Quality Account 2024-25

thriving people,
healthy communities

Contents

Part 1: Statement on Quality from the Chief Executive 5
1.1 Signed Declaration .... Error! Bookmark not defined.
1.2 Statement of Directors' responsibilities in respect of the Quality Report 6
1.3 What is a Quality Account 7
1.4 Scope and Structure of the Quality Account 7
2.2 Quality Performance 2024/25 9
2.2.1 Priority 1 Patient Safety 9
2.2.2 Priority 2 Clinical Effectiveness 9
2.2.3 Priority 3 Patient Experience 9
2.3 Quality Account Priorities 2024/25 9
2.3.1 Priority 1 Patient Safety 9
2.3.1a Safe Discharge 9
2.3.1b Safe Maternity Services (Place based priority) 11
2.3.1c Pressure Ulcer Management 14
2.3.1d Falls Ulcer Management 16
2.3.2 Priority 2 Clinical Effectiveness 18
2.3.2a Medicines Safety – Omitted and Delayed Doses of Time Critical Medicines 18
2.3.3 Priority 3 Patient Experience 23
2.3.3a Deteriorating Patient 21
2.3.3b Care of People with Dementia 23
2.4 Quality Improvement Priorities for 2025/26 25
2.4.1 Care of Acutely Ill Patient (CAIP) 26
2.4.1a Sepsis 26
2.4.1b Matha's Rule 26
2.4.1c Hospital At Night 27
2.4.1d ReSPECT / Resus 27
2.4.2 Urgent and Emergency Care 28
2.4.3 Patient Safety Culture and Speaking Up 29
2.5 Participation in clinical audit and national confidential enquiries 30
2.5.1 Participation in Clinical Research 37
2.5.2 Use of Commissioning for Quality and Innovation framework 38
2.5.3 Registration with the CQC 38
2.5.4 Information on the Quality of Data 38
2.5.5 Learning from Deaths 40
2.5.6 Duty of Candour 41
2.5.7 Staff who speak up 41

2.5.8 Learning Disabilities Improvement Standards 42
2.6 Reporting Against Core National Indicators 45
Domain 1 – Preventing people from dying prematurely 45
Domain 2 – Enhancing the quality of life for people with long-term conditions .. 45
2.6.1 Summary hospital-level mortality indicator (SHMI) 45
Domain 3 – Helping people recover from episodes of ill health or following injury 47
2.6.2 Patient Reported Outcome Measures (PROMs) 47
2.6.3 Percentage of emergency re-admissions to Airedale NHS Foundation Trust within 30 days of discharge 48
Domain 4 – Ensuring that people have a positive experience of care 49
2.6.4 Responsiveness of Airedale NHS Foundation Trust to the personal needs of patients. 49
2.6.5 The percentage of staff employed by, or under contract to the Trust during the reporting period, who would recommend Airedale NHS Foundation Trust as a provider of care to their family or friends 51
2.6.6 Friends and Family Test (FFT) – Patient Feedback 53
Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm 55
2.6.7 Percentage of patients admitted to hospital and were risk assessed for venous thromboembolism 55
2.6.8 Rate of C. *difficile* infection per 100,000 bed days in Airedale NHS Foundation Trust patients aged 2 or over 56
2.6.9 Reported number and rate of patient safety incidents per 1000 bed days reported within the Airedale NHS Foundation Trust and the number and percentage that resulted in severe harm or death 58
3.1 Organisational Quality Improvements 62
3.1.1 Surgery and Diagnostics Division Quality overview 2024/2025 62
3.1.2 Women, Children and Specialist Services Division Quality overview 2024/2025 62
3.1.3 Medicine, Therapies and Community Division Quality overview 2024/2025...... 63
3.2 Performance Against Key National Priorities 65
Part 4 Annex 68
4.1 Bradford District and Craven Health and Care Partnership NHS West Yorkshire Integrated Care Board 68
4.2 Overview and Scrutiny Committee 70

Part One

thriving people,
healthy communities

Part 1: Statement on Quality from the Chief Executive

It is my pleasure to introduce the Quality Account Report for 2024/25, which outlines some of our achievements and challenges and is underpinned by a continuous quality focus and ambition of colleagues across our organisation for the people we serve.

We continue to focus on our responsibilities as an integrated acute and community provider. Partnership is a key element of our Trust strategy, and a key enabler of us improving the services and pathways for our population. This year, we have continued to support our New Hospital plans, engaging with all stakeholders, and progressing at pace with some key milestones identified for the year ahead. Our role as an anchor institution is one which we take very seriously, and we continue to provide clinical services across a number of locations including some innovative mobile and digital services.

The report this year includes a review of achievements against our Quality Priorities for 24/25 and sets out comprehensive plans for our priorities for the next year. The priorities for 25/26 were jointly agreed at our first Quality Summit where a collaborative approach was taken to share knowledge, think creatively and identify barriers to quality improvement.

As the NHS progresses its new 10 Year Plan, these priorities will continue to be adapted around the three shifts publicised, from treatment to prevention, from hospital to community and from analogue to digital.

This year we have successfully opened our Urgent Treatment Centre which has meant that appropriate patients have been streamed from our Emergency Department which has had a positive impact in reducing overcrowding and wait times.

It has been another busy year for teams, and one in which there are a number of transformation priorities. Despite this the Quality Accounts demonstrate the wide range of quality improvement initiatives that have been undertaken right across our organisation. The overarching intent of our Trust Strategy remain true – the ambition to have Thriving People and Healthy Communities.

I would like to thank all our colleagues and service users, and our wider community, for the support which you continue to offer to the Trust.

1.1 Signed Declaration

It is important that our Quality Report is accurate and presents an honest picture of our care. We seek to foster an open and transparent culture so we can understand where improvements are needed. As Chief Executive of Airedale NHS Foundation Trust, I can confirm that the information used and published in the Quality Report is, to the best of my knowledge, accurate and complete.

…………………………

Foluke Ajayi Chief Executive
Airedale NHS Foundation Trust
Date: 30 June 2025

1.2 Statement of Directors' responsibilities in respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2023/24 and supporting guidance Detailed requirements for Quality Reports 2020/21
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.
- board minutes and papers for the period April 2024 to (the date of this statement)
- papers relating to quality reported to the board over the period April 2024 to (the date of this statement)
- feedback from commissioners
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
- the 2024 national patient survey
- the 2024 national staff survey
- the latest CQC report

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

………………………………………	………………………………………
Foluke Ajayi Chief Executive	**Andrew Withers Interim Chair**
Airedale NHS Foundation Trust	**Airedale NHS Foundation Trust**
Date: 30 June 2025	**Date: 30 June 2025**

1.3 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.
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)

1.4 Scope and Structure of the Quality Account

This report summarises our progress on the quality priorities we set for 2024/25. Our focus remains to provide safe, effective and a positive experience of care.
This report is divided into three parts:

- **Part 1** presents a statement from the Chief Executive about the quality of health services provided during 2024/25.

- **Part 2** describes our progress in 2024/25 and how we plan to monitor and report progress and our priorities for improvement for 2025/26. It contains statements of assurance relating to the quality of services. This includes statements on the National Clinical Audits programme which NHS England advises Trusts to prioritise for participation and inclusion in their Quality Accounts for 2024/25 and, a description of our research work.

- **Part 3** includes performance against national priorities and our local indicators.

- **Part 4** the annex section includes comments from our external stakeholders.

The direct alignment of the Quality Account with, Our Vision and Strategy- Airedale NHS Foundation Trust, Annual Report, and Quality and Safety Strategy 2020-2025 ensures a cohesive approach that actively supports the organisation in fulfilling its strategic objectives.

The table below identifies how the Quality Priorities 2025/26 directly align to the Quality and Safety Strategy 2020-2025

Quality Priority	Quality and Safety Strategy
Care of the Acutely Ill Patient (CAIP)	Clinical effectiveness • Early detection of deterioration in patient condition and timely intervention • Improve the management of sepsis
Urgent and Emergency Care Improvement	Patient Safety • Work with partners across the integrated care system to support safety improvement in priority areas Patient Experience • We will create an environment where we really listen and use feedback for improvement where staff feel encouraged to listen, adapt and learn •
Patient safety Culture and Speaking Up	Just and Learning Culture • Nurture a just, fair and psychologically safe culture that ensures equity, diversity and inclusion and one that is underpinned by civility.

Part Two

2.1 How quality initiatives are prioritised in the Trust

This Quality Report identifies the progress made against the quality and safety agendas in 2024/25 and identifies the quality improvement priorities for 2025/26. Quality initiatives are chosen and prioritised based on quality, safety, and experience data to ensure we focus improvement activities around greatest need and that decisions are made based on robust data.

2.2 Quality Performance 2024/25

The quality priorities set out in the Quality and Safety Strategy in 2020 were divided into three key areas Patient Safety, Patient Experience and Clinical Effectiveness.
At the Quality and Safety Committee in October 2022 there was support for the proposal to have fewer quality priorities with a clear focus on outcomes. In addition, there will need to be an alignment to the quality priorities identified as part of the Integrated Care Board for Bradford, Airedale, and Craven.
The priorities listed below are monitored in sub committees to the board, the Divisional Performance review process and are also reported within the Integrated Performance Report which is presented to board.

2.2.1 Priority 1 **Patient Safety**

- Safe discharge of patients
- Safe Maternity Services (Place based priority)
- Pressure ulcer and falls management

2.2.2 Priority 2 **Clinical Effectiveness**

- Medicines safety – time critical medicines
- Mental Health for Adults and Children (Place based priority)
- Deteriorating patient – management of sepsis

2.2.3 Priority 3 **Patient Experience**

Care of people with Dementia

Progress against each priority and next steps is summarised on the following pages

2.3 Quality Account Priorities 2024/25

2.3.1 Priority 1 Patient Safety

2.3.1a Safe Discharge

The Safe Discharge Oversight Group was established in response to a number of failed discharges which prompted the trust to consider this area as one of the Quality Account priorities for 2024-25. This summary highlights developments, analysis of data and ongoing improvement actions. The aim is to ensure continuous improvement in the promotion and management of safe discharges by learning from incidents reporting unsafe discharges.

Following a thematic review of all failed discharge incidents and qualitative feedback sessions with multi-disciplinary professionals, six key areas for improvement were identified:

- Night Discharge Planning List
- Packages of Care
- TTO delivery
- Educational needs and discharge training
- Criteria to discharge practices
- Discharge lounge use and review.

Night Discharge List

This was proving to be time intensive but unreliable in predicting discharges, so this was discontinued thus releasing staff time to care.

Packages of Care

- Meetings with East Lancashire Local Authority have been increased to focus on supporting patient pathways for timelier discharges
- Social care information to wards has been updated to include care provider details/times and contact numbers enhancing more effective communication and opportunities for troubleshooting around the whole patient discharge experience.
- Home fast service continues to work well with an increase in areas to be covered and increased to support 3 patient discharges per day.
- North Yorkshire continues to trial Home First discharges to provide a more effective, supportive service.
- The Local Authorities have implemented an escalation plan for if there is no response to referrals to prompt a timelier discharge. This is currently being audited.

TTO Delivery Issues

TTO is the reference made to medicines supplied to take home (To Take Out).
Medication related incidents remain a key theme for discharge failures.

- An audit of pharmacy interventions is being undertaken to determine the level of corrections needed for TTOs which ultimately reduce the medication conversations with patients and families/carers
- The request from some patients/families for transportation of TTOs is not likely to be supported due to the high risks involved in transportation of medications.
- Increase in pharmacy staffing should meet anticipated capacity by August 2025 ensuring a greater presence in clinical areas to support patient discharges.
- Moving forwards, the implementation of EPR is likely to increase timeliness of information for discharge and TTOs, thus improving the service.

Educational Needs & Discharge Training

- A revised discharge education and training package has been developed and is currently being rolled out to all B6 and B7 staff to enhance knowledge and skills linked to referral processes across 3 local authorities; discharge summaries; use of different EPR systems.

Criteria to Discharge Practices

- A refresh of SAFER discharge practices has been implemented to ensure timelier discharges.

- A review of data indicating when patients do not meet the criteria to remain [NMCTR] is being undertaken, which will support greater accuracy of information and trigger appropriate multidisciplinary actions.
- The trust is undertaking a review and further roll out of nurse-led discharges. These work well in surgery but require further development in the medical division.

Discharge lounge review

The discharge lounge remains a valuable resource, and it is evident that when used effectively, it increases safer discharges. An example of safer discharge is the introduction of a checklist which has enabled significant reduction in people being discharged with a cannula in situ. This was a KPI and has demonstrated a significant improvement over the year.

Key Notes of Safe Discharge performance

- The number of discharges across the trust is approximately 10,000 per month.
- The total number of failed discharges for 2024-25 is 148 which represents less than 1.5% of total discharges.
- The most common theme is communication issues/poor documentation.
- There is a reduction in the number of people being discharged with a cannula in situ.
- There is no direct correlation between failed discharges and the number of PALS concerns and complaints.

Next Steps
A more detailed approach regarding actions and quality improvements from each of the workstreams continues to capture the good work and further areas of improvement that are taking place across the organisation.

2.3.1b Safe Maternity Services (Place based priority)

Our ambition is to be a provider of high quality, safe and effective maternity care for women, birthing people and their families. We strive to listen and learn and embed continuous improvement with improved outcomes that demonstrate a clear focus on patient safety and experience. We commit to working collaboratively with our key stakeholders, locally, regionally and nationally to provide patient centred care that is effective and responsive.
We take pride in actively engaging with and listening to the voices of our diverse local population, we work jointly with our Maternity Neonatal Voices Partnership Leads and Airedale Birth Voices to ensure that the services we are providing are responsive to our populations needs.
This is a summary of some the key quality improvements we have delivered throughout 2024/2025.

Key Achievements in 2024/25

Care Quality Commission (CQC)

Airedale NHS Foundation Trust participated in an inspection by the Care Quality Commission (CQC) of maternity services on 6th December 2022. The service was rated as Requires Improvement under the Safe and Well Led Domains and has undertaken work to address the required improvements the CQC identified. This included a review of the Maternity Assessment Centre Triage pathways, improved compliance to mandatory staff training, improvements to governance processes, leadership and workforce. The actions have been monitored through Directorate, Divisional and Trust Risk and Compliance. To ensure continued oversight and monitoring of the ongoing actions the themes have been incorporated into the overarching Three Year Plan.

Maternity Assessment Centre

A key part of the CQC inspection was the improvements that were required around the Maternity Assessment Centre Triage pathways. Improvements were required around the risk assessment and priority of timescales for women and birthing people to be assessed once present on the unit. A structured quality improvement plan has resulted in an improved triage pathway, prioritisation and escalation. The Maternity Assessment Centre is now open 7 days per week and the pathways are evaluating well. Compliance with the process/pathways and timescales are monitored monthly through a series of Key Performance Indicators (KPI's) and outcomes of themes and trends are reported monthly to Governance groups.

CQC Maternity Picker Survey

This is an annual survey undertaken by the CQC with voluntary participation from service users. The 2024 Maternity survey involved 300 women and birthing people who received care from maternity services at Airedale NHS Foundation Trust in January and February 2024. 125 responses were received (42.1%), this is slightly lower than average response rate of the 30 trusts surveyed by 'patient perspective' which was 45%. The 2024 mean average score for the trust was 81.3%, this was a 2.5% improvement from scores received in 2023.

Of the 63 questions included in the survey the trust scored within the top 20% for 7 questions and in the bottom 20% for 7 questions. 4 questions showed a greater than 10% improvement from last year's scores and no questions were worse than 10%.

The maternity service has developed a co-produced action plan with the Maternity Neonatal Voices Partnership lead and has been designed to address areas within the report that Airedale maternity services could improve upon when compared with other Trusts. This Quality Improvement work is currently in progress and triangulates with the wider service user feedback.

Perinatal Quality Surveillance – Minimum Data Set

In 2020, in response to the adverse finding contained within the Ockenden report NHS England introduced a national Quality Surveillance Model to provide consistent and methodical oversight of Maternity services to Trust Boards. The model was developed to gather ongoing learning and insight, to inform improvement in the delivery of perinatal services and to ensure a positive experience for women and families.

In 2020, the Trust maternity service fully embraced and implemented this model, and in 2024-25 has worked with the Trust Informatics team to further develop performance dashboards. This is to assist Trust Board with a clear visual oversight of performance data, based on Making Data Count methodologies. This information is shared within local Governance meetings; Quality Safety Committee, Trust Board and the external ICB/LMNS Perinatal Oversight Group to support oversight, scrutiny and challenge of performance activity.

