NHS
Airedale
NHS Foundation Trust

Quality Report 2019-20

YOUR HOSPITAL *Here to care*

About Airedale NHS Foundation Trust

Airedale NHS Foundation Trust provides acute and community services to a population of over 200,000 from an area covering some 700 square miles across West and North Yorkshire and East Lancashire. Care and treatment is provided from our main site at Airedale General Hospital. Community services are provided from locations which include Castleberg in Settle, Coronation Hospital in Ilkley and Skipton Hospital as well as health centres and general practices. We employ over 3000 staff, including a community based workforce and have approximately 350 volunteers.

Contents

Part 1: Statement on quality from the Chief Executive 3
1.1 Introduction 3
1.2 Signed declaration 4
Current view of Airedale NHS Foundation Trust's position and status on quality 5
Part 2: Priorities for improvement and statements of assurance from the Trust Board of Directors 11
2.1 Priorities for improvement 2019/20 12
2.1.1 Priority 1 patient experience: improving the care and support for people with mental health needs 13
2.1.2 Priority 2 patient safety: falls prevention 16
2.1.3 Priority 3 clinical effectiveness: management of sepsis 19
2.2 Statements of assurance from the Board of Directors 22
2.2.1 Review of services 22
2.2.2 Participation in clinical audits and national confidential enquiries 22
2.2.3 Participation in clinical research 31
2.2.4 Use of Commissioning for Quality and Innovation framework 32
2.2.5 Registration with the Care Quality Commission 33
2.2.6 Information on the quality of data 34
2.2.7 Learning from deaths 35
2.2.8 Seven day hospital services 36
2.2.9 Sign up to Safety 37
2.2.10 Duty of candour 37
2.2.11 Staff who speak up 38
2.2.12 Workforce Race Equality Standard 39
2.2.13 Learning disabilities improvement standards 40
2.2.14 Safe working hours: doctors and dentists in training 40
2.3 Reporting against core national indicators 42
Part 3: Other quality improvement information 56
3.1 Patient experience 56
3.2 Patient safety 65
3.3 Clinical effectiveness 73
3.4 Performance against key national priorities 81
Part 4: Annex 82
4.1 NHS Bradford District and Craven Clinical Commissioning Group 82
4.2 Overview and Scrutiny Committee 85
4.3 Healthwatch 85
4.4 Statement of directors' responsibilities in respect of the Quality Report 86
4.5 NHS Improvement guidance for data quality assurance on Quality Reports 88
4.6 Glossary 89

Part 1: Statement on quality from the Chief Executive

1.1 Introduction

I am delighted to present our annual Quality Report, the majority of which was collated prior to our COVID-19 pandemic and which will be reviewed in future accounts. The aim of this report is to explain the quality of our care over the last year and how we seek to improve this. Ensuring that those using our services have safe, clinically effective care as well as a positive experience is at the forefront of everything we do. Our achievements, the challenges that we face and our ambitions are set out in this report.

This year has seen the appointment of an Associate Director of Quality and Patient Safety to take the lead on our quality and safety agenda as part of our executive team. As a former Deputy Chief Inspector with the Care Quality Commission, the post-holder is working with teams and across organisations to ensure quality goals – as set out in our newly developed Quality and Safety Strategy 2020-22 – meet the needs of our patients and the standards we aspire to.

It is important that in implementing quality improvement we are able to sustain and monitor change. The last year has seen a significant focus via our People Plan on leadership and recruitment – with input from NHS Improvement – and governance systems from the front line to the Board of Directors.

Unparalleled healthcare demand linked to increasing numbers of older people with complex health and care requirements makes collaboration between health and social care organisations crucial. As part of the West Yorkshire Association of Acute Trusts and the wider West Yorkshire and Harrogate Health and Care Partnership, our goal is to implement the NHS Ten Year Plan by bringing the contributions of GPs, district nurses, social workers, mental health providers, care homes, voluntary organisations and local hospitals into a single integrated care system. Our reputation for innovation – through the Airedale Digital Hub assistive technologies and our electronic integrated health record between primary and secondary care – means we are well placed to further develop and deliver the best care to our local population, not least in our rural localities.

To create the foundations for clinically effective and sustainable patient pathways and services – such as for stroke, head and neck cancer, vascular services and the pathology network – clinical leaders are taking prominent roles to work in partnership across services via the Acute Provider Collaboration Programme with Bradford Teaching Hospitals NHS Foundation Trust.

I am encouraged that so many wish to be involved in these plans. Indeed I continue to be impressed by the commitment of staff and volunteers to quality improvement and would like to take this opportunity to thank them all for their resilience and professionalism.

With recognised national shortages within staffing groups and specialisms, it remains vital that we cherish our workforce. We continue to focus on what we can do to attract people into working within health, social care and the voluntary sector in our localities and how we retain people. This year has seen the implementation of Schwartz Rounds, a forum for colleagues from all backgrounds, grades and disciplines across the hospital and community areas to come together to talk about the emotional, personal and social challenges of working within healthcare. Of particular importance to me over the last year has been our European Union colleagues, not least in ensuring they have the required support and guidance around Settled Status.

Following on from previous dynamic infrastructure projects, this year has seen the re-opening of our intermediate care facility at Castleberg Hospital in Settle following significant refurbishment to improve patient experience, including consideration in the upgrade to dementia and end of life care. The model of care aims to integrate services closer to patients' homes; the site acts as a community-based facility with the option to provide a broader range of support services, including both physical and mental wellbeing.

Other quality achievements and initiatives over the last twelve months include:

- *97% of inpatients rated our care as excellent or very good and 99% across Community Service.*
- *The Trust was named for the eighth time as one of the top 40 performing hospitals by CHKS. This is a national patient safety award by an independent provider of healthcare intelligence.*
- *Our Frail Elderly Pathway Team's work as part of the NHS Improvement Collaborative on Frailty and the early assessment, diagnosis and management of constipation was voted "improvement most likely to be adopted across the NHS".*
- *To support the delivery of safer maternity care, our service was able to demonstrate the required progression in last year to meet the ten safety actions designed to improve the delivery of best practice in maternity and neonatal services.*
- *Successful achievement of Anaesthesia Clinical Services Accreditation (ACSA, a peer review programme run by the Royal College of Anaesthetists. This is acknowledgement of the standard of care provided by the team.*
- *Pathology successfully achieved United Kingdom Accreditation Service (UKAS) endorsement.*
- *Recognition of the work of one of our Macmillan Gynaecology clinical nurse specialists, who won the Royal College of Nursing's Cancer Nursing Award, for the positive work to enable ovarian cancer patients to access a life-prolonging drug.*
- *Our Endoscopy team achieved formal JAG re-accreditation in meeting best practice quality standards.*
- *Our Audiology team became one of the first groups in the country to be awarded the Gold Standard for tinnitus support groups by the British Tinnitus Association (BTA).*
- *Gold Standards Framework re-accreditation of Wards 5 and 9, recognising their commitment to delivering excellent end of life care.*
- *Launch of Fracture Liaison Service.*

1.2 Signed declaration

It is important that our Quality Report is accurate and presents an honest picture of our care. We seek to foster an open and transparent culture so we can understand where improvements are needed. I am pleased to confirm that the Board of Directors has reviewed the 2019/20 Quality Report. As Chief Executive of Airedale NHS Foundation Trust, I can confirm that the information used and published in the Quality Report is, to the best of my knowledge, accurate and complete as possible at the time of the COVID-19 pandemic response.

Brendan Brown,
Chief Executive,
Airedale NHS Foundation Trust
4th November 2020

Current view of Airedale NHS Foundation Trust's position and status on quality

Our ambition is to provide high quality care that is safe, clinically effective, compassionate and responsive to the needs of individual patients and their families, as set out in our new *Quality and Safety Strategy 2020-22* and underpinned in our all-encompassing strategy for the next five years which focuses on Patients, People, Progression, Partnership and Population. Our approach to quality and improvement has been reviewed over the last year to incorporate local insight and national priorities, recommendations from the 2018 Care Quality Commission core service inspection and assurance that the plans for quality are sustainable in respect of activity and workforce. The following provides a brief overview of quality measures which evidence patient outcomes for key quality improvement ambitions alongside details of our approach to leadership and governance to underpin and oversee progress.

Harm free care

Harm occurs when care is sub-optimal, either as the result of something we did or did not do for the patient. According to the NHS Safety Thermometer indicator around 93 per cent of our acute patients receive harm free care. Regrettably, however, this year the Trust reported three Never Events: misplaced naso-gastric tube, wrong procedure and wrong site surgery.

Never Events are serious, largely preventable patient safety incidents that should not occur, with a high potential for severe harm or death. In collaboration with NHS Improvement these events have been reviewed and key objectives to improve system reliability and underpinning processes are being enacted: the consistent application of *Five Steps to Safer Surgery*; the roll out of *Steps to Safer Interventional Procedures*, reduction in pathway complexity, simulation testing to embed practice; and the introduction of human factors training across the organisation, more recently on distraction awareness. To further communicate key messages, Quality Summits have been held over the year bringing together clinical and non-clinical staff groups across the organisation and our wider partners in recognition of the responsibility we all have in delivering a safe healthcare environment for patients, visitors and colleagues. Key messages from patient safety incidents are reinforced and disseminated via a *Report, Learn and Share* newsletter.

Of the incidents reported in the period April to September 2019, 98.1 percent were categorized as low or no harm. An effective safety culture is dependent on an open culture. Open forum discussions on quality and safety are held regularly by the Medical and Nursing Directors where staff can offer personal insight and raise concerns. The Freedom to Speak up Guardian offers an equally important means for staff to voice patient safety concerns.

In the 2019 *NHS National Staff Survey* the Trust's safety culture scored above the average for the benchmarking group of 85 providers. Scores for staff confidence and security in reporting and addressing unsafe clinical practice are better than the national average with staff reporting that our organisation treats those involved in an incident fairly.

Infections as a result of healthcare interventions for the fiscal year are: one case of hospital acquired MRSA bacteraemia and 24 cases of C.*difficile*[1] of which, five were found to be avoidable). C.*difficile* infection per 100,000 bed days in Trust patients aged 2 or over is below the England average based on available figures. (See sections 2.3.8 and 3.2.1 for the detail).

Patient Safety Alerts are published by NHS England regularly, warning hospitals about practices that are potentially unsafe. The warnings recommend a date by which changes to practice should be implemented. The Trust has closed all alerts issued in the preceding twelve months in the applicable time frames. Ongoing monitoring of

[1] *C.difficile* provider objectives for 2019/20 have been revised to include two categories: hospital onset [three or more days] and community onset [or within two days of admission to hospital] invalidating comparison between years.

compliance as recommended by the CQC is now integrated into governance arrangements.

Patient complaints can offer insight into safety- related problems which may not be identified via incident reporting or case note review. There have been 84 formal complaints in the last fiscal year against a five year median of 73. Across England in the preceding fiscal year, hospital and community services saw an increase in formal complaints of two per cent; across Yorkshire and Humber there was a decrease of 5.6 per cent. Over the last year two complaints were sent to the Health Service Public Ombudsman for review, one of which originated in the previous year.

Through monitoring complaints, the Trust aims to support managers to make swift improvements. A newsletter – *Quality and Safety Matters* – highlighting learning from complaints and incidents is circulated to staff each month to reinforce learning.[2] For example:

You said … ***"****Patient discharged home following ankle surgery without stair assessment. (The patient was being nursed upstairs at home and could not get up and down stairs without considerable support.)"*

We did ... Improved therapy assessment to include: home circumstances and family support.

You said … *"Parent queried whether a child with chicken pox should be moved from ambulance handover to public children's waiting area in ED."*

We did ... *Nursing safety brief issued to remind nursing team to isolate chicken pox wherever possible."*

The 2018 CQC inspection highlighted that we do not always respond to and close complaints within our then threshold of 40 days. Action has been taken and monitoring indicates a statistically significant improvement in our average response time. As a consequence, our threshold was revised down to 35 days from 1st September 2020.

[2] Detailed analysis and learning from complaints can be found in the complementary statutory annual *Complaints and Concerns Report 2019/20* available in June 2019 at: http://www.airedale-trust.nhs.uk/about-us/corporate-publications/ [accessed 16/102/19].

Learning from relevant national investigations has or will be implemented, including recommendations following failings in maternity care at Furness General Hospital and more recently at Shrewsbury and Telford Hospital NHS Trust. Our Maternity Service has been subject to both local and external review (by NHS Improvement) with actions incorporated into the Trust's governance review. The *CQC Maternity Survey 2019* service is above the national average ('better') in respect of raising concerns.

The annual Patient-Led Assessment of the Care Environment (PLACE) provides a snapshot of how an organisation is performing against a range of areas which impact on the patient experience of care. A fundamental aspect of the assessment is the inclusion of lay assessors who make up to half of the inspection team. Assessment includes: cleanliness, food and drinks, the quality of buildings, including criteria on how well healthcare providers' premises are equipped to meet the needs of caring for patients with dementia and disability. Our most recent PLACE assessment was carried out in September 2019 over six days. The Emergency Department, nine inpatient wards and four outpatient areas were assessed. Of the 261 participating organisations, 214 were NHS providers.

Airedale General Hospital site performance is about the same as other providers for *"privacy, dignity and wellbeing"; "condition, appearance and maintenance", "dementia"* and *"disability".* Overall, the highest national domain score is for "*cleanliness*". For this area and the food domains our site scores are in the lower quartile of providers. Actions are being taken to address environmental cleaning issues identified at the time of the assessment; national food standards are being implemented.

No avoidable mortality

Key mortality measures – Summary Hospital-level Mortality Indicator and the Hospital Standardised Mortality Ratio – show performance for the Trust within the expected range.

The Trust has responded to the recommendations from NHS England's (2017) *National Guidance on Learning from Deaths* which highlighted variable responses across the country as to how deaths are investigated and families treated. Led by the Medical Director, processes continue to be reviewed and encapsulated in a dedicated and recently refreshed *Responding to and Learning from Deaths Policy*. This year we addressed feedback from the 2018 Care Quality Commission inspection to improve the timeliness of local case note review and the dissemination of learning. (See sections 2.2.7 and 2.3.1 in this report for greater detail on mortality.). The planned medical examiner led-system will introduce a new level of scrutiny with all deaths subject to greater investigation; work is underway in partnership with Bradford Teaching Hospitals NHS Foundation Trust to implement this role.

Under Regulation 28, the Coroner has a legal duty to issue a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. The Trust has received no such notification over the last year.

Innovative real-time quality intelligence

To drive forward and monitor improvement, meaningful patient information and clinical intelligence is essential. This year has seen us embark on a project to implement inpatient documentation through SystmOne. This builds on shared SystmOne record access across primary and secondary healthcare which allows a tailored view of an individual's health information across care settings. In the run up to the transition, listening and drop in sessions were held by our Integrated Health Record Team to gather understanding of what works well in SystmOne, where improvements can be made and how the roll out should take place.

Accurate and responsive healthcare intelligence is essential to the clinical effectiveness of care. Recording of National Early Warning Score (NEWS2) e-Observations on iPads has been live on all adult inpatient wards since May 2019. The roll out of Neuro Observations commenced in September 2019; the delivery of Maternity and Paediatric physiological parameter measures is planned by the end of the year. Automatic escalation for those patients at risk of deterioration is a key feature of the digitalisation.

Other electronic developments in the last year in collaboration with TPP, the software supplier of SystmOne, include:

- Radiology Requesting Live (via the ICE application);
- Roll out of e-referral across Outpatient specialties;
- Recording of children's safeguarding concerns;
- Results of Newborn and Infant Physical Examinations (NIPE);
- Calculation of venous thromboembolism scores; and,
- Migration to NHSMail, a national email service which is secure for the transmission of patient identifiable data.

All the above work is supported by a comprehensive staff training package. Patient safety incidents and feedback from colleagues are closely monitored to ensure there is no adverse impact as processes switch over. Thus only one patient record can be open in SystmOne at any one time, a change made following concerns expressed by clinical colleagues.

The West Yorkshire and Harrogate Health and Care Partnership, of which we are a part, has received £12 million in funding to transform Pathology services in the last year. This funding is earmarked for the implementation of a new Laboratory Information Management System (LIMS) across the six acute hospitals. Once the system is in place it will mean that test requests can be ordered, tracked and results reported electronically to hospital and GP services across our region.

No avoidable delays in care

NHS England has indicated that instances of delayed transfers of care from hospital to other care settings are increasing across the country with an associated impact on the flow of patients through the hospital. The *2018 CQC Adult Inpatient Survey* results show patients' experience of the time between arrival at the hospital and getting a bed on a ward and the experience of leaving hospital as *"about the same"* as the 144 participating providers.

Our focus is to look beyond the hospital setting, to redesign pathways of care and avoid unnecessary admissions whilst improving hospital throughput through an emphasis on the integration of the contributions of district nurses, social workers, mental health professionals, GPs, care homes and voluntary organisations into one cohesive system.

Over the last year and alongside local partners, we have identified three key operational priorities with the goal being to deliver care in different ways: care co-ordination across health, social care and the voluntary and community sectors; outpatient transformation; and, Urgent Care where attention is focused on four specific patient cohorts – respiratory, mental health, working-age adults and frailty. Meanwhile community teams are looking at how we can reduce Emergency Department attendance and admittance for those with a diagnosis of Parkinson's through the innovative use of assistive technologies.

The work of the Airedale Digital Care Hub in using enabling technology to provide a single point of access to all aspects of specialist health and social care advice provides an opportunity to reduce unnecessary hospital attendance and GP visits where clinically appropriate. The Multi-Agency Referral Hub is located on the Digital Care Hub; the team brings together the Case Management Team and the Intermediate Care Hub and focuses on a systematic and planned approach to discharge, including remote discharge to those nursing homes using telemedicine.

Allied to these services, a series of initiatives have been implemented to improve patient flow and prevent unnecessary waiting for patients including the SAFER patient bundle, a week-long Multi-agency Discharge Event, recruitment of Flow Facilitators to manage discharge, the "*End PJ Paralysis*" campaign and the Red Bags Pathway. In spite of this and other initiatives including a Patient Flow Rapid Improvement Event, seven day opening of the Ambulatory Care Unit, appointment of a Patient Flow Matron, *"Get Me Home"* multi-agency meetings every day to review complex discharges and the establishment of a Discharge Lounge during the busiest months, multiple pressures across the whole health and care system continue to affect the delivery of services.

In the last 12 months, we have not been able to consistently deliver national standards with pressures around maximum waiting times for: the Emergency Department, referral to treatment, diagnostics and some cancer standards. We apologise for not consistently achieving these important quality priorities. We know that sustaining a low wait time remains a key factor in providing high quality and responsive care and continue to implement local and system wide action. In these measures and other key the Trust regularly out performs the England average.[3]

People – workforce

With recognised national and local workforce shortages – and not exclusively amongst the nursing and medical professions – we continue to take all possible actions to recruit, retain and mitigate for clinical staff vacancies.

Having the right number and mix of staff with the appropriate skills, at all times, is integral to providing safe, high-quality care. The 2018 Care Quality Commission inspection highlighted concerns about nurse and medical staffing levels with unfilled shifts for registered nurses in some clinical areas and gaps in medical cover in the Emergency Department and out of hours within Critical Care.

The care of patients is of the utmost importance and a series of robust

[3] BBC NHS Performance Tracker [current at 28/10/19]

mechanisms monitor nurse, midwifery and medical staffing levels. Actual and planned staffing rates are cross-referenced with key quality markers, patient acuity and bed occupancy. The introduction of an electronic staff roster supports the utilisation of staff in the most clinically effective and efficient way possible. A Guardian of Safe Working ensures junior doctor trainees are protected against protracted working hours and receive the training, supervision and support required.

Where possible unstaffed capacity is proactively filled with locum and bank staff to maintain safe staffing levels and skill mix across clinical areas at all times. More recently the priority has been a review of the process for booking bank and agency staff to avoid short-term planning and a high number of unfilled shifts. In collaboration with the West Yorkshire Association of Acute Trusts we are developing a collaborative staff bank to offer more opportunities for additional work, particularly to junior medical staff, to reduce the use of agency doctors. However, an increase in demand in the last 12 months of almost seven per cent on previous years has resulted in an ongoing requirement to staff additional beds and the use of temporary staffing with a concomitant burden on existing staff resilience and wellbeing. In January 2020 the Board of Directors recognised these escalation beds as a core component of the bed base and agreed the funds to substantively staff them in support of patient safety and effectiveness.

Active recruitment of additional doctors, nurses and allied health professionals remains ongoing. Successful nursing recruitment events have been held through the year, both in the United Kingdom, Ireland and India with recruits now being deployed across inpatient wards. In collaboration with colleagues across the health and social care and through our *People Plan* we continue to review staff roles and evaluate different ways of clinical working. For instance, and as part of the Stroke Collaboration Project, our medical, nursing and therapy staff and those from Bradford Teaching Hospitals NHS Foundation Trust have undertaken shifts at each other's sites. The Trust is participating in Health Education England's Nursing Associate Programme to build capability, offer an improved career pathway and strengthen workforce retention.

Other initiatives to build capacity include: establishing an Enhanced Care Team, an Acute Assessment Flow Co-ordinator post, Discharge Liaison Officers, and Pharmacy Assistants to support the administration of medication to patients. The responsibilities of Healthcare Support Workers (HCSW) have been reviewed to enhance nursing support through, for example, the taking and recording of vital signs. An apprentice HCSW quarterly cohort scheme has been introduced. There is a team of Advanced Clinical Practitioners working across the Acute Assessment Unit and on specialist wards to provide advanced clinical skills to the level of a junior doctor. The training is comprehensive and clinically supervised by consultant medical staff.

Post-graduate Physician Associates are being recruited to support doctors in the diagnosis and management of patients. The Trust is: exploring the potential for further international recruitment to fill gaps at consultant and middle tier level; has introduced Trust grade doctors to fill junior doctor gaps; and is implementing the Associate Specialist Grade and other senior level appointments to attract and retain key employees.

It is as equally important that we respond to workforce supply challenges in other areas. As set out in the Trust's *People Plan* we are implementing a range of initiatives within healthcare science, pharmacy and the allied health professions to develop and nurture talent. By involving employees in decision-making, valuing diversity and inclusion, looking after the health and wellbeing of people, we aim to make the Trust a great place to work.

The Acute Provider Collaboration Programme is working with specialties to develop collaborative clinical service models for the shared population of Bradford District and Craven. In doing so work is also focusing on the enabling factors such as information communication technology, Human Resources and car parking to make it easier for people to work across both Airedale and Bradford Hospital sites if required.

It is important to acknowledge that for existing staff there is an increased level of pressure with the potential to affect staff morale and wellbeing. A pastoral nurse is in post and the nursing preceptorship package has been re-designed. Effective leadership to ensure there is ongoing support is fundamental. This year has seen the implementation of Schwartz rounds, a proven method to reduce stress and isolation of staff.

Staff must feel valued and have the ability to progress and maintain skills, through for example attendance at mandatory training. The General Medical Council National Training Survey of junior doctors published July 2019, indicates deterioration in our global satisfaction score.

The Trust has been selected to be part of the Pathway to Excellence® *"nursing excellence"* framework which aims to create a positive practice environment for nursing staff. By placing nursing and midwifery staff at the centre of the decision-making process, collective ownership in developing and improving practice is fostered and professional pride engendered. Such initiatives alongside our *Great Place to Work Programme* are key areas of focus.

Governance and Leadership

In order to provide clarity to those individuals working within an organisation, it is vital there is effective and robust leadership with a common vision and purpose, underpinned by effective governance arrangements and accountability. In the 2018 CQC inspection the 'Well-Led' domain was rated as "*Requires improvement*".

Improving leadership at all levels of our organisation has been an area of significant focus over the last year. A Leadership Development Programme (supplemented by a series of leadership enrichment sessions open to all staff) has been implemented, augmented by the delivery of Leadership Community sessions. Running alongside is our Great Place to Work initiative which includes a coaching programme that is open to not only Trust employees, but external partners across health, voluntary and local government sectors. This is an opportunity for people to work in partnership with these organisations and share expertise and knowledge.

A key area of attention remains our complex governance structure which is not always understood within the organisation. The assessment and escalation of risk has been reviewed to ensure all work is ultimately overseen by one of the Board committees. These committees, for example the Quality and Safety Committee, act to assure the Board of Directors that the organisation is running effectively and safely.

Open communication and a common purpose has been revitalised through the promotion of key values and behaviours. To foster a dynamic quality improvement culture, dialogue between staff, patients, senior managers and executives is vital.

The annual anonymous *National NHS Staff Survey*[4] (published by NHS England) helps us to improve the working lives of all our staff. Results from the 2019 survey indicate we are better than average compared to other acute trusts in nine of the 11 key themes, which cover areas such as health and wellbeing, line managers, morale, inclusion, working in a safe environment, safety culture and staff engagement. Improvements around support from immediate line managers, staff engagement, developing a safety culture and the quality of appraisals were also reported. The latter has been a particular area of focus in the last year.

There are some areas where staff would like to see further improvements. Some staff reported that they are not satisfied with the quality of care or work they are able to deliver. This appears to be due to system and workforce pressures, but we need to understand this better and ensure staff are either involved in, or understand, ongoing initiatives across the system and at Airedale to respond to these challenges. Results are being reviewed at the People Committee,

[4] NHS *Staff Survey 2019* is available from: http://www.nhsstaffsurveyresults.com/wp-content/uploads/2020/02/NHS_staff_survey_2019_RCF_full.pdf [Accessed 18/02/20]

which is a sub-committee of the Trust Board; areas of focus for the coming year will be agreed. Trust-wide actions will be included in the development of a *People Strategy* over the coming year.

