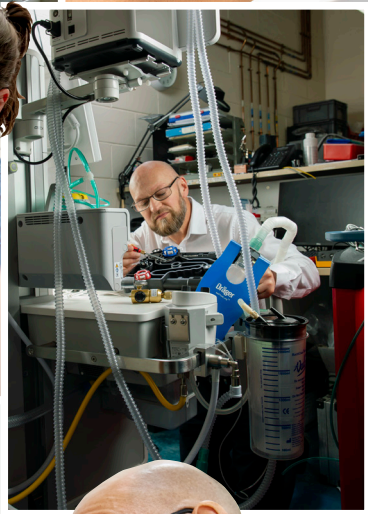
Bradford Teaching Hospitals
NHS Foundation Trust

Quality Account

2023/24



Contents

Chapter 1

STATEMENT OF QUALITY FROM THE CHIEF EXECUTIVE

I am delighted to present the Quality Account for the year 2023/24 as Chief Executive of Bradford Teaching Hospitals NHS Foundation Trust. This document is a comprehensive reflection of our continuous commitment to delivering the highest standards of care to our patients and our dedication to quality improvement across all our services.

At Bradford Teaching Hospitals NHS Foundation Trust, our vision is to be an outstanding provider of healthcare, research and education, and a great place to work. This year, we have made significant strides in enhancing patient experience, improving clinical outcomes, and fostering a culture of excellence.

Our quality improvement initiatives are underpinned by our core values:

- We Care,
- We Value People,
- We are one team

And our successes are built on respect, integrity, and collaboration.

Achievements and highlights

We updated and launched three new strategies in the last 12 months. The Patient Experience and Engagement Strategy replaced our previous patient experience strategy, our equality, diversity and inclusion strategy 'We are Bradford: We value diversity and champion inclusion' was launched in May 2023 and our Improvement Strategy was approved in November 2023.

These three pivotal strategies set out our commitments to ensure that the voices of patients and staff are heard, decisions are made collaboratively and that we will drive change and improvement by continuously listening and learning.

Patient safety

We have implemented several key measures to enhance patient safety for all the services we provide. We successfully transitioned to the new Patient Safety Incident Response Framework in December 2023 with the approval of our Patient Safety Incident Response Plan. This included the execution of a comprehensive training package with 242 staff being trained in investigation methodologies, systems analysis and human factors. We have also implemented a new risk management and incident reporting system, 'IRIS', supported by our new partner InPhase. This has also provided us with the opportunity to advance our patient safety learning through new monitoring systems, and robust incident reporting mechanisms linked to our improvement programmes within our Patient Safety Plan.

Clinical effectiveness

Our clinical teams have been at the forefront of adopting new evidence-based practices. This year, we have built on our previous successes in improving the management of deteriorating patients. Having implemented a Hospital at Night team along with a nightly Safety Huddle, we have seen a decrease in patients having an unplanned admission to our critical care services. In addition, we took part in NHS England's 'Worries and Concerns' Improvement Collaborative to develop, test and implement new ways to involve patients, carers, and families in raising their worries and concerns about acute illness and deterioration. Using our improvement approach we adapted a patient wellness questionnaire which was shared nationally and has resulted in the Trust taking part in Phase 1 of the implementation of 'Martha's Rule'.

Our Maternity Servies have now fully implemented the Saving Babies Lives Care Bundle Version 3, supporting our commitment to reduce still births and provide our women with an outstanding maternity service.

Patient experience

Ensuring that our patients have a positive experience remains a top priority. Our Spiritual, Pastoral and Religious Care (SPaRC) service has received national recognition for their Ramadan Allies Project as winners of the Health Service Journal workforce award in November 2023. They also launched a training video to support their SPaRC App to be used by both staff and patients. Our Bereavement team have also been recognised regionally for the work they have done to improve the experience of patients and relatives. We have continued to seek outpatient feedback and have delivered numerous patient and public involvement events which have provided valuable insights and helped us tailor our services to better meet patient needs.

Challenges and future plans

While we are proud of our achievements, we acknowledge the challenges we face, including the increasing demand for services and the need for continuous innovation. We are committed to addressing these challenges by investing in our workforce, embracing new technologies, and strengthening our partnerships with other healthcare providers.

Looking ahead, we have identified the following key priorities for the coming year:

- Improving the management of deteriorating patients including the implementation of Martha's Rule
- Implementing the 3-year plan for maternity and neonatal services based on the Ockenden review and Saving Babies Lives
- Understanding and tackling health inequalities
- Embedding the Trust's Patient Safety Incident Response Plan including the development of metrics to demonstrate its effectiveness

The achievements outlined in this Quality Account are a testament to the dedication and hard work of our staff, who strive every day to provide the best possible care for our patients. We are grateful for the continued support of our patients, their families, and our partners.

As Chief Executive Officer, I am proud of the progress we have made and excited about the future. Together, we will continue to build on our successes and work towards our vision of providing outstanding healthcare to our community.

Thank you for taking the time to read our Quality Account. Your feedback is invaluable in helping us to further improve our services.

Professor Mel Pickup
Chief Executive Officer

June 2024

1.1 ABOUT BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST

Bradford Teaching Hospitals NHS Foundation Trust (our Trust) is responsible for providing hospital services for the people of Bradford and communities across Yorkshire, serving a core population of around 650,000 people.

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

In addition to Bradford Royal Infirmary and St Luke's Hospital, our Trust provides a range of services from community sites at Westbourne Green, Westwood Park, Shipley, Eccleshill, Skipton and the Bradford Macula Centre.

We have approximately 630 acute beds for overnight stays, 60 intermediate/community care beds, and 120 beds for day only admissions, plus a further 160 beds/cots within the Maternity and Neonatal Units. We employ over 6,750 members of staff, and have more than 500 volunteers supporting our services. In 2023/24 our Trust services delivered 5,314 babies, performed 17,087 operations in theatre and handled 504,333 outpatient appointments. We had 145,016 attendances at our Emergency Department, and a further 25,854 emergency attendances to other parts of the hospital.

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

1.2 WHAT IS A QUALITY ACCOUNT?

All providers of NHS services in England have a statutory duty to produce an annual report to the public about the quality of services they deliver. This is called the Quality Account and includes the requirements of the appropriate regulations[1]

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

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

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

1.3 SCOPE AND STRUCTURE OF THE QUALITY ACCOUNT

This report summarises our progress on the quality priorities we set for 2023/24. Our focus remains to provide safe, effective and a positive experience of care. This report is divided into three parts:

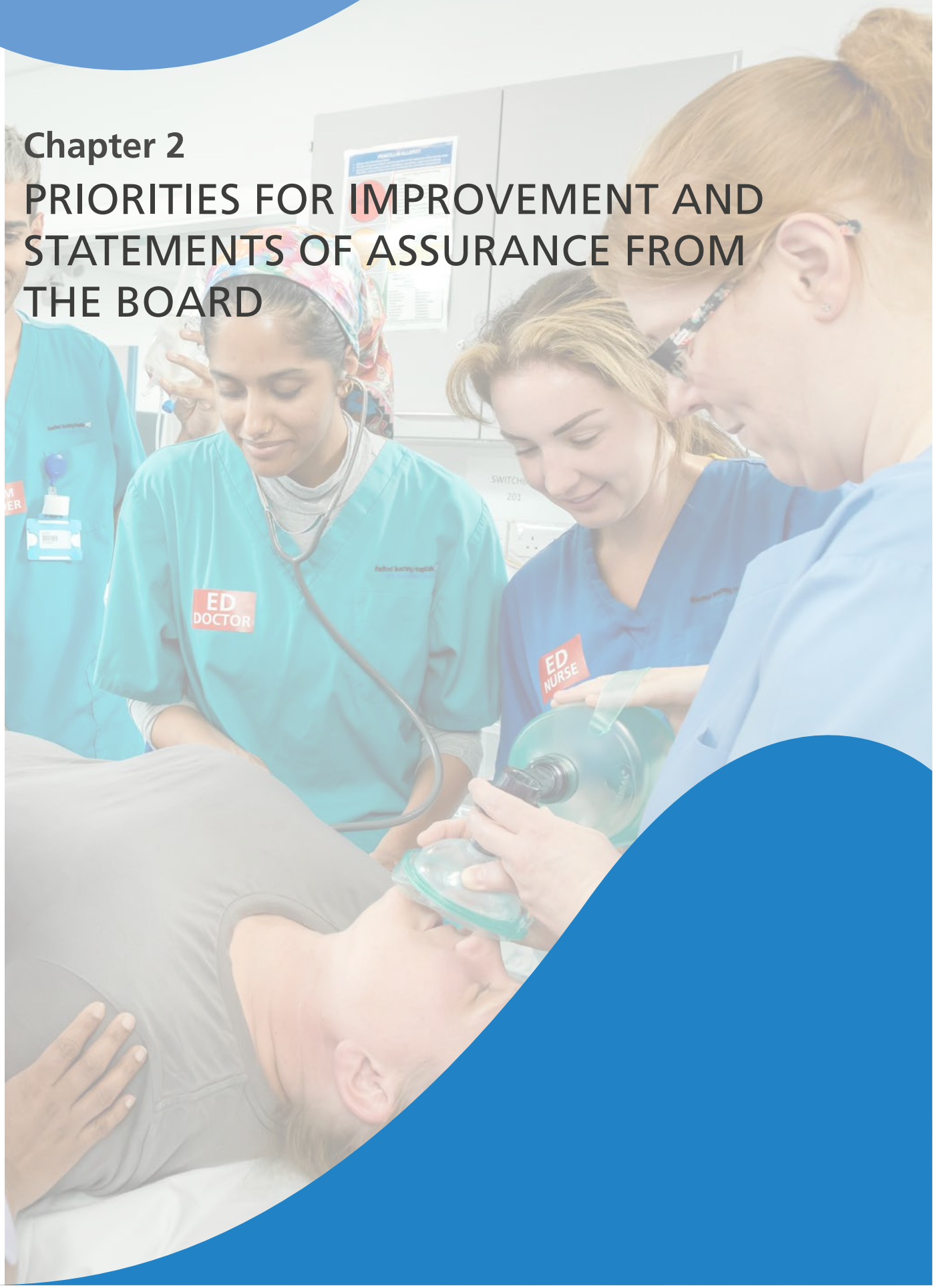
- **Part 1** presents a statement from the Chief Executive about the quality of health services provided during 2023/24.
- **Part 2** describes our priorities for improvement for 2024/25, the rationale, our progress in 2023/24 and how we plan to monitor and report progress. It contains statements of assurance relating to the quality of services. This includes statements on the National Clinical Audits programme which NHS England advises Trusts to prioritise for participation and inclusion in their Quality Accounts for 2023/24 and, a description of our research work.
- **Part 3** includes performance against national priorities and our local indicators.

The annex section includes comments from our external stakeholders.

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

Chapter 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD



2.1 PRIORITIES FOR IMPROVEMENT

Our Quality Priorities for 2023/24 were:

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

Progress against key metrics have been monitored at the Board's Quality and Patient Safety Academy.

Following engagement and feedback from key stakeholders we have agreed the following four priorities for improvement for 2024/25.

- Improving the management of deteriorating patients including the implementation of Martha's Rule
- Implementing the 3-year plan for maternity and neonatal services based on the Ockenden review and Saving Babies Lives
- Understanding and tackling health inequalities
- Embedding the Trusts Patient Safety Incident Response Plan including the development of metrics to demonstrate its effectiveness

2.1.1
PROGRESS AGAINST THE 2023/24 PRIORITIES

Priority 1

Improving the management of deteriorating patients

This priority continues to be a focus of improvement efforts for the Trust and aligns to the National Patient Safety Improvement programme for Managing Deterioration Safety. The aim is to reduce deterioration-associated harm by improving the prevention, identification, escalation and response (PIER) to physical deterioration via safe and reliable pathways of care and better co- ordination across systems. This work is overseen by the Recognition and Response of the Acutely Unwell Patient (RRAUP) group.

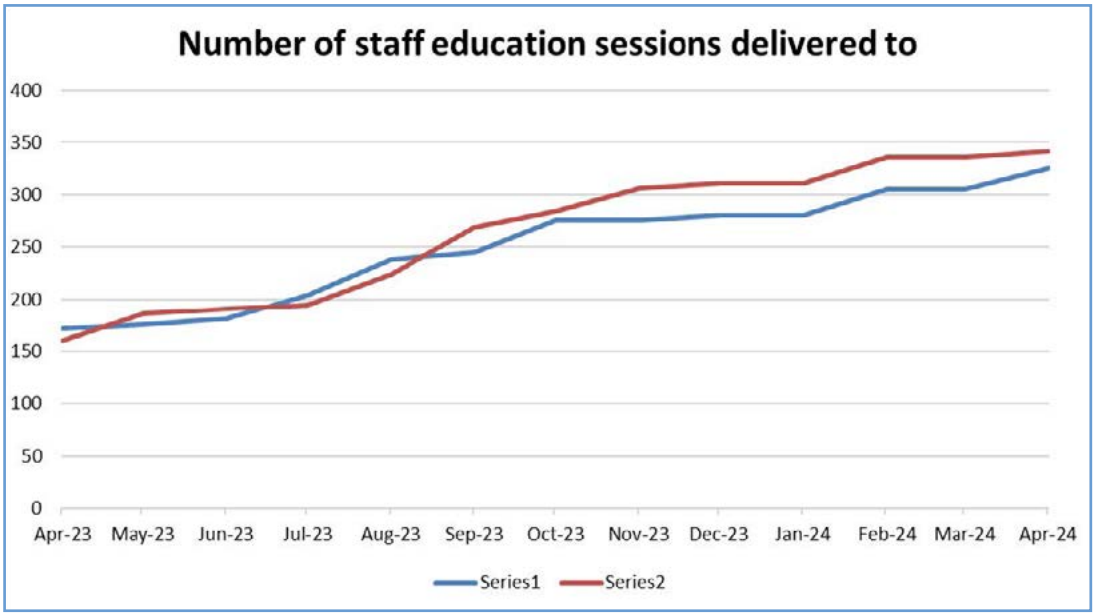
Patient Deterioration Tile

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

In 2023/24, we continued to monitor the use of the tile. We are undertaking observational audits across different wards to help improve the timings, frequency of monitoring and recognition of deterioration which we recognise are 3 factors which can impact on patient's overall length of stay in hospital and outcomes.

The ward areas we work with receive an education session on recognition of deterioration. These sessions are available to all adult trained staff by request. A formal training package to assist nursing staff in the recognition of a deteriorating patient is being developed with the education team. Figure 1 shows the increasing number of staff educations sessions delivered month on month.

Figure 1



Hospital at night pilot – Progress

Following the Hospital at Night Pilot we have designated 5.44 WTE (whole time equivalent) Care Support Worker's (CSWs) to work at night alongside the junior doctors to support with procedures such as, phlebotomy, cannulation, and ECGs (electro-cardiographs). In addition, a 1-year trial of medical student assistants is due to start in July 2024. A long-day bank shift will be available every Saturday, Sunday, and Bank Holidays for a 5th year medical student from the University of Leeds to work as a CSW. It is anticipated that they will be able to support with a fixed list of clinical procedures to support junior doctors.

BTHFT Hospital@Night

QI Project: The Safety Huddle

In November 2023, a nightly Safety Huddle was implemented as part of the wider Hospital at Night project. The huddle takes place in the Command Centre and includes, the Command Centre coordinator, the ICU (Intensive care unit) Specialist registrar (SpR) and Trainee, Critical Care Outreach, Medical SpRs, Paediatrics and Surgery.

The aims of the Safety Huddle are:

- To facilitate early identification of patients at risk of deterioration
- Subsequent prompt escalation of patients, early management, and decisions on treatments
- To foster inter-speciality and interprofessional relationships
- To ensure clear role allocation at cardiac arrests
- To address capacity issues in enhanced care areas and develop contingencies
- To improve the experience of junior doctors overnight

It has taken place every night since implementation. The huddle follows a structured proforma to review and discuss existing patients of concern, new patients identified on the Deteriorating Patient Tile, bed capacity in enhanced care areas including for example, ICU and contingencies for breaching capacity.

The huddle also allocates roles, identifies any educational needs for the crash team and reviews patients with altered airways outside of ICU i.e. tracheostomy or laryngectomy patients on ENT or respiratory wards. A register is kept recording attendance and confirmation of topics reviewed.

At the time of writing a total of 180 meetings have been reviewed regarding attendance and content of the discussions which are highlighted in the figure 2 below:

Figure 2

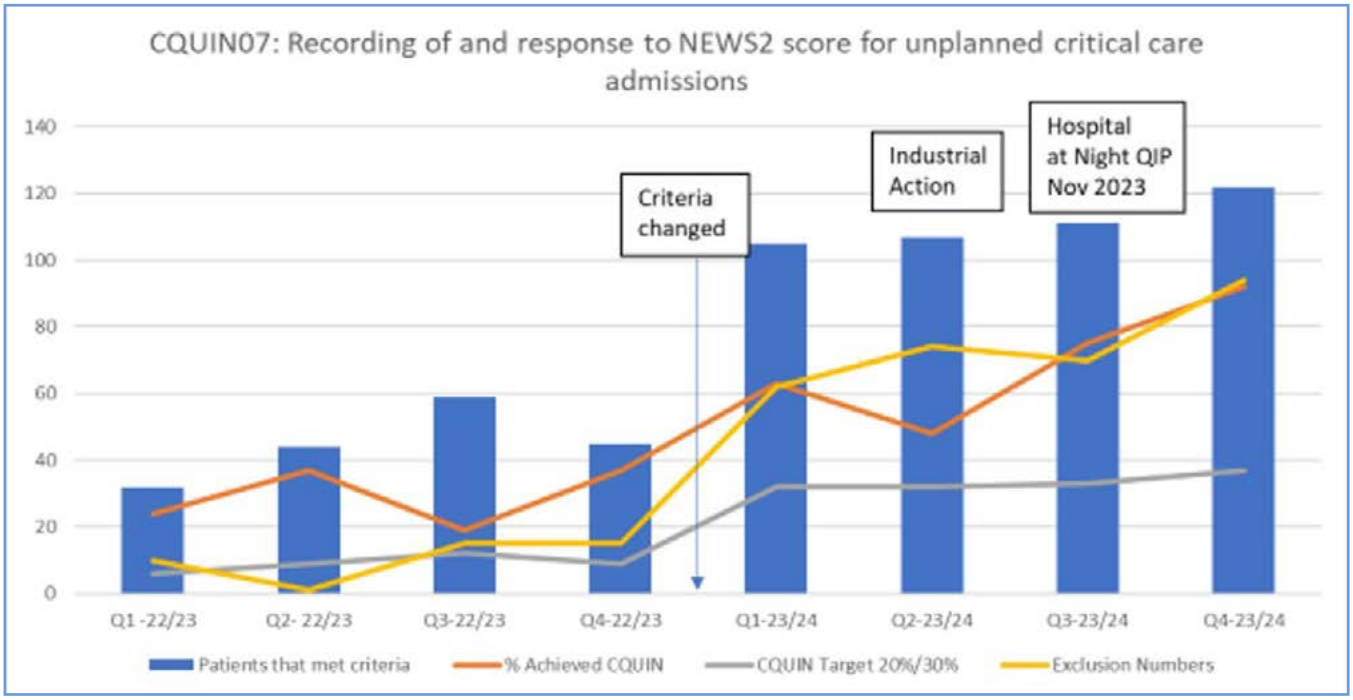
Attendance	Content
• Command Centre: 100% • ICU: 83% • CCOR 95% • Medicine 97% • Surgery: 6 attendances • Paediatrics: 5 attendances	• 54% of meetings identified one or more new patients of concern by reviewing the Deteriorating Patient Tile • Capacity in enhanced care areas was an issue in 74% of meetings, however the huddle allowed for advance planning and prompt admissions made possible.

Learning and Impact

Since implementation of the Safety Huddle, there has been a marked improvement in CQUIN07: Recording of and response to NEWS2 score for unplanned critical care admissions.

Despite an increase in the number of patients referred to ICU or CCOR, fewer of the unplanned admissions to ICU have a NEWS2 score >5 at any point prior to admission to ICU which potentially implies that patients are being admitted earlier in their admission and thus avoiding deterioration.

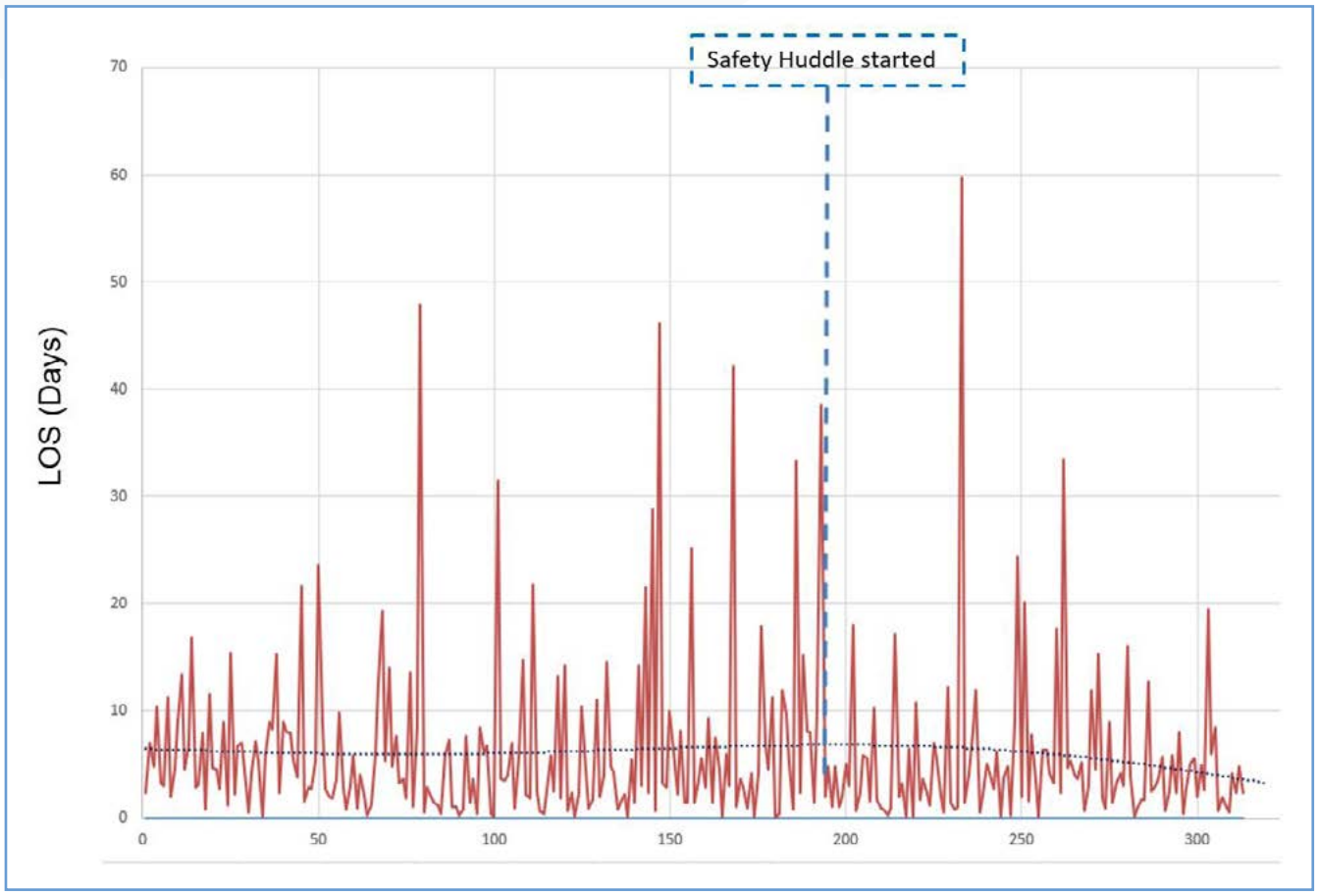
Figure 3



The Intensive Care National Audit & Research Centre (ICNARC) data for unplanned admissions, suggests there is a downward trend in the length of stay in unplanned admissions in ICU, which may be due to earlier admission and intervention contributing to reduced length of stay (see figure 3 above)

Figure 4 shows length of stay in days for all patients admitted between 1 January 2023 and 20 April 2024. A dotted trendline demonstrates the overall trend in length of stay.

Figure 4



NHS England 'Worries & Concerns' Improvement Collaborative

The Trust has participated in NHS England's national improvement collaborative to develop, test, and implement ways to involve patients, carers, and families; encouraging them to raise worries and concerns about acute illness and deterioration. This ran from April 2023 to April 2024.

The aims of the collaborative were:

1. To develop, test, implement and evaluate reliable methods for patients (or their families/carers) to escalate worries and concerns about acute illness and deterioration when standard care is not meeting their needs.
2. To develop, test, implement and evaluate reliable methods for patients (or their families/carers) to routinely input their views regarding their wellness/illness and trajectory, and any worries and concerns into the health record, with evidence that those views and worries and concerns are considered and acted on by the healthcare team.

Using an improvement approach we have focussed on aim 2 to test the patient wellness questionnaire[2] (PWQ) in routine care across three wards at Bradford Royal Infirmary. This has been led by a muliti-professional team with patient and public involvement.

2 *Albutt, A., O'Hara, J., Conner, M., & Lawton, R. (2020). Involving patients in recognising clinical deterioration in hospital using the Patient Wellness Questionnaire: A mixed-methods study. Journal of Research in Nursing, 25(1), 68-86.

What are we trying to accomplish

Aim: To actively engage with patients (or carers/families) in the acute care setting to routinely input their views regarding their wellness/illness and trajectory into their health record, with evidence that any worries and concerns are considered and acted on by the healthcare team by 31 March 2024.

