BOARD OF DIRECTORS OPEN

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18 January 2024

09:30 GMT Europe/London

Conference Room, Field House, BRI

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AGENDA -18.1.24

REFERENCES

Only PDFs are attached

Bo.1.24.0 - Open board agenda 18.1.24 - v4.pdf

BOARD OF DIRECTORS MEETING IN PUBLIC AGENDA

Date:	Thursday, 18 January 2024	**Time:**	09:30 – 12:35
Venue:	Conference Room, Field House, BRI	**Chair:**	Helen Hirst, Interim Chair

10:30-10:50– Sara Hollins, Director of Midwifery – Bo.1.23.9 - Maternity and Neonatal Services Update

Observers: David Wilmshurst, Governor, Zafir Ali, Pauline Vickers

No.	Agenda Item	Lead	Outcome	Papers attached
09:30 Section 1: Opening matters				
Bo.1.24.1	Apologies for Absence • Altaf Sadique, Non-Executive Director • Jon Prashar, Non-Executive Director • Sughra Nazir, Non-Executive Director • Mohammed Hussain, Non-Executive Director • Ray Smith, Chief Medical Officer (John Bolton representing)	Interim Chair	For information	Verbal
Bo.1.24.2	Declarations of Interest	Interim Chair	For information	Bo.1.24.2
09:35 Section 2: Business from Previous Board Meeting				
Bo.1.24.3	Minutes of the meeting held on 16 November 2023	Interim Chair	For approval	Bo.1.24.3
Bo.1.24.4	Matters arising	Interim Chair	For information	Verbal
09:40 Section 3: Business Reports				
Bo.1.24.5	Report from the Interim Chair	Interim Chair	For information	Bo.1.24.5
Bo.1.24.6	Report from the Chief Executive	Chief Executive	For information	Bo.1.24.6

10:05 Section 4a: Delivery of the Trust's Corporate Strategy				
Bo.1.24.7	Board Assurance Framework and High-Level Risks	Associate Director of Corporate Governance/Board Secretary	For assurance	Bo.1.24.7

10:20 Section 4b: Quality and Patient Safety				
Bo.1.24.8	Report from the Chair of the Quality and Patient Safety Academy – November & December 2023	Chair of the Quality and Patient Safety Academy	For assurance	Bo.1.24.8
Bo.1.24.9	a. Maternity and Neonatal Services Update b. Maternity Incentive Scheme	Chief Nurse	For assurance For approval	Bo.1.24.9a Bo.1.24.9b
Bo.1.24.10	Proposal to establish a Maternity & Neonatal Task & Finish Group	Chief Nurse	For approval	Bo.1.24.10

BREAK 11:00 – 11:15

11:15 Section 4c: People				
Bo.1.24.11	Report from the Chair of the People Academy – November 2023	Chair of the People Academy	For assurance	Bo.1.24.11

Bo.1.24.12	Equality & Diversity Council update	Chief Executive	For assurance	Bo.1.24.12
11:35 Section 4d: Finance and Performance				
Bo.1.24.13	Report from the Chair of the Finance and Performance Academy – November 2023	Chair of the Finance and Performance Academy	For assurance	Bo.1.24.13
11:45 Section 4e: Supporting reports				
Bo.1.24.14	Integrated Dashboard	Chief Executive	For assurance	Bo.1.24.14
Bo.1.24.15	Finance report	Director of Finance	For assurance	Bo.1.24.15
Bo.1.24.16	Performance report	Chief Operating Officer	For assurance	Bo.1.24.16
12:05 Section 4f: Audit & Assurance				
Bo.1.24.17	Report from the Chair of the Audit Committee – November 2023	Chair of the Audit Committee	For assurance	Bo.1.24.17
12:15 Section 5: Governance				
Bo.1.24.18	Distributed Leadership Model – Director of Nursing & Quality	Chief Nurse	For information	Bo.1.24.18
Bo.1.24.19	Constitution amendments	Chief Executive	For approval	Bo.1.24.19
Bo.1.24.20	Academy work plans	Associate Director of Corporate Governance/Board Secretary	For approval	Bo.1.24.20
12:30 Section 6: Board Meeting Outcomes				
Bo.1.24.21	Any other business	Interim Chair	For information	Verbal
Bo.1.24.22	Issues to refer to Board Committees/Academies or elsewhere	Interim Chair	For approval	Verbal
Bo.1.24.23	Review of meeting	Interim Chair	For information	Verbal
Bo.1.24.24	Date and time of next meeting: • 14 March 2024 – 9.30am	Interim Chair	For information	Verbal

Annexes for the meeting of the Board of Directors 18 January 2024

Annex 1: For Information				
Bo.1.24.25	Green Plan annual update	Chief Operating Officer	For information	Bo.1.24.25
Bo.1.24.26	Board of Directors work plan	Associate Director of Corporate Governance/Board Secretary	For information	Bo.1.24.26

Annex 2: For Information: reports received by Board Committees/Academies				
Bo.1.24.27	Healthcare worker flu vaccination best practice assurance	Interim Director of HR	For information	Bo.1.24.27
Bo.1.24.28	Research activity in the Trust	Chief Medical Officer	For information	Bo.1.24.28

Annex 3: For Information: Board Committee/Academy Governance				
Bo.1.24.29	Confirmed Academy minutes: • Quality & Patient Safety Academy –1 November 2023 • People Academy – 25 October 2023 • Finance & Performance Academy –1 November 2023	Chairs of Academies	For information	Bo.1.24.29
Bo.1.24.30	Confirmed Audit Committee minutes – 12 September 2023	Chair of the Audit Committee	For information	Bo.1.24.30

BO.1.24.1 - APOLOGIES FOR ABSENCE

BO.1.24.2 - DECLARATIONS OF INTEREST

REFERENCES

Only PDFs are attached

Bo.1.24.2 - Declarations of Interest.pdf

BO.1.23.3 - MINUTES OF THE MEETING HELD ON 16 NOVEMBER 2024

REFERENCES

Only PDFs are attached

Bo.1.24.3 - Minutes of the meeting held on 16 November 23.pdf

Employee	Role	Date Incurred	Year	Interest Type	Date Ended	Interest Description (Abbreviated)	Provider	Value £'s
Altaf Sadique	Non-Executive Director	01/12/2020	2020/21	Outside Employment	05/10/2021	Director Gane Datascan produce healthcare virtualization and IoT software for Helios Healthcare, Germany, Northampton General Hospitals NHS Trust and Great Western Hospital NHS Foundation Trust	Gane Datascan Limited	0
Altaf Sadique	Non-Executive Director	01/12/2020	2020/21,2021/22,2022/23,2023/24	Outside Employment		industrial member	GS1	0
Altaf Sadique	Non-Executive Director	01/12/2020	2020/21	Outside Employment	30/12/2021	member	5G health association	0
Altaf Sadique	Non-Executive Director	01/12/2020	2020/21	Outside Employment	30/06/2021	advisor board	Yorkshire Asian Business Association	0
Altaf Sadique	Non-Executive Director	01/12/2020	2020/21	Outside Employment	30/03/2022	steering group	Northern Asian Power Group	0
Altaf Sadique	Non-Executive Director	01/06/2021	2021/22,2022/23,2023/24	Outside Employment		ibox healthcare is working with healthcare providers across the UK and global markets to deliver dashboards & data visualisation solutions help optimise patient flow and operational efficiency. Key customers NGH NHS Trust, NHSD, NHSHSA & Helios. Partners Telefonica, GS1, Zebra & Patient Source.	Ibox Healthcare (part of IHG Group ltd)	0
Altaf Sadique	Non-Executive Director	08/12/2021	2021/22,2022/23,2023/24	Loyalty Interests		Full member 6G health institute (EU)_	6G Health for Institute (EU)	0
Altaf Sadique	Non-Executive Director	01/09/2022	2022/23,2023/24	Loyalty Interests		Known to myself as a personal friend of long standing	Hanif Malik	0
Altaf Sadique	Non-Executive Director	04/05/2023	2023/24	Gifts		Free course; Creating Safe Systems including Human Factors	HC-UK Conferences	300
Barrie Senior	Non-Executive Director	01/02/2009	2015/16 & before,2016/17,2017/18,2018/19,2019/20,2020/21,2021/22,2022/23	Outside Employment		Consultancy practice	Senior Associates LLP	0
Barrie Senior	Non-Executive Director	01/08/2009	2015/16 & before,2016/17,2017/18,2018/19,2019/20,2020/21,2021/22,2022/23	Outside Employment		Architects and Building Consultants	AHR Management Services LLP	0
Barrie Senior	Non-Executive Director	01/12/2017	2017/18	Loyalty Interests	07/12/2020	Daughter-in-law is Senior Solicitor with Capsticks Solicitors LLP.	Daughter-in-law	0
Barrie Senior	Non-Executive Director	07/12/2020	2020/21	Loyalty Interests	19/07/2021	Daughter-in-law is Partner with Capsticks Solicitors LLP.	Daughter-in-law	0
Barrie Senior	Non-Executive Director	19/07/2021	2021/22,2022/23	Loyalty Interests		partner in DAC Beachcroft LLP	Daughter-in-law	0
Dorothy Bryant	Non-Executive Director	01/09/2023	2023/24	Nil Declaration				0
Faeem Lal	Deputy Director of Human Resources	28/03/2023	2022/23	Nil Declaration				0
Helen Hirst	Non-Executive Director	01/04/2022		Shareholdings and other ownership interests		Own management consultancy business operating outside of West Yorkshire (Director of Helen Hirst Ltd)	Helen Hirst Ltd	0
Helen Hirst	Non-Executive Director	01/06/2022		Loyalty Interest		Trustee of Wakefield Hospice	Wakefield Hospice	0
Helen Hirst	Non-Executive Director	01/06/2022		Loyalty Interest		Trustee of Staying Put Bradford (domestic abuse charity)	Staying Put Bradford (domestic abuse charity)	0
Helen Hirst	Non-Executive Director	01/07/2022		Outside Employment		Chair of Calderdale and Huddersfield NHS Foundation Trust	Calderdale and Huddersfield NHS Foundation Trust	0
James Rice	Chief Digital & Information Officer	22/03/2021	2020/21	No Change to existing declarations				0
James Rice	Chief Digital & Information Officer	04/01/2021	2020/21,2021/22,2022/23,2023/24	Outside Employment		Trustee of Yorkshire Cancer Research	Yorkshire Cancer Research	0
James Rice	Chief Digital & Information Officer	04/01/2021	2020/21,2021/22,2022/23,2023/24	Loyalty Interests		wife is employee of Rotherham Doncaster and South Humber NHS Trust	Rotherham Doncaster and South Humber NHS Trust	0
James Rice	Chief Digital & Information Officer	01/06/2019	2019/20,2020/21,2021/22,2022/23,2023/24	Loyalty Interests		member of the strategic advisory board	Strategic Advisory Board of the Yorkshire & Humber AHSN	0
James Rice	Chief Digital & Information Officer	01/07/2020	2020/21,2021/22,2022/23,2023/24	Loyalty Interests		fellow of the British Computing Society	British Computing Society	0
James Rice	Chief Digital & Information Officer	01/07/2021	2021/22,2022/23,2023/24	Loyalty Interests		CIO Advisory Council	CIO Advisory Council of the Digital Health Netwwork nationally	0
James Rice	Chief Digital & Information Officer	28/09/2021	2021/22	Hospitality		Meal following presentation at HETT conference	Google	35
James Rice	Chief Digital & Information Officer	03/11/2021	2021/22	Hospitality		Dinner following conference	ATOS	40
James Rice	Chief Digital & Information Officer	17/11/2021	2021/22	Hospitality		Attend Tech UK Annual Health and Care Dinner	Ethical Consulting	40
James Rice	Chief Digital & Information Officer	01/09/2022	2022/23,2023/24	Loyalty Interests		Son is now an employee of Yorkshire Ambulance Services.	Bradford Teaching Hospitals NHS Foundation Trust	0
James Rice	Chief Digital & Information Officer	08/09/2022	2022/23	Hospitality		Attended a CIO Dinner hosted by Agilysys in York on the evening of 8th September	Agilysis	30
James Rice	Chief Digital & Information Officer	14/09/2022	2022/23	Hospitality		Meal incorporating business development conversation re AFT EPR	Ethical Consulting	30
James Rice	Chief Digital & Information Officer	13/09/2023	2023/24	Hospitality		Meal at Tattu, Leeds, following a CIO roundtable event.	Credera Healthcare	45
James Rice	Chief Digital & Information Officer	13/12/2023	2023/24	Hospitality		Meal paid for by company following a visit to AFT and BTHFT.	Luscii	40
Jon Prashar	Non-Executive Director	01/02/2018	2017/18	Outside Employment	21/09/2022	board member and customer experience committee chair - leeds and yorkshire housing association	Leeds and Yorkshire Housing Association	0
Jon Prashar	Non-Executive Director	01/02/2018	2017/18	Outside Employment	31/10/2021	board member - housing diversity network	Housing diversity network	0
Jon Prashar	Non-Executive Director	01/09/2021	2021/22,2022/23	Outside Employment		Associate Consultant occasional freelance consultancy Undertake 30 days per year	Enhance the UK Charity	0
Julie Lawreniuk	Non-Executive Director	13/09/2019	2019/20	Outside Employment	12/05/2021	Group Board Member	Incommunities	0
Julie Lawreniuk	Non-Executive Director	11/03/2021	2020/21	Loyalty Interests		Daughter employeed as a business manager by the foundation trust	Bradford Teaching Hospitals	0
Julie Lawreniuk	Non-Executive Director	01/09/2019	2019/20	Outside Employment		board member	Incommunities housing association	0
Julie Lawreniuk	Non-Executive Director	31/03/2021	2020/21	No Change to existing declarations				0
Julie Lawreniuk	Non-Executive Director	01/07/2022	2022/23	Outside Employment		Board member and chair of system finance and performance committee	Bradford District and Craven Partnership	0
Karen Dawber	Chief Nurse	12/07/2017	2017/18	Nil Declaration				0
Karen Dawber	Chief Nurse	21/12/2017	2017/18	Gifts		The member of staff gave me a traditional Pakistani shawl / cloth that is given to people as a sign of respect. The gift was to recognise the work I have been doing re inclusivity	Member of staff who was leaving	25
Karen Dawber	Chief Nurse	03/09/2018	2018/19	Nil Declaration				0
Karen Dawber	Chief Nurse	31/03/2019	2018/19	End of Year Nil Declaration				0
Karen Dawber	Chief Nurse	13/02/2020	2019/20	Outside Employment	01/09/2020	Appointed as a School Governor, to be ratified on 11/3/2020	Primrose Hill Primary School Euxton	0
Karen Dawber	Chief Nurse	17/03/2021	2020/21	Nil Declaration				0
Karen Dawber	Chief Nurse	16/03/2022	2021/22	Nil Declaration				0
Karen Dawber	Chief Nurse	01/09/2022	2022/23	Loyalty Interests		Honorary Professor	University of Bradford	0
Karen Dawber	Chief Nurse	12/11/2022	2022/23	Loyalty Interests		Member of Professional Body	Member of the Royal College of Nursing	0
Karen Dawber	Chief Nurse	01/04/2022	2022/23	Loyalty Interests	30/11/2023	Related by marriage (niece)	Megan McCallion	0
Karen Dawber	Chief Nurse	01/11/2021	2021/22	Loyalty Interests		Ellie is my daughter and a volunteer in the PPE hub	Ellie Dawber	0

Karen Dawber	Chief Nurse	10/09/2023	2023/24	Hospitality		Due to my role as Honorary Professor at the University of Bradford and as my role of Chief Nurse at BTHFT, I was invited to visit Pakistan on a shared learning journey to see how the healthcare system is operating in Lahore. The trip was also part of ongoing ideas for the Universities to team up with our Trust to host a junior nursing programme, for students to study two years in Lahore and two years in Bradford and would involve placements at our hospitals. Return flights to Pakistan.	University of Bradford	4362.73
Karen Dawber	Chief Nurse	10/09/2023	2023/24	Hospitality		Due to my role as Honorary Professor at the University of Bradford and as my role of Chief Nurse at BTHFT, I was invited to visit Pakistan on a shared learning journey to see how the healthcare system is operating in Lahore. The trip was also part of ongoing ideas for the Universities to team up with our Trust to host a junior nursing programme, for students to study two years in Lahore and two years in Bradford and would involve placements at our hospitals. Accommodation - but price unknown as this was arranged by University of Lahore.	University of Lahore	0
Karen Walker	Non-Executive Director	04/01/2021	2020/21	Nil Declaration				0
Karen Walker	Non-Executive Director	01/07/2022	2022/23	Outside Employment		Deputy Chair, People Committee	Bradford District and Craven Health Care Partnership	0
Laura Parsons	Associate Director of Corporate Governance/Board Secretary	16/12/2020	2020/21	Nil Declaration				0
Laura Parsons	Associate Director of Corporate Governance/Board Secretary	04/01/2022	2021/22	Nil Declaration				0
Laura Parsons	Associate Director of Corporate Governance/Board Secretary	01/11/2022	2022/23	Nil Declaration				0
Laura Parsons	Associate Director of Corporate Governance/Board Secretary	04/05/2023	2023/24	Nil Declaration				0
Matthew Horner	Director Of Finance	12/07/2017	2017/18,2018/19,2019/20,2020/21,2021/22,2022/23,2023/24	Outside Employment		Board member of north of England commercial procurement collaborative	Board member of north of England commercial procurement collaborative	0
Matthew Horner	Director Of Finance	12/07/2017	2017/18,2018/19,2019/20,2020/21,2021/22,2022/23,2023/24	Loyalty Interests		Dr Paul Smith, Consultant Cardiologist, employed by the Foundation Trust is married to my sister in law	Dr Paul Smith, Consultant Cardiologist	0
Matthew Horner	Director Of Finance	01/12/2019	2019/20,2020/21,2021/22,2022/23,2023/24	Outside Employment		Director of Pet Food Manufacturer (Family Business)	E&S Feeds	0
Matthew Horner	Director Of Finance	01/04/2018	2018/19,2019/20,2020/21,2021/22,2022/23,2023/24	Outside Employment		Board Member of Audit Yorkshire (Consortium)	Audity Yorkshire	0
Matthew Horner	Director Of Finance	31/03/2021	2020/21	No Change to existing declarations				0
Matthew Horner	Director Of Finance	07/03/2022	2021/22	No Change to existing declarations				0
Matthew Horner	Director Of Finance	03/01/2021	2020/21,2021/22,2022/23,2023/24	Outside Employment		Board Member of ILS & IPS - Both LLP's are Joint Ventures owned by BTHFT, AFT and HFT	Integrated Laboratory Services and Integrated Pathology Services (Both LLP's)	0
Melany Pickup	Chief Executive	01/06/2020	2020/21	Loyalty Interests		Mel is Honorary Professor at the University of Bradford.	University of Bradford	0
Melany Pickup	Chief Executive	02/02/2022	2021/22	No Change to existing declarations				0
Melany Pickup	Chief Executive	25/07/2022	2022/23	Hospitality		Attended a curry awards dinner hosted by Asian Sunday at the Bradford Hotel following an invite to attend.	Asian Sunday via Bradford Hotel	40
Melany Pickup	Chief Executive	10/07/2023	2023/24	Hospitality		Bradford Curry Awards	Asian Standard	40
Melany Pickup	Chief Executive	22/06/2023	2023/24	Hospitality		Lit Fest Launch Dinner Midland Hotel Bradford	Bradford Literary Festival	40
Melany Pickup	Chief Executive	18/12/2023	2023/24	Gifts		A small christmas hamper containing a christmas cake and several other goods, including chocolate, syrup, sauce, brownies and mince pies.	The Storyt Team	15
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment		Senior clinical lead	NSH digital	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment	31/07/2023	LPN Pharmacy chair	NHS England	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment		director	White Rose Pharmacy Services Ltd	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment		fellow	Royal Pharmaceutical Society	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment		Honorary fellow	Associate pharmacy Technicians UK	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment		founding fellow	Uk Faculty of Clinical Informatics	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment		external advisory board	university	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment		occasional contributor to health journals	health journals various	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment		occasional consultancy work in pharmacy and education	consultancy work	0
Mohammed Hussain	Non-Executive Director	01/09/2019	2019/20,2020/21,2021/22,2022/23	Outside Employment		non executive director	Director ofPropharmace Ltd	0
Mohammed Hussain	Non-Executive Director	31/03/2022	2021/22	No Change to existing declarations				0
Mohammed Hussain	Non-Executive Director	03/01/2022	2021/22,2022/23	Outside Employment		Trustee of a charity which is a nil remuneration post.	Pharmacist Support (Charity)	0
Mohammed Hussain	Non-Executive Director	24/04/2023	2023/24	Hospitality		Offered a london marathon running place with lunch at the finish line	Tata consultancy services	20
Mohammed Hussain	Non-Executive Director	26/07/2023	2023/24	Outside Employment		Digital therapeutics lead for Viatris	Viatris	0
Raymond Smith	Consultant Anaesthetics	01/04/2017	2017/18	Clinical Private Practice	10/10/2018	Anaesthesia - General and Regional	Ray Smith Anaesthetic Services Ltd	0
Raymond Smith	Medical Director	10/10/2018	2018/19,2019/20,2020/21,2021/22,2022/23,2023/24	Clinical Private Practice		Anaesthesia - General and Regional	Ray Smith Anaesthetic Services Ltd	0
Raymond Smith	Medical Director	03/12/2019	2019/20,2020/21,2021/22,2022/23,2023/24	Clinical Private Practice		Anaesthetic services in line with my clinical work in the Trust	Ray Smith Anaesthetic Services Ltd	0
Raymond Smith	Medical Director	01/12/2019	2019/20,2020/21,2021/22,2022/23,2023/24	Clinical Private Practice		Anaesthetics within scope of normal clinical practice	Ray Smith Anaesthetic Services Ltd	0
Raymond Smith	Medical Director	16/03/2021	2020/21	No Change to existing declarations				0
Raymond Smith	Medical Director	28/02/2022	2021/22	No Change to existing declarations				0
Sajid Azeb	Chief Operating Officer	12/10/2020	2020/21	Loyalty Interests		Wife own optometry business which hold NHS England Contract	Optometry Business	0
Sajid Azeb	Chief Operating Officer	12/10/2020	2020/21	Loyalty Interests		Brother a GP and Primary Care Clinical Lead for Calderdale CCG	Calderdale CCG / Calderdale PCN	0

Sajid Azeb	Chief Operating Officer	12/10/2020	2020/21	Outside Employment		Family Property businesses	Directorship at Greenroyd Ltd and Skircoat Development Ltd	0
Sajid Azeb	Chief Operating Officer	12/10/2020	2020/21	Outside Employment		MBA Industry Advisory Board Chair	Bradford University	0
Sajid Azeb	Chief Operating Officer	31/03/2021	2020/21	No Change to existing declarations				0
Sajid Azeb	Chief Operating Officer	24/12/2021	2021/22	Gifts		90 vouchers to value of £25 each distributed via the command center for those people who were on shift on Christmas day on a first come first serve basis. The command center have taken down the name and department of everyone who received a voucher.	My Lahore Restaurant	2250
Sajid Azeb	Chief Operating Officer	15/04/2022	2022/23	Gifts		130 Iftar food packs were provided as part of Fasting Friday which were distributed to staff (Muslim and Non-Muslim) who were fasting and working at the time of breaking the fast on Friday 15th April. The food packs were provided by Bradford Foundation Trust with the catering by My Lahore. Value of fast packs unknown.	My Lahore	0
Sajid Azeb	Chief Operating Officer	16/05/2023	2023/24	Hospitality		Eid Milan Event - Invited and attending as part of BTHFT Charity representative	Yorkshire Cricket Club (Hilcrest)	25
Sughra Nazir	Non-Executive Director	02/02/2022	2021/22,2022/23	Outside Employment		Care Excellence Partnership Consultancy business supporting CQC regulated services	Care Excellence Partnership	0
Sughra Nazir	Non-Executive Director	02/02/2022	2021/22	Outside Employment	01/10/2023	associate with Social Care Institute of Excellence	Social Care Institute of Excellence	0
Sughra Nazir	Non-Executive Director	02/02/2022	2021/22,2022/23	Loyalty Interests		Parish councillor Sandy Lane Parish Council	Sandy Lane Parish Council	0
Sughra Nazir	Non-Executive Director	01/10/2023	2023/24	Outside Employment		associate with Social Care Institute of Excellence	Social Care Institute of Excellence	0

BOARD OF DIRECTORS OPEN MEETING MINUTES

Date:	Thursday 16 November 2023	**Time:**	10:30-14:30
Venue:	Meeting room, Listening for Life, BRI	**Chair:**	Helen Hirst, Interim Chair
Present:	**Non-Executive Directors:** - Helen Hirst (HH) - Julie Lawreniuk (JL) - Sughra Nazir (SN) - Jon Prashar (JP) - Barrie Senior (BS) - Karen Walker (KW) - Mohammed Hussain (MHu) - Louise Bryant (LB) **Executive Directors:** - Professor Mel Pickup, Chief Executive (MP) - Sajid Azeb, Chief Operating Officer & Deputy Chief Executive (SA) - Professor Karen Dawber, Chief Nurse (KD) - Dr Ray Smith, Chief Medical Officer (RS) - Dr Paul Rice, Chief Digital and Information Officer (PR) - Matthew Horner, Director of Finance (MH)		
In Attendance:	- Faeem Lal, Interim Director of Human Resources (FL) - Laura Parsons, Associate Director of Corporate Governance & Board Secretary (LP) - Sara Hollins, Director of Midwifery (SH) for item Bo.11.23.3 only - Judith Connor, Associate Director of Quality for items Bo.11.23.16 and Bo.11.23.17 only		
Observing:	- Katie Shepherd, Corporate Governance Manager - Andrew Hughes, Managing Director, ANHH Consulting - Dr Farzana Khan, Staff Governor - Tabitha Lawreniuk, Personal Business Manager as Secretariat		

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Section 1: Opening Matters		
	Chair's Opening Remarks HH welcomed all attendees to the meeting. She made the following statement regarding the former Chairman's resignation: "Welcome to today's board meeting in public. I am Helen Hirst and I have been appointed as the interim chair following the resignation of Max McLean until a substantive chair is appointed. I want to start with a few comments about what has happened since the last board meeting, what we have been advised to do next by	

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	NHS England and what my plans are for the next two to three months. As has now become public knowledge, the Trust commissioned an independent review into concerns raised by the previous Chairman and the Chief Executive. I have not seen this review, but I do have a copy of the action plan and we will be discussing this later. It is coming to our closed board meeting today for the Board to endorse the plan. The plan covers matters of policy and procedure, specific areas of concern re patient safety, staff welfare and staff illness, Board member appraisals and specific communication and relationship issues between the former chair and chief executive. Given the chair is no longer here it seems appropriate to make some of the specific points referred to in the plan into more generic action points. Once these amendments have been made the plan will be presented to our open board in January along with a response to the letter from Richard Barker which is in your pack of papers. The former chair has written to individuals within the trust making two specific points where he believes communications sent out by the Trust were incorrect. The first relates to a communication that said that the Chief Executive had not fallen short of the expected standards for the role. I have discussed this point with the Chief Executive and the Deputy Chair. They informed me that the review did find that both the former chair and the chief executive actions, in some specific areas, fell short of the standard expected. The review did not find that either fell short of the overarching the standards or principles for public life expected of those occupying the role of Chair and CEO - the Nolan principles. The communication could have been clearer in this regard. The second point challenged by the former chair is whether he resigned voluntarily or was asked to resign. It is my understanding from discussions with those involved that he was asked to resign. Moving onto the letter from Richard Barker, Regional Director for NHSE. The letter sets out five specific actions that are all in train. The letter also asks the board to confirm that it accepts the findings of the review and will learn the lessons. This takes me onto my next steps as interim chair. Yesterday I discussed the timeframe for commissioning an external well led review with the NHSE Regional Office. This will start in January. In the meantime, I have restarted the board development work that was started in February 2023 and Andrew Hughes is here today observing our board. He will feedback to us at our next board development session in December where we will agree a programme of board development for the coming year. I have also asked Andrew to undertake a similar piece of development with the council of governors. And I am meeting the governors in early December to scope this. This has been a difficult time for the trust and for individuals involved specifically Max and Mel, and I hope we are able to now move	

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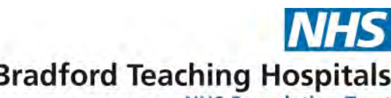

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	forward with clear plans for improvement and truly learn the lessons, so we respond much more quickly in the future if things go wrong. I cannot erase what's happened, but I do want to draw a line under it."	
Bo.11.23.1	**Apologies for Absence** Apologies were received as follows: - Altaf Sadique, Non-Executive Director (AS)	
Bo.11.23.2	**Declarations of Interest** No declarations of interest were noted.	
Bo.11.23.3	**Maternity and Neonatal Services Update** KD and SH introduced the maternity and neonatal services update, which included a focus on the discussion held at the Quality and Patient Safety Academy (QPSA) on 1st November and an update on delivery of the three-year plan for maternity and neonatal services. KD recognised that the Trust had been subject to a Rapid Quality Review led by NHS England and supported by the West Yorkshire Integrated Care Board. The Board was asked to consider if a task and finish group was required to review how to report on neonatal and maternity performance to provide maximum assurance. SH stated that the perinatal update papers were presented to both the September and October QPSA meetings, covering the August and September period respectively, which had approved the recommendations under delegated authority of the Trust Board. Details of harms including stillbirths, neonatal deaths and completed investigation reports included learning were shared with the closed Board papers for information. The main discussion points from the August and September report included the following key items: • The number of harms which were received and discussed. • One investigation had now completed. The SI reports that had closed in September were discussed including learning and progress on actions. • The PMRT quarterly report was presented, and it was noted that the department was on track to achieve this standard. • The maternity training compliance was presented and discussed. • The October QPSA meeting received an update on progress for the three-year plan and this would be discussed further during this update to Board. • A summary of maternal deaths in the last 3 years was shared and a wider system learning event was being developed focusing on maternal suicides. • The quarterly Board level report and implementation plan for Saving Babies Lives Care Bundle V3 was noted and it was anticipated that the Trust would be able to demonstrate 50%	

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	compliance in each element and 70% compliance overall across all six elements by the next QPSA meeting in December. SH also provided an update on the three-year plan, the purpose of which is to improve the safety and quality of maternal and neonatal services. A summary of the plan has been presented to the Executive Team Meeting and Board in May, including the risks associated with delivery. Compliance with the long-standing Maternity Incentive Scheme 10 safety actions will support delivery of the plan in many areas, but SH noted that there were a number of areas which will prove challenging and may require Board level support in the next 12 months. These challenges included the need to achieve UNICEF accreditation, which will involve a significant training input additional to the core competency framework requirements, the progression of further maternity continuity of carer teams when safe staffing is achieved and sustained, and the new Equality Lead role within the service covering implantation. There was also a potential challenge in the development of an in-house equality dashboard and improvement plan based on findings, and maternity neonatal voices partnership involvement in co-production of services. SH provided an overview of the maternal deaths in the 2020-2023 period, noting that there were 4 antenatal deaths, 1 of which was an inpatient at the time of death and 1 of which was an early pregnancy not yet booked in. 5 were postnatal deaths, 4 of which were suicides and all of which were discharged from maternity care at the time of death. In terms of ethnicity, of the 9 total deaths, 2 identified as white British, 2 black African, 2 south Asian and 3 eastern European. All had been reported to MBRRACE-UK, 4 were referred to HSIB, 4 were reviewed by BDCT as a serious incident, and 1 was reviewed by both BTHFT and BDCT as a serious incident. This increase in maternal suicide was noted, and SH advised that a number of these were currently subject to a domestic homicide review. It had been agreed to hold a system wide learning event and this was being developed to identify opportunities to better identify postnatal women at risk of suicide, particularly in cases where there has been removal of a baby or significant safeguarding concerns. LB and MHu confirmed receipt of this comprehensive suite of papers in the QPSA and confirmed that they were assured by the information contained within. Consideration was being made regarding the potential for a separate discussion outside of the usual Academy routine on maternity, recognising the level of scrutiny in this area. MHu noted further work is to be done around health inequalities but recognised that the presentation shared by SH did include recognition of this. MHu recognised the need to consider the maternity and neonatal services update alongside the nursing and midwifery staffing review, which are also linked with the risk on the high-level risk register regarding the lack of safe staffing in maternity. KD reflected that the	

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	maternity staffing risk has been on the register for a long time, and there is a national shortage of midwives. The safe staffing review focuses on red flags in maternity around 1:1 care in labour, administering of pain relief etc., and this is directly linked to the risk on the risk register. KD recognised that the maternity report could include reflection on risks as part of the information shared at each Board meeting to support the Board to triangulate the information being presented. KW thanked SH for the clarity of information shared with the Board. She noted that there were some innovative and creative ideas for developing the Equality Lead role but recognised the need for the entire population to be covered by this. JL recognised the numbers of maternal deaths and welcomed the planned event to identify opportunities to prevent these. She queried if there was anything for the Board to be concerned about in relation to harms. SH advised that the team continues to undertake thematic reviews of harms to identify if there are any trends. Whilst none have yet been identified, the reviews would continue to be undertaken. If themes were identified, focused work would be undertaken to support this. SH highlighted that the Trust is an outlier in hypoxic brain injuries and work was ongoing to investigate these to understand what could be done differently, particularly for those which were avoidable. JL also reflected on the Equality Lead role and the request for financial support, and whilst this felt like the right direction of travel, there would be a need to consider this against other financial priorities considering the challenges currently faced by the Trust. *Post-meeting clarification – The request was for 'support' and not a request for the Board to make funds available.* SN welcomed the implementation of the Equality Lead and the need to ensure that this is representative of the broader community. In terms of further information, she referred to the culture leadership programme being informed by a survey that had a response rate of 41%, and queried whether this low response rate was truly representative in terms of themes identified. SH advised that an external company was providing guidance for the analysis and so this was pending, however the initial feedback was reflective of the department. The maternity and neonatal department were encouraging staff involvement in the staff survey to aid in capturing more feedback. SN also referred to the number of women in pregnancy with gestational diabetes and queried if considerations were being made as to managing this differently. SH recognised the large cohort of women with gestational diabetes and advised that there was lots of activity in train to try to reduce this risk, including reaching out to women in the community instead of requiring attendance at the BRI, and to ensure that NICE guidance in relation to scanning regimes was being met. She also highlighted that this was one of the key	**Chief Nurse / Director of Midwifery**

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	workstreams within the outstanding maternity programmes and remains on the radar, but there were many complexities attached to it the subject and there was no easy quick fix. SN reflected on the recurrent issues with blood transfusion and queried how this was being improved. SH advised that this was a Trust-wide issue rather than being maternity specific, but from a maternity perspective, the team was looking to increase uptake in the 'train the trainer' approach to ensure that more maternity staff were able to deliver the training to colleagues. JP thanked SH for the transparency of the information shared and noted his assurance of the information received. JP queried whether mental health issues were to be considered as part of the review of the maternal suicides. SH confirmed that a number of these women had already been known to have mental health problems and it was believed that they had been transferred onto other system partners with clear knowledge of this. She recognised the high workload of the perinatal mental health midwife and the need for a more focused team on continuity of mental health once safe staffing levels are in place. JP also referred to the recent CQC announcement in relation to maternity and the impact this would likely have on staff confidence and morale. SH reflected that colleagues did receive recognition of the excellent work that they do in maternity, and this would need to be continually reinforced, notwithstanding the need for continued improvement within the department. MP thanked SH for her excellent presentation. She flagged the work alluded to on a multiagency basis in respect of the maternal deaths and advised of some changes she had been alerted to regarding the removal of babies into care, which had previously often been traumatic. A system wide meeting would be held on 4th December to reflect on whether there was a need to remove so many babies into care and this would provide an opportunity to help reduce these numbers. She also welcomed the concentrated efforts around inequalities, and the connection into the children and families workstream at place. SH confirmed representation at the 1001 days stream of the Act as One programme and noted the ongoing efforts of the system to improve equality at place. MH reflected on the need to draw together all financial asks and consider them in totality to agree which to prioritise and share the rationale for these decisions. HH referred to the original ask relating to the development of a task and finish group to focus on maternity and neonatal related issues, and it was agreed that this would be welcomed to ensure the QPSA could also focus on other equally important topics, as well as maternity and neonatal services. HH also recognised the need for a further discussion on the Board's overall strategy around equality and whether there is sufficient oversight of this.	**Associate Director of**

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	The Board: • confirmed it was assured that, as a committee of the Board with delegated authority, the QPSA had reviewed and discussed the contents of the August and September Maternity and Neonatal (Perinatal) Services Update Papers and had reviewed the Quarter 2 Perinatal Mortality Review Tool (PMRT) report including the learning required to demonstrate compliance with safety action 1 of the Maternity Incentive Scheme; • noted the information included within the closed Board papers describing the stillbirths, HIE and neonatal deaths occurring in August and September 2023 and both newly reported and ongoing investigations; • acknowledged that Appendix 4a (completed internal incident report including learning) was shared at the October QPSA meeting and is available for the attention of closed Board; • approved Appendix 5, the quarterly Board level report and implementation plan for Saving Babies' Lives Care Bundle Version 3, which has had external review from LMNS and ICB representatives. The Board noted it was anticipated that the Trust would be able to demonstrate 50% compliance in each element and 70% compliance overall across all 6 elements by the submission date; and • received and acknowledged the accompanying presentation including update on progress with delivery of the Three-Year Plan for Maternity and Neonatal Service.	**Corporate Governance and Board Secretary**
Section 2: Business From Previous Board Meeting		
Bo.11.23.4	**Minutes of the Meeting held on 21 September 2023** The minutes of the meeting held on 21 September 2023 were approved as a true and accurate record.	
Bo.11.23.5	**Matters Arising** The actions from the log were reviewed and the outcomes agreed have been recorded within the action log. **Correction to the minutes of the meeting held on 20 January 2022** HH advised that there was an error in the minutes of the meeting held on 20 January 2022 in relation to item Bo.1.22.12, Maternity Services Update. The Board approved the proposed amendment on page 2 of the minutes, as follows (amendments included in italics): *Two* of the deaths were due to the Klebsiella outbreak, *both* were very premature babies.	
Section 3: Business Reports		

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Bo.11.23.6	**Report from the Chief Executive** MP asked that the paper be taken as read but drew the Board's attention to the letter received on 8th November from NHS England with an ask to undertake a rapid two-week exercise to agree actions required to deliver the priorities for the remainder of the financial year following the announcement of funds being provided to offset the deficits as a result of industrial action. The Trust was asked to deliver a plan to meet the original activity plan submitted, which would then feed into an ICB and Regional level plan. The plan did require Board sign off, but it was unlikely that this would be available before the close of the Board meeting today and so would need to be signed off via delegated authority. The Board confirmed they were content for JL, MH, and MP to sign off the plan submission on behalf of the Board. MHu referred to reports in the media regarding the likely areas of capital expenditure reallocation and whether the Trust was aware how this would apply to the NHS. MP advised that there had been no indication yet as to what impact this would have on the NHS and so capital investments continue to proceed as planned until notification is given to do otherwise. MHu was also interested in understanding the implications of the ICB restructure and whether there would be an impact for the Trust in terms of colleagues providing additional support to maintain business alongside the reduction in staffing. MP confirmed that the ICB operating model consultation is still ongoing and is in its final phases to determine the future structure. The intent is to create an operating model that is deliverable and fit for purpose in order to not adversely affect colleagues in having to provide additional support. MHu referred to communications on the Gaza / Israel conflict which were welcomed, and reflected a desire for the Trust to communicate parameters and boundaries about expressing solidarity at this time rather than rectifying issues when these boundaries are crossed. MP advised that the Trust continues to regularly share update communications and ensure support is available for all colleagues in a neutral and non-judgemental way. The Board noted the report.	
Section 4: Delivery of the Trust's Clinical Strategy		
Bo.11.23.7	**Corporate Strategy** MP introduced the corporate strategy which included a 'plan on a page' document representing the organisational strategy, and which was being shared with Board for assurance on progress made against the strategy. The paper details the delivery of the strategy and reinforces the reporting that goes to each Academy to ensure cross referencing. She clarified that green in the RAG rating does not mean that this is	

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	complete, it means that progress is on track. She was pleased to advise that there were no red ratings in the logic model. HH recognised the need for strategy to feel like something that is directing and informing the work that the Trust does, and this did appear to be reflected in the items on the Board's agenda. BAS recognised that whilst the RAG rating was a good indicator of progress, it would be useful to understand what actions were being taken to move the amber ratings to green. It was agreed that a note would be shared with the Board detailing additional information on the approach to progressing the amber areas to green. JL requested that a key be added to the document, and it was confirmed that this would be included in future updates. KW reflected that the strategy is aligned to the place, and it was important and relevant to note this. MHu highlighted the need to consider how Board learning connects with the strategy around culture and the need to continually consider whether the values and culture are lived by the Board. KW recognised this can be influenced through Academies, and whilst the vision and overarching strategy will not change, the supporting actions can be influenced. FL advised that the Trust is taking part in the NHS cultural leadership programme and the importance of measuring the culture within the organisation not just in terms of what the Board perceives as culture. As part of that, there is a cross sector working group of staff in place and this will help inform steps forward in terms of a cultural piece across the organisation. The Board was assured by the update.	
Bo.11.23.8	**Digital Strategy Annual Report** PR introduced the paper which sought to update the Board regarding developments and outputs with respect to Digital, Data, Intelligence and Insight at the Trust and provided the following key highlights: • Historically the Trust has captured important data but has had challenges in rendering it back to the organisation. Improvements have been made to this, using 'making data count' principles and the triangulation of quality, performance, and HR elements. • A lot of EPR development work is underway, using the 'adopt and adapt' model which is creating opportunities for Bradford colleagues to reflect on their practice to see if anything can be improved. • The Virtual Royal Infirmary programme continues to progress well. • In terms of how the digital team intends to work differently going forwards, there would be a focus on CSU business objectives	

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	and supporting operational colleagues in their ambitions to deliver higher quality care. • The team had recently recruited a business manager with a strong background in HR to help support staff-health and wellbeing. MHu recognised that the migration to Microsoft 365 was successful, and the flexibility it gives the Trust to support staff was welcomed. He referred to a recent discussion at the QPSA which identified that the Trust was lacking in depth of coding and queried how this could be improved with the help of digital. PR confirmed that a focus programme of work was being undertaken to improve depth of coding. BAS advised that a progress report on the Command Centre has not been shared with the Board for some time and questioned when a further report would be available. PR and SA would provide an update and present to either an Academy or Board. HH also recognised visibility was needed via a high-level action plan to ensure oversight of the work ongoing to improve the depth of coding. PR would develop this and bring back to a future Board meeting. The Board was assured by the report.	**Chief Digital and Information Officer / Chief Operating Officer** **Chief Digital and Information Officer**
Section 4a: People		
Bo.11.23.9	**Report from the Chair of the People Academy – September and October 2023** KW introduced the report and highlighted the following key points: • The Academy reviewed the high-level risk in relation to access to a lone worker device for colleagues working in the community. • There was a robust discussion in relation to staffing, with improvements made to the onboarding process. • Registered Nurse turnover has reduced from 13.5% to 10.2% over the last 6 months and midwifery turnover is one of the lowest rates in the region. • The achievements of the Organisational Development team were celebrated following them being awarded the 'Team of the Year' at the HPMA Awards. • Negotiations have started in an attempt to end the consultant and junior doctor strikes with no further strikes planned. • The Academy discussed a new risk in relation to recruitment of staff given the recent adverse publicity and the impact on the reputation of the Trust. • There have been 25 concerns raised via FTSU in the last quarter, and all these are being reviewed and followed up as appropriate. • Two Health Care Support Workers in the Trust had been awarded the Chief Nurse of England award.	

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	• The Trust has relaunched the 'Thriving Together' programme and a steering group has been set up chaired by the CEO in relation to this. Updates will be provided via the People Academy and the Board. The Board was assured by the report.	
Bo.11.23.10	**Equality and Diversity Council Update** MP advised that there has not been a meeting of the EDC since the last Board meeting so there was nothing to report.	
Bo.11.23.11	**Nursing and Midwifery Staffing Review** KD advised that the nationally mandated staffing review has been discussed at several forums previously including the People Academy. She highlighted that the review is based on established posts, not actual numbers of staff in post. All nursing areas have been reviewed and the specific areas detailed in the paper were identified as increasing or decreasing in established posts. MP noted that this had already been subject to scrutiny at ETM where detailed context was provided to make appropriate challenge. MHu referred to the attached appendix in relation to maternity red flags and one of the highest scoring red flags being a delay in transfer to labour ward and queried how the staffing review supports improvement against this. KD advised that this particular issue is not supported by the staffing review as the delay in transfer to labour ward is often due to beds not being available due to high numbers of patients labouring rather than being a staffing issue. JL queried how we can be assured that the number of beds is appropriate, and SA advised that this is part of the planning process and reviewing the profile of demand historically. SN referred to an article in the local press this week regarding availability of beds and shortage of staff in the maternity unit which resulted in a woman giving birth at home. KD advised there is a current delay in inductions due to increased numbers of women presenting in labour, and this was impacting across the system not just within BTHFT. She noted that the normal practice is for women to be subject to a number of safety checks to ensure they are not sent home unless clinically safe to do so. The Board noted the paper and confirmed assurance of the process undertaken as part of the review in line with national recommendations. The Board supported the recommendation of the Chief Nurse for the 6 monthly strategic nurse staffing review and noted that where there is a change in service delivery the staffing implications will be presented as part of a business case from the CSU with Chief Nursing oversight of the recommendations related to nurse or midwifery staffing.	

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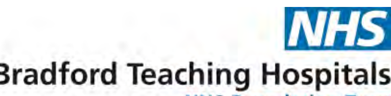

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Section 4b: Finance and Performance		
Bo.11.23.12	**Report from the Chair of the Finance and Performance Academy – September and October 2023** JL introduced the report and highlighted the following key points: • The Trust forecasts a deficit of £3.6m at year end (on the assumption that industrial action costs are funded), but there is a lot of work required to achieve this. • The Trust is under heightened financial scrutiny and therefore there has been an increased level of internal financial governance and governance. • A piece of work is being undertaken at Bradford place looking at programme budgeting and where there is potential to improve productivity and efficiency. • Consideration needs to be given to the balanced scorecard and ensuring waste reduction opportunities don't destabilise quality, safety and performance All Trusts are facing this challenge. • Elective performance is strong and waiting lists are good in comparison to other local trusts, but there is still a desire to improve further. • The opening of a younger person's frailty ward and an increased capacity for stroke rehabilitation will result in improved quality for patients. • The Academy was pleased to see the intermediate care review work happening at Place level which should impact on winter performance and was a good example of wider footprint working. The increase in place-based approaches to working was also welcomed. MH reinforced the heightened scrutiny that all Trusts are under, and the financial challenges faced. There would likely be further controls around specific areas of cost to ensure that the Trust is doing all it can to reduce the forecast financial deficit and deliver a breakeven position by year end. SA referred to the Delivering Operational Excellence Workshop held with CSUs to look at quality, patient experience and performance. Outputs were being pulled from the workshop which would form the improvement plan for the next 18 months to two years, and this would be brought back to the F&P Academy in either November or January. The Board was assured by the update.	
Bo.11.23.13	**Emergency Preparedness, Resilience and Response, and NHSE Core Standards** SA introduced the paper which provided an update on the organisation's position against the 2023 NHS England Emergency Preparedness, Resilience and Response (EPRR) core standards. He advised that annually, NHSE organisations are required to submit a	

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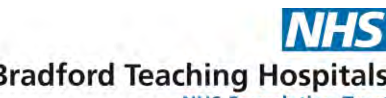

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	self-assessment against core standards and this year this would include evidence submissions as part of the assurance process. In line with the deadline of 29th September, the Trust completed its initial self-assessment against the 62 core standards and uploaded over 300 documents to the repository portal as part of the evidence requirement and stated its compliance level to be partially compliant. Feedback from the initial self-assessment was received on 24th October 2023 for the 62 standards after the check and challenge review process had been undertaken and supplementary evidence was then provided by the Trust resulting in a non-compliant rating of 32%. Currently there are 42 standards that are listed as partially compliant, and no standards listed as non-compliant. SA highlighted that a certain number of standards had to be rated as fully compliant to reach an overall 'partially compliant' rating, and as the Trust did not meet this, it has been rated as non-compliant. It was important to note that this did not mean the Trust was not able to respond adequately in an emergency, but that the evidence provided was not considered sufficient. SA highlighted that this low compliance has been seen across our region with Trusts either at the same compliance rating as BTHFT or scoring even lower (as low as 4%). Learning had been shared across WYAAT and to NHSE regional team. In addition to the self-assessment, the Trust is also required to submit an action plan to NHSE by 20th November. The action plan will require further work due to the short timescale from receipt as meetings need to be held with relevant internal and external stakeholders to pursue the actions, with indicative dates added. A more robust plan will be written going forward. The final documents require Board approval by 31st December detailing how full compliance will be achieved on the remaining partially compliant core standards. As there is no planned Board meeting in December, it was requested that sign off is provided by the Finance and Performance Academy via e-mail in December 2023. SA recognised that there has been plenty of opportunity to test the command-and-control structure and business continuity plans in place due to a number of incidents this year, including the industrial action periods, the severe weather disruption caused by snow in March, and the electrical outage. Learning exercises have been undertaken following each event. The EPRR team has increased by 100% with two WTEs now in place, but this may need increasing even further given the additional ask now in terms of providing evidence for EPRR standards. Any request for further staffing would be submitted via the planning committee. MHu queried as part of the learning from previous incidents what consideration has been made to EPR loss and recovery. SA confirmed that a full business continuity plan was in place in relation to EPR and this had been subject to an internal audit last year. There	

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No.	Agenda Item	Action
	are also regular EPRR 'tests' to ensure business continuity plans are effective. KW queried whether staff are sighted on this compliance declaration, and whether they understand that this is not a deterioration in the Trust performance but rather a re-baselining of numbers. SA advised that staff would know if they had the relevant training to chair a command-and-control situation if required but would not necessarily have knowledge of the scores and detail against each of the standards. MP recognised that this was also demoralising for Steve Amos, Emergency Planning Manager who had worked to get the Trust to a good EPRR standard and suddenly at a change of goalposts this had reduced in compliance. It was acknowledged that this was not a reflection on the performance of the EPRR team. The Board noted the significant work undertaken to provide the evidence portfolio to NHSE for the review and noted the resultant compliance. The Board also provided approval for the sign off for the submission to NHSE by 20th November and approved the delegation of authority to the Finance and Performance Academy via email for the final documents due by 31st December.	
Section 4c: Quality and Patient Safety		
Bo.11.23.14	**Report from the Chair of the Quality and Patient Safety Academy – September and October 2023** MHu introduced the report and highlighted the following key points: • The concern around the delay in responding to SIs within the target time was acknowledged and discussed. It was recognised that the learning and outcomes from these was much more important than the length of time taken to respond. It was felt that the move to PSIRF would help support learning further. • There remained an ongoing theme of communication difficulties and this could be a key factor for potential harm to patients and so there was need for the Board to consider opportunities to improve this. • The discussion on SHMI and subsequent report and presentation to Academy was excellent, and learning could be taken from this. • The November Academy was extended to ensure a focus on neonatal serious incidents, and as a result the Academy was as assured as they could be regarding these, but recognition given to the need to now pivot to learning and improvement. • There was a spike in children's deaths in the period 28/09/21 – 17/10/23 and investigations and clinical reviews into these will continue. LB reflected that the meeting in November was unusual given the extra time added to ensure sufficient focus on the neonatal serious incidents' discussion, and that the task and finish group to focus on maternity would be welcomed as it is taking up a large proportion of	

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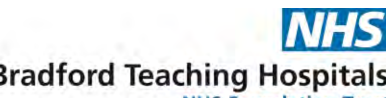

No.	Agenda Item	Action
	the Academy time and other important matters are not being considered sufficiently. RS reflected that despite the meeting in November overrunning, items were still considered sufficiently, for example the PSIRF item, due to colleagues recognising the importance of this. The fact that a member of staff felt that they could demand sufficient time given to their agenda item was reflective of the culture of the organisation. The Board was assured by the update.	
Bo.11.23.15	**Research Activity in the Trust** RS introduced the report which was taken as read and provided information on some of the key research activities in the Trust. RS advised that the report felt more informative than assurance based and sought Board consideration as to whether this was still required and if so, whether it should be noted for information rather than for assurance and how often it should be reported on. MH reflected that the research update was something that the Board collectively requested given that research is such a large part of the organisation. However, consideration should be made as to how this could be presented differently, such as the use of a research dashboard and what metrics should be included for the Board to understand. He would be keen to understand the value and benefit directly to patient care and have some visibility of the Improvement Academy to help bridge this gap. There could also be increased visibility of the smaller research at ward level. RS advised that the research dashboard is in development, and he had hoped it would be ready for now, but it was delayed slightly. In terms of the Improvement Academy, Mike McCooe, Associate Medical Director, would be happy to attend the Board and share updates on the improvements made for the community. In addition, Rebecca Lawton, Director of the Patient Safety Research Centre would be happy to present at Board. LB recognised there was prestige, motivation and value for staff being involved in research and the Board should be sighted on this, perhaps via the People Academy. However, it would be difficult to apply a quantitative metric against it. There should also be a financial benefit for the Trust in being involved in research, and LB queried whether this is optimised as much as it could be. It would also be good to see how the research undertaken in Bradford impacts on strategic priorities. HH agreed on the importance of ensuring that we consider the impact and opportunities on strategy and improvement works. KW referred to the stroke research which was presented at the Board previously and which was now visible in terms of manifestation of this into the stroke wards.	

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No.	Agenda Item	Action
	MP advised that there is a large number of research and innovation assets within the district and a piece of work called 'Research as One' to tie these assets together. It would be good to get business insight and intelligence into our contribution to this place level piece of work too in advance of the next report. The Board was assured by the update.	**Chief Medical Officer**
Bo.11.23.16	**Improvement Strategy** JC introduced the Trust's improvement strategy which had been shared with the Board for approval. This strategy sets out the Trust's ambitions over the next 5 years to embed the approach to Quality and Improvement and it was hoped that by taking an aligned and integrated approach to improvement delivery and building improvement capability across the organisation and the wider system, investing in people, and working with local communities, it will create a culture of safety, where people can freely speak about quality of care, value diversity, and embody compassionate leadership. JC advised that a number of teams, including transformation and organisational development had contributed to the development of the strategy. PR and RS shared their appreciation for JC and her colleagues for the work on developing this strategy and recognised the contribution of varied teams to develop this. JL welcomed the language used in the document which was comprehensive. KW recognised the need to embed this within the organisation with support from the organisational development team. JC confirmed that Cat Shutt, Head of Organisational Development was heavily involved with the strategy and would support embedding this. JC was also due to hold a session with the Clinical Service Units (CSUs) to bring improvement to life and get the work implemented at ground level. RS reflected that the engagement between the quality and improvement team and the CSUs is better than it has ever been. HH referred to the need to ensure that any improvement methodology is robust. JC confirmed they have adopted the Institute of Health Improvement's model for improvement as well as developing outstanding programmes using that methodology. The Board approved the Improvement Strategy.	
Bo.11.23.17	**Patient Safety Incident Response Framework (PSIRF) Plan** JC presented the PSIRF policy and plan, advising that this had been discussed previously with executive colleagues at ETM. Contractually, the Trust is obliged to transition to PSIRF this Autumn and so a new policy was developed to detail how incidents would be investigated under this framework. The plan had been developed in consultation with external stakeholders including Bradford Council.	

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	JC reminded the Board that PSIRF is a core element of the NHS Patient Safety Strategy. It will replace the current SI framework and represents a significant shift in the way the NHS responds to patient safety incidents, centring on compassion and involving those affected; system-based approaches to learning and improvement; considered and proportionate responses; and supportive oversight. JC commented that the main difference with the new PSIRF in comparison with the old incident framework is that the Board owns the oversight and outcomes of investigations rather than the healthcare partnership. It moves away from a criterion / investigative approach to a learning style approach, looking at how resources could be used more effectively and efficiently. There are two major priorities in the plan, one around mental health and supporting patients in the Trust with both physical and mental health needs, and the other on internal transfers. There is a third 'catch all' in the plan too for incidents such as a loss of power. RS recognised the challenge in the Board changing how they think about investigations and reports given it is such a steep change but welcomed the opportunity to embrace this and work better as a result. KW welcomed the introduction of the PSIRF framework and was struck by the quote 'we need to stop pulling people out of the river and go upstream to see why they are falling in' – she queried what work was ongoing to support this idea. She asked if there were opportunities for colleagues to input to this and create a bottom-up culture. JC noted there were opportunities to have these discussions and an external provider had been sourced to provide training at all levels across the organisation to enable this thought process. It was recognised that PSIRF went hand in hand with the improvement strategy. MHu hoped that PSIRF would help the Board better understand positive assurances and negative factors and any culture or other themes that they needed to be aware of. The Board approved the policy and plan, and the transition date of 1st December.	
Section 4d: Partnerships		
Bo.11.23.18	**Partnerships Dashboard** MP introduced the item noting that the Partnership Dashboard provides a single view of the partnership indicators aligned to the Trust's Strategic Objective. The Board is asked to review and challenge the elements of the Dashboard presented. MP opened for any questions. There were no questions or clarification required from colleagues. The Board was assured by the update.	

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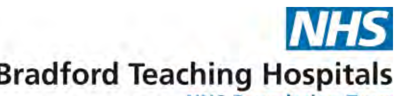

No.	Agenda Item	Action
Section 4e: Audit & Assurance		
Bo.11.23.19	**Report from the Chair of the Charitable Funds Committee – November 2023** JL presented the report and highlighted the following key points: • A neonatal appeal was underway to raise funds to develop a unit for families who are using neonatal services. • The aspiration of charitable funds team is to have a 25% rate of return on spending, discussion was held about how to achieve this including the need for big appeals to meet those targets and expansion of the charity team. There had been some minor changes made to the terms of reference and these were shared with the Board for approval. The Board was assured by the update and approved the updated terms of reference.	
Bo.11.23.20	**Board Assurance Framework (BAF) and High-Level Risks** LP introduced the BAF and advised that there have been no changes to the risk scores since this was last presented at the Board meeting. She also advised that this had been reviewed at ETM and alluded to a discussion held about whether to add a new risk in relation to well-led in the overall governance of the organisation. At both the People and Finance & Performance Academies, it was suggested that consideration be given to the potential impact of recent adverse publicity on staff recruitment (BAF risk 3.1). This will be considered with the Interim Director of HR when the BAF is next reviewed. LP also provided an overview of high-level risks noting that there was one risk past its mitigation date that has since been closed (3880) in relation to the increasing cost of gas and power which has now been reflected in budgets and contracts. This would be reflected in the next report to the Board. There were four new risks added to the high-level risk register and one risk reduced in score which were all detailed in the paper. BAS referred to the rescheduling of mitigated target dates and queried whether it was acceptable for the target date to be deferred numerous times. MP recognised this was a fair challenge and that in some instances, such as staff shortages, the target is reached but then the goalposts have shifted and so it remains a risk to the organisation and stays on the risk register for considerable time. However, the Board does need to challenge itself on risks such as in relation to a specific function where the mitigations should be complete. KD suggested that it be made routine practice to review the overarching risk assessment upon changing a risk target mitigation date.	**Associate Director of Corporate**

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No.	Agenda Item	Action
	In additional, further consideration could be made to the presentation of the risks to assure Board that progress is being made on risks even if the target date is deferred. MHu suggested that the target level for risks and the steps being taken to reach this should be included as part of the main cover paper rather than within appendices for clarity on this. LP would make these changes in future editions of the report. The Board was assured that all risks on the HLRR and BAF were appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled.	**Governance and Board Secretary**
Section 5: Governance		
Bo.11.23.21	**Communications – Annual Update** SA introduced the paper which detailed the business of the communications team. It included an overview of the areas most accessed via the Intranet and the website, detailed the positive coverage in the media including the recognition of the Yorkshire Midwives on Call programme and the Baggins the Bear charity initiative which was shared on Look North and results in a substantive donation from a Charity Partner to support this further. SA recognised that there were also other digital channels such as social media platforms that has resulted in engagement opportunities, and the communications team have collaborated with colleagues to share Thrive activities such as the Conference and recent events including the Filipino Celebration. KW commented that previously she has been of the view that BTHFT has been modest in terms of its communications and welcomed the change in approach. She also acknowledged the considerable number of Freedom of Information and media enquiries received. She highlighted that BTHFT is fifth on the list for website hits on vacancies so recent media coverage of the events in the Trust does not seem to have impacted negatively on recruitment. The Board noted the update.	
Bo.11.23.22	**Membership Plan – 6 Monthly Update** LP introduced the paper which had been shared with the Board for information. There were two areas being focused on in terms of membership which is Keighley constituents and members aged between 16-22 as these categories are currently underrepresented. This focused work has led to the recruitment of 13 new younger members so far, but as yet there were no further new memberships from Keighley constituents. There will shortly be an election however for a new Keighley Governor and on the back of the promotional material circulated new members will be sought.	

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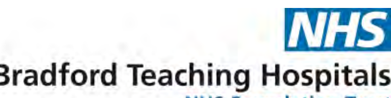

No.	Agenda Item	Action
	HH sought Board approval to transfer responsibility of the member ship plan to the Council of Governors with support provided from the Board as and when required. The Board noted the update and confirmed approval for the transfer of responsibility for this to the Council of Governors.	
Bo.11.23.23	**Non-Executive Director Champion Roles – Annual Review** HH recognised that NED appraisals had not yet taken place in 2023 and suggested that the review of NED champion roles be considered as part of the appraisal process. She hoped to conduct all NED appraisals in January 2024. The Board approved this approach.	
Bo.11.23.24	**Board Work Plan – 2024/25** LP introduced the 2024/25 workplan for Board approval. She recognised there would be changes to this following the effectiveness work and this would continue to be a live document that would be updated and brought back to Board as appropriate. The workplan was approved by the Board.	
Section 6: Board Meeting Outcomes		
Bo.11.23.25	**Any Other Business** No other business was discussed.	
Bo.11.23.26	**Issues to Refer to Board Committees/Academies or Elsewhere** There were no issues to refer to the Committees/Academies or elsewhere.	
Bo.11.23.27	**Review of Meeting** HH recognised that the meeting had overrun but it was felt that full consideration was given to the set agenda with appropriate and fair challenges made. JP noted that the earlier discussion on Board Development and working together was helpful and reflected within the Board meeting. However, he recognised the need to rebuild trust between the Board and staff colleagues, some of whom were now sceptical and distrusting of the Board. SN suggested that the BAF could be reviewed at the start of the agenda as more consideration and reflection might be given if it is at the start rather than at the end.	

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No.	Agenda Item	Action
Bo.11.23.28	**Date and Time of Next Meeting** 18th January 2024, 9:30am	

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ACTIONS FROM BOARD OF DIRECTORS OPEN MEETING – 16 November 2023

Action ID	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
Bo23002	Bo.3.23.3	**Patient Story:** KD proposed that a briefing session is organised for Governors and Non-Executive colleagues in relation to communication with patients and how to improve this for the benefit of all patients.	Associate Director of Corporate Governance and Board Secretary	January 2024	Date to be arranged. Added to the Council of Governors meeting agenda (6 February 2024). Action closed.
Bo23003	Bo.3.23.10	**Health Inequalities & Waiting List Analysis:** KD endorsed the work that has been undertaken and suggested an expansion of this to look at other areas. It was agreed to add this as a discussion point for a future board development session.	Associate Director of Corporate Governance and Board Secretary	January 2024	Added to Board Development planner – date to be confirmed. Action closed.
Bo23010	Bo.11.23.3	**Maternity and Neonatal Services Update:** There would be a need for a further Board discussion on the overall strategy around Equality.	Associate Director of Corporate Governance and Board Secretary	January 2024	On the Board workplan for March 2024. Action closed.
Bo23011	Bo.11.23.3	**Maternity and Neonatal Services Update:** KD recognised that the maternity report could include reflection on risks as part of the information shared at each Board meeting to help further link these together.	Chief Nurse / Director of Midwifery	January 2024	To be addressed under agenda item Bo.1.24.10 on the agenda. Action closed.
Bo23012	Bo.11.23.8	**Digital Strategy Annual Report:** PR and SA would provide an update on the Command Centre progress and bring back through either an Academy or Board.	Chief Digital and Information Officer / Chief Operating Officer	January 2024	
Bo23014	Bo.11.23.15	**Research Activity in the Trust:** MP advised that there is a large number of research and innovation assets within the district and a piece of work called 'Research as One' to tie these assets together. It would be good to get business insight and intelligence into our contribution to this place level piece of work too in advance of the next report.	Chief Medical Officer	January 2024	See briefing note at Appendix 1. Action closed.

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Action ID	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
Bo23015	Bo.11.23.20	**Board Assurance Framework and High-Level Risks:** It was suggested that the target level for risks and the steps being taken to reach this should be included as part of the main cover paper rather than included as part of the main cover paper rather than within appendices for clarity on this. LP would make these changes in future editions of the report.	Associate Director of Corporate Governance and Board Secretary	January 2024	Target risk scores have been added to the cover paper. Action closed.
Bo23013	Bo.11.23.8	**Digital Strategy Annual Report:** PR to develop a high-level action plan to ensure oversight of the work ongoing to improve depth of coding and bring this to a future Board meeting.	Chief Digital and Information Officer	March 2024	
Bo23008	Bo.9.23.7	**Report from the Chief Executive – Sexual Safety Charter:** KD agreed to provide an informal update at a Board Development Session in approximately six months to share the progress as well as the findings that are emerging both locally and nationally as well as the definitions of what would be classed as sexual harassment	Chief Nurse	March 2024	
Bo23016					

Appendix 1 – Briefing in relation to Action ID Bo23014

'Research as One' was the City of Research and was rebranded to fit in line with 'Act as One'. City of Research was also felt to exclude Airedale which we were keen to avoid. The 'Research as One' work is led by the research leads from around Bradford and Airedale (primary care, acute hospitals, council, University of Bradford, Ambulance Trust, Bradford District Care Trust and Y&H Network) and is focused on four areas which aims to make research more accessible, less bureaucratic, collaborative, synergistic and improve research staffing and training. The four areas that we are focusing on are : Development, Governance, Research Delivery & Dissemination. We have representation on the Priorities and Enablers meeting of the Health Care Partnership meeting too. As a Trust we are very much involved in this piece of work; It's a continuation of the collaboration we have been doing as research organisations for the last 15 years and aligning it with the ICS structures.

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BO.1.23.4 - MATTERS ARISING

BO.1.24.5 - REPORT FROM THE INTERIM CHAIR

REFERENCES

Only PDFs are attached

Bo.1.24.5 - Report from the Interim Chair.pdf

Bo.1.24.5 - Appendix 1 - QIG Update letter.pdf

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.5

Report from the Interim Chair

Presented by	Helen Hirst, Interim Chair	
Author	Jacqui Maurice, Head of Corporate Governance	
Lead Director	Helen Hirst, Interim Chair	
Purpose of the paper	To provide an update on activity and engagement involving the Council of Governors and Membership since the previous written report provided to the Board in September 2023 and verbal report provided in November 2023.	
Key control	N/A	
Action required	For Information	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Committee/Group**	**Date**

Situation

1. Council of Governors meeting held 9 November 2023

I am pleased to advise that I chaired my first Council of Governors meeting on 9 November 2023. The meeting was held via 'ms teams' and the link to the meeting and the annotated agenda is available here.

Key items considered by the Council at their open meeting included:

- A summary of the discussion that took place at the Governor and NED pre-meeting held earlier in the day.
- CEO Report covering key activity since the last report covering our Patients, People, Partners and Place.
- A focus on the recent discussions held between Governors and the Interim Chair in relation to the former Chair's resignation and the next steps.
- Disciplinary Policy briefing provided by the Interim Director of HR
- An update on Bradford Hospitals Charity from the Charity Director
- The work of the Governors Nominations & Remuneration Committee (NRC)
- The Annual Report from Deloitte, the External Auditor for 2022/23

Summary of the key items and outcomes considered by the Council at extraordinary meetings and at the closed meeting.

New Non-Executive Director (NED) appointments: I am very pleased to advise that two new NED appointments were approved by the Council on 23 October. These are to replace Jon Prashar and Barrie Senior (Chair of the Audit Committee) whose second terms will complete at the end of January 2024. We anticipate that all the necessary checks being undertaken in relation to the 'Fit and Proper Persons' requirements will shortly be complete, and our new Non-Executive Directors will be in place as full members of the Board by 1 February 2024.

Chair Appointment process: The Council approved the recommendation from the Governors Nominations and Remuneration Committee (NRC) to undertake a search for the appointment of a new Chair which will be undertaken in line with the 'appointment process' approved by the Council in July 2023.

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.5

Since the Council meeting in November the Governors NRC has confirmed the Chair job role and person specification and has worked with GatenbySanderson, Executive Search Agency, with the support of the Foundation Trust, to identify suitable candidates for the role. The deadline for receipt of applications was 5 January and the longlisting took place with the Governors NRC on 9 January. Shortlisting is expected to take place on 19 January by which time the NRC is also expected to confirm the membership of two stakeholder panels and the Chair selection panel. The Board is asked to note that in line with the Code of Governance for NHS Provider Trusts the selection panel will include an external assessor from NHS England (confirmed as Regional Director, Richard Barker) and Cathy Elliott, Chair of the NHS West Yorkshire Integrated Care Board. The selection panel will meet on 2 February 2024 following which the Governors NRC will receive the recommendation from the selection panel on 5 February, and then provide their recommendation for approval to the Council of Governors on 6 February 2024.

2. Our thanks to Barrie Senior and Jon Prashar, Non-Executive Directors (NEDs)

Our outgoing NEDs, Jon Prashar and Barrie Senior, have each served two terms of three years.

I would like to thank Jon for his contributions, in particular, as Maternity Board Safety Champion and Wellbeing Guardian, and his support with the Trust's work on equality, diversity and inclusion.

My thanks also to Barrie Senior who has directed and overseen significant changes to our Audit Committee over the past six years which serves the Board well in providing an independent and objective view of internal controls to the Board of Directors and the Accountable Officer.

On behalf of the Board and our Council I would like to extend our sincere thanks and appreciation for Jon and Barrie's contributions to our organisation and wish them both well for the future.

3. Our next Council meeting – rescheduled date

The date for our next Council meeting has been rescheduled. The meeting will now take place on Tuesday 6 February 2024, 3.30pm to 5.30pm and will be held in-person at Carlisle Business Centre, 60 Carlisle Rd, Manningham, Bradford BD8 8BD.

4. Annual Members Meeting / Annual General Meeting

Our Annual Members Meeting/Annual General Meeting took place on Wednesday 15 November 2023. Detailed information, including the programme, is available online here.

We also delivered a showcase event taking prior to the AGM/AMM and our special guest speaker provided the keynote presentation following the AGM/AMM which focussed on progress made regarding the Trust's Virtual Royal Infirmary programme. A virtual ward is a 'ward without walls', where a patient's treatment and care can begin and end in their own home with the support of a multi-discipline clinical team every step of the way. A special page has been created on the Trust's website here where you can see the recording of the event, and access all related documents including the Governor's 'Your Guide to our Year' 2022/23.

5. Elections to the Council of Governors

Our next elections process will launch on Friday, 9 February 2024. Further information will be shared shortly across the Trust and with our members and the public. Governors and Board members will be asked to support our elections campaign and share information amongst their networks. We will be seeking nominations for the following public seats:

- Bradford South
- Bradford West
- Bradford East
- Keighley
- ‘Rest of England and Wales’ (for those members who live outside of the Bradford District area)
- Patient - (for those who have been treated at our Trust but who live outside of the Bradford District areas)

If Board members know of anyone who may be interested then please do encourage them to get in touch through our membership office via membership@bthft.nhs.uk or they can visit our membership pages here for comprehensive information regarding our elections.

6. Communications with members

Our members have continued to be in receipt of ‘Mel’s monthly roundups’ featuring news from across the trust. Now also included are other elements of news relevant for sharing with our members. The latest edition is available here.

7. Key Trust Communications

Key communications continue to be shared with Governors so that they remain in touch with developments at our Trust. Governors also continue to have access to Let’s Talk (staff newsletter) and global emails containing a range of updates to staff.

8. Letter from NHS England – Quality Improvement Group

At the last Board meeting, the Chief Nurse advised that the Rapid Quality Review process had transitioned to a Quality Improvement Group (QIG). The first QIG meeting was held on 20 December 2023 and a letter providing an update on the discussions was received from Margaret Kitching, Regional Chief Nurse at NHS England. The letter is attached for reference at Appendix 1.

Recommendation

The Board is asked to note this report.

Margaret Kitching
Regional Chief Nurse,
North East and Yorkshire,
NHS England

Email: Margaret.kitching@nhs.net

Helen Hirst
Interim Chair
Bradford Teaching Hospital NHS FT

Sent by email

22 December 2023

Dear Helen,

Quality Improvement Group – Bradford Teaching Hospital NHS FT

I'm writing to update you on discussions at the Bradford Teaching Hospital Quality Improvement Board held on 20 December 2023.

The group received very positive assurances following the commissioner visit to neonatal services. They heard how the visit was appreciated by staff who were pleased to have the opportunity to showcase their work and the opportunity for staff and families to share their experiences.

The group noted the plan to postpone the Well Led Review to Q4 to coincide with the new Chair's appointment and were in support of that approach.

The ongoing work on the action plan was positively received and the Trusts response and actions to date are addressing the initial concerns raised. It was proposed that you and Professor Pickup may like to attend a future meeting to fully articulate the Trusts work and progress in that area. The next meeting is scheduled for 26 January 2024, 10.00am – 12.00noon via Microsoft Teams, and the agenda can be flexible to accommodate your existing commitments.

Based on the draft reports and updates provided, the Quality Improvement Group were significantly assured as to the quality of care, clinical governance and good practice demonstrated by the Trust.

If you would like to discuss further detail, please don't hesitate to get in touch with Julie Clennell, Regional Director of Nursing.

Yours sincerely,

Margaret Kitching
Regional Chief Nurse, North East and Yorkshire
NHS England

Copy to:
Professor Mel Pickup, Chief Executive Officer, Bradford Teaching Hospital NHS FT
Richard Barker, Regional Director, North East and Yorkshire, NHS England
Julie Clennell, Director of Nursing – Clinical Quality, North East and Yorkshire, NHS England
Yvette Oade, Regional Medical Director, North East and Yorkshire, NHS England
Rob Webster, Chief Executive, West Yorkshire Integrated Care Board

BO.1.24.6 - REPORT FROM THE CHIEF EXECUTIVE

REFERENCES

Only PDFs are attached

- Bo.1.24.6 - Report from the Chief Executive.pdf
- Bo.1.24.6 - Appendix 1 - Update on planning for 2024_25.pdf
- Bo.1.24.6 - Appendix 2 - NHSE Letter 8 November 2023.pdf
- Bo.1.24.6 - Appendix 3 - 05.12.23 Rapid Reset of Organisational and Financial Plans.pdf
- Bo.1.24.6 - Appendix 4 - Letter NHSE Statement on Health Inequalities.pdf
- Bo.1.24.6 - Appendix 5 - LeDeR-2022-takeaways.pdf

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.6

Report from the Chief Executive

Presented by	Professor Mel Pickup, Chief Executive	
Authors	Katie Shepherd, Corporate Governance Manager	
Lead Director	Professor Mel Pickup, Chief Executive	
Purpose of the paper	The report provides the Board with a summary position with regard to our Patients, People, Place and Partners since the last report to the Board in November 2023.	
Key control	N/A	
Action required	To note	
Previously discussed at/ informed by	N/A	
Previously approved at:	Committee/Group	Date

Situation

1. Patients

- **Operational Update**

Industrial Action

As at the end of December 2023 the Trust has responded to the following periods of Industrial Action (IA):

Union	Dates	Duration
RCN	20 & 21 Dec 2022	24 hours
RCN	6 & 7 Feb 2023	24 hours
BMA JD	13 – 17 March 2023	72 hours
RCN	30 April – 1 May 2023	28 hours
BMA JD	11 – 15 May 2023	96 hours
BMA JD	14 – 17 June 2023	72 hours
BMA JD	13 – 18 July 2023	120 hours
BMA Consultants	20- 22 July 2023	48 hours
BMA JD	11- 15 August 2023	96 hours
BMA Consultants	24-26 August 2023	48 hours
BMA Consultants	19-20 September 2023	48 hours
BMA JD	20-22 September 2023	72 hours
BMA Consultants	2-5 October 2023	72 hours
BMA JD	2-5 October 2023	72 hours
BMA JD	20-23 December 2023	72 hours

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IA continues to impact on elective activity leading to a required reduction in elective surgery and a reduction in outpatients in order to allow sufficient cover to maintain cover for acute services during the affected days.

The loss of activity associated with the December Junior Doctor (JD) Strike is demonstrated below:

- Outpatients 648 cancelled (20.5%)
- Cancer 39 cancelled (10%)
- Inpatients 49 cancelled (52%)
- Daycases 77 cancelled (54%)

A further period of JD IA is taking place from January 3rd and 9th. Our clinical and operational team have prioritised the clinically urgent patients given the significant non-elective demand expected during this period of the industrial action.

Planning Guidance 2024/25

We are currently awaiting the release of the operational and financial planning priorities from NHS England for 2024/25. We would ordinarily have received the key priorities prior to the Christmas break to meet the tight timescales enabling local delivery plans to be developed agreed and signed off at a Trust, Place and Integrated Care System (ICS) level. An update was provided by NHSE on 22 December; see the letter attached at Appendix 1. Given the impact of the Industrial Action and the ongoing discussions between NHS England and Government the 2024/25 priorities and planning guidance has not yet been released, however is expected imminently. In the absence of this planning guidance we continue to develop our operational, finance and workforce plans based on the information already available to us. We remain committed to further progressing the good work we have undertaken across Urgent & Emergency Care (UEC), Elective (Referral to treatment waiting times and Cancer) and Diagnostic services and plans are being formulated to achieve the key milestones as outlined within previously issued national guidance. We will continue work up our response for the achievement of a balanced financial plan and this work will be refined once the latest national guidance is issued. 2024/25 will be a very difficult year, which will likely impact on the priorities we set ourselves and the decisions we make. Achieving the indicative targets across our balanced scorecard will be a significant ask and will require a stepped change in our coordinated efforts to deliver them and potentially our risk appetite when impact assessing proposals. As the plans evolve we will present updates to future Academy meetings / Board meetings.

In November I referred to a communication received from NHS England asking systems to complete a rapid two-week exercise to agree actions required to deliver the priorities for the remainder of the 23/24 financial year (see Appendix 2). A subsequent letter received from Rob Webster, Chief Executive of West Yorkshire ICB regarding the rapid reset of operational and financial Plans is attached at Appendix 3.

- **Performance**

BTHFT continues to benchmark positively against the Emergency Care Standard at a WYAAT, Regional and National level. Considerable progress has been made to expedite care for patients with conditions that do not require admission treated via our Urgent Care Centre and Ambulatory Emergency Care Unit. Unfortunately, some patients do end up having an extended length of stay in the Emergency Department (ED) whilst awaiting a bed.

In terms of demand for beds, average daily attendances to the department are slightly above previous year but in line with growth we anticipated in our modelling however our rates of admission have increased. To improve this situation and explore options to provide the most appropriate care for our patients, ED consultants are now reviewing all potential admissions, medical and surgical consultants are reaching into ED, and we continue to utilise our Virtual and Community Services.

In advance of winter pressure, we have increased overall bed capacity by opening a Stroke Rehabilitation ward but unfortunately the impact of this positive step has been reduced by an increase in patients waiting to be discharged to either a care setting or to their own home with a care package. Our multi-disciplinary approach to discharge is minimising the impact and we are working with social care partners to find a longer-term solution to this issue. Some of this increase we believe is linked to the changes made by the Local Authority to the Intermediate Care Bed (IMC) bed base and the provision of Package of Care (POC) provision. We continue to engage at system level to address this issue.

Having performed strongly with respect to timely ambulance handover and expanded our ambulance assessment in preparation for winter our performance has taken a step back with a change in the YAS ambulance process with the handover clock starting earlier based on GPS and a drift in compliance with the electronic sign out that concludes the process. YAS are supporting recovery with a Hospital Ambulance Liaison Officer (HALO) coordinating YAS crews within the ED.

Work to reduce elective waiting times has continued but industrial action means we are now slightly behind the trajectories set in our annual plan. This is a position shared by all acute Trusts and we continue to benchmark well despite the challenges. We remain hopeful that a position of no patients waiting longer than 65 weeks by the end of March 2024 can still be achieved with robust plans to treat outstanding patients and work with Independent Sector colleagues to transfer some patients to bring their date for surgery forward. However, there is the potential that our progress could falter with continued IA during January. The full impact of this is not know at the time of writing this report.

Suspected cancer referrals remain significantly higher than previous years and increased further over summer, specifically for Skin cancer. Diagnostic turnaround times for imaging and histopathology increased during this same period leading to a deterioration in our cancer performance but we have made inroads that have stabilised and now recovered our position. Demand is starting to reduce and the continued commitment to prioritising outpatient and theatre capacity for cancer pathways will help recover the position. The Trust benchmarks well for cancer performance and is focussed on further pathway improvements, working with system partners on earlier diagnosis and implementing optimal

pathways when cancer is suspected. Further funding from the Cancer Alliance will allow us to add weekend theatre capacity to treat additional patients in Q4.

- **St Luke's Day Case Unit (SLH DCU)**

The development of SLH DCU is progressing well, with the target for opening in mid-April 2024. The facility will provide much needed ringfenced capacity for our day case patients.

The Clinical Pathways and Workforce groups are progressing procurement of equipment and recruitment of colleagues for the Go Live.

The programme is being managed through a dedicated Programme Board chaired by Sajid Azeb, Chief Operating Officer & Deputy Chief Executive reporting into the Capital Strategy Group.

- **Endoscopy Unit (BRI)**

The Trust was successful in securing £24.8m capital funding for a new 8 room Endoscopy unit. A Programme Board has been established chaired by Sajid Azeb and responsible for coordinating the work to ensure delivery of the scheme which is due to complete in 2025.

Work to select a principal contractor has progressed and Robertsons have been awarded the contract to help develop the design to the next stage of completeness and establish the site mobilisation plan. Enabling works are progressing at the current time and will involve the relocation of the green portacabins currently occupying part of the area identified for development. This will involve the relocation of a number of staff from this area to another location on the Trust premises.

2. People

- **NHS Staff Survey 2023**

The NHS Staff Survey was undertaken between Wednesday 20th September 2023 and Friday 24th November 2023. The overall response rate for the survey was 43% which is an increase of 6% on the 2022 staff survey. The results will be release in early March with results being embargoed prior to their release. This year we have worked with our survey provider to ensure we can have more detailed breakdown of the results and any team with 10 or more staff will get an individual report for their team. This will allow for teams to look at how staff feel within their service specifically and take learning to improve staff experience that is bespoke for their teams.

- **Industrial Action**

Junior Doctor strike action took place from Wednesday 20 December until Saturday 23 December 2023, this action preceded the weekend before Christmas with the strike action finishing on Saturday before the Christmas bank holiday. This therefore meant the impact of the action spanned a significant period and at a time when staffing levels are reduced due to leave over the festive period. Strike action

also took place from Wednesday 3 January 2024 to 9 January 2024, this was the longest single period of action so far. Staff across the organisation have worked hard to ensure patient safety is maintained and we are thankful to our colleagues who have and continue to work relentlessly to ensure we are able to keep our patients safe during periods of industrial action.

- **Acts of Kindness**

The Executive team thanked staff by going out across the organisation and selecting staff at random to thank them for their hard work. Executive colleagues gave out thank you cards and vouchers to staff as recognition for the hard work and effort of colleagues across the organisation.

3. Place

- **New Secretary of State for Health**

The Rt Hon Victoria Atkins MP was appointed as the Secretary of State for Health following the government reshuffle in November. The reshuffle also includes changes to the wider ministerial team at the Department for Health and Social Care, with Andrew Stephenson and Andrea Leadsom replacing Will Quince and Neil O'Brien. This briefing from NHS Providers provides more details including biographies for ministers and a wider list of all Cabinet ministers.

- **Closing the Gap: meeting our financial challenge**

Our Bradford District and Craven Health and Care Partnership is committed to working in a collaborative way to respond to the extreme financial challenges that face all of us. To meet these challenges head on, we are in the process of setting up a project group and programme. This programme of work is called Closing the Gap.

As a health and care system with responsibility for making the best use of our collective resource, our integrated care system for West Yorkshire has been advised by NHS England that we must look for all savings to cover the expected financial gap. As a result, our integrated care system has asked that we, in Bradford District and Craven, must find approximately £5-6 million of additional savings across our NHS partners during the remainder of this current financial year – and then we will need to continue to look for very significant savings for April 2024 and beyond.

This is to close the gap we currently have between the budget available and our current expected spending across all sectors. Please see our full briefing paper that introduces the Closing the Gap programme.

- **Bradford Council's finance position**

On Thursday 21 December, Bradford Council's Executive was informed about the scale of the financial challenges facing the local authority. The Council is requesting Exceptional Financial Support in order to balance the budget and without this support a Section 114 notice will have to be issued. In early

January, the council published its financial position ahead of a budget consultation that's taking place until mid-February. **At the time of writing the link to the consultation was not available however we will share this with board members and more widely.** This will help determine the next steps that need to be taken.

As partnership we know that the financial challenge for the council, alongside our wider Closing the Gap work described above, will have an impact on local people and communities as well as our workforce. We recognise that to address these issues we have to work closely together, while accepting that we will be faced with difficult decisions to make to achieve a level of financial balance. We will continue to provide updates to help our communities and our colleagues understand what action is being taken.

- **Connected on Ability - inspire and enable festival**

Our partnership remains committed to learning from the lived experience of communities and colleagues to create inclusive and welcoming workplaces and services. Our second Connected on Ability Festival, co-designed by colleagues from across our partnership with lived experience of disabilities, took place from 4-8 December. This gave people an opportunity to learn more about the challenges, opportunities and new ideas that can help us ensure we can make the changes needed to help current and future colleagues. Recordings from this year's events as well as those from last year can be accessed from our website.

- **Inclusive language guide**

Sticking with the theme of creating an inclusive experience for everyone across our partnership, a small number of colleagues have come together to develop our first inclusive language guide. The guide is for everyone however it is primarily focused at people working within communications and involvement to ensure the language, words and information we produce includes rather than excludes people. The guide will be reviewed twice a year to ensure we continue to develop it to reflect changes in language and terminology as well as introducing new content. Please do download the guide and share any feedback.

- **Deputy Chief Medical Officer visits Bradford**

Janelle De Gruchy, the Deputy Chief Medical Officer for England, visited Bradford to find out more about Living Well our whole systems approach to tackle obesity and improve wider wellbeing of local people. Janelle visited Jude's Urban Kitchen to learn more about a community-based scheme to tackle food insecurity, before finding out about a scheme at Girlington Primary School and then calling it at Bradford Royal Infirmary to hear more about how some of the Living Well work on healthy lifestyles is supporting patients pre and post treatment.

4. Partners

- **West Yorkshire Integrated Care Board (WY ICB), 21st November 2023 and 16th January 2024**

I attended the WY ICB meeting on 21st November 2023, where we ratified the changes made under the urgent decision process to the terms of reference for the WY ICB Finance Investment and Performance Committee, Quality Committee, Transformation Committee and Remuneration and Nomination Committee. There was a focussed discussion on Primary Care, with a further update to be provided at the meeting in March 2024. We received the usual reports, had an update on Winter Planning for 2023/24 and received the annual assurance of EPRR core standards.

The next meeting of the WY ICB is planned for 16th January 2024 which post-dates this report, where we will hear an update from each Place on the progress against their winter plans and receive the integrated performance report, including financial performance.

- **WYAAT Programme Executive, 5th December 2023 and 9th January 2024**

I attended the WYAAT Programme Executive on 5th December 2023 where we agreed the site selection for pharmacy aseptics, discussed the strategy and 2024/25 annual plan, and agreed out future approach to WYAAT SRO roles. We had an update on specialised commissioning, and approved the proposal for Cohort 2 of the Senior Leadership Programme.

At the meeting on 9th January 2024, we had an update on NSO, we discussed the impact of the industrial action and the current position as a result, and we received an update on RAAC. We also received the Five Year Strategy and 2024/25 Annual Delivery Plan, and had an update on neurology and haematology services.

- **West Yorkshire Partnership Board, 5th December 2023**

The West Yorkshire Partnership Board was held on 5th December, including a focus on the ambition to increase the years of live that people live in good health in West Yorkshire (we noted the collective action taken to date to understand and address inequalities as a system; to support the continued focus on health inequalities and to continue to provide leadership to enable an equity-based system focusing on accountability, allocation, and advocacy.), our ambition to reduce suicide by 10% across West Yorkshire, including the consideration of approach for limited but sustainable WY funding where we can do things once as a system, and narrowing inequalities through inclusive recruitment.

- **Mike Farrar session with West Yorkshire Leaders, 13th December 2023**

West Yorkshire Leaders have been discussing the evolution of the ICS operating model in light of their lived experience of the first year of a statutory ICB, and the shifting context of increasing operational and financial pressures that they face, coupled with potential shifts in policy emanating from the next General Election. On 13th December 2023, a workshop was held with Mike Farrar designed to enable West Yorkshire leaders from Places, Collaboratives, and the ICB to consider why change is needed, what changes are proposed and how these might be taken forward in each place and across West Yorkshire. We worked in small groups of 5/6 to discuss the specific implications for places,

collaboratives, local authorities and ICBs, what we might need to manage the process of change effectively, and how we are preparing for such changes.

5. National Reports

- **NHSE Statement on Information on Health Inequalities:**

Purpose of the Health Inequalities Statement

To help understand and improve health access, experience and outcomes, NHS England's view is that relevant NHS bodies should collect, analyse and publish information on health inequalities. By reporting on certain indicators this would help understand and improve health access, experience and outcomes. As such, NHS England have published a Heath Inequalities Statement which requests each NHS organisation to report on certain indicators concerning health inequalities. The intention is that this information on health inequalities will encourage better quality data, completeness and increased transparency. The data would then be used by relevant NHS bodies to shape and monitor improvement activity to further reduce healthcare inequalities.

Alignment with existing priorities

The indicators for reporting are aligned to the Core20Plus5 (both children and adults) and the five priority areas –

- restoring NHS services inclusively
- mitigating against digital exclusion
- ensuring datasets are complete and timely
- accelerating preventative programmes
- strengthening leadership and accountability.

The Statement has also been developed to align with annual reporting processes (such as the Trust's Annual Report) and the NHS Standard Contract. NHSE anticipate that the Statement will be revised periodically to include further indicators. The current statement is relevant from 1 April 2023 to 31 March 2025.

Impacts on Bradford Teaching Hospitals NHS Foundation Trust (BTHFT)

ICBs NHS trusts/Foundation Trusts have been given separate reporting indicators. However, all NHS organisations are encouraged to utilise joint strategic needs assessments (JSNAs) for local places to identify opportunities for improvement wherever possible.

BTHFT are asked to report on the indicators within the Annual Report or alongside it and summarise the inequalities it reveals and how the information has been used in the relevant period to guide action.

Appendix 1 of the Statement contains all the indicators that NHSE has published. Below are the indicators relevant to BTHFT. It's worth noting that BTHFT would need to cover deprivation, ethnicity, age and gender for the listed indicators –

- Elective Recovery –
  - Elective activity vs pre-pandemic levels for under 18s and over 18s
- Urgent and Emergency Care –
  - Emergency admissions for under 18s
- Mental Health –
  - Rates of total Mental Health Act detentions
  - Rates of restrictive interventions
  - Talking Therapies recovery (formerly IAPT)
  - Children and young people's mental health access
- Smoking Cessation
  - Proportion of adult acute inpatient settings offering smoking cessation services
  - Proportion of maternity inpatient settings offering smoking cessation services
- Oral Health –
  - Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under

Actions in progress at BTHFT

- Understand the Trust position in being able to report on the suggested indicators
- Progress made in relation to such indicators from clinical services
- Work towards Annual Report deadlines for the publication of the data
- Attend NHSE webinar in January to understand requirements in more detail
- Ensure BTHFT's role and approach in tackling health inequalities is aligned to the Statement
- Ensure progress is reported to the Trust's Equality and Diversity Council

See the letter received dated 28 November 2023 at Appendix 4.

The full Statement can be accessed here: https://www.england.nhs.uk/long-read/nhs-englands-statement-on-information-on-health-inequalities-duty/

- **2022 learning from lives and deaths reviews for people with learning disability and autistic people (LeDeR) report**

It is a requirement within the NHS standard contract for eligible deaths to be reported to LeDeR. For deaths occurring in 2022, those of people aged 4 and above with a learning disability, and autistic adults aged 18 years and above were in scope of LeDeR. There remain a proportion of deaths of people with a learning disability and autistic people that are not known to services and not notified meaning that the report is not the totality of all eligible deaths.

Whilst there have been some gradual improvements on previous years when compared to the general population care and outcomes continue to fall below the standard expected. See Appendix 5 for a breakdown of the findings.

The report can be accessed here: https://www.kcl.ac.uk/research/leder

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.6

- **Independent Inquiry into the issues raised by the David Fuller case – Phase 1 report**

The inquiry has been established to investigate how David Fuller was able to carry out inappropriate and unlawful actions in the mortuary of Maidstone and Tunbridge Wells NHS Trust and why they went apparently unnoticed, for so long.
Phase 1 of the Inquiry examines what happened at Maidstone and Tunbridge Wells NHS Trust. The Report covers the findings from this first phase. As the Terms of Reference for Phase 1 was focused on what happened at Maidstone and Tunbridge Wells NHS Trust, no comparison was made with the management and assurance of mortuaries in other NHS trusts. This will be explored in Phase 2.

The report finds that despite the additional assurances in place following the Lampard review (Saville enquiry) re Leeds mortuary Fuller was still able to offend for a period of 15 years and be undetected. At BTHFT we will be reviewing all of the recommendations and providing an update to Quality and Patient Safety Academy in February 2024.

The report can be accessed here: https://www.gov.uk/government/publications/david-fuller-inquiry-phase-1-report

Recommendation

The Board is asked to note this report.

Meeting Title	Board of Directors		
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Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for patients				g		
To deliver our financial plan and key performance targets				g		
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☒	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☒	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☐	☒	☐

Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	☒	☐
Quality implications	☒	☐
Resource implications	☒	☐
Legal/regulatory implications	☒	☐
Diversity and Inclusion implications	☒	☐
Performance Implications	☒	☐

Regulation, Legislation and Compliance relevance	
NHS Improvement: (please tick those that are relevant)	
☒Risk Assessment Framework	☒Quality Governance Framework
☒Code of Governance	☒Annual Reporting Manual
Care Quality Commission Domain: Well Led	
Care Quality Commission Fundamental Standard: Good Governance	
NHS Improvement Effective Use of Resources: Choose an item.	
Other (please state):	

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality & Patient Safety	Finance & Performance	
☒	☒	☒	

Date published: 22 December, 2023
Date last updated: 22 December, 2023

Update on planning for 2024/25

Publication (/publication)

Content

- Update on planning for 2024/25

Publication reference: PRN01063

To:

- Integrated care board (ICB) and trust:
  - chief executives
  - chairs
  - directors of finance
  - chief operating officers
  - medical directors
  - chief nurses
  - chief people officers

cc:

- Regional directors

Dear colleague

Update on planning for 2024/25

Thank you for all you have contributed to the NHS and the people we serve over the last year. We are enormously grateful for the commitment, adaptability and professionalism colleagues across the NHS have shown in responding to the significant challenges we face – including the strikes that are happening today.

We are particularly thankful for all your work to ensure the NHS is as prepared as possible for this winter. This includes the very significant expansion of core G&A beds, virtual ward and ambulance capacity, and the continued development of clinically-led System Control Centres to effectively manage risk. Despite industrial action and continued pressures on social care capacity, we have seen sustained improvements in headline A&E and ambulance service performance compared to last year, as well as increased discharge volumes.

In November, we wrote following discussions with Government to provide clarity on the funding and actions the NHS has been asked to take over the remainder of 2023/24 to manage the financial pressures created by industrial action. Since then we have been working to agree expectations and priorities for 2024/25. Discussions with Government on this remain live, and we will therefore not be able to publish the 2024/25 priorities and planning guidance until the new calendar year.

In the meantime, we are asking that you do not wait to start planning for next year. We have already published financial allocations for 2024/25. The overall financial framework will remain consistent, including the payment approach used to support elective recovery. System plans will need to achieve and prioritise financial balance.

The priorities and objectives set out in 2023/24 planning guidance (https://www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/) and the published recovery plans on urgent and emergency care (https://www.england.nhs.uk/publication/delivery-plan-for-recovering-urgent-and-emergency-care-services/), primary care access (https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/), and elective and cancer care (https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care/) will not fundamentally change.

The key requirements will be for systems to maintain the increase in core UEC capacity established in 2023/24, complete the agreed investment plans to increase diagnostic and elective activity and reduce waiting times for patients, and maximise the gain from the investment in primary care in improving access for patients, including the new pharmacy first service. The final position and performance expectations will be confirmed in Planning Guidance.

As we have talked about in various settings, the coming year will require us to continue to focus on recovering our core service delivery and productivity. We will continue to target a reduction in the cost of temporary staffing. We will also work

with ICBs and providers to agree a standard set of metrics that all executive teams and boards should use as a minimum to track productivity alongside service delivery.

We will set out the details of the national planning process and timetable separately, but systems should work on the basis that initial planning returns will be expected by the end of February.

Alongside this letter, we are publishing the following documents, which would ordinarily accompany planning guidance:

- Draft NHS Standard Contract for 2024/25 and associated documents (https://www.england.nhs.uk/nhs-standard-contract/24-25/)
- Proposed amendments to the NHS Payment Scheme for 2024/25 (https://www.england.nhs.uk/publication/amendments-2023-25-nhs-payment-scheme)
- Updated Joint Forward Planning guidance for 2024/25 (https://www.england.nhs.uk/publication/joint-forward-plan/)
- Guidance on developing 2024/25 Joint Capital Resource Use plans (https://www.england.nhs.uk/publication/joint-forward-plan/)

We will be setting up a webinar for finance directors, as well as wider engagement, in the new year to discuss this further. In the interim, please do raise any questions with your relevant regional teams, and we will endeavour to provide any clarifications that we are able, particularly where these are material to any procurement or commissioning decisions required to maintain continuity of services beyond the end of this financial year.

Yours sincerely

Amanda Pritchard, NHS Chief Executive.

Julian Kelly, Chief Financial Officer.

Emily Lawson, Chief Operating Officer (Interim).

Date published: 22 December, 2023
Date last updated: 22 December, 2023

To:
- ICB and Trust:
  - Chief executives
  - Chief finance officers
  - Chief operating officers

cc.
- ICB and Trust:
  - Chairs
  - Chief Nurses
  - Medical Directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

8 November 2023

Dear colleague

Addressing the significant financial challenges created by industrial action in 2023/24, and immediate actions to take

We are writing to provide clarity on the funding and actions the NHS has been asked to take to manage the financial and performance pressures created by industrial action following discussions with Government.

As a result of these pressures, for the remainder of the financial year our agreed priorities are to achieve financial balance, protect patient safety and prioritise emergency performance and capacity, while protecting urgent care, high priority elective and cancer care.

In response, we are asking systems to complete a rapid two-week exercise to agree actions required to deliver the priorities for the remainder of the financial year.

Financial pressures in 2023/24

We asked you to set ambitious plans for 2023/24 in the context of NHS funding increasing in real terms between 2019/20 and 2023/24 to over £160bn, recognising the actions you have had to take to deal with a range of significant new pressures.

Plans were set on the basis that there would not be significant ongoing industrial action. Despite 10 months of strikes, the NHS has made progress on the delivery of the UEC, primary care access and elective recovery plans, while also displaying professionalism in planning for and managing periods of action. The strikes have nonetheless had a significant impact on patients and staff.

Publication reference: PRN00942

The impact of the more than 40 days of industrial action this financial year has created unavoidable financial costs that we estimate to be around £1 billion, with an equivalent loss of elective activity.

National action

To cover the costs of industrial action to date we are taking the following actions which have been agreed with Government:

- Allocating a total of £800 million to systems sourced from a combination of reprioritisation of national budgets and new funding.

- Reducing the elective activity target for 2023/24 to a national average of 103%, which will now be maintained for the remainder of the financial year. Discontinuing the application of holdback to the Elective Recovery Fund (ERF) for the rest of the year and formally allocating systems their full ERF funding.

Actions for ICBs and Trusts

We are asking ICBs and providers, by 22 November, to agree the steps required to live within their re-baselined system allocation and reflecting the impact of the reduced elective activity goal. Plans should be based on a scenario where there are no further junior doctor or consultant strikes.

The foundation of this reset should be protecting patient safety, including in maternity and neonatal care, and prioritising UEC so that patients receive the best possible care this winter. Progress on existing commitments on elective and primary care recovery programmes, as well as other goals, should build on that foundation.

Actions to deliver UEC performance should include the agreed investments in capacity – including beds and ambulance services – as well as other components of UEC plans, including admissions avoidance and discharge schemes. Following the additional funding and changes to the ERF threshold, these are expected to be fully implemented without further delay.

The primary focus for elective activity should be on long waits and patients with urgent care and cancer needs, including reducing the cancer backlog. Primary care plans should protect improvements in access.

In showing how you will deliver financial balance you will need to show:

- you have fully worked up efficiency plans, including the reductions in agency staffing set out at the start of the year;

- where you require flexibility on programme funding;

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- an elective plan that is refocused on driving productivity from core capacity, identifying the insourcing/outsourcing and waiting list initiatives you still consider necessary within a balanced financial plan focused on the longest waits, urgent elective, and cancer care.

Returns should identify the total activity you forecast to do and the implications of any changes on the trajectory to the March 2024 65ww target, including how maintaining existing patient choice, tiering and the GIRFT programme can all support delivery (including on inpatient length of stay, day case rates and capped theatre utilisation).

The current pause in strike action is a positive step. However, it will be important to understand the alternative, and so your plans should also include an assessment of a scenario where the junior doctor and consultant strikes continue in a pattern consistent with the last four months and how those costs can be minimised as far as possible. In this scenario the focus should be on what steps you would take to minimise additional costs.

Next steps

Following yesterday’s webinar with ICB and provider CEOs and Directors of Finance, we are holding a further session this afternoon with Directors of Finance.

We will schedule sessions for each individual ICB Executive and their provider colleagues from 27 November to agree proposed actions.

We know how hard you have been working to maintain progress on implementing the recovery plans for elective care, urgent and emergency care, and primary care – as well as wider Covid recovery and priority transformation programmes – in the face of extraordinary pressures from prolonged industrial action.

We hope that this letter provides the clarity you have been seeking to now enact, along with system partners, those actions necessary to balance these financial challenges with your wider responsibilities.

Yours sincerely,

Julian Kelly Chief Financial Officer NHS England	**Dame Emily Lawson, DBE** Interim Chief Operating Officer NHS England	**Professor Sir Stephen Powis** National Medical Director NHS England	**Dame Ruth May** Chief Nursing Officer, England

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White Rose House
West Parade
Wakefield
WF1 1LT
Visit: www.wypartnership.co.uk
Twitter: @WYpartnership

05 December 2023

To: NHS Provider Chief Executives and Place Accountable Officers

(sent via email)

Dear colleague,

RAPID RESET OF OPERATIONAL AND FINANCIAL PLANS

Further to our call yesterday, I wanted to extend my thanks again for the collective focus and effort that you and your teams have directed towards the work to refresh our operational and financial plans. The response from the Partnership has demonstrated the strength of our working relationships, and I am grateful for your continued action to address the financial challenges we face.

We have agreed that we must take some difficult decisions around resource prioritisation. This will include reviewing all areas of expenditure to ensure that we are spending our limited resources in the best possible way. In all such conversations, we agreed we will ensure patient safety is paramount; that we work to consider the consequences of any changes on the public, patients and our partners; and that we will live the values that guide our actions in tough times.

Our conversation was focussed on the financial position of the West Yorkshire system for 2023 / 24, and the underpinning assumptions and actions required to deliver a balanced financial position. One of the key assumptions was that there would need to be further improvement of c.£10m across the 11 statutory NHS organisations (to which currently there are no specific unidentified mitigations). There is an indicative distribution of this across the five Places, based on relative population sizes. In considering this, it is important that each part of the system demonstrates the same level of risk appetite and consistency around decision-making to support mutual accountability and our principle of working to manage risks in organisations, Places and the system.

We agreed that there were five specific areas where your leadership and support is critical:

- Ensuring full and rigorous implementation of all of the **expenditure controls** (around vacancy controls, agency expenditure, non-pay expenditure) that were set out by NHS England in May 2023, and which have been assessed and discussed via the West Yorkshire Integrated Care System (WY ICS) Finance Forum and WY ICS System Oversight and Assurance Group.

- Reviewing all potential **flexibility** around deployment of **Service Development Funding** (other than that which is contractually obligated has been nationally determined as out of scope for review). This includes commitments where direct costs have not already been incurred. In all such instances, assessments will be made of the implications of not progressing.

- Maximising the financial income and consequence of reducing the number of patients waiting more than **52 weeks** (in line with the West Yorkshire approach to **Elective Recovery Funding**).

- Supporting the approach led by Directors of Finance to reviewing **consistency in balance sheets** as part of a West Yorkshire review, to ensure an appropriate and mutually understood approach.

- Whenever possible, **bringing forward waste reduction / efficiency / productivity** schemes where in pipeline or in discussion for 2024 / 25.

These actions combine a focus on delivering this year's financial position and laying foundations for next year's financial plans.

As noted, delivering a balanced financial system position secures access to additional operational capital (this year, c.£15m), and also put us in a better place for securing NHS England support and assistance where required (e.g. accessing early approvals for the capital development at Calderdale Royal Hospital). It is also the case that any overspend against our system allocation this year will lead to a reduction in allocation in future years, and we want to avoid this if possible.

Our plans are not without risk, and this is understood by all parties. I have continued to make this clear to our regulator and national leaders. I have continued to remind colleagues that systems like ours should be rewarded and incentivised to work in this way.

We will continue to utilise our individual organisational, Place and system governance and leadership arrangements to progress and oversee these plans. They form a bridge into next year and our medium-term financial plan.

Thanks again for your leadership at this time. We continue to demonstrate what is possible with good governance and good relationships, in service of delivering improved outcomes for local people.

Take care,

Rob Webster CBE
Chief Executive

NHS West Yorkshire Integrated Care Board
West Yorkshire Health and Care Partnership

Cc: West Yorkshire System Leadership Team

Classification: Official

To:
- Integrated Care Boards:
  - Chief executives
  - Chair
- NHS Trusts chief executive
- Foundation Trusts chief executive

cc.
- Regional SROs for Health Inequalities

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

28 November 2023

Dear Colleague,

Publication of NHS England's Statement on Information on Health Inequalities

NHS England published its first Statement on Information on Health Inequalities on Monday 27 November 2023. This letter outlines what this means for your Integrated Care Board (ICB), Trust or Foundation Trust (relevant NHS body).

a) Health inequalities duties

The NHS Act 2006 (as amended, by the Health and Care Act 2022) places a range of health inequalities duties on the NHS. Changes arising from the Health and Care Act 2022 provided extended legal duties on reducing and tackling health inequalities. NHS commissioners (NHS England and ICBs) are under specific legal duties to take account of health inequalities issues in the exercise of their functions. Aspects of the legal regime that applies to NHS providers, also include requirements to consider health inequalities. The key legal duties are set out in the Table in Annex 1.

b) Statement on Information on Health Inequalities

Under duty s. 13SA of the National Health Service (NHS) Act 2006 NHS England is required to publish a Statement setting out:

- a description of the powers available to relevant NHS bodies to collect, analyse and publish information; and
- the views of NHS England about how those powers should be exercised in connection with such information. The current Statement provides information on how powers should

Publication reference: PR2128_ii

be exercised in connection with health inequalities information for the period 1 April 2023 to 31 March 2025.

The Statement is designed to help relevant NHS bodies understand their duties and powers and how they can be exercised. Relevant NHS bodies are not expressly required in the NHS Act 2006 to adhere to it. It does not create any new legal responsibilities in and of itself. However, relevant NHS bodies are required, **in their annual reports, to review the extent to which the body in question has exercised its functions consistently with NHS England's views set out in the Statement**. A summary of NHS England's views can be found in Annex 2.

While NHS England recognises the value of collecting, analysing and publishing information on health inequalities, to manage the burden on relevant NHS bodies, we are taking a proportionate and phased approach to helping organisations gather and make use of available information on health inequalities. Consequently, this first Statement focuses on a small number of data indicators that are available for interpretation, along with a limited number of expectations on how the information should be used. These indicators are aligned to the five priority areas for addressing healthcare inequalities set out in Priorities and Operational Planning Guidance, the Core20PLUS5 approach.

Alongside the information set out in the Statement, relevant NHS bodies may be gathering and using other health inequalities information as part of national monitoring or for use locally.

c) Relationship with the Public Sector Equality Duty (PSED)

In addition to the Health Inequalities Duties, the Public Sector Equality Duty (PSED) applies to the NHS in relation to both its functions and workforce and prescribes characteristics to be considered.

d) Further information on health inequalities duties

In 2023, NHS England will be publishing a **new reference document** on the Health Inequalities Duties and Equality Duties. This will replace the Guidance for NHS commissioners on equality and health inequalities legal duties (2015).

We will produce some Frequently Asked Questions (FAQs) and further support materials on the health inequality legal duties, in response to the needs of relevant NHS bodies. We are delivering a webinar on **Wednesday 24th January 2024, 12-1pm** to explain the legal duties and answer your questions. Please register here: https://www.events.england.nhs.uk/events/health-inequalities-legal-duties-support-webinar.

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Please send questions, information on the type of support you would find useful, or feedback on the Statement to: england.healthinequalities@nhs.net

We would like to take this opportunity to thank you for all your work in reducing healthcare inequalities to deliver exceptional quality healthcare **for all,** ensuring equitable access, excellent experience and optimal outcomes.

Yours sincerely

Chris Hopson
Chief Strategy Officer
NHS England

Dr Bola Owolabi
Director, Health Inequalities
NHS England

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Annex 1 – Overview of legal duties on NHS bodies

The following table provides an overview of the health inequalities by type of NHS body under the NHS Act 2006[1]

	NHS England	ICBs	Trusts and Foundation Trusts
Commissioning and delivery of services			
Arranging services to meet reasonable needs	s. 1H	s. 3/3A	No statutory duty, but responsibilities are set out in contracts with commissioners
Duty to exercise functions efficiently, effectively and economically	s. 13D	s. 14Z33	s. 26 (NHS Trusts)
Duty to have regard to reducing inequalities in access and outcomes	s. 13G	s. 14Z35	n/a
Duty as to improvement in quality of services	s. 13E	s. 14Z34	n/a[2]
Duty to promote integration	s. 13N	s. 14Z42	n/a
Considering effects of wider decisions on inequalities	s. 13NA	s. 14Z43	s. 26A, s. 63A
Planning and reporting			
Annual business plan	s. 13T		n/a
Joint forward plans	n/a	s. 14Z52	s. 14Z52
Performance assessment of integrated care boards	s. 14Z59	n/a	n/a
Annual report	s. 13U	s. 14Z58	Sch. 4, para, 12, 1B Sch. 7, para. 26, 1B
Statement on processing information on inequalities	s. 13SA		

[1] Legally, many of the changes in the Health and Care Act 2022 amend the NHS Act 2006, where the core legal duties on NHS England, ICBs, Trusts and Foundation Trusts are set out.

[2] Providers are required to ensure care is safe, effective, caring, well-led and responsive under CQC requirements.

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Annex 2 Summary of NHS England's views on how relevant NHS bodies should exercise their powers to collect, analyse and publish information on health inequalities

For the period of 2023-24 and 2024-25 NHS England's views on how relevant NHS bodies should exercise their powers to collect, analyse and publish information on health inequalities include the need to:

- Understand healthcare needs including by adopting population health management approaches, underpinned by working with people and communities.
- Understand health access, experience and outcomes including by collecting, analysing and publishing information on health inequalities set out in the Statement and summarised below.
- Publish information on health inequalities within or alongside annual reports in an accessible format.
- Use data to inform action including as outlined in the Statement.

Relevant NHS bodies should include in their annual reports 2023/24 and 2024/25 a review of the extent to which they have exercised their functions consistently with NHS England's views set out in the Statement and explain whether the information has been published, summarise the inequalities it reveals, and how the information has been used in the relevant period to guide action.

Information on health inequalities

The Statement includes which information on health inequalities should be collected, analysed and published in relation to the domains listed in the table below. The Statement includes one or more indicators for each domain, and where data is available these should be disaggregated by age, sex, ethnicity and deprivation.

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Domain	Level data available	
	ICB	Trust/Foundation Trust
Elective recovery	Y	Y
Urgent and emergency care	Y	Y
Respiratory (Covid 19/Flu Vaccination)	Y	
Mental health	Y	Y
Cancer	Y	
CVD	Y	
Diabetes	Y	
Smoking cessation		Y
Oral health (Children and young people)	Y	Y
People with a learning disability and autistic people	Y	
Maternity and neonatal care	Y	

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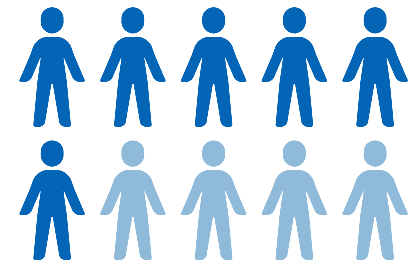
KEY FINDINGS OF REVIEW OF LIVES AND DEATHS FOR 2022

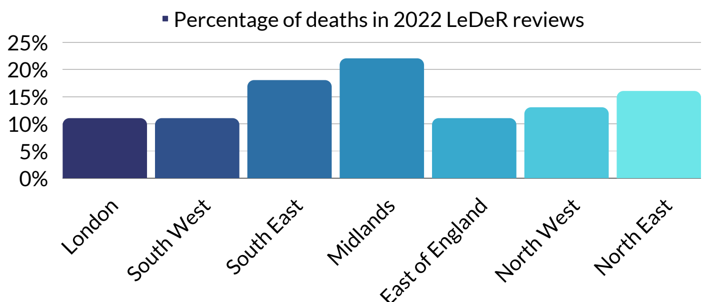
SEX

55% of people with a learning disability who died in 2022 were male.



REGION

LeDeR reviewed deaths of people with a learning disability from all 7 regions of England.



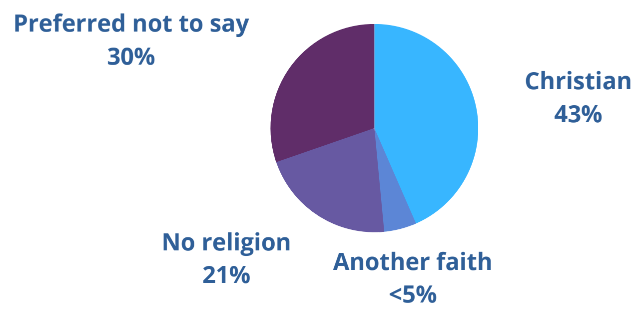
94%

ETHNICITY

94% of people with a learning disability who died in 2022 were denoted as white.

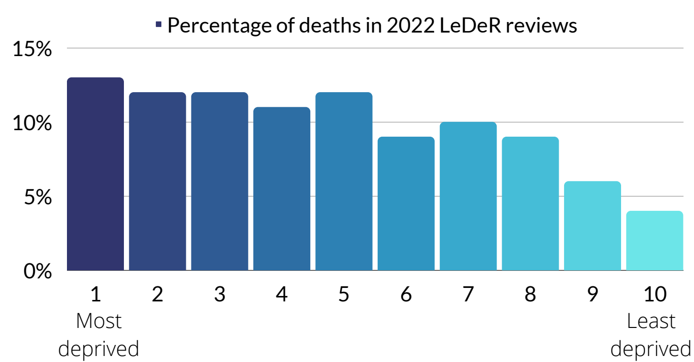
RELIGION

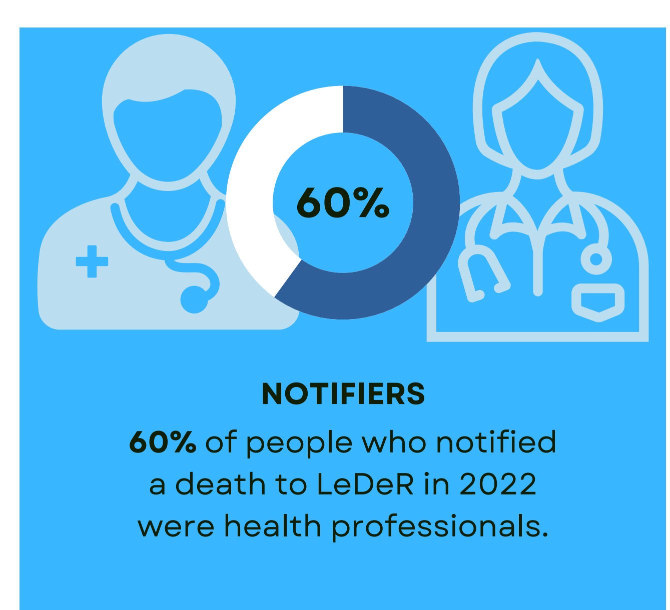
43% of people with a learning disability who died in 2022 were denoted as Christian.