Part 2: Priorities for improvement and statements of assurance from the Trust Board of Directors

How we engage with others in developing our quality goals

The opinions of our patients, staff and local partner organisations are important and we receive feedback via a number of methods including: surveys such as the Friends and Family Test, compliments, complaints and concerns, social media, Patient Safety (and peer) Walk Rounds, listening events and Healthwatch enter and view visits. In the 2018 *NHS Inpatient Survey* we were one of the best scoring amongst the 144 participating sites for the question, *"During your hospital stay, were you ever asked to give your views on the quality of your care?"* Such feedback provides us with vital information with which to improve services.

Patient and staff stories are a potent and reflective tool providing invaluable intelligence. At the monthly Board of Directors' meeting, the first agenda item is, by agreement, a patient story told from the perspective of patient and family. The following example recounts the experience of a patient with uncontrolled epilepsy following a surgical day case procedure. It illustrates how we can improve the experience of patients and families through listening:

In Recovery Melissa had a seizure and whilst, in her words, the nurses were "brilliant", had her husband or carer – "the people who know her best" – been present their knowledge and experience would have helped significantly. Although healthcare professionals may know generally what to do in the case of an epileptic seizure, they cannot necessarily know how a particular individual will react and what aftercare they will need.

The Surgical Team responded to Melissa's feedback by introducing pagers into Theatres for the families of patients with particular needs. This means that when a patient comes out of Theatre a family member/carer can be paged and can be with them in Recovery as they come round and be "the expert in the room" on an individual's condition.

Source: Board of Directors' meeting October 2019

The 2019 *NHS Staff Survey* places the Trust above average amongst acute providers for the number of staff reporting the effective use of patient/service user feedback across services.

Our volunteers and the Council of Governors play an invaluable role in representing the views and interests of the local community; their engagement work informs and guides our vision. Where a patient group is not well represented, efforts are made to seek feedback. For those patients or individuals who have complex communication needs and/ or whose views are seldom heard, specific engagement events and focus groups are arranged for example, an end of life relatives' focus group. The Trust is represented at the Bradford and Airedale Equality and Diversity Leads Group, the Dementia Strategy Group and the Learning Disability Healthier Lives Service User Group. Our Maternity Service is part of the Maternity Voices Partnership, bringing together health professionals and women in Bradford District and Craven to give voice to local people and groups, including the black, Asian and minority ethnic (BAME) communities.

The Board of Directors continues to work closely with colleagues at neighbouring providers, local commissioning groups, Healthwatch and local authorities as well as across the wider region – via the West Yorkshire and Harrogate Health and Care Partnership – to make sure we listen to our local communities and provide health and social care that meets the needs of the Airedale, Wharfedale and Craven population.

The last year has seen us working with the voluntary community group Exclusively Inclusive which works to reduce social isolation.

2.1 Priorities for improvement 2019/20

Selected quality priorities reflect national and local goals as well as current performance and have been approved by the Board of Directors. In last year's *Quality Report*, we identified our three key local quality priorities for this fiscal year. These are listed below with detailed information on how we performed set out in this section of the *Quality Report*:

2.1.1 Patient experience: *improving the care and support for people with mental health needs;*

2.1.2 Patient Safety: *falls prevention; and,*

2.1.3 Clinical Effectiveness: *the management of sepsis.*

We also committed to reporting on a number of aspects of improvement work within the three domains of quality. Our progress and performance over the last year for the following quality goals is reported in **Part 3** of this report:

3.1 Patient experience:
- *Improving the quality of wound care for patients both in hospital and the community;*
- *Improving care for patients living with dementia*; and,
- *Privacy and dignity: promotion of a customer services culture.*

3.2 Patient safety:
- *Infection prevention and control;*
- *Improve the prevention, early identification and management of Acute Kidney Injury; and,*
- *Frail Elderly Care Pathway Team initiative (to identify frailty and enhance care planning between health and social care).*

3.3 Clinical effectiveness:
- *Airedale Digital Care Hub and the overall quality of healthcare for people with long-term conditions;*
- *The monitoring of Caesarean section rates through the optimisation of opportunities for physiological birth; and,*
- *Fractured neck of femur improvement project.*

Future priorities for 2020/21

1. **Patient experience:** *improving the care and support for people with mental health needs;*
2. **Patient Safety:** *falls prevention; and,*
3. **Clinical Effectiveness:** *management of sepsis.*

Other local quality improvement work identified for inclusion in the 2020/21 Quality Report is as follows:

3.1 Patient experience:
- *Improving mental health in children and adolescents*
- *Improving care for patients living with dementia*; and,
- *Privacy and dignity: promotion of a customer services culture.*

3.2 Patient safety:
- *Infection prevention and control;*
- *Improve the prevention, early identification and management of the deteriorating patient – to include Acute Kidney Injury – into a whole system of holistic care,*
- *Frail Elderly Care Pathway Team initiative (to identify frailty and enhance care planning between health and social care).*

3.3 Clinical effectiveness:
- *Airedale Digital Care Hub and the overall quality of healthcare for people with long-term conditions;*
- *The monitoring of Caesarean section rates through the optimisation of opportunities for physiological birth, including vaginal birth after Caesarean; and,*
- *Development of Briefing, Debriefing and the WHO checklist in interventional procedures.*

The above 2020/21 local quality improvement work is dependent upon the timeframe and capacity to return to business as usual post the COVID -19 pandemic.

It has been agreed that the following will no longer be reported upon in future *Quality Reports:*

- *Fractured neck of femur improvement project:* this initiative will continue to be progressed via the specialty and as part of wider Acute Provider Collaboration with benchmarked performance monitored through the National Hip Fracture Database.
- *Improving the quality of wound care for patients both in hospital and the community:* following the successful implementation of the 2017-19 national CQUIN, the re-configuration of SystmOne and the tracking of full holistic assessment in local developmental plans there is considered to be an established, integrated and individualised programme of management and treatment.

.

2.1.1 Priority 1 patient experience: improving the care and support for people with mental health needs

The challenge and our aim

According to QualityWatch[5], people with known mental ill health are five times more likely to be admitted to acute providers. Whilst the primary reason for someone attending our Emergency Department and using our services may be physical, it is clearly important that we ensure that we are equipped to detect urgent mental health needs and identify underlying mental health conditions.

Our latest CQC inspection report highlights concerns about the assessment and management of patients with mental health needs, particularly within the Emergency Department. Gaps in out of hours mental health liaison meant some patients who arrived in the night – via our Emergency Department and as an inpatient – were still waiting next morning. We identified that many of this patient group may benefit from assessment and review of care plans with specialist mental health staff and further interventions from mental health, social care and voluntary sector services. In order to successfully deliver effective care and treatment we therefore aim to improve partnership working and joint governance between commissioners, acute providers, mental health providers and other key local stakeholders.

How we monitor progress

Progress including outcome measures will be set out in a proposed collaborative mental health strategy currently under development with Bradford District Care NHS Foundation Trust. This work will build on existing partnership working - notably within the Emergency Department and described below – and will seek the views of the wider public, including service users and staff across acute and mental health sectors. Initially progress will be monitored via the Trust's Quality and Safety Committee and at a system wide level through the care co-ordination programme.

Current status

Anecdotally, we know that at a national level people with mental ill health make considerable use of the Emergency Department, often staying there for long periods due to lack of alternatives even though it is often not the best setting. In recent years the Trust has undertaken work to ensure that people presenting at our Emergency Department with mental health needs have these met more effectively through an improved, integrated service to reduce future attendances, as set out in the

[5] https://www.nuffieldtrust.org.uk/qualitywatch [accessed 31/09/19]

2017/19 Commissioning for Quality and Innovation (CQUIN scheme).

Working with Bradford District Care NHS Foundation Trust, the ambulance and police services, alcohol and substance misuse services, the voluntary sector and primary care, we have improved our knowledge (via data capture and coding), communication and care pathways for people with mental ill health. Over the previous two fiscal years the Emergency Department was able to demonstrate progress in key milestones, including:

- Reducing attendances of a selected cohort of frequent attenders to Emergency Department (that benefitted from mental health and psychosocial interventions):
  - above 20 per cent reduction for the 2017/18 cohort;
  - above 40 percent reduction for the 2018/19 cohort;
- Reduction in all Emergency Department attendances of people with a primary mental health diagnosis of above 20 per cent in 2018/19.

Although the CQUIN is now complete, we continue to build on and embed this multi-disciplinary initiative within the Emergency Department and the wider hospital through a focus on attendance and admission avoidance.

We completed the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) *Treat as One* dedicated audit tool, a review of the quality of mental health and physical health care for patients aged 18 years or older with a significant mental disorder who are admitted to acute care has been undertaken (sample 50 patients). The objective was to take a critical look at areas where the care of patients might be improved. Findings highlighted improved documentation, notably around mental health liaison assessment; mental capacity assessments; and, clinical coding. There was clear demonstrable progress in medication reconciliation within the first 24 hours of admission. In the two standards where compliance was below 50 per cent –

- Liaison psychiatry review documented plans; and,
- Inclusion of mental healthcare in step-up/down documentation

– interpretation was hindered by a limited subset sample size. Recommendations include review of responses "*not documented*" and/or *"not known"* to identify any possible nascent themes. Outcomes have been shared with clinical groups, commissioners and partners working in mental health. We have continued to build on this and it is supporting our work with Bradford District Care NHS Foundation Trust to develop a pathway of assessment and care.

Initiatives and progress in 2019/20

In response to the CQC inspection findings, work has commenced with Bradford District Care NHS Foundation Trust to develop a policy for *The Treatment of Patients with Mental Health Disorder in an Acute Hospital Setting* as part of the wider mental health strategy. This includes standards, protocols and escalation processes based on best practice as defined in NCEPOD's *Treat as One* with its emphasis on bridging the gap between mental and physical healthcare in general hospitals. This work involves the review and update of the service level agreement between providers to ensure the needs of vulnerable patients such as those with learning disabilities and/or living with dementia are fully addressed.

National level results from the 126 participating providers in the *CQC Maternity Survey 2019* indicate that a significant proportion of women felt the quality of information provided about mental health could be improved. Local results reported on the experience of the 111 women – response rate 37 per cent comparable with the national rate – using our services in February 2018.

- Of the 98 respondents to the question, *"During your antenatal check-ups did your midwife ask you about your mental health?"* Airedale scored 8.1. The higher

the score the better. Results are about the same as other providers.

- Of the 99 respondents to the question, *"Did a midwife or health visitor ask you about your mental health?"* Airedale scored 9.2 out of a possible score of ten. Results are about the same as other providers.
- Of the 89 respondents to the question, *"Were you given information about any changes you might experience to your mental health after having your baby?"* Airedale scored 7.1. Results are about the same as other providers.
- Of the 91 respondents to the question, *"Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?"* Airedale scored 7.7. Results are about the same as other providers.

The Trust's Maternity Service is part of the Maternity Voices Partnership Group, set up to support the voices of service users to be heard and shape future services. Survey feedback is used to inform discussion around current and future service provision. How other patient survey intelligence can be effectively used to inform, monitor and benchmark progress across services is under consideration.

Other work:

- Monitoring of the completion of an initial risk assessment for those attending Emergency Department with a mental health presentation has been implemented. Ensuing actions include revised documentation to facilitate this process.
- Initiatives to increase staff attendance at *Mental Health Act* training within the Trust are ongoing for example through alternative routes of delivery, including an advisor.
- The Emergency Department Mental Health Assessment Room has been evaluated against current recommendations and work is ongoing with AGH Solutions to ensure full compliance against the established standards.

Next steps

- Set out key milestones and outcomes for achievement as part of the *Quality and Safety Strategy 2020-22*;
- Develop a shared *Mental Health Pathway* between ourselves and Bradford District Care NHS Foundation Trust;
- Contribute to the system-wide Quality Committee's priority for Mental Health with the emphasis upon Child and Adolescent Mental Health (CAHMS) by participating in their programme of development;
- Review and revise the *Mental Health Act* training with Bradford District care Trust NHS Foundation Trust to ensure it meets the needs of acute staff; and,
- Monitor compliance with established standards for the Emergency Department Mental Health Assessment Room.

2.1.2 Priority 2 patient safety: falls prevention

The challenge and our aim

Falls are a cause of injury, pain, distress, delay in discharge and loss of independent living. Evidence suggests that the effect is particularly compounded for people over the age of 65.[6] The effective management to reduce the number of falls sustained by our inpatients is therefore an important high priority. Current research indicates three key actions as part of a comprehensive multi-disciplinary falls intervention can result in fewer falls and reduce hospital length of stay:

1. Documentation of lying and standing blood pressure;
2. No hypnotics or anxiolytics to be given during stay (or rationale documented); and,
3. Mobility assessment and walking aid to be provided if required.

Working with the Improvement Academy and NHS Improvement and using core safety improvement principles, the Trust aims to achieve 80 per cent of older patients (over 65 years) receiving key falls prevention actions.

How we monitor progress

The three high impact actions to prevent hospital falls are measured and reported through the 2019/20 falls prevention CQUIN scheme. Key interventions and milestones, including the adoption and delivery of the National Institute for Health and Clinical Excellence (NICE) guidance, are monitored by a multi-disciplinary Trust's Falls Steering Group; these actions require nursing, pharmacy, physiotherapy and medical input. The Trust is an active member of the district-wide Falls Pathway Development Group with local representation to take into account the views of wider public as well as staff.

Current status

Based on case note review of a minimum of 100 patient case notes each quarter aggregated results are indicated below. Areas sampled were the Acute Admissions Unit and Wards 4, 6 and the Intermediate Care Unit. These are clinical areas most likely to care for patients who fulfil the inclusion criteria. The target threshold for achievement is 80 per cent.

Table 1: High impact actions to prevent hospital falls – available results 2019/20

	QTR1 compliance [sample 123]	**QTR2 compliance [sample 101]**
Q1. Lying and standing blood pressure recorded?	67%	52%
Q2. Hypnotics, antipsychotics or anxiolytics given during hospital stay	12%	10%
If yes to Q2, was a clear rationale recorded?	100%	100%
Q3. Mobility assessment documented within 24 hours of admission?	100%	90%

[6] Department of Health (2009) Falls and Fractures: effective interventions in health and social care. Crown copyright: COI for DH.

	QTR1 compliance [sample 123]	QTR2 compliance [sample 101]
Was a walking aid required?	72%	78%
If walking aid required, was this provided within 24 hours of admission?	100%	86%

Data source: Clinical Audit Airedale NHS Trust– national CQUIN submission

The Trust participated in the 2018 Royal College of Physicians' *National Falls and Fragility Audit* which has a particular focus on inpatient falls resulting in fracture neck of femur in the period January to June 2019 (four inpatients sustained such a fracture in this period). The Trust also registered for the second phased of this audit for the period July 2019 to January 2019. It is hoped findings will be available before the end of the next fiscal year.

A sign of a strong safety culture is a reduction in the number of incidents resulting in harm such as fracture. Between April 2019 and March 2020 there were 17 falls across services which resulted in fracture compared to 25 in the preceding fiscal year. To ensure we maximise learning from those falls resulting in significant harm a new tool (FRESH) has been introduced.

Initiatives and progress in 2019/20

- Replacement of falls risk screening tool (Bart's tool) with a multi-factorial and multi-disciplinary falls assessment for all patients over 65 years old that is also applicable to patients aged 50 to 64 with an underlying condition likely to put them at risk of falling. The 2018 CQC inspection highlighted that this demographic is not consistently considered.
- Access to the most appropriate type of walking aids seven days a week. The Frail Elderly Pathway Team is working with the Emergency Department and Acute Assessment Unit (AAU) to ensure staff have the competency to measure patients for walking aides.
- In collaboration with the Yorkshire and Humber Improvement Academy, the Trust is embedding the fall safety briefing (known as a safety huddle). The Academy visited Ward 4, Ward 6, the Intermediate Care Unit and Acute Assessment Unit in January 2019. A cluster of falls with harm on the Acute Assessment Unit resulted in the initiation of twice daily safety huddles. Follow up visits in July and December 2019 focused on the remaining wards and departments. Led by a senior clinician, the objective is to identify those patients at high risk of falling and thereby determine how to prevent such a fall. Data is collated to support monitoring and surveillance. Work to sustain progress is being further supported by an initiative to measure the days between falls. This is a cultural shift away from accepting inpatient falls as "*normal*" and forms part of a proactive approach to prevention.
- Further areas where developmental actions have been taken are around frailty and dementia, including continence care planning and the management and assessment of delirium.

Other initiatives:

- Delivery was taken in July 2019 of 330 new electronic beds to replace broken and faulty stock and support fall reduction efforts.
- Quality improvement work through collaboration with the Enhanced Care Improvement Collaborative and district wide colleagues. This is an NHS Improvement-led programme which focuses on improving the experience of patients who need enhanced supervision, as well as the experience of their carers and staff providing care. For example, increasing the number of activities for patients.

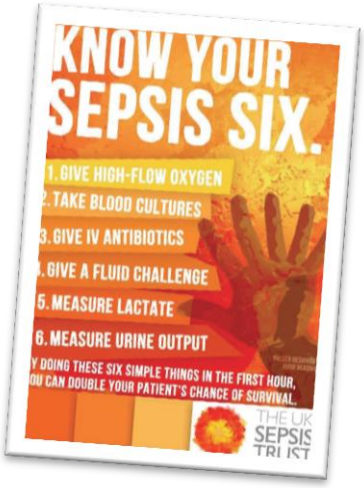
- In the last year a series of active ageing events hosted by the Airedale, Wharfedale and Craven clinical commissioning group have been aimed at older people with information about falls prevention.

Next steps

- Progress and learning from the falls prevention CQUIN;
- Evaluation of the FRESH reporting tool;
- Review of the twice daily safety huddles in relation to wider adoption across the Trust;
- Relaunch of the Falls Steering Group to give more operational focus and continued collaboration with the work of the Yorkshire and Humber Improvement Academy; and,
- Implementation of recommendations from the 2018 Royal College of Physicians' *National Falls Audit.*

2.1.3 Priority 3 clinical effectiveness: management of sepsis

The challenge and our aim



Sepsis is a common and potentially life-threatening condition where the body's immune system overacts to an infection. Affecting all age groups, sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 35,000 deaths attributed to sepsis annually.[7] Reports by the Parliamentary and Health Service Ombudsman have highlighted problems in the detection and treatment of sepsis. [8] Sepsis is a key national priority. Whilst there has not been any local patient engagement as such, patients have fed into the national toolkit and staff have participated in the Healthcare Quality Improvement Partnership as part of the Clinical Outcome Review Programme's *Sepsis Study*.

The Trust seeks to embed identification and treatment of sepsis in line with national guidance.

How we monitor progress

Progress is measured and reported through the NHS standard contract. Key actions and milestones are monitored by the Clinical Groups and reported at the Integrated Performance Review meeting and to the Quality and Safety Committee.

Current Status

A range of actions are recommended for rapid implementation when a patient presents with sepsis known as the Sepsis Six Bundle. The UK Sepsis Trust and others have developed the concept of the 'Sepsis Six' – a set of six tasks including oxygen, cultures, antibiotics, fluids, lactate measurement and urine output monitoring – to be instituted within one hour by non-specialist practitioners at the front line.[9] It is the prompt administration of antibiotics which is regarded as the most crucial action in the prevention of morbidity and mortality. The Trust has adopted tools for the screening and initial management of sepsis and continues to monitor compliance originally initiated by the 2017/19 CQUIN:

1. Screening for sepsis (Emergency Department and hospital inpatients) – adults and children.
2. Administration of antibiotics (Emergency Department and hospital inpatients) – within one hour.

Electronic observations are now in place across the trust apart from in the Emergency Department (under development as part of electronic triage [e-triage]). This scores patients on the nationwide recommended NEWS2 early warning score. Screening of sepsis continues for those patients who score five or above in their early warning score. Patients deemed septic are targeted for antibiotic administration within one hour, commencing at the time a diagnosis of sepsis by a clinical decision maker.

---

[7] Royal College of Physicians (2014) Acute Care Toolkit 9: Sepsis https://www.rcplondon.ac.uk/sites/default/files/acute_care_toolkit_9_sepsis.pdf. [Accessed 23/10/18]

[8] Parliamentary and Health Service Ombudsman, *Time to Act. Severe sepsis: rapid diagnosis and treatment saves lives sepsis.* Available at: https://www.ombudsman.org.uk/publications/time-act-severe-sepsis-rapid-diagnosis-and-treatment-saves-lives-0 [Accessed 23/10/18]

[9] http://www.survivingsepsis.org/bundles/Pages/default.aspx [Accessed 23/10/18]

The CQUIN data for last previous fiscal year gave a 75 per cent average for screening of patients in the Emergency Department and 69 per cent for adult inpatients. There was some fluctuation but generally the percentages were similar throughout the year. For time to antibiotics the averages were 80 per cent for the Emergency Department and 69 per cent for adult inpatients. Although there is scope for further improvement, there is indication of progress: for example, time to antibiotics was 55 per cent in the first quarter of 2018/19 and 76 per cent in the final quarter for adult inpatients.

There have been some positive signs regarding this current year's data from the Emergency Department:

- For screening 100 per cent of patients were screened.
- For antibiotic administration the percentage getting their antibiotics within one hour was 97 per cent.

Inpatient delivery of antibiotics improved in the year from 55 per cent within one hour in the first quarter to 73 per cent at quarter three.

Initiatives in 2019/20 to achieve progress

- An e-Observation system has been developed for inpatients. An automatic flag for sepsis review will eventually be part of this system for those patients with NEWS2 at five or above. We are hopeful this will improve timely recognition and management of the deteriorating patient. Currently (to allow the system to embed fully and be tested) nursing staff escalate via phone/bleep as has been usual practice. The e-Observation Team is pushing for escalations to be normal practice as soon as possible.
- Ongoing development of the Emergency Department e-triage system as part of a phased electronic patient record. Sepsis screening has been built into this model.
- Embedding of Sepsis Champions across Trust through nurse educators. Other providers have "sepsis nurses'" who both collect data and educate staff. This work is further supported by ongoing education and training initiatives to improve identification of septic patients on wards.
- General sepsis management is continually reviewed within the Mortality Review Group. The Mortality Group feedback where they feel there has been evidence of good practice and/or areas of concern. Previously there has also been a dedicated Sepsis Themed Mortality Review where a number of sepsis associated deaths are reviewed. The mortality group has been asked to run this again.
- As a trust our Standardised Hospital Mortality Index data shows that we are below expected numbers of deaths for Pneumonia, Septic Shock and Urinary Tract Infections.
- Scoping the potential for Patient Group Direction to enable the Outreach Team to administer an immediate dose of antibiotics.
- In addition to the above, the CQC tasked the Trust with ensuring the paediatric sepsis pathway documentation – introduced in 2017 – is initiated and completed. Sepsis screening tool documentation is in place and compliance with completion is part of ongoing audit monitoring.

Next steps

- There has been progress in the identification and management of sepsis within the organisation. It is anticipated that the ongoing implementation of e-Observations will further improve the recognition and escalation of the sick or deteriorating patient and provide more timely and responsive monitoring.
- There are a number of e-learning modules from the Sepsis Trust available for e-learning. It is being considered whether these should be part of mandatory training for all staff.
- We have been approached by a volunteer from the Sepsis Trust who is keen to help

create a post-Sepsis Support Group for local patients. These have been developed in other areas of the country and proved very valuable. The volunteer is keen to offer services in terms of raising the publicity of Sepsis and helping with education for staff into its management.

2.2 Statements of assurance from the Board of Directors

The following statements serve to offer assurance that the Trust is measuring clinical outcomes and performance, is involved in national projects aimed at improving quality and is performing to essential standards.

2.2.1 Review of services

During 2019/20 Airedale NHS Foundation Trust provided and/or sub-contracted 79 relevant health services [as per NHS Improvement's Provider License].

The Airedale NHS Foundation Trust has reviewed all the data available to them on the quality of care in79 of these relevant health services.

The income generated by the relevant health services reviewed in 2019/20 represents 89 per cent of the total income generated from the provision of relevant health services by the Airedale NHS Foundation Trust for 2019/20.

2.2.2 Participation in clinical audits and national confidential enquiries

Clinical audit measures the quality of care and services against agreed national and local standards and recommends improvements where necessary. National confidential enquiries into patient outcomes and death are conducted by specialists with the aim of improving patient care and safety.

During 2019/20, 49 national clinical audits and 5 national confidential enquiries covered relevant health services that Airedale NHS Foundation Trust provides.

During that period Airedale NHS Foundation Trust participated in 92 per cent of national clinical audits and 100 per cent of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Airedale NHS Foundation Trust was eligible to participate in during 2019/20 are as follows: see tables 3 and 4.

The national clinical audits and national confidential enquiries that Airedale NHS Foundation Trust participated in during 2019/20 are as follows: see tables 3 and 4.