How will we know that a change is an improvement

Key Measures for Improvement:

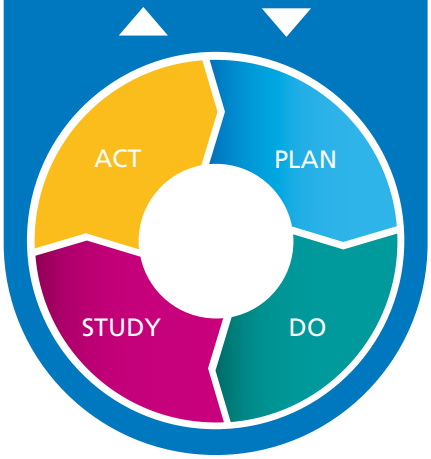
- Number of PWQs completed per day
- Percentage of PWQ's completed that are documented in the electronic health care record
- Number of Critical Care Outreach Team referrals
- Qualitative: Patient feedback and Staff feedback

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

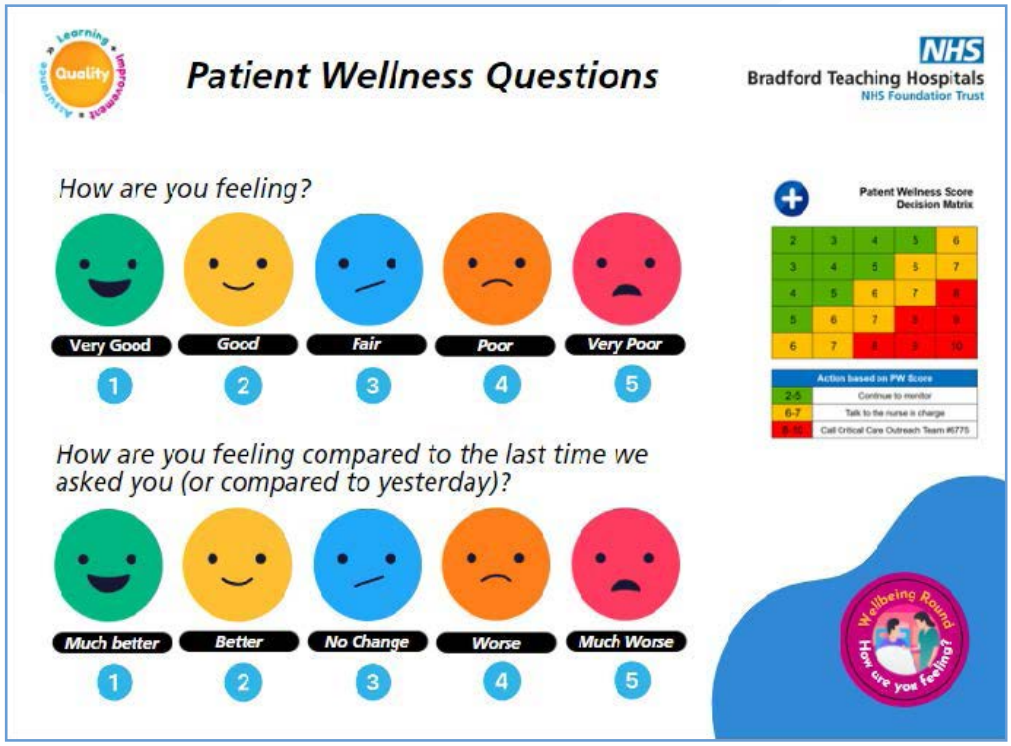


Change idea

We have adapted and tested the Patient Wellness Questionnaire (PWQ) to capture patients' ratings of their wellness to detect early changes to their condition. It is anticipated that we may detect earlier 'soft signs' of deterioration by listening and involving patients, carers, and families, to escalate concerns to a specialist team (CCOR) and acting on those concerns.

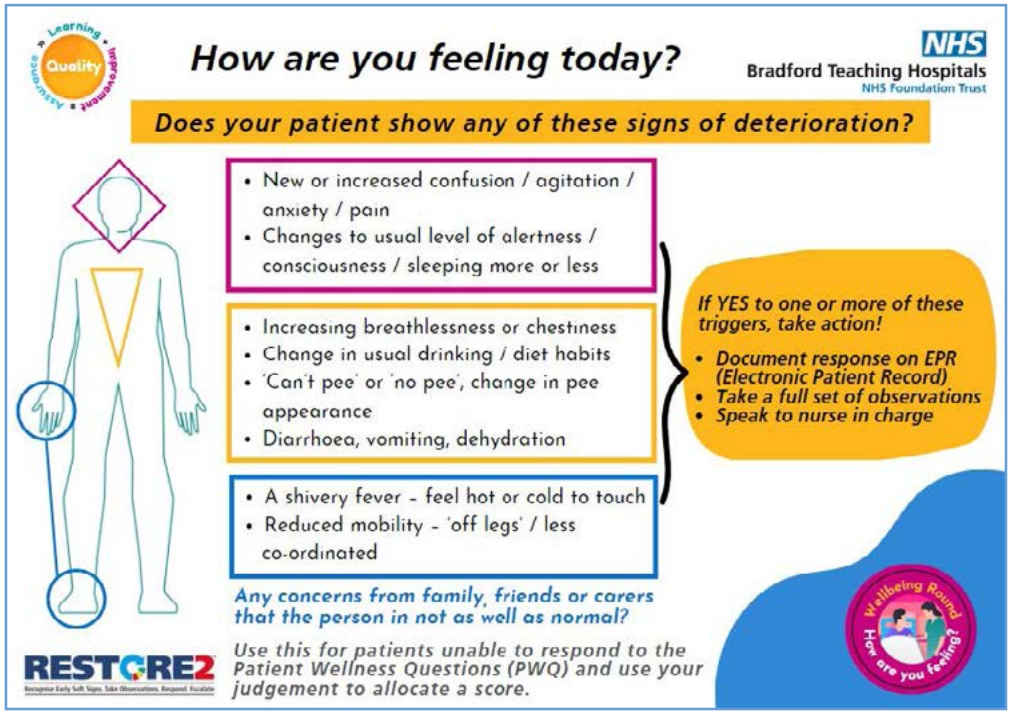
As part of the iterative process, we have changed the name to 'Patient Wellness Questions' as the language of questionnaire could be perceived to more research in nature. The idea was to have a more pragmatic measure to assess patient-reported wellness/ illness (figure 5).

Figure 5



We also have adapted resources for people with Learning Disabilities and Autism to support the use of the PWQ. This may allow for a better assessment using key words and prompts by patients, carers, and families to communicate wellness/illness trajectories more accurately and usefully for staff to act upon any worries and concerns (figure 6).

Figure 6



How we used the Patient Wellness Questionnaire (PWQ)

The PWQ is a two itemed questionnaire, *How are you feeling? How are you feeling compared to the last time we asked you?* Using a five point to measure the patient's feelings about their wellness.

On admission, or as required, for example, patient transfers from another ward/area the baseline question is asked *How are you feeling?* On the following occasion both questions are asked.

Using the five-point scale the scores are then added together to provide a single score. Depending on the score this will trigger the following intervention:

- Combined Score 2-5 – continue to monitor
- Combined Score 6-7 – tell nurse in charge with review by senior ward staff
- Combined Score 8-10 – call Critical Care Outreach Team

Plan-Do-Study-Act Cycles

Ward 21 - Planned Surgery Ward (20 beds) PDSA cycles:

- Healthcare Assistants using the PWQ using paper forms at the same time taking observations
- Bay 2 plus side room – 5 beds
- Healthcare Assistants using the PWQ at the same time taking observations
- Bay 3 plus side rooms – 5 beds
- Whole ward – 20 beds
- Whole ward – with Registered Nurses using the PWQ at the time of intentional rounding

Ward 7 - Infectious Diseases ward (12 beds all side rooms)

PDSA cycles:

- Registered Nurses using the PWQ at the time of intentional rounding
  Whole ward
- Removed paper forms – recording into electronic patient notes

Ward 9 Stroke Rehab (22 beds) PDSA cycles:

- Registered Nurses using the PWQ as the time of intentional rounding
- Reported directly into electronic health care record – nursing notes
- Whole ward
- Healthcare Assistants added

Insights - what have we learnt?

- Using a Quality Improvement approach

By using the Model for Improvement to conduct small tests of change safely we have understood why things worked or didn't work. As a result we have adapted the way the PWQ was used for individual wards /cohort of patients.

- Engaging and empowering staff
  - Executive support and sponsorship were vital to support the success of the work
  - Leadership – ward leadership positively impacted the success and sustained changes
  - Buy-in and support from the Critical Care Outreach Team (CCORT) was essential from the outset

- Support from Quality Improvement specialists also had a positive impact on the robustness of the improvement process and supported clinical staff at times when it was busy on wards to complete data collection and analysis.
- There was little resistance to why this was considered essential project to improve the recognition and response of the acutely unwell patient from clinical or medical staff.

- Staff feedback
  - Registered Nurses valued the PWQ to create time to talk and listen to patients. As one ward manager expressed:

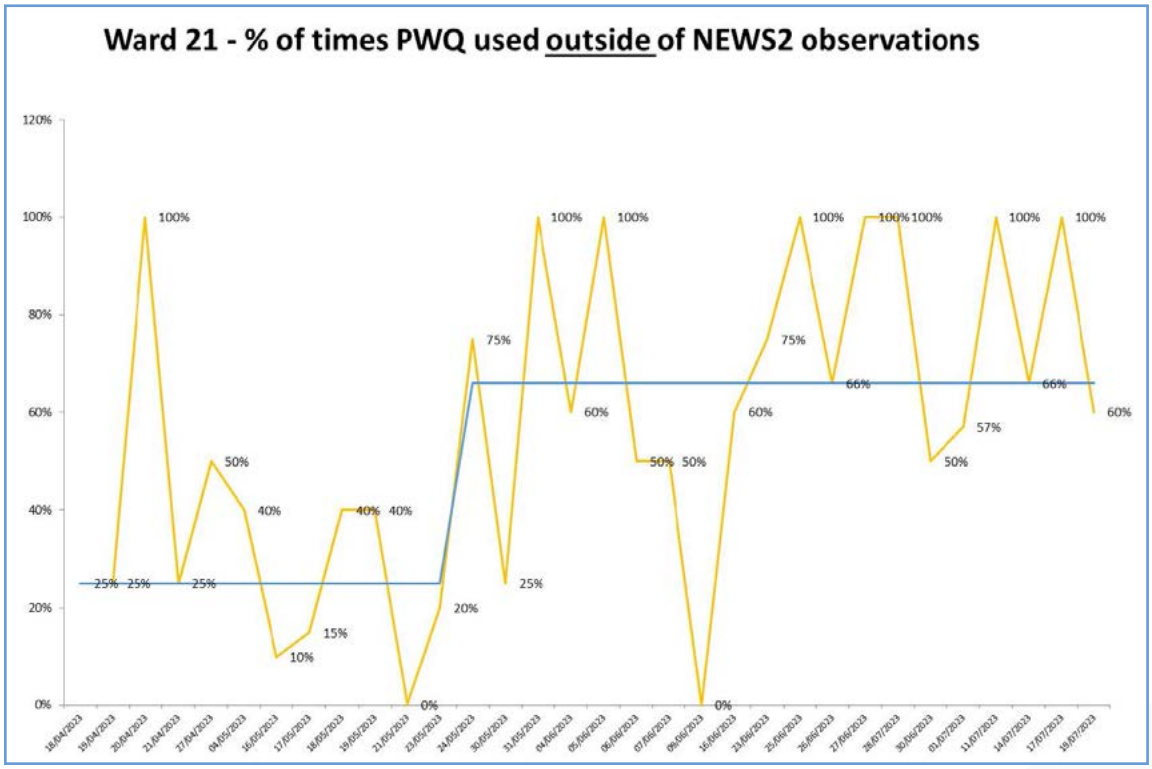
'We are very proud to be part of the pilot, this has allowed the team to bring life back to the basics of nursing care. Allowing the nurses to utilise their assessment skills and recognise early signs of a deteriorating patient. Not waiting for the NEWS2 score to trigger a doctor review. As nurses we hone into our assessment skills and do not reply upon the NEWS score as this does not detect early signs of deterioration and how we can prevent this in some cases. It has also allowed the team to have interactions with patients which are generally missed and listening by using correct dialogue to extract the information required to make an assessment.'

The PWQ has been used as a tool that provided a measure for 'soft signs' of deterioration.

- Patient feedback

The tool was received well, was considered easy to use. We have also spent time with patient group to elicit feedback about the tool and barriers to use. We have created the PWQ in different languages and plan to test using a new app that supports translation verbally and written using a handheld device.

Figure 7



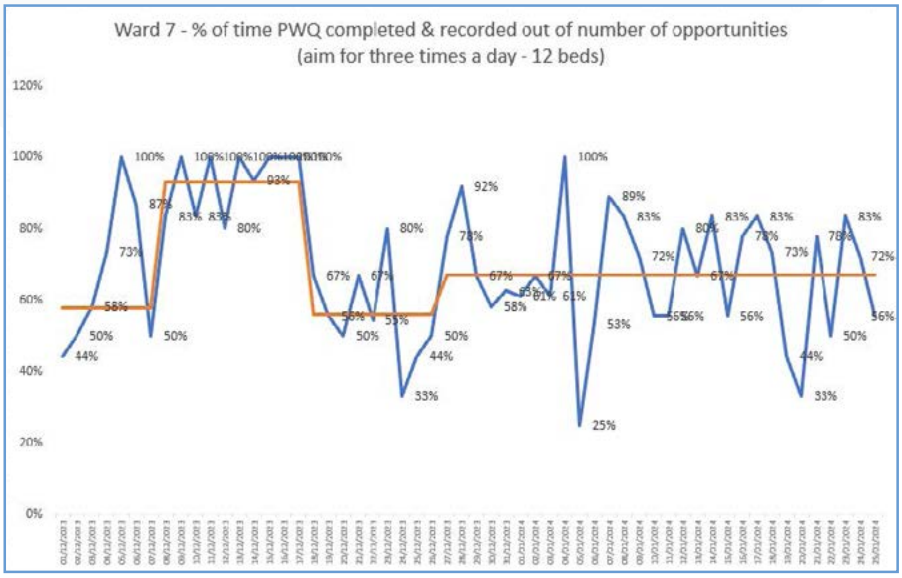
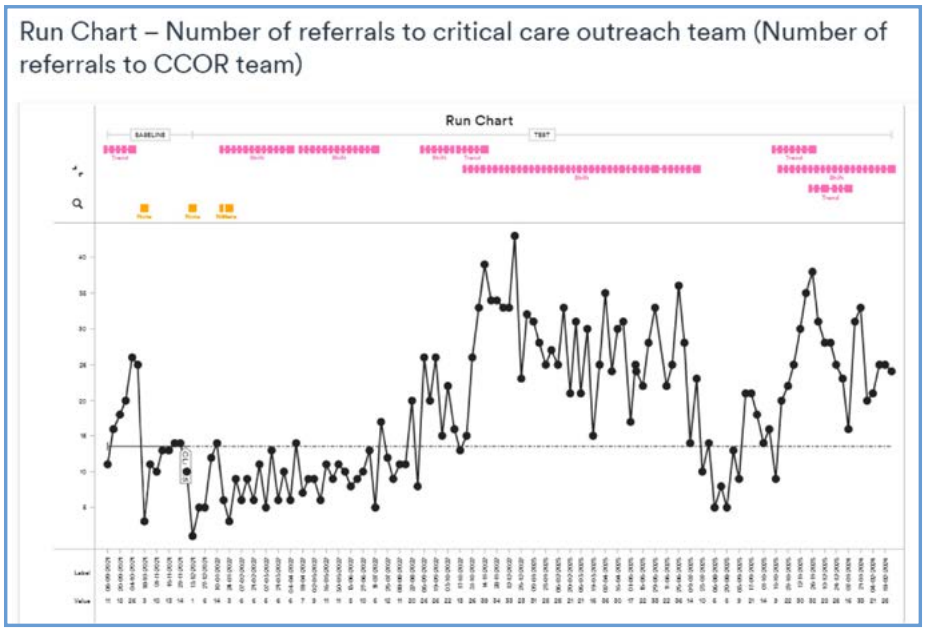


Figure 8

Outcomes

- Staff attended all 5 Learning Sets and celebration event hosted by NHS England and hosted a learning event with Royal Bolton NHS Foundation Trust.
- Invited to share learning and insights at National Policy Sprints with Dr Henrietta Hughes at a face-to-face event at the Department of Health and Social Care, London
- Presented at the Chief Nursing Officer for England Summit in November 2023 as part of the opening plenary with Merope Mills.
- Presented to the Yorkshire Quality and Safety Research group to share our improvement journey and how we have adapted and used the PWQ in acute care setting.

Figure 9



2024-25 Martha's Rule Phase 1

This is one of our new priorities for 2024/25. The Trust has again been successful in applying to take part in Phase 1 to implementing Martha's Rule in the NHS. Martha's Rule is building on the work from the Worry and Concern Improvement Collaborative which began in 2023, where we have played an active role in shaping. The three proposed components of Martha's Rule are:

1. All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient.
2. All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about the patient's condition.
3. The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

We are very pleased to be part of this work and will be sharing our improvement journey across our region and nationally in the quest to listen and act upon concerns of the patient and those who know the patient best.

We will be co-designing our approach to provide a service for staff, patients, and families to have 24/7 access to a rapid review from our Critical Care Outreach Team.

Priority 2

Implementing saving babies lives care bundle version 3

The Outstanding Maternity Services (OMS) Programme launched in August 2021 as a 2-year focused, transformation programme which is now embedded in the maternity services structure. The service has a multi-disciplinary approach to continuous quality improvement, with women, birthing people, and families at the heart of every service improvement or redesign.

The OMS use of Quality Improvement (QI) methodology has seen improvements in several projects during 2023/24, including improving the experience of women using the Induction of Labour suite and alignment of growth scans with antenatal appointments to both improve the experience of women and reduce the risk of harm caused by women not attending for the review appointment and revised plan of care.

There has been a continued focus and commitment to reduce stillbirths during 2023/24, which will remain a key focus and priority during the next financial year. More details on the stillbirth data can be found in this Quality Account under section 2.3.2 Stillbirths.

2023 ended with a total of 27 stillbirths, a reduction on the 32 recorded in 2022. The number included 6 babies who were not expected to survive. This resulted in an adjusted rate of 4.2 per 1000 births, a slight decrease on the 5.0 per 1000 births in 2022.

Saving Babies Lives Care Bundle Version 3 was launched in 2023. External scrutiny of progress with implementation is monitored by the West Yorkshire and Harrogate Local Maternity and Neonatal System (LMNS) on a quarterly basis. Following full implementation, 2024/25 will focus on ensuring that the care bundle is fully embedded and monitored in line with the Maternity Incentive Scheme, Year 6, recommendations.

During 2023/24, the maternity service continued to implement and maintain initiatives to reduce inequalities, recognising that poor maternal and neonatal outcomes are more likely amongst women and birthing people living in the highest indices of deprivation.

Initiatives include a 2nd year of partnership with Bradford Metropolitan Food Bank, enabling Community Midwives and service users to access emergency food bags from the Women's and Newborn Unit.

The maternity unit has also hosted a 'warm coat rail' over the winter months, with over 100 coats donated and available to anyone in need.

There have also been several initiatives to improve communication with service users whose first language is not English. This included the rollout of upgraded 'Language Line' carts and an associated 'app' for use in community settings; Parent Education classes provided in 2 additional languages; and development of a bi-lingual language module for staff, designed to improve confidence using additional language skills in a healthcare setting. This will be rolled out from April 2024.

Reducing inequalities and improving access to maternity services remains a key priority during 2023/24, with plans to explore how Consultant led services can be provided in areas of the City other than the BRI site, to reduce 'Did Not Attend' (DNA) rates by providing services closer to home.

Three Year Delivery Plan for Maternity and Neonatal Services

Reducing stillbirths will continue to be a key priority for Maternity Services for the foreseeable future, and sits alongside other priorities intended to reduce harm amongst women, birthing people, and their babies. These priorities are encapsulated within the March 2023, NHSE, 'Three Year Delivery Plan for Maternity and Neonatal Services'. The three-year plan aims to make maternity care safer, more personalised, and more equitable using 4 key themes:

- **Listening to women and families with compassion** which promotes safer care
- **Supporting our workforce** to develop their skills and capacity to provide high-quality care
- **Developing and sustaining a culture of safety** to benefit everyone
- **Meeting and improving standards and structures** that underpin our national ambition

Delivery of the plan is the joint responsibility of Trusts, Integrated Care Boards and Integrated Care Systems, and NHS England.

The Maternity Service has benchmarked its position against the plan, and has a local improvement plan to monitor progress, which is updated on a quarterly basis with progress/challenges reported to Quality and Patient Safety Academy and Trust Board.

Priority 3

Improving patient experience by advancing equality, diversity and inclusion

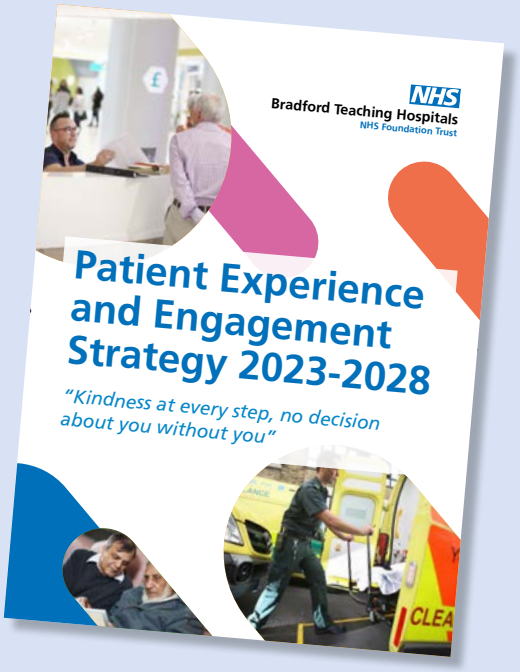
Work in relation to Patient Experience has gone from strength to strength over the past year. Below are some of the headlines:

- The Patient Experience Strategy was updated and replaced with the Patient Experience and Engagement Strategy 2023-2028.
- Numerous patient and public involvement projects have taken place to improve facilities and services and ensure they are inclusive to all our community.
- Interpreting services have joined the patient experience and involvement team and have enabled co working and development of patient and family enhancing services.
- Introduction of CardMedic.
- The Spiritual, Pastoral and Religious Care (SPaRC) service (formally chaplaincy) has received national recognition and award for their Ramadan Allies Project as winner of the HSJ workforce award in November 2023.
- The SPaRC team have developed a training video to promote their SPaRC App and the services they provide.
- Improvement work in relation to patient information and education, including the introduction of the Eido leaflets.
- During 2023 closer working with the Membership Plan Delivery Group has enabled each access to engage with community members and invite them to be involved in projects.
- Review and improvement of numerous processes within the Bereavement services to improve patient and relatives experience. This was recognised at Bradford District and Craven health and Partnership Awards (Celebrate as One). The team was a **finalist** and highly recommended for their work in Bereavement services.

Some of the highlights are shared in the following sections.

Patient Experience and Engagement Strategy

During the first half of the financial year The Patient Experience Strategy was updated and replaced with the Patient Experience and Engagement Strategy 2023-2028. This strategy takes the work on "embedding kindness" to "kindness at every step, no decision about you without you". The aim of the strategy sets out how the Trust is committed to ensure it works towards including patients, families, and carers in decisions about the care that is being provided. The patient's voice is to be at the centre of all improvement work and there is a commitment to collaborate with partners like Healthwatch and colleagues in various agencies within the district to achieve this. The Trusts aim is to ensure that patient, family, and carer experience is at the heart of all the work carried out and recognise the importance of community engagement and working.



The strategy sets out 6 aims and a framework for improvement of how the work is to be achieved by:

- Ask and capture
- Listen and understand
- Act to improve
- Measure and share

All of which will support a culture of improving experience. The strategy has been developed with assistance from the community in the development of this. Within the organisation there has been a shift to make patient experience a standing agenda item on additional meetings to highlight the general overall importance and links to patient safety.

Spiritual, Pastoral and Religious Care (SPaRC) team

The new Bradford model SPaRC (formally chaplaincy) focuses on collaborative working with patients and their families and becoming part of the wider hospital team. The model is underpinned by 7 anchors:

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

The model has been well received by staff and patients and is utilised by both alike. During 2023 the team carried out a staggering 30,000 visits and the table below (figure 10) represents this.

The SPaRC team have a team of volunteers named End of Life Companions (ELC). The primary role is to assist the palliative care team with patients who are at the end of life and have no family or carers that are available to reach them at their last stages in life. The role of the ELC is to accompany patients to be with them during this time.

Several new projects have taken place during 2023, one which includes *Front Door* support. The SPaRC team has teamed up with the Accident and Emergency Department to support patients and triage in this busy and unpredictable environment. The SPaRC team member and volunteers support the department three times a week and this is facilitated by a SPaRC core team member.

The SPaRC Team has been delivering tailor made cultural competency training to various departments across the Trust upon request. The SPaRC team play an active role in delivering training to newly appointed Health Care Assistants monthly.

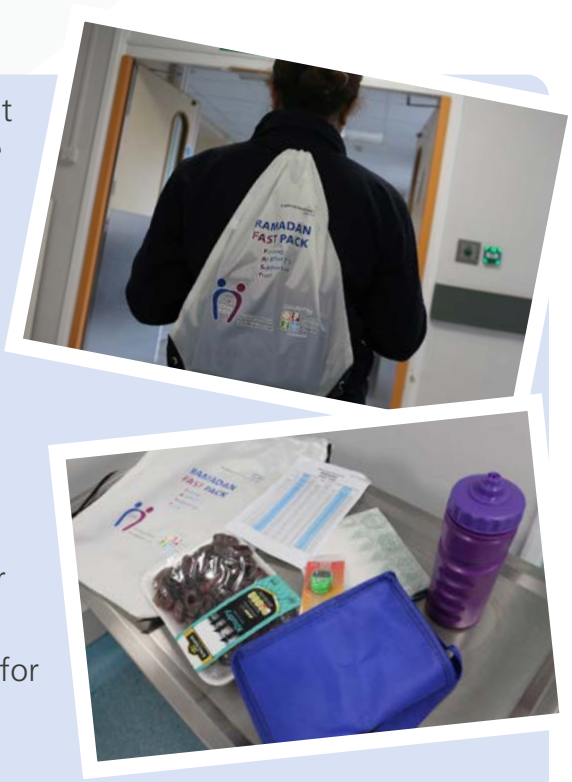
Figure 10: *SPaRC Visits for patients and visitors during 2023*

Month	Patient Visits
Apr-23	1,834
May-23	1,701
Jun-23	1,810
Jul-23	1,925
Aug-23	2,339
Sep-23	2,218
Oct-23	1,617
Nov-23	1,830
Dec-23	1,938
Jan-24	2,109
Feb-24	1,801
Mar-24	2,393
Total	30,792

There has been external recognition and enquiries about SPaRC *Fast Packs* first developed in 2022. These include pop up prayer facility packs that have helped managers support their colleagues during the Ramadan period. A bigger and more organised campaign commenced for the Holy month of Ramadan that started mid-March 2023.