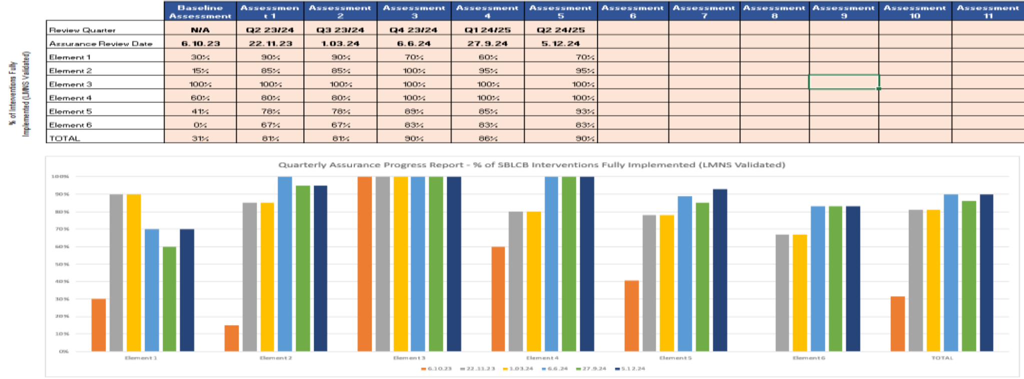
Local Maternity Neonatal System (LMNS)

In 2024-25 the Maternity service participated in an external assurance visit by the West Yorkshire & Harrogate LMNS. The overall summary from the visit noted that the maternity services had a welcoming team who were proud of their service; there was evidence of a positive investment in the Midwifery and Nursing leadership team; there are visible and engaged Safety Champions with clear pathways for obtaining and escalating staff and patient feedback. The Midwifery leaders had a clear vision for the future development of the service, including succession planning.
Pleasingly, the LMNS team particularly commended that significant progress had been observed since previous assurance visits.

Saving Babies Lives Version 3

The Saving Babies Lives care bundle is a national Quality Improvement initiative aiming to reduce perinatal mortality. Version 3 was released in July 2023 and encompasses 6 workstreams of which include: Reducing smoking in pregnancy, Fetal Growth, Risk Assessment, Surveillance and Management, improved awareness of reduced fetal movements, effective fetal monitoring during labour, reducing pre-term birth and management of diabetes.

The service benchmarked against the Saving Babies Lives Care Bundle and following a significant amount of work resulting in improved pathways, coding and data collection and the introduction of designated leads have achieved the expected trajectories for 2024/2025. The service is reporting an overall 90% compliance rate and will prioritise the ongoing quality improvements required within the care bundle for 2025/2026.



% of Interventions Fully Implemented (LMNS Validated)

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5	Assessment 6	Assessment 7	Assessment 8	Assessment 9	Assessment 10	Assessment 11
Review Quarter	N/A	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25						
Assurance Review Date	6.10.23	22.11.23	1.03.24	6.6.24	27.9.24	5.12.24						
Element 1	30%	90%	90%	70%	60%	70%						
Element 2	15%	85%	85%	100%	95%	95%						
Element 3	100%	100%	100%	100%	100%	100%						
Element 4	60%	80%	80%	100%	100%	100%						
Element 5	41%	78%	78%	89%	85%	93%						
Element 6	0%	67%	67%	83%	83%	83%						
TOTAL	31%	81%	81%	90%	86%	90%						

Table 1 – Saving Babies Lives Progress 2024/25

Maternity Incentive Scheme year 6

The Maternity Incentive Scheme (MIS) is a financial incentive program designed to enhance maternity safety within NHS Trusts. It financially rewards Trusts that can demonstrate they have implemented a set of core safety recommendations, aiming to improve the quality and safety of care for women, families and their babies. There are ten standardised safety recommendations in the scheme that have been agreed by senior clinicians to help drive improvements in maternity.
In 2024-25, the Maternity Service has successfully declared full compliance against the requirement of the Maternity Incentive Scheme.

Maternity and Newborn Safety Investigations (MNSI)

The MNSI programme is an initiative in England that investigates certain cases of early neonatal deaths, intrapartum stillbirths and severe brain injuries in babies born at term and maternal deaths. Trusts are required to notify such cases for investigation by an external independent team. The service fully co-operates with this process. The service has declared 0 reportable cases to MNSI in 2024-25.

Maternity and Neonatal Voices Partnership (MNVP)

National Maternity Neonatal Voices is the national group of Maternity Neonatal Voices Partnerships (MNVP) in England, an NHS working group made up of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.

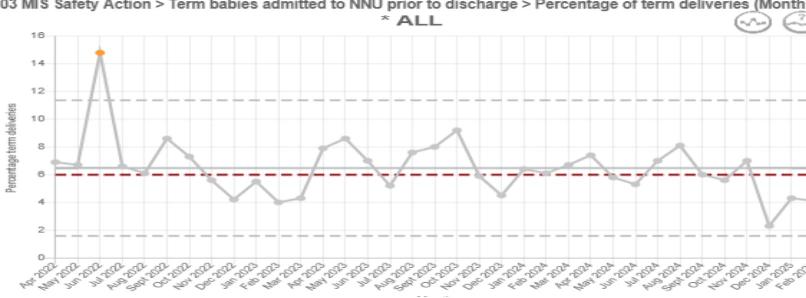
The Service is a member of the local Bradford and Airedale MNVP group who work closely with the service, providing service user perspectives to drive service improvements. In 2024-25 members of the MNVP visited the neonatal and Maternity unit to undertake a '15 steps' visit and made recommendations and suggestions for improvements. The service identified a theme following service user engagement around the induction of labour pathway.

In 2024-25, the teams have reviewed the induction of labour guidelines, pathways, methods of induction and patient information and work is now in progress to roll out a revised pathway. Service user feedback and MNVP input has been integral to the quality of the revised pathway and provides an example of how the service user voice is pivotal to improving our services and patient experience.

Avoiding Term Admissions to the Neonatal Unit (ATAIN)

ATAIN is a national program aimed at reducing avoidable admissions of term infants (born at 37 weeks gestation or later) into neonatal units. The program focuses on identifying and addressing factors contributing to these admissions, with a primary goal of avoiding the separation of mothers and babies.

During 2024-25 the service has undertaken focussed Quality Improvement work to reduce unavoidable admissions, which has demonstrated sustained reductions in such admissions.
This success has been achieved with collaborative multi-disciplinary working with neonatal colleagues of which included revised guidelines, additional training and education and the introduction of an "In Reach" neonatal nurse service. This model was commended by the LMNS at a recent assurance visit as having been a positive investment to reduce admissions to the neonatal unit.



2.3.1c Pressure Ulcer Management

The priority for pressure ulcers 2024/25 was to implement a new Risk Assessment tool Purpose T. including an associated care plan.
The Purpose T risk assessment tool is an evidenced based risk assessment tool, supported by the national wound care strategy. The purpose T includes a screening stage for all patients and a full assessment for those at potential/actual risk and supports care planning in response to patients' risk factors. The implementation of the tool ensures patients are accurately assessed and an individualised care plan implemented.
Staff were trained using a train the trainer approach supported with prompt cards and ESR training. The Purpose T was launched July 2024.

The Trust processes are aligned with national guidance from national wound care strategy, and aligned with EUPAP, and NICE guidance.
NWCSP guidance for categorisation of pressure ulcers indicated SDTI PU should be referred to as vulnerable skin, there was concern this group of PU would deteriorate or not be managed effectively, they have remained to be reported and monitored as suspected deep tissue injuries but given a definitive PU category, some PU in this category may remain if for example the patient dies or gets discharged, most will be given a definitive category 1-4.

Staff training

Staff have received training for Purpose T risk assessments using ESR module. Staff have access to ESR training for pressure ulcers and wound care – this is not mandatory. New training face to face training has been booked for February 2025 throughout the year monthly, these sessions comprise of Pressure ulcer and wound care theory as an interactive session. Staff are offered Negative pressure wound care training provided by the representative company, supported by the practice educators.

Patient information

Patients are provided information verbally and there is a new national pressure ulcer prevention leaflet from the national wound care strategy programme available on Aireshare.

Documentation

The purpose T care plan is similar to the care plan which will be implemented on Cerner, this will support correct and accurate completion after we move to Cerner. It uses the ASSKING bundle and supports bringing all pressure ulcer intervention strategies together. Photographs are obtained of all pressure damage (with consent) to aid with assessment and monitoring of healing and deterioration of skin and pressure damage. Photos also are useful to ensure accurate reporting and categorisation.

Reporting progress and governance

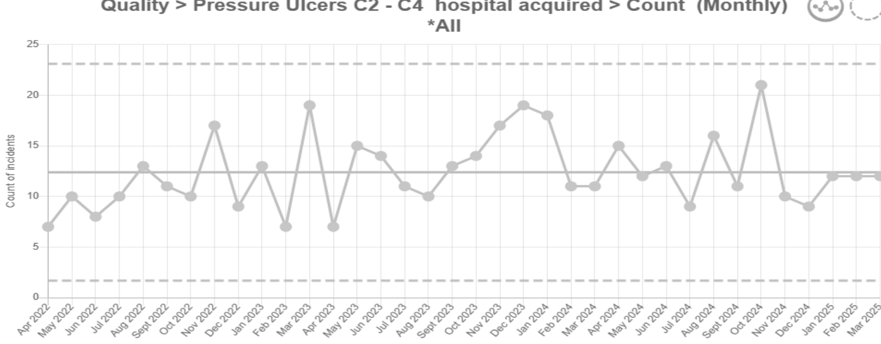
There is good evidence of pressure ulcer reporting, the tissue viability team review all SDTI, cat 3 and 4 pressure ulcers. The unstageable category was removed as per guidance from the national wound care strategy and these pressure ulcer categories are referred to as a minimum category 3.

Pressure ulcers are now provided a harm rating individually using the national harm indicators. Category 3 pressure ulcers are no longer consistently grouped as moderate harm. If the pressure ulcer later presents as moderate harm this will be reviewed by the ward team and the tissue viability team and duty of candour completed. Staff are still encouraged to be open and honest and have conversations with patients, families about any pressure/skin damage incidences.

Pressure ulcers and skin damage incidences are reviewed and an AAR is completed as appropriate, there has been 2 AAR, 1 for medicine, 1 for surgery.
Pressure ulcers are discussed at local directorate meetings (quality and safety) and then at higher directorate level (during DPR).

Data analysis 2024/25

Area	April	May	June	Aug	Sep	October	December	January	Feb	Total
Castleberg								**1**		**1**
Surgery	**1**	**1**		**1**	**1**	**1**		**1**		**6**
Medicine	**1**	**2**	**4**	**2**	**1**	**2**	**1**		**2**	**15**
Neonates		**1**								**1**
Total	**2**	**4**	**4**	**3**	**2**	**3**	**1**	**2**	**2**	**23**



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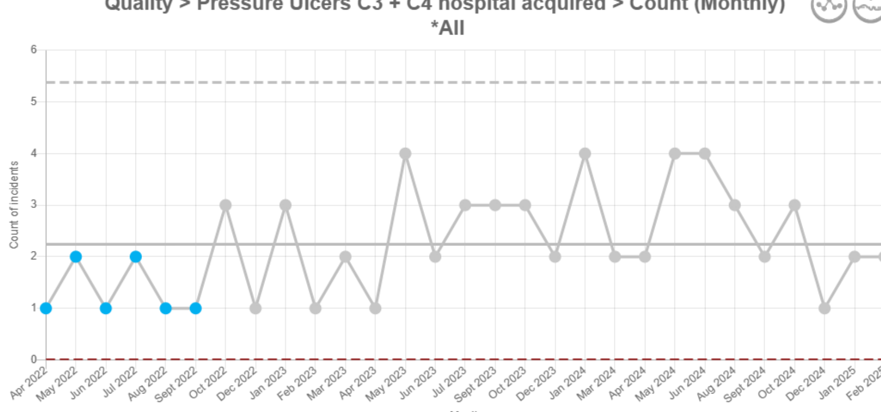
Pressure ulcer occurrences have decreased as the Purpose T risk assessment tool and care plan has been embedded into care, but there is not yet a special cause variation in the decreasing number of pressure ulcers.



Category 3 and 4 pressure ulcers are decreasing since the implementation of purpose T and care plan– but again there is not yet a special cause variation. There have been zero category 4 pressure ulcers in 2024/2025.

Next steps
To consider how the organisation can start monitoring and taking action to prevent category 2 pressure ulcers.
Implement PU risk assessment and interventions/equipment in ED, long waits attribute to deteriorating skin further on in patients' journey.

Ensure model hospital information is correct with coding team and undertake benchmarking with other similar organisations.
Update of air cushions with newer model (under existing revised contract with Arjo).

2.3.1d Falls Ulcer Management
Outlined are key workstreams that have been undertaken as a result of the ongoing work related to the management and prevention of falls within Airedale NHS Foundation Trust.

National guidance

The slips, trips and falls policy for adults and children in-patients has recently been updated in line with NICE guidance.
The Falls Lead has participated in the national review of the *Falls: assessment and prevention in older people and people 50 and over at higher risk* which will be released in quarter 2 2025.

Progress to date

- All falls documentation has been reviewed and the Falls Policy updated.
- A live database where all falls are recorded allows us to monitor all falls and target those where significant harm has occurred.
- All falls' AEFs are checked to monitor falls especially where a patient has fallen more than once.
- As a Trust we have continued to work with the Royal College of Physicians on the National Audit of In-patient falls since 2017.

Staff training

- The Trust falls lead supports the Trust corporate induction programme by providing falls training to new nursing starters to the Trust.
- Proposal submitted for all nurses and HCP will complete the ELFH e-learning for falls. This was identified as an issue after an external audit.

Patient information

The Falls Lead has completed the following audits in the past 12 months, and they will all be repeated in April 2025.
Lying and standing BP audit which measures whether lying and standing BP has been completed on 30 sets of notes and measures it against the national average.

The lying and standing BP audit scrutinised 30 sets of notes and Systmone records for 30 patients who were known to have suffered a fall in hospital. Of these 30 patients 63% had a lying and standing BP recorded which is well above the national average of 48%. A repeat audit will be completed before the end of April 2025.

An audit of the post falls review form was completed on 30 sets of notes to measure how well they are completed.

The results show that of the 30 sets of notes examined in 100% a post fall review from was completed. In 50% of the notes examined the nursing section was fully completed and in 93% of the notes examined the medical section was fully completed. A repeat audit will be done before the end of April and an action plan developed if improvement is identified.

Next steps

The Trust will work towards developing the use of a Hot debrief (within 24 hours of a fall) and an after-action review (within 5 days of a fall) using resources supplied by the Royal College of Physicians to ensure that early learning takes place following a fall.
The Falls Lead will visit any ward where a patient sustains more than one fall during an in-patient stay. The purpose of this is to identify any issues which will increase a patient's risk of falling and ensure early learning is identified,

2.3.2 Priority 2 Clinical Effectiveness

2.3.2a Medicines Safety – Omitted and Delayed Doses of Time Critical Medicines

Background and update

Over 2.4 million doses of medication are prescribed electronically on SystmOne across the Trust, with many more doses prescribed on paper drug charts. Medicine doses may be omitted or delayed for a variety of appropriate reasons, but inappropriate doses omissions or delays can lead to patient harm.

Around 200,000 doses are prescribed on SystmOne monthly, with around 160,000 of these doses fully administered. Contextually, there are legitimate reasons why doses are not given, for example doses may be omitted at the discretion of the administering nurse or under direction of a medical practitioner for appropriate clinical reasons (such as a sleeping patient being prescribed sedative medication to aid sleep; pain medication for a patient no longer in pain; or oral medication omitted before or after surgery). Other reasons for dose omissions include at the patient's request (for example laxatives or pain relief that are no longer required). Non-medical items such as snacks may also be prescribed on the medication chart which may be refused or missed.

Doses Administered for All Prescribed Medication

The percentage of doses of medicines administered on SystmOne has been gradually increasing since the start of reporting in December 2020 (Figure 1). Over the last year 24/25 an average of 80.84% of all doses were administered, which is slightly lower than the previous year 23/24 of 81.45%.

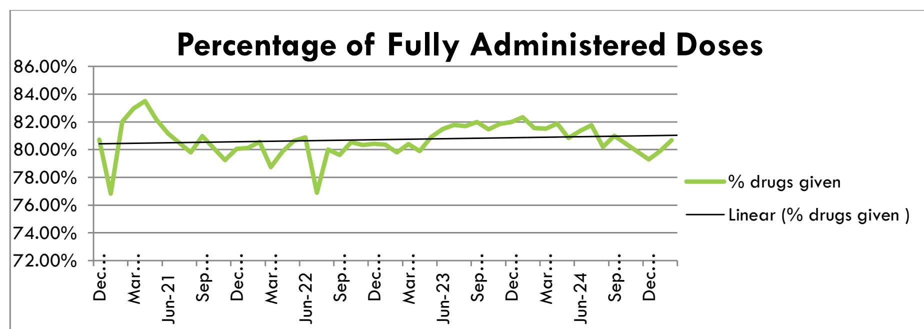


Figure 1: Percentage of Doses Administered on SystmOne

Doses Missed due to Medication Unavailable

Doses documented as medication unavailable refers to a situation where the dose has not been administered to the patient as it was not available to the member of staff undertaking the medicines administration. This may be due to the medication not being available on the ward or being able to find the medication.

The percentage of doses of medication omitted due to the medication being unavailable has seen a consistent decline since December 2020 (Figure 2). Over the last year (24/25) an average 2.33% of doses were omitted, which was is down from the previous 12 months (23/24) that had an average of 2.41%.

