in well-led from Inadequate to Good with the safe domain remaining as Requires Improvement. The inspection did not impact on the overall rating for Maternity (as only two domains were inspected). However, the movement from Inadequate to Good in the well-led domain meant that the rating for Bradford Royal Infirmary has moved from Requires Improvement to Good. The Trust remains Good overall.

2.2.7 NHS NUMBER AND GENERAL MEDICAL PRACTICE CODE VALIDITY

During 2022/23 we submitted data to the secondary uses service (SUS) for inclusion in the hospital episode statistics (HES) that it publishes. The percentage of records in the published data that included patients' valid NHS number and general practitioner registration code is displayed in figure 9 below. Percentages for 2022/23 are in line with peers and exceed national England averages on all measures except for Valid General Medical Practice Code in Admitted Patient Care, which is 0.9% below national England average.

Figure 9: *Percentage of records which included the patient's valid NHS number/GP*

Record type	Area	2022/23	2021/22	2020/21	2019/20
		April to November 2021	April to November 2021	April to November 2020	April to November 2019
Patients' valid NHS number	Admitted patient care	**99.9%**	97.3%	99.7%	99.8%
	Outpatient care	**99.9%**	100%	99.9%	99.9%
	Emergency department care	**99.6%**	99.6%	99.2%	99.1%
Patients' valid general medical practice code	Admitted patient care	**87.1**	88%	100.0%	99.7%
	Outpatient care	**91.3%**	90.4	100.0%	99.6%
	Emergency department care	**98.9%**	98.8%	100.0%	99.6%

10 https://api.cqc.org.uk/public/v1/reports/d7a4bd50-0442-4973-b45c-7fb6ba2463a2?20230526070057

2.2.8 DATA SECURITY AND PROTECTION TOOLKIT

The Data Security and Protection Toolkit (DSPT) contains 10 data security standards (with underlying assertions). These are self-assessed and evidenced to provide overall assurance of the Information Governance related systems, standards and processes within an organisation.

In 2021/22 the Trust achieved 'Standards Met' which means that all mandatory assertion items have been evidenced by final submission. The deadline for all organisations for the DSPT assessment (formerly the IG toolkit) for 2022/23 is the 30 June 2023. This national date for annual DSPT assessment submissions for all organisations changed from 31 March during the pandemic.

Our final Information Governance assessment overall position for 2022/23 is therefore incomplete at the time of this report. A sample of the DSPT evidence has been independently assessed by Audit Yorkshire, their draft opinion had not been provided at the time of this report.

The Trust is currently forecasting 'Standards Met' as in 2021/22, to be confirmed on 30 June 2023.

NB: *the DSPT is no longer scored as a percentage / RAG graded (if one of the mandated assertions is not evidenced the outcome would be 'Approaching Standards').*

2.2.9 PAYMENT BY RESULTS CLINICAL CODING AUDIT

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

The Audit Commission did not impose a payment by results clinical coding audit on the Trust during 2020/21 or 2021/22.

Each year we commission an external audit to assess coding accuracy for continued assurance of data quality and compliance with the NHS Digital DSPT. The DSPT is an online self-assessment tool that allows organisations to measure their performance against the national Data Guardian's 10 data security settings. The accuracy of the coding is an indicator of the accuracy and completeness of documentation within patient records. The Trust was subject to an external DSPT clinical coding audit during 2020/21, and the 2021/22 audit took place from 9-20 May 2022, in compliance with the DSPT submission dates in June.

The audit sample of 220 finished consultant episodes (FCEs) was selected using random sampling methodology from spells of inpatient discharges between 1 April 2021 and the 30 April 2022. All episodes were audited against National Clinical Coding Standards.[11]

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

11 https://digital.nhs.uk/services/terminology-and-classifications/clinical-classifications

Primary procedure error rates have declined slightly during the period, though still above national standards (>=90% accuracy). Secondary procedures have decreased in accuracy, though still above national standards (>=80% accuracy). A contributing factor to this is the cancellation of elective activity as a response during this period to the pandemic. The severe decrease in the number of elective admissions has had an unbalancing effect on the usual quality measures, in this instance with a smaller representation of secondary procedures in the sample set meaning a small number of errors produced a large percentage change.

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

Figure 10: *Clinical coding error rate*

Coding field	Percentage incorrect								
	2021/22	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15	2013/14
Primary diagnoses incorrect	7.7%	6.30%	5%	5.70%	8.60%	8.17%	5.50%	9%	8%
Secondary diagnoses incorrect	5.5%	7.80%	3.80%	6.30%	10.20%	9.20%	4.80%	9.47%	5.90%
Primary procedures incorrect	9.9%	3.80%	8.30%	4.70%	8.10%	9.09%	9.10%	2%	0.70%
Secondary procedures incorrect	12.9%	6.80%	5.30%	2.10%	7.20%	14.79%	5.60%	8.02%	8.70%

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

2.2.10 DATA QUALITY

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

High quality data is a fundamental requirement for the Trust to conduct its business efficiently and effectively. We are committed to a 'right first time' approach to data quality which applies to all areas: patient care; service development and transformation; corporate governance; and operational and performance management. High quality data is crucial to enable the right decisions to be made regarding patient care.

Our data quality strategy, remit and performance have oversight from the Quality and Patient Safety Academy via a new digital and data transformation committee. A data governance board, paused during COVID-19 is being re-established and will reinstate controls related to the maintenance of the Trust's business critical and master data are appropriate and effective. These controls ensure subsequent reports, analyses, and decision making are based on high quality, accurate and reliable data. This robust structure advocates a culture whereby data quality is everyone's responsibility, driving ownership from ward to Board.

Although paused during the pandemic, the Data Governance Board (DGB) is in the process of being re-established and will meet quarterly.

The data quality strategy, remit and performance has oversight from the Board of Directors' Audit and Assurance Committee. The DGB ensures controls related to the maintenance of business critical and master data are appropriate and effective, ensuring subsequent reports, analyses, and decision-making are based on high quality, accurate and reliable data.

The Data Quality Issue resolution group has reformed with subject matter panel experts sourced from Corporate Access Team, Informatics Business Intelligence, Informatics Data Quality, Education and Training team and Clinical Informatics. This group will review and agree actions needed to resolve issues, identify process or configuration changes required, undertake a risk assessment of process failures and assess training requirements and targeted support. This group will report into the Data Governance Board.

An EPR Data Quality prevent, correct & Clear model is currently being progressed to support the Data Quality Policy enabling the 'right first time' aim by implementing a tiered infrastructure for operational teams to follow that will enable prevention, correctional locally with support corporately for complex corrections and clear, minimising risk of backlog growths, delays to patient care and improved activity recording.

Virtual data quality drop-in sessions are available for administrative and clinical staff to raise issues and focus on priorities relating to error prevention, correction and validation at an operational level.

Formal education and training programmes support appropriate use of our key information systems for new starters (clinical and administrative) and refresher training is available for priority areas. The Business Intelligence data quality improvement team offers bespoke training support through drop-in sessions, and one-to-one engagement workshops for operational staff focusing on areas for improvement (approximately 70 delivered per annum).

2.2.11 LEARNING FROM DEATHS

During 2022/23, a total of 1515 patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 311 in the first quarter
- 337 in the second quarter
- 452 in the third quarter
- 415 in the fourth quarter

The Learning from Deaths process: scrutiny and structured judgement reviews

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

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

Structured Judgement Review Process

Our Trust uses the structured judgement review (SJR) methodology for the mortality review process. This is a nationally recognised approach with the underpinning principle that trained clinicians use explicit statements to comment on the quality of healthcare in a manner that is reproducible2.

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

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

By 31st March 2023, 76 SJRs had been carried out in relation to of the deaths during 2022/23.

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

- 37 in the first quarter
- 7 in the second quarter
- 21 in the third quarter
- 11 in the fourth quarter

There were no deaths representing 0.0% of the patient deaths during the reporting period that were judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of:

- 0 deaths representing 0.0% for the first quarter
- 0 deaths representing 0.0% for the second quarter
- 0 deaths representing 0.0% for the third quarter
- 0 deaths representing 0.0% for the fourth quarter

Summary of learning from structured judgement reviews (SJRs)

The key learning and areas for improvement from the SJR's conducted in 2022/23 are summarised below:

Key Learning points

Celebrating excellence:

- Excellent communication between staff and patients, carers and their families in order to ascertain ceiling of care and most appropriate treatment. In the most difficult circumstances there was evidence of excellent support including bereavement support to families.
- Multiple examples of clinicians working hard to fast-track end-of-life patients in order for them to be discharge to their preferred place of death.
- Prompt recognition of end of life care for our patients. It was noted that the palliative care the patient received was outstanding particularly around pain management.
- Early recognition of sepsis leading to prompt fluid resuscitation and spectrum antibiotics.
- In cases of patients with severe mental health illnesses, their mental health status and social history were clearly assessed and needs addressed.
- Of particular note were the actions of staff on Ward 29 who provided access to beds, open visits and parking permits for the family of a young Learning Disability patient who was recognised as palliative. These actions allowed the patient's family to be present during the patient's final hours and days.

Areas for improvement:

- Improving documentation during assessments and investigations.
- Raise further awareness of the Trust's Learning Disabilities Team and encourage staff to contact the LD Team for advice in managing and treating vulnerable LD patients.
- Issues with medicines management including, missed doses of regular medications, a shortfall in pain medication administration and the conversion of epilepsy medications to intravenous therapy. A list of essential medications has been highlighted at junior doctor PEARL teaching sessions within ED to mitigate this issue.
- Issues with delays between IV fluids, antibiotics and other medications being prescribed and administered.
- Issues with exit blocks from the Emergency Department to specialty wards.
- Issues with Mental Capacity Assessments not being conducted and/or documented for patients who lacked capacity.
- Issues with a lack of escalation to senior consultants when needed. These incidents appear to have occurred during out-of-hours.
- Issues with significant delays in medical/clinical reviews in patients who were medical outliers. These incidents appear to have occurred during out-of-hours.
- Issues with a lack of referral to and/or discussion with ICU/critical care staff when patients would have benefitted from this input.
- More awareness needed of various O2 delivery systems and importance to ensure appropriate O2 is applied when using equipment.

In the period 2022/23 the Trust's 'Learning from Deaths' team have taken numerous actions including:

- Building working relationships with the MEO to support the creation of feedback mechanisms about learning and improvement activities
- Development of a Learning from Deaths application/database to support learning at an organisational and specialty level. It is anticipated that this will provide assurance on the quality of care being provided to patients that have died whilst in our care.
- Established a Multi-Disciplinary Learning from Deaths Panel to undertake peer-review SJR's for complex and complicated patient cases if, a Stage 1 SJR deems the overall Quality of Care to be 'Poor'.
- Undertaken a cluster review (2021 - 2023) for 17 patients that died following a definite Hospital Onset COVID-19 Infection (HOCI). The aim was to review the quality of care delivered in order to identify learning and inform improvement work.
- Undertaken a cluster review (2021-2023) for 10 patients who died following emergency laparotomies as part of the National Emergency Laparotomy Audit (NELA). The aim was to review quality of care delivered in order to determine if there was cause for concern in our mortality rate within the NELA audit. Learning and improvement opportunities were also identified during the review.
- Undertaken an extensive review of deaths that occurred in December 2022 in light of an increased number of adult inpatient mortalities. The review involved liaising with the Medical Examiner's Office at BTHFT to access Medical Certificates of Cause of Death (MCCDs) for patients who passed away in December 2022 and December 2021. This was to ascertain if there was any pattern in cause of death for patients in December 2022, with a comparison to the previous year. In addition, all SJR requests for December 2022 were expedited as a cluster review to determine if there was a cause for concern in the overall quality of care delivered to patients throughout December 2022. No cause for concern was found and all learning and potential improvements identified in the review has been escalated where appropriate.
- Following a meeting of the Anaesthesia Clinical Services Accreditation (ACSA) committee, the committee were impressed with the BTHFT Learning from Deaths Structured Judgement Review Process flowchart. In recognition of this the committee submitted a request to the Learning from Deaths Team here at BTHFT for the flowchart to be included in the Royal College of Anaesthetists (RCoA) Good Practice library with due credit given to BTHFT.

The impact of the above actions has demonstrated the Trust's commitment to learning in line with National Guidance on Learning from Deaths[12] and the NHS Patient Safety Strategy[13]. We anticipate that as our learning approach matures we will be able to provide assurance that we are providing the highest quality of care, as identified in the Trusts' mission statement.

There were 23 SJRs completed after 31st March 2022 which related to deaths which

12 *National Quality Board. (2017). National Guidance on Learning from Deaths—NHS England*

13 *NHS England and NHS Improvement (2019). The NHS patient safety strategy. Safer culture, safer systems, safer patients.*

took place before the start of the reporting period:

- 2 for deaths occurring in the first quarter of 2021/22
- 1 for deaths occurring in the second quarter of 2021/22
- 8 for deaths occurring in the third quarter of 2021/22
- 12 for deaths occurring in the fourth quarter of 2021/22

There were no deaths representing 0.0% of the patient deaths before the reporting period that were judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of:

- 0 deaths representing 0.0% for the first quarter of 2021/22
- 0 deaths representing 0.0% for the second quarter of 2021/22
- 0 deaths representing 0.0% for the third quarter of 2021/22
- 0 deaths representing 0.0% for the fourth quarter of 2021/22

2.2.12 STAFF WHO SPEAK UP (INCLUDING WHISTLEBLOWING)

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

- by emailing a secure email – speakup.guardian@bthft.nhs.uk;
- by scanning a QR code to download a referral form (which can be used anonymously); or
- by contacting the FTSU Ambassadors directly by telephone, email or in writing.