This rewarding and exciting work has led to national and local nominations for awards as follows:

- Bradford District and Craven health and Partnership Awards (Celebrate as One). **Team of the Year** (delivering frontline service) Ramadan Allies, October 2023.
- Health Service Journal (wellbeing category) **Winner** for Ramadan Allies work, November 2023.
- Nursing Times **Finalist** for Ramadan Allies work, November 2023.



Ramadan fast pack and contents

SPaRC team receiving the Celebrate as One, Team of the Year award.

Additional Needs Team

The Additional Needs team was formed in 2023 and comprises of:

- Lead Nurse for Learning Disabilities
- Lead Nurse for Dementia &
- Mental Health Specialist Practitioner

These roles have previously existed within the Trust however sat within the Safeguarding Adults team, the decision to separate them was in recognition that not everyone with Dementia, a Learning Disability, or a Mental Health condition needs Safeguarding. The focus on the team is access to services and ensuring reasonable adjustments are made to ensure they receive the best care they can whilst in Hospital.

Learning Disabilities

The Red Bag VIP pathway was launched in 2022 in conjunction with Waddiloves Learning Disability Health Centre (BDCT), Bradford People First run by experts by experience (EBE) and Choice Support.

To offer a more modern approach the bags were revamped to a rucksack style and are now individual for each person. As they are now individualised the bags can be personalised and filled with critical medications, items of comfort and the VIP passport.

Dementia

The VIP passport has been in use within the Trust for approximately 4 years. VIP wristbands have been launched to work alongside the rucksacks and passports to identify patients with a Learning Disability and prompt staff to think about reasonable adjustments. The idea for the wristbands came from a conversation with some of our experts by experience. The wristbands were trialled initially in Accident and Emergency and are now being rolled out across the wards.

VIP red bag

The commitment to training in relation to caring for people with a Learning Disability was established in 2023 with the Trust rolling out the Oliver McGowan Training. All staff are required to complete this training.

A focus for the Dementia Lead Nurse was to review and ensure appropriate training was accessible to staff within the Trust, specifically relating to Dementia. Work has been ongoing across the district with partners in other organisations to review the training available and ensure it is consistent for all staff who care for people with Dementia. A training package was designed by Bradford University and the first participants were welcomed in Autumn of 2023.

The recognition of the important role carers play in a person's stay in Hospital has been an ongoing focus, and the carers lanyards were launched. The lanyards were inspired by Calderdale and Huddersfield Trust. The lanyard promotes the role of the carer recognising that they are experts in their loved one. These are a part of the carers passport work and aim to identify carers within the hospital setting so staff can utilise the carers knowledge of the patient they care for.

The Trust's Dementia strategy has been reviewed and will be relaunched in 2024.

Patient and Public Involvement work and Engagement

The patient and public involvement team have worked with several groups around improving accessibility. *Walk arounds* with members of the HI Vis group has enabled feedback from members of the community who have accessed BTHFT to provide feedback from a partially sighted and deaf perspective, which have led to amendments in signage and several other accessibility changes.

Other partnership working is the ongoing relationship with the EDI team to ensure full consideration is given for people with additional needs which includes language support, learning disabilities and protected characteristics.

Community Engagement

The Patient Experience Team continues to work with partners in the district to improve patient experience and engagement. Meetings have been set up across the district to facilitate and share work in this area. The Trust is a member of the Citizen Engagement Forum, which has membership from across the Bradford District and Craven Health Care Partnership. The group has been established to operate as a network of networks and plans to bring people and communities together to host several events with the relevant parties for communities to access relevant information.

Regular meetings and joint work take place with local Healthwatch. This ensures that teams are sighted on any areas of concern raised by the public at the earliest opportunity and provides the opportunity for the teams to invite relevant staff to answer to areas of concern raised. BTHFT have been active members in the *Listening in* events which have been held at various locations throughout the district and provided the opportunity for community members to have access to different staff members from statutory and voluntary organisation to enable their voices and concerns to be heard. The programme for 2024 plans to repeat these listening events following the previous year's success, with the aim this year of the programme being based on themes. The first theme of the programme will be *Children and young people*.

The success of the Trust Community Engagement meeting has continued with an open forum to enable different community service and teams (both statutory and voluntary) to request and share concerns internally at BTHFT and listen regarding new and planned projects.

During 2023 closer working with the Membership Plan Delivery Group has enabled each access to engage with community members and invite them to be involved in projects.

The Relatives Line

The Relatives Line was implemented during COVID-19 however it has been so successful it has been made a substantive service. It is staffed by three registered nurses and reduces the number of calls from families to the wards allowing staff time to deliver care. Users of the service value the nursing expertise and the time they provide to support their enquiries. Between April 2023 and March 2024, the service received 15,111 calls and managed to answer over 82% of the calls received.

Figure 11: *Relatives Line Activity 2023/24*

Month	Calls Presented	Calls Handled	%HANDLED
April -23	893	796	89%
May-23	1,009	931	92%
Jun-23	1,584	1,381	87%
Jul-23	1,275	1,117	88%
Aug-23	1,369	1,147	84%
Sep-23	1,152	969	84%
Oct-23	1,173	996	85%
Nov-23	1,508	1,302	86%
Dec-23	1,303	1,030	79%
Jan-24	1,506	1,096	73%
Feb-24	1,465	967	66%
Mar-24	874	641	73%
Total	15,111	12,373	82%

Interpreting Services

During 2023/24 the interpreting service became part of the wider Patient Experience Team. This has brought several benefits and opportunities to work closely on joint projects to enhance patient experience. An example of this joint work is when the bereavement team arrange hospital funerals and when English is not the first language an interpreter is now arranged for the family.

Our interpreting services team supported people on no fewer than **51,008** occasions, and in over 50 different languages. It meets the needs of non-English speakers and British Sign Language users, primarily through face-to-face interpreting. We also provide support using telephone and video, to ensure 24-hour access, seven days a week. Requests for support in other formats, such as Braille, are also met through our team. The top 10 languages requested are shown in figure 12.

Interpreters are used to communicate with patients about their medical history, to obtain information from them about their current problem, to discuss diagnosis and treatment options, to obtain consent for any treatment or procedure and delivering bad news.

Figure 12: *top 10 languages requested through interpreting services*

Urdu/Punjabi	24781
Czech/Slovak	6320
Arabic	3290
Polish	3194
Bengali	3137
Hungarian	1260
Kurdish	1085
Pushto	1017
Farsi	760
BSL	725

To further support inclusivity the patient experience team were proud to announce a partnership with CardMedic, the latest innovation adopted at the Trust as part of the "Clinical Insite" membership of the NHS Clinical Entrepreneur Programme.

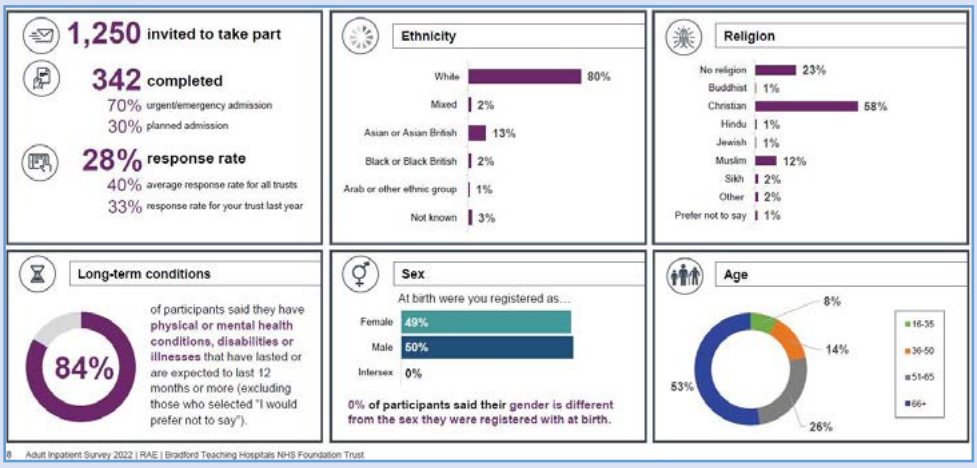
CardMedic is a language translation App available on Trust iPads, clinical desktops and available for clinical BTHFT staff to download onto Trust mobiles. It is an A-Z collection of digital flashcards, written by clinical experts, simply and succinctly. It replicates conversations around common healthcare topics with simple questions and explanations to guide the interaction between patient and carer.

CardMedic is designed to supplement existing interpreting service, provide help with translation where it wouldn't be convenient or appropriate to call for an interpreter. Or where an interpreter is unavailable.

This App is proving great benefit to patients and staff to facilitate communication in a variety of accessible formats. Content can be translated into 49 different languages and each translation has been human reviewed for accuracy. Some cards have sign language videos, and many have an *Easy Read* format intended for use with patients who have learning difficulties or cognitive impairments such as dementia. A SOP was produced to support the use and application.

CQC Surveys

During 2023/24 the Trust has taken part in the mandated CQC surveys (Inpatient survey and Maternity surveys). Below are the headlines from the Inpatient survey.



The results were as follows:

Better

- Your trust's results were much better than most trusts for 0 questions.
- Your trust was better than most trusts for 0 questions.
- Your trust was somewhat better than most for 1 question.

Worse

- Your trusts results were much worse than most trusts for 0 question.
- Your trusts results were worse than most trusts for 6 questions.
- Your trusts results were somewhat worse than most trusts for 10 questions.

Same

- Your trusts results were about the same as other trusts for 28 questions.

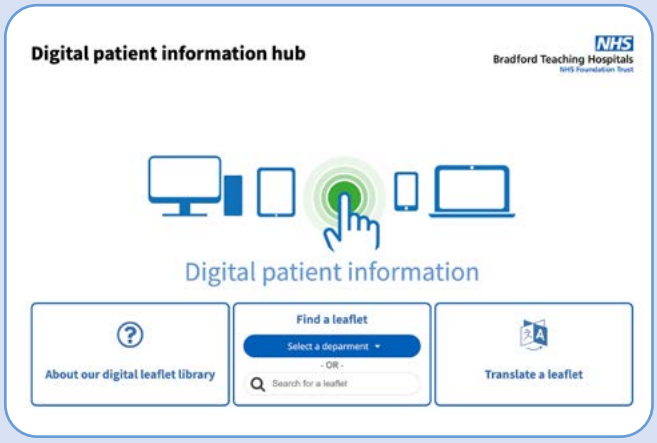
From the above results an action plan was developed with dedicated areas of accountability for improvement work and a working group led by the Lead Nurse for Patient Experience oversees this work and updates from the work streams feed back into the Patient Experience Group.

Complaints

Our Trust performance regarding complaints is included under section '3.1.5 Patient Experience' in this Quality Account.

Patient Information

There has been a vast improvement in relation to how patient information is accessed and stored on the Trust intranet with the development of a A-Z library and webpage to store all information in one place. There is ongoing work required to look at process for production and update of internal information during the next financial year.



There continues to be ongoing work with the *Working Academy* and the VRI to develop education videos.

The Patient Experience Team were pleased to commission Eido leaflets. This is an externally produced library of patient information available via Trust clinical desktops for internal print to provide for patients. All leaflets produced are written by nationally practicing clinicians and support written information for medical procedures. The library is endorsed by national medical *Royal Colleges* and is reviewed by members of the *Plain English Campaign*.

The library is available in various additional formats to enable the Trust to fulfil their obligations under government non-discriminatory standards and legislation such as the Accessible Information Standard.

The Eido leaflets (produced by EIDO Healthcare) are available in multiple different languages, *Easy Read*, and large print.

Bereavement Services

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

Improvements to Bereavement Services

- Publications for next of kin – work with internal Communications team to add relatives search requests along with a local newspaper advert.
- New process for Funeral Directors requesting cremation forms –Mortuary agreed that FD's would call them direct and send these requests through via email. This free's up the phone line for relatives to make contact.
- Review process for *Free from infection* – new process has been proposed and is awaiting final signoff.
- Review of full hospital funeral process including finances responsibility, property from house searches and *Tell us Once* responsibilities. This will enable a full review and update to the Bereavement policy in 2024.
- Website content internal/external both live and updated.
- Revamp of the Bereavement booklet in March 2024 – new booklet now in circulation to ward areas.
- Working closely with the Interpreter's team to communicate with parents when arranging baby funerals – working together ensures bereaved parents feel comfortable and fully understand all the information during the very sensitive conversations discussing funeral arrangements.
- Working with other Patient Experience services to present at HCA inductions to educate new members of staff on Bereavement services.
- Patient Property Disposal Review – working with AED to donate to need. Bereaved relatives are given the option to 'donate to need' any deceased items that they don't want to collect. If the item is in a good condition this is taken to AED so they can hand out as part of the Dignity project.
- Revised internal property process – electronic internal database to log all property that comes to bereavement. All property logged and signed into the bereavement office. Reiterated bereavement will not take property without a property list.
- Collection of unwanted glasses from families and is then donated to the charity Lions.
- Active involvement in the national end of life care audit to promote feedback and support changes for improvements.
- Bradford District and Craven health and Partnership Awards (Celebrate as One). **Finalist**, highly recommended for the work in Bereavement services.

Projects for the Patient Experience and Involvement team for the year ahead

- Continued promotion of Patient Experience and Engagement strategy.
- In partnership with the University of Bradford launch our 'Clinical Customer Care' training.
- Patient Experience data dashboard to be developed.
- Continue improvements in Patient Information via several methods including leaflets and videos.
- Strengthen the learning from complaints, sharing wider in the organisation and evidencing the *You Said We Did*.
- Ongoing work with the EDI team to support EDI2022 objectives.
- Continued contribution to the districtwide Community Engagement agenda.
- AIS implementation work, training, and awareness.
- QI measurement work following CardMedic and Eido contract agreement.
- Work with the Governance team regarding PSIRF and recruitment of Patient Safety Partner's to ensure shared alignment.
- Partnership work with HealthWatch regarding interpreting feedback.

The above are just a few of the plans for the Patient Experience and Involvement teams during 2024/25.

Equality, diversity and inclusion

Strategic Equality and Diversity Council

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

Equality and Diversity Strategy

The Trust's EDI strategy sets out the Trust's ambitions and plan of actions to promote and advance equality of opportunity, with sharp focus on belonging and inclusion. It has been shaped from our willingness to listen and involve our staff and key stakeholders through extensive consultation; from partnerships with our staff equality networks, understanding their 'lived experiences' of working and being service users and patients, and from the learning we have gained from external benchmarking, peers, and partners. The strategy aims to drive a step change in the culture of our organisation, helping us to embed and advance equality, diversity and inclusion, for the benefit of our staff, patients, and the wider community. As part of the strategy the following five refreshed strategic objectives have been identified to develop and action over the next three years (2023 – 2025). These are:

1. Education, Empowerment and Support
2. Effective Staff and Community Engagement and Involvement
3. Population Health Inequalities
4. Promoting Inclusive Behaviours
5. Reflective and Diverse Workforce

We have focussed on implementing the strategy over the last 12 months with focus on ensuring that progress is being made on the five strategic equality objectives. There has been a range of presentations to CSU's and directorates as part of the strategy development with focus on working with CSU's on the wider equality objectives and ensuring these are being progressed across the Trust.

Equality Delivery System 2022

The EDS2022 is a framework that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS whilst meeting the requirements of the Equality Act 2010.

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. It is the foundation of equality improvement within the NHS, acting as an accountability and improvement tool for NHS organisations - in active conversations with patients, public, staff, staff networks and trade unions - to review and develop their services.

In August 2022, NHS England published a new version of EDS, EDS2022. NHS commissioners and provider services are required to undertake an EDS evidence collection and grading exercise on an annual basis.

The EDS comprises eleven outcomes spread across three Domains, which are:

1. Commissioned or provided services
2. Workforce health and well-being
3. Inclusive leadership.

A staff engagement and community engagement event took place in Q4 where the evidence was presented on all 3 domains and feedback gathered from stakeholders. The Trust was rated 'Achieving' on all 3 domains and some useful feedback was gathered which will help feed into both our WRES/ WDES action plans (as we refresh them over the coming months) and the work of the Patient Experience team. The EDS2022 report is published on the Trust website and the Head of EDI is planned to meet with regional partners, including the Integrated Care Board (ICB) to discuss plans and our approach for 2024 review.

Staff Equality Networks

Our staff Equality Networks are continuing to raise the profile of EDI across the Trust with a range of events and celebratory days organised by the networks. These events are creating dialogue, raising awareness of EDI, and more importantly providing support for our diverse staff across the organisation. All three of our equality networks have been instrumental in raising the profile of EDI through their lived experiences and actively influencing EDI at a strategic level, including regular attendance, and having a standard agenda item at the Trust's EDI Council which is chaired by the CEO.

Respect Civility & Resolution

The proposed 'Respect, Civility & Resolution' policy is currently reaching the end of an extensive consultation process including members of the HR management team and staff side representatives and is hoped to be approved by JNCC and ready to launch in May 2024. Once approved there will be a clear implementation plan which will be agreed to ensure the policy is shared widely through global comms/ CSU's and department meetings and accompanied by an on-line toolkit and training which is to be developed for managers in informal resolution (e.g. facilitated conversations).

A review of the existing staff advocacy service took place last year with focus on reviewing and refreshing the role of staff advocates, ensuring that this aligns with the newly developed Respect, Civility and Resolution policy. Our 5 newly trained staff advocates are already starting to pick up cases and provide valuable support to staff across the Trust, the EDI team are in the process of developing refreshed comms to re-launch the service in conjunction with the ratification of the Respect, Civility & Resolution policy which is expected to be finalised in May 2024. The re-launch will also work to promote the ongoing Workplace Civility training (which is in high demand and receiving some fantastic feedback), along with the established Workplace Mediation Service, the Civility Toolkit, Our People Charter and our three thriving Staff Equality Networks.

EDI Training

Our refreshed half day EDI training course for managers, which has been mandated for those with line management responsibility, continues to receive positive feedback on the quality and contents of the training. The training explores the impact of EDI both in terms of patients our diverse workforce and includes focus on our wider responsibilities in managing and advancing EDI in the workplace.

Staff Survey – EDI feedback

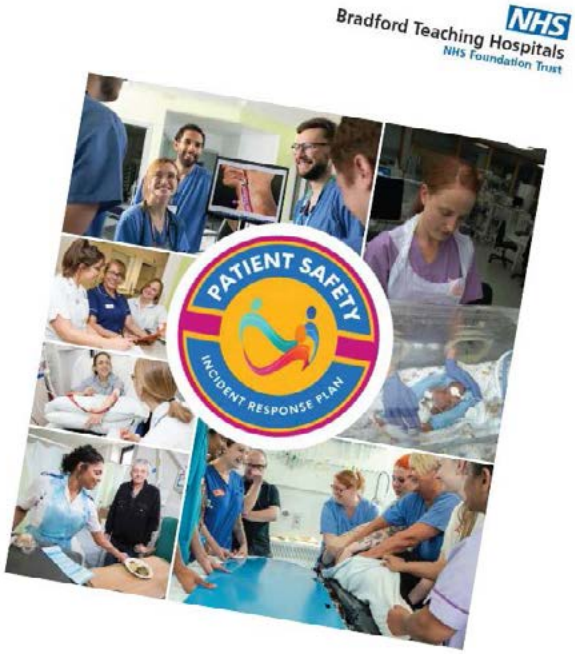
We have seen an improvement in our overall 'Equality and Diversity' score in the 2023 staff survey results, rising above the average score of 8.2 to 8.26 (and higher than the national average of 6.96).

We have also seen a rise from 6.9 to 7.0 in the overall 'inclusion' score (and higher than the national average of 6.86). These elements fall under the 'We are compassionate and inclusive' element of the People Promise for 2023.

Priority 4

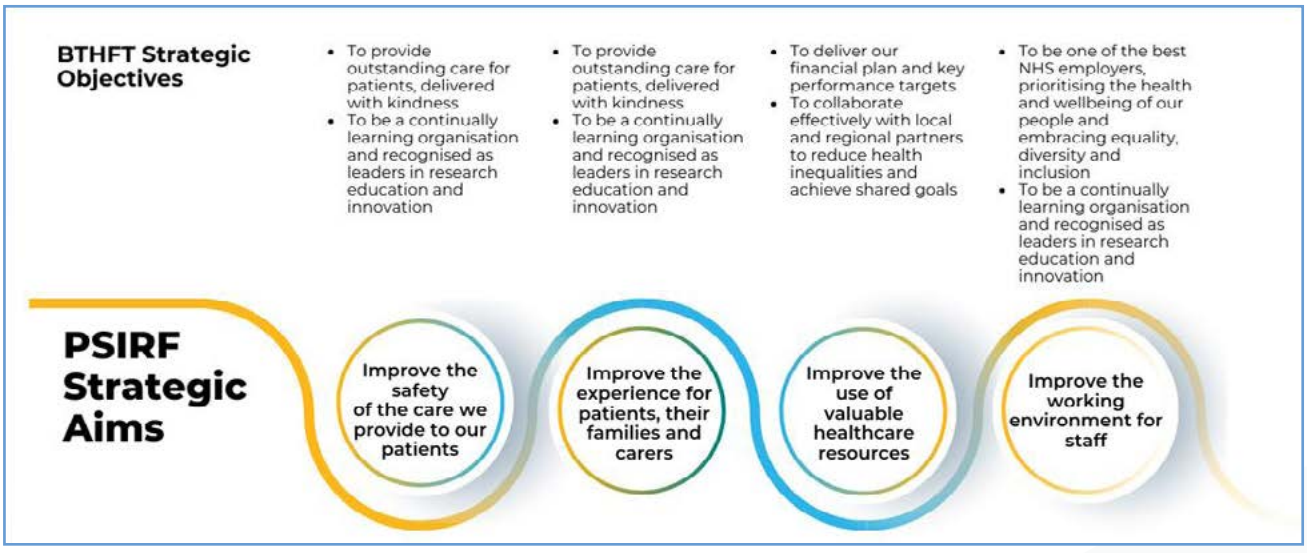
New: Implementation of the Patient Safety Response Framework

Following the publication of the Patient Safety Incident Response Framework (PSIRF) on 16 August 2022, our Trust has been undertaking a phased period of preparation ahead of completing the Transition from the Serious Incident Framework. A PSIRF implementation group was established which was responsible for providing strategic and operational leadership and oversight for the implementation and delivery of PSIRF across our Trust. The PSIRF Implementation Group achieved this through the establishment and oversight of several task and finish groups. The task and finish groups worked towards the key deliverables of the PSIRF to enable the development of our Patient Safety Incident Response Plan and Patient Safety Incident Policy. The culmination of this work was our transition to the PSIRF on 1 December 2023.



The aim of the PSIRF is to improve the safety and experience of care for our patients, carers, families, and staff whilst using our resources effectively. Our Plan reflects how the strategic aims of the PSIRF are aligned to our Trust corporate strategic objectives (see figure 13).

Figure 13. Alignment of PSIRF aims and the Trust's strategic objectives.

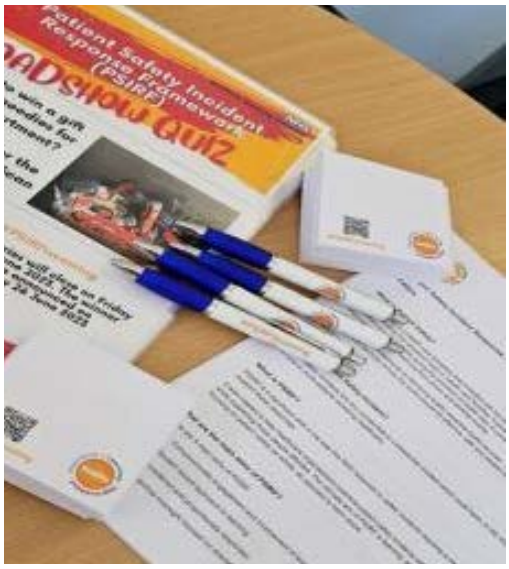


To facilitate the effective transition to the PSIRF we organised a series of stakeholder events, culminating in a PSIRF roadshow that spanned the entirety of our organisation. This comprehensive engagement involved patients, carers, relatives, and colleagues, ensuring a broad and inclusive approach. This engagement was instrumental in developing our Patient Safety Incident Response Plan, highlighting the value of inclusive and comprehensive engagement in enhancing patient safety.

To support our successful transition to the PSIRF we have trained 94 colleagues in safety event investigation across our Trust to help facilitate a proportionate response to our patient safety incidents using a range of learning response tools.

Following our transition to the PSIRF we have been successful in the recruitment of a Patient Safety Partner (PSP). Our PSP will act as a voice for service users and patients across our Trust, assisting to develop and improve our services so that they are safer for our patients. It is our ambition to grow our numbers of PSPs through a wider recruitment drive which ensures our partners are representative of the population we serve.

Our Trust has successfully transitioned from the National Reporting and Learning System (NRLS) to the new Learn from Patient Safety Events platform (LFPSE). The Trust began reporting live into the LFPSE platform from 17 January 2024 in line with national contract.



2.2 STATEMENT OF ASSURANCE FROM THE BOARD

2.2.1 REVIEW OF SERVICES

During 2023/24 Bradford Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 43 designated Commissioner Requested Services.

Bradford Teaching Hospitals NHS Foundation Trust has reviewed the data available to it on the quality of care in all these relevant services.

The income generated by the relevant health services reviewed in 2023/24 and represents 100% of the total income generated from the provision of relevant services by Bradford Teaching Hospitals NHS Foundation Trust for 2023/24.

