About Airedale NHS Foundation Trust

Airedale NHS Foundation Trust provides acute and community services to a population of over 220,000 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 Coronation Hospital in Ilkley and Skipton Hospital as well as health centres and general practices. We employ over 2,500 staff, including a community based workforce and have approximately 400 volunteers.

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Part 1: Statement on quality from the Chief Executive

1.1 Introduction

I am proud to have the opportunity to introduce the annual Quality Report, my first as Chief Executive of Airedale NHS Foundation Trust. The report explains the quality of care we offer and how we are seeking to improve this. Our ambitions, achievements and the challenges that we face are reflected in this report.

Against a backdrop of financial constraint and unprecedented demand linked to increasing numbers of older people with complex health and care needs, collaboration between health and social care organisations is vital if we are to deliver high quality, personalised and join-up care that meets individual circumstances – the “Right Care”. The last year has seen us working as part of the West Yorkshire Association of Acute Trusts and the West Yorkshire and Harrogate Health and Care Partnership to bring the contributions of GPs, district nurses, social workers, mental health providers, care homes, voluntary organisations and local hospitals into a single integrated care system which meets the national ambitions of the NHS Ten Year Plan. We have scrutinised services where we already work collaboratively with Bradford Teaching Hospitals NHS Foundation Trust – such as stroke and vascular services – to provide a basis in the future to make patient pathways more clinically effective and sustainable.

Before I joined the Trust I was aware of the Airedale Digital Hub’s well-deserved reputation for innovation and its tangible outcomes for patients and families. Through assistive technologies the Hub provides a single point of access to all aspects of specialist health and social care advice, for example, to care homes and those patients at the end of life via our Gold Line Service.

Part of our goal of making treatment and care seamless across primary, secondary and ultimately social care is through the effective use of an electronic patient record. Our Digital Hub can access GP records – SystmOne – to ensure information about a patient is up to date, avoiding delays and minimising risk. From April 2018 SystmOne became the primary record in the hospital setting.

Delivering modern healthcare from a hospital over 40 years old can be a challenge. This year has seen the completion of a new £7 million Acute Assessment Unit – an integrated Acute Medical, Surgical Assessment, and Ambulatory Care Unit. This follows on from other dynamic infrastructure projects in recent years which endeavour to optimise clinical decision-making and patient flow whilst supporting safe and dignified standards of care.

In establishing the new Acute Assessment Unit staff worked tirelessly to maintain the provision of care and treatment for our community whilst ensuring training and orientation were effective. With recognised national shortages within staffing groups and specialisms it has never been more important to cherish our most valuable asset – our staff. Across services I have been 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.

The Care Quality Commission undertook its annual Well-led and Core Service Inspection at the close of 2018, selecting Critical Care, Medical Care, Surgery and Urgent and Emergency Care and Diagnostics for review. We were rated as “Good” for the ‘Responsive’, ‘Caring’, and ‘Effective’ domains, and “Requires Improvement” for ‘Safe’ and ‘Well-led’. Overall our quality rating stayed the same – “Requires improvement”. Inspectors recognised that we have made progress since our last inspection, but identified areas where further and more rapid improvement is required, including nurse and medical staffing levels and skill mix, and how well leaders improve the quality of services and safeguard high standards of care. Steps are being taken to address all required actions and recommendations, many of which are detailed in this report.
I hope the Quality Report provides you with a clear picture of how important quality improvement, patient safety and patient and carer experience are to us all at the Foundation Trust. Although we have further work to do there is much to be proud of as highlighted at our annual Pride of Airedale awards and recognised at a national level. The Trust was named for the seventh time one of the top 40 performing hospitals by CHKS. This is a national patient safety award by an independent provider of healthcare intelligence.

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.
- Appointment of a Head of Collaboration for Stroke to improve stroke services for the population of Bradford and Airedale.
- Opening in August 2018 of a new pathology blood sciences laboratory as part of a complete renovation of Pathology to meet increasing demand for services across Airedale and Bradford.
- Extended funding for the ACE2 cancer pilot site to establish a “one stop shop” designed to give patients with cancer symptoms rapid access to diagnostic tests.
- Provision of a mobile cancer care unit. Funded as part of a partnership with the Hope for Tomorrow charity, the unit is the first of its kind in the North of England and offers treatment – such as chemotherapy – in remote areas thereby avoiding lengthy travel time for patients who may feel unwell.
- Successful achievement of Joint Advisory Gastrointestinal Endoscopy Accreditation.
- The Trauma and Resuscitation Team Skills (TaRTS) course – evidence based resource developed at Airedale and now being implemented in other hospitals – singled out by the CQC as outstanding practice.

- Running of Diabetes made easy educational sessions across the district with a particular area of focus on engagement with the South Asian community.
- National Midwifery Council registration of the first cohort of nursing associates in January 2019. We are a national pilot site for this programme.

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 2018/19 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.

Brendan Brown, Chief Executive Airedale NHS Foundation Trust
30th May 2019
1.3 Current view of Airedale NHS Foundation Trust’s position and status on quality

We remain committed to providing the “Right Care” – 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 Quality Improvement Strategy and the Trust’s Annual Plan. The following provides a brief review of quality outcomes against our quality and safety aims.

Harm free care

We have been named as one of the top five hospitals for patient safety in the CHKS Top Hospitals programme 2018 – the only trust in the North of England. This is in recognition of our performance in providing a safe hospital environment for patients and is based on a range of 16 indicators, including rates of hospital-acquired infections and mortality.

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 94 per cent of our patients receive harm free care. Regrettably however, this year the Trust reported three Never Events: wrong site surgery (wrong site block); retained guidewire in a central line; and, wrong site interventional radiology procedure.

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, simulation testing to embed practice; and, the introduction of human factors training across the organisation. To further communicate key messages, three 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.

Of the incidents reported in the period April to September 2018, 98.8 percent were categorized as low or no harm. 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. Having a safety culture is dependent on an open culture. The Freedom to Speak up Guardian offers an important means for staff to voice patient safety concerns.

The 2018 NHS National Staff Survey indicates that Trust’s safety culture has significantly improved since the previous survey. 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. According to the 2018 Care Quality Commission inspection report, there is a strong focus within the organisation on learning and improvement. However, the ‘Safe’ domain was rated as “Requires improvement” with the following issues highlighted for attention:

- Staffing levels and skill mix;
- Initial assessment of patients and review of inpatient risk assessments;
- Mandatory training compliance for medical staff;
- Adherence to the Safer Surgery checklist;
- Record keeping (including document control and storage); and,
- Assessment and management of patients with mental health needs.

Inspectors were not assured services had adequate oversight of these concerns. This is not what we aspire to for our patients and key findings have been incorporated into an overarching Quality Improvement Action Plan for progression.

Infections as a result of healthcare interventions for the fiscal year are: one case of hospital acquired MRSA bacteraemia and five cases of C. difficile (all of which were
found upon investigation to be unavoidable). *C. difficile* infection per 100,000 bed days in Trust patients aged 2 or over is below the England average based on available figures.

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.

Patient complaints can offer insight into safety related problems which may not be identified via incident reporting or case note review. In the last year we reported 56 formal complaints compared to 59 in the preceding period. This is the lowest number reported in the last five years. Across England in the preceding fiscal year, hospital and community services saw a decrease in formal complaints of 3.3 per cent with Yorkshire and Humber recording a reduction of almost one per cent. Over the last year no complaints were either upheld or partially upheld by the Health Service Public Ombudsman.

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.¹ For example:

**You said …** “Planned surgery was cancelled due a failure to ensure the availability of appropriately trained staff.”

**We did ...** To prevent further re-occurrence, specialist teams are now fully involved in the planning meetings.

**You said …** “Lighting around payment meters in the car park is poor. With the shorter winter days, visitors felt vulnerable and potentially at risk.”

**We did ...** Installed additional lighting.”


The latest CQC inspection highlighted that we do not always respond to and close complaints within our target of 40 days; action is being taken to ensure our service is responsive. In October 2018 Healthwatch Bradford and the Independent Published Complaints Advocacy Team undertook a survey to investigate the experience and views of 97 people regarding the healthcare complaints process across the Bradford district. Whilst it is not possible to determine within the report specific issues that relate to Airedale NHS Foundation Trust, the report recommendations are being worked through.

**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 *Responding to and Learning from Deaths Policy*. This year we have drawn on national guidance to evaluate how we care for and involve bereaved families and carers following a patient’s death. The guidance complements a broader programme of work – the implementation of the Duty of Candour, evaluation of organisational systems when families seek to address their concerns – to ensure engagement is meaningful and individualised.

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 received one such notification over the last year in which the Coroner directed that procedures at hospital discharge for those patients neurologically assessed with head injuries are reviewed. An action plan has been developed and shared with the Coroner.
Innovative real-time quality intelligence

To drive forward and monitor improvement, meaningful patient information and clinical intelligence is essential. Alongside other acute services across Yorkshire and Humber, the Trust was successful in a joint bid to become a Local Health and Care Record Exemplar (LHCRE) site. Each partnership will receive up to £7.5 million to fully develop interoperability between the various distinct clinical information technology (IT) systems.

From April 2018 SystmOne became the principal record in the hospital setting. Through the use of SystmOne shared primary and secondary healthcare record access, information can be accessed securely across care settings to obtain a tailored view of an individual’s health information. This development is part of our goal for a shared electronic patient record across primary, secondary and ultimately social care which will improve the accuracy of clinical information and services to patients.

Developments in the last year include:

- Collaboration with TPP, the software supplier of SystmOne, to:
  - Transfer the Maternity Service primary patient record to SystmOne; and,
  - Enable the recording of observations for inpatient calculation of early warning scores (NEWS2) and automated escalation for deteriorating patients.
- Permitting of prescriptions recorded in the Emergency Department (ED) to be automatically transferred to the inpatient chart via the Electronic prescribing and medicine administration (EPMA) system.
- Implementation of a SystmOne ED e-triage.
- E-observations pilot project to use smart devices and apps as part of care.
- Switching from paper referrals to e-referrals to allow greater flexibility for patients to book, change and cancel appointments.
- Roll out across wards and departments of an e-QUIP Asset Management system as a repository for recording medical device training and compliance.

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. This has an impact on the flow of patients through the hospital. The Improving Patient Co-ordination and Flow Programme is part of our transformational work to focus on the “whole system flow”. That is, to look beyond the hospital setting, to redesign pathways of care to avoid unnecessary admissions whilst improving hospital throughput. Emphasis is placed on the integration of the contributions of district nurses, social workers, mental health professionals, GPs, care homes and voluntary organisations into one cohesive system.

In 2018 the CQC reviewed 20 local health and care systems to understand how older people move between the health and social care system. The Bradford locality, including our services, was invited to participate. Many of the following initiatives are highlighted in the published report.

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 the opportunity to reduce unnecessary hospital attendance and GP visits where clinically appropriate. The Multi-Agency Integrated Discharge Team (MAID) 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.

Allied to these services, a series of initiatives have been implemented to improve patient flow and prevent unnecessary waiting for

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patients including the SAFER patient bundle, recruitment of Flow Facilitators to manage discharge and the “End PJ Paralysis” campaign. The latter aims to mobilise patients and where appropriate, encourage inpatients to dress in normal day wear to keep patients active and reduce the risk associated with bed rest such as muscle atrophy. The 2017 CQC Adult Inpatient Survey results show significant improvement in patients’ experience of the time between arrival at the hospital and getting a bed on a ward. However, there remains aspects around leaving hospital where patient experience could be improved though better dialogue between healthcare professionals and patients and carers and greater support and information on how to manage health conditions.

In partnership with commissioners, the innovative Red Bags Pathway was launched in 2018. The bags contain key paperwork, medication and personal items all of which travel with patients from care homes to hospital. The aim is to ensure care home residents who attend hospital attend with vital information that could help healthcare professionals make informed decisions. Such initiatives are part of our wider partnership work with care home providers and local authority services.

The new Acute Assessment Unit opened in spring 2018 and allows rapid access to appropriate staff, diagnostic tests, clinical treatments and enhanced multi-disciplinary working. This vision and how it has helped patient flow has been showcased in NHS Improvement’s Action on A&E, a yearbook illustrating achievements across the North of England. ³

In spite of this and other initiatives including 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 Winter Room 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 including the six week diagnostic standard and ED maximum waiting time of four hours from arrival to admission, transfer or discharge. We apologise for not achieving these important quality standards. We know that sustaining a low wait time remains a key factor in providing high quality and responsive care. However, in this measure and other key standards – waiting times for cancer and referrals to treatment – the Trust regularly performs better that the England average.⁴

People – workforce

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 has 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 ED and out of hours within Critical Care.

The care of patients is of the utmost importance and a series of robust 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, to ensure patient safety is maintained. However, there are recognised national and local workforce shortages and not exclusively amongst nurses and doctors. There is a national deficit in, for example, trained sonographers and in other clinical roles. The situation is further compounded by increasing demands on services by an ageing population. We are therefore keen to address the supply challenges and the findings in the CQC inspection by continuing to take all possible actions to recruit, retain and mitigate for medical and nursing staff vacancies.

Where possible unstaffed capacity is proactively filled with locum and bank staff to ensure that safe staffing levels and staffing skill mix is maintained across clinical areas at all times. A priority in the coming year is to review the process for booking bank and

³ Available at: http://intranet.anhst.nhs.uk/TeamCentre/Communications/Misc/Yearbook%20-%202018%20LR.pdf [Accessed 23/11/18]

⁴ BBC NHS Performance Tracker [current at 13/12/18]
agency staff. Active recruitment of additional doctors, nurses and allied health professionals remains ongoing. In collaboration with colleagues across the health and social care and through our People Plan we continue to review staff roles and responsibilities 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 release nursing time include: Acute Assessment Flow Co-ordinator, 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 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.

In terms of doctors 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. However, it is equally important that we respond to workforce supply challenges in other areas. So in healthcare science we are recruiting graduate scientists, supporting the provision of training of the Healthcare Scientist to undertake extended and advanced roles whilst also developing and nurturing talent within the existing Healthcare Scientists.

We are also taking similar actions with Allied Health Professionals, in Pharmacy and across corporate services, with a focus on enhancing skills in role and developing new roles supported by effective recruitment strategies. In Community Services we offer student placements in support of longer-term employment. This work is captured in the Trust’s People Plan. By involving employees in decision making, valuing diversity and inclusion, looking after the health and well-being of people, and developing and nurturing their talent we aim to make the Trust a great place to work.

It is important to acknowledge that for existing staff there is an increased level of pressure with the potential to affect staff morale and well-being. Staff must feel valued and have the ability to progress and maintain skills, through for example attendance at mandatory training. Effective leadership to ensure there is ongoing support is seen as fundamental. With the arrival of the new Chief Executive, governance has been identified as a key area of immediate focus.

**Governance and Leadership**

In the 2018 CQC inspection the ‘Well-Led’ domain was rated as “Requires improvement”. 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, supported by clear governance arrangements and accountability.

Over the last year the leadership team has overseen a series of improvements, not least in the organisational culture and in the visibility of management. A key area of focus has been our complex governance structure which is not always understood within the
organisation. The assessment and escalation of risk has been evaluated to ensure all work is ultimately overseen by one of the Board committees. These committees act to assure the Board of Directors that the organisation is running effectively and safely.