We have 16 FTSU Ambassadors who support the person raising the concern throughout any period of further investigation. At the initial meeting, the person who has raised a concern is informed that they will not suffer any detriment as a result of speaking up, and this is monitored throughout the support.

Following any investigation, the FTSU guardian will, if necessary shares the recommendations with the person who spoke up. Once the case is closed, the FTSU Ambassadors 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 11: *Number of concerns raised in 2022/23*

Quarter 2022/2023	Number of concerns raised
Q1	16
Q2	23
Q3	14
Q4	12
Total	65

2.2.13 GUARDIAN OF SAFE WORKING

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

undertaken or planned. There have been no fines levied during this year.

Trainees submit an exception report if they are working beyond contracted hours or if educational opportunities are missed. The annual report for 2022/23 shows that the number of exception reports has increased by 41% with an associated increase in additional hours claimed for payment or time off in lieu by a third.

There is also a high locum requirement in Emergency Medicine and General Medicine revealing these high pressure specialities with notable rota gaps. The number of locum requests this year had increased by 60% with around a quarter remaining unfilled.

One speciality within the Trust continues to have a non-compliant rota, this is due to the weekend working pattern; discussion with the trainees in-post show they are happy with the current work patterns. We continue to review this with every new trainee that rotates into the speciality and seek approval from the Junior Doctor Forum.

The Guardian of Safe Working Hours and the Director of Education continue to work closely with the junior doctors' forum to review concerns, support development and improvements, and provide regular feedback to operational colleagues and assurance to the Board. Improvements, new ideas and lessons learnt are also shared across the Trust particularly new workforce initiatives or opportunities to fill rota gaps. Some changes this year include a new rota for Junior trainees in ED which includes study / self-development time, a new rota for Foundation doctors in General Surgery and a pilot 'Hospital at night' to support and reduce workload for junior doctors in surgery. The chief registrar is currently working with medical teams to improve the medical rota which will hopefully start this coming financial year.

2.3 REPORTING AGAINST CORE INDICATORS

2.3.1 SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR (SHMI)

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

The current available Healthcare Evaluation Data (HED) covers a 12-month period from February 2021 to December 2022 with our current SHMI value being 113.89 which is within the expected range (See figures 12 and 13). The Trusts SHMI demonstrates that the Trust has remained within expected limits during the reporting period. Our current SHMI of 113.89 is marked and shows us as within expected range.

Figure 12: *SHMI score (12 month rolling: Feb 2021- Dec 2022): 113.89 – within expected range*

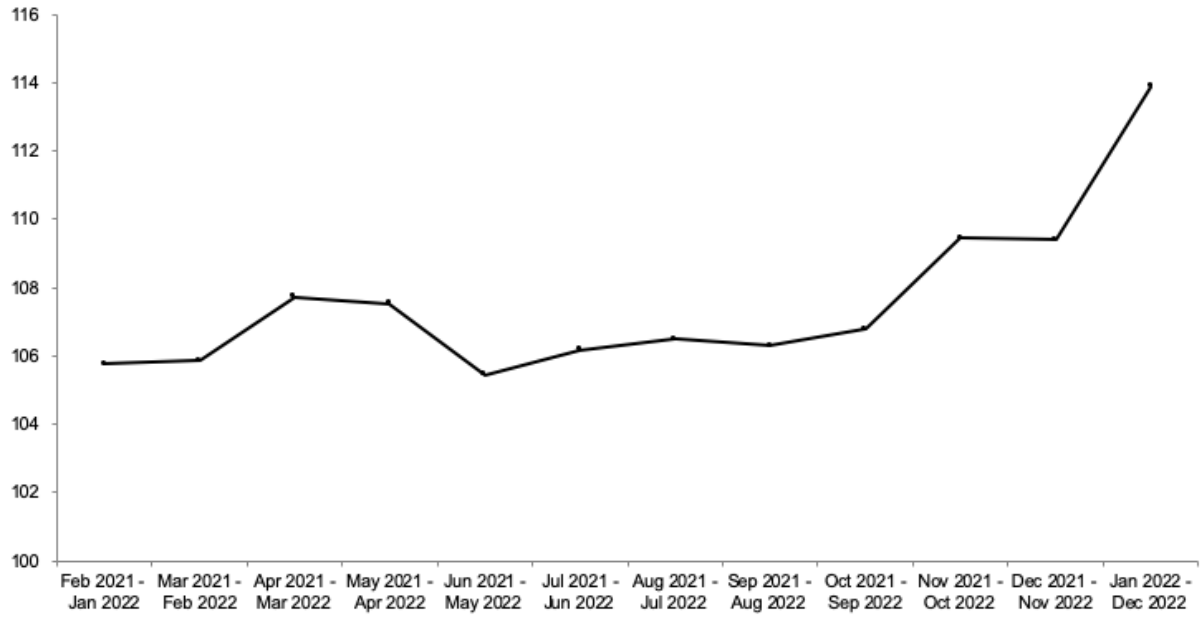
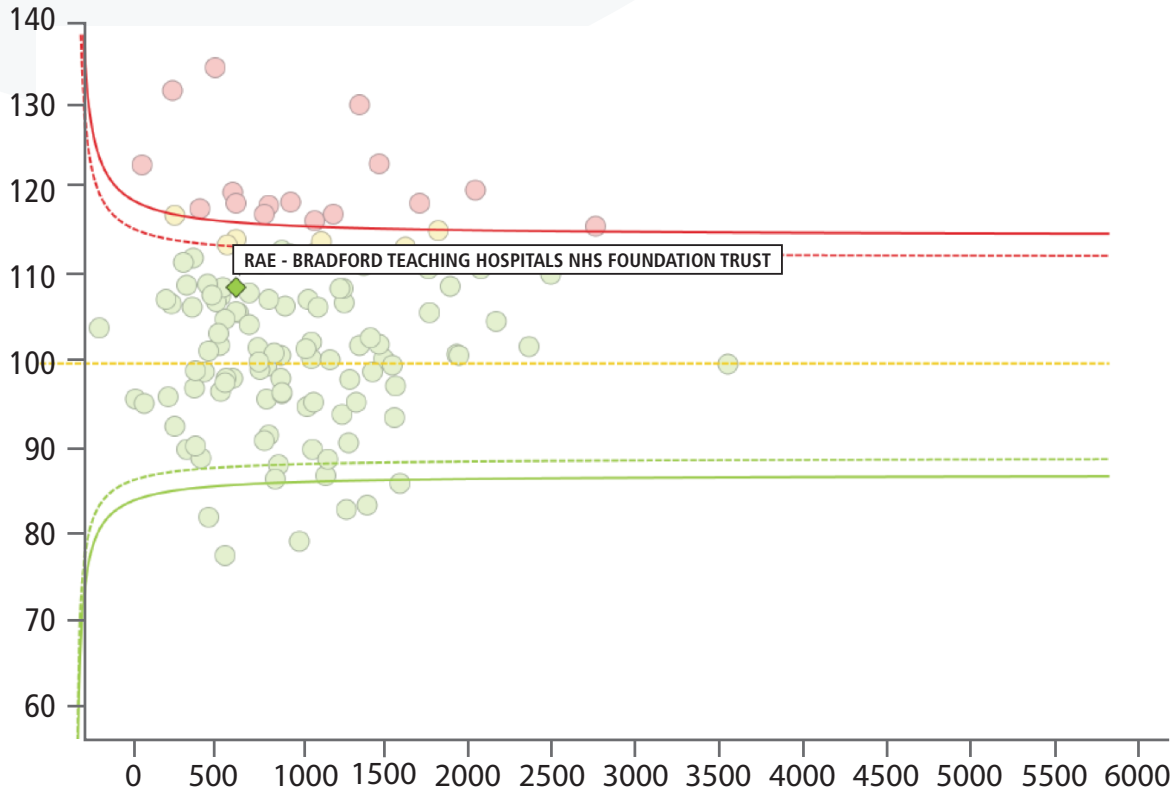


Figure 13: *SHMI indicator values, discharges, observed deaths and expected deaths numbers*

SHMI 12-month rolling	Indicator Value	Number of Discharges	Number of Observed Deaths	Number of Expected Deaths
Feb 2021 - Jan 2022	105.77	71,746	1,569	1,483.39
Mar 2021 - Feb 2022	105.85	72,520	1,568	1,481.28
Apr 2021 - Mar 2022	107.72	72,744	1,582	1,468.69
May 2021 - Apr 2022	107.54	72,520	1,555	1,445.92
Jun 2021 - May 2022	105.44	72,296	1,516	1,437.75
Jul 2021 - Jun 2022	106.17	72,092	1,526	1,437.28
Aug 2021 - Jul 2022	106.49	71,652	1,513	1,420.85
Sep 2021 - Aug 2022	106.29	71,646	1,507	1,417.86
Oct 2021 - Sep 2022	106.78	71,754	1,503	1,407.60
Nov 2021 - Oct 2022	109.44	71,960	1,525	1,393.51
Dec 2021 - Nov 2022	109.41	72,420	1,510	1,380.12
Jan 2022 - Dec 2022	113.89	72,973	1,554	1,364.51

Figure 14: *SHMI Funnel Plot*



The funnel plot at figure 14 shows our Trust's SHMI performance in relation to all other acute hospital trusts.[14]

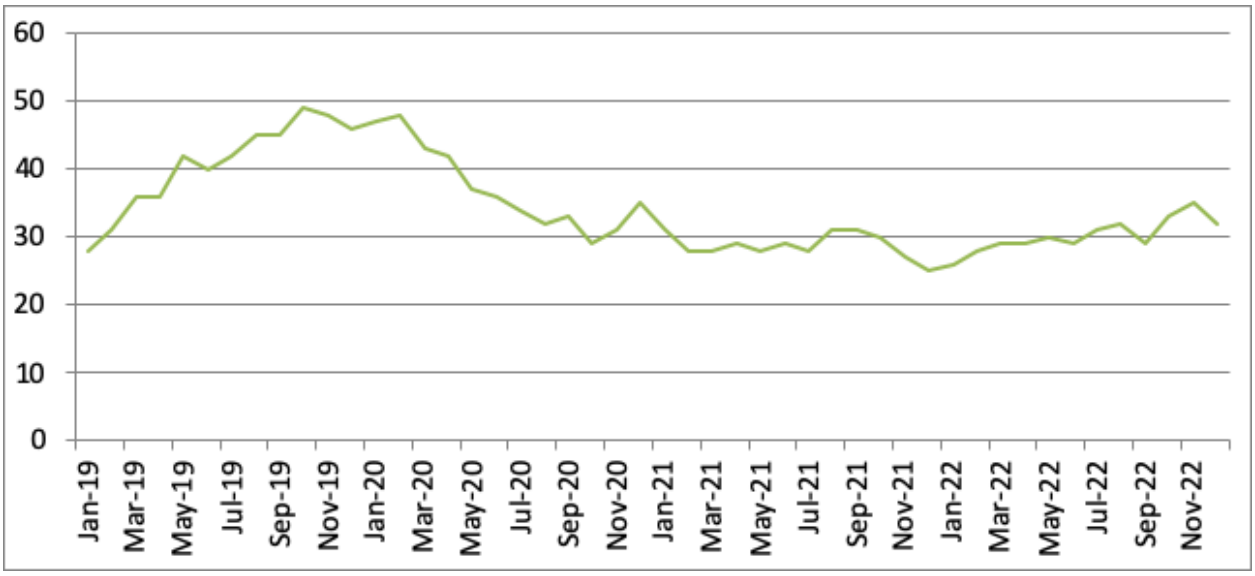
14 A value within expected range is marked in green; a value between 90% upper limit and 95% upper limits is marked in Amber; a value above the 95% upper limit is marked in red.

Stillbirths

The Trust was a regional and national outlier for stillbirths. The service reported an annual reduction in stillbirths during 2020, with a further reduction in 2021 which was sustained during 2022. This is demonstrated in the table 15.

Stillbirth reduction remains a key priority and the maternity service is committed to implementing the next version of the Saving Babies' Lives care bundle, and continuing the local focus and initiatives on reducing inequalities.

Figure 15: *Stillbirths 2022 – Rolling Total 2019 onwards*



Figures 16 and 17 demonstrate the crude and adjusted stillbirth rates over the last 3 years, reflecting the increase in families who choose to continue a pregnancy where there is a known lethal abnormality.

