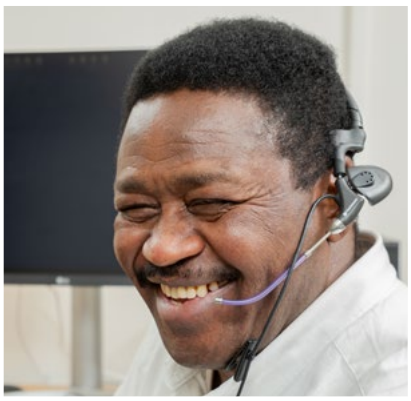
NHS

Bradford Teaching Hospitals

NHS Foundation Trust

Quality Account

2024/25



Contents

Chapter 1

STATEMENT OF QUALITY FROM THE CHIEF EXECUTIVE

I am delighted to present the Quality Account for the year 2024/25 as Chief Executive of Bradford Teaching Hospitals NHS Foundation Trust (BTHFT).[1] 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 our 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 by 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.

Our successes are built on respect, integrity, and collaboration.

Our achievements and Highlights from 2024/25

Neonatal Services[2] rated as outstanding[3] by the Care Quality Commission

Our Neonatal Unit[4] which provides specialist care to newborn babies who need additional support achieved an 'outstanding' rating from the Care Quality Commission (CQC).

The CQC found the service was 'performing exceptionally well', was 'exceptionally caring' and families felt valued and part of the team caring for their baby. This rating is testament to the hard work and dedication of all our staff who work on the Neonatal Unit. The unit provides a unique and specialist service to babies, mothers and families at what is often an extremely worrying and emotional time. We are very proud that the CQC found the team to be committed to treating patients and those close to them with compassion and kindness. Every colleague on the unit has helped in developing a culture of quality that is embedded in our work every day and reflects our aim of delivering outstanding care for patients. The service includes a Neonatal Intensive Care Unit (NICU), one of only four NICUs in the Yorkshire and Humber region which cares for some of the sickest and most premature babies. While our outstanding Neonatal rating and improvements in other services are great news for patients, colleagues and communities, this is not about standing still. There will always be areas we need to focus on to improve service users and carers' experience of our services and we will work tirelessly to do this.

1 *https://www.bradfordhospitals.nhs.uk/*

2 *https://www.youtube.com/watch?v=UeLe7rKQ4mg*

3 *https://www.cqc.org.uk/press-release/cqc-publishes-reports-services-run-bradford-teaching-hospitals-nhs-foundation-trust*

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

Improvement & Collaboration

'Martha's Rule'[5]

As we continued to build on our previous work with NHS England to implement Martha's Rule, our Quality Improvement team along with clinical colleagues were commended at the Health Service Journal 'Patient Safety Awards' in September 2024, receiving a high commendation for "Early-Stage Patient Safety Innovation of the Year." This was for the work we have been doing to develop a 'Patient Wellness Questionnaire' to support patients and their families to raise concerns.

Additionally, our improvement team have supported over 18 organisations, shared resources via the NHS Futures IT platform, and contributed to the regional learning community.

We are also working in collaboration with the Yorkshire Quality and Safety Research Group to support the evaluation of this work to understand how Martha's Rule is experienced and utilised by people from different backgrounds and with different characteristics. This will help inform future policy and ensure inclusivity by engaging diverse communities.

Our partner organisation, Bradford Institute for Health Research [6], based at Bradford Royal Infirmary continues to be one of the leading centres for health research in the UK. This year we recruited 18,988 patients to research trials in 2024/25, making our Trust the 4th highest recruiting NHS site in the UK.

Staff Engagement & Development

We saw a 7% rise in our response rate (50%) in the 2024 NHS Staff Survey: surpassing national averages in 8 of the 9 People Promise themes.

Some of the key improvements that we have identified to support our staff in realising their potential are:

- Quality appraisals and career development.
- Creation of a BTHFT People Forum for staff networking.
- National Equality Diversion and Inclusion (EDI)/Health Inequalities Conference, inclusive management training, new Respect, Civility and Resolution policy.
- Promotion of flexible working via updated policies.

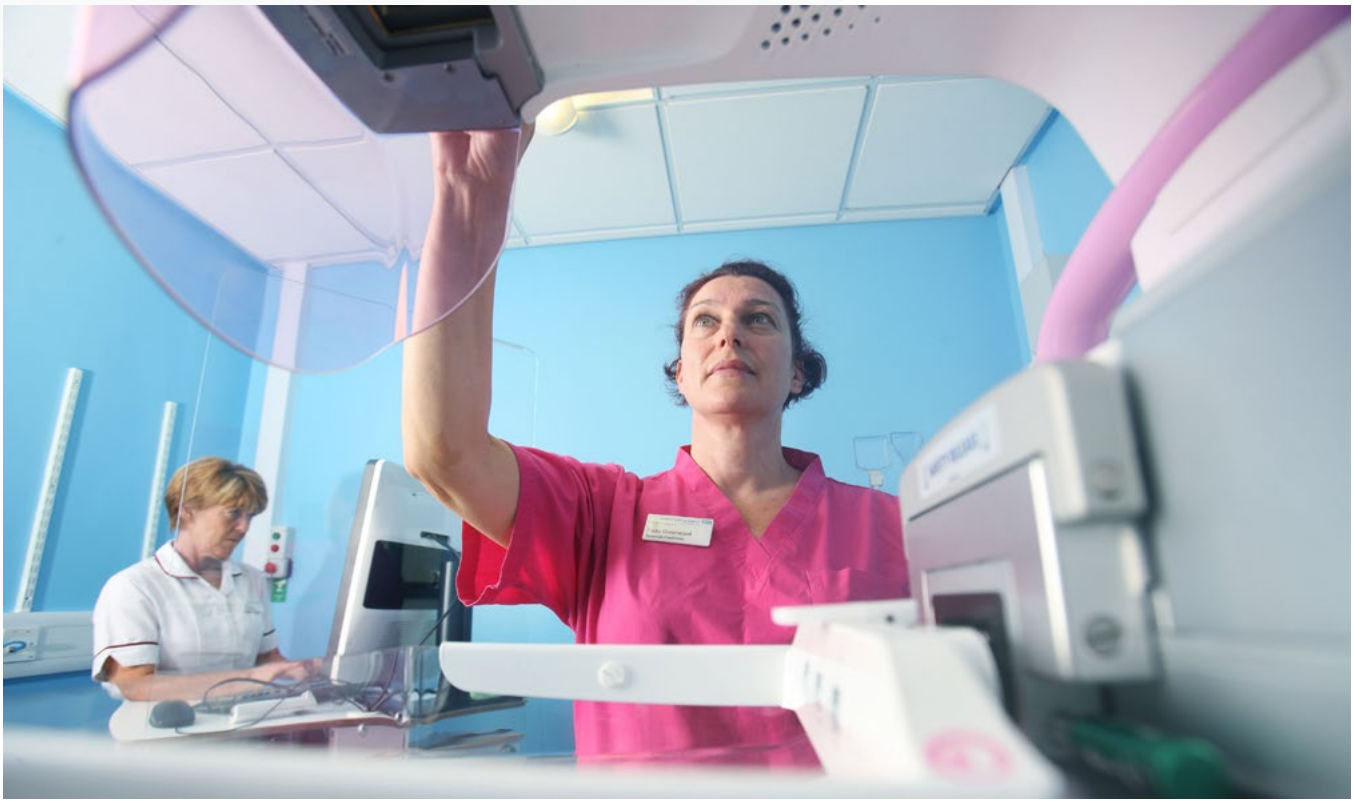
Patient Experience & Service Improvements

We have continued to increase our opportunities to work with patients and service users[7] as collaborators in improving services.

5 *https://www.england.nhs.uk/patient-safety/marthas-rule/#:~:text=About%20Martha's%20Rule,and%20advertised%20across%20the%20hospital*

6 *https://bradfordresearch.nhs.uk/*

7 *https://www.bradfordhospitals.nhs.uk/patient-stories-and-patient-public-involvement/*



Breast Screening

We recognised from the national screening report that our Bradford District take-up rate was second to the bottom in the country at 58%. Work was undertaken to understand why patients were not taking up the offer of a breast screening appointment and what were the potential barriers for this low uptake.

As a result, we have developed a short video/ animation[8] and amended our approach to corresponding with patients to make sure it is patient friendly and easy to understand.

Rheumatology Advice Line

We have implemented a more responsive service to patients wanting to contact Rheumatology services. This involved a new online option to enable patients to request a call back from the nurse or book an appointment or obtain information. The Rheumatology team recently received an award in the category of Efficiency of NHS services at the Health Service Journal Partnership Awards for this innovative work.

National Inpatient Survey

We have identified several initiatives to enhance patient experience following the results of our national in-patient survey. These include, the introduction of an information technology application CardMedic[9] to support translation and accessibility as well as an online patient information leaflet service, Eido[10].

8 *https://youtu.be/XB3R2xRm4qs?si=fXrfxw5Vh77paMCH*

9 *https://nhsaccelerator.com/innovation/cardmedic/*

10 *https://www.bradfordhospitals.nhs.uk/patients-and-visitors/patient-information/#tools*

Spiritual, Pastoral and Religious Care (SPaRC)

Our SPARC team[11] continue to go from strength to strength. They have:

- delivered a staggering 39,722 visits across our services in 2024–25.
- Extended presence in our Emergency Department and expanding to ICU (Intensive care units)
- Developed a SPaRC WebApp with global faith resources and life scenarios.
- Supported festivals and celebrations (e.g., Vaisakhi[12] with over 1,000 staff attendees).
- Working with volunteers and community groups to extend support.

Voluntary Services

We have significantly increased our volunteers service[13] by redesigning our recruitment and induction processes. This has resulted in 177 active volunteers with 102 more in the pipeline. We also created a Volunteer Coordinator role which has enabled us to extend our reach and integration across all departments and services.

Additional Needs & Inclusive Care

We have formed an Additional Needs Team to focus on access rather than safeguarding. This has enabled us to provide a more tailored service for our patients as well as support staff to undertake the first tier of the Oliver McGowan training [14]. The Care navigator role was also recognised at the HSJ awards in 2024.

11 https://www.bradfordhospitals.nhs.uk/sparc/

12 https://www.sikhnet.com/news/vaisakhi-biggest-sikh-celebration

13 https://www.bradfordhospitals.nhs.uk/our-people/volunteering/

14 https://www.hee.nhs.uk/our-work/learning-disability/current-projects/oliver-mcgowan-mandatory-training-learning-disability-autism

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:

1. Building on our previous work to improve the management of the deteriorating patient we will fully implement all 3 components of Matha's Rule[15] to all adult in-patient wards.
   a. **Component 1:** Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way
   b. **Component 2:** All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.
   c. **Component 3:** This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.
2. Building on our success in implementing Saving Babies Lives[16] will continue to make improvements in our maternity and neonatal services with a focus on reducing health inequalities.
3. We will continue to develop and embed our approach to patient safety and clinical governance by implementing fully the recommendations from our internal audit reports relating to risk management and patient safety.

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 communities.

Thank you for taking the time to read our Quality Account. Your feedback is invaluable in helping us to further improve our services and you can share this with us here [17].

Professor Mel Pickup
Chief Executive Officer
June 2025

15 https://www.england.nhs.uk/patient-safety/marthas-rule/#:~:text=About%20Martha's%20Rule,and%20advertised%20across%20the%20hospital

16 https://www.england.nhs.uk/publication/saving-babies-lives-version-three/

17 https://www.bradfordhospitals.nhs.uk/patients-and-visitors/compliments-concerns-complaints/

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 550,000 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.

We employ over 6,500 members of staff who work over several sites, including Bradford Royal Infirmary, which provides most inpatient services, and St Luke's Hospital, which predominantly provides outpatient and rehabilitation services. We also provide a range of services from community sites at Westbourne Green, Westwood Park, Eccleshill, Skipton and the Bradford Macula Centre.

As a teaching hospital, we are at the forefront of education and development in healthcare, and have an excellent reputation for research performance.

The Bradford Institute for Health Research (BIHR), based at Bradford Royal Infirmary, is one of the leading centres for clinical and applied health research in the UK. Our people-powered research has built a City of Research that fosters innovation and cutting-edge science.

The Bradford Education & Training Centre at Bradford Royal Infirmary is dedicated to educating, training and developing our current and future workforce. We have modern and well equipped teaching facilities to enhance learning, including a simulation centre, technical skills laboratories and practical skills laboratories.

As a continually learning organisation 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[18]

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 2024/25.

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 2024/25.
- **Part 2** describes our priorities for improvement for 2025/26, the rationale, our progress in 2024/25 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 2024/25 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.

18 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

The Trust's quality priorities are assigned to the appropriate committee of the Board where regular reports are received from the leads providing updates and progress. The granularity of the priorities is addressed at the relevant working group. Progress against key metrics is monitored at the Quality Committee, a sub-committee of the Board.

The Trust identified four quality priorities to focus on during the last year:

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.

Following engagement and feedback from key stakeholders we have agreed the following priorities for 2025/26.

1. Building on our previous work to improve the management of the deteriorating patient we will fully implement all 3 components of Matha's Rule to all adult in-patient wards.

   Component 1: Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way

   Component 2: All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.

   Component 3: This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.

2. Building on our success in implementing Saving Babies Lives will continue to make improvements in our maternity and neonatal services with a focus on reducing health inequalities.
3. We will continue develop and embed our approach to patient safety and clinical governance by implementing fully the recommendations from our internal audit reports relating to risk management and patient safety.

Our core vision continues to be a leading centre for healthcare driven by excellence in patient experience, research, teaching and education. Our overall ambition is to become one of the top university teaching hospitals in the UK.

We want everyone who works at our Trust to share this vision and place quality at the heart of everything we do by embracing and demonstrating the following Trust values of 'We Care, We Value People, We are one Team'. Our Trust is supporting this vision via several initiatives through our overarching strategic objectives, supported by strategies in patient experience, cultural improvement and workforce.

2.1.1 PROGRESS AGAINST THE 2024/25 PRIORITIES

Priority 1

Improving the management of deteriorating patients including the implementation of Martha's Rule

This priority continues to be a focus of improvement efforts for our 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.

The Secretary of State for Health and Social Care and NHS England are committed to implementing 'Martha's Rule' to ensure the concerns of the patient and those who know the patient best are listened to and acted upon. The three components to Martha's Rule are: (December 2024)

Component 1: Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.

Component 2: All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.

Component 3: This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.

Our Trust was part of NHS England's Phase 1 pilot conducted from May 2024 to March 2025, building upon the work our Trust implemented as part of NHS England's 'Worries and Concerns Improvement Collaborative' [19]. The original aim of the pilot set out by NHS England was for all Phase 1 sites to test and implement all three components of Martha's Rule in all appropriate settings by the end of March 2025.

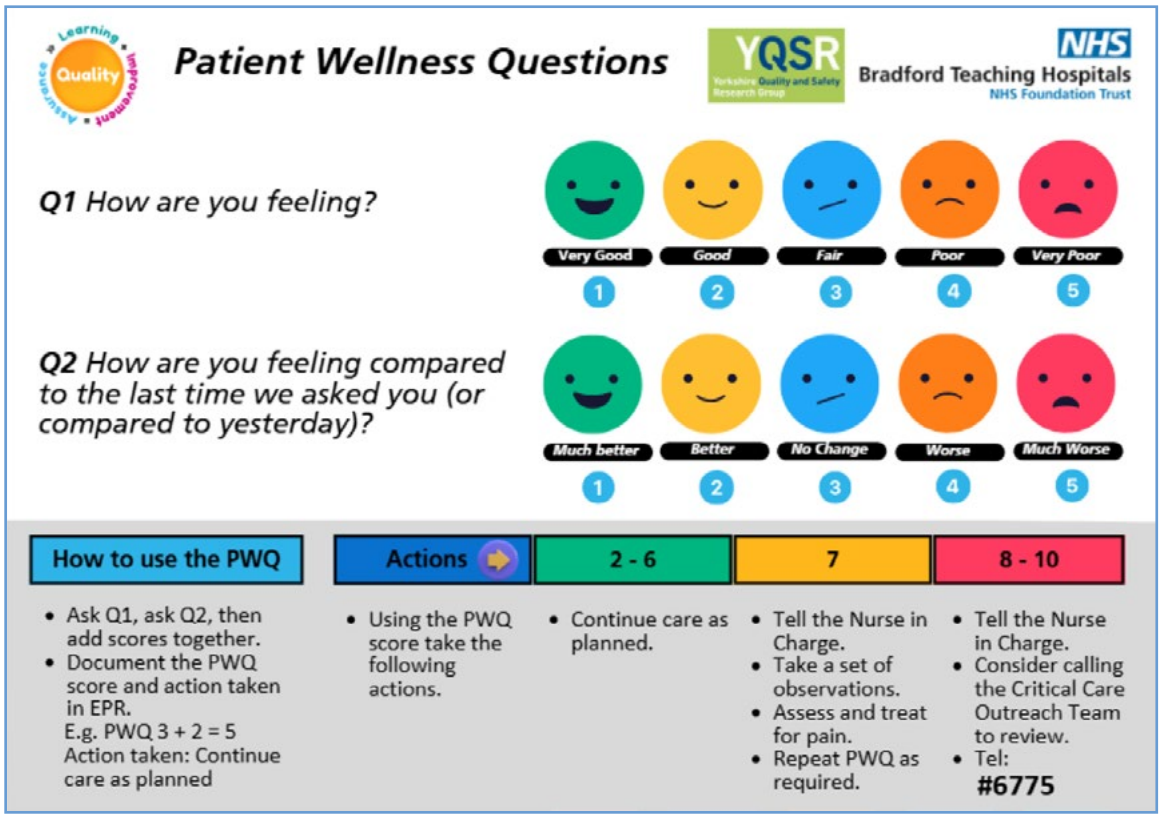
However, this year has been described as a 'learning year' by NHS England as the challenge of the scope and scale of the changes was recognised. NHS England's ambition for the reporting period (2025/26) is to continue to build and embed all three components over the coming year.

The standardised and branded communication package for patients and families, was released in early April 2025, which will now be used to inform the information and escalation approach to support the implementation of the third component.

19 https://www.england.nhs.uk/patient-safety/patient-safety-improvement-programmes/#:~:text=From%20April%202024%20the%20programme,pilots%20and%20began%20in%202023.

We have taken a robust improvement approach, which has been evident in the PDSA cycles (Plan, Do Study Act) [20]. We have taken the learning from the 'study' phase of these cycles taking an iterative approach to adapting the tool for use on adult ward areas. We have also amended our measurement plan to make data analysis feasible and we are currently adapting the tool and process for use in our paediatric in-patient ward setting. We are currently using the 'Patient Wellness Questionnaire' on 17 wards at our Bradford Royal Infirmary site with good evidence that this is being used at least once in 24hours, which is the NHS England target.

Figure 1: *Patient Wellness Questionnaire v3.0 following PDSA (plan, do, study, act) cycles*



During this phase of implementation there were a total of 23 calls made by ward staff asking for a Critical Care Outreach review between September 2024 to March 2025. Most reviews resulted in advice from the team. The key theme was pain management. This has been built into the latest iteration of the Patient Wellness Questionnaire using a prompt to ask healthcare professionals to assess and treat any pain. One patient was admitted to ICU based upon early detection of deterioration using the Patient Wellness Questionnaire and subsequent NEWS2[21] scores.

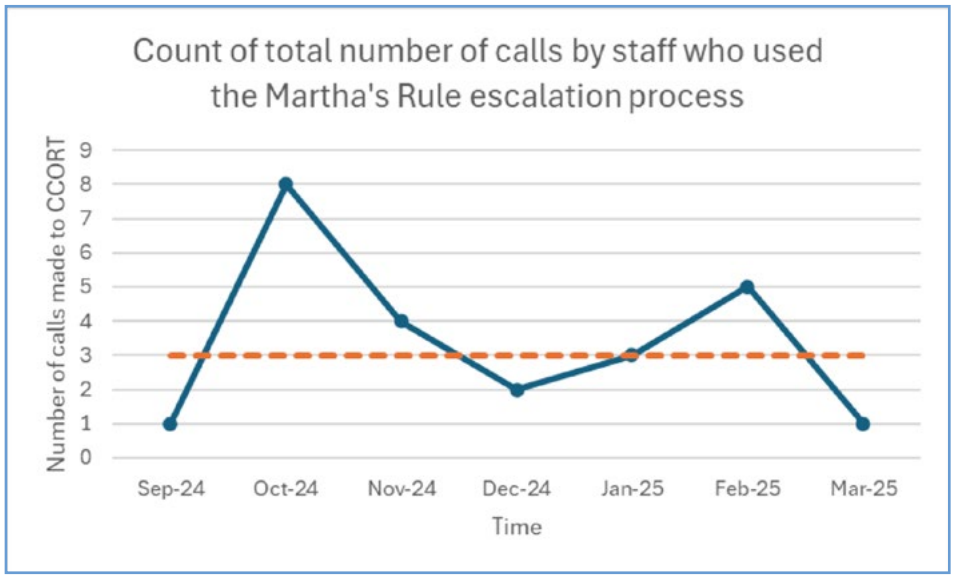
20 Plan, Do Study Act (PDSA) is a method of evaluation that allows you to test the impact of an initiative and continuously learn from your experiences, whilst improving your approach.

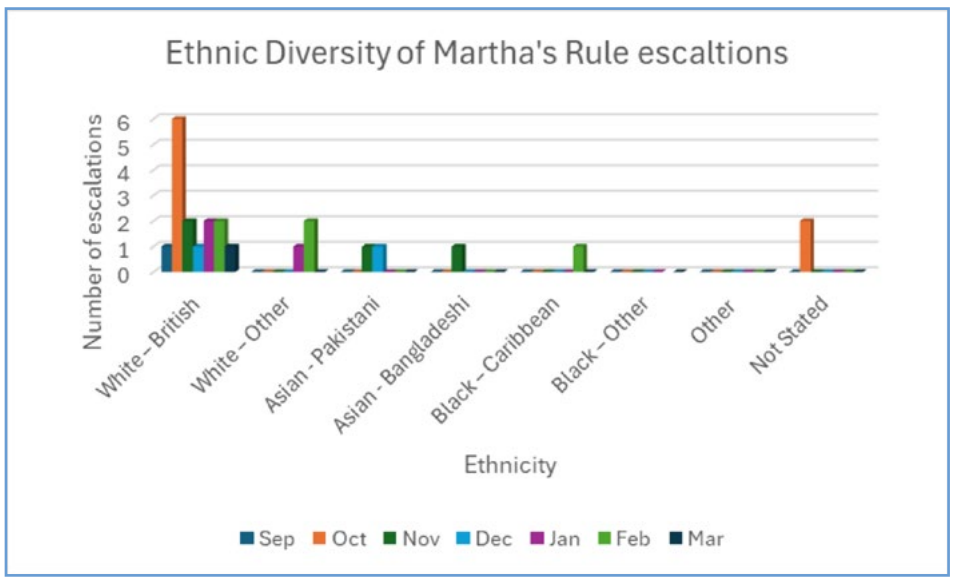
21 NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. NEWS2 has been endorsed by NHS England for use in acute and ambulance settings.

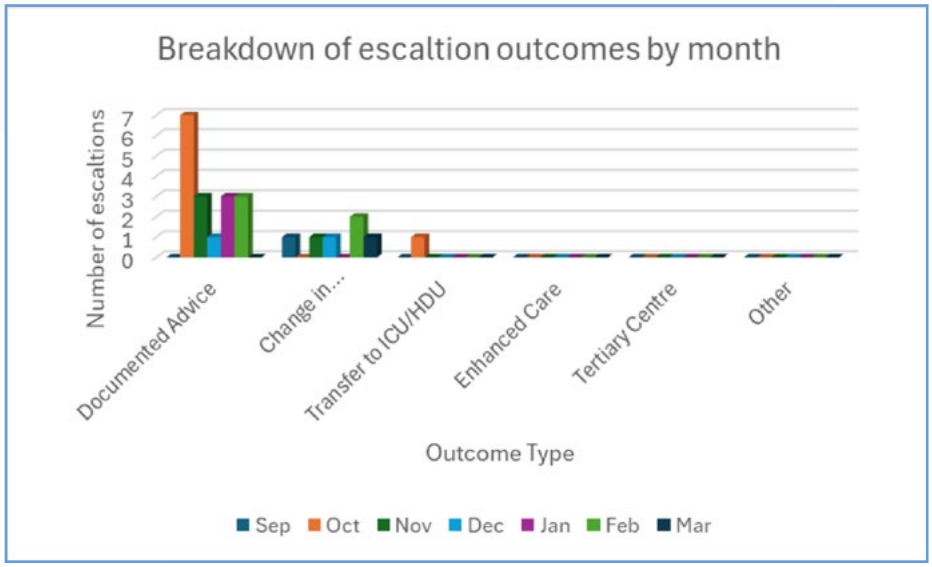
Feedback from staff and patients indicate that this is a useful tool to provide a metric for soft signs of deterioration and provides a structured approach to a conversation about how people are feeling.

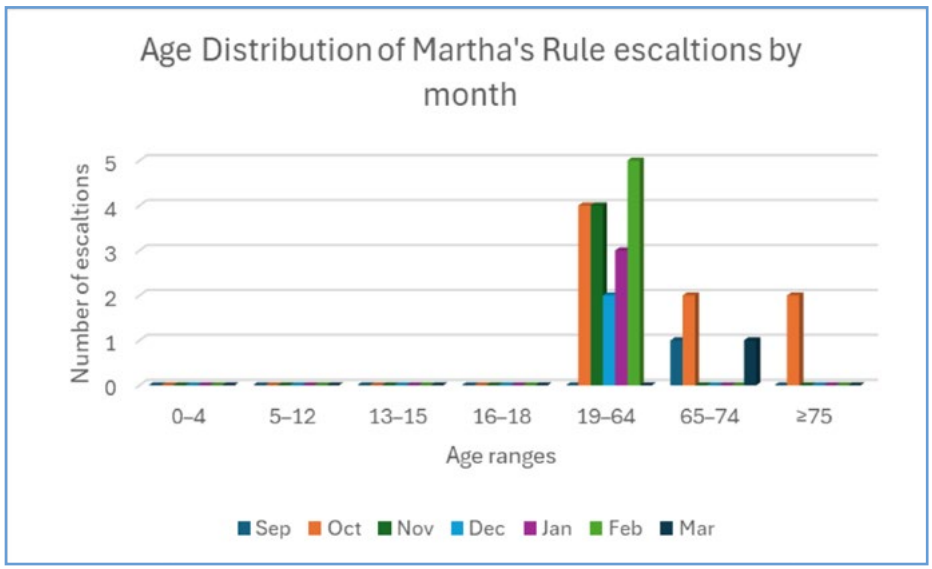
The measurement plan for the implementation also includes demographic data to ensure health inequalities and accessing the tool are monitored and reflect our patient population. The following five graphs at figure 2 show various metrics reflecting escalation data September 2024 to March 2025

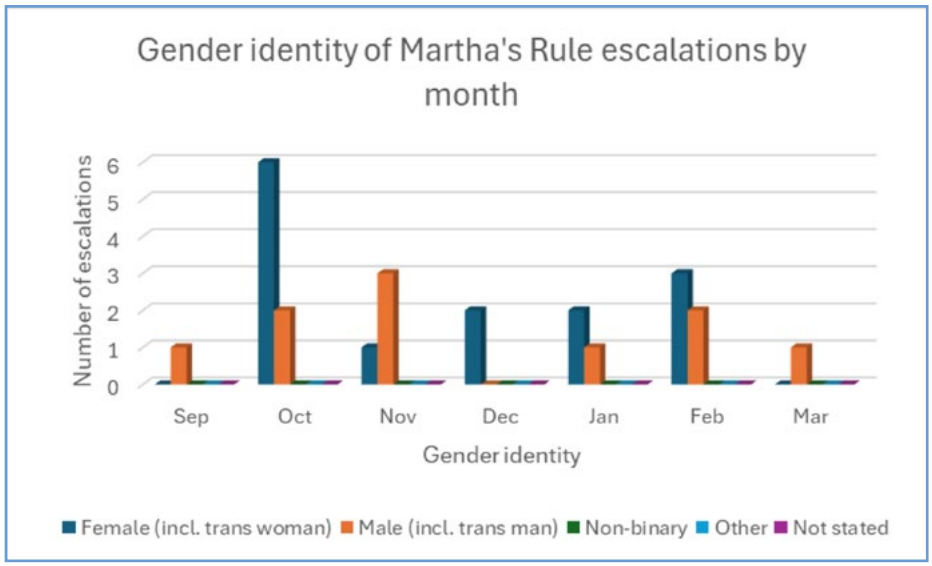
Figure 2: *Escalation data September 2024 to March 2025*






Breakdown of escaltion outcomes by month
Number of escaltions
0
1
2
3
4
5
6
7
Documented Advice
Change in...
Transfer to ICU/HDU
Enhanced Care
Tertiary Centre
Other
Outcome Type
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Age Distribution of Martha's Rule escaltions by month
Number of escaltions
0
1
2
3
4
5
0–4
5–12
13–15
16–18
19–64
65–74
≥75
Age ranges
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Gender identity of Martha's Rule escalations by month
Number of escalations
0
1
2
3
4
5
6
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Gender identity
Female (incl. trans woman)
Male (incl. trans man)
Non-binary
Other
Not stated

Our core improvement team have also provided support and learning to 18 organisations, shared resources openly on the NHS Futures[22] platform in the spirit of collaboration and, contributed to the regional learning community hosted by the Improvement Academy [23]. We are also collaborating with the Yorkshire Patient Safety Research Group[24] and the University of Bradford with some preliminary evaluation of the Patient Wellness Questionnaire as a predictive tool of deterioration as part of work from the national team at NHS England. We also received a high commendation award from the Health Service Journal Patient Safety Award for 'Early-Stage Patient Safety Innovation of the year'[25]

Figure 3: *Clinical Staff attending the Health Service Journal Patient Safety awards ceremony on 16 September 2024*

The second year (25/26) will focus on completing the implementation and ensuring sustainability. Emphasis will be placed on the final component, engaging with patients, local communities, and the public whilst considering the impact on health inequalities.