Strategic leadership, previously strengthened through the establishment of a triumvirate for each service group composed of a Clinical Director, Head of Nursing or Midwifery and Assistant Director of Operations, has been further augmented through the appointment of two Deputy Medical Directors for Integrated Care and Children’s Services and Surgery, Critical Care, Diagnostics and Women’s Services. The aim is to align Trust strategy as set out in the Annual Plan, to specific service group ambitions and ensure objectives share a common purpose.

Our People Plan, which offers practical guidance to managers through a leadership and coaching programme – Consistently Good Line Manager Conversations Toolkit –, has been refreshed. Much focus in the last year has been on the annual appraisal process to ensure everyone has an effective review aligned to our ambitions and “Flight Care” values and behaviours. In relation to medical staff, the Trust continues to report high appraisal completion rates. Our goal remains to develop leaders with the required skills at every level of the organisation.

Open communication and a common purpose is encouraged through the promotion of a learning culture. Quality and Safety Walk-round programme is part of a dynamic cycle of improvement, promoting dialogue between staff, patients and the senior executive team with the aim of increasing openness and communication.

The annual anonymous National NHS Staff Survey (published by NHS England) helps us to improve the working lives of all our staff. On the basis of last year’s survey results, we have focussed in the last 12 months on improving:

- The quality of appraisals and non-mandatory training and development;
- The experience of staff in Estates and Facilities, Pharmacy, Radiology, Theatres and new administration teams;
- Improving leadership and line management;
- Addressing the experience of disabled colleagues; and,
- Responding to concerns relating to bullying, harassment and abuse.

Results from the 2018 NHS Staff Survey indicate improvements across a range of questions. Overall the Trust is above average compared to other acute providers across England in eight of the ten key themes, which cover areas such as health and wellbeing, line managers, morale, inclusion, working in a safe environment, safety culture and staff engagement. Statistically significant improvement was reported by staff when compared to last year in relation to immediate managers and safety culture.

The Trust scored above the national average as a place to work and for the standard of care for friends and relatives. There are some areas where staff would like to see further improvements. We know that almost everyone had an appraisal this year, but that the quality of appraisals is inconsistent. 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 reviewed at the People Committee, which is a sub-committee of the Trust Board, for them to consider and agree areas of focus for the year ahead. Trust-wide actions will be included in our refreshed People Plan.

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5 Medical Revalidation and Responsible Officer Annual Report to NHS England July 2018 Board of Directors public meeting
6 NHS Staff Survey 2017 is available from: http://www.nhstaffsurveys.com/Page/1064/Latest-Results/2018-Results/ [Accessed 26/02/19]
Part 2: Priorities for improvement and statements of assurance from the Trust Board

How we engage with others in developing our quality goals

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 2018 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. According to the recent findings of the CQC inspection, there is “positive engagement with patients, staff, public and local organisations to seek feedback as a way to improve services.”

The views 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, patient and staff stories, compliments, complaints and concerns, social media, Patient Safety and commissioner Quality Walk rounds, listening events and Healthwatch enter and view visits. This feedback provides us with vital information with which to improve 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 “Right Care” vision. Where a patient group is not well represented, efforts are made to seek feedback. Our Youth Forum now meets regularly to offer a young person’s perspective on our services. 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, the Diabetes Made Easy education sessions. Our Maternity Service is part of a new partnership – 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. The group presented to the Board of Directors in November 2018.

2.1 Priorities for improvement 2018/19

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 quality of wound care for patients both in hospital and the community;

2.1.2 Patient Safety: improve the prevention, early identification and management of Acute Kidney Injury; 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 care for patients living with dementia;
- Privacy and dignity:
  - Promotion of a customer services culture; and,
  - A patient-led care environment.

3.2 Patient safety:
- Infection prevention and control;
- Reduction of slips, trips and falls sustained by patients admitted to our hospital wards; 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 2019/20**

1. **Patient experience:** improving the care and support for people with mental health needs

The latest CQC inspection 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 (ED and as an inpatient) were still waiting next morning. Quality improvement work will focus on how we can ensure the needs of this vulnerable patient group are considered and delivered through an improved and integrated service. Progress including performance metrics will be set out in a Mental Health Strategy currently under development and monitored by the Quality and Safety Committee.

2. **Patient Safety:** fall prevention (formerly Reduction of slips, trips and falls sustained by patients admitted to our patient wards).

3. **Clinical Effectiveness:** management of sepsis.

Other local quality improvement work identified for inclusion in the 2019/20 Quality Report is as follows:

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.

Following review, the creation of a patient-led care environment is judged to be a fundamental aspect of all the above priorities and will therefore be encompassed in future updates. Thus dementia environmental adaptations will be contained in the priority ‘Improving care for patients living with dementia’.
2.1.1 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 is measured through the 2017-19 national CQUIN - Improving the assessment of wounds – with the objective being to increase the number of patients who have a full assessment of chronic wounds.

Current status

Over the last two years Community Services in collaboration with Bradford District Care Foundation NHS Trust has undertaken an audit of 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 has been agreed: namely, that by March 2019, 80 per cent of wounds that have failed to heal within four weeks will have a comprehensive wound assessment. Progress is illustrated in the following chart and indicates the target was met six months ahead of schedule with latest results showing 87 per cent of the Craven patient group receiving a full wound assessment.

The number of full wound assessments undertaken is denoted by the blue bar for each audit of a district nursing caseload of patients meeting the chronic wound criteria. The black triangle indicates the percentage compliance achieved. The red broken line designates the threshold target of 35 per cent in 2017/18, stretching to 60 percent at by the end of September 2018 and 80 per cent by March 2019. The service gained and has maintained compliance from March 2018.
In tandem with above, review of patient case notes registered within the Airedale, Wharfedale and Craven locality to evaluate the quality of care and treatment has highlighted areas requiring greater consideration: the effect of medication on wound healing, the impact on quality of life, including social isolation, and, greater attention to potential systemic infection.

**Initiatives and progress in 2018/19**

Baseline review and ongoing audit inform the local strategies adopted across providers and the Airedale, Wharfedale and Craven locality to reduce this burden of harm, and include the following key actions:

- Delivery of holistic wound assessment training across all relevant Community Service teams.
- Evaluation of the SystmOne configuration to improve the quality of data capture. A SystmOne wound assessment template has been developed based on best practice. Following an initial delay in access experienced by Community Services, this is now available across the district. Limitations of the system have been identified e.g. inclusion of those patients with more than one wound. To support compliance, it is not possible to proceed through the assessment without completing all relevant stages.
- Review of wound associated templates in use across district providers to address completion of each component of the comprehensive wound assessment.
- Uniform and consistent approach to using photography to monitor progress.
- 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.
- Implementation of a Skin Tear Pathway to support accurate assessment and appropriate treatment.
- The acute wound care Formulary is currently under review.

The overall objective is to ensure continuity in the use of creams and dressings, a more accurate assessment of a wound and ultimately increased healing time. In support of this, quarterly wound care study days are available to all staff as is bespoke training for specific departments.

**Next steps**

- Configuration of SystmOne to ensure a seamless transfer of care at the point of admission and/or discharge.
- Link the findings and recommendations with other quality improvement work streams, such as the management of
sepsis and the completion of the Malnutrition Universal Screening Tool (MUST) score.

- Continue to work to achieve nationally set absolute levels of performance based on the assessment of national data returns and review of the latest evidence.
- 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.

2.1.2 Priority 2 patient safety: 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. Up to 30 per cent of these deaths may be potentially avoidable. 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 National Confidential Enquiry.

In recognition that early detection and management has a profound effect upon patient outcomes we seek in collaboration with our “Right Care” 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.

How we monitor progress

A multi-disciplinary AKI Task and Finish Group has been established, chaired by a Consultant in Acute Medicine, to measure the quality improvement, co-ordinate the work streams and consider

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9 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) [2009] Adding Insult to Injury
where additional work is required. Progress is monitored by the clinical groups and reported across the Trust’s Integrated Performance Review meeting.

Current status

The primary aim of NHS England’s acute kidney programme “Think Kidneys” is to reduce the risk of acute kidney injury. To do so, establishing local and national data collection and audit is paramount.

- A standardised data flow via the implementation of a nationally agreed algorithm for laboratory information management systems for the early detection of AKI has been established. Our Pathology Service is one of the 72 per cent of laboratories across England reporting AKI warning stage test results to the UK Renal Registry.
- A patient outcome baseline review for the period February to April 2017 was undertaken by the clinical lead. Of the total number of acute admissions, eight per cent of admitted patients (sample 522) had a diagnosis of AKI. Differentiating patients with a hospital acquired AKI from patients that had an AKI on arrival to hospital is more complex than first appreciated, in part as the hospital code “hospital acquired” is seldom used. As a result we have not been able to identify a robust informatics solution to quickly and reliably assess progress. Currently it is necessary to access individual patient records via the pathology reporting system.
- A mortality case note review undertaken over the last year by the Mortality Review Group highlighted 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 8 tool was appropriately completed. Themes identified related to the End of Life pathway and communication with relatives and between specialists.

Initiatives and progress in 2018/19

Following the introduction of a care bundle – AKI 8 – in September 2017 (planned to align with the junior doctor changeover), and an underpinning education programme, a pilot commenced on the Acute Medical Unit in October 2017. In response to clinician feedback the AKI8 tool was re-designed this year and re-formatted as the AKIR3. It was re-launched on the Acute Assessment Unit with support from consultants. Although a snap audit showed reasonable uptake with completing the form to some degree, compliance with action points was poor and informal feedback remains that clinicians see the form as cumbersome and unhelpful. It has not been rolled out further.

Detailed review of AKI within the trust showed no evidence of benefit following introduction of either the AKI8 or AKI R3. The evidence base for AKI care bundles leading to a measurable improvement in either AKI incidence or clinical outcome remains weak.

The setting up of “sick day rules” on SystmOne i.e. guidance on temporary cessation of medicines to patients deemed at high risk of AKI based on an individual risk assessment.

Next steps

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. The GP Clinical Director has taken on the AKI clinical lead to progress initiatives in the coming year. Through working with community partners it is hoped a preventative approach can be fostered to improve clinical practice and patient outcomes.
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. Reports by the Parliamentary and Health Service Ombudsman have highlighted problems in the detection and treatment of sepsis. Sepsis is a key national priority for NHS England and local commissioning groups. 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 for the Commissioning for Quality and Innovation (CQUIN).

How we monitor progress

Progress is measured and reported through the joint CQUIN Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) indicator. NHS England and NHS Improvement believe that the issues of sepsis and antimicrobial resistance are complementary and that developing and implementing a joint CQUIN supports a coherent approach within provider organisations towards reducing the impact of serious infections whilst at the same time reducing the likelihood of the development of strains of bacteria that are resistant to antibiotics. Key actions and milestones are monitored by the Clinical Groups and reported at the Integrated Performance Review meeting.

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. 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. The national CQUIN has four components. (The fourth arm concerns the reduction in use of antibiotics and is discussed in section 3.2.1 Infection Prevention and Control.) The first three components are:


12 http://www.survivingsepsis.org/bundles/Pages/default.aspx [Accessed 23/10/18]
1. Screening for sepsis (Emergency Department and hospital inpatients)

Each month a random sample of ED patients – adult and children – and inpatients who present with symptoms associated with sepsis are reviewed to assess the proportion that are screened.

2. Administration of antibiotics (Emergency Department and hospital inpatients)

Retrospective case note review of a random sample of ED and acute adult inpatients where clinical codes indicate sepsis are reviewed each month. One of its purposes is to understand the level of compliance with the one hour local protocol for the administration of intravenous antibiotics.

The chart below shows ED and hospital inpatient performance against these measures. It must be noted that the CQUIN now specifies one hour from the time seen by the decision-making clinician, rather than our previous measure of one hour from arrival. This allows us more accurate comparison with other providers who have already been using the clinician-to-antibiotic timing for some time. This does not affect our aspiration to give antibiotics as soon as is appropriate in the patient journey, and the ED nursing staff are empowered to seek immediate review of patients if they are concerned about red flag sepsis.

**Figure 2: Percentage compliance with screening and administration of antibiotics**

Data source: Performance Team – national CQUIN submission.

3. Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.

To reduce both total and inappropriate antibiotic usage in hospitals, a competent healthcare professional is required to review the antibiotic prescription within three days of commencement to determine if it is still needed, and if so, if the appropriate antibiotic is being used. This is important as antimicrobial resistance continues to increase and is a major healthcare risk. Based on a quarterly review of 30 patients, the average compliance for the fiscal year is 65.5 per cent [combined results] with an observed quarter on quarter improvement in performance.

The Intensive Care National Audit Research Centre (ICNARC) provides useful measures and insight. In 2017/18 the number of high risk sepsis admissions to the Unit is below the national average. Risk adjusted mortality is within the expected range.
Initiatives in 2018/19 to achieve progress

The priority in the last year has been part 2b of the CQUIN: administration of antibiotics within one hour. A number of initiatives to help achieve this are in development, including Sepsis Trolleys in key areas and an education and training programme in intravenous administration and the fostering of a culture of responsibility within the prescriber of the antibiotics.

Emergency scenarios – for example, recognising sepsis – are regularly enacted in the clinical environment, utilising a high fidelity manikin and actual clinical teams to ensure the experience is as realistic as possible. The primary objective is the identification of latent risks – staff knowledge – which can then be addressed.

Electronic triage (e-triage) is now used within SystmOne for the ED as part of a phased electronic patient record. Sepsis screening has been built into this (similar to the AAU model). We hope that this will prompt earlier summoning of a clinician to assess the need for IV antibiotics.

A National Early Warning Score (NEWS), developed by the Royal College of Physicians to standardise the process of recording, scoring and responding to changes in routinely measured physiological parameters in acutely ill patients, was updated in December 2017. The chronic hypoxia sub chart helps to better tailor escalation to baseline oxygen levels in those with respiratory disease. It includes the addition of delirium to the consciousness sub chart, and the reinforcement of the value of aggregate scores versus single parameter extreme recordings. The NEWS2 chart was launched across the acute setting in July 2018.

Other work includes:

- Review of adverse events with reference to the categories to understand where the deficiencies are –
  - Delay in recognition of sepsis;
  - Delay in delivery of intravenous antibiotics;
  - Delay in the delivery of the Sepsis Six (others); and,
  - Delay in senior review/ongoing management.
- Expansion of the Sepsis Champion role across the Trust.

Review of patient case notes by clinical leads is ongoing with the objective of improving screening and the administration of antibiotics. The first sepsis themed mortality case note review took place in December 2018.

Up to April 2017 it has been recognised at national level that coding for sepsis and systemic inflammatory response syndrome (SIRS) is challenging with a lack of consistency for clinical coding practice for sepsis between providers. Recent national changes to coding for sepsis are designed to improve data quality. The Coding Department continues to work closely with clinical leads to improve the accuracy of coding.

Next steps

- Scoping the potential for Patient Group Direction to enable the Outreach Team to administer an immediate dose of antibiotics;
- An electronic Observation System is being developed and soon to go live across the Trust. Automatic flag for Sepsis Review will eventually be part of this system for those patients with NEWS2 greater than five;
- Further themed mortality case note review;
- Embedding of Sepsis Champions across Trust; and,
- Ongoing development of the ED e-triage system, with continuous developments from TPP supporting progress.