Figure 16

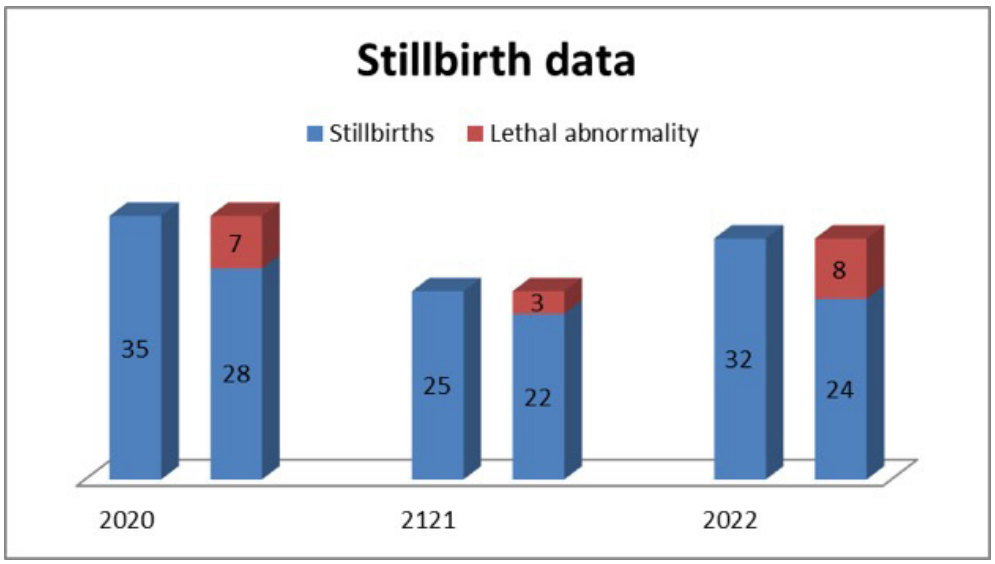


Figure 17

	Births	Crude total stillbirths per 1000 births	adjusted rate excluding lethal abnormalities per 1000 births
2020	5145	6.7/1000	5.6/1000
2021	5179	4.8/1000	4.2/1000
2022	5001	6.4/1000	4.8/1000

2.3.2 PATIENT REPORTED OUTCOME MEASURES (PROMS)

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

- hip replacements
- knee replacements

Our Trust is not able to provide any benchmarking data for PROMs. As a consequence of the Covid Pandemic insufficient data (from all Trusts) has been submitted to NHS Digital to enable any meaningful judgments to be formed.

2.3.3 28-DAY READMISSIONS

The percentage of patients aged 0 to 14 years old and 15 years old or over readmitted to hospital within 28 days of being discharged is presented in figures 18 and 19 below.

For patients aged 15 years old or over readmitted to hospital within 28 days this continues to fall.

Pre-pandemic our trust average for re-admission rate was 12% and it is currently consistently below 10%.

This is in line with regional average re-admission rates.

Figure 18: *28 day readmission rates for patient's aged 0-14 year olds*

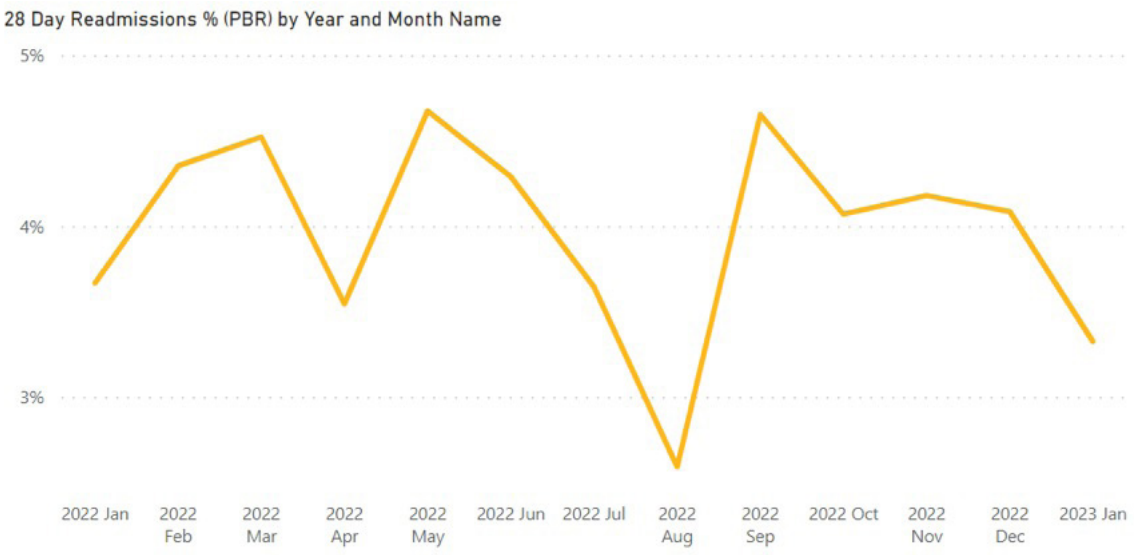
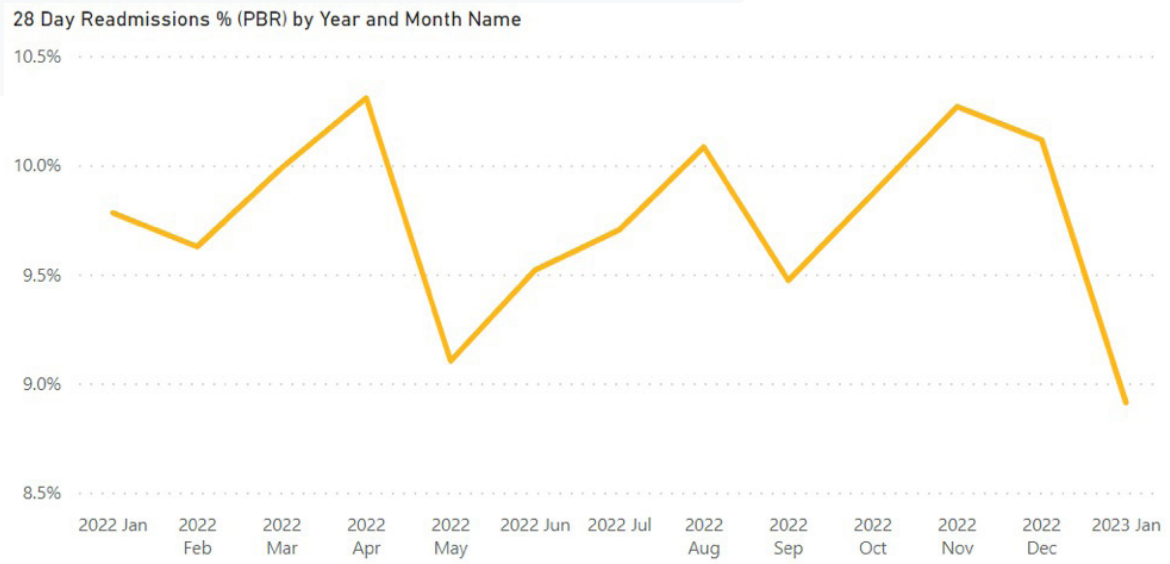


Figure 19: *28 day readmission rates for patient's aged 15 year olds and over*



2.3.4 RESPONSIVENESS TO PATIENT NEED

The overall Trust position score from FFT at time of reporting is a decreased score of 78.9% of patients scoring the Trust as 'very good' or 'good' in comparison to the previous year of 84.0%. This is reflective of datix reports[15] and complaints received due to a number of variables including staffing and acuity of patients which can lead to increased dissatisfaction.

Figure 20: *Friends and Family Test Responses 2022/23 by Area*

	Very Good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Grand Total
A&E Feedback	4,670	2,374	900	832	1,864	102	10,679
Inpatient Feedback	1,924	341	27	6	14	3	2,315
Outpatient Feedback	5,337	742	162	90	143	16	6,490
Maternity Feedback	134	10	3	10	19	2	178
Totals	**12,065**	**3,467**	**1,092**	**938**	**2,040**	**123**	**19,662**

15 Datix is a risk management Information System designed to collect and manage data on adverse events

SMS text messaging made up the majority of the responses included in the table below.

Figure 21: *Friends and Family Test Responses 2022/23*

Rating	No.	Percentage
Very good	12,065	61.17%
Good	3,467	17.58%
Neither good nor poor	1,092	5.54%
Don't know	123	0.62%
Poor	938	4.76%
Very poor	2,040	10.34%

CQC surveys

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

A report on the actions undertaken in response to the feedback is included in section 2.1 under patient experience which is one of the Trust's improvement priorities for 2022/23.

2.3.5 PEOPLE PULSE AND NHS STAFF SURVEY

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

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

The survey consists of the nine questions which make up the existing Engagement theme of the NHS Staff Survey, measuring motivation, advocacy, and involvement. It runs in quarter one, two and four. There is not a requirement to participate in the survey in quarter three to account for the annual staff survey fieldwork which already captures answers to the nine engagement theme questions. The results of the People Pulse survey are used to inform local actions to improve the experiences of our people and patients.

In 2022/23 our NHS Staff Survey received a response rate of 37%. We improved in all of the 9 People Promise elements of the survey compared to our 2021/22 results and scored above the national average for all elements except 'We are Safe and Healthy' which is in line with the national average.

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

- Ensuring staff feel confident and safe to speak out if there is something that needs to change (raising concerns);
- Continue with our focus on civility and behaviours at a local department level;
- Embedding a Restorative Just Culture approach;
- Supporting our people with access to the right learning and development opportunities when they need them and invest in our people to build confidence and capability;
- Supporting our managers to have effective conversations – such as Stay Interviews, Wellbeing Conversations and Talent Management conversations;
- Improving staff engagement levels and morale – a focus on supporting each other, ensuring the organisation is a good, supportive and compassionate place to work;
- Focus on our people feeling that they are valued and recognised for what they do.

2.3.6 VENOUS THROMBOEMBOLISM EVENT RISK ASSESSMENT (12 MONTH ROLLING)

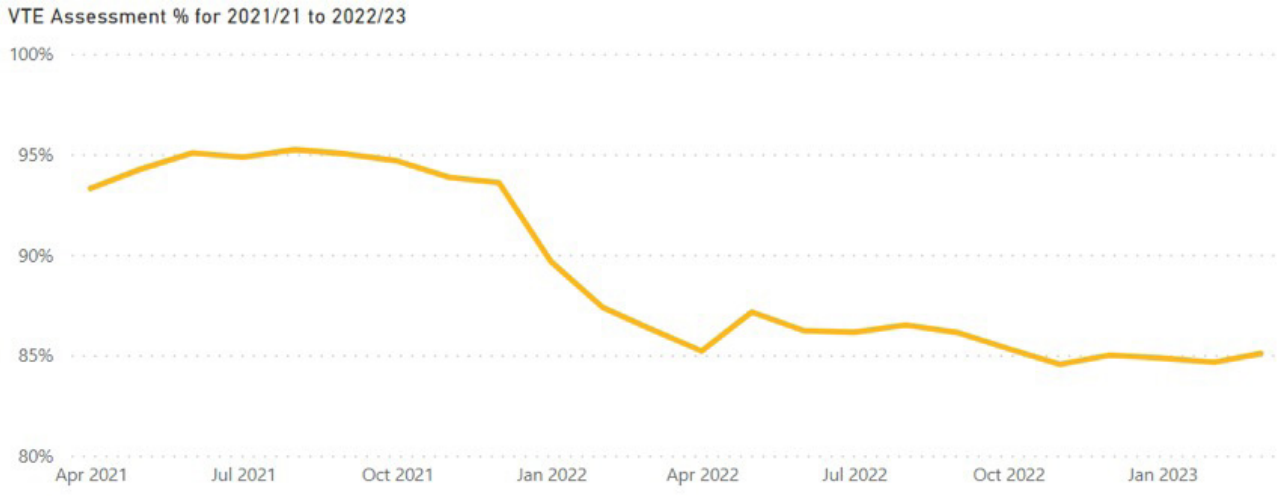
As part of the Trust's NHS standard contract reporting and information requirements we are required to audit patients at risk of venous thromboembolism. We collate the numbers of in-patient hospital admissions, aged 16 and over, who are risk assessed for a venous thromboembolism event (VTE) based on NICE (NG158)[16] national guidance.

This indicator displays the percentage of spells where the patient has been risk-assessed for a venous thromboembolism event (VTE). A higher percentage would mean that the trust has a higher compliance rate with the NICE guidelines, which state that all patients who are admitted to hospital should be risk-assessed for VTE. The data in figure 22 demonstrates that during 2022/23 on average over 85 % of patients were risk assessed for VTEs.

Figure 22: *Percentage of adult in-patients that were assessed for VTE's in 2022/23*

It is recognised that the data when compared to the previous year indicates a reduction in the percentage of VTE risk assessments being recorded as complete (see figure 23).

Figure 23: *Percentage of adult in-patients that were assessed for VTE's in 2021/23.*



16 https://www.nice.org.uk/guidance/ng158

This is partly owing to the Trust's continued response to the COVID-19 pandemic with increased clinical activity related to winter pressures and delivering the backlog recovery plan. We will continue to improve VTE risk assessment rates as part of the quality and safety agenda at service level. We will achieve this by delivering training to our Junior Doctors and non-medical prescribers, using real time data collection to monitor rates and working with our clinical nurse specialist to support learning and improvement activities. We are also working with our Business Intelligence colleagues to ensure we have a robust method to ensure we gather data from all eligible areas and for inpatient areas exempt from the standard are recoded appropriately within the system. This will be monitored monthly basis by the Quality and Patient Safety Academy.

2.3.7 C DIFFICILE

Clostridioles difficile is a type of bacteria which causes diarrhoea and abdominal pain and can be more serious in some patients.