DEPRIVATION

25% of people with a learning disability who died in 2022 lived in the most deprived neighbourhoods by decile, compared to **10%** in the least deprived.





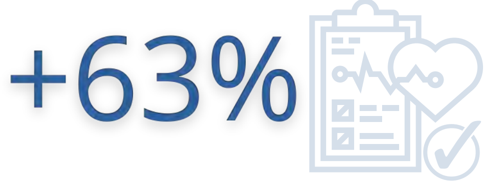
NOTIFIERS

60% of people who notified a death to LeDeR in 2022 were health professionals.

KEY FINDINGS ON CAUSES AND CIRCUMSTANCES OF DEATH

DNACPR

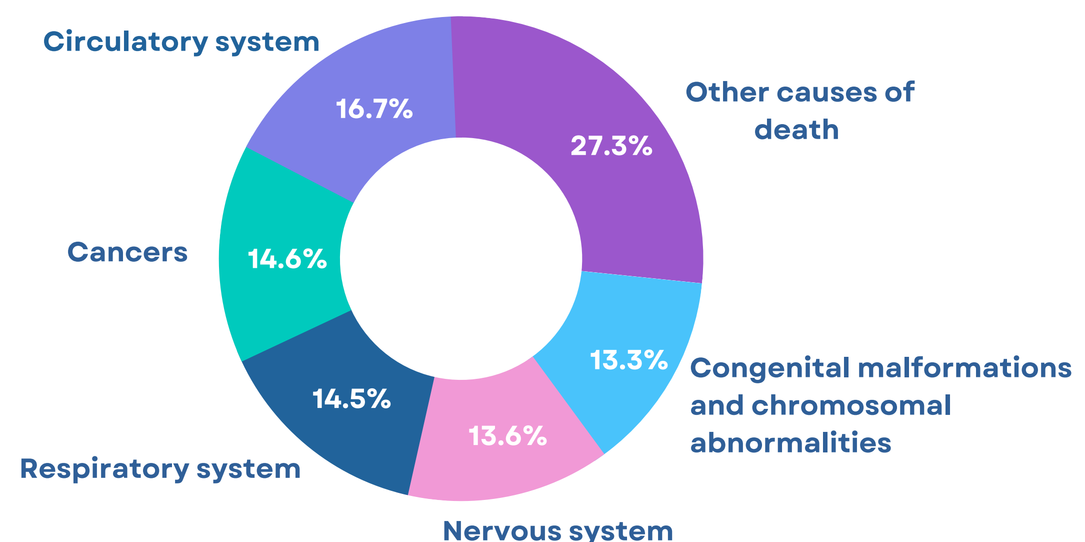
74% of people who died in 2022 had a DNACPR in place at the time of death. Reviewers judged this was correctly followed **63%** of the time. This compares with **61%** of the time in 2021.



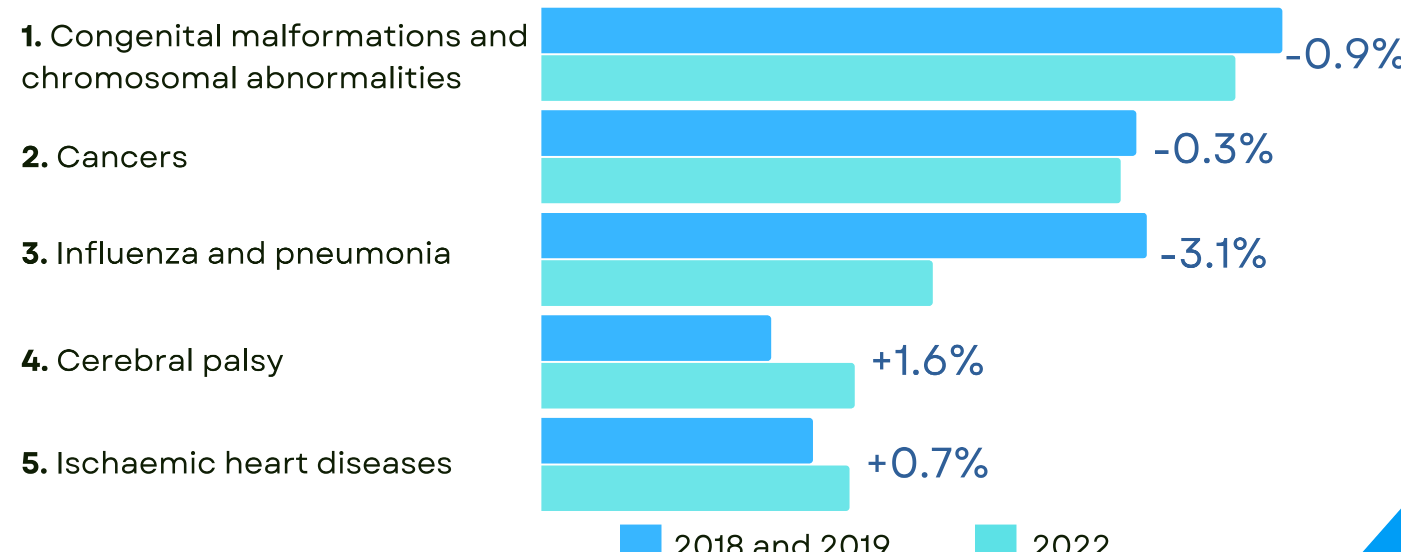
REFERRALS TO A CORONER

25% of deaths that occurred in 2022 were referred to a coroner. This compares to **19%** in 2020 and 2021 and **22%** in 2018 and 2019. **36%** of deaths in the general population were referred to a coroner.

5 MOST COMMON CAUSES OF DEATH (ICD-10 CHAPTER)



5 MOST COMMON LEADING CAUSES OF DEATH (2022 VS 2018 AND 2019)

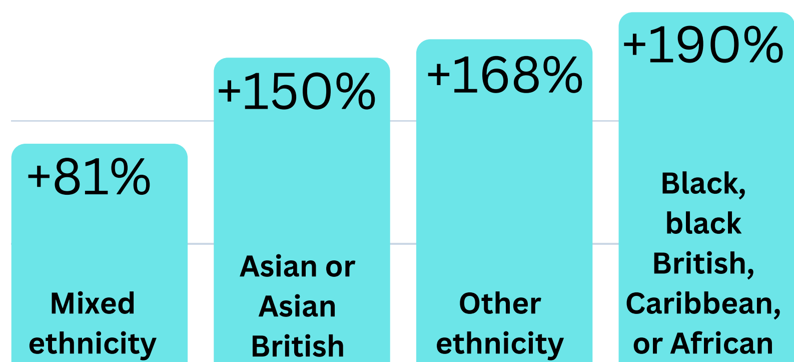


KEY FINDINGS OF FACTORS ASSOCIATED WITH AGE AT DEATH

AGE AND ETHNICITY

People from all ethnic minority groups died at a **younger age** in comparison to people of white ethnicity, when adjusting for sex, region of England, deprivation, place of death, and type of accommodation.

% increased risk of dying earlier by ethnic minority group, in comparison with people from white ethnicity backgrounds, when adjusting for other demographic factors



EPILEPSY AND AGE AT DEATH

Epilepsy was the long-term condition that was most **strongly associated with dying at a younger age**. This was followed by deep vein thrombosis, and degenerative diseases.

CARE AND PREMATURE DEATH

Appropriate care was associated with **reductions** in **premature death**. For instance, care packages that meet a person's needs and have an appropriate use of Deprivation of Liberty safeguards to deliver care are associated with a reduced risk of a premature death.

AGE AT DEATH

62.9* years old was the median age at death for people with a learning disability in 2022. This is an i**ncrease from 2018**, where the median age at death was 61.8 years. This increase was seen despite the COVID-19 pandemic, showing a continuous improvement between 2018 and 2022.

62.9 YEARS

TREATMENT AND PREVENTION

The use of **appropriate medical treatment and prevention**, such as the use of vaccines to protect against COVID-19 and pneumococcus and mental health treatments (medications), are associated with **reduction** in the risk of an earlier age at death.

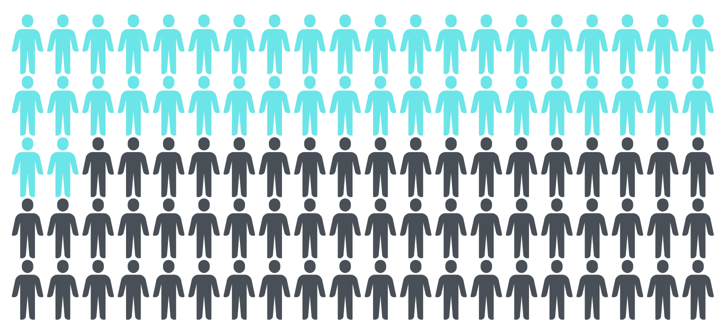
*Calculation based on adult (>18 years old) data only for both 2022 and 2018.

KEY FINDINGS OF AVOIDABLE MORTALITY

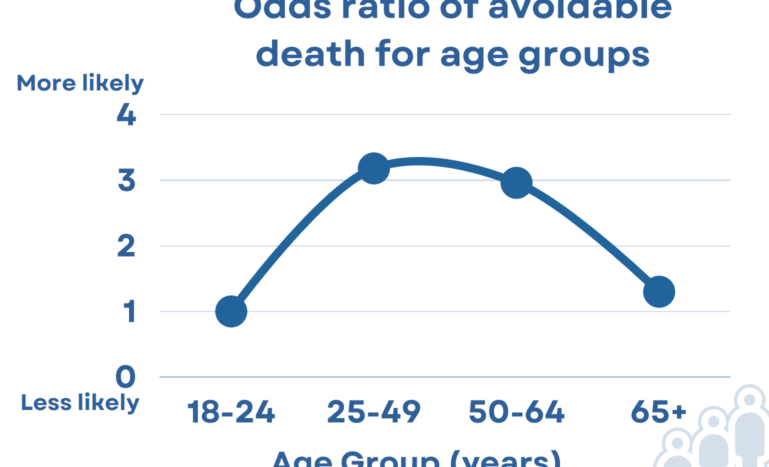
AVOIDABLE DEATHS

42% of deaths were deemed "avoidable" for people with a learning disability. This is a reduction from 2021 data, which found 50% of adult deaths were avoidable.

This compares to 22% for the general population.



42% of deaths were deemed avoidable



AGE AND AVOIDABLE DEATHS*

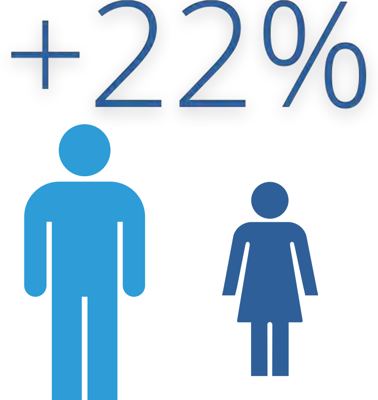
Deaths were more likely to be classified as avoidable with increasing age, peaking in the 25-49 age group before decreasing again for those who died over the age of 65 years.

*note: deaths of people aged 75+ are defined by the OECD as not being avoidable.

AVOIDABLE DEATH AND SEX

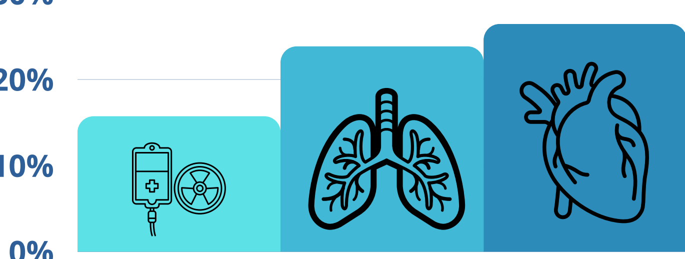
Men were found to be **22% more likely** to die from an avoidable cause of death than women.

+22%



TOP 3 CAUSES OF AVOIDABLE DEATHS**

26.4% of avoidable deaths were linked to cardiovascular conditions, 23.8% to respiratory conditions (excluding COVID-19), and 15.7% to cancers.



**Unadjusted analyses.

KEY FINDINGS ABOUT QUALITY OF CARE

DATA

The findings in this chapter are based on 563 focused reviews of deaths in 2021 and 503 focused reviews of deaths in 2022. We looked at what reviewers said about the quality of care of the person with a learning disability who died.

CARE PACKAGE

8 out of 10 of reviewers indicated that the **care package provided met the needs of the individual** in deaths in 2022.

PROBLEMS WITH CARE

Organisation systems and processes were the most commonly reported area of problems with care.

CONCERNS ABOUT QUALITY OF CARE ARE REDUCING

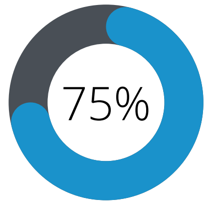
Concerns with care were expressed in **39%** of deaths which occurred in 2021 and **25%** deaths in 2022

EVIDENCE OF GOOD PRACTICE

9 out of 10 reviews included evidence of good practice.

REASONABLE ADJUSTMENTS

Personalised reasonable adjustments were highlighted as crucial tools to support people.



THE MENTAL CAPACITY ACT

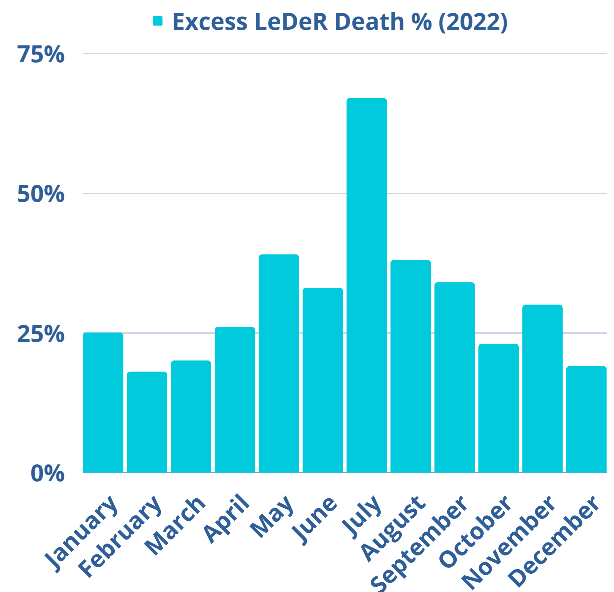
The Mental Capacity Act was correctly followed in three-quarters of deaths in 2022 where it was deemed relevant.

KEY FINDINGS OF EXCESS DEATHS, COVID-19, AND CLIMATE CHANGE

EXCESS DEATHS

Deaths notified to LeDeR of occurring in July 2022 appear to be **greater than expected for every month of 2022** when compared to notifications from 2018 and 2019. July 2022 demonstrated the greatest excess.

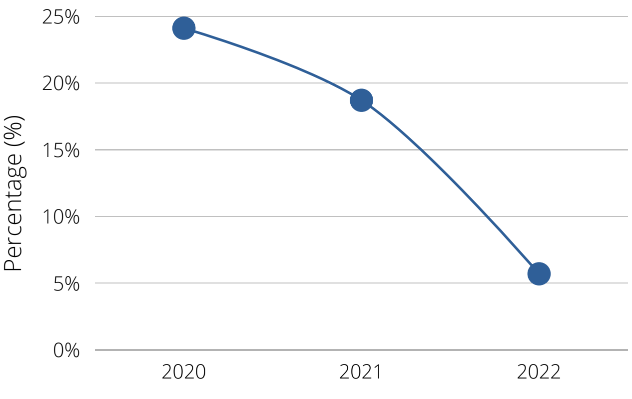
This may be due to better reporting of deaths, as well as the impact of the pandemic and the heatwave.



COVID-19

COVID-19 has **decreased** from 24% of all causes of death in 2020 to 19% in 2021 and **6%** in 2022 for adults with a learning disability. It has gone from the most common cause of death to the 6th most common.

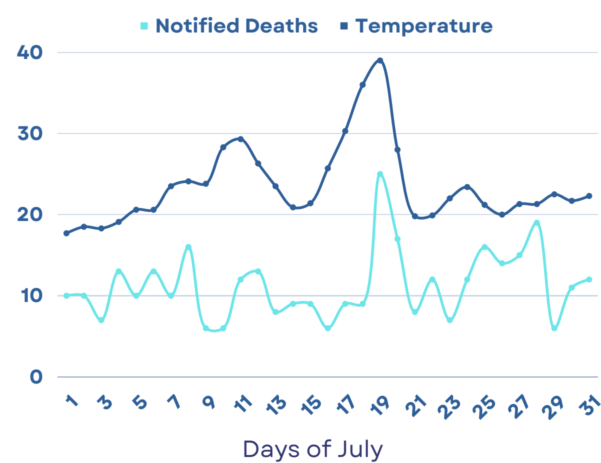
DEATHS DUE TO COVID-19 ARE FALLING YEAR ON YEAR



THERE WAS A SPIKE IN NOTIFICATIONS OF DEATHS AROUND THE JULY 2022 HEATWAVE PEAK

July 2022 recorded the highest number of notifications of deaths in 2022, **13% of which occurred on the 19th and 20th of July**.

The 19th of July saw a record high temperature of 40.3°C in England. This spike in deaths was not due to COVID-19 or flu, and appears to be linked to the extreme heat.



KEY FINDINGS ABOUT AUTISTIC ADULTS WITHOUT A LEARNING DISABILITY IN 2022

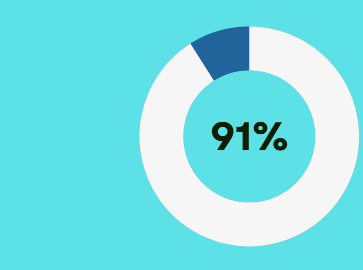
DATA FOR 2022

2022 was the first year LeDeR reviewed deaths of autistic adults without a learning disability. The amount of reviews was **small**, with **36 completed reviews**. These reviews are not representative of all autistic adults without a learning disability, and only limited conclusions can be made. Increased reporting is needed to be able to better determine areas for improvement in the care of autistic adults without a learning disability.

THE MOST FREQUENT CAUSES OF DEATH

Underlying cause of death for autistic adults without a learning disability (grouped ICD-10 codes)	Totals in the data
Suicide, misadventure* or accidental death**	11
Respiratory conditions	8
Cadiovascular and stroke related	<5
Cancer	<5
Other	8

Note: * includes drug and alcohol related deaths that were not thought by the coroner to be intentional.
** includes falls.

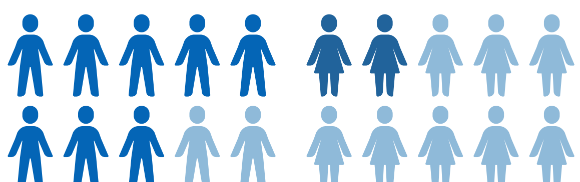


ETHNICITY

91% of autistic adults without a learning disability were denoted as white.

SEX

81% of autistic adults without a learning disability who died in 2022 were male, **19%** were female*.

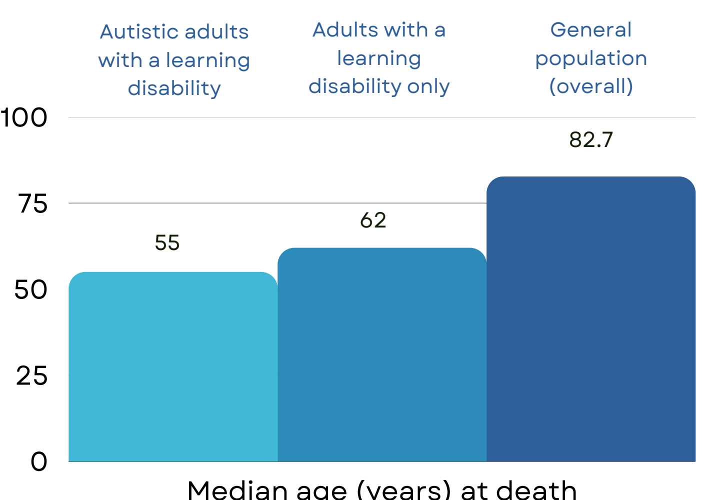


*a small number (<5) identified as neither male or female, or transgender, but could not be reported in order to ensure de-identified data.

KEY FINDINGS ABOUT AUTISTIC ADULTS WITH A LEARNING DISABILITY

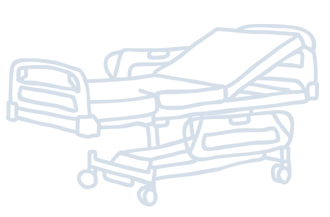
AGE AT DEATH

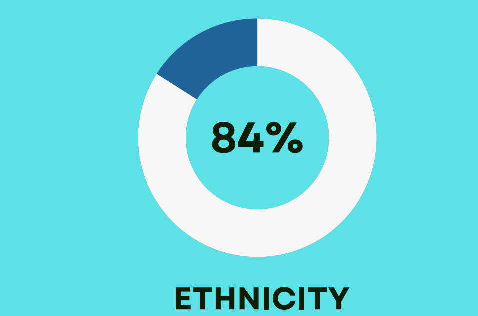
The median age at death for the 178 autistic adults with a learning disability was **55 years**. The median age at death for the general population in 2018-2020 was **82.6 years for males and 86.1 for females.**



THE 5 MOST FREQUENT CAUSES OF DEATH (EXCLUDING "OTHER")

Underlying cause of death for autistic adults with a learning disability (grouped ICD-10 codes)	Totals in the data
Respiratory conditions	66
Cardiovascular conditions	27
Cancer	22
COVID-19	17
Stroke, Cerebral Haemorrhage or Embolism	8



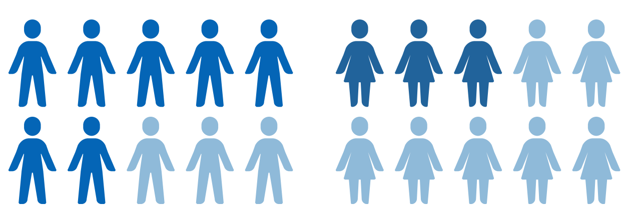


ETHNICITY

84% of autistic adults with a learning disability and died in 2022 were denoted as white.

SEX

68% of autistic adults with a learning disability who died in 2022 were male, 30% were female*.



*a small number (<5) did not have information regarding their sex available in the data.

BO.1.24.7 - BOARD ASSURANCE FRAMEWORK AND HIGH LEVEL RISKS

REFERENCES

Only PDFs are attached

Bo.1.24.7 - BAF & HLRR - Board cover paper.pdf

Bo.1.24.7 - Appendix 1 - BAF December 2023.pdf

Bo.1.24.7 - Appendix 2 - HLRR December 2023.pdf

Bo.1.24.7 - Appendix 3 - Risk on a Page Report.pdf

Bo.1.24.7 - Appendix 4 - Target Mitigation.pdf

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.7

Board Assurance Framework & High Level Operational Risks

Presented by	Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
Author	Executive Directors Laura Parsons, Associate Director of Corporate Governance/Board Secretary Katie Shepherd, Corporate Governance Manager	
Lead Director	Mel Pickup, Chief Executive	
Purpose of the paper	This paper provides a profile of risks, controls and assurances related to the delivery of the Trust's strategic objectives	
Key control	Understanding the Board's risk appetite related to the achievement of the Trust's strategic objectives is a key component of the Board Assurance Framework	
Action required	For assurance & approval	
Previously discussed at/ informed by	Board Assurance Framework: ETM – 11 December 2023, Quality and Patient Safety Academy 13 December 2023, People Academy Finance and Performance Academy via email in December 2023 as no meetings took place. High Level Risk Register: ETM – 13 November 2023 and 11 December 2023 Academies – Quality and Patient Safety Academy 29 November 2023 and a verbal update on 13 December 2023; People Academy – 29 November 2023 and no meeting took place in December 2023, Finance and Performance Academy – 29 November 2023 and no meeting took place in December 2023.	
Previously approved at:	**Committee/Group**	**Date**
	N/A	

Key Options, Issues and Risks

In line with the Risk Management Strategy, the Board's role in relation to the Board Assurance Framework (BAF) and High Level Risks is as follows:

- Seek assurance from the Executive Team and Academies that all risks on the High Level Risk Register and BAF are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled.
  (NB Where risks relating to a particular strategic objective are not aligned to an Academy, the Board will seek assurance directly from the Executive Team.)

BAF – Strategic Risk

The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the organisation's strategic objectives.

The BAF collates information about risk appetite, relevant risks, and assurance, for each of the Trust's five Strategic Objectives. This supports Board members in considering the papers and topics discussed at Board meetings and informs an overall view about the level of assurance provided.

The BAF is attached at Appendix 1 for review. The key points to note are included on the summary pages of the BAF (pages 1-2). The details behind each risk including the relevant controls, assurances, gaps and actions to address gaps are then set out on individual pages.
ETM noted the following particular points:

- Risk 2b.2 relating to the recovery of backlogs and increased demand has been reduced in score from 16 to 12 (likelihood score reduced from 4 to 3), due to the positive work undertaken to clear the backlogs.
- As agreed at the November Board meeting, a new risk has been added to the BAF in relation to board leadership and governance (see risk 6 on page 19 of the BAF). This risk is currently scored at 20 and is aligned to all strategic objectives. The Board is asked to review and approve the addition of this risk to the BAF.

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The BAF was reviewed and updated by the lead executives, and was reviewed and agreed by the Executive Team on 11 December 2023. The Quality and Patient Safety Academy reviewed the BAF risks within its remit on 13 December 2023. The People Academy and Finance and Performance Academy reviewed the BAF risks within their remit via email during December 2023 as no meetings took place.

High Level Risk Register (HLRR) – Operational Risk

All **operational** risks scoring 15 and above (high level risks) are escalated to the Executive Team Meeting (ETM) on a monthly basis and then to the relevant Academies and the Board.

At its meetings on 13 November and 11 December 2023, ETM considered a summary of all high level risks, including any new risks, closures and changes in score, and those risks which had passed their review date.

The Academies reviewed the high level risks within their remit at their meetings as follows:

- Quality and Patient Safety Academy – 29 November 2023 and 13 December 2023
- People Academy – 29 November 2023 (there was no meeting during December 2023)
- Finance and Performance Academy – 29 November 2023 (there was no meeting during December 2023)

The HLRR, showing all high level risks rated 15+ for December 2023, is attached at Appendix 2.

High Level Risks Report on a Page

The document at Appendix 3 provides a visual overview of all high level risks at BTHFT for November and December 2023, and shows trends over a number of cycles and flags areas that ETM, the Academies and Board may wish to consider.

The following information is included:

- An overview of the risk profile, with details of the total number of high level risks.
- An overview of whether scores are increasing, decreasing or staying static.
- A graph showing the changing number of risks on the register.
- Static risks which demonstrates over time how long risks have remained static for. A risk that remains static over a number of months may be an indication that further work is required to control the risk.

Target Mitigation Dates

Risks beyond their target mitigation date

ETM noted two risks had passed the target date for completion of the mitigating actions:

Risk ID:	Current Score:		Risk Description:	Lead Director:	Target date for completion of mitigating actions:	Academy:
November/December 2023:						
3810	16	6	Service risk to Haematology • Risk to Acute consultant Rota and timely inpatient reviews • Risk to Outpatient delivery and the increase to wait times for Urgent / routine / cancer and the specialised Haemophilia patients	Dr Ray Smith	30/09/2023	People, Quality & Patient Safety Academy

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			• Service delivery for the whole Haemophilia service, surgical and outpatient work • Service delivery for complexity of haematology patients In reach to transfusion service			
3468	15	9	There is a risk that staff are not following or being able to follow the correct process for recording activity or patient pathway steps on EPR which results in incorrect or missing information will cause; Delays to treatment.	Sajid Azeb, Chief Operating Officer	30/11/2023	Finance and Performance; Quality and Patient Safety Academy

The target mitigation date relating to risk 3810 has since been amended to 30 September 2024. Risk 3468 will be reviewed and updated as soon as possible.

Changes to target mitigation dates

The document at Appendix 4 provides a detailed overview of all current high level risks and the number of changes made to the target mitigation date for each risk since it was created.

New risks to the High Level Risk Register (HLRR)

In November, ETM agreed to accept one new risk to the HLRR, but agreed that this risk should be amended as it will affect all specialties that rely on histopathology. It was therefore agreed that the risk should be owned by the Specialist Medicine CSU (which is responsible for histopathology) rather than Women's. The risk will be updated as soon as possible to reflect this:

Risk ID:	Score:	Target Score:	Risk Description:	Lead Director:	Academy:
November 2023:					
3896	16	5	There is potential for harm due to the risk of gynaecology histopathology being delayed for women who access the Women's service at BTHFT.	Dr Ray Smith, Chief Medical Officer	Quality and Patient Safety Academy

In December, ETM was notified of two risks which had increased in score and were therefore proposed for inclusion on the HLRR. ETM reviewed the two risks (see below) and agreed that the appropriate mitigations should be considered further before re-evaluating the risk scores. The additional mitigations and revised risk scores will be considered by ETM at their meeting on 22 January 2024.

Risk ID:	Score:	Target Score:	Risk Description:	Lead Director:	Academy:
December 2023:					
3530	16	6	Potential fire risk and trip hazards due to requirement for HR team in Heaton House to use extension leads.	Matthew Horner, Director of Finance	People Academy
3788	20	6	Roof leaks in Heaton House causing risk of collapse, damp/mould etc. and impact on health of staff working in the immediate area.	Matthew Horner, Director of Finance	People Academy

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Risks which have been removed/closed

ETM has agreed the closure of one risk since the last report:

Risk ID:	Score before closure:	Risk Description:	Lead Director:	Reason for closure:
3800	20	Significant Increase in the cost of Trusts gas and power from the 1st April 2024	Sajid Azeb, Chief Operating Officer	The inflation that has occurred within the gas and electricity markets, initially due to the post Covid recovery and then increased significantly by the conflict in Ukraine, will translate to higher utility prices over the next two financial years. The increases in costs highlighted by this risk have been factored into the energy budgets. Further geopolitical issues within the Middle East have added to market volatility but the policy of buying well ahead of consumption is still the most prudent approach for the Trust. The Trust's gas and electricity has been bought at a capped rate for 2024/25 and 2025/26. The procurement strategy for 2026/27 will be reviewed at the start of next financial year and purchasing of utilities given at least an 18 month window to achieve the best possible prices at an acceptable level of risk to the Trust.

Risks which have changed in score

ETM agreed three changes in risk score:

Risk ID:	Current Score:	Previous Score:	Target Score:	Risk Description:	Lead Director:	Reason for change in score:	Academy:
November 2023:							
3732	16	20	10	Nursing & Midwifery Staffing Levels	Karen Dawber, Chief Nurse	Risk reviewed for adult areas, with the start of the newly qualified nurses and success of the international nurses completing OSCE and ongoing recruitment into HCA roles this risk has reduced however with there are still significant ongoing staffing challenges keeping the risk at 16.	People, Quality & Patient Safety Academy
December 2023:							
3823	12	16	4	BTHFT Mortuary Refrigeration and Freezer storage facilities	Matthew Horner, Director of Finance	Procedures in place to deal with this.	Finance and Performance Academy
3748	20	16	3	There is a risk that as the demand for haemodialysis (HD) at Bradford Teaching Hospitals NHS Foundation Trust renal dialysis units has reached	Ray Smith, Chief Medical Officer	Given Skipton is now the only available site with capacity and is expected to be utilised from January 2024 with capacity for 20 patients, the risk likelihood has been increased meaning the overall risk score is now 20.	Quality and Patient Safety Academy

				the available capacity and that it will not be possible to provide timely dialysis for some patients.			

It was also proposed that risk 3881 (below) was reduced from a score of 16 to 12. It was confirmed that 8 newly qualified pharmacists had been appointed, and on reviewing the reconciliation rates for the 5 months Jan – May 23 the average reconciliation rate was 60%, with the 5 months May-Oct 23 having achieved an average rate of 68%. However ETM agreed that the score should remain at 16 until further improvement is seen in the medicines reconciliation rate.

Risk ID:	Current Score:	Target Score:	Risk Description:	Lead Director:	Academy:
3881	16	8	If we are unable to recruit to a number of unfilled pharmacy vacancies and provide cover to deliver a 7 day service then the Trust will not improve and sustain medicines reconciliation rates to above national average resulting in a regulatory risk to the Trust's aspiration to become an 'Outstanding' provider and an increased risk of harm to patients if unresolved.	Sajid Azeb, Chief Operating Officer	People, Quality & Patient Safety Academy

Risks beyond their review date

ETM noted there were two risks that were beyond their review date:

Risk ID:	Score:	Risk Description:	Lead Director:	Review Date:
November 2023:				
3696	16	There are a number of significant risks to the organisation arising from the age and condition of the pharmacy aseptic unit.	Sajid Azeb, Chief Operating Officer	31/12/2023
December 2023:				
3627	20	If the Trust does not invest significant capital resources to reduce the identified backlog maintenance and critical infrastructure risk of its estate, significant business continuity impact due to failure of estates infrastructure / engineering systems / building fabric will be experienced.	Matthew Horner, Director of Finance	11/12/2023

Risk 3696 was reviewed with a new review date set at 31 December 2023. Risk 3627 has been reviewed with a new review date set at 19 March 2024.

Ongoing risks

ETM noted the ongoing risks and no further comments were raised.

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Recommendation
The Board is asked to: • confirm whether it is assured that all risks on the High Level Risk Register and BAF are appropriately recognised and recorded, and that all appropriate actions are being taken within appropriate timescales where risks are not appropriately controlled; and • approve the addition of risk 6 (board leadership and governance) to the BAF.

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Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for patients, delivered with kindness				g		
To deliver our financial plan and key performance targets				g		
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Risk Implications	Yes	No
Risk register and/or Board Assurance Framework Amendments		▪
Quality implications		▪
Resource implications		▪
Legal/regulatory implications		▪
Diversity and Inclusion implications		▪

Regulation, Legislation and Compliance relevance
NHS Improvement: *Risk assessment framework, quality governance framework, code of governance*
Care Quality Commission Domain: *well led*
Care Quality Commission Fundamental Standard: *good governance*
Other (please state):

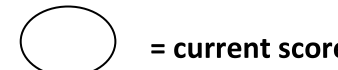
Relevance to other Board of Director's Committee:	
Audit Committee	Other (please state)
▪	Academies

Board Assurance Framework – Summary of Strategic Risks

Ref	Strategic Risks	Current Score & Direction of travel	Target Score	Executive Lead	Commentary (e.g. change in risk score, completed actions, reasons for any delays in actions)
Strategic Objective 1 - To provide outstanding care for our patients, delivered with kindness	**Risk appetite: Open –** We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward			**Assuring Academy: Quality & Patient Safety**	**Overall Assurance Level 2023/24:** Q1 / Q2 / Q3 / Q4
1.1	**If** we fail to understand and address the needs of our population, **then** we won't be able to deliver appropriate services, **resulting in** worsening health inequalities	12 ↔	8	Chief Nurse / Chief Medical Officer	Work underway to understand our waiting list and the impact of health inequalities on timely access to treatment. Score previously amended to reflect current pressure on waiting times, particularly following the impact of on-going industrial action. No further change in score for this period.
1.2	**If** we fail to maintain and develop our care environment, **then** we may not be able to deliver modern, outstanding care for our patients, **resulting in** poor patient experience and outcomes and limited ability to deliver services	12 ↔	8	Chief Nurse / Chief Medical Officer	Score previously increased to 12 to reflect ongoing pressures and demand which our estate is not designed for e.g. high ED attendances, requirement for side rooms etc.
3.1	**If** we are unable to recruit to our vacancies, **then** our current staff will be placed under additional pressure and we may be unable to provide safe staffing levels, **resulting in** an adverse impact on patient safety and experience, staff experience and wellbeing, and an increase in staff turnover **NB This risk is also linked to Strategic Objective 3 - To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion**	16 ↔	9	Director of HR / Chief Medical Officer / Chief Nurse	No change to overall risk score. Staffing across areas remains closely managed. Nurse staffing vacancies continue to be high. Higher sickness absence levels continue compared to pre-Covid. Additional services for elective on board with continued pressure of non-elective demand. Rolling domestic and international recruitment campaigns remain ongoing.
Strategic Objective 2a – To deliver our financial plan	**Risk appetite: Open –** We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward			**Assuring Academy: Finance & Performance**	**Overall Assurance Level 2023/24:** Q1 / Q2 / Q3 / Q4
2a.1	**If** we continue to face financial challenges associated with cost inflation, increased demand for services and System/Place affordability, **then** we may fail to maintain financial stability and sustainability, **resulting in** reduced opportunities to meet demand and to maintain/improve the quality of care, an increased likelihood of system intervention, potential regulatory action, and a negative impact on the Trust's reputation.	20 ↔	8	Director of Finance	The Trust has targeted a balanced financial plan for 2023/24. This includes a very stretching waste reduction requirement of £29m. The gap is created by an underlying run rate inclusive of projected inflationary uplift that is in excess of the income allocation. The waste reduction target is forecast to be delivered from a range of measures with a focus on productivity improvements that will reduce the Trust's reliance on outsourcing and insourcing, together with the allocation of improvement targets across all CSUs and corporate departments and the deployment of non recurrent measures. To facilitate delivery, the Trust has established a waste reduction group and a clinical services improvement group with a view to triangulating various sources of data/ information that signpost potential improvement opportunities. Delivery of the target will be managed and monitored through the existing performance management governance arrangements, with further support and assurance provided by the Waste Reduction Group and the Clinical Services Improvement Group.
2a.2	**If** we fail to manage Income & Expenditure within planned parameters, **then** we may have insufficient cash and liquidity resources to sustainably support the underlying Income & Expenditure run rate, **resulting in** an impact on operational and capital investment decisions, reduced opportunities to meet demand and to maintain/improve the quality of care, an increased likelihood of system intervention, potential regulatory action, and a negative impact on the Trust's reputation.	20 ↔	8	Director of Finance	See 2a.1 above
2a.3	**If** the capital funding allocation from the ICS is not sufficient to meet our requirements and/or we are unable to deliver our capital programme in full by the end of the financial year, **then** we may not be able to make the capital investments required to maintain safe and sustainable services, **resulting in** a negative impact on the quality of care, the capacity available to treat patients in a safe environment and a negative impact on the Trust's reputation.	16 ↔	8	Director of Finance	The Trust has a capital plan of £59m for 2023/24 which includes the St Luke's Day Case Unit, the endoscopy development and the Community Diagnostic Centre which are externally funded schemes. Operational Capital (internal capital) totals £25.6m, which has been allocated on a risk based approach. The full value of the operational capital has been allocated with a small contingency for prioritised risks that materialise in year. If new risks materialise (depending on values) they will need to be risk stratified against the existing schemes, which may need to be removed or deferred if schemes with a higher risk are identified. A reserve list has been identified should the Trust experience slippage on the existing approved schemes.
Strategic Objective 2b – To deliver our key performance targets	**Risk appetite: Open –** We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward			**Assuring Academy: Finance & Performance**	**Overall Assurance Level 2023/24:** Q1 / Q2 / Q3 / Q4
2b.1	**If** the Trust is unable to transform its services, **then** we may not be able to deliver resilient services that are fit for the future, **resulting in** a loss of staff, and a negative impact on patient safety, experience and outcomes	12 ↔	9	Chief Operating Officer	Overall score remains at 12. Likelihood previously reduced from 4 to 3 due to ongoing work across a number of areas e.g. NSO, haematology, NVIR, VIR. Although progress is being made the risk is not fully mitigated, therefore the assurance level remains at amber.
2b.2	**If** the Trust is unable to recover the backlogs created by COVID-19, combined with the increase in demand, **then** we may not be able to deliver our key performance targets, **resulting in** an adverse impact on patient safety, patient experience and potential regulatory action	12 ↓	8	Chief Operating Officer	Overall score reduced from 16 to 12 (Likelihood score reduced from 4 to 3). Positive work undertaken to clear the backlogs created as a result of COVID-19 and non-elective demand. Industrial action risk potentially reduced due to a new pay offer for Consultants, therefore further industrial action over winter period is unlikely. Board approval for roll over of insourcing for six-months in 23/24. Elective Task and Finish Group established to deliver sustainable in house capacity to reduce reliance on insourcing/outsourcing. Revised operational plan and priorities plan submitted to ICB in November 2023 in line with the operational planning guidance.
Strategic Objective 3 – To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion	**Risk appetite: Seek** - We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)			**Assuring Academy: People**	**Overall Assurance Level 2023/24:** Q1 / Q2 / Q3 / Q4
3.1	**If** we are unable to recruit to our vacancies, **then** our current staff will be placed under additional pressure and we may be unable to provide safe staffing levels, **resulting in** an adverse impact on patient safety and experience, staff experience and wellbeing, and an increase in staff turnover **NB This risk is also linked to Strategic Objective 1 - To provide outstanding care for our patients, delivered with kindness**	16 ↔	9	Director of HR / Chief Medical Officer / Chief Nurse	No change to overall risk score. Staffing across areas remains closely managed. Nurse staffing vacancies continue to be high. Higher sickness absence levels continue compared to pre-Covid, however absence rates are reducing. Additional services for elective on board with continued pressure of non-elective demand. Rolling domestic and international recruitment campaigns remain ongoing.

Ref	Strategic Risks	Current Score & Direction	Target Score	Executive Lead	Commentary (e.g. change in risk score, completed actions, reasons for any delays in actions)
3.2	**If** we are unable to maintain a healthy and engaged workforce, **then** we will be unable to reduce sickness absence and turnover rates, **resulting in** an adverse impact on patient safety and experience, and staff experience, wellbeing and morale.	9 ⟺	6	Director of HR	No change to overall risk score. Industrial action continues to impact.
3.3	**If** we are unable to recruit, retain and develop a workforce at all levels that is representative of the population we serve , **then** we may have low levels of staff engagement and morale, **resulting in** an adverse impact on patient safety and experience, staff experience and wellbeing, and a failure to attract staff to work for our Trust	9 ⟺	6	Director of HR	No change to overall risk score. Improved overall workforce position from ethnicity perspective, smaller improvement at Band 8A +.
Strategic Objective 4 – To be a continually learning organisation and recognised as leaders in research, education and innovation **Risk appetite: Open –** We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward		**Assuring Academy: Quality & Patient Safety**			**Overall Assurance Level 2023/24:** Q1 | Q2 | Q3 | Q4
4.1	**If** it is not possible to fill rota gaps or provide experienced trainers, **then** we may fail to provide an appropriate learning experience for trainees, **resulting in** an adverse impact on our reputation and potential withdrawal of the Trust's training accreditation status	9 ⟺	6	Chief Medical Officer	Score reduced from 12 to 9. Improved GMC training survey results compared to last year. Some previous areas of concern e.g. plastic surgery and obstetrics have shown improvement across the board. We are not an outlier in any particular domain.
4.2	**If** we fail to attract research funding and researchers to BIHR, **then** our research capacity and capability will be negatively impacted, **resulting in** a negative impact on patient care and population wellbeing, and the Trust's reputation as a leader in research	6 ⟺	6	Chief Medical Officer	No change in score. Continued success at securing research grants. New five year research strategy was launched in April 2023. Development of a research dashboard is almost complete. Successful bid for £8m funding for Secure Data Environment (SDE) developments.
4.3	**If** we do not have robust processes for incident identification, escalation and learning **then** we may fail to learn from incidents, **resulting in** gaps in safe clinical care	12 ⟺	8	Chief Medical Officer	New PSIRF now released and implementation process begun. Learning from deaths processes well-established. Well established Trust governance processes in place. New operational structure launched. Patient safety facilitators aligned to every CSU. A PSIRF training needs analysis was submitted to the Executive Team for review in early April 2023 and training was delivered to the Board in October. InPhase commissioned as our new system to support incident and risk management. InPhase will be launched December 2023/January 2024. The PSIRF Policy and Plan was approved by Board in November 2023. The Medical Examiner were undertaking an extended hours trial
Strategic Objective 5 – To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals **Risk appetite: Seek -** We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)		**Assuring Academy: N/A - Board**			**Overall Assurance Level 2023/24:** Q1 | Q2 | Q3 | Q4
5.1	**If** we do not effectively identify, develop and implement opportunities for collaboration and alignment across the ICS, **then** we may fail to deliver seamless, integrated care for the people of West Yorkshire, **resulting in** poor patient and staff experience, poor outcomes for patients, and missed opportunities to address health inequalities.	9 ⟺	6	Chief Executive	No changes to note. Board Discussion (May 2023) agreed Partnership Dashboard was pessimistic and proposed a moderated rating of "green"
5.2	**If** we do not effectively influence implementation of the Strategic Partnering Agreement and other elements of system integration in our Bradford District & Craven place, **then** we may fail to deliver seamless, integrated care for the people of Bradford District and Craven, **resulting in** poor patient and staff experience, poor outcomes for patients, and missed opportunities to address health inequalities.	9 ⟺	6	Chief Executive	Inequalities now featured as a key component within the EDI strategy as approved by the Board in March 2023, and reported to Q&PS Academy in May 2023 (QA.5.23.5). Work is progressing against the action plan.
Risk relevant to all strategic objectives **Risk appetite: Open –** We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward		**Assuring Academy: N/A - Board**			**Overall Assurance Level 2023/24:** Q1 | Q2 | Q3 | Q4
6	**If** we don't have effective Board leadership or robust governance arrangements in place, **then** the Board won't be able to lead and direct the organisation effectively, **resulting in** poor decision making, a failure to manage risks, failure to achieve strategic objectives, regulatory intervention and damage to the Trust's reputation.	20 (new risk)	10	Chief Executive	New risk as agreed by Board. Current score 20 due to gaps in control. Actions in place to address gaps and external consultancy commissioned to support this work.

Heat Map – August



= current score

LIKELIHOOD	CONSEQUENCE				
	Negligible (1)	Low (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost Certain (5)					
Likely (4)				3.1, 2a.3	2a.1, 2a.2, 6
Possible (3)			3.3, 5.1, 5.2, 3.2, 4.1	2b.1, 4.3, 1.1, 1.2, 2b.2	
Unlikely (2)			4.2		
Extremely unlikely (1)					

Strategic Objective 1 - To provide outstanding care for our patients, delivered with kindness	
Ref: 1.1	**Strategic Risk: If** we fail to understand and address the needs of our population, **then** we won't be able to deliver appropriate services, **resulting in** worsening health inequalities

Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	**Movement in score December 2022 – December 2023**	**Initial Score (CxL): 4x3=12**
Date added: 1 April 2022 **Date of last review:** 24 November 2023		**Current Score (CxL): 4x3=12**
Lead Director: Karen Dawber, Chief Nurse / Ray Smith, Chief Medical Officer		**Target Score (CxL): 4x2=8**

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance	
• Community Engagement Meetings - monthly • Patient Experience team gathers insights and shares with teams as appropriate • Patient and public engagement undertaken as part of Act as One programmes • Membership Plan - objective to increase engagement with members • Work with third sector e.g. Maternity Voices Partnership • Patient and Public Engagement Officer in post • Quality Improvement Programmes • Strategic Equality & Diversity Council • Community Contact Programme (wellbeing outreach to community venues identifying indicators of poor health) • Patient Experience Survey for surgical patients (part of OTS) • EDI Strategy • Health Inequalities & Waiting List Analysis • Born in Bradford BIHR programme • Age of Wonder BIHR programme • Ref: Strategic Risk 3.3 – controls in place to ensure our workforce is representative of our population. • Improvement Strategy approved by Board 16th November 2023. • EDI Quality Priority. • Oliver McGowan Training funding approved (online element mandated for this year).	**Internal** **Positive:** • Patient Experience Annual Report 2021/22 (inc. complaints, compliments, PALS, FFT) • Patient Experience 6 monthly update – May 2023 • Patient Experience Group Update – latest October 2023 • Monthly Maternity Services Update – latest as at October 2023 • CLIP Report – latest as at Q4 22/23 • SI Report – latest as at October 2023 • Quality Dashboard – latest as at October 2023 • LeDeR Annual Report • Health Inequalities & Waiting List Analysis Report – Board September 2023 • Quality Account 22/23 • REACT year 1 analysis reported to Board September 2023. **Negative:** • CLIP Report – latest as at Q4 22/23 • SI Report – latest as at October 2023 • Quality Dashboard – latest as at October 2023	**Independent** **Positive:** • Internal Audit reports: ➢ End of Life Care – Patients with LDs – Significant assurance (October 2021) ➢ Quality Improvement & Oversight – High assurance (May 2022) ➢ Safeguarding – Domestic Violence – Significant assurance (January 2023) ➢ Complaints – Significant Assurance (March 2023) • GIRFT Litigation Report – timeliness of responses • Annual Inpatient Survey • Urgent & Emergency Care Survey 2020 – number of improved areas e.g. confidence in clinicians, cleanliness. • WRES/WDES Report • Annual Maternity Survey • National Audit for Care at the End of Life (NACEL) – reported within the Palliative Care Annual Report at Quality and Patient Safety Academy January 2023. • Best Employer for Diversity and Inclusion – Nursing Times Award **Negative:** • Internal Audit reports: ➢ Consent – Limited assurance (January 2022) ➢ ReSPECT – Limited assurance (January 2022) ➢ NatSSIPs – Limited assurance (April 2023) • GIRFT Litigation Report • Annual Inpatient Survey • Urgent & Emergency Care Survey 2020 – clear theme re: better communication required.	**Gaps in control** • Inequalities in access to our services • Impact of industrial action – increased waiting list could worsen health inequalities **Gaps in assurance** • Quality & Patient Safety Dashboard doesn't' capture issues regarding inequalities	**Action** • Waiting list analysis work and actions to address findings • Operational plans to manage industrial action • Dashboard to be updated.	**Timescale** Ongoing Current position: Agreed approach has successfully prioritised patients with LD and this process will continue with oversight within the RTT Access meetings as business as usual. Waiting list analysis routinely considers Index of Multiple Deprivation (IMD), ethnicity and age alongside referral priority and treatment function, allowing us to monitor the impact of elective recovery efforts in line with national guidance. A focus on reducing DNA rates is part of operational plans for the current year as we have evidenced that this reduces the wait time for patients who historically have poorer health outcomes. Ongoing Item to Quality and Patient Safety Academy in November 2023 regarding Health Inequalities.
Related risks on the high level risk register (operational risks)	N/A				

Strategic Objective 1 – To provide outstanding care for our patients, delivered with kindness

Ref: 1.2	**Strategic Risk: If** we fail to maintain and develop our care environment, **then** we may not be able to deliver modern, outstanding care for our patients, **resulting in** poor patient experience and outcomes and limited ability to deliver services

Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 1 April 2022

Date of last review: 24 November 2023

Lead Director: Karen Dawber, Chief Nurse / Ray Smith, Chief Medical Officer

Movement in score December 2022 – December 2023

25
20
15
10
5
0

December, February, April, June, August, October, December

Current Score
Target Score

Initial Score (CxL): 4x4=16

Current Score (CxL): 4x3=12

Target Score (CxL): 4x2=8

Key controls (what are we doing about the risk?)

- Virtual Royal Infirmary (VRI) Project
- Infection Prevention & Control policy and processes in place, oversight through IPC Committee and Quality & Patient Safety Academy
- Quality Improvement Programmes
- Action plans in place to address findings of e.g. Inpatient Survey and Urgent & Emergency Care Survey
- Funding secured for twin day case theatres on SLH site – build started.
- Plans for improvement of IPC compliant patient accommodation developed and funded.
- IPC Awareness Day – took place on 24 November 2022
- Embedding Kindness and Civility Programme
- Worries and Concerns Pilot
- £25m successful bid for endoscopy unit, will include regional immersion training centre.
- Sepsis dashboard went live in August 2023.
- Work being done to improve theatre environment – including anaesthetic rooms, pre-waiting areas, reception, changing areas.
- Development of outdoor areas, e.g. gardens.
- Closed ED model – Phase 1 is now operational.
- Main entrance BIHR – Elm investment.
- St Luke's Hospital Day Case.
- Ward 1-3 new side rooms for higher PPLV room/2 negative pressure for where there is a risk of infected patients.

Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)

Internal

Positive:

- Estates & Facilities Quarterly Service Report – latest Q4 2022/23
- IPC Quarterly Report – latest November 2023
- IPC Board Assurance Framework – latest report as at November 2023
- PAM Report to Board September 2023.

Negative:
N/A

Independent

Positive:

- Meeting National Cleaning Standards
- Meeting National Food Standards
- Annual Inpatient Survey
- Urgent & Emergency Care Survey 2020 – number of improved areas e.g. cleanliness.
- Internal Audit reports:
  - Infection Control – PPE Availability & Compliance – High assurance (July 2021)
  - Estates Planned Preventative Maintenance (PPM) Compliance – Significant assurance (September 2021)
  - Hospital Acquired Infections – Significant assurance (December 2021)
  - Pressure Ulcers – Significant assurance (December 2021)
  - Health & Safety inc RIDDOR – Significant assurance (March 2022)
  - IPC Board Assurance Framework – Significant assurance (July 2022)
  - Catering – Significant assurance (September 2022)
  - Pharmacy & Medicine Management; Controlled Drugs – Significant assurance (October 2022)
  - Medical Devices – Significant assurance (January 2023)
  - Ionising Radiation – Significant assurance (January 2023)
  - Ward Accreditation internal audit – Significant assurance (April 2023)
  - Visiting Internal Audit – High assurance (April 2023)
  - Infection Prevention and Control; Bloodstream infections – High assurance (August 2023)
- HTA inspection March 2023
- Women and Children's Pilot presented to Chief Nurse of England Meeting

Negative:

- Annual Inpatient Survey
- EPRR assessment – non-compliant.
- Internal Audit reports:
  - Nutrition & hydration – Limited assurance (January 2022)
  - Patient Safety; Sepsis Management – Limited assurance (September 2023)

Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?) / **Actions to address gaps in controls or assurance**

Gaps in control	Action	Timescale
Some areas are not suitable for airborne infections	Manage patient flow according to side room specifications	Ongoing
Lack of negative pressure isolation rooms	Daily review of potential patients for de-isolation.	Ongoing. Work on ward 1 is nearing completion.
No formal lead allocated for anti-microbial stewardship (AMS)	A business case is being prepared for another anti-microbial clinical pharmacist	Ongoing. Current position: A risk assessment and gap analysis would be undertaken to support the development of the business case.
Gaps in assurance		
N/A		

Related risks on the high level risk register (operational risks)

- **3627** – Backlog maintenance and critical infrastructure risk (current score: 20)
- **3748** – Renal services capacity (current score: 16)

Strategic Objective 2a – To deliver our financial plan

Ref: 2a.1	**Strategic Risk:** **If** we continue to face financial challenges associated with cost inflation, increased demand for services and System/Place affordability, **then** we may fail to maintain financial stability and sustainability, **resulting in** reduced opportunities to meet demand and to maintain/improve the quality of care, an increased likelihood of system intervention, potential regulatory action, and a negative impact on the Trust's reputation.

Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 1 April 2022

Date of last review: 5 December 2023

Lead Director: Director of Finance

Movement in score December 2022 – December 2023

25
20
15
10
5
0
December
February
April
June
August
October
December
Current Score
Target Score

Initial Score (CxL): 5x4=20

Current Score (CxL): 5x4=20

Target Score (CxL): 4x2=8

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?) – Internal	Assurance – Independent	Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance – Action	Timescale
• Continued evolution of the Clinical Service Unit financial management arrangements and framework, with associated accountability and performance management framework • Performance management and reporting of Waste Reduction plans • Creation of the Waste Reduction Group with a view to monitoring and supporting delivery • Scheme of Delegation, internal financial control environment (revised February 2023). • Financial governance and control arrangements. • Quality Impact and Financial Impact Assessment processes. • Revised Budgetary Management Framework (presented and approved at Executive Team and September 2022 Finance and Performance Academy) • Update to Procurement strategy, risk register and work plan • Establishment of a Waste Reduction Group and task and finish groups focussing on specific workstreams to improve the run rate (targeting known hot spots, overspending cost lines – e.g. Elective Recovery and the reduction of in and outsourcing, Junior Doctor rota overspends & general e-roster controls and management). • Establishment of separate Financial Performance Meetings for escalated CSU's, with meetings chaired by Deputy Ops Directors and supported by Service Area Triumvirate.	**Internal** **Positive:** • Extended Monthly Finance Report to F&P Academy, latest as at October 2023 (ongoing improvements to content to improve understanding and reflect performance management BAU activities) • Extended CSU Monthly Finance reports to improve understanding of underlying and projected performance • Monthly F&P Academy Dashboard, latest as at October 2023 • Quarterly Capital Report, latest as at October 2023 • Bi-Annual Treasury Management Report, latest October 2023 • Bi-Annual report on Pathology Joint Venture financial position, latest May 2023 • Quarterly Place and System Financial Update Report, latest as at June 2023 • Waste Reduction Group updates to the F&P Academy (Monthly) • September 2022 update to Procurement strategy, risk register and work plan (presented to Finance & Performance Academy) – with periodic updates provided (e.g. Sept 2023 F&P Academy) • CSU specific financial performance review meetings for escalated CSU's, supported by service area triumvirate **Negative:** N/A	**Independent** **Positive:** • Future Focused Finance Level 1 Accreditation • Internal audit reports: ➢ PLICS – High assurance (March 2022) ➢ Effective Procurement – High assurance (March 2022) ➢ Payroll – Significant assurance (May 2022) ➢ Improving NHS Financial Sustainability - no opinion given (November 2022) ➢ Financial Planning & Budget Setting – High assurance (December 2022) ➢ IFRS 16 Effectiveness & Risk Management - High Assurance (January 2023) ➢ Financial Transactions – High Assurance (April 2023) **Negative:** N/A	**Gaps in control** The focus on operational pressures to provide safe care throughout winter and the periods of industrial actions have impacted on the capacity and capability to establish a waste reduction plan that would sustainably secure the financial target for 2023/24.	Maintaining equilibrium across the balanced scorecard requires the commitment to apply normal financial management arrangements. Attention must turn to identifying recurrent and sustainable run rate improvements for 2023/24.CSUs and Support Departments to source, develop and implement recurrent, sustainable run rate improvements	On-going throughout 2022/23 and into 2023/24 Qtr 3 2023/24
			Gaps in assurance CSUs and support departments have not identified the full value of their waste reduction targets. The CSUs and corporate departments have been set a Q1 target date for identification of Waste reduction plans. Q1 delivery will be dependent on known and live schemes together with the deployment of non-recurrent measures.	Increased focus required on the identification and implementation to waste reduction plans supported by business partners and the governance arrangements established to support identification, implementation and delivery	Qtr 3 2023/24

Related risks on the high level risk register (operational risks)	• **3800** - Significant Increase in the cost of Trust's gas and power from the 1st April 2024 (current score: 20)

Strategic Objective 2a – To deliver our financial plan	
Ref: 2a.2	**Strategic Risk:** **If** we fail to manage Income & Expenditure within planned parameters, **then** we may have insufficient cash and liquidity resources to sustainably support the underlying Income & Expenditure run rate, **resulting in** an impact on operational and capital investment decisions, reduced opportunities to meet demand and to maintain/improve the quality of care, an increased likelihood of system intervention, potential regulatory action, and a negative impact on the Trust's reputation.

	Movement in score December 2022 – December 2023	
Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward		**Initial Score (CxL): 5x4 = 20**
Date added: 1 April 2022 **Date of last review:**5 December 2023		**Current Score (CxL): 5x4 = 20**
Lead Director: Director of Finance		**Target Score (CxL): 4x2 = 8**

Movement in score December 2022 – December 2023

25
20
15
10
5
0
December
February
April
June
August
October
December
Current Score
Target Score

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?) – Internal	Assurance – Independent	Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance – Action	Timescale
• The cash & liquidity position is managed and monitored by the Cash Committee with updates provided to the Finance & Performance Academy via the monthly Finance Report and the periodic Treasury Management Report. • Continued sourcing of cash releasing efficiencies. • Additional measures taken to improve financial control in the immediate and longer term, for example the curtailment of planned investments in the Capital Programme. • Scheme of Delegation, internal financial control environment (revised February 2023). • Adoption of appropriate financial controls (extending beyond those already in place) to manage the run rate, as proposed by the Region & ICB when reviewing the operational plan and the current status of the system financial position.	**Internal** **Positive:** • Monthly Finance Report , latest as at October 2023 • Monthly F&P Academy Dashboard, latest as at October 2023 • Bi-Annual Treasury Management Report, latest October 2023 **Negative:** N/A	**Independent** **Positive:** • Internal audit reports: ➢ PLICS – High assurance (March 2022) ➢ Effective Procurement – High assurance (March 2022) ➢ Financial transactions – High assurance (April 2023) ➢ Payroll – Significant assurance (May 2022) ➢ Expenditure with Independent Sector – Significant assurance (November 2022) ➢ Improving NHS Financial Sustainability - no opinion given (November 2022) ➢ Financial Planning & Budget Setting – High assurance (December 2022) ➢ IFRS 16 Effectiveness & Risk Management - High Assurance (Jan 2023) ➢ Financial Transactions – High Assurance (April 2023) **Negative:** N/A	**Gaps in control** The focus on operational pressures to provide care throughout winter and the periods of industrial actions has impacted on the capacity and capability to establish a waste reduction plan that would sustainably secure the financial target for 2023/24.	**Action** Maintaining equilibrium across the balanced scorecard requires the commitment to apply normal financial management arrangements. Attention must turn to identifying recurrent and sustainable run rate improvements for 2023/24.CSUs and Support Departments to source, develop and implement recurrent, sustainable run rate improvements	**Timescale** On-going throughout 2022/23 and into 2023/24 Qtr 3 2023/24
			Gaps in assurance CSUs and Support Departments have not identified the full value of their waste reduction targets.	Increased focus required on the identification and implementation to recurrent waste reduction plans supported by business partners and the governance arrangements established to support identification, implementation and delivery	Qtr 3 2023/24
Related risks on the high level risk register (operational risks)	N/A				

Strategic Objective 2a – To deliver our financial plan

Ref: 2a.3	**Strategic Risk: If** the capital funding allocation from the ICS is not sufficient to meet our requirements and/or we are unable to deliver our capital programme in full by the end of the financial year, **then** we may not be able to make the capital investments required to maintain safe and sustainable services, **resulting in** a negative impact on the quality of care, the capacity available to treat patients in a safe environment and a negative impact on the Trust's reputation.

Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 1 April 2022

Date of last review: 5 December 2023

Lead Director: Director of Finance

Movement in score December 2022 – December 2023

25
20
15
10
5
0
December
February
April
June
August
October
December
Current Score
Target Score

Initial Score (CxL): 4x4 = 16

Current Score (CxL): 4x4 = 16

Target Score (CxL): 4x2 = 8

Key controls (what are we doing about the risk?)

- Pre planning and visibility on high risk investment requirements.
- List of risk stratified prioritised long list of investment requirements has been established.
- Intensified oversight and governance of the capital programme via Capital Strategy Group and Capital Operational Group.
- Project phasing or the bringing forward of projects to manage the overall quantum.
- Re-purpose existing capital allocations elsewhere in overall programme to support risk.
- Look to source alternative income flows to support the investment plan that do not impact on CDEL (eg charitable donations).
- Small contingency retained for emergency capital requirements.
- Creation of a reserve list to draw from, should the approved schemes project a shortfall on their annual allocation – to ensure the full allocation is spent in year.

Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)

Internal
Positive:

- Monthly Finance Report , latest as at October 2023
- Monthly F&P Academy Dashboard, latest as at October 2023
- Bi-Annual Treasury Management Report, latest October 2023
- Capital Plan approved by 2023/2024 – Board of Directors March 2023 and F&P Academy March 2023
- Capital report to F&P Academy, latest October 2023
- Scheme slippages have been replaced by the schemes on the reserve list
- Approval of additional posts within the Estates capital team to increase capacity

Independent
Positive:

Internal Audit reports:

- Capital Projects – Significant assurance (May 2022)
- Improving NHS Financial Sustainability - no opinion given (November 2022)
- Financial Planning & Budget Setting – High assurance (December 2022)

Negative:

N/A

Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance: Action	Timescale
Gaps in control There are no material gaps in control, with the programme managed and monitored through the Capital Strategy Group and Capital Operational Group. The scoring of the risk is reflective of: 1. The operational capital allocation which is an externally determined value and as such limits the value that can be invested into capital on an annual basis. 2. The ability to deliver a £59m programme from an external supply chain perspective, with extended lead times on delivery experienced across all aspects of the capital programme. This includes Estates schemes where the development, design and procurement timeline is in excess of 6 months.	Closely monitor delivery of the Programme and ensure the full value of the programme is delivered	On-going on a monthly basis
Gaps in assurance The assurance that the Trust has sufficient resource/ support in place to deliver a programme of £59m in 2023/24.	To continually monitor ongoing delivery with early identification of risk	On-going on a monthly basis

Related risks on the high level risk register (operational risks)	**3627** – Capital resource to reduce identified backlog maintenance (current score: 20)

Strategic Objective 2b – To deliver our key performance targets

Ref: 2b.1	**Strategic Risk: If** the Trust is unable to transform its services, **then** we may not be able to deliver resilient services that are fit for the future, **resulting in** a loss of staff, and a negative impact on patient safety, experience and outcomes

Risk Appetite: Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	**Movement in score December 2022 – December 2023**	**Initial Score (CxL): 4x4 = 16**
Date added: 1 April 2022 **Date of last review:** 30 November 2023		**Current Score (CxL): 4x3 = 12**
Lead Director: Chief Operating Officer		**Target Score (CxL): 3x3 = 9**

Chart data (Movement in score December 2022 – December 2023):

	December	February	April	June	August	October	December
Current Score	16	16	16	16	12	12	12
Target Score	12	12	12	9	9	9	9

Key controls (what are we doing about the risk?)

- Service planning
- Operational Improvement Plan (Delivering Operational Excellence) 2023-25 approved
- Act as One Programmes
- Acute collaboration with Airedale
- WYAAT – Transformation Programmes, Fragile services workstream
- To address workforce gaps – dedicated recruitment (national and international), regional rota
- Outstanding work programmes (Outstanding Theatres Services (OTS), Outstanding Pharmacy Services (OPS))
- Exec to CSU meetings
- Hospital Management Group
- NSO North Sector Programme Director role appointed and workshops established
- CSU Restructure implemented (Delivering Clinical Excellence)
- Creation of operational, financial and workforce plans to achieve operational planning guidance expectations 23/24.
- Capital investments such as MRI scanner and a bid application submitted and approved for St Luke's Day Case Unit (completion due 15 April 2024) and Community Diagnostic Centre (completion due by March 2024).
- Bid submitted and approved and project board set up for Endoscopy Unit (£24m)
- Virtual Royal Infirmary programme
- Elective Task and Finish Group established to deliver sustainable in house capacity to reduce reliance on insourcing/outsourcing
- Younger persons frailty ward open.
- Stroke Rehab Ward due to open 11th December 2023.
- Pharmacy Aseptic Unit funding agreed (£4.5m)

Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)

Internal

Positive:

- Act as One Updates to F&P Academy – latest October 2023
- Partnerships Dashboard – latest as at November 2023
- WYAAT ICS Programme Updates – latest July 2023 – e.g. WYVAS second arterial centre
- Exec to CSU scorecard / rating
- Outstanding Theatres Programme update to Quality Academy – latest September 2023
- Outstanding Pharmacy Programme update to People Academy – November 2023
- Cancer Performance Improvement Plan to F&P Academy – latest July 2023
- RTT Improvement Plan to F&P Academy – latest July 2023
- Urgent & Emergency Care Improvement Plan to F&P Academy – latest September 2023
- Winter Response Plan – F&P Academy – October 2023
- Delivering Operational Excellence Plan to F&P November 2023
- Endoscopy Business Case report to F&P March 2023. Formal confirmation of approval from NHS team received. Ratification of contract through Board in September 2023. Preferred contractor appointed.
- Approval of capital investments for St Luke's Day Case Unit and Community Diagnostic Hub. Contract work being undertaken. Practical completion is 15th April 2024. CDC to be live by 31 March 2024.
- Performance Report to F&P November 2023
- Operational Improvement Plan - 22/23 Progress Update & ambitions for 23/24 – F&P Academy June 2023.

Negative:

- WYAAT reports (e.g. Non-Surgical Oncology, Haematology)

Independent

Positive:

- GIRFT reports
- CQC Maternity Report – 'well led' improved to Good and overall BRI site now rated Good
- Royal Colleges reports
- Exit from Maternity Support Programme confirmed January 2023
- Benchmarking of recovery position compared to other Trusts (Performance Report to F&P Academy, latest March 2023)
- SSNAP (Stroke Audit Programme) – Quarter 4 (Jan-Mar23) Overall 'C' Rating – improved position.
- Internal audit reports:
  - Asset Utilisation – Endoscopy (follow up) (December 2021)
  - Centralised Patient Booking Service – Significant assurance (March 2022)
  - Recovery of Cancer Services – Significant assurance (April 2022)
  - Recovery of Elective Services – Significant assurance (May 2022)
  - Recovery of services post Covid-19 – Significant assurance (May 2023)
  - Patient Safety; National Standards for Cancer Patients - Significant Assurance(May 2023)
  - Management of Patient Flow – Command Centre – High assurance (July 2023)
  - Demand Management – Significant assurance (June 2023)
- Human Tissue Act assessment

Negative:

- GIRFT Reports
- Joint venture – loss of UKAS accreditation

Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?) / Actions to address gaps in controls or assurance

Gaps in control	Action	Timescale
Workforce gaps in some service areas (e.g. VIR, NVIR,NSO) resulting in inability to maintain service provision in the longer term and shorter term gaps associated with industrial action	BTHFT / CHFT / AGH group of clinical leads and managers established to work through sustainable NVIR service model. NVIR service model in place. Ongoing discussions with Finance colleagues across Place.	Financial model to be agreed.
	Locum agency / international search for suitable VIR candidates	Ongoing
Fragile services e.g. Stroke, Haematology, NVIR, VIR, Histopathology	WYH Cancer Alliance / NSO steering group input to deliver recommended sector model. NSO North Sector Group – 5 sessions held and target operating model developed.	Ongoing
	Work with COO / MD counterparts at AGH to develop service resilience plans at place. The Acute Provider Collaborative to establish a formal working relationship.	Ongoing
	Haematology service review across WYAAT. First meeting taken place and subsequent meetings planned. Subsequent work plan for on call rota being worked through. Internal Haematology improvement project established.	Ongoing
Financial challenges for 2023/24 resulting in less resources to develop and transform services	Work with CSUs in order to have robust CIPs in place ensure we are able to invest in transforming our services. Waste Reduction Group established.	Ongoing
	Work with CHFT to review clinical model for plastic surgery across Bradford CHT footprint.	Ongoing
Gaps in assurance		
N/A		

Related risks on the high level risk register (operational risks)

- **3808** – Industrial Action (current score: 20)

Strategic Objective 2b – To deliver our key performance targets

Ref: 2b.2	**Strategic Risk: If** the Trust is unable to recover the backlogs created by COVID-19, combined with the increase in demand, **then** we may not be able to deliver our key performance targets, **resulting in** an adverse impact on patient safety, patient experience and potential regulatory action

Risk Appetite:
Open - We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 1 April 2022

Date of last review: 30 November 2023

Lead Director: Chief Operating Officer

Movement in score December 2022 – December 2023

25
20
15
10
5
0
December
February
April
June
August
October
December
Current Score
Target Score

Initial Score (CxL): 5x4 = 20

Current Score (CxL): 4x3 = 12

Target Score (CxL): 4x2 = 8

Key controls (what are we doing about the risk?)

- Service Planning process
- Ward Escalation Plan
- Delivering Operational Execellence Plan 2023-25
- Command and Control structure (Gold, Silver, Bronze)
- CSU to Executive conversations
- Command Centre and day-to-day capacity management
- Engagement with regulators (CQC inspection manager)
- Use of Independent Sector
- Operational planning (in line with planning guidance)
- Bid made under TIF to create dedicated day case theatres at St Luke's Hospital (SLH) – contractor approved and onsite. Practical completion 15th April 2024.
- Weekly operational restart and recovery meeting
- Board approval for continued insourcing for 6 months in 23/24.
- Elective Task and Finish Group established to deliver sustainable in house capacity to reduce reliance on insourcing/outsourcing
- Winter Response Plan
- Ring fenced elective wards and capacity (at BRI site)
- Creation of operational, financial and workforce plans to achieve operational planning guidance expectations 23/24
- Endoscopy unit - business case submitted to national team has been approved and contract award ratified at Board September 2023. Contractor in place.
- Community Diagnostic Centre live in Q4 2023/24.

Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)

Internal
Positive

- Finance & Performance Academy Dashboard – monthly, latest as at November 2023
- Operational Performance Highlight Report, latest as at September 2023
- Performance Report – monthly, latest as at November 2023
- Cancer Performance Improvement Plan to F&P Academy – latest July 2023
- RTT Improvement Plan to F&P Academy – latest October 2023
- Urgent & Emergency Care Improvement Plan to F&P Academy – September 2023
- Delivering Operational Excellence Plan 23-25 – F&P Academy November 2023

Negative

- EPRR self assessment core standards - 32% compliant – overall non-compliant

Positive (areas meeting or exceeding plan):	Negative (areas not meeting plan):
• Cancer 28 Day Faster Diagnosis • 104 Week Waits (RTT) • 78 Week Waits (RTT) • Cancer 2 Week Wait	• Diagnostics Waiting Times • RTT Incomplete • 18 Week Waits (RTT) • 52 Week Waits (RTT) • Length of Stay ≥21days • Cancer 62 Day First Treatment • Cancer 62-day backlog • Ambulance Handover 30-60mins • Ambulance Handover 60+mins • Emergency Care Standard

Green = improving
Black = no change
Red = deteriorating

Independent
Positive:

- Benchmarked performance data from NHSE.
- Approach from NHSE for mutual aid support to Sheffield Teaching Hospitals Cancer Urology Department.
- Provide mutual aid to Airedale NHS Foundation Trust in relation to Urgent & Emergency Care.
- NHSE Quarterly place-based assurance visits for Bradford
- COVID-19 no longer classified as a national level 3 incident
- SSNAP (Stroke Audit Programme) – Quarter 4 (Jan-Mar 23) Overall 'C' Rating – improved position.
- Internal audit reports:
  - Management of Patient Flow – Significant assurance (December 2021)
  - Asset Utilisation – Endoscopy (follow up) (December 2021)
  - EPRR – Significant assurance (January 2022)
  - Centralised Patient Booking Service – Significant assurance (March 2022)
  - Recovery of Cancer Services – Significant assurance (April 2022)
  - Recovery of Elective Services – Significant assurance (May 2022)
  - Recovery of services post Covid-19 – Significant assurance (May 2023
  - Patient Safety; National Standards for Cancer Patients - Significant Assurance(May 2023)
  - Management of Patient Flow – Command Centre – High assurance (July 2023)
  - Demand Management – Significant assurance (June 2023)

Negative:

- Benchmarked performance data from NHSE

Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?) / **Actions to address gaps in controls or assurance**

Gaps in control	Action	Timescale
• Lack of up-to-date operational, financial and workforce plans to deliver appropriate level of activity due to uncertainty around funding allocations and national priorities for future years	• Working with national and regional partners to influence and input into reviews of services	Ongoing
• Lack of ring-fenced ultra-green elective offsite facility	• Following successful TIF bid, implementation of dedicated day case theatres at SLH. Practical completion confirmed 15th April 2024.	April 2024
• JAG accreditation not achieved, lack of physical capacity	• Development of new endoscopy unit at BRI. Contractor appointed.	Business case approved - £24m (£8.5m in 2022/23 and £16m in 2023/24). Programme board established. Sign off for emergency decision complete and ratified at Board September 2023.
• Impact from industrial action	• Industrial action response plan and working with areas to minimise patient impact. National offer under review by BMA. Unlikely further industrial action throughout winter.	Ongoing
Gaps in assurance		
• Lack of assurance about longer term capacity of independent sector and ongoing funding to support reset and recovery of elective services	• Ongoing work with independent sector and our internal task and finish group to reduce the reliance on independent section	Ongoing

Related risks on the high level risk register (operational risks)

- **3877**: If we are unable to manage ongoing operational pressures due to high demand and Covid backlogs, then there may be delays to treatment, resulting in harm to patients and/or poor patient experience (current score: 16)
- **3808** – Industrial Action (current score: 20)

Strategic Objective 1 – To provide outstanding care for our patients, delivered with kindness

Strategic Objective 3 - To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion

Ref: 3.1	**Strategic Risk: If** we are unable to recruit to our vacancies, **then** our current staff will be placed under additional pressure and we may be unable to provide safe staffing levels, **resulting in** an adverse impact on patient safety and experience, staff experience and wellbeing, and an increase in staff turnover

Risk Appetite:
Seek: We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)

Date added: 1 April 2022

Date of last review: 24 November

Lead Director: Director of HR / Chief Medical Officer / Chief Nurse

Movement in score December 2022 – December 2023

25
20
15
10
5
0
December
February
April
June
August
October
December
Current Score
Target Score

Initial Score (CxL): 4x4 =16

Current Score (CxL): 4x4 = 16

Target Score (CxL): 3x3 = 9

Key controls (what are we doing about the risk?)

- Recruitment plans – domestic and international. Significant number of international nurses due to start in Autumn 2023.
- Recruitment Open Days – including for St Luke's Day Case Unit
- Engagement of marketing company to market HCA/RN vacancies
- Widening participation programme of work
- Development programmes for managers
- Re-launch and re-brand of the Band 5-7 development days (Step Ladder to Success)
- Links with further and higher education institutions
- Development of Thrive
- Place based 'Growing for the Future' workstream
- WYAAT Fragile services workstream and joint recruitment plans
- Apprenticeship workplan
- Optimise the use of the TRAC system
- Workforce planning processes
- Development/expansion of new roles i.e. Medical Support Worker, Physicians Associates (Lead Physician Associate starts in Sept 2023)
- People Promise Exemplar Site
- Business case agreed for Specialist Recruitment Adviser and increases to recruitment team – additional resource being recruited following business case
- Adherence to national guidance documents for all professions
- Twice yearly strategic nursing and midwifery review of safe staffing levels (skill mix, specialist requirements)
- Adherence to GIRFT / Model Hospital Guidance on clinical services
- Electronic roster (Allocate) linked to acuity score of patient (Safe Care)
- Operational oversight daily: Silver / Gold
- Outstanding Maternity Services, Outstanding Theatres and Outstanding Pharmacy Services programmes
- Development of facilities within theatres e.g. changing areas
- Development of outdoor spaces e.g. gardens
- Link Medics – recruited an additional 8 FY1 doctors
- Chief Registrar role
- ETM approval to bid for NHSE Clinical Leadership Fellow
- Approval for two Clinical Support Workers to work at night as part of the Hospital at Night project
- Introduction of Legacy Nurse mentors, to support staff and aid retention
- Progression towards the interim quality mark for Preceptorship (expected January 2024)
- Development of an extended 10 day HCSW induction delivered by subject matter experts to ensure our HCSWs have the skills required for role and are aligned to Trust values
- Ward 17 – new model launched.
- Job planning.

Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)

Internal

Positive:

- Workforce report – recruitment data – latest as at October 2023
- Junior doctor August rotation fill rates
- People Dashboard – number of apprenticeships – latest as at December 2022
- CSU to Executive meetings re: recruitment activity
- Nursing recruitment and retention plan- February 2023
- Nursing & Midwifery Staffing Review – November 2023
- Nursing & Midwifery Staffing Data Publication – November 2023
- Nurse Staffing Board Assurance Framework - latest April 2023
- Workforce planning submission – People Academy March 2023

Negative:

- People Dashboard: staff sickness rates and turnover rates – latest as at June 2023. Still not meeting plan but an improved position.
- Agency fill rates

Independent

Positive:

- Internal audit reports:
  - Temporary Workforce – Bank staff - Significant assurance (September 2021)
  - Attendance controls for locum doctors – Significant assurance (October 2021)
  - Healthcare Support Worker; Recruitment & Development – Significant assurance (May 2022)
  - Recruitment & Retention; NHS People Plan – Significant assurance (May 2022)
  - Safer Staffing Assurance Framework – High assurance (August 2022)
  - Recruitment Practice & Process – High assurance (September 2022)
- Model Hospital benchmarking data e.g. agency usage
- Growing Our Workforce highlight report – BD&C Workforce Committee – April 2023
- GMC Survey.

Negative:

- Internal audit reports:
  - Fixed Term Contracts - Limited assurance (January 2022)
- Model Hospital benchmarking data e.g. sickness absence
- GMC Survey – Foundation Year Doctors.

Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance	
Gaps in control	**Action**	**Timescale**
Recruitment team – turnover and vacancies	Recruitment to vacancies and use of bank staff.	Ongoing
Industrial action (Junior doctors and consultants) – no indications of negotiations to resolve	Operational plans to manage.	Ongoing
Gaps in assurance		
Lack of assurance re: workforce supply with gaps in some service areas	Local and national issue – actions ongoing within the Trust and at place and national levels	Ongoing

Related risks on the high level risk register (operational risks)

- **3732 –** Inability to maintain safe staffing levels (current score: 16)
- **3630** - Staffing shortages are compromising the ability of the Children's community team to provide the level of respite care that has been agreed with commissioners (current score: 16)
- **3404** - There is a risk that Optimal staffing levels within all areas of the maternity services not achieved due to vacancies, maternity leave, Covid isolation rules and long/short term sickness levels (current score: **15)**
- **3808** – Impact of industrial action (current score: 20)
- **3660** - Rapid increase in number of attendances to Paediatric ED and CCDA (current score: 16)

Strategic Objective 3 - To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion

Ref: 3.2	**Strategic Risk: If** we are unable to maintain a healthy and engaged workforce, **then** we will be unable to reduce sickness absence and turnover rates, **resulting in** an adverse impact on patient safety and experience, and staff experience, wellbeing and morale.

Risk Appetite: Seek: We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)	**Movement in score December 2022 – December 2023**	**Initial Score (CxL): 3x4 = 12**
Date added: 1 April 2022 **Date of last review:** 7 December 2023		**Current Score (CxL): 3x3= 9**
Lead Director: Director of HR		**Target Score (CxL): 2x3 = 6**

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?) – Internal	Assurance – Independent	Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance – Action	Timescale
• Thrive programme – to support improved wellbeing – including Leadership Conference • HR policies and wellbeing support offers • Occupational Health Service • EAP provision • Exit interview process (face to face and ESR) • ‘Stay’ interviews • Application of absence management policy • Staff networks • Staff survey action plan • Civility at Work programme • Freedom to Speak Up (FTSU) policy and processes • Guardian of Safe Working processes • Mediation and Staff Advocacy services • Looking after our People Trust and Place level delivery groups in place • People Promise Exemplar site • Leadership pathway development • Wellbeing conversations • Quarterly Pulse surveys in place • Psychology staff support offer • Drama based civility training	**Internal** **Positive:** • People Dashboard and Workforce Report – as at October 2023 • FTSU cases • Occupational Health / Psychological support referrals (management referrals, limited data on self referrals) • FTSU Annual report and Quarterly Report – latest as at Q2 2023/24 • 2022 Staff Survey action plan – People Academy June 2023 • Guardian of Safe Working Quarterly Report – latest as at Q2 2023/24 • Psychology staff support offer - clinically and statistically significant improvement for staff in individual, occupational and social functioning – presentation to People Academy September 2022 **Negative:** • Sickness absence and turnover rates – behind plan but improving position – June 2023 • Appraisal rates	**Independent** **Positive:** • Staff survey results – slightly above average for compassion and inclusion, recognition/reward, voice that counts, for learning, working flexibly, team working, staff engagement and morale. On par nationally for safe and healthy. • Quarterly pulse surveys • Model Hospital benchmarking • Improved GMC training survey results for 2023 compared to 2022. Some previous areas of concern e.g. plastic surgery and obstetrics have shown improvement across the board. We are not an outlier in any particular domain. • Internal audit reports: ➢ FTSU – Significant assurance (September 2021) ➢ Junior Doctor E-Rostering – Significant assurance (June 2021) ➢ Non Clinical Appraisal – Significant assurance (November 2022) **Negative:** • Model hospital benchmarking	**Gaps in control** • Method of measuring and managing short term sickness needs review	• Review sickness absence policy	Q1 24/25
			• Insight into reasons why staff stay at BTHFT / what makes a good staff experience	• Review/extend ‘stay’ interviews. Pilot underway in Education services, further areas being considered.	Q4 23/24
			• Temperature checks of the general ‘mood’	• Increase uptake of quarterly pulse survey	Q4 23/24
			• Occupational Health Service pressures	• Recruitment to OH Clinical Psychologist post and remaining vacant nursing hours.	Q4 23/24
			• Industrial action (Junior doctors and consultants) – no indications of negotiations to resolve	• Operational plans to manage.	Ongoing
			Gaps in assurance N/A		

Related risks on the high level risk register (operational risks)	
	• **3767** - Maternity staff: access to lone worker devices (current score: 16) • **3808** – Impact of industrial action (current score: 20)

Strategic Objective 3 - To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion

Ref: 3.3	**Strategic Risk: If** we are unable to recruit, retain and develop a workforce at all levels that is representative of the population we serve, **then** we may have low levels of staff engagement and morale, **resulting in** an adverse impact on patient safety and experience, staff experience and wellbeing, and a failure to attract staff to work for our Trust

Risk Appetite: **Seek:** We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)	**Movement in score December 2022 – December 2023**	**Initial Score (CxL): 3x3 = 9**
Date added: 1 April 2022 **Date of last review:** 7 December 2023		**Current Score (CxL): 3x3=9**
Lead Director: Director of HR		**Target Score (CxL): 3x2=6**

Movement in score December 2022 – December 2023

25
20
15
10
5
0
December
February
April
June
August
October
December
Current Score
Target Score

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?) – Internal	Independent	Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance – Action	Timescale
• Implementation of WRES / WDES / Gender Pay Gap action plans • Equality & Diversity Council • Staff networks • Gender Equality Reference Group • Recruitment and selection training programme • Development programmes for managers including Leadership programmes • Head of Equality, Diversity & Inclusion and team in post • Reciprocal mentoring programme • 3 year EDI Strategy in place with refreshed EDI objectives and implementation plan • NHS Improvement plan – 6 high impact actions • Implementation of Equality Delivery System 2022 (EDS) • EDI training for managers in place (including EDI related case studies, with specific focus on disability, race and LGBT+ equality and ensuring compassionate and inclusive leadership)	**Internal** **Positive:** • People Dashboard: BAME overall workforce – latest as at March 2023 • Gender Pay Gap – improving position – latest as at March 2023 • Annual report to Board re disciplinary processes - May 2023 • WRES/WDES/EDI Update report - - May 2023 (People Academy) **Negative:** • Disability declaration rate • People Dashboard: BAME representation at senior level– latest as at March 2023 • Report to Board: disciplinary processes – latest as at 31 August 2023	**Independent** **Positive:** • WRES/WDES benchmarking reports: positive • NHS Staff survey outcomes: positive • Gender pay gap benchmarking reports [to confirm if positive or negative after publication] • Inclusion & Belonging highlight report – BD&C Workforce Committee – April 2023 • Internal audit reports: ➢ NHS People Plan; Belonging in the NHS (February 2023) – Significant assurance **Negative:** • WRES/WDES benchmarking reports • NHS Staff survey outcomes: negative • Gender pay gap	**Gaps in control** • Remaining improvements to Recruitment & Selection from an EDI perspective (e.g. finalisation of managers toolkit) • Meaningful equality impact assessments resulting in service improvements	**Action** • In development • To continue to roll out the equality impact assessment guidance and proforma	**Timescale** December 2023 Ongoing
			Gaps in assurance N/A		
Related risks on the high level risk register (operational risks)	N/A				

Strategic Objective 4 - To be a continually learning organisation and recognised as leaders in research, education and innovation

Ref: 4.1	**Strategic Risk: If** it is not possible to fill rota gaps or provide experienced trainers, **then** we may fail to provide an appropriate learning experience for trainees, **resulting in** an adverse impact on our reputation and potential withdrawal of the Trust's training accreditation status

Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 1 April 2022

Date of last review: 24 November 2023

Lead Director: Chief Medical Officer / Chief Nurse

Movement in score December 2022 – December 2023

25
20
15
10
5
0
December
February
April
June
August
October
December
Current Score
Target Score

Initial Score (CxL): 4x4=16

Current Score (CxL): 3x3=9

Target Score (CxL): 3x2=6

Key controls (what are we doing about the risk?)

- Internal training and network support for appraisers.
- Guardian of Safe Working Hours process.
- Identification of missed training opportunities and taking action where appropriate.
- Training and support for education supervision.
- Training facilities.
- Simulation and clinical skills laboratories with funded time for consultant supervision.
- Junior Dr rota co-ordinator in place who works with the Flexible Workforce team to ensure gaps are covered.
- Junior Dr representative on JNCC.
- Junior Drs forum.
- Education Strategy.
- Education Quality Meeting – Bi-Monthly.
- Ongoing recruitment of non trainee medical staff to fill gaps in rotas.
- Appointment of an SAS Advocate role.
- Appointment of a Chief Registrar to feedback and input into clinical training and education.
- Physician Associate Preceptorship Pilot Project.
- ASPiH accreditation achieved for simulation centre and services provided at BTHFT.
- Appointment of Lead Physician Associate.
- Development of Education Services Dashboard.
- Increasing numbers of trained assessors/supervisors by provision of online supervisor and assessor training.
- Piloting new models of supervision in maternity and adult placements areas.
- Increased student capacity by utilising newly established services and trialling a rota based system for students.
- Implementation of student led clinics in physiotherapy.
- Providing additional opportunities for students/trainees to provide feedback via formal and informal methods.
- Recruitment of legacy mentors in maternity and nursing.
- Recruitment and retention plan being implemented for nursing/midwifery and AHPs.
- Progress towards gaining the interim Quality mark for Preceptorship – expected January 2024.
- Provision of development opportunities related to retention of staff.
- Multi-professional preceptorship programme in place for Newly Qualified Nurses, Midwives and AHPs.
- Multi-professional student forums offered on monthly basis.
- HEE National Education & Training Survey (NETS) is actively promoted to all learners on placement.
- Quarterly meetings with GMC Employment Liaison Advisor.
- Maximising recruitment of short term doctors to fill rota gaps – annual programme of recruitment.
- Hospital at Night Project – pilot complete, full business case under consideration.
- Link Medics – recruitment of 8 additional FY1 doctors.
- ETM approved recruitment of 3.4 WTE Clinical Fellows who will provide supervision to medical students and relive pressures in clinical areas.
- ETM approval to bid for NHSE Clinical Leadership Fellow. 12 month contract to commence from August 2024.
- Medical rota re-written to increase Junior Doctor presence in daytime hours and reduce out of hours working.
- Development of a Supporting Students Policy.
- Environmental improvements for doctors mess facilities.

Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)

Internal

Positive:

- Guardian of Safe Working Hours – quarterly reports – latest report Q4 22/23 (People Academy – September 2023
- Appraisal & Revalidation Annual Report – latest report 22/23 (People Academy – 5 July 2023).
- Appraisal Quality Assurance Group – annual review of appraisal quality.
- Results of appraisal feedback questionnaires.
- Annual Medical Appraisal Report / Board compliance statement June 2023

Negative:

- Guardian of Safe Working Exception reports re: missed educational opportunities or additional hours.
- GOSW hours annual report (May 2023)

Independent

Positive:

- HEE Yorkshire and the Humber Quality Interventions: Trust Update Report – 2022 – no Enhanced Monitoring Cases, two requirements closed following improvements being made.
- HEE National Education & Training Survey (NETS) – January 2023. Positive outliers for every domain.
- University of Leeds Medical School MPET Report (Annual) – October 2022 – improved scores in e.g. overall placement rating, learning environment and support.
- University of Leeds Medical School MPET Report (Interim) – March 2022 – overall placement rating improved, other positives e.g. welcoming and friendly staff, clinical skills teaching.
- PARE 2022 Feedback for Nursing and Midwifery show high scores and good practice relating to clinical handover.
- Improved GMC training survey results for 2023 compared to 2022. Some previous areas of concern e.g. plastic surgery and obstetrics have shown improvement across the board. We are not an outlier in any particular domain. Ranked 55/226 in the UK for Clinical Supervision Out of Hours.
- Apprenticeship team recognised through the Bradford Means Business awards for their work across the district with young people and improved educational opportunities.
- Senior Leaders engagement event with NHSE in November 2023 – positive feedback report.

- Internal audit reports:
  - Medical Education – Significant assurance (April 2022)
  - E-Rostering – Junior Doctors – Significant assurance (June 2022)
  - Medical Revalidation – Significant assurance (August 2022)

Negative:

- HEE National Education & Training Survey (NETS) – January 2023 – FY1 doctors in Surgery were negative outliers.
- GMC survey 2023 BTHFT ranked 217/229 in the UK for Workload and 201/228 for Facilities.
- University of Leeds Medical School MPET Report (Interim) – March 2022 – areas for improvement e.g. overcrowding, no provision for supervisors being on leave, induction/orientation.
- PARE 2022/2023 Student feedback for Nursing and Midwifery placements identified some areas of concern regarding Trust staff behaviours and values. Some reports of belittling or racist behaviour towards students.

Gaps in controls or assurance

Gaps in control

- Numbers of junior doctors on rotas

Gaps in assurance

N/A

Actions to address gaps in controls or assurance

Action	Timescale
Lobby Deanery to increase trainee numbers	Ongoing
Development of Hospital at Night project.	December 2023 Phase 1 – Clinical Support Workers – advert out.

Related risks on the high level risk register (operational risks)	N/A

Strategic Objective 4 - To be a continually learning organisation and recognised as leaders in research, education and innovation

Ref: 4.2	**Strategic Risk: If** we fail to attract research funding and researchers to the Trust, **then** our research capacity and capability will be negatively impacted, **resulting in** a negative impact on patient care and population wellbeing, and the Trust's reputation as a leader in research

Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 1 April 2022

Date of last review: 24 November 2023

Lead Director: Chief Medical Officer

Movement in score December 2022 – December 2023

25
20
15
10
5
0
October
December
February
April
June
August
October
Current Score
Target Score

Initial Score (CxL): 3x3=9

Current Score (CxL): 3x2=6

Target Score (CxL): 3x2=6

Key controls (what are we doing about the risk?)

- Ensure research activity and involvement encouraged by providing infrastructure and support for research; this is being done in a number of ways including:
- Research infrastructure – Bradford Institute for Health Research, NIHR Patient Recruitment Centre, Wolfson Centre for Applied Health Research.
- Research Governance and Management Structure in place within the Trust, i.e. Director of Research, R&D Office, financial management of research, etc, which provide advice, support and leadership and oversee activity and performance.
- Trust Research Strategy and Trust policy on conducting research in the Trust.
- Trust Research Committee and reporting to Quality & Patient Safety Academy and Trust Board.
- Strong research reputation particularly in the fields of applied health research and these teams are continually applying for grant funding.
- Raising awareness of research, publicity of research successes, part of Trust induction.
- All research teams have research targets and performance reports sent to them along with relevant CSU on a quarterly basis and CSUs sign off capacity and capability that can conduct new research.
- New Research Strategy document completed and reported to Board.
- City of Research Framework Document circulated for approval by partners.
- New BIHR main entrance at build stage and to be completed by May 2024.
- Research Matron, now responsible for management of Research Nurses.
- Mobile Research Vehicle– funded by NIHR – to take research into communities.
- BIHR - successful £8m bid for Secure Data Environment (SDE).
- £5.8M NIHR funding secured for continuation of the Patient Safety Research Centre.
- £5M Health Determinants Research Collaboration (HDRC) funding secured.

Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)

Internal

Positive:

- Quarterly Research Activity reports to Quality & Patient Safety Academy– latest November 2023.
- Quarterly Research reports and presentations on research projects to Board – latest November 2023.
- Research Performance Reports for Research teams sent out on quarterly basis.
- Internal annual review with each research team.
- Internal audit of research.

Negative:

- Unclear how the CSUs use the research performance reports to manage research activity.
- Some teams are not achieving targets due to lack of clinician input due to interest/ time.
- Lack of awareness that research is core business for Trust - survey 2021 conducted by R&D office.

Independent

Positive:

- Annual reports and reviews for projects where we are the lead organisation, e.g. NIHR programme grants, NIHR RCF annual reporting.
- External Performance review meetings and annual reports for NIHR Patient Recruitment Centre, etc.
- Annual review meeting with Yorkshire and Humber Clinical Research Network.
- Various research finance audits.
- Participant Research Experience Survey 'PRES' – positive responses.
- Promotion of PRES completion leading returns target being exceeded.
- NIHR quarterly 'Performance in Initiating and Delivering Clinical Research' submission 'PID submission'.

Negative:

- Some research areas not meeting targets in terms of Recruitment to Time and Target.

Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?) / **Actions to address gaps in controls or assurance**

Gaps	Action	Timescale
Gaps in control		
Promotion of research activity and raise awareness that research is a core business for Trust.	Trust Research Strategy and associated action plan.	Strategy approved September 2022; implementation started
How research is promoted and managed within CSUs as Core Business.	CSUs' research activity to be part of the formal Trust Performance Framework	Ongoing
Gaps in assurance		
Better research information to allow real time reporting and improved research activity management by CSUs and research teams.	Production of research dashboard that can be accessed by Trust staff.	Delayed; originally scheduled to be June 2022 but anticipating that achieved by March 2024.
	Promotion of ward entrance	March 2024.

Related risks on the high level risk register (operational risks)	N/A

Strategic Objective 4 - To be a continually learning organisation and recognised as leaders in research, education and innovation

Ref: 4.3	**Strategic Risk: If** we do not have robust processes for incident identification, escalation and learning **then** we may fail to learn from incidents, **resulting in** gaps in safe clinical care

Risk Appetite: Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 1 April 2022

Date of last review: 24 November 2023

Lead Director: Chief Medical Officer

Movement in score December 2022 – December 2023

25
20
15
10
5
0
December
February
April
June
August
October
December
Current Score
Target Score

Initial Score (CxL): 5x3=15

Current Score (CxL): 4x3=12

Target Score (CxL): 4x2=8

Key controls (what are we doing about the risk?)

- Exec led weekly Quality of Care (QuOC) Panel.
- Daily Trust Safety Event Huddles led by Quality Governance Team.
- Weekly Safety Event Group.
- Monthly Patient Safety Group.
- Support CSU triumvirates in developing narrative in quality quadrant within performance balance score card.
- New roles developed to support Quality Governance Framework: Quality and Patient Safety Facilitators aligned to new CSUs.
- Assessment of Trust's readiness for the transition to new Patient Safety Incident Management System replacing the NRLS and STEIS.
- Full-time Patient Safety Specialist in post supported by 4 senior leads.
- Gap analysis complete for National Patient Safety Strategy identifying key work streams for transition to Patient Safety Incident Response Framework (PSIRF). Implementation meetings held and training undertaken for those managing incidents and investigators.
- Continue with QI tests of change to support incident reporting.
- Develop intranet pages for clinical negligence claims / coroner cases, Incident reporting, Risk management and Learning from Deaths.
- Develop bite size training modules to support understanding of above.
- Just Culture and Civility work streams / Freedom to Speak Up supported by People Academy.
- Develop learning framework.
- Being Open / Duty of Candour Policy updated 2021.
- Incident Reporting & Investigation Policy to be reviewed to align to PSIRF form December 2023.
- Participation in the West Yorkshire Association of Acute Trusts Learning Forum.
- Commissioner membership of Quality and Patient Safety Academy.
- Quality Account and identification of priority areas.
- Quality & Patient Safety Academy – meetings split between assurance and learning/improvement focus.
- Communications with Datix has resumed to support required upgrade to facilitate transition to LFPSE (replacing NRLS). Deadline for transition is October 2023 we are on track to do this. CLIP report has been introduced which triangulates, complaints, litigation, incidents and patient experience data to establish further opportunities for learning.
- Continue to be part of the 'Learning Together' research programme.
- Monthly Quality and Safety meetings have commenced in all CSUs, most are using standardised Quality Governance Framework. The Associate Director of Quality is planning on attending in each CSU to evaluate how well embedded this is over the coming weeks.
- Role of Medical Examiner who has scrutinised 100% of deaths since October 2021.
- Learning from Deaths work.
- InPhase commissioned as our new system to support incident and risk management.
- QI training for consultants.
- 'Worry and concerns' pilot.
- NatSSIPs handbook updated and lead reinstated.
- Improvement Strategy approved.
- PSIRF policy and plan approved by Board on 16 November 2023.

Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)

Internal

Positive:

- Quality Oversight & Assurance Profile – monthly – latest report as at July 2023.
- Serious Incident Report – latest as at July 2023.
- CLIP (Complaints, Litigation, Incidents, Patient Experience) report – quarterly – latest report June 2023 (covering 22/23).
- Tracking of actions from safety events overseen by Patient Safety Group.
- Ward / department quality accreditation programme.
- Quality Account – progress on priority areas – Quality Academy (March 2023)
- Medical Examiner has scrutinised 100% of deaths since October 2021.
- Learning from Deaths – latest report May 2023.
- Deep dive review of SHMI May 2023

Negative:

Assurance programme to be re-started.

Independent

Positive:

- Internal audit reports:
  - Incident reporting – Significant assurance (December 2021)
  - Quality & Patient Safety Academy – Significant assurance (January 2022)
  - Quality Improvement & Oversight – High assurance (May 2022)
  - Serious Incidents – Significant assurance (May 2023)
  - CSU Governance Structures – Significant assurance (July 2023)
  - Safety Alerts – Significant assurance (
- Commissioner review of incident investigation reports that meet the criteria under the current SI Framework.

Negative:

- External bodies feedback e.g. CQC, Coroner PFD Regulation 28
- Internal audit reports:
  - Safer Procedures; NatSSIPs - Limited assurance (March 2023)

Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)

Actions to address gaps in controls or assurance

Gaps in control	Action	Timescale
Strong lines of governance accountability through CSU, Service group.	Quality Strategy to be developed.	Complete.
	Implementation of PSIRF.	December 2023.
Current Datix license to expire in early 2023.	Renew/replace – InPhase commissioned.	December 2023/ January 2024
Gaps in assurance		
N/A		

Related risks on the high level risk register (operational risks)	N/A

Strategic Objective 5 – To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals

Ref: 5.1	**Strategic Risk: If** we do not effectively identify, develop and implement opportunities for collaboration and alignment across the ICS, **then** we may fail to deliver seamless, integrated care for the people of West Yorkshire, **resulting in** poor patient and staff experience, poor outcomes for patients, and missed opportunities to address health inequalities.

Risk Appetite: **Seek:** We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)	**Movement in score December 2022 – December 2023**	**Initial Score (CxL): 3x3 = 9**
Date added: 1 April 2022 **Date of last review:** 5 December 2023		**Current Score (CxL): 3x3 = 9**
Lead Director: Chief Executive		**Target Score (CxL): 3x2 = 6**

25
20
15
10
5
0
December
February
April
June
August
October
December
Current Score
Target Score

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance	
	Internal	**Independent**	**Gaps in control**	**Action**	**Timescale**
• Supporting ongoing work across the ICS to implement the requirements of the Health and Social Care Act through the WY Health & Care Partnership (HCP – i.e. integrated care system) and WYAAT (WY association of acute trusts). • Implementation of BTHFT's Corporate Strategy 2022-2027 through service development; collaborative working is a regular feature of Exec/CSU discussions. • Cross system participation in: ➢ WYHCP Partnership Board and ICB ➢ WYAAT Programme Exec (CEOs); Committee in Common (BTHFT Chair & CEO); Exec Directors' groups (e.g. Finance, Med Directors, HR Directors, COOs, Strategy Directors) ➢ Development of clinical networks and collaborative solutions e.g. for non-surgical oncology, pathology, aseptics, LIMS replacement. ➢ Development of a clinical strategy for West Yorkshire as part of our WYAAT (acute trust) programme. • CEO involvement in and leadership of WYHCP and WYAAT programmes e.g. critical care	**Positive:** • Partnerships Dashboard has consistently shown "green/amber" rating *(e.g. Bo.5.23.17 – May 2023)* and Board has encouraged a more positive report based on current position, so Dashboard is predominantly Green from Sept 2023 • CEO and Chair reports to Board consistently highlight positive examples of collaborative working *(e.g. CEO report Bo.7.23.7 – July 2023)* • Updates to Board on BTHFT input to WYHCP developments *(e.g Board Development session 9th February 2023 to discuss WYAAT strategy led by Lucy Cole – WYAAT Programme Director)* • There is a Health Inequalities workstream in place at BTHFT providing regular reports to the Equality & Diversity Council. **Negative:** N/A	**Positive:** • WYAAT & WYHCP programme update reports and position summary to every Board of Directors meeting demonstrate BTHFT input *(e.g. Bc.7.23.12 – July 2023)* **Negative:** N/A	N/A **Gaps in assurance** • We do not currently have a simple credible metric to demonstrate the degree of collaboration/integration and measure progress. In the November 2020 "Integrating Care" document, NHSE/I stated that "Next year we will introduce new measures and metrics to support … [stronger system working]… including an "integration index" for use by all systems". Further updates are awaited (as at July 2023). • There is no discrete Committee or Academy for Strategic Objective 5, which includes health inequalities, so we are reliant on this being covered in general discussion in Academies, Board, and associated bodies to assess our progress. This can work very well but need to maintain discipline to ensure the theme does not get "lost in the mix" or timed out at the end of meetings.	• Revise existing Partnerships Dashboard to capture activity/progress in a more meaningful/accessible way • Ensure that inequalities component of all our work is recognised at every opportunity e.g. in all three Academies and in broader Board discussions. In July 2022 the Board received a comprehensive analysis of waiting lists – Bo.7.22.14, and a further update in March 2023 – Bo.3.23.10.	• Revised Partnerships dashboard has been developed (May 2022) and is now submitted to each Board with updated entries to provide relevant and timely information • Ongoing – Board dashboard includes Reducing Inequalities update (e.g. Bo.7.23.19 – July 2023) • Since May 2023 Health Inequalities is reported at the "Learning and Improvement" sessions of the Quality & Patient Safety Academy (QA.5.23.5).
Related risks on the high level risk register (operational risks)	N/A				

Strategic Objective 5 – To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals

Ref: 5.2

Strategic Risk: If we do not effectively influence implementation of the Strategic Partnering Agreement and other elements of system integration in our Bradford District & Craven place, **then** we may fail to deliver seamless, integrated care for the people of Bradford District and Craven, **resulting in** poor patient and staff experience, poor outcomes for patients, and missed opportunities to address health inequalities.

Risk Appetite:
Seek: We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)

Date added: 1 April 2022

Date of last review: 5 December 2023

Lead Director: Chief Executive

Movement in score December 2022 – December 2023

Initial Score (CxL): 3x3 = 9

Current Score (CxL): 3x3 = 9

Target Score (CxL): 3x2 = 6

Key controls (what are we doing about the risk?)

- The revised governance of our BD&C H&CP involves oversight by a Partnership Board and a Leadership Exec (PLE) – BTHFT is represented on both.
- BTHFT is involved in all of the BD&C HCP revised priority areas: Access to Care; Communities; Children, Young People and Families; Mental Health, and Workforce. The previous 7 transformation programmes have moved into the new priorities and will continue to operate in the short-medium term. Respiratory, diabetes and healthy hearts have moved into the Access to Care priority area to form a long term conditions stream along with cancer care. The Access to Care Programme Board is chaired by BTHFT's Chief Operating Officer.
- We will increasingly work with the Population Health programme - a source of detailed local data to support identification of inequalities – to better target our work.
- Our refreshed Corporate Strategy "Patients, People, Partners & Place" (June 2022) is closely aligned to new Place-based strategy and emphatically reinforces our commitment to BD&C Health & Care Partnership.
- BTHFT is actively involved in:
  - the Strategic Partnering Agreement (SPA),
  - joint 2023/24 plans to NHSE (via WYHCP), including the new Joint Forward Plan
  - place based committees (e.g. Finance, Quality) and
  - operational matters like COVID-19 vaccination programmes, and "enabling" programmes in support of revised priority areas. Our CEO is the Place Lead.
- Extensive collaboration between BTHFT clinicians and system partners for example with AFT in multiple specialties (e.g. stroke) and with Primary Care in VRI work. AFT and BTHFT are re-establishing an acute collaboration programme with a clearer focus on a few specialties than previous initiatives
- Director of Strategy & Integration involvement in BD&C Inequalities Alliance; "Alliance for Life Chances" etc.
  - Cross system participation in Bradford & District Wellbeing Board
- Development of integrated bid for strategic capital investment (new hospitals).
- Exploring the potential to work collaboratively across the BD&C Health & Care Partnership for specific innovations that are part of the NHS Clinical Entrepreneur Programme.
- Developing a BD&C Health and Care Partnership approach to virtual ward delivery as part of the VRI Programme.
- Inequalities now featured as a key component within the Trust's EDI strategy.
- Working with Quality colleagues to explore how HIs can be included within CSUs' service development/quality improvement work. (supported by Patient Safety Facilitators).

Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)

Internal	Independent
Positive: • Partnerships Dashboard has consistently shown "green/amber" rating *(e.g. Bo.5.23.17 – May 2023)* and Board has encouraged a more positive report based on current position, so Dashboard is predominantly Green from Sept 2023 • CEO and Chair reports to Board consistently highlight positive examples of collaborative working *(e.g. CEO report Bo.7.23.7 – July 2023)* • Updates to Board on BTHFT input to BD&C HCP developments *(e.g. Procurement Strategy Bo.5.22.10 – May 2022)* **Negative:** N/A	**Positive:** • Act as One programme updates, reporting to revised priority Boards *s)* **Negative:** N/A

Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?) / **Actions to address gaps in controls or assurance**

Gaps	Action	Timescale
Gaps in control N/A		
Gaps in assurance • We do not currently have a simple credible metric to demonstrate the degree of collaboration/integration and measure progress. In the November 2020 "Integrating Care" document, NHSE/I stated that "Next year we will introduce new measures and metrics to support … [stronger system working]… including an "integration index" for use by all systems". Further updates are awaited (July 2023)	• Revise existing Partnerships Dashboard to capture activity/progress in a more meaningful/accessible way.	• Revised dashboard has been developed and is submitted - with recently updated entries - to Board for information e.g. Bo.3.23.21 in March 2023.
• There is no discrete Committee or Academy for Strategic Objective 5, which includes health inequalities, so we are reliant on this being covered in general discussion in Academies, Board, and associated bodies to assess our progress. This can work very well but need to maintain discipline to ensure the theme does not get "lost in the mix" or timed out at the end of meetings.	• Ensure that inequalities component of all our work is recognised at every opportunity e.g. in all three Academies and in broader Board discussions. In July 2022 the Board received a comprehensive analysis of waiting lists – Bo.7.22.14, and a further update in March 2023 – Bo.3.23.10.	• Ongoing – Board dashboard includes Reducing Inequalities update (e.g. Bo.7.23.19 – July 2023) • Since May 2023 Health Inequalities is reported at the "Learning and Improvement" session of the Quality & Patient Safety Academy (QA.5.23.5)

Related risks on the high level risk register (operational risks): N/A

Risk relevant to all strategic objectives

Ref: 6

Strategic Risk: If we don't have effective Board leadership or robust governance arrangements in place, **then** the Board won't be able to lead and direct the organisation effectively, **resulting in** poor decision making, a failure to manage risks, failure to achieve strategic objectives, regulatory intervention and damage to the Trust's reputation.