In addition to the above, the CQC has tasked the Trust with ensuring the paediatric sepsis
pathway documentation – introduced in 2017 – is initiated and completed.

2.2 Statements of assurance from the Board

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 2018/19 Airedale NHS Foundation Trust provided and/or sub-contracted 77 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 in 77 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 90.0 per cent of the total income generated from the provision of relevant health services by the Airedale NHS Foundation Trust for 2018/19.

2.2.2 Participation in clinical audits and national confidential enquires

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 2018/19, 48 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 98 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 2018/19 are as follows: see tables 3 and 4.

The national clinical audits and national confidential enquiries that Airedale NHS Foundation Trust participated in during 2018/19 are as follows: see table 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 2018/19, 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>
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<th>Participation</th>
<th>Per cent eligible patients submitted</th>
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### Table 2: National Confidential Enquiries (NCEPOD) undertaken by Airedale NHS Foundation Trust

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<th>Ref</th>
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<th>Eligible</th>
<th>Participation</th>
<th>Per cent eligible patients submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cancer in Children, Teens and Young Adults (Child Health Clinical Outcome Review Programme [NCEPOD])</td>
<td>×</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>Learning Disability Mortality Review Programme</td>
<td>✓</td>
<td>✓</td>
<td>100</td>
</tr>
<tr>
<td>3</td>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme</td>
<td>✓</td>
<td>✓</td>
<td>100</td>
</tr>
<tr>
<td>4</td>
<td>Pulmonary Embolism (Medical &amp; Surgical Clinical Outcome Review Programme [NCEPOD])</td>
<td>✓</td>
<td>✓</td>
<td>100</td>
</tr>
<tr>
<td>5</td>
<td>Peri-Operative Diabetes (Medical &amp; Surgical Clinical Outcome Review Programme [NCEPOD])</td>
<td>✓</td>
<td>✓</td>
<td>100</td>
</tr>
<tr>
<td>6</td>
<td>Mental Health Clinical Outcome Review Programme</td>
<td>×</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>7</td>
<td>National Mortality Case Record Review Programme</td>
<td>✓</td>
<td>✓</td>
<td>100</td>
</tr>
</tbody>
</table>

### Exceptions/Comments:

- **10:** Responses received from patients. All patients are offered the opportunity to participate, but not everyone chooses to do so.
- **11:** Responses received from patients. All patients are offered the opportunity to participate, but not everyone chooses to do so.
- **25:** 100 per cent of data for the cases where the Trust opted to submit i.e. home based intermediate care.
- **31:** 100 per cent data submitted from Quarter 3 2018/19 when this audit commenced.
- **36:** Signed up to participate but did not have any massive haemorrhages in the audit period so were unable to submit data.

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.

Data source: Airedale NHS Foundation Trust Clinical Audit Department.
The reports of 34 national clinical audits were reviewed by the provider in 2018/19 and Airedale NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

The following is a sample selected on the basis of the 2018 CQC inspection report and its Insight Report findings:

**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.
- The Community Stroke Team is providing occupational therapy support, including psychological access.
- Early detection of atrial fibrillation via inpatient heart monitoring is in place to support initiating of anticoagulation.
- The latest SSNAP results published in February 2019 show an improvement in the Trust’s banding score for both the patient centred and team centred results.

**Key issues:**
- Therapy staffing levels means there is an inability to provide the required level of rehabilitation. A staffing recruitment process has commenced.
- There is no Stroke Early Supported Discharge Team.

**National Neonatal Audit Programme (NNAP)**

**Aim:** The NNAP assesses whether babies admitted to neonatal units in the United Kingdom (UK) receive high quality care and identifies areas for quality improvement in relation to the delivery and outcomes of care.

**Key successes:**
- Generally the unit is average or above against standards. Whilst audit numbers are small so unlikely to be statistically significant, improvement is noted in: the percentage of babies with an admission temperature within the target range; the percentage of mothers that receive antenatal steroids; and, the two year neonatal follow-up rate.

**Key issues:**
- Previous data suggested that not all eligible mothers were given magnesium sulphate. Review indicated this was a recording issue; latest results show compliance in line with the national average.
- Consultant paediatricians have reviewed how information systems can ensure all patients receive follow up.

**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:**
- Improved proportion of pre-operative documentation of the risk of death for patients undergoing emergency laparotomy; performance is better than the national average.
- The proportion of high risk cases with a consultant surgeon and anaesthetist present in theatre has increased and is above the national average.

**Key issues:**
- Whilst the majority of highest risk patients are admitted to the Critical Care Unit following emergency laparotomy, results are worse when compared to the national average. This has been highlighted to the service and the wider delivery group.
- Computerized tomography (CT) which has been the subject of local clinical audit (see next section for outcomes).
Severe Sepsis and Septic Shock

Aim: Based on the Sepsis Six, the national audit aims to assess compliance with the Royal College of Emergency Medicine (RCEM) clinical standards for severe sepsis and septic shock to support improved recognition and treatment.

Key successes:
- By the end of 2016 quality focus indicated improved screening levels of 95 per cent using the then measure of a full set of observations and calculation of the National Early Warning Score for ED patients.

Key issues:
- Published in the previous year, 2016/17 data submitted to the national Royal College of Emergency Medicine on the management of sepsis yielded poor results. Subsequent review highlighted data quality input issues which affected ED patient outcomes against fundamental standards. Actions have been taken to ensure validation of data for all RCEM audits.

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 Trust continues to submit data to the West Yorkshire Adult Critical Care Operational Delivery Network and reviews this on a monthly basis.
- The 2018 CQC inspection report notes that hospital mortality and non-clinical transfers are within the expected range.

Key issues:
- The proportion of non-delayed, out-of-hours discharges to a ward is worse than expected; the Trust is implementing actions to address this.

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.
- Availability of stereotactic body radiation therapy (SBRT) has increased overall radiotherapy rates; 15 per cent of patients are now receiving SBRT.
- The proportion of patients with confirmed histology going on to have curative surgery has increased year on year.

Key issues:
- There are no concerns raised by the national audit.

National Bowel Cancer Audit (NBOCA)

Aim: The aim of the National Bowel Cancer Audit (NBOCA) is to measure the quality of care and outcomes of patients with bowel cancer in England and Wales.

Key successes:
- The majority of data is captured although work to enhance data quality is ongoing.
- A high number of laparoscopic surgery cases compared to the national average. Complications and mortality is low.

Key issues:
- Variation in risk assessment grades for patients compared to the national data. The issue has been raised and discussed with anaesthetic colleagues.
- Length of stay post-surgery; it is hoped that a new discharge team strategy will expedite the process.

The reports of 130 local clinical audits were reviewed by the provider in 2018/19 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.

Doctor’s Knowledge of Anaphylaxis Treatment

Aim: To ascertain ongoing knowledge of doctors about anaphylaxis.

Key successes:
- Of the sample of 40 doctors/advanced nurse practitioners, 85 per cent were aware of the correct treatment.
- Anaphylaxis training is now included in induction for all medical staff and advanced nurse practitioners. Treatment reminders are routinely communicated.

Key issues:
- The need for ongoing training.

Craven Virtual Ward Last Days of Life Follow-up Re-Audit

Aim: To establish whether recommendations for care during the last days of life are being adhered to and documented by health professionals following the implementation of actions identified in a baseline audit conducted in April 2017.

Key successes:
- There is evidence of improvement in the documentation around end of life including full utilisation of the end of life template.
- The proportion of patients with a documented preferred place of death, a Do Not Attempt Cardiopulmonary Resuscitation in place and, a Comfort and Dignity Plan, has increased since the last audit with evidence that reversible causes have been considered.

Key issues:
- Nine per cent fewer patients with a documented preferred place of death actually died in that location compared to the 2017 audit.
- There has been a decrease in conversations being documented regarding spiritual beliefs and personal values.

Prescription and Administration of Parkinson’s Medications

Aim: To evaluate prescription and administration of medications for those patients with Parkinson’s disease.

Key successes:
- The majority of patients had the correct medication doses prescribed on admission.

Key issues:
- Nearly a third of dosages were administered over half an hour early or late. Immediate actions have been taken to ensure that low dose Parkinson’s medications in soluble and patch form are available on key wards; a critical timed medication flag has been added on SystmOne; and an education programme for junior doctors and healthcare professionals about Parkinson’s disease is available.

Bone Protection Recommendations at Transfer of Care after Hip Fracture in Elderly Patients – Does Orthogeriatric Advice Reach Primary Care?

Aim: To ensure that all elderly patients with fractured neck of femurs have orthogeriatric assessment and that bone protection recommendations are communicated from acute to primary care.

Key successes:
- Results indicate 98 per cent of patients were assessed and reviewed by the Orthogeriatric Team

Key issues:
- 45 of the 100 patients were started on secondary bone protection; 18 were communicated to the GP and three continued on treatment. Identified actions include consideration of SystmOne tasks for notifying GPs about specific patients on discharge; work with Pharmacy to understand how best to ensure medications continue in community; and, establish a Fracture Liaison Service.
Trauma Computerized Tomography (CT) Re-Audit

Aim: A national trauma peer review programme (TARN) raised serious concerns regarding CT scanning performance for trauma patients at Airedale NHS Foundation Trust. It was considered that results did not accurately reflect local performance and an audit was undertaken to understand compliance levels.

Key successes:
- Between 8am and 10 pm, 91 per cent of CT scans for trauma are reported within an hour of request.

Key issues:
- Between 10pm and 8am CT scan reporting guidance levels are not being met; 48 per cent of scans met the 60 minute threshold. This is a decrease on the 2016 result of 93 per cent compliance.
- Following a recruitment and training programme in April 2018, there has been a 24/7 on-site CT radiographer cover to improve time to CT results out of hours.

Cardiac Rehabilitation Exercise Class Outcome Audit

Aim: To audit the outcomes of Phase 3 cardiac rehabilitation exercise class against national standards.

Key successes:
- The completion rate for cardiac rehabilitation is above nationally reported figures, including in the percentage of patients who have a clinically significant improvement in the shuttle walk test and in the Hospital Anxiety and Depression Scale (HADS) score.

Key issues:
- The HADS is not always completed at initial and final assessment for all patients. Actions have been identified to address this shortfall, including individualised programmes for those patients an increased risk of non-completion.
- Real time input of data has commenced to support more timely analysis.

Audit of Conversions from Day-case Surgery to Inpatient Stay

Aim: To understand why our day case admission rate is high and the extent to which these are potentially avoidable.

Key successes:
- Potential options for reducing the admission rate have been identified including revised Theatre scheduling, new opening times for Ward 20 and nurse-led discharge.
- New fasting guidelines and post-operative urine guidelines have been developed.

Key issues:
- Outstanding actions around the use of fentanyl (rather than morphine for rescue analgesia) and multi-model analgesia anaesthetic techniques.

Bowel Cancer Screening Programme Pathology

Aim: To audit compliance with the operational requirements for departments reporting cases from the NHS Bowel Cancer Screening Programme in particular: the typing of polyps, particularly adenomas; the grading of dysplasia; and, the measurement of polyp size and the avoidance of digit bias.

Key successes:
- The audit demonstrated excellent compliance with national standards and a high quality of diagnostic reporting with due attention to grading, categorisation and measurement.
- All cases are reported within five working days with an average turnaround of 1.8 days.
- Dysplasia grading is consistent with previous audits and within suggested thresholds.

Key issues:
- None identified. Standards are met and no actions required.
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 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 1000.

Airedale NHS Foundation Trust was involved in conducting 71 clinical research studies across all specialties during 2018/19 of which 51 were on the National Portfolio. During 2018/19 Airedale has been commended by the Clinical Research Network for achieving national benchmarks for performance in initiating and delivering research and for exceeding patient recruitment targets.

There were 47 senior clinical staff actively participating in research approved by a research ethics committee at Airedale NHS Foundation Trust during 2018/19, 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 2018/19.

In the last three years, Airedale has been formally acknowledged as a contributor to studies reported in 40 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 35 papers arising from academic and own account research have been published in peer reviewed journals since April 2016.

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.

An Airedale Research Education Event was held in November 2018 showcasing some of the research generated.

The following local research project received financial support from the Health Foundation (an independent charity) in 2010. The grant covered clinician and nursing time to set up and administer the programme during its first year. Outcomes of the research were published in 2016.

Impact of a blood management protocol on transfusion rates and outcomes following total hip and knee arthroplasty

N. Frew, D. Alexander, J. Hood, and A. Acornley

Introduction

Preoperative anaemia remains undertreated in the UK despite advice from national agencies to implement blood conservation measures. A local retrospective audit of 717 primary hip/knee replacements in 2008–2009 revealed 25 per cent of patients were anaemic preoperatively. These patients experienced significantly increased transfusion requirements and length of stay. We report the results of a simple and pragmatic blood management protocol in a district general hospital.

Methods

Since 2010 patients at our institution who are found to be anaemic when listed for hip/knee replacement have been offered iron supplementation and/or erythropoietin depending on haemoglobin and ferritin levels. In this study, postoperative blood transfusions,

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length of stay and readmissions were assessed retrospectively for all patients undergoing elective primary hip/knee replacement in 2014 and compared with the baseline findings.

Results

During the 12-month study period, 406 patients were eligible for inclusion and none were excluded. Eighty-nine patients (22 per cent) were anaemic preoperatively and sixty-five received treatment. The transfusion rate fell from the baseline levels of 23.0 per cent and 6.7 per cent to 4.3 per cent and 0.5 per cent for hip and knee replacements respectively (p<0.001). The median length of stay reduced from 6 to 3 days (p<0.001) for both hip and knee replacements. The rate for readmissions within 90 days fell from 13.5 per cent to 8.9 per cent (p<0.05).

Conclusions

Preoperative anaemia is common in patients listed for hip/knee replacement and it is associated strongly with increased blood transfusion. The introduction of a blood management protocol has led to significant reductions in transfusion and length of stay, sustained over a four-year period. This suggests that improved patient outcomes, conservation of blood stocks and cost savings can be achieved.

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 2018/19 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 2018/19 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 2018/19 for the delivery of services to our patients was dependent upon achieving a range of quality markers. This scheme (CQUIN) linked £3,043,947 of our funding to the delivery of the agreed quality indicators. (This is based on the indicative outturn value for 2018/19.)

During 2018/19 Airedale NHS Foundation Trust delivered CQUINs to the value of £3,002,168 to the satisfaction of our commissioners (to be confirmed).

The monetary total of funding conditional to the delivery of agreed quality indicators in 2017/18 was £2,909,753.

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 2018/19.

Airedale NHS Foundation Trust has participated in special reviews or
investigations by the Care Quality Commission relating to the following areas during 2018/19:

In February 2018 the Care Quality Commission carried out a local systems review in Bradford, where they looked at the flow of over 65-year-olds through the health and social care system. The type of review does not result in a rating, but is designed to understand where improvements can be made. Published in June 2018, the report is generally positive, highlighting how different agencies work collaboratively to keep people safe at home, how we all have a shared purpose, vision and strategy and how well information-sharing is working. There are areas for improvement: access to GPs, better signposting and medicines management after leaving hospital, and quality of domiciliary care. The Bradford and Airedale Health and Wellbeing Board is leading on the identified actions to address areas of shortfall.