The national clinical audits and national confidential enquiries that Airedale NHS Foundation Trust participated in, and for which data collection was completed during 2019/20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 2: National clinical audits undertaken by Airedale NHS Foundation Trust

Ref	Title	Eligible	Participation	Per cent eligible patients submitted
01	Assessing Cognitive Impairment in Older People / Care in Emergency Departments	✓	✓	66 cases
02	BAUS Urology Audits: Cystectomy	×	N/A	N/A
03	BAUS Urology Audits: Female Stress Urinary Incontinence	✓	✓	*
04	BAUS Urology Audits: Nephrectomy	✓	✓	*
05	BAUS Urology Audits: Percutaneous Nephrolithotomy	✓	✓	*
06	BAUS Urology Audits: Radical Prostatectomy	×	N/A	N/A
07	Care of Children in Emergency Departments	✓	✓	130 cases
08	Case Mix Programme (CMP)	✓	✓	100
10a	Elective Surgery (National PROMs Programme) - Hip Replacement	✓	✓	81.3
10b	Elective Surgery (National PROMs Programme)- Knee Replacement	✓	✓	81
11	Endocrine and Thyroid National Audit	✓	✓	100
12a	Falls and Fragility Fractures Audit Programme (FFFAP) - National Hip Fracture Database	✓	✓	100
12b	Falls and Fragility Fractures Audit Programme (FFFAP) - Fracture Liaison Service Database	✓	✓	100*
12c	Falls and Fragility Fractures Audit Programme (FFFAP) – Inpatient Falls	✓	✓	100
13a	Inflammatory Bowel Disease (IBD)	✓	×	N/A
13b	National Bowel Cancer Audit (NBOCA)	✓	✓	100
14	Major Trauma Audit (TARN)	✓	✓	75*
15	Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	✓	✓	100
18	Mental Health - Care in Emergency Departments	✓	✓	120 cases
19	Mental Health Care Pathway - CYP Urgent & Emergency Mental Health Care and Intensive	×	N/A	N/A
21	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	✓	✓	*
22	National Audit of Breast Cancer in Older Patients (NBACOP)	✓	✓	100
23	National Audit of Cardiac Rehabilitation (NACR)	×	N/A	N/A
24	National Audit of Care at the End of Life (NACEL)	✓	✓	100
25	National Audit of Dementia (Care in general hospitals)	✓	×	N/A
26	National Audit of Pulmonary Hypertension National Outcomes and Tertiary Care (specialist centres)	×	N/A	N/A
27	National Audit of Seizure Management in Hospitals (NASH3)	✓	×	N/A

Ref	Title	Eligible	Participation	Per cent eligible patients submitted
28	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	✓	✓	100
29	National Bariatric Surgery Registry (NBSR)	×	N/A	N/A
30	National Cardiac Arrest Audit (NCAA)	✓	✓	100
31a	Adult Cardiac Surgery	×	N/A	N/A
31a	National Heart Failure Audit	✓	✓	100
31b	Cardiac Rhythm Management (CRM)	✓	✓	100
31c	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	✓	100
31d	Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	×	N/A	N/A
31e	Congenital Heart Disease (CHD) Adult	×	N/A	N/A
32	National Clinical Audit of Anxiety and Depression	×	N/A	N/A
33	National Clinical Audit of Psychosis	×	N/A	N/A
34a	National Diabetes Audit - Adults National Core	✓	×	N/A
34b	National Diabetes Audit - Adults National Footcare Audit	✓	✓	100
34c	National Diabetes Audit - Adults National Inpatient Audit	✓	✓	100
34d	National Diabetes Audit - Adults National Pregnancy in Diabetes Audit	✓	✓	100
35	National Early Inflammatory Arthritis Audit (NEIAA)	✓	✓	*
36	National Emergency Laparotomy Audit (NELA)	✓	✓	100
37	National Gastro-intestinal Cancer Programme: Oesophago-gastric Cancer (NAOGC)	✓	✓	100
38	National Joint Registry (NJR) Knee Replacement & Hip Replacement	✓	✓	100
39	National Lung Cancer Audit (NLCA)	✓	✓	100
40	National Maternity and Perinatal Audit (NMPA)	✓	✓	100
41	National Neonatal Audit Programme- Neonatal Intensive and Special Care (NNAP)	✓	✓	*
42	National Ophthalmology Audit (NOD)	✓	✓	100
43	National Paediatric Diabetes Audit (NPDA)	✓	✓	100
44	National Prostate Cancer Audit	✓	✓	100
45	National Smoking Cessation Audit	✓	✓	100
46	National Vascular Registry	×	N/A	N/A
47	Neurosurgical National Audit Programme	×	N/A	N/A
48	Paediatric Intensive Care Audit Network (PICANet)	×	N/A	N/A

Ref	Title	Eligible	Participation	Per cent eligible patients submitted
49	Perioperative Quality Improvement Programme (PQIP)	✓	✓	*
50	Prescribing Observatory for Mental Health (POMH-UK)	×	N/A	N/A
51	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	✓	✓	*
52	Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	100
53	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	✓	✓	100
54	Society for Acute Medicine's Benchmarking Audit (SAMBA)	✓	✓	100
55	Surgical Site Infection Surveillance Service	✓	✓	100
56	UK Cystic Fibrosis Registry	×	N/A	N/A
57	UK Parkinson's Audit	✓	✓	100*

Exceptions/Comments:

01, 07 and 18: a local decision was taken to collect and submit sufficient data necessary to understand how to improve services.
08. All relevant patients have been entered onto the database; there is currently a three month backlog with regard to clinical data updates.
10a and 10b: responses are received directly from patients. All patients are offered the opportunity to participate, but not everyone chooses to do so.
12b. The Fracture Liaison Service commenced in October 2019 with 100 per cent submissions being achieved since initiation.
13. The Registry has a subscription fee; finances have not been allocated.
14. 100 per cent submissions were achieved between July and September 2019 following on from the 40 per cent achieved in the period April to June 2019. There are a number of reasons for the backlog and this has been added to the Risk Register. TARN support is to be reviewed with a view to increasing hours/personnel.
25. This was a short 'spotlight' audit; the Trust did not participate.
27. The Trust did not participate in this audit.
34a. Data was collated, but regrettably the deadline was missed owing to a change in the hosting platform.
38. The cases not fully completed are those which are awaiting component details from the National Joint Registry.
49. Data submission as required by the PQIP team. The speciality is unable to recruit all the patients coming for surgery due to the variable work patterns of the team members.
57. 100 per cent submissions for Elderly Medicine. However, numbers were not sufficient to be included in national analysis.

*Where final submission deadlines have not yet passed, the Trust can confirm that data submissions are up to date and a robust system is in place to ensure that all relevant cases are submitted. Submission percentages marked with an * are those where we have been unable to verify the current submission status owing to covid-19 demands on clinical leads.*

Table 3: National Confidential Enquiries (NCEPOD) undertaken by Airedale NHS Foundation Trust

Ref	Title	Eligible	Participation	Per cent eligible patients submitted
17a	Out of Hospital Cardiac Arrests (Medical & Surgical Clinical Outcome Review Programme [NCEPOD])	✓	✓	100
17b	Acute Bowel Obstruction (Medical & Surgical Clinical Outcome Review Programme [NCEPOD])	✓	✓	100
17c	Dysphagia in People with Parkinson's Disease (Medical & Surgical Clinical Outcome Review Programme [NCEPOD])	✓	✓	100
17d	Long Term Ventilation (Medical & Surgical Clinical Outcome Review Programme [NCEPOD])	×	×	N/A
16	Maternal, Newborn and Infant Clinical Outcome Review Programme	✓	✓	100
9	Child Health Clinical Outcome Review Programme	✓	N/A No new studies	N/A
20	Mental Health Clinical Outcome Review Programme	×	×	N/A

Data source: Airedale NHS Foundation Trust Clinical Audit Department.

The reports of 48 national clinical audits were reviewed by the provider in 2019/20 and Airedale NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

The following is a sample selected to reflect the range of Trust services and not included elsewhere in this report. Those selected are regarded as key in the CQC inspection programme and its review of healthcare intelligence:

National Maternal and Perinatal Audit (NMPA)

Aim: The National Maternity and Perinatal Audit (NMPA) aims to improve the treatment of mothers and babies during their stay in a maternity unit by evaluating a range of care processes and outcomes in order to identify good practice and areas for improvement.

Key successes:

- Whilst the NMPA indicates higher than expected third and fourth degree tears in 2016/17, more recent analysis shows an improved rate for both assisted and unassisted deliveries and a return in line with the Yorkshire and Humber average.
- Improved scrutiny around key quality indicators including "heavy" post-partum haemorrhage and Apgar scores in support of understanding, comparison and improvement.
- Joint collaboration with Bradford University and neighbouring provider on the management of third degree tears.

Key issues:

- Data quality – since 2016/17 (when the audit took place) the service switched to SystmOne to collect its healthcare intelligence and continues to improve the reliability of its data.

Intensive Care and National Audit Research Centre (ICNARC)

Aim: Through ongoing participation in the national clinical audit of care for critically ill patients, information is provided that can help improve the standard of our care.

Key successes:

- The proportion of non-delayed, out-of-hours discharges to a ward is within the expected range (previously lower than expected).

Key issues:

- Whilst the Trust continues to collect, due to Covid-19 planning a backlog in clinical data is highlighted. data to the West Yorkshire Adult Critical Care Operational Delivery Network Data quality – since 2016/17 (when the audit took place) the service

Sentinel Stroke National Audit Programme (SSNAP)

Aim: The overall aim of SSNAP is to provide timely information on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients. SSNAP measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence based standards, including the 2016 National Clinical Guideline for Stroke.

Key successes:

- Joint working with Bradford Teaching Hospital NHS Foundation Trust and commissioners to delivers acute and rehabilitation phases.
- A dedicated SSNAP data analyst means we are now better able to understand potential shortfalls in the service pathway.

Key issues:

- The latest SSNAP results show a slight reduction in the Trust's banding around access to a specialist stroke unit, specialist assessment and thrombolysis.
- Workforce continues to be a priority particularly in relation to the recruitment and retention of speech and language therapy.

National Emergency Laparotomy Audit (NELA)

Aim: Through the provision of high quality comparative data from all providers of emergency laparotomy, NELA aims to enable

the improvement of the quality of care for patients undergoing emergency laparotomy.

Key successes:

- 91.5 per cent of patients had their operative risk documented pre-operatively;
- 97.6 per cent input by a consultant surgeon and anaesthetist when the risk of death was greater than five percent;
- 88.2 per cent input by a consultant intensivist when risk of death was greater than five percent;
- Consultant anaesthetist present in theatre 90 per cent of the time when the risk of death greater than five percent;
- 88 per cent of patients were admitted to Critical Care when the risk of death was greater than five per cent; and,
- 100 per cent admission to Critical Care when risk of death was greater than 10 per cent.

Key issues:

- 11 per cent of patients over 70 years were assessed by an Elderly Medicine specialist and whilst this is similar to the majority of providers nationally, the Trust has implemented an action plan to seek to improve this return.

National Care at the End of Life Audit

Aim: The *National Care at the End of Life* audit reviews how people's preferences regarding care at the end of life are identified, discussed and implemented during their last admission in acute and community hospitals. The audit focuses on organisational issues, a case note review and a survey of relatives of patients who died whilst in hospital.

Key successes:

- Availability of specialist palliative care support face to face, seven days a week and around the clock consultant advice.
- Written guidance for symptom control in last days of life.
- Frequent examples of excellent practice highlighted by auditors and fewer numbers of complaints relating to end of life compare to national figures.
- Instigation of Schwartz rounds.

Key issues:

- Project to improve care for relatives underway, looking at before and after death of patient.
- Survey planned to determine staff training needs and how this can be effectively delivered.
- Review to improve care plan for last days of life.

National Lung Cancer Audit (NCLA)

Aim: The NLCA was developed in response to the finding in the late 1990s that outcomes for lung cancer patients in the UK lagged behind those in other westernised countries and varied between providers.

Key successes:

- Data quality is robust comparing well across the Yorkshire region.
- The one year survival rate is above the national average with active, radical and systemic treatment rates aligned or better than.

Key issues:

- A local action plan is being compiled to understand histological and surgical rates which remain low albeit not statistically.
- Review of best practice standards of care, gap analysis of the National Optimal Lung Pathway and other relevant healthcare intelligence will be included in local actions.

The reports of 88 local clinical audits were reviewed by the provider in 2019/20 and Airedale NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

The following is a sample selected to reflect the range of Trust services, including pathways of care and healthcare professions. Further actions planned and undertaken in response to audit findings are detailed in the Trust's annual *Clinical Audit Report*.

Pre-operative fasting times following implementation of a new *Fasting Policy*

Aim: To ascertain whether the new *Fasting Policy* introduced in January 2018 has reduced length of time patients fast for fluid before surgery. Emerging evidence has

revealed that prolonged fasting can result in negative outcomes and delayed recovery.

Key successes:
- More than 90 per cent of patients were found to take water as part of the *"sip until we send*" policy.
- Work selected for presentation at the British Society of Day Surgery and received a local Pride of Airedale instant award.

Key issues:
- Whilst fewer patients complained of thirst than in a previous patient satisfaction survey, it was felt this could be improved.
- Ambiguity in the phrasing of questions meant there was not a definite time from last drink to theatre.

Paediatric febrile neutropenia

Aim: To investigate our management of febrile neutropenia and specifically adherence with our guideline – intravenous antibiotics are commenced within one hour for any child presenting with a temperature or who appears unwell with a possible infection.

Key issues:
- Highlighted the need to start intravenous antibiotics sooner and not wait for blood results.

Action taken:
The nursing staff has had additional training around this.

Hip fracture rehabilitation in the first three weeks following fractured neck of femur

Aim: To evaluate whether patients meet the national guidelines of two hours of daily physiotherapy in the first seven days post-surgery and two hours subsequently until the patient achieves their individual goals.

Key successes:
- All patients were assessed by a physiotherapist within 24 hours post-surgery.
- 80 per cent of patients received three types of rehabilitation as described in the standards.
- Those patients discharged within the first week following surgery continued to receive rehabilitation at home.

Key issues:
- Patients not medically optimised to post-surgery to allow engagement in physiotherapy rehabilitation.
- Insufficient therapy capacity to provide recommended level of rehabilitation. Full seven day service not available; for example, there is no occupational therapist service at weekends. Further analysis has been undertaken to understand the effect of a reduced service at weekends as compared to weekdays.

***"Stop before you block"* safety initiative for upper and lower limb Orthopaedic surgeries**

Aim: "*Stop before you block*" is a Royal College of Anaesthesia campaign which aims to reduce the incidence of inadvertent wrong - sided nerve block during regional anaesthesia. The objectives of the audit were:
- To assess compliance with the initiative;
- Identify factors that potentially prevent full compliance; and,
- Evalutate the documentation of peripheral nerve blocks undertaken in Theatres.

Key successes:
- Of the sample (33 patients), 29 had the *"Stop before you block"* documented.

Key issues:
- Documentation was not correctly completed in eight cases.
- Reasons for poor documentation or not performing the *"Stop before you block"* included: delays in check of the patient, locums unaware of the requirement, distractions in the room, difficulties communicating with the patient and positioning of the patient prior to the block. In response an education programme for locums has been undertaken, alongside an initiative to encourage staff to speak out where a check has been overlooked.

Elderly Medicine – At the time of discharge how well are we documenting a patient's diagnosis of delirium to inform their GP in primary care?

Aim: A diagnosis of delirium increases the risk morbidity and mortality. According to NICE guidance, a diagnosis of delirium should be documented in the hospital and primary care record. Where an episode of delirium was suspected, the audit assessed the accuracy/completeness of documentation (letter) at time of discharge.

Key issues:

- Of the 20 patients audited, nine were diagnosed with delirium during their admission. Five of these did not have the diagnosis included in the discharge documentation (for the primary care record).
- Zero patients were diagnosed with delirium using a validated screening tool such as the 4-AT recommended by NICE.

Action taken:

- Education programme undertaken to highlight the importance and significance of including a delirium diagnosis on discharge documentation.
- Consideration of inclusion 4-AT assessment tool in the Acute Assessment Unit's clerking proforma.

Advanced Clinical Practitioner record keeping

Aim: The maintenance of accurate and clear medical records ensures that a patient's assessed needs are met comprehensively. The purpose of the audit was to evaluate quality of record keeping undertaken by Advanced Clinical Practitioners.

Key successes:

- Full compliance for the following: date and time; name signed and printed for all entries; relevant patient history including medication and social.
- Discharge documentation letter was correctly written with clear communication to patients and GPs.
- Most Advanced Clinical Practitioners scored above 94 per cent with only two scoring under 90 per cent.

Key issues:

- The findings from the audit have been fed back to the Advanced Clinical Practitioners Team and the Medical Team to maximise learning as the audit highlighted some areas of shortfall amongst individuals and within other staffing group documentation.

Compliance of inpatients prescribed oral nutritional supplements (ONS)

Aim: To identify whether patients on the Elderly Ward and the Intermediate Care Unit are receiving the correct ONS and determine if the recommended dose has been consumed.

Key successes:

- Identification of factors that are contributing to non-compliance of prescribed ONS, for example, the flavour, timing with mealtimes.
- Findings showed consumption of Fortijuice as higher compared to other supplements confirming its continued use within the inpatient cohort.

Key issues:

Of the sample and against a 90 per cent achievement threshold, the audit found 88 per cent of patients received the correct prescribed ONS and 66 per cent consumed the recommended prescribed amount. Variation in compliance between the Intermediate Care Ward and the Elderly Ward was found. Findings suggest that although nutrition is an important aspect of clinical care, it may not be regarded as a priority in the clinical setting.

Action taken:

- Initiative to improve staff and patient awareness around the importance and potential benefits of ONS;
- Improve the range of flavours available to patients to boost compliance; and,
- Discuss results with Nutricia representative and recommend re-design of packaging to make it easier to quantify consumption.

Diabetes Specialist Nurses' Weekend Service

Aim: To investigate whether inpatients experiencing problems due to their diabetes receive specialist nursing care at weekends and that their length of stay is minimised as recommended by NHS England and NHS Improvement.

Key successes:

- All 63 (100 per cent) of inpatients referred to the service were reviewed by the Diabetes Specialist Nurse on the same day as the referral. Following review 22 per cent (14) of patients were discharged on the day they were seen (Saturday or Sunday) and deemed fit for diabetic discharge.
- Reduction in length of stay and improved efficiency: a total of 24 days were estimated saved as a result of the 14 inpatient weekend discharges.
- Improved the patient care, treatment and experience. Positive feedback from clinical staff suggested enhanced job satisfaction.

Action taken:

- An enhanced Diabetes Specialist Nurses' Weekend Service is planned.

2.2.3 Participation in clinical research

Research is a core part of the NHS, enabling it to improve the current and future health of the people it serves. The people who do research are mostly the same doctors and other health professionals who treat our patients. A clinical trial is a particular type of research that tests one treatment against another.

The number of patients receiving relevant health services provided or sub-contracted by Airedale NHS Foundation Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 700.

Airedale NHS Foundation Trust was involved in conducting 66 clinical research studies across all specialties during 2019/20 of which 55 were on the National Portfolio. A further 67 studies are still in various stages of follow-up. During 2019/20 Airedale has achieved all National Institute for Health Research high level objectives for performance in initiating and delivering research and for reaching patient recruitment targets.

There were 48 senior clinical staff actively participating in research approved by a research ethics committee at Airedale NHS Foundation Trust during 2019/20, participating in research across 19 clinical specialties. The Trust has been committed to expanding research into new specialties to improve the quality of care and outcomes for our patients. The primary motivation for conducting research within the Trust is for the advancement of knowledge and promotion of evidence-based practice within clinical care. We aim to offer every patient the opportunity to take part in a clinical trial. This is reflected in the number of research studies undertaken during 2019/20.

In the last three years, Airedale has been formally acknowledged as a contributor to studies reported in 24 publications due to our involvement in National Institute for Health Research portfolio studies. This demonstrates our commitment and desire to improve patient outcomes and experience across the NHS. In addition to this, a further 24 papers arising from academic and own account research have been published in peer reviewed journals since April 2017.

Our engagement in clinical research demonstrates the commitment of Airedale NHS Foundation Trust to improving the quality of care offered to our patients and to making our contribution to wider health improvement leading to better outcomes for patients.

The following illustrates how research taking place locally has produced new evidence with the potential to affect understanding and change clinical practice.

PERSEPHONE breast cancer study [10]

Introduction

The PERSEPHONE trial, a £2.5 million study of over 4,000 women funded by the UK National Institute for Health Research and Cancer Research UK, is the largest trial of its kind, examining the impact of shortening the duration of Herceptin treatment.

Herceptin has been a major breakthrough for the women with breast cancers that carry the HER2 receptor on the surface of the cancer cells. Around 15 out of every 100 women with early breast cancers have HER2 positive disease. Based on clinical research a 12 month treatment course has been adopted. However, a further clinical study suggested a shorter duration could be as effective, but with fewer side effects and costs.

Methods

Between 2007 and 2015 across 152 participating sites, around half of participants were assigned to 12 month Herceptin treatment and half to six month treatment. A four year follow up of patient outcomes were analysed.

Results

The results of the PERSEPHONE trial indicate that taking Herceptin for six months is as effective as 12 months for many women. Only four per cent of women in the six month arm ceased taking the drug prematurely due to heart problems compared to eight per cent in the 12 month arm.

Conclusions

Women at similar risk of recurrence as to those included in the trial have the potential to avoid unnecessary side effects of longer treatment without losing any benefit. In turn, this has a cost saving for the NHS and may prompt studies for other conditions where the optimum duration of treatment is not known.

[10] H.M Earl, L. Hiller, AL Vallier et al., (2019) Six versus 12 months of adjuvant trastuzumab for HER2-positive early breast cancer (PERSEPHONE): four year disease-free survival results of a randomised phase 3 non-inferiority trial. Available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)30650-6/fulltext [accessed 1/07/19]

2.2.4 Use of Commissioning for Quality and Innovation framework

Commissioners are responsible for ensuring that adequate services are available for their local population by assessing needs and purchasing services. A proportion of a provider's income is conditional on the achievement of quality and innovation as set out in the Commissioning for Quality and Innovation (CQUINS) payment framework.

Use of CQUINS payment framework

A proportion of Airedale NHS Foundation Trust's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between Airedale NHS Foundation Trust, and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2019/20 and for the following 12 month period are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/cquin/

Use of CQUINS payment framework

A proportion of Airedale NHS Foundation Trust's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between Airedale NHS Foundation Trust, and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2019/20 and for the following 12 month period are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/cquin/

As part of the drive to improve quality, an amount of funding to be paid to the Trust during 2019/20 for the delivery of services to our patients was dependent upon achieving a

range of quality markers. This scheme (CQUIN) linked £1,722,833 of our funding to the delivery of the agreed quality indicators. (This is based on the indicative outturn value for 2019/20.)

During 2019/20 Airedale NHS Foundation Trust delivered CQUINs to the value of £1,640,504 to the satisfaction of our commissioners (to be confirmed).

The monetary total of funding conditional to the delivery of agreed quality indicators in 2018/19 was £3,043,947.

2.2.5 Registration with the Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and social care in England.

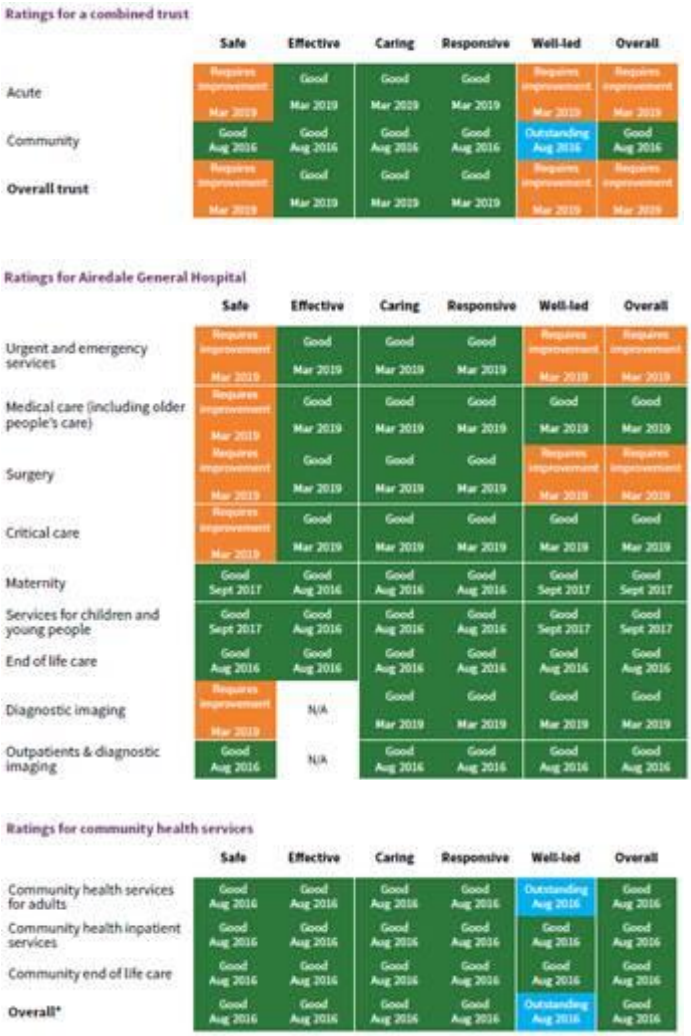
Statements from the Care Quality Commission

Airedale NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is without conditions. Airedale NHS Foundation Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Airedale NHS Foundation Trust during 2019/20.

Airedale NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2019/20:

The Care Quality Commission undertook its annual inspection a Well-led and Core Service Inspection in November and December 2018. The final report was published in March 2019 with the ratings below. The rating for the safety and well-led domain is "*Requires improvement*" as is the overall Quality summary rating for the Trust.



In February 2019 the Care Quality Commission performed a Review of Services for looked after children in Bradford. The Trust was involved and was subjected to a two day on-site visit to the Emergency Department and Maternity Services. Reviewers found a good culture of learning across the health partnership and saw evidence of improvements to safeguarding practice and policy being made. There were some local recommendation made, including: ensuring effective documentation and strengthening of some arrangements to improve our response to the vulnerabilities of children and young people. An action plan was developed against all recommendations with progress monitored via the Strategic Safeguarding Group with quarterly updates of progress submitted to the CQC via the designated nurse at the Clinical Commissioning Group. Most actions are now complete with outstanding actions risk rated.

All CQC inspection reports are available at: http://www.cqc.org.uk/directory/RCF

Airedale NHS Foundation Trust has made the following progress by 31st March 2020 in taking such action:

In response to the final report the Trust developed a *Quality Improvement Plan* that clearly details the responsible persons alongside robust accountability review at the Quality and Safety Committee for sustained compliance with the improvements required. The plan centres not only of the *"must and should do"* recommendations but also on issues identified within the body of the report.

Airedale NHS Foundation Trust has made the following progress by 31st March 2019 in taking such action:

The *Quality Improvement Plan* developed in response to the CQC *Quality Report* of March 2019 has been monitored throughout 2019/20 with added rigor in relation to embedding for consistent and sustained improvements. In addition the Trust has taken the opportunity to review previous CQC reports to identify any outstanding aspects and included within the current improvement plan.