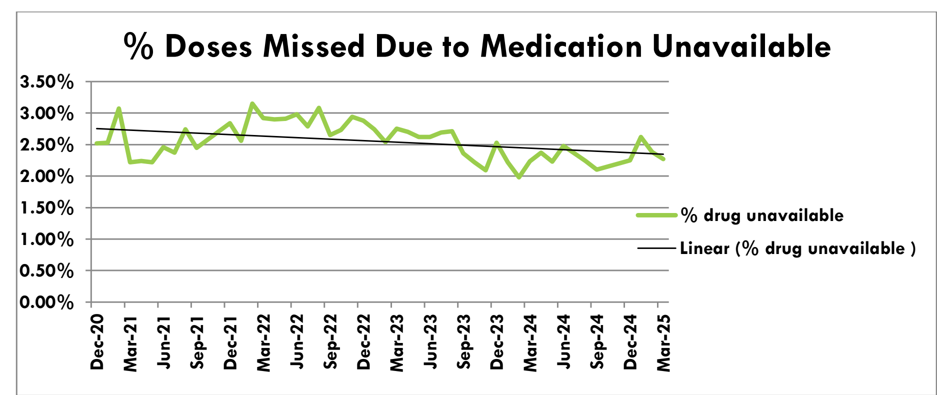


Figure 2: Percentage of Doses Omitted Due to Medication Unavailable

Patient Refusal

The percentage of all medicines missed due a patient refusing to take the dose has increased to 8.5% in 23/24 from 8.05% for 23/24. Reasons for patients refusing doses can be variable, such as clinical condition (for example confusion), a refusal of a 'non-medication' such as nutritional support (includes fortified drinks, snacks, and milk). It could also relate to medication the patient deems they no longer need such as pain relief or laxatives.

Clinical Omissions

Doses not administered to a patient for a clinical reason by either a nurse or under the direction of a medical practitioner has steadily fallen. Over the last year an average of 3.07% of doses were omitted for a clinical reason, down from the preceding 12 months that had an average of 3.12%.

Other Reasons for Dose Omission

The category with the next largest number of dose omissions is for medication that has been intentionally held for clinical reasons. This includes medicines that are not administered every day (i.e. alternate day dosing) and those where the clinical indication requires the medicine to be withheld for a number of days (e.g. patients admitted with acute kidney failure would have renally toxic medication withheld). This category accounts for approximately 2.97% of all doses.
All other reasons for dose omissions account for around 2.53% of doses.

Omission of Critical Medication

SystmOne reporting does not feasibly allow the reporting of dose omissions for critical medication, only total dose omissions by various categories. Consequently, throughout the past year quarterly audits of inpatients prescribed a critical medication were undertaken. These audits revealed that no patients missed any of the doses inappropriately, with all medication available.

Discussion

The Clinical Pharmacy team have an important role in avoiding omitted and delayed doses, as well as identifying and rectifying missed doses where they may occur, along with managing any adverse effects. In the case of critical medication, the team work to expedite supply from pharmacy to ensure a missed dose is administered as soon as possible. The Clinical Pharmacy team work with the Medication Safety Officer and nursing staff to ensure that where missed doses do occur, the reasons are understood, resolved and that learning is also shared.

Since omitted and delayed doses for time critical medicines became a quality priority for the Trust, a range of quality improvement actions have been undertaken. These include:

- Medication stock locator added to Aireshare, allowing nursing staff to identify clinical areas that hold a particular medicine as stock, so that medication can be obtained when needed.
- Change in Controlled Drug (CD) policy to allow CDs to be borrowed out of hours.
- Review of the medication kept in the Out of Hours Room to ensure urgent medication can be obtained out of hours in a timely manner.
- Regular review of medication used as an antidote to make sure that these are available in line with the Royal College of Emergency Medicine and National Poisons Information Service Guideline.
- Utilisation of ordering medication through an electronic format.
- Pharmacy team undertaking regular stock checks encompassing more clinical areas.
- Pharmacists being aligned to specific wards.
- Pharmacy Technicians allocated specific clinical specialities.
- Pharmacy clinical prioritisation tool implemented which includes high risk medication.
- Implementation of the Omnicells® with stock holding streamlined and optimised. Automatic reordering based on real time levels help to ensure the medication is available at the point of need, as well as having a live view of the stock holding within the Omnicells® supporting nursing staffing obtaining a medicine.
- Improvements to the pharmacy dispensary and the new robot have helped increase workload capacity to ensure medication are being processed and delivered rapidly.
- The process of pharmacy ordering patient specific medication has been redesigned to ensure the timely supply of medication.
- Clinical staff are informed of the importance of administering time critical medication at induction.
- Ongoing monitoring for omitted and delayed doses.
- Identifying time critical medicines on admission and including this information on the handover.
- Review of the pharmacy weekend service to undertake medicines reconciliation at weekends as well as reviewing high risk patients. This has increased the number of patients on a Monday morning with a medication history from 73% to 91% and pharmacist reviews from 66% to 89%.
- 84% of patients admitted (including at weekends) had a drug history complete within 24 hours.
- Auditing specific time critical medicines.
- Continual review of ward stock holding, including the Omnicells® to ensure medication is available including utilising information from the medication supplied from pharmacy out of hours.

2.3.2b Mental Health for Adults and Children (Place based priority)

Throughout 2024 we have continued to work proactively with our partners across Bradford District and Craven Health and Care Partnership to collectively plan and shape services to offer the best care to our communities.

We have robust escalation processes in place to escalate delays for patients requiring inpatient mental health services with the aim of ensuring that patients are able to access the appropriate services in a timely manner. For Children we have established daily multi agency huddles to prioritise and respond to the mental health needs of children.

Established working relationships with Bradford District care Trust supports mutual aid in managing the care of patients with mental health needs who may be awaiting services from other neighbouring organisations

The most recent internal audit (Jan 2024) gave significant assurance that are appropriate governance

arrangements in place for the monitoring and reporting of MCA. It was evident that local procedures are in place that summarise the MCA process to follow, a flow chart for managing DoLS referrals in and out of hours has been designed for staff to utilise. A DoLS fact sheet has also been designed to aide staff.
The Mental Health Act Policy has been reviewed and updated as one of the actions from the report.

2.3.2c Deteriorating Patient

Management of sepsis

As part of the Trusts commitment to providing Harm Free Care and in line with the quality priorities an overview of the Deteriorating Patient has been provided.

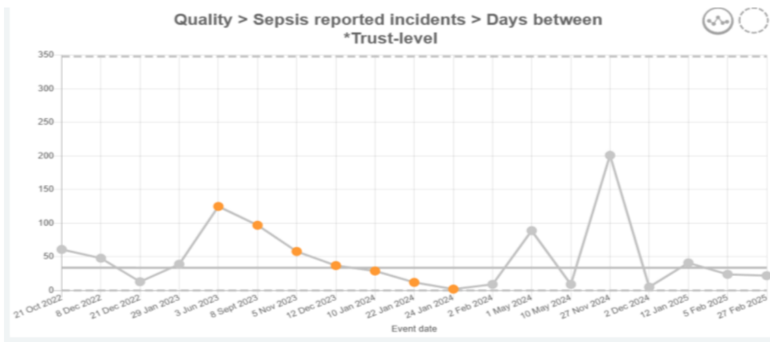


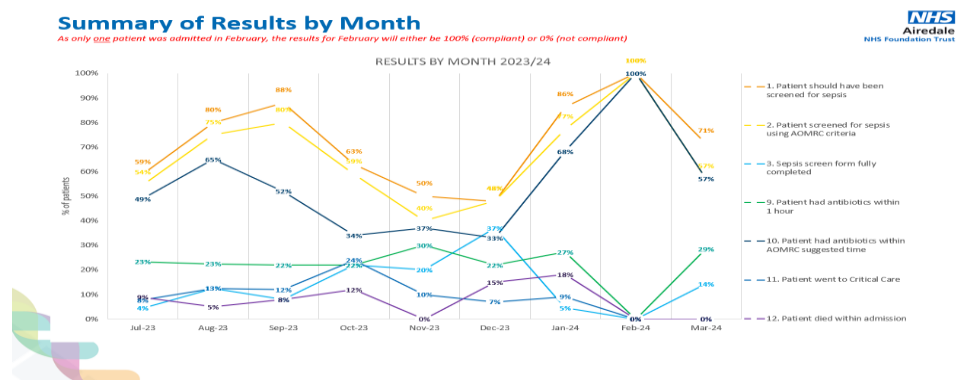
Chart 1. Sepsis related incidents

The sepsis data demonstrates common cause variation with no significant changes, Covering period October 2022 to February 2025.

Chart 2 is data reported from 2023-2024. It needs to be acknowledged that there is variation in sample size, it was different auditors per quarter and requires benchmarking against National results. Ongoing Live Audits for 2024-2025, Sepsis - Timely Identification & Management in ICU & ED 2024-2025 and Sepsis Management at Airedale NHS Foundation Trust 2024-2025.

An action in response to the data is the developing Care of the Acutely Ill Patient (CAIP) Group. A Quality Improvement initiative has been undertaken to improve our time to treatment for Sepsis and will upskill our Critical Care Outreach Team to support the delivery of this treatment in a timely manner. Work continues in introducing the latest Sepsis 6 bundle within the Trust.

Chart 2. Sepsis - Timely Identification & Management in ICU & ED 2023-2024



Education and Training Strategy

Training has a vital role to play in raising awareness, developing our staff's knowledge, skills and competencies when caring for the Acutely Ill Patient.

Chart 3. total number of staff that have attended the deteriorating patient course for 2023-2025

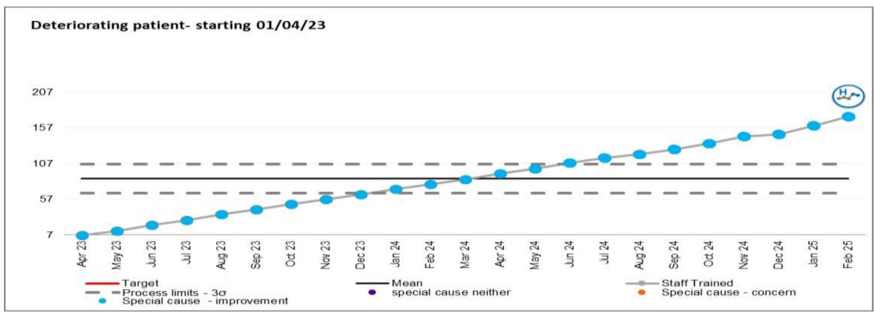
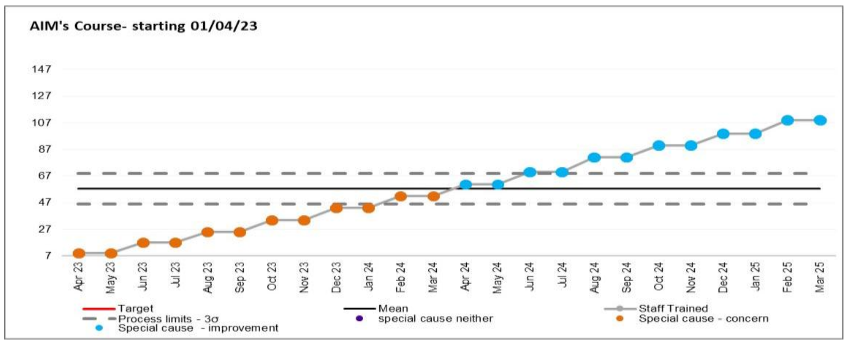


Chart 4. total number of staff that have attended the AIM's Course for 2023-2025



Night medical handover

The aims of the safety huddle are:

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

It is recognised that these are the overarching principles, and we are committed to moving this forward in 2025 through the CAIP programme.

2024-2025 Martha's Rule Phase 1

This is a new priority for 2024/2025. The Trust has been successful in applying to take part in phase 1 to implementing Martha's Rule in the NHS. The three proposed components of Martha's Rule are:

- **Component 1.** Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.
- **Component 2.** All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.
- **Component 3.** This escalation route will also always be available to patients themselves, their families, and carers and advertised across the trust.

We commenced trialling component 1 on the 31/03/2025 on a surgical ward through the patient wellness questions and will be submitting data to the Trust and NHS England monthly from April 2025

Ongoing Monitoring

- Continue to undertake Local and National Audits on Sepsis reviewed through the CAIP group.
- The Martha's Rule implementation group continue to meet monthly to progress actions and identify learning.
- The Resus group continue to meet quarterly to identify actions and learning.
- We continue to monitor our training delivered monthly.
- CCOT data is monitored and reported through Divisional Performance Review process to ensure they are appropriately reviewed, and any learning identified.

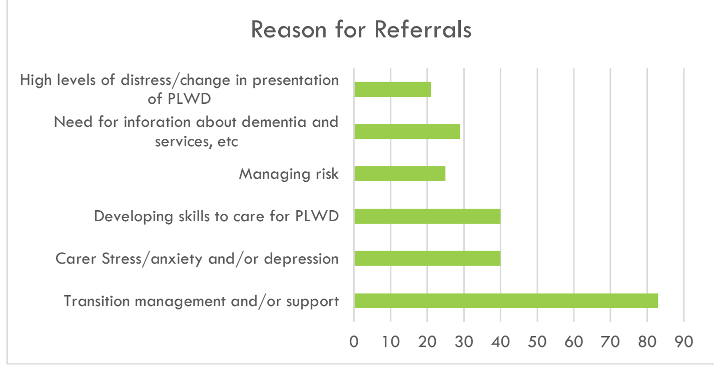
Improvement actions

- The CAIP group to establish working groups for all elements-Sepsis, Deteriorating Patient, Martha's Rule, Hospital at Night, Respect/Resus.
- Improved reporting is required to provide further assurance regarding Sepsis.
- A more detailed approach regarding the improvement actions from each of the workstreams is required in the subsequent updates to capture the good work that is taking place across the organisation.

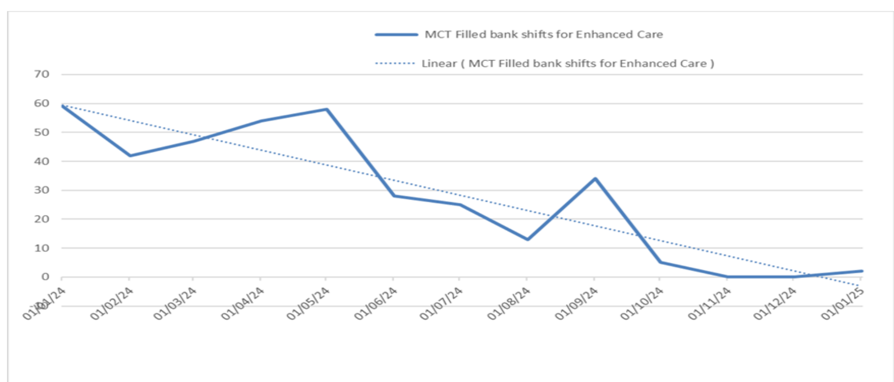
2.3.3 Priority 3 Patient Experience

2.3.3a Care of People with Dementia

From April 2024 – March 2025, the Admiral Nurse has received 383 referrals across the Trust supporting carers and people living with or suspected to be living with Dementia. The top 4 reasons for referrals are supporting people to receive care and support, carer skills, managing risk and carers stress. These themes were also the top reasons for ward-based support for staff.



In 2024, the enhanced care observation tool was reviewed, and a new tool was developed to improve ward-based care of patients especially those with higher levels of distress or changes in behaviour. We have seen a significant improvement in waste reduction in relation to one-to-one bank shifts needing to be created. We have also seen a reduction in over enhancing.



A review of Tier 1 mandatory training for Airedale and AGH solutions is on average between 95-96%. The national requirement is 90% or more. Collaborative work has been ongoing in partnership with other organisations in the Bradford and Craven District to review the training available and ensure it is consistent for all staff who care for people with Dementia.

Next Steps

From analysing the reasons for referrals relating to carer stress, information sharing and skill development, the dementia lead is developing a carers passport to the Trust allowing for a positive experience and care involvement. This will also allow for improvements in patient safety and care delivery. It will also work in partnership with the enhanced care observations.

Looking at reasons for referrals and support within the Trust as well as aims and objectives in place in other Trust strategies in England, the Dementia Strategy will be introduced in 2025. Provisionally, there will be 6 key objectives over 3 years with an aim to focus on 2 objectives per year starting with personalised care and staff skills.
These objectives include:

- Caring well in hospital
- End of Life Care (Dying Well Matters)
- Supporting and Understanding Well (Staff Skills)
- Personalised Care
- Patient Assessments
- Working in Partnership

2.3.3b End of Life Care

Specialist palliative care teams look after end of life (EOL) patients who have complex needs and also support generalist health and social care staff to provide good care to patients with less complex needs. Airedale employs *specialists* in palliative and EOL care, namely the hospital palliative care team. Specialist palliative care nurses supporting Craven community are employed by Sue Ryder Manorlands, we work very closely.

Good care at the end of life requires many services to work together across the boundaries of home, care homes, hospitals and hospice. Joined up working is key to getting things right. In Bradford, District and Craven Place (BdC Place) we are fortunate that our services work well together, this is helped by the use of a shared electronic patient record (EPR) (Systm1) and the Goldline service which supports and coordinates care 24/7 365 days a year. Palliative and end of life service providers work closely together across BdC to plan and monitor services via the Palliative Care Network (PCN).

Across Bradford District and Craven we have promoted the use of The Gold Standards Framework (GSF) for many years. This is a national scheme that promotes the identification of patients who are likely to be in or approaching the last year of life. Once patients have been identified, sensitive conversations and support to put appropriate plans in place can take place. Key information is recorded on Systm1 using the dedicated end of life template.

Once a patient is placed on the GSF, they then can be referred to GoldLine. GoldLine celebrated its 10th anniversary in 2023. This 24/7 telephone line simplifies the process of seeking help once back in the community, providing one contact number to the GoldLine service who will then arrange the support needed.