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 2-day on-site visit by the inspection team; at the time of reporting there has been no outcome published.

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

Airedale NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

In response to the final report the Trust developed a Quality Improvement Plan that clearly details the responsible persons along with robust accountability review 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 dialogue of the report.

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

The Quality Improvement Plan was developed in response to the CQC Quality Report of March 2019 and will be monitored during 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 that will be included within the current improvement plan.

The Trust will maintain active communication with the CQC during a programme of relationship meetings and continue to extend 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 2018/19 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:
99.9 per cent for admitted patient care; 99.4 per cent for outpatient care; and 99.5 per cent for accident and emergency care.
– which included the patient’s valid General Practitioner Registration Code was:
95.7 per cent for admitted patient care; 97.5 per cent for outpatient care; and 95.6 per cent for accident and emergency care.

Information Governance Assessment Report

Information governance (IG) ensures necessary safeguards for, and appropriate use of patient and personal information. The IG toolkit was formerly used as a system which allowed NHS organisations and partners to assess themselves against national information governance policies and standards. From April 2018 the new Data Security and Protection Toolkit (DSPT Toolkit) replaces the Information Governance Toolkit (IG Toolkit). It forms part of a new framework for assuring that organisations are implementing ten data security standards and meeting statutory obligations on both data protection and data security.

As such, it is no longer possible to provide the prescribed regulatory statement and overall score for the Information Governance Assessment Report. However, the Airedale Foundation Trust Data Security and Protection Toolkit for 2018/19 is published as “Standards Met”. Findings are substantiated by a significant assurance rating from third party review.

Clinical Coding error rate

Airedale NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.14 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: 5.5 per cent (DSPT – mandatory required level <10 per cent)
- Secondary Diagnosis: 4.8 per cent (DSPT – mandatory required level <20 per cent)
- Primary Procedure: 6.3 per cent (DSPT – mandatory required level <10 per cent)
- Secondary Procedure: 9.1 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).

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14 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. It is therefore likely that providers will be stating that they were not subject to “the Payment by Results clinical coding audit” referred to above during 2018/19.
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:

- All errors found in the audit were fed back to the Coding Team. Any individual training issues have been identified.
- Staffing levels in light of the high FCE to coder ratios remain in view although the low error rates suggest that this is not a major issue despite high FCE per coder ratio.
- The impact of late documentation and non-definitive diagnosis continues to be relayed at monthly speciality clinical governance meetings and to individual consultants.

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 2018/19; 652 of Airedale NHS Foundation Trust inpatients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
- 158 in the first quarter;
- 148 in the second quarter;
- 154 in the third quarter;
- 192 in the fourth quarter.

By 31/03/19, 247 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:
- 58 in the first quarter;
- 72 in the second quarter;
- 58 in the third quarter;
- 59 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 on-line tool. Any issues both where learning can be achieved along with excellent care provided are shared within the Mortality Review Group and 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 2018/19 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 during 2018/19.
- Variation in the use of the End of Life Pathway; there are examples of excellence in a greater number of clinical areas than during 2017/18.
- 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.
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.

Bereavement leaflet updated for carers and families with clear guidance regarding raising concerns via PALS in the first instance.

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 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 right care 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.

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 focussed 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

Provisioners 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 in February 2019 for the period Autumn/Winter are as follows:
Seven day overall results

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Weekday results

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Weekend results

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<td>Met</td>
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*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 is committed to creating the right conditions for safer care. We have 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:

- A special staff event focusing on our approach to improvement and facilitating learning opportunities. Led by the Organisational Learning and Improvement Team, the key message is that anyone can make improvements.
- Rapid Improvement Events or team-based problem solving designed to focus on process/system problems. Events in the last year have looked at:
  - Complex discharges and how GP referrals for admission are handled to manage patient flow; and.
  - Ways of working and patient pathways within the Acute Assessment Unit.
- A series of Quality Summits focussing on delivering a safe healthcare environment for patients, visitors and colleagues. Key messages were shared via a "Report Learn Share Week", which highlighted aspects of quality and safety from around the Trust.

- The establishment of an Innovation Forum to showcase quality improvement projects – for example implementing medical handovers – and provide an opportunity to discuss with the Organisational Learning and Improvement Team how to start a project and what tools and training is available.

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 201Care 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. Over the last year there is one exception: a serious incident where the Trust is unable to complete its obligations in relation to the Duty of Candour owing to this being an ongoing police investigation.

2.2.11 Staff who speak up

In response to the *Gosport Independent Panel Report* Airedale NHS Foundation Trust publishes an annual *Freedom to Speak up Guardian Report* on staff who speak up (including whistleblowers).15

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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. Key actions include:

- Improving visibility through marketing of the role via payslips, posters, screensavers, the Respect and Dignity Campaign, and inclusion in corporate induction, junior doctor training and nursing preceptorship.
- Appointment of a non-executive director with responsibility for speaking up to augment leadership on this issue.
- Supporting employees to raise concerns by improving the skills, knowledge and capability of staff, including managers through a structured mandatory training programme and development of associated resources.

Feedback received from those who have raised concerns has highlighted the need for further work to ensure learning is effectively disseminated and where actions are taken those raising the concern are aware of the outcome and improvements made. This is a key area of ongoing focus.

National data indicates that raising a concern is stressful for individuals; for this reason the Trust 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. Whilst comparatively few concerns are raised anonymously, suggestive of a degree of confidence in the speaking up process, around half of all concerns raised are done so in confidence with the most common reasons being fear of reprisals, a perception that a line manager is complicit and/or a lack of trust in the process. 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;
- Collection and analysis of data relating to protected characteristics; and,
- Promotion of a zero tolerance approach to anyone suffering disadvantage as a result of raising a concern.

Protect (formerly Public Concern at Work) are experts in whistleblowing and have identified that people from vulnerable groups are the least likely to raise concerns, yet the most likely to report experiencing detriment as a result of raising concerns. Whilst quantitative analysis does not indicate this is an issue for the Trust, this intelligence informs both established inclusion focus group work and initiatives to encourage junior doctors and students to speak up.

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 2018 NHS Staff Survey (published 2018):

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

For BAME staff 24.8 per cent reported experiencing harassment, bullying or abuse from staff in the last 12 months compared to an average of 28.6 per cent across acute providers in England. For white staff, 20 per cent reported experiencing harassment, bullying or abuse from staff in the last 12 months compared to 26.4 per cent across the benchmark group. Results for both groups are about the same as the 2017 survey.

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

Whilst there is no significant change from 2017 for white staff, with around 90 per cent reporting equal opportunities for career progression, 82.4 per cent of BAME staff reported equal opportunities, an improvement on the 69.5 per cent 2017 return. For both
groups scores compare favourably with 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, Lesbian, Gay, Bisexual and Transgender (LGBT), 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. We are one of the NHS Employers’ Diversity and Inclusion Partners Programme, an initiative to further strengthen this work. This year’s Staff Open Day celebrated difference and Equality, Diversity and Human Rights Week hosted two workshops on the theme of exclusion.

The *Workforce Race Equality Action Plan* progresses key issues with specific and measurable actions identified to deliver improvement. The Trust has an *Inclusion Strategy* 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.

### 2.2.13 2018/19 Annual Report on 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 has been appointed to act 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 a newly formed Junior Doctors Forum. In addition it is planned to produce a consolidated annual report – anticipated September 2019 – which will include details of rota gaps and the planned actions for improvement to reduce occurrence. Whilst not timely enough for inclusion in this publication, outcome findings will be reported in the ensuing *Quality Report*. Review of quantitative and qualitative intelligence year to date indicates that trainee doctors are working safely. Where issues have arisen – rostering and induction – the Guardian of Safe Working is working with trainees and departmental leads to identify and implement workable solutions.
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.16

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.17

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>
<thead>
<tr>
<th>Table 3: SHMI</th>
<th>Jan17 – Dec 17</th>
<th>Apr 17 – Mar 18</th>
<th>Jul 17 – Jun 18</th>
<th>Oct 17 - Sep 18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pub: Jul 18</td>
<td>Pub: Sep 18</td>
<td>Pub: Dec 18</td>
<td>Pub: Feb 19</td>
</tr>
<tr>
<td>Airedale NHS Foundation Trust SHMI value</td>
<td>0.99</td>
<td>0.94</td>
<td>0.94</td>
<td>0.90</td>
</tr>
<tr>
<td>National average</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>The highest value for any acute trust</td>
<td>1.22</td>
<td>1.23</td>
<td>1.26</td>
<td>1.27</td>
</tr>
<tr>
<td>The lowest value for any acute trust</td>
<td>0.72</td>
<td>0.70</td>
<td>0.70</td>
<td>0.69</td>
</tr>
</tbody>
</table>

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.

16 Definitions are based on national guidance, including the NHS Outcomes Framework 2017/18 Technical Appendix.
17 Data source: http://content.digital.nhs.uk/qualityaccounts
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.

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 Group each month using a standardised and structured case note review process. This is essentially a more in-depth and validated process; fewer sets of notes are reviewed, but the time spent by the reviewer is considerably longer. Where potentially avoidable mortality is identified, action plans are formulated and learning disseminated.
- A maternal death, death of a child or a death in the ED 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 teams and confirmation sought of how this is cascaded.
- Appraisal of mortality, morbidity and other correlative data at the Quality and Safety Committee and specialty clinical governance meetings further supports this work.
- Areas identified for development: continued recruitment and training of in-house multi-disciplinary reviewers to improve process resilience; inclusion of learning into the schedule of Quality Summits planned for 2019/20.
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 2018/19 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 provided. The following information relates to all procedures (primary and revisions).

![Figure 3](image1.png)

![Figure 4](image2.png)
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 or better.
- Participation and response rates compare favourably with the national average for England for all procedures.
- The Trust is above the upper 95 per cent control limit for the 2015/16 EQ5D average adjusted health measure for knee replacement; outcomes are better than expected for this patient group.

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 emergency re-admissions to Airedale NHS Foundation Trust within 28 days of discharge

The data for this section has not been published by Digital Health since December 2013. The section below and comments are historical, but are required to be included. Also provided is our own data on re-admissions to offer more recent information on performance.

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 to allow comparison with other organisations and is presented in age groups: 0 to 15 and 16 years and over. A low percentage score is good.

<table>
<thead>
<tr>
<th>Table 4: Emergency re-admissions</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airedale NHS Foundation Trust percentage 0 to 15 years</td>
<td>11.70</td>
<td>11.32</td>
<td></td>
</tr>
<tr>
<td>National percentage average [England] 0 to 15 years</td>
<td>10.01</td>
<td>10.01</td>
<td></td>
</tr>
<tr>
<td>The highest* percentage return by small acute trust 0 to 15 years</td>
<td>12.61</td>
<td>14.87</td>
<td></td>
</tr>
<tr>
<td>The lowest* percentage return by small acute trust: 0 to 15 years</td>
<td>6.19</td>
<td>5.74</td>
<td></td>
</tr>
<tr>
<td>Airedale NHS Foundation Trust percentage 16 years or over</td>
<td>10.30</td>
<td>10.04</td>
<td></td>
</tr>
<tr>
<td>National percentage average [England] 16 years or over</td>
<td>11.43</td>
<td>11.45</td>
<td></td>
</tr>
<tr>
<td>The highest* percentage return by small acute trust 16 years or over</td>
<td>12.69</td>
<td>12.69</td>
<td></td>
</tr>
<tr>
<td>The lowest* percentage return by small acute trust 16 years or over</td>
<td>7.14</td>
<td>8.73</td>
<td></td>
</tr>
</tbody>
</table>

* The highest and lowest rates are taken from comparable trusts [small acute]. Indirectly age, sex, method of admission, diagnosis and procedure standardised per cent.

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. Datasets have not been updated since December 2013. No attempt is made by NHS Digital to assess whether the readmission is linked to the discharge in terms of diagnosis or procedure; nor does the return identify whether the emergency admission is avoidable.

0 to 15 years: the re-admission rate is above average, but has fallen in the last (available) year. 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.

16 years or over: the re-admission rate is below average and has fallen in the last available year as above. A number of actions have had an impact, including a target for urgent referrals to community of 95 per cent of patients being seen within 24 hours of discharge from hospital.
During the data collection period the Trust will have coded some of the patients attending the ambulatory care unit (ACU) as admissions. These are patients who in the past would have been admitted to a hospital bed for treatment (for example, deep vein thrombosis, pulmonary embolism patients). The referrals (mainly from GPs) are now triaged by a consultant who will assess suitability for ambulatory care instead of an admission. It is likely that in the data period 2011/12 and 2013/14 some of the patients attending ACU will have been classified as a re-admission if they had an admitted spell within 28 days. Data collection changed in March 2015.

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:

16 years or over:

Medical re-admissions by consultant are incorporated into performance metrics, circulated to colleagues and discussed at the monthly General Internal Medicine 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.

For the period April 2018 to March 2019 and using the methodology developed by the Health and Social Care Information Centre (now NHS Digital), the Trust’s Information Service has calculated the percentage of emergency re-admissions occurring within 28 days of the last and previous discharge from the Trust for all ages as 12.75 per cent.\(^\text{18}\)

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\(^{18}\) **Indicator construction:**

**Numerator:**
The number of finished and unfinished continuous inpatient spells that are emergency admissions within 0 to 27 days (inclusive) of the last, previous discharge from hospital (see denominator), including those where the patient dies, but excluding the following: those with a main speciality upon re-admission coded under obstetric; and those where the re-admitting spell has a diagnosis of cancer (other than benign or in situ) or chemotherapy for cancer coded anywhere in the spell.

**Denominator:**
The number of finished continuous inpatient spells within selected medical and surgical specialities, with a discharge date up to 31 March within the year of analysis. Day cases, spells with a discharge coded as death, maternity spells (based on specialty, episode type, diagnosis), and those with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the spell are excluded. Patients with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the 365 days prior to admission are excluded.
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 annual 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>
<thead>
<tr>
<th>Year</th>
<th>Airedale NHS Foundation Trust overall percentage score</th>
<th>National percentage score</th>
<th>Highest percentage for any acute trust</th>
<th>Lowest percentage for any acute trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>69.9</td>
<td>69.6</td>
<td>86.2</td>
<td>54.4</td>
</tr>
<tr>
<td>2016</td>
<td>67.7</td>
<td>68.1</td>
<td>85.2</td>
<td>60.0</td>
</tr>
<tr>
<td>2017</td>
<td>69.8</td>
<td>68.6</td>
<td>86.2</td>
<td>54.4</td>
</tr>
</tbody>
</table>

The 2018 Adult Inpatient Survey is due in June 2019.

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

The 2017 response rate is 39 per cent compared to a national rate of 41 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 60 and above.

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 2018 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 each year and aligns closely to the Inclusion Strategy and “Right Care” principles and the Trust’s Quality Improvement Strategy.
- Listening and learning from patient experiences via the Friends and Family Test (FFT) and the Real-time (inpatient) Survey as well as social media and taking action where necessary. Friends and Family reports on the public facing website have been streamlined for simpler access and a link embedded for patients to complete the FFT after discharge.
- We continue to work with partner organisations to ensure a holistic approach to patient engagement.

