Bradford Teaching Hospitals
NHS Foundation Trust

Quality Account 2025/26

CONTENTS

1. STATEMENT OF QUALITY FROM THE CHIEF EXECUTIVE

Welcome to our Quality Account. Delivering safe, high-quality care a good experience of care is at the heart of everything we do. Our vision is to be an outstanding provider of healthcare, research and education and a great place to work. To achieve this, we aim to foster a culture where both our patients and our staff feel safe to speak up. I am incredibly proud of all our colleagues who serve as our eyes and ears, working hard every day to improve care and learn from our successes and challenges.

We recognise the rich and diverse population we serve. However, there are significant health inequalities leading to wide variations in health life expectancy. Our continued focus on providing high-quality care means we are designing services that reflect the needs of local communities. Working in partnership across our local system we aim to improve equity and access to care to improve population health.

During 2025/26 we underwent several Care Quality Commission (CQC) inspections, including a Trust wide Well-Led review. We are proud to have maintained an overall rating of 'Good' with an 'Outstanding' rating for our neonatal services. This demonstrates the amazing work and effort from our colleagues as we strive to deliver the very best experiences and outcomes of care. We have provided good assurance of effective leadership, governance and continued progress in embedding ways to support learning and improvement.

An additional area of progress to highlight is the opening of our new endoscopy unit, alongside the achievement of 'JAG accreditation' for endoscopy services, reflecting the high standards of care, patient safety, and clinical quality delivered by our teams. *The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) provides the formal UK accreditation for gastrointestinal endoscopy services.*

Integral to delivering quality care is the involvement of patients, families and carers. We are committed to listening to feedback, learning from experience and ensuring that people feel heard, respected and involved in decisions about their care. Initiatives such as Martha's Rule reinforce our commitment to acting promptly on concerns and strengthening a culture of openness and responsiveness. We have continued to embed Martha's Rule, supporting a culture where patients, families and staff feel empowered to speak up and where concerns are addressed promptly.

Over the past year, we have continued to strengthen our position as a leader in high-quality care, research and innovation. Our close partnerships with the Universities of Leeds and Bradford, alongside the work of the Bradford Institute for Health Research, have enabled us to translate evidence rapidly into practice and contribute to reducing health inequalities across our communities. Nationally recognised programmes such as Born in Bradford, NIHR initiatives and Connected Bradford continue to drive improvements in outcomes and population health, supporting the city's ambition to be a "City of Research." We are proud that more than 16,900 patients took part in research during 2025/26, our highest level to date, reflecting the commitment of our patients and staff. This integrated approach to care, teaching and research places us among a small group of trusts striving for excellence across all three domains, reinforcing our dedication to patient safety, quality improvement and innovation.

Our priorities for improvement for 2026/27 have been informed by our strategic objectives, the national outcomes framework (NOF), the Maternal Care Bundle (MCB) as well as learning from incidents, patient experience and staff feedback. Our priorities are:

1 Learning disability and autism
2 Workforce planning

3 Enhanced therapeutic observations and care (ETOC)
4 Maternity learning
5 Harm prevention and reduction

We are committed to listening to our patients and families while supporting and developing our workforce, fostering a culture where staff feel valued and empowered to deliver compassionate, personalised, and high-quality care. These priorities have been chosen to strengthen the link between staff experience and patient outcomes, recognising that engaged, supported teams are fundamental to delivering safe, effective, and person-centred care.

I am proud of the progress we have made and confident in our continued ambition to drive further improvements in quality, safety and care for our patients. Finally, I would like to thank everyone who has been involved in the work reflected in this report, as we continue to improve the safety, experience and effectiveness of care for all.

Professor Mel Pickup
Chief Executive Officer

June 2026

1.1. ABOUT BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST

Bradford Teaching Hospitals NHS Foundation Trust (our Trust) provides hospital services for the people of Bradford and surrounding areas across Yorkshire, serving a core population of around 667,000 people.

We are an integrated Trust delivering acute, community, inpatient and children's health services. Our acute services are primarily provided from Bradford Royal Infirmary, alongside a wide range of outpatient, rehabilitation and specialist services across multiple sites.

We employ more than 7,500 members of staff working across several locations, including Bradford Royal Infirmary, which provides most inpatient services, and St Luke's Hospital, which predominantly delivers outpatient and rehabilitation services. We also provide services from community sites including Westbourne Green, Westwood Park, Eccleshill, Skipton Hospital and the Bradford Macula Centre.

As a teaching hospital, we are committed to education, training and research. We work in partnership with universities and regional organisations to support the development of our current and future workforce and to advance healthcare innovation.

The Bradford Institute for Health Research (BIHR), based at Bradford Royal Infirmary, is one of the UK's leading centres for clinical and applied health research. Our people-powered research approach supports Bradford's reputation as a City of Research and enables innovation that benefits our patients and communities.

The Bradford Education & Training Centre at Bradford Royal Infirmary provides modern teaching facilities, including a simulation centre and dedicated technical and practical skills laboratories, supporting high-quality education and professional development.

As a learning organisation, we are proud of our focus on delivering high-quality care and our ambition to provide outstanding healthcare for all our communities. We work closely with partners across the health and care system, listen to feedback from patients and communities, and continue to innovate and improve the services we provide.

1.2. WHAT IS A QUALITY ACCOUNT?

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

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

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

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

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

1.3. SCOPE AND STRUCTURE OF THE QUALITY ACCOUNT

This report summarises our progress on the quality priorities we set for 2025/26.

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 2025/26.

- Part 2 describes our priorities for improvement for 2026/27, the rationale, our progress in 2025/26 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 2025/26 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.

2. PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1. PRIORITIES FOR IMPROVEMENT

Our Trust's quality priorities are approved by the Board and are overseen through the appropriate Board committees. These committees receive regular reports from the executive and clinical leads responsible for delivery, providing assurance on progress against each priority. Detailed implementation and monitoring are undertaken through relevant operational and clinical working groups, which reports to the Quality Committee to ensure effective governance and oversight.

During the reporting period, our Trust identified and focused on the following three quality priorities:

1. Improving the recognition and management of deteriorating patients, including the implementation of Martha's Rule.
2. Delivery of the Maternity and Neonatal Improvement Plan.
3. Further development and embedding of our Trust's Patient Safety Incident Response Plan (PSIRP), including the establishment of measures to assess its effectiveness.

These priorities were selected following analysis of performance data, learning from patient safety incidents, internal and external assurance processes, and engagement with clinical teams and stakeholders.

Following further engagement and feedback from key stakeholders, including clinicians, senior managers and patient safety leads, our Trust has agreed the quality priorities for 2026/27, which are set out below.

Quality Priorities for 2026/27: These priorities reflect identified areas of risk, opportunity for improvement, national guidance and learning from incidents and assurance processes.

Priority 1: Learning Disabilities and Autism

Our Trust will continue to improve the experience and outcomes of people with a learning disability and autistic people by:

- Making reasonable adjustments clearer, more consistent and more visible across all services
- Increasing proactive use of hospital passports to support personalised care
- Expanding delivery of Oliver McGowan Mandatory Training
- Strengthening partnership working with carers and families to support safe, person-centred care

Priority 2: Workforce Planning

Our Trust will strengthen workforce sustainability and capability by:
- Developing long-term workforce plans (1-year, 3-year and 5-year horizons) aligned to the NHS Long Term Workforce Plan
- Improving staff wellbeing, retention and leadership capability
- Expanding opportunities for education, training and career progression to support a skilled, flexible, multi-professional workforce
- Creating a sustainable workforce pipeline through education providers and partner organisations
- Enhancing digital skills and data literacy to support productivity, efficiency and quality improvement

Priority 3: Enhanced Therapeutic Observations & Care

Our Trust will improve safety and experience for patients requiring enhanced observations by:
- Ensuring compassionate and meaningful interactions during observation
- Providing training in trauma-informed care, de-escalation and relational approaches
- Reducing restrictive practices where possible
- Improving documentation and communication within and between teams
- Increasing patient involvement in personalised safety planning

Priority 4: Maternity Learning

Our Trust will strengthen maternity safety and learning by:
- Acting promptly on learning from incidents, national reports and recommendations
- Implementing the NHS England Maternity Safety Improvement Programme care bundles
- Improving escalation behaviours and multi-disciplinary team communication
- Supporting psychological safety for staff
- Ensuring families' voices are embedded within learning and improvement processes

Priority 5: Harm Reduction & Prevention

- For patients sustaining a hip fracture in the community, our Trust will focus on:
  - Reducing time to surgery
  - Improving pre-operative assessment and optimisation
  - Strengthening multidisciplinary coordination
  - Ensuring early therapy involvement and mobilisation

- For hospital-acquired infections, our Trust will focus on:
  - Antimicrobial stewardship
  - Reducing E. coli bacteraemia, MRSA bacteraemia and *Clostridioides difficile* infections
  - Strengthening infection prevention and control practices
  - Early recognition and timely intervention
  - Optimising hydration, nutrition and supportive care

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

Our Trust is committed to placing quality at the heart of everything it does. All staff are expected to embrace and demonstrate our Trust values of ***We Care, We Value People, and We Are One Team***. Delivery of this vision is supported through our Trust's overarching strategic objectives and enabling strategies for patient experience, cultural improvement and workforce development.

2.1.1 PROGRESS AGAINST THE 25/26 PRIORITIES

Priority 1: Building on our previous work to improve the management of the deteriorating patient with the full implementation of all 3 components of **Martha's Rule** to all adult in-patient wards.

Our Trust has prioritised improving how deteriorating patients are recognised and responded to, with a significant focus on the rollout of Martha's Rule. Introduced nationally following the death of 13-year-old Martha Mills, the rule aims to ensure that patient, family and staff concerns about deterioration are heard and acted upon promptly. Martha's Rule strengthens existing clinical systems by embedding a more person-centred approach to escalation and response.

Core components of Martha's Rule. Martha's Rule comprises three key components:

- Daily patient input – Patients are asked daily how they feel and whether they believe their condition is improving or worsening. Responses are acted on through a structured escalation process.
- Staff-initiated escalation – Any member of staff can request an urgent review from another clinical team if they feel a patient is deteriorating and that concerns are not being adequately addressed.
- Patient and family escalation – Patients, families and carers have a clearly advertised, direct route to trigger an urgent escalation at any time.

The underlying principle is that listening to *"soft signs"* such as subtle concerns expressed by patients and families can aid earlier detection of deterioration and prevent avoidable harm. Early national data (September 2024 to September 2025) indicates that Martha's Rule enhances existing systems by adding a sensitive, human-centred layer of safety.

Implementation of the Patient Wellness Questions (PWQ). To support delivery of Components 1 and 2, our Trust has introduced the Patient Wellness Questions (PWQ) tool. This provides a structured and consistent method for patients to report how well they feel and supports earlier recognition and escalation of deterioration.

Key elements of the PWQ approach include**:**

- The PWQ consists of two questions, each scored using a five-point scale. The combined score directs staff to the appropriate escalation pathway.
- Learning from early testing resulted in refinements to the process, including prompting staff to assess and manage pain prior to requesting a rapid clinical review, as higher scores were frequently associated with poorly controlled pain.
- A modified PWQ has been developed for paediatric patients, with escalation managed within Children's Services. Rapid reviews are undertaken by an alternative paediatric team, reflecting the absence of an on-site paediatric intensive care unit.
- Within maternity services, patient concerns are already embedded within the existing Modified Early Warning Score (MEWS), which includes escalation to the Critical Care Outreach (CCOR) team.

Direct escalation for patients and families (Component 3). Component 3 provides a direct escalation route for patients, families and carers to contact the CCOR team if they are concerned about deterioration. This system is now live across adult and paediatric inpatient areas, offering a visible, accessible and reliable means of requesting urgent assistance.

Dedicated escalation phone lines were launched for:

- Adult inpatient wards: 6 November 2025
- Paediatric inpatient wards: 24 November 2025

Martha's Rule has been actively promoted across our Trust using the national communications toolkit. This includes A3 posters displayed on all wards, pull-up banners in the BRI main concourse, and information published on both our Trust's public website and staff intranet. Intranet information is available in multiple languages to support accessibility for diverse patient and family groups.

Early outcomes and monitoring. Between January 2025 and March 2026, the CCOR team undertook 19 rapid reviews following staff escalations using the PWQ tool. From November 2025 to March 2026, there were eight family-initiated calls to the Martha's Rule escalation line. No calls or staff-led PWQ escalations were received within children's inpatient services during this period.

Across all reviews, the CCOR team provided advice, guidance and reassurance to staff, patients and families, and there were no unplanned admissions to intensive care arising from these escalations.

Governance and assurance. Martha's Rule was identified as a key improvement priority within the Trust's 2025/26 Quality Account. Now that full implementation has been achieved, ongoing oversight and assurance will include:

- Monthly ward-level audits to confirm consistent use of the PWQ tool
- Continued monitoring of escalation and rapid review data by the CCOR team
- Regular reporting of PWQ compliance and Martha's Rule activity through the Recognition and Response of the Acutely Unwell Patient Group and the Patient Safety Group, supporting continuous learning and improvement

With all three components of Martha's Rule fully embedded, our Trust now meets the NHS Standard Contract requirements for 2026/27.

Priority 2: Building on the success in implementing *Saving Babies' Lives* will continue to make improvements in our maternity and neonatal services with a focus on reducing health inequalities.

In response to the recommendations issued in November 2024, the service has developed an updated improvement plan. This plan demonstrates good progress against the required actions, with no areas of significant concern identified to date. Ongoing improvement activity includes strengthened collaborative working with pharmacy colleagues, particularly the introduction of a process to monitor ambient room temperatures in areas where medicines are stored, along with clear actions to be taken when temperatures fall outside agreed parameters.

Following the unannounced CQC maternity inspection in September 2025, the service has now received the published inspection report and accompanying ratings, which are publicly available on the CQC website. The service is pleased to report that it has been rated **'Good' across all five CQC domains**, resulting in an overall rating of **'Good'**. This outcome reflects the service's continued improvement journey and sustained commitment to delivering high-quality care, which remains a key priority.

The inspection report was reviewed in detail during December to identify any areas requiring further focus and improvement. A subsequent improvement plan was developed and shared with the Quality Committee in early 2026.

Priority 3: 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.

Our Trust transitioned to the national Patient Safety Incident Response Framework (PSIRF) in December 2023, publishing the Patient Safety Incident Response Plan (PSIRP) and associated policy at that time.

Following the internal audit programme and ongoing PSIRF implementation work, the PSIRP was reviewed in April 2025. This review concluded that no significant changes were required. However, a decision was taken to undertake a full review one year earlier than originally planned to ensure continued alignment with national PSIRF expectations and organisational risk. This review was intended to be completed by 1 April 2026, and the CQC was notified of this revised timescale during inspections in Quarter 3 of 2025/26.

Due to unforeseen external factors and limited capacity within the Quality Team, sufficient stakeholder engagement, essential to a robust PSIRP review, has not been possible within the original timeframe. As a result, the Trust has agreed to revise the delivery timeline to ensure the review is conducted thoroughly and to the required standard.

A comprehensive review of the PSIRP requires protected time and capacity to ensure it is evidence-based, reflective of organisational risk, and fully aligned with national PSIRF standards. This process involves detailed analysis of incident data, synthesis of thematic learning from multiple assurance sources, collaboration with clinical and operational leaders, and structured involvement of patients and families. It is therefore not appropriate for this work to be undertaken rapidly or without adequate engagement.

Without this deliberate investment of time, the PSIRP would not provide sufficient assurance or strategic clarity to support effective patient safety improvement. The revised plan must clearly demonstrate how learning drives improvement actions, describe mechanisms for sharing lesson-learned, commit to regular review and quality assurance, and confirm that appropriate resources are in place to support continuous improvement.

The full review of the PSIRP will now be undertaken during Quarter 4 of 2025/26 and Quarter 1 of 2026/27, with the revised plan to be published by 1 July 2026, in line with recommendations from the Internal Audit Programme. The updated PSIRP will be more closely aligned with nursing, medical and allied health professional practice and will include measurable outcomes aligned to the Foundation Trust's strategic objectives.

As part of this work, an executive-approved audit of the quality of local incident investigations within IRIS (Project and Program Risk Management Software) will be undertaken. This audit will support improvements in the quality and consistency of incident reporting and investigation and strengthen learning at both local and organisational levels.

Following engagement with key stakeholders, our Trust agreed priority themes for Patient Safety Incident Investigations for 2024/25, which have continued to guide activity throughout 2025/26.

Figure 1. Priorities for Patient Safety Investigations

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 approach. A thematic approach will look at all of the After Action Reviews 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.	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.

	A thematic approach will look at all of the local investigation responses and MDT reviews to gather system wide learning.	
Emerging patient safety themes where learning and improvement can be gained	Locally lead PSII	

Following an in-depth review of incidents with our stakeholders, four priority areas for improvement were identified:

- Pressure ulcers
- Patient falls
- Medicines safety
- Blood transfusion

These incident types have been subject to detailed investigation over the past four years, enabling us to develop a strong understanding of the key contributory factors. In light of this learning, we adopted a quality improvement–focused approach, working collaboratively with clinical staff and wider stakeholders to test and implement novel interventions that support learning and deliver sustainable change.

This approach is underpinned by the PSIRF principle of *doing less, but doing it better*. Rather than undertaking multiple reactive investigations, we focused our resources on targeted improvement activity within these four areas. This methodology and the associated interventions are described in the table below.

Figure 2. 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	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.

The ‘INSIGHT’ report (received by the Quality Committee) has evolved significantly over the past 12 months and now brings together a comprehensive range of intelligence, including mortality data, incidents, complaints, Care Quality Commission (CQC) enquiries, claims, and inquests. The purpose of the report is to support organisational learning, improvement, and assurance.

This represents a step change in the way data is triangulated across our Trust, enabling more robust identification of themes, emerging trends, and areas requiring improvement. Robust trackers are in place to provide oversight and assurance that local incident investigations which do not meet the Patient Safety Incident Investigation (PSII) threshold are completed within the timeframes set out in Trust policy, and that learning is appropriately shared and embedded across services.

In addition, a nationally approved Learning Response Review and Improvement Tool has been adopted to assess the quality of PSIIs and other learning responses. This tool underpins the panel review model that has been in operation since April 2025, strengthening the consistency, quality, and impact of our learning response processes.

2.2. STATEMENT OF ASSURANCE FROM THE BOARD

2.2.1. REVIEW OF SERVICES

During 2025/26 our Trust provided and/or sub-contracted 38 designated Commissioner Requested Services.

The income generated by the relevant health services reviewed in 2025/26 represents 100% of the total income generated from the provision of relevant services by our Trust for 2025/26.

2.2.2. PARTICIPATION IN CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

Our Trust’s approach to quality improvement is underpinned by a continuous cycle of learning and assurance, providing confidence to patients, staff and the Board that high-quality care is consistently delivered.

Clinical audit plays a central role in this approach, enabling services to identify areas of good practice, positive patient outcomes, and opportunities for improvement. During 2025/26, our Trust continued to strengthen its arrangements for the oversight and coordination of clinical audit activity, supporting clinical teams to monitor compliance with national standards and evidence-based best practice.

The High Priority Clinical Audit Programme for 2025/26 was informed by requirements set out within the NHS Standard Contract[2], including participation in the National Clinical Audit and Patient Outcomes Programme[3] (NCAPOP) and any other relevant audits listed within the NHS England Quality Accounts guidance[4].

Between 1 April 2025 and 31 March 2026, out of 88 workstreams included within the Quality Accounts List for 2025-26 (May 2025) the Trust was eligible to participate in 38 clinical audits as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and 34 additional national clinical audits as part of the NHS Standard Contract There were 16 programmes that the Trust did not participate in as these related to services not provided by the Trust.

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NCAPOP participation included:

1. Child Health Clinical Outcome Review Programme

[2] https://www.england.nhs.uk/nhs-standard-contract/
[3] https://www.hqip.org.uk/national-programmes/
[4] https://www.hqip.org.uk/national-programmes/quality-accounts/

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 (NAIF)
    - 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):
    - 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 Audit of Eating Disorders (NAED)
10. 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)
11. National Child Mortality Database (NCMD)
12. National Early Inflammatory Arthritis Audit (NEIAA)
13. National Emergency Laparotomy Audit (NELA)
14. National Maternity and Perinatal Audit (NMPA)
15. National Neonatal Audit Programme (NNAP)
16. National Paediatric Diabetes Audit (NPDA)
17. National Respiratory Audit Programme (NRAP)
    - COPD Secondary Care
    - Adult Asthma Secondary Care
    - Children and Young People's Asthma Secondary Care
18. National Vascular Registry (NVR)
19. Sentinel Stroke National Audit Programme (SSNAP)
20. UK Parkinson's Audit

Other national quality improvement programmes:

The Trust was also eligible to participate in a range of additional national quality improvement and registry programmes, including:

1. BAUS Data & Audit Programme
    - British Audit of the Investigation and referral of Women with Recurrent Urinary Tract Infection using recent Guidance (BOOMERANG)
    - Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)
2. Breast and Cosmetic Implant Registry
3. Case mix programme
4. Emergency medicine QIPs
    - Adolescent Mental Health
    - Care of Older People

- Mental Health Self Harm
- Time Critical Medications

5. Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR)
6. National Audit of Cardiac Rehabilitation
7. National Bariatric Surgery Registry
8. National Cardiac Arrest Audit (NCAA)
9. National Cardiac Audit Programme
    - National Heart Failure Audit (NHFA)
    - National Audit of Cardiac Rhythm Management (NACRM)
    - Myocardial Ischaemia National Audit Project (MINAP)
    - National Audit of Percutaneous Intervention (NAPCI)
10. National Comparative Audit of Blood Transfusion
    - 2025 Major Haemorrhage Audit
11. National Joint Registry (NJR)
12. National Major Trauma Registry
13. National Ophthalmology Database (NOD)
    - Age-related Macular Degeneration Audit
    - Cataract Audit
14. National Perinatal Mortality Review Tool (PMRT)
15. Perioperative Quality Improvement Programme (PQIP)
16. Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme
17. UK Interstitial Lung Disease (ILD) Registry
18. UK Renal Registry Chronic Kidney Disease Audit
19. UK Renal Registry National Acute Kidney Injury Audit

The Trust did not participate in every eligible programme, reflecting service scope, prioritisation, and capacity.