The objectives for reduction for CDI for 2022/23 were set as 43 cases. The Trust reported 46 hospital attributable cases during 2022/23. We consider that this data is accurate because it is captured, processed and analysed through the Trust-wide Laboratory Management Systems (LMS), industry-standard data warehousing and analytical and business intelligence tools. Data is processed by dedicated reporting teams according to standard operating procedures, is validated by clinical staff and Infection Prevention and Control (IPC) Team and is signed off by the Chief Nurse (Executive IPC Lead for the Trust).

To improve this performance, and so the quality of services, we are continually monitoring quality of care through our quality oversight system. In addition, any case of confirmed infection is subject to a comprehensive Post Infection review (PIR) process to identify any lessons to learn. Each room occupied by a patient with C. difficile receives a full decontamination utilising hydrogen peroxide vapour.

Antibiotic usage is the most common risk factor associated with Clostridioides difficile infection;

The role of antibiotic stewardship is a primary preventative strategy in the prevention of Clostridioides difficile infection and will be a focus during 2023/24 to reduce the usage of the high risk antibiotics.

Figure 24: *Healthcare Evaluation Data (HED) for C. difficile*

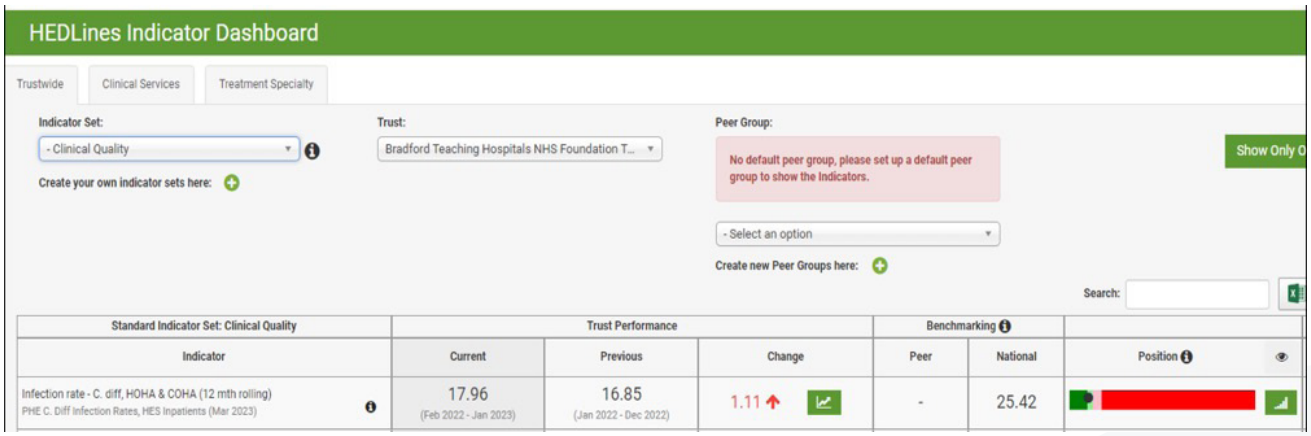
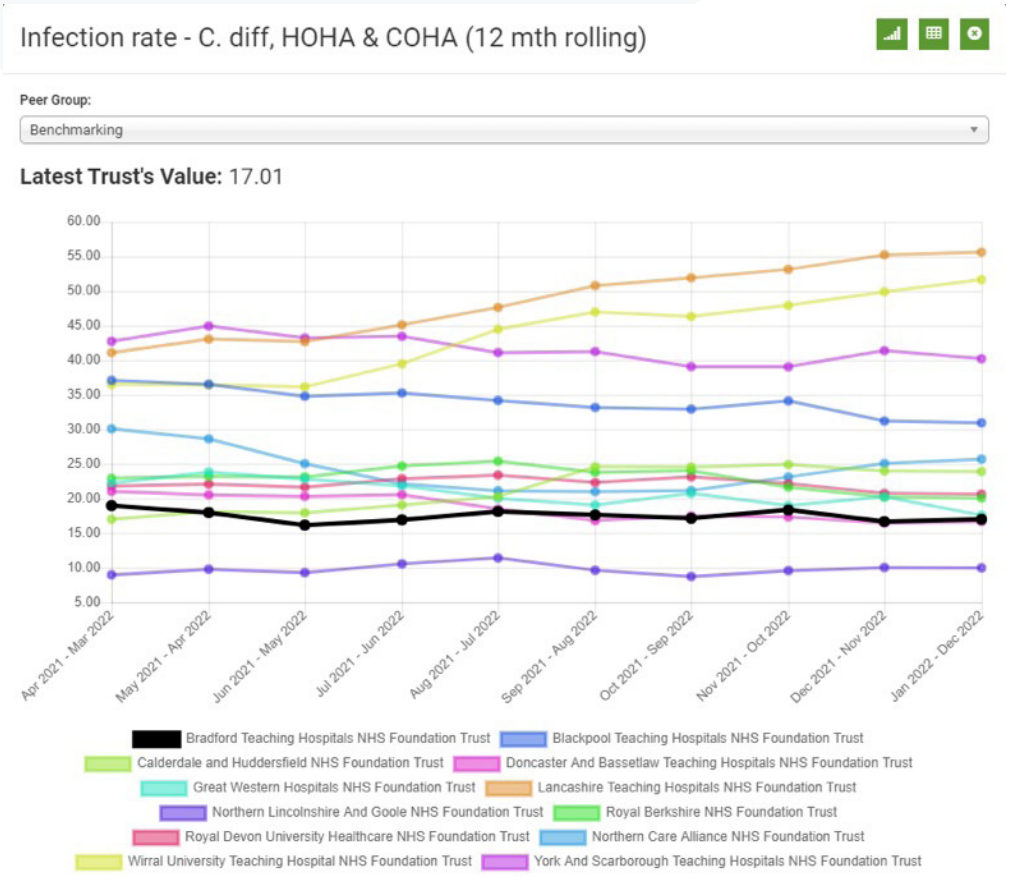


Figure 25: *Healthcare Evaluation Data (HED) for C. difficile: Benchmarking data for both Yorkshire Region and National Acute NHS Trusts (the black line represents our Trust)*



2.3.8 PATIENT SAFETY INCIDENTS WITH SEVERE HARM OR DEATH

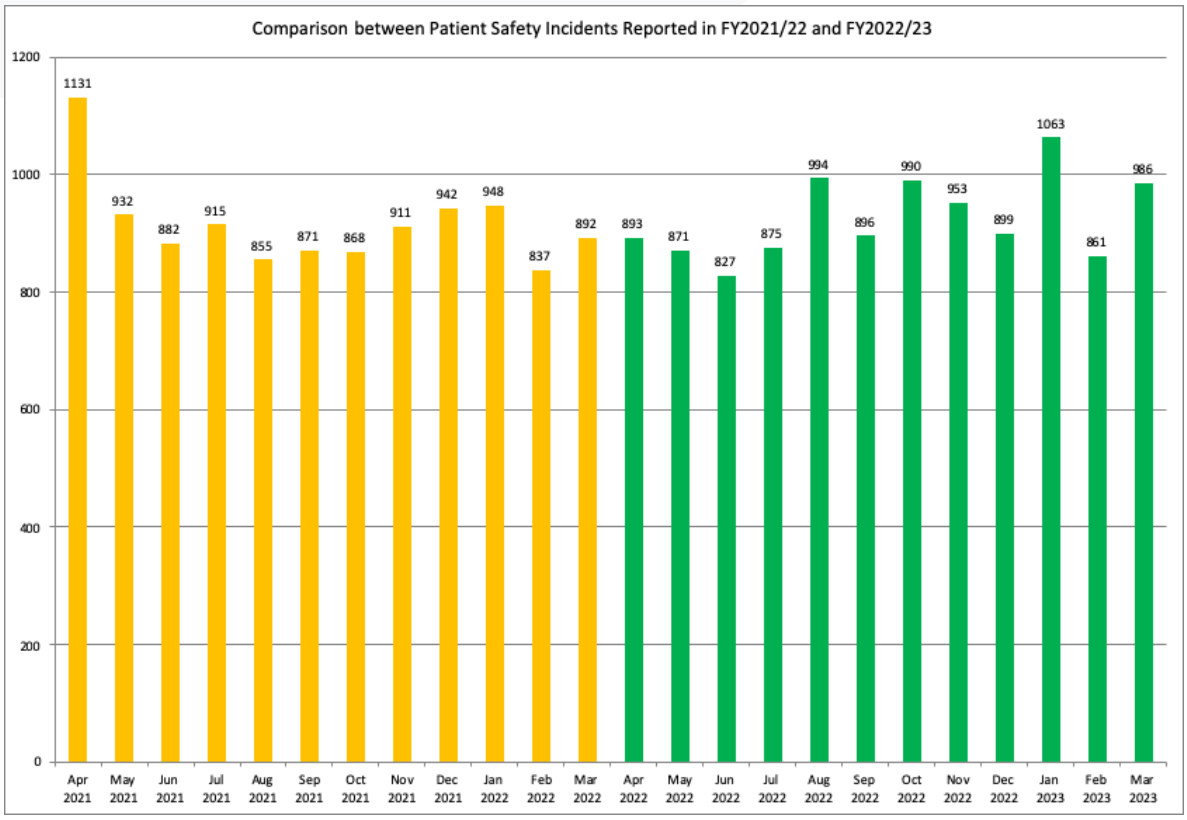
The Trust uses an electronic reporting system (Datix) to monitor and manage patient safety incidents and concerns. The Trust is currently reviewing and adapting the reporting system to ensure it meets the new requirements of the Patient Safety Incident Response Framework (PSIRF) due to come into effect in autumn 2023. This includes reporting to the 'learn from patient safety incidents' (LFPSE) service as required by NHS England and NHS Improvement.

The Trust has a robust governance and quality oversight system in place to identify learning and improvement in order to provide assurance about the quality of care we deliver.

The Quality Team produces a quarterly 'Complaint, Litigation, Incidents and Patient Advice and Liaison Service (CLIP) report for quarters one to three and an annual report at the end of quarter four. This supports the triangulation of data from safety incidents, learning and improvement from across the Trust. The Trust also engages in a West Yorkshire learning forum to ensure this learning is shared more widely.

There were a total of 11,109 patient safety incidents reported within the Trust during 2022/23. This represents an increase of 114 (1.03%) when compared with the previous reporting period (see figure 26). There were 37 (0.34%) patient safety incidents that resulted in severe harm or death during 2022/23.

Figure 26: *Comparison between Patient Safety Incidents Reported in FY2021/22 and FY2022/23*



A five year view of the number of patient safety incidents resulting in severe harm (see figure 27) or death (see figure 28) has been provided in the charts below.

Figure 27: *Number of Patient Safety Incidents resulting in Severe Harm (2018/23)*

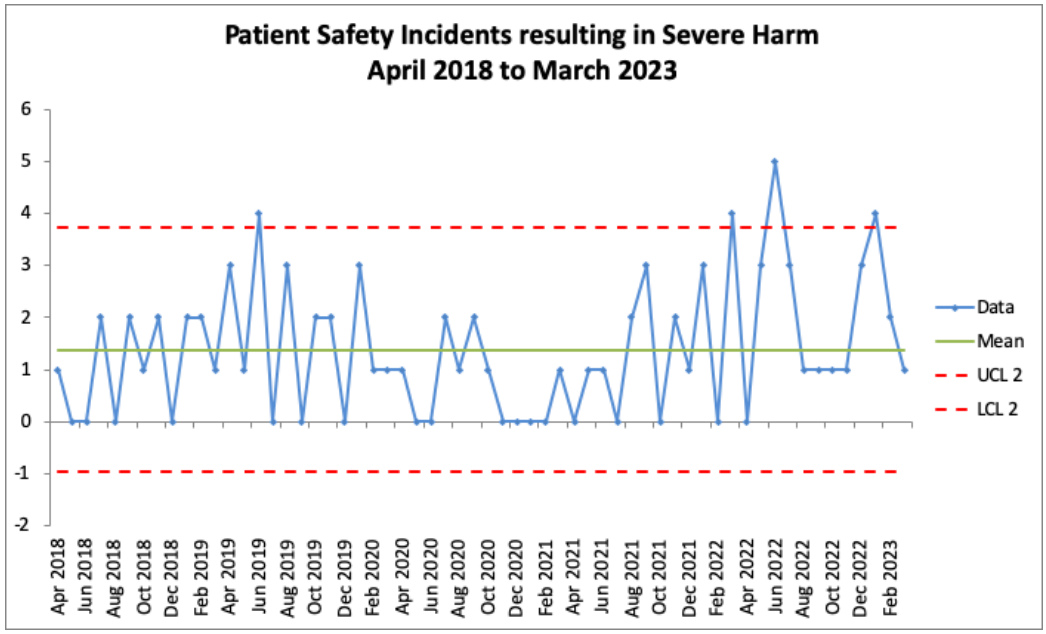
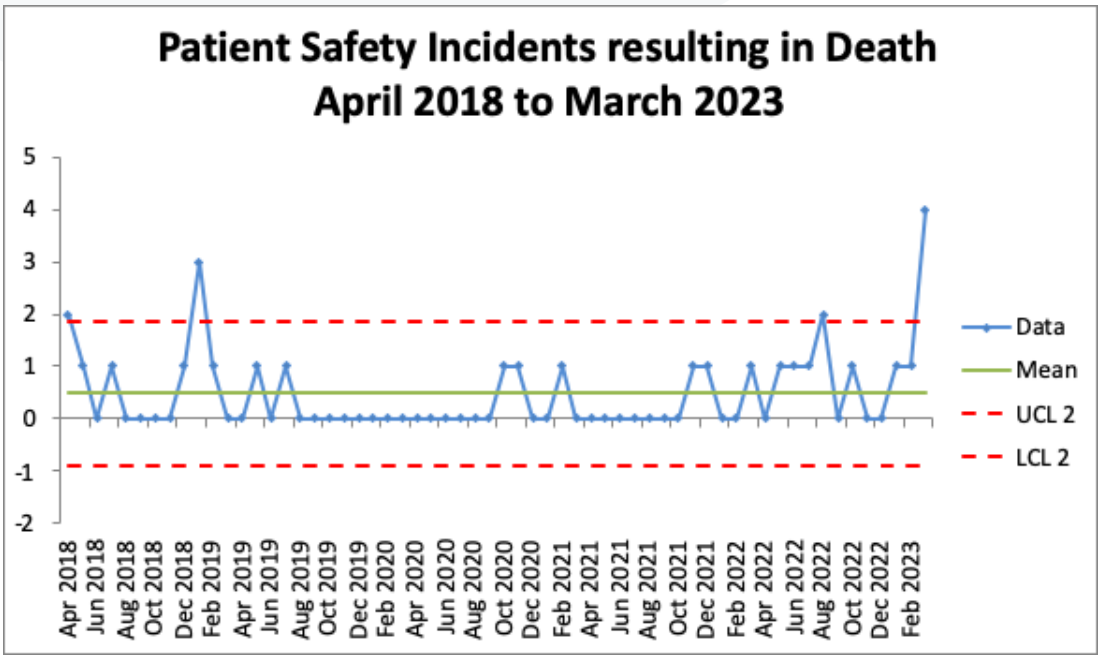