Risk Appetite:
Open – We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward

Date added: 6 December 2023

Date of last review: 6 December 2023

Lead Director: Chief Executive

Score December 2023

Initial Score (CxL): 5x4 = 20

Current Score (CxL): 5x4 = 20

Target Score (CxL): 5x2 = 10

Key controls (what are we doing about the risk?)	Assurance (+ve or –ve) (how do we know if the things we are doing are having an impact?)		Gaps in controls or assurance (what more should we be doing and what additional assurance do we need?)	Actions to address gaps in controls or assurance	
	Internal	**Independent**	**Gaps in control**	**Action**	**Timescale**
• Board and Committee/Academy structure • Committee/Academy Chair reports to the Board • Arrangements in place to ensure compliance with Code of Governance for NHS Provider Trusts and NHS Provider Licence • Suite of governance documents in place and reviewed regularly including Constitution, Scheme of Delegation, Standing Orders • Corporate Strategy sets out the objectives and ambitions of the Trust • Suite of supporting strategies • Board Development Sessions • Effectiveness reviews of Board, Committees, Academies • Appraisal process for Board members • Risk Management Strategy • Risk Appetite Statement agreed and reviewed on an annual basis • High Level Risk Register and Board Assurance Framework • Conflicts of Interest Policy and processes • NED Champion roles • Board member participation in PLACE and 15 steps visits • Board member attendance at Equality & Diversity Council • Reviews of composition of Board through NRC and Governors NRC • Fit and Proper Person checks undertaken annually • Council of Governors – quarterly meetings including holding the NEDs to account for the performance of the Board	**Positive:** • Annual Governance Statement • Annual Report • Quality Account • Annual review of compliance against Code of Governance and NHS Provider Licence • Annual review of NED independence • Corporate Strategy annual update • BAF • High Level Risk Register • Academy/Committee Chair reports to the Board **Negative:** • BAF and High Level Risk Register – risks above target score / risk appetite level	**Positive:** • Annual VFM assessment • Head of Internal Audit Opinion • Internal Audit reports: ➢ Organisation governance – effectiveness of Academies & reporting lines – Significant assurance (September 2022) ➢ Policy Management - High assurance (September 2023) ➢ Board Assurance & Risk Management Framework – Significant assurance (April 2023) **Negative:** N/A	• Improvements to 'technical' governance e.g. Board/Committee/Academy arrangements • Improvements to Board 'dynamics' • Separation of SID and Deputy Chair roles • NED appraisals to be completed • Fit and Proper Person checks to be completed in line with new framework • Executive and Non Executive vacancies • Substantive Chair not in post	• Annual Board/Academy/Committee effectiveness reviews to be completed including reviews of agendas, TORs, work plans, reporting templates • Creation and delivery of Board development programme • New SID to be appointed • Interim Chair to complete appraisals • Checks to be completed • Recruitment to vacancies • Recruitment of new Chair	March 2024 12-18 months – June 2025 TBC February 2024 March 2024 March 2024 March 2024
			Gaps in assurance • External Well Led Review to be undertaken	• Review to be commissioned	• Q4 23/24
Related risks on the high level risk register (operational risks)	N/A				

All Open Operational Risks with a current scoring of >=15 sorted by risk score - highest to lowest (December 2023)

ID	Date of entry	Lead Director	Risk Lead	Source of risk	Assuring Academy	Description	Next review date	Risk Rating (Initial)	Consequence (Initial)	Likelihood (Initial)	Risk Rating (Residual)	Consequence (Residual)	Likelihood (Residual)	Existing control measures	Current Summary of risk treatment plan/mitigation	Target date	Risk Rating (Current)	Consequence (Current)	Likelihood (Current)
3627	10/02/2021	Horner, Matthew	Davies, Chris	Business Continuity	Quality & Patient Safety Academy	If the Trust does not invest significant capital resources to reduce the identified backlog maintenance and critical infrastructure risk of its estate, significant business continuity impact due to failure of estates infrastructure / engineering systems / building fabric will be experienced. The Trust has identified backlog maintenance and critical risk remedial works calculated at £93m (excluding associated asbestos abatement estimated at a further £30m). Due to the limited financial capital allocations available to the Trust to support the associated risk prioritised remedial work plan, the Trust is unable to significantly reduce the business continuity risk associated with failure of the estate and its engineering system and catch up with the expediential life expiry of the estate.	19/03/2024	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	10	(5) Catastrophic	(2) Do not expect it to happen again but it is possible	•An identified backlog maintenance programme of work has been identified •Risk assessments and weighted assessments for backlog risk prioritisation is being undertaken. •A current facet survey inspection is being undertaken to identify and allocate funding resources. (exp April 22) •Planned Preventative Maintenance is undertaken as per HTM/Statutory and good practice guidance to maintain buildings and building services plant and equipment.	Sept 2023: The 5 year programme continues to progress using the allocated budget.	31/03/2025	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue
3748	15/02/2022	Smith, Dr Ray	Green, Jen	Directorate Objective	Quality & Patient Safety Academy	Renal Services Capacity There is a risk that as the demand for hemodialysis (HD) at Bradford Teaching Hospitals NHS Foundation Trust renal dialysis units has reached the available capacity and that it will not be possible to provide timely dialysis for some patients. Increasing demand within the local demographic and an aging and limited foot print has created a risk that any loss of capacity could lead to clinical harms for patients resulting from sub optimal dialysis provision as the only means of managing dialysis across the patient group. There is a high risk of increasing down time at the St Luke's site and the satellite unit at Skipton because of the aging infrastructure. Loss of either facility for an extended period would be unsustainable without seeking support from organizations both within and without the region.	29/02/2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue	3	(3) Moderate	(1) Cannot believe that this will ever happen again	Patients who cannot be dialysed in a timely way are monitored and clinically managed on a daily basis. We are providing twice weekly dialysis (instead of 3 sessions) where it is clinically appropriate, this is not to manage capacity. Patients who require urgent care through lack of timely dialysis can be brought to BTHFT for treatment as acute patients, however capacity to deliver this is very limited, and emergency/ reactive dialysis carries a high degree of risk of adverse outcomes and would place severe unsustainable stress our on call emergency dialysis service which should be reserved for acutely ill inpatients. Specialist nurse staffing is augmented by TNR and agency staff Additional staffing capacity has been built into the rota using existing staff. Patients are encouraged to take up peritoneal dialysis where clinically appropriate and where possible with the restricted theatre availability. We have introduced a fluoroscopic PD catheter insertion service and are strongly promoting home-based renal replacement therapies, including renal transplantation. Provision of an HD service requires specialist nursing skills which can be augmented by agency or TNR nurses. In the event of a sustained loss of facility, further mitigation would be implemented (but our staffing is also stretched and this would compromise the following additional steps): Services extended into overnight/out of hours 6 or 7 days a week. Further reduced dialysis sessions Displacement of patients to other facilities potentially at some distance of travel.	11/11/23 Given Skipton is now the only available site with capacity and is expected to be utilised from January 2024 with capacity for 20 patients, the risk likelihood has been increased meaning the overall risk score is now 20.	30/09/2024	20	(4) Major	(5) Will undoubtedly recur, possibly frequently
3808	06/10/2022	Lal, Faeem	Lal, Faeem	Trust Wide Risk	Finance and Performance, People, Quality & Patient Safety Academy	Risk of impact on patient care and safety, impact on staff morale and resilience. If industrial action persists it will have an impact on the Trust's ability to continue to provide safe care for patients and could result in patient safety incidents or harm. There is the risk of negative impact on staff morale. There is the risk of delays to patient treatment and the Trust's ability to manage the back log from the pandemic. Ongoing strike action is having an impact on staff who are covering during strikes and senior managers who are responsible for ensuring safe staffing and patient safety.	31/03/2024	12	(3) Moderate	(4) Will probably recur, but is not a persistent issue	16	(4) Major	(4) Will probably recur, but is not a persistent issue	Operational planning response, command structure in place when notified of industrial action. Command structure in place on strike days. Daily operational planning meetings in place. Department/service impact assessments in place. Detailed communications plan in place. Operational strike planning meetings in place. Assurance checklist in place. Unable to fully mitigate risks at present.	Update 04/08/2023 - continued strike action now including Consultants as well as junior doctors with further restriction now in place on the use of agency workers to cover gaps for striking staff. Operational plans being developed to manage patient safety. Command and Control structure in place as per previous strikes. Ops Huddle meetings in place daily. Rota's being reviewed and service impact assessments in place. Elective activity to be reviewed once rota information available but expected to be significantly impacted due to restrictions on use of agency and with it being peak leave period.	31/03/2024	20	(4) Major	(5) Will undoubtedly recur, possibly frequently
3881	27/07/2023	Azeb, Sajid	Smith, David	CQC Visit	People, Quality & Patient Safety Academy	If we are unable to recruit to a number of unfilled pharmacy vacancies and provide cover to deliver a 7 day service then the Trust will not improve and sustain medicines reconciliation rates to above national average resulting in a regulatory risk to the Trust's aspiration to become an 'Outstanding' provider and an increased risk of harm to patients if unresolved	29/12/2023	16	(4) Major	(4) Will probably recur, but is not a persistent issue	8	(4) Major	(2) Do not expect it to happen again but it is possible	- Pharmacy team in place to complete medicines reconciliation - Utilisation of locum and bank staff to help fill gaps - Prioritisation of patients to see use the Cerner EPMA system. - Skill mix to push more technicians out onto the wards to support meds rec - Trust policy in place defining approach to undertaking daily medicines reconciliation	23/10/23 More pharmacists now in place to undertake med rec. Risk score reduced to 12. Further review once the department is fully staffed Update 08/09/23 A number of new starters have commenced with the service and are currently being trained up. In addition a number of colleagues have returned from leave. To retain current risk rating and then review when impact of new staff on meds rec figure is known. - Active recruitment campaign in place. Phil Moore – Assistant Director of Pharmacy – Clinical Services (ongoing) - Skill mix to attract and recruit a greater number of foundation level pharmacists. Amna Khan-Patel Clinical Pharmacy Team Leader Education and Training (completed) - Skill mix to recruit two teacher practitioner posts at the local schools of pharmacy to further attract staff. Amna Khan-Patel Clinical Pharmacy Team Leader Education and Training (Recruited UoB Post – awaiting start date, UoH Post at recruitment stage) - Recruitment of a Pharmacist in the Emergency Department to facilitate medication reconciliation. David Smith - Director of Pharmacy, Farah Naz - Senior General Manager – Urgent, Elderly and Intermediate care - To explore the feasibility of creating SytmOne access for junior doctors in Urgent and Emergency care to ensure medication reconciliation, Farah Naz - Senior General Manager – Urgent, Elderly and Intermediate care	30/08/2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue
3469	11/10/2019	Dawber, Karen	Dawber, Karen	Trust Wide Risk	Quality & Patient Safety Academy	ReSPECT is a national document which summarises the emergency care part of wider Advance or Anticipatory Care planning. It creates a summary of recommendations for a person's clinical care in a future emergency in which they may be unable to express their choices. It includes a decision on resuscitation. Recommended Summary Plan for Emergency Care & Treatment (ReSPECT) has been implemented across Acute Trusts in Yorkshire & Humber region and continues to roll out nationally across both adult and paediatric services. The document at BTHFT is paper based and patients discharged from BTHFT with a ReSPECT document or admitted with a plan in place risk communication breakdown between inpatient and community / Ambulance and GP services due to no single shared IT system containing a live document. The risk is that a patient will be admitted or discharged with a ReSPECT form which contains a resuscitation related decision that will not be adhered to leading to resuscitation or not which contradicts their recorded wishes.	30/01/2024	6	(2) Minor	(3) May recur occasionally	8	(4) Major	(2) Do not expect it to happen again but it is possible	•BTHFT ReSPECT Steering group, Sarah Freeman, Quarterly, 1 hour •BDC ReSPECT Steering Group, Carla Smith, Quarterly, 1 hour •Regional ReSPECT Group, Rod Kersh, Quarterly, 1 hour 30 •National ReSPECT Group, Temi Oyewole, Quarterly, 1 hour 30 •BDC PCN Strategy Meeting, Becky Owen, 8 weekly, 2 hours **Governance:** •Reported Risks and incidents relating to ReSPECT discussed. •National issues e.g. recent incident when gentleman in a CH choked & died & an ambulance did not attend as he had a DNACPR discussed. •ReSPECT on Risk Register (3469) •ReSPECT related activity has an ongoing work plan •The ReSPECT workstream reports into the Quality and Patient Safety Academy **Audit:** •The audit of ReSPECT has increased to a quarterly basis from October 2023, which will be undertaken using a new quality assurance and improvement auditing software tool (Genome). •Audit results are shared with the national team **Education:** •ReSPECT covered in BLS/ ILS/ ALS and staff induction •National resources are available on the Resuscitation UK Website & have recently been updated. •A series of district wide webinars have been undertaken: o2020: introduction & understanding of ReSPECT webinar o2022: ReSPECT the process o2022: Are you aware of ReSPECT •Joint Bradford District & Craven competency and training programme has been developed & ratified by the Steering Group. This is to support CNSs/ACPs/ANPs to complete ReSPECT forms including a resuscitation decision. •'5 moments' posters developed & shared with all clinical areas **Policy:** •The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) including Cardiopulmonary Resuscitation (Adults, Infants and Children) Joint policy was developed in 2020. Which was written jointly with: oAiredale NHS Foundation Trust oBradford District Care NHS Foundation Trust oBradford Teaching Hospitals NHS Foundation Trust oYorkshire Ambulance Service NHS Trust oLocal Care Direct oManorlands Hospice - Sue Ryder oMarie Curie Hospice – Bradford oHosted by BTHFT •Equality Impact Assessment Completed •BDC Steering Group is developing a user friendly policy for Care Home staff. **Digital:** •All providers apart from BTHFT use an electronic ReSPECT form on SyStmOne. •There is limited sharing of clinical decisions and recommendations documented on a ReSPECT form between primary and secondary care. This can increase the risk of patients receiving inappropriate treatment and there have been several incidents reported. Introduction of an electronic form on Cerner will mitigate some of the risks. **Communication:** ReSPECT patient information leaflets are available on the RCUK website in several languages. (there are no plans nationally to make the ReSPECT form in different languages)	13.11.23 Audit Yorkshire BH/09/24 ReSPECT Audit completed here at Bradford Teaching Hospitals NHS Foundation Trust and published in a report in October 2023 highlighted low assurance regarding aspects of the use of ReSPECT in clinical practice focusing on three key areas: •Training requirements : To review training requirements across BTHFT, consider the following areas and levels: Level 3) Authorship , Level 2) ReSPECT overview (Clinical) and Level 1) ReSPECT level 1 (non-clinical) •Documentation: Audit has highlighted identification of incomplete ReSPECT Plans which do not meet the quality and content standard set out by procedural documentation, which also includes not having a review and sign off by the Senior Responsible Clinician. •Moving to an electronic form on EPR (e-ReSPECT): This system will allow the system to clearly highlight mandatory fields for completion. EPR project plan is to be presented to the Executive team meeting and the quality and patient safety academy by December 2023. This project plan will include time scales, milestones and deliverables. Work going forward 1.The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) including Cardiopulmonary Resuscitation (Adults, Infants and Children) Joint policy is next due to be reviewed in March 2024. 2.BTHFT use Cerner EPR and are planning to develop & implement an electronic ReSPECT form. Work will begin in Spring 2024 & take approx. 6 months. Ben McKay & Sarah Freeman will progress this & will establish a Task & Finish Group. They may need some primary care input but this will be discussed at the Steering Group. As part of EPR roll out BTHFT will need to consider: Patient communication, Communication with primary and secondary care partners and YAS, Formalising a shared process of sharing with our partners and making sure it's up to date at all times. 3.Education provision – to review training requirements and provision. 4.Audits to continue	30/04/2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue

ID	Opened	Owner	Manager	Source	Committee	Description	Review date	Initial score	Consequence	Likelihood	Current score	Consequence	Likelihood	Controls	Progress	Target date	Target score	Consequence	Likelihood
3660	25/05/2021	Dawber, Karen	Jepps, Helen	Risk Assessment	People, Quality & Patient Safety Academy	•Rapid increase in number of attendances to Paediatric ED and CCDA •High complexity of patients on the ward (an example is often 10 or more 'red patients' at any one time requiring 1:1 care and/or Non Invasive Ventilation (NIV) •Reduced nurse staffing (resignation and maternity leave) causing a reduction in number of beds available •A further anticipated increase in August 2021 of numbers of children requiring care/admission The above issues compromises and negatively impacts on: •Ward safety •Ward flow •Ability to support Paediatric ED •Ability to sustain Paediatric Surgery •Ability to achieve the aim of the Consultant review (in line with RCPCH standards)	08/03/2024	12	(3) Moderate	(4) Will probably recur, but is not a persistent issue	12	(4) Major	(3) May recur occasionally	•Patients: may receive substandard care - Patient to staff ratio high. Newly Qualified nurses will be caring for complex patients •Poor patient experience: Reduced bed availability means long waits in ED or CCDA •Nursing staff: will have high workloads with high acuity patients. (They will potentially be required to take even more patients due to the lack of regional capacity) Newly Qualified nurses will be caring for complex patients impacting on morale •Medical staff: (Middle grade and trainees) - will have high patient workload plus the additional impact of ED waits. •The ward environment: is high risk for the night shift and will be at further risk if doctors have to go to ED to support flow/transfers to other hospitals •Consultant body: Intense working days on the ward •All staff:(Qualified/trainees) continuous pressures impacts staff morale •Trust- reputational risk: No residential cover for peak hours of activity as per national standards	Update 08/12/2023 - Medical Recruitment process for the 2 consultant posts in Phase 1- appoint ted to both posts. Awaiting HR checks In meantime utilizing winter funds for PRA/agency. Nursing Recruitment phase on going, with new staff commenced Sept and Oct, plan to be signed off as competent take owrklaod Dec/Jan AED/Ward collaboration commenced with start date Nov 23 Score remains unchanged.	31/03/2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue
3696	18/08/2021	Azeb, Sajid	Smith, David	Business Continuity	Finance and Performance, Quality & Patient Safety Academy	There are a number of significant risks to the organisation arising from the age and condition of the pharmacy aseptic unit. The risks are specifically:- 1. a patient safety risk arising from the potential inability to provide critical medicines such as chemotherapy and total parenteral nutrition 2.a reputational risk to the organisation arising from the potential failure of, and or regulatory intervention into the, pharmacy aseptic unit. 3.A risk to organisational performance against RTT targets arising from this risk due to the potential inability to deliver treatment within specified timescales. The risk arises from the due to:- 1.The unit being almost 25 years and no longer up to current design standards. 2.The inability of the air-handling unit and associated pipework being able to deliver the required number of room air changes per hour. 3.The poor design of said pipework meaning it is impossible to satisfactorily test the integrity of the terminal HEPA filters due to leak paths of unknown origin. 4.Some of the filter housings being modified by a third party from top entry to side entry meaning the airflows immediately prior to the filter will not match the airflows the filters are designed to work with. 5.The materials and design of the unit do not support efficient cleaning of the unit – cabinets are old and damaged and the ceiling is of a modified lay in grid type formation. 6.The unit has begun to fail some of the environmental monitoring tests which means failure is more likely. 7.The MHRA and the Regional Quality Assurance Pharmacist both commented on the condition of the unit at their last regulatory inspections issuing the Trust with a Major concern and significant risk respectively.	31/12/2023	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	12	(3) Moderate	(4) Will probably recur, but is not a persistent issue	Environmental Monitoring and SOPs Colleagues working in the unit follow standard operating procedures (SOPs) for all functions undertaken. These SOPs cover all aspects of the operation of the unit but specific to this risk cover the cleaning and environmental monitoring regimens. The SOPs are part of the wider Quality Management System which operates in the unit. The QMS ensures that all products produced are produced according to the SOPs and to the required regulatory standards. Where deviations from the SOPs occur e.g. due to a product failing a final check an official deviation investigation is commenced which includes Corrective and Preventative Actions (CAPA) to minimise the chance of the deviation occurring again. In the event of a change in practice is needed a change control form is raised which ensures that any change is safe and effective, approved by both the production and quality managers and that it is cascaded to all. In relation to this deterioration of the DOP testing results, a change control form was implemented to increase the intensity and frequency of the cleaning of the unit. In addition to this the active air sampling in the rooms was increased from quarterly to monthly. Colleagues working in the unit continue to monitor the settle plates to identify any colony forming units which would potentially indicate a further deterioration in the cleanliness of the unit. Workload Colleagues have looked to outsource what work they can to other NHS units and third party providers. In addition to this they have looked to standardise some of the products produced meaning that the workload in the unit is such that sufficient time can be given to ensuring the unit is clean and the QMS is followed. Contingency Plans Contingency plans are being worked up with colleagues at Airedale NHS Foundation Trust which would mean if the unit did fail and or was issued a stop notice work could be temporarily transferred to utilise whatever spare capacity ANHSFT has to offer. In addition to this colleagues from the WYATT trusts have been asked to consider if they have any capacity to support BTHFT should the unit fail. Estate Works Colleagues from estates have visited the unit and along with advice from BTHFT's Consultant Nurse for Infection prevention and control have identified a number of actions which could be taken immediately, including some minor works, which would help to address some of the issues with the unit. Consultants have also been brought in to understand what action, if any, could be taken to address the AHU, associated pipework and filter housings. New Unit A short-life working group has been established to manage the existing risk and to work up options as to the potential mid to long-term solutions for the unit. Such options may include, a new unit, an extensively refurbished unit, or a decision to close the unit and seek support from elsewhere. In addition to this the group will work with the units customers to build greater resilience in to their workflows in order to support the functioning of the unit and ultimately the care to the trusts patients. This group will also look to better quantify the consequences, in terms of patient care, of a unit failure / shut down.	24/11/2023 Temporary unit has been repaired. Awaiting sign off by contractor before passing over to the trust to validate.	31/03/2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue
3732	20/01/2022	Dawber, Karen	Hilton, Joanne	Risk Assessment	People, Quality & Patient Safety Academy	There is a risk of harm to patients, staff and visitors within planned and un-planned care due to the Trust's inability to maintain safe staffing levels as a result of the sustained Covid-19 pandemic; potentially resulting in, poor experiences of care, increased patient and staff dissatisfaction, complaints, incidents, increased sickness levels, claims, and a negative impact on the reputation and financial status of the Trust.	31/01/2024	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	10	(5) Catastrophic	(2) Do not expect it to happen again but it is possible	Processes in place: Use of national guidance Health and well being activities - Thrive Workforce planning -agreed establishments Workforce re-deployment Use of temporary workforce Recruitment and retention Training and development Monitoring and review; Silver / Gold reference groups Tactical Silver / Gold Matron Huddles Quality oversight and escalation Patient experience oversight Senior Nurse assessment and decision making Further detail within full risk assessment and QIA	04/11/2023(JH) - risk reviewed for adult areas, with the start of the newly qualified nurses and success of the international nurses completing OSCE and ongoing recruitment into HCA roles this risk has reduced however with there are still significant ongoing staffing challenges keeping the risk at 16. The mitigation date has been amended to reflect the remaining international nurses to commence and the beginning of the year newly qualified nurses.	31/03/2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue
3767	19/04/2022	Dawber, Karen	Beer, Jo	Community Risk Register	People	There is a risk that Maternity staff are working within the Bradford community on a daily basis and do not always carry or have access to a lone worker device as per Trust policy Staff who have a lone worker device have reported that they rarely use it due to the age of the device causing short battery life resulting in the need for recharging at least once throughout the day. This can be difficult if staff do not have a car charger for the device. Also the devices take a long time to programme for each appointment/visit. The Trust is currently waiting for a new lone worker contract to be agreed and do not have any spare devices until this is in place.	29/12/2023	16	(4) Major	(4) Will probably recur, but is not a persistent issue	4	(1) Negligible	(4) Will probably recur, but is not a persistent issue	Staff member and student midwives providing care in the community are at increased risk of harm if they are unable to raise an alarm in the event their safety is at risk. The experience of violence and aggression whilst at work increases work related stress and the risk of absence from work. Increase in staff anxiety can lead to poor job satisfaction	Sept 23- Lone worker devices are ordered and the expected delivery timeframe mid-end of October 2023. Training and launch of devices expected November 23.	29/12/2023	16	(4) Major	(4) Will probably recur, but is not a persistent issue
3810	14/10/2022	Smith, Dr Ray	Green, Jen	Risk Assessment	People, Quality & Patient Safety Academy	Highlighting the service risk for Haematology, oRisk to Acute consultant Rota and timely inpatient reviews oRisk to Outpatient delivery and the increase to wait times for Urgent / routine / cancer and the specialised Haemophilia patients oService delivery for the whole Haemophilia service , surgical and outpatient work oService delivery for complexity of haematology patients oIn reach to transfusion service There is no clinical haematology representation at cross site senior management meetings Pathology . Neither site BTHFT / AFT can provide time to attend this and lack of clinical haematology support has been identified - Lack of clinical direction for the lab, Delay in reporting of blood films for complex technical cases Lack of regular review of clinical documentation eg reference range review and validation Inability to obtain clinical advice in a timely manner and including out of hours when needed Lack of morphology case training and competency for BMS staff to ensure additional essential underpinning knowledge and experience.	29/02/2024	20	(5) Catastrophic	(4) Will probably recur, but is not a persistent issue	6	(3) Moderate	(2) Do not expect it to happen again but it is possible	Leeds Comprehensive Care Centre Support oCover for out of hours on call for the regional haemophilia network oLeeds are the agreed point of contact and can support with severe, surgery, high risk and acquired haemophilia patients oHigh risk patients to be transfer to Leeds. oAcquired haemophilia , to be transferred to Leeds oSharing of protocols , triaging protocols of what patients they can support and not oMild issues, Leeds can give guidance – consultant to consultant (Meadows – CNS can communicate to Leeds) oContact can be made to duty haemophilia consultant oSevere patients to have 6 monthly review at Leeds oPregnant patients transferred to Leeds if Dr Pollard unavailable oLeeds to get back about elective patients – in first instance, call from consultant to consultant to find out urgency and sensible triage oLeeds want consultant to consultant communication/discussion, not comfortable with CNS queries oIn reach to the paediatric service oSarah Garside to work with CNS – offer support and suggestions. Sarah and Cecilia to sort a list of patients who are classed as high risk bleeders oLeeds to write clear rules on what they can and cannot do oTransfer of new outpatient complex patients They cannot support: oOn-site support oMilder Haemophilia Inpatient care oOutpatient review of the routine and new patients currently in our system oVery elective patients, these would have to be delayed oAny thrombosis patients Submitted ETM paper to executives to be discussed Monday 12th September 2022 Recruitment approval for locum doctor Advert for substantive consultant Request to recruit through agencies	11/11/23 - Locum in post and providing acute support with some outpatient work. The service continues to have clinic capacity issues with new routine referrals, urgent referrals and cancer patients on active treatment. The latter present a clinical risk if not seen in a certain time frame. Initial work has started regarding a service review but dedicated clinical leadership is required with a clear and agreed workplan.	30/09/2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue
3877	14/06/2023	Azeb, Sajid	Azeb, Sajid	Trust Wide Risk	Finance and Performance, Quality & Patient Safety Academy	If we are unable to manage ongoing operational pressures due to high demand, Covid backlogs and industrial action, then there may be delays to treatment, resulting in harm to patients and/or poor patient experience.	31/12/2023	16	(4) Major	(4) Will probably recur, but is not a persistent issue	12	(4) Major	(3) May recur occasionally	Elective Recovery Plans and Elective Recovery Task and Finish Group. Subcontracting arrangements with the independent sector and insourcing. Operational Improvement Plan in place which is reported to the Finance and Performance Academy. Accountability Framework in place including Daily and weekly access meetings. Mutual Aid at WYAAT level. Capacity Planning. Clinical prioritisation of waiting list.	12/10/2023 As per previous updates - continuing to work through Delivering Operation Excellence plan across UEC, Cancer, Diagnostic and Elective Pathways (RTT). UEC now open, CDC at Ecceslshill due to come on line later on in the calendar year, SL Daycase unit scheduled for completion April 2024, BRI Endoscopy unit business case approved and letter of intent issued to contractor October 2023 with anticipated go-live 2025. On going work on daily, weekly and monthyl processes to reduce waiting time in line with operation plan with an aim of no >65 week waits by March 2024. Operational Excellence workshop held with CSU 12/9/23 and new plan for aspiration of delivering top quartile perfomance being developed.	01/04/2025	16	(4) Major	(4) Will probably recur, but is not a persistent issue

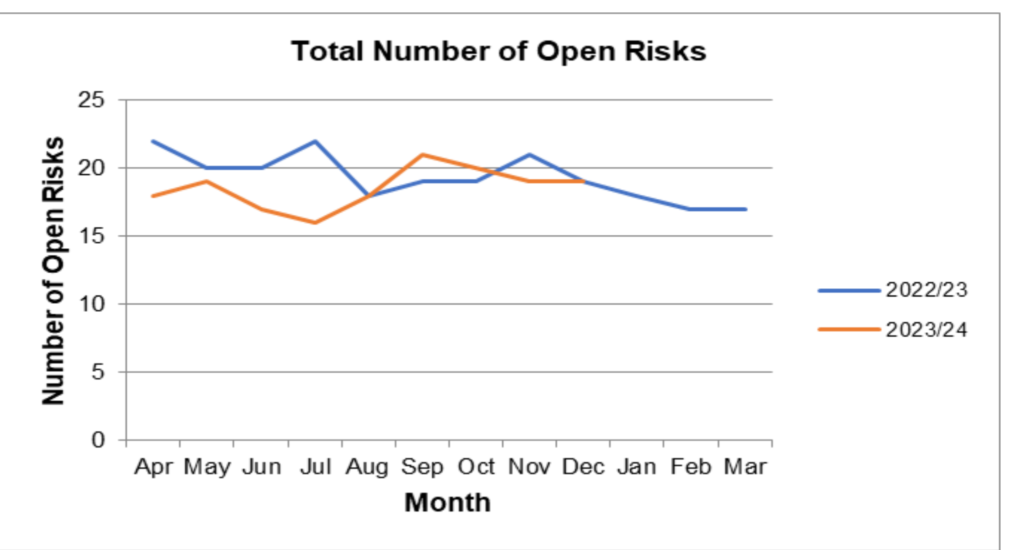
3896	01/10/2023	Smith, Dr Ray	Hollins, Sara	Incident Reporting	Quality & Patient Safety Academy	There is potential for harm due to the risk of gynaecology histopathology being delayed for women who access the Women's service at BTHFT. The most significant harm is for those women awaiting a cancer diagnosis causing a delay in their cancer pathway also resulting in delays in KPIs, public confidence and the reputation of BTHFT. For women awaiting results from the colposcopy service with cervical pre cancers, this can cause heightened anxiety and reputational damage for the cervical screening programme. It also affects the KC65 targets and can delay management of high grade pre malignant changes to the cervix	30/04/2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue	5	(5) Catastrophic	(1) Cannot believe that this will ever happen again	1.Internal monitoring of a patients pathways such as results obtained and the date obtained , are mapped and monitored via the failsafe officer employed by the Women's CSU gynaecology service, the Women's CSU Business Team and by the cancer tracking team. 2.Gynae Oscopy team tracking results and escalating though DGM where results are not reported within 7 days 3.Gynae Oscopy team, the Women's CSU Business Team and by the cancer tracking team track results, escalate delays in results not reported within 7 days and then ensure that the patient is communicated to following the results being reported as soon as possible. 4.Macmillan nurse aware of the number of cases involved and would be able to trace women missing genetic testing through audit. 5.The Oscopy team track all patient results from cash up of clinic until they are returned so the delay in pathology reporting has not lead to any results been missed.	1. To ensure the failsafe process for monitoring the delays in histopathology reporting is reviewed and reinstated 2.To update the expected progress of the histopathology consultant appointment to BTHFT 3.Communicate the outcome of the pathology meeting September 23 with CSU leads	31/10/2024	16	(4) Major	(4) Will probably recur, but is not a persistent issue
3404	31/05/2019	Dawber, Karen	Hollins, Sara	Escalated from Division	People, Quality & Patient Safety Academy	There is a risk that Optimal staffing levels within all areas of the maternity services not achieved due to vacancies, maternity leave, and long/short term sickness levels leading to; Patient safety concerns Ability to provide 1 to 1 care to all labouring women. Possible closure of beds and services. Patients may require divert for care at another Trust. Staff job satisfaction. Maternity unit reputation.	31/05/2024	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	9	(3) Moderate	(3) May recur occasionally	WTE establishment Recruitment in progress. Effective use of the managing attendance policy. Effective use of the escalation policy. Requests for Bank staff TNR and Agency. Hot desk midwife Monday to Friday office hours to support risk assessments and staff movement. On call senior midwife rota covers all unsocial hours. Senior midwifery management team/Chief nurse team	11/10/23Birth Rate Plus full review has been commissioned and will commence in November 2023 and a report expected by May 2024.	31/05/2024	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently
3468	11/10/2019	Azeb, Sajid	Stephenson, Carl	Trust Wide Risk	Finance and Performance, Quality & Patient Safety Academy	There is a risk that staff are not following or being able to follow the correct process for recording activity or patient pathway steps on EPR which results in incorrect or missing information will cause; Delays to treatment. Sharing incorrect information with patients. Using incorrect information to make decisions about patient care. Patients attending unnecessary appointments. Staff anxiety from being unable to prevent or fix errors. Admin or clinical time spent correcting errors. Loss of income from missing or un-coded activity. Reputational harm from reporting inaccurate data / performance.	31/01/2024	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	9	(3) Moderate	(3) May recur occasionally	Knowledge and training – induction training has been partially updated following learning from errors but SOP's and reference materials require review. Some "how to" videos, guides and additional SOP's produced for additional support. Issue resolution – focus is on correcting at source but the existing model has several gaps, particularly the operational knowledge needed to do this but also the central capacity to deal with existing volume of enquiries and corrections. There is a multi-department meeting every two weeks which reviews issues and themes. This supports the change prioritisation process and provides updates for knowledge and training, whilst also taking corrective action wherever appropriate. Oversight – some KPI are in place; used within weekly and monthly performance meetings to highlight areas of concern but broader suite of measures under development via the MBI dashboard review. DQ error clearance – where errors are not corrected at source they drop into one of three cohorts (covered by multiple DQ KPI). Master Patient Index (MPI) errors are covered by informatics, pathway and activity errors are covered by the Central Access Team. Mapping issues are monitored weekly as they drop onto a single queue. These are reviewed centrally and where possible corrected. If central correction isn't possible CBU teams are instructed to re-order the next step and this is monitored until complete. Despite these controls the number of errors highlighted by DQ KPI remains high and this means corrections are made for priority cohorts only. Themes from these corrections feed into the fortnightly issue resolution meeting.	06/11/2023 - reviewed by Zeeshan risk mitigation as per previous update. 11/10/2023 – all existing controls continue as per previous updates, specific focus on error rates and working with teams in response to these including sessions with corporate access and CSU teams to validate waiting lists have been prioritised in August/September.	30/11/2023	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently
3824	14/09/2023	Smith, Dr Ray	Naz, Farah	Risk Assessment	People, Quality & Patient Safety Academy	If we are unable to provide a sufficient number of middle and senior grade doctors that meets the 24 hour capacity and demand of the Emergency Department then there may be a mismatch of patient acuity and demand versus the number and competencies of clinical decision makers on duty at any one time resulting in an increased risk of patient harm, compromised quality and performance and a negative impact on efficiency and patient flow	31/10/2024	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	6	(3) Moderate	(2) Do not expect it to happen again but it is possible	•The Trust has supported the ED with the ability to go to super sessions and agencies to support the workforce model as it stands •New medical staffing model paper in development to be presented at ETM, this will take into account the skill mix of the workforce for a 24 hour period which takes in account volume and acuity •Increase pools of ACP's, physician associates and SAS posts •Temporary winter pressures funding has been approved to cover locums i.e. increased funding for super sessions •Weekly rotas review and day to day management of rotas •Trainees in place to support medical coverage in the emergency department •Consultant cover ED on the weekend and evenings	1.New medical staffing model paper in development to be presented at ETM 2. Active management of medical rota by rota co-ordinators, concerns escalated as needed to clinical lead	28/02/2024	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently
3850	29/03/2023	Azeb, Sajid	Smith, David	Risk Assessment	Finance and Performance, People	There is a risk to the patient care, staff wellbeing and trust finances arising from inadequate pharmacy accommodation. The key risk are: Aseptic Unit The pharmacy aseptic unit is listed as a separate risk – risk 3696. **Pharmacy Dispensary** The Pharmacy dispensary is cramped and can be overcrowded at busy times which increases the risk of dispensing errors. In addition to this, the cramped accommodation means the trust is unable to further automate the dispensary with the latest dispensing robots. Current dispensing robots are significantly more efficient meaning dispensing times can be further reduced and include technology such as automatic labelling which further reduces the chances of dispensing errors. The current accommodation means waiting times are longer and dispensing errors more likely than a modern automated dispensary. **Pharmacy Quality Assurance / Control** The quality assurance area has recently been face lifted but like other areas accommodates more colleagues than there are spaces for. In addition to this there is inadequate storage areas to store expensive equipment which may become damaged leading to a financial risk to the organisation. There is also a lack of space for the incubators which are key to the functions of the department. Incubators are currently located in a long corridor without windows meaning the working environment is poor. The current accommodation means there is a financial risk to the organisation arising from potential damage to equipment and through staff absence resulting from the poor environment. **Pharmacy Stores** The pharmacy store is currently spread across two floor levels and two separate unheated store rooms. In addition to this the layout of the building means that automation, common in other trusts, cannot be installed. The lack of automation increases the risk of stock outages and picking issues leading to an increased risk of patients missing doses of medication and potential patient harm. **Equality Diversity and Inclusion** The department has numerous different floor levels, some of which are connected by ramps whilst others are connected by stairs. This means that any staff or visitors who are mobility impaired will be unable to access all areas of the department Staff rest facilities are inadequate in that there are only two toilets for over 130 people. Office accommodation is limited meaning colleagues often need to hot desk which limits the scope for work station related adjustments. The accommodation also means that staff are less able to mix and form a coherent team leading to issues with morale impacting staff wellbeing. The current accommodation means there is a risk to staff wellbeing and trust finances through absences as a result of the poor accommodation.	31/01/2024	20	(4) Major	(5) Will undoubtedly recur, possibly frequently	6	(2) Minor	(3) May recur occasionally	SOPs are in place to ensure processes are as safe as possible in the current accomodation. Additional accomodation has been sought with two further portacbins provided to house colleagues. Flexible working and home working has been explored and is utilised where possible. Minor works have been undertaken to improve the accomodation including staff rest facilities. Work has been undertaken to relocate the pharmacy aseptic unit which will give opportunities to redevelop the BRI site.	The intention is to relocate the pharmacy aseptic unit which will then allow space for redevelopment of the existing pharmacy footprint. In the short to mid term continued focus and work as part of the Outstanding Pharmacy service will look at what other improvements can be made.	01/04/2025	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently
3885	08/08/2023	Azeb, Sajid	Davies, Chris	Risk Assessment	People	There is a risk to patients, staff and visitors across the Trust due to a lack of supervision of a 24/7 operational security team/service (an existing band 3 supervisor vacancy, Mon-Fri 37.5 hours does not provide adequate supervisory cover, only covering 22% of the 24/7 period) Without supervision and management oversight, security staff are working outside of standard operating policy and procedures and not following safe practices on a regular bases Has the potential to result in reputational damage and litigation to the organisation as well as the safety risk to staff, patients and visitors.	31/01/2024	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently	6	(3) Moderate	(2) Do not expect it to happen again but it is possible	There is limited experienced management oversight and therefore no assurance in place on a daily basis that policies and procedures are being followed and the risk of hazards minimised.	Security Model Review ongoing, ETM option appraisal paper presented August 2023. Business Case submitted and to be presented at planning committee on 14 September 2023 outlining a case for 24 hour supervision, Head of Security appointment and dedicated resource for AED and Womens and Childrens Unit Band 5 Deputy Manager in post. Approval to recruit to 24/7 , Band 4 Supervision and Head of Service positions. Head of Security starts employment with the Trust on 8 January 2024, the Band 4 Supervisor positions are currently out to advert.	31/03/2024	15	(3) Moderate	(5) Will undoubtedly recur, possibly frequently
3890	30/08/2023	Dawber, Karen	Stott, Carly	Risk Assessment	Quality & Patient Safety Academy	There is a risk that the service cannot achieve the 72 hour timeframe for undertaking fetal ultrasound scans due to a lack of scan capacity	29/02/2024	15	(5) Catastrophic	(3) May recur occasionally	5	(5) Catastrophic	(1) Cannot believe that this will ever happen again	Issues with scan capacity are escalated to the Obstetrics Team Manager and service manager USS department are asked to reschedule any routines/non-urgent patients, scope for an additional list or if they can find capacity anywhere else. Capacity availability in the next 7 days is ascertained The clinical records of the patients who will breech the 72 hour timeframe are reviewed by a Consultant to formulate a plan prioritising the patients into the next scan dates available. Some patients are invited to attend MAC/ANDU over the weekend for a well-being check and CCTG prior to the scan appointment which impacts on this areas workload. Referrals are vetted to ensure scans are justified and the correct test for the patient is being carried out	Radiology;Plans to train 2 sonographers in obstetrics 2023/2024. They will qualify the end of Summer 2024. 3.Scope how USS will be affected with additional scans in light of the new growth chart which has identified new centiles which trigger growth scans 5.Develop a paper which outlines the risks, service gaps and requirements to achieve local and national guidance and a safe standard of care to women and their unborn baby	31/08/2024	15	(5) Catastrophic	(3) May recur occasionally

High Level Risks Report on a Page – December 2023

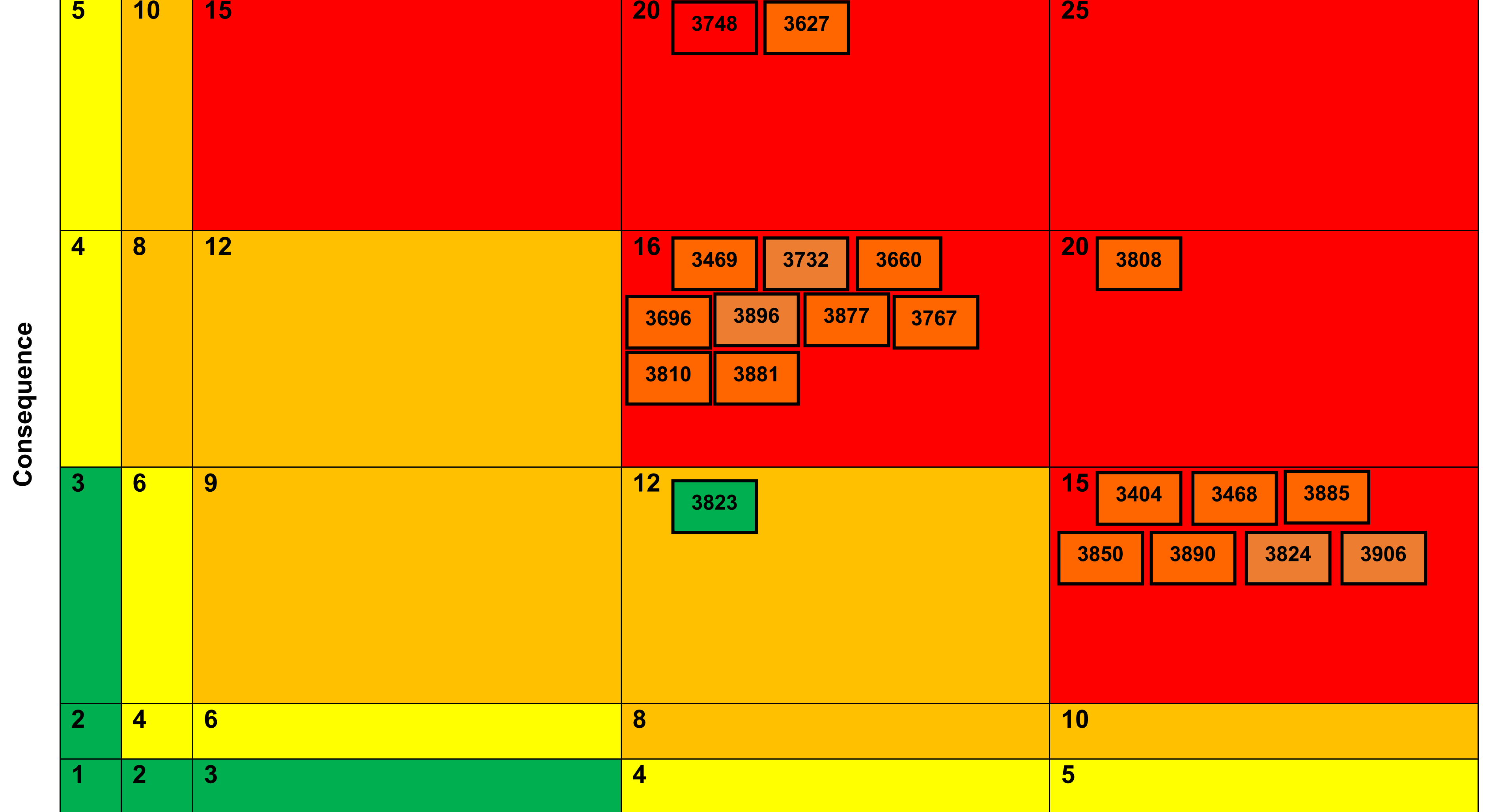
Total High Level Risks	19*
Aligned to F&PA	5
Aligned to QPSA	15
Aligned to PA	10
Aligned to Board	1

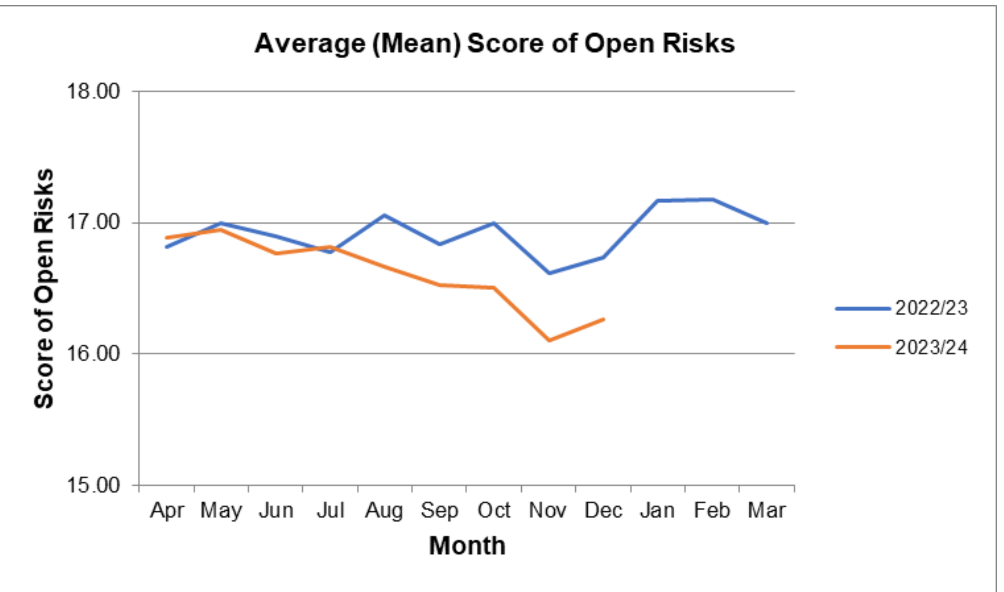
*Note some risks are aligned to more than one Academy

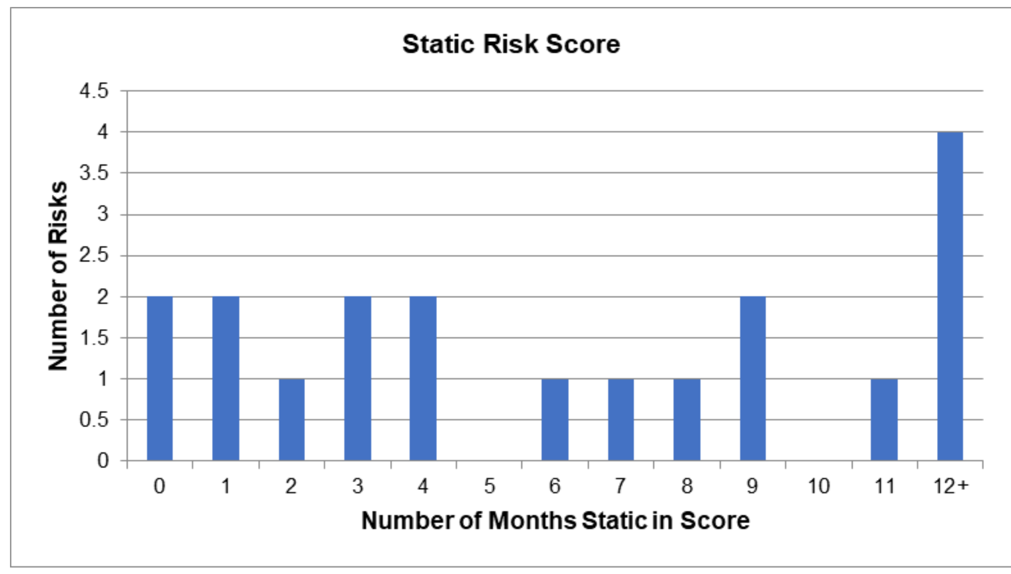
Movement of Risks	
New	0
Marked for closure	0
Risk score increased	1
Risk score static	18
Risk score decreased	1



Risk Overview







Changes to Target Mitigation Date of Current High Level Risks-December 2023

ID	Date of entry	Academy	Current Score - Dec 2023	Target Score	Original	1st Change	2nd Change	3rd Change	4th Change	5th Change	6th Change	7th Change	8th Change	9th Change	10th Change	11th Change	12th Change	13th Change	14th Change
3404	31/05/2019	PA & QPSA	15	9	31/05/2019	31/12/2019	28/02/2020	31/03/2020	31/12/2020	31/01/2021	30/07/2021	31/01/2022	31/01/2023	31/03/2023	30/09/2023	31/01/2024	31/05/2024		
3660	25/05/2021	PA & QPSA	16	12	30/09/2021	31/10/2021	26/02/2022	31/03/2022	30/04/2022	31/10/2022	30/12/2022	30/06/2023	31/07/2023	31/08/2023	31/12/2023	31/03/2024			
3468	11/10/2019	F&P & QPSA	15	9	01/04/2020	01/04/2021	30/04/2021	31/10/2021	31/12/2021	31/12/2022	31/01/2023	30/06/2023	31/10/2023	30/11/2023					
3696	18/08/2021	F&P & QPSA	16	12	31/12/2021	31/01/2022	31/07/2022	01/11/2022	30/11/2022	31/03/2023	30/04/2023	31/10/2023	31/03/2024						
3808	06/10/2022	F&P, PA & QPSA	20	16	11/11/2022	12/12/2022	31/01/2023	31/03/2023	31/05/2023	31/07/2023	31/10/2023	31/03/2024							
3810	14/10/2022	PA & QPSA	16	6	31/10/2022	08/12/2022	01/04/2023	30/06/2023	30/09/2023	30/09/2024									
3469	11/10/2019	QPSA	16	8	31/12/2019	30/09/2021	29/07/2022	29/07/2023	30/04/2024										
3767	19/04/2022	PA	16	4	30/12/2022	31/03/2023	31/05/2023	30/09/2023	29/12/2023										
3732	20/01/2022	PA & QPSA	20	10	02/01/2023	31/03/2023	31/05/2023	31/10/2023	31/03/2024										
3627	10/02/2021	QPSA	20	10	30/04/2021	31/05/2021	31/03/2023	31/03/2025											
3748	15/02/2022	QPSA	16	3	31/01/2023	31/01/2024	30/09/2024												
3877	14/06/2023	F&P & QPSA	16	12	31/03/2024	01/04/2025													
3824	14/12/2022	PA & QPSA	15	6	28/02/2024														
3850	29/03/2023	F&P & PA	15	6	01/04/2025														
3885	08/08/2023	PA	15	9	31/03/2024														
3890	30/08/2023	QPSA	15	5	31/08/2024														
3896	01/10/2023	QPSA	16	5	31/10/2024														
3881	27/07/2023	PA & QPSA	16	8	30/08/2024														
3906	17/10/2023	Board	15	10	30/11/2023	31/03/2024													

Key:

Target mitigation date changed since last report

Past the target mitigation date

BO.1.24.8 - REPORT FROM THE CHAIR OF THE QUALITY AND PATIENT SAFETY ACADEMY ?NOVEMBER & DECEMBER 2023

REFERENCES

Only PDFs are attached

Bo.1.24.8 - Report from the Chair of the QPSA Academy - November 2023.pdf

Bo.1.24.8 - Report from the Chair of the QPS Academy - December 2023.pdf

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.8

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality and Patient Safety Academy/Committee

Date of meeting: 29 November 2023

Key escalation and discussion points from the meeting
Alert:
Maternity and Neonatal Services Update The board is asked to note that during November there was a significant backlog of women awaiting planned inductions. The reasons for the development of this backlog were multi-factorial and the position was escalated by the Chief Nurse to the ICB Chief Nurse who in turn escalated to the NE&WY Regional Midwife. During this period one case of harm occurred leading to the unfortunate death of a baby to a woman waiting for induction for a clinical reason. Details discussed at Academy: • The maternity unit has a significant backlog of inductions which has contributed to a recent case of harm, in which an intra-uterine death occurred. • The unit has experienced challenges as there have been unintended consequences on the back of 'point of care testing' related to the Trusts participation in a research project which involves testing for Streptococcus B (very dangerous for babies but not for mothers). This has though led to an increased 'length of stay' for mothers (and their babies) who would otherwise be fit to be released. • There have also been changes to NICE guidance - around the timing of the offer of induction of labour - which have also had an unintended consequence on the scheduling of inductions. • Staffing was also presenting challenges. • The challenges being faced by the ward were escalated to the ICB Chief Nurse Beverley Geary, who in turn escalated to Tracey Cooper, Chief Midwife for the North East and Yorkshire, NHS England. • Regularity of meetings increased following the case of harm. Actions put in place included additional on-call senior midwives to help get through the volume of inductions. • Mutual aid has also been sought (and given) from neighbouring trusts. Team has seen real harm as well as an impact on patient experience. Situation being monitored. Difficult questions with regard to ensuring capacity for Bradford babies over babies coming from other areas.
Advise:
Increased attendance in A&E – reported under matters arising Over the last two weeks there have been increased attendances at A&E with quite a few days with more than 400 attendances daily. This has led to increased pressures on the

hospital site and concerted efforts are being made to discharge patients as long as it is safe to do so.

SI Report

- Test reporting of patient safety incidents to the new NHSEI Learning from Patient Safety Events platform, which is replacing the outdated National Reporting and Learning System (NRLS) commenced in September 2023. Live reporting will commence when the Trust transitions from Datix to InPhase.
- One SI was declared during October.
- There are 11 ongoing SIs at the time of the report, 4 are being investigated by the Maternity and Newborn Safety Investigations (MNSI) programme, 3 within the 60 day deadline and 1 HSIB within the 160 day deadline.
- 7 investigations are underway, 3 of which are HSIB investigations, with extensions in place.
- One SI has concluded – lessons learned shared and discussed with the Academy.
- Academy discussed the impact of PSIRF (Patient Safety Incident Response framework) on the nominal 60-day time limit for completion of SIs currently in place. Academy advised of amendments to the terms of reference for key sub-groups (Safety Event Group, Quality of Care Panel and Patient Safety Groups) to reflect the process for tracking actions. Assurance will be provided to the Academy via the Complaints, Litigation, Incident & PALS (CLIP) report to ensure that assurance and learning is embedded, and actions completed.

Health Inequalities

The Academy discussed ways of improving information presented moving forward which would benefit from the addition of tangible examples of the work undertaken in this area along with the outcomes and actions. Key area discussed was how to engage staff with this area, particularly given that staff are patients too and the majority are part of our local populations and as such have lived experience that can support improvements in patient experience and, can proactively support tackling health inequalities.

Equality Delivery System 2022

Key to note the work underway in relation to the NHS Equality Delivery System 2022 (EDS22) framework.

The Academy discussed the importance of acknowledging that the majority of our staff are part of the local community and as such are also our patients and service users. The Trust should be taking on board the valuable insights offered by staff regarding patient experience – this connection should be made more apparent so that staff also feel empowered to engage with improvements and help to address health inequalities.

Assure:

High Level Risks

- There is one risk past its target date – Risk ID 3810 – pressures on haematology services.
- The risk has subsequently been updated due to a lot of work with the service. The target date has been extended to September 2024.

Meeting Title	Board of Directors		
Date	January 2024	Agenda item	Bo.1.24.XX

- There is one new risk – Risk ID 3896 – histopathology delays resulting from samples from gynaecological services.
- One risk has been closed – Risk ID 3800 - Cost of gas and power.
- There are two risks which have reduced in score:
    - Risk ID 3732 – nursing and midwifery staffing levels.
    - Risk ID 3881 – pharmacy vacancies.
- There is one risk past its review date – Risk ID 3696 – Pharmacy aseptic unit. The review date is now amended to 31 December 2023.

IPC update
The numbers of MSSA bacteraemia infections in the community are rising which is reflected in the rise in patients being admitted who are testing positive. A challenging situation however the IPC team has put measures in place to address the situation.

Report completed by:

Professor Louise Bryant
Academy Chair and Non-Executive Director

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.8

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality and Patient Safety Academy/Committee

Date of meeting: 13 December 2024

Key escalation and discussion points from the meeting
Alert:
Items reported under 'matters arising': 1. **Forthcoming Junior Doctor Industrial Action** - The dates have been confirmed for action to take place from 20 to 22 December inclusive. The industrial action is expected to have a significant impact on elective surgery with 600 of the 3,000 planned out-patient appointments being cancelled. Planning is again underway and ongoing as with previous industrial action. 2. **A&E and Hospital Flow** - Activity remains high within the A&E department and across the Trust with pressure on flow and beds. The situation remains difficult and challenging particularly with the forthcoming industrial action.
Advise:
1. **Quality Oversight and Assurance Profile** In relation to the CQC report on caring for adults with a learning disability and health inequalities it was noted that all appropriate learning is fed through to the additional needs team and the vulnerabilities group which reports to the safeguarding group and to the Integrated Safeguarding Committee. Assurance provided. 2. **CLIP (Complaints, Litigation, Incidents and Patient Experience) Report Q1&2** • 231 complaints received with the majority from the AED (against 70,000 attendances) • Patient Advice and Liaison Service (PALS) received over 1,000 concerns – many cases resolved with first contact. No PALS issues remain open. • 33 new claims received in Quarter 1 and 41 new claims received in Quarter 2 - a slight increase compared to the same period last year (19 have been closed with involvement of NHS Resolution). • 123 inquests remain open with long delays experienced for listing: being monitored by Chief Medical Officer and the Medical Examiner's Office. During this period 44 new requests have been received and seven inquests held. The Academy noted that any learning following an inquest is circulated and shared with the relevant teams. • Over 25,914 Patient Safety Incidents have been reported in total with falls, pressure ulcers and blood transfusion forming the three highest reported categories. • During Q1 and 2 a total of 12 SIs have been reported. • 31 RIDDOR reportable incidents were received – this is more than the number received for the whole of last year and the non-clinical risk team are scrutinising this information and data to seek to understand the reasons. This will be reported to the Academy at the end of February 2024. This huge report triangulates data from many different areas. It was agreed that it would be improved by the addition of more analysis and insight. The Academy is keen to see this. This should be facilitated by the move to PSIRF and the transition from Datix to InPhase. The Academy also supported the addition of a metric to the Quality dashboard for the next year whilst the InPhase system is embedded, and staff become more familiar with the use of PSIRF.

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3. Electronic Patient Record (EPR) Programme update
The Academy received a high-level overview of the discussed and noted key EPR activity to date alongside the key deliverables planned for 2024/25. Of note were the items forming part of the EPR Programme deep dive – which covered: ReSPECT, Sepsis, HIV Services, Renal, SDEC, Discharge MPage and, Mobility. Some of these areas were at different levels of development or maturity. Two sessions had been held recently with clinical colleagues who are assisting with several of the programmes. The Academy was keen for this area of work to progress at pace and to continue with the involvement of the clinical colleagues.

Assure:

1. QPSA Dashboard
Two main points identified: (1) Summary Hospital-level Mortality Indicator (SHMI) which is higher than expected. The previously reported coding issues are being addressed and confidence that this is a statistical blip rather than a real deterioration in the position. A report will be presented to the System Quality Committee to provide further clarity. (2) Medical Examiner's (ME) Office. There is 100% scrutiny of all deaths in the Trust to provide assurance on the quality of care provided. This further supports the conclusion drawn on the SHMI position. C.Difficile, MRSA and Ecoli - there were '0' cases of C.Difficile and MRSA and approximately 6 cases of Ecoli reported for this month. In relation to Pressure Ulcers the position remains steady and within the usual limits. There has also been a steady improvement in 'Falls with Harm' demonstrating a welcome improving picture resulting from the related work undertaken during the year.

2. Maternity
- The LMNS Assurance visit was undertaken in November and the full report from the West Yorkshire & Harrogate Local Maternity & Neonatal System was shared with the Academy.
- A monthly stillbirth position of 2 was reported and the Academy was provided with a description of the incidents and any immediate actions/lessons learned.
- There are 8 ongoing maternity SIs/Level 1 investigations, 6 Maternity and Neonatal Safety Investigations (MNSI) and 2 Trust level.
- There was 1 reportable Serious Incidents (SI) declared in November.
- There were 10 occasions in November where the unit was assessed as needing to divert women to other organisations. In my previous chair report (November 2023), this is escalated to the Board. The Academy noted increased pressures in November, including the back log of inductions, and heard from the Director of Midwifery and the Chief Nurse on the steps taken to address and manage this situation. Assurance given.
- Following the November PROMPT training, the service can demonstrate full compliance with Safety Action 8 of the Maternity Incentive Scheme (90% of all staff groups within timeframe).

The Academy approved the three-year training plan, which forms part of the 'Core Competency Framework Version 2. Concerns were raised regarding the delivery of the plan over the next year as such a level of staff training may compromise safe staffing levels in the unit. Trusts may challenge the MIS for a review of the standard on this basis. The recommendation to Board will be however that the plan is approved as it is recognised that core training will improve safety.

3. SI report
- Bradford District and Craven Health and Care Partnership have approved the Trust's transition to the Patient Safety Incident Response Framework (PSIRF) from 1st December 2023, following the approval of the Trust's Patient Safety Incident Response Policy and Plan by the Trust Board of Directors.

- The last declaration of a SI under NHS England's Serious Incident Framework was declared on the 28/11/2023 therefore the trajectory for investigation to be fully completed and submitted under these criteria is 28/2/2023.
- Test reporting of patient safety incidents to the NHS England Learning from Patient Safety Events (LFPSE) platform is continuing through the Trust's Datix test environment. Live reporting will commence when the Trust transitions from Datix to InPhase in January 2024.
- Between December 2022 and November 2023, the reporting of serious incidents (SIs) by the Trust has remained within normal cause variation except for January 2023.
- Our organisation continues to meet the Duty of Candour requirements and no breaches have occurred since August 2016.
- Academy has noted that of the 8 Trust led serious incident investigations extensions are in place for 3 investigations and heard that work is ongoing to reduce the number of extension requests made to ensure we can close outstanding SI investigations as quickly as possible to extract any further learning and progress our transition to PSIRF.
- Academy also noted that a new assurance report would be developed reflect the new investigation arrangements under the Patient Safety Incident Response Framework.

4. Safeguarding Adults and Safeguarding Children – Six monthly update

Two comprehensive mid-year reports from the Safeguarding leads for Adults and for Children.

- The two teams are closely linked with some crossover agendas such as MCA/Deprivation of Liberty Safeguards (DoLS) and work closely together to achieve safety outcomes.
- It was good to hear about the development of the Navigator role under 'Safeguarding Adults' and the positive feedback this was eliciting from carers and other professionals. It was hoped this may become a permanent role.
- The Mental Capacity Act assessment template is now live in EPR as of 12 December 2023 and the new 'best interest' template is also live in EPR - this will allow regular audits to review the quality of the information and is a strong, powerful, and legally robust tool.
- The Children's safeguarding training has been reviewed by the place and all training delivered from 2024 will be multi-disciplinary. The teams are seeing an increasing complexity in safeguarding issues including an increase in domestic abuse.
- Reference was made to the concerns raised in June 2023 regarding the inability of Cerner to link with SystmOne. This remains a longstanding issue and an update has been requested from the Chief Digital and Information Officer on particularly on progress to date regarding electronic records in relation to safeguarding children.

The Academy requested that the Childrens safeguarding lead share the response to their annual report from the ICB to provide additional assurance in this area.

5. Board Assurance Framework

There has been no change since the last BAF review, and no change made to any of the risk scores. The Academy has concluded that the risks are being appropriately managed and confirm that there are no matters to escalate to the Board of Directors' January 2024 meeting.

Report completed by:

Professor Louise Bryant, Academy Chair and Non-Executive Director and
Jacqui Maurice, Head of Corporate Governance

BO.1.24.9 - MATERNITY AND NEONATAL SERVICES UPDATE AND MATERNITY INCENTIVE SCHEME PRESENTATION

REFERENCES

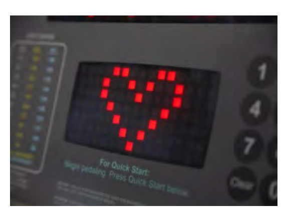
Only PDFs are attached

Bo.1.24.9 - Maternity and Neonatal Services - Maternity Incentive Scheme Board presentation January 2024.pdf

Board of Directors
January 2024

Maternity and Neonatal update October/November 2023 and Maternity Incentive Scheme submission

Sara Hollins, Director of Midwifery



Together, putting patients first

Highlights October/November

- The October and November perinatal update papers were presented to November and December Quality and Patient Safety Academies respectively.
- As a delegated authority of Trust Board, Academy received and approved the papers, appendices and recommendations.
- Details of harms, including stillbirths, neonatal deaths and hypoxic ischaemic encephalopathy, and completed investigation reports including learning, were shared and are also available to Trust Closed Board for information.

Discussion Points

- The number of harms occurring in October and November, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths, and number of HSIB and SI cases were discussed.
- 2 completed internal investigations/SI reports closed in October were discussed including learning and progress on actions and are available for Closed Board information.
- November QPSA approved the Quarter 2 Avoiding Term Admissions Into Neonatal Unit (ATAIN) report and associated action plan. The rate remains well below the national average and a focused piece of work around Transitional Care Unit is planned for early 2024.
- November QPSA was informed verbally of increased unit pressures impacting on delayed induction of labour, unit flow and the provision of 1:1 care in labour and of the action taken to escalate and mitigate. This position has now improved.
- December QPSA was informed that the 90% of all relevant staff groups achieved compliance in PROMPT (emergency skills training), Newborn Life Support and Fetal Monitoring training by the Maternity Incentive Scheme, Year 5, deadline of 1 December.
- December QPSA approved the 3 Year Training Plan, Core Competency Framework 2, a requirement of the Maternity Incentive Scheme, Year 5. The plan was also approved at the West Yorkshire and Harrogate Local Maternity and Neonatal System (LMNS), December Board meeting.
- December QPSA was informed of the extremely positive LMNS assurance visit in November and that there were no immediate or significant actions.

Board Recommendations

Bradford Teaching Hospitals NHS Foundation Trust

- Trust Board to confirm that they are assured that QPSA have reviewed and discussed the contents of the October and November Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority. Appendices 1 and 2.
- Closed Trust Board to note appendices 3 and 4 describing the stillbirths, HIE and neonatal deaths occurring in October and November 2023 and both newly reported and ongoing investigations.
- Trust Board to acknowledge that appendices 3a and 3b, completed internal incident report including learning and completed MNSI report, were shared with November QPSA and are available for the attention of Closed Board.
- Trust Board to confirm that they are assured that QPSA, as a committee of the Board with delegated authority, have reviewed and approved the Quarter 2 ATAIN report and action plan, required to demonstrate compliance with Safety Action 3 of the Maternity Incentive Scheme, Year 5.
- Trust Board to confirm that they are assured that November People Academy, as a committee of the Board with delegated authority, have reviewed and approved the Obstetric Medical Workforce audits, required to demonstrate compliance with Safety Action 4 of the Maternity Incentive Scheme.
- Trust Board to formally record in Trust Board minutes that they are assured that November People Academy, as a committee of the Board with delegated authority, received and approved the Neonatal Medical and Nursing Workforce review and associated action plan required to demonstrate compliance with Safety Action 4 of the Maternity Incentive Scheme.
- Trust Board to confirm that they are assured that December QPSA approved the 3 Year Training Plan Core Competency Framework version 2, required to demonstrate compliance with Safety Action 8 of the Maternity Incentive Scheme.
- Trust Board to receive and acknowledge this presentation.

Maternity Incentive Scheme

- Year 5 of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS), intended to support the delivery of safer maternity care in all acute Trusts.
- BTHFT have declared full compliance with the scheme in the previous 4 years.
- The Board Declaration Form must be signed by the Chief Executive and the Accountable Officer for the Integrated Care System and submitted no later than 12 noon on 1 February 2024.

Board Reporting Process

Bradford Teaching Hospitals
NHS Foundation Trust

- The Maternity and Neonatal Services Monthly Update Paper is used as the primary mechanism for updating Quality and Patient Safety Academy/Board on progress throughout the reporting year.
  - Quarterly ATAIN reports
  - Quarterly PMRT reports
  - Bi-annual Midwifery Workforce papers
- Throughout the year the evidence required to demonstrate compliance is also presented and discussed in a number of places.
  - ATAIN/PMRT/Early Notification Scheme (ENS)/HSIB cases discussed at joint obstetric/neonatal speciality meetings, core governance groups and at the bi-monthly Maternity Safety Champion Meetings.
  - Workforce Papers are discussed and approved at People Academy prior to presentation to Board.
- All maternity Board papers are shared with the maternity leads at the ICS and West Yorkshire and Harrogate Local Maternity and Neonatal System leads, monthly Perinatal Quality Surveillance Oversight Meetings.

Board Reporting Process

- An annual MIS summary is provided pre-submission including risks and additional action required, and a final assessment of the position of each of the 10 safety actions.
- The same summary was shared and agreed with the Accountable Officer for the ICS and Lead Midwife for the LMNS on 3 January 2024.
- Meeting with the CEO to complete the Board reporting form to enable CEO submission by 12 noon on 1 February 2024.

Year 5 Position

- The Maternity Service believes that the standards for each of the 10 safety action have been met, subject to:
  - That Safety Action 1 will meet compliance if the Board self declaration form includes the mitigation narrative regarding the 1 baby where surveillance information was not completed within 4 weeks of death, due to an Information Technology Issue.
    - This may be subject to further scrutiny from MBRRACE post submission, but it is anticipated that the mitigation will be accepted based on conversations with NHS Resolution.
  - Board formally record approval of the Neonatal Medical and Neonatal paper and action plans (appendix 2) in the January 2024 Board minutes. These were approved at November People Academy.
  - Board approve the 1:1 care in labour risk/assessment action plan (appendix 3), required to achieve compliance with Safety Action 5.

Year 5 Position

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Y
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Y
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Y
4	Can you demonstrate an effective system of clinical* workforce planning to the required standard?	Y
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Y
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Y
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Y
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Y
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Y
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	Y

Questions?

BO.1.24.9A - MATERNITY AND NEONATAL SERVICES UPDATE

REFERENCES

Only PDFs are attached

Bo.1.24.9a - Maternity and Neonatal Services Update (cover sheet).pdf

Bo.1.24.9a - Maternity and Neonatal Services Update - Appendix 1 (PERINATAL) October 2023.pdf

Bo.1.24.9a - Maternity and Neonatal Services Update - Appendix 2 (PERINATAL) November 2023.pdf

Meeting Title	Board of Directors		
Date	18.01.24	Agenda item	Bo.1.24.9a

MATERNITY AND NEONATAL (PERINATAL) BOARD ASSURANCE – OCTOBER/NOVEMBER 2023

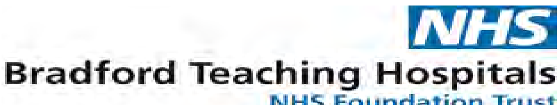
Presented by	Sara Hollins, Director of Midwifery	
Author	Sara Hollins, Director of Midwifery	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	To provide Trust Board with the bi-monthly assurance that Quality and Patient Safety Academy, has reviewed, considered and approved the monthly Maternity and Neonatal (Perinatal) Update papers.	
Key control	N/A	
Action required	For assurance	
Previously discussed at/informed by	Details of any consultation	
Previously approved at:	e.g. Academy / ETM / CSU group	**Date**
	Quality and Patient Safety Academy	November and December 2023
Key Options, Issues and Risks		

The December 2020, NHS publication 'Implementing a revised perinatal quality surveillance model' set out a number of requirements to ensure that there is Trust Board level oversight of perinatal clinical quality and safety.

The requirements to strengthen and optimise Board oversight for maternity and neonatal safety includes:

- That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board.
- That all maternity Serious Incidents (SIs) are shared with Trust Boards and the LMS, in addition to reporting as required to Maternity and Neonatal Safety Investigations (MNSI) formerly HSIB.
- To use a locally agreed dashboard drawing on locally collected intelligence to monitor maternity and neonatal safety at Board meetings.

The monthly maternity and neonatal services report presented to Quality and Patient Safety Academy (QPSA), ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that QPSA, as a delegated authority of Trust Board has assurance of an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services. A summary of incidents is provided to Closed Trust Board, in addition to any completed Maternity and Neonatal Safety Investigations (MNSI) and internal Serious Incident (SI) reports.



The format of the monthly reports supports the Trust level implementation of the Perinatal Clinical Quality Surveillance Model and ensures that key elements of the framework are visible and transparent at Trust Board level.

The monthly paper also serves as the main mechanism for QPSA, as a delegated authority of Trust Board, to have oversight of key elements of the NHS Resolution Maternity Incentive Scheme (MIS), throughout the annual reporting period, such as quarterly Perinatal Mortality Review Tool reports, quarterly Avoiding Term Admissions Into Neonatal Units (ATAIN) reports, and monthly midwifery and obstetric staffing updates.

This bi-monthly Maternity and Neonatal (Perinatal) Board Assurance paper provides a summary of the key elements of the monthly paper presented and discussed at QPSA, including the approval of any reports required to demonstrate compliance with the annual MIS.

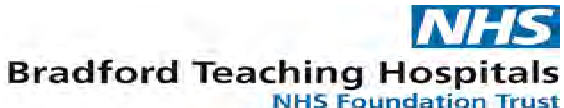
Analysis

The Director of Midwifery and the Chair of QPSA provide Trust Board with the assurance that a monthly review of maternity and neonatal quality and safety relating to October and November 2023 activity, was presented and key elements discussed including:

- The number of harms occurring in October and November, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths, and number of MNSI and SI cases were discussed.
- 2 completed MNSI and internal investigations/SI reports closed in October were discussed including learning and progress on actions.
- December QPSA was asked to note that the Perinatal Leadership Quad joined the November bi-monthly perinatal safety Champion meetings and that there were no safety escalations requiring support from Board.
- November Academy approved the Quarter 2 ATAIN report and action plan.
- November QPSA was verbally informed of increased unit pressures impacting on delayed induction of labour, unit flow and the provision of 1:1 care in labour.
- November People Academy approved the Obstetric Medical Workforce audits and the Neonatal Medical and Nursing Workforce reviews and associated action plans.
- December QPSA approved the 3 Year Training Plan Core Competency Framework version 2, which was also approved at LMNS Board in December.
- December QPSA were informed of the extremely positive LMNS Assurance visit which took place in November.

Recommendation

- Trust Board to confirm that they are assured that QPSA have reviewed and discussed the contents of the October and November Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority. Appendices 1 and



Meeting Title	Board of Directors		
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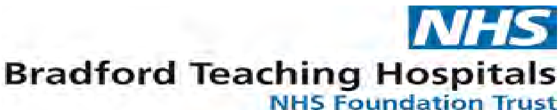
2. Closed Trust Board to note appendices 3 and 4 describing the stillbirths, HIE and neonatal deaths occurring in October and November 2023 and both newly reported and ongoing investigations.

- Trust Board to acknowledge that appendices 3a and 3b, completed internal incident report including learning and completed MNSI report, were shared with November QPSA and are available for the attention of Closed Board.
- Trust Board to confirm that they are assured that QPSA, as a committee of the Board with delegated authority, have reviewed and approved the Quarter 2 ATAIN report and action plan, required to demonstrate compliance with Safety Action 3 of the Maternity Incentive Scheme, Year 5.
- Trust Board to confirm that they are assured that November People Academy, as a committee of the Board with delegated authority, have reviewed and approved the Obstetric Medical Workforce audits, required to demonstrate compliance with Safety Action 4 of the Maternity Incentive Scheme.
- Trust Board to formally record in Trust Board minutes that they are assured that November People Academy, as a committee of the Board with delegated authority, received and approved the Neonatal Medical and Nursing Workforce review and associated action plan required to demonstrate compliance with Safety Action 4 of the Maternity Incentive Scheme.
- Trust Board to confirm that they are assured that December QPSA approved the 3 Year Training Plan Core Competency Framework version 2, required to demonstrate compliance with Safety Action 8 of the Maternity Incentive Scheme.
- Trust Board to receive and acknowledge the accompanying presentation.

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for our patients, delivered with kindness			g			
To deliver our financial plan and key performance targets			g			
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						



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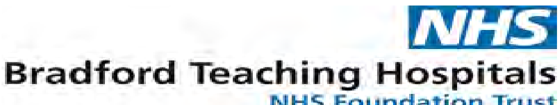
Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☒	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☒	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☒	☐	☐

Risk Implications (see section 5 for details)	Yes	No
High Level Risk Register and / or Board Assurance Framework Amendments	☐	☐
Quality implications	☒	☐
Resource implications	☐	☒
Legal/regulatory implications	☐	☒
Equality Diversity and Inclusion implications	☒	☐
Performance Implications	☐	☒

Regulation, Legislation and Compliance relevance
NHS England: (please tick those that are relevant) ☒Risk Assessment Framework ☒Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain: Choose an item.
Care Quality Commission Fundamental Standard: Choose an item.
NHS England Effective Use of Resources: Choose an item.
Other (please state):

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality & Patient Safety	Finance & Performance	Other (please state)
☐	☒	☐	☐



Meeting Title	Board of Directors		
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1 PURPOSE/ AIM

The purpose of the Maternity and Neonatal (Perinatal) Board Assurance paper is to provide Trust Board with the bi-monthly assurance that Quality and Patient Safety Academy as a committee of Board with delegated authority, has reviewed, considered and approved the monthly Maternity and Neonatal (Perinatal) Update papers and any associated reports required to demonstrate compliance with the Maternity Incentive Scheme (MIS).

2 BACKGROUND/CONTEXT

The December 2020, NHS publication 'Implementing a revised perinatal quality surveillance model' set out a number of requirements to ensure that there is Trust Board level oversight of perinatal clinical quality and safety.

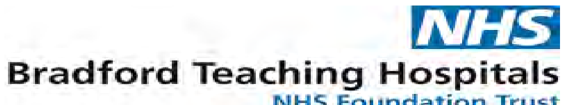
The requirements to strengthen and optimise Board oversight for maternity and neonatal safety include:

- That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board.
- That all maternity Serious Incidents (SIs) are shared with Trust Boards and the LMS, in addition to reporting as required to Maternity and Neonatal Safety Investigations (MNSI) formerly HSIB.
- To use a locally agreed dashboard drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.

The monthly maternity and neonatal services report presented to Quality and Patient Safety Academy (QPSA), ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that QPSA, as a delegated authority of Trust Board has assurance of an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services. A summary of incidents is provided to Closed Trust Board, in addition to any completed MNSI and internal Serious Incident (SI) reports.

The format of the monthly reports supports the Trust level implementation of the Perinatal Clinical Quality Surveillance Model and ensures that key elements of the framework are visible and transparent at Trust Board level.

The monthly paper also serves as the main mechanism for QPSA, as a delegated authority of Trust Board, to have oversight of key elements of the NHS Resolution Maternity Incentive Scheme (MIS), throughout the annual reporting period, such as quarterly Perinatal Mortality Review Tool reports, quarterly Avoiding Term Admissions into Neonatal Units (ATAIN) reports, and monthly midwifery and obstetric staffing updates.



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This bi-monthly Maternity and Neonatal (Perinatal) Board Assurance paper provides a summary of the key elements of the monthly paper presented and discussed at QPSA, including the approval of any reports required to demonstrate compliance with the annual MIS.

Maternity and Neonatal Updates October and November 2023 (Appendices 1 and 2):

The October and November updates and associated appendices were respectively discussed at November and December QPSA.

In addition, a number of items requiring approval to demonstrate compliance with elements of the Maternity Incentive Scheme, Year 5, were presented to November People Academy as a committee of Board with delegated authority.

The key elements of the paper discussed included:

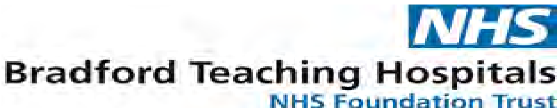
- The number of harms occurring in October and November, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths (NND), maternal deaths, and number of MNSI and SI cases were discussed and are available to Closed Trust Board as appendices 3 and 4.There were 2 completed Internal/MNSI reports including learning, shared in November (Appendices 3a and 3b).
- November QPSA reviewed and approved the Quarter 2 ATAIN report and action plan, required to demonstrate compliance with Safety Action 3 of the Maternity Incentive Scheme, Year 5. Academy was informed of the continued low rate of term admissions, well below the 5% national average, and of the plan to commence a focused piece of work around transitional care staffing in the New Year.
- November QPSA was verbally updated on increasing service delivery challenges experienced in November due to staffing, increased activity, increased acuity and high numbers of women requiring induction of labour. This impacted on delayed induction of labour, including 1 reportable serious harm, increased attempts at diverting services and reduced opportunities to provide 1:1 care in labour. The mitigation and actions to manage were discussed in detail.
- December QPSA received the written update on the activity challenges experienced in November, and was verbally updated that activity had started to return to an expected level, particularly the demand for induction of labour.
- November People Academy received and approved the Obstetric Medical Workforce audits and the Neonatal Medical and Nursing Workforce reviews and associated action plans, required to demonstrate compliance with Safety Action 4 of the Maternity Incentive Scheme, Year 5. The Obstetric audits demonstrated timely attendance of consultant/consultants in all audited cases that were deemed requiring consultant presence on the RCOG work force document for the period between the first of May 2023 and the 31st of October 2023. The Neonatal Medical and Nursing workforce reviews and updated action plans demonstrated

positive progress towards achieving the required British Association of Perinatal Medicine (BAPM) standards. The action plans were shared with the Neonatal Operational Delivery Network (ODN) and the LMNS as required by the Maternity Incentive Scheme. Maternity Training Compliance is presented to QPSA on a monthly basis. December QPSA was informed that following the November PROMPT training, the service was able to demonstrate full compliance with Safety Action 8 of the Maternity Incentive Scheme, due to 90% of all staff groups attending training within the required timeframe. This exceeded the revised 80% compliance rate acknowledging the impact of industrial action on training attendance, and reflects the commitment of the services to prioritise multi-disciplinary emergency training.

- December QPSA was asked to note that the Perinatal Leadership Quad joined the August bi-monthly perinatal safety Champion meetings and that there were no safety escalations requiring support from Board.
- December QPSA approved the 3 Year Training Plan Core Competency Framework version 2, required to demonstrate compliance with Safety Action 8 of the Maternity Incentive Scheme. A discussion took place that whilst the plan was relevant and meets the framework, the service is concerned about the ability to release both staff and faculty to meet the training requirements of 5 days per midwife, an increase of 2 days per midwife. QPSA was advised that any concerns regarding achieving the mandatary days would be escalated via the monthly update papers.
- December QPSA were updated on the extremely positive Local Maternity and Neonatal System (LMNS) assurance visit on 6 November 2023 to review progress on the Ockenden actions and to celebrate successes and achievements. The visit was overwhelmingly positive, with complimentary comments regarding the passion, enthusiasm and commitment of staff sharing and describing the learning journey, despite a back drop of increased unit pressure due to increased activity and acuity. There were no immediate safety recommendations and an acknowledgement of the progress made and sustained since the 2022 assurance visit.
- November and December QPSA reported and recorded that they were assured by the papers, presentation and discussion. There was nothing identified requiring escalation to Board.

3 RECOMMENDATIONS

- Trust Board to confirm that they are assured that QPSA have reviewed and discussed the contents of the October and November Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority. Appendices 1 and 2. Closed Trust Board to note Appendices 3 and 4 describing the stillbirths, HIE and neonatal deaths occurring in October and November 2023 and both newly reported and ongoing investigations.



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- Trust Board to acknowledge that Appendices 3a and 3b, completed internal incident report including learning and completed MNSI report, were shared with November QPSA and are available for the attention of Closed Board.
- Trust Board to confirm that they are assured that QPSA, as a committee of the Board with delegated authority, have reviewed and approved the Quarter 2 ATAIN report and action plan, required to demonstrate compliance with Safety Action 3 of the Maternity Incentive Scheme, Year 5.
- Trust Board to confirm that they are assured that November People Academy, as a committee of the Board with delegated authority, have reviewed and approved the Obstetric Medical Workforce audits, required to demonstrate compliance with Safety Action 4 of the Maternity Incentive Scheme.
- Trust Board to formally record in Trust Board minutes that they are assured that November People Academy, as a committee of the Board with delegated authority, received and approved the Neonatal Medical and Nursing Workforce review and associated action plan required to demonstrate compliance with Safety Action 4 of the Maternity Incentive Scheme.
- Trust Board to confirm that they are assured that December QPSA approved the 3 Year Training Plan Core Competency Framework version 2, required to demonstrate compliance with Safety Action 8 of the Maternity Incentive Scheme.
- Trust Board to receive and acknowledge the accompanying presentation.

4	Appendices

- Appendix 1 - Maternity and Neonatal Services Update Paper, October 2023
- Appendix 2 - Maternity and Neonatal Services Update Paper, November 2023
- Appendix 3 - 3a and 3b, Closed Board Harms October 2023 and completed MNSI and Internal Investigation reports
- Appendix 4 - Closed Board Harms November 2023

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MATERNITY AND NEONATAL (PERINATAL) SERVICES UPDATE – OCTOBER 2023

Presented by	Sara Hollins, Director of Midwifery	
Author	Sara Hollins, Director of Midwifery	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	To provide the Quality and Patient Safety Academy (QPSA) and Trust Board with a monthly update on progress with the Maternity Improvement Plan, including Care Quality Commission (CQC) Action Plan, monthly stillbirth position and continuity of carer. Ensures that key elements of the Perinatal Quality Surveillance Model are visible and transparent at Trust Board level.	
Key control	Identify if the paper is a key control for the Board Assurance Framework	
Action required	For assurance	
Previously discussed at/ informed by		
Previously approved at:	**Academy/Group**	**Date**

Key Options, Issues and Risks

The December 2020, NHS publication 'Implementing a revised perinatal quality surveillance model' set out a number of requirements to ensure that there is Trust Board level oversight of perinatal clinical quality and safety.

The requirements to strengthen and optimise Board oversight for maternity and neonatal safety includes:

- That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board.
- That all maternity Serious Incidents (SIs) are shared with Trust Boards and the Local Maternity System (LMS), in addition to reporting as required to Maternity and Neonatal Safety Investigation (MNSI) programme, formerly Healthcare Safety Investigation Branch (HSIB).
- To use a locally agreed dashboard drawing on locally collected intelligence to monitor maternity and neonatal safety at Board meetings.

This paper is prepared on a monthly basis and presented to Quality and Patient Safety Academy as a Committee of the Board, holding delegated authority to interrogate, challenge and approve/agree maternity and neonatal information and recommendations, including papers and reports prepared to demonstrate compliance with the NHS Resolution Maternity Incentive Scheme (MIS). A separate summary paper is presented to Trust Board providing assurance that Quality and Patient Safety Academy has executed its delegated authority.

The monthly maternity and neonatal services report presented to Quality and Patient Safety Academy ensures that there is a timely and structured reporting mechanism of maternal and

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neonatal outcomes including learning from incidents, and that the Academy on behalf of Board as an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services. The format of this report supports the Trust level implementation of the Perinatal Clinical Quality Surveillance Model and ensures that key elements of the framework are visible and transparent at Trust Board level.

The monthly paper also serves as the main mechanism for Quality and Patient Safety Academy on behalf of Trust Board to have oversight of key elements of the NHS Resolution Maternity Incentive Scheme (MIS), throughout the annual reporting period, such as quarterly Perinatal Mortality Review Tool reports, quarterly Avoiding Term Admissions Into Neonatal Units (ATAIN) reports, and monthly midwifery and obstetric staffing updates.

This paper is shared with the Maternity Leads at Bradford District and Craven, Health Care Partnership and feeds into the West Yorkshire and Harrogate (WY&H) Local Maternity and Neonatal System (LMNS) perinatal quality oversight groups.

Analysis

This paper provides Quality and Patient Safety Academy on behalf of Trust Board with information and data regarding perinatal quality and safety, enabling Academy members to rapidly identify any emerging concerns, trends or issues.

It is open and transparent and provides information and evidence of compliance with national maternity reports and schemes.

The overarching maternity improvement plan has been updated to include the Ockenden Assurance action plan and a sustainable Care Quality Commission (CQC) action plan.

The service presented proposed transformation plans to Board of Directors in May 2020, focusing on key areas of improvement identified as necessary to reduce the stillbirth rate. The Outstanding Maternity Services Programme is now the key driver for transformation within the service and is well embedded within the culture of the unit.

Monitoring of the monthly stillbirth rate continues, with every case subject to a 72 hour review and discussion with the Executive, Non-Executive and Trust level Maternity Safety Champions. This process is well embedded, including the rapid identification and escalation of in-month ‘spikes’ in the stillbirth rate which are subject to thematic reviews and reporting of any findings and subsequent learning to Trust Board.

Recommendation

- Quality and Patient Safety Academy is asked to note the contents of the Maternity and Neonatal (Perinatal) Services Update, October 2023.
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position of 4, including the description of incidents and any immediate actions/lessons learned.

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- Academy is asked to note that there were 2 cases of HIE reported in October.
- There were 3 neonatal deaths in October.
- Academy is informed that there were no maternal deaths in October.
- There are 6 ongoing maternity SIs/Level 1 investigations, 4 Maternity and Neonatal Safety Investigations (MNSI) HSIB and 2 Trust level.
- Academy is asked to note that there are no new neonatal SI's or ongoing neonatal SI's.
- There are 2 completed HSIB/Internal Serious Incident reports to share with QPSA /Closed Board in October.
- Quality and Patient Safety Academy is asked to note that there were 3 MNSI reportable cases (1 accepted, 2 in triage) and 0 reportable Serious Incidents (SI) declared in October.
- Academy is asked to note Appendix 2, the Quarter 2 ATAIN report and action plan to demonstrate compliance with Safety Action 3 of the Maternity Incentive Scheme, year 5. A focused piece of work around Transitional Care is planned for early 2024.
- Academy to note that there was 1 occasions in October where the unit was assessed as needing to divert women to other organisations, for a total of 52 hours. This has impacted in the provision of 1:1 care in labour, delayed induction of labour and the experience of some women.

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for our patients, delivered with kindness			g			
To deliver our financial plan and key performance targets			g			
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	**Yes**	**No**	**N/A**
Is there Model Hospital data relevant to the content of this paper?	☒	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☒	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☒	☐	☐

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Risk Implications (see section 5 for details)	Yes	No
High Level Risk Register and / or Board Assurance Framework Amendments	☐	☐
Quality implications	☒	☐
Resource implications	☐	☒
Legal/regulatory implications	☐	☒
Equality Diversity and Inclusion implications	☒	☐
Performance Implications	☐	☒

Regulation, Legislation and Compliance relevance	
NHS England: (please tick those that are relevant)	
☒Risk Assessment Framework	☒Quality Governance Framework
☐Code of Governance	☐Annual Reporting Manual
Care Quality Commission Domain: Choose an item.	
Care Quality Commission Fundamental Standard: Choose an item.	
NHS England Effective Use of Resources: Choose an item.	
Other (please state):	

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality & Patient Safety	Finance & Performance	Other (please state)
☐	☒	☐	☐

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1	PURPOSE/ AIM

The purpose of this paper is to provide a monthly update on progress with the Maternity Improvement Plan, including the Care Quality Committee (CQC) Action Plan, the monthly stillbirth position and continuity of carer. It also provides an update on the Outstanding Maternity Service quality improvement/transformation programme, intended to improve key areas of the service and support the journey towards being outstanding.

The December 2020, NHS publication 'Implementing a revised perinatal quality surveillance model' set out a number of requirements to ensure that there is Trust Board level oversight of perinatal clinical quality and safety.

The requirements to strengthen and optimise Board oversight for maternity and neonatal safety include:

- That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board.
- That all maternity Serious Incidents (SIs) are shared with the Trust Board and the LMS, in addition to reporting as required to MNSI.
- To use a locally agreed dashboard drawing on locally collected intelligence to monitor maternity and neonatal safety at Board meetings.

This paper is prepared on a monthly basis and presented to Quality and Patient Safety Academy as a Committee of the Board, holding delegated authority to interrogate, challenge and approve/agree maternity and neonatal information and recommendations, including papers and reports prepared to demonstrate compliance with the NHS Resolution Maternity Incentive Scheme (MIS). A separate summary paper is presented to Trust Board providing assurance that Quality and Patient Safety Academy has executed its delegated authority.

The monthly maternity and neonatal services report presented to Quality and Patient Safety Academy ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that the Academy on behalf of Board has an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services.

The format of this report supports the Trust level implementation of the Perinatal Clinical Quality Surveillance Model and ensures that key elements of the framework are visible and transparent at Trust Board level.

The monthly paper also serves as the main mechanism for Quality and Patient Safety Academy on behalf of Trust Board to have oversight of key elements of the NHS Resolution Maternity Incentive Scheme (MIS), throughout the annual reporting period, such as quarterly Perinatal Mortality Review Tool reports, quarterly Avoiding Term Admissions Into Neonatal Units (ATAIN) reports, and monthly midwifery and obstetric staffing updates.

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This paper is shared with the Maternity Leads at Bradford District and Craven, Health Care Partnership and feeds into the West Yorkshire and Harrogate (WY&H) Local Maternity and Neonatal System (LMNS) perinatal quality oversight groups.

2	BACKGROUND/CONTEXT

Ockenden Report of Maternity Services at Shrewsbury and Telford NHS Trust, Ockenden Assurance Plan and East Kent Report

The Ockenden report of Maternity Services at Shrewsbury and Telford NHS Trust was published on 10 December 2020 followed by the 2nd Report on 30 March 2022. The reports looked at maternal and neonatal harms occurring between 2000-2019 at Shrewsbury and Telford Hospital and resulted in 27 recommendations for the named Trust with a further 7 early recommendations, referred to as immediate and essential actions (IAE's) to be implemented by all NHS Maternity services. A further 15 IAE's were included in the 2nd report.

The service had its Regional Maternity Team assurance visit on 29 June 2022. The full report was received in August 2022 and reflects the initial feedback presentation shared with Board in the July 2022 update paper. An Ockenden Assurance Action Plan update is to be shared with West Yorkshire and Harrogate (WY&H) Local Maternity and Neonatal System (LMNS) in January.

The LMNS is undertaking a further assurance visit on 6 November, to review progress on the Ockenden actions and to celebrate successes and achievements.

The services outstanding compliance action is regarding the lack of ability to audit of the use of the Personalised Care Plan (PCP).

There has been a small amount of progress in relation to the PCP solution.

Shipley Community Midwifery team will be piloting 'Doctor, Doctor' an electronic PCP option, from October 2023. The team will share the PCP with women on their case load, and will utilise feedback on the functionality to decide if this is a viable option that can be rolled out across all teams. The one significant challenge with this option is that it is not an editable document, which means that a new document must be started in the event of any changes initiated by the woman and her preferences or as a result of changes to her clinical risk factors. However, it is appreciated that as options are very limited, this should not deter from piloting. This Pilot is still ongoing at the time of the report.

East Kent Report:

The Kirkup Report, 'Reading the signals: Maternity and neonatal services in East Kent- the Report of the Independent Investigation' was published on 19 0ctober 2022 examining failings in maternity and neonatal services at The Queen The Queen Mother Hospital (QEQM) and the William Harvey Hospital (WHH), part of East Kent Hospitals University NHS Foundation Trust, between 2009 and 2020.

A precis of the report and actions for the maternity service and Trust Board was presented to November 2022 Board. There have been no Regional or National updates or requests for information/local action since the report was published.

NHS England published the 'Three year delivery plan for maternity and neonatal services' at the end of March. The purpose of the three year plan is to improve the safety and quality of maternity and neonatal services, incorporating recommendations from key reports such as Ockenden and Kirkup.

A summary of the plan was presented to Executive Team Meeting (ETM) and Trust Board in May, including the risks associated with delivering the plan. The three year plan has been benchmarked in September and shared with West Yorkshire and Harrogate, Local Maternity and Neonatal System, ahead of our planned assurance visit in November.

Compliance with the long standing Maternity Incentive Scheme 10 safety actions will support delivery of the plan in many areas. However, there are a number of areas which will prove challenging and may require Board level support.

- Achieve UNICEF accreditation- will involve a significant training input additional to the Core Competency Framework requirements.
- Progression of further Maternity Continuity of Carer teams when safe staffing achieved and sustained.
- Equality Lead within the service.
- Development of an in house equality dashboard and an improvement plan based on findings - will need support from BI and Digital colleagues.
- MNVP involvement in co-production of services - ongoing challenges with the current ICP resource available to support Bradford and Airedale.

An update on progress with the Three year delivery plan was shared in the September paper presented to October QPSA, highlighting the anticipated challenges listed above. There was no request of Board at that time and the update was for information only.

Perinatal Cultural Leadership Programme

Following a reginal nomination process, 4 members of the senior maternity and neonatal (perinatal) leadership teams have embarked on a 6 month programme intended to support a positive and nurturing safety cultural in perinatal services.

The aim is to support all perinatal teams in England to create and craft the conditions for a positive culture of openness, safety and continuous improvement. Reviews of maternity services have highlighted cultural and leadership issues as a common theme that contributes to

underlying patient safety failures across organisations. Strong and positive leadership creates effective teamwork and therefore improved clinical care.

The programme will focus on the perinatal quadrumvirate, or 'quad', groups of senior leaders in perinatal services (typically including senior midwifery, obstetric, neonatal and operational representation). Co-designed by frontline teams and leadership experts, this programme will bring together senior leaders from across maternity and neonatal services to improve the quality, safety and experience of care for women.

The programme commenced in January with the Director of Midwifery, Deputy Clinical Director for Obstetrics and Gynaecology, Consultant Neonatologist and General Manager for Women's CSU, attending a 3 day course in London.

The 'quad' have continued to attend a series of individual action learning sets (ALS), focusing on their individual leadership styles and learning needs, in addition to a further session in London.

The SCORE culture survey was launched at the end of March and closed in May.

The quad team have a series of meetings planned with an external company who will support the analysis of the survey results and the associated actions required. The quad team and additional members of the senior leadership team, met with the external survey support team on 31 August and the highlights and areas for consideration were shared.

- 41% response rate overall.
- Staff responded positively to the unit being:
  - Positive safety culture.
  - Improvement ready.
  - Providing a good work life balance.
  - Positive regarding job certainty.
  - Intention to leave was low.
  - Good opportunity for growth.
- Areas for improvement:
  - Staff rated emotional recovery related to work as low.

There was a short discussion within the group around improving emotional recovery, including learning from the access to psychology model available within the neonatal unit. The next steps will be to share the high level feedback with the wider team before commencing smaller focus groups to look at any improvement work the wider team wish us to consider.

A number of key staff received training as 'Culture Coaches' to support and facilitate conversations with staff.

Score analysis with the Perinatal Leadership Quadrumvirate continues, with further meetings planned for December.

Midwifery Staffing

Safety Action 9 of the Maternity Incentive Scheme, Year 4, requires that there is evidence that discussions regarding safety intelligence, including minimum staffing in maternity services are taking place at Board level.

The most recent bi-annual midwifery staffing paper was presented to People Academy and Board in May, as an appendix to the overarching Nursing and Midwifery staffing paper. The next paper will be presented to October People Academy prior to sign off at November Board.

The recommendations, including the request to support the required uplift in 'headroom' from 22% to 24.3% so this can be accurately built in to the calculations used in the Birth Rate Plus full review in November 2023, were approved by October People Academy and November Trust Board.

Based on the revised table top calculations the current vacancy against the safe staffing establishment is 8.54 WTE which includes the agreed uplift for maternity leave. This is a huge improvement on the 29.61 WTE reported last month, and is attributed to the newly qualified midwives.

Achieving the safe staffing establishment continues to be our priority figure.

Current vacancy against the revised funded establishment, which includes the number of midwives required to provide Midwifery Continuity of Carer (MCoC) is 33.96 WTE.
October maternity leave is 10.94 WTE.

Staffing gaps continue to be closely managed by the Bed Manager and staffing Matron of the day, utilising the amber risk assessment and escalation processes as required.

11 of the 22 newly qualified midwives (NQM) appointed in the spring commenced in post in October. Several NQM will hopefully join the service incrementally following exam board re-sit results and a number of others are delayed due to maternity leave or personal requests to delay start dates.

Additional initiatives are also being explored/implemented to improve safe staffing numbers including:

- The service has executive approval to pay bank shifts at surge rate until the end of January, to encourage the uptake of unfilled shifts.

- Plans to offer bank shifts to registered nurses, to provide additional registrant support for non-midwifery specific tasks such as post-operative care, drug rounds, intravenous drug administration, to release midwifery specific time.
- Number of quality improvement (QI) plans to improve efficiency across the unit.
- Senior attendance at Regional Induction of Labour 'deep dive' day in December.
- Further progression of 'apprentice midwife' posts for existing maternity support workers.
- Birth rate plus to recommence in November.

Obstetric Staffing

We continue to ensure a 100% consultant presence on the labour ward for 98 hours per week.

We continue to ensure safe cover of both Obstetrics and Gynaecology services during industrial actions.

Maternity Improvement Plan and CQC rating

The Maternity Services received an onsite inspection in January, focusing on 'Safe' and 'Well-Led' domains only.

The final report was received in May and reflects the positive improvements made and since the 2019 inspection. Whilst the overall rating remains 'Requires Improvement', the 'Well-Led' domain has improved from 'Inadequate' to 'Good', with 'Safe' remaining as 'Requires Improvement'.

An action plan addressing the 2 'Must Do' actions and 5 'Should Do', has been returned to the CQC and presented to May QPSA, June Board and progress will be monitored through 'Women's Core Governance Group' and QPSA.

The Improvement plan is due to be updated in November and shared at the November 'Moving to Outstanding' meeting.

Stillbirth Position

There were 4 stillbirths in October. Details are included in Appendix 1.

Table 1 is the running total of stillbirths in 2023, including the number of cases requiring further detailed investigation, and the number of butterfly babies whose deaths were expected.

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Table 1:

Stillbirths 2023			Expected deaths within total number	Further detailed investigation
Month	**Number of babies**	**Running total**	**Butterfly babies/Congenital abnormalities**	**Number of cases**
January	1	1	1	0
February	1	2	0	0
March	2	4	0	0
April	2	6	0	1 (HSIB)
May	5	11	1	0
June	2	13	1	0
July	1	14	1	0
August	1	15	0	0
September	4	19	0	1 (level 1)
October	4	23	1	1 (MNSI ref)

Hypoxic Ischaemic Encephalopathy (HIE)

There were 2 babies diagnosed with HIE in October. See Appendix 1. Both cases were referred to MNSI. 1 accepted the other awaiting triage.

Serious Incidents (SIs) and serious harms

The December 2020 Ockenden Report, independent review of Maternity services at the Shrewsbury and Telford Hospital NHS Trust, contained 7 immediate and essential actions (IAE) to improve care and safety in maternity services for all Trusts.

IAE 1: Enhanced Safety, recommends that all maternity SI reports and a summary of the key issues, must be sent to the Trust Board and the Local Maternity and Neonatal System (LMNS).

There were 3 MNSI reportable cases occurring in as previously discussed, and no internal SIs.

Safety Action 9 of the Maternity Incentive Scheme, Year 4, requires that there is evidence that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified and actions being taken to address any issues, are taking place at Board level. It is anticipated that this standard will continue in the Year 5 publication.

Ongoing Maternity SIs:

Appendix 1 includes a position summary of ongoing maternity SIs. There are 2 completed reports for the attention of Quality and Patient Safety Academy and Closed Board this month, appendix 1a and 1b.

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There are 6 ongoing maternity SIs/Level 1 investigations, 4 HSIB and 2 Trust level. A number of reports are at factual accuracy checking and expected to be completed in the next month.

There were no neonatal SIs declared in October and no ongoing neonatal SIs under investigation.

Neonatal Deaths (NND)

There were 3 neonatal deaths in October.

- Term baby with HIE as noted in Appendix 1.
- 24 week baby born following cord prolapse.
- 25+2 death from early onset sepsis at 1 day of age.

Please see Table 2 below:

Table 2:

NND 202			**Expected deaths within total number**	**Further detailed investigation**
Month	**Number of babies**	**Running total**	**Extreme preterm/congenital anomalies/life limiting conditions**	**Number of cases**
January	1	1	1	0
February	5	6	4	0
March	2	8	0	0
April	3	11	1	0
May	6	17	4	0
June	1	18	0	0
July	2	20	0	0
August	4	24	4	0
September	2	26	1	0
October	3	29	1	1 (MNSI)

Maternal Deaths

There were 0 Maternal Deaths in October.

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MNSI (HSIB) Cases and Progress in achieving Maternity Incentive Scheme Safety Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?
Following the Ockenden Report, all cases referred to the Maternity and Neonatal Safety Investigation (MNSI) will be declared as SIs. There were 3 cases meeting the MNSI referral criteria in October.

MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with the Trust
The implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on this is a monthly minimum data measure for Trust Board overview.

There were no direct requests for action made directly to the Trust in October.

Coroner Regulation 28 made directly to Trust
Again, the implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on this is a monthly minimum data measure for Trust Board overview.

The service can confirm that there have been no such requests to date this year.

Avoiding Term Admissions In to Neonatal Unit (ATAIN)
Appendix 2 is a copy of the Quarter 2 ATAIN action plan required to demonstrate with Safety Action 3 of the Maternity Incentive Scheme. The plan will be shared at both Neonatal and Maternity core Governance groups in December and a focused piece of QI regarding Transitional Care is planned for early next year.

ATAIN rates at BTHFT remain consistently below the accepted national average of 5%, 12 admissions in October, which was a rate of 2.86 and 3-month rolling average of 3.07. Further improvements noted in the action plan will serve to maintain this positive rate and reduce avoidable admissions.

Perinatal Bi-Monthly Safety Champion meetings
The Safety Champions met on 17 October. Appendix 3 is a copy of the meeting notes and action log. The recent scrutiny into the 3 neonatal SI's occurring in April 2021 was discussed in great detail. The meeting was attended by members of the Perinatal Leadership Quadrumvirate, who had no issues to escalate requiring Board level support.

Monthly staff feedback from Safety Champions and walk-rounds
The October meeting was chaired by Karen Dawber who reiterated the processes in place for staff to escalate safety concerns, including the Freedom to Speak Up (FTSU) process.

Staff escalated concerns regarding recent car crime in the Women's and Newborn car park. Drop in sessions to discuss car safety will be facilitated in the unit foyer.

Maternity Unit Diverts

There was 1 partial/attempted unit diverts/escalations in October recorded on the closure log. Whilst only 1 occasion, the duration of the partial and attempted divert lasted 52 hours and was attributed to increased activity and an increase in the acuity of some of the women accessing the service, compounded by staffing levels. Only 1 woman was diverted to a neighbouring organisation for care during this time period, due to other maternity services within the LMNS reporting similar pressures and escalations. This meant that the service continued to accept and admit women which impacted on the ability to provide 1:1 care in labour, delays in triage and delays to women waiting for induction of labour.

Table 4:

MONTH	Full Divert	Partial divert	Attempted Divert	Number of women diverted
JANUARY	0	0	0	0
FEBRUARY	0	1	0	TBC
MARCH	0	1	0	4 (no births)
APRIL	0	2	0	2
MAY	0	4	0	10
JUNE	0	3	0	10
JULY	0	2	0	2
AUGUST	0	0	3	0
SEPTEMBER	0	3	5	2
OCTOBER	0	1	0	1
Total	0	14	8	31

Midwifery Continuity of Carer (MCoC) Action plan

Appendix 3 is a copy of the high level MCoC action plan discussed with the Chief Nurse in October. The MCoC lead midwife and Chief Nurse also discussed the current teams and where they were at in terms of on calls. The Chief Nurse was informed that the first continuity forum

had taken place for the existing teams and that they have begun to collect data and will be restarting their infographics monthly and other promotion.

9% of all bookings were booked into a continuity team. Barriers to increasing the amount of women receiving continuity were discussed with midwifery staffing being the biggest barrier until the staffing across the service improves and safe staffing is achieved. The lead also discussed perceptions of MCoC from other staff and the negative associations of MCoC and the plan to overcome these.

Maternity Dashboard

Appendix 4 is a copy of the maternity dashboard including data up to September 2023. There is a current delay in validating dashboard data due to current vacancy of the Digital Midwife post. The Associate Deputy Director of Midwifery is managing this until a replacement is found and also plans to work with business intelligence colleagues (BI) to recommence production of maternity data in a statistical process control (SPC) format. It is hoped that this will provide a more meaningful way of displaying the data and identifying any areas of concern or celebration.

1:1 care in labour continues to be the key metric of concern. This continues to be as expected given ongoing staffing challenges and the requirement to divert services, but with limited organisations able to accept as reported in the divert section of the report. No harm is reported as a result of failure to achieve 1:1 care. However, it is acknowledged that this impacts on the birth experience of some women. Mitigation including the redeployment of midwifery staff, is utilised but at times it remains challenging to provide 1:1 care. The inpatient ward Matron is working with teams to look at any efficiency that may improve flow of women through the unit, freeing capacity on the labour ward. Additional measures reported in the Midwifery staffing section of this report will also contribute towards the improvement of this metric.

Training Compliance

Appendix 5 is the monthly training compliance for maternity staff.

QPSA is asked to note that PROMPT training continues to be closely managed in order to meet the 90% Maternity Incentive Scheme compliance rate by the revised date of 1 December 2023. It is now looking extremely likely that this target will be achieved by the deadline due to expected attendance at the November training date.

Infant feeding practical training compliance, required to meet Unicef Baby Friendly Initiative (BFI) accreditation standards, is currently at 0%. This is primarily due to the capacity of the Infant Feeding Specialist Midwife to undertake the practical assessments, and the workload pressures of the staff requiring sign off.

Whilst we are currently in the preliminary stages of preparing for accreditation, this is not an immediate priority. However, a plan is in place to train ward and department managers to undertake the competency reviews in their clinical areas from the New Year.

Current training records shows 33 of 45 training compliances are within agreed target, 8 areas of training where compliance is between 75-85% and 4 with compliance below 75% (improved from 6).

The attached report provides a summary of the actions in place to support improvement.

Perinatal Quality Surveillance Model minimum data set for Trust Boards

Appendix 6 is the populated copy of the Perinatal Quality Surveillance Model minimum data set for Trust Boards. Much of the information required for presentation for Board is contained within the narrative of this report.

Service User Feedback

There were no planned MNVP meetings in October. However a number of discussions with ICP colleagues have taken place regarding the increase in MNVP attendance at service meetings and events, and the current funding arrangements. The LMNS are aware of the current challenges.

The service continues to liaise closely with the MNVP leads, responding to email requests for information.

The Parent Education team and OMS lead midwife have also provided additional examples of how service user feedback outside of the MNVP structure, has been used to inform and support service changes. For example, in direct response to feedback from partners, a ‘partners parent education’ session has now been created, focusing on the needs of birth support people in addition to the birthing person.

3 PROPOSAL

The service proposes that the Perinatal Update paper continues to be presented to Quality and Patient Safety Academy on a monthly basis with an assurance paper presented to Board bi-monthly.

This is to ensure that Trust Board receives timely information regarding perinatal quality and safety issues, in addition to quality improvement and transformation.

The service also proposes that the report will include the minimum data set described within the Perinatal Quality Surveillance Model.

Any urgent concerns emerging outside of the monthly reporting arrangements will be escalated by the Trust Level Safety Champions to the Board Level Safety Champion.

4 BENCHMARKING IMPLICATIONS

The service will continue to benchmark and monitor performance and position at both regional and national level, using the existing benchmarking tools including the Yorkshire and Humber regional maternity dashboard, MBRRACE-UK publications etc.

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Continuity of Carer is monitored through the West Yorkshire and Harrogate LMS.

5 RISK ASSESSMENT

Stillbirths and Midwifery Continuity of Carer pathways are on the maternity risk register, updated regularly and monitored through Women's Core Governance Group.

6 RECOMMENDATIONS

- Quality and Patient Safety Academy is asked to note the contents of the Maternity and Neonatal (Perinatal) Services Update, October 2023.
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position of 4, including the description of incidents and any immediate actions/lessons learned.
- Academy is asked to note that there were 2 cases of HIE reported in October.
- There were 3 neonatal deaths in October.
- Academy is informed that there were no maternal deaths in October.
- There are 6 ongoing maternity SIs/Level 1 investigations, 4 Maternity and Neonatal Safety Investigations (MNSI) HSIB and 2 Trust level.
- Academy is asked to note that there are no new neonatal SI's or ongoing neonatal SI's.
- There are 2 completed HSIB/Internal Serious Incident reports to share with QPSA/ Closed Board in October.
- Quality and Patient Safety Academy is asked to note that there were 3 MNSI reportable cases (1 accepted, 2 in triage) and 0 reportable Serious Incidents (SI) declared in October.
- Academy is asked to note Appendix 2, the Quarter 2 ATAIN report and action plan to demonstrate compliance with Safety Action 3 of the Maternity Incentive Scheme, year 5. A focused piece of work around Transitional Care is planned for early 2024.

Academy to note that there was 1 occasions in October where the unit was assessed as needing to divert women to other organisations, for a total of 52 hours. This has impacted in the provision of 1:1 care in labour, delayed induction of labour and the experience of some women.

7 Appendices

- Appendix 1, 1a and 1b - Maternity and Neonatal Harms October and completed investigation report including learning.
- Appendix 2 - ATAIN Quarter 2 report and action plan.
- Appendix 3 - High Level MCoC timeline.
- Appendix 4 - Maternity Services Dashboard July 2023.
- Appendix 5 - Maternity Training Compliance report August.
- Appendix 6 - Perinatal Quality Surveillance Model minimum data set for Trust Boards.

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MATERNITY AND NEONATAL (PERINATAL) SERVICES UPDATE – NOVEMBER 2023

Presented by	Sara Hollins, Director of Midwifery	
Author	Sara Hollins, Director of Midwifery	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	To provide the Quality and Patient Safety Academy (QPSA) and Trust Board with a monthly update on progress with the Maternity Improvement Plan, including Care Quality Commission (CQC) Action Plan, monthly stillbirth position and continuity of carer. Ensures that key elements of the Perinatal Quality Surveillance Model are visible and transparent at Trust Board level.	
Key control	Identify if the paper is a key control for the Board Assurance Framework	
Action required	For assurance	
Previously discussed at/ informed by		
Previously approved at:	**Academy/Group**	**Date**

Key Options, Issues and Risks

The December 2020, NHS publication 'Implementing a revised perinatal quality surveillance model' set out a number of requirements to ensure that there is Trust Board level oversight of perinatal clinical quality and safety.

The requirements to strengthen and optimise Board oversight for maternity and neonatal safety includes:

- That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board.
- That all maternity Serious Incidents (SIs) are shared with Trust Boards and the Local Maternity System (LMS), in addition to reporting as required to Maternity and Neonatal Safety Investigation (MNSI) programme, formerly Healthcare Safety Investigation Branch (HSIB).
- To use a locally agreed dashboard drawing on locally collected intelligence to monitor maternity and neonatal safety at Board meetings.

This paper is prepared on a monthly basis and presented to Quality and Patient Safety Academy as a Committee of the Board, holding delegated authority to interrogate, challenge and approve/agree maternity and neonatal information and recommendations, including papers and reports prepared to demonstrate compliance with the NHS Resolution Maternity Incentive Scheme (MIS). A separate summary paper is presented to Trust Board providing assurance that Quality and Patient Safety Academy has executed its delegated authority.

The monthly maternity and neonatal services report presented to Quality and Patient Safety Academy ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that the Academy on behalf of Board

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as an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services. The format of this report supports the Trust level implementation of the Perinatal Clinical Quality Surveillance Model and ensures that key elements of the framework are visible and transparent at Trust Board level.

The monthly paper also serves as the main mechanism for Quality and Patient Safety Academy on behalf of Trust Board to have oversight of key elements of the NHS Resolution Maternity Incentive Scheme (MIS), throughout the annual reporting period, such as quarterly Perinatal Mortality Review Tool reports, quarterly Avoiding Term Admissions Into Neonatal Units (ATAIN) reports, and monthly midwifery and obstetric staffing updates.

This paper is shared with the Maternity Leads at Bradford District and Craven, Health Care Partnership and feeds into the West Yorkshire and Harrogate (WY&H) Local Maternity and Neonatal System (LMNS) perinatal quality oversight groups.

Analysis

This paper provides Quality and Patient Safety Academy on behalf of Trust Board with information and data regarding perinatal quality and safety, enabling Academy members to rapidly identify any emerging concerns, trends or issues.

It is open and transparent and provides information and evidence of compliance with national maternity reports and schemes.

The overarching maternity improvement plan has been updated to include the Ockenden Assurance action plan and a sustainable Care Quality Commission (CQC) action plan.

The service presented proposed transformation plans to Board of Directors in May 2020, focusing on key areas of improvement identified as necessary to reduce the stillbirth rate. The Outstanding Maternity Services Programme is now the key driver for transformation within the service and is well embedded within the culture of the unit.

Monitoring of the monthly stillbirth rate continues, with every case subject to a 72 hour review and discussion with the Executive, Non-Executive and Trust level Maternity Safety Champions. This process is well embedded, including the rapid identification and escalation of in-month ‘spikes’ in the stillbirth rate which are subject to thematic reviews and reporting of any findings and subsequent learning to Trust Board.

Recommendation

- Quality and Patient Safety Academy is asked to note the contents of the Maternity and Neonatal (Perinatal) Services Update, November 2023.
- Academy is informed that the LMNS Assurance visit was undertaken in November and that the feedback was extremely positive (Appendix 1).
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position of 2, including the description of incidents and any immediate actions/lessons

learned.

- Academy is asked to note that there were 0 cases of HIE reported in November.
- There were 0 neonatal deaths in November.
- Academy is informed that there were no maternal deaths in November.
- There are 8 ongoing maternity SIs/Level 1 investigations, 6 Maternity and Neonatal Safety Investigations (MNSI) and 2 Trust level.
- Academy is asked to note that there are no new neonatal SI's or ongoing neonatal SI's.
- There are 0 completed HSIB/Internal Serious Incident reports to share with QPSA /Closed Board in November.
- Quality and Patient Safety Academy is asked to note that there were 0 MNSI reportable cases and 1 reportable Serious Incidents (SI) declared in November.
- Academy to note that there were 10 occasions in November where the unit was assessed as needing to divert women to other organisations. This has impacted in the provision of 1:1 care in labour, delayed induction of labour and the experience of some women.
- Quality and Patient Safety Academy is asked to note the increased unit pressures experienced in November, including the back log of inductions and the steps taken to address and manage this issue.
- Academy is informed that following the November PROMPT training, the service is able to demonstrate full compliance with Safety Action 8 of the Maternity Incentive Scheme, due to 90% of all staff groups attending training within the required timeframe.
- Quality and Patient Safety Academy is asked to approve Appendix 5, 3 Year Training Plan, Core Competency Framework, Version 2, as a committee of Board with delegated authority, and note the perceived concerns regarding delivery.

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for our patients, delivered with kindness			g			
To deliver our financial plan and key performance targets			g			
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					

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Explanation of variance from Board of Directors Agreed General risk appetite (G)	

Benchmarking implications (see section 4 for details)	**Yes**	**No**	**N/A**
Is there Model Hospital data relevant to the content of this paper?	☒	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☒	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☒	☐	☐

Risk Implications (see section 5 for details)	**Yes**	**No**
High Level Risk Register and / or Board Assurance Framework Amendments	☐	☐
Quality implications	☒	☐
Resource implications	☐	☒
Legal/regulatory implications	☐	☒
Equality Diversity and Inclusion implications	☒	☐
Performance Implications	☐	☒

Regulation, Legislation and Compliance relevance
NHS England: (please tick those that are relevant) ☒Risk Assessment Framework ☒Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain: Choose an item.
Care Quality Commission Fundamental Standard: Choose an item.
NHS England Effective Use of Resources: Choose an item.
Other (please state):

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality & Patient Safety	Finance & Performance	Other (please state)
☐	☒	☐	☐

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1 PURPOSE/ AIM

The purpose of this paper is to provide a monthly update on progress with the Maternity Improvement Plan, including the Care Quality Committee (CQC) Action Plan, the monthly stillbirth position and continuity of carer. It also provides an update on the Outstanding Maternity Service quality improvement/transformation programme, intended to improve key areas of the service and support the journey towards being outstanding.

The December 2020, NHS publication 'Implementing a revised perinatal quality surveillance model' set out a number of requirements to ensure that there is Trust Board level oversight of perinatal clinical quality and safety.

The requirements to strengthen and optimise Board oversight for maternity and neonatal safety include:

- That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board.
- That all maternity Serious Incidents (SIs) are shared with the Trust Board and the LMS, in addition to reporting as required to MNSI.
- To use a locally agreed dashboard drawing on locally collected intelligence to monitor maternity and neonatal safety at Board meetings.

This paper is prepared on a monthly basis and presented to Quality and Patient Safety Academy as a Committee of the Board, holding delegated authority to interrogate, challenge and approve/agree maternity and neonatal information and recommendations, including papers and reports prepared to demonstrate compliance with the NHS Resolution Maternity Incentive Scheme (MIS). A separate summary paper is presented to Trust Board providing assurance that Quality and Patient Safety Academy has executed its delegated authority.

The monthly maternity and neonatal services report presented to Quality and Patient Safety Academy ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that the Academy on behalf of Board has an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services.

The format of this report supports the Trust level implementation of the Perinatal Clinical Quality Surveillance Model and ensures that key elements of the framework are visible and transparent at Trust Board level.

The monthly paper also serves as the main mechanism for Quality and Patient Safety Academy on behalf of Trust Board to have oversight of key elements of the NHS Resolution Maternity Incentive Scheme (MIS), throughout the annual reporting period, such as quarterly Perinatal Mortality Review Tool reports, quarterly Avoiding Term Admissions Into Neonatal Units (ATAIN) reports, and monthly midwifery and obstetric staffing updates.

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This paper is shared with the Maternity Leads at Bradford District and Craven, Health Care Partnership and feeds into the West Yorkshire and Harrogate (WY&H) Local Maternity and Neonatal System (LMNS) perinatal quality oversight groups.