National confidential enquiries:

During the reporting period, the Trust participated in the following national confidential enquiries:

- Acute Illness in People with a Learning Disability – 100% case submission (6/6)
- Stabilisation of the Critically Ill Child Study – 100% case submission (5/5)
- Pleural Procedures Study – 75% case submission (6/8)

Overall, the Trust achieved 100% case ascertainment in two of the three studies, with participation maintained across all enquiries. It is recognised that this work relies heavily on clinician time alongside competing service pressures.

We reached 100% case ascertainment from two 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.

National audit outliers and learning:

In November 2025, Bradford Royal Infirmary was confirmed as a **Gold-level NJR Quality Data Provider**, reflecting:

- Positive outlier status alert: National Joint Registry (NJR).
  November 2025: Confirmation received that Bradford Royal Infirmary has been awarded as a gold level NJR Quality Data Provider:
    - 100% compliance with data submission by 31 August 2025
    - 0.0% missing case status
    - 0.0% missing cases

This recognition provides strong assurance regarding data quality and governance.

- National Prostate Cancer Audit (Negative Outlier)

In June 2025, our Trust received a negative outlier notification for the proportion of patients experiencing a genitourinary complication requiring intervention within two years of radical prostatectomy (Trust 15.1% vs national 6.0%). All 29 cases were reviewed. After excluding investigations where no pathology or intervention was required, 11 patients (11/158; 6.9%) required interventions attributable to robotic prostatectomy. Most issues were managed conservatively or with minor endoscopic procedures, with only two patients requiring major surgical intervention. Case mix review identified a higher proportion of locally advanced disease (54%) compared to the national average (37%), reflecting greater technical complexity. Learning from the review has been shared within the clinical team and continues to inform surgical decision making and patient counselling.

2.2.3. PARTICIPATION IN CLINICAL RESEARCH ACTIVITIES

Our Trust continues to demonstrate strong performance in research delivery, governance and assurance. During the year, research teams submitted a wide range of reports to funders, sponsors and regulators, supporting transparency, accountability and full compliance with Good Clinical Practice. These submissions reflect the scale, quality and maturity of research activity across the Trust.

Research participation remained high, with **over 16,900 participants recruited during 2025/26**, placing the Trust among the most research-active organisations nationally. During the 2025 Care Quality Commission (CQC) inspection, research services were viewed very positively. Inspectors highlighted the strong culture within research teams and the value of research programmes for patients and local communities.

Further information is available at www.bradfordresearch.nhs.uk[5] Key highlights from this year are summarised below:

Born in Bradford and Population Health Research

Born in Bradford (BiB)[6] is a large, long-term programme working in partnership with local communities to understand what helps people live healthier lives and why health inequalities persist. The programme includes more than **60,000 participants** and follows people from pregnancy through childhood, adolescence and into adulthood. By linking health, education, social and environmental data, BiB produces evidence that informs NHS care, local decision-making and national policy, with a strong emphasis on trust, fairness and community voice.

Cohort Studies

Born in Bradford's Better Start (BiBBS)[7] and BiBBS ACHIEVE[8] focus on giving children the best possible start in life. BiBBS successfully recruited 5,500 babies and their families, with strong support from local maternity services. Building on this, the programme secured a prestigious multi-million-pound Wellcome Discovery Award award[9] to extend follow-up into the primary school years through BiBBS ACHIEVE. This research is helping services understand how early-years interventions, family circumstances and wider pressures such as the cost-of-living crisis affect children's long-term health and development.

[5] http://www.bradfordresearch.nhs.uk/
[6] https://borninbradford.nhs.uk/
[7] https://www.betterstartbradford.org.uk/project/born-in-bradfords-better-start/
[8] https://borninbradford.nhs.uk/what-we-do/studies/bibbs-achieve/
[9] https://borninbradford.nhs.uk/news/prestigious-4-5m-wellcome-discovery-award-boosts-bradford-research-to-tackle-childhood-health-inequalities/

Age of Wonder[10] follows tens of thousands of Bradford teenagers through adolescence into young adulthood. The programme combines surveys, health measurements and creative approaches to explore mental health, wellbeing, relationships, social media use and identity. Young people are actively involved in shaping the research, ensuring their experiences and priorities are clearly represented.

This year has also seen the launch of the Age of Wonder data notes series which share the findings from this study more widely and accessibly. These findings create the most comprehensive, diverse picture of British adolescence ever produced. The research is already informing policy, practice and public understanding of what young people face today.

Connected Bradford[11] provides the secure data backbone for much of this work, linking anonymised health, education and social care data for over 600,000 people. Developed with strong public involvement, it allows researchers and services to understand population needs more clearly and to identify where inequalities exist, helping decision-makers target support more effectively.

Physical Activity and Healthy Families Research

The JU:MP[12] (Join Us: Move Play) programme is a flagship example of applied research leading directly to better health outcomes for children. The research demonstrated that children involved in JU:MP increased their physical activity by more than an hour per week on average, with results stronger than those seen in comparable programmes nationally and internationally. JU:MP works at neighbourhood level, supporting families, schools and communities to make physical activity a normal and enjoyable part of everyday life.

Alongside JU:MP, wider healthy families research focuses on reducing inequalities and supporting groups that are often under-represented in physical activity. Programmes such as Leaders Like Us work with young women and gender diverse young people to build confidence, leadership skills and long-term engagement in activity. These initiatives are developed through co-production with young people and communities, ensuring they are inclusive, culturally relevant and sustainable.

Mental Health Research

Mental health research continues to be a major priority. Our Trust secured £1.2 million from the Wellcome Trust[13] to lead a large, randomised trial testing whether restricting social media use improves mental health and wellbeing in young people aged 12 to15, The In Real Life Trial[14]. This high-profile study will recruit around 4,000 participants and is scheduled to begin in October 2026. The launch of this study has already attracted a great deal of media attention with the study already being featured on both regional and national new channels. This study will add much needed evidence to the debate on a social media band for teenagers.

The AIM Bradford[15] programme continues to evaluate local mental health services and interventions, including school-based mental health support teams and social prescribing. The programme combines routine data analysis with in-depth qualitative work with young people to understand what works, for whom and in what circumstances.

Healthy Places, Homes and Environment

Research on healthy places explores how neighbourhoods, housing, transport and the wider environment affect health and wellbeing. The healthy urban places programme works in

[10] https://borninbradford.nhs.uk/our-impacts/age-of-wonder-campaign/
[11] https://borninbradford.nhs.uk/what-we-do/research-centres/connected-bradford/
[12] https://joinusmoveplay.org/
[13] https://wellcome.org/
[14] https://bradfordresearch.nhs.uk/the-irl-trial/
[15] https://borninbradford.nhs.uk/what-we-do/studies/aim-bradford/

partnership with communities to understand how people experience their local environments and how changes to places can reduce inequalities. Findings are already informing regeneration, transport and planning discussions.

Healthy Homes[16] research looks at the impact of housing quality on health, particularly in low-income and multi-ethnic communities. Early findings show that cold homes, damp and poor indoor air quality are common and linked to worse health outcomes. This research is helping identify how housing improvements can deliver health, environmental and cost benefits without unintended negative consequences.

Academic Unit for Ageing and Stroke Research.

The Academic Unit for Ageing and Stroke Research[17] focuses on improving health, wellbeing and independence for older people and for those living with stroke and long-term conditions. The unit brings together NHS clinicians, researchers, social care partners and local communities to develop research that responds directly to the needs of Bradford's ageing population and addresses inequalities in access to care and outcomes. A key principle of this work is that research should lead to real change in how services are designed and delivered.

A major area of national impact has been the Unit's work on frailty identification and management. Researchers led the development and validation of the updated Electronic Frailty Index (eFI2)[18] which improves how frailty is identified using routine GP records. The updated tool is now used widely across primary care in England to support earlier identification of frailty, better care planning and more personalised support for older people. This work directly supports NHS priorities around prevention, integrated care and helping people remain independent for longer.

The Unit also leads a broad programme of research to improve stroke recovery and rehabilitation. Studies such as RECREATE[19] and ADAPT[20] explored how to reduce inactivity after stroke and how care can be adapted to better support different groups of stroke survivors. Importantly, this research has been carried out in partnership with patients and carers, ensuring their experiences shaped both the research questions and the solutions tested. Creative approaches, including public art exhibitions by stroke survivors, have been used to share findings widely and engage the public, clinicians and decision-makers.

In addition, the Unit is addressing gaps in care for older people with complex health needs. Research has explored issues such as pain management in people living with frailty, osteoporosis care for older women, and barriers to accessing appropriate support. Findings have highlighted gaps in communication, care navigation and service design, and have been used to co-produce practical resources for both patients and healthcare professionals. This work helps services better recognise and respond to the needs of older adults, particularly those who may feel unheard or overlooked.

Yorkshire Quality and Safety Research Group

The Yorkshire Quality and Safety Research Group[21] leads research focused on making care safer, more reliable and more responsive to patients' needs. The Group works closely with patients, carers, frontline staff, managers and national organisations to understand where risks arise in healthcare and what changes can prevent harm. Its work spans hospital, community and primary

[16] https://borninbradford.nhs.uk/what-we-do/studies/healthy-homes/
[17] https://ageingstrokeresearch.org/
[18] https://www.bgs.org.uk/the-electronic-frailty-index-2-%E2%80%93-using-patient-data-to-predict-older-people%E2%80%99s-care-needs
[19] https://ageingstrokeresearch.org/research-projects/recreate/
[20] https://ageingstrokeresearch.org/research-projects/the-adapt-study-using-an-ideal-type-approach-to-tailor-an-intervention-focused-on-reducing-sedentary-behaviour-after-stroke/
[21] https://yqsr.org/

care settings and addresses issues that matter directly to patients, such as communication, medicine safety and transitions between services.

A major area of national influence has been the Group's research supporting Martha's Rule[22], a new approach aimed at ensuring patients, families and carers can quickly raise concerns if a patient's condition is worsening. The Group undertook a large-scale evaluation across multiple NHS Trusts, involving interviews with staff and patients as well as observations of care. Findings from this work are informing NHS England's national rollout of Martha's Rule, helping Trusts understand how it can be implemented safely, fairly and effectively, including how to ensure it works for people from different backgrounds.

The Group has also led extensive research on improving the safety of care transitions, particularly when older people move from hospital to home. This work identified practical, low-cost changes that improve communication between staff, patients and carers, reducing confusion and preventable harm at discharge. The resulting intervention has been shown to be clinically effective and cost-effective, and the Group is now working to support wider adoption across the NHS.

Another important focus is medicines safety. The Group's research has explored how medication checking processes can unintentionally increase workload without improving safety. Findings have contributed to national guidance and new research programmes aimed at simplifying medicines administration while maintaining high safety standards.

Patient-facing resources developed by the Group have been adopted into national toolkits, helping people manage their medicines more confidently and safely at home.

Across all its work, the Group places strong emphasis on equity, patient involvement and real-world impact. Research actively explores how safety interventions are experienced by different groups, including people from ethnic minority backgrounds, older adults and those with additional needs. This ensures that improvements to care do not widen inequalities and that patient safety initiatives work for everyone.

NIHR Applied Research Collaboration (ARC) – Yorkshire and Humber

The NIHR Applied Research Collaboration[23] (ARC) for Yorkshire and Humber is a key part of how the Trust turns research evidence into meaningful improvements in day-to-day care. Hosted by Bradford Teaching Hospitals NHS Foundation Trust, the ARC works with NHS organisations, councils, universities, voluntary organisations and local communities to address the health and care challenges that matter most to people across the region.

The ARC focuses on applied research — research designed to improve services, outcomes and experiences. Its work supports priority areas such as reducing avoidable hospital admissions, improving urgent and emergency care, supporting people living with frailty, strengthening mental health provision, improving outcomes for children and families, and tackling health inequalities. Research is closely aligned to NHS and Integrated Care Board priorities, ensuring findings are relevant and useful for frontline staff and system leaders.

During the reporting period, the Trust secured £11.5 million in NIHR funding to continue leading the ARC for a further five years from April 2026. This funding reflects the strength of the ARC's partnerships, the quality of its research, and its proven ability to deliver real-world impact. The Yorkshire and Humber ARC has also been invited to co-lead the new National ARC Network[24], supporting stronger alignment of applied research across England and increasing national impact.

[22] https://yqsr.org/the-formative-evaluation-of-the-implementation-of-marthas-rule-interim-report/

[23] https://arc-yh.nihr.ac.uk/

[24] https://www.nihr.ac.uk/funding/nihr-applied-research-collaborations-network-arc-network/2025442

A particular strength of the ARC is its focus on knowledge mobilisation — ensuring that research findings are actively used to improve care. This includes training researchers and practitioners to translate evidence into practice, embedding knowledge mobilisation fellows within Integrated Care Boards, and working directly with services to apply research findings in areas such as frailty, urgent care, virtual wards and neighbourhood working.

ARC-supported research has contributed to national policy discussions and guidance in areas including falls prevention, same-day emergency care and reducing unnecessary hospital admissions. Several projects have been highlighted in national NIHR communications, demonstrating how research carried out in Bradford and across the region is shaping care beyond Yorkshire and Humber. Throughout this work, the ARC places strong emphasis on involvement of patients, professionals and communities, helping ensure that research improves care fairly and does not widen inequalities.

Improvement Academy

The Improvement Academy[25] plays a vital role in turning research evidence into real improvements for patients and staff. It works alongside clinical teams, services and partner organisations to support quality improvement, patient safety and service change. Drawing on improvement science and research, the Academy helps teams test, adapt and sustain changes that improve care.

The Academy provides training, coaching and hands-on support across our Trust, NHS partners and wider systems, including social care and the voluntary sector. It also supports national improvement initiatives and hosts one of NHS England's Patient Safety Collaboratives. By combining research evidence with frontline experience, the Improvement Academy helps ensure that improvements are practical, achievable and lasting.

Clinical Research and the NIHR Commercial Delivery Centre: Bradford and West Yorkshire

Clinical research plays a vital role in improving patient care by giving people access to new treatments, supporting innovation in clinical practice, and ensuring services are informed by the latest evidence. Our Trust has a long-standing and strong track record in delivering high-quality clinical research across a wide range of specialties, embedded within routine care and aligned to national NHS and NIHR priorities.

Research activity spans non-commercial and commercial trials and includes studies in most health conditions. Patient feedback consistently highlights positive experiences of taking part, demonstrating that research is delivered in a way that is safe, respectful and person-centred.

A major development during this period has been the successful establishment of the NIHR Commercial Research Delivery Centre (CRDC) for Bradford and West Yorkshire[26]. Our Trust secured almost £7 million of NIHR funding to host the CRDC, as part of a nationally coordinated network of centres designed to strengthen the UK's ability to deliver high-quality commercial clinical trials. The CRDC supports life sciences innovation while ensuring patients benefit from early access to new and emerging treatments.

The CRDC operates on a hub-and-spoke model, working closely with partner Trusts across West Yorkshire to increase research capacity, share expertise and reduce duplication. Dedicated staff, streamlined processes and improved oversight enable faster study set-up, more efficient recruitment and consistent delivery standards. This work aligns directly with national ambitions to reduce clinical trial set-up times and improve the UK's attractiveness for commercial research investment.

[25] https://improvementacademy.org/
[26] https://bradfordresearch.nhs.uk/researcharea/nihr-bradford-west-yorkshire-crdc/

A strong emphasis of the CRDC is fair and inclusive access to research. The Centre actively supports studies in community and non-acute settings and promotes approaches that reduce barriers to participation for people from under-represented groups and those living in areas of greatest health need. This helps ensure that new treatments are tested in diverse populations and that the benefits of research are shared equitably.

Research Infrastructure and Capacity Building

Continued investment in research infrastructure has strengthened our Trust's ability to deliver safe, high-quality and efficient research while supporting future growth. This includes improvements to physical facilities, digital systems, workforce development and governance arrangements, ensuring that research is embedded as a core function of the organisation.

Having secured £1.3 million of NIHR Capital Funding our Trust is expanding clinical research facilities through the development of new modular research space. This expansion will increase capacity for outpatient and day-case research, enhance laboratory and pharmacy facilities, and provide improved environments for participants and research staff. These developments support higher volumes of complex research activity and improve the experience for patients taking part in studies.

To improve access and inclusion, our Trust introduced a Mobile Research Vehicle[27] ('MRVin'), enabling research activity to take place in community settings such as shopping centres, at community events and local neighbourhoods. This innovation reduces barriers to participation, increases engagement from under-served communities and supports our Trust's wider population health and inequalities agenda.

Significant progress has also been made in strengthening research workforce capability and sustainability. This includes support for professional registration of clinical research practitioners, targeted training and development opportunities, and improved systems to track staff competencies and readiness to support new studies. Centralised oversight of training and skills enables the Trust to respond quickly to new research opportunities, including large-scale or time-critical trials.

Improvements to research governance and quality systems further underpin confidence in research delivery. Enhanced monitoring, thematic review of findings from sponsors and regulators, and standardised processes support compliance with Good Clinical Practice and continuous quality improvement. These developments ensure research remains safe, well-managed and aligned to regulatory and sponsor expectations.

2.2.4. CARE QUALITY COMMISSION (CQC) REGISTRATION

Our Trust is required to be registered with the Care Quality Commission[28] (CQC). Our Trust remains registered with the CQC without conditions.

During the period 1 April 2025 to 31 March 2026, the CQC did not take any enforcement action against our Trust, providing assurance regarding ongoing compliance with regulatory requirements.

2.2.5. CQC SPECIAL REVIEWS AND INVESTIGATIONS

During 2025/26, the Care Quality Commission (CQC) undertook a programme of unannounced service-level inspections, alongside a Trust-wide Well-Led inspection. Services inspected during

[27] https://bradfordresearch.nhs.uk/meet-our-mobile-research-vehicle/
[28] https://www.cqc.org.uk/

the year included Maternity, Outpatients, Urgent and Emergency Care, and Community Hospital inpatient services.

Our Trust-wide Well-Led inspection, carried out between 3 and 6 November 2025, resulted in an overall rating of Good for Bradford Teaching Hospitals, in line with the CQC Single Assessment Framework methodology.

Inspection outcomes during the year were positive, with services receiving Good ratings across the five CQC key domains of Safe, Effective, Caring, Responsive and Well-Led.

- Maternity Services were inspected between 16 and 17 September 2025 were rated Good across all domains, resulting in an overall Good rating.
- Outpatient services at St Luke's Hospital were inspected between 23 and 24 September 2025, received Good ratings across all domains.
- Community Health inpatient services were inspected in October 2025 receiving an overall rating of Good.
- Urgent and Emergency Care was inspected between 16 to 18 September 2025. At the time of writing our Trust is awaiting the final outcome of this inspection.

In response to the reports, our Trust has developed robust action plans, supported by clear executive leadership and ongoing executive oversight to ensure improvements.

These inspection outcomes provide assurance to patients, families and carers that our Trust continues to deliver high-quality, safe and compassionate care, and reflect the professionalism, commitment and dedication of staff across our Trust.

Figure 3 below illustrates the current CQC rating across the five key domains and provides a comparison with outcomes from previous inspections.

Figure 3. Care Quality Commission ratings for Bradford Teaching Hospitals NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Bradford Royal Infirmary (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
St Lukes Hospital (Outpatients)	Good ↔ Jan 2026	Good ↔ Jan 2026	Good ↔ Jan 2026	Good ↔ Jan 2026	Good ↔ Jan 2026	Good ↔ Jan 2026
Bradford Royal Infirmary (Maternity)	Good ↔ Nov 2025	Good ↑ Nov 2025	Good ↔ Nov 2025	Good ↑ Nov 2025	Good ↔ Nov 2025	Good ↑ Nov 2025
BTHFT – Community Health inpatient services	Good ↔ Jan 2026	Good ↔ Jan 2026	Good ↔ Jan 2026	Good ↑ Jan 2026	Good ↔ Jan 2026	Good ↔ Jan 2026
Key	Same	Up one rating	Up to ratings	Down one rating	Down two ratings	
Symbol	↔	↑	↑↑	↓	↓↓	

2.2.6. NHS NUMBER AND GENERAL MEDICAL PRACTICE CODE VALIDITY

During 2025/26 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 peers, with a number scoring 100% compliance. This has been achieved through focussed data quality cleansing sprints and greater engagement with front-line/operational staff.

Figure 4. 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%

2.2.7. CYBER ASSESSMENT FRAMEWORK (CAF) ALIGNED DATA SECURITY AND PROTECTION TOOLKIT (DSPT)[29]

The CAF aligned DSPT contains five Objective areas with a total of 47 Outcomes that sit below.

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

Most outcomes sit with Information Technology (IT)/cyber. As was the case last year, agreement between the Information Governance (IG) Manager and the Cyber Security Manager (CSM) was that the CSM would be point of contact for all Cyber and IT Outcomes. He would liaise with Head of IT and other colleagues and manage the collation/requirements. Meetings between the IG Manager and Business Owners, principally with the CSM, have taken place to provide assurance that 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[30] is undertaking its annual review of agreed Objectives. The review started on 23 March 2026 and closed on 6 April. The draft report providing audit opinion at this stage of the assessment is awaited.