43
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>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1061 replies; 2699 surveyed</td>
<td>1254 replies; 2753 surveyed</td>
<td>1192 replies; 2591 surveyed</td>
</tr>
<tr>
<td>Airedale NHS Foundation Trust percentage</td>
<td>71</td>
<td>73</td>
<td>74</td>
</tr>
<tr>
<td>National average percentage acute trusts [England]</td>
<td>70</td>
<td>70</td>
<td>71</td>
</tr>
<tr>
<td>Highest percentage for any acute trust</td>
<td>85</td>
<td>86</td>
<td>87</td>
</tr>
<tr>
<td>Lowest percentage for any acute trust</td>
<td>69</td>
<td>47</td>
<td>40</td>
</tr>
</tbody>
</table>

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

The response rate is 46 per cent which is above average for acute trusts and consistent with the 2017 rate.

Overall staff engagement has improved to 7.2 compared with 7.0 in 2017 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 2018 NHS Staff Survey results compare favourably with trusts of a similar type (acute trusts). The Trust was better than average in eight out of ten of the 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:

- The Trust will be launching a leadership and management enrichment programme to supplement the current leadership development offer and will be developing a leadership community across the Trust.
- Quality of appraisals: to link appraisals to improvements in the way jobs are done and to strengthen objective setting. The next round of appraisals commencing April 2019 will be the focus of guidance and training.
- Inappropriate behaviours: whilst the Trust scores in relation to people experiencing discrimination, harassment, bullying and abuse are better than most other trusts, 15 per cent of staff reported experiencing inappropriate behaviours from colleagues and nine per cent from managers. This appears to be within particular pockets in the Trust. Future focus will be on
reinforcing behavioural expectations and targeted support to hotspot areas.

- Targeted support to teams and departments where colleague experience is below the Trust average.
- Employee involvement in work to address national and local workforce supply issues and to further improve the Trust’s approach to governance in relation to quality and safety.

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.  

<table>
<thead>
<tr>
<th>Table 7: Friends and Family Test Airedale NHS Foundation Trust - percentage recommendation score</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department Average</td>
<td>94.0%</td>
<td>96.7%</td>
<td>94.8%</td>
</tr>
<tr>
<td>Inpatient Average</td>
<td>97.4%</td>
<td>96.3%</td>
<td>97.1%</td>
</tr>
<tr>
<td>Community Services</td>
<td>98.0%</td>
<td>98.8%</td>
<td>99.0%</td>
</tr>
<tr>
<td>Maternity Services</td>
<td>99.3%</td>
<td>97.3%</td>
<td>98.0%</td>
</tr>
</tbody>
</table>

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

- 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.
- Minimum response targets have been set of 15 per cent for the Emergency Department; and 25 per cent for Maternity Services (births) and Inpatients (which includes Day Cases). Performance is consistently above the target for most inpatient wards.

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:

- The FFT card for the Emergency department was redesigned to include a triage information card on the reverse side. This keeps patients better informed about their care and their waiting time in the department, as well as impacting on response rates for FFT because staff are required to hand out these cards as part of the triage process.
- NHS England is conducting a review of the Friends and Family Test with the purpose of giving greater emphasis to qualitative feedback in quality improvement. The new guidance is expected to be released in April 2019 and key actions will focus on its implementation.

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 (VTE)

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>
<thead>
<tr>
<th>Table 8: Risk assessment for VTE</th>
<th>Jan-Mar 2018</th>
<th>Apr-Jun 2018</th>
<th>Jul-Sep 2018</th>
<th>Oct-Dec 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airedale NHS Foundation Trust percentage</td>
<td>95.68</td>
<td>95.20</td>
<td>95.34</td>
<td>93.76</td>
</tr>
<tr>
<td>National percentage average [England]</td>
<td>95.21</td>
<td>95.63</td>
<td>95.49</td>
<td>95.65</td>
</tr>
<tr>
<td>The highest percentage return for any acute trust</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>The lowest percentage return for any acute trust</td>
<td>67.04</td>
<td>75.84</td>
<td>68.67</td>
<td>54.86</td>
</tr>
</tbody>
</table>


Data Source: NHS Improvement.

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

- The national threshold was maintained through 2018 until October. Remedial action has been identified to address the shortfall and provisional figures indicate the target has been achieved between January and March 2019.
- 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 VTE care.
- A new clinical lead has been appointed with particular focus on the consistent application of VTE prophylaxis.
2.3.8 Rate of \textit{C. difficile} infection per 100,000 bed days in Airedale NHS Foundation Trust patients aged 2 or over

Hospital associated \textit{C. difficile} can be preventable. Since 2012 revised guidance on the clinical testing protocol has resulted in more consistent testing and reporting of cases of \textit{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>
<thead>
<tr>
<th>Table 9: Rate of \textit{C. difficile}</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Airedale NHS Foundation Trust rate per 100,000 bed days</td>
</tr>
<tr>
<td>National average rate [England] rate per 100,000 bed days</td>
</tr>
<tr>
<td>The highest rate for any acute trust rate per 100,000 bed days</td>
</tr>
<tr>
<td>The lowest rate for any acute trust rate per 100,000 bed days</td>
</tr>
</tbody>
</table>

\textit{Figures based on Trust apportioned cases for specimens taken for patients aged 2 or over.}

\textit{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 \textit{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 \textit{C. difficile} risk assessment and action plan via an assurance route governed by the Quality and Safety 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 \textit{C. difficile} infection/colonisation;
- Monitoring of the use of antibiotics in comparison with neighbouring and similar sized acute trusts;
- Discussion of anti-microbial prescribing in community at the District Wide Infection Prevention Team Meeting; and,
- Sustaining staff engagement and motivation in the prevention of HCAI.
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 10: Patient safety incidents

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Airedale NHS Foundation Trust</td>
<td>Airedale NHS Foundation Trust</td>
</tr>
<tr>
<td></td>
<td>National position</td>
<td>National position</td>
</tr>
<tr>
<td></td>
<td>[acute non-specialist n=131]</td>
<td>[acute non-specialist n=134]</td>
</tr>
<tr>
<td></td>
<td>The highest value</td>
<td>The highest value</td>
</tr>
<tr>
<td></td>
<td>[acute non-specialist n=131]</td>
<td>[acute non-specialist n=134]</td>
</tr>
<tr>
<td></td>
<td>The lowest value</td>
<td>The lowest value</td>
</tr>
<tr>
<td></td>
<td>[6 complete months]</td>
<td>[6 complete months]</td>
</tr>
<tr>
<td></td>
<td>[acute non-specialist n=131]</td>
<td>[acute non-specialist n=134]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>All reported patient safety incidents</th>
<th>Severe harm</th>
<th>Death</th>
<th>Number</th>
<th>Rate [per 1000 bed days]</th>
<th>Number</th>
<th>Percentage</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airedale NHS Foundation Trust</td>
<td>3,127</td>
<td>60.8</td>
<td>2</td>
<td>0.1</td>
<td>2</td>
<td>0.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National position [acute non-specialist n=131]</td>
<td>731,348</td>
<td>42.4</td>
<td>1,771</td>
<td>0.2</td>
<td>706</td>
<td>0.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The highest value [acute non-specialist n=131]</td>
<td>9,467</td>
<td>107.4</td>
<td>13</td>
<td>0.1</td>
<td>1</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The lowest value [6 complete months] [acute non-specialist n=131]</td>
<td>374</td>
<td>13.1</td>
<td>3</td>
<td>0.5</td>
<td>0.0</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>All reported patient safety incidents</th>
<th>Severe harm</th>
<th>Death</th>
<th>Number</th>
<th>Rate [per 1000 bed days]</th>
<th>Number</th>
<th>Percentage</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airedale NHS Foundation Trust</td>
<td>2,829</td>
<td>47.7</td>
<td>5</td>
<td>0.2</td>
<td>1</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National position [acute non-specialist n=134]</td>
<td>730,151</td>
<td>40.87</td>
<td>1,810</td>
<td>0.2</td>
<td>712</td>
<td>0.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The highest value [acute non-specialist n=134]</td>
<td>19,897</td>
<td>124.0</td>
<td>78</td>
<td>1.2</td>
<td>24</td>
<td>0.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The lowest value [acute non-specialist n=134]</td>
<td>1,311</td>
<td>24.2</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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. The Trust has in place:

- Consistent 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 2018 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.
- 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 whilst,
  - Key quality and safety messages are shared in a monthly Quality and Safety Matters bulletin. Learning has been further augmented via a “Report, Learn, Share Week” in December 2018, which highlighted key aspects of quality and safety –
    - learning from documentation,
    - insulin prescribing and administration medication errors – by drawing from analysis of incident reporting, serious incident investigations, clinical audit and, litigation.
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 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." 20 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 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 for 2016-2020.

How we monitor progress

Up to 2018 a multi-disciplinary and agency Here to Care Group co-ordinated the key dementia priorities: training, enhancing the environment (wayfinding), patient flow and elective pathway. Membership included Dementia Friends Keighley representatives who together provide independent insight on how we can improve care for this patient group. The Trust is currently in the process of developing a Dementia Strategy which will set out revised governance arrangements for all work streams.

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. 20 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 2018/19.

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Figure 7: Time series showing the percentage of eligible patients asked the screening question against the target threshold

Complaints provide valuable qualitative information which may not be identified by more traditional indicators. From a total of 56 formal complaints over the year, four complaints have been received concerning patients living with dementia. Review indicates that in three cases the complaints were directly related to the patients’ specific needs; feedback has been shared with teams. In the 2018 Care Quality Commission inspection of Medical Care (including older people’s care), it found the service worked hard to provide for the needs of vulnerable groups, such as those with dementia whilst within the Surgical Service there were good examples of innovative practice which improved patient experience for those living with dementia.

Initiatives and progress in 2018/19

In 2016 the Trust participated in the National Audit of Dementia to assess the delivery of care for people with dementia admitted to hospital. Whilst results indicated progress is being made, the audit indicated some areas of shortfall, particularly in respect of patient experience: carer communication was ranked below average and the carer rating of patient care was in the lower quartile of participating sites. In 2018 the Trust was selected 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. Staff from Ward 6 and Ward 9 and other key colleagues attended project training to set project aims, establish monitoring as well as understand the principles of enhanced supervision and associated assessment tools. Weekly meetings oversaw progress and identified key actions. A roll out of the Enhanced Care Project to other wards is planned with pilot wards offering support.

In parallel with the above project, progress has continued across four established work streams:

1) Improving care initiatives:

- Dementia memory trolleys across wards, Theatres and the ED in addition to a digital and reminiscence therapy unit stocked with games, quizzes, conversation prompts, tactile products, arts/drawing equipment and cognitive activities for use by patients with dementia. Linking with young people’s volunteering we aim to deliver more reminiscence and therapeutic activities for patients to participate in.
- Accessible information such as an ED leaflet and placemats for patients with key ward information. A communication support toolkit has also been created and will be rolled out to all wards and other clinical areas in 2019. This is 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 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). Thus the Butterfly Tea Room on the elderly ward provides a social space for patients to use and take part in activities such as bingo and crafts.
- Collaboration with dementia-related charities in Dementia Action Week July 2018 through a marketplace event hosted on our Airedale site for healthcare professionals, patients and carers. Outreach sessions in Keighley town centre commenced in 2018 to garner feedback from patients and carers.

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. During Dementia Action Week a staff session on the acute dementia pathway was held.

Patient stories are a potent and reflective tool in reinforcing caring behaviours and can be a valuable learning tool for staff. Such stories both celebrate excellent care and highlight where improvements can be made. The following recounts the experience of a patient and carer on an Orthopaedic ward as part of the Enhance Care Project.

The Board heard about a patient on Ward 9. Mr A. has Parkinson’s and dementia, and was admitted with fractured neck of femur, following a fall. He stayed in total for two months. During this time his wife visited daily, for several hours, and helped with his care.

The ward asked Mrs A. for specific feedback around enhanced care supervision and, as a result of her feedback and that of others, it has:

- Introduced tabards for staff giving enhanced supervision
- Provided placemats with daily updated information
- Created ‘Why am I on enhanced care?’ posters
- Introduced more activities
- Given all relatives verbal and written information about enhanced supervision
- Organised special events such as Eid and Royal Wedding parties

Source: Board of Directors’ meeting June 2018
By the end of March 2019, 94.1% per cent of the Trust’s workforce had achieved competency in dementia awareness training (this incorporates privacy and dignity training).  

3) Patient management and assessment: over the last two years the safety huddle methodology at staff handover has been introduced across clinical areas.

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 a collaborative and holistic approach to care. More recently guidance for the assessment of delirium, dementia and depression – the 3Ds – has been developed and implemented.

This 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). A relaunch of this initiative commenced in 2017 spearheaded by Ward Butterfly Champions. To reinforce the effectiveness of this initiative, around 80 Butterfly Champions were recruited from staff.

Hospital stays are generally damaging to people with dementia who can find the acute setting a difficult and disorientating environment. It is not uncommon for a person living with dementia to experience a loss of functioning level and independence following an acute admission. The Trust has adopted John’s Campaign, a national drive to promote flexible hospital visiting hours for those caring for people living with dementia. John’s Campaign focuses on an open visiting culture, supporting carer access outside of normal visiting hours to minimise the stress and anxiety. This may include staying overnight. Over the last year a Visitor’s Charter has been introduced explaining what patients can expect from us during a hospital stay, including enhanced visiting times. The objective is to ensure an approach that is inclusive of visitors and patients whilst being mindful of the need for rest and recovery.

Next steps

- The Trust is participating in the 2018 National Audit of Dementia (Care in General Hospitals). As part of the audit, hospital staff who work on an inpatient ward and care for people living with dementia are asked what support and training they have received to help them provide the best care possible. Those caring for someone living with dementia are also encouraged to participate as an invaluable means of understanding the quality of care being provided. Results are anticipated later in 2019. In the meantime the Trust continues to address areas of shortfall identified in the 2016 national audit.
- A Dementia Strategy is planned for the organisation with an implementation plan to monitor progress against work streams.

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21 Data source: Human Resources NHS Foundation Trust [consolidated figure].
3.1.2 Privacy and dignity

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. We know there is a link between the well-being of staff and that of patients. Our priorities are to:

1) Embed our Fundamental Standards of Caring for People with Dignity and Respect.
2) Develop a patient-led care environment that is clean, safe, accessible and equipped to underpin privacy and dignity.

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.

3.1.2.1 Creating a Customer Service Culture

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. Sustained performance for patients feeling they are treated with respect and dignity whilst in hospital is noted (Q68).