Figure 28: *Number of Patient Safety Incidents resulting in Death (2018/23)*



Patient Safety Incidents resulting in Severe Harm and Death

There were 25 patient safety incidents resulting in severe harm (see figure 29). This included 11 patient safety incidents related to falls (this includes patient fall, slip or trip from the same level and fall from height). Our Trust has a falls prevention improvement programme in place which is described in more detail in section 3.1.3. The remaining 14 incidents resulting in severe harm were owing to, delay in diagnosis, inappropriate admission, alleged sexual assault (patient on patient), care and treatment, medication management, delivery/labour, dialysis, patient procedures and patient transportation.

The total number of reported patient safety incidents resulting in death was twelve. Five were declared as serious incidents (SI). Four SI investigations have been completed and closed on StEIS. There is one ongoing SI investigation and two internal investigations at the time of report writing (April 2023).

See figure 29 for more information.

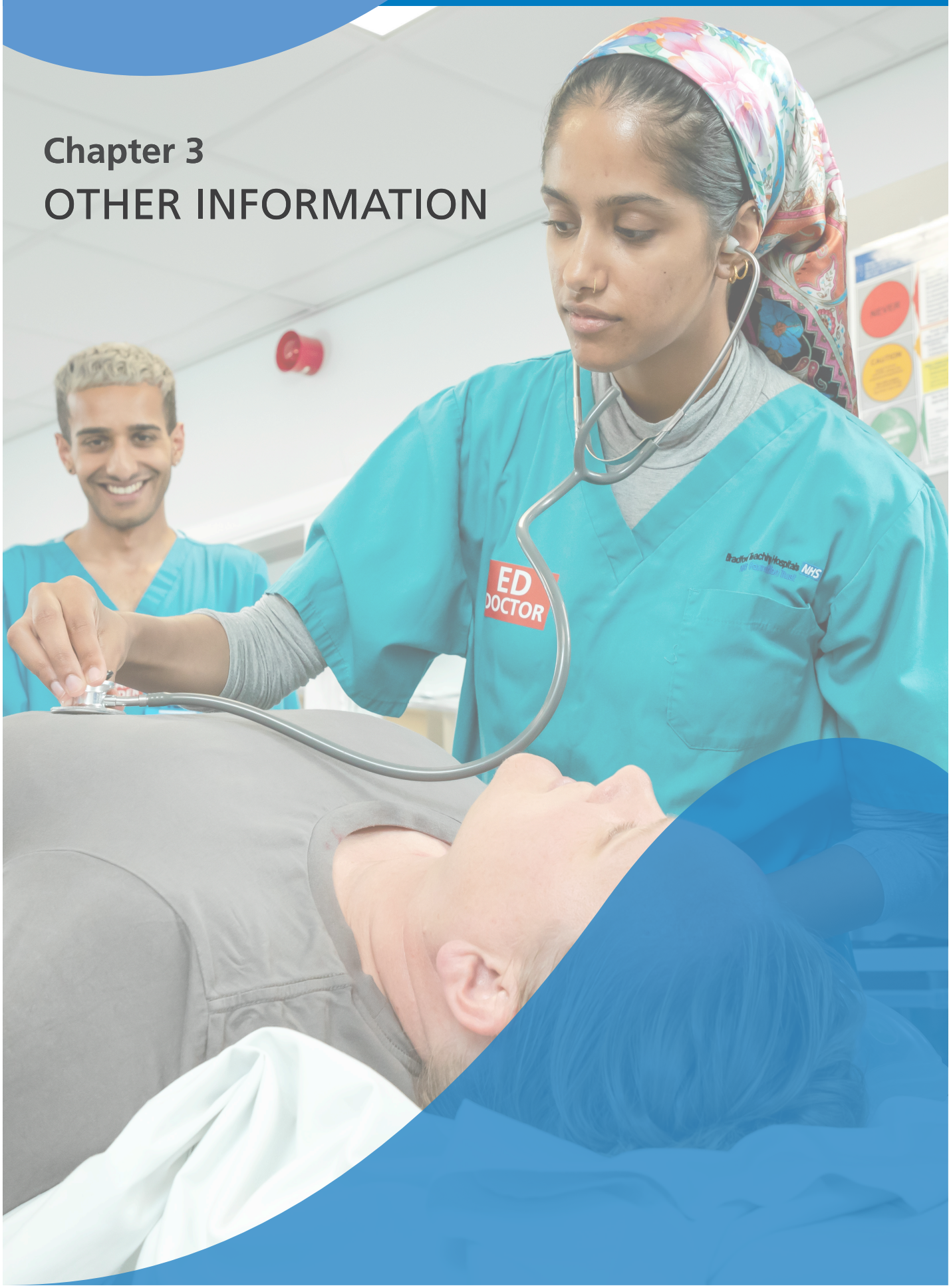
Figure 29: Number of Patient Safety Incidents by Category and Harm during 2022/23

Severe n=number of patients	Death n=number of patients	Category
n=3	*-*	*Delay in diagnosis*
n=11 *Sustained a fracture n=9/11* *Sustained a head injury n=1/11* *Sustained a fracture and head injury n=1/11*	*n=1* *Sustained a head injury n=1/1*	*Falls (patient fall, slip or trip from the same level and fall from height)*
n=1	*-*	*Inappropriate admission*
n=1 system safeguarding investigation	*-*	*Alleged sexual assault (patient on patient)*
n=3	*n=3*	*Care and treatment*
n=1	*-*	*Medication management*
n=2	*-*	*Delivery/Labour*
n=1	*-*	*Dialysis*
n=1	*n=1*	*Patient Procedures*
n=1 delay in ambulance arrival being reviewed by YAS	*-*	*Patient transportation*
-	*n=1*	*Antenatal*
-	*n=1*	*Discharge*
-	*n=1*	*Service Provision*
-	*n=4*	*Unexpected death*

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

Chapter 3

OTHER INFORMATION

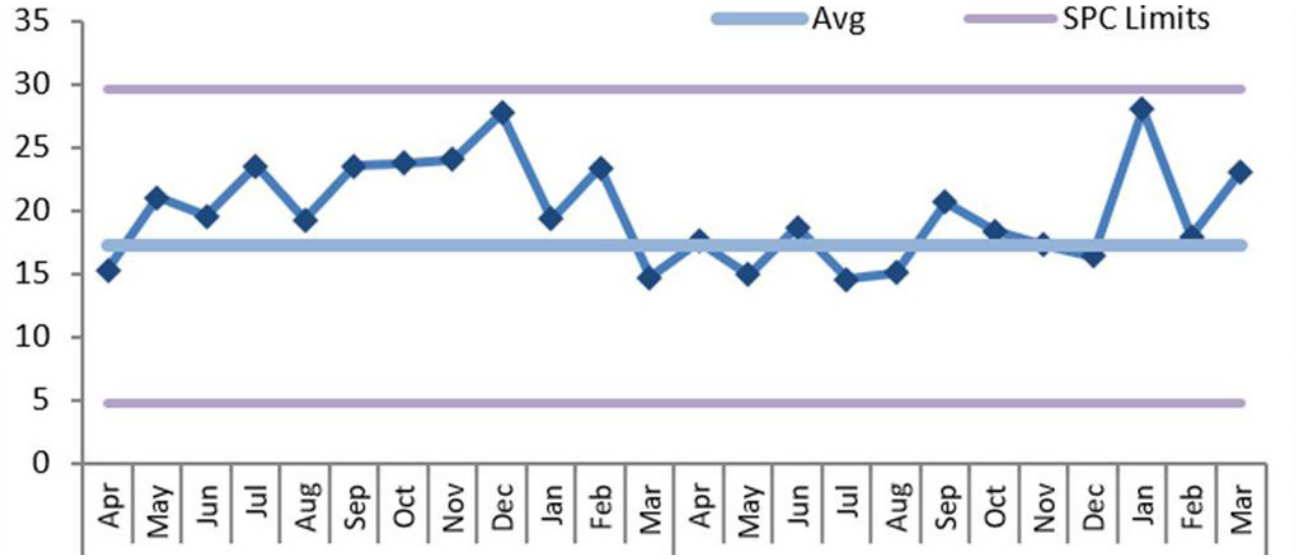


3.1 INDICATORS FOR PATIENT SAFETY

3.1.1 PRESSURE ULCERS

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

Figure 30: *Pressure ulcer incidence (category 3 and above) during 2022/23*



The Trust follows 2018 NHS England guidance on the definition and measurement of pressure ulcers. Revised guidance is expected to be published by NHS England later this year.

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

The pandemic has had a negative impact on pressure ulcer incidents. This was in part due to the increased use of medical devices such as tightly fitting face masks used to treat patients with COVID-19 and the severity of the patients' conditions. Incidents have remained above pre-pandemic levels, in part due to increased patient frailty. We continue to focus on improving pressure ulcer prevention through quality improvement methodology, training and education and implementation of evidence based patient care. We will be reviewing the way we investigate hospital acquired pressure ulcers in line with PSIRF. We will also be replacing the Waterlow risk assessment tool with a new evidence-based pressure ulcer risk assessment tool (PURPOSE T) later this year as well as new pressure ulcer pathways. New e-learning modules on

pressure ulcer prevention that were developed by the National Wound Care Strategy programme were introduced at the Trust in March 2023.

3.1.2 SEPSIS SCREENING AND TIME TO TREATMENT

The Trust routinely monitors patient screening and antibiotic treatment times for patients with suspected sepsis. Our approach to support the recognition, diagnosis and early management of sepsis is informed by the NICE guideline [NG51][17] and requirements as set out in the NHS Standard Contract 2022/23.

NICE (2017) guidance states that patients of any age with a suspected infection should be assessed to identify:

- Possible source of infection
- Risk factors for sepsis
- Indicators of clinical concern

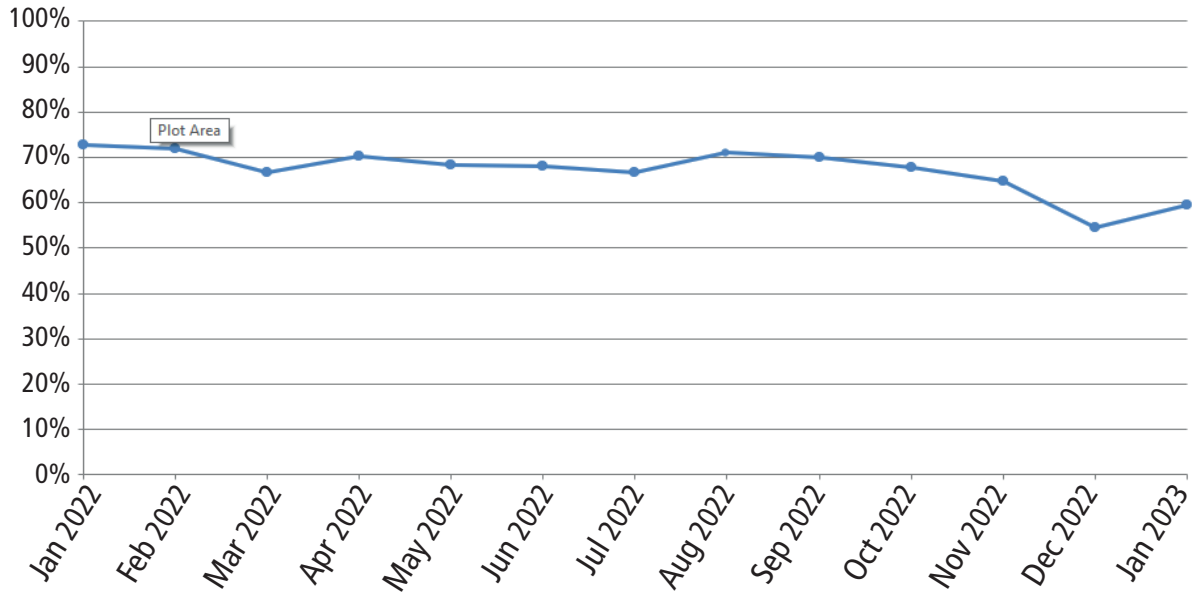
For any patient that have been screened using a structured assessment tool where all the factors above have been confirmed intravenous antibiotic treatment should be given within one hour of diagnosis. There is no target set within the NICE guidelines to achieve either screening or administration time of antibiotics.