2.2.2 PARTICIPATION IN CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

Our approach to quality is underpinned by our learning health system that informs our improvement efforts to provide assurance to our patients, staff, and our Board that we continual strive to deliver outstanding care.

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

The High Priority Clinical Audit Programme for 2023/24 was informed the Trust's NHS Standard contract requirements which includes by the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and any other relevant national programme included within the NHS England Quality Accounts List.

During 1 April 2023 to 31 March 2024, the Trust was eligible to participate in 59 out of 74 national clinical audits within the National Clinical Audit and Patient Outcomes Programme and national programmes included within the NHS England Quality Accounts List (2023-24, February 2023) relevant to the Services provided by Bradford Teaching Hospitals NHS Foundation Trust. This includes:

- Adult Respiratory Support Audit
- BAUS Nephrostomy Audit
- Breast and Cosmetic Implant Registry
- British Hernia Society Registry
- Case Mix Programme (CMP)
- Child Health Clinical Outcome Review Programme
- Elective Surgery (National PROMs Programme)
- **Emergency Medicine QIPs**
  - Care of Older People
  - Mental Health (Self Harm)
- Epilepsy 12: National Clinical Audit of Seizure and Epilepsies for Children and Young People
- **Falls & Fragility Fracture Audit Programme (FFFAP)**
  - Fracture Liaison Service Database (FLS_DB)
  - National Audit of Inpatient Falls
  - National Hip Fracture Database (NHFD)
- Improving Quality in Crohns and Colitis (IQICC)
- Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)
- Maternal and Newborn Infant Clinical Outcome Review Programme

- Medical and Surgical Clinical Outcome Review Programme
- National Adult Diabetes Audit
  - National Diabetes Inpatient Safety Audit
  - National Pregnancy in Diabetes Audit
  - National Diabetes Core Audit
- National Asthma and COPD Audit Programme (NACAP)
  - COPD Secondary Care
  - Adult Asthma Secondary Care
  - Children and Young People's Asthma Secondary Care
- National Audit of Cardiac Rehabilitation
- National Audit of Care at the End of Life (NACEL)
- National Audit of Dementia
- National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer
- National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer
- National Cardiac Arrest Audit
- National Cardiac Audit Programme (CAP)
  - National Heart Failure Audit
  - National Audit of Cardiac Rhythm Management
  - Myocardial Ischaemia National Audit Project (MINAP)
  - National Audit of Percutaneous Coronary Intervention
- National Child Mortality Database
- National Comparative Audit of Blood Transfusion
  - 2023 Audit of Blood Transfusion against NICE Quality Standard 138
  - 2023 Bedside Transfusion Audit
- National Early Inflammatory Arthritis Audit (NEIAA)
- National Emergency Laparotomy Audit (NELA)
- National Gastro-Intestinal Cancer Audit Programme (GICAP)
  - National Bowel Cancer Audit (NBOBA)
  - National Oesophago-Gastric Cancer Audit (NOGCA)
- National Joint Registry
- National Lung Cancer Audit (NLCA)
- National Maternity & Perinatal Audit
- National Neonatal Audit Programme
- National Obesity Audit
- National Ophthalmology Database (NOD) Audit - National Cataract Audit
- National Paediatric Diabetes Audit
- National Prostate Cancer Audit
- National Vascular Registry
- Out of Hospital Cardiac Arrest Outcomes
- Perinatal Mortality Review Tool
- Perioperative Quality Improvement Programme
- Sentinel Stroke National Audit Programme (SSNAP)1
- Serious Hazards of Transfusion UK National Haemovigilance Scheme
- Society for Acute Medicine Benchmarking Audit
- Trauma Audit and Research Network (TARN)
- UK Renal Registry Chronic Kidney Disease Audit
- UK Renal Registry National Acute Kidney Injury Audit

The national confidential enquiries that Bradford Teaching Hospitals NHS Foundation Trust were eligible to participate in during the reporting period of April 2023 to March 2024 were, Endometriosis, End of Life Care and Juvenile Idiopathic Arthritis. Of the three studies, the trust participated in two (Endometriosis and End of Life Care). The percentage of cases submitted for Endometriosis was 50% and for End-of-Life Care was 17%. The national confidential enquiries rely on clinician time and engagement to ensure cases are reviewed and enquiries completed. It is noted that we have not reached 100% case ascertainment for the identified enquiries. However, during the reporting period, there have challenges for staff owing to high levels of clinical activity in response to addressing to recovery post COVID-19 and ongoing industrial action. This may have contributed to reduced number of cases submitted compared to previous years.

The annual reports that were published in 2023/24 for national clinical audits were reviewed by the clinical audit leads. The following clinical audits and programmes presented at the monthly Clinical Outcomes Group meeting, which aims to share best practice, learning and improvement work:

- Sentinel Stroke National Audit Programme
- National Clinical Audit Paediatric Asthma in Secondary Care
- National Audit for Dementia
- National Lung Cancer Audit
- Epilepsy 12: National Clinical Audit of Seizure and Epilepsies for Children and Young People
- National Audit of Care at the End of Life
- UK Renal Registry (UKRR)
- Getting It Right First Time (GIRFT)

During 2023/24 the Trust received outlier notices for the national clinical audit programme.

Positive outlier status alert

June 2023 - National Clinical Audit for Seizures and Epilepsies in Children and Young People: Epilepsy 12 2021/22 measures.

Measure: Epilepsy Specialist Nurse (ESN) input – percentage of children and young people with Epilepsy with input by an ESN within the first year of care. National average = 77%

Bradford Teaching Hospitals NHS Foundation Trust = 95%

Outlier Reports

September 2023 - National Audit for Dementia

Following anonymous feedback from a carer questionnaire we have looked at the way we support patients with Dementia. Actions included:

- Ensure people admitted to hospital that have dementia or suspected dementia have an initial review, provided with relevant support and guidance and to notify the Dementia Lead.
- Asked ward areas to identify champions so that we can ensure their training is up to date and offer training to new champions.
- Asked matrons to remind staff of the importance of using the forget-me-not tools to identify people with dementia/ suspected dementia and delirium.
- Invited individuals living with dementia to attend the dementia champions meeting to talk to about their experiences of accessing our services and answer questions from staff.

ICNARC – Intensive Care National Audit & Research Centre Data period (01/04/2022 - 31/03/2023)

Measure: Out-of-hours discharges to the ward (not delayed)

Bradford Teaching Hospitals observed number of discharges between 22.00 and 06.59 for the reporting year was 8.4% (n=50) compared to an expected rate of 2.2%.

An outlier is a result that is, statistically significantly further from the expected comparator value than would usually occur by chance alone. All 50 cases identified were reviewed to check the time of discharge from the intensive care and the data was found to be correct. It is acknowledged that best practice is not to move patients overnight. However, owing to the challenges to ensure patients are in the right place at the right time to receive the appropriate care with pressure on bed availability it is sometimes necessary to move patients overnight. The time period of the data set also suggests that there were exceptional circumstances as the Trust was responding to the COVID-19 pandemic, where that was a high demand for intensive care beds. Work continues to monitor out-of-hours-discharges within the Unit to prevent unnecessary bed moves at night.

2.2.3 PARTICIPATION IN CLINICAL RESEARCH ACTIVITIES

In 2023/24 Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) continued to have an extensive programme of health care research.

The number of patients receiving relevant health services provided or subcontracted by BTHFT in 2023/24 that were recruited during that period to participate in research trials, approved by a research ethics committee, was more than 25,000. Our Trust was the highest recruiting hospital site to National Institute of Health and Care Research portfolio studies in the United Kingdom .

Further information about our research can be found at www.bradfordresearch.nhs.uk however some highlights from this year include:

Research Activity: Born in Bradford

Age of Wonder

- Funded by Wellcome Trust, seven –year project capturing journeys of up to 30,000 Bradford teenagers during adolescence using quantitative and qualitative methods.
- Since September 23 schools recruited, over 3800 young people have completed questionnaires and over 1300 Year 9 students taken part in physical health measures.

JU:MP (Join Us: Move Play)

- First follow-up of a world leading control trial to assess the effect of the intervention on health outcomes, including physical activity levels, body mass index, social, emotional, and behavioural health.
- Baseline data collected in 2021-22 from 37 schools and over 1400 children.
- Team completed the 1st follow-up (September 2023-February 24). Data has been collected from 34 schools and over 1200 children. Data will now be cleaned, processed, and analysed.

Better Start Bradford Innovation Hub (BSBIH)

- Research and Evaluation working in partnership with Better Start Bradford Programme to develop the evidence base of what works to give children best start in life.
- Learning from BSBIH been used to support local decision making about future of Better Start Bradford interventions and further roll out.

Born in Bradford's Better Start (BiBBS) birth cohort

- This is the 2nd birth cohort within the BiB cohort family and is recognised internationally as the world's first interventional cohort, designed to evaluate interventions delivered as part of the Better Start Bradford programme.

Bradford Inequalities Research Unit

- Have worked with Reducing Inequalities in Communities programme (Bradford District & Craven CCG and WY Integrated Care Board)
- BIRU provided evidence that:
- Pro-Active Care team (PaCT), run by BDCFT, provides proactive, holistic short-term care and support for vulnerable individuals. For patients who received PaCT, the odds of an unplanned hospital admission were 31% lower, and the odds of an A&E attendance was 41% lower, compared to the matched control group.
- Bradford Central Locality Integrated Care Services (CLICS) intervention, which integrates social prescribing and general practice). For those who received CLICS, the odds of an unplanned hospital admission were 17% lower compared to the matched control group.

Collaboration Bristol NIHR Biomedical Research Centre

- Projects include young people with Type 2 diabetes, physical activity in children with disabilities, impact of school PE kit policies on girl's perceptions of body image and experience of PE, and understanding the relationship between movement and behaviours and eating disorders.

BIB Breathes

- Working with Bradford Council and academic colleagues tracking the impact of the Clean Air Zone on air pollution levels and health outcomes in particular changes in number of A&E and GP visits for respiratory, cardiovascular and birth outcomes.
- Indoor air quality projects being conducted:
- Understanding the sources, transformation, and fates of indoor air pollutants (INGENIOUS) and Improving indoor air quality and health: Identification of chemical and biological determinants, their source and strategies to promote health homes in Europe (INQUIRE)

Centre for Applied Education Research

- Improving outcomes for children and young people through the power of science.
- After successful launch of CAER-coordinated commissioned report for Child of North All-Party Parliamentary Group, CAER collaborating with Centre for Young Lives and N8 Research Partnership, asked to produce 12 parliamentary reports over 2024 – each will focus on topics that are challenging to children and young people, e.g. autism, childhood poverty through schools, improving mental health in education settings.

Connected Bradford

- Innovative research database that links healthcare data across multiple healthcare providers and expands data linkages with non-healthcare data for up to 5 million individuals.
- Playing significant role in NHS England Secure Data Environments led by the Trust. The SDE platform is designed to provide researchers with access to anonymised data while maintaining its security and protection.

Bradford Genes & Health

- Aims to learn how genes vary in adult Bangladeshi and Pakistani communities to better understand why heart disease, diabetes and stroke occur in higher levels in these groups.
- 5350 participants recruited to study

BaBi network

- Following success of BIB4All, BaBi network set up in 2022 and now 12 BaB sites across country: Bradford, Leeds, Doncaster, Wakefield, East London, Tameside, Warwick, York, Scarborough, Harrogate, Hull, and Nottingham.
- Aims to make use of routinely collected data from health, education and social care and other sources to build up a rich picture of families over time and help understand what helps to keep families happy and healthy.
- Over 32,000 mothers and babies in the study with 800 midwives and other clinical staff trained to consent for BaBi across the country.

Research Activity: National Institute of Health Research (NIHR)

Number of major grants awarded

- £2.3M funding from NIHR Health Technology Assessment to establish whether comprehensive geriatric assessment (plus usual care) is a clinically and cost-effective intervention to sustain independence in activities of daily living (IADL) for older people with heart failure with preserved ejection fraction and frailty when compared with usual care alone; project in collaboration with Universities of Leeds, Exeter and Liverpool and Liverpool University Hospitals NHS Foundation Trust.
- £1M grant funding from NIHR to improve quality and accessibility of structured medication reviews (SMRs) to reduce overprescribing for older people with severe frailty living in the community and care home residents, informed by intersectional characteristics and experiences to improve medication reviews for overprescribing in severe frailty; project in collaboration with Universities of Bradford, Leeds, and Liverpool and UCL and NHS West Yorkshire Integrated Care Board.
- Funding from The Dunhill Medical Trust for a Reimagine Ageing Doctoral Research Programme for 3 PhD opportunities focusing on sustaining the independence and well-being of older people through cross-disciplinary research.

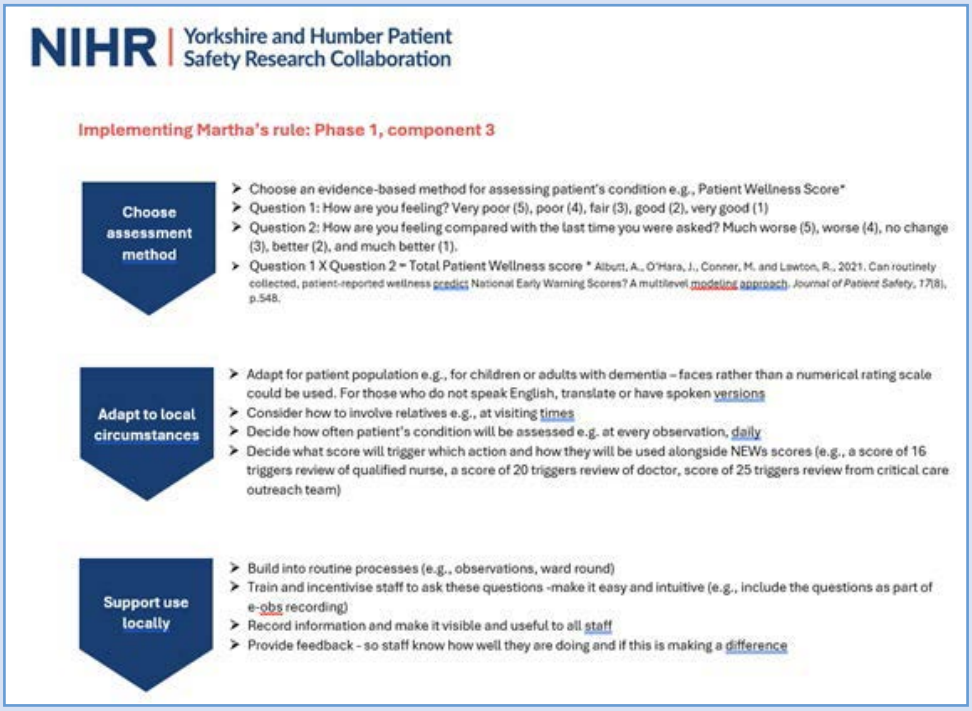
CARE75+ Completion

Established national cohort of 1325 adults aged 75+ with 4 years of rich data collected on conditions, medications, quality of life and more. Over 4 million items of data captured, and this rich dataset has been supporting a range of research projects across the UK.

Research Activity: Yorkshire Quality and Safety Research Group

Home to the largest of three NIHR Patient Safety Research Collaborations (PSRC) – aim to develop, validate, and test innovations, approaches and interventions that have the potential to lead to improvements in patient safety and the safety of health and care services.

- **Learn Together:** Completed project investigating how to support patient/family involvement in safety investigations, produced resources focusing on restorative justice and ensuring that investigations, at the very least do not result in compounded harm for staff and patients. Findings have been incorporated into the first version of NHS England guidance to support engagement and involvement in incident responses.
- **Partners At Care Transitions (PACT) Trial:** Large cluster RCT evaluating "Your Care Needs You" intervention to reduce readmissions through patient empowerment. Found a significant impacts at 90 days with readmissions being 13% lower in the intervention group.
- **Martha's Rule:** Working with NHS England on early evaluation of implementing access to a rapid review from a critical care outreach team for staff, patients, and families if worried about a patient's condition.
- **Patient Wellness Questionnaire:** Developed tool with patients/families/staff to collect patient condition information in structured way.



NIHR Applied Research Collaboration Yorkshire and Humber

- Extension funding received from September 2024 to March 2026 due to success to date. Focus on knowledge mobilisation and building regional links and partnerships to increase dissemination.
- Continue to build partnerships with the Yorkshire & Humber ICS and ICBs including chairing communities of practice in the region and will be leading a series on prioritisation events for the ICBs to set regional research priorities and agendas.

NIHR Patient Recruitment Centre

2.2.4 COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

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

A CQUIN scheme must be offered to each Provider which provides healthcare services under the NHS Standard Contract, where indicated in the API (Aligned Payment and Incentive) rules within the National Tariff Payment System.

The CQUIN schemes contain goals for quality and innovation that have been agreed between the Trust and its Commissioners (NHSE and ICB's). The CQUIN financial incentive (1.25% as a proportion of the fixed element of payment as set out in the Trust's NHS Standard Contract) is only 'earnable' on the five most important indicators for each contract, as agreed by commissioners.

Progress against CQUINS selected for 2023/24

Listed below are the five core indicators which were agreed by the Trust with the Commissioners for 2023/2024:

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

All CQUIN targets were met for the reporting period 2023/24 when referring to final average score (see figure 14).

Figure 14 CQUIN indicators included in financial incentive for 2023/24

ID	CCG Indicators	Target	Q1	Q2	Q3	Q4	Q1-Q4 Average
CCG3	Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	20%-60%	75%	83%	83%	83%	81%
CCG4	Compliance with timed diagnostic pathways for cancer services	55%-65%	40%	50%	64%	69%	55%
CCG9	Cirrhosis and fibrosis tests for alcohol dependent patients	20%-35%	1.40%	7%	100%	100%	52%
PSS1	PSS1: Achievement of revascularisation standards for lower limb Ischaemia	40% -60%	n/a*	<5**	50%	<5%**	50%
PSS5	Achieving priority categorisation of patients within selected surgery	74%-98%	0	0	0	0	0

Regarding CCG3 and CCG9, these indicators we were above the target (highlighted in yellow). There was significant improvement work undertaken by the multi-professional team to provide a new care pathway for alcohol dependent patients requiring cirrhosis and fibrosis tests to ensure we met this new indicator. The success of this service is being monitored to ensure we are meeting the needs of this specific patient group as identified in the rationale for this indicator.

CQUIN indicators 2023/24

Listed below are the five core indicators which were agreed by the Trust with the Commissioners for 2023/2024:

- **CQUIN02:** (ICB) Supporting patients to drink, eat and mobilise after surgery
- **CQUIN07:** (ICB) Recording of and response to NEWS2 score for unplanned critical care admissions
- **CQUIN08:** (NHS E) Achievement of revascularisation standards for lower limb ischaemia
- **CQUIN10:** (NHS E) Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway
- **CQUIN12:** (ICB) Assessment and documentation of pressure ulcer risk

The basis for payment for all indicators is based on a performance assessment conducted at the end of the scheme. At the time of writing, the final assessments are expected to be completed by midsummer 2024.

2.2.5 CARE QUALITY COMMISSION (CQC) REGISTRATION

Our Trust is required to register with the CQC, and its current registration status is registered with the CQC without conditions. The CQC has not taken enforcement action against our Trust during the period 1 April 2023 to 31 March 2024.

2.2.6 CQC SPECIAL REVIEWS AND INVESTIGATIONS

Our Trust has not participated in any special reviews during the reporting period.

The Care Quality Commission (CQC) undertook an unannounced inspection of our medical inpatient areas as a core service on the 12 March 2024, this also included an inspection of our pharmacy services. The Well Led aspect of the inspection took place between 16 April and 18 April 2024.

An unannounced inspection of our Maternity and Neo-Natal Services took place on 15 and 16 May 2024.

At the time of writing the Trust is awaiting the final outcomes of all inspections.

2.2.7 NHS NUMBER AND GENERAL MEDICAL PRACTICE CODE VALIDITY

During 2023/24 we submitted data to the secondary uses service (SUS) for inclusion in the hospital episode statistics (HES) that it publishes. The percentage of records in the published data that included patients' valid NHS number and general practitioner registration code is displayed in figure 9 below. Percentages for 2023/24 are in line with peers and exceed national England averages on all measures except for Valid General Medical Practice Code in Admitted Patient Care, which is 0.9% below national England average.

Figure 15 Percentage of records which included the patient's valid NHS number/GP

Record type	Area	2023/24 April to November 2023	2022/23 April to November 2022	2021/22 April to November 2021	2020/21 April to November 2020
Patients' valid NHS number	Admitted patient care	**99.9%**	99.9%	97.3%	99.7%
	Outpatient care	**99.9%**	99.9%	100%	99.9%
	Emergency department care	**99.6%**	99.6%	99.6%	99.2%
Patients' valid general medical practice code	Admitted patient care	**87.1%**	87.1	88%	100.0%
	Outpatient care	**91.3%**	91.3%	90.4	100.0%
	Emergency department care	**98.9%**	98.9%	98.8%	100.0%

2.2.8 DATA SECURITY AND PROTECTION TOOLKIT

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

In 2022/23 the Trust achieved 'Standards Met' which means that all mandatory assertion items have been evidenced by the time of final submission. The submission deadline for all organisations for the DSPT assessment for 2023/24 is 30 June 2024.

Our final Information Governance assessment overall position for 2023/24 is therefore incomplete at the time of this report. A sample of the DSPT evidence is independently reviewed by Audit Yorkshire, their draft opinion had not been provided at the time of this report.

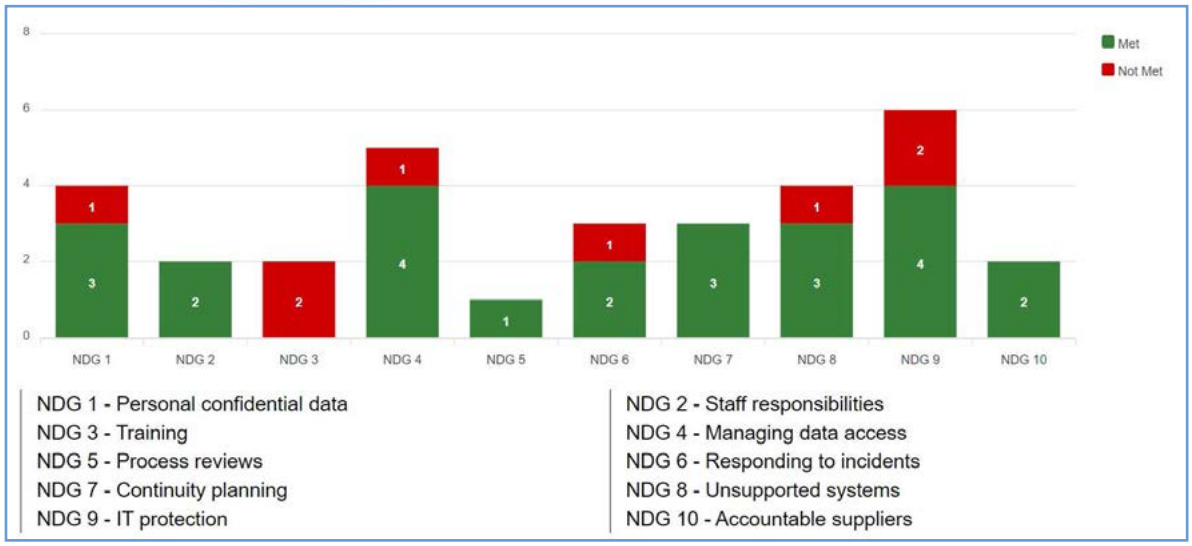
The Trust forecast position is 'Standards Met' for 2023/24 as previously, this will be confirmed before submission on 30 June 2024.

NB: DSPT is not scored as an overall percentage or RAG graded (if one of the mandated assertions is not evidenced the outcome would be 'Approaching Standards' for the entire Assessment with a requirement to have an improvement plan in place).

Optional extra:

Current position shown below indicates assertion items within the standards still in progress, which will be confirmed complete prior to the June submission (see figure 16).

Figure 16



2.2.9 PAYMENT BY RESULTS CLINICAL CODING AUDIT

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

The Audit Commission did not impose a payment by results clinical coding audit on the Trust during 2020/21, 2021/2022 or 2022/23. This may change in coming years due to a move to the National Elective Recovery Fund (ERF) model.

Each year we commission an external audit to assess coding accuracy for continued assurance of data quality and compliance with the NHS Digital DSPT. The DSPT is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security settings. The accuracy of the coding is an indicator of the accuracy and completeness of documentation within patient records. The Trust was subject to an external DSPT clinical coding audit during 2021/22, and the 2022/23 audit took place May-June 2023, in compliance with the DSPT submission dates in June.

The audit sample of 220 finished consultant episodes (FCEs) was selected using random sampling methodology from spells of inpatient discharges between 1 April 2022 and the 30 April 2023. All episodes were audited against National Clinical Coding Standards[3].

The error rates reported in the latest preliminary published audit for that period for diagnoses and treatment coding are shown in figure 3. All error rates meet the national standards (>=90% and >+ 80% accuracy for primary and secondary, respectively). Principal diagnosis error rates have worsened slightly since the previous audit. This is mainly due

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

to incorrect code assignments at block level due to inconsistencies with documentation which will be addressed through monitored improvement plans. All other areas have shown improvement, likely due to improved documentation of comorbidities and work done to improve Charlson comorbidity recording. A plan to improve these error rates is already in place and has a positive trajectory.

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

Figure 17 Clinical coding error rate

Coding field	Percentage incorrect									
	2022/23	2021/22	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15	2013/14
Primary diagnoses incorrect	9%	7.70%	6.30%	5%	5.70%	8.60%	8.17%	5.50%	9%	8%
Secondary diagnoses incorrect	4.20%	5.50%	7.80%	3.80%	6.30%	10.20%	9.20%	4.80%	9.47%	5.90%
Primary procedures incorrect	5.60%	9.90%	3.80%	8.30%	4.70%	8.10%	9.09%	9.10%	2%	0.70%
Secondary procedures incorrect	5.70%	12.90%	6.80%	5.30%	2.10%	7.20%	14.79%	5.60%	8.02%	8.70%

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

2.2.10 DATA QUALITY

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

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

We have ensured that there are systems and processes in place for the collection, recording, analysis, and reporting of data. Robust controls are in place to continually evaluate data and ensure it remains accurate, valid, reliable, timely, relevant, and complete on use. These controls are visible via a Trust-wide data quality framework. All data collection and information systems used to record pathway data, clinical activity and/or administrative information across the Trust are within the scope of these controls which assure data across the entire lifecycle, from the point of capture through to disposal.