In 2024/25 our 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

[29] The CAF aligned DSPT links to Quality Accounts by integrating baseline cyber and data security into the core governance and reporting expected of NHS Trusts. Because robust data security is now recognized as vital for patient safety and clinical continuity, compliance and maturity against CAF objectives must be documented in Quality Accounts.
[30] https://www.audityorkshire.nhs.uk/

CAF-DSPT assessment for 2025/26 is 30 June 2026. Our final assessment overall position for 2025/26 is therefore incomplete at the time of this report. Our Trust forecast position is 'Standards Met' for 2025/26 as previously, but this will be confirmed before submission on 30 June 2026.

2.2.8. 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 our Trust during the past five financial years. This may change in coming years due to new mixed funding models and greater scrutiny outlined in the NHS 10 Year Plan.

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. Our Trust was subject to an external DSPT clinical coding audit in November 2025.

The audit sample of 221 finished consultant episodes (FCEs) was selected using random sampling methodology from spells of inpatient discharges between 1 April 2025 and November 2025. All episodes were audited against the National Clinical Coding Standards[31] 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 improved by around 3% since the previous audit. Errors are 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 as part of a broader clinical coding strategy is already in place and has a positive trajectory.

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

Figure 5. Error rates reported in audit for Inpatient diagnoses and treatment coding

Coding Field	%Incorrect							
	25/26	24/25	23/24	22/23	21/22	20/21	19/20	18/19
Primary Diagnosis Incorrect	6.80%	10%	9%	7.70%	6.30%	5%	5.70%	8.60%
Secondary Diagnosis Incorrect	8%	4.40%	4.20%	5.50%	7.80%	3.80%	6.30%	10.20%
Primary Procedures Incorrect	6.10%	7.10%	5.60%	9.90%	3.80%	8.30%	4.70%	8.10%
Secondary procedures Incorrect	5.10%	3.80%	5.70%	12.90%	6.80%	5.30%	2.10%	7.20%

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

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. 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 our 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 our 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*[32] 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 an associated data issue tracking and resolution system, which presents anomalies to operational teams to support visibility, proactive management and timely resolution. A further suite of data quality dashboards targeting specific DQ issues is currently in development. Oversight of data quality has transitioned to the Digital Strategy Group, which brings together subject matter expertise from operational, clinical, informatics and business intelligence teams. This group provides strategic direction and ensures alignment with organisational priorities. It also considers process and system improvements, undertakes risk-based assessments of data quality concerns, and supports the identification of training and development needs.

There is an increased organisational focus on improving data capture to support our Trust's recovery programme over the next three years. Accurate and timely recording of activity is a key priority, underpinning service planning, performance management and patient care. Work is underway to strengthen data capture processes at the point of care, with an emphasis on consistency, completeness and real-time validation to meet the NHS 10 Year plan requirements for effective tracking of conditions across systems.

The Maternity Data Quality Committee continues to meet monthly to review data completeness and reporting, ensuring compliance with national and regional requirements while driving improvements in patient safety and experience. A similar framework of metrics and governance is being embedded following the TACC EPR solution go-live. *The TACC (Theatres, Anaesthesia and*

[32] https://www.england.nhs.uk/publication/making-data-count/

Critical Care) is an extension of the Cerner Millennium Electronic Patient Record (EPR) system being implemented by Bradford Teaching Hospitals and Airedale NHS Foundation Trust.

Formal education and training programmes continue to support the effective use of key information systems for both new starters and existing staff. The Data Quality team remains available for administrative and clinical staff, providing a forum to raise issues and focus on priorities relating to error prevention, correction and validation at an operational level.

2.2.11 LEARNING FROM DEATHS

During 2025/26, a total of 1,347 patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 312 in the first quarter
- 322 in the second quarter
- 370 in the third quarter
- 343 in the fourth quarter

The Learning from Deaths process: scrutiny and structured judgement reviews

The Medical Examiner Service for our 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. 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 6 below.

Figure 6. 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 2026, 71 SJRs had been carried out in relation to of the deaths during 2025/26.
The number of deaths in each quarter for which a SJR was carried out was:

- 18 in the first quarter
- 19 in the second quarter
- 17 in the third quarter
- 16 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 2025/26 are summarised in figure 7 below.

Figure 7. 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).
- Good understanding of LD patients' baselines with Red Bag and VIP passports at bedside.
- Parents heavily involved in treatment plans for adult LD patients.
- Excellent MDT discussions which included family and long-term carers to discuss the patient's needs and wants regarding treatment.
- Patients with NEWS >5 receiving observations every 20 minutes.
- Nursing care emphasised 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.
- Early involvement of senior clinicians in ED including ICU input and Palliative Care.
- Early involvement of REACT team as patient previously expressed wish not to be in hospital and were looking at ways to try to get them home to their preferred place of death.
- Early recognition that infection markers were not typical for a simple UTI prompting further investigation for sources of infection.
- Early discussions with the patient themselves regarding resuscitation.

Areas for improvement

- Non-verbal patients being prescribed pain medication PRN - *this is a recurring issue with our vulnerable patients and has formed one of the core learning points from a Patient Safety Incident Investigation (PSII) into treatment of our patients with learning disabilities.*
- Missed opportunity to have a patient seen by the mental health service - this patient had expressed past suicidal ideation and was an IV drug-user.
- Consent4 was used in a patient without any evidence of a mental capacity assessment being performed.
- Lack of recognition of patients being in Type 2 Respiratory Failure.
- Delayed response from doctors to a patient suffering a vasovagal episode.
- Potential sources for Sepsis (e.g. dressed leg wounds) not being checked.
- Lack of communication with families around prognosis and just how unwell some patients were - in one case the family did not realise that their relative was approaching end-of-life, leading to significant distress.
- Initial positive support declined once patient admitted to ward – patient was frequently described as 'difficult' and 'poorly behaved' without ward staff acknowledging LD status, individual needs or reasonable adjustments – one patient in particular was threatened with Security input which should not have happened.
- Ward staff not reaching out to Additional Needs Team to help create holistic plans of care for patients who need reasonable adjustments.
- Earlier access to ReSPECT forms to facilitate better management of patients close to end-of-life
- No blood cultures taken on admission and no discussions with microbiology despite failure to respond to antibiotic treatment.
- Arterial blood gas levels to be taken at initial investigation.
- Delays in giving antibiotics in a sepsis patient (8 hours post admission).
- Failure to recognise significance of CT findings in patient with severe necrotizing fasciitis.
- Patient sent to AMU not CCU despite ongoing nSTEMI requiring monitoring.

- Long wait in ED (>12 hours) without medicines documentation or evidence of clinicians reviewing primary care record in order to ensure regular medicines from the community were administered – a lack of access to SystemOne by resident doctors in compounding this issue.

There were 5 SJRs completed after 31st March 2025 which related to deaths which took place before the start of the reporting period:
- 0 for deaths occurring in the first quarter of 2024/25
- 0 for deaths occurring in the second quarter of 2024/25
- 1 for deaths occurring in the third quarter of 2024/25
- 4 for deaths occurring in the fourth quarter of 2024/25

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.

We have 2 FTSU Guardians and 22 FTSU Ambassadors across our 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 Guardians 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 our 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 our Trust most of the concerns raised have an element of inappropriate attitudes and behaviours. See figure 8 for the number of FTSU concerns raised.

Figure 8. Number of concerns raised in 2025/26

Quarter 2025/26	Number of concerns raised
Q1	25
Q2	26
Q3	51
Q4	32
Total	134

2.2.13 Guardian of Safe Working Hours

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 financial year.

Trainees submit exception reports if working beyond contracted hours or educational opportunities are missed. Key changes to the exception reporting process were implemented from early February 2026. Going forward exception reports relating to missed educational opportunities are managed by the Director of Education and, the Human Resources team can authorise requests for additional hours. The Guardian of Safe Working Hours retains oversight of all exception reports, including those which are withdrawn, and remains the final escalation point for any disputes.

There were 289 exception reports submitted during this year, highlighting concerns around working hours/rest and missed educational opportunities. This Is a reduction on the previous year when 304 reports were submitted. Most exception reports came from Foundation Doctors, predominantly the General Surgery and Medicine teams. This sits alongside the General Medical Council survey results highlighting workload pressures as a concern for Resident Doctors at our Trust.

There was a 4.93% decrease in exception reports in 2025/26 compared with 2024/25 with an associated 40.3% decrease in extra hours claimed in payment or 'time off in lieu'. While this is an improvement, work is ongoing to focus on workload pressures experienced by our resident doctors. This includes a business case to expand the 'Hospital at Night' Clinical Support Worker provision to reduce out of hours workload, recruitment into our Chief Registrar post to support the Resident Doctor forum and, work towards the Resident Doctor '10 point plan'.

A higher locum requirement continues in Emergency Medicine and General Medicine, reflecting these high-pressure specialties with rota gaps. Work is ongoing around self-rostering and workforce analysis, along with an application to the Yorkshire and Humber Deanery to support an additional six Foundation Doctors from August 2026. Palliative Medicine remains the only non-compliant rota (due to weekend working patterns). The trainees in post remain happy with their current pattern.

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 our Trust particularly new workforce initiatives or opportunities to fill rota gaps.

2.2.14 EDUCATION AND TRAINING

One year on from the launch of the Education Strategy 2025–2030, our Trust has continued to build on its established strengths while introducing a clearer focus on innovation, research, and adaptability. This has enhanced educational provision across the workforce, ensuring that training remains current, responsive, and aligned with future healthcare demands and patient needs. A key area of progress during the first year has been a strengthened commitment to fostering innovation and embedding research as core components of education and training.

Feedback from learners is actively encouraged and welcomed in all its forms. It is systematically reviewed, collated, and acted upon, demonstrating a strong commitment to continuous improvement and the ongoing enhancement of educational quality. National measures of learner experience, including the General Medical Council (GMC) Training Survey and the National Education and Training Survey (NETS), are routinely reviewed alongside local and regional feedback. Together, these sources support benchmarking and provide assurance regarding the quality of education and training delivered by our Trust. Overall, our Trust continues to provide positive learning opportunities and high-quality educational experiences for its learners.

General Medical Council (GMC)Training Survey. In July 2025, the General Medical Council published the results of its annual survey on postgraduate medical training. The survey was completed by 65% of trainees across our Trust, a decrease from 77% in 2024. Aggregate scores were within the middle quartile across all 18 indicators, indicating broadly comparable performance to other organisations.

Some specialties were identified as having a higher number of negative outliers (more than two indicators), including Emergency Medicine Foundation Year 2, Foundation training (Surgery Foundation Years 1 and 2), Haematology, Internal Medicine, and Obstetrics and Gynaecology. In addition, a small number of areas have demonstrated recurrent challenges over three consecutive years. These include workload in Emergency Medicine Foundation Year 2, rota design in Surgery Foundation Year 1 and local teaching in Internal Medicine (Stage 1), and aspects of the supportive environment within general internal medicine.

Our Trust's ranking for workload (224th out of 226 UK acute and mental health trusts) highlights a sustained challenge consistent with previous surveys. This remains a key organisational priority, with targeted actions in place through education governance structures and workforce planning groups to address workload, rota design, and the overall training environment. Progress in these areas is subject to ongoing monitoring and review.

National Education and Training Survey (NETS). The 2025 NETS, published in March 2026, gathered feedback from 225 learners and trainees at our Trust, the majority of whom were postgraduate medical learners. The results present a mixed but informative picture of the learning environment.

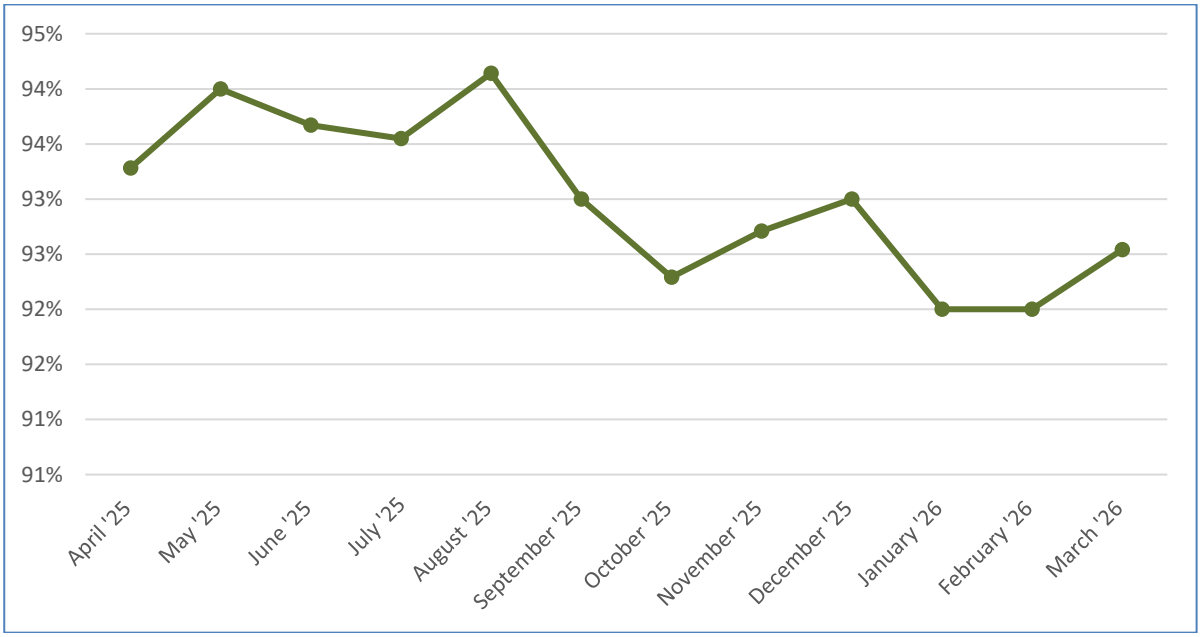
Our Trust continues to demonstrate clear strengths in education and training, with strong performance in teamwork, safety culture, raising concerns, and sexual safety. Improvements in wellbeing were also reported compared to the previous year. Learners frequently cited supportive colleagues, good educational support, and a positive learning environment as reasons for recommending our Trust as a place to train, with around three quarters of respondents indicating they would be likely or extremely likely to recommend Bradford Teaching Hospitals.

However, workload remains the most significant and worsening area of concern, particularly for postgraduate medical learners and those working in high-pressure specialties. Declines were also observed in overall experience and perceived quality of care, suggesting that service pressures are increasingly impacting the training environment.

For nursing and midwifery learners, the survey highlighted reduced confidence in transition to practice, alongside pressures on supervision and limited access to development opportunities. In response, the Trust is undertaking a detailed review and specialty-level action planning, with a focus on workload, learning environment, culture, and supervision. This includes coordinated work through the Medical Workforce Group and triangulation of NETS findings with other intelligence sources to support sustained improvement in learner experience and educational quality.

Mandatory and Statutory Training. The Trust has maintained strong compliance with mandatory and statutory training, consistently achieving rates above 92% against a target of 85%. This demonstrates sustained performance above the required standard and supports safe clinical practice by ensuring that staff are appropriately trained to deliver high-quality care. Monthly compliance performance is presented in Figure 9. Performance is monitored regularly through governance structures, with targeted follow-up in areas where compliance falls below the expected standard.

Figure 9. Mandatory training compliance



2.2.15 Health Inequalities

Our Trust serves a population of around 670,000 people across Bradford and the surrounding area. Bradford is one of the most deprived areas in England, and the health of its residents reflects that. Healthy life expectancy varies by up to 23 years between the most and least deprived parts of the district. Almost half of our population lives in the most deprived 20% of postcodes. Reducing health inequalities is central to our purpose and how we work.

Our comprehensive statement on health Inequalities is included in our Annual Report 2025/26. Once published this will be available on our website here[33]. The statement sets out how our Trust has collected, analysed and published information on health inequalities in 2025/26, in line with NHS England's Statement on Information on Health Inequalities (November 2025). It describes our understanding of the population we serve, the inequalities in access, experience and outcomes we have identified, and the actions we have taken in response. Population health data is drawn from the Bradford District JSNA (November 2025) and the Bradford District and Craven Health and Care Partnership strategy (September 2025).

2.3 REPORTING AGAINST CORE INDICATORS

2.3.1 SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR (SHMI)

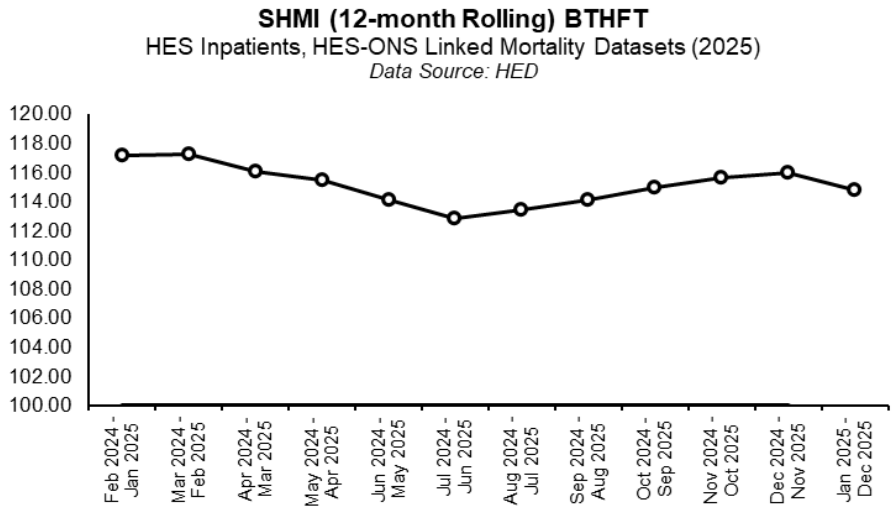
The Summary Hospital-Level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die during or within 28 days of hospitalisation at our Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated. If 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 2024 to December 2025 with 12 data points. Our current SHMI value was 114.81, a reduction on our SHMI at this point last year (*116.42 at last report*).

Throughout this year our Trust recognised our SHMI had been high. Following an in-depth review, 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 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 10. SHMI score (12-month rolling: Feb 2024 - Dec 2025): 114.81



[33] https://www.bradfordhospitals.nhs.uk/our-trust/reports-and-accounts/

Figure 11. 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 2024 - Jan 2025	117.19	80,296	1,785	1,523.22
Mar 2024 - Feb 2025	117.27	80,173	1,790	1,526.41
Apr 2024 - Mar 2025	116.11	80,338	1,781	1,533.93
May 2024 - Apr 2025	115.45	80,475	1,783	1,544.42
Jun 2024 - May 2025	114.12	80,595	1,750	1,533.45
Jul 2024 - Jun 2025	112.86	80,649	1,736	1,538.17
Aug 2024 - Jul 2025	113.40	80,818	1,738	1,532.59
Sep 2024 - Aug 2025	114.11	80,578	1,735	1,520.48
Oct 2024 - Sep 2025	114.97	80,525	1,748	1,520.42
Nov 2024 - Oct 2025	115.61	80,420	1,757	1,519.81
Dec 2024 – Nov 2025	115.95	80,381	1,752	1,511.00
Jan 2025 – Dec 2025	114.81	78,967	1,724	1,501.56

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 25/26 NHS England have published the Finalised Patient Reported Outcome Measures (PROMs) in England for the following reporting periods:

- April 24 to March 25

NHS England has investigated a variety of challenges with the way the data are processed on complex legacy systems. In January 26, NHS England proposed that, due to processing challenges and low response rates, the final information for 24/25 would be released as management information rather than as an official statistic.

NHS England continues to investigate the issues and as such, has advised that while this work is underway, all findings are to be treated with caution[34].