2	BACKGROUND/CONTEXT

Ockenden Report of Maternity Services at Shrewsbury and Telford NHS Trust, Ockenden Assurance Plan and East Kent Report

The Ockenden report of Maternity Services at Shrewsbury and Telford NHS Trust was published on 10 December 2020 followed by the 2nd Report on 30 March 2022. The reports looked at maternal and neonatal harms occurring between 2000-2019 at Shrewsbury and Telford Hospital and resulted in 27 recommendations for the named Trust with a further 7 early recommendations, referred to as immediate and essential actions (IAE's) to be implemented by all NHS Maternity services. A further 15 IAE's were included in the 2nd report which has since been incorporated into the Three Year Plan for Maternity and Neonatal Services.

The West Yorkshire and Harrogate (WY&H) Local Maternity and Neonatal System (LMNS) undertook an assurance visit on 6 November, to review progress on the Ockenden actions and to celebrate successes and achievements. The visit was overwhelmingly positive, with complimentary comments regarding the passion, enthusiasm and commitment of staff sharing and describing the learning journey, despite a back drop of increased unit pressure due to increased activity and acuity. Appendix 1 is a copy of the LMNS report to the Trust.

There were no immediate safety recommendations and areas for further improvement are:

- Increasing the role of the Maternity and Neonatal Voices Partnership with more capacity
  - The Service are committed to this and are working with both the Integrated Care Board (ICB) and the LMNS to pursue further funding.
  - MNVP and Non -Executive Director Safety Champion engagement should also be improved when capacity permits.
- The services only outstanding compliance action is regarding the lack of ability to audit of the use of the Personalised Care Plan (PCP), which has made progress since the 2022 assurance visit, due to the current pilot of an electronic PCP option. The LMNS acknowledged the pilot and look forward to the evaluation.
- Staffing challenges were acknowledged and the impact this has on the consistent availability of the Birth Centre as a choice of place of birth.
  - The LMNS recommended that this is kept under constant review, which is the situation at present.

East Kent Report:

The Kirkup Report, 'Reading the signals: Maternity and neonatal services in East Kent- the Report of the Independent Investigation' was published on 19 0ctober 2022 examining failings in maternity and neonatal services at The Queen The Queen Mother Hospital (QEQM) and the William Harvey Hospital (WHH), part of East Kent Hospitals University NHS Foundation Trust, between 2009 and 2020.

A precis of the report and actions for the maternity service and Trust Board was presented to November 2022 Board. There have been no Regional or National updates or requests for information/local action since the report was published.

NHS England published the ‘Three year delivery plan for maternity and neonatal services’ at the end of March. The purpose of the three year plan is to improve the safety and quality of maternity and neonatal services, incorporating recommendations from key reports such as Ockenden and Kirkup.

A summary of the plan was presented to Executive Team Meeting (ETM) and Trust Board in May, including the risks associated with delivering the plan. The three year plan has been benchmarked in September and shared with West Yorkshire and Harrogate, Local Maternity and Neonatal System, ahead of the assurance visit in November.

An update on progress with the Three year delivery plan was shared in the September paper presented to October QPSA and November Trust Board. There was no request of Board at that time and the update was for information only.

Perinatal Cultural Leadership Programme

Following a reginal nomination process, 4 members of the senior maternity and neonatal (perinatal) leadership teams have embarked on a 6 month programme intended to support a positive and nurturing safety cultural in perinatal services.

The aim is to support all perinatal teams in England to create and craft the conditions for a positive culture of openness, safety and continuous improvement. Reviews of maternity services have highlighted cultural and leadership issues as a common theme that contributes to underlying patient safety failures across organisations. Strong and positive leadership creates effective teamwork and therefore improved clinical care.

The programme will focus on the perinatal quadrumvirate, or ‘quad’, groups of senior leaders in perinatal services (typically including senior midwifery, obstetric, neonatal and operational representation). Co-designed by frontline teams and leadership experts, this programme will bring together senior leaders from across maternity and neonatal services to improve the quality, safety and experience of care for women.

The programme commenced in January with the Director of Midwifery, Deputy Clinical Director for Obstetrics and Gynaecology, Consultant Neonatologist and General Manager for Women’s CSU, attending a 3 day course in London.

The ‘quad’ have continued to attend a series of individual action learning sets (ALS), focusing on their individual leadership styles and learning needs, in addition to a further session in London.

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The SCORE culture survey was launched at the end of March and closed in May.

The quad team have a series of meetings planned with an external company who will support the analysis of the survey results and the associated actions required. The quad team and additional members of the senior leadership team, met with the external survey support team on 31 August and the highlights and areas for consideration were shared.

- 41% response rate overall.
- Staff responded positively to the unit being:
    - Positive safety culture.
    - Improvement ready.
    - Providing a good work life balance.
    - Positive regarding job certainty.
    - Intention to leave was low.
    - Good opportunity for growth.
- Areas for improvement:
    - Staff rated emotional recovery related to work as low.

There was a short discussion within the group around improving emotional recovery, including learning from the access to psychology model available within the neonatal unit. The next steps will be to share the high level feedback with the wider team before commencing smaller focus groups to look at any improvement work the wider team wish us to consider.

A number of key staff received training as 'Culture Coaches' to support and facilitate conversations with staff.

Score analysis with the Perinatal Leadership Quadrumvirate continues, with further meetings planned for December.

Midwifery Staffing

Safety Action 9 of the Maternity Incentive Scheme, Year 4, requires that there is evidence that discussions regarding safety intelligence, including minimum staffing in maternity services are taking place at Board level.

The most recent bi-annual midwifery staffing paper was presented to People Academy and Board in May, as an appendix to the overarching Nursing and Midwifery staffing paper. The next paper will be presented to October People Academy prior to sign off at November Board.

The recommendations, including the request to support the required uplift in 'headroom' from 22% to 24.3% so this can be accurately built in to the calculations used in the Birth Rate Plus full review in November 2023, were approved by October People Academy and November Trust Board.

Based on the revised table top calculations the current vacancy against the safe staffing establishment is 8.54 WTE which includes the agreed uplift for maternity leave.

Achieving the safe staffing establishment continues to be our priority figure.

Current vacancy against the revised funded establishment, which includes the number of midwives required to provide Midwifery Continuity of Carer (MCoC) is 33.96 WTE.
October maternity leave is 10.94 WTE.

Staffing gaps continue to be closely managed by the Bed Manager and staffing Matron of the day, utilising the amber risk assessment and escalation processes as required and despite an improved vacancy position, the service continued to experience extreme pressure during November due to increased activity and acuity, which has impacted on the ability to facilitate planned inductions of labour. This challenge will be described in more detail later in the report.

Additional initiatives continue to be explored/implemented to improve safe staffing numbers including:

- The service has executive approval to pay bank shifts at surge rate until the end of January, to encourage the uptake of unfilled shifts and has had approval for ‘super surge’ to manage the backlog of inductions until 30 November.
- Bank Shifts are now available for registered nurses, to provide additional registrant support for non-midwifery specific tasks such as post-operative care, drug rounds, and intravenous drug administration, to release midwifery specific time.
- Number of quality improvement (QI) plans to improve efficiency across the unit.
- Senior attendance at Regional Induction of Labour ‘deep dive’ day in December.
- Further progression of ‘apprentice midwife’ posts for existing maternity support workers.
- Birth rate plus acuity review recommenced in November.
- Birth Rate plus daily acuity app to be demonstrated to the senior team in December, to support flow and decision making.

Obstetric Staffing

We continue to ensure a 100% consultant presence on the labour ward for 98 hours per week.
We do have a strain on the consultant body with 1 consultant level gap:

1 Fully funded Obstetric only consultant post gap– previously advertised and not recruited to. This job was re advertised and no suitable candidate found. We have advertised for a locum Obs and Gynae consultant for 12 months and we are interviewing for the post on 27/11/2023. There were 2 candidates who were eligible and the offer was made to the higher scoring candidate. We plan to re advertise the post in a substantive capacity when suitable senior trainees are available and become eligible to apply.

There are currently 2 other significant areas of extra strain on the consultant body at the present time summarised on the local risk register:

1) Gynaecology on call rota: The CSU management team has completed the process of job planning gynaecology hot week as well as OOH gynaecology cover. The new job plans are in effect from April 23rd 2023.

2) The volume of extra clinical sessions covered by colleagues (consultant gaps, colleague who has left and covering their work until replacement new consultant starts in post, degree of annual leave and aspects of the service that have to be covered).

In view of average job plans equalling 11.75pA per consultant there is little scope to ask more of the team and consultants are claiming for extra sessions covered and on calls work provided. Unfunded activity using up flexi sessions: Additional sessions in hysteroscopy and colposcopy to assist with the increasing demands in these areas.

Funding is mobilised to cover the additional 8 extra general gynaecology clinics. These additional clinics are created to attempt to address the ever-growing number of triaged general gynaecology patients requiring a new general gynaecology appointment. We are on path to meet our goal of clearing the backlog in the proposed time frame.

Flexi sessions are intended to cover gynaecology elective operating lists.

Registrars:
Currently we have 15 deanery trainee Registrars filling 11 full time equivalent slots and 2 slots filled with trust grade doctors on a 1:13 rota. We have 5 x ST3 registrars that need senior cover and support with an SR or consultant present on each shift out of hours (to meet entrustability standards set by the RCOG) until they acquire all the necessary skills to be competent on the labour ward. 2 of those are paired with a senior registrar and 3 remain needing that cover which essentially means additional gaps on the on-call sessions. We continue to have 1.4 full time gaps in the middle grade rota. This is due to maternity and less than full time training arrangements. This will change to 2.4 gaps from January 2024 due to maternity leave. Escalated rates to cover the gaps have been continued and agreed by HR until end of December 2023.

SHOs: There are no gaps in the current SHO rota.

Neonatal Staffing
There is currently 1 vacancy at Consultant level which has been successfully recruited to, with a start date of April 2024.

Nurse staffing has improved significantly in the last 12 months, and there is currently a small vacancy of 3.42 WTE.

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Maternity Improvement Plan and CQC rating

The Maternity Services received an onsite inspection in January, focusing on 'Safe' and 'Well-Led' domains only.

The final report was received in May and reflects the positive improvements made and since the 2019 inspection. Whilst the overall rating remains 'Requires Improvement', the 'Well-Led' domain has improved from 'Inadequate' to 'Good', with 'Safe' remaining as 'Requires Improvement'.

An action plan addressing the 2 'Must Do' actions and 5 'Should Do', has been returned to the CQC and presented to May QPSA, June Board and progress will be monitored through 'Women's Core Governance Group' and QPSA.

The Improvement plan was updated in November (appendix 2) and shared at the November 'Moving to Outstanding' meeting. Progress continues on target and includes the recent submission of a business case for the uplift in medical staffing to achieve the 'must do' action regarding medical staffing in MAC.

Induction of Labour Delays:

During November the service has recognised and responded to an emerging concern managing the number of women requiring induction of labour on a daily basis, specifically an increase in delays due to high levels of activity, challenges with flow and bed capacity, safe staffing levels.

The service perception is that there are a number of reasons why this is occurring and we are currently collecting the data to evidence and support the theories:

- Changes to NICE guidance regarding the offer of induction for women at term with reduced fetal movements, improved detection and management of small babies etc. has resulted in a small, daily increase in the number of women requiring induction on a daily basis.
- Increase in the number of women requiring enhanced maternity care (EMC) immediately post-delivery, which results both in bed-blocking on labour ward and affects the ability to provide 1:1 care in labour.
- Research trial point of care testing for Group B Streptococcal (GBS) infection, which can cause serious illness and sometimes death in newborns. Positive in that detection rate has increased, but unintended consequence that this increases the length of stay in the postnatal period when antibiotic therapy is required.
- The 2 points above are impacting the flow on both labour ward and postnatal discharges which in turn affects the ability to admit and proceed with women requiring induction of labour due to a lack of intrapartum beds.

This has resulted in direct harm to 1 woman and baby, and has impacted on the ability to provide 1:1 care in labour, increased need to divert women to other units. The impact on women's experience and psychological safety is difficult to quantify, but is almost certainly affected in many cases. It is also impacting on the ability to accept in utero transfers of women requiring tertiary unit cots for very preterm babies, due to the potential prioritisation of women at risk of harm due to delayed induction.

Immediate actions taken to address and mitigate where possible:

- Daily LMNS safety huddle and SitRep to identify service pressures and assess neighbouring organisations ability to support and offer mutual aid.
- Escalation of the current pressures to the North East and Yorkshire Regional Maternity Team, who have in turn escalated this to the National Maternity Team.
- Neonatal ODN letter drafted to inform them of the current challenges and position.
- Discussed at Bi-monthly maternity and neonatal safety champion meeting.
- Super surge rates in place for registered midwives until 30 November.
    - Aim is to achieve minimum safe staffing levels and to create additional shifts where possible to manage increased demand and induction backlog/surveillance of women delayed.
- Senior Midwife on call presence in the unit on a weekend where possible.
- Registered Nurse shifts offered to gynaecology nurses to undertake generic registrant tasks (drug administration, postoperative care, ward assurance safety checks) to release midwifery specific time.
- All women with a delayed induction are offered a daily wellbeing check.

Next steps/further action:

- Trust attendance at Regional Induction of Labour 'Deep Dive' on 4 December (issues are not unique to BTHFT).
- Review of the data to support pressure theories and determine need for service review.
- Birth Rate Plus acuity tool recommissioned (planned) and data collection commenced in November.
    - Will recalculate risk categories of service users which feels to have increased to inform establishment required to deliver safe services.
- Demonstration of Birth Rate Plus daily acuity app to support management of flow planned in December.

Stillbirth Position

There were 2 stillbirths in November. Details are included in Appendix 3.

Table 1 is the running total of stillbirths in 2023, including the number of cases requiring further detailed investigation, and the number of butterfly babies whose deaths were expected.

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Table 1:

Stillbirths 2023			Expected deaths within total number	Further detailed investigation
Month	**Number of babies**	**Running total**	**Butterfly babies/Congenital abnormalities**	**Number of cases**
January	1	1	1	0
February	1	2	0	0
March	2	4	0	0
April	2	6	0	1 (HSIB)
May	5	11	1	0
June	2	13	1	0
July	1	14	1	0
August	1	15	0	0
September	4	19	0	1 (level 1)
October	4	23	1	1 (MNSI ref)
November	2	25	1	1 (Internal SI)

Hypoxic Ischaemic Encephalopathy (HIE)

There were 0 babies diagnosed with HIE in November.

Serious Incidents (SIs) and serious harms

The December 2020 Ockenden Report, independent review of Maternity services at the Shrewsbury and Telford Hospital NHS Trust, contained 7 immediate and essential actions (IAE) to improve care and safety in maternity services for all Trusts.

IAE 1: Enhanced Safety, recommends that all maternity SI reports and a summary of the key issues, must be sent to the Trust Board and the Local Maternity and Neonatal System (LMNS).

There were 0 MNSI reportable cases occurring in November, and 1 internal SIs.

Safety Action 9 of the Maternity Incentive Scheme, Year 4, requires that there is evidence that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified and actions being taken to address any issues, are taking place at Board level. It is anticipated that this standard will continue in the Year 5 publication.

Ongoing Maternity SIs:
Appendix 3 includes a position summary of ongoing maternity SIs. There are 0 completed reports for the attention of Quality and Patient Safety Academy and Closed Board this month.

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There are 8 ongoing maternity SIs/Level 1 investigations, 6 HSIB and 2 Trust level. A number of reports are at factual accuracy checking and expected to be completed in the next month.

There were 0 neonatal SIs declared in November and no ongoing neonatal SIs under investigation.

Neonatal Deaths (NND)

There were 0 neonatal deaths in November within the first 28 days of life.

Please see Table 2 below:
Table 2:

NND 202			Expected deaths within total number	Further detailed investigation
Month	**Number of babies**	**Running total**	**Extreme preterm/congenital anomalies/life limiting conditions**	**Number of cases**
January	1	1	1	0
February	5	6	4	0
March	2	8	0	0
April	3	11	1	0
May	6	17	4	0
June	1	18	0	0
July	2	20	0	0
August	4	24	4	0
September	2	26	1	0
October	3	29	1	1 (MNSI)
November	0	29	0	0

Maternal Deaths

There were 0 Maternal Deaths in November.

MNSI (HSIB) Cases and Progress in achieving Maternity Incentive Scheme Safety Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Following the Ockenden Report, all cases referred to the Maternity and Neonatal Safety Investigation (MNSI) will be declared as SIs. There were 0 cases meeting the MNSI referral criteria in November.

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MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with the Trust

The implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on this is a monthly minimum data measure for Trust Board overview.

There were no direct requests for action made directly to the Trust in November.

Coroner Regulation 28 made directly to Trust

Again, the implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on this is a monthly minimum data measure for Trust Board overview.

The service can confirm that there have been no such requests to date this year.

Perinatal Bi-Monthly Safety Champion meetings

The main focus of the meeting on 27 November, appendix 4, was the unit pressures experienced during November, specifically the delayed inductions as described earlier in the paper. The agreement was to continue with the actions and mitigations in place and review the data to determine any service changes required.

The Neonatal Safety Champion discussed the ATAIN quarter 2 report shared with QPSA in the October paper, and that there is to be a focus on transitional care.

The meeting was attended by members of the Perinatal Leadership Quadrumvirate, who had no issues to escalate requiring Board level support.

Monthly staff feedback from Safety Champions and walk-rounds

The Non-Executive Director Safety Champion walked around the unit in November, thanking staff for their continued hard work and commitment to the service. No safety concerns were escalated during the visit.

Maternity Unit Diverts

There were11 partial/attempted unit diverts/escalations in November recorded on the closure log. At least 2 of the partial/attempted diverts lasted a number of days due to ongoing levels of high activity, high acuity, limited flow, backlog of inductions as described earlier in this report.
6 women were diverted to a neighbouring organisation for care during the partial diverts, and on a number of occasions no other maternity services within the LMNS were in a position to accept, reporting similar pressures and escalations. This meant that the service continued to accept and admit women which impacted on the ability to provide 1:1 care in labour, delays in triage and delays to women waiting for induction of labour.

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As described earlier, the pressures experienced in Bradford initiated a daily LMNS safety huddle, and a number of women were transferred to Harrogate who were able to facilitate induction of labour.

Table 4:

MONTH	Full Divert	Partial divert	Attempted Divert	Number of women diverted
JANUARY	0	0	0	0
FEBRUARY	0	1	0	TBC
MARCH	0	1	0	4 (no births)
APRIL	0	2	0	2
MAY	0	4	0	10
JUNE	0	3	0	10
JULY	0	2	0	2
AUGUST	0	0	3	0
SEPTEMBER	0	3	5	2
OCTOBER	0	1	0	1
NOVEMBER	0	8	3	5
Total	0	25	11	36

Midwifery Continuity of Carer (MCoC) Action plan

The high level MCoC action plan was updated and shared in October and will be reviewed again in January.

Maternity Dashboard

There is a current delay in validating dashboard data due to current vacancy of the Digital Midwife post as reported in the October paper. October data is incomplete and will be shared in the December paper.

The Associate Deputy Director of Midwifery is managing this until a replacement is found and also plans to work with business intelligence colleagues (BI) to recommence production of maternity data in a statistical process control (SPC) format. It is hoped that this will provide a more meaningful way of displaying the data and identifying any areas of concern or celebration.

Training Compliance

Due to the timing of December QPSA, the monthly maternity training compliance report is not available at the time of writing and will be presented with the December update.

However, QPSA is informed that following the November training dates, the service has successfully achieved 90% compliance of all staff grades attendance at PROMPT, meeting the requirements of Safety Action 8 of the Maternity Incentive Scheme, Year 5.

The service would like to formally acknowledge the hard work and vigilance of the Professional Development Midwife and PROMPT faculty, in achieving this target.

The required standard for fetal monitoring training was also achieved in November.

Appendix 5 is a copy of the 3 Year Draft Training Plan Core Competency Framework 2 (CCF2), describing the plan for the implementation of version 2 of the framework. This is a requirement to demonstrate compliance with Safety Action 8 of the Maternity Incentive Scheme, Year 5.

The plan has been reviewed and amended in line with comments from the LMNS and was approved at the LMNS Workforce Steering Group on 9 November in preparation for sign off at LMNS Board on 5 December.

There is a requirement that the plan is also signed off at Trust Board.

Whilst the plan is comprehensible, meets the framework and the content appropriate, the concerns are in the service’s ability to deliver the increased number of training days, both releasing staff to attend and the faculty to deliver the training.

The Bi-annual Midwifery Staffing Paper, presented to October People Academy and November Board, recommended that the service calculation regarding the required uplift to establishment to deliver the training, be used in the current Birth Rate Plus acuity calculation. This recommendation was approved.

The service will include updates on any challenges delivering the training plan through this paper.

Perinatal Quality Surveillance Model minimum data set for Trust Boards

Appendix 6 is the populated copy of the Perinatal Quality Surveillance Model minimum data set for Trust Boards. Much of the information required for presentation for Board is contained within the narrative of this report.

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Service User Feedback

There were no planned MNVP meetings in November. However a number of discussions with ICP colleagues have taken place regarding the increase in MNVP attendance at service meetings and events, and the current funding arrangements. The LMNS are aware of the current challenges.

The service continues to liaise closely with the MNVP leads, responding to email requests for information.

The next MNVP main meeting is 6 December.

3 PROPOSAL

The service proposes that the Perinatal Update paper continues to be presented to Quality and Patient Safety Academy on a monthly basis with an assurance paper presented to Board bi-monthly.

This is to ensure that Trust Board receives timely information regarding perinatal quality and safety issues, in addition to quality improvement and transformation.

The service also proposes that the report will include the minimum data set described within the Perinatal Quality Surveillance Model.

Any urgent concerns emerging outside of the monthly reporting arrangements will be escalated by the Trust Level Safety Champions to the Board Level Safety Champion.

4 BENCHMARKING IMPLICATIONS

The service will continue to benchmark and monitor performance and position at both regional and national level, using the existing benchmarking tools including the Yorkshire and Humber regional maternity dashboard, MBRRACE-UK publications etc.

Continuity of Carer is monitored through the West Yorkshire and Harrogate LMS.

5 RISK ASSESSMENT

Stillbirths and Midwifery Continuity of Carer pathways are on the maternity risk register, updated regularly and monitored through Women's Core Governance Group.

6 RECOMMENDATIONS

- Quality and Patient Safety Academy is asked to note the contents of the Maternity and Neonatal (Perinatal) Services Update, November 2023.
- Academy is informed that the LMNS Assurance visit was undertaken in November and that the feedback was extremely positive (Appendix 1).
- Quality and Patient Safety Academy is asked to acknowledge the monthly stillbirth position of 2, including the description of incidents and any immediate actions/lessons learned.
- Academy is asked to note that there were 0 cases of HIE reported in November.

- There were 0 neonatal deaths in November.
- Academy is informed that there were no maternal deaths in November.
- There are 8 ongoing maternity SIs/Level 1 investigations, 6 Maternity and Neonatal Safety Investigations (MNSI) and 2 Trust level.
- Academy is asked to note that there are no new neonatal SI's or ongoing neonatal SI's.
- There are 0 completed HSIB/Internal Serious Incident reports to share with QPSA/Closed Board in November.
- Quality and Patient Safety Academy is asked to note that there were 0 MNSI reportable cases and 1 reportable Serious Incidents (SI) declared in November.
- Academy to note that there were 10 occasions in November where the unit was assessed as needing to divert women to other organisations. This has impacted in the provision of 1:1 care in labour, delayed induction of labour and the experience of some women.
- Quality and Patient Safety Academy is asked to note the increased unit pressures experienced in November, including the back log of inductions and the steps taken to address and manage this issue.
- Academy is informed that following the November PROMPT training, the service is able to demonstrate full compliance with Safety Action 8 of the Maternity Incentive Scheme, due to 90% of all staff groups attending training within the required timeframe.
- Quality and Patient Safety Academy is asked to approve Appendix 5, 3 Year Training Plan, Core Competency Framework, Version 2, as a committee of Board with delegated authority, and note the perceived concerns regarding delivery.

7 Appendices

- Appendix 1 - LMNS Assurance visit report.
- Appendix 2 - Maternity CQC Improvement Action Plan.
- Appendix 3 - Maternity and Neonatal Harms November.
- Appendix 4 - Bi-Monthly Perinatal Safety Champion meeting notes November 2023.
- Appendix 5 - 3 Year Training Plan CCF2.
- Appendix 6 - Perinatal Quality Surveillance Model minimum data set for Trust Boards.

BO.1.24.9B - MATERNITY INCENTIVE SCHEME

REFERENCES

Only PDFs are attached

- Bo.1.24.9b - Maternity Incentive Scheme (CNST) (cover sheet) Year 5.pdf
- Bo.1.24.9b - Maternity Incentive Scheme - Appendix 1 - Maternity Incentive Scheme Year 5.pdf
- Bo.1.24.9b - Maternity Incentive Scheme - Appendix 2 - PMRT Final position MIS Period Yr5 30May23-7Dec23.pdf
- Bo.1.24.9b - Maternity Incentive Scheme - Appendix 2a - PMRT Case List For MIS Year 5.pdf
- Bo.1.24.9b - Maternity Incentive Scheme - Appendix 3 - Neonatal Staffing Nov 2023 (Cover Sheet).pdf
- Bo.1.24.9b - Maternity Incentive Scheme - Appendix 3.1 - Neonatal Staffing Nov 2023.pdf
- Bo.1.24.9b - Maternity Incentive Scheme - Appendix 3.2 - Neonatal Staffing Nov 2023.pdf
- Bo.1.24.9b - Maternity Incentive Scheme - Appendix 4 - Risk assesment One to One Care in Labour.pdf
- Bo.1.24.9b - Maternity Incentive Scheme - Appendix 5 - Submission - HSIB Investigations for December2022 - 7December2023.pdf

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MATERNITY INCENTIVE SCHEME (MIS) (CNST) YEAR 5

Presented by	Sara Hollins, Director of Midwifery	
Author	Sara Hollins, Director of Midwifery	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	To provide Trust Board with the actions and assurance prior to self-certification to complete the Maternity Incentive Scheme (CNST) year 3.	
Key control	Yes	
Action Required	For approval	
Previously discussed at/ informed by		
Previously approved at:	**Committee/Group**	**Date**

Key Options, Issues and Risks

This paper is presented to ensure that Trust Board is fully sighted on the Maternity Incentive Scheme (MIS) and the requirement to sign off the submission prior to 1 February 2024 at 12 noon to enable a discount on the premium (Approximately £600k).

The attached document (Appendix 1) provides an update against all ten criteria and confirms that we are proposing to be fully compliant against all ten standards.

The contents of the document and the plan to declare full compliance with the scheme, was discussed with the Accountable Officer (AO) for the Integrated Care System (ICS) and Lead Midwife for West Yorkshire and Harrogate Local Maternity and Neonatal System on 3 January 2024 prior to signing the Board self-declaration form as a condition of the submission.

Analysis

The document shows, by each standard, the standard to be met, the evidence required and an assessment of compliance.

The Trust will be in a position to declare full compliance with the scheme on 1 February 2024.

Recommendation

- Trust Board is asked to acknowledge the contents of the paper and attached appendices.
- Trust Board is asked to note that the contents of the document and the plan to declare full compliance with the scheme, was discussed with the Accountable Officer for the Integrated Care System and Lead Midwife for the on West Yorkshire and Harrogate Local Maternity and Neonatal System on 3 January 2024.
- Trust Board is asked to note the narrative regarding NHS Resolutions advice relating to 1 missed surveillance case required for Safety Action 1, due to an information technology issue. The service recommends that compliance is declared along with completion of the action plan as recommended, with the caveat that there is a small risk that this may be challenged by MBRRACE following external verification.
- Board is asked to formally record approval of the Neonatal Medical and Neonatal paper and action plans (Appendix 2) in the January 2024 Board minutes. These were approved at November People Academy.
- Board is asked to approve the 1:1 care in labour risk/assessment action plan (Appendix 3), required to achieve compliance with Safety Action 5.
- Trust Board is asked to support the proposal that subject to agreement with the

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recommendations above, compliance with the 10 safety actions of the year 5 scheme can be declared.

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☒	☐	☒
Is there any other national benchmarking data relevant to the content of this paper?	☒	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☒	☐	☐

Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	☐	☒
Quality implications	☐	☒
Resource implications	☒	☐
Legal/regulatory implications	☒	☐
Diversity and Inclusion implications	☐	☒
Performance implications	☐	☒

Regulation, Legislation and Compliance relevance	
NHS Improvement: (please tick those that are relevant)	
☒Risk Assessment Framework	☒Quality Governance Framework
☐Code of Governance	☒Annual Reporting Manual
Care Quality Commission Domain: Choose an item.	
Care Quality Commission Fundamental Standard: Safety	

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NHS Improvement Effective Use of Resources: Clinical Services
Other (please state):

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality & Patient Safety	Finance & Performance	Other (please state)
☐	☒	☐	☐

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1	PURPOSE/AIM

The purpose of the report is to provide Trust Board and the Accountable Officer for the Integrated Care System with an update on the actions and evidence required to enable full Board sign off of the MIS.

2	BACKGROUND/CONTEXT

This is the fifth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS), intended to support the delivery of safer maternity care in all acute Trusts.

BTHFT was successful in achieving the ten safety actions in years one to four and recovered the 10% maternity premium and a share of the unallocated funds.

The ten safety action titles remain unchanged in year five, although there are some subtle changes to the descriptions and details of each of the standards.

The contents of the document (Appendix 1) and the plan to declare full compliance with the scheme, was discussed and agreed with the Director of Nursing/Accountable Officer for the Integrated Care System and Lead Midwife for West Yorkshire and Harrogate Local Maternity and Neonatal System on 3 January 2024.

The monthly Maternity and Neonatal Services Update Papers presented to Trust Board and Quality and Patient Safety Academy throughout the MIS reporting period, have served as the primary mechanism for providing Board/Academy with the necessary evidence required to demonstrate compliance.
Including:

- Quarterly Perinatal Mortality Review Tool (PMRT) reports.
- Quarterly Avoiding Term Admissions Into Neonatal Units (ATAIN) reports and audits.
- Bi-annual Midwifery Workforce paper.

Many elements of the scheme are also included in the bi-monthly Maternity and Neonatal Safety Champion meetings as part of the standing agenda. These papers are shared monthly with the Integrated Care Partnership and the Local Maternity and Neonatal System, through the Perinatal Quality Surveillance Oversight Group process.

Obstetric and Neonatal workforce information required for Safety Action 4, have been submitted to and approved by People Academy, as an Academy of the Board with delegated authority.

Challenges/Issues:

Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Appendices 2 and 2a are the final quarterly PMRT Board reports for the Year 5 submission period.
The service has met the required standard with the exception of 1 baby, which met the criteria for standard a but not b or c. The surveillance form was started in time but not completed within one month of the death due to an information technology (IT) issue involving the temporary loss of the PMRT local database. This did not impact on the review of the care or impact on the experience of the family. This case was escalated to NHS Resolution for advice, including the email evidence trail confirming the dates of the lost files. NHS Resolution advised that Safety action one is externally verified by MBRRACE who will have the overall say as to whether this affects compliance. However, MBBRACE do take mitigating circumstances into consideration when they review compliance and NHS Resolution therefore

recommended that if we declare full compliance with Safety Action 1, the associated action plan on the declaration form is populated to describe the mitigating circumstances.

The service recommends that compliance is declared along with completion of the action plan, but accepts that there is a small risk that this may be challenged by MBRRACE following verification.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

The service has met the required standard for the obstetric, anaesthetic and neonatal elements.

The Neonatal Staffing updates paper and associated action plans (appendix 3) were received and approved at November 2023 People Academy, and will be presented to Trust Board in January 2024 for completeness. This standard will be met on condition that there is a formal recording of the Neonatal Medical and Neonatal paper and action plans in the January 2024 Board minutes.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

The service has met the required standard to declare compliance with this action, subject to Board approval of the 1:1 care in labour risk/assessment action plan (appendix 4).

The risk assessment and associated actions were approved at Women's Core Governance Group, 20 December 2024. This metric is monitored and reported to QPSA on a monthly basis and improvement is expected within the next 6 months.

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Bradford, Airedale and Craven Maternity and Neonatal Voices Partnership (MNVP) have had a period of reorganisation and change of leadership during this reporting period, which they continue to work through with the support of the ICB and Maternity Services at both Airedale and Bradford.

There are ongoing discussions regarding the funding available for remuneration of the MNVP Leads, versus the available hours required to deliver the LMNS agreed work plan. The service has received confirmation from the Integrated Care Partnership, that the standard has been met for Year 5, but that this is a potential risk going into Year 6 if the standard remains the same.

Conclusion:

Considering the challenges/issues described above and the actions required, the maternity service believes that all 10 safety actions have been met and that the Trust is in a position to declare full compliance with the Year 5 scheme.

3	PROPOSAL

The service proposes that Trust Board and the Accountable Officer for the Integrated Care System have sufficient evidence to support the self-declaration of full compliance with the 10 Safety Actions for the Year 5 scheme.

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4	BENCHMARKING IMPLICATIONS

In gathering the evidence and supporting information a number of sources, both internal and external, have been used. External verification will occur for a number of safety actions.

5	RISK ASSESSMENT

All of the standards have been assessed for compliance; we believe there is minimal risk to the achievement of the MIS.

6	RECOMMENDATIONS

- Trust Board is asked to acknowledge the contents of the paper and attached appendices.
- Trust Board is asked to note that the contents of the document and the plan to declare full compliance with the scheme, was discussed with the Accountable Officer for the Integrated Care System and Lead Midwife for the on West Yorkshire and Harrogate Local Maternity and Neonatal System on 3 January 2024. Trust Board is asked to note the narrative regarding NHS Resolutions advice relating to 1 missed surveillance case required for Safety Action 1, due to an information technology issue. The service recommends that compliance is declared along with completion of the action plan as recommended, with the caveat that there is a small risk that this may be challenged by MBRRACE following external verification.
- Board is asked to formally record approval of the Neonatal Medical and Neonatal paper and action plans (Appendix 2) in the January 2024 Board minutes. These were approved at November People Academy.
- Board is asked to approve the 1:1 care in labour risk/assessment action plan (Appendix 3), required to achieve compliance with Safety Action 5.
- Trust Board is asked to support the proposal that subject to agreement with the recommendations above, compliance with the 10 safety actions of the year 5 scheme can be declared.

7	Appendices

- Appendix 1 - Maternity Incentive Scheme (MIS) – Year Five Declaration against standards.
- Appendix 2 and 2a - Final PMRT Quarterly Board reports.
- Appendix 3 - Neonatal Medical and Nursing Workforce updates and action plan.
- Appendix 3.1 - MIS Action Plan: Medical and AHP. November 2023
- Appendix 3.2 - MIS Action Plan: Nursing. November 2023
- Appendix 4 - 1:1 Care in Labour Risk Assessment and actions.
- Appendix 5 - MIS submission HSIB investigations for December 2022 to 7 December 2023.

Appendix 1 - Maternity Incentive Scheme (MIS) – Year Five. Declaration against standards

Background:

This is the fifth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS), intended to support the delivery of safer maternity care in all acute Trusts.

BTHFT was successful in achieving the ten safety actions in years one to four, and recovered the 10% maternity premium and a share of the unallocated funds.

The ten safety action titles remain unchanged in year five. However, there are subtle amendments to the evidence required to demonstrate compliance in some of the domains.

The contents of this paper were discussed and agreed with the Accountable Officer for West Yorkshire Integrated Care System and the Lead Midwife for the West Yorkshire and Harrogate Local Maternity and Neonatal System, on 3 January 024.

The Board Declaration Form must be signed by the Chief Executive and the Accountable Officer for the ICB, and submitted no later than 12 noon on 1 February 2024.

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Required standard	a) All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death. b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards. c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months. d) Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023.
Minimum evidential requirement for trust Board	Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website. The PMRT must be used to review the care and reports should be generated via the PMRT. A report should be received by the Trust Executive Board each quarter from 30 May 2023 that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications.
What is the relevant time period?	From 30 May 2023 until 7 December 2023
What is the deadline for reporting to NHS Resolution?	12 noon on 1 February 2024

Safety Action 1 Evidence:

Quarterly PMRT Reports have been submitted to:

- Maternity and Neonatal Services Update June 2023 paper, presented to:
    - 26 July 2023 Quality and Patient Safety Academy
    - September 2023 Trust Board
- Maternity and Neonatal Services Update September 2023 paper, presented to:
    - 1 November 2023 Quality and Patient Safety Academy
    - November 2023 Trust Board

- Maternity and Neonatal Services Update December 2023 paper (Appendices 2 and 2a), to be presented to:
    - January 2024 Quality and Patient Safety Academy
    - January 2024 Trust Board

The PMRT report is reviewed by the Board Level Safety champion prior to submission to Trust Board/Quality Academy.

The service has met the required standard with the exception of 1 baby, which met the criteria for standard a but not b or c, had the surveillance form started in time but not completed within one month of the death due to an information technology (IT) issue involving the temporary loss of the PMRT local database. This was escalated to NHS Resolution, including the email evidence trail confirming the dates of the lost files, who advised that Safety action one is externally verified by MBRRACE who will have the overall say as to whether this affects compliance. However, MBBRACE do take mitigating circumstances into consideration when they review compliance and NHS Resolution therefore recommended that if we declare full compliance with Safety Action 1, the associated action plan on the declaration form is populated to describe the mitigating circumstances.

The service recommends that compliance is declared along with completion of the action plan, but accepts that there is a small risk that this may be challenged by MBRRACE following verification.

Outstanding evidence required for Quality Academy/Trust Board/Executive sign off:

Nil

Safety Action Status:

Green, pending the inclusion of the narrative described on the Board submission form action plan.

Safety action 2: Are you submitting data to the Maternity Services Data Set to the required standard?

Required standard	This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. 1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023. 2. July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) 3. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the " Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics: Midwifery Continuity of carer (MCoC) Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable. i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation.

	Final data for July 2023 will be published in October 2023. If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information). 4. Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023. Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.
Minimum evidential requirement for trust Board	The “Clinical Negligence Scheme for Trusts: Scorecard” in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.
Validation process	All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS England and Improvement will cross-reference self-certification of criteria 2 to 7 (inclusive) against NHS Digital data
What is the relevant time period?	From 30 May 2023 until 7 December 2023
What is the deadline for reporting to NHS Resolution?	1 February 2023 at 12 noon

Safety Action 2 Evidence:

- July MSDS data published in October 2023 passed the required data quality criteria.
- The Trust can confirm that there are 3 people, currently working at the organisation who are registered to submit MSDS data to SDCS Cloud as required.

Outstanding evidence required for Quality Academy/Trust Board/Executive sign off:

None

Safety Action Status:

Green

Safety action 3: **Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?**

Required standard	a) Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director, or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB. c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.
Minimum evidential requirement for trust Board	Evidence for standard a) to include: Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: • There is evidence of neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted. Evidence for standard b) to include: • Evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks. • Evidence of an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks. • Evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan. • Evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with

	the plan. Evidence for standard c) to include: Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring OR An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation.
What is the relevant time period?	30 May 2023 to 7 December 2023

Safety Action 3 Evidence:

Transitional Care Admission Criteria Guideline in date on the intranet. Review date November 2026.

A Consultant Neonatologist reviews all term admissions to neonatal unit on a monthly basis.

The ATAIN action plan is a standing agenda item at the Bi-monthly maternity safety champion meetings and quarterly reports have been presented to Quality and Patient Safety Academy/Board during the relevant time period. Meeting notes are available.

The ATAIN quarterly reports are included in the corresponding Maternity and Neonatal Update paper which are shared with the ICB and LMNS via the Perinatal Quality Surveillance Oversight process.

- Quarter 4 22/23 presented to May Quality and Patient Safety Academy and July Trust Board
- Quarter 1 23/24 presented to August Quality and Patient Safety Academy and September Trust Board
- Quarter 2 23/24 presented to November Quality and Patient Safety Academy will go to January Trust Board

Outstanding evidence required for Quality Committee/Trust Board/Executive sign off:

None

Safety Action Status:

Green

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

<table>
<tr><td>Required standard</td><td>a) Obstetric medical workforce
1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:
a. currently work in their unit on the tier 2 or 3 rota
b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)
c. hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.
or

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf

3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

rcog-guidance-on-compensatory-rest.pdf
4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document:

b) Anaesthetic medical workforce
A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)

c) Neonatal medical workforce
The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing.
If the requirements have not been met in year 3 and or 4 or 5 of</td></tr>
</table>

	MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. If the requirements **had been met** previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN). **d) Neonatal nursing workforce** The neonatal unit meets the BAPM neonatal nursing standards. If the requirements **have not been met** in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed
Minimum evidential requirement for trust Board	**Obstetric medical workforce** 1) Trusts/organisations should audit their compliance via Medical Human Resources and if there are occasions where these standards have not been met, report to Trust Board Trust Board level safety champions and LMNS meetings that they have put in place processes and actions to address any deviation. Compliance is demonstrated by completion of the audit and action plan to address any lapses. Information on the certificate of eligibility (CEL) for short term locums is available here: www.rcog.org.uk/cel This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk) A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk 2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance and have a plan to address any shortfalls in compliance. Their action plan to address any shortfalls should be signed off by the Trust Board, Trust Board level safety champions and LMNS. 3) Trusts/organisations should provide evidence of standard operating procedures and their implementation to assure Boards that consultants/senior SAS doctors working **Anaesthetic medical workforce** The rota should be used to evidence compliance with ACSA standard 1.7.2.1. **Neonatal medical workforce** The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

	Neonatal nursing workforce The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN)
Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	Obstetric medical workforce 1. After February 2023 – Audit of 6 months activity 2. After February 2023 – Audit of 6 months activity 3. 30 May 2023 - 7 December 2023 4. 30 May 2023 - 7 December 2023 Anaesthetic medical workforce Trusts to evidence position by 7 December 2023 at 12 noon Neonatal medical workforce A review has been undertaken of any 6 month period between 30 May 2023 – 7 December 2023 Neonatal nursing workforce Nursing workforce review has been undertaken at least once during year 5 reporting period 30 May 2023 – 7 December 2023
What is the deadline for reporting to NHS Resolution?	1 February 2024 at 12 noon

Safety Action 4 Evidence

Obstetric Workforce:

1. No short term locums employed in the past 12 months who full fill the above criteria. A discussion with the Head of Service for Workforce Information and Flexible Workforce has confirmed that flexible work force is aware and has access to all the RCOG recommendations and that these checks are embedded into employment processes for obstetrics and gynaecology.
2. As above
3. A Snap shot audit of 5 consultants work pattern and pre and post on call rest period review revealed 100% compliance. This is to reinforce the fact that our rolling rota weekly rota and sessions allocation follows the RCOG workforce document.
4. 6 months audit presented at peoples academy on 29/11/2023 This confirmed timely attendance of consultant/ consultants in all audited cases that were deemed requiring consultant presence as described in the RCOG work force document for the period between the first of May 2023 and the 31st of October 2023.

Anaesthetic Workforce:

ACSA Standards met in full electronic copies of rotas are available as evidence to support.

Neonatal Medical and Nursing Workforce:

The Neonatal Staffing update paper and associated action plans were received and approved at November 2023 People Academy, and will be presented to Trust Board in January 2024 for completeness.

The Neonatal service remains non-compliant against the national service specification. However, significant progress has been made since the Year 4 submission and the associated action plans and risk assessments describe the ongoing plans.

The action plans were submitted to the Yorkshire and Humber Neonatal Operational Delivery Network on 30 November 2023 and the LMNS on 18 December 2023.

Outstanding evidence required for sign off:

None: Pending presentation formal recording of the Neonatal Medical and Neonatal paper and action plans (appendix 2) in the January 2024 Board minutes.

Safety Action status:

Green

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated above. c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. d) All women in active labour receive one-to-one midwifery care. e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.
Minimum evidential requirement for trust Board	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. o The midwife to birth ratio o The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical

	numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	30 May 2023 – 7 December 2023
What is the deadline for reporting to NHS Resolution?	1 February 2024 at 12 noon

Safety Action 5 Evidence:

Bi-annual Midwifery workforce reports were received by:

- People Academy April 2023 and Trust Board 11 May 2023
- People Academy October 2023 and Trust Board 16 November 2023
- 1:1 Care in Labour Risk Register entry and action plan approved by Women's Core Governance Group, 20 December 2023

The reports meet the recommended criteria described in the standard.

Birth Rate Plus table top reviews were undertaken in both 6 monthly papers and the calculated establishment was supported and funded by Board as requested. The funded establishment is broken down into 2 components:

- Birth rate Plus traditional calculation for safe staffing based on acuity, birth rate and existing models of care
- Birth rate Plus calculation for 100% Midwifery Continuity of Carer (MCoC) as a default position for all women

Due to the ongoing national midwifery recruitment issues, the service have again prioritised the achievement of safe staffing in year 5, but have consistently received Trust Board support to work towards the larger MCoC establishment as and when safe staffing is achieved and sustained.

1:1 care in labour.
Achieving 1:1 care in labour has been a constant challenge for the last 10 months of the current reporting period, with rates consistently being between 85-89%. This has been regularly reported to Quality and Patient Safety Academy/Board via the monthly Maternity and Neonatal Services Update papers, including any mitigation in place and explanations for the deteriorating position. It has also been a regular discussion point at the Bi-Monthly Perinatal Safety Champion meetings throughout the same reporting period and shared with the ICB/LMNS as part of the monthly Perinatal Quality Surveillance Oversight meetings.

Appendix 3 is the most recent risk register update approved at December Women's Core Governance Group, which includes existing mitigation in place and an associated action/improvement plan. Board level sign off of this plan will enable the Trust to declare full compliance with this safety action.

Not achieving 1:1 care in labour is a red flag event captured by the Labour ward co-ordinator team. The mitigation in place is reflected in the action plan attached as appendix 3.

Not achieving supernumerary labour ward co-ordinator status is also a red flag incident, and has occurred on 2 occasions during the reporting period. The MIS standard requires Trust's to declare non-compliance if failure to achieve supernumerary co-ordinator status is a recurrent event (I.e. occurs on a regular basis and more than once a week). 2 occasions in a 12 month period does not affect the ability to declare compliance with this standard.

Outstanding evidence required for sign off:

None

Safety Action status:

GREEN: Pending Trust Board approval of the 1:1 care in labour action plan.

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Required standard	1) Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024. 2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool.
Minimum evidential requirement for trust Board	1) The Three-Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three by March 2024. A new implementation tool is now available to help maternity services to track and evidence improvement and compliance with the requirements set out in version three. The tool is based on the interventions, key process and outcome measures identified within each element, and is available at https://future.nhs.uk/SavingBabiesLives Providers should use the new national implementation tool to track compliance with the care bundle and share this with the Trust Board and ICB. To evidence adequate progress against this deliverable by the submission deadline in February, **providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element.** These percentages will be calculated within the national implementation tool. 2) Confirmation from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust, using the implementation tool and includes the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved.

	• Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.

Safety Action 6 Evidence

The Service has utilised the new national implementation tool to track compliance with the care bundle and met to discuss progress and review evidence with the LMNS and ICB representatives during quarter 2 and quarter 3. A further meeting is planned in quarter 4 (January).

- Q2: The quarterly Board level report and implementation plan was presented to October QPSA and November Board.
- Q3: The quarterly Board level report and implementation plan will be presented to January QPSA and January Trust Board.

The LMNS/ICB/Service Quarter 3 meeting confirmed that implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element has been achieved, therefore meeting the required compliance standard for Year 5 submission.

Outstanding evidence required for sign off:

None

Safety Action status:

Green

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Required standard	1. Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023).Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group. 2. Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board. 3. Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.
Minimum evidential requirement for trust Board	Evidence should include: • Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff. • Evidence that MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support. • The MNVP's work plan. Evidence that it is fully funded, minutes of the meetings which developed it and minutes of the LMNS Board that ratified it. • Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses. • Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.

Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	Trusts should be evidencing the position as 7 December 2023
What is the deadline for reporting to NHS Resolution?	1 February 2024 at 12 noon

Safety Action 7 Evidence:

Bradford, Airedale and Craven Maternity and Neonatal Voices Partnership (MNVP) have had a period of reorganisation and change of leadership during this reporting period, which they continue to work through with the support of the ICB and Maternity Services at both Airedale and Bradford.
The recent December 2023 publication of the MNVP Guidance will further inform and direct the structure in the future.
The partnership has held 4 main meetings since the Year 4 submission, attended by representatives from the maternity service, with minutes available.

The terms of reference and written confirmation regarding the remuneration arrangements are available as supporting evidence. The proposed MNVP work plan for 2023/24 was presented and approved at the December 2023 West Yorkshire and Harrogate Local Maternity and Neonatal System Board meeting.

The maternity service is well represented at the main meetings by the Director of Midwifery and a range of clinical and specialist midwives, who provide the group with an update on the service. There is a standing agenda item for any issues and concerns raised by service users.

The service has shared the 2022 annual CQC Maternity Survey results, including narrative comments, with members of the MNVP who have provided feedback to inform the development of an appropriate action plan. There are plans in place to review the 2023 survey results in early January and co-produce an action plan in response.

The service can provide other examples of how the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, have been heard and used to inform and improve service developments.

- Engagement event with Bevan House mums (asylum seekers)
- Parent Education sessions for dads/partners developed in direct response to feedback
- Parent Education sessions provided in 3 other languages for women whose first language is not English

Outstanding evidence required for sign off:

None

Safety action status:

Green

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Required standard	1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework. 2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. 3. The plan is developed based on the "How to" Guide developed by NHS England.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	12 consecutive months should be considered from 1st December 2022 until 1st December 2023 to ensure the implementation of the CCFv2 is reported on and, an appropriate timeframe for trust boards to review. It is acknowledged that there will not be a full 90% compliance for new elements within the CCFv2 i.e Diabetes. 90% compliance is required for all elements that featured in CCFv1

Safety Action 8 Evidence

1. An updated local training plan for implementation of Version 2 of the Core Competency Framework, was agreed at October Women's Core Governance. The plan is based on the 'How to Guide'.

This was then approved at:

- WY&H Local Maternity and Neonatal System: Workforce Steering Group, 9 November 2023
- WY&H Local Maternity and Neonatal System Board (ICB representation) 5 December 2023
- Quality and Patient Safety Academy 13 December 2023

2. 90% of each relevant maternity unit staff group attended an in house multi professional training day (PROMPT) which included maternity emergencies, fetal monitoring and newborn life support, during the relevant time period. Training records available for all relevant staff grades.

Immediate newborn life support is incorporated into PROMPT training, attended by midwives including midwifery managers, bank midwives and theatre midwives who also work outside of theatre. In addition, relevant staff have attended NLS training in the relevant period, including neonatal nurses, neonatal consultants and neonatal advanced practitioners.
90% compliance has been achieved or exceeded for midwives, neonatal consultants, neonatal junior doctors and neonatal advanced practitioners.

Face to face antenatal and intrapartum fetal monitoring training is included in PROMPT multi professional training, in addition to a full day MDT fetal monitoring day followed by completion of 4 K2 competency assessments by all relevant staff groups. 90% compliance was achieved by 1 December.

Outstanding evidence required for sign off:

None

Safety action rating:

Green

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Required standard	a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded. b) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings. c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.
Minimum evidential requirement for trust Board	Evidence for point a) is as per the six requirements set out in the Perinatal Quality Surveillance Model and specifically: • Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues. • Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs). • To review the perinatal clinical quality surveillance model in full and in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, provide evidence to show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need. Evidence for point b) • Evidence that in addition to the monthly Board review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaints data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. This should continue to be undertaken quarterly as detailed in MIS year 4. These discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting. Evidence for point c): Evidence that the Board Safety Champions have been involved in the NHS England Perinatal Culture and Leadership Programme. This will include: • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available.

	• Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team at a minimum of quarterly (a minimum of two in the reporting period) and that any support required of the Board has been identified and is being implemented.
Validation process	Self-certification to NHS Resolution using the Board declaration form
What is the relevant time period?	By 1 February 2024 at 12 noon

Safety Action 9 Evidence

a):

- Jon Prashar is the named Non-Executive Director safety champion for this reporting period.
- The monthly Maternity and Neonatal Services Update paper presented to Quality and Patient Safety Academy and Board, includes the minimum reporting requirements set out in the Perinatal Quality Surveillance Model.
- Monthly Perinatal Quality Surveillance Oversight Meetings are in place, to share Trust level intelligence and provide a mechanism for early escalation, action and support. The meetings are attended by the LMNS and the maternity leads for the Integrated Care Partnership.
- Closed Board appendix to the Maternity and Neonatal Services Update paper presented monthly to Quality and Patient Safety Academy and Board including immediate learning from new SI's/Incidents and learning/recommendations from completed investigations.

b):

- Claims Score card is reviewed at Women's Core Governance meeting

c):

- Karen Dawber and Jon Prashar are both registered on the dedicated FutureNHS workspace
- The Perinatal 'Quad' leadership team attend the Bi-monthly perinatal safety champion meetings and have met at least twice in the reporting period, with nothing requiring escalation for Board level support. This is evidenced in the Bi-monthly Perinatal Safety Champion meeting notes, and is also referenced in the monthly Maternity and Neonatal Services Update paper to QPSA/Board

Outstanding evidence requiring Trust Board sign off:

None

Safety action rating:

Green

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

Required standard	A) Reporting of all qualifying cases to HSIB/ MNSI from 6 December 2022 to 7 December 2023. B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 until 7 December 2023. C) For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that: i. the family have received information on the role of HSIB//MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.
Minimum evidential requirement for trust Board	Trust Board sight of Trust legal services and maternity clinical governance records of qualifying HSIB//MNSI/EN incidents and numbers reported to HSIB//MNSI and NHS Resolution. Trust Board sight of evidence that the families have received information on the role of HSIB/MNSI and EN scheme. Trust Board sight of evidence of compliance with the statutory duty of candour.
Validation process	Self-certification to NHS Resolution using Board declaration form. Trusts' reporting will be cross-referenced against the HSIB/MNSI database and the National Neonatal Research Database (NNRD) and NHS Resolution database for the number of qualifying incidents recorded for the Trust and externally verify that standard a) and b) have been met in the relevant reporting period. In addition, for standard C1 there is a requirement to complete field on the Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.
What is the relevant time period?	Reporting to HSIB – from 6 December 2022 to 7 December 2023 Reporting period to HSIB and to NHS Resolution – from 6 December 2022 to 7 December 2023
What is the deadline for reporting to NHS Resolution?	By 1 February 2024 at 12 noon

Safety Action 10 Evidence

All eligible incidents and cases referred. Duty of Candour met in all eligible cases. Appendix 4 is a copy of the eligible HSIB cases during the required time frame.

QPSA and Closed Trust Board receive a monthly update on eligible MNSI and internal SI cases, including immediate learning and recommendations, as part of the Maternity and Neonatal Update paper.
Copies of completed MNSI/SI investigation reports and learning are also shared with QPSA and Board as part of the same process. Trust Board have had sight of the completed reports referenced in appendix 4 throughout the reporting year.

Outstanding evidence requiring sign off:

None

Safety action rating:

Green

Conclusion:

Action No.	Maternity safety action	Action met? (Y/N)
1	**Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?**	Y
2	**Are you submitting data to the Maternity Services Data Set to the required standard?**	Y
3	**Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?**	Y
4	**Can you demonstrate an effective system of clinical workforce planning to the required standard?**	Y
5	**Can you demonstrate an effective system of midwifery workforce planning to the required standard?**	Y
6	**Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?**	Y
7	**Listen to women, parents and families using maternity and neonatal services and coproduce services with users**	Y
8	**Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?**	Y
9	**Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?**	Y
10	**Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?**	Y

Safety action 1 final report for MIS Year 5

Standards for safety action 1 **MIS year 5**	**Standard description**	**Progress**
Standard a	All eligible perinatal deaths should be notified to MBRRACE UK within **7 working days** For deaths from **30 May 2023 to the 7 December 2023,** MBRRACE-UK surveillance information should be completed within **one month** of the death	There are 33 perinatal deaths eligible for this reporting criterion. 100% of eligible cases have been reported to MBRRACE within 7 days. 1 surveillance only case missed the one month completion deadline therefore 97**%** compliance was achieved. NHSR and MBRRACE have been informed of the mitigating circumstances around not achieving this case.
Standard b	For **95%** of all the deaths of babies in BTHFT eligible for perinatal mortality review tool (PMRT), parents should have their perspectives of care and any questions they have sought from **30 May 2023 onwards.**	There were 34 eligible cases for this standard and all (100%) of parents were told that a review of their baby's death will take place, and their perspectives and questions and/or concerns about their care and that of their baby have been sought**.**

Standard c	For deaths of babies who were born and died in your trust multidisciplinary reviews using the PMRT should be carried out from **30 May 2023 to the 7 December 2023** **95%** of reviews should be started within **2 months** of the death. A minimum of **60%** of MDT reviews should be completed to the **draft report stage** within **four months** of the death A minimum of **60% published cases within six months.**	33 cases were eligible for PMRT review and all cases were started within 2 months of the death. There were 10 PMRT cases eligible for completion to draft report stage within the 4 month reporting period. 9 of the 10 cases met the draft report stage within four months (90%). There were 4 PMRT cases eligible for publication within the 6 months reporting period. 3 of the 4 cases were published within six months (75%). To Note: The service is exceeding the criteria for achieving draft and published reporting within the set 4 and 6 month time frames. An additional 5 reports have been completed to draft (14 in total) and an additional 5 published (8 in total) for the cases reported since 30 May 2023.

Appendix 1 – Case list for MIS year 5

The report includes 45 reported cases

36 cases were eligible for some or all of the criteria within MIS year 5 standards.

4 cases were notification only due to being terminations of pregnancy

1 case does not meet the standards on the basis the woman was unbooked therefore unknown to trust and birthed unattended at home of a concealed pregnancy with no antenatal or intrapartum care

1 case did not meet the standard but were assigned to another organisation due to being in-utero/ex-utero transfers

2 babies reported were still alive but sadly their sibling has died

1 case did not meet the standards as the baby died after 28 days of birth

4 of the 45 cases were the responsibility of other Trusts to complete due to cross boundary care.

All cases where baby died in MIS/CNST period: 30/05/2023 to 07/12/2023
Report rows are per baby; report date 28/12/23 11:28

Case ID	Baby	Reporting hospital	Live birth	Termination	Date of birth	Date of death	Date reported	Responsible Trust at birth	Responsible Trust when baby died	Surveillance case status	Date surveillance first closed	Review status	Date review opened	Factual questions currently completed (%)	Date draft report first available	Date review first published	HSIB case	Eligible for CNST standards	Working days to notify	Surveillance in standard	Review in standard	Standard a surveillance complete	Standard a complete deadline	Standard b parents informed	Standard b parents input sought	Standard c review started	Standard c started deadline	Standard c report drafted	Standard c drafted deadline	Standard c report published	Standard c published deadline
90884	1 of 1	Bradford Royal Infirmary	Yes	No	11/11/2023	14/11/2023	15/12/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	22/12/2023	Reviewing	15/12/2023	100%	Not set	Not set		Yes	23	Yes	Yes	Met	Not applicable	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
90536	1 of 1	Bradford Royal Infirmary	Yes	No	17/10/2023	21/11/2023	24/11/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Notification complete, no additional information is required	Not set	Reviewing	24/11/2023	100%	Not set	Not set		Not eligible as post-neonatal													
90380	1 of 1	Bradford Royal Infirmary	No	Yes	13/11/2023	13/11/2023	15/11/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Notification complete, no additional information is required	Not set	Review not supported	Not applicable	Not applicable	Not applicable	Not applicable		Notification only	2												
90332	1 of 1	Bradford Royal Infirmary	No	No	12/11/2023	12/11/2023	12/11/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	19/11/2023	Reviewing	12/11/2023	100%	Not set	Not set		Yes	0	Yes	Yes	Met	Not applicable	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
90265	1 of 1	Bradford Royal Infirmary	No	No	04/11/2023	04/11/2023	07/11/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	21/11/2023	Reviewing	07/11/2023	100%	Not set	Not set		Yes	1	Yes	Yes	Met	04/12/2023	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
90098	1 of 1	Bradford Royal Infirmary	Yes	No	28/10/2023	28/10/2023	30/10/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	19/11/2023	Review not supported	Not applicable	Not applicable	Not applicable	Not applicable		Yes	0	Yes	Not suitable for review	Met	28/11/2023	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
90038	1 of 1	Bradford Royal Infirmary	No	No	25/10/2023	25/10/2023	25/10/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	19/11/2023	Reviewing	25/10/2023	100%	Not set	Not set		Yes	0	Yes	Yes	Met	25/11/2023	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
90023	1 of 1	Bradford Royal Infirmary	Yes	No	20/10/2023	21/10/2023	24/10/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	21/11/2023	Reviewing	24/10/2023	28%	Not set	Not set		Yes	1	Yes	Yes	Met	21/11/2023	Met	Met	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
90022	1 of 1	Bradford Royal Infirmary	No	No	22/10/2023	22/10/2023	24/10/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	19/11/2023	Reviewing	24/10/2023	100%	Not set	Not set		Yes	1	Yes	Yes	Met	22/11/2023	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
89926	1 of 1	Bradford Royal Infirmary	No	No	15/10/2023	15/10/2023	17/10/2023	N/A (Home/community)	N/A (Home/community)	Surveillance complete	21/11/2023	Reviewing	17/10/2023	100%	Not set	Not set	Potential HSIB case	Not eligible as baby did not die in your trust													
89922	1 of 1	Bradford Royal Infirmary	No	No	14/10/2023	14/10/2023	17/10/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	09/11/2023	Reviewing	17/10/2023	100%	Not set	Not set		Yes	1	Yes	Yes	Met	14/11/2023	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
89851	1 of 1	Bradford Royal Infirmary	Yes	No	12/10/2023	12/10/2023	13/10/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	07/11/2023	Reviewing	13/10/2023	100%	Not set	Not set		Yes	1	Yes	Yes	Met	12/11/2023	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
89848	1 of 1	Bradford Royal Infirmary	No	No	12/10/2023	12/10/2023	13/10/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	07/11/2023	Reviewing	13/10/2023	100%	Not set	Not set		Yes	1	Yes	Yes	Met	12/11/2023	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
89791	1 of 1	Bradford Royal Infirmary	Yes	No	06/10/2023	06/10/2023	10/10/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	04/11/2023	Reviewing	10/10/2023	100%	Not set	Not set	Potential HSIB case	Yes	2	Yes	Yes	Met	06/11/2023	Met	Met	Met	06/12/2023	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
89790	1 of 1	Bradford Royal Infirmary	No	No	08/10/2023	08/10/2023	10/10/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	07/11/2023	Reviewing	10/10/2023	100%	Not set	Not set		Yes	1	Yes	Yes	Met	08/11/2023	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
89789	1 of 1	Bradford Royal Infirmary	No	No	06/10/2023	06/10/2023	10/10/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	04/11/2023	Reviewing	10/10/2023	100%	Not set	Not set		Yes	2	Yes	Yes	Met	06/11/2023	Met	Met	Met	06/12/2023	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
89746	1 of 1	Bradford Royal Infirmary	No	No	06/10/2023	06/10/2023	06/10/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	02/11/2023	Reviewing	06/10/2023	100%	Not set	Not set		Yes	0	Yes	Yes	Met	06/11/2023	Met	Met	Met	06/12/2023	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
89645	1 of 1	Bradford Royal Infirmary	No	No	28/09/2023	28/09/2023	29/09/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	18/10/2023	Reviewing	29/09/2023	100%	Not set	Not set		Yes	1	Yes	Yes	Met	28/10/2023	Met	Met	Met	28/11/2023	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
89521	1 of 1	Bradford Royal Infirmary	No	Yes	21/09/2023	21/09/2023	22/09/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Notification complete, no additional information is required	Not set	Review not supported	Not applicable	Not applicable	Not applicable	Not applicable		Notification only	1												
89489	1 of 1	Bradford Royal Infirmary	No	No	20/09/2023	20/09/2023	20/09/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	18/10/2023	Reviewing	20/09/2023	100%	Not set	Not set		Yes	0	Yes	Yes	Met	20/10/2023	Met	Met	Met	20/11/2023	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
89478	1 of 1	Bradford Royal Infirmary	Yes	No	18/09/2023	18/09/2023	19/09/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	16/10/2023	Reviewing	19/09/2023	100%	Not set	Not set		Yes	1	Yes	Yes	Met	18/10/2023	Met	Met	Met	18/11/2023	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
89476	1 of 1	Bradford Royal Infirmary	Yes	No	16/09/2023	16/09/2023	19/09/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	20/11/2023	Review not supported	Not applicable	Not applicable	Not applicable	Not applicable		Yes	1	Yes	Not suitable for review	Not met	16/10/2023	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
89262	1 of 1	Bradford Royal Infirmary	No	Yes	04/09/2023	04/09/2023	05/09/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Notification complete, no additional information is required	Not set	Review not supported	Not applicable	Not applicable	Not applicable	Not applicable		Notification only	1												
89233	1 of 1	Bradford Royal Infirmary	No	No	01/09/2023	01/09/2023	04/09/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	28/09/2023	Writing report	04/09/2023	100%	14/12/2023	Not set		Yes	1	Yes	Yes	Met	01/10/2023	Met	Met	Met	01/11/2023	Met	Not applicable	Not applicable	Post-qualifying date
89232	1 of 1	Bradford Royal Infirmary	No	No	01/09/2023	01/09/2023	04/09/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	28/09/2023	Writing report	04/09/2023	100%	13/12/2023	Not set		Yes	1	Yes	Yes	Met	01/10/2023	Met	Met	Met	01/11/2023	Met	Not applicable	Not applicable	Post-qualifying date
89133	1 of 2	Bradford Royal Infirmary	Yes	No	28/08/2023	Baby is still alive	29/08/2023	Bradford Teaching Hospitals NHS Foundation Trust	Still alive (n/a)	Surveillance complete	26/09/2023	Baby is still alive (at 28 days)	Not applicable	Not applicable	Not applicable	Not applicable		Not eligible as baby is still alive													

89133	2 of 2	Bradford Royal Infirmary	No	No	28/08/2023	28/08/2023	29/08/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	26/09/2023	Writing report	29/08/2023	100%	13/12/2023	Not set	Yes	0	Yes	Yes	Met	28/09/2023	Met	Met	Met	28/10/2023	Met	Not applicable	Not applicable	Post-qualifying date
89127	1 of 2	Bradford Royal Infirmary	Yes	No	27/08/2023	28/08/2023	29/08/2023	Barnsley Hospital NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance started	Not set	Reviewing	29/08/2023	100%	Not set	Not set	Yes	0	Not eligible as surveillance assigned	Yes	Not applicable	Not applicable	Met	Met	Met	28/10/2023	Not applicable	Not applicable	Not applicable	Not applicable
89127	2 of 2	Bradford Royal Infirmary	Yes	No	27/08/2023	29/08/2023	29/08/2023	Barnsley Hospital NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance started	Not set	Reviewing	29/08/2023	100%	Not set	Not set	Yes	0	Not eligible as surveillance assigned	Yes	Not applicable	Not applicable	Met	Met	Met	29/10/2023	Not applicable	Not applicable	Not applicable	Not applicable
89125	1 of 1	Bradford Royal Infirmary	No	No	26/08/2023	26/08/2023	29/08/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	18/09/2023	Writing report	29/08/2023	100%	13/12/2023	Not set	Yes	0	Yes	Yes	Met	26/09/2023	Met	Met	Met	26/10/2023	Met	Not applicable	Not applicable	Post-qualifying date
88865	1 of 1	Bradford Royal Infirmary	No	No	08/08/2023	08/08/2023	11/08/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	06/09/2023	Writing report	11/08/2023	100%	04/12/2023	Not set	Yes	3	Yes	Yes	Met	08/09/2023	Met	Met	Met	08/10/2023	Met	Not applicable	Not applicable	Post-qualifying date
88781	1 of 1	Bradford Royal Infirmary	Yes	No	14/07/2023	04/08/2023	07/08/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	29/08/2023	Writing report	07/08/2023	100%	04/12/2023	Not set	Yes	1	Yes	Yes	Met	04/09/2023	Met	Met	Met	04/10/2023	Met	04/12/2023	Not applicable	Post-qualifying date
88753	1 of 1	Bradford Royal Infirmary	Yes	No	04/08/2023	04/08/2023	04/08/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	25/08/2023	Review complete	04/08/2023	100%	26/11/2023	26/11/2023	Yes	0	Yes	Yes	Met	04/09/2023	Met	Met	Met	04/10/2023	Met	04/12/2023	Met	Not applicable
88694	1 of 1	Bradford Royal Infirmary	No	No	28/07/2023	28/07/2023	01/08/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	21/08/2023	Review complete	01/08/2023	100%	21/11/2023	21/11/2023	Yes	2	Yes	Yes	Met	28/08/2023	Met	Met	Met	28/09/2023	Met	28/11/2023	Met	Not applicable
88642	1 of 1	Bradford Royal Infirmary	Yes	No	19/07/2023	27/07/2023	28/07/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	21/08/2023	Review complete	28/07/2023	100%	21/11/2023	14/12/2023	Yes	1	Yes	Yes	Met	27/08/2023	Met	Met	Met	27/09/2023	Met	27/11/2023	Met	Not applicable
88509	1 of 1	Bradford Royal Infirmary	No	No	18/07/2023	18/07/2023	19/07/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	07/08/2023	Review complete	19/07/2023	100%	09/11/2023	09/11/2023	Yes	1	Yes	Yes	Met	18/08/2023	Met	Met	Met	18/09/2023	Met	18/11/2023	Met	Not applicable
88311	1 of 1	Bradford Royal Infirmary	No	Yes	09/07/2023	09/07/2023	10/07/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Notification complete, no additional information is required	Not set	Review not supported	Not applicable	Not applicable	Not applicable	Not applicable	Notification only	0												
88286	1 of 1	Bradford Royal Infirmary	Yes	No	03/07/2023	05/07/2023	07/07/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	04/08/2023	Review complete	07/07/2023	100%	02/11/2023	14/12/2023	Yes	2	Yes	Yes	Met	05/08/2023	Met	Met	Met	05/09/2023	Met	05/11/2023	Met	Not applicable
87937	1 of 2	Bradford Royal Infirmary	Yes	No	08/06/2023	10/06/2023	13/06/2023	Calderdale & Huddersfield NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	06/10/2023	Review pre-published	13/06/2023	100%	06/10/2023	Pre-published on 04/12/2023	Yes	1	Not eligible as surveillance assigned	Yes	Not applicable	Not applicable	Met	Met	Met	10/08/2023	Not applicable	Not applicable	Not applicable	Not applicable
87937	2 of 2	Bradford Royal Infirmary	Yes	No	08/06/2023	Baby is still alive	13/06/2023	Calderdale & Huddersfield NHS Foundation Trust	Still alive (n/a)	Surveillance complete	06/10/2023	Baby is still alive (at 28 days)	Not applicable	Not applicable	Not applicable	Not applicable	Not eligible as baby did not die in your trust													
87841	1 of 1	Bradford Royal Infirmary	No	No	06/06/2023	06/06/2023	07/06/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	27/06/2023	Review complete	07/06/2023	100%	03/10/2023	03/10/2023	Yes	1	Yes	Yes	Met	06/07/2023	Met	Met	Met	06/08/2023	Met	06/10/2023	Met	06/12/2023
87766	1 of 1	Bradford Royal Infirmary	No	No	02/06/2023	02/06/2023	02/06/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	27/06/2023	Review complete	02/06/2023	100%	03/10/2023	03/10/2023	Yes	0	Yes	Yes	Met	02/07/2023	Met	Met	Met	02/08/2023	Not met	02/10/2023	Met	02/12/2023
87724	1 of 2	Bradford Royal Infirmary	Yes	No	30/05/2023	Baby is still alive	31/05/2023	Bradford Teaching Hospitals NHS Foundation Trust	Still alive (n/a)	Surveillance complete	27/06/2023	Baby is still alive (at 28 days)	Not applicable	Not applicable	Not applicable	Not applicable	Not eligible as baby is still alive													
87724	2 of 2	Bradford Royal Infirmary	No	No	30/05/2023	30/05/2023	31/05/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	27/06/2023	Review complete	31/05/2023	100%	26/09/2023	21/11/2023	Yes	1	Yes	Yes	Met	30/06/2023	Met	Met	Met	30/07/2023	Met	30/09/2023	Met	30/11/2023
87721	1 of 1	Bradford Royal Infirmary	Yes	No	22/05/2023	30/05/2023	31/05/2023	Bradford Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust	Surveillance complete	27/06/2023	Reviewing	31/05/2023	100%	26/09/2023	Not set	Yes	1	Yes	Yes	Met	30/06/2023	Met	Met	Met	30/07/2023	Met	30/09/2023	Not met	30/11/2023

Meeting Title	People Academy		
Date	29 November 2023	Agenda item	PA.11.23.14b

Safety Action 4 – Progress with Neonatal workforce planning

Presented by	Professor Karen Dawber, Chief Nurse	
Author	Dr Sam Wallis/Jamie Steele	
Lead Director	Dr Helen Jepps	
Purpose of the paper	Maternity Incentive Scheme (MIS) Year 5 – Safety Action 4. To update Executive and Board on progress with Neonatal workforce planning.	
Key control		
Action required	For assurance	
Previously discussed at/ informed by	Maternity Incentive Scheme Year 4 – November 2022. ETM	
Previously approved at:	ETM	**Date:** Nov 22

Key Options, Issues and Risks

Background

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.
The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.
The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution nhsr.mis@nhs.net by 12 noon on 1 February 2024

Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Update on the other Safety Actions will be provided by the Maternity Team but specific to 4c) Neonatal medical workforce and 4d) Neonatal Nursing workforce.

- *Neonatal medical workforce The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing. If the requirements have not been met in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. If the requirements had been met previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).*
- *Neonatal nursing workforce The neonatal unit meets the BAPM neonatal nursing standards. If the requirements have not been met in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed and include new relevant actions to address deficiencies. If the requirements had been met previously without the need of*

developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

Analysis

Staffing is non compliant with national service specification with respect to

- Junior / medical grade cover
    - Insufficient numbers of medical trainees to fill rotas
- Nurses qualified in speciality (QiS)
    - Insufficient numbers to provide sufficient intensive care activity required of a NICU

As a result, a detailed staffing paper and action plans were approved in 2021. These have been updated and approved yearly. Action Plans have been updated for this year and are for approval (*Appendices 3.1+ 3.2*)

Progress has been made over the last year

- Medical
    - New consultant appointed (start Mar 24) to replace retired colleague (Mar 23). Senior clinical fellow appointed in interim to partially cover gap.
    - Additional NHSE funding secured as of November 2023. £62,400 per year recurrent to support junior doctor medical rota
    - Approval for permanent Staff grade position (LTFT. Tier 2)
    - Clinical fellow appointed to help Tier 1 / 2 rotas
    - Participating in Neonatal Network (ODN) medical recruitment project (targeted at international trainees, clinical lead for project is Bradford Consultant)
    - 2 new trainees ANNPs (ACPs) approved and appointed (started Sept 23)

- AHP (Allied Health Professionals)
    - Permanent funding secured to cover meet most AHP requirements

- Nursing
    - Improved nurse recruitment and retention following increase in nurse establishment in 2022
    - Headcount of Nursing colleagues significantly increased compared to early 2022. Recruited to near full physical establishment.
    - Education plan ongoing with clinical educators x 3 in place and junior nurses undertaking specialist training.
    - Safety roles created and fully recruited to (Special Care/Discharge Coordinator), in order to enhance leadership, senior supervision and support for Junior colleagues.

- Other team development work
    - Neonatal Excellence Project (NEP) underway. 1 priority workstream is focussed on workforce

Ongoing challenges remain

- Medical: continued fall in numbers of trainee doctors to fill junior medical gaps
    - Increase in LTFT working and reducing training duration leads to fewer trainees across the region. This means more gaps on both Tier 1 and Tier 2 rotas.

Meeting Title	People Academy		
Date	29 November 2023	Agenda item	PA.11.23.14b

- Community trainees previously helped cover out of hours work for the neonatal service. This provision is reducing (and may disappear) as their training needs focus more on daytime work.
- Recent resignation of Paediatric Surgeon attached to Bradford. Still in post at present. Option being explored via Surgery in Children (SIC) network.

- Nursing: Insufficient QIS (Qualified in Speciality) nurses:
  - QIS nurses are required to look after babies requiring intensive care
  - Recommendations are for QiS to make up 70% of workforce (currently 39%)
  - Overall Nursing numbers have improved significantly because of additional recruitment over the last 2 years but this means the current workforce is very junior and it takes time to train nurses in QiS.
  - Access to courses limited by external factors despite having colleagues willing to engage.
  - Seemingly unable to recruit external QIS nurses despite best efforts (Both band 5 and band 6)

Recommendation

Review and Approve Action Plans (Appendix 3.1 and 3.2) as per MIS requirements.

- Once approved at Board then share with LMNS and ODN

Acknowledgement of ongoing risk.

- Neonatal Nurse Staffing risk assessment updated November 2023, to be approved via CSU governance.

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for our patients, delivered with kindness			g			
To deliver our financial plan and key performance targets			g			
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Meeting Title	People Academy		
Date	29 November 2023	Agenda item	PA.11.23.14b

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☐	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☐	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☐	☐	☐

Risk Implications (see section 5 for details)	Yes	No
High Level Risk Register and / or Board Assurance Framework Amendments	☐	☐
Quality implications	☐	☐
Resource implications	☐	☐
Legal/regulatory implications	☐	☐
Equality Diversity and Inclusion implications	☐	☐
Performance Implications	☐	☐

Regulation, Legislation and Compliance relevance
NHS England: (please tick those that are relevant) ☐Risk Assessment Framework ☐Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain: Choose an item.
Care Quality Commission Fundamental Standard: Choose an item.
NHS England Effective Use of Resources: Choose an item.
Other (please state):

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality & Patient Safety	Finance & Performance	Other (please state)
☐	☐	☐	☐

Appendices

The bulk of the narrative should be in the appendix, but clearly referenced within the body of the paper.

Appendix 3.1: MIS Action Plan: Medical and AHP. November 2023

Appendix 3.2: MIS Action Plan: Nursing. November 2023

NICU MIS Action Plan

No.	Description of issue/ area for improvement	Recommendation	Owner	Completion Deadline	Comment
	Date of commencement: Sept 2021		**Reviewer:** Sam Wallis - reviewed November 2023		
1	Junior medical cover - short term	Increase ANNP cohort to work on Tier 1+2 rota Employ Staff grades / non-training grade Doctors Internal locums to cover shifts	SW / YG / LL	Ongoing	Ongoing challenge to staff rotas - variable number of gaps at Tier 1+2 due to; changes in training, loss of neonatal component of community registrar job, increasing numbers of LTFT trainees. 2 qualified ANNPs in post. Trainee ANNP recruitment x 2 in 2021, in Yr 2 of 3 but now working Tier 1 shifts with supervision. Staff grades recruited - One LTFT job has been made permanent which should ensure retention. One international Dr now in post. Other temporary staff grades recruited where suitable candidates arise. Plan to use new NHSE funding (£31k this year, 62k recurrent to recruit further ANNPs / Staff grades. Internal bank of previous trainees willing to do locums.
2	Junior medical cover - medium/long term	Increase permanent workforce to replace increasing numbers of gaps on Tier 1 + 2 1. Increase ANNP cohort to work on Tier 1+2 medical rota. 2. Increase non-training grade doctor numbers further. 3. NHSE recurrent funding bid via ODN successful (Nov 23).	SW / YG / LL	Ongoing	1. **ANNPs (ACPs):** Recruiting qualified ANNPs is difficult and has been unsuccessful. Recognition that majority of ANNPs will need to be trained internally. Takes 3 years before fully qualified. Due to ongoing gaps / retirement / loss - the service need to train 2 trainees every 2 years over next 8-10 years to grow ANNP cohort sufficiently. 2023 update: Further 2 x ANNP Trainees recruited Sept 23 intake. 2 in year 2/3 of training (although 1 may have to take training break). 2 qualified ANNPs in post but 1 due to retire 2026. 2. **Medical**: **Airedale** have expressed renewed interest in paying for their juniors Drs to work some Tier 1 shifts in Bradford (to gain neonatal intensive care training/experience), discussion ongoing. ODN has identified non-recurrent funding agreed to target network wide junior medical recruitment (to attract out of region / international doctors). Recruitment agency involved. Bradford has expressed interest, using any money from gaps to pay rotating Drs. Bradford consultant is clinical lead for this project. 3. NHSE recurrent funding bid via ODN successful (Nov 23). Increased medical staffing budget (by £62k). Funding specifically for trainee ANNPs and non-training grade Doctors.
3	Neonatal Consultant	Business case for 8th Consultant – strong local candidate(s) available 2022 Review current on-call models to maximise on-site cover	SW / HJ / LL	Complete October 22	8th Consultant appointed. Retirement of colleague March 23 but Senior fellow appointed to fill gap. New consultant appointed Nov 23 (to start April 2024).Decision to continue with current on-call model at present but to keep under review.
4	Allied Health Professionals	Agree AHP strategy between Paediatric and Therapies CBU Business cases to address priority areas of Physiotherapy and Psychology (where current gap is most significant) Revisit discussions about funding for Outpatient Physiotherapy / SaLT to comply with NICE guidance Incorporate AHPs more closely into inpatient neonatal interventional programmes (neurodevelopment, nutrition) and explore additional roles AHPs may be able to undertake in neonatal care. Work collaboratively with Neonatal Network and other units to benchmark current services and share good practice.	SW / JS / LL	Complete November 22	AHP strategy agreed. LTP funding secured. AHPs recruited (Physiotherapy, OT, Psychology, SALT) for sufficient hours to meet current unit needs. Additional Pharmacy and Dietetic resource also agreed to increase NNU provision. Intially posts were temporary but additional national funding now means that the majority of these posts can be made permanent. Recent gaps due to sickness / absences - Physiotherapy / Pharmacy. Management plan in place.
5	Paediatric Surgery	Secure 1-2 PAs / week of Paediatric Surgical time at BRI for inpatient review.	LL / SW	Ongoing	Bradford has had a Paediatric Surgical consultant jointly appointed with Leeds. She provides excellent support but has recenlty resigned (Nov 23). Still in post at present. May be potential for her to continue to do some Bradford based work. Other options to explore via Surgery in Children Network (SIC), where SW and Kay Rushforth provide representation).
6	Ophthalmology	Support Ophthalmology colleagues/ CBU to appoint replacement for retiring consultant and agree appropriate job planned time to provide ROP service.	LL / RP	Ongoing	Unable to recruit full replacement. Siutation mitigated by Calderdale surgeon agreeing to provide additional cover for remaining Ophthalmologist (Prof Pilling) but risk remains. On Risk Register and under regular review. Aug 23: approval for permanent staff grade post in Neonates. Some job planned time to support ROP screening on unit.

NICU MIS Action Plan

	Date of commencement: Sept 2021		**Reviewer:** Jamie Steele		
No.	Description of issue/ area for improvement	Recommendation	Owner	Completion Deadline	Comment
1	Increase Nursing establishment @ band 6	Add 5 additional WTE	JRS	31/03/2023	Partial completion. Uplift from 10.43 in April 2021 to 14.2. This however includes new educator posts. Further work ongoing to create additional band 6 clincial care posts. UPDATE 18/09/23 - Action complete. Senior establishment increased to a total of 16.69 wte 13.93 clinical sisters, 1.8 clinical educator and 0.96 Infant feeding lead. All working in the clinical area (not back office) In addition to this we have also increased band 7 leadership from 4.64 wte to 5.4wte
2	Increase Nursing establishment @ band 5	Add 5 additional WTE	JRS	Complete 01/04/2022	LTP monies secured. Band 5 nurse staffing wte increased from 50.95 in April 2021 to 63.2
3	Recruit permanent Matron	-	KR	Complete May 22	
4	Increase size of education team to aid skill development and subsequent retention of staff	Recruit additonal 1.8 wte band 6 education sisters	JRS	Complete June 22	
5	Ensure engagement with ongoing education / CPD	Neonatal Foundation Programme - Make attendance mandatory condition of employment.	JRS	Complete Sept 22	Contracts amended to make this a mandatory requirement of being recruited into a band 5 nursing role on the unit. All new starters must apply to join the course before their probation ends.
6	Ensure that we are growing our own QIS nurses	Close management of staff to ensure application to appropriate courses at appropriate times	JRS	Ongoing (Continue to commit to sending 10 to 12 QIS students a year over next 3 years)	Nov intake 22 = 6 nurses on the QIS course (2 more than agreement in 2021) UPDATE 18/09/23 QIS in post on NICU on 30/09/23 who work predominently clinical is 31.43 wte vs 28.09 wte 30/09/23 We have 6 going on the QIS course in Septmber 23 and a further 3 signed up at the current time who will start early in 2024 but we will be looking to increase the size of this intake. Unfortunately a we have lost quite a few QIS in the last few months to a recruitment drive in Airedale and 2 QIS deciding that their future lie in adult community nursing and not neonates
7	Develop ANNP workforce to meet future needs of service	Recruit a further 2 trainee ANNP's to commence training in Sept 2023	JRS/CH/LL/SW	Complete sept 23	2 x TANNP's recruited and starting work / uni next week
8	Develop recruitment/retention plan	-	JRS	Complete Aug 2022	Plans in place to achieve staffing at full establishment. This includes rolling out adverts for Band 5 staff nurses regularly, attending recruitment events, engaging with recruitment of overseas nurses, providing Student Nurses with HCA bank opportunities on the unit, skill mixing team to provide good leadership on all shifts. In terms of retention we feel that high level education and support will help to achieve this. Our growth of the education team will be instrumental in retention. We have also recruited psychology support for our team to ensure that staff mental health is prioritised.

9	Manage Risk appropriately and in a timely way	Continue to work with the MDT (Risk, triumvirate, IPCC) to support the risk action plan, monitor and update risk assessments and register.	JRS/SW/KR	Measures in place	RA and RR updated accordingly. Monitored by risk and governance facilitator and discuss at risk meetings
10	Maintain adequate and appropriate ICU cot availability	Work regionally to maintain and support bed bases locally ensuring that right baby is receiving right care, right time, right place	JRS	Ongoing	Staffing challenges related to high level of staff sickness have impacted the unit's ability to be open in recent months however all appropriate mitigations are put in place. UPDATE 18/09/23 - This continues to be a priority and is somewhat impacted at times by QIS nurse availability. However the team continue to assess daily whether lower dependency babies can be cared for elsewhere in order to maintain a good level of ICU capacity
11	Engage with the network to ensure up to date accurate information including that regarding LTP requirement and funding, review regional data.	Matron attends Network meetings	JRS		
12	Engage with Network OPEL status reporting	Daily OPEL reports submitted to Network, Matron reviews	JRS		ongoing
13	To monitor registered : unregistered ratio in line with recruitment (maintaining 70:30 split in special care).Neonatal Nursing Workforce does not specify nurse banding only WTE numbers. Maintain regular establishment monitoring of skill mix.	-	JRS		ongoing 83% to 17% split currently UPDATE 18/09/23 Split currently approx 85% to 15% - no planned changes to this establishment over the next 12 months
14	Minimum annual establishment reviews	-	JRS		review submitted in October 22 UPDATE 18/09/23 - Review booked in for 19/09/23 with KR and further review a week later at board level.
15	Over recruit x 5 RN to NNU as a result of over-recruitment paper	Progress once at full establishment	JRS	Sep-24	Not yet at full establishment UPDATE 18/09/23 at time of writing close to establishment. 7 RN's recruited awaiting HR check completion and start date. This will leave 2wte band 6 vacancy and 4 wte band 5 vacancy - both out to advert. Closest position unit has been to fully established in recent memory. This is a great progress from our 30+wte vacancies we were carrying 18 months ago

Risk Assessment

<table>
<tr><td colspan="5">Risk title: One to one care in labour</td></tr>
<tr><td>Summarise from the description below:</td><td colspan="4">1 to 1 care in labour rates of >90% have not been achieved since march 2023.</td></tr>
<tr><td>Risk description:</td><td>CAUSE</td><td>EVENT</td><td>EFFECT</td><td>Risk location:</td></tr>
<tr><td rowspan="2">Include any relevant background information to provide context of why the risk is being assessed:</td><td>IF……..</td><td>THEN……..</td><td>RESULTING IN……..</td><td rowspan="2">Labour ward</td></tr>
<tr><td colspan="3">If women in active labour do not receive one-to-one care and support from an assigned midwife then this will decrease the likelihood of the woman having a 'normal' vaginal birth without interventions, and will contribute to increasing both the length of labour and the number of operative deliveries and affect the quality of patient care, where care provided could be compromised for both women and babies. (NICE, 2023, Intrapartum care, Quality standard [QS105]).

Other associated concerns include;

One to one care rates are collected for the maternity dashboard and are reportable locally and nationally. There is a reputational risk as women may choose to birth at a Trust where 1 to 1 care is more likely.

Job satisfaction may be affected if midwives are unable to provide a good standard of care

The maternity incentive scheme safety action 5 standards recommends all women in active labour receive one-to-one midwifery care and if this is not achieved an action plan is required.</td></tr>
</table>

Assessment:				
Identify the hazards - Think about what may cause harm (these are called hazards).	**Assess the potential for harm -** Who might be harmed and how?	**Existing control measures -** Indicate what is currently in place to control the hazard.	**Gaps in control measures -** Why are the existing control measures inadequate?	**Further controls required -** What further action could you take to control the hazards/ potential cause of harm?
Example: *We are unable to release clinical staff for mandatory training due to staffing levels*	*Patients may be put at risk of harm if staff are not up to date with mandatory training resulting in avoidable harm*	*Managers informed on a weekly basis of non-compliant staff to prioritise their release to complete the training*	*Staff may not be able to be released at the time of the scheduled training sessions*	*Devise alternative ways to deliver the training; for example, by video or in the ward/department by clinical leads*
Identify the hazards	**Assess the potential for harm**	**Existing control measures**	**Gaps in control measures**	**Further controls required**
We are unable to consistently achieve national recommendations of all women in active labour receiving one-to-one care and support from an assigned midwife.	Increase the risk to patients especially those who may require increased surveillance, intervention and treatment. An increased risk of potential morbidity and /or mortality for women and babies.	Data is collated through cerner EPR and staffing tools. Midwives complete the work flow question which asks if the woman received 1 to 1 care in labour. This data is used to calculate the overall rate which is recorded on the dashboard and communicated to the wider service by the monthly infographics report. Use of the escalation tool and reporting of our opel	The service has consistently had a vacancy rate which does not meet safe maternity staffing rates in line with the recommendations of the birth rate plus acuity tool calculations. Additional pressures are placed on staff when they are redeployed to labour ward as they are required to work in areas there are not originally assigned to. Closure of essential service such as specialist midwife	Further training and recruitment of staff – apprentice midwifery, rolling recruitment drive, supporting MSC shortened midwifery course training to achieve safe maternity staffing rates. Await the results of the commissioned birth rate plus full assessment. Disseminate and action the results of the SCORE survey. Disseminate and action results from the patient satisfaction survey.

		status. Regional and local regular safety huddles. Periodic Trust exec level sign off for extra remuneration for working additional shifts at times of very high acuity. Red flag data is being collected and reported in relation to themes. Patient outcomes and experience is being monitored via the maternity dashboard and incident reporting system. Escalation policy is initiated when 1 to 1 care is not being achieved. Supernumerary status for labour ward coordinators is protected to provide support on the unit. The risk of protecting this has been deemed greater than the risk of not delivering 1 to 1 care.	clinic appointments, the birth centre and home birth services increases staff job dissatisfaction and reduces service user birth place choices. Availability at short notice of additional band 7 staff to cover roles such as hot desk. The core services training framework 2 requires staff to attend 5 study days which is reduces the clinical workforce and creating challenges covering rosters to achieve agreed staffing establishment. Short and long term staff sickness.	Continue to learn from safety events occurring and share learning locally and regionally. Review the escalation policy and tools used within it, such as the opel scoring, with an aim to gain a more accurate reflection of the acuity of the unit during periods of escalation. Review of unit flow and the impact and mitigation required following the introduction of national guidance, introduction of research studies and SBLv3 recommendations.

		Hot desk midwife to support maintenance of safe staffing in clinical areas. Commissioning of the birth rate plus tool.		

Current/Initial Risk Score

(Current/initial risk score assessed at the time the risk assessment is undertaken)

Consequence		Likelihood		Total score
3	X	4	=	12

Rationale – include narrative

Inability to provide one to one care in labour is shown to increase the risk of morbidity and mortality for women and babies.

Consequence	Likelihood				
	1	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Actions Required: add more lines as required

Action – develop actions to address the further controls required.	**Responsible Lead** – who needs to carry out the action	**Expected date for completion**
1. Periodic uplift in pay for staff to encourage the taking on of additional shifts to cover shortfalls at short notice.	Sara Hollins – Director of Midwifery	Ongoing
2. Await the results of the commissioned birth rate plus full assessment and develop a paper to present at Board to include the required recommendations.	Sara Hollins - Director of Midwifery Carly Stott - Associate Deputy Director of	March 2024

	Midwifery	
3. Further training and recruitment of staff – apprentice midwifery, rolling recruitment drive, supporting MSC shortened midwifery course training to achieve safe maternity staffing rates.	Sara Hollins - Director of Midwifery Emma Flearly – Pastoral support midwife	March 2024
4. Disseminate and action the results of the SCORE survey	Leadership team and culture survey coaches	March 2024
5. Disseminate and action results from the patient satisfaction survey.	Maternity Matrons	March 2024
6. Review the escalation policy and tools used within it, such as the opel scoring, with an aim to gain a more accurate reflection of the acuity of the unit during periods of escalation.	Carly Stott - Associate Deputy Director of Midwifery WYH LMNS Maternity Matrons	March 2024
7. Review of unit flow and the impact and mitigation required following the introduction of national guidance, introduction of research studies and SBLv3 recommendations.	Senior leadership team, ward managers and neonates	June 2024
8. Continue to learn from safety events occurring and share learning locally and regionally.	Quality & Safety Team	Ongoing

<table>
<tr><td colspan="5">Residual Risk Score (This is the risk score once all mitigation has been actioned and adequate control measures are in place)</td></tr>
<tr><td>Consequence</td><td></td><td>Likelihood</td><td></td><td>Total score</td></tr>
<tr><td>2</td><td>X</td><td>3</td><td>=</td><td>6</td></tr>
<tr><td colspan="5">Rationale – include narrative

Having the correct levels of staffing for acuity and more effective patient flow will enable labour ward coordinators to allocate midwives to provide one to one care.</td></tr>
</table>

Consequence	Likelihood 1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Risk Assessment Owners	
Risk Assessment Lead: For example, Ward manager/Matron/CBU lead/Speciality Lead.	Maryanne Naylor- Matron, labour ward and the birth centre
Risk Assessment created by:	Maryanne Naylor- Matron, labour ward and the birth centre
Date:	15/12/23.

TRUST WIDE AND MATERNITY

MNSI INVESTIGATIONS

6 December 2022 – 7 December 2023

NHS RESOLUTION'S EARLY NOTIFICATION SCHEME

FROM 6 December 2022 to 7 December 2023

Author: Helen Sharp, Quality and Safety Specialist Midwife & Amanda Hardaker, Quality & Safety Lead Matron

Date: 27 December 2023

From 1 October 2023, the Health Care Service Investigation Branch (HSIB) became known as the Maternity and New-born Safety Investigations (MNSI) programme, hosted by the Care Quality Commission (CQC). For the purposes of this report, in view of the reporting period, there will be reference to MNSI which supports Safety action 10 of the Maternity Incentive Scheme (MIS) year 5.

MNSI total referrals	12
Rejected by MNSI– family choice/non-engagement	2
Rejected by MNSI – does not meet criteria	3
Progressed by MNSI	7
Completed reports by MNSI	3
Current MNSI active cases	4
Completed internal investigations	1
Current Internal investigations	1

In summary;

12 cases were referred to MNSI.

7 cases have progressed to an investigation led by MNSI

9 cases have been reported as serious incidents within the Trust.

The declined cases either did not meet the MNSI criteria following MRI head findings or review at MNSI panel or the family declined or did not engage. Prior to the 1st December 2023 and the introduction of the new Patient Safety Response Framework (PSIRF), the Clinical Service Unit proceeded to conduct a Trust level 1 investigation for cases where consent was not obtained from families. 2 cases that did not progress to MNSI investigation also did not proceed to an internal level1 investigation as there was no immediate learning which would or may have made a difference to the outcome for the baby when reviewed by a local multidisciplinary team as per PMRT grading criteria.

All the completed reports and investigations are embedded in this report.

ENGAGEMENT WITH FAMILY & DUTY OF CANDOUR

An initial verbal discussion takes place with families who meet the MNSI and NHSR ENS criteria. A dedicated named person within the Quality & Safety team deliver duty of candour (DOC) and provides information in regards to the MNSI and NHSR ENS. This is followed with a written letter outlining the discussion. Once the investigation has been completed a duty of candour letter is sent to the families with the final report, if internally written, or to acknowledge that MNSI have completed their investigation. The letter includes an apology and an offer of a meeting to discuss the investigation findings.

GOVERNANCE ARRANGEMENTS

All incidents that meet the MNSI reporting criteria have been escalated and discussed at the BTHFT internal Safety Event Group (SEG). All cases are again sited at SEG following MNSI decision making to inform if MNSI are progressing the investigation. Further escalation takes place to the Quality of Care Group (QuOC) meeting when the investigation is being progressed by MNSI or when the family have not engaged and the case meets the criteria set within the serious incident framework (SI). 1 case in the reporting period progressed to an internal investigation due to the family not engaging with MNSI.

The Patient Safety Incident Response Framework (PSIRF) was commenced by Bradford Teaching Hospitals NHS Foundation Trust as a result of the National Patient Safety Incidence Response Plan (PSIRP) on the 1st December 2023. In the event that a case does not progress with MNSI a review will take place to decide if the case should be investigated using the PMRT process or if an alternative method of investigation is warranted.

All MNSI cases have been presented at the Local maternity and Neonatal Safety and learning Group (LMNS SLG) previously known as the Local Maternity Neonatal System Serous incident meeting (LMNS SI peer review meeting) as advised within the Ockenden recommendations.

All newly reported case are shared with the Trust Board as part of the monthly Maternity update paper.

Completed investigations

The final MNSI or internal investigation reports, including recommendations and actions, are sited at SEG and QuOC following CSU approval.

The immediate learning and safety recommendations are shared with the LNMS.

Final reports are also included in the monthly Maternity update paper which is presented to Trust Board.

Recommendations and actions from completed MNSI and local level 1 investigations are discussed and agreed at the monthly Women's, Quality and Safety Core Governance meeting.

Description	HSIB reference	Date of incident	HSIB outcome (completed, declined, in progress)	Summary	NHSR referral made and reference number
HIE -cooled	MI-020351	2/01/23	Completed	1 safety recommendation 1.The trust to ensure that local guidance supports decision making to continue CTG monitoring when a decision for a caesarean birth	M19CT389/007

				is made.	
HIE -cooled	MI-025596	7/04/23	Completed	2 safety recommendations 1. The Trust to ensure the clinician is supported to have a structured peer review performed at four hourly intervals and documented within the mother's computerised records in line with the local SOP. This will facilitate transfer to continuous CTG monitoring if indicated. 2. The Trust to review methods to assess the whole clinical picture in the birth centre setting. This should include, but not be exclusive to, the physical assessment of the mother, the use of IA and timely escalation to an obstetric team member when considering risk factors that are present.	M23CT389/004
cooled	MI-028368	5/06/23	Completed	2 safety recommendations 1.The Trust to ensure that Mothers who are in labour are cared for in a birthing room that facilitates access to both additional equipment and staff when required. 2. The Trust to ensure that a full risk assessment is carried out that supports determining the	M23CT389/010

				urgency required for an assisted vaginal birth.	
Seizures-readmitted	MI-023451	10/01/23	In progress	A 3 day old infant was readmitted with hypoglycaemia to the children's ward with altered feeding pattern. Floppy, comatose and seizures	M23CT389/001
Stillbirth	MI-025499	9/04/23	In progress	Intrapartum Stillbirth at Term- Gestational Diabetes and Reduced Fetal Movements	N/A
NND	MI-034805	6/10/23	In progress	Attended with reduced fetal movements at 40+3 weeks gestation in addition to suspected labour. NND at 7 hours if age	N/A
Seizures-readmitted	MI-035859	25/10/23	In progress	Baby readmitted at 2 days old with hypoglycaemia and seizures	M23CT389/025
Cooled	MI-026323	18/04/2023	Not progressed by MNSI or trust	Baby readmitted at 4 days old due to seizures. No trust concerns following MDT review. Local plan for results tracking.	N/A

Cooled	MI-029259	2/07/2023	Not progressed by MNSI or trust	Baby born in poor condition and admitted for therapeutic cooling - normal MRI- no family or trust concerns No trust or family safety concerns-	N/A
Seizures	MI-034737	22/09/2023	In progress as a trust level 1 investigation	Term baby born via category 2 caesarean section, admitted to the NNU and diagnosed with electrical seizures	M23CT389/018

Cooled	MI - 021240	23/01/23	Completed as Level 1 investigation	Term baby, cord prolapse, admitted to NNU.	M23CT389/004
Stillbirth	MI-035496	20/10/23	Not progressed	Concealed pregnancy, stillbirth born at home (BBA)	N/A

BO.1.24.10 - PROPOSAL TO ESTABLISH A MATERNITY & NEONATAL TASK & FINISH GROUP

REFERENCES

Only PDFs are attached

Bo.1.24.10 - Proposal to Establish a Maternity and Neonatology Task and Finish Group.pdf

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.10

PROPOSAL TO ESTABLISH A MATERNITY AND NEONATOLOGY TASK AND FINISH GROUP

Presented by	Professor Karen Dawber, Chief Nurse	
Author	ANHH Consulting	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	The paper proposes the establishment of a short-life, Unitary Board task and finish group to discuss and propose the optimal assurance forum for Maternity and Neonatal services.	
Key control	This will be an additional control for strategic risk 2b.1: "If the Trust is unable to transform its services, then we may not be able to deliver resilient services that are fit for the future, resulting in a loss of staff and a negative impact on patient safety, experience and outcomes".	
Action required	For approval	
Previously discussed at/ informed by	This was discussed by the Interim Chair, Chief Nurse, Associate Director of Corporate Governance/Board Secretary, and Andrew Hughes from ANHH Consulting on 6 December. It has subsequently been discussed with other members of the Unitary Board.	
Previously approved at:	N/A	N/A

Key Options, Issues and Risks

The Board is aware that Maternity and Neonatal ("**MatNeo**") Services are high on the national and local agenda. Events elsewhere in the NHS (Shrewsbury and Telford, Nottingham, Chester, etc.) have highlighted safety and quality issues and the NHS centrally has developed transformation programmes.

MatNeo services are a standing agenda item at both the Quality and Patient Safety Academy ("**QPSA**") and the Board of Directors ("**BoD**"). The Director of Midwifery presents at every BoD meeting, and senior clinicians often attend to offer reassurance and to supplement written reports.

The Trust must not lose its grip of these important issues and, indeed, could be considered in the vanguard of the way in which it has addressed them. Equally, however, the Trust must ensure that all other services are subject to the same rigorous, evidence-based scrutiny, and that there is no diminution in quality assurance for other services.

The proposal is to convene a short-life, Unitary Board task and finish group ("**TFG**") to discuss reporting and assurance on MatNeo services and to consider the best solution moving forward.

Analysis

"Governance Mechanics" – The way in which reporting, escalation, and assurance flow up within an organisation, and the corresponding way in which decisions, direction, and delegation flow down it – is fundamental to good governance. The Interim Chair is commissioning a review of governance mechanics at the level of Board and Academies, and this proposal will sit well within that overall package of work.

The proposed Terms of Reference for the MatNeo TFG, which are attached, describe the key parameters for the exercise. The aim is to recommend a preferred solution at the meeting of the BoD on 14 March.

Recommendation

The BoD is asked to:

- **APPROVE** the establishment of the MatNeo TFG
- **APPROVE** the Terms of Reference

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.10

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for our patients, delivered with kindness				g		
To deliver our financial plan and key performance targets				g		
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☐	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☐	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☐	☐	☐

Risk Implications (see section 5 for details)	Yes	No
High Level Risk Register and / or Board Assurance Framework Amendments	☒	☐
Quality implications	☐	☐
Resource implications	☐	☐
Legal/regulatory implications	☐	☐
Equality Diversity and Inclusion implications	☐	☐
Performance Implications	☐	☐

Regulation, Legislation and Compliance relevance	
NHS England: (please tick those that are relevant)	
☐Risk Assessment Framework	☐Quality Governance Framework
☐Code of Governance	☐Annual Reporting Manual
Care Quality Commission Domain: Well Led	
Care Quality Commission Fundamental Standard: Good Governance	
NHS England Effective Use of Resources: Clinical Services	
Other (please state):	

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality & Patient Safety	Finance & Performance	Other (please state)
☐	☒	☐	☐

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.10

TERMS OF REFERENCE

1	INTRODUCTION AND BACKGROUND

To ensure best governance in the management and leadership of high-profile, high-risk services, and to learn from evidence and experience elsewhere in the NHS, the Trust needs to consider the optimal assurance forum and approach.

A TFG will be established, to operate from mid-January to early March 2024, to advise the BoD on appropriate and scalable solutions. The TFG will focus on MatNeo services but will consider whether its proposals would fit other services.

2	ROLE OF THE TASK AND FINISH GROUP

The MatNeo TFG will bring together Executive and Non-Executive members of the Unitary Board and subject matter experts from governance and the two services.

The MatNeo TFG will:

- Consider the advantages and disadvantages of the existing reporting arrangements to QPSA and BoD
- Identify alternative reporting and assurance options, e.g., MatNeo sub-committee of QPSA, dedicated MatNeo Academy, Management Committee, other
- Document the benefits that could be realised from the options, e.g., capacity, resilience, best use of resources (staffing and financial), other
- Document the risks associated with the various options, e.g., reduced assurance, increased reliance on reassurance, gaps in control, increased bureaucracy, other
- Review and appraise other organisations' arrangements in this regard
- Recommend a preferred option for MatNeo services to the BoD
- Consider any gaps in existing arrangements for learning from clinical incidents elsewhere in the NHS and how best to improve those arrangements in the future
- Consider whether the proposed arrangements for MatNeo services could be replicated/scaled up for other services that may require future internal focus and/or response to NHS priorities.

3	MEMBERSHIP

Co-Chair of QPSA (Chair)
Co-Chair of QPSA (Deputy Chair)
Non-Executive Director member of QPSA
Chief Nurse (Lead Director)
Chief Medical Officer
Director of Midwifery
Associate Director of Quality
Associate Director of Corporate Governance

4	RESPONSIBILITIES OF MEMBERS

All TFG members are to attend personally. Deputies must be agreed in advance with the Chair.

The Chair may ask other Trust officers to attend to assist with its discussions.

5 FREQUENCY OF MEETINGS

The TFG will aim to meet a maximum three times between mid-January and early March. Work will be conducted between meetings and may be supplemented by email communication between members.

6 QUORUM

The TFG will be considered quorate when at least one Non-Executive and one Executive member is present, together with the required subject matter experts.

7 SECRETARIAT

The TFG will be supported by the Corporate Governance team. The output of the TFG will be a report for receipt by BoD on 14 March as part of the wider review of governance mechanics.

8 AUTHORITY

The TFG is established as a stand-alone forum by the BoD and has no authority beyond that described in these Terms of Reference.

BO.1.24.11 - REPORT FROM THE CHAIR OF THE PEOPLE ACADEMY ? NOVEMBER 2023

REFERENCES

Only PDFs are attached

Bo.1.24.11 - Report from the Chair of People Academy - November 2023.pdf

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.11

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: People Academy

Date of meeting: 29 November 2023

Key escalation and discussion points from the meeting
Alert:
Maternity Incentive Scheme (MIS) Safety Action 4 – Nada Sabir and Sam Wallis attended to update on the MIS and Neonatal Staffing. Safety Action 4 asks the Trust to demonstrate an effective system of clinical workforce planning to the required standard. The team audited all after hours delivery cases over 6 months and found good practice relating to communication, debriefs and consultant presence but further work is required on documenting of all cases on Cerner. The Academy asked whether the recording issue is a 'system' issue or a mindset issue in moving away form handwritten notes. The team advised it's both and they will address this. The Neonatal unit must meet the British Association of Perinatal Medicine (BAPM) national standards of medical and nursing staffing. If staffing requirements are not met in years 3, 4 or 5 of MIS, the Trust Board should evidence progress against the previous action plan and include new actions to address deficiencies. Staffing is non-compliant with the national service specification with respect to Junior/Medical Grade cover and Nurses qualified in specialty as there are insufficient numbers of medical trainees to fill the rota, and insufficient (Qualified in Speciality) QiS nurses to provide sufficient intensive care activity required of a Neonatal Intensive Care Unit (NICU). The Academy took assurance that significant progress has been made over the last year but challenges remain with fewer trainees across the region and the time taken to train new nurses to become qualified specialists. The Academy reviewed the plans in detail, acknowledged the risk and approved them for inclusion at the next Board meeting.
Advise:
Risks – there are three risk changes relating to this Academy: the haematology workforce risk (3810) was due to reduce 30 Sept 23 but this deadline has been extended to Sept 24. The risk to Nursing and Midwifery Workforce (N&MW) staffing (3732) has been reduced from 20 to 16 following recent recruitment success. The Medicine Reconciliation risk (3881) should be reduced from 16 to 12 following improved pharmacist resources now in place, once the Chief Operating Officer (COO) has assurance that medicines reconciliation rates have improved. Faeem updated on the Industrial Action risk: medical unions are taking the offer on consultants pay to their members and there was ongoing dialogue about Junior Doctor pay. We discussed the media attention of the N&MW workforce feeling undersold and the potential for further strikes and Faeem shared the timeline for a mandate which would be the back end of winter.

Meeting Title	Board of Directors		
Date	29 November 2023	Agenda item	Bo..23.x

Dashboard – turnover has dropped to 10.01% from 10.25% in October and absence continues to fall, now at 5.91% from 5.96% and on track for the stretch target of 5.5% by the end of March. The Academy acknowledged that absence could rise over winter and impact the great progress.
Contacts with the Advocacy Service have dipped slightly and there is an increase in the proportion of cases resolved informally. The volume of bullying and harassment cases is stable with 6 cases reported over the last 6 months - 50% of cases resolved informally, 17% resulted in disciplinary action and in 33% cases there was no case to answer. There have been 2 cases referred for mediation over the last 6 months, with positive outcomes.

NHS Long Term Workforce plan – Faeem updated the Academy on the plan which is focused on a system approach to the long term sustainability of the NHS, built around Train Retain Reform. This is backed by £2.4bn in government investment to fund a 27% increase in training places by 2027-28 to address an expected shortfall of 260,000 to 360,000 over the next 10 years. When challenged, the type of exit reasons for the Trust was highlighted as multifactorial and Ray raised the significant costs for support services to meet the plan.

Assure:

Outstanding Pharmacy Services – Kate Lavery, joined by Ali and Sophie from the Pharmacy team, shared an update on progress since their last visit to the Academy. Since the programme launch, 6 workstreams have been developed and 45% of the Pharmacy team are engaged in these workstreams. The biggest workstream is wellbeing and culture and this covers wellbeing, civility and behaviours, recognition and celebrating, inclusion and fairness with initiatives such as civility training, a Pharmacy Charter, celebration boards, a Greatix scheme, thank you cards, increased communication, stay interviews and Equality, Diversity and Inclusion (EDI) celebrations being developed and rolled out. There has been a 23% improvement in the engagement temperature check since February and we celebrated the amazing 79% response rate to the recent Annual Staff Survey. Questions were raised about how the team is reaching the 55% of people not engaged in the programme, how the leadership and programme teams are working together and whether personal development was being addressed and the Academy took assurance that the team were trying many methods of communicating progress, the leadership and programme teams now operated as one team and that there was work ongoing to address personal development.

Just R Candidate Journey – whilst we ran out of time to discuss this in detail, it's worth noting that Just R have created two recruitment campaigns signposting people to the Trust open days – one for St Lukes Day Case Unit and one for General nursing and Midwifery. The campaigns reached 2.2m people, yielded 1134 candidates registering interest with 370 enquiry forms completed and 59 people appointed (20 Registrants and 39 Health Care Support Workers (HCSWs). The effectiveness of the Just R campaign for General N&MW is difficult to track as other attraction and recruitment methods were

used in parallel but for the St Luke's Day Case recruitment, this was the only campaign and resulted in 50-60 offers with 38 made to people outside the Trust.

An overly ambitious agenda meant that some items were noted for info rather than discussion. Only one Non-Executive Director present, the Chair, who highlighted the need for other attendees to challenge Academy content. The Executives, and other attendees, did a great job of challenging and questioning.

Report completed by:

Karen Walker
Academy Chair and Non-Executive Director

29 November 2023

BO.1.24.12 - EQUALITY AND DIVERSITY COUNCIL UPDATE

REFERENCES

Only PDFs are attached

Bo.1.24.12 - Equality and Diversity Council Update.pdf

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.12

Strategic Equality and Diversity Council January 2024 Update

Presented by	Mel Pickup – Chief Executive Officer	
Author	Ruth Haigh, EDI Manager	
Lead Director	Faeem Lal, Director of Human Resources	
Purpose of the paper	The purpose of this report is to: Update the Trust Board on the work of the Equality and Diversity Council and provide an overview of the key areas of focus since our last update in September 2023.	
Key control	N/A	
Action required	For assurance	
Previously discussed at/ informed by	N/A	
Previously approved at:	**Academy/Group**	**Date**
	N/A	

Key Options, Issues and Risks

The Trust's Equality and Diversity Council (EDC), chaired by CEO, has a remit for both workforce and wider health inequalities in the district and continues to meet quarterly.

This report provides an update on the key highlights from the last EDC meeting which was held on 15th December 2023

Analysis

The following key items were discussed at December EDC meeting:

- Update on Nursing Times Workforce Award and HSJ Award
- Staff Equality Network Updates on progress and future plans
- Update on Objective 1 of the EDI Strategy: "Equality, Diversity & Inclusion Briefing for Managers"
- Update on "Reach-in Reach-out"
- Update on "Root out Racism"
- Addressing Population Health Inequalities through Community Health Checks

Recommendation

It is recommended that the Trust Board:
1. Note the contents of this report; and
2. Support the proposed areas of work identified in section 3.1.

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.12

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for patients				g		
To deliver our financial plan and key performance targets				g		
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☐	☒	☐
Is there any other national benchmarking data relevant to the content of this paper?	☐	☒	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☐	☐	☒

Risk Implications (see section 5 for details)	Yes	No
High Level Risk Register and / or Board Assurance Framework Amendments	☐	☒
Quality implications	☒	☐
Resource implications	☐	☒
Legal/regulatory implications	☒	☐
Equality, Diversity and Inclusion implications	☒	☐
Performance Implications	☐	☒

Regulation, Legislation and Compliance relevance			
NHS England: (please tick those that are relevant) ☐Risk Assessment Framework ☐Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual			
Care Quality Commission Domain: Well Led			
Care Quality Commission Fundamental Standard: Good Governance			
NHS England Effective Use of Resources: People			
Other (please state):			
Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
☒	☐	☐	☐

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.12

1 PURPOSE/ AIM

1.1 The purpose of this report is to:

- Update the Trust Board on the work of the Trust' Equality and Diversity Council and provide an overview of the key areas of focus since our last update in September 2023.

2 BACKGROUND/CONTEXT

2.1 EDC has been in place since January 2021 and continues to meet every quarter, providing strategic direction, leadership and support to the Trust EDI agenda, including the Trust's approach in tackling population health inequalities.

2.2 **EDC Membership**

2.3 All EDC members are encouraged to attend each meeting and EDC is usually very well attended. Where attendance is not possible members are asked to send a representative on their behalf.

2.4 Chairs of each of the Trust's staff equality networks are included as members of EDC with dedicated agenda time at each meeting. This enables staff networks to have a voice where they can actively influence EDI across the Trust.

3 Highlights of the EDC Meeting – Friday 15th December 2023

3.1 This section provides a summary of agenda items and actions arising from EDC since the last Trust Board update provided in September 2023.

The table below captures some of the key discussions from the meeting which took place on 15th December 2023.

Update on Nursing Times Workforce Award and HSJ Award
The Trust has received two national awards in recognition of the work we are doing in advancing Equality, Diversity & Inclusion In November 2023 our EDI team along with representatives from all 3 staff equality networks attended the Nursing Times Workforce Awards at the London Metropole and won in the category for "Best Employer for Diversity & Inclusion" for our excellent work in reviewing, refreshing and re-launching our staff equality networks, supporting them to ensure they are thriving and having a real voice in the organisation. In November 2023 our SPaRC team also won the Health Service Journal Workforce Wellbeing Award for their innovative work on the "Ramadan Allies" project, which supports Muslim staff to undertake their prayers during Ramadan and continue to deliver the services they are responsible for. The SPaRC team were also finalists for the Nursing Times Workforce Award (wellbeing award) for their newly launched SPaRC app which is available for patients and staff and features all major world faiths and is available in multiple languages.

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Staff Network Updates

Enable Staff Network

Update:

Sonia Sarah, EDI Manager/ Co-chair of the Enable Network provided an update to EDC on recent network activity and future plans. A meeting for the wider network was held on 16th October where the focus was on a wellbeing check-in for members and providing a safe space for discussion with a chance to meet with Susan Parker (new co-chair) and Jill McCarthy who is trialling the role of comms officer for the network. This was also an opportunity to progress network plans for Disability History Month and to discuss the networks role in the "Connected on Ability festival" (a place based event, which ran during the first week of December). As part of the "Connected on Ability" festival Kez Hayat led a session on disability declaration and sharing the learning from our successful WDES innovation fund project. The session was well attended and received some great feedback. As part of Disability History Month; the network also had a precence on the main concourse to showcase the WDES innovation fund display.