Every year around 700 patients die in the hospital, a small number are sudden deaths but most can be expected and are preceded by hours/days when care can be tailored to the individual needs of that patient and their family. To prompt staff to remember all the care required and documented, an individualised care planning document is used. Care in the last days of life is audited annually as part of a national audit.

2.4 Quality Improvement Priorities for 2025/26

Following consultation with our stakeholders, we would like to highlight the following as our quality account improvement priorities for 2025/26

2.4.1 Care of Acutely Ill Patient (CAIP)

The CAIP priority aims to reduce deterioration associated harm by improving the prevention, identification, escalation, and response (PIER) to physical deterioration via safe and reliable pathways of care and improved co-ordination across systems. The key workstreams identified are detailed below:

2.4.1a Sepsis

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

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

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

Improvement actions

- Quality improvement work is ongoing to improve our time to treatment for sepsis and will upskill our critical Outreach Team to support the delivery of this treatment in a timely manner.
- Work is ongoing in introducing the latest Sepsis 6 bundle within the Trust.
- Education and training continue and is embedded in delivering Sepsis training.
- To provide monthly reports on percentage of patients given antibiotics within 1 hour of identification for high-risk sepsis and 3 hours of identification for moderate risk sepsis.

Deteriorating Patient

This priority continues to be a focus of improvement for the Trust and aligns to the National Patient Safety Improvement programme for Managing Deterioration Safety.

Our focus is to provide safe, effective, high quality and positive experience of care.

Improvement actions

- To increase our AIMS course to monthly, however, for 2025-2026 this remains an area of concern due to an increase in Maternity leave in a small team.
- CCOT to continue to deliver the deteriorating patient course to all registered Nurses and health care support workers.
- To provide monthly reports on the percentage of patients seen by CCOT within one hour for patients NEWS >5

2.4.1b Matha’s Rule

As described previously the Trust has been successful in applying to take part in phase 1 to implementing Martha’s Rule in the NHS. The three proposed components of Martha’s Rule are:

- **Component 1.** Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.
- **Component 2**. All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.
- **Component 3**. This escalation route will also always be available to patients themselves, their families, and carers and advertised across the trust.

Improvement actions

- To continue with the role out of the PWQ to all inpatient areas meeting component 1 requirements
- To consider the implementation of component 2 and 3
- To provide monthly reports on the percentage of patients asked daily the Patient Wellness Question (PWQ) in the pilot areas.
- To provide monthly reports on the number of occasions the PWQ triggers a change in treatment

2.4.1c Hospital At Night

Hospital at night is a multiprofessional, multi-speciality approach to delivering care at night and out of hours, with the aim of improving patient safety.

The aims of the safety huddle are:

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

Improvement actions

- To monitor attendance at night-time safety huddle.
- To report monthly percentage of patients who are seen within 1 hour of high priority task been logged.

2.4.1d ReSPECT / Resus

The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices.
These recommendations are created through conversations between a person, their families, and their health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment.

Improvement actions

- To report monthly percentage of patients who have a DNACPR form completed more than 24hrs prior to death.

Ongoing Monitoring

- The CAIP group will meet bi-monthly in order to progress actions and identify learning.
- Continue to undertake Local and National Audits on Sepsis reviewed through the CAIP group.
- The Martha's Rule implementation group continue to meet monthly to progress actions and identify learning.
- The Resus group continue to meet quarterly to identify actions and learning.
- We continue to monitor our training delivered monthly.
- CCOT data is monitored and reported through Divisional Performance Review process to ensure they are appropriately reviewed, and any learning identified.

Overall summary

Further work is required to embed best practice:

- The CAIP group to establish working groups for all elements-Sepsis, Deteriorating Patient, Martha's Rule, Hospital at Night, Respect/Resus.
- Improved reporting is required to provide further assurance for all elements of CAIP.
- A more detailed approach regarding the improvement actions from each of the workstreams is required in the subsequent updates to capture the good work that is taking place across the organisation.

2.4.2 Urgent and Emergency Care

This UEC Improvement Plan outlines the actions the Trust will take to enhance the performance and quality of urgent and emergency care services. The plan is structured around three core, measurable quality priorities, supporting NHS England's recovery and transformation objectives. These priorities are aligned to national guidance, CQC standards, and the needs of our local population.

Reduce Emergency Department (ED) 12 hour Wait Times

Aim: Achieve a reduction of patients being admitted, transferred, or discharged within 12 hours by end Q4 in line with planning submission.
Why this matters: Long ED waits lead to increased clinical risk, poor patient experience, and staff dissatisfaction. Reducing wait times supports flow and safety.
Planned Actions:

- Optimise the use of/increase capacity of the Same Day Emergency Care (SDEC)
- Strengthen clinical streaming and rapid triage protocols.
- Use of real-time dashboards for operational oversight and respond appropriately.

Measurement & Targets:

- Metric: 4-hour /12 hour ED performance
- Establish baseline
- Target:

2025/2026	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Percentage of attendance at type 1 A&E department over 12 hours	6.0%	4.0%	4.0%	4.0%	5.0%	5.5%	7.0%	7.5%	8.0%	9.5%	6.5%	5.0%

Monitoring: Via UEC recovery meeting and monthly reporting to board

Improve Ambulance Handover Times

Aim: Reduce ambulance handovers >45 minutes to 0.
Why this matters: Delayed handovers reduce ambulance availability and impact patient safety, particularly for high-acuity cases.
Planned Actions:

- Introduce Hospital Ambulance Liaison Officer (HALO) roles.
- Develop Rapid Assessment and Treatment teams for frontline offloading.
- Apply escalation protocol tied to handover delay thresholds.
- Increase SDEC capacity and optimise.

Measurement & Targets:

- Metric: Number of handovers >45 minutes
- Target: Reduction of all ambulance handover waits over 45minutes to 0 by Q3 2025

Monitoring: Daily site meetings , Via UEC recovery meeting and monthly reporting to board

Reduction in length of stay on AAU

Aim: To reduce the length of stay on AAU from admission to request to transfer/discharge.
Why this matters: Patients length of stay on AAU is increasing once a bed has been requested for the speciality unit, thus potentially increasing their length of stay and providing a poor patient experience.
Planned Actions:

- PTWR completed within 4 hours working day hours 08:00 – 20:30). Patients to be seen by a consultant within 12 hrs.
- Early ward rounds
- Consultant of the day
- Speciality in reach across AAU
- Increase SDEC capacity and optimise
- Establish Frailty SDEC
- Review patient pathways

Measurement & Targets:

- Metric: Patients transferred/discharged within 4 hrs of decision.
- > 95% positive FFT recommendation and patient surveys.
- Reduce Length of Stay in line with 72-hour national target.

Monitoring: Via UEC recovery meeting and monthly reporting to board

Enablers and Dependencies

- Digital Enablers: EPR, maximise use of virtual ward and digital hub.
- Expansion of SDEC
- Collaboration with specialities and clinical engagement.
- Partnerships: Collaboration with ambulance trusts, primary care, and community services critical for admission avoidance and discharge planning

2.4.3 Patient Safety Culture and Speaking Up

Safety culture is one of the two key foundations of the NHS Patient Safety Strategy (2019). A supportive culture enables individuals to openly talk about and raise patient safety concerns, without fear of blame, reprimand, or intimidation, ensuring that teams, and the broader NHS, can learn from these events to make care safer. It helps to shift to a just and restorative culture where the focus is on understanding and learning. It maximises the learning opportunities, so underlying issues around safe systems and ways of working can be identified and addressed.

The Improving Patient Safety Culture Guide (2023) builds on the NHS People Plan which recognised the importance of an inclusive and compassionate culture to support the delivery of safe services. The guide breaks a safety culture down into six areas and invites Trusts to focus on key areas of development from the below list:

- Teamwork
- Communication

- Just culture
- Psychological safety
- Promoting diversity and inclusive behaviours
- Civility

It is recognised that cultural change within an organisation is a long-term endeavour, but this can be supported via key targeted workstreams. When considering local context, it is proposed that the focus would be on just culture, psychological safety, civility and promoting diversity and inclusive behaviours.

Key Measures

KPI 1 A sustained increase in reporting of all incidents with a decrease in incidents causing harm
KPI 2 Sustained reporting of staff concerns but decrease in incidences of incivility
KPI 3 A sustained increase in reporting to FTSU Guardian but reduction in anonymous reporting
KPI4 An increase in the number of colleagues recommending the Trust as a place to work back to pre-pandemic levels with an ambition to be best in class when compared to peer Trusts

Initial Workstreams for Discussion

- Promote openness and speaking up by using first names in staff interactions (when not with patients) to facilitate greater confidence in raising patient safety concerns.
- Review of values and behaviours to simplify and facilitate ownership of the trust vision.
- Active bystander and compassionate conversations training and embedded approach.
- Define, develop, and embed and approach to just and learning culture, with supporting policies and frameworks.
- Implement and embed the civility saves lives initiative.

Key staff from across MDT will be identified to progress these core activities.

References

NHSE (2023) *Improving Patient Safety Culture Guide* London, UK
NHS England » Improving patient safety culture – a practical guide

NHSE (2019) *National Patient Safety Strategy* London, UK.
NHS England » The NHS Patient Safety Strategy

2.5 Participation in clinical audit and national confidential enquiries

During the year 2024/25-year period Airedale NHS Hospitals Foundation Trust's (ANHSFT) participated in 40 of 49 eligible national audits for the 2024/25 quality accounts of which (5) were confidential enquiries. The Trust was ineligible for the Society for Acute Medicine's Benchmarking Audit (SAMBA) and could not participate in (9) audits for several reasons including staffing and external database issues. The Trust's attempted move to the Electronic Patient Records (EPR) system also impacted on data entry for some audits.

A breakdown of audits and confidential enquiries for which data were submitted including non-participations and audits with provider database issues are listed in Table 1. In the same period a total of 131 ad hoc audits were supported by the clinical audit and effectiveness team.
The following are highlights from some of the national audits:

Sentinel Stroke National Audit Programme (SSNAP)

This is a joint work with Bradford Teaching Hospital NHS Foundation Trust and commissioners. It provides timely intelligence of stroke care for the continuous improvement of the service. The audit has been overhauled in the past year resulting in changes in key indicators. The following are the highlights from the 2024/25-year period:

Successes

- The hyperacute pathway showed significant improvement over the past year now scoring and now scoring a D.
- MDT Assessment now the highest scoring domain with a C

Actions

- Business case submitted for front end staff, responder type service, psychology and therapy recruitments.
- Review of the orthoptic referral process.

Time Critical Medication (TCM)

The is part of the Royal College of Emergency Medicine (RCEM) quality improvement programme aimed at early identification of TCM, administration of TCM according to regime while in the emergency department and empowerment of patients and carers to self-administer their TCM when applicable.

Key successes:

- Time to identification is lower than the national average at both the emergency department and if waited for clinician 22.6minutes and 3hours and 21 minutes respectively.

Actions:

- Empowering patients to safely self-administer TCMs.
- Improve on documentation of when people usual take their TCMs.

Local Audits

131 local audits were registered in the 2024/25 the same as the previous year. Below are summaries from some completed audits during the period.

The Midline Project - Long Term IV Antibiotics - Midline Catheter Insertion in Cardiology-Infective Endocarditis Patients**.**

Aims: To evaluate if it would be of benefit to patient care to insert a midline catheter in the interim in patients waiting for a PICC line for long term Antibiotics. Also to evaluate if it would be of benefit to patient care as well as from a business case standpoint to consider discharging a patient with a midline catheter & community nurse/OPAT aftercare for patients awaiting a PICC line.

Key Successes:

- Success in selecting accurate cohort of patients, building and managing a team of clinicians, acquiring patient files, constructing data collection tool and successfully collecting data.
- Identified a clear intervention in the same cohort of patients, to be implemented and results re-audited with a second cycle.

Actions required:

- Present to clinical educators, procurement, PSMs, etc.

- Train doctors for midline insertion.
- Re-audit

AF Risk Factors in Elderly and Therapy Services
Aims: To retrospectively screen cardiology and elderly admissions and outpatient attendances for atrial fibrillation (AF) risk factors (as per AF prediction tool) and follow-up at 6 months to identify new cases of AF.

Key Successes:
- The FIND-AF algorithm can be prospectively implemented in hospital records to identify cardiology and geriatric patients at risk of incident AF, heart failure, thromboembolic disease, and death.
- There is an opportunity to conduct risk-guided screening in the context of hospital attendances.

Actions required:
- Standards met; no action required.

Appropriate Use of Cardiac Telemetry: A Quality Improvement Project
Aims: Aid development of local guideline, reduce inappropriate use of finite resource (telemetry), increase proportion of appropriate use for appropriate duration.

Key Successes:
- Majority of telemetry used for appropriate indications.
- Majority of decisions to stop telemetry made in hours.

Actions required:
- Standards met; no action required.

Management of Patients with Diabetic Ketoacidosis (DKA)
Aims: To assess if we are following the guidelines for DKA management.

Key Successes:
- Overall Management of DKA is of a high standard and with very low mortality.
- We could identify the most common precipitating cause of DKA in our local region.

Actions required:
- Discuss findings and educate the medical and nursing team about the management of DKA.
- Support the nursing staff for careful documentation of monitoring.
- Re-audit next year

Table 1: National clinical audits undertaken by Airedale NHS Foundation Trust

Ref	Audit Title	Eligible	Participated	Per cent /Number of cases
1	Society for Acute Medicine's Benchmarking Audit (SAMBA)	*		
2	National Cardiac Audit Programme: Heart Failure Audit (NCAP)	✓	✓	100%
3	National Cardiac Audit Programme: Myocardial Ischaemia/MINAP	✓	✓	100%
4	National Cardiac Audit Programme: Cardiac Rhythm Management	✓	x	-
5	National Diabetes Audit - Adult Core	✓	✓	100%
6	National Diabetes Audit - Adult Footcare	✓	✓	100%
7	National Diabetes Audit - Adult Inpatient Care	✓	✓	100%
8	National Diabetes Audit - Adults Pregnancy in Diabetes	✓	✓	100%
9	Care of Older People (COP)	✓	✓	100%
10	National Major Trauma Registry Network	✓	✓	100%
11	National Respiratory Audit Programme COPD Secondary Care	✓	x	-
12	National Respiratory Audit Programme Asthma Secondary Care	✓	x	-
13	National Lung Cancer Audit (NLCA)	✓	✓	100%
14	National Early Inflammatory Arthritis Audit (NEIAA)	✓	✓	100%
15	Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	100%
16	Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy (I-DUNC) Audit	✓	x	-

Ref	Audit Title	Eligible	Participated	Per cent /Number of cases
17	Environmental Lessons Learned and Applied to the Bladder Cancer Pathway (ELLA) Audit	✓	x	-
18	Penile Fracture (SNAP) Audit	✓	x	-
19	National Oesophageal Cancer Programme (NOGCA)	✓	✓	100%
20	National Prostrate Cancer	✓	✓	100%
21	National Emergency Laparotomy Audit (NoLap))	✓	**	-
22	National Emergency Laparotomy Audit (Lap)	✓	**	-
23	Breast Cancer, Primary People (NAoPri)	✓	✓	100%
24	Case Mix Programme (CMP)	✓	✓	100%
25	National Ophthalmology Audit (NOD)	✓	✓	100%
26	Elective Surgery - National PROMS Programme - Hip Replacement	✓	✓	52.9%
27	Elective Surgery - National PROMS Programme - Knee Replacements	✓	✓	44.4%
28	Falls and Fragility Fractures Audit Programme (FFFAP) - Hip Fracture Database	✓	✓	298 cases
29	Falls and Fragility Fractures Audit Programme (FFFAP) - Fracture Liaison Database	✓	✓	980 cases
30	National Joint Registry (NJR)	✓	✓	100%
31	National Bowel Cancer Audit (NBOCAP)	✓	✓	100%
32	Falls and Fragility Fractures Audit Programme (FFFAP) - Inpatient Falls	✓	✓	100%

Ref	Audit Title	Eligible	Participated	Per cent /Number of cases
33	National Audit of Dementia (Care in General Hospitals)	✓	x	-
34	National Cardiac Arrest Audit (NCCA)	✓	✓	100%
35	Learning Disabilities Mortality Review Programme (LeDer)	✓	✓	100%
36	Serious Hazards of Transfusion Scheme (SHOT)	✓	✓	100%
37	National Comparative Audit of Blood Transfusion	✓	✓	100%
38	National Maternity and Perinatal Audit (NMPA)	✓	✓	100%
39	Maternal and Newborn Infant Clinical Outcome Review Programme (MBRRACE-UK)	✓	✓	100%
40	National Audit of Seizures and Epilepsy in Children and Young People (Epilepsy 12)	✓	✓	100%
41	National Neonatal Audit Programme - Neonatal and Special Care (NNAP)	✓	✓	100%
42	National Paediatric Diabetes Audit (NPDA)	✓	✓	100%
43	National Audit of Care at the End of Life (NACEL)	✓	✓	178 Cases
44	Breast and Cosmetic Implant Registry	✓	✓	100%
45	National Respiratory Audit Programme - Pulmonary Rehabilitation	✓	✓	100%

Ref	Audit Title	Eligible	Participated	Per cent /Number of cases

Table 1: National Confidential Enquiries (NCEPOD) undertaken by Airedale NHS Foundation Trust

Ref	Title	Eligible	Participation	Per cent eligible/patients submitted
46	Emergency surgery in children and young people	✓	✓	7 cases
47	Acute Limb Ischaemia	✓	✓	100%
48	Blood Sodium Study	✓	✓	5 cases
	Managing acute illness people with learning disability	✓	✓	On going
50	Rehabilitation following critical illness	✓	✓	4 Cases

** Eligible but not selected for the audit*
*** Could not submit data due to provider database issues*
X Did not participate

2.5.1 Participation in Clinical Research

Research is a core part of the NHS, focused on improving the current and future health of the population. The people who carry out research here are the same doctors and other health professionals who treat and care for our patients daily. Currently there are 116 senior clinical staff actively participating in ethically approved research across 20 differing clinical specialties.