It is particularly important for us to assure the quality and accuracy of elective waiting time and patient pathway data. We have a range of governance mechanisms to ensure that data generated,collected, and used, both internally and externally, is subject to an appropriate level of scrutiny, validation procedures and assurance processes. This includes data quality 'kite marking' of all Board dashboard indicators, service sign-off processes for mandatory reports, and an annual rolling improvement plan.

Priority data quality issues are monitored through a suite of exception reports and associated data issue tracking and resolution application which presenting anomalies to operational teams for increased visibility and pro-active management and resolution. Reporting from this informs areas of focus for the Data Quality Resolution Group Meeting.

The Data Quality (DQ) Issue Resolution Group is made up of subject matter experts sourced from Corporate Access Team, Informatics Business Intelligence, Informatics DQ, Education and Training team and Clinical Informatics. This group will review and agree actions needed to resolve issues, identify process or configuration changes required, undertake a risk assessment of process failures, and assess training requirements and targeted support.

The Maternity Data Quality Committee group meets monthly to review maternity data completeness and reporting to ensure we are compliant with national and regional requirements for data and improvements are made to improve patient safety and experience.

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

Our data quality maturity is assessed on a bi-annual basis through a standard model, reported and approved by the DGB through to the Audit Committee and Quality and Patient Safety Academy.

Formal education and training programmes support appropriate use of our key information systems for new starters (clinical and administrative) and refresher training is available for priority areas.

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

The Business Intelligence data quality improvement team offers bespoke training support through drop-in sessions, and one-to-one engagement workshops for operational staff focusing on areas for improvement.

2.2.11 LEARNING FROM DEATHS

During 2023/24, a total of 1,423 patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 347 in the first quarter
- 316 in the second quarter
- 390 in the third quarter
- 370 in the fourth quarter

The Learning from Deaths process: scrutiny and structured judgement reviews

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

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

Structured Judgement Review Process

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

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

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

By 31st March 2024, 64 SJRs had been conducted in relation to of the deaths during 2023/24. The number of deaths in each quarter for which a SJR was conducted was:

- 12 in the first quarter
- 19 in the second quarter
- 19 in the third quarter
- 14 in the fourth quarter

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

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

Summary of learning from structured judgement reviews (SJRs)

The key learning and areas for improvement from the SJR's conducted in 2023/24 are summarised below:

Key Learning points

Celebrating excellence:

- Evidence of incredibly detailed notes and interventions for chest physiotherapy for a patient on non-invasive ventilation oxygen – this had previously been raised an area for improvement in Q3 2022/23.
- Good, open, and honest conversations with family around patients deteriorating status as they approach end-of-life.
- Extensive care by the Virtual Ward to support patients at home with evidence of excellent care to prevent admission to hospital in a safe and timely manner.
- Good radiological input and communication with patient and family including facilitating bedside liver biopsy to attempt to confirm suspected diagnosis of disseminated malignancy.
- Direct involvement of patients in discussions around ceiling of care, considering the patient's own wishes when faced with the knowledge of their disease progression. This allowed the patient to choose highly personalised care as they approached end -of-life.
- Clinicians referring to the Trust's Spiritual, Pastoral and Religious Care (SPaRC) Team early into admission to ensure the spiritual needs of the patient and their families were met.
- Recognition of excess alcohol intake in a patient which led to early admission to facilitate pre-operative ward-based detox.
- Examples of excellent multidisciplinary team approaches during the pre-operative phase of care between anaesthetic and surgical teams. This led to outstanding documentation of post-operative management plans.

Areas for improvement:

- A lack of referrals to the Palliative Care team when it is appropriate to do so.
- Medicines reconciliation upon admission to ward. This was apparent in several cases where medicines were not converted to intravenous therapy in patients with nasogastric tubes in place.
- An overly complex system for referring into other specialities when dealing with multi-morbid patients. This led to delays in patients being moved onto appropriate wards.
- Failure to recognise a patient's Learning Disability status on admission to the Emergency Department.
- Failure to conduct Mental Capacity Assessments when appropriate to do so.

In the period 2023/24 the Trust's 'Learning from Deaths' team have taken numerous actions following reviews. Many of these are direct actions following a secondary review of a case at the Trust's Mortality Review Improvement Group (MRIG):

- MRIG identified an overly complex system for referring into other specialties when dealing with multi-morbid patients. The mitigate this concern, the group has begun discussions on forming rapid multidisciplinary groups via WhatsApp and Microsoft Teams to help facilitate which specialty is best to treat complex patients.
- MRIG identified that in several cases, patients with learning disabilities did not have their status recognised on admission to ED. Following the reviews a reminder to staff has been circulated on the importance of recognising LD status in patients and the use of the VIP passport in ED.
- In one case reviewed, it was found that junior clinicians did not recognise hypoglycaemia and hypothermia as markers of developing Sepsis in a patient. Following a further review at MRIG this case formed a 10-minute teaching session on the Care of the Elderly Wards.
- A review raised a concern around a delay in involving the Stroke Team when a patient with suspected stroke was admitted to the Emergency Department. Following the case record review this learning was disseminated via the EDucate WhatsApp forum and also a formed a 10-minute PEARL teaching session on the Thrombolysis Pathway within ED.
- Contributed reviews and data to the Hospital-at-Night project – this helped those who were forming the business plan for this ambitious project understand some of the barriers our clinicians and patients face during out-of-hours.
- Aided the decision-making process for Ward 17 to change into a "Young Frailty" ward under the direction of the Care of the Elderly specialty through reviews highlighting the quality of care received by multi-morbid patients under the age of 77 treated on this ward.

The impact of the above actions has demonstrated the Trust's commitment to learning in line with National Guidance on Learning from Deaths[4] and the NHS Patient Safety Strategy[5]. We anticipate that as our learning approach matures, we will be able to provide assurance that we are providing the highest quality of care, as identified in the Trusts' mission statement.

There were 5 SJRs completed after 31st March 2023 which related to deaths which took place before the start of the reporting period:

- 0 for deaths occurring in the first quarter of 2022/23
- 0 for deaths occurring in the second quarter of 2022/23
- 0 for deaths occurring in the third quarter of 2022/23
- 5 for deaths occurring in the fourth quarter of 2022/23

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

- 0 deaths representing 0.0% for the first quarter of 2022/23
- 0 deaths representing 0.0% for the second quarter of 2022/23
- 0 deaths representing 0.0% for the third quarter of 2022/23
- 0 deaths representing 0.0% for the fourth quarter of 2022/23

2.2.12 STAFF WHO SPEAK UP (INCLUDING WHISTLEBLOWING)

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

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

We have 12 FTSU Ambassadors who promote FTSU and are a point of contact for staff who raise a concern. The FTSU Guardian and ambassadors provide support to the person raising the concern throughout any period of further investigation. At the initial meeting, the person who has raised a concern is informed that they will not suffer any detriment because of speaking up, and this is monitored throughout the support.

Following any investigation, the FTSU guardian will, where necessary share the recommendations with the person who spoke up. Once the concern is closed, the FTSU team follow up with the person raising the concern and ask if they would speak up again and the reason for their answer. The feedback from staff is shared via the quarterly FTSU board reports. Staff are also asked to complete an Equality monitoring form which enables us to learn and improve our spread of staff awareness around FTSU. See figure 19 for the number of concerns raised.

Figure 19: *Number of concerns raised in 2023/24*

Quarter 2023/2024	Number of concerns raised
Q1	19
Q2	25
Q3	31
Q4	26
Total	101

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

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

2.2.13 GUARDIAN OF SAFE WORKING

The safety of patients is the paramount concern for the NHS. Significant staff fatigue is a hazard both to patients and to the staff themselves; the safeguards around doctors' working hours are designed to ensure that this risk is effectively mitigated and that this mitigation is assured. The role of the Guardian of Safe Working Hours is to ensure that issues of compliance with safe working hours are addressed by the doctor and employer/host organisation as appropriate. The guardian provides assurance to the board that doctors' working hours are safe, and this assurance is provided in a quarterly report detailing information on doctors and dentists in training working hours, exception reporting, work schedule reviews, rota gaps and any fines levied. An annual report is also presented to the Board with an overview of the year, recommendations and any improvement work undertaken or planned. There have been no fines levied during this year.

Trainees submit an exception report if they are working beyond contracted hours or if educational opportunities are missed. The annual report for 2023/24 shows that the number of exception reports has decreased by 58% with an associated decrease in additional hours claimed for payment of 57%.

There is continued high locum requirement in Emergency Medicine and General Medicine revealing these high-pressure specialities with notable rota gaps. The number of overall locum requests this year had decreased by 22% with around a 15% remaining unfilled.

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

The Guardian of Safe Working Hours and the Director of Education continue to work closely with the junior doctors' forum to review concerns, support development and improvements, and provide regular feedback to operational colleagues and assurance to the Board. Improvements, new ideas and lessons learnt are also shared across the Trust particularly new workforce initiatives or opportunities to fill rota gaps. Some changes this year include a change to the rota in General Medicine and a trial of self-rostering for the ED trainees. The previously successful pilot of hospital at night is now recruiting for permanent clinical support workers to reduce the workload of trainee doctors at night.

Some changes this year include a new rota for Junior trainees in ED which includes study / self - development time, a new rota for Foundation doctors in General Surgery and a pilot 'Hospital at night' to support and reduce workload for junior doctors in surgery. The chief registrar is currently working with medical teams to improve the medical rota which will hopefully start this coming financial year.

2.3 REPORTING AGAINST CORE INDICATORS

2.3.1 SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR (SHMI)

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

The current available Healthcare Evaluation Data (HED) covers a 12-month period to December 2023 with our current SHMI value being 119.24 which is high (See figures 12 and 13).

The Trust recognises that the SHMI score has been high throughout the period. There has been work undertaken to understand the issues affecting the scores which include, reviewing clinical coding processes and practices. It is important to note that SHMI is not an indication of avoidable deaths or of quality of care. To provide assurance, the Learning from Deaths Team reports on Crude Mortality Rates and continues to assess the quality of care received by patients through the Structured Judgement Review Process.

Figure 20: *SHMI score (12 month rolling: Feb 2022- Dec 2023): 119.24 – within expected range*

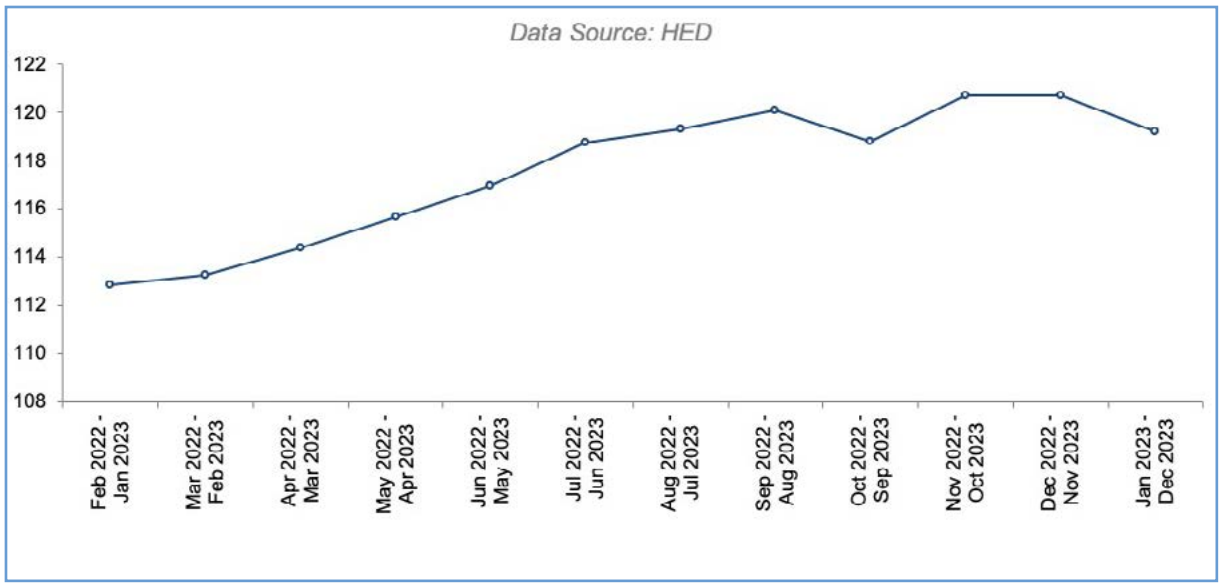


Figure 21: *SHMI indicator values, discharges, observed deaths and expected deaths numbers*

SHMI 12-month rolling	Indicator Value	Number of Discharges	Number of Observed Deaths	Number of Expected Deaths
Feb 2022 - Jan 2023	112.86	74,272	1,591	1,409.72
Mar 2022 - Feb 2023	113.26	75,037	1,609	1,420.68
Apr 2022 - Mar 2023	114.39	75,614	1,611	1,408.40
May 2022 - Apr 2023	115.7	75,940	1,619	1,399.33
Jun 2022 - May 2023	116.97	76,619	1,642	1,403.77
Jul 2022 - Jun 2023	118.78	76,953	1,665	1,401.70
Aug 2022 - Jul 2023	119.35	77,867	1,687	1,413.43
Sep 2022 - Aug 2023	120.09	78,356	1,694	1,410.57
Oct 2022 - Sep 2023	118.81	78,933	1,679	1,413.19
Nov 2022 - Oct 2023	120.72	79,825	1,710	1,416.48
Dec 2022 – Nov 2023	120.71	80,304	1,719	1,424.08

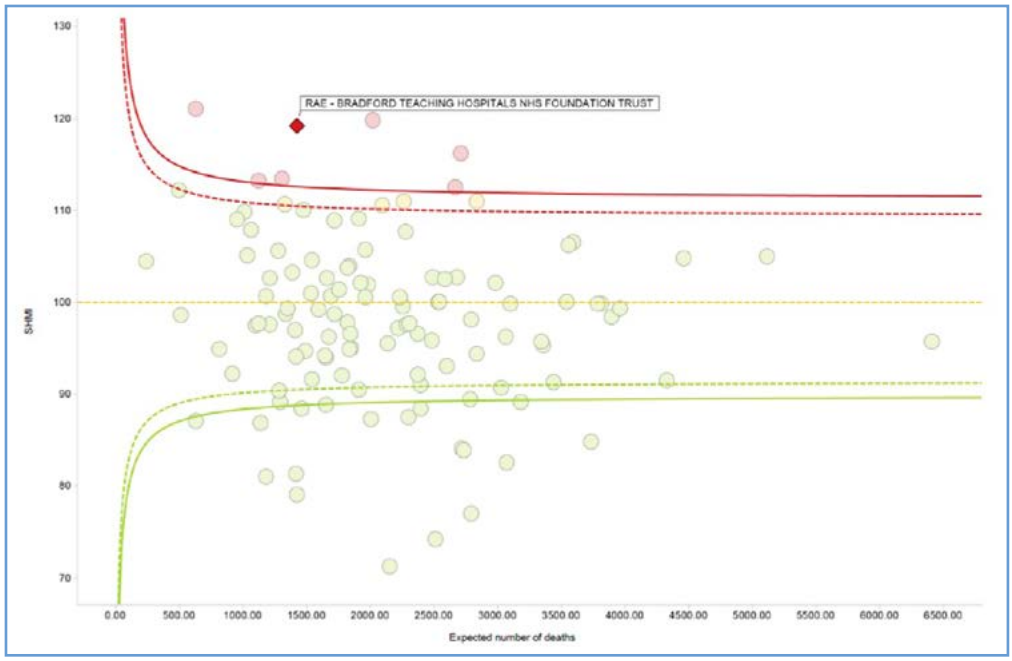


Figure 22: *SHMI Funnel Plot*

The funnel plot at figure 14 shows our Trust's SHMI performance in relation to all other acute hospital trusts.[6]

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

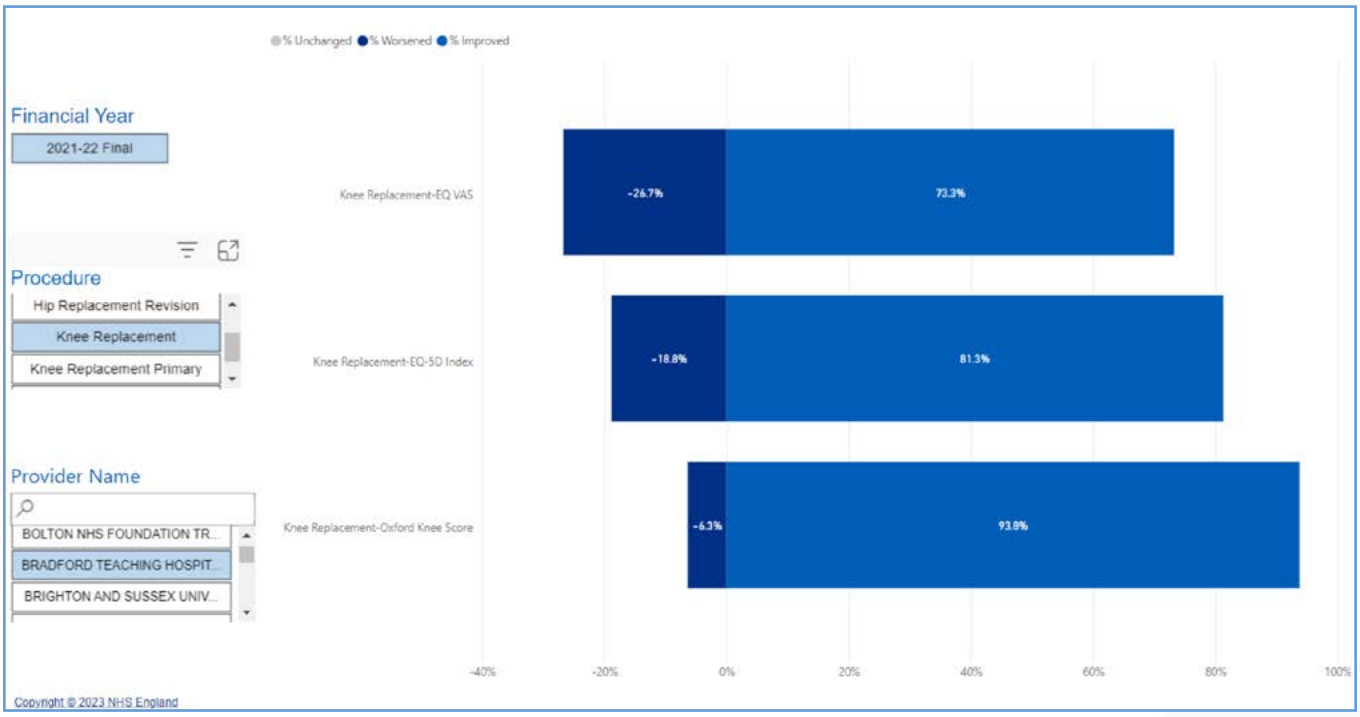
2.3.2 PATIENT REPORTED OUTCOME MEASURES (PROMS)

Patients undergoing elective inpatient surgery for hip and knee replacement funded by NHS England are asked to complete questionnaires before and after their operations, to assess improvement in health as perceived by the patients themselves. The questionnaire is designed to measure a patient's health status or health-related quality of life at a single point in time.

The Finalised Patient Reported Outcome Measures (PROMs) in England for April 2021 to March 2022 were released on 13 July 2023. It is noted that this publication covers a period when health services were affected by the COVID-19 pandemic. The completion, return, processing, and analysis of questionnaire data occurred during a period where restrictions on movement and changes to behaviours may have affected response levels. As a result, the Trust had insufficient data returned to calculate scores for this current reporting period for key PROMs. These scores rely upon modelled records (a statistical approach to account for patients of differing complexity) which require pre-operative and post-operative questionnaires to be linked together and to be complete.

At a provider level, available PROMS data only related to Knee Replacements with 73.3% of patients reporting an improvement in their global assessment of health (EQ-VAS), and 81.3% of patients reporting an improvement in health in terms of the level of problems. With regard to the Oxford Knee Score (a 12-item questionnaire developed to assess function and pain after total knee replacement surgery), 93.8% of patients reported an improvement following knee replacement, which is comparable to the national average of 95% (See figure 23 below).

Figure 23 : *Improvement rate by procedure and measure*



2.3.3
28-DAY READMISSIONS

Average re-admission rates for under 15yr olds have remained at 4%, in line with expectations. However, average re-admission rates for adults appears to have increased from 9.5% to over 10.5% since April 2023. This is higher than expected and higher than regional average. This may be related to higher risk taking on discharge decisions to free up beds capacity and aid flow.

However, further analysis will be required to understand what is driving re-admission rates up during this period.

Figure 24 : *28 day readmission rates for patient's aged 0-14 year olds*

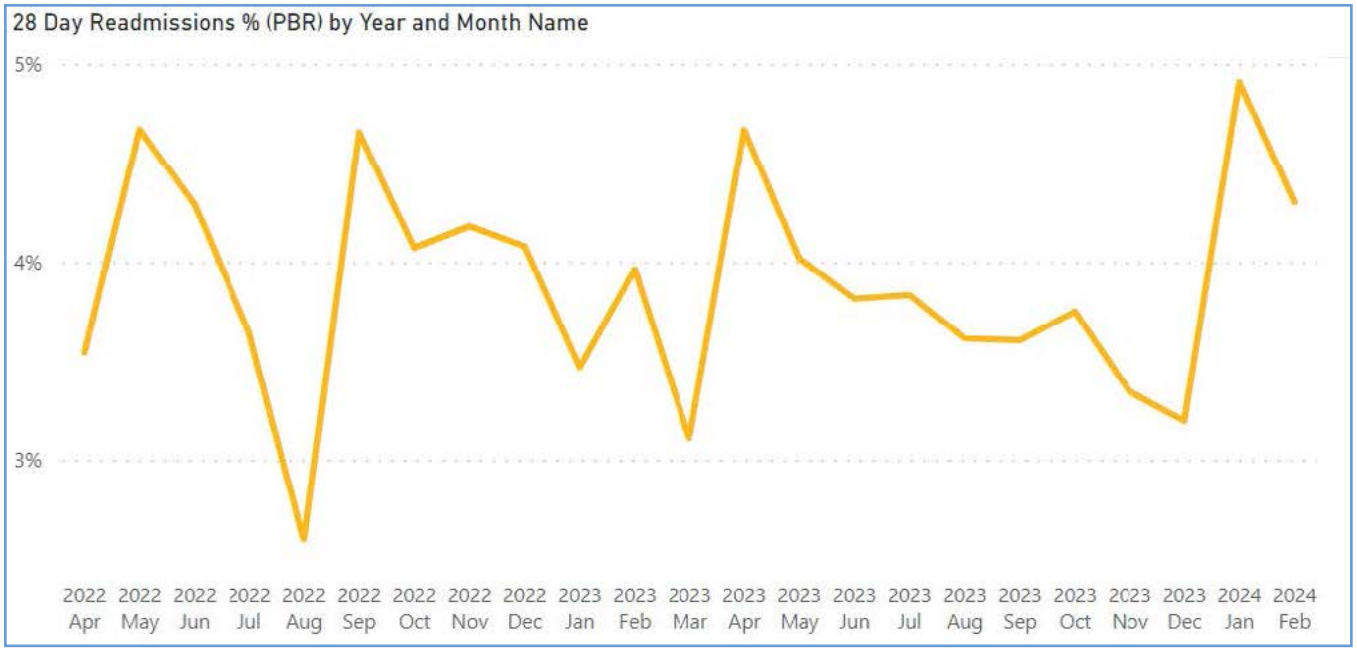
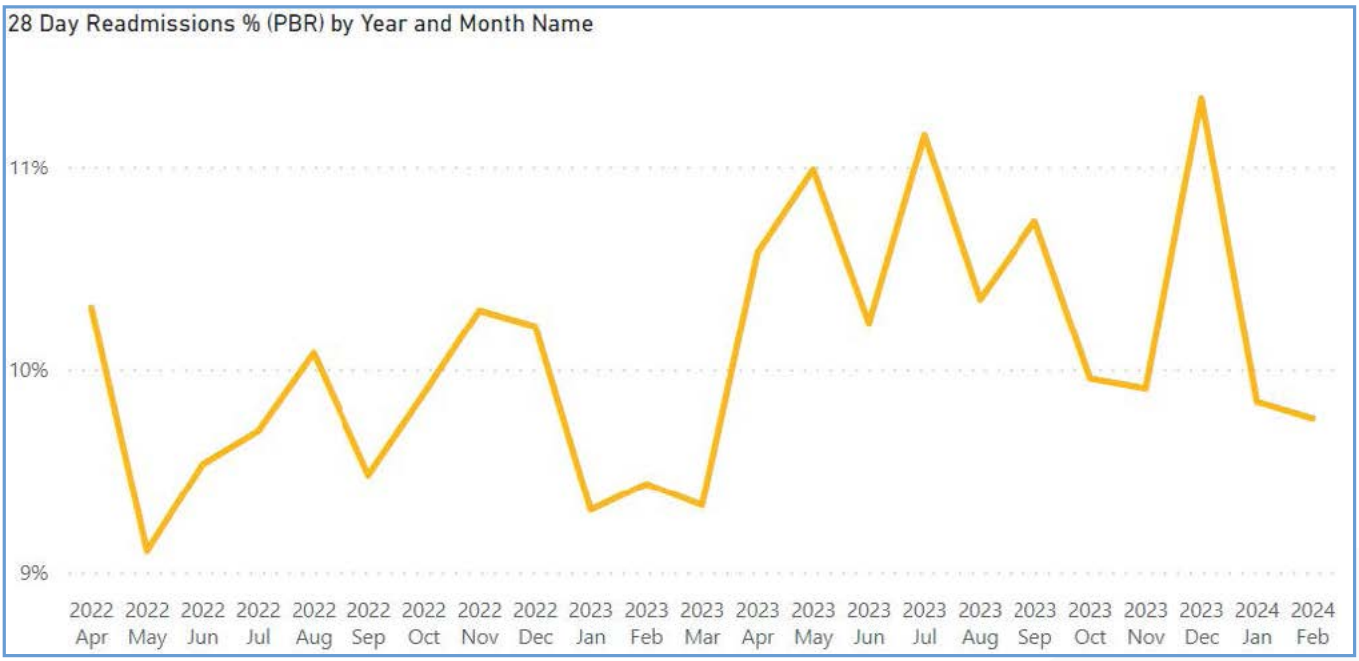


Figure 25: *28 day readmission rates for patient's aged 15 year olds and over*



2.3.4 RESPONSIVENESS TO PATIENT NEED

Friends and Family Test (FFT)

During 2023/24 the Trust has commissioned a new contractor to analyse all the FFT data. This company HealthCare Communications collects the data in several different ways:

- Text following outpatient visits, Admissions and AED visits.
- Via scanning of QR codes.
- Via iPad in clinical areas.
- Paper format (including accessible and child friendly formats).