At a provider level, our Trust PROMS data for the reporting period for all hip and knee replacements are illustrated in Figures 12 to 15 below:

[34] https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms/final-2024-25-data

Figure 12. Improvement rate by measure for Hip Replacement 2024/25

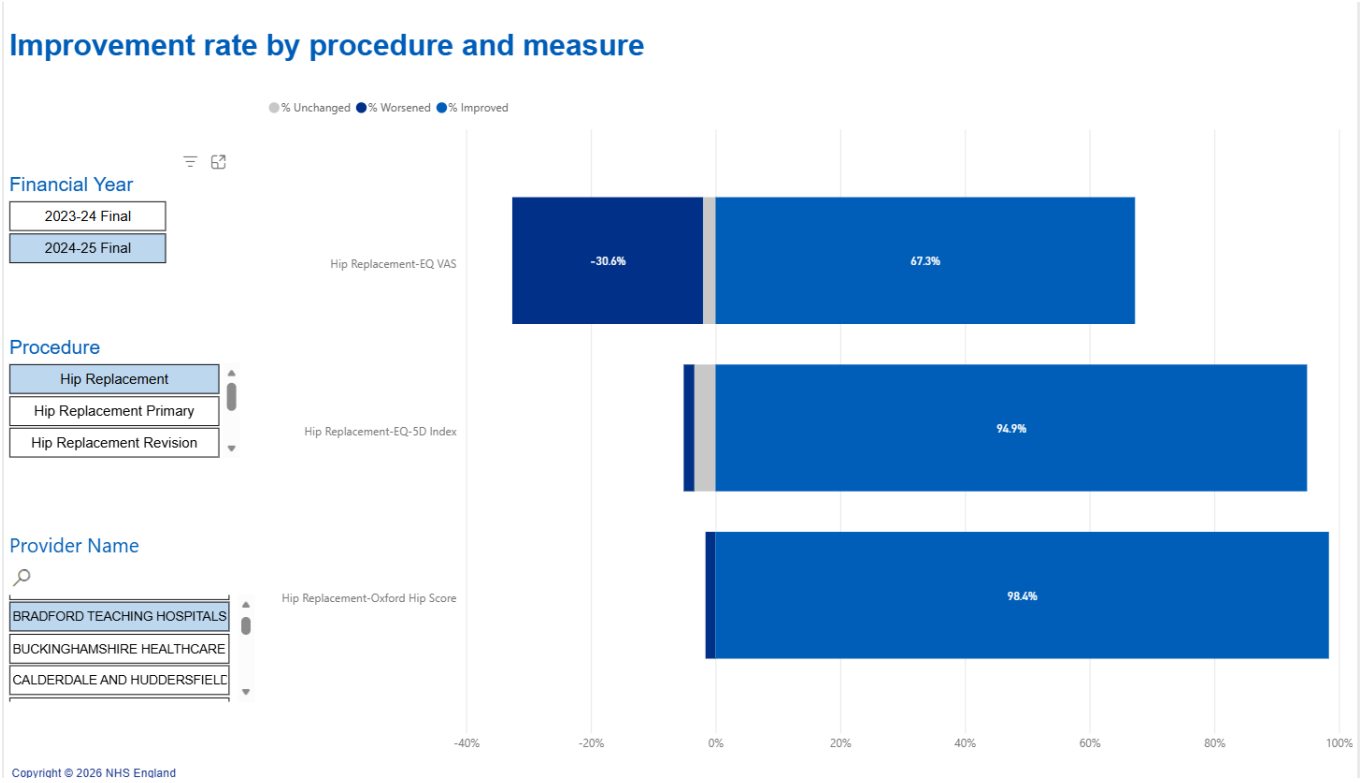


Figure 13. Improvement rate by measure for Knee Replacement 2024/25

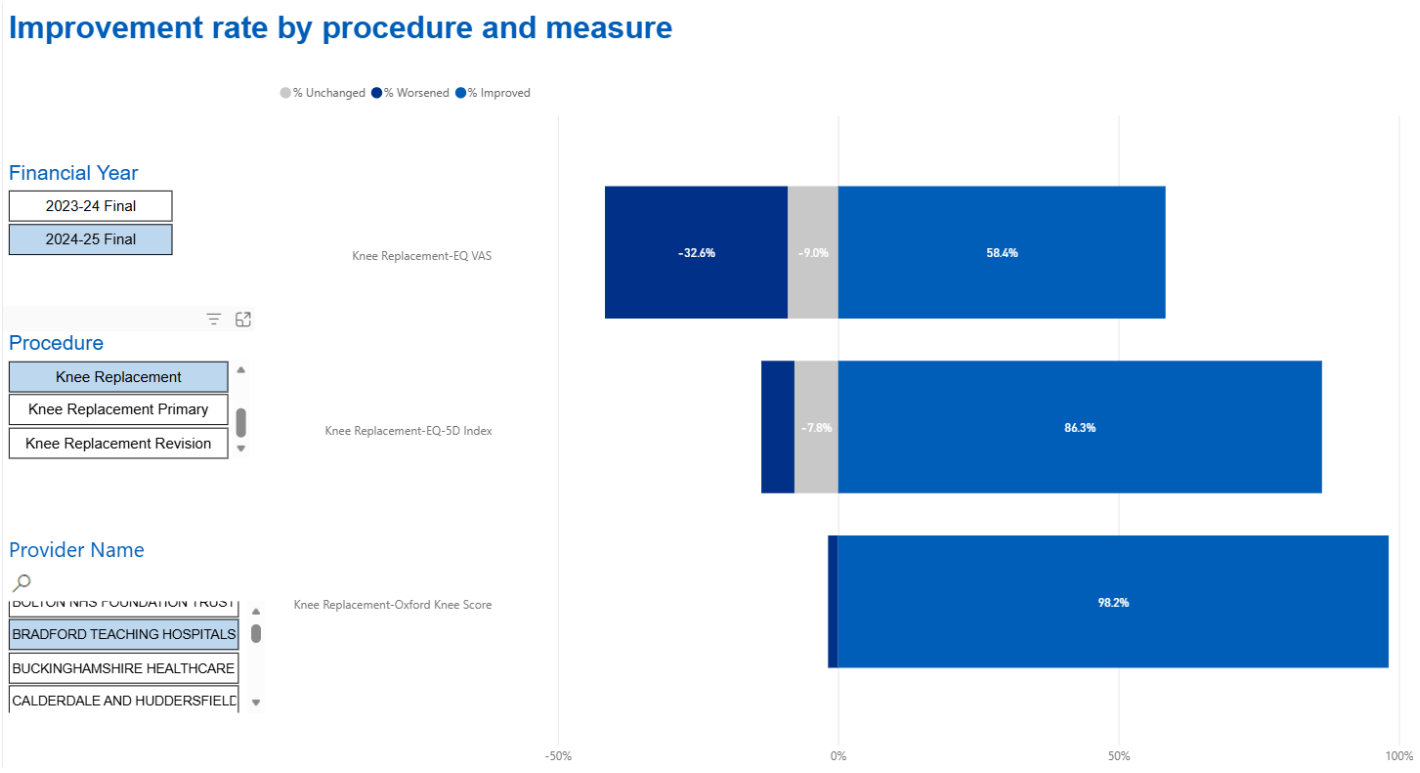


Figure 14. Pre and post-operative patients reporting the most severe scores for condition specific questionnaires 2022/23 – Oxford Hip Score

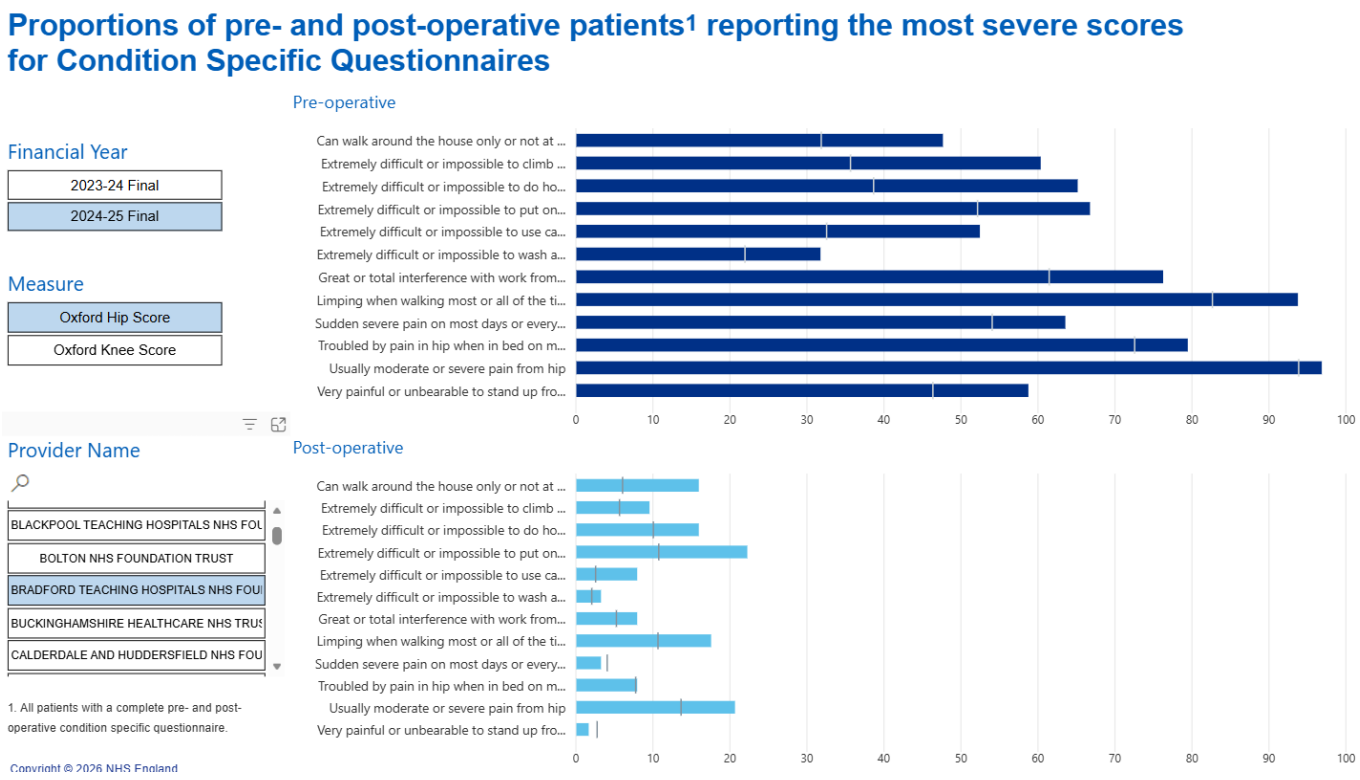
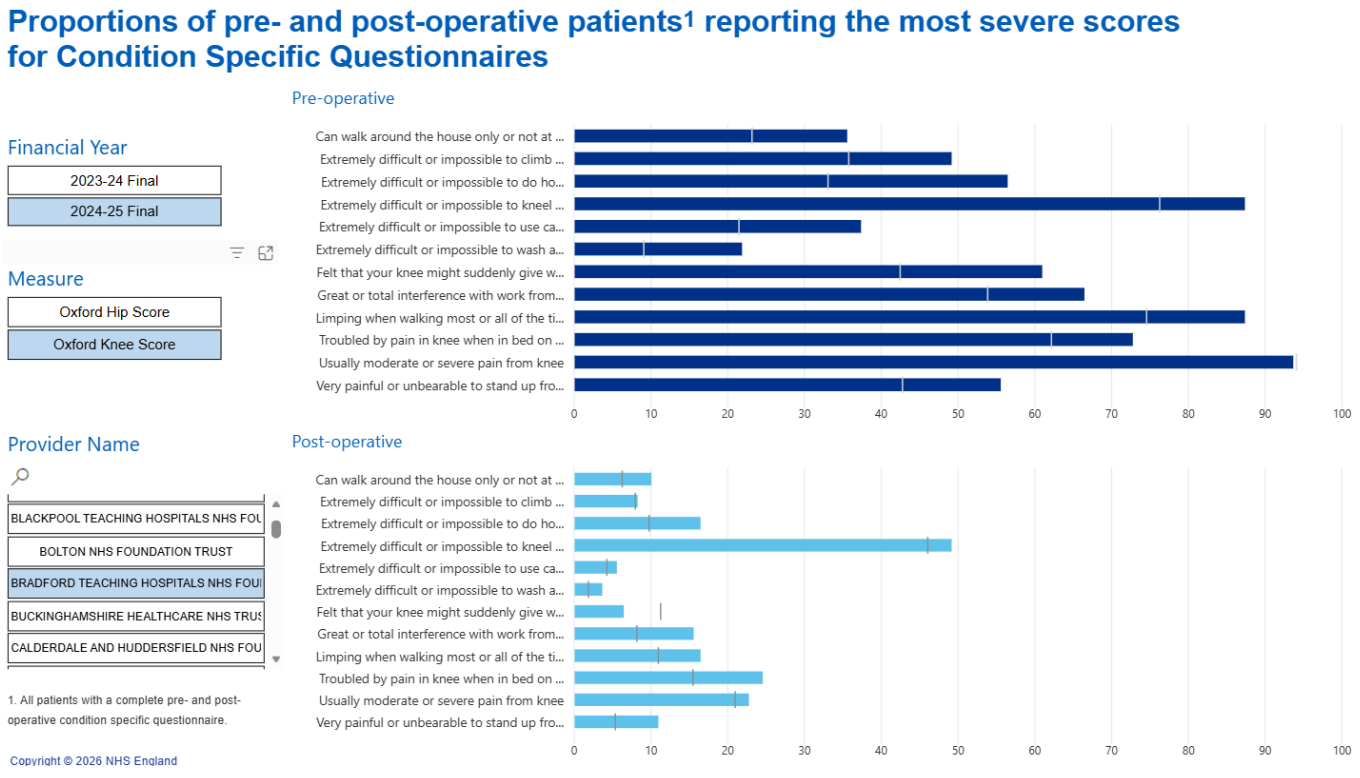


Figure 15. Pre and post-operative patients reporting the most severe scores for condition specific questionnaires 2024/25– Oxford Knee Score

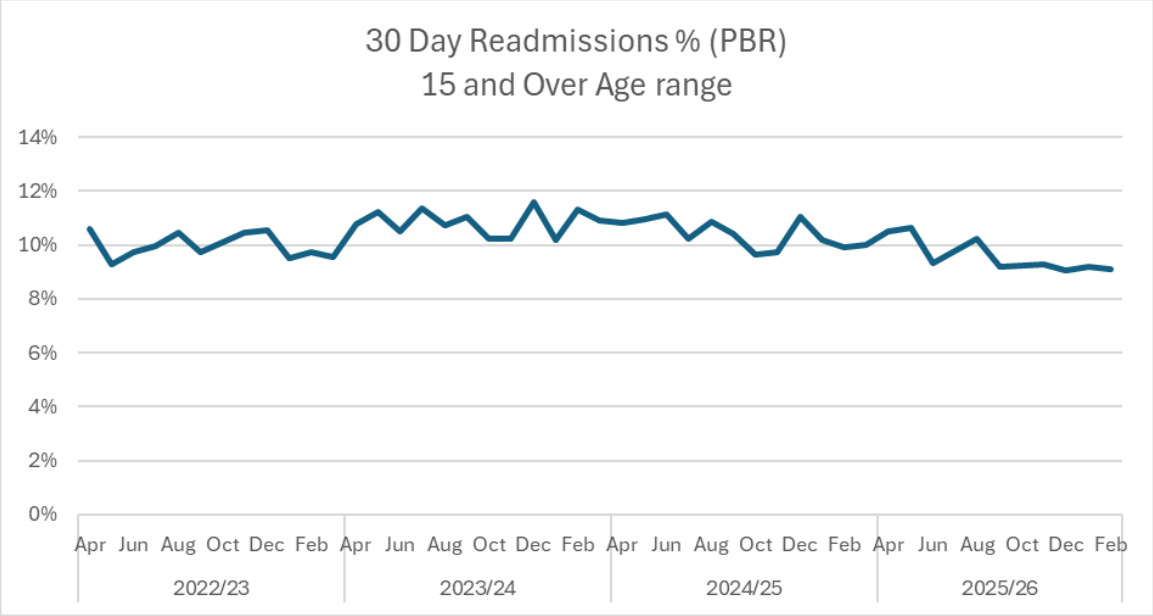


2.3.3 30-DAY READMISSIONS

30-day readmission rates for adults have continued to gradually fall during 2025/26 compared to previous years.

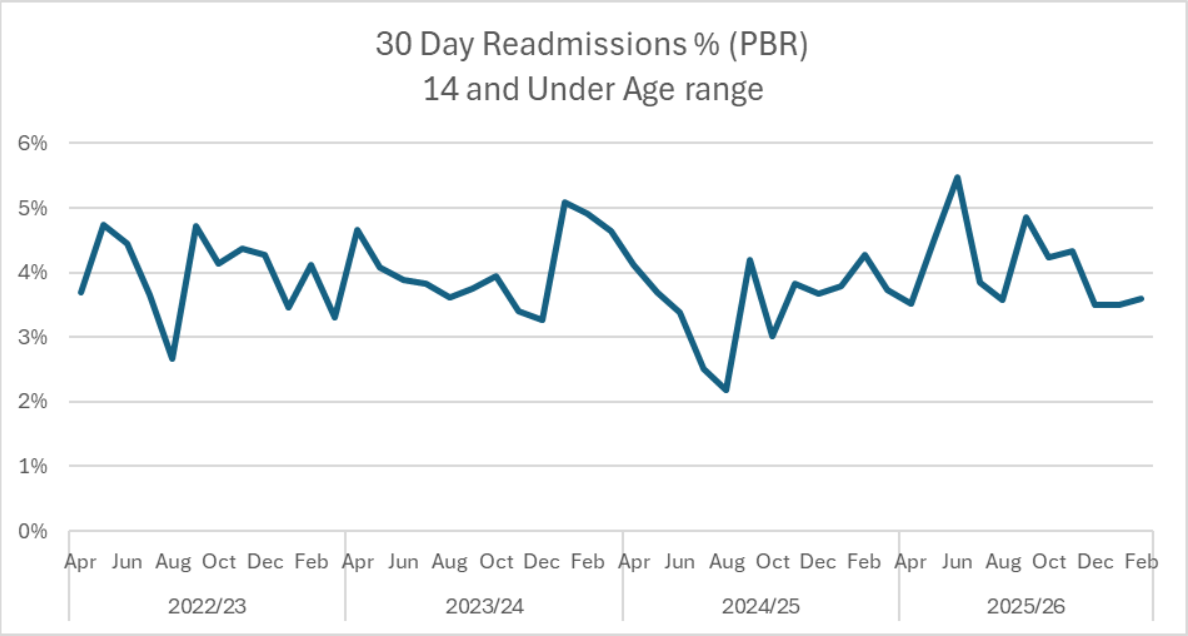
For those 15 and over, it has averaged at 9.3%, compared to around 9.8% in 2024/25 and 10.1% in 2023/24 (see figure 16)

Figure 16. 30-day readmission rates for patient's aged 15 and over



Fort patients under 15 continue, there has been a slight uptick, with an average of 4.1% in 2025/26, compared to an average of 3.9% across the previous 3 years.

Figure 17. 30-day readmission rates for patient's aged under 15



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 2025 our Trust continued to work with its contractor to improve and analyse all our FFT data and feedback. The company we work with (Health Care 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).

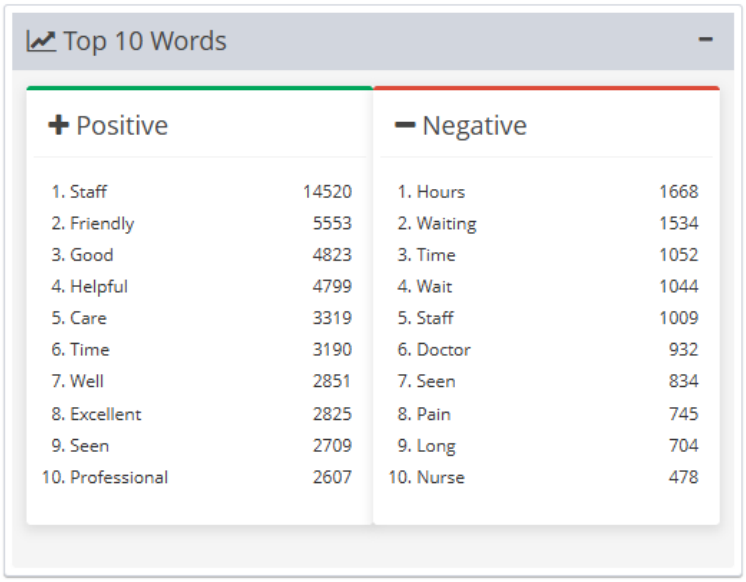
This increase in methods used and the availability of the different real time methods has enabled our Trust to gather more feedback and collate themes to enable ward areas to focus on improving patient experience projects. SMS text messaging comprised most of the responses included in figure 18 below.

Figure 18. Friends and Family Test Responses 2025/26

	Very Good	Good	Neither Good nor Poor	Poor	Very Poor	Don't Know	Total
A&E Feedback	5,701	2,056	7941	721	1,867	53	11139
Inpatient Feedback	7087	1337	223	153	230	18	9048
Outpatient Feedback	23370	2744	469	330	425	61	23,978
Maternity Feedback	1,857	243	60	63	114	4	2341
Totals	39,015	6380	1,493	1,267	2,636	136	49927
Percentage	75.14%	12.78%	2.99%	2.54%	5.28%%	0.27%	

Although the overall total responses have gone down slightly from the previous year, the *Very Good* and *Good* response form 88.92% of the total responses. There has been a decrease in the responses received from inpatients but an increase in all other areas. We are exploring a volunteer role to support FFT collection. All other areas increased on the previous year.

Top Positive and Top Negative words extracted from the overall FFT feedback**.**



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.

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 19. 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.

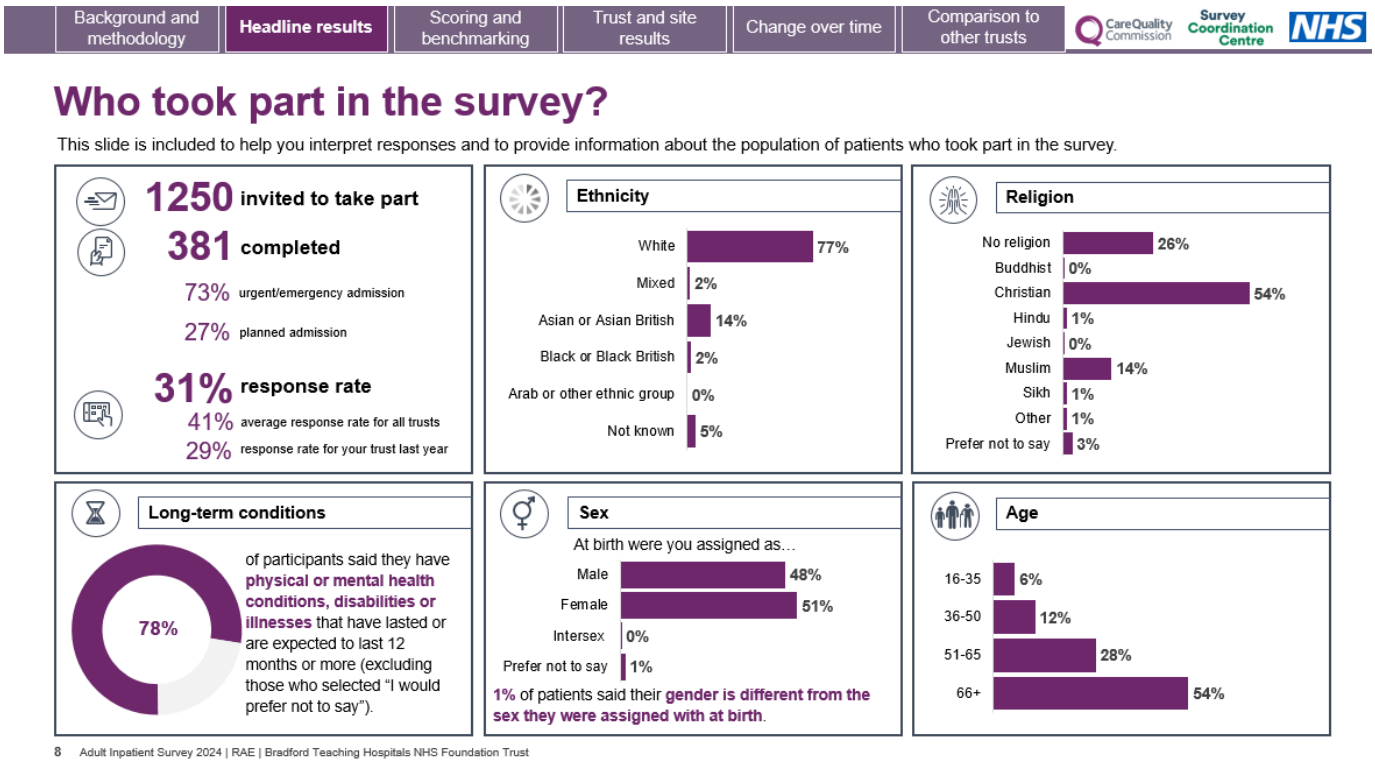
Care Quality Commission (CQC) Surveys. During 2024/25, our Trust received the results of three mandated CQC surveys. These covered, the National In-Patient Survey 2024, Urgent and Emergency Care 2024, and the Maternity Survey 2024.