Current focus: continues to be engagement and in increasing network membership, but over the coming weeks they are planning to focus on the EDI High Impact actions and how the network can align their work plans to the Trust' EDI priorities.

LGBT Staff Network

Update:

The network welcomed 2 core group members into key roles; Nick Sanderson as co-chair and Karla Pawlowski as comms officer. At a recent meeting Joanna Mutlow, Humanist practitioner from the SPaRC team attended to discuss how the new SPaRC app can be made more user-friendly and beneficial for our LGBT+ community. Some really insightful discussions took place with plans to work more closely together in the future. The network are also working with the Bradford District and Craven LGBT+ Collaborative to develop a staff app that should interface with the SPaRC app.

Current focus: The network are planning events to mark LGBT+ History Month (in February) and plan to use some of their budget to purchase merchandise and display materials. The network are also really keen to progress an idea for a "Wellbeing Hub" on the main concourse, which could provide QR codes to discretely provide information for staff and service users around staff networks and the SPaRC service. EDC discussed some potential avenues for obtaining a phone box or similar for this purpose (as suggested by the network) Sugrah Nazir agreed to make enquiries with a Parish Council contact who may be able to help and Mel suggested Comms might go out to T&A to see if anyone wants to donate a phone box or similar.

The network are also keen to develop the idea of a "Rainbow Garden" and it has been suggested that charities funding could be used to develop the proposed staff recreational area outside Field House (funding pending approval). Mel suggested the network bring this back to EDC as a proposal.

RESIN staff network

Update: Raquel Licas shared photos from recent network activity and talked about collaborative working with the FTSU and SPaRC team and Bradford Hospital Charities. Network membership continues to increase and has risen from 173 members in October to 224 in December, many of whom are new overseas recruits to the Trust. One of the newer members (a midwife. Janette, who has

worked at the Trust for a year) recently represented BTHFT at an event held at Buckingham Palace to celebrate the contribution of internationally educated nurses and midwives (as part of a group of staff from the North east & Yorkshire Region). The event was held as part of the NHS 75th anniversary and the 75th birthday celebrations for King Charles. Janette was also a keynote speaker at the event and recorded her experiences of becoming a midwife at BTHFT as part of a podcast.

Celebration events over the last 3 months include;

- Filipino celebration day celebrating 20 years of service for 120 staff, including one nurse who has been honoured with the Daisy Award (for extraordinary nurses)
- Diwali (festival of lights)
- Black History Month

All events provided the opportunity to raise the profile of race equality in the Trust where network members shared their lived experiences and insight into their culture (including food, dancing and singing) with plans to be even more ambitious next year

Update on Objective 1 of the EDI Strategy "Equality, Diversity & Inclusion Briefing for Managers"

The EDI briefing for managers has been aligned to Objective 1 of the Trust' EDI Strategy around "Education, Empowerment and Support".

Following an initial pilot session in April we have successfully rolled out a half-day, face-to-face training course for line managers which focusses on providing safe spaces for open, honest and supportive conversations around EDI, bringing in real life case studies (including videos) to aid discussions. We have already delivered around five to six sessions and have had some really good feedback from managers, who value the time away from the workplace to explore issues that are really relevant to their role as line managers, ensuring they feel empowered and are provided with the necessary skills/ tools and insight to manage diversity in the workplace.

In terms of course content the focus is on:

- Bias and how it affects perception
- Compassionate and Inclusive Leadership (including discussions around reasonable adjustments/ flexible working)
- Workplace Civility and the importance of "nipping issues in the bud"
- Our collective roles and responsibilities in advancing EDI across the Trust
- An awareness of the policy, guidance and support that exists to support managers and staff

EDC welcomed this valuable work.

Update on "Reach-in Reach-out"

Initial proposal: Sarah Waite provided an update on Reach-in Reach-out, which was initially proposed as a way to to improve visibility of senior leaders and to support the development of trust and understanding (a sense of One Team) beween staff and senior leaders (in line with our Trust Values and People Charter) and enhancing our offer of Thrive.

The Reach-out element supports delivery of our Trust Strategic Objectives on many levels including; promoting health, reducing health inequalities, delivering the best possible care for our local population within the resources available, continually learning and collaborating effectively with local and regional partners. Bringing to life the vision of "Act as One", building a workforce that reflects and is built around the assets of our local communities

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Pilot phase: 45 colleagues were invited to take part in the pilot programme in August 2023. The were required to spend half a day Reaching-in (spending time with theirs or another team in the Trust "a shift in my shoes"). They were also required to arrange to spend half a day volunteering in the local community.

Next Steps: Some changes have been proposed in response to feedback from the pilot phase:

- Broadening the Reach-in opportunities to any team in the Trust (including informal mentoring/ buddying)
- Working with Bradfor City Council and VCS to build a directory of volunteering opportunities
- Widen the pool of colleahues eligible to take part (8a+, including medics/ speciality leads)
- Move to an annual timeframe rather than quarterly (allowing more meaningful time spent on individual projects)

Next steps for Spring 2024 will be to

- Develop a communications plan which will include a quarterly focus in Let's Talk/ Social Media on a person/ team who have taken part.
- Incorporate the programme into the new Advancing Leaders Pathway
- Refresh the guidance pack/ FAQ's and evaluation form to reflect the upcoming changes.
- Develop professional branding for the programme
- Explore ways to electorincally monitor/ measure the impact of the programme on colleagues and the wider community (e.g. through ESR/ Health Roster)

EDC members shared some of their really positive experiences of the programme from both a reach-in and reach-out perspective

Update on "Root out Racism"

Ali-Jan Haider provided EDC members with a detailed update report on "Root out Racim" and shared some of the highlights in the meeting.

Ali-Jan shared some background and examples on how racism has impacted his own life and the lives of staff and service users who have shared their personal experiences and the issues faced in challenging racism when it arises.

Root out Racism was formed out out of a commitment from local leaders, following the tragic death of Geoge Floyd, to robustly address the issue of racism in West Yorkshire and was launched in 2021 with a high profile event in Centenery Square. Ali-Jan was tasked with reinvigorating this commitment in 2023, to ensure we are are not only respecting the Human Rights of our diverse patients and colleagues but to also ensure we are providing fair and equitable health services in accordance with the NHS Constitution.

Root out Racism movement aims to:

- Eliminate the impact of racism on our staff, our services and our patients
- Drive an anti-racist culture (ensuring racism is unequivocably understood as unacceptable)
- Using lived experience to improve service access/ ouctomes/ experience/ innovation
- Evidence inclusivity in leadership at all levels
- Maximise the role of BTHFT as an anchor organisation

Ali-Jan called on the members of EDC to provide their commitment and bravery in ensuring the success of Root out Racism, helping to embed a cultural change throughout the organisation and

become anti-racism champions. He emphasised the importance of supporting the voices of our diverse staff to be amplified and "heard" in a brave space (not just in a safe space) and supported through allyship to have some of those difficult, but necessary conversations.

Ali-Jan provided EDC with some specific area's of focus (themes) which have been identified in how we can achieve the objectives of Root out Racism:

1) Mental Health & wellbeing
2) Maternity experiences of Black and South Asian Mothers
3) Young ethnically diverse people into employment
4) Addressing education inequalities that hinder social mobility and well-being

Ali-Jan invited members of EDC to contact him if there were specific areas of focus that they would like to be involved in and to be involved in developing some of the target metrics over the coming months.

Addressing Population Health Inequalities through Community Health Checks

Vishal Sharma (Associate Director – Improvement Academy) gave a presentation around a pilot scheme to address Health Inequalities in Bradford with specific focus on Cardio Vascular Disease.

Vishal provided some data from 2019 highlighting the extent of the problem, the impact in terms of mortality rate (1,238 deaths due to Cardio Vascular Disease in those under 75yrs, of which 55.3% reside in the most deprived quintile) there was also the additional cost to the NHS (£20 billion each year), including some of the anecdotal evidence gathered via social media and community groups such as;

- People from Ethnic Minority groups presenting at A&E with cardiovascular events at a younger age on average that those from a White British background
- Difficulties in getting GP appointments
- Young people in their 40s were dying on a regular basis from CVD
- Many of those suffering strokes had been previously asymptomatic

This prompted a more detailed analysis of the Connected Bradford data which confirmed the problem.

Their solution was to offer Community Health Checks to those who may be at greater risk, and ideally before they became symptomatic, to improve chances they might respond to intervention.

Challenges included identifying how to access those most at risk and then working to break down the myths about CVD and empowering people to take control of their future health & wellbeing.

Next Steps: The Improvement Academy plan to develop a model to make the programme sustainable and then work with organisations across Bradford. The will continue to analyse the data and measure the impact on the local community.

Sughra Nazir suggested the Improvement Academy link up with some of the work being done on a national level by NHS England and also agreed to connect them up with the Council of Mosques with a view to accessing more people who may be at greater risk (and potentially some additional funding).

Mel offered to connect Vishal with collleagues who are overseeing the well-being hubs with a view to utilising this resource for future health check events (e.g. Manningham Mills).

Kez offered to support Vishal in identifying any' yet to reach' groups outwith the mosques such as the women's groups/ Khidmat centres.

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Any Other Business
Kez notified EDC that he will be taking a paper to ETM providing a gap analysis on the 6 high impact actions for the EDI Improvement Plan and how we can ensure we achieve the required deadlines. This paper will be shared with EDC for information. Kez specifically referred to the need to ensure all senior managers have an EDI objective as part of their appraisal by end of March 2024. Results of the EDS2022 review which is currently under way will be taken to Quality Academy/ People Academy at the end of February 2024

3.2 Next EDC is due to take place on Monday 15th April 2024.

4 RECOMMENDATIONS

It is recommended that the Trust Board:

1. Note the contents of this report; and
2. Support the proposed areas of work identified in section 3.1.

5 Appendices

N/A

BO.1.24.13 - REPORT FROM THE CHAIR OF THE FINANCE AND PERFORMANCE ACADEMY ? NOVEMBERR 2023

REFERENCES

Only PDFs are attached

Bo.1.24.13 - Report from the Chair of Finance and Performance Academy - November 2023.pdf

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.13

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Finance and Performance Academy

Date of meeting: 29th November 2023

Key escalation and discussion points from the meeting
Alert:
Monthly Finance Report – there continues to be a risk to delivering the 2023/24 financial plan. The risk is in the main due to increased costs due to strike action and slow progress in delivering the Waste Reduction Plan. As at month 7 the Trust is £2.15m in deficit (although additional funding to support this deficit had been received from the ICS) and is forecasting a full year break- even position. The Academy discussed the significant underlying financial position, the risk to delivering the plan this financial year and the actions being taken to minimise this risk and the significant deficit being carried into next financial year. **Treasury Management Report** – the Trusts cash position is forecast to continue to deteriorate over the next few years. The cash management group are working to ensure that the cash position is optimised and that any operational impacts of the worsening cash position are minimised.
Advise:
Operational Improvement Plan – The Academy reviewed the output from the workshops that had taken place to look back at the 2023/24 performance improvement plan, including what had worked well and what could have been done better. The ambition for 2024/25 is to attain best quartile performance by March 2024 and top decile performance by March 2025 for all constitutional targets. The plan for 2024/25 across the 3 programme areas (RTT, Urgent Care and Cancer) once again highlights transformational actions, actions to proactively improve performance and improvements to business-as-usual performance that need to happen to achieve our ambition. A discussion took place about the new St Lukes Day Case Unit and how leaning and best practice is being used in establishing this new initiative. **Performance Highlight Report** – The Academy received and reviewed the monthly comprehensive report. Our performance remains strong in comparison with our West Yorkshire (WY) peers. It was pleasing to see following that following the cleansing of our waiting list we now have 98% confidence in the data. A discussion took place about the SSNAP data and the staffing of the new stroke ward. Once the ward is opened we should start to see an improvement in stroke performance.
Assure:

Meeting Title	Board of Directors		
Date		Agenda item	

Financial Improvement Plan – A new oversight group chaired by John Bolton has been established to agree a framework for delivering future waste reduction. The group will review opportunities, benchmarking and the art of the possible. As well as the financial impact of delivering waste reduction the operational impact and the quality impact will be considered by the group.

High Level Risks Relevant to the Academy - The Academy was assured at the end of the meeting that all relevant risks had been identified, reported to the Academy and were being managed appropriately. No new risks were included in the risk register for the Academy. The Academy noted that the risk re Gas and Electricity prices has been removed. The impact of increased prices will be built into next year's budgets.

Challenge in the meeting was good and there was good participation across the range of attendees in the meeting.

Report completed by:

Julie Lawreniuk
Academy Chair and Non-Executive Director
December 6th 2023

BO.1.24.14 - INTEGRATED DASHBOARD

REFERENCES

Only PDFs are attached

Bo.1.24.14 - Integrated Dashboard (cover).pdf

Bo.1.24.14 - Board Dashboard - November 23.pdf

Meeting Title	Board of Directors		
Date	18 November 2024	Agenda item	Bo.1.24.14

Integrated Dashboard

Presented by	Mel Pickup, Chief Executive.	
Author	Paul Rice, Chief Digital & Information Officer.	
Lead Director	Paul Rice, Chief Digital & Information Officer.	
Purpose of the paper	The integrated dashboard provides a single view of quality and performance across the Trust for Board oversight and challenge.	
Key control	The integrated dashboard is a key control for all Trust strategic objectives.	
Action required	For information,	
Previously discussed at/ informed by	Relevant sections of the dashboard have been discussed at the Quality and Patient Safety Academy, the People Academy and the Finance and Performance Academy.	
Previously approved at:	**Academy/Group**	**Date**

Key Options, Issues and Risks

The integrated dashboard provides a single view of quality and performance aligned to the Trust's strategic objectives. The Board Academies review and challenge the elements of the dashboard relevant to their terms of reference. Any specific matters for escalation to the Board of Directors are identified during the meetings and provided in a specific agenda item for the Board's attention or included in the Academy's highlight report.

Analysis

The relevant sections of the integrated dashboard will be considered to support the discussions at the Board of Directors meeting.

Recommendation

The Board of Directors is asked to use the integrated dashboard to support discussions related to assurance and the Board Assurance Framework and to decide if further assurance is required.

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for patients, delivered with kindness			g			
To deliver our financial plan and key performance targets			g			
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		

Meeting Title	Board of Directors		
Date	18 November 2024	Agenda item	Bo.1.24.14

To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)	The Dashboard demonstrates a number of areas where risk is at variance with the risk appetite and defined risk tolerance of the Trust. The Strategic Risk Register reflects these risks and describes the current mitigation.					

Benchmarking Implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☐	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☐	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☐	☐	☐

Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	☒	☐
Quality implications	☒	☐
Resource implications	☒	☐
Legal/regulatory implications	☒	☐
Diversity and Inclusion implications	☐	☐
Performance Implications	☒	☐

Regulation, Legislation and Compliance Relevance	
NHS Improvement: (please select those that are relevant)	
☐Risk Assessment Framework	☐Quality Governance Framework
☐Code of Governance	☐Annual Reporting Manual
Care Quality Commission Domain: Choose an item.	
Care Quality Commission Fundamental Standard: Choose an item.	
Other (please state):	

Relevance to Other Board of Director's Academy: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
☒	☐	☒	☐

Integrated Dashboard

Board of Directors

30th November 2023

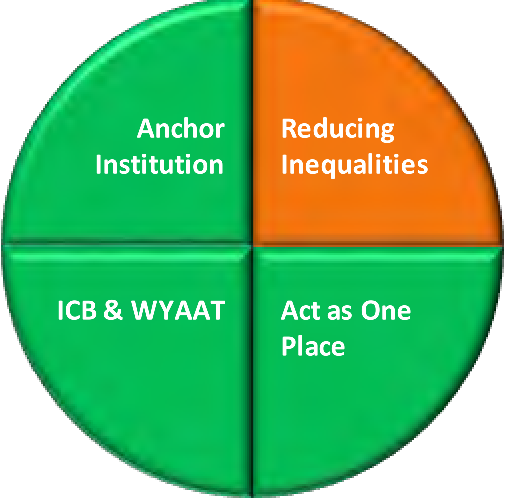
Integrated Dashboard
30th November 2023

To provide outstanding care for patients, delivered with kindness

To deliver our financial plan and key performance targets

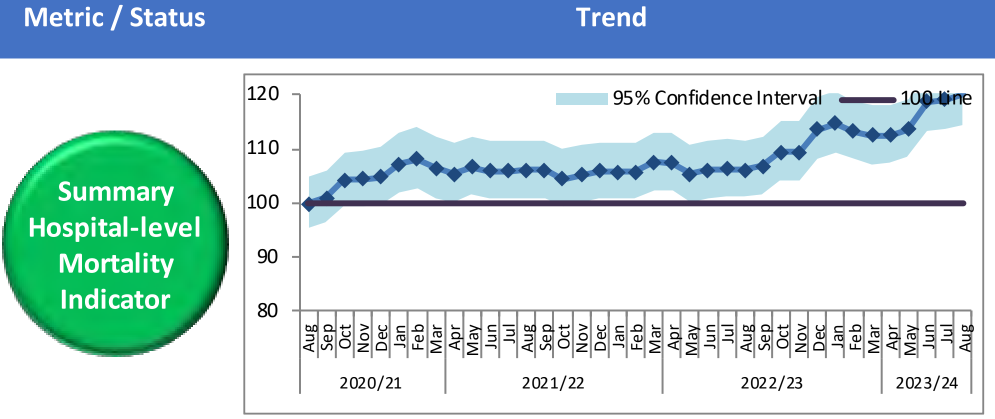
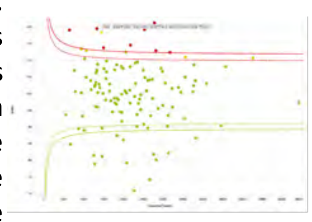
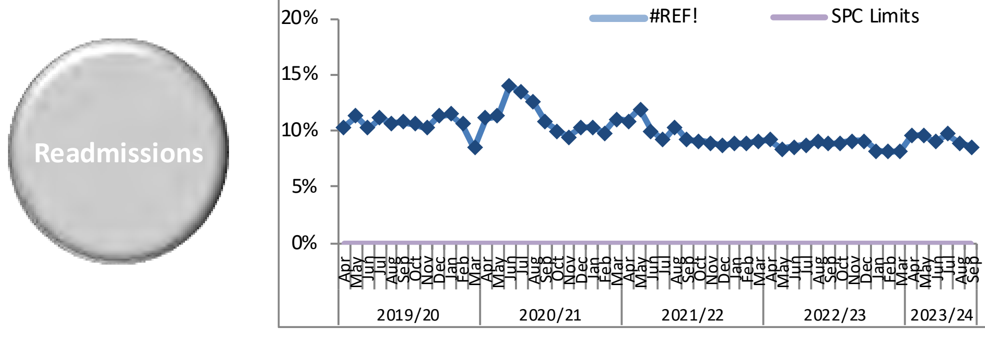
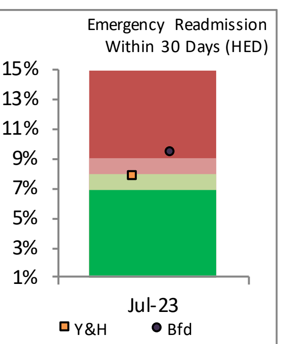
To be one of the best NHS employers, Prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion

To collaborate effectively with local and regional partners



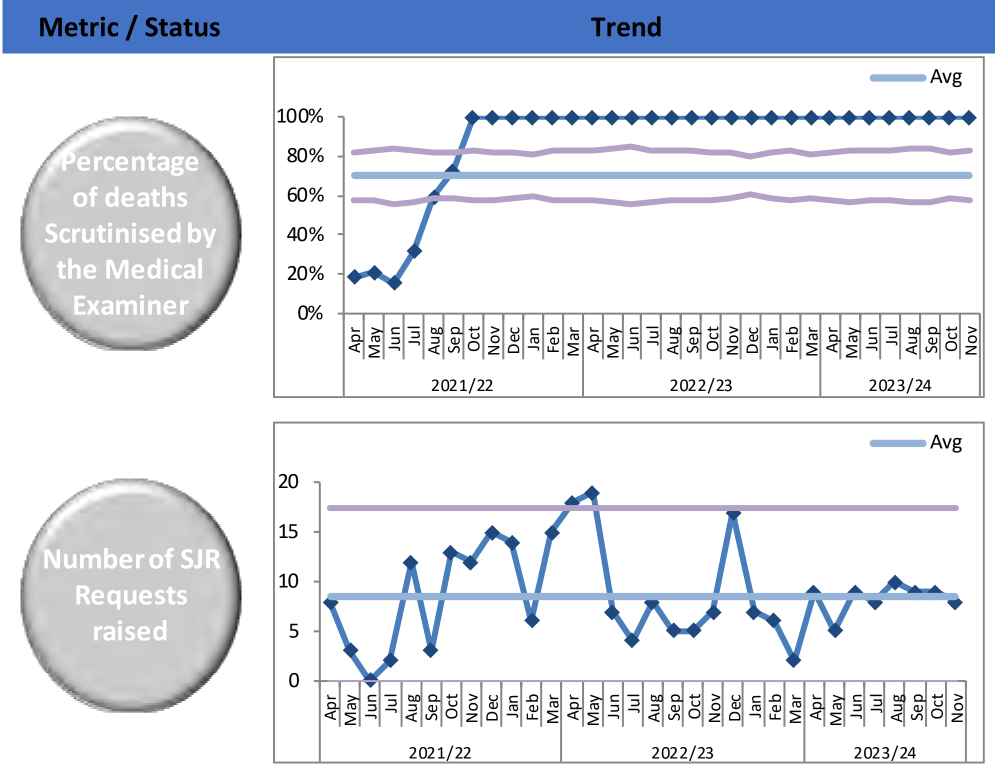
To be a continually learning organisation and recognised as leaders in research, education and innovation

To provide outstanding care for patients
Clinical Effectiveness

Metric / Status	Trend	Challenges and Successes	Benchmarks
Summary Hospital-level Mortality Indicator		The Summary Hospital-level Mortality Indicator (SHMI) shows the ratio of the observed to the expected number of deaths up to 30 days after discharge from hospital, multiplied by 100. The SHMI reports on mortality at trust level for acute trusts across the NHS in England, and is evaluated over all diagnosis groups in a specified patient group. It excludes stillbirths, and a death is counted only once and to the last discharging acute provider. The SHMI value is not an indication of avoidable deaths or a measure of the quality of care delivered. If the HSMR is significantly higher or lower than expected this will trigger further investigation, as this could signal data quality issues, changes in pathways/practices, or issues with quality of care. SHMI – NHS Digital (12 month rolling) NHS Digital SHMI Dataset (November 2023): 118.37 – high (>95%).	
Readmissions		Re-admission rates within 28 days continues to fall in line with regional average. There is evidence to show there is a correlation between shorter length of stays (LoS) with higher re-admission rates. During 2019/20 our average LoS for non-elective spells was 3.1 days (lowest in region) and our re-admission rates were 11% (highest in region). In 2022/23 our average Length of Stay has increased to 4.2 days and our re-admission rates have fallen to 8% (both in line with regional average).	

To provide outstanding care for patients
Learning from Deaths

Metric / Status	Trend	Challenges and Successes	Benchmarks



We continue to meet 100% scrutiny for all hospital deaths. There were 113 hospital deaths dealt with via our office in November 2023. We have engaged with all of the GP practices in our remit (55 out of 55 GP sites).

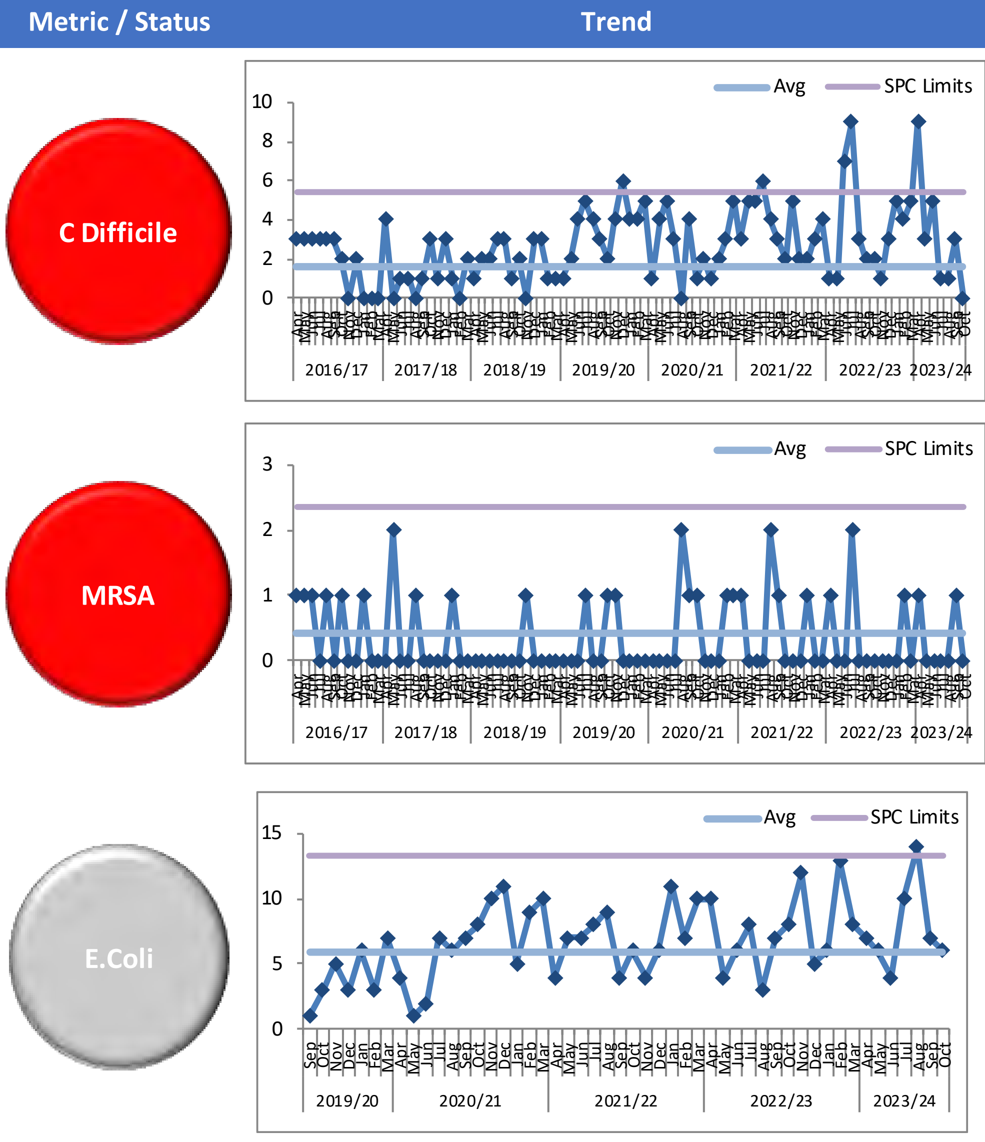
There were eight SJRs requested via the Medical Examiner's office for November 2023 on a background of 113 adult inpatient deaths. A total of four SJRs were completed by reviewers throughout November with all four scoring between Adequate to Excellent overall care. Please note that three of the requests for November 2023 concern deaths in the community, not at BTHFT; Two referrals have been referred to HM Coroner for investigation and one incident was Datixed rather than having a SJR performed.

Reasons for the SJR's requests raised in November 2023 include:

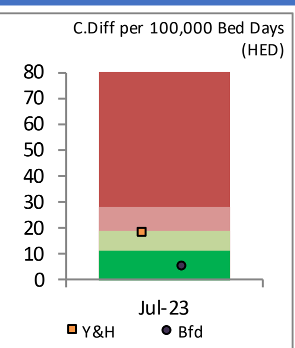
- Where the bereaved or staff have raised significant concerns (n=1)
- Those with severe mental health illnesses (n=1)
- Those who were elective admissions (n=1)
- Those in the community (n=3)
- Where learning will inform the provider's Quality Improvement work (n=2)

To provide outstanding care for patients
Patient Safety

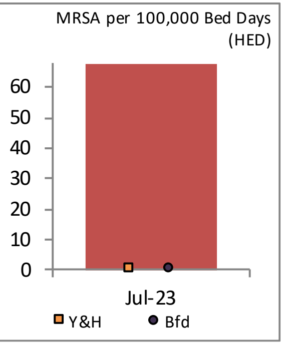
Metric / Status | **Trend** | **Challenges and Successes**



The Trust reported 43 cases of C. diff infection during 2022/23. So far **27** trust attributable cases have been identified. There were 9 trust attributable cases in the April 2023. There was no evidence of an outbreak or transmission between patients. Antibiotic usage was considered the most common risk factor associated with these cases. A review meeting was convened with all stakeholders to review the antibiotic prescribing practices. Enhanced cleaning and disinfection was also carried out. As a result, there has been significant reduction in the number of attributable cases since May 2023.



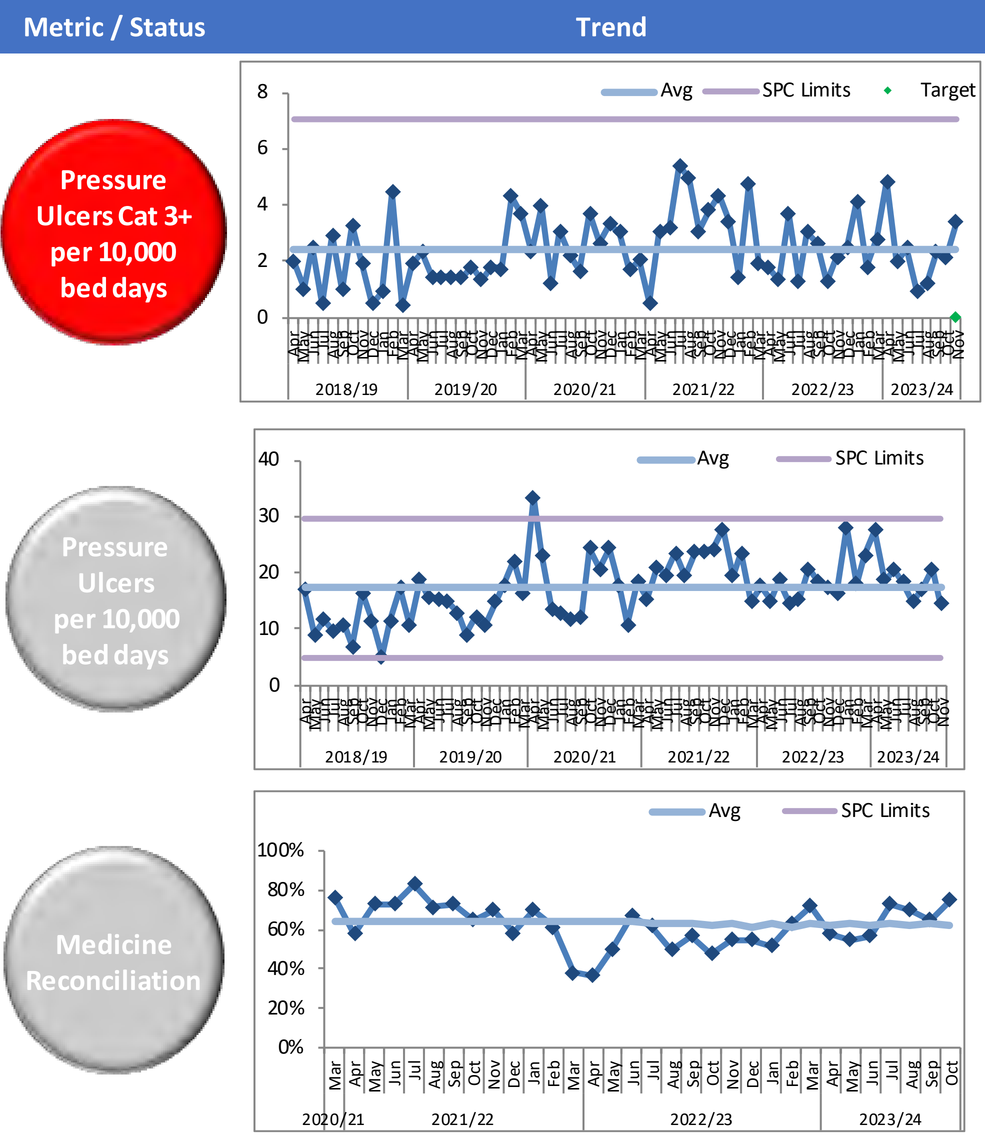
The trust reported 4 cases of MRSA bacteraemia during 2022/2023. So far **3** cases of MRSA bacteraemia have been identified in 2023/2024 with one case each in April and September 2023. Staphylococcus aureus improvement plan is in place with Progress against actions are monitored at IPCC. Particular focus has been on providing all acutely admitted patients with a 5-day supply of Octenisan body wash with compliance monitored using EPR. All patients with new CVC's followed up post insertion by IPCT until discharge to ensure high standards of aftercare are maintained.



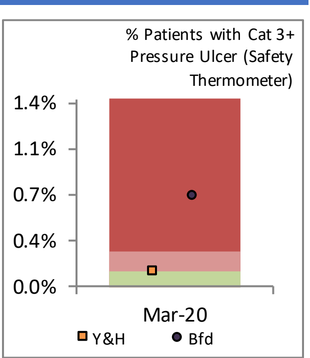
The Trust reported 91 trust attributable E. coli bacteraemia cases during 2022/23. So far **61** cases of trust attributable E. coli bacteraemia have been identified. Most of them were categorised as Community onset healthcare associated (COHA). A quality improvement initiative to improve hydration in the elderly began in April 2023. In addition, initiatives to promote care and maintenance of both urinary catheter and mouthcare are being worked up by IPCT to support the hydration improvement plan with elderly patients in the first instance.

To provide outstanding care for patients
Patient Safety

Metric / Status | **Trend** | **Challenges and Successes** | **Benchmarks**



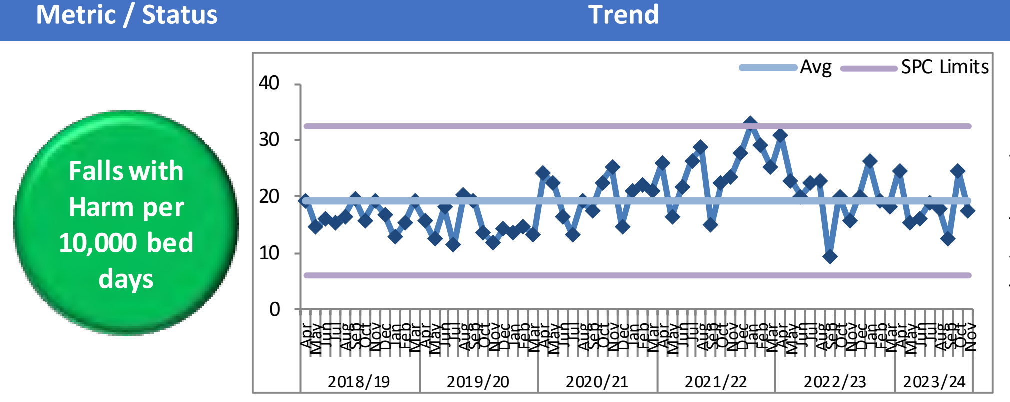
Pressure ulcer incidents increased at the beginning of 2023. Increased demand, increased patient frailty and deconditioning and staffing pressures may have been contributory factors. A risk assessment was completed, and action plan developed to mitigate the risks. There has been a successful roll out of the new pressure ulcer risk assessment tool in July (phase 1; phase 2 will include maternity and community) which is being supported by an e-learning package and other resources. The introduction of PSIRF in relation to pressure ulcers is also in development – this will include the use of after-action learning to replace root cause analysis and development of feedback process at the pressure ulcer improvement group to share learning and improvement. New e-learning modules were introduced this year and the clinical practice educators and legacy nurses are being utilised to support the development of staff which will add to existing learning measures already in place which includes bespoke ward-based training and teaching at induction. Tissue Viability conference held in November – theme of the day was assessment. It was well-attended by colleagues.



Medicines reconciliation is the overarching formal process of obtaining a complete accurate and up to date list of the patient's current medicines and comparing this list to the prescribed medication, taking into account adherence prior to admission and the patient's current clinical presentation. Medicines reconciliation is considered complete when any discrepancies identified have been communicated to the relevant health care professional for resolution. The data shows the percentage of patients that had medicines reconciliation carried out by pharmacy team within 24 hours of admission from a sample of sixty patients.

To provide outstanding care for patients
Patient Safety

Metric / Status | **Trend**



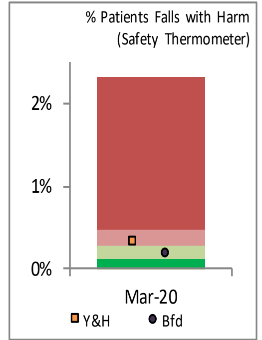
Falls are being reviewed by the Lead for falls Improvement. A new process has started, in line with PSIRF, to meet learning and assurance needs for individuals and the wider organisation. CSU teams will be asked to attend the Falls Improvement group to present all falls and their themes for learning and improvement. They will discuss how they are implementing the actions or QI work they have identified.

The new process involves –

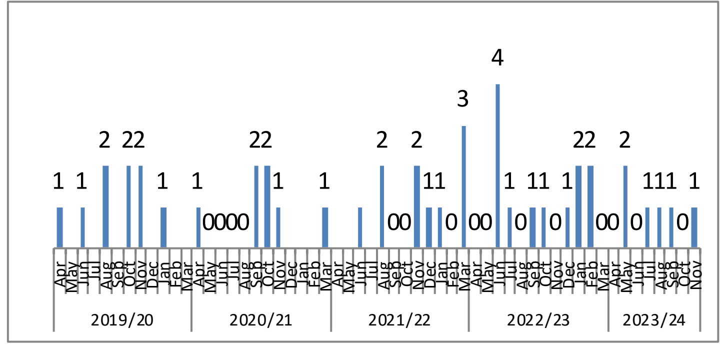
- Medical review (if suspected harm, within 30 minutes of the patient falling)
- Completion of DATIX
- Completion of the hot debrief form by Registered Nurse(on the same shift as the fall happened)
- Fall reviewed by falls lead – this is to give recommendations for the after action review.
- If a fall has cause moderate harm or above, this will be escalated to the Quality and Patient Safety facilitators to be taken to SEG/QuoC
- An After Action Review will be completed within 5 days of the fall. This is an MDT approach.
- The completed form will be sent to the Falls Lead for accuracy and learning points.
- This will then be signed and sent back to the ward manager to attach to DATIX
- When invited, the CSU will discuss their falls and themes for learning at the Falls Improvement group.

The hot debrief and after action review have now been merged into one document to prevent repetition and make the process easier, whilst including all aspects of falls management. This whole process will replace the previous panel process.

Resources are also available on our Frailty Padlet - Frailty (https://padlet.com/paulstreet2/frailty-reur5ccm1crymiyq) so staff can access this 24 hours a day.

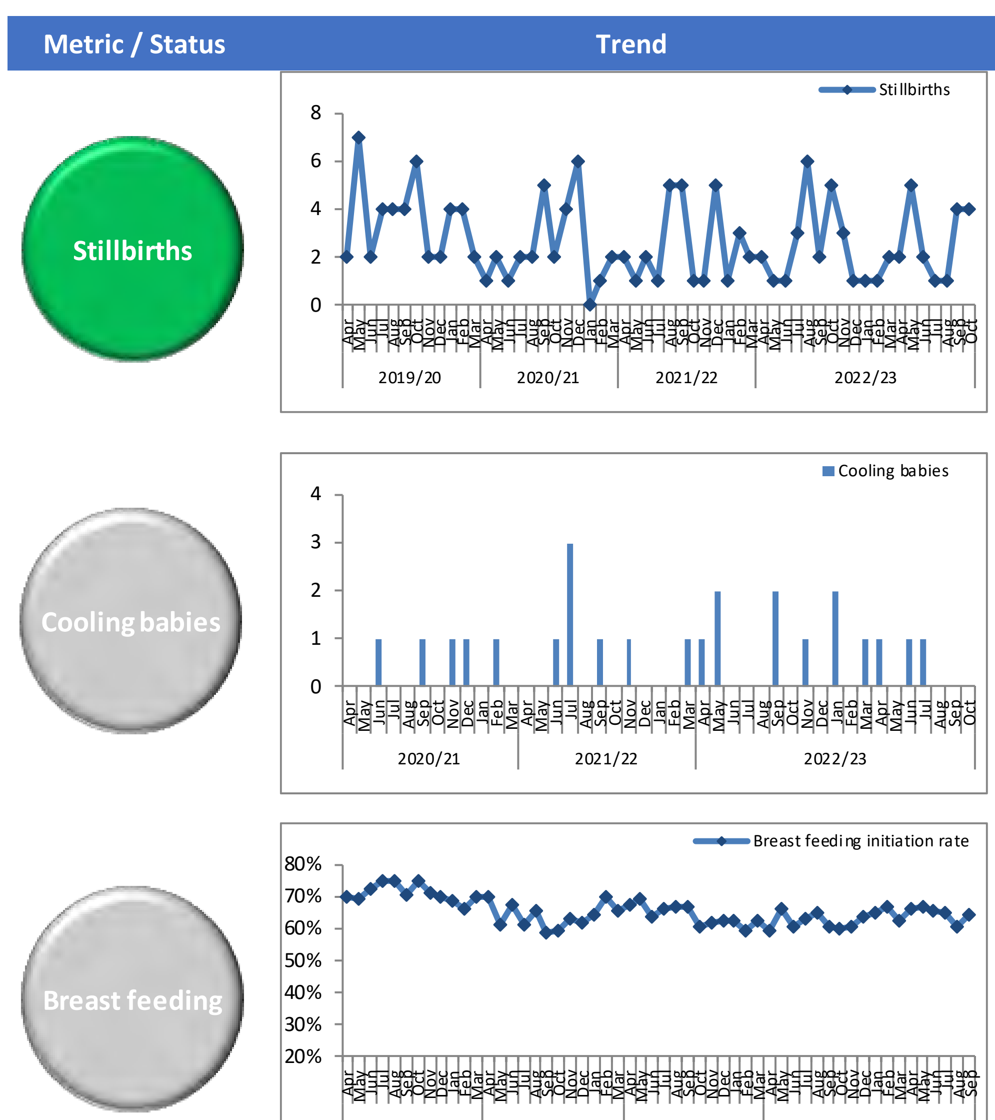


No benchmark comparator available



To provide outstanding care for patients
Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks

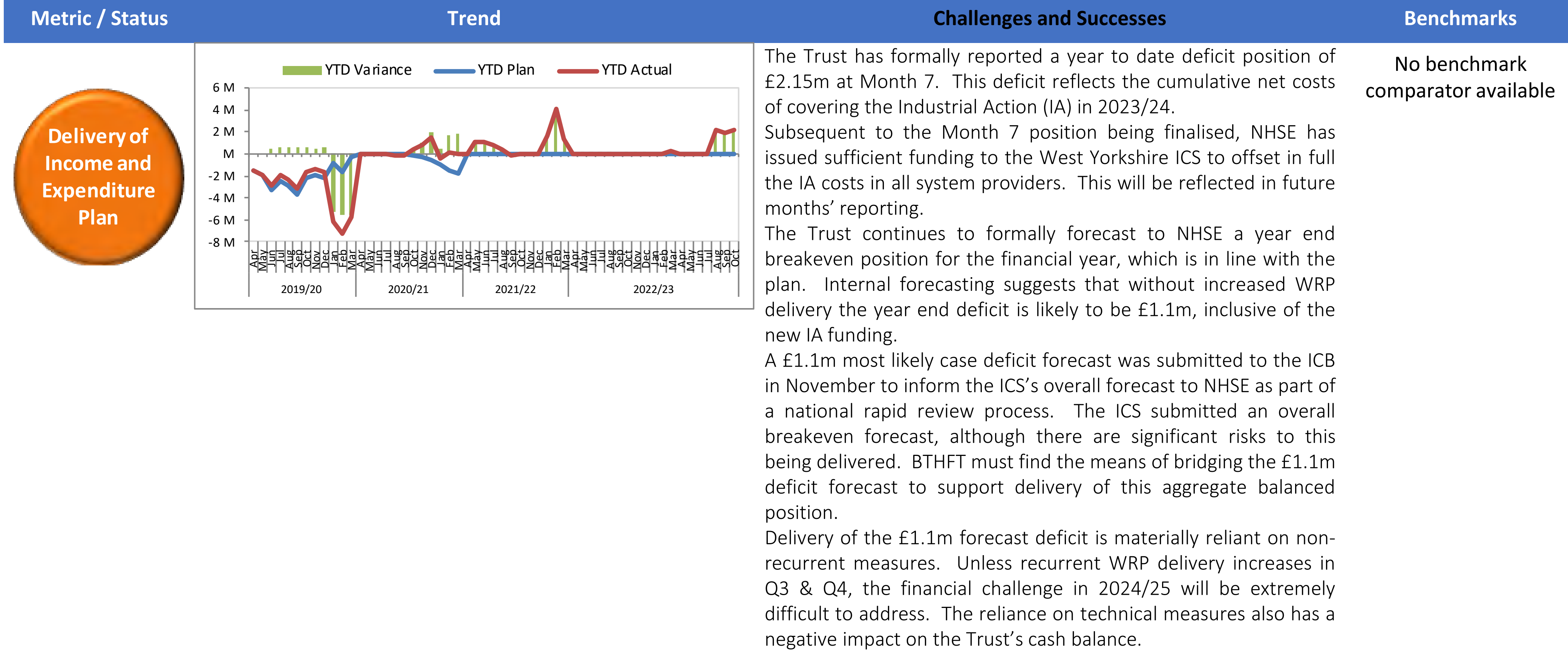


Stillbirths continue to be monitored on a monthly basis with each case subject to a 72 hour clinical review, reporting to PMRT, referral to HSIB in cases of term babies where the mother was in labour at the time death was diagnosed. There is nothing significant to update for November.

An MDT review of HIE cases during 2022 and 2023 was held in October. Findings were shared at the November QPSA and the next Maternity/Neonatal Joint Speciality group to discuss any improvement work required.

The Trust has committed to the long term plan to achieve, embed and sustain Unicef Baby Friendly standards. The Infant Feeding co-ordinator appointed a number of midwives (with a special interest in breastfeeding based on M4) to support good practice, improve initiation rates and provide education for mothers and staff. At the October QPSA meeting it was agreed that this metric would be temporarily suspended from the dashboard as the data is not accurate due to missing data fields/DQ issues. Processes to validate data are being reviewed by maternity services and Business Intelligence.

To deliver our key performance targets and financial plan
Finance



The Trust has formally reported a year to date deficit position of £2.15m at Month 7. This deficit reflects the cumulative net costs of covering the Industrial Action (IA) in 2023/24.

Subsequent to the Month 7 position being finalised, NHSE has issued sufficient funding to the West Yorkshire ICS to offset in full the IA costs in all system providers. This will be reflected in future months' reporting.

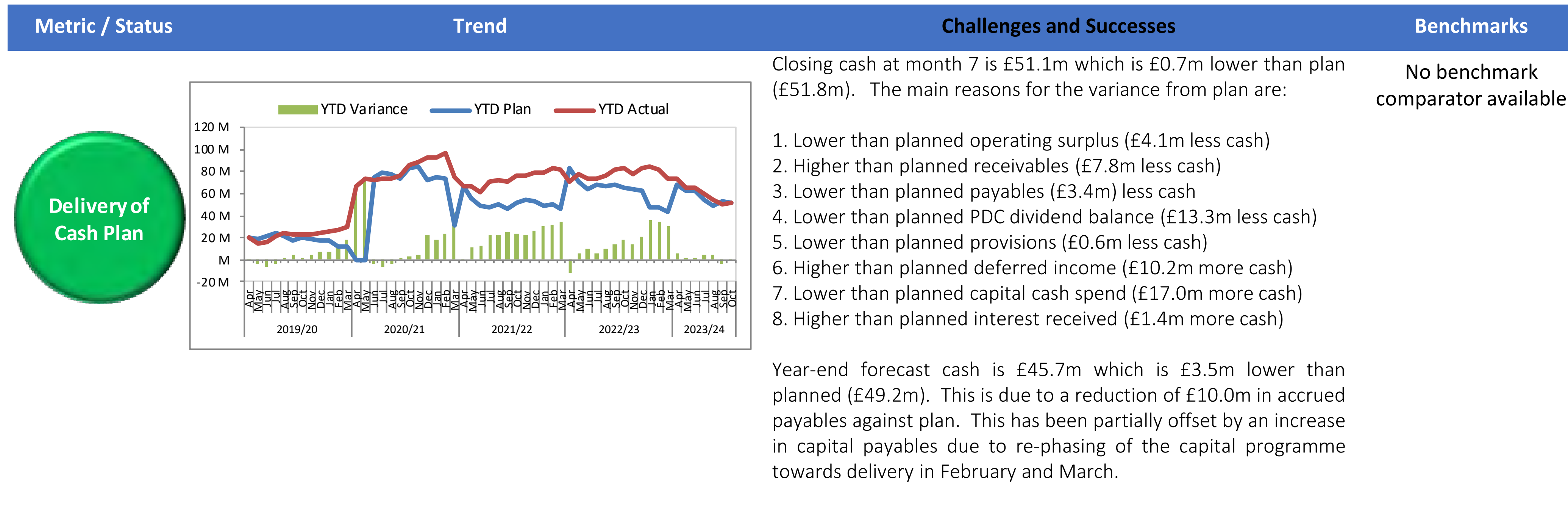
The Trust continues to formally forecast to NHSE a year end breakeven position for the financial year, which is in line with the plan. Internal forecasting suggests that without increased WRP delivery the year end deficit is likely to be £1.1m, inclusive of the new IA funding.

A £1.1m most likely case deficit forecast was submitted to the ICB in November to inform the ICS's overall forecast to NHSE as part of a national rapid review process. The ICS submitted an overall breakeven forecast, although there are significant risks to this being delivered. BTHFT must find the means of bridging the £1.1m deficit forecast to support delivery of this aggregate balanced position.

Delivery of the £1.1m forecast deficit is materially reliant on non-recurrent measures. Unless recurrent WRP delivery increases in Q3 & Q4, the financial challenge in 2024/25 will be extremely difficult to address. The reliance on technical measures also has a negative impact on the Trust's cash balance.

No benchmark comparator available

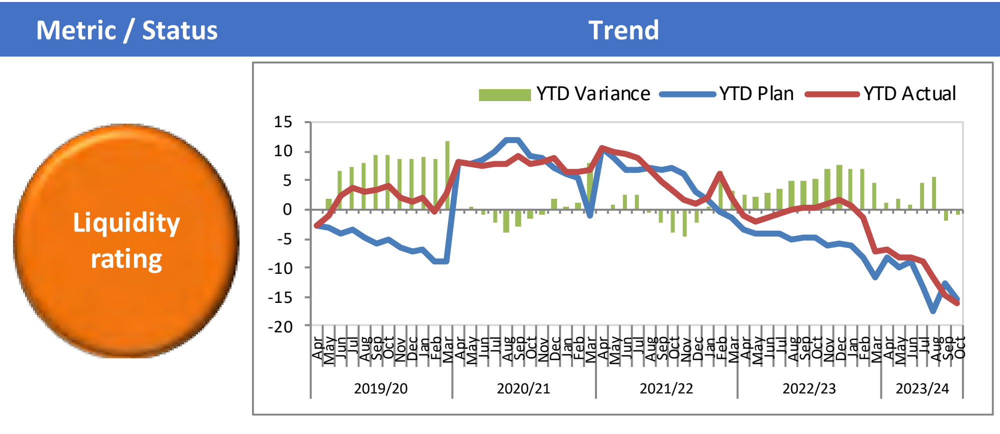
To deliver our key performance targets and financial plan
Finance



Metric / Status	Trend	Challenges and Successes	Benchmarks
Delivery of Cash Plan		Closing cash at month 7 is £51.1m which is £0.7m lower than plan (£51.8m). The main reasons for the variance from plan are: 1. Lower than planned operating surplus (£4.1m less cash) 2. Higher than planned receivables (£7.8m less cash) 3. Lower than planned payables (£3.4m) less cash 4. Lower than planned PDC dividend balance (£13.3m less cash) 5. Lower than planned provisions (£0.6m less cash) 6. Higher than planned deferred income (£10.2m more cash) 7. Lower than planned capital cash spend (£17.0m more cash) 8. Higher than planned interest received (£1.4m more cash) Year-end forecast cash is £45.7m which is £3.5m lower than planned (£49.2m). This is due to a reduction of £10.0m in accrued payables against plan. This has been partially offset by an increase in capital payables due to re-phasing of the capital programme towards delivery in February and March.	No benchmark comparator available

To deliver our key performance targets and financial plan
Finance

Metric / Status	Trend	Challenges and Successes	Benchmarks



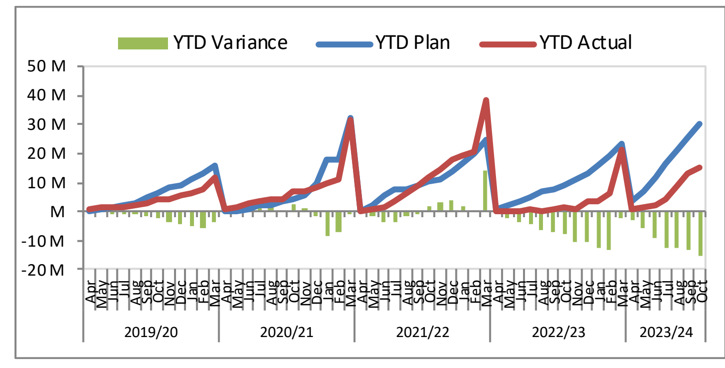
Liquidity represents the number of days the Trust could meet its operating costs from its liquid resources (current assets less stocks and current liabilities).

Year to date liquidity is negative 16.1 days which is 0.8 days lower than plan (negative 15.3 days). Liquidity is lower than plan due to behind plan capital expenditure by £14.9m and current liabilities being higher than plan by £8.7m.

Liquidity is rated as amber due to the year-end forecast of negative 17.3 days by year end. This indicates that the Trusts short term liabilities exceed the value of liquid assets available to the Trust to service them. This could require the introduction of measures to manage the Trusts cashflow.

Total capital departmental expenditure limit ("CDEL") for 2023/24 is £58.1m (operational capital budget reduced by 5%). The Trust is forecasting to spend its full CDEL allocation by 31 March 2024.

No benchmark comparator available

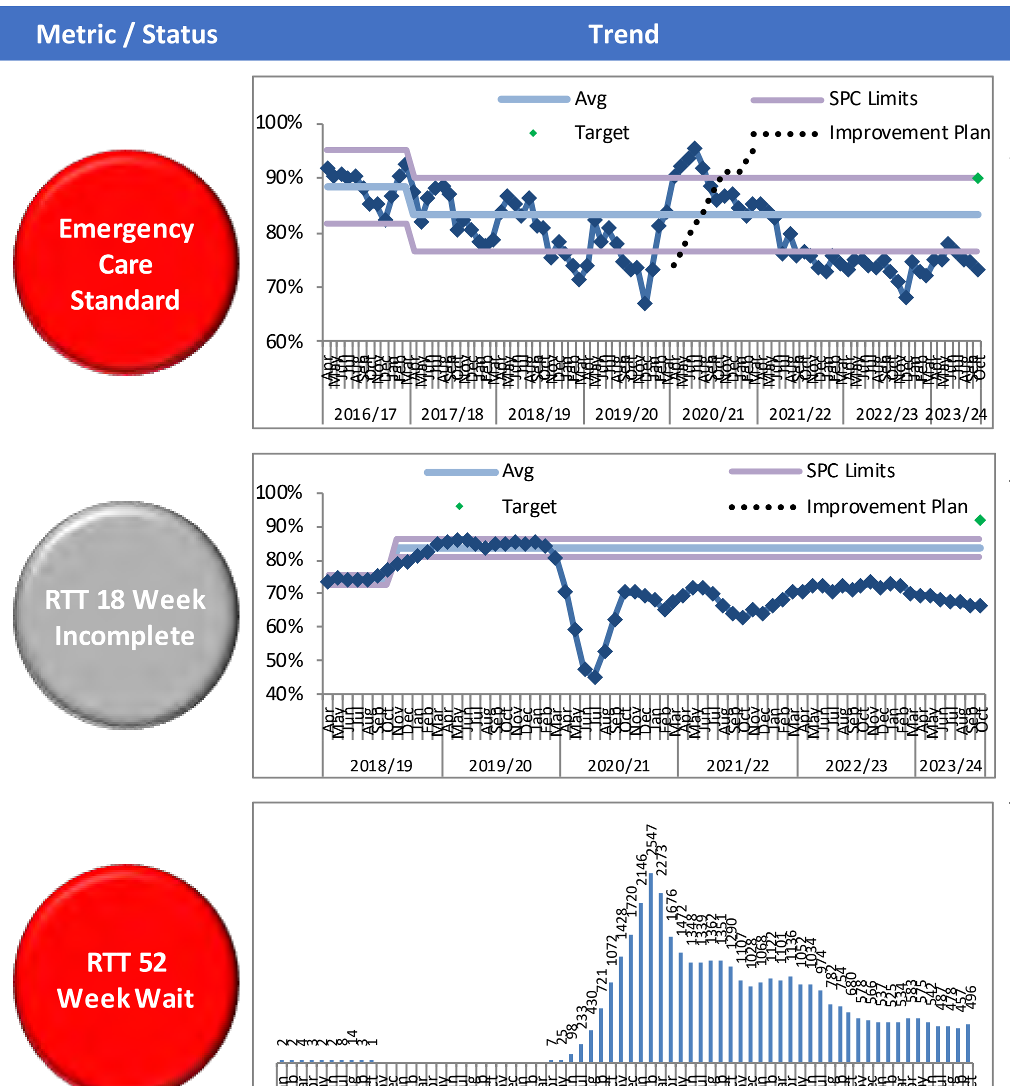


At month 7 the Trust reported a year-to-date underspend of £14.9m. This is due to delays in the delivery of internally funded Estates schemes (£5.8m). PDC funded schemes are behind plan due to delays to the Eccleshill Community Diagnostic Centre (£4.4m). The TIF funded Day Case Unit is behind plan by £5.9m due to delays in starting the project. The slippage reported on the schemes identified will be recovered by the end of the year.

Capital expenditure is amber rated as 74% of the programme needs to be delivered in the remaining 5 months of the year. This presents resourcing challenges in the teams responsible for delivery of the programme and can lead to difficulty sourcing items with long lead times before delivery.

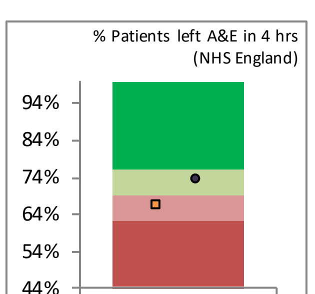
To deliver our key performance targets and financial plan
Performance

Metric / Status	Trend	Challenges and Successes	Benchmarks

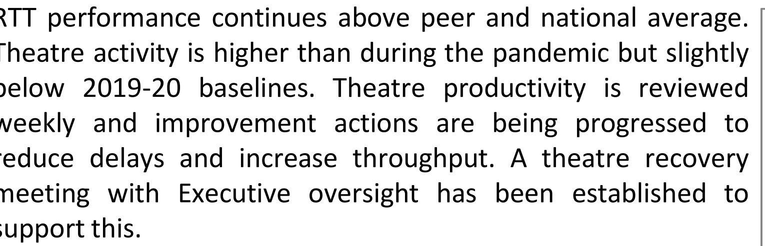


Emergency Care Standard

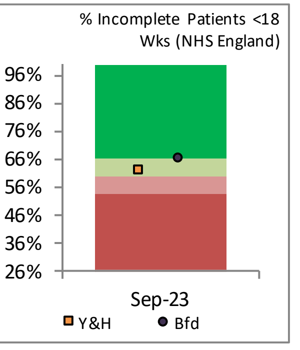
Emergency Care Standard (ECS) performance was at 72.96% for October 2023, which remains above peer and national average. Admissions from ED into the hospital remain stable and improvement plans to increase admission avoidance continue. Initial assessment and patient flow improvements are being sustained. Further improvement anticipated as the urgent care centre and the New Ambulatory Emergency Care Unit progress and ED is decongested.



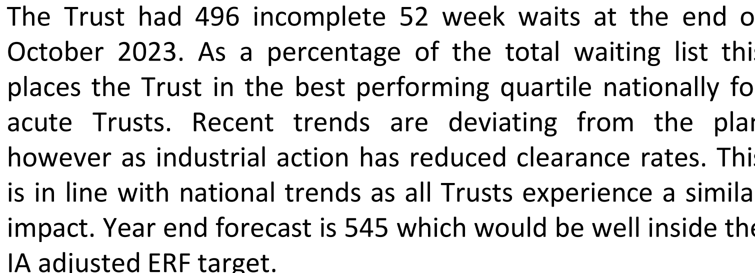
RTT 18 Week Incomplete



RTT performance continues above peer and national average. Theatre activity is higher than during the pandemic but slightly below 2019-20 baselines. Theatre productivity is reviewed weekly and improvement actions are being progressed to reduce delays and increase throughput. A theatre recovery meeting with Executive oversight has been established to support this.



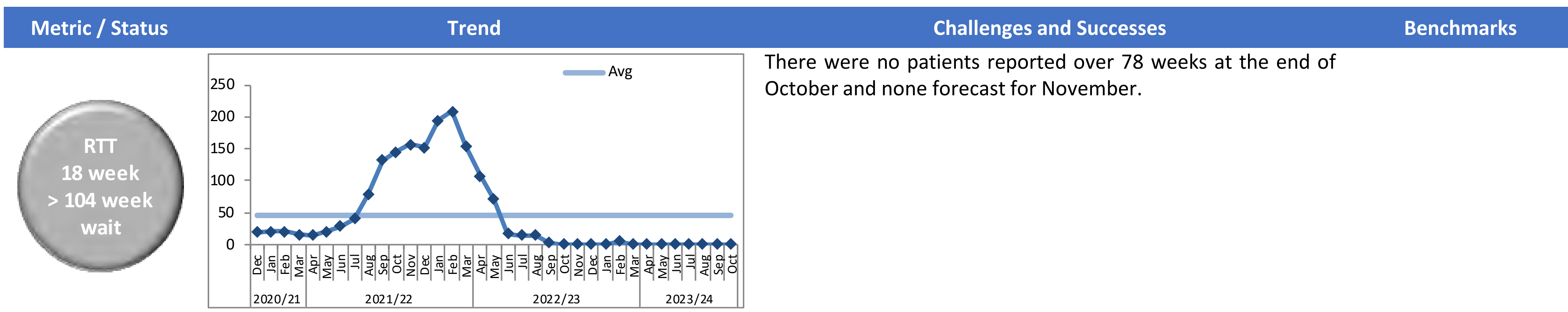
RTT 52 Week Wait



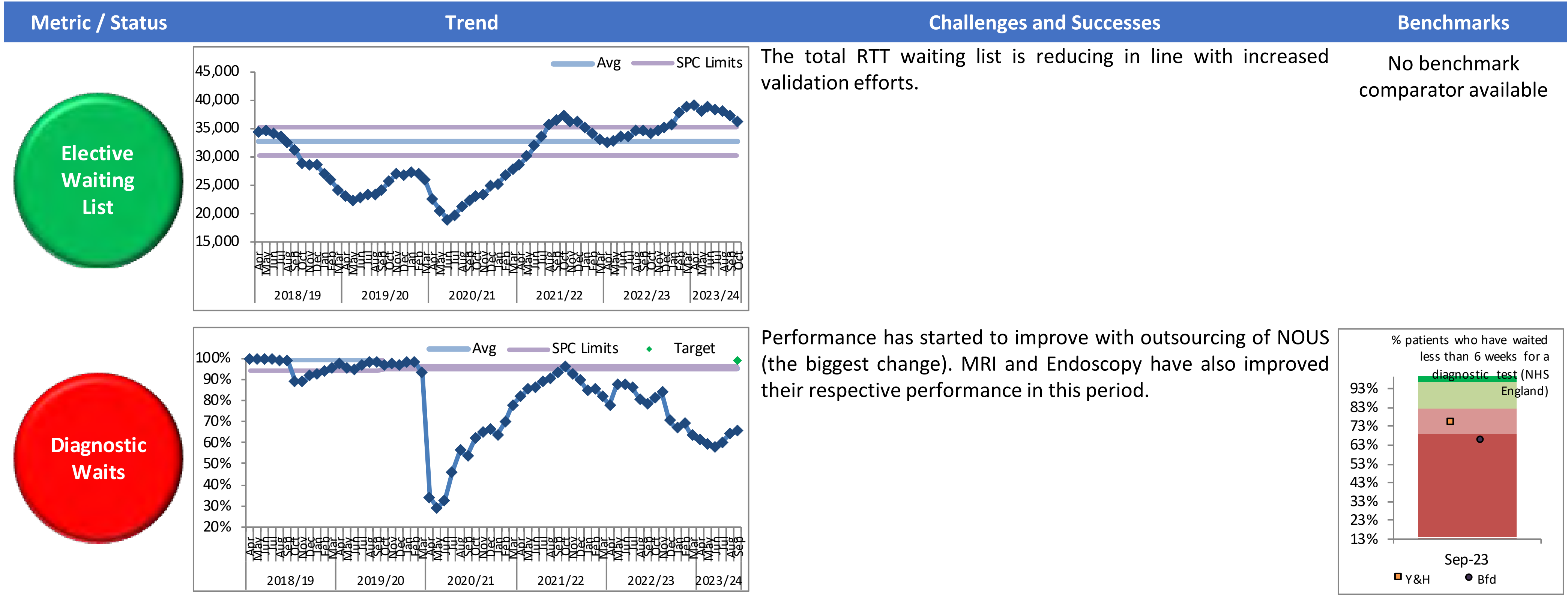
The Trust had 496 incomplete 52 week waits at the end of October 2023. As a percentage of the total waiting list this places the Trust in the best performing quartile nationally for acute Trusts. Recent trends are deviating from the plan however as industrial action has reduced clearance rates. This is in line with national trends as all Trusts experience a similar impact. Year end forecast is 545 which would be well inside the IA adjusted ERF target.

No benchmark comparator available

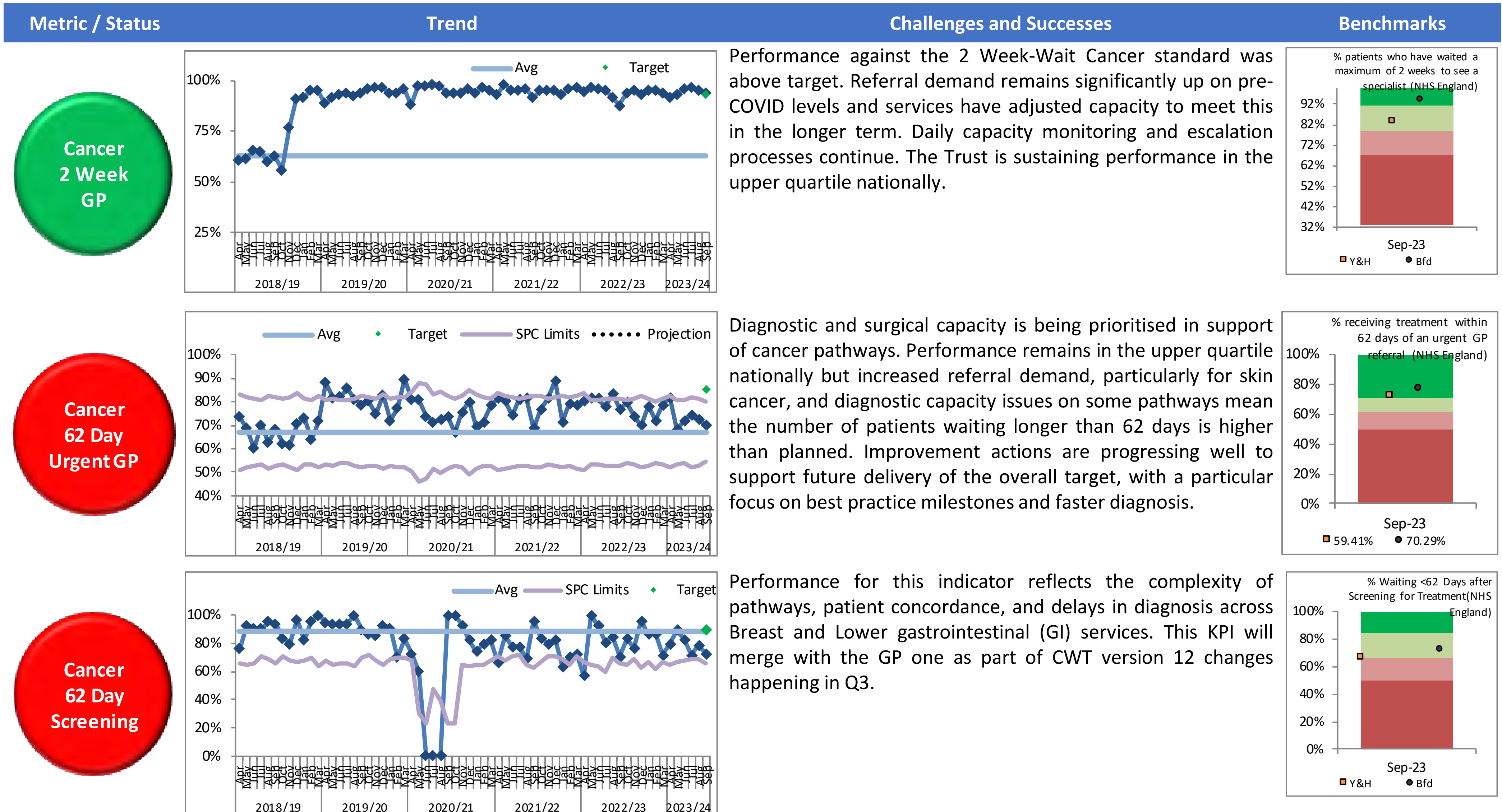
To deliver our key performance targets and financial plan
Performance

Metric / Status	Trend	Challenges and Successes	Benchmarks
RTT 18 week > 104 week wait		There were no patients reported over 78 weeks at the end of October and none forecast for November.	

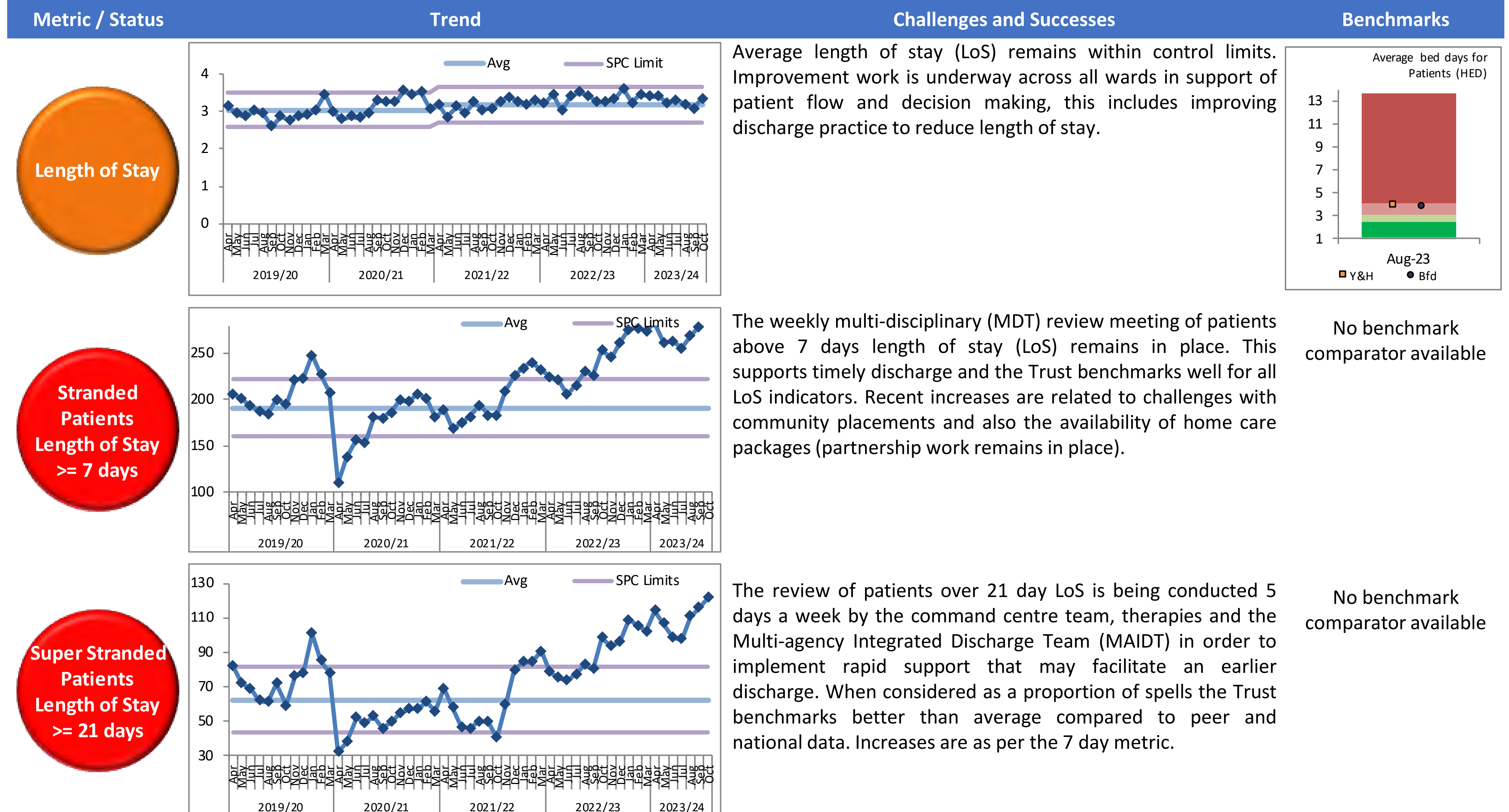
To deliver our key performance targets and financial plan
Performance



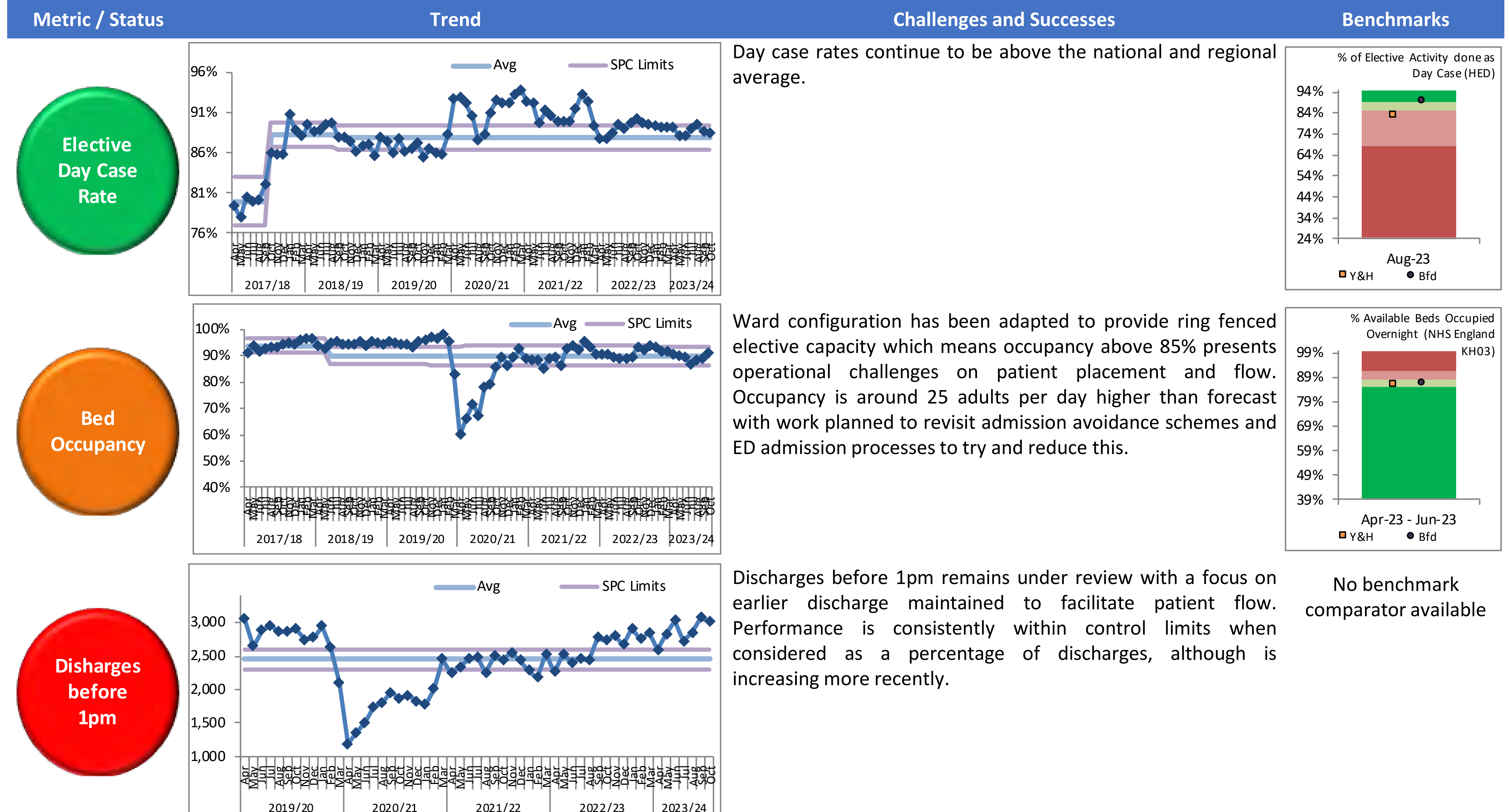
To deliver our key performance targets and financial plan
Performance



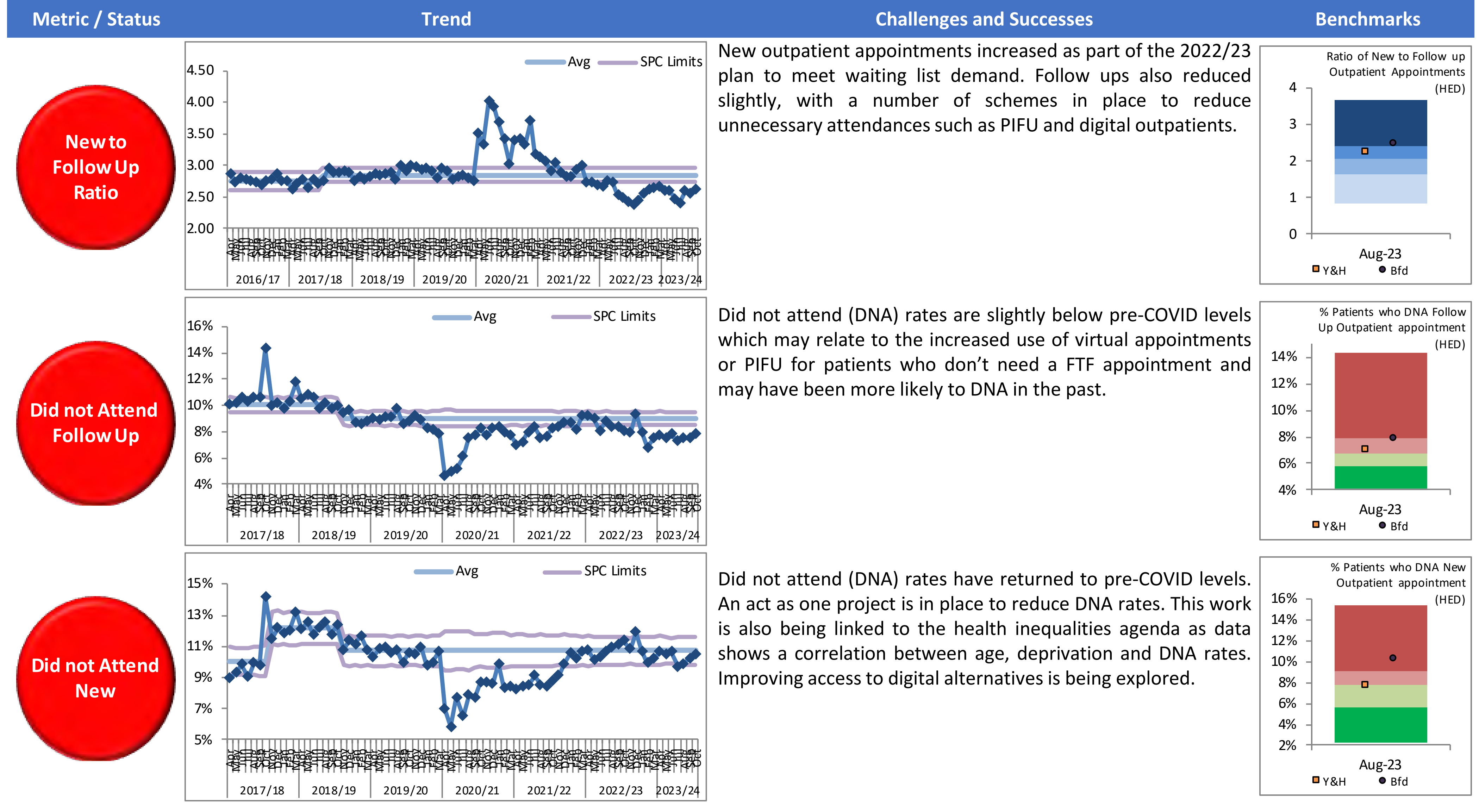
To deliver our key performance targets and financial plan
Productivity



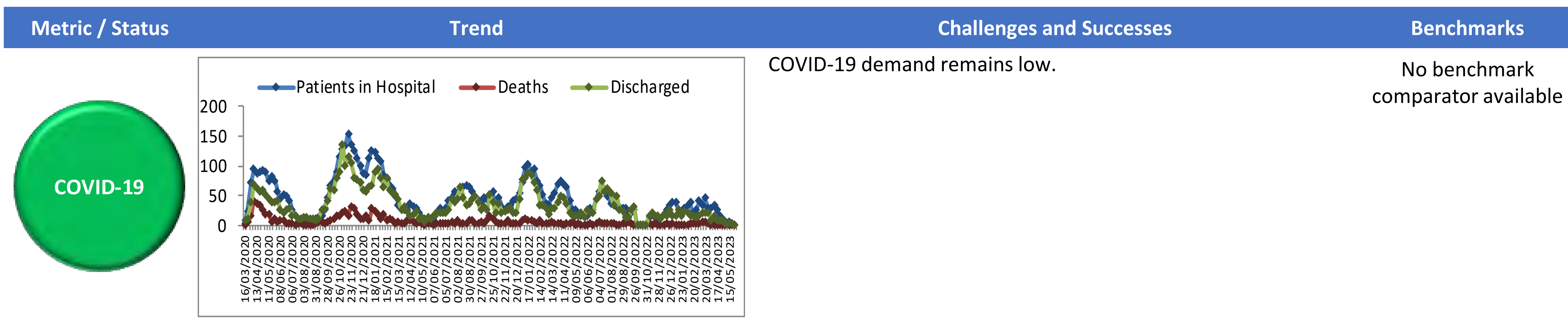
To deliver our key performance targets and financial plan
Productivity



To deliver our key performance targets and financial plan
Productivity

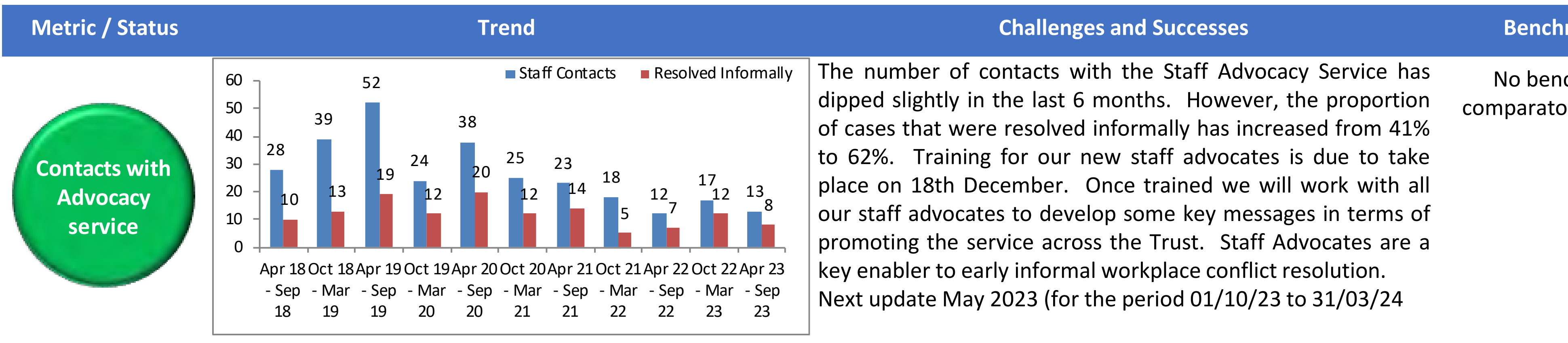


Covid-19



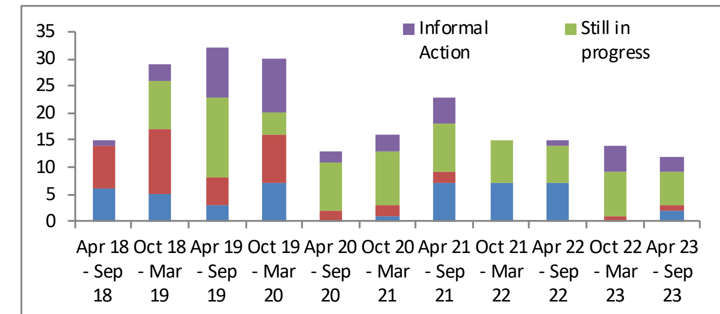
Metric / Status	Trend	Challenges and Successes	Benchmarks
COVID-19		COVID-19 demand remains low.	No benchmark comparator available

To be in the top 20% of employers
Engagement



The number of contacts with the Staff Advocacy Service has dipped slightly in the last 6 months. However, the proportion of cases that were resolved informally has increased from 41% to 62%. Training for our new staff advocates is due to take place on 18th December. Once trained we will work with all our staff advocates to develop some key messages in terms of promoting the service across the Trust. Staff Advocates are a key enabler to early informal workplace conflict resolution.
Next update May 2023 (for the period 01/10/23 to 31/03/24

No benchmark comparator available

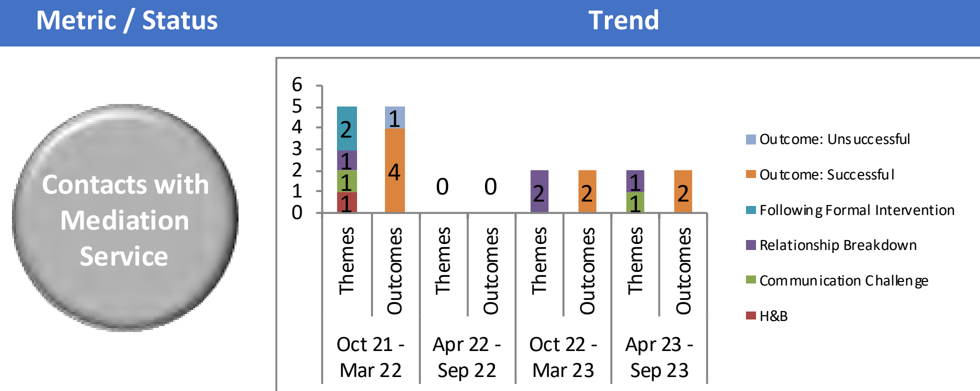


The number of formal cases has stayed fairly static since the last 6 month update. Of the 6 cases that were completed during the period 50% resulted in some form of “informal action” (e.g. recommendation for mediation). 17% (just 1 case) resulted in disciplinary action and 33% (2 cases) resulted in no case to answer. There are currently a further 6 cases that are still in progress. Our Trust wide civility in the workplace campaign is making excellent progress. The Introduction of a new people charter, workplace mediation service, refresh of the staff advocacy service, EDI training for line managers, poster campaign, refresh of the harassment & bullying policy and drama based training based around case studies will all play a crucial role in the wider culture change required to reduce the number of formal cases, with a focus on “nipping issues in the bud” at an early stage.
Next update May 2023 (for the period 01/10/23 to 31/03/24

No benchmark comparator available

To be in the top 20% of employers
Equality & Diversity

Metric / Status	Trend	Challenges and Successes	Benchmarks

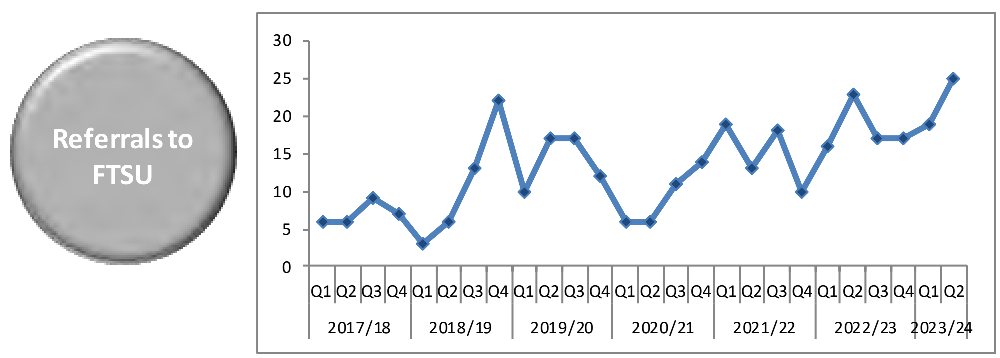


* (please see narrative)

2 referrals have resulted in mediation taking place over the last 6 months. Both cases resulted in some level of success, which is positive. 1 further case being pursued resulted in both parties resolving their issues prior to interactive mediation session. There are two cases currently in the pipeline, including one case that is a planned as a follow-up mediation. Mediation provides a crucial role in supporting staff to deal with any workplace disagreements/conflict and is an important tool for ‘nipping issues in the bud’. The mediation service will become a key component of the newly developed Respect, Civility and Resolution policy and process when it is finalised over the next couple of weeks.
Next update May 2023 (for the period 01/10/23 to 31/03/24

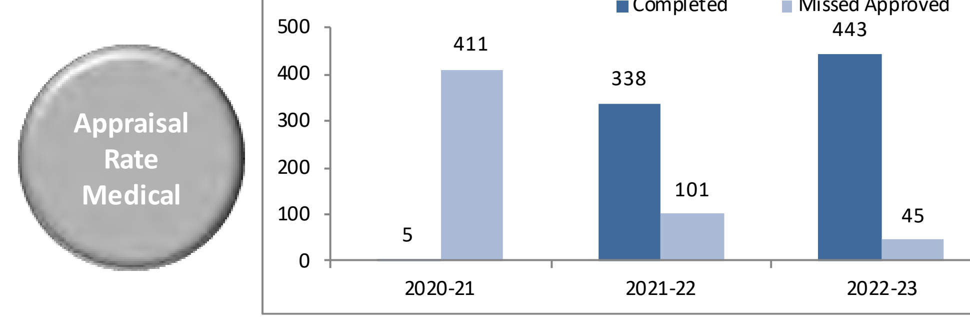
To be in the top 20% of employers
Engagement

Referrals to FTSU



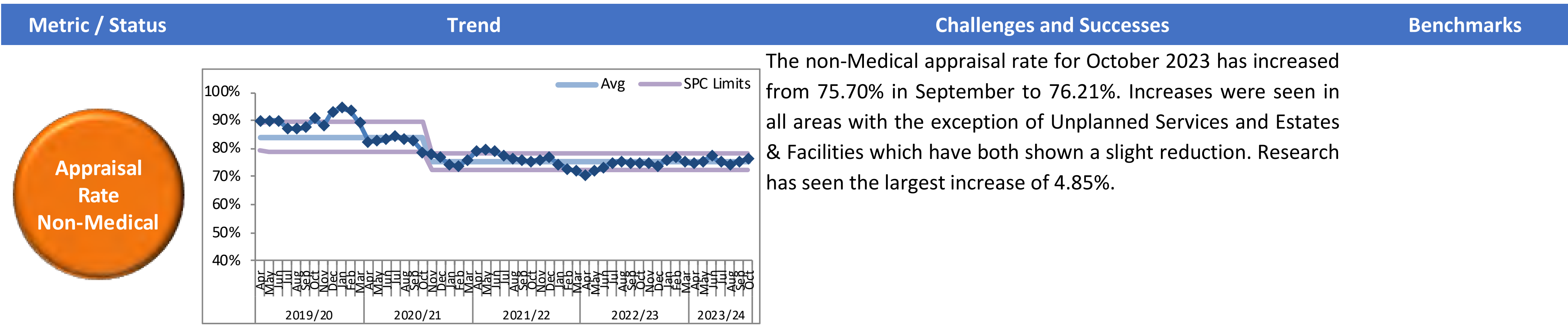
In Q2 there were 25 concerns raised to the Freedom to Speak Up team. 3 concerns were raised anonymously via the FTSU app. Anonymous concerns are dealt with on an individual basis; the National Guardian's office advocate that staff should be able to raise concerns anonymously if necessary.
Of the 25 concerns* raised in Q2, 10 concerns were raised due to patient safety, 8 concerns were raised due to inappropriate attitudes and behaviours, 3 for bullying and harassment and 7 for worker safety or wellbeing. (*- some concerns have more than one category).

Appraisal Rate Medical



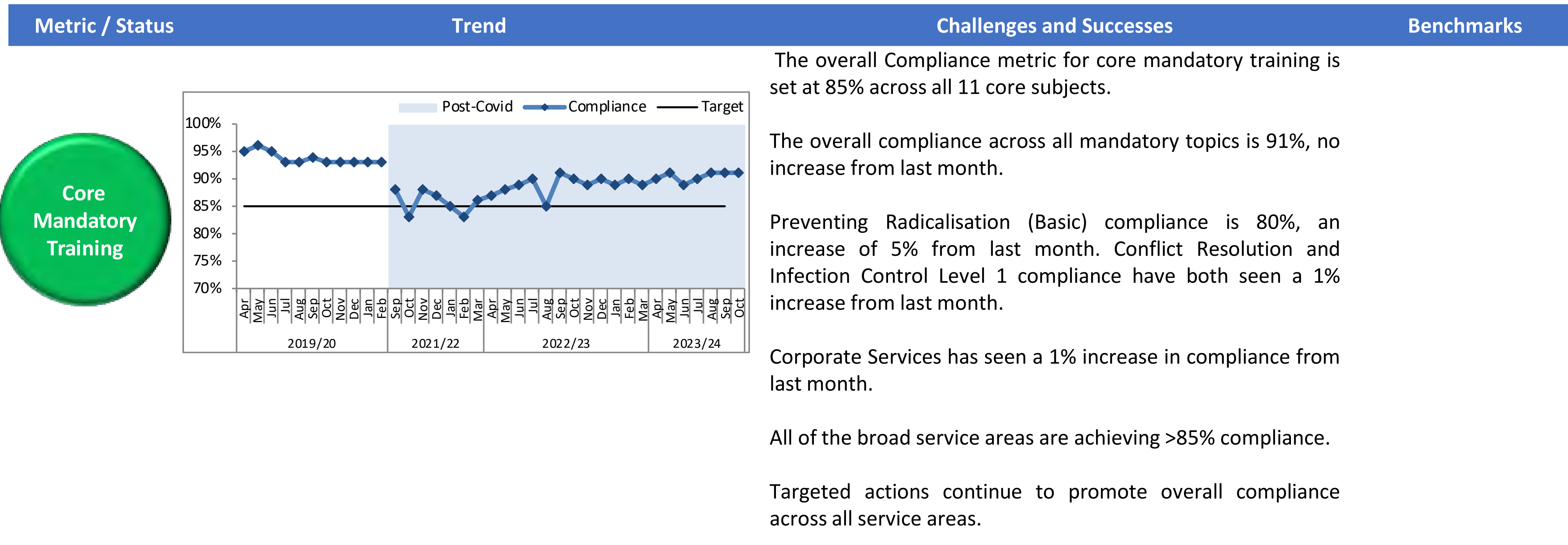
Suspended following the onset of Covid.
At 31st March 2023, 488 doctors had a prescribed connection with the Trust. This was comprised of:
340 Consultant staff
38 Specialty doctor grades
110 Doctors with temporary or short-term contracts.
For the appraisal year 2022-2023:
443 (90.78%) doctors received an Outcome Measure 1 (Completed appraisal).
43 (8.81%) doctors were allocated an Outcome Measure 2 (Approved Missed appraisal). This includes doctors on long-term sick leave, maternity leave, recent retirements and new connections at 31st March 2023 who have not been in post for a sufficient duration to have undertaken the appraisal process.
There were 2 Outcome Measure 3 appraisals (0.41%) (Unapproved Missed) for this period.
The AOA and board sign off has been submitted to NHSE
All doctors with a prescribed connection have been allocated an appraisal month for 2023-24.

To be in the top 20% of employers
Engagement



The non-Medical appraisal rate for October 2023 has increased from 75.70% in September to 76.21%. Increases were seen in all areas with the exception of Unplanned Services and Estates & Facilities which have both shown a slight reduction. Research has seen the largest increase of 4.85%.

To be in the top 20% of employers
Training & Development



The overall Compliance metric for core mandatory training is set at 85% across all 11 core subjects.

The overall compliance across all mandatory topics is 91%, no increase from last month.

Preventing Radicalisation (Basic) compliance is 80%, an increase of 5% from last month. Conflict Resolution and Infection Control Level 1 compliance have both seen a 1% increase from last month.

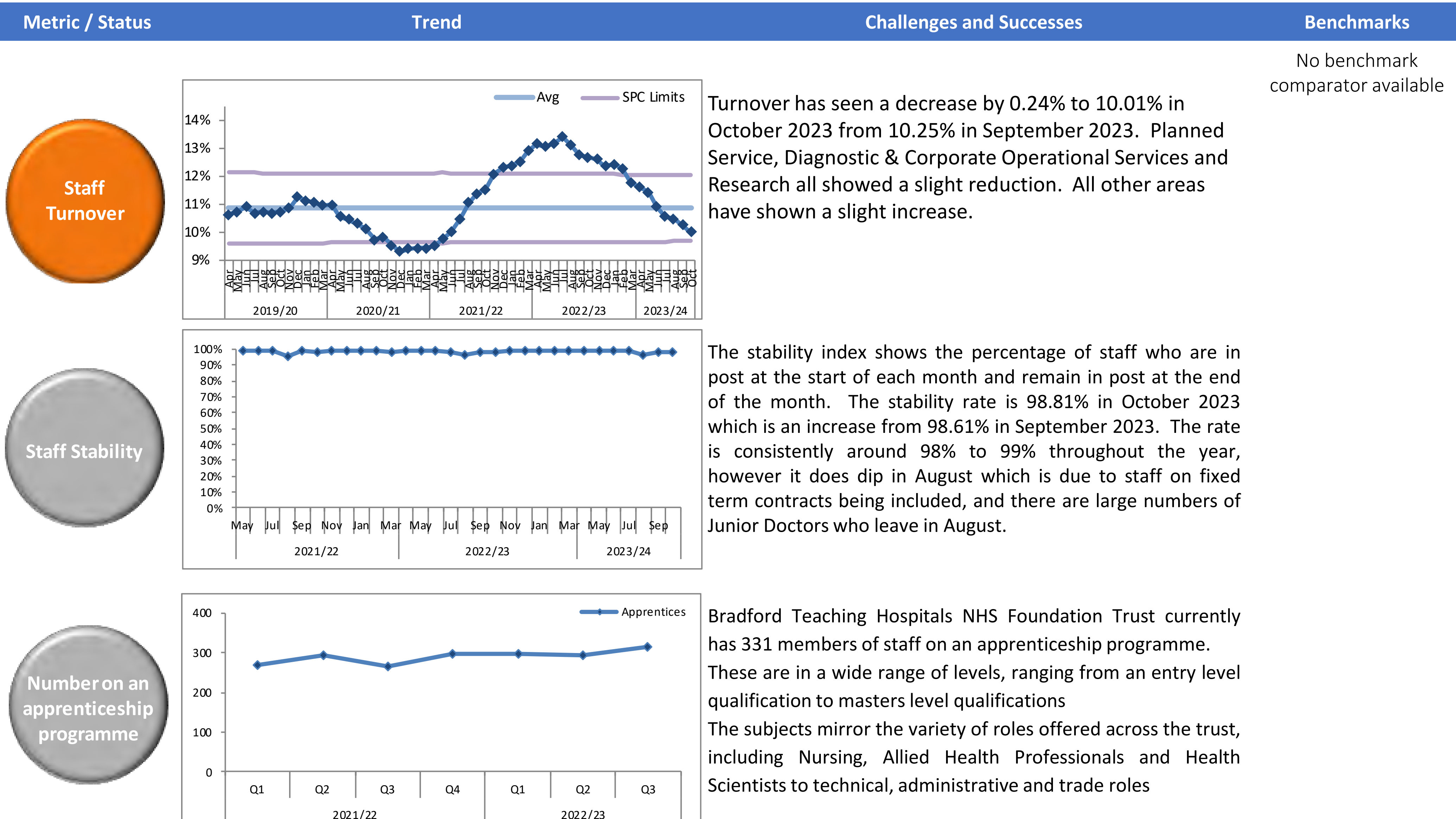
Corporate Services has seen a 1% increase in compliance from last month.

All of the broad service areas are achieving >85% compliance.

Targeted actions continue to promote overall compliance across all service areas.

To be in the top 20% of employers
Staffing

Metric / Status	Trend	Challenges and Successes	Benchmarks



No benchmark comparator available

Turnover has seen a decrease by 0.24% to 10.01% in October 2023 from 10.25% in September 2023. Planned Service, Diagnostic & Corporate Operational Services and Research all showed a slight reduction. All other areas have shown a slight increase.

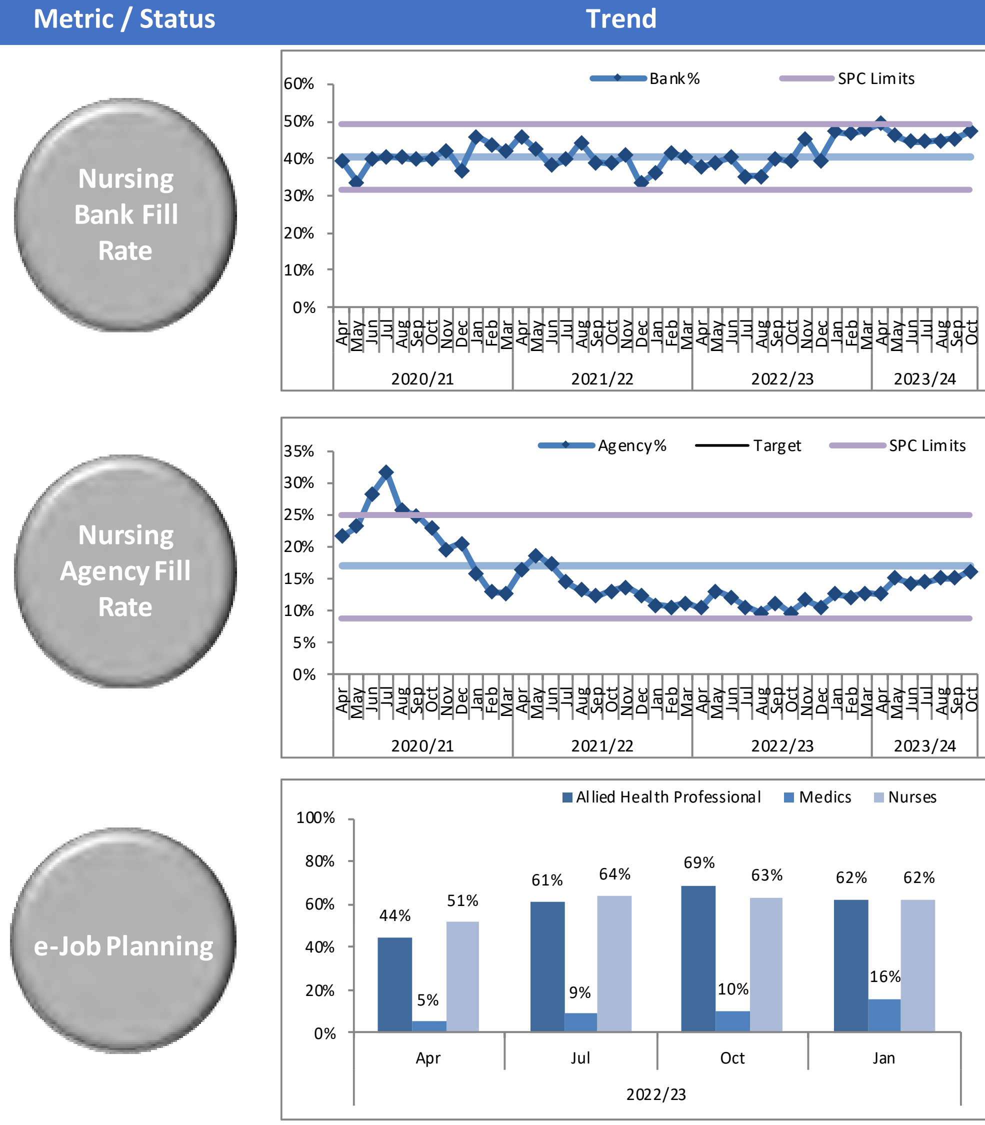
The stability index shows the percentage of staff who are in post at the start of each month and remain in post at the end of the month. The stability rate is 98.81% in October 2023 which is an increase from 98.61% in September 2023. The rate is consistently around 98% to 99% throughout the year, however it does dip in August which is due to staff on fixed term contracts being included, and there are large numbers of Junior Doctors who leave in August.

Bradford Teaching Hospitals NHS Foundation Trust currently has 331 members of staff on an apprenticeship programme. These are in a wide range of levels, ranging from an entry level qualification to masters level qualifications

The subjects mirror the variety of roles offered across the trust, including Nursing, Allied Health Professionals and Health Scientists to technical, administrative and trade roles

To be in the top 20% of employers
Staffing

Metric / Status	Trend	Challenges and Successes	Benchmarks

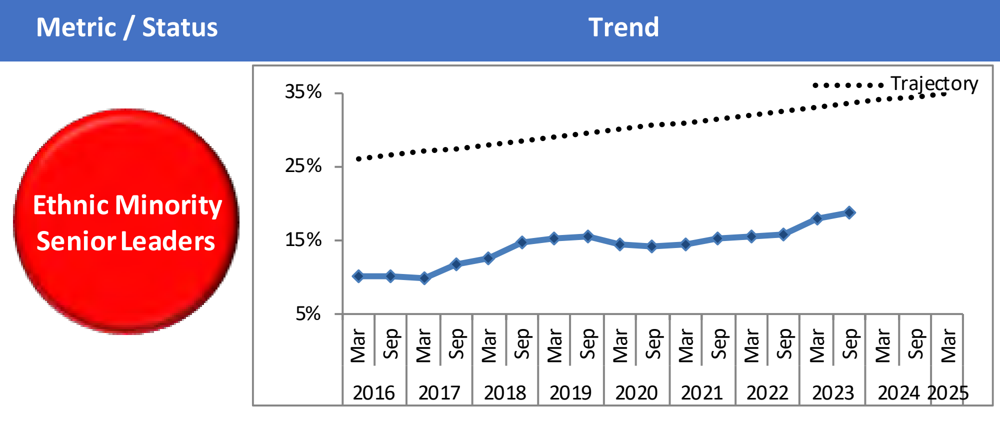
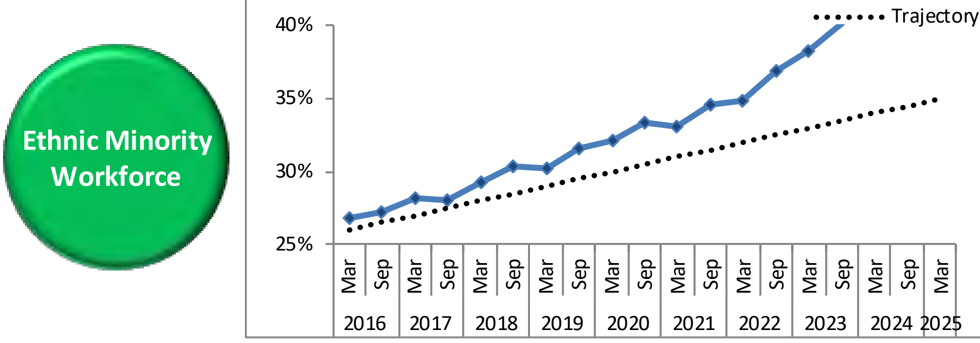


In September the total number of requests sent to bank was 12370 compared with Augusts requests of 13028 a decrease of -658 requests. This is split as 5417 requests for registered staff and 6953 requests for unregistered staff. Of those 12370 requests a total of 7487 were filled by bank staff which is 60.5% compared with 59.4% in August – a increase of 1.1%. 2456 are filled by registered and 5031 filled by unregistered staff. Out of the 5417 requests for registered staff, the filled shifts were 2456 (45.3%) and for the 6953 requests for unregistered staff the filled shifts were 5031 (72.4%). Compared with August, fill rates increased by 0.6% for registered and increased by 1.2% for unregistered. Out of the 2456 filled registered shifts, 415 were filled by registered Theatre staff.

Agency staff filled 822 shifts in the month of September. This is split 819 registered and 3 unregistered staff. Out of the 819 filled registered shifts, 221 were filled with registered theatre staff. In September Agency fill rates increased by .1% for registered staff and decreased by 0 for unregistered staff.

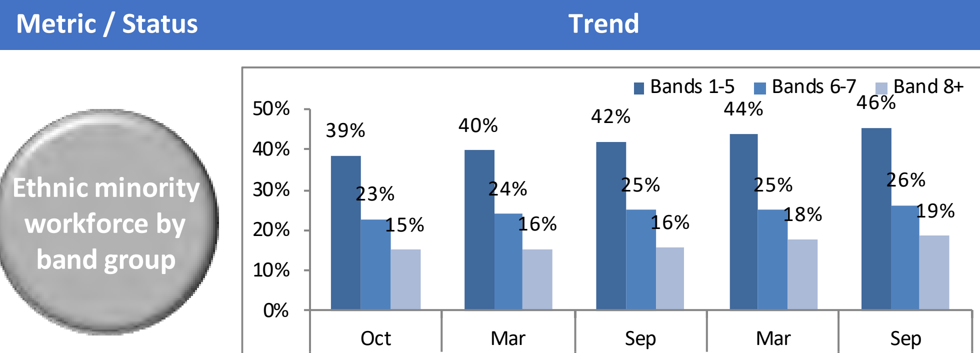
This data highlights the percentage of signed off job plans within the electronic system. Medics (consultants/specialist doctors), Allied Health Professionals and Nurses (Clinical Nurse Specialists) are all required to have a signed off job plan. There are currently 906 clinicians registered within the system, all with a job plan either in progress or signed off. This figure is made up of 375 Medics, 351 AHPs and 180 Nurses. The focus going forward is to continue to improve on the amount of job plans signed off within each CSU. There has been a dip in Signed off job plans possibly because these have been put back into discussion but there has been an increase of 19 job plans in review and 65 awaiting the 2nd sign off, which indicates job plans are being published and reviewed following steering group and face to face training

To be in the top 20% of employers
Equality & Diversity

Metric / Status	Trend		Benchmarks
Ethnic Minority Senior Leaders		A further slight increase in our Ethnic Minority representation at Senior Management levels over the last 6 months which has risen from 17.84% to 18.67%. At our current rate of trajectory, achieving our ambition to have a senior workforce reflective of the local population (35% by 2025) continues to be challenging. However, this continues to be a key focus of our WRES action plan, as we continue to focus our efforts on providing development opportunities for aspiring leaders from an ethnic minority background and in ensuring we consider positive action approaches to recruitment for senior level roles as they arise. Next update May 2023 (for the period 01/10/23 to 31/03/24	No benchmark comparator available
Ethnic Minority Workforce		The proportion of Ethnic Minority staff in the workforce has increased again in the last 6 months from 38.22% to 40.24%. We continue to exceed our target of having an overall workforce reflective of the local population (35%). Our focus in going forward will be to ensure we achieve this representation at all levels in the organisation. Next update May 2023 (for the period 01/10/23 to 31/03/24	No benchmark comparator available

To be in the top 20% of employers
Equality & Diversity

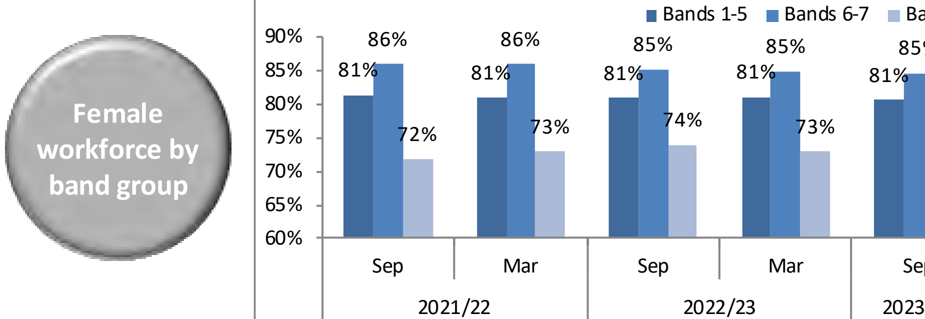
Metric / Status	Trend	Challenges and Successes	Benchmarks



The data shows that the over-representation of ethnic minority staff in the lower bands (Bands 1-5) has increased again from 44% 45.59%. Above Band 5 there continues to be an under-representation. However, we have seen a slight reduction in this under-representation in the last 6 months, including slight increase from 25.14% to 26.39% for Bands6/7.

Our WRES action plan continues to focus on engaging with the race equality staff inclusion network in ensuring that development offers meet the needs of our ethnically diverse staff and with consideration of some targeted approaches for staff at Bands 2-7.

Next update May 2023 (for the period 01/10/23 to 31/03/24

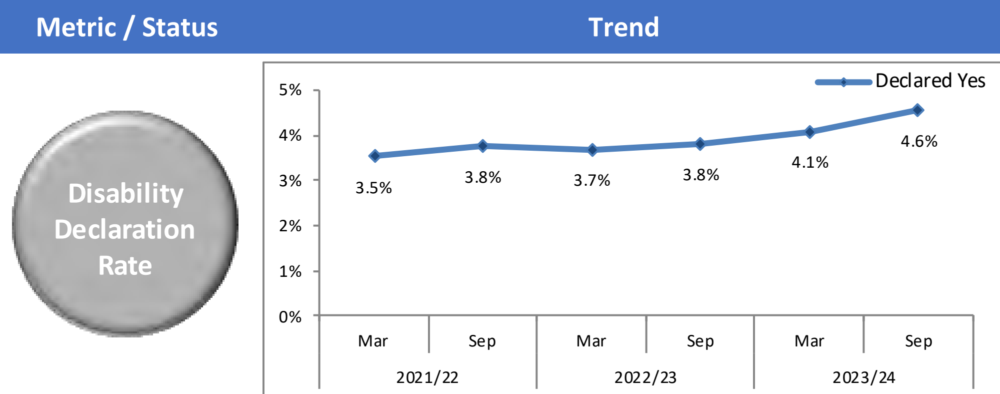


Females currently make up 81% of our non-medical workforce. Whilst they are proportionately represented at lower levels (80.64%), they continue to be under-represented at senior levels (72.70%) and slightly over-represented at middle management levels (84.72%). With no real change in the data this position has stayed roughly the same for the last 12 months.

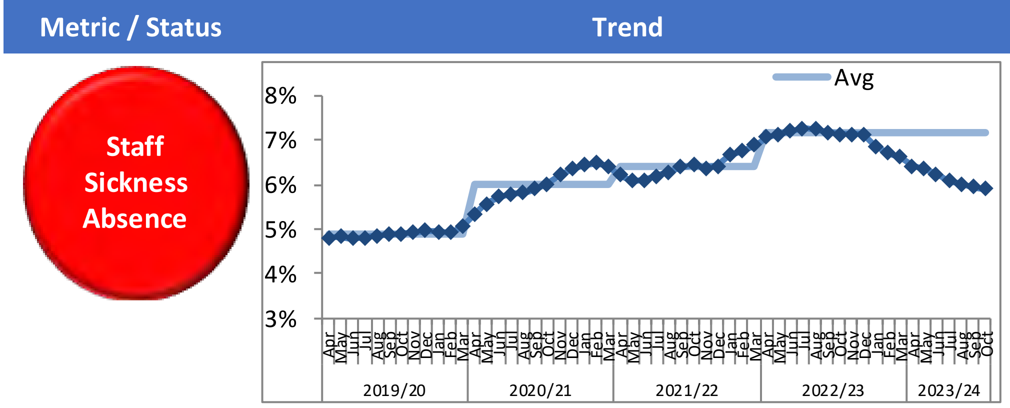
We will be working collaboratively with our gender equality reference group and the wider ICS over the next few months to address gender inequalities in the workplace, with focus on women in leadership and addressing potential blockages to development.