This increase in methods used and the availability of the different real time methods has enabled the Trust to gather more feedback and collate themes to enable ward areas to focus on improving patient experience projects. SMS text messaging made up most of the responses included in figure 26 below.

Figure 26: *Friends and Family Test Responses 2023/24*

	Very Good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Grand Total
A&E Feedback	6,619	2,632	965	847	1,987	77	13,127
Inpatient Feedback	17,598	2,738	550	332	609	103	21,930
Outpatient Feedback	19,434	2,885	542	296	372	97	23,626
Maternity Feedback	1,169	99	18	11	34	2	1,333
Totals	**44,820**	**8,354**	**2,075**	**1,486**	**3,002**	**279**	**60,016**
Percentage	**74.68%**	**13.92%**	**3.46%**	**2.48%**	**5.00%**	**0.46%**	

The overall Trust position for 2023/24 is an increased score of 88.6% of patients scoring the Trust as 'very good' or 'good' in comparison to the previous year of 78.9%.

CQC surveys

During 2023/24 the Trust has taken part in the mandated CQC surveys (Inpatient survey and Maternity surveys).

A report on the actions undertaken in response to the feedback is included in section 2.1.1 Priorities for Improvement (Priority 3: Improving patient experience by advancing equality, diversity and inclusion) 2023/24.

2.3.5 NHS STAFF SURVEY AND PEOPLE PULSE SURVEYS

Staff Survey

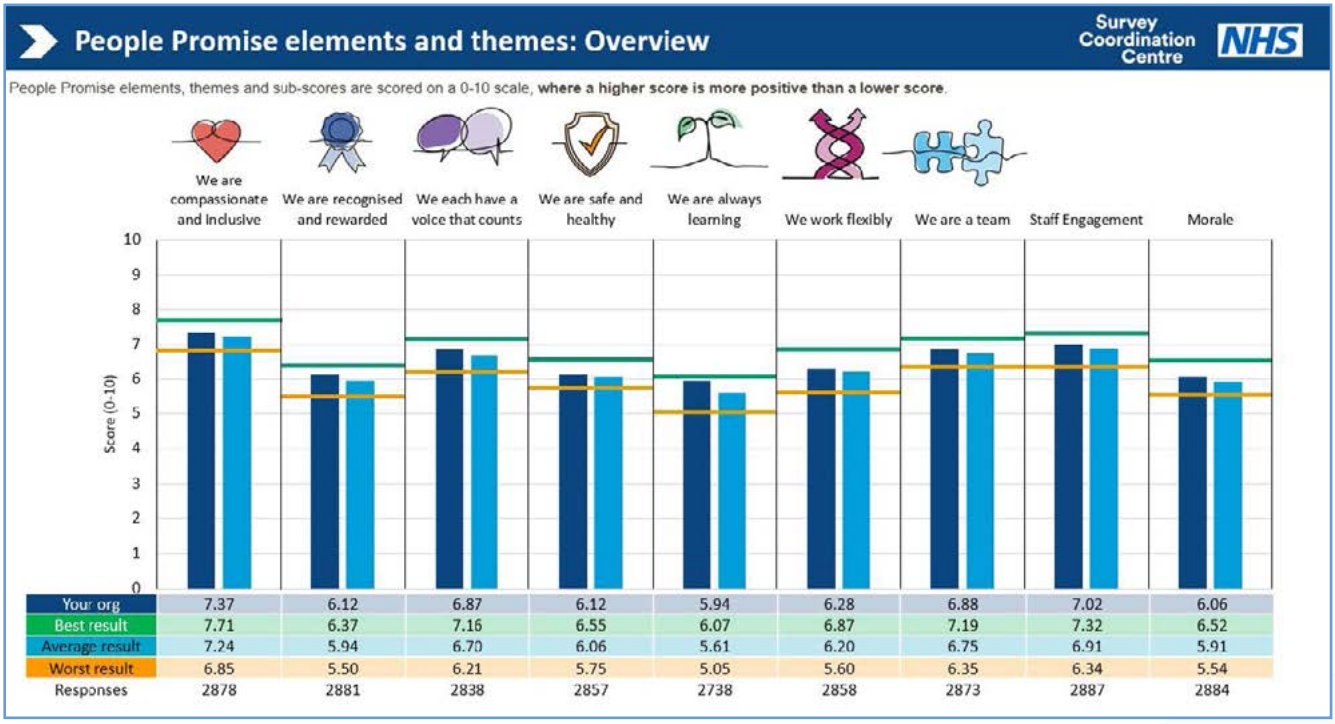
Here at BTHFT 2,905 colleagues (43%) took part in the 2023 NHS Staff Survey; this is an increase of 6% from 2022.

2023 saw the inclusion of the Bank Staff Survey. BTHFT has approximately 1,400 Bank Staff who were eligible to take part in the survey.

There have been significant improvements compared to our 2022 results and we have continued to improve our scores in every element of the People Promise.

Our results show that we are above average in all nine of the themed People promise areas.

We have also increased our own scores on every element of the People Promise for the second year running which should be recognised and celebrated.



At the time of writing the priorities for the staff survey have yet to be agreed and approved, we are in consultation with colleagues in shaping our action plan.

The areas which were highlighted for particular focus from our staff survey results have been aligned with the NHS People Plan.

People Pulse Survey

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

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

The survey included seven core questions and nine employee engagement questions, to support delivery of the NQPS - measuring motivation, advocacy, and involvement. It runs in quarter one, two and four. There is not a requirement to participate in the survey in quarter three to account for the annual staff survey fieldwork which already captures answers to the nine engagement theme questions. The results of the People Pulse survey are used to inform local actions to improve the experiences of our people and patients.

The results provide a snapshot of current colleague opinion and wellbeing and supports listening and engagement activities. The pulse survey asks colleagues how supported, informed, motivated or anxious they may feel, and what support would make the biggest difference to their experience at work.

For the first time in July 2023, there was an option to include up to 5 additional local questions. BTHFT were one of 35 organisations nationally that utilised the local question's function and added 5 questions around health and wellbeing. In January 2024, we used the additional questions to focus on reward and recognition.

Our response rate for the survey fluctuates (BTHFT 2023 People Pulse survey scores were higher than the NHS overall scores) however we are continually exploring new ways to engage with our colleagues to promote participation.

Work to highlight the importance of completing the survey was communicated through screen savers and invitations were sent out directly to new starters, bank staff, General Managers and Staff Engagers. Promotion also took place in the Thrive Bulletin, Let's Talk and Twitter. The OD team visited wards and departments with I-pads to engage and encourage participation.

Our vision for 24/25 is to increase participation of the Pulse survey and encourage more of our colleagues to have their say.

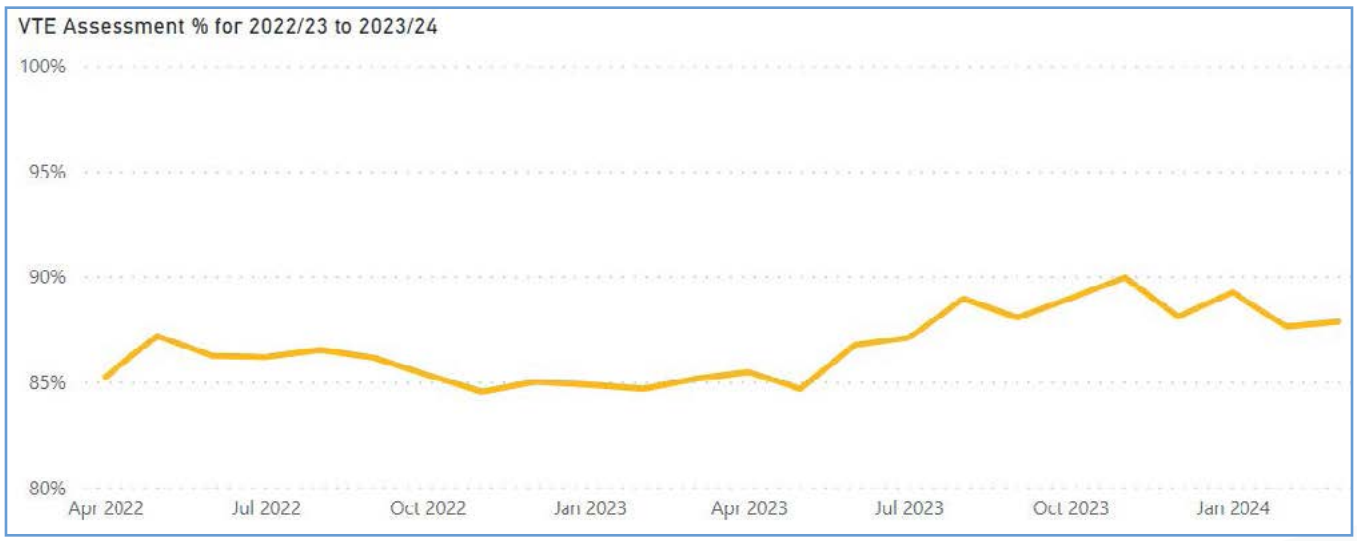
2.3.6 VENOUS THROMBOEMBOLISM EVENT RISK ASSESSMENT (12 MONTH ROLLING)

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

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

The data demonstrates that during the reporting period for 2023/24 we have improved patients being risk assessed for VTEs.

Figure 27: *Percentage of adult in-patients that were assessed for VTE's from April 2022 to Jan 2024*



In April 2024, we reviewed our systems and processes that are in place to effectively and safely undertake patient VTE assessments, as part of our external audit programme.

An overall High Assurance opinion has been given. This is based on VTE assessments for in- patients being completed in a timely manner, in conformance to the national NICE guidelines, results being acted upon with prophylaxis or interventions being prescribed, and evidence of reassessments being undertaken when a patient's condition has changed, or they have moved wards. Assessments are completed on EPR as part of the main patient record and are therefore accessible to all staff.

The Foundation Trust does not offer its own training package, but uses the modules available on ESR. Staff are not able to undertake VTE assessments without completing this training. According to the Education Lead for Mandatory and Statutory Training, compliance was at 96%.

2.3.7 C DIFFICILE

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

The objectives for reduction for CDI for 2023/24 were set as 39 cases. The Trust reported 39 hospital attributable cases during 2023/24. This was a significant achievement considering that nine cases were identified in the first month (April 2024). We consider that this data is accurate because it is captured, processed, and analysed through the Trust-wide Laboratory Management Systems (LMS), industry-standard data warehousing and analytical and business intelligence tools. Data is processed by dedicated reporting teams according to standard operating procedures, is validated by clinical staff and Infection Prevention and Control (IPC) Team and is signed off by the Chief Nurse (Executive IPC Lead for the Trust).

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

Antibiotic usage is the most common risk factor associated with Clostridioides *difficile* infection. The role of antibiotic stewardship is a primary preventative strategy in the prevention of Clostridioides *difficile* infection and will be a focus during 2024/25 to reduce the usage of the high- risk antibiotics.

Figure 28: *Healthcare Evaluation Data (HED) for C. difficile*

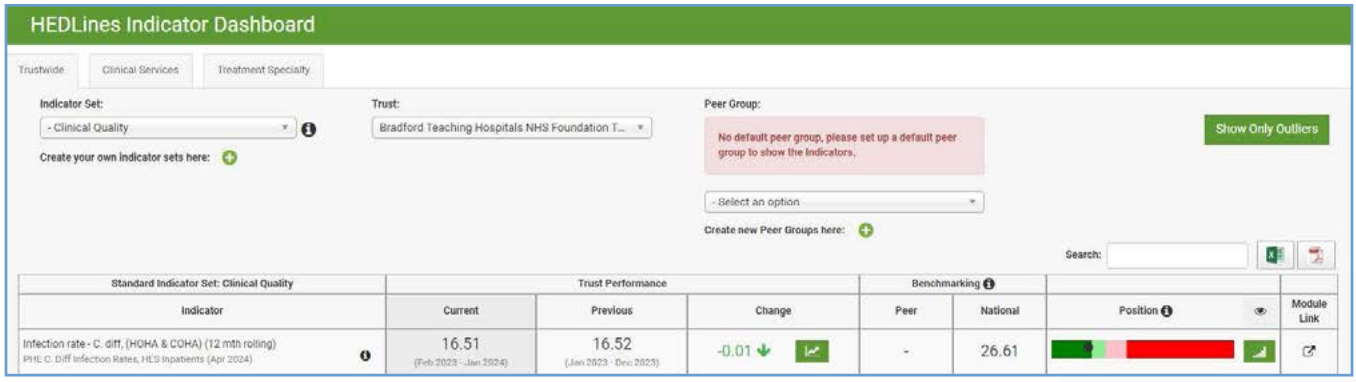
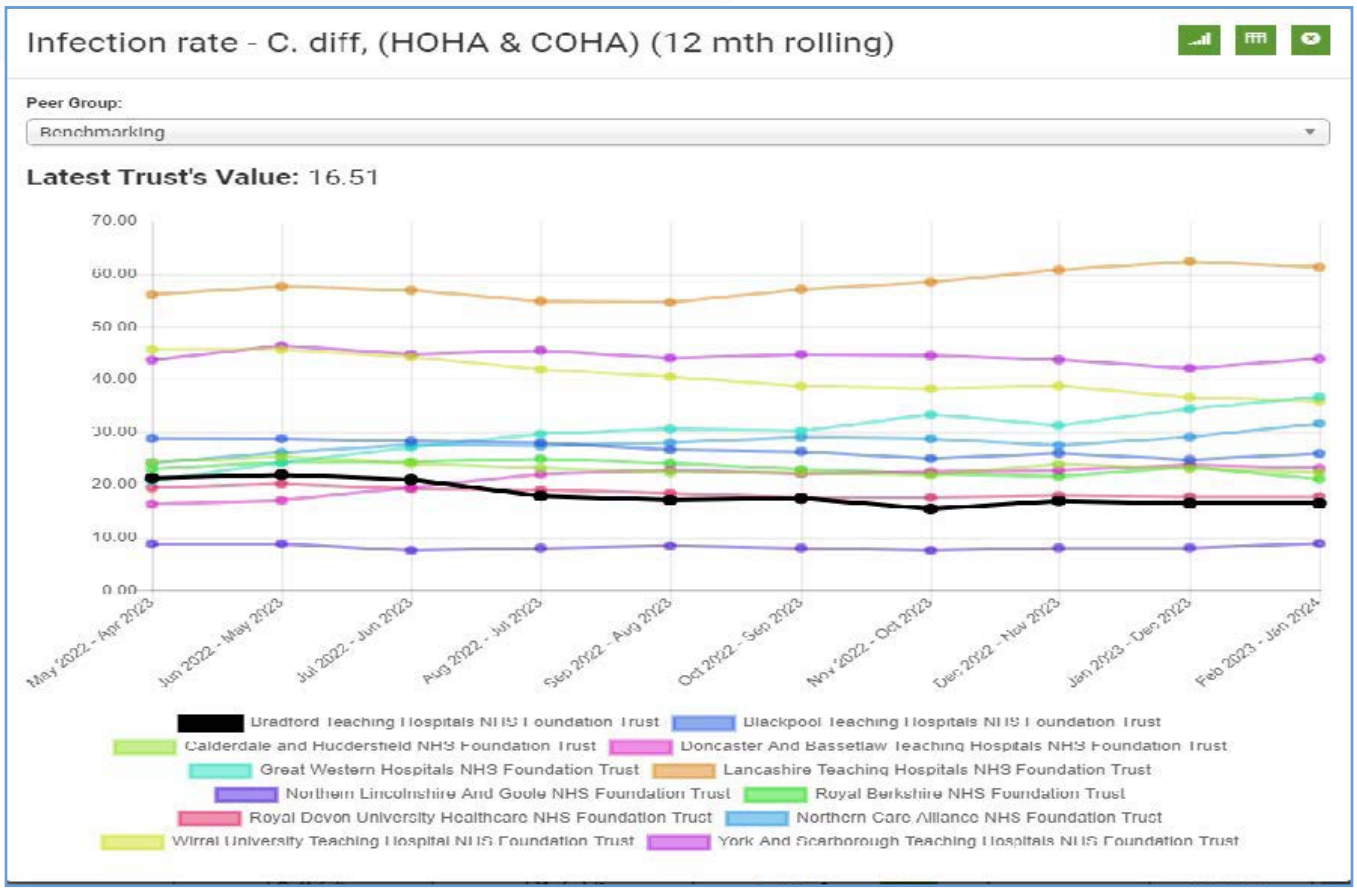


Figure 29: *Healthcare Evaluation Data (HED) for C. difficile: Benchmarking data for both Yorkshire Region and National Acute NHS Trusts (the black line represents our Trust)*



2.3.8 PATIENT SAFETY INCIDENTS WITH SEVERE HARM OR DEATH

The Trust used Datix as its electronic risk management system to monitor and manage patient safety incidents and concerns up to 17th January 2024. On 17th January 2024 a new electronic reporting, learning and improvement system was implemented (IRIS powered by InPhase). The new system facilitates the "live" reporting of patient safety incidents to the new NHS England (NHSE) Learn from Patient Safety Events (LFPSE) and meets the new requirements of the Patient Safety Incident Response Framework (PSIRF) which came into effect in April 2024. The Trust transitioned to the requirements within PSIRF ahead of time in November 2023 with the Board of Directors approval of our Patient Safety Incident Response Plan and associated policy.

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

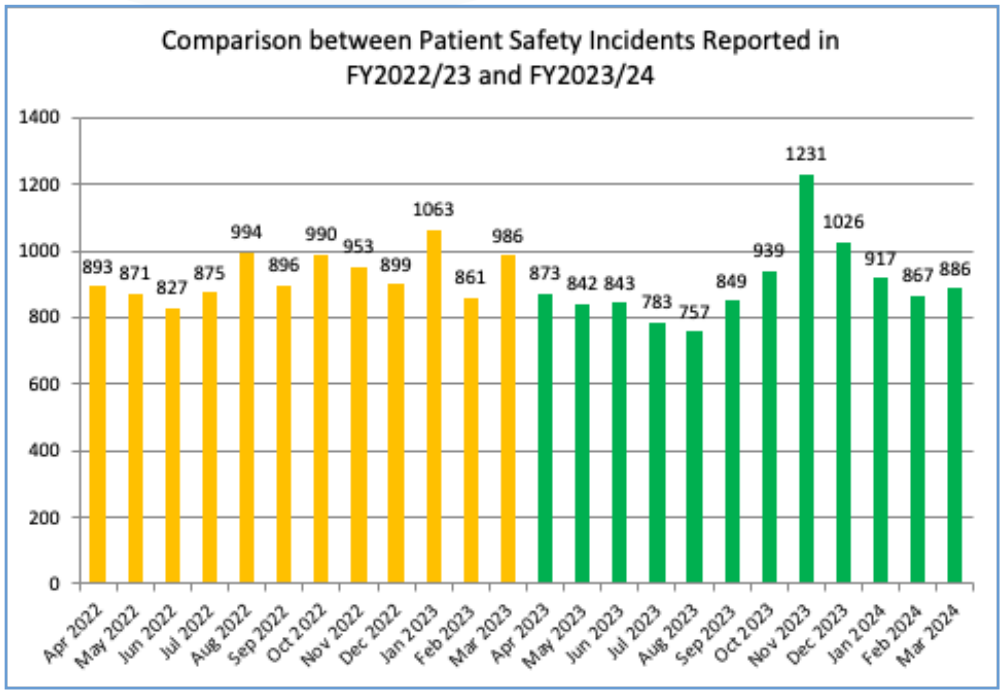
The Quality Team produces a quarterly 'Complaints, Litigation, Incidents and Patient Experience (CLIP) report for quarters one to three and an annual report at the end of quarter four. This supports the triangulation of data from all these aspects to identify learning and opportunities for improvement. The Trust also engages in a West Yorkshire learning forum to ensure learning from patient safety incidents is shared more widely.

There was a total of 10,813 patient safety incidents reported within the Trust during

2023/24. This represents a slight reduction of 296 (2.66%) when compared with the previous reporting period (see figure 30).

There were 43 (0.38%) patient safety incidents that resulted in severe harm or death during 2023/24.

Figure 30: *Comparison between Patient Safety Incidents Reported in FY2022/23 and FY2023/24*



A five-year view of the number of patient safety incidents resulting in severe harm (see figure 31) or death (see figure 32) has been provided in the charts below.

Figure 31: *Number of Patient Safety Incidents resulting in Severe Harm (2019/24)*

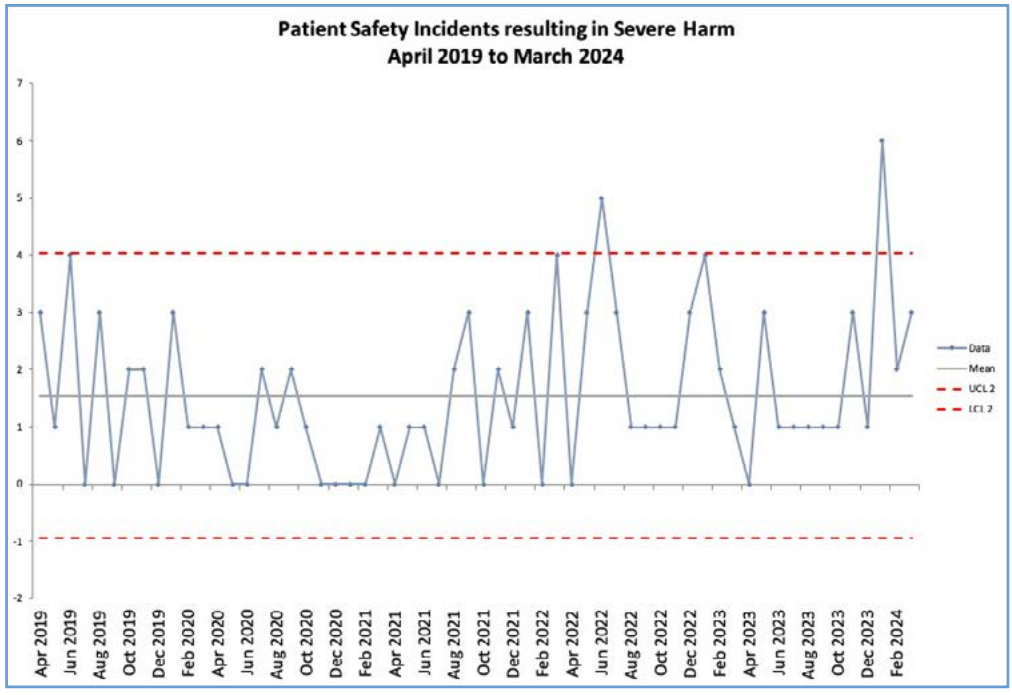
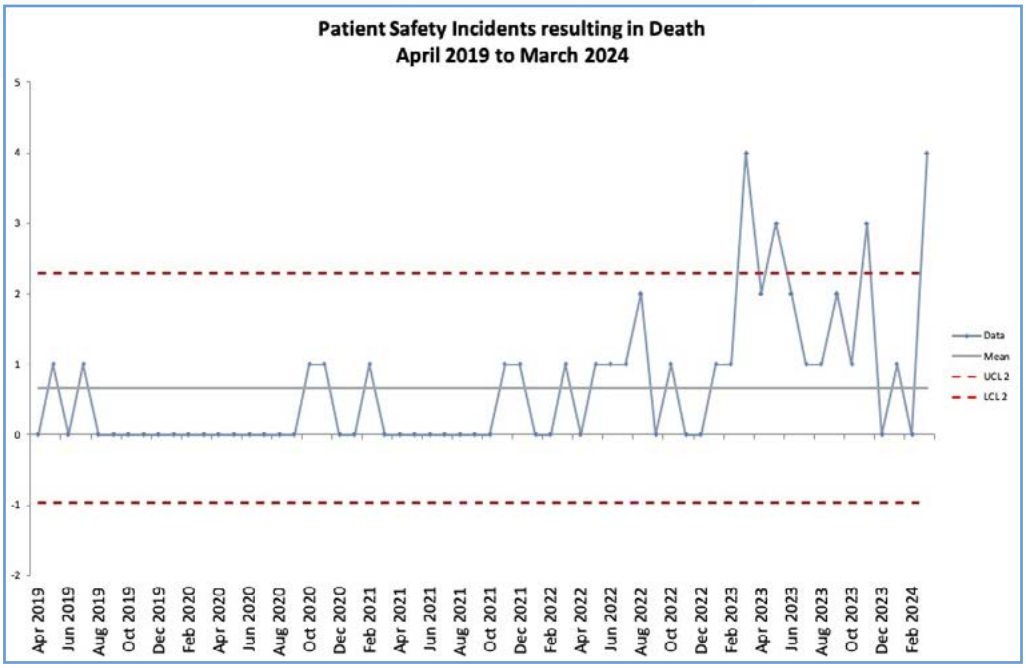


Figure 32: *Number of Patient Safety Incidents resulting in Death (2019/24)*



Patient Safety Incidents resulting in Severe Harm and Death

There were 23 patient safety incidents resulting in severe harm (see figure 31). This included 9 patient safety incidents relating to falls (this includes patient fall, slip, or trip from the same level and fall from height). Our Trust has a falls prevention improvement programme in place which is described in more detail in section 3.3.3. The remaining 14 incidents resulting in severe harm were owing to, communication, delayed diagnosis, information technology, inappropriate admission, care and treatment, medication management, maternity and neonatal safety and patient procedures.