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[35] We focus below on the outcomes from our national in-patient survey 2024.

The 2024 survey of adult inpatient's experiences involved 131 NHS acute Trusts in England. The survey centre received responses from 62,444 patients, a response rate of 41%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital during November 2024 and were not admitted to maternity or psychiatric units. Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between January 2025 and April 2025.

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

Figure 20. Demographics of our CQC Inpatient 2024 survey

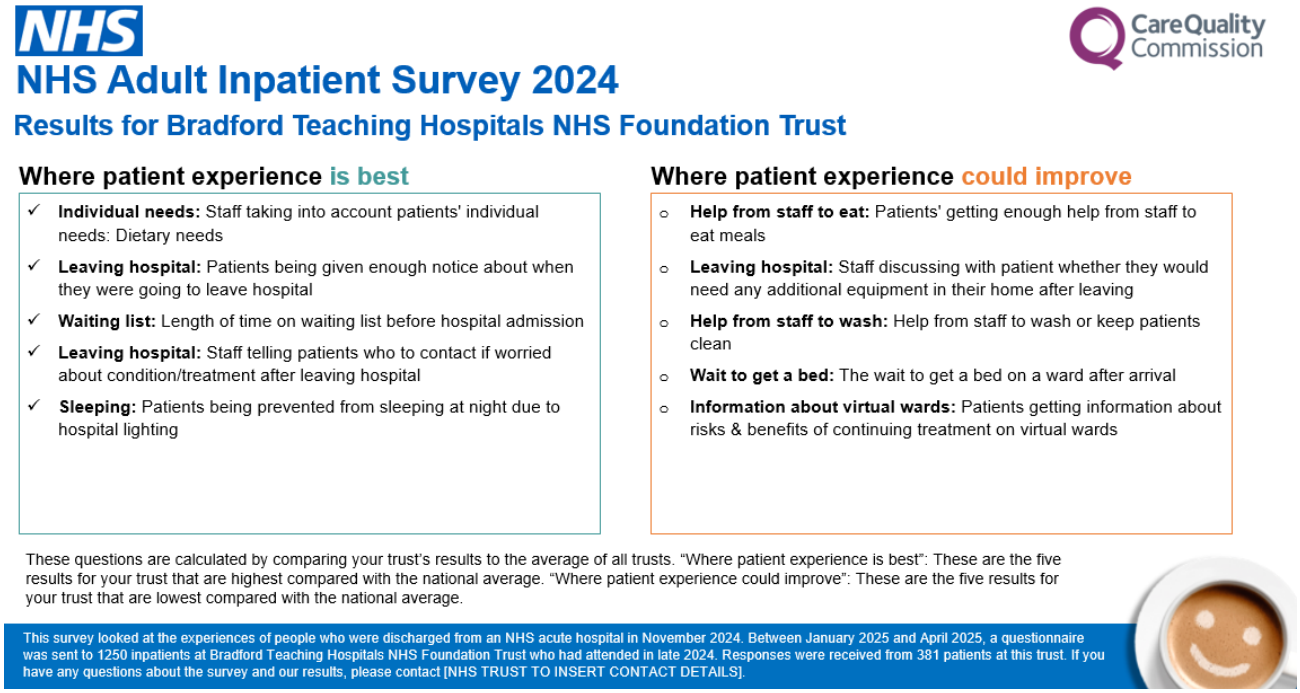


Respondents and response rate.

- 1,250 invited to take part.
- 381patients responded to the survey.
- An overall response rate of 31% an increase on the previous year.
- Below national average response rate which is 42%.
- 78% of responses noted to have long term conditions, were following urgent/acute admissions.
- 92% of respondents were over the age of 51.

Figure 21. Summary of results and comparison with our 2024 Inpatient survey)

- Compared to the previous year's Inpatient survey results (20243) Our Trust was
- About the same on 39 questions.
- Somewhat worse than expected on 6 questions (detailed below).
- Worse than expected on 0 questions.
- Much worse than expected on 1 question (detailed below).



An action plan has been devised and Back to Basics campaign to be revisited and re-imagined through the Nursing and Midwifery Excellence NAME) group to look at meeting hygiene needs, eating meals and waiting for beds. CQC Inpatient survey steering Group commenced.

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.

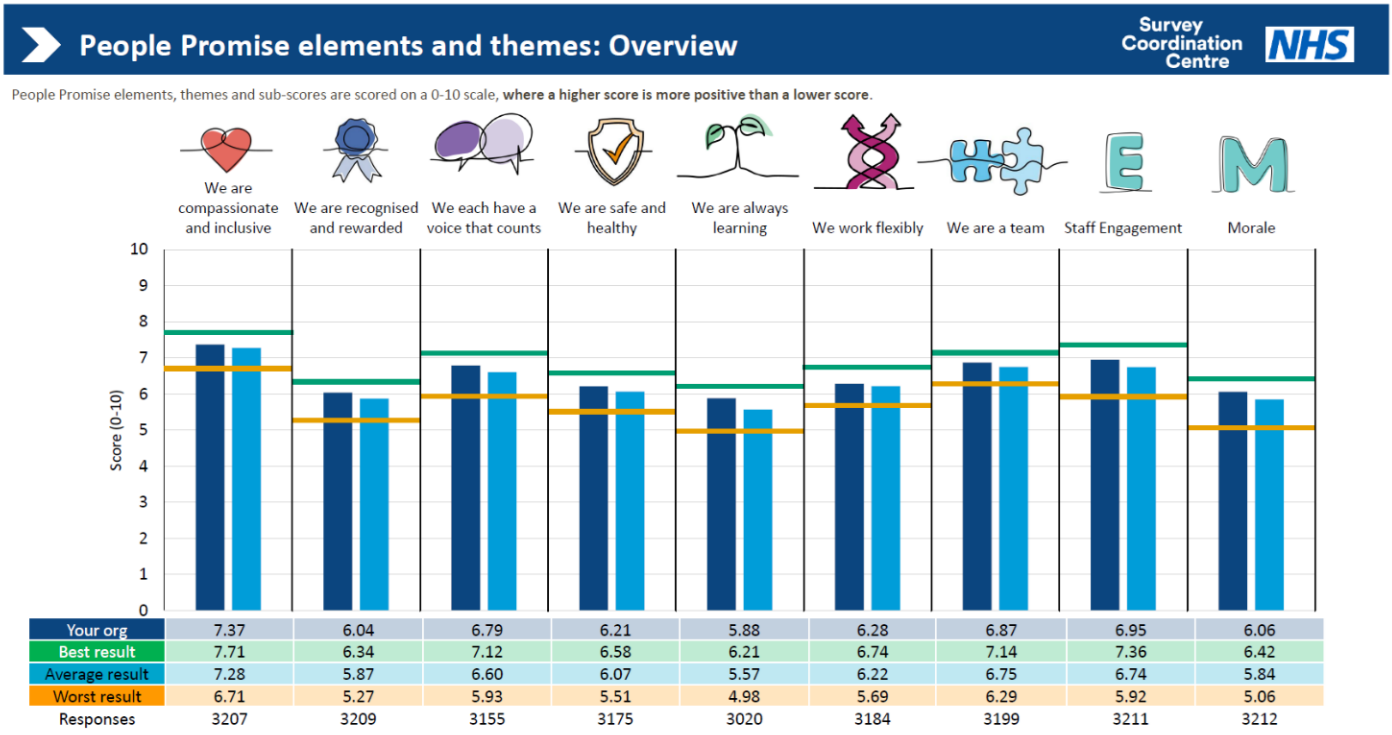
2.3.5 NHS STAFF SURVEY

The response rate to the 2025 survey among Trust staff was 43% (3236 respondents). There was a 7% decrease in the Trust's staff engaging with the survey compared to the 2024 staff survey (2024 response rate - 50%). At BTHFT, registered nurses and midwives were the largest responding occupational group followed by Admin and Clerical and Allied Health Professionals.

We remain above the national average (compared to other Acute and Acute and Community Trusts) in all of the People Promise themes and elements, including all 21 'sub-themes'. (see figure 22 below)

Since 2024, the biggest areas of growth in the sub-themes are 'appraisals', 'support for work-life balance' and 'flexible working' and there have been some positive improvements with regards to career progression.

Figure 22. Trust results for the People Promise elements and themes of the NHS Staff Survey 2025



After holding Listening Sessions with colleagues and staff networks, an action plan has been created which focuses on three key areas for development. These are:

- Creating a sense of belonging by tackling any form of discrimination;
- Improving how we hear from our colleagues (listening and learning); *and*
- Further developing wellbeing support.

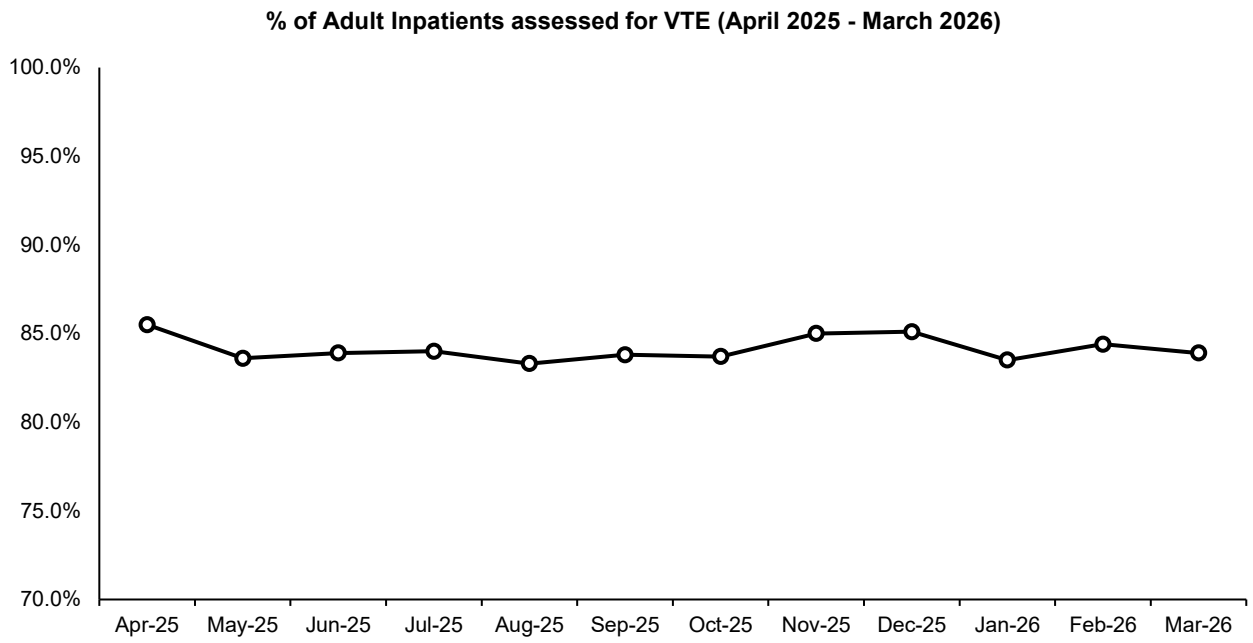
As a Trust we are pleased with our increased response rate to our staff survey for 2025 and we remain committed in working towards further improvements in our results for 2026.

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 NICE (NG158) national guidance.

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

Figure 23: Percentage of adult in-patients that were assessed for VTE's from April 2025 to March 2026



In April 2025 the Clinical Effectiveness and Business Intelligence team undertook a comprehensive review of the cohorting methodology for Venous Thromboembolism (VTE) assessment compliance. This included refreshing the inclusion and exclusion criteria for defined patient groups who are clinically exempt from standard VTE assessment processes but are recognised as compliant for audit purposes. These cohorts, which contribute 100% compliance within the assessment framework, were formally approved by the Chief Medical Officer and incorporated into Trust policy.

The revised list of inclusion and exclusion criteria, including associated coding, was shared with Clinical Service Units (CSUs). CSU triumvirates were invited to review and propose any additional clinically appropriate exceptions, ensuring the criteria reflected frontline practice. The finalised cohorting framework was subsequently approved by the Clinical Outcomes Group, providing appropriate clinical governance oversight.

The updated inclusion and exclusion criteria were applied retrospectively to the 2024/25 dataset during the national resubmission window in June 2025, in line with guidance from the NHS England Data Collections Team.

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 24 below.

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

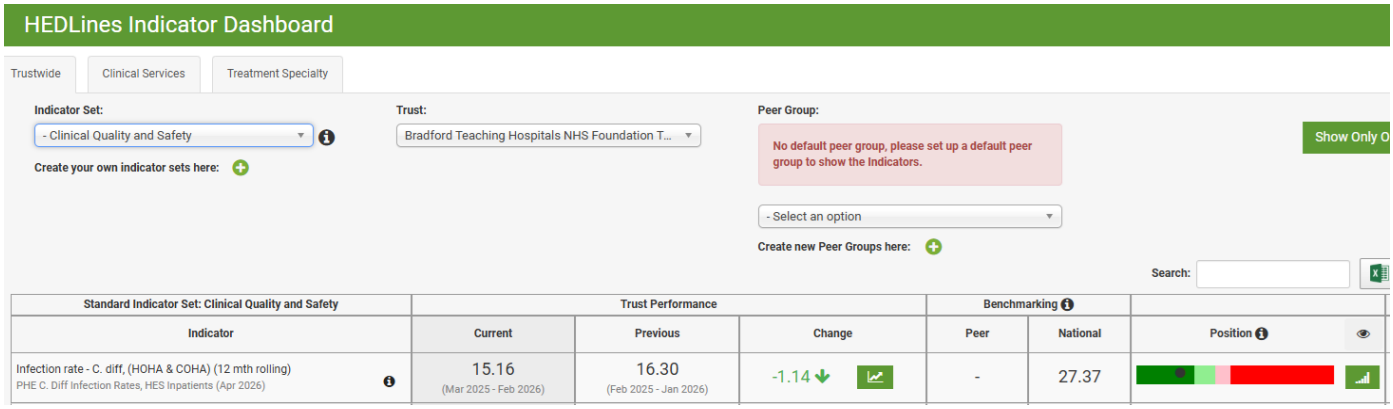
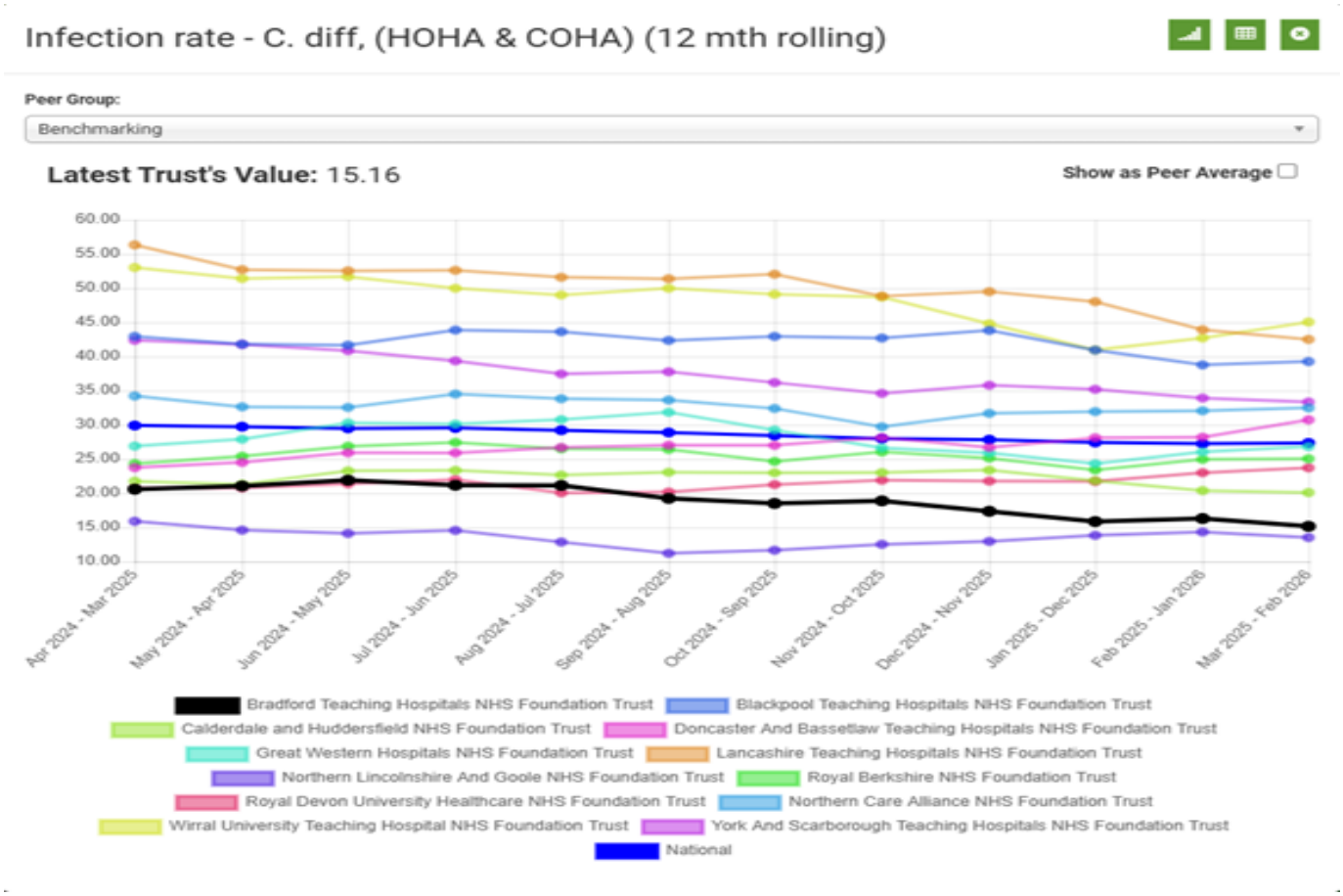


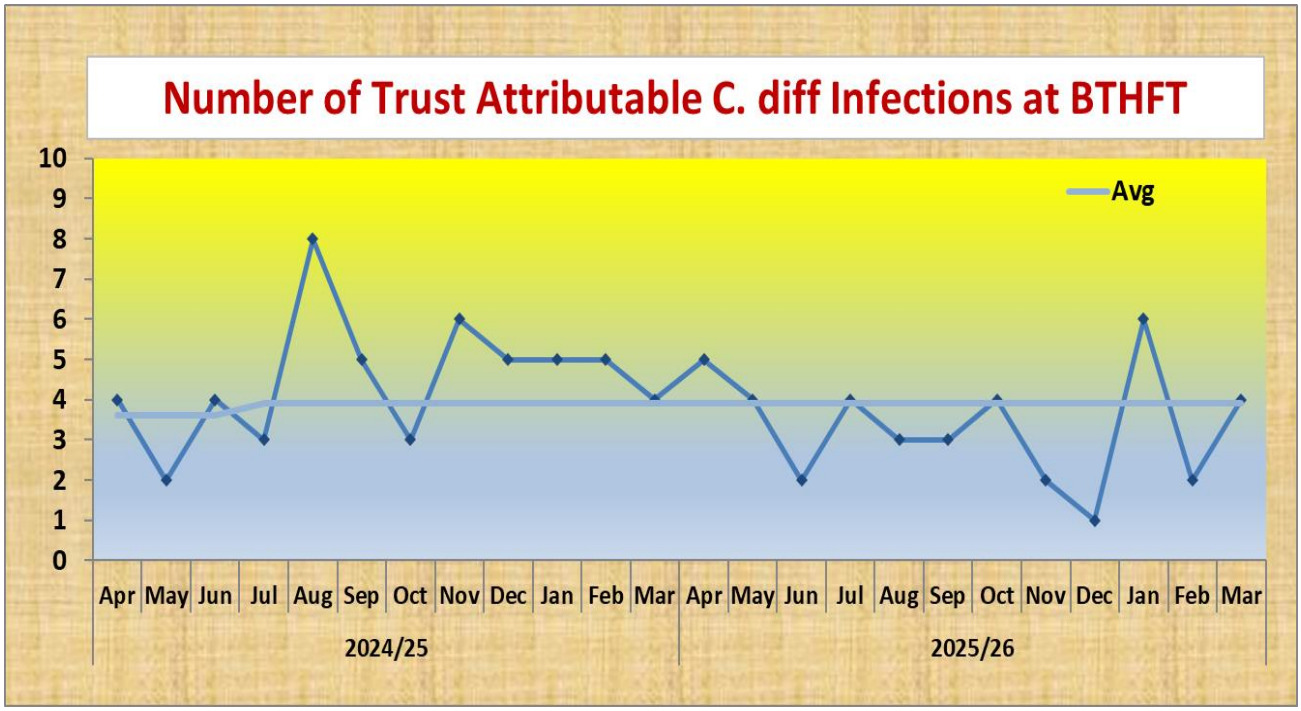
Figure 25. Healthcare Evaluation Data (HED) for C. *difficile*: Benchmarking data for both Yorkshire Region and National Acute NHS Trusts *(the black line represents our Trust)*



Our Trust has performed better than other Acute Trusts in the region as shown in Figure 25.