The Trust maintains active communication with the CQC via a programme of relationship meetings, including invitations to the CQC to attend events and visit clinical areas.

2.2.6 Information on the quality of data

Good data quality underpins the effective delivery of improvements to the quality of patient care. The Secondary Uses Service (SUS) is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

NHS Number and General Medical Practice Code Validity

Airedale NHS Foundation Trust submitted records during 2019/20 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data – which included the patient's valid NHS number, was:
99.94 per cent for admitted patient care;
99.99 per cent for outpatient care; and
99.66 per cent for accident and emergency care.
– which included the patient's valid General Practitioner Registration Code was:
69.54 per cent for admitted patient care;
73.12 per cent for outpatient care; and
72.81 per cent for accident and emergency care.[11]

Information Governance Assessment Report

Information governance (IG) ensures necessary safeguards for the appropriate use of patient and personal information. The Data Security and Protection Toolkit (DSPT) allows NHS organisations and partners to assess themselves against national Information Governance policies and standards. It forms part of a new framework for assuring that organisations are implementing the ten National Data Guardian security standards and meeting statutory obligations on both data protection and data security.

The deadline for organisations to submit their final assessment is September 2020 due to COVID-19 pandemic. The Airedale Foundation Trust Data Security and Protection Toolkit for 2019/20 is published with all mandatory "Standards Met". Audit Yorkshire completed its annual review of evidence towards the assessment and returned a significant assurance rating.

[11] Reference period: April 2019 to February 2020. In previous years we counted default codes as valid codes; this year we have sought to use these to identify patients where there was no GP registered code associated with their outpatient attendance or Inpatient stay or A& E attendance. This has led to a significant difference in returns between previous year data and recent data.

Clinical Coding error rate

Airedale NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/20 by the Audit Commission.[12]

However, the Trust was subject in this period to an external Clinical Coding Audit as part of *Data Security and Protection Toolkit* (DSPT) national requirements. The error rate reported for diagnoses and treatment clinical coding was as follows:

- Primary Diagnosis: 6.7 per cent (DSPT – mandatory required level <10 per cent)
- Secondary Diagnosis: 4.8 per cent (DSPT – mandatory required level <20 per cent)
- Primary Procedure: 5.3 per cent (DSPT – mandatory required level <10 per cent)
- Secondary Procedure: 6.3 per cent (DSPT – mandatory required level <20 per cent)

The audit covered a cross-section of all inpatient specialties and across all members of the Clinical Coding Team. The audit reviewed the clinical coding accuracy of 200 finished consultant episodes (FCEs).

It should be noted that results from clinical coding audits should not be extrapolated further than the actual sample audited.

Airedale NHS Foundation Trust will be taking the following actions to improve data quality as recommended in the audit report:

The final draft of the audit has now been received and recommendations will be reviewed in coming months. All errors found in the audit were fed back to the Coding Team and training needs identified as applicable.

[12] NHS Improvement comment: References to the Audit Commission are now out of date because it has closed. From 2014 responsibility for coding and costing assurance transferred to Monitor and then NHS Improvement. From 2016/17 this programme has applied a new methodology and there is no longer a standalone 'coding audit' with errors rates as envisaged by this line in the regulations.

2.2.7 Learning from deaths

The Trust has acted on guidance published by NHS Improvement in relation to the *Learning from Deaths Framework*; monitoring and learning from mortality is published each quarter.

During 2019/20; 636 of Airedale NHS Foundation Trust inpatients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
146 in the first quarter;
129 in the second quarter;
164 in the third quarter;
197 in the fourth quarter.

By 31/03/20, 225 case record reviews and zero investigations have been carried out in relation to the deaths included above.

In zero cases a death was subjected to both a case record review and an investigation.
The number of deaths in each quarter for which a case record review or an investigation was carried out was:
54 in the first quarter;
67 in the second quarter;
57 in the third quarter;
47 in the fourth quarter

Zero per cent of the patient deaths during the reporting period are 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:
Zero per cent in the first quarter;
Zero per cent in the second quarter;
Zero per cent in the third quarter;
Zero per cent in the fourth quarter.

These numbers have been estimated using the Trust Mortality Review Tool; whereby a random 20 sets of medical records are chosen and reviewed by trained reviewers using an online tool. Any issues both where learning can be achieved along with excellent care provided are discussed within the Mortality Review Group and shared with Speciality Governance for improved care.

The following is a summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the overall inpatient deaths:

There have been a number of themes identified during the process in 2019/20 and these include

- Communication with relatives; this has shown to be excellent during some cases and less good in others; however there are more examples of excellence than less good communication during 2019/20.
- Variation in the use of the *End of Life Pathway*; the increase in excellence in a greater number of clinical areas reported in 2018/19 has continued in 2019/20
- Clear evidence of good leadership and multi-professional team working resulting in an improved patient and family experience.
- Variation in the recognition and treatment of sepsis, such as time to administer first dose of antibiotics.

As a consequence of what that the Trust has learnt during the reporting period, the following actions have been taken:

- Sharing of monthly learning outcomes with relevant specialty governance leads for discussion and action planning.
- Learning from Deaths was a dedicated theme within the Learn, Share Week
- Bespoke discussion following thematic reviews with the specialty for onward cascading of the findings and learning.
- Sharing of excellence in the use of the *End of Life Pathway* and other areas of patient care.
- Sharing of excellence in care by individuals and teams in various trust settings.
- Multi-disciplinary reviewers recruited and trained that has built resilience into the system.

The following actions are proposed following the reporting period:

- Training will continue to be delivered in relation to the challenging conversations for staff in caring for dying patients and their families.
- Additional multi-disciplinary reviewers will be continue to be recruited and trained to enable further resilience and support for the review process.

An assessment of the impact of the actions taken by the provider during the reporting period is as follows:

- Improved communication/relationship between governance leads and mortality chair.
- Improved communication/relationship between mortality review group and consultant body.
- Recognition of positive behaviours with examples of excellence flagged to individuals and teams.
- Increased recognition of patients who are dying and with increased use of end of life pathway for dying patients.

Zero case record reviews and zero investigations completed after 01/04/18 related to deaths which took place before the start of the reporting period.

Zero per cent of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

Zero per cent of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.2.8 Seven day hospital services

The seven day services programme is designed to ensure patients that are admitted as an emergency receive high quality and consistent care, regardless of whether they are admitted to hospital on a weekday or weekend. Through the provision of a seven day consultant-led acute service there is an opportunity to improve clinical outcomes and deliver a more patient focused and efficient service; diagnostic equipment, pathology laboratories and operating theatres can be more effectively utilised.

To move toward routine services being available seven days a week, ten clinical standards have been developed, four of which have been identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

- Standard 2 – Specified time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing specified consultant review by consultant twice daily if high dependency patients, daily for others

Providers have been tasked with implementing these four standards by 2020.

To support quality improvement and measure progress, the Trust is required to submit audit data on a biannual basis to NHS England using an online survey tool. The organisation self-assesses against a compliance threshold of 90 per cent. Results published in July 2019 for the period winter/ spring are as follows:

Seven day overall results			
Standard 2 Met	Standard 5 Met	Standard 6 Met	Standard 8 Met
Weekday results			
Standard 2 Met	Standard 5 Met	Standard 6 Met	Standard 8 Met
Weekend results			
Standard 2 Met	Standard 5 Not Met*	Standard 6 Met	Standard 8 Met

Source: *NHS England.*

*Echocardiography is not available; Magnetic Resonance Imaging (MRI) by informal arrangement. Although we meet the standard overall, partial compliance for standard 5 weekend results are in line with national benchmarking.

2.2.9 Sign up to Safety

The patient safety campaign, *Sign up to Safety*, is a national initiative to improve safety and reduce avoidable harm by half. The Trust signed up in 2014 and has used the campaign as an opportunity to learn from others. The following are examples of initiatives developed elsewhere that we have implemented locally in the last year:

- Quality Summits focusing on delivering a safe healthcare environment for patients, visitors and colleagues.
- A quarterly *"Report Learn Share Week*" to highlight aspects of quality and safety from around the Trust such as the impact of deconditioning and distractions.
- Participation in the World Patient Safety Day converging on what patient safety means to staff.
- A *Freedom to Speak Up!* Skills Workshop, supporting staff to challenge bad practice and understand how to raise concerns whilst feeling safe.
- A patient flow rapid improvement event.

2.2.10 Duty of candour

In 2014, in response to the inquiry into Mid Staffordshire NHS Foundation Trust, the CQC introduced the statutory duty of candour. The duty of candour explains what we should do to make sure we are open and honest with people when something goes wrong with their care and treatment. There is an organisational and professional requirement for healthcare providers and registered practitioners to be open with patients and apologise when things go wrong as detailed in the Trust's Being Open Policy. The latest Care Quality Commission inspection found that when something went wrong, staff were open and honest and had a good awareness of the duty of candour.

Mandatory training is delivered to all clinical and non-clinical staff. Incident monitoring systems are aligned to ensure any incident resulting in moderate harm and above follows the necessary duty of candour steps. Annual audit is undertaken to provide assurance of ongoing scrutiny. Completed in December 2019, the audit shows improved compliance across six of the eight standards with three standards achieving full compliance including verbally informing the patient/relative and following this up in writing. An external audit undertaken by Audit Yorkshire provided the Trust with "high assurance" and one minor recommendation

around documentation. Over the last year there has been one reported exception notified to Commissioners via agreed processes and one ongoing exception due to a police investigation.

2.2.11 Staff who speak up

In response to the *Gosport Independent Panel Repor*t Airedale NHS Foundation Trust publishes an annual *Freedom to Speak up Guardian Report* on staff who speak up (including whistle-blowers).[13]

It is important to cultivate an open and honest culture where reporting concerns is seen as an opportunity to learn. To encourage staff to speak up if they have concerns over quality of care, patient safety or bullying and harassment, the Freedom to Speak up Guardian has focused on collaborative working with employees and their professional representatives, Human Resources as well as Employee Health and Wellbeing. The last year has seen the appointment of a non-executive director with responsibility for speaking up to augment leadership on this issue. Steps to provide greater resilience, through the appointment of a deputy post, have also been taken.

Key actions over the last year to improve the visibility of the service through a structured mandatory training programme and the development of associated resources has meant the service has been well-utilised. It is pleasing to report that 78 per cent of concerns were raised in an open manner compared to 40 per cent in the previous equivalent period. This is accompanied by a decrease in those concerns made in confidence. This combined intelligence is suggestive of a degree of assurance in our speaking up process.

Analysis has been undertaken to understand where potential under-reporting exists within services, staffing groups, including protected characteristics, to enhance the initiative. For example it is recognised that black, Asian and minority ethnic (BAME) colleagues are less likely to speak up about concerns and more likely to suffer detriment as the result of speaking up.

National comparison indicates the Trust is performing well in the frequency of cases involving elements of bullying, harassment, patient safety or quality and instances of detriment following the raising of a concern. However, feedback received from those who have raised concerns over the last year has highlighted the need for independent review; effective feedback of investigation outcomes; and, the provision of support to both staff raising a concern and those involved.

We recognise that raising a concern is stressful for individuals; for this reason the Trust's approach is part of a wider programme of work to improve the workplace culture and the health and wellbeing of employees through the *People Plan.* To support employees the following actions have been taken:

- Ensuring that employees suspended from work or leaving the Trust are aware of the work of the Freedom to Speak up Guardian;
- Working with Stonewall to ensure the Trust is responsive to and aware of the needs of Lesbian, Gay, Bisexual and Transgender and Queer (LGBTQ+) staff. The Trust recently started collating data on gender and disability.
- Continuing to find opportunities and mechanisms to listen to staff. All those raising concerns have the opportunity to provide anonymous feedback.
- Promotion of a zero tolerance approach to anyone suffering disadvantage as a result of raising a concern.

Often the root of a problem is line management and associated skills. Whilst this has resulted in a number of tailored training programmes, wider learning has informed initiatives such as Personal Development Reviews and around having difficult conversations.

[13] [13] Detailed analysis and learning from concerns raised can be found in annual *Freedom to Speak up Guardian Annual Report* - latest edition 2017/18: : http://www.airedale-trust.nhs.uk/wp/wp-content/uploads/2018/10/item-12i-FTSU-Annual-report-2017-18-v2.pdf [Accessed 22.01.19]

The following actions have been identified from case review and review by the Board of Directors as priorities:

- Targeted approach to improve representation from under-represented groups and services;
- Improved dissemination of lessons learned;
- Introduction of Freedom to Speak Up Ambassadors; and,
- Training for mediators.

2.2.12 Workforce Race Equality Standard

The following measures are included as part of the Workforce Race Equality Standard and are sourced from the *2019 NHS Staff Survey* (published 2020):

- *Indicator 6: The percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.*

For 116 BME staff responses, 29.3 per cent reported experiencing harassment, bullying or abuse from staff in the last 12 months compared to an average of 28.8 per cent across acute providers in England. For 1172 white staff, 20.4 per cent reported experiencing harassment, bullying or abuse from staff in the last 12 months compared to 25.8 per cent across the benchmark group. Whilst results for white staff are about the same as the 2018 survey, the experience of BME staff has deteriorated.

- *Indicator 7: The percentage of staff believing that the Trust provides equal opportunities for career progression or promotion.*

White staff recorded an improved experience, with almost 92 per cent of the 800 responses reporting equal opportunities for career progression, a return above the national benchmark average. For 72 BME staff, 69.4 per cent reported equal opportunities; this is a deterioration on the 82.4 per cent 2018 return and five per cent below the national average for acute providers in England.

The *NHS Constitution* recognises that staff have a right to an environment free from harassment, bullying, aggression and violence. The Trust actively promotes a culture where staff – for example our European and international nurses and doctors – are treated with respect at work and have the tools, training and support to deliver care and the opportunities to develop and progress. BAME, LGBTQ+, Disability and gender inclusion focus groups have been established to support the Trust to become a more inclusive employer, giving voice to the experiences of under-represented groups. As well as a member of the Stonewall Diversity Champions Programme, the Trust is one of the NHS Employers' Diversity and Inclusion Partners Programme, an initiative to further strengthen this work. A dedicated Inclusion Day Event was held in October 2019. The Trust is currently reviewing our approach to abuse from patients directed towards staff.

Underpinning this work is a dedicated *Inclusion Strategy* designed to help us to become a more encompassing employer. An action plan and annual report overseen by the Board of Directors details the progress made and areas of shortfall such as data collection and analysis, recruitment and development as well as setting out targets for representation and recruitment by 2020. One such initiative is Stepping Up, a leadership development programme for BAME colleagues who work within healthcare. Aimed at BAME leaders and aspiring leaders, the programme is designed for those individuals who want to be involved in creating a transformational change in equality and diversity across the healthcare sector. In a further initiative BAME staff are sharing their insight and lived experience with Board members in support of more inclusive leadership. The reciprocal mentoring scheme facilitates conversations about unconscious bias and the difficulties and barriers faced by BAME colleagues. The aim is to develop a leadership approach across the trust that values the diversity of our workforce.

The *Workforce Race Equality Action Plan* progresses key issues with specific and measurable actions identified to deliver improvement. A joint workshop was held with other providers, commissioners, voluntary and community leaders in November 2019 to garner feedback on how the Trust is meeting is equality objectives

2.2.13 Learning disabilities improvement standards

The Trust is committed to developing services and pathways for people with learning disabilities, autism or both. Learning disability improvement standards for NHS trusts were published in June 2018 to support providers to measure and improve care for this group who may often be vulnerable. Compliance with the standards shows that structures, processes, workforce and skills are in place to deliver the outcomes that people with learning disabilities, autism or both, their families and carers should expect.

To understand the current state of care a survey across all types of providers in England was undertaken in 2018 with results published in July 2019. The Trust was one of the 129 acute providers who participated, reviewing organisational-level data collection and surveying both staff and service users. This intelligence provides a baseline view of the quality of care across services and offers the opportunities to improve care and learn from others good practice across the following:

Standard 1: Respecting and protecting rights
Standard 2: Inclusion and engagement
Standard 3: Workforce
Standard 4: Specialist learning disability services

Key areas identified at national and local level are the ability to reliably identify people with a learning disability and having the capacity to ensure effective system-wide liaison and co-ordination. In response an action plan has been developed focusing on the needs of patients with learning disabilities and their carers. Progress is monitored as part of the Trust's *Personalised Care Strategy Programme*.

The Trust continues to participate in the national survey on an annual basis to chart progress and identify where improvement efforts should be concentrated. Via the Learning Disability Healthier Lives Service User Group, the Trust continues to work with our local learning disability communities, including Exclusively Inclusive and Keighley and Craven People First.

2.2.14 Safe working hours: doctors and dentists in training

All doctors in training posts within our Trust are employed under the *2016 Terms of Conditions of Service for NHS Doctors and Dentists in Training (England).* As part of this contract, a Guardian of Safe Working acts as champion of safe working hours for doctors in approved training programmes within the Trust and to provide assurance to doctors and employers that doctors are safely rostered and enabled to work in accordance with the revised terms of conditions of service.

As part of these requirements a *Guardian of Safe Working Report* is presented on a quarterly basis to the (public) Board of Directors. This report includes details of all rota gaps on all shifts and is provided to the local negotiating committee and the Junior Doctors Forum. In addition a consolidated annual report – May 2019 – includes details of rota gaps and the planned actions for improvement to reduce occurrence.

Both medical and surgical medical rosters remain reliant on locums to support services; this can create additional pressures on the existing medical workforce and potential delays in patient care. Shortfall in rotas can be due to a number of factors outside of Trust vacancies: Deanery shortfall, supernumerary doctors, less than full time trainees and/or maternity leave. Issues are compounded when we are unable to procure locums or at the opening of additional winter beds as a result of seasonal pressures. Junior doctors may be moved between wards and where this is at short notice, local induction and immediate supervision can be inadequate. In such circumstances, it is difficult for trainees to access annual and/or study leave. In response ward swaps are now kept to a minimum and where doctors are required to move – usually precipitated by on-the-day sickness – the transfer is confined where possible to within their specialty.

Doctors are mostly working safe hours in terms of day to day shift length. Whilst the

Guardian of Safe Working continues to work with trainees and departmental leads to identify and implement solutions, many of the issues highlighted remain dependent on expansion of the existing workforce.

2.3 Reporting against core national indicators

To provide a better understanding of comparative performance, the *Quality Report* includes a core set of mandatory national quality indicators selected from the *NHS Outcomes Framework* and categorised within national quality improvement domains. The measures reflect data that providers report on nationally and conform to specified data quality standards and prescribed standard national definitions which are subject to appropriate standardised scrutiny and review.[14]

To understand whether a particular number represents good or poor performance, the national average, outlier intelligence and a supporting performance commentary is included (where available). *Unless indicated, the data source for the following indicators is NHS Digital. In line with national guidance, information for (at least) the last two reporting periods is provided.*[15]

Domain 1 – Preventing people from dying prematurely

Domain 2 – Enhancing the quality of life for people with long-term conditions

2.3.1. Summary hospital-level mortality indicator (SHMI)

The SHMI is not an absolute measure of quality but is a useful indicator for supporting organisations to ensure they properly understand their mortality rates across services.

The SHMI is based on all primary diagnoses, with deaths measured which take place in or out of hospital for 30 days following discharge. The SHMI value is the ratio of observed deaths in the Trust over a period of time divided by the expected number given the characteristics of patients treated (where 1.0 represents the national average). Depending on the SHMI risk adjusted value, trusts are banded between 1 and 3 dependent on whether their SHMI is low (3), as expected (2) or high (1) compared to other trusts.

Table 4: SHMI

	Jan 18 – Dec 19 Pub: May 19	**Apr 18 – Mar 19 Pub: Sep 19**	**Jul 18 – Jun 19 Pub: Nov 19**	**Oct 18- Sep 19 Pub: Feb 20**
Airedale NHS Foundation Trust SHMI value	0.90	0.92	0.90	0.90
National average	1.00	1.00	1.00	1.00
The highest value for any acute trust	1.26	1.21	1.19	1.19
The lowest value for any acute trust	0.70	0.71	0.70	0.70
Airedale NHS Foundation Trust SHMI banding	2	2	2	2

The SHMI takes account of underlying illnesses such as diabetes and heart disease. By including a measurement of the potential impact of providing palliative care on hospital mortality, additional context to the SHMI value and banding is offered.

[14] Definitions are based on national guidance, including the *NHS Outcomes Framework 2017/18 Technical Appendix.*

[15] Data source: http://content.digital.nhs.uk/qualityaccounts

	Jan 18 – Dec 19 Pub: May 19	Apr 18 – Mar 19 Pub: Sep 19	Jul 18 – Jun 19 Pub: Nov 19	Oct 18- Sep 19 Pub: Feb 20
Percentage of patient deaths with palliative care coded at either diagnosis or speciality level for Airedale NHS Foundation Trust	26.5	26.0	25.0	23.9
Percentage of patient deaths with palliative care coded at either diagnosis or speciality level average for England	34.3	35.0	36.0	36.0
The highest value for any acute trust	59.8	60.0	60.0	59.0
The lowest value for any acute trust	15.1	12.0	15.0	12.0

The Airedale NHS Foundation Trust considers that this data is as described for the following reasons:

- Trust mortality data is submitted in accordance with established information reporting procedures and data quality definitions.
- To date, the SHMI for the Trust has remained consistent and not subject to significant variation. The Trust continues to view this in line with internal scrutiny of data quality.
- SHMI data is provided through NHS Indicators and is formally signed off by the Medical Director on a quarterly basis.

The Airedale NHS Foundation Trust intends to take /has taken the following actions to improve this rate, and so the quality of its services, by:

- Preliminary screening of all inpatient deaths ensures any deaths deemed avoidable or associated with an adverse event are highlighted. All such cases and an additional random sample are routinely reviewed by a Consultant-led Trust Mortality Review Group each month using a standardised and structured case note review process. Processes have been reviewed following feedback from the CQC to improve the timeliness of the initial review from the date of death and responsiveness to any trends or themes. Where potentially avoidable mortality is identified, action plans are formulated.
- A maternal death, death of a child or a death in the Emergency Department are not included in this work, but instead are subject to a specialist independent process.
- Highlighted themes and learning, including good practice, is disseminated to the appropriate specialty governance lead for cascade
- Appraisal of mortality, morbidity and other correlative data at the Quality and Safety Committee, Patient Safety Group and specialty clinical governance meetings further supports this work.

Areas identified for development:

- Learning from mortality has been included within the schedule of publications regarding speak up for safety within the Trust
- Themes mortality review will continue to identify any learning within specialities and across the organisation.
- Consideration will be given to inclusion of learning from mortality within the planned quality summits for 2020/21.

Domain 3 – Helping people recover from episodes of ill health or following injury

2.3.2 Patient Reported Outcome Measures (PROMs)

PROMs indicate patients' health status or health-related quality of life from their perspective, based on information gathered from a questionnaire that they complete before and after surgery. PROMs offer an important means of capturing the extent of patients' improvement in health following ill health or injury.

Airedale's adjusted average health gain is presented alongside the national average and 95 per cent control limits. An average adjusted health gain allows fair comparison as the characteristics of the patient and level of complexity is accounted for. It is a measure of outcomes in the sense of how much a patient has improved as a result of the surgery. A high health gain score is good.

As in previous years, the 2019/20 dataset is not included as there is limited response data at this stage: post-operative questionnaires are not sent to Orthopaedic patients until six months after the procedure is carried out. The standardised EQ-5D measure is presented as this applies to all elective conditions. However, this is less sensitive than condition specific measures and for a more complete analysis, the Oxford Score is also provided. The following information relates to all procedures (primary and revisions).

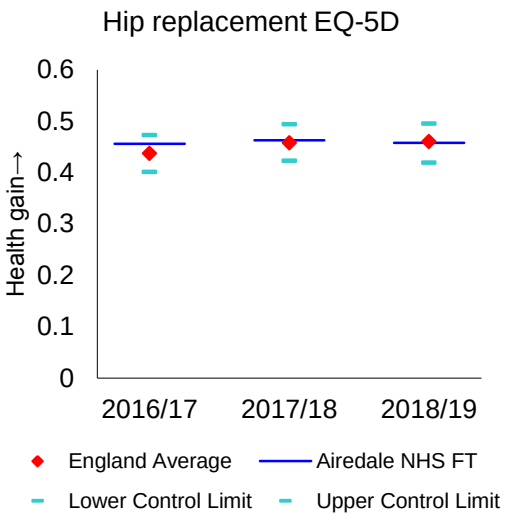


Figure 1

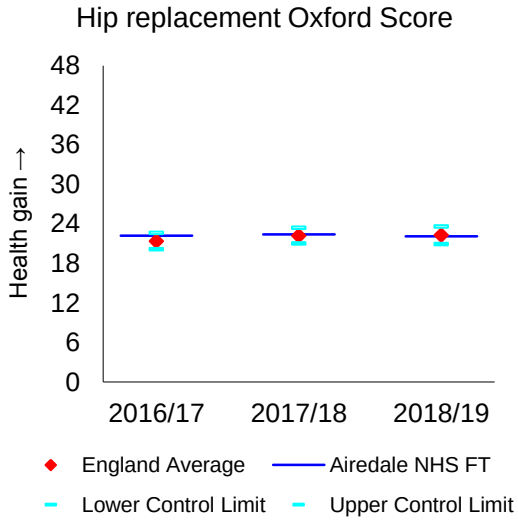


Figure 2

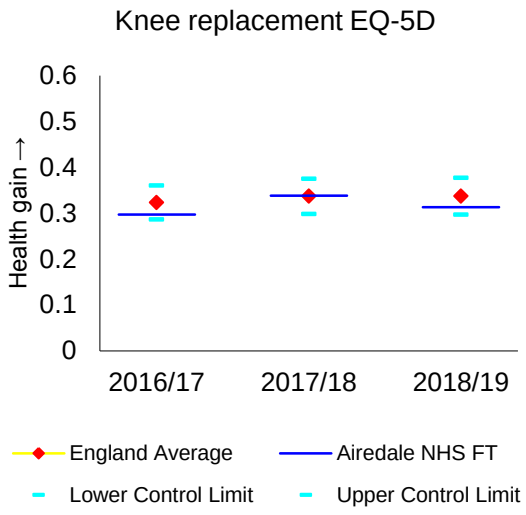


Figure 3

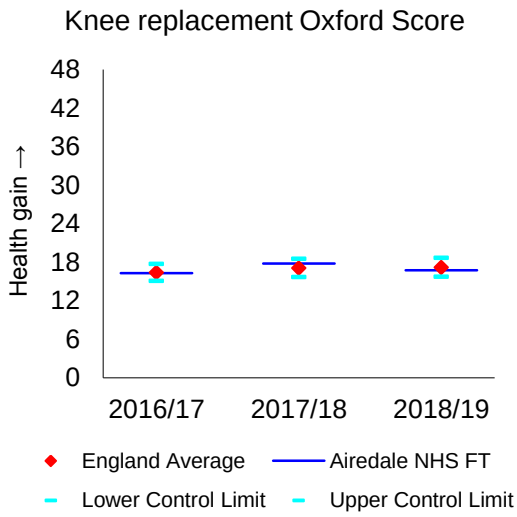


Figure 4

The Airedale NHS Foundation Trust considers that this data is as described for the following reasons:

- Performance for these measures is within the expected range for patient groups.
- Response rates compare favourably with the national average for England for all procedures.