The total number of reported patient safety incidents resulting in death was 20. Three were declared as Serious Incidents (SI) and one was declared as a Patient Safety Incident Investigation (PSII) under the new Patient Safety Incident Response Framework (PSIRF). Two of the SI investigations and the PSII investigation have been completed and closed on StEIS. There is one ongoing SI investigation at the time of report writing (April 2024). See figure 33 for more information.

Figure 33: *Number of Patient Safety Incidents by Category and Harm during 2023/24*

Severe n=number of patients	Death n=number of patients	Category
n=1	-	Communication
n=4	-	Delayed diagnosis
n=1 169 vascular ultrasound patients placed in wrong section on CRIS	Information technology	
n=9 Sustained a fracture n=8/9 Sustained a head injury n=1/9	-	Falls (patient fall, slip or trip from the same level and fall from height)
n=1	-	Inappropriate admission
n=4	n=5	Care and treatment
n=1	-	Medication management
n=2 delivery/labour	n=1 postnatal care	Maternity and neonatal safety
-	n=4	Patient Procedures
-	n=1	Discharge safety
-	n=9	Unexpected death

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

Chapter 3
OTHER INFORMATION

3.1 INDICATORS FOR PATIENT SAFETY

3.1.1 PRESSURE ULCERS

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

Figure 33: *Pressure ulcer incidence (category 2 and above) during 2023/24*

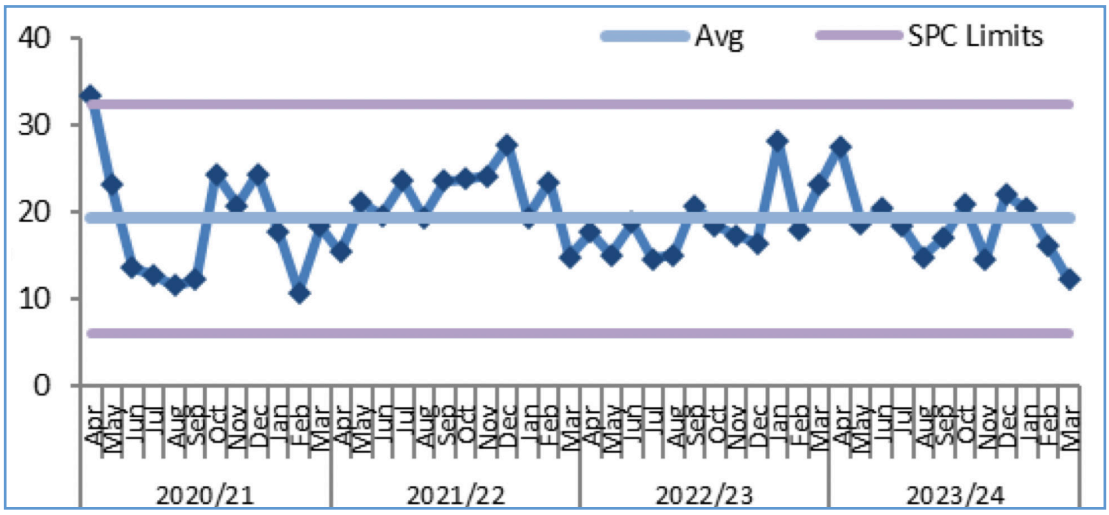
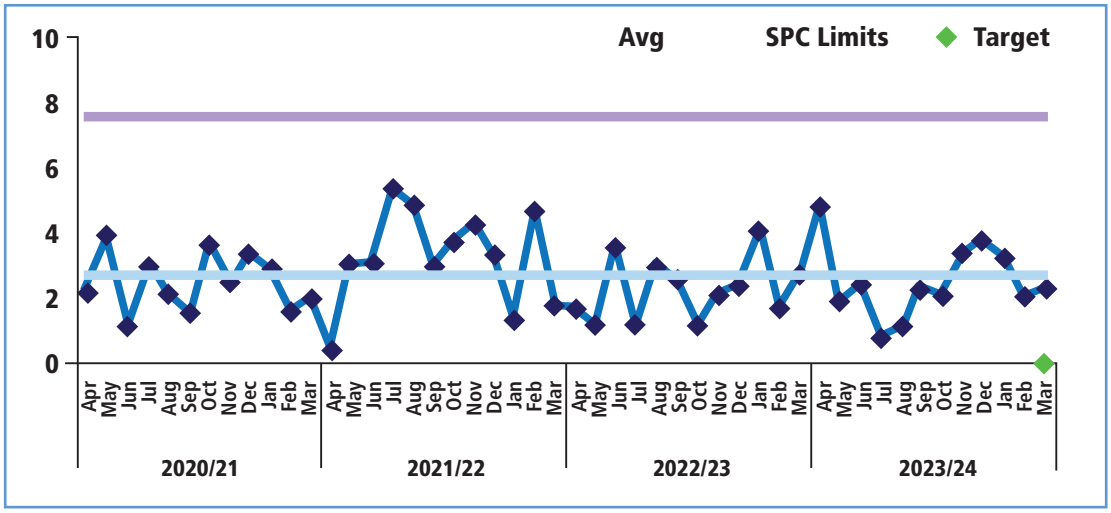


Figure 34: *Pressure ulcer incidence (category 3 and 4) during 2023/24*



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

We continue to focus on improving pressure ulcer prevention through quality improvement methodology, training and education and implementation of evidence-based patient care. In July 2023 we replaced the Waterlow and Glamorgan pressure ulcer risk assessment tools with PURPOSE T, which is an evidence-based tool and is recommended with the new National Wound Care Strategy Programme guidelines. We also updated pressure ulcer prevention and management care plans to reflect this change and relaunched these as red, amber, and green pathways. We have reviewed the way we investigate and learn from pressure ulcer incidents in line with PSIRF. In December we commenced the use of after-action reviews for all category 2 and above pressure ulcer incidents. This should be done as soon as possible after the event and include the patient. The ward areas are also sharing their learning and improvement plans and results at the monthly pressure ulcer improvement group.

3.1.2 SEPSIS SCREENING AND TIME TO TREATMENT

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

NICE (2024) guidance states that patients of any age with a suspected infection should be assessed to identify:

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

For any patient that have been screened using a structured assessment tool where all the factors above have been confirmed intravenous antibiotic treatment should be given within one hour of diagnosis of severe sepsis or three hours for a diagnosis of uncomplicated sepsis.

Our sepsis dashboard was launched in 2020/21 pulling data from EPR enabling wards and specialties to monitor key outcome and process measures shared within the graphs below. The dashboard is fully accessible to all staff with the aim of each CSU using it to review and share their data at speciality level. The plan for the coming year will be to include all the sepsis 6 elements to understand where the key areas for improvement are. The dashboard reports data on all patients that alert for sepsis

Performance against screening for sepsis

Overall sepsis screening has been sustained at an average of 64% for eligible patients in the Emergency Department (AED) and an average of 47% for all patients (see Figures 35 and 36).

Figure 35: *Percentage of patients that were screened for sepsis in AED*

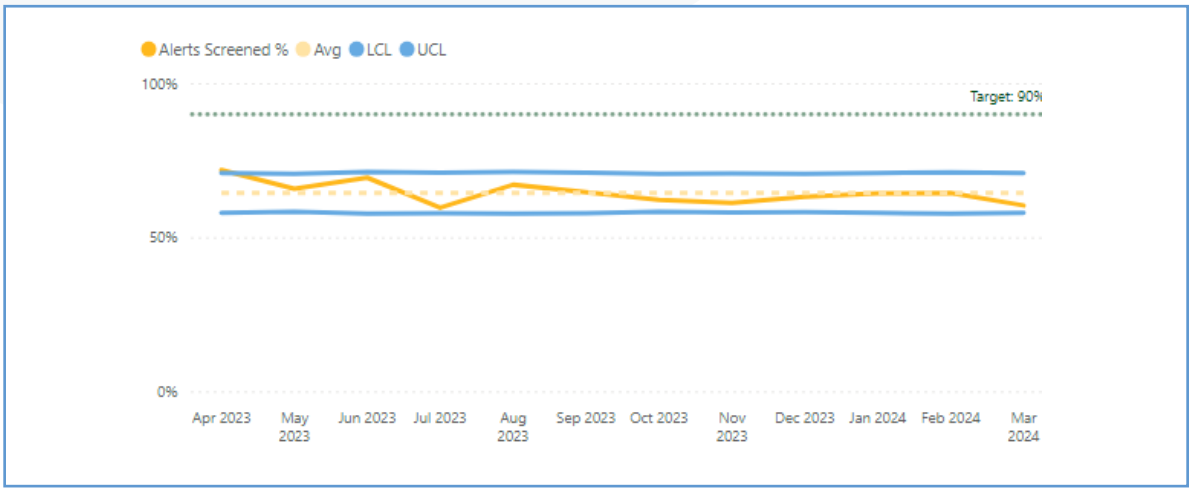
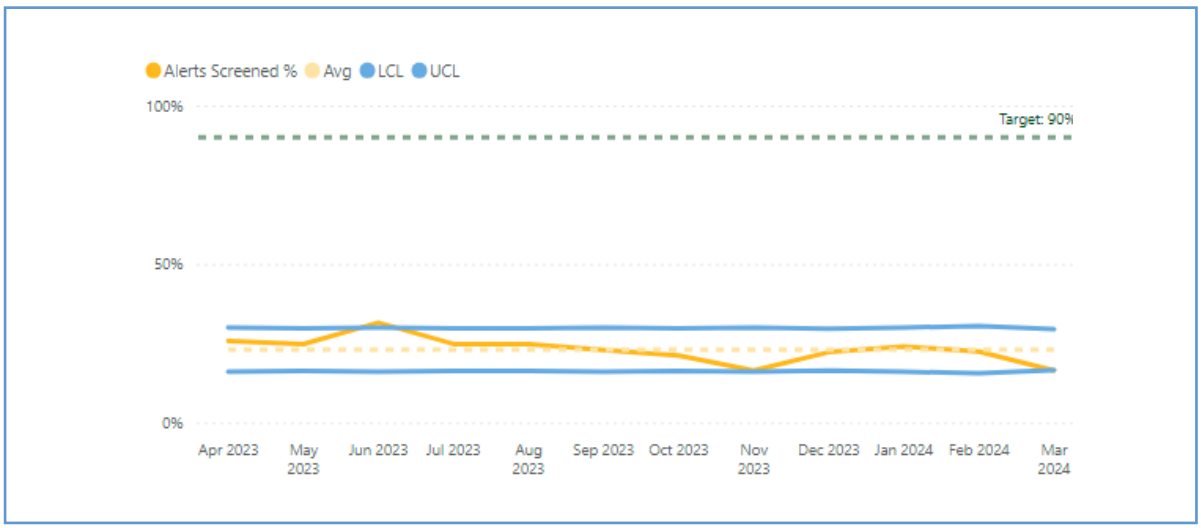


Figure 36: *Percentage of patients that were screened for sepsis on in-patient wards including AED*

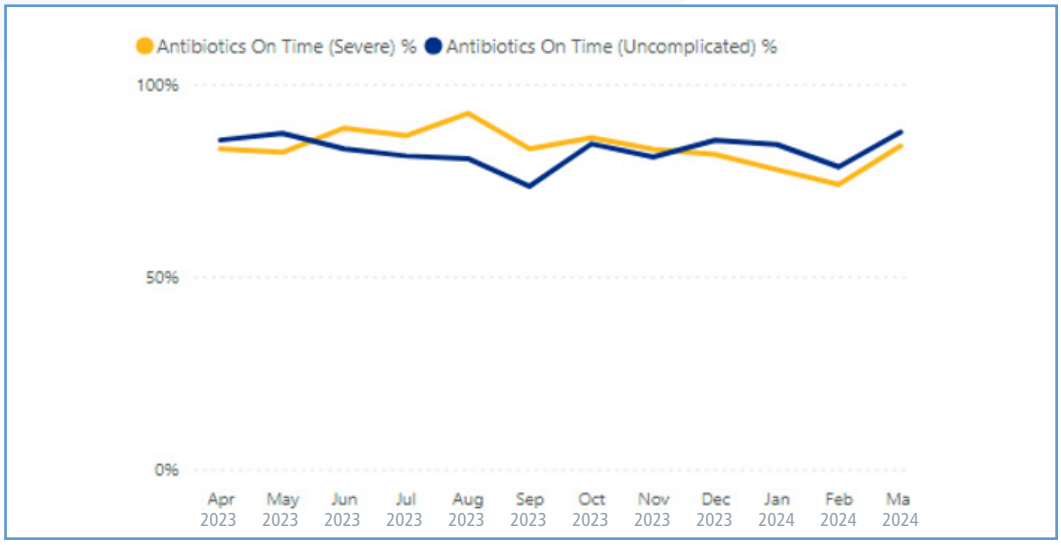


Performance against administering intravenous antibiotics within 1 hour

The average time to treatment for patients with suspected severe sepsis (antibiotics within a maximum of 1 hour) within AED was 75%. The average time to treatment for patients with suspected uncomplicated sepsis (antibiotics within a maximum of 3 hours) within AED was 78% (see figure 37).

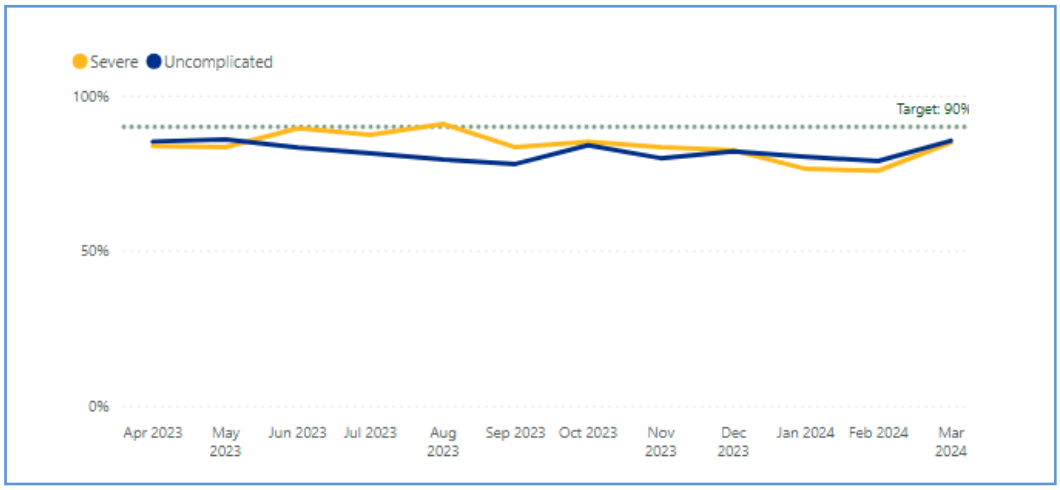
We continue to focus on improvement efforts to achieve 90% target set out in the NHS standard contract.

Figure 37: *Percentage of patients that received intravenous antibiotics in the AED within one hour for severe sepsis (yellow line) and 3 hours for uncomplicated sepsis (blue line)*



The average time to treatment for patients with suspected severe sepsis (antibiotics within a maximum of 1 hour) on in-patient wards was 82 %. The average time to treatment for patients with suspected uncomplicated sepsis (antibiotics within a maximum of 3 hours) on in-patient wards was 76% (see figure 38).

Figure 38: *Percentage of patients that received intravenous antibiotics on in-patient wards within one hour for severe sepsis (yellow line) and 3 hours for uncomplicated sepsis (blue line) on inpatient wards*



Although we have seen a small drop in averages for sepsis screening when compared to last year, we audit our data monthly. We have evidence to suggest that treatment for sepsis is commenced often before the digital alerts are triggered owing to good clinical judgement.

EPR and Sepsis

In 2024/25 the Trust's sepsis screening tools will be updated in EPR to follow the NICE (NG51) guidelines: Suspected sepsis: recognition, diagnosis and early management update and release in January 2024, this was following the recommendations made within the Academy of Royal Colleges Statement on the initial antimicrobial treatment of sepsis in October 2022. We will expect completion of sepsis screening to improve with the role out of the new screening tools as they will be more focused on identifying the most at risk patients.

Blood culture Improvement Project

In 2023 a monthly Trust collaborative was launched following a recommended NHS England's report into blood culture practices promoting the opportunity to improve our blood culture pathway, antimicrobial stewardship, and patient outcomes from sepsis. This collaborative involves staff from both Bradford and Airedale and from the MDT. The work has focused on the pre analytical phase, predominately volume of blood in the culture bottle and time from collection of the sample to the laboratory.

We collect data from the laboratory monthly to look at the both the volume and time to laboratory. There has been a new e-learning package launched within the trust for all clinical staff to complete.

Figure 39: *Monthly average time to laboratory*

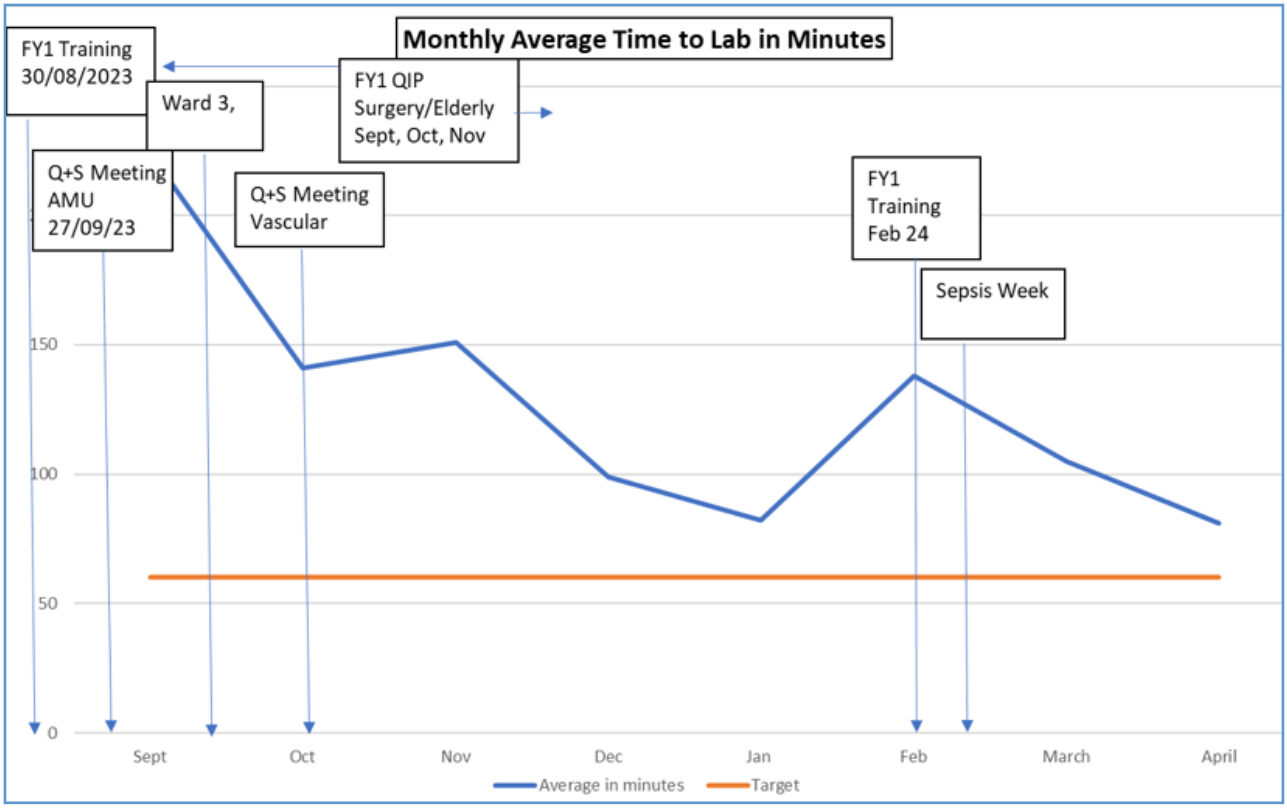
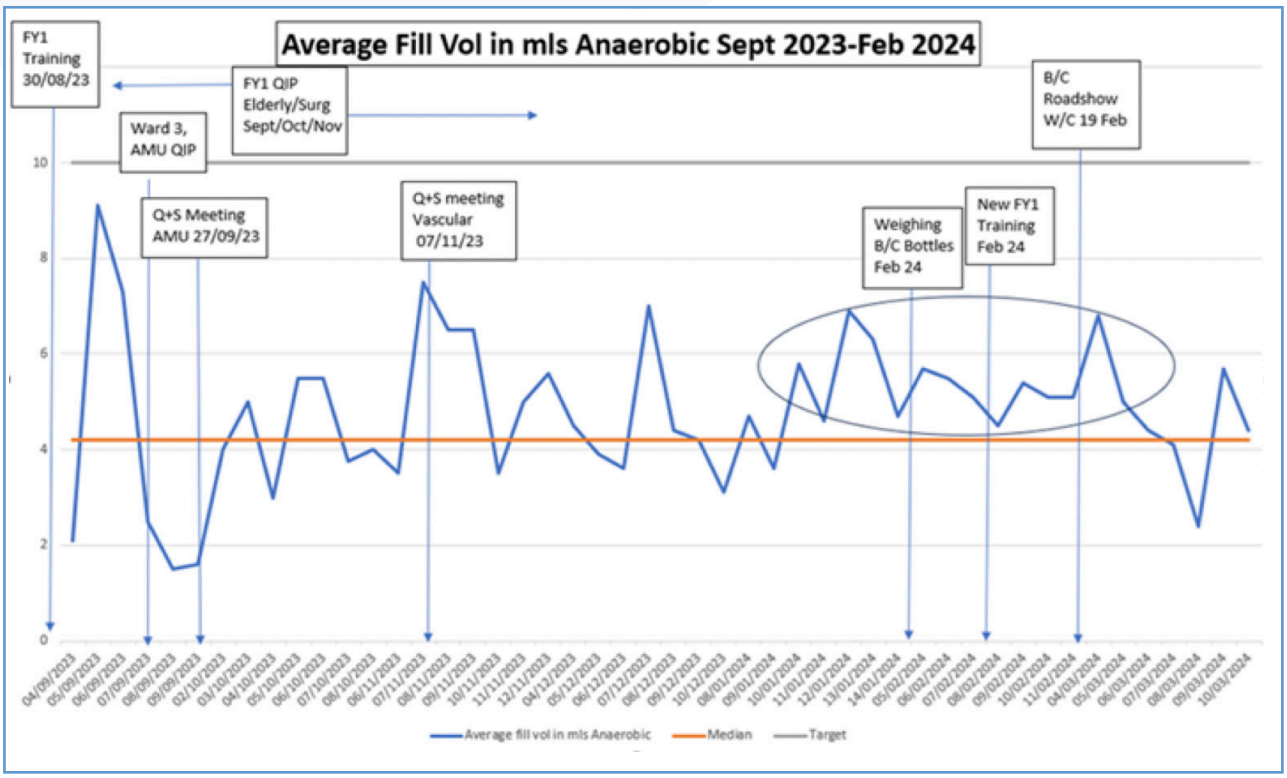


Figure 40: *Average Fill volume in blood culture bottles*



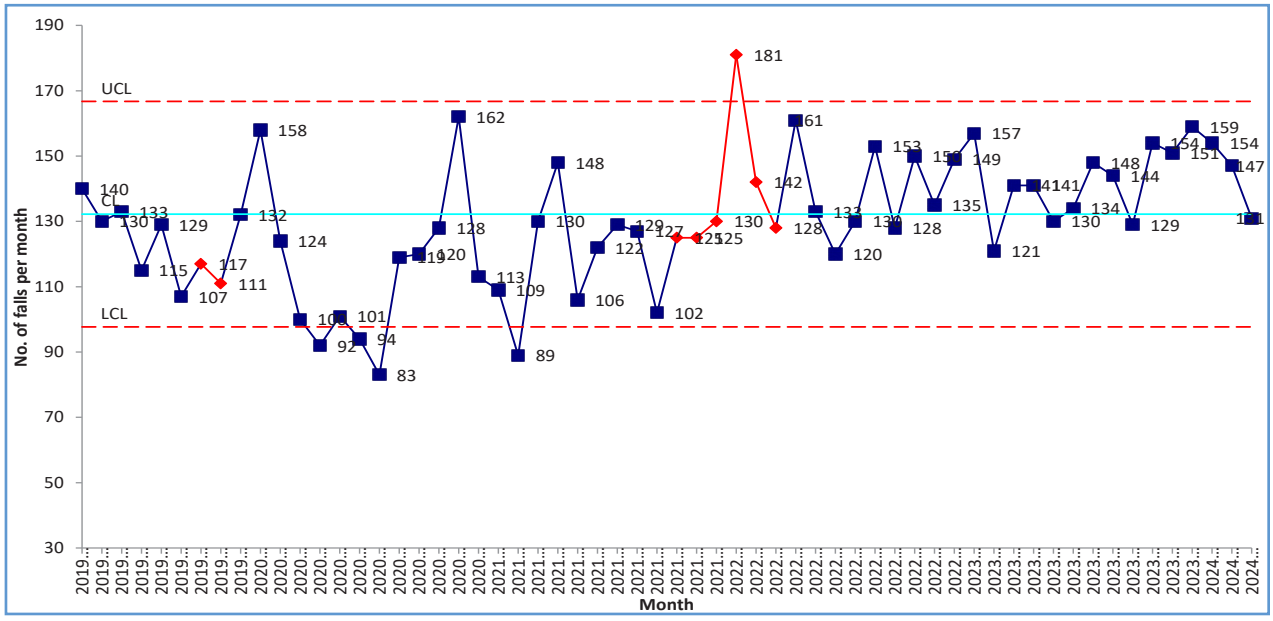
In 2024/25 we are hoping to continue to see improvements and to change the process within the analytical phase of the blood culture pathway.