The NHS Standard Contract recommends all patients, excluding pregnant women and children under the age of 16, who undergo a sepsis screen and screen positive should receive intravenous antibiotic treatment within one hour. The target has been set at 90% for all eligible in-patients.

Performance against screening for sepsis

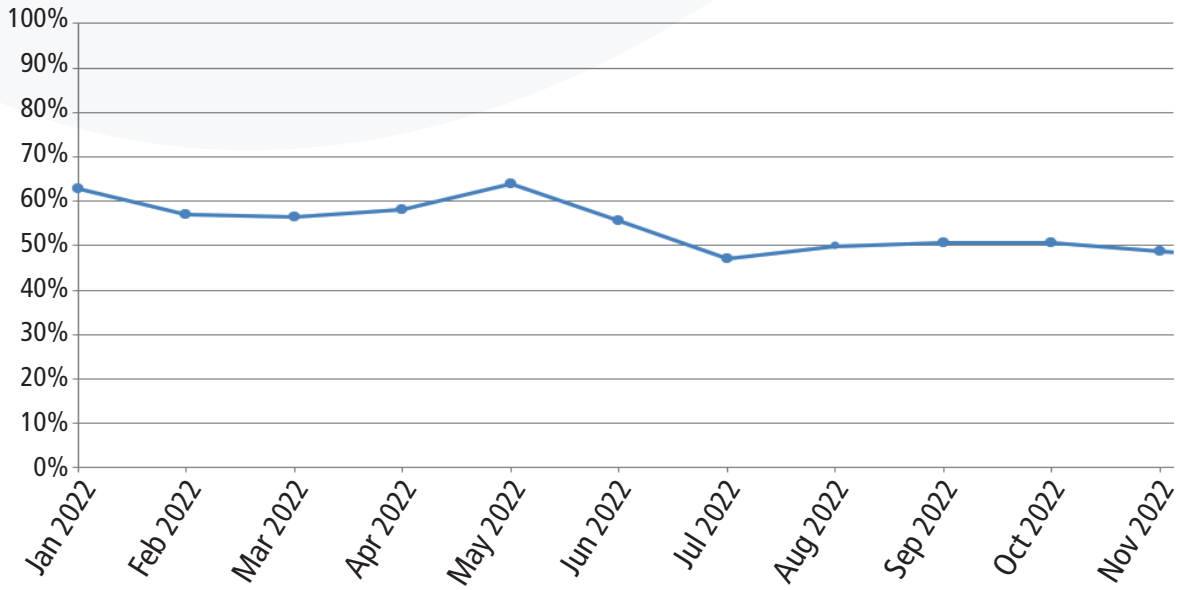
Overall sepsis screening has been sustained at an average of 70% for eligible patients in the Emergency Department (AED) and an average of 50% for patients in adult in-patient wards (see figures 31 and 32).

Figure 31: *Percentage of patients that were screened for sepsis in AED*



17 Sepsis: recognition, diagnosis and early management. NICE guideline [NG51]Published: 13 July 2016 Last updated: 13 September 2017 www.nice.org.uk/guidance/ng51

Figure 32: *Percentage of patients that were screened for sepsis on in-patient wards*



Sepsis screening in ED has seen a small reduction towards the end of 2022 owing to operational pressures on Urgent and Emergency Care pathways. The same pattern can be seen on in-patient ward areas highlighting the additional winter pressures seen throughout the trust.

The Trust experienced an increased level of patient activity owing to high numbers of patients presenting with Flu symptoms and COVID-19 infections in November and December 2022.

Performance against administering intravenous antibiotics within 1 hour

The time to treatment for patients with suspected severe sepsis (and therefore requiring antibiotics within a maximum of 1 hour) within AED and for in-patient areas across the Trust has been achieved for over 85% of patients (see figures 33 and 34). We have sustained the consistency in administration of antibiotics from year 2021/22 to date. We continue to focus on improvement efforts to achieve 90% target set out in the NHS standard contract.

A sepsis screensaver and flashcard used to promote awareness of sepsis symptoms

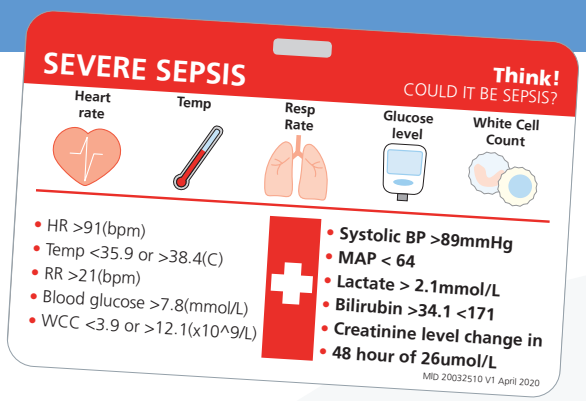


Figure 33: *Percentage of patients that received intravenous antibiotics in the AED that were diagnosed with severe sepsis*

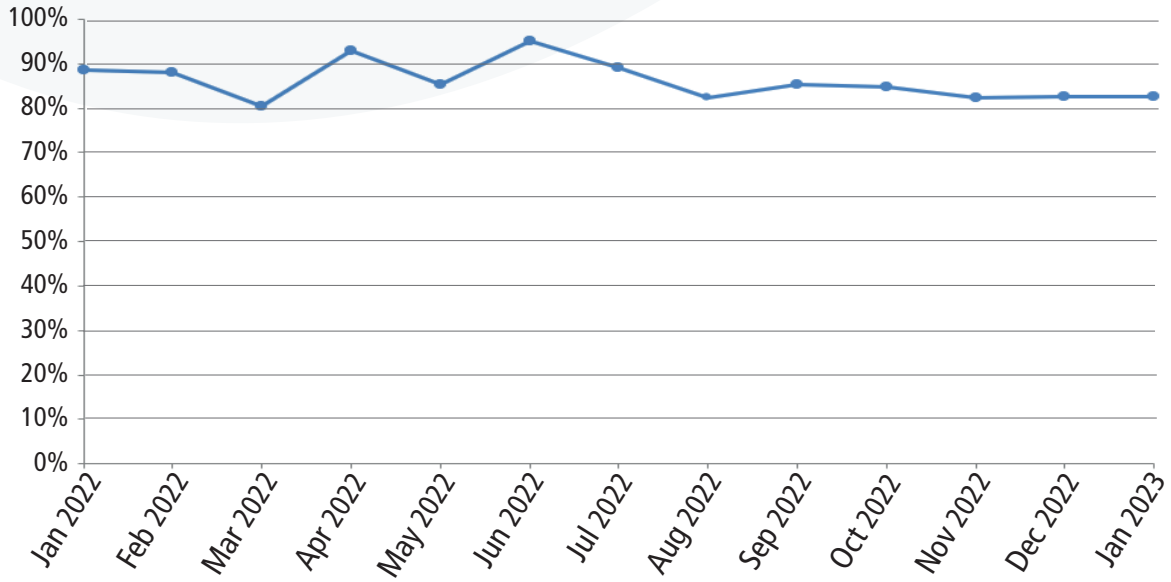
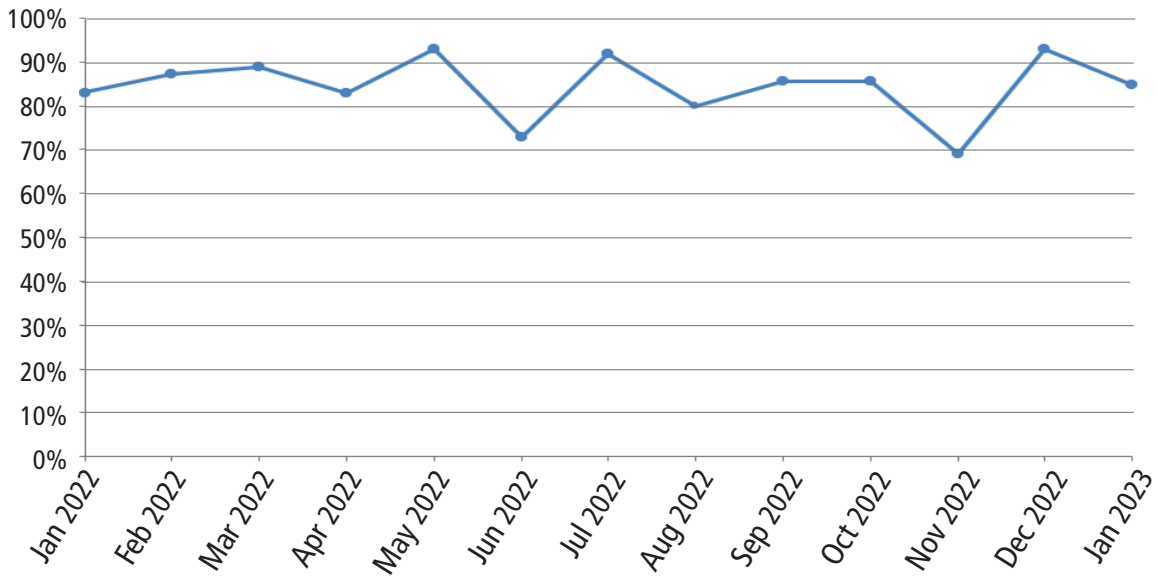


Figure 34: *Percentage of patients that received intravenous antibiotics on in-patient wards that were diagnosed with severe sepsisChanges to NICE guidelines*



The NICE guideline [NG51] is currently under review and is due to be published in July 2023. The update will focus on the risk stratification of adults to identify patients who are at risk of severe illness or death from sepsis and appropriate timing of antibiotic delivery for different risk categories.

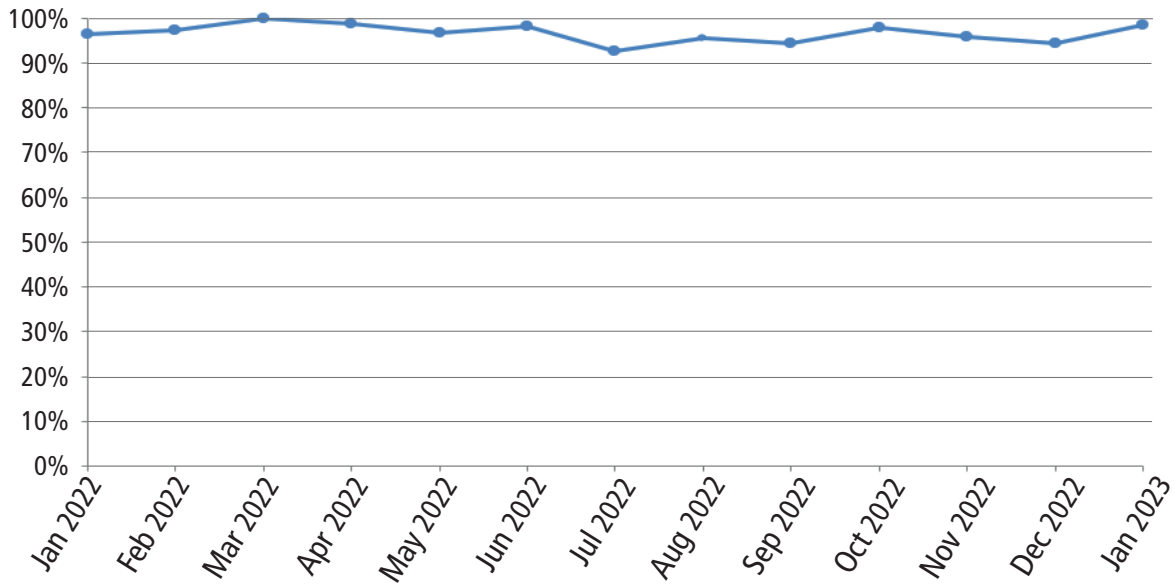
This review has been prompted following a report published by the Academy of Medical Royal Colleges 'Statement on the initial antimicrobial treatment of sepsis' (2022).[18] This report suggests reducing the time to antibiotics for patients with uncomplicated sepsis to three hours, which differs from the current NICE guidance of all risk stratified patients receiving antibiotics within one hour.

As a Trust, we will be updating our adult electronic sepsis pathway in collaboration with Calderdale and Huddersfield Foundation Trust (CHFT) to reflect the recommendations following the publication of the NICE guidelines later this year. However, we have already adapted our data to reflect the changes in time to antibiotic administration and report on both antibiotics given within one and three hours for our patients.