A clinical trial is a particular type of research that evaluates one treatment against another.

Airedale research team recruited 1314 participants onto national ethically approved clinical trials and studies in 2024/25. As a research active Trust during the previous year, we participated in 72 clinical research studies across a wide range of specialties, of which 65 were on the National Portfolio database of studies, of these portfolio studies 4 were commercial portfolio studies. During 2024/25 Airedale achieved all the National Institute for Health Research high level objectives for performance in initiating and delivering research, exceeding the participant recruitment target by over 200%, we are currently ranked as the top site in the Yorkshire and Humber for recruitment of first patient within 30 days of opening at trial.

The Trust has been committed to expanding research into new specialties to improve the quality of care and outcomes for the population we serve. The primary motivation for conducting research within the Trust is for the advancement of knowledge and promotion of evidence-based practice within clinical care. We aim to offer every patient the opportunity to take part in a clinical trial or study. This is reflected in both the number of research studies undertaken during 2024/25, and the participants recruited onto clinical trials and studies.

In the last three years, Airedale has been formally acknowledged as a contributor to studies reported in several publications due to our involvement in National Institute for Health Research portfolio studies. This demonstrates our commitment and desire to improve patient outcomes and experience across the NHS. In addition to this, a further 47 papers arising from academic and own account research have been published in peer reviewed journals since April 2024.

Our engagement in clinical research demonstrates the commitment of Airedale NHS Foundation Trust to improving the quality of care offered to our patients, whilst contributing to wider health improvement, aiming to help the population we serve to live longer healthier lives.

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

DRAFT 3:

The DRAFT3 study directly compares patients receiving a cast with patients receiving a splint for treating broken wrists. It aims to discover if levels of pain and the ability to do everyday tasks are similar between the two groups. The trial also compares the cost of both treatment options to the NHS, and society as a whole. In most hospitals in the UK, people with a broken wrist are given a plaster cast. After 4 to 6 weeks, they go back to hospital to have the cast taken off. The results of a recent research study show that a removable wrist splint might provide the wrist with the same amount of support as a cast. The benefit of this is that; patients can take the splint off by themselves at home, the need to have it removed at a hospital. This is more convenient for patients and also provides treatment cost savings of £120.50 per patient for the NHS compared to usual care. The study remains open to recruitment until 30 November 2025.

SWEET:

The purpose of the SWEET study is to investigate whether the HT&Me support package can improve hormone therapy adherence, and quality-of-life when compared to the standard NHS follow-up care offered in hospital. Many women are prescribed hormone therapy following diagnosis and hospital treatment for breast cancer. Hormone therapy significantly reduces the chances of breast cancer returning. Usually, women are recommended to take hormone therapy, in the form of a daily tablet, for several years. However, we know that some women either do not take this medication everyday as prescribed or sometimes stop taking it all together (known as "poor adherence"); this can increase their risk of breast cancer returning. The HT&Me support package aims to encourage and support women to take their hormone therapy as prescribed and hopefully reduce the risk of breast cancer returning. The study remains open to recruitment until 31/12/2025.

2.5.2 Use of Commissioning for Quality and Innovation framework

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

Use of CQUINS payment framework

In preceding years, a proportion of Airedale NHS Foundation Trust's income was conditional on achieving quality improvement and innovation goals agreed between Airedale NHS Foundation Trust, and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework (where applicable).
NHS England confirmed its proposal to pause the nationally mandated CQUIN quality incentive scheme for all providers for 2024/25. Providers were not required to implement CQUIN requirements, carry out CQUIN audits or submit CQUIN performance data.

2.5.3 Registration with the CQC

Airedale NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is without conditions. Airedale NHS Foundation Trust has no conditions on registration and the Care Quality Commission has not taken enforcement action against Airedale NHS Foundation Trust during 2024/25.

The CQC implemented their Single Assessment Framework throughout England from February 2024 following a series of pilots in the South of England. The new Framework is currently undergoing review by the CQC and will retain the 5 key questions of Safe, Effective, Caring, Responsive and Well-Led which set clear expectations for providers.

The Trust has actively taken part in events facilitated by CQC and maintains active communication via a programme of engagement meetings which take place on a quarterly basis. These alternative between virtual and onsite visits which include visiting clinical areas.

2.5.4 Information on the Quality of Data

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

NHS Number and General Medical Practice Code Validity

Airedale NHS Foundation Trust submitted records during 2024/25 in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data – which included the patient's valid NHS number, was:

99.9 per cent for admitted patient care.
100 per cent for outpatient care; and
99.7 per cent for accident and emergency care:
which included the patient's valid General Practitioner Registration Code was:

100 per cent for admitted patient care.
100 per cent for outpatient care; and
100 per cent for accident and emergency care.[1]

Information Governance Assessment Report

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

The former annual DSPT (Data Security and Protection Toolkit) 2023/24 assessment deadline for submission for all NHS Trusts was 30th June 2024 and is when our end of year submission took place. The Trust was compliant with all mandatory standards and declared Standards Met.

The DSPT 2024/25 Assessment is still underway with completion and final submission to take place on 30th June 2025. An annual internal audit review began 7th April 2025 scheduled to complete 25th April 2025. Progress against the 2024/25 Assessment is being closely monitored and progressed at pace. It is reported through Information Governance Group. An interim position reported as of 17th April 2025 has been provided for Audit and Risk Committee. The forecast final position of Standards Met can only be confirmed once all evidence has been provided against the mandatory objective outcomes and will be approved prior to final submission on 30th June 2025.

Clinical Coding error rate

Airedale NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2024/25 by the Audit Commission. [2]
However, the Trust was subject in this period to an approved external clinical coding audit as part of *Data Security and Protection Toolkit* (DSPT) national requirements. The error rate reported in March 2025 for diagnoses and treatment clinical coding is as follows:

- Primary Diagnosis: 6 per cent (DSPT – mandatory required level <10 per cent)
- Secondary Diagnosis: 4.9 per cent (DSPT – mandatory required level <20 per cent)

- Primary Procedure: 8.6 per cent (DSPT – mandatory required level <10 per cent)
- Secondary Procedure: 7.8 per cent (DSPT – mandatory required level <20 per cent)

[1] NHS Digital *Data Quality Maturity Index – November 2024* [published February 2025]

Data Quality Maturity Index (DQMI) methodology - NHS England Digital

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

The audit reviewed the clinical coding accuracy of 200 finished consultant episodes (FCEs) and covered a cross-section of all inpatient specialties and was across all members of the Clinical Coding Team.[3]

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

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

All mandatory standards were met, the following audit recommendations will be reviewed in coming months:

- Introduce bite size training or Teams meetings to visit clinical coding errors in the report.
- Introduce bite size training or Teams meetings to visit clinical teams for awareness.

2.5.5 Learning from Deaths

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

During 2024/25 621 of Airedale NHS Foundation Trust inpatients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

148 in the first quarter;

116 in the second quarter;

165 in the third quarter;

192 in the fourth quarter.

By 31/03/2025, 117 structured judgement review0 and 4 patient safety incident investigations have been completed in relation to the deaths included above.

The number of deaths in each quarter for which a structured judgement review was carried out was:

28 in the first quarter;

33 in the second quarter;

26 in the third quarter;

30 in the fourth quarter;

2/117 (2%) of patient deaths during the reporting period are judged to be ‘more likely than

[3] The sampling consisted of a random selection of episodes between November 2024 and January 2025 and a random selection from the following specialities: General Surgery, Urology, Trauma and Orthopaedics, ENT, Ophthalmology, Oral Surgery, Accident and Emergency, General Medicine, Gastroenterology, Clinical Haematology, Cardiology, Respiratory Medicine, Medical Oncology, Neurology, Rheumatology, Paediatrics, Geriatric Medicine.

not' to have been due to problems in the care provided to the patient.

(Scored 1: death definitely avoidable or Scored 2: Strong evidence of avoidability of death)

In relation to each quarter, this consisted of:

2% in the first quarter;

0% in the second quarter;

0% in the third quarter;

0% in the fourth quarter.

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

2.5.6 Duty of Candour

The Duty of Candour regulation requires the Trust to be open and transparent with patients and apologise when things go wrong. There are regulatory and professional requirements in relation to notifiable safety incidents for healthcare providers and registered practitioners in line with the duty. This is detailed in the Trust's Duty of Candour and Being Open Policy. A flow chart within the policy enables easy access to information for staff to guide them on which incidents required Duty of Candour to be undertaken.

Training on the Duty of Candour is available for all staff and is included in the patient safety element of face-to-face staff induction.

The Trust incident reporting system provides evidence of compliance with the Duty of Candour Regulation where it applies. The governance leads for the Divisions and the patient safety team have oversight of incidents where Duty of Candour applies and are available for advice. An annual audit of compliance with the Duty of Candour is in place.

2.5.7 Staff who speak up

Freedom to Speak Up (FTSU) is core to the delivery of the People Strategy, supporting the development of our culture at Airedale and reinforcing the Right Care values and behaviours. FTSU processes are in place to support patient safety and improve staff experience.
In the first two quarters of 2024, a total of 33 concerns were raised through the guardian route, which is a significant increase on previous years. Less than a third of the cases (30%) referenced bullying or other inappropriate attitudes or behaviours as the primary reason for contacting the guardian. This represents a sizable decrease compared to the same time last year when 54% of cases identified some form of poor behaviour as the main reason for contacting the guardian.

There were only two anonymous cases raised during the first two quarters and there was no detriment reported, both good indicators that colleagues have confidence in the speaking up arrangements.

A FTSU action plan is in place to support the work to improve the FTSU culture at the Trust. It is important to note that the development side of the role has continued to be a challenge because of an increasing caseload. However, a new Deputy FTSU Guardian has just been appointed, which will increase capacity and support service development.

Our successes in quarters 1 and 2:

- Reviewed and updated case recording system for FTSU
- Listening sessions with REN and Enable Networks
- Delivered a briefing to the Admin Network
- Delivered FTSU training to Patient Experience Champions
- Raised profile of FTSU service – attended team meetings, working in partnership with AGH Solutions, working with communications colleagues to implement Communications plan
- Recruitment to the new Deputy FTSU Guardian role

2.5.8 Learning Disabilities Improvement Standards

Learning Disability Improvement Standards 2024

The NHS Learning Disability Improvement Standards are structured around four core areas that support trusts in delivering equitable, safe, and personalised care for people with a learning disability and autistic people. At Airedale NHS Foundation Trust, our commitment to these standards is reflected in our continued engagement with the benchmarking data collection work and our continuous improvement work, which is guided by our organisational values: Compassion, Respect, Integrity, and Learning.

Respecting and Protecting Rights

We believe that everyone deserves fair access to healthcare and the right to be treated with dignity. The appointment of a Specialist Practitioner to lead the strategic and operational development of services for individuals with learning disabilities and autistic people has demonstrated significant value to our patients, staff, and organisation.

The identification all people with learning disabilities and / or autistic people accessing services within our organisation is an essential trust process and a key priority in 2023-24. Research data states that one of the biggest contributory factors to avoidable deaths is the difficulty people with a learning disability and autistic people have in accessing healthcare.

Our trust has grown in confidence in identifying and supporting the needs of people with a learning disability and or autistic people. Our practices uphold this principle by ensuring that people with learning disabilities and autistic people are being seen, heard, and valued and fully involved in decisions about their care.

- NHS England requires all organisations delivering NHS services or publicly funded adult social care to comply with the Accessible Information Standard (AIS). This is a legal obligation under Health and Social Care Act 2012, and is supported by the Equality Act 2010, which mandates that service providers make reasonable adjustments for disabled individuals—including offering information in formats they can access and understand. The standard outlines a consistent process for identifying, recording, flagging, sharing, and meeting the communication and information needs of patients, service users, carers, and parents who have a disability, impairment, or sensory loss. The Care Quality Commission (CQC) expects providers to deliver appropriate, accurate, and up-to-date information in formats tailored to each person's individual needs. Our ongoing work in review of the Accessible Information Standard Policy and resources ensures that individuals receive information in formats they understand, supporting their autonomy and rights in the decision-making process.

- Our implementation of NHS England Digital's Reasonable Adjustment Digital Flag within electronic health records enables early identification of specialist needs and facilitates the sharing of required adjustments across care settings. This process supports compliance with the legal duties set out in the Equality Act 2010, ensuring that care is as accessible for disabled individuals as it is for others. Additionally, it aligns with wider commitments, including the AIS and those in the NHS Long Term Plan, aimed at reducing health inequalities for people with disabilities. The Phases for the operational implantation of the flag is underway with focus on the digital mapping for the anticipated move from SystemOne to Cerner Electronic Patient Record.

- The introduction of the Carers Passport formally recognises and strengthens the role of families and unpaid carers, affirming their rights and enhancing collaboration in care planning. To ensure we champion the Ask, Listen, Do principles we launched our Carer's survey, which was very well received and provided valuable first-hand feedback which has shaped our work in supporting Carers to continue to care. ANHSFT proudly support the national change movements, John's Campaign and Sophie's Legacy.

- Hospital/Healthcare Passports are recognised as good practice for individuals with a learning disability and autistic people. ANHSFT are avidly promoting the use of Hospital Passports, especially the VIP Hospital Passport which was developed by people with lived experience and is recognised across our neighbouring acute and community trusts. The use of Hospital Passport has significantly improved the person-centred care and patient experience. It plays a key role in supporting legal duties under the Equality Act 2010 and Mental Capacity Act 2005, particularly in relation to reasonable adjustments and best interest decisions. The passport can also link to more detailed care plans, such as those for communication, eating and drinking, or advance care planning. Hospital Passports empower individuals and carers by enabling shared decision-making and helping inform clinical decisions. They improve patient safety by promoting clearer, more consistent communication, and contribute to reducing health inequalities. In addition, they support professionals and organisations to meet their legal responsibilities, including making reasonable adjustments and ensuring meaningful involvement in decision-making for those who lack capacity. The passport complements tools like the Reasonable Adjustment Digital Flag by providing more personalised context, including details about protected characteristics such as race, culture, and ethnicity.

Airedale's value of Respect is demonstrated in our inclusive care practices and our commitment to ensuring every patient is treated as an individual.

Inclusion and Engagement

To continue building on our partnership working with community self-advocacy and health groups, a key priority for the year ahead is the launch of the Treat Me Well – Learning Disability & Autism Working Group. This group will welcome people with learning disabilities, autistic people, carers, community partners, and our staff who are champions. Their insights will guide service redesign and help prioritise the projects that matter most to those we serve.

- In September 2024, ANHSFT's Clinical Induction Programme celebrated 12months of partnership working with People First Keighley and Craven team of people with lived experience in delivering monthly sessions to our staff on 'supporting people with learning disabilities and those on the neurodiverse spectrum'. Looking ahead to May 2025, the awareness work will be shared with all staff in the monthly Mandated Induction Programme.

- Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR) is a service improvement programme established in 2017 and funded by NHS England. It aims to improve care for people with a learning disability and autistic people, reduce health inequalities, and prevent premature deaths within these populations. Data

shows that approximately half of all deaths among people with a learning disability are considered avoidable, compared to less than a quarter in the general population. ANHSFT continues to report all deaths of patients with a learning disability or those who are autistic. All inpatient deaths are subject to an internal Structured Judgment Review, which is reported to the Trust Mortality Review Group. The Trust actively engages in the LeDeR review process and participates in monthly focused review panel meetings and local governance groups. This ensures that learning, good practice, and any concerns are identified and appropriately actioned within ANHSFT.

The value of Compassion drives our efforts to listen and engage meaningfully with patients, carers, and families.

Workforce Development

The Trust is invested in equipping our workforce with the right knowledge, skills, and confidence to deliver high-quality care to people with learning disabilities and autistic people.

- The Oliver McGowan Mandatory Training (OMMT) is the standardised training that was developed for this purpose and is the government's preferred and recommended training for health and social care staff. This training also supports the NHS Long Term Workforce Plan ambition by upskilling the wider health workforce to provide appropriately adjusted care for people with a learning disability and autistic people to reduce health inequality and avoidable deaths. The training is co-delivery by experts by experience, embedding authentic voices in the learning journey. ANHSFT continue to work in partnership across PLACE and WYAAT with our WY ICB working group and Bradford and Craven working group on the implementation of the OMMT Tier 2 to all staff in the coming year. In January 2025, we launched the e-learning component of the Oliver McGowan Mandatory Training (OMMT) as a mandated module for all staff. In a short period, we have seen strong engagement, with 58% of staff having already completed the training.

- The development of the Emergency Department's Learning Disability Champions are our frontline staff supporting their teams in recognising when reasonable adjustments are needed, promote, and providing inclusive care.