3.1.3 FALLS

This data is collected via EPR (Electronic Patient Record) and our incident monitoring system (IRIS) and is validated by clinical staff. The Trust routinely monitors all 'Falls' patient safety incidents that take place within Trust premises. The Lead Nurse for Falls fixed term post has been approved for permanent recruitment. This role routinely reviews all falls across the Organisation irrespective of outcome. This is in line with the PSIRF principles as much learning can be taken from low and no harm incidents.

We have seen a decrease of 83 in the total numbers of falls over the last twelve months (see figure 41 below) and a drop of 6 fractured neck of femurs in the past twelve months from 15 to 9.

Figure 41: *Number of falls per month*



In line with the PSIRF principles the Root Cause Analysis (RCA) process has been replaced with hot debriefs which are completed for all falls irrespective of harm by the nurse in charge of the patient at the time. This is then discussed with the wider MDT and learning points are identified and recorded on an after-action review template within 5 days of the fall occurring.

Each CSU attends the falls improvement group quarterly to present their data and learning from falls from within the specialities. This allows the learning from incidents to be shared with the wider Organisation and has supported teams to better understand their data and what actions need to be taken to address falls within their areas.

Learning and improvement

The Royal College of Physicians National Audit of Inpatient Falls (NAIF) Annual Report 2023[7] has also provided us with areas where improvement is needed, and these have helped develop our objectives for 2024/2025 alongside our teams' insights.

The National Audit of in-patient falls reviews the care of patients that have sustained a fractured neck of femur following a fall in hospital. In the past 12 months we have reported 9 fractured neck of femur incidents which is a reduction of 6 incidents from the previous year. In 2025 the audit is set to expand to incorporate all falls that result in a fracture or head injury.

The six recommendations from this report were taken as the objectives for the falls improvement group for 2023/4. These were-

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

The Lead Nurse for Falls has led the focus of this work with the clinical teams. The post falls hot debrief reviews have demonstrated significant improvement in completion of lying and standing blood pressures,

Bedside visual checks have now been implemented to improve risk assessments and raise awareness of reasonable adjustments that staff need to take to support those identified at risk.

The current focus is on ensuring there is documented evidence of medication reviews and ensure that careful consideration is given to medication that increases the risk of a person falling.

The hot debrief has demonstrated that post fall care and management has improved with most patients being safely moved from the floor and those patients with injuries being administered pain relief within 30 minutes in most cases.

The Trust transitioned from the single question in delirium (SQuID) within the Electronic Patient Records to the 4AT screening tool in line with National guidance. The Falls Lead has supported staff with this transition in assessing and recognising when delirium is increasing the risk of falls for an individual.

The focus for the coming year is to continue to improve on these recommendations but to also improve continence assessments.

3.1.4 INDICATORS FOR CLINICAL EFFECTIVENESS

Crude Mortality Rate

In conjunction with using SHMI as an indicator of potential excess mortality, BTHFT has also been monitoring the crude mortality rate for the Trust over the period. This is calculated by the number of deaths within the Trust against the number of patients seen within a given period. It is a much clearer indicator for mortality when taken against activity at an acute Trust. A high mortality rate would corroborate the SHMI data calculated by NHS Digital.

7 *https://www.rcp.ac.uk/improving-care/resources/naif-annual-report-2023/*

The current Healthcare Evaluation Data (HED) covers a 12-month period from March 2022 – January 2024 with our current 12-month average mortality rate being 2.05% (see figures 42 and 43).

Figure 42: *Crude Mortality Rate (12 month rolling: Mar 2022 – Jan 24): 2.05%*

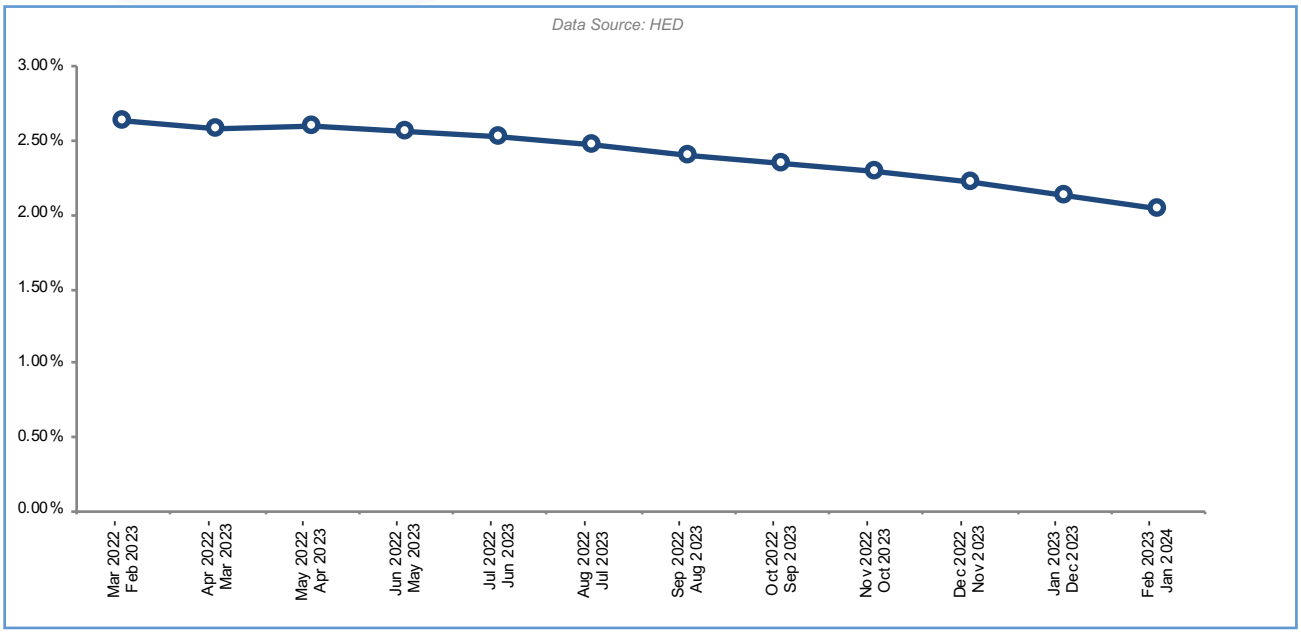


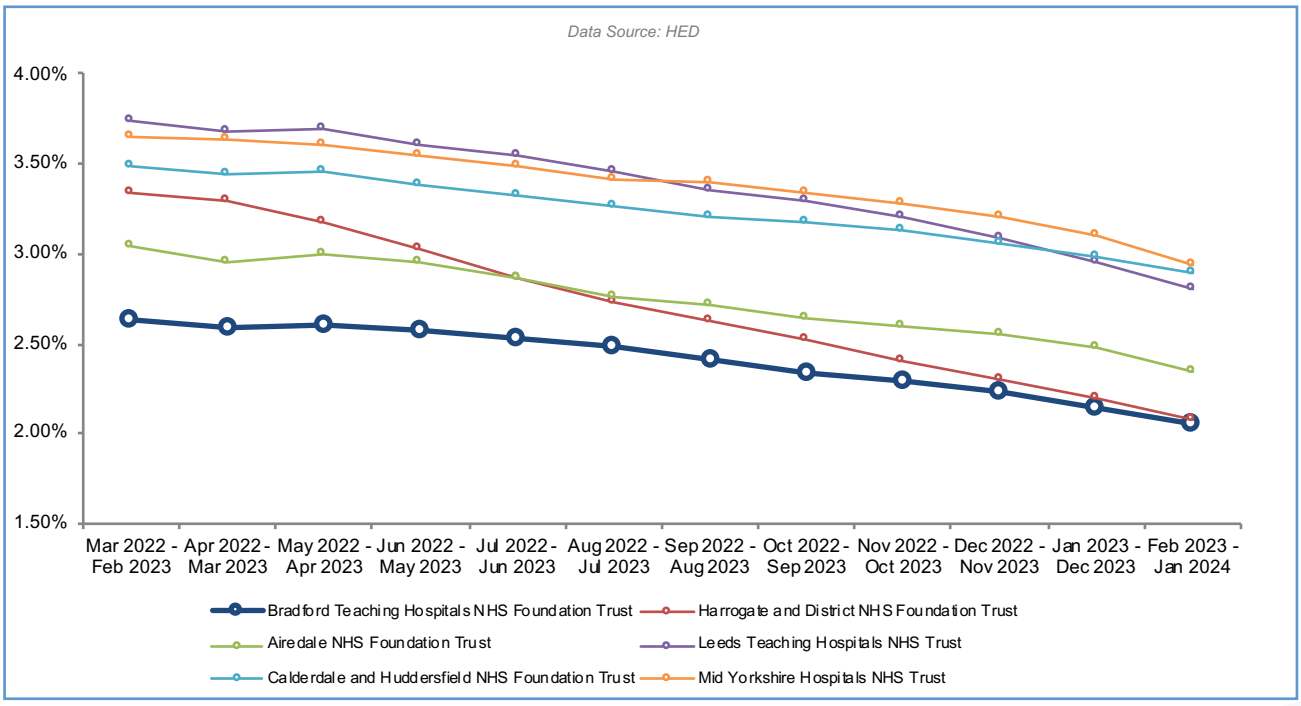
Figure 43: *Crude Mortality Rate, observed deaths and discharges*

Crude Mortality Rate 12-month rolling	Indicator Value %	Number of Observed Deaths	Number of Discharges
Mar 2022 - Feb 2023	2.63%	3,090	117,458
Apr 2022 - Mar 2023	2.59%	3,067	118,253
May 2022 - Apr 2023	2.60%	3,093	118,827
Jun 2022 - May 2023	2.57%	3,074	119,579
Jul 2022 - Jun 2023	2.53%	3,044	120,334
Aug 2022 - Jul 2023	2.48%	2,998	121,129
Sep 2022 - Aug 2023	2.41%	2,939	121,798
Oct 2022 - Sep 2023	2.34%	2,859	122,303
Nov 2022 - Oct 2023	2.30%	2,827	123,088
Dec 2022 - Nov 2023	2.23%	2,754	123,660
Jan 2023 - Dec 2023	2.14%	2,648	123,684
Feb 2023 - Jan 2024	2.05%	2,544	124,039

Figure 44: *Crude Mortality Rate across West Yorkshire Acute Trusts*

Crude Mortality Rate 12-month rolling	BTHFT	Harrogate & District	Airedale	Leeds Teaching Hospitals	Calderdale & Huddersfield	Mid Yorkshire Hospitals
Mar 2022 - Feb 2023	2.63%	3.34%	3.04%	3.74%	3.49%	3.65%
Apr 2022 - Mar 2023	2.59%	3.30%	2.95%	3.68%	3.44%	3.63%
May 2022 - Apr 2023	2.60%	3.18%	3.00%	3.70%	3.46%	3.61%
Jun 2022 - May 2023	2.57%	3.02%	2.96%	3.60%	3.39%	3.54%
Jul 2022 - Jun 2023	2.53%	2.86%	2.86%	3.55%	3.32%	3.49%
Aug 2022 - Jul 2023	2.48%	2.73%	2.76%	3.46%	3.26%	3.42%
Sep 2022 - Aug 2023	2.41%	2.62%	2.71%	3.35%	3.20%	3.40%
Oct 2022 - Sep 2023	2.34%	2.52%	2.64%	3.29%	3.17%	3.34%
Nov 2022 - Oct 2023	2.30%	2.41%	2.60%	3.21%	3.13%	3.28%
Dec 2022 - Nov 2023	2.23%	2.30%	2.56%	3.08%	3.06%	3.20%
Jan 2023 - Dec 2023	2.14%	2.19%	2.48%	2.95%	2.99%	3.10%
Feb 2023 - Jan 2024	2.05%	2.08%	2.34%	2.81%	2.89%	2.94%

Figure 45: *Crude Mortality Rate (12 month rolling: Mar 2022 – Jan 24) across West Yorkshire Acute Trusts*



The chart (at figure 45) shows the Trust's crude mortality rate performance in relation to all other acute hospital trusts within West Yorkshire.

3.1.5 PATIENT EXPERIENCE

The Patient Experience team receive complaints, PALS and compliments into the organisation and support the CSUs in responding to concerns.

The number of complaints as shown in figure 46 has increased overall to date in comparison to the previous year. Many complaints are now resolved through face-to-face meetings with complainants. Arranging to meet with complainants has led to a timelier investigation/response.

Figure 46: *Complaints Comparison between 2022/23 and 2023/24.*

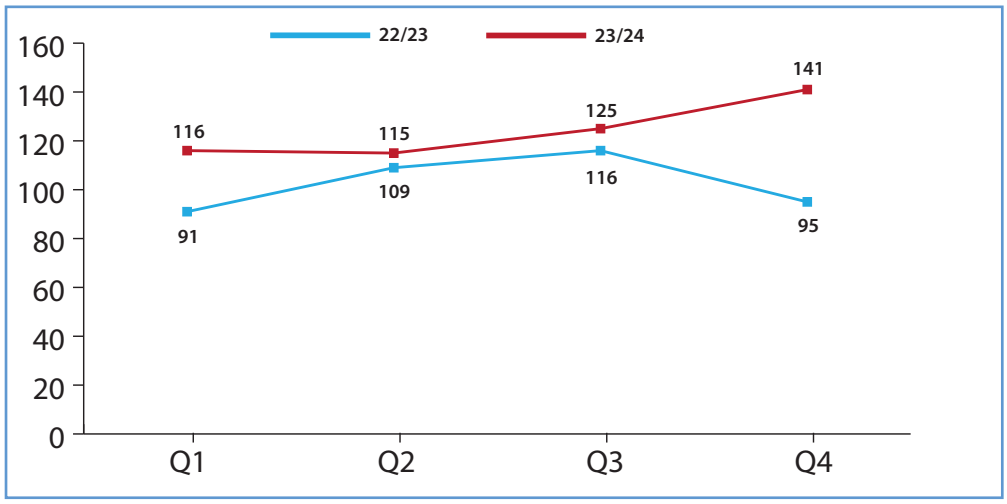
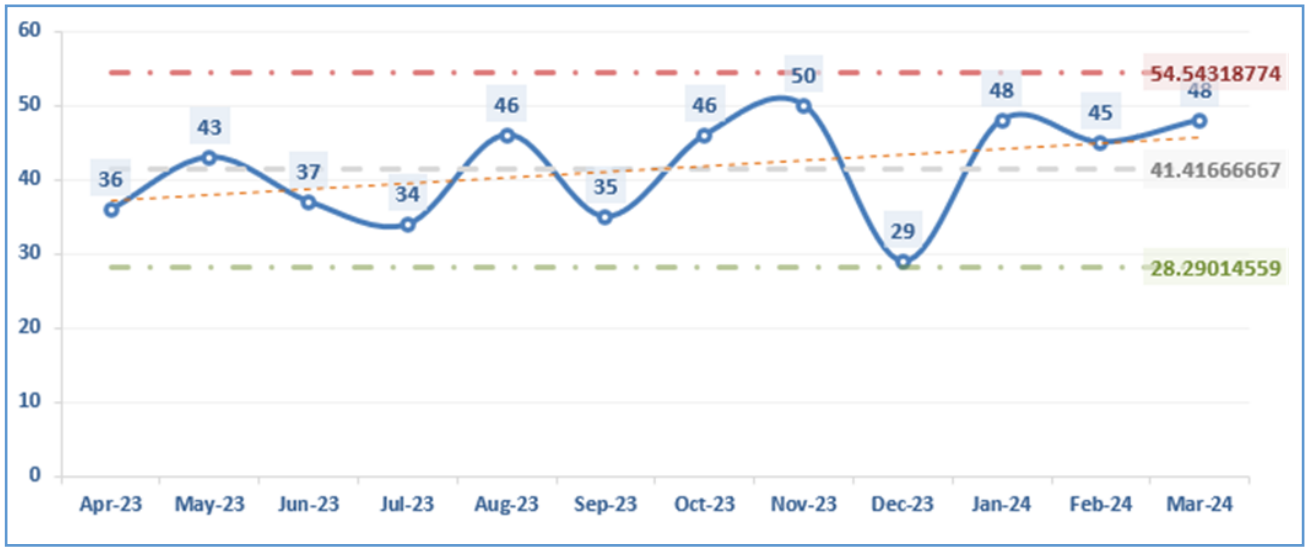


Figure 47: *Annual complaints against the actual upper and lower limited against the calculated fields based on the averages.*



- The red and green lines in figure 47 show the upper and lower control limits (these are calculated fields based on the actuals)
- The blue lines are the actuals e.g., the number of complaints.
- The grey line is the average of the actuals.
- The orange dotted line is the trend (again, based on the actuals)

Peaks above the average are evident in the second two quarters of the year except for December. This coincides with winter months where services are at their busiest. There is often a reduced number of complaints in December around Christmas.

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

Chapter 4
ANNEXES

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

4.1.1 STATEMENT FROM NHS BRADFORD DISTRICT AND CRAVEN HEALTH AND CARE PARTNERSHIP

Bradford District and Craven Health and Care Partnership

ACTasONE

NHS West Yorkshire Integrated Care Board

1 Bolton Road
Bradford
BD1 4AS

13 June 2024

Bradford Teaching Hospitals Quality Accounts 2023/2024

On behalf of NHS Bradford District and Craven Health and Care Partnership West Yorkshire Integrated Care Board (WYICB), I welcome the opportunity to feedback to Bradford Teaching Hospitals on its 2023/2024 Quality Report.

The Quality Account has been shared with key members across the Bradford District and Craven Health and Care Partnership and this response is on behalf of the organisation.

I acknowledge and congratulate the Trust's achievements for 2023/24:

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

Improving the management of the deteriorating patient was achieved by:

- Continued alignment to the National Patient Safety Improvement programme for Managing Deterioration Safety to reduce risk associated harm
- Continued use of the 'patient deterioration tile', with increased educational and training support for staff
- Progress with the 'Hospital at Night' pilot, with increased staffing support agreed

- The implementation of the Night Safety Huddle and includes professionals from a number of departments, which has taken place every night since starting.
- Being part of the 'NHS England 'Worries and Concerns' Improvement Collaborative, with positive outcomes for patient and carer experience, staff well-being and inclusion of patients with protected characteristics.

Implementing Saving Lives Care Bundle version 3 was achieved by:

- Continued embedding of the 'Outstanding Maternity Services' Programme
- Reducing stillbirths, which will be a continued commitment into the next year
- Continued to implementation and maintenance of initiatives to reduce inequalities, which included access to emergency food bags, hosting a warm coat rail over the winter months, and several initiatives to improve communication for women accessing the services.

Improving patient experience by advancing equality, diversity, and inclusion was achieved by:

- The Patient Experience and Engagement Strategy 2023-2028 was implemented with a focus on 'kindness' to support a culture of improving experience.
- The Spiritual, Pastoral and Religious care (SPaRC) service carried out over 30,000 visits, worked collaboratively with patients and their families, supported patients at their end of life, supported patients in A+E recognising the complexity and difficulty the busy environment can be for people, delivered training, and have received local and national recognition and awards for their Ramadan Allies Project.
- The development of the Additional Needs team, which includes specialist practitioners in learning disabilities, dementia and mental health care. This has included the development and modernisation of the Red VIP bag for patients with LD in conjunction with the LD community team and improved dementia awareness through training and carer recognition.
- Numerous patient and public involvement projects have taken place to improve facilities and services and ensure they are inclusive to the local community and continued community engagement and inclusion.
- The Relatives Line which was set up during the pandemic has continued as it was recognised that this facility reduced ward staff's potential time away from care delivery and supported family members effectively.
- Interpreting services have joined the patient experience and involvement team and this has enabled co-working and development of patient and family enhancing services and has included the introduction of CardMedic, an app based translation service, with over 49 languages available.
- Completion of CQC surveys, resulting in development plans led by the Lead Nurse for Patient Experience.
- Improved access and availability of patient leaflets, provided in a number of languages to meet need.

- Review and improvement of numerous processes within the Bereavement services to improve patient and relatives experience, including information and process review and development. It is noted that the work was recognised by Bradford District and Craven health and Partnership Awards (Celebrate as One), and the team were highly recommended for the work in Bereavement services.
- It is commendable that this improvement work for bereavement services will continue into the next financial year, with the noted projects underway.
- The Equality and Diversity Council continued to focus on advancing progress on workforce equality and diversity related matters, and this included the Trust's approach to tackling health inequalities.
- Equality, Diversity and Inclusion - The EDI strategy was launched and had clear objectives to reduce health inequalities and has strong executive leadership, Engagement in the Equality Delivery System was positive with the Trust scoring as 'achieving' in the three domains, Staff Equality Networks continue, EDI training offer has improved and the staff engagement survey highlighted an improvement in EDI.
- The 'Respect, Civility and Resolution' policy has been reviewed and updated and is expected to be finalised for launch in May 2024.

Implementation of the Patient Safety Response Framework was achieved by:

- Planned transition to PSIRF, and development of the PSIRP with the official launch taking place in December, 2023
- 94 staff have been trained in safety event investigation, Patient safety partners have been successfully recruited and the successful transition from the National Reporting and Learning System (NRLS) to the new Learn from Patient Safety Events platform (LFPSE) with reporting live into the LFPSE platform from 17 January 2024 in line with national contract.

Additional Improvements:

- The Dementia Strategy has been reviewed and will be relaunched in 2024.
- During 1 April 2023 to 31 March 2024, the Trust was eligible for and participated in 59 out of 74 national clinical audits within the National Clinical Audit and Patient Outcomes Programme.
- The Trust was a National outlier for Epilepsy Nurse Specialist input for children; National target 77%, Bradford achieved 95%
- A quality improvement plan was developed following anonymous feedback on dementia care, which included securing immediate support for patients with dementia to ensure effective person centred care
- Continued involvement in a plethora of research opportunities including a number included in the 'Born in Bradford' programme.
- Receipt of a number of grants from the National Institute of Health Research to support learning for older adults.

- Involvement in three research projects aimed at patient safety and experience initiatives.
- Successful recruitment initiatives and drive
- Learning from deaths additional scrutiny has identified good care examples and some improvements required; these have been acknowledged
- All CQUIN targets were met.
- The Trust employs 12 Freedom to Speak up Ambassadors and the Guardian for Safe Working Hours supports staff safety and well-being.
- The Friends and Family Test results highlights an increase in satisfaction
- An improvement in assessment for patients at risk of Venous Thromboembolism events, thus reducing incidence and continued focus on improving pressure ulcer prevention through quality improvement methodology, training and education and implementation of evidence-based patient care
- A decrease in falls

I acknowledge that The Care Quality Commission (CQC) undertook an unannounced inspection of medical inpatient areas on the 12 March 2024, which also included an inspection of your pharmacy services. The Well Led aspect of the inspection took place between 16 April and 18 April 2024. I also acknowledge that an unannounced inspection of the Maternity and Neo-Natal Services took place on 15 and 16 May 2024, and note that the Trust is awaiting the final outcomes of all inspections.

2024/2025 Quality Account Priorities

I recognise that to sustain and embed quality improvement the quality priorities for the next year remain largely unchanged and I am in agreement with your selected Quality Priorities for 2024/2025:

1. Improving the management of deteriorating patients including the implementation of Martha's Rule
2. Implementing the 3-year plan for maternity and neonatal services based on the Ockenden review and Saving Babies Lives
3. Understanding and tackling health inequalities
4. Embedding the Trusts Patient Safety Incident Response Plan including the development of metrics to demonstrate its effectiveness

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

Finally, I am required to confirm that NHS Bradford Districts and Craven Health Care Partnership, West Yorkshire Integrated Care Board (WYICB) has reviewed the Quality Account and believe that the information published provides a fair and accurate representation of Bradford Teaching Hospitals quality initiatives and activities over the last year.

I would like to thank you and your staff for the achievements made in 2023/2024 and your continued commitment to high quality care delivery, despite the exceptional challenges that you have faced this year. The Quality Account demonstrates a high level of commitment to quality in the broadest sense and I support the positive approach taken by the Trust.

Yours sincerely

Nancy O'Neill
Director of Partnerships and Place
Bradford District Health and Care Partnership

4.1.2
STATEMENT FROM HEALTHWATCH BRADFORD AND DISTRICT

Healthwatch Bradford and District welcomes this opportunity to comment on the Bradford Teaching Hospitals Foundation Trust Quality Report for 2023/24.

As the independent champion for people using health and care services, we welcome the work and commitment of the Trust in ensuring the voices of patients and service users are heard. Once again we recognise the commitment to the continued delivery of excellent services for the citizens of Bradford.

We also recognise the challenges that industrial action by nurses and junior doctors has had on service delivery of care as well as the challenging financial circumstances faced by the Trust and the wider Integrated Care System.

We continue to maintain a close and effective working relationship with colleagues at all levels across the Trust. We particularly value the regular meetings with the Deputy Chief Nurse for Patient Experience and their team. The commitment of the Trust to improving patient experience is considerable, and has resulted in a number of 'quick wins', as well as more lengthy service improvements and changes to service delivery. Healthwatch Bradford & District look forward to continuing this relationship and working together on specific projects to evaluate and improve patient experience.

Healthwatch are particularly pleased to have seen numerous changes to services that put patients, and their carers' at the heart of decision making. These include involvement in the NHS England 'Worries and Concerns' Improvement Collaborative and the multiple improvements within maternity services, both demonstrating an embedded and ongoing commitment to listen and improve.

The use of 'Experts by Experience' to improve inclusivity in all areas including facilities, communication and clinical service delivery has been transformational and we commend the Trust for this approach whilst hoping to see similar initiatives to support other marginalised groups.

In addition to our direct work with Trust colleagues we influence Trust work via our membership of key strategic Boards and Committees across the wider system where policy and patient experience is robustly challenged. We look forward to working with the Trust and partners to continually improve services to patients and to see the workforce thriving in a supportive and successful environment.

It has been a pleasure to work directly with key Trust personnel to provide support and challenge to both strategy and delivery.

Helen Rushworth
Chief Executive

June 2024

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

Bradford Metropolitan District Council (BMDC) Health and Social Care Overview and Scrutiny Committee (HSCOSC) has advised the Trust that it has opted not to provide comments on the 2023/24 Quality Account on this occasion.

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

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

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

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

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

By order of the Board,

Sarah Jones
Chair
June 2024

Professor Mel Pickup
Chief Executive Officer
June 2024