The Airedale NHS Foundation Trust intends to take /has taken the following actions to improve the score and so the quality of its services, by:

- Continuing to monitor our rates of participation for each procedure and, although we have less direct influence, response rates are similarly reviewed. The Trust emphasises the importance of returning the questionnaires at pre-operative assessment and in the ward environment at discharge.
- A quarterly monitoring report is circulated to clinical operational leads for dissemination.

2.3.3 Percentage of emergency re-admissions to Airedale NHS Foundation Trust within 30 days of discharge

There is an ongoing review by NHS Digital of emergency re-admissions indicators across reporting frameworks, many of which have not been published since 2014. Phase one has aligned indicator definitions, including the use of the 30 day re-admission period rather than 28 and the revision of age bands in the standardisation. Emergency re-admissions within 30 days of discharge from hospital were published in May 2019 with the last three years of intelligence detailed below.

Whilst some emergency re-admissions following discharge from hospital are an unavoidable consequence of the original treatment, others could potentially be avoided through ensuring the delivery of optimal treatment according to each patient's needs, careful planning and support for self-care. The following is standardised and whilst this allows comparison with other organisations reference data is taken from both NHS and non-NHS providers, including mental health. Data is presented in age groups: persons under and over 16 years. A low percentage score is good.

Table 5: Emergency re-admissions	**15/16**	**16/17**	**17/18**
Airedale NHS Foundation Trust percentage persons <16 years	12.4	12.9	13.1
National percentage average [England] persons <16 years	11.5	11.6	11.9
The *highest** percentage return by provider persons <16 years	80.5	68.4	32.9
The *lowest** percentage return by provider persons <16 years	2.6	1.6	1.3
Airedale NHS Foundation Trust percentage persons 16 years +	10.9	10.9	12.8
National percentage average [England] persons 16 years +	13.4	13.6	14.1
The *highest** percentage return by provider persons 16 years +	94.1	121.5	46.4
The *lowest** percentage return by provider persons 16 years +	1.3	0.9	1.8

The Airedale NHS Foundation Trust considers that this data is as described for the following reasons:

The figures presented are from the NHS Digital portal and are derived from information provided by Airedale and other trusts. Elements of this information are subject to commissioner scrutiny and a variety of external audits. No attempt is made by NHS Digital to assess whether the re-admission is linked to the discharge in terms of diagnosis or procedure; nor does the return identify whether the emergency admission is avoidable.

Persons 16 years and below: according to NHS Digital the 2015/16 Trust return lies within the expected variation, the returns in the last two available fiscal years are significantly higher than the national average at a 95 per cent confidence level.

As part of Trust strategy to get patients home as soon as possible, we frequently discharge and then offer families 24 hour open access for review on the unit. This allows the patient to be readmitted directly to the ward if the parent or carer feels there is any deterioration or if they are struggling with caring for the patient for any other reason.

Clearly this will impact on the re-admission rate.

Persons 16 years plus: according to NHS Digital the returns for the last three available fiscal years are lower than the national average at a confidence level of 99.8 per cent.

The Airedale NHS Foundation Trust intends to take /has taken the following actions to improve this percentage, and so the quality of its services, by:

Medical re-admissions by consultant are incorporated into performance metrics, circulated to colleagues and discussed at the monthly medical governance meeting. A similar process is in place within Surgical Services and provides the opportunity to discuss, understand the rationale and accuracy of clinical coding and ensure re-admissions are correctly captured on the Trust's patient administrations system.

Domain 4 – Ensuring that people have a positive experience of care

2.3.4 Responsiveness of Airedale NHS Foundation Trust to the personal needs of patients

An organisation's responsiveness to patients' needs is regarded as a key indication of the quality of patient experience and care. The score for the inpatient setting is part of the *NHS Outcomes Framework* (indicator 4b: Ensuring that people have a positive experience of care).

Based on the CQC's annual *Adult Inpatient Survey*, the measure is the overall average percentage score for answers covering five domains: access and waiting; safe, high quality, coordinated care; better information, more choice; building closer relationships; and a clean, comfortable, friendly place to be. The scores are presented out of 100 with a high score indicating good performance.

Table 6: Responsiveness to patient needs	**2016** 485 replies; 1250 surveyed	**2017** 474 replies; 1250 surveyed	**2018** 574 replies; 1250 surveyed
Airedale NHS Foundation Trust overall percentage score	67.7	69.8	66.5
National percentage score	68.1	68.6	67.2
Highest percentage for any acute trust	85.2	85.0	85.0
Lowest percentage for any acute trust	60.0	60.5	58.9

The *2019 Adult Inpatient Survey* is due in June 2020.

The Airedale NHS Foundation Trust considers that this data is as described for the following reasons:

The 2018 response rate is 48 per cent compared to a national rate of 45 per cent. The Trust sample varies from year to year and a difference in outcomes is to be expected unlike the national score which is, by definition, adjusted data. This should be factored in when making comparison between years. Demographic analysis shows that a high proportion of patients are aged 66 and older; a group more likely to report a positive experience depending on the gender split.

Improvements or deterioration of patient experience continue to be monitored via our Real-time (inpatient) Survey and Friends and Family Test so that remedial actions can be introduced in a timely way. The 2019 *NHS Staff Survey* places the Trust above average amongst 89 acute providers for the number of staff reporting the effective use of patient/service user feedback.

The Airedale NHS Foundation Trust intends to take /has taken the following actions to improve this score and so the quality of its services, by:

- Monitoring of local and national patient survey results by the Trust's Patient and Public Engagement and Experience Steering Group.
- Implementation of the *Patient and Public Engagement and Experience Strategy* for 2016-2020. The implementation plan follows a phased approach.
- Listening and learning from patient experiences via the Friends and Family Test and the Real-time (inpatient) Survey as well as social media and taking action where necessary. The national review of the Friends and Family Test will allow for patients to feed back at any time about their experience of health and care services. It is hoped this will provide more comprehensive information.

We continue to work with partner organisations to ensure a holistic approach to patient engagement.

2.3.5 The percentage of staff employed by, or under contract to the Trust during the reporting period, who would recommend Airedale NHS Foundation Trust as a provider of care to their family or friends

How members of staff rate the care that their employer organisation provides can be a meaningful indication of the quality of care and a helpful measure of improvement over time.

The following is the percentage of staff that "*agree*" or "*strongly agree*" with the statement *"If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust"* and is based on the annual *NHS Staff Survey* (question 21d).

The scores are presented out of 100 with a high score indicating good performance.

Table 7: Staff recommendation	**2017** 1254 replies; 2753 surveyed ***Pub: Mar 2018***	**2018** 1192 replies; 2591 surveyed ***Pub: Feb 2019***	**2019** 1384 replies; 2661 surveyed ***Pub: Feb 2020***
Airedale NHS Foundation Trust percentage	73	74	73
National average percentage acute trusts [England]	70	71	71
Highest percentage for any acute trust	86	87	87
Lowest percentage for any acute trust	47	40	40

The Airedale NHS Foundation Trust considers that this data is as described for the following reasons:

The response rate is 52 per cent which is above the median response rate for the 85 providers of a similar type (acute trust) and an improvement on the previous year.

Overall staff engagement is consistent at 7.2 and is above average when compared with other trusts of a similar type. Possible scores range from one to ten, with a higher score indicating high levels of engagement.

Overall the Trust's 2019 *NHS Staff Survey* results compare favourably with other acute trusts. The Trust was better than average compared to other trusts in nine of the 11 key themes.

The Airedale NHS Foundation Trust intends to take /has taken the following actions to improve this score and so the quality of its services, by:

- Local results have been reviewed by managers to build on the things that are good and tackle the things that need improvement.
- Results will also be reviewed at the People Committee, which is a sub-committee of the Trust Board. Those teams with less positive results will be asked to present their action plans for improvement.
- All Trust-wide actions are to be included in the development of a *People Strategy* over the coming year.
- A series of events have been organised to ensure the voices and views of staff inform future developments.

Building a positive safety culture through the following mechanisms:

- Monitoring of staffing levels within the Trust and development of new workforce models;
- Reviewing incidents reported through risk management processes to ensure that these are investigated and appropriate action is taken where necessary;
- Provision of training to all staff in the assessment of risk so these can be appropriately identified and escalated; and,
- Further promotion of the Freedom to Speak up Guardian role to enable staff to feel confident about raising concerns.

2.3.6 Friends and Family Test (FFT) – Patient

The NHS Friends and Family Test (FFT) is a quick and anonymous way for those using services to give their views after receiving care or treatment. It was created to help service providers and commissioners understand satisfaction levels with a service and where improvements can be made.

The percentage of the patient group who are either "*likely*" or "*extremely likely*" to recommend services is presented from a single question posed to patients, *"If a friend or relative needed treatment, I would be happy with the standard of care provided by the Trust."* The higher the percentage score, the better. Although there is no statutory requirement to report on the patient element of the Friends and Family Test, we have included this information to support an open picture. No national benchmarks are provided below as, according to NHS England, results are not statistically comparable against other organisations because of the various data collection methods employed. [16]

Table 8: Friends and Family Test Airedale NHS Foundation Trust - percentage recommendation score	**2017/18**	**2018/19**	**2019/20**[17]
Emergency Department Average	96.7%	94.8%	93.3%
Inpatient Average	96.3%	97.1%	97.2%
Community Services	98.8%	99.0%	99.3%
Maternity Services	97.3%	98.0%	98.9%

The Airedale NHS Foundation Trust considers that this data is as described for the following reasons:

- Currently the Trust monitors response rates against the national average for the Emergency Department, Inpatients and Maternity Services to ensure a sufficient and reliable sample size.
- From April 2020 when new reporting guidelines are enacted, published response rates will no longer be available as there will be no time limit on when a patient can give feedback. This will have an impact on internal governance reporting that utilises FFT response rates.

The Airedale NHS Foundation Trust intends to take /has taken the following actions to improve this score and so the quality of its services, by:

- Following a national review of the FFT, new guidance has been released with implementation from April 2020. The main changes are intended to: make the wording of the mandatory question and standard response scale more effective in collecting good quality feedback; and, make it easier for patients to give feedback by ensuring timing requirements are consistent across all settings. Key actions are focussing on effective local implementation.

[16] NHS England Friends and Family Test data: https://www.england.nhs.uk/ourwork/pe/fft/ [Accessed 01/02/18].
[17] Based on the period April 2019 to January 2020

Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

2.3.7 Percentage of patients admitted to hospital and were risk assessed for venous thromboembolism

Venous thromboembolism (VTE) can cause death and long-term morbidity. According to NICE many cases of VTE acquired in healthcare settings are preventable through effective risk assessment and prophylaxis. A high percentage score is good.

Table 9: Risk assessment for VTE	**Jan –Mar 2019**	**Apr-Jun 2019**	**Jul-Sep 2019**	**Oct-Dec 2019**
	Pub: Jun 19	Pub: Sep 19	Pub: Dec 19	Pub: Mar 20
Airedale NHS Foundation Trust percentage	96.3	95.2	95.4	94.7
National percentage average [England]	95.7	95.6	95.5	95.3
The highest percentage return for any acute trust	100.0	100.0	100.0	100.0
The lowest percentage return for any acute trust	74.0	69.8	71.7	71.6

Data Source: *NHS Improvement.*

The Airedale NHS Foundation Trust considers that this data is as described for the following reasons:

- Data is provided weekly to all managers and lead clinicians. Broken down by clinical group, this allows those areas which are under reporting to be identified and supported with improvement and restorative actions.
- The VTE risk assessment tool is embedded in the clinical areas and features prominently in clinical decision making, ensuring vigilance in completing risk assessments.

The Airedale NHS Foundation Trust intends to take /has taken the following actions to improve this percentage, and so the quality of its services, by:

- Continuing to benchmark Airedale's performance against other providers in England and report on a monthly basis through the Trust's Patient Safety Scorecards.
- Regular discussion of VTE assessment data with clinical directors to educate and improve rates across groups.
- Promoting processes of root cause investigation for reported VTE with the dissemination of results to improve overall hospital-associated VTE care.

2.3.8 Rate of C. *difficile* infection per 100,000 bed days in Airedale NHS Foundation Trust patients aged 2 or over

Hospital associated C. *difficile* infection can be preventable. Since 2012 revised guidance on the clinical testing protocol has resulted in more consistent testing and reporting of cases of C. *difficile* infection across the country.

The rate provides a helpful measure for the purpose of making comparisons between organisations and tracking improvements over time. A low rate is good.

Table 10: Rate of C. difficile	**2016/17**	**2017/18**	**2018/19**
Airedale NHS Foundation Trust rate per 100,000 bed days	11.2	5.2	4.7
National average rate [England] rate per 100,000 bed days	13.2	13.7	12.2
The highest rate for any acute trust rate per 100,000 bed days	82.7	91.0	79.7
The lowest rate for any acute trust rate per 100,000 bed days	0.0	0.0	0.0

Figures based on Trust apportioned cases for specimens taken for patients aged 2 or over.

Data Source: *Public Health England.*

The Airedale NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has a rigorous diagnostic testing protocol to identify cases. All confirmed cases are monitored through internal processes and reported to Public Health England, NHS Improvement and commissioners.
- Performance is reflective of: a robust *Antibiotic Policy* closely scrutinised by Pharmacy staff, high standards of staff and patient hand hygiene, environmental cleanliness and the continued vigilance and awareness of staff.
- Post infection review of all hospital acquired cases is undertaken to ensure opportunities to improve practice are identified and enacted.
- All cases are reviewed with Community Service staff to assess which are avoidable.
- Receipt of the C.*difficile* risk assessment and action plan via an assurance route governed by the Quality (Board) Committee.

The Airedale NHS Foundation Trust intends to take /has taken the following actions to improve this rate, and so the quality of its services, by:

Implementing further strategies during the forthcoming year, including:

- Early detection of all cases;
- Ensuring the environment is fit for purpose and supports good infection prevention practices;
- SystmOne antibiotic prescribing flag for those patients with a history of C.*difficile* infection/colonisation;
- Monitoring of the use of antibiotics in comparison with neighbouring and similar sized acute trusts; and,
- Sustaining staff engagement and motivation in the prevention of healthcare acquired infections.
- The Trust has adopted the recommendation from the West Yorkshire Association of Acute Trusts that first line treatment for all cases of C *difficile*, regardless of severity, should be oral vancomycin.
- The Trust has signed up to the ARK-study, which aims to evaluate an alternative approach to antibiotic initiation.

Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm

2.3.9 Reported number and rate of patient safety incidents per 1000 bed days reported within the Airedale NHS Foundation Trust and the number and percentage that resulted in severe harm or death

Patient safety incidents are adverse events where either unintended or unexpected incidents could have led or did lead to harm for those receiving NHS healthcare. Based on national evidence about the frequency of adverse events in hospitals, it is likely that there is significant under reporting. An open, transparent culture is important to readily identify trends and take timely, preventative action.

This indicator is designed to measure the willingness of an organisation to report incidents and learn from them and thereby reduce incidents that cause serious harm. The expectation is that the number of incidents reported should rise as a sign of a strong safety culture, whilst the number of incidents resulting in severe harm or death should reduce. (Severe signifies when a patient has been permanently harmed as a result of an incident.)

Table 11: Patient safety incidents

Apr – Sep 2019 [Issue: Mar 2020]

	All reported patient safety incidents		Severe harm		Death	
	Number	Rate [per 1000 bed days]	Number	Percentage	Number	Percentage
Airedale NHS Foundation Trust	3273	60.59	1	0.00	3	0.09
National position [acute non-specialist n=130]	815852	49.79	1896	0.23	628	0.08
The highest value [acute non-specialist n=130]	11620	103.84	0	0.00	1	0.00
The lowest value [6 complete months] [acute non-specialist n=130]	2173	26.29	17	0.78	9	0.41

Oct 2018 – Mar 2019 [Issue: Sep 2019]

	All reported patient safety incidents		Severe harm		Death	
	Number	Rate [per 1000 bed days]	Number	Percentage	Number	Percentage
Airedale NHS Foundation Trust	3285	64.71	1	0.03	6	0.18
National position [acute non-specialist n=131]	765221	46.06	1780	0.23	678	0.09
The highest value [acute non-specialist n=131]	8289	95.94	16	0.19	12	0.14
The lowest value [acute non-specialist n=131]	1580	16.90	15	0.95	0	0.00

Data source: NHS Improvement – National Reporting and Learning System.

The Airedale NHS Foundation Trust considers that this data is as described for the following reasons.

- Consistent and timely reporting of all patient safety incidents to the National Reporting and Learning System (NRLS) against each of the required six month periods.
- The Trust is characteristically in the upper quartile of reporters. According to the NRLS, organisations that report more incidents usually have a better and more effective safety culture. In order to improve, an understanding of the problems is essential.
- An open and engaged culture to learn from incidents and improve the quality and safety of services as illustrated in the latest 2019 *NHS Staff Survey.*
- Clear and accessible policy and guidelines that ensure incidents are effectively identified, managed and investigated and that appropriate measures are taken to prevent recurrence.

The Airedale NHS Foundation Trust intends to take /has taken the following actions to improve this rate, and so the quality of its services, by:

- Maintaining and improving an open and transparent reporting culture, one which encourages all healthcare staff to report all adverse events and near misses. For example it is important that staff report safety risk promptly so that action can be taken to prevent harm to others. The time taken in closing incident investigations has been prioritised with the median time comparing favourably with the provider cohort over recent reporting periods.
- Streamlining of incident categories to support classification and allow more effective evaluation of trends and themes, most recently in respect of revised national pressure ulcer definitions.
- Appointment of a Freedom to Speak up Guardian to provide confidential, independent advice and support to staff in relation to concerns about patient safety, care and treatment.
- Additionally, a quarterly Learning from Serious Incidents Report provides oversight of contributory factors and augments wider organisational learning.
- Key quality and safety messages are shared in a monthly *Quality and Safety Matters* bulletin. Learning has been further augmented via a quarterly *"Report, Learn, Share Week"* which highlights key aspects of quality and safety.

Part 3: Other quality improvement information

As well as the improvement projects detailed in section two, the *Quality Report* takes the opportunity to outline other local priority work in the three areas of quality: patient experience, safety and clinical effectiveness. A series of metrics or indicators are included to understand performance and where possible, historical and benchmarking data is provided to support interpretation.

3.1 Patient experience

The Trust is committed to the principle that all patients and the public are treated as individuals with dignity and respect, that cultural and ethnic diversity are valued, and that vulnerable and seldom heard groups have equal opportunity to be fully involved in all aspects of their care. Where practicable, the principles of experience based co-design are integrated into work streams to ensure patient experience is central.

3.1.1 Priority 1 patient experience: improving the quality of wound care for patients both in hospital and the community

The challenge and our aim

The care we provide to patients who have or develop wounds can fundamentally improve the quality of their lives. According to the National Institute for Health Research, there are approximately 79,500 people in England who have a complex wound at any one time; healing can take months, years or never happen at all. Research evidence demonstrates that over 30 per cent of chronic wounds – identified as wounds that have failed to heal for four weeks or more – do not receive a full wound assessment. This can contribute to ineffective treatment and further delay wound healing for patients. Through the provision of standardised care based on research and best practice, patients have the greatest opportunity for healing.

Working collaboratively between primary care, community and the hospital setting the Trust, alongside commissioners and partner organisations, aims to ensure there is an integrated and individualised programme of treatment to support wound healing and garner the associated benefits. Selection of this priority builds on patient feedback on quality improvement initiatives across the local health and social care system to prevent and effectively manage pressure area care.

How we monitor progress

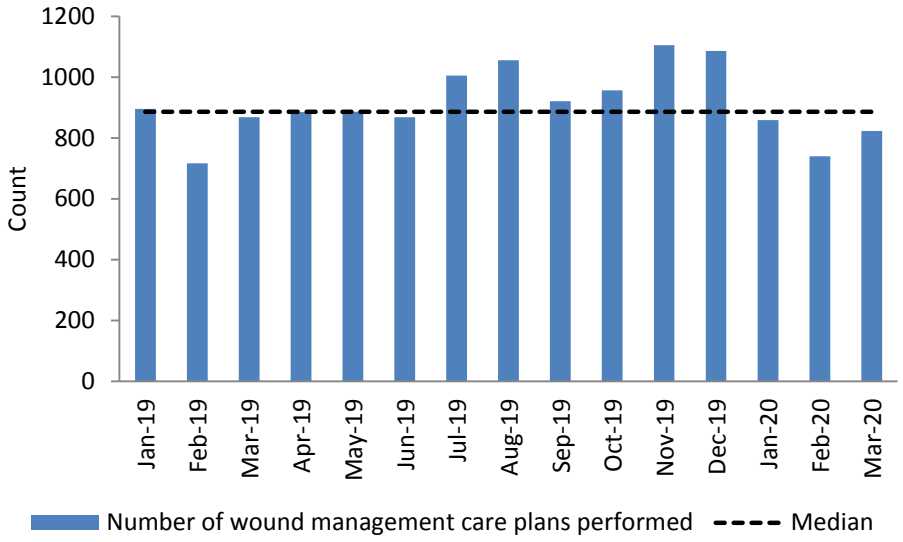
Key actions and milestones are monitored via the Community Services' Quality and Safety meeting and reported through the Integrated Performance Review meeting. Progress was initially measured through the 2017-19 national CQUIN - Improving the assessment of wounds – where the objective was to increase the number of patients who have a full assessment of chronic wounds. Following completion of the CQUIN and to ensure high numbers of full holistic assessment is maintained and embedded in practice, Community Service compliance with wound care assessment is tracked in local development plans.

Current status

Over the last two years Community Services in collaboration with Bradford District Care Foundation NHS Trust audited the number of wounds that have failed to heal within four weeks and the number of wound assessments completed. This initial review conducted in 2017 found 6.3 per cent of the Trust's district nursing applicable patient group had a full wound assessment. An incremental trajectory for improvement was subsequently agreed and over the last two fiscal years Community Services increased the number of full wound assessments for chronic wounds to 87 per cent (at March 2019).

Following developmental work, Community Services now have access to electronic wound assessment templates as part of the SystmOne patient record. Anyone who has any type of wound has a Wound Management Care Plan. Wounds are numbered as there can be more than one wound requiring management per patient. SystmOne has been configured so all fields in the wound assessment must be completed to progress thus ensuring full wound assessment where applicable. For ongoing management of the wound, the wound management template personalises the care that the wound requires. If the wound heals, then the template is reviewed and discontinued. If there is significant deterioration or the wound is not healed within four weeks, then a further full wound assessment is completed using the appropriate template. Whilst it is not possible to differentiate the length of wounding healing of multiple wounds for this patient group, the service monitors the number of times a Wound Management Care Plan is performed each month to understand activity levels.

Figure 5: Airedale NHS Foundation Trust District Nursing Wound Management Care Plan completion numbers



Data source: *Information Services Airedale NHS Foundation Trust*

It is planned to undertake clinical audit of wound care within the acute setting in 2020.

Initiatives and progress in 2019/20

The following key actions have been taken across the Airedale, Wharfedale and Craven locality to reduce this burden of harm:

- Delivery of holistic wound assessment training across all relevant Community Service teams.

- Uniform approach to using photography to monitor progress. Individual staff members have a camera to support wound care practice (for upload onto the clinical system). This enables those involved in care to offer insight regarding assessment, treatment regime and care planning.
- Systematic dissemination of findings at various meetings and forums.

To improve the delivery of holistic skin and wound assessment within the acute setting, the following work has been undertaken:

- A Skin Assessment and Wound Care Plan is now embedded on the ward areas.
- Establishment of a joint wound care Formulary aligned with Community Services and Bradford District Care Foundation NHS Trust to support improved co-operation around pathways of care.
- Implementation of a Skin Tear Pathway to support accurate assessment and appropriate treatment.
- Planning is underway to develop a Tissue Viability Nurse cupboard which will stock specialist dressings to ensure patients have appropriate and timely care to prevent dressing wastage and improve overall patient experience. In addition ward dressing stock is being reviewed to ensure specific dressings/sizes are available for each ward. This will ensure continuity in the use of creams and dressings, a more accurate assessment of a wound and ultimately faster healing time. In support of this, quarterly wound care study days are available to all staff as is bespoke training for specific departments.
- The Trust's *Clinical Photography Policy* is under review. A task and finish group has been set up with the objective of providing guidance around photography and wound assessment.
- New electronic beds across the Trust – as previously described – and an education programme to ensure controls are used effectively to minimise harm.
- A plaster cast form has been collectively developed for use in all areas where casts are applied including Theatres, ED and the Plaster Room; this will standardise and improve skin assessments and plaster care across the Trust.