- ANHSFT celebrated the Neurodiversity and Learning Disabilities Week in March and June 2024 and our trust's communications team promoted the local and national resources. We continue to share and promote events in support of people with lived experience, support for carers and awareness for practitioners.

The value of Learning is central to this work—recognising that improvement begins with understanding and education

Specialist Care

To ensure access to expert input, we continue to strengthen pathways that support proactive, coordinated, and specialist care for people with complex needs.

- We are long standing members of community health groups, sharing a forthright unequivocal aim to reduce the inequalities and improve the access to health care. Through the collaborative working ethos ANHSFT is working to reduce the number acute admissions and regular A7E attendances and we are able to work closely with our teams who deliver specialist care and treatment for the co-occurring conditions such as Cancer (linked the national and local mortality data i.e. NHS' Core 20+).

- Feedback has enabled our Trust to identify and implement an important adaptation to our A&E triage prioritisation protocols. Individuals identified as having a learning disability and/or being autistic will now be prioritised within their physical health-need triage category. This approach has already shown positive outcomes, particularly for those who may experience sensory overload or communication difficulties.

The value of Integrity underpins our commitment to safe, appropriate care and being accountable for the services we deliver.

2.6 Reporting Against Core National Indicators

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

To understand whether a particular number represents good or poor performance, the national average, outlier intelligence and a supporting performance commentary is included (where available). Unless indicated, the data source for the following indicators is NHS Digital. In line with national guidance, information for (at least) the last two reporting periods is provided.[4]

Domain 1 – Preventing people from dying prematurely

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

2.6.1 Summary hospital-level mortality indicator (SHMI)

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

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

Table 4: SHMI	**Jan 23 – Dec 24**	**Apr 23 – Mar 24**	**Jul 23 – Jun 24**	**Oct 23- Sep 24**
	Pub: May 24	**Pub: Aug 24**	**Pub: Nov 24**	**Pub: Feb 25**
Airedale NHS Foundation Trust SHMI value	0.93	0.97	0.97	0.98
National average	1.00	1.00	1.00	1.00
The highest value for any acute trust	1.26	1.31	1.31	1.31
The lowest value for any acute trust	0.72	0.71	0.70	0.70
Airedale NHS Foundation Trust SHMI banding	2	2	2	2

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

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

	Jan 23 – Dec 24	**Apr 23 – Mar 24**	**Jul 23 – Jun 24**	**Oct 23- Sep 24**
	Pub: May 24	**Pub: Aug 24**	**Pub: Nov 24**	**Pub: Feb 25**
Percentage of patient deaths with palliative care coded at either diagnosis or speciality level for Airedale NHS Foundation Trust	26	25	26	25
Percentage of patient deaths with palliative care coded at either diagnosis or speciality level average for England	42	45	44	44
The highest value for any acute trust	16	17	18	17
The lowest value for any acute trust	67	67	69	67

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

- Trust mortality data is submitted in accordance with established information reporting procedures and data quality definitions.
- SHMI data is provided through NHS Indicators and is formally signed off by the Deputy Medical Director for Quality and Safety on a quarterly basis.
- To date, the SHMI for the Trust has remained consistent and not subject to significant variation. The Trust continues to view this in line with internal scrutiny of data quality.
- As of May 2024, published data (January to December 2023) the following change in SHMI methodology was enacted: the inclusion of COVID-19 activity where the discharge date is on or after 1 September 2021.

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

- Preliminary screening of inpatient deaths ensures any deaths deemed avoidable or associated with an adverse event are highlighted. Any identified cases along with an additional random sample are routinely reviewed by a consultant-led Trust Mortality Review Group each month using a standardised and structured case note review process.
- A maternal death, death of a child or a death in the Emergency Department are not included in this work, but instead are subject to a specialist independent process.
- The Quality and Safety Committee receives an enhanced, integrated Learning from Deaths report deriving information from multiple sources. This compliments the "metrics" in HSMR and SHMI in the Integrated Board report.
- Appraisal of mortality, morbidity and other correlative data at the Quality and Safety Committee, Clinical Governance - Patient Safety – Quality Group and specialty clinical governance meetings further supports this work.

Areas identified for development:

- Themed mortality reviews will continue to identify any learning within specialities and across the organisation.
- Integration of the community and in hospital elements of the Medical Examiner service across Bradford District and Craven are providing a rich opportunity to derive further learning and share best practice.

Domain 3 – Helping people recover from episodes of ill health or following injury
2.6.2 Patient Reported Outcome Measures (PROMs)

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

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

The standardised EQ-5D measure is presented as this applies to all elective conditions. However, this is less sensitive than condition specific measures and for a more complete analysis, the Oxford Score is also provided. The following information relates to all procedures (primary and revisions).

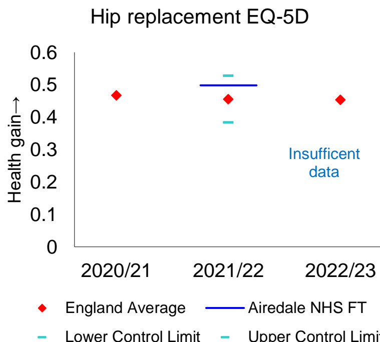


Figure a

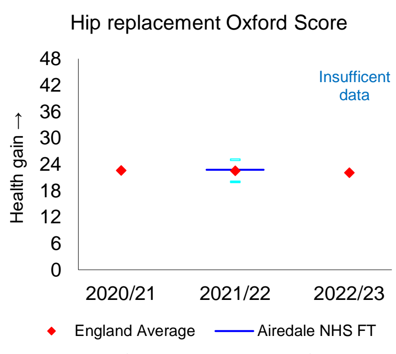


Figure b

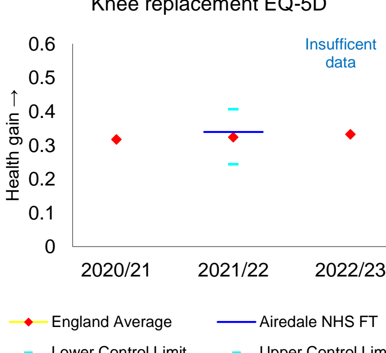


Figure c

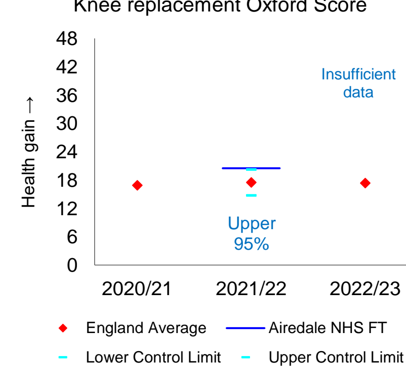


Figure d

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

- As in previous years, the 2023/24 dataset is not included and as there is limited response data at this stage; post-operative questionnaires are not sent to Orthopaedic patients until six months after the procedure is carried out.
- NHS hospitals in England were instructed to suspend all non-urgent elective surgery for patients for parts of the 2020/21 reporting period. A reduced service continued during the 2021/22 reporting period. This directly impacted upon reported volumes of activity pertaining to hip and knee replacements reported in PROMS.
- To generate meaningful intelligence NHS Digital, require at least 30 modelled records for each procedure. There were 28 eligible hip replacement procedures and 24 eligible knee replacement procedures in 2022/23, insufficient to generate a health gain score.
- Airedale's participation rates are below the England mean in 2022/23. Data cover a period where restrictions and changes to behaviours may have affected participation levels. Where patients have responded, rates are in line with the England mean.

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

- The service is a positive outlier for the 2021/22 Oxford Score adjusted health gain; this is considered the more sensitive measure.
- The service continues to encourage and emphasise the importance of returning the questionnaires at pre-operative assessment and in the ward environment at discharge.
- When data is published by NHS Digital a monitoring report is circulated to clinical operational leads for dissemination.

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

Emergency re-admissions within 30 days of discharge from hospital intelligence is detailed below with the last two available reporting periods.

While some emergency re-admissions following discharge from hospital are an unavoidable consequence of the original treatment, others could potentially be avoided through ensuring the delivery of optimal treatment according to each patient's needs, careful planning, and support for self-care. The following is standardised and while this allows comparison with other organisations reference data is taken from both NHS and non-NHS providers, including mental health.

Data is presented in age groups: persons under and over 16 years. A low percentage score is good.

Table 5: Emergency re-admissions within 30 days of discharge	**21/22**	**22/23**	**23/24**
Airedale NHS Foundation Trust percentage persons <16 years	13.2	14.1	15.6
National percentage average [England] persons <16 years	12.5	12.8	13.2

The *highest* percentage return by provider persons <16 years	46.9*	37.7*	69.1*
The *lowest* percentage return by provider persons <16 years	3.3*	3.7*	1.6
Airedale NHS Foundation Trust percentage persons 16 years +	12.4	12.5	11.5
National percentage average [England] persons 16 years +	14.6	14.4	15.1
The *highest* percentage return by provider persons 16 years +	41.5*	46.8*	99.6*
The *lowest* percentage return by provider persons 16 years +	2.1*	2.5*	1.7*

**NHS Digital caution: warning on data – numbers of patients too small for meaningful comparisons (below 2)*

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

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

- Persons 16 years and below: the return in the last available fiscal year is significantly higher than the national average at the 99.8 per cent level. As part of Trust strategy to get patients home as soon as possible, we frequently discharge and then offer families 24-hour open access for review on the unit. This allows the patient to be readmitted directly to the ward if the parent or carer feels there is any deterioration or if they are struggling with caring for the patient for any other reason. Clearly this policy can potentially impact on the re-admission rate.

- Persons 16 years plus: according to NHS Digital the return for the last fiscal year is significantly lower than the national average at the 99.8 per cent confidence level.

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

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

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

2.6.4 Responsiveness of Airedale NHS Foundation Trust to the personal needs of patients.

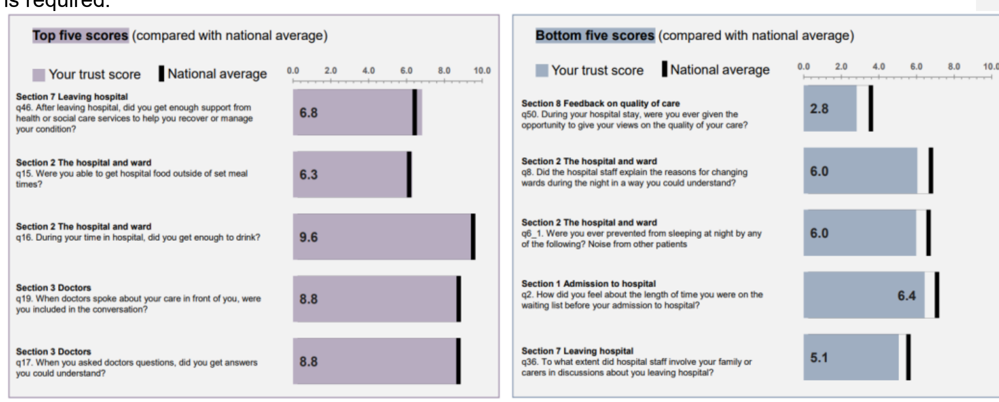
The NHS Outcomes Framework Indicator is a composite of several questions from the annual Adult Inpatient Survey. While the Care Quality Commission (CQC) publish results from each question individually, the composite score cannot be calculated from this data. As part of NHS England's review of the *NHS Outcomes Framework*, unfortunately it has indicated that it will no longer be updating the composite score, on the basis that the results added little value to survey results.

Results from the NHS patient surveys are published in detail on the Care Quality Commission (CQC) website here: [Surveys - Care Quality Commission]

NHS Adult Inpatient Survey 2023 (published 2024): the Care Quality Commission compare trust results to understand where patient experience is highest compared to the average of all trusts. Where patient experience could improve, this is the results for a provider that are lowest compared to the average of all trusts. The Trust's results for 2023 were "*about the same*" as other providers across all categories. The survey was undertaken in November 2023 and based on a response rate of 44 per cent (535 completed questionnaires).

Organisational responsiveness to patient need is regarded as a key indicator in the quality of patient experience and care. Airedale NHS Foundation Trust use different tools to monitor and measure effectiveness of responding to patient experience to provide person centred care.

The annual CQC Inpatient survey reports on the experience of having an overnight stay as an inpatient in an acute hospital setting. The results indicate good experience and where improvement is required.



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

- The 2023 response rate is comparable to the national rate of 42 per cent.
- The latest survey covers a period where health services were affected by industrial action which may have affected participation and responses.

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

- Monitoring local and National CQC Patient Experience survey results and responses to actions and recommendations through the Patient Experience steering group and Clinical Governance, Patient Safety and Quality group.
- Listening, learning, and acting in response to feedback of experience from.
- Friends and Family Test, PALS, formal complaints, lived experience from patient stories and social media.
- Continue to embed the use of digital systems to seek patient feedback and embed FFT feedback into reviews of care and actions in response to learning and report to governance structures.

- Continue to work across health and care partnerships and in collaboration with partner organisations to ensure a holistic approach to patient and public engagement and involvement, and maintain membership of place, system level networks and forums.
- PALS and formal complaints will continue to drive improvement initiatives with actions and evaluation of impact monitored at clinical and operational groups and progress assurance will be reported to governance structures

During 2024 the Trust has been committed to addressing health inequalities across a number of areas which is also confirmed in the Annual report :

- Introduction of the Community Diagnostic Centre. This model plays a vital role in addressing health inequalities by removing barriers such as travel, cost, and accessibility—ensuring that our communities receive timely and equitable care.
- We have continued to develop our approach to understand and reduce health inequalities. We have profiled patients accessing various categories of care (emergency, elective, day case and outpatient) by factors of age, sex, ethnicity and continue to strengthen our reporting.
- An Airedale Patient Experience Strategy is in development and is due to be finalised by September 2026. It will include and focus on
    i. Ensuring our environment is accessible and inclusive.
    ii. Ensuring our information is inclusive, easy to understand and readily available.
    iii. Working with our service users to be person centred and meeting the needs of our diverse communities.

As part of continued commitment to address health inequalities, work is underway to enhance our regular reporting processes. This improved reporting will be integrated within existing governance structures.
The Trust will take the following actions to address health inequalities in 2025/2026

- Implement targeted interventions to reduce DNA rates among deprived patients. This could include reminder systems, transportation assistance, or flexible scheduling.

- Enhance access to technology for deprived patients to increase participation in virtual appointments. This could involve providing devices or internet access.

- Conduct additional research to identify other factors contributing to these disparities, such as age, ethnicity, or specific socio-economic conditions.

As an anchor institution and one of the biggest employers locally, we have a responsibility to support and represent our local community. By helping them to improve their health and wellbeing and working with our partners to tackle health inequalities, we will achieve our strategic ambition of "thriving people, healthy communities", and contribute to Bradford District & Craven's ambition of "happy, healthy, at home".

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

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

The following is the percentage of staff that "*agree*" or "*strongly agree*" with the statement *"If a friend*

Table 7: Staff recommendation	**2022** 1499 replies. 3661 surveyed	**2023** 1334 replies. 3771surveyed	**2024** 1546 replies. 3523 surveyed
	Pub: Mar 2023	***Pub: Mar 2024***	***Pub: Mar 2025***
Airedale NHS Foundation Trust percentage	64.3	63.8	62.6
National average percentage Acute and Acute Emergency Trusts [England]	61.9	63.3	61.5
Highest percentage for benchmark group	86.4	88.8	89.6
Lowest percentage for benchmark group	39.2	44.3	39.7

or relative needed treatment, I would be happy with the standard of care provided by this Trust" and is based on the annual *NHS Staff Survey* (question 25d).The scores are presented out of 100 with a high score indicating good performance.

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

The Trust's 2024 response rate is 44 per cent, this is below the median response rate for the 122 providers of a similar type (acute and acute community trusts) which is 49 per cent. As part of the analysis and engagement relating to the 2024 results, the Trust has undertaken a detailed review of response rates to understand any gaps in response and used this to inform engagement plans across the year.

Overall, the Trust's 2024 *NHS Staff Survey* results across the seven domains of the NHS People Promise and two additional themes of staff engagement and morale, improved in all areas except for 'we each have a voice that counts' which reduced by 0.1. The Trust's scores are above the reported average in five areas, which is an improved position from 2023.

Analysis of the Trustwide results identified areas of strength and areas for development. The Trust has continued to prioritise the following areas of focus for development:

- Civility and Respect
- Speaking Up
- Importance of Line Management

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

Area of Focus	**Proposed Action**	**Timescale**
Kindness and Civility	Champion the civility saved lives agenda as part of the fair and just culture work Embed anti-harassment anti-discrimination statement: • Line Manager Letter • Microaggressions video • Develop allyship toolkit • Innocent Bystander Training • NHS Resolution Compassionate Conversations training	Quarter one Quarter one Quarter one Quarter three Quarter three Quarter two

Line Manager Skills	Wellbeing conversations • Review templates • Roll out training • Recording and reporting Launch and embed bespoke line manager skills programme to complement current provision Embed the learning from the shadow board programme and decision needed on the divisional development programme funding	Quarter one Quarter two Quarter three Quarter three Quarter one and two
Speaking Up	Evaluate the effectiveness of the People Champion model to inform the development of the approach Undertake a gap analysis and develop an action plan for the just and learning culture based on best practice Evaluate actions taken to reduce barriers to determine whether they have been effective with an inclusion lens Share some of the learning that is coming through the FTSU route to build confidence among colleagues that the organisation is listening and responding to concerns raised through speaking up channels	Quarter two Quarter two Quarter three and four Quarter three

The results were considered by the People Committee in March 2025 who supported the action identified in line with the above strategic priorities. The discussion focused around areas where results continue to be strong and areas of focus for future development.