The objectives for reduction for CDI for 2025/26 were set as 40 cases. Our Trust reported 40 hospital attributable cases during 2025/26. This is a decrease of 12 cases compared to the last year. See figure 26 below for the number of cases per month.

Figure 26. Healthcare associated Clostridioides difficile Infections at 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 2026/27 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.

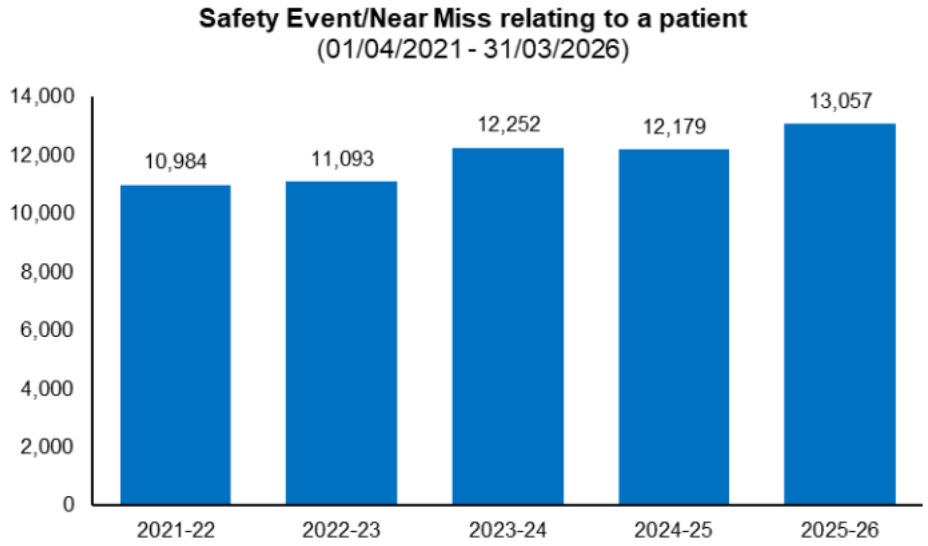
Our Trust has a robust clinical governance and quality oversight system in place to identify learning and improvement from incidents which facilitates appropriate levels of assurance about the quality of care we deliver.

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 13,057 patient safety incidents reported within our Trust during 2025/26. This represents an increase of 878 (7.2%) when compared with the previous reporting period (see figure 27). Early feedback from staff tells us that the new reporting system and accessibility of the application is supporting an increase in reporting of incidents.

Figure 27. Comparison between all grades of Patient Safety Incidents Reported in 2021/22 to 2025/26



There were 61 (0.5%) patient safety incidents that resulted in severe harm or death during 2025/26.

A five-year view of the number of patient safety incidents resulting in severe harm (see figure 28) or death (see figure 29) has been provided in the charts below.

Figure 28. Number of Patient Safety Incidents resulting in Severe Harm (2021 to 2026)

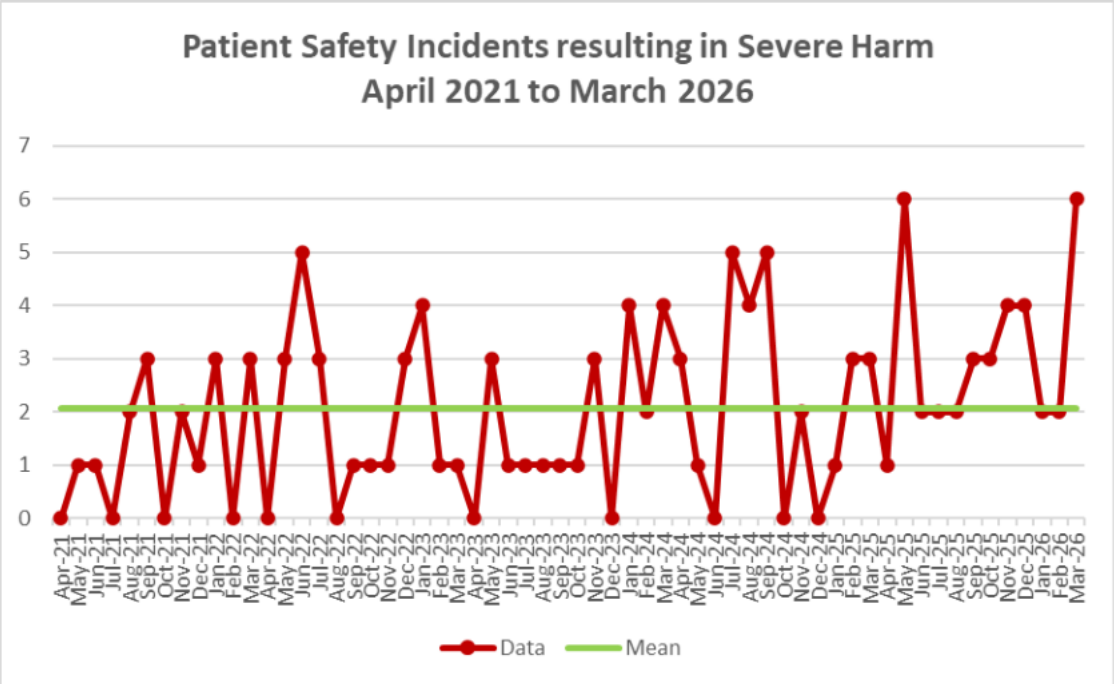
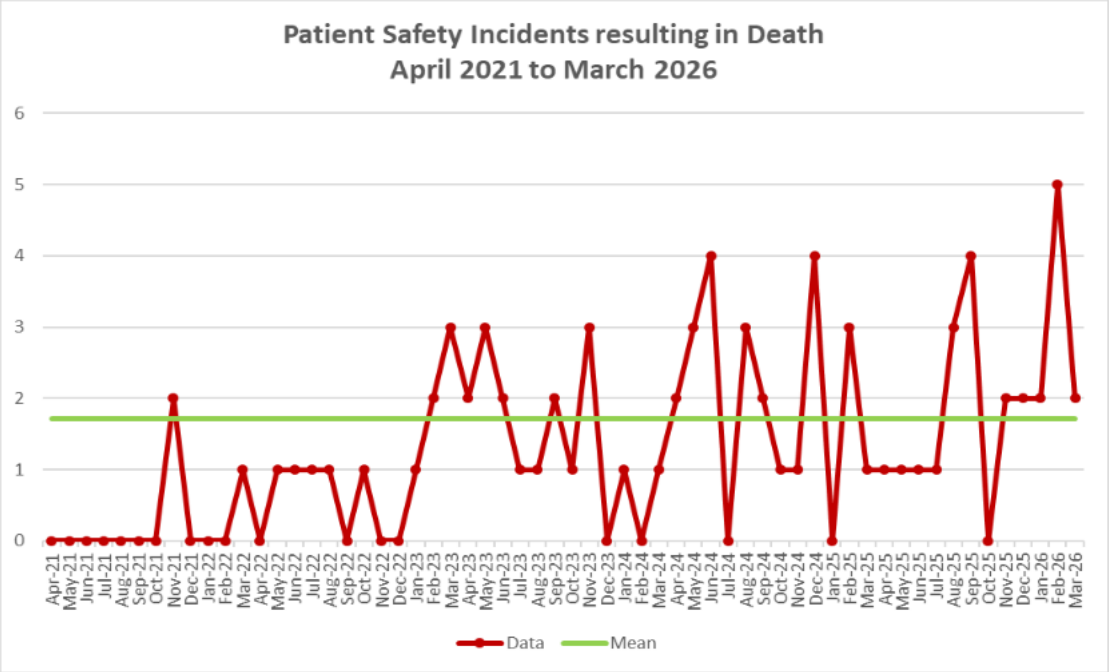


Figure 29. Number of Patient Safety Incidents resulting in Death (2021 to 2026)



There were 37 patient safety incidents resulting in severe harm between 1 April 2025 and March 2026 (see figure 30).

Figure 30: Number of Patient Safety Incidents by Category and Harm during 2025/26

Severe n=number of patients	Death n=number of patients	Category
-	n=1	Blood transfusion
n=13	n=9	Care and treatment
n=1	-	Communications
n=4	n=2	Delayed diagnosis
-	n=1	Deteriorating patients
-	n=1	Discharge safety
n=3	n=1	Maternity and Neonatal safety
n=1	-	Medical device
n=1	-	Medicine administration
n=1	-	Medicine prescribing
n=1	-	Operational safety (pathways/capacity etc)
n=11	n=1	Patient falls (fall, slip or trip on same level / fall from height)
-	n=1	Safeguarding
n=1	n=4	Safer Procedures
-	n=3	Unexpected death

This included 11 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 2025 and 31 March 2026 the total number of reported patient safety incidents resulting in death was 24 (see figure 30). Eight 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). Three of the PSII investigations and one of the MNSI investigations have been completed. There are five ongoing PSII and one ongoing MNSI investigations (April 2026).

Although there were apparent increases in fatal patient safety incidents in September 2025 and February 2026, a proportion of these cases relate to incidents where the harm occurred in another organisation. In line with the Policy Guidance on Recording Patient Safety Events and Levels of

Harm (NHS England, updated March 2026), Trusts are required to record the level of harm regardless of where the incident took place. The guidance explicitly states that organisations "should record the harm level of an incident in another organisation as you would for an incident that occurred in your organisation" and that "the harm should not be downgraded because it occurred elsewhere."

As a result, the reported number of fatal harm incidents at BTHFT appears higher, as the Trust is required to record the full extent of harm experienced by patients across the wider NHS system, regardless of whether the originating incident occurred within the organisation or elsewhere.

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 31: Pressure ulcer incidence (category 2 and above) during 2024/25

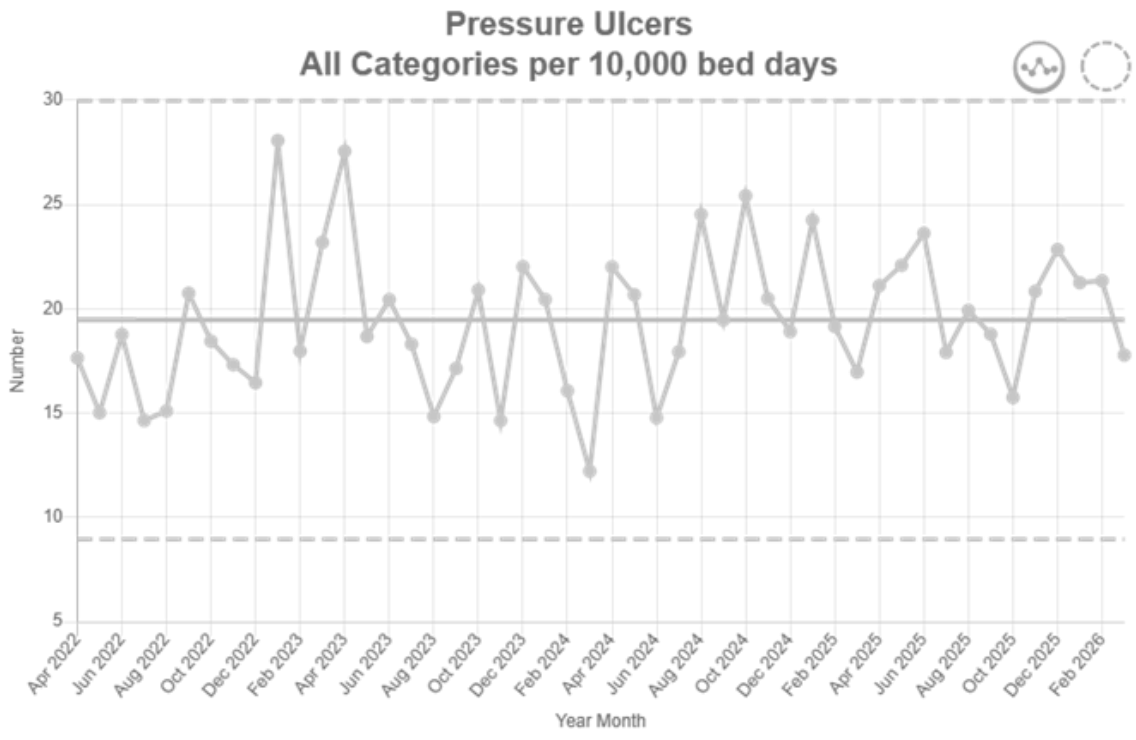


Figure 32: Pressure ulcer incidence (category 2) during 2023/24

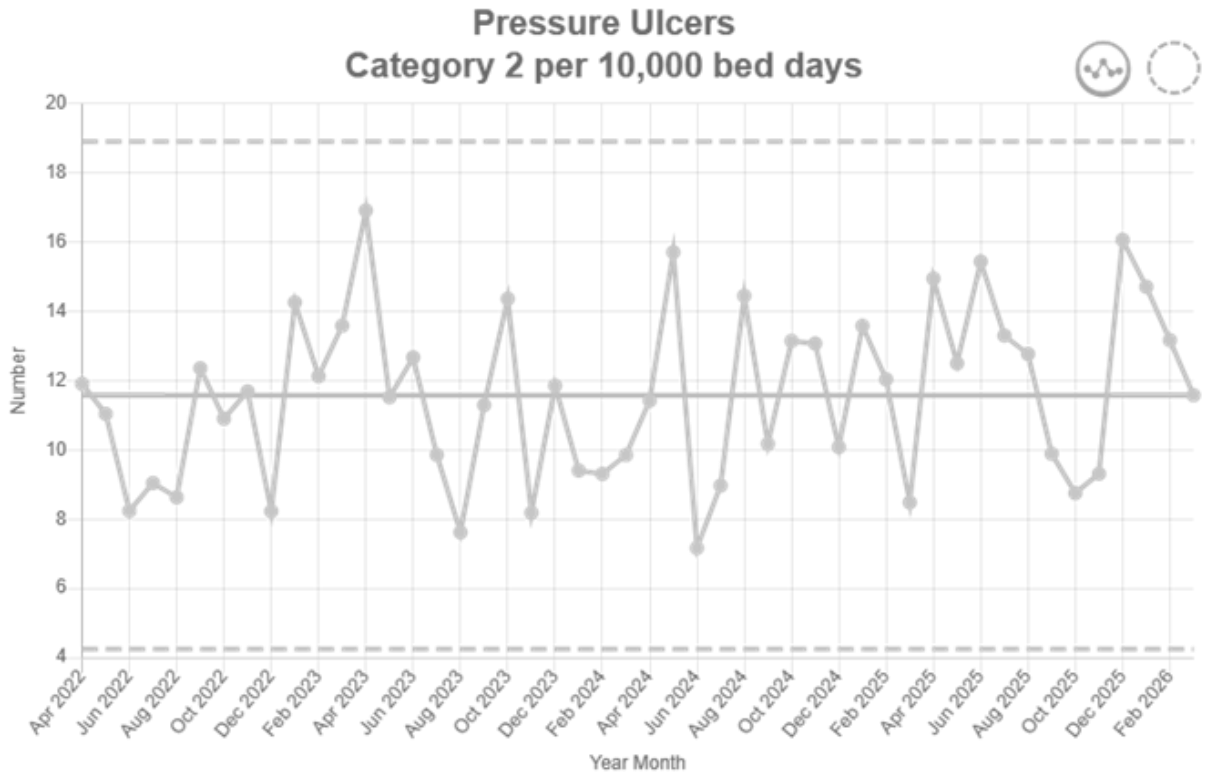
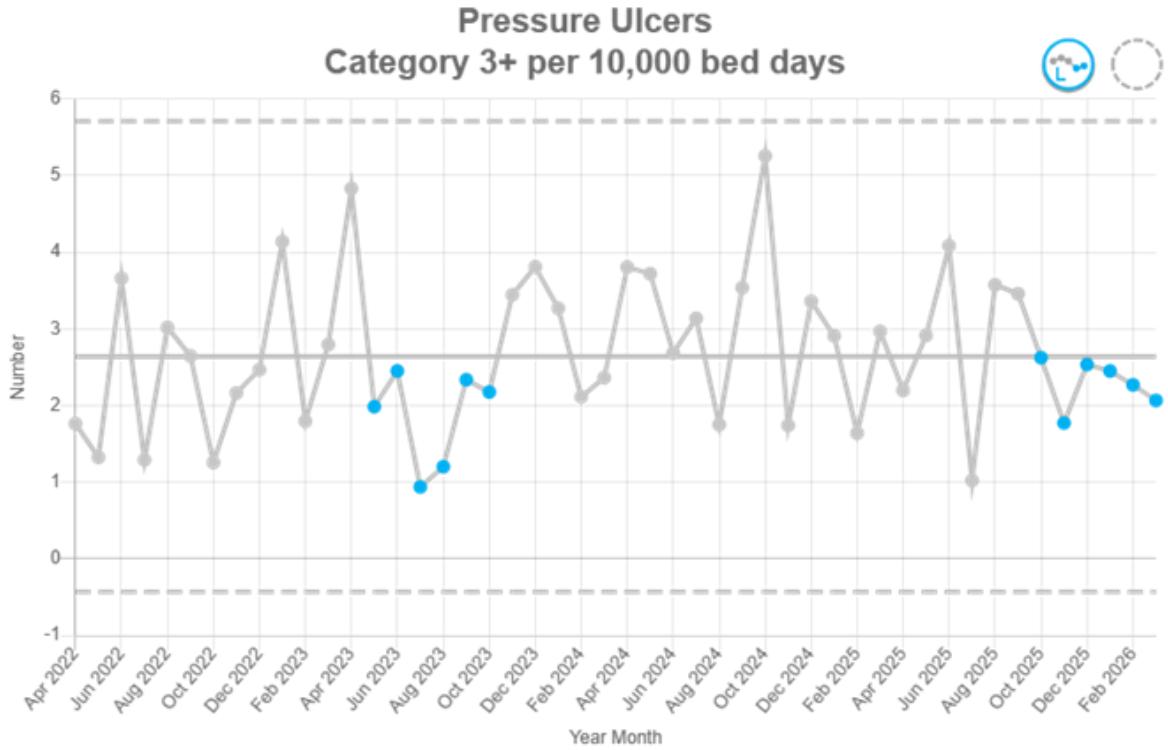


Figure 33: Pressure ulcer incidence (category 3 and 4) during 2023/24



We routinely monitor all pressure ulcer incidents that are category two and above (this includes 'hospital acquired' and pressure ulcers present on admission). 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 apart from category 3 and above incidents which has shown a statistically significant improvement in incident rates over the past six months. 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. We have just commenced a pressure ulcer improvement collaborative with six wards/ departments with the highest number of incidents. The collaborative will be using quality improvement methods to test change ideas and support improvement.

The patient and public information leaflets on pressure ulcer prevention were reviewed and updated in 2025. Pressure ulcer prevention care is one of the standards for ward accreditation which is used to identify good practice and areas of patient care where improvement is required.

3.1.2 SEPSIS SCREENING AND TIME TO TREATMENT

The Trust routinely monitors sepsis screening and timely administration of intravenous antibiotics for patients with suspected sepsis. The approach to recognition, diagnosis and early management is informed by NICE guideline [NG51] and aligns with requirements set out in the NHS Standard Contract.

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

- The possible source of infection
- Risk factors for sepsis
- Indicators of clinical concern

Where a structured assessment confirms these factors, intravenous antibiotics should be administered within one hour for high-risk sepsis and within three hours for moderate-risk sepsis. In November 2024, the Trust implemented a new sepsis screening tool within the electronic patient record (EPR), developed in collaboration with Airedale NHS Foundation Trust and Calderdale and Huddersfield NHS Foundation Trust. This aligned with updated NICE guidance (January 2024) and included the introduction of a maternity-specific screening tool.

A Trust-wide sepsis dashboard, established in 2020/21, supports monitoring of key process and outcome measures by drawing data directly from the EPR. The dashboard is accessible to all staff and enables Clinical Service Units (CSUs) and specialties to review performance locally. It reports on all patients triggering sepsis alerts across the organisation.

Sepsis-related mortality is monitored using monthly death certification data, identifying cases where sepsis is recorded as either the immediate cause of death or a contributing factor. This approach is considered more accurate than Hospital Episode Data (HED), which is dependent on coding of inpatient activity. Ongoing review ensures that no unintended variation in mortality occurs following changes to the sepsis pathway.

Oversight is provided through regular review by the Sepsis / Deteriorating Patient Lead Nurse, with reporting to the Recognition and Response to the Acutely Unwell Patient Group (RRAUP) on a quarterly basis and onward reporting to the Clinical Outcomes Group. Sepsis mortality data is also reported to the Quality Committee for assurance.

The following data relates to the period April 2025 to March 2026.