We are looking forward to bringing our teams together and exploring how we can collaborate to support each other in achieving this.

22 *https://future.nhs.uk/*

23 *https://improvementacademy.org/about-us/*

24 *https://yqsr.org/*

25 *https://awards.patientsafetycongress.co.uk/award-category/early-stage-patient-safety-innovation-year*

Priority 2

Implementing the 3-year plan for maternity and neonatal services based on the 'Ockenden review' and 'Saving Babies Lives'

Saving Babies Lives Care Bundle Version 3[26] was launched in 2023 and the service has met the Year 6 Maternity Incentive Scheme standard[27] and making good progress towards full implementation. External scrutiny on progress with implementation is monitored by the West Yorkshire and Harrogate Local Maternity and Neonatal System[28] on a quarterly basis. Following full implementation, 25/26 will focus on ensuring that the care bundle is fully embedded and monitored in line with the Maternity Incentive Scheme Year 7[29] recommendations.

Our quarterly review meetings with the Local Maternity and Neonatal System will continue during 25/26, focusing on compliance and areas for shared learning. Updates from the review meetings, including risks and any Board level support required, are discussed at our Trust's bi-monthly perinatal safety champion meetings, and included in the monthly perinatal update paper presented to the Quality Committee.

We have had a continued focus on, and commitment to, reducing stillbirths during 24/25, which will remain a key focus and priority during 25/26.

During 24/25, our 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.

Our collaboration with Bradford Metropolitan Food Bank is firmly embedded, enabling Community Midwives and service users to access emergency food bags from the Women's and Newborn Unit.

The Women's and Newborn unit hosted a 'warm coat rail' over the winter months for a second year running which has been extremely well accessed and offered a free school uniform rail during the summer months.

26 https://www.england.nhs.uk/wp-content/uploads/2023/05/PRN00614-Saving-babies-lives-version-three-a-care-bundle-for-reducing-perinatal-mortality.pdf

27 https://resolution.nhs.uk/wp-content/uploads/2024/04/MIS-Year-6-guidance.pdf

28 https://www.wypartnership.co.uk/our-priorities/maternity

29 https://resolution.nhs.uk/wp-content/uploads/2025/04/MIS-Year-7-guidance.pdf

Three Year Delivery Plan for Maternity and Neonatal Services

Reducing stillbirths will continue to be a key priority for Maternity Services and sits alongside other priorities intended to reduce harm amongst women, birthing people, and their babies. These priorities are encapsulated within the March 2023, NHS England, 'Three Year Delivery Plan for Maternity and Neonatal Services' [30]. 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.

Our Maternity Service has benchmarked our position against the plan, and we have a local improvement plan to monitor progress, which is updated on a quarterly basis with progress / challenges reported to our Quality Committee and Board.

Our service has worked closely with the Maternity and Neonatal Voices Partnership leads, during 24/25, including co-production of the annual Maternity CQC Survey findings improvement plan. Our ambition for 25/26 is to improve the response rate of women and birthing people to include more representation from diverse communities.

Our Maternity and Neonatal Voices Partnership Lead is a core member at several key governance meetings including Perinatal Services Forum, Perinatal Safety Champion, and Perinatal Mortality Review Tool meetings, ensuring that the service user voice is heard at every level.

Strengthening the relationship with the Maternity and Neonatal Voices Partnership Lead and continued engagement with women and birthing people across our diverse communities, is a key focus for 25/26.

During 24/25, our Diverse Workforce Forum was established, intended to support Black, Brown and Minority Ethnic maternity colleagues, with opportunities for career development and progression. Our forum feeds into the Outstanding Maternity Services workforce work stream, and feeds into our Trust wide 'Race Equality Staff Inclusion Network'. The first year of the forum is being evaluated to assess the impact and agree its aims and objectives for 25/26.

30 https://www.england.nhs.uk/publication/three-year-delivery-plan-for-maternity-and-neonatal-services/

Priority 3

Understanding and tackling health inequalities

Over 24/25, we have made significant progress in strengthening our health inequalities programme. We have worked with partners in an increasingly larger number of initiatives and their input has been vital in shaping our health inequalities programme.

Our key achievements include:

- Facilitating a health inequalities focused Board Development Session which was well received by participants and helped to set a strategic direction for the health inequalities work at our Trust.
- Developing capability and knowledge within staff on health equity by integrating health inequalities modules into our staff induction, and promoting opportunities for staff development.
- We have launched key initiatives to provide equitable care for patients on the palliative care pathway and for trans/non-binary patients in Nuclear Medicine.
- We have carried out the NHS Providers Health Inequalities self-assessment allowing us to identify areas to improve resulting in the creation of our Health Equity Oversight Group.

Priority 4

Embedding the Trusts Patient Safety Incident Response Plan including the development of metrics to demonstrate its effectiveness.

Our Trust transitioned to the national Patient Safety Incident Framework in December 2023 publishing our Patient Safety Response Plan and policy at the same time.

Following engagement and feedback from key stakeholders we agreed the following priorities for Patient Safety Incident Investigations (PSII) for 24/25 as shown in figure 4.

Figure 4: *Priorities for Patient Safety Investigations for 24/25*

Patient safety Priority area (PSII)	How we will learn	How we will Improve
People (adults & children) admitted in a mental health crisis with medical or surgical needs.	Individual patient safety incident level we will use an After Action Review (AAR) approach. A thematic approach will look at all the AAR's to gather system- wide learning.	We will use our Quality Governance framework to monitor and manage learning generated from our PSII 1 and 2 We will use a range of improvement tools and technique
Safe Internal hospital movement of patients	Low and no harm - individual patient safety events we will use a local level investigation Moderate, harm and above - individual patient safety events multidisciplinary Team Review. A thematic approach will look at all the local investigation responses and MDT reviews to gather system wide learning.	We will collaborate with our local partner organisations across our system. We will use patient safety audit to monitor systems and processes to provide assurance of patient safety.
Emerging patient safety themes where learning and improvement can be gained	Locally led PSII	

Following an in-depth review of incidents with our stakeholders we identified 4 areas of improvement:

1. Pressure Ulcers
2. Patient Falls
3. Medicines Safety
4. Blood Transfusion

These four incident types have been thoroughly investigated in the past 4 years, and we understand the contributary factors. We have therefore taken an improvement approach, working with our clinical staff and other stakeholders to test out novel interventions to support learning and sustainable change.

This approach is underpinned by the PSIRF (Patient Safety Incident Response Framework [31]) aim of doing less but doing it better. This is described in figure 5 below.

31 https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/#:~:text=The%20Patient%20Safety%20Incident%20Response,learning%20and%20improving%20patient%20safety.

Figure 5: *Patient Safety Incident Themes*

Patient safety incident theme	Planned learning response	Service improvement work underway or planned
Pressure ulcers	Exploring everyday work - Observations in clinical areas - Conducting interviews with staff and patients Daily horizon scanning by the tissue viability team to identify new themes and trends. For category 2 and above pressure ulcers ward / department complete local after action review learning response tool.	Build a case for improvement plan managed through the Pressure Ulcer Improvement group reporting into the Patient Safety Group. Themes and trends reported into Safety Event Group weekly to identify need for a formal Patient Safety Review. Ward Level data used to inform local level improvement programmes which will report into the Pressure Ulcer Improvement group to inform insight involvement and improvement.
Falls	Exploring everyday work - Observations in clinical areas - Conducting interviews with staff and patients Daily horizon scanning by the falls lead to identify new themes. All falls ward / department completed hot debrief tool. Where further learning is identified an after action review learning response tool will be completed.	Build a case for improvement plan managed through the Falls Improvement group reporting into the Patient Safety Group Themes and trends reported into Safety Event Group weekly to identify need for a formal Patient Safety Review. Ward Level data used to inform local level improvement programmes which will report into the Falls Improvement group to inform insight involvement and improvement.
Medication Safety	Continued monitoring of patient safety incident records to determine any emerging risks/issues.	Build a case for improvement plan managed through the Medicines Safety group reporting into the Patient Safety Group Themes and trends reported into SEG weekly to identify need for a formal Patient Safety Review.
Blood Transfusion	Blood Transfusion Continued monitoring of patient safety incident records to determine any emerging risks/issues. Transfusion practitioner teamwork with areas with high safety events to establish the cause and work on an action plan	Review incident reporting data following the Scan for Safety Implementation Monthly reporting to the hospital transfusion team (HTT) meetings observing open incidents, progress and reviewing themes and trends.

Our 'INSIGHT' report has evolved over the last 12 months and is intended to bring data together related to claims, litigation, inquests and Care Quality Commission (CQC) enquiries and triangulate with our incident reports, PALS (patient advice and liaison enquiries) and complaints, for the purpose of learning, improvement and assurance. This is a step change in the way we triangulate the data we hold, to identify themes and trends as well as areas for improvement.

Trackers are in place to ensure that local incident investigations that do not meet the Patient Safety Incident Investigations priorities are completed within the timeframes stipulated within the Trusts policy and learning is disseminated appropriately.

A nationally approved Learning Response Review and Improvement Tool has been adopted to review the quality of our Patient Safety Incident Investigations and other learning responses. This tool will form the basis of a new panel review model which is being implemented from April 2025.

2.2. STATEMENT OF ASSURANCE FROM THE BOARD

2.2.1. REVIEW OF SERVICES

During 24/25 Bradford Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 38 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 24/25 and represents 100% of the total income generated from the provision of relevant services by Bradford Teaching Hospitals NHS Foundation Trust for 24/25.

2.2.2. PARTICIPATION IN CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

Our approach to quality is underpinned by a continuous cycle of learning and improvement to provide assurance to our patients, staff and Board that we are providing high quality care.

Clinical audit is a way that that allows services to identify good practice and positive patient outcomes, as well as areas for improvement. Our Trust has been developing better ways to support clinical teams with oversight of clinical audit activity and ways to monitor to ensure that care is being delivered in line with national standards and best practice.

The High Priority Clinical Audit Programme for 24/25 was informed by the NHS Standard Contract[32] requirements which include the National Clinical Audit and Patient Outcomes Programme[33] (NCAPOP) and any other relevant national programme within the NHS England Quality Accounts List [34].

During 1 April 2024 to 31 March 2025, out of 91 workstreams in the Quality Account List for 24/25 our Trust was eligible to participate in 37 clinical audits as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and 40 national clinical audits as part of the NHS Standard Contract. There were 14 programmes that our Trust did not participate in as these were related to services not provided by the Trust.

32 https://www.england.nhs.uk/nhs-standard-contract/

33 https://www.hqip.org.uk/national-programmes/

34 https://www.hqip.org.uk/national-programmes/quality-accounts/

The clinical audits within NCAPOP included:

1. Child Health Clinical Outcome Review Programme
2. Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People
3. Falls and Fragility Fracture Audit Programme (FFFAP)
   - Fracture Liaison Service Database (FLS_DB)
   - National Audit of Inpatient Falls
   - National Hip Fracture Database (NHFD)
4. Maternal, Newborn and Infant Clinical Outcome Review Programme
5. Medical and Surgical Clinical Outcome Review Programme
6. National Adult Diabetes Audit (NDA):
   - Diabetes Prevention Programme (DPP) Audit
   - National Diabetes Footcare Audit (NDFA)
   - National Diabetes Inpatient Safety Audit (NDISA)
   - National Pregnancy in Diabetes Audit (NPID)
   - Transition (Adolescents and Young Adults) and Young Type 2 Audit
   - Gestational Diabetes Audit
7. National Audit of Care at the End of Life (NACEL)
8. National Audit of Dementia (NAD)
9. National Cancer Audit Collaborating Centre (NATCAN):
   - National Audit of Metastatic Breast Cancer (NAoMe)
   - National Audit of Primary Breast Cancer (NAoPri)
   - National Bowel Cancer Audit (NBOCA)
   - National Kidney Cancer Audit (NKCA)
   - National Lung Cancer Audit (NLCA)
   - National Non-Hodgkin Lymphoma Audit (NNHLA)
   - National Oesophago-Gastric Cancer Audit (NOGCA)
   - National Ovarian Cancer Audit (NOCA)
   - National Pancreatic Cancer Audit (NPaCA)
   - National Prostate Cancer Audit (NPCA)
10. National Child Mortality Database (NCMD)
11. National Early Inflammatory Arthritis Audit (NEIAA)
12. National Emergency Laparotomy Audit (NELA)
13. National Maternity and Perinatal Audit (NMPA)
14. National Neonatal Audit Programme (NNAP)
15. National Paediatric Diabetes Audit (NPDA)
16. National Respiratory Audit Programme (NRAP)
    - COPD Secondary Care
    - Adult Asthma Secondary Care
    - Children and Young People's Asthma Secondary Care
17. National Vascular Registry (NVR)
18. Sentinel Stroke National Audit Programme (SSNAP)

Other national quality improvement programmes where our Trust was eligible to take part included:

1. BAUS Data & Audit Programme
2. Breast and Cosmetic Implant Registry
3. British Hernia Society Registry
4. Case mix programme
5. Emergency medicine QIPs
6. National Audit of Cardiac Rehabilitation
7. National Bariatric Surgery Registry
8. National Cardiac Arrest Audit (NCAA)
9. National Cardiac Audit Programme
10. National Comparative Audit of Blood Transfusion
11. National Joint Registry
12. National Ophthalmology Database (NOD)
13. National Perinatal Mortality Review Tool
14. Perioperative Quality Improvement Programme
15. Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS):
16. Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme
17. Society for Acute Medicine Benchmarking Audit (SAMBA)
18. UK Renal Registry Chronic Kidney Disease Audit
19. UK Renal Registry National Acute Kidney Injury Audit

We did not participate in all these improvement programmes.

The national confidential enquiries that our Trust was eligible to participate in during the reporting period of April 2024 to March 2025 were:

- Emergency non-elective surgery in children
- Blood Sodium (hyponatraemia & hypernatraemia)
- Acute Limb Ischaemia

The percentage of cases submitted for Emergency non-elective surgery in children was 50% (2/4 questionnaires completed), for Blood Sodium (hyponatraemia & hypernatraemia) 67% of cases submitted (4/6 questionnaires completed) and for Acute Limb Ischaemia 100% (3/3 questionnaires completed). The organisational questionnaire related to each study were all returned.

We reached 100% case ascertainment from one out of three studies during the reporting period. It is noted that this work relies heavily on clinician's time with competing priorities to deliver care and services and we have actively taken part in all three studies.

During 24/25 our Trust received outlier notices for the following as part of the national clinical audit programme.

- Positive outlier status alert: National Neonatal Audit Programme (NNAP)

July 2024: Confirmation received that Bradford Royal Infirmary has been identified as Outstanding for the audit measures:

  - Retinopathy of prematurity screening (92.9% compared to the national average of 78.4%)
  - Two-year follow-up (96.9% compared to the national average of 77.0%).

- Outlier Reports: ICNARC (Intensive Care National Audit & Research Centre)

December 2024: potential outlier alert.

The Trust Intensive Care Unit (ICU)/High Dependency Unit (HDU) for the period 1 January 2023 to 31 March 2024 was identified as an outlier, falling above the 99.8% predicted range for:

- Out-of-hours discharges to the ward (to delayed).

All cases (40 patients) were reviewed by clinical ICU staff who identified issues with flow and accessing downstream/stepdown beds in a timely manner. The response was completed and sent to the audit provider within the allotted time frame with no further action required.

- National Bowel Cancer Audit

October 2024: outlier notification received for the following standard:

- Adjusted 30-day unplanned readmission after major resection

Trust Result: 25.9% compared to National Result (E&W):11.0%.

All cases (19 patients) were reviewed. It was highlighted that 11 patients had unplanned attendances to the surgical assessment unit (SAU). All the patients were assessed and discharged directly home the same day. These attendances at SAU have been documented as readmissions which may not be the case in other organisations.

Our Trust has increased the capacity of specialist nurses with patient telephone follow up on discharge which will hopefully reduce the unplanned attendances whilst maintaining appropriate support for the patients.

- Adjusted 90-day mortality after major resection

Trust Result: 8.2% compared to National Result (E&W): 2.7%.

All cases were reviewed in this time period regarding the quality of care. No concerns were raised. The key reasons for patients undergoing major resections included, planned palliative resection, elective and emergency cases. It is recognised that this type of surgery is high risk, but is a joint patient and clinician decision made to undertake the surgery.

2.2.3. PARTICIPATION IN CLINICAL RESEARCH ACTIVITIES

In 24/25 our Trust continued to have an extensive programme of health care research.

The number of patients receiving relevant health services provided or subcontracted by our Trust in 24/25 that were recruited during that period to participate in research trials, approved by a research ethics committee, was 18,988. Our Trust was the 4th 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:

Born in Bradford (BiB) - Age of Wonder (AoW)

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 24 year we have recruited 25 schools, collected over 6000 questionnaire responses, over 1000 sets of physical health measurements, and over 100 blood samples.

We have also conducted 31 in-depth interviews, involved 43 young people in group discussions, and collected 54 creative expressions of participants' hopes, dreams, and fears for the future. Participants have used video, poetry, photography, drawing, painting, voice notes, written expressions, memes, screen recordings of video games, and music to share their creative expressions, which describe different aspects of their health and wellbeing.

Our end of school year celebration, BiB Wonderfest, saw over 150 parents, young people and community members come together at the Midland Hotel to celebrate the project; activities included an AoW documentary premiere, prize-giving, interactive stalls, and an AoW data gameshow. We also co-authored a paper with co-production group members; the paper describes the co-production of the AoW project and shares general reflections on co-production from peer researchers involved in co-producing AoW.

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.

Our researchers have analysed the data from our 24-month follow-up and the findings are promising, showing positive effects of the JU:MP Programme on children's levels of physical activity.

Better Start Bradford Innovation Hub (BSBIH)

BSBIH is a centre for research and evaluation working in partnership with Better Start Bradford Programme to develop the evidence base of what works to give children the best start in life.

The team has worked alongside both statutory, and voluntary and community sector stakeholders to develop a robust and pragmatic approach to integrating research and evaluation into practice. Using a range of methods, we are evaluating multiple early years interventions delivered to families with children aged 0-4 years in three wards of the district.

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

The second of the Born in Bradford family of birth cohorts - BiBBS (Born in Bradford's Better Start) successfully finished recruitment in July 2024 with 5,500 babies and their families included in the study. The successful recruitment to BiBBS is thanks to the support of midwives and maternity services at the BRI.

Following this success, the study team have recently been awarded a prestigious £multi-million Wellcome Discovery Award which will create insights on, and solutions to, the stark health and developmental inequalities experienced by many Bradford families.

Centre for Applied Education Research

Born in Bradford's Centre for Applied Education Research (CAER) remains committed to improving outcomes for children and young people through the power of science.

CAER have continued to coordinate a series of reports in collaboration with the Centre for Young Lives and the Child of the North initiative. In total, there are now 11 published reports, with the final report to be launched in March 2025. Over 2025 we will segue into producing corresponding "How to" guides for every report, explicitly stating how schools, paediatricians and local authorities can implement recommendation across their local areas. We have already engaged these stakeholders and are excited to partner on this.

Connected Bradford

Connected Bradford is a nationally trailblazing population digital repository that unites the whole of Bradford and Airedale health, education, social care, and environmental data for over 600,000 people within a secure and expansive research database.

Created through extensive engagement with patients and the public and building upon the foundation established by Born in Bradford, Connected Bradford holds significant promise to unlock the power of a data driven revolution. By maintaining strong ties with our partners and the public, we are able to understand their needs and leverage the power of linked anonymised data.

Bradford Genes & Health

This study 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.

We have extended our recruitment activities to Kirklees and Calderdale and Leeds and some parts of South Yorkshire, working closely with research partners across the West Yorkshire region, engaging with GP practices and community settings including Mosques. To date we have recruited over 5893 participants to the study.

BaBi network

The BaBi study aims to invite all pregnant women at a participating Trust to join. The study, supported by the NIHR Applied Research Collaboration Yorkshire & Humber aims to make use of routinely collected data from health, education, social care and other sources to build up a rich picture of families lives over time. This data can then be used to help us understand what helps to keep families happy and healthy.

In June, the BaBi Network recruited its 40,000th participant

Bradford Mental Health Collaboratory

Funded by a recent NIHR Programme Grant for Applied Research, the new Bradford Mental Health Collaboratory aims to establish a programme of interventional research to address the gap that currently exists in finding good quality evidence on the effectiveness of preventative interventions which tackle adolescent mental health. The programme will build on the substantial research infrastructure in Bradford, allowing for efficient evaluations.

Academic Unit for Ageing and Stroke Research

The Unit successfully won a new research grant (£879k) funded by National Institute for Health and Care Research. The project aims to investigate ethnicity-based inequalities in access to treatment for 'mini-stroke' (TIA).

The CHART trial started recruitment and aims to establish whether Comprehensive Geriatric Assessment (CGA) including a 12-week progressive rehabilitation programme (plus usual care) is a clinically and cost-effective intervention to sustain independence in Instrumental Activities of Daily Living (IADL) for older people with heart failure with preserved ejection fraction and frailty when compared with usual care alone.

The Nuffield Foundation has granted £892,518 to establish the Well-being in later life in Bradford cohort study Led by Professor Andrew Clegg and Dr Jamilla Hussain, the research team will explore factors that improve or reduce well-being for older people, focusing on frailty, care transitions, care needs, and care networks. Their findings will aim to help the NHS and social care to improve services to meet people's needs as they age.

The INCLUDE Study team within the Academic Unit for Ageing and Stroke Research have been amazed and overwhelmed (in a good way!) by the response to their survey exploring older people's digital engagement. Surveys were sent in Spring to people aged 65+ registered at two regional GP practices. Over 3000 responses have been received. These data will support development of a replicable identification system for digitally excluded older adults - the first part of the INCLUDE study.

A new research grant (NIHR Research for Patient Benefit Programme) to undertake qualitative exploration of older women and healthcare professional experiences to guide improvements in osteoporosis care started this year. The Women's Health Strategy for England highlights the lack of focus on older women's needs and experiences. Older women told us they felt unseen, unimportant, unheard and uninformed. They also felt bone/joint health and osteoporosis were important issues for women like them (aged 70+). Osteoporosis leads to around 180,000 fractures per year causing significant pain, disability and death. The related cost is estimated at £4.4 billion a year. Our aim is to develop strategies to improve osteoporosis care using insights from the experience of primary healthcare professionals and older women.

Yorkshire Quality and Safety Research Group

The YQSR group lead the national NIHR Policy Research Unit for patient safety.

One of our projects focuses on conducting a formative evaluation of Martha's Rule. The aim of this is to develop the evidence base and produce a set of recommendations for future research, policy and guidance for Trusts planning to implement the initiative. An important component of the work is to understand how Martha's Rule is experienced and utilised by people from different backgrounds and with different characteristics. To fully explore this, we have engaged with community groups and sought advice from our Martha's Rule Patient Advisory Group to understand how we best engage people with protected characteristics in the research.

Medicines management resources included in national GP toolkit

Important resources to support patients to manage their medicines, developed by the Quality and Safety research team, have been included in the new national GP Repeat Prescribing Toolkit. I Manage My Meds, available at www.imanagemymeds.org

In January 2025 we began a new five-year programme of research funded by NIHR Programme Grants for Applied Research. These grants support the development and large-scale evaluation of complex interventions in health services. Our grant titled 'Single and Safe Intervention for MEDication administration (SaSI-MEDs)' will develop and evaluate an intervention to de-implement unnecessary double-checking of medicines in hospital. We will be seeking hospital sites to work with us throughout this programme and we are excited to be able to work with the Trust to do this work. This work aligns with a programme of research we are leading on de-cluttering safely for safety.

NIHR Applied Research Collaboration Yorkshire and Humber

Influenced policy through our externally validated novel falls prediction model, eFalls. Using routinely collected primary care electronic health records (EHR), it predicts risk of emergency department attendance or hospitalisation with fall or fracture within 1 year. This predictive clinical tool received considerable media interest and support from the Health Minister and has been submitted to NICE for the forthcoming falls prevention guidelines.

Our work in the priority area of identifying solutions for Avoidable Hospital Admissions continued with a policy briefing and recommendations to the DHSC explaining the characteristics of winter admission demand. These findings identified variation in key management strategies such as utilisation of Same Day Emergency Care (SDEC), a key intervention highlighted in the NHSE Urgent and Emergency Care (UEC) Recovery Plan 23-24. As a result, national work is now underway to examine best SDEC practices in England, in collaboration with the Royal College of Emergency Medicine.

NIHR Commercial Research Delivery Centre Bradford and West Yorkshire

Following our successful award of almost £7million from the NIHR for the Bradford & West Yorkshire Commercial Research Delivery Centre (CRDC), work is well underway in operationalising this. Our launch event took place on 26th March 2025. Our CRDC is one of twenty CRDCs that have been established, beginning in April 2025 with £72million investment over 7 years. Part of NIHR Infrastructure, the CRDCs will enhance the speed and efficiency of commercial clinical research delivery.

Leading a 'hub and spoke' model, we will work with our partners Mid-Yorkshire Teaching NHS Trust and Calderdale and Huddersfield NHS Foundation Trust to:

- Build further capacity in commercial research
- Provide dedicated staff and facilities to conduct commercial research
- Making taking part in research as easy as possible by supporting activity in non-acute settings
- Increase research including to ensure people from all eligible communities, including those living with the greatest burden of disease, can participate in clinical trials.

Improvement Academy

Based within Bradford Institute for Health Research, the Improvement Academy undertakes implementation and improvement projects nationally, provides training across many areas, including Quality Improvement, Thematic Analysis, and Behaviour Change.

The Improvement Academy and the Assuring Autonomy International Programme (AAIP) at the University of York aiming to understand how Artificial Intelligence might be used in the real world with clinicians and patients. Different human-machine interaction models for shared decision-making in healthcare were tested and their ethical and legal implications considered. Data collection has almost completed, and we have started analysing the data.

The Yorkshire and Humber Secure Data Environment is an NHSE-led national programme to develop secure data environments to provide approved researchers with approved projects secure access to NHS data. Bradford Teaching Hospitals NHS Foundation Trust is one of 11 selected sites to host a regional secure data environment, and we are working with colleagues across Yorkshire and Humber to develop the SDE and make data available for research and to improve population health.

NIHR Research Support Service

NIHR | Research Support Service
Specialist Centre for Public Health

Delivered by Newcastle University and Partners

The NIHR is increasing investment in research that happens outside the NHS, for example research around the wider determinants of health including things like education, transport and air quality, housing and outdoor spaces. These areas generally fall within the remit of local government so the NIHR is supporting the development of research capacity and activity in local authorities. Part of the NIHR investment has included a new Specialist Centre for Public Health as part of the NIHR Research Support Service. The Centre was created in October 2023 and provides support for public health research outside the NHS with the aim of supporting high-quality research to inform policy and practice and improve public health and reduce inequalities.

The Centre has 3 satellites across England and Bradford Institute for Health Research is one of these. Our satellite provides specialist methodological support for epidemiological and quasi-experimental methods drawing on our significant experience in population research and cohort longitudinal studies. Read more at Research Support Service Specialist Centre for Public Health | NIHR

Mobile Research Vehicle

Funded by the NIHR capital funding scheme with additional funding from Bradford Hospitals Charity, (£190k in total) the BIHR team have commissioned the production of an electric Mobile Research Vehicle (MRV). It will allow researchers to access a more diverse range of participants and ensure that health research opportunities are open to everyone in all corners of the community. As well as being used to deliver research studies the MRV will be used to promote health research at festivals and charity events, shopping and sports centres, etc.

Production of the MRV is well underway and it is anticipated that it will be completed May/ June 2025.

2.2.4. COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

The Commissioning for Quality and Innovation (CQUIN) financial incentive 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.

The CQUIN programme was suspended for 24/25, however, the improvement work continued despite this and progress continues to support quality patient outcomes and continued improvement.

1. Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions. This has been incorporated into the work we are doing to fully implement Martha's Rule as described in section 2.1.
2. Compliance with timed diagnostic pathways for cancer services continues to be a priority for the Trust.

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 2024 to 31 March 2025.

2.2.6. CQC SPECIAL REVIEWS AND INVESTIGATIONS

The Trust last received a rated inspection on 12 March 2024. The Care Quality Commission (CQC) conducted an unannounced inspection of medical care services at Bradford Royal Infirmary and St Luke's Hospital. This included an inspection of our pharmacy services. Following this inspection, the services maintained an overall Good rating.

A further unannounced inspection of our Maternity and Neonatal Services was undertaken on 15 and 16 May 2024. We are pleased to report our Neonatal Services was rated as Outstanding. Maternity services received a rating of Requires Improvement. The inspection included assessment of the Well-led and Safe domains. The rating for the Safe domain remained good from the 2023 inspection and the Well-led was maintained as Good. Effective, responsive and Caring were not included in this inspection and therefore we were unable to receive a re-rating of the full service.

Figure 6 below shows the current rating by the five key domains and compares results to previous inspections:

Figure 6: *Care Quality Commission ratings for Bradford Teaching Hospitals NHS Foundation Trust*

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Neonatal Services	Good ↔ May 2024	Good ↔ May 2024	Outstanding ↑ May 2024	Good ↔ May 2024	Outstanding ↑ May 2024	Outstanding ↑ May 2024
Bradford Royal Infirmary (Medical Care)	Good ↔ Nov 2024	Requires Improvement ↔ Nov 2024	Good ↔ Nov 2024	Good ↔ Nov 2024	Good ↑ Nov 2024	Good ↑ Nov 2024
St Lukes Hospital (Medical Care)	Good ↔ Jan 2025	Good ↔ Jan 2025	Good ↔ Jan 2025	Good ↔ Jan 2025	Good ↔ Jan 2025	Good ↔ Jan 2025
Maternity	Good ↑ May 2024	Requires Improvement ↔ April 2020	Good ↔ April 2020	Requires Improvement ↔ April 2020	Good ↑ May 2024	Requires Improvement ↔ May 2024
Key	**Same**	**Up one rating**	**Up two ratings**	**Down one rating**	**Down two ratings**	
Symbol	↔	↑	↑↑	↓	↓↓	

The Well Led aspect of the inspection took place between 16 April and 18 April 2024. At the time of writing our Trust is awaiting the final outcomes of this inspection.