The time to treatment for patients with suspected uncomplicated sepsis (antibiotics to be administered within a maximum of 3 hours) within AED and for in-patient areas across the Trust has been consistently achieved at an average of over 90% (see figures 35 and 36).

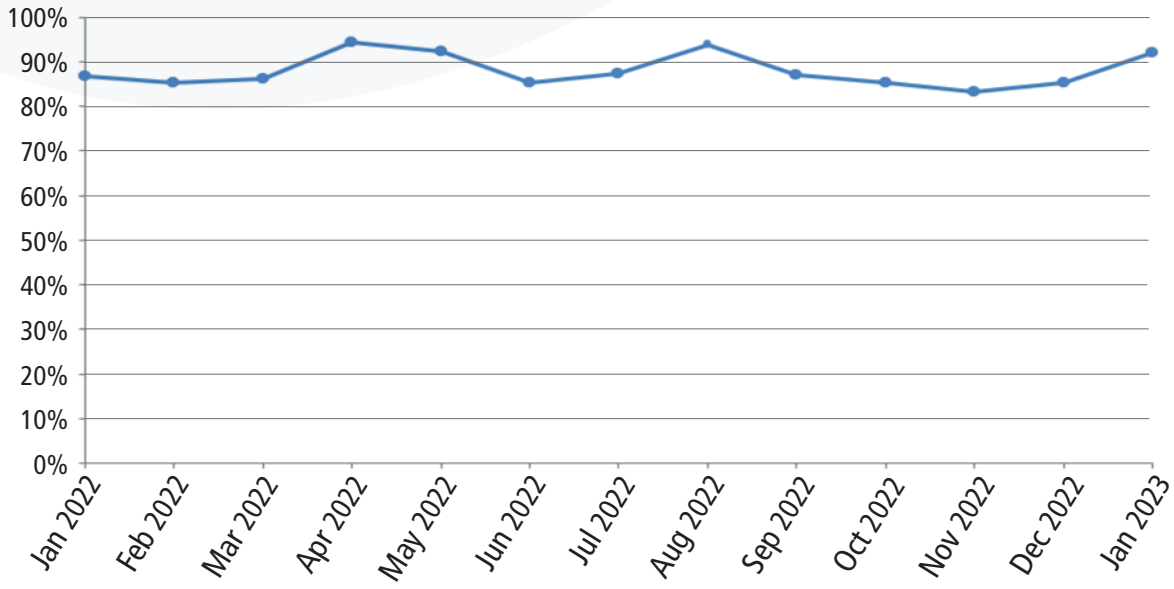
The screening time to antibiotic compliance rate is good and demonstrates that patients are being treated in a timely manner despite the screening assessment tool in EPR not being completed as required.

Figure 35: *Percentage of patients that received intravenous antibiotics in the AED that were diagnosed with uncomplicated sepsis*



18 The Academy of Medical Royal Colleges (AoMRC) Sepsis Statement update 20 Oct 2022. www.rcseng.ac.uk/news-and-events/news/archive/aormc-sepsis-statement-update/

***Figure 36:** . Percentage of patients that received intravenous antibiotics on in-patient wards that were diagnosed with uncomplicated sepsis*



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

We use multiple approaches to drive improvement, including staff education, audit and feedback, monthly data reviews with clinical teams and engagement with staff to understand the importance of completing our electronic screening tool supporting clinical judgements.

We have maintained our screening performance from 2021/22. This will be addressed through our improvement work in 2023/24 when we will undergo a programme of trust wide changes to the adult sepsis identification and treatment pathway. Examples of specific improvement efforts have been described in Section 2.1.

3.1.3 FALLS

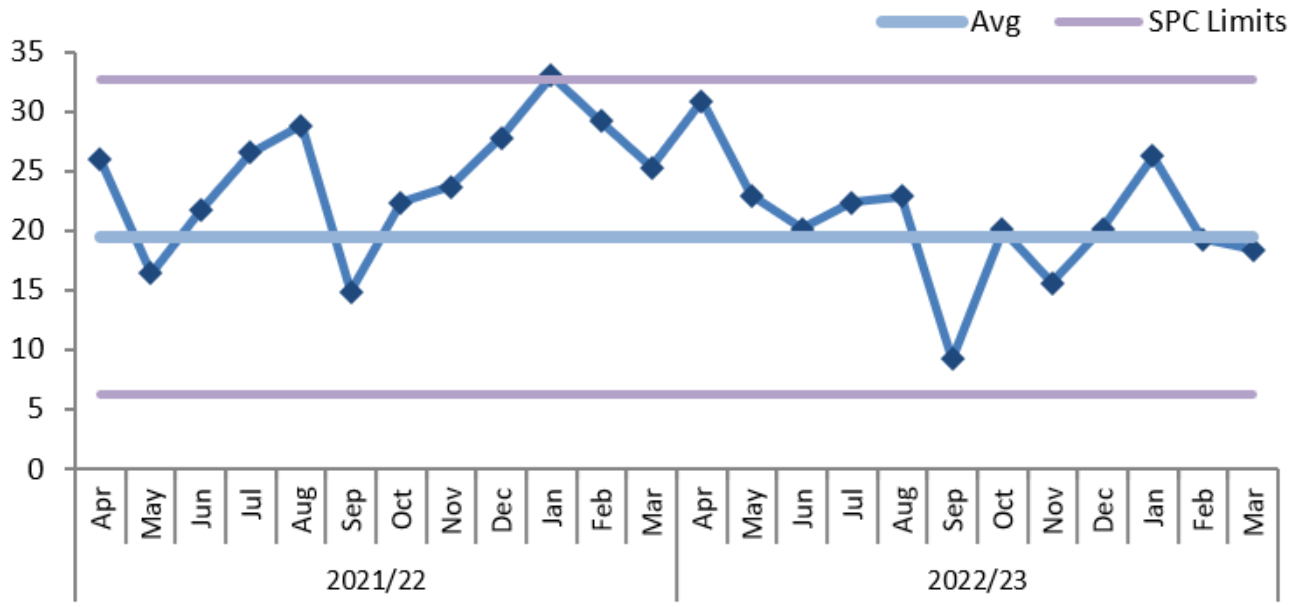
This data is collected via EPR and our incident monitoring system (Datix) and is validated by clinical staff. The Trust routinely monitors all 'Falls' patient safety incidents that take place within Trust premises. The Lead Nurse for Falls is now in post and routinely reviewing all falls irrespective of outcome. This is a change from the previous year where a detailed review was undertaken only in falls with moderate or above harm by a Deputy Director of Nursing or the Nursing and Midwifery Quality Lead to ascertain if further investigation was required to determine a cause. This change in process is enabling a review of all falls and learning to be shared and disseminated across the organisation through the Falls Improvement Group.

We have seen a decrease in our total numbers of falls over the last twelve months (see figure 37) - having introduced a reinvigorated

the Falls Quality Improvement (QI) approach across all inpatient areas with a target of achieving a 50% reduction in falls by end of 2022-2023 financial year. This target was achieved in November 2022 however we continue to see variation in falls reported due to an increase in patient acuity and frailty over Quarter 4 and are showing a 38% reduction at the end of March 2023.

Learning from the monitoring and management of falls revealed that staff completed risk assessments, initiated care plans and put interventions into place, such as, non-slip red socks and the use of falls alarms. However, 50% of falls with moderate harm and above required further investigation following a review by the Falls Panel team (this includes the Deputy Director of Nursing and Nursing and Midwifery Quality Lead).

Figure 37: *Total number of in-patient falls over 2022/23*



The Falls QI roadshow format has enabled us to reach every inpatient ward in the Trust and to discuss falls prevention with their MDT's. This has given the Falls Improvement group areas to focus upon over the following year to embed and sustain the improvements seen. A dedicated falls lead nurse is now in post to work with the clinical teams to help embed these changes. The Royal College of Physicians National Audit of Inpatient Falls (NAIF) Annual Report 2022[19] has also provided us with areas where improvement is needed and these have helped develop our objectives for 2023/2024 alongside our teams insights.

19 The Royal College of Physicians National Audit of Inpatient Falls (NAIF) Annual Report 2022
NAIF annual report 2022 | RCP London

These are;

1. Improve the quality of the multi factorial risk assessment.
2. Increase documentation of patients being checked for injury before being moved.
3. Increase documentation of how patients were moved from the floor post fall.
4. Increase number of patients receiving post falls medical assessment within 30 minutes.
5. Increase number patients having Lying and Standing Blood Pressure recorded when identified as being at risk of falls.
6. Ensuring patients that sustain injuries receive analgesia within 30 minutes.

The Falls Improvement Group have implemented the NAIF Hot debrief for all inpatient falls to ensure that all assessments, adjustments and learning is completed as soon as possible by the clinical teams and the patient is involved to prevent further falls and we are currently trialling an additional aspect to this for those Falls resulting in Moderate or above harm to replace Root Cause Analysis and move us towards working with the Patient Incident Review Framework (PSIRF) which is to be implemented nationally in Autumn 2023.

3.1.4 INDICATORS FOR CLINICAL EFFECTIVENESS

Hospital standardised mortality ratio (HSMR)

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

The current available Healthcare Evaluation Data (HED) covers a 12-month period from March 2021 to January 2023 with our current HSMR value being 105.81 which is within the expected range (see figures 38 and 39). The Trusts HSMR demonstrates that the Trust has remained within expected limits during the reporting period.

Figure 38: *HSMR score (12 month rolling: Mar 2021 – Jan 23): 105.81 – within expected range*

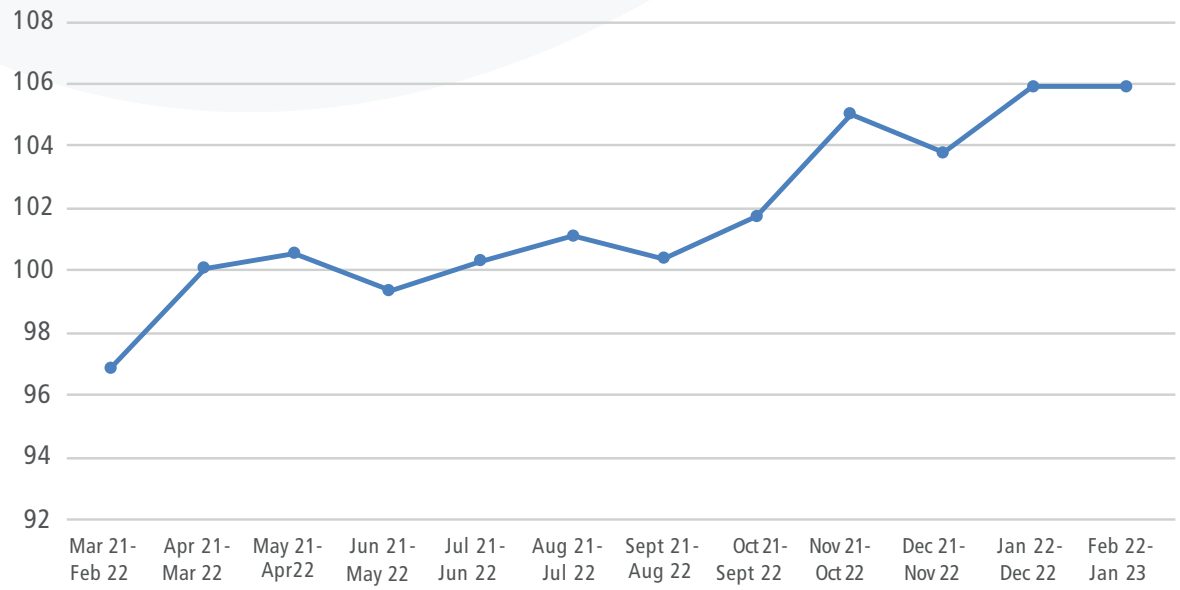
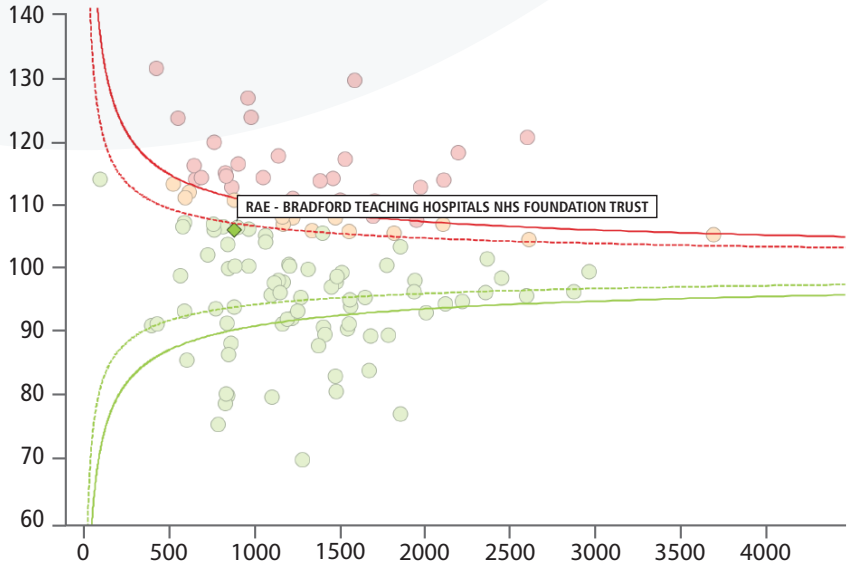