Performance against screening for sepsis

Average sepsis screening rates were:

- 27.8% for eligible patients attending the Emergency Department (ED)
- 16.8% across all other inpatient settings

(*See Figures 34 and 35*)

Figure 34. Percentage of patients that were screened for sepsis in AED

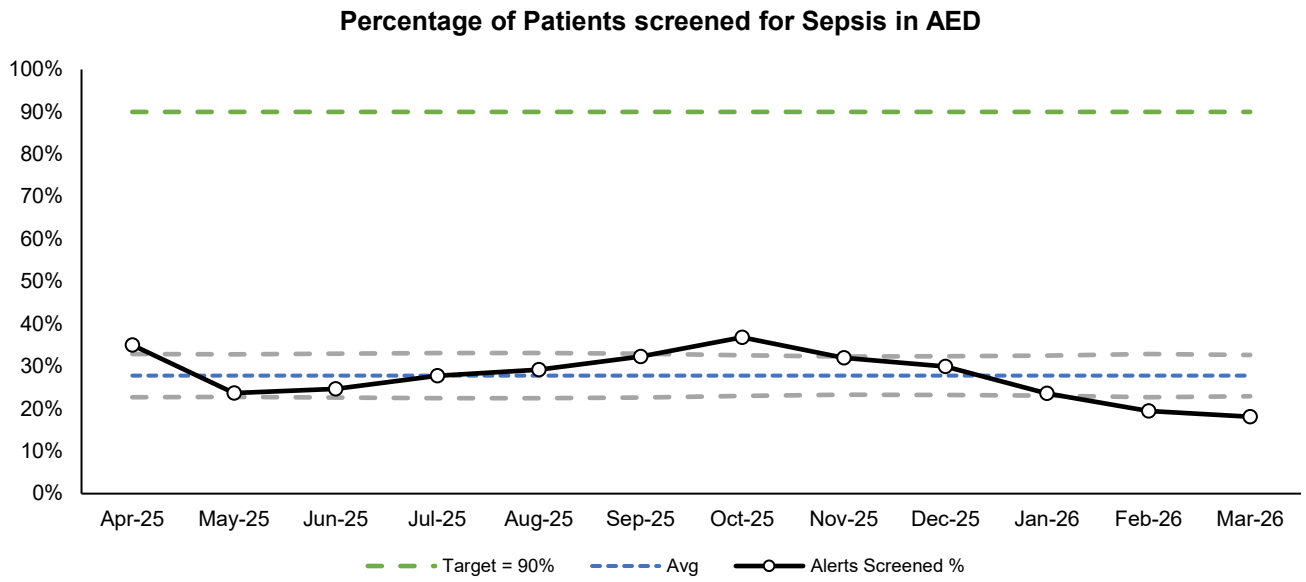
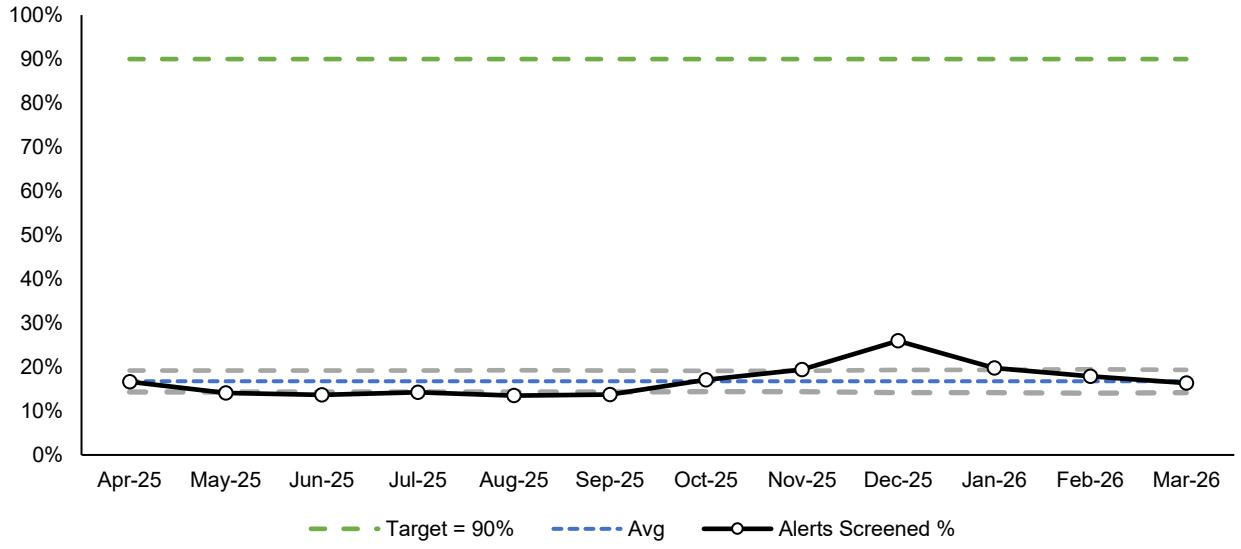


Figure 35. Percentage of patients that were screened for sepsis on in-patient wards including AED

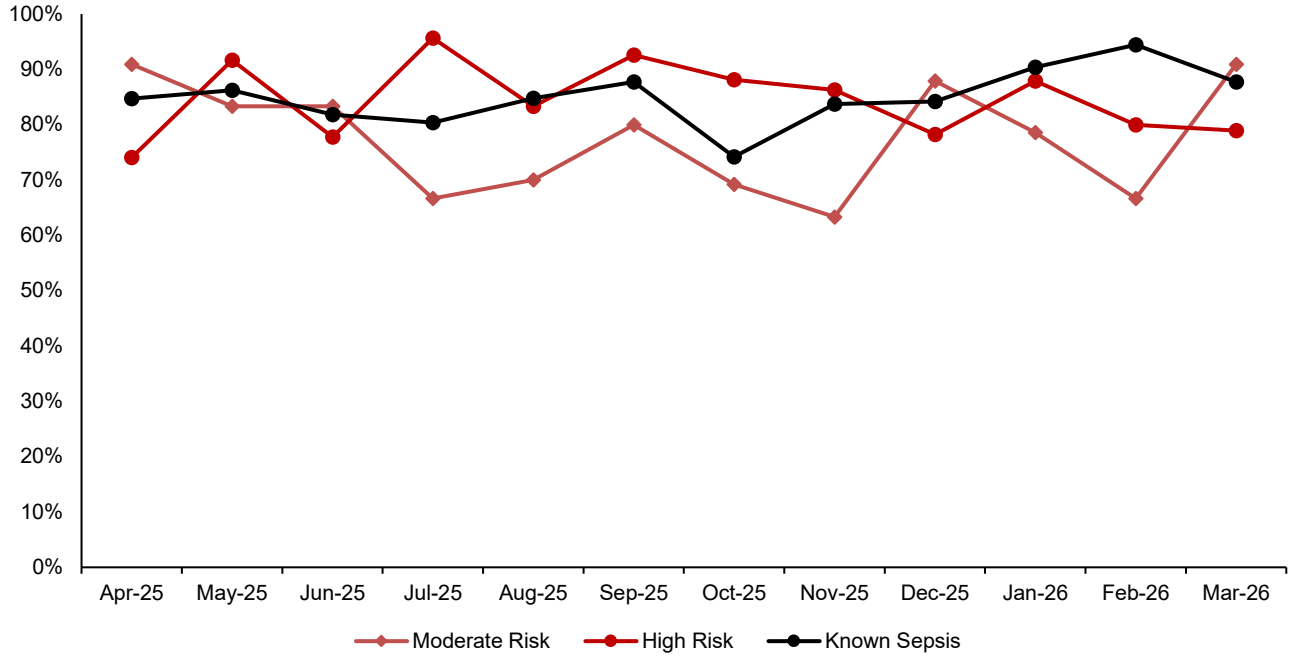


Performance against administering intravenous antibiotics within 1 hour and 3 hours

In the Emergency Department, 84.5% of patients with suspected high-risk sepsis received intravenous antibiotics within one hour (an improvement from 79% in 2024/25). 77.6% of patients

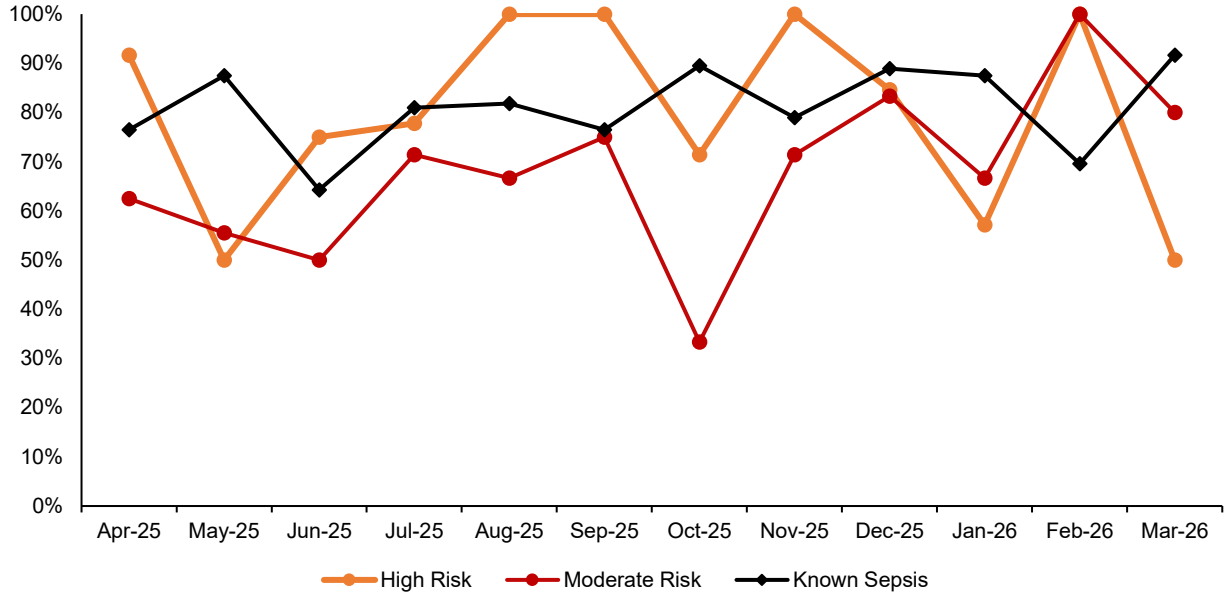
with suspected moderate-risk sepsis received intravenous antibiotics within three hours (*see figure 36)*.

Figure 36. Percentage of patients that received intravenous antibiotics in the AED within one hour for high risk sepsis and 3 hours for moderate risk sepsis



On inpatient ward, 78.8% of patients with suspected high-risk sepsis received intravenous antibiotics within one hour. 63% of patients with suspected moderate-risk sepsis received intravenous antibiotics within three hour (see figure 37).

Figure 37. Percentage of patients that received intravenous antibiotics on in-patient wards within one hour for high risk sepsis and 3 hours for moderate sepsis on inpatient wards



While a small reduction in recorded screening rates has been observed compared to the previous year, performance in time to antibiotics has improved. Audit data suggests that treatment is frequently initiated based on clinical judgement prior to digital screening tool activation.

A range of quality improvement initiatives are underway across wards and departments, led by resident doctors and overseen by specialty consultants. Performance data is reviewed monthly within CSU patient safety meetings.

Targeted education and training is delivered to nursing, medical and allied health professional staff to reinforce the importance of early recognition and treatment of sepsis. In addition, our Trust is developing a dedicated sepsis e-learning package for all clinical staff.

Further work is being undertaken through the Recognition and Response to the Acutely Unwell Patient Group (RRAUP) to optimise digital screening tools. This includes collaboration between clinical teams and digital services to ensure tools are clinically sensitive and support effective decision-making.

Our Trust remains focused on continuous improvement, with the aim of achieving the 90% compliance target set out in the NHS Standard Contract.

3.1.3 FALLS

National and Local Context. Nationally, falls and fall-related injuries are a common and serious problem for older people. People aged 65 years and older have the highest risk of falling, with around one in three people aged over 65, and one in two people aged over 80, experiencing at least one fall each year. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence, and mortality. Falls are also more common in clinical care settings, including acute hospitals and rehabilitation units, where patients may be acutely unwell, frail, or experiencing reduced mobility.

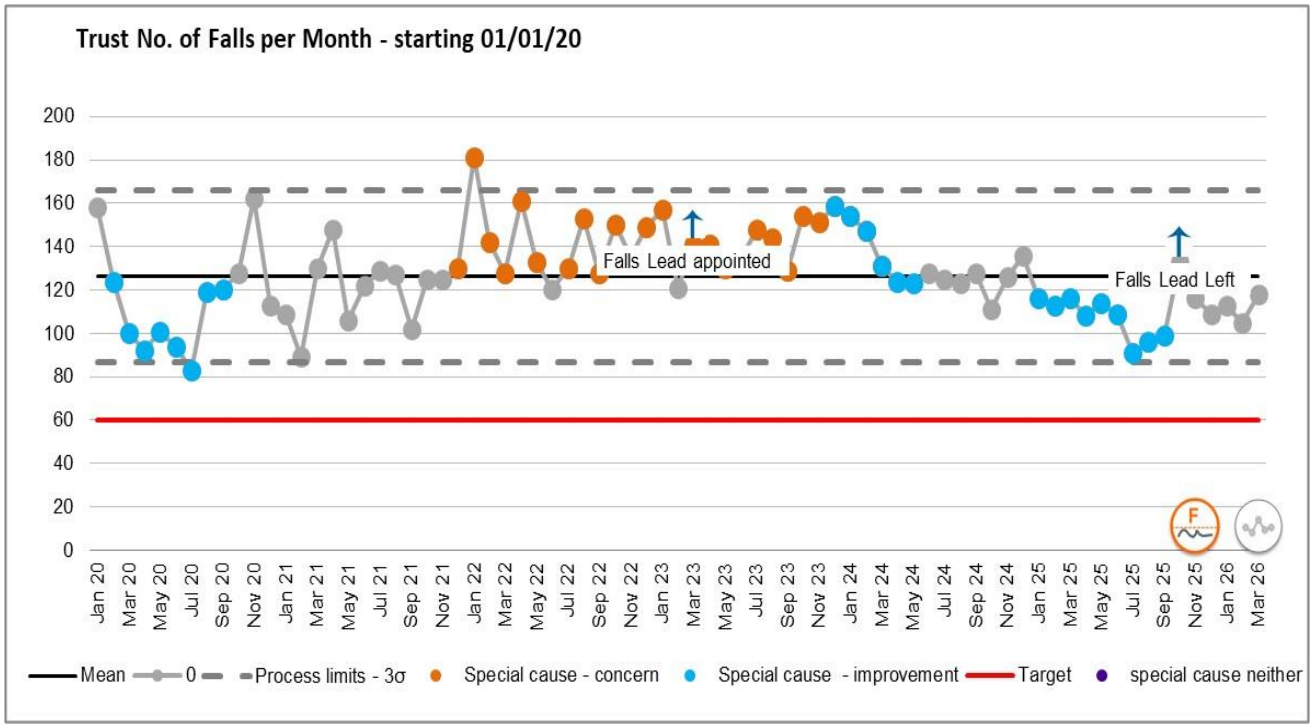
Although Bradford has a younger population profile than the national average, people locally are developing frailty at a younger age. Long-term conditions, deprivation, and wider health inequalities contribute to reduced strength, balance, and physiological resilience earlier in life for some individuals. As a result, patients who would not traditionally be considered “older people” may nonetheless be more susceptible to falls and fall-related harm, particularly during acute illness or hospital admission. This reinforces the need for a whole-system approach to inpatient falls prevention.

Overview. During 2025/26, inpatient falls remained a key Trust safety priority, reflecting national challenges and local population need. The Trust continued to monitor falls using Statistical Process Control (SPC) methodology to support a proportionate, improvement-focused response to variation.

The Trust remains compliant with the National Audit of Inpatient Falls (NAIF), ensuring that all patients sustaining a fracture or head injury as a result of a fall are accurately recorded and reported, enabling national benchmarking, learning, and transparency.

Falls Performance 2025/26. Across 2025/26, inpatient falls remained below historic peak levels, although some variation persisted.

- SPC analysis shows performance generally below the long-term mean of approximately 125 falls per month.
- An upward signal during late 2025 and early 2026 coincided with changes in falls leadership arrangements, highlighting the importance of sustained oversight and clinical leadership.
- Overall performance remained within expected control limits, with no evidence of an uncontrolled process.



Falls and Level of Harm. Most falls during the reporting period resulted in no or low physical harm, consistent with national profiles.

In March 2026:

- 118 falls were reported
- 54 incidents (46%) resulted in no physical harm
- 59 incidents (50%) resulted in low physical harm
- 4 incidents (3%) resulted in moderate harm
- 1 incident (<1%) resulted in severe harm
- No fatal falls occurred

All falls resulting in fracture or head injury were recorded in line with NAIF requirements.

NAIF Compliance and Key Performance Indicators. The Trust continues to use NAIF to drive improvement:

- KPI 2 – Checking for injury before moving: Strong compliance demonstrated.
- KPI 3 – Safe lifting equipment used to move the patient: Strong compliance maintained across inpatient areas.
- KPI 4 – Medical assessment within 30 minutes of a fall causing injury: Strong compliance, supporting timely clinical management.
- KPI 1 – High-quality multifactorial post-fall assessment:
  Remains an identified area of focus, with further work required to ensure consistent, high-quality assessment and translation into updated care plans.

Learning, Improvement and Governance (2025/26). During 2025/26, the Trust undertook targeted improvement work in areas with higher inpatient falls rates, which has shown significant improvement following the implementation of the Falls Prevention Bundle. The bundle provides clear visual cues to highlight increased falls risk and prompts staff to deliver timely support, while encouraging patients to remain active and independent within their individual limitations.

To further support improvement against NAIF KPI 1, a ward-level falls dashboard was developed. This provides staff with a quick visual overview of patient records, enabling teams to easily identify completed and outstanding falls multifactorial assessments to optimise safe activity (MASA). This

has strengthened day-to-day oversight, supported timely action, and reinforced shared responsibility for safe mobility.

To strengthen oversight and accountability:
- Falls data are shared monthly with senior leaders in each Clinical Service Unit, enabling proactive review and targeted action.
- Performance is reviewed through the monthly Falls Improvement Group, ensuring multidisciplinary scrutiny, learning, and coordination.
- Outputs from these meetings feed directly into the Trust's quality governance and assurance structures, providing organisational oversight and supporting continuous improvement.

This combination of targeted ward-level intervention, routine data review, and senior leadership oversight supports a robust, system-wide approach to reducing harm from falls.

Priorities for 2026/27. Key priorities include:
- Improving performance against NAIF KPI 1
- Sustaining strong compliance with KPIs 2, 3 and 4
- Continued roll-out and embedding of the Falls Prevention Bundle
- Ensuring clarity and continuity of falls prevention leadership
- Further reduction in falls resulting in moderate and severe harm
- Strengthening translation of learning into personalised care plans

Conclusion. Within the context of a national challenge and a local population experiencing earlier onset of frailty, the Trust continues to demonstrate a robust, learning-led and well-governed approach to inpatient falls prevention. During 2025–2026, targeted interventions, routine senior oversight, and strong governance arrangements have supported sustained improvement. The Trust remains committed to reducing avoidable harm and improving the safety, dignity, and experience of patients.

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 2024 to January 2026 with our current 12-month average mortality rate being 2.00% (see figure 16). This is one of the lowest mortality rates in the country and shows that mortality is not excessive at the 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 38: Crude Mortality Rate (12-month rolling: Mar 2024 to Jan 26): 2.00%

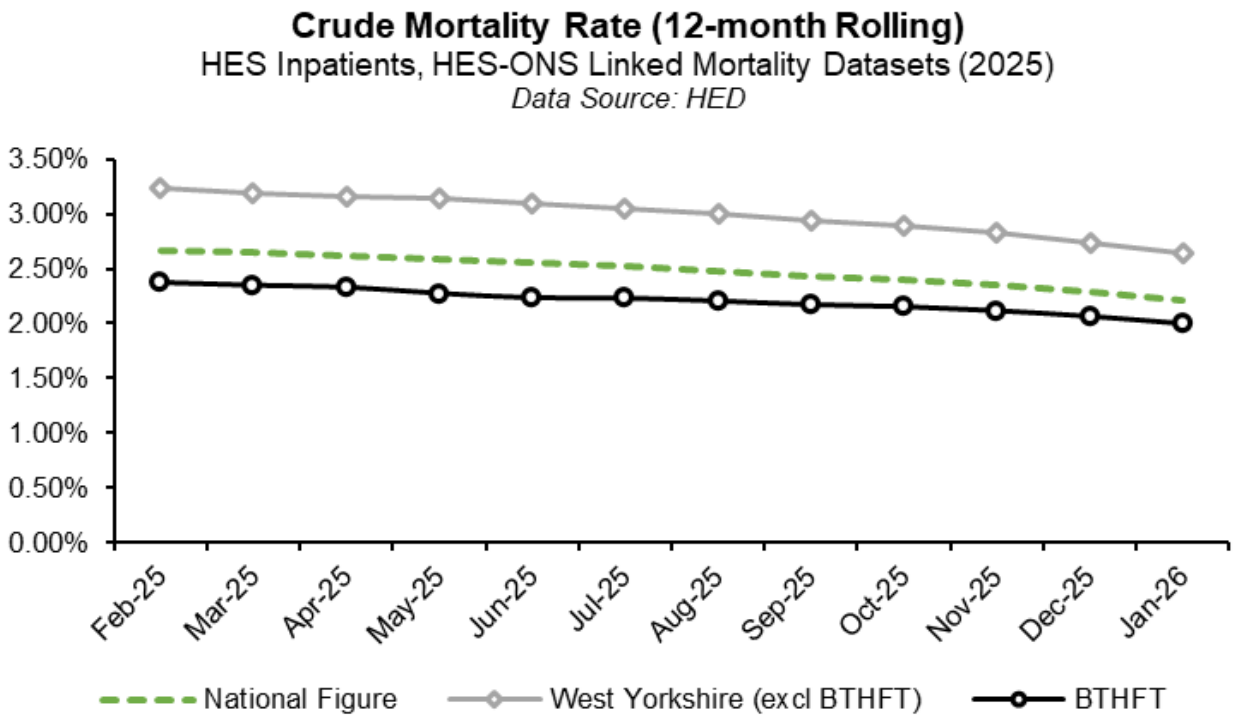


Figure 39: Crude Mortality Rate, observed deaths and discharges

Crude Mortality Rate 12-month rolling	Indicator Value	Number of Deaths	Number of Discharges
Mar 2024 - Feb 2025	2.37%	2,965	125,113
Apr 2024- Mar 2025	2.34%	2,947	125,727
May 2024- Apr 2025	2.33%	2,930	125,912
Jun 2024 - May 2025	2.27%	2,854	125,713
Jul 2024 - Jun 2025	2.23%	2,806	125,830
Aug 2024 - Jul 2025	2.23%	2,809	126,198
Sep 2024 - Aug 2025	2.20%	2,769	125,875
Oct 2024 - Sep 2025	2.17%	2,735	126,259
Nov 2024 - Oct 2025	2.15%	2,700	126,255
Dec 2024 - Nov 2025	2.11%	2,660	126,054
Jan 2025 – Dec 2025	2.06%	2,570	124,735
Feb 2025 – Jan 2026	2.00%	2,465	123,538

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[36] included work in relation to End of Life Care and Breast Screening awareness.
- Introduction of CardMedic[37] which provides translation cards and provides this information in Easy Read, Audio, British Sign Language and over 50 different languages.
- Accessible Information Standard[38] 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[39].
- The Spiritual Pastoral and Religious Care (SPaRC)[40] 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.