Recent inspections in Nuclear Medicine IRMER

The visit on 16 October 2024 was part of the Care Quality Commission (CQC) Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection of the Nuclear Medicine department at Bradford Royal Infirmary. The primary objective of this inspection was to assess the department's compliance with IR(ME)R regulations and their application in clinical practice.

During the inspection, the CQC inspectors conducted a thorough review of the department's documentation, performed walk-arounds to observe the facilities and operations, and engaged in focused discussions with staff. This proactive inspection was part of a regular programme and was not triggered by any specific incident.

Overall, the inspection yielded positive results, with no immediate concerns raised. The inspection report detailed three actions that needed to be addressed. These actions have since been implemented, and the inspection has been officially closed.

GIRFT (Getting it Right First Time) site visit for Interventional Radiology

On 24 January 2025, a GIRFT (Getting It Right First Time) Interventional Radiology site visit took place. The primary objective of this visit was to conduct a comprehensive review of the interventional radiology services, explore potential recruitment opportunities, and ensure the effective management of radiology and imaging services. The visit brought together a diverse group of stakeholders, including clinical leads, radiology managers, and consultants, who engaged in detailed discussions and evaluations.

Following the visit, a thorough report was generated, outlining several key recommendations aimed at enhancing the quality and efficiency of the interventional radiology services. These recommendations are currently being integrated into a strategic action plan to drive improvements and ensure the successful implementation of the proposed changes.

The Screening Quality Assurance Service inspection of Pennine Breast Unit (PBS)

The Screening Quality Assurance Service (SQAS) conducted an inspection on 4 March 2025, focusing on breast screening services. The primary objective of this inspection was to ensure that these services are delivered to the highest standards and are in full compliance with national guidelines. During the inspection, no immediate concerns were identified, indicating that the breast screening services are functioning well. The service is now awaiting the final report, which will provide a comprehensive evaluation and any recommendations for further improvements.

BSI (British Standards Institution) reaccreditation: Radiation Physics

The visit on 18 March 2025 was conducted to reassess compliance with BSI ISO 9001:15 standards. The service was successfully reaccredited. However, during the assessment, it was acknowledged that we have workforce challenges that can cause delays in the delivery of day-to-day services.

Haemoglobinopathy peer review

A peer review was undertaken by the UK Forum for Haemoglobin Disorders on the 1 May 2024 of the service we provide for children, young people, and adults with Haemoglobin disorders as a co-ordinating centre. Several areas of good practice were identified as well as areas for the Trust to consider as part of the delivery of this service. The Trust is working closely with local specialist commissioners and the local centre in Leeds to identify where pathways can be improved for our patients.

UKAS review of Pathology Services

A review of our Pathology services was undertaken on 3 March 2025. Several areas were identified for improvement across the service for which a comprehensive improvement plan has been developed.

West Yorkshire Critical Care Network (WYCCN) Peer Review of Critical Care service.

The BTHFT Critical Care service had a planned visit from the West Yorkshire Critical Care Network (WYCCN) Peer Review on 7 February 2025. The WYCCN peer review takes place every 3 years to review and assess the provider organisation processes and quality of care against national guidelines and standards. The Peer Review visit was positive and the final report has been received.

Anaesthesia Clinical Service Accreditation (ACSA)

A two day review of our anaesthetic services took place on 19 and 20 March 2025. This saw successful re-accreditation of our services. At the time of writing this report we are still awaiting the final report.

2.2.7. NHS NUMBER AND GENERAL MEDICAL PRACTICE CODE VALIDITY

During 2024/25 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 below. Compliance across all metrics is in line or better than our peers, with a number scoring 100% compliance. This has been achieved through focused data quality cleansing sprints and greater engagement with frontline/operational staff.

Figure 7: *Percentage of records which included the patient's valid NHS number/GP*

Record type	Area	2024/2025 April to November 2024	2023/24 April to November 2023	2022/23 April to November 2022	2021/22 April to November 2021
Patients' valid NHS number	Admitted patient care	**99.9%**	99.9%	99.9%	97.3%
	Outpatient care	**100%**	99.9%	99.9%	100%
	Emergency department care	**99.6%**	99.6%	99.6%	99.6%
Patients' valid general medical practice code	Admitted patient care	**100%**	87.1%	87.1	88%
	Outpatient care	**100%**	91.3%	91.3%	90.4
	Emergency department care	**100%**	98.9%	98.9%	98.8%

2.2.8. CAF (CYBER ASSESSMENT FRAMEWORK) ALIGNED DATA SECURITY AND PROTECTION TOOLKIT

The new CAF aligned DSPT contains five objective areas with a total of 47 outcomes that sit below.

Each objective area has a nationally set expectation (that is the level that Trusts are expected to meet this first assessment year), which is Achieved, Partially Achieved or Not Achieved. The Trust's assessment confirms how it is performing against each outcome. If it meets (or exceeds) the expectation for each objective area then the final position would be Standards Met.

Most outcomes sit with IT/Cyber. An initial meeting between the IG (Information Governance) Manager and the Cyber Security Manager (CSM) resulted in agreement the CSM would be point of contact for all Cyber and IT outcomes and he would liaise with the Head of IT and other colleagues and manage the collation/requirements. Regular meetings between the IG Manager and Business Owners, principally with the CSM, have taken place to provide assurance that the evidence complies with the expected outcomes. The Information Governance team has received updates from the CSM and other Owners and their assurances on evidence they have provided.

Progress has been good. A review of all available evidence to date has been completed at the time of this report. Some will require further final review, for example where statements confirm compliance but additional or the required supporting evidence is yet to be included or reviewed or where clarification is needed. All incomplete items are being progressed at pace and will be reviewed once they are complete.

Audit Yorkshire is undertaking its annual review of agreed objectives. The review started on 7 April 2025 and will close on the 23 April 2025. The draft report providing an audit opinion at this stage of the assessment is being considered.

In 23/24 the Trust achieved 'Standards Met', which means that all mandatory items have been evidenced by the time of final submission. The submission deadline for all organisations for the DSPT assessment for 24/25 is 30 June 2025.

Our final assessment overall position for 24/25 is therefore incomplete at the time of this report. The Trust forecast position is 'Standards Met' for 24/25, but as previously, this will be confirmed before submission on the 30 June 2025.

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 record, 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 20/21, 21/22, 22/23 or 23/24. 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 the continued assurance of data quality and compliance with the NHS Digital DSPT (Data Security and Protection Toolkit). 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 22/23 and the 23/24 audit took place in May-June 2024, in compliance with the DSPT submission dates in June. The 24/25 audit is similarly scheduled.

The audit sample of 221 finished consultant episodes (FCEs) was selected using random sampling methodology from spells of inpatient discharges between 1 April 2023 and 30 May 2024. All episodes were audited against the National Clinical Coding Standards[35] and local policies.

The error rates reported in the latest preliminary published audit for that period for diagnoses and treatment coding are shown in figure 8 below. 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 to incorrect code assignments at a block level due to inconsistencies with documentation, which will be addressed through monitored improvement plans. Other areas have shown consistency or improvement, likely due to the 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.

35 https://digital.nhs.uk/developer/guides-and-documentation/building-healthcare-software/clinical-coding-classifications-and-terminology

Figure 8: *Error rates reported in the latest preliminary published audit for diagnoses and treatment coding*

	Coding Field			
Percentage Incorrect	Primary diagnoses incorrect	Secondary diagnoses incorrect	Primary procedures incorrect	Secondary procedures incorrect
2023/24	210%	4.40%	7.10%	3.80%
2022/23	9%	4.20%	5.60%	5.70%
2021/22	7.70%	5.50%	9.90%	12.90%
2020/21	6.30%	7.80%	3.80%	6.80%
2019/20	5%	3.80%	8.30%	5.30%
2018/19	5.70%	6.30%	4.70%	2.10%
2017/18	8.60%	10.20%	8.10%	7.20%
2016/17	8.17%	9.20%	9.09%	14.79%
2015/16	5.50%	4.80%	9.10%	5.60%
2014/15	9%	9.47%	2%	8.02%
2013/14	8%	5.90%	0.70%	8.70%

The audit was undertaken by an NHS Digital approved clinical coding auditor and was compliant with all the 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

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.

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

It is particularly important for us to assure the quality and accuracy of elective waiting times and patient pathway data. We have a range of governance mechanisms in place to ensure that the data generated, collected and used, both internally and externally, is subject to an appropriate level of scrutiny, validation procedures and assurance processes. This includes an app that provides near real time waiting list validation for Access colleagues, service sign-off processes for mandatory reports and meaningful engagement with services in validation and development. We are applying Making Data Count[36] principles to board reports and an all-user, accessible Insights Centre by using clear, meaningful data visualisations, reducing reliance on tables and providing real-time insights to encourage ownership, engagement and informed decision-making across all levels of the organisation.

Priority data quality issues are monitored through a suite of exception reports and associated data issue tracking and resolution applications, which present anomalies to the operational teams for increased visibility and proactive 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 the Corporate Access Team, Informatics Business Intelligence, Informatics DQ, the Education and Training team and Clinical Informatics. This group reviews and agrees the 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 meets monthly to review maternity data completeness and reporting to ensure we are compliant with the national and regional requirements for data and improvements are made to improve patient safety and experience. A similar set of metrics and approach are in development following the TACC (Theatre Administration and Clinical Communications) EPR (Electronic Patient Record) solution go-live in November. Data quality drop-in sessions are available for administrative and clinical staff to raise issues and focus on priorities relating to error prevention, correction and validation at an operational level. Formal education and training programmes support the appropriate use of our key information systems for new starters (clinical and administrative) and refresher training is available for priority areas. The Business Intelligence Data Quality Improvement Team offers bespoke training support through drop-in sessions and one-to-one engagement workshops for operational staff focusing on areas for improvement.

2.2.11 LEARNING FROM DEATHS

During 24/25, a total of 1,438 patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 350 in the first quarter
- 302 in the second quarter
- 396 in the third quarter
- 390 in the fourth quarter

The Learning from Deaths process: scrutiny and structured judgement reviews

The Medical Examiner Service for the Trust was set up in November 2020 and reached full staffing establishment in January 2022. Since October 2021 the Medical Examiner Service has scrutinised 100% of all in-patient deaths.

36 https://www.england.nhs.uk/publication/making-data-count/

In September 2024, the Service became statutory nationwide and since then, the Service has also scrutinised 100% of all deaths within the community. Following scrutiny, the Medical Examiner 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. The process is described in figure 9 below.

Figure 9: *Structured Judgement Review Process*

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

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

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

By 31 March 2025, 73 SJRs had been carried out in relation to of the deaths during 24/25.

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

- 15 in the first quarter
- 23 in the second quarter
- 25 in the third quarter
- 10 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 24/25 are summarised in figure 10 below.

Figure 10: *Key learning points*

Celebrating excellence

- Significant improvements in the recognition and treatment of Learning Disability patients on Ward 23 – this had been a recurring issue raised during reviews in the previous year (2023/24).
- Ward 17 staff also demonstrating good understanding of LD patients' baselines with Red Bag & VIP passports at bedside.
- Parents heavily involved in treatment plan for adult LD patient.
- Patients brought in by YAS triaged in 20 mins despite exceptional pressures within the ED department.
- Throughout the winter this year, despite the pressures within ED, excellent patient care was delivered in ED despite patients experiencing some significant delays to ward admission. This included timely and thorough investigations undertaken by clinicians as well as regular observations and appropriate referrals.
- Patients with NEWS >5 receiving obs every 20 minutes.
- In half of the cases reviewed, nursing care was emphasised explicitly as being exceptional.
- Early recognition of end-of-life with very clear focus on comfort and pain relief.
- Multiple examples of clinicians working hard to fast-track end-of-life patients back into the community or preferred place of death. These patients were admitted with community DNACPR orders and/or ReSPECT forms in place and were recognised early in admission that they were approaching end-of-life.
- Numerous examples of good communication with family members, next-of-kin, carers and/or Nursing Home staff. This evidence was well documented in patient notes by junior members of staff.
- Staff thinking 'outside of the box' by sending a patient's children to the paediatric ward with support from bereavement while treating their critically ill parent.
- Arrest teams provided comprehensive care treating reversible causes and managing the needs of patients' families and carers. The team also ensured they supported each other after treating the patient.

Areas for improvement

- While an NG Tube was sited without concern in a LD patient, the patient's father had concerns around positioning. The tube was used against the father's wishes which led to the patient vomiting and the need for antibiotics which could have been avoided.
- Missed opportunity to have a patient seen by the Mental Health Service. This patient had expressed past suicidal ideation and was a repeated user of 'spice'.
- An example of a delayed response from doctors for a patient having a vasovagal episode.
- Consent 4 was used in a patient without any evidence of an MCA being performed.
- Earlier use of NIV in a patient Type 2 Respiratory Failure – in this case clinicians failed to recognise the patient was in type 2 failure.
- Non-verbal patients being described pain medication PRN – this is a recurring issue with our vulnerable patients and is forming one of the core learning points from an ongoing review into treatment of our patients with learning disabilities.
- Bilateral leg dressings noted but not examined to check as a possible source of sepsis.
- No daily INR performed in a patient who was new to warfarin post-operation – this led to a high INR that had to be reversed with Vitamin K.
- Prescribing and signing delays for critical medications.

In the period 24/25 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 a lack of recognition of just how unwell some deteriorating patients are with no escalation to senior clinicians – this case has been reviewed not only by MRIG but also the Recognition and Response to Acutely Unwell Patient Group (RRAUP) to ensure learning gains maximum dissemination.

MRIG identified that in several cases, non-verbal patients were being described pain medication PRN (as and when needed) – this is a recurring issue with our vulnerable patients and is forming one of the core learning points from an ongoing review into treatment of our patients with learning disabilities.

In one case reviewed, amylase testing was not requested at triage which would have led to earlier diagnosis of acute pancreatitis – this incident and it's learning has been collated into an educational learning bite document by ED staff around the presentation and management of acute pancreatitis.

Issues were found around a lack of piped oxygen in sections of some wards. Following further review at MRIG our Respiratory colleagues advised that there were issues trust-wide with piped oxygen in some areas and to liaise with Respiratory teams if HDU was possibly required. Since then, it has been confirmed that Ward 15 has been given capital funding to install piped oxygen on the ward.

A review found that a patient was referred to Lung MDT late at night and had their case reviewed the next day – numerous MRIG clinicians across specialties raised that the Lung MDT does exceptional work and is always open to referrals, regardless of when the case is referred - something that is not replicated in other Acute Trusts. The Associate Medical Director for Learning from Deaths and Chief Medical Officer contacted members of the Lung MDT to acknowledge this excellence.

Undertaken an extensive review of deaths that occurred in December 2024 in light of an increased number of adult inpatient mortalities. The review involved liaising with the Medical Examiner's Service at BTHFT to access Medical Certificates of Cause of Death (MCCDs) for patients who passed away in December 2024. This was to ascertain if there was any pattern in cause of death for patients in that month to explain the increased mortality. In addition, all SJR requests for December 2024 were expedited as a cluster review to determine if there was a cause for concern in the overall quality of care delivered to patients throughout December 2024. No cause for concern was found and all learning and potential improvements identified in the reviews has been escalated where appropriate.

The impact of the above actions has demonstrated the Trust's commitment to learning in line with National Guidance on Learning from Deaths [37].

There were 2 SJRs completed after 31st March 2024 which related to deaths which took place before the start of the reporting period:

- 0 for deaths occurring in the first quarter of 2023/24
- 1 for deaths occurring in the second quarter of 2023/24
- 0 for deaths occurring in the third quarter of 2023/24
- 1 for deaths occurring in the fourth quarter of 2023/24

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 2023/24
- 0 deaths representing 0.0% for the second quarter of 2023/24
- 0 deaths representing 0.0% for the third quarter of 2023/24
- 0 deaths representing 0.0% for the fourth quarter of 2023/24

2.2.12 STAFF WHO SPEAK UP (INCLUDING WHISTLEBLOWING)

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

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

37 https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

We have 24 FTSU Ambassadors across the Trust. They have a vital role in awareness raising to ensure that workers understand the importance of speaking up, listening up and following up. Their role includes signposting staff with details of speaking up routes as stated in the organisation's FTSU policy. They also promote a positive speaking up culture.

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.

When a FTSU concern is raised the FTSU guardian will seek consent to speak to someone senior in their team about their concerns. That person will investigate their concerns and provide feedback to the Guardian which is shared with the person who raised the concerns. 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 FTSU Guardian completes quarterly reports to the People Academy, Quality and safety committee and Trust board to provide assurance in relation to the conduct and outcome management of the FTSU arrangements in the Trust. The FTSU Guardian is expected to also report quarterly to the National Guardian's office the following information:

- The number of cases raised with the FTSU Guardian
- Those that are raised anonymously
- Those raised with an element of;
  - patient safety/quality
  - worker safety or wellbeing
  - bullying or harassment
  - other inappropriate attitudes and behaviours
- where people indicate that they are suffering disadvantageous and/or demeaning treatment because of speaking up
- brought by professional/worker groups
- where there was a response to the feedback questions
- themes from feedback and learning points

This data informs our understanding of the implementation, utilisation and development of the FTSU Guardian role and the trends and themes in speaking up. Here at BTHFT most of the concerns raised have an element of inappropriate attitudes and behaviours. See figure 11 for the number of FTSU concerns raised.

Figure 11: *Number of concerns raised in 2024/25*

Quarter 2024/2025	Number of concerns raised
Q1	22
Q2	36
Q3	27
Q4	37
Total	122

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 24/25 shows that the number of exception reports has increased by 155% with an associated increase in additional hours claimed for payment or time off in lieu of 210%.

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 16% with approximately 8% remaining unfilled.

One speciality within our 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 Resident Doctor Forum.

The Guardian of Safe Working Hours and the Director of Education continue to work closely with the resident 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. There have been successes in the expansion of self-rostering in ED and now Anaesthetics leading to increased levels of satisfaction for trainees and a reduction in rota gaps and locums.

2.2.14 EDUCATION AND TRAINING

This year (24/25) marked the successful conclusion of our existing Trust Education Plan 2019-2024, laying a solid foundation for the transition into a bold and forward-looking strategy for 2025–2030. This signifies a pivotal development in our approach to education, training, and workforce development.

The newly launched Education Strategy 2025-2030 is designed to build on the strengths of the previous plan while introducing a renewed focus on innovation, research, and adaptability. It presents a significant opportunity to enhance educational provision for our workforce, ensuring that training is not only current and responsive but also aligned with future healthcare demands and patient needs. At the heart of the strategy is a commitment to fostering innovation and embedding research as essential pillars of education and training.

Education and training encourage and welcome feedback of all kinds from learners, feedback is reviewed, collated and actions implemented showcasing our commitment to continuous improvement and enhancing quality. National feedback metrics examining learner's experiences at our Trust include the National Education and Training Survey (NETS) and General Medical Council (GMC) Training Survey. These are reviewed in conjunction with local and regional feedback metrics which feeds into our ability to benchmark the education and training we provide. Overall, our Trust remains in a strong position and provides positive learning opportunities and experiences.

General Medical Council Training Survey

In July 2024, the GMC released the full results of its annual survey on postgraduate medical training, completed by 77% of trainees at our Trust across various specialties. The report showed that aggregate scores fell within the middle quartile for all 18 indicators, with excellent feedback in Gastroenterology, Neonatal Medicine, Oral and Maxillo-Facial Surgery, Paediatrics Foundation Year (FY) 2, and Trauma and Orthopaedics. Significant improvements were noted since 2023 in Emergency Medicine FY2, Medicine FY2, and Plastic Surgery. However, there were notable negative outliers in Internal Medicine Stage 1, Obstetrics & Gynae FY2, Ophthalmology, and Surgery FY1, though Surgery FY1 displayed improvement compared to 2023. Persistent issues included workload concerns in Emergency Medicine FY2 and rota design and support in Surgery FY1, marking these areas as priorities for intervention. Our Trust is ranked 216th out of 230 UK Trusts for workload, highlighting the need for continued action.

National Education and Training Survey (NETS)

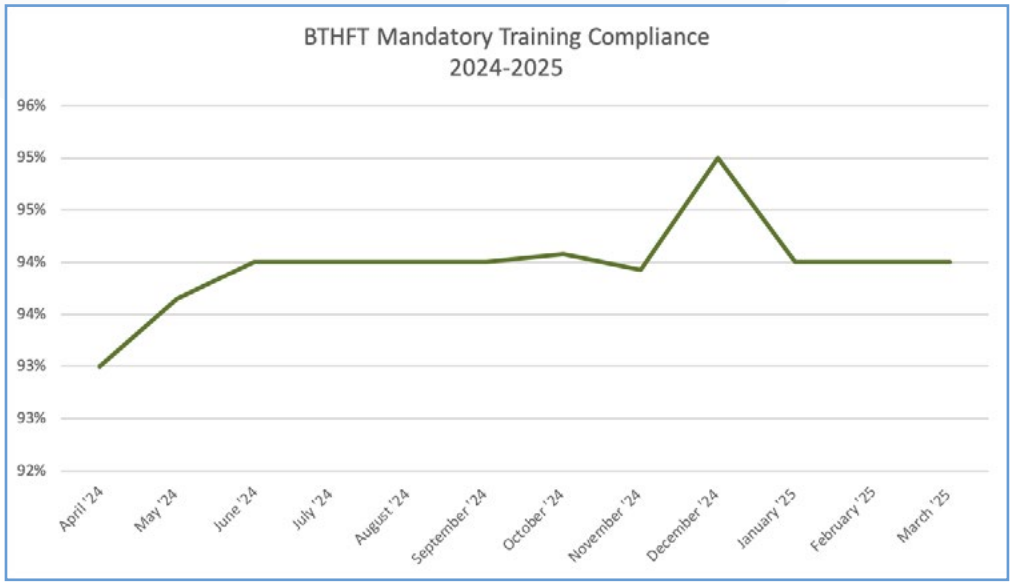
In March 2025, NHS England published the National Education and Training Survey (NETS), capturing feedback from 257 learners on placement at our Trust during October and November 2024. Representing 25% of eligible learners, with the majority being doctors in training. Five out of ten indicators showed improvement from the previous year, with our Trust achieving the highest scores in 11 out of 13 domains among West Yorkshire Association of Acute Trusts (WYAAT). Paediatrics and Anaesthetics stood out for their positive supervision and learning experience, whist Histopathology and Ophthalmology required action for improvement. As echoed in other surveys workload was identified as a concern. Results identify that actions to address bullying, discrimination, and sexual safety can be strengthened. The survey celebrated good practices and improvements but bolstered our commitment to address challenges to ensure a safe and inclusive environment for all learners.

Our Trust provides a high-quality learning experience for a wide variety of learner groups and this is showcased through feedback received.

Here at our Trust Undergraduate Medical Education training provision is benchmarked across all Trusts, and we averaged 89% which is 1% above the all-Trust average.

In 24/25 we have consistently maintained over 93% compliance with Mandatory and Statutory training as shown in figure 12 below.

Figure 12: *Compliance with Mandatory training.*



Our Trust has achieved the interim Preceptorship Quality Mark for our multi-professional preceptorship programme and is continuing to work towards national guidance for further development.

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 based on 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 period from February 2023 to December 2024 with 12 data points. Our current SHMI value was 116.37, a reduction on our SHMI at this point last year (SHMI was 119.24 at last report).

Throughout this year the Trust recognised our SHMI had been high. Following an in-depth review, it was recognised that further work was required to ensure that our coding was accurate and reflective of our complex patient population. A significant amount of work has been undertaken by our Business Intelligence Coding team to address our depth of coding as well as undertaking a retrospective exercise to address historic errors.

This work is ongoing but has already yielded significant results and positive changes to our SHMI throughout this reporting period.

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 13. SHMI score (12 month rolling: *Feb 2023 - Dec 2024): 116.37*

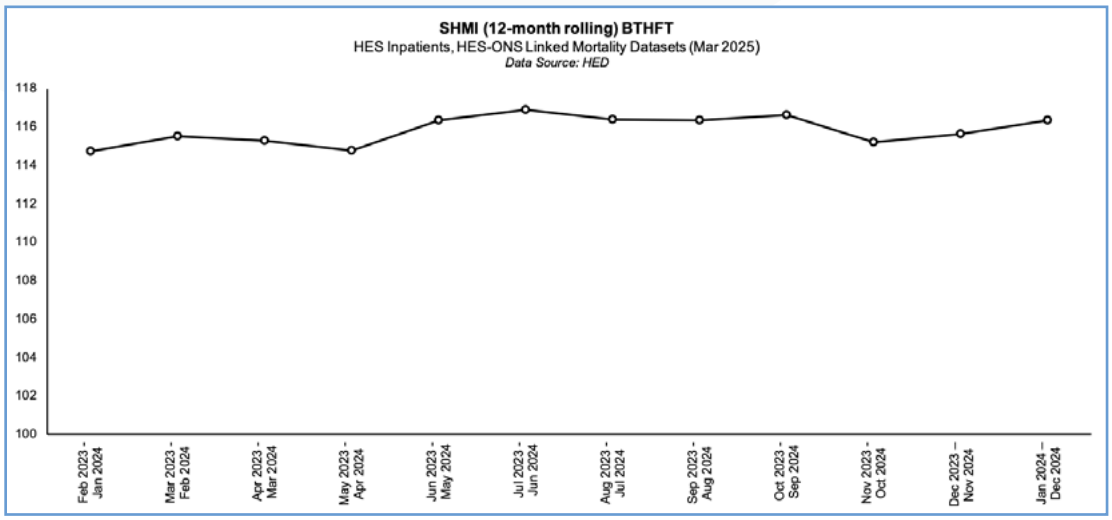


Figure 14. SHMI indicator values, discharges, observed deaths and expected deaths numbers

SHMI 12-month rolling	Indicator Value	Number of provider spells	Number of patients who died in hospital or within 30 days of discharge	Number of Expected Deaths
Feb 2023 - Jan 2024	114.73	81,434	1,826	1,591.60
Mar 2023 - Feb 2024	115.51	81,547	1,822	1,577.36
Apr 2023 - Mar 2024	115.28	81,275	1,791	1,553.57
May 2023 - Apr 2024	114.79	81,535	1,776	1,547.14
Jun 2023 - May 2024	116.36	81,247	1,791	1,539.21
Jul 2023 - Jun 2024	116.90	81,407	1,796	1,536.41
Aug 2023 - Jul 2024	116.41	81,475	1,792	1,539.40
Sep 2023 - Aug 2024	116.35	81,430	1,791	1,539.36
Oct 2023 - Sep 2024	116.63	81,081	1,790	1,534.75
Nov 2023 - Oct 2024	115.19	80,755	1,750	1,519.19
Dec 2023 – Nov 2024	115.64	80,252	1,755	1,517.61
Jan 2024 – Dec 2024	116.37	80,416	1,760	1,512.44

2.3.2 PATIENT REPORTED OUTCOME MEASURES (PROMS) / PATIENT REPORTED EXPERIENCE MEASURES (PREMS)

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

In 24/25 NHS England have published the Finalised Patient Reported Outcome Measures (PROMs) in England for the following reporting periods:

- April 2022 to March 2023
- April 2023 to March 2024

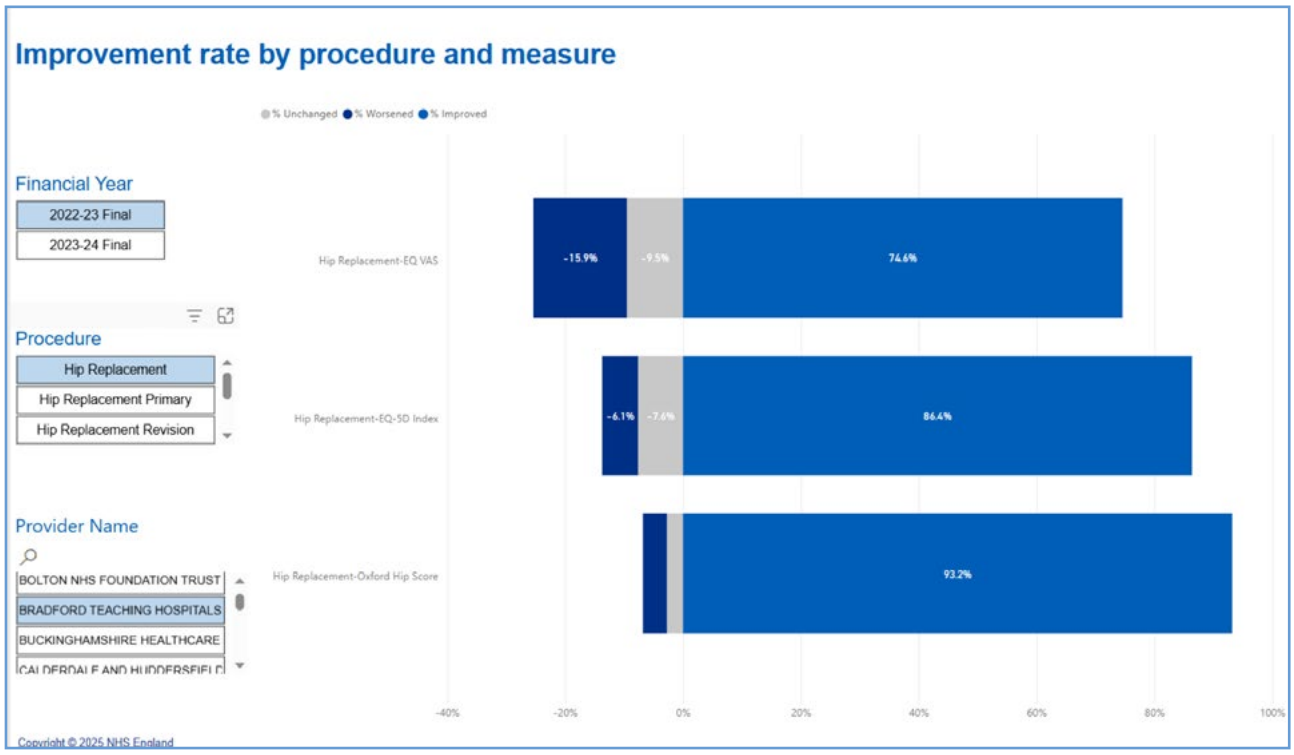
NHS England note that response rates could still be impacted by the COVID-19 pandemic and a reduction in resources in recent years and may consider revising key figures if a large volume of questionnaires are received late for their publication.