Next steps

- Configuration of SystmOne to ensure a seamless transfer of care at the point of admission and/or discharge. The referral template has been trialled in Craven and is to be embedded across the locality.
- Greater collaboration with Bradford Teaching Hospitals NHS Foundation Trust and Bradford District Care NHS Foundation Trust. This may include standardising care pathways and improved continuity of care, but will focus primarily on a joint formulary.

3.1.2 Improving care for patients living with dementia

The challenge and our aim

"An estimated 25 per cent of hospital beds are occupied by people with dementia. People with dementia … stay in hospital for longer, are more likely to be re-admitted and more likely to die than patients admitted for the same reason." [18] If patients living with dementia are diagnosed in a timely way, this patient group can receive treatment, care and support to improve their experience of the condition.

Through focusing on developing the skills and expertise of our workforce in the recognition and the care of patients living with dementia, the Trust

[18] Department of Health (2014*), Dementia . A state of the nation report on dementia care and support in England*. William Lea.

seeks to improve the prompt and appropriate referral to specialist services. This initiative is part of priorities within the *Patient and Public Engagement and Experience Strategy 2016-2020*.

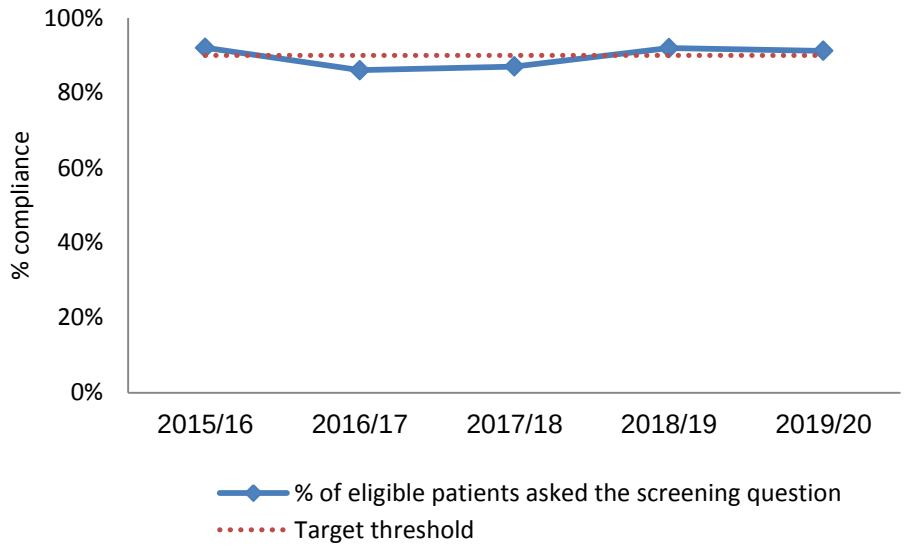
How we monitor progress

Over the last year, the Trust has developed in collaboration with patients, the wider public and staff as well as local partner organisations, an overarching *Personalised Care Strategy* focusing on: people living with dementia and frailty, people with learning disabilities and how to support carers. The multi-disciplinary Dementia and Frailty Group will co-ordinate the key dementia priorities: admission avoidance, accelerated discharge and provision of a positive patient experience.

Current status

It is estimated that less than half of people with dementia in England have a formal diagnosis or have contact with specialist services. If diagnosed in a timely way, this patient group can receive the treatment, care and support – social and psychological, as well as pharmacological – to improve their experience of this condition. To ensure prompt and appropriate referral to specialist services, all patients aged 75 and over admitted as an emergency are screened for dementia or delirium. A 90 per cent target of achievement was met in 2019/20.

Figure 6: Time series showing the percentage of eligible patients asked the screening question against the target threshold [April 2019 to February 2020]



Data source: *Information Services Airedale NHS Foundation Trust*

Complaints provide valuable qualitative information which may not be identified by more traditional indicators. From a total of 84 formal complaints over the year, six complaints have been received concerning patients living with dementia**.** Review indicates that in four cases the complaints were directly related to the patients' specific needs; feedback has been shared with teams.

Initiatives and progress in 2019/20

In 2018 the Trust participated in the *National Audit of Dementia (Care in General Hospitals)* to assess the delivery of care for people with dementia admitted to hospital. Whilst results indicated progress is being made, particularly around the initial assessment and delirium, the audit continues to indicate areas of shortfall in respect of patient experience: carer communication was ranked in

the lower quartile and the carer rating of patient care was below the national average. Using an action planning toolkit, the Dementia and Frailty Group are enacting key recommendations.

1) Improving care initiatives:

- The Trust was selected in 2018 as a national pilot site for the Enhanced Care Project; this is work that aims to improve the patient experience by ensuring that for those patients who require more frequent observation, interactions are engaging and meaningful. Initially based on Wards 6 and 9, a roll out of the project to other wards is planned with the pilot wards offering support.
- Dementia memory trolleys across wards, Theatres and the Emergency Department in addition to a digital and reminiscence therapy unit stocked with games, quizzes, conversation prompts, tactile products, art/drawing equipment and cognitive activities for use by patients with dementia. Linking with young people's volunteering, the objective is to deliver more reminiscence and therapeutic activities for patients to participate in.
- A communication support toolkit has been created to help staff communicate with patients who have communication difficulties.
- Adoption of the "*End PJ Paralysis*" campaign to promote the importance of mobility in avoiding the risk of reduced bone mass and muscle strength, increased dependence, confusion and demotivation.
- The Trust has adopted John's Campaign, a national drive to promote flexible hospital visiting hours for those caring for people living with dementia. A *Visitor's Charter* explains our approach that is inclusive of visitors and patients whilst being mindful of the need for rest and recovery. Evaluation of flexible visiting arrangements in planned for 2020.
- The planning and design of spaces to reflect the requirements of patients living with dementia in regards to their surroundings and the environment (a core element of the Trust's *Estate Strategy*):
  - ✓ *A special bus stop on Ward 9 gives a place to walk to and sit for dementia patients, helping to reduce the anxiety a hospital environment can engender.*
  - ✓ *In October 2019 Castleberg Hospital opened its doors to patients for the first time since March 2017; the hospital has undergone a complete upgrade and is designed to the same dementia standards as Airedale General Hospital including a new wayfinding system.*

2) Staff education and practice development:

Mandatory training for clinical and non-clinical staff – including volunteers and bank – ensures all staff have knowledge and skills in caring for people with dementia. By the end of March 2020, 94.9 per cent of the Trust's workforce had achieved competency in dementia awareness training (this incorporates privacy and dignity training). [19]

[19] Data source: *Human Resources NHS Foundation Trust [consolidated figure].*

- A Dementia Action Week in May 2019 ran a series of activities to raise staff awareness, including an innovating for dementia staff competition. The event joined up with dementia-related charities to host a marketplace event on our Airedale site for healthcare professionals, patients and carers. Outreach sessions in Keighley town centre garner feedback from patients and carers.

3) Patient management and assessment:

- Over recent years the safety huddle methodology at staff handover has been introduced across clinical areas.
- The Carer Navigator Project supports carers and families so that timely decisions are made in collaboration with the hospital from the point of admission onwards. The aim is to ensure the best outcomes for those who will need significantly different arrangements. Carer Navigators, as members of the Multi-agency Referral Hub – work directly with families to support understanding of the available options and ensure the views and situation of the family/carer area are articulated clearly when discharge decisions are made.
- Quality improvement work is underpinned by our work as an Ambassador Trust for the Butterfly Scheme, an initiative which seeks to highlight the unique needs of those patients affected by dementia by displaying a butterfly icon on the bed management system to make staff aware of a Butterfly Care Plan (individualised care plans detailing personal preferences).

4) The development of guidelines for practice: the *Cognitive Impairment/ Dementia Pathway* has been developed within the hospital to complement the Community Collaborative Care Team's dedicated pathway as part of an approach to care. More recently guidance for the assessment of delirium, dementia and depression – the 3Ds – has been developed and implemented.

Next steps

The dementia priority work is a key aspect of a broader Frailty Collaborative between members of the public, health and social and voluntary sectors to improve frailty services for local people. Spearheaded by NHS Improvement and overseen by a multi-professional group, the goal is to progress a *Personalised Care Strategy* that builds on best practice and reduces variation in care.

3.1.3 Privacy and dignity – promotion of a customer services culture

The challenge and our aim

In recent years, high profile reports and inquiries have shown a failure at an individual and organisational level to deliver care with compassion, privacy and dignity. It is important to continually reflect on and challenge the way in which we treat and care for patients, relatives, friends, carers and staff. Patient and wider public feedback indicates the importance of embedding our *Fundamental Standards of Caring for People with Dignity and Respect.* We know there is a link between the wellbeing of staff and that of patients. Through promoting staff health and wellbeing we aim to support the quality of patient care.

How we monitor progress

Privacy and dignity are key principles within the Trust's

Patient and Public Engagement and Experience Strategy 2016-2020 as agreed by the Board of Directors in consultation with stakeholders. Implementation is monitored via the Patient Experience and Engagement Steering Group, established to ensure the experiences of those who use our services and carers are captured and acted upon to improve future care and treatment. Representation includes Estates, the Patient and Carer Panel, local Healthwatch organisations and voluntary groups as well as commissioners.

Current status

The following metrics have been selected to measure improvement in our patients' experience. Each year, as part of the annual CQC *Adult Inpatient Survey*, people are asked by the CQC about different aspects of their care and treatment. Based on these responses, health providers receive scores out of ten. A higher score is better. Results show the Trust is performing *"about the same"* as most other providers; scores do not indicate a statistically significant change since 2017/18.

Table 12: Results of the Care Quality Commission Adult Inpatient Survey for last available three years – performance against selected metrics for Airedale NHS Foundation Trust

	2016/17	2017/18	2018/19
[Q34] Were you involved as much as you wanted to be in decisions about your care and treatment?	**7.5**	**7.5**	**7.3**
[Q35] Did you have confidence in the decisions made about your condition or treatment?	**8.3**	**8.3**	**8.4**
[Q36] How much information about your condition or treatment was given to you?	**8.2**	**8.8**	**8.8**
[Q48] Did you feel you were involved in decisions about your discharge from hospital?	**7.2**	**7.0**	**7.3**
[Q62] Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	**5.7**	**6.2**	**6.3**
[Q67] Overall, did you feel you were treated with respect and dignity while you were in hospital?	**9.0**	**9.0**	**9.0**
[Q68] Overall, how would you rate the care you received?	**8.0**	**8.2**	**8.1**

Data source: Care Quality Commission *National NHS Adult Inpatient Survey 2018 (published June 2019).*

Benchmarks:

GREEN = best performing trusts. **GREY** = about the same **RED** = worst performing trusts.

In addition to the annual *CQC Adult Inpatient Survey*, NHS England's *National Cancer Patient Experience Survey* 2018 of 350 patients – a response rate of 68 per cent and above the national rate – was published in September 2019 with the following case-mix adjusted findings for privacy, dignity and compassionate care:

- Of the 127 respondents to the question, "*Were you always treated with dignity and respect by staff?"* 84 per cent agreed. This result is below the national average, albeit not significantly.
- Of the 127 respondents to the question, "*Were you always given enough privacy when discussing your condition or treatment?"* patients gave an average score of 83 per cent. The score is within the expected range.
- For the overall care rating where zero is poor and ten is very good, patients gave an average rating for Airedale of 8.7; the national average score was 8.8.

Other patient survey results published in the last year:

Emergency Department Survey 2018, published October 2019. Eligible patients were aged 16 or over who attended the Emergency Department during September 2018. Responses were received

from 413 patients, a response rate of 34 per cent as compared to a national rate for the 132 participating departments of 30 per cent. Privacy at the reception, acknowledging patients, involving family, friends or carers and privacy when examined was *"about the same"* as other providers. Overall respect and dignity was *"about the same"* with a score of nine out of a possible ten (the highest possible score).

Children and Young People's Survey 2018, published December 2019 looked at the experience of children, young people (under the age of 16) admitted to hospital between November and December 2018 and that of their parents and carers. The response rate was 23 per cent as compared to a national rate of 25 per cent for the 129 participating sites.

- Overall parents and carers said they were treated with dignity and respect by staff looking after their child with a score *"about the same"* as other providers: 9.2 out of a possible ten.
- Children and young people scored privacy during their care and treatment as *"about the same"* as other providers.

CQC Maternity Survey 2019 reports on the experience of the 111 women – response rate 37 per cent comparable with the national rate – using our services in February 2018. The following results have been compared against the 126 participating providers with the following results:

  - Of the 108 respondents to the question, "*Thinking about your care during labour and birth, were you treated with respect and dignity?*" Airedale scored 9.5 out of a possible score of ten. The higher the score the better. Results were in line with the 2018 return and about the same as other providers.
- The Trust was one of the better performing providers in the following questions:
  - *"During your pregnancy, did you have a telephone number for a member of the midwifery team that you could contact?"*
  - *"If you raised a concern during labour and birth, did you feel that it was taken seriously?"*
  - *"Thinking about your care during labour and birth, were you spoken to in a way you could understand?"*
  - *"When you were at home after the birth, did you have a telephone number for a midwife or midwifery team that you could contact?"*
- There were no areas identified as worse amongst other providers.

Initiatives and progress in 2019/20

Individualised care is predicated on good communication for patients, carers and families. Training initiatives continue to encourage staff to reflect on how compassionate care can be embedded into practice and reinforcing four principles of patient experience:

1. *"Through your eyes."*
2. *"Making every contact count."*
3. *"No decision about me without me."*
4. *"The patient at the heart of everything we do."*

Patient stories are a potent and reflective tool in reinforcing caring behaviours and can be a valuable learning tool for staff whether this is at the Board of Directors meeting or at more local team level. Such stories both celebrate excellent care and highlight where improvements can be made. Patient stories received at the Board of Directors are in future to be reviewed during the year to ensure that where learning is identified this has been acted upon.

Engagement events with patients and staff, particularly for the more vulnerable groups, aim to understand how substantive improvement in patient experience can be made. Over the last year the Trust has been working with Breast Cancer Now to develop our Pledge for Breast Cancer service which aims to improve the patient experience of cancer care by giving voice to what matters most to this patient group. The Trust also is part of the NHS Rainbow Badge initiative. This is a way for staff to demonstrate awareness of the issues that LGBTQ+ people can face when accessing healthcare.

The 2018 CQC inspection highlighted that the Trust is not fully compliant with the accessible information standard in relation to those people with communication needs relating to disability, impairment and sensory loss. Following participation in July 2019 in the Care Quality Commission's dedicated workshop on how patient and carer needs can be better met, key actions have been planned and include: customer service training *"See the person, not the disability"*; an awareness raising campaign; inclusion of five steps to accessible information within the new quick reference guide for nurses; consideration of the provision of hearing loops; and, the introduction of text assist information on all patient leaflets (staff guidance has been developed).

The extent to which our environment supports the delivery of care with privacy and dignity is a key area of focus. In recent years, a number of estate refurbishment and development projects – most recently Castleberg Hospital – have been undertaken that serve to ensure that people are cared for in a modern hospital environment with privacy and dignity. Following a formal public consultation on the future of Castleberg, the site has undergone a programme or remedial work which has included the creation of two new side rooms with en suite facilities, a new consulting room and family breakout room. This provides greater flexibility with regards to rehabilitation and end of life care.

The Trust aims to promote a culture where staff are treated with respect at work and have the tools, training and support to deliver care and the opportunities to develop and progress. Following the launch of core staff values and leadership behaviours, the *People Plan* has been developed offering practical guidance to managers through a leadership and coaching programme which has seen considerable development in the last year. A Leaders Programme is aimed at new medical consultants, clinical, support service and corporate leaders; the objective being to provide more formalised developmental training.

Our Health and Wellbeing Programme aims to help staff eat well, exercise and take care of mental health; resilience training is available to aid staff to deal with stress. The Staff Open Day entitled, *"A great place to work"* showcased many of these initiatives. This year has seen the launch of Schwartz Rounds, a forum for colleagues from all backgrounds, grades and disciplines across the hospital and community areas to come together to talk about the emotional, personal and social challenges of working within healthcare. Providing a safe environment, the forum allows staff the time and space to reflect on their role, share their stories and offer support to one another.

Our Respect and Dignity Campaign continues to look at how we treat our colleagues. It is important that each of us has an understanding and appreciation of one another's roles and responsibilities. Disrespectful behaviours can be perceived as bullying or harassment, whereas small gestures can make staff feel valued and part of a team. Developmental inclusion work spearheaded by the inclusion groups – BAME, gender, disability and LGBTQ+ – continues to be progressed. Amongst the Brexit uncertainty of the last year, the wellbeing of European Union colleagues has been to the fore with a number of events held to provide the required support and guidance, particularly around settled status. As previously described, an inclusion event was held in October 2019.

Next steps

Future identified areas of improvement are:

- Development of the SUPPORT Programme for patients near the end of life and their relatives and carers with the aim of offering and gathering feedback to direct future improvement work.
- Implementation of the workforce and inclusion strategies via the *People's Plan* and the *Patient and Public Engagement and Experience Strategy 2016-2020*.

3.2 Patient safety

Through targeted quality improvement work, the Trust seeks to reduce patient harm traditionally associated with healthcare, particularly amongst the frail elderly where there is a heightened risk.

3.2.1 Infection prevention and control

The challenge and our aim

Healthcare associated infections (HCAI) are infections that are acquired as a result of healthcare interventions. According to the National Institute for Health and Clinical Excellence, HCAI are a serious risk to patients, causing significant morbidity to those infected. Whilst there are a number of factors that can increase a patient's risk of acquiring an infection, high standards of infection control practice minimise the risk of occurrence. The Trust aims for sustained reduction in the incidence of avoidable harm from C. *difficile*, MRSA and E.coli bacteraemia infection in line with national and local priorities.

How we monitor progress

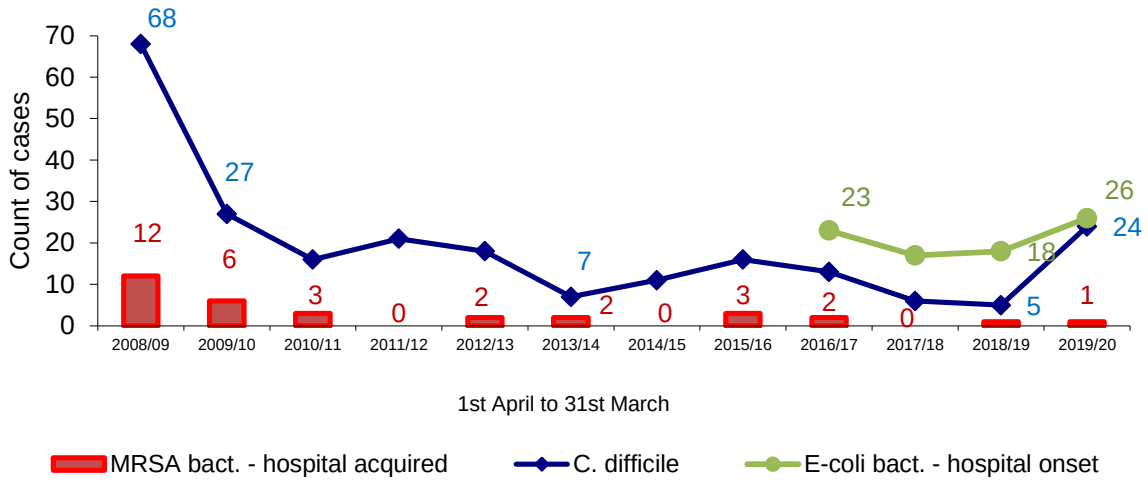
The Infection Control Committee monitors compliance with the standards of *The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance* (Public Health England, 2015). The Bradford and Airedale Infection Prevention Team continues to support an integrated approach to infection prevention and control work streams. To engage with local groups and minimise harm from HCAI, a lay member sits on the Infection Control Committee.

Current status

This fiscal year the Trust reported one hospital acquired MRSA bacteraemia. C.*difficile* reporting objectives changed in 2019/20 with an addition of a prior healthcare exposure element for community onset cases and a reduction in the number of days to apportion hospital-acquired cases, invalidating comparison with previous years. Whilst our threshold target of ten avoidable cases was met, a cluster of cases were identified on an inpatient ward. Key actions around cleanliness have been taken with no further occurrence in that location. This year 26 cases of hospital-acquired E.coli bacteraemia were reported. (All data is governed by standard national definitions.)

In response to the following *2018 NHS Adult Inpatient Survey* question, *"In your opinion, how clean was the hospital room or ward that you were in?"* the Trust scored 8.9 out of a possible score of ten. A higher score indicates better performance. The score is *"about the same*" as other providers.

Figure 7: HCAI cases at Airedale General Hospital



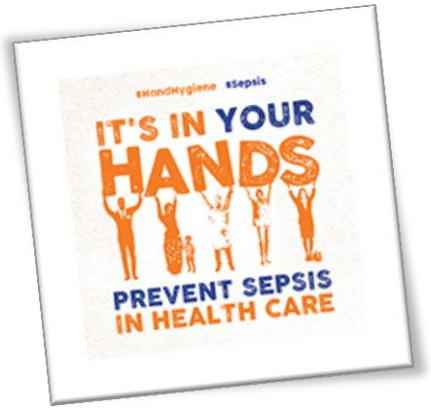
Data source: *Airedale NHS Foundation Trust Infection Prevention.*

Initiatives and progress in 2019/20

To prevent HCAI, we continue to monitor closely the rates of infection, strengthen infection prevention and control measures and learn from best practice. Key measures are described below and should be reviewed in conjunction with section *2.3.8: Rate of C.difficile infection* which outlines additional initiatives and processes. Please note that preparations and support to manage the COVID-19 pandemic in line with national guidance commenced in February 2020 and remain ongoing at the compilation of this report.

Monitoring of infection prevention and control practices:

- Infection Prevention updates and assurance on measures implemented to reduce HCAI are tabled through the nursing and medical governance groups and via the Infection Control Committee.
  - All hospital acquired MRSA bacteraemia and C. *difficile* infections are subject to Post Infection Reviews with learning points cascaded immediately to clinical teams. Methicillin-sensitive Staphylococcus aureus (MSSA) and E.coli cases are investigated if the Consultant Microbiologist requests a review.
  - Infection alerts are in place on SystmOne to ensure staff are aware of patients with a history of MRSA, C.*difficile* and multi-resistant organisms. GPs using SystmOne can now access messages entered by the Infection Prevention Team regarding the infection status of patients.
  - Based on our exemplary national data capture system completion rate, the Trust was selected to take part in the NHS England's protocol, *Understanding the epidemiology of E.coli bloodstream infections in the North of England* from 1st April 2019.



- A new microbiology method of CPE (Carbapenemase-producing Enterobacteriaceae) testing to allow for faster results has been introduced.
- The CQUIN, *Lower Urinary Tract Infection in Older People* aims to promote early diagnosis and appropriate treatment.

Sustained engagement of staff to maintain motivation in preventing HCAI:

- The monthly hand hygiene audit reports a Trust aggregated compliance average of 96.4 per cent between April 2019 and February 2020.[20] This is part of a robust and ongoing infection prevention clinical audit programme to evaluate standards. For example, of cannula and urinary catheter care and Intensive Care Unit's care bundle completion rates.
- Flu vaccination uptake was above the target threshold of 80% for clinical staff in the latest available period.
- The Infection Prevention Team continue to develop and ensure existing policies and guidelines are current. This includes complementary patient information leaflets. Screensavers alerting staff to key infection control and prevention messages have been adopted, for example, Norovirus and CPE.
- Mandatory training and bespoke programmes are ongoing and now includes Gram negative bloodstream infections. Staff are assessed against aseptic technique competency. A Bradford and Airedale Infection Prevention Study Day aims to promote infection prevention and control principles to a wider audience.

Ensure the environment is fit for purpose and supports infection control practice:

- To improve patient hydration, water stations have been made available on the elderly care wards.
- Domestic Services, Matrons and the Infection Prevention Team have worked closely to monitor standards of cleanliness, including inspections of the care environment, spot audits and routine cleanliness audits in line with national NHS specifications. A project group has been established to initiate work on Draft National Cleaning Standards from NHS Improvement.
- A change to ward domestic allocation, for example out of hours, enables a higher level of cleaning. A recruitment drive has further augmented the standard of service, particularly in the evenings.
- Routine cleanliness audits are undertaken in line with the NHS framework of audit; a work programme is maintained by the Enhanced Cleanliness Team, including a programmed curtain change.
- Biannual hygiene audit of catering is ongoing. The Department of Health awarded five stars to the main hospital site.
- Legionella has been effectively targeted through a programme of work to remove little used water outlets with enhanced surveillance in place to ensure progress is maintained. Pseudomonas aeruginosa have now been added to work around water outlets
- Following on from the CQC 2018 inspection recommendation that Surgical Service ensures all applicable equipment is included within cleaning schedules and is fit for use, processes have been established with all necessary actions implemented.
- In response to a national clinical waste disposal issue in September 2018 which lasted for a 12 month period of time, waste management in the organisation reverted back to *"business as usual"* with the exception of non-infectious health care waste (offensive waste) continuing to be held in a container on site.
- To provide an ultra-clean environment to enhance the surgical procedures undertaken in the Dales Suite, particularly our cataract service, the Trust has ordered a SurgiCube.

Antimicrobial stewardship is crucial to minimising resistance. Antibiotic prescribing for inpatients is reviewed by the Consultant Microbiologist and Antibiotic Pharmacist on a weekly basis to optimise the appropriate treatment of patients with infections and minimise the risks associated with inappropriate antibiotic treatment (anti-microbial resistance and healthcare acquired infections). Antibiotic audit indicates a high compliance with Trust guidance. Work to align antibiotic guidance across regional acute providers and harmonise prescribing across community settings is ongoing.