Next update May 2023 (for the period 01/10/23 to 31/03/24

To be in the top 20% of employers
Equality & Diversity

Metric / Status	Trend	Challenges and Successes	Benchmarks
Disability Declaration Rate		Our current disability declaration rate as recorded in the Electronic Staff Record (ESR) has remained fairly static at around 4% since we commenced reporting this for the Workforce Disability Equality Standard (WDES) in 2018. There has been a small but positive increase in this percentage over the last 6 months up to 4.56%. However, whilst the 2022 staff survey results only represent 37% of our workforce, there continues to be a much higher proportion of staff survey respondents (c. 25% in 2022) who declared a disability/ long term health condition, indicating there may be a number of staff who are not declaring their status in ESR. We continue to work with our Enable staff network in increasing confidence to declare a disability. The WDES Innovation Fund display and video has been shared widely on a regional and national basis, and with a number of events taken place across the Trust to raise the profile of disability equality and managing long-term health conditions. This has been really helpful in raising the profile of EDI across the Trust and has recently generated lots of interest from wider staff in joining the Enable network and with staff registering their interest for key roles within the network core group. Next update May 2023 (for the period 01/10/23 to 31/03/24	

To be in the top 20% of employers
Health & Wellbeing

Metric / Status	Trend	Challenges and Successes	Benchmarks
		The rolling 12-month sickness absence rate at the end of October 2023 was 5.91% compared to 5.96% in September. Decreases were seen in all areas of the Trust apart from Planned Services and Corporate Services which have shown a slight increase. The largest decrease seen in Estates & Facilities. Monthly absence in October increased to 6.12% from 5.60% in September. Sickness target agreed at the Looking After Our People Group in March at 5.5% Which has been approved by ETM.	

To collaborate effectively with local and regional partners
Partnership

Metric / Status	Trend	Challenges and Successes	Benchmarks
Reducing Inequalities		Significant activity across the Trust to address inequalities in access, experience and outcomes, continues. We are collating information from CSUs and identifying opportunities to share best practice. An analysis of waiting times to understand the impact of factors (including ethnicity and deprivation) showed variation in referral rates that is being investigated. Health Inequalities has a dedicated section in the new EDI Strategy (published June 2023) and 5 priorities have been agreed and published in this strategy. These are "making HIs a priority of focus for our teams", "utilising data", "our role as an anchor organisation", "care based on population profiles" and "collaboration with other organisations to address HIs". An action plan aligned to these workstreams has been refreshed. An Anchor Institution Assessment for BTHFT has been carried out to understand any potential areas of focus. The Health Equity Assessment Tool (HEAT) training module has been integrated into ESR and communicated across the Trust. BTHFT is a member of BD&C Reducing Inequalities Alliance, RIC Steering Group, and inequalities is now a standing item on the Equality & Diversity Council agenda	No benchmark comparator available
Act as One Place		BD&C Health & Care Partnership was formally established with a renewed focus on five topics: Children, Young People and Families; Workforce Development; Communities; Access to Care; Mental Health, LD & Neurodiversity. BTHFT supports these priorities and is prominent in the diabetes and respiratory transformation work although these are no longer discrete programmes. All BD&C HCP activity is aligned to the Core 20 plus 5 inequalities approach. The implications of the reduction in funding through the ICB mean that the workforce is under review, with redundancies among ICB staff expected. Some of the priority programmes may have to review current workload to ensure it is manageable with the revised staffing figures.	No benchmark comparator available
ICB & WYAAT		BTHFT is actively involved in new and existing clinical and operational networks, and discussions about sustainability of WY-wide services. For example, the future of non-surgical oncology, with the intention of consolidating provision of the service across WY. Agreement has been reached on a joint approach to the provision of aseptic services, with a super hub at Leeds and further investment in BTHFT's "spoke". Work is progressing to consider the implications and how efficiencies across the ICB might be made. The Trust's status as one of 10 national test and evaluation sites of the NHS Clinical Entrepreneur Programme alongside Leeds Teaching Hospitals has created an opportunity to develop a WYAAT-wide approach to innovation – discussions on how best to progress this are underway.	No benchmark comparator available
Anchor Institution		Act as One enables BTHFT to work with partners to address the big issues that affect the health of local people. We have programmes to widen access to employment e.g. Project Search, Apprenticeships, improving Band 8/8+ BAME representation at BTHFT and school outreach projects. A new initiative was launched in September 2023 and is the partnership, as a Bradford Place, with Generation Medics in a project aimed at assisting young people from underprivileged communities into careers in health and social care. The Bradford Inequalities Research Unit (BIRU) is also taking a data driven approach to understand poor detection rates and management of chronic illnesses and premature mortality. BTHFT is supporting the new "Alliance for Life Chances" which brings together system partners with a focus on early years, educational attainment & employment prospects	No benchmark comparator available

Glossary

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
To provide outstanding care for patients, delivered with kindness				
Clinical Effectiveness				
Crude Mortality	Crude Mortality rates, i.e., per admissions.	Chief Medical Officer	Red – Latest 2 points in a row above upper control limit, Amber – latest point above upper control limit, Green – Below upper control limit	3.9
HSMR	The mortality indicator is evaluated from a standardised mortality ratio (SMR). The formula for the ratio is observed deaths divided by expected deaths, multiplied by 100. This is calculated for each provider within the data.	Chief Medical Officer	Red Benchmark 3 standard deviations above mean, Amber 2 standard deviations above mean, Green within two standard deviations above mean	4.7
SHMI	The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	Chief Medical Officer	Red Benchmark 3 standard deviations above mean, Amber 2 standard deviations above mean, Green within two standard deviations above mean	4.7
Stillbirths	Number of stillbirths per 1,000 births and number of stillbirths over 500g per 1,000 births	Chief Nurse	Red > 7, Amber 5 - 7, Green < 5	To be confirmed
Deaths Screened	Percentage of Deaths Screened	Chief Medical Officer	Red Two consecutive points outside control limits, Amber Outside control limits, Green Within control limits	To be confirmed
Learning from Deaths	Proportion of reviews undertaken finding good or excellent care provided	Chief Medical Officer	Red Two consecutive points outside control limits, Amber Outside control limits, Green Within control limits	To be confirmed
Readmissions	The number of readmissions within 30 days of discharge from hospital.	Chief Medical Officer	Red bottom 25% of Trusts, Amber middle 50% of Trusts, Green Lowest 25% of trusts	2.4

Glossary Continued

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
Patient Safety				
Never Events	The number of serious incidents that occur despite there being defined processes and procedures to prevent them.	Chief Medical Officer	Red > 0, Green = 0	4.0
Audit of WHO checklist	Audit of the World Health Organisation surgical checklist monitoring the number that were complete compared to the number of checklists.	Chief Medical Officer	Red < 90%, Amber >=90% & < 95%, Green >=95%	2.9
Clostridium Difficile (C. Diff)	The number of cases either attributable or pending review.	Chief Nurse	Red >= 3, Amber = 2, Green <=1	3.9
MRSA	Counts of patients with Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia.	Chief Nurse	Per month: Red >= 1, Green 0	3.9
CAUTI	Urinary tract infections in patients with a catheter. The benchmarking data comes from the Safety Thermometer prevalence information.	Chief Nurse	Red > 1.5%, Amber 1%-1.5%, Green < 1%	4.1
Sepsis Patients antibiotics	Percentage of patients who were found to have sepsis during the screening process and received IV antibiotics within 1 hour.	Chief Nurse	RAG criteria subjective – Executive informed.	To be confirmed
Sepsis Patients Screened	Percentage of patients screened for Sepsis	Chief Medical Officer	Red < 50%, Amber 50%-90%, Green >= 90%	5.0
Pressure Ulcers Cat3+	Number of reported hospital acquired category 3 and 4 pressure ulcers per 10,000 bed days. The benchmarking data comes from the Safety Thermometer prevalence information.	Chief Nurse	Red >= 6, Amber 5, Green < 5	4.3
Serious Incidents	Unexpected or avoidable death, serious harm, never events, service delivery prevention compared to all incidents reported.	Director of Strategy and Integration	Red > 5, Amber 3-5, Green <=2	4.0
Falls with Harm	Patient falls resulting from harm per 10,000 bed days. The benchmarking data comes from the Safety Thermometer prevalence information.	Chief Nurse	Red upper quartile, Amber mid quartiles, Green lower quartile	4.3
Falls with Severe Harm	Falls with Harm classed as Severe	Chief Nurse	Red = reported for consecutive months, Amber = 1, Green = 0	4.3
Missed Doses	Proportion of patients with an omission of a critical medicine	Chief Nurse	Red - above national average Amber – 0 - <1% below the average Green - > 1%+ the national average	3.9

Glossary Continued

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
Patient Experience				
Friends and Family Test	The percentage of patients who strongly recommend the Trust.	Chief Nurse	RAG criteria subjective – Executive informed.	2.6
Complaints	Number of complaints.	Chief Nurse	Red >= 50, Amber 40-49, Green < 40	4.7

Glossary Continued

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
To deliver our financial plan and key performance targets				
Finance				
Delivery of Income & Expenditure Plan	Delivery of finances against plan.	Director of Finance	Red – off plan (adverse) Green on plan or better	3.3
Use of Resources – Financial	Use of resources is a calculation on the status of a number of financial measures – Capital Servicing Capacity, Liquidity, I & E Margin, and Agency Spend.	Director of Finance	Red - Rating of 4 Amber – Rating of 2 or 3 Green – Rating of 1	3.3
Delivery of Cash Plan	Delivery of cash against plan.	Director of Finance	Red Cash below £5m Amber Cash between £5m & £10m Green Cash over £10m	3.3
Liquidity Rating	A measure of how many days an organisation can continue to fund its operations based on the level of net current assets and available borrowing.	Director of Finance	Red - minus 14 days liquidity Amber - 0 days to minus 14 days liquidity Green – greater than 0 days liquidity	4.1

Glossary Continued

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
Performance				
Emergency Care Standard	Percentage of patients seen in A&E within 4 hours.	Chief Operating Officer	Red < 90%, Green >= 90%	2.4
RTT 18 weeks Incomplete	Percentage of patients waiting within 18 weeks on an incomplete pathway.	Chief Operating Officer	Red < 92%, Green >= 92%	3.9
RTT 52 weeks waits	Number of patients waiting more than 52 weeks.	Chief Operating Officer	Red > 0, Green = 0	4.0
Elective wait list	Wait list of patients on an elective pathway.	Chief Operating Officer	Red Greater than last month Green Less than last month	3.7
Diagnostic Waits	Percentage of patients who have waited less than 6 weeks for a diagnostic test.	Chief Operating Officer	Red < 99%,Green >= 99%	3.4
Cancer 2 week wait GP	Percentage of patients who have waited a maximum of 2 weeks to see a specialist for all patients referred with suspected cancer symptoms	Chief Operating Officer	Red < 93%, Green >= 93%	3.9
Cancer Urgent 62 day GP	Proportion of patients receiving treatment for cancer within 62 days of an urgent GP referral for suspected cancer.	Chief Operating Officer	Red < 85%, Green >= 85%	3.9
Cancer Urgent 62 day Screening	Proportion of patients receiving treatment for cancer within 62 days of an NHS Cancer Screening service.	Chief Operating Officer	Red < 96%, Green >= 96%	3.9
Full Blood Count acute wards 2 hours	The time taken for the laboratory to process Full Blood Counts samples from all Acute Wards and validated results are available on the Laboratory Information Management System (LIMS). The time measured is from the sample being booked on to the LIMS and results being validated on the LIMS and available to requestors	Chief Operating Officer	Red <85%, Amber >=85% & < 90%, Green >=90%	3.9

Glossary Continued

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
Productivity				
Length of Stay	The average length of stay for patients, in days.	Chief Operating Officer	Red Top 25% of Trusts, Amber 50-75% of Trusts, Green Better than mean	2.0
Stranded Patients LoS >=7	The average number of patients (excluding Maternity) who have been in hospital 7 days or more.	Chief Operating Officer	Red >208, Amber 189-207, Green <= 189	4.1
Super Stranded Patients LoS >=21	The average number of patients (excluding Maternity) who have been in hospital 21 days or more.	Chief Operating Officer	Red >71, Amber 62-71, Green <= 62	4.1
Elective Day Case Rate	The number of patients admitted for planned procedure and leave same day as a % of all procedures.	Chief Operating Officer	Red < 83%, Amber <87% & >=83% ,Green >= 87%	1.0
Bed Occupancy	Average percentage of available beds which were occupied overnight.	Chief Operating Officer	Red >=95%, Amber 85-95%, Green <85%	2.3
Discharges before 1pm	Number of discharges from hospital which happened before 1 pm.	Chief Operating Officer	Red = Outside control limits, Green = Inside control limits	2.3
New to Follow-up Ratio	The ratio between New and Follow Up Outpatient appointments. Benchmarking data is from HED, which has a subtly different calculation, which can result in very small differences in numbers.	Chief Operating Officer	Red < 50th Percentile England, Amber 50 – 25th Percentile, Green Upper Quartile England	2.4
DNA Follow-up	This is the % of Follow-up Outpatient appointments where the patient does not attend.	Chief Operating Officer	Red < 50th Percentile England, Amber 50 – 25th Percentile, Green Upper Quartile England	2.6
DNA New	This is the % of New Outpatient appointments where the patient does not attend.	Chief Operating Officer	Red < 50th Percentile England, Amber 50 – 25th Percentile, Green Upper Quartile England	2.6
Covid-19				
COVID-19	For Covid-19 patients – average number in hospital, number who died, number discharged to usual place of residence	Chief Operating Officer	RAG criteria subjective – Executive informed.	To be confirmed

Glossary Continued

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion				
Engagement				
Staff FFT Treatment	Percentage of staff recommending the Trust as a place to receive care or treatment as part of the staff Friends and Family Test.	Director of Human Resources	Red <Yorkshire &Humber, Green >Yorkshire &Humber	4.4
Staff FFT Work	Percentage of staff recommending the Trust as a place to work as part of the staff Friends and Family Test.	Director of Human Resources	Red <Yorkshire &Humber, Green >Yorkshire &Humber	4.4
Appraisal Rate Non-medical	Percentage of eligible staff employed at the Trust who have had an appraisal in the last 12 months.	Director of Human Resources	Red <75%, Amber >=75% and <95%, Green >=95%	5.0
Contacts with Advocacy service	Percentage of Staff Advocate Service Contacts resulting in investigations.	Director of Human Resources	New metric in a phase of trending therefore RAG criteria subjective. – Executive informed.	3.6
Harassment & Bullying outcomes	Percentage of Harassment and Bullying related Contacts resulting in disciplinary action.	Director of Human Resources	New metric in a phase of trending therefore RAG criteria subjective. – Executive informed.	4.6
Training & Development				
New Starter Training	Percentage of new staff who are compliant with mandatory training requirements.	Chief Medical Officer	Red < 90%, Amber >=90% & <100%, Green = 100%	4.4
Refresher Training	Percentage of staff who are compliant with mandatory training requirements.	Chief Medical Officer	Red < 75%, Amber >=75% & <85%, Green >= 85%	4.4

Glossary Continued

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
Staffing				
Care Staff Shifts filled	Percentage of time care staff staffing hours are filled compared with planned.	Chief Nurse	Red < 80%, Amber 80% – 95%, Green > 95%	3.7
Care Staff Care Hours	Total of the actual number care staff hours for the month divided by the total number of patients who were an inpatient at midnight for each day of that month.	Chief Nurse	Red = Lower two quartiles, Green = Upper two quartiles	3.7
Nursing Care Hours	Total of the actual number of Registered Nurse / Midwife hours for the month divided by the total number of patients who were an inpatient at midnight for each day of that month.	Chief Nurse	Red = Lower two quartiles, Green = Upper two quartiles	3.7
Use of Agency Staff	Agency Full Time Equivalents (FTE's) as a percentage of all FTE's.	Director of Human Resources	RAG criteria subjective.	4.0
Staff Turnover	Number of employees who have left the organisation in the past 12 months as a percentage of the average number of employees over the same period.	Director of Human Resources	Red > 14%, Amber 12% – 14%, Green < 12%	4.0
Maternity patients receiving 1:1 care	Percentage of maternity patients receiving one-to-one care	Chief Nurse	RAG Criteria being reviewed.	To be confirmed
Equality & Diversity				
BAME Senior Leaders	Percentage of staff employed in Band 8+ Senior Manger roles at the Trust who are of Black, Asian or Minority Ethnic (BAME) background.	Director of Human Resources	Red >=2% below Trajectory Target, Amber >2% of Target, Green >= Target	4.6
BAME Workforce	Percentage of staff employed at the Trust who are of Black, Asian or Minority Ethnic (BAME) background.	Director of Human Resources	Red >=2% below Trajectory Target, Amber >2% of Target, Green >= Target	5.0
Health & Wellbeing				
Staff Sickness Absence	Percentage of staff time lost due to sickness in a given period (the reported month, year to date is the previous 12 months rolling average for which the Trust target is 4.5%.	Director of Human Resources	Red >1% point above Target, Amber within 1% point above Target, Green <= Target	4.0
Frontline Staff Flu Vaccination	Flu vaccine uptake percentage amongst frontline staff	Director of Human Resources	RAG Criteria being reviewed.	4.6

Glossary Continued

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals				
Partnership				
Reducing Inequalities	Working with partners to contribute to the overall reduction of health inequalities across Bradford District and Craven.	Director of Strategy & Integration	RAG rating subjectively agreed by the committee	Qualitative Metric
Act as One Place	Working with local partners and contribute to the formal establishment of a responsive, integrated care system, and to actively participate in system-wide programmes of work.	Director of Strategy & Integration	RAG rating subjectively agreed by the committee	Qualitative Metric
ICS and WYAAT	Working with other providers to ensure resilient services, reduce outcome variation, address workforce shortages, and achieve efficiencies. Contribute to the establishment of an effective Integrated Care System in West Yorkshire.	Director of Strategy & Integration	RAG rating subjectively agreed by the committee	Qualitative Metric
Anchor Institution	Working across Bradford to ensure the Trust is actively engaging with the population to support community development through anchor attributed such as employment initiatives, local procurement and developing the estate as a community asset.	Director of Strategy & Integration	RAG rating subjectively agreed by the committee	Qualitative Metric

Glossary Continued

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
To be a continually learning organisation and recognised as leaders in research, education and innovation				
Learning Hub				
Learning Hub Progress	Progress on embedding the Learning Hub in the Trust against the plan.	Director of Strategy and Integration	RAG criteria subjective – Executive informed.	Qualitative Metric
Research				
Research patients recruited	Number of patients recruited to studies against the planned recruitment.	Chief Medical Officer	Red <60%, Amber >=60% & <80%, Green >=80%	4.0
Governance				
Duty of Candour	Patient informed duty of candour.	Director of Strategy and Integration	Red > 0, Green = 0	4.0
Information Governance Breaches	The number of reported breaches of information governance standards.	Chief Digital and Information Officer	Red > 6, Amber <=6 & > 2, Green <=2	3.7
Out of Date Policies	Percentage of policies that are currently out of date.	Director of Strategy and Integration	Red < 95%, Amber >=95% & <100%, Green = 100%	3.3

Dashboard Key

Summary Charts

To provide outstanding care for patients

Clinical Effectiveness

Patient Safety

Patient Experience

Trust objective

Objective "Slices"

Key areas contributing to the Trust objective. Each slice includes relevant "composite" metrics which contribute to an overarching Red, Amber, Green (RAG) rating.

RAG Rating Calculations

Objective Slice RAG

Weighted score of composite metric RAGs within a slice divided by the number of composite indicators within a slice.

Red =< 1.5

Amber > 1.5

Green => 2.5

Metric RAG

Each metric has separate RAG criteria updated on a monthly basis by Responsible Owners as defined in the Metric glossary. This demonstrates the current status of the metric.

DQ Kite Mark

RAG status of assurance of the data quality of the information being presented – average score RAG rated across 7 domains; timeliness, audit, reliability, relevance, granularity, validation and completeness.

DQ Score	Summary
1	Insufficient systems, processes or documentation available to provide assurance on the asset (i.e. dataset).
2	Limited systems, process and documentation are available and therefore assurance is limited.
3	Systems, processes and documentation are available and the asset has been locally verified to provide assurance.
4	Full systems, processes and documentation are available and the asset has been locally verified to provide assurance.
5	Full systems, processes and documentation are available and the asset has been independently verified with full assurance provided.

Statistical Process Control (SPC) Chart

The information is generally presented using "control limits" to determine whether any one month is statistically high or low. The average is calculated over the first 12 months, and after this time if there is a period of 8 months in a row which are all above (or below) the average, a new average and control limits are calculated from this point.

Benchmarking

The majority of benchmarking charts show information for the most recently available period. The range of other Acute Trusts values are split into 4 quartiles, showing the range of the bottom 25% of Trust values, 25-50% of Trust values etc. The value for Bradford Teaching Hospitals is shown alongside a single value looking at the average of Acute trusts in Yorkshire and Humber.

BO.1.24.15 - FINANCE REPORT

REFERENCES

Only PDFs are attached

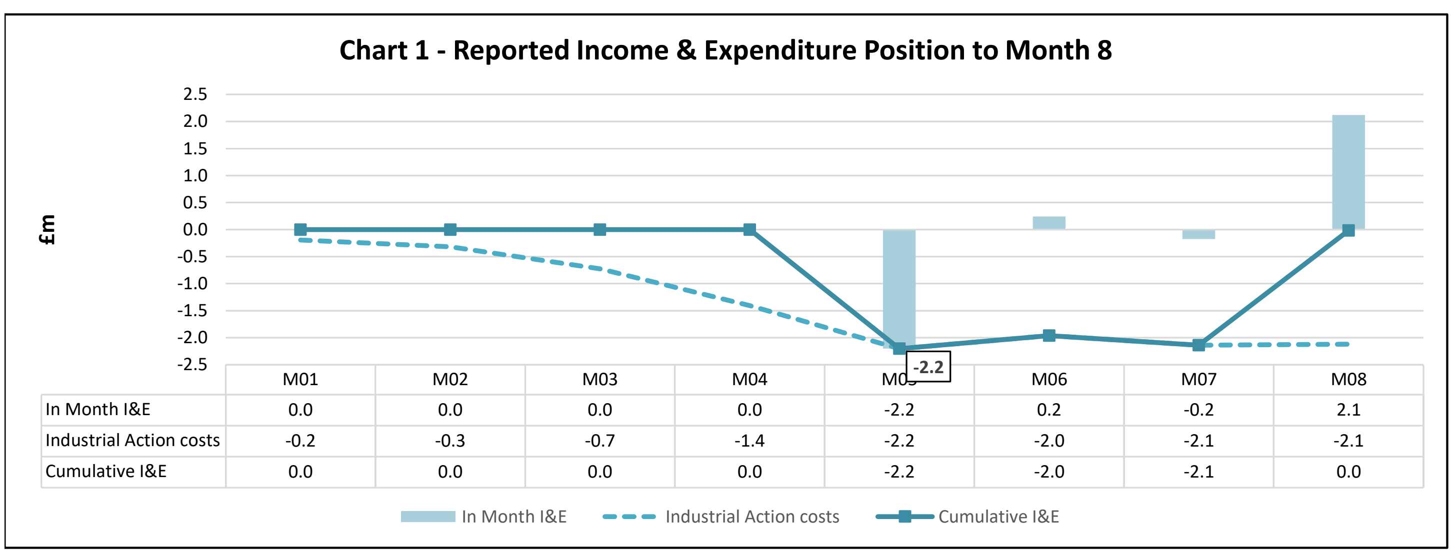
Bo.1.24.15 - Finance Report.pdf

FINANCIAL PERFORMANCE REPORT	MONTH 8

Meeting:	**Board of Directors Meeting in Public**
Meeting Date:	**18 January 2024**
Agenda Item:	**Bo.1.24.15**

1. Summary Year to Date Income & Expenditure Position (£m)

Details	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Year End Forecast	Forecast Variance
Income	46.3	50.4	4.1	373.0	380.3	7.3	559.4	567.7	8.3
Pay	(29.9)	(31.4)	(1.5)	(239.7)	(247.0)	(7.3)	(359.7)	(369.4)	(9.7)
Non-Pay	(16.9)	(18.3)	(1.4)	(144.4)	(143.6)	0.8	(213.1)	(218.9)	(5.8)
WRP outstanding	0.5	1.4	0.9	11.1	10.4	(0.7)	13.3	20.6	7.3
Grand Total	**(0.0)**	**2.1**	**2.1**	**(0.0)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**



Commentary - Reported I&E Position

The Trust has formally reported a year to date break even position at Month 8. This is a £2.1m improvement on the position reported at Month 7. The improvement is due to additional non-recurrent funding received from NHSE via the ICB to fully offset 100% of the Industrial Action costs incurred to the end of October 2023.

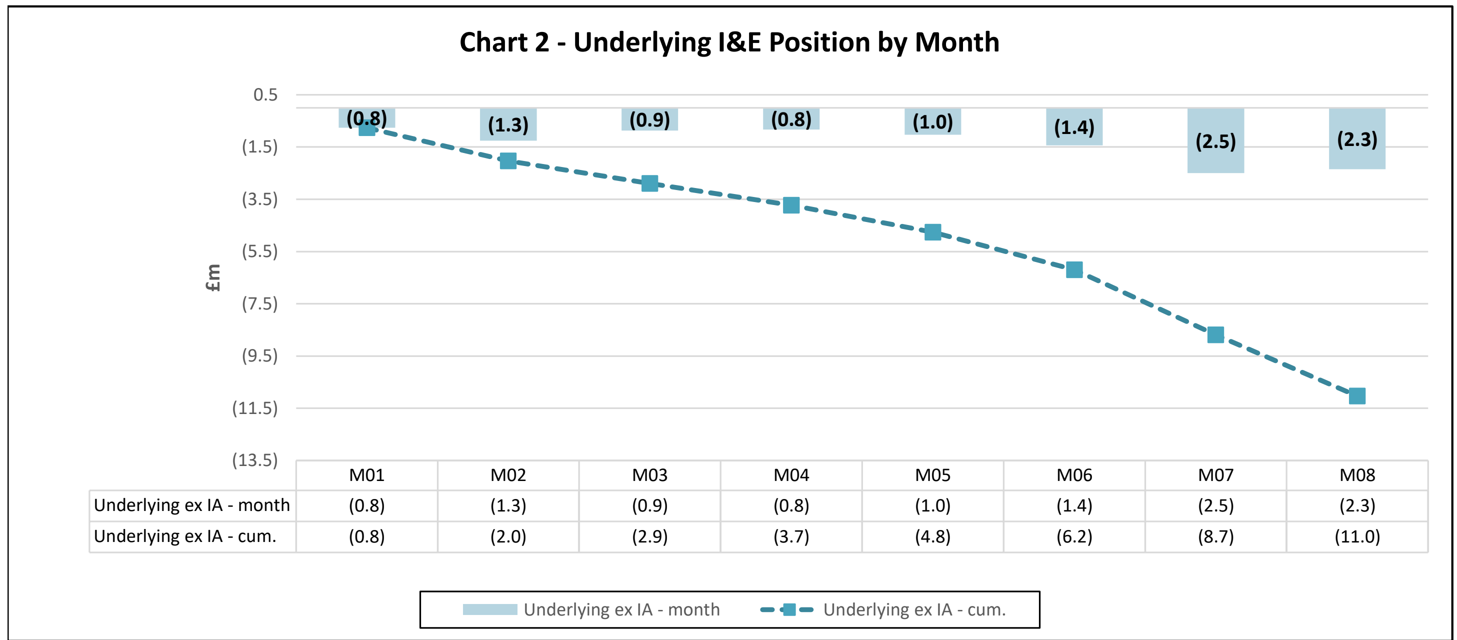
The Trust continues to formally forecast a year end breakeven position for the financial year to NHSE, which is in line with the plan.

NHSE requested a rapid response review of all ICB and provider forecasts in November 2023 in light of the additional £0.8bn funding allocated to ICSs (which included the £2.1m IA funding allocated to BTHFT). To inform this forecast, BTHFT carried out a comprehensive review of CSU forecasts and all potential non-recurrent technical mitigations.

The BTHFT forecast submitted to the ICB for inclusion in the WY ICS rapid response review was a deficit of £1.1m. This is an optimistic forecast and includes the deployment of all available technical measures but does not factor in any unplanned expenditure thay may arise in the final months of the financial year. At present, the organisation does not have plans in place to address this £1.1m deficit, meaning the formal breakeven forecast submitted to NHSE represents an ambitious best case scenario.

The Trust is making every effort to mitigate this risk through increased financial governance and controls, and increased focus on delivery of the Waste Reduction Programme (WRP). The formal breakeven forecast remains the Trust's objective, however it must be recognised that this is the best case scenario forecast. Further improvements in WRP plans are being actively pursued to mitigate this forecast to deliver the breakeven plan.

2. Underlying Income & Expenditure Position



	M01	M02	M03	M04	M05	M06	M07	M08
Underlying ex IA - month	(0.8)	(1.3)	(0.9)	(0.8)	(1.0)	(1.4)	(2.5)	(2.3)
Underlying ex IA - cum.	(0.8)	(2.0)	(2.9)	(3.7)	(4.8)	(6.2)	(8.7)	(11.0)

Commentary - Underlying I&E Position

Visibility of the underlying income and expenditure position, which excludes any non-recurrent technical flexibilities and IA costs, and therefore represents the true scale of the financial challenge the Trust's income and expenditure structure currently represents, is crucial for understanding the financial outlook.

The November in-month underlying position was a deficit of £2.3m, which is £0.2m worse than the deficit previously forecast for Month 8.

The reported YTD breakeven position could only be achieved by deploying £11m of non-recurrent income and non-recurrent flexibilities. The true average underlying run rate in the last 3 months (Months 6 - 8) is a monthly deficit of £2.1m per month - this is the difference between what the Trust is actually spending each month on a recurrent basis and the external funding it is receiving. This rate of deficit is increasing and is forecast to increase further in the remainder of Quarters 3 and 4.

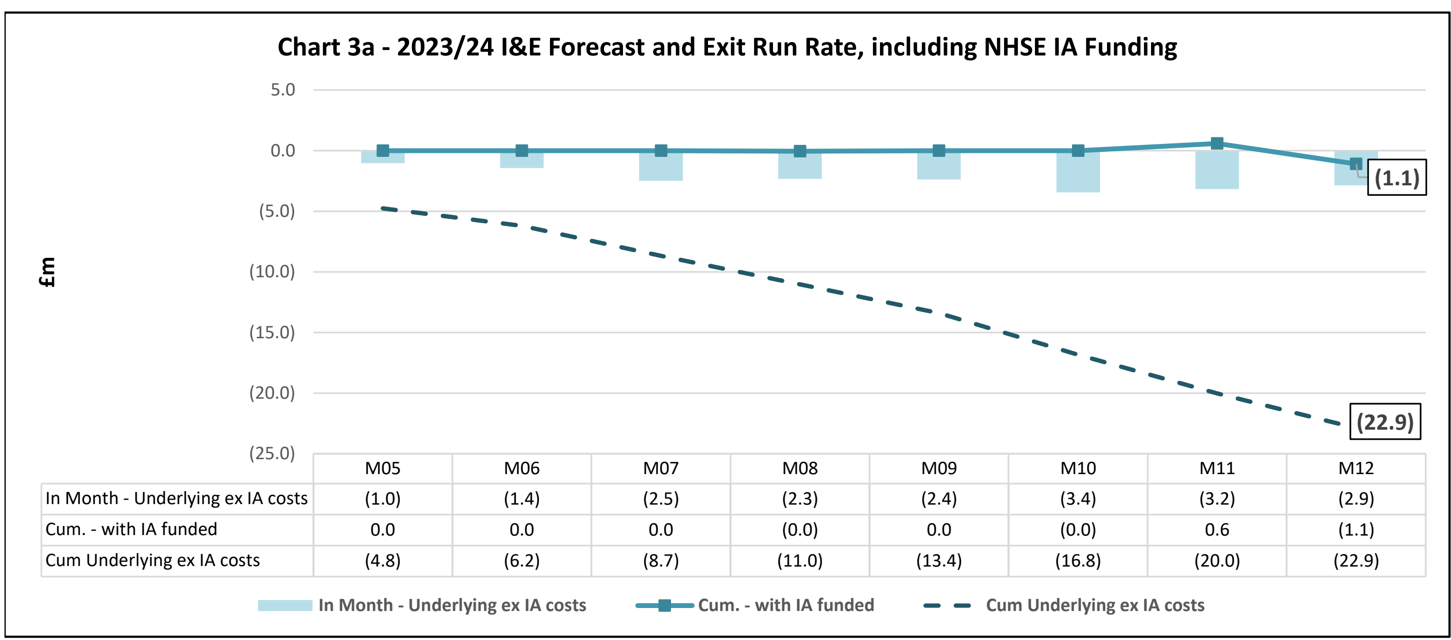
The cumulative underlying deficit at Month 8 is £11m.

The annual plan anticipated the need to deploy £7.8m of non-recurrent flexibilities to support the financial position up to Month 7, with the expectation that Waste Reduction Plans (WRP) would deliver increasing run rate expenditure reductions from Month 6 onwards. Delivering this phased plan would deliver a breakeven position for 2023/24 and would phase out the reliance on non-recurrent measures in Half 2, resulting in a sustainable exit run rate heading into 2024/25.

Shortfalls on WRP plan delivery and unplanned for cost pressures have resulted in an underlying position which is £3.2m worse than planned at Month 8. The prospects for material recurrent improvements to the exit run rate in Quarter 4 are currently limited.

The implications of the underlying run rate deficit are discussed below.

3a. Forecast Income & Expenditure Position 2023/24 - Summary



	M05	M06	M07	M08	M09	M10	M11	M12
In Month - Underlying ex IA costs	(1.0)	(1.4)	(2.5)	(2.3)	(2.4)	(3.4)	(3.2)	(2.9)
Cum. - with IA funded	0.0	0.0	0.0	(0.0)	0.0	(0.0)	0.6	(1.1)
Cum Underlying ex IA costs	(4.8)	(6.2)	(8.7)	(11.0)	(13.4)	(16.8)	(20.0)	(22.9)

Commentary - I&E Forecast

The current most likely scenario forecast is a year end deficit of £1.1m.

The underlying monthly run rate deficit, excluding IA costs, is forecast to deteriorate materially in the final months of the financial year to be in the region of £3m per month. This is a consequence of planned recruitment into vacancies, notably on internationally recruited nurses, approved investments coming on line, inflationary pressures and the increased costs which are always incurred in the winter months.

The total forecast underlying deficit for 2023/24 is projected to be £22.9m. A further £12.8m of non-recurrent flexibilities have been identified to supplement the £7.8m identified in the original financial plan, providing a total of £20.6m of non-recurrent support to the I&E position in 2023/24. New ERF income of £1.2m was been notified to the Trust in November and will be received in Quarter 4. This results in £21.8m of non-recurrent measures deployed in the 2023/24 forecast.

This figure remains insufficient to offset the forecast run rate deficit in totality. It is currently projected that all non-recurrent measures will be exhausted in Quarter 4 and that the Trust will fall into unmitigated monthly run rate deficit at that point, posting a £1.1m year end deficit position.

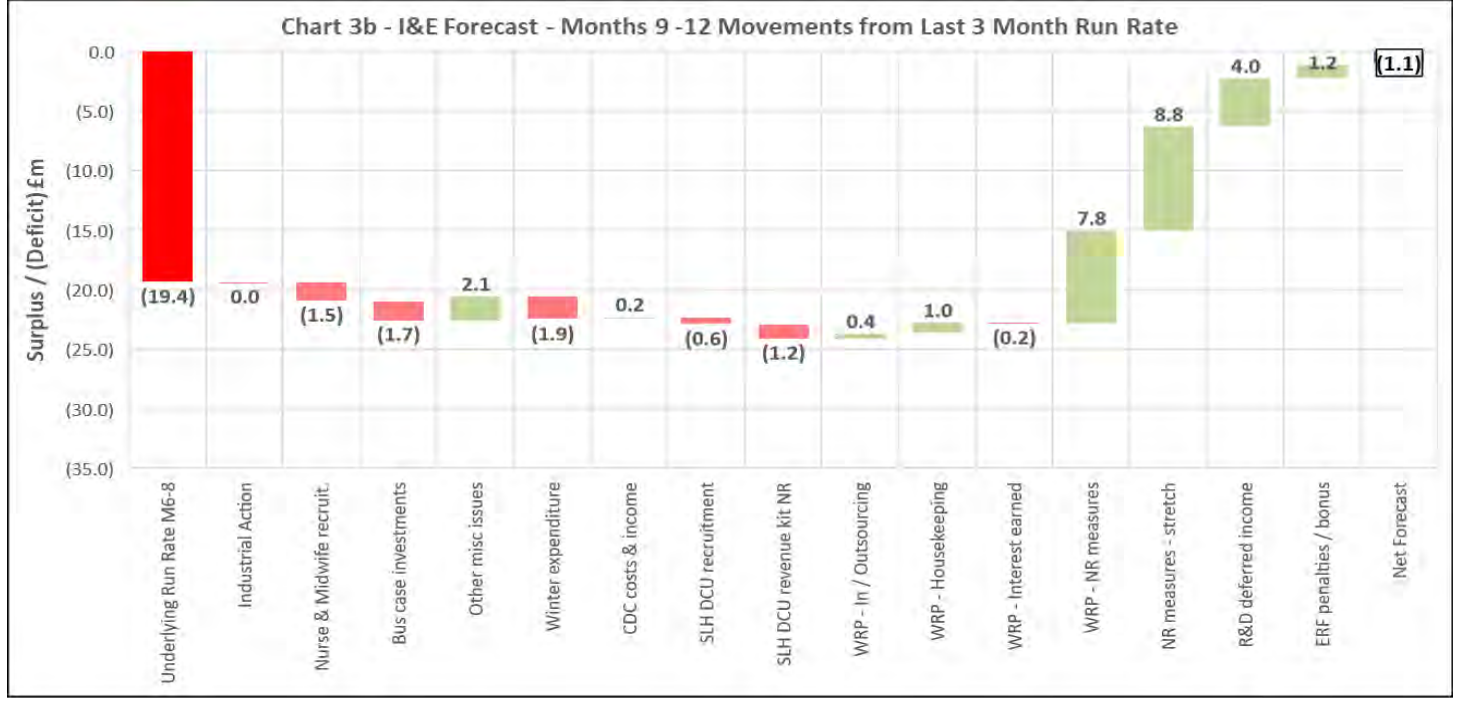
The forecast in month deficit in Month 12 is £2.9m, however this includes the increased winter rates of expenditure and is not therefore fully indicative of the full year run rate for inclusion in the plan for 2024/25. It should also be noted that the forecasts for Months 10 - 12 include £0.4m per month of non-recurrent revenue expenditure for equipping the new SLH Daycase unit.

It is projected that, without improved WRP delivery, the exit run rate heading into 2024/25 will be at least £2m per month. This equates to a £24m opening deficit position for next financial year. The usual nationally imposed tariff efficiency factors, inflation and other pressures would increase this 2024/25 deficit position to the region of £40m - this would represent an unachievable financial challenge for the Trust.

The Trust's financial management focus is now on all budget holders identifying recurrent improvements to their latest forecasts both to mitigate the 2023/24 outlook and to bring the exit run rate down to a more manageable level. The most financially challenged CSUs have moved into escalation, with increased financial scrutiny and support to produce financial recovery plans.
This approach is being supplemented by increased financial controls in line with NHSE's mandated measures. The immediate focus is on bridging the £1.1m forecast gap in 2023/24 and the expectation is that the organisation must achieve this. This expectation supports the ongoing breakeven forecast submitted to NHSE, although the £1.1m deficit forecast remains the most likely scenario at present.

The greater challenge will be implementing sufficient recurrent solutions to materially improve the exit run rate forecast and its impact on 2024/25 - it is anticipated that the organisation will have more clarity on this position at the end of Quarter 3 once the impact of the CSU's improved WRP forecasts and the tighter financial controls are better understood.

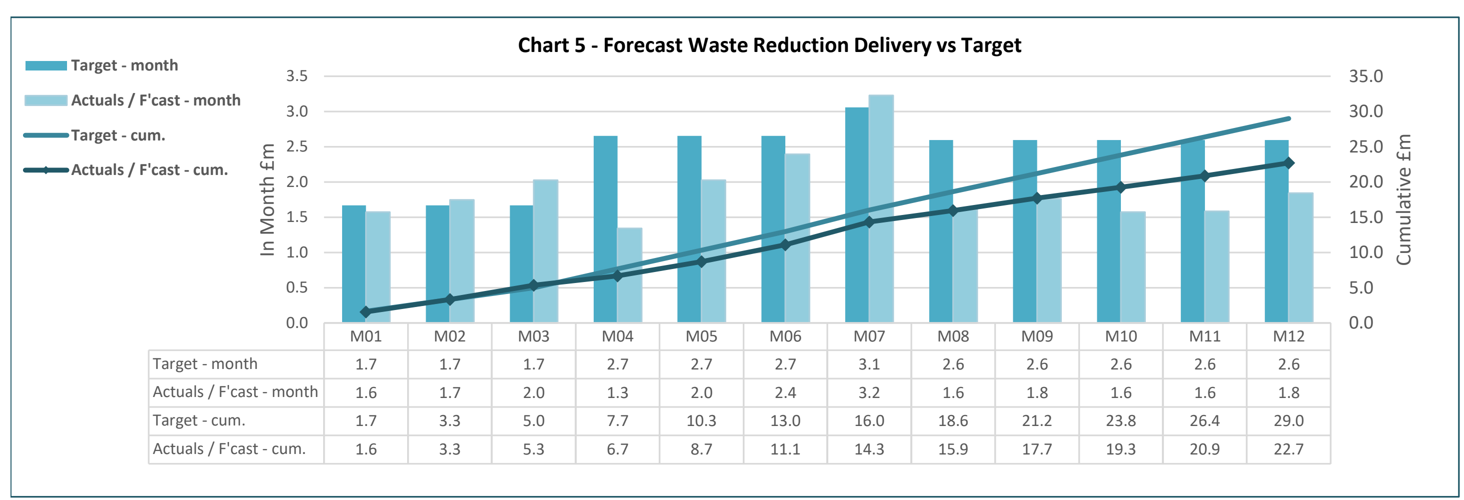
3b. Forecast Income & Expenditure Position 2023/24 - Details



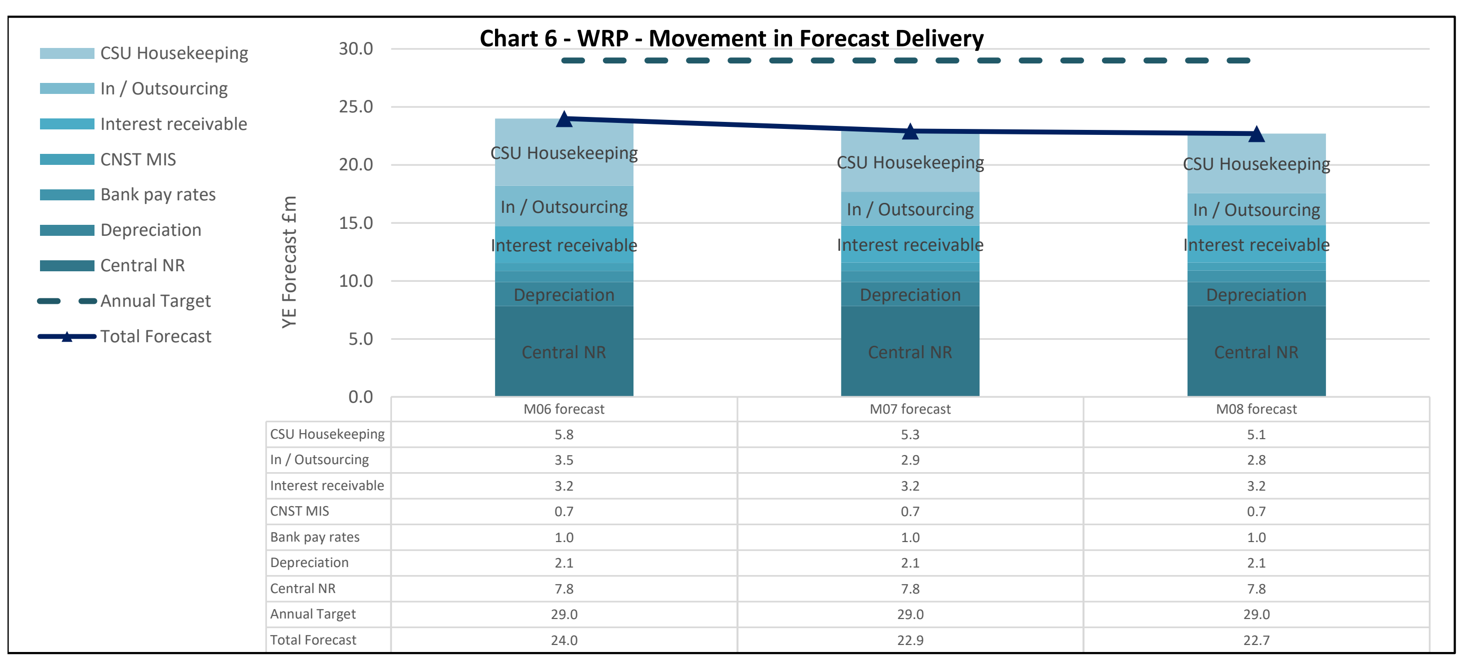
Commentary - I&E Forecast Details
Chart 3b explains how the current year end forecast £1.1m deficit is derived, starting with the underlying YTD position at Month 8 and an extrapolation of the underlying Month 6 - 8 run rate into Months 9 - 12. This gives a base case forecast year end deficit of £19.4m. Actual and forecast Industrial Action costs are netted off against an equal funding stream, meaning the IA now has zero impact on the forecast. The chart then plots projected adverse deviations from this base case forecast in Months 9 - 12 resulting from planned investments, recruitment, winter pressures and other issues including estimates of inflationary pressures, together with projected run rate improvements resulting from CSU WRP forecasts to generate a forecast deficit prior to mitigations of approximately £23m. The Trust has been notified it can expect to receive £1.2m of non-recurrent ERF funding as a consequence of the national relaxation of targets to provide partial mitigation for Industrial Action costs. £20.6m of non-recurrent measures are then factored in to arrive at the projected position after all currently identified mitigations, which is a deficit of £1.1m. The mitigations to the forecast deficit must be delivered by increased CSU WRP delivery in response to the escalation process and tighter financial controls.

4a. Waste Reduction Programme Summary (£000s)

Scheme Category	In Month Target	In Month Actual	In Month Variance	YTD Target	YTD Actual	YTD Variance	Annual Target	YE Forecast	YE Forecast Variance
Bank rates of pay	125	103	(22)	1,000	625	(351)	1,500	977	(523)
Centrally managed NR	0	0	0	7,824	7,824	(0)	7,824	7,824	0
CNST MIS	59	59	0	469	469	0	704	704	0
CSU Housekeeping	987	572	(415)	4,937	2,300	(1,799)	8,886	5,134	(3,752)
Depreciation	173	173	0	1,383	1,383	0	2,074	2,074	0
In / Outsourcing	1,169	439	(729)	2,337	1,084	(391)	7,012	2,779	(4,232)
Interest receivable	83	263	180	667	2,256	1,409	1,000	3,207	2,207
Total plans in Trackers	**2,596**	**1,609**	**(986)**	**18,617**	**15,941**	**(1,132)**	**29,000**	**22,699**	**(6,301)**



	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
Target - month	1.7	1.7	1.7	2.7	2.7	2.7	3.1	2.6	2.6	2.6	2.6	2.6
Actuals / F'cast - month	1.6	1.7	2.0	1.3	2.0	2.4	3.2	1.6	1.8	1.6	1.6	1.8
Target - cum.	1.7	3.3	5.0	7.7	10.3	13.0	16.0	18.6	21.2	23.8	26.4	29.0
Actuals / F'cast - cum.	1.6	3.3	5.3	6.7	8.7	11.1	14.3	15.9	17.7	19.3	20.9	22.7



	M06 forecast	M07 forecast	M08 forecast
CSU Housekeeping	5.8	5.3	5.1
In / Outsourcing	3.5	2.9	2.8
Interest receivable	3.2	3.2	3.2
CNST MIS	0.7	0.7	0.7
Bank pay rates	1.0	1.0	1.0
Depreciation	2.1	2.1	2.1
Central NR	7.8	7.8	7.8
Annual Target	29.0	29.0	29.0
Total Forecast	24.0	22.9	22.7

Commentary on Waste Reduction Programme progress 2023/24

At Month 8, the WRP for 2023/24 is projected to deliver £22.7m of efficiencies, which is £6.3m below plan. £11.9m of these savings are non-recurrent in nature, leaving a balance of £10.8m of true recurrent efficiencies forecast to be delivered in 2023/24.

Overall forecast WRP delivery has *decreased* by £0.2m since Month 7. This reflects a re-assessment of some of the CSUs' more risky schemes and their subsequent removal from the forecast and limited progress in the identification of new deliverable plans.

The impact of the ongoing industrial action on the organisation's ability to develop and implement waste reduction plans has been significant. CSU management time that could otherwise have been dedicated to WRP has been unavoidably diverted to managing the impact of IA, with a corresponding adverse impact on WRP delivery.

There is a projected £0.5m shortfall against a reduction in the rates of bank pay to align with WYAAT peers. The full implementation of the new rates was delayed until July 2023 and some priority staff groups have remained on the previous higher rates. Progress will be monitored as the year proceeds.

The latest CSU projections suggest a substantial amount of in / outsourcing will continue in Quarters 3 & 4, notably in Theatres, Breast Surgery and Plastic Surgery. This results in a forecast £4.2m shortfall against the associated £7m WR target. If this position does not improve, this will be problematic for the exit run rate and 2024/25 financial plan, as the medium term planning assumptions are based on a recurrent £14m cost reduction from these schemes.

The Month 8 version of the CSUs' housekeeping WR plans suggest up to £5.1m of efficiencies will be made in 23/24. This is £3.8m below the £8.9m targets allocated to the CSUs.

The WRP is now overseen by the Waste Reduction Steering Group, which meets monthly to review progress and to agree actions to progress against corporate targets. The Elective Recovery Group chaired by the COO is overseeing the plans to reduce in / outsourcing and a task and finish group has been established to investigate opportunities to reduce significant overspends against junior doctors bank budgets which may offer a signficant WRP opportunity not curently factored into forecasts. A project to focus on improving nurse rostering processes was initiated in July.

The Executive Management Team has approved an escalation process for the most financially challenged CSUs which will initially be supported by financial performance review meetings chaired by the relevant Deputy Director of Operations and which entails a requirement for regular formal progress updates to be submitted by the CSU Triumvirate to the Director of Finance to provide assurance that the necessary steps are being taken. The first escalation meetings took place in the week commencing 20 November 2023, however the responses received to date have provided limited assurance that run rate improvements will be delivered.

4b. Recurrent Impact of Waste Reduction Plans on 2024/25 Outlook

Row Labels	Total Target 23/24	Total Forecast 23/24	Forecast Variance 23/24	FYE Target 24/25	FYE Forecast 24/25	Forecast Variance 24/25
Recurrent	**19,102**	**10,826**	**(8,276)**	**29,076**	**13,477**	**(15,598)**
Bank rates of pay	1,500	977	(523)	1,500	1,056	(444)
CNST MIS	704	704	0	704	704	0
CSU Housekeeping	8,886	3,159	(5,727)	11,849	5,044	(6,805)
In / Outsourcing	7,012	2,779	(4,232)	14,023	5,084	(8,939)
Interest receivable	1,000	3,207	2,207	1,000	1,590	590
Non-recurrent	**9,898**	**11,873**	**1,975**	**0**	**0**	**0**
Non-recurrent flexibility	7,824	7,824	(0)	0	0	0
CSU Housekeeping	0	1,975	1,975	0	0	0
Depreciation	2,074	2,074	0	0	0	0
Grand Total	**29,000**	**22,699**	**(6,301)**	**29,076**	**13,477**	**(15,598)**

Commentary Recurrent WRP Outlook for 2024/25

The phasing of the main WRP targets in the 2023/24 annual plan was designed to ensure delivery would result in £29m of recurrent cost improvements being carried forward into the next financial year as a result of the cumulative run rate improvements that were required to be put in place in Half 2 of 2023/24. The plan was to ensure the financial challenge in 2024/25 was limited to the new year's national efficiency targets, rather than adding brought forward unmet WRP targets to the 2024/25 I&E planning gap.

The CSUs' Housekeeping targets were phased to deliver £8.9m over the final 9 months of 2023/24 with the recurrent full year run rate improvement in 2024/25 equating to £11.8m. Similarly, the In / Outsourcing reduction target was phased into the final 6 months of 2023/24 - delivering the £7m target recurrently in Half 2 would result in a £14m run rate improvement in 2024/25.

Table 4b shows the recurrent impact on the 2024/25 outlook of both the £6.3m WRP shortfall forecast for 2023/24 and the over-reliance on non-recurrent measures in the current financial year. If forecast recurrent WRP delivery does not improve in Half 2, a £15.6m I&E planning gap related to undelivered 2023/24 WRP will be carried forward into 2024/25.

5. Agency Expenditure by Month (£000s)

Staff Groups	APR-23	MAY-23	JUN-23	JUL-23	AUG-23	SEP-23	OCT-23	NOV-23	YTD Total
Consultants	113	102	151	115	127	159	176	218	1,161
Other Med staff	8	9	11	24	22	10	1	4	89
Nurses & Midwives	204	217	284	274	275	113	274	239	1,880
Other clinical roles	109	101	124	152	160	135	174	174	1,129
HCAs	17	34	64	79	66	2	1	0	264
A&C / Managers	38	35	58	35	50	54	37	53	361
Estates & Facilities	303	178	236	262	308	227	199	202	1,916
YTD Total	**794**	**677**	**928**	**941**	**1,008**	**701**	**862**	**890**	**6,800**
Total Pay Costs	**29,196**	**30,639**	**30,450**	**30,206**	**32,946**	**30,803**	**31,365**	**31,389**	**246,995**
Agency % of Total Pay	**2.7%**	**2.2%**	**3.0%**	**3.1%**	**3.1%**	**2.3%**	**2.7%**	**2.8%**	**2.8%**

Commentary on Agency Expenditure

Agency costs at 2.7% of total pay costs remain well below the nationally mandated 3.7% ceiling. Forecast full year expenditure of £10.1m is marginally above the locally agreed £9.9m target included in the annual plan.

The nursing agency expenditure is largely driven by vacancies in specific disciplines. The most substantial expenditure is in Renal nursing. A business case was approved in September to increase the substantive renal nursing establishment which will address the agency overspend.

NHSE's Agency Rules mandate that non-clinical agency usage should cease in 2023/24. The Trust is currently reliant on circa 60 agency staff within Estates & Facilities to provide cleaning, catering and security services. This is being reviewed to ensure non-clinical agency use is managed down to ensure compliance. The business case to recruit into some of these posts substantively was approved at the July Planning Committee and the E&F management team is in the process of recruiting into the new posts.

Administrative and managerial agency staffing costs relate to ad hoc appointments to cover vacancies in admin & clerical / professional roles.

BO.1.24.16 - PERFORMANCE REPORT

REFERENCES

Only PDFs are attached

Bo.1.24.16 - Performance Report.pdf

Meeting Title	Open Board of Directors Meeting		
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PERFORMANCE REPORT – FOR THE PERIOD NOVEMBER 2023

Presented by	Sajid Azeb, Chief Operating Officer & Deputy Chief Executive	
Author	Carl Stephenson, Associate Director of Performance	
Lead Director	Sajid Azeb, Chief Operating Officer & Deputy Chief Executive	
Purpose of the paper	To update on the current levels of performance and associated plans for improvement.	
Key control	This paper is a key control for the strategic objective to deliver our financial plan and key performance targets.	
Action required	For assurance	
Previously discussed at/ informed by		
Previously approved at:		**Date**

Key Options, Issues and Risks

This report provides an overview of performance against several key national and contractual indicators as at the end of November 2023.

Analysis

Ambulance Handovers:

- Attributable performance for handovers within 15 minutes was 73.83% in November 2023 and is projected to be at 68.94% in December 2023.
- The average number of ambulances arriving at BTHFT has increased with a daily average of 111 in November and 116 arrivals within December to date (vs 101 in December 2022).
- Nationally mandated changes to the recording of clock start times came into effect in October with handover now commencing as soon as the vehicle parks at the destination. This has adversely impacted performance adding an approximate 7-8 minutes on to average handover times, which is reflected in performance since October.
- Observations conducted by the ED team demonstrated that YAS colleagues were not routinely recording patient handovers on the C2 screens within the ED department following the changes in October. Improving this practice will be incorporated in the joint work with YAS and the HALO person that is now working within the department.
- The reporting change has impacted all Trusts and BTHFT continues to maintain its' position in the upper quartile of the Northeast and Yorkshire region. This position has been achieved through a continued collaborative approach between YAS and the Emergency Department's Senior Leadership Team.
- Joint work will next focus on periods of peak demand to agree an early escalation process that allows for improved preparation and response plans. New pathways will also be developed for patients who are suitable to be taken directly to the UCC or AECU.

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Emergency Care Standard (ECS):

- ECS performance for Type 1 & 3 attendances was 73.94% for November 2023 and is currently forecast at 77.92% for December. The position remains favourable against other acute Trusts in WYAAT and against the national benchmark which reflects the challenges everyone is facing.
- The Urgent Care Centre (UCC) remains operational and streaming prior to triage went live in December. The full benefits of steaming have not yet been realised due to a peak in acuity and staff absences in the Primary Care Stream and in Minor Injuries, but the model has reduced type 1 patients going through the main department.
- The AECU service went live in late November 2023. Following initial assessments any patient streamed to the AECU are recorded as a type 5 attendance at which point the 4-hour clock is stopped. Recent performance data shows the AECU model has reduced the number of ECS breaches, reduced admissions into the hospital, and reduced time patients spend in ED.
- In November the number of paediatric attendances peaked. High acuity demand was above low acuity demand for the first time in 2023 as a result. The increased wait time in the department has in turn increased the number of patients leaving without being seen further work is being conducted in this area.
- A UCC project group continues to look at further opportunities to achieve ECS performance recovery, a number of workstream leads are in place to achieve: improved utilisation, development of new pathways, review triage, and contractual arrangements with Bradford Care Alliance (BCA) who provide the GP input to the UCC.

Long Length of Stay (Stranded Patients):

- The daily average number of patients with a length of stay (LOS) > 21 days was 114 in November 2023, and December 2023 is projected to be a daily average of 108.
- A ‘Criteria to Reside’ meeting occurs twice weekly and is attended by health, social care, therapies, the team leaders/managers are currently reviewing changes required to this meeting.
- The Multi-agency Integrated Discharge Team (MAIDT), ward teams, senior nursing, therapies and health and social care are working closely throughout the week to enable timely discharge of long length of stay (LLOS) patients.
- There is a virtual review of patients who have a LLoS > 21days, which is sent to the deputy directors of nursing and the matrons for each ward for review. An update is provided and is received by the MAIDT, patients are then coded and updated in EPR with the information received. This process is not achieving the desired outcome of reducing LLOS patients and there is a QI project to be launched early 2024.
- The majority of the LLoS patients >21days residing in BRI are patients still requiring medical treatment and/or therapy. Of those LLoS patients who are residing in IMC, most of these patients (51 currently) no longer meet the criteria to reside. The number of patients that were awaiting Packages of Care remained high in November and this is mostly attributed to the on-going external challenges with P1 capacity which we are working through with Local Authority partners. Indications are this is likely to continue into the New Year.

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Inpatient and Outpatient Activity:

- Outpatient, Elective and Day Case activity increased in November 2023 however remained below plan. Volumes are projected to remain below plan in December 2023 due to increased annual leave and 3 days of industrial action.
- Weekly meetings continue to review theatre productivity with schedules now being reviewed beyond 6 weeks against targets to maximise utilisation of available sessions. The underpinning 6-4-2 process is being continually improved to ensure all services are fully sighted on theatre utilisation with escalation for same-day cancellation of operations continuing.

Referral to Treatment:

- Referral to Treatment (RTT) performance was relatively stable in November at 66.59% and remains within the upper quartile compared to other Acute Trusts.
- Focus remains on increasing activity levels whilst ensuring the longest waiting and most clinically urgent patients are part of prioritisation practices through regular weekly access meetings and targeted patient-level long waiter reviews.
- There were 0 patients reported over 78 weeks at the end of November, with 0 patients projected to breach 78 weeks at the end of December. Progress on reducing over 52 week waits is behind original plans but ahead of national expectations when adjusted for the impact of industrial action.
- The national validation toolkit has been implemented and patients are being involved in this via the use of SMS text messages. 47,922 patients have been contacted to date with 1,753 requesting discharge (3.7%). Confidence in the RTT waiting list, as expressed nationally via the Luna Dashboard, has increased from 96% to 99% during 2023/24. Validation is now better coordinated between teams and the themes from corrections are being fed into preventative work.
- Monthly recovery meetings from January should support further improvement in wait times by reviewing productivity, booking processes as well as demand & capacity with each CSU.

Diagnostic waiting times:

- The DM01 performance for November was 69.74% which is an improvement on October. This is projected to further improve in December with areas benefitting from recruitment and successful insourcing arrangements.
- Non-obstetric ultrasound (NOUS) GP direct access requests continue to be transferred to Yorkshire Health Solutions which is reducing the number of long waits. Insourcing plans are also underway with two providers due to begin work imminently which will support sustained improvement.
- MRI outsourcing of MSK patients continues to have a positive impact by freeing up in house capacity. Successful recruitment including locums and sonographers is expected to further improve performance and the CDC going live in January will also provide additional scanning capacity.
- Cardiology continues to face sustained challenges relating to referrals, equipment, and staffing with plans to ensure additional capacity, expected to be in place from January with longer term sustainability plans also in the final stages.

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Cancer Wait Times:

- 2-week wait (2WW) demand remained high in October and national awareness campaigns also led to an uplift in referrals to certain sites. Trust performance was at 95.83% which remains above the 93% target and in the upper quartile nationally.
- The 28-day faster diagnosis standard (FDS) was 83.50% in October and is expected to be sustained at a similar level into November. High demand, particularly skin referrals needing histopathology, means the number of patients undiagnosed and over 28 days had increased. This will put some pressure on future performance with some mitigation is being provided through improved consultant capacity in key tumour groups.
- 62 Day First Treatment performance was below the target of 85% in October at 69.50%. November performance is projected to dip further due to delays in the diagnostic phase. Patients waiting beyond 62 days for treatment has increased across West Yorkshire and the cancer alliance is supporting system wide improvement schemes. Focus on diagnostic capacity and tumour group specific pathway milestone is supporting a reduction in these waits at BTHFT.

Other KPI of note:

- One breach of the 28-day cancelled operation re-booking target occurred in November. The number of reportable cancellations that require rebooking increased and industrial action is expected to increase patient cancellations further in December.
- Stroke performance remains an area of focus with significant development in terms of planned solutions which are reliant upon estate work and staff recruitment which is anticipated to be completed later in this year.

Recommendation

The committee is asked to:

- Receive assurance that overall delivery against performance indicators is understood.
- Note the escalation of areas of underperformance and be assured on the improvement actions.

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Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients, delivered with kindness			G			
To deliver our financial plan and key performance targets			G			
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					G	
To be a continually learning organisation and recognised as leaders in research, education and innovation				G		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					G	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
Explanation of variance from Board of Directors Agreed General risk appetite (G)	**Risk (*)** Recovery continues but industrial action has impacted on the volume of activity undertaken in the reporting period and delayed some progress.					

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☒	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☒	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☒	☐	☐

Risk Implications (see section 5 for details)	Yes	No
High Level Risk Register and/or Board Assurance Framework Amendments	☐	☐
Quality implications	☐	☐
Resource implications	☐	☐
Legal/regulatory implications	☐	☐
Equality Diversity and Inclusion implications	☐	☐
Performance Implications	☐	☐

Regulation, Legislation and Compliance relevance
NHS Improvement: (please tick those that are relevant) ☐Risk Assessment Framework ☐Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain: Well Led
Care Quality Commission Fundamental Standard: Choose an item.
NHS Improvement Effective Use of Resources: Clinical Services
Other (please state): Commissioning contracts with ICB and NHS England

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality & Patient Safety	Finance & Performance	Other (please state)
☐	☒	☐	☐

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APPENDIX 1

LATEST REPORTED PERFORMANCE – September 2023

1. Introduction

The following report describes performance against key national and contractual measures, the improvement activity associated with these and timescales for any expected changes. Performance is presented as the latest reported position with forecasting used where national returns are in arrears.

2. Summary of Content

Table 1 Headline KPI Summary

Section	Headline KPI	Latest Month	Target / Trajectory	Performance	3 months Trend
3	Ambulance Handover 30-60	Nov-23	30	**220**	↑
3	Ambulance Handover 60+	Nov-23	10	**45**	↑
5	Emergency Care Standard	Nov-23	84.70%	**73.94%**	↓
7	Length of Stay ≥21days	Nov-23	84	**114**	↑
9.1	18 Week RTT Incomplete	Nov-23	72.32%	**66.59%**	→
9.2	52 Week RTT Incomplete	Nov-23	1.10%	**1.37%**	→
10	Diagnostics Waiting Times	Nov-23	66.00%	**69.74%**	↑
11.1	Cancer 2 Week Wait	Oct-23	93.00%	**95.80%**	↑
11.2	Cancer 28 Day FDS	Oct-23	75.00%	**83.50%**	↑
11.3	Cancer 62 Day First Treatment	Oct-23	85.00%	**69.50%**	↓

Red performance = not meeting plan; **Green** performance = meeting or exceeding plan.

Red arrow = trend is a deterioration; **Green** arrow = trend is an improvement.

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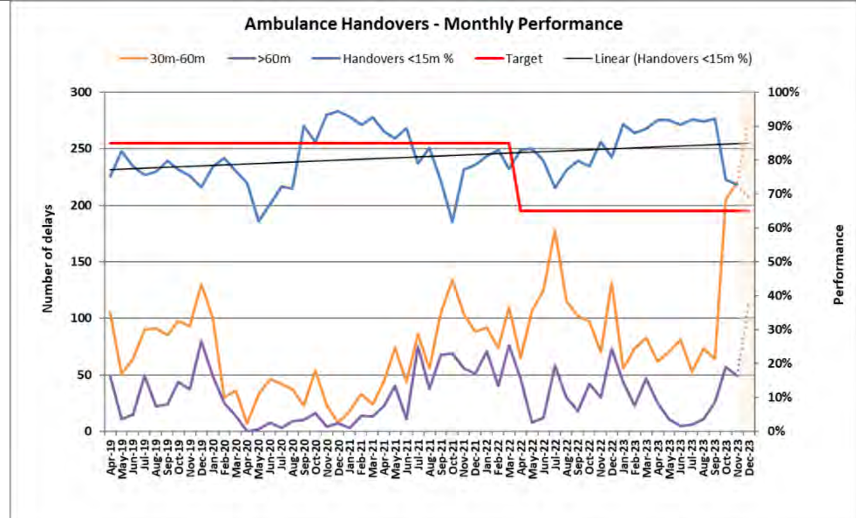
3. Emergency Ambulance Handover Performance

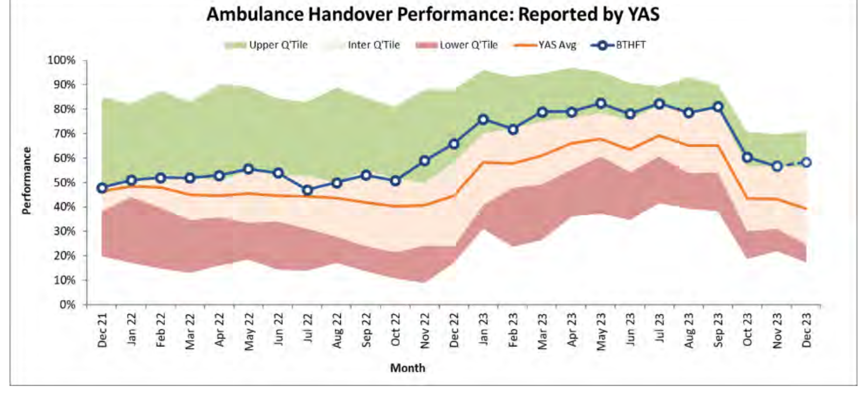
Figure 1 Ambulance Handovers – Attributable to BTHFT



The number of delayed handovers in November was 220 between 30 and 60 minutes and 45 over 60 minutes (this is the validated internal position which excludes resus, crew delays and patients transferred to other units).

Note: Changes in YAS clock reporting commenced in October.

Figure 2 Ambulance Handovers – Yorkshire Comparison



Benchmarking data as supplied by the Yorkshire Ambulance Service (YAS) shows performance at BTHFT remains above the regional average for handover within 15 minutes (all reasons for delay included).

Ambulance Handover Improvement:

- Live data sharing continues to support the deployment of YAS leads at site when required.
- Escalation protocol is in place with assessment area expansion as required. System Control Centre (SCC) exception reports are being used to identify improvement actions.
- Executive-level oversight continues to ensure rapid intervention for any handover delay more than 2 hours, or when there are more than 5 handover delays more than 1 hour.
- Estate works completed in September for the ambulance assessment area have increased bay capacity by 20%.
- Following business case approval YAS have appointed a HALO person for BTHFT, the HALO started post in early December 2023, working weekdays between 10am to 8pm.
- Daily validation exercise in place to support timely remedial action, a reduction can be seen in number of records requiring correction since HALO person started in December.

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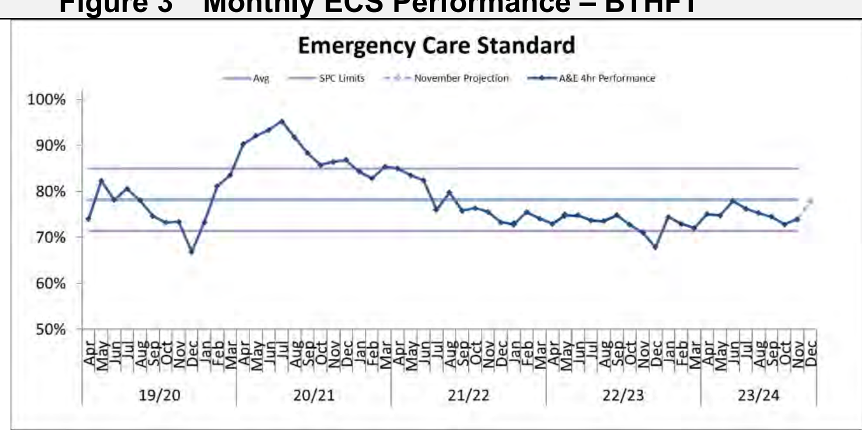
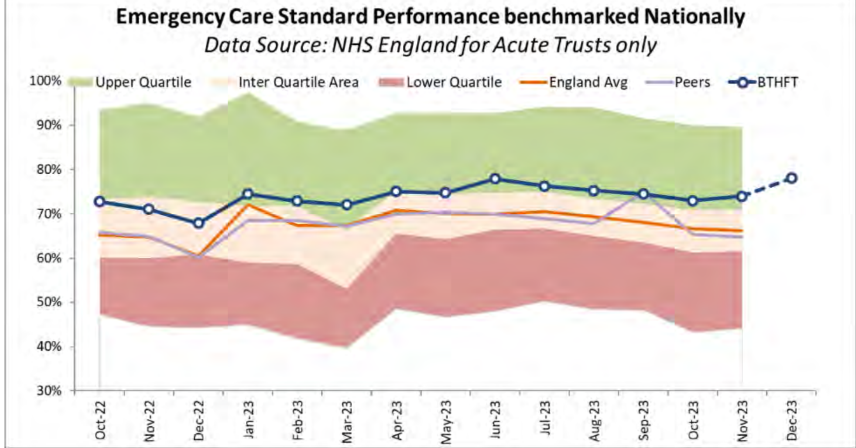
4. Emergency Care Standard (Type 1&3)

Figure 3 Monthly ECS Performance – BTHFT



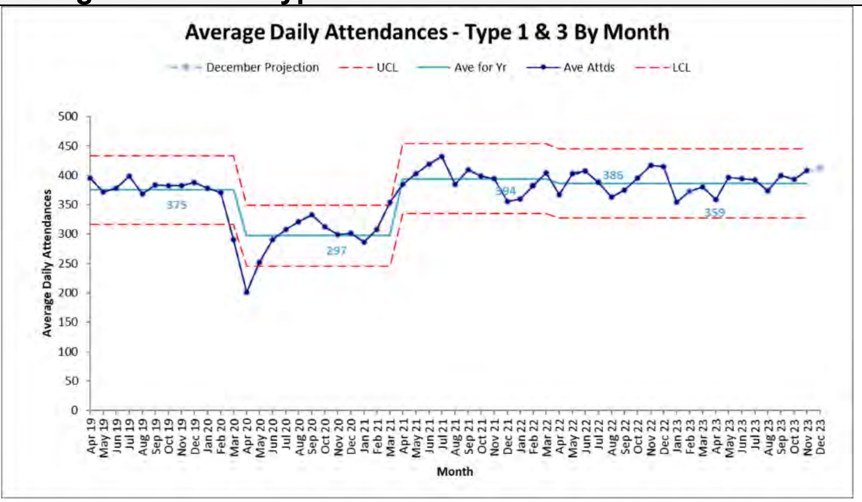
BTHFT reported a position of 73.94% for the month of November 2023. December 2023 position is forecast to be 77.92%.

Figure 4 ECS Performance – National Comparison



A comparison of ECS performance for acute Trusts in England shows that BTHFT's performance remains above the England and peer averages. It also continues to be within the upper quartile of performance.

Figure 5 ECS Type 1&3 A&E Attendances – BTHFT



The Trust has continued to experience a high number of daily attendances during November 2023, with a daily average of 408.

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5. Emergency Department Measures

Table 2 ECS KPI Performance – BTHFT

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Average Daily Attendances	354	373	381	359	396	394	392	373	400	393	408	409
Average Daily Breaches	91	101	106	89	100	87	93	92	102	107	106	90
ECS Performance	74.44%	72.92%	72.03%	75.08%	74.79%	77.91%	76.31%	75.30%	74.48%	72.84%	73.94%	78.06%
Arrival to Assess	00:22	00:24	00:25	00:22	00:22	00:22	00:21	00:22	00:22	00:24	00:26	00:24
Assess to Treat	01:49	01:59	02:09	01:41	01:47	01:42	01:44	01:40	01:47	01:47	01:58	01:41
Treatment Length	02:18	02:29	02:32	02:25	02:17	02:09	02:09	02:19	02:23	02:27	02:39	02:25
Total LOS - Discharged Patients	03:50	04:05	04:09	03:52	03:47	03:39	03:37	03:41	03:49	03:53	03:46	03:10
Total LOS	04:54	05:19	05:20	04:53	04:44	04:39	04:41	04:43	04:50	04:53	04:45	04:19

Medical workforce pressures and patient flow delays within the hospital continue to have an impact on the performance of the department with attendance levels remaining high. The launch of the AECU model in late November has contributed to reducing the number of ECS breaches and improved total LOS in the department.

Emergency Department Improvement:

- Expanded GP stream with a start time of 8am continues, supported by a primary care ANP, streamer and receptionist. Band 6 streamers started post in Dec 23, providing rapid assessments into the primary care services.
- Additional GP stream capacity was organised with Bradford Care Alliance's (BCA) to support the surge in the department. Minors/MSK service is now seeing paediatric children from the age of 8, prior to this it was 12 years of age. Work continues to expand the age range and conditions covered by the GP Stream, with an aim to maximise number of patients redirected from ED, utilisation of GP stream in November was 80% and total contracted activity delivered at 90%.
- The change in the front door model has allowed the department to time-stamp patients at initial assessment with a senior nurse. This has improved the accuracy and performance of this KPI and has also helped contribute to managing the Ambulance Handover performance more effectively.
- The introduction of the AECU model in November has shown several benefits for ED, including improving ECS performance. Once a patient is assessed and streamed to the AECU, the 4-hour clock is stopped as a type 1, and then recorded as a type 5 attendance.
- A follow-up senior consultant led Rapid Assessment Triage (RAT) trial is planned for December. The purpose of the trial is to investigate and deep dive the reasons for patient delays and blockages, improve patient flow, provide a forum for quality/safety discussions, and undertake regular team huddles to act upon feedback and identify improvement opportunities.
- By utilising RAT, UCC, Primary Care, AECU and Streaming we expect the outcomes of this trial to reduce waiting times in ED, assessment areas, the number of unnecessary admissions and the number of patients waiting for discharge within 4 hours.

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6. Hospital Admission Measures

Table 3 ED Admissions KPI Performance – BTHFT

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Conversion Rate*	25.82%	25.27%	23.83%	23.71%	24.01%	22.63%	24.26%	24.69%	24.18%	24.98%	23.01%	20.44%
Average Daily Admissions	91	94	91	85	95	89	95	92	97	98	94	84
DTA to Admit	04:37	05:20	05:21	04:42	04:17	03:38	03:20	04:03	04:02	04:21	05:06	04:42
Total LOS - Admitted Patients	07:51	08:42	09:00	08:11	07:44	07:03	06:42	07:15	07:31	07:38	08:01	08:05
% of Patients >12 Hours LoS	5.44%	7.23%	7.85%	5.41%	4.68%	3.79%	3.11%	5.43%	5.70%	5.87%	6.80%	6.29%

There has been a notable reduction in admissions post AECU go live, notably 0 to 1 day LOS (SDEC incorporated into AECU). An improvement has also been seen in timely in-reach to the A&E department from various specialties, allowing decisions for admission to be managed appropriately and support admission avoidance. When compared to our WYATT peers, our conversion rates are now comparable to other sites post-AECU.

ED Admission Improvement:

- A performance monitoring structure remains in place, analysing the impact of wards and supporting services on ED performance. The weekly ECS Breach Review meeting has been extended to the wider teams to support improvements.
- A 7-day consultant of the week model remains in place, ensuring all inpatients receive a senior review daily, including those in downstream medical and surgical beds.
- The introduction of the AECU model is expected to relieve over-crowding and improve department flow across ED. Prior to AECU, an increase in the number of patients being admitted to SDEC had been sustained, which was contributing to relieving pressure from ED. It is expected the AECU will improve conversion rates and LoS metrics.
- VRI (Virtual Royal Infirmary) project is underway to introduce virtual pathways for inpatients to reduce LOS and overall bed occupancy and improve flow from ED to wards.
- The Patient Flow Hub, formed in July 2023 continues to focus on operational running of the department and maintaining a high quality and safe service. The hub provides situational oversight within the department to ensure a high-level understanding of how many patients are in the department and associated risks. It is a single access point for coordinating information and ensuring a swift response to operational issues.
- The ED team continues to attend the operational huddle twice a day, improving communication across the department and ward flow.

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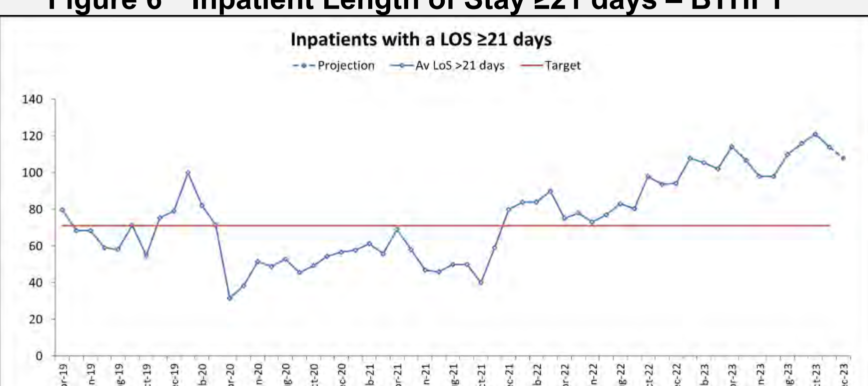
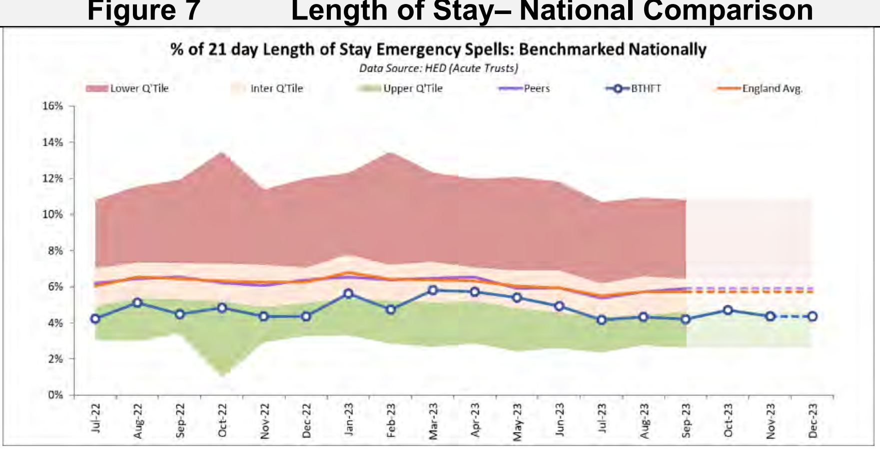
7. Inpatient Length of Stay (LOS) and Discharge KPI

Figure 6 Inpatient Length of Stay ≥21 days – BTHFT



The number of patients with a LOS over 21 days remains high, increasing to an average of 114 patients per day in November 2023. December 2023 position is projected at 108 patients per day.

Figure 7 Length of Stay– National Comparison



The percentage of patients with a LoS over 21 days has reduced to 4.38% in November.

The number of patients with >21-day LoS remains high due to the number requiring therapy intervention in addition to external factors such as waiting for care home beds and social care assessment. A system approach to reducing the pressure on social care is being explored but the availability of care packages and IMC capacity will present a challenge for discharge delays until resolved.

Table 4 Discharges on Discharge Ready Date (MFFD)

	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
# Total Adult G&A Discharges from Inpatient Wards	3191	3643	3526	3676	3262	3222	3225	3017	3103
Of those Discharged, # with Discharge Ready Date	3030	3448	3334	3517	3090	3035	3006	2831	2873
Of those Discharged, % with Discharge Ready Date	95%	95%	95%	96%	95%	94%	93%	94%	93%
# discharged on or before MFFD date	2504	2821	2694	2908	2522	2470	2465	2257	2204
% discharged on or before MFFD date	83%	82%	81%	83%	82%	81%	82%	80%	77%
# discharged beyond MFFD date	526	627	640	609	568	565	541	574	669
% discharged beyond MFFD date	17%	18%	19%	17%	18%	19%	18%	20%	23%
Avg stay beyond discharge ready (MFFD) date	3	3	3	3	4	3	4	5	5

In addition to delays, the Trust is monitoring several discharge KPI using the medically fit for discharge date and criteria to reside process. MFFD data capture is at 93% for discharges from adult inpatient wards. Of those with an MFFD 81% are discharged as planned. Of those not discharged on this date the average delay is just under 4 days.

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A patient's suitability for discharge is also expressed through their criteria to reside which is reported nationally each day. At present c.15% of patients in adult G&A beds do not have a criteria to reside meaning they are ready to be discharged but remain in a hospital bed. The increase in NCTR is mostly attributed to the on-going external challenges with P1 capacity which we are working through with Local Authority partners. Indications are this is likely to continue into the New Year

Length of Stay and Discharge Improvement:

- A daily review of patients who no longer meet the 'Criteria to Reside' in a hospital bed for their episode of care is in place. This KPI is part of the extended weekly oversight and improvement meetings.
- A review of IMC processes is being undertaken to identify efficiencies, and to escalate when required to system partners regarding the delays experienced in IMC.
- Our lead for in-patient therapy continues to review all those patients with a LLOS >21 days attributed to being medically but not yet therapy optimised and attends the weekly ECS meeting where trends and themes will be identified and shared for learning and continuous improvement.
- Discussions continue between Multi Agency Integrated Discharge Team (MAIDT) and Therapy colleagues to determine any roles and/or tasks that the therapists currently complete that could potentially be undertaken by the discharge co-ordinator.
- Ward 27 is our designated ward for patients who are medically optimised and are waiting for therapy or social care input before discharge.
- All stroke patients automatically referred to the MAIDT at the point they are stepped down from HASU for MDT and family discussions regarding discharge to begin early.
- Weekly deep dive of LLOS >21 days, and meetings are held with Deputy Directors of Nursing, & Therapies to focus on this cohort of patients, and this will continue for the coming weeks.
- A 6-week QI programme is being developed for launch in early 2024, aimed at more involvement from the wider MDT and leadership teams involved in these patients care and discharge planning.

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8. Activity Compared to Plan

8.1. Inpatient Activity

Figure 8 Elective Spells

Day Case Spells (Source: EPR)

	Target	Plan	Actual
Apr-23	110%	91%	85%
May-23	110%	95%	89%
Jun-23	110%	115%	109%
Jul-23	110%	100%	91%
Aug-23	110%	120%	109%
Sep-23	110%	108%	96%
Oct-23	110%	111%	95%
Nov-23	110%	118%	107%
Dec-23	110%	112%	*95%*
Jan-24	110%	107%	
Feb-24	110%	113%	
Mar-24	110%	107%	

Ordinary Spells (Source: EPR)

	Target	Plan	Actual
Apr-23	110%	82%	75%
May-23	110%	85%	81%
Jun-23	110%	94%	88%
Jul-23	110%	96%	78%
Aug-23	110%	102%	76%
Sep-23	110%	105%	81%
Oct-23	110%	111%	78%
Nov-23	110%	108%	86%
Dec-23	110%	100%	*95%*
Jan-24	110%	102%	
Feb-24	110%	95%	
Mar-24	110%	99%	

Day case and elective ordinary activity increased in November however both remain significantly behind plan. Total elective activity recorded an average of 1,020 spells per week and 205 spells per day, exceeding the baseline of 964 spells per week in November 2019. Day case activity is projected to reduce in December whilst ordinary activity is expected to increase.

The number of patients per theatre list has marginally increased to 2.0, whilst overall time utilisation remains at the 2019/20 average. Weekly reviews continue to support theatre productivity at a speciality level. A forward view of theatre utilisation has now been introduced into weekly Access meetings alongside targets to facilitate greater oversight of list allocation and identify/remedy issues in advance.

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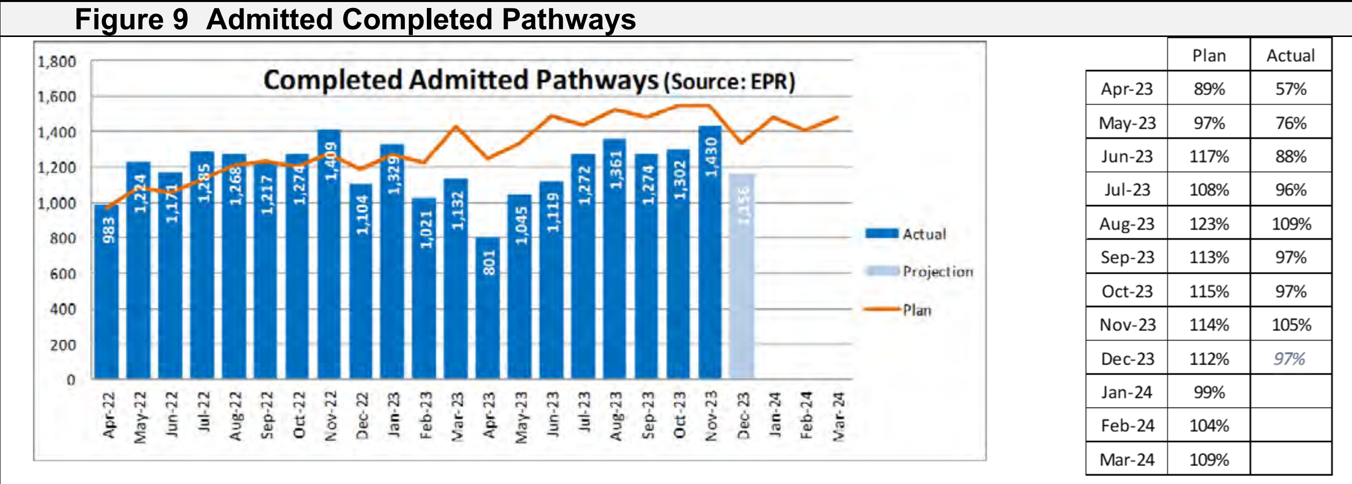
Figure 9 Admitted Completed Pathways

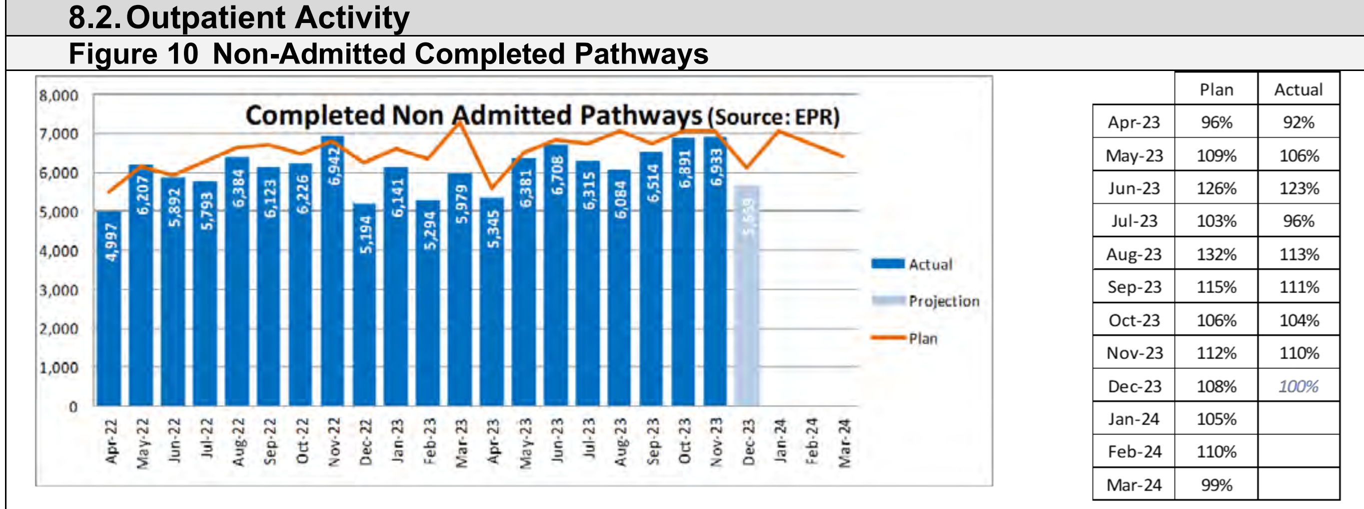


	Plan	Actual
Apr-23	89%	57%
May-23	97%	76%
Jun-23	117%	88%
Jul-23	108%	96%
Aug-23	123%	109%
Sep-23	113%	97%
Oct-23	115%	97%
Nov-23	114%	105%
Dec-23	112%	*97%*
Jan-24	99%	
Feb-24	104%	
Mar-24	109%	

The number of admitted clock stops increased in November in line with elective activity but remains behind plan. The number of completed admitted pathways is expected to decrease in December due to industrial action.

8.2. Outpatient Activity

Figure 10 Non-Admitted Completed Pathways



	Plan	Actual
Apr-23	96%	92%
May-23	109%	106%
Jun-23	126%	123%
Jul-23	103%	96%
Aug-23	132%	113%
Sep-23	115%	111%
Oct-23	106%	104%
Nov-23	112%	110%
Dec-23	108%	*100%*
Jan-24	105%	
Feb-24	110%	
Mar-24	99%	

Non-admitted clock stops increased in November in line with new and follow up activity and ongoing focus on validation. Clock stops in December are projected to decrease.

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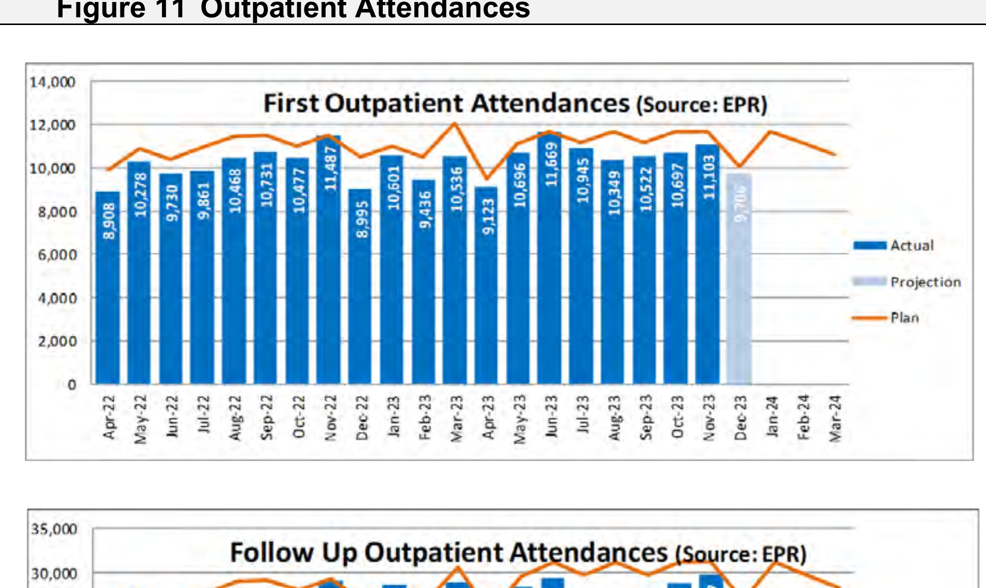
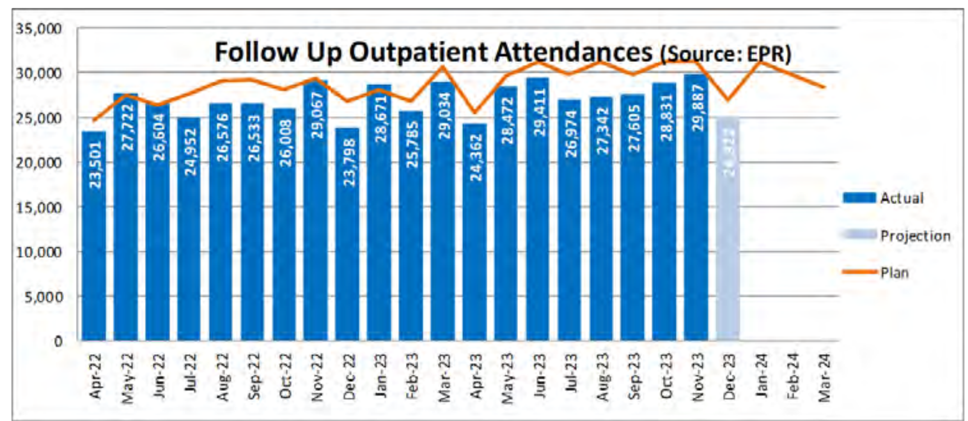
Figure 11 Outpatient Attendances



	Target	Plan	Actual
Apr-23	110%	100%	96%
May-23	110%	112%	108%
Jun-23	110%	126%	126%
Jul-23	110%	105%	103%
Aug-23	110%	128%	113%
Sep-23	110%	116%	109%
Oct-23	110%	113%	103%
Nov-23	110%	119%	113%
Dec-23	110%	116%	*111%*
Jan-24	110%	112%	
Feb-24	110%	122%	
Mar-24	110%	121%	

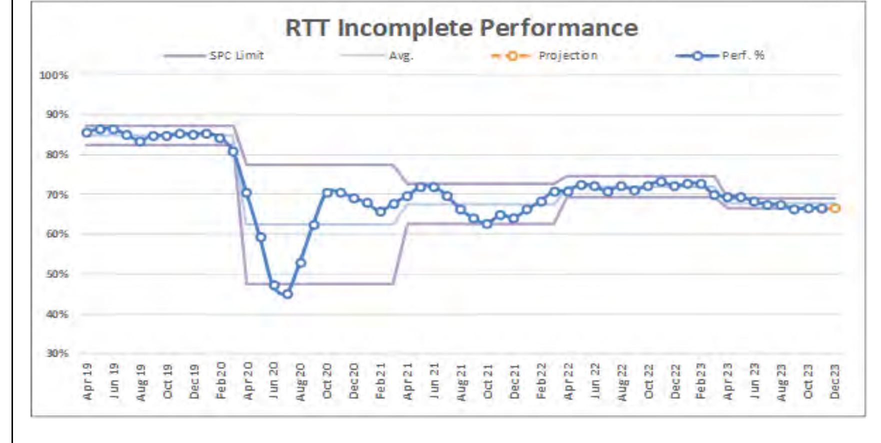


	Target	Plan	Actual
Apr-23	85%	91%	87%
May-23	85%	104%	100%
Jun-23	85%	115%	109%
Jul-23	85%	97%	88%
Aug-23	85%	121%	107%
Sep-23	85%	104%	97%
Oct-23	85%	102%	94%
Nov-23	85%	111%	106%
Dec-23	85%	108%	*100%*
Jan-24	85%	103%	
Feb-24	85%	113%	
Mar-24	85%	101%	

First and follow up attendance activity increased in November. A forward view on clinic utilisation has been introduced to weekly Access to ensure efficient use of available slots. PIFU options have been improved on Cerner to support further uptake across all services which should result in a reduction of follow ups in line with the 25% reduction target.

9. Referral to Treatment (RTT)

Figure 12 Monthly 18 Week RTT Incomplete Performance



The Trust's 18 Week RTT position for November 2023 is 66.59%. Performance is currently projected to remain relatively stable in December to 66.49%.

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Figure 13 Monthly 18 Week RTT Incomplete Performance

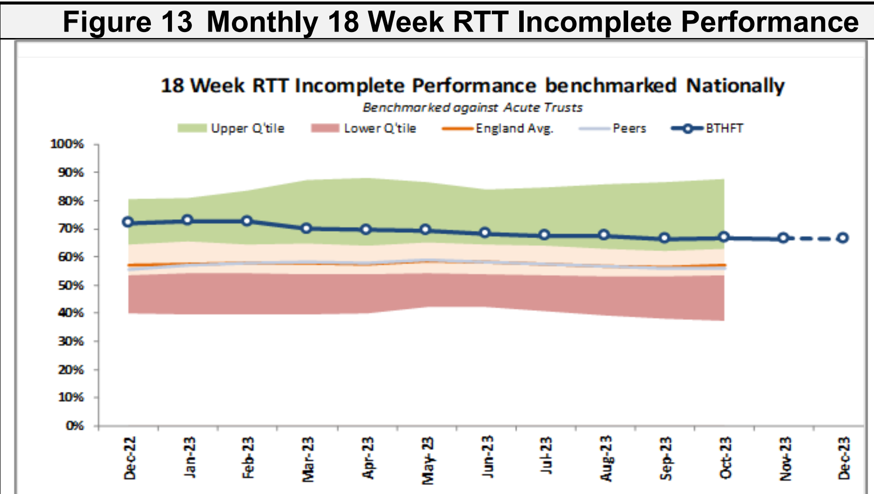
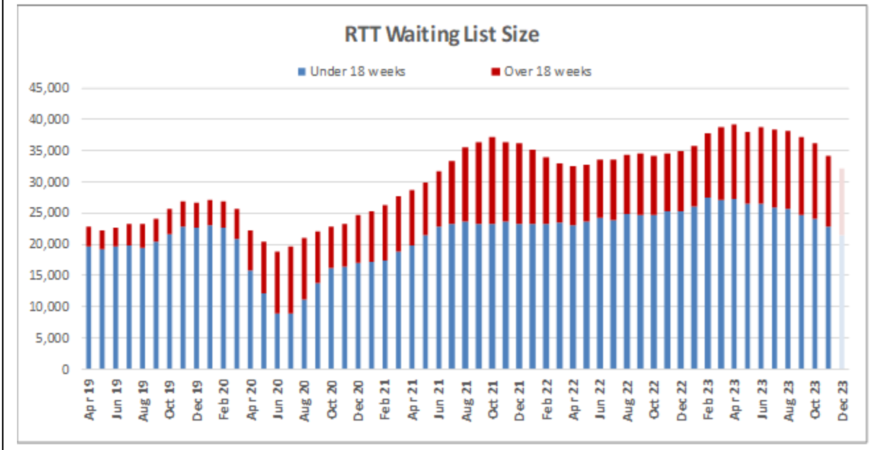


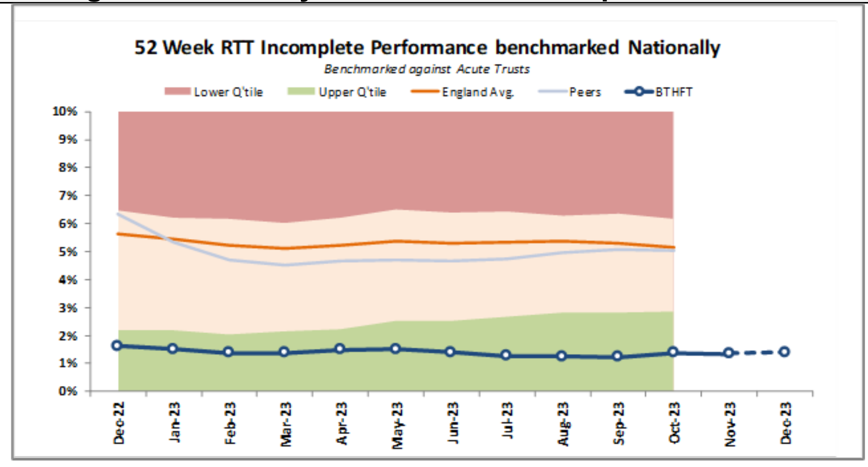
Figure 13 shows a national comparison of RTT Incomplete performance for acute Trusts with BTHFT significantly above the England and Peer average and remaining in the upper quartile.

Figure 14 RTT Total Waiting List



The overall waiting list has decreased in November and is projected to reduce further in December.

Figure 15 Monthly 52 Week RTT Incomplete Performance



52 Week RTT performance stands at 1.37% in November. 0 patients had a wait time of 78+ weeks at month end. Current projections indicate there will be 0 patient that will breach the 78+ week position by the end of December with focus now on the cohort of patients who risk breaching 65+ by year end.

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Activity and RTT Improvement:

- Application of GIRFT outpatient guidance continues to be reviewed across all services and weekly meetings to review progress have now commenced.
- Patients are being routinely contacted via SMS as part of the waiting list management initiative aligned to the national validation toolkit recommendations. 47,922 patients have been contacted to date who meet the required criteria with 1,753 requesting discharge (3.7%).
- PIFU use decreased to 1.9% in November (-0.2% to October). The Trust has worked with Calderdale to update PIFU options on Cerner to support a consistent process that's more easily adopted.
- A video to support elective admissions into the hospital will be shared with patients. It will be produced in multiple languages to support our patient demographic. A similar video for outpatient attendances is also being planned. These should improve patient experience and compliance and will be part of the pre-op assessment project with VRI.
- Services continue to trial text messages to reduce DNA rates, with 11 specialities now trialling the top 2 reminder messages. These messages will run until the end of February 2024, where the impact of the messages on the DNA rate will be quantified. Additional ideas will be generated through the WYATT DNA improvement group. The Trust will explore the use of a DNA predictor tool which will advise services of the patients most likely to DNA.
- Bookwise is expected to launch in H2 to improve oversight and management of room utilisation.
- SeeMeSooner is being implemented and will allow patients to have greater involvement in their appointments which will further support reductions in DNAs and help improve clinic utilisation.
- Weekly access meetings are utilising forward view reports which enable services to take action to ensure theatre lists and clinics are fully utilised, meeting internal targets.
- Web-based waiting list management tools are being launched which will improve functionality and support better oversight of patient pathways. These tools are expected to be launched in Q4. Work is also underway to improve visibility of RTT weeks wait for our clinicians through an RTT dashboard.
- Performance improvement and recovery meetings will commence in January to support in-depth waiting list reviews, and capacity and demand planning.
- Services will also be asked to participate in service improvement planning, beginning in Q4. This will take the form of a service review of various core elements of service management work to be presented back to the wider group.
- CPBS to CSU agenda has been agreed to ensure clinic utilisation targets and chronological booking is being adhered to.
- Validation of the non-RTT waiting list is underway with services being supported by the Access Team to ensure a cleansed position. All non-RTT patients over 3 months past their see by date have now been validated and all patients who were last validated 12 months ago have been revalidated. Text based validation will be extended to non-RTT waits in the coming quarter.
- The Corporate Access Team is delivering face to face and virtual drop-in pathway validation sessions for secretaries and admin staff across the trust.
- A review of RTT sequencing on Cerner is underway as a joint project between BTHFTs, CHFT's and AGH's access teams. The output of this project will improve clinic outcome options for clinicians, in line with RTT pathway management.

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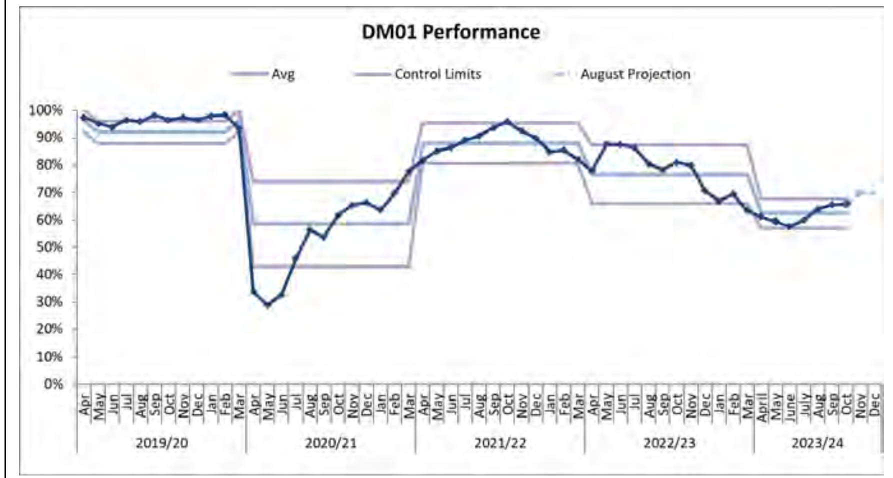
10. Diagnostic Waiting Times

Figure 16 Monthly 6 Week DM01 Performance



November 2023 performance which was 69.74% and part of an improving trend.

Figure 17 Diagnostics – National Comparison

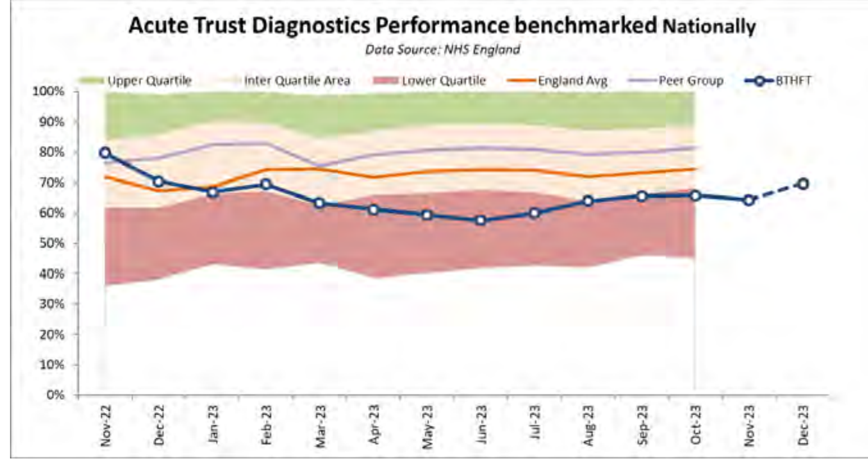


Figure 17 shows a national comparison of DM01 6-week diagnostic performance. Further work is being undertaken in this area and performance is expected to improve as the new Community Diagnostic Centre come on line in February 2024.

Table 4 DM01 6-week diagnostic standard by modality

Site	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	*Dec-23*
TRUST	**66.9%**	**69.4%**	**63.3%**	**61.2%**	**59.4%**	**57.5%**	**59.9%**	**63.9%**	**65.6%**	**65.8%**	**69.7%**	***69.8%***
Audiology Assessments	86.9%	95.7%	92.2%	88.1%	95.1%	85.1%	80.4%	79.3%	79.0%	75.5%	68.8%	***67.9%***
Cardiology - echocardiography	90.8%	93.0%	76.2%	71.8%	86.4%	86.2%	90.2%	91.7%	83.8%	65.5%	57.4%	***49.8%***
Colonoscopy	47.9%	51.6%	70.1%	72.4%	76.0%	72.5%	71.6%	72.1%	66.3%	75.9%	73.6%	***73.1%***
Cystoscopy	97.1%	96.1%	96.2%	97.2%	94.6%	72.5%	82.0%	100.0%	100.0%	100.0%	100.0%	***100.0%***
Flexi sigmoidoscopy	56.8%	64.3%	70.2%	80.2%	70.4%	75.3%	84.2%	70.7%	74.6%	84.5%	80.0%	***80.0%***
Gastroscopy	51.0%	55.6%	72.9%	73.4%	67.6%	77.3%	75.7%	71.5%	69.3%	77.0%	74.2%	***73.1%***
Computed Tomography	92.4%	99.6%	94.3%	90.1%	95.9%	94.7%	97.4%	94.3%	94.3%	92.3%	99.7%	***98.1%***
DEXA Scan	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	***100.0%***
Magnetic Resonance Imaging	72.0%	78.8%	64.1%	73.6%	75.3%	76.0%	80.1%	71.3%	68.7%	67.8%	74.2%	***74.6%***
Non-obstetric ultrasound	53.5%	52.6%	44.5%	38.8%	33.2%	33.1%	32.3%	38.9%	38.6%	42.4%	49.1%	***53.7%***
Neurophysiology - periph neuro	100.0%	98.8%	100.0%	100.0%	100.0%	98.5%	100.0%	94.0%	100.0%	100.0%	100.0%	***100.0%***
Respiratory phys - sleep studies	97.1%	99.0%	97.9%	92.6%	95.8%	97.1%	93.1%	88.2%	79.8%	67.8%	70.7%	***70.5%***
Urodynamics - pressures & flows	98.0%	91.7%	85.1%	89.0%	80.7%	81.8%	91.1%	86.3%	76.0%	71.4%	64.3%	***61.2%***

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Diagnostic Improvement:

- Strategic workforce planning supported by HR Business partners is underway to unpick and resolve recruitment issues across diagnostic modalities, working holistically to grow the workforce for the future and improve resilience through long term joined up planning.
- The BRI Endoscopy Programme Board are leading work and planning for the new Endoscopy Unit. Under this umbrella a Workforce Delivery Group will be established to ensure appropriate workforce are in place to deliver the associated care.
- NOUS outsourcing is continuing to Yorkshire Health Solutions with a sustainability plan in place which will introduce insourcing to run alongside existing provision.
- Medinet continue to provide insourced MRI capacity, which is reducing numbers of patients waiting and the longest wait for patients will have dramatically decreased within the next few weeks.
- The CDC is expected to go live in January for Ultrasound and then in February for MRI, CT & primary imaging. With greater community diagnostic provision being planned, a gap analysis is underway to develop a system-wide approach for access and the visibility of patient information.
- Endoscopy validation continues to highlight issues affecting performance. The reported position is expected to improve as a result, and the backlog reduce even further. Working with informatics to trial a new validation tool in place of spreadsheets will help speed this up.
- A mobile CT scanner will be in place at BRI as part of a significant piece of work which is underway to bring the Cardiac CT waiting list down. It is expected that this will begin to positively impact the DM01 performance from November.
- A new booking process has been implemented in Endoscopy during November which will see the service booking ahead for the next 6 weeks. A 6-4-2 process will also be introduced from 20/11/2023, replicating what is already in place in theatres.

11. Cancer Standards

Table 5 Cancer Standards – Overview by Indicator – BTHFT

Measure	Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	*Nov-23*	*Dec-23*
14 day GP referral for all suspected cancers	93%	95.3%	95.6%	94.1%	91.5%	93.4%	95.8%	96.8%	94.9%	94.0%	95.8%	*96.4%*	*96.5%*
14 day breast symptomatic referral	93%	97.4%	96.9%	94.4%	97.3%	98.7%	93.5%	97.4%	94.5%	96.9%	93.5%	*96.6%*	*96.3%*
31 day first treatment	96%	93.8%	92.5%	96.8%	94.7%	97.3%	93.6%	94.3%	97.3%	93.1%	92.6%	*88.7%*	*92.8%*
31 day subsequent drug treatment	98%	78.7%	97.6%	97.3%	88.1%	93.4%	95.0%	96.9%	93.5%	98.3%	91.4%	*83.6%*	*88.1%*
31 day subsequent surgery treatment	94%	77.0%	79.1%	86.5%	83.3%	89.1%	91.1%	95.0%	93.8%	90.7%	88.6%	*84.8%*	*86.8%*
62 day GP referral to treatment	85%	78.2%	72.0%	78.7%	81.9%	67.0%	76.2%	74.6%	72.2%	70.3%	69.5%	*61.1%*	*66.1%*
62 day screening referral to treatment	90%	82.1%	87.0%	71.4%	83.3%	84.2%	87.1%	71.4%	78.6%	28.1%	75.6%	*65.3%*	*63.2%*
62 day consultant upgrade to treatment		44.4%	42.1%	27.3%	37.5%	70.6%	71.4%	100.0%	66.7%	66.7%	71.4%	*72.1%*	*58.3%*

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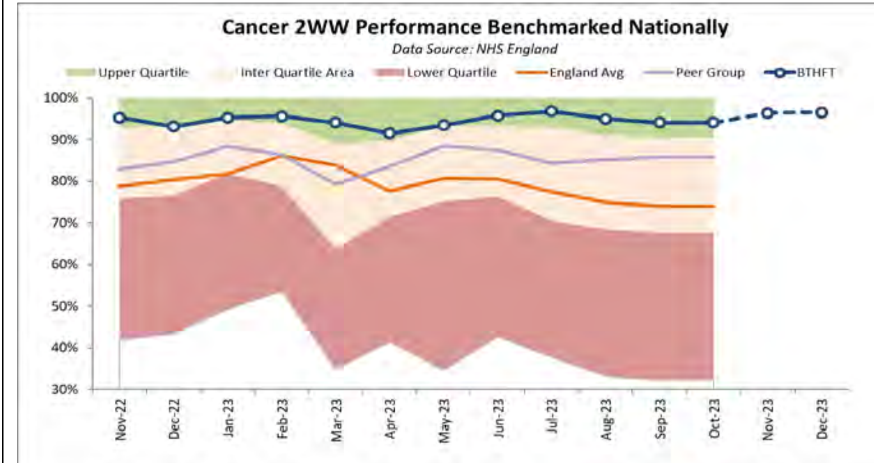
Cancer Wait Time Improvement:
• Joint working with primary care is underway to better understand high referral patterns with a specific focus on Increasing earlier diagnosis, particularly for communities with low presentations and poorer outcomes. • Planning is underway to further roll out Pathway Navigator role expansion to all tumour groups, along with Cancer Nurse Specialist roles as appropriate. The impact of existing roles has been positive improving patient access and experience. • Implementation of frailty pathways for Cancer which has been identified as a service level priority in response to our known population demographics and the success of the previous GI pilot is progressing. Subsequent comprehensive geriatric assessments offer an opportunity to identify and address health problems which may then optimise fitness and well-being for this cohort of patients. • Significant work continues around FDS performance, with a continuing Transformation piece of work focusing on histology pathways alongside job planning and prioritisation processes to develop system improvement. • Best Practice Timed Pathway monitoring is being rolled out across additional Tumour sites with medium term plans to develop a BPTP dashboard to support and inform service level performance against patient pathway milestones which can then highlight challenges and shape plans for improved patient experience and outcomes. • GIRFT reviews have indicated that in line with BPTP further areas would benefit from the development of the one stop clinic model. Planning is underway to facilitate this and modify systems accordingly to accommodate the change, supported by BI and Performance. • Changes to appointment letters which provide more information about what patients should expect have been approved. This greater will reduce DNA caused by patients wishing to change their appointment at the last minute. • Version 12 of the Cancer Wait Time standards is being implemented. Reporting is expected to transition to reflect the new standards on December providing greater visibility of performance against the 31day first treatment standard, and a combined 62day performance. • Early in October services started planning for the prolonged Christmas and New Year holidays and escalating where issues are identified. Work to switch and add extra capacity are already underway to mitigate impacts on patients and sustain clinics throughout the festive period.

11.1. Cancer 2 Week Wait

Figure 18 2WW National Comparison – BTHFT



Performance in October 2023 places the Trust in the upper quartile, significantly above peer group and England average.