Overall, the data for both reporting periods demonstrates improved health outcomes for patients undergoing hip and knee surgery at ourTrust. This is also evident for patients reporting the most severe scores for condition specific questionnaires e.g. The Oxford hip and knee scores [38].

April 2022 to March 2023

At a provider level, our Trusts PROMS data for the reporting period for all hip and knee replacements are illustrated in Figures 15 to 22 below:

Figure 15. Improvement rate by measure for Hip Replacement 2022/23



38 The Oxford Hip Score is a patient-reported outcome measure (PROM) used in the NHS to assess pain and function in patients undergoing total hip replacement surgery. The Oxford Knee Score is designed to assess function and pain in your knee. https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms/patient-reported-outcome-measures-proms-in-england-2010-11-special-topic-oxford-hip-score-and-oxford-knee-score

Figure 16. Improvement rate by measure for Hip Replacement Primary 2022/23

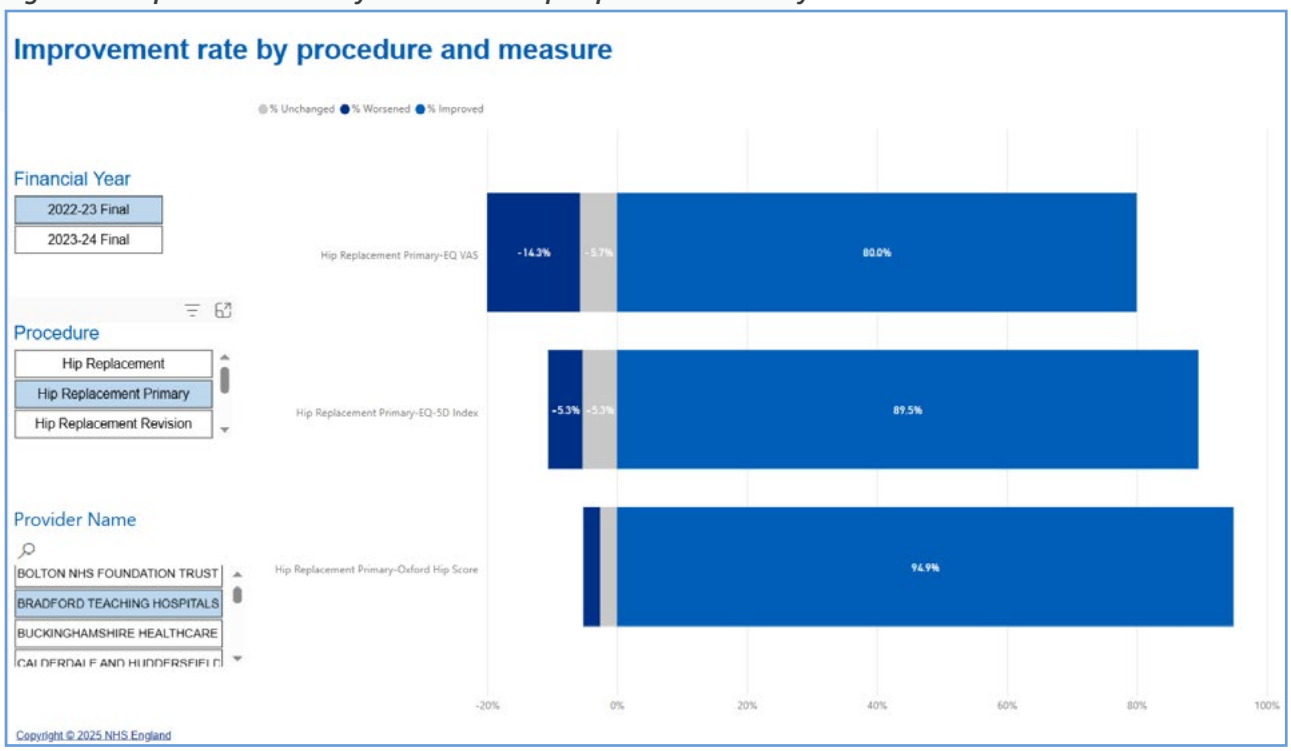


Figure 17. Improvement rate by measure for Hip Replacement Revision 2022/23

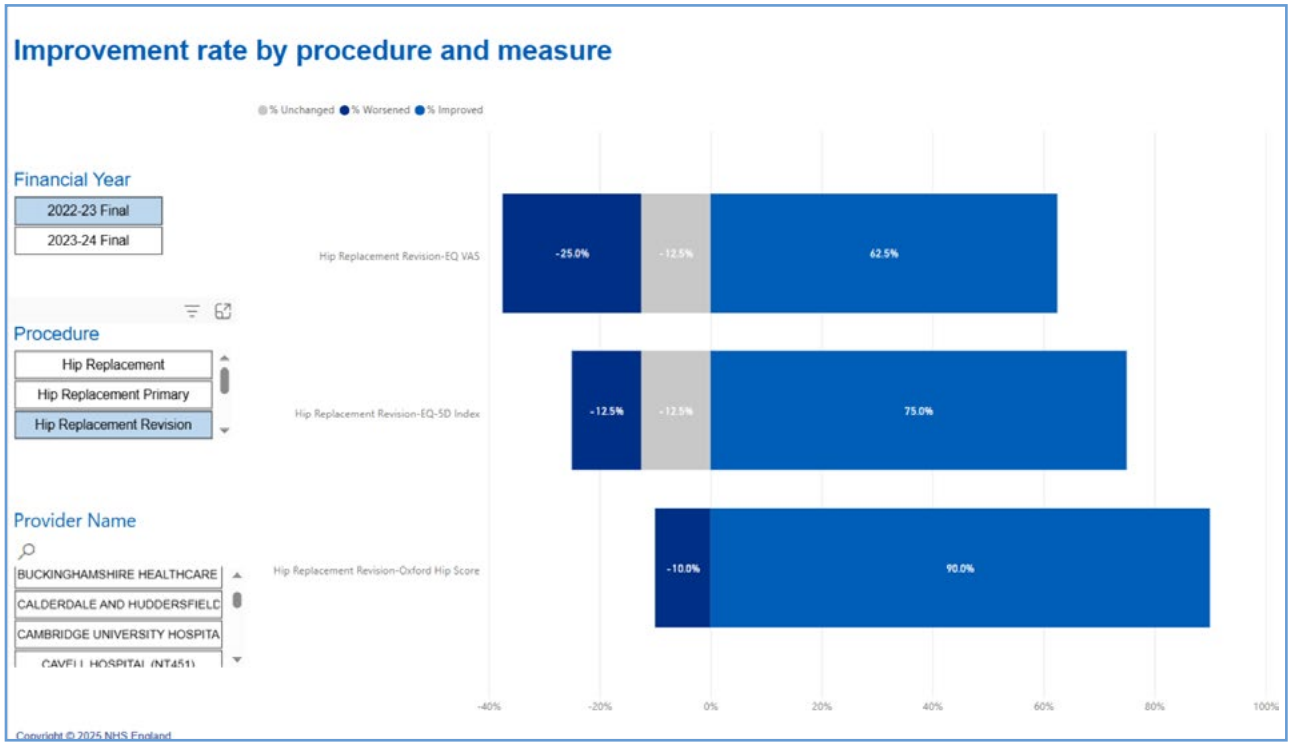


Figure 18. Improvement rate by measure for Knee Replacement 2022/23

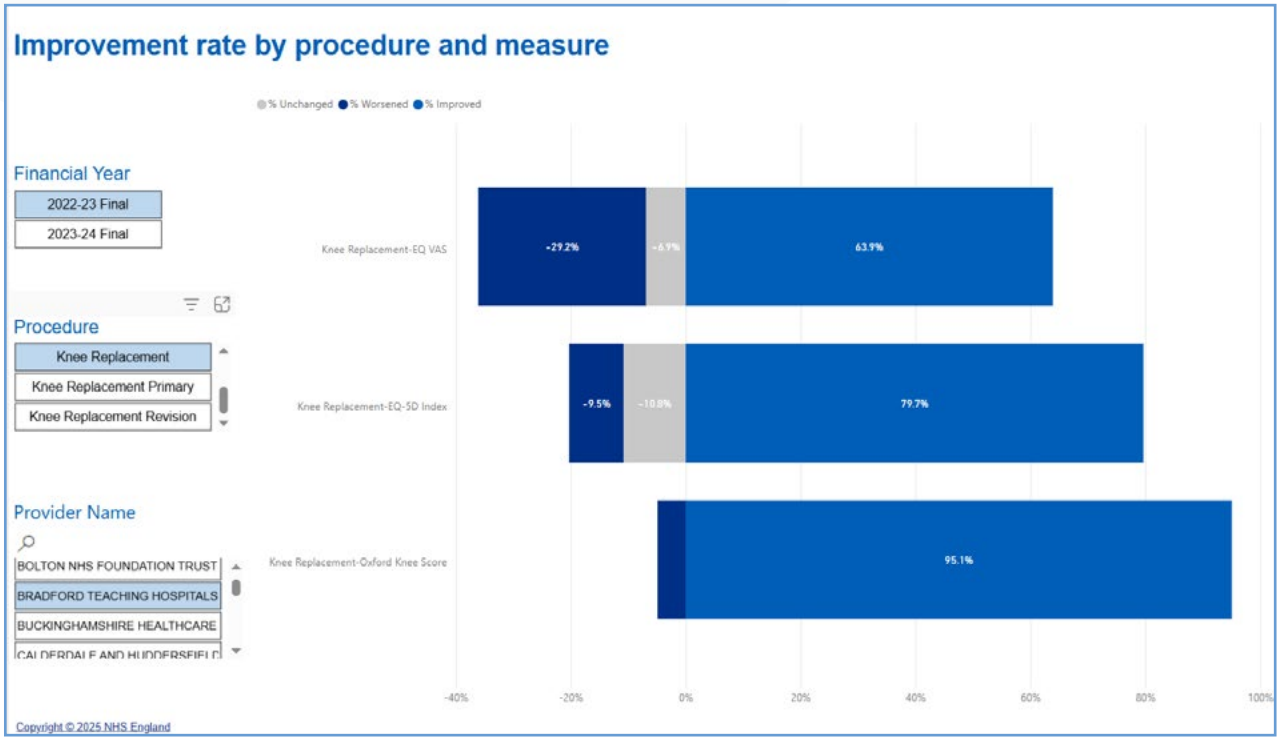


Figure 19. Improvement rate by measure for Knee Replacement Primary 2022/23

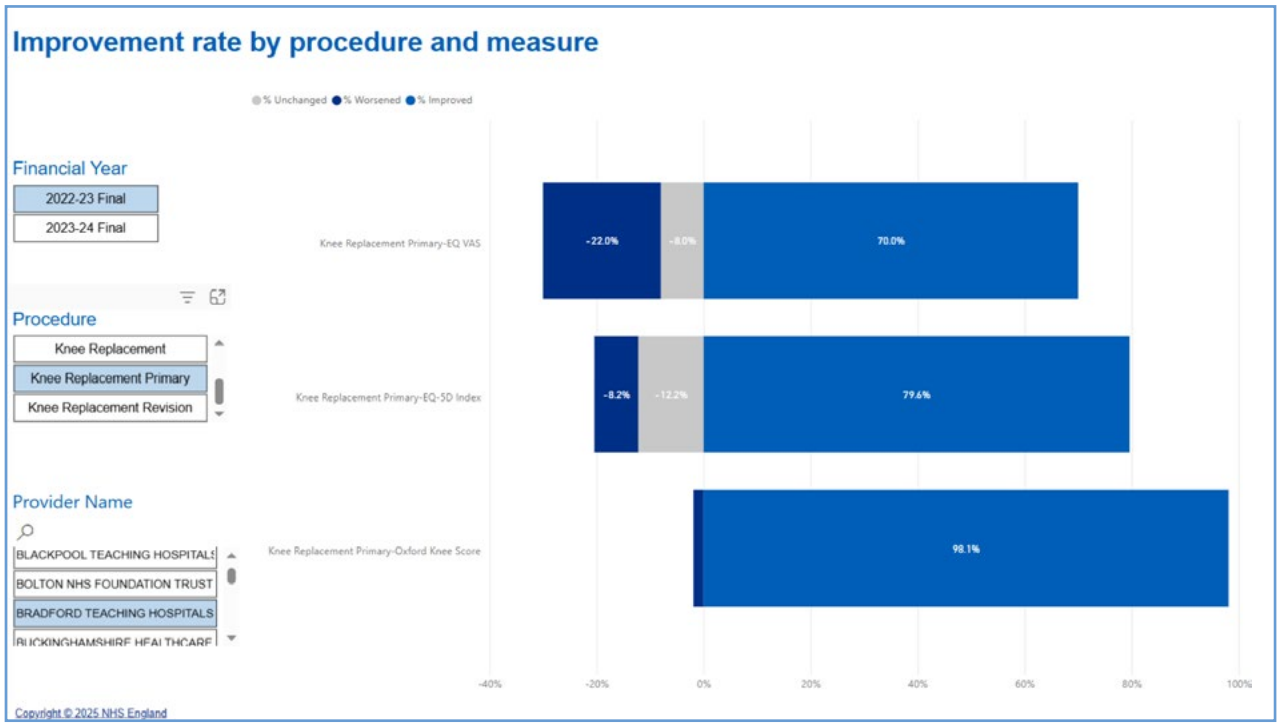


Figure 20. Improvement rate by procedure and measure for Knee Replacement Revision 2022/23

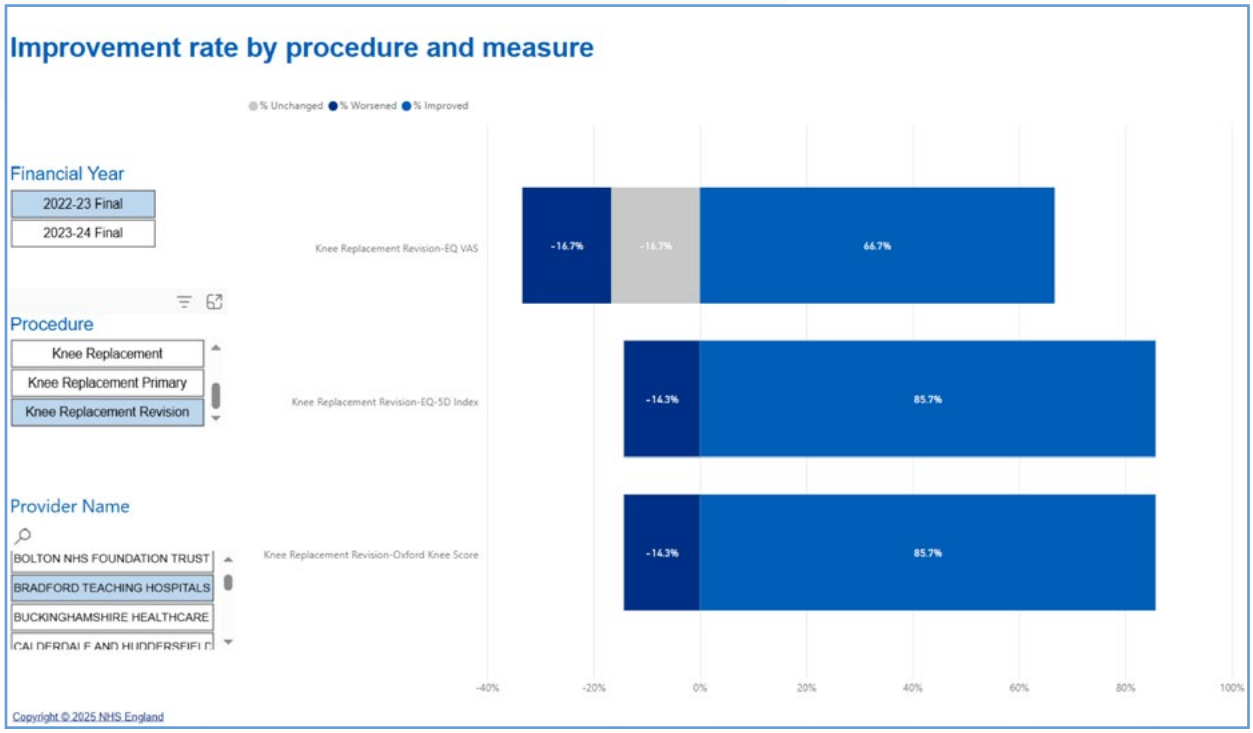


Figure 21. Pre and post-operative patients reporting the most severe scores for condition specific questionnaires 2022/23 – Oxford Hip Score

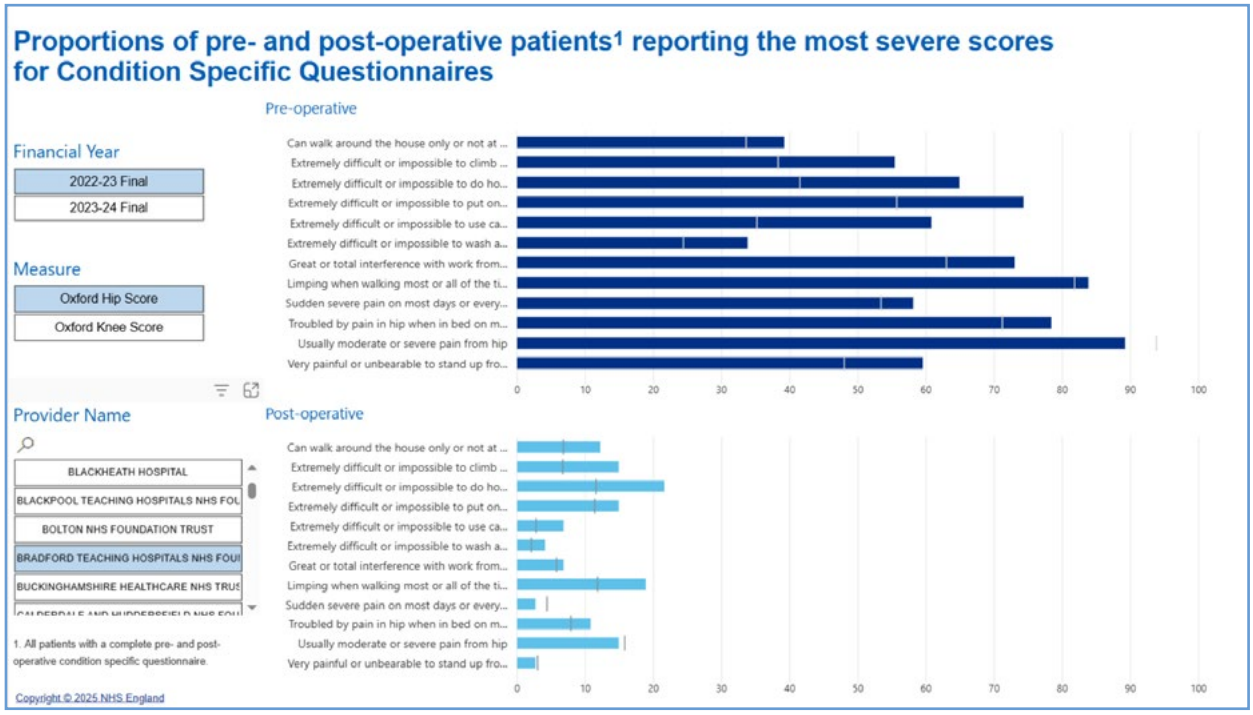
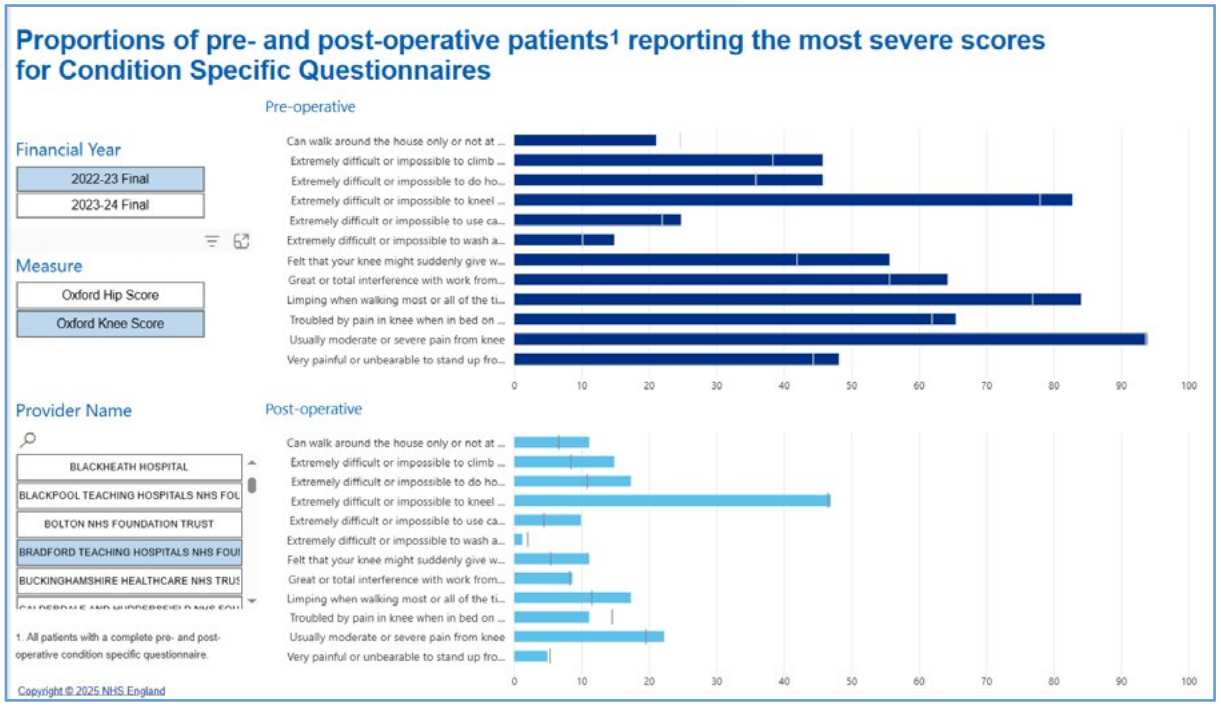


Figure 22. Pre and post-operative patients reporting the most severe scores for condition specific questionnaires 2022/23– Oxford Knee Score



April 2023 to March 2024 (available data as at 30 April 2025)

At a provider level, our Trust PROMS data for all hip and knee replacements for the reporting period are illustrated in Figures 23 to 26 below:

Figure 23. Improvement rate by measure for Hip Replacement 2023/24

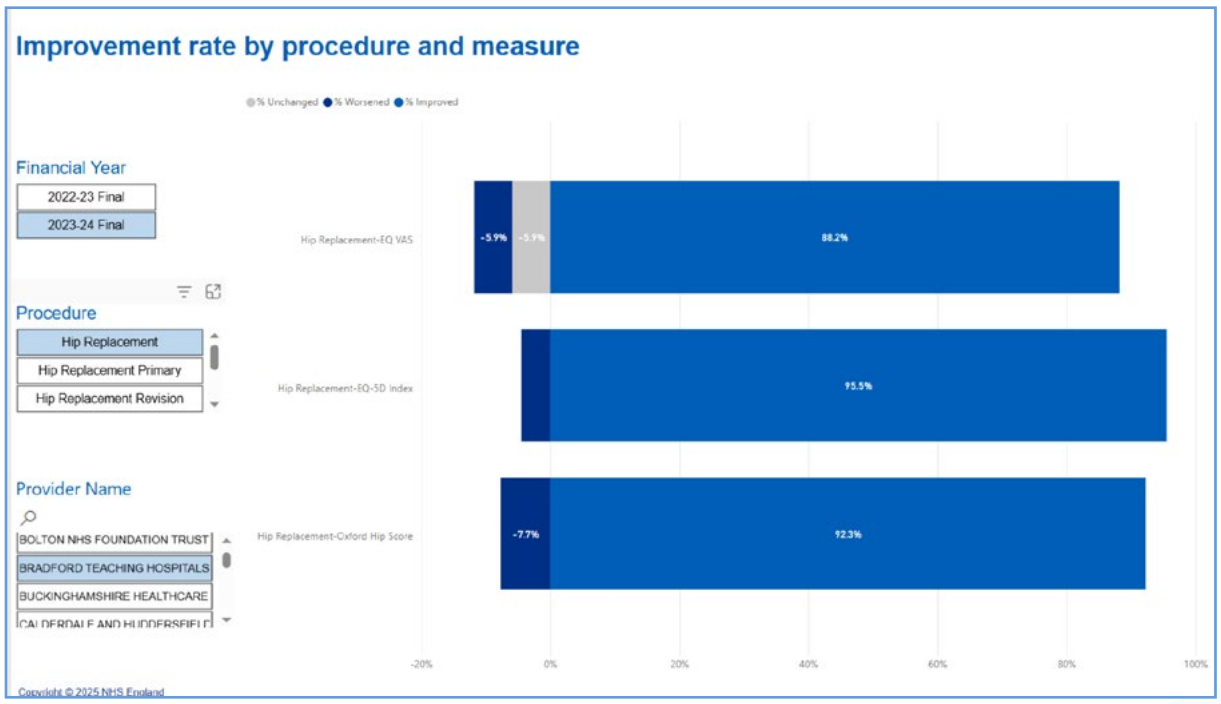


Figure 24. Improvement rate by measure for Knee Replacement 2023/24

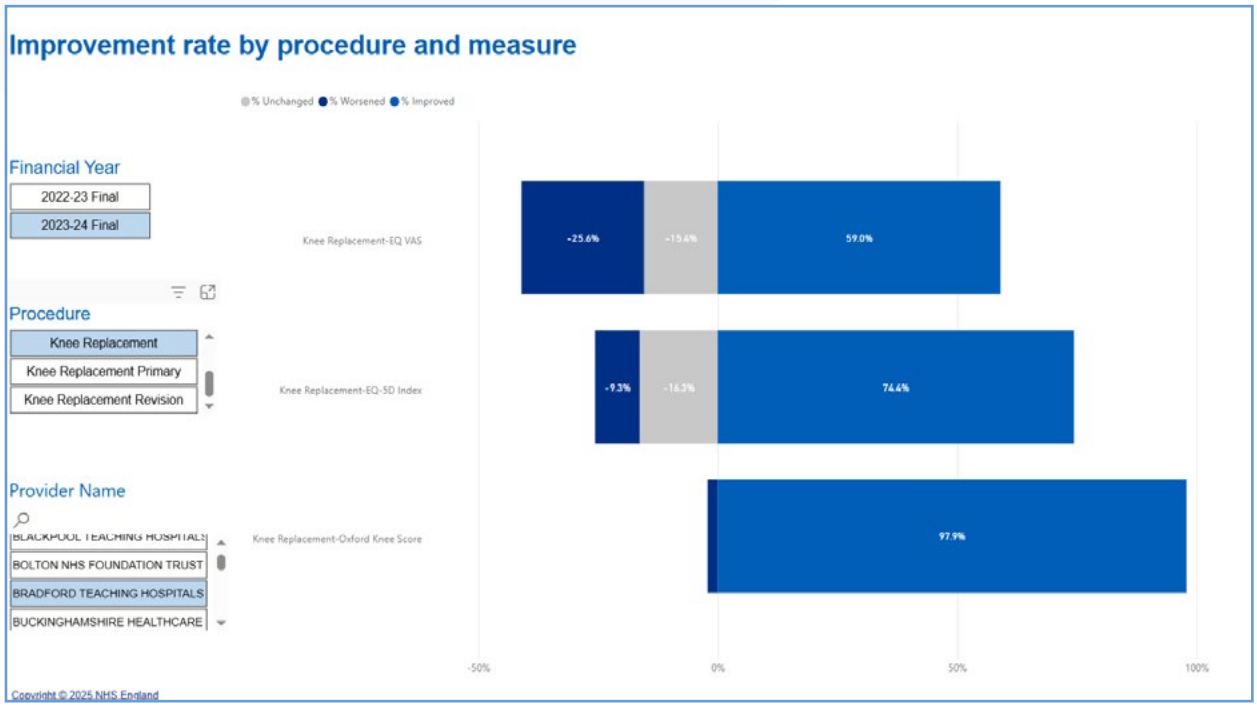


Figure 25. Pre and post-operative patients reporting the most severe scores for condition specific questionnaires – Oxford Hip Score