Figure 39: *HSMR indicator values, discharges, observed deaths and expected deaths numbers*

HSMR 12-month rolling	Indicator Value	Number of Discharges	Number of Observed Deaths	Number of Expected Deaths
Mar 2021 - Feb 2022	96.78	33,420	893	922.69
Apr 2021 - Mar 2022	100.05	33,548	916	915.51
May 2021 - Apr 2022	100.52	34,692	917	912.22
Jun 2021 - May 2022	99.38	34,735	906	911.64
Jul 2021 - Jun 2022	100.29	34,547	916	913.36
Aug 2021 - Jul 2022	101.09	34,262	916	906.14
Sep 2021 - Aug 2022	100.31	34,329	913	910.21
Oct 2021 - Sep 2022	101.72	34,495	921	905.4
Nov 2021 - Oct 2022	104.99	34,598	956	910.57
Dec 2021 - Nov 2022	103.72	34,690	953	918.84
Jan 2022 - Dec 2022	105.83	34,703	975	921.27
Feb 2022 - Jan 2023	105.81	33,394	928	877.08

Figure 40: *HSMR Activity Overview Funnel Plot*

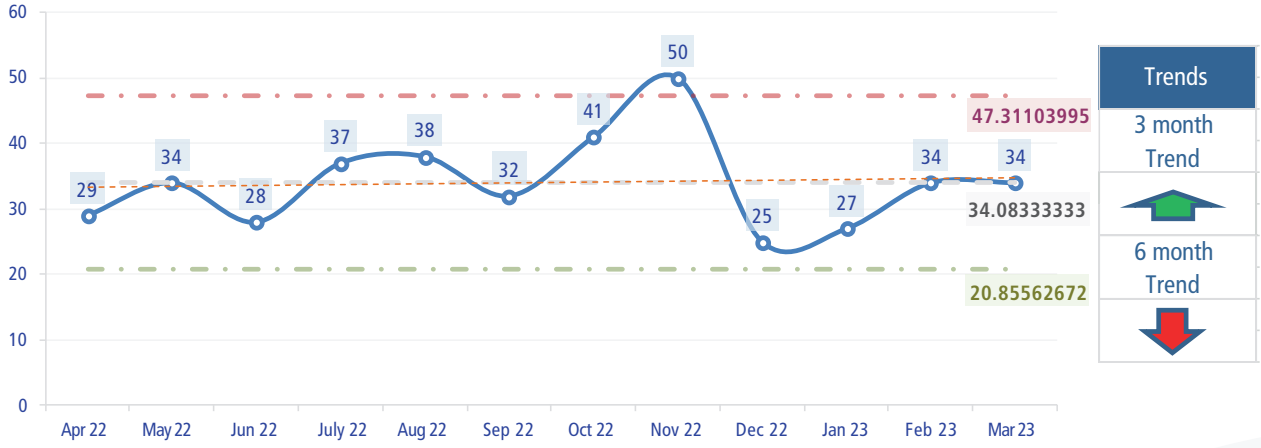


The funnel plot (at figure 40) shows the trust's HSMR performance in relation to all other acute hospital trusts.[20] Our current HSMR of 105.81 is marked and shows us as within expected range.

3.1.5 PATIENT EXPERIENCE

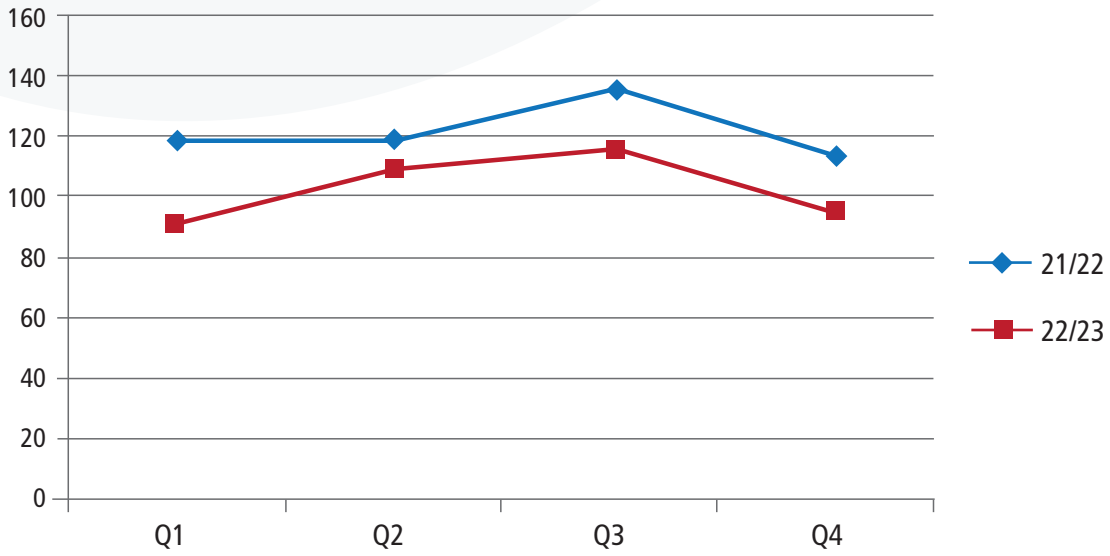
The Patient Experience team receive complaints and compliments into the organisation and support the clinical service units in responding to concerns. The number of complaints as shown in the table have reduced overall in comparison to the previous year Many complaints are now resolved through face to face meetings with complainants. By arranging to meet with complainants it has led to a timelier investigation/response as per policy.

Figure 41: *Total Complaints by Month 2022/23*



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

Figure 42: *Total Complaints by Month 2022/23 and 2021/22*



Learning from complaints is being shared via different forums and in liaison with patients and the Equality, Diversity and Inclusivity service. Patient stories are shared at the trust board with patients who are keen to support organisational learning.

Chapter 4
ANNEXES

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

4.1.1 STATEMENT FROM NHS BRADFORD DISTRICT AND CRAVEN HEALTH AND CARE

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

PARTNERSHIP

Scorex House
1 Bolton Road
Bradford
BD1 4AS

Date: 30th May 2023

Bradford Teaching Hospitals Quality Accounts 2022/2023

On behalf of NHS Bradford District and Craven Health and Care Partnership (BDCHP), I welcome the opportunity to feedback to Bradford Teaching Hospitals on its 2022/23 Quality Report.

The Quality Account has been shared with key members across the BDCHCP.

Despite the continued impact of the global COVID -19 pandemic, quality improvement continues to be evident in Bradford Teaching Hospitals. Indeed, the elective recovery programme is on track due to the innovative and collaborative ways of working between departments. In particular, the emergency department at Bradford Teaching Hospitals saw record numbers of people attending and although not rated by the Care Quality Commission was found to be providing safe and compassionate care.

I acknowledge and congratulate the Trust's achievements for 2022/23:

Improving the management of the deteriorating patient was achieved by:

- The relaunch of the 'Critical Care Outreach Team' to identify early deterioration and provide support to wards on a 24 hou basis.
- Introduction of the visual system, in all ward areas.
- Improved reporting via the sepsis dashboard to monitor outcomes and process measures.
- A project focussed on junior doctors' tasks at night, prioritizing patient acuity.
- Improving Patient Experience.
- Embedding the Patient Experience Strategy, which received national and local interest #embeddingkindness.

- Embedding civility in the workplace.
- The Spiritual, Pastoral and Religious Care (SPaRC) service (formally chaplaincy) has received national recognition and is supported by religious leaders.
- Working towards obtaining Veteran Accreditation status.
- The VIP pathway and red backpacks were introduced for people with additional needs. The pathway is in response to patient feedback and was developed collaboratively with people with additional needs to improve their experience.
- The paediatric inpatient team and the VRI (Virtual Royal Infirmary) are developing a virtual tour of the hospital to alleviate anxiety in children with additional needs.
- The Relatives line is now permanently staffed following a trial.
- Representing the region for the 'Worry and Concerns 'programme.

Reducing Still Births

- Focused work and commitment to reduce stillbirths
- Full compliance with the implementation of the Saving Babies Lives Care Bundle Version 2 and early presentation with reduced fetal movements.
- Health inequality initiative, improved access to food when attending maternity appointments, to address food poverty associated with stillbirths.

I acknowledge the CQC inspection of Maternity Services in January 2023, and the positive verbal feedback, highlighting the many improvements made since the last inspection in 2019.

Advancing Equality, Diversity and Inclusion (EDI)

- EDI strategy launched and has clear objectives and strong executive leadership.
- Refreshed Workforce Disability/ Race Equality standard action plans co-produced with staff equality networks in response to the 2022 workforce/ staff survey data.
- Targeted activity has taken place to improve data and ultimately the experiences of diverse staff.

Additional Improvements:

- The 'Outstanding Maternity Service' has been working with patients and staff to improve outcomes for service users and their babies.
- National recognition with their television documentary following the home birth team.
- Participation in 100% of national clinical audits and 100% of eligible national confidential enquiries.
- Continued focus and increase in research activity with national and regional research bodies.
- Engagement with frontline staff in quality improvement projects.
- Development of strong infrastructure and progress to implement the Patient Safety Improvement Response Framework.

- Completion of the CQC 4 'should do' actions -improving sepsis care, the environment, provision of new Urgent Care centre and governance of audits.
- Improvements to clinical coding.
- Learning from deaths additional scrutiny has identified good care examples and improvements, where there was an identified increase in mortality.

2013/2014 Quality Account Priorities

I recognise that to sustain and embed quality improvement the quality priorities for the next year remain largely unchanged with the exception of implementing the National Patient Safety Incident Response Framework. I can see that this will consolidate your work on improving the safety culture and embed the just culture and civility approaches.

I am in agreement with your selected Quality Priorities for 2023/24:

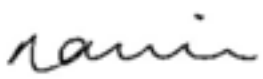
1. Improving the management of deteriorating patients.
2. **New:** Implementing Saving babies Lives Care Bundle version 3.
3. **New:** Improving patient experience by advancing equality, diversity and inclusion.
4. **New:** Implementation of the Patient Safety Response Framework including transition from the National Reporting and Learning System to the new Learning from Patient Safety Events platform.

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

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

I would like to thank you and your staff for the achievements made in 2022/23 and your continued commitment to high quality care delivery, despite the exceptional challenges that you have faced this year. The Quality Account demonstrates a high level of commitment to quality in the broadest sense and I support the positive approach taken by the Trust.

Yours sincerely



Nancy O'Neill
Chief Operating Officer
Bradford District Health and Care Partnership

4.1.2
STATEMENT FROM HEALTHWATCH BRADFORD AND DISTRICT

Healthwatch Bradford and District welcomes this opportunity to comment on the Bradford Teaching Hospitals NHS Foundation Trust Quality Report for 2022/2023.

As the independent champion for people using health and care services, we welcome the work and commitment of the Trust in ensuring the voices of patients and service users are heard, despite the ongoing difficult circumstances imposed by the COVID-19 pandemic and its legacy. Once again we recognise the commitment to the continued delivery of excellent services for the citizens of Bradford.

We commend the Trust on their drive, and success, in ensuring elective services are prioritised where appropriate to 'catch up' with the inevitable cancellations caused by the pandemic. We also recognise the challenges that industrial action by nurses and junior doctors has had on service delivery of elective and outpatient care.

We continue to be a member of the Trust Community Engagement Group alongside our regular meetings with the quality and patient engagement leads. These are an effective means of communication both informally and allowing the opportunity to raise issues in a more formal way.

This is representative of our respectful and positive relationship with a wide range of staff and trustees within the Trust. We are able to have open and honest conversations around people's experiences of services – both directly and through robust challenge on the Place Based Partnership Board and BMDC's Wellbeing Board and the Health and Social Care Overview and Scrutiny Committee.

The priorities for the coming year appear to be reflective of patient feedback which is both pleasing and reassuring. We are particularly pleased to see that two of the priorities are carried forward in some format from last year. This reflects the robust nature of the Trust's self-assessment and recognition of areas of ongoing improvement.

A recent development has been the publication of the report on the latest CQC inspection of maternity services. Whilst the grading remains as Requires Improvement, we have been aware of the huge amount of work that has taken place in improving services and were pleased that this was recognised in the report.

We are also pleased to see the BRI site receive an overall rating of Good as a result of this inspection.

We have enjoyed working with the Trust over the last year to explore their Virtual Royal Infirmary initiative and have recently produced a report sharing patient and public feedback

that will be used to shape the design of this innovative service. We look forward to seeing how the service develops.

Healthwatch Bradford and District commend the leadership of the Trust for their commitment to continued improvement and look forward to our continued relationship of trust and challenge.

Helen Rushworth
Lead Officer
Healthwatch Bradford & District

June 2023

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

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Bradford Metropolitan District Council (BMDC) Health and Social Care Overview and Scrutiny Committee (HSCOSC) has advised the Trust that it has opted not to provide comments on the 2022/23 Quality Account on this occasion.

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

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and Social Care issued guidance on the form and content of annual Quality Accounts, which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010. The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017. These added new mandatory disclosure requirements relating to 'Learning From Deaths' to quality accounts from 2017/18 onwards.

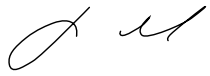
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

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

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

By order of the Board

Ms Julie Lawreniuk
Deputy Chair
June 2023



Professor Mel Pickup
Chief Executive Officer
June 2023