Ongoing engagement is noted as a key enabler to improving staff survey responses, the following engagement priorities will be progressed by the Trust.

- The implementation of a Trust wide action plan to cover three key areas of focus with oversight through the People Experience Group and the People Committee.
- Detailed analysis and engagement at a divisional level to establish divisional and department improvement actions, supported by a team-based toolkit to support local discussions.
- Launch of a line manager landing pack to support team-based discussions.
- A campaign of Trust wide communications, from April to November focusing on elements of the People Promise. Supported by a senior leadership videos dedicated to staff survey engagement.
- Triangulating feedback received to identify areas of focus each quarter to target engagement actions.

- Inviting People Stories through the People Experience Group to consider the areas of focus identified, sharing learning and best practice across the organisation.

2.6.6 Friends and Family Test (FFT) – Patient Feedback

The NHS friends and Family Test (FFT) is a quick anonymous way for service users, families, and carers to give their view on the quality of their care and treatment. The survey supports service providers and commissioners to understand satisfaction with services and where improvements can be made.

In 2020 NHS England enacted new reporting guidelines following a review of FFT. The reasons for change included the need for a question that makes more sense to patients and staff and to offer more useful feedback from patients – not just "thank you." Those using services are asked to following question, "*Overall, how was your experience of our service?"* with possible answers ranging from *"Very good," "good"* through to *"poor," "very poor."* The table below indicates the positive

percentage score – *“very good”* and *“good”* - across all Trust services for each quarter of 2023/24, using quarter 1 as the baseline. The higher the score, the greater is the satisfaction of those using services.

Airedale NHS Foundation Trust are committed to continued learning and change improvement, FFT provides rich insightful data that enables organisational learning and development. Feedback and experience are monitored through ward and department-based leadership structures, the patient experience assurance group and is reported to clinical governance groups.

Table 8: Satisfaction score of those using services

Department	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25	Summary
Inpatients	85.5%	87.4%	84.6%	88.2%	87.1%
Emergency Department	82.6%	83.4%	82.8%	84.3%	83.2%
Outpatients	93.3%	93.4%	93.4%	93.4%	93.4%
Day Case	96.4%	96.3%	94.7%	96.7%	96.0%
Community	88.5%	92.8%	91.3%	89.8%	90.7%
Maternity	92.9%	93.9%	93.7%	91.2%	93.1%
Summary	**91.0%**	**91.0%**	**90.0%**	**91.0%**	

The Airedale NHS Foundation Trust considers the summary of data as described below:

- The Trust has developed and implemented a digital based FFT system using text messaging in collaboration with Healthcare Communications. Feedback is gathered in an online database called Messenger Envoy.
- The Messenger Envoy system has enhanced functionality that allows staff to access improved data, including trends and themes (sentiment analysis) with the capability to provide a more rounded view of the experience of patients in the Trust.
- While focus has shifted from, “How many responses?” to “What are patients saying?” and “How shall we use this information?”, the Trust continues to monitor response rates – 13 per cent (31,753 responses) in the reference period – to ensure that intelligence is representative of those using services.

The Trust has taken the following actions to improve responses and scores and so improve the quality of services:

- Streamlining the SMS text message to asking for feedback and providing the online link and PALS contact details.
- Aligning QR codes and online links to wards and departments and ensuring visibility and accessibility.
- Education and training to new staff to highlight the importance of actively asking, listening, learning and acting from feedback.
- Business cards to provide to patients, families, and carers.
- Provision of paper surveys to provide written feedback and feedback surveys specifically for children and young people.
- Training and education on use of the digital system.
- Volunteering collection of feedback form visiting wards and departments.
- Embedding FFT consistently as contributory data into governance reporting functions at directorate and divisional level.

- Triangulating data with PALS and CQC surveys to enrich learning and sharing the data for a joint approach to improvement

PALS and Complaints – improving experience

PALS record contacts to Airedale NHS Foundation Trust relating to compliments, concerns, feedback and requests for information and formal complaints in relation to experience of care and treatment when using or visiting Trust services.

Contacts

Information 24/25	Compliments 24/25	Concerns 24/25	Complaints 24/25	Feedback/ Unspecified 24/25	Total 24/25
583	549	1495	59	136	2763

Airedale NHS Foundation Trust describe the summary as:

- All PALS concerns are recorded and responded to within three days and aim to be closed within a further seven days.
- Response times for initial contact and closure of cases will be audited from April 2025 onwards.
- Formal complaint response times are audited and are reported through governance structures to Quality and Safety Committee for executive board assurance.
- Guidelines for managing all responses are taken from the Parliamentary Health Service Ombudsmen (PHSO) NHS Complaints Standards and local Airedale policy is developed in line with PHSO recommendations.

The Trust are taking the following actions to improve the experience of using the PALS and complaints service:

- Timeframes for completing an investigation 23/24 were set at 35 working day, this target has not been consistently achieved.
- A review of current Trust targets to complete an investigation and instances of achieving 35 working days target in conjunction with PHSO recommended timeframe of up to 180 days to complete an investigation has resulted in a change to Trust targets. From April 2025 35 working days will be extended to 60 working days, resulting in realistic expectations, timeframes to support robust and thorough investigations and recommended actions and improved compliance aligning to Trust expectations.

- Weekly divisional meetings to monitor and support lead investigators in progressing investigations and monthly case reporting to governance structures.
- Weekly progress report to senior leaders of current cases and monthly tracker reporting progress of open and closed cases and actions in progress shared with senior leaders.

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

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

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

prophylaxis. A high percentage score is good. The VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic.

Table 8: Risk assessment for VTE	**Jan –Mar 2024**	**Apr-Jun 2024**	**Jul-Sep 2024**	**Oct-Dec 2024**
Airedale NHS Foundation Trust percentage	*96.4%*	*96.8%*	*97.4%*	*97.1%*
National percentage average [England]				
The highest percentage return for any acute trust				
The lowest percentage return for any acute trust				

Data Source: *Airedale NHS Foundation Trust Information Services*

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

- National data reporting recommenced from April 2024 with publication awaited.
- The Trust consistently meets what was once the national target threshold of 95 per cent with average compliance of around 97 per cent.
- Local intelligence continues to be provided to managers and lead clinicians. Broken down by clinical group, this allows those areas which are under reporting to be identified and supported with improvement and restorative actions.
- The VTE risk assessment tool is embedded in the clinical areas and features prominently in clinical decision making, ensuring vigilance in completing risk assessments.

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

- Regular discussion of VTE assessment data through Integrated Performance reviews, and with clinical directors to educate and improve rates across groups.
- Focus on VTE risk assessment and other quality indices through work of the multi-professional Clinical Governance Patient Safety and Quality Group.

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

Hospital associated C. *difficile* infection can be preventable. Since 2012 revised guidance on the clinical testing protocol has resulted in more consistent testing and reporting of cases of C. *difficile* infection across the country. The rate provides a helpful measure for the purpose of making comparisons between organisations and tracking improvements over time. A low rate is good.

Table 9: Rate of* C. *difficile	**2021/22**	**2022/23**	**2023/24**
Airedale NHS Foundation Trust rate per 100,000 bed days	20.4	16.8	26.1
National average rate [England] rate per 100,000 bed days	16.3	18.3	18.8
The highest rate for any acute trust rate per 100,000 bed days	53.6	73.3	56.6
The lowest rate for any acute trust rate per 100,000 bed days	0.0	0.0	0.0

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

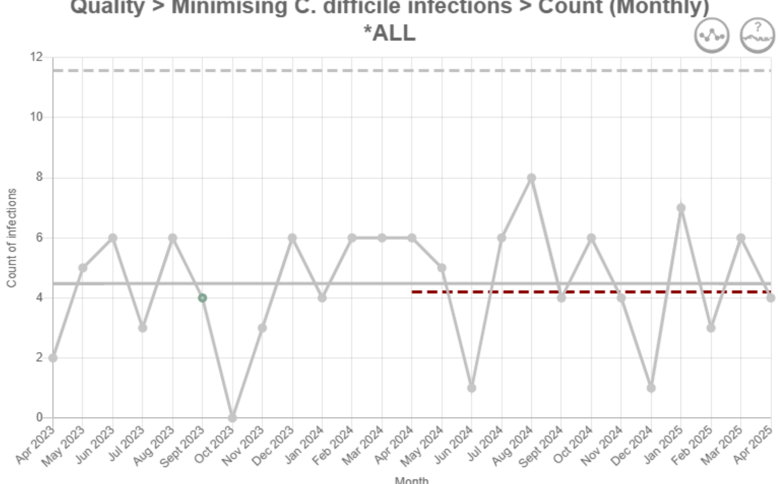
Data Source: *UK Health and Security Agency*

The national benchmark for C. *difficile* 2024/2025 has not been released as yet by the UK Health and Security Agency (UKHSA).

In 2024/2025 Airedale had a threshold of 50 C. *difficile* trust attributed cases set by UKSHA. In 2024/25 Airedale reported 57 hospital attributed cases, 7 cases over the threshold set by UKHSA. This is an increase in the number of cases reported in 2023/2024, in which 50 C. *difficile* trust attributed cases where reported. UKHSA have reported a sustained increase in C. *difficile* cases reported in England compared with 2023/24.

Historical increases in C. *difficile* incidence have been linked to newly emergent strains and/or antibiotic prescribing. Neither cause appears to explain the current increase. In 2024/2024 the Chief Nurse for England asked for a national focus group to review why C. *difficile* is at the highest rates recorded since 2011.

The Graph below shows the number of Healthcare Associated C. *difficile* reported by Airedale from April 2023- April 2025



If a ward/department has 2 or more C. *difficile* cases within 28 days, a period of increased surveillance is initiated. During this period outbreak measures are implemented to prevent further spread of the infection. In 2024/2025 eight periods of increased surveillance where reported. Five C. *difficile* cases were deemed to be avoidable in 2024/2025 4 out of the 5 avoidable cases were linked to time and space and had the same ribtoype. The fifth avoidable case was due to inappropriate antibiotic usage. All C. *difficile* samples are sent for ribotyping and reviewed to identify links to time and place.

Further assurance regarding the management of Healthcare Associated Infection (HCAI) is gained by

- The Trust has a rigorous diagnostic testing protocol to identify cases. All confirmed cases are monitored through internal processes and reported to UK Health Security Agency.

- Post infection review of all hospital onset healthcare-associated and community onset healthcare associated cases is undertaken to ensure opportunities to improve practice are identified and enacted.
- Established and coordinated antibiotic stewardship programme in place to ensure that antibiotics are appropriately prescribed, used and effectiveness monitored to minimise antibiotic resistance.
- Hand hygiene is monitored monthly and action plans in place for sub-optimal practice
- Cleaning audits demonstrate that the Trust is meeting the cleaning standard set out in the national cleaning standards 2025.
- The infection prevention team respond to national guidance and support the implementation of new/changes to guidance.

In line with best practice and national recommendations, hydrogen peroxide vapour (HPV) cleaning was introduced in April 2025 to be used for any side room following the discharge or transfer of a patient with C. *difficile*. In addition antimicrobial disposable curtains where also introduced in March 2025, The aim of both of these initiatives is to reduce the risk of potential cross infection from the environment to the patients.

Airedale NHS Foundation Trust will continue with the following actions to improve this rate, and so the quality of its services, by:

- Early recognition and management of suspected infective diarrhoea.
- Trust wide C. *difficile* reduction action plan.
- SystmOne antibiotic prescribing flag for those patients with a history of C. *difficile* infection/colonisation.
- Work with community colleagues looking at district wide approach to prevention of C. *difficile*.
- Monthly Infection prevention reports from divisions and IPC on challenges/improvements and action plans.
- Working with colleagues to ensure that building work does not increase the risk of patients acquiring infections

2.6.9 Reported number and rate of patient safety incidents that resulted in severe harm or death

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

This indicator is designed to measure the willingness of an organisation to report incidents and learn from them and thereby reduce incidents that cause serious harm.

The expectation is that the number of incidents reported should rise as a sign of a strong safety culture, while the number of incidents resulting in severe harm or death should reduce. (Severe signifies when a patient has been permanently harmed as a result of an incident.)

The Trust has further developed our Local Risk Management System (Ulysses) to support improved oversight and triangulation of data from incidents, risks, complaints and Patient Safety Alerts. A dashboard is available for all staff which provides a live overview of incident reporting data.
Ulysses facilities the 'live' reporting of patient safety incidents to the Learn From Patient Safety Events Service (LFPSE). The Trust was the first in West Yorkshire to transition to this system.

- The transition to the Patient Safety Incident Support Framework (PSIRF) will continue to support an open and transparent reporting culture and focus on improving the experience for

those involved. This transition is being supported at Place and at a wider regional level with organisations working together and sharing learning.

- PSIRF will also facilitate a focus on the after-incident review process and support identification of immediate actions and learning. The move from root cause analysis to a systems-based system for investigations will mean the focus is on a Human Factors systems approach to understanding care systems, processes, and outcomes. A systems-based approach considers the full range of contributory factors across a system. Recommendations are targeted at system changes, rather than individual behaviours, which are more likely to produce sustained safety improvements.

- Learning from patient safety incidents and PSIRF updates are reported each month through Divisional and Trust Clinical Governance, Quality and Patient Safety meetings.

- Key quality and safety messages are shared in a monthly Quality and Safety Matters bulletin. In reach training to clinical teams is also provided by the Patient Safety team, which includes the Trust induction programme.

- The Trust has two accredited Patient Safety Specialists who have a key role in local implementation of the NHE Patient Safety Strategy and support the development of safety system and a positive patient safety culture through senior leadership.

Table 10: Patient safety incidents

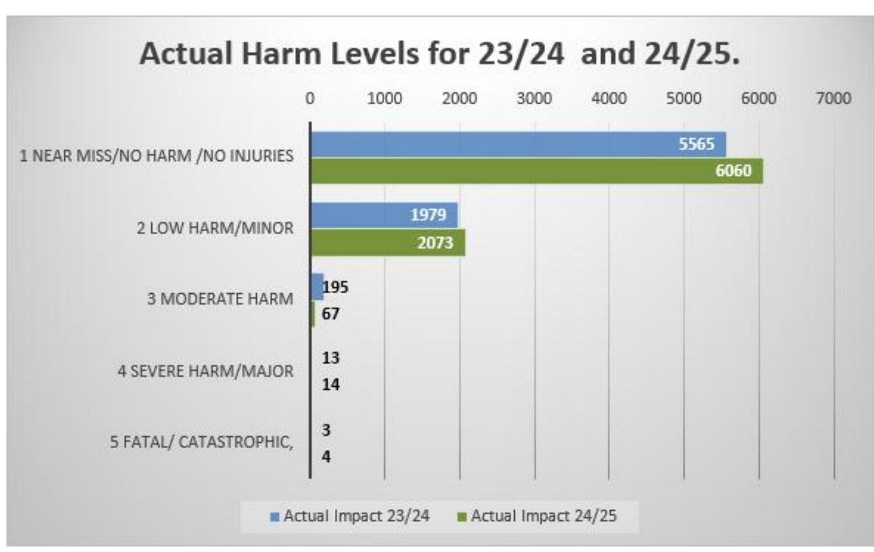
National incident data reporting has changed with the transition from NRLS to LFPSE. Current data is therefore not comparable with that in previous Quality Accounts.
National Trust reported data from LFPSE is not currently available, however, reported numbers of incidents are in line with similar sized Trusts and there is no reported 'lag' time for incident reporting suggesting the reporting system is working as expected.

The following is data from our Local Risk Management System (Ulysses):

The graph below represents an increase of 5.89% compared to the previous reporting period.

Harm Levels	Actual Impact 23/24	Actual Impact 24/25
1 Near Miss/No Harm /No Injuries	5565	6060
2 Low Harm/Minor	1979	2073
3 Moderate Harm	195	67
4 Severe Harm/Major	13	14
5 Fatal/ Catastrophic,	3	4
Grand Total	**7755**	**8218**

There were 18 (0.2%) patient safety incidents that resulted in severe harm or fatality during 2024/2025.



Patient Safety Incidents by harm level and category.

Severe: 1 Delay in Clinical Assessment, Diagnosis
1 Fracture Other – Slip,Trip,Fall
12 Fractured Next of Femur – Slip/Trip/Fall

Commented [LC1]: This has increased from 10 in 23/24

Fatal: 1 Learning from Deaths
1 Patient Injured During Clinical Intervention
2 Slip/Trip/Fall (Significant Harm)

- An open and engaged culture to learn from incidents and improve the quality and safety of services as illustrated in the latest *NHS Staff Survey 2024* where:
    a. Almost 71 per cent of those staff who participated said the Trust acts on concerns raised by patients and service users which is in line with the benchmarked average.
    b. 72 per cent of participating staff recorded feeling secure in reporting unsafe clinical practice, above the national benchmarked average of 70 per cent.
    c. 57 per cent of those who responded were confident that the Trust would address their concern in line with the benchmark average.
    d. 64 per cent of surveyed staff felt safe to speak up about anything of concern within the Trust compared to a benchmark average of 60 per cent. Of participating staff, 50.0 per cent said that if they spoke up about something concerning them, the Trust would address in line with the benchmark average.