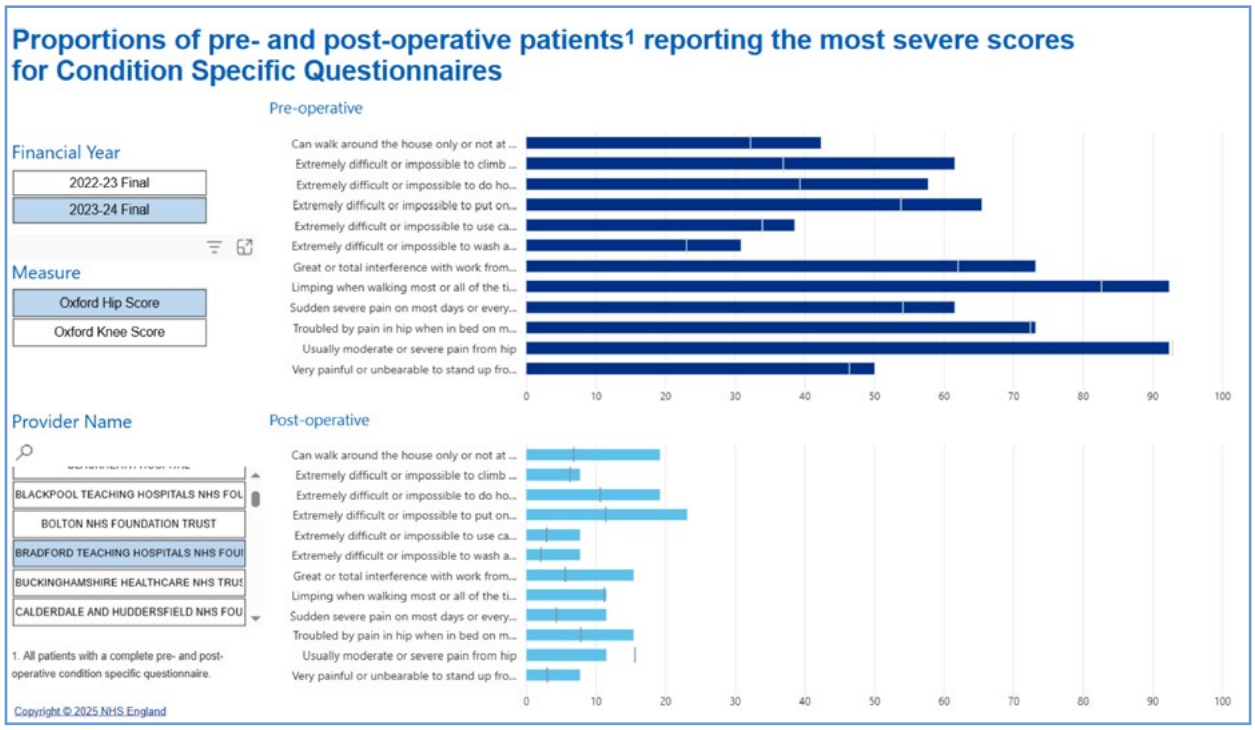
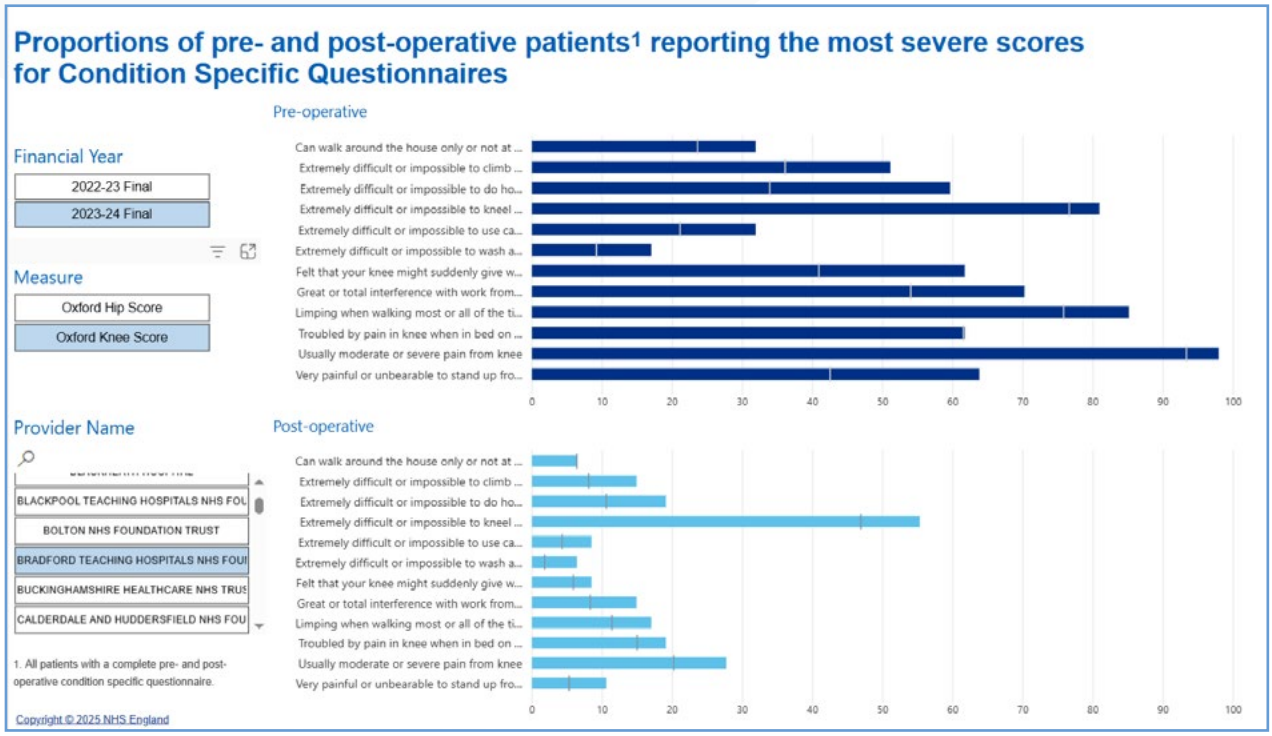


Figure 26. Pre and post-operative patients reporting the most severe scores for condition specific questionnaires – Oxford Knee Score



2.3.3 30-DAY READMISSIONS

30-day readmission rates have been higher than expected for both age groups over the last 2 years.

Throughout 24/25 work has been on-going with paediatrics, general surgery and gynaecology to analyse the data and to understand what has been driving these higher-than-expected values.

It became apparent that there was a coding issue where patients who were being brought back for a planned follow-up, (e.g. hot-clinic, day case or review clinic), after discharge from an in-patient spell, were being coded incorrectly.

After correctly re-coding the follow-up spells readmission rates in paediatrics fell from 4% to 3% and in adults from 10.5% to 6%, which appears to have brought the values in line with regional averages.

Figure 27 : *30 day readmission rates for patient's aged 0-14 year olds*

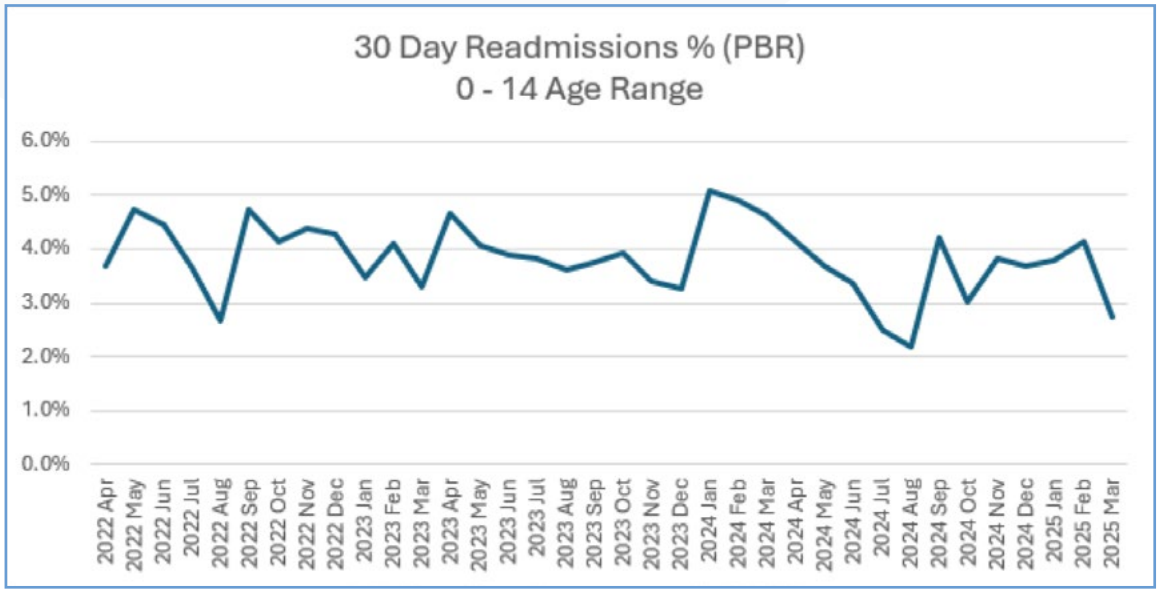
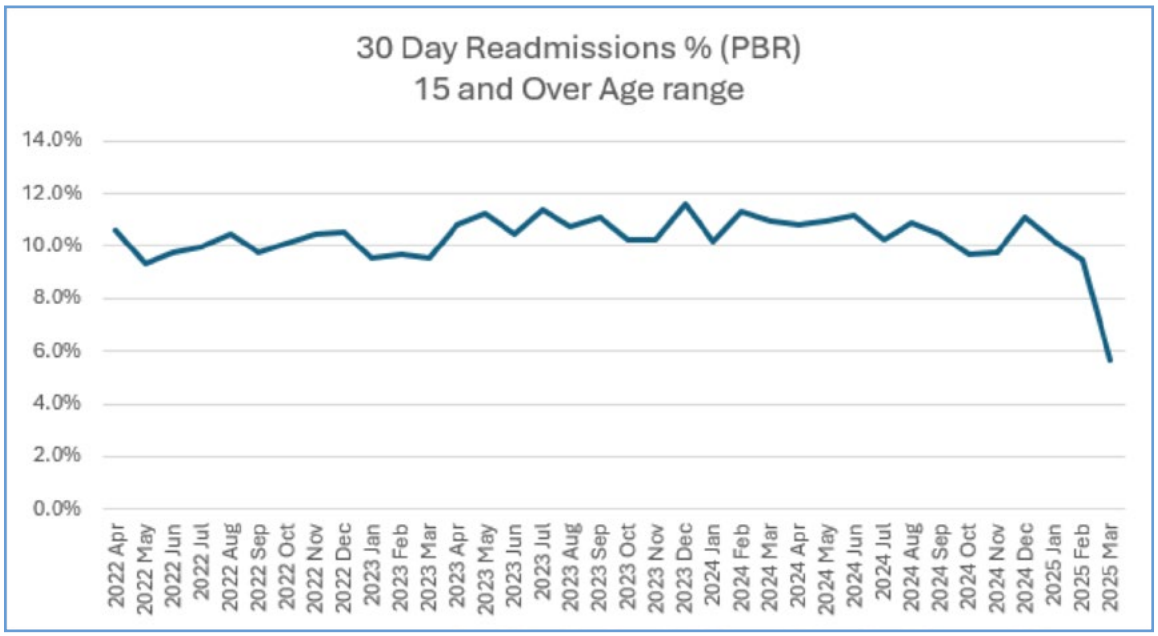


Figure 28: *30 day readmission rates for patient's aged 15 year olds and over*



2.3.4 RESPONSIVENESS TO PATIENT NEED

Friends and Family Test (FFT)

The FFT format no longer requires patients to fill the questions in once but encourages patients to complete the questions multiple times throughout their journey in the healthcare system. As a result, Trusts' can no longer measure the response rate based on admission or discharge per clinical area.

During 2024 our Trust continued to work with its contractor to improve and analyse all our FFT data and feedback. The company we work with (HealthCare Communications) collects the data in several different ways which include:

- Text following outpatient visits and admissions and Emergency Department visits.
- Scanning of QR codes.
- From iPads in clinical areas.
- Via a paper format (including accessible and child friendly formats).

This increase in methods used and the availability of the different real time methods has enabled our Trust to gather more feedback and collate themes to enable ward areas to focus on improving patient experience projects. SMS text messaging comprised most of the responses included in figure 29 below.

Figure 29. Friends and Family Test Responses 2024/25

	Very Good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total
A&E Feedback	5,378 ↓	2,087 ↓	799 ↓	673 ↓	1,814 ↓	79 ↑	**10,830 ↓**
Inpatient Feedback	12,847 ↓	2284 ↓	388 ↓	248 ↓	441 ↓	73 ↓	**16,281 ↓**
Outpatient Feedback	20,273 ↑	2611 ↑	416 ↓	247 ↑	320 ↓	111 ↑	**23,978 ↑**
Maternity Feedback	1,321 ↑	153 ↑	24 ↑	37 ↑	40 ↑	5 ↑	**1,580 ↑**
Totals	**39,819 ↓**	**7,135 ↓**	**1,627 ↓**	**1,205 ↓**	**2,615 ↓**	**268 ↓**	**52,669 ↓**
Percentage	**75.60% ↑**	**13.55% ↓**	**3.09% ↓**	**2.29% ↓**	**4.96% ↓**	**0.51% ↑**	

Although the overall total responses have gone down slightly from the previous year, the Very Good and Good response has increased from 88.6% to 89.15% of the total responses falling in these two categories.

There is ongoing work with the Data Warehouse Team to review the current pipelines which provide the specific feedback from individual areas. The team also consider where new areas of feedback could be captured to enrich the information received. This should also improve the response rates, alongside highlighting of the patient experience work within the Ward Insight Reports.

Members of our Patient Experience staff team promoting our Trust FFT response cards

Patient Led Assessment of the Care Environment (PLACE)

Patient Led Assessments of the Care Environment (PLACE) is a voluntary self-assessment of the care environment, which contributes to health delivered in the NHS and the Independent/ Private Healthcare sector in England. PLACE aims to promote the principles established by the NHS Constitution, which focus on areas that matter to patients, families and carers; committing to ensure that services are provided in a clean and safe environment that is fit for purpose. PLACE is about being open and honest, making a point-in-time assessment, against set criteria.

Unannounced assessments for PLACE were carried out in both clinical and non-clinical areas of our Trust sites between September and December 2024. The inspections were undertaken by teams of public volunteers (Assessors) facilitated by Trust staff members (Facilitators). The assessments are not reflective of the whole Trust but provide a framework for assessing quality against common guidelines and standards to quantify our facility's cleanliness, food and hydration provision, the extent to which the provision of care with dignity is supported, and whether our premises are equipped to meet the needs of people with dementia or with a disability.

The areas assessed are categorised under the following domains:

- Cleanliness.
- Combined Food Score.
- Organisational Food.
- Ward Food.
- Privacy, Dignity and Wellbeing (how the environment supports the delivery of care with regards to the patient's privacy dignity and wellbeing).
- Condition, Appearance and Maintenance of healthcare premises.
- Dementia (whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria).
- Disability (the extent to which premises can meet the needs of people with disability against a specified range of criteria).

Unannounced inspections were carried out at Bradford Royal Infirmary, St Luke's Hospital and our Community Hospital sites. Assessments included wards, outpatient areas, our Accident and Emergency Department (AED), communal and external areas.

The number of areas to be assessed is clearly defined in the guidance and on all sites. For organisations such as ours a minimum of 25% of wards or 10, whichever is greater, should be assessed. We visited 10 inpatient areas and 4 outpatient areas including our community hospital sites which cover Westwood Park, Westbourne Green, Eccleshill and St Luke's Hospital.

The guidance aims to make scoring as consistent and objective as possible; however, there are subjective elements to the process which cannot be eliminated (such as food tasting).

PLACE assessments are intended to provide motivation and direction for improvement by providing a clear message - directly from patients - about how our environments and the services we provide might be enhanced. Results are published to help drive improvements locally and nationally. The assessment focuses exclusively on the environment in which care is delivered and does not cover clinical care provision.

The PLACE data (collated and distributed by NHS Digital) has been scrutinised and developed into several informative charts.

Figure 30. PLACE Scores for our Trust 2024 and 2023

Domain	2024 score	2023 score	% Difference
Cleanliness Score %	95.63%	96.62%	-0.99%
Combined Food Score %	85.98%	82.79%	3.19% ↑
Organisational Food Score %	73.61%	67.36%	6.25% ↑
Ward Food Score %	89.49%	86.03%	3.46% ↑
Privacy, Dignity and Wellbeing Score %	**86.21%**	**81.82%**	**4.39%** ↑
Condition, Appearance and Maintenance Score %	**97.31%**	**96.98%**	**0.33%** ↑
Dementia Score %	**83.84%**	**81.36%**	**2.48%** ↑
Disability Score %	**83.50%**	**83.46%**	**0.04%** ↑

Figure 30 highlights the scores obtained for each domain have shown improvement except for cleanliness, compared to previous year's results. Organisational food scores remain disappointingly low at 73%, but acknowledgement must be given for a 6% improvement. Estates and Facilities colleagues are currently carrying out several transformation improvements including digital ordering of food, serving analysis and variety of options for Halal meals, not always a curry option and the hope is that this improvement work will continue to increase the scores for the 2025 PLACE assessments.

The improvements in the privacy, dignity and disability scores are pleasing, particularly as there have been several engagement projects during the previous year which have taken place to improve the environment. These have included community listening events, work with the Sensory Needs Group and direct walk arounds with people with a range of different disabilities to enable constructive feedback and improvements to be made following these.

There is a PLACE steering group held quarterly which meets to update improvements and actions made and track progress. Updates are provided to the Patient Experience Group at regular intervals and feedback is provided directly to our patient assessors who support this program. The PLACE programme has been independently audited by Audit Yorkshire following the latest inspection to provide assurance around this work.

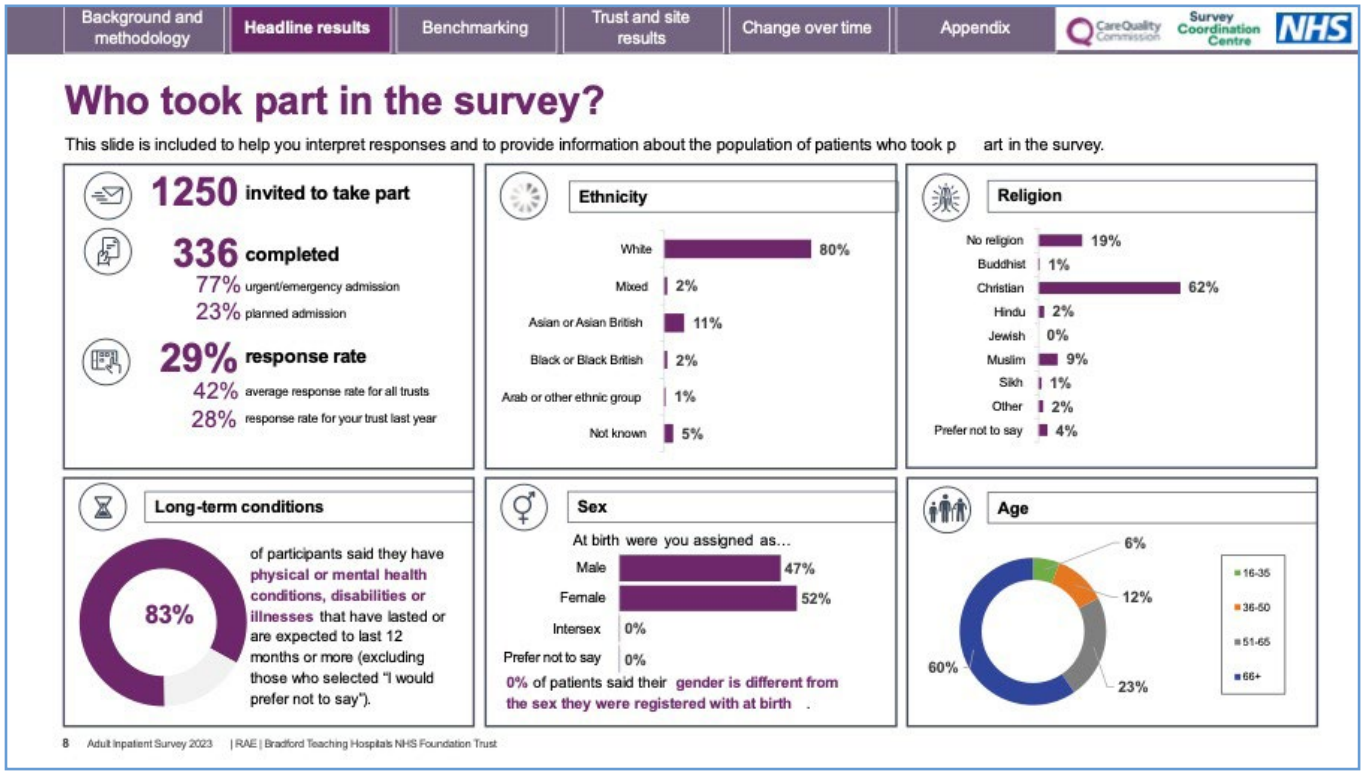
Care Quality Commission (CQC) Surveys

During 2024/25, our Trust received the results of three mandated CQC surveys. These covered, the National In-Patient Survey 2023, Urgent and Emergency Care 2024, and the Maternity Survey 2024

The results from all surveys are reported to the Trust's Patient Experience Group and developments and action plans are monitored for assurance. A paper and presentation of the full results were also presented to our Quality Committee (a sub-committee of the Board). Full details of all the survey results and benchmarking against other Trusts can be found on-line here Surveys - Care Quality Commission[39] We focus below on the outcomes from our national in-patient survey 2023.

The National Inpatient Survey programme covers 131 NHS Trusts. This programme ran from January 2024 to April 2024 and covered patients who were discharged from Inpatient stays in our Trust in November 2023. This survey offered a mixed method of survey, offering both paper and SMS. The survey offered 48 questions, 10 demographic questions and 3 free text questions. Figures 31 and 32 below shows the results of our Trust CQC Inpatient survey.

Figure 31. Demographics of our CQC Inpatient 2023 survey

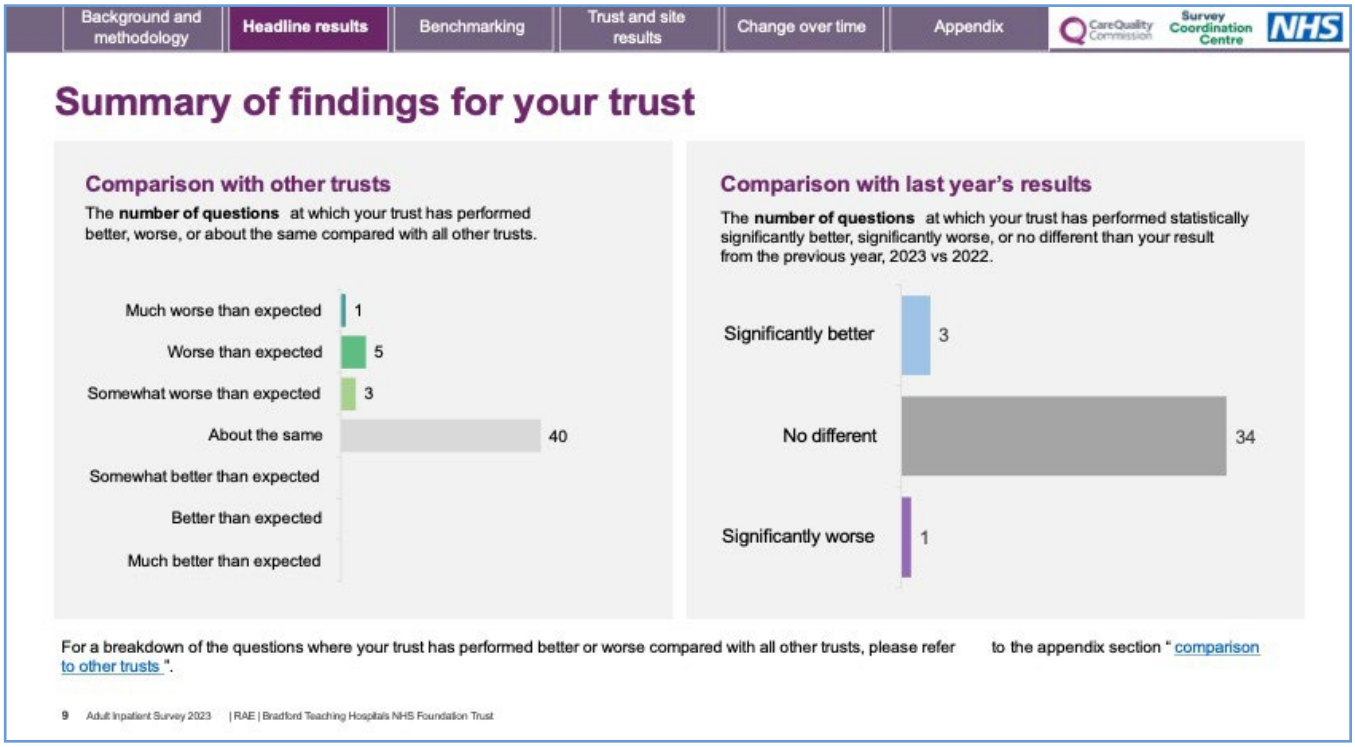


39 *https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf*

Respondents and response rate.

- 1,250 invited to take part.
- 336 patients responded to the survey.
- An overall response rate of 29%.
- Below national average response rate which is 42%.
- 83% of responses noted to have long term conditions, were following urgent/acute admissions.
- 83% of respondents were over the age of 51.

Figure 32. Summary of results and comparison with our 2023 Inpatient survey



The best scoring questions on the survey related to:

- To what extent did you understand the information you were given about what you should and should not do after leaving hospital (above national average result).
- Did hospital staff tell you who to contact if you were worried about your condition and treatment after you left hospital (above national average result).
- Were you given enough privacy when being examined or treated (national average result).

The above results are positive and reflect some of the patient experience projects that have taken place in terms of discharge planning, providing patient information in multiple formats and languages and, work in relation to speaking up about care and treatment where there are concerns (Martha's rule).

Compared to the previous year's Inpatient survey results (2023):

- Our Trust was significantly better on 3 questions.
- There was no statistically significant change in 34.
- Our Trust was significantly worse on 1.

Key areas identified for improvement are:

- Noise at night reduction: relaunch of the Trust's Good Night Sleep Tight campaign.
- Equipment required on discharge: our 'discharge meetings' will focus on partnership improvements between hospital and community regarding communication of the equipment needs of patients due for discharge.
- Patients getting enough help from staff to wash, dress and with meals: inclusion of additional survey questions to steer future improvements.
- Length of wait for a bed: the command team are leading on several projects to expedite discharge hold-ups. These include the H-FAST project (NHS continuing healthcare fast-track pathway) [40], expediting medications and patients being cared for by the virtual ward team. All these interventions help increase bed capacity, which should then lead to shorter waits for beds for incoming patients.

Our Trust collects data about age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation as part of several patient feedback measures. Examples of where this data is collected includes Friend and Family Test and Care Quality Commission Surveys mentioned above. Plans are in place to strengthen this work in relation to complaints for the forthcoming year.

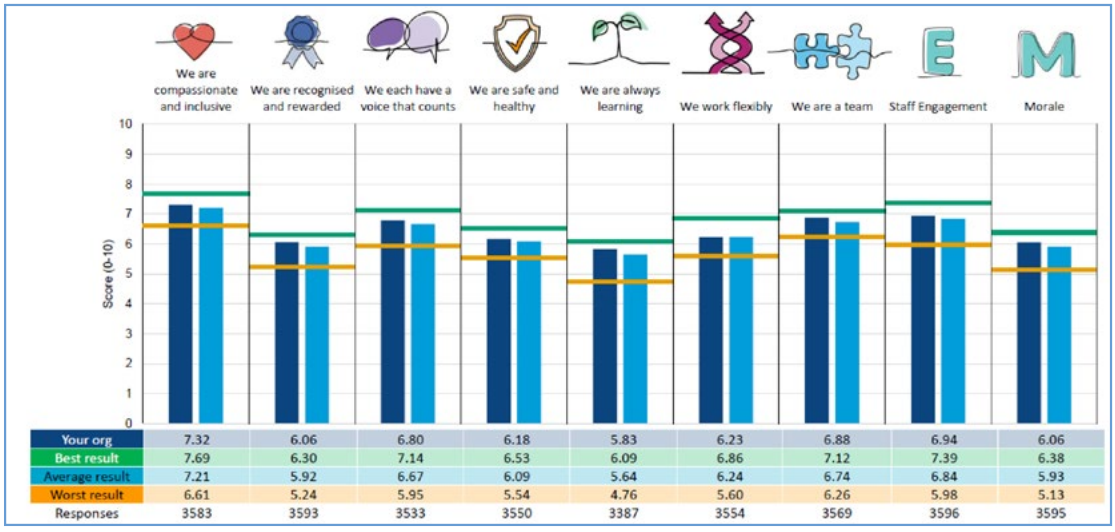
2.3.5 NHS STAFF SURVEY

In the 2024 NHS Staff Survey, 3,612 colleagues (50%) responded, a 7% increase compared with 2023 and exceeding the national response rate for Acute and Acute and Community Trusts.

We remain above the national average on eight of the overall People Promise elements and themes, with one (we work flexibly) just 0.01% under the national average (see figure 33 below).

We have seen significant improvements in our scores around the role of immediate line managers and colleagues responding favourably around teams and teamwork.

Figure 33. Trust results for the People Promise elements and themes of the NHS Staff Survey 2024



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.32	6.06	6.80	6.18	5.83	6.23	6.88	6.94	6.06
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	3583	3593	3533	3550	3387	3554	3569	3596	3595

40 The H-FAST project, or NHS continuing healthcare fast-track pathway, is a mechanism for quickly assessing and providing funding for individuals who are experiencing a rapidly deteriorating condition and may be nearing the end of their life. This pathway aims to ensure that appropriate care and support packages are put in place as soon as possible, typically within 48 hours.

An action plan has been created which focuses on several key areas for development. These include:

- We are always learning
  - Ensuring our people have quality 1-1 conversations and appraisals.
  - Creating opportunities for career progression to support colleague development and retention.
- Engagement
  - To support engagement, networking and peer connection we will establish a BTHFT People Forum.
- We are compassionate and inclusive
  - Organise and deliver a national EDI/ health inequalities conference in collaboration with our Staff Equality Networks.
  - Develop a series of bite-size drop in sessions for managers to share their responsibilities in managing disability, equality and reasonable adjustments in the workplace.
  - Launch of the Respect, Civility and Resolution policy and Managers Toolkit.
- We work flexibly
  - Update the flexible working policy and continue to promote opportunities for flexible working to managers and colleagues through meetings, workshops and other conversations.

As a Trust we are pleased with our increased response rate to our staff survey for 2024 and we remain committed in working towards further improvements in our results for 2025.