Table 11: Results of the Care Quality Commission Adult Inpatient Survey for last available three years – performance against selected metrics for Airedale NHS Foundation Trust

<table>
<thead>
<tr>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Q34] Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.6</td>
<td>7.5</td>
<td>7.5</td>
</tr>
<tr>
<td>[Q35] Did you have confidence in the decisions made about your condition or treatment?</td>
<td>8.3</td>
<td>8.3</td>
<td>8.3</td>
</tr>
<tr>
<td>[Q36] How much information about your condition or treatment was given to you?</td>
<td>8.0</td>
<td>8.2</td>
<td>8.8</td>
</tr>
<tr>
<td>[Q48] Did you feel you were involved in decisions about your discharge from hospital?</td>
<td>7.0</td>
<td>7.2</td>
<td>7.0</td>
</tr>
<tr>
<td>[Q63] Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?</td>
<td>5.5</td>
<td>5.7</td>
<td>6.2</td>
</tr>
<tr>
<td>[Q67] Overall, did you feel you were treated with respect and dignity while you were in hospital?</td>
<td>8.9</td>
<td>9.0</td>
<td>9.0</td>
</tr>
<tr>
<td>[Q73] During your time in hospital did you feel well looked after by hospital staff?</td>
<td>8.8</td>
<td>8.7</td>
<td>See note</td>
</tr>
<tr>
<td>[Q68] Overall, how would you rate the care you received?</td>
<td>8.0</td>
<td>8.0</td>
<td>8.2</td>
</tr>
</tbody>
</table>

Data source: Care Quality Commission National NHS Adult Inpatient Survey 2017 (published June 2018). Q73 was removed from the 2017 survey and therefore will not be included in the 2019/20 Quality Report.
The CQC Adult Inpatient Survey 2017 score for privacy when being examined or treated within the Emergency Department shows significant deterioration on the preceding period.

In addition to the annual CQC Adult Inpatient Survey, NHS England's National Cancer Patient Experience Survey 2017 of 413 patients – a response rate of 64 per cent and in line with the national rate – was published in September 2018 with the following case-mix adjusted findings for privacy, dignity and compassionate care:

- 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.
- Of the 152 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 152 respondents to the question, “Were you always given enough privacy when discussing your condition or treatment?” patients gave an average score of 75 per cent. The score is significantly below the expected range.

Other patient survey results published in the last year:

CQC Maternity Survey 2018 of 123 women – response rate 42 per cent compared to a national rate of 37%– was published January 2019. The survey reports on the experience of women in February 2018. The following results have been compared against other participating providers with the following results:

- Of the 121 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 broadly in line with the 2017 return and about the same as other providers.
- The Trust was one of the better performing providers – there were 129 participating sites – in the following questions:
  - “During your pregnancy, if you contacted a midwife, were you given the help you needed?”
  - “Thinking about your antenatal care, were you spoken to in a way you could understand?”
  - “At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?”
  - “Did the staff treating and examining you introduce themselves?”
  - “Looking back, do you feel the length of your stay in hospital after the birth was about right?”
  - “Were your decisions about how you wanted to feed your baby respected by midwives?”
  - “Did you feel that midwives and other health professionals gave you consistent advice about feeding your baby?”
  - “When you were at home after the birth, did you have a telephone number for a midwife or midwifery team that you could contact?”

- Performance was worse amongst other providers for:
  - “Did a midwife tell you that you would need to arrange a postnatal check-up of your own health with your GP?”

There were three mixed sex accommodation breaches notified in April 2018, a time of peak demand. To date there have been no further re-occurrences.
Initiatives and progress in 2018/19

Areas of improvement have been identified from the results of the CQC Adult Inpatient Survey 2017 notably in the areas of:

- Care and treatment: emotional support to address worries and fears of patients.

It is hoped new uniforms and badges will assist patients and visitors in identifying staff. A Ward Directory Project is ongoing with information available on how to access appropriate support. New volunteer roles to develop activities and to befriend are being implemented. Piloting of the Patient Reporting and Action for a Safe Environment (PRASE) iPad survey continues. Its purpose is to allow inpatients to provide feedback on safety, for example, staff communication, equipment availability and care planning. The pilot began on Ward 9 and in the Emergency Department in January 2018.

- Leaving hospital

To ensure patients are involved in discharge decisions and that home situations are part of the discussion, the qualitative findings are disseminated to the Multi-Agency Integrated Discharge Team and the Discharge Facilitators. To address a perceived shortfall in support from professionals to manage conditions and a lack of written and printed information about medication, nursing and therapy leads have been tasked with ensuring that selected formats for communication are effective.

A series of training initiatives, including Customer care training – “Right Care”, encourage staff to reflect on how compassionate care can be embedded into practice. To instil core values and challenge opposing attitudes and complacency, the Trust created its own customer care training module – “Right Care” – for clinical and non-clinical staff. The package refreshes key messages of who our customers (patients, carers, relatives) are and the importance of treating people as individuals. Training is aligned with line management standards, the NICE patient experience standard (QS15) and the NHS Constitution. Drawing on the real experiences of patients of good and inadequate customer care, its objective is to reinforce 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.”

Staff and volunteers come to work to do their best for patients and their families, and they deserve a happy, supportive working environment. The Trust aims to promote an environment 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 on from 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. The “Right Care” Leaders Programme is aimed at new medical consultants, clinical, support service and corporate leaders; the objective being to provide more formalised developmental training. A Health and Well-being 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.

A Respect and Dignity Campaign was launched in October 2017, 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

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work spearheaded by the inclusion groups – BAME, gender, disability and LGBT – is progressing. The Trust is currently piloting a new approach to staff exit surveys to garner feedback that can be used to support retention.

Next steps

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. The criteria have been reviewed; an action plan developed which will be implemented over the coming year.

Other planned actions:

- Promotion of the work across the organisation of our “Right care” Champions.
- Continued commitment to engagement events with both patients and staff, particularly for the more vulnerable groups with the aim of understanding how substantive improvement in their experience can be made.
- Introduction of Schwartz Rounds, a forum for colleagues from all backgrounds, grades and disciplines across both hospital and community areas of the Trust to come together to talk about the emotional, personal and social challenges of working within healthcare. The aim is to provide a safe environment to allow people the time and space to reflect on their roles, share their stories and offer support to one another.

3.1.2.2 A patient-led care environment

The challenge and our aim

There are a range of non-clinical factors which can have an impact on the patient experience of care: cleanliness – the condition, appearance and maintenance of healthcare premises – and the quality and availability of food and drink. The extent to which our environment supports the delivery of care with privacy and dignity is a key area of focus within the “Right Care” portfolio.

In recent years, a number of estate refurbishment and development projects have been undertaken that serve to ensure that people are cared for in a modern hospital environment with privacy and dignity. We aspire to an environment that is pleasant, comfortable, calming, clean and safe in clinical and non-clinical areas. We want to make all our open spaces accessible, including outside spaces such as courtyards.

Current status

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 between May and June 2018 over seven days and included ten wards and four outpatient departments. Results were published in September 2018. Assessments were undertaken across 270 organisations, of which 218 were NHS providers. The assessment tool, the composition of the inspection team and the wards selected vary each year.
invalidating comparison with previous years. The following table provides the site level scores and, to support appraisal, the national average.

### Table 12: Airedale General Hospital 2018 PLACE results

<table>
<thead>
<tr>
<th></th>
<th>AGH % site score</th>
<th>National % average site level score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleanliness</td>
<td>97.20</td>
<td>98.47</td>
</tr>
<tr>
<td>Food and hydration</td>
<td>90.57</td>
<td>90.17</td>
</tr>
<tr>
<td>Organisation food (catering service)</td>
<td>82.33</td>
<td>90.00</td>
</tr>
<tr>
<td>Ward food</td>
<td>93.11</td>
<td>90.50</td>
</tr>
<tr>
<td>Privacy, dignity and well-being</td>
<td>80.53</td>
<td>84.16</td>
</tr>
<tr>
<td>Condition, appearance and maintenance</td>
<td>89.03</td>
<td>94.33</td>
</tr>
<tr>
<td>Dementia</td>
<td>72.50</td>
<td>78.89</td>
</tr>
<tr>
<td>Disability</td>
<td>83.35</td>
<td>84.19</td>
</tr>
</tbody>
</table>

Data source: NHS Digital 2018

Key findings:

- At national level the largest increases in scores are seen for the dementia and disability domains. Airedale General Hospital site performance is about the same as the national average for disability; performance for dementia is in the lower quartile of providers.
- Overall, the highest national average domain score is for cleanliness, at 98.5 per cent; the Airedale General Hospital site score is 97.2 per cent.

Where issues are identified, these are included in the ongoing PLACE Improvement Plan, which is monitored and progressed through the Patient Environment Action Group meetings. Mini-PLACE audits are carried out on a quarterly basis and include a comprehensive inspection of waste, linen, cleanliness, environment and, food safety at ward level. The Infection Prevention Team and Airedale General Hospital (AGH) Solutions Limited undertake these audits alongside Matrons. In addition, environmental audits are conducted to identify where improvements in the aesthetic elements of the patient environment can be made; individual actions to upgrade are being progressively addressed.

**Initiatives and progress 2018/19**

The new Acute Assessment Unit opened in the spring of 2018 and includes ensuite facilities and larger bed space than current wards with more privacy for patients; single bedroom facilities for people to stay over; and provision for speciality care (dementia and end of life patients). Accessible toilets and wheelchair access are incorporated into plans. A waiting area, reception and ambulatory lounge are also part of the design. Research indicates that for those living with dementia, changes in the physical surroundings – eye-catching colour contrasting schemes and signage – can encourage greater independence, help patients find their way around and reduce distress. Dementia principles are embedded in the Estate’s Capital Development Plan.
Strategy reflected in the wards programme.

Other developments in the last year:

- Ward refurbishment continues on a rolling programme. Following concerns expressed by a patient’s family, the cleanliness, condition and appearance of the Ward 5 care environment has been the subject of investigation. Immediate action to relocate the ward was taken with significant work subsequently undertaken to address areas of shortcomings.
- Following on from remedial actions to improve the Dales Unit environment, a business case to incorporate the Dales Unit activity into a wider vision of Theatres has advanced. Subject to capital approval, the new facility should open in 2020; plans include a barn theatre incorporating two theatres and a procedure room.
- A previous CQC inspection tasked the Trust with ensuring that the clinical environment in the Haematology Oncology Day Unit (HODU) meets patient needs and national guidance. Agreed actions include revised pathways to reduce waiting times and clarification of the need for HODU attendance. Through the development of the mobile cancer service – as previously described in this report – we aim to release further clinic time.
- A dedicated space on Ward 7 to provide cystoscopies (bladder investigations) and bronchoscopies (lung investigations, otherwise known as EBUS). These procedures enable early detection of bladder/prostate and lung diseases and having more capacity supports our urology and lung cancer pathways, meaning a swifter diagnosis for patients.
- The opening in August 2018 of a new pathology blood sciences laboratory as part of a complete renovation of Pathology to meet increasing demand for services and create a state of the art facility.
- A reflective non-denominational space is now available within the Chaplaincy complex. This has been further augmented by a wild garden. Friends and relative spaces are incorporated in the ED and within the new Acute Assessment Unit.
- The opening in October 2018 of the Sunbeam Baby Remembrance Garden and the Tree of Tranquillity, an important community resource for those experiencing the loss of a baby.
- The Trust had hoped to work with Transdev to establish a regular bus service that runs between Skipton and Keighley. Regrettably regular delays leaving the hospital site have hindered progress in advancing this initiative. Recent changes to traffic streams on the public road have improved traffic flow and if sustained, discussion with Transdev will be resumed.

Next steps

- Planning permission to construct additional on-site parking has been agreed. The objective is to offer additional patient spaces closer to services and alleviate the pressures on staff parking.
- Building on significant capital developments over the previous years, through the Health and Social Care Partnerships we have submitted bids to further develop our wards and operating theatres.
- The catering contract will be run by AGH Solutions Limited from June 2019 and consultation with wards and departments on how to enhance current provision are underway.
- Castleberg Hospital was closed in April 2017 because of safety concerns following issues with its power supply, heating and drainage. Following extensive consultation with the local Craven community, commissioners have decided to provide inpatient care and restore the hospital. The future model of care will aim to integrate services closer to patients’ homes and will include Castleberg Hospital acting as a community-based facility, with the option to provide a broader range of support services, both physical and mental well-being. Castleberg will be subject to a significant refurbishment with two additional single rooms.
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 of healthcare associated infections and falls.

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 and MRSA bacteraemia infection.

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 District Wide 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; the last case prior to this was in June 2016. Five C. difficile cases developed in hospital. Root cause analysis showed that all cases were unavoidable. This year 18 cases of hospital-acquired E.coli bacteraemia were reported. (All data is governed by standard national definitions.)

In response to the following 2017 NHS Adult Inpatient Survey question, “In your opinion, how clean was the hospital room or ward that you were in?” the Trust scored 8.8 out of a possible score of ten. A higher score indicates better performance. The score is “about the same” as other providers.
Figure 8: HCAI cases at Airedale General Hospital

Data source: Airedale NHS Foundation Trust Infection Prevention.

Initiatives and progress in 2018/19

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 include the following (please read in conjunction with section 2.3.8: Rate of C. difficile infection which outlines additional initiatives and processes):

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, or 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.

Sustained engagement of staff to maintain motivation in preventing HCAI:

- The monthly hand hygiene audit reports a Trust aggregated compliance average of 98 per cent since April 2018.23 This is part of a robust and ongoing infection prevention clinical audit programme to evaluate standards for example, of cannula and urinary catheter care.
- Flu vaccination uptake was above the target threshold of 75% for clinical staff in the latest available period.
- Screensavers alerting staff to key infection control and prevention messages have been adopted, for example, Norovirus and CPE (Carbapenemase-producing Enterobacteriaceae).

23 Airedale NHS Foundation Trust Infection Prevention.
- Mandatory training and link worker programmes are ongoing with uptake monitored via the Mandatory Training Group. A clinical workbook has been development and external events such as Bradford and Airedale Infection Prevention Study Day promote infection prevention and control principles to a wider audience.

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

- As described earlier in this report, the cleanliness, condition and appearance of the Ward has been upgraded in response to concerns.
- 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.
- Changes to ward domestic allocation, for example out of hours, enables a higher level of cleaning as staff are not working around the service.
- 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. Ward kitchens need attention due to wear and tear and receive focus when allocating capital funds.
- 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.

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 i.e. antimicrobial resistance and healthcare acquired infections. Antibiotic audit indicates a high compliance with Trust guidance.

During 2018-2019, work was completed in moving the prescribing of gentamicin paper based system to an electronic prescribing system, and launch of an electronic vancomycin prescribing system is imminent. These two antibiotics are safer from other options from a clostridium difficile infection and MRSA treatment perspective, but carry risks in terms of complex dosing and acute kidney injury.

**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.
- Following the CQC 2018 inspection recommendation that the Surgical Service ensures all applicable equipment is included within cleaning schedules and fit for use, this action is being worked through.
3.2.2 Reduction of slips, trips and falls sustained by patients admitted to our hospital wards

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. The effective management to reduce the number of falls sustained by our inpatients is therefore a high priority.

Current research indicates that multi-component interventions are effective in reducing falls, and that continuous improvement should be built on small incremental changes using a systematic approach to test the impact and feasibility - Plan-Do-Study-Act. Working with the Improvement Academy and using core safety improvement principles, the Trust continues to focus on an incremental decrease in the number of falls and the level of harm these engender.

How we monitor progress

The multi-disciplinary Trust’s Falls Steering Group oversees this initiative with the following key areas of focus: multi-factorial falls risk assessment, care and management of patients following a fall, discharge, patient and family information, equipment, and training and education. The Trust is an active member of the district-wide Falls Pathway Development Group.