Kindness work continues with an ESR module (NHS Electronic Staff Record (ESR) Learning Management module) now available for staff to review. This video[41] is also being shared at induction events with the support of colleagues in Training and Education following its launch on 13 November 2025, World Kindness day.

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.

[36] https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/#:~:text=The%20Equality%20Delivery%20System%20(EDS,of%20the%20Equality%20Act%202010.
[37] https://nhsaccelerator.com/innovation/cardmedic/
[38] https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/
[39] https://www.healthwatchbradford.co.uk/
[40] https://www.bradfordhospitals.nhs.uk/sparc/
[41] https://share.dynamicbusiness.co.uk/2025/NHS_Bradford/Kindness/Bradford_Kindness-FULL-V2.2-SUBS-HB.mp4?

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.
- Ward walkarounds 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 was also produced in an *Easy Read* format during 2025.

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 2025 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[42] 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.

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 2025/26, as shown in figure 41, has increased overall to date in comparison to the previous year with a significant increase in March 2026. 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[43] (PHSOs) recommendation as best practice for management of complaints.

[42] https://www.bradfordhospitals.nhs.uk/vri/
[43] https://www.ombudsman.org.uk/organisations-we-investigate/good-complaint-handling

Figure 41. Complaints: comparison between 24/25 and 25/26

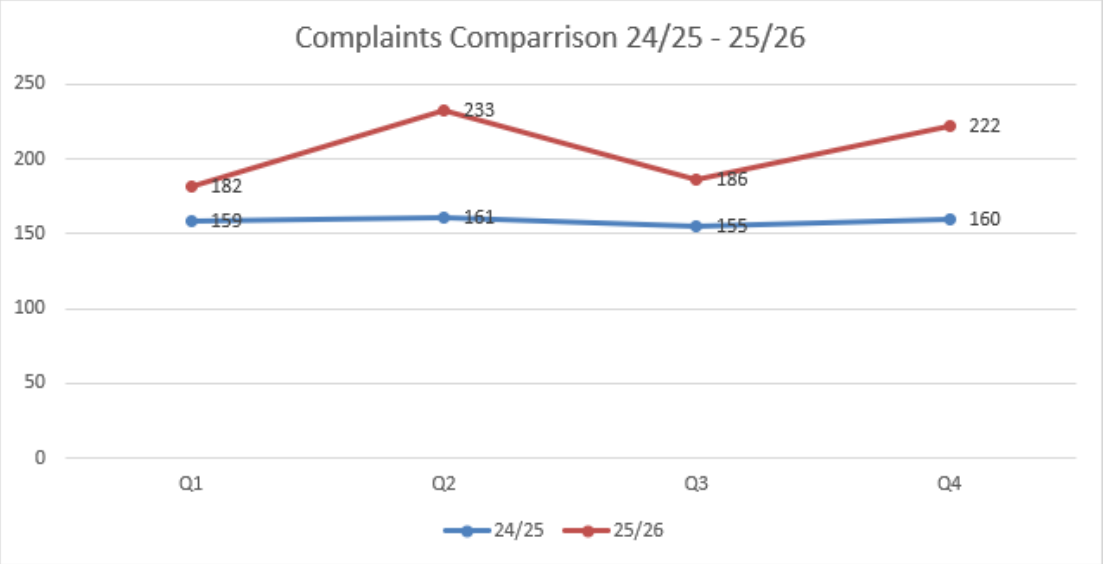
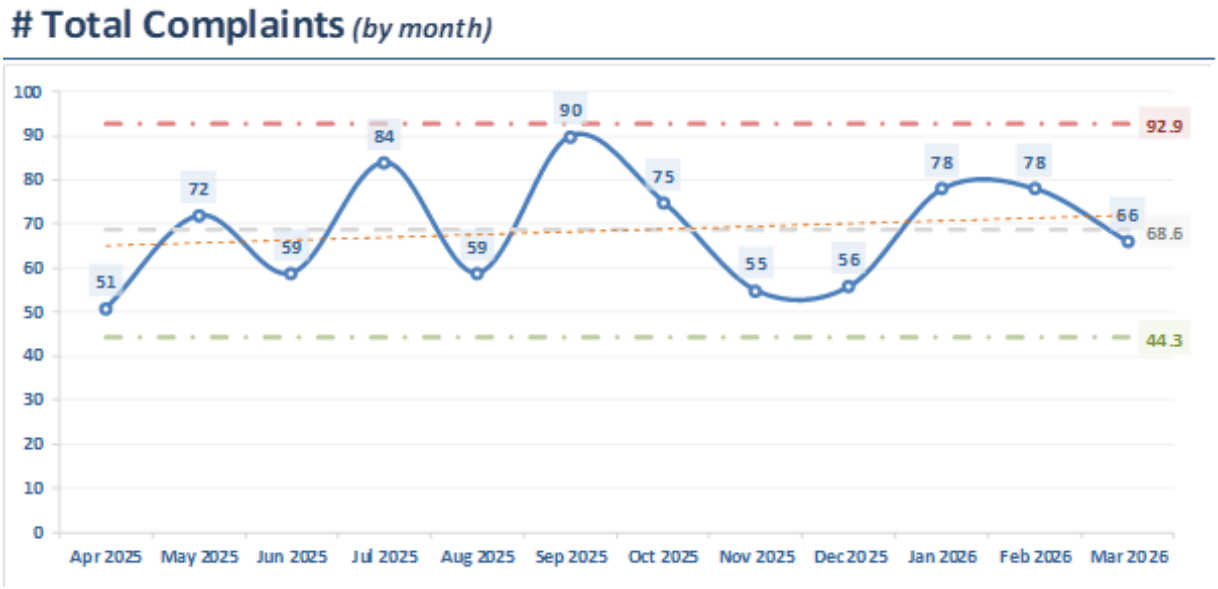


Figure 42. Annual complaints against the actual upper and lower limited against the calculated fields based on the averages



As shown in figure 42 above:

- 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.

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 25/26 the team carried out a total of 35,443 visits. The monthly breakdown for this exceptional number of visits is in figure 40 below.

Figure 40. SPaRC visits for patients and visitors during 2025 to 2026

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Patient visits	2,733	2,701	3,104	3,413	3,179	3,781	3,685	3,175	3,554	2,401	2,992	3,467

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.

The SPaRC team work with Education colleagues in the delivery of training sessions. This includes newly appointed Health Care Assistants. Due to the positive feedback from these sessions, practice educators have asked for further support from the SPaRC team for cultural competency training sessions.

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[44] 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[45] demonstrates the WebApp including how to access these services.

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

[44] https://sparc.bradfordhospitals.nhs.uk/
[45] https://vimeo.com/925951596/0351ffce72?share=copy

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.

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[46] 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.

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 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[47] 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[48] 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.

Multidisciplinary team working has grown through the past year, as evidenced through work carried out jointly with Martin House Children's Hospice[49] 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.

[46] https://bradfordhospitalscharity.org/
[47] https://www.hee.nhs.uk/our-work/learning-disability/current-projects/oliver-mcgowan-mandatory-training-learning-disability-autism
[48] https://www.bdct.nhs.uk/our-services/learning-disability-services/learning-disability-health-support-team/
[49] https://www.martinhouse.org.uk/

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[50] during 2024. This highlighted that a significant number of admissions (16%) were for people with 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.

The National Audit of Dementia is undergoing a full redesign across a three-year period and will apply to both general acute hospitals and dementia diagnostic services. As a result, no data collection took place nationally during 2025. The redesign aims to increase the use of routine data and reduce the administrative burden of audit participation

Dementia Workforce Training and Development. Training and development of the Bradford Teaching Hospitals NHS Foundation Trust workforce continues to be a priority to ensure all colleagues—clinical and non-clinical—are equipped to support individuals living with dementia or cognitive impairment. Embedding dementia awareness across the Trust strengthens compassionate care, improves patient experience, and supports a positive organisational culture.

This year, dedicated funding enabled the Trust to host the Dementia Bus, a 15-minute immersive simulation experience that recreates the sensory and cognitive challenges faced by people living with dementia. Through altered lighting, sound, and environmental factors, the experience deepens staff understanding of distressed behaviours and highlights how everyday clinical environments may unintentionally increase confusion or anxiety.

Two Dementia Bus training days have already taken place, with almost 100 staff participating. A further two sessions are planned. Due to exceptional feedback and demonstrable impact on staff confidence and communication, the Trust intends to submit a further funding bid for 2026/27 to expand access.

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*[51] 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.

Dementia-Friendly Environmental Enhancements. A range of dementia-friendly improvements have been completed or are underway across the Trust to create safer, more accessible, and cognitively supportive environments.

Ward 17

- Installation of high-contrast corridor handrails to support safe mobility.
- Introduction of yellow toilet doors to improve wayfinding.

[50] https://www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-audit-of-dementia
[51] https://www.lucentia-design.com/

- Internal toilet door signage redesigned to reduce anxiety and support orientation.
- Development of clear bed-space wall graphics to aid recognition and reduce confusion.
- Dementia-friendly design specifications fully embedded with the appointed contractor.
- Ongoing refurbishment of toilet and shower facilities, with colours and finishes selected to support dignity, privacy, orientation, and visual contrast.

Ward 24
- Installation of calming wall graphics in all side rooms to enhance therapeutic environments and support those with cognitive impairment or delirium.

Horton Wing – Completed Works
- Completion of high-contrast handrails across all three levels of Horton Wing, including Cardiology and Adult Outpatients, improving wayfinding in high-footfall areas.

ENT Access Improvements
Although not dementia-specific, ongoing accessibility improvements will benefit:
- patients with visual impairment
- individuals experiencing cognitive challenges
- anyone requiring clearer wayfinding and reduced environmental stressors

This aligns with the Trust's commitment to inclusive design principles.

Dementia-Friendly Estates Standard. In collaboration with colleagues across Estates and clinical teams, the Trust has developed a Dementia-Friendly Estates Standard. This new framework outlines required design considerations for all future capital projects and refurbishment schemes. It now forms part of the Trust's Estates Project Standard, ensuring dementia-friendly principles are embedded consistently and systematically across the organisation.

National Audit of Dementia. The National Audit of Dementia is undergoing a full redesign across a three-year period and will apply to both general acute hospitals and dementia diagnostic services. As a result, no data collection took place nationally during 2025. The redesign aims to increase the use of routine data and reduce the administrative burden of audit participation.

The Trust has registered for the *Voluntary Census Day*, planned during Carer's Week (8–12 June 2026). This one-week census will provide timely point-in-time data on the prevalence of hospital-admitted patients living with dementia and support awareness of person-centred practices. Results will influence targets for the 2027 audit cycle, with national goals including:

- increased use of structured assessments in key areas of care
- increased proportion of staff trained to Tier/Level 2
- improved identification of patients with dementia at admission
- expanded use of Personal Information Documents to support individualised care

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[52] (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.

[52] https://hi-vis.org/hivisuk-and-bradford-partnership-boost/

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 the Citizen Voice Forum[53] 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[54]. 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*'[55] 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.

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.

[53] https://engagebdc.com/west-yorkshire-voice
[54] https://www.healthwatchbradford.co.uk/
[55] https://engagebdc.com/listen-in-bdc

Our Trust interpreting services team supported people on at least 56,094 occasions during 25/26, 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 43 below.

Figure 43. Top 10 languages requested through interpreting services from 1 April 2025 to 31 March 2026

Urdu/Punjabi	29,068
Czech/Slovak	6,590
Polish	3424
Arabic	3413
cBengali	3262
Kurdish	1387
Hungarian	1131
Pushto	1027
Russian	762
BSL	756

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 756 sessions during 25/26.

To further support inclusivity the Patient Experience Team were proud to announce a partnership with CardMedic[56], the latest innovation adopted at the Trust as part of the "Clinical Insite" membership of the NHS Clinical Entrepreneur Programme[57]. 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 25/26.

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.

[56] https://www.cardmedic.com/
[57] https://nhscep.com/

- Patient Experience Team approached by the service leads to undertake patient engagement for the Pennine Breast Screening Service[58] 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[59] 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[60] to take part in a pilot for the new NHS England self-assessment framework for the AIS[61]. 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[62] 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.

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 2026/27

- 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.
- 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[63].

[58] https://www.bradfordhospitals.nhs.uk/pennine-breast-services/
[59]https://www.bradfordhospitals.nhs.uk/patients-and-visitors/accessible-information/#:~:text=Accessible%20Information%20Standard%20(AIS),and%20pictures)%20or%20via%20email.
[60] https://www.healthwatchbradford.co.uk/
[61] https://www.england.nhs.uk/nhsimpact/assessment-and-improvement/self-assessment/
[62] https://www.accessable.co.uk/bradford-teaching-hospitals-nhs-foundation-trust
[63]https://www.england.nhs.uk/patient-safety/marthas-rule/

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

Bradford Teaching Hospital Foundation Trust Quality Account 2025/2026

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 2025/26. The Quality Account has been shared with key members across the Bradford District and Craven Place, and this response is on behalf of the organisation.

The priorities set out in 2025/2026 have been linked to three key themes and I note the key achievements mapped against last year's priorities, which include:

Priority 1 - Building on previous work to improve the management of the deteriorating patient with the full implementation of all 3 components of Martha's Rule to all adult in-patient wards:

- To support implementation, the Trust introduced the Patient Wellness Questions (PWQ) tool, which provides a structured method for capturing patient feedback and guiding escalation. This tool uses a two-question, fivepoint scoring system to help guide effective and safe escalation for further clinical review. Adaptations have been made for paediatric and maternity services to align with existing care models and service capabilities.
- Direct escalation by patients and families is delivered through dedicated phone lines to the Critical Care Outreach (CCOR) team, implemented across adult and paediatric inpatient areas in November 2025. The initiative has been widely promoted using national communication resources and accessible information formats.
- Early monitoring data (January 2025 to March 2026) indicates limited but effective use of escalation pathways: 19 staff-initiated rapid reviews via PWQ and eight family-initiated calls, with no paediatric escalations recorded. All cases resulted in advice and reassurance, with no unplanned intensive care admissions.
- Martha's Rule forms part of the Trust's 2025/26 Quality Account priorities. Ongoing governance includes regular audits, continuous monitoring of escalation activity, and structured reporting through patient safety forums. Full implementation ensures compliance with NHS Standard Contract requirements for 2026/27, supporting continuous improvement in patient safety.

Priority 2 - Building on the success in implementing Saving Babies' Lives will continue to make improvements in our maternity and neonatal services with a focus on reducing health inequalities:

- The service developed an updated improvement plan in response to recommendations issued in November 2024, demonstrating good progress with no significant concerns identified. Key developments include enhanced collaboration with pharmacy colleagues and the implementation of processes to monitor ambient medication storage temperatures, with defined actions for deviations.
- Following an unannounced CQC maternity inspection in September 2025, the service received a published report confirming a 'Good' rating across all five domains and overall. This reflects sustained progress and a strong commitment to high-quality care.
- The inspection findings were reviewed in December 2025 to identify further improvement opportunities, leading to the development of an additional improvement plan, which was presented to the Quality Committee in early 2026.

Priority 3 - 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 Trust implemented Patient Safety Incident Reporting Framework (PSIRF) in December 2023 and, following a 2025 review, committed to an earlier full reassessment of its Patient Safety Incident Response Plan (PSIRP) to maintain alignment with national expectations. Due to capacity constraints and the need for robust stakeholder engagement, the review timeline has been extended, with completion now planned by July 2026.
- The revised PSIRP will be evidence-based, aligned to organisational priorities, and focused on measurable improvement. Supporting work includes an audit of incident investigations and continued focus on four key safety priorities: pressure ulcers, falls, medicines safety, and blood transfusion.
- The Trust has strengthened its approach to learning through improved data triangulation (INSIGHT report), targeted quality improvement activity, and enhanced oversight of investigations. Adoption of a national review tool and panel model has further improved the quality and consistency of patient safety learning and response processes.

The Trust has made further strategic quality improvement priorities by ensuring that quality is embedded. The most notable improvements include:

- In November 2025, Bradford Royal Infirmary was confirmed as Gold-level Quality Data Provider for the National Joint Registry scheme (NJR).
- Opening of the new endoscopy unit, alongside the achievement of 'Joint Advisory Group (JAG) accreditation' for endoscopy services.
- National programmes and strong research participation are helping improve outcomes and position the organisation as a leading "City of Research," while its integrated approach to care, teaching and research supports a continued focus on safety, quality and innovation.

The CQC rating remains as 'Good' with an 'Outstanding' rating for the neonatal services. I acknowledge that the CQC undertook an unannounced service-level inspection, alongside a Trust-wide Well-Led inspection in November 2025. I acknowledge that the CQC has not taken any enforcement actions. I note the key local priorities for quality improvement for 2026/27 will be focused on:

- Priority 1: Learning Disabilities and Autism - The Trust aims to enhance the experience and outcomes for individuals with learning disabilities and autistic people by improving the clarity, consistency, and visibility of reasonable adjustments across services. It will promote more proactive use of hospital passports to support personalised care, expand the delivery of Oliver McGowan Mandatory Training, and strengthen collaboration with carers and families to ensure safe, person-centred care.

- Priority 2: Workforce Planning - The Trust will aim to enhance workforce sustainability and capability through a coordinated, long-term approach aligned with the NHS Long Term Workforce Plan. Alongside targeted efforts to improve staff wellbeing, retention, and leadership development, you aim to expand access to education, training, and career progression opportunities.

- Priority 3: Enhanced Therapeutic Observations & Care - The Trust aims to enhance the safety and experience of patients requiring enhanced observations through a series of coordinated improvements. These include promoting compassionate and meaningful interactions during observation, equipping staff with training in trauma-informed care, de-escalation techniques, minimising the use of restrictive practices wherever possible, strengthening documentation and communication across teams and ensure greater patient involvement in personalised safety planning.

- Priority 4: Maternity Learning- The Trust aims to enhance maternity safety and organisational learning through a structured and proactive approach. This includes responding promptly to insights from incidents, national reports, and recommendations, and implementing the NHS England Maternity Safety Improvement Programme care bundles. The Trust also seeks to strengthen escalation processes and multidisciplinary communication, while fostering a culture of psychological safety for staff. Central to this approach is the meaningful inclusion of families' perspectives in learning and improvement activities.

- Priority 5: Harm Reduction & Prevention – The Trust is prioritising improvements in hip fracture care and hospital-acquired infection management. For hip fractures, the focus is on faster surgery, better preoperative preparation, and coordinated multidisciplinary care to support early mobilisation. For infections, the emphasis is on prevention, reduction of key infection rates, effective antimicrobial use, early identification, and improved supportive care.

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 the opportunity to comment on the Bradford Teaching Hospitals NHS Foundation Trust Quality Account for 2025/26.

As the independent champion for people using health and care services, we recognise the important role the Trust plays in delivering healthcare services across Bradford District and Craven. We welcome the Trust's continued commitment to ensuring that the voices of patients, families and carers are heard and reflected in the planning, delivery and improvement of services.

We acknowledge the ongoing challenges facing the NHS, including increasing demand, workforce pressures and financial constraints. Despite these challenges, it is encouraging to see the Trust maintaining a strong focus on quality improvement, patient safety, clinical effectiveness and patient experience.

We particularly welcome the continued emphasis on patient engagement and involvement throughout the Quality Account. The Patient Experience and Engagement Strategy demonstrates a clear commitment to ensuring that patient voice remains central to service development and improvement. The wide range of engagement activities described throughout the report reflects a genuine effort to listen to local communities, understand their experiences and use feedback to drive positive change.

We also welcome the Trust's continued focus on improving patient safety through initiatives relating to falls prevention, pressure ulcer reduction, sepsis management and learning from patient experience. The examples of partnership working, accessibility improvements, support for people with additional needs, and investment in communication and interpreting services demonstrate a commitment to delivering inclusive, person-centred care for Bradford's diverse communities.

Healthwatch Bradford and District continues to maintain a close and constructive working relationship with colleagues across the Trust and values the openness with which patient feedback and community insight are received. We particularly appreciate the ongoing engagement with the Patient Experience Team and the organisation's commitment to involving patients and communities in service improvement.

In addition to our direct engagement with Trust colleagues, Healthwatch Bradford and District contributes to improvement and assurance activity through involvement in key strategic groups and partnerships across the health and care system. This enables us to provide both support and constructive challenge, ensuring that the experiences and priorities of local people remain central to service development.

Through our role as Partner Governor and participation in the Excel Project Steering Group, which oversees improvements to urgent and emergency care services, we continue to champion patient voice and support positive change across the Trust. We look forward to continuing this collaborative relationship and working together to improve outcomes and experiences for patients, families and communities across Bradford District and Craven.

Helen Rushworth
Chief Executive
Healthwatch Bradford and District

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

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Bradford Metropolitan District Council (BMDC) Health and Social Care Overview and Scrutiny Committee (HSCOSC) has advised the Trust that it has opted not to provide comments on the 2025/26 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

Karen Walker, Acting Chair

Professor Mel Pickup, CEO