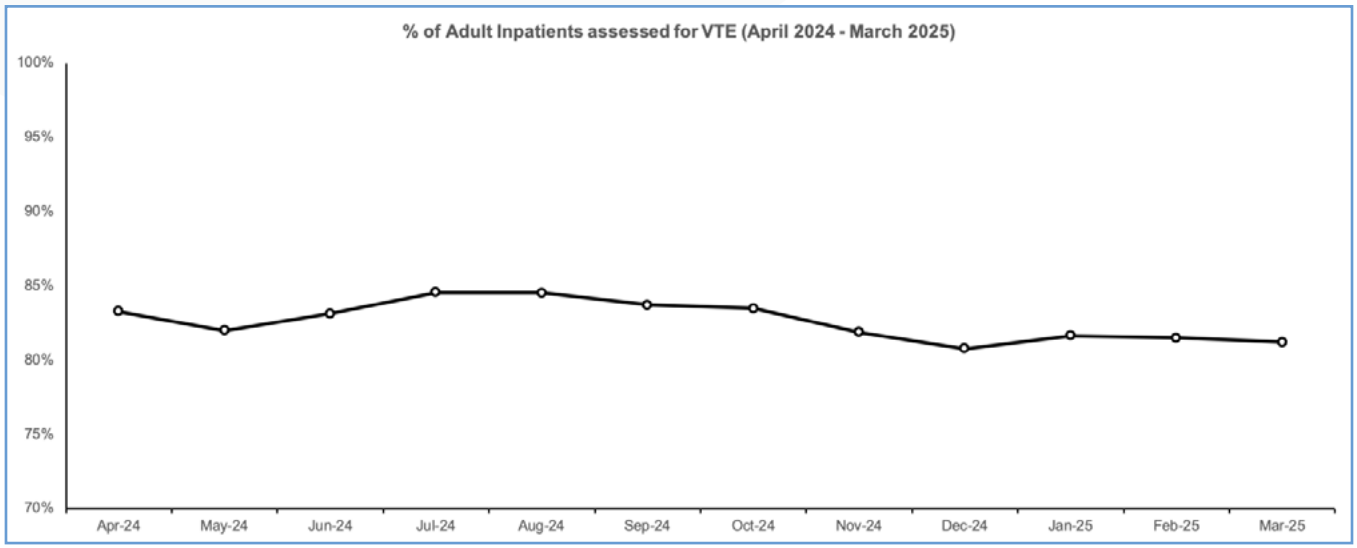
2.3.6 VENOUS THROMBOEMBOLISM EVENT RISK ASSESSMENT (12 MONTH ROLLING)

As part of our 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 the National Institute of Clinical Excellence (NICE) NG158 national guidance[41].

This indicator displays the percentage of spells where the patient has been risk-assessed for a VTE event. A higher percentage would mean that our 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.

41 https://www.health-ni.gov.uk/consultations/nice-clinical-guideline-ng158-venous-thromboembolic-diseases-diagnosis-management-and-thrombophilia-testing

Figure 34. Percentage of adult in-patients that were assessed for VTE's from April 2024 to March 2025



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.

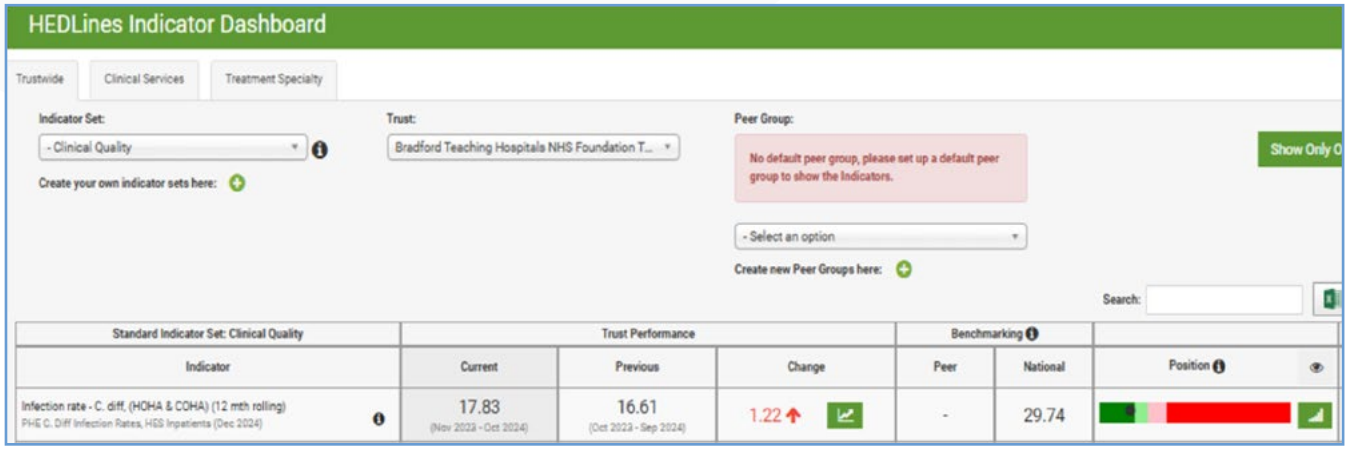
An overall High Assurance opinion has been given. This is based on VTE assessments for in-patients being completed in a timely manner, in conformance to the national NICE guidelines, results being acted upon with prophylaxis or interventions being prescribed, and evidence of reassessments being undertaken when a patient's condition has changed, or they have moved wards. Assessments are completed on EPR (electronic patient record) 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 (electronic staff record). Staff are not able to undertake VTE assessments without completing this training. Compliance is currently reported at 96%.

2.3.7
C DIFFICILE

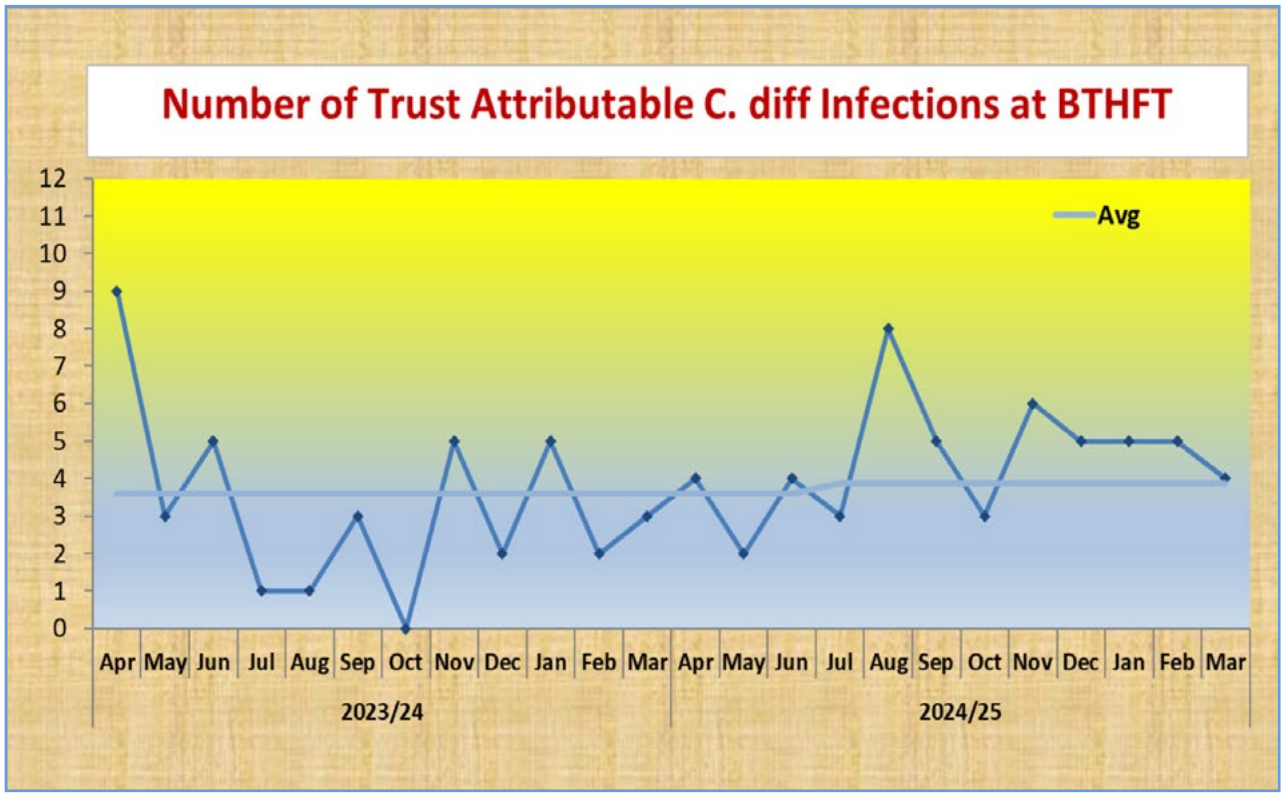
Clostridioides difficile is a type of bacteria which causes diarrhoea and abdominal pain and can be more serious in some patients. Any case of confirmed C. difficile infection (CDI) is reported to the United Kingdom Health Security Agency (UKHSA) through a Data Capture System (DCS) and is subject to a quick review to identify learning. See figure 35 below.

Figure 35. Healthcare Evaluation Data (HED) for C. difficile



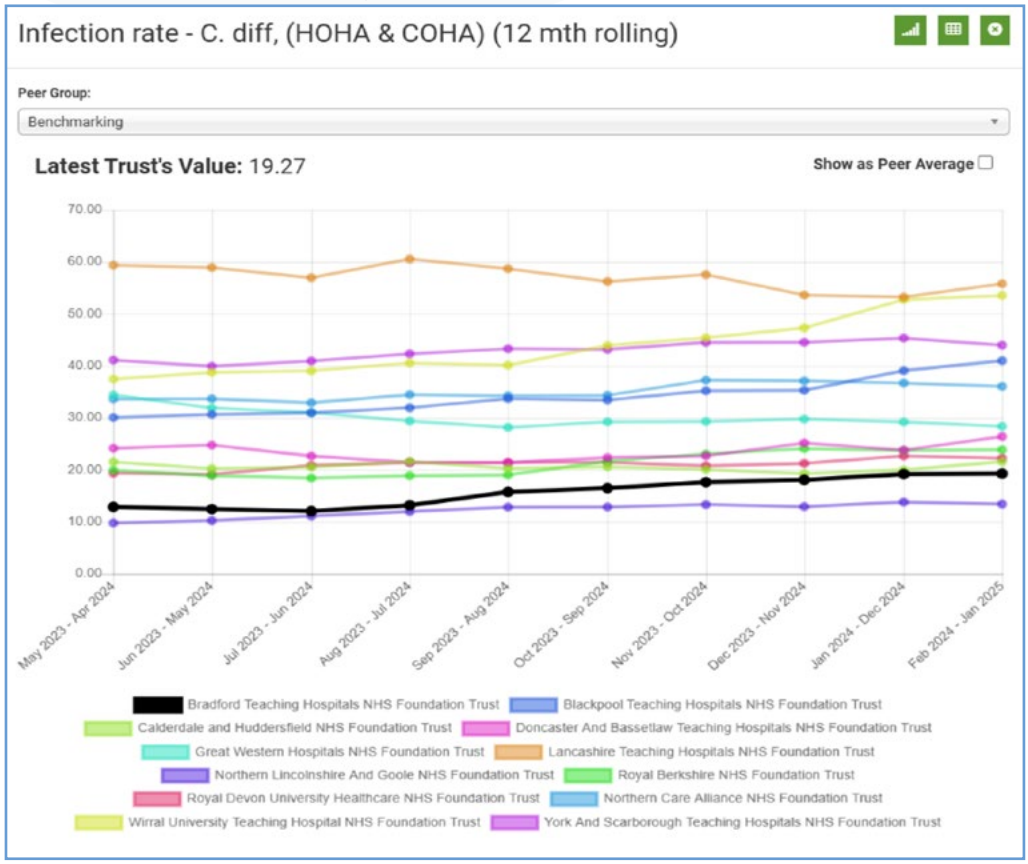
The objectives for reduction for CDI for 2024/25 were set as 40 cases. Our Trust reported 51 hospital attributable cases during 2024/25. This is an increase of 12 cases compared to the last year. See figure 36 below.

Figure 36. Healthcare associated Clostridioides difficile Infections at our Trust



Although the number of infections have increased our Trust has performed better than other Acute Trusts in the region as shown in Figure 37.

Figure 37. Healthcare Evaluation Data (HED) for C. difficile: *Benchmarking data for both Yorkshire Region and National Acute NHS Trusts (the black line represents our Trust)*



Each CDI case is sent to a reference laboratory for typing. Where there are any similar typing results, a search is undertaken to identify any potential risks for cross transmission (for example, the same ward either at the same time or at different times). The Ribotyping results for the cases in 2024/25 don't indicate transmission between patients. 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 2025/26 to reduce the usage of the high-risk antibiotics. Cleaning and decontamination, including hydrogen peroxide vapour (HPV) fogging for any side room following the discharge or transfer of a patient with CDI has continued and clinical wards and departments have maintained their audit programme for hand hygiene and PPE compliance.

2.3.8 PATIENT SAFETY INCIDENTS WITH SEVERE HARM OR DEATH

Our Trust previously used the Datix risk management system moving to a new incident reporting system 'InPhase' in January 2024. The new system included several applications, an incident reporting, learning and improvement system to monitor and manage patient safety incidents and concerns .The new system facilitates the "live" reporting of patient safety incidents to the new NHS England 'Learn from Patient Safety Events' (LFPSE) and meets the requirements of the Patient Safety Incident Response Framework (PSIRF) which came into effect in April 2024. Our 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.

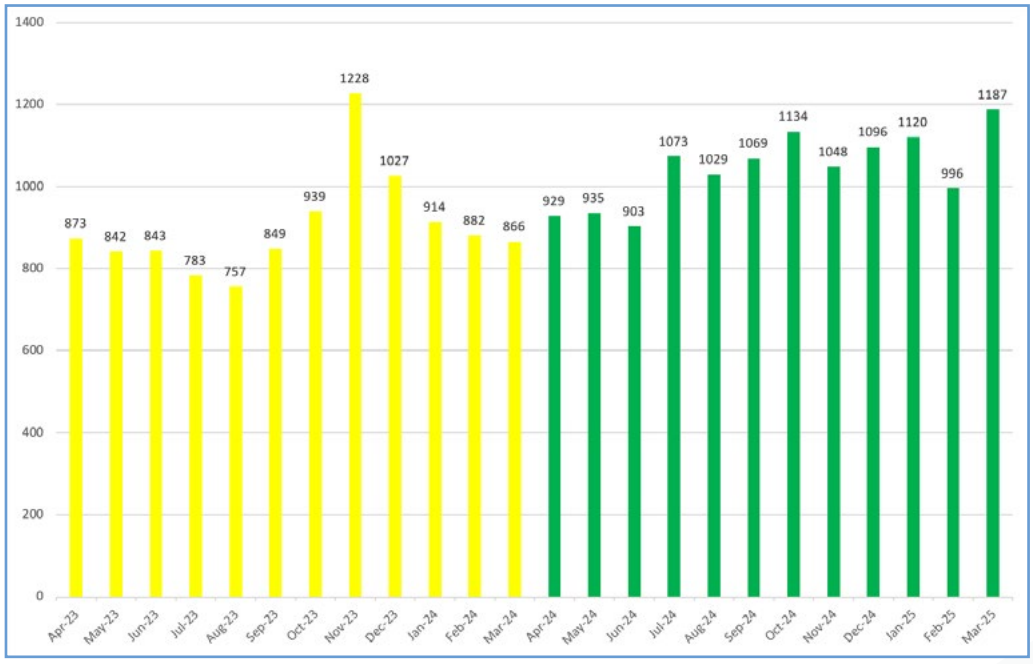
Our Trust has a robust clinical governance and quality oversight system in place to identify learning and improvement from incidents which facilitates appropriate levels of assurance about the quality of care we deliver.

Our Trust has transitioned from a combined report for incidents, complaints, Patient Advocacy and Liaison Service (PALS) and claims, to an evolving methodology to triangulate our data. We have named this our 'Insights Report' in line with the National Patient Safety Strategy. This supports the early identification of learning and opportunities for improvement. Our Trust also engages in a West Yorkshire Association of Acute Trusts (WYAAT) learning forum to ensure cross pollination of learning from patient safety incidents across the region.

There were a total of 12,519 patient safety incidents reported within our Trust during 24/25. This represents an increase of 1,706 (15.8%) when compared with the previous reporting period (see figure 38). Early feedback from staff tells us that the new reporting system and accessibility of the application is supporting an increase in reporting of incidents.

There were 64 (0.5%) patient safety incidents that resulted in severe harm or death during 2024/25.

Figure 38. Comparison between all grades of Patient Safety Incidents Reported in FY2023/24 and FY2024/25



A five-year view of the number of patient safety incidents resulting in severe harm (see figure 39) or death (see figure 40) has been provided in the charts below.

Figure 39. Number of Patient Safety Incidents resulting in Severe Harm (2020 to 2025)

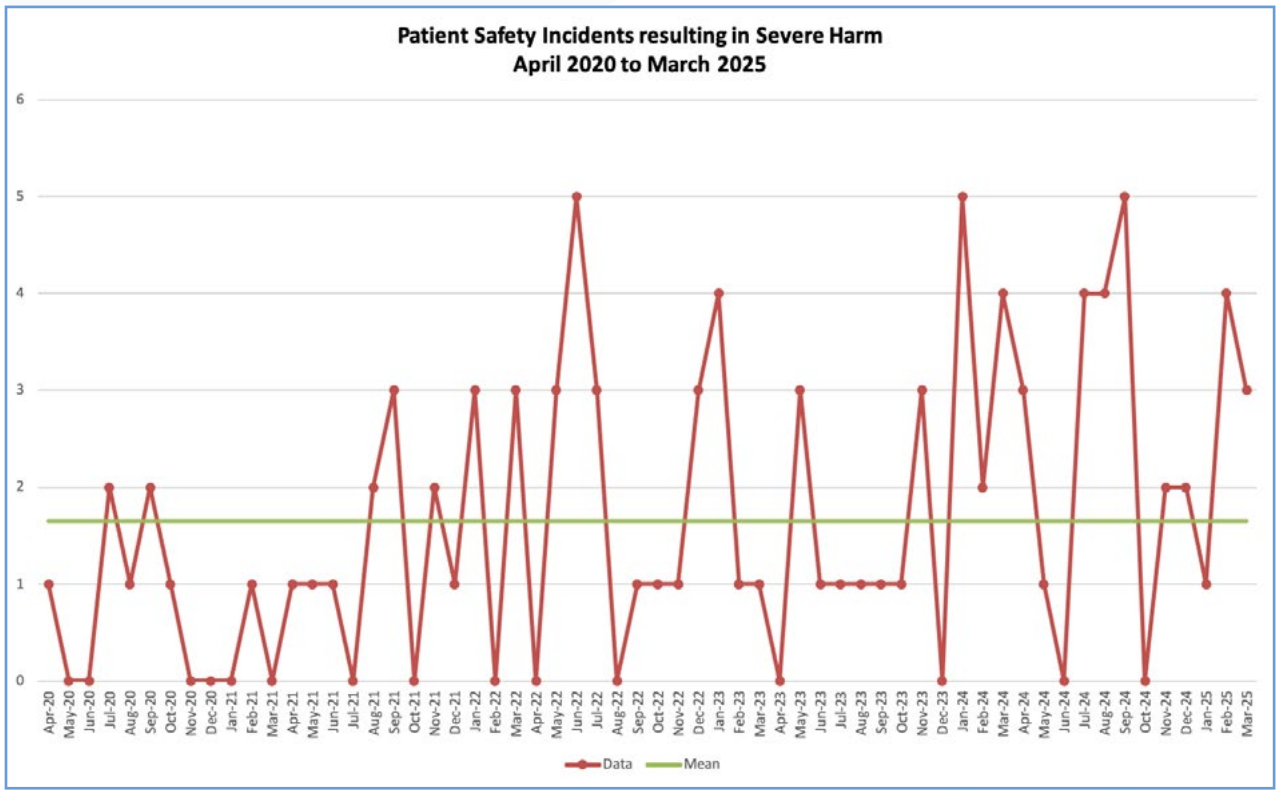
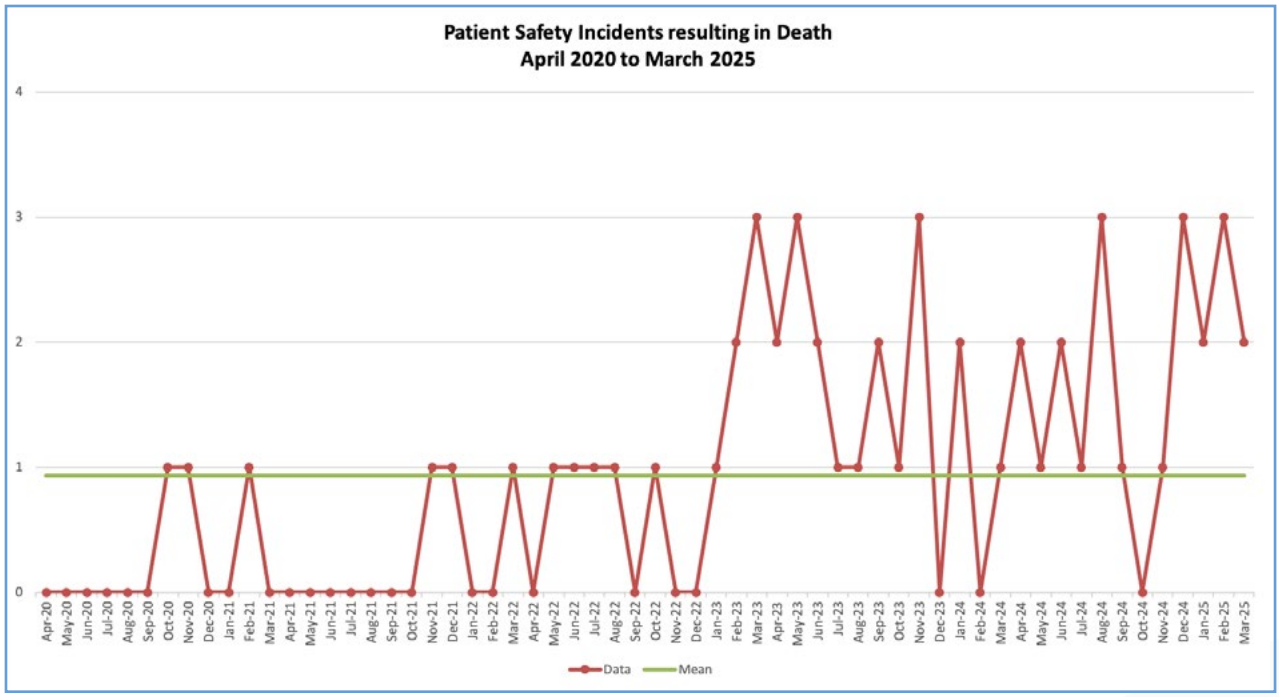


Figure 40. Number of Patient Safety Incidents resulting in Death (2020 to 2025)



- Patient Safety Incidents resulting in Severe Harm and Death

There were 21 patient safety incidents resulting in severe harm between 1 April 2024 and March 2025 (see figure 39). This included 15 patient safety incidents relating to falls. Our Trust has a falls prevention improvement programme in place which is described in more detail in section 3.1.3.

Between 1 April 2024 and 31 March 2025 the total number of reported patient safety incidents resulting in death was 33. 3 were declared as Patient Safety Incident Investigations (PSII) under the new Patient Safety Incident Response Framework (PSIRF) and two were referred for and accepted as Maternity & Neonatal Safety Investigations (MNSI). Two of the PSII investigations and one of the MNSI investigations have been completed and closed on the national Strategic Executive Information System (StEIS). There is one ongoing PSII and one ongoing MNSI investigation report writing (April 2025). See figure 41 for more information.

Figure 41: *Number of Patient Safety Incidents by Category and Harm during 2024/25*

Severe n=number of patients	Death n=number of patients	Category
n=8	n=7	Care and treatment
n=4	n=2	Delayed diagnosis
-	n=3	Deteriorating patients
-	n=1	Discharge safety
n=2	n=1	Infection control
n=1	n=3	Maternity and Neonatal safety
n=2	n=4	Other
n=12	n=2	Patient falls (patient fall, slip or trip from the same level and fall from height)
-	n=2	Safer Procedures
-	n=1	Self-harm
n=1	-	Specimens and samples
-	n=7	Unexpected death
n=1	-	VTE prevention

Our Trust considers that this data is as accurate for the following reason: Our Trust's internal incident reporting, learning and improvement system is available for all employees to access and report safety events. It is checked, verified and validated by the Central Quality Team and 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 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 and is one of the Trust's patient safety priorities.

Figure 34: *Pressure ulcer incidence (category 2 and above) during 2024/25*

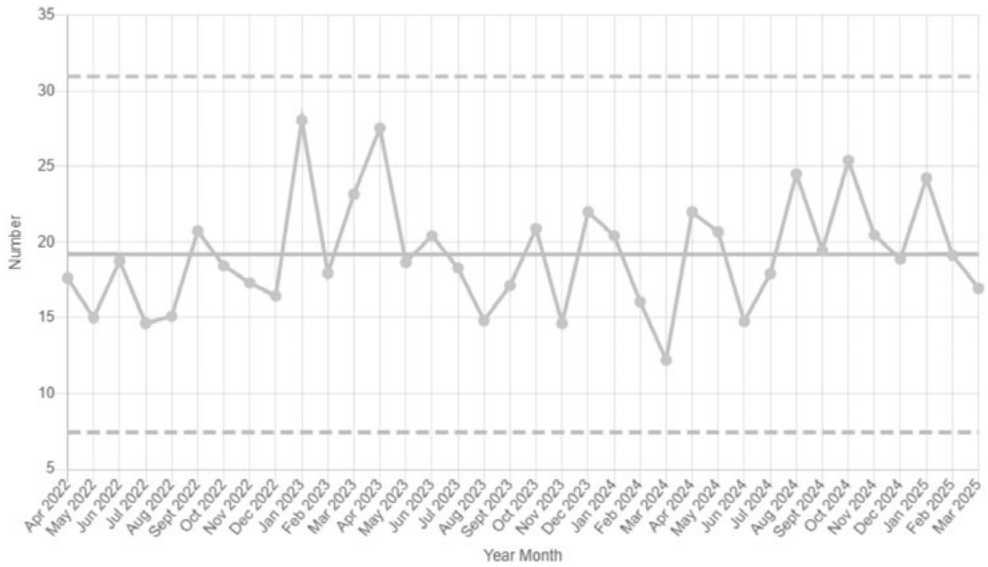


Figure 35: *Pressure ulcer incidence (category 2) during 2023/24 Figure 35: Pressure ulcer incidence (category 2) during*

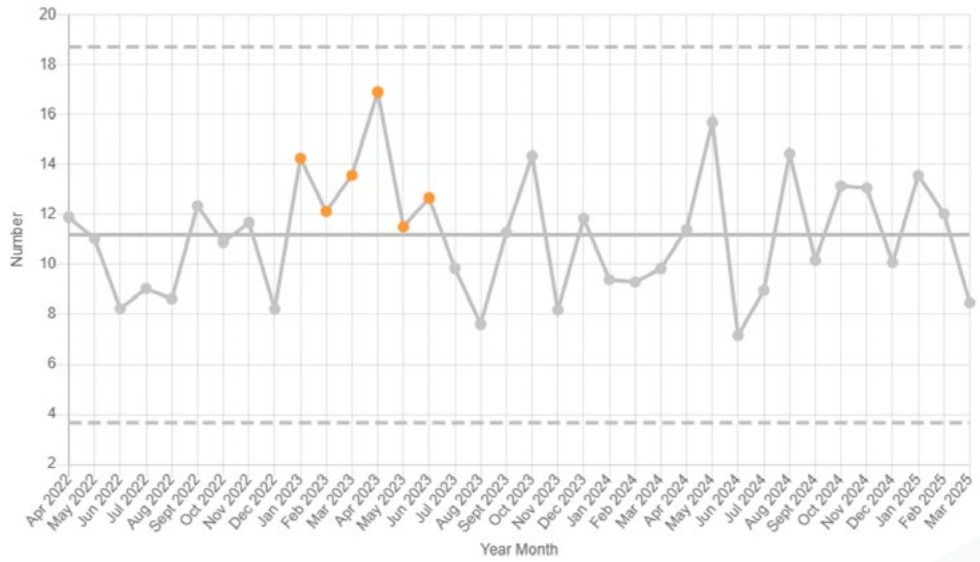
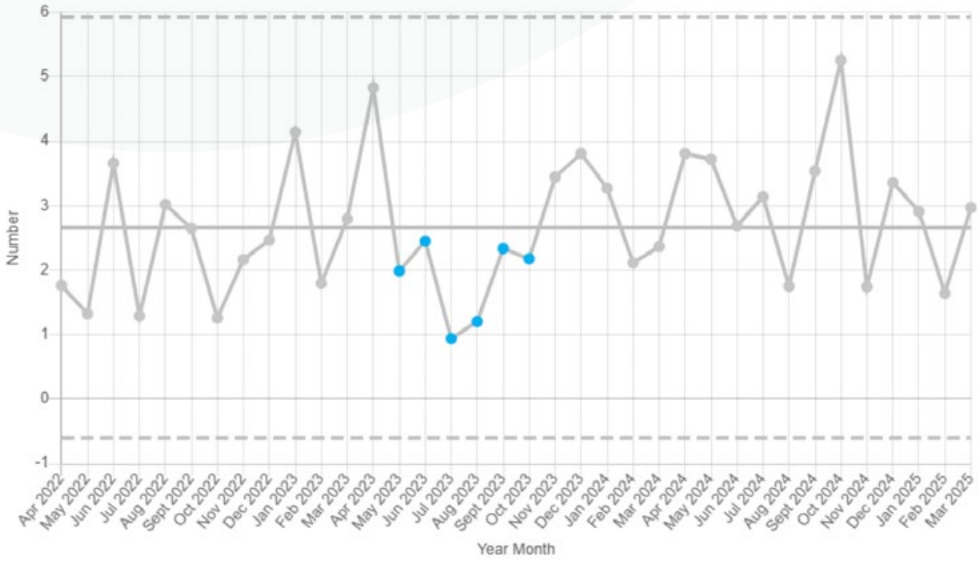


Figure 36: *Pressure ulcer incidence (category 3 and 4) during 2023/24*



We routinely monitor 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 (electronic patient record) and InPhase, our incident monitoring system, and is validated by clinical staff. The data presented in this report includes hospital acquired category two and above pressure ulcers with a breakdown for category 2, category 3 and 4, and suspected deep tissue injuries. The data demonstrates a normal variation in incident rates. Our thematic reviews have shown an increase in patients presenting with frailty and this is a contributory factor.