[20] Airedale NHS Foundation Trust Infection Prevention.

Next steps

In support of the above we continue to:

- Develop new and existing policies, guidelines and information leaflets for patients.
- Monitor and risk assess the potential impact of any new or emerging infections and new developments or innovations.
- Plan to reduce Gram-negative bloodstream infections by 50 per cent by 2023; and,
- Promote hand hygiene for patients with a particular focus before meals and after using the toilet.

3.2.2 Improve the prevention, early identification and management of Acute Kidney Injury

The challenge and our aim

Acute kidney injury (AKI) is a sudden episode of kidney failure or kidney damage that happens within a few hours or days, usually as a complication of another serious illness. AKI causes a build-up of waste products in the blood making it difficult for the kidneys to correct the balance of fluid in the body. It usually occurs without symptoms making it difficult to identify. It is estimated that one in five emergency admissions into hospital are associated with AKI and that up to 40,000 excess deaths per year in hospital are due to AKI.[21] Up to 30 per cent of these deaths may be potentially avoidable.[22] Whilst there has not been any local patient engagement as such in the local prioritisation of this work, patients have fed into the national initiatives with our staff participating in the Acute Kidney Injury National Confidential Enquiry.

In recognition that early detection and management has a profound effect upon patient outcomes we seek in collaboration with our partners to raise awareness with the aim of reducing the number of patients who develop AKI across the locality. More specifically within the hospital the aim is a reduction in preventable hospital acquired acute kidney injury and in mortality.

How we monitor progress

Progress is monitored via the Trust's Patient Safety Group and as part of the multi-disciplinary mortality review process overseen by the Medical Director with performance evaluated through the summary hospital-level mortality indicator acute and unspecified renal failure diagnosis breakdown.

Current status

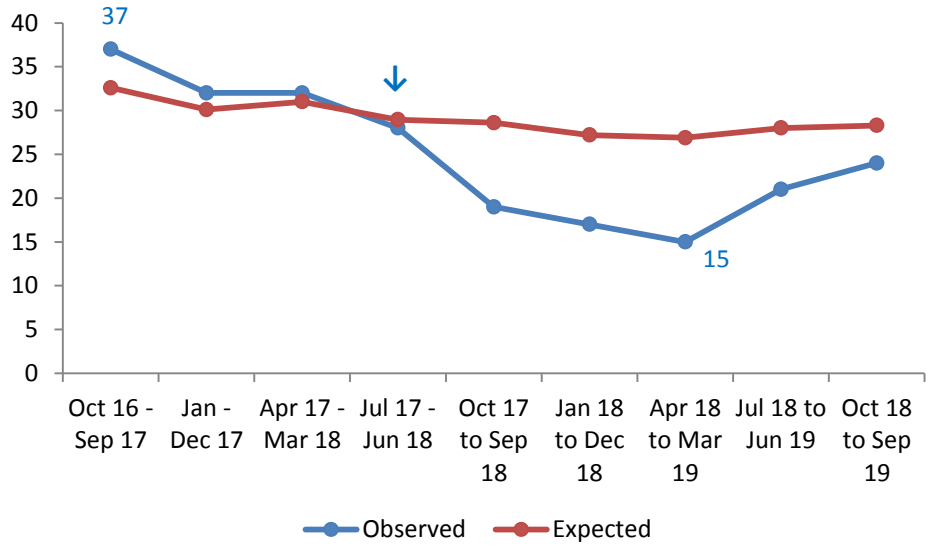
Mortality ratios can provide useful measures and insight. The summary hospital-level mortality indicator is the ratio of actual deaths and the number expected to die within 30 days of discharge from hospital on the basis of average England figures, given the characteristics of the patients treated. The indicator is updated quarterly and based on a rolling one year and released six months

[21] Wang H, E, Muntner P, Chertow G, M, Warnock D, G, Acute Kidney Injury and Mortality in Hospitalized Patients. Am J Nephrol 2012;35:349-355

[22] National Confidential Enquiry into Patient Outcome and Death (NCEPOD) [2009] Adding Insult to Injury

in arrears. The following figure charts observed deaths against expected for the acute and unspecified renal failure diagnosis breakdown.

Figure 8: Summary hospital-level mortality indicator – observed: expected acute and unspecified renal failure



Data source: *NHS Digital [latest release February 2020]*

Over the last two years observed deaths have decreased from a high of 37 to a low of 15. Case mix will account for some natural variation between data points. However, the sustained shift of observed deaths below those expected by the risk model commencing in the period July 2017 to June 2018 indicates an important change in outcome. Quality improvement initiatives around the management and treatment of sepsis – described in 2.1.3 of this account – is considered to have supported this improvement in patient outcomes.

Initiatives and progress in 2019/20

A revised care bundle – AKI R3 – was launched in 2018 within the Acute Assessment Unit. However, detailed review showed little evidence of benefit and the evidence base for AKI care bundles leading to a measurable improvement in either AKI incidence or clinical outcome remains weak. A mortality case note review undertaken by the Mortality Review Group highlights the challenge of identifying patients with a hospital acquired AKI from patients with AKI on arrival, making assessment of care and treatment difficult. Of the five AKI deaths reviewed, it was noted that the AKI R3 tool was appropriately completed.

The primary aim of NHS England's acute kidney programme "*Think Kidneys"* is to reduce the risk of acute kidney injury. It is thought that two of every three cases of AKI are already present before hospital admission. In those cases that develop in hospital there may be factors that link to primary care such as a delayed admission with acute illness or inappropriate prescribing. Developmental work to improve and co-ordinate clinical pathways and work streams between primary and secondary sectors is being undertaken to understand where additional work is required. In addition a review of patient safety leads within the organisation is planned with the aim of integrating quality improvement initiatives – AKI, management of sepsis and venous thromboembolism, standardised clinical assessment (National Early Warning Score - NEWS2) – into a whole system of holistic care around the deteriorating patient to further avoid potentially preventable deaths.

Next steps

Future work and our approach will be guided by the 2020 NICE guideline on the detection, management of acute kidney injury in children, young people and adults. It aims to improve assessment and detection by non-specialists, and specifies when people should be referred to specialist services. Through early recognition and treatment, the risk of complications in people with acute kidney injury is reduced.

3.2.3 Frail Elderly Pathway Team initiative

According to NHS England there has been a 65 per cent increase in the episodes of care in hospitals for those aged 75 and over. As we age, we can become more vulnerable to sudden events such as an infection or a fall. Whilst there are times when a frail older person requires hospital admission, evidence suggests that if frail older people are supported to retain and/or recover independence after illness or injury they are less likely to reach crisis and require urgent care.[23]

Care co-ordination is part of transformational work to integrate and co-ordinate the contributions of nursing, medical, allied healthcare professionals, social workers, mental health professionals, GPs, care homes and voluntary organisations into a cohesive system. One such initiative developed over the last five years is the Frail Elderly Pathway Team which aims to instigate proactive care models such as personalised care and support planning and the targeting of geriatric resources.

Composed of Physiotherapists, Occupational Therapists, a Dietician and Senior Nurse, and with some social work input, the team is based on the Acute Assessment Unit with Emergency Department in-reach. The Frail Elderly Pathway Team's key objectives are to:

- Reduce hospital admissions by early specialist integrated assessment and intervention;
- Facilitate early discharge by commencing rehabilitation at the earliest stage to optimise recovery;
- Reduce length of hospital stay by rapid signposting to Intermediate care and Community Services;
- Act as an interface with Community Advanced Nurse Practitioners from the Collaborative Care Teams and work alongside voluntary and charitable services to avoid unnecessary admission through timely onward referrals; and,
- Provide integrated holistic care and treatment.

How we monitor progress

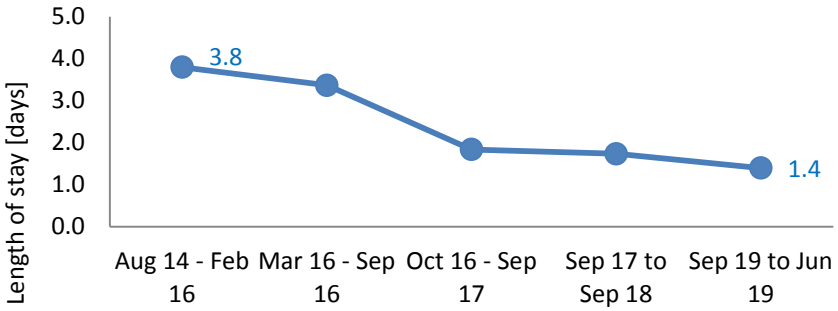
From conception of the Frail Elderly Pathway Team in 2014, monthly governance meetings were held until 2019 when this became *"business as normal".* Frail Elderly Pathway Team activity data is reviewed monthly in order to improve the active management and care for older patients attending the Emergency Department and admitted to the Acute Admissions Unit. Intelligence on length of stay, discharge numbers, as well as patient feedback is shared with the Acute Admissions Unit Team and its governance meetings.

[23] NHS England (2014), *Safe, compassionate care for frail older people using an integrated care pathway.* https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf [Accessed: 8/12/17]

Current status

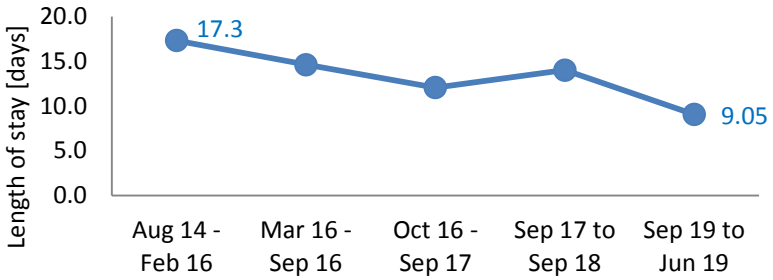
A key performance indicator is length of stay, with the Frail Elderly Pathway Team aiming to reduce hospital stays for individual patients during each admission. The data below includes a baseline period (August 2014 to February 2016) when data collection commenced, and performance following the merger of the Ambulatory Care Unit with the Acute Medical Unit – now the Acute Assessment Unit – and the extension of the Team (March 2016 to September 2016). Between October 2016 and September 2017 seven day working was fully established which allows assessment of whether the Team has been able to improve outcomes from the point at which it was able to work most effectively. More recent figures allow evaluation of longer-term performance.

Figure 9: Length of Stay for patients seen by the Frail Elderly Pathway Team and discharged directly from the Acute Assessment Unit



Overall and since the establishment of the team there has been a 2.4 day reduction in average length of stay per patient.

Figure 10: Length of Stay for patients seen by the Frail Elderly Pathway Team on the Acute Assessment Unit before being transferred to base wards for input from other specialties prior to discharge



Data source: *Airedale NHS Foundation Trust Information Services.*

Overall and since the establishment of the Team there has been an 8.3 day reduction in average length of stay per patient who after Frail Elderly Pathway assessment are admitted to a base ward. An average of 25 patients are seen each month in the Emergency Department with 48 per cent of these being discharged to the community and not admitted to an acute ward. Of the patients seen by the Frail Elderly Pathway Team in the Acute Assessment Unit, almost 53 per cent were discharged to the community and not admitted to an acute ward.

Qualitative patient feedback regarding the Frail Elderly Pathway Team indicates the Team is making a tangible difference to the patient experience.

"All members of the team were very polite and introduced themselves. They made me feel very safe, even though the assistance was 'hands off' allowing me to move myself in my own fashion".

Initiatives and progress in 2019/20

The Frail Elderly Pathway Team is an integral component of the Acute Assessment Unit – the integrated Emergency Department, Acute Medical, Surgical Assessment, and Ambulatory Care Unit. Seeking to avoid admissions, the Team offers advice on the Unit's pathways of care and contributes to the rapid improvement events. The Team leads the daily safety walk-rounds. Patients at risk of falling are provided with their usual walking aid (if this was not brought into hospital), non-slip socks and call bell.

More recently the Team invited Social Services to attend daily meetings in support of effective discharge planning. This has developed into the *"Get Me Home"* meetings and includes patients from across the hospital. To improve synergy with the Digital Care Hub, the Frail Elderly Pathway Co-ordinator is located in the Digital Care Hub and works closely with the Multi-agency Referral Hub. The Frail Elderly Pathway Team continues to identify suitable patients for the existing Home First Services for East Lancashire and the new Airedale, Wharfedale and Craven Home First Service. A Geriatrician attached to the Frail Elderly Pathway Team commenced in January 2019.

Other progress and achievements:

- A robust in service training programme for staff working within the Team and also for the ward based staff is in place. Over the last year the Team has delivered training on: the Red Bag Pathway, frailty, walking aids, catheter care, dementia and delirium, and gait and mobility. The Frail Elderly Pathway Team has also participated in the NHS Improvement Collaborative Frailty initiative, focussing on the recognition, treatment and prevention of constipation.
- Research into the positive impact of a dietician improving outcomes in fail elderly patients has been published in the last year.[24] Increased numbers of patients are being reviewed by the Frail Elderly Pathway Team dietician with the majority of patients seen in the community setting. With demonstrable improvement in weight, strength, mobility, activity and wellbeing, patient feedback also suggests patients appreciate a home visit rather than clinic appointment. In the last year the Frail Elderly Pathway Team welcomed a dietician from the Humber region interested in our work and establishing a similar service.
- The Community Malnutrition Pathway has been updated and includes a formulary for oral nutritional supplements.
- The Team dietitian continues to provide teaching and training with 18 sessions delivered across services and 177 attendees. These sessions aim to increase knowledge and understanding of the importance of nutrition and hydration.
- Minimising the effect of deconditioning from being in hospital for an extended period of time. Research has highlighted that (new) incontinence develops in 42 per cent of older people within 24 hours of admission. There is a 35 per cent loss of muscle strength within seven days. These factors increase the risk of falling in hospital. Initiatives to counter these effects include: ensuring patients understand the harm of bed rest, encouragement of inpatients to get out of bed and mobilise, promotion of a nutritious diet to prevent muscle atrophy, and discharge home as soon as possible.
- The perceptible transformation made by the establishment of a Frail Elderly Pathway Team has been recognised at local and national level through a series of awards and nominations. In the last year the Frailty Team's work as part of the NHS Improvement Collaborative on Frailty on the early assessment, diagnosis and management of constipation has been voted *"improvement*

[24] The Positive Impact of a Dietitian Improving Outcomes in Frail Elderly Patients in the Community Nick Bergin & Riddhi Desai (2019). CN Focus; Vol 11, No. 3

most likely to be adopted across the NHS". These continuing accolades illustrate the unique role that allied health professionals can play within the wider social, health and care sectors.

Next steps

- Extending the Frail Elderly Pathway Team working day was trialled from December 2019; data is being collated to understand the impact.
- Staffing-wise, there is consideration of the introduction of Assistant Practitioners into the existing team. A Frailty Advanced Nurse Practitioner is planned to start with the Frail Elderly Pathway Team in 2020.
- Social workers are to be based in the Digital Care Hub in 2020 to improve communication and responsiveness.
- It is planned to have a Frailty Unit based on Ward 10.

3.3 Clinical effectiveness

The following projects focus on the delivery of clinical excellence in care and treatment through the delivery of evidence based guidance.

3.3.1 Quality of healthcare for people with long-term conditions – Airedale Digital Care Hub

The challenge and our aim

There is evidence – both at local and national level – to suggest that people, particularly those with long-term conditions, want to have control over decisions about their care, desire to live a normal life and do not wish to spend time in hospital unnecessarily.[25] Assistive technologies, such as telemedicine, can allow patients to manage their conditions and avoid time-consuming and costly trips either to hospital or outpatient clinics. Airedale's Digital Care Hub aims to care for patients closer to home whenever it is safe to do so; people with chronic illness can avoid emergency treatment and admission if their condition is well-managed.[26]

How we monitor progress

The multi-disciplinary Digital Care Hub Business and Governance Group is responsible for the delivery of this priority. Qualitative and quantitative monitoring is ongoing both internally and externally to support assessment of the impact of the innovation and inform future initiatives and strategy.

Current status

The Airedale Digital Care Hub offers teleconsultation by secure video link with nursing and residential homes. Staffed seven days around the clock by highly skilled registered healthcare practitioners (24/7), the team has developed to include Acute Care, Urgent Care and District

[25] Department of Health (2011), *Whole System Demonstrator Programme.* Available from:- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215264/dh_131689.pdf [Accessed 02/02/18].

[26] Dr Foster Intelligence (2013), *Dr Foster Hospital Guide 2013*. Dr Foster Limited. p.10.

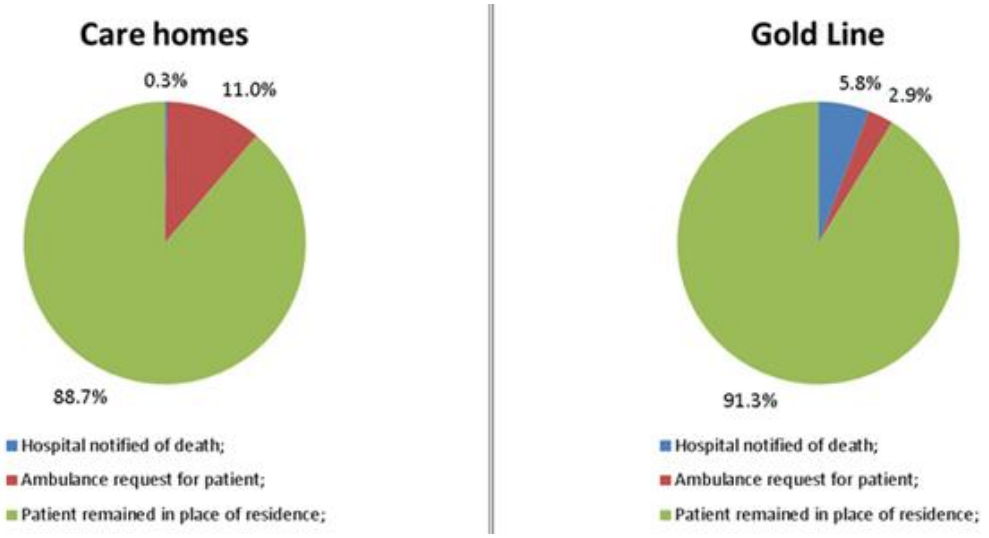
Nurses, Fall Practitioners and Occupational Therapists. Areas of additional expertise include specialisms in dementia and palliative care. If required, escalation to a Consultant is available. Via the Hub, the team can review ongoing clinical observations. Access to the SystmOne GP record has made available care plans and patient medication information in support of clinical decision-making. It also means that a patient's GP is kept informed of consultations. If a patient needs to come to hospital, staff are able to communicate with the Ambulance Service to ensure a direct admission.

Country-wide over 400 nursing and residential care homes are connected to the Hub via the Immedicare Service. Some of the primary reasons for care homes contacting the Hub include: falls, suspected urinary tract infections, skin complaints, chest infections, pain management and medication issues. Where care homes have Hub access, remote assessment can reduce hospital stays, helping residents to get back home whilst ensuring support and monitoring is in place. Although the Immedicare across Airedale, Wharfedale and Craven district was decommissioned in 2018, the service has been commissioned in two new facilities: Valley View Keighley and Mayfield in Ilkley.

The Gold Line Service is another example of an innovative approach available via the Digital Hub. Created in partnership with patients, carers, GPs, commissioners and Manorlands Hospice, and made possible through a grant from the Health Foundation. The Gold Line service provides a single point of contact for patients in the last year of life and their carers to be able to access 24/7 help and advice via the Hub. The initial pilot commenced in 2013 across Airedale, Wharfedale and Craven and was extended to the remainder of the Bradford district and its metropolitan populations in 2014. Five years on, 97 per cent of patients accessing this innovative service remain at home at the end of life.

The following chart illustrates patient outcomes for those registered with and accessing these assistive technologies from the Hub.

Figure 11: Patient outcomes April to December 2019



Data source: *Airedale NHS Foundation Trust Information Services.*

- ✓ The Hub regularly receives around 2000 video calls each month from nursing and residential home patients across England and received calls from over 6500 thousand individual patients between April and December 2019.
- ✓ Each month the Gold Line Service handles around 1500 telephone calls and received almost 2000 individual patient calls between April and December 2019.

✓ Patients from over 500 GPs and 50 plus commissioning groups have been triaged across both the Care Home and Gold Line services. [27]

Other services and progress in 2019/20

Services delivered from the Digital Care Hub which support safe and clinically effective standards of care for those patients with long-term conditions include:

- The Multi-agency Referral Hub

With the launch of the Multi Agency Discharge Team (MAID) in late 2017 a review of how this service and the Intermediate Care Hub (IC-Hub) worked together was undertaken. As a result, overlap and duplication was removed and a new team created called the Multi-agency Referral Hub replacing the previously separate services to deliver a holistic and responsive care model.

During 2019 two new services were launched in the Digital Care Hub:

- A 24/7 service to support patients living with Parkinson's disease who are registered to the Parkinson's Specialist Nursing Service. The aim of this service is to support patients in their own homes by providing support and advice from the Digital Care Hub clinical team and where needed co-ordinating their care by referring to other services to provide specialist support or arranging a home visit.
- *MyCare24* for patients presenting in the Emergency Department or the Acute Admissions Unit who may need some extra support at home for a short period of time. Proactive telephone or video calls are made by the clinical team to ensure the patient is managing at home. Patients are also able to call the MyCare24 team in the Digital Care Hub if at any time they should feel anxious, unwell, become worried or are finding it difficult to get help.

- Specialist Speech Therapy Service

Following a successful 2017/18 pilot project to deliver an on-screen stammering therapy, the service offers a specialist speech therapy service to adults across the UK via video link to patients' laptops, tablets and mobile phones. For patients this approach has many advantages over traditional clinic-based therapy: no travel or parking costs and no need to take time off work. Having won a Guardian Public Service award in 2017, the team were finalists at the 2018 Health Service Journal awards and in 2019 its manager received a Giving Voice award from the Royal College of Speech and Language Therapists in recognition of her commitment to improve the lives of people who need speech and language therapy. The service continues without external funding. The team are successfully supporting people to access the service through Individual Funding Requests submitted via their GP, and referrals have also been received from other providers who do not offer a specialist service.

Next steps

MyCare24 is being developed further to provide support to people living with chronic obstructive pulmonary disease in Airedale, Wharfedale, Craven and Bradford. The service will be launched in the early part of 2020 and will initially run as a six month pilot; an evaluation will test the viability of the service. As a rural Trust it is important to consider the needs and respond to the challenges of looking after people in rural areas. As highlighted, the pilot initiative to support Parkinson's patients with the Hub helps to keep these patients in their own homes and prevent potentially unnecessary

[27] Data source: *Airedale NHS Foundation Trust Information Services.*

Emergency Department attendances through the provision of clinical and psychological support. Such innovative approaches have a key part to play in the delivery of the *NHS Ten Year Plan*.

3.3.2 The monitoring of Caesarean section rates through the safe promotion of physiological birth

The challenge and our aim

Whilst it is important to point out that a caesarean is in itself, not an adverse outcome and in many cases is the most appropriate action to take to ensure that there is no preventable loss or morbidity, there are a number of risks associated with this procedure for mother and baby. The Maternity Unit aims to optimise opportunities for active physiological birth and to reduce medical intervention where appropriate. Both medical and midwifery staff are fully committed to this philosophy of care.

Following the Royal College of Midwives revised guidance regarding *"normal birth"* we have reviewed our guidelines. We scrutinise what women tell us about our service – most recently in the *2019 CQC Maternity Survey* – and as a service are committed to providing a positive experience for all women under our care.

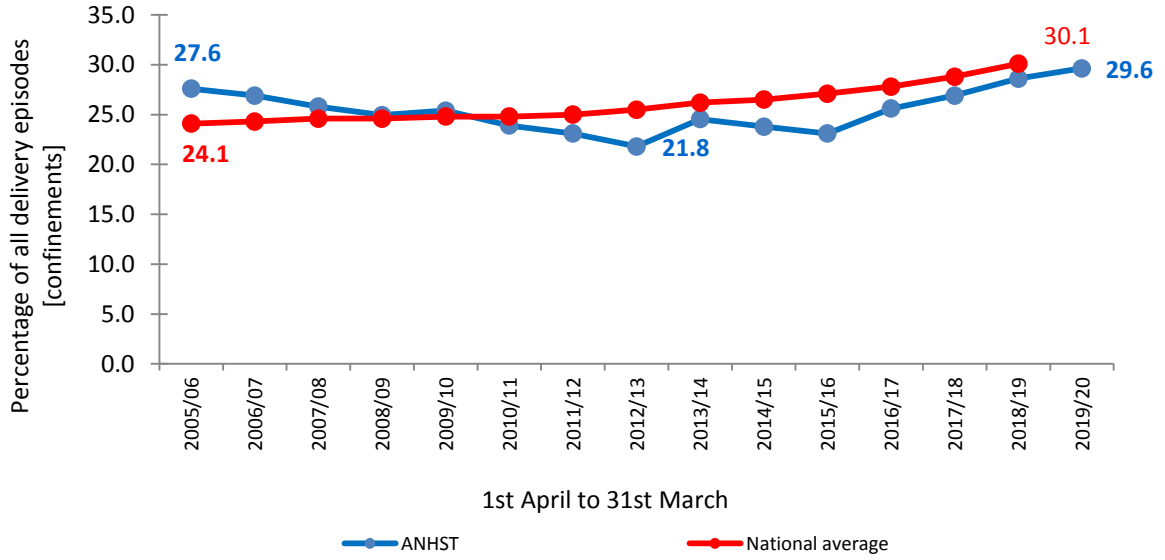
How we monitor progress

To understand performance against this priority, the multi-disciplinary Women's Integrated Governance Group receives monthly aggregated and disaggregated caesarean section rates. Case note review by senior staff against guidance and recommendations for best practice in respect of elective and non-elective caesarean section is regularly undertaken and informs the group discussion. Maternity Voices Partnership Groups have been set up to support the voices of service users to be heard and shape future services. Alongside Family and Friends and Real Time Survey findings, this feedback informs discussion around service provision.