- The response rate was 44 per cent which was below the median response rate for the 122 providers of a similar type (acute and acute community trusts) of 49 per cent.
- Clear and accessible policy and guidelines that ensure incidents are effectively identified, managed, and investigated and that appropriate measures are taken to prevent recurrence.

Part Three

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Part 3: Other Quality Improvement

3.1 Organisational Quality Improvements

3.1.1 Surgery and Diagnostics Division Quality overview 2024/2025

Highlights within division include the September inspection of the Endoscopy service, meeting all accreditation standards and being awarded JAG accreditation for 5 years. Congratulations to the team for the high standard of achievement, and for their hard work during the accreditation process.

A busy year within our Anaesthetics and Theatre teams with ACSA (Anaesthesia Clinical Service Accreditation) reaccreditation and then shortlisted in the HSJ awards for collaboration work with Changeology and elective recovery plan.

January 2025 began with Critical Care having successful WYCCODN peer review with installation of the Wellbeing/learning environment space within the unit and patient pathway board in 2024. Acknowledgement of improvements to quality working in collaboration to establish tracheostomy pathway to avoid unnecessary admissions to ICU.

Our Fracture Liaison Service has put Airedale on the global map currently as a 'Blue Star', which recognises the initiation of FLS activity in the local healthcare provider site and was awarded a Gold star in recognition of this achievement in February 2025.

Our inpatient wards launched their 'Fundamentals' training to support both our new and loyal colleagues in ensuring our patients receive evidence based, safe and effective care.

3.1.2 Women, Children and Specialist Services Division Quality overview 2024/2025

Across the Womens and Childrens Division there have been several quality improvements and from our womens service our Endometriosis service has been fully accredited making our service the second provider of this specialist service in West Yorkshire after Mid Yorkshire Hospitals.

Severe endometriosis causes chronic pain and fertility issues. It has a significant impact on the patient, her family and society as a whole. For the past 20 years the British Society for Gynaecological Endoscopy (BSGE) has set the criteria that must be met for units to provide care for patients with severe endometriosis. As well as requiring highly skill surgical care, endometriosis centres are required to meet additional standards to improve the holistic care of patients.

After 3 years of work, Airedale General Hospital was awarded full accreditation for 2025. The accreditation has been achieved through audit and gathering video evidence demonstrating the team can manage a sufficient level of patient complexity.

For patients this brings a number of quality improvement benefits as our centre can now treat complex patients who would otherwise be referred elsewhere. A comprehensive audit scheme gathers data for all patients with advanced disease using standardised QoL and disease impact questionnaires during their patient journey to support future service development.

For some patients waiting to receive elective care, some have been waiting longer than 65 weeks for their procedures following the Covid 19 pandemic. Acknowledging the potential impact of this waiting time to surgery, the gynaecology team have actively been managing their waiting lists to prioritise these patients for surgery and at the end of this year this patient cohort has been treated. The team are applying these same principles to reduce this waiting time to less than 52 weeks aspiring to bring this to under 40 weeks within the next year.

Access to diagnostic tests for those patients on a cancer pathway has remained a priority and the gynaecology team have been working with the Community Diagnostic Centre (CDC) to provide timely access to these tests and improve quality outcomes through earlier diagnosis.

Clinic capacity for Gynaecology Acute Treatment Unit (GATU) has been increased providing timely clinic access for women requiring an acute gynaecology assessment.

For those women choosing an elective caesarean section we have worked with the anaesthetic team to provide additional elective capacity for this pathway. This has improved patient experience and outcomes.

Across all paediatric areas we are committed to improving our response rate for FFT and are reviewing new ways to capture these responses to help us understand satisfaction levels with our service and where improvements can be made.

Patient experience is a key area of focus and we have been working with our services users to raise awareness of the Neonatal Unit, working collaboratively with maternity, neonates, and services users we are implementing a Facebook live. The paediatric team have introduced the Baby friendly initiative (BFI)- which aims to improve practice for infant feeding in health care settings.

The paediatric team have been able to introduce a non resident rota for their consultant grades which has increased the number of outpatient clinics the team can provide which is reducing waiting times for new and follow up outpatient appointments.

From within the Women and Children Division Pharmacy have made several quality improvements through the year and their service has seen the introduction of the Pharmacy Prescription Tracking system which enables detailed tracking of outpatient and discharge prescriptions, with future roll out to the wards to support patient flow. There is now an agreement with primary care for the supply of urgent medication in pregnancy, increasing patient safety, maintaining timely supply of medication and has a positive impact on the workload in primary care.

The pharmacy team have also extended their pharmacy hours with sustainable staffing levels, supporting flow, reducing omitted and delayed doses. This has improved the clinical pharmacy service with the timely resolution of prescribing errors and improving the rate of medicines reconciliation within 24 hours.

Through the West Yorkshire Association of Acute Trusts pharmacy project, this Trust now received ready to administer piperacillin/tazobactam bags each week, increasing patient safety and releasing nursing time to care. There has also been the introduction of a new pathway for pre-operative patients on warfarin, increasing patient safety. The team have also managed to complete a refresh of the Quality Assurance relating to the Pharmacy MHRA Wholesale Dealers Authorisation Licence.

The Pharmacy team have also been party to the creation of the Northeast and Yorkshire Region Inclusive Pharmacy Practice Manifesto, making pharmacy workplaces more inclusive, improving health inequalities and supporting widening access and participation in pharmacy as a career.

3.1.3 Medicine, Therapies and Community Division Quality overview 2024/2025

The Division has led and completed a quality improvement initiative that related to patients requiring enhanced care and therapeutic observations.
Results showed:

- Improvements in the care quality, safety and patient experience for patients receiving enhanced care and therapeutic interventions.
- Improvements seen in staff and workforce experience when providing enhanced care and therapeutic interventions.
- Time released 'back to care' for general ward tasks and to support team effectiveness. An improved and more efficient working environment was seen.
- The use of temporary staffing spends and number of requests, in addition to budgeted workforce models, so a significant reduction.
- There was a culture shift and reduction in the reliance of temporary staffing spend to deliver enhanced therapeutic observations and care seen across the Division.

Although this initiative did align to the waste reduction programme it also allowed more clinical resource on the ward areas, as well as providing an improved patient experience removing barriers that could be caused by a deprivation of liberty. This approach was led by the engagement and commitment of the enhanced care task and finish group and ward nursing and clinical teams. There has been no deterioration in patient quality and safety metrics. Inpatient falls remain in common cause variation and the Division has seen a reduction in hospital acquired pressure damage which is linked to releasing time to care.

The Home First Assessment Support Team (now known as H-Fast) was launched in 2024 to support people, who no longer needed hospital care, but may require a period of assessment to establish what support they need to remain at home. It's proven to be an excellent service which is helping people to get home sooner and having their assessments in their own home environment.

Our Stammering Lead was a guest at a Parliamentary reception to see the launch of a report supporting children who stammer. She was part of a focus group of Speech and Language Therapists who contributed to the report, launched by the organisation Action for Stammering Children (ASC).
The Emergency Department led a 'Resus Improvement' month following the increase seen in patient acuity and feedback from staff working within that area. This quality improvement led to the changes in resus equipment, layout of the space, new paediatric resus trollies, improved stock levels, guidelines being updated and additional resus SIM training sessions.

The Urgent Treatment Centre opened in July 2024, which has allowed for our minor injuries and illness work to be delivered in a bespoke clinical environment. This has seen significant improvements in our care quality, patient experience and operational performance within that clinical area.

The Emergency Department also held an ED Culture month which focussed on teams working together for the promotion of civility and inclusion. It focussed on the elimination of incivility and discrimination. This work involved culture QI forums available for all, displays within the department, sharing 'change begins with me' blogs across all staff groups, the development of a new starter group, department champions and the importance of recognising and responding to 'micro-aggression and active bystander skills training.

The Division is also proud of the quality improvement 'stop and feed initiative' that has been completed across Ward 10 and Ward 14. This quality improvement work has focussed on protected mealtimes and effective teamwork. This has involved all roles of staff stopping all non-essential activities, and tasks, to be available to assist and support patient mealtimes. The wards have received numerous excellence reports and fantastic patient/relative feedback. The wards have just celebrated 12 months of this work, and this is being rolled out across all areas within the Division.

Our lead clinical nurse specialist for haematology, oncology and chemotherapy, attended a reception at Buckingham Palace alongside cancer charity Hope for Tomorrow, to showcase the work that we do to support cancer treatments closer to home on our two mobile cancer units and support vehicles. Our mobile units cover 8 locations. Two locations are within the Skipton area and there is one in each

of Settle, Ilkley, Harden, Keighley, Colne, and Burley. They have delivered over 7,300 patient contacts with the Trust delivering more treatments on mobile cancer units than any other Trust in the country.

HODU have launched the Careology app for patients on a cancer pathway. Careology is a digital cancer care platform that is clinically validated, connecting patients to their healthcare teams and caregivers. Patients feel empowered and in control, healthcare teams have 'always on' access to comprehensive insights and caregivers are equipped to help navigate a cancer diagnosis better together. Together, Careology and Airedale was successful in obtaining funding through a Competitive Innovation Award Scheme looking at innovations that directly support cancer service recovery and contribute to the achievement of the West Yorkshire & Harrogate Cancer Alliance Five Year Plan. This funding has enabled the deployment of the Careology platform in acute oncology at Airedale for 12 months. This has proven to improve patient experience and education, improved clinician experience and streamlined care coordination.

MyCare24 Pathways has been developed and embedded to support patients with the long-term conditions of COPD, Parkinson's, Respiratory conditions, heart failure and UTI's. Patients on these pathways receive scheduled calls and have access to a clinician 24/7. Remote home monitoring is available for these patients if required. This supports earlier supported discharge from the acute hospital environment.

The Neurology Community Nurse Specialist (CNS)undertook a piece of work to review the waiting lists for patients awaiting a neurology consultant appointment (both new and ongoing). At the time of the review newly referred patients were waiting 36 weeks for an initial appointment.

The CNS checked all 3300 patients on the neurology waiting list. Any patient who was on both the Consultant and CNS caseload without a requirement for continued Consultant neurologist intervention were discharged from the consultant list.

180 patients were discharged from the Neurology waiting list and were seen by the CNS instead, this freed up 45 hours for Consultants to see new patients.

New process implemented for Consultants to refer to CNS if appropriate rather than arranging a routine follow up appointment.

Following attendance at National Conference where a patient had shared their story about their lack of understanding about what a virtual ward was, the team attending conference committed to reviewing and improving information given to people accessing services at ANHSFT.

A project team was set up to undertake this work and a resulting in video clips/story boards being produced which are now available on the Community Services area of the Trust Website and can be shared via social media. A QR code has been added to the patient information leaflet which takes people to the Virtual Ward webpage.

3.2 Performance Against Key National Priorities

The following indicators support the national priorities. Returns conform to specified data quality standards and prescribed standard national definitions.

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

*The combined metric as per national reporting requirements from October 2023

Indicator	**Threshold**	**Quarter 1 2024/25**	**Quarter 2 2024/25**	**Quarter 3 2024/5**	**Quarter 4 2024/25**
*All cancers: 62-day referral to first treatment	85%	83.5%	83.0%	83.9%	79.4%
Maximum 18 week waits from referral to treatment in aggregate – patients on an incomplete pathway	92%	62.4%	65.8%	68.5%	71.4%
A&E maximum waiting time of four hours from arrival to admission/ transfer/ discharge	78%	66.37%	64.09%	61.43%	61.59%
Maximum 6 week wait for diagnostic procedures	95%	86.54%	97.62%	93.50%	98.70%

Part Four

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Part 4 Annex

4.1 Bradford District and Craven Health and Care Partnership NHS West Yorkshire Integrated Care Board

Bradford District and Craven
Health and Care Partnership

Scorex House
1 Bolton Road
Bradford BD1 4AS
25 June 2025

Airedale NHS Foundation Trust Quality Accounts 2024/2025

On behalf of NHS Bradford District and Craven Health and Care Partnership West Yorkshire Integrated Care Board (WYICB), I welcome the opportunity to feedback to Airedale NHS Foundation Trust on its 2024/2025 Quality Report. The Quality Account has been shared with key members across the Bradford District and Craven Health and Care Partnership (BDCHCP). I acknowledge and congratulate the Trust's achievements for 2024/2025:

A review of those quality priorities for improvement/key achievements include:

- **Maternity Assessment Centre Triage pathways** - a structured quality improvement plan has resulted in an improved triage pathway, prioritisation, and escalation.
- **The Maternity service** participated in an external assurance visit by the West Yorkshire & Harrogate Local Maternity Neonatal System - feedback was that significant progress had been observed since previous assurance visits.
- **Avoiding Term Admissions to the Neonatal Unit** - focussed quality improvement work has been undertaken to reduce unavoidable admissions, which has demonstrated sustained reductions in such admissions.
- **Safe discharges** - the introduction of a checklist which has enabled significant reduction in people being discharged with a cannula in situ.
- **The Trust's pharmacy service** includes improvements to the pharmacy dispensary to ensure medications are being processed and delivered rapidly and the process of pharmacy ordering patient specific medication has been redesigned to ensure the timely supply of medication.
- **Pressure ulcer management** - the implementation of the Purpose T risk assessment tool to ensure patients are accurately assessed and an individualised care plan is implemented.
- **Care of people with dementia** – an enhanced care observation tool was developed to improve ward-based care of patients especially those with higher levels of distress or changes in behaviour.
- **The establishment of daily huddles** to prioritise and respond to the mental health needs of children.
- **The continuation of the established networks** across services to provide good palliative and end of life care to our population.

Additional successes include:

- **The Trust's endoscopy service** being awarded Joint Advisory Group (JAG) accreditation.
- **The Trust's fracture liaison service** being awarded a gold star in recognition of achievements.
- **The Trust's endometriosis service** being fully accredited making the service the second provider of this specialist service in West Yorkshire.

One of the key priorities indicated in last year's Quality Account was clinical effectiveness and included within that priority area was mental health for adults and children (place-based priority). More information is needed with regards to improvement work undertaken in relation to mental health for adults and children. One of the key priorities indicated in last year's Quality Account was patient experience and included within that priority area was end of life care. More information is needed with regards to improvement work undertaken in relation to end of life care.

In relation to falls management the Trust will work towards developing the use of a hot debrief (within 24 hours of a fall) and an after-action review (within 5 days of a fall) to ensure that early learning takes place following a fall. As a response to the overview of the data on sepsis a quality improvement initiative will be undertaken to improve the time to treatment for sepsis.

It is acknowledged that the Trust has further developed its Local Risk Management System (Ulysses) to support improved oversight and triangulation of data from incidents, risks, complaints, and Patient Safety Alerts and that a dashboard is available for all staff which provides a live overview of incident reporting data. The Trust now has two accredited Patient Safety Specialists who have a key role in local implementation of the Patient Safety Strategy and support the development of safety system and a positive patient safety culture through senior leadership.

It is noted that during 2024/25 Airedale achieved all the National Institute for Health Research high level objectives for performance in initiating and delivering research, exceeding the participant recruitment target by over 200%. The Trust's engagement in clinical research demonstrates the commitment to improving the quality of care offered to patients, whilst contributing to wider health improvement, aiming to help the population to live longer healthier lives.

It is acknowledged that a Freedom to Speak Up (FTSU) action plan is in place to support the work to improve the FTSU culture at the Trust and that a new Deputy FTSU Guardian has been appointed to increase capacity and support service development.

Quality Priorities for 2025/2026:

Quality priority 1 - Care of Acutely Ill Patient

- To reduce deterioration associated harm by improving the prevention, identification, escalation, and response (PIER) to physical deterioration via safe and reliable pathways of care and improved co-ordination across systems.
- To improve treatment time for sepsis.
- To introduce the latest Sepsis 6 bundle within the Trust.
- To deliver the deteriorating patient course to all registered nurses and health care support workers.
- To roll out Martha's rule to all inpatient areas meeting component one requirements and to consider the implementation of component 2 and 3.

Quality priority 2 - Urgent and Emergency Care

- To reduce Emergency Department 12 hour, wait times.
- To improve ambulance handover times.
- Reduction in length of stay on the acute admissions unit.

Quality priority 3 - Patient Safety Culture and Speaking Up

- To define, develop, and embed an approach to just and learning culture, with supporting policies and frameworks.
- Implement and embed the civility saves lives initiative.

During the year 2024/25-year period Airedale NHS Hospitals Foundation Trust participated in 40 of 49 eligible national audits for the 2024/25 quality accounts, of which five were confidential enquiries. The Trust continues to have a focus in the participation of clinical research to help improve patient safety and promote evidence-based practice within clinical care which demonstrates a commitment to improving quality of care and outcomes.

I would like to thank you and your staff for all the achievements made in 2024/2025. Finally, I am required to confirm that NHS Bradford Districts and Craven Health Care Partnership (WYICB) has reviewed the Quality Account and believe that the information published provides a fair and accurate representation of Airedale NHS Foundation Trust quality initiatives and activities over the last year.

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

4.2 Overview and Scrutiny Committee

The Quality Account have been shared with Bradford District and Craven Health and Care Partnership NHS West Yorkshire Integrated Care Board and has been presented to the Trust Quality and Safety Committee for oversight and approval.