Table 6 2WW Performance by Tumour Group

Site	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
TRUST	95.3%	95.6%	94.1%	91.5%	93.4%	95.8%	96.8%	94.9%	94.0%	95.8%	96.43%	96.54%
Breast	99.5%	96.5%	96.3%	96.6%	99.5%	95.8%	96.8%	97.5%	97.8%	93.4%	96.96%	95.81%
Gynae	93.7%	90.7%	96.6%	92.6%	93.5%	92.2%	94.5%	93.3%	78.2%	93.1%	94.16%	95.45%
Haematology	8.3%	56.5%	75.0%	84.6%	88.2%	66.7%	100.0%	40.0%	90.5%	76.5%	85.71%	90.91%
Head & Neck	96.4%	97.6%	94.5%	96.2%	93.7%	94.9%	98.3%	96.6%	91.3%	95.1%	96.35%	96.30%
Lower GI	93.3%	90.0%	83.6%	69.3%	80.7%	93.6%	93.8%	86.9%	86.5%	92.1%	94.68%	94.34%
Lung	98.1%	100.0%	100.0%	98.2%	100.0%	98.1%	100.0%	100.0%	100.0%	100.0%	100.00%	100.00%
Other	100.0%	97.4%	96.8%	100.0%	85.7%	97.7%	95.5%	100.0%	100.0%	100.0%	100.00%	100.00%
Skin	98.8%	99.5%	98.3%	100.0%	97.3%	96.4%	97.0%	98.9%	99.5%	99.3%	97.93%	97.43%
Upper GI	90.7%	97.0%	92.5%	92.4%	96.4%	99.2%	97.2%	95.7%	89.6%	93.2%	94.81%	97.32%
Urology	99.2%	99.3%	97.4%	98.4%	100.0%	99.2%	99.2%	96.6%	98.5%	99.3%	97.74%	100.00%
NSS							100.0%	100.0%	100.0%	100.0%	96.15%	94.12%

Demand remained high in October due to sustained high seasonal referrals and national awareness campaigns. November will see greater capacity and an improvement in overall performance as a result.

Referrals to skin have remained extremely high during October but consistent forward planning of additional clinics and monitoring utilisation kept performance over 99%. The National awareness campaigns running through October specifically focused on lung and breast cancer awareness which led to increased referral rates. Services are planning additional capacity and adapting clinic capacity to accommodate going forwards.

Moving into November improvements in booking processes, along with services returning to full clinical capacity are supporting a continued improvement in 2WW performance.

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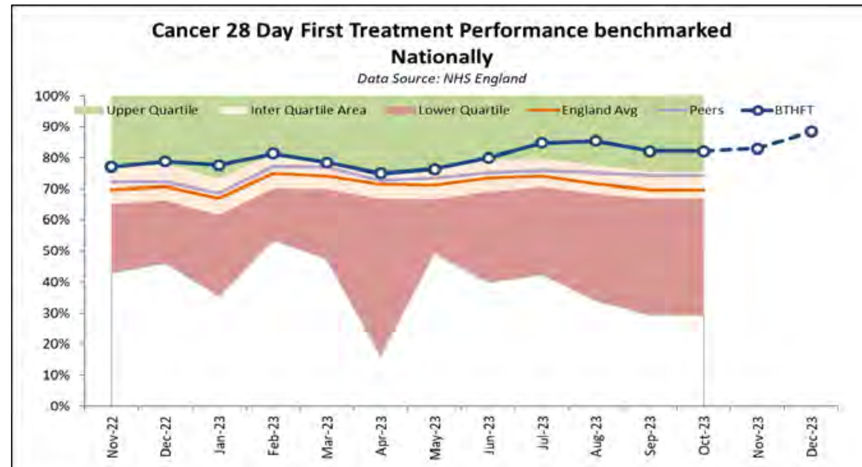
11.2. Cancer 28 Day Faster Diagnosis

Figure 19 28 Day National Comparison – BTHFT



Performance in October 2023 places the Trust in the upper quartile, remaining above peer group and England average.

Table 7 28 Day Faster Diagnosis Standard (FDS)

Site	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
TRUST	75.5%	80.4%	76.8%	73.3%	75.1%	79.3%	84.2%	85.1%	81.5%	83.5%	83.01%	88.54%
Breast	98.0%	101.8%	98.7%	96.1%	97.5%	98.4%	97.4%	97.6%	97.7%	96.6%	98.69%	96.84%
Gynae	51.1%	70.1%	55.2%	61.5%	63.3%	65.7%	59.3%	67.5%	49.6%	64.7%	94.12%	89.83%
Haematology	5.9%	23.8%	36.8%	50.0%	23.1%	27.3%	30.0%	20.0%	70.0%	33.3%	43.75%	50.00%
Head & Neck	75.3%	73.3%	66.8%	77.6%	77.4%	74.3%	81.6%	91.3%	80.4%	86.5%	87.15%	95.48%
Lower GI	69.6%	74.6%	74.2%	64.5%	63.0%	68.8%	80.2%	77.6%	71.9%	73.6%	71.63%	76.19%
Lung	85.7%	85.2%	81.7%	86.5%	87.9%	87.2%	96.7%	76.7%	90.0%	83.3%	78.38%	83.87%
Other	36.0%	84.0%	71.4%	65.0%	79.4%	61.1%	97.6%	33.3%	100.0%	100.0%	0.0%	33.33%
Skin	83.5%	85.5%	81.7%	74.6%	79.5%	88.5%	87.6%	89.0%	88.5%	86.7%	81.87%	90.91%
Upper GI	68.6%	85.4%	80.0%	72.5%	62.2%	73.5%	79.1%	89.6%	76.7%	84.7%	92.19%	91.07%
Urology	73.1%	69.6%	65.4%	65.1%	71.7%	71.8%	67.5%	80.5%	65.7%	81.3%	73.75%	82.76%
NSS							20.0%	57.1%	66.7%	50.0%	75.00%	81.82%

FDS performance has continued above target at 83.53% in October. Current overall performance is higher due to the volume of skin referrals and the relatively strong performance of this tumour group. The number of patients undiagnosed and over 28 days has increased however and therefore future performance is expected to drop slightly although targeted work on the administrative systems around updating diagnosis or ruling out of cancer are expected to have a positive impact going forward.

Histology delays have been a significant problem for certain tumour groups with intensive work continuing with the service so that a sustainable solution is embedded. Skin and Gynae were impacted most by these delays, hence specific process improvements are being trialled to see what brings about the greatest sustainable improvements. Work is underway to amend job plans to ensure areas with the highest volumes of referrals are targeted whilst addressing the longest waiting patients. New prioritisation methodologies or approaches are being closely monitored and any improvements measured to support longer term solutions and sustain improved performance.

Improvements to Gynae, Skin and Urology performance are forecast for November due to greater capacity and regularity of MDT's. Lower GI and Upper GI are also expected to improve as we head into December with improvements to referral and booking processes being embedded.

Meeting Title	Open Board of Directors Meeting		
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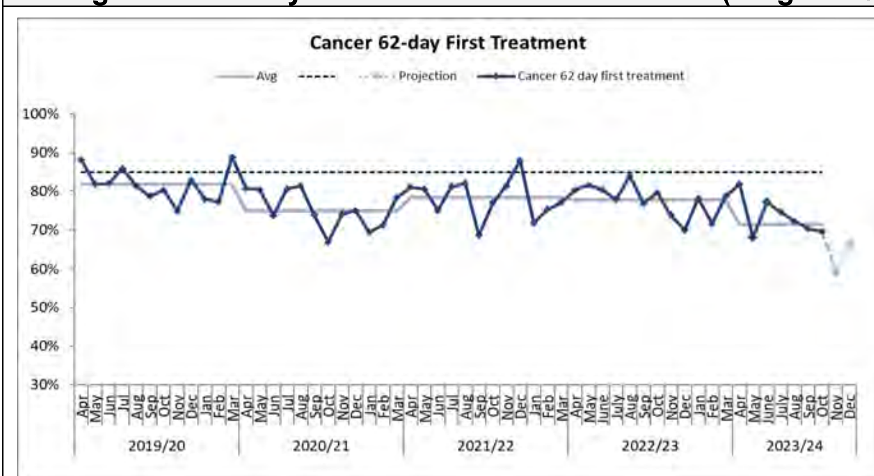
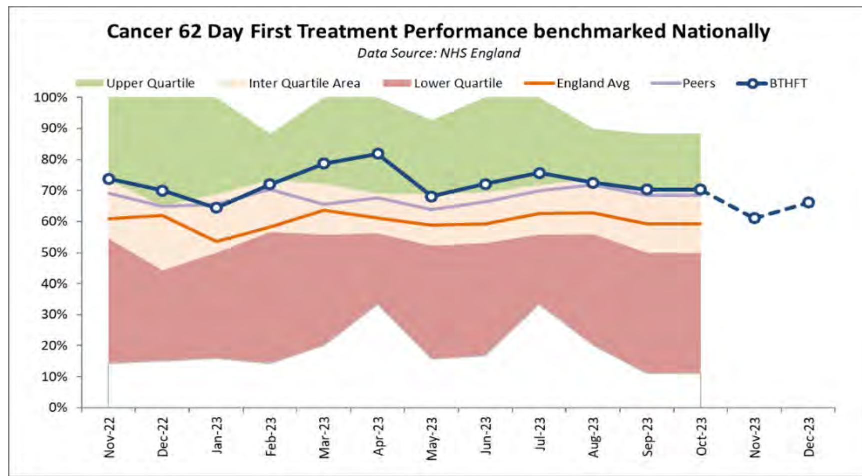
11.3. Cancer 62 Day First Treatment Performance

Figure 20 62 Day First Treatment Performance (Target 85%)



The 62 Day First Treatment in October 2023 was 69.50%. This is a sustained dip in performance due to ongoing pressures.

Figure 21 62 Day First Treatment Performance – National Comparison



BTHFT performance for October 2023 remained in the upper quartile and above the England Average.

Figure 22 62 day or over waiting list size

The number of patients waiting over 62 days increased in September and October peaking in early November where improvement can be seen continuing into December.

Meeting Title	Open Board of Directors Meeting		
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Table 5 62 Day First Treatment Performance by Tumour Group

Site	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
TRUST	78.2%	72.0%	78.7%	81.9%	68.1%	77.3%	74.6%	72.2%	70.3%	69.5%	61.1%	66.1%
Breast	80.0%	94.1%	100.0%	92.3%	64.7%	100.0%	81.8%	83.3%	72.7%	73.3%	100.0%	87.5%
Gynae	52.6%	50.0%	33.3%	40.0%	22.2%	100.0%	66.7%	63.6%	28.6%	57.1%	33.3%	28.6%
Haematology	66.7%	25.0%	33.3%	100.0%	33.3%	60.0%	60.0%	50.0%	75.0%	100.0%	28.6%	50.0%
Head & Neck	28.6%	71.4%	73.3%	85.7%	38.5%	60.0%	75.0%	50.0%	50.0%	33.3%	56.3%	36.8%
Lower GI	46.2%	50.0%	66.7%	36.4%	45.0%	72.7%	70.6%	52.0%	57.1%	54.5%	63.6%	35.7%
Lung	80.0%	16.7%	20.0%	50.0%	18.2%	16.7%	0.0%	0.0%	15.4%	0.0%	33.3%	50.0%
Other		100.0%	0.0%	0.0%	66.7%	0.0%	33.3%	0.0%	0.0%			50.0%
Skin	97.0%	100.0%	97.0%	100.0%	96.8%	93.8%	100.0%	91.4%	77.1%	81.3%	62.5%	83.3%
Upper GI	50.0%	42.9%	66.7%	100.0%	0.0%	60.0%	0.0%	66.7%	0.0%	50.0%	25.0%	60.0%
Urology	86.4%	64.2%	85.1%	81.4%	83.0%	73.4%	68.8%	69.7%	84.9%	81.4%	68.1%	79.5%

Cancer 62 Day First Treatment performance has continued below the target of 85% at 69.50% in October with a further dip in performance forecast for November. December performance is expected to improve as diagnostic recording and treatment booking processes are streamlined and embedded.

Looking ahead to November winter pressures are expected to impact on certain treatments, planning is underway to ensure consistency of clinics and prepare for additional session over December to reduce impacts of this along with the holiday season.

Treatment timeliness for cancer continues to be the focus with fast-track patients taking priority and early identification of capacity issues is in place with services flipping any capacity where possible to respond to demand.

Using the 31-day standard as a headline KPI in reports from December 2023, there will be greater visibility of pathway granularity at the MDT and treatment phases. This will support identification of specific areas for improvement and enable measurement of actions taken.

12. Other Contractual KPI – by exception

12.1. Cancelled Operations

Table 9 28 Day Rebook Breaches

	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23
Cancellations to rebook	38	48	43	54	30	55	40	26	39	40	33	54
28 day rebook breaches	3	5	3	5	6	7	11	4	3	4	3	1

Only 1 breach of the re-booking target occurred in November. Industrial action is expected to increase patient cancellations in December.

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12.2. Sentinel Stroke National Audit Programme (SSNAP)

Table 10 SSNAP Level: Bradford and Airedale Stroke Unit

Team	Bradford and Airedale SU	Bradford and Airedale SU	Bradford and Airedale SU	Bradford and Airedale SU
Time period	Apr-Jun 2023	Jul-Sep 2023	Oct 2023 Projected	Nov 2023 Projected
SSNAP level	C	C	D	D
1) Scanning	C	B	B	B
2) Stroke unit	E	E	E	E
3) Thrombolysis	D	E	E	E
4) Specialist Assessments	C	D	D	D
5) Occupational therapy	B	B	B	C
6) Physiotherapy	B	B	B	C
7) Speech and Language therapy	C	C	C	C
8) MDT working	B	C	D	D
9) Standards by discharge	A	A	A	A
10) Discharge processes	A	A	A	A

Ward 9 opened on 13th December 2023 as a neurorehabilitation unit, initially with 12 beds (increasing capacity from 27 to 49) with a further 7 beds due in Spring 2024. The opening of this ward will directly impact on the SSNAP scores, particularly the domain 2 'Stroke Unit' metric which measures the time from arrival in the A&E department to admission to a specialist stroke ward, and the proportion of a stroke patients' hospital stay based on a specialist stroke unit.

Ward 9 will relieve pressure on Ward 6, facilitating constant availability of HASU capacity to enable swifter transfer of patients from A&E, and having a second specialist stroke unit will avoid having outliers on other medical wards. The team are hoping these improvements will be seen in early 2024, although it should be highlighted that in the short time since opening ward 9, the services have achieved the aim of always having a minimum of 2 HASU beds available at all times.

The stroke response team have now recruited all Physicians Associate positions, with one having already started and three in the HR pre-employment process. In the meantime, a locum SHO is providing regular support to the stroke responder team as a dedicated resource from 8am to 4pm daily. This has improved time to scanning and thrombolysis which again will become apparent in the SSNAP scores in early 2024.

Weekly breach review meetings continue to take place within the team to understand the specific pressure points and ensure there is mitigation where possible. Ongoing meetings between the Urgent Care CSU and Therapies around the role of therapists in the rehabilitation pathway, with a view to reviewing criteria for discharge and making timely decisions.

Significant work is ongoing with our Airedale colleagues around task and finish groups, targeting areas of priority from a mixture of the SSNAP metrics, the strategic objectives for collaboration and the Right Care stroke toolkit. All task and finish groups have a clear set of objectives and measurable KPIs. A full update for the Executive Team will be provided at the next CSU to Exec meeting.

Meeting Title	Open Board of Directors Meeting		
Date	18 January 2024	Agenda item	Bo.1.24.16

APPENDIX 2

SUMMARY OF CONTRACTUAL KPI

Operational Planning	Month	Threshold	Trajectory Target	Performance
Elective Day Case Spells	Nov-23	110%	118%	107%
Elective Ordinary Spells	Nov-23	110%	108%	86%
First Outpatient Attendances	Nov-23	110%	119%	113%
Admitted Clock Stops	Nov-23	n/a	114%	105%
Non-Admitted Clock Stops	Nov-23	n/a	112%	110%
RTT - Patients waiting >52 weeks on incomplete pathways	Nov-23	476	235	468
RTT - Patients waiting >78 weeks on incomplete pathways	Nov-23	0	0	0
RTT - Total Waiting List size	Nov-23	39,122	37,059	34217
Cancer - Patients waiting over 62 days	Oct-23	42	42	69
Operational Standards	**Month**	**Threshold**	**Trajectory Target**	**Performance**
A&E Emergency Care Standard	Nov-23	95.00%	84.70%	73.94%
Ambulance handovers taking between 30-60 minutes	Nov-23	0	30	220
Ambulance handovers taking longer than 60 minutes	Nov-23	0	10	45
Trolley waits in A&E longer than 12 hours	Nov-23	0	0	95
Emergency Inpatient Length Of Stay >=21days	Nov-23	80	84	114
Cancer 2 week wait	Oct-23	93.00%	93.00%	95.80%
Cancer 2 week wait - breast symptomatic	Oct-23	93.00%	93.00%	93.50%
Cancer 28 day Faster Diagnosis	Oct-23	75.00%	75.00%	83.50%
Cancer 31 day First Treatment	Oct-23	96.00%	96.00%	92.60%
Cancer 31 day Subsequent Surgery	Oct-23	94.00%	94.00%	88.60%
Cancer 31 days for subsequent treatment - anti-cancer drug regimen	Oct-23	98.00%	98.00%	91.40%
Cancer 62 day First Treatment	Oct-23	85.00%	85.00%	69.50%
Cancer 62 days from referral - NHS screening service to first definitive treatment for all cancers	Oct-23	90.00%	90.00%	75.60%
Diagnostics - patients waiting under 6 weeks for test	Nov-23	99.00%	66.00%	69.74%
RTT - Patients waiting <18 weeks on incomplete pathways	Nov-23	92.00%	72.32%	66.59%
Mixed-sex accommodation breach	Nov-23	0	0	0
Cancelled Operations 28 day breach	Nov-23	0	0	0
Urgent operation cancelled for a second time	Nov-23	0	0	0

**Latest prediction at the time of writing*

BO.1.24.17 - REPORT FROM THE CHAIR OF THE AUDIT COMMITTEE - NOVEMBER 2023

REFERENCES

Only PDFs are attached

Bo.1.24.17 - Report from the Chair of the Audit Committee - November 23.pdf

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.17

AUDIT COMMITTEE REPORT TO BOARD

Presented by	Barrie Senior, Non-Executive Director and Audit Committee Chairman	
Author	Barrie Senior, Non-Executive Director and Audit Committee Chairman	
Lead Director	Matthew Horner, Director of Finance	
Purpose of the paper	To provide an update to Board regarding matters covered in and relating to the Audit Committee meeting held on **21 November 2023**	
Key control		
Action required	For assurance	
Previously discussed at/ informed by		
Previously approved at:		**Date**

Key Options, Issues and Risks
See attached report

Analysis
See attached report

Recommendation
The Board is asked to note and derive assurance from this report.

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.17

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for our patients, delivered with kindness				g		
To deliver our financial plan and key performance targets				g		
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☐	☒	☐
Is there any other national benchmarking data relevant to the content of this paper?	☐	☒	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☐	☐	☒

Risk Implications (see section 5 for details)	Yes	No
High Level Risk Register and / or Board Assurance Framework Amendments	☐	☐
Quality implications	☐	☐
Resource implications	☐	☐
Legal/regulatory implications	☐	☐
Equality Diversity and Inclusion implications	☐	☐
Performance Implications	☐	☐

Regulation, Legislation and Compliance relevance	
NHS England: (please tick those that are relevant)	
☐Risk Assessment Framework	☐Quality Governance Framework
☐Code of Governance	☐Annual Reporting Manual
Care Quality Commission Domain: Choose an item.	
Care Quality Commission Fundamental Standard: Choose an item.	
NHS England Effective Use of Resources: Choose an item.	
Other (please state):	

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality &Patient Safety	Finance & Performance	Other (please state)
☒	☒	☒	☐

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.17

AUDIT COMMITTEE REPORT TO BOARD

1 PURPOSE/ AIM

To provide an update to Board regarding key matters covered in and relating to the Audit Committee meeting held on 21 November 2023.

2 BACKGROUND/CONTEXT

The agenda of the Audit Committee meeting held on 21 November 2023 was driven by and derived from the 2023/24 Audit Committee Annual Workplan.

The key matters discussed, considered and from which, where appropriate, assurance was gained were:

- Annual policy review – use of external audit for non-audit purposes
- Accounts delivery and external audit improvement plan
- Internal Audit progress report
- Follow up on Internal Audit Recommendations
- Annual Internal Audit performance review
- Counter Fraud progress report
- Charitable Funds Annual Report & Accounts
- Proposed changes to Scheme of Delegation/Standing Financial Instructions
- Monitoring compliance with the Policy for the Development and Management of Trust Policies, and compliance with Trust Policies
- Assurance: Key IT systems progress report
- Assurance: Data Quality

3 RECOMMENDATIONS

The Board is invited to note and derive assurance from this report.

4 Appendices

See the attached report.

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.17

Audit Committee Report to the Board, 21 November 2023

1. Introduction

The purpose of this paper is to provide the Board of Directors with a summary of the key matters discussed and considered, in accordance with the Audit Committee's 2023/24 workplan, during and in relation to the Committee meeting held on 21 November 2023.

2. Key Matters discussed

- **Annual policy review – use of external audit for non-audit purposes**
  The Committee noted and approved the proposed changes in accordance with guidance issued by the National Audit Office and the Financial Reporting Council.

- **Accounts delivery and external audit improvement plan**
  Against a backdrop of the Trust's 2022/23 Annual Report and Accounts being filed 10 days late due to audit delays, the Director of Finance reported on the constructive meetings held with Deloitte so as to avoid a repeat this year.

  A key focus will be on better communication between Finance and External Audit. In particular, in view of the substantial capital programme in progress, frequent meetings will take place during Q4.

- **Internal Audit progress report**
  Internal Audit reported that good progress was being made in executing the 2023/24 Audit Plan.

  The Committee noted, considered and approved changes to the 2023/24 Audit Plan, and was satisfied that the changes represented a dynamic internal audit process, responding to changes and evolving priorities within the Trust.

  Internal Audit reported that 14 audit reviews had been completed since the Audit Committee meeting in September:

  - Three Limited Assurance
  - Seven Significant Assurance
  - Two High Assurance
  - Two audits not resulting in an assurance rating

Patient Safety; Sepsis Management – Limited Assurance

The objective of this audit was to provide assurance that there are effective systems and processes in place to treat and manage cases of sepsis.

The Chief Medical Officer(CMO) joined the meeting to discuss the audit findings and recommendations.

The audit had found that there are appropriate governance arrangements in place for monitoring and reporting sepsis activity, evidenced by Patient Safety Group and Quality and Patient Safety Academy minutes.

A new dashboard has been introduced that will ensure that sepsis activity is consistently and effectively monitored by wards and departments, prompting and enabling tracking of improvements where appropriate.

The audit generated ten recommendations, six Moderate and four Minor. The CMO confirmed that most had already been actioned. He confirmed that full completion by April 2024 was on track.

ReSPECT – Limited Assurance

The objective of the audit was to gain assurance regarding the effectiveness of arrangements and controls within the ReSPECT process. This process is designed to create and make available a personalised recommendation for a patient's care in emergency situations where the patient is unable to make decisions or express their wishes.

The Chief Nurse and the Chief Digital & Information Officer joined the meeting to discuss the audit results. The Committee noted that an internal audit review of ReSPECT in January 2022 had also resulted in a Limited Assurance opinion.

The Chief Nurse explained that, after the January 2022 audit review, paper documentation was abandoned, replaced by electronic records. Work is in progress to implement an e-ReSPECT function within the Cerner Electronic Patient Record system, with a roll-out of associated staff training, due to go live by 31 March 2024. An increased level of local audits to ensure effective Trust-wide compliance is also planned.

Control of Substances Hazardous to Health (COSHH) – Limited Assurance

The objective of the audit was to provide assurance that the Trust has systems and processes in place to ensure compliance with the COSHH regulations and that they are being complied with.

The Head of Non-Clinical Risk attended the meeting to discuss the results of the audit. She explained that the combination of a key staff shortage and the pressures associated with Covid had resulted in a growing backlog of COSHH assessments.

At peak, c.5,000 COSHH assessments were outstanding. In the last 9 months this has reduced to c.2,500 and work is continuing to reduce this further to what is, in practice, an irreducible minimum of c.500. Work is progressing to address the three Moderate and five Minor audit recommendations arising from the review.

Staff Suspension - Significant Assurance

The purpose of this audit was to gain assurance that the Trust's policy regarding staff suspensions is appropriate and is being effectively and proportionately administered. The audit resulted in no significant adverse findings, and only three minor recommendations.

Management of To Take Out (TTO) medication – Significant Assurance

The objective of the audit was to provide assurance that TTO medications are managed in line with Trust policy.

The audit confirmed that effective controls are in place to manage the risks related to TTO pre-labelled medicines, including security arrangements for the storage of medicines both in Pharmacy Stores and on the wards.

Three Moderate recommendations were made, relating to weaknesses in the accurate recording of receipts onto wards and insufficient evidence relating to regular stock check reconciliations being undertaken against ward records.

Patient-Led Assessments of the Care Environment (PLACE) – Significant Assurance

The objective of this audit was to provide assurance that PLACE assessments are being reviewed and any required actions are being fully implemented. PLACE assessments provide motivation for improvement in patient care, directly from patients, about how the hospital environment or services might be enhanced.

The audit identified that there are appropriate governance arrangements in place for the monitoring, response to and reporting of PLACE assessments.

Management of Waste Segregation – Significant Assurance

The purpose of this audit was to provide assurance that waste segregation is being effectively managed throughout the Trust.

The audit confirmed that there are effective waste management controls in place, with only one Moderate recommendation.

Safety Alerts – Significant Assurance

The objective of this audit was to provide assurance that the Trust effectively responds to NHS Safety Alerts.

The audit confirmed that there is a good level of control over the monitoring of and response to Safety Alerts, with only two Minor recommendations.

Charitable Funds – Significant Assurance

The objective of the audit was to provide assurance regarding the systems for recording and receipting of income, making payments and monitoring of fund investments.

The audit confirmed that the Trust has appropriate policies, procedures and controls in place, with only one Minor recommendation.

Cleaning Standards – Significant Assurance

The objective of this audit was to ensure that the Trust's cleaning arrangements comply with the NHS England National Cleaning Standards. The audit resulted in one Moderate and three Minor recommendations so as to resolve minor areas of non-compliance.

NICE Guidance – High Assurance

The purpose of this audit was to provide assurance that the Trust is effectively monitoring new NICE (National Institute for Health and Care Excellence) guidance and responding to it in a timely manner.

The review confirmed that adequate system controls are in place for the dissemination, implementation and monitoring of NICE guidance and recommendations.

Premises Assurance Model – High Assurance

The objective of this audit was to provide assurance that the NHS Premises Assurance Model is utilised correctly by the Trust. The audit confirmed that there are effective control mechanisms and governance arrangements in place, with no audit recommendations being generated.

Pennine Breast Screening Unit Equipment – Advisory Report with no assurance rating

The objective of this review was to provide independent advice regarding the suitability and procurement of some screening equipment. The Director of Finance confirmed that most of the actions and recommendations set out in the report have been completed with all deadlines due to be met.

This matter, due its commercial sensitivity, was discussed at a recent Closed Board meeting. A further report will be presented to the Audit Committee at its 6 February meeting.

Bradford Hospitals Charity – Control Improvement Audit with no assurance rating

The objective of the audit was to review the Trust's current compliance with the Code of Fundraising Practice and the Charities Act and to consider the steps necessary if the Charity was to extend and increase its activities as a standalone entity. This supplements the Significant Assurance Charitable Funds audit mentioned above.

- **Follow up on Internal Audit Recommendations**
  Internal Audit presented a benchmarking report that demonstrated that the Trust was making better than average progress in actioning outstanding Internal Audit recommendations compared to peer organisations audited by Audit Yorkshire. Whilst acknowledging operational pressures, both Internal Audit and the Audit Committee encouraged management to continue to press forward with the completion of outstanding audit recommendations.

- **Annual Internal Audit performance review**
  The Director of Finance confirmed that questionnaires had been circulated to all Executive Directors, positive responses had been received and a report would be presented to the February Audit Committee meeting.

- **Counter Fraud progress report**
  Counter Fraud provided a report on progress since the last Audit Committee meeting which the Committee, in general, received with satisfaction.

  Two current investigations were discussed at some length and the Committee awaits further information at its next meeting. (Further details withheld for reasons of confidentiality.)

- **Charitable Funds Annual Report and Accounts**
  The Committee noted that the Annual Report and Accounts were due to be audited in November and early December. The Annual Report, Accounts and Auditor's Report will be shared virtually with the Committee in order that the approved Report and Accounts can be filed with the Charities Commission prior to the 31 January filing deadline.

- **Monitoring compliance with the Policy for the Development and Management of Trust Policies, and compliance with Trust Policies**
  The Associate Director of Corporate Governance/Board Secretary reported that the review of the second annual random sample of 20 Trust-wide policy and procedure documents had been completed. The review resulted in an overall compliance rate of 81%, the same as reported in last year's review.

  The specific review results will be shared with authors of each of the policies reviewed, and general trends/shortfalls will be shared with all policy owners.

- **Assurance: Key IT systems progress report**
  The Chief Digital & Information Officer (CD&IO) provided an update on progress to achieve and maintain adequate assurance regarding the reliability, availability and security of the Trust's key IT applications, including in-house testing and the results of Internal audit activity.

  The CD&IO noted that Airedale are due to go live on Cerner EPR in September 2024, utilising the same instance of the software as Bradford. This will provide an opportunity for a fresh review of the EPR application.

- **Assurance: Data Quality**
  The CD&IO provided the Committee with further information, reassurance and assurance regarding activities designed to ensure the quality of key Trust data. He referred to new working groups that have now been set up to focus on data quality regarding maternity, waiting lists, finance, urgent & emergency care and discharge returns. A steering group sits above these working groups to coordinate activity and prioritise actions.

  The Committee sought and received reassurance that the poor performance in depth of coding on SHMI data discussed at a recent Board meeting is receiving urgent and effective attention.

- **Audit Committee Annual Self Assessment**
  The Committee agreed to continue to wait for the publication by the HFMA of the fifth edition of the NHS Audit Committee Handbook that will include revised self assessment questionnaires designed to reflect the requirements and implications of the Health and Care Act 2022.

3. Other matters

3.1 Matters to share with other Academies/Committees

None.

3.2 Matters raised in the meeting to escalate to Corporate Risk Register

None.

3.3 Other matters to escalate to the Board of Directors

None.

4. Recommendation

The Board of Directors is asked to note this report and the assurance and reassurance that it provides.

Barrie Senior
Audit Committee Chairman

12 January 2024

BO.1.24.18 - DISTRIBUTED LEADERSHIP MODEL ? DIRECTOR OF NURSING & QUALITY

REFERENCES

Only PDFs are attached

- Bo.1.24.18 - Distributed Leadership Model - Director of Nursing and Quality - Review (Cover Sheet).pdf
- Bo.1.24.18 - Distributed Leadership Model - Director of Nursing and Quality - Review - District & Craven PLE.pdf
- Bo.1.24.18- Distributed Leadership Model - Director of Nursing and Quality - Appendix 1.pdf
- Bo.1.24.18 - Distributed Leadership Model - Director of Nursing and Quality - Appendix 2 - Senior Leadership Survey.pdf
- Bo.1.24.18- Distributed Leadership Model - Director of Nursing and Quality - Appendix 3 - Quality Hub Development Session Summary.pdf

Meeting Title	Board of Directors		
Date	18.01.24	Agenda item	Bo.1.24.18

DISTRIBUTED LEADERSHIP MODEL – DIRECTOR OF NURSING AND QUALITY

Presented by	Professor Karen Dawber, Chief Nurse	
Author	Professor Karen Dawber, Chief Nurse	
Lead Director	Professor Karen Dawber, Chief Nurse	
Purpose of the paper	Focused statement as to the purpose of the paper	
Key control	Identify if the paper is a key control for the Board Assurance Framework	
Action required	For information	
Previously discussed at/ informed by		
Previously approved at:		Date
	Partnership Leadership Executive (Please see frontsheet dated 24.11.23)	24.11.23

Key Options, Issues and Risks

On the 30 June Clinical Commissioning Groups (CCG) were formally replaced by Integrated Care Boards. The Director of Quality and Nursing BDC ICB gave notice of the intention to retire and formally retired on the 31 March 2023. This has given an opportunity to review both the existing and future arrangements.

The three provider Chief Nurses and the Director of Nursing and Quality have reviewed the possibility of a distributed leadership model shared between the three Provider Chief Nurses.

This model has now been in place since the 1 April 2023, division of the duties is attached as Appendix I. As part of the agreement to trial the arrangements for a one-year period a 6 monthly review and evaluation was to be presented to Partnership Leadership Executive.

Analysis

As part of the review views have been sought from key stakeholders via survey monkey (see Appendix II) and the team working directly to the Director of Nursing (see Appendix III).

Overall, the feedback has been positive although it should be noted that the engagement session with direct reports and wider team was held just prior to the operating model consultation period commencing and overall moral was poor at this time.

Partnership Leadership Executive (PLE) was asked to approve the following recommendations:

1. The distributed model of leadership is continued and rolled over for a further 12 months with a review in 6 months' time.
2. The respective Boards will be asked to endorse the approach.
3. The role is rebranded to "Quality Director" to provide greater clarity and separation from the substantive organisational roles.

Meeting Title	Board of Directors		
Date	18.01.24	Agenda item	Bo.1.24.18

Recommendation
To note the proposal approved at PLE and endorse the current arrangements for the Chief Nurse to continue with the distributed leadership model.

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for our patients, delivered with kindness			g			
To deliver our financial plan and key performance targets			g			
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☐	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☐	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☐	☐	☐

Risk Implications (see section 5 for details)	Yes	No
High Level Risk Register and / or Board Assurance Framework Amendments	☐	☐
Quality implications	☐	☐
Resource implications	☐	☐
Legal/regulatory implications	☐	☐
Equality Diversity and Inclusion implications	☐	☐
Performance Implications	☐	☐

Regulation, Legislation and Compliance relevance	
NHS England: (please tick those that are relevant)	
☐Risk Assessment Framework	☐Quality Governance Framework
☐Code of Governance	☐Annual Reporting Manual
Care Quality Commission Domain: Choose an item.	

Meeting Title	Board of Directors		
Date	18.01.24	**Agenda item**	Bo.1.24.18

Care Quality Commission Fundamental Standard: Choose an item.
NHS England Effective Use of Resources: Choose an item.
Other (please state):

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality & Patient Safety	Finance & Performance	Other (please state)
☐	☐	☐	☐

Bradford District and Craven
Health and Care Partnership

Meeting name:	Partnership Leadership Executive (PLE)
Agenda item no:	6
Meeting date:	24.11.23
Report title:	Distributed Leadership Model – Director of Nursing and Quality (Final)
Report presented by:	Professor Karen Dawber, Chief Nurse, Bradford Teaching Hospitals NHS Foundation Trust Amanda Stanford, Chief Nurse, Airedale NHS Foundation Trust Phillipa Hubbard, Director of Nursing, Professions/Care Standards, Director of Infection, Prevention and Control, Deputy Chief Executive, Bradford District Care NHS Foundation Trust
Report approved by:	Professor Karen Dawber, Chief Nurse, Bradford Teaching Hospitals NHS Foundation Trust Amanda Stanford, Chief Nurse, Airedale NHS Foundation Trust Phillipa Hubbard, Director of Nursing, Professions/Care Standards, Director of Infection, Prevention and Control, Deputy Chief Executive, Bradford District Care NHS Foundation Trust
Report prepared by:	Professor Karen Dawber, Chief Nurse, Bradford Teaching Hospitals NHS Foundation Trust Amanda Stanford, Chief Nurse, Airedale NHS Foundation Trust Phillipa Hubbard, Director of Nursing, Professions/Care Standards, Director of Infection, Prevention and Control, Deputy Chief Executive, Bradford District Care NHS Foundation Trust

Purpose and Action			
Assurance ☐	Decision ☒ (approve/recommend/ support/ratify)	Action ☐ (review/consider/comment/ discuss/escalate	Information ☐
Previous considerations:			
Meetings have taken place with Michelle Turner, Director of Quality and Nursing, Bradford District and Craven Health and Care Partnership Board, Karen Dawber, Phil Hubbard and Amanda Stanford to understand the scope of the role. Advice has been sought from Bev Geary (Integrated Care Board (ICB) Chief Nurse) and Margaret Kitching (West Yorkshire ICB Chief Nurse). Discussed with Professor Mel Pickup, Chief Executive Officer, Bradford Teaching Hospitals NHS Foundation Trust/Place Based Lead Bradford District and Craven Health and Care Partnership in the form of an outline proposal prior to full work up.			

Working arrangements have been in place since April 2023 after being approved at PLE and relevant Trust Boards.

Executive summary and points for discussion:

Situation

On the 30 June Clinical Commissioning Groups (CCG) were formally replaced by Integrated Care Boards. The Director of Quality and Nursing BDC ICB gave notice of the intention to retire and formally retired on the 31 March 2023. This has given an opportunity to review both the existing and future arrangements.

The three provider Chief Nurses and the Director of Nursing and Quality have reviewed the possibility of a distributed leadership model shared between the three Provider Chief Nurses.

This model has now been in place since the 1 April 2023, division of the duties is attached as Appendix I. As part of the agreement to trial the arrangements for a one-year period a 6 monthly review and evaluation was to be presented to PLE.

Background

The role of the Health and Care Partnership Director of Nursing (BDC) has a number of statutory roles: Patient Safety; Quality Assurance and Oversight; Safeguarding and Continuing Health Care. There are also a number of key meetings attended by the responsible Chief Nurse across the West Yorkshire Integrated Care System (WY ICS) to ensure strong governance and oversight is maintained.

The new operating model and the transition is currently ongoing and although does not impact directly on the "Director of Nursing" role it does impact on the staffing models and ways of working, the Chief Nurses have supported the development of the new model and core functions within the ICS Director of Nursing portfolio.

Quality Assurance

The National Quality Board issued guidance on the role of the System Quality Group and its overriding function in the role of **quality assurance**. National Quality Board (NQB) describes that effective quality systems must serve three main aims for the ICB, Local Authorities and partners:

a) Timely insight and intelligence sharing into opportunities for learning and improvement, and issues that need to be addressed and escalated.
b) Positive assurance that statutory duties are being met, concerns and risks are addressed, and improvement plans are having the desired effect.
c) Confidence in the ongoing improvement of care quality, drawing on timely diagnosis, insight and learning. This includes confidence that inequalities and unwarranted variation are being addressed.
d) Review of the oversight and governance surrounding care homes and independent providers.
e) Review the current Terms of Reference for the System Quality Committee including the revision of the highlight reports and subgroups.

Safeguarding

The task of organising **safeguarding** arrangements is shared by three partner agencies (Local Authorities, Police, and ICBs). The partners must work together to safeguard children and

promote the welfare of all children in their area, and to monitor and ensure the effectiveness of those arrangements. They will be equally accountable for the system they create.

The three safeguarding partners should agree:

a) Local priorities and ways to co-ordinate their safeguarding services with relevant agencies.
b) Establishing a strategic leadership group in supporting and engaging others.
c) Implementing local and national learning from serious child safeguarding incidents.
d) Processes that facilitate and drive action beyond usual institutional and agency constraints and boundaries.
e) Effective protection of children is founded on lasting and trusting relationships with children and their families.
f) A dispute resolution and an independent review process.
g) The relationship and processes between Health and Wellbeing Boards (HWB).
h) Deputise for the safeguarding independent chairs including direct line management of the designated doctors.

Patient Safety

Patient safety, in part is covered in the revised Patient Safety Incident Response Framework (PSIRF - previously Serious Incidents). The ICB has an overarching role in overseeing the implementation of PSIRF. The ICB should:

a) Collaborate with their providers in the development, maintenance and review of provider patient safety incident response policies and plan the relationship and processes between HWBs.
b) Agree provider patient safety incident response policies and plans.
c) Oversee and support effectiveness of systems to achieve improvement following patient safety incidents.
d) Support coordination of cross-system learning and response.

Share insights and information across organisations/services to improve safety with statutory responsibility to support Care Quality Commission (CQC) and other regulators to ensure overview and scrutiny of all NHS contracted services.

Continuing Health Care

NHS **Continuing Health Care** (CHC) is a package of ongoing care that is arranged and funded by Health. It is the responsibility of the ICB to decide the appropriate package of support for NHS CHC. It is assessed as having a primary health need and is not based on a specific diagnosis or where that health is provided.

Assessment

As part of the review views have been sought from key stakeholders via survey monkey (see Appendix II) and the team working directly to the Director of Nursing (see Appendix III).

Overall, the feedback has been positive although it should be noted that the engagement session with direct reports and wider team was held just prior to the operating model consultation period commencing and overall moral was poor at this time.

The survey monkey was sent to all members of PLE and wider stakeholders in West Yorkshire ICB. The results in full are available in Appendix II. The results show some key areas for further development as well as several positives.

Areas of improvement for the portfolio going forward based on these comments will be:

- Consider rebranding the role to Director of Quality.
- Refresh and reiterate the different areas covered by each person.
- Provide a pen portrait of each person, to wider stakeholders, including areas of interest, expertise and contact details.
- Work with the development of the new operating model to clearly define the interaction and responsibilities for Primary Care.

In September a meeting was held face to face with all staff within the portfolio. The session received very positive feedback and was the first event of this type that all staff attended. The summary results including next development steps are included as Appendix III.

Areas of ongoing focus include:

- Ongoing communication and visibility.
- 3 x per year team development sessions.
- Support through the consultation of the operating model.

We previously described some emerging risks within the portfolio, although not fully mitigated, wider progress has been made that has resulted in more streamlined working, better oversight of risk and quality assurance and improvements in key performance indicators.

- Continuing Health Care.
  - Processes have been improved, the team has been reviewed and appointments have been made to key posts.
  - Back log of reviews has been identified and robust processes now in place.
  - Numbers of outstanding assessments have reduced significantly.
- Quality Assurance and Oversight – Systems and processes.
  - Process now in place with providers to review, sign off and share serious incidents.
  - Process for supporting Local Authority Partners with Care home oversight including all independent providers.
  - Support Primary Care with quality oversight and development.
  - Infection Prevention and Control with all partners across place including the management of outbreaks.
  - Monitoring of Independent Mental Health Providers.
  - Learning from Deaths Review (LeDeR) on behalf of WY ICS.
- PSIRF Implementation (oversight and sign off).
  - Planned to be signed off via Boards in November 2023.
  - Triangulation of concerns, complaints to support a learning organisation.
- SEND/Complex Children – Ongoing.
  - Systems and processes in place for oversight and assurance in a planned and thematic way including oversight of the Written Statement of Actions and attendance at OFSTED/NHSE Monitoring visits.
- Maternity Oversight group now in place, note chaired by BDCFT Chief Nurse.
- Line management and succession planning.
  - All lines of accountability and responsibility defined.
  - Single point of contact, Deputy Director of Nursing in interim role.

Our assessment, following several discussions, is that a distributed model of leadership is a credible solution to modern and sustainable ways of working. The first 6 months have been challenging and rewarding in equal measure, benefits have been:

- Structured programmes of work with robust oversight
- Salient discussions with one person.
- Greater understanding of the scope of the role.
- Improving staff engagement and a sense of team post pandemic.

Challenges do remain, some of which can be (and are) mitigated:

- Staff moral and uncertainty in relation to the new operating model.
  - Team building event in September 2023, plan to roll out on regular basis.
- Time management and allocation.
  - Mitigated by the PAs although is time consuming, not helped by separate IT systems.
- Single point of contact.
  - Mitigated by the Deputy Director of Nursing.
- Wider engagement of Primary Care and Primary Care oversight.
  - To be worked through as part of the System Quality Committee.
  - Changes in job roles and responsibilities have led to some confusion, this will be mitigated once the new operating model in finalised.
- Greater awareness and visibility of the role.
  - This is a new way of working and it is acknowledged that change is difficult, the insight from senior leaders will help to move forward with the areas for further development.

Outline how this supports our partnership vision and strategy

Our Purpose - All working to the same goal, for our population to have more chances to lead healthier lives.

Our Population - Supporting the delivery of our priorities and a better experience of health and care prioritising those with the worst outcomes.

Our Place - Making our district a great place to live, work and thrive.

Our Partnership – Greater value through the best use of our collective resources, minimising duplication and waste.

Recommendation(s)

The Partnership Leadership Executive (PLE) is asked to endorse the following recommendations:

1. The distributed model of leadership is continued and rolled over for a further 12 months with a review in 6 months' time.
2. The respective Boards will be asked to endorse the approach.
3. The role is rebranded to "Quality Director" to provide greater clarity and separation from the substantive organisational roles.

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:
Appendices
Appendix I - Director of Nursing and Quality – Operational Plan. Appendix II – Survey Monkey – Senior leaders. Appendix III – Summary of Hub away day.
Acronyms and Abbreviations explained

What are the implications for?

Residents and Communities	Improved quality of care and reduced inequities
Quality and Safety	To ensure that there is oversight of the quality and provision of care across BDC
Equality, Diversity and Inclusion	To ensure that there is oversight of the quality and provision of care across BDC
Finances and Use of Resources	
Regulation and Legal Requirements	Compliance with statutory requirements
Conflicts of Interest	As the model uses Chief Nurses from 3 organisations there is a conflict of interest if matters involve their own organisation. However, the distributed approach allows for this to be fully mitigated.
Data Protection	None
Transformation and Innovation	Opportunity to reduce duplication of roles and provide greater integration across ICB
Environmental and Climate Change	None
Future Decisions and Policy Making	None
Citizen and Stakeholder Engagement	None

APPENDIX 1

Director of Nursing and Quality – Operational Principles

Single Point of Contact

The Single point of contact in the first instance for all operational issues will be the Deputy Director of Nursing and Quality.

There will be a separate rota and shared Calendar that will show who the Executive lead for that day is, this will be on a weekly basis (Monday to Friday).

Copies of the rota for the named Executive will be made available in advance to the Chief Executive Officer, Bradford Integrated Care Board and the Chief Nurse for West Yorkshire Integrated Care Board.

Division of Responsibilities

There are four key areas of responsibility; these have been allocated on a named basis:

Quality Assurance and Oversight – Chief Nurse, Airedale NHS Foundation Trust.

- Maternity and Neonatal Services.
- Learning from Deaths including Learning Disabilities Mortality Review (LeDeR).
- Enhanced Surveillance.

Continuing Health Care (Including Children's) – Chief Nurse, Bradford Teaching Hospitals NHS Foundation Trust.

- Complex Children's Services.
- Personalised Commissioning.

Safeguarding – Chief Nurse, Bradford District Care NHS Foundation Trust.

- Special Educational Needs and Disability (SEND)/Looked After Children (LAC).
- Asylum Seekers.
- Mental Health.

Lead for Patient Safety – All depending on who is best suited (note conflicts of interest).

- Patient Safety Incident Response Framework (PSIRF).
- Serious Incident (SI)/Risk Management.
- Major Incident.
- Complaints.
- Infection Prevention and Control/Outbreak.

Practical Working Arrangements

Quality Oversight and Assurance will be supported by the Associate Director of Quality (ADQ), this will enable clear and discreet separation from the operational elements of the portfolio. The ADQ will report directly to the Airedale NHS Foundation Trust Chief Nurse.

The Deputy Director of Nursing will report to the Chief Nurses of both Bradford District Care NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust.

The existing Executive Assistant/Personal Assistant arrangements will remain in place and they will be responsible for the maintenance, update and creation of joint folders and calendars.

The three Chief Nurses will meet on a weekly basis with the two deputies. This will enable the development of the short, medium and longer term work plans, the ongoing oversight and assessment of risk and timely communication and updates.

The three Chief Nurses will work one day per week each from Scorex House; this will enable visibility and easy action for staff. The working days will be set.

A monthly operational briefing, from the three Chief Nurses will be provided to the BDC ICB Lead.

Professor Karen Dawber
Chief Nurse, Bradford Teaching Hospitals NHS Foundation Trust

Amanda Stanford
Chief Nurse, Airedale NHS Foundation Trust

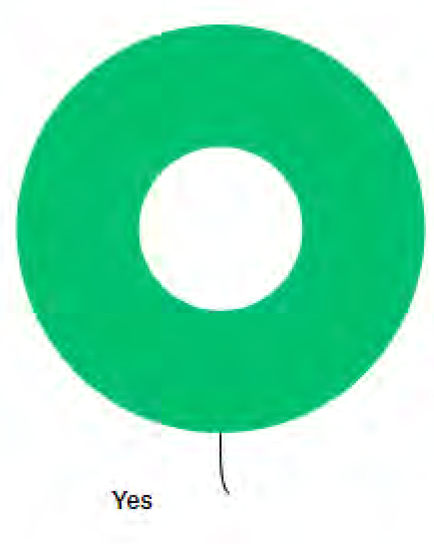
Phillipa Hubbard
Director of Nursing, Professions/Care Standards, Director of Infection, Prevention and Control, Deputy Chief Executive, Bradford District Care NHS Foundation Trust

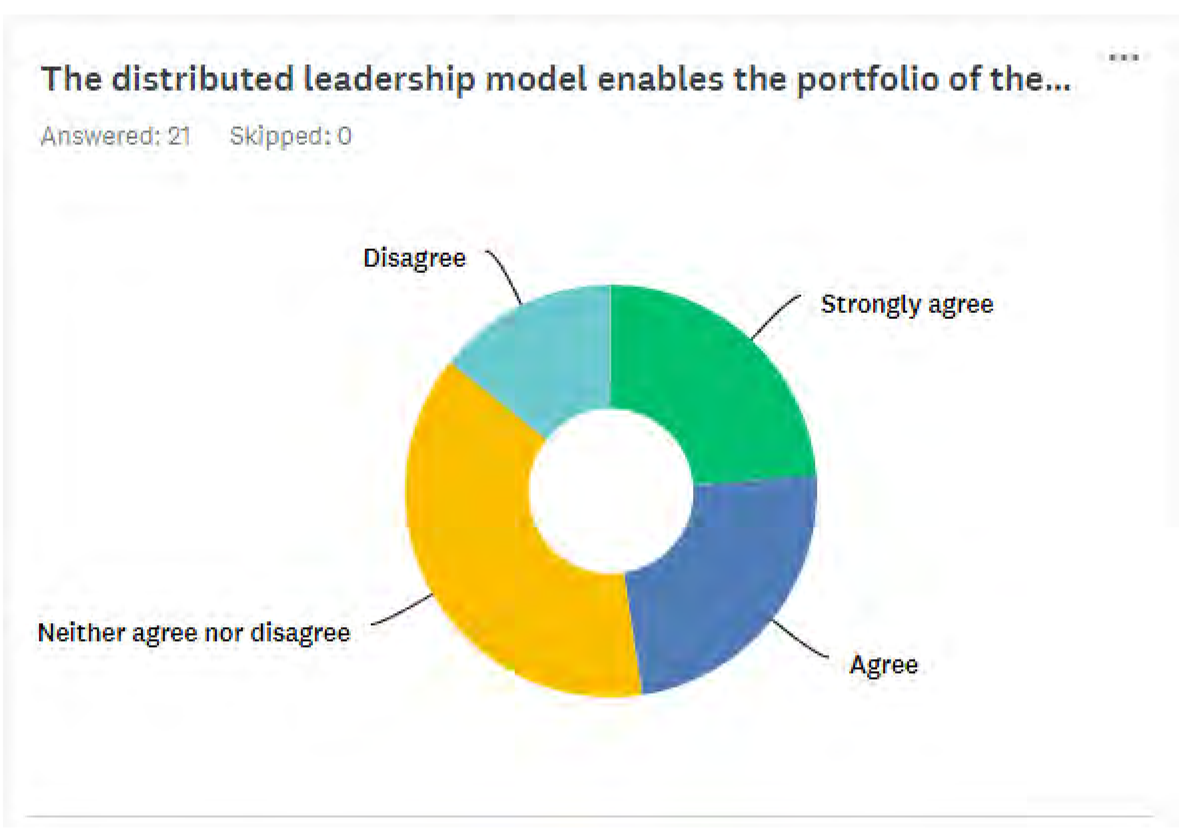
Version 1: 03/03/2023

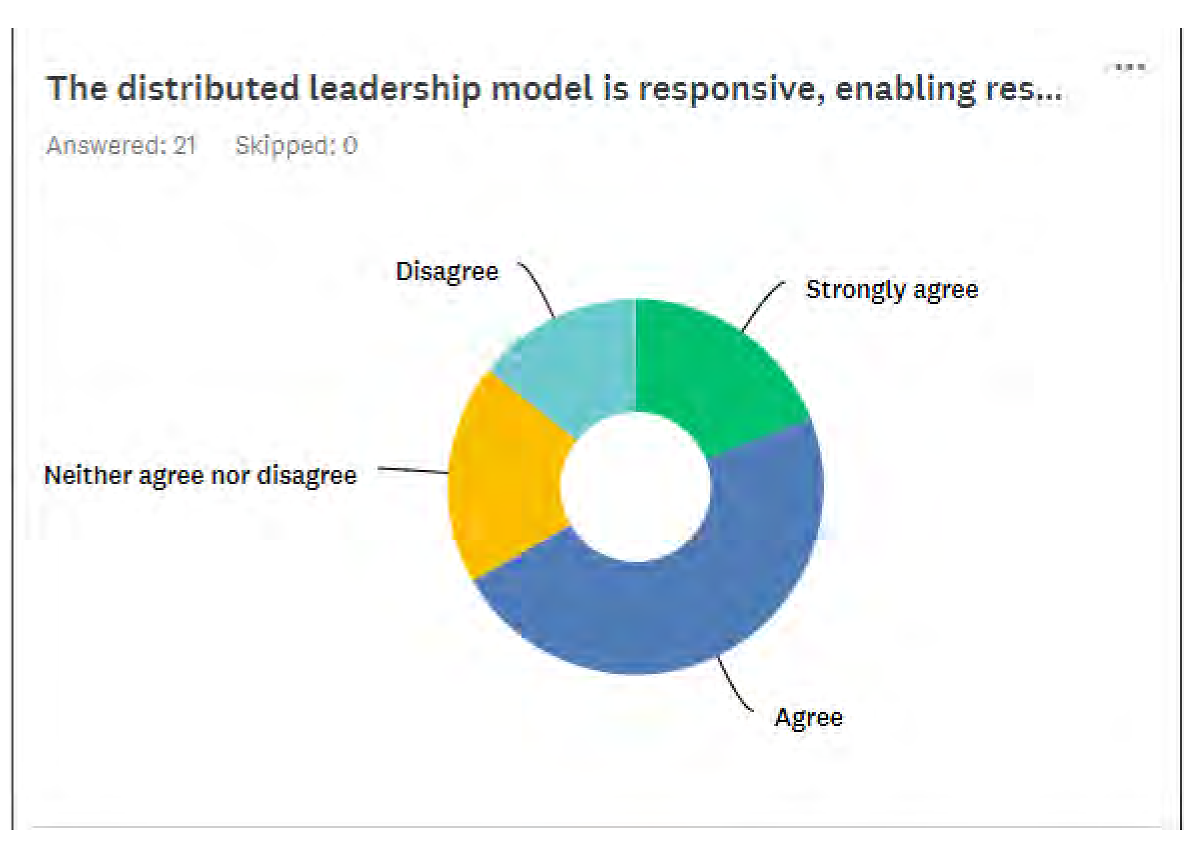
Appendix II – Survey Monkey – PLE / Senior Stakeholders

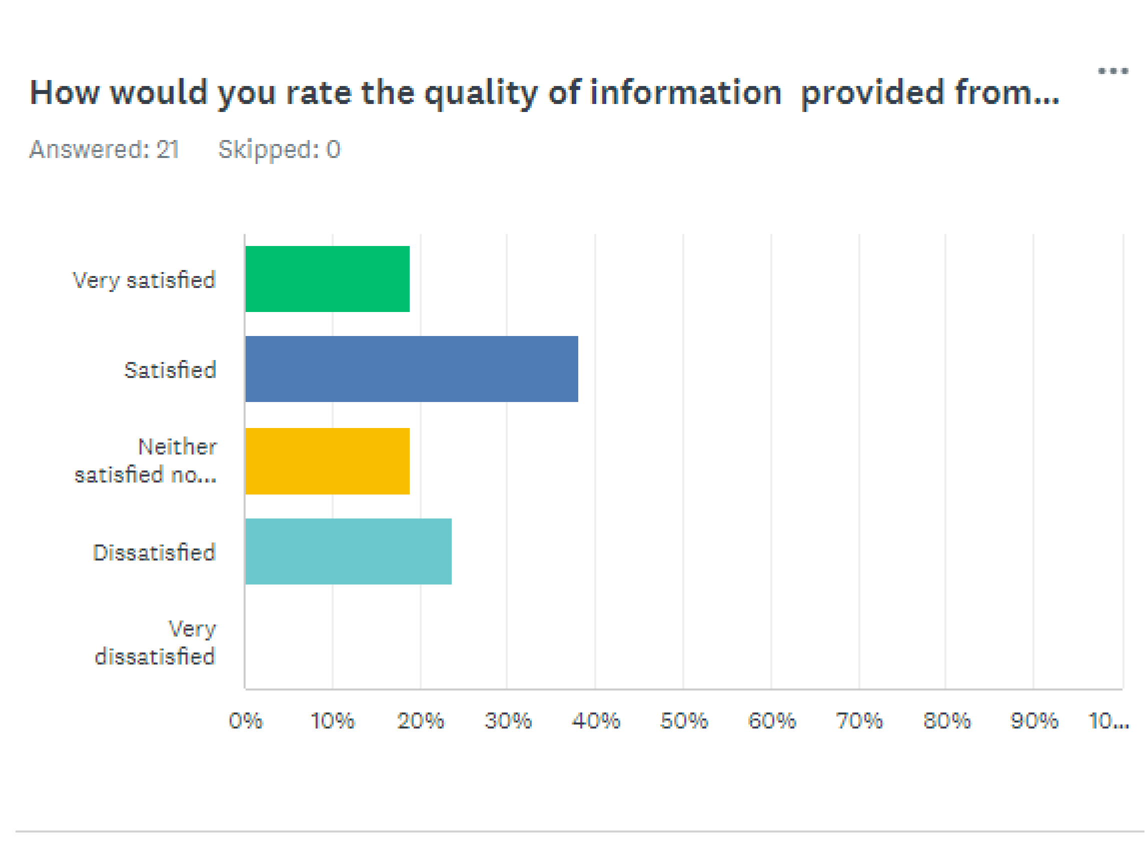
Are you aware of the distributed leadership model across Bra...

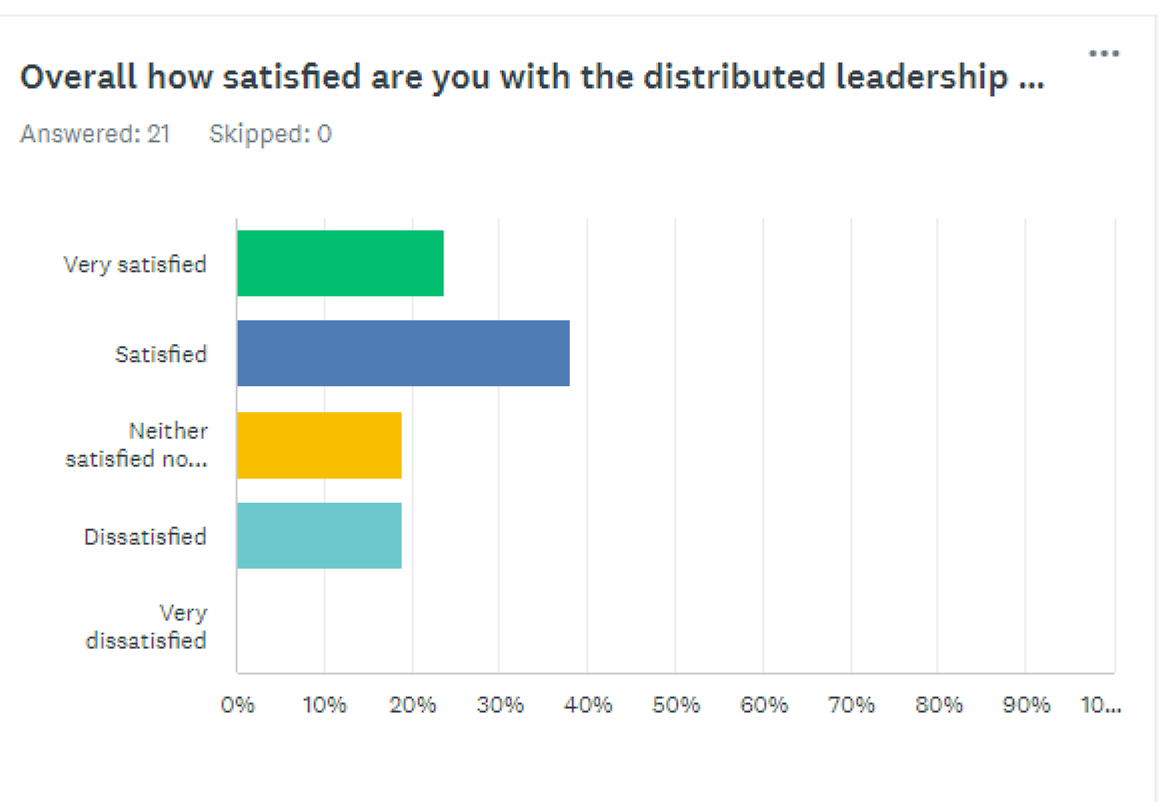
Answered: 21 Skipped: 0






The distributed leadership model is responsive, enabling res...
Answered: 21 Skipped: 0
Disagree
Strongly agree
Neither agree nor disagree
Agree


How would you rate the quality of information provided from...
Answered: 21 Skipped: 0
Very satisfied
Satisfied
Neither satisfied no...
Dissatisfied
Very dissatisfied
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
10...


Overall how satisfied are you with the distributed leadership ...
Answered: 21 Skipped: 0
Very satisfied
Satisfied
Neither satisfied no...
Dissatisfied
Very dissatisfied
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
10...

Are there any areas for consideration or development that wi...

Answered: 11 Skipped: 10

Lack of communication , visibility. Not sure of priorities and not having knowledge of areas covered.

clear communication from chief nurses in a timely manner, more visibility of the chief nurses

If there is a clear issue which has been aired in meetings it feels fairly straight forward to get engagement and move things forward. There have been a couple of issues raised which fall between the gaps and it is quite difficult to get a reply which tends to colour your perspective on how well it works. The areas need to be more clearly communicated to partners. A central contact that then filters to the relevant person would be useful. External partners have to deal with many people and if each place was times 3 as Bradford is, it would be completely unmanageable.

The quality oversight seems increasingly complex - with a deputy, three executive Chief Nurses, and an ICB Chief Nurse. Assurance/ information is being sought through multiple routes. This includes quality metrics which sit more in a medical (including primary care space) where the IBC medical director should perhaps be interfacing.

Are there any areas for consideration or development that wi...

Answered: 11 Skipped: 10

The role identity needs to be reframed - I understood that the role was about assurance re quality and safety, therefore the role should be termed Director of Quality. The fact that the postholders are nurses should not have a bearing.....

none

It's less about the distributed leadership model which I think is working extremely well and more about the general evolution /maturing of the quality committee and the clinical forum. Things are going in the right direction .

Would be good to have clarity on any areas of special interest/expertise that each of the nursing leaders cover to help with ensuring queries go straight to the right person

Further clarity of how quality functions of ICB will be effectively shared between place and 'core'. Work on quality assurance provided to place partnership

Clarity on leadership roles and responsibilities to enhance objectivity from an individual's own organisation

Are there any areas of good practice that you would wish to h...

Answered: 12 Skipped: 9

Approachable at times when they are visible.

The work around Cygnet and CHC, Im sure there are others. The tripartite SMT are all very helpful and approachable

The efforts of the individuals to try and make it work

The new way of working appears to be very successful

Each of the chief nurses bring individual strengths to the role which is a significant benefit and means they probably add more than if it was just 1 individual in the post

Opportunity to provide balanced/unbiased perspectives majority of the time

great approach to problem solving and action based approach is fabulous, great to have the provider approach to problem solving

Are there any areas of good practice that you would wish to h...

Selected: 12

great approach to problem solving and action based approach is fabulous, great to have the provider approach to problem solving

The work done in Continuing Health care, work on Asylum seekers. Responding to the complex needs of children. The design of quality and safeguarding arrangements in the new operating model. Visible and present leadership and development of the nursing/ patients safety / quality teams. Influencing at West Yorkshire level.

Leaders appear to be working together very closely and communicating effectively, and I've found that responsiveness has been brilliant

responsiveness to issues is good

All Chief Nurses are accessible and approachable

Less duplication across place with one agreed version of the truth

Bradford District and Craven
Health and Care Partnership

Quality Hub Development Session

8th September 2023

Summary of Findings

Context

Since March 2023 there have been a number of changes impacting on the Quality Hub including the changes to the delivery model for the hub. This has centred around the provision of clinical quality leadership being provided through the chief nurses from the three provider organisations (BTHFT, ANHSFT and BDCFT).

A development session was held on 8th September 2023 for members of the Quality, Safeguarding and Personalised Commissioning Teams to meet with the Chief Nurses to discuss what is working well, what lessons we can learn, and how we may strengthen the leadership within the Quality Hub.

During the session a Menti session was held which consisted of 11 questions. Following the development session, a survey monkey was distributed to the hub to provide people who could not attend the session a chance to respond.

The results from 54 individuals who participated in the Menti and Survey Monkey are presented in the slides below.

On a scale of 0 to 10, where 0 represented a strong disagreement and 10, a strong agreement, the following questions were asked.

- Q1- The leadership team is accessible, and you can contact the right person when necessary- **Average Score: 5.7**
- Q2- You and your team is encouraged to focus on the right issues- **Average Score: 5.7**
- Q3- The leadership team has removed obstacles and/or provided you with the resources needed to enable you and your team to be as effective as possible- **Average Score: 4.1**
- Q4- You feel confident that you know who is leading and who to ask about each element of your role and responsibilities- **Average Score: 5.9**
- Q5- You will receive a consistent response to any questions or queries you might raise- **Average Score: 4.5**
- Q6- Supported in your role and enabled to fulfil the role fully- **Average Score:5.2**
- Q7- Confident that you are able to let the hub and managers know how you feel and comfortable providing feedback- **Average Score: 5.5**

Q8- You and your work are valued

37
Within the hub

8
Within the organisation

9
Not answered

Of the 54 individuals, 37 felt they and their work was valued within the Quality Hub, compared to 8 individuals who felt they and their work was valued within the organisation. 9 individuals did not answer the question.

Q9- Do you feel you have enough access to the Deputy Director of Nursing and is the role visible

No
Interested
really
formally meet
Start to engage more
population
access
Not
have
impact
responsive
available
beyond
Who
formal
not
role
to
Yes
meet
better
there
far
Don't
DDN
Approachable
Visible
know
Unsure
Available
accessible
barrier
removed
doesn't

Q10- Please provide details of what you think the leadership team should start, stop, and /or continue doing?

subordinates
friendly
unrealistic practical engaging way positive
environment relationships especially
attend
feelings really meet plans decisions
effectiveness teams
employ point governance working providing
supported
approach objectives pressure
unsure approachability
feel improve leadership think
time
developments
training
need
transparency
visibility
workstream
admin
clearer
keep
improvement
bandings
visible
informed affect value
future
happening
management
new
relationships
options restrictive
returning
behaviours
continue-stay
job
dedicated
everyone
person
freely
subject
without
hoop
work
seeking
people
provide
meeting
support stop
clarity
actual
seen
looking first
listen
nice
team
building
processes
involved
expected
whole
putting
disruptive
expressed
meetings
concerns
morale
exploring
skills
single felt
gaps
equity
acknowledgement
fully
happy better
peoples
directly
access
continue
clarify
wellbeing
love
hard
processes/governance
assuming
roles
streams
good
news
required
feedback
faces
opportunities
enable
appreciate
developments
great
nursing
open
staff
organisation
leaders
discussions
changes
hub
hierarchy
help
needs
resourced
struggle
small
effectively
different
understand
formally
impacts
issues
difficult
know
approachable
sharing
unmentionable
aims
encourage
introduced
start
icb
clearer
paths
start-openly
presence
career
comment
extremely
information
years
inclusive
easier
structure
involve
arrangements
professional
events
policies promoting
progression
excessive
commission conversations historical

Q11- Are you happy in your role?

roles
finance
stress icb
relevant
clinicians will
work
good
joined
involve
admin
notice
senior
systematically remaining
difficult
happy
busy
every
ensure
organisational
cuts
pay
increases
progression
wellbeing
uncertainty
working
team
result issue
workplace
replace
need
enjoy
ring-fenced
impacting
normal well
support
workload
yes
intentions
little
listen
department
level
staff
processes
managers
unsupportive
majority
safety
impacts
supported
refused
present
agency
worse
recognition
improvements
moving
trusting
service
suffer
review
day
failure
task
moment
part-time
years
welcome
upgraded
morale
worked
jobs
lack
leaving
valued
never
targets
worried
told
stretched
role
plans
like
people
patient
resources
frustrated
urgent
systems
reluctant
days
feel
ignorance
perform
time
under-paid
complete
management
complicated
easier
happier
love band
leaders
opportunities nurses
restructure

Next Steps

How can we make things better:

- More working together- as a team/ development sessions
- Social gatherings
- Governance meetings
- Share learning as a service
- Remove ‘building’ barriers
- D2A onto wards/ teams
- Structure of meetings - feedback/communication process
- Opportunity direct lines for communication/presentation of detail
- Methods to get efficiencies and quality of services
- Technology/IT/Phone
- Finance approval- delays

Next Steps

What I can do:	What leadership team can do:
▪ Communication lines ▪ Wear red lipstick at all times ▪ Be more visible ▪ Read emails from ICB/ organisation ▪ Get our backlog down ▪ Keep me informed of the bigger picture ▪ Make note to increase conversations - phone or in person ▪ I will ensure that I strengthen the relationships across quality and safeguarding team ▪ Be more positive in my role ▪ Speak up about an issues I have ▪ Speak out and feel comfortable ▪ Stop overthinking ▪ Electronic rota ▪ Training for Nurse £1000 CPD ▪ Management course ▪ I want to be a good manager ▪ Be more open and ask questions	▪ 4 day week ▪ Team development days more often ▪ Learning sets- share knowledge expertise ▪ More working together- as a team/development sessions ▪ Provide opportunities for more joined up working between CHC, Quality, Safeguarding ▪ Meet together more ▪ Link more with other departments in quality hub ▪ Yes to commit to continue to plan development sessions ▪ Have more meetings - more low key events for staff wellbeing ▪ Management need to be more interactive and supportive ▪ Continue to communicate ▪ To endeavour to meet with us in relation to our specific role/work objectives and how this relates to BDC and the ICB ▪ Exec lead/deputy attending safeguarding meetings ▪ More fun days - maybe activities/away days ▪ Team visibility ▪ Working in the office – no home working ▪ More team building with your team and other teams ▪ These meetings at least 3 x yearly ▪ More events such as today

BO.1.24.19 - CONSTITUTION AMENDMENTS

REFERENCES

Only PDFs are attached

Bo.1.24.19 - Constitution amends.pdf

Meeting Title	Open Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.19

Constitution amendments

Presented by	Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
Author	Jacqui Maurice, Head of Corporate Governance	
Lead Director	Mel Pickup, Chief Executive	
Purpose of the paper	To propose an update to the constitution regarding the role of Deputy Chief Executive	
Key control	N/A	
Action required	For approval	
Previously discussed at/ informed by	N/A	
Previously approved at:	N/A	Date

Key Options, Issues and Risks

The Constitution currently allows for up to two Deputy Chief Executives to be voting members of the Board, under section 7.12 (b) (vi) of the Constitution (see extract below for reference):

‘7 BOARD OF DIRECTORS

7.1 Composition of the Board of Directors

7.1.1 The Foundation Trust is to have a Board of Directors. It is to consist of Executive and Non-Executive Directors.

7.1.2 The Board is to include–

(a) The following Non-Executive Directors –

(i) a Chair
(ii) a Non-Executive Director appointed by the Leeds Medical School, and may include a Non-Executive Director appointed by the University of Bradford, such appointments being subject to approval of the Council of Governors at a general meeting,
(iii) at least 5 other Non-Executive Directors

(b) The following Executive Directors –

(i) a Chief Executive (and Accounting Officer),
(ii) a Finance Director,
(iii) a Medical Leader, who must be a registered Medical or Dental practitioner (within the meaning of the Dentists Act 1984)
(iv) a Chief Nurse, who must be a registered Nurse or registered Midwife
(v) a Chief Operating Officer

and may include–

(vi) up to two Deputy Chief Executives; where the role is either;
- combined with an Executive Director identified at (b) (ii), (iii), (iv) and (v) or;
- combined with an Executive Director not identified at (b) (ii), (iii), (iv) and (v) or;
- a Deputy Chief Executive appointed solely to this role.

Where there are two Deputy Chief Executives in post, at least one will be combined with an Executive Director identified at (b) (ii), (iii),(iv) and (v), in order to ensure that at least half of the Board consists of independent Non-Executive Directors.'

- Sajid Azeb, Chief Operating Officer currently holds the role of Deputy Chief Executive.
- John Holden, Director of Strategy and Integration, retired from the Trust from 31 August 2023 and also held the role of Deputy Chief Executive under section 7.12 (b) (vi).

Whilst the Chief Operating Officer role falls within the remit of voting executives the role of Director of Strategy and Integration does not. As such, following the departure of John Holden the Board has one less voting Executive.

The Chief Executive is not proposing to appoint a second Deputy CEO. However, to ensure that the number of voting executives on the board remains at 6, it is requested that either the Chief People and Purpose Officer or the Director of Strategy and Transformation is appointed as a voting Executive.

Recommendation

The Board is asked to agree the appointment of either the Chief People and Purpose Officer **or** the Director of Strategy and Transformation as a voting member of the Board.

The Constitution will be amended in line with the Board's decision and the proposed amendment/s will then be presented to the Council of Governors for approval on 5 February 2024.

Meeting Title	Open Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.19

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for our patients, delivered with kindness				g		
To deliver our financial plan and key performance targets				g		
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☐	☒	☐
Is there any other national benchmarking data relevant to the content of this paper?	☐	☐	☒
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☐	☐	☒

Risk Implications (see section 5 for details)	Yes	No
High Level Risk Register and / or Board Assurance Framework Amendments	☐	☒
Quality implications	☐	☒
Resource implications	☐	☒
Legal/regulatory implications	☒	☐
Equality Diversity and Inclusion implications	☐	☒
Performance Implications	☐	☒

Regulation, Legislation and Compliance relevance	
NHS England: (please tick those that are relevant)	
☐Risk Assessment Framework	☐Quality Governance Framework
☒Code of Governance	☐Annual Reporting Manual
Care Quality Commission Domain: Well Led	
Care Quality Commission Fundamental Standard: Good Governance	
NHS England Effective Use of Resources: Choose an item.	
Other (please state):	

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality & Patient Safety	Finance & Performance	Other (please state)
☐	☐	☐	☐

BO.1.24.20 - ACADEMY WORK PLANS

REFERENCES

Only PDFs are attached

Bo.1.24.20 - Academy Work Plans cover paper.pdf

Bo.1.24.20 - Finance and Performance Academy Workplan 24-25.pdf

Bo.1.24.20 - People Academy Workplan 24-25.pdf

Bo.1.24.20 - Quality and Patient Safety Academy Workplan 24-25.pdf

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.20

ACADEMY WORK PLANS

Presented by	Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
Author	Laura Parsons, Associate Director of Corporate Governance/Board Secretary	
Lead Director	Mel Pickup, Chief Executive	
Purpose of the paper	To present the Academy work plans for approval	
Key control	N/A	
Action required	For approval	
Previously discussed at/ informed by	Academy Meetings – 29 November 2023	
Previously approved at:	**Academy/Group**	**Date**
	Academies	29.11.23

Key Options, Issues and Risks

The Academy work plans for January 2024 to March 2025 were agreed by the Academies at their meetings in November and are attached at appendices 1-3 for review and approval by the Board.

Board members are asked to note that the completion of the Academy effectiveness reviews, and reviews of Academy terms of reference will be undertaken as part of the wider ‘transactional’ board development work currently being commissioned. Any resulting amendments to the work plans and terms of reference will be presented to the Board for approval.

Recommendation

The Board is asked to:

- **Receive and approve** the Academy work plans for 2024-25.

Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.20

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for our patients, delivered with kindness				g		
To deliver our financial plan and key performance targets				g		
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☐	☐	☒
Is there any other national benchmarking data relevant to the content of this paper?	☐	☐	☒
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☐	☐	☒

Risk Implications (see section 5 for details)	Yes	No
High Level Risk Register and / or Board Assurance Framework Amendments	☐	☒
Quality implications	☐	☒
Resource implications	☐	☒
Legal/regulatory implications	☐	☒
Equality Diversity and Inclusion implications	☐	☒
Performance Implications	☐	☒

Regulation, Legislation and Compliance relevance	
NHS England: (please tick those that are relevant)	
☐Risk Assessment Framework	☐Quality Governance Framework
☒Code of Governance	☐Annual Reporting Manual
Care Quality Commission Domain: Well Led	
Care Quality Commission Fundamental Standard: Good Governance	
NHS England Effective Use of Resources: Choose an item.	
Other (please state):	

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality & Patient Safety	Finance & Performance	Other (please state)
☒	☒	☒	☐

DRAFT FINANCE AND PERFORMANCE ACADEMY WORK PLAN 2024-25

Item	Lead	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Sep-24	Oct-24	Nov-24	Jan-25	Feb-25	Mar-25	Notes	Relevant Strategic Commitments
Finance and Performance Academy Dashboard	DoF/COO	x	x	x	x	x	x	x	x	x	x	x	x	x		
Monthly Finance Report	DoF	x	x	x	x	x	x	x	x	x	x	x	x	x		
Bradford Place and ICS System Financial Update	DoF	x			x			x			x	x			To include key updates on work programmes (by way of exception).	
Capital Update	DoF	x			x			x		x		x				
Capital Programme	DoF		x										x			
Contract Update	DoF				x					x						
Treasury Management Update	DoF					x					x					
Procurement Update	DoF			x					x					x		
Pathology Joint Venture - Financial Position	DoF					x					x					
Budgetary Management Framework	DoF					x										
Budget Setting Process and Timetable	DoF	x	x							x		x	x			
Financial Plan / NHSE Operational Plan Submission	DoF / COO	x										x				Pat6a
Internal Audit - Audit Plan	DoF		x										x			
High Level Risks	DoF/COO	x	x	x	x	x	x	x	x	x	x	x	x	x		
Board Assurance Framework - strategic risks relevant to the Academy	Board Secretary		x		x		x			x			x		NB updates in August and December to be circulated via e-mail	
Operational Highlight Report	COO	x	x	x	x	x	x	x	x	x	x	x	x	x		
Performance Report	COO	x	x	x	x	x	x	x	x	x	x	x	x	x		
F&P Academy Terms of Reference Review & Effectiveness Review	Board Secretary								x							
F&P Academy Annual Report	Board Secretary				x											
F&P Academy Work Plan	DoF/COO	x	x	x	x	x	x	x	x	x	x	x	x	x		
Finance Improvement Plan	DoF	x	x	x	x	x	x	x	x	x	x	x	x	x		
Operational Improvement Plan	COO	x	x	x	x	x	x	x	x	x	x	x	x	x	Urgent & Emergency Care, RTT, Cancer (one per month in this order)	Pat4a, Pat4b, Pat6a, Pat 6b, Pat6c
Service Development Post Implementation Reviews	DoF					x					x					
WYAAT / ICS Programme Updates	DoF	x			x			x		x		x			Quarterly update	Pat6b
CIP Methodology	DoF														Date TBC	
Winter Planning	COO									x						
Winter Review	COO														Date TBC	
Act As One Programme Update	Act As One Programme Director	x		x			x			x		x		x	Quarterly	Pat6b, Pl1b
EPRR Submission	COO									x						
Prioritising LD Patients	COO/CDIO		x					x					x			
Internal Audit Reports relevant to the Academy	Chair	x	x	x	x	x	x	x	x	x	x	x	x	x	Standing item - as an annex for information only	

Key:
Planned item
Planned item deferred to future meeting
Planned item cancelled and not re-planned in / state reason in notes
Item discussed at the meeting

DRAFT PEOPLE ACADEMY WORK PLAN 2024-25																
Item	Lead	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Sep-24	Oct-24	Nov-24	Jan-25	Feb-25	Mar-25	Notes	Relevant Strategic Commitments
Looking After Our People	Director of HR		x		x		x		x		x		x			Pe1a, Pe1c, Pe1d
Workforce Growth and Transformation	Associate Chief Nurse – Quality & Workforce	x		x		x		x		x		x		x	Bi-monthly - Jan/Mar/May/Jul/Oct	Pat1c, Pe3d, Pe3e, Pe3f, Pe3g, Pe4a, Pe4b, Pe4c, Pe4d, Pe4e
People Academy Dashboard	Director of HR	x	x	x	x	x	x	x	x	x	x	x	x	x		Pe2a
Workforce Report	Director of HR	x			x			x			x	x			Quarterly	Pe2a
High Level Operational Risks	Director of HR	x	x	x	x	x	x	x	x	x	x	x	x	x		
Board Assurance Framework - strategic risks relevant to the Academy	Board Secretary		x		x		x			x			x		NB updates in August and December to be circulated via e-mail	
People Plan/Strategy workplan	Director of HR				x					x						Pat1c, Pe1a, Pe2a, Pe2b, Pe3d, Pe3f, Pe3g, Pe4b, Pe4c
Nursing Recruitment and Retention Plan	Chief Nurse		x						x				x			Pat1c, Pe3f, Pe3g, Pe4a, Pe4b, Pe4e
NHS Staff Survey Results & Action Plan	Director of HR		x										x		Debbie Jackson & Julie Snellgrove to present	Pe2a, Pe2b
NHS Staff Survey Action Plan Updates	Director of HR						x			x						Pe2a, Pe2b
Review of People Academy ToRs	Director of HR	x							x							
People Academy Annual Effectiveness Review	Director of HR	x							x							
People Academy Annual Report to Board	Director of HR				x											
People Academy Work Plan	Director of HR / Academy Chair	x	x	x	x	x	x	x	x	x	x	x	x	x		
Guardian of Safe Working Hours / Quarterly / Annual Report	Chief Medical Officer		x		xQ4	xAR		x		x			x			Pe1c
Equality Update (WRES/WDES)	Director of HR					x									Annual report, date subject to change pending availability of data	Pe2a, Pe2b, Pe2c, Pe2d
Gender Pay Gap	Director of HR			x										x		Pe2a
FTSU Quarterly Report	Chief Nurse		x			xAR		x		x			x			Pe1b
Nursing & Midwifery Staffing Establishment Review	Chief Nurse				x					x						Pat1c, Pe3g, Pe4a, Pe4b
Medical Appraisal and Revalidation Annual Report	Chief Medical Officer						x									Pe1c
Healthcare Worker Flu Vaccination Best Practice Assurance	Director of HR										x					
Review of GMC Survey Feedback	Chief Medical Officer/Director of Education								x							
Review of National Education & Training Survey (NETS) Feedback	Chief Medical Officer				x											Pe4c
Education Annual Report	Chief Medical Officer				x											Pe4b, Pe4c,Pe4d, Pe4e
Workforce Civility Update	Director of HR	x		x			x		x			x		x	Quarterly	Pat2a, Pe1b
Report / Minutes from Health & Safety Committee	Director of Estates & Facilities	x		x		x		x		x		x		x	Bi-monthly	
Board Assurance Framework for Nurse Staffing	Chief Nurse			x					x					x		
Nursing and Midwifery Staffing Data Publication Report	Chief Nurse	x	x	x	x	x	x	x	x	x	x	x	x	x		
Workforce Planning Submission	Director of HR	x										x				Pe3f, Pe4a, Pe4b
Staff Story	Director of HR	x		x		x		x		x		x		x	Jan - Outstanding Theatre Services	Pe1c
Act as One Programme Updates - People Perspective	Act as One Programme Directors														Quarterly - dates TBC	Pe3f
Bradford District & Craven People Committee Updates	Director of HR	x		x		x		x		x		x		x	Bi-monthly	Pe3f, Pe4b
Internal Audit Reports relevant to the Academy (information only unless there are exceptions to report)	Director of HR	x	x	x	x	x	x	x	x	x	x	x	x	x		
Violence Prevention & Reduction Standard	Director of Estates & Facilities	x						x				x			2024 - January and July (inc Annual Security Report)	
Industrial Action	Director of HR	x	x	x	x	x	x	x	x	x	x	x	x	x	Standing item - verbal	
Organisational Culture	Director of HR			x					x					x		
Outstanding Pharmacy Services	Director of S&I			x			x				x			x	3x per year	
NHS Long Term Workforce Plan	Director of HR														Frequency/timing TBC	
NHS EDI Improvement Plan	Director of HR														Frequency/timing TBC	
Equality Delivery System 2- workforce elements	Director of HR		x													

Key:
Planned item
Planned item deferred to future meeting
Planned item cancelled and not re-planned in / state reason in notes

Item discussed at the meeting

QUALITY ACADEMY - 2024-25 DRAFT ASSURANCE WORK PLAN

Item	Lead	28/02/2024	24/04/2024	26/06/2024	04/09/2024	23/10/2024	18/12/2024	26/02/2025	Notes	Relevant Strategic Commitments
Infection Prevention and Control BAF	CN								*IPC BAF included as appendix to IPC quarterly reports*	Pat1a
Quality & Patient Safety Academy Dashboard	CN/CMO	x	x	x	x	x	x	x		
Quality Oversight & Assurance Profile	CMO	x	x	x	x	x	x	x		
Serious Incidents Report	CMO	x	x	x	x	x	x	x		
CLIP Report (Complaints, Litigation, Incidents, Patient Experience)	CMO	x Q3		x Q4 AR	x Q1		x Q2	x Q3	Quarterly Report, Q4 is annual report	
High Level Risks	CN/CMO	x	x	x	x	x	x	x	As Assuring Academy	
Board Assurance Framework - strategic risks relevant to the Academy	Board Secretary	x	x	x	x	x	x	x		
Maternity and Neonatal Services Update	CN	x	x	x	x	x	x	x		
Safeguarding Adults	CN			x			x		Annual report in June & 6 monthly update in Dec (Dec report to include external feedback on annual report)	
Safeguarding Children	CN			x			x		Annual report in June & 6 monthly update in Dec (Dec report to include external feedback on annual report)	
Digital Report	CDIO		x		x		x		Three reports per year	Pat5a, Pat5b, Pat5c, Pl2a, Pl2b, Pl3a
Digital & Data Transformation Committee (highlight report / minutes)	CDIO		x		x		x			Pat5a, Pat5b, Pat5c, Pe3e, Pl2a, Pl2b, Pl3a
SIRO Report	CDIO								Date TBC	Pat5a, Pat5b, Pat5c
Bradford District & Craven Quality Committee (highlight report / minutes)	CN/CMO	x	x	x	x	x	x	x		
Estates & Facilities Service Report	Dir Estates & Facilities		x Q3&4			x Q1&2				Pl4a, Pl4b
15 Steps Assurance Programme	CMO	x		x		x		x	Quarterly	
PLACE Annual Report	CN			x						Pat2b, Pat2c
Quality Academy Work Plan	Chair	x	x	x	x	x	x	x		
Quality Academy Annual Report	Chair		x							
Internal Audit Reports relevant to the Academy (information only unless there are exceptions to report)	Chair	x	x	x	x	x	x	x		
Moving to Outstanding Quarterly Update TBC	CN								TBC	
Freedom to Speak Up Quarterly Update (information only)	CN	x		x	x	x		x		
Nursing and Midwifery Staffing Data Publication Report (information only)	CN	x	x	x		x		x		
Update on Ward Accreditation	CN		x							
Equality Delivery System	Head of Equality	x								

Key:
Planned item
Planned item deferred to future meeting
Planned item cancelled and not re-planned in / state reason in notes
Item discussed at the meeting

QUALITY ACADEMY - DRAFT 2024-25 LEARNING/IMPROVEMENT WORK PLAN

Item	Lead	Jan-24	Mar-24	May-24	Jul-24	Sep-24	Nov-24	Jan-25	Mar-25	Notes	Relevant Strategic Commitments
Improvement Strategy	**CMO/CN**						x			Annual	Pat3a
Palliative Care Annual Report	**CN**	x						x			
Quality Account	**CMO/CN**		x	x		x	x		x	Quarterly progress updates Annual Quality Account for sign off in May	
Review of Quality Academy ToRs / Effectiveness Review	**Chair**					x					
High Level Risks	**CN/CMO**	x	x	x	x	x	x	x	x	As Assuring Academy	
Infection Prevention and Contol	**CN**	x		x	x		x	x		Quarterly Report IPC BAF to be included as an appendix	Pat1a
Research activity in the Trust - Update (Month/Year) - This paper then to be submitted to Board of Directors	**CMO**		x	x		x	x		x	Quarterly Report TBC	Pat3c, Pl3a, Pl3b, Pl3c
Patient Safety Group	**CMO**	x	x	x	x	x	x	x	x		
Clinical Outcomes Group	**CMO**	x	x	x	x	x	x	x	x		
Patient Experience Group	**CN (Joanne Hilton)**	x	x	x	x	x	x	x	x		Pat2a, Pat2b, Pat2c
Patient Experience - 6 monthly report	**CN**	x		x			x			May - Annual report	Pat2a, Pat2b, Pat2c
Serious Incidents Report (focus on learning)	**CMO**	x	x	x	x	x	x	x	x		
Inpatient Survey	**CN**						x			Annual	Pat2b, Pat2c
Children & Young People's Patient Experience Survey	**CN**							x		Every 2 years - date TBC	Pat2b, Pat 2c
Urgent & Emergency Care Survey	**CN**							x		Every 2 years - date TBC	Pat2b, Pat2c
National Patient Safety Improvement Programme Update	**CMO**	x			x			x		Bi-annual	
Learning from Deaths	**CMO**	x		x		x		x		3 times per year co-ordinated with Mortality review	
Maternity and Neonatal Services Update	**CN**	x	x	x	x	x	x	x	x		
Clinical Audit High Priority Plan	**CMO**			x							
Clinical Audit Annual Report	**CMO**			x							
Bradford Nursing and Midwifery Professional Practice Model	**CN**		x		x		x		x		Pat 1a, Pat 1b, Pat3c
Quality Improvement Programme update	**CMO**	x		x		x		x			
Mortality Review Improvement Programme	**CMO**	x		x		x		x		Co-ordinated with Learning from Deaths	
LD Improvement Standards	**CN**									Dates TBC	
Mental Health Strategy	**CN**		x						x		
Outstanding Theatres Programme	**CMO**	x								Programme ends Jan 2024	Pat1b, Pat3b
GIRFT Update	**CMO**			x							Pat3b
Update on Health Inequalities	**Dir Strategy & Integration**			x			x				
WYAAT Quality and Safety Meeting Update	**CN**		x			x			x	Bi-annual	
Patient Safety Incident Response Framework	**CMO**	x	x	x	x	x	x	x	x		
Outstanding Pharmacy Programme (quality impacts)	**TBC**									Date TBC	
Nursing and Midwifery Staffing Data Publication Report (information only)	**CN**	x	x	x	x	x	x	x	x		

Key:
Planned item
Planned item deferred to future meeting
Planned item cancelled and not re-planned in / state reason in notes
Item discussed at the meeting

BO.1.24.21 - ANY OTHER BUSINESS

BO.1.24.22 - ISSUES TO REFER TO BOARD COMMITTEES OR ELSEWHERE

BO.1.24.23 - REVIEW OF MEETING

BO.1.24.24 - DATE AND TIME OF NEXT MEETING

BO.1.24.25 - GREEN PLAN ANNUAL UPDATE

REFERENCES

Only PDFs are attached

Bo.1.24.25 - Green Plan Annual Update (Cover Sheet).pdf

Bo.1.24.25 - Green Plan Annual Update.pdf

Meeting Title	Open Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.25

Annual Update on the Implementation of Bradford Teaching Hospitals NHS Foundation Trust's Green Plan

Presented by	Sajid Azeb, Chief Operating Officer & Deputy Chief Executive	
Author	Don MacKenzie, Environement and Sustainability Manager, and Molly Corner, Policy Manager	
Lead Director	Sajid Azeb, Chief Operating Officer & Deputy Chief Executive	
Purpose of the paper	To provide the Board with an annual update on progress on the implementation of BTHFT Green Plan	
Key control	This paper is not a key control for the Board Assurance Framework	
Action required	For information	
Previously discussed at/ informed by	Implementation of the BTHFT Green Plan is monitored by the Green Plan Implementation Group, chaired by the Executive Director of Strategy	
Previously approved at:		Date

Key Options, Issues and Risks

This paper presents an update on the implementation of the Trust Green Plan. The Plan was developed and agreed by the Board in 2020 as a means to meeting the requirements of the move to a Net Zero NHS by 2040 (subsequently revised to to 2038 in line with West Yorkshire Combined Authority targets).

Since then, the Board had a report in January 2022 and January 2023 outlining what progress had been made to this point. This paper updates the progress that has been made since that last report, and gives an overview of what work is planned for 2024, including the development of a new Green Plan for the trust which will reflect anticipated new guidance and tools from NHS England, and to move towards a broader sustainability plan for the trust.

Analysis

The Health and Social Care Act 2022 introduced a legal requirement for all NHS Trusts and NHS Foundation Trusts to meet the requirements of NHS England guidance on the reduction of emssions and the development of a NetZero NHS. The Green Plan was developed in 2020 in line with guidance from NHS Engalnd that was in place at the time. This update reflects the content of the plan and what we have achieved in terms of its implementation. It does not reflect the full range of activity across the Trust on sustainability where we continue to make progress across clinical areas, for example where we have reduced the use of nitrous oxide for anaesthesia, and we have switched to using recyclable packaging in our pharmacy, where possible to do so.

The Tust will be required to update its Green Plan to take into account of the wider range of activity across the trust on all aspects of sustainability, not just the NetZero environmental requirements. This plan is in development and will be picked up by the new Director of Strategy and Integration on commencement in role.

Recommendation

The Board is asked to note the content of the paper.

Meeting Title	Open Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.25

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for our patients, delivered with kindness				g		
To deliver our financial plan and key performance targets				g		
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☐	☒	☐
Is there any other national benchmarking data relevant to the content of this paper?	☐	☐	☒
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☐	☐	☒

Risk Implications (see section 5 for details)	Yes	No
High Level Risk Register and / or Board Assurance Framework Amendments	☐	☒
Quality implications	☐	☒
Resource implications	☐	☒
Legal/regulatory implications	☒	☐
Equality Diversity and Inclusion implications	☐	☒
Performance Implications	☐	☒

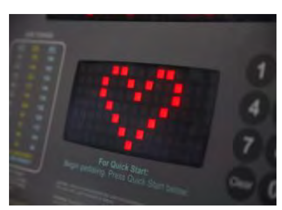
Regulation, Legislation and Compliance relevance
NHS England: (please tick those that are relevant) ☐Risk Assessment Framework ☐Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain: Well Led
Care Quality Commission Fundamental Standard: Good Governance
NHS England Effective Use of Resources: Choose an item.
Other (please state): It is part of the new CQC inspection framework, and is included in the requirements of the NHS Contract. NHS England publishes statutory guidance. The Health and Care Act 20222 introduced a statutory requirement for each trust to have a Green Plan.

Meeting Title	Open Board of Directors		
Date	18 January 2024	**Agenda item**	Bo.1.24.25

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality & Patient Safety	Finance & Performance	Other (please state)
☐	☐	☐	☐

Progress report on the implementation of the Trust's Green Plan

18th January 2024



Together, putting patients first

Introduction

- This report provides an update on how the Trust is performing against the Board approved green plan as well as progress in achieving the NHS net zero carbon emission commitments
- In a challenging financial environment in an economy recovering from Covid and affected by geopolitical events; a range of improvements made over the past year show the Trust's commitment to improving sustainability
- The Trust has continued to rise to the challenge of reducing its carbon footprint and completed many positive actions, some of which are highlighted in this report

Governance

- The Trust approved its first Green Plan in Jan 2020.
- BTHFT's Green Plan Implementation Group (GPIG) and its sub-groups have developed and begun monitoring progress against a series of work plans that are aligned with the Greener NHS areas of focus.
- The Trust is required to produce an updated Green Plan in 2024 using revised guidance and support tools from NHS England which will include revised governance for sustainability, ensuring it includes all staff groups and interests.

NHS net zero targets

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

- In July 2022 the Health and Care Act 2022 introduced a statutory duty on all NHS bodies to meet the ambitions of the Delivering a Net Zero NHS report, originally published in 2020 and updated in 2022.
- NHS organisations are legally required to be net zero:
  - **by 2038 for carbon emissions** for areas they can control (electricity, water and waste), with an interim target of 80% reduction in carbon emissions by 2032 and
  - **by 2045 for areas they can influence** (how suppliers deliver their goods and services through to how patients, visitors and employees travel to the healthcare facilities) with an interim target of 80% reduction in carbon emissions by 2039.

Highlights since Jan 2023

- The Green Plan Implementation Group have worked with colleagues from Bradford District Care and Airedale to develop a place-based climate change adaptation plan which will be developed further as the effects of climate change cause more severe weather events such as flooding and heatwaves.
- The Trust's carbon footprint which will be presented in its annual report is being developed to capture the effects of Trust activity such as Nitrous Oxide and air miles that haven't previously been reported.
- At St Luke's Hospital environmental initiatives such as No Mow May and the planting of a hedge supplied by the NHS Forest are improving the biodiversity of this city centre site.

Sustainable travel

- Links with Bradford Council are strengthening as the Clean Air Zone and associated green travel initiatives become embedded into transport policies.
- The Bicycle and Runners User Group has been relaunched with regular meetings to address barriers to active travel being addressed and events for summer 2024 being planned.
- Trust Shuttle bus under review – via the Taxi contract.

Procurement

- A 10% weighting for 'social value and sustainability' is standard in all of our tenders and the evaluation of these criteria is now embedded in procurement practice.
- Carbon Reduction Plans are now a requirement for bidders in procurements over £5Million/annum
- Engagement has occurred with the Net Zero and Sustainable Procurement Team in order to understand the effect of the supply chain on the Trust's overall carbon footprint.

Waste Management

- In line with the requirements for Net Zero healthcare waste management a new Waste Policy has been launched.
- Cardboard recycling will be emphasised as a priority with the introduction of dry mixed recycling being phased in over the next 15 months.
- Food waste from ward catering now goes to anaerobic digestion to reduce the previously high carbon footprint of this waste stream.

Sustainable Utilities

- The new Day Case Unit at St Luke's Hospital will include heat pump based electrical heating to allow a pathway to net zero for this building.
- Heat Decarbonisation Plans for Bradford Royal Infirmary and St Luke's Hospital have been developed that utilise heat pump have been developed.
- In order to switch to heat pump technologies, tens of millions of pounds of capital funding are likely to be required, a challenge that the NHS and the rest of the public sector is facing.
- The continued development of building management systems within the existing gas fired heating systems aims to reduce current carbon footprints

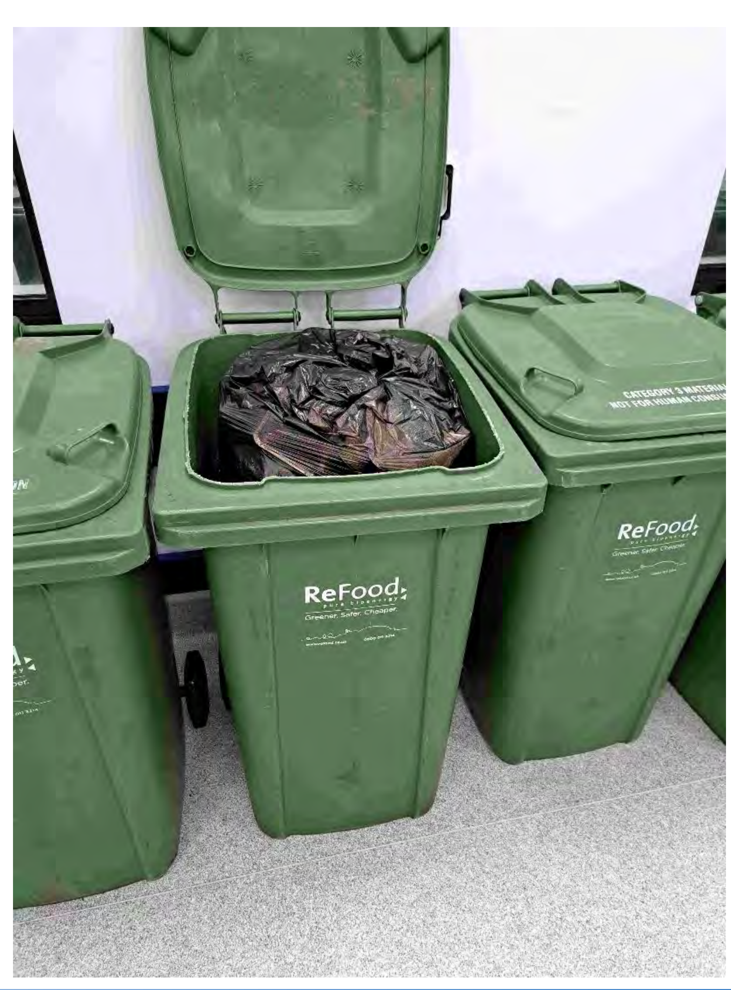
Bradford Teaching Hospitals
NHS Foundation Trust

Clinical Sustainability

- After the successful phasing out of the high carbon anaesthetic Desflurane, the emphasis for carbon reduction is now on Nitrous Oxide.
- Work is ongoing to accurately calculate Nitrous Oxide usage and capture this in the Trust's overall carbon footprint.
- Engagement with Maternity Services and the New Endoscopy Unit Project Team has occurred looking at the feasibility of cracking Nitrous Oxide through technology that has been deployed in some larger trusts such as Newcastle University Hospitals.

No Mow May St Luke’s

Food Waste Bins



Place Based Adaptation

Bradford Teaching Hospitals
NHS Foundation Trust

Bradford Place Climate Change
Adaptation Action Plan

2023– 2027

The next 12 months

- Recruitment of a new **Director of Strategy and Integration** whose responsibilities will include promoting sustainability across the trust; supporting local/departmental initiatives; connecting across West Yorkshire and refreshing the trust's Green Plan
- **Guidance, tools and strategies** launched by NHS England and the Government to accelerate the journey to becoming sustainable will be adopted. This includes introducing dry mixed recycling across the Trust by April 2025.
- Developing a **new BTHFT Green Plan** for publication later in 2024.
- Producing final **heat decarbonisation plans** for our sites to plot a pathway to net zero heating.
- Launching initiatives across the trust aimed at raising awareness of and taking action on **active travel**, providing support where needed.
- Continuing partnership working on **climate change adaptation** across the Bradford District and Craven

BO.1.24.26 - BOARD WORK PLAN 2024/25

REFERENCES

Only PDFs are attached

Bo.1.24.26 - Board of Directors Workplan.pdf

BOARD OPEN 2024-25

Item	Lead	Jan 24	Mar 24	May 24	Jun 24*	Jul 24	Sep 24	Nov 24	Jan 25	Mar 25	Notes (*Accounts Meeting)
STRATEGY											
Corporate Strategy Annual Update	Director of Strategy & Transformation							x			
Mental Health Strategy Annual Update	Chief Nurse			x							
Green Plan Annual Update	Director of Strategy & Transformationn	x							x		Jan 2024 - for information only
Communications - Annual Update	Director of Strategy & Transformation							x			
Digital Strategy Annual Report	CDIO							x			
Improvement Strategy Annual Update	Chief Medical Officer							x			
Engagement Strategy Annual Update	Chief Nurse					x					
EDI Strategy Annual Update	Chief People & Purpose Officer		x							x	Presentation
People Strategy	Chief People & Purpose Officer										Date TBC
QUALITY & PATIENT SAFETY											
Quality Account	Chief Medical Officer/Chief Nurse				x						
CQC Reports/Action Plan	Chief Nurse										Only when there is relevant information to report
Infection Prevention & Control Q4 Report (Annual Report)	Chief Nurse					x					
Maternity and Neonatal Services Update	Chief Nurse	x	x	x		x	x	x	x	x	
Annual Research Report	Chief Medical Officer			x							
Research Activity in the Trust	Chief Medical Officer	x		x*			x		x		*Presentation from Research Team
PEOPLE											
Equality, Diversity & Inclusion Update (WRES, WDES)	Chief People & Purpose Officer		x								Presentation
Equality & Diversity Council	Chief Executive	x		x		x	x	x	x	x	
Staff Survey Results	Chief People & Purpose Officer		x							x	
Freedom to Speak Up Annual Report	Chief Nurse					x					
Nursing & Midwifery Staffing Review	Chief Nurse			x				x			
Looking after our people (verbal update)	Chief People & Purpose Officer		x			x		x		x	
FINANCE & PERFORMANCE											
Operational Plan Submission	Chief Operating Officer / Director of Finance		x								
Financial Plan	Director of Finance		x								
Capital Programme	Director of Finance		x								
Budget setting process & timetable	Director of Finance										Date TBC
Winter Plan	Chief Operating Officer							x			
Health Inequalities & Waiting List Analysis	Chief Operating Officer		x				x			x	
Annual Report & Accounts, ISA260 & Letter of Representation	Director of Finance				x						
Charity ISA 260, Draft Annual Report & Accounts and draft Letter of Representation	Director of Finance	x							x		
PARTNERSHIPS											
Partnerships Dashboard	Director of Strategy & Transformation	x	x	x		x	x	x	x	x	
GOVERNANCE / ASSURANCE											
Board Assurance Framework	Director of Finance	x	x	x		x	x	x	x	x	
High Level Risk Register	Director of Finance	x	x	x		x	x	x	x	x	
Review of Standing Orders/SFIs/Scheme of Delegation	Director of Finance		x				x			x	SFIs/SOD - March SOs - Sept
Constitution - annual review	Director of Finance			x							
Self Certification of Provider Licence	Director of Finance		x	x							
NED Independence Test	Director of Finance			x							
Compliance with NHS Code of Governance	Director of Finance			x							

BOARD OPEN 2024-25

Item	Lead	Jan 24	Mar 24	May 24	Jun 24*	Jul 24	Sep 24	Nov 24	Jan 25	Mar 25	Notes (*Accounts Meeting)
Well Led Review & Board Self Assessment	Director of Finance										Date TBC
Annual Report from Academies	Academy Chairs			x							
Annual Report from Audit Committee	Chair of Audit Committee						x				
Risk Appetite Review	Director of Finance			x							
Annual Fire Safety Report	Director of Estates & Facilities			x							
Annual Health & Safety Report	Director of Estates & Facilities							x			
Premises Assurance Model Progress Report	Director of Estates & Facilities						x				
Annual Security Report	Director of Estates & Facilities					x					
Violence Prevention & Reduction Standard	Director of Estates & Facilities		x				x			x	Sept - part of Annual Security Report
Membership Plan	Director of Finance			x				x			
Data Security & Protection Toolkit	CDIO			x							
DPO Annual Report	DPO						x				
Emergency Preparedness, Resilience & Response & NHSE Core Standards	Chief Operating Officer							x			
Use of the Trust Seal	Director of Finance						x				
NED Champion Roles - annual review	Chair		x					x			March - deferred from Nov 23
COG Engagement Policy	Director of Finance		x								
STANDING ITEMS											
Patient Story - every alternate board	Chief Nurse		x			x		x		x	Removed from Jan agenda
Getting to know the CSUs	COO			x			x		x		
Chair's Report	Chairman	x	x	x		x	x	x	x	x	
Chief Executive's Report	Chief Executive	x	x	x		x	x	x	x	x	
Chair's report from Academies	Academy Chairs	x	x	x		x	x	x	x	x	
Chair's report from Audit Committee	Audit Committee Chair	x	x	x		x	x		x	x	
Chair's report from Charitable Funds Committee	Charitable Funds Committee Chair	x		x		x		x	x		
ITEMS FOR INFORMATION ONLY											
Confirmed Charitable Funds Committee minutes	Chair	x		x		x		x	x		
Confirmed Audit Committee minutes	Audit Chair	x	x	x		x	x		x	x	
Confirmed Academy minutes	Academy Chairs	x	x	x		x	x	x	x	x	
Integrated Dashboard	All	x	x	x		x	x	x	x	x	
Adults & Children Safeguarding Annual Report	Chief Nurse					x					
Finance Report	Director of Finance	x	x	x		x	x	x	x	x	
Guardian of Safe Working Hours quarterly report	Chief Medical Officer		xQ3	xQ4				xQ1&2		xQ3	
Medical Appraisal & Revalidation Annual Report	Chief Medical Officer					x					
Gender Pay Gap Report	Chief People & Purpose Officer		x							x	
Workforce Report	Chief People & Purpose Officer		x			x	x			x	
Freedom to Speak Up Quarterly Reports	Chief Nurse		x			x	x	x		x	
Performance Report	Chief Operating Officer	x	x	x		x	x	x	x	x	
Healthcare Worker Flu Vaccination Best Practice Assurance	Chief People & Purpose Officer	x							x		

Key:
Planned item
Planned item deferred to future meeting
Planned item cancelled and not re-planned in / state reason in notes
Item discussed at the meeting

BO.1.24.27 - HEALTHCARE WORKER FLU VACCINATION BEST PRACTICE ASSURANCE

REFERENCES

Only PDFs are attached

Bo.1.24.27 - Healthcare Worker Flu Vaccination Best Practice Assurance (Cover Sheet).pdf

Bo.1.24.27 - Healthcare Worker Flu Vaccination Best Practice Assurance.pdf

Meeting Title	People Academy		
Date	29 November 2023	Agenda item	Bo.1.24.27

Healthcare worker flu vaccination best practice assurance

Presented by	Faeem Lal, Interim Director of HR	
Author	Amanda Grice, Workplace Health & Wellbeing Centre Manager	
Lead Director	Faeem Lal, Interim Director of HR	
Purpose of the paper	Healthcare worker flu vaccination best practice management checklist for public assurance by Trust boards	
Key control		
Action required	For assurance	
Previously discussed at/ informed by	*N/A*	
Previously approved at:		Date
	People Academy	29.11.2023

Key Options, Issues and Risks

The purpose of the paper is to provide assurance to the People Academy/Trust Board that the Trust is on track to deliver the flu vaccination programme for 2023/24, evidencing this through the best practise management checklist as requested by NHS England and NHS Improvement.

Analysis

The vaccination of healthcare workers against seasonal flu is a key action to help protect patients, staff and their families.

The staff winter vaccination programme has been delivered by colleagues from Rimmington's pharmacy. This allowed co-administration of both flu vaccine and covid vaccine in one single appointment, along with increased availability of vaccination clinics across all Trust sites.

There have been delays with data flow from Rimmington's and due to administrative resourcing issues in Occupational Health this has impacted our ability to provide weekly uptake data. However we are confident that the offer to staff is significant and mitigates any short fall in data flow. Informal feedback about the vaccination team has been positive from staff across the Trust.

Recommendation

It is recommended that the People Academy acknowledge the request from NHS England and NHS Improvement to present the best management checklist for the vaccination of healthcare workers and to note actions that have been met.

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for our patients, delivered with kindness				g		

Meeting Title	People Academy		
Date	29 November 2023	**Agenda item**	**Bo.1.24.27**

To deliver our financial plan and key performance targets				g		
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☐	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☐	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☐	☐	☐

Risk Implications (see section 5 for details)	Yes	No
High Level Risk Register and / or Board Assurance Framework Amendments	☐	☐
Quality implications	☐	☐
Resource implications	☐	☐
Legal/regulatory implications	☐	☐
Equality Diversity and Inclusion implications	☐	☐
Performance Implications	☐	☐

Regulation, Legislation and Compliance relevance	
NHS England: (please tick those that are relevant)	
☐Risk Assessment Framework	☐Quality Governance Framework
☐Code of Governance	☐Annual Reporting Manual
Care Quality Commission Domain: Choose an item.	
Care Quality Commission Fundamental Standard: Choose an item.	
NHS England Effective Use of Resources: Choose an item.	
Other (please state):	

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality &Patient Safety	Finance & Performance	Other (please state)
☒	☐	☐	☐

Appendix 1

Healthcare worker flu vaccination best practice management checklist for public assurance via trust boards by December 2023

A	Committed leadership	Trust self-assessment
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers.	Confident
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers.	Completed. QIVc and aQIV ordered and received for staff immunisation campaign
A3	Board receive an evaluation of the flu programme 2022/23, including data, successes, challenges and lessons learnt.	Evaluation paper sent to HR Director 30/08/23 findings used to support proposal and decision making agreed by ETM 18/09/23 - Confident
A4	Agree on a board champion for flu campaign.	Chief Nurse and Chief Medical Officer - Confident
A5	All board members receive flu vaccination and publicise this.	Publicity being scheduled with comms team - Confident
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives.	Confident
A7	Flu team to meet regularly from September 2023.	Scheduled meetings in place - Confident
B	**Communication plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions.	Staff communication campaign commenced 28/09/23 - Confident
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper.	Completed and communicated
B3	Board and senior managers having their vaccinations to be publicised.	Publicity being scheduled with comms team - Confident
B4	Flu vaccination programme and access to vaccination on induction programmes.	Incorporated with staff communication campaign - Confident
B5	Programme to be publicised on screensavers, posters and social media.	Incorporated with staff communication campaign, awaiting delivery of PHE posters/leaflets - Confident
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups.	Limited confidence due to the delay in data flow however we are confident that the offer to staff is significant and mitigates any short fall in data flow.
C	Flexible accessibility	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered.	Vaccination team established via Rimmington's pharmacy colleagues - Confident

Appendix 1

C2	Schedule for easy access drop in clinics agreed.	Schedule completed
C3	Schedule for 24 hour mobile vaccinations to be agreed.	Schedule completed
D	Incentives	
D1	Board to agree on incentives and how to publicise this.	Agreed not to incentivise
D2	Success to be celebrated weekly.	Incorporated with staff communication campaign - Confident

BO.1.24.28 - RESEARCH ACTIVITY IN THE TRUST

REFERENCES

Only PDFs are attached

Bo.1.24.28 - Research Activity in the Trust (Cover Sheet).pdf

Bo.1.24.28 - Research Activity in the Trust.pdf

Meeting Title	Board of Directors		
Date	Thursday 18th January 2024	**Agenda item**	Bo.1.24.28

Research Activity in the Trust – Update

Presented by	Dr Ray Smith and Dr Michael McCooe	
Author	Professor John Wright (Director of Research) & Dr Tracy Watson (Director of Research Operations) & Research Department Heads	
Lead Director	Dr Ray Smith, Chief Medical Officer	
Purpose of the paper	To provide information on some of the key research activities in the Trust	
Key control	NA	
Action required	For information	
Previously discussed at/ informed by	Quality and Patient Safety Academy	
Previously approved at:		**Date**

Key Options, Issues and Risks

This report for research describes some of the main areas of work and progress over the last few months; these include:

- Applied Health Research Activity
- Clinical Research Activity.

Analysis

As above.

Recommendation

This report is for information and highlights how important research activity is for healthcare and treatment improvement.

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for our patients, delivered with kindness			g			
To deliver our financial plan and key performance targets			g			
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					

Meeting Title	Board of Directors		
Date	Thursday 18th January 2024	Agenda item	Bo.1.24.28

Explanation of variance from Board of Directors Agreed General risk appetite (G)	

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☐	☐	☒
Is there any other national benchmarking data relevant to the content of this paper?	☐	☐	☒
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☐	☐	☒

Risk Implications (see section 5 for details)	Yes	No
High Level Risk Register and / or Board Assurance Framework Amendments	☐	☒
Quality implications	☐	☒
Resource implications	☐	☒
Legal/regulatory implications	☐	☒
Equality Diversity and Inclusion implications	☐	☒
Performance Implications	☐	☒

Regulation, Legislation and Compliance relevance
NHS England: (please tick those that are relevant) ☐Risk Assessment Framework ☐Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain: Choose an item.
Care Quality Commission Fundamental Standard: Choose an item.
NHS England Effective Use of Resources: Choose an item.
Other (please state):

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality &Patient Safety	Finance & Performance	Other (please state)
☐	☐	☐	☐

Research in the Trust

Report for Quality Academy

November 2023

This report provides an update on research in the Trust, highlighting some of the activities of our research teams and provides information on some of the developments that are happening.

Research Activity and Performance

At the end of Quarter 2 the Trust's target for recruitment into research studies was 8874 and 8459 participants have been recruited (95% of target achieved).

In order to improve research experience and as a requirement of the NIHR, we take part in the PRES- Participant Research Experience Survey. The Trust's target for 2023/24, as set by the NIHR Y&H Clinical Research Network, is 514; at mid-November 444 surveys have been completed (86% of target achieved to date).

APPLIED HEALTH RESEARCH

The Yorkshire and Humber Applied Research Collaboration (YH ARC) continues to work with partner organisations across the region to speed up the translation of research into practice. Since the last report, one of our main focuses has been to improve our communication and engagement strategy to expand dissemination and implementation of our research. This includes an emphasis on highlighting the overall impact of the YH ARC both locally and nationally and increasing understanding of what YH ARC does.

To do this our communications plan now includes a monthly focus to showcase our work in different areas, such as our PhD students research, coproduction and working with the public, implementation, and impact. To share our ARC members expertise, we have also developed a series of 'Lunch & Learn' webinars on different topics, that have been shared nationally, and each event has over 60 people signed up. More information can be found here.

Our website is being redeveloped to include a searchable list of projects and publications, bite sized research summaries, and more emphasis on how YH ARC can help implement our findings with organisations such as NHS Trusts and Local Authorities.

We are awaiting feedback from NIHR on the business plan for the 18 month extension period and look forward to sharing that outcome in the next report.