We continue to focus on improving pressure ulcer prevention through quality improvement methodology, training and education and the implementation of evidence-based patient care. The ward areas share learning and improvement plans at the monthly pressure ulcer improvement group using data from incidents, audits and ward accreditation results. Three of our ward teams have completed improvement projects that have examined the use of visual prompts for repositioning, the use of safety huddles to improve communication, and prevention of pressure damage from oxygen masks.

Over the last year we have been working closely within the Emergency Department team to ensure that all measures are being taken at the earliest opportunity.

The pressure ulcer prevention and management policy was reviewed and updated in 2024. The patient and public information leaflets on pressure ulcer prevention are currently being reviewed. The pressure ulcer standard for ward accreditation has been reviewed to include patient feedback on information and advice provided and involvement in care.

3.1.2 SEPSIS SCREENING AND TIME TO TREATMENT

Our 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][42] and requirements as set out in the NHS Standard Contract.[43]

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 patients 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 high-risk sepsis or three hours for a diagnosis of moderate-risk sepsis.

In November 2024 we introduced a new sepsis screening tool to our EPR (electronic patient record). This was in collaboration with Airedale and Calderdale and Huddersfield NHS trusts and aimed to align with the updated NICE guidance from January 2024. Our Trust also introduced a new maternity specific screening tool at this time.

Our sepsis dashboard was launched in 20/21 pulling data from EPR enabling wards and specialties to monitor key outcome and process measures shared within the graphs below (see figures 37 and 38).

The dashboard is fully accessible to all staff with the aim of each CSU (clinical support unit) to review and share their data at speciality level. The dashboard reports data on all patients that alert for sepsis across our Trust.

From November 2024 the sepsis dashboard has been under reconstruction to enable correct reporting of patients triggering for sepsis. Because of the limited availability of data to review, ongoing auditing of patients triggering for suspicion of sepsis has been undertaken since November 2024 to provide oversight and assurance there has been no harm to patients. Other assurance measures are in place to support this work such as clinical reviews of all patients who have had an unplanned admission to our Intensive Care Unit.

In 23/24 this was part of the commissioning for Quality and Innovation (CQUIN), Indicator CQUIN07: 'Recording of and response to NEWS2 score for unplanned critical care admissions'. Although the national mandatory reporting has been paused, we are continuing to monitor our processes and outcomes to inform our Trust of areas for improvement.

Our Trusts overall mortality from sepsis is monitored using the monthly data obtained from the recording of death certificates. If sepsis is documented as the immediate cause of death (1a) or is the contributing factor to multi organ failure (1b) they meet the criteria. This is felt to be more accurate than the 'healthcare evaluation data (HED)' reported which relies on the coding of any In-patient encounters. Review of this data ensures there are no unexplained increases following any changes to the sepsis pathway.

Both these reviews are undertaken by the sepsis/deteriorating patient lead nurse and reported to the 'Recognition and Response to the Acutely Unwell Patient Group' quarterly and then to the clinical outcomes group for scrutiny. The mortality data is also reported to the Quality Committee for oversight.

The data shared in this report is from April to November 2024 to ensure accuracy of reporting.

42 https://www.nice.org.uk/guidance/ng51

43 https://www.england.nhs.uk/nhs-standard-contract/

Performance against screening for sepsis

Our overall sepsis screening was at an average of 55% for eligible patients in the Emergency Department (AED) and an average of 30% (see Figures 37 and 38) for all other patients.

Figure 37: *Pressure ulcer incidence (category 3 and 4) during 2023/24*

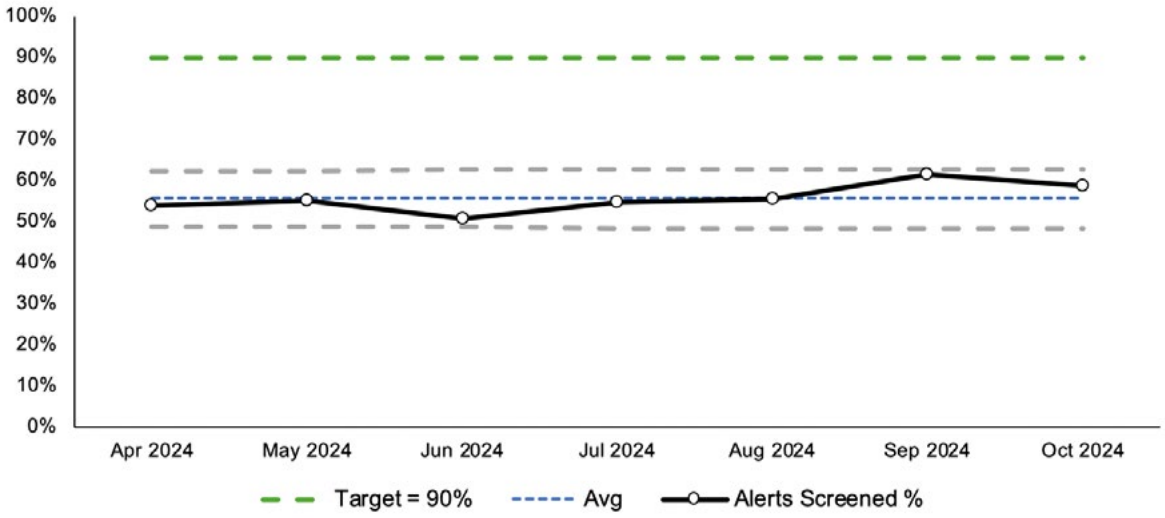
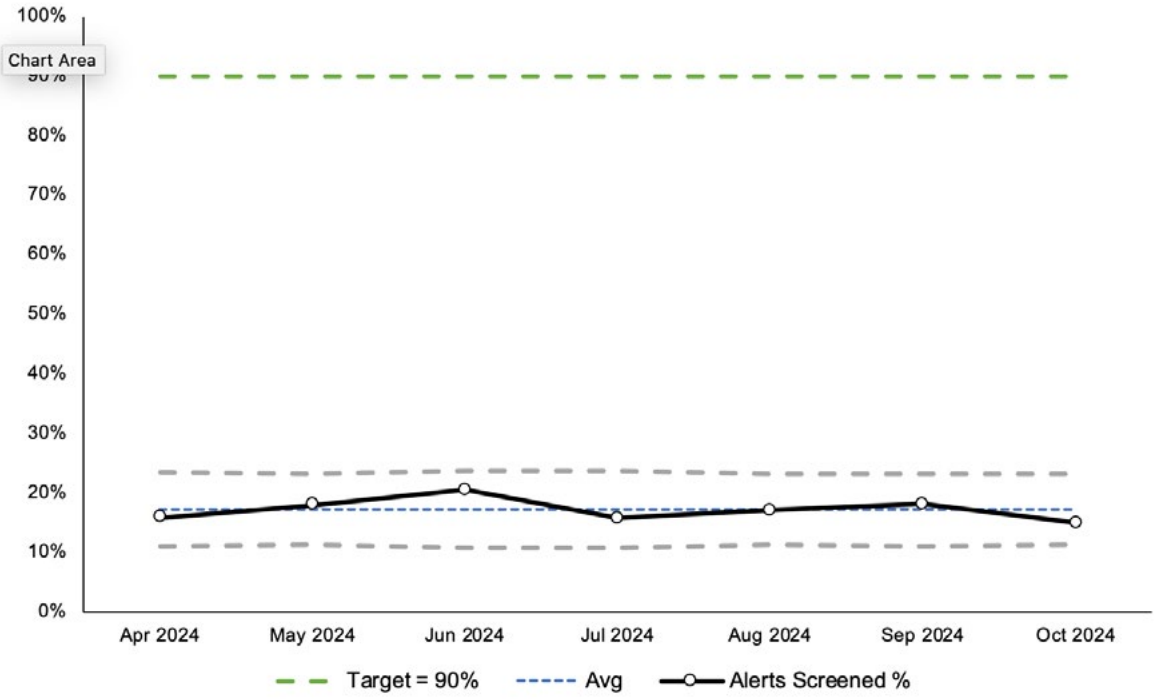


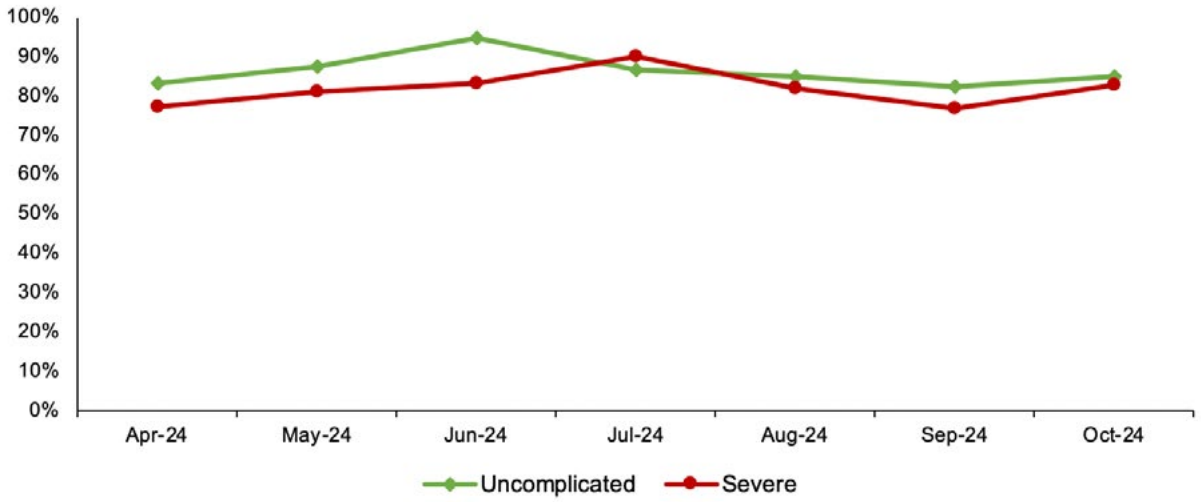
Figure 38: *Percentage of patients that were screened for sepsis on in-patient wards including AED*



Performance against administering intravenous antibiotics within 1 hour and 3 hours

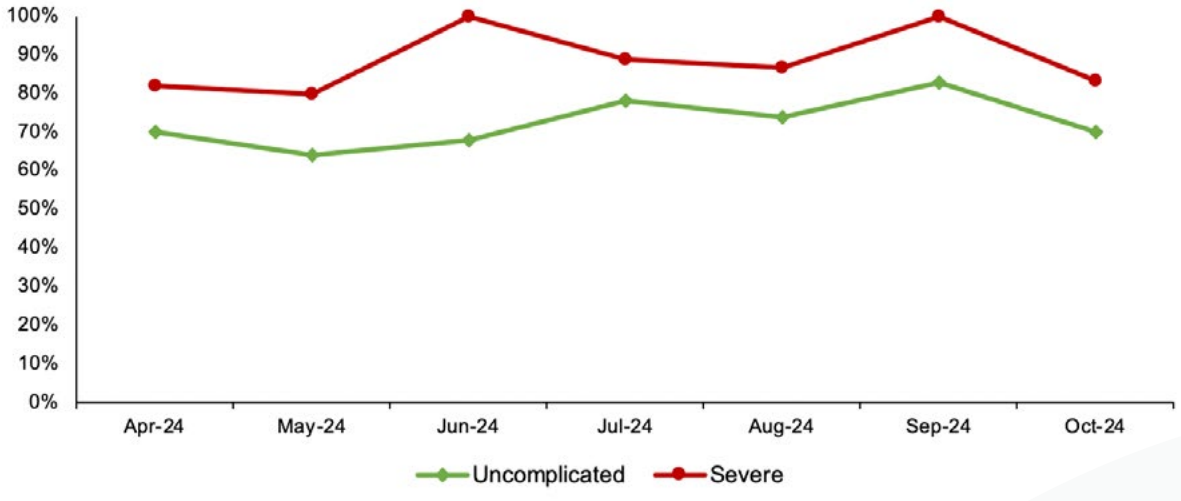
The average time to treatment for patients with suspected high risk sepsis (antibiotics within a maximum of 1 hour) within AED was 79%. The average time to treatment for patients with suspected moderate risk sepsis (antibiotics within a maximum of 3 hours) within AED was 81% (see figure 39).

Figure 39: *Percentage of patients that received intravenous antibiotics in the AED within one hour for high risk sepsis (red line) and 3 hours for moderate risk sepsis (green line)*



The average time to treatment for patients with suspected high-risk sepsis (antibiotics within a maximum of 1 hour) on in-patient wards was 84 %. The average time to treatment for patients with suspected moderate risk sepsis (antibiotics within a maximum of 3 hours) on in-patient wards was 63% (see figure 40).

Figure 40: *Percentage of patients that received intravenous antibiotics on in-patient wards within one hour for high risk sepsis (red line) and 3 hours for moderate sepsis (green line) on inpatient wards.*



Although we have seen a small drop in averages for sepsis screening when compared to last year, we have seen an improvement in our time to administer antibiotics and we continue to 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.

Quality improvement projects across wards and departments within our Trust continue to be undertaken to address both screening and time to antibiotics by resident doctors, this work is being overseen by speciality consultants. The information is also shared at CSU patient safety meetings monthly. Training is delivered to both nursing, medical staff and AHP's (allied health professionals) to continue to raise awareness of the importance of identifying patients with suspected sepsis. Our Trust is aiming to develop a Sepsis E-Learning package for all clinical staff to access and complete.

There is also work being undertaken through the 'Recognition and Response to the Acutely Unwell Patient Group' to identify further improvements that can be made to our Trust wide digital screening tools. These improvements include reviewing the parameters for triggering sepsis screening and initiating the sepsis protocol. We are working closely with our digital team to make adaptions as timely as possible.

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

Blood Culture Improvement Project

In 2023 a monthly Trust 'Collaborative and Improvement Group' was launched following a recommendation in NHS England's report into blood culture practices[44], 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 (multi-disciplinary team). The work initially focused on the pre analytical phase, predominately volume of blood in the culture bottles and time from collection of the sample to the laboratory. During 2024 this has expanded into also looking at time to incubation. In October 2024 we had our on-site incubation equipment turned on which is enabling the incubation of blood cultures taken from areas across our Trust were patients are clinically at higher risk of deterioration.

During 2025 we expect to be in receipt of 2 further incubators, one in the main laboratory and one within the neonatal unit to enable incubation of all blood cultures taken on the Bradford Royal Infirmary site. This is a step change in our Trust. The intended outcome of this is earlier identification of organisms in the blood stream and therefore the timely administration of appropriate antimicrobial therapy. This supports the antimicrobial stewardship and antimicrobial resistance programmes nationally.

The Government has developed an Antimicrobial Resistance 5 year national action plan, 'Confronting antimicrobial resistance 2024 to 2029'[45], which aims to:

- optimise the use of antimicrobials
- reduce the need for, and unintentional exposure to, antibiotics
- support the development of new antimicrobials.

44 https://www.england.nhs.uk/publication/improving-the-blood-culture-pathway-executive-summary/

45 https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2024-to-2029/confronting-antimicrobial-resistance-2024-to-2029

The World Health Organization (WHO)[46] are also supporting antimicrobial stewardship with the AWaRe (Access, Watch and Reserve)[47] programme with the aim of Trusts' reducing their use of broad-spectrum antimicrobials by 10% following the national trend.

The blood culture collaborative will have a direct impact on both the national and international programmes of work, supporting the use of the correct antibiotics at the right time.

In 24/25 we are hoping to continue to see improvements and to change the process within the analytical phase of the blood culture pathway working closely with our colleagues at Airedale NHS Foundation Trust.

There is a Trust e-learning package available to all clinical staff. Since it went live last year over 400 staff have completed this.

We collect and share with the clinical teams data from the laboratory monthly in relation to volume of blood collected in each bottle, and time to laboratory from collection (see figures 41 and 42). Since introducing the incubator on site at Bradford Royal Infirmary we have been able to show a significant reduction in time to incubation as shown in Figure 43.

Figure 41: *Monthly average time to laboratory*

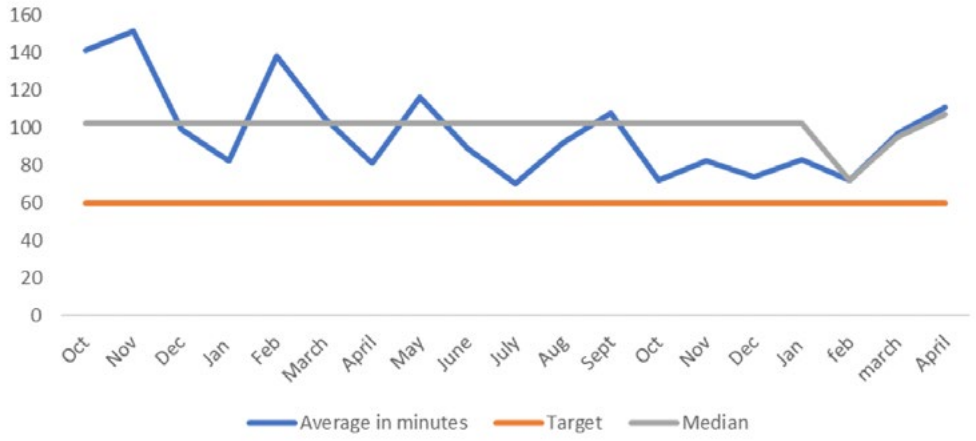
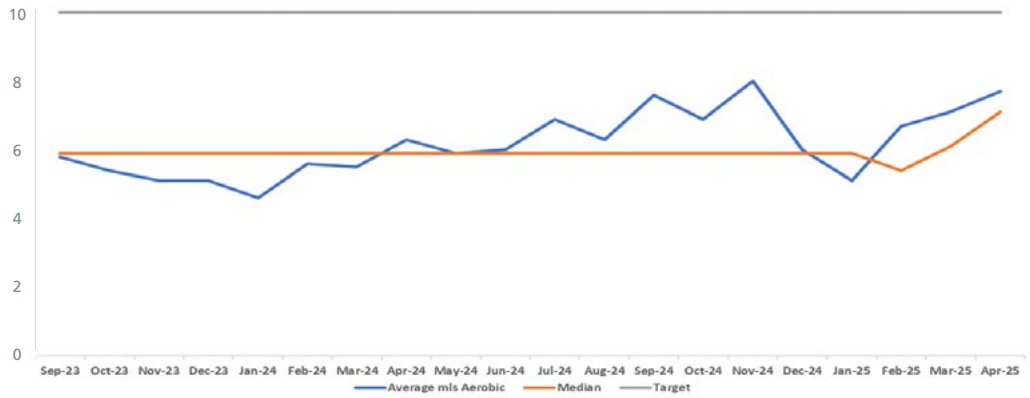


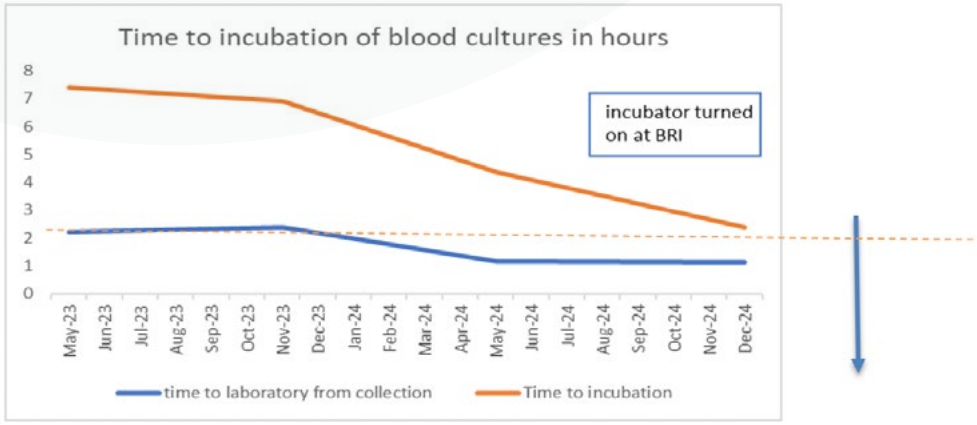
Figure 42: *Average Fill volume in blood culture bottles*



46 *https://www.who.int*

47 *https://www.who.int/publications/i/item/9789240062382*

Figure 43. *Time for cultures to be incubated once received in the Laboratory*



Improvement work in the above areas continues and, with engagement from resident doctors supporting projects in key wards and departments across our Trust, we aim to continue making improvements to our antimicrobial stewardship work.

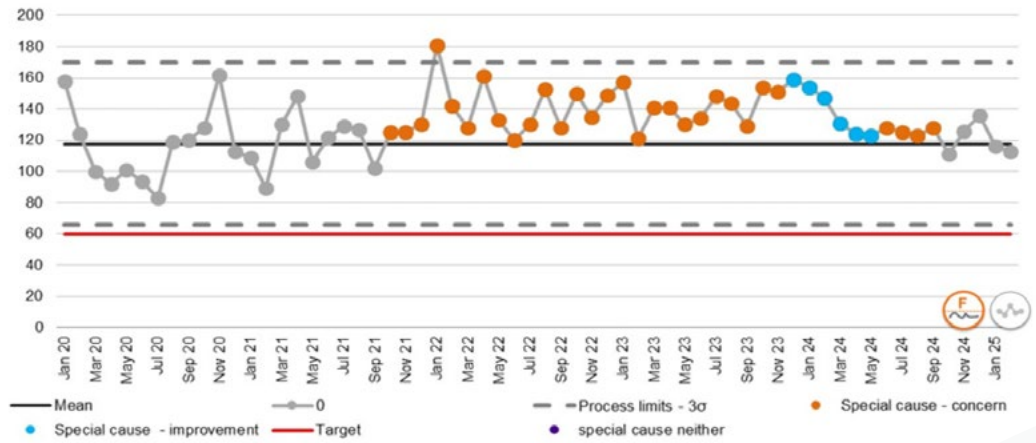
3.1.3 FALLS

This data is collected via our EPR (Electronic Patient Record) and our incident monitoring system Integrated Reporting Learning and Improvement System (IRIS) and is validated by clinical staff.

Our Trust routinely monitors all 'Falls' patient safety incidents that take place on our Trust premises. The Lead Nurse for Falls Improvement routinely reviews all falls across our organisation irrespective of outcome. This is in line with the Patient Safety Incident Response Framework (PSIRF) principles, as much learning can be taken from low and no harm incidents.

We have seen a decrease of 332 falls in total over the last twelve months (see figure 44 below), and we have reported 7 fractured neck of femur incidents which is a reduction from 9 in the previous year and a reduction in the number of moderate harm incidents reported.

Figure 44: *Number of falls per month*



The patient safety incident reporting framework is fully embedded in the falls incident review process. The hot debriefs and after-action reviews identify any areas for improvement for the clinical teams to focus on. This learning is shared by the clinical service units (CSUs) in their quality and safety meetings and in the falls improvement group. Each CSU take turns to showcase the work that they have undertaken to reduce the number of falls within their areas.

Learning and Improvement

The Royal College of Physicians National Audit of inpatient Falls (NAIF) Annual Report 24/25[48] has provided feedback on the 7 fractured neck of femurs reported to help develop objectives for 25/26.

To address the potential for harm caused by hospital acquired deconditioning a new approach is being taken that focuses on promoting activity and using assessments to ensure each patient is fit to move as safely as possible. In recognition of this the previously named multifactorial risk assessment (MFRA) is changing its name to multifactorial assessment to optimise safe activity (MASA).

There are four key performance indicators (KPIs) for this next year and 5 national recommendations which will form the key areas of focus for the falls improvement group over the coming year.

- KPI 1. Ensuring high-quality multifactorial assessment to optimise safe activity.
- Post fall
- KPI 2. Checking for injury before moving.
- KPI 3. Safe lifting equipment used to move the patient from the floor.
- KPI 4. Medical assessment within 30 minutes of the fall that caused injury.

The recommendations are:

- Ensuring that policies and practice ensure that patients are enabled to be as active as possible.
- Ensure that all older people are screened for delirium upon admission to hospital.
- -Ensure there are robust governance processes in place to understand when post-fall checks fail to correctly identify a fall related injury.
- All patients that sustain an injury especially hip fractures are administered analgesia within 30 minutes of the injury.
- Ensure that the Trust is ready for the audit expansion in January 2025.

For 25/26 we will be reporting on all inpatient falls that result in any fracture not just fractured neck of femurs and any intercranial bleeds.

3.1.4 INDICATORS FOR CLINICAL EFFECTIVENESS

Crude Mortality Rate

In conjunction with using SHMI (Summary Hospital-level Mortality Indicator) as an indicator of potential excess mortality, we have also been monitoring the crude mortality rate for our Trust over the period. This is calculated by the number of deaths within our 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.

The current Healthcare Evaluation Data (HED) covers a period from March 2023 to January 2025 with our current 12-month average mortality rate being 2.04% (see figure 50). This is one of the lowest mortality rates in

48 https://www.rcp.ac.uk/improving-care/resources/naif-annual-report-2024

the country and shows that mortality is not excessive at our Trust despite having a high SHMI. Within the West Yorkshire region, we have consistently had the lowest average mortality rate of all acute Trusts in the area over the period reported and well below the national average crude mortality rate.

Figure 45: *Crude Mortality Rate (12 month rolling: Mar 2023 to Jan 25): 2.04% 3.1.5* *PATIENT EXPERIENCE*

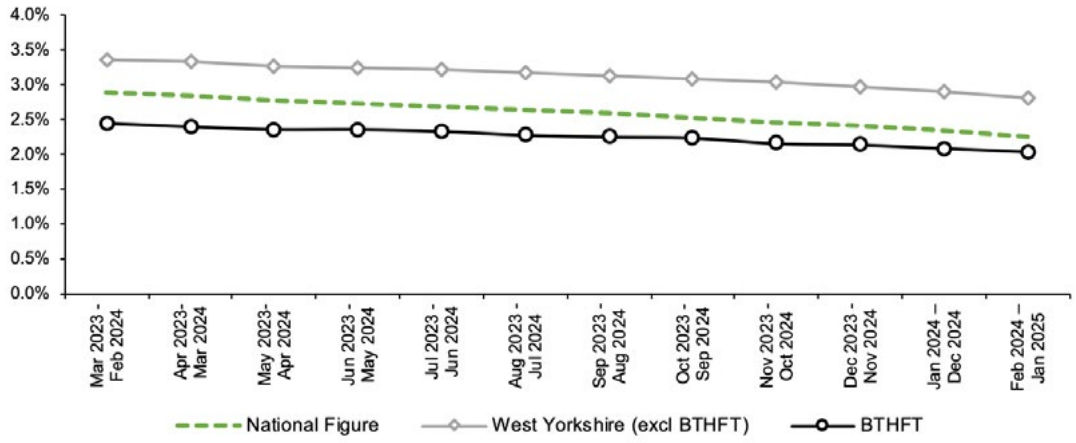


Figure 46: *Crude Mortality Rate, observed deaths and discharges*

Crude Mortality Rate 12-month rolling	Indicator Value %	Number of Observed Deaths	Number of Discharges
Mar 2023 - Feb 2024	2.45%	3,040	124,007
Apr 2023- Mar 2024	2.40%	2,966	123,501
May 2023- Apr 2024	2.36%	2,934	124,139
Jun 2023 - May 2024	2.36%	2,936	124,239
Jul 2023 - Jun 2024	2.34%	2,902	124,274
Aug 2023 - Jul 2024	2.28%	2,845	124,783
Sep 2023 - Aug 2024	2.25%	2,809	124,615
Oct 2023 - Sep 2024	2.24%	2,787	124,470
Nov 2023 - Oct 2024	2.16%	2,689	124,661
Dec 2023 - Nov 2024	2.14%	2,655	124,265
Jan 2024 – Dec 2024	2.09%	2,612	124,984
Feb 2024 – Jan 2025	2.04%	2,547	124,853

3.1.5
PATIENT EXPERIENCE

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.
- Continued contribution to the district wide Community Engagement agenda.
- Numerous patient and public involvement projects have taken place to improve facilities and services and ensure they are inclusive for all our communities.
- Ongoing work with the Equality, Diversity and Inclusion (EDI) team in relation to public engagement and feedback to support EDI 2022 objectives[49] included work in relation to End of Life Care and Breast Screening awareness.
- Introduction of CardMedic[50] which provides translation cards and provides this information in Easy Read, Audio, British Sign Language and over 50 different languages.
- Accessible Information Standard[51] work has been improved through a monthly working group, focusing on promoting and supporting people with diverse communication needs receiving their information in the correct format.
- Improvement work in relation to patient information and education, including the introduction of the Eido leaflets, which also provide Easy Read and different language formats.
- Work with the Governance team regarding PSIRF (Patient Safety Incident Response Framework) and recruitment of a Patient Safety Partner, who is now a member of the Patient Experience Group to provide valuable challenge to the group.
- Ongoing Partnership working with Healthwatch[52].
- The Spiritual Pastoral and Religious Care (SPaRC)[53] service has been busy promoting their SPaRC App.
- Production of Patient Stories from our diverse patient communities to learn and share lived experience and target further improvement work.
- The interpreting team have carried out over 57,000 interpreting sessions supporting the needs of our diverse communities during health consultations in multiple languages and providing over 900 British Sign Langue sessions for members of our deaf community.
- Extension to visiting hours, to support CQC (Care Quality Commission) regulation (9A) and joint work with the SPaRC team regarding visiting over important religious festivals to enable extended family time during these periods.

A number of these highlights are expanded upon in the following sections. Patient Experience and Engagement Strategy.

49 www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds

50 nhsaccelerator.com/innovation/cardmedic/

51 www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/

52 www.healthwatchbradford.co.uk/

53 www.bradfordhospitals.nhs.uk/sparc/

Patient Experience and Engagement Strategy

During the last year, the Patient Experience and Engagement Strategy 2023-2028 has continued to be embedded. This strategy takes the work on "embedding kindness" from the previous patient experience strategy, to "kindness at every step, no decision about you without you". The strategy sets out how our Trust is committed to ensuring we work towards including patients, families, and carers in decisions about the care that is being provided. The patient's voice is 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. Our aim is to ensure that patient, family, and carer experience is at the heart of all the work carried out. We also recognise the importance of working with our partners and engaging with our diverse communities.