Current status

Table 13: Airedale NHS Foundation Trust rate of inpatient falls per 1000 bed days

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Bed days [Y]</th>
<th>Reported Falls [X]</th>
<th>Reported falls per 1000 bed days</th>
<th>*Reported falls resulting in fracture</th>
<th>Reported falls resulting in fracture per 1000 bed days</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018/19</td>
<td>117214</td>
<td>730</td>
<td>6.228</td>
<td>21</td>
<td>0.179</td>
</tr>
<tr>
<td>2017/18</td>
<td>125885</td>
<td>853</td>
<td>6.776</td>
<td>18</td>
<td>0.143</td>
</tr>
<tr>
<td>2016/17</td>
<td>120771</td>
<td>921</td>
<td>7.626</td>
<td>19</td>
<td>0.157</td>
</tr>
</tbody>
</table>

Data source: bed days – Airedale NHS Foundation Trust Information Services; patient safety incidents – Airedale Quality and Safety Team [Ulysses database].

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*A bed day is a day during which a person is confined to a bed and in which the patient stays overnight in a hospital (OECD Health Data 2013. June 2013).

Methodology:
Bed occupancy and inpatient falls are calculated from data from Wards: 1/AAU [2]/4/5/6/7/9/10/13/14/16/17/18/19/21 includes Wards 6 Annex when open as temporary ward.

Bed days supplied by the Trust’s Information Services Department. Falls comparable with National Reporting and Learning System (NRLS) calculation as follows:
- \( X \) = the total number of all patient falls reported in hospital/unit in the most recent year for which data are available.
- \( Y \) = the total number of occupied bed days in your hospital/unit in the most recent year for which data are available, multiplied by 1000.
- \( X \) divided by \( Y \) gives the number of falls per 1000 occupied bed days.

Taken from: The Third Report from the Patient Safety Observatory, Slips, Trips and Falls in Hospital (NPSA, 2007).

Data quality subject to third party review in 2015/16.
Falls are the most commonly reported patient safety incident across acute providers. The table shows all reported inpatient falls across the Trust for the last three years and those which resulted in a fracture. The overall performance shows a decrease year on year in the reported falls rate per 1000 occupied bed days. A sign of a strong safety culture is a reduction in the number of incidents resulting in harm such as fracture. Whilst underlying fracture numbers are at similar levels, those resulting in fracture neck of femur (inpatient wards) have halved in the last year from ten to five cases.

The Royal College of Physician’s National Hip Fracture Database 2018 annual report describes the variation in care for the frail older patient who typically suffers this injury. Ward environments and staffing can contribute to the risk of a hospital fall. In the 2017 report, 5.3 per cent of Airedale inpatients sustained a hip fracture; Airedale reported a value 3.5 per cent in the 2018 report with performance showing an improvement. Across England in 2017, 3.7 of inpatients sustained a hip fracture.

**Initiatives and progress in 2018/19**

A key component in this quality work has been the introduction of a fall safety briefing (known as a safety huddle) on Wards 4, 5, 6, 9 and the Acute Assessment Unit. 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. Support from the Improvement Academy is provided in the team’s own clinical environment, an approach which recognises the clinical expertise of front line health professionals. Work in the last year has focused on re-invigorating this initiative to ensure staff understand its purpose and continue to prioritise the bundle particularly in times of heightened activity where the temptation can be to focus on the immediate tasks and needs of patients. Monitoring of daily falls data indicates that there are fewer falls on those days where such a huddle is undertaken. Work to sustain progress is being further supported by an initiative to measure the days between falls. From July 2018, work to promote safety huddles has been prioritised with additional support and mentoring provided from the Yorkshire and Humber Improvement Academy. Work to sustain progress is being further supported by an initiative measuring the days between falls. From April 2018 to March 2019, Ward 5 recorded a stretch of 116 days between falls whilst the AAU, Wards 4 and 9 reported a period of more than 23 days between falls. This is a cultural shift away from accepting inpatient falls as “normal” and forms part of a proactive approach to prevention. All wards are in possession of bed and chair alarms; other specific medical equipment is also available, such as low beds, in support of patients assessed as at risk of falling.

Other constituent interventions which have demonstrated success in reducing falls include the “End PJ Paralysis” initiative goal is to get inpatients up, dressed and moving and avoid muscle atrophy from inactivity. The recommendation of the Royal College of Physicians 2017 National Falls Audit England and Wales that providers ensure that all patients who need walking aids have access to the most appropriate type from the time of admission is being prioritised. The Frail Elderly Pathway Team is working with the ED and AAU to ensure staff have the competency to measure patients for walking aids. Further areas where developmental actions have been taken are around continence care planning and the management and assessment of delirium. An assessment tool for delirium, dementia and depression – the 3Ds – has been rolled out in conjunction with a Continence Care Plan.

Focussed work continues regarding patients who fall more than once. A key objective is to identify those patients at high risk of falling and determine how to prevent such a fall. Research indicates that an emphasis on reducing multiple falls (by the same patient) can reduce falls by between 20 and 30 per cent with a concomitant reduction in the overall level of harm. Key interventions include intentional rounding – a structured process whereby regular checks are carried out with individual patients at set intervals – and enhanced supervision to improve the care and safety of those patients at a high risk of falling. In addition, the Enhanced Care Collaborative initiative has been
adopted by Wards 4, 6 and 9. Other ward areas are actively using the core principles of enhanced care to provide person centred care promoting safety and optimising wellbeing. 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 needing enhanced supervision helps staff engagement and supports individualised care and patient experience.

Training is fundamental in raising awareness of the role that staff can play in fall prevention. Training is provided at a multi-disciplinary level via monthly induction organised by Practice Development with bespoke sessions available by request.

Other initiatives:

- Review of the process for reporting falls resulting in significant harm. Senior corporate nursing leads provide support to clinical teams by attending those clinical areas where a patient has fallen and sustained significant harm. The Rapid Response Visit identifies any immediate learning prior to a more formal investigative process.
- To evaluate compliance with NICE guidance, a clinical audit has been undertaken of those patients identified from incident data as having sustained a head injury. Resultant actions: the standard operating procedure has been reviewed with roles and responsibilities updated to reflect the changing clinical profile of the workforce.

**Next steps**

Continue to focus on:

- Best practice and new approaches to patient-centred care. This includes participation in the 2018 Royal College of Physician's *National Falls Audit* with a particular focus on inpatient falls resulting in fracture neck of femur.
- Quality improvement work through collaboration with Yorkshire and Humber Improvement Academy, the Enhanced Care Improvement Collaborative and district wide colleagues. 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 fall prevention.
- Ongoing review of fall risk assessments – the 2018 CQC inspection highlighted that these are not consistently considered.

**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 and body systems decline, 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.  

The Trust’s Patient Co-ordination and Flow Programme 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 four 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 Medical 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

Meeting monthly, the multi-disciplinary Frail Elderly Pathway Joint Management Team aims to improve the active management of care for older people through review of outcome data – for example length of stay and patient and staff feedback. The group also looks at service improvements and training opportunities to improve the care and assessment of frail elderly patients including: updates on lying and standing blood pressure; medications with an influence on falls; and, use of the Rockford Frailty screening tool. The Patient Co-ordination and Flow Programme forms part of the “Right Care” portfolio and is monitored by the Board of Directors with progress reviewed on a quarterly basis.

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 compares a baseline period (August 2014 to February 2016) when data collection commenced, with performance following the merger of the Ambulatory Care Unit with the Acute Medical Unit and the extension of the Team (March 2016 to September 2016). More recently (October 2016 to 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.

Patients seen by the Frail Elderly Pathway Team and discharged directly from the Acute Assessment Unit:

I. August 2014 - February 2016: 3.80 days average  
II. March 2016 – September 2016: 3.37 days average  
III. October 2016 – September 2017: 1.84 days average  
IV. September 2017 to September 2018: 1.74 days average

Overall and since the establishment of the team there has been a 2.06 day reduction in average length of stay per patient.

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:

I. August 2014 - February 2016: 17.3 days average
II. March 2016 – September 2016: 14.6 days average
III. October 2016 – September 2017: 12.05 days average
IV. September 2017 to September 2018: 14 days average

Data source: Airedale NHS Foundation Trust Information Services.

Overall and since the establishment of the Team there has been a 3.3 day reduction in average length of stay per patient who after Frail Elderly Pathway assessment are admitted to a base ward. An average of 26 patients are seen each month in ED with 45 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 over the last 13 months, 49 per cent were discharged to the community and not admitted to an acute ward.

Qualitative feedback regarding the Frail Elderly Pathway Team commenced collection in August 2018. Assessment indicates the Team is making a tangible difference to the patient experience. An appraisal of the Dietician’s community intervention will be undertaken in March 2019 and reported in the next update of this report. 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. These accolades highlight the unique role that allied health professionals can play within the wider social, health and care sectors. The CQC 2017 inspection report and local system report for Bradford of how older people move between health and social care commends the team for its proactive approach to ensure patients received the “Right Care” as quickly as possible whilst highlighting the effectiveness of relationships-building amongst team members from the health and social care sectors.

Initiatives and progress in 2018/19

The Frail Elderly Pathway Team has been involved from the planning stages of the new Acute Assessment Unit – the integrated ED, Acute Medical, Surgical Assessment, and Ambulatory Care Unit. Seeking to avoid admissions, the Team has offered advice on the Unit’s pathways of care and contributed to the rapid improvement events. 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.

Other progress:

- In 2017 a quality improvement project looked at the use of the Rockford Frailty score to screen for frailty among patients on the Acute Medical Unit; results indicated the tool supported both identification and appropriate referrals. As a consequence, it has been added to the SystmOne assessment templates.
- To optimise efficiency and avoid the involvement of too many people in one person’s care, team members have developed competencies beyond their own core areas.
- Knowledge and ideas to improve the process are shared across disciplines and locations. For example, the evaluation of walking and aid training for ward staff.
- Airedale is one of ten participating sites across Yorkshire and South West England in the HERO (Home-based Extended Rehabilitation of Older people) study, involving older people with frailty admitted to hospital following acute illness or injury. The overall aim is to investigate whether an
extended rehabilitation programme using a home-based exercise intervention developed for older people with frailty improves health-related quality of life. The Community Therapists are providing this intervention in the community above usual care for a randomly assigned group over a 24 week period. The aim of the study is to inform community rehabilitation needs for this group of patients.

Next steps

- The Frail Elderly Pathway Team is supporting the new streaming of patients by attending the Ambulatory Care Unit (ACU) where GPs have requested a patient assessment.
- Continue to develop the daily “Get Me Home” meeting to improve flow within the AAU and hospital bed base.
- Identifying suitable patients for the existing Home First Service for East Lancashire patients and the new Airedale, Wharfedale and Craven Home First Service.
- Staffing-wise, consideration of the possible introduction of Assistant Practitioners into the existing team is planned. A Geriatrician attached to Frail Elderly Pathway Team commenced in January 2019.

3.3 Clinical effectiveness

The following projects focus on the delivery of clinical excellence in care and treatment and reflect key priorities.

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

The challenge and our aim

There is evidence 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. 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.

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

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29 Dr Foster Intelligence (2013), Dr Foster Hospital Guide 2013. Dr Foster Limited. p.10.
The Airedale Digital Care Hub offers teleconsultation by secure video link with nursing and residential homes. Staffed 24/7 by highly skilled registered healthcare practitioners, the team has developed to include Acute Care, Urgent Care and District 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. The Immedicare Service across Airedale, Wharfedale and Craven district has been decommissioned in the last year.

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 seven day, around the clock 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.

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

**Figure 9: Patient outcomes April to December 2018**

![Pie chart for Care homes and Gold Line outcomes](image)

<table>
<thead>
<tr>
<th>Category</th>
<th>Care homes</th>
<th>Gold Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient remained in place of residence</td>
<td>88.1%</td>
<td>91.1%</td>
</tr>
<tr>
<td>Ambulance request for patient</td>
<td>11.5%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Hospital notified of death</td>
<td>0.5%</td>
<td>6.2%</td>
</tr>
</tbody>
</table>

Data source: Airedale NHS Foundation Trust Information Services.

- The Hub regularly receives in excess of 2500 video calls each month from nursing and residential home patients across England and received calls from over seven thousand individual patients between April and December 2018.
Each month the Gold Line Service handles around 1500 telephone calls and received almost two thousand individual patient calls between April and December 2018.

Patients from over 600 GPs and 50 plus commissioning groups have been triaged across both the Care Home and Gold Line services.

Other services and progress in 2018/19

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 Intermediate Care Hub (IC_HUB)
  
  This is a joint health and social care approach, and the result of organisational and district-wide integration work. The IC Hub acts as a health and social care referral point for adults needing rehabilitation or recovery care after an illness, such as a stroke. It offers quick interventions to prevent major health problems developing should a patient’s long-term condition deteriorate. The approach seeks to prevent unnecessary admissions into hospital where patients can be more effectively cared for in community settings and provide a supported and speedier discharge from hospital.

- The Multi-agency Integrated Discharge Team (MAID Service – known more latterly as Multi-agency Referral Hub)
  
  The Multi-agency Integrated Discharge Team (MAID Service) launched in November 2017. This is a collaboration between the IC_Hub team, Case Management Team and social care. The MAID Team aims to practice person centred care planning and support for eligible adults with complex needs, with a clear commitment to ensure patients are discharged safely into the most appropriate setting. The key areas of focus for this service are to maximise well-being, choice, control, independence and function; ensure people get the right care the first time; and, enable safe discharge from hospital.

- Specialist Speech Therapy Service
  
  Following a successful pilot project to deliver an on-screen stammering therapy service from April 2017 to April 2018, the results have been evaluated by Leeds Beckett University and show positive patient outcomes. The project 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. The service is now continuing 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

A project group has been established to explore the feasibility of providing a Care Co-ordination Centre across Airedale Wharfedale and Craven. Basic elements of this service exist within the Digital Care Hub – the Immedicare Care Home Service, Gold Line and IC-Hub and MAID Service. The project aims to harmonise services and deliver a holistic and responsive care model that provides the support to manage long-term conditions within the best setting for the individual.

Data source: Airedale NHS Foundation Trust Information Services.
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 2018 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 28.8 per cent for 2017/18, reflecting a continuing national incremental trend in caesarean birth. The Trust’s overall 2018/19 caesarean section rate of 27.7 per cent compares favourably although also shows an increasing trend. Finer grained analysis indicates that the rate for electives is 13.1 percent compared to the England 2017/18 average of 12.6 per cent.
Figure 10: Caesarean section rate for Airedale NHS Foundation Trust long-term trend

Initiatives and progress in 2018/19

- 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. Nominated improvement leads from our service continue to build on their knowledge of improvement theory by attending learning sessions and developing improvement goals.
- Maternity Safety Champions within the service promote safer maternity care focusing on human dimensions, systems and processes, clinical excellence and patient experience.
- 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 2018 indicate almost seven per cent of women labouring in the pool and around six 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, 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. Those women with tocophobia or extreme anxiety can be referred to the Healthcare Psychology Service.
  - Wireless cardiotocography – CTG – monitors allow women who have had a previous caesarean section to be monitored while remaining active in labour and even to labour in water.
- High risk antenatal care, low risk intrapartum (HALO) care system permits women with antenatal risk factors, but no intrapartum risk factors, to be cared for in labour by a midwife on the Midwife
Led Unit, reducing the possibility of obstetric intervention and offering the best opportunity for a vaginal birth in a low risk setting.