The BaBi Network

The BaBi Network has expanded to include two new sites, Warwick and Tameside. These sites join Bradford, Leeds, Doncaster, Wakefield and East London recruiting to this multi-site study, run by Born in Bradford and supported by NIHR ARC YH that aims to find out what influences the health and wellbeing of families across the country. The BaBi Network now has 26661 participants across the 7 sites, and we hope they will be joined by Harrogate, Nottingham, Hull, York and Scarborough by the end of the year.

The BaBi Network recently co-hosted a collaborative workshop with the Humber and North Yorkshire Integrated Care Board, to introduce the BaBi study to regional partners and Trusts interested in setting the study up. This provided an opportunity for local authorities, Hospital Trusts, and the Integrated Care System to connect and begin conversations around potential funding, support, and introductions to key personnel that could assist with local implementation of BaBi.

ACTEARLY

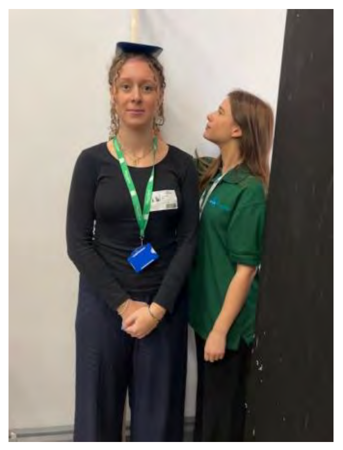
ActEarly is a UKPRP funded collaboration between Bradford and Tower Hamlets in London. The ActEarly vision is to create City Collaboratories in areas of high child poverty that provide research ready, people-powered and data-linked test beds to co-produce, implement and evaluate multiple early life interventions to prevent disease and reduce inequalities. Highlights since our last update include further local authority briefings, progress towards our ActEarly meta-evaluation including international collaboration and knowledge sharing around the ENCOMPASS Framework model underpinning this work, further academic and community knowledge sharing, and a writing retreat for our ActEarly research fellows. More information on these activities can be found on our website which also includes a link to sign up for our monthly newsletter here

NIHR RSS Public Health Specialist Centre - BIHR Satellite

The new NIHR Research Support Service (RSS) launched on 1st October 2023. As part of the new service, a Public Health Specialist Centre (PHSC) has been confirmed that will focus specifically on supporting public health research outside the NHS. This is a significant new investment by NIHR to support the development of research structures and research capacity to strengthen the wider determinants of health evidence base. The PHSC will work with local authorities, VCSE sector and others to support the development of research where it can have most impact on the health of our local communities. The PHSC includes 3 satellite centres that will help deliver the service and one of these is **BIHR** which will be the satellite for the Yorkshire & Humber region. This is an exciting opportunity for the Institute, further strengthening our connections to NIHR infrastructure and building on our commitment and current activities to support the development of research activity and an evidence culture in local government. Research Support Service Specialist Centre for Public Health | NIHR

Born in Bradford

Age of Wonder – our adolescent follow-up funded by Wellcome is now in the second year of full implementation. In year one we collected questionnaire data on 4274 pupils aged 12-15 years old and conducted measurements of height and weight on 1748 Year 9 students. These measures were opt-out and this model seems to work well. Opt-in consent from parents for bloods was 16%. We are keen to explore alternatives to traditional blood draw (e.g. blood spots).



Our new Indoor air quality project INGENIOUS has recruited 160/300 BiB families. We are monitoring three rooms within each home for two weeks using commercially available sensors, with more detailed measurements of volatile organic compounds and particulate matter in a subset. Recruitment is due to complete March 2023. More details here: https://youtu.be/d1uaQtLIt7E

Our ActEarly co-production strategy was shortlisted for an award at the inaugural 'Celebrate as One partnership Awards 2023' under the 'research initiative of the year' category. The event hosted by Bradford District and Craven Health and Care Partnership wards was held on 18th of October. We didn't win, but were very honoured to have made the shortlist.

Our new CoPPeR (Co-production and Peer Research) Network has launched. Funded by NIHR this will see us working with four community organisations, co-producing community led research addressing key community priorities with seldom heard groups. Creating energetic and sustainable community research partnerships. Developing the Co-production and Peer Research (CoPPer) network to improve health and reduce inequality | NIHR

Improvement Academy

Based within Bradford Institute for Health Research, the Improvement Academy undertakes implementation and improvement projects nationally, provides training across many areas, including Quality Improvement and Behaviour Change, and hosts one of NHS England's Patient Safety Collaboratives. The Improvement Academy is also the implementation arm of

the Yorkshire and Humber Applied Research Collaborative. Below details some of the work in which we are currently involved.

Patient Safety Incident Response Framework

The [Patient Safety Incidence Response Framework](#) (PSIRF) sets out a systems approach when conducting patient safety incident investigations, with a focus on learning from incidents to improve patient safety and the support available to staff. The adoption of a systems-based approach fits with the Improvement Academy's ethos around patient safety.
To support the implementation of PSIRF we have developed a training course to complement the national training and support teams in understanding PSIRF, the identification of safety actions, and the development of quality improvement projects. The training follows the practical approach to learning that we have used in other training, such as Quality Improvement and Structured Judgement Reviews. This enables attendees to get hands-on experience of conducting an investigation and the identification of safety actions. We are hosting an event on the 24th November to staff across the region to gather feedback before a formal rollout.

To further support Trusts with the implementation of PSIRF we have developed training for Thematic Analysis, a core component of PSIRF to assist teams in identifying patterns when conducting an incident investigation. Additionally, we are currently developing training relating to the meaningful involvement of patients and families in investigations.

Celebrating 10 years of HUSH

The Improvement Academy has been celebrating 10 years of its flagship Huddle Up for Safer Healthcare (HUSH) programme: an evidence-based intervention that has consistently demonstrated significant improvement in staff teamworking, improved team communication, job satisfaction and safety culture, and a reduction in patient harm.

HUSH provides a structured approach for implementing safety huddles in healthcare settings and encourages all team members (clinical and non-clinical) to come together briefly every day with a focus on an area of harm. The shared knowledge at the huddle improves situational awareness and teamwork, thus reducing patient harm as harms are anticipated and prevented and errors are learnt from.

Some highlights from the HUSH programme include:

- Supporting 500 teams in 32 organisations across the UK
- Worked in 9 Healthcare delivery settings including, Mental Health, Community, Primary Care, Care Homes, Prison Health teams, Hospices, and Acute hospital wards.
- Teams have reduced harm in 16 different areas including, falls, pressure ulcers, deterioration, medication errors, restrictive practice, and violence and aggression.
- In the last 10 years, Huddles have helped to prevent over 12,000 falls.

Further information can be found on our website.

Celebrating 36 years of world-class Ageing and Stroke Research in Bradford

36 years of commitment, innovation and perseverance in conducting world-class research to improve the health and care of older people and survivors of stroke.

In 1987 Professor John Young and Professor Anne Forster, founders of Academic Unit for Ageing and Stroke Research (ASR), conducted their first research study together at Bradford Hospitals.

From a small team of two, the ASR is now home to 38 members of staff and students, with 27 active projects and over £26m active research grant awards.

Key Highlights

- National implementation of the electronic Frailty index, which supported the assessment of frailty for over 1 million older people in the UK
- Our validated LUNS tool to identify longer term unmet needs after stroke, and Patient Reported Experience Measure (PREM) tool have been translated into different languages and used internationally.
- We conducted two of the world's largest stroke rehabilitation trials
- 400+ publications – currently lead on five Cochrane reviews
- Establishment of large Frailty Cohort with over 1700 registered participants
- Professor Anne Forster was awarded the prestigious NIHR Senior Investigator award

Over the years the ASR has brought together healthcare providers, service users, members of the public, academics, commissioners and many more, to develop and implement meaningful research to address the real needs of the population. We are pleased to see our research findings have been able to inform changes to national policies and to services.

We would like to take this opportunity to celebrate the achievements and also to thank everybody who have contributed to making our research happen. With 36 years of success and hundreds of completed research projects, the ASR continues to grow and maintain its leading role in ageing and stroke research

Project Update

The INCLUDE study, exploring digital exclusion of older people, officially opened on 1st November! Funded by the Dunhill Medical Trust as part of their 'social determinants of healthy older age' call, the study aims to: develop an inclusive way of identifying older people who are digitally excluded, explore older people's views of the internet and what might help them get online, adapt available digital support so it addresses a wide range of needs, then test the feasibility and acceptability of the new approach. The team would like to welcome to the study Caroline Brundle, Senior Research Fellow - she will be managing the project over the next two and a half years.

More details can be found here or please contact Caroline or Liz Graham, Project Lead.

Clinical Research

Clinical Research Delivery Workforce

The Trust clinical research workforce have now all come together as one large team through our centralisation project. This allows for all clinical research staff to be part of a larger, more flexible and responsive workforce which is now line managed through Research. The Research Matron, Senior Research Nurses and Midwife are meeting monthly in an operational capacity to strengthen the strategic overview of the current clinical trials portfolio and their delivery.

The team have welcomed the following new staff members:

- Bev English as the new Senior Research Nurse for the teams at SLH
- -Imran Hamid – Oncology Research Charge Nurse
- -Rachel Calvert – Research Nurse
- -Samantha Turner – Cross-Specialty Clinical Trials Assistant

The Trust Research Induction package has been launched and is now in use with new staff to clinical research.

Trust Research Unit Council

As one of the first Trust unit councils the team are establishing terms of reference and membership of the group. The members are currently completing the NHS QSIR Quality

improvement programme and are commencing work on some of the issues identified by staff from the recent council survey.

Clinical Research Specialty News

Stroke: BTHFT is the highest recruiter to stroke research studies in the Y&H region.

Cancer Teams Our Oncology and Haematology team have merged and welcomed a new research nurse allowing them to review their portfolio and re-open some suspended studies.

St Luke's research teams (Renal, Dermatology and Rheumatology) now have a dedicated Senior Research Nurse with oversight and support for all three teams. They also have new archiving space due to a re-purposed area from space utilisation work. Space created from digital storage of X-rays has led to archiving availability for research.

BO.1.24.29 - CONFIRMED ACADEMY MINUTES

REFERENCES

Only PDFs are attached

Bo.1.24.29 - Confirmed Finance & Performance Academy Minutes - 1.11.23.pdf

Bo.1.24.29 - Confirmed People Academy Minutes - 25.10.23.pdf

Bo.1.24.29 - Confirmed QPS Academy Minutes - 1.11.23.pdf

FINANCE AND PERFORMANCE ACADEMY
MINUTES, ACTIONS & DECISIONS

Date	1 November 2023	**Time:**	08:30-10.30
Venue:	Via Microsoft Teams	**Chair:**	Julie Lawreniuk, Non-Executive Director (JL)
Present:	- Sajid Azeb, Chief Operating Officer / Deputy Chief Executive (SA) - Matthew Horner, Director of Finance (MH) - Chris Danson, Director of Transformation (CD) - Sarah Freeman, Deputy Chief Nurse (SF) - Mohammed Hussain, Non-Executive Director (MHu) - Ellie MacIver, Deputy Director of Operations for Cancer and Diagnostics (EM) - Shaun Milburn, Deputy Director of Operations – Unplanned Care (SM) - Michael Quinlan, Deputy Director of Finance (MQ) - Terri Saunderson, Director of Operations (TS) - Chris Smith, Deputy Director of Finance (CSm) - Carl Stephenson, Associate Director of Performance (CSt)		
In Attendance:	- Laura Parsons, Board Secretary/Associate Director of Corporate Governance (LP) - Barrie Senior, Non-Executive Director (BS) - Helen Farmer, Programme Director – Access to Care (HF) for item FA.11(1).23.11 - Louise Keighley, Senior Head of Integrated Health and Care (LK) for item FA.11(1).23.11 - Andrew Wilson, Service Manager – Renal and Histopathology (AW) - Tabitha Lawreniuk, Personal Business Manager as Secretariat (TL)		

No.		**Action**
FA.11(1).23.1	**Apologies for Absence**	
	The following apologies were noted: - Karen Walker Non-Executive Director - Louise Bryant, Non-Executive Director - John Bolton, Deputy Chief Medical Officer - Rachel Waddington, Deputy Director of Operations Planned Care - James Taylor, Deputy Chief Operating Officer	
FA.11(1).23.2	**Declarations of Interest**	
	No declarations of interest were made.	
FA.11(1).23.3	**Unconfirmed Minutes of the Meeting held 27th September**	
	The minutes of the meeting held on the 27th September 2023 were approved as an accurate record.	

FA.11(1).23.4	**Matters Arising**	
	The Academy reviewed the actions. Updates are noted within the action log and the following action were closed: - **FA230033:** Information on Act as One awards was shared with colleagues via our regular comms updates. Action closed.	
	Assurance	
FA.11(1).23.5	**Finance & Performance Academy Dashboard**	
	SA and MH confirmed that the details within the dashboard would be discussed under the relevant agenda items later in the meeting.	
FA.11(1).23.6	**Finance & Performance Academy Work Plan**	
	LP confirmed that no changes had been made to the workplan since the last meeting. The item on Service Development – Post Implementation Reviews - would be deferred to the next meeting and this would be reflected on the workplan.	Board Secretary FA230038
FA.11(1).23.7	**High Level Risks Relevant to the Academy**	
	JL noted that no new risks had been added to the register and no existing risks had changed in score or been closed since the last meeting. There was one risk beyond its mitigation date in relation to the increase in cost of gas and power, and SA confirmed that the increased cost would be reflected in the financial plan as it was not possible to reduce this and therefore the risk could now be closed. The Academy was assured by the update.	
FA.11(1).23.8	**Board Assurance Framework**	
	LP advised that the Board Assurance Framework sets out the risk to the Trust's strategic objectives, and there were five risks pertaining to the two strategic objectives within the Academy's remit. There had been no change to the risk scores since the paper was last presented to the Academy. MH referred to the reputational risk identified as a result of adverse media coverage and the recent events following the Chairman's resignation, and queried how this risk would be monitored. LP confirmed these would sit within the risk register for the Closed Board and a discussion would be held at the next Closed Board meeting as to whether to include a risk in relation to 'well-led' on the Board Assurance Framework. There would also be a discussion around the potential to expand on the current risk in relation to recruitment and retention of staff.	

FA.11(1).23.9	**Finance & Performance Academy Effectiveness Review – Update**	
	JL referred to the Academy Effectiveness Review which had taken place at the last Finance and Performance Academy meeting. The next step would be to hold a meeting with all Academy Chairs and Lead executives to review the results as there were a number of common themes. This would then be discussed at either the November or January Academy dependent on when this meeting takes place. In the meantime, LP would share the results with all attendees.	Board Secretary FA230039
FA.11(1).23.10	**Winter Plan**	
	SA referred to the winter plan presentation which had been shared with colleagues and developed in conjunction with the Bradford, District and Craven Place and the West Yorkshire ICB, noting that this was a live document subject to change to reflect pressures as and when they arise. SM highlighted that there were two nationwide asks from the national team - to deliver 76% A&E performance by 31st March 2024 and achieve an average of 30 minute response time for category 2 ambulances. There were also two stretch targets for acute providers – to achieve 80% performance for quarter four and for 90% of ambulance handovers to be completed within 30 minutes throughout quarters 3 and 4. If these stretch targets were achieved, there was potential for Trust's to be eligible to bid against a £150m capital fund. The presentation set out bed demand assumptions, and the plan for expanding bed capacity as demand increases. There were also plans for reducing long length of stay in wards 17 and 9, and a number of admission avoidance schemes including vetting of all bed requests by a consultant / senior A&E doctor, and the combining of SDEC and Green Zone into an ambulatory emergency care unit. Side room utilisation would be prioritised for those patients who require IPC isolation. SM also noted the change in OPEL reporting, which had been developed to ensure consistency in OPEL status across the country. There were now 9 parameters that contributed towards the reported OPEL score for an acute hospital, including number of escalation beds open, the mean ambulance handover time, and ED four hour performance. SM noted that Bradford is able to upload these metrics automatically so there is no additional requirement to manually submit. In terms of full capacity protocol, SM highlighted the change in focus to assessing workforce and decision making rather than using corridor care as perhaps is the case in some organisations. Lessons learned from the junior doctor strike included the reduction in NEL admissions by 25% and conversion rates reduced by 7% when a consultant is the decision maker. There were a number of key triggers for enacting the full protocol including 30 bed transfer requested in A&E, no step-down capacity for patients and winter bed capacity open as planned. This year, the plan had a focussed section on paediatrics. SM advised that a small amount of resilience funding had been provided to paediatrics	

	to support nursing and medical staff in managing the high amount of acute paediatric admissions that occur throughout winter. The plan this year was for one nursing team to manage both paediatric A&E workforce and the children's decision unit ward. SA highlighted the intent to protect elective capacity, with elective beds ring fenced and not included within the non-elective bed base. These would only be converted for acute use as a last resort. The Academy approved the Winter Plan and thanked the operational team for their work in preparing this.	
	Learning & Improvement	
FA.11(1).23.11	**Act as One Programme Update**	
	LK and HF from the Act as One programme joined the meeting to provide the Academy with a focused update on the work of the Healthy Communities priority led by LK and a more general summary update of the wider priorities of the programme. LK advised that there was a rapid review of intermediate care services undertaken at the end of last year and a range of recommendations came out of this. In January it was agreed that the recommendations would be supported and delivered through the health and care workstream at Place level. There has been a significant increase in the pace of change required due to the closure of one of the local authority care homes as a result of financial pressures. A Place level summit was held to understand the risks and mitigations of the resultant reduction in community bed base, and an action plan has now been developed to support both over winter and more long term. There are a number of meetings with key colleagues to ensure progression against the action plan, including an IMC meeting every 4-6 weeks to understand any wider implications. LK and colleagues were also developing a Place level discharge SOP to supporting in understanding high level processes and to help with accountability. There is also an agreed phased opening and implementation plan within the three remaining intermediate care units. LK recognised the importance of partnership working and how demonstrative this is within the Bradford Place. HF shared a summary of other Act as One workstreams detailing the progress made to date, what they were working on, and the next steps. SF echoed LKs comments regarding the excellent level of partnership working across Bradford which continuously improves year on year and thanked Act as One colleagues for their work in driving this. The update was noted by the Academy and JL thanked LK and HF for joining.	

FA.11(1).23.12	**Finance Improvement Plan**	
	MH gave a brief update on the finance improvement plan noting the following key points: - As of November, a non-pay controls panel will be introduced, and financial performance review meetings will be held with those CSUs in escalation due to their current financial position, projections and delivery of their waste reduction plans. - A paper had been taken to the Executive Team meeting regarding a number of thresholds that a business case would need to meet to be considered at the Planning Committee. - All Clinical Directors have been asked to provide a monthly update to MH highlighting their projected run rate, progress against corrective actions to deliver their recovery plans and whether they have achieved what they intended to. - The Finance Team continue to review what task and finish groups can be implemented through the Waste Reduction Group with a paper due to a future Executive Meeting around strengthening the coordination and management of the junior doctor rotas and rosters. - There was an ask to reconcile 19/20 WTEs to current numbers, and this showed there was 833 more WTEs now than in 19/20. Work was ongoing to understand the changes that have occurred over this timeframe. In relation to general productivity, SA alluded to the work undertaken when NHSE first sent out their benchmarking report on the loss of productivity across the region. He advised that measures have been undertaken to reduce the use of outsourcing whilst maintaining activity levels, including providing more resilient support. MH drew attention to the work ongoing across Place and System to close the financial gap and to establish a programme budget model to look at what transformation work needs to take place to improve financial performance. MH would update the Academy on progress with this work as appropriate. From a CSU perspective, EM shared that colleagues did feel slightly uncomfortable because of the level of scrutiny that has previously not applied, but they understand why this has now escalated and recognise the need. The Academy noted the update.	
FA.11(1).23.13	**Operational Improvement Plan – RTT**	
	SA provided an overview of the Operational Improvement Plan which had a particular focus on Referral to Treatment as the monthly subject area. The aspiration for the Trust was to be in the top quartile of performance against RTT and to maintain this for the rest of the year. SA referred to the Delivering Operational Excellence event on the 12th September which helped to inform a plan for all elective standards for the	

	next 18-24 months and he would bring these back to the Academy in due course. In terms of current performance against key indicators, SA advised that the Trust was at 64% against the constitutional target of 92% for 18 week waits. The Trust continues to focus on the clinically most urgent and booking patients in chronological order with focus on patients who have been waiting longer than 52 weeks. The Trust remained in the top quartile performance for this standard. In terms of 52 week waits, the October position was 1.47% against a standard of 0%. All 104 and 78 week waits were now cleared. CSUs were creating plans to ensure all patients who would be at 65 weeks by the end of March 24 receive treatment. In comparison with other Trust's across the region, the Trust was performing very well and had seen good improvement. The presentation detailed four key areas of transformation focus including the Outstanding Theatres Programme, the Virtual Royal Infirmary Programme, Outstanding Outpatients and the work with system-wide programmes in transforming access to care. All four areas were on target for achieving their aims. The proactive Performance Management workstream had seen significant progress with elements moving towards or into business as usual. SA noted that there had been a dip in elective performance from July which was due to the impact of industrial action. It was hoped that conversations with the BMA would be successful and there would be no further industrial action which would allow for a focus on improving performance to get back on track. MH queried the projected increase in 65 week performance detailed in the presentation and CSt advised that this projection was guided by the West Yorkshire ICS position. JL hoped that the slide would demonstrate an intent to reduce 52 week wait to zero and when this might be recovered. She also queried whether pre-Covid there was any such waits. SA confirmed that prior to Covid there was zero 52 week waits, and the current focus is to reduce all 65 weeks to zero as this is the national ask, and that the target for 52 weeks is to reduce them as much as possible. CSt noted that intelligence is that 52 week waits will likely be between 600-1000 by year-end, and acknowledged that whilst this feels an uncomfortable figure it is representative of the trend being seen elsewhere in West Yorkshire. The Trust had also been asked to support other local Trusts with particular elective areas, for example providing radical prostatectomies for Sheffield which affected capacity within the Trust. This request is currently being explored. SA also referred to the introduction of PIDMAS, which is the offer of an alternative provider for those patients waiting beyond 40 weeks and who do not have a plan in the subsequent 8 weeks. The impact of this is as yet unknown. MH noted that as an organisation, BTHFT often is incoherent about	

	providing information for patients in other languages and recognised that there would need to be a more consistent approach in terms of language challenges and communication difficulties. MH also referred to a recent survey around the single biggest reason for missed appointments which highlighted lack of clarity around appointment date as the number one reason. SA advised that the Trust is trying to improve on this including the sending of text messages and calling patients to try and communicate appointments clearly. BS referred to the previous mentions of an imbalance in productivity and sought an update on progress against this. SA reflected that a large amount of the non-elective reduction in productivity was due to more costly models of care, such as the development of SDEC. However, there was likely an accurate reduction in productivity for elective and actions had been put in place to address this. There was agreement that MH and SA would work together to bring back an update to a future F&P to share the work ongoing in relation to this. The Academy was assured by the update.	Chief Operating Officer / Director of Finance FA230040
	Performance	
FA.11(1).23.14	**Operational Highlight Report**	
	CSt presented the operational highlight report and noted the following key points: - As expected, acute demand continues to increase as we move into winter. - A lot of effort and money has been put in to clearing data quality errors found on EPR and creating a prevent, correct and clear programme to ensure these errors do not continue to impact. This will be a brilliant model once established but is currently developing. - A big change made this year is to support CSUs to take ownership and responsibility of their own validation process. - There has been an increased demand for diagnostics and has resulted in increased pressure to meet the 28 day cancer target. - There has been a change in capturing ambulance handovers which adds onto the time taken to handover by approximately five minutes, but at the moment the additional time is slightly higher than this. This is reflected across the region and work is ongoing to tighten this pathway to enable smooth handovers. - Further improvements in stroke will be seen once staff are recruited into posts and trained up, and ward reconfiguration work is completed. BS reflected on the importance of setting targets and aspirations for stroke services whilst maintaining a high level of stroke management. SM confirmed that the business case submitted in relation to the ward reconfiguration intended to maintain at least a B against SSNAP throughout the year. The Academy was assured by the report.	

FA.11(1).23.15	**Performance Report**	
	The performance report was noted.	
	Finance	
FA.11(1).23.16	**Monthly Finance Report**	
	MH provided an overview of the report and made the following key points: - The Trust is currently averaging an underlying deficit of £1m per month but this is predicted to increase to £2m per month. - It is expected that the overall exit run rate deficit will be around £20m from a recurrent perspective, so the focus is on how to address this. - A number of improvement and control mechanisms were currently in place and an update on these would be provided to the next Academy meeting. - Non-recurrent measures are being deployed to get to a breakeven position other than reporting a £2m deficit associated with industrial action costs. The Academy was assured by the update.	
FA.11(1).23.17	**2024/25 Budget Setting Process**	
	CSm shared the presentation in relation to the 2024/25 Budget Setting Process and highlighted several key points: - There are a lot of unresolved variables and uncertainties around planning for next year and there has not been any guidance received from NHSE to rely upon. Assumptions are being made around planning parameters to allow for internal planning to continue ahead of the next financial year. - The Trust is forecasting a £3.6m deficit in 2023/24 on the assumption that industrial action costs are covered, with the intention to mitigate this deficit and report a year end break even position. - There is a risk of entering 2024/25 with a £20m deficit due to the non-recurrent measures deployed in 23/24. When considering new pressures for 24/25 and excluding growth funding and costs, this opening deficit could increase to £36.8m. - As the biggest variable in planning assumptions is growth funding, three scenarios had been worked up varying from a 0.2% worst case funding and 2.4% best case which resulted in very varied budgets. - There was a detailed timeline for internal budget setting with the aim that final budget plans are approved by the Executive Team at the meeting on 19 February 2024 and submitted to the F&P Academy on 28 February 2024. The Academy approved the budget setting process as detailed in the paper.	

FA.11(1).23.18	**Capital Update**	
	MQ gave an update on capital developments and highlighted the following key points: - As of month 6, the Trust is reporting a YTD capital spend of £12.8m which is which is an underspend of £12.8m, largely due to some of the larger capital projects, in particular the SLH day case unit and the Eccleshill Diagnostic Centre. There is also a significant underspend in the estates schemes equating to £4.4m. - In terms of forecast spend, a £3.6m overspend is projected at month 6. An updated forecast position would be presented to the next Capital Strategy group. - The key risk to note is around the deliverability of the capital programme – there is around £45m left to spend in Q3 and Q4 which is 80% of the budget total. - The ICS working capital group have indicated that all Trusts may need to reduce their operational capital by 5% this financial year, and if this is the case, the Trust will need to reprioritise its existing capital programme. The £3.6m forecast deficit currently includes the proposed 5% reduction. JL queried why there is a projected £3.6m overspend, and how confident the Academy can be in the ability to deliver the capital programme. MQ advised that there is some concern around the deliverability of the estates schemes, and the maternity scheme. He would discuss this further with colleagues at the next Capital Strategy Group. The Academy was assured by the update.	
FA.11(1).23.19	**Service Development – Post Implementation Reviews**	
	This item was deferred to the next Academy meeting.	
FA.11(1).23.20	**Any Other Business**	
	No other business was raised. JL thanked the attendees for their time.	
FA.11(1).23.21	**Matters to Share with Other Academies**	
	There were no matters to share with other Academies.	
FA.11(1).23.22	**Matters to Escalate to Board**	
	The following matters would be escalated to Board: - The financial challenge of this year and the £36m potential risk for 2024/25. - The response to the gas and electricity risk. - The need for an organisational approach to the challenge of language barriers. - The potential reputational risk in relation to recruitment and retention as	

	a result of recent events.	
FA.11(1).23.23	**Date and Time of the Next Meeting**	
	29 November 2023 – 08:30-10:30	

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM THE FINANCE AND PERFORMANCE ACADEMY – 1 November 2023

Action ID	Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
FA230038	01/11/23	**FA.11(1).23.6**	**Finance and Performance Academy Workplan:** The item on Service Development – Post Implementation Reviews would be deferred to the next meeting and this would be reflected on the workplan.	Board Secretary/ Associate Director of Corporate Governance	29/11/23	Workplan updated and item on agenda for next meeting on 29 November. Action complete.
FA230039	01/11/23	**FA.11(1).23.8**	**Board Assurance Framework:** LP to share the results of the academy effectiveness survey with all attendees.	Board Secretary/ Associate Director of Corporate Governance	29/11/23	Results shared by Sheridan Osbourne on 01/11/23. Action complete.
FA230035	26/07/23	**FA.7(2).23.10**	**Operational Improvement Plan – Cancer and Diagnostic Performance:** National and local directives to be listed separately in the next update.	Deputy Chief Operating Officer	31/01/24	Next cancer and diagnostic performance update to the Academy due on 31 January.
FA230037	27/09/23	**FA.9(1).23.5**	**Finance & Performance Academy Effectiveness Review:** LP would review all responses and bring a more detailed update on possible ways to improve to next Academy meeting including the potential for a face to face meeting every quarter and how best to engage CSUs into attending some meetings.	Board Secretary/ Associate Director of Corporate Governance	31/01/24	LP provided a verbal update on 1 November and a paper would be brought back to the Academy in November/January. Update 21/11/23: Meeting of Academy chairs and lead execs to be arranged. Update to be presented in January 2024.

FA230040	01/11/23	**FA.11(1).23.13**	**Operational Improvement Plan – RTT:** SA & MH to bring back an update to a future F&P to share the work ongoing in relation to closing the productivity gap.	Chief Operating Officer / Director of Finance	31/01/24	
FA230041						

PEOPLE ACADEMY
MINUTES

Date:	Wednesday 25th October 2023	**Time:**	11:30-13:30
Venue:	MS Teams meeting	**Chair:**	Karen Walker, Non-Executive Director
Present:	- Karen Walker, Non-Executive Director (KW) - Sughra Nazir, Non-Executive Director (SN) - Altaf Saddique, Non-Executive Director (ASa) - Jon Prashar, Non-Executive Director (JP) - Faeem Lal, Interim Director of HR (FL) - Karen Dawber, Chief Nurse (KD) - Catherine Shutt, Head of Organisational Development (CS) - Joanne Hilton, Deputy Chief Nurse (JH) - Kez Hayat, Head of Equality, Diversity & Inclusion (KH) - Samia Hussain, Associate Director of HR (SH) - Jane Kingsley, Lead Allied Health Professional (JK) - Raquel Licas, Interim Chair of RESIN (RL) - Sarah Freeman, Director of Nursing (Operations (SF) - Laura Gornall, Education Manager- Professional Education (LG) - Amandeep Singh, Partnership Lead (ASi) - Georgi Dyson, Assistant Director of HR (GD) - Laura Parsons, Associate Director of Corporate Governance/Board Secretary (LP)		
In Attendance:	- Richard Nixon, Mortuary Assistant for agenda item PA.10.23.6 only (RN) - Sean Willis, Associate Chief Nurse (SW) - Caroline Nicholson, Head of Non-Clinical Risk (CN) - Ruth Haigh, Equality, Diversity and Inclusion Manager (RH) - Susan Franklin, Associate Chief Nurse for Quality Improvement\Freedom to Speak Up Guardian for agenda item PA.10.23.16 only (SFr) - Jacqui Maurice, Head of Corporate Governance (JM)		
Observers	- Justine Carroll, HR Business Partner - Liam Bilson, HR Graduate Trainee		

Agenda Ref	Agenda Item	Actions
PA.10.23.1	**Apologies for Absence**	
	- Ray Smith, Chief Medical Officer Absent: - James Taylor, Deputy Chief Operating Officer - Amy Ilsley, Clinical Lead for Medical Workforce - Abbie Wild, Chair of Staff LGBT Network - Susan Parker, Co-chair of the Enable Staff Equality Network - Sonia Sarah, Co-Chair of the Enable Staff Equality Network - David Smith, Director of Pharmacy - Adam Griffin, Deputy Chief Information Officer - Carly Wilson, People Promise Manager	
PA.10.23.2	**Declarations of Interest**	
	No interests were declared.	

PA.10.23.3	**Draft minutes of the meeting held on 27th September 2023**	
	The minutes of the meeting held on 27th September 2023 were approved as an accurate record.	
PA.10.23.4	**Matters arising**	
	There were no matters arising from the minutes that were not already on the agenda. Verbal updates were provided at the meeting on the outstanding and closed actions and these are reflected in the action log.	
PA.10.23.5	**People Academy annual effectiveness review**	
	Further to the review that took place at the previous meeting, KW shared the responses. The Academy noted the following feedback: - 100% of people who completed the survey stated that meetings have improved over the last 12 months. - 83% felt that the meetings have the right mix of assurance/ learning and improvement, but further Improvements can be made from learning from external organisations, idea sharing, staff stories etc. - Request for other NEDs to speak up. - More participation from all members. - Members supported the clarity of purpose, role and remit of the People Academy and its members, however this could be made easier if individuals are challenged and asked questions. - Less slide reading, questions in advance of meeting, papers made available earlier, taking responsibility for challenge and question. - To bring in subject matters experts to attend the meeting. - Smaller agenda. - More focus on learning from others, there were suggestions that high profile cases are presented to this academy. - Lessons learned. - Do we have the right people involved with this academy. - Bringing and sharing materials with academy members and sharing information with staff members outside of this meeting. - Mixture of face to face and teams meetings. KW informed members that all Academies have undertaken an effectiveness review, all Academy chairs will meet to discuss their feedback which will then be discussed at a future meeting.	
PA.10.23.6	**Staff story – Embedding our values**	
	Sughra Nazir highlighted a story of the Trust's people and community working as one team, to allow a deceased Muslim patient a dignified passage to their resting place. A unique set of circumstances saw the Mortuary, Bereavement, Nursing, Porters and other teams enable the washing ritual for the patient in a very dignified way as there were issues with moving and handling. The team went above and beyond including using equipment from elsewhere to allow the ritual to take place in the Mortuary. The staff supported the family throughout. Feedback from the family was that the end-to-end experience - from the patient being admitted to the patient leaving hospital for	

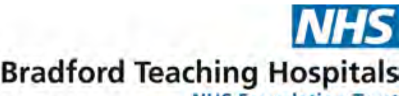
	the funeral - was kind, compassionate, dignified and respectful and they were incredibly grateful. Sughra commented that the Trust's values were brought to life and she gave special mention to Richard Nixon, a new Mortuary Assistant, for making this happen. SN welcomed and introduced RN to the meeting. Richard has only been with the Trust for 8 weeks and said he believed the process captured the values and how the Trust values diversity, as it is not common for ritual bathing to take place in the Mortuary. From RNs experience he felt everybody involved was keen to help and everybody pulled out all the stops to make this happen, to ensure that the deceased individual was treated with dignity and respect. KW thanked RN for attending the meeting.	
PA.10.23.7	**Workforce Growth and Transformation**	
	SW presented the paper. He advised that the focus of this group is to look at new ways of working, delivering care and growing for the future. The group is well represented from members of staff within the organisation, as well as members from external organisations. From the report, the Academy noted the following: - SW which included reference to the launch of the new volunteer website and the live intranet page for staff. The volunteer team is working with human resources to streamline the process for volunteers to work within the Trust. One of the workstreams within BTHFT and across Act as One is, the 'volunteer to career programme' where work is ongoing to progress with this over the next 12 months. - Human resources have set out their plan for the new HIRE (Improving Recruitment Experience) Programme Board. The aim is to reduce time to hire; use TRAC to its full potential including assurance reporting and, improve the onboarding and candidate journey into the organisation. - The education team introduced the trust's new preceptorship and legacy mentor lead. The team is working with Airedale NHS FT to buy the license to deliver The NHS Leadership Academy, Mary Seacole 6-month Leadership Programme. When delivered in-house the cost per candidate is reduced from £1000 to £150, which is within the current CPD funding allocation. The Education team are also looking to purchase access to NHS Elect, which will allow the trust to commission up to 20 bespoke educational packages per year and allow staff access to a range of resources. - SW advised that Bradford University had provided an update on their recent visit to the University of Lahore, and the importance of developing a cultural connection between the two cities and healthcare systems. The Academy noted the update.	

PA.10.23.8	**Nursing and Midwifery staffing establishment review**	
	JH provided an overview of the presentation which detailed the outcomes and recommendations of the Chief Nurse, 6-month strategic staffing review for 2023. The Academy noted that the paper has been shared with matrons and senior staff on the wards, before it was presented to ETM earlier in the week. The Academy discussed the contents of the document and noted the following. • 1 additional HCA post has been supported on ward 18. • Ward 19 requested support for an additional nurse, this was not supported by ETM as activity review for location of paracentesis underway. • Ward 23 requested two additional night nurses, this was supported. • Ward 27 reduced staffing for 1 Registered Nurse and increased 1 HCSW, this was approved. The funding which has been identified by this ward will support the increased on other areas. • Ward 22 DCU – this has seen an increase in demand and capacity and the volume of work, this is not part of the establishment review process and will be processed through as a business case to review the additional support for 1 HCSW. • F6 - Request for increase in band 2 establishment to band 3 – this was approved. • Westwood Park and Westbourne Green – request for increase to a band 7 fully supernumerary with band 5 backfill – this was not supported but is under review. • Several business cases that have been approved are: - Renal cases approved. (Acute dialysis, F7/8, Skipton) - Meadows case approved - Children case approved. - Hand unit approved. - There are a further 3 renal cases which are being developed. • Critical Care – to note there is a requirement coming from the critical care network for ICU to have additional uplift to 35% from 21.5% to create sufficient headroom for all training requirements. This has not yet been adopted by Trusts in WYAAT but will be a recommendation. • There have been no changes to Childrens staffing. • Maternity staffing has undergone a full review - the paper included in the pack detailed all the changes. JH advised that the Chief Nurse's team is aware of the financial challenges the organisation is going through, but there are still nurse staffing vacancies. SN referenced the reconfiguring skill mix on ward 27 and asked at what stage do conversations take place with staff teams so that they understand the rationale? JH advised that this took place from the beginning with the ward and clinical staff whereby a review of the data and metrics takes place with recommendations then presented to the Matron. ASa queried if decisions were shared directly with ward staff. JH	

	stated that this did not happen however, she would do this in the future. RL asked whether pastoral care is offered to international and local nurses who come to work at the Trust? JH advised that the legacy roles offer pastoral support to the newly qualified nurses and international nurses. The HCSW pastoral roles which we have in placed were spoken of positively by a team from NHSE which visited recently. JH added that pastoral support is reviewed and evaluated on a regular basis. RL raised some concerns with regards to staff facilities, JH agreed to discuss this with RL outside of the meeting. **Action:** RL to discuss the concerns relating to staff facilities with JH outside of the meeting. The Academy approved the recommendations presented within the paper and noted that the report will now be presented to the Board of Directors for assurance.	Deputy Chief Nurse & Interim Chair of RESIN (PA23027)
PA.10.23.9	**Nursing and Midwifery Staffing data publication report**	
	SW presented the report which provides an update on the fill rates. The fill rate currently is at 74-75% which is like previous months rates. The risk associated to this, is scored at 20 and the Moving to Outstanding meeting has asked SW to re-review the risk, in view of the new staff members who have joined the organisation. SW provided the following overview: • 66 local newly qualified staff have commenced employment with the Trust. • 40 international Nurses joined the organisation in October. • Moved to a monthly recruitment pipeline for HCAs. • Registered leavers have reduced from 45 to 11. • HCAs has reduced to 7 leavers per month. • The Daisy Awards are going from strength to strength and 2 HCSWs had been awarded the Chief Nurse of England award. • Legacy Nurses are now in operation across nursing, midwifery, AHPs and HCSWs. SW also mentioned that the Datix for staffing does feed into this report and SW will feedback to those individuals who have reported the Datix. The Academy noted the update.	
PA.10.23.10	**Nursing Training and Placements**	
	The report provides assurance to the People Academy on the quality of student nurse placements provided by BTHFT and an overview of feedback received from student nurses. In England, nursing applications had fallen by 16% from 43,170 to 36,400. The Trust is working with four education institutes to offer quality student placements. Each of the Universities and their Practice	

	Learning Partners have undergone a Quality assurance (QA) process to ensure their teaching and training meets the NMC's standards and proficiencies required to prepare students to become registrants. The NMC's Quality Assurance Framework was updated in May 2023. The education team at the Trust carried out a pilot feedback session with 162, year two students to gather real time data on their worries and concerns. This has highlighted areas of good practice as well as scope for improvements. The Academy noted the update.	
PA.10.23.11	**People Academy Dashboard**	
	FL referred to the dashboard and informed the Academy of the following: • Appraisal Rate Medical –The rate is above 90% which is similar to last month's figures. • Appraisal rate non-medical – Rates have increased in September from 74.35% to 75.70%. The appraisal process has been linked to incremental dates. • Core Mandatory Training – the compliance rate is 91%, this has not increased from the previous month. • Staff Turnover – this has seen a decrease by 0.23% to 10.25 in September. • Number on apprenticeship programme – there currently 311 members of staff on an apprenticeship programme. • Nursing bank fill rates –In September the total number of requests sent to bank was 12370 compared with August's requests of 13028 a decrease of -658 requests. • Staff sickness absence – this is continuing to reduce with a target of 5.5% at March 2024 and we are on track with this. The Academy noted the update.	
PA.10.23.12	**High level operational risks**	
	LP presented the high-level operational risks and drew members attention to the following: • There was one risk past the target date for completion of the mitigating actions, which was risk 3800. The risk is aligned to the Finance and Performance Academy, and it will be picked up at their meeting next week. • There is one new risk 3824 reported to ETM, that has been added to the HLRR since the last report, which relates to the Emergency Department Medical Staff Coverage – weekend and evenings, which has scored at 15. This risk is aligned to this academy as well as the Quality and Patient Safety Academy (QPSA). • ETM (Executive Team Meeting) also agreed to add a risk to the HLRR, which relates to the potential reputational damage and impact following the resignation of the Chair. Two new risks have been developed relating to this and will be included on the	

	closed board agenda. • Two risks have reduced in score, these are 3598 and 3630. • Risk number 3808, which relates to the industrial action, is beyond its review date. JH mentioned that a risk was previously reported here relating to the lone worker devices, the devices have now been issued to the Community Midwifery team, and the team is happy with the devices that have been procured. In relation to risk number 3598 and 3630 new guidelines have been developed and the education has been rolled out for this, hence the reason in the reduction in score. The Academy was assured that all the relevant key risks were identified and reported to the Academy and managed appropriately.	
PA.10.23.13	**Board Assurance Framework**	
	LP provided an overview of the circulated papers and highlighted the following: • 3 risks are aligned to this academy, with the first risk being we are unable to recruit to our vacancies, which is scoring at 16, with a target score of 9. • The second risk relates to maintaining a healthy and engaged workforce, which is scoring at 9 with a target of 6. • The third risk where we are unable to recruit, retain and develop a workforce at all levels that is representative of the population we serve. This is scoring at 9, with a target of 6. There are no major changes since the previous review. The Academy noted the update.	
PA.10.23.14	**People Plan/Strategy workplan**	
	CS informed members that the paper was an update on the national NHS People Plan and our practical actions as an employer against each key area. CS provided an overview of the key areas which were addressed in the paper. The Academy noted the update.	
PA.10.23.15	**Organisational Culture and Thriving Together**	
	CS shared an update on what the Trust is undertaking to measure its culture. There are many ways that this can be monitored and assessed and the Trust will use a variety of data to support the work. CS advised that Culture is impacted by many factors such as legacy, generational differences, how people feel and think. The Trust has launched the NHS Culture and Leadership Programme, rebranded as Thriving Together, which is a long-term programme that requires the Trust to challenge itself to get to the deeper elements of culture that are more difficult to change.	



	A Change team of 30 people from across the organisation has been recruited to support the programme. There is a steering group in place, which is chaired by the Chief Executive and a Thriving Together Network will be established to create ambassadors to spread the word and work of the programme. 'Thrive' has been recognised as the brand for all culture and staff initiatives. The Thrive portal has had just under 170,000 viewings in the first two years since its launch and there are plans to refresh the portal. Other initiatives include 'Thrive Live' which takes place monthly, where the CEO and other senior colleagues in the department hold a live Q&A session, where a service or team hosts the event. Planning for the Thrive Leadership Conference 2024 is underway, where the focus will be on culture. The launch of the Advancing Leaders Programme will commence in April 2024, this is a 12-month programme aimed at senior leaders. CS advised that further updates on the initiatives will be provided through the People Academy and at Board meetings. The Academy noted the update.	
PA.10.23.16	**FTSU Quarterly Report**	
	SF joined the meeting and informed members that the circulated report covers the Quarter 2 period of 2023-24. SF summarised the data, where 25 concerns were raised across a variety of categories, which is the highest number per quarter since the launch of FTSU (freedom to speak up). The Academy derived assurance that people felt able to raise concerns through FTSU as well as all the other channels available. Nursing and Midwifery raise 28% of cases and this is a national trend (29%), aligned to the workforce profile. The highest volume of concerns relates to patient safety or quality, closely followed by inappropriate attitudes and behaviours and worker safety or wellbeing. All cases have been followed up. Based on the concerns raised, there are three areas relating to bullying and harassment, inappropriate attitudes and behaviours and civility - these are being investigated and initiatives have been developed with the HR and OD teams. SF informed colleagues that NHSE has published a new FTSU policy, which the Trust must adopt to by January 2024. All NHS organisations are required to adopt this. It links with the NHS People promise, ensuring staff have a voice. This is attached in the appendices of the report. Following a Board development session for FTSU held earlier in the year, an action plan was developed. The Chief Nurse will lead	

	on this and will present the action plan at this Academy as well as at the Board meeting. ASi asked that we urge those involved in Datix investigations to follow up with those raising them in a timely manner. KD advised that the weekly QuOC (Quality of Care) meetings includes an 'improvement trajectory' which reviews all Datix reports. There is an internal target of 30 days to close all reports. KD suggested that the QPSA reviews the Datix process and asked KW to include this in her Chair report to the Board of Directors **Action:** It was agreed that KW would include in her Chairs report to the Board, reference to the issues with Datix reporting. The Academy noted the update.	Chair (PA23028)
PA.10.23.17	**NHS EDI Improvement plan**	
	KH presented the plan and informed the Academy that the national EDI plan, is primarily seeking to improve the workforce inequalities in the wider NHS. The plan includes six high impact actions. All areas of the plan are progressing and some actions have been amalgamated. The Academy noted the update.	
PA.10.23.18	**Revised WRES & WDES action plans for 2024**	
	The Trust has been reporting progress on the Workforce Race Equality Standard (WRES) since 2015 and the Workforce Disability Equality Standard (WRES) since May 2019. KH highlighted the key areas of focus within the refreshed plans and informed the Academy that the plans have been developed in conjunction with other heads of service and more importantly our staff equality networks have influenced the development of these plans. KH stated that separate meetings have taken place with custodians to discuss the actions highlighted in the action plan, so that department heads are themselves leading on the delivery of the actions. The action plans have recently been shared with staff equality networks and have been well received. There is a contractual obligation for the Trust to publish the action plans by 31st October 2023 with NHSE. KH welcomed feedback from colleagues and asked for this to be submitted to his team by 31st October. ASi questioned the imbalance with the disciplinary actions and noticed that data indicates that the gap has widened between BAME and non BAME staff. The report only references the disciplinary policy and does not mention any interventions. ASi asked if there was anything specifically targeted to address this ongoing issue? FL responded by saying that according to data, this year there have been fewer processes and this doesn't seem to be disproportionate	

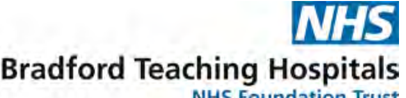
	between BAME and non BAME staff, as there is only a small number of individuals going through a disciplinary process. A deep dive has been carried out to review whether there is any bias or anomalies between how BAME and non BAME cases are dealt with, and it was found that there was no unfair treatment between the two. HR will continue to monitor the cases and will address any inconsistencies. ASi also mentioned, that he is a member of the Health and Safety committee, where violence and aggression is discussed. Due to poor attendance the meetings have been cancelled on several occasions. FL agreed that he will investigate this matter with Chris Davies, Deputy Director of Estates and Facilities, to review the attendee list and ensure relevant members are invited to the meeting. **Action:** FL agreed to discuss the issues raised in relation to the Health and Safety Committee with Chris Davies, Deputy Director of Estates and Facilities. The Academy noted the update.	Interim Director of HR (PA23029)
PA.10.23.19	**Health and safety annual report**	
	Members were asked to read the circulated report and direct any questions to CN.	
PA.10.23.20	**Just R – Candidate journey report**	
	Due to time constraints, it was agreed to defer this item to the next meeting.	
PA.10.23.21	**NHS long term workforce plan**	
	Due to time constraints, it was agreed to defer this item to the next meeting.	
PA.10.23.22	**Industrial action update**	
	FL stated that as the Unions and Government have started discussions to end the Consultants and Junior Doctor strikes, this is good news for the Trust as we become subject to winter pressures. No further strikes are planned at this stage.	
PA.9.23.23	**Bradford District and Craven People Committee**	
	The Academy was asked to read the circulated paper for any updates.	
PA.9.23.24	**People Academy work plan**	
	The Academy was asked to refer the circulated paper for any updates.	
PA.9.23.25	**Any other business**	
	There was no other business discussed.	
PA.9.23.26	**Matters to share with other Academies**	
	There were no matters to share with other Academies.	

PA.9.23.27	**Matters to escalate to the Board of Directors**	
	It was agreed to escalate the potential risk that; with the recent adverse publicity surrounding the ex-Chairman's departure, the Trust's reputation is affected alongside the impact on the relationship between the Board and our staff. There is also a risk that, despite strong improvements and efforts to recruit and retain good people, potential candidates may choose to look elsewhere for work, based on the media attention. This reputational damage needs addressing. KW agreed to include reference to this in her Chairs report to the Board.	Chair (PA23030)
PA.10.23.28	**Date and time of next meeting**	
	29 November 2023 11.00 – 13.00pm.	
PA.9.23.29	**Internal Audit Reports relevant to the Academy – Staff suspension report**	
	The Academy was asked to refer to the circulated paper for updates.	

ACTIONS FROM PEOPLE ACADEMY – 25th October 2023

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
PA23028	25.10.2023	PA.10.23.16	**FTSU Quarterly Report:** It was agreed that KW would include in her Chairs report to the Board, reference to the issues with Datix reporting.	Chair	29.11.2023	Included in the Chairs report to the Board of Directors. **CLOSED**
PA23029	25.10.2023	PA.10.23.	**Revised WRES & WDES action plans for 2024:** FL agreed to discuss the issues raised in relation to the Health and Safety Committee with Chris Davies, Deputy Director of Estates and Facilities.	Interim Director of HR	29.11.2023	Meeting has been arranged. **CLOSED**
PA23030	25.10.2023	PA.10.23.27	**Matters to escalate to the Board of Directors:** It was agreed to escalate the potential risk that, with the recent adverse publicity surrounding the ex-Chairman's departure, the Trust's reputation is damaged and the trust between the Board and staff. There is also a risk that, despite strong improvements and efforts to recruit and retain good people, potential candidates may choose to look elsewhere for work, based on the media attention. This reputational damage needs addressing. KW agreed to include this in her Chairs report to the board.	Chair	29.11.2023	Included in the Chairs report to the Board of Directors. **CLOSED**
PA23008	22.02.2023	PA.2.23.13	**Gender Pay Gap:** LP to arrange an exceptional People Academy session on EDI and Gender Pay Gap.	Associate Director of Corporate Governance / Board Secretary	31.01.2024	LP agreed to arrange an EDI and Gender Pay Gap session towards the end of the year. **25/10/23. It was agreed to move this action to Jan 2024, in line with the pay process.**

PA23027	25.10.2023	PA.10.23.8	**Nursing and Midwifery staffing establishment review:** RL to discuss the concerns relating to staff facilities with JH outside of the meeting.	Deputy Chief Nurse & Interim Chair of RESIN	31.01.2024	



QUALITY AND PATIENT SAFETY ACADEMY (QPSA) ASSURANCE MINUTES

Date:	Wednesday, 1 November 2023	**Time:**	14:00-17:00
Venue:	Microsoft Teams Meeting	**Chair:**	Louise Bryant Non-Executive Director/Chair

Present:	**Non-Executive Directors:** - Louise Bryant (LB), Non-Executive Director / Co-Chair - Mohammed Hussain (MH), Non-Executive Director / Co-Chair - Altaf Sadique (AS), Non-Executive Director - Jon Prashar (JP), Non-Executive Director - Sughra Nazir (SN), Non-Executive Director **Executive Directors:** - Ray Smith (RS), Chief Medical Officer - Karen Dawber (KD), Chief Nurse - Saj Azeb (SA), Chief Operating Officer, in attendance for agenda item QA.11(1).23.5 - Matthew Horner (MHo), Director of Finance, in attendance for agenda iten QA.11(1).23.5
Attendees:	- Jo Hilton (JH), Deputy Chief Nurse - Judith Connor (JC), Associate Director of Quality - Louise Horsley (LH), Senior Quality Governance Lead - Sara Hollins (SH), Director of Midwifery - Yaseen Muhammad (YM), Director of Infection Prevention and Control - David Smith (DS), Director of Pharmacy - Sarah Freeman (SF), Director of Nursing – Operations - Laura Parsons (LP), Associate Director of Corporate Governance/Board Secretary - Kay Pagan (KP), Assistant Chief Nurse Informatics - Grainne Eloi (GE), Associate Director of Nursing & Quality, BDC Health and Care Partnership, in attendance for agenda item QA.11(1).23.5 - Jacqui Maurice (JM), Head of Corporate Governance **In attendance** - Sam Wallis (SW), Consultant Neonatologist, in attendance for agenda item QA.11(1).23.5 - Jamie Steele (JS), Matron for Neonatal Services, in attendance for agenda item QA.11(1).23.5 - Kay Rushforth (KR), Associate Director of Nursing for Children and Neonatal Services, in attendance for agenda item QA.11(1).23.5 - Louise Lacy (LL), General Manager, Children's Services, in attendance for agenda item QA.11(1).23.5 - Ben McKay (BM), Education Manager, in attendance for agenda item QA.11(1).23.5 - Nazzar Butt (NB), Moving to Outstanding Lead, in attendance for agenda item QA.11(1).23.16 - Karon Snape (KS), Head of Facilities, in attendance for agenda item QA.11(1).23.15 - Liz Tomlin (LT), Head of Quality Improvement - LeeAnne Elliott (LAE), Consultant Paediatric Radiologist/Deputy FTSU Guardian - Karen Bentley (KB), Assistant Chief Nurse

Observers:	- Barrie Senior, Non-Executive Director, in attendance for agenda item QA.11(1).23.5 - Julie Lawreniuk, Non-Executive Director, in attendance for agenda item QA.11(1).23.5 - Farzana Khan, Staff Governor, in attendance for agenda item QA.11(1).23.5 - Dermot Bolton, Governor, in attendance for agenda item QA.11(1).23.5 - Kerry Warhurst, Deputy Director of Nursing at NHS England, in attendance for agenda item QA.11(1).23.5 - Kursh Siddique, Governor - Alastair Goldman, Governor - Elizabeth Brooks, Quality & Patient Safety Facilitator

Agenda Ref	Agenda Item	Actions
QA.11(1).23.1	**Apologies for Absence**	
	- Dr Paul Rice, Chief Digital & Information Officer - John Bolton, Deputy Chief Medical Officer - Adele Hartley-Spencer, Director of Nursing (Operations) - Charlotte Keasey, Senior Head of Facilities **Absent:** - Deborah Horner, Deputy Chief Medical Officer	
QA.11(1).23.2	**Declarations of Interest**	
	There were no declarations of interest.	
QA.11(1).23.3	**Minutes of the meeting held on 27 September 2023**	
	The minutes of the meeting held on 27 September 2023 were approved as an accurate record.	
QA.11(1).23.4	**Matters arising**	
	RS explained that although national negotiation talks are ongoing with Consultants and Junior Doctors, the suggestion is that industrial action will continue until the end of this financial year. RS advised that NHS England and the Department of Health have shared some learning regarding processes and noted that there are some changes and clarifications being developed, particularly around derogations and what is meant by 'Christmas Day Cover'. Additionally, RS shared that currently Junior Doctors are required to give 2 weeks' notice of industrial action, and Consultants 6 weeks' notice, to allow for planning. This will change to a 2 week notice period for consultant strikes to allow maximum time for negotiations.	
QA.11(1).23.5	**Review of Neonatal SIs and Timelines**	
	KD introduced the item, explaining that the Academy had been extended this month to accommodate an in-depth review of Neonatal Serious Incidents (SIs), including improvements that have been made since 2021 when the incidents occurred. LB recognised that recent weeks had been difficult for both the families affected by the SIs and Trust colleagues. LB noted ahead of the presentation delivered by the Neonatal Team that	

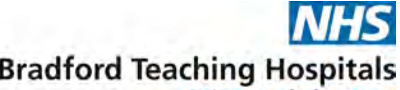
	an action plan had been developed to identify learning at both the Quality and Patient Safety Academy and the Board of Directors. Sam Wallis, Consultant Neonatologist (SW) and Jamie Steele, Matron for Neonatal Services (JS), introduced themselves to the Academy and presented the slides shared with the agenda. SW gave some background of the Bradford Neonatal Intensive Care Unit, noting that the unit cares for all gestations, as one of four units in the Yorkshire and Humber region. The following three Serious Incidents from April 2021 were summarised, with SW providing thorough explanations as to the detail, rapid review outcomes, learning, and additional work undertaken, as displayed on the slides. • Serious Incident 2021/8864 Umbilical bleed • Serious Incident 2021/9386 Meningitis • Serious Incident 2021/9379 Osteomyelitis Regarding SI 2021/9386, MH queried what the learning was from this incident, noting that the SI report for the incident suggests that the learning was not consolidated. Additionally, MH noted that the staff culture at the time of the incident was discussed within the report and was portrayed negatively, noting the use of the word ‘toxic’. Finally, MH outlined some information written in the SI report identifying learning and assurances given around infection prevention control standards. MH then noted the outbreak of Klebsiella in November 2021, in which the learning identified in that report appears to mirror the same content. Overall, MH expressed concerns with consistency in ensuring that the learning identified in the reports is sustained. SW acknowledged the difficulty in ensuring that identified learning can bring about real change. SW praised the efforts of the team in implementing and embedding these changes. Regarding SI 2021/9386, SW noted that the report identified some important details, particularly regarding clear changes to clinical practice. It was acknowledged that the way in which investigations are carried out can leave staff feeling vulnerable; SW shared that since 2021 staff are offered more support and communication is clearer, having a positive effect on the culture of the team. Further to this, it was identified that the educational needs of junior nursing staff were not being met, perhaps due to efforts made to deliver a good service. In addition, SW explained that there were no infection control omissions identified as causing the case of Meningitis reported in SI 2021/9386. In order to demonstrate openness and honesty, Infection Control were asked to observe practice to identify any issues. SW shared that improvements to develop Infection Prevention Control practices are ongoing. Addressing the comments made by MH regarding the Klebsiella outbreak, SW stressed that this was not due to an issue with staff education or a failure to complete or embed actions from	

	the earlier SIs in April 2021. RS provided an explanation of how Klebsiella Oxytoca can develop in a vulnerable baby, and this is not always due to failures in practice. RS went on to note that the investigations were based on a PSIRF model whereby it was good practice to look into the bigger picture. Regarding the mention of 'toxic environments' RS commented that it may not be right to make a judgement about the culture retrospectively. Due to the PSIRF type process used for the analysis of the three incidents, RS identified that this allowed the investigation to identify learning that would have otherwise not been discovered. Additionally, RS advised caution when discussing culture or mistakes, commenting that Clinicians do make mistakes and that changes can take time to embed, which is why it is important to have an open and honest culture, to allow for learning and psychological safety. SW summarised that in all cases presented, the Trust did everything possible to not only address the root cause, but also look at other factors to address what can be done better going forward. SW then provided a timeline of events between April 2021 to January 2023 illustrating what actions, reports and learning were developed following the three incidents. SW explained that an external review was done by the Liverpool Women's Hospital, which found that all of the incidents were individual events and had no common themes. It was highlighted that the review described high calibre reporting and commended the openness and honesty of the team. MH referenced the document shared as the Liverpool Women's Hospital review, and queried whether there was a more detailed report, having noticed that the date and author was not easily found on the document. It was established that the document was the full report, and MH identified that as the level of detail was missing, it may perhaps cause difficulties for the Board to be confident that they can give assurance. As detailed on the slides, SW outlined the cases of infants that were exposed to Klebsiella Pneumoniae, identified as SI 2021/23948, and explained the difficulties that presented in each case, particularly when the infection caused death. SW explained that an outbreak was declared following the death of two infants, in which nine further infants were found to be positive for Klebsiella, of which 5 were the same organism. The actions following the declaration of an outbreak were highlighted including the establishment of an outbreak control group, notifying of the executive team, regulatory bodies and families, a review of IPC practices, and discussion with microbiology lab about the reporting process. The SI report was published in March 2022 and reported to the Board in December 2021 at which point actions were already underway. As a result of those actions, there was no further transmission to other babies on the unit.	

	All affected families were supported, and written communication was shared with all families on the unit. A decision was made with agreement from the executive teams to limit capacity on NICU until the outbreak was controlled with a stepped increase in line with recommended staffing levels. The IPC review highlighted that whilst training and guidance was in place, practices were likely affected by acuity, staffing, and space, with staff responding to the clinical needs of the babies on the unit which sadly meant that occasionally IPC controls were missed. There were a number of recommendations around equipment, environment, cleaning practices and recording, and agreements on ongoing monitoring via infection group. With regards to the issues around reporting processes with microbiology, work remains ongoing to ensure timely reporting of organisms, but SW recognised this remains an area of concern that requires further improvement particularly given the risk of antibiotic resistance. In relation to the timeliness and transparency of the April 2021 SI reports, SW reported that these took a while and ideally would have been completed quicker. He shared that families were left waiting which was frustrating for them. However, learning and improvement opportunities were identified very early on and the delays in reporting did not prohibit learning from the incidents at an early stage. He did not believe that there was any additional clinical risk to patients as a result of the delay in the final reports. MH agreed that the 60-day timeline for serious incidents is a red herring, and the most important aspect of incidents was learning. Qualitatively, the SI from November felt different and much more detailed with a much broader scope considered. He felt that the quality of the SI was excellent and well-reviewed, but the report did mention some of the same learning issues seen in April and therefore MH did not feel like the learning had been acted upon when first identified. He questioned how to ensure learning is embedded in a more systematic way. KR noted this focus is on reporting and being open and honest, and she felt that the team have demonstrated that both internally and externally. She recognised the importance in staff feeling comfortable to continue reporting and being honest, which could be hindered by some comments which felt like criticism of the process rather than learning and improvement focused. RS highlighted the need for a psychologically safe environment with a confidence in being able to speak up if staff identified issues. He recognised that changing culture takes time and sometimes takes many months to change, which can sometimes lead to the same learning being identified twice. He reflected that the unit is in a very different and better place than two years ago with more great people and less external pressures, that was not something to be critical of, rather an opportunity to repeat and reinforce the learning. He felt that clearly the process	

	of learning had worked because the processes and the staffing and the culture has now been transformed. It was important that staff cannot be scared to bring up learning that perhaps was there 6 months ago and not be punished for learning not having taken place immediately. He highlighted that these events happened 2.5 years ago and have been talked about a lot, both at the time and since then, so he hoped that the Academy would not be judgmental about historical things when everyone was doing their absolute best at the time. JC reminded colleagues that the QPSA should be a safe place, with a culture of patient centred improvement with support offered by all attendees. She did not feel the Academy had lost sight of this but recognised the importance of supporting colleagues through these challenges. SW noted that infection on the neonatal is part and parcel of the nature of the unit, and no amount of IPC would reduce all risk of infection. There are infections that do not cause issues for babies in the womb but then become a problem once born as babies, particularly pre-term babies, do not have immune systems to prevent infections. He advised that all neonatal units get outbreaks occasionally so it was highly likely that BTHFT will see an outbreak again. This is not due to a lack of learning or careless prevention, but simply due to all babies, pre-term babies in particular, being immunocompromised, and cannot be made sterile. All the unit can do is try their very best to minimise risks as much as possible. SW also commented that any baby who dies in the Trust's services is fully reviewed with the medical examiner, and the coroner is involved if necessary. JS recognised the importance of psychological safety as mentioned previously. He referred to the Lucy Letby case that had had a significant impact on colleagues on the unit, with nurses feeling under intense scrutiny and very upset, and media reports taking a toll on senior staff who really care. JS has seen an all-time high in colleagues attending his office feeling upset as a result of this. JS stressed that in 2021, Covid-19 was still prevalent, and April 2021 was a peak time for Covid-19. The service was not as resilient at that time, but this was out of the unit's control. In April 2021, there were shifts that only had 8 registered nurses on the unit against a target of 13. There was high staff nurse vacancy, with approximately 15 band 5 vacancies, multiple senior sister vacancies, high levels of staff sickness peaking at 11.5%, and a staff turnover rate of 4.4%. There had also been multiple changes in leadership, a QIS deficit, and problems with the culture. To try and improve the situation, the team lead conversation cafés to understand how they could improve, looked at data and made decisions to remedy issues, held team away days to foster	

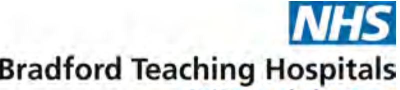
	improved cohesion, recruited to key AHP posts with staff psychology being key, centralised recruitment and focused on flexible working to help support work / life balance. In terms of data, JS shared that the number of colleagues employed within neonatal has increased from just above 90 to nearly 140. The number of staff able to take a workload on NICU is now significantly above the midline and has been since the beginning of this year. The percentage of workforce identifying as 'white British' has decreased year on year to become more representative of the community. GE congratulated JS on the improvement of the workforce which demonstrates the commitment to looking after people. She was heartened that having reviewed records, they were all reported in a very prompt timeframe to the ICB, and all formal procedures followed despite Covid-19 being prevalent at the time. She was very assured that the vision is focused on learning and not criticism. LB asked colleagues to come back to the learning and improvement academy to present this work and discuss further. The Academy has been assured by the Review of Neonatal SIs, and Timelines which were presented, noting that the review is ongoing, assurance may be considered a process but accepting there was no further evidence that could be sought. At the Academy it was agreed that any further questions should be directed through email.	
QA.11(1).23.6	**Review of Quality Academy ToRs / Effectiveness Review**	
	LP shared the following highlights from the Quality and Patient Safety Academy Terms of Reference and Effectiveness Review. • The Academy has improved in the last year, with a good mix of learning, assurance, and improvement. • Academy members were clear on the role and remit of the Academy. <u>Suggestions for further improvement:</u> • Better management of agendas, with fewer papers and slides. • More participation from all members. • Messages from Academy shared across the Trust. • More face-to-face meetings. • More learning from external organisations and other Trusts. • Patient stories and representation. • More representation from CSUs. In terms of next steps, LP advised that all of the Academy chairs and lead Executive Directors will meet to discuss the feedback. Proposed changes to the Terms of Reference will be fed back to the Academy over the coming months. The Academy noted the update.	



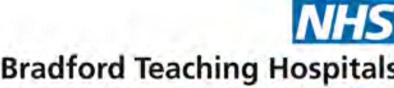
QA.11(1).23.7	**Maternity and Neonatal Services Update**	
	SH provided an update on Maternity and Neonatal Services from September 2023. The September update was noted as read, with SH observing the highlights as depicted on the slides shared with the papers. SH shared the details of the September cases, in which 4 stillbirths were summarised. Additionally, SH shared that there was one Case of HIE, one Level 1 incident, and one completed investigation in September. SH presented some information regarding nine Maternal Deaths during 2020 – 2023. Highlighted on the table depicted on the slides were women who had taken their own lives in the postnatal period; SH outlined these cases are being looked at in line with the recent publication of the MBRRACE-UK report. SH highlighted that BTHFT data on Maternal Deaths regarding Ethnicity was consistent with the reporting of the MBRRACE report, though noted that overall, there were no thematic elements to the BTHFT cases. SH summarised the reporting and investigation process of the cases and shared that there will be a system wide learning event to identify opportunities to better identify postnatal women at risk of suicide. SH went on to share details of a closed case of a baby who had died, and the learning and recommendations that have been identified. SH presented a question to the Academy regarding the level of detail presented to the meeting. MH commented that there is some overlap of Maternity SIs and wider SIs, and the level of information could hinder the triangulation of the information. SH suggested there could be more Non-Executive Director representation at departmental meetings. There was a discussion on the importance of providing positive challenge to reports, to demonstrate that questions are being asked about assurance. It was noted that some data in the Dashboard at Appendix 5 would be reviewed for possible clarification. There was some discussion regarding the Implementation of the Saving Babies Lives Care Bundle at Appendix 4, where it was noted that some of the self-assessment and assessment from the Local Maternity and Neonatal System (LMNS) differed. CS noted that some of the guidelines were in the process of being updated at the time had therefore not been submitted to the LMNS; it was also recognised that the suggestions from the LMNS were helpful contributions for ideas that could be put in place. The Academy were assured by the on Maternity and Neonatal Services update.	

QA.11(1).23.8	**CQC National Inpatient Survey 2022**	
	KB explained that the results of the CQC National Inpatient Survey 2022 were received in September 2023, with the full details of the survey shared within the papers. In addition, some background information, shown on the slides, was provided for the Academy. KB presented the key findings of the survey and provided explanations for some of the key responses, noting the improvements that will be made in response. It was noted that the response rate had decreased from previous years, and KB explained that the survey is now provided in 18 different languages, covering the top five languages seen at the Trust. The Academy were assured by the CQC National Inpatient Survey 2022.	
QA.11(1).23.9	**Patient Safety Incident Response Framework (PSIRF) Plan**	
	JC reminded colleagues that the transition to PSIRF has been ongoing for 12 months, with a view to fully transition by 1st December 2023. It was explained that the new policy outlines how the Trust will investigate and review incidents under the new framework. JC clarified the differences between PSIRF and the current system, as set out in the paper shared with the agenda. In light of challenges presented at the Academy today during agenda item QA.11(1).23.5, JC noted that PSIRF was the framework used when investigating the Serious Incidents discussed. There were some concerns shared that given the difficult nature of the conversations, it may not be possible to approve the plan. There was a discussion regarding the Board Development Day focusing on PSIRF, which some members had been unable to attend. The training was identified as beneficial to those who had been able to attend. It was agreed that an additional session or recording of the training would be made available to those who missed the training. There was some discussion regarding the PSIRF approach, where colleagues recognised that constructive challenge had resulted from the April 2021 Serious Incidents. This prompted further discussions regarding how the Academy can ensure the best line of sight, in order to ensure the best learning outcome. It was recognised that culture changes in taking on PSIRF will take time and challenges will be presented; however, in order to focus on collective learning, themes and trends, colleagues thought it helpful to establish what the Academy required in terms of assurance from PSIRF. RS commented that PSIRF is an opportunity to concentrate on the learning and the types of learning we derive from Serious Incidents. JC noted that identifying the learning will be a challenge, though recognised that triangulation will ensure that learning is being embedded.	

	The Academy approved the Patient Safety Incident Response Framework (PSIRF) Plan, ahead of it being presented to the Board.	
QA.11(1).23.10	**Quality and Patient Safety Academy Dashboard**	
	RS highlighted that the Summary Hospital-level Mortality Indicator (SHMI) value has increased further, though RS assured that the reason for this is understood and is being discussed in detail at Board level. RS noted that the Trust has the fourth lowest crude mortality, and the second worst depth of coding in the country. This strongly suggests that patient deaths are actually low relative to expected, and that the rise in SHMI is as a result of a low depth of coding. Assurances were given that Clinical Coding is working through this, and that SHMI does not equate to quality of care. The Academy can be assured that the Trust has a well-established and robust learning from deaths process. There was a discussion in relation to reductions made by NHS England within the SHMI algorithm, to which it was agreed that RS will discuss at the meeting of the Board of Directors on 16 November 2023. It was acknowledged that there can be difficulties in understanding this data. In addition, KD noted that a falls practitioner had been employed by the Trust earlier this year, which had been very beneficial to impacting falls. The Academy were assured by the Quality and Patient Safety Academy Dashboard.	
QA.11(1).23.11	**Quality Oversight and Assurance Profile**	
	LH shared the highlights of the Quality Oversight and Assurance report. It was noted that in relation to discussions at agenda item QA.11(1).23.10 – Quality and Patient Safety Academy Dashboard, at Appendix 7 there is a mortality deep dive, which gives assurance that the learning in these areas is being understood. The following items were shared, in which it was noticed that further detail was available in the presentations and appendices circulated. • As a result of escalated themes: identification checks when porters are transferring patients are being developed, transfer of patients with oxygen cylinders switched off, and a risk assessment ongoing regarding Radiology reporting delays. • The details of HSIB investigations and the learning from those were shared. • It was noted that as of 30 September 2023 there were 11 ongoing Serious Incidents. • There were 17 Central Alerting System (CAS) alerts issues between 1 August 2023 and 20 September 2023.	



	Regarding an alert in relation to Philips Ventilators, LH shared that advice from the MHRA declared that it was satisfactory, and the alert has been signed off. • Detail of Claims and Inquests were shared. • It was noted that detail of organisation learning is provided at Appendices 6 – 9. There was a discussion regarding Claims, in which it was suggested that claims at a certain monetary amount could be picked up on and investigated further. There was discussion about SIs ongoing over 60 days and the extensions in place. Within PSIRF the longest time taken should be 60 days. There was a question regarding learning and immediate actions which is shared with the Health and Care Partnership via a 72 hour report currently. The Academy were assured by the Quality Oversight and Assurance Profile.	
QA.11(1).23.12	**Serious Incident Report**	
	LH noted that serious incident (SI) reporting is transferring to PSIRF from 1 December 2023. The following information was highlighted from the report: • From October 2022 – September 2023 (with one exception in January 2023), the Trust has remained within the normal cause variations with numbers of SIs. • There have been no breaches of Duty of Candour requirements since 2016. • Training has been developed for new approaches and investigation tools. • Test reporting of patient safety incidents has commenced in to the new Learn from Patient Safety Events (LFPSE) platform. • There is a focus on SIs with extensions in place. It was noted that further information within the report regarding current ongoing SIs. Regarding SI 2023/17239, MH recommended looking into whether a medicines reconciliation had been done. MH also commented that it is important to have transparency about why there are delays when considering the timelines for SIs and that it would be helpful to see within the report. LH explained that going forward timescales will be commissioned by the Quality of Care Panel (QuOC), to monitor in line with PSIRF. LH added that numbers of extensions have been significantly reduced. There was a further discussion regarding what assurances colleagues required from the Quality and Patient Safety Academy. It was agreed by the Co-Chairs and Chief Nurse that it would be beneficial to develop some guidelines. LH	



	commented that in terms of assurances regarding the reporting SIs, immediate actions are undertaken and included within the report, and similarly internal reviews are undertaken whilst waiting for external HSIB reports. It was agreed that the way in which these are demonstrated to the Academy is important. The Academy were assured by the Serious Incident report.	
QA.11(1).23.13	**High level risks**	
	The Academy were assured that all relevant key risks have been identified, reported to the academy, and were being managed appropriately.	
QA.11(1).23.14	**Board Assurance Framework –Strategic risks relevant to the Academy**	
	The Academy noted the Board Assurance Framework – Strategic risks relevant to the Academy.	
QA.11(1).23.15	**Estates and Facilities Quarterly Service Report**	
	KS joined the Academy to deliver a presentation on the Portering Transformation Project. It was explained that there are a number of reasons why the project has been undertaken, as shown on the slides. Achievements made so far during the project were shared, as well as ongoing work and upcoming changes. AS queried what the process was regarding patient identification and if there are any improvements to be sourced from technology. KS advised that a new process whereby porters check the identification as a secondary check is being developed with the Chief Nurse team but is not yet implemented. The Academy was assured by the Portering Transformation Project report. The Estates and Facilities Quarterly Service Report was noted as read.	
QA.11(1).23.16	**15 Steps Assurance Programme**	
	NB gave a presentation sharing the steps taken so far in implementing the 15 Steps Assurance Programme. It was highlighted that the programme was imperative to gaining insight of a patient's perspective, and some positive patient feedback had been shared as a result of the actions that had been taken so far. In addition to the work that had been carried out so far, NB shared some next steps to develop the programme further. It was queried how long the programme will run, and whether it is being embedded routinely. NB explained that the intention is complete for all areas within a one-year cycle, with a view to assess the effectiveness of the work carried out. It was agreed that it would be beneficial to have some Non-Executive Director Involvement.	

	The Academy noted the 15 Steps Assurance Programme update.	
QA.11(1).23.17	**Any other business**	
	Unexpected children's deaths in the month of October 2023 (Urgent) KD shared with the Academy that over a period of four weeks the Trust saw an increased number of child deaths. It was noted that the paper distributed with the agenda gives detail of each of the specific cases. KD explained that this is being shared at the Academy in order to demonstrate openness and honesty, and to raise awareness of the Sudden Unexpected Death in Childhood (SUDIC) process that outlines the procedures for sudden unexpected deaths in children. KD noted that this is explained in detail in the paper. There was a discussion on how the reporting of unexpected deaths would be brought to the Academy in the future. There was some question as to whether there was appropriate guidance available, however RS commented that there are processes in place for both adult and child sudden deaths. It was suggested that details of deaths to the academy may not be necessary as a matter of routine but may be done as an exception where there are increased numbers or emerging trends. SH noted that there is a Child Death Review Panel within the Trust. Additionally, there was a query around how the Trust receives warnings of things happening in the community. KD explained that the Trust have good relationships with both the Police and Safeguarding Board but may not receive all of the helpful information. It was recognised that annual reports will be developed by the Bradford Child death overview panel (CDOP), and any exceptional reports could then be brought to the Quality and Patient Safety Academy, for instance more than two 2 inpatient child deaths in a month. Further to this, there was a query regarding how staff are supported in these instances, with KD clarifying a number of ways in which staff are supported in the Trust in cases such as this.	
QA.11(1).23.18	**Matters to share with other Academies**	
	There were no matters to share with other Academies.	
QA.11(1).23.19	**Matters to escalate to the Board of Directors**	
	It was agreed at agenda item QA.11(1).23.10 that the Dashboard, in particular the SHMI data will be discussed at the meeting of the Board of Directors on 16 November 2023.	
QA.11(1).23.20	**Date and time of next meeting**	
	29 November 2023, 14:00-16:30	
	Annexes for the Quality and Patient Safety Academy	

	Annex 1 - Documents for Information	
QA.11(1).23.21	**Bradford District and Craven Quality Committee (highlight report/minutes)**	
	Noted for information.	
QA.11(1).23.22	**Quality and Patient Safety Academy Work Plan**	
	Noted for information.	
QA.11(1).23.23	**Freedom to Speak Up Quarterly Report**	
	Noted for information.	
QA.11(1).23.24	**Nursing and Midwifery Staffing Data Publication Report**	
	Noted for information.	

Assurance Meeting Actions

Learning and Improvement Actions

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA23017	26.03.23	QA.3.23.6	**Serious Incidents Report (Focus on learning)** ST to do some work with the local police on how the Trust can make improvements to their communication regarding vulnerable patients, bringing a report to the Academy in four months' time.	Assistant Chief Nurse Vulnerable Adults	December 2023	26.07.23: Conversations have started with the Superintendent for partnerships re this. There are a number of key personnel changes within the Police and we have agreed to start work when the new staff are in post within the police. Currently we communicate or pick up on vulnerabilities with patients with the Police through the safeguarding police team who are able to provide information to us but also task other officers with specific actions where needed. 16.08.23: Update to be provided at the September Academy. 21.09.23: Meetings undertaken with YAS and Police. Police shared their protocols and ST will pull some information together for Trust staff, providing a copy to the Police and YAS. 19.10.23: ST advised that BTHFT is also involved in the districtwide Mental Health and Criminal Justice

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
						meetings which undertaking a piece of work titled 'Right Care / Right Person'.
QA23030	26.07.23	QA.7.23.9	**2022 Urgent and Emergency Care Survey - Pre-Publication Results** Paul Rice and the Informatics team to look in to the reasons for the screens not working in the Emergency Department, and to work with the Estates Department to find a solution.	Chief Digital and Information Officer	December 2023	27.09.23: PR gave an update advising that this work is ongoing. A further update to be provided at the October meeting. 19.10.23: Ian Scott, Head of Information Technology, advised that all screens will be replaced in 2023/2024.
QA23031	23.08.23	QA.8.23.6	**Quality Oversight and Assurance Profile** It was agreed that guidance would be developed to advise staff of what to do if an incident occurs on the Trust site. An update to be brought to the October meeting.	LB	Ongoing	27.09.23: There was a discussion regarding addressing one particular incident as a wider issue. It was noted that there is an investigation ongoing, the outcome of which will be brought back to a future meeting once the investigation has been concluded. It will then be decided whether guidance would be produced. 18.10.23: Emails exchanged between NED LB to NED KW regarding this action. KW advised that this can be picked up at the People Academy. 25.10.23: A meeting took place on 27 November between LB, KD, JC and Susan Franklin, Freedom to Speak Up Guardian. It was agreed that some work on Active Bystander education would support the work of

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
						the People Academy and the FSU guardians and is being taken forward by Karen Walker Chair of the PA. This action is now completed within the QPSA remit, but when relevant can be fed back. Action closed.

BO.1.24.30- CONFIRMED AUDIT COMMITTEE

REFERENCES

Only PDFs are attached

Bo.1.24.30 - Confirmed Audit Committee Minutes - 12.9.23.pdf

CONFIRMED AUDIT COMMITTEE MEETING MINUTES

Date	Tuesday, 12 September 2023	**Time**	14:00-17:00
Venue	Virtual Meeting – MS Teams	**Chair**	Barrie Senior, Non-Executive Director

Present	• Barrie Senior, Non-Executive Director and Chair (BAS) • Sughra Nazir, Non-Executive Director (SN)
In Attendance	• Matthew Horner, Director of Finance (MH) – joined the meeting at 14:49 • Michael Quinlan, Deputy Director of Finance (MQ) • Richard Maw, Counter Fraud, Audit Yorkshire (RM) • Paul Hewitson, Deloitte (PH) • Jonathan Hodgson, Internal Audit (JH) • Chris Boyne, Internal Audit (CB) • Karina Rodgers, Internal Audit (KR) • Laura Parsons, Associate Director of Corporate Governance/Board Secretary (LP) • Jacqui Maurice, Head of Corporate Governance (JM) • Faeem Lal. Interim Director of HR (FL) - Executive Director in attendance • Dr Paul Rice, Chief Digital & Information Officer (PR) for items A.9.23.20 & A.9.23.21 • Judith Connor, Associate Director of Quality (JC) for items A.9.23.23 & A.9.23.24 • Sue Franklin, Associate Chief Nurse for Quality Improvement\Freedom to Speak Up Guardian (SF) for item A.9.23.25 • Jo Hilton, Deputy Chief Nurse (JHi) for item A.9.23.25
Observer	• Raquel Licas, Staff Governor (RL)

No.	Agenda Item	Action
A.9.23.1	**Apologies for absence** • Julie Lawreniuk, Non-Executive Director • Jon Prashar, Non-Executive Director • Helen Higgs, Audit Yorkshire • Nick Rayner, Deloitte	
A.9.23.2	**Declarations of interest** No interests were declared.	
A.9.23.3	**Minutes of the meeting held 23 May, 22 June and 27 June 2023** The minutes were accepted as a fair representation of the meetings.	
A.9.23.4	**Matters arising** The Committee noted that the greyed-out items on the action log at Appendix 1 indicated those actions closed at the previous meeting. Regarding the actions due for consideration at this meeting, the following updates were provided, as shown on the action log: **<u>Open items discussed</u>** • **A23025 - Partnership arrangements: implications for the Audit**	

	Committee - JH noted that an update to the public sector internal audit standards is due imminently which will be shared once it is received. Item on hold pending the update which is due in 2024/25 - action to remain open. **Closed items – 23 May 2023** • **A22058 - Progress report on compliance with the 'Policy for the development and management of Trust policies'**. action closed. • **A23021 - Audit Committee Annual Self-Assessment** – item on the September agenda – action closed. • **A22028 – Third party assurance** –action closed. • **A23029 – Draft Annual Report 2022/23** – action closed. • **A23030 – Draft Annual Report 2022/23** - action closed. • **A23031 – Draft Annual Report 2022/23** - action closed. • **A23020 – Compliance with NHS Provider Licence and FT Code of Governance** - action closed. • **A23022 – Internal Audit progress report -** action closed. • **A23023 – Internal Audit progress report-** action closed. • **A23024 – Follow up of internal audit recommendations -** action closed. • **A23025 – Partnership arrangements: implications for the Audit Committee** - action closed. • **A23026 – Assurance: Key IT systems progress report update -** action closed. • **A23027 - Assurance: Key IT systems progress report update -** action closed. • **A23028 - Assurances regarding all relevant third parties that deliver key functions to the Trust -** action closed. **Closed items – 22 June 2023** • **A23032 – ISA 260 Foundation Trust –** action closed. • **A23033 - ISA 260 Foundation Trust –** action closed. • **A23034 – ISA 260 Foundation Trust –** action closed. • **A23035 – ISA 260 Foundation Trust –** action closed. • **A23036 – ISA 260 Foundation Trust –** action closed. • **A23037 – Final Annual Accounts 2022/23** – action closed • **A23038 – Draft letter of representation 2022/23-** action closed	
A.9.23.5	**Auditor's Annual Report 22/23 and Certificate of Completion** LP advised that the Audit Committee had received the Annual Report and Certificate of Completion previously by email. This is presented here for information. The Committee noted the paper.	
A.9.23.6	**Annual External Audit performance review** MQ provided an update on progress around the performance review. He advised that discussions had taken place with the internal annual accounts group to collect information. A meeting with external audit has been arranged for the 13 October where a formal review will take place, which would include lessons learnt and any additional works that need to take place to improve the process. The Committee noted the verbal update.	

A.9.23.7a **A.9.23.7b**	**Sector update and benchmarking report** PH stated that there is no sector update or benchmarking report as these reports are only available during the audit window. **ISA 260 – Response to Sector Development recommendations** LP provided an overview of the paper and progress to date on the recommendations. It was agreed that a further update on progress will be provided to the November 2023 meeting. Once the new UK Code of Corporate Governance is published a paper will be brought to a future meeting to discuss any potential implications. The Committee noted the report.	Board Secretary A23039 Board Secretary A23040
A.9.23.8	**Use of External Audit to provide non-audit services (standing item)** There was nothing to report on this item.	
A.9.23.9	**Annual Internal Audit performance review** MH stated that Internal Audit have produced a schedule of historic questions with some new additions and work is ongoing to automate the review to be sent out to Executive and Non-Executive colleagues for their feedback. A consolidated report will be provided to the November Audit meeting. The Committee noted the verbal update.	Board Secretary A23041
A.9.23.10	**Internal Audit Annual Report and Head of Audit Opinion 2022/23** JH provided an overview of the paper which covered the work undertaken by Internal Audit during 2022/23 and the Head of Internal Audit Opinion which was previously presented to the May and June Audit Committee meetings. The Committee noted the report and approved the Head of Internal Audit Opinion.	
A.9.23.11	**Internal Audit progress report 2023/24** JH highlighted the following key points within the report and the activity made regarding progress: • A good start to 2023/24 has been made to the plan with 132 days (24%) being utilised so far. • Five reports have been issued as final since the last meeting. Two have high assurance, two have significant assurance and one does not provide an opinion (Control Improvement Audit – advisory). • Three reports have been issues in draft; two have a significant assurance and one has a limited assurance opinion. JH noted that work will continue to finalise the Sepsis report as soon as possible. • Eight KPIs have been issued to date. Out of the five final reports there have been two that have exceeded the 15 working day management response deadline.	

	BAS queried the rationale for determining how a Control Improvement Audit (CIA) is implemented. JH stated that there is a protocol in place, in line with public sector internal audit standards, which gives an opportunity to offer consultancy advice if a risk or issue is drawn to the attention of Internal Audit. The aim is for it to be supportive and responsive to risks and issues within the organisation that arise if there is a new system or process to be developed or put in place. The scope of the audit is to look at the entirety of the systems and processes in place. The outcome is to develop a strong system and monitor the actions whilst allowing the organisation time to embed the system. A robust and effectively controlled system has been designed that is both effective from a control perspective and from an anti- fraud and corruption perspective. JH provided an overview of the management requests for changes to the 2023/24 plan which were due in part to operational pressures and the recent changes to Director portfolios. There had been three deferred items, two additions and one cancelled item. JH drew attention to the deferred items: **<u>Deferred items</u>** • Delayed Transfers of Care (DTOC) - defer to 2024/25 – there previously a requirement of NHSE to report against all delayed transfers. This has now been dropped for 2023/24. However, Internal Audit will continue to re-assess as part of the planning process in the coming months. As the Patient Flow audit received a high assurance opinion it was suggested that this isn't included as a key risk area at present. • Estates Strategy - defer to Q4 – due to the changes in Executive leadership this item will be deferred until a replacement Director of Estates and Facilities is in place. • VTE Assessments - defer to Q4 – deferred due to management staffing pressures and workload. Due to this deferment, it has allowed for the ReSPECT audit to be undertaken in its place. • Capital Assets and Charges - defer to Q3 – deferred due to management staffing pressures and workload. BAS suggested that an update is provided to the Audit Committee members of any changes made to the audit plan at the time of the change so that all are aware prior to the next Audit Committee meeting. BAS queried if there are sufficient controls and processes in place to prevent and detect fraud in the areas of financial transactions, payroll and procurement. MH confirmed that all Internal Audits undertaken in these areas are tested with rigour. MH felt that there was an opportunity to review the scope of the audit whilst it is in the planning stage and agreed to meet with internal audit. JH confirmed that management has adjusted well to the change in reporting format, and it makes the reading of the report much clearer. JH felt that the new style did not highlight the positives within the report as	Internal Audit A23042 Director of Finance A23043

	well as it used to, so a second iteration of the report is taking place shortly. SN queried whether the internal audit around Sepsis would include the issues around diagnosis and timely access to antibiotics. JH confirmed that it will include early diagnosis, remedial actions and also if there are sufficient resources in place. The Committee noted the report and the assurance provided.	
A.9.23.12	**Follow up of Internal Audit recommendations** BAS questioned whether there could be some changes made to the document in relation to the columns headed 'management response', 'rationale for delay' and 'the latest update'. He felt that these columns could be amalgamated to make this less onerous to complete and easier to follow up on actions. JH suggested incorporating the columns together and to call it 'latest update' which would include the rationale. JH highlighted that the outstanding recommendations have reduced from 27, at year end, to 12 to date. Those with a revised date have reduced from 15, at year end, to 10 to date. It was felt that clear focus and positive progress has been made and work with the management team will continue, to reduce the outstanding recommendations. The Committee noted the report and the assurance provided.	Internal Audit A23044
A.9.23.13	**Counter Fraud progress report** RM provided an overview of the report and drew attention to the following key points: • The appendix relating to Artificial Intelligence is a developing document which will continue to be monitored and updated via the action log. • A plan is in place relating to the risk assessments for standard 3 of the Counter Fraud Return. It is the aim to achieve green level in the next couple of years. SN queried if the correct safeguards were in place to mitigate staff members adding themselves to additional shifts on the E-rostering system referred to at page 2 of the report (INV/23/895). RM confirmed that once the case has concluded he would be able to provide further details on the outcome. He suggested that one recommendation might be to provide a quarterly review to monitor any changes or manipulations on the system. FL confirmed that it was normal practice, on conclusion of cases, to review the systems and processes to mitigate any risks or failures. BAS referred to page 3 of the report relating to Bribery and Contract Fraud allegations in Estates (INV/23/1015) and queried if this was progressing at a reasonable speed due to this potentially occurring over the last 4-5 years. RM confirmed that this was progressing with checks being made on the systems and processes in place but there was	

	potential that any bribery and corruption may have taken place off the record and outside of the systems we have in place. BAS queried whether HR had the appropriate processes in place to ensure that all issues, handed over by Local Counter Fraud Services (LCFS), are successfully dealt with. FL confirmed that each case is reviewed, with the appropriate HR manager, to assess if the case requires formal investigation and the disciplinary process. If it is deemed that there is an issue, with our systems and processes, conversations with line managers will take place to review their local processes and policies. The Committee noted the report and the assurance provided.	
A.9.23.14	**Exception reports: Schedule of losses and special payments and appropriateness of single source tenders** MQ provided an overview of the paper and confirmed that there have not been any reported breaches of SFIs or standing orders during Q1. A further update, on the overseas debt recovery, will be provided at the November meeting once the internal audit review has concluded. SN asked for further clarification on the figure relating to *'ex gratia payment relating to g. other for £11,779.05'.* MQ confirmed that this relates to the costs of a tribunal case and the compensation payment made to an individual. BAS queried the lack of financial signatories on page two of the waivers document. MQ confirmed that senior management from various departments sign the waivers along with Shahid Nazir, Head of Procurement. BAS queried the financial input specifically for waiver WT44-23 for £99.792 as he felt that this should have been reviewed and signed by a finance manager. MQ agreed to review in more detail the signatories for all waivers listed in the document and report back to the November meeting. The Committee noted the report and the assurance provided.	Deputy Director of Finance A23045 Deputy Director of Finance A23046
A.9.23.15	**Proposed changes to Standing Orders/Standing Financial Instructions/Scheme of Delegation (standing item)** LP stated that the Standings Orders for the Board of Directors are reviewed every two years. In the document presented there are some minor amendments made, shown in track changes, and the Audit Committee is asked for any comments before they are presented to the Board of Directors for approval. LP confirmed that we have not benchmarked our Standing Orders against other Trusts and confirmed that she would undertake this prior to the paper being presented at the September Board meeting. The Committee approved the proposed amendments.	Board Secretary A23047
A.9.23.16	**Trust compliance with Standing Orders, Standing Financial Instructions/Scheme of Delegation (standing item)**	

	There was nothing to report on this item.	

A.9.23.17	**Suspension of Standing Orders/Standing Financial Instructions (standing item)** There was nothing to report on this item.	
A.9.23.18	**Other assurance functions (standing item)** There was nothing to report on this item.	
A.9.23.19	**Partnership arrangements: implications for the Audit Committee** LP asked the committee to note that she continued to have regular meetings with her counterparts from other Trusts and from the Bradford District and Craven Partnership. There was however nothing to highlight to the committee at this time. LP confirmed that we are still awaiting the publication of the new HFMA Audit Committee handbook which was expected to take account of the new partnership arrangements and integrated working. The Committee noted the verbal update.	
A.9.23.20	**Assurance: Key IT systems progress report update** PR provided a verbal update on progress to date on the assurance regarding the IT systems that the organisation relies upon to deliver effective, efficient, high quality safe patient care via a variety of methods within an overall framework. He noted that the work on the key IT systems hasn't progressed as well as he had hoped, due to a number of reasons, although he felt that the list of those systems previously discussed would not alter. PR confirmed that he has been focussing on a couple of challenges relating to the new Laboratory Information Management System (LIMS) and the relationship with the supplier. Through the operational delivery of services several clinically significant concerns have arisen. This is now being discussed and managed with colleagues in Leeds who had been involved in the implementation of our system, albeit as a learning experience for them, prior to their own implementation. Due to the priority one escalations that have been raised they have decided not to go ahead with the WINPATH element until the issues have been resolved. In relation to Cerner, we are now in the current state validation stage of engagement with Airedale NHS FT (ANHSFT). Regular meetings with ANHSFT and Cerner are taking place to discuss the 'EPR go live' preparation. PR agreed to have further discussions with Internal Audit and Ellie MacIver, Deputy Director of Operations regarding the proposed framework. PR agreed to provide an updated report on the priority systems and processes to the November Audit Committee meeting.	Chief Digital & Information Officer A23048

	The Committee noted the verbal update.	

A.9.23.21	**Assurance: Data Quality** PR provided an overview on progress to date of aspects of key required data quality within the Trust. Discussion took place on the improvements made, the assurance gained from progress made, the forward plans detailed within the paper and, the ongoing Internal Audit taking place. BAS suggested PR attend the November Audit Committee meeting to provide a list of prioritisation hotspots and the scrutiny undertaken to evaluate these and progress made. PR agreed to include within the report any issues identified by Internal Audit. PR provided an overview of the paper and drew attention to the concerns specifically around the quality of data that has been captured in relation to waiting lists. Work with an external company had been undertaken to clean the data in the first instance. Internally, further data quality improvement roles had been implemented to work on the PREVENT side of data quality waiting lists which seem to be making improvements. He noted that NHSE have recently set the organisation a range of challenges in relation to waiting list management, strike action and elective recovery and this data quality document will form part of the portfolio of evidence sent to NHSE. JH confirmed that the internal audit on data quality was complete, and it highlighted that the work of the data quality team was robust. The difficulties lie with the system administration of downstream systems and the lack of oversight. SN asked for an update on cyber security in relation to resources. PR confirmed that the Annual Data Protection Officer Information Governance Report is due to be discussed at the 21 September Open Board. He provided an overview of the content of the paper and confirmed that discussion takes place regularly with the Data Protection Officer on resources. Benchmarking with other organisations takes place as a comparison. He confirmed that he informs Executive colleagues if he feels there is any risk to the organisation in relation to the structure of the team. The EPR programme at ANHSFT has allowed for an additional resource to the team with the aim of balancing the workload across both teams. The Committee noted the report and the assurance provided.	Chief Digital & Information Officer A23049
A.9.23.22	**Assurances regarding all relevant third parties that deliver key functions to the Trust** MQ referred to the three third party assurance reports relating to payroll, Shared Business Services and the Cerner service auditor review and progress to date. The Audit Committee noted in particular:	

	• An assurance report had been received from Shared Business Services and notes that the audit option relating to the systems controls are sufficient and in line with expectations. This action can now be closed. • The Bradford District Care Trust, which hosts the payroll arrangements, have decided not to conduct the payroll audit this financial year. The main reason being is that it had received significant or high assurance over the last five years. Therefore, there is no independent audit report for this financial year. • The digital team are currently waiting for the latest EPR Cerner assurance report and MQ suggested that once the report is available PR is invited to attend an Audit meeting to present the paper. This action to remain open. The Committee noted the paper and the assurance provided.	
A.9.23.23	**Assurance regarding compliance with Risk Management Strategy** Judith Connor (JC) joined the meeting and LP provided an overview of the paper and the role of the Audit Committee in reviewing the effectiveness of our risk management arrangements. LP provided assurance around the regular reporting taking place through the Executive team, the Academies and the Board around the high-level operational risks scoring 15 and above and the BAF. LP stated that a review of the format of the high-level risks report has been undertaken in the last few months and this is now aligned more closely with the reporting that is undertaken by the ICB and PLACE committees. She highlighted the changes to the report. The Audit Committee noted that the Executive team, in a separate session, reviewed several risks in more detail that had been on the register for a long time and had several changes made to the target dates. A yearly internal audit has been undertaken around the risk management framework which provided significant assurance and the recommendations have been implemented. JC confirmed that the CSU's had been restructured in September 2023 in line with the operational structure and each CSU has an aligned Quality and Patient Safety Facilitator and reports are available for each CSU for review at their monthly Quality & Patient Safety meetings. An internal audit on our governance framework has provided significant assurance. The Committee noted the paper and the assurance provided.	
A.9.23.24	**Clinical Audit High Priority workplan/Clinical Audit annual report** BAS queried if we only perform nationally mandated audits or are we doing all of the national audits that we should do and that are appropriate for us to do in the previous year. JC confirmed we do take part in all of the mandate national audits and	

	each clinical team also identifies their speciality clinical audit program for the year. Work is now taking place with the CSUs to identify their local audit programmes as well as the national audit programmes. A 'Moving to Outstanding' lead has been appointed who is working with the CSU's and the Specialties to ensure they have appropriate evidence against the key lines of enquiry and the new single assessment framework for the CQC. Our ambition is to be able to give real time feedback to Clinical teams so improvement work can be undertaken whilst waiting for the national audit reports to be circulated. It is hoped that once this is embedded, we shouldn't be in a position where we are reporting against outliers because the majority of the actions will be complete, and improvements will begin to be made. All teams are expected to report their improvement plans against the audits via the Clinical Outcomes Group meeting. A statement is also included within the Quality Account stating that we have taken part in all the national mandated audits and our position. BAS queried whether the Quality Governance Framework and the Accountability Framework has been embedded over the past year. JC confirmed that the internal audit against the Quality Governance Framework provided significant assurance, so it demonstrates that meetings are taking place and that there are standardised items on the agendas. She confirmed that work is ongoing with the CSUs to embed this, and significant progress had been made over the last 12 months. Work is ongoing with the Quality & Patient Safety facilitators, the Moving to Outstanding lead, the Clinical Audit leads within the specialties and the new specialist Chief Registrar to get back to a pre COVID position in relation to local audits. The local audit programme will be discussed via the Clinical Outcomes Group alongside the national audit programme. The Committee noted the report and the assurance provided.	
A.9.23.25	**Freedom to Speak Up annual report and Effectiveness of Whistleblowing/Freedom to Speak Up (FTSU) arrangements** Su Franklin (SF) and Jo Hilton (JHi) joined the meeting to provide an overview of the paper presented. SF stated that due to the confidentiality of the concerns raised much of the details/feedback cannot be shared. However, the Audit Committee noted that updates are reported in the quarterly reports on any investigations ongoing in certain areas. SN queried the lack of concerns raised within the Allied Health Professional (AHP) group and from that would we take assurance that things are reasonably good or is further work required to generate more transparency and feedback from those staff groups? SF stated that this could show that there are good systems in place and managers are listening to staff when concerns are raised. She added that the categories within the report are pre-determined nationally. SN stated that other organisations are looking at the rigour and robustness around investigations where colleagues raise concerns	

	around patient safety/never events such as the Lucy Letby incident. She queried whether we are being directed nationally or the organisation has internal plans in place to be confident in our own systems and processes. SF stated that the organisation is receiving guidance from NHSE and the National Guardians Office around the robustness and rigour of people raising patient safety concerns. At the last quarterly meeting with the Chair, Chief Executive, Non-Executive Director lead and the Executive lead for FTSU discussed the Lucy Letby case thoroughly. SN stated that it is imperative that all managers listen to concerns raised by staff and that the three modules from Health Education England, relating to FTSU, are circulated, and completed by staff. BAS questioned how the Trust is guarding against people being too frightened to speak up. JHi stated that we had to ensure open conversations are taking place with staff about how they are feeling, and we continue to be proactive and open with staff. FL stated that we need to ensure there are multiple channels for people to raise concerns alongside the FTSU channel. He felt that the more opportunities we provide to staff to raise matters - that will help to embed the culture of raising their concerns. The Committee noted the report and the assurance provided.	
A.9.23.26	**Conflicts of Interest annual report** LP provided an overview of the report and asked the Audit Committee to note that the declaration rate for this year, 1 April 2022 to 31 Marcy 2023, has slightly dropped to 95% from 98% in the previous year. This was expected as we are now capturing all staff on a band 8A and above this year rather than band 8D and above in previous years. We are benchmarking well against our peers across WYAAT which provides positive assurance. Work is ongoing to increase awareness, provide guidance and making it as easy and accessible for people to declare their interests. New guidance documents on how to use and access the system have been produced aimed at consultants, other decision makers, staff who are asked to approve declarations and all other staff. Regular communications via our staff newsletter will be sent to remind staff of the need to make timely declarations. The Committee noted the report and the assurance provided.	
A.9.23.27	**Draft Audit Committee Annual Report July 22 – June 23** The Committee took the paper as read and approved the report to Board.	
A.9.23.28	**Audit Committee Annual Self-Assessment (proposal)** The HFMA are producing an updated version of the Audit Committee handbook which will incorporate changes to the Health & Care Act. Therefore, BAS proposed, we should await the updated handbook due in late Autumn to assess any changes that may have an impact on our activities as an Audit Committee.	

	The Committee noted the verbal update.	
A.9.23.29	**Annual Review of Terms of Reference and submission to Board** The Committee reviewed and approved the changes proposed. The Committee approved the report to Board.	
A.9.23.30	**Any other business** There was no other business to report.	
A.9.23.31	**Matters to share with other committees** The Sepsis internal audit report to be discussed at F&P and QPS academies.	Board Secretary A23050
A.9.23.32	**Matters to escalate to the Risk Register** There were no matters identified to escalate to the high-level operational risk register.	
A.9.23.33	**Matters to escalate to the Board of Directors** There were no matters identified to escalate to the Board of Directors.	
A.9.23.34	**Items deferred to subsequent meetings** There were no items deferred to subsequent meetings.	
A.9.23.35	**Attendees for subsequent audit committee meeting** Paul Rice to provide additional reporting on Data Quality and IT Assurance at the November meeting.	
A.9.23.36	**Review of meeting** No comments were made regarding the review of the meeting.	
A.9.23.37	**Date and time of next virtual meetings:** 21 November 2023 2-5pm	

Action log from the Audit Committee Meeting held 12 September 2023

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
		Next number in sequence	**A23051**		
12.9.23	A.9.23.31	**Matters to share with other committees** The Sepsis internal audit report to be discussed at F&P and QPS academies.	**Board Secretary A23050**	November 2023	Shared at F&P and QPS Academies on 27 September 2023 – action closed
12.9.23	A.9.23.21	**Assurance: Data Quality** BAS suggested PR attend the November Audit Committee meeting to provide a list of prioritisation hotspots and the scrutiny undertaken to evaluate these and progress made. PR agreed to include within the report any issues identified by Internal Audit.	**Chief Digital & Information Officer A23049**	November 2023	Item added to November agenda– action closed
12.9.23	A.9.23.20	**Assurance: Key IT systems progress report update** PR agreed to have further discussions with Internal Audit, and Ellie MacIver, Deputy Director of Operations regarding the proposed framework. PR agreed to provide an updated report on the priority systems and processes to the November Audit Committee meeting.	**Chief Digital & Information Officer A23048**	November 2023	Item added to November agenda – action closed
12.9.23	A.9.23.15	**Proposed changes to Standing Orders/Standing Financial Instructions/Scheme of Delegation (standing item)** LP confirmed that we have not benchmarked our Standing Orders against other Trusts and confirmed that she would undertake this prior to the paper being presented at the September Board meeting.	**Board Secretary A23047**	November 2023	Review was undertaken prior to the September Board meeting. Our Standing Orders are in line with other Trusts and follow a standard template – action closed

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
12.9.23	A.9.23.14	**Exception reports: Schedule of losses and special payments and appropriateness of single source tenders** BAS queried the financial input specifically for waiver WT44-23 for £99.792 as he felt that this should have been reviewed and signed by a finance manager. MQ agreed to review in more detail the signatories for all waivers listed in the document and report back to the November meeting.	**Deputy Director of Finance A23046**	November 2023	Item added to November agenda – action closed
12.9.23	A.9.23.14	**Exception reports: Schedule of losses and special payments and appropriateness of single source tenders** A further update, on the overseas debt recovery, will be provided at the November meeting once the internal audit review has concluded.	**Deputy Director of Finance A23045**	November 2023	Item added to November agenda – action closed
12.9.23	A.9.23.12	**Follow up of Internal Audit recommendations** BAS questioned whether there could be some changes made to the document in relation to the columns headed 'management response', 'rationale for delay' and 'the latest update'. He felt that these columns could be amalgamated to make this less onerous to complete and easier to follow up on actions. JH suggested incorporating the columns together and to call it 'latest update' which would include the rationale.	**Internal Audit A23044**	November 2023	Email send to BAS on 16.10.23 – action closed
12.9.23	A.9.23.11	**Internal Audit Progress report 2023/24** BAS queried if we have sufficient controls and processes in place to prevent and detect fraud in the areas of financial transactions, payroll and procurement. MH confirmed that all Internal Audits undertaken in these areas are tested with rigour. MH	**Director of Finance A23043**	November 2023	Fraud prevention and detection will be considered and agreed with internal Audit when establishing the audit brief for Financial Transactions, Payroll, Procurement and other relevant audits - action closed

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
		felt that there was an opportunity to review the scope of the audit whilst it is in the planning stage and agreed to meet with Internal Audit.			
12.9.23	A.9.23.11	**Internal Audit Progress report 2023/24** BAS suggested that an update is provided to the Audit Committee members of any changes made to the audit plan at the time of the change so that all are aware prior to the next Audit Committee meeting.	**Internal Audit A23042**	November 2023	Agreed – action closed
12.9.23	A.9.23.9	**Annual Internal Audit performance review** MH noted that Internal Audit have produced a schedule of historic questions with some new additions and work is ongoing to automate the review to be sent out to Executive and Non-Executive colleagues for their feedback. A consolidated report will be provided to the November Audit meeting.	**Board Secretary A23041**	November 2023	Item added to November agenda – action closed
7.2.23	A.2.23.18	**Proposed changes to Scheme of Delegation/Standing Financial Instructions (standing item)** MH suggested he report back to the November 2023 meeting with the schedule of approvals that have taken place at the upper end of the threshold limit for comparison and assurance.	**Director of Finance A23009**	November 2023	Added to November agenda – action closed
7.2.23	A.2.23.10	**BH132023 Improving Financial Sustainability internal audit report** JH noted that in relation to the Financial Sustainability report we are required to follow up on the actions but are awaiting timeframes from NHSE/I. The audit will be included in the 2023/24 plan with a report to the AC in November 2023.	**Internal Audit A23002**	November 2023	Added to November agenda – action closed JH noted that in relation to the Financial Sustainability report we are required to follow up on the actions but are awaiting timeframes from NHSE/I. The audit will be included in the 2023/24 plan with a report to the AC in November 2023. As of yet we haven't been notified that a follow up on the actions is

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
					required. We have received confirmation from Chris Smith that the one recommendation in our Internal Audit report has been completed. To provide a verbal update to the AC in November.
12.9.23	A.9.23.7b	**ISA 260 – Response to Sector Development recommendations** Once the new UK Code of Corporate Governance is published a paper will be brought to a future meeting to discuss any potential implications	**Board Secretary A23040**	February 2024	Item deferred to February 2024 meeting as UK Code of Corporate Governance has not yet been published – action to remain open
12.9.23	A.9.23.7b	**ISA 260 – Response to Sector Development recommendations** LP gave an overview of the paper and progress to date on the recommendations. It was agreed that a further update on progress will be provided to the November 2023 meeting.	**Board Secretary A23039**	February 2024	Item deferred to February 2024 meeting – action to remain open
7.2.23	A.2.23.12	**Internal Audit Effectiveness Review** MH suggested re-running the questionnaire early next year to address if the issues highlighted have improved to report back to the AC in November 2024	**Director of Finance A23003**	November 2024	
23.5.23	A.5.23.22	**Partnership arrangements: implications for the Audit Committee** JH noted that an update to the public sector internal audit standards is due imminently which will be shared once it is received.	**Internal Audit A23025**	2024/25	12.9.23 – item on hold pending the update which is due in 2024/25 – action to remain open. Awaiting the publication of the standards. Once issued they will be shared with the Committee – action to remain open

Appendix 1

Actions closed at the meeting of the audit committee held 12 September 2023

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
11.10.22	A.10.22.25	**Progress report on compliance with the 'Policy for the development and management of Trust policies'**. LP suggested including within the imminent policy management audit a section relating to the steps that are taken to understand whether colleagues have read the policies relevant to their role. This would be included as part of the brief.	**Board Secretary A22058**	September 2023	12.9.23 - Internal audit is taking place around our policy management and that has high assurance and is included in the internal audit progress report. The annual audit of policies is underway at present. It was noted that policies are reviewed as part of other internal audits that take place. action closed. 23.5.23 - BAF audit currently underway. Internal audit for policies will then be undertaken and will include a focus on the procedures in place to check that staff have access to new or revised policies and that policies are complied with. To be discussed when the policy audit brief is agreed. The start of this audit has been delayed until the BAF audit is complete. A policy audit planning meeting has been arranged for early May – action to remain open
18.4.23	A.4.23.31	**Audit Committee Annual Self-Assessment** A revised version of the handbook is due to be published and a re-assessment will take place in due course. An update will be presented at a future AC meeting.	**Board Secretary A23021**	September 2023	2.8.23 - New version of handbook not yet available – item on September agenda - action closed
24.5.22	A.5.22.24	**Third party assurance.** BAS requested that once the information is received from EPR this is forwarded via email to the Chief Digital & Information Officer.	**Deputy Director of Finance A22028**	October 2022	12.9.23 – item on September agenda – action closed 23.5.23 – further discussion will take place with

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
					PR on the issue of IT systems assurance and the Cerner service auditor report forms part of that - action to remain open 11.10.22 – awaiting report - action to remain open 26.7.22 – action to remain open
23.5.23	A.5.23.26	**Draft annual report 2022/23** Page 50 shows Altaf Sadique term ends 31st November 2023. This should read 30th November 2023	**Board Secretary A23029**	June 2023	Updates complete – action closed
23.5.23	A.5.23.26	**Draft annual report 2022/23** JL remuneration relating to payment for the Partnership Board, which should be reimbursed by the ICB, to be reviewed by MH to identify the appropriate way to report it	**Director of Finance A23030**	June 2023	Updates complete – action closed
23.5.23	A.5.23.26	**Draft annual report 2022/23** JL profile information to be updated to include her membership of the Partnership Board.	**Board Secretary A23031**	June 2023	Updates complete – action closed
18.4.23	A.4.23.30	**Compliance with NHS Provider Licence and FT Code of Governance** The declaration relating to our corporate governance arrangements will be brought back to the June AC because of the interdependencies with the Annual Governance Statement and the Annual Report and we do not have the required information yet	**Board Secretary A23020**	June 2023	Updates complete – action closed
23.5.23	A.5.23.9	**Internal audit progress report** JH agreed to circulate the internal audit reports to members as and when available.	**Internal Audit A23022**	September 2023	Reports included in year-end papers – action closed

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
23.5.23	A.5.23.9	**Internal audit progress report** JH also agreed to provide an updated internal audit progress report for year-end highlighting the changes made since the last report	**Internal Audit A23023**	September 2023	Reports included in year-end papers – action closed
23.5.23	A.5.23.10	**Follow up of internal audit recommendations** MH agreed to re-iterate, with the executive team at a future ETM, the requirement to provide updates on any blank areas within the report particularly the progress commentaries and rationale.	**Director of Finance A23024**	September 2023	Action complete – action closed
23.5.23	A.5.23.23	**Assurance: Key IT systems progress report update** PR agreed to map out a plan of action, with input from internal audit, to provide the Audit Committee, at appropriate stages, an analysis assurance statement on our key IT systems	**Chief Digital & Information Officer A23026**	September 2023	Item added to September agenda – action closed
23.5.23	A.5.23.25	**Assurances regarding all relevant third parties that deliver key functions to the Trust** All three assurance reports will be brought to the September AC meeting for further discussion.	**Assistant Director of Finance A23027**	September 2023	Item added to September agenda – action closed
23.5.23	A.5.23.25	**Assurances regarding all relevant third parties that deliver key functions to the Trust** LP noted that she had reviewed the ESR auditor report as part of the Annual Governance Statement and this had received a qualified opinion but this is being reviewed by the relevant team. LP agreed to forward a copy of the document to MQ	**Board Secretary A23028**	September 2023	Completed – action closed
22.6.23	A.6.23.5	**ISA 260 – Foundation Trust** It was agreed that the wording, relating to vesting certificates, would be expanded upon within the Letter of Representation and the AC would then build on the	**Deloitte A23032**	June 2023	Wording updated – action closed

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
		recommendations made in the ISA 260 in future years. The ISA 260 will be updated to ensure it reflects with the wording added to the Letter of Representation.			
22.6.23	A.6.23.5	**ISA 260 – Foundation Trust** Special Payments and non-contractual payments to staff – A disclosure relating to the payments needs adding to update the position to date	**Deloitte A23033**	June 2023	Update complete – action closed
22.6.23	A.6.23.5	**ISA 260 – Foundation Trust** It was agreed that an extraordinary Audit Committee meeting should be scheduled on 27 June at 3.30pm, prior to the Board meeting, to ensure the Committee has a view of the ISA 260 before the Board. It was further noted that there may be a need to make a recommendation to the Board for delegated authority for approval and sign off of key documents, if the ISA260 remained in draft form.	**Board Secretary A23034**	June 2023	Meeting arrange for 27 June – action closed
22.6.23	A.6.23.5	**ISA 260 – Foundation Trust** PH agreed to provide the updated ISA 260, with track changes, by the morning of 27 June for review by the extraordinary AC.	**Deloitte A23035**	June 2023	Updates provided – action closed
22.6.23	A.6.23.5	**ISA 260 – Foundation Trust** BAS suggested adding an agenda item to the September AC meeting to consider how we respond to the Sector Development recommendations at pages 28 to 36. LP agreed to add to the work plan.	**Board Secretary A23036**	September 2023	Added to the September AC meeting agenda - action closed
22.6.23	A.6.23.6	**Final Annual Accounts 2022/23** JL stated that following on from the analytical review meeting it would be helpful to understand more going forward, on the administration and estates section (to include headcount, productivity and proportions of	**Board Secretary A23037**	September 2023	Item to be scheduled at a F&P Academy meeting

Meeting date	Agenda reference	Agenda item	Lead	Review date	Comments/update
		administrative and estates staff). This was not something to consider today however it might be more appropriate to schedule this at the Finance and Performance Academy. The Committee agreed			
22.6.23	A.6.23.7	**Draft Letter of Representation 2022/23** The Letter of Representation will be updated to including reference to vesting certificates discussed previously at A.6.23.5. PH agreed to remove the reference to shareholders meetings at point 21 and to update the Companies Act reference to the GAM reference. A tracked changes version will be provided to the extraordinary AC meeting on 27 June.	**Deloitte A23038**	June 2023	Updates actioned – action closed