Our strategy sets out six aims and a framework for improvement of how the work is to be achieved through:

- 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. Within the organisation there has been a shift to make patient experience a standing agenda item on additional meetings to highlight the importance of, and links to, patient safety.

The strategy has been presented at several forums and meetings throughout the year to raise the profile. These forums include the following:

- Quality Committee.
- Community Engagement meeting.
- District wide Citizen Forum.
- EDI 2022 community event.
- Healthwatch.
- Nursing and Midwifery Excellence event.
- Annual General Meeting, ward walks and public events.

Work is planned to continue embedding our strategy and cross pollinating with other Trust strategies to ensure patient experience and involvement are at the centre of all that we do. The strategy has also been produced in an Easy Read format during 2024.Spiritual Pastoral and Religious Care (SPaRC).

The SPaRC model (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 and Data
- Data and Organising

During 24/25 the team carried out an exceptional 39,722 visits, represented in figure 47 below.

Figure 47. SPaRC visits for patients and visitors during 2024 to 2025

Month	Patient Visits
Apr-24	3,325
May-24	3,463
Jun-24	3,330
Jul-24	3,609
Aug-24	3,825
Sep-24	3,826
Oct-24	3,256
Nov-24	2,978
Dec-24	2,873
Jan-25	3,340
Feb-25	3,137
Mar-25	2,760
Total	39,722

Over the last 12 months the SPaRC team has played an active and positive role in supporting our patients and staff in the Emergency Department, committing to providing dedicated time from a SPaRC core team member. This presence has benefitted both staff and patients, whilst waiting to be seen by a clinical or a medical practitioner. The success of this project will now be mirrored in the Intensive Care Unit, with the intention of working closely with the Family Liaison Officer, to support patients, families and staff.

There has been ongoing work with the voluntary services team to support the return of SPaRC volunteers and increase the numbers. Volunteers play an important role in providing pastoral support to patients whilst in the Trust. This additional support allows for SPaRC work to be delivered to all hospital locations, including our community hospitals.

A SPaRC WebApp[54] has been developed to support patients and staff with understanding individuals spiritually, pastoral, and religious needs whilst in hospital. It holds the world's major beliefs and various video clips to aid understanding. In addition, it has life scenarios such as feeling lonely, anxiety, baby loss, and receiving bad news. The App has received positive feedback alongside national interest from several other NHS organisations who would like to develop something similar.
A short video[55] demonstrates the WebApp including how to access these services.

54 www.sparc.bradfordhospitals.nhs.uk/

55 vimeo.com/925951596/0351ffce72?share=copy

The SPaRC team have been working very closely with our local communities throughout the year and are actively involved in supporting several festivals and celebrations. The Vaisakhi celebration was held on the main concourse at Bradford Royal Infirmary with the Sikh community who provided hot meals. The event attracted well over 1,000 staff members to their stalls.

Vaisakhi celebration

Christmas was celebrated on the main concourse at Bradford Royal Infirmary and on the wards with guests from the Bradford Chorale which attracted a large crowd including patients, staff and the public, setting the scene for the delivery of a range of other activities running up to Christmas.

Ramadan saw the return of Fast Packs. These were first delivered in 2022 and include pop up prayer facility packs, dates and water bottles issued to staff. These packs have helped at least 80 managers support their colleagues during the Ramadan period. Our Bradford hospitals charity[56] has helped fund the Fast Packs for our Muslim staff.

Work over the next 12 months is planned to engage further with our local community by promoting the work of SPaRC in the hospital, speaking at local churches and a Muslim team member is delivering 'death and dying' sessions at a local community group.

Education improvement work is planned jointly with cancer services developing video clips with a religious perspective and a 'train the trainer' programme is being developed for Practice Educators raising awareness of different cultures to help overseas staff have a more positive experience whilst working at our Trust.

Ramadam FAST pack

Additional Needs Team

The Additional Needs Team was formed in 2023 and consists of the following staff.

- Lead Nurse for Learning Disabilities
- Mental Health Specialist Practitioner
- Care Navigator

These roles have previously existed within the Trust's Safeguarding Adults team. The decision to separate them was in recognition that not everyone with a Learning Disability or a Mental Health.

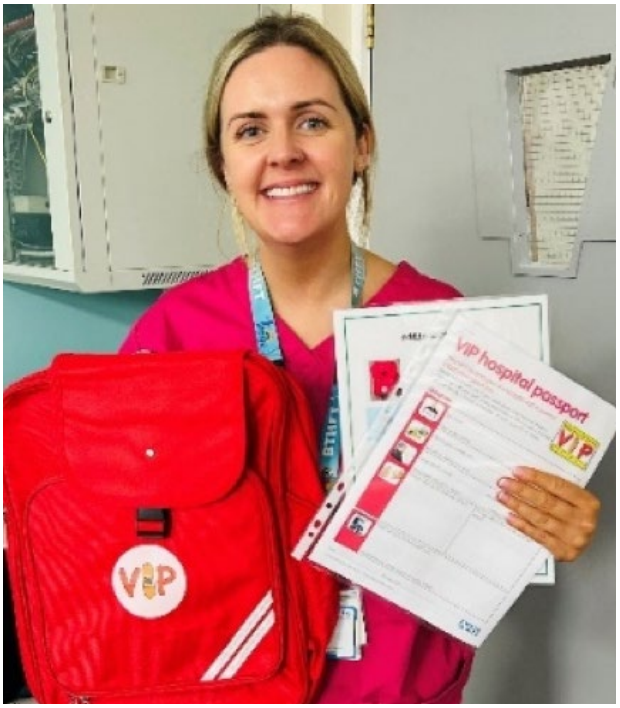
condition needs safeguarding. The team focusses on access to services and ensuring

56 *bradfordhospitalscharity.org/*

reasonable adjustments are made so that patients receive the best care possible whilst they are in hospital. The role out of the Oliver McGowan Training in Learning Disabilities and/or Autism[57] has been embraced with a high percentage of staff across our organisation completing the first tier. Our Trust has recruited staff specifically dedicated to this vital training in preparation for tier 2 rollout.

The VIP red bags and VIP passports remain a consistent identifier of people with a learning disability when accessing healthcare at our Trust. The bags were co-produced with Waddiloves Health Centre[58] in Bradford and people with a learning disability who expressed their need to be seen as a person who may require additional support. These bags travel with the patient and contain individual information pertinent to that individual.

VIP red bag



Multidisciplinary team working has grown through the past year, as evidenced through work carried out jointly with Martin House Children's Hospice[59] and community learning disability services to support young people transitioning to adult services to ensure all care needs are considered when accessing services and during admissions to the Trust.

The additional needs team welcomed the role of the care navigator in 2023, the success of this role and the positive response received led to a Health Service Journal (HSJ) nomination recognising the holistic person-centred approach that has been delivered. The care navigator role has evolved to meet the needs of people with a learning disability and mental health through training, "out of the box" thinking and challenging professional bias.

Dementia and Frailty

Over the last year our Trust has embraced the opportunity to incorporate the dementia focused work into our frailty work and look at how acute hospital stays impact on this vulnerable group of people. Our Trust held a conference on 'deconditioning in hospital' in October 2024 to focus attention on the need to keep people up and out of bed and active wherever possible. This was the catalyst for more focused work to be rolled out across our organisation in 2025/26.

Our Trust participated in the National Audit of Dementia[60] during 2024. This highlighted that a significant number of admissions (16%) were for people with dementia.

57 *www.hee.nhs.uk/our-work/learning-disability/current-projects/oliver-mcgowan-mandatory-training-learning-disability-autism*

58 *www.bdct.nhs.uk/our-services/learning-disability-services/learning-disability-health-support-team/*

59 *www.martinhouse.org.uk/*

60 *www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-audit-of-dementia*

This useful audit provided a focus for dementia and frailty improvement work for 25/26 and these areas specifically include:

- Pain- assessment of and route of administration.
- Discharge - planning.
- Communication- multidisciplinary.
- Work with carers- co-production to include needs and satisfaction
- Training and awareness.

From an environmental perspective, our Trust continues to work to enhance the clinical spaces to be more responsive to the needs of patients and less clinical in their appearance. Our estates and facilities team worked with patients and Lucentia Design[61] to create a more calming space for patients and relatives at St Luke's Hospital, by producing artwork for the ward corridors. The designs were influenced by conversations with patients and their love of nature and being by the sea with the intention of stimulating conversations with patients whilst on the ward in support of their recovery and wellbeing.

Partnership Working and Engagement

The patient and public involvement team have worked with several groups around improving accessibility. Walk arounds with members of the Hi-VisUK Group[62] (a sensory needs group commissioned by Bradford Metropolitan District Council) has enabled feedback from members of the community who have accessed our Trust to provide feedback from a partially sighted and deaf perspective. This has led to amendments in signage and several other accessibility changes. More recently this group has contributed specifically to the Emergency Department improvement project which has received positive feedback from staff running the program as they have been made aware of things they hadn't previously considered and from the participants in the engagement event who stated that they felt listened to.

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

An example of joint work with EDI included the annual contribution to the Equality Delivery System 2022 work. A community engagement event took place on 14 January 2025 where a range of evidence and presentations were shared, including discussions with service representatives and colleagues from the Patient Experience & Involvement team. Feedback received from this event includes:

- Good engagement with good representation from diverse communities.
- Positive feedback on the presentations and content/ format of the event
- Some excellent practice taking place in the chosen service discussed (end of life and breast screening) to meet the needs of our diverse patients and communities.
- Recognition that there are still areas where improvements can be made to continue improving access, experience and outcomes.

Community Engagement

Our Patient Experience team continues to work with partners in the district to improve patient experience and engagement. Meetings regularly take place to facilitate and share work in this area. Our Trust is a member of

61 www.lucentia-design.com/

62 hi-vis.org/hivisuk-and-bradford-partnership-boost/

the Citizen Voice Forum[63] which has members from across the Bradford District and Craven Health and 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 for communities to access relevant information.

Regular meetings and joint working takes place with local Healthwatch[64]. This ensures that teams are sighted on any areas of concern raised by the public at the earliest opportunity. Our Trust has been an active member in the 'Listen in'[65] events, held at various locations throughout the district, providing opportunities for community members to access staff from statutory and voluntary organisations to enable their voices and concerns to be heard. The programme for 2025 plans to repeat these listening events following the previous year's success.

The success of our Trust Community Engagement meeting has continued. It provides an open forum to enable different community services and teams (both statutory and voluntary) to share concerns at our Trust and, connect with new and planned projects.

During 2024 there have been increased opportunities for our Foundation Trust members to become involved in projects which are communicated via our Trust's monthly membership e-newsletter.

Examples form our overall engagement work include:

- Joint work with the Parliamentary Health Service Ombudsman in relation to complaints.
- Engagement with formal bodies, CQC when asked for any patient experience information.
- Patient, staff and relatives' feedback on visiting hours.
- Emergency Department feedback and walkarounds to suggest accessibility improvements.
- Patient and public involvement team projects which include breast Screening and Radiology.

Patient Information

Our Trust recognises that patient information is a crucial part of the patient journey. It is a key element in the overall quality of the patient's experience and is important for achieving informed consent and informed decision making. It also enables patients to choose in certain circumstances what option in best for them.

In January 2024 our Communicating with Patients Approval Group (CPAG) approved 63 new patient communication items, reviewed 299 items, approved 42 video scripts linked with the work being undertaken by our virtual hospital[66] and logged 78 external resources.

Work will now take place over the next 12 months to:

- Streamline the approval process for requests for new patient information.
- Reduce the duplication of information produced within the Trust.
- Produce a digital leaflet library of all patient information used within the Trust to have a more comprehensive governance process to make sure information is current and up to date.

63 engagebdc.com/west-yorkshire-voice

64 www.healthwatchbradford.co.uk/

65 engagebdc.com/listen-in-bdc

66 www.bradfordhospitals.nhs.uk/vri/

This is in line with our review of the Communication with Patients Policy and Guidelines for the Development of Patient Information. The Patient Experience team will be working on ensuring compliance with the Policy. Compliance with help ensure that patients are properly prepared for procedures, treatment, or appointments which re key elements in the overall quality of the patient experience.

Complaints

The Patient Experience team receive complaints, requests managed by our Patient Advice and Liaison Service (PALS) and compliments. The team supports our Clinical Service Units (CSUs) in responding to concerns.

The number of complaints received in 24/25, as shown in figure 53, has increased overall to date in comparison to the previous year with a significant increase in March 2025. Themes and trends from CSU complaints are presented to the Patient Experience Group. Many complaints are now resolved through face-to-face meetings with complainants which has led to more timely investigations and responses. This follows the Parliamentary Health Service Ombudsman[67] (PHSOs) recommendation as best practice for management of complaints.

Figure 48. Complaints: *comparison between 23/24 and 24/25*

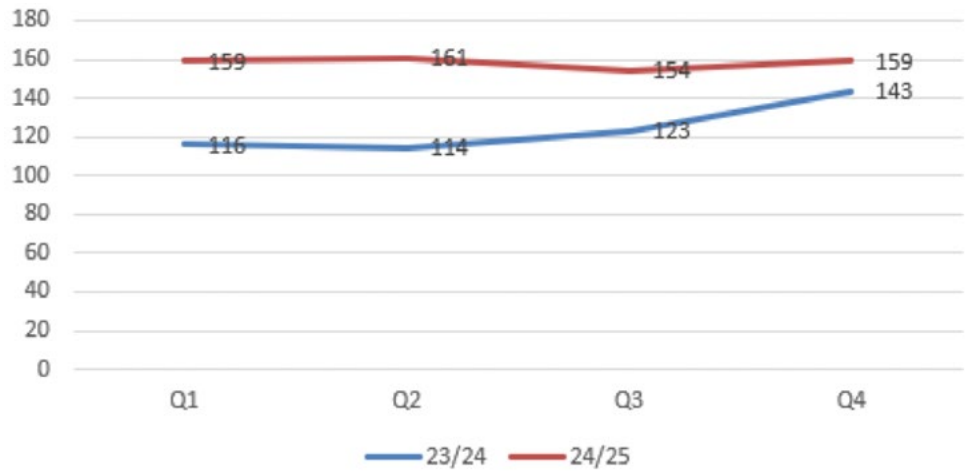
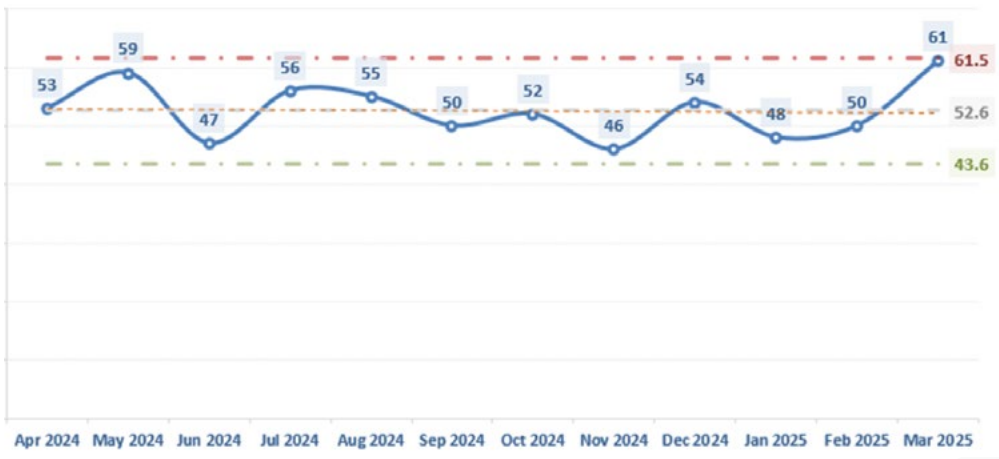


Figure 49. *Annual complaints against the actual upper and lower limited against the calculated fields based on the averages*



67 *www.ombudsman.org.uk/organisations-we-investigate/good-complaint-handling*

As shown in figure 49 (previous page):

- The red and green lines show the upper and lower control limits (these are calculated fields based on the actuals)
- The blue lines are the actuals, i.e. 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 seen in several months through the year with no trend on previous years. Work is underway to triangulate data from complaints, and other patient experience metrics to enhance learning.

Learning from complaints is being shared at our Trust via different forums and in liaison with patients and, the Equality, Diversity and Inclusion (EDI) service.

Patient stories

Patient stories are shared at our Trust Board. Patients who have shared their stories are keen to feedback where improvements could be made and in support of further learning. The stories are heard from a diverse range of backgrounds and specialities. This diversifies learning and promote inclusivity. Our patient stories are a valuable tool for supporting organisational learning and education.

Interpreting services

Bradford has a diverse and multi-cultural population, which is reflected in our patient profile. The language Interpreters play a vital role in ensuring our Trust provides high quality, safe and equitable care to all patients. Accurate communication between clinicians and patients is essential for diagnosis conversations, treatment and care.

Our Trust interpreting services team supported people on at least 57,438 occasions during 24/25, and in over 60 different languages. The service meets the needs of non-English speakers and British Sign Language users, primarily through face-to-face interpreting. We also have the ability to provide support via telephone and video consultation, to ensure 24-hour access, seven days a week. Requests for support in other formats, such as Braille, are also met through the team.

The top 10 languages requested are shown in figure 50 below.

Figure 50. *Top 10 languages requested through interpreting services from 1 April 2024 to 31 March 2025*

Language	No. Requests
Urdu / Punjabi	29,697
Czech / Slovak	6,781
Bengali	3,731
Polish	3,381
Arabic	3,134
Hungarian	1,258
Pushto	1,106
BSL	946
Kurdish	778
Farsi	769

Interpreters are used to communicate with patients regarding their medical histories, current concerns, diagnosis and treatment options and, to obtain consent for treatment or procedures.

Our Trust also makes use of remote interpreting, to increase efficiencies, improve responsiveness and adapt to the digital delivery of services. The use of remote Interpreting Services (Telephone / Video) has increased to over 20% during the past year.BSL Interpreting has also been provided by the team, delivering over 900 sessions during 24/25.

To further support inclusivity the Patient Experience Team were proud to announce a partnership with CardMedic[68], the latest innovation adopted at the Trust as part of the "Clinical Insite" membership of the NHS Clinical Entrepreneur Programme[69]. CardMedic is designed to supplement existing interpreting services, provide help with translation where it wouldn't be convenient or appropriate to call for an interpreter or, where an interpreter is unavailable. The App is proving to be of 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. Use of the app has also added to improvements in patient experience in 24/25.

68 www.cardmedic.com/

69 nhscep.com/

Internal collaboration work

The Equality, Diversity and Inclusion (EDI) team has collaborated with the Patient Experience and Involvement Team on ensuring EDI is a 'golden thread' running through our recently launched Patient Experience & Engagement Strategy. Our Patient Experience & Involvement Team provide focus on engaging with under-represented groups and communities to provide support in sharing their lived experience and, supporting teams and departments across the Trust in addressing some of the potential health inequalities and challenges that exist within the Bradford district. We see this co-production as a key to meaningful change. The Patient Experience & Involvement Team regularly share learning at the Trust's Equality Diversity Council and at Board where patient stories are heard, with a view to support Trust wide learning and improvement. A few examples of work undertaken during 24/25 to promote equality of service delivery are highlighted below.

- Patient Experience Team approached by the service leads to undertake patient engagement for the Pennine Breast Screening Service[70] with the aim of better understanding why patients are not taking up the offer of a breast screening appointment and to explore any potential barriers. This resulted in the development and sharing of a short, animated video addressing some of the concerns raised and to improvements in the accessibility of appointment letters and service information.
- Accessible Information Standard (AIS) Training[71] is being rolled out across our Trust for reception staff. To date all staff in the Central Patient Booking Service Team have undertaken their training. At the request of the Senior General Managers, there is a requirement for all reception staff within the Clinical Service Units (CSUs) to undertake the training, which has also been included as part of our Trust Induction Programme.
- Our Trust was asked by Healthwatch Bradford[72] to take part in a pilot for the new NHS England self-assessment framework for the AIS[73]. Taking part in the pilot was a chance to evaluate the framework and provide feedback and recommendations to NHS England on clarity, usability, relevance, and impact of the self-assessment framework before finalisation.
- Our Trust continues to work with AccessAble[74] which we partnered with several years ago to create detailed access guides for all our Trust hospitals. The guides provide useful information including parking, hearing loops, walking distances and accessible toilets. Further development during 2024 included bespoke visual maps to several key locations on the BRI site.
- Staff training has been commissioned for a selection of staff to undertake British Sign Language Training. Our Trust adheres to the Accessible Information Standard and provide information in different formats which include easy read, large print braille, and text-phone for hearing and speech difficulties. Our interpreting services provides written and verbal translations where required and support clinic appointments.

70 www.bradfordhospitals.nhs.uk/pennine-breast-services

71 www.bradfordhospitals.nhs.uk/patients-and-visitors/accessible-information/#:~:text=Accessible%20Information%20Standard%20(AIS),and%20pictures)%20or%20via%20email.

72 www.healthwatchbradford.co.uk/

73 www.england.nhs.uk/nhsimpact/assessment-and-improvement/self-assessment/

74 www.accessable.co.uk/bradford-teaching-hospitals-nhs-foundation-trust

Our Trust continues to use the equality impact assessment methodology and processes in ensuring assessments are being conducted on new policies and practices. In January 2025, the newly refreshed Bereavement Policy underwent a full equality impact assessment to ensure that any potential impacts were considered and mitigated by colleagues, taking into consideration the diverse needs of patients and visitors in respect of cultural, or religious needs and preferences at End of Life. This is an issue that has received significant development over the last 12 months following the establishment of an End-of-Life working group with the opportunity to showcase some of this progress at the Community Engagement event as part of the Equality Delivery System review where the inclusive work of the Trust Adult Palliative Care team was described as "Brilliant".

Projects for the Patient Experience and Involvement Team for the year ahead 25/26

- Improvement work taking place to create a dashboard of patient experience metrics.
- Re launch of the Kindness work and further embedding the Patient Experience and Engagement Strategy.
- In partnership with Shipley College Bradford, launch the "Clinical Customer Care" training.
- Continued improvement work for patient information leaflets to include increased accessible formats including easy read and different languages.
- Further development of Bereavement services to include aftercare support for families and improvements to collecting feedback.
- Strengthening the learning from complaints and sharing this more widely across the organisation to evidence 'You Said We Did' communications and, to support the better triangulation of data.
- Supporting staff to undertake the British Sign Language Training.
- Relaunch of the 'Knitted Hearts' for End of Life patients.
- Work with Quality team around Martha's rule[75].

75 www.england.nhs.uk/nhsimpact/assessment-and-improvement/self-assessment/

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

Scorex House
1 Bolton Road
Bradford
BD1 4AS

10 June 2025

Bradford Teaching Hospital Foundation Trust Quality Account 2024/25

On behalf of NHS West Yorkshire Integrated Care Board, I welcome the opportunity to feedback to Bradford Teaching Hospital Foundation Trust on its Quality Report for 2024/25. The Quality Account has been shared with key members across the Bradford and Craven Place and this response is on behalf of the organisation.

The four priorities set out in 2023/2024 have been achieved, along with improvements in other key areas.

Priority 1 Improving the management of deteriorating patients including the implementation of Martha's Rule-for example, the introduction of the Patient Wellness Questionnaire has led to improved discussion with patients regarding pain management. Staff have also found the structured conversation guidance tool helpful. Information on Martha's rule is clearly visible in the hospital.

Priority 2 Implementing the 3-year plan for maternity and neonatal services based on the Ockenden review and Saving Babies Lives. This has included continued implementation of the Saving Babies Lives Care Bundle Version 3 and meeting the Year 6 Maternity Incentive Scheme standard.

Priority 3 Understanding and tackling health inequalities-linked with priority 2, collaboration with Bradford Metropolitan Food Bank is firmly embedded, enabling Community Midwives and service users to access emergency food bags from the Women's and Newborn Unit. In addition, the Women's and Newborn unit hosted a 'warm coat rail' over the winter months for a second year running which has been extremely well accessed and offered a free school uniform rail during the summer months. Developing capability and knowledge within staff on health equity

by integrating health inequalities modules into our staff induction and undertaking the NHS Providers Health Inequalities self-assessment allowed identification of areas to improve.

Priority 4 Embedding the Trusts Patient Safety Incident Response Plan including the development of metrics to demonstrate its effectiveness. This has been achieved with good engagement from all services and a continued emphasis on embedding a positive learning culture to support learning and change.

Achievements and Highlights from 2024/2025

- Further implementation of Martha's rule led to the Quality Improvement team along with clinical colleagues commended at the Health Service Journal 'Patient Safety Awards' receiving a high commendation for "Early-Stage Patient Safety Innovation of the Year."
- Improvement work to improve uptake of breast screening.
- Development of the INSIGHT report- brings data together related to claims, litigation, inquests, and Care Quality Commission (CQC) enquiries and triangulates with incident reports, PALS (patient advice and liaison enquiries) and complaints, for the purpose of learning, improvement, and assurance.
- Audit participation- BTHFT was eligible to participate in 37 clinical audits as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and 40 national clinical audits as part of the NHS Standard Contract. Reviews were undertaken where identifying an outlier to understand if patient harm and identify any improvements required.
- Research Activity-BTHFT was the 4th highest recruiting hospital site to National Institute of Health and Care Research portfolio studies in the United Kingdom. Born in Bradford is well recognised, and the reports will now lead to guides explicitly stating how schools, paediatricians and local authorities can implement recommendation across their local areas. Other research areas include the
- Wellbeing in later in life in Bradford-again the findings will influence health and social care, digital engagement and older people and Exploration of why heart disease, diabetes and stroke are at high-levels in Pakistani and Bangladeshi communities.
- Care Quality Commission-several inspections occurred this year and the overall rating remains good with the neonatal unit receiving an outstanding rating from their CQC inspection.
- Several other external/peer and accreditation reviews (radiology intervention, breast screening, radiology, anaesthesia, critical care) took place -no immediate concerns and recommendations followed up.
- Learning from Deaths-steps taken to address improvements are clearly visible, with a particular focus on people with a learning disability, or speech problems. The Medical Examiner's process is now fully implemented.
- Thirty- day readmission rates – the increase was analysed and processes relating to incorrect coding have been addressed.

- Patient experience-positive results from CQC survey. Improvement projects that have taken place are:
  - Discharge planning
  - Noise at night reduction
  - Improving availability of equipment required on discharge.
  - Length of wait for a bed.
  - Introduction of a system which provides translation cards and provides this information in Easy Read, Audio, British Sign Language and over 50 different languages.

Further examples to support diverse communities include production of Patient Stories from diverse patient communities to learn and share lived experience and target further improvement work. In addition, the interpreting team have carried out over 57,000 interpreting sessions supporting the needs of our diverse communities during health consultations in multiple languages and providing over 900 British Sign Language sessions for members of our deaf community.

- Staff survey- showed significant improvements in our scores around the role of immediate line managers and colleagues responding favourably around teams and teamwork.
- Specific improvement work has yielded successful change in specific care pathways; blood culture analysis; falls have decreased over the last twelve months following the implementation of the falls bundle; the completion of risk assessments for venous thromboembolism were found to have high levels of compliance; pressure ulcers- improvement methodology were applied to the Emergency department so risk and necessary action is identified early; improvement in time to administer antibiotics in line with the sepsis improvement work.

The overall CQC rating remains as 'Good,' and I note that the three key local priorities for quality improvement for 2025/26 will have a continued focus on change which will have the greatest impact on patient safety:

1. Building on previous work to improve the management of the deteriorating patient, the further three components of Martha's Rule across all adult in-patient wards will be implemented.

Component 1: Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.

Component 2: All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.

Component 3: This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.

2. Building on success in implementing Saving Babies Lives you will continue to make improvements in maternity and neonatal services with a focus on reducing health inequalities.

3. You will continue to develop and embed your approach to patient safety and clinical governance by implementing fully the recommendations from your internal audit reports relating to risk management and patient safety.

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

Finally, I am required to confirm that the Bradford District and Craven Health and Care Partnership has reviewed the Quality Account and believe that the information published provides a fair and accurate representation of Bradford Teaching Hospital's quality initiatives and activities over the last year.

I can also confirm that the Bradford District and Craven Health and Care Partnership has taken reasonable steps to validate the accuracy of information provided within this Quality Account and can confirm that the information presented appears to be accurate and fairly interpreted; the Quality Account demonstrates a high level of commitment to quality in the broadest sense and we support the positive approach taken by the Trust.

Yours sincerely,

Matt Sandford
Director of Partnership and Place
Deputy Accountable Officer BDC ICB

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 2024/25.

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 of significant funding cuts and the re-organisation of health services for the Trust and the wider Integrated Care System, and the pressure this places on all aspects of Trust work.

The commitment of the Trust to improving patient experience is tangible and clearly demonstrated in the 5-year Patient Experience & Engagement Strategy and the Chief Executive recognising "patients and service users as collaborators in improving services".

This is further embedded in the work of the staff and patient assessors and the examples of 'quick wins' given in this Quality Account demonstrates how listening to patients often results in improved services that are achieved simply and without significant demand on resources. Patient involvement is nothing to be scared of!

The Community Engagement Group is another excellent example of listening to, and working with service users. It is pleasing to note that waiting times, visiting times and x-ray were all identified as areas of concern by patients, and programmes of improvement have been created and successfully implemented to address the issues raised.

Healthwatch Bradford & District was pleased to congratulate the Trust on its Outstanding grading after the Care Quality Commission inspection of neonatal services, however we also recognise and welcome the importance of 'Saving Babies Lives' as a strategic priority of the Trust.

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 Assistant Chief Nurse for Patient Experience and their team.

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.

As a recently appointed Partner Governor Healthwatch Bradford & District work directly with the Board to positively influence the strategic direction of policy and to ensure the patient voice is present in all decisions.

It has been a pleasure to work directly with key Trust personnel to provide support and challenge to both strategy and delivery and look forward to continuing this relationship

Helen Rushworth
Chief Executive

June 2025

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 2024/25 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 2025

Professor Mel Pickup
Chief Executive Officer
June 2025