Current status

The latest available England percentage of caesarean hospital deliveries is 30.1 per cent for 2018/19, reflecting a continuing national incremental trend in caesarean birth. The Trust's overall 2019/20 caesarean section rate of 29.6 per cent and shows an increasing trend. Finer grained analysis indicates that the rate for electives is 14.2 percent compared to the England 2018/19 average of 13.2 per cent.

Figure 12: Caesarean section rate for Airedale NHS Foundation Trust long-term trend



Data Source: *Information Services and NHS Digital .*

Initiatives and progress in 2019/20

The service has worked with women, midwives, clinicians, leaders, managers, researchers and commissioners to implement the national *Better Births (*Maternity Review *2016)* recommendations to reduce stillbirths and mother and child deaths through the implementation of a team continuity of care model. Team continuity is defined as each woman having an individual midwife who is responsible for co-ordinating care and who works in a team of up to six midwives. The woman may potentially meet all members of the team but a "*buddy system*" is in place to reduce the number of midwives seeing women.

The initial trajectory was that 20 per cent of women booked for maternity care at Airedale NHS Foundation Trust would receive team continuity of carer by March 2019. The Trust is currently at approximately 12 to 15 per cent continuity of carer. The team have an on call approach to delivery of care; feedback from women as to this approach is positive. Due to the impact of continuity of carer across the wider midwifery workforce, a project manager has been appointed to re-scope midwifery teams. A phased approach to meeting the 35 per cent March 2020 threshold is planned with support being received from Human Resources and the Local Maternity System (LMS).

Other ongoing work includes:

- The service is part of the National Maternity and Neonatal Health Safety Collaborative, a three year programme launched in 2017 to promote a safety culture and national and neonatal systems and thereby reduce rates of maternal and neonatal deaths, stillbirths and injuries that occur during or soon after birth. In Phase 1 the service has implemented quality improvements around post-partum haemorrhage and third and fourth degree tear rates. A LMS wide drive to improve safety and ensure right place of birth for preterm babies has been agreed.
- The bespoke Midwifery Led Unit provides a homely environment. With access to a private outdoor space and a less clinical labour room, it offers a relaxing place to give birth. Resources include a birthing pool. Figures for 2019 indicate almost seven per cent of women labouring in the pool and around four per cent giving birth in water.
- Women who have had one previous caesarean section for a non-recurring reason and who are not at increased risk of uterine rupture in labour are actively encouraged to aim for vaginal birth

in the subsequent pregnancy (VBAC). The service's goal is to reduce the number of second caesarean sections through the implementation of the following:

  - The Patient Decision Aid (PDA), introduced in 2014 and reviewed and updated in 2019, aims to ensure that all women eligible for VBAC receive and have the opportunity to discuss essential information upon which to base their decision about method of delivery.
  - The Midwife led VBAC clinic, allowing those women who are undecided about VBAC following discussion with an obstetrician, to have a further opportunity to discuss all options prior to a final decision. Clinic attendance is low and has been incorporated in quality improvement initiatives in the coming year.

- External Cephalic Version is offered to women with a baby in the breech position and for whom it is safe. This may remove the need for caesarean section in those women for whom this manoeuvre is successful.
- A Rapid Improvement Event supported by the Quality Improvement Team was held focusing on induction of labour with an emphasis on a multi-disciplinary team approach and supporting informed choices. Ongoing quality improvement is taking place across the LMS.

Next steps

Other planned and ongoing work includes:

- Joint working with Bradford University and the multi-disciplinary team to improve care of the perineum in second stage of labour and reduction in third/fourth degree tears.
- Review of midwifery workforce to facilitate the safe introduction of continuity of carer, *Saving Babies Lives* and improved patient experience for women who attend the unit for induction of labour.
- Inclusion of antenatal home risk assessments in the *Vulnerable Women Pathway.*
- Training of midwives to undertake New-born Infant Physical Examination and BCG vaccinations.
- Support of Neonatal Unit to transition of a Level One Unit. Work will include the standardisation of local guidelines and pathways with Bradford Teaching Hospitals NHSFoundation Trust.
- Continued monitoring and evaluation of term admissions to the neonatal unit and re-admissions of mothers and babies to improve outcomes for mothers and babies.

3.3.3 Fractured neck of femur improvement project

The challenge and our aim

A broken hip, also known as a fractured neck of femur, is the most serious consequence of a fall, with the risk of occurrence increasing with age. According to NICE, the majority of fractured necks of femur happen in elderly patients with osteoporosis; mortality is high although most deaths are from associated conditions and not the fracture itself.[28] For those who recover, there is a possibility of a loss in mobility and independence.

Research suggests that organisational factors in a patient's treatment can affect outcomes. Our aim is to improve recovery from fractured neck of femur by focussing on such factors in a patient's treatment.

How we monitor progress

[28] NICE (2011), Hip Fracture. *The management of hip fracture in adults. NICE clinical guideline 124.* NICE: Manchester.

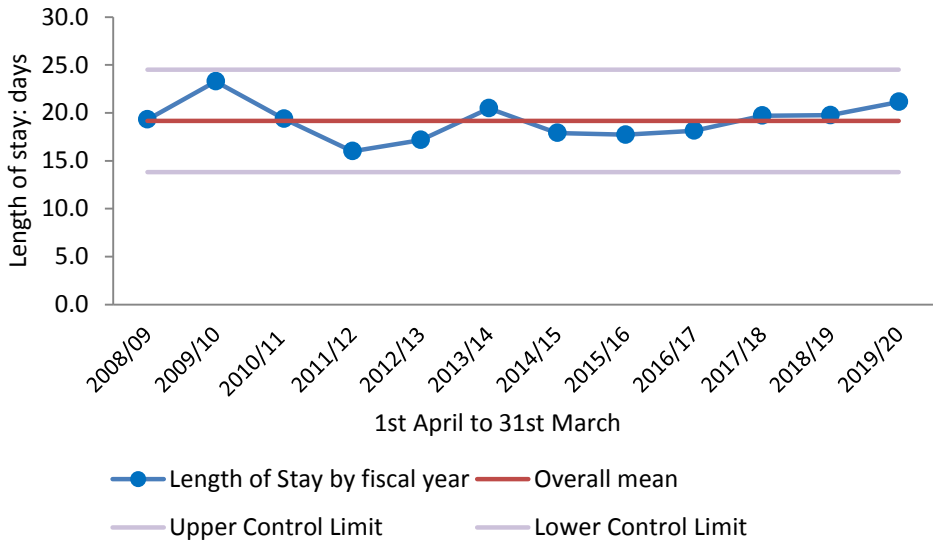
Orthopaedic multi-disciplinary audit governance meetings are held monthly to identify areas of improvement and understand outcomes for this group of patients.

Current status

Measurement over time is essential to understand progress and the governance group monitors best practice targets and participates in the Royal College of Physicians' Falls and Fragility Fracture Audit Programme. According to the National Hip Fracture Database, of the 316 patients admitted with a fractured neck of femur in 2019, 220 were eligible for best practice tariff, a nationally agreed standard of care that all hospitals should adhere to. In the last calendar year performance has improved by four per cent to 73.5 per cent.

A further marker of the quality of care that patients receive is the total length of NHS care following a fractured neck of femur with a shorter length of stay associated with less risk.

Figure 13: Fractured neck of femur mean length of stay [days] for Airedale General Hospital patients



Data source: *Airedale NHS Foundation Trust Information Services.*

The figure describes our performance in the last ten years in the reporting period 1st April to 31st March: mean length of stay is around 19 days with upper and lower confidence interval (three standard deviations) ranging from 14 to 25 days. These intervals help to identify variation which falls outside the expected limits and supports understanding of whether length of stay is longer or shorter than expected. Performance is consistently around the average.

Initiatives and progress in 2019/20

The eight key areas for the best practice tariff are: nutrition risk assessment; mental test score on admission; 36 hour target to Theatre; delirium assessment; 72 hour target to be seen by ortho-geriatrician; falls assessment; bone health assessment; and, physiotherapy assessment. The best practice tariff has been extended from January 2020 and now includes distal, shaft, and peri-prosthetic fractures. To augment delivery of the best practice pathway and improve fragility fracture outcomes for this patient group, the following actions have also been undertaken:

- As of April 2018 post-operative provision of physiotherapy seven days a week (prior to this it was only available weekdays). This ensures that all patients who are fit enough are mobilised from bed the day following surgery to reduce complications.
- Commencing April 2018 all hip fracture patients are only admitted to the Orthopaedic ward (Ward 9). The provision of a Hip Fracture Receiving Bed on Ward 9 supports the fast track transfer of a patient with a hip fracture from the Emergency Department. The patient can then be moved into another Ward 9 bed rather than being nursed in beds not overseen by specifically trained orthopaedic nurses.
- Delivery of pre-operative carbohydrate loading drinks to minimise unnecessary pre-operative starving of hip fracture patients awaiting surgery. Ongoing advice and support has been augmented to improve provision. Post-operative nutrition has been addressed through offering protein supplements as there is evidence of benefits for this patient with a fragility fracture.

Other initiatives:

- In collaboration with commissioners, the Orthopaedic Team has set up a Fracture Liaison Service (FLS) to minimise future fragility fractures. Launched in October 2019 and led by an Orthopaedic Clinical Specialist Sister and an Orthopaedic Consultant, the multi-disciplinary service aims to identify, investigate, initiate treatment and integrate care for all eligible inpatients aged 50 and over with a fragility fracture. Areas of focus are: improved nutrition, exercise and risk assessment for inpatients as well as an outpatient clinic. This initiative addresses areas of shortfall against the NICE guidelines for fragility fractures as identified in local clinical audit of standards. To ensure the effective implementation, a robust patient pathway has been agreed with the National Osteoporosis Society and additional nursing staff recruited.
- Established of an ad-hoc dressing clinic for orthopaedic patients needing wounds re-dressed or reviewed. Patients requiring this service are referred directly to the Orthopaedic Nurse Specialist (ONS).
- The opening of an Intermediate Care Unit and Harden Ward Castleberg to rehabilitate patients.

Next steps

- As a small acute provider, there can be wide variations in activity. It is planned that there will be additional Theatre capacity in Orthopaedics in 2021. This will allow flexibility to absorb these fluctuations in demand for acute theatre time.
- To continue to develop FLS, particularly collaborative working with other multi-disciplinary teams – physiotherapists, dieticians, and GPs – and possible provision of bone medication clinics.
- FLS team to undertake post graduate certificate in Osteoporosis and Falls Management
- Airedale will be involved in a quality improvement collaborative commencing June 2020 to improve mortality after hip fracture by establishing a nutritional assistant post.
- There is also collaborative work being undertaken with Bradford Teaching Hospitals NHS Foundation Trust within the Orthopaedic Unit (as part of the wider Acute Provider Collaboration). So far this has consisted of a launch meeting. A workshop is being organised.

3.4 Performance against key national priorities

The following indicators support the national priorities and form part of the appendices 1 and 3 of the current *Single Oversight Framework*. Returns conform to specified data quality standards and prescribed standard national definitions[14] and are subject to third party scrutiny and review.

Indicator	Threshold	2018/19	2019/20
All cancers: 62-day wait for first treatment, comprising either:			*National data reporting was suspended in 2019/20 to reduce the burden and release capacity within the NHS to manage the COVID-19 pandemic. Final and complete figures for the fiscal year are therefore not available.*
▪ from urgent GP referral to treatment	85%	Ⓐ 86.05%	
▪ from NHS Cancer screening service referral	90%	90.7%	
Maximum 18 week waits from referral to treatment in aggregate – patients on an incomplete pathway	92%	92.7%	
A&E maximum waiting time of four hours from arrival to admission/ transfer/ discharge	95%	Ⓐ 89.22%	
Clostridium difficile: variance from plan	6	6*	
Maximum 6 week wait for diagnostic procedures	99%	96.3%	

* One case awaiting review.

Ⓐ = subject to third party audit on behalf of NHS Improvement. Data testing was stopped in 2019/20.

Data source: *Airedale NHS Foundation Trust Information Services.*

Part 4: Annex

4.1 NHS Bradford District and Craven Clinical Commissioning Group (CCG)

The draft *Quality Report* 2019/20 was circulated to NHS Bradford District and Craven CCG for comment with the following feedback received:

NHS
Bradford District
and Craven
Clinical Commissioning Group

Scorex House
1 Bolton Road
Bradford
BD1 4AS

Tel: 01274 237290

25th August 2020

Dear Brendan

Airedale NHS Foundation Trust Quality Accounts 2019/2020

On behalf of NHS Bradford District and Craven CCG, I welcome the opportunity to feedback to Airedale NHS Foundation Trust (ANHSFT) on its Quality Report for 2019/20.

This has been an unprecedented time for global health services and of course for the NHS and it is within this context that I provide the following feedback.

I would like to start by congratulating the Trust on your key achievements during 2019/20 which include:

- 99% of community patients and 97% of inpatients rated the care as 'excellent' or 'very good'.
- The Frail Elderly Pathway Team's work, as part of the NHS Improvement Collaborative, was voted "improvement most likely to be adopted across the NHS".
- Achievement of Anaesthesia Clinical Services Accreditation
- Pathology received United Kingdom Accreditation Service (UKAS) endorsement
- Formal JAG re-accreditation in meeting best practice quality standards
- The audiology team became one of the first groups in the country to be awarded the Gold Standard for tinnitus support groups by the British Tinnitus Association.
- End of Life Gold Standards Framework re-accreditation (wards 5 and 9) recognising their commitment to delivering excellent end of life care.
- Royal College of Nursing's cancer nursing award received by the Trust's Macmillan Gynaecology clinical nurse specialist for the positive work to enable ovarian cancer patients to access a life-prolonging drug.

It is great to see your commitment and initiatives that contribute to the strengthening of the wider health and care system which include:

- Clinical leaders taking prominent roles to work in partnership across services with BTHFT via the Acute Provider Collaboration Programme to establish clinically effective and sustainable patient pathways and services.

- Leadership contribution to the Bradford District and Craven System Quality Committee which included a greater emphasis upon improving Child and Adolescent Mental Health
- Leadership of the Bradford District and Craven integrated workforce programme to address the challenges facing our local workforce
- The re-opening of the intermediate care facility at Castleberg Hospital in Settle in October 2019 following significant refurbishment to improve patient experience
- Participation in Health Education England's Nursing Associate Programme to build capability, offer improved career pathways and strengthen workforce retention.
- Joint working with Bradford University and the multi-disciplinary team to improve care of the perineum in second stage of labour and reduction in third/fourth degree tears
- Collaborative working with Bradford District Care NHS Foundation Trust to develop a policy for the care of patients with a Mental Health Disorder in an Acute Hospital Setting as part of the system mental wellbeing strategy

In common with many, challenges over the past 12 months have meant that the Trust has been unable to consistently deliver national standards, with pressures around waiting times for the emergency department, referral to treatment, diagnostics and some cancer standards noted. I acknowledge the ongoing actions taken to improve patient flow and prevent unnecessary waiting for patients.

Following the CQC annual well-led and core service inspection, published in March 2019, whilst the Trust received an overall rating of 'Requires Improvement', you were rated as 'Good' for the 'Responsive', 'Caring' and 'Effective' domains.

I understand that the CQC acknowledged that much progress had been made since the last inspection. The report identified areas requiring further and rapid improvement which included:

- workforce staffing levels and skill mix,
- leadership to improve the quality of services and safeguard high standards of care.

I understand that the Trust's Quality Improvement Plan developed in response to this has been monitored throughout 2019/20 with 'added rigor' to embed consistent and sustained improvements. I also welcome the development of a new Quality and Safety Strategy 2020-22 which will focus on Patients, People, Progression, Partnership and Population.

In response to the recognised national and local workforce shortages and through the Trust's 'People Plan' the Trust is making every effort to recruit, retain and mitigate against medical and nursing staff vacancies. I also welcome the Trust's focus on governance and leadership, including the goal to develop leaders with the required skills at every level of the organisation.

I note that the most recent Patient-Led Assessment of the Care Environment (PLACE) was carried out in September 2019 and that actions have being taken to address environmental cleaning issues and national food standards.

The Trust reported three Never Events during 2019/20. I welcome that the Trust is working in collaboration with NHS Improvement and the quality report details how learning is being implemented into practice with the support of the CCG's quality team.

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

- Replacement of falls risk screening tool (Bart's tool) with a multi-factorial and multi-disciplinary falls assessment for all patients over 50 years old with an underlying condition likely to put them at risk of falling.

- Establishment of a joint wound care formulary aligned with community services and BDCT to support improved co-operation around pathways of care
- The development of the Cognitive Impairment/ Dementia pathway within the hospital to complement the Community Collaborative Care Team's dedicated pathway
- Embedding of Sepsis Champions across Trust through nurse educators
- Quality improvement work through collaboration with the Enhanced Care Improvement Collaborative and district wide colleagues focuses on improving the experience of patients who need enhanced supervision, as well as the experience of their carers and staff providing care
- Great Place to Work initiative which includes a coaching programme that is open to not only Trust employees, but external partners across health, voluntary and local government sectors
- The launch of 'Schwartz Rounds', a forum for colleagues from all backgrounds, grades and disciplines across the hospital and community areas to come together to talk about the emotional, personal and social challenges of working within healthcare.

The Trust has identified a number of priority areas for 2020-21 which include:

- Privacy and dignity – promotion of a customer services culture
- Frail Elderly Pathway Team initiative - to identify frailty and enhance care planning between health and social care
- Improve the prevention, early identification and management of the deteriorating patient; to include Acute Kidney Injury – into a whole system of holistic care
- Airedale Digital Care Hub and the overall quality of healthcare for people with long-term conditions
- The monitoring of Caesarean section rates through the safe promotion of physiological birth
- Development of briefing, debriefing and the WHO checklist in interventional procedures

It is also important that we collectively concentrate our effort, BTHFT, BDCFT, the CCG and yourselves to reduce the numbers of Children Looked After who require a health assessment and children and young people requiring a neuro diversity assessment.

I looked forward to seeing the outcomes of the Trusts new Quality and Safety Strategy 2020-22 which will focus on Patients, People, Progression, Partnership and Population and will continue to ensure that the CCG supports the Trust to achieve its vision.

The Trust has continued in its commitment to the development of the health and care system actively supporting local community partnerships and PCNs. The Trust has clearly demonstrated its commitment to the 'Act as One' programme which bringing together the contributions of all GPs, district nurses, social workers, mental health providers, care homes, voluntary organisations and local hospitals into a single integrated care system for Bradford district and Craven. The Trust is committed to working as part of the West Yorkshire Association of Acute Trusts and the West Yorkshire and Harrogate Health and Care Partnership.

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

I look forward to continuing to work with you and other partners across the health and social system to ensure that local people will be healthier, happier, and have access to high quality care that is clinically, operationally and financially stable. I commend the Trust's ongoing commitment to improve the quality and safety of the care that our communities receive.

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

Kind regards,

Helen Hirst
Chief officer
NHS Bradford District and Craven CCG

4.2 Overview and Scrutiny Committee

The draft *Quality Report* 2019/20 was circulated to Bradford Metropolitan District Council Health Overview and Scrutiny Committee and North Yorkshire County Council Overview and Scrutiny Committee for comment. Both acknowledged receipt.

The Quality Account has been noted by the Chairman of the North Yorkshire County Council Scrutiny of Health Committee, Cllr John Ennis. There is nothing specific that he wishes to raise with you regarding the Quality Account. He is satisfied that there is a good working relationship between the committee and Airedale NHS FT.

4.3 Healthwatch

The draft *Quality Report* 2019/20 was circulated to Healthwatch Bradford and District and Healthwatch North Yorkshire and Healthwatch Lancashire for oversight. Receipt was acknowledged.

How to provide feedback on the Quality Report

Hopefully the Quality Report has been informative. We welcome your feedback and suggestions you may have for next year's publication.

The Annual report and *Quality Report* will be available on our website at:
www.airedale-trust.nhs.uk

If you need a copy in a different format, such as large print or in another language, then please contact our Interpreting Services on telephone: 01535 292811 or email interpreting at interpreting.services@anhst.nhs.uk

4.4 Statement of directors' responsibilities in respect of the Quality Report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:

    o board minutes and papers for the period April 2019 to the date of this statement.

    o papers relating to quality reported to the board over the period April 2019 to [the date of this statement]

    o feedback from commissioners dated 25/08/20

    o feedback from governors dated 06/02/20

    o feedback from local Healthwatch organisations - none received

    o feedback from Overview and Scrutiny Committee dated 04/09/2020

    o the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 29/07/2020

    o the [latest] national patient survey 20/06/2019

    o the [latest] national staff survey 18/02/2020

    o the Head of Internal Audit's annual opinion of the trust's control environment dated - not undertaken

    o CQC inspection report dated 14/03/2019

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Chair

Date: 4th November 2020

Chief Executive

Date: 4th November 2020

4.5 NHS Improvement guidance for data quality assurance on Quality Reports

NHS Improvement requires foundation trusts to obtain external assurance on its *Quality Reports*. Arrangements were underway to audit the following key performance indicators. *However, in order to reduce the burden and release capacity within the NHS to manage the COVID-19 pandemic, testing was stopped.*

4.5.1 Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

The indicator is defined within the technical definitions that accompany *Everyone counts: planning for patients 2014/15 - 2019/20* and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf

Detailed rules and guidance for measuring A&E attendances and emergency admissions can be found at https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf

Numerator
The total number of patients who have a total time in A&E of four hours or less from arrival to admission, transfer or discharge. Calculated as: (Total number of unplanned A&E attendances) – (Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge)

Denominator
The total number of unplanned A&E attendances

Accountability
Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: NHS Constitution Measures).

Indicator format
Reported as a percentage

4.5.2 Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways

The indicator is defined within the technical definitions that accompany *Everyone counts: planning for patients 2015/16 - 2018/19* and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf

Detailed rules and guidance for measuring referral to treatment (RTT) standards can be found at http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

Detailed descriptor
E.B.3: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period

Numerator
The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks

Denominator
The total number of patients on an incomplete pathway at the end of the reporting period

Accountability
Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: www.england.nhs.uk/wp-20

Indicator format
Reported as a percentage

4.6 Glossary

Acute trust An acute trust provides hospital services; mental health hospital services are provided by a mental health trust.

Board of Directors The Board of Directors is responsible for the effective governance of the organisation by setting the corporate strategy, supervising the work of the executive directors, setting the organisation's culture, taking those decisions that the Board reserves to itself and being accountable to its stakeholders. Executive directors are responsible for the management of the foundation trust and are accountable to the Board of Directors, of which they are part, for the performance of the foundation trust. The Board of Directors is accountable to the Council of Governors via the non-executive directors.

Care Quality Commission (CQC) The independent regulator of health and social care in England.

CHKS A provider of healthcare improvement services, including analytic tools. It is part of the Capita plc. group.

Commissioning for Quality and Innovation (CQUIN scheme) A proportion of a healthcare provider's income is conditional on quality and innovation through the CQUIN payment framework.

Clinical Commissioning Groups (CCG) The local NHS organisation responsible for making sure that appropriate health services are in place to meet local people's needs.

Foundation Trust A type of NHS trust in England created to devolve decision-making from central government control to local organisations and communities to ensure they are responsive to the needs and wishes of local people. NHS foundation trust members are drawn from patients, the public and staff, and are governed by a Board of Governors comprising people elected from and by the membership base.

Health Foundation An independent, charitable foundation working to improve the quality of healthcare in the UK and beyond.

Healthwatch England An independent consumer champion for health and social care in England. Working with a network of 152 local Healthwatch organisations, it ensures that the voices of consumers reach the ears of the decision makers.

NHS Digital The national provider of information, data and information technology systems for health and social care.

NHS Constitution sets out the rights of NHS patients and staff. These rights cover how patients access health services, the quality of care, confidentiality, information and the right to complain if things go wrong.

NHS England is empowered to make informed decisions, spend taxpayers' money wisely and provide high quality services through the mechanism of the clinical commissioning groups (CCGs).

NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers of NHS funded care. It aims to support the delivery of high quality, compassionate care within local health systems that are financially sustainable.

The National Institute for Health and Clinical Excellence (NICE) An independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

NHS Outcomes Framework sets out the national outcome goals and indicators that the Secretary of State uses to monitor progress of the NHS.

Overview and Scrutiny Committees (OSC) These are committees made up of locally elected lay members which provide a mechanism by which the local authority or population can scrutinise the NHS.

Patient Advice and Liaison Service (PALS) PALS ensures that the NHS listens to patients, carers and friends, answers their questions and resolves concerns as quickly as possible.

Parliamentary Health Service Ombudsman (PHSO) The role of the PHSO is to provide a service to the public by undertaking independent investigations into complaints where the NHS in England has not acted properly or fairly or has provided a poor service.

Patient Safety Walk Rounds Whereby senior executives spend time on the frontlines of care, talking with staff and observing work. The aim is to improve the safety of healthcare delivery by providing a systematic approach for engaging senior executives with the work system challenges faced by front-line staff and ensuring follow-up and accountability for addressing these challenges.

Primary Care The first point of contact for most people, for example, services provided by local GPs and their teams.

Registration From April 2009, every NHS trust that provides healthcare directly to patients has to be registered with the Care Quality Commission (CQC).

SAFER patient flow bundle SAFER is a practical tool to reduce delays for patients in adult inpatient wards. It stands for: S - Senior Review; A – All patients will have an expected discharge date and clinical criteria for discharge; F - Flow of patients to commence at the earliest opportunity from assessment units to inpatient wards; E – Early discharge; R – Review. A systematic multi-disciplinary team review of patients with extended lengths of stay.

Secondary Care A service provided by medical specialists who generally do not have first contact with patients.

Special Review A review carried out by the CQC to look at themes in health and social care. Reviews focus on services, pathways of care or groups of people.