- External Cephalic Version – ECV – 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 Positive Birth Group has been established by the Labour Ward Manager. Comprised of midwives, the group aims to increase positive birth messages. For example, a Ward Birth Lead has been identified and discussions around increasing training to boost staff facilitation has commenced.

- A pilot has been ongoing for over a year to develop partnership working between Airedale Maternity Unit and local independent midwives and offers the opportunity to support women’s birthing choices, continuity of care and enhance safety through, for example, information sharing and training. This approach is proving successful with independent midwives participating in the obstetric emergency training.

**Next steps**

Planned and ongoing work includes:

- A Rapid Improvement Event supported by the Quality Improvement Team to focus on induction of labour with emphasis on a multi-disciplinary approach.

- Work with women, midwives, clinicians, leaders, managers, researchers and commissioners to implement 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 eight midwives. The woman may meet all members of the team but a “buddy system” is in place to reduce the number of midwives seeing women. The initial trajectory is that 20 per cent of women booked for maternity care at Airedale NHS Foundation Trust will receive team continuity of carer by March 2019. Our pilot consists of two teams of hospital and community based midwives. In the initial phase the midwives will work predominantly within their current area of practice, but gradually will work across both hospital and community to increase intrapartum continuity for women. In addition to this we have several fully independent midwives attached to Airedale. We look forward to updating you on progress in the coming year.
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 neck of femurs happen in elderly patients with osteoporosis; mortality is high although most deaths are from associated conditions and not the fracture itself. 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

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 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 Annual Report (NHFD) 2018, of the 264 cases submitted in 2017, performance is within the top quartile of the 175 eligible providers for the following standards for the management of hip fracture:

- Mobilised out of bed by the day after surgery;
- Nutritional risk assessment;
- Surgery on day of, or day after, admission;
- Spinal anaesthetic and nerve block
- Proportion of arthroplasties which are cemented; and,
- Intertrochanteric fractures (excl. reverse oblique) treated with sliding hip screw

Performance was within the lower quartile for the following:

- Mental test score recorded on admission;
- Documented final discharge destination;
- Discharge to original residence within 120 days; and,
- 120 day follow up – not currently undertaken.

In 2018 the best practice tariff was met in 69.8 per cent of Airedale patients compared to 63.2 per cent across England. We aim to continually improve our overall performance for achieving the NHFD best practice tariff. Where standards are not met, the reasons are investigated to understand if clinical care can be more effectively delivered.

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.

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The figure describes our performance in the last ten years in the reporting period 1\textsuperscript{st} April to 31\textsuperscript{st} March: mean length of stay is 18.9 days with upper and lower confidence interval (three standard deviations) ranging from 12.8 to 25.0 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. Over the last six years performance has been consistently around the average. Between 1\textsuperscript{st} January and 31\textsuperscript{st} December 2017, the overall hospital mean length of stay for eligible England was 18.6 days; performance for Airedale General Hospital was 21.7 days.\textsuperscript{32} No adjustment for case mix is made.

\textbf{Initiatives and progress in 2018/19}

To support the delivery of the best practice pathway and improve outcomes for this patient group, the following actions have been taken to address either areas identified in 2017 as requiring improvement or to advance current provision:

- 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. This minimises unnecessary pre-operative starving of hip fracture patients awaiting surgery and improves provision of pre-operative carbohydrate loading drinks.

- An Advanced Nurse Practitioner (ANP) works alongside an Orthopaedic Nurse Specialist (ONS) on Wards 9 and 18 to improve continuity of care for Orthopaedic patients.

- The introduction of a blood management protocol for fracture neck of femur patients.

- Post-operative nutrition has been addressed through offering protein supplements as there is evidence of benefits for this patient with a fragility fracture.

• The 4AT is a rapid clinical instrument for delirium detection. Championed by the ONS, the short test is designed to be used by any healthcare professional when delirium is suspected.

• As of April 2018 post-operative physiotherapy is being provided seven days a week (prior to this it was only available weekdays). The idea is to ensure that all patients who are fit enough are mobilised from bed the day following surgery to reduce complications.

• All junior ward doctors are trained at the start of their rotation by the orthopaedic ANP and ONS to carry out fascia iliaca blocks. Our aim is to offer and maintain nerve block in the perioperative period. An audit of its use is planned.

• The aspiration is for all patients with a fractured neck of femur to be admitted under Orthogeriatrics and to be cared for by this team. Due to long-term staffing pressures, including a national shortage of consultant Orthogeritricians, this remains a challenge. In order to support junior doctors and the Care of the Elderly Medical Team a medical post in Care of Elderly Orthopaedics has been funded and staffed by a series of able, competent and motivated Foundation Year 3 doctors. This acts to fill the shortfall between desired Consultant Orthogeriatric Care and available Consultant Orthogeriatric Care.

Next steps

• In line with Public Health England’s system based approach, Airedale’s Orthopaedic Team is seeking to set up a Fracture Liaison Service (FLS) within the Trust to minimise future fragility fractures. A multi-disciplinary service would identify, investigate, initiate treatment and integrate care for all eligible patients aged 50 and over with a fragility fracture with the aim of reducing the risk of further fractures via education, exercise and risk assessment. Such a service would also address areas of shortfall against the NICE guidelines for fragility fractures as identified in local clinical audit of standards.

Other local trusts, including Bradford Teaching Hospital NHS Foundation Trust, have successful FLS in place. Meetings have been held with commissioners, the Board of Directors and the National Osteoporosis Society to develop a robust patient pathway with staff keen to implement. Unfortunately funding from the commissioners is yet to be obtained and discussions as to provision of a FLS in the near future remain ongoing. In the interim a risk assessment to address this deficiency is in place.

• As a small acute trust, there can be wide variations in activity. It is planned that there will be additional theatre capacity in Orthopaedics within the next 12 to 18 months. This will allow flexibility to absorb these fluctuations in demand for acute theatre time.
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* and are subject to third party scrutiny and review.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Threshold</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cancers: 62-day wait for first treatment, comprising either:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• from urgent GP referral to treatment</td>
<td>85%</td>
<td>92.3%</td>
<td>89.1%</td>
<td>✄ 86.05%</td>
</tr>
<tr>
<td>• from NHS Cancer screening service referral</td>
<td>90%</td>
<td>93.8%</td>
<td>91.2%</td>
<td>90.7%</td>
</tr>
<tr>
<td>Maximum 18 week waits from referral to treatment in aggregate – patients on an incomplete pathway</td>
<td>92%</td>
<td>✄ 91.5%</td>
<td>✄ 92.3%</td>
<td>92.7%</td>
</tr>
<tr>
<td>A&amp;E maximum waiting time of four hours from arrival to admission/ transfer/ discharge</td>
<td>95%</td>
<td>✄ 90.6%</td>
<td>✄ 93.3%</td>
<td>✄ 89.22%</td>
</tr>
<tr>
<td>Clostridium difficile: variance from plan</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>6*</td>
</tr>
<tr>
<td>Maximum 6 week wait for diagnostic procedures</td>
<td>99%</td>
<td>-</td>
<td>97.8%</td>
<td>96.3%</td>
</tr>
</tbody>
</table>

* One case awaiting review.

✄ = subject to third party audit on behalf of NHS Improvement. See section 4.5 for detail of data testing in 2018/19.

Data source: *Airedale NHS Foundation Trust Information Services*. 
Part 4: Annex

4.1 Airedale, Wharfedale and Craven Clinical Commissioning Group (CCG)

The draft *Quality Report 2018/19* was circulated to NHS Airedale, Wharfedale and Craven CCG, Bradford City CCG and Bradford Districts CCG with the following feedback received:

Airedale NHS Foundation Trust Quality Report 2018/19

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

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

I would like to start by offering my congratulations to the Trust on their key achievements during 2018/19 which include:

- Being named as one of the top five hospitals for patient safety in the CHKS Top Hospitals programme 2018.
- The implementation of the Trauma and Resuscitation Team Skills (TaRTS) course in other hospitals and identified as outstanding practice by the Care Quality Commission (CQC)
- Successful achievement of Joint Advisory Gastrointestinal Endoscopy Accreditation.
- Extended funding for the ACE2 cancer pilot site to establish a ‘one stop shop’.
- Provision of a mobile cancer unit, the first of its kind in the North of England.
- Successful in a joint bid to become a Local Health and Care Record Exemplar (LHCRE) site.

I am also encouraged by the initiatives that contribute to the strengthening of the wider system, which include:

- Joint working with Bradford Teaching Hospitals NHS Foundation Trust and commissioners on the Acute Provider Collaboration programme and in particular the improvement in the stroke services that are delivered across the District. The most recent Sentinel Stroke National Audit Programme (SSNAP) reports an improvement for ANHSFT’s score for both patient and team centred.
- The opening of the new pathology blood science laboratory as part of a whole system pathology renovation.
- As a national pilot site, the successful registration of the first cohort of Nursing Associates with the Nursing and Midwifery Council in January 2019.
The launch of and inclusion in the Red Bag Hospital Transfer pathway to improve the experience for older people in care homes.

Following the Care Quality Commission (CQC) annual well-led and core service inspection during November and December 2018, I note the Trust received an overall rating of ‘Requires Improvement’ and also received a combined rating from NHS Improvement (NHSI) and the CQC of ‘Good’ for ‘Use of Resources’. I note that the Trust were rated as ‘Good’ for the ‘Responsive’, ‘Caring’ and ‘Effective’ domains, and ‘Requires Improvement’ for ‘Safe’ and ‘Well-Led’. I acknowledge that the inspectors recognised that progress had been made since your last inspection, but identified areas requiring further and more rapid improvement. These include nurse and medical staffing levels and skill mix, and how well leaders improve the quality of services and safeguard high standards of care. In response to the CQC ‘Quality Report’ of March 2019, I am pleased to note you have developed a Quality Improvement Plan that you will be monitoring with added rigor to embed consistent and sustained improvements.

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

It is disappointing that the Trust have reported three Never Events during 2018/2019. I welcome that the quality report makes reference to working collaboratively with NHS Improvement and details how learning is being implemented into practice. The priority areas identified by ANHSFT for 2019/20 include a continuation from the previous year in recognition that there are further improvements required. These are:

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

Patient safety:
- Infection prevention and control
- Reduction of slips, trips and falls sustained by patients admitted to our hospital wards
- Improve the prevention, early identification and management of Acute Kidney Injury
- Frail Elderly Care Pathway Team initiative (to identify frailty and enhance care planning between health and social care)

Clinical effectiveness:
- Management of sepsis;
- 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.

A new priority area for 2019/20 is:
- Improving the care and support for people with mental health needs.

The report includes a review of last years’ priorities and I note the improvements the Trust has achieved against these, which includes:
Collaborative working to successfully achieve the 80% target for wounds that have failed to heal within four weeks to have a comprehensive wound assessment.

Identification and management of acute kidney injury; working to the recently introduced care bundle alongside an educational programme and raising awareness of the “Think Kidneys initiative”.

Management of sepsis; working to the recently introduced care bundle, the adoption of screening tools and the introduction of sepsis trolleys in key areas.

Other initiatives include:

- Screening of patients aged 75 and over admitted as an emergency for dementia or delirium, with a 90% target being achieved in 2018-19.
- Adoption of the ‘End PJ Paralysis’ campaign.
- Developing the skills and expertise of the workforce to improve care for patients with dementia.
- The introduction of a fall safety briefing (safety huddle) across a number of wards.

ANHSFT continues in its aspirations to provide high quality safe and effective services and I welcome the Trust’s commitment to further build and improve on these priorities.

ANHSFT has committed to working as one system to integrate care and actively supports local community partnerships. Demonstrable progress has been made towards utilising the opportunities a shared system will bring involving other partners which includes 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 recognise that the workforce remains hugely committed to meeting the needs of the local population in a year of both progress and pressures. I commend the Trust’s ongoing commitment to improve the quality and safety of the care that our communities receive. 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.

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.

Helen Hirst
Chief Officer
NHS Airedale, Wharfedale & Craven,
Bradford City & Bradford Districts CCGs
4.2 Overview and Scrutiny Committee

The draft Quality Report 2018/19 was circulated to Bradford Metropolitan District Council Health Overview and Scrutiny Committee and North Yorkshire County Council Overview and Scrutiny Committee for comment. Receipt was acknowledged by both group and the following feedback was received.

Statement from the Chairman of the Scrutiny of Health Committee:

Over the past 12 months, the North Yorkshire Scrutiny of Health Committee has continued to work with the Airedale NHS Foundation Trust to better understand the financial, workforce and clinical pressures within the local health system and the measures that have been put in place to respond to them. This has involved engagement in the West Yorkshire and Harrogate Joint Health Overview and Scrutiny Committee, which is looking at area wide changes to health services including Craven.

The NHS nationally, regionally and locally is undergoing a sustained period of change both planned and reactive. The Scrutiny of Health Committee is committed to maintaining a system-wide view of services that helps to ensure that individual responses to individual problems do not lead to variations in health care provision which mean that people are disadvantaged by where they live in the county.

In 2018/19, the support that has been provided by lead members of the Trust has been appreciated. Over the next year, the Scrutiny of Health Committee looks forward to working with commissioners and providers on the development of integrated and sustainable systems of care in rural areas that use the assets that are currently available in new ways.

County Councillor Jim Clark
Chairman, North Yorkshire Scrutiny of Health Committee
1 May 2019

4.3 Healthwatch

The draft Quality Report 2018/19 was circulated to Healthwatch Bradford and District and Healthwatch North Yorkshire and Healthwatch Lancashire for comment. No feedback was received.

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:
  - board minutes and papers for the period April 2018 to the date of this statement.
  - papers relating to quality reported to the board over the period April 2018 to [the date of this statement]
  - feedback from commissioners dated 20/05/19
  - feedback from governors dated 14/03/19
  - feedback from local Healthwatch organisations - none received.
  - feedback from Overview and Scrutiny Committee dated 01/05/2019.
  - the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019
  - the [latest] national patient survey 13/06/2018
  - the [latest] national staff survey 26/02/2019
  - the Head of Internal Audit’s annual opinion of the trust’s control environment dated 24/05/2019
  - CQC inspection report dated 14/03/2018
- the Quality Report presents a balanced picture of the NHS foundation trust’s performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review 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: 28 May 2019

Chief Executive
Date: 28 May 2019
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. Set out below is the detailed 2018/19 guidance for auditors to enable review and testing of data quality. To the best of our knowledge and belief the information used to calculate indicators is complete, accurate and relates to the reporting period.

4.5.1 Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

Data definition
All cancer two-month urgent referral to treatment wait.

Numerator
Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Denominator
Total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Accountability

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

Source of indicator definition and detailed guidance


This indicator is as required to be reported by the Risk Assessment Framework: A&E four-hour wait: waiting time is assessed on a provider basis, aggregated across all sites: no activity from off-site partner organisations should be included. The four-hour waiting time indicator applies to minor injury units/walk-in centres.

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

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 